Maryland
Hospital Association

May 18, 2016

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 (MHA) 64 member hospitals and health systems, this letter follows up on the May 11 commission meeting, at which we offered alternative proposals to the current staff-recommended global budget update and update for revenues not governed by global budgets for fiscal year 2017. In addition to this letter, MHA will be sending two others: one on the regional transformation grants, and another on the quality-based incentive programs. You'll also receive letters from Maryland's hospitals in response to Commissioners' questions about the transformative work they've been engaged in over the past two years.

If adopted, the staff proposed update would be a premature overcorrection that would jeopardize Maryland's momentum under the new All-Payer Model. As described below, what has been displayed as a proposed two percent increase in total revenue for hospitals in the state, **is actually only a one percent increase available to all hospitals**. Also described below: based on more current data than used by staff, **a higher update can be provided without encroaching on the staff-recommended Medicare total cost of care cushion.**

Constraining hospital funding now, at this sensitive stage, would undermine hospitals' nascent success and threaten their ability to meet the waiver's continued requirements; the commission's support through reasonable funding levels early on has been an essential building block of the success to date. But at levels as low as those proposed by staff, hospitals will be unable to pay needed wage increases, cover the increased cost of core operations and care, or follow through on population health investments in the community.

Of greater concern, an update this low calls the question on support for the demonstration and next steps. Now is a time when the state and stakeholders should be together, sharing with federal officials and the nation our collective successes in the first two years of this model and continuing to shape the hard work still ahead. But a too-low update would confirm concerns expressed all along about the model – that because of the total cost of care metric, we in Maryland could be hampered in truly innovating care delivery and reduced to simply chasing national Medicare performance. Cumulatively to date Maryland has met every metric and far exceeded most. Hospitals have outspent the funding provided in rates by the Commission for investments in population health. The delivery of care has changed and continues to change against a backdrop of exceedingly, and sometimes unrealistically, high expectations about the time and resources required to implement dramatic change not only inside hospitals but also

within communities working voluntarily with physicians, nursing homes and other community partners.

Instead, MHA proposes a modest addition of 1.12 percentage points to the per capita staff recommendation.

Update for Revenue under Global Budgets
HSCRC staff's proposal suggests a limit on revenue growth for hospitals in 2017 of 2.02 percent (1.49 percent per capita) after accounting for required reductions in uncompensated care and the Medicaid hospital assessment spend-down. However, as shown in the chart below, that number is misleading. In fact, a significant portion of the proposed update would be available only to *some* hospitals:

- **0.50 percent** is for unforeseen adjustments which, as reported at the last meeting, has been set aside for the last two years but not added to rates
- **0.07 percent** is for one hospital only - Holy Cross Germantown Hospital
- **0.51 percent** is for certain hospitals that apply and are approved for specific programs (e.g. high-cost drugs, partnership grants, workforce support) where in all cases, hospitals will likely spend more money than the amount proposed
- **0.52 percent** is for needed care increases due to population growth

Factoring in those set-asides for only some hospitals, *all* hospitals, on average, would receive a total revenue increase of just 1.1 percent (***a scant 0.60 percent per capita*** compared to the one-year ceiling of 3.58 percent per capita) to cover the increased costs of caring for patients (workers' wages, operations, care improvement and community investment).

HSCRC Proposed Update: An Alternative Presentation		**Total Revenue Growth**	**Per Capita Revenue Growth**
Total Revenue Growth, Per Staff Presentation		2.02%	1.49%
Less:	Amounts for unforeseen adjustments that may never be paid	(0.50)%	
	Amount only provided to Holy Cross Germantown	(0.07)%	
	Amounts only provided to hospitals that apply and are approved to incur new expenses for specified programs (new drugs, partnership grants, workforce support)	(0.51)%	
	Amount provided to hospitals incurring new expenses associated with population growth	(0.52)%	
Plus:	Reduction in funding needed for uncompensated care and Medicaid taxes	0.70%	
Balance:	Available to all hospitals for operations, care improvement, and community investment	1.12%	0.60 %

MHA is proposing a modest increase to the update. **A 1.12 percentage point increase to the 1.49 percent per capita staff recommendation – for a total 2.60 percent per capita update.** Only some of this (1.80 percent per capita) would go to all hospitals. The 2.60 percent per capita update would still fall far below the one-year 3.58 percent per capita growth ceiling, but would provide hospitals with the resources and stability they need to advance ongoing health care delivery transformation and maintain success under the all-payer model.

This alternative could be achieved with three minor adjustments to the current staff proposal, as detailed on Chart 1:

- **Increase the proposed 1.72 percent inflation adjustment to the currently projected 2.49 percent growth**. Staff has proposed applying an estimated downward "correction factor" in advance. However, as noted in Chart 2, based on a 16-year analysis of Global Insights projections, Global Insights is more likely than not to *underestimate, not overestimate,* inflation. Basing a forecast error adjustment on just the three most recent years is arbitrary. Applying it now for the first time to reduce the update while ignoring years in which inflation was underestimated and hospital rates should have been increased is arbitrary. This fosters system instability and unpredictability. And a higher amount is important because your update decision is *not solely a unit price inflationary increase*. Rather, it is the limited amount by which hospitals' total revenue may increase, which means it must accommodate price increases, funds to cover the risk assumed by hospitals in their global budgets for volume, case mix change and other costs, as well as the investments needed to improve the health of entire communities.
- **Reduce from -0.61 percent to -0.16 percent the net quality-based payment program adjustment by lowering the expected shared savings offset for Potentially Avoidable Utilization.** As we'll detail in a separate letter, this adjustment sets an expectation that hospitals will reduce Prevention Quality Indicators and readmissions by a combined *11 percent in a single year*. That is both unrealistic and unachievable. In the last two years, the annual reduction averaged three percent. To our knowledge, no other demonstration in the nation has shown a one-year reduction in potentially avoidable utilization of the magnitude suggested by staff.
- **Reduce from 0.50 percent to 0.40 percent the set-aside for unforeseen adjustments**. This 0.5 percent has been set aside but not used in each of the past two years, withholding more than $150 million in payments. These funds could be used to further develop much-needed partnerships with non-hospital community providers or to cover the expense of high-cost drugs without carving more from the inflation update.

Total Cost of Care Concerns

Most important, these modest changes would keep the state *well within the boundaries of the waiver's financial metrics* – metrics. Specifically:

- **Per Capita Spending** – MHA's proposal yields cumulative all-payer spending growth through FY 2017 of 7.5 percent per capita, far below the 13.1 percent ceiling

- **Medicare Savings** – Cumulative Medicare savings of $251 million are already more than five times the 2015 target of $49 million and savings through FY 2017 are projected to surpass the target, even if no additional hospital savings accrue
- **Medicare Total Cost of Care** – While Medicare total cost of care grew faster than the nation in 2015, Maryland did not exceed the ceiling.

However, HSCRC staff have proposed a lower update designed to reduce hospital spending even more, beyond the current $251 million in savings, in an effort to use lower hospital spending to drive lower total cost of care. That reduction is unnecessary. Staff has estimated the maximum per capita increase that can be given to obtain the desired savings to control the total cost of care. But in that calculation – the difference statistic – staff uses older data (CY 2015) to derive the factor (0.89) to translate Medicare spending trends into all payer trends. The most recent data (January - March 2016) for the conversion factor is higher (2.13), which translates into an allowable all-payer per capita growth rate of 3.38 percent (Chart 3). MHA's proposed update of 2.60 percent is well within this updated allowable growth rate.

Moreover, it is in neither the state's nor the federal government's interest to manage the total cost of care metric as a guillotine, rather than a guardrail. It is important to all stakeholders for the HSCRC to manage and balance the system within the financial targets of the all-payer model. MHA's proposed 2.60 percent global budget update would do just that. But even the agreement with CMMI acknowledges that Maryland may meet one metric (per capita hospital spending) and not meet another (Medicare savings) and still provides for a path forward. And there are several indications that CMS would work closely with Maryland to ensure that the all-payer system remains viable and replicable in other parts of the country:

- **Model architects understood that over a five-year period, there would be volatility in year-over-year performance and data calculations**, which is why the contract includes a comprehensive process to analyze and for the state to explain any infractions should they occur, and specifically says that CMS "…may or may not require corrective action, depending on the totality of the circumstances."
- **Maryland has already experienced what occurs when a metric is not met, and CMMI has been highly supportive of working with the state without threatening a waiver termination** – When readmissions reduction targets appeared to fall short in calendar years 2014 and 2015, CMMI not only recognized the possibility of data integrity issues, but worked closely with the state to continue the progress under the all-payer model
- **CMMI is looking at Maryland as a model for the rest of the country** – A recent Request for Information published by CMS (Chart 4) looks to interest hospitals nationally in global budgets, and cites Maryland's global budget approach as the example of "better management of cost and quality for a community's population, by providing clear revenue expectations and connecting services across outpatient and inpatient sectors"

Update for Revenue Not under Global Budgets
MHA recommends an update of 1.99 percent (instead of 1.24 percent) for non-global revenues, and 2.30 percent (instead of 1.55 percent) for the psychiatric hospitals and Mt. Washington Pediatric Hospital. The HSCRC staff recommends a 0.50 percent adjustment for productivity improvement, with which we agree. However, their recommendation also includes a reduction of 0.75 percent, which is the Medicare hospital payment cut intended to fund part of the cost of the Affordable Care Act. It is inappropriate to apply this federal Medicare reduction amount to all payer revenue in Maryland (Medicaid, CareFirst, United, others). It creates a larger-than-intended reduction for hospitals and a windfall for non-Medicare payers.

We look forward to further discussion of our proposal with you, as the commission moves forward on this critical funding decision for the next year. Thank you for your consideration.

Sincerely,

Michael B. Robbins
Senior Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
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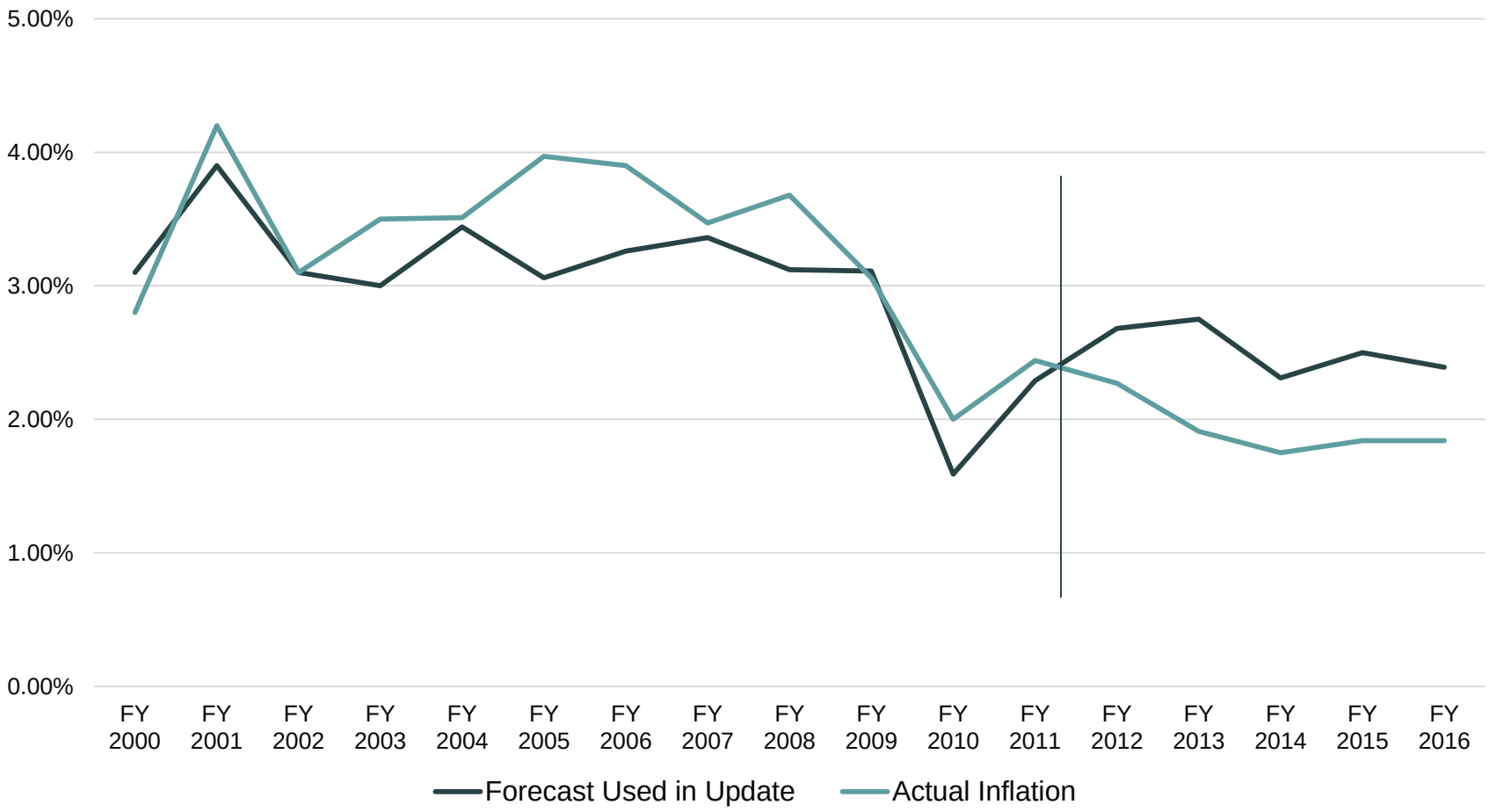
HSCRC Staff Preliminary Update Factor Component Breakdown FY 2017

	HSCRC Staff Proposal 05/11/16	MHA Proposal 05/11/16	Difference
Inflation (Current Market Basket is 2.49%)	1.72%	2.49%	0.77%
Net Quality-Based Payment Programs	-0.61%	-0.16%	0.45%
Adjustment for ACA Savings (Productivity)	0.00%	0.00%	0.00%
Subtotal	**1.11%**	**2.33%**	**1.22%**
Adjustment for Volume	**0.52%**	**0.52%**	0.00%
Care Coordination Allowances, by Application			
Rising Risk with Community Based Providers	0.00%	0.00%	0.00%
Complex Patients w/ Regional & Community Partnerships	0.25%	0.25%	0.00%
Long Term & Post-Acute Care	0.00%	0.00%	0.00%
Workforce Support Program, by Application	0.06%	0.06%	0.00%
Allowance for High Cost New Drugs, by Application	0.20%	0.20%	0.00%
Subtotal - available through application process	**0.51%**	**0.51%**	**0.00%**
Other Statewide Amounts			
Holy Cross Germantown	0.07%	0.07%	0.00%
Set Aside for Unknown Adjustments	0.50%	0.40%	-0.10%
Subtotal	**0.57%**	**0.47%**	**-0.10%**
Statewide Total Revenue Growth, prior to UCC/assessments	**2.72%**	**3.84%**	**1.12%**
Statewide Per Capita Growth, prior to UCC/assessments	**2.18%**	**3.30%**	**1.12%**
Other Adjustments			
Uncompensated Care Allowance	-0.55%	-0.55%	0.00%
Medicaid Tax Reduction	-0.15%	-0.15%	0.00%
Statewide Total Revenue Growth, after UCC/assessments	**2.02%**	**3.14%**	**1.12%**
Statewide Per Capita Growth, after UCC/assessments	**1.49%**	**2.60%**	**1.12%**

Why Adjust the Inflation Forecast Now?



Note: 9 of 16 years under estimated by avg. 0.02%
2000-2010 Underestimated 8 of 10 years by avg. 0.40%
2011-2016 Overestimated 5 of 6 years by avg. 0.54%

Allowable All-Payer Growth

Maximum Medicare Increase that Can Produce Desired FY 2017 Medicare Savings

	Scenario 1 (Staff proposal)	Scenario 2 (Staff proposal)	Scenario 3 (Current difference statistic)
Estimated Medicare Growth (FY 2017)	1.20%	1.75%	1.75%
Savings Goal (FY 2017)	-0.50%	-0.50%	-0.50%
Maximum Growth Rate that Will Achieve Savings	0.70%	1.25%	1.25%

Conversion to All-Payer

	Scenario 1 (Staff proposal)	Scenario 2 (Staff proposal)	Scenario 3 (Current difference statistic)
Actual Statistic Between Medicare and All-Payer	0.89%	0.89%	2.13%
Conversion to All-Payer per capita	1.60%	2.15%	3.38%
Conversion to Total All-Payer Revenue Growth	2.12%	2.68%	3.92%

Regional Budget Payment Concept

Share

The Centers for Medicare & Medicaid Services (CMS) is interested in seeking input on a concept that promotes accountability for the health of the population in a geographically defined community. Under the Maryland All-Payer Model, CMS and the State of Maryland are testing a new hospital global budget payment program in which all payers in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. CMS is seeking input on the feasibility of similar approaches for other geographical areas, which could include areas smaller than a state. In this concept, providers could receive a prospective budget for the care of the population of a community, and would be accountable for the total cost of care across the entire continuum of care and health outcomes for the entire population. The purpose of this approach would be to support better management of cost and quality for a community's population, by providing clear revenue expectations and connecting services across outpatient and inpatient sectors. The concept could also incentivize collaboration of provider systems with community-based services outside the traditional health system. Lastly, this concept could encourage the inclusion of rural providers through providing incentives tailored to the unique needs and opportunities presented in rural areas.