maryland
health services
cost review commission

Payment Model Workgroup

March 29, 2023

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Payment Models Meeting Agenda

March 29, 2023

11:00 am -1:00 pm

Health Services Cost Review Commission

I	Introductions and Meeting Overview
III	RY24 Update Factor Modeling
IV	CY Preliminary Modeling
V	CY22 TCOC Update
VI	Surge Funding
VII	Macro Inflation Trends
VIII	MHA Position on the 2024 Annual Update
IX	Adjourn

RY24 Update Factor Modeling

Update Factor Inputs*

Base Year Revenue ($ Millions) - 33% Medicare FFS		$20,150	$6,649
Item	% Increase	All-payer $ Increase (Millions)	Medicare $ Increase (Millions)
Inflation	3.14%	$633	$209
Drug Inflation	0.02%	$4	$1
Care Coordination/Population Health	-0.03%	-$6	-$2
Volume (DA, Drugs)	0.00%	$0	$0
Set Aside for Unknown Adjustment	0.00%	$0	$0
Low Efficiency Outliers	0.00%	$0	$0
Surge Funding	0.20%	$40	$13
Complexity & Innovation	0.03%	$5	$2
Reversal of one-time adjustments for drugs	-0.09%	-$18	-$6
PAU	-0.33%	-$66	-$22
Quality Adjustments (Net of Reversals)	-0.38%	-$77	-$25
2nd half Oncology Drug Adjustment	0.00%	$0	$0
Total Hospital Update Full Rate Year 24	2.56%	$516	$170
Per Capita Fiscal Year	**2.56%**	**$516**	**$170**
Revenue Offsets with no impact to Hospitals	0.05%	$10	$3
Total Revenue Update Full Rate Year 24	2.61%	$526	$174
Per Capita Fiscal Year	**2.61%**	**$526**	**$174**

**Drug value, Set Aside, and Low Efficiency line items are not yet finalized.*

- 3.14% inflation plus 0.02% drug inflation equals 3.16% inflation based on the fourth quarter book of CY 2022. One-time surge funding of 0.20% is also provided. Inflation of drugs is a placeholder and will be updated.
- Department of Planning is projecting negative population growth of -0.16%. Given new findings staff is considering other options (TBD)
- In CY 2022, hospitals charged $2.1B for PAU related services. Withholding 3.16% inflation on these cases represents -0.33% statewide
- Quality adjustments are net negative mainly because of the reversal of RY 2023 RRIP rewards in RY 2024

Quality Breakout

RY 2024 Program	# of Rewards	Rewards ($)	# of Penalties	Penalties ($)	Total ($)	Total Update Factor Impact (%)
RRIP	30	$75.9M	14	-$11.1M	$64.8M	0.32%
RRIP PAI	9	$10.1M	NA	NA	$10.1M	0.05%
MHAC	12	$11.6M	22 (8 held harmless)	-$46.4M	-$34.8M	-0.17%
QBR*					-$51M	-0.25%
Total						-0.05%

- RY 2024 Quality adjustments are approximately budget neutral statewide
- The net impact of prior year Quality adjustments and RY 2024 adjustments is -0.38% due to the reversal of RRIP and RRIP PAI (-0.33%), which was the only Quality program implemented in RY 2023

*QBR at this time uses RY 2022 adjustment; will update at next meeting

Demographic Adjustment

- The Demographic Adjustment is provided each year to hospitals to recognize utilization growth related to
  - Population Growth and
  - Aging of the Population

Age group	Per Capita Revenue	Age Cost Weights
0 to 4	$1,825	0.64
5 to 14	$397	0.14
15 to 44	$1,714	0.60
45 to 54	$2,583	0.91
55 to 64	$4,162	1.46
65 to 74	$5,940	2.09
75 to 84	$8,045	2.83
85+	$8,121	2.85
Total	$2,845	1.00

- When first implemented, the Commission elected to use Claritas to estimate population growth by eight age cohorts at the zip code level, which is then age adjusted based on the cohorts' per capita hospital revenue spend relative to the statewide average
  - Allocation of the population growth is done by assessing a hospital's casemix adjusted market share in a given zip code

- The Commission further elected to scale statewide age adjusted growth so that it was equivalent to the annual population estimates published by the Maryland Department of Planning

Issues with Demographic Adjustment

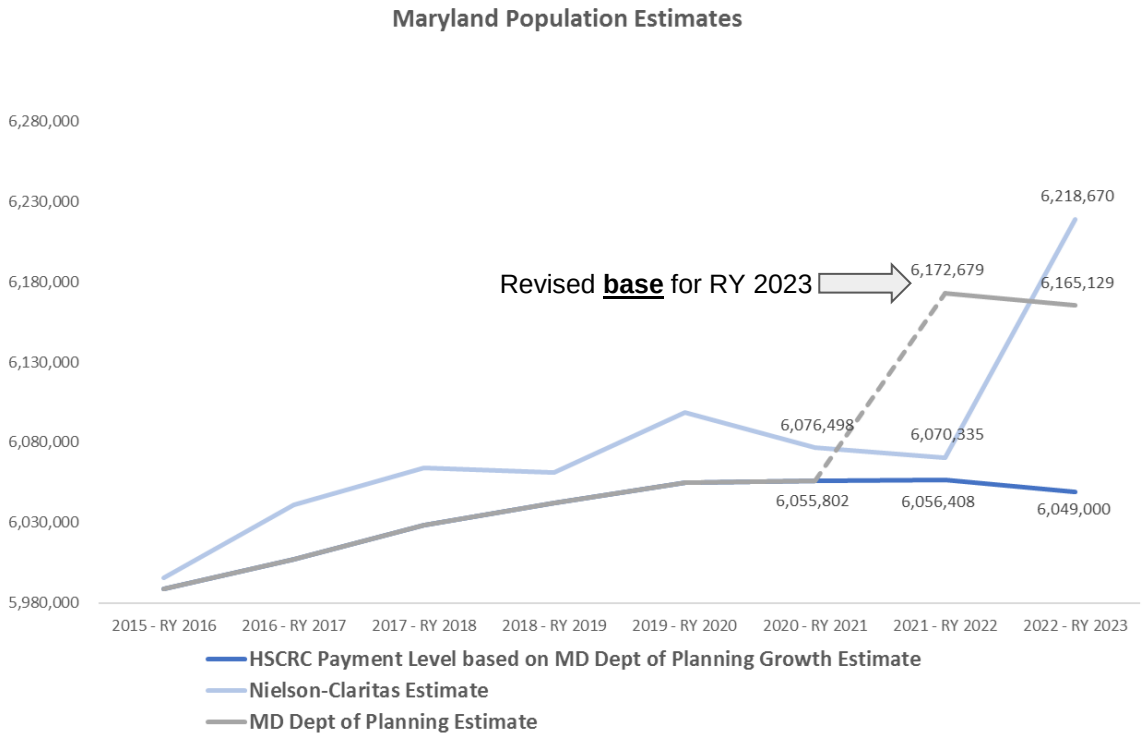
- Claritas and Department of Planning reflect different time periods.
  - Claritas is always 6 months in advance of Department of Planning

Demographic Adjustment	Claritas (Corresponding Time Period)	Department of Planning (Corresponding Time Period)
RY15	CY14/CY13	April 2012-July 2013
RY16	CY15/CY14	April 2013-July 2014
RY17	CY16/CY15	April 2014-July 2015
RY18	CY17/CY16	April 2015-July 2016
RY19	CY18/CY17	April 2016-July 2017
RY20	CY19/CY18	April 2017-July 2018
RY21	CY20/CY19	April 2018-July 2019
RY22	CY21/CY20	April 2019-July 2020
RY23	CY22/CY21	April 2020-July 2021
RY24	CY23/CY22	April 2021-July 2022

- The limit of the statewide Demographic Adjustment is Department of Planning projected growth.
  - Thus, if a hospital has projected age adjusted growth that is less than the scaling required to make Claritas' statewide age adjusted growth equal to Planning's estimate, a hospital will receive an overall negative Demographic Adjustment

- When the census data from 2020 became available it became clear both Claritas and the Department of Planning had significantly underestimated growth from 2010-2020
  - Claritas underestimated by by 2.72%, Planning by 2.01%. Much of this is to do with low estimates of immigration
  - Only Claritas appears to have reflected a catch up in a performance year due to the 2020 census forecasting error

Alternate Approaches to 10 Year Forecasting Error



- The July 2021 estimate from Department of Planning that was used as the RY 2023 Demographic Adjustment was -0.12%
  - It did not reflect census catch up of 2.01%
- Claritas' estimate of CY 2022, which was used for RY 2023 DA, was 2.44%
  - Variance was due to alternate approaches to addressing 10 year forecasting error
- The diverging methods to account for the forecasting error underscored one of the underlying issues with the Demographic Adjustment, i.e. potential redistribution
  - 27 hospitals with Claritas projected age adjusted growth received a negative Demographic Adjustment in RY 2023

Staff Demographic Adjustment Proposal

1. Do not implement Department of Planning negative population growth estimate of -0.16% (April 2021 - July 2022) in RY 2024.
   a. Continue to use Claritas estimates to determine age adjusted growth.
   b. Scale statewide age adjusted growth statistic back to 0%, not -0.16%

2. Consider reversing RY 2023 adjustments related to Department of Planning scaling factor, i.e., Claritas 2.82% age adjusted growth of 2.82% scaled back -**2.95%** to Department of Planning population growth estimate of -0.12%.
   a. Some measure of scaling is appropriate because we do not fund age adjusted growth at a statewide level and Planning miss was 2.01% from 2010 to 2020 (1.93% from revised RY 2023 base) AND population based methodologies did not exist for the entirety of the last decade
   b. Focus initial efforts on hospitals that had a net negative adjustment in RY 2023 because the policy effectively funded population growth in some parts of the State by removing funding from other parts of the State. Eliminating all negative adjustments (~$80M), would result in a net add to the UF of ~0.40%
   c. The State's position on the savings tests both this year and last do not permit a large catch up adjustment

3. Convene workgroup with industry and stakeholders to correct RY 2023 Demographic Adjustment
   a. Will need to consider how much of the 10 year forecasting error is attributable to time period when State had Global Budgets, i.e., 2014 to 2020.
   b. Must establish how quickly this correction should be made
   c. Will likely use the reversal of future negative growth estimates from Department of Planning as corrective tool

CY23 PRELIMINARY MODELING

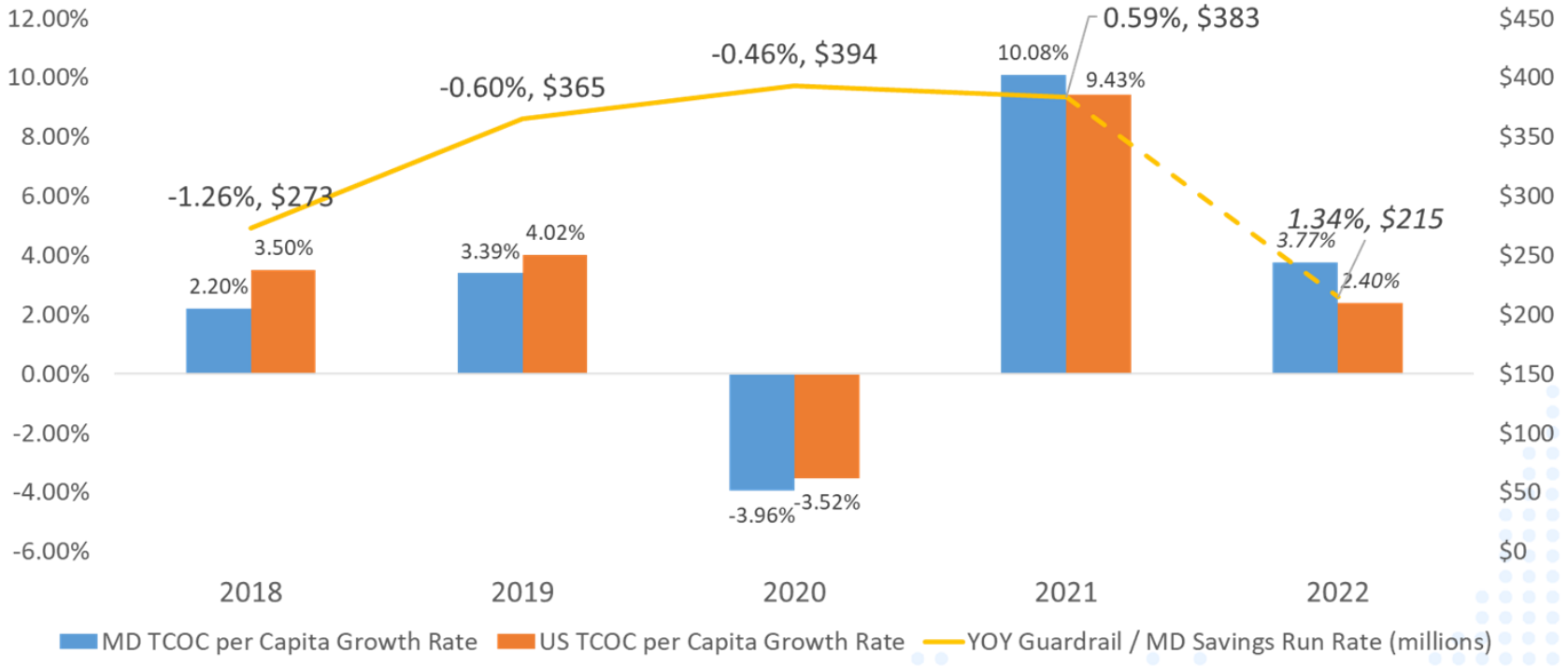
CY 2023 Revenue Scenarios

Estimated Position on Medicare Test		
Actual Revenue CY 2022		19,988,280,340
Step 1:		
Approved GBR RY 2023		20,149,673,365
Actual Revenue 7/1/22-12/31/22		9,932,183,960
Approved Revenue 1/1/23-6/30/23		10,217,489,405
FY23 Undercharge in First Half of CY23		-34,166,781
Anticipated Revenue 1/1/23-6/30/23	**A**	**10,183,322,624**
Step 2:		
Approved GBR RY 2023		20,149,673,365
Reverse One Time Extraordinary Adjustments:		
Adjusted GBR RY 2023		20,149,673,365
Projected Approved GBR RY 2024		20,676,475,053
Permanent Update RY 2024		2.61%
Adjusted Change from GBR RY 2023		2.61%
Step 3:		
Estimated Revenue 7/1/23-12/31/23 (after 49.73% & seasonality)		10,282,411,044
		-
		-
Projected Revenue 7/1/23-12/30/23	**B**	**10,282,411,044**
Step 4:		
Estimated Revenue CY 2023		**20,465,733,668**
Increase over CY 2022 Revenue		2.39%

- The estimate of CY 2023 Revenue growth first accounts for actual GBR spend in CY 2022 to develop a baseline statistic
  - Non-GBR hospitals are not reflected this in this value ($19.9B)
- Approved revenue not charged in the current fiscal year determines the first six month spend in CY 2023 (Jan-June,$10.2B)
  - Value is discounted by anticipated RY 2023 undercharge ($34.2M)
- Inflating RY 2023 permanent revenue by RY 2024 Update Factor and then applying seasonality adjustment estimates second six month spend in CY 2023 (July-Dec, $10.3B)
  - RY 2024 Update Factor of 2.61% is inclusive of one-time adjustments and reversals
  - Seasonality adjustment is enforced by mid-year GBR targets

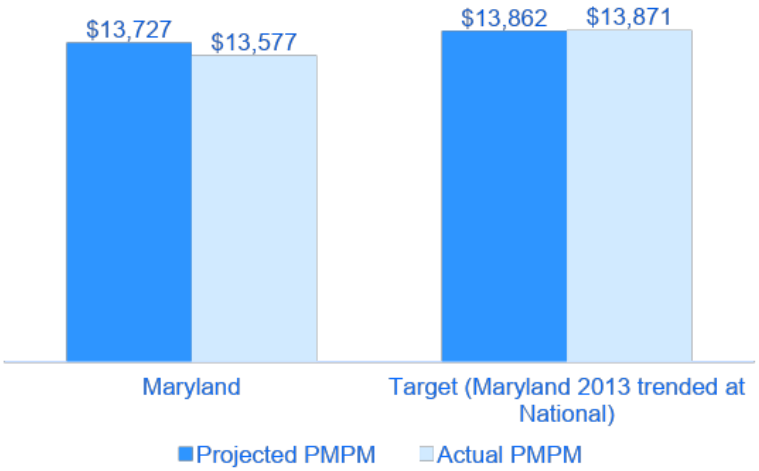
CY22 TCOC UPDATE

Medicare Savings Run-Rate Projection Update – CY22



Revised Projection Overview

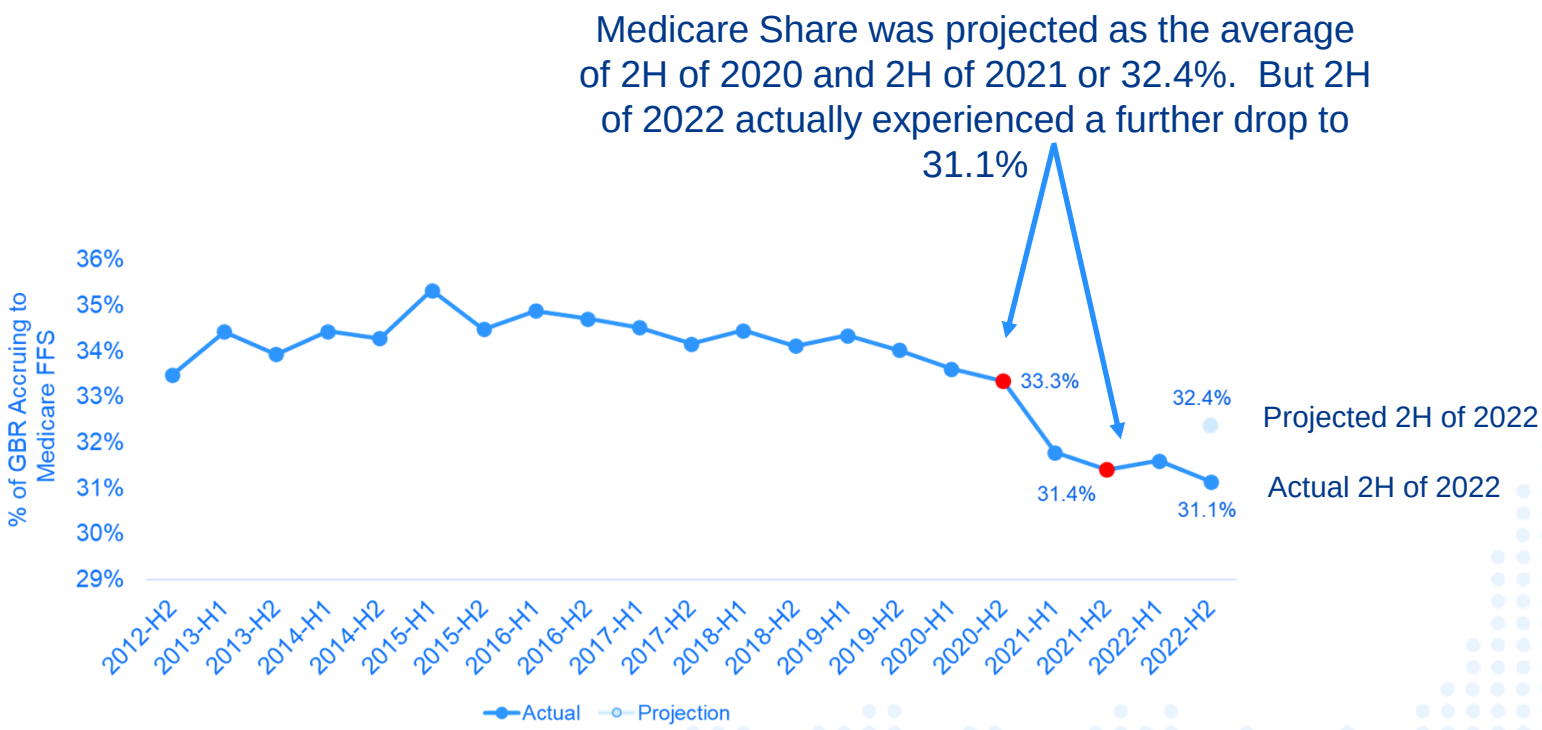
While National spending came in within 0.1% of projected, Maryland spending was 1.1% lower resulting in a $135M improvement
=$149 MD + ($14) National



Maryland variance was driven by a lower-than-expected share of the GBR accruing to Medicare. July variance was discounted due to noise in billing patterns but then was reinforced by significant positive variances in November and December.

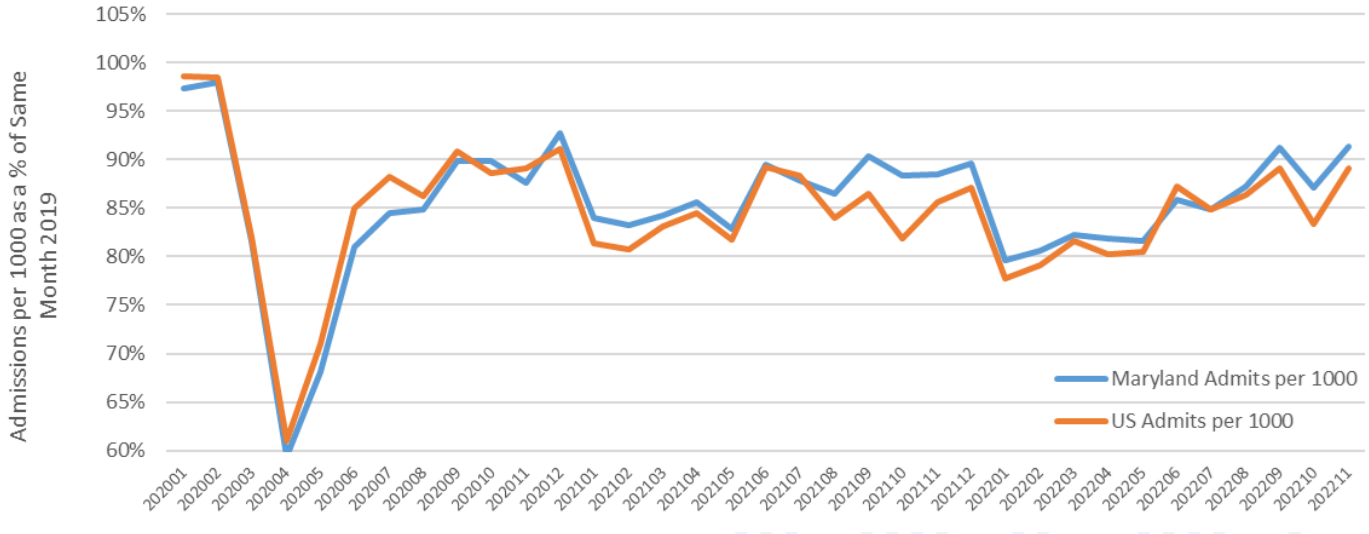
Month	Savings Better than Projection, $ M
Jul-22	$60
Aug-22	$6
Sep-22	$10
Oct-22	$8
Nov-22	$28
Dec-22	$37
Total	**$149**

Share of GBR Accruing to Medicare FFS



Admissions per 1000 as a % of same month 2019, 2020 to 2022

- Trends remain relatively flat versus per pandemic levels. Some uptick in current month but:
  - Maryland more so than national
  - Least complete period



Guardrail Tests - Initial Proposed Scenarios

- All scenarios uses HSCRC revenue projection for Part A and Part B MD Hospital

- For MD Non-Hospital and US Hospital and Non-Hospital

  Scenario 1: 2022 Trended forward at 2017 - 2019 Trend

  Scenario 2: 2022 Trended forward at 2015 - 2019 Trend

  Scenario 3: 2022 Trended forward at 2021 - 2022 Trend

  Scenario 4: 2019 Trended forward at 2015 - 2019 Trend (bounce back)

- Scenarios 1, 2 and 4 mirror last year.
  - Scenario 2 was added last year as Scenario 1 approach proved too generous in 2021.
  - Scenario 2 was closest projection to 2022 actual. Scenario 4 is similar to OACT approach
- Scenario 3 added this year.
- No variance statistic included at this time

Guardrail Tests and Savings

- Uses December paid through January with Completion Factors (Will update with additional month of data soon)
- 1/1 Temporary mitigation reflects impact of approved differential change and MPA savings component and all-payer.

Variables	TCOC Improvement ($ Millions)	Comments
TCOC Improvement Plan - All-Payer Reduction	$ -	Already In CY Revenue Projections
TCOC Improvement Plan - Differential	$20	Implemented in April
TCOC Improvement Plan - MPA Savings Component	$64	
MPA Increment	$11	
Total	$95	

Scenario 1: 2022 Trended Forward at 2017-2019			
2 Year Growth	Maryland	US	
2022	$13,566	$11,751	
2023	$14,072	$12,216	Variance
YOY Growth	3.73%	3.96%	-0.23%
Impact of 1/1 Temporary Mitigation			-0.85%
			-1.08%
Estimated 2023 Savings in Millions			$341

Scenario 2: 2022 Trended Forward at 2015-2019			
2 Year Growth	Maryland	US	
2022	$13,566	$11,751	
2023	$14,003	$12,086	Variance
YOY Growth	3.22%	2.85%	0.37%
Impact of 1/1 Temporary Mitigation			-0.85%
			-0.48%
Estimated 2023 Savings in Millions			$271

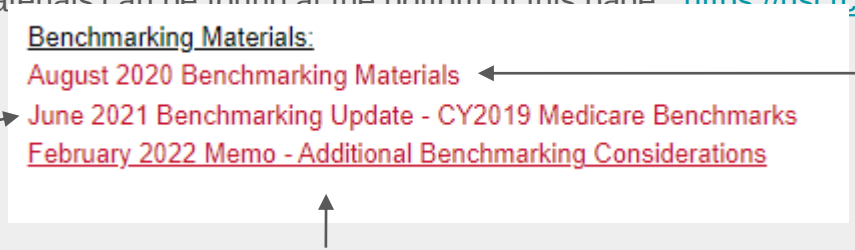
Scenario 3: 2022 Trended Forward at 2021-2022			
2 Year Growth	Maryland	US	
2022	$13,566	$11,751	
2023	$13,918	$12,041	Variance
YOY Growth	2.59%	2.47%	0.12%
Impact of 1/1 Temporary Mitigation			-0.85%
			-0.73%
Estimated 2023 Savings in Millions			$287

Scenario 4: 2019 Base applied 2015-2019 CAGR			
2 Year Growth	Maryland	US	
2022	$13,566	$11,751	
2023	$14,087	$12,194	Variance
YOY Growth	3.84%	3.77%	0.07%
Impact of 1/1 Temporary Mitigation			-0.85%
			-0.78%
Estimated 2023 Savings in Millions			$321

Benchmarking Update

Benchmarking Materials can be found at the bottom of this page: https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx

Three links:



2019 Medicare data

Complete set of 2018 materials. Page 26 of the PPT in the package is a guide to the other files.

Package also contains a release form to access additional detailed Commercial data. About half of hospitals have completed the release.

Memo with additional modeling in response to comments received various policy discussions.

Expect to release Commercial 2019 and 2021 data and Medicare 2021 data later this spring.

Staff Received two sets of benchmarking questions prior to this meetings:

- One set was hospitals specific and Staff are following up with the hospital
- Other set included a range of specific technical questions. Staff will respond in writing and discuss at a future Volume or TCOC meeting.

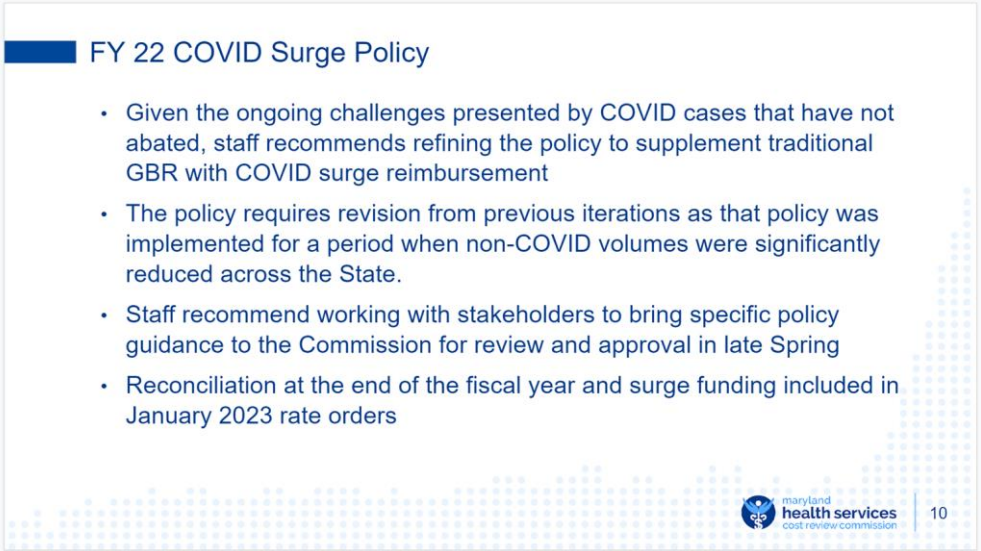
Please continue to submit any questions on the benchmarking to: william.henderson@maryland.gov.
Questions received in the next few weeks will be addressed in writing and/or at the April meetings.

FY22 COVID SURGE FUNDING

COVID Surge Policy History

- The original policy covered FY20 and FY21. $32 M disbursed starting in January 2022 under this policy
- In response to high COVID surge in winter 21-22, Staff shared the proposal at right with Commissioners and the public.
- Follow-up was delayed due to the CY22 savings shortfall.
- Staff is now proposing to develop a response for inclusion with the RY2024 Update Factor Recommendation

From January 2022 Commission Meeting:



COVID Surge Policy History

- Generally, the policy funds COVID-19 volumes to the extent they would have caused a hospital to exceed their GBR at standard rates.
  - The concept being that COVID was a legitimate variance where volume variable funding would be appropriate if GBR funding was inadequate.
  - The original policy provided funding as follows:

    "the FY2020 and FY2021 GBR will be equal to NonCOVID GBR plus COVID funding, where:

    1. Non-COVID GBR = FY2020 or FY2021 Original GBR
    2. COVID Funding = The greater of: A) $0 B) COVID Standardized Charges – (GBR – Non-COVID Standardized Charges)"
- January 2022 Session outlined the following principles to be considered in CY2022 funding
  - Focus funding for hospitals with higher than typical COVID volumes
  - Focus funding for hospitals with higher than typical total volumes where COVID is a significant contributor to the higher volumes
  - Focus funding on COVID cases where a patient is being treated for COVID as primary diagnosis, as opposed to all those with COVID exposure (the original policy used the more generous definition)
  - Reduce funding for offsetting alternative sources of funding such as PRF funds.

Overview of New Approach

- New Concept: A hospital must both be overcharged due to COVID at standard rates (original policy) but is also limited to recovering only the amount which exceeded State average experience.
  - This also addresses the situation of hospitals that have higher standardized charges than GBR for non-COVID reasons, a scenario that was not considered in the original policy.
- General Calculation:

  the FY2022 GBR will be equal to Non-COVID GBR plus COVID funding, where:

  1. Non-COVID GBR = FY2022 Original GBR
  2. COVID Funding = The greater of: A) $0 and the B) lessor of
     - i) COVID Standardized Charges – (GBR – Non-COVID Standardized Charges)
     - ii) Hospital GBR * (Hospital COVID Standardized Charge Share – State Average COVID Standardized Charge Share)
- In addition to adding the restriction in 2ii, calculation specifics were revised
  - Definition of COVID claims is more limited
  - FY2021 Standard rates trended forward are used in calculating Standard Charges rather than the FY22 rates.
- See next slide and excel distribution for detailed calculation walk through.

Proposed CY 2022 Approach – Specific Steps

Step	Approach	Original Approach	Rationale
1. Isolate COVID Claims	Include claims where COVID is the primary diagnosis or A41.89 Sepsis is the primary diagnosis	Included all claims with a COVID diagnosis in any position	Prevalence of COVID means many individuals admitted for non-COVID reasons may test positive and have a COVID diagnosis. Sepsis code was identified as the code that increased significantly during COVID crisis, but primary diagnosis would not be COVID.
3. Reprice all FY2022 experience at standard rates	Multiply volumes per experience data by FY2021 standard rates trended forward based on the change in the total GBR from FY21 to FY22	Priced at applicable year standard rates	FY2021 rates trended forward were used to remove the impact of rebasing in FY2022 rates which reduced the capacity in the GBR. Original policy was prior to rebasing.
3. Price COVID claims at standard rates	Calculate COVID claims in 1 at Standard rates in 2 for each hospital	None	
4. Calculate COVID experience above State average	Multiply CY22 GBR by State average share of COVID from #3 and subtract it from the Hospital's experience. Negative amounts are treated as 0.	Not in original approach	
5. Calculate COVID overcharge	If in Step 2 the hospital was overcharged at Standard rates calculate the lessor of the overcharge or COVID claims from Step 3.	None	
6 Determine final COVID Surge funding	Lessor of Step 4 and Step 5	All COVID experience that causes overcharge is funded.	COVID is becoming endemic and therefore only outlier experience should be funded.

Other Policy Notes and Next Steps

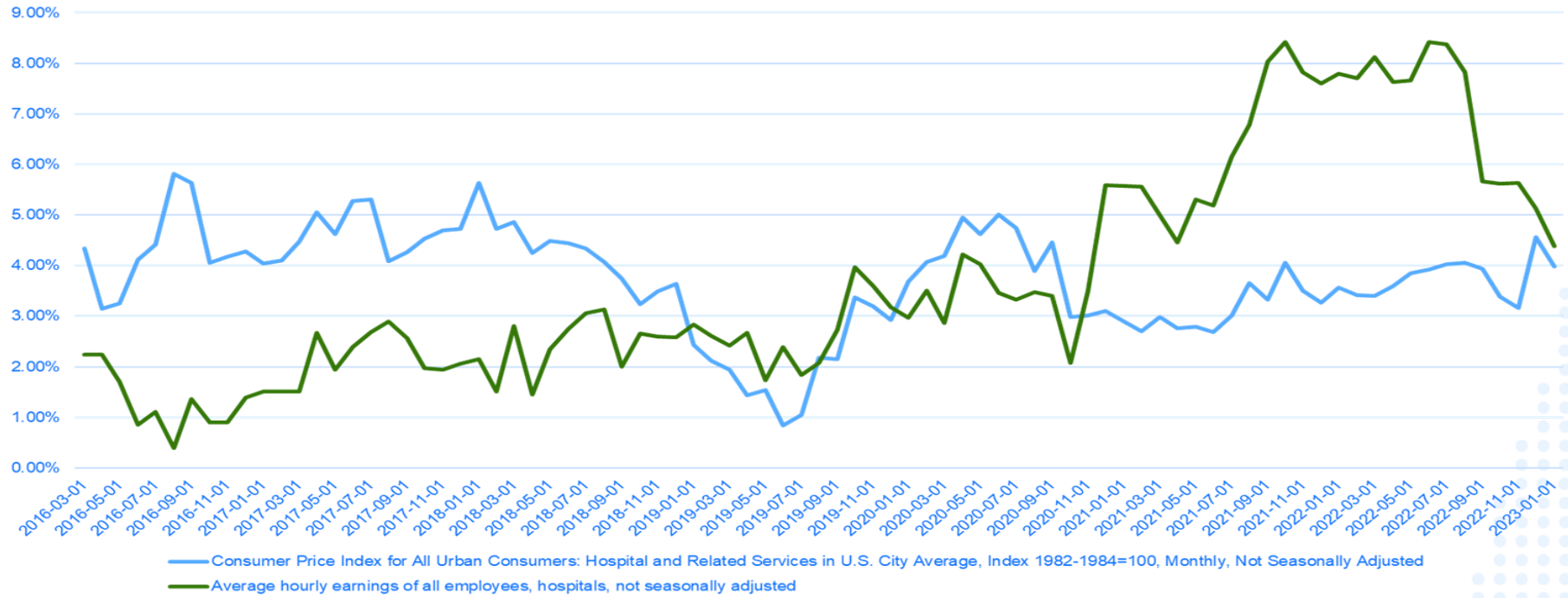
- Related Policy Items
  - Staff is not adjusting for PRF funds due to limited additional funds distributed since the original policy
  - Staff is not intending to make any adjustments for COVID expenses as FY20 and FY21 analysis showed limited exposure and FY22 issues are broader than COVID
  - Staff will include in the recommendation that the Commission make no further special accommodations for COVID as it now part of standard operations and should be managed via standard HSCRC policies
- Formal approval will be included in the Update Factor recommendation

MACRO INFLATION TRENDS

Overview on Inflation

- Altarum's overall Health Care Price Index (HCPI) increased by 2.7% year over year in February.
  - Growth in the HCPI continues to remain remarkably steady, sitting between a tight 2.0% to 3.0% year-over-year growth rate range for 17 of the most recent 18 months.
  - Prices for health care services paid for by private insurance increased by 4.1% in February (up from 3.5% in January), while Medicare prices actually fell slightly last month, down -0.2% year over year.
- Wage growth in health care has been declining since mid-2022 and has now fallen slightly below economywide wage growth.
  - In January 2023, health care wages grew by 4.2% year over year while total private sector wages grew by 4.4%.
  - Wage growth was high between April 2021 and July 2022. Wage growth has substantially eased since then.

Hospital Prices vs Wages



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