maryland
health services
cost review commission

Payment Model Work Group

March 5,2021

Agenda:

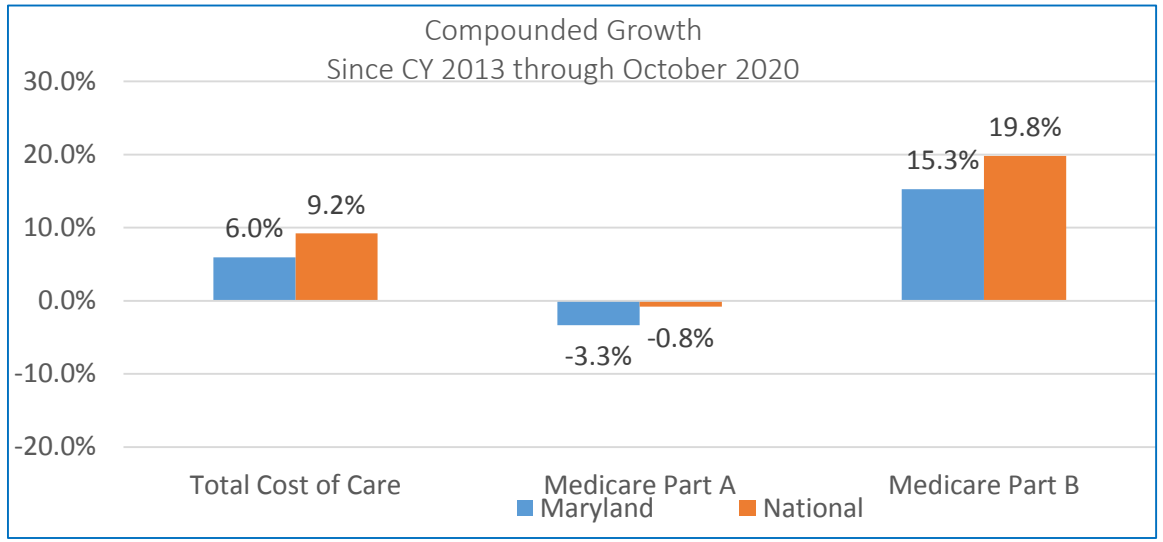
- TCOC Update & Profit Data
- Update Model Overview
- PAU Update
- CARES Funding Update

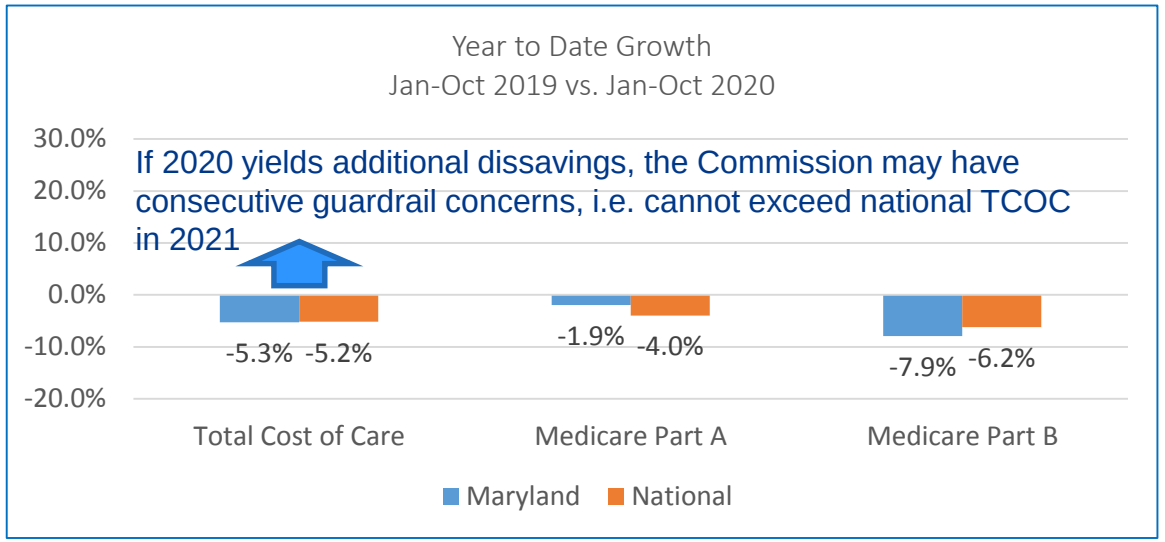
Update on Medicare FFS Data & Analysis

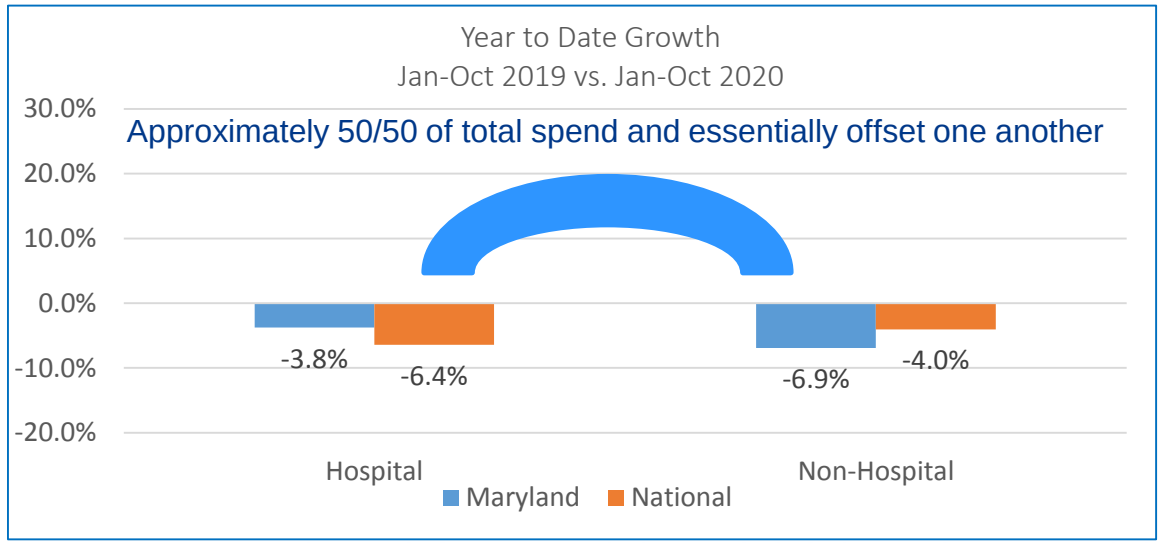
Data through October 2020, Claims paid through December 2020

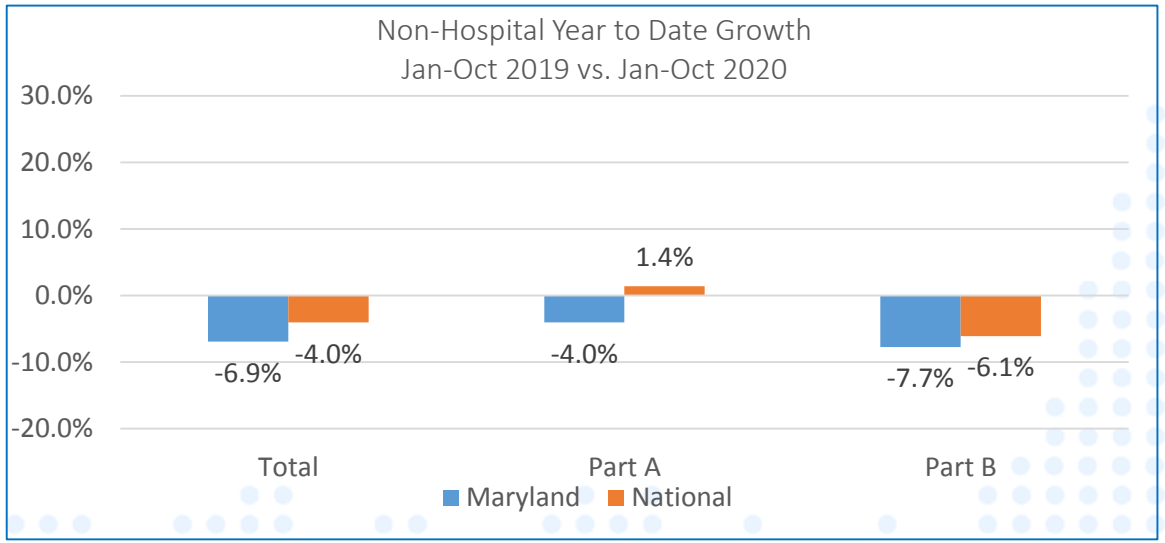
Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Total Cost of Care Payments per Capita



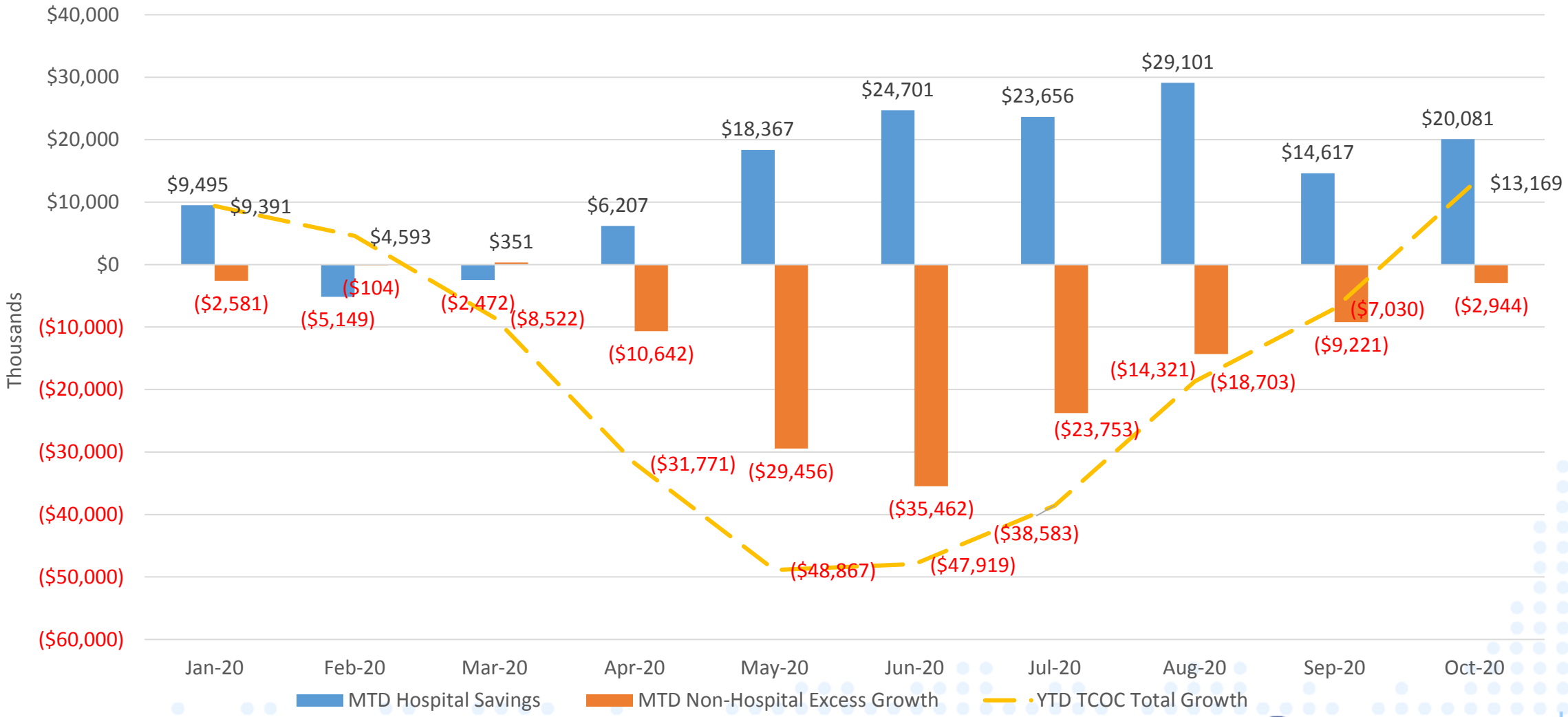






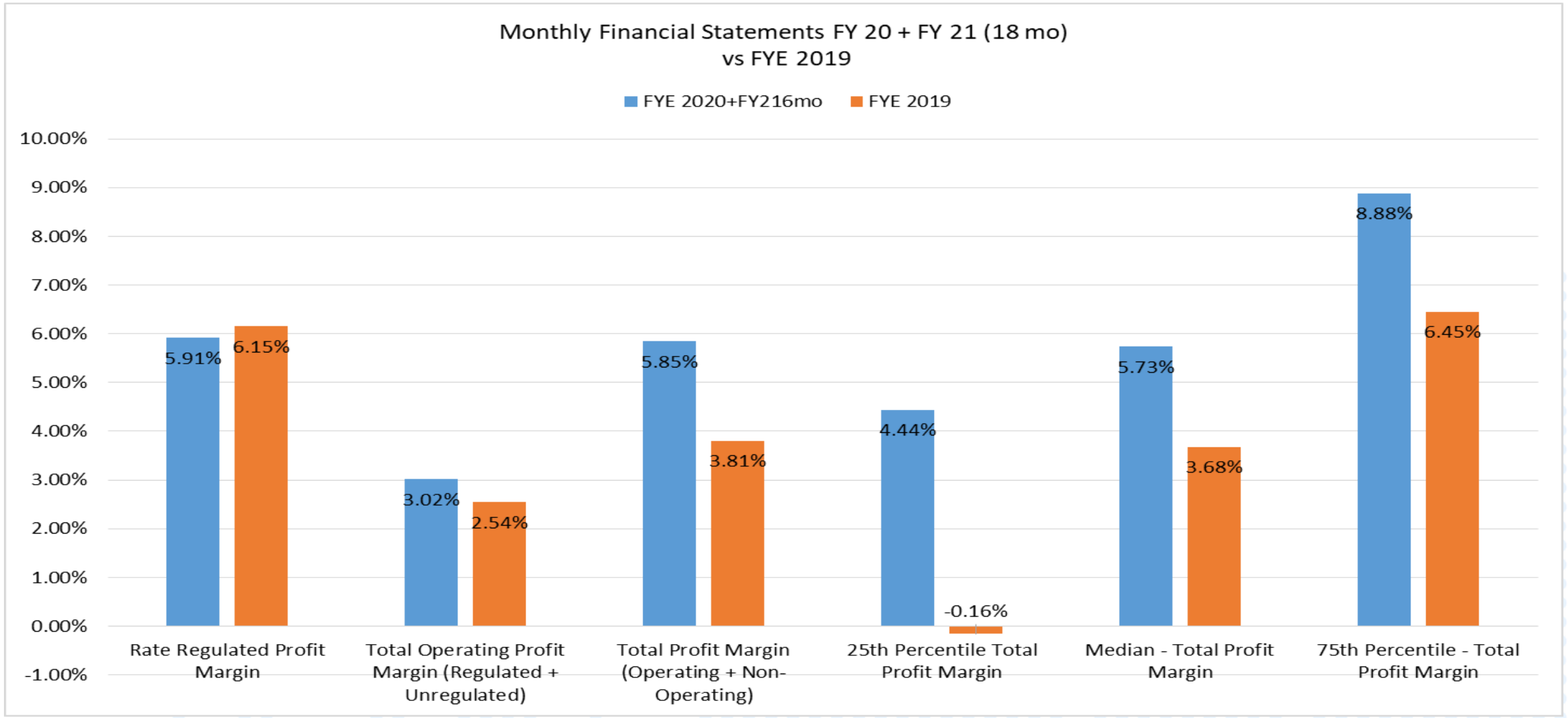
Maryland Medicare Hospital & Non-Hospital Growth

CYTD through October 2020



Profits & GSP

Profit Margins from Monthly Financial Statements FY20 + FY21 (18 mo) vs. FY19



Gross State Product

Measure	Growth %
5 Year GSP	2.89%
5 Year Growth in Annualized Charges	1.87%
3 Year GSP	2.62%
3 Year Growth in Annualized Charges	1.47%
All-Payer Growth Limit	3.58%

- 5 year growth in annualized charges are 1.02 percentage points below the 5 year GSP
- 3 year growth in annualized charges are 1.15 percentage points below the 3 year GSP
- GSP Figures will be updated when final CY20 data is available

*3 & 5 year growth figures use Q3 GSP data and annualized charges for 2020

**GSP growth 2020 vs. 2019 shows decline of .17 percent

Update Factor Overview

Balanced Update Model for RY 2022			
Components of Revenue Change Link to Hosptial Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 1.45% for compensation)			2.14%
- Rising Cost of Outpatient Oncology Drugs			0.23%
Gross Inflation Allowance	**A**		**2.37%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.33%
- Regional Partnership Grant Funding RY22			0.14%
Total Care Coordination/Population Health	**B**		**-0.19%**
Adjustment for Volume			
-Demographic /Population			0.16%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.16%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.00%
- Low Efficiency Outliers	E		0.00%
- Complexity & Innovation	G		0.10%
-Reversal of one-time adjustments for drugs	H		-0.04%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.06%**
Quality and PAU Savings			
-PAU Savings	J		-0.24%
-Reversal of prior year quality incentives	K		-0.12%
-QBR, MHAC, Readmissions			
-Current Year Quality Incentives	L		0.11%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.25%**
Total Update First Half of Rate Year 22			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**2.15%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1+0.16%)	**1.99%**
Adjustments in Second Half of Rate Year 22			
-Oncology Drug Adjustment	P		0.00%
-QBR	Q		0.00%
Total Adjustments in Second Half of Rate Year 22	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 22			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**2.15%**
Per Capita Fiscal Year	**T =**	(1+S)/(1+0.16%)	**1.99%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		0.08%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**0.08%**
Total Update First Half of Rate Year 22			
Revenue growth, net of offsets	**X =**	N + W	**2.23%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1+0.16%)	**2.07%**
Total Update Full Rate Year 22			
Revenue growth, net of offsets	**Z =**	S + W	**2.23%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1+0.16%)	**2.07%**

REVENUE SCENARIOS

Estimated Position on Medicare Target				
		As Charged	As Charged +Staff COVID policy	Proforma Including CARES
Actual Revenue CY 2020		17,663,547,233	17,663,547,233	17,663,547,233
CARES Act $ Adjustment		-	-	1,150,000,000
				18,813,547,233
Step 1:				
Estimated Approved GBR RY 2021		19,127,140,103	19,127,140,103	19,127,140,103
Actual Revenue 7/1/20-12/31/20		9,337,804,834	9,337,804,834	9,337,804,834
Approved Revenue 1/1/21-6/30/21	**A**	**9,789,335,269**	**9,789,335,269**	**9,789,335,269**
Step 2:				
Estimated Approved GBR RY 2022		19,554,173,502	19,554,173,502	19,554,173,502
Permanent Update		2.23%	2.23%	2.23%
Step 3:				
Estimated Revenue 7/1/21-12/31/21 (after 49.73% & seasonality)		9,724,290,483	9,724,290,483	9,724,290,483
CARES Act $ Payback			(336,000,000)	(336,000,000)
Projected Revenue 7/1/21-12/30/21	**B**	**9,724,290,483**	**9,388,290,483**	**9,388,290,483**
Step 4:				
Estimated Revenue CY 2021	**A+B**	**19,513,625,752**	**19,177,625,752**	**19,177,625,752**
Increase over CY 2020 Revenue		10.47%	8.57%	1.94%

Scenario 1a: CY20 National TCOC Growth

As Charged

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY2020 -5.17%)	A	-5.17%		
Savings Goal for FY 2022	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	-5.17%		
Conversion to All-Payer				
*Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
*Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-0.92%		
Net Difference Statistic Related to Total Cost of Care	D	0.03%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**-5.14%**	**10.30%**	**-15.44%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**-4.99%**	**10.47%**	**-15.46%**

*Actual Statistic & Excess Growth are placeholders from RY21 update. At this time, staff does not believe adding CY20 data to these statistics to be suitable. These figures are under review.

Scenario 1b: CY20 National TCOC Growth

As Charged +Staff COVID policy

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY2020-5.17%)	A	-5.17%		
Savings Goal for FY2022	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	-5.17%		
Conversion to All-Payer				
*Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
*Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-0.92%		
Net Difference Statistic Related to Total Cost of Care	D	0.03%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**-5.14%**	**8.40%**	**-13.54%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**-4.99%**	**8.57%**	**-13.56%**

*Actual Statistic & Excess Growth are placeholders from RY21 update. At this time, staff does not believe adding CY20 data to these statistics to be suitable. These figures are under review.

Scenario 1c: CY20 National TCOC Growth

Proforma Including CARES

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY2020-5.17%)	A	-5.17%		
Savings Goal for FY2022	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	-5.17%		
Conversion to All-Payer				
*Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
*Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-0.92%		
Net Difference Statistic Related to Total Cost of Care	D	0.03%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**-5.14%**	**1.77%**	**-6.91%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**-4.99%**	**1.94%**	**-6.92%**

*Actual Statistic & Excess Growth are placeholders from RY21 update. At this time, staff does not believe adding CY20 data to these statistics to be suitable. These figures are under review.

- Even when accounting for CARES Funding, any potential inflation looks unreasonable because the Commission's historical proxy for current year TCOC growth is the prior calendar year (CY 2020 in this case)
- Given CY 2020 is not likely a good proxy for TCOC growth in CY 2021, should staff consider an alternative benchmark?

Scenario 2a: GSP Growth

As Charged

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 2.62%)	A	2.62%	**Recommendation:**	**Savings:**
Savings Goal for FY 2022	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	**2.62%**	**10.30%**	**-7.68%**
Conversion to total All-Payer revenue growth (1+C)*(1+0.16%)-1	D	**2.78%**	**10.47%**	**-7.69%**

- In addition to a GSP test being a hallmark to our Model tests, Staff believes it may more accurately represent the infusion of CARES dollars in CY20.

Scenario 2b: GSP Growth

As Charged +Staff COVID policy

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 2.62%)	A	2.62%	**Recommendation:**	**Savings:**
Savings Goal for FY 2022	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	**2.62%**	**8.40%**	**-5.78%**
Conversion to total All-Payer revenue growth (1+C)*(1+0.16%)-1	D	**2.78%**	**8.57%**	**-5.79%**

Scenario 2c: GSP Growth

Proforma Including CARES

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 2.62%)	A	2.62%	**Recommendation:**	**Savings:**
Savings Goal for FY 2022	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	**2.62%**	**1.77%**	**0.85%**
Conversion to total All-Payer revenue growth (1+C)*(1+0.16%)-1	D	**2.78%**	**1.94%**	**0.85%**

- While this appears more reasonable, the question remains if the 3 prior years of GSP is a good proxy for anticipated TCOC growth in CY 2021, especially given:
  - The bounce back in national utilization is unknown
  - Presumed, differential national hospital growth will be offset by presumed, differential non-hospital growth in Maryland
  - There are likely TCOC guardrail concerns in CY 2021 (cannot exceed the nation in consecutive years)

PAU Statewide Reduction and Distribution

Determination of Statewide PAU Reduction for RY 2022

- Given the challenges of CY 2020 as a performance year, the statewide PAU reduction for RY 2022 will be determined using the following:
  - RY 2020 Approved Permanent Revenue
  - CY 2019 PAU Charges
  - RY 2022 Inflation Factor & Demographic Adjustment
- Given PAU represents a fairly consistent percentage of total permanent revenue (~10.50%-11.00%), staff believe using CY 2019 is preferable to extrapolating charges from July to December to generate a full year assessment.
- Staff would also note that updating to RY 2021 revenue:
  - Makes use of CY 2019 PAU charges incongruous
  - Has little substantive impact on statewide reduction value

Calculation of Statewide PAU Reduction for RY 2022

Table 1: Calculation of Statewide Reduction (calculated)	Formulas	Value
RY 2020 Total Approved Permanent Revenue	A	17,658,042,368
RY 2022 Inflation Factor + Population Growth (Demographic Adjustment)	B	2.14% + 0.16% (placeholder) = 2.3%
Total experienced PAU $ **CY 2019**	C	1,844,766,206
Proposed Required Revenue Reduction $	D = B*C	-$42,429,623
Proposed Required Revenue Reduction %	E = D/A	-0.24028%
Adjusted proposed required revenue reduction % (Rounded)	**F = ROUND(E,4)**	**-0.24%**
Adjusted proposed required revenue reduction	**G = F*A**	**-$42,379,302**
Total PAU %	H	10.43%
Total PAU $	I = A*H	$1,842,058,805
Required Percent Reduction PAU	J = G/I	-2.30%

Value put in Update Factor Model

PAU Reduction: Distribution by Hospital

Ultimate distribution of the PAU reduction is pending further analyses:

- PAU readmission measure will follow RRIP analyses regarding the reliability and validity of the measure and the most appropriate evaluation period

- Per Capita PQI rates will be investigated over different date ranges to determine best course of action:
  - Currently processing data to get 6-month and 12-month per capita PQI rates for CY 2019 and CY 2020 (preliminary data through December)
  - Will review and conduct correlation and reliability analyses similar to other programs

- COVID positive patients are removed from both readmission and PQI measure

CARES Funding Update

Potential Revisions to Staff Approach On COVID Funding

- Based on industry feedback staff is considering two modifications to the COVID settlement approach discussed in the February Commission meeting
  1. Revise to settle on a fiscal year basis rather than as of December 31, 2020 but make a preliminary adjustment in July 1, 2021 Rate Orders
  2. Use State Averages in determining the amount of CARES funds to be allocated to unregulated

Revised Adjustment Timing

- Revise to settle on a fiscal year basis rather than as of December 31, 2020 but make a preliminary adjustment in July 1, 2021 Rate Orders
  - Extends undercharge guarantee to 6/30/21
  - Avoids creating artificial December 31st settlement point and allows hospitals to offset over/undercharge in the second half of FY21
  - Allows savings to be achieved in Calendar 2021 which is likely needed under Medicare guardrails. Staff would propose to adjust the full amount in the first 6 months of FY22
  - Utilize preliminary FY21 charge data (e.g. through April 2021) in making the July 1, 2021 adjustment.

Settlement Approach Remains Largely the Same

Approved Revenue	
Total FY20 and ~~First Six Months of~~ FY21 Charges inclusive of Approved Expanded Corridors	A
FY 20 Undercharge + FY 21 Undercharge ~~for First Six Months~~	B
Impact of COVID on FY20 Expenses (1)	C
Impact of COVID on FY21 Expenses (1,2)	D
FY21 Funding Under Current COVID Surge Policy - if any (3)	E
Total Approved Revenue	F = A + B + C + D + E
Actual Revenue	
Actual Charges for FY20 and ~~First Six Months of~~ FY21	G
Regulated Portion of CARES funding (4)	H
Total Actual Revenue	I = G + H
Net Under (Over) Funding	J = F - I

- If analysis shows a net under funding hospital will be allowed to bill revenue in subsequent periods. If a net over funding hospitals will be required to reduce future charges to eliminate the over funding - earliest effective date is July 1, 2021.
- Some adjustments were made for hospitals that were undercharged in FY20 in the 1/1/21 rate orders. Any such adjustments will be offset against the July 1, 2021 rate order.
- If material CARES Act monies are subsequently recaptured by the Federal Government, the Commission will work with hospital to recover these funds through additional charges in subsequent rate years.

(1) Expenses will be assessed through aggregated annual filing analysis; will not calculate individual COVID related cost increases
(2) As these amounts will not be known until early FY22, final adjustment will likely be in the FY23 rate order.
(3) Calculated based on monthly assessments
(4) HSCRC will use amounts reported in Federal Reporting on the HHS Provider Relief Fund multiplied by the % of regulated revenue reported by the hospital entity in FY19. Hospital should submit separate reporting if that amount is not appropriate. HSCRC will also compare this amount to revenue reported in the annual filing (see potential change #2 in this presentation).

Adjusted Timing Under Revised Approach

		Rate Effective Date		
Approved Revenue		July 1, 2021 (1)	Jan 1, 2022	July 1, 2022
Total FY20 and FY21 Charges inclusive of Approved Expanded Corridors	A	Final FY20 + Preliminary FY21	Final FY21	
FY 20 Undercharge + FY 21 Undercharge	B	Final FY20 + Preliminary FY21	Final FY21	
Impact of COVID on FY20 Expenses	C	Final FY20		
Impact of COVID on FY21 Expenses	D	Preliminary FY21	Preliminary FY21	Final FY21
FY21 Funding Under Current COVID Surge Policy - if any (3)	E	Final for period beginning 11/1/20	If needed	If needed
Total Approved Revenue	F	F = A+B+C+D+E	F = A + B + D	F = D
Actual Revenue				
Actual Charges for FY20 and FY21	G	Final FY20 + Preliminary FY21	Final FY21	
Regulated Portion of CARES funding (2)	H	Net Received as of 5/31/21	Net Received as of 6/30/21	Revise if Needed
Total Actual Revenue	I	I = G + H	I = G + H	
Net Under (Over) Funding	J	J = F - I		J = F

(1) All Adjustments made July 1, 2021 would set to result in full recover in the first 6 months of the year.
(2) Amounts would be revisited as the Federal Government recovers CARES dollars

Current Estimated July 1, 2022 Adjustment

	Initial FY20 Adjustment			FY21 Estimate Plus Other Estimates and Revisions						Impact on Rates July 1, 2022	
	(1)	(2)	(3) = (1) + (2)	(4)	(5)	(6)	(7)	(8)	(9) = sum (3,4,5) - sum (6,7,8)	(10)	(11) = (9) - (10)
$ in Milions	FY 20 (Under) Over Charge	Plus: CARES Funding, net of unregulated portion as of 1/6/20	FY20 Net (Under) Over Charge to be adjusted in July 1 Rates	Plus: Additional CARES Funding to date	Plus: Estimated FY21 (Under) Over Charge (a)	Less: FY20 Expenses (b)	Less: Preliminary FY21 Expenses (c)	Less: COVID Surge Funding	Total Net (Under) Over Charge	Less: (Under) Charges in Jan 1, 2021 Rate Order	Net (Under) Over Charge to be adjusted in July 1, 2021 Rates (d)
Luminis	(54)	71	17	0	?	?	?	?	17	0	17
Adventist	(32)	88	56	0	?	?	?	?	56	0	56
Holy Cross	(23)	70	47	0	?	?	?	?	47	0	47
Johns Hopkins	(268)	243	(26)	0	?	?	?	?	(26)	(26)	0
LifeBridge	(67)	75	9	5	?	?	?	?	14	0	14
MedStar	(25)	151	126	0	?	?	?	?	126	0	126
Tidal	(22)	26	4	0	?	?	?	?	4	0	4
UMMS	(264)	293	29	13	?	?	?	?	42	0	42
All Other	(185)	134	(51)	12	?	?	?	?	(39)	(71)	32
Total	(941)	1,152	211	30	?	?	?	?	241	(97)	338

a. Actual implementation will use most complete possible FY21 data (April/May?)
b. Amounts will be calculated based on cost reporting and other data submitted by hospitals but will be captured net of estimated offsetting cost savings.
c. Commission will utilize FY20 experience and other hospital submitted reporting to include a preliminary estimate.
d. Amount will be set in rates to complete the adjustment in the first 6 months of FY22.

Revise Method to Allocate CARES funds to Unregulated

- Use State averages in determining the amount of CARES funds to be allocated to unregulated
  - Recognizes the varying ways in which unregulated business is organized and expenses are reported
    - Some systems report more or less business within their regulated entity
    - Commission has limited reporting on non-regulated business
  - Allows Commission to acknowledge these differences without complex or subjective new reporting requirements on non-regulated business.

Potential Implementation Approaches

- Alternative 1: Use simple state average to determine % attributed to unregulated for all hospitals
  - Uses simple rather than weighted average to reflect smaller hospitals equally in the amount
  - Helps larger hospitals with low %'s where non-regulated business is outside the entity. Hurts smaller hospitals with simpler corporate structures
  - Net $20 M (~10%) reduction in recoveries due from hospitals
- Alternative 2: Use greater of simple state average or actual % attributed to unregulated hospital
  - Reduces impact of alternative 1 on smaller hospitals by allowing them to use their own higher than average value
  - Increase net impact to $45 M (~20%)