All Payer Hospital System Modernization
Payment Models Workgroup

Meeting Agenda

May 3, 2018
9:00 am to 12:00 pm
Health Services Cost Review Commission
Conference Room 100
4160 Patterson Avenue
Baltimore, MD 21215

I	Introductions and Meeting Overview
II	Medicare Monitoring through December
III	FY 2018 Update Factor
IV	Adjourn

Update on Medicare Fee-for-Service (FFS) Data & Analysis

May 2018 Update using restated beneficiary data (CME database)

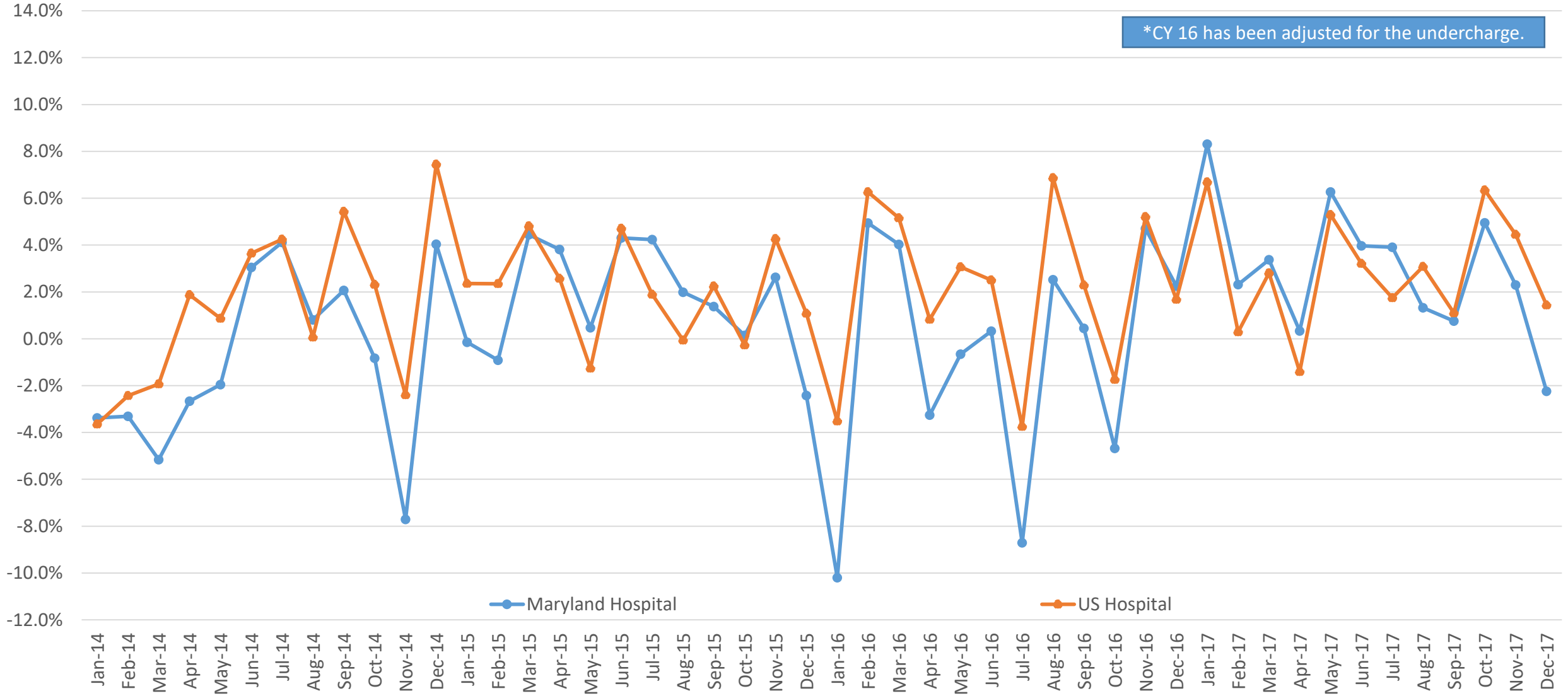
Data through December (CY16 Adjusted for the Undercharge)

Claims paid through March

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

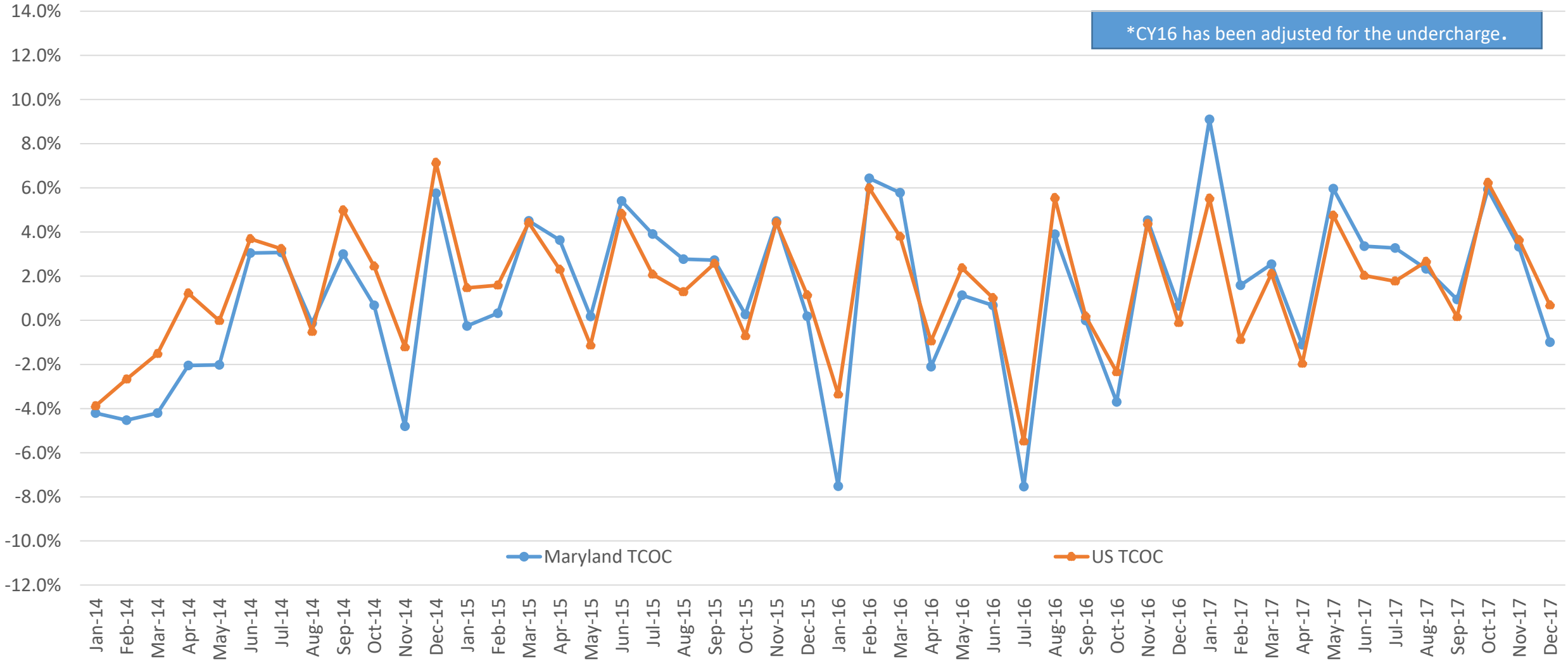
Medicare Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)

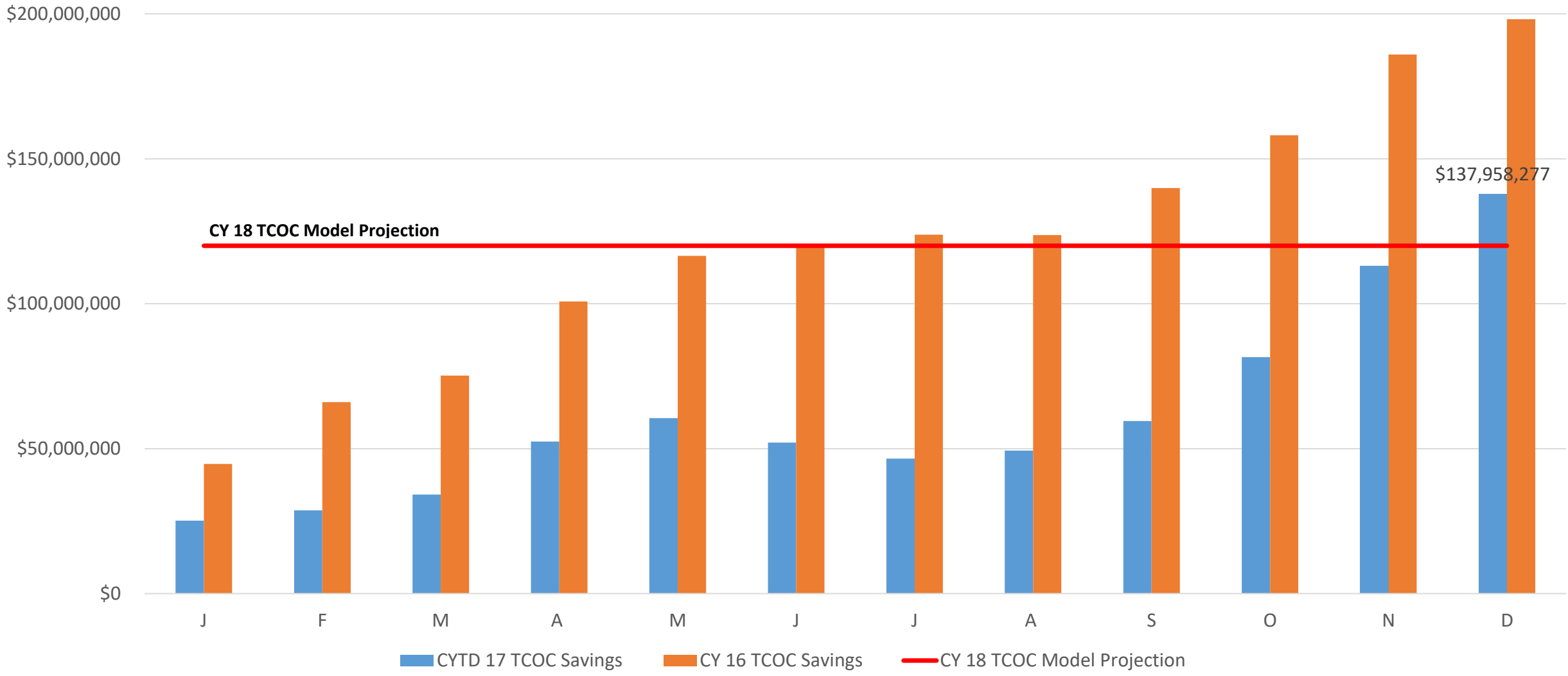


Medicare Total Cost of Care per Capita

Actual Growth Trend (CY month vs. prior CY month)

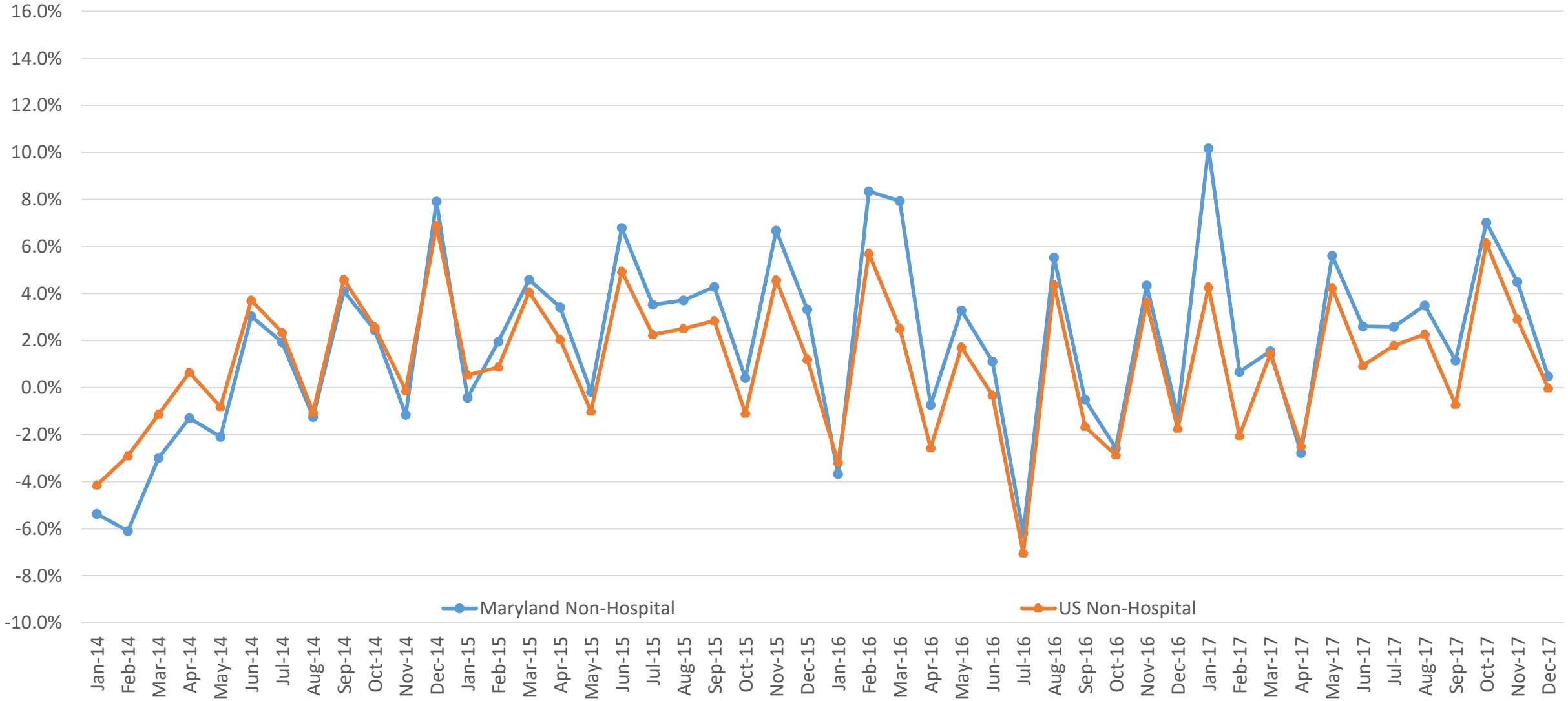


Annual Total Cost of Care Savings



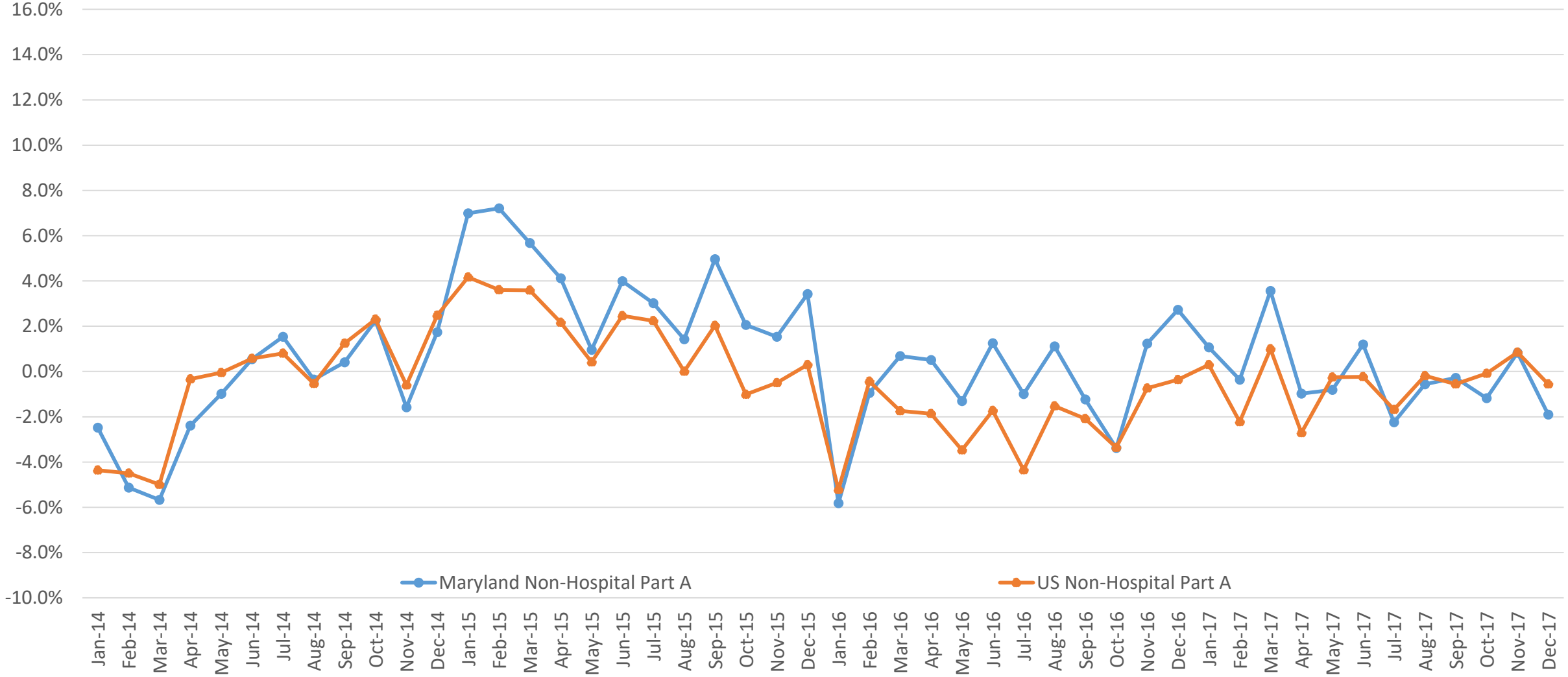
Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



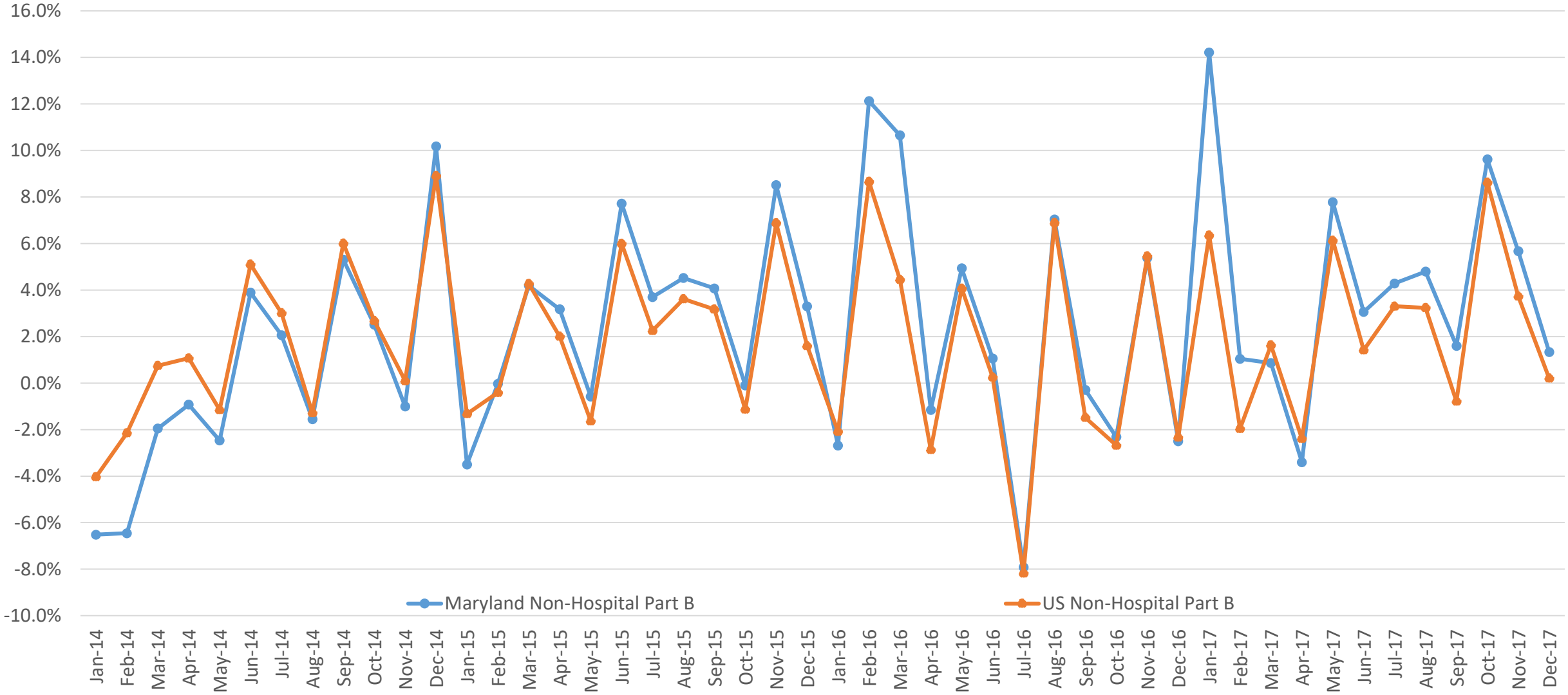
Medicare Non-Hospital Part A Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



Medicare Non-Hospital Part B Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



Balanced Update Model for Discussion

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

			Weighted Allowance
Adjustment for Inflation (this includes 2.4% for wages)			2.33%
- Total Drug Cost Inflation for All Hospitals*			0.24%
Gross Inflation Allowance	**A**		**2.57%**
Care Coordination			
-Rising Risk With Community Based Providers			
-Complex Patients With Regional Partnerships & Community Partners			
-Long Term Care & Post Acute			
	B		
Adjustment for volume	**C**		**0.46%**
-Demographic Adjustment (0.46%)			
-Transfers			
-Drug Population/Utilization			
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.25%
- Categoricals (net amount for Hopkins/UMMS: 0.23%)	E		0.23%
Net Other Adjustments	**F =**	**Sum of D thru E**	**0.48%**
-Reversal of one-time adjustments for drugs	G		0.00%
-Reverse prior year's PAU savings reduction	H		1.45%
-PAU Savings	I		-1.75%
-Reversal of prior year quality incentives	J		-0.25%
-QBR, MHAC, Readmissions			
-Positive incentives & Negative scaling adjustments	K		-0.15%
Adjustments in Second Half of Fiscal Year 19	L		
-QBR, Oncology Drug Adjustment			
Net Quality and PAU Savings	**M =**	**Sum of G thru L**	**-0.70%**
Net increase attributable to hospitals	N =	Sum of A + B + C + F + M	**2.81%**
Per Capita	O =	(1+N)/(1+0.46%)	**2.33%**

Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements

-Uncompensated care reduction, net of differential	P		-0.32%
-Deficit Assessment	Q		-0.19%
Net decreases	**R =**	**P+ Q**	**-0.51%**
Revenue growth, net of offsets	S=	M + Q	**2.29%**
Per capita revenue growth	T =	(1+S)/(1+0.46%)	**1.82%**

* Provided Based on proportion of drug cost to total cost (drug index 4.5% X 5.4% national weight)

Estimated Position on Medicare Target		
Step 1:		
Approved GBR FY 2018		17,183,983,214
Actual Revenue 7/1/17-12/31/17		8,421,055,533
Projected Revenue 1/1/18-6/30/18	**A**	**8,762,927,681**
Step 2:		
Estimated Approved GBR FY 2019		17,578,009,012
Permanent Update		2.29%
Step 3:		
Estimated Revenue 7/1/18-12/31/18 (after 49.73% & seasonality)		8,741,543,882
Change in Hopkins Payback		10,000,000
	B	**8,751,543,882**
Step 4:		
Estimated Revenue CY 2018	**A+B**	**17,514,471,563**
Increase over CY 2017 Revenue		2.69%

Maximum All-Payer Increase that will still produce the Desired FY 2019 Medicare Savings

With 0.50% Savings Goal

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare Growth (CY 2018 2.32%)	A	2.32%		
Savings Goal for FY 2019	B	-0.50%		
Maximum growth rate that will achieve savings (A+B)	C	1.82%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer		0.86%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation		-0.49%		
Net Difference Statistic Related to Total Cost of Care	D	0.37%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**2.20%**	**2.22%**	**-0.02%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.46%)-1	F	**2.67%**	**2.69%**	**-0.02%**

Without 0.50% Savings Goal

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare Growth (CY 2018 2.32%)	A	2.32%		
Savings Goal for FY 2019	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	2.32%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer		0.86%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation		-0.49%		
Net Difference Statistic Related to Total Cost of Care	D	0.37%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**2.70%**	**2.22%**	**0.48%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.46%)-1	F	**3.17%**	**2.69%**	**0.48%**

Draft Recommendations on the Update Factors for FY 2019

May 9, 2018

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This document reflects the Draft Recommendation on the Update Factors for FY 2019. Please send all written comments to hscrc.payment@maryland.gov no later than May 25, 2018.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
ACO	Accountable Care Organization
CAGR	Compound Annual Growth Rate
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DBM	Department of Budget Management
DSH	Disproportionate Share Hospital
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global budget revenue
HSCRC	Health Services Cost Review Commission
MACRA	Medicare Access and CHIP Reauthorization Act
MHA	The Maryland Hospital Association
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RY	Rate year, which is July1 through June 30 of each year
UCC	Uncompensated care

INTRODUCTION AND BACKGROUND

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

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

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

It is important to note that the proposed update incorporates both price and volume adjustments for revenues under global budgets. Thus, the proposed update should not be compared to a rate update that does not control for volume changes. It is also important to view the revenue updates in the framework of gross and net revenue. Specially, beginning in calendar year 2014, the expansion of Medicaid and other Affordable Care Act enrollment has reduced uncompensated care and the State has reduced several related hospital assessments. The revenue reductions for uncompensated care and associated assessment reductions implemented by HSCRC decrease gross revenues, but they do not decrease net revenues. Therefore, the net revenue increases are higher than gross revenue increases during these periods.

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

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

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to

Maryland and thus Medicare does not pay on the basis of those rates. This includes psychiatric hospitals and Mount Washington Pediatric Hospital.

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

ASSESSMENT

Overview of Preliminary Update Factors Recommendations

As described in detail below, for RY 2019, HSCRC staff is proposing a preliminary update of 1.82 percent per capita for global revenues and a preliminary update of 1.77 percent for non-global revenues.

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

The calculation of the inflation/trend adjustment Global Revenues and Non-Global Revenues, including psychiatric hospitals and Mt. Washington Pediatrics, starts by using the gross blended statistic of 2.57 percent growth[1], which was derived from combining 91.20 percent of Global Insight's Fourth Quarter 2017 market basket growth of 2.70 percent with 8.80 percent of the capital growth estimate of 1.20 percent, which calculates to 2.57 percent. The proposed inflation/trend adjustment follows:

Table 1. RY 2019 Proposed Inflation/Trend Adjustment

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

For psychiatric hospitals and Mt. Washington Pediatric Hospital, staff proposes using a productivity adjustment of 0.80 percent. This results in a proposed update of 1.77 percent. The proposed rule for FY 2019 Inpatient Psychiatric Facilities applies a 0.80 percent reduction for productivity and a 0.75 percent reduction for ACA savings mandate to a market basket update of 2.80 percent resulting in a proposed payment update of 1.25 percent. Additionally, these hospitals get a volume adjustment, rather than a population adjustment. HSCRC staff is currently working on implementing quality measures for these hospitals for future rate years.

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

Summary of Other Policies Impacting RY 2019 Revenues

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

Table 2 summarizes the net impact of the HSCRC staff's current proposals for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments on global revenues. The proposed adjustments provide for an estimated net revenue growth of 2.81 percent and per capita growth of 2.33 percent for RY 2019, before accounting for reductions in UCC and assessments. After accounting for those factors, the revenue growth is estimated at 2.29 percent with a corresponding per capita growth of 1.82 percent for RY 2019. Descriptions of each step and the associated policy considerations are explained in the text following the table:

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

Balanced Update Model for Discussion			
Components of Revenue Change Linked to Hospital Cost Drivers/Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 2.4% for wages)			2.33%
- Total Drug Cost Inflation for All Hospitals*			0.24%
Gross Inflation Allowance	**A**		**2.57%**
Care Coordination			
-Rising Risk With Community Based Providers			
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Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
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Per capita revenue growth	T =	(1+S)/(1+0.46%)	**1.82%**

* Provided Based on proportion of drug cost to total cost (drug index 4.5% X 5.4% national weight)

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

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

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

- **Adjustment for Inflation:** As described above the inflation factor uses the gross blended statistic of 2.57 percent. The gross inflation allowance is calculated using Fourth Quarter 2017 market basket growth of 2.70 percent with 8.80 percent of the capital growth estimate of 1.20 percent. A portion of the 2.57 inflation allowance (0.24 percent) will be allocated to hospitals based on each hospital's proportion of drug costs to total costs to more accurately provide revenues for increases in drug prices.
- **Adjustments for Volume**: Staff proposes a 0.46 percent adjustment that is equal to the Maryland Department of Planning's estimate of population growth for CY 2018[2]. Hospital-specific adjustments will vary based on changes in the demographics of each hospital's service area. In the past, a portion of the adjustment was set aside to account for growth in highly specialized services at Johns Hopkins Hospital (JHH) and University of Maryland Medical Center (UMMC). Several workgroup members suggested that these increases be funded through avoidable utilization reductions rather than the demographic adjustment. For RY 2019, the staff is proposing to recognize the full value of the 0.46 percent growth for the demographic adjustment to hospitals and to account for the cost of categoricals separately in the formulation of the revenue increase. The demographic adjustment has been criticized for providing revenue increases to hospitals that are experiencing volume decreases. The HSCRC staff are working to analyze alternative approaches, but the analysis will take time and require stakeholder and Commissioner input. There is a need for improved outpatient volume measures for cycle billed services as well as expanded measures for avoidable and unnecessary utilization. The HSCRC staff are actively working on improving outpatient volume measures. HSCRC staff has also identified a need for better drug case-mix data submissions from hospitals to improve the accuracy in recognizing

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

volume changes of drugs utilized. These core improvements in measurement are building blocks that are required to improve policy analysis and changes in the demographic adjustment as well as improving efficiency comparisons among hospitals and to other delivery settings. Also, with ICD-10 conversion and electronic medical record conversions mostly complete, case-mix and volume measurement should become more stable.

- **Rising Cost of New Outpatient Drugs**: The rising cost of drugs, particularly of new physician-administered drugs in the outpatient setting, continues to be a growing concern among hospitals, payers, and consumers. Not all hospitals provide these services and some hospitals have a much larger proportion of costs devoted to these services. To address this situation, staff recommends earmarking 0.24 percent of the inflation allowance to fund increases in the cost of drugs and provide this allowance based on the portion of total hospital costs that were comprised of drug costs in FY 2017.

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

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

  In the current update recommendation, there is no allowance for growth in high cost outpatient drugs. However, industry briefs suggest that there will be substantial increases in RY 2019. After additional consultations, staff will provide an allowance in the second half of RY 2019 for increases in costs related to net volume growth of high cost oncology medications for RY 2018 over RY 2017, as well as a potential adjustment for emerging medications, if warranted. Staff will provide further updates to the Commission on these matters at the June commission meeting. (For further discussion, see Supplemental Report Information).

- **Categoricals:** At the January commission meeting, JHH and UMMC made a presentation regarding new and expensive inpatient therapies for cancer and spinal

muscular atrophy. The HSCRC staff has been working to develop an approach to provide a revenue adjustment for these expensive therapies together with adjustments for existing categorical cases (transplants, cancer research cases). HSCRC staff has been provided a wide range of potential volume estimates for these services. To create a fixed pool of funds for these services, staff has proposed a set aside of a one percent revenue adjustment for these two academic medical centers for RY 2019. While this adjustment will increase the permanent base revenue of these two institutions for RY 2019 and beyond, the Commission will need to deliberate how to fund these types of services in the future. This approach applies only to RY 2019, and there are certain conditions that must be met to receive this funding. Staff has proposed a set of conditions for JHH, which are presented in a separate report. Discussions with UMMC are still underway.

- **QBR Adjustment:** Because the Quality Based Reimbursement (QBR) adjustment data comes from CMS, there is a delay in the calculation of this adjustment. This adjustment is expected to be negative, based on the changes in Commission policy and preliminary modeling. The HSCRC staff will provide an estimate of this adjustment, which will be made in the second half of Rate Year 2019, at the June meeting, along with an estimated drug adjustment.
- **Set-Aside for Unforeseen Adjustments**: Staff recommends a 0.25 percent set-aside to fund unforeseen adjustments during the year. This figure is reduced from the amount provided in RY 2015 through RY 2017. Although this adjustment was fully utilized in RY 2018, staff's estimate of the high cost drug volume adjustment was excessive and, as a result, revenue growth is expect to be lower. As a reminder, in its final regulations, CMS lowered its update by approximately 0.60 percent for the federal fiscal year that began in October 2017 relative to its initial proposal. HSCRC did not lower hospitals' revenue budgets when this occurred. Fortunately, drug volume increases came in lower and, as a result, helped to offset the lower federal inflation provision.
- **Reversal of the Prior Year's PAU Savings Reduction and Quality Incentives**: The total RY 2018 PAU savings and quality adjustments are restored to the base for RY 2019, with new adjustments to reflect the PAU savings reduction and quality incentives for RY 2018.
- **PAU Savings Reduction and Quality Scaling Adjustments**: The RY 2019 PAU savings will be continued, and an additional 0.30 percent savings is modeled for RY 2019. Staff have provided preliminary estimates for both positive and negative quality incentive programs.

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

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

- **Uncompensated Care (UCC) Reductions**: The proposed uncompensated care reduction for FY 2019 will be -0.32 percent. The amount in rates was 4.51 percent in RY 2018, and the proposed amount for RY 2019 is 4.19 percent.
- **Deficit Assessment**: The legislature reduced the deficit assessment by 30 million dollars in RY 2019, as a result, this line item is -0.19 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers, as mentioned in Table 2. These additional variables include one-time adjustments, as well as revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

Shifts to Unregulated

A growing focus continues to be on total cost of care. Hospitals must notify the HSCRC in writing when services are moved to unregulated settings at least 30 days in advance, or at the earliest time thereafter. In addition to notifying the HSCRC in advance, hospitals must submit annual disclosures (Appendix F & G to the GBR Agreement) regarding changes in provided services within their service areas. These disclosures are due 30 days after the end of each fiscal year. Global budgets must be adjusted for shifts from regulated to unregulated settings to prevent double payment for the services and dis-savings. Adjustments related to shifts, whether to related or unrelated entities, must be made in a timely manner. In order to ensure better reporting and facilitate disclosure, staff is proposing to withhold 0.50 percent of a hospital's total update if the hospital fails to submit a properly executed disclosure.

Consideration of All-Payer Model Agreement Requirements

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

All-Payer Financial Test

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

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

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

Table 4 below shows the allowed all-payer growth in gross revenues. Staff has removed adjustments due to reductions in uncompensated care (UCC) and assessments that do not affect the hospitals' bottom lines. Staff projects that the actual cumulative growth, excluding changes in uncompensated care and assessments, through FY 2019 is 18.07 percent. The actual and proposed revenue growth is well below the maximum levels.

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

	CY 2014 A	CY 2015 B	CY 2016 C	CY 2017 D	CY 2018 E	CY 2019 F	Cumulative Growth G = (1+A)*(1+B)*(1+C)*(1+D)*(1+E)*(1+F)
Maximum Gross Revenue Growth Allowance	**2.13%**	**4.21%**	**4.06%**	**3.95%**	**4.06%**	**4.06%**	**24.66%**
Revenue Growth for Period	0.90%	2.51%	2.47%	2.20%	2.62%	2.29%	13.71%
Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line		1.09%	1.40%	0.69%	0.18%	0.51%	3.93%
Revenue Growth with UCC & Assessment Savings Removed	0.90%	3.60%	3.87%	2.89%	2.80%	2.81%	**18.07%**
Revenue Difference from Growth Limit							**6.59%**

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

Medicare Financial Test

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

Performance years one through three (CY 2014, CY 2015, and CY 2016) of the Model generated approximately $586 million in Medicare savings. Performance year four (CY 2017) savings have not yet been audited, but current staff projections show an estimated savings of $330 million, bringing the four-year cumulative savings to over $916 million. Under these calculations, the cumulative savings are ahead of the required savings of $330 million.

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

While cumulative savings are above the required level, staff has estimated that the year over year total cost of care growth is above the national growth rate for Medicare for CY 2017 over CY 2016. This annual excess growth was caused by increases in Maryland's non-hospital Part B services, which were not offset by sufficient hospital savings. As a result, Maryland must set out ensure that growth does not exceed the national Total Cost of Care growth for Medicare in CY 2018.

A commitment to continue the success of the first four years is critical to building long-term support for Maryland's Model. At this point, staff recommends maintaining the goal used in the RYs 2015, 2016, 2017 and 2018 updates; for RY 2019 account for growth of Maryland hospital costs per beneficiary at 0.50 percent slower than the nation. Attainment of this goal will help achieve total cost of care savings, as well as provide evidence of the Model's continued success. However, this goal must be balanced with the overall goals of the update.

Consideration of National Cost Figures

Medicare's Proposed National Rate Update for FFY 2019

CMS published proposed updates to the federal Medicare inpatient rates for FFY 2019 in the Federal Register in late-April 2018.[3] These updates are summarized in the table 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 3.05 percent in FFY 2019 compared to FFY 2018, after accounting for inflation, a disproportionate share increase, and other adjustments required by law. The proposed rule includes an initial market basket update of 2.80 percent for those hospitals that were meaningful users of electronic health records and for those hospitals that submitted data on quality measures, less a productivity cut of 0.80 percent and an additional market basket cut of 0.75 percent, as mandated by the Affordable Care Act (ACA). This proposed update also reflects a proposed 0.50 percentage point increase for documentation and coding required by the American Taxpayer Relief Act of 2012. Disproportionate share payment changes resulted in an increase of approximately 1.30 percent from FFY 2018.

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

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

Applying the inpatient assumptions about market basket, productivity, and mandatory ACA outpatient savings, staff estimates a 1.30 percent Medicare outpatient update effective January

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

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

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

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

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

A feature of the current hospital Model that will continue in the Total Cost of Care All-Payer Model is that Maryland Medicare total cost of care cannot exceed national Medicare total cost of care growth by 1 percent in any single year and cannot exceed the one percent limit in two consecutive years; these are known as “total cost of care guardrails.” Maryland is projected to be above Medicare national growth in CY 2017. In an effort to ensure Maryland that does not exceed the national Medicare growth rate in CY 2018, staff is proposing an adjustment for non-hospital excess growth. This will assess Medicare growth in unregulated settings and factor this

excess growth into allowable hospital rate increases for RY 2019. This is calculated by taking a four-year average of non-hospital excess costs for Medicare Parts A and B and converting that amount to an all-payer figure. This adjustment will be offset against the difference statistic seen below in Tables 6A and 6B.

Staff calculated two different scenarios, using the conservative difference statistic and non-hospital excess cost growth calculations, to evaluate how the Maryland RY 2019 all-payer update factor will affect the State's ability to stay within the total cost of care guardrail. Under the first scenario (Table 6A), the maximum all-payer per capita growth rate that will allow the State to realize a 0.50 percent FY 2019 Medicare savings is 2.67 percent. The second scenario (Table 6B) shows a maximum all-payer per capita growth rate of 3.17 percent and does not build in the savings goal for 0.50 percent. Both scenarios are pictured below. The expected calendar year growth for CY 2018 of 2.69 percent is represented in the below tables as well as any potential savings associated with this growth.

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

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare Growth (CY 2018 2.32%)	A	2.32%		
Savings Goal for FY 2019	B	-0.50%		
Maximum growth rate that will achieve savings (A+B)	C	1.82%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer		0.86%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation		-0.49%		
Net Difference Statistic Related to Total Cost of Care	D	0.37%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**2.20%**	**2.22%**	**-0.02%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.46%)-1	F	**2.67%**	**2.69%**	**-0.02%**

Table 6B. Scenario 2 Maximum All-Payer Increase that will still produce the Desired FY 2019 Medicare Savings (without 0.50% savings goal)

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare Growth (CY 2018 2.32%)	A	2.32%		
Savings Goal for FY 2019	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	2.32%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer		0.86%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation		-0.49%		
Net Difference Statistic Related to Total Cost of Care	D	0.37%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**2.70%**	**2.22%**	**0.48%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.46%)-1	F	**3.17%**	**2.69%**	**0.48%**

Staff is also evaluating CY 2018 growth and its likely impact on guardrails. Table 7 below shows the current revenue projections for CY 2018 and FY 2019 to assist in estimating Maryland's position on future growth and savings.

Table 7. Estimated Position on Medicare Target

Estimated Position on Medicare Target		
Step 1:		
Approved GBR FY 2018		17,183,983,214
Actual Revenue 7/1/17-12/31/17		8,421,055,533
Projected Revenue 1/1/18-6/30/18	**A**	**8,762,927,681**
Step 2:		
Estimated Approved GBR FY 2019		17,578,009,012
Permanent Update		2.29%
Step 3:		
Estimated Revenue 7/1/18-12/31/18 (after 49.73% & seasonality)		8,741,543,882
Change in Hopkins Payback		10,000,000
	B	**8,751,543,882**
Step 4:		
Estimated Revenue CY 2018	**A+B**	**17,514,471,563**
Increase over CY 2017 Revenue		2.69%

Steps to explain Table 7 are described as below:

- Step 1: The table begins with the approved global revenue for FY 2018 and actual revenue for the last six months for CY 2017 to calculate the projected revenue for the first six months of CY 2018. (i.e. the last six months of FY2018).
- Step 2: This step shows the estimated FY 2019 global budget revenue based on the information that staff has available to date. The permanent update over FY 2018 shows 2.29 percent, as shown in Table 2.
- Step 3: For this step, to determine the calendar year revenues, staff estimates the revenue for the first half of FY 2019 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for FY 2019 and hospital specific seasonality adjustments. An adjustment for the temporary rate adjustment for Johns Hopkins Hospital is added to revenues.

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

Stakeholder Input

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed FY 2019 updates.

RECOMMENDATIONS

Based on the currently available data and the staff's analyses to date, the HSCRC staff is providing the following preliminary draft recommendations for the FY 2019 update factors.

For Global Revenues:

a) Provide an overall increase of 2.29 percent for revenue (net of uncompensated care offset) and 1.82 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, staff is proposing to split the approved revenue into two targets, a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

b) Allocate 0.24 percent of the total inflation allowance based on each hospital's proportion of drug cost to total cost to more equitably adjust hospitals' revenue budgets for increases in drug prices and high cost drugs. Continue to adjust for volume changes of high cost oncology drugs at the mid-year data point for RY 2018 over RY 2017.

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

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

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

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

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

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

APPENDIX I. SUPPLEMENTAL INFORMATION ON RISING COST OF HOSPITAL DRUGS

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

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

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

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

Staff will provide additional information regarding drugs at the June Commission meeting.