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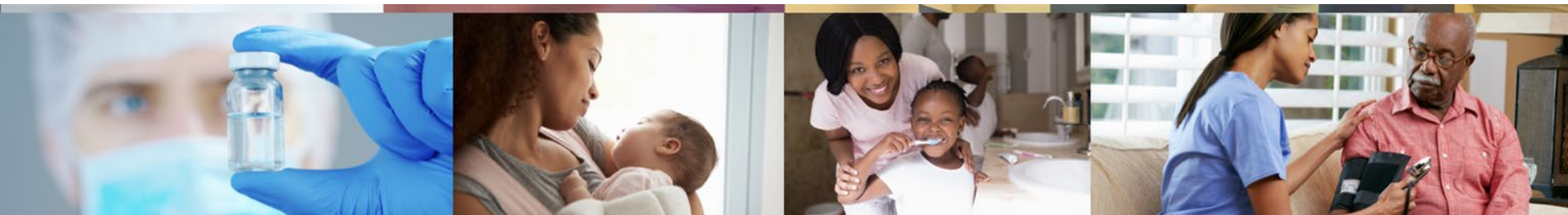
Healthcare Transformation Advisory Committee
Meeting 2

Jon Kromm, Executive Director of the HSCRC

Marie Grant, Assistant Secretary for Health Policy

February 16, 2024



Technical Logistics

- For speaking/asking questions:

  Members (Panelists):

  - Please **use the "Raise hand" function** at the bottom of your screen and unmute yourself once the presenter has recognized you to speak ***OR*** send a **chat message** to "All Panelists."
  - If you have technical issues, please **send a chat message to Rick Stoddard** (Host).

  Non-members (Attendees):

  - There will be a public comment period at the end of the meeting. Please **use the "Raise hand" function** at the bottom of your screen and unmute yourself once the presenter has recognized you to speak during the public comment period.
  - You may also send written comments to mdh.maryland-model@maryland.gov email if you wish or if we run out of time during the public comment period.

- Muting (Everyone): Unless you have raised your hand and have been recognized to speak, **please keep yourself on mute**.
- Closed Captioning (Everyone): M**ay be turned on/off by clicking the "CC" icon** in the lower left corner of the Webex window.

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Agenda

- Introductions
- AHEAD requirements refresher
- Recap meeting 1
- Priorities for healthcare transformation in Maryland's AHEAD model
- Public comment

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H-TAC Member List

- Andrew Pollack, M.D.
(University of Maryland Medical System)
- Benjamin Lowentrit, M.D., FACS
(Chesapeake Urology)
- David Krajewski
(LifeBridge)
- Delegate Emily Shety
(House of Delegates, District 18)
- Ed Beranek
(Johns Hopkins Health System)
- Gene Ransom
(MedChi)
- Johanna Fabian-Marks
(Maryland Health Benefit Exchange)
- John Colmers
- Jonathan Patrick, M.D., FACC
(MedStar Health)
- Josh Repac
(Meritus Health)
- Lori Golden
(UnitedHealth)
- Maria Maguire, M.D., MPP, FAAP
(Health Officer - Talbot County)
- Melony Griffith
(Maryland Hospital Association)
- Paul Miller
(Lifespan)
- Reverend Sandra Conner, Ed.D.
(Healthcare For All)
- Robin Moter-Mast, D.O., MBA, CPE, FAAFP (Greater Baltimore Medical Center)
- Will Daniel
(CareFirst)

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AHEAD Requirements Refresher

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5

AHEAD Overview

Three advisory committees are established to receive input for the AHEAD application. H-TAC focused on hospital global budgets and all-payer cost growth targets.

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 Growth Targets	Total cost of care Medicare savings target and all payer hospital spending target.	Total cost of care Medicare savings target, primary care investment targets, and all payer total cost of care spending 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 for 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.

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HGB Methodology Alignment Requirements

The NOFO sets forth requirements for a wide spectrum of states. Maryland's existing TCOC model aligns with ALL requirements.

AHEAD Requirement	HSCRC Policy
1. Adjusted for both medical and social risk for either the beneficiaries the hospital serves or the hospital's geographic service area.	• Demographic adjustment provide additional funding to account for population growth and aging (medical, geography). • Payments by individual payments are risk adjusted as a result of rate setting system (medical). • Efficiency adjustment sets guardrails to ensure payments are adequate given medical and social risk of patients served by the hospital (medical and social). • Uncompensated Care (UCC) policy provides an equitable method that ensures that hospitals with high volumes of low-income patients are not at a financial disadvantaged (social).
2. Adjusted for hospital-level quality performance. *Hospital performance on those measures must achieve or surpass the measured results in terms of patient outcomes and cost savings as the CMS national hospital quality programs.*	• Several performance based programs adjust global budgets for attainment and improvement in quality measures that are similar to CMS's national quality programs. • Financial impact of quality programs far exceeds the amounts applied by CMS.

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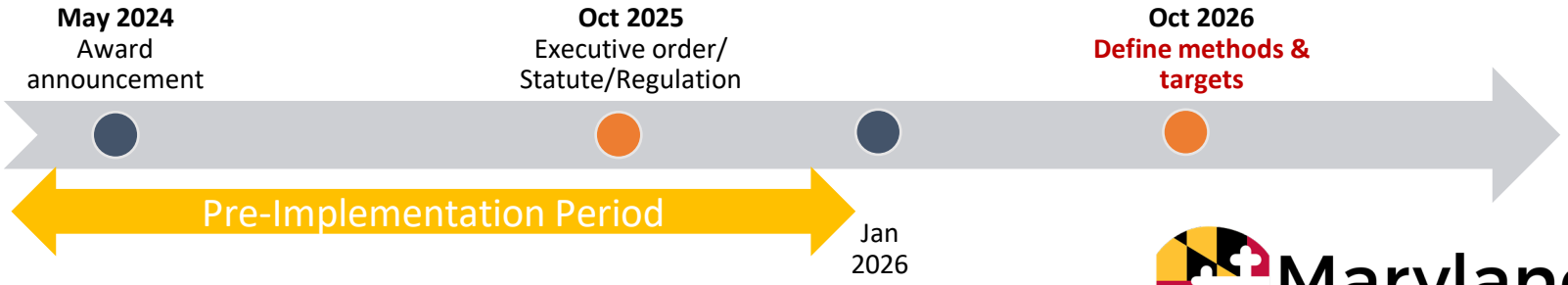
HGB Methodology Alignment Requirements-con.

AHEAD Requirement	HSCRC Policy
3. Adjusted for performance on disparities-sensitive quality measures for improving health equity.	Readmission Reduction Improvement Program (RRIP) provides additional incentive to reduce disparities readmission rates within the same hospital.
4. Hold hospitals accountable for Medicare FFS TCOC of a defined beneficiary population via a performance adjustment. *Include a process by which hospital global budgets can be adjusted in the event the state misses the statewide Medicare FFS TCOC target(s) and is on a Corrective Action Plan*	• Medicare Performance Adjustment (MPA) adjust hospital payments based on Medicare TCOC performance of attributed beneficiaries. • Efficiency policy considers TCOC performance in assessing the hospital's performance. • The Care Transformation Initiatives (CTI) program also holds hospitals accountable for driving care transformation.
5. Account for changes in service line and unplanned volume shifts, while not incentivizing FFS-oriented utilization.	• Market shift adjustment, unregulated settings and transfer adjustments. • Variable cost factor is applied to remove FFS-oriented utilization incentive.
6. Account for annual changes, such as inflation.	Update factor provides annual inflation adjustment.

All-Payer Cost Growth Targets- Requirements

Although there are many policy and regulatory levers to control growth of all-payer costs, establishing an official growth target will be a new requirement for Maryland. Timeline to determine the methodology and targets is longer than the pre-implementation period.

- Award recipients will be accountable all-payer total cost of care (TCOC) growth, including all-insured residents.
    - *Medicare (FFS or Medicare Advantage) , Medicaid (FFS or managed care), Commercial insurance, including employer-based insurance, state employee health plans and Marketplace plans*
- Each award recipient will be expected to generate savings relative to the counterfactual (e.g., compared to the state's projected TCOC growth absent the model) during the Model Implementation Period.
    - *CMS will identify state-specific factors (e.g., historic spending) in considering both the construction of the counterfactual as well as the magnitude of expected savings.*



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Recap of H-TAC Meeting #1

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10

H-TAC Summary of Comments

Topic	Comment
Hospital Global Budgets	Additional considerations for highly specialized services, high cost drugs, and risk adjustment methods for target determinations
	Emphasize successes we had in outcomes and infrastructure developed for building consensus on how we measure quality for all-payers, and data infrastructure (CRISP) to support transformation.
	Link global budgets to direct measures of patient outcomes.
	Aim for flexibility, clarity on physician participation in national models (mentioned oncology, bundled payment models specifically)
	Develop new strategies for reducing excess capacity.

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H-TAC Summary of Comments

Topic	Comment
All-Payer Total Cost Targets	Need to assess capacity to determine what the all-payer TCOC target should be - complexity of care, equity, and any characteristics of the population that should be accounted for, particularly for AMCs. Consider risk adjustment for the targets.
	AHEAD increases emphasis beyond Medicare; Medicaid and Commercial payers need to engage more; consider policy development/statutory authority to increase engagement beyond Medicare and expand on accountability frameworks.
	TCOC definitions may be different for all-payer vs. Medicare FFS. State should develop clear definitions what should be excluded from TCOC benchmarks.
	In setting TCOC targets, consider how to account for missing data (ERISA plans) and impact of Medicare Advantage enrollment increase, and how growth in primary care investments will impact all-payer total cost performance.
	Collaborating with State's medical schools to build skills to help state achieve TCOC goals is important.

Priorities for Health Care Transformation in the AHEAD Model

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Model Progression Priority Items Discussed in Prior Years

- AHEAD requirements for hospital global budgets are minimum requirements and Maryland TCOC Model already meets/exceeds these requirements.
- HSCRC workgroups convened and discussed the following topics:
  - Cost-Containment & Financial Targets
  - Population Health & Health Equity
  - Consumer Engagement
  - Multi-Payer Alignment
  - Post-Acute and Long-Term Care
  - Physician Engagement & Alignment

Source:*More information can be found at https://hscrc.maryland.gov/Pages/TCOCModelProgression.aspx

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Feedback Shared Previously

- In developing any future demonstration designs under the Maryland Model:
  - Proactively seek out the necessary flexibilities and accommodations to maintain and expand alignment programs, ensuring that participation in new versions or similar initiatives remains entirely voluntary for all eligible entities.
  - Should not lead HSCRC or the State to determine physician payment levels, or otherwise determine maximum physician payments.
- Ideas for new versions of GBR
  - Hospitals would have the option to have a **total cost of care** target based on the historical total cost of care for an attributed geography and updated for inflation and demographic growth.
  - The hospital would receive any total cost of care savings created and would be at risk for an increase in total cost of care (this would generally be analogous to full capitation risk).

Feedback Shared Previously - con.

- Develop a standard of access based on measurement of supply and demand for services.
- Seek the flexibilities in a future model to permit savings sharing with consumers through the addition of benefits should sustained savings be sufficient to merit this addition.
- Generate additional savings and improved quality outcomes through investments in care alignment such as:
  - SNF value-based care
  - MA investments
  - Additional physician investments focused on underserved areas

Priorities for Healthcare Transformation in Maryland's AHEAD model

TAC Discussion

As the State considers AHEAD pre-implementation planning, where do you see the most opportunity to develop and invest in new approaches for alignment, TCOC accountability and growth targets to promote high-quality and equitable care?

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Public Comment

Additional comments may be sent to: mdh.maryland-model@maryland.gov

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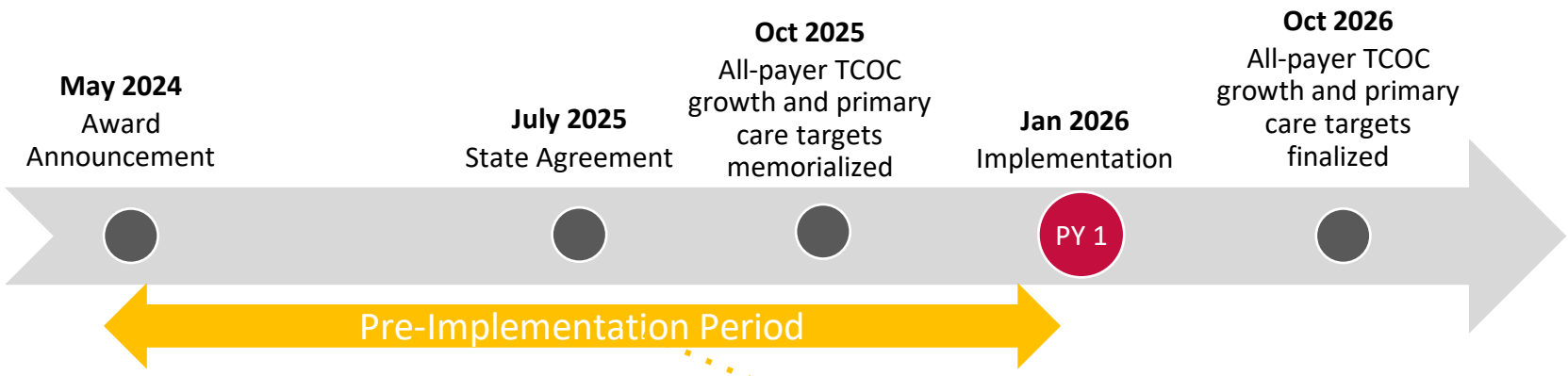
Next Steps



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. The TACs may evolve to maximize effectiveness depending on our work plan for the pre-implementation period.

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Thank you!

Additional comments may be sent to: mdh.maryland-model@maryland.gov
All meeting materials can be found at: https://hscrc.maryland.gov/Pages/ahead-model.aspx

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