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In Senior Care and Services*

**ISSUE BRIEF:
Health Care Delivery Under Maryland’s Total Cost of Care Model**

Where We’ve Been (1977 – 2018)

In 1977, Maryland implemented a system where hospitals were paid based on a unit-based rate system.

In 2014, Maryland shifted hospital payments from a unit-based rate system to a global budget system under the **All-Payer Model Contract**, focusing on enhancing patient care, improving health, and lowering health care costs.

Programs were developed through hospitals to reduce avoidable use and improve quality and coordination of health care services. Examples:

- Care redesign programs focused on partnerships between hospitals and care partners within the hospital through the Complex and Chronic Care Improvement Program and between hospitals and community care partners through the Hospital Care Improvement Program; and
- Transformation grants provided to hospitals focused on reducing potentially avoidable utilization at Maryland hospitals through better care coordination and provider alignment

Under the first phase of the All-Payer Model Contract, Maryland satisfied the following benchmarks:

- Hospital revenue growth less than or equal to 3.58% per capital annually;
- Medicare savings in hospital expenditures greater than \$330 million cumulative over 5 years;
- Medicare savings in total cost of care lower than the national average growth rate;
- 30% reduction over 5 years in primary care conditions;
- Readmissions reductions for Medicare less than national average (Maryland reduced more rapidly than the nation).

Where We’re Going (2019 – 2029)

In July 2018, Maryland renegotiated the replacement of the All-Payer Model Contract with the new **Total Cost of Care Model (TCOC Model)**. This revised model builds on the All-Payer Model Contract. Hospitals will continue to receive a global budget to financially incentivize hospitals to provide value-based care and reduce the number of unnecessary hospitalizations, including readmissions. But, more so than the All-Payer Model Contract, the TCOC Model will move beyond hospitals to encompass health care services that patients receive both inside the hospital **and** in the community.

Under revised terms of the TCOC Model,¹ Maryland will need to:

- Achieve Medicare savings of \$300 million annually (not cumulatively);
- Limit growth in all-payer hospital revenue to 3.58% annually;
- Continue to set quality of care goals, such as reducing unnecessary hospital utilization and readmissions; and
- Focus on six high-priority areas to improve population health - substance-use disorder, diabetes, hypertension, obesity, smoking and asthma.

As part of the TCOC Model, Maryland is in the process of developing two new programs with implementation dates of January 1, 2019:

Episode Care Improvement Program (ECIP):

- Participating hospitals will act as the “episode initiator” and must select from 23 clinical episodes for which it will commit to being held accountable from a defined list. Interventions are those activities and processes that the hospital may choose such as clinical care/care redesign, beneficiary/caregiver engagement, care coordination/transitions.
- ECIP payments will be received from the federal Centers of Medicare and Medicaid (in the form of a positive adjustment to the hospital’s Medicare Performance Adjustment) if the Medicare expenditures for selected clinical episodes are below the target prices of those episodes and negative amounts by which Medicare expenditures for selected clinical episodes are above the benchmark prices for those episodes. Individual post-acute care providers participating as care partners will continue to be reimbursed fee-for-service, but the expenditures will be compared to the final target price for the clinical episode. Hospitals may elect to distribute incentive payments to care partners.
- Hospital care partners may participate in multiple hospital’s ECIP programs and be general/specialist physician; clinical nurse specialist/nurse practitioner; physician assistant; physical therapist; skilled nursing facility; home health agencies; long-term care hospitals; hospice; and inpatient rehabilitation facilities.
- At a minimum, care partners must:
 - ✓ Have a National Provider Identifier (NPI) and a facility must have a Taxpayer Identification Number (TIN);
 - ✓ Participate in the Medicare program;
 - ✓ Be licensed;
 - ✓ Use CEHRT and CRISP; and
 - ✓ Pass the federal program integrity screening process.

Maryland Primary Care Model:

- MDPCP is a voluntary program open to all qualifying Maryland **primary care providers** that provides funding and support for the delivery of advanced primary care throughout the state.

¹ The TCOC Model is designated as an **Advanced Alternative Payment Model** established under the Medicare Access and CHIP Reauthorization Act of 2015. Providers who participate in Maryland’s Care Redesign Programs are now eligible for an incentive payment from the federal government beginning in 2018.

- Focuses on physicians, clinical nurse specialists, nurse practitioners, and physician assistants with a variety of specialty designations, including: General Practice, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatric Medicine, Geriatric Medicine, and co-located Psychiatry.
- The MDPCP supports the overall health care transformation process by allowing primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.
- NOTE: Organizations whose residents/clients maintain separate relationships with primary care providers should contact those providers to determine if the provider is participating in the MDPCP and the impact on the residents/clients' care.

Other Care Redesign Programs:

Under the TCOC Model, CMS will consider programs operated by “non-hospital conveners,” i.e., post-acute care providers, physicians, etc. Entities will need to discuss, develop and submit to CMS.

How Organizations Can Be Successful Under TCOC Model

- ✓ Educate your organization on the TCOC Model as well as the ECIP and Primary Care Program to better understand how each will affect the care provided to your residents/clients and how you or your residents/clients could participate under each program.
 - Resources:
 - <https://hscrc.maryland.gov/Pages/tcocmodel.aspx>;
 - <https://hscrc.maryland.gov/Pages/CareRedesign.aspx>;
 - <https://health.maryland.gov/mdpcp/Pages/home.aspx>
- ✓ Connect with CRISP (Maryland’s Health Information Exchange) to discuss your organization’s data and how it may compare to others in your area.
- ✓ Engage with your local hospitals.
 - Discuss with each hospital the needs of the hospital in implementing the TCOC Model.
 - Inquire as to whether the hospital is planning to participate in ECIP.
 - If so, what care episodes will be the focus of the program?
 - Discuss with the hospital any specialty care that sets you apart from others.
 - Remember – a hospital will be receiving a payment from CMS if target costs are below the threshold. However, the hospital is not mandated to distribute. Post-acute care providers should inquire also about shared incentive payments.
 - Outside of ECIP, are there programs that the hospital is focusing on related to the six priority areas (substance-use disorder, diabetes, hypertension, obesity, smoking and asthma) or in avoiding preventable admissions or readmissions. Discuss ways your organization can assist with those goals.
- ✓ Questions that the hospital may ask in selecting care partners.

1. Describe your organization's admission schedule. Specifically, can your organization admit residents/clients 24 hours a day from the emergency department, hospital or a community-setting.
2. What is the process for clinically evaluating residents/clients upon admission or within 48 hours of admission.
3. Describe the standard procedure for evaluating residents/clients while they are receiving services.
4. Describe staff coverage for evenings, nights, and weekends. Does your organization use telehealth?
5. Are rehabilitation services available and how are decisions determined regarding length of time, etc.
6. Describe any special processes that your organization has put in place to:
 - Support the six priority areas of substance-use disorder, diabetes, hypertension, obesity, smoking and asthma; or
 - Address any of the designated 23 clinical care episodes.
7. Describe your error monitoring process and provide examples of recent actions taken as a result of the monitoring process.
8. Describe your standard process for identifying changes in clinical status among residents/clients.
9. Describe the processes in place to ensure all residents/clients have a MOLST form, if required.
10. Describe your discharge processes, standard communication for sharing medical information during any care transitions and any follow-up care that is provided.
11. Does your facility utilize CRISP to promote health information exchange with referring or receiving providers? If yes, please describe your current use of CRISP.
12. What processes do you have in place to reduce frequency of potentially avoidable transfers to hospitals?
13. What fall prevention programs do you have in place?
14. Describe any hospice/palliative care services or home care agencies that your organization works with.
15. What are some opportunities for a hospital to improve transition of care by partnering with your organization.

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