Final Recommendation for the Update Factors for Rate Year 2020

June 12, 2019

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This document reflects the Final Recommendation on the Update Factors for RY 2020 as approved by the Commission on June 12, 2019.

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List of Abbreviations

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
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
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

Summary

The following report includes a final recommendation for the Update Factor for Rate Year (RY) 2020. This update is designed to meet the Total Cost of Care Requirements while keeping healthcare affordable in the State of Maryland.

The staff requests that Commissioners consider the following final recommendations:

a) Provide an overall increase of 3.59 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.28 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.
    i) Allocate 0.19 percent of the total inflation allowance to high cost outpatient oncology and infusion drugs, providing a 10 percent increase based on the amount each hospital reported for estimated cost and utilization for the top 80 percent of these drugs for RY 2018.
    ii) Provide a conditional additional allowance to the two major Academic Medical Centers of one percent for growth in high cost inpatient procedures and intensity for RY 2020.
    iii) Prospectively reduce Global Budgets by 0.30 percent statewide for Potentially Avoidable Utilization.
b) Provide an overall increase of 2.46 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) 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.

Effective January 1, 2013, the State entered into an All-Payer Model Agreement with the Center for Medicare & Medicaid Services ("CMS"), which required the State to limit the growth in total hospital costs per resident in line with the long term growth in the economy, to achieve Medicare savings per beneficiary relative to national Medicare growth rates, to improve quality, and to transform the hospital reimbursement system away from fee for service to population-based payments. Preliminary data from December 2018 shows that the State has met all of the requirements of the All-Payer Model. In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of $300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. The Medicare TCOC Savings Requirement compares the growth in total Medicare FFS expenditures per Maryland Medicare beneficiary to the national growth rate. These expenditures include both hospital and non-hospital costs. Because the State lacks regulatory authority over providers other than hospitals, meeting the Medicare TCOC savings requirement will require a greater emphasis on initiatives that control the total cost of care though transformation and population

health improvement efforts. The HSCRC will increasingly tie hospitals revenue adjustments to Medicare Total Cost of Care performance under the Medicare Performance Adjustment (MPA) Policy.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will need to place increased emphasis on ensuring that the Medicare TCOC Savings Requirement is met. The approach to ensuring that the RY 2020 annual update is in line with these Model requirements is outlined in this report.

Update Factors are Revenue Updates

It is important to note that the proposed update factor is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

Hospital Revenue Types Included in this Recommendation

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 freestanding psychiatric hospitals and Mount Washington Pediatric Hospital.

This recommendation proposes Rate Year (RY) 2020 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2020, HSCRC staff is proposing an update of 3.28 percent per capita for global revenues and an update of 2.46 percent for non-global revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's Fourth Quarter 2018 market basket growth estimate with a capital growth estimate. For RY 2020, HSCRC staff combined 91.20 percent of Global Insight's First Quarter 2019 market basket growth of 3.10 percent with 8.80 percent of the capital growth estimate of 1.50 percent, calculating the gross blended amount as a 2.96 percent inflation adjustment.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the FFY 2020 Inpatient Psychiatric Facilities Medicare productivity reduction of

0.50 percent to the inflation adjustment. When subtracting the 0.50 percent productivity adjustment from the gross blended inflation adjustment of 2.96 percent growth, this results in a proposed update of 2.46 percent. Additionally, HSCRC staff note that these hospitals receive a volume adjustment, rather than a population adjustment. HSCRC staff continues to work toward implementing quality measures for these hospitals in future rate years.

Table 1

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.96%	2.96%
Productivity Adjustment		-0.50%
Proposed Update	2.96%	2.46%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the Total Cost of Care Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model; and
- Incorporating quality performance programs.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 3.64 percent and per capita growth of 3.33 percent for RY 2020. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 3.59 percent with a corresponding per capita growth of 3.28 percent for RY 2020.

Staff needs to split the annual Rate Year revenue into six month targets to calculate financial tests, which are performed on Calendar Year (CY) results. Consistent with the past several years, the staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2020 estimated revenue used to evaluate the Rate Year 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.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC staff's final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global

revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2

Balanced Update Model for RY 2020			
Components of Revenue Change Linked to Hospital Cost Drivers/Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 3.10% for compensation)			2.77%
- Rising Cost of Outpatient Oncology Drugs			0.19%
Gross Inflation Allowance	**A**		**2.96%**
Care Coordination/Population Health	**B**		**0.00%**
Adjustment for Volume			
-Demographic /Population			0.30%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.30%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.10%
- Low Efficiency Outliers	E		-0.04%
- Capital Funding -Adventist White Oak Medical Center	F		0.09%
- Categoricals & Innovation (1%)	G		0.23%
-Reversal of one-time adjustments for drugs	H		-0.03%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.34%**
Quality and PAU Savings			
-PAU Savings	J		-0.30%
-Reversal of prior year quality incentives	K		0.53%
-QBR, MHAC, Readmissions			
-Positive incentives & Negative scaling adjustments	L		0.18%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**0.41%**
Total Update First Half of Rate Year 20			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**4.02%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1+0.30%)	**3.71%**
Adjustments in Second Half of Rate Year 20			
-Oncology Drug Adjustment	P		0.00%
-QBR	Q		-0.37%
Total Adjustments in Second Half of Rate Year 20	**R =**	P + Q	**-0.37%**
Total Update Full Fiscal Year 20			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**3.64%**
Per Capita Fiscal Year	**T =**	(1+S)/(1+0.30%)	**3.33%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		0.10%
-Deficit Assessment	V		-0.16%
Net decreases	**W =**	U + V	**-0.06%**
Total Update First Half of Rate Year 20			
Revenue growth, net of offsets	**X =**	N + W	**3.96%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1+0.30%)	**3.65%**
Total Update Full Rate Year 20			
Revenue growth, net of offsets	**Z =**	S + W	**3.59%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1+0.30%)	**3.28%**
Private Payer Growth Rate, based on Total Update for Full Rate Year			**4.79%**
Public Payers Growth Rate			**3.09%**

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 2.96 percent. The gross inflation allowance is calculated using Global Insight's First Quarter 2019 market basket growth of 3.10 percent with 8.80 percent of the capital growth 1.50 percent estimate. The adjustment for inflation includes 3.10 percent for compensation. A portion of the 2.96 inflation allowance (0.19 percent) will be allocated to hospitals in order to accurately provide revenues for increases in outpatient oncology drugs. This drug cost adjustment is further discussed below.

- **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 began allocating a specific part of the inflation adjustment to fund increases in the cost of drugs in Rate Year 2016, based on the portion of each hospital's total costs that were comprised of drug costs.

  In addition to the drug inflation allowance, in RY 2017, HSCRC initiated a utilization adjustment for changes in use of high cost oncology and infusion drugs. The adjustment for change in use is made utilizing information provided in a supplemental report provided by the hospitals for the top 80 percent of these specified outpatient medications. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment.

  In 2019, staff prepared a drug funding analysis evaluating funding levels by hospital and drug category from RY 2013 through RY 2018. Drug costs were split into three categories: inpatient drugs, outpatient oncology and infusion drugs, and other outpatient drugs. In this evaluation, staff found that oncology and infusion drug costs averaged a 10 percent annual increase, while inpatient and other outpatient drugs rose more in line with general inflation. As a result of these findings, staff is recommending a modification to the approach it used in RY 2019 to focus the additional inflation for drugs to high cost outpatient oncology and infusion drugs. This will result in a higher growth allowance for these high cost drugs, while continuing to provide inflation for other categories of drugs through the overall inflation allowance. For Rate Year 2020, staff proposes to apply a 10 percent growth allowance, based on drug-specific growth trends, to the top 80 percent of the specified outpatient medications, as reported on hospitals' supplemental drug cost for RY 2018. In RY 2019, 0.31 percent was set aside for inflation for drugs. For RY 2020, staff proposes to set aside 0.19 percent of the inflation allowance to apply to high cost oncology and infusion drugs, leaving the remaining drug inflation together with the general inflation allowance.

  For Rate Year 2021, staff may explore use of a standard list of drugs, which could be used to calculate the inflation allowance as well as the drug utilization adjustment component of funding

for these high cost drugs. Staff will review this possibility and the standard list of drugs with stakeholders during the upcoming months.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2018 is 0.30 percent. For RY 2020, the staff are proposing recognizing the full value of the 0.30 percent growth for the Demographic Adjustment to hospitals in keeping with prior year norms.

- **Set-Aside for Unforeseen Adjustment:** Staff recommends a 0.10 percent set-aside for unforeseen adjustments during RY 2020.

- **Low Efficiency Outliers:** Staff built in a -0.04 percent reduction to account for the Midtown spend down for RY 2020. The revenue impact is a $7.4 million reduction.

- **Capital Funding:** Adventist Health Care is opening a new hospital, White Oak Medical Center, in Silver Spring Maryland. This facility is expected to open in August of 2019. This recommendation includes 0.09 percent for capital for the opening of this facility, which is approximately $15 million as approved by the Commission during the CON process.

- **Categorical Cases & Innovation Funding:** Existing categorical cases include transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. The HSCRC staff has been working to develop an approach to provide a revenue adjustment for these and other expensive therapies performed primarily at University of Maryland Medical Center and Johns Hopkins Hospital. In Rate Year 2019, the HSCRC provided these two AMC hospitals an additional one percent revenue adjustment to create a fixed pool of funds for these and other quaternary services. For RY 2020, staff is again proposing to provide these two AMCs an additional one percent revenue adjustment for RY 2020. Similar to RY 2019, this adjustment will be contingent upon receipt of data regarding productivity and cost levels relative to national peers and ongoing cost savings efforts submitted by the AMCs, which are essential in assuring that the AMCs are improving productivity levels. HSCRC staff will continue to evaluate the level of funding and funding mechanisms that will be employed for RY 2021 and beyond, and the Commission will need to continue to deliberate how to fund these types of services in the future.

- **QBR Adjustment:** CMS provides data for the Quality Based Reimbursement (QBR) adjustment. Due to the data delivery schedule, HSCRC does not have the final data available to calculate this adjustment at this time. HSCRC expects the adjustment to be approximately -0.37 percent, based on the changes in Commission policy and preliminary modeling. HSCRC staff will include this adjustment in the second half of RY 2020.

- **Quality Scaling Adjustments:** Quality scaling adjustments include Maryland Hospital Acquired Conditions (MHAC) and Readmission Reduction Incentive Program (RRIP). The RY 2019 adjustments have been restored in the base and new adjustments are reflected in staff's recommendation. The amount for these two programs which will be adjusted for in the first half of the rate year is 0.18 percent.

- **PAU Savings Reduction:** The statewide RY 2020 PAU savings adjustment is now calculated based on update factor inflation and demographic adjustment applied to CY 2018 PAU revenue. RY 2020 PAU savings adjustment represents the change between RY 2019 and RY 2020. Previous years of PAU savings adjustments are not reversed out.

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):** The proposed uncompensated care adjustment for RY 2020 will be 0.10 percent. The amount in rates was 4.16 percent in RY 2019, and the proposed amount for RY 2020 is 4.26 percent. This is the first year since 2014 that staff is not reducing UCC in rates since 2014. This outcome is to be expected as Medicaid Expansion and Affordable Care Act Enrollment have plateaued, and thus UCC has remained stable.
- **Deficit Assessment:** The legislature reduced the deficit assessment by $25 million in RY 2020, and as a result, this line item is -0.16 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. 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.

PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY2020, the calculation of the statewide value of the PAU Savings will be included in the Update Factor Recommendation; however, PAU measurement policy will be presented separately. For this year, a brief summary of the PAU performance and measure methodology is available in the appendix, but in subsequent years, staff plans to produce PAU policy reports that will include measure and hospital-specific scaling discussions.

Starting in RY 2020, the incremental amount of statewide PAU Savings reductions will be determined formulaically using inflation and demographic adjustment applied to the amount of PAU revenue (see Table 3). In previous years, staff reversed out the prior year cumulative PAU reduction and recalculated the cumulative PAU reduction with an incremental increase to realize additional savings from continued reductions in PAU. In the current policy, staff recommends keeping prior year reductions in place and only implementing additional incremental reductions in keeping with actual rate setting implementation norms. With this change, staff also proposes discontinuing the additional protection for hospitals with high socioeconomic burden, as the smaller incremental reduction lessens the need for continued protections.

Staff compared the actual PAU savings reductions from RY 2014-RY 2019 to the cumulative formulaic inflation-based approach and found that cumulatively PAU savings reductions were about $7.2 million more than under the formulaic approach. Therefore, staff and stakeholders suggest reducing the RY2020 reduction amount by $7.2 million ($58.1 million to $50.8 million) to ensure that the cumulative PAU reduction and cumulative PAU inflation net out to zero in RY 2020. This will result in a RY 2020 PAU savings reduction of about -0.3021 percent statewide. For simplicity's sake, staff recommends rounding this value to -0.30 percent.

Table 3

Statewide Results		**Value**
RY 2019 Total Estimated Permanent Revenue	A	$16,842,884,479
Total RY20 PAU %	B	10.77%
Total RY20 PAU $	C	$1,922,894,085
Statewide Total Calculations (formulaic)		**Value**
RY 2020 Inflation Factor (preliminary)	D	3.02%
RY 2020 Revenue Adjustment $	E=C*D	-$58,071,401
Ry 2020 Revenue Adjustment %	F=E/A	-0.345%
Statewide Total Calculations (adjusted)		
Cumulative difference	G	-$7,188,437
RY 2020 Revenue Adjustment $	H=E-G	-$50,882,964
Ry 2020 Revenue Adjustment %	I=H/A	-0.302%
Recommended RY2020 Revenue Adjustment %		-0.30%

Change in Differential

In December 2018, the Commission voted to approve staff's recommendation to increase the differential from 6.0 percent to 7.7 percent effective July 1, 2019. The State of Maryland has employed a differential since the 1970s whereby public payers (Medicare and Medicaid) pay less than other payers (primarily commercial payers) due to business practices that avert bad debt in hospitals and keep Maryland's hospital costs low. Hospital charges are adjusted via a markup to ensure that the differential's reduction in charges to public payers does not result in a decline in hospitals' total revenue. Given recent trends of increasing bad-debt write-offs in commercial coverage, it is most equitable that the differential be increased 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to ensure that these costs are not shifted to Medicare and Medicaid. This change accounts for the changes in business practices of private Maryland payers that have resulted in higher bad debt costs. To implement the differential, hospital rates will be increased by approximately 1.2 percent. Medicare and Medicaid will receive an additional discount of 1.7 percent off of charges, and the net revenue effect will be revenue neutral to hospitals. As reflected at the bottom of table 2, this change in the differential results in a private payer

growth rate of 4.76 percent and a public payer growth rate of 3.06 percent based on the full rate year update.

With the adoption of this increased differential, the Commission specified that any savings to Medicare from this adjustment could not be utilized to result in a higher all-payer rate adjustment. As shown in the following tables 5a and 5b, staff is using the all-payer revenue increase to evaluate whether Maryland is meeting the all-payer and Medicare growth targets, rather than the lower Medicare increase resulting from the changed public payer differential. Through this approach, staff is ensuring that the savings to Medicare resulting from the differential calculation are not increasing the level of update allowed to hospitals.

Consideration of All-Payer Model Agreement Requirements & National Cost Figures

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 TCOC Model agreement requirements. The staff's considerations in regards to the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

Based on the staff's calculations, the proposed update keeps Maryland within the constraints of the TCOC Model's Medicare savings test. This test requires the Model to generate $300 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by 2023. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care. Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were added up to determine the total *hospital* savings. The TCOC Model requires that the State reach *annual* savings of $300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance over time to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2018 performance, staff expects to exceed the TCOC Model's annual Savings Requirement of $120 million for performance year one (CY 2019). However, similar to the All-Payer Model, there are TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may

not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

The growth in Medicare expenditures in Maryland outside of hospitals continues to exceed the national growth rate. Under the All-Payer Model, the HSCRC built a conservative approach to estimating variations in hospital cost growth. For the Total Cost of Care Model, HSCRC staff proposes to extend this approach to evaluating variations in Total Cost of Care performance. This revised approach will be discussed in the following section.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In order to ensure Model savings and guardrails are being met, staff compared Medicare growth estimates to the all-payer spending limits. Because the actual revenue resulting from updates in RY 2019 affect the CY 2019 results, staff must convert the recommended RY 2020 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2019 to assist in estimating the impact of the recommended update factor together with the projected RY 2019 results. The overall increase from the bottom of this table is used in Table 5a.

Table 4

Estimated Position on Medicare Target		
Actual Revenue CY 2018		17,341,823,084
Step 1:		
Estimated Approved GBR RY 2019		17,494,637,515
Actual Revenue 7/1/18-12/31/18		8,596,133,432
Projected Revenue 1/1/19-6/30/19	**A**	**8,898,504,082**
Step 2:		
Estimated Approved GBR RY 2020		18,187,268,870
Permanent Update		3.96%
Step 3:		
Estimated Revenue 7/1/19-12/31/19 (after 49.73% & seasonality)		9,044,528,809
Reversal of AdHoc One-Times*		(1,000,000)
Estimated Undercharge Percentage**		(22,611,322)
	B	**9,020,917,487**
Step 4:		
Estimated Revenue CY 2019	**A+B**	**17,919,421,569**
Increase over CY 2018 Revenue		3.33%

*Hopkins Payback, Shady Grove GBR Adj, CarT & Spinraza

**0.25% estimated undercharge to mid-year target

Steps to explain Table 4 are described as below:

· Step 1: The table begins with the estimated global revenue for RY 2019 and actual revenue for the last six months for CY 2018 to calculate the projected revenue for the first six months of CY 2019 (i.e. the last six months of RY 2019).
· Step 2: This step shows the estimated RY 2020 global budget revenue based on the information that staff have available to date. The permanent update over RY 2018 of 3.96 percent represents the portion of the RY 2020 update provided during the calendar year 2019, 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 2020 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2020 and hospital specific seasonality adjustments. An adjustment for the temporary rate adjustment for Johns Hopkins Hospital and Adventist Behavioral Health is also added to revenues. Staff also included a 0.25 estimate for CY 2019 undercharge into this amount.
· Step 4: This step shows the resulting estimated revenue for CY 2019 and then calculates the increase over actual CY 2018 Revenue.

For the past five updates, Maryland obtained calendar year Medicare fee-for-service growth estimates from the CMS Office of the Actuary. The projected per capita amount for Medicare Parts A and B for CY 2019 is 4.03 percent. Due to the variability in the estimates from actual performance, particularly with estimates beyond the current year, staff is proposing using actual national Medicare FFS total cost of care growth from the previous calendar year moving forward in our guardrail and savings test, absent large policy changes that would suggest significantly different growth estimates. National Medicare FFS total cost of care growth for CY 2018 was 3.50 percent, shown in line A of Table 5a and 5b.

During CY 2014-CY 2018, 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.

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. This conservative statistic has been updated each year using data provided by HSCRC. For the RY 2020 update, CareFirst and HSCRC staff calculated a difference of 0.83 percent, which used a five-year average difference between Maryland Medicare and all-payer claims reduced by the average annual absolute variance.

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.’ In an effort to ensure that Maryland does not exceed the national Medicare growth rate in CY 2019, 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 2020. Staff modeled non-hospital excess growth, inclusive of a conservative factor of -1.18 percent, which was calculated by taking a five year average of non-hospital excess growth and additionally accounting for the absolute average variance to provide conservatism.

In prior years the staff has included a 0.50 percent reduction in the Medicare Growth target to ensure the State achieves savings under the All-Payer Model. This year we omitted that adjustment in both tables 5a and 5b, as results for CY 2018 show the State well ahead of savings targets. In future years this target adjustment will not be necessary, assuming the Commission subsequently approves the MPA Efficiency Component draft recommendation reviewed in April 2019 which provides a vehicle for achieving savings on a Medicare-only basis. If that policy is not approved the all-payer approach to achieving Medicare savings will be restored to the update factor.

The first scenario, shown in Table 5a calculates savings using the calendar year growth calculated in Table 4. The second scenario, shown in Table 5b calculates savings using the growth rate projection of 2.31 percent per capita for the second half of the rate year from January to June. Both scenarios project a favorable outcome based on staff's projections.

Table 5a – Using Calendar Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY 2018 3.5%)	A	3.50%		
Savings Goal for FY 2020	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.50%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer *with conservatism*		0.83%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-1.18%		
Net Difference Statistic Related to Total Cost of Care	D	-0.35%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.14%**	**3.02%**	**0.12%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.30%)-1	F	**3.45%**	**3.33%**	**0.12%**

Table 5b – Using Second Half of Rate Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY 2018 3.5%)	A	3.50%		
Savings Goal for RY 2020	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.50%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer *with conservatism*		0.83%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-1.18%		
Net Difference Statistic Related to Total Cost of Care	D	-0.35%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.14%**	**2.31%**	**0.82%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.30%)-1	F	**3.45%**	**2.62%**	**0.83%**

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the State Gross Domestic Product (State GDP, which was previously called the Gross State Product (GSP)). The purpose of this modeling is to ensure that healthcare remains affordable in the state. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GDP numbers

available. (CY14-CY17). The 3-year CAGR calculation shows a per capita amount of 3.42 percent. Staff compared that number to the calendar year increase shown in Table 6 to ensure that the update provided in this final recommendation would maintain growth in line with economic growth. The chart below shows this comparison.

Table 6 – Using Calendar Year Growth Estimate

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 3.42%)	A	3.42%	**Recommendation:**	**Savings:**
Savings Goal for FY 2020	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	**3.42%**	**3.02%**	**0.40%**
Conversion to total All-Payer revenue growth (1+C)*(1+0.30%)-1	D	**3.73%**	**3.33%**	**0.40%**

Medicare's Proposed National Rate Update for FFY 2020

CMS published proposed updates to the federal Medicare inpatient rates for FFY 2020 in the Federal Register in mid-April 2019. These updates are summarized in Table 7 below. These updates will not be finalized for several months and are subject to change. In the proposed rule, CMS would increase rates by approximately 3.20 percent in FFY 2020 compared to FFY 2019, after accounting for inflation, a disproportionate share increase, and other adjustments required by law. The proposed rule includes an initial market basket update of 3.20 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 0.50 percent. 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 0.18 percent from FFY 2019.

Table 7

	Inpatient	**Outpatient**
Base Update		
Market Basket	3.20%	3.20%
Productivity	-0.50%	-0.50%
ACA	0.00%	0.00%
Coding	0.50%	
	3.20%	2.70%
Other Changes		
DSH	0.18%	0.00%
Other Changes	0.00%	0.00%
	0.18%	0.00%
	3.38%	2.70%

Applying the inpatient assumptions about market basket, and productivity, staff estimates a 2.70 percent Medicare outpatient update effective January 2020. This estimate is pending any adjustments that may be made when the final update to the federal Medicare outpatient rates is published.

Stakeholder Comments

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2020 update. Staff received and reviewed comments from the Maryland Hospital Association (MHA), CareFirst, Anne Arundel Medical Center, Johns Hopkins Health System, MedStar Health, and University of Maryland Medical System.

Comment: CareFirst agreed with the approach that staff took to formulate the RY 2020 update and believes that the proposed update will meet the financial targets of the TCOC Model and will keep healthcare affordable. CareFirst believes that in the future the 1 percent categorical adjustment for Johns Hopkins and University of Maryland Medical Center should reflect actual amounts not previously funded and should reflect incremental costs moving forward.

Response: Staff is committed to assessing special needs that occur at Academic Medical Centers that include both high intensity cases and new innovations and will continue to explore ways to fund these cases.

Comment: MHA and Johns Hopkins Health System agree with a Commissioner comment that the HSCRC should engage the Maryland Insurance Administration to ensure that generated savings are being passed along to the public.

Response: Staff have begun to explore external sources that can help validate these concerns. In addition, staff intends to reach out to the Maryland Insurance Administration to discuss this matter.

Comment: MHA request that the proposed update be increased by 0.33 percent. Anne Arundel Medical Center, MedStar Health, and University of Maryland Medical System also submitted letters supporting this request.

Response: Staff believes that the proposed update is fair and reasonable and does not agree with the recommendation to increase the update factor. The Model requirements are evaluated on an annual basis. As such, staff formulates the update factor to ensure that performance requirements are met each year. The actual national Medicare total cost of care growth for CY 2018, which staff used to calculate calendar guardrail, was 3.50 percent. This revised figure is 0.22 percentage points lower than the figure used in the draft update proposal. As a result, the estimated savings for the CY 2019 shown in Table 5a have decreased from the draft proposal. In addition, hospital profits have been favorable. Median regulated profits over the course of the model have been in excess of 10 percent and median total profits have been in excess of 3 percent. The profits have deteriorated slightly in RY 2019 - Fiscal year to date through

March 2019 show the median regulated operating profit at 6.95 percent, while total operating profits are 1.73 percent.

Comment: University of Maryland Medical System and MedStar have concerns that PAU savings disproportionately impacts community hospitals and that the new methodology is flawed due the treatment of all 'potentially' avoidable utilization as avoidable.

Response: HSCRC staff agrees with UMMS that not all Potentially Avoidable Utilization is avoidable, which is why the PAU savings adjustment only represents a small portion of the statewide PAU revenue. PAU, as measured by readmissions and PQIs, currently measures $1.8 billion dollars annually. The 0.30 percent PAU savings adjustment is equivalent to about $50.5 million dollars, or 2.80 percent of the total PAU revenue. HSCRC recognizes that the current evaluation of hospital-specific PAU has some challenges, and is working with stakeholders to evaluate PAU measurement and ensure that hospital efforts to reduce PAU are reflected in PAU scores. These changes include adding pediatric measures and moving to a per capita measurement-based approach that will should better reflect how a hospital is working with their community to reduce PAU.

Recommendations

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following final recommendations for the RY 2020 update factors.

a) Provide an overall increase of 3.59 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.28 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.
    i) Allocate 0.19 percent of the total inflation allowance to high cost outpatient oncology and infusion drugs, providing a 10 percent increase based on the amount each hospital reported for estimated cost and utilization for the top 80 percent of these drugs for RY 2018.
    ii) Provide a conditional additional allowance to the two major Academic Medical Centers of one percent for growth in high cost inpatient procedures and intensity for RY 2020.
    iii) Prospectively reduce Global Budgets by 0.30 percent statewide for Potentially Avoidable Utilization.
b) Provide an overall increase of 2.46 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

Appendix A. Potentially Avoidable Utilization (PAU) Savings Methodology

This year the PAU Savings reduction has been incorporated into the Update Factor recommendation since the statewide reduction is now being linked to the update factor inflation and demographic adjustment. This appendix provides additional details on the RY 2020 PAU measurement methodology, as well as the future direction of PAU measurement.

RY2020 PAU Hospital-Specific Measurement

The PAU Savings Policy applies the statewide reduction (as specified in the body of Update Factor Recommendation) to each hospital's total permanent revenue. The statewide reduction is scaled for each hospital based on the amount of PAU revenue assigned to that hospital (e.g., hospitals with PAU revenue greater than the statewide average receive a higher revenue adjustment than the statewide reduction). For RY 2020, PAU revenue is defined as revenue associated with 30-day, all-cause readmissions[1] and ambulatory-care sensitive condition admissions (measured by AHRQ Prevention Quality Indicators (PQIs)).

Readmissions: In prior years, readmissions were assigned to the hospital that received the readmission (i.e., the hospital where the readmission occurred). In response to Commissioner and stakeholder feedback, staff has changed the methodology to assign readmissions to the sending or index hospital for the RY 2020 adjustment. To calculate the readmission revenue associated with the sending hospital, staff vetted with Performance Measurement Workgroup applying the average cost of an intra-hospital readmission (i.e., cost of readmissions that occurred to and from the same hospital) to the total number of sending readmissions assigned to each hospital. Applying this average cost avoids holding sending hospitals accountable for the cost structure at a receiving hospital.

PQIs: HSCRC will use AHRQ PQI version 2018 for Calendar Year 2018 performance.[2] As with previous PAU Savings policy, PQI revenue will exclude revenue flagged as both a PQI and a readmission. Revenue flagged as both PQI and readmission will be included in the readmissions revenue.

Protection: As detailed in the Final RY 2020 Update Factor Recommendation, staff recommends discontinuing the additional protection for hospitals with high socioeconomic burden. In prior years, the PAU savings reductions were capped at the state average if a hospital served a high proportion of disadvantaged populations.[3] This policy was initially adopted because hospitals serving areas with higher socioeconomic burden may face additional challenges in reducing PAU, such as issues with transportation, family and community resources, or health literacy barriers. On the other hand, the Commission does not want to excuse poor quality of care or inadequate care coordination for patients in disadvantaged communities. Due to these issues, staff indicated a potential future phasing out of the protection in the RY 2019 PAU Savings Policy.

Staff believes ending the additional protection for incremental PAU adjustments ensures that these hospitals have the needed resources to serve their communities, while still incentivizing them to reduce

[1] 30-day, all-cause, all-payer, all-hospital readmissions for inpatient stays and observation stays greater than 23 hours, excluding planned admissions, same and next day transfers, oncology cases, and newborns.
[2] Starting in 2018, staff will begin to phase out the use of PQI02 perforated appendix. PQI02 data after October 2018 will NOT be included in determining performance and revenue adjustments due to AHRQ logic issues.
[3] In the RY2019 Policy, this criterion was defined as hospitals in the top quartile in Maryland in terms of the percentage of their total inpatient equivalent case-mix adjusted discharges that are Medicaid/Self-Pay/Charity.

their PAU percentage below the statewide level to receive a lower reduction. Because PAU savings adjustments are built into permanent revenue, hospitals that received the protection continue to benefit from prior years of protection. With the policy shift to calculating only incremental PAU savings adjustments, this historically protected revenue will remain in permanent revenue. Only new PAU Savings adjustments will not have the protection.

RY2020 Hospital-specific results: Draft and final PAU revenue adjustments by hospital will be posted on the HSCRC website (https://hscrc.maryland.gov/Pages/PAU-Savings.aspx) as they are available.

PAU refinement and expansion

Based on Commissioner and stakeholder feedback, staff and stakeholders explored approaches to modernize the PAU measurement in order to increase measure comprehensiveness, resolve methodological concerns with PQI measures, and align with the Total Cost of Care Model. Staff discussed potential expansion and refinement of PAU with a PAU subgroup in the summer and fall of 2018, as well as with the Performance Measurement Workgroup throughout 2018.

Low Value Care. The subgroup proposed and considered a total of thirty-six potential low value care measures, and based on stakeholder input and data availability, the HSCRC calculated three measures for consideration. Ultimately, subgroup members felt the tested measures were too narrow and represented too small dollar values to be worth implementation. Many subgroup members felt that broader measures of utilization represented greater opportunities for making meaningful change and impact on total cost of care. However, they also felt that the PAU Savings policy may not be the most appropriate incentive mechanism, given that many of these measures are not clearly specified, or may occur outside the hospital. Given this feedback, HSCRC is planning on monitoring broad utilization through Medicare data to identify outliers and consider taking action on a case-by-case basis.

New measures. In response to strong consumer and Medicaid support, staff plans on recommending the addition of avoidable pediatric admissions to the PAU measurement for RY 2021.[4]

Per Capita. For RY2021, HSCRC staff intends to recommend a shift to a per capita PAU performance evaluation for PQIs. This approach better aligns with the original population-based intention of PQIs, better recognizes hospital accountability in communities, and enables inclusion of avoidable pediatric admissions. Working with the PAU subgroup and Performance Measurement Work Group, HSCRC plans to propose a methodology for attributing avoidable admissions to hospitals that incorporates the Medicare Performance Adjustment (MPA) attribution process for applicable Medicare beneficiaries, followed by a geographic attribution approach for other patients. Currently, the staff and stakeholders have not made a decision on whether or how to measure readmissions under a per capita model, but starting in 2019 PQI admissions will be flagged prior to readmissions (i.e., if both a PQI and a readmission, then will count as PQI). HSCRC is working with CRISP to produce per-capita performance reports for CY 2019 on PQIs and PDIs as data becomes available. With the incorporation of the MPA attribution in per-capita PQI calculation[5], HSCRC anticipates that CRISP reports for per-capita PQI performance results will be available approximately three to four months following the encounter. A detailed memo on the overall

[4] AHRQ pediatric quality indicators (PDIs) and PQI 09 Low Birthweight Newborns
[5] MPA relies on Medicare billing data that has longer data lags compared to hospital case-mix data. In addition, the first reports of the year may have an additional delay due to loading of new algorithm information.

PQI per capita attribution and readmission measurement will be available as details are vetted by stakeholders and moved into production for CY 2019 performance measurement.

Appendix B. Comment Letters

The Maryland Hospital Administration
CareFirst
Anne Arundel Medical Center
MedStar Health
Johns Hopkins Health System
University of Maryland Medical System