Update Factors Recommendations for FY 2015

Health Services Cost Review Commission
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June 11, 2014

These recommendations were approved by the Commission at the June 2014 Public Commission Meeting.

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% 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 initiated in conjunction with transition policies 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 hospitals that remain on a Charge-Per-Episode (CPE)/Charge-Per-Case (CPC) agreement and hospital revenues excluded from a global budget, such as revenues for non-residents.
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 fiscal year (FY) 2015 updates.

STAKEHOLDER INPUT

HSCRC staff has worked with the Payment Models work group to provide input and review of its draft recommendations regarding updates and short-term adjustments. A draft work group report entitled "Report on Balanced Update and Short-Term Adjustments" was presented to the Commission at the April public meeting. A copy of the draft report is included as an attachment to this recommendation to facilitate reference and review.

Comments were received from CareFirst and United supporting the draft recommendation. The Maryland Hospital Association(MHA) provided comments in support of the recommendation with three proposed areas for additional consideration: 1)Consideration be given to providing additional infrastructure support in hospitals' rates; 2)HSCRC staff should pursue Medicaid deficit assessment reductions based on the update level; and 3)HSCRC should increase the update for non-waiver hospitals to eliminate the ACA impact adjustment. Each of these items will be discussed below in the analysis.

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ANALYSIS

Calculation of Update Factors for Revenue Categories 1-3

In this draft staff 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 and shared savings relative to readmissions.

Updates for both categories 1 and 2 start by using the actual blended statistic of 2.41% growth, derived from combining 91.2% of the 2014 estimates of 2.5% from Global Insights for market basket increase with 8.8% of the capital growth estimate of 1.5%. For those revenues that are

not subject to global budgets, additional subtractions are made to reflect productivity and an additional reduction provided under the Affordable Care Act for Medicare. The 0.5% reduction for productivity is 0.1% above the amount used in the Medicare adjustment, but Medicare makes other adjustments that have not been applied. As a result, the proposed rate adjustment would be as follows:

	Global Revenues	Non-Global Revenues
Proposed base update	2.41%	2.41%
Productivity adjustment		-0.50%
ACA adjustment		-0.20%
Proposed update	2.41%	1.71%

MHA commented that the allowance should be increased to provide for additional infrastructure investment. While staff recognizes the need for additional infrastructure, hospitals have already been provided some funding. As shown in the balanced update table and discussed in the April 2014 HSCRC meeting, the legislature reduced the MHIP assessment by .7% but provided that up to $15 million of this amount could be placed back in hospital rates to fund programs and infrastructure that would support three part aim of the new All-Payer Model. Staff recommends evaluating whether those funds could be used to support infrastructure development that could benefit hospitals statewide, particularly in the development of care management infrastructure and analytics. While staff is not prepared at this time to recommend additional funding, this $15 million level of funding is already accounted for in the analysis and could be deployed toward development of infrastructure.

For psychiatric hospitals and Mt. Washington Pediatric Hospital, we turn to the proposed psychiatric facility update for Medicare. Medicare applies a 0.7% reduction for productivity and ACA savings mandates to a market basket update of 2.7% to derive a net amount of 2.0%. HSCRC staff initially proposed to use the same factor and net adjustments for the Maryland psychiatric hospitals and Mt. Washington Pediatric Hospital. MHA argued that the ACA adjustment should be eliminated. While Medicare will apply this adjustment in determining payment to the psychiatric hospitals, there are changes underway in the Medicaid program to reorganize psychiatric and substance abuse services. Additionally, the recognition of the importance of the integration of somatic and behavioral health makes it critical that these hospitals effectively coordinate care and integrate services with both community based providers, families, and other hospitals. Similarly, Mt. Washington Pediatric Hospital plays an important role in providing care for children with complex health problems that must be carefully coordinated and integrated with other providers. Staff agrees with the need for increased care coordination for these hospitals. In that light, Staff has changed its recommendation to provide .3% for care coordination and population health resources, offsetting

the ACA adjustment. In order to receive the additional monies, the hospitals will be required to use the funds solely for care coordination and population health infrastructure and to file a plan and report results using the same format that is being developed for reporting population health infrastructure investments for global budget hospitals.

Medicare Growth

Under the previous waiver, HSCRC focused on cost per case. Under the new All-Payer model, the Medicare savings requirement is driven by changes in Medicare payments per beneficiary in Maryland relative to changes in per beneficiary payment nationally.

HSCRC staff obtained per beneficiary projections from the Office of the Actuary, reviewed proposed and actual updates for PPS, and reviewed the 2014 MedPac repot for use in its evaluation. The table below presents the estimates received from the Office of the Actuary. These tables were provided based on projections used for the federal budget as of February 2014. The most significant factor driving per beneficiary increases is outpatient volumes. As discussed in the following paragraphs, the impact of Medicare's Disproportionate Share adjustment (DSH) is significant while also being difficult to ascertain. Medicaid enrollment increases may cause the allowance to go up while the law mandates a reduction in the levels paid, decreasing the allowance[1]. Actual Medicare cost increases could vary significantly from the estimates.

HSCRC staff will be working with CMS staff to monitor the actual results and will be acquiring actuarial and other assistance from outside vendors to help monitor these factors on an ongoing basis. HSCRC staff will confer with MedPac and CMS staff gain additional insights where possible.

[1] MedPac estimates a 0.7% increase in DSH payments in 2014 followed by more than a 2% decrease in DSH payments in 2015. The CMS website indicates, "As part of the PPACA, Medicare DSH payments will be reduced 75 percent by 2019, or $49.9 billion. The 2015 proposed rule would cut overall Medicare DSH payments by 1.1 percent in FY 2015, compared with FY 2014. Medicare DSH payments would continue to be distributed under the new policy, which is based on hospitals' uncompensated care amounts."

Per Capita Hospital Spending Projections

[Based on the President's FY 2015 Budget]

	Annual Per Capita Expenditures			Per Capita Trend		
CY	Inpatient	Outpatient	Total Hospital	Inpatient	Outpatient	Total Hospital
2013	3,704	1,085	4,789			
2014	3,724	1,144	4,868	0.5%	5.5%	1.7%
2015	3,730	1,221	4,952	0.2%	6.8%	1.7%
2016	3,759	1,306	5,065	0.8%	6.9%	2.3%
2017	3,843	1,389	5,233	2.2%	6.4%	3.3%
2018	4,022	1,481	5,503	4.6%	6.6%	5.2%

Proposed updates to federal Medicare inpatient rates for 2015 have just been published in the Federal Register. These will not be finalized for several months and could change. A summary description of proposed changes is attached. Additional subtracting from the CMS updates include value based purchasing, HAC, and readmission adjustments, as well as the DSH adjustment. The Medicare figures below do not include a provision for volume increases. The inpatient adjustment becomes negative when considering the other adjustments to the base.

Federal FY 2015	Proposed IP	Estimated OP based on IP
Base Update		
Market Basket	2.70%	
Productivity	-0.40%	
ACA	-0.20%	
Coding	-0.80%	N/A
	1.30%	2.10%

In its December 2013 report, Staff estimated updates of 0.2% for inpatient (effective 10.1.2013) and 1.7% for outpatient (effective 1.1.2014).

Medicaid Deficit Assessment

The Medicaid deficit assessment for FY 2015 is unchanged from FY 2014, 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 2014.

MHA recommended that HSCRC staff pursue a reduction in the Medicaid assessment based on the 2014 BRFA legislation that would allow a reduction in the event of Medicaid savings under the new All-Payer model. HSCRC staff notes that any assessment reduction based on savings may not be applicable prior to FY 2016 under the 2014 legislation. However, staff agrees that the process of calculating savings must begin in order to support this possible outcome in 2016 or sooner.

Calendar Year Impact

Staff has completed global models for more than 90 percent of revenues falling under the All-Payer Model. The global models determine the amount of revenue that will be generated for the first half of the Calendar Year 2014, while the update factors will guide the revenue allowed in the second half of Calendar Year 2014. By subtracting December year to date revenues from the FY 2014 allowed amounts, staff was able to determine the estimated revenues for January through June 2013 and compare those revenues to the first six months of Calendar Year 2013, which is the base period for the new All-Payer Model. In making the comparisons, staff concluded that the revenues would fall within the limits of the All-Payer Model for the first six months of the year, with the result that there would be no expected need to adjust the update factor for any overage from this period.

Evaluation of the Balanced Update

Staff has inserted the figures above into the balanced update model (see Attachment) that was presented in the Draft Payment Models Workgroup Report on Balanced Updates and Short-Term Adjustments from the April 2014 meeting of the Commission. The table has been reordered to facilitate the understanding of the impact of uncompensated care and assessments on the results. A section has been added to the table to compare the update results to the CareFirst model that projects the impact of the update on the Medicare savings estimates. When using the recommended update allowances provided above, the model projects that an update within the parameters of the allowed 3.58% per capita can be derived on an All-Payer basis for the fiscal year and that the Medicare savings can be achieved if the differential statistic of 2% is maintained and if the national actuarial projections are reasonable.

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 for readmissions and the uncompensated care and MHIP reductions):

1) Provide update for the three categories of hospitals and revenues as follows:
   a) Revenues under global budgets--2.4%;

b) Revenues not under global budgets but subject to Medicare rate setting waiver--1.7%;
c) Revenues for psychiatric hospitals and Mt. Washington Pediatric Hospital--2.0% with an additional .3% provided for care coordination and population health infrastructure investments.

2) Establish the update factor for a 6 month period to allow for consideration of calendar year performance and unanticipated changes under the new model. Monitor and review results on an ongoing basis and make changes as needed on January 1;
   - Complete guardrail policy recommendations from workgroup relative to approaches to make adjustments when targets are not being met.

3) Calculate the Medicaid deficit assessment for FY 2015 at the same total amount as FY 2014 and apportion it between hospital funded and rate funded in the same total amounts as FY 2014.

4) Begin the process of working with Medicaid to develop the calculations to determine whether savings are accruing under the new All-Payer model that would allow for a reduction in the Medicaid deficit assessment.

ATTACHMENT--Balanced Update Model as of 6/11/14

Maximum allowed growth

Maximum revenue growth allowance	A	3.58%	per capita
Population growth	B	0.71%	
Maximum revenue growth allowance ((1+A)*(1+B)	C	4.32%	

Components of revenue change-increases

	Proportion of Revenues	Allowance	Weighted Allowance
Adjustment for inflation/policy adjustments			
-Global budget revenues	95%	2.41%	2.29%
-Non global revenues	5%	1.71%	0.09%
			2.38%
Adjustment for volume			
-Global budget revenues	95%	0.80%	0.76%
-Non global revenues	5%	1.20%	0.06%
-Market share adjustments			
			0.82%
Infrastructure allowance provided			
-Global budget revenues except TPR	85%	0.33%	0.28%
CON adjustments-			
-Opening of Holy Cross Germantown Hospital			0.40%
Net increase before adjustments			3.87%
Other adjustments (positive and negative)			
-Set aside for unforeseen adjustments			0.50%
-Reverse prior year's shared savings reduction			0.20%
-Positive incentives			0.00%
-Shared savings/negative scaling adjustments			-0.40%
Net increases attributable to hospitals			4.17%
Per Capita			3.44%

Components of revenue changes-net decreases not hospital generated

-Uncompensated care increase	0.38%
-Uncompensated care reduction, net of 6% differential	-1.02%
-MHIP adjustment	-0.45%
-Other assessment changes	
Net decreases	-1.09%
Net revenue growth	3.08%
Per capita revenue growth	2.35%

The first chart below compares the expected maximum All-Payer Growth that could occur to achieve Medicare savings based on the 2% difference statistic model. As stated before, the actual results for Medicare will be different than the projections and those differences may be material.

The second chart shows that when using the recommended update allowances provided, the model projects that an update within the parameters of the allowed 3.58% per capita can be derived on an All-Payer basis for the fiscal year and that the Medicare savings can be achieved if the differential statistic of 2% is maintained and if the national actuarial projections are reasonable.

Balanced Update Model-Medicare Savings Requirement

Maximum Increase that Can Produce Medicare Savings (CareFirst Formula)		
Medicare		
Two year average of Medicare growth (CY 2014 + CY 2015)/2	D	1.70%
Savings Requirement for Year 2/2 years	E	-0.50%
Maximum growth rate that will achieve savings (D+E)	F	1.20%
Conversion to All-Payer		
Difference statistic between Medicare and All-Payer	G	2.00%
Conversion to All-Payer growth per resident (1+F)*(1+G)-1	H	3.22%
Converstion to total All-Payer revenue growth (1+H)*(1+B)-1	I	3.96%

Comparison of Medicare Savings Requirements to Model Results

Comparison to Modeled Requirements	**All-Payer Maximum to achieve Medicare Savings**	**Modeled All-Payer Growth**	**Difference**
Revenue Growth	3.96%	3.08%	-0.88%
Per Capita Growth	3.22%	2.35%	-0.87%

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May 12, 2014

John M. Colmers
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Dear Chairman Colmers:

On behalf of the 66 members of the Maryland Hospital Association (MHA), we would like to take this opportunity to comment on the draft *Update Factors Recommendations for FY 2015* scheduled to be presented to the commission at its May 14 meeting. The hospital field has been actively engaged in the discussions held by the commission's Payment Models Workgroup, which has provided guidance to the staff as it prepared the recommendations to be considered. We would like to compliment commission staff on the constructive dialogue that has taken place throughout these deliberations. The commission should be proud of the efforts to date in moving forward expeditiously with the implementation of Maryland's new all-payer model. Much work will remain after the commission takes action on this fiscal year 2015 balanced update recommendation, and hospitals will continue our commitment to the workgroup process.

In its final report, the HSCRC's Advisory Council provided important advice to the Commission: "…***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***." Based on that advice, we ask for three changes to the draft recommendation on the update before you: (1) the level of infrastructure allowance provided for global budget hospitals; (2) adjustments for other assessments; and (3) the proposed update for non-waiver hospitals.

Infrastructure Allowance

During the Payment Models Workgroup deliberations, there was general concern expressed that the level of infrastructure funding being provided in the proposed update (0.33 percent for global budget hospitals, for an overall system impact of 0.26 percent) was insufficient for hospitals to make the necessary adjustments to achieve sustainable success under the waiver. In their initial Total Patient Revenue (TPR) agreements three years ago, TPR hospitals were provided incentive funding well in excess of the amounts proposed here to allow them to undertake the risks inherent in the global budget model. We urge the commission to increase (from 0.33 percent as proposed, to 0.66 percent of the new global budget hospital revenues, or 0.50 percent overall system impact) this critical infrastructure funding for fiscal year 2015. The additional funding should come from the "set aside for unforeseen adjustments and cushion" indicated in staff's draft balanced update model. Staff has charged a sub-group with designing a formal reporting template for all global budget hospitals to provide an accounting of their use of these infrastructure funds, so that commissioners will be able to link the investment of these funds with measurable outcomes of the programs hospitals will be implementing/enhancing to ensure long-term success under the new all-payer model.

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Other Assessments

At the request of MHA, the staff model includes a line for "other assessment adjustments," to specifically account for reductions in the Medicaid deficit assessment that should be anticipated in this balanced update model for fiscal year 2015. The net reduction in uncompensated care and the Maryland Health Insurance Plan assessment will save Medicaid money in fiscal year 2015, potentially as much as $15 million in general funds, as a result of these two rate reductions alone. Just as the commission has prospectively anticipated reductions in uncompensated care from the full benefits now provided to the Medicaid Primary Adult Care population and lowered rates accordingly, the Commission should prospectively reduce rates, accounting for the lower Medicaid assessment. That way, the Medicaid assessment reduction in rates is available to reduce costs to all payers, including the Medicare program.

Non-waiver Hospital Update

Staff has recommended an update of 2.0 percent for the psychiatric hospitals and Mt. Washington Pediatric Hospital for next year. They derive this recommendation by using the offsets in the Medicare proposed rule for Inpatient Psychiatric Facilities (0.4 percent for productivity, and 0.3 percent as required for those facilities under the Affordable Care Act). We oppose applying the Medicare budget-mandated offset of 0.3 percent to non-Medicare payers in Maryland, and propose instead an update for these facilities of 2.3 percent. For Medicare, the psychiatric hospitals in Maryland would receive the same 2.0 percent update as hospitals nationally, so there would be no impact on the Medicare waiver savings calculation by accepting the MHA recommendation. Furthermore, these hospitals are excluded from the all-payer test calculation, so allowing the additional request of 0.3 percent in all-payer rates will have no impact on the all-payer test calculation. Just like their waiver hospital counterparts, these non-waiver hospitals will be critical to the long-term success of managing the health of entire populations under our all-payer model, especially for the unique populations that they serve. We believe that the update request of 2.3 percent for fiscal year 2015 will provide these hospitals with the critical resources they need

We appreciate the opportunity you have provided us to address the *Update Factor Recommendations for FY 2015*, and look forward to further discussion of the concerns that we have raised at the commission meeting on May 14. In the meantime, if you have any questions, please contact me at MHA.

Sincerely,

Michael B. Robbins

Michael B. Robbins, Senior Vice President Financial Policy & Advocacy

cc: Herbert Wong, PhD, Vice Chairman
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May 9, 2014

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Re: HSCRC DRAFT Recommendation: Update Factors for FY2015

Dear Mr. Colmers and Ms. Kinzer,

I would like to take this opportunity to say that staff did an excellent job engaging all stakeholders, assessing all industry issues and comments and developing an Update Factor recommendation that we believe will favorably position the State of Maryland to meet all the conditions of the Medicare Waiver agreement, especially the All-Payer and the Medicare financial targets.

As CareFirst noted at the April Public meeting, Maryland's Demonstration model is predicated on successfully achieving both the All-Payer target of 3.58% and the Medicare savings target of $330M over five years. As you well know, meeting these dual targets will be challenging given the difference in the historical growth rates of Medicare and All-Payer Maryland hospital expenditures. The Medicare actuaries are forecasting the Medicare cost trend to be 1.7% for fiscal years 2014 and 2015.

In order to achieve the Medicare annual savings, we must curb the Medicare trend in Maryland to approximately 1.2% in each of these years. We believe there is evidence to support an approximate 2.0% differential rate of growth between the All-Payer and Medicare trends, in part due to different service use patterns of Medicare beneficiaries. As a result, we need to be conservative on the All-Payer allowance and at the same time focus utilization control measures most specifically on the Medicare population. This conclusion is included in the recommendation in the draft report. CareFirst strongly supports this overall strategy and believes it will position Maryland to successfully achieve both targets over the course of the Demonstration.

Overall, CareFirst supports the Update Factor recommendation which has been structured to provide hospitals reasonable allowances for inflation, volume, and infrastructure while providing a slight cushion which we believe is necessary given current forecasting uncertainties and the yet unproven ability to manage the utilization specific to the Medicare population. This recommendation will allow time to demonstrate that our new policies, incentives, and reimbursement models are producing the expected results.

Thank you for this opportunity to provide comments on this recommendation.

Sincerely,

Chet Burrell
President and Chief Executive Officer

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May 14, 2014

Mr. John Colmers
Chairman
Health Services Cost Review Commission
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Re: HSCRC Draft Recommendation: Update Factors for FY2015

Dear Mr. Colmers:

United Healthcare would like to extend our appreciation for the leadership of Ms. Donna Kinzer, Executive Direction and her staff in preparation of the Update Factor Recommendation for FY2015. We have reviewed the Staff recommendation and believe this will enable the State of Maryland to be in compliance with the new Medicare Waiver agreement or specifically for the All-Payer and Medicare financial targets.

As Carefirst presented in the April Public meeting, both the All-Payer 3.5% target and the Medicare savings target of $330 million over five years must be met, respectively. United agrees both targets are essential to the success of the Maryland Demonstration. We realize meeting both targets will be a challenge based upon the Maryland historical growth rates occurring in the hospital payments.

United recommends to be conservative on the All-Payer allowance while focusing efforts on reducing utilization and/or redirecting to the proper location of service in behalf of Medicare beneficiaries. We note this position is included in the recommendation in the draft report.

In summary, United supports the Update Factor recommendation. We believe this recommendation provides a reasonable adjustment for inflation, volume, and adequately funds infrastructure in this early adoption of the new Medicare Waiver agreement. We further encourage the HSCRC to be conservative while new policies, hospital incentives are implemented as well as new reimbursement models to ensure expected results are obtained.

Respectfully

Gary B. Simmons
Regional Vice President, Networks

Cc: Ms. Donna Kinzer, Executive Director