Final Recommendations on the Update Factors for FY 2019

June 13, 2018

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This document reflects the Final Recommendation on the Update Factors for FY 2019 as ultimately approved by the Commission on June 13, 2018.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
ACO	Accountable Care Organization
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DSH	Disproportionate Share Hospital
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
JHHS	Johns Hopkins Health System
MACRA	Medicare Access and Chip Reauthorization Act
MDPCP	Maryland Primary Care Program
MHA	The Maryland Hospital Association
MPA	Medicare Performance Adjustment
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RY	Rate year, which is July1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

CHANGES FROM DRAFT TO FINAL

This final recommendation adjusts the draft recommendation to include amounts for QBR, estimated to be -0.38 percent, and the oncology drug adjustment, estimated to be 0.20 percent. The total net value of these adjustments is -0.18 percent and is reflected in Table 2 on page 5. This recommendation also includes contract language relating to shifts to unregulated on page 9, staff responses to stakeholder input on page 17, and an overview on preparing for the Total Cost of Care Model on page 22, which begins on January 1, 2019. Staff has indicated changes to the draft by highlighting these areas in yellow.

The Commission voted to amend staff's final recommendation and decrease the update for Global Budget Revenues by 0.25 percent. This reduction has been removed from the gross inflation amount and is reflected throughout the report.

INTRODUCTION AND BACKGROUND

The Maryland Health Services Cost Review Commission (HSCRC or Commission) has been setting hospital payment rates for all payers since 1977. As part of this process, the HSCRC updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy related adjustments, other adjustments related to performance, and settlements from the prior year.

On January 1, 2014, the Centers for Medicare & Medicaid Services (CMS) approved the implementation of a new All-Payer Model in Maryland. The All-Payer Model aims to promote better care, better health, and lower costs for all Maryland patients. In contrast to Maryland's previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the All-Payer Model (Model) focuses on controlling increases in total hospital revenue per capita. The Model established a cumulative annual limit on per capita revenue growth of 3.58 percent and a Medicare savings target of $330 million over the five-year Model period.

In order to meet the requirements of the All-Payer Model and assure that the annual update will not result in a revenue increase beyond the 3.58 percent limit, the update process needs to account for all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents. In addition, the HSCRC needs to consider the effects of the update on the Model's $330 million Medicare savings requirement and the total hospital revenue that is set at risk for quality-based programs. While rates and global budgets are approved on a fiscal year basis, the All-Payer Model revenue limits and Medicare savings are determined on a calendar year basis. Therefore, the HSCRC must account for both calendar year and fiscal year revenues when establishing the fiscal year updates.

It is important to note that the proposed update incorporates both price and volume adjustments for revenues under global budgets. Thus, the proposed update should not be compared to a rate update, which does not control for volume changes. It is also important to view the revenue updates in the framework of gross and net revenue. Specially, beginning in calendar year 2014, the expansion of Medicaid and other Affordable Care Act enrollment has reduced

uncompensated care and in response the State has reduced several related hospital assessments. The revenue reductions for uncompensated care and associated assessment reductions decrease gross revenues, but they do not decrease net revenues. Therefore, the net revenue increases are higher than gross revenue increases during these periods.

For rate year (RY) 2019, there are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay on the basis of those rates. This includes psychiatric hospitals and Mount Washington Pediatric Hospital.

The purpose of this report is to present analyses and make recommendations for the update factors for RY 2019 for global revenues and non-global revenues.

ASSESSMENTS

Overview of Final Update Factors Recommendations

As described in detail below, for RY 2019, HSCRC staff is proposing a final update of 1.62 percent per capita for global revenues and a final update of 1.77 percent for non-global revenues.

Calculation of the Inflation/Trend Adjustment for Global and Non-Global Revenues

The calculation of the inflation/trend adjustment to Global Revenues and Non-Global Revenues, including psychiatric hospitals and Mt. Washington Pediatrics, starts by using the gross blended statistic of 2.57 percent growth[1], which was derived by combining 91.20 percent of Global Insight's Fourth Quarter 2017 market basket growth of 2.70 percent with 8.80 percent of the capital growth estimate of 1.20 percent, calculating to 2.57 percent. The Commission voted to amend staff's recommendation and decrease inflation by 0.25 percent for Global Budget Revenues. As a result, the gross inflation decreased from 2.57 percent to 2.32 percent. The proposed inflation/trend adjustment follows:

[1] Any inflation increase published in Global Insights 2018 First Quarter data and used in this recommendation will have a forecasting error applied.

Table 1. RY 2019 Proposed Inflation/Trend Adjustment

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.32%	2.57%
Productivity Adjustment		-0.80%
Proposed Update	2.32%	1.77%

For psychiatric hospitals and Mt. Washington Pediatric Hospital, staff proposes using a productivity adjustment of 0.80 percent. When subtracted from the gross blended 2.57 percent growth, this results in a proposed update of 1.77 percent. The proposed Medicare rule for the federal FY 2019 Inpatient Psychiatric Facilities rate update applies a 0.80 percent reduction for productivity and a 0.75 percent reduction for ACA savings mandate to a market basket update of 2.80 percent, resulting in a proposed payment update of 1.25 percent. HSCRC staff has proposed to take the Medicare productivity update into account, as staff have done in the past. However, staff will eliminate the application of the ACA adjustment when calculating the update used for payers other than Medicare under HSCRC's rate setting authority. Additionally, HSCRC staff note that these hospitals get a volume adjustment, rather than a population adjustment. Staff are currently working on implementing quality measures for these hospitals in future rate years.

Summary of Other Policies Impacting RY 2019 Revenues

The inflation/trend adjustment is just one component of the adjustments to hospital global budgets for RY 2019. In considering the system-wide update for the hospital global budgets under the All-Payer Model, HSCRC staff sought to achieve balance among the following conditions: 1) meeting the requirements of the All-Payer Model agreement; 2) providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes; 3) ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the All-Payer Model; and 4) incorporating quality performance programs.

Table 2 summarizes the net impact of the HSCRC staff's current proposals for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments on global revenues. The proposed adjustments provide for an estimated net revenue growth of 2.38 percent and per capita growth of 1.91 percent for RY 2019, before accounting for reductions in UCC and assessments. After accounting for those factors, the revenue growth is estimated at 1.83 percent with a corresponding per capita growth of 1.37 percent for RY 2019. As discussed below in this report, some of the financial tests under the All-Payer Model Agreement are made on a calendar year basis. Since several fiscal year updates occur at the midpoint rather than at the beginning of the year, Table 2 provides subtotals for update percentages through December

31 to facilitate the calculation of calendar year tests. Descriptions of each step and the associated policy considerations are explained in the text following the table:

Table 2. Net Impact of Adjustments on Hospital Global Revenues, RY 2019

Balanced Update Model for Discussion			
Components of Revenue Change Linked to Hospital Cost Drivers/Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 2.4% for wages)			2.01%
- Total Drug Cost Inflation for All Hospitals*			0.31%
Gross Inflation Allowance	**A**		**2.32%**
Care Coordination			
-Rising Risk With Community Based Providers			
-Complex Patients With Regional Partnerships & Community Partners			
-Long Term Care & Post Acute	**B**		
Adjustment for Volume			
-Demographic Adjustment (0.46%)			
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.46%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.25%
- Categoricals (net amount for Hopkins/UMMC: 0.23%)	E		0.23%
-Reversal of one-time adjustments for drugs	F =		0.00%
Net Other Adjustments	**G =**	**Sum of D thru F**	**0.48%**
Quality and PAU Savings			
-Reverse prior year's PAU savings reduction	H		1.45%
-PAU Savings	I		-1.75%
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	J		-0.25%
-Positive incentives & Negative scaling adjustments	K		-0.15%
Net Quality and PAU Savings	**L =**	**Sum of H thru K**	**-0.70%**
Total Update First Half of Fiscal Year 19			
Net increase attributable to hospitals	M =	Sum of A + B + C + G + L	**2.56%**
Per Capita First Half of Fiscal Year (July - December)	N =	(1+M)/(1+0.46%)	**2.09%**
Adjustments in Second Half of Fiscal Year 19			
-Oncology Drug Adjustment	O		0.20%
-QBR	P		-0.38%
Total Adjustments in Second Half of Fiscal Year 19	Q =	O+P	**-0.18%**
Total Update Full Fiscal Year 19			
Net increase attributable to hospital for Fiscal Year	R =	M + Q	**2.38%**
Per Capita Fiscal Year	S=	(1+R)/(1+0.46%)	**1.91%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care reduction, net of differential	T		-0.35%
-Deficit Assessment	U		-0.19%
Net decreases	V =	T + U	**-0.54%**
Total Update First Half of Fiscal Year 19			
Revenue growth, net of offsets	W =	M + V	**2.01%**
Per Capita Revenue Growth First Half of Fiscal Year	X =	(1+W)/(1+0.46%)	**1.55%**
Total Update Full Fiscal Year 19			
Revenue growth, net of offsets	Y =	S + V	**1.83%**
Per Capita Fiscal Year	Z =	(1+Y)/(1+0.46%)	**1.37%**

* Provided Based on proportion of drug cost to total cost (drug index 5.3% X 5.9% national weight)

Beginning in RY 2017, the HSCRC split the approved revenue for the year into two targets, a mid-year target and a year-end target. Through this process, the HSCRC deferred a portion of the update from one calendar year to the next. This deferral was meant to address a particularly low federal Medicare update for FFY 2017, and also better matched the historic volume patterns incurred by hospitals, with higher volumes through the winter months of January through March. This revenue split more accurately matched historical volumes, and therefore the HSCRC staff plans to continue this split. The staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Of note, there are a few hospitals that do not follow this seasonal pattern, particularly Atlantic General Hospital. Thus, HSCRC staff will adjust the revenue split to accommodate their normal seasonality.

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC staff accounted for a number of factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 2.57 percent. The gross inflation allowance is calculated using Global Insight's Fourth Quarter 2017 market basket growth of 2.70 percent with 8.80 percent of the capital growth 1.20 percent estimate As noted above, the Commission amended the staff recommendation to decrease overall inflation by 0.25 percent for Global Budget Revenues. As a result, the gross inflation decreased from 2.57 percent to 2.32 percent. A portion of the 2.32 inflation allowance (0.31 percent) will be allocated to hospitals based on each hospital's proportion of drug costs to total costs in order to accurately provide revenues for increases in drug prices. This drug cost adjustment is further discussed below.
- **Adjustments for Volume**: Staff proposes a 0.46 percent adjustment that is equal to the Maryland Department of Planning's estimate of population growth for CY 2018.[2] Hospital-specific adjustments will vary based on changes in the demographics of each hospital's service area. In the past, a portion of the adjustment was set aside to account for growth in highly specialized services at Johns Hopkins Hospital and University of Maryland Medical Center. Several workgroup members suggested funding these increases through avoidable utilization reductions, rather than the demographic adjustment. For RY 2019, the staff are proposing recognizing the full value of the 0.46 percent growth for the demographic adjustment to hospitals and accounting categoricals cost separately in the formulation of the revenue increase. The demographic adjustment

[2] See http://planning.maryland.gov/msdc/.

has been criticized for providing revenue increases to hospitals that are experiencing volume decreases. The HSCRC staff is working to analyze alternative approaches, but the analysis will take time and require stakeholder and Commissioner input. There also is a need for improved outpatient volume measures for cycle billed services and expanded measures for avoidable and unnecessary utilization. The HSCRC staff is actively working on improving outpatient volume measures. HSCRC staff has also identified a need for better drug case-mix data submissions from hospitals to improve the accuracy when recognizing volume changes of drugs utilized. These core measurement improvements are building blocks necessary to improve policy analysis and demographic adjustment changes while improving efficiency comparisons among hospitals and other delivery settings. Also, with ICD-10 conversion and electronic medical record conversions mostly complete, case-mix and volume measurements are expected to become more stable.

- **Rising Cost of New Outpatient Drugs**: The rising cost of drugs, particularly of new physician-administered drugs in the outpatient setting, continues to be a growing concern among hospitals, payers, and consumers. Not all hospitals provide these services and some hospitals have a much larger proportion of costs allocated. To address this situation, staff recommends earmarking 0.31 percent of the inflation allowance to fund increases in the cost of drugs and provide this allowance based on the portion of total hospital costs that were comprised of drug costs in RY 2017.

  In addition to the 0.31 drug inflation allowance, this recommendation also addresses high cost oncology drugs. In RY 2017, HSCRC initiated a volume adjustment for growth in high cost oncology drugs. The adjustment for growth between RY 2015 and RY 2016 was made utilizing information provided in a supplemental report provided by the hospitals for the top 80 percent of these outpatient medications. Half of the estimated cost changes due to volume were recognized as a one-time adjustment and half were recognized as a permanent adjustment. On July 1 2017, hospitals were provided a prospective estimate to account for potential volume changes in RY 2017 over RY 2016 while awaiting the supplemental reporting results. A true up of the estimate was made with the RY 2018 mid-year adjustments based on the supplemental reports provided by hospitals.

  For RY 2019, as a result of their experience adjusting the estimates to the actual reports, staff plans to eliminate the prospective volume estimate for these high cost drugs. Staff is also proposing accelerating the due date for the supplemental drug report and they are meeting with industry representatives and experts to evaluate the potential to make just-in-time adjustments for emerging drugs. Staff will make the outpatient high-cost drug volume adjustment for RY 2018 over RY 2017 with the mid-year adjustments for RY 2019.

  Industry briefs suggest that there will be substantial increases in oncology drug costs for RY 2019. There are several drugs with expected introductions or new indications

for use. Staff is expecting to get improved claims data drug information in October. By mid-year, staff will determine whether the improved information can be used to make adjustments for a very limited set of new oncology drugs. After additional consultations and calculations, staff will provide an allowance in the second half of RY 2019 for increases in costs related to net volume growth of high cost oncology medications for RY 2018 over RY 2017. Staff will also potentially provide an adjustment for emerging medications, if warranted. Based on early estimates contained in industry briefs, staff is utilizing an estimate of 0.20 percent to calculate the overall RY 2019 update (for further discussion, see Supplemental Report Information).

- **Categoricals:** At the January commission meeting, Johns Hopkins Hospital and University of Maryland Medical Center made a presentation regarding new and expensive inpatient therapies for cancer and spinal muscular atrophy. The HSCRC staff has been working to develop an approach to provide a revenue adjustment for these expensive therapies together with adjustments for existing categorical cases (transplants, cancer research cases). HSCRC staff has been provided a wide range of potential volume estimates for these services. To create a fixed pool of funds for these services, staff proposed a set aside of a one percent revenue adjustment for these two academic medical centers for RY 2019. While this adjustment will increase the permanent base revenue of these two institutions for RY 2019 and beyond, the Commission will need to deliberate how to fund these types of services in the future. This approach applies only to RY 2019, and there are certain conditions that must be met to receive this funding. The Commission approved a set of conditions for Johns Hopkins Hospital at the June Commission meeting. Discussions with University of Maryland Medical Center are still underway.
- **QBR Adjustment:** Because the Quality Based Reimbursement (QBR) adjustment data comes from CMS, there is a delay in the calculation of this adjustment. This adjustment is expected to be approximately -0.38 percent, based on the changes in Commission policy and preliminary modeling. This adjustment will be made in the second half of RY 2019.
- **Set-Aside for Unforeseen Adjustments**: Staff recommends a 0.25 percent set-aside to fund unforeseen adjustments during the year. Although the actual unforeseen adjustments in RY 2018 were above this amount, staff's estimate of the high cost drug volume adjustment was excessive and, as a result, the revenue growth remained on target for the year. It is important to note that CMS's final regulations lowered its update by approximately 0.60 percent for the federal fiscal year that began in October 2017 relative to its initial proposal. HSCRC did not lower hospitals' revenue budgets when this occurred. Fortunately, high cost drug volume increases came in lower than expected and, as a result, helped to offset the lower federal inflation provision.
- **Reversal of the Prior Year's PAU Savings Reduction and Quality Incentives**: The total RY 2018 PAU savings and quality adjustments are restored to the base for RY 2019, with new adjustments to reflect the PAU savings reduction and quality incentives for RY 2018.

- **PAU Savings Reduction and Quality Scaling Adjustments**[3]: The RY 2019 PAU savings will be continued, and an additional 0.30 percent savings is recommended for RY 2019. Staff have provided final figures for both positive and negative quality incentive programs.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC) Reduction:** The proposed uncompensated care reduction for FY 2019 will be -0.35 percent. The amount in rates was 4.51 percent in RY 2018, and the proposed amount for RY 2019 is 4.16 percent.
- **Deficit Assessment**: The legislature reduced the deficit assessment by $30 million in RY 2019, as a result, this line item is -0.19 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers, as mentioned in Table 2. These additional variables include one-time adjustments, 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.

Shifts to Unregulated

A growing focus in Maryland continues to be on the total cost of care. Global budgets must be adjusted for shifts from regulated to unregulated settings to prevent double payment for the services and dis-savings. Adjustments related to shifts, whether to related or unrelated entities, must be made in a timely manner. The GBR agreements that apply to each hospital clearly anticipate revenue reductions when services are shifted and require timely reporting to the HSCRC so that adjustments may occur. In order to ensure better reporting and facilitate disclosure, staff is proposing to withhold 0.50 percent of a hospital's total update if the hospital fails to submit a properly executed disclosure. The applicable GBR agreement provisions are provided in the following paragraphs below.

[3] The RY 19 MHAC and QBR penalties are significantly higher than the RY 18 penalties because the scale was modified to use full distribution of scores. Furthermore for QBR the mortality benchmark increased in RY19 and this resulted in greater penalties. For RRIP, there was an increase in penalties because improvement in readmissions slowed down. There were 22 hospitals that had increases in their case-mix adjusted readmission rate.

Section IV.B.3a. Of the Global Budget Agreement states the following:

The HSCRC and the Hospital recognize that some services may be offered more effectively in an unregulated setting. When services covered by the GBR model are moved to an unregulated setting, the HSCRC staff will calculate and apply a reduction to the Hospital's Approved Regulated Revenue. At a minimum, the reduction will ensure that the shift provides a savings to the public and Medicare after taking into consideration the payment amounts likely to be made for the same services in an unregulated setting.

Furthermore, section VI.3 of the Global Budget Agreement states the following:

Significant changes in the health care delivery system in the Hospital's Primary and Secondary Service Areas could influence the appropriateness of the Approved Regulated Revenue established for the Hospital under this Agreement. Therefore, the Hospital agrees to declare and describe, in Appendix G, any financial interest (or control) it holds in other hospitals or entities that provide services, including non-hospital services, in the Hospital's Primary and Secondary Service Areas, as of the Effective Date of this Agreement.

In addition, the Hospital agrees to inform the HSCRC at least thirty (30) days in advance, in writing, or at the earliest practicable time thereafter, of any acquisitions or divestitures which it undertakes regarding such interests.[4] The HSCRC may request data from the Hospital, on a periodic or ongoing basis, regarding the utilization of the services provided by such related entities, to ensure that the Hospital complies with the GBR constraint through better management of its existing regulated services and not by moving services from the HSCRC-regulated sector to unregulated sectors of the hospital or non-hospital environment in ways that do not comport with the objectives of the GBR model, the Three Part Aim and the final contract between CMMI and the State of Maryland.

The Hospital will provide [two] annual disclosure and certification report, regarding changes in the services it provides. [One disclosure report includes initiation of ventures outside the hospital which may result in a shift in volumes. The other disclosure report requires a reporting of any shift in volumes to unregulated settings, whether initiated by the hospital or another party] The initial report[s] [were] due upon signing of [the GBR] Agreement and additional reports will due on an annual basis within 30 days after the end of each subsequent Rate Year.

Hospitals have expressed some confusion regarding shifts to unregulated settings. In order to provide additional guidance to hospitals, HSCRC staff recommend that a sub-group of the

[4] This would include the purchase or divestiture of physician practices, joint-venture arrangements with other providers to establish unregulated services that duplicate or could substitute for regulated services currently provided by the Hospital (such as, but not limited to, unregulated clinic, urgent care, or ambulatory surgery services), or other non-hospital services.

Payment Models Workgroup meet to outline and provide additional guidance regarding reporting and adjustments for shifts to unregulated settings.

Consideration of All-Payer Model Agreement Requirements

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Additionally, based on staff calculations, the proposed update falls within the financial parameters of the All-Payer Model agreement requirements. The staff's considerations in regards to the All-Payer Model agreement requirements are described in detail below.

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 limits the annual growth rate for all-payer per capita revenues for Maryland residents at 3.58 percent. Compliance with this test is measured by comparing the cumulative growth in revenues from the CY 2013 base period to a ceiling calculated assuming an annual per capita growth of 3.58 percent. To evaluate the impact of the recommended update factor on the State's compliance with the all-payer revenue test, staff calculated the maximum cumulative growth that is allowable through the end of CY 2019. As shown in Table 3, cumulative growth of 23.50 percent is permitted through CY 2019.

Table 3. Calculation of the Cumulative Allowable Growth in All-Payer per Capita Revenue for Maryland Residents

	CY 2014 A	CY 2015 B	CY 2016 C	CY 2017 D	CY 2018 E	CY 2019 F	Cumulative Growth G = (1+A)*(1+B)*(1+C)*(1+D)*(1+E)*(1+F)
Calculation of Revenue Cap	3.58%	3.58%	3.58%	3.58%	3.58%	3.58%	23.50%

Table 4 below shows the allowed all-payer growth in gross revenues. Staff removed adjustments due to reductions in uncompensated care (UCC) and assessments that do not affect the hospitals' bottom lines. Staff projects that the actual cumulative growth, excluding changes in uncompensated care and assessments, through FY 2019 is 17.78 percent. The actual and proposed revenue growth is well below the maximum levels.

Table 4. Evaluation of the Proposed Update's Projected Growth and Compliance with the All-Payer Gross Revenue Test

	Actual Jan -June 2014 A	Actual FY 2015 B	Actual FY 2016 C	Actual FY 2017 D	Staff Est. FY 2018 E	Proposed FY 2019 F	Cumulative Growth G = (1+A)*(1+B)*(1+C)*(1+D)*(1+E)*(1+F)
Maximum Gross Revenue Growth Allowance	**2.13%**	**4.21%**	**4.06%**	**3.95%**	**4.06%**	**4.06%**	**24.66%**
Revenue Growth for Period	0.90%	2.51%	2.47%	2.20%	2.62%	2.01%	13.40%

Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line		1.09%	1.40%	0.69%	0.18%	0.54%	3.96%
Revenue Growth with UCC & Assessment Savings Removed	0.90%	3.60%	3.87%	2.89%	2.80%	2.56%	**17.78%**
Revenue Difference from Growth Limit							**6.87%**

"Maximum Gross Revenue Growth Allowance" includes the following population estimates: FY17/CY16 = 0.36%; FY18/CY17 = 0.46%

Medicare Financial Test

The proposed balanced update also keeps Maryland within the constraints of the Model's Medicare savings test. This second test requires the Model to generate $330 million in Medicare fee-for-service (FFS) savings in hospital expenditures over five years. The savings for the five-year period were calculated assuming that Medicare FFS hospital costs per Maryland beneficiary would grow about 0.50 percent per year slower than the Medicare FFS costs per beneficiary nationally after the first performance year (CY 2014).

Performance years one through four (CY 2014 through CY 2017) of the Model generated $916 million in cumulative hospital savings. Under these calculations, the cumulative hospital savings are ahead of the required savings of $330 million.

However, there continues to be a shift toward greater utilization of non-hospital services in the State, relative to national rates of growth. When calculating savings relative to total cost of care, the four-year (CY 2014-CY2017) cumulative savings estimate is $599 million, still well above the required savings level. Maryland's All-Payer Model Agreement with CMS contains requirements relative to the total cost of care, which includes non-hospital cost increases. The purpose is to ensure that cost increases outside of the hospital setting do not undermine the Medicare hospital savings that result from the Model implementation. If Maryland exceeds the national total cost of care growth rate by more than 1.00 percent in any year, or exceeds the national total cost of care growth rate in two consecutive years, Maryland is required to provide an explanation of the increase and potentially provide steps for corrective action.

While cumulative savings are above the required level, staff has calculated that the year over year total cost of care growth was above the national growth rate for Medicare for CY 2017 over CY 2016. This annual excess growth was caused by increases in Maryland's non-hospital Part B services, which were not offset by sufficient hospital savings. As a result, Maryland must set out to ensure that growth does not exceed the national total cost of care growth for Medicare in CY 2018. A commitment to continue the success of the first four years is critical to building long-term support for Maryland's Model.

Consideration of National Cost Figures

Medicare's Proposed National Rate Update for FFY 2019

CMS published proposed updates to the federal Medicare inpatient rates for FFY 2019 in the Federal Register in late-April 2018.[5] These proposed updates are summarized in Table 5 below; they will not be finalized for several months and are subject to change. In the proposed rule, CMS would increase rates by approximately 3.05 percent in FFY 2019 compared to FFY 2018, after accounting for inflation, a disproportionate share increase, and other adjustments required by law. The proposed rule includes an initial market basket update of 2.80 percent for those hospitals that were meaningful users of electronic health records and for those hospitals that submitted data on quality measures, less a productivity cut of 0.80 percent and an additional market basket cut of 0.75 percent, as mandated by the Affordable Care Act (ACA). This proposed update also reflects a proposed 0.50 percentage point increase for documentation and coding required by the American Taxpayer Relief Act of 2012. Disproportionate share payment changes resulted in an increase of approximately 1.30 percent from FFY 2018.

Table 5. Medicare's Proposed Rate Updates for FFY 2019

	Inpatient	Outpatient
Base Update		
Market Basket	2.80%	2.80%
Productivity	-0.80%	-0.80%
ACA	-0.75%	-0.75%
Coding	0.50%	
	1.75%	1.25%
Other Changes		
DSH	1.30%	0.00%
Other Changes	0.00%	0.00%
	1.65%	0.00%
	3.05%	1.25%

Applying the inpatient assumptions about market basket, productivity, and mandatory ACA outpatient savings, staff estimates a 1.25 percent Medicare outpatient update effective January

[5] See httpshttps://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Proposed-Rule-Home-Page.html.

2019. This estimate is pending any adjustments that may be made when the final update to the federal Medicare outpatient rates is published.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

For the past four updates, Maryland obtained calendar year Medicare fee-for-service growth estimates from the CMS Office of the Actuary. Staff then compared Medicare growth estimates to the all-payer spending limits. During CY 2014-CY 2017, all-payer growth outpaced Medicare growth on a per capita basis and in the updates staff adjusted the all-payer growth limit using the difference in Medicare and all-payer per capita growth to estimate the implied limit for Medicare. Staff also incorporated a targeted Medicare savings of 0.50 percent in hospital payment growth relative to the national growth rate, designed to provide at least $330 million in cumulative savings over a five-year period. The CMS Office of the Actuary provided national Medicare fee-for-service per capita hospital spending increase estimates of 2.10 percent for CY 2018 and of 2.00 percent for total cost of care (Parts A and B). The updates provided by the Office of the Actuary did not include a provision for DSH in the amount of 1.30 percent that is included in the federal update and begins on October 1. Due the federal update beginning with three months left in the calendar year, staff have added 25 percent of the DSH cost to the CY 2018 projections. This was calculated by taking 25 percent of the 1.30 percent and multiplying that by the inpatient percentage of total hospital payments, approximately 71 percent. This calculation results in a revised increase of 2.32 percent for hospital spending. Staff also calculated a revised increase for total cost of care by taking the 0.23 percent increase from the hospital projection and multiplying that by the hospital percentage of total cost of care of approximately 50 percent. This calculation produced a 0.12 percent increase which was added to the total cost of care projection resulting in a revised estimate of 2.13 percent. These revised spending projections were used by staff to estimate desired CY 2018 Medicare savings (Tables 6A and 6B).

For the purposes of evaluating the maximum all-payer spending growth that will allow Maryland to meet the per capita Medicare FFS target, the Medicare target must be translated to an all-payer growth limit. There are several ways to calculate the difference between Medicare FFS and all-payer growth rates using recent data trends. A consultant to CareFirst developed a “conservative difference statistic’ that reflected the historical increase in Medicare per capita spending in Maryland relative to all-payer per capita spending growth. CareFirst has updated this statistic each year using data provided by HSCRC staff. For the FY 2019 update, CareFirst and HSCRC staff calculated a difference of 0.86 percent, which used a four-year average difference between Maryland Medicare and all-payer claims reduced by the average annual absolute variance.

A feature of the current hospital Model that will continue in the Total Cost of Care All-Payer Model, which begins January 1, 2019, is that Maryland Medicare total cost of care cannot exceed national Medicare total cost of care growth by one percent in any single year and cannot exceed the national growth by any amount in two consecutive years; these are known as ‘total cost of care guardrails.’ Maryland ended the year above Medicare national growth in CY 2017. In an effort to ensure Maryland that does not exceed the national Medicare growth rate in CY 2018, staff modeled the impact of excess non-hospital growth on the maximum hospital update that

could be provided. This calculation assesses Medicare growth in unregulated settings and factors this excess growth into allowable hospital rate increases for RY 2019. Staff modeled two different estimates of excess growth. The first scenario uses a lower four-year average of non-hospital excess costs for Medicare Parts A and B, while the second scenario uses the actual non-hospital excess cost growth in 2017. While there is little room for error with the higher estimates of non-hospital cost growth, under either scenario the proposed hospital update would be expected to result in total cost of care growth within the guardrail requirements.

Table 6A. Scenario 1 Maximum All-Payer Increase that will still produce the Desired FY 2019 Medicare Savings

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare Growth (CY 2018 2.32%)	A	2.32%		
Savings Goal for FY 2019	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	2.32%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer		0.86%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation		-0.49%		
Net Difference Statistic Related to Total Cost of Care	D	0.37%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**2.70%**	**2.08%**	**0.62%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.46%)-1	F	**3.17%**	**2.55%**	**0.63%**

Table 6B. Scenario 2 Maximum All-Payer Increase that will still produce the Desired FY 2019 Medicare Savings

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare Growth (CY 2018 2.32%)	A	2.32%		
Savings Goal for FY 2019	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	2.32%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer		0.86%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation		-0.95%		
Net Difference Statistic Related to Total Cost of Care	D	-0.09%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**2.23%**	**2.08%**	**0.15%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.46%)-1	F	**2.70%**	**2.55%**	**0.15%**

Because the actual revenue resulting from updates in RY 2018 affect the CY 2018 results, staff must convert the recommended RY 2019 update to a calendar year growth estimate. Table 7 below shows the current revenue projections for CY 2018 to assist in estimating the impact of

the recommended update factor together with the projected FY 2018 results. The overall growth from this table is used in Table 6A.

Table 7. Estimated Position on Medicare Target

Estimated Position on Medicare Target		
Actual Revenue CY 2017		17,056,291,338
Step 1:		
Approved GBR FY 2018		17,183,983,214
Actual Revenue 7/1/17-12/31/17		8,421,055,533
Projected Revenue 1/1/18-6/30/18	**A**	**8,762,927,681**
Step 2:		
Estimated Approved GBR FY 2019		17,529,893,859
Permanent Update		2.01%
Step 3:		
Estimated Revenue 7/1/18-12/31/18 (after 49.73% & seasonality)		8,717,616,216
Change in Hopkins Payback		10,000,000
	B	**8,727,616,216**
Step 4:		
Estimated Revenue CY 2018	**A+B**	**17,490,543,897**
Increase over CY 2017 Revenue		2.55%

Steps to explain Table 7 are described as below:

- Step 1: The table begins with the estimated global revenue for FY 2018 and actual revenue for the last six months for CY 2017 to calculate the projected revenue for the first six months of CY 2018 (i.e. the last six months of FY2018).
- Step 2: This step shows the estimated FY 2019 global budget revenue based on the information that staff have available to date. The permanent update over FY 2018 of 2.01 percent represents the portion of the RY 2019 update provided during the calendar year 2018, as shown in Table 2.
- Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2019 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for FY 2019 and hospital specific seasonality adjustments. An adjustment for the temporary rate adjustment for Johns Hopkins Hospital is added to revenues.

- Step 4: This step shows the resulting estimated revenue for CY 2018 and then calculates the increase over CY 2017 Revenue.

Stakeholder Input

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed FY 2019 updates. Staff has received and reviewed comments from CareFirst, the Maryland Hospital Association, MedStar Health (Good Samaritan, Union Memorial, Montgomery, Harbor, and Franklin Square), Johns Hopkins Health System, Holy Cross Health, and Mount Washington Pediatrics. Stakeholder comments and staff responses are provided below.

Comment: CareFirst expressed concern that the proposed update may place the State at risk of exceeding total cost of care guardrails. CareFirst stated that Maryland has exceeded the nation in non-hospital growth every year since 2014 and believes it is imperative that staff reflect the increasing growth in non-hospital excess cost growth in its modeling, to ensure that the update provided does not place Maryland at risk of violating the total cost of care guardrail.

Response: Staff updated Table 6B to include a more conservative amount for non-hospital cost growth of 0.95 percent. Staff projected that the State will still meet the total cost of care growth limit guardrail requirements with higher non-hospital cost growth, although there is very little room for error with this higher non-hospital growth estimate.

The Maryland Hospital Association (MHA) and its member hospitals provided feedback on the draft recommendation. Staff has outlined MHA's concerns in addition to providing comments on each item below.

Comment: MHA believes that 0.23 percent revenue adjustment for Johns Hopkins Hospital and University of Maryland Medical Center shouldn't be funded through the annual payment update.

Response: Staff accounts for all estimated growth in revenue in determining whether it will meet the revenue growth limit and savings test. It would not be accurate to exclude a category of hospital revenue growth from the analysis.

Comment: The annual payment update should be increased by at least 0.50 percent. MHA expressed several reasons to support this statement.

Response: Staff does not agree with MHA's recommendation to increase the update factor. The RY 2018 update appears to be providing an increased level of regulated operating profits and staff believe the inflation factor provided for RY 2019 is reasonable. The PAU adjustment of -0.30 percent is far lower than the reductions to Medicare provided by CMS in the proposed federal Inpatient Prospective System update.

i. MHA has expressed that there is an additional cushion built into the growth projections and believes that the conservative estimates staff used to project growth are not needed. MHA made projections based on the first three months of the federal fiscal year (October 2017 – December 2017). **Response:** Staff is not willing to make projections on hospital spending based on three months of data.

ii. MHA also expressed concern that the projections provided in the President's budget may be under-projected based on prior year's data. **Response:** Staff agrees that the actuals came in higher than the projections for the previous year. However, staff must use the estimates provided by the Office of the Actuary and has no basis to make additional projections based on those figures.

iii. MHA also noted that the national IPPS proposed rule shows a rate payment update of 3.40 percent, which is 0.35 percent higher than the 3.05 percent shown in the draft recommendation. **Response:** Staff believes the additional growth of 0.35 percent reflects CMS's estimate of volume growth. Also, conversations with the Office of the Actuary indicate that modeling included all estimates except for the proposed change in the disproportionate share funding. Therefore, staff would not change its calculations even if the federal update were higher due to other miscellaneous estimates.

iv. MHA stated in their letter, that Maryland is an all-payer state, yet it is limited by Medicare growth. **Response:** The All-Payer Model Agreement with CMS requires the State to perform under multiple tests. The HSCRC staff has recommended an update, which they believe balances the need to meet the requirements of the Agreement with CMS as well as providing for efficient cost growth due to inflation and other factors. Staff believes that the Potentially Avoidable Utilization (PAU) savings amount, which is proposed at an increment of 0.30 percent for RY 2019, is reasonable and appropriate in light of the requirements to achieve savings through quality improvements. There are no additional productivity subtractions that are input into the update, including the Affordable Care Act reduction of 0.75percent and the productivity reduction of 0.80percent that are built into the FFY 2019 proposed rule. Furthermore, the Commission provided an update for RY 2018 that resulted in higher year-over-year Medicare growth for CY 2017 over CY 2016 than the nation. It is important that Maryland not exceed the national Medicare growth rate two years in a row.

v. MHA stated that the Medicare Performance Adjustment (MPA) is in effect and the incentives in place provide a cushion for Medicare total cost of care performance in 2018. **Response:** Staff does not agree that the MPA provides a cushion, but rather, is an incentive to help focus hospitals on total cost of care for beneficiaries they serve. Further, adjustments related to performance in 2018 will not be reflected until RY 2020. Staff will make sure to account for MPA adjustments when developing future estimates for the total cost of care guardrail test.

vi. MHA also stated that the update does not fully account for expected service growth from an aging population and expressed concern that the update model is limited to statewide population growth. **Response:** HSCRC staff utilizes population growth statistics from the Maryland Department of Planning to determine population growth. This approach is consistent with the calculation requirements under the Agreement with CMS. In addition, staff adjusts for high cost drug growth, categoricals cases (very high cost inpatient services concentrated in The Johns Hopkins Hospital and University of Maryland Medical Center) and actual population growth, which results in a larger adjustment for volume growth. For example, the final RY 2019 recommendation provides 0.46 percent for a volume adjustment. When drug cost estimates, (0.20 percent,) and categoricals, (0.23 percent) are included actual volume adjustments account for 0.89 percent of the total update, before accounting for reductions in avoidable utilization.

vii. MHA expressed a concern that the shared savings has exceeded infrastructure investment funding. **Response:** Staff believes this is a very narrow view of the Model and does not provide a holistic view of the Model funds flow. Hospitals should provide funding from their own resources since they expect a return on investment and are permitted to keep the revenues from reducing PAUs, except for the portion that is reduced through the PAU savings adjustment. As stated earlier, the incremental adjustment for PAU savings in this year's update is -0.30 percent. The proposed rule for IPPS has taken a -0.80 percent cut for productivity and an additional -0.75 percent cut for the ACA. The adjustment for PAU savings built into the update is far less than the productivity reductions proposed for Medicare. Moreover, staff notes that while a PAU adjustment is required in order to comply with the Model Agreement, the hospital industry has been able in some measure to succeed in this test because of the reduction of uncompensated care, which was primarily due to the Medicaid expansion, the elimination of the Maryland Health Insurance Plan assessment, and the decreases in the Medicaid Deficit Assessment.

viii. Another point that MHA expressed in their letter was an observation that the State has followed a pattern in past years, namely that the year following an unfavorable year the State tends to be favorable in regards to the total cost of care guardrail. **Response:** Staff does not believe that future projections can be based on the assumption that a past short-term cyclical observation will continue.

ix. MHA expressed concern that the draft recommendation did not reflect the Quality Based Reimbursement adjustment. **Response:** Staff has included an estimate for QBR in the final recommendation.

Comment: MHA has stated that the productivity offset for Maryland's psychiatric and specialty hospitals should be eliminated, or at least reduced.

Response: Staff does not agree. Staff has not made a reduction for ACA similar to what occurs on the national landscape. Also, these specialty hospitals have very low use of drugs compared to the general acute hospitals, and, as a result, the inflation factor provided is higher than would be expected. Also, these hospitals are not restricted in their ability to derive additional revenues through volume growth.

In addition the above points, MHA requested that staff provide support for several reconciliations and analyses. Staff shared these analyses with the Payment Model work group meeting on May 31, 2018 where stakeholder comments and concerns were discussed.

Comment: MedStar Health, including five of the seven community hospitals that make up the system, expressed concern that the overall update will vary among each hospital and some hospitals may receive updates below inflation, based on PAU savings, the demographic adjustment, and other factors. Each hospital expressed that the update should be increased by 0.50 percent to continue investments in the community and overcome the criticisms levied against current HSCRC methodologies. One reason to increase the update factor was the increased cost in nursing support.

Response: Many of the concerns raised have been already been addressed in the response to the MHA comments. Hospitals in areas of declining population and with high levels of avoidable utilization should expect to have updates that are lower than factor cost inflation, given their opportunities to control costs through the reduction of avoidable and unnecessary utilization. There are various opinions in the industry regarding retention of revenues for volume reductions, especially those that result from market shift or reductions unrelated to avoidable utilization. As noted above in the Central Components of Revenue Change, staff is working to analyze the volume policies including the demographic adjustment, market shift, and potentially avoidable utilization. Staff commit to work with the industry to enhance these adjustments. While it is not HSCRC practice to dictate how a hospital apportions its outlays, staff do believe that the inflationary increase of 2.40 percent built into the update factor for wages, together with the additional inflation provided in RY 2018, should help hospitals address needed wage increases consistent with national trends.

Comment: MedStar Health hospitals also expressed concern regarding HSCRC's mention of hospitals' contractual obligations to notify the HSCRC about movements of services from regulated to unregulated.

Response: Staff will be sure to work with the industry to provide additional guidance regarding the expectations and needs with respect to any shifts to an unregulated space, but notes that the GBR contracts clearly delineate the obligations of the hospital to notify the HSCRC about any shifts in volume from regulated to unregulated. HSCRC staff must make adjustments as needed to ensure that payers are not facing increased costs that could result if services shifted from the hospital to an unregulated setting did not result in decreased hospital revenues.

Comment: Johns Hopkins Health System (JHHS) comments solely focused the section of the draft recommendation dedicated to shifts to unregulated services. JHHS believes that while

notification surrounding service shifts to unregulated is necessary for improving total cost of care in the state of Maryland, there needs to be a well formulated policy. JHHS suggest a policy should consider the following: clear process and timeline, incentives to move to a lower cost setting, and the factors that contributed to the shift. It was also stated that penalties should not be made for shifts outside of the hospitals control and retroactive adjustments should not be made.

Response: Staff notes that each hospital signed a global budget agreement that included language pertaining to shifts to unregulated settings. In addition, each hospital is required to submit an annual disclosure that includes any changes in these items from the previous year. One-time adjustments are necessary if staff finds that a hospital did not provide notification and money was left in the global budgets. If staff does not make one-time adjustments for undisclosed shifts, it would discourage hospitals from reporting shifts and result in excess billings to payers. In some instances, these excess billings could be a compliance problem. Staff believes it has the obligation to evaluate the reported shifts and make necessary adjustments.

Staff must still be notified timely when a hospital is aware of shifts that occur as the result of physician or payer decisions. The issue is not who is making the decision, but the need to eliminate duplicate payment for a service when it is covered under a global budget and is also being billed by another party. Staff agrees with the need to work with payers and providers to provide additional policy guidance.

Comment: Holy Cross Health expressed support for a higher update factor to include making investments in population health initiatives. Holy Cross also noted drug shortages are causing an increase in total drug costs and expressed the need for the rate system to fund pharmaceuticals.

Response: Staff appreciates the investments Holy Cross has made towards population health. Staff believes the proposed update factor is appropriate. The RY 2018 update provided increased profit levels and hospitals have additional opportunities to reduce costs through productivity improvements and reduced avoidable or unnecessary utilization. Through FY 2017, HSCRC has overfunded drug cost growth statewide through the inflation adjustment, together with the high cost drug volume adjustment. Staff will update the analysis for FY 2018, when the data is available, and consider additional policy adjustments as needed.

Comment: Mt. Washington Pediatric Hospital requested relief from the proposed update of 1.77 percent. Mt. Washington stated that offsetting inflation by the productivity adjustment increases overall statewide costs and detracts from the ability to continue to be a niche in the continuum of care in Maryland.

Response: As previously noted, staff believes the 1.77 percent proposed update is appropriate and notes that the non-acute hospitals are not subject to the volume limitations of the global budget hospitals.

RECOMMENDATIONS

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following final recommendations for the FY 2019 update factors.

For Global Budget Revenue Hospitals:

a) Provide an overall increase of 1.83 percent for revenue (net of uncompensated care offset) and 1.37 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, staff is proposing to split the approved revenue into two targets, a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

b) Allocate 0.31 percent of the total inflation allowance based on each hospital's proportion of drug cost to total cost to more equitably adjust hospitals' revenue budgets for increases in drug prices and high cost drugs. Continue to adjust for volume changes of high cost oncology drugs at the mid-year data point for RY 2018 over RY 2017. Evaluate the need for an additional adjustment for growth in high cost drugs during RY 2019.

c) The Commission should continue to closely monitor performance targets for Medicare, including Medicare's growth in total cost of care and hospital care costs per beneficiary during the performance year. As always, the Commission has the authority to adjust rates as it deems necessary.

d) Hospitals should submit, 30 days after the fiscal year, their annual disclosures of their GBR Agreements to disclose any shifts from regulated to unregulated and unregulated to regulated (Appendix F); as well as changes in financial interest, ownership, or control of hospital or non-hospital services within the service area (Appendix G). Failure to submit these disclosures will result in a holdback of 0.50 percent of a hospital's update for RY 2019. HSCRC should convene a sub-group to outline additional guidance to hospitals in reporting shifts to unregulated settings, as well as outlining the expectations for revenue adjustments.

e) Continued refinements should be made to adjust revenues for volume changes in high-cost drugs. Hospitals must report shifts to unregulated settings to avoid duplicate billing. Data collection should be expedited and improved and external resources consulted in order to improve the timeliness and ease of adjustments.

Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

a) Provide an overall update of 1.77 percent by using a productivity adjustment of 0.80 percent from the inflation factor of 2.57 percent.

b) Continue to focus on implementation of quality measures and value based programs for psychiatric facilities.

PREPARATION FOR THE TOTAL COST OF CARE MODEL EFFECTIVE JANUARY 1, 2019

During May, 2018, Governor Hogan announced the federal approval of a ten-year Total Cost of Care Model, which builds on the existing All-Payer Model and moves beyond hospitals to address total cost of care for Medicare beneficiaries. The new Total Cost of Care Model will require increased efforts to improve population health, enhance chronic condition management, and align efforts with physicians, nursing homes, and other parts of the system to increase patient-centered care. Hospitals will take on increased financial responsibility for performance through the Medicare Performance Adjustment.

The new Model will necessitate changes in the annual update and in the global revenue agreement. There are several considerations:

Maryland Primary Care Program Care Management Fees

The Maryland Primary Care Program (MDPCP) will be initiated in January 2019. Primary care physicians will receive care management fees for their Medicare patients when they participate in the voluntary program. During a start-up period, hospital utilization reductions may not be adequate to offset the increased care management fees. Under the current update formulation, growth in care management fees could result in a reduced hospital update. The Commission wishes to avoid this result because it might dampen enthusiasm for the MDPCP, which is important to the long term goal of improving chronic care and population health. As a result, staff recommends a supplemental resolution for Commission consideration. This resolution should state that:

1. Any adjustments to hospital payments necessary to ensure the State meets the annual savings targets of the Total Cost of Care Model as a result of the inclusion of MDPCP care management fees will not be effectuated on an all-payer basis, but only in a way that recaptures the Medicare costs resulting from the inclusion of the care management fees in the Medicare total cost of care calculation; and,

2. The HSCRC will advocate for additional funding sources to offset early start-up costs of the MDPCP that will help provide for the cost of care management fees in excess of Medicare savings achieved.

Updated Hospital Contract

The HSCRC will need to update the Global Budget Revenue agreements for the new Total Cost of Care Model and the alignment programs. There will be a contract amendment for the Medicare Performance Adjustment, effective July 1, 2018, which is necessary for MACRA eligibility in care redesign programs. The HSCRC staff also proposes to work with a sub-group

of the Payment Models Workgroup to evaluate needed updates to the contract, in addition to the Medicare Performance Adjustment amendment. Staff will establish a schedule with the objective of completing a contract amendment effective July 1, 2018, with a full replacement contract to be put in place with an effective date of January 1, 2019.

Changes to the Annual Update

In order to drive success in achieving population health improvements and reducing avoidable and unnecessary utilization, new aggressive goals will need to be established. HSCRC should consider how to adjust the inflation process to assure the adoption of aggressive goals (Bold Improvement Goals, BIG). Some portion of inflation (say 0.50 percent) could be set aside and only those hospitals adopting approved aggressive (BIG) improvement goals would be eligible for that portion of inflation. For example, one hospital could commit to a thirty percent reduction in COPD related admissions with interventions that start with early detection and prevention of COPD, disease and medication management supports, pulmonary rehabilitation, vaccines for pneumonia and flu, among others. Other hospitals might commit to reduced hospitalizations for sepsis, hospital related pneumonia or urinary tract infections, a reduction in diabetes and other related improvements. The HSCRC will need to quickly formulate an overall approach to facilitate planning for the upcoming year. Staff recommends that this formulation take place through discussions among the Commission, senior stakeholder executives, and staff.

The Total Cost of Care Agreement with CMS will have different features and requirements than the existing All-Payer Model Agreement. HSCRC staff recommends that the Payment Model Workgroup continue working through the fall to evaluate adjustments that will be needed to the annual update process as a result of the new Agreement with CMS.

Recommendations regarding preparation for the Total Cost of Care Model, effective January 1, 2019:

a) The Commission should adopt a resolution and policy regarding the treatment of Maryland Primary Care Program care management fees during the start-up of the program.

b) HSCRC staff should update the hospital revenue agreement template to reflect the new Model requirements.

c) The annual update process should be reconfigured to conform to the new Total Cost of Care Model Agreement with CMS.

d) The annual update should be reconfigured, in consultation with stakeholders, to promote aggressive and progressive care delivery changes that will improve population health, chronic care management, and reduce unnecessary and avoidable utilization, consistent with the goals of the new Total Cost of Care Model.

APPENDIX I. SUPPLEMENTAL INFORMATION ON RISING COST OF HOSPITAL DRUGS

Staff completed, separate from this recommendation, an analysis that focused on the rising cost of hospital drugs. The purpose of this analysis was to aid staff, the Commission, and stakeholders in assessing funding levels and future policymaking decisions. Currently, hospitals are provided drug funding through two avenues: 1) drug cost inflation distributed using each hospital's drug cost in proportion to total drug costs and 2) changes in volume for the top 80 percent spend of high cost oncology drugs (providing 50 percent of the growth as a permanent adjustment and 50 percent of the growth as a one-time adjustment).

The drug cost analysis showed that drug costs increased faster than total hospital costs since 2014 in every year, except 2017, and that outpatient cost growth is the primary cost driver. Academic medical centers and hospitals with large outpatient programs were the largest proportion of this growth. Since 2014, there has been a statewide excess in funding provided in rates and funding in total appears to be adequate, although the analysis also found a variation by hospital in funding levels versus cost growth.

There have been some shifts of drugs to unregulated settings. As a result of specialization, some hospitals may be affected more by new drug introductions than others. The staff will continue to focus on making adjustments for changes in volumes of high cost drugs to address these and other dynamics. Staff is working to remove oncology drugs from the hospital market shift to avoid overlaps in adjustments and to more accurately measure changes in volumes of cycle-billed services such as clinics.

Inflation rates appear to be high enough to pick up the costs for much of the drug funding. However, funding for new oncology and biological drug costs continue to be a growing concern. Staff is continuing to refine the methodologies used to provide adjustments for changes in drug costs.

APPENDIX II. STAKEHOLDER COMMENT LETTERS

Chet Burrell
President and Chief Executive Officer

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May 22, 2018

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini:

The purpose of this letter is to provide CareFirst's comments on the HSCRC staff's "Draft Recommendations on the Update Factors for FY 2019" which will be applied to hospital rates effective July 1, 2018.

It is now clear that the growth in Maryland's Total Cost of Care (TCOC) per Medicare FFS beneficiary in CY 2017 exceeded the US TCOC growth per FFS beneficiary for a second time in the four years of the Model Demonstration. This threatens a key "Guardrail" limitation in the Model Agreement that requires Maryland Medicare TCOC growth not to exceed US TCOC growth in any two consecutive years. If Maryland TCOC in CY 2018 were to violate this provision, a "Triggering Event" would occur thereby threatening the demonstration.

Stated another way, exceeding the growth in US Medicare TCOC in three years out of five would call into question the overall value of the Demonstration in a profound way.

It is noteworthy that, in CY 2014, the Maryland percentage change in non-hospital expenditures payments was approximately 1.03% percent below the US non-hospital growth rate and that, in every subsequent year, it has been well above the US growth rate with the pace of nonhospital payments growing more rapidly relative to the nation in each successive year.

Given this context, we believe it is imperative for the HSCRC to approve an Update Factor that is low enough to ensure that the growth in non-hospital expenditures for Maryland FFS beneficiaries is not underestimated again.

Our estimates of the growth rates for Maryland Medicare non-hospital expenditures relative to the US over the period CY 2014 to CY 2017 are as follows:

CY 14	CY 15	CY 16	CY 17
-1.03%	+1.19%	+1.30%	+1.37%

While we agree with the general structure used by staff in formulating its Update Factor recommendation this year, we believe that the staff has failed to provide a realistic forecast of the likely level of excess Maryland Medicare non-hospital expenditures during CY 2018. Accordingly, CareFirst strongly recommends that the estimate of excess growth in Maryland's Medicare non-hospital expenditures be based on a projection methodology that recognizes this escalating trend going forward to CY 2018 and bases the Update Factor on a nonhospital cost growth rate no less than that experienced in 2017. If this is done, we believe the Commission would need to approve an Update of no more than 1.4 percent in order to be reasonably sure that Maryland will not exceed the TCOC trigger.

We note that the HSCRC staff have suggested that the proposed permanent Update of 2.29 percent is conservative partly because it includes a 0.5 percent hospital savings factor for Medicare. However, the 0.5 percent factor was included in past years and Maryland TCOC growth still exceeded the US growth in two out of four years.

We would be happy to share our calculations with staff and the Commission in detail, if this would be helpful.

Sincerely,

Chet Burrell
President & CEO

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
John Colmers
James N. Elliott, M.D.
Adam Kane
Jack Keane
Donna Kinzer, Executive Director

Maryland
Hospital Association

May 22, 2018

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, I write to share feedback from the hospital field on the commission's rate year 2019 (RY 2019) annual payment update. Hospitals appreciate the work of commission staff and the careful consideration of the payment update by the commission. We look forward to discussing the considerations in our letter.

Changes Needed for the Final Update

1. **Categorical funding should be excluded from the annual payment update**
   The draft recommendation identifies a 0.23 percent revenue adjustment for The Johns Hopkins Hospital and University of Maryland Medical Center to fund an expected increase in new and expensive therapies. Hospital innovation should be funded through the rate setting system, but the annual payment update is not the proper vehicle for addressing the concerns of individual institutions.

   We recommend that the commission create a work group with all stakeholders to address this issue.

2. **Increase the annual payment update by at least 0.5 percent**
   Maryland's hospitals recognize the limits imposed by the Medicare Total Cost of Care (TCOC) guardrail. Based on discussions with commission staff and the commission's discussion of the draft recommendation, we understand the commission's desire to exercise caution when approving a revenue increase that will affect calendar year 2018 TCOC performance. That said, there is ample justification for a modest increase. There is room within the model to accommodate such an adjustment.

   There are several reasons to support a higher increase:

   i. There is additional cushion built into the national payment growth projection.
   ii. Maryland is an all-payer state, yet we are limited by Medicare growth.
   iii. The Medicare Performance Adjustment is currently in effect.

iv. The update does not fully account for expected service growth from an aging population.
v. Savings shared with payers exceeds infrastructure investment funding.
vi. The prior year base period affects Maryland's total cost of care guardrail.
vii. The draft recommendation does not reflect the Quality Based Reimbursement adjustment.

Below we elaborate upon each of these points.

i. **There is additional cushion built into the national payment growth projection.** The draft recommendation draws on several conservative estimates to project national and Maryland growth including:

- For the first quarter of federal fiscal year 2018 (October 2017 through December 2017), *national Medicare hospital spending per beneficiary* [redacted] compared to the same quarter in the previous year. In federal fiscal year 2018, national hospital spending growth per beneficiary is projected to grow [redacted]. (This figure combines one quarter of calendar year 2017 and three quarters of calendar year 2018 and is based on hospital spending growth rates in the President's budget.) For this federal fiscal year 2018 projection to hold, the remaining three quarters must [redacted] or less per capita growth. Such a projection is highly unlikely to hold (Chart 1).

*Data redacted above and in Chart 1 by HSCRC staff due to agreement with Federal government.

- HSCRC revenue projection assumes that the 0.25 percent allowance for unforeseen adjustments will be used in full, beginning July 1, the first day of the fiscal year. The draft recommendation states that the entire set-aside was used during rate year 2018, but no summary was included to detail previous uses of these funds. Even if true, this would be the first time these funds were spent in their entirety.

- Commission staff appropriately adjusted the projected national growth rate for the fourth quarter of calendar year 2018, with one minor modification. Per the Centers for Medicare & Medicaid Services, the recently published Medicare Inpatient Prospective Payment System proposed rule reflects a national payment increase of 3.4 percent beginning in October 2018. The staff adjustment, 3.05 percent, is short by 0.35 percent.

- In addition to actual growth exceeding what was projected for the first quarter, the national spending growth from the President's budget projections is, in itself, under-projected. When projections from the federal fiscal year 2019 budget are compared to the prior year, all prior period growth rates have been revised upward, reflecting actual spending above what was projected (Chart 2).

ii. **Maryland is an all-payer state, yet we are limited by Medicare growth.**
The All-Payer Model is predicated on controlling both all-payer spending per capita and Medicare spending per beneficiary (per capita for the Medicare population). Spending can be managed by controlling prices, controlling service use, or both. The commission has regulated hospital prices since its inception, and has shifted its focus to the incentives to control service use since the beginning of the All-Payer Model.

Service use should be measured as a function of population change, particularly by payer. Unfortunately, global budget mechanics have had the unintended consequence of increasing Medicare payments even though Maryland's hospitals have controlled Medicare utilization per capita better than expected.

From 2013 to 2017, using equivalent case mix adjusted discharges (ECMADs) as the measure, Medicare service use declined 1.84 percent. All-payer service use declined 3.48 percent. Under global budgets, hospitals then collectively raised prices by 3.48 percent to achieve global budgeted revenue compliance, resulting in a 1.70 spending increase to Medicare. (Chart 3).

For the same period, the number of Maryland Medicare beneficiaries rose by 8.04 percent while the overall population of Maryland grew by 2.35 percent. *Measured on a per person basis, Medicare utilization declined 9.15 percent compared to an all-payer utilization decline of 5.70 percent*. Even if there was an implicit price increase of 5.70 percent to account for the all-payer reduction per capita, this would have resulted in Medicare savings of 3.66 percent, more than 5 percent greater than the actual experience (3.66 percent savings versus a 1.70 percent increase.) These per capita volume changes are consistent with the monthly commission reports, reflecting Medicare and all-payer volume changes and volume changes per 1,000 population.

If the commission is concerned about the annual payment update causing Medicare payment growth to exceed the total cost of care guardrail, it should consider a review of the effects of utilization reduction per capita and the interaction with global budgets, then rebalance the rate setting system using the payer differential. The timing of this differential adjustment is appropriate before Maryland moves to the Enhanced Total Cost of Care Model in January 2019.

iii. **The Medicare Performance Adjustment (MPA) is currently in effect.**
In 2017, the commission adopted the MPA, beginning with a calendar year 2018 performance period. The MPA places hospitals at risk for the variance in calendar year 2018 Medicare total cost of care. The commission adopted this policy to drive hospital-specific accountability for total cost of care growth in calendar year 2018 via rewards or penalties. This new incentive gives additional cushion for Medicare TCOC performance in 2018.

iv. **The update does not fully account for expected service growth from an aging population.**
During the last Payment Models Work Group meeting on May 3, MHA noted that the 0.46 percent set-aside for the demographic adjustment limits the amount provided for age-weighted use rates. Commission staff agreed. The commission's calculation weights service use by age classifications (for example, people aged 75-84 use services about three times the statewide average, while people aged 15-44 use services at about 60 percent of the average). Each of these age-weighted use rates is calculated for every hospital, minus an adjustment for potentially avoidable utilization (PAU) and application of a 50 percent variable cost factor. However, the update model limits the demographic adjustment to statewide population growth. On a cumulative basis, this creates a 0.36 percent negative difference (Chart 4).

v. **Savings shared with payers exceeds infrastructure investment funding.**
On an ongoing and permanent basis, *hospitals are returning an additional $77 million* in payer savings, per year, beyond care transformation investments. The HSCRC staff's draft recommendation removes 1.75 percent, or $299 million, of statewide revenue for payer savings. Including the 2014 through 2016 infrastructure investments, regional transformation grants, and the original Total Patient Revenue (TPR) incentives, 1.35 percent, or $222 million, was placed in hospital rates for infrastructure and care transformation incentives (Chart 5). It will be extremely challenging to expand upon the field's care transformation efforts when the first $77 million needs to be funded from current operations, combined with receiving a payment update below inflation.

Hospitals do not support the HSCRC's shared savings policy, which would reduce revenue by an estimated 1.75 percent. The amount of the reduction is too severe. Moreover, the way the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs) are quantified as a percentage of a hospital's total revenue is an inappropriate use of the indicators. PQIs are intended to measure the percentage of admissions for "ambulatory sensitive conditions" within a population, not as a percentage of hospital discharges, as HSCRC measures them. Hospital discharges shift for a number of reasons, making the calculation unsteady as a basis for payment incentives that materially affect hospitals' viability. HSCRC staff are aware of this concern and in the process of revising how PQIs are measured, the proposed revenue reduction should be eliminated until this issue can be resolved.

vi. **The prior year base period affects Maryland's total cost of care guardrail.**
Growth in hospital costs and total cost of care during the first four years of the model shows two peaks and two valleys. These peaks and valleys did not affect the favorable performance on the *cumulative* hospital savings measure, but did result in unfavorable performance on the *annual* total cost of care measure (Chart 6).

In year one and year three, Maryland's Medicare hospital spending per beneficiary growth rate was substantially below the nation's. In year two and year four, Maryland's

hospital spending per beneficiary growth rate was only slightly below the nation's. The strong performance in years one and three likely contributed to the higher statewide growth rates in years two and four, if for no other reason than that the base period was lower, affording a greater risk to grow faster than the nation. Assuming the pattern continues, calendar year 2018 (year five) should see favorable total cost of care performance compared to calendar year 2017.

vii. **The draft recommendation does not reflect the Quality Based Reimbursement (QBR) adjustment.**
The amount approved by the commission will apply to rate year 2019. Though the final adjustment is not expected until January 1, 2019, the estimated revenue change for Maryland's QBR program is not included in the template. At the May public meeting, staff stated that they expect the QBR placeholder to be negative – that is, adverse to hospitals. Early projections suggest this amount would *reduce the average update by at least another 0.3 percent,* reducing all-payer spending per capita to 1.52 percent. HSCRC staff also suggested that some funding may be included for oncology drugs, but this amount is unlikely to offset the entire QBR reduction.

3. **The productivity offset for Maryland's psychiatric and specialty hospitals should be eliminated, or at least reduced**
HSCRC staff is recommending an update of 1.77 percent, or 2.57 percent inflation less a 0.8 percent productivity adjustment, for Maryland's psychiatric and specialty hospitals. At the time when investments are sorely needed, the 0.8 percent reduction will put serious pressure on the ability to invest in critical behavioral health services. The proposed adjustment is double what the productivity offset was for rate year 2018. Mt. Washington Pediatric Hospital has no Medicare volume and will not impact the total cost of care growth. We respectfully request staff consider eliminating, or at least reducing, the productivity offset.

Commission Process for Handling of Stakeholder Comments

At the May public meeting, the commission discussed the process for stakeholders to provide feedback to commission staff and how that feedback was incorporated into the draft recommendation. As mentioned during the discussion, the commission's Payment Models Work Group is used to solicit feedback from stakeholders.

We appreciate commission staff listening to stakeholder concerns and attempting to be fair and balanced in developing the draft recommendation. In the recently adopted guidance on adopting staff recommendations, the commission approved a policy that requires staff to address stakeholder comments in the final recommendation. We look forward to these written responses.

Already, MHA has raised several considerations that have not been addressed in the Payment Models Work Group, or for which responses are not clear. First, staff noted that the scheduled payback from The Johns Hopkins Hospital will increase revenue by $10 million in calendar year

2018. It is not clear if the amount provided to Johns Hopkins, net of last year's payback, is reflected in the calendar year 2017 base period figure.

Second, for rate year 2018, the commission approved an all-payer revenue increase of 3.34 percent, or 2.97 percent per capita. This year's staff recommendation reflects an actual global budgeted revenue increase from $17.1 billion in rate year 2017 to $17.5 billion in rate year 2018. That amounts to an all-payer revenue increase of 2.64 percent. We have respectfully asked staff to clarify this discrepancy.

Third, we requested a reconciliation of the amounts provided for unforeseen adjustments in rate year 2018.

Finally, in the last work group meeting, the hospital field noted that the first quarter calendar year 2018 Global Insight data reflect an inflation factor of 2.68 percent, 0.11 percent higher than the previous estimate. Staff did not account for this adjustment in their presentation of the draft recommendation at the May public meeting. Historically, the Global Insight release from the first quarter of the calendar year immediately preceding the update has been used as the inflation factor.

We did not expect staff responses to all of these requests be included in the draft recommendation, but we would appreciate receiving this information at the next work group meeting on May 31.

We look forward to discussing the update at the May 31 meeting and at the HSCRC's monthly public meeting on June 13, as we continue to work together on behalf of the patients and communities we serve.

Sincerely,

Brett McCone,
Vice President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James Elliott, M.D.
Adam Kane
Jack C. Keane
Donna Kinzer, Executive Director
Jerry Schmith, Director, Revenue & Compliance

Enclosure

Chart 1

National Medicare Hospital Spending per Beneficiary Growth

Actual First Quarter Federal Fiscal Year 2018 Compared to First Quarter Federal Fiscal Year 2017;

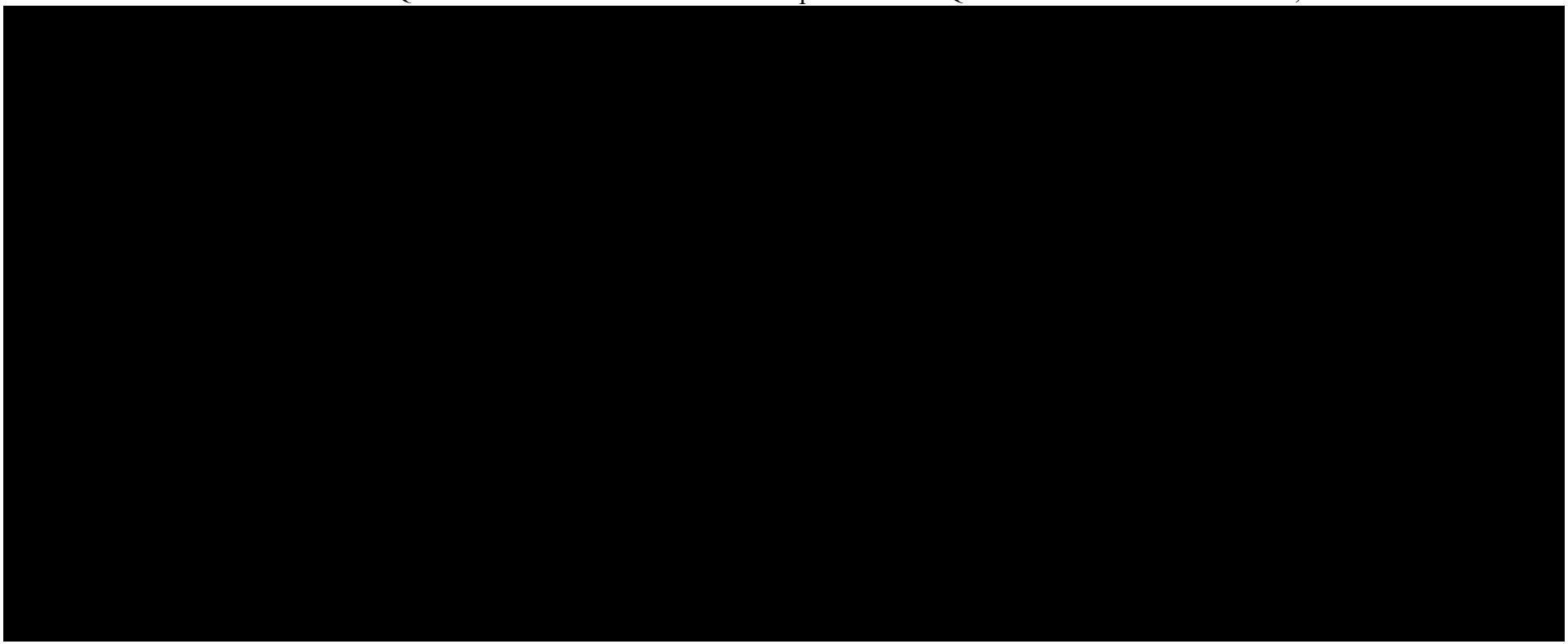


Chart 2

Medicare Per Capita Hospital Spending Projections

[Based on Fiscal Year 2019 President's Budget]

Hospital Spending per Beneficiary

	Annual Per Capita Expenditures			Per Capita Trend				
CY	Inpatient	Outpatient	Total Hospital	Inpatient	Outpatient	Total Hospital	Prior Year President's Budget	Difference
2013	$ 3,666	$ 1,095	$ 4,761					
2014	3,645	1,241	4,886	-0.6%	13.3%	2.6%	2.6%	0.00%
2015	3,682	1,346	5,028	1.0%	8.5%	2.9%	2.6%	0.31%
2016	3,753	1,425	5,178	1.9%	5.9%	3.0%	1.1%	1.87%
2017	3,783	1,548	5,331	0.8%	8.6%	3.0%	1.6%	1.33%
2018	**3,776**	**1,667**	**5,442**	**-0.2%**	**7.7%**	**2.1%**	**3.1%**	*-1.06%*
2019	3,862	1,775	5,637	2.3%	6.5%	3.6%		

CY14 - CY17 average difference	**0.88%**

Chart 3

Change in Medicare and All-Payer Utilization, and Utilization per Capita

Utilization defined as Equivalent Case Mix Adjusted Discharges (ECMADs)

	A	B = A(tot)	C = (1+A) / (1-B)-1	D	E = (1+A) / (1+K)-1	F = E(tot)	G = (1+E) / (1-F) - 1	H = C - G
	Unadjusted Use and Spending % Change			**Use and Spending % Change per Beneficiary**				
Payer	Service Use % Change (ECMADs)	Price Increase	Net Change in Spending	Beneficiary or Population Change	Service Use % Change per Beneficiary	Price Increase (if per capita)	Net Change in Spending	**Cost Shift to/(from) payer**
Medicare	-1.84%	3.48%	1.70%	8.04%	-9.15%	5.70%	-3.66%	**5.36%**
All Payer	-3.48%	3.48%	0.00%	2.35%	-5.70%	5.70%	0.00%	**0.00%**

Chart 4

Demographic Adjustment Compared to Population Growth Limit

	Age and PAU Adjusted Weighted Amount	Variable Cost Factor (VCF)	Age/PAU Weighted Factor @ 50% VCF	Demographic limit	**Limit Over / (Under) Age/PAU @ 50% VCF**
Rate year 2018	0.86%	50%	0.43%	0.36%	**-0.07%**
Rate year 2017	1.32%	50%	0.66%	0.44%	**-0.22%**
Rate year 2016	1.18%	50%	0.59%	0.47%	**-0.12%**
Rate year 2015	1.10%	50%	0.55%	0.60%	**0.05%**
Total					**-0.36%**

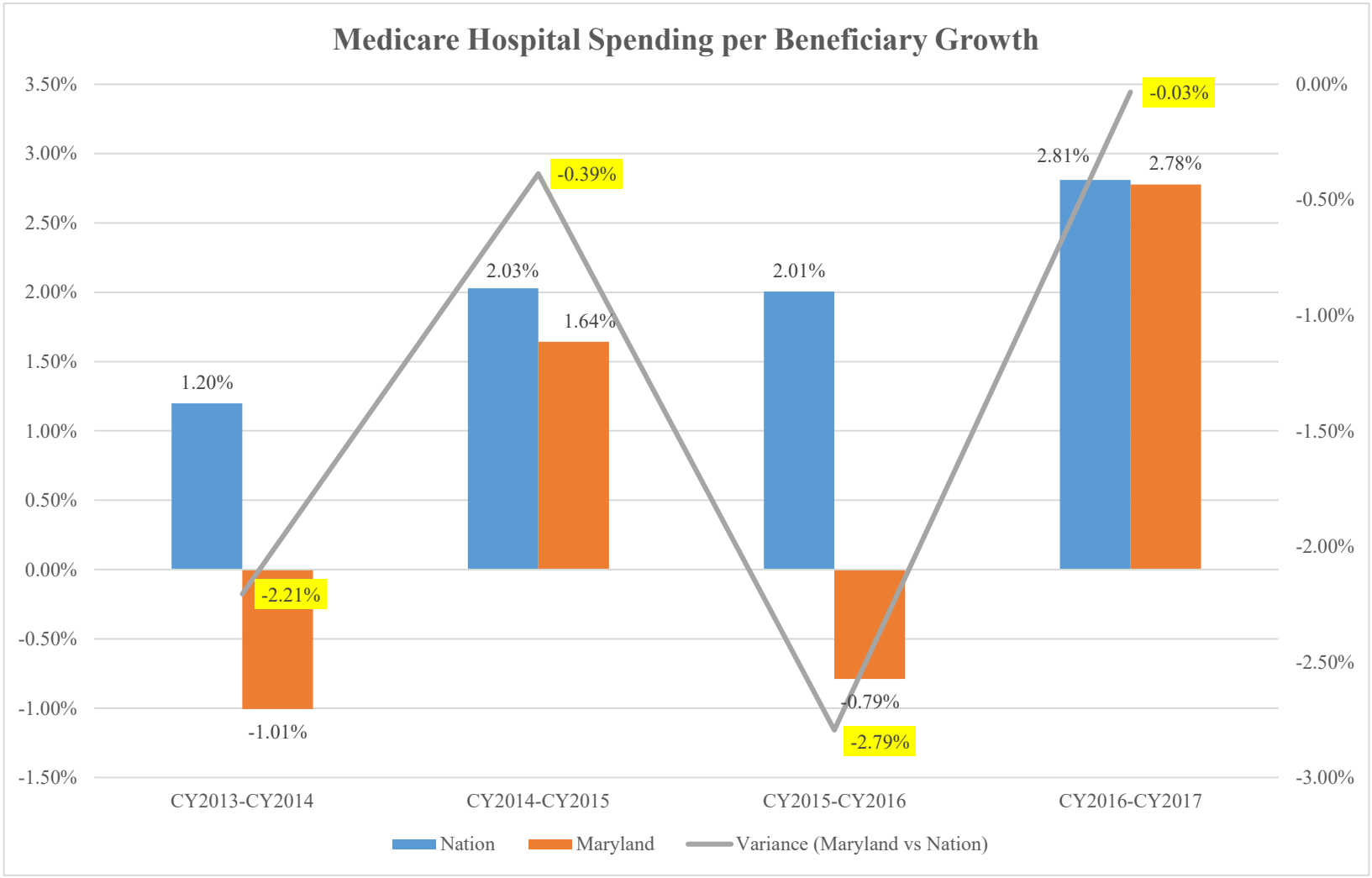
Chart 5

Cumulative Infrastructure Funding; Cumulative Potentially Avoidable Utilization Savings

Financial impacts in FY2018 dollars

	% Rate Funding	$ Impact	Notes/Comments
Potentially avoidable utilization (PAU) savings and other funding offsets			
Shared savings offset			
FY2014	-0.20%	(34,200)	Annual PAU savings offset
FY2015	-0.20%	(34,200)	Annual PAU savings offset
FY2016	-0.20%	(34,200)	Annual PAU savings offset
FY2017	-0.65%	(111,150)	Annual PAU savings offset, increased for FY2017
FY2018	-0.20%	(34,200)	Annual PAU savings offset
FY2019 (proposed)	-0.30%	(51,300)	Annual PAU savings offset
Subtotal PAU savings offset	**-1.75%**	**(299,250)**	
Infrastructure / care coordination funding			
TPR conversion funding (provided in FY2011)	0.27%	$ 46,581	2011 TPR incentive, price leveled by 2% for five years
Infrastructure fudning			
FY2014	0.22%	$ 38,011	HSCRC report to CMS (FY2014 budget was 0.25%)
FY2015	0.28%	48,583	HSCRC GBR Summary File
FY2016	0.37%	63,057	HSCRC GBR Summary File
FY2017	-	-	No funding
FY2018	-	-	No funding
FY2019	-	-	No funding
Subtotal infrastructure funding	0.88%	149,652	
TPR plus infrastructure funding	**1.15%**	**196,232**	
Regional transformation grants (2016-2017); net of required return on investment (1/3 of total)	0.15%	25,926	Total less 30% return; HSCRC Nov 16 rec.
Total infrastructure and transformation funding	**1.30%**	**$ 222,158**	
PAU Savings net of infrastructure and transformation funding	**-0.45%**	**$ (77,092)**	

Chart 6


Medicare Hospital Spending per Beneficiary Growth
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
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-1.50%
-2.00%
-2.50%
-3.00%
1.20%
-1.01%
-2.21%
2.03%
1.64%
-0.39%
2.01%
-0.79%
-2.79%
2.81%
2.78%
-0.03%
CY2013-CY2014
CY2014-CY2015
CY2015-CY2016
CY2016-CY2017
Nation
Maryland
Variance (Maryland vs Nation)

HOLY CROSS HEALTH

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May 25, 2018

Nelson Sabatini
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini,

Holy Cross Health appreciates the opportunity to provide comment regarding the proposed 2019 annual global budget update. Holy Cross is committed to the care transformation goals of the Maryland All-Payer Model but it is essential for adequate funding to be available to continue our transformational work and support the necessary programing, technology and infrastructure to improve care coordination.

With the approval of the Maryland Total Cost of Care All Payer Model and the implementation of Medicare Performance Adjustment in 2018, Maryland hospitals are already incentivized to effectively manage utilization and care delivery across the entire health system. To be successful in lowering total cost of care (TCOC), hospitals must be innovative in care coordination and post-acute service delivery and align our efforts with physicians and other providers to achieve these goals. Providing an insufficient rate update to cover projected cost increases makes it even more challenging to invest in the essential resources to improve care coordination processes and lower overall costs. In addition, a less than adequate update will make it challenging to fund enhancements to the current programs that directly improve care coordination and reduce the total cost of care. It will also impact our ability to provide competitive wages for our employees in a market where the demand is already greater than supply and retention is key to continuity in care delivery. The state health systems, as you know, are also experiencing significant drug shortages which is causing an increase in our total drugs cost. As we look for alternative options, including reduction of opioid use, we need the support of our rate system to ensure coverage of high cost, low supply pharmaceuticals.

Holy Cross Health has and continues to invest in Population Health initiatives beyond the amounts funded in rates. We continue to innovate and collaborate within our regional partnership (Nexus Montgomery) and bring in expertise from other states through our Trinity Health affiliation. The initiatives below are some of our recent investments in managing the care continuum and further expansion of these efforts are essential to lowering the overall cost of healthcare in our community:

- Dedicated case managers in the Emergency Department to work with clinical teams in defining and facilitating patient assessments that include hospitalization alternatives
- Increase in case management discharge planning staff through Nexus Montgomery
- Providing home visits by a nurse and follow-up coaching calls for uninsured patients and for those not qualifying for payer supported home care service
- Providing home pharmacy visits with medication reconciliation, counseling and home delivery
- Dedicated coordinators with skilled nursing facilities to assure accurate and complete information is available for care transitions
- Review of "high utilizers" with Montgomery County EMS providers to create integrated care plans
- Implementation of a tablet-based real time interaction with a nurse for high risk patients as part of post-acute home care services

This critically important work takes substantial resources and funding to implement successfully and achieve the benefits projected. Providing insufficient resources to continue these efforts will jeopardize the achievement of our universal objectives under the triple aim.

To continue the progress we have made in improving the coordination of care while meeting the needs of our community, we urge the HSCRC to provide a reasonable update factor which will help us meet our total cost of care goals. The Maryland Hospital Association has proposed a reasonable alternative to the staff-recommended global budget update and Holy Cross Health supports the MHA recommendation.

The hospital industry has performed well under this new system but it will be difficult to meet the challenges of the updated payer model without developing and implementing additional innovative care programs. Thank you for the opportunity to provide our comments as we look forward to continuing our efforts in transforming our care delivery system.

Sincerely,

Norvell V. Coots, M.D.
Chief Executive Officer

Yancy Phillips, M.D.
Chief Quality Officer

Anne Gillis
Chief Financial Officer

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James Elliott, M.D.
Adam Kane
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Donna Kinzer, Executive Director

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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

May 25, 2018

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

Dear Ms. Kinzer:

The purpose of this letter is to provide a response on behalf of the Johns Hopkins Health System to the "Shifts to Unregulated" portion of the HSCRC staff recommendation for the FY 2019 Update Factor as presented at the May 2018 public meeting.

We agree that a hospital needs to notify the HSCRC well in advance of moving services to an unregulated setting when it is an intentional decision by the hospital. We are also in agreement that the hospital's GBR should be adjusted in a timely fashion under these circumstances. There are situations however, when advanced notification and an associated adjustment to GBR revenue are not always possible or warranted.

These points should be included in a well formulated policy developed by the HSCRC. The policy should include:

1. The process and time lines for notification to the HSCRC
2. The specific information required to be reported
3. Incentives to the hospitals for moving services to a lower cost setting and improving the overall Total Cost of Care (TCOC).
4. The factors that are leading to the shift of services
   A. Is the move an intentional decision by the hospital (movement of an entire program)
   B. Is the movement caused by payor behavior/actions

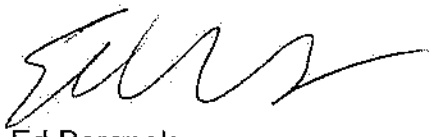
C. Is the movement due to physician shifts/changes that may not have been anticipated or even known by the hospital.

5. Reasonable fines or consequences for not complying with the policy. There should be no retroactive adjustments. Additionally, there shouldn't be penalties when hospitals are faced with changes outside of their control.

In conclusion, a thorough policy around shifting business from a hospital setting to an unregulated setting should improve TCOC for the state as a whole. It will also benefit hospitals in that they can apply the policy rules to make informed business decisions about where to provide the most appropriate care in a setting with the lowest cost possible.

We appreciate the opportunity to comment on this important industry topic and look forward to working with the HSCRC on the development of a policy.

Sincerely,



Ed Beranek

Vice President of Revenue Management and Reimbursement
Johns Hopkins Health System

MedStar Montgomery Medical Center

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David Havrilla, CFO
VP of Finance

Administration

May 25, 2018

Nelson J. Sabatini
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of MedStar Health, Montgomery Medical Center, I am writing to share a few additional comments on the Staff's Draft Recommendation for Rate Year 2019 beyond the Maryland Hospital Associations letter for the hospital industry.

The following areas are specific to MedStar Montgomery Medical Center and we would like to bring them to your attention

1) An in-flux of Behavioral Health patients in our Emergency Department presenting with extraordinary needs:
    - Longer length of stay due to difficulty in placement
    - Higher workplace violence for our associates resulting in escalated staff turnover
        - Workplace violence incidents are trending higher by 30%, increasing Worker's Compensation
        - Lost work day cases of associates have increased 54%

2) Greater need for additional staff to expand our transitional care programs:
    - Patients participating in transitional care have significant reduction in readmission (50%)

3) The cost of Information Technology (IT):
    - Our cost of IT continues to grow for the implementation of EHR.
    - With increases in the number of subscribers with deductible/co-pays, we are striving to improve collection at point of service
    - Increased regulatory reporting requirements

4) Increase nursing costs to address vacancy factors for RNs:
    - Premium pay for nursing staff increases our cost 30-50% due to contractual rates and additional training
        - Agency nurses/Overtime
        - Additional orientation/training

5) Economic inflation from Healthcare partners:
    - OR supplies and implants
    - Outside contract services/Purchased Services
    - Utilities

We would appreciate your consideration for the items listed above as we continue to serve our community under population health. Therefore, we strongly urge you to consider an additional 0.5% for the FY 19 update factor.

Thank you for your time and consideration.

Sincerely,

David Havrilla
Vice President & Chief Financial Officer

MedStar Health

Bradley S. Chambers
President, MedStar Good Samaritan Hospital
President, MedStar Union Memorial Hospital
Senior Vice President, MedStar Health

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MedStar Union Memorial Hospital
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MedStarUnionMemorial.org

May 22, 2018

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of the MedStar Health System, MedStar Good Samaritan Hospital and MedStar Union Memorial Hospital, I am writing to share a few additional comments on the Staff's Draft Recommendation for Rate year 2019 beyond the Maryland Hospital Association's letter for the Hospital Industry.

While we appreciate the HSCRC staff deliberations on the proposed update factor, I remain extremely concerned that the current proposal will result in another year of expense inflation outpacing revenue inflation. This disconnect continues at a time when we are striving to build programs that align with our obligations under Waiver 2.0.

As you know, the community we serve, in particular at MedStar Good Samaritan, has a unique patient population. Our patients consistently have multiple chronic conditions and co-morbidities. The PAU methodology already disproportionately penalizes these hospitals due to the type of patients we serve. Providing lower than inflation update factors only compounds the problem.

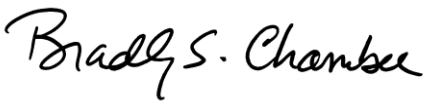
Our ability to better manage the chronic population we serve will be critical to our success under the new waiver. We have a number of program plans under way that will allow us to better manage these patients in the outpatient setting as desired under the new waiver. These programs include, but are not limited to the following:

- Expansion of the Center for Successful Aging
- Addition of the Center for Chronic Disease Management
- Investments in post acute care coordination
- Expansion of services provided in the Good Health Center
- Investment in resources in the Emergency Department to ensure patients are being treated in the most appropriate care setting

These are just a few of the initiatives we are currently working on. Continuing to provide revenue updates at a rate below expense inflation, coupled with the disproportionate penalties of some of the pay for performance programs, will absolutely slow our progress on these important initiatives because our ability to fund these priorities will be severely limited. Without investment in these types of programs, our ability to meet the goals of the new waiver will be compromised. Therefore, I strongly urge you to consider an additional 0.5% for the FY 19 update factor.

Thank you for the opportunity to comment.

Sincerely



Bradley S. Chambers
President MedStar Good Samaritan and MedStar Union Memorial Hospitals

cc: Joseph Antos, Ph.D., Vice Chairman
Adam Kane
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Jack C. Keane
John M. Colmers
James Elliott, M.D.
Donna Kinzer, Executive Director
Jerry Schmith, Director Revenue and Compliance

P:\m\d\HSCRC\Update Ltr GSH_UMH May 2018

MedStar Harbor Hospital

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medstarharbor.org

May 25, 2018

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of MedStar Harbor Hospital (MHH), I would like to thank you for the opportunity to share my thoughts on the proposed HSCRC update for FY2019. The schedule released by the HSCRC staff shows an update for MHH that is significantly below projected inflation of 2.57% as well as projected demographic growth. I am further concerned about the 0.30% PAU savings projection, which affects hospitals like MHH operating in traditionally underserved areas disproportionally given the weighting of the AHRQ Prevention Quality Indicator/ Ambulatory Care Sensitive Conditions (ASC's) as a percentage of hospital discharges.

Patients in our communities suffer a higher baseline prevalence of chronic conditions (as compared to hospitals that are more surgically or tertiary care oriented), and have historically been underserved from the perspective of access to primary care and other preventive services. I am concerned that multiple years of revenue updates below inflation will adversely impact the transformation needed to meet the obligations under the new model, as well as the ability to serve our communities as we strive to develop partnerships with local care providers to improve access to care and clinical outcomes.

MHH has made significant investments in a wide-range of population health improvement initiatives including bridge clinics, palliative care programs, patient medication assistance, care coordination, and is considered an area leader in ED Peer Support through the SBIRT and survivor's outreach programs. We recently made an $8M+ investment to meet the urgent and growing behavior health needs of our region. We now provide a wide-range of behavioral health services including crisis intervention, inpatient, partial hospitalization, and intensive outpatient counseling services. MHH is a major provider of high risk obstetrical services to the South Baltimore community and is meeting the growing needs for care of drug addicted mothers and babies through innovative and collaborative campus-based programs dedicated to the care of these vulnerable populations.

MedStar Harbor Hospital is working hard to increase the value and access of services to our communities. I appreciate your consideration of the Maryland Hospital Association's request for an additional .50% being added to the proposed update factor.

Sincerely,

Stuart M. Levine, MD, FACP
President & Chief Medical Officer, MedStar Harbor Hospital
Senior Vice President, MedStar Health

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Susan K. Nelson
Executive Vice President and
Chief Financial Officer

May 25, 2018

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of MedStar Health and our Maryland hospitals, I am writing to share a few additional comments on the Staff's Draft Recommendation on the Update Factors for Rate Year 2019 supplementing the Maryland Hospital Association's letter on behalf of the hospital industry.

Update Factor

The HSCRC update schedule indicates an average hospital rate increase of 2.81%; however, the range of increase by hospital is quite wide. For example, the application of this proposed update to MedStar hospitals results in a range of rate increases from .98% to 2.39% with an average of 1.73%. These increases are significantly below projected inflation of 2.57% and projected demographic growth of .96% for the populations we serve. There are several factors contributing to this lower update factor than what is shown on the HSCRC schedule:

(1) The additional .30 % PAU savings in the HSCRC update schedule impacts several of our hospitals disproportionally. The methodology was changed to add Ambulatory Sensitive Conditions and as a result penalizes community hospitals that are treating patients with chronic conditions and providing little tertiary or specialized services.
(2) The Academic Medical Centers receive an additional 1.0% for new technology, which equates to a statewide average of .23%.
(3) The update of 2.81% provides the add-back for the Quality Based Reimbursement, but excludes any estimates for the FY19 adjustments. Based on information provided by the staff related to the change in the policy, we estimate this will be a reduction statewide of .35%.
(4) There is a set-aside for unknown adjustments of .25% which is not distributed to the hospitals in the update factor.

We expect other community hospitals will also receive updates below the average 2.81% on the HSCRC update schedule. We are concerned that continued updates below inflation will impact the ability of hospitals to continue on-going transformation activities needed to meet the obligations under Phase 2 of the Waiver. In addition, it should be noted that community hospitals as well as academic medical centers are experiencing drug and supply cost increases above the projected inflation of 2.57% as well as salary and benefit increase pressures in a competitive labor market. We hope you will strongly consider the MHA request for an additional .50%, increasing the average rate increase for MedStar Hospital's to 2.23%, which is still more than 1.0% below inflation.

Shift to Unregulated Services

We believe hospitals need clarification related to the HSCRC definition and process around the reporting of shifts to unregulated services as described in the draft recommendation on the update factor for FY2019.

The historical application required notification to the HSCRC when a hospital closed a service or moved a service to deregulated space. It appears that the language in the draft recommendation broadens this

definition. The additional guidance should address partial shifts of services due to physician preference, payer preference and change in clinical protocols. In addition, consideration should also be given to operational challenges that hospitals may experience in complying with the required reporting.

We appreciate the opportunity to comment on this important matter.

Sincerely,

Susan K. Nelson

Susan K. Nelson
Executive Vice President and Chief Financial Officer

cc:
Joseph Antos, Ph.D., Vice Chairman
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Samuel E. Moskowitz, FACHE
President
Senior Vice President, MedStar Health

May 25, 2018

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of MedStar Franklin Square Medical Center (MFSMC), I am writing to offer my thoughts on the proposed HSCRC update for FY2019. The schedule released by the HSCRC staff shows an average of 2.8% for Maryland hospitals which includes the Global Insights inflation estimate. Unfortunately, it appears as though MFSMC will not receive an adjustment that is close to the Global Insights inflation factor of 2.57%.

The reductions to the update factor that raise concern include:

(1) The update of 2.81% provides the add-back for the Quality Based Reimbursement but does not have any estimates for FY2019 adjustments, including planned reductions for any changes in policy. We estimate this would translate into a hidden statewide reduction of 0.35%;

(2) The additional 0.30% for PAU savings affects MFSMC (and several of our MedStar hospitals) disproportionally when the methodology was changed to add Ambulatory Care Sensitive Conditions (ASC's). The inclusion of ASC's penalizes community hospitals like MFSMC who have a disproportionate share of patients in our communities suffering from chronic conditions (as opposed to hospitals that are more surgically or tertiary care oriented); and,

(3) A set aside for unknown adjustments that is not released to the hospital industry in a formalized process.

I expect other community hospitals will see update factors that are well below existing inflation. Should hospitals see update factors like this moving forward, we will not be able to continue to invest in the transformation necessary to succeed under the new Maryland Model. MFSMC has made significant investments in a wide-range of population health improvements including medication assistance, patient transportation, patient navigators, assignment of transitional care nurses, the use of palliative care, and other care coordination assistance. I hope the HSCRC will strongly consider the MHA request of an additional 0.50% being added to the proposed update factor. This increase, while still below the Global Insights inflation factor, will allow us to continue to serve the communities that call upon us within the goals outlined in the new Maryland Model.

Sincerely,

Samuel E. Moskowitz, FACHE
President

Mt. Washington Pediatric Hospital

Where Children Go to Heal and Grow

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

May 25, 2018

Mr. Sabatini,

Mt. Washington Pediatric Hospital occupies a unique niche in the Maryland healthcare continuum. As a lower-cost post-acute provider, the hospital helps reduce overall expense by treating medically-appropriate patients who transfer from a NICU or PICU. At the same time, the hospital generates almost no Medicare revenue as few pediatric patients are covered. In addition, its inpatient medically complex children are particularly vulnerable and cannot safely be transitioned to an outpatient setting at this stage in their care.

For these reasons, MWPH is writing to request rate relief from the proposed 1.77% update factor, which is the result of reducing the 2.57% inflation rate by a 0.8% productivity adjustment. This steep of a productivity adjustment detracts from MWPH's ability to fulfill its mission, increases overall statewide costs, and does not provide a measureable benefit to Maryland's effort to meet its goals under the Federal Demonstration Project.

Mt. Washington serves a unique patient population. Virtually all admissions come from an acute care hospital, typically from a NICU or a PICU. For this reason, admissions to Mt. Washington reduce overall hospital costs in Maryland, as patients are moving from more expensive acute care to a less expensive post-acute setting. The highest daily room rate at MWPH is $1,237; area NICU rates average $1,703 and area PICU rates average $3,172. In addition to reducing the cost per day of care, transferring patients to MWPH opens NICU and PICU beds for the infants and children who need them.

Reducing rate growth below inflation for MWPH restricts our ability to hire and retain the staff required to treat these patients. Although our daily rates are

lower than acute care, we have to pay the same market rates to attract nurses and other providers. Due to market forces, MWPH may need to increase nursing salaries by 3% for FY 2019 to hire and retain staff. The .8% rate reduction would cost the hospital almost $400 thousand, reducing our ability to attract clinical personnel. When MWPH can't retain staff, admissions are delayed or denied and it becomes more likely patients will spend additional time in more expensive settings.

In fact, inpatient volumes have declined over the past two years. The average daily census was 62 in FY16, but only 58 in FY17 and in FY18. As a result, our operating margin declined in FY17, and is projected to decline again in FY18. Although referrals from acute care hospitals have remained consistent this year, the hospital has struggled to retain the clinical staff needed to care for these patients. We estimate that about one admission per week has been denied or significantly delayed due to inadequate staffing. With our average length of stay of 34 days, this can result in up to 1,500 lost post-acute patient days.

Although its rate structure is linked to the state's psychiatric hospitals, Mt. Washington is different. MWPH has almost no patients that are covered by Medicare. Over the past three years, annual Medicare revenue averaged just $87,000 per year. A rate increase of 2.57%, rather than 1.77%, would total less than $1,000 in additional Medicare revenue.

While the productivity adjustment serves as an incentive to move care from inpatient to outpatient or other lower-intensity settings, the medically complex children that MWPH admits as inpatients are a particularly vulnerable population. The hospital's work is already overseen by insurers, who typically review inpatient cases weekly or bi-weekly to assure that inpatient stays do not last longer than is medically necessary. The 0.8% productivity adjustment would not serve to limit length of stay or readmissions. Instead, it would only limit the number of patients MWPH could serve, leaving the state to pay higher costs in acute care settings. For these reasons, MWPH requests that it receive the full 2.57% rate increase, without a productivity adjustment.

Thank you for your consideration.

Mt. Washington Pediatric Hospital

Where Children Go to Heal and Grow

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

Sincerely,

Sheldon Stein, CEO

Mary Miller, CFO

Cc: Donna Kinzer, Executive Director, HSCRC
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