Senate Finance Committee

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice-Chair

Tuesday, January 21, 2025

Agenda

1:00 p.m.

Briefing on AHEAD Model Implementation and Emergency Department Wait Times

I. Maryland Department of Health and Health Services Cost Review Commission

1. AHEAD Model Implementation
Laura Herrera Scott, MD, MPH, Secretary of Health
Jonathan N. Kromm, Executive Director, HSCRC

2. Emergency Department Wait Times
Laura Herrera Scott, MD, MPH, Secretary of Health
Jon Kromm, Executive Director, HSCRC
Tina Simmons, Associate Director, Quality Methodologies, HSCRC

II. Maryland Hospital Association

1. AHEAD Model Implementation
Melony Griffith, President & CEO, MHA
Tom Kleinhanzl, President & CEO, Frederick Health
Patrick Carlson, VP, Health Care Payment, MHA
Andrew Nicklas, SVP, Government Affairs & Policy, MHA

2. Emergency Department Wait Times
Melony Griffith, President & CEO, MHA
Tom Kleinhanzl, President & CEO, Frederick Health
Patrick Carlson, VP, Health Care Payment, MHA
Andrew Nicklas, SVP, Government Affairs & Policy, MHA

AHEAD Overview

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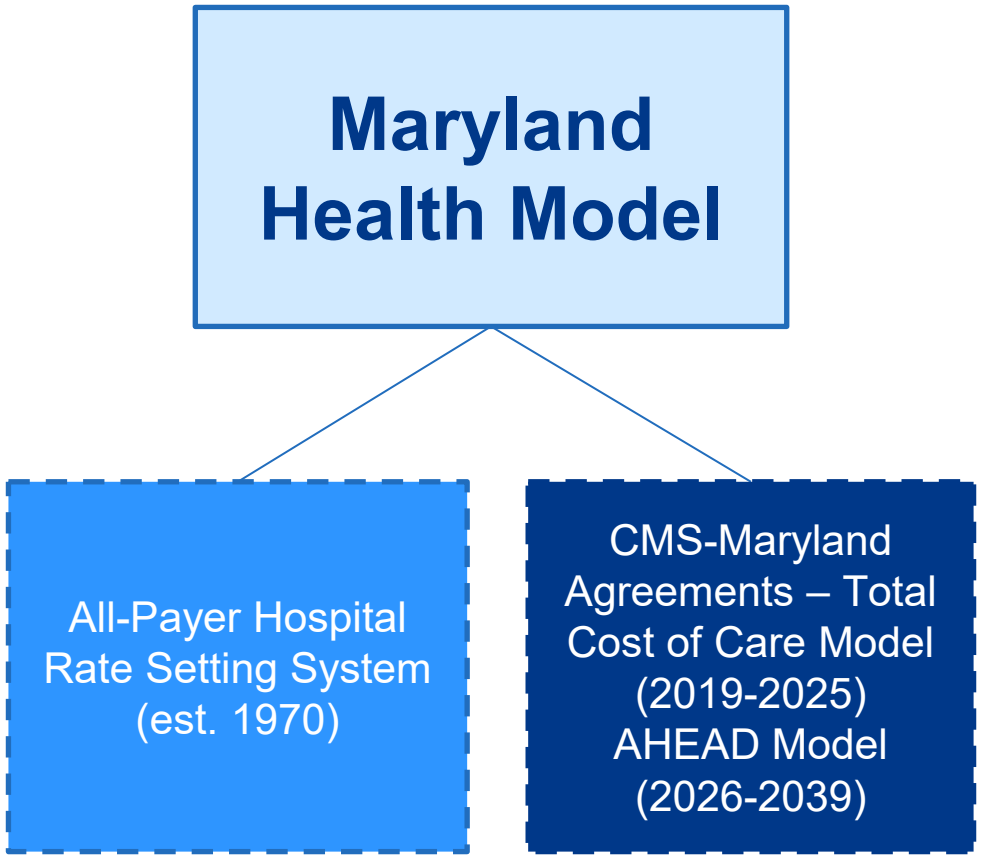
Ensuring a world-class health system for all Marylanders

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

- Community
- Primary Care
- Specialty Care
- Hospital Care
- Post Acute Care
- Palliative Care
- End of Life Care

Equity, Community, & Population Health

Background and Where We are Today (con't)



Strengths of the Maryland Health Model:

- Enables **cost containment** for the public
- Ensures all-payer **hospital charges correlate with costs**
- Guarantees **equitable funding of uncompensated care**
- Creates **transparency and cost savings** for the public and a **stable financing system** for hospitals
- Funds **investments in population health**
- Establishes Maryland as a **leader in linking quality and payment**
- Provides **support for pioneering state healthcare infrastructure** and subject matter expertise
- Incentivizes **care transformation** across all settings of care
- Invests **in primary care**
- Allows for **innovation**

Where Are We Going: 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.

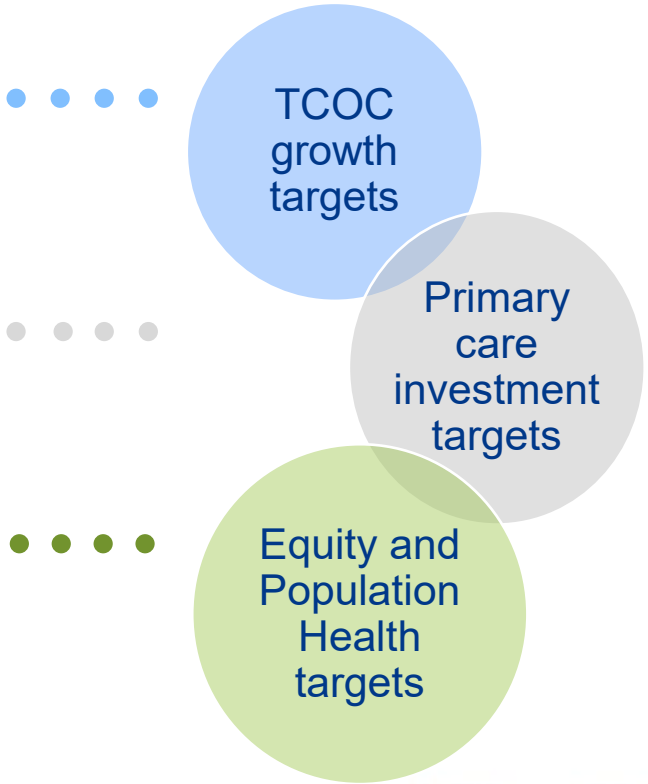
AHEAD is the pathway to secure continuation of the Maryland Model.

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

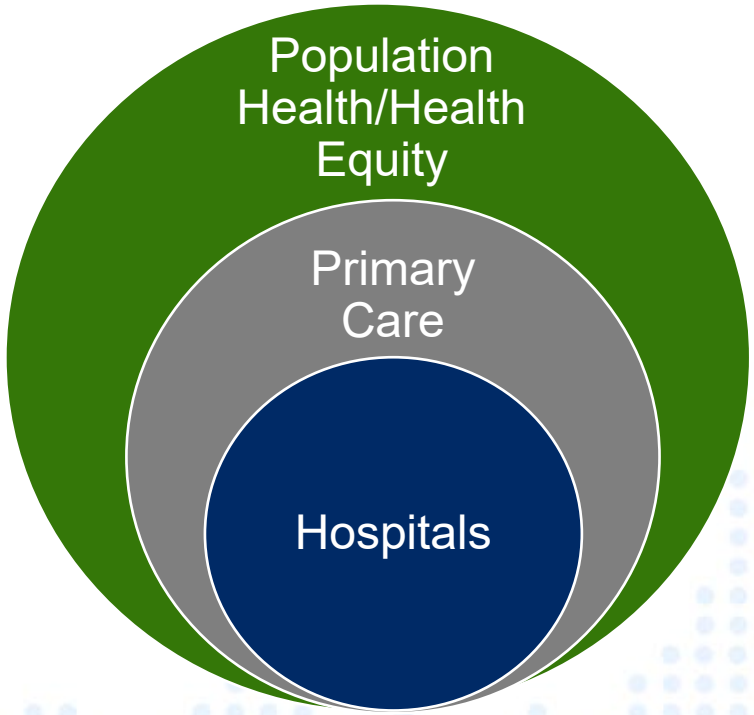
AHEAD Builds on the TCOC Model

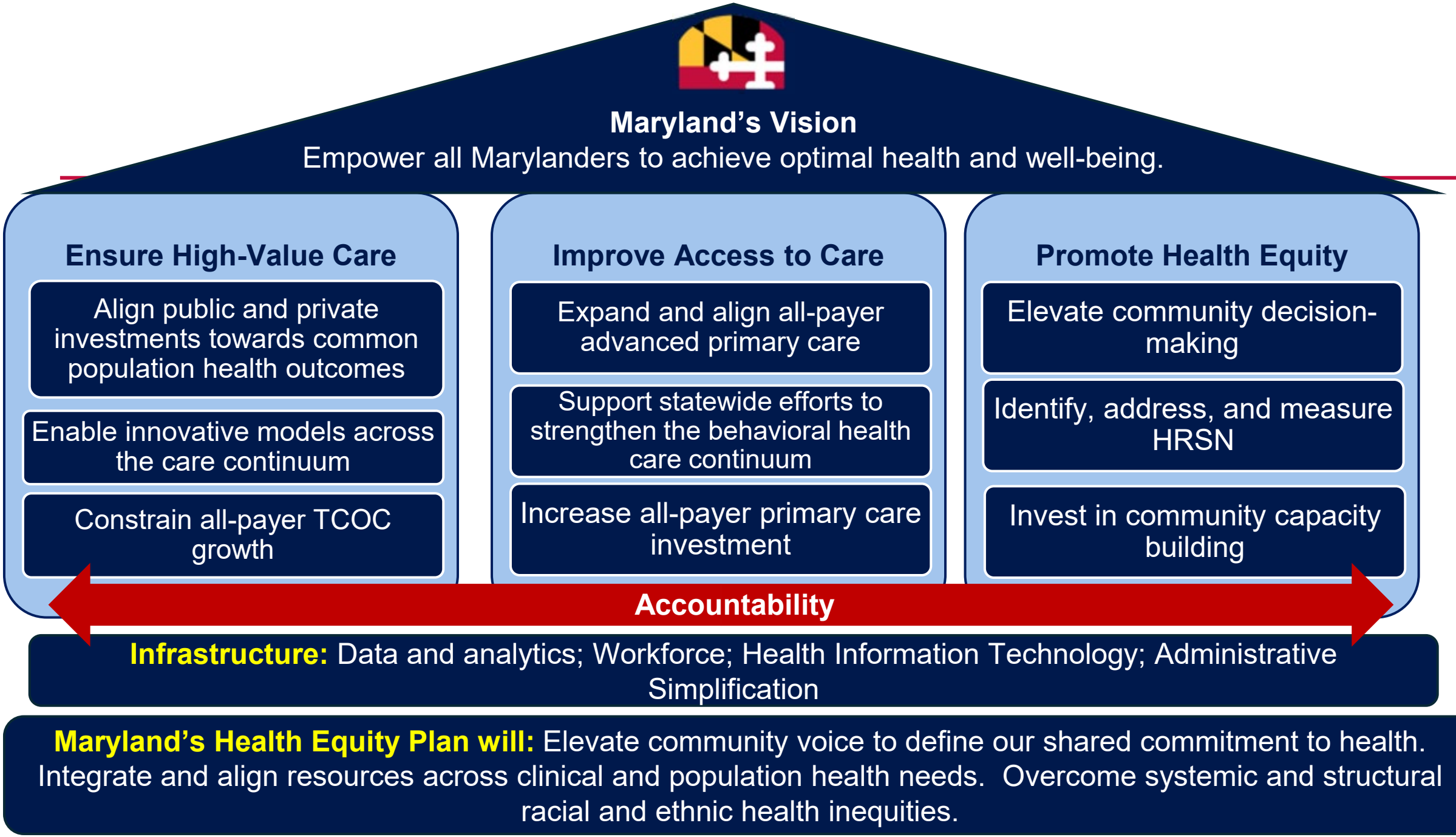
The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model is a state total cost of care (TCOC) model designed to:

- 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's Vision
Empower all Marylanders to achieve optimal health and well-being.
Ensure High-Value Care
Align public and private investments towards common population health outcomes
Enable innovative models across the care continuum
Constrain all-payer TCOC growth
Improve Access to Care
Expand and align all-payer advanced primary care
Support statewide efforts to strengthen the behavioral health care continuum
Increase all-payer primary care investment
Promote Health Equity
Elevate community decision-making
Identify, address, and measure HRSN
Invest in community capacity building
Accountability
Infrastructure: Data and analytics; Workforce; Health Information Technology; Administrative Simplification
Maryland's Health Equity Plan will: Elevate community voice to define our shared commitment to health. Integrate and align resources across clinical and population health needs. Overcome systemic and structural racial and ethnic health inequities.

The AHEAD Model Preserves….

- Maryland receives an additional $1.7B in federal payments for Medicare and Medicaid patients.
- Hospital rates for public payers (Medicare and Medicaid) are higher than rates at peer hospitals nationally.
- There are no reimbursement negotiations across payers - HSCRC sets rates based on costs, and all payers pay the same hospital rates.
- Uncompensated Care (UCC) is equitibly funded across payers and hospitals.

The AHEAD Model…

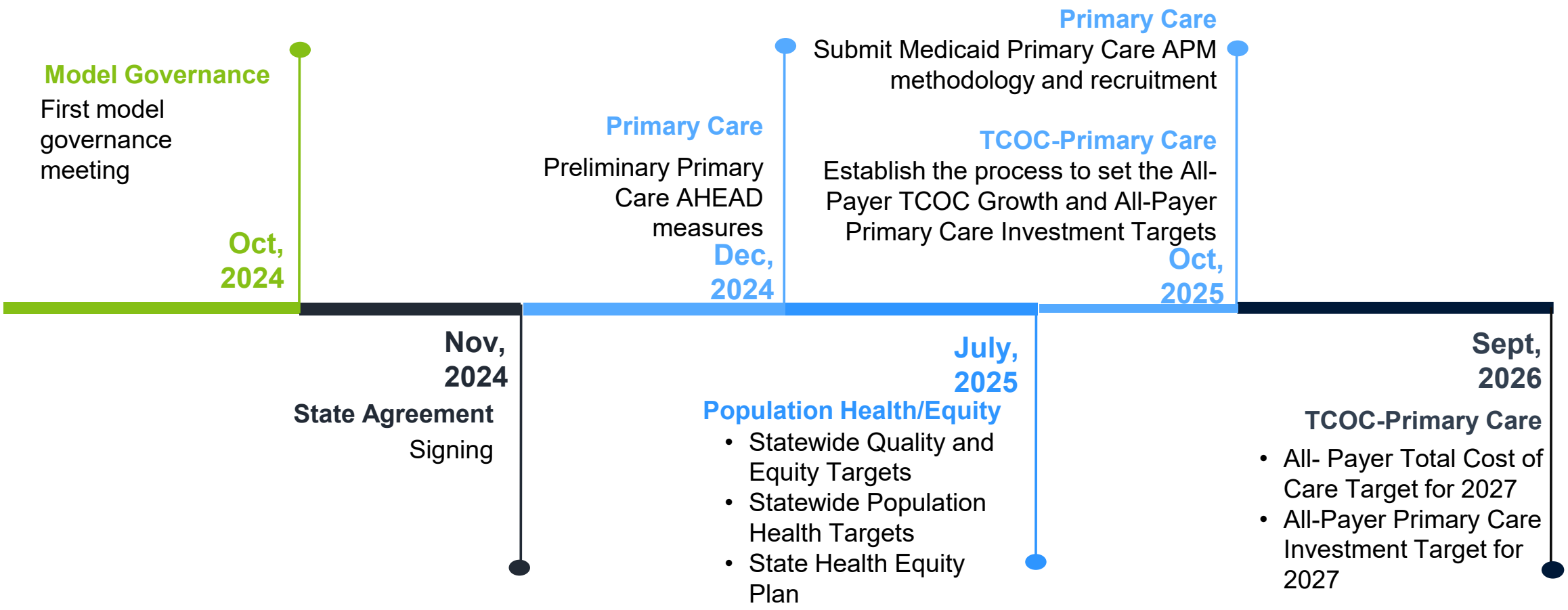
- Establishes a State-wide Health Equity Strategy
- Helps Fund Investments in Population Health
- Continues Improvements in Healthcare Affordability
- Supports State Healthcare Delivery Infrastructure
- Provides State With Access To Critical Data
- Incentivizes Care Transformation Beyond Hospitals

AHEAD Model State Agreement

The AHEAD Model State Agreement creates a framework for partnership between the State and CMMI during the AHEAD pre-implementation and implementation periods. The agreement-

- Memorializes CMMI's commitment to Maryland's all-payer hospital rates; and
- Preserves the State's authority to set policy to manage hospital global budgets, population health, the MDPCP, and health equity.

Timeline of AHEAD Major Milestones



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Maryland Commission on Health Equity (MCHE) Update

Laura Herrera Scott, MD, MPH
Secretary

Membership Composition

HB 1333 - rolling off

- Agriculture
- Commerce
- Environment
- General Services
- Information Technology
- Juvenile Services
- Labor
- Natural Resources
- State Police
- Transportation
- Veterans Affairs
- Commissioner of Correction

Continuing Members

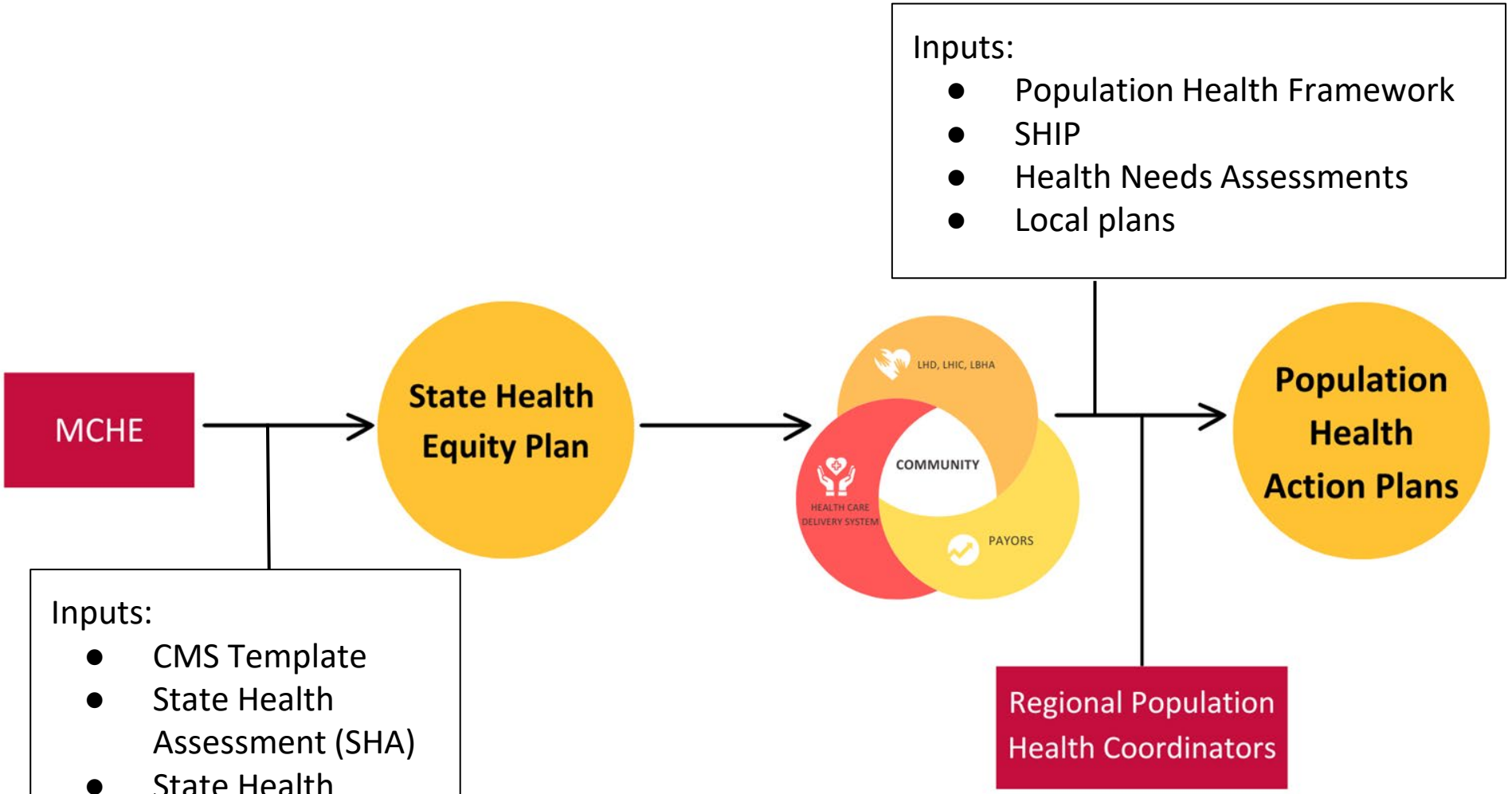
- Senate
- House of Delegates
- Aging
- Budget and Management
- Disabilities
- Superintendent of Schools (Education)
- Housing and Community Development
- Human Services
- Planning
- Behavioral Health Administration (BHA)
- Public Health Services (PHS)
- Insurance
- Maryland Association of County Health Officers (MACHO)

HB 1333 - newly added

- Deputy Secretary of Health Care Financing
- Executive Director of HSCRC
- Executive Director of the Office of Minority Health and Health Disparities (MHHD)
- Executive Director of the Maryland Health Care Commission (MHCC)
- Executive Director of the Maryland Community Health Resources Commission (CHRC)
- Hospital representative
- Hospital-based population health (2)
- FQHC representative
- CBO representative (2)
- MCO representative
- Commercial insurance representative
- Clinicians not affiliated with an FQHC or hospital (2)
- State's office on rural health representative,
- Tribal community representative
- Patient representative from underserved community (2)

Overall, the total membership of MCHE increases from 26 members to at least 33 members.

Proposed SHEP Implementation Process



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State Health Equity Plan (SHEP)

- CMS has provided a template for state's to use for SHEP development
- SHEP contains 5 key parts:
    1. Identifies health disparities and population health focus areas
    2. Sets measurable goals to reduce disparities and improve population health
    3. Identifies evidence-based strategies to advance towards goals
    4. Informs plans for allocating resources
    5. Develops processes to include stakeholders in implementation
- SHEP can be informed by existing work (e.g. State Health Improvement Plan)

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State Health Equity Plan components

5 Core Domains +1 "Optional" Domain

1. Population Health
2. Prevention and Wellness
3. Chronic Conditions
4. Behavioral Health
5. Health Care Quality and Utilization
6. "Optional" domain - Must pick 1 of the following:
   - Maternal Health Outcomes
   - Prevention Measures
   - Social Drivers of Health

- A State Health Need must be identified for each Domain
- MD must select an aligned AHEAD measure AND set a population health target in each domain
- MD must set a target for a sub-population experiencing a disparity for at least one of the AHEAD measures (equity target)

Deadline: SHEP is due to CMS by July 2025

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Data Advisory Committee (DAC) Representation

Maryland Department of Health (MDH) *	Community Health Resources Commission (CHRC)
Chesapeake Regional Information System for our Patients (CRISP) *	Commercial Payor
Health Services Cost Review Commission (HSCRC)	Maryland Primary Care Program CTO
Maryland Health Care Commission (MHCC)	Local Health Department
Behavioral Health Administration (BHA)	Community organization involved in health-related social needs
Maryland Medicaid	Population Health and/or Health Equity Researcher
Maryland Hospital Association (MHA)	Patient
Hospital - Urban	PCP/Community Health Center
Hospital - Rural	

* Denotes co-chair

DAC Member Roster

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Health Services Cost Review Commission & the Maryland Department of Health: Emergency Department Briefing

January 21, 2025

Addressing the Issue

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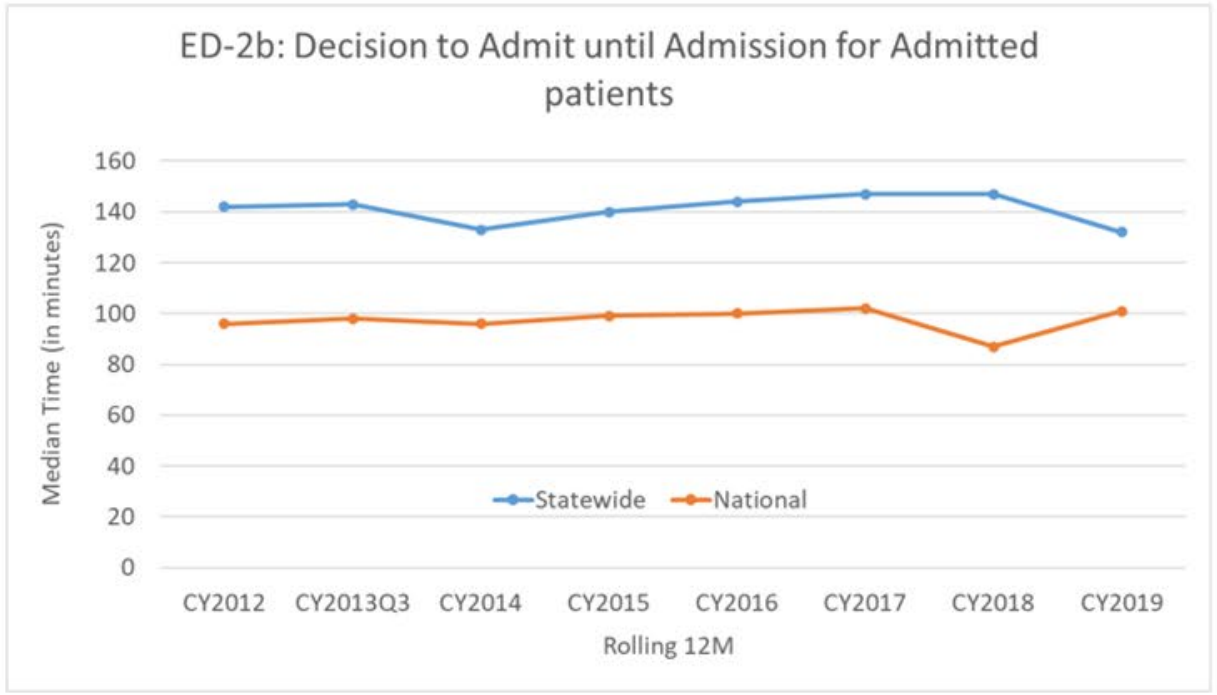
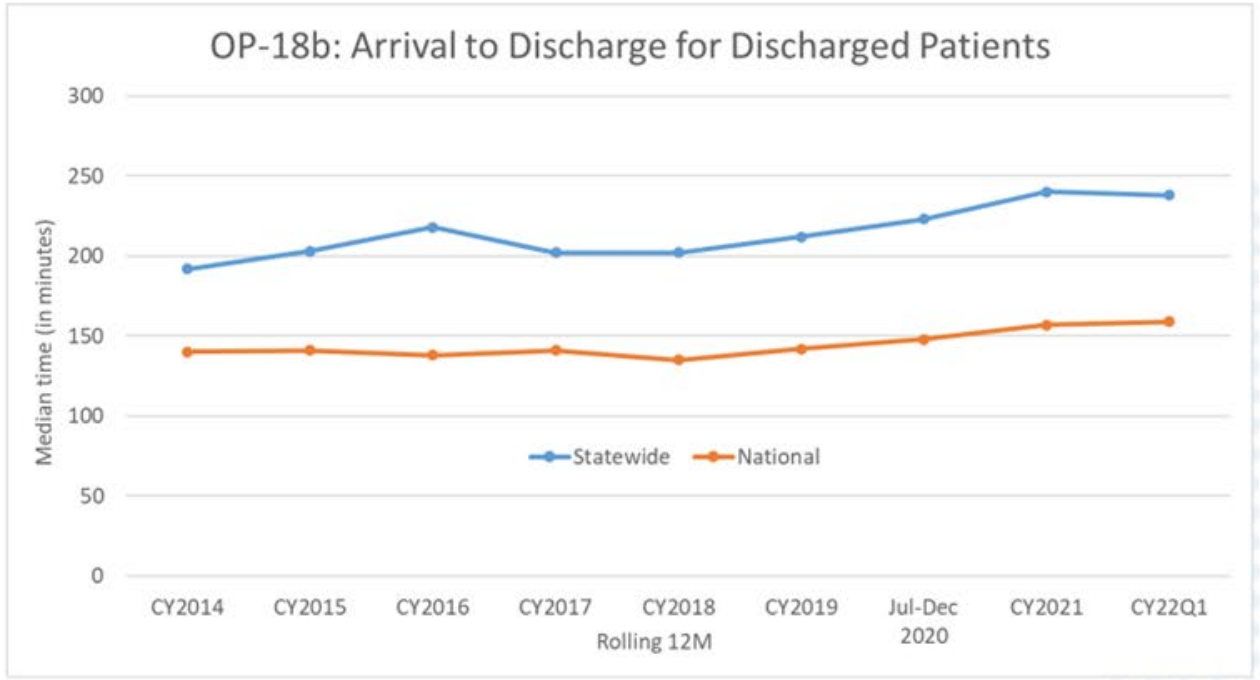
What is the Extent of the ED Length of Stay Problem?





Maryland's ED Length of Stay (LOS) was first publicly reported CY 2012.

ED Length of Stay - Hospital Factors

Key Hospital Factors

- Institutional Complexity
- Hospital Capacity
  - Length of stay
  - Bed distribution and type
  - Staffing
- ED Volume

Non-Hospital Factors

- Skilled Nursing Facility (SNF) Capacity
- Access to Primary Care
- Access to Behavioral Health Care

Additional Factors

- Surgical Intensity
- End of Life Care
- Teaching Status
- Urban Service Area

Ongoing ED Focused Work to Date Prior to Commission

Emergency Department Dramatic Improvement Effort (EDDIE)

EDDIE is a Commission-developed quality improvement initiative that began in June 2023 with two components:

EDDIE: Improved ED Experience for Patients

Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED throughput/length of stay
- Learning collaborative
- Convened by MHA

Commission Reporting

- Public reporting of monthly data for three measures
  - ED-1, OP18, EMS Turnaround times
- Led by HSCRC and MIEMSS

Staff may propose suspending EDDIE data collection once ED LOS can be routinely calculated from case-mix date and time stamps

Quality Based Reimbursement (QBR) Program

Purpose

To incentivize quality improvement across three patient-centered quality measurement domains:

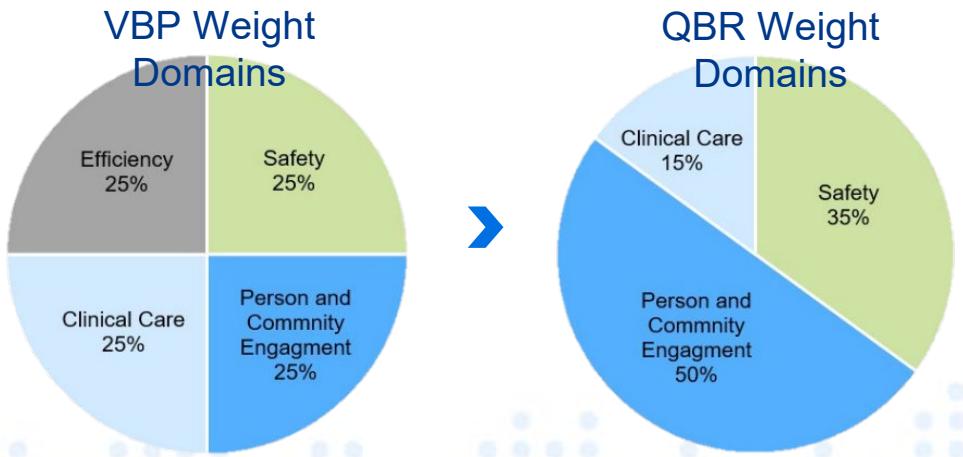
1. **Person and Community Engagement (HCAHPS)** - 8 survey-based measures + follow-up + ED Length of Stay
2. **Clinical Care** - inpatient mortality rate + hip/knee replacement complication rate
3. **Safety** - 6 measures of in-patient Safety (National Healthcare Safety Network (NHSN) Healthcare Associated Infections) + Patient Safety Index (PSI-90)

How it Works: Revenue-at-Risk

The Program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)

Federal Alignment

The QBR program uses **similar measures to the federal Medicare Value-Based Purchasing (VBP) program** but has an all-payer focus and adjustable domain weights that focus on MD-specific improvements.



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MDH Actions to Address ED Wait Times

1915(i)

Mobile Crisis and Crisis Stabilization

ACIS Expansion

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1915(i) Services

A component of Medicaid plans that provides home and community-based behavioral health services (HCBS) that supports youth and their families in their communities

Services include:

- Intensive In-Home Services
- Respite Services
- Family Peer Support
- Experiential and Expressive Therapies

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1915(i) Proposed Changes

- 12/27/24 released for public comment
  - Key proposed changes included:
    - Increase the timeframe that a face-to-face psychosocial assessment must be completed or update to within 60 days of submission
    - Expand participant eligibility to include a score of 2 for both the CASII and ECSII
    - Expand participant eligibility so participants who receive a score of 5 or higher on the CASII do not have to meet additional needs-based criteria
    - Update the frequency for POC reviews and CFT meetings from every 30 days to 60 days
    - Remove the separate reimbursement for telephonic peer support services and clarify that FPSS can be provided in-person and via audio-visual and audio-only telehealth, and consolidate the maximum units of service to 27 hours per month
    - Add coverage of Youth Peer Support Services

https://health.maryland.gov/mmcp/Documents/Public%20Notice/SPA%20MD-25-00xx%201915%28i%29%20Public%20Notice%20and%20Draft.pdf

https://health.maryland.gov/mmcp/Pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx

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Urgent & Acute Care Service Continuum

Someone to Call	*Someone to Respond*		*Somewhere Safe to Go*
			
988 Helpline	Community-Based Mobile Crisis Response & Stabilization	Crisis Receiving & Stabilization Facility Services	Post-Stabilization Support, Care Coordination

Adapted from Pearsall & Wilkness, NASHP Brief, April 2023

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Improve and Expand Mobile Crisis Teams

- In-person support by a team, including a licensed behavioral health professional and often a peer
- Available 24/7/365 to go to individual in the community
  - e.g., home, school, public setting (not a hospital)
- Services to de-escalate, assess, stabilize, and make warm handoffs to treatment; conduct follow up
- Continue to support evidence-based youth/family response and stabilization model

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Assistance in Community Integration Services Pilot Overview

- ACIS pilot has been in effect since July 1, 2017.
- Provides housing and tenancy related services and supports to qualifying individuals experiencing housing insecurity.
- Local health departments or other local governmental entities are eligible to apply and serve as Lead Entities; contract with local service providers to deliver services.
- To qualify for ACIS, Medicaid participants must meet specific health and housing needs-based criteria.
- Currently Maryland has 900 spaces allocated across Baltimore City, Cecil, Montgomery and Prince George's County.

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ACIS Expansion

- The Department is requesting an amendment to expand the Pilot to better serve the eligible population, facilitated by the inclusion of $5.4 million in state general funds.
- The Department's request is twofold:

  1) To update existing payment methodologies to require ACIS LEs to bill through the standard claiming process; and

  2) To allow an additional 1,240 participant spaces for the ACIS pilot to facilitate participation from additional jurisdictions within Maryland.

MD Emergency Department Wait Time Reduction Commission

Establishment of Maryland ED Wait Time Reduction Commission

Bill went into effect July 1, 2024, and terminates June 30, 2027, Annual Reports due Nov 2025 and Nov 2026

- ***Purpose:*** To address factors throughout the health care system that contribute to increased Emergency Department wait times
- ***Specific focus:*** Develop strategies and initiatives to recommend to state and local agencies, hospitals, and health care providers to reduce ED wait times, including initiatives that:
  - *Ensure patients are seen in most appropriate setting*
  - *Improve hospital efficiency by maximizing flow of ED and Inpatient (IP) throughput*
  - *Improve postdischarge resources to facilitate timely ED and IP discharge*
  - *Identify and recommend improvements for the collection and submission of data*
  - *Facilitate sharing of best practices*

ED Wait Time Reduction Commission & Subgroup Composition

- HSCRC Staff
- MDH Staff
- Maryland Institute for Emergency Medical Services Systems Representative
- Maryland Health Care Commission Representative
- Managed Care Plan Representative
- Physicians and RNs with leadership experience in the ED
- Local EMS
- Behavioral Health Providers
- Advanced Primary Care Practice Representative
- Patient Advocacy Organization Representative
- Chesapeake Regional Information System for our Patients (CRISP)
- KPMG
- Mathematica

ED Wait Time Reduction Commission:

Collaborate on behavioral health, post-acute, primary care, and other areas of opportunity.

Improve Access

Maryland Primary Care Program

Expand Behavioral Health Framework

SNF/Post-Acute

Implement Hospital Payment Programs to Improve Clinical Care

MD Hospital Quality Policies

ED "Best Practices" Incentive

Increase Transparency

MHCC Public Quality Reporting

ED Dramatic Improvement Effort

Reduce Avoidable Utilization

Programs to optimize high value care and reduce avoidable utilization

Reducing the number of people who need the ED

Improving throughput within the hospital

Improving the hospital discharge process and post-ED community resources

Increasing Transparency

Workforce Issues

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Commission Wait Time Reduction Subcommittees

Access to Non-Hospital Care

- Integrate and optimize best practices and data analytics for advanced primary care, specialty care, home health, post-acute care, and ancillary services in an effort to reduce avoidable ED and hospital utilization and improve care transition workflows throughout the continuum of care.
- Meetings every six to eight weeks.

Data Subcommittee

- Identify different data sources across healthcare platforms to include ambulatory, acute care, post-acute care, and third-party data.
- Meetings every six to eight weeks.

ED Hospital "Throughput" Best Practices

- Develop a set of hospital best practices and scoring criteria to improve overall hospital throughput and reduce ED length of stay, advise on revenue at-risk and scaled financial incentives, and provide input on data collection and auditing.
- Meetings every four weeks.

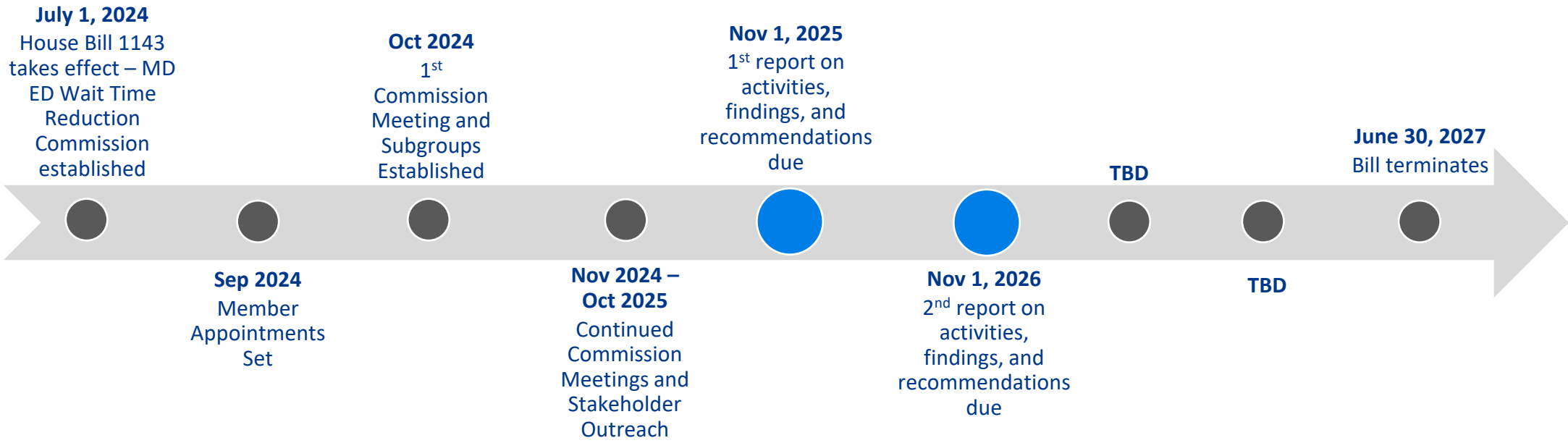
Hospital Capacity, Operations & Staffing

- Subgroup will convene in April 2025.
- Planned focus of the subgroup is to assess access and capacity across the State, collaborate with commercial payers, Medicare, and Medicaid, and optimize workforce development opportunities.
- Meetings every four to six weeks.

Key Priorities

- **Key Priority Identified: Hospital Throughput & ED Boarding**
- Staff are focusing on the following key drivers impacting hospital throughput & ED boarding:
  - **Optimize capacity across the continuum of care (ambulatory, acute, post-acute, and community resources)**
  - **Care transitions within the hospital that impact length of stay (best practice subgroup focused on these efforts)**
  - **Care transitions to post-acute levels of care, inclusive of skilled nursing, palliative care, and home health**

Commission Timeline



- HSCRC maintains ongoing collaboration with the Maryland Department of Health, hospital representatives, state agencies, and industry stakeholders while communicating about upcoming meeting dates, agendas, and priorities.
- HSCRC has implemented monthly meetings with the Maryland Hospital Association leadership to discuss ongoing priorities including the ED Wait Time Reduction Commission.
- All Emergency Department Wait Time Reduction Commission and subgroup materials are available on the HSCRC webpage: https://hscrc.maryland.gov/Pages/ED-WTR-Commission.aspx

LEGISLATIVE BRIEFING: AHEAD MODEL

January 2025

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OVERVIEW

Maryland Hospital Association Overview

Maryland Hospitals: A Track Record of Success

AHEAD Model: New Opportunities to Care for Patients & Communities

Preparing for AHEAD: Ensuring a sustainable future for hospitals

MHA MISSION

Maryland Hospital Association

Advancing health care and the health of all Marylanders

MHA serves Maryland's hospitals and health systems through collective action to shape policies, practices, financing and performance to advance health care and the health of all Marylanders.

60+ MEMBERS


Adventist HealthCare
Adventist HealthCare White Oak Medical Center
Adventist HealthCare Rehabilitation
Adventist HealthCare Shady Grove Medical Center
Adventist HealthCare Fort Washington Medical Center
MedStar Good Samaritan Hospital
MedStar Union Memorial Hospital
Mt. Washington Pediatric Hospital
NORTHWEST HOSPITAL
CARE BRAVELY
MedStar Harbor Hospital
MedStar Health
MedStar Southern Maryland Hospital Center
TidalHealth
SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE
Encompass Health
Rehabilitation Hospital of Salisbury
MedStar Franklin Square Medical Center
MedStar Montgomery Medical Center
Ascension Saint Agnes
MedStar St. Mary's Hospital
UNIVERSITY of MARYLAND UPPER CHESAPEAKE MEDICAL CENTER
ATLANTIC GENERAL HOSPITAL
Children's National
Luminis Health
Anne Arundel Medical Center
Luminis Health
JOHNS HOPKINS MEDICINE
THE JOHNS HOPKINS HOSPITAL
BROOK LANE
ChristianaCare
Mercy
BALTIMORE, MD
LEVINDALE
A LifeBridge Health Center
CARE BRAVELY
UNIVERSITY of MARYLAND ST. JOSEPH MEDICAL CENTER
UPMC WESTERN MARYLAND
CalvertHealth
NIH Clinical Center
UNIVERSITY of MARYLAND CAPITAL REGION MEDICAL CENTER
CARROLL HOSPITAL
A LifeBridge Health Center
CARE BRAVELY
Frederick Health
JOHNS HOPKINS MEDICINE
Howard County Medical Center
UNIVERSITY of MARYLAND CAPITAL REGION HEALTH
GARRETT REGIONAL MEDICAL CENTER
WVUMedicine
UNIVERSITY of MARYLAND LAUREL REGIONAL HOSPITAL
JOHNS HOPKINS MEDICINE
JOHNS HOPKINS BAYVIEW MEDICAL CENTER
JOHNS HOPKINS MEDICINE
LIFEBRIDGE HEALTH
UNIVERSITY of MARYLAND MEDICAL CENTER
GBMC
HOLY CROSS HEALTH
A Member of Trinity Health
UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH
UNIVERSITY of MARYLAND CHARLES REGIONAL MEDICAL CENTER
Sheppard Pratt
GRACE MEDICAL CENTER
A LifeBridge Health Center
CARE BRAVELY
UNIVERSITY of MARYLAND MEDICAL SYSTEM
Encompass Health
Rehabilitation Hospital of Bowie
Kennedy Krieger Institute
SINAI HOSPITAL
A LifeBridge Health Center
CARE BRAVELY
UNIVERSITY of MARYLAND BALTIMORE WASHINGTON MEDICAL CENTER

MARYLAND HOSPITALS: 5 THINGS TO KNOW

Over 5 Million Lives Touched Annually

Beyond the Bedside: $2.09 Billion in Community Benefit

Backbone of Maryland's Economy: Support for 223,000 Jobs

Caring for Maryland's Most Vulnerable: $2.2 Million Daily in Care for Those Unable to Pay

National Model for Health Care

A TRACK RECORD OF SUCCESS

- Maryland hospitals **drive innovation** under Maryland's unique Model through health care payment reform
- In the All-Payer Model and the Total Cost of Care Model, hospitals generated **$4.6 billion in Medicare savings** through high-quality, efficient care delivery
- Hospitals **reduced disparities** in unplanned readmissions, preventable admissions, and timely follow-up by race and place
- The AHEAD Model builds on this legacy with an even greater focus on **equity and population health** and creates new opportunities to improve the health of Marylanders

CARING FOR COMMUNITIES ACROSS THE STATE

WHAT HOSPITALS DO…

ACUTE CARE

- Provide life-saving interventions for emergencies (e.g., injuries, trauma, stroke, heart attack)
- Deliver high-quality care for acute illnesses and injuries through 24/7/365 emergency services
- Manage complex conditions using advanced technology and specialized expertise
- Ensure smooth transitions to post-acute or rehabilitation care for recovery

COMMUNITY WELLNESS/PREVENTION

- Promote healthy lifestyles through campaigns on nutrition, exercise, and smoking cessation
- Provide screenings and early detection for chronic diseases like diabetes and cancer
- Address social determinants of health, including housing, food security, and transportation
- Partner with organizations to support underserved and at-risk populations
- Lead vaccination drives and public health initiatives to prevent disease outbreaks

AHEAD MODEL:
NEW OPPORTUNITIES TO CARE FOR PATIENTS & COMMUNITIES

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MOVING AHEAD

The AHEAD Model creates new opportunities to develop partnerships and share accountability across the health care spectrum and reinforce the importance of population health and health equity.

Population Health

Health Equity

Partnerships

OPPORTUNITY: POPULATION HEALTH

Population Health

- Hospitals will play a critical role in leading local interventions that focus on identifying populations that are most at risk for poor outcomes and developing targeted interventions that improve health.

OPPORTUNITY: HEALTH EQUITY

Health Equity

- Each hospital will create health equity plans, in alignment with the State Health Equity Plan, to demonstrate how equity is actively incorporated in hospital operations, strategies, and services.

OPPORTUNITY: PARTNERSHIPS

Partnerships

- Hospitals will partner across the care spectrum to improve care coordination and ensure patients get care at the right time and in the right setting.

PREPARING FOR AHEAD:
ENSURING A SUSTAINABLE FUTURE FOR HOSPITALS

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BUILDING A SUSTAINABLE FUTURE FOR MARYLAND HOSPITALS

Gaps in Primary Care

The AHEAD Model aims to strengthen primary care through increased investment and resources.

Today, primary care is still limited in certain communities.

Unique Role of Hospitals

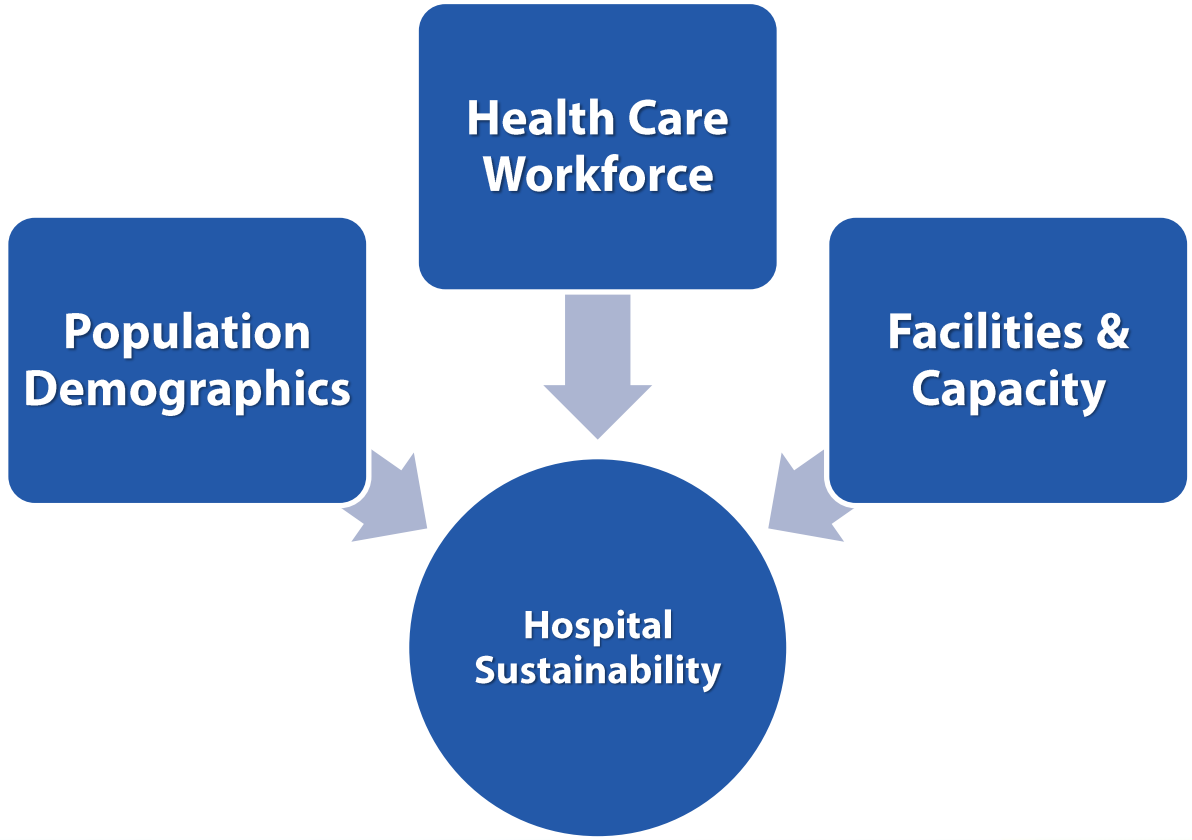
- Hospitals are a critical safety net for Marylanders, providing 24/7/365 care for acute and complex health needs for communities with limited resources and for patient needs that are above and beyond primary care services.

Comprehensive Health Care Access

- Hospitals must be sustainable to provide Marylanders with the full spectrum of essential health care services.

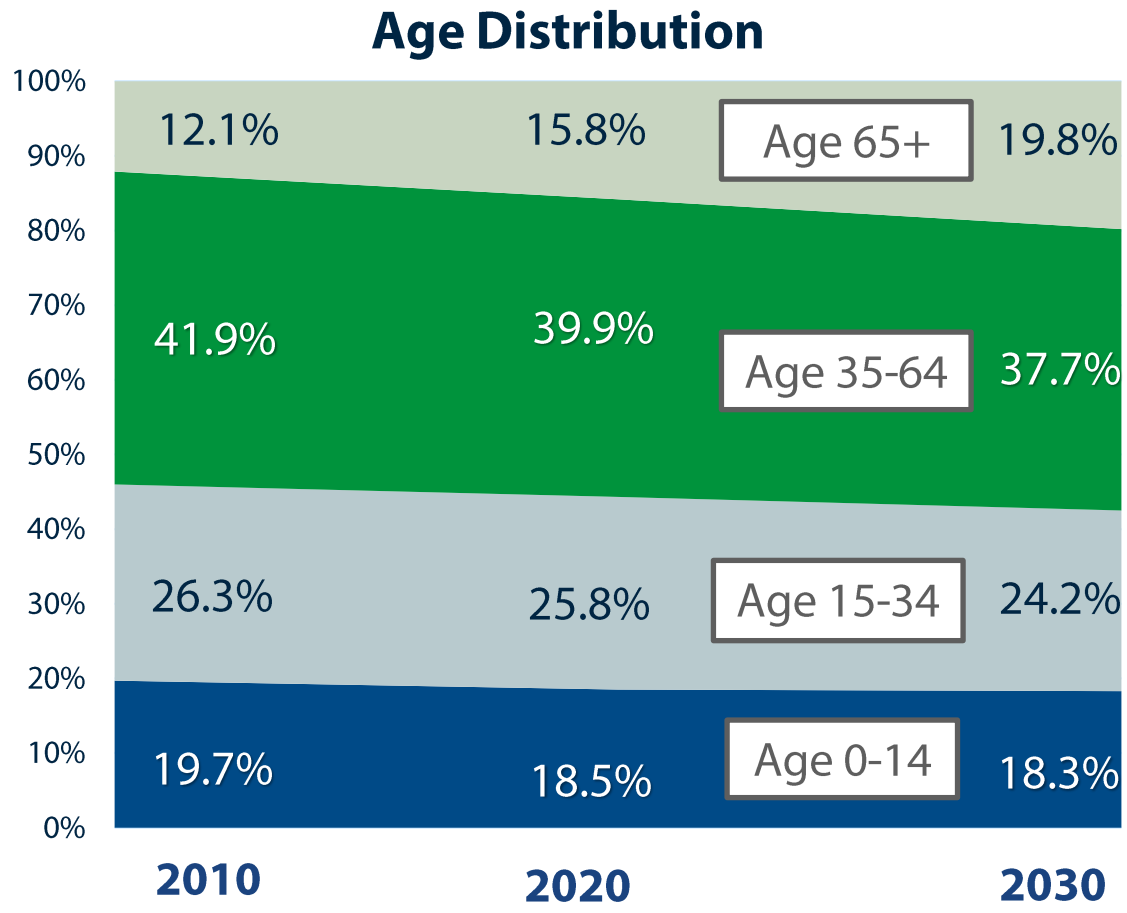
HEALTHY HOSPITALS AND COMMUNITIES

Hospitals need AHEAD Model policies that ensure they are prepared to provide the 24/7/365 access that communities rely on.



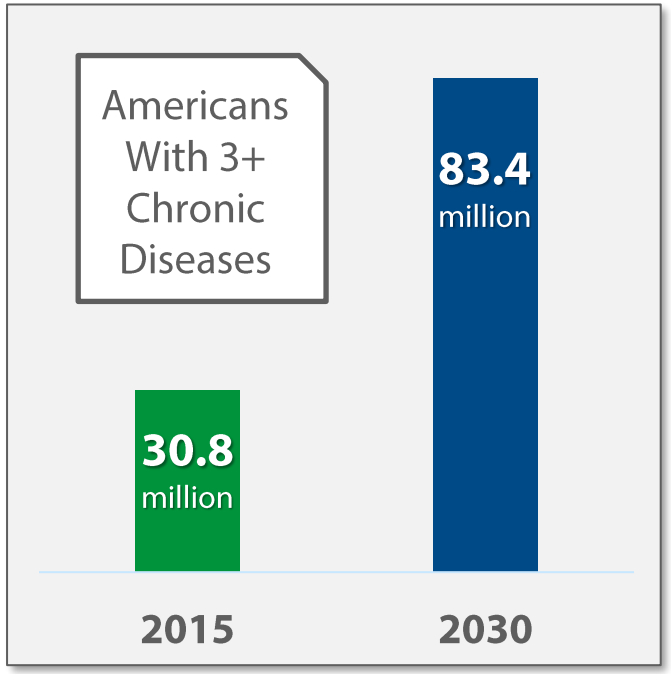
POPULATION DEMOGRAPHICS: GROWING AND AGING POPULATION

- Maryland's population is growing, aging, and becoming more complex with multiple chronic conditions.
- The demand for hospital care will only increase.
- Hospitals must be equipped to handle these changing needs for everyone's health and safety.



Source: Maryland Department of Planning, Projections and State Data Center, 2017

POPULATION DEMOGRAPHICS: CHRONIC DISEASE BURDEN RISING



***Heart disease** costs expected to **triple** by 2030, to **$818** billion, or **17%** of U.S. health spending*

SPOTLIGHT: FUTURE OF DIABETES IN MARYLAND

	Total Pop. 2020	Total Pop. 2030	65+ Pop. 2030
Prediabetes	28.9%	29.8%	51.0%
Diagnosed with Diabetes	9.7%	11.6%	18.9%
Undiagnosed with Diabetes	3.4%	3.7%	7.0%
Total with Diabetes	**13.1%**	**15.3%**	**25.9%**

"Maryland is projected to spend $11.1 billion by 2025 on diabetes-associated health care, including costs related to prediabetes and undiagnosed diabetes. Nearly 50 percent of these costs are projected to come from the senior population."

Sources: Milken Institute, Costs of Chronic Disease in the U.S., 2018; American Heart Association, "Costs of heart disease will triple between now and 2030," 2018; Institute for Alternative Futures, Maryland Diabetes Data and Forecasts, 2015; Maryland Dept of Health, Diabetes Outcomes-Based Credit Methodology under the Maryland Total Cost of Care Model, 2019

FACILITIES & CAPACITY

The AHEAD Model creates opportunities to revisit policies to support hospital modernization and ensure health care infrastructure keeps pace with evolving needs.

Address Maintenance Needs

Allocate resources for routine upkeep of hospital facilities statewide to ensure safe, functional, and efficient settings

Increase Capacity

Expand space and resources to accommodate the growing demand for acute and complex care services, safeguarding quality care for all patients

STRENGTHENING RECRUITMENT AND RETENTION

Hospitals need skilled physicians, nurses, and staff

Rising costs of health care staff must be addressed to prevent shortages and maintain care quality

Policies must support hospitals' ability to attract and retain these critical staff members

PREPARING FOR AHEAD

The AHEAD Model provides Maryland with an opportunity to further deliver on the promise of healthy communities and healthy hospitals.

HEALTHY COMMUNITIES

- Develop new initiatives to improve care delivery & outcomes:
  - ✓ **Population Health interventions and goals**
  - ✓ **Statewide Health Equity Plan & Hospital Specific Health Equity Plans**
  - ✓ **Partnerships across the health care spectrum**

HEALTHY HOSPITALS

- Adopt policies, regulations, or legislation to ensure hospitals are resourced to:
  - ✓ **Support the growing and increasingly complex patient population**
  - ✓ **Modernize facilities, address routine maintenance needs in buildings, and ensure capacity**
  - ✓ **Recruit and retain essential physicians, nurses, and other hospital staff**

FOR MORE INFO

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EMERGENCY DEPARTMENT WAIT TIMES OVERVIEW & IMPROVEMENT EFFORTS

January 2025

Maryland
Hospital Association

OVERVIEW

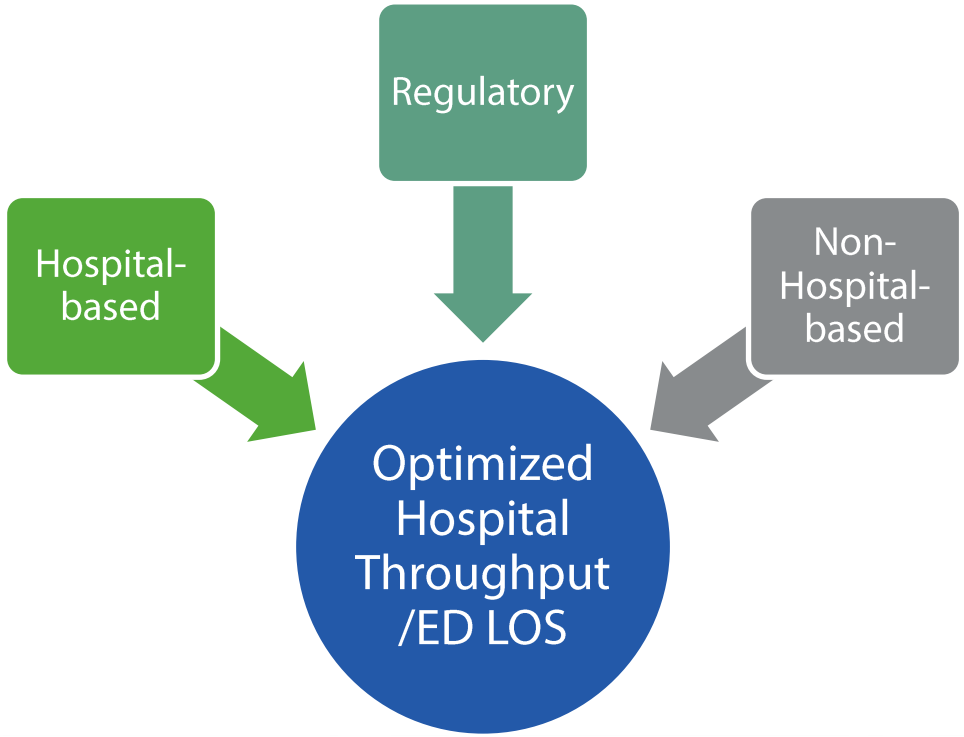
Hospital Initiatives to Address Throughput

Maryland Health Services Cost Review Commission (HSCRC) Policies

Non-hospital Areas of Focus

EFFORTS AIMED AT OPTIMIZING HOSPITAL THROUGHPUT AND ED LOS

Success requires integrating all domains. By aligning efforts across these areas, we can achieve sustainable improvements in patient flow and ED performance.



HOSPITAL BASED INITIATIVES

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MHA HOSPITAL THROUGHPUT COLLABORATIVE

- **Timeline:** August 2023 - July 2024
- **Purpose:** Engaged hospitals around opportunities to improve hospital throughput by:
  - Sharing and identifying common challenges and barriers;
  - Discussing approaches to measure key driver processes;
  - Expanding the view of hospital experiences to account for unique geographical and demographic issues;
  - Enhancing engagement across multidisciplinary stakeholders.

HOSPITAL THROUGHPUT IMPROVEMENT TARGETS

Hospitals submitted inventory of performance improvement efforts and best practices implemented within their organizations across the full spectrum of hospital flow: **Input, Throughput and Output.** Each participating hospital defined at least one AIM statement to improve outcome or process measure(s) identified as a key driver of hospital throughput and ED wait times.

Input	Throughput	Output
• EMS offload • ED patient treatment cycle • ED patient triage	• Inpatient length of stay • ED to IP care transition	• Early discharge identification • Discharge time of day • Discharge lounge

REGULATORY INITIATIVES

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HSCRC POLICY DEVELOPMENT

- Emergency Department Length of Stay
  - Hospitals supported ED LOS measure in payment policy.
    - Hospitals held financially accountable for ED LOS performance
    - *MHA and the field supported including this measure in payment policy*
- Hospital ED Best Practices Policy
  - Incentivizes hospitals to improve throughput performance by optimizing the implementation of industry standards and best practices.
- Emergency Department Dramatic Improvement Effort (EDDIE).
  - MHA throughput collaborative

NON-HOSPITAL AREAS OF FOCUS

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THEMES

INFRASTRUCTURE AND SYSTEMS

INCREASE ACCESS TO PREVENTATIVE AND POST-ACUTE CARE

WORKFORCE ,OVERSTAYS, & CAPACITY

INFRASTRUCTURE & SYSTEMS

Enhance Maryland behavioral health infrastructure and systems

- Improve care coordination and placement within & outside MD
- Increase reimbursement for residential treatment providers and other community settings to ensure adequate access to care
- Enhance targeted case management and other wraparound services for the SMI population to enable care in the community

Reform Public Disclosures of Payer Denials and Address Increasing Denial Rates

- Enhance transparency and refine data disclosures around payer denials
- Examine and reform factors that contribute to excessive denial rates such as the use of AI in claims reviews and prior-authorizations

INCREASE ACCESS TO PREVENTATIVE & POST-ACUTE CARE

Expand access to preventative care – primary and urgent care – and support treatment at the highest level for the service area

Expand access to and care coordination with post acute providers such as skilled nursing facilities and nursing homes – including limitations on transportation to expedite discharge

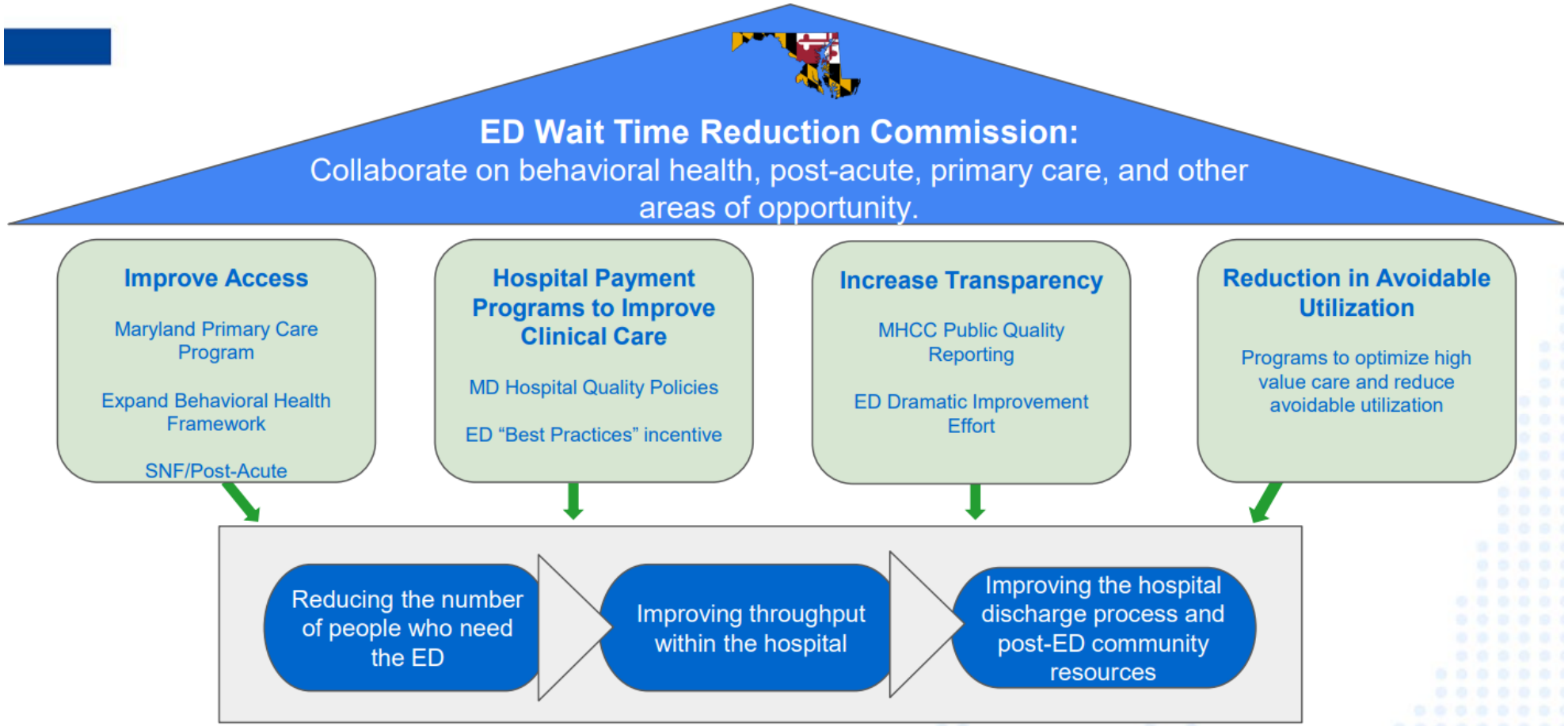
WORKFORCE, OVERSTAYS, AND CAPACITY ISSUES

Enhance workforce development across the continuum of care including clinical and non-clinical emergency department staff

Address overstays – patients 'stuck' in hospitals beyond medical necessity – by increasing community based pediatric behavioral care settings and improving guardianship process

Ensure Maryland hospitals can accommodate demands for care – especially with growing and aging population

STATEWIDE ED WAIT TIMES REDUCTION COMMISSION



FOR FOLLOW UP AND QUESTIONS – PLEASE CONTACT

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