Final Recommendation for the Update Factors For Rate Year 2021

June 10, 2020

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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 Factors for Rate Year (RY) 2021. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness, both during and after the COVID-19 response, and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. Staff recognizes that the COVID-19 crisis has created significant uncertainty and will likely drive large short and long-term changes in the healthcare industry. However, in order to maintain simplicity and stability during the crisis, this policy reflects approaches established prior to the COVID-19 crisis and does not explicitly address COVID-19 specific challenges. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis

At this time, the staff requests that Commissioners consider the following final recommendations:

a) Provide an overall increase of 3.52 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.35 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.

b) Provide an overall increase of 2.77 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

c) Continue to work with all stakeholders to address specific COVID-19 issues such as anticipated hospital undercharges, the challenge of maintaining affordability in a time of economic crisis and the need to ensure sufficient ongoing health system liquidity.

d) The Total Cost of Care Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders. This responsibility has been acknowledged through a cumulative test against a static historic average Gross State Product (GSP) in the Total Cost of Care contract, and more recently through a comparison to recent GSP in the FY20 and FY21 Update Factor Recommendations and the acknowledgement of maintaining growth below GSP in the MPA Framework and Capital Policies approved by the Commission. However, none of these policies create an active, defined method for evaluating the affordability of hospital rates against GSP. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare total cost of care contract and the Commission's approach to rate setting. To address these issues the Commission should task staff with:

    i) Developing, by December 31st 2020, in conjunction with industry, a recommendation for evaluating future update factors against GSP, over the most recent 1 to 5 years, as a proxy for affordability. The recommendation should include both (1) a methodology for identifying the affordability standard and (2) policies for adjusting the update factor should the inflation provided differ from the affordability standard in future years, in order to maintain long-term affordability.

ii) Preparing in the same timeframe, in conjunction with industry, a report discussing how Maryland hospital rates relate to the premiums paid for commercial insurance as maintaining the affordability of healthcare for Marylanders also requires that hospital rates are translated into affordable premiums,

iii) Working with CMS to assess the feasibility of converting the Medicare guardrails to a Fiscal Year basis and utilizing retrospective Medicare growth rates in Medicare tests in a way that recognizes multiple years of results.

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. For this upcoming fiscal year, the HSCRC is considering the extraordinary circumstances of the COVID-19 response in the development of the update factor. Specifically, while staff will implement any and all adjustments that had a performance period prior to the onset of COVID-19 pandemic in the United States (e.g. CY 2019 Market Shift, RY 2021 Readmissions Reduction Incentive Program), staff will not reduce inflation or anticipated utilization growth (related to general population growth) due to total cost of care performance, both the cumulative savings test and the annual total cost of care guardrail tests.

Staff recognizes that this approach could result in less than favorable Maryland Medicare performance in CY 2020. However, given Maryland's overall Medicare savings in the Total Cost of Care contract to date (approximately $335 million relative to an contractually obligated value of $300 million by 2023), and Maryland's positive performance in the total cost of care guardrail the last two years (1.3% under in 2018, 0.3% in 2019), staff believes the proposed update factor will provide greater certainty to an industry in the midst of a pandemic while not jeopardizing the continuance of the Total Cost of Care Model.

If the 1% guardrail threshold is triggered, the reason is likely due to the extraordinary circumstances of COVID-19, which will necessitate a request to exercise the exogenous factor clause in the Total Cost of Care contract. Finally, staff would note that while the proposed test of assessing projected Maryland total cost of care growth to prior year national growth reduces many uncertainties in the annual update factor formulation, it has a potential flaw if multiple years of unforeseen positive performance relative to national Medicare compound, and then this accumulation of savings relative to the nation is not accounted for in future update factors. As such, staff proposes to convene a workgroup to establish a more permanent benchmark for assessing Medicare total cost of care growth that complies with the tenets of the Total Cost of Care contract and responsibly credits hospitals for continued Medicare savings. Staff will also endeavor to create a defined method for assessing the affordability of healthcare in Maryland, one that creates an active, defined method for evaluating the affordability of hospital rates against GSP.

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. To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure after the COVID-19 crisis abates that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to ensure that the RY 2021 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) 2021 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2021, HSCRC staff is proposing an update of 3.35 percent per capita for global revenues and a rate update of 2.77 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 2019 market basket growth estimate with a capital growth estimate. For RY 2021, HSCRC staff combined 91.20 percent of Global Insight's Fourth Quarter 2019 market basket growth of 2.90 percent with 8.80 percent of the capital growth estimate of 1.40 percent, calculating the gross blended amount as a 2.77 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 normally applies the FFY 2021 Inpatient Psychiatric Facilities Medicare productivity reduction of 0.40 percent to the inflation adjustment. This productivity offset is usually made for expected

improvements that could reasonably be expected with allowed volume growth. Since volumes are not growing due to COVID 19, staff recommends suspending this adjustment for this year only.

Table 1

	Global Revenues	Psych & Mt. Washington	
Proposed Base Update (Gross Inflation)	2.77%	2.77%	
Productivity Adjustment		-0.40%	(SUSPENDED)
Proposed Update	2.77%	2.77%	

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the TCOC 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 3.49 percent and per capita growth of 3.32 percent for RY 2021. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 3.52 percent with a corresponding per capita growth of 3.35 percent for RY 2021.

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 2021 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 2021			
Components of Revenue Change Link to Hosptial Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 3.10% for compensation)			2.64%
- Rising Cost of Outpatient Oncology Drugs			0.13%
Gross Inflation Allowance	**A**		**2.77%**
Care Coordination/Population Health			
- Regional Partnership Grant			0.19%
Total Care Coordination/Population Health	**B**		**0.19%**
Adjustment for Volume			
-Demographic /Population			0.16%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.16%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.25%
- Low Efficiency Outliers	E		0.00%
- Capital Funding	F		0.03%
- Complexity & Innovation	G		0.10%
-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		-0.28%
-Reversal of prior year quality incentives	K		0.19%
-QBR, MHAC, Readmissions			
-Current Year Quality Incentives	L		0.11%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**0.02%**
Total Update First Half of Rate Year 21			
Net increase attributable to hospitals	N =	Sum of A + B + C + I + M	3.49%
Per Capita First Half of Rate Year (July - December)	O =	(1+N)/(1+0.16%)	3.32%
Adjustments in Second Half of Rate Year 21			
-Oncology Drug Adjustment	P		0.00%
-QBR	Q		0.00%
Total Adjustments in Second Half of Rate Year 21	**R =**	**P + Q**	**0.00%**
Total Update Full Fiscal Year 21			
Net increase attributable to hospital for Rate Year	S =	N + R	3.49%
Per Capita Fiscal Year	T =	(1+S)/(1+0.16%)	3.32%
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		0.12%
-Deficit Assessment	V		-0.09%
Net decreases	W =	U + V	0.03%
Total Update First Half of Rate Year 21			
Revenue growth, net of offsets	X =	N + W	3.52%
Per Capita Revenue Growth First Half of Rate Year	Y =	(1+X)/(1+0.16%)	3.35%
Total Update Full Rate Year 21			
Revenue growth, net of offsets	Z =	S + W	3.52%
Per Capita Fiscal Year	AA =	(1+Z)/(1+0.16%)	3.35%

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 2.77 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's Fourth Quarter 2019 market basket growth of 2.90 percent with 8.80 percent of the capital growth index change of 1.40 percent. The adjustment for inflation includes 2.90 percent for compensation. A portion of the 2.77 inflation allowance (0.13 percent) will be allocated to hospitals in order to more 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 outpatient infusion and oncology drugs in the outpatient setting, continues to be a 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 RY 2016, based on the portion of each hospital's total costs that were comprised of drug costs. In RY 2020 this was refined to focus increases on the hospitals with the high-cost, outpatient infusion and oncology drugs that drive the overall drug inflation.

  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 from the HSCRC's Casemix dataset and a supplemental report provided by the hospitals for a list of 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.

  For Rate Year 2021, staff began using a standard list of drugs based on criteria established with the industry in evaluating high cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high cost drugs.

- **Care Coordination / Population Health:** In November 2019, The Commission approved 0.25 percent of RY 2021 hospital revenue for funding streams that focus on Diabetes & Management and Behavioral Health Crisis Program. The 0.25 percent will be reduced by 0.06 percent from unspent funds from prior rate years reducing the grant funding to 0.19 percent.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2020 is 0.16 percent. For RY 2021, the staff are proposing recognizing the full value of the 0.16 percent growth for the Demographic Adjustment to hospitals in keeping with prior year norms.

- **Set-Aside for Unforeseen Adjustment:** Staff recommends a 0.25 percent set-aside for unforeseen adjustments during RY 2021.

- **Capital Funding:** Suburban Hospital received approval in 2015 for a Certificate of Need (CON) totaling $200 million to replace and renovate the Hospital facility. The Commission approved a $7.7 million capital adjustment as part of Suburban's Full Rate Application in RY2020. The hospital received $2.6 million for this adjustment in RY2020. The remaining $5.1 million of the capital adjustment is included in RY2021. To account for the remaining capital adjustment 0.03 percent is included in the update factor for RY2021.

- **Categorical Cases:** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC staff developed an approach to provide a higher variable cost factor (100% for drugs and supplies, 50% for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center in RY 2017, 2018 and 2019. Based on this analysis, staff concluded that the historical average growth rate was 0.43 percent, which equates to a combined state impact of 0.10 percent for the RY 2021 Update Factor.

- **Quality Scaling Adjustments:** The RY 2020 adjustments have been restored in the base for the Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement (QBR) adjustment. New adjustments are reflected in staff's recommendation. The amount for RRIP and MHAC, is 0.41 percent of total permanent revenue. 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 the QBR adjustment at this time. HSCRC expects the QBR adjustment to be approximately -0.32 percent of total permanent revenue, based on the changes in Commission policy and preliminary modeling.

- **PAU Savings Reduction:** The statewide RY 2021 PAU savings adjustment is now calculated based on update factor inflation and demographic adjustment applied to CY 2019 PAU revenue. RY 2021 PAU savings adjustment represents the change between RY 2020 and RY 2021. 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 increase in uncompensated care adjustment for RY 2021 will be 0.12 percent. The amount in rates was 4.26 percent in RY 2020, and the proposed amount for RY 2021 is 4.38 percent.
- **Deficit Assessment:** The legislature reduced the deficit assessment by $15 million in RY 2021, and as a result, this line item is -0.09 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 RY 2020, the calculation of the statewide value of the PAU Savings is included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March.

Starting in RY 2020, the incremental amount of statewide PAU Savings reductions is determined formulaically using inflation and demographic adjustment applied to the amount of PAU revenue (see Table 3). This will result in a RY 2021 PAU savings reduction of -0.28 percent statewide, or $49,415,935. Hospital performance on avoidable admissions per capita and sending readmissions estimated revenue determines each hospital's specific PAU savings reduction.

Table 3

Statewide PAU Reduction		**Value**
RY 2020 Total Estimated Permanent Revenue	A	17,648,548,348
RY 2021 Inflation Factor (preliminary)	B	2.72%
Total RY20 PAU $	C	$1,844,766,206
RY 2021 Revenue Adjustment $	D=B*C	-$50,177,641
Ry 2021 Revenue Adjustment %	E=round(D/A)	-0.28%
RY 2021 Revenue Adjustment $ - Rounded	F = E*A	$49,415,9354

*Does not include revenue from Grace, UM-Laurel, or free standing EDs.

Consideration of Total Cost of Care 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 2019 performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual Savings Requirement of $120 million for performance year one (CY 2019), reaching approximately $335 million in savings. 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 2020 affect the CY 2020 results, staff must convert the recommended RY 2021update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2020 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 2019		17,895,385,316
Adjust for MU Change 1/31/19-6/30/19		106,559,120
Adjusted Actual Revenue CY 2019		18,001,944,436
Step 1:		
Estimated Approved GBR RY 2020		18,383,120,012
Actual Revenue 7/1/19-12/31/19		9,015,458,624
Approved Revenue 1/1/20-6/30/20	A	**9,367,661,388**
Step 2:		
Estimated Approved GBR RY 2021		19,029,783,082
Permanent Update		3.52%
Step 3:		
Estimated Revenue 7/1/20-12/31/20(after 49.73% & seasonality)		9,463,511,127
Estimated Undercharge Percentage**		(101,259,569)
Projected Revenue 7/1/20-12/30/20	B	**9,362,251,557**
Step 4:		
Estimated Revenue CY 2020	**A+B**	**18,729,912,945**
Increase over CY 2019 Revenue		4.04%

Steps to explain Table 4 are described as below:
The worksheet begins with actual revenue for CY 2019. This revenue is adjusted for the impact of the "Differential Adjustment" that was made on July 1, 2019 and not included in the first six months of actual revenue from January 1, 2019 to June 30, 2019.

· Step 1: The table uses the estimated approved global budget revenue for RY 2020 and actual revenue for the last six months for CY 2019 to calculate the projected revenue for the first six months of CY 2020 (i.e. the last six months of RY 2020).

· Step 2: This step shows the estimated RY 2021 global budget revenue based on the information that staff have available to date. The permanent update over RY 2019 of 3.52 percent represents the portion of the RY 2021 update provided during the calendar year 2020, 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 2021 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2021 and estimated undercharge adjustment.
· Step 4: This step shows the resulting estimated revenue for CY 2020 and then calculates the increase over actual CY 2019 Revenue.

In prior year 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 2020 is 4.28 percent. However, due to the variability in the estimates from actual performance, particularly with estimates beyond the current year, staff is again 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 2019 was 3.84 percent, shown in line A of Table 5a and 5b.

During CY 2014-CY 2019, 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 2021 update, CareFirst and HSCRC staff calculated a difference of 0.95 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 2020, 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 2021. Staff modeled non-hospital excess growth, inclusive of a conservative factor of -0.92 percent, which was calculated by taking a two 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. Again this year we have omitted that adjustment in

both tables 5a and 5b. Starting with RY 2020 this target adjustment is no longer necessary, as the Commission approved the MPA Framework in the fall of 2019. The MPA Framework provides a vehicle for achieving savings on a Medicare-only basis if needed to meet contract targets.

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 for the second half of the fiscal year. (January 2021 to June 2021.)

Table 5a – Using Calendar Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY2019 3.84%)	A	3.84%		
Savings Goal for FY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.84%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-0.92%		
Net Difference Statistic Related to Total Cost of Care	D	0.03%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.87%**	**3.88%**	**0.00%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**4.04%**	**4.04%**	**0.00%**

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

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY 2019 3.84%)	A	3.84%		
Savings Goal for RY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.84%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-0.92%		
Net Difference Statistic Related to Total Cost of Care	D	0.03%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.87%**	**3.20%**	**0.67%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**4.04%**	**3.37%**	**0.67%**

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. (CY16-CY19). The 3-year CAGR calculation shows a per capita amount of 3.39 percent. Staff compared that number to the calendar year increase shown in Table 6 to evaluate whether 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 3.39%)	A	3.39%	**Recommendation:**	**Savings:**
Savings Goal for FY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	**3.39%**	**3.88%**	**-0.49%**
Conversion to total All-Payer revenue growth (1+C)*(1+0.16%)-1	D	**3.56%**	**4.04%**	**-0.49%**

While the Update Factor proposed for RY 2021 exceeds the 3-year CAGR, it should be noted that the Update Factor last year was 0.42 percent below the 3-year CAGR calculation.

Medicare's Proposed National Rate Update for FFY 2021

On May 11, 2020, CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate. The proposed increase to the Operating Rate is 3.1%. However, other adjustments to payments would lower the payment increase to 1.6%. The proposed Outpatient Prospective Payment (OPPS) payment rate is 2.5%.Combined, these two payment rates are approximately equivalent to a 1.9% increase for hospital payments, which is the analog to the HSCRC Update Factor. These increase are proposed and will not be finalize until August 2020 and will not go into effect until October 1, 2020. This also does not take into account volume changes.

Stakeholder Comments

HSCRC staff received and reviewed comments from Maryland Hospital Association (MHA), Johns Hopkins Health Systems (JHHS), University of Maryland Medical System (UMMS,) MedStar Health, Mt Washington Pediatrics Hospital, Sheppard Pratt, CareFirst and Transit Health & Welfare Fund. Stakeholders expressed concern over the following aspects of the Draft Recommendation:

- Creating an update that creates Medicare dissavings in CY 2020
- Creating an update that is unaffordable relative to Gross State Product (GSP) growth
- Creating a hard cap test for the update factor based on GSP
- Continuing the Potentially Avoidable Utilization (PAU) shared savings adjustment
- Implementing a Productivity Adjustment for Non GBR Hospitals
- Creating a clear plan to use federal relief funding in determining hospital revenues moving forward

Comment: While generally supportive of the Draft RY 2021 Update Factor recommendation, CareFirst and the Transit Health and Welfare Fund expressed concerns regarding Maryland losing ground against national Medicare, as measured by the annual total cost of care (TCOC) saving test (projected dissaving's of .34%). These stakeholders were similarly concerned that the proposed update would exceed staff's measure of affordability, namely an evaluation of projected growth relative to a three year average growth in Growth State Product (projected dissavings of .64%).

Response: Staff shares the concern about the projected dissavings in the various tests that are employed to ensure the Update Factor is reasonable and affordable. In the draft recommendation, staff tried to strike a balance between providing an update that allowed hospitals to adequately respond to cost pressures, especially as volume dissipated due to the COVID-19 pandemic, and protecting the public from large price increases in the midst of a faltering economy.

Staff believes a projected dissavings of .34% in TCOC is still in keeping with the TCOC test, as the State has had two consecutive years of savings relative to national Medicare growth and the projected dissavings does not exceed 1%. That said, staff has reviewed the various adjustments made to the update factor and the TCOC test to better ensure there are no projected Medicare dissavings. Staff conducted this review because the formulaic approach outlined in the RY 2020 Update Factor asserted that in the absence of an automatic 0.50% offset to ensure Medicare savings, which instead has been replaced by the Medicare Performance Adjustment Savings Component, staff would not put forward an all-payer update that creates dissavings to Medicare. Moreover, given the relatively low proposed rule of 1.9% for Medicare IPPS/OPPS in fiscal year 2021, staff thought it important to ensure the Update Factor did not result in Medicare TCOC dissavings.

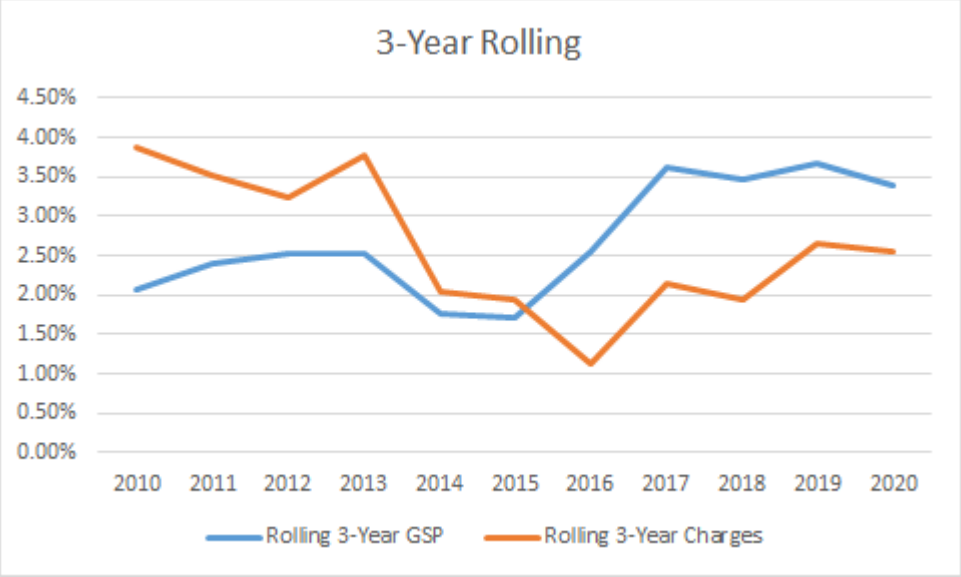
Specifically, staff proposed two changes to the Draft Update Factor Recommendation:

1) Implementing the Quality Based Reimbursement (QBR) program effective July 1, 2020 as opposed to January 1, 2020. In addition to reducing projected dissavings in CY 2020, this approach represents a methodological improvement because consumers will receive a more similar price for hospital services throughout the fiscal year. Staff believe this approach, which relies on quarterly estimates for QBR is acceptable, as the variance between estimates based on 9 months of data and the actual QBR adjustment has been minimal (at the statewide and hospital level) and will be reconciled in the January 1st mid-year rate orders, if necessary.

2) Reassessing the non-hospital excess cost calculation to exclude 2015 through 2017 from the average, because non-hospital dissavings have exhibited a much lower trend in recent years. This adjustment will have no impact to hospitals or payers but, upon further review, is more indicative of anticipated non-hospital dissavings, which have slowed in 2018 and 2019. The conservative factor in the non-hospital excess cost calculation, which is a measure of average absolute deviation, still utilizes all five years of data (2015-2017), as this statistic is more meaningful if it includes multiple variables that deviate from the average.

While the inclusion of these adjustments result in no Medicare TCOC dissavings, there are still projected dissavings relative to staff's measure of affordability, namely three year compound annual GSP growth. With these adjustments, the dissavings relative to GSP goes from .64% to .49% for CY 2020. Staff are

concerned about this outcome but note that hospital expenditure growth has been well below the 3.58% annual growth rate required in the All-Payer and Total Cost of Care contracts and hospital expenditure growth has lagged behind GSP growth in recent years, as evidenced by the table below:



Additionally, the Update Factor, recommended and approved, for FY 2020 was 0.42% below the 3 year average GSP. Given the adjustments staff has proposed and the positive performance of hospital charges relative to recent GSP growth, staff do not recommend any further modifications to the update factor recommendation.

Comment: The Maryland Hospital Association, Johns Hopkins Health System and University of Maryland Medical System all expressed concern about creating a new Gross State Product test for the Update Factor that would be binding or a "hard cap."

Response: Staff remain concerned that while the Total Cost of Care Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders, there is no policy to create an active, defined method for evaluating the affordability of hospital rates against GSP. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare total cost of care contract and unnecessary complexities related to assessing calendar year performance with a fiscal year update. To address these concerns, staff feel it is important to convene a workgroup to discuss the various tests included in the annual Update Factor.

Comment: The Maryland Hospital Association, MedStar Health and the University of Maryland Medical Center expressed concern over the continued implementation of the Potentially Avoidable Utilization (PAU) shared savings adjustment in RY 2021. Specific arguments included that the global budgets already have the incentive to reduce PAU, PAU is included in multiple methodologies and is potentially over utilized, Maryland's overall Medicare use rate is below the national average, and it is unclear how patient utilization patterns will change, especially since "volumes have dropped significantly as a result of the COVID-19 pandemic and Potentially Avoidable Volumes have largely been eliminated." Carefirst, conversely, is in support of the PAU adjustment.

Response: Staff continues to believe the PAU adjustment is necessary to incentivize hospitals to continue to reduce avoidable utilization, and given the projected tightness of our various tests (Medicare guardrail and GSP growth), this adjustment is necessary to not backslide in Medicare and to keep healthcare affordable in Maryland. It is important to note that our comparison values for these tests are last year's figures, which will not include the unprecedented declines staff anticipates in national Medicare figures and Maryland gross state product.

Staff also recognizes that Maryland hospitals have made significant improvements in reducing potentially avoidable utilization, as evidenced by the fact that the overall Maryland Medicare use rate is below the national average, Medicare readmissions are slightly better than the national average, and on a risk adjusted basis (age and gender adjusted), Maryland in 2019 was 5% below 2016 national norms for avoidable admissions (PQIS) - this last relative statistic changes to Maryland being 13% over 2016 national norms when observation over 24 hours is included. Given the incentives of the Model, which no other hospital system in the country has to the same degree, staff believe it is important to continue to incentivize reductions in PAU that move Maryland well beyond national average performance.

Finally, staff would note that a fundamental hallmark of the All-Payer and Total Cost of Care Model is to reinforce the primary incentives of the model(s) in multiple methodologies, in this case reducing potentially avoidable utilization. PAU is included in the Demographic Adjustment as means to redistribute the availability of funding for anticipated utilization growth related to changes in the population of Maryland and it is also included in the Market Shift Adjustment methodology to ensure that hospitals receive a reward, i.e. full retention of revenue, when PAU is reduced. Adding PAU to the update factor to ensure that inflation is not provided for readmissions and avoidable admissions is yet another example of reinforcing one of the primary incentives of the Total Cost of Care Model.

Comment: Mt Washington Pediatrics Hospital and Sheppard Pratt Hospital both requested that the productivity adjustment of 0.40 percent for non-GBR hospitals be removed from the Update Factor Recommendation.

Response: The 0.40 percent productivity offset is normally applied to the estimated inflation provision to recognize productivity gains from expected volume growth. A review of each hospital’s current volumes show a large decline probably due to COVID-19. Therefore, staff has recommended to suspend this adjustment for FY 2021.

Comment: Transit Health & Welfare Fund expressed that they would like to see a clear plan to address the possibility that hospital revenue from payers and additional federal and/or state COVID-19 relief funds might exceed hospital expenses.

Response: Staff will be engaging industry over the next few months to refine the State’s response to the COVID-19 pandemic and the implications it has for our hospital industry. Specific topics will include: identifying all federal funding provided in response to COVID-19; reducing RY 2020 guaranteed income, which was not charged due to volume dissipation, by federal relief dollars dedicated to offset regulated hospital losses; calculating all capital surge expenditures and potentially creating an indemnification program for those expenses in line with the directive from the Maryland Secretary of Health, and implementing at a future date an efficiency policy that can transition hospitals to a post-COVID market.

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 2021 update factors.

a) Provide an overall increase of 3.52 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.35 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.

b) Provide an overall increase of 2.77 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

c) Continue to work with all stakeholders to address specific COVID-19 issues such as anticipated hospital undercharges, the challenge of maintaining affordability in a time of economic crisis and the need to ensure sufficient ongoing health system liquidity.

d) The Total Cost of Care Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders. This responsibility has been acknowledged through a cumulative test against a static historic average Gross State Product (GSP) in the Total Cost of Care contract, and more recently through a comparison to recent GSP in the FY20 and FY21 Update Factor Recommendations and the acknowledgement of maintaining growth below GSP in the MPA Framework and Capital Policies approved by the Commission. However, none of these policies create an active, defined method for evaluating the affordability of hospital rates against GSP. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare total cost of care contract and the Commission's approach to rate setting. To address these issues the Commission should task staff with:

    i) Developing, by December 31st 2020, in conjunction with industry, a recommendation for evaluating future update factors against GSP, over the most recent 1 to 5 years, as a proxy for affordability. The recommendation should include both (1) a methodology to determine the affordability standard and (2) policies for adjusting the update factor should the inflation provided differ from the affordability standard in future years, in order to maintain long-term affordability.

    ii) Preparing in the same time frame, in conjunction with industry, a report discussing how Maryland hospital rates relate to the premiums paid for commercial insurance as maintaining the affordability of healthcare for Marylanders also requires that hospital rates are translated into affordable premiums,

    iii) Working with CMS to assess the feasibility of converting the Medicare guard rails to a Fiscal Year basis and utilizing retrospective Medicare growth rates in Medicare tests in a way that recognizes multiple years of results.