Draft Recommendations on the Update Factors for FY 2017

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This document contains the draft staff recommendations for the update factors for FY 2017.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
CON	Certificate of need
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year
FY	Fiscal year
GBR	Global budget revenue
HSCRC	Health Services Cost Review Commission
MHIP	Maryland Health Insurance Plan
TPR	Total patient revenue

INTRODUCTION AND BACKGROUND

The Maryland Health Services Cost Review Commission (HSCRC or Commission) has been setting hospital payment rates for all payers since 1997. As part of this process, the HSCRC updates hospitals' rates and approved revenues on July 1 of each year to account for such factors as inflation, policy adjustments, and 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 has a triple aim of promoting 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 New All-Payer Model focuses on controlling increases in total hospital revenue per capita. The Model established a cumulative annual limit on per capita growth of 3.58 percent and a Medicare savings target of $330 million over the initial five-year period of the Model.

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 order to meet the requirements of the New All-Payer Model and assure that the annual update will not result in a revenue increase beyond the 3.58 percent limit. 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 New 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 when reviewing the proposed updates to understand that they incorporate both price and volume adjustments for revenues under global budgets. They cannot simply be compared to a rate update that does not control for volume changes, since they are intended to compensate for both price and volume changes.

There are three categories of hospital revenue under the New All-Payer Model. The first two categories are under the HSCRC's full rate-setting authority. 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 of hospital revenue are:

1. Hospitals/revenues under global budgets, including Global Budget Revenue (GBR) agreements and Total Patient Revenue (TPR) agreements for the 10 hospitals that were renewed on 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 the HSCRC, such as revenues for out-of-state residents at certain hospitals.

3. 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. 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 fiscal year (FY) 2017.

ASSESSMENT

Calculation of the Update Factors for Revenue Categories 1-3

In this draft recommendation, staff focused on the update factor for inflation/trend for hospitals or revenues in each of the three categories. Separate staff reports provide recommendations on uncompensated care and shared savings relative to potentially avoidable utilization.

The inflation/trend adjustment for Category 1 and Category 2 revenues starts by using the gross blended statistic of 2.49 percent growth, which was derived from combining 91.2 percent of Global Insight's First Quarter 2016 market basket growth of 2.60 percent with 8.80 percent of the capital growth estimate of 1.30 percent. For the global revenues, staff has determined that the correction factor to the First Quarter market basket growth estimate has averaged -.56% for the last three years. Staff is applying the correction factor in advance, in order to avoid overstatement of growth for FY 2017. For non-global revenues, staff applies the 0.50 percent reduction for productivity and a reduction of 0.75 percent for Affordable Care Act (ACA) adjustment that are equivalent to the amount used in Medicare's proposed inpatient prospective payment system update for FY 2017. As a result, the proposed inflation/trend adjustment would be as follows:

Table 1. FY 2017 Proposed Rate Adjustments

	Global Revenues	Non-Global Revenues
Proposed Base Update	2.49%	2.49%
Productivity Adjustment		-0.50%
ACA Adjustment		-0.75%
Average Correction Factor	-0.56%	
Proposed Update	1.92%	1.24%

For psychiatric hospitals and Mt. Washington Pediatric Hospital, staff turns to the proposed psychiatric facility update for Medicare. Medicare applies a 0.50 percent reduction for productivity and a 0.75 percent reduction for ACA savings mandates to a market basket update of 2.80 percent to derive a net amount of 1.55 percent. HSCRC staff recommends adopting the same factor and net adjustments for the Maryland psychiatric hospitals and Mt. Washington Pediatric Hospital.

Summary of Other Policies Impacting FY 2017 Revenues

The update factor is just one component of the adjustments to hospital global budgets for FY 2017. In considering the system-wide update for the All-Payer Model, staff sought 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 the expectations of reduced avoidable utilization.

Table 2 summarizes the net impact on global revenues of staff proposals for inflation, volume, shared savings, uncompensated care, and other adjustments. The proposed adjustments provide for estimated net revenue growth of 2.71 percent and per capita growth of 2.18 percent for FY 2017 before accounting for reductions in uncompensated care and assessments. After accounting for those factors, the revenue growth is estimated at 2.01 percent with a corresponding per capita growth of 1.49 percent. Descriptions and policy considerations are discussed for each step in the text following the table.

Table 2. Net Impact of Update Factors on Hospital Global Revenues, FY 2017

Balanced Update Model for Discussion			
Components of Revenue Change Linked to Hospital Cost Drivers/Performance			
			Weighted Allowance
Adjustment for Inflation			1.72%
- Allowance for High Cost New Drugs			0.20%
Gross Inflation Allowance	A		1.92%
Implementation for Partnership Grants	B		0.25%
Care Coordination			
-Rising Risk With Community Based Providers			
-Complex Patients With Regional Partnerships & Community Partners			
-Long Term Care & Post Acute			
	C		
Adjustment for volume	D		0.52%
-Demographic Adjustment			
-Transfers			
-Categoricals			
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	E		0.50%
- Workforce Support Program	F		0.06%
-Holy Cross Germantown	G		0.07%
- Non Hospital Cost Growth	H		0.00%
Net Other Adjustments	I =	Sum of E thru H	0.63%
-Reverse prior year's shared savings reduction	J		0.60%
-Shared Savings	K		-1.25%
-Reversal of prior year quality incentives	L		-0.15%
-Positive incentives (Readmissions and Other Quality)	M		0.47%
-Negative scaling adjustments	N		-0.28%
Net Quality and Shared Saving	O =	Sum of J thru N	-0.61%
Net increase attributable to hospitals	P =	Sum of A + B + C + D + I + O	2.72%
Per Capita	Q =	(1+P)/(1+0.52%)	2.19%
Components of Revenue Change with Neutral Impact on Hosptial Finanical Statements			
-Uncompensated care reduction, net of differential	R		-0.55%
-Deficit Assessment	S		-0.15%
Net decreases	T =	R + S	-0.70%
Net revenue growth	U =	P + T	2.02%
Per capita revenue growth	V =	(1+U)/(1+0.52%)	1.49%

Components of Revenue Change Linked to Hospital Cost Drivers and Performance

Staff accounted for a number of factors that are linked to hospital costs and performance. These include:

- Adjustments for Volume: Staff proposes a 0.52 percent adjustment that is equal to the Maryland Department of Planning's estimate of population growth for calendar year (CY) 2016[1]. In the previous year, we used an estimate based on 5 year growth projections for population. For the last two years, the actual growth estimate has been lower than the forecast. As a result, we propose to use the most recent growth rate as a proxy for the 2017 growth estimate. Hospital-specific adjustments will vary based on changes in the demographics of each hospital's service area, as well as the portion of the adjustment set aside to account for growth in highly specialized services.
- High Cost New Drugs: The rising cost of new physician-administered drugs in the outpatient setting is 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 0.20 percent of the inflation allowance to provide a pool for outpatient physician administered drugs, with a focus on partial funding of new drugs and growth in the use of high cost drugs. Staff is currently working on the methodology for determining what drugs should be included in this adjustment and how this money will be allocated to the hospitals that qualify.
- Implementation Grants: Last year, the HSCRC approved funding of up to 0.25 percent for infrastructure implementation proposals that would accelerate the implementation of care coordination efforts and provide for early reductions in avoidable utilization The evaluation of these proposals has taken longer than anticipated, as staff needed to address concerns about the deployment of funds that had already been provided as well as the concerns regarding the progression in reducing avoidable utilization. As a result, as these funds are awarded, they will increase the hospital revenues in 2017 rather than in 2016, as originally anticipated.
- Population Health Workforce Program: In December 2015, the Commission approved up to $10 million in FY 2017 hospital rates to be provided on a competitive basis to train and hire workers from geographic areas of high economic disparities and unemployment. The workers will focus on population health and community based care interventions consistent with the All-Payer Model.

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

- Certificate of Need (CON) Adjustments: Holy Cross Germantown Hospital opened in the fall of 2014. The FY 2017 adjustment of 0.07 percent is the estimated increase of $12 million for FY 2017.
- Set-Aside for Unforeseen Adjustments: Staff recommends a 0.50 percent set-aside to fund unforeseen adjustments during the year. A similar allowance was made for both FY 2015 and FY 2016.
- Reversal of Prior Year's Shared Savings Reduction and Quality Incentives: The total FY 2016 shared savings and quality adjustments are restored to the base for FY 2017, with new adjustments to reflect the shared savings reduction and quality incentives for FY 2017.
- Shared Savings Reduction and Scaling Adjustments: The FY 2017 shared savings are continued, and an additional 0.65 percent savings is targeted for FY 2017. A recommendation on this item will be set forth to the Commission in a separate staff report and is discussed in additional detail later in this document. Preliminary estimates are provided for both positive and negative Quality Incentive programs, which have been changed so that they are no longer revenue neutral. Staff is working to finalize these figures.

Components of Revenue Change that are Not Hospital Generated

Several changes will decrease the revenues for FY 2017. These include:

- **Uncompensated Care Reductions**: The proposed uncompensated care reduction for FY 2017 will be -0.55 percent. The amount in rates was 5.25 percent in FY 2016, and the proposed amount for FY 2017 is 4.70 percent. The FY 2017 policy is the subject of a separate recommendation to the Commission.
- **Deficit Assessment**: The legislature provided for a specific level of deficit assessment reduction for 2017. This line item reflects that reduction.

While Table 2 computes 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 FFY 2017

CMS published proposed updates to the federal Medicare inpatient rates for federal fiscal year (FFY) 2017 in the Federal Register in mid-April.[2] These updates are summarized in the table

[2] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Proposed-Rule-Home-Page-Items/FY2017-IPPS-Proposed-Rule-Regulations.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

below. These updates will not be finalized for several months and could change. The proposed rule would increase rates by approximately 0.4 percent in FFY 2017 compared to FFY 2016, after accounting for inflation, disproportionate share reduction, outlier adjustments, 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 in FFY 2015 and that submit data on quality measures, less a productivity cut of 0.50 percent and an additional market- basket cut of 0.75 percent, as mandated by the ACA. This also reflects a proposed 1.5 percentage point reduction for documentation and coding required by the American Taxpayer Relief Act of 2012 and a proposed increase of approximately 0.80 percentage points to remove the adjustment to offset the estimated costs of the Two Midnight policy and address its effects in FFYs 2014 through 2016.[3] Additionally, -0.20 percent will be removed to account for the increase in a high cost outlier threshold. Disproportionate share payment reductions resulted in a decrease of -0.30 percent from FFY 2016.

Table 3. Medicare's Proposed Rate Updates for FFY 2017

	Inpatient	Outpatient
Base Update		
Market Basket	2.80%	2.80%
Productivity	-0.50%	-0.50%
ACA	-0.75%	-0.75%
Coding	-1.50%	
Two Midnight Rule	0.80%	
	0.85%	1.55%
Other Changes		
DSH	-0.30%	
Outlier Adjustment	-0.20%	
	-0.50%	
	0.4%	

Applying the inpatient assumptions about market basket, productivity, and mandatory ACA savings to outpatient, staff estimates a 1.55 percent Medicare outpatient update effective January 2017. This estimate is pending any adjustments that may be made when the proposed update to Federal Medicare outpatient rates get published.

[3] CMS reduced hospital rates for the implementation of the Two Midnight rule, based on an estimate that some patients that were being treated in observation would be admitted. Subsequently, this estimate was overturned. The adjustments noted above include one time and prospective adjustments relative to this matter.

Discussion of the FY 2017 Balanced Update

The staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors while providing savings for purchasers through a shared savings adjustment. The proposed adjustments coupled with the ongoing incentives to reduce potentially avoidable utilization inherent to the Model should allow the hospital industry to make additional investments while maintaining operating margins at reasonable levels. As discussed below, the proposed update falls within the financial parameters of the All-Payer Model agreement.

Shared Savings

Maryland is now in its third year of the All Payer Model. The model is based on the expectation that an All Payer approach and global or population based budgets will provide an approach that will result in more rapid changes in population health, care coordination, and other improvements that will result in reductions of avoidable utilization. To that end, the Commission has provided for revenue budgets that did not offset Medicare's ACA and productivity adjustments, and also has provided infrastructure investment funding to support care coordination activities. For FY 2015 and 2016, the HSCRC applied a shared savings adjustment with an incremental revenue reduction averaging 0.20 percent to allocate and ensure savings for purchasers of care. This was calculated using predicted versus actual readmissions. The staff is proposing to increase the shared saving adjustment for an incremental increase of 0.65 percent, bringing the total adjustment to 1.25 percent. The staff is also proposing to apply the adjustment based on the proportion of each hospital's revenue relative to admissions/observations that are classified as Potentially Avoidable Utilization. This progression in approach is important to advance the model objectives of ensuring savings from reducing avoidable utilization. This approach, and its implications are more fully discussed in a separate staff recommendation.

Investments in Care Coordination

The HSCRC has provided funding for some initial investments in care coordination resources. There are several categories of investments and implementation that the staff believes are critical to the success of the model. Multiple workgroups have identified the need to focus on high needs patients--complex patients and patients with chronic conditions and other factors that place them at risk of requiring extensive resources. Of particular concern are Medicare patients, who have more extensive needs but fewer system supports. Additionally, there are several important major opportunities with post-acute and long-term care that are important to address. There is significant variation in post-acute care costs, and hospitals need to work with partners to address this variation. There are also potentially avoidable admissions and readmissions from post-acute and long-term care facilities. There are documented successes in reducing these avoidable admissions, both in Maryland and nationally. These improvements require partnerships and coordination among hospitals and long-term and post-acute care providers. For FY 2018, the

staff intends to evaluate an update that differentiates the levels of rates provided based on implementation progress in three areas:

- Care management for complex patients with Regional Partnerships and Community Partners
- Care coordination and chronic care improvement focused on rising risk patients with Community Partners
- Effective approaches to address Post-Acute and Long Term Care opportunities

As hospitals continue implementation of these approaches in FY 2017, declines in utilization may free up resources to make additional investments, if there is not a corresponding increase in non-hospital costs.

Market Shift Adjustment

The HSCRC staff discussed its intent to move market shift updates to a bi-annual process starting July 1. At this time, we want to consider moving the market shift adjustment to a quarterly adjustments that culminates in a final adjustment for year end. Quarterly adjustments create some potential flaws, as shorter timeframes exacerbate the impact of small cells. While these will work themselves out over the course of the year, they may create different results as the quarters build on each other. Also, the importance of timeliness and accuracy of hospital data increases. Nevertheless, we find ourselves reviewing market shift with requests for corridor relief, and request for relief from hospitals that are experiencing increases in market shift. As such, we are requesting comments on the advisability of quarterly market shift adjustments.

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 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 annual per capita growth of 3.58 percent. This concept is illustrated in Table 4 below. As shown in the table, the maximum cumulative growth allowed through CY2017 is 15.11 percent.

Table 4. Calculation of the Cumulative Allowable Growth in Per Capita All-Payer Revenue for Maryland Residents

	CY 2014 A	CY 2015 B	CY 2016 C	CY 2017 D	Cumulative Growth E = (1+A)*(1+B)*(1+C)*(1+D)
Calculation of Revenue Cap	3.58%	3.58%	3.58%	3.58%	15.11%

For the purpose of evaluating the impact of the recommended update factor on compliance with the all-payer revenue test, staff calculated the maximum cumulative growth that is allowable

through the end of FY 2017 (the first 42 months of the waiver). As shown in Table 5, cumulative growth of 13.12 percent is permitted through FY 2017. Staff projects actual cumulative growth through FY 2017 of 6.40 percent. This estimate reflects:

- Actual CY 2014 experience January through June, Actual FY 2015 experience;
- The assumption that hospitals will use the full charge capacity available through their global budgets for FY 2016; and
- The staff recommended update for FY 2017.

Table 5. Proposed Update and Compliance with the All-Payer Per Capita Revenue Test

	A Actual Jan- June 2014	B Actual FY 2015	C Staff Est. FY 2016	D Proposed FY 2017	E = (1+A)*(1+B)*(1+C)*(1+D) Cumulative Through FY 2017
Maximum Per Capita Revenue Growth Allowance	**1.79%**	**3.58%**	**3.58%**	**3.58%**	**13.12%**
Per Capita Growth for Period	0.57%	1.85%	2.36%	1.49%	6.40%
Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line		1.09%	1.41%	0.70%	3.23%
Per Capita Growth with UCC & Assessment Savings Removed	0.57%	2.94%	3.77%	2.19%	**9.78%**
Per Capita Difference between Cap & Projection					**3.34%**

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

Medicare Financial Test

The second key financial test under the Model is to generate $330 million in Medicare fee-for-service (FFS) savings over five years. The savings for the five-year period were calculated assuming that Medicare FFS costs per Maryland beneficiary would grow about 0.50 percent per year slower than the national per beneficiary Medicare FFS costs after the first year.

Year one of the demonstration generated approximately $116 million in Medicare savings. CY 2015 savings have not yet been audited, but current projections show an estimated savings of $135 million, bringing the two-year cumulative savings to just over $250 million. Cumulative savings are ahead of the required savings of $49.5 million for two years. However, there has been a shift toward greater utilization of non-hospital services in the state relative to national rates of growth, and Maryland is currently exceeding the national growth rate for the total cost of care by an estimated $60 million (which is a preliminary figure that is subject to change). When calculating savings on total cost of care, the two-year cumulative estimate is $213 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, including non-hospital cost increases. The purpose is to ensure that cost increases outside of hospitals do not undermine the Medicare savings that result from implementation of the All Payer Model by hospitals. If Maryland exceeds the national growth rate by more than .90 percent in any year or exceeds the national growth rate in two consecutive years, it is required to provide an explanation of the increase and

potentially provide for corrective action. Since staff estimates that the Total Cost of Care growth exceeds the national growth for CY 2015, staff is focused on determining the causes of increase. About half of the excess growth is in Medicare Part A services (skilled nursing facility, home health, and hospice), which are related to hospital services. The other half is in Part B services. The staff has determined that the growth is primarily in professional fees, and we are making further assessments of the cause of increases. Staff recommends maintaining the Model contract goal of growing Maryland costs per beneficiary about 0.50 percent slower than the nation in FY 2017. Attainment of this goal will both maintain any ongoing savings from prior periods and help achieve savings in the total cost of care, as well as providing evidence of continuing success of the model.

A commitment to continue the success of the first two years is critical to building long-term support for Maryland's Model.

Allowable Growth

If the projections from the CMS Office of the Actuary for CYs 2016 and 2017 are correct, national Medicare per capita hospital spending will increase by 1.75 percent in FY 2017. The staff goal of limiting Maryland's Medicare per capita growth to 0.50 percentage points below the national rate results in a maximum allowable Medicare per capita growth of 1.25 percent. Since we are concerned about the Total Cost of Care requirements for Medicare in calendar year 2016, as previously explained, we also measure the results against the CY 2016 projection of 1.20 percent growth.

For the purpose of evaluating the maximum all-payer growth that will allow Maryland to meet the per capita Medicare FFS growth target, the Medicare target must be translated to an all-payer growth limit (Table 6A and 6B). During deliberations on the FY 2015 update, a consultant to CareFirst developed a "difference statistic" that reflected that the historical increase in Medicare per capita spending was lower than All Payer per capita spending in Maryland. HSCRC used a difference statistic of 2 percent when calculating the comparisons for the Medicare target limit for FY 2016. However, the actual difference was lower for CY 2015, and as a result, the difference statistic was updated for use in the FY 2017 update. This figure is added to the Medicare target to calculate an all-payer target. Using a blend of case-mix data from CY 2011-2015 and experience data from CY2013-2015, the difference statistic was calculated as a conservative projection of 0.89 percent.

Using the revised difference statistic, staff calculates two different scenarios. Under the first scenario (Table 6A), that the maximum all-payer per capita growth that will allow the state to realize the desired FY 2017 Medicare savings is 2.12 percent. The second scenario (Table 6B) shows a maximum all-payer per capita growth of 2.68 percent. Both scenarios are pictured below and fall within the all-payer guardrails.

Table 6A: Scenario 1 Maximum All-Payer Increase that will still produce the Desired FY 2017 Medicare Savings

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth CY 2016	A	1.20%
Savings Goal for FY 2017	B	-0.50%
Maximum growth rate that will achieve savings (A+B)	C	0.70%
Conversion to All-Payer		
Actual statistic between Medicare and All-Payer	D	0.89%
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	1.60%
Conversion to total All-Payer revenue growth (1+E)*(1+0.52%)-1	F	2.12%

Table 6B: Scenario 2 Maximum All-Payer Increase that will still produce the Desired FY 2017 Medicare Savings

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth (CY 2016 + CY 2017)/2	A	1.75%
Savings Goal for FY 2017	B	-0.50%
Maximum Growth Rate that will Achieve Savings (A+B)	C	1.25%
Conversion to All-Payer		
Actual Statistic between Medicare and All-Payer	D	0.89%
Conversion to All-Payer Growth per Resident (1+C)*(1+D)-1	E	2.15%
Conversion to Total All-Payer Revenue Growth (1+E)*(1+0.52%)-1	F	2.68%

Note: National Medicare growth projection 1.2% for CY 2016 and 2.3% for CY 2017 from CMS Office of Actuary, February 2016 analysis.

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 (Tables 7A and 7B).

Table 7A: Scenario 1 Comparison of Medicare Savings Requirements to Model Results

Comparison to Modeled Requirements	All-Payer Maximum to Achieve Medicare Savings	Modeled All-Payer Growth	Difference
Revenue Growth	2.12%	2.01%	-0.11%
Per Capita Growth	1.60%	1.49%	-0.11%

Table 7B: Scenario 2 Comparison of Medicare Savings Requirements to Model Results

Comparison to Modeled Requirements	All-Payer Maximum to Achieve Medicare Savings	Modeled All-Payer Growth	Difference
Revenue Growth	2.68%	2.01%	-0.67%
Per Capita Growth	2.15%	1.49%	-0.67%

Stakeholder Input

HSCRC staff worked with the Payment Models Work Group to review and provide input on the FY 2017 updates. See Appendix I for all written comments on the staff recommendation for the FY 2017 update factors

RECOMMENDATIONS

The preliminary 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 and the uncompensated care reductions):

1. Update the three categories of hospitals and revenues as follows:
    a. Revenues under global budgets should increase by 2.01 percent.
    b. Revenues that are not under global budgets but subject to the Medicare rate-setting waiver should increase by1.24 percent.
    c. Revenues for psychiatric hospitals and Mt. Washington Pediatric Hospital should increase by1.55 percent.

APPENDIX I. COMMENT LETTERS ATTACHED