maryland
health services
cost review commission

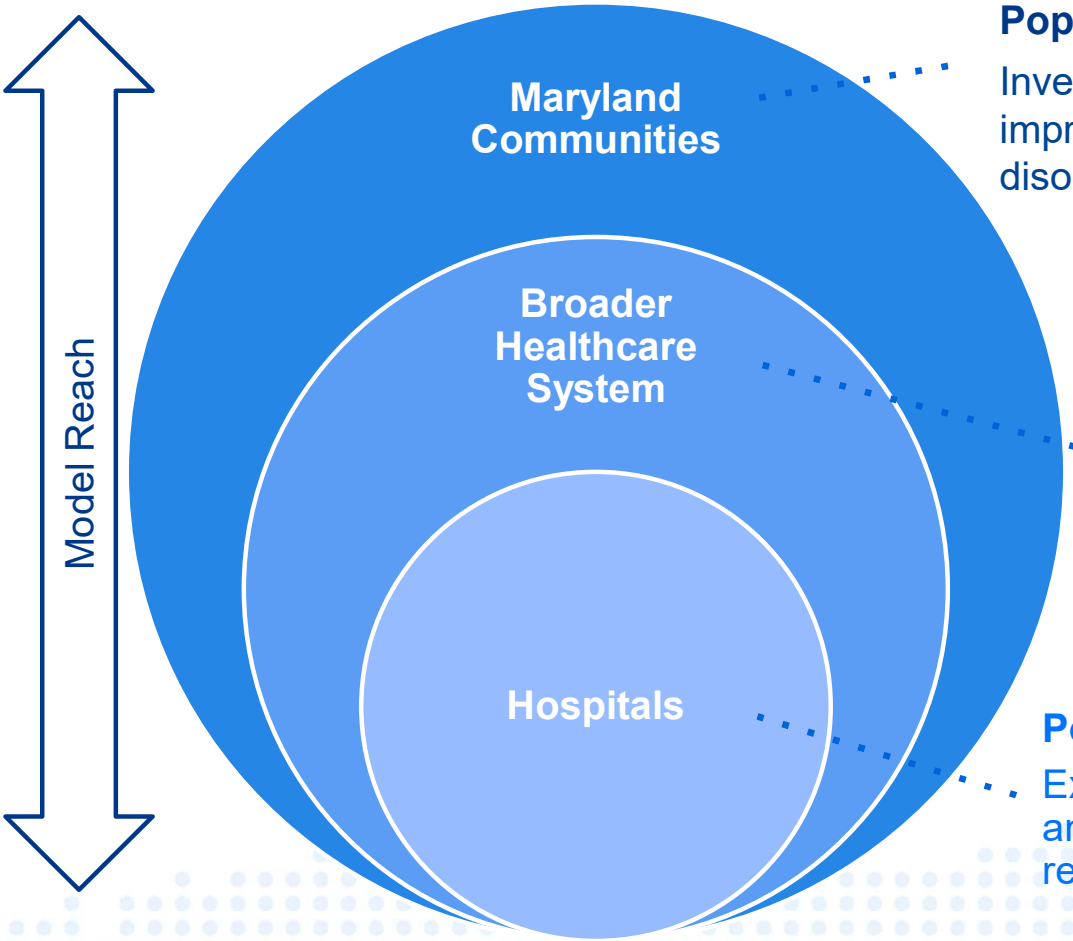
Total Cost of Care Model
AHEAD Model
Improving ED Wait Times

HGO Briefing, January 17, 2023

Jon Kromm, Executive Director, HSCRC

Laura Herrera Scott, MD, MPH, Secretary of Health

TCOC Model Components



Population Health and Health Equity

Investment in initiatives that aim to make statewide improvements in the areas of diabetes, opioid use disorder, and maternal and child health

Payment and Delivery System Reform

Incentives to transform care and create partnerships across settings of care by expanding opportunities for non-hospital provider participation in value-based programs

Population-Based Revenue / Global Budgets

Expanded hospital quality requirements, incentives, and responsibility to control total costs through limited revenue-at-risk

Innovating for Population Wide Impact

Hospital Population-Based Revenues

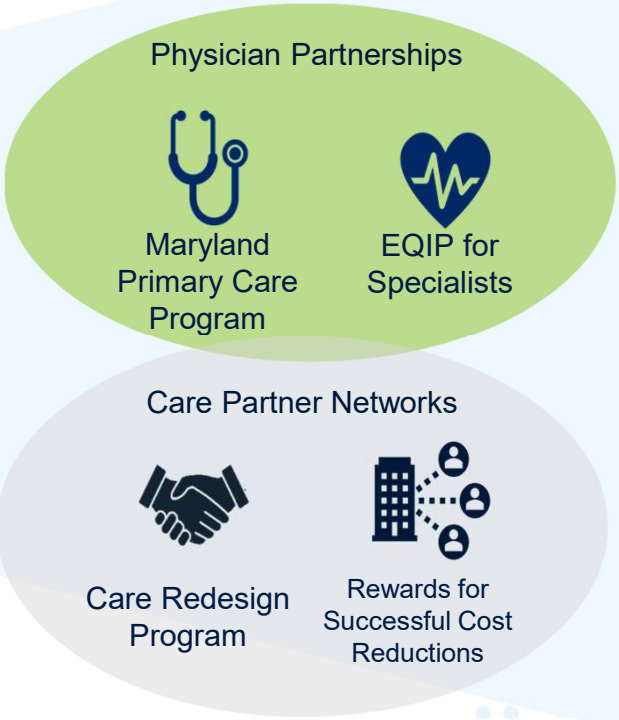
98% **Of hospitals revenues** are under a population-based reimbursement methodology

85% **Of hospitals** with Care Management/ Coordination Clinics

40% **Of hospitals** with Home Visit Programs

7.4% **Of hospital all-payer revenue at risk** for quality outcomes and total costs

Health System Collaboration



Statewide Reach

- Consumer Access, Affordability, and Price Transparency
- Rural Hospital and COVID-19 Support
- Multi-Payer Alignment
- Statewide Integrated Health Improvement Strategy
- Health Equity in all Policies

Performance on CMS Annual TCOC Measures: Years 1-4

Performance Measures	Annual Targets	2019	2020	2021	2022
Annual Medicare TCOC Savings	$120M (2019), $156M (2020), $222M (2021), and $267M (2022) in annual Maryland Medicare TCOC per Beneficiary of savings for MY4 (2022)	✓	✓	✓	✓
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	✓	✓	✓	*
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	✓	✓	✓	✓
Improvement in All-Payer Potentially Preventable Conditions	Improve upon the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	✓	✓	✓	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries	✓	✓	**	**
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	✓	✓	✓	✓

*0.9 percentage points above the National growth rate in 2022 and 0.6 percentage points above in 2021. CMS did not ask the State to take additional corrective action in part because, in December 2022, HSCRC took steps to reduce 2023 growth (should allow the State to meet their 2023 TCOC Guardrail requirement), and because Maryland's 2022 growth was partly based on CMS OACT estimates of growth that were significantly larger than actual growth.

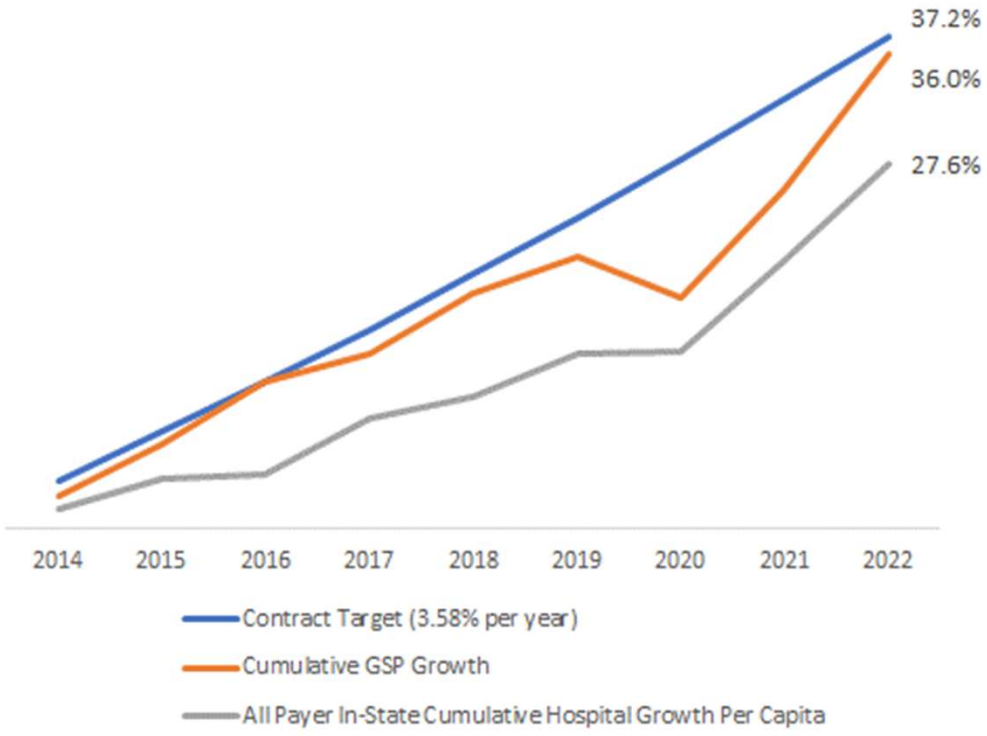
**HSCRC staff has shown the unadjusted readmission rate has increased due to increases in patient acuity in Maryland's hospitals, relative to the nation, an expected effect of GBRs. CMMI has agreed to a risk-adjusted measure but also requested that the State conduct activities related to readmission improvements.

Total Cost of Care Model Results

Quality (since 2019)	Cost**
↓3.8%* Outpatient ED Visits and Observation Stays	**$4.408 Billion** Estimated Medicare Savings through 2013-2023
↓16%* Potentially Preventable Admissions	**15.2 Percentage Points Lower Growth** than National Medicare Spending (2013- Sept. 2023)
↓9.5%* Unplanned Readmissions within 30 days of Discharge	**8.4% Percentage Points Lower** All-Payer Cost Growth than State Gross Product (2013-2022)
↓27%** Complications in Pay-for-Performance Program	

*Mathematica, "Evaluation of the Maryland Total Cost of Care Model: Quantitative-Only Report for the Model's First Three Years (2019 to 2021)", December 2022 (produced under contract with CMS).
** HSCRC Data

Hospital Cost Growth is Below Gross State Product (GSP)



Under the TCOC Model Contract-

- all-payer per capita in-state revenue is not allowed to exceed annual growth of 3.58%
- per capita hospital cost growth is well below both the model target and actual State GSP Growth.

HSCRC Health Equity Initiatives

Hospital Quality Pay-For-Performance Programs

- Measures hospital-acquired infections, patient experience and satisfaction, unplanned readmissions, and potentially avoidable utilization
- Aligned with broader State health initiatives
- Increasing focus on disparities, including first in the nation readmissions disparities pay-for-performance program that started in FY 22

Special Funding Programs

- Funded more than 118,000 COVID vaccines in communities with low healthcare access
- Funded increases in behavioral health crisis services capacity, including crisis stabilization centers (2 on the eastern shore and 1 coming soon in Prince George's County) and mobile crisis response services

Data and Hospital Reporting

- One of the best hospital data sets in the country
- High quality data on race
- Current focus: improve data on sexual orientation and gender

Financial Assistance and UCC Funding

- Hospitals are required to provide free care to all patients under 200% FPL and discounted care to patients under 300% FPL
- Financial assistance is provided regardless of immigration status
- HSCRC's policies support access to care in low-income communities by equitably distributing UCC funding to hospitals

Other TCOC Updates

Maryland Primary Care Program

Advanced Primary Care Program with increased care management, quality measures, and behavioral health integration

- 500+ primary care practices
- 380,000+ Medicare Beneficiaries
- Health equity payments to increase support for high-risk patients

Care Transformation Initiatives

Opportunity for hospitals to earn a reward for innovations in care delivery that save Medicare dollars.

- $130 M scored savings for Maryland
- $56 M redistributed between hospitals as penalty/benefit

Episode Quality Improvement Program

Popular value-based payment programs for specialty physicians

- 5,000+ specialist physicians
- $20 M scored gross savings in EQIP

Revenue for Reform

New opportunity for hospitals to retain revenue for investments in-

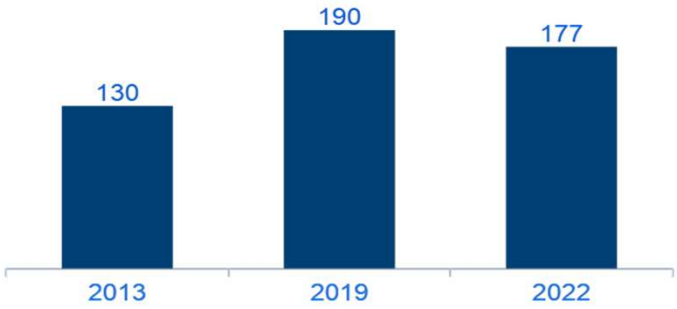
- evidence-based population health investments outside of the hospitals, or
- Primary care, behavioral health, and dental providers

Investments must be connected to national, State, and/or local population health goals

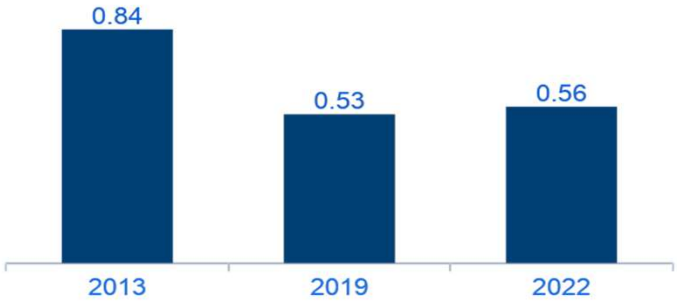
Growing Financial Strength

- Balance sheets of Maryland hospitals are stronger now than prior to hospital global budgets. Days cash on hand has increased while debt ratios have improved.
- Collectively Maryland's not-for-profit hospitals had over **$13 Billion** in cash and investments at the end of Fiscal Year 2022.
- Hospitals emerged from the pandemic with relatively small deterioration in balance sheet strength
- Margins have varied with economic conditions but since the start of global budgets average margins have been higher than prior to global budgets.
- Maryland hospitals in rural and low-income areas receive higher total public payer reimbursement per person than peer hospitals in other states.

Days Cash on Hand



Debt to Unrestricted Net Assets



Source: Metrics are shown as of June 2013 (pre-GBR), June 2019 (pre-pandemic) and June 2022 (most recent period available). Hospital Audited Financial Statements. Amounts are system-level not regulated entity balances, and generally reflect cash, and short and long-term investments, excluding those with donor or other restrictions but including board-designated funds. Excludes primarily non-Maryland domiciled systems: WMHS, ChristianaCare Union, Ascension and Trinity. Adventist data is as of December 31, 2021. See appendix for system values.

AHEAD Overview

Maryland
DEPARTMENT OF HEALTH

Vision

Equity and Excellence in Maryland's Health Care Delivery System that Improves the Health of All

Maryland
DEPARTMENT OF HEALTH

States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

Statewide Accountability Targets

Medicare and All-Payer Cost Growth, Medicare and All-Payer Primary Care Investment, and Equity and Population Health Outcomes through State Agreements with CMS

Components

Cooperative Agreement Funding

Hospital Global Budgets (facility services)

Primary Care AHEAD

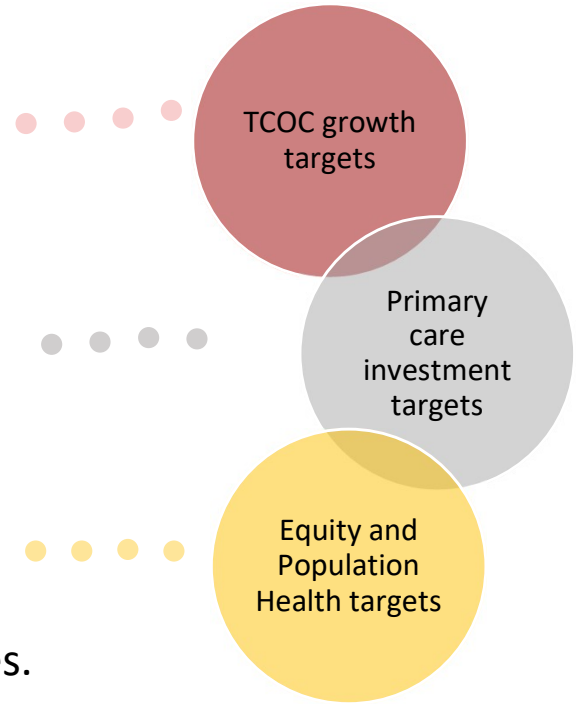
Strategies

- Equity Integrated Across Model
- Behavioral Health Integration Across Care Settings
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

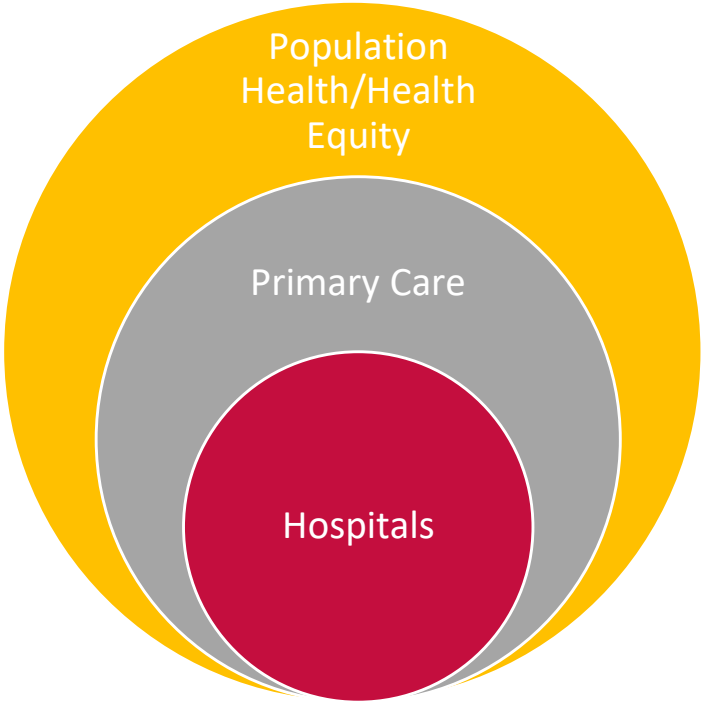
AHEAD Builds on the TCOC Model

The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model is a state total cost of care (TCOC) model designed to:

- curb growth in healthcare cost spending;
- improve population health; and
- advance health equity by reducing disparities in health outcomes.



Similar to the Maryland Total Cost of Care (TCOC) Model, AHEAD focuses on three overlapping domains to achieve its goals.



Maryland DEPARTMENT OF HEALTH

The Maryland Health Model is important to our State

The Maryland Health Model improves the quality of life of Marylanders by:

- Controlling hospital cost growth while enhancing quality (care is provided in the right setting at the right time).
- Guaranteeing equitable funding of uncompensated care
- Stabilizing hospitals in order to ensure access to care in all parts of the state (ex. COVID-19)
- Equalizing hospital charges for all payers (including the uninsured), benefiting consumers, and employers
- Supporting population health and health equity initiatives

Losing the Model would deprive **Maryland communities of these benefits**.

Maryland
DEPARTMENT OF HEALTH

Why AHEAD

The Total Cost of Care TCOC Model agreement, which is key to Maryland's all-payer rate setting authority, is authorized through December 2026.

CMMI developed AHEAD as the federal policy approach for state implementation of population-based payment models.

AHEAD is the pathway to secure continuation of the Maryland Model.

The AHEAD Model enables Maryland to **continue and expand on its long-term commitment** to statewide improvements in healthcare quality while controlling costs.

Maryland
DEPARTMENT OF HEALTH

What Maryland Brings to the Table

The AHEAD Model reflects decades-long lessons from Maryland and other states. Thus, Maryland brings many unique strengths to its AHEAD application, including:

- Maryland has a long history of **successfully financing healthcare on an all-payer basis**.
- Maryland has the opportunity to **harness existing momentum and align** different **health equity promotion activities** at the local and state levels.
- **Maryland's Medicaid program has partnered for decades** with the HSCRC to implement innovative payment models.
- The **robust Maryland Model governance structure** provides a solid foundation for evolution of AHEAD Model governance.
- Maryland's experience **operating the Maryland Primary Care Program** will help advance the goals of Primary Care AHEAD.
- Maryland's **technical expertise in establishing and improving global budgets** is unparalleled.
- Maryland's **decades of investment in a robust data infrastructure** support AHEAD Model success.

Maryland
DEPARTMENT OF HEALTH

TCOC Model and AHEAD

Feature	MD TCOC Model	AHEAD
Hospital Global Budgets	Maryland has a well developed all payer hospital global budget model.	Maryland can use the same methodology under AHEAD, subject to CMS approval.
Cost Targets	Medicare savings target.	Medicare savings target, primary care investment targets, and all payer savings targets (including Medicaid, MA, and commercial insurance)
Primary Care Program	Maryland has a well-developed Medicare primary care program.	A primary care program that is aligned between Medicare and Medicaid is required.
Quality	Maryland has a robust hospital quality program, including a measure on disparities. The MDPCP Program also has a quality program.	Similar hospital quality targets. For other providers/programs, Maryland will select quality measures from a list of measures provided by CMS.
Population Health & Equity	Maryland set population health targets related to diabetes, opioids, maternal morbidity, and childhood asthma.	States will select a set of population health measures from a menu of options provided by CMS. State must develop a health equity plan and equity targets.

Maryland
DEPARTMENT OF HEALTH

Advisory Committees

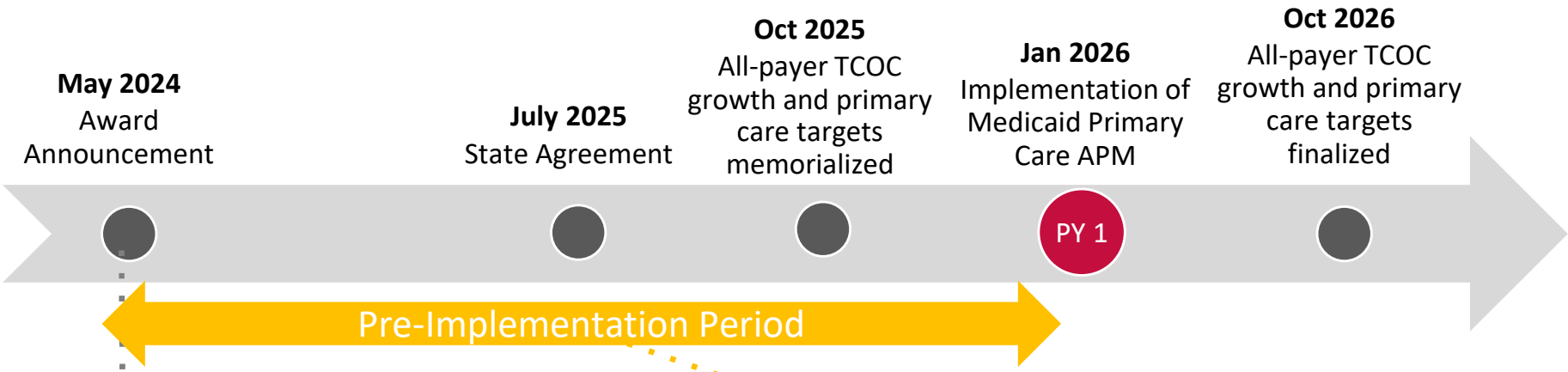
Population Health Transformation Advisory Committee (P-TAC)	Primary Care Transformation Advisory Committee (PCP-TAC)	Healthcare Transformation Advisory Committee (H-TAC)
• Advise the State on the approach to equity-centered population health improvement.	• Advise the State on the approach to equity-centered population health improvement through access to robust, value-based primary care.	• Advise the State on continued transformation of Maryland's healthcare delivery system, including all-payer cost growth targets.

160 applicants.

Clinicians, public health experts, consumers, academic institutions, hospitals, and payers.

Maryland
DEPARTMENT OF HEALTH

Looking AHEAD



Maryland's NOFO response will seek to **leverage new federal resources** to plan for the future of the Maryland Health Model.

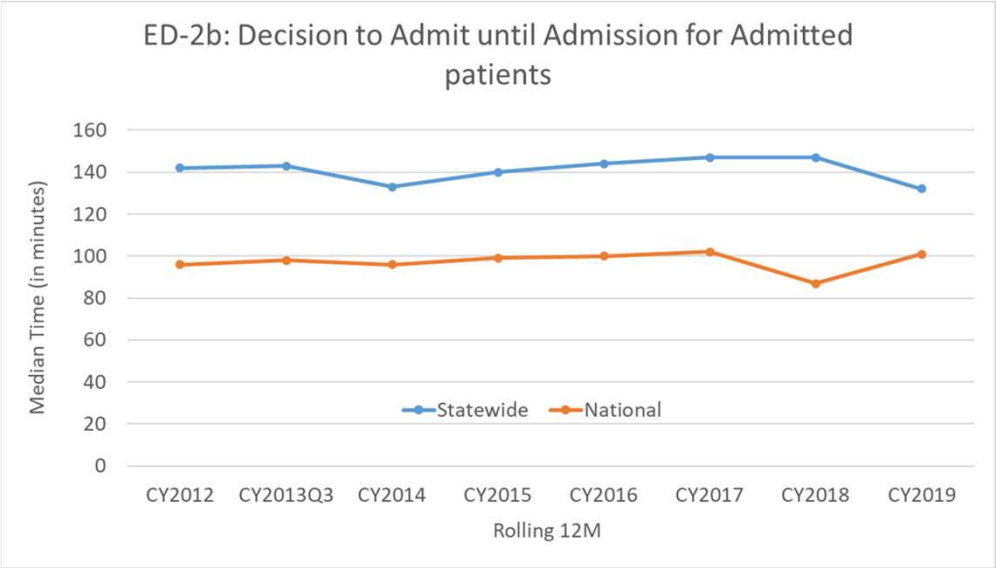
Applying in Cohort 1 will secure **Maryland's role as a leader** in competing for federal funding while providing it **time to negotiate** new model terms prior to 2026 implementation.

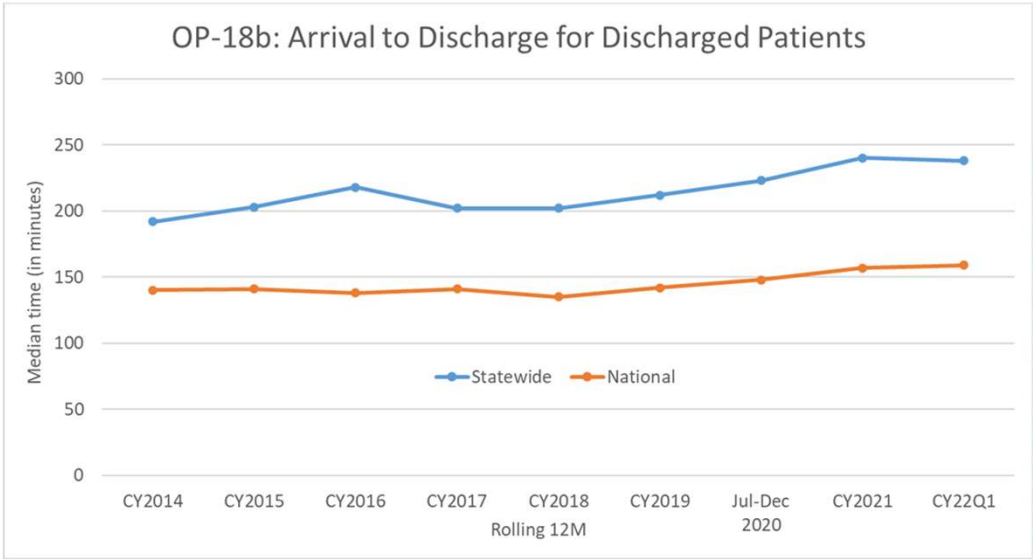
The State envisions that **policy development and decision-making** will begin in July 2024 (the beginning of the Pre-Implementation Period) and continue through the July 2025 execution of the State Agreement. There will be **opportunity for community input** throughout this time frame.

Maryland
DEPARTMENT OF HEALTH

Emergency Department Wait Times

What is the Extent of the ED Wait Times Problem?





- Maryland's performance has been poor since measures were first publicly reported in CY 2012 (CY 2014 for OP-18b), before hospitals were under global budgets on revenue
- Performance gap has remained relatively unchanged

Hospital Factors influence ED Wait Times

- HSCRC analyzed data from all U.S. hospitals to identify factors that contribute to long ED wait times.
- Staffing, bed management, organizational structure and other hospital traits have a large impact on ED wait times.
  - Maryland hospitals are larger, more complex, and more likely to be teaching facilities than other hospitals.
  - Structural factors (Bed size, complexity, teaching status, ED size) are associated with longer ED wait times.
  - Hospital occupancy is an important determinant of ED wait times. Occupancy is impacted by surgical volume, inpatient length of stay, end-of-life ICU days, and nursing home access.
- HSCRC analysis shows that hospital-level interventions can be effective.

Policies that may improve ED wait times

HSCRC analysis finds these policies could be impactful

Addressing Inpatient Occupancy

- Improved hospice access
- Improved palliative care services
- Improved SNF access
- Improved behavioral health access in the community
- Planning elective surgery and medical admissions to avoid constraining ED admissions

Improvements in Primary care

- Maryland Primary Care Program (MDPCP) and other advanced primary care programs
- Increasing primary care supply

Addressing Social Determinants of Health

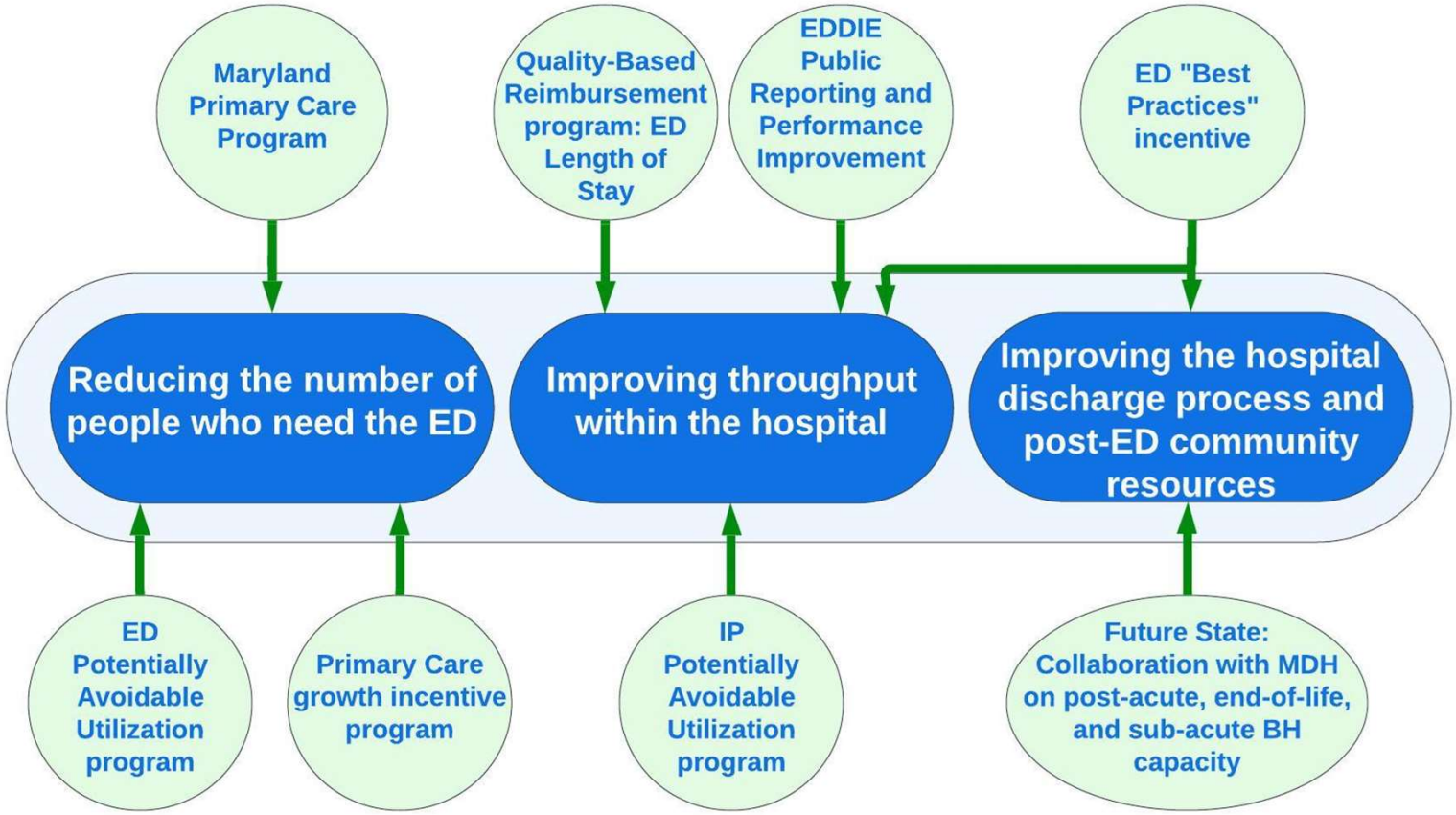
New hospital beds are not the best solution (HSCRC Analysis)

- Expanding inpatient capacity would be a costly solution that has negative implications for TCOC model performance
- Expanding inpatient capacity is a lengthy process
- Adding beds does not change operational and workforce challenges that limit ED throughput

Other solutions reach the same goal

- Ex. Decreasing length of stay to 2019 levels would → an increase of staffed bed capacity by 246 beds, equivalent to a new hospital

Incentives for Improving ED Length of Stay



HSCRC's Specific Actions to Improve ED Wait Times

Emergency Department Dramatic Improvement Effort (EDDIE)

- **Public Data Reporting:** Monthly, HSCRC publicly reports on three ED wait time measures
- **Rapid-Cycle Quality Improvement:**
  - All hospitals submitted goals & provide monthly progress updates
  - Goal: bring Maryland ED wait times towards the national average

Proposed ED Potentially Avoidable Utilization Policy

HSCRC is considering a policy that provides a financial reward to hospitals for reduction in the percentage of ED visits accounted for by patients with 4 or more visits per year

Quality Pay-for-Performance Program

- HSCRC staff are developing an ED wait time measure to include in HSCRC's hospital pay-for-performance quality program.
- CY 2024 data will be used for rate year 2026 adjustments.

Thank you!

- Jon Kromm, Executive Director, HSCRC
  - Jon.Kromm@Maryland.gov
- Laura Herrera Scott, Secretary of Health
  - Laura.HerreraScott@maryland.gov

Legislative Liaisons

- Deb Rivkin, Director of Government Affairs, HSCRC
  - Deborah.Rivkin@maryland.gov
- Sarah Case-Herron, Director of Governmental Affairs, MDH
  - Sarah.Case-Herron@maryland.gov

Appendix

Glossary

AHEAD – States Advancing All-Payer Health Equity Approaches and Development Model, a new model from CMS.

CTIs – Care Transformation Initiatives

CMS – Centers for Medicare & Medicaid Services

ED - Emergency Department

EDDIE – Emergency Department Dramatic Improvement Effort

EQIP - Episode Quality Improvement Program

FFS – Fee For Service

H-TAC – Healthcare Transformation Advisory Committee

ICU - Intensive Care Unit

IP – Inpatient

MHAC – Maryland's Hospital Acquired Condition program, part of HSCRC's hospital quality pay-for-performance program

MDPCP – Maryland Primary Care Program

P-TAC – Population Health Transformation Advisory Committee

PPCs – Potentially Preventable Conditions

PCP-TAC – Primary Care Program Transformation Advisory Committee

QBR – Quality-Based Reimbursement program, part of HSCRC's hospital quality pay-for-performance program

SNF - Skilled Nursing Facility

TCOC – Total cost of care. This may refer to either the Total Cost of Care Model (an agreement between Maryland and CMS) or the total cost of Medicare Part A and Part B services.

GBRs contribute to stable hospital finances

	Total Operating Margin	Regulated Operating Margin
Last 3 Years	1.6%	7.6%
Last 5 Years	1.8%	7.7%
Under GBRs	2.4%	7.9%

- In the most recent period, with the weakest regulated and total margins, margins are positive, indicating resources in total are sufficient to meet financial requirements.
- The Model is intended to generate long-term stability.
- Hospital margins have been stable under GBRs.
- FY22 and FY23 margins were weak mainly driven by worse unregulated margins. HSCRC is seeing some recovery in the first half of FY24.

Based on data through June 2023.