Maryland
Hospital Association

May 22, 2018

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

Dear Chairman Sabatini:

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

Changes Needed for the Final Update

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

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

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

   There are several reasons to support a higher increase:

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

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

Below we elaborate upon each of these points.

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

- For the first quarter of federal fiscal year 2018 (October 2017 through December 2017), *national Medicare hospital spending per beneficiary increased 5.64 percent* compared to the same quarter in the previous year. In federal fiscal year 2018, national hospital spending growth per beneficiary is projected to grow 2.32 percent. (This figure combines one quarter of calendar year 2017 and three quarters of calendar year 2018 and is based on hospital spending growth rates in the President's budget.) For this federal fiscal year 2018 projection to hold, the remaining three quarters must average 1.20 percent or less per capita growth. Such a projection is highly unlikely to hold (Chart 1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commission Process for Handling of Stakeholder Comments

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

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

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

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

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

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

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

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

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

Sincerely,

Brett McCone,
Vice President

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

Enclosure

Chart 1

National Medicare Hospital Spending per Beneficiary Growth

Actual First Quarter Federal Fiscal Year 2018 Compared to First Quarter Federal Fiscal Year 2017;
Projection from President's Budget

Actual Medicare Hospital Spending per Beneficiary (Actual Data)

	October To December			
	2016	2017	Change	% Change
Payments	$ 42,486,196,993	$ 44,648,855,230	$ 2,162,658,237	5.09%
Beneficiaries	36,620,463	36,430,537	(189,926)	-0.52%
Payment per Beneficiary	$ 1,160	$ 1,226	$ 65	**5.64%**

Projected Medicare Hospital Spending per Beneficiary (President's Budget)

	Calendar Year		Federal Fiscal Year 2018
	2017	2018	(25% 2017 + 75% 2018)
Medicare Hospital Spending per Beneficiary	3.0%	2.1%	**2.3%**

Chart 2

Medicare Per Capita Hospital Spending Projections

[Based on Fiscal Year 2019 President's Budget]

Hospital Spending per Beneficiary

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

CY14 - CY17 average difference	**0.88%**

Chart 3

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

Utilization defined as Equivalent Case Mix Adjusted Discharges (ECMADs)

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

Chart 4

Demographic Adjustment Compared to Population Growth Limit

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

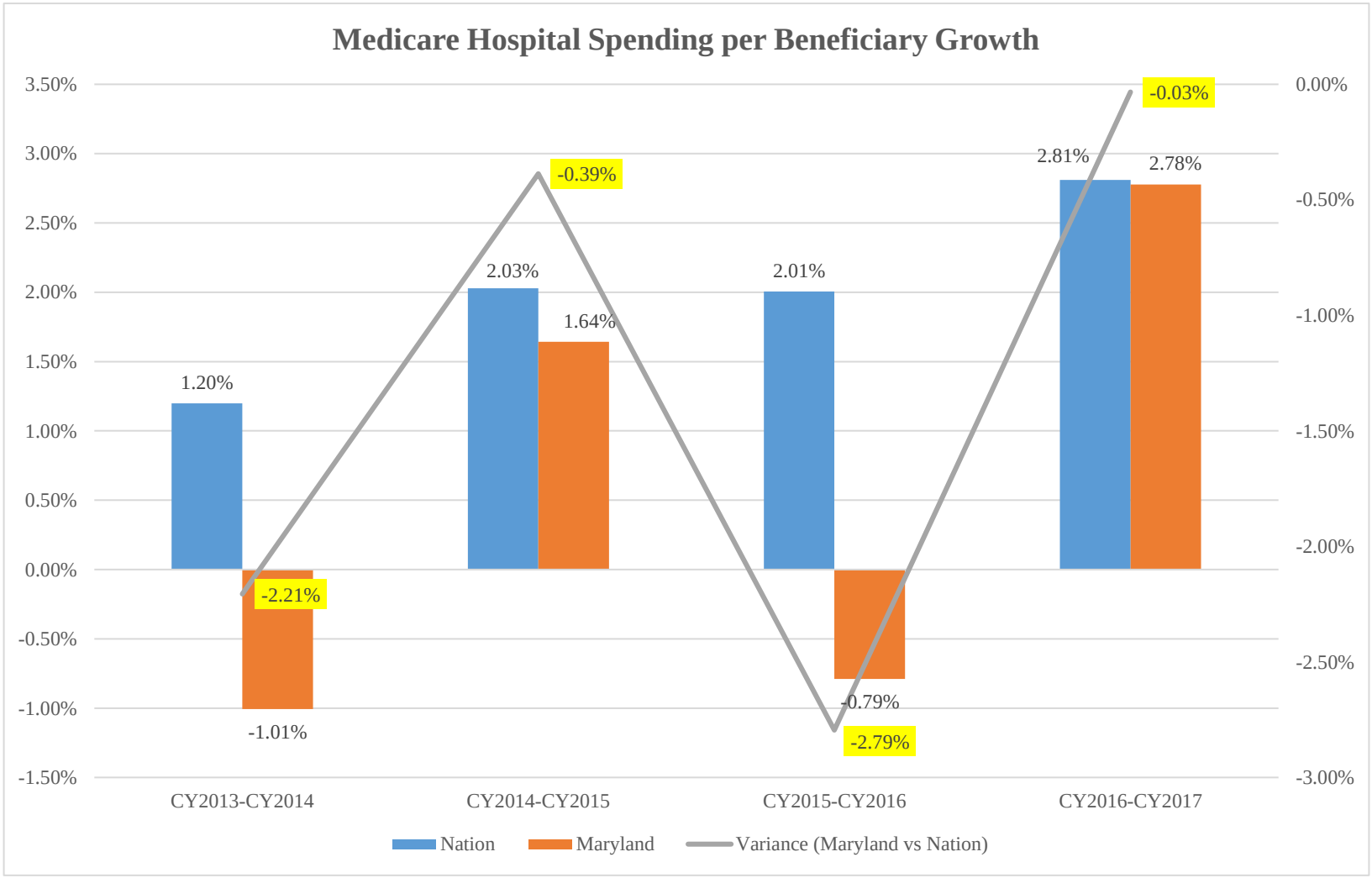
Chart 5

Cumulative Infrastructure Funding; Cumulative Potentially Avoidable Utilization Savings

Financial impacts in FY2018 dollars

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

Chart 6


Medicare Hospital Spending per Beneficiary Growth
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
-0.50%
-1.00%
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-1.00%
-1.50%
-2.00%
-2.50%
-3.00%
1.20%
-1.01%
-2.21%
2.03%
1.64%
-0.39%
2.01%
-0.79%
-2.79%
2.81%
2.78%
-0.03%
CY2013-CY2014
CY2014-CY2015
CY2015-CY2016
CY2016-CY2017
Nation
Maryland
Variance (Maryland vs Nation)