Final Recommendations on Update Factors for FY 2016

Health Services Cost Review Commission
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May 13, 2015

This document contains the approved final Staff recommendations for the Update Factors for FY 2016.

Final Recommendations on Update Factors

INTRODUCTION

Overview

On July 1 of each year, the HSCRC updates hospitals' rates and approved revenues to account for inflation, policy adjustments, and other adjustments related to performance and settlements from the prior year.

On January 10, 2014, the Center for Medicare & Medicaid Innovation (CMMI) approved the implementation of a new All-Payer Model for Maryland. The All-Payer Model has a three part aim of promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita. The Model establishes both an All-Payer limit of 3.58% cumulative annual per capita growth for Maryland residents for the first three years of the Model and a Medicare savings target of $330 million over the initial five-year period of the Model.

The update process needs to take into account all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents in order to meet the requirements of the All-Payer Model and assure that the annual update approved by the HSCRC will not result in a revenue increase beyond the limit. In addition, HSCRC needs to consider the effect of the update on the Model's Medicare savings requirement and the total hospital revenue at risk for quality, care delivery, and value enhancement. While rates and global budgets are approved on a fiscal year basis, the All-Payer Model revenue limits and the Medicare savings are determined on a calendar year basis. Therefore, it is necessary to account for both calendar year and fiscal year revenues in establishing updates for the fiscal year.

There are three categories of hospital revenue under the All-Payer Model. The first two categories are under full rate setting authority of HSCRC. The third category of hospital revenue includes hospitals where HSCRC sets rates, but Medicare does not pay on the basis of those rates. The three categories are:

1. Hospitals/revenues under global budgets, including the Global Budget Revenue (GBR) agreements and Total Patient Revenue (TPR) agreements for 10 hospitals that were renewed July 1, 2013 for their second three-year term.
2. Hospital revenues that are not included under global budgets but are subject to rate regulation on an All-Payer basis by HSCRC, including hospital revenues excluded from a

global budget, such as revenues for non-residents at certain hospitals and the start-up years for Holy Cross Germantown Hospital.

3. Hospital revenues for which HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMMI has not waived Medicare's rate setting authority to Maryland. This includes psychiatric hospitals and Mount Washington Pediatric Hospital.

This report includes final recommendations for FY 2016 updates.

STAKEHOLDER INPUT

The Payment Models work group provided staff with input on the draft FY 2016 update recommendations. Staff also received and reviewed written comments on the draft recommendations from CareFirst, the Maryland Hospital Association, the coalition of the TPR hospitals, and the Maryland Medicaid Program.

The Maryland Hospital Association expressed support for the recommendations with two proposed modifications:

- Revision of the proposed update for psychiatric hospitals and Mt. Washington Pediatric Hospital from 1.9 percent to 2.3 percent.
- Reconsideration of the amount set-aside for competitive grants after the commission has an opportunity to review the comprehensive care coordination plans that are due December 1, 2015.

CareFirst opposed the allocation of any additional funding to infrastructure investments given the recent favorable financial performance of Maryland hospitals and the opportunities to generate savings presented by global budgets. Both Care First and Maryland Medicaid recommended that the Commission carefully evaluate and monitor each hospital's use of any additional infrastructure funding. Specific suggestions included:

- More frequent reporting on the programs and activities funded with additional infrastructure dollars.
- Ensuring that at least a portion of the infrastructure dollars fund creation of common State-level infrastructure.
- Allocating funding based on achievement of specific milestones.
- Expecting and obtaining a return on investment in infrastructure in future updates. Monitoring the performance of hospitals in terms of reductions in avoidable readmissions and avoidable utilization.

All of the written comments received are enclosed in Appendix 3.

ANALYSIS

Calculation of Update Factors for Revenue Categories 1-3

In this final recommendation, we are focused on recommending the update factor that will be provided for inflation/trend for hospitals or revenues in each of the three categories. There are separate staff reports that provide recommendations on uncompensated care (approved by Commission in May) and shared savings relative to readmissions. The Commission was briefed at its April 15th meeting on a FY 2016 global contract adjustment to capture the ongoing impact of the Affordable Care Act's Medicaid expansion on hospital volumes.

The inflation/trend adjustment for Category 1 and Category 2 revenues starts by using the actual blended statistic of 2.40% growth, derived from combining 91.2% of Global Insight's FY 2016 market basket growth of 2.5% with 8.8% of the capital growth estimate of 1.4%. For those revenues that are not subject to global budgets, subtractions are made to reflect productivity and an additional reduction provided under the Affordable Care Act for Medicare. The 0.6% reduction for productivity is equivalent to the amount used in Medicare's proposed inpatient prospective payment system update for FY 2016, but Medicare makes other adjustments (e.g. -0.8% for coding) that have not been applied. As a result, the proposed rate adjustment would be as follows:

Table 1

	Global Revenues	Non-Global Revenues
Proposed base update	2.40%	2.40%
Productivity adjustment		-0.60%
ACA adjustment		-0.20%
Proposed update	2.40%	1.60%

For psychiatric hospitals and Mt. Washington Pediatric Hospital, we turn to the proposed psychiatric facility update for Medicare. Medicare applies a 0.6% reduction for productivity and 0.2% reduction for ACA savings mandates to a market basket update of 2.7% to derive a net amount of 1.9%. HSCRC staff initially proposed adopting the same factor and net adjustments for the Maryland psychiatric hospitals and Mt. Washington Pediatric Hospital. MHA argued that the Commission should also adjust for the 0.4% wage index budget-neutrality adjustment that

Medicare is making to its per diem rates. Staff do not recommend incorporating the budget-neutrality adjustment into Maryland's calculation. The adjustment does not reflect changes in underlying costs and there are other adjustments to the Medicare update (such as a decrease in payments for outlier patients) that depress the rate of payment growth. Recognizing that the specialty hospitals have an important role to play in reducing readmissions and other forms of avoidable utilization, staff recommend a 0.30% infrastructure adjustment for the specialty hospitals effective July 1, 2015. Specialty hospitals receiving the infrastructure funding will be required to:

- Submit a plan for enhancing care coordination and reducing avoidable utilization to the Commission by December 1, 2015; and

- Begin submitting admission and discharge data to CRISP no later than July 1, 2016 to facilitate monitoring of readmissions.

Summary of Other Policies Impacting FY 2016 Revenues

The update factor is just one component of the adjustments to hospital global budgets for FY 2016. In considering the system-wide update for the All-Payer Model, staff sought balance amongst the following conditions: 1) meeting requirements of the All-Payer Model agreement; 2) providing hospitals with the necessary resources to keep pace with changes in inflation and population; 3) ensuring hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the All-Payer model; 4) taking into account factors outside of the Model such as the Medicaid coverage expansion under the Affordable Care Act (ACA).

Table 2 summarizes the net impact on global revenues of staff proposals for inflation, volume, shared savings, infrastructure investments, uncompensated care, and the MHIP assessment. To facilitate an understanding of what the update means for hospitals and payers, adjustments are grouped into three categories:

- **Proposed revenue adjustments linked to hospital cost drivers and performance.** This category is the best representation of the underlying new revenue available to hospitals to cover growth in costs and invest in improving care, improving health, and lowering cost. Inflation, volume, and infrastructure investments are included in this category along with shared savings and quality incentives. These adjustments provide hospitals with net revenue growth of 4.10% and per capita growth of 3.51%. An example of infrastructure includes care coordination resources for patients with complex needs and extensive chronic conditions.

- **Revenues adjustments that may not materialize.** A 0.5% placeholder is proposed for unforeseen adjustments. These funds may not all be allocated in FY 2016. If the funds are allocated, the gross revenue allocated to hospitals will rise to from 4.10% to 4.60%.

- **Revenue Reductions with neutral impact on hospital financial statements.** The decline in uncompensated care and the elimination of the MHIP assessment are included in this category. These items constrain the growth in hospital revenues and provide rate relief to payers without adversely impacting the hospitals. The hospital revenue reduction for the MHIP assessment is offset by hospitals' being relieved from paying the assessment. The decline in revenue for uncompensated care funding is based on an expected reduction in hospitals' uncompensated care levels, fueled by Medicaid payments for patients who were previously uninsured or underinsured. These two items reduce gross hospital revenue by a combined 1.41%.

The net recommended revenue growth combining the three categories is 3.19% with per capita growth of 2.61%. A more detailed summary of the adjustments is provided in Appendix 2. Descriptions and policy considerations are discussed for each step in the text below.

Table 2
Summary of Balanced Update Model

		Revenue Adjustments	Per Capita Adjustments
Revenue Adjustments Linked to Hospital Cost Drivers/Performance			
Inflation	A	2.40%	
Volume (population growth)	B	0.57%	
Medicaid Expansion - Ongoing Utilization Growth	C	0.38%	
Infrastructure (includes up to 0.25% for competitive grants)	D	0.59%	
Opening of Holy Cross Germantown Hospital	E	0.21%	
Shared Savings (net adjustment)	F	-0.20%	
Quality Incentive Payments	G	0.15%	
Planned Revenue Increase for Hospitals	**H= Sum of A thru G**	**4.10%**	**3.51%**
Reserve for Unforeseen Adjustments	I	0.50%	
Revenue Increase for Hospitals if All Reserves are Allocated	**J = H + I**	**4.60%**	**4.00%**
Adjustments with Neutral Impact on Hospital Financial Statements			
MHIP Assessment: Funds removed from rates; hospitals relieved from paying assessment	K	-0.57%	
Uncompensated Care: Amount in rates reduced; decline in rates offset by Medicaid payments for previously uninsured/underinsured patients	L	-0.84%	
Total Allowed Revenue Growth	**M = J + K + L**	**3.19%**	**2.61%**

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

A number of factors linked to hospital costs and performance are accounted for including:

- **Adjustments for Volume:** A 0.57% adjustment is recommended equal to the Maryland Department of Planning's estimate of population growth. Hospital specific adjustments will vary based on changes in the demographics of each hospital's service area. The net cost of market share and transfer policy adjustments will be absorbed within this volume allowance. Growth in revenue associated with unique (categorical exclusions) volumes such as transplants will also be funded from the 0.57% adjustment.

- **Impact of Medicaid Expansion:** As discussed in the staff's April report to the Commission, enrollees in the Affordable Care Act's Medicaid expansion are using more hospital services than they did prior to the expansion. Much of the increase reflects a temporary surge in demand for surgical procedures. The ongoing portion of the utilization uptick, after applying a 50% variable cost factor, is about $60 million

- **Infrastructure Adjustments:** Infrastructure adjustments of 0.325% in FY 2014 and an additional 0.325% in FY 2015 were included in global budgets to enable the successful transition to the new model. These adjustments recognized the need for investments in care management, population health improvement, and other requirements of global models. Successful care management and population health efforts will require hospitals to maintain and enhance their investments in addressing needs of complex patients, improving and coordinating care for individuals with chronic conditions, integrating and coordinating care with other hospital and non-hospital providers, and investing in IT, analytics, human resources, training, and alignment models to support these efforts. Recognizing the substantial scaling of infrastructure required, staff propose an additional 0.4% infrastructure investment in all GBR hospitals for FY 2016 No additional infrastructure funding is proposed for TPR hospitals. Generally, TPR hospitals were provided forward funding incentives considerably higher than the .65% infrastructure initially provided to GBR hospitals [1]. CareFirst opposes the provision of additional infrastructure funding arguing infrastructure needs should be funded out of savings generated by the hospitals. Well designed strategies should generate significant care improvements, health improvements, and returns on investment over time. Significant ongoing investments, however, are required in the near term to accelerate implementation of care coordination and provider alignment strategies and provide for sustainability for

[1] Garrett Hospital was not provided an incentive funding amount, and should be provided infrastructure allowances consistent with GBR hospitals.

Maryland hospitals under the All Payer Model as well as continuing preparation for an enhanced focus on total cost of care for all payers.

Hospitals should expect to spend a small portion of the new infrastructure funding to expand and enhance CRISP's ability to facilitate care coordination through the collection and sharing of data. A budget for CRISP's FY 2016 activities will be presented to the Commission at a future meeting.

Staff propose providing up to an additional 0.25% for competitive grants to hospitals to fund implementation of innovative care coordination, provider alignment, and population health strategies. All hospitals – including TPR and specialty hospitals – are eligible to compete for the funds. Grant proposals would be due December 1, 2015 with awards in January 2016 (Despite the mid-year award date, the amount of funding available for awards will amount to a full year of 0.25% to provide adequate seed money to launch each initiative). The amount of the grant awards would be a permanent 0.25% adjustment to hospital rates.

The performance requirements of the All-Payer Model contract necessitate the wise investment of infrastructure dollars in FY 2016 and future years. To provide the Commission with assurances that each hospital is engaged in the long-term success of the Model Contract, staff recommends that the Commission require each acute care hospital, including GBR, TPR, and other hospitals, to submit a plan by December 1, 2015 summarizing their short-term and long-term strategies and incremental investment plans for improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with non-hospital providers. These reports are important to understand the plans and strategies of hospitals under the new All Payer model, as well as to facilitate planning for continued development and focus on total cost of care. Continued receipt of the new FY 2016 infrastructure funding for GBR hospitals is contingent upon submission of a comprehensive plan. TPR hospitals have been provided the same inflation funding provided to GBR hospitals and were previously provided incentive funding. HSCRC has similar expectations of TPR hospitals and anticipates that TPR hospitals will focus on developing innovative approaches beyond the walls of hospitals to improve care delivery and population health.

Once the investment plans are received, aggregated and evaluated, the Commission will be in a better position to assess future needs, investment requirements, expected return on investment, etc. Both the Maryland Medicaid Program and CareFirst have recommended enhanced monitoring and evaluation of infrastructure investments. Staff agrees that the Commission must carefully monitor the use of the additional infrastructure funding and hold hospitals accountable for their investments. In addition to requiring the strategic

plan and continuing the annual infrastructure spending reporting requirement, staff intend to:

- Require hospitals to identify in their strategic plans specific process and quality measures that they will include in their annual infrastructure spending report. Staff also expect to collect data and monitor performance on outcome and process measures that pertain to all hospitals such as PAU spending and patients identified as in need of care coordination who have been assigned to a coordinator.

- Seek returns on investment for patients and payers in future updates by continuing and enhancing the shared savings program that provides for savings for expected reductions in potentially avoidable utilization;

- Engage consultants to assist HSCRC and DHMH staff in developing a plan template to guide hospitals' submissions, to assist in the review and evaluation of hospitals' strategic plans, to develop a learning collaborative together with the Maryland Hospital Association and other stakeholder organizations, and as necessary to provide technical assistance to hospitals with in developing plans;

- Evaluate the benefits of converting the annual infrastructure spending report to a biannual report and modifying the report to align with the strategic plans.

- **Certificate of Need (CON) Adjustments:** Holy Cross Germantown Hospital opened in the Fall of 2014. The FY 2016 increase annualizes last year's adjustment.

- **Other Adjustments:**

  - **Set-Aside for Unforeseen Adjustments:** Staff recommends a 0.5% set-aside to fund unforeseen adjustments during the year. A similar allowance was made for FY 2015.

  - **Reversal of Prior Year's Shared Savings Reduction:** The total FY 2015 shared savings adjustment is restored to the base for FY 2016, with a new adjustment (see below) to reflect the shared savings reduction for FY 2016.

  - **Shared Savings Reduction and Negative Scaling Adjustment:** The FY 2015 shared savings are continued and an additional 0.2% savings is targeted for FY 2016. A separate recommendation on this item will be made for the Commission's consideration.

- **Positive Incentives:** Positive incentives of 0.15% are expected to be paid in FY 2016 for performance on readmission and other quality metrics.

Components of revenue change with Neutral Impact on Hospital Bottom Lines

Several changes will decrease the revenues for FY 2016. These include:

a) **UCC Reductions:** The FY 2016 policy is the subject of a separate recommendation to the Commission. The Commission voted to approve the policy at its May 2015 meeting.

b) **MHIP/BRFA Adjustment:** The General Assembly's FY 2016 budget actions assume a zero assessment for the fiscal year. The FY 2015 assessment was 1% for the first quarter and 0.3% for the remainder of the year. This item also includes the removal of $15 million in one-time funding for care coordination and regional planning that was authorized in the Budget Reconciliation of Financing Act (BRFA) of 2014.

While Table 2 enumerates the central provisions leading to a balanced update for All-Payer Model overall, there are additional variables to consider such as one-time adjustments, as well as revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

Medicare's Proposed National Rate Update for FY 2016

Proposed updates to federal Medicare inpatient rates for 2016 have just been published in the Federal Register and are presented in the table below. The update will not be finalized for several months and could change. The base update provides growth of 1.1%, about half the 2.4% inflation/trend update proposed by the HSCRC. Additional adjustments including value based purchasing, hospital acquired conditions, readmissions, and the Disproportionate Share Hospitals reduce the expected growth in payments to 0.3%. These CMS projections do not include a provision for volume changes.

Table 3

Federal FY 2016	Proposed IP	Estimated OP based on IP
Base Update		
Market Basket	2.70%	
Productivity	-0.60%	
ACA	-0.20%	
Coding	-0.80%	N/A
	1.10%	1.90%
Other Changes		
Disproportionate Share	-1.00%	
Other Adjustments	0.20%	
	-0.80%	
Net Change to Payments	**0.30%**	

Applying the inpatient assum ptions about m arket basket, productivity, and m andatory ACA savings to outpatient, staff esti mate a 1.9% Me dicare outpatient update effective January 2016. The estimated blended inpatient/outpatient Medicare increase for 2016 updates is about 0.7%.

Discussion of FY 2016 Balanced Update

The staff pr oposal properly increases the resources available to hospitals to account for rising inflation and upward pressure on volum es from population grow th and the ACA expansion. Almost $100 million of the new funding is included for the development of the care coordination and population health in frastructure necessary fo r continu ed success. Th is new funding brings the total ongoing comm itment for infrastructure over the period FY 2014 to FY 2016 to about $180 million for GBR hospitals - - an am ount approaching the ongo ing operating costs that th e consultants supporting the care coordination w orkgroup pegged as an estim ated level to fund care coordination across the State.

The proposed adjustm ents coupled with the on going incentives to redu ce potentially avoidable utilization inherent to the model should allow the hospital industry to make significant additional investments while maintaining operating profits. Median operating profits year-to-date are about 3.5% with statewide profits at 2.8%. As discussed below, the proposed update is also within the financial parameters of the All-Payer agreement.

All-Payer Financial Test

The proposed balanced update keeps Maryland within the constraints of the model's All-Payer revenue test. Maryland's agreement with CMS caps the average annual growth rate for All-Payer per capita revenues for Maryland residents at 3.58%. Compliance with this test is measured by comparing the cumulative growth in revenues from the calendar 2013 base period to a ceiling calculated assuming annual per capita growth of 3.58%. This concept is illustrated in Table 4 below. As shown in the table, the maximum cumulative growth allowed through calendar 2016 is 11.13%.

Table 4
Calculation of Cumulative Allowable Growth
Per Capita All-Payer Revenues for Maryland Residents

	CY 14	CY 15	CY 16	Cumulative Growth
	A	B	C	D = (1+A)*(1+B)*(1+C)
Calculation of Revenue Cap	3.58%	3.58%	3.58%	11.13%

For the purpose of evaluating impact of the recommended update factor on compliance with the All-Payer test, staff have calculated the maximum cumulative growth that is allowable through the end of FY 2016 (the first 30 months of the waiver). As shown in Table 5, cumulative growth of 9.21% growth is permitted though FY 2016. Staff project actual cumulative growth through FY 2016 of 5.24%. This estimate reflects:

- Actual CY 2014 experience;
- The assumption that hospitals will use the full charge capacity available through their global budgets for the final six months of FY 2015 (January to June 2015); and
- The staff recommended update for FY 2016.

A decline in both uncompensated care and the MHIP assessment in FY 2015 and again in FY 2016 contribute to the magnitude of the gap between the maximum allowable cumulative growth and the projected growth. If not for these declines, per capita charges would grow by a cumulative 7.91% through FY 2016. Under either approach, the proposed update keeps Maryland within the limits of the All-Payer test.

Table 5
Proposed Update Leaves Maryland in Compliance with All-Payer Test Per Capita All-Payer Revenues for Maryland Residents

	A Actual Jan to June 2014	B Staff Est. FY 2015	C Proposed FY 2016	D=(1+A)*(1+B)*(1+C) Cumulative Thru FY 2016
Maximum Per Capita Revenue Growth Allowance	**1.79%***	**3.58%**	**3.58%**	**9.21%**
Per Capita Growth for Period	0.57%**	1.99%	2.61%	5.24%
Savings from Uncompensated Care & MHIP declines that do not adversely Impact Hospital Bottom Line		1.09%	1.41%	2.52%
Per Capita Growth with UCC/MHIP Savings Removed	**0.57%**	**3.07%**	**4.00%**	**7.80%**
Per Capita Difference Between Cap & Projection				**1.41%**

*3.58% annual growth divided by 2 to capture half year.
**1.13% growth divided by 2 to capture half year

Medicare Financial Test

The second key financial test under the model is to generate $330 million of Medicare fee-for-service savings over five years. The savings figure for the five-year period was calculated assuming Medicare fee-for-service costs per Maryland beneficiary would grow about 0.5% per year slower than national per beneficiary Medicare fee-for-service costs after the first year..

Preliminary calendar 2014 data currently under review by HSCRC contractors show a gap of nearly two percentage points between the Maryland (-1.5%) and national (+0.5%) per capita growth rates. If these numbers are correct, Maryland savings will exceed $100 million in year one of the model. While the first year savings are favorable, staff recommend maintaining the model contract goal of growing Maryland costs per beneficiary about 0.5% slower than the nation in FY 2016. Attainment of this goal will both maintain any ongoing savings from prior periods (retention of ongoing savings requires Maryland to limit its growth rate to the national rate in FY 2016) and grow those savings by roughly $30 million (from holding the Maryland growth rate below that of the nation again in FY 2016).

A commitment to continue the success of year one is critical to building long-term support for Maryland's model and to build a cushion against adverse performance in future years (for example from increased inflation or utilization expansion from the aging population).

The initial savings generated under the model contract could be adversely affected by:

- Modest projections for future national Medicare growth. As shown in Table 6 below, the CMS Office of the Actuary is forecasting just 0.3% growth in Medicare per beneficiary hospital spending in CY 2015 and 2.4% growth in CY 2016. Federal inpatient charge growth is constrained in the near term by modest inflation updates and steep decreases in disproportionate share payments. More robust outpatient growth is forecast due to increases in volumes. The out-year projections likely overstate this growth as recent announcements by Secretary Burwell indicate that Medicare will rapidly shift to alternative payment models for doctors and hospitals over the next few years in an effort to refocus financial incentives from growing volume to improving quality.

- Increasing Maryland's rates to cover more infrastructure may affect the savings levels in the short term, but should contribute to sustainability of the model and help limit future growth in utilization and costs.

Table 6
Per Capita Medicare Hospital Spending Projections
Office of the Actuary

	Per Capita Trend		
CY	Inpatient	Outpatient	Total Hospital
2013			
2014	-1.4%	11.0%	1.5%
2015	-2.0%	6.9%	0.3%
2016	1.4%	5.1%	2.4%
2017	2.5%	6.3%	3.5%
2018	4.5%	6.4%	5.0%

- A recent pattern of lower than expected growth in national Medicare costs. Projections of national per capita hospital trends by Medicare's Office of the Actuary have overstated the actual experience over the last couple of years as shown in Table 7 below. Even the February 2015 estimate of CY 2014 growth appears to overstate the actual trend as nearly real time data provided to Maryland though the waiver shows national CY 2014 spending growing at a rate of about 0.5% compared to the official estimate of 1.5%. The instability of the estimates creates risk for the State in establishing savings targets.

Table 7
Per Capita Medicare Hospital Spending Projections
February 2014 and February 2015 Estimates Compared
Office of Actuary

CY	Feb-14 Estimate	Feb-15 Estimate	% Point Difference
2014	1.70%	1.5%*	-0.2%
2015	1.70%	0.3%	-1.4%
2016	2.30%	2.4%	0.1%
2017	3.30%	3.5%	0.2%
2018	5.20%	5.0%	-0.2%

*Medicare fee-for-service data received by HSCRC shows national growth at 0.5% for CY 2014.

Allowable Growth

If the projections from the CMS Office of the Actuary for calendar 2015 and calendar 2016 are correct, national Medicare per capita hospital spending will increase by 1.35% in State FY 2016. The staff goal of limiting Maryland's Medicare per capita growth to 0.5 percentage points below the national rate results in a maximum allowable Medicare per capita growth of 0.85%.

For the purpose of evaluating the maximum All-Payer growth that will allow Maryland to meet the per capita Medicare fee-service growth target, the Medicare target must be translated to an All-Payer growth limit (Table 8). During deliberations on the FY 2015 update, CareFirst developed a "difference statistic" of two percentage points that was added to the Medicare target to calculate an All-Payer target. As shown in Appendix 1, Maryland's All-Payer per capita spending rose faster than Medicare fee-for-service per capita spending in each of the last six years and is on pace to do so again in FY 2015. The actual FY 2014 experience and the year-to-date experience for FY 2015 support the continued use of a two percentage point difference statistic.

Using the difference statistic, staff calculate that the maximum All-Payer per capita growth that will allow the State to realize the desired FY 2016 Medicare savings is 2.87%. The staff recommended update will produce the desired savings if national actuarial projections are accurate and the difference statistic correctly translates the Medicare growth to All-Payer growth (Table 9).

Table 8
Maximum All-Payer Increase that will Still Produce Desired FY 2016 Medicare Savings

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Two year average of Medicare growth (CY 2015 + CY 2016)/2	A	1.35%
Savings Goal for FY 2016	B	-0.50%
Maximum growth rate that will achieve savings (A+B)	C	0.85%
Conversion to All-Payer		
Difference statistic between Medicare and All-Payer	D	2.00%
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	2.87%
Converstion to total All-Payer revenue growth (1+E)*(1+0.57%)-1	F	3.45%

Note: National Medicare growth projection 0.3% for CY 2015 and 2.4% for CY 2016 from CMS Office of Actuary, February 2015 analysis.

Table 9

Comparison of Medicare Savings Goal to Model Results			
Comparison to Modeled Requirements	**All-Payer Maximum to Achieve Medicare Savings**	**Staff Recommended All-Payer Growth**	**Difference**
Revenue Growth	3.45%	3.19%	-0.26%
Per Capita Growth	2.87%	2.61%	-0.26%

Medicaid Deficit Assessment

The Medicaid deficit assessment for FY 2016 is unchanged from FY 2015, and the hospital funded portion and rate funded portion will remain at the same level and be apportioned to hospitals in a similar manner as FY 2015.

RECOMMENDATIONS

The final recommendations of the HSCRC Staff are as follows and are offered on the assumption that the other policy recommendations that affect the overall targets are approved (including the shared savings adjustment):

1) Provide update for the three categories of hospitals and revenues as follows:
   a) Revenues under global budgets--2.4% with an additional 0.4% provided for care coordination and population heath infrastructure investments;
   b) Revenues not under global budgets but subject to Medicare rate setting waiver--1.6%;
   c) Revenues for psychiatric hospitals and Mt. Washington Pediatric Hospital— 1.9% with an additional 0.30% provided for infrastructure investments to support reductions in readmissions and other potentially avoidable utilization.

2) Require all acute hospitals to submit multi-year plans for improving care coordination, chronic care, and provider alignment by December 1, 2015.

3) Require psychiatric hospitals and Mt. Washington Pediatric Hospital to submit a report outlining plans to reduce readmissions and other avoidable utilization by December 1, 2015 and to begin submitting admission and discharge data to CRISP by April 1, 2016.

4) Provide an additional 0.25% for competitive awards to hospitals to implement or expand innovative care coordination, provider alignment and population health strategies.

5) Calculate the Medicaid deficit assessment for FY 2016 at the same total amount as FY 2015 and apportion it between hospital funded and rate funded in the same total amounts as FY 2015.

Appendix 1

Difference Statistic

	All Payer	Medicare	Difference
FY 2009	5.4%	2.0%	3.40%
FY 2010	2.2%	-2.1%	4.30%
FY 2011	4.5%	2.9%	1.60%
FY 2012	5.0%	1.9%	3.10%
FY 2013	1.2%	-1.1%	2.30%
FY 2014	1.63%	-0.92%	2.55%
FY 2015 (thru Feb.)	0.87%	-0.79%	1.66%
Seven Year Average			2.70%
Average of FY 14 & FY 15			2.11%

For FY 2015, difference statistic of 2.0 percentage points was applied.

Appendix 2

Balanced Update Model

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

		Weighted Allowance
Adjustment for inflation	A	2.40%
Adjustment for volume	B	0.57%
-Demographic Adjustment		
-Transfers ($1 M -$5 M impact)		
-Categoricals		
-Market share adjustments ($4 M est. impact)		
0.1%		
Utilization Impact of Medicaid Expansion ($60 M)	C	0.38%
Infrastructure allowance provided	D	0.59%
- 0.40% included in GBR rates on 7/1/15 (Net .34% adjustment since TPR & non-global revenues are excluded))		
- Upto another 0.25% allocated via a competitive process in January 2016		
CON adjustments-		
-Opening of Holy Cross Germantown Hospital	E	0.21%
Other adjustments (positive and negative)		
-Set aside for unknown adjustments	F	0.50%
-Reverse prior year's shared savings reduction	G	0.40%
-Positive incentives (Readmissions and Other Quality)	H	0.15%
-Shared savings/negative scaling adjustments	I	-0.60%
Net increase attributable to hospitals	J = Sum of A thru I	4.60%
Per Capita	K = (1+J)/(1+0.57%)	4.00%
Components of Revenue Change with Neutral Impact on Hosptial Finanical Statements		
-Uncompensated care reduction, net of differential	L	-0.84%
-MHIP (Assumes $0 MHIP in 2016)/2015 BRFA adjustment	M	-0.57%
Net decreases	N = L + M	-1.41%
Net revenue growth	O = J + N	3.19%
Per capita revenue growth	P = (1+O)/(1+0.57%)	2.61%

Appendix 3 – Comment Letters Attached

Maryland
Hospital Association

May 21, 2015

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Baltimore, Maryland 21211

Dear Chairman Colmers:

On behalf of the Maryland Hospital Association's 65 member hospitals and health systems, I am writing in support of the Health Services Cost Review Commission (HSCRC) staff's fiscal year 2016 revenue update recommendation, with two proposed modifications:

- Reconsideration of the amount of funding to be made available for the competitive grants on January 1, 2016, based upon the comprehensive care coordination plans that all hospitals will be submitting on December 1, 2015
- Revision of the proposed update for psychiatric hospitals and Mt. Washington Pediatric Hospital from 1.9 percent to 2.3 percent

A Tectonic Shift

Eighteen months ago, Maryland's hospitals dove headfirst into our new all-payer model. Prior to January 1, 2014, per capita revenues were growing at an annualized rate of 6.8 percent, with very limited incentives to control utilization. Today, 95 percent of hospitals' revenue is governed by global budgets. Maryland's hospitals no longer rely on unit volume to secure financial stability and have committed to being accountable for controlling their total spending from that historical level of 6.8 percent to no more than 3.58 percent per capita. This new environment no longer regulates just hospital unit rates, but hospital global revenue growth. That seismic change in operating models required a corresponding change in thinking, policy, and regulation on the part of all stakeholders.

While still in its infancy, Maryland's bold experiment with this new all-payer model has already delivered highly encouraging results:

For patients:

- Statewide, there has been nearly a 16 percent reduction in potentially avoidable utilization from calendar years 2013 to 2014 (as a percentage of total hospital charges)
- Medicare readmissions rates, while falling short of our target, are declining faster than the nation as a whole
- Inpatient admissions and use rates are down more than 4 percent

For payers and the public:

- All-payer hospital spending growth per capita grew by an estimated 1.47 percent in calendar year 2014, well below the annual 3.58 percent ceiling

- Medicare hospital spending growth per beneficiary is down by 1.50 percent in 2014, well below national growth projections. This will save Medicare an estimated $100 million in 2014 alone, nearly one-third of the $330 million in savings required over the five-year experiment, and a remarkable achievement in light of the fact that no savings were required in the first year of our agreement with the Center for Medicare & Medicaid Innovation.

Shared Objectives

As we consider the global budget revenue update for fiscal year 2016, Maryland's hospitals remain mindful of the need to find more secure footing in the form of a "safety cushion," or reserve of funds, to ensure our collective ability to succeed over the course of this five-year experiment. Stakeholders are fully aware that the Centers for Medicare & Medicaid Services expects us to achieve the goals of the demonstration agreement, and Maryland's hospitals continue to embrace the opportunity to improve our performance as we meet those expectations.

HSCRC Advisory Council Guidance

As we evaluated the staff recommendation on the global budget revenue update for next year, we remained mindful of several important Advisory Council recommendations:

On meeting model requirements:
"*Global payment methods for Maryland hospitals should be the tool of preference to assure revenue controls."*

On meeting budget targets while making important investments:
"*The Advisory Council urges the HSCRC to strike a balance between near-term cost control, which is paramount, and making the required investments in physical and human infrastructure necessary for success. If we do not meet the near-term targets, there will be no long-term program. But if we fail to make the needed infrastructure investments, we will not have the toolkit of reforms necessary to achieve lasting success."*

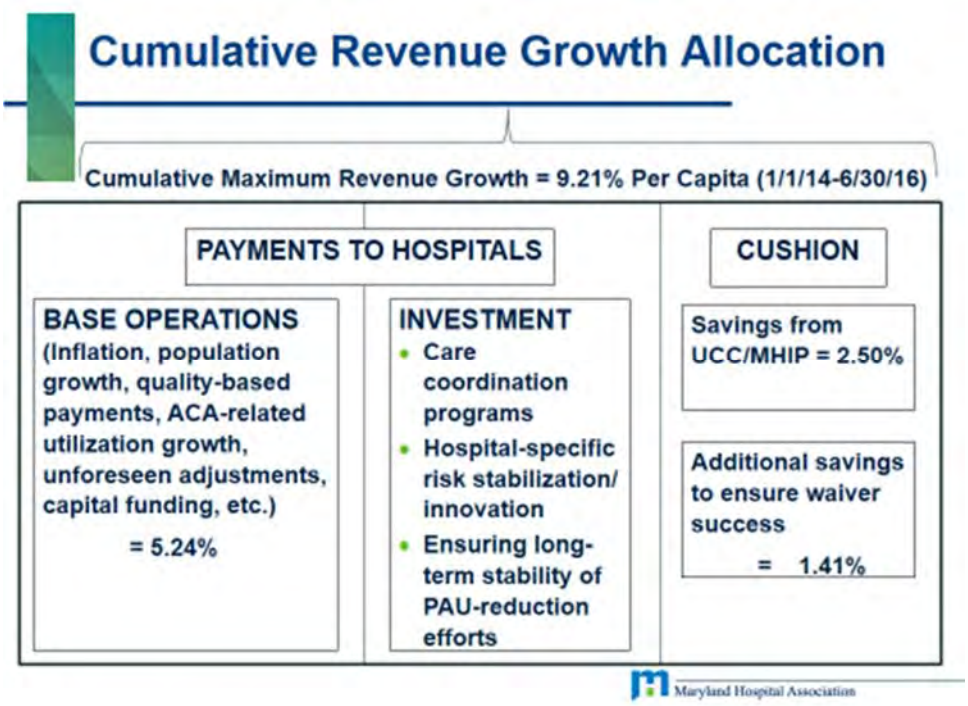
"*Given the challenging targets in this initiative, goals should be set in the aggregate as close to the targets as practicable…hospitals should be able to retain and reinvest a high percentage of their savings."*

On regulatory flexibility:
"*Within the context of per capita growth ceilings on hospital spending, HSCRC should allow considerable flexibility for the health care sector to implement its own strategies for achieving the desired results while recognizing the importance of following evidence-based best practices and the potential value of some standardization."*

"*The consensus of the hospital industry should have a significant weight in policy development…the Council recommends that the HSCRC give significant consideration and preference to policy recommendations that reflect a consensus among hospitals."*

These recommendations underline the delicate balance that commissioners must maintain between regulatory oversight and operational flexibility, and between investing for success and meeting the financial goals of the waiver – all while ensuring the financial stability of the field that has taken on

such significant risk under this new model. Because hospitals are now fully accountable for managing this risk under a global budget, the resources needed to mitigate the risk should reside with hospitals. This balancing act is reflected in the graphic below:



Hospitals readily and rapidly accepted this risk by shifting more than 95 percent of revenues to global budgets because they expected to be provided the tools and resources to get the job done.

For example:

- Based on preliminary infrastructure reports we have received from Maryland's hospitals, we estimate that the average global budget revenue hospital to date has invested about 1.1 percent of its total revenues in activities designed to make care better and more efficient, improve the health of their communities, and invest in novel, forward-thinking care programs. When compared with the infrastructure funding already provided, this suggests that an additional 0.50 percent in funding is needed to cover the programs that have already been implemented, slightly higher than the amount staff have recommended.
- As pictured above, based on the staff recommendation before you, the commission will have set aside more than 42 percent of the total potential cumulative hospital spending (3.91 percent of the total 9.21 percent) as a cushion to achieve the challenging financial targets of the all-payer model.

In the early years of system transformation, the work of reducing potentially avoidable utilization is both challenging and experimental. Based on the experience of Maryland's Total Patient Revenue (TPR) hospitals, it is unlikely that savings from reducing utilization will be sufficient to offset the

risk incurred under global budgets in these initial years. Only hospitals that have invested in and developed the foundation for sustained savings over time can count on using those savings for investment purposes. We believe that the additional resources recommended for fiscal year 2016 will help us build that foundation for long-term success.

We make two requests of commissioners as you consider this recommendation:

- As we work with staff to define the parameters of the comprehensive care coordination reports to be submitted by December 1, we ask that the commission reconsider whether the funding to be provided on January 1 will be sufficient to support those plans. As commissioners discussed at the May meeting, providing additional funding in competitive grants of up to 0.25 percent is to accelerate the implementation of the programs needed to ensure long-term waiver success. After commissioners have had the opportunity to review the plans that hospitals submit, they could determine the appropriate level of funding needed to ensure the timely implementation of the full range of acceptable plans, without limiting either the scope or number of programs implemented at that time.
- We also ask that the proposed update for psychiatric hospitals and Mt. Washington Pediatric Hospital be increased from the proposed 1.9 percent to 2.3 percent. Staff has used the proposed rule for the Medicare Inpatient Psychiatric Facility Prospective Payment System as the basis for its recommendation; based on MHA's reading of the proposed rule, we believe that the federal per diem is being increased by 2.3 percent.

Thank you for your consideration, and we look forward to your final action on the staff recommendation at the June meeting.

Sincerely,

Michael B. Robbins
Senior Vice President

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

Chet Burrell
President and Chief Executive Officer

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May 18, 2015

John Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: HSCRC FY 2016 Hospital Update Factor DRAFT Recommendation

Dear Mr. Colmers and Ms. Kinzer:

CareFirst welcomes this opportunity to provide comments on the HSCRC staff's Draft Recommendation for the Update to Hospital Rates for the Fiscal Year ending 2016. We believe the staff has provided a balanced discussion of the key facts and issues in regard to this upcoming year's Update as it was developed through meetings with the HSCRC's Payment Work Group and in other venues.

We also believe it is important to temper an early sense of achievement under the waiver with the recognition that much remains to be done in the coming years. At this point, the rate of increase in hospital (and total) health costs has dropped precipitously throughout the U.S. Health costs are no longer growing as a share of the Gross Domestic Product (GDP). It is possible that we could meet our 3.58% limit on the growth in all payer hospital costs per resident in Maryland and find that our performance simply kept pace with the national average. If we merely meet the Medicare savings requirements, match the U.S. on All-Payer hospital cost growth, and fail to make improvements in quality as required in the Demonstration, we could find it difficult to persuade CMS to continue to support the Maryland waiver beyond the term of the current Demonstration contract.

In this context, we have serious concerns about the Update recommendation that would add 0.59% of infrastructure funding into the rates of the hospitals. The Global Budget Revenue (GBR) and Total Patient Revenue (TPR) arrangements that are in effect with all Maryland hospitals give them a great opportunity to generate savings by eliminating unnecessary volume while still getting paid up to their GBR target.

Accordingly, the hospitals are in a strong position to fund infrastructure investments using their own resources because such investments should generate positive returns. Hospital margins are at 2.8% on an overall operating basis (despite continued and significant losses on physician subsidies) and even higher (i.e., 5.0%) on regulated activities. Given these margins, shouldn't one of the highest uses of a portion of

the regulated margin be the development of an infrastructure that could enable each hospital to better achieve the objectives of the waiver? We believe the answer to this question is "yes". Hence, we do not believe there is a need to provide the hospitals with additional infrastructure funding at this time.

We also note that the Update Factor recommendation is significantly greater than CMS' current proposal for its Inpatient Prospective Payment System. We are concerned that the inclusion of the infrastructure adjustment will make it more difficult to meet the requirements of the waiver down the line?

We further believe that, to the extent that if the HSCRC approves infrastructure funding, it should only do so in the context of policy that would:

- Require the hospitals to report, on a periodic basis, in reasonable detail, the programs and activities they have implemented using any infrastructure money they have received;

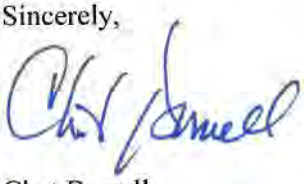
- Monitor the performance of the hospitals in terms of reductions in avoidable readmissions, reductions in potentially avoidable volume (PAU), reductions in unnecessary volume beyond the services reflected in the PAU calculations, and improvements in safety and quality of care; and

- Require the infrastructure investments to generate a payback (e.g., ROI) which should be achieved in the form of offsets to the Update factor in future years. The funding that is provided to the hospitals for infrastructure is paid for by public agencies, including Medicare and Medicaid, by employers and by patients. They are entitled to receive a return on their investment.

- Make any infrastructure allowance subject to change by the Staff if hospitals fail to fully document demonstrable results in improved performance related to such funding.

Thank you for giving us the opportunity to provide these comments.

Sincerely,



Chet Burrell
President and Chief Executive Officer

Transit Employees'

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May 13, 2015

John Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: HSCRC 2016 Hospital Update Factor

Dear Mr. Colmers and Ms. Kinzer:

I want to thank the commissioners and the Commission staff for allowing me the privilege of participating in the Payment Models Work Group and to provide comments on the staff recommendation to the Update Factors. The staff and the other members of the work group have been very patient with me as I gradually get up to speed with this rate setting process.

I am the Executive Director of the Transit Employees' Health and Welfare Fund. We are the entity that pays the health and other benefits for the 12,000 active and retired members of ATU Local 689 employed by the Washington Metropolitan Area Transit Authority, about 70% of METRO's workforce

I represent a minority voice in this process: the voice of those plan sponsors that write the checks that provide the funds for carriers like CareFirst, United Health Care and Kaiser to pay hospitals. We are the ones whose bottom lines take the hit from increasing health care costs. We are the ones who must deduct increasingly larger amounts from our employees' pay checks in order to pay those health care bills.

Employers and workers across Maryland have for decades absorbed increases in health care costs that far exceed the rate of inflation and the rate of growth in the economy. It is partly because these increases are unsustainable that Congress passed the Affordable Care Act and that Maryland embarked on this pioneering effort to restructure the way that hospitals are paid

I have often repeated to others the words of an early story in the Washington Post. This is the most significant state initiative in the country next to Vermont. Now that Vermont's efforts to evolve into a single payer system have unfortunately floundered, the eyes of the nation are on Maryland

Those on the Payment Models Work Group have heard me say that I think the 3.58% allowable growth rate is far too generous and I applaud the efforts of the hospitals in Maryland to come in well under that target in its first year under this new model. We in the plan sponsor community face cost pressures from several directions. Just this past year the cost of our prescription drug program increased nearly 30% from first quarter 2014 to fourth quarter of 2014.

Those increases are largely attributable to new specialty medications for Hepatitis C that are expected to reduce long term inpatient and outpatient treatment costs for that disease. We are warned that many more very expensive treatments and cures are in the pipeline. Next up is PCSK9 a revolutionary drug to treat high cholesterol.

If we are spending more money on medications to reduce long term hospital costs, then we expect to see reductions in hospital costs, not just slower increases. In a recent article in the Journal of the American Medical Association (JAMA)[1], Don Berwick challenged the provider community to become leaders in making the changes necessary to achieve the goals of the Triple Aim. And he very specifically challenged those leaders to bring total spending on health care to under 15% of GDP.

From where I sit, Maryland is doing an outstanding job of bringing the provider community to the table to assume a leadership role in this process. But allowing hospital costs to track the growth in the Maryland economy will not reduce per capita spending and will never allow it to do Maryland's part to get health care spending below 15% of GDP.

Additionally a major concern of the employer community is the impending excise tax on so called "Cadillac Plans". This 40% marginal tax rate will eventually hit every single employer in Maryland, including the state of Maryland, perhaps the largest single group health plan in the state – unless total spending is reduced to below the rate of inflation – something that I don't think has happened to employer health care costs in my life time. The only way employers can avoid this tax is by shifting point of service costs on to their employees. Discussions at the Payment Model Work Group reveal that hospitals are having difficulty collecting these higher patient out of pocket expenses and it is affecting their bottom lines and the rate setting process.

In the first year of the waiver the hospitals have done an outstanding job of reducing revenue, improving quality while also enhancing their bottom lines. Who could ask for more? I see no reason, therefore, why the full .59% infrastructure allowance is necessary and ask the Commissioners to reconsider its inclusion in the final rate setting factors. Maryland hospitals have proven that they can meet their cost and quality targets without the additional money. Countless publications have described overuse and inappropriate volume in the system. Reducing those related costs should be sufficient to fund the necessary infrastructure improvements.

I would call attention to a slide presented at the last meeting of the Commissioners in April that showed that the median profit margin for Maryland hospitals increased by 1.18% - double what the commissioners are being asked to add to the rates for 2016 infrastructure improvement. So why is this additional money necessary?

However, if the infrastructure allowance is allowed to remain, then I ask that the Commissioners and staff to be vigilant to ensure that it is used to actually lower per capita health care costs in Maryland. I ask the Commissioners and the staff to expand its scope of unnecessary and inappropriate admissions by looking at population based metrics and benchmarking themselves against the best in class elsewhere in the nation.

That is the only way that Maryland will truly get the attention it deserves.

Thank you and I do hope that you will continue to involve the voice of the plan sponsor community in this process as you move forward.

Sincerely,

James L. McGee, CEBS
Executive Director

[i] Berwick DM, Feeley D, Loehrer S. Change From the Inside Out: Health Care Leaders Taking the Helm. *JAMA*. 2015;313(17):1707-1708. doi:10.1001/jama.2015.2830.

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

May 12, 2015

John M. Colmers
Chairman
The Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers,

The Medicaid program has reviewed the Health Services Cost Review Commission's (HSCRC) Staff proposed rates for Fiscal Year 2016. We are writing to urge the HSCRC to build in more accountability for hospitals to receive monies for infrastructure development. Specifically, the recommendation of the HSCRC Staff for an update factor includes additional monies for infrastructure development—roughly 0.59 percent (or $84 million). This is in addition to the infrastructure adjustments included in global budgets for both FY 2014 and FY 2015—specifically, 0.325 percent for each year, for a cumulative amount of 0.65 percent (or $96 million).

The HSCRC Staff proposal will build 0.4 percent into rates starting July 1, 2015, but will require hospitals to submit a plan by December 1, 2015, to qualify for an additional 0.25 percent in rates.[1] HSCRC will review the hospital plans to determine whether an additional 0.25 percent is warranted. HSCRC Staff proposes requiring the hospitals to dedicate a portion of these infrastructure monies to the care coordination recommendations for common state-level support, which is estimated to cost around $51 million.

Medicaid strongly supports the creation of common state-level support; any release of infrastructure monies needs to include a requirement to fund these and the boarder care coordination recommendations.

The various proposals seeking Regional Partnership Planning Grants demonstrate that not all hospitals or regions are at the same level in their planning efforts—some areas need more technical assistance. Given this, any monies built into rates for infrastructure development that exceed the monies built into global budgets for FYs 2014 and 2015 and go beyond the

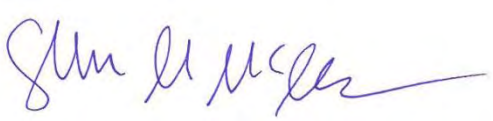
[1] The 0.65 percent is for the GBR hospitals. The net adjustment is 0.34 percent because TPR and non-global revenues are excluded.

recommendations of the care coordination workgroup need to be evaluated and monitored closely. HSCRC oversight needs to go beyond mere approval of the hospital plans, and recognize that the development of community resources must also be tied to broader population health accountability within the global budgets that will benefit all payers, including Medicaid.

Medicaid is specifically interested in assuring that Maryland may be able to benefit from reform efforts in other states that include robust accountability for community infrastructure development for hospitals. For example, under its recently-awarded DSRIP (Delivery Service Reform Incentive Payment) waiver, New York is requiring participating hospitals to create Performing Provider Systems statewide. Based on the results of a community needs assessment, these Performing Provider Systems select various pre-approved projects in the areas of system transformation, clinical improvement and population health. In turn, the State pays the Performing Provider Systems based on the achievement of certain milestones.

Medicaid looks forward to working with the HSCRC to develop additional mechanisms to ensure accountability and further the State's goal to transform the health care delivery system. If you have any questions, please contact Tricia Roddy, Director for the Office of Planning at 410-767-5809 or tricia.roddy@maryland.gov.

Sincerely,



Shannon M. McMahon
Deputy Secretary
Health Care Financing

UNION HOSPITAL

May 26, 2015

Ms. Donna Kinzer, Executive Director
State of Maryland Health Services Cost Review Commission
41600 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kinzer,

This letter presents the comments and suggestions of Western Maryland Hospital Center, Meritus Medical Center, Calvert Memorial Hospital, Union of Cecil County Hospital, Garrett County Memorial Hospital, and McCready Memorial Hospital ("TPR hospitals") relative to three subjects: the HSCRC staff's ("Staff") proposals for infrastructure funding in the FY-2016 annual update; the Staff's agreement to enhance the opportunity for certain appeals in connection with the Market Shift Adjustment ("MSA") calculations; and the inherent instability of the MSA statistics. Our suggestions related to the MSA are offered in the context of our strong support of global budget arrangements and the incentives of such arrangements to reduce marginal or unnecessary volumes of service and of our recognition of the need for market shift adjustments, provided that the MSAs comport with your stated objective of maintaining or strengthening the incentives of global budgets. We believe that this objective would be more effectively realized if our proposals for amending the MSA were adopted. Our comments and suggestions on all three topics are set forth in the following sections.

Infrastructure Funding

We support the need for infrastructure funding as a part of the All-Payer Model and understand that the Staff's proposal includes two components of the hospital's annual allowances dedicated to infrastructure funding:

- A .4% infrastructure adjustment applicable to the rates of all hospitals, including Garrett County Memorial Hospital ("Garrett"), that does not apply to the other TPR hospitals; and
- A .25% adjustment, effective on January 1, for hospitals selected in a competitive process involving proposals for infrastructure investments. This competitive process, as we understand it, does not exclude the TPR hospitals.

We understand that the TPR hospitals, other than Garrett and McCready Memorial Hospital ("McCready"), received infrastructure funding during the 2010/2011 TPR Agreement process and, therefore, Staff is recommending the .4% adjustment be withheld

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www.uhcc.com

from the 2016 increase for TPR hospitals. However, there is much left to do under the All-Payer Model that requires infrastructure investments by the TPR hospitals. Furthermore, such investments in support of coordinated care and other clinical management may substantially improve access and quality without improving a hospital's financial condition. Therefore, while we are grateful for the opportunity to compete for the second component of infrastructure payments in FY-2016, we would hope that additional infrastructure payments would be made available to the TPR hospitals in the succeeding years of the All-Payer Model.

The Opportunity to Appeal the Scope and Impact of the MSAs

As discussed more fully in the next section, we believe that a hospital's reductions in volume resulting from the application of evidence-based medicine or other clinical management initiatives may be incorrectly identified as a market shift and the savings associated with the initiative reduced or eliminated. Therefore, we strongly support the Staff's willingness to allow each hospital to identify product lines that are targeted by the particular hospital's clinical management initiatives and to exempt those product lines from the hospital's MSA calculation. These appeals will be especially useful in support of the clinical management initiatives funded by infrastructure payments and in support of similar initiatives to be carried out by the TPR hospitals. However, there are many clinical management initiatives such as home visits, SNF follow-ups, and IT investments that involve infrastructure expenditures with associated volume reductions that cannot be traced to individual product lines. Therefore, while the MSA appeals enhance the incentives of the global budget arrangements, we believe that these incentives need to be strengthened by further increasing the stability of the MSA statistics.

The Stability of the MSA Statistics

In the materials which we prepared for your consideration prior to our meeting on April 27th, we suggested that the ECMAD statistics calculated by zip code and product line were not sufficiently stable to ensure that changes in the distribution of the ECMADs over hospitals from one year to the next were actual market shifts rather than random fluctuations in the number and distribution of the ECMADs. In some product lines, including product lines that affect the MSA calculations of the TPR hospitals, the number and distribution of ECMADs in a geographic area is affected by a change in the supply of such services: a service, such as obstetrics, may close; one or more specialists at a hospital providing services in the product line may retire or change their hospital affiliation; or additional specialists may be recruited by a hospital, either as employed or attending physicians. However, the number and distribution by specialty of the physicians on the attending medical staffs of the TPR hospitals are generally stable from one year to the next. Therefore, the lion's share of the zip code and product line MSAs are not the result of changes in the supply of the product line services but rather random fluctuations in the number and distribution of such services.

The materials that we have submitted to you have suggested three relatively simple changes to the MSA formula intended to increase the actuarial stability of the underlying statistics. These changes were:

- To aggregate the zip codes in each Maryland county, calculating the MSAs by county and product line rather than by zip code and product line
- To limit the TPR MSAs to those Maryland zip codes included in the hospital's primary service area (PSA) as defined in the TPR Agreement
- To establish a budget neutral corridor derived from a hospital's Demographic Adjustment that would reduce positive MSAs and increase negative MSAs. The Demographic Adjustments are a form of volume allowance and are therefore appropriately offset against positive MSAs. The corresponding adjustment to the negative MSAs works to ensure budget neutrality of the MSA calculations.

In the aggregate, these proposed changes improved the impact of the MSA calculations on the TPR hospitals. However, as the primary purpose of the proposed changes was to increase the actuarial stability of the underlying statistics of the MSA calculation, the particular proposals were not selected so as to individually improve the MSA results for the TPR hospitals. Therefore, your decision to aggregate the zip codes of selected Maryland counties as a modification to the MSA increased the MSA offsets of the TPR hospitals that reduced their volumes of service and, in general, increased the MSA offsets of hospitals with volume reductions.

We do not believe that these increased offsets support the objectives of the All-Payer Model, in part, because they are not consistent with your stated principle of crafting the MSA methodology so as to maintain the incentives of the GBR target budgets.

Therefore, we would again suggest that the MSA calculations be subject to a budget neutral corridor following the precedent of the corridor limitations of the transfer policy, whereby a hospital's positive MSA would be reduced by the hospital's Demographic Adjustments; provided, that the reduced MSA would be greater than or equal to 0. With a corresponding increase for hospitals with a negative MSA, the corridors would substantially reduce the effects of random variation in the MSA calculations while enhancing the effect of the MSA on the incentives of the GBR target budgets.

We thank you for the opportunity to comment on the Staff's proposals for FY-2016 and for the substantial effort you have made in developing them. We would also like to thank you for your consideration of our past proposals and your helpful presentations at our meetings. We look forward to working with you in the future.

Sincerely Yours,

Kenneth S. Lewis, MD, JD