# Draft Update Factors Recommendations for FY 2016

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# Draft Recommendations on Update Factors

## INTRODUCTION

### Overview

On July 1 of each year, the HSCRC updates hospitals' rates and approved revenues to account for inflation, policy adjustments, and other adjustments related to performance and settlements from the prior year.

On January 10, 2014, the Center for Medicare & Medicaid Innovation (CMMI) approved the implementation of a new All-Payer Model for Maryland. The All-Payer Model has a three part aim of promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita. The Model establishes both an All-Payer limit of 3.58% cumulative annual per capita growth for Maryland residents for the first three years of the Model and a Medicare savings target of $330 million over the initial five-year period of the Model.

The update process needs to take into account all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents in order to meet the requirements of the All-Payer Model and assure that the annual update approved by the HSCRC will not result in a revenue increase beyond the limit. In addition, HSCRC needs to consider the effect of the update on the Model's Medicare savings requirement and the total hospital revenue at risk for quality, care delivery, and value enhancement. While rates and global budgets are approved on a fiscal year basis, the All-Payer Model revenue limits and the Medicare savings are determined on a calendar year basis. Therefore, it is necessary to account for both calendar year and fiscal year revenues in establishing updates for the fiscal year.

There are three categories of hospital revenue under the All-Payer Model. The first two categories are under full rate setting authority of HSCRC. The third category of hospital revenue includes hospitals where HSCRC sets rates, but Medicare does not pay on the basis of those rates. The three categories are:

1. Hospitals/revenues under global budgets, including the Global Budget Revenue (GBR) agreements and Total Patient Revenue (TPR) agreements for 10 hospitals that were renewed July 1, 2013 for their second three-year term.
2. Hospital revenues that are not included under global budgets but are subject to rate regulation on an All-Payer basis by HSCRC, including hospital revenues excluded from a

global budget, such as revenues for non-residents at certain hospitals and the start-up years for Holy Cross Germantown Hospital.

3. Hospital revenues for which HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMMI has not waived Medicare's rate setting authority to Maryland. This includes psychiatric hospitals and Mount Washington Pediatric Hospital.

This report includes draft recommendations for FY 2016 updates.

## STAKEHOLDER INPUT

HSCRC staff has worked with the Payment Models work group to provide input and review of its draft recommendations regarding the FY 2016 updates.

## ANALYSIS

### Calculation of Update Factors for Revenue Categories 1-3

In this draft staff recommendation, we are focused on recommending the update factor that will be provided for inflation/trend for hospitals or revenues in each of the three categories. There are separate staff reports that provide recommendations on uncompensated care and shared savings relative to readmissions. The Commission was briefed at its April 15th meeting on a FY 2016 global contract adjustment to capture the ongoing impact of the Affordable Care Act's Medicaid expansion on hospital volumes.

The inflation/trend adjustment for Category 1 and Category 2 revenues starts by using the actual blended statistic of 2.40% growth, derived from combining 91.2% of Global Insight's FY 2016 market basket growth of 2.5% with 8.8% of the capital growth estimate of 1.4%. For those revenues that are not subject to global budgets, subtractions are made to reflect productivity and an additional reduction provided under the Affordable Care Act for Medicare. The 0.6% reduction for productivity is equivalent to the amount used in Medicare's proposed inpatient prospective payment system update for FY 2016, but Medicare makes other adjustments (e.g. -0.8% for coding) that have not been applied. As a result, the proposed rate adjustment would be as follows:

**Table 1**

| | Global Revenues | Non-Global Revenues |
|---|---|---|
| Proposed base update | 2.40% | 2.40% |
| Productivity adjustment | | -0.60% |
| ACA adjustment | | -0.20% |
| Proposed update | 2.40% | 1.60% |

For psychiatric hospitals and Mt. Washington Pediatric Hospital, we turn to the proposed psychiatric facility update for Medicare. Medicare applies a 0.6% reduction for productivity and 0.2% reduction for ACA savings mandates to a market basket update of 2.7% to derive a net amount of 1.9%. HSCRC staff recommend adopting the same factor and net adjustments for the Maryland psychiatric hospitals and Mt. Washington Pediatric Hospital.

## Summary of Other Policies Impacting FY 2016 Revenues

The update factor is just one component of the adjustments to hospital global budgets for FY 2016. In considering the system-wide update for the All-Payer Model, staff sought balance amongst the following conditions: 1) meeting requirements of the All-Payer Model agreement; 2) providing hospitals with the necessary resources to keep pace with changes in inflation and population; 3) ensuring hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the All-Payer model; 4) taking into account factors outside of the Model such as the Medicaid coverage expansion under the Affordable Care Act (ACA).

Table 2 summarizes the net impact on global revenues of staff proposals for inflation, volume, shared savings, infrastructure investments, uncompensated care, and the MHIP assessment. The proposed adjustments provide hospitals with net revenue growth of 3.19% and per capita growth of 2.61% for FY 2016. Descriptions and policy considerations are discussed for each step in the text following the table.

**Table 2**

## Balanced Update Model

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

| | | Weighted Allowance |
|---|---|---|
| Adjustment for inflation/policy adjustments | A | 2.40% |
| Adjustment for volume | B | 0.57% |
| -Demographic Adjustment | | |
| -Transfers ($1 M -$5 M impact) | | |
| -Categoricals | | |
| -Market share adjustments ($4 M est. impact) | | |
| Utilization Impact of Medicaid Expansion ($60 M) | C | 0.38% |
| Infrastructure allowance provided | D | 0.59% |
| - 0.40% included in GBR rates on 7/1/15 (Net .34% adjustment since TPR & non-global revenues are excluded)) | | |
| - Upto another 0.25% allocated via a competitive process in January 2016 | | |
| CON adjustments- | | |
| -Opening of Holy Cross Germantown Hospital | E | 0.21% |
| Net increase before adjustments | F = A + B+ C+ D + E | 4.15% |
| Other adjustments (positive and negative) | | |
| -Set aside for unknown adjustments | G | 0.50% |
| -Reverse prior year's shared savings reduction | H | 0.40% |
| -Positive incentives (Readmissions and Other Quality) | I | 0.15% |
| -Shared savings/negative scaling adjustments | J | -0.60% |
| Net increase attributable to hospitals | K = F + G + H + I+ J | 4.60% |
| Per Capita | L = (1+K)/(1+0.57%) | 4.00% |
| **Components of Revenue Change - Not Hospital Generated** | | |
| -Uncompensated care reduction, net of differential | M | -0.84% |
| -MHIP (Assumes $0 MHIP in 2016)/2015 BRFA adjustment | N | -0.57% |
| Net decreases | O = M + N | -1.41% |
| Net revenue growth | P = K + O | 3.19% |
| Per capita revenue growth | Q = (1+P)/(1+0.57%) | 2.61% |

0.1%

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

A number of factors linked to hospital costs and performance are accounted for including:

- **Adjustments for Volume:** A 0.57% adjustment is proposed equal to the Maryland Department of Planning's estimate of population growth. Hospital specific adjustments will vary based on changes in the demographics of each hospital's service area. The net cost of market share and transfer policy adjustments will be absorbed within this volume allowance. Growth in revenue associated with unique (categorical exclusions) volumes such as transplants will also be funded from the 0.57% adjustment.

- **Impact of Medicaid Expansion:** As discussed in the staff's April report to the Commission, enrollees in the Affordable Care Act's Medicaid expansion are using more hospital services than they did prior to the expansion. Much of the increase reflects a temporary surge in demand for surgical procedures. The ongoing portion of the utilization uptick, after applying a 50% variable cost factor, is about $60 million

- **Infrastructure Adjustments:** Infrastructure adjustments of 0.325% in FY 2014 and an additional 0.325% in FY 2015 were included in global budgets to enable the successful transition to the new model. These adjustments recognized the need for investments in care management, population health improvement, and other requirements of global models. Successful care management and population health efforts will require hospitals to maintain and enhance their investments in addressing needs of complex patients, improving and coordinating care for individuals with chronic conditions, integrating and coordinating care with other hospital and non-hospital providers, and investing in IT, analytics, human resources, training, and alignment models to support these efforts. Recognizing the substantial scaling of infrastructure required, staff propose an additional 0.4% infrastructure investment in all GBR hospitals for FY 2016 No additional infrastructure funding is proposed for TPR hospitals. Generally, TPR hospitals were provided forward funding incentives considerably higher than the .65% infrastructure initially provided to GBR hospitals[1].

  Hospitals should expect to spend a small portion of the new infrastructure funding to expand and enhance CRISP's ability to facilitate care coordination through the collection and sharing of data. A budget for CRISP's FY 2016 activities will be presented to the Commission at a future meeting.

  Staff propose providing up to an additional 0.25% for competitive grants to hospitals to fund implementation of innovative care coordination, provider alignment, and population health strategies. Grant proposals would be due December 1, 2015 with awards in January 2016 (Despite the mid-year award date, the amount of funding available for awards will amount to a full year of 0.25% to provide adequate seed money to launch each initiative). The amount of the grant awards would be a permanent 0.25% adjustment to hospital rates.

  The performance requirements of the All-Payer Model contract necessitate the wise investment of infrastructure dollars in FY 2016 and future years. To provide the Commission with assurances that each hospital is engaged in the long-term success of the

[1] Garrett Hospital was not provided an incentive funding amount, and should be provided infrastructure allowances consistent with GBR hospitals.

Model Contract, staff recommends that the Commission require each acute care hospital to submit a plan by December 1, 2015 summarizing its short-term and long-term strategies and incremental investment plans for improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with non-hospital providers. Continued receipt of infrastructure funding is contingent upon submission of a comprehensive plan.

Once the investment plans are received and evaluated, the Commission will be in a better position to assess future needs, investment requirements, expected return on investment, etc.

- **Certificate of Need (CON) Adjustments:** Holy Cross Germantown Hospital opened in the Fall of 2014. The FY 2016 increase annualizes last year's adjustment.

- **Other Adjustments:**

  - **Set-Aside for Unforeseen Adjustments:** Staff recommends a 0.5% set-aside to fund unforeseen adjustments during the year. A similar allowance was made for FY 2015.

  - **Reversal of Prior Year's Shared Savings Reduction:** The total FY 2015 shared savings adjustment is restored to the base for FY 2016, with a new adjustment (see below) to reflect the shared savings reduction for FY 2016.

  - **Shared Savings Reduction and Negative Scaling Adjustment:** The FY 2015 shared savings are continued and an additional 0.2% savings is targeted for FY 2016. A separate recommendation on this item will be made for the Commission's consideration.

  - **Positive Incentives:** Positive incentives of 0.15% are expected to be paid in FY 2016 for performance on readmission and other quality metrics.

**Components of revenue change – not hospital generated**

Several changes will decrease the revenues for FY 2016. These include:

a) **UCC Reductions:** The FY 2016 policy is the subject of a separate recommendation to the Commission.

b) **MHIP/BRFA Adjustment:** The General Assembly's FY 2016 budget actions assume a zero assessment for the fiscal year. The FY 2015 assessment was 1% for the first quarter and 0.3% for the remainder of the year. This item also includes the removal of $15 million in one-time funding for care coordination and regional planning that was authorized in the Budget Reconciliation of Financing Act (BRFA) of 2014.

While Table 2 enumerates the central provisions leading to a balanced update for All-Payer Model overall, there are additional variables to consider such as 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.

## Medicare's Proposed National Rate Update for FY 2016

Proposed updates to federal Medicare inpatient rates for 2016 have just been published in the Federal Register and are presented in the table below. The update will not be finalized for several months and could change. The base update provides growth of 1.1%, about half the 2.4% inflation/trend update proposed by the HSCRC. Additional adjustments including value based purchasing, hospital acquired conditions, readmissions, and the Disproportionate Share Hospitals reduce the expected growth in payments to 0.3%. These CMS projections do not include a provision for volume changes.

**Table 3**

| Federal FY 2016 | Proposed IP | Estimated OP based on IP |
|---|---|---|
| **Base Update** | | |
| Market Basket | 2.70% | |
| Productivity | -0.60% | |
| ACA | -0.20% | |
| Coding | -0.80% | N/A |
| | 1.10% | 1.90% |
| **Other Changes** | | |
| Disproportionate Share | -1.00% | |
| Other Adjustments | 0.20% | |
| | -0.80% | |
| **Net Change to Payments** | **0.30%** | |

Applying the inpatient assumptions about market basket, productivity, and mandatory ACA savings to outpatient, staff estimate a 1.9% Medicare outpatient update effective January 2016. The estimated blended inpatient/outpatient Medicare increase for 2016 updates is about 0.7%.

## Discussion of FY 2016 Balanced Update

The staff proposal properly increases the resources available to hospitals to account for rising inflation and upward pressure on volumes from population growth and the ACA expansion. Almost $100 million of the new funding is included for the development of the care coordination and population health infrastructure necessary for continued success. This new funding brings the total ongoing commitment for infrastructure over the period FY 2014 to FY 2016 to about $180 million for GBR hospitals - - an amount approaching the ongoing operating costs that the consultants supporting the care coordination workgroup pegged as an estimated level to fund care coordination across the State.

The proposed adjustments coupled with the ongoing incentives to reduce potentially avoidable utilization inherent to the model should allow the hospital industry to make significant additional investments while maintaining operating profits. Median operating profits year-to-date are about 3.5% with statewide profits at 2.8%. As discussed below, the proposed update is also within the financial parameters of the All-Payer agreement.

## 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 caps the average annual growth rate for All-Payer per capita revenues for Maryland residents at 3.58%. Compliance with this test is measured by comparing the cumulative growth in revenues from the calendar 2013 base period to a ceiling calculated assuming annual per capita growth of 3.58%. This concept is illustrated in Table 4 below. As shown in the table, the maximum cumulative growth allowed through calendar 2016 is 11.13%.

**Table 4**
**Calculation of Cumulative Allowable Growth**
**Per Capita All-Payer Revenues for Maryland Residents**

| | CY 14 | CY 15 | CY 16 | Cumulative Growth |
|---|---|---|---|---|
| | A | B | C | D = (1+A)*(1+B)*(1+C) |
| Calculation of Revenue Cap | 3.58% | 3.58% | 3.58% | 11.13% |

For the purpose of evaluating impact of the recommended update factor on compliance with the All-Payer test, staff have calculated the maximum cumulative growth that is allowable through the end of FY 2016 (the first 30 months of the waiver). As shown in Table 5, cumulative growth of

9.21% growth is permitted though FY 2016. Staff project actual cumulative growth through FY 2016 of 5.24%. This estimate reflects:

- Actual CY 2014 experience;
- The assumption that hospitals will use the full charge capacity available through their global budgets for the final six months of FY 2015 (January to June 2015); and
- The staff recommended update for FY 2016.

A decline in both uncompensated care and the MHIP assessment in FY 2015 and again in FY 2016 contribute to the magnitude of the gap between the maximum allowable cumulative growth and the projected growth. If not for these declines, per capita charges would grow by a cumulative 7.91% through FY 2016. Under either approach, the proposed update keeps Maryland within the limits of the All-Payer test.

**Table 5**
**Proposed Update Leaves Maryland in Compliance with All-Payer Test Per Capita All-Payer Revenues for Maryland Residents**

| | A<br>Actual<br>Jan to June<br>2014 | B<br>Staff Est.<br>FY<br>2015 | C<br>Proposed<br>FY<br>2016 | D=(1+A)*(1+B)*(1+C)<br>Cumulative<br>Thru<br>FY 2016 |
|---|---|---|---|---|
| **Maximum Per Capita Revenue Growth Allowance** | **1.79%*** | **3.58%** | **3.58%** | **9.21%** |
| Per Capita Growth for Period | 0.57%** | 1.99% | 2.61% | 5.24% |
| Savings from Uncompensated Care & MHIP declines that do not adversely Impact Hospital Bottom Line | | 1.09% | 1.41% | 2.52% |
| **Per Capita Growth with UCC/MHIP Savings Removed** | **0.57%** | **3.07%** | **4.00%** | **7.80%** |
| **Per Capita Difference Between Cap & Projection** | | | | **1.41%** |

*3.58% annual growth divided by 2 to capture half year.
**1.13% growth divided by 2 to capture half year

## Medicare Financial Test

The second key financial test under the model is to generate $330 million of Medicare fee-for-service savings over five years. The savings figure for the five-year period was calculated assuming Medicare fee-for-service costs per Maryland beneficiary would grow about 0.5% per year slower than national per beneficiary Medicare fee-for-service costs after the first year..

Preliminary calendar 2014 data currently under review by HSCRC contractors show a gap of nearly two percentage points between the Maryland (-1.5%) and national (+0.5%) per capita growth rates. If these numbers are correct, Maryland savings will exceed $100 million in year one of the model. While the first year savings are favorable, staff recommend maintaining the model contract goal of growing Maryland costs per beneficiary about 0.5% slower than the nation in FY 2016. Attainment of this goal will both maintain any ongoing savings from prior periods (retention of ongoing savings requires Maryland to limit its growth rate to the national rate in FY 2016) and grow those savings by roughly $30 million (from holding the Maryland growth rate below that of the nation again in FY 2016).

A commitment to continue the success of year one is critical to building long-term support for Maryland's model and to build a cushion against adverse performance in future years (for example from increased inflation or utilization expansion from the aging population).

The initial savings generated under the model contract could be adversely affected by:

- Modest projections for future national Medicare growth. As shown in Table 6 below, the CMS Office of the Actuary is forecasting just 0.3% growth in Medicare per beneficiary hospital spending in CY 2015 and 2.4% growth in CY 2016. Federal inpatient charge growth is constrained in the near term by modest inflation updates and steep decreases in disproportionate share payments. More robust outpatient growth is forecast due to increases in volumes. The out-year projections likely overstate this growth as recent announcements by Secretary Burwell indicate that Medicare will rapidly shift to alternative payment models for doctors and hospitals over the next few years in an effort to refocus financial incentives from growing volume to improving quality.

- Increasing Maryland's rates to cover more infrastructure may affect the savings levels in the short term, but should contribute to sustainability of the model and help limit future growth in utilization and costs.

**Table 6**
**Per Capita Medicare Hospital Spending Projections**

**Office of the Actuary**

| CY | Per Capita Trend | | |
|---|---|---|---|
| | Inpatient | Outpatient | Total Hospital |
| 2013 | | | |
| 2014 | -1.4% | 11.0% | 1.5% |
| 2015 | -2.0% | 6.9% | 0.3% |
| 2016 | 1.4% | 5.1% | 2.4% |
| 2017 | 2.5% | 6.3% | 3.5% |
| 2018 | 4.5% | 6.4% | 5.0% |

- A recent pattern of lower than expected growth in national Medicare costs. Projections of national per capita hospital trends by Medicare's Office of the Actuary have overstated the actual experience over the last couple of years as shown in Table 7 below. Even the February 2015 estimate of CY 2014 growth appears to overstate the actual trend as nearly real time data provided to Maryland though the waiver shows national CY 2014 spending growing at a rate of about 0.5% compared to the official estimate of 1.5%. The instability of the estimates creates risk for the State in establishing savings targets.

**Table 7**
**Per Capita Medicare Hospital Spending Projections**
**February 2014 and February 2015 Estimates Compared**
**Office of Actuary**

| CY | Feb-14 Estimate | Feb-15 Estimate | % Point Difference |
|---|---|---|---|
| 2014 | 1.70% | 1.5%* | -0.2% |
| 2015 | 1.70% | 0.3% | -1.4% |
| 2016 | 2.30% | 2.4% | 0.1% |
| 2017 | 3.30% | 3.5% | 0.2% |
| 2018 | 5.20% | 5.0% | -0.2% |

*Medicare fee-for-service data received by HSCRC shows national growth at 0.5% for CY 2014.

## Allowable Growth

If the projections from the CMS Office of the Actuary for calendar 2015 and calendar 2016 are correct, national Medicare per capita hospital spending will increase by 1.35% in State FY 2016. The staff goal of limiting Maryland's Medicare per capita growth to 0.5 percentage points below the national rate results in a maximum allowable Medicare per capita growth of 0.85%.

For the purpose of evaluating the maximum All-Payer growth that will allow Maryland to meet the per capita Medicare fee-service growth target, the Medicare target must be translated to an All-Payer growth limit (Table 8). During deliberations on the FY 2015 update, CareFirst developed a "difference statistic" of two percentage points that was added to the Medicare target to calculate an All-Payer target. As shown in Appendix 1, Maryland's All-Payer per capita spending rose faster than Medicare fee-for-service per capita spending in each of the last six years and is on pace to do so again in FY 2015. The actual FY 2014 experience and the year-to-date experience for FY 2015 support the continued use of a two percentage point difference statistic.

Using the difference statistic, staff calculate that the maximum All-Payer per capita growth that will allow the State to realize the desired FY 2016 Medicare savings is 2.87%. The staff recommended update will produce the desired savings if national actuarial projections are accurate and the difference statistic correctly translates the Medicare growth to All-Payer growth (Table 9).

**Table 8**
**Maximum All-Payer Increase that will Still Produce Desired FY 2016 Medicare Savings**

| | | |
|---|---|---|
| **Maximum Increase that Can Produce Medicare Savings** | | |
| **Medicare** | | |
| Two year average of Medicare growth (CY 2015 + CY 2016)/2 | A | 1.35% |
| Savings Goal for FY 2016 | B | -0.50% |
| Maximum growth rate that will achieve savings (A+B) | C | 0.85% |
| **Conversion to All-Payer** | | |
| Difference statistic between Medicare and All-Payer | D | 2.00% |
| Conversion to All-Payer growth per resident (1+C)*(1+D)-1 | E | 2.87% |
| Converstion to total All-Payer revenue growth (1+E)*(1+0.57%)-1 | F | 3.45% |

Note: National Medicare growth projection 0.3% for CY 2015 and 2.4% for CY 2016 from CMS Office of Actuary, February 2015 analysis.

**Table 9**

| Comparison of Medicare Savings Goal to Model Results | | | |
|---|---|---|---|
| Comparison to Modeled Requirements | All-Payer Maximum to Achieve Medicare Savings | Staff Recommended All-Payer Growth | Difference |
| Revenue Growth | 3.45% | 3.19% | -0.26% |
| Per Capita Growth | 2.87% | 2.61% | -0.26% |

### Medicaid Deficit Assessment

The Medicaid deficit assessment for FY 2016 is unchanged from FY 2015, and the hospital funded portion and rate funded portion will remain at the same level and be apportioned to hospitals in a similar manner as FY 2015.

## RECOMMENDATIONS

The final recommendations of the HSCRC Staff are as follows and are offered on the assumption that the other policy recommendations that affect the overall targets are approved (including the shared savings adjustment for readmissions and the uncompensated care and MHIP reductions):

1) Provide update for the three categories of hospitals and revenues as follows:
   a) Revenues under global budgets--2.4% with an additional 0.4% provided for care coordination and population heath infrastructure investments;
   b) Revenues not under global budgets but subject to Medicare rate setting waiver--1.6%;
   c) Revenues for psychiatric hospitals and Mt. Washington Pediatric Hospital— 1.9%.

2) Require all acute hospitals to submit multi-year plans for improving care coordination, chronic care, and provider alignment by December 1, 2015.

3) Provide an additional 0.25% for competitive awards to hospitals to implement or expand innovative care coordination, provider alignment and population health strategies.

4) Calculate the Medicaid deficit assessment for FY 2016 at the same total amount as FY 2015 and apportion it between hospital funded and rate funded in the same total amounts as FY 2015.

Appendix 1

**Difference Statistic**

| | All Payer | Medicare | Difference |
|---|---|---|---|
| FY 2009 | 5.4% | 2.0% | 3.40% |
| FY 2010 | 2.2% | -2.1% | 4.30% |
| FY 2011 | 4.5% | 2.9% | 1.60% |
| FY 2012 | 5.0% | 1.9% | 3.10% |
| FY 2013 | 1.2% | -1.1% | 2.30% |
| FY 2014 | 1.63% | -0.92% | 2.55% |
| FY 2015 (thru Feb.) | 0.87% | -0.79% | 1.66% |
| | | | |
| Seven Year Average | | | 2.70% |
| Average of FY 14 & FY 15 | | | 2.11% |

For FY 2015, difference statistic of 2.0 percentage points was applied.