Draft Recommendations on the Update Factors for FY 2017

May 2, 2016

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This document contains the draft staff recommendations for the update factors for FY 2017. Any comments may be sent to Cait Grim at Caitlin.Grim@maryland.gov or Deon Joyce at Deon.Joyce@maryland.gov by COB on May 25, 2016.

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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
PAU	Potentially Avoidable Utilization
PQIs	Prevention Quality Indicators
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 potentially avoidable utilization savings.

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 -0.56 percent 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, PAU 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			
Maximum allowed growth			
Maximum revenue growth allowance	A		3.58%
Population growth	B		0.52%
Maximum revenue growth allowance ((1+A)*(1+B)	C		4.12%
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 PAU savings reduction	J		0.60%
-PAU 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 PAU Savings	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, staff used an estimate based on five-year population growth projections. For the last two years, the actual growth estimate has been lower than the forecast. As a result, staff proposes 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 FY 2017 rather than in FY 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 the Prior Year's PAU Savings Reduction and Quality Incentives: The total FY 2016 PAU savings and quality adjustments are restored to the base for FY 2017, with new adjustments to reflect the PAU savings reduction and quality incentives for FY 2017.
- PAU Savings Reduction and Scaling Adjustments: The FY 2017 PAU 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 the 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 below. These updates will not be finalized for several months and could change. The proposed

[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.

rule would increase rates by approximately 0.40 percent in FFY 2017 compared to FFY 2016, after accounting for inflation, disproportionate share reductions, 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 1.50 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 the 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 PAU 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.

PAU Savings Adjustment

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, which will result in reductions in 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 FYs 2015 and 2016, the HSCRC applied a PAU 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. Staff proposes an incremental increase in the PAU saving adjustment of 0.65 percent, bringing the total adjustment to 1.25 percent. Staff also proposes to apply the adjustment based on the proportion of each hospital's revenue relative to admissions/observations that are classified as potentially avoidable utilization, comprised of readmissions and admissions for ambulatory care sensitive conditions (PQIs). 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. Staff believes that several categories of investments and implementation 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 the following 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 to implement 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, staff would like 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, staff is reviewing market shift with requests for corridor relief, and request for relief from hospitals that are experiencing increases in market shift. As such, staff is 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 5A, 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 and 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 5A presents figures on a per capita basis while figure 5B shows allowed growth in gross revenues. Staff has removed adjustments due to reductions in uncompensated care and assessments that do not affect hospital's bottom lines for comparison to the maximum growth allowances.

The actual and proposed revenue growth is well below the maximum levels.

Table 5A. 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		1.08%	1.40%	0.70%	3.21%
Per Capita Growth with UCC & Assessment Savings Removed	0.57%	2.93%	3.76%	2.19%	**9.76%**
Per Capita Difference between Cap & Projection					**3.36%**

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

Table 5B. Proposed Update and Compliance with the All-Payer Gross 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 Gross Revenue Growth Allowance	**2.13%**	**4.26%**	**4.12%**	**4.12%**	**15.44%**
Revenue Growth for Period	0.90%	2.51%	2.94%	2.02%	8.62%
Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line		1.09%	1.41%	0.70%	3.23%
Revenue Growth with UCC & Assessment Savings Removed	0.90%	3.60%	4.35%	2.72%	**12.04%**
Revenue Difference between Cap & Projection					**3.40%**

*population estimates: FY15/CY14 0.66%; FY16/CY15 0.52%

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 0.90 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 the 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. Staff determined that the growth is primarily in professional fees and is 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 provide 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 staff is concerned about the total cost of care requirements for Medicare in calendar year 2016, as previously explained, staff also measures 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 (Tables 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 PAU 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 2.02 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. UPDATING AND REEVALUATING THE DIFFERENCE STATISTIC METHODOLOGY

Calculating the Annual Update Allowance Under the Demonstration

Updating and Reevaluating the Difference Statistic Methodology

Jack Cook

April 15, 2016

Executive Summary

In a previous paper, *Calculating the Annual Update Allowance under the Demonstration*, we suggested a methodology for calculating the annual update so as to have the HSCRC be in compliance with both the All-Payer Waiver Test and the Medicare Waiver Test prescribed by the Demonstration.

Each of the Waiver Tests prescribed a limit on the rate of growth in hospital payments calculated on a per capita basis. The All-Payer Waiver Test limits the annual growth in the hospitals charges for services to Maryland residents calculated on a per resident basis (the All-Payer Statistic). The Medicare Waiver Test limits the growth in all hospital payments for services to resident Medicare FFS beneficiaries calculated on a per beneficiary basis (the Medicare Statistic). The proposed methodology is formulated in terms of an estimate (the Difference Statistic) of the difference between the annual increase in the All-Payer Statistic and the annual increase in the Medicare Statistic. For example, if in 2015, the All-Payer Statistic had increased by, say, 2.58% and the Medicare Statistic by 1.53%, then the Difference Statistic for 2015 would be 1.05%.

$$1.05\% = 2.58\% - 1.53\%$$

In the previous paper we estimated the Difference Statistic using five years of HSCRC claims data (2009-2013), determined the average over the five years, 2.94%, and proposed the use of a conservative Difference Statistic of 2.0% for the purpose of deriving he Annual Update Allowance. The technical details of the suggested methodology require the use of a conservative Difference Statistic in order to provide reasonable assurance that both Waiver Tests will be met.

This paper updates the calculation of the Difference Statistic using the HSCRC claims from 2011 to 2015 and an enhanced method of estimating the increase in the Medicare Statistic: the initial derivation of the Difference Statistic estimated the annual increase in the FFS beneficiaries based on the increase in the age 65+ population in Maryland; the updated estimates used the actual number of Part A and Part B beneficiaries weighted to create a single measure of the FFS beneficiaries residing in Maryland.

The updated calculation resulted in an average Difference Statistic of 2.10 and a conservative Difference Statistic projection of 1.24. However, it was noted that the Difference Statistic applicable to 2012 was unusually large (3.50) and that the four years of Difference Statistics used to calculate the average split between the first two years (2012 and 2013) preceding the term of the Demonstration and the second two years (2014 and 2015) being the first two years of the Demonstration. This split, for which there was no counterpart in the initial calculation of the Difference Statistics since the Demonstration hadn't begun, suggests that the updated calculation might be limited to the first two years of the Demonstration. Using the data from the first two years of the Demonstration, the Difference Statistic is 1.73% and a conservation projection is 1.0%.

One would like to corroborate the estimates of the Difference Statistics derived from the HSCRC claims data by the use of Medicare payment data, preferably including out of state claims. These complete payment data from 2006 to 2012 are available from CMS and the Maryland hospital payments for Medicare services to resident FFS beneficiaries are available from 2013 to 2015. However, we have not been able to reconcile and unify these Medicare payment data in a credible way. Therefore, the corroboration that we have been able to carry out involves only the Maryland hospital payments from 2013 to 2015.

For these years the average Difference Statistic was 1.80% and the conservatively projected Difference Statistic was .89%. These results therefore corroborate the Difference Statistic (1.73%) and the conservation projection (1.0%) derived from the HSCRC claims in the period 2013-2015.

1. Schedule 1: Maryland Hospital Charges per Resident

The hospital charge data in columns 1 and 2 of Schedule 1 were derived from the HSCRC's case mix tapes for 2011 through 2015 by the HSCRC staff.

Column 1 includes the hospital charges for all services and column 2 the hospital charges for services to Maryland residents. Column 3 computes the percentage of the hospital's total charges accounted for by services to Maryland residents. The uniformity of the column 3 percentages suggests that the coding of the residences of Maryland patients was done consistently throughout 2011 to 2015.

Column 4 records the Maryland population; column 5 the hospital charges per Maryland resident (col 2/ col 4); and column 6 the annual rate of increase in the charges per resident. The annual increases in the hospital charges for services to Maryland residents is the first of the two statistics used to derive the Difference Statistic.

Schedule 1

Maryland Hospital Charges per Resident
Annual Increases: 2011- 2015

Hospital Charges (000,000's)

CY	Total	MD Residents	% MD Res Claims	MD Population (000's)	MD Res Claims/ Capita Charge	% Change from Prior Year
2011	$14,540.1	$13,317.2	91.6	5,844.2	$2,279	-
2012	$15,017.5	$13,732.1	91.4	5,890.7	$2,331	2.38
2013	$15,44.3	$14,025.2	90.8	5,936.0	$2,363	1.37
2014	$15,741.2	$14,331.8	91.0	5,975.3	$2,399	1.52
2015	$16,211.1	$14,784.6	91.2	6,006.4	$2,461	2.58

2. Schedule 2: Maryland Hospital Charges per Resident Medicare FFS Beneficiary

The hospital charges in column 1 represent the charges of Maryland hospitals to Medicare FFS beneficiaries residing in Maryland. Column 2 reports the number of such beneficiaries; column 3 the hospital charges per beneficiary (column 1/ column 2); and column 4 records the annual percentage change in the hospital charges per FFS beneficiary. The annual percentage change in the hospital charges per FFS beneficiary are the second statistics used to derive the Difference Statistic.

Schedule 2

Maryland Hospital Charges per Resident Medicare FFS Beneficiaries
Annual Increase 2011- 2015

Year	Hospital Charges (000,000's)	Resident FFS Beneficiaries (000's)	Charge/Beneficiary	% Charge
2011	$4,958.1	712.6	$6,958	
2012	$5,058.9	736.1	$6,873	-1.22
2013	$5,270.3	767.3	$6,869	-.06
2014	$5,391.5	792.0	$6,807	-.89
2015	$5,641.8	816.3	$6,911	1.53

3. Schedule 3: The Difference Statistic and Variances

Columns 1 and 2 record the hospital charges per resident for services to Maryland residents and the annual increases in such charges per resident from Schedule 1. Column 3 and 4 record the Maryland hospital charges per resident FFS beneficiary and the annual increase in these amounts from Schedule 2.

Column 5 calculates the Difference Statistic in each year 2012-2015 and the average 2.10 over the five years. Column 6 specifies for each year the absolute value of the difference between the particular year's Difference Statistic and the average. For example, in 2012, the variance in Column 6 is 1.40, the difference between the Difference Statistic (3.50) and the average Difference Statistic (2.10):

$$1.40= 3.50 – 2.10$$

The conservative projection of the Difference Statistic based on the results of Schedule 3 is 1.24, the average Difference Statistic (2.10) minus the average variances (0.86):

$$1.24 = 2.10- .86$$

Schedule 3

The Difference Statistic and Variance
Maryland Hospital Charge Data: 2011- 2015

Maryland Residents

Year	Chrg/Res	% Change	Chrgs/FFS Beneficiary	% Change	Diff Statistic	Variance
2011	$2,279	-	$6,958	-		
2012	$2,331	2.28	$6,873	-1.22	3.50	1.40
2013	$2,363	1.37	$6,869	-.06	1.43	0.67
2014	$2,399	1.52	$6,807	-.89	2.41	0.31
2015	$2,461	2.58	$6,911	1.53	1.05	1.05
Average					2.10	0.86
Difference Statistic – Avg Variance					1.24	

4. Discussion of Schedule 3

The statistics on Schedule 3 are derived from the consistently accumulated claims data of the HSCRC. However, these claims data for Medicare FFS beneficiaries residing in Maryland provide only an imperfect estimate of the statistic used in the Medicare Waiver Test (the total Medicare payments for hospital services to the resident FFS beneficiaries) because:

- The HSCRC claims do not include the claims for hospital services of resident FFS beneficiaries provided by out of state hospitals, and
- The claims do not reflect the variation in the payment to charge ratio for Medicare hospital services resulting from Medicare policies, including the Sequester

In addition, the four years of estimated Difference Statistics cover two periods in which the dynamics of hospital reimbursement in Maryland were very different. The first period (2012-2013) preceded the term of the All-Payer Model Demonstration and included the beginning of the Sequester in March 2013. The second (2014-2015) represented the first two years of the Demonstration, the implementation of the GBR target budgets, and the impact of enrollment under the ACA.

Over these two periods the average Difference Statistic dropped from 2.465 ((3.5 + 1.43)/2) to 1.730 ((2.41 + 1.05)/2), reflecting a moderation in the growth of private sector volume in period 2. Furthermore, the average variance dropped from 1.035 ((1.40+0.67)/ 2) to 0.68 ((.31+ 1.05)/ 2). This suggests that the use of a Difference Statistic of approximately 1.00 would be an appropriately conservative estimate based on the second period's data.

5. Alternative Estimates of the Difference Statistic

The HSCRC staff has accumulated Medicare inpatient and outpatient payments for Maryland hospital services for resident Medicare FFS beneficiaries for the period 2013-2015, including a 2-month run out with completion factors. Schedule 2A sets forth these payment data, the number of FFS beneficiaries, the payment per beneficiary and the annual percentage change in these payments per beneficiary in 2014 and 2015. These percentage changes are then used on Schedule 3A to re-estimate the Difference Statistic.

Schedule 2A

Summary of Maryland Hospital Medicare Payments
FFS Beneficiaries 2013-2015

CY	Inpatient	Outpatient	Total	FFS Beneficiaries (000's	Payment/ Beneficiary	% Change Payment/ Beneficiary
2013	$3,379.1	$1,285.3	$4,664.4	767.3	$6,079	-
2014	$3,390.0	$1,366.0	$4,756.0	792.0	$6,005	-1.20
2015	$3,514.5	$1,469.9	$4,984.5	816.3	$6,106	1.69
Combined	2015/2013					.49

Schedule 3A records the percentage change in the Maryland hospital charges per resident for 2014 and 2015 from Schedule 1 and the percentage change in the payments per beneficiary from Schedule 2A. The Difference Statistics derived from these results average 1.80 and the average variance is .91. This suggests that the use of a Difference Statistic of .89 would be likely to ensure compliance with the Medicare Waiver Test.

Schedule 3A

CY	% Change MD Resident Charges per Capita (Sch 1)	% Change Medicare Payment Per Beneficiary (Sch 2A)	Difference Statistic	Variance
2013	1.52	-1.20	2.72	.92
2014	2.58	1.69	.89	.91
Average			1.80	
Average Variance			.91	
Conservatively Projected Diff Statistic			.89	

APPENDIX II. COMMENT LETTERS ATTACHED

Maryland
Hospital Association

May 9, 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 64 member hospitals and health systems, I am writing to provide feedback on the Health Services Cost Review Commission (HSCRC) staff draft recommendations on the global budget update factor for fiscal year 2017. The decision before you is critical to the future of the all-payer model in Maryland. Every one percentage point subtracted from or added to this update equals $160 million either withheld from or paid to Maryland's hospitals for patient care inside and outside the hospital.

We ask that commissioners please consider the following important data that augment the current draft recommendation:

Savings Far Exceed Targets
As stated in our April 19 letter, substantial progress has been made in the first two years of the waiver, particularly on Medicare savings (see attached charts):

- The Medicare hospital savings through the end of the waiver's second year was more than ***five*** **times the minimum savings required under the agreement**, and already ahead of the minimum required by June 30, 2017 (chart 1)
- If hospitals continue to save 0.50 percent ***below*** the national growth rate for the remainder of the agreement, total savings are projected to exceed **$850 million, more than *two-and-a-half times* the agreement's minimum required savings of $330 million** (chart 2)
- If Maryland hospital spending grew ***at*** the national rate for the balance of the five-year agreement, total hospital savings would be **$681 million, more than *double* the minimum savings requirement** (chart 2)

The staff's proposed update would push savings and reductions in the all-payer rate of spending for hospital care even further. Staff propose a total all-payer growth through June 30, 2017, of **7.81 percent per capita** (**6.40 percent** after removing the savings from uncompensated care and assessment reductions). This limited growth in spending for hospital care is more than ***one-third*** lower than the allowed ceiling under our all-payer demonstration (chart 3).

Full Range of Allowable Growth Options Not Presented
On pages 13-14 of the staff proposal, two charts present paths to achieve the desired fiscal year 2017 Medicare hospital savings of 0.50 percent. This is an opportunity to engage in a critical policy discussion about the cumulative minimum level of Medicare hospital savings to be achieved, when the minimum required savings through June 30, 2017 have already been exceeded and the all-payer agreement specifies a minimum ***cumulative*** five-year savings total of $330 million.

The Medicare hospital savings requirement of $330 million was calculated assuming the growth in Maryland's spending for hospital care would be lower than the national growth rate by 0.50 percent per year. In the agreement's first year, Maryland reduced that growth rate by far more – 2.15 percent. The commission can set a savings target for fiscal year 2017 less than the 0.50 percent recommended by staff, and still ***significantly exceed*** the minimum savings required. Setting a policy on hospital savings that does not account for the significant cumulative savings to date would undermine the still-tenuous status of the all-payer model.

In addition, Page 13 of the draft proposal suggests that the maximum all-payer growth rate that could be granted to achieve desired savings is limited to between 2.12 percent and 2.68 percent (1.59 percent to 2.15 percent per capita). However, two elements of the calculation are subject to a range of estimates not presented:

- **The projection of national Medicare spending growth for fiscal year 2017.** Several sources of data can be used for projecting Medicare national spending growth. We believe the most reliable is the projection of hospital spending in the Medicare Trustees annual report to Congress. In its latest report, spending growth is projected at 1.81 percent in calendar year 2016 and 2.52 percent in calendar year 2017, for a fiscal year 2017 projected growth of 2.18 percent (compared with staff's indicated range of 1.20-1.75 percent). Further, in its report, the CMS Actuary indicates that based on a study of its estimates for the time period 1997-2013, it has historically *underestimated* hospital spending by about 0.4 percentage points per year.

- **The "difference statistic" that estimates the difference in all-payer spending per capita and Medicare hospital spending per beneficiary.** In calendar years 2014 and 2015, the average difference between the all-payer spending per capita and the Medicare spending per beneficiary was 1.62 percent, nearly double the "conservative projection" of the difference statistic staff are using (0.89 percent).

In short, there are several alternative scenarios not shown on pages 13 and 14 of your materials that commissioners might consider for fiscal year 2017's maximum allowable all-payer increase. These scenarios demonstrate the ability to further increase the update.

Maximum Increase that Can Produce Desired FY 2017 Medicare Savings

	Scenario 1 (Page 13)	**Scenario 2 (Page 14)**	**Alternative Scenario 3**	**Proposed Scenario 4**
Estimated Medicare Growth (FY 2017)	1.20%	1.75%	2.18%	1.85%
Savings Goal (FY 2017)	-0.50%	-0.50%	-0.0%	-0.25%
Maximum Growth Rate that Will Achieve Savings	0.70%	1.25%	2.18%	1.60%

Conversion to All-Payer

	Scenario 1 (Page 13)	**Scenario 2 (Page 14)**	**Alternative Scenario 3**	**Proposed Scenario 4**
Actual Statistic Between Medicare and All-Payer	0.89%	0.89%	1.62%	1.25%
Conversion to All-Payer per Resident	1.60%	2.15%	3.84%	2.87%
Conversion to Total All-Payer Revenue Growth	2.12%	2.68%	4.38%	3.41%

At the May 11 meeting, MHA will provide commissioners with our recommendation for the update for fiscal year 2017, which will be well within the range of allowable increases that commissioners could consider. We ask commissioners to review the broader range of alternative scenarios and provide an update that does not undercut, at this still early stage, the important achievements and continued investments needed for successfully improving care delivery and health in Maryland.

Thank you for your consideration.

Sincerely,

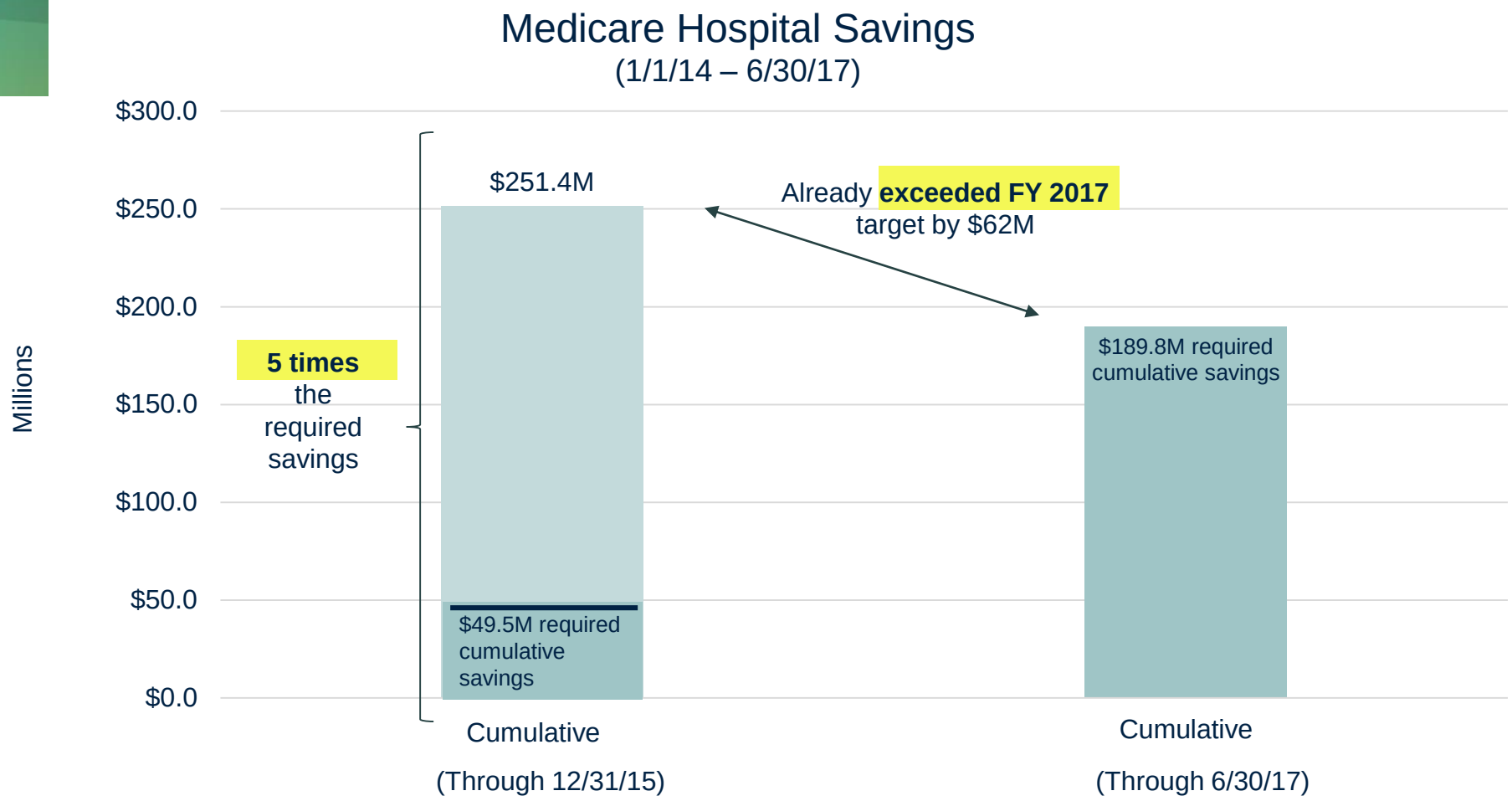
Michael B. Robbins

Michael B. Robbins
Senior Vice President

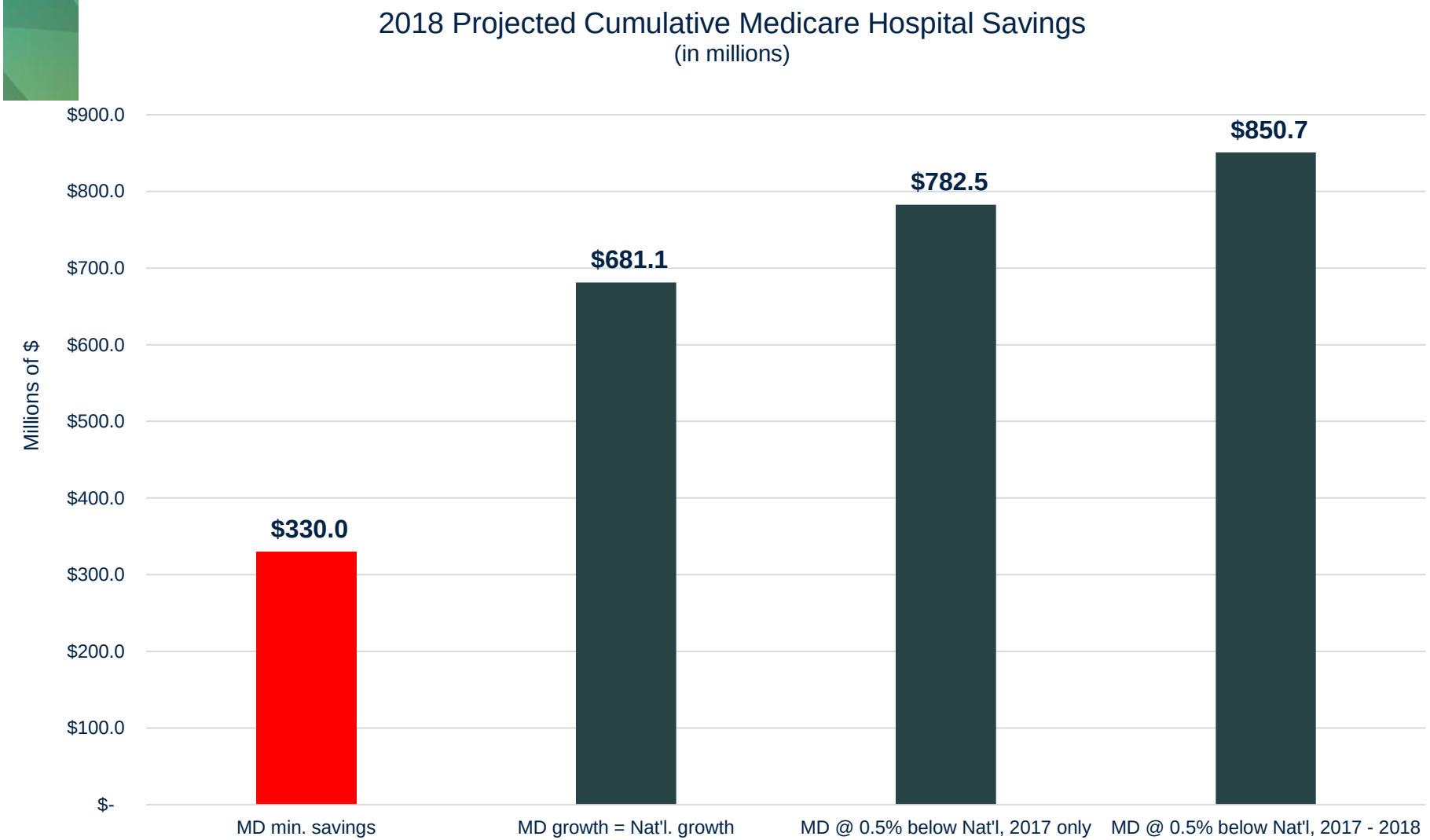
cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director

Attachment

Medicare Hospital Savings is Already Five Times the Required Amount

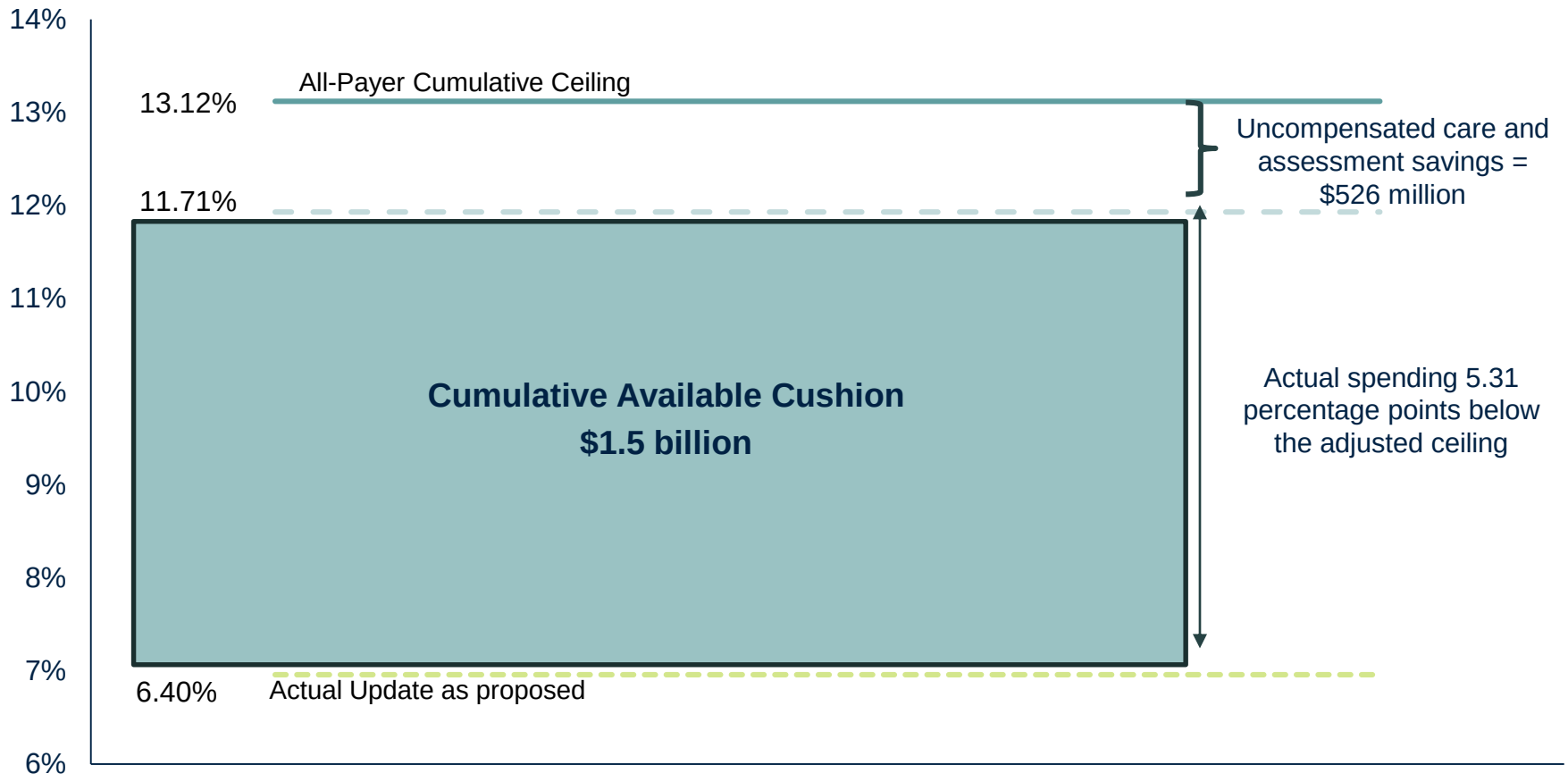


Expected Medicare Savings will far Exceed Requirement



Plenty of Cushion is Available

All-Payer Cumulative Update Capacity
(per capita; 1/1/14 – 6/30/17)



Chet Burrell
President and Chief Executive Officer

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May 6, 2016

Nelson J. Sabatini, Chairman
Donna Kinzer, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini and Ms. Kinzer:

This letter provides CareFirst's comments on the HSCRC staff's Draft Recommendations for the Update to Hospital Rates and the "PAU Savings Program" (PSP) for the Fiscal Year ending 2017.

Background

It appears that in the first year of the Model Agreement (CY 2014), the Maryland rate setting system easily met the All Payer test and both of the Medicare financial tests: 1) the U.S. FFS Medicare hospital expenditure savings requirement of $0; and 2) the national total Medicare Part A and Part B expenditures "Total Cost of Care" (TCOC) test. However, while continuing to achieve strong cumulative savings through CY2015, this performance trend has slipped somewhat causing a need for further root cause assessments. Preliminary data indicates that Maryland is exceeding the U.S. Medicare TCOC growth rate in CY 2015 and it is imperative to provide an Update at July 1, 2016 that ensures compliance with this waiver term for CY2016. If Maryland's Medicare TCOC growth exceeds that of the U.S. by more than 1.0 percentage points in CY 2015, or if it exceeds the national growth rate for two consecutive years (e.g., CY 2015 and CY 2016), the State would experience a "Triggering Event," which would elicit a "Warning Notice" from CMS that might, after some discussion, require Maryland to file an acceptable "Corrective Action Plan" (CAP) with CMS to avoid termination of the Model Agreement. Obviously, termination of the waiver would be disastrous for the State and its hospitals. Experiencing a Triggering Event in the midst of negotiations with CMS/CMMI regarding the continuation of the Model Agreement could jeopardize the ability of the State to obtain a Phase II extension.

The less favorable performance in CY 2015 appears to be a function of:

1) A high FY 2016 Update that increased both CY 2015 and CY 2016 spending, but has not been offset by reduced Medicare utilization;

2) An increase in the use of Part A post-acute care services (i.e., skilled nursing facility and home health services) in CY 2015 that will likely continue into CY 2016. The Model Agreement included the TCOC test so that savings under the hospital system would not be more than offset by increases in costs outside the hospital setting and to ensure that hospitals did not shift routine hospital services to non-hospital settings/facilities; and

3) What the HSCRC staff has characterized as an "uneven implementation of care coordination strategies thus far" by hospitals (particularly as it relates to the Medicare population);

Moreover, despite the infusion of nearly $200 million of care management infrastructure funding into the hospital system, there appears to have been virtually no change to date in the statewide level of PAUs over the past several years. Significantly, slightly more than half of the hospitals currently have increases in PAUs.

PAU Savings Program

Given these results, CareFirst strongly supports the staff's proposal to increase the PAU Savings Program (PSP) offset to rates to 1.25% in FY 2017 (from 0.60% in FY 2016) and to scale these rate offsets based on each hospital's level of PAUs. An increased emphasis on reducing PAUs is consistent with the HSCRC's GBR-based model of rate control. The Commission has frequently noted that, under fixed target budgets, the reduction of unnecessary utilization is an essential source of savings that should be used to offset investments in community-based initiatives and care coordination activities.

2017 Update Factor

In addition, we believe that the FY 2017 update factor must reflect the reality of the State's current and projected position relative to TCOC. We base this on the fact that CY 2015 performance on the Medicare TCOC test appears to have been unfavorable and this performance may also negatively affect performance in the first half of CY 2016 because the relatively high update factor that was approved in July 2015 will remain in effect until June 30, 2016.

The FY 2016 Update Factor— which provided hospitals with over 4.0% additional revenue, when the effects of termination of the MHIP assessment and reduction in hospital Uncompensated Care (UCC) provisions are considered— was predicated on a projected level of Medicare volume reductions that has not been realized.[1]

We have reviewed the methodology and the assumptions that the HSCRC staff used to develop the draft FY 2017 Update of 2.02% that is contained in the "Draft Recommendations on the Update Factor for FY 2017" (May 2, 2016) and provided in the pre-meeting package for the May public meeting and we generally support the approach taken by the staff. However, we have concerns that approving the full Update provision at July 1 could result in Maryland exceeding the National TCOC guardrail for the second consecutive year, causing a "triggering event". Specifically, we believe that the total hospital revenue increase needs to be held to no more than 2.11% in CY 2016 if Maryland is to meet the Medicare tests in the Model Agreement. Given that the approved revenue increase for FY 2016 was 2.94%, approximately half of that amount (i.e., 1.47%) will have been consumed in the first half of CY 2016.

[1] The elimination of the MHIP assessment and reduction in hospital UCC worked to reduce hospital gross patient revenues (their gross charge levels), however, hospital net patient revenues increased by approximately 4.35%. A similar dynamic is occurring in FY 2017 associated with a reduction in the Medicaid Deficit Assessment of 0.15% and an estimated drop in hospital Uncompensated Care of 0.55%. Thus, while gross patient service revenue would increase by 2.01% (under the current staff proposal), the hospitals' net revenues would increase by 2.71% (the 2.02% recommended GBR increase plus 0.70% = 0.15%+0.55%).

This would mean that the maximum revenue increase that the HSCRC could approve effective July 1, 2016 without jeopardizing the Model Agreement is 1.28% (i.e., 1.47% + .50 x 1.28% = 2.11%). Exhibit 1 to this letter illustrates this point in more detail.

If, after six months, it is clear that the system is outperforming the Medicare financial tests, the HSCRC could reasonably consider increasing the Update effective January 1, 2017.

PAUs

Finally, we believe that the HSCRC staff's formulation of PAUs—which includes unplanned readmissions, observation cases, Prevention Quality Indicator (PQIs) and Maryland Hospital Acquired Conditions (MHACs) —is a good first step in defining a methodology to incent hospitals to reduce PAUs.

However, we believe that the Commission should consider the following modifications and refinements to the PAU methodology:

1) The PAU list consists of inpatient services only in relation to each hospital's total (inpatient and outpatient) revenue. This calculation masks the level of PAUs at hospitals that have relatively large proportions of outpatient services;

2) The exemption of procedure-based utilization from the PAU list leaves a large pool of services that may or may not be appropriate outside the scrutiny of the PAU methodology. This means that hospitals with relatively high levels of procedural services— which are not considered in the determination of PAU levels— will tend to show lower PAU levels as a proportion of their total services. We suggest that the HSCRC revise its PAU methodology to compute the level of PAUs relative to the share of each hospital's revenue that is subject to the PAU definitions; and

3) The PAU list currently does not address the fact that the health services literature has amply established the fact that a substantial number of hospital procedures are unnecessary—either because they have little value under any circumstances, or they are over-utilized or they could be performed in more appropriate settings. The HSCRC should over time expand the PAU list to encompass such procedures with the assistance of experts— such as those at RAND, Dartmouth and other organizations—that have done extensive work in this area for many years.

We would like to recognize the HSCRC Staffs openness throughout this process of balancing all stakeholder concerns and comments and putting forward a very reasonable and workable recommendation. Thank you for this opportunity to comment on these very important policy initiatives.

Sincerely,

Chet Burrell
President & CEO

Exhibit I – Recommended Modification to the staff FY Update Proposal

In order for the State to achieve its goal of generating the desired level of 0.5% savings relative to the U.S. Medicare national FFS hospital growth rate, the impact of the FY 2016 approved revenue Update on the period January through June 2016 must be offset by a lower approved Update for FY 2017 (which will impact the last six months of CY 2016).

Table 1 below shows that, in order to meet the staff's goal, the HSCRC should approve a FY 2017 overall GBR revenue Update of 1.28%, not 2.01%, which was the amount that was being considered by the staff at the time of the May 2 Payment Models work group meeting. This 1.28% amount is the maximum affordable update for FY 2017 because the Commission must offset the impact of the large FY 2016 Update, which has inflated hospital revenues during the first six months of the calendar year.

If the HSCRC were to approve a 2.02% GBR revenue Update for FY 2017, Maryland could fail to meet the goal of achieving the desired level of Medicare hospital savings in CY 2016 (i.e., the CY 2016 U.S. Medicare FFS hospital expenditure per beneficiary growth rate less the 0.5% savings provision).

TABLE 1[2]

Meeting the Dual Waiver Tests with a Projection of Maximum GBR Increases
Combining Fiscal Year Approved Revenue Growth for both FY16 & FY 17

		Per Beneficiary	
(1) CMS Actuary Projection CY16 US hospital growth		1.20%	
(2) Less annual Savings %		-0.50%	
(3) Medicare Test Target		0.70%	
(4) Conservative Difference Statistic		0.89%	
(5) Projected Increase in MD Charges per Resident		1.59%	
(6) Population Growth		0.52%	
(7) Allowed CY 2016 Revenue Growth ((5) + (6))		2.11%	
	FY16 Approved Revenue Increase		FY 17 Approved Revenue Increase to hit Medicare Waiver Target
(8) Approved GBR Revenue Increase	2.94% (1)		1.28%
(9) Six Months of FY16 Approved GBR	1.47%		
(10) Six Months of FY 17 Approved			0.64%
(11) Allowed CY 2016 Revenue Growth (9) + (10)		2.11%	

(1) Derived from the FY16 approved Update of 3.19% less the 0.25% Transformation Grant funding delayed to FY17

[2] Table 1 shows a 2.11% update because this is the level necessary to meet the U.S. Medicare FFS Hospital expenditure per beneficiary less 0.5% target for FY 2016. Staff recommended a 2.02% update in order to provide a cushion for meeting this goal. However, as noted, it did not factor in the impact of the larger Update effective FY 2016 which impacts the first six months of CY 2016.

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,

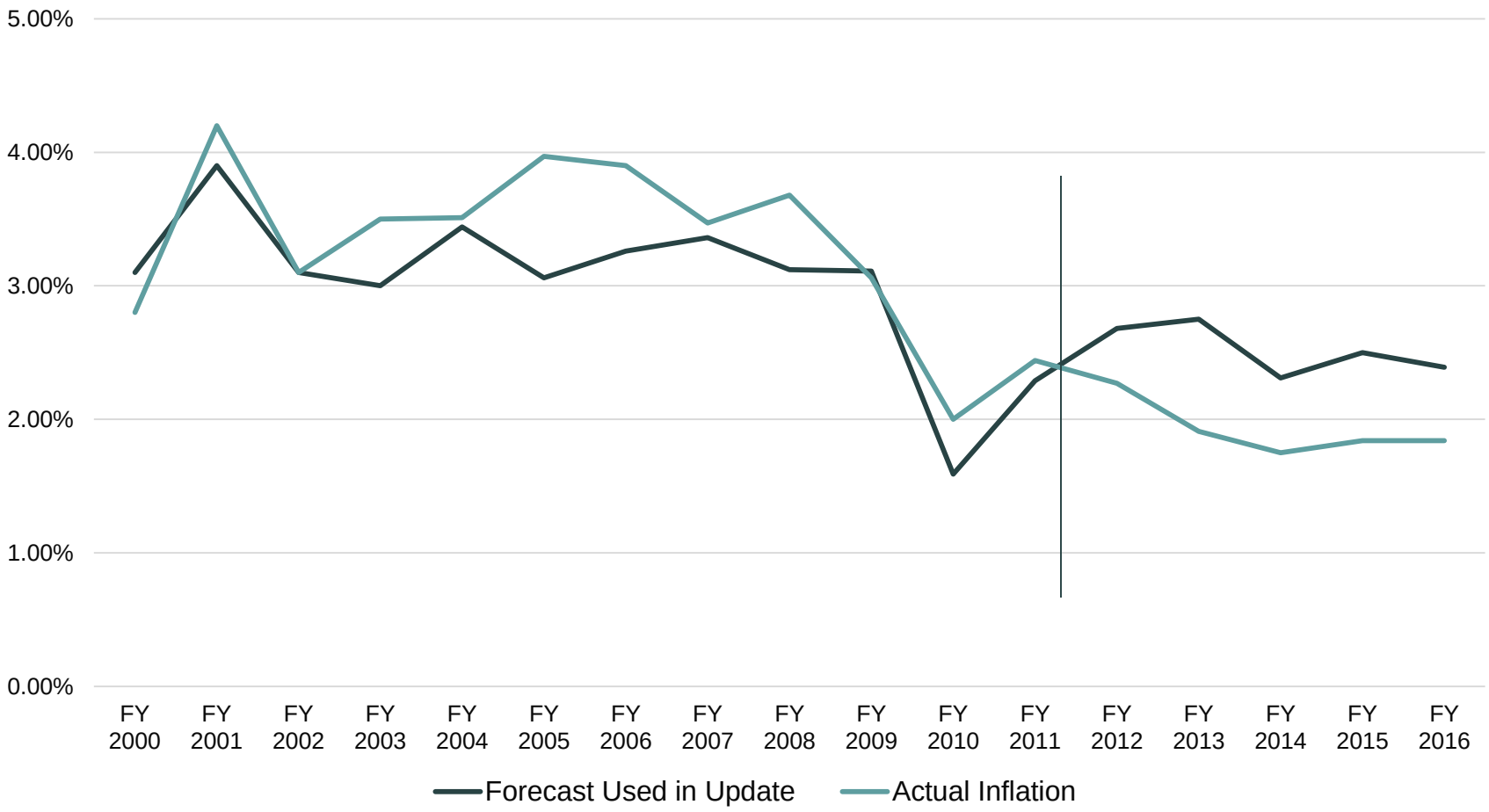
Michael B. Robbins
Senior Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director

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.

GARRETT REGIONAL MEDICAL CENTER

A PROUD AFFILIATE OF
WVUMedicine

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

May 19, 2016

Dear Chairman Sabatini:

On behalf of Garrett Regional Medical Center (GRMC), this letter is in response to the May 11, 2016 commission meeting, at which the Maryland Hospital Association (MHA) offered alternative proposals to the current staff-recommended global budget update and update for revenues not governed by global budgets for fiscal year 2017. I contend that, if adopted, the staff proposed update would be a premature overcorrection that would jeopardize the momentum under the new All-Payer Model and that a higher update can be provided without encroaching on the staff-recommended Medicare total cost of care spending cushion.

GRMC has been engaged in work to transform healthcare in the region over the past two years. The hospital has made significant investments in patient care management and care coordination. GRMC has added social workers and case management staff in an effort to reduce readmissions and manage chronic disease conditions in the most appropriate and cost effective settings. New programs that work to reduce the overall cost of healthcare in the region include the following:

- The implementation of an outpatient cardiac rehabilitation program to reduce inpatient utilization for COPD, CHF, and AMI
- A Chronic Kidney Disease (CKD) clinic to better manage patients with potential renal failure
- Diabetes education programs and obesity counseling
- A wound care clinic to prevent inpatient hospital utilization for wound management
- The hospital now employs an integrated team approach to focused patient care management (Case Management) of the identified high utilizers of inpatient care through a multi-stakeholder discharge planning team. This team includes physicians, social workers, pharmacists, home health nurses, hospital nursing staff, behavioral health practitioners, and nursing home representatives.
- GRMC funds the activities of a Health Planning Council which is a multi-stakeholder team based at the Garrett County Health Department to create the community health plan and health needs assessment.
- GRMC also reaches out to each of the local nursing homes to assure successful care transitions and effective care management to reduce readmissions and potentially avoidable utilizations.

- The hospital's community wellness and outreach also includes the following:
  - GRMC Leads and sponsors the County Annual Health Fair
  - Sponsors tobacco cessation programs
  - Provides preventive health screenings and blood draw panels at local events
  - Provides bone density screenings
  - Provides medically supervised diet and exercise classes
  - Public Flu Vaccination Clinics
  - Provides atrial fib screenings
  - Facial skin analysis cancer screens
  - Breath carbon monoxide screens and expiratory lung capacity tests
  - Public programs that assist people with weight, body fat, BMI management
  - Dental health improvement initiatives in partnership with Garrett County Health Department

All of this aforementioned work takes an incredible amount of resources and funding in order to implement successfully. Indeed GRMC has been successful and consistently experiences a very low readmission rate. The hospital is committed to reducing the total cost of care, which takes resources and time. Finally, the hospital assumes all risk for these aforementioned initiatives; therefore a reasonable revenue update will be critical to continued success.

With respect to the current update, there is plenty of cushion for a more appropriate update; the cumulative savings the model has already secured for Medicare, Medicaid and commercial payers ensures that a reasonable update can be provided that will be far below the model's spending guardrails.

The current staff proposal for the update is inadequate, as it is far below inflation. It also sets aside funding available only to some hospitals via an application process, which means commissioners would put at risk wage increases for workers, and the ability of GRMC to keep up with the basic costs of running the hospital, notwithstanding the investments required to improve community care and reduce utilization. GRMC currently has the lowest charge per case in the state. However, at this time, GRMC is also running on a negative 2% operating margin, which it cannot sustain without staffing cuts that will be detrimental to the local economy.

In summation, I am reaching out to you to support a more appropriate global budget update. The Maryland Hospital Association sent you a fiscal year 2017 global budget update recommendation, which provides commissioners specific ways to turn the HSCRC staff's proposal from inadequate to helpful, without threatening the all-payer model's spending limits. I ask you to please consider these recommendations before approving the global budget update.

Best Regards,

Mark Boucot,
President and CEO

May 19, 2016

Dear HSCRC commissioners:

As the President and CEO of Meritus Medical Center and a member of the executive committee of the Maryland Hospital Association, I would like to address the proposed fiscal year 2017 global budget update for hospitals.

Since our entry into Total Patient Revenue or TPR nearly six years ago, we have remained resolute to improve the health of the population, enhance the experience and outcomes of the patient and reduce the cost of care. In just a few years into our health care transformation, we have experienced success in reducing emergency room visits and hospital admissions, decreasing readmissions from skilled nursing facilities, lowering health care-associated infections and driving out waste and removing variability in patient care processes throughout the health system.

Although early in our care delivery transformation, we have already experienced significant improvement in how to manage the health of our community.

For instance, we have hired an inpatient diabetes educator to educate patients about their disease process and provide resources to help them remain compliant with their care plan. We have also placed diabetic educators in primary care practices to act as a resource to physicians and patients and round out the continuum of diabetic care in the community. Preliminary data indicates that among a sample group of Meritus Health patients engaged with an outpatient diabetes educator, a four percent reduction in HbA1c levels was attained.

In addition, four years ago we began to place RN care managers in our emergency department to develop care plans for high utilizers. Since then, we have seen a 26 percent reduction in ED visits, a 36 percent drop in inpatient admissions and a 25 percent decrease in observation unit visits.

Also, the physicians in our primary care practices utilize RN care managers and a team of social work care managers, diabetic educators, pharmacists, behavioral health counselors and respiratory therapists to proactively manage patients' health care needs. This outpatient team allows primary care providers to focus on providing medical care to patients while the team helps educate, mitigate and resolve psychosocial barriers to improve patient compliance and outcomes. This multidisciplinary team has also been instrumental in creating disease management programs for patients with COPD, asthma and congestive heart failure.

Funding from the Health Service Cost Review Commission has given us the resources to create this multidisciplinary health care team and focus on improving the health of our patients.

When we embedded RN care managers into skilled nursing facilities or SNFs, we immediately saw a decrease in 30-day readmission rates. Since this partnership began, we have improved care transitions, provided patient education and benchmarked quality data sharing. Meritus Health pharmacists also provide consultation on formulary changes between hospital-to-SNF-to-primary care handoffs. The teamwork between care managers and pharmacists saves time and money, prevents possible adverse medication events and optimizes drug therapy.

We have also discovered that 80 percent of our behavioral health ED visits do not require hospitalization. Recently, we integrated behavioral health professionals into our primary care practices to bring behavioral health services to the patient versus the patient coming to a behavioral health practice. Our counselors identify patients at risk, initiate treatment and support and link patients to appropriate community resources. Already, we are increasing immediate access to behavioral health care, improving care coordination, enhancing patient engagement and treatment compliance and decreasing ED visits and potential hospitalization.

As you can see, we are on the path to better care, healthier people and smarter spending, but to continue in this direction, we need investment in innovative care programs, adequate staffing and competitively compensated health care workers and the resources necessary to meet the basic costs of running a hospital.

Hospitals are the only entities at risk for the model's success. In order for us to succeed, we require a reasonable update to the 2017 global budget. However, the imminent decision as to how much of a global budget update will be provided to hospitals at the midpoint of our five-year Medicare agreement concerns me. Maryland's hospitals must have adequate investment to deliver on cost control and quality improvements.

As a hospital CEO, I support MHA's Fiscal Year 2017 Global Budget Update recommendation. I am committed to the care transformation goals of the all-payer model and I share your desire to provide care in the most efficient and cost-effective manner. However, in order to achieve success in population health and lead the nation in transforming health care delivery, Maryland's hospitals, like Meritus Medical Center, need your help and consideration.

Sincerely,

Joseph P. Ross, FACHE
President and CEO, Meritus Medical Center

Heather Lorenzo, M.D.
Vice President and Chief Medical Officer

Thomas Chan
Vice President and Chief Financial Officer