Improving Health with the Affordable Care Act in Maryland

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Secretary
Department of Health and Mental Hygiene
May 16, 2014
Background: Health Outcomes
Background: Health Costs

Figure 2. Employer Premiums as Percentage of Median Household Income for Under-65 Population, 2003 and 2009


Health care spending is the primary driver of the debt.

Source: Congressional Budget Office (August 2011)
## Background: Quality

![Figure 3.6: Medicare Hospital Readmissions Rates 2011](image)

### Medicaid Hospital Readmissions Rates 2011

<table>
<thead>
<tr>
<th>State</th>
<th>Rate</th>
<th>State Rank</th>
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<tbody>
<tr>
<td>DC</td>
<td>23.60%</td>
<td>1</td>
</tr>
<tr>
<td>MD</td>
<td>21.37%</td>
<td>2</td>
</tr>
<tr>
<td>NJ</td>
<td>21.14%</td>
<td>4</td>
</tr>
<tr>
<td>NY</td>
<td>20.72%</td>
<td>6</td>
</tr>
<tr>
<td>National</td>
<td>19.12%</td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>19.07%</td>
<td>20</td>
</tr>
<tr>
<td>DE</td>
<td>17.86%</td>
<td>30</td>
</tr>
</tbody>
</table>

Source: Institute of Medicine’s Geographic Variation Data Request (January 2013 Update)
ACA Insurance Reform: Maryland Impact

- > 46,000 young adults on parent’s coverage
- 1.5 million people with better coverage for preventive health benefits
- $13 million in refunds under 80/20 rule
- No lifetime caps on coverage

Seniors in 2012:
- 48,949 in Maryland saved over $38 million on Rx drug coverage
- 543,632 individuals with traditional Medicare used one or more free preventive service

Source: HHS
Goal: 260,000 enrolled by end of first open enrollment period
Actual: >300,000 enrolled
The ACA & Health in Maryland

1. Community health planning
2. Primary care enhancement
3. Population-based data analysis and planning
4. Long-term care reform
5. Behavioral health homes
6. Payment reform
1. Community Health Planning

http://dhmh.maryland.gov/SHIP
Maryland’s State Health Improvement Process

18 Local Health Improvement Coalitions
  - Typically Co-Chaired by Hospital and Public Health leaders and include cross-section of health and human services

State and Local Accountability
  - 39 measures: health outcomes and determinants
  - State and county baselines and 2014 targets
  - Racial/ethnic disparity information
2. Primary Care Enhancement
Increased Payments in Medicaid Program

Nov 21, 2013, 4:03pm EST

Docs react positively to Maryland Medicaid boost, group says

As Medicaid enrollment soars under the Affordable Care Act, a top doctor advocacy group in Maryland says more physicians are considering joining the program.

Forty-six percent of doctors say they're contemplating for the first time opening their practice to patients covered by the federal-state insurance plan for the poor, according to a member survey conducted by MedChi, the Maryland State Medical Society.

Of physicians who already accept Medicaid, 57 percent said they plan to increase the number of Medicaid patients they treat.

$73 million in funding FY2013-FY2015
3. Population-based data analysis and planning

All-Payer Claims Database
- Allows tracking of resources, identification of outliers

Health Information Exchange
- Real-time reporting on aggregate hospital services, regional or community utilization, and trending analysis
Maryland’s Health Information Exchange

- Connects all acute care facilities.
- The Query portal allows authorized users to locate medical records from hospitals, radiology centers, and laboratories in real-time from across Maryland.
CRISP Is a Common Platform

- Encounter Notification System (ENS) is a solution to notify a participant in real time when one of their patients has an encounter at any hospital in Maryland.

- Prescription Drug Monitoring Program

- Rapid readmission measurement across hospitals

- Provider database for Maryland Health Connection (https://providersearch.crisphealth.org)
Mapping Capability

- Based on the indexed utilization information, Maryland’s Health Information Exchange can produce visualizations of hospital utilization data in near real time.

- Community Integrated Medical Homes can leverage geographic data to better understand localized use of services and opportunities for targeted interventions.
Example: Hospital Utilization by Census Tract – Prince George’s County
Example: Patient Level Hospital Utilization – West Baltimore

(total real data)
Planning for a New Model of Primary Care and Community Health

Community Health
- Local health departments
- Community organizations
- Social services
- Hospitals
- Other providers

Primary Care
- Primary care physicians
- Nurse practitioners
- Allied health professionals
- Community pharmacists

Shared Data

Care Manager
Community health worker
4. Long-Term Care Reform

- We identified an overreliance on long-term care facilities and an inadequate infrastructure for aging in place as a major weakness of our health care system.

- The **Balancing Incentive Program (BIP)** was a competitive program created under the ACA to support rebalancing.

- Maryland submitted a successful proposal describing a strategy to advance rebalancing goals, and received $106 million that will be utilized to support over 10,000 Marylanders who will be served in community-based settings instead of nursing facilities.
Rebalancing long-term care

- **Community First Choice program** provides common standard for personal care services across Medicaid and waivers
  - $>20$ million in federal funding, allowing better payment to providers, more services for enrollees, and self-direction

*Note that waiver participants living in assisted living facilities are not eligible for CFC or included in this chart.*

In the future, most participants will receive their services through Community First Choice. Chart 2.
Community Aging in Place—Advancing Better Living for Elders (CAPABLE)

National Institutes of Health RO1 (4/1/2012 – 8/31/2017)
Center for Medicaid and Medicare Services Innovation Grant (7/1/12 – 6/30/15)
Robert Wood Johnson Nurse Faculty Scholars Program (9/1/11 – 8/31/14)

With the number of older adults expected to double to 71 million by 2030, reducing the societal burden of age-related chronic disease is crucial. The Community Aging in Place—Advancing Better Living for Elders (CAPABLE) is a client-centered home-based intervention to increase mobility, functionality, and capacity to "age in place" for low-income older adults. Abstract

Meet the Investigators

- Sarah L. Szanton, PhD, CRNP, Principal Investigator, JHU School of Nursing
- Elizabeth K. Tanner, PhD, RN, JHU School of Nursing
- Laura M. Gillin, PhD, JHU School of Nursing
- Jack Guralnik, MD, PhD, University of Maryland School of Medicine
- Cynthia M. Boyd, MD, MPH, JHU Bloomberg School of Public Health
- Carlos Weiss, MD, MHS, Johns Hopkins Medicine
- Jennifer Wolff, PhD, JHU Bloomberg School of Public Health
- David Bishai, MD, PhD, JHU Bloomberg School of Public Health
5. Behavioral Health Homes

- Open to psychiatric rehabilitation programs, mobile treatment, or opioid treatment programs
- Will serve up to 15,000 people with serious, persistent mental illness, opioid use disorders, or children with serious emotional disturbance
- Behavioral health homes:
  - Receive per member, per month reimbursement if meeting requirements
  - Real time hospital alerts and Pharmacy use data from CRISP
Map of Maryland Behavioral Health Homes

27 sites approved, 31 pending
6. Payment Reform

The Centers for Medicare and Medicaid Services (CMS) are developing shared savings programs to help physicians, hospitals, and other health care providers coordinate care. Accountable Care Organizations (ACOs) allow providers to work together to reduce the cost of care for their Medicare population and then share a portion of the savings.

- 3 advanced payment ACOs
Hospital Payment Reform under the ACA

- Maryland: only hospital rate-setting state in nation
- Using unique authority granted to CMS through the ACA, Maryland and CMS agreed upon a fundamental reform of this system.
Background on Rate Setting

- Health Services Cost Review Commission oversees hospital rate regulation in Maryland
- Independent 7 member Commission
  - Decisions appealable to the courts
  - Balanced membership
  - Experienced staff
- Broad statutory authority
  - Has allowed Commission methods to evolve
Maryland’s Hospital Cost Review Commission at 40
A Model for the Country

By EB. Adashi
Friday, October 2, 2009

The search is on for tried-and-true methods to enhance revenue, health-care reform, or to "bend the curve," as the effort has become known. Adashi, health economist and political expert, offers a prescription for controlling costs. Preference will be given to publicly accountable, enlightened curve-benders mastering hard-nosed, data-driven cost containment. One such model is in Annapolis.

Maryland’s Health Services Cost Review Commission (HCRC) is the small regulatory agency that cost-containment advocates have long watched. In 1971, by an act of the legislature to set hospital-specific rate-sets for all payers, the HCRC was to bring about hospital cost containment and unwarranted patient access to care. Overseen by expert commissioners appointed by the governor, the HCRC became a model for others to follow.

The Washington Post
In Annapolis, Lessons on 'Bending the Curve'

By EB. Adashi
Friday, October 2, 2009

Over three decades, the HCRC’s current annual budget of about $4.9 million has enabled it to reduce statewide hospital bills by as much as $2B, a return on investment of about 250:1. A comparable national system here would cut costs by the same ratio, the commissioner says, with savings in the billions.

Maryland’s health-care market is largely free of dysfunctional price behavior, according to Adashi, and some time ago the state undertook to control hospital costs. The HCRC’s success is held up as a model for others to follow. Over three decades, the HCRC has allowed the state to reduce hospital bills by as much as 50%, a return on investment of about 250:1. A comparable national system here would cut costs by the same ratio, the commissioner says, with savings in the billions.
HSCRC Sets Hospital Rates for All Payers

- Medicare waiver granted July 1, 1977 as demonstration
  - Allows HSCRC to set hospital rates for Medicare—unique to Maryland
  - State law and Medicaid plan requires others to pay HSCRC rates

- Old Waiver test (2 parts)
  - Lower cumulative rate of increase in Medicare payment/admission from 1/1/81
    - Must remain all payer

- All payers pay their fair share of full financial requirements
  - Uncompensated Care
  - GME/IME
  - Capital

- Considerable value to patients, State and hospitals
HSCRC Cost Accomplishments

- Cost containment (all payer)—From 26% above the national average cost per case in 1976 to 2% below in 2007
PAYMENT REFORM

By Lisa E. Reinhardt

ANALYSIS & COMMENTARY

The Many Different Prices Paid To Providers And The Flawed Theory Of Cost Shifting: Is It Time For A More Rational All-Payer System?

ABSTRACT
In developed nations that rely on multiple, competing health insurers—for example, Switzerland and Germany—the prices for health care services and products are subject to uniform price schedules that are either set by government or negotiated on a regional basis between associations of health insurers and associations of providers of health care. In the United States, some states—notably Maryland—have used such all-payer systems for hospitals only. Elsewhere in the United States, prices are negotiated between individual payers and providers. This situation has resulted in an opaque system in which payers with market power force weaker payers to cover disproportionate shares of providers’ fixed costs—a phenomenon sometimes termed cost shifting—or providers simply succeed in charging higher prices when they can. In this article I propose that this price-discriminatory system be replaced over time by an all-payer system as a means to better control costs and ensure equitable payment.

In December 2010 America’s Health Insurance Plans published a report titled “Recent Trends in Hospital Prices in Oregon and California.” This report showed the growth in average transaction prices actually paid by the ten largest private health insurers to hospitals in Oregon during the period 2005–09, as well as the growth in net revenue per patient day paid to California hospitals by Medicaid, Medicare, and private insurers during the period 2006–09. Transaction prices—the amount of money that a hospital actually receives rather than the amount it charges—are not routinely reported by the insurance industry, which makes the report so illuminating.

Exhibit 1 presents the average annual compound growth rate in hospital transaction prices paid in Oregon for a number of well-defined procedures. The average price paid to hospitals for childbirth by a normal vaginal delivery, for example, increased from $3,800 in 2005 to $6,400 in 2009. Exhibit 2 shows data for California.

The data for Oregon raise the question Why did the ten largest private health insurers in that state—in effect, the purchasing agents on behalf of employers and employees—not resist the steep price increases during 2005–09, in the midst of one of the deepest recessions buffeting the United States since the Great Depression? This question is relevant to any strategy that relies heavily on private health insurers as agents of cost control.

In this article I explore the question at greater length, beginning with a brief discussion of the most commonly advanced explanation: the cost-shifting theory. According to this theory, private health insurers have no choice but to compensate health care providers for payment shortfalls...
Challenges of the Old Waiver Model

- Medicare participation premised on Maryland keeping cost per case increase below increase in national rate of growth per case
- Emphasis on cost per case kept focus only on hospital inpatient services, not overall health care spending
- Not well fitted to innovations in health care
Diminishing “Waiver Cushion”

**Exhibit 5**

**Medicare Waiver Cushion**

*Fiscal 1998-2014*

- **Waiver Test Cushion** (solid line)
- **HSCRC Ideal Level** (dashed line)
- **Fiscal 2013 Projection** (dotted line)

**HSCRC**: Health Services Cost Review Commission

Note: Data shown are values/estimates for the end of each fiscal year. Fiscal 2012 through 2014 estimates are estimates. Fiscal 2014 estimate is based on a 2% Medicare payment cut through federal sequestration (current law) and a 0% hospital update factor.

Source: DLS
Total Patient Revenue (TPR)

- Voluntary three-year rate arrangements
- Establishes fixed global revenue levels for hospitals for all inpatient and outpatient revenues regardless of volume
- Revenues subject to adjustments for quality and performance standards
- Ten hospitals began operating under this structure in FY 2011, mostly in isolated rural facilities with defined catchment areas
Total Patient Revenue Hospitals

TPR Hospitals

- 10% of net revenue
- Mostly rural

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<tr>
<th></th>
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<th>Non-TPR</th>
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<td><strong>Inpatient Admissions</strong></td>
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<tr>
<td>FY2010</td>
<td>91,672</td>
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<td>FY2013</td>
<td>75,478</td>
<td>608,166</td>
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<td>% Change</td>
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<td><strong>Same Hospital Readmissions</strong></td>
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<td>FY2010</td>
<td>9,530</td>
<td>64,842</td>
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<td>FY2012</td>
<td>7,729</td>
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<td>% Change</td>
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<td><strong>Avoidable Admissions (PQI90)</strong></td>
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<td>CY2010</td>
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<td>57,148</td>
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<tr>
<td>% Change</td>
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Note: FY2013 is based on 6 month data and annualized.
Lessons in Maryland for Costs at Hospitals

CUMBERLAND, MD. — This hardscrabble city at the base of the Appalachian makes for an unlikely hotbed of health care innovation.

Yet Western Maryland Health Systems, the major hospital serving this poor and isolated region, is carrying out an experiment that could leave a more profound imprint on the delivery of health care than President Obama’s reforms.

Over the last three years, the hospital has taken its services outside its walls. It has opened a diabetes clinic, a wound center and a behavioral health clinic. It has hired people to follow up with older, sicker patients once they are discharged. It has added primary care practices in some neighborhoods.

The goal, seemingly so simple, has so far proved elusive
Overview of New All-Payer Model
Model Hypothesis

- Maryland is the only state in the nation with an all-payer hospital rate setting system.
- Our hypothesis: By aligning all-payer rate setting with other critical reform efforts, Maryland can become a model for cost control, improved health outcomes, and a better patient experience for patients.
Proposed Model at a Glance

- Transformational shift of hospital revenue to global payment models
  - Goal is to move virtually 100% of hospital revenue into global payments
- All-Payer total hospital per capita cost growth ceiling
  - 3.58% - tied to long term growth of state economy
- Significant savings compared to Medicare trend
  - $330 million in Medicare savings under national trend
  - Target is dynamic as Maryland must beat national spending trend
Proposed Model at a Glance cont.

- Requirements for significant continuing progress on performance measures
- Readmission
  - Model will deliver substantially faster decline in readmissions than national rate of decline to bring Maryland into alignment with national performance
- Hospital Acquired Conditions (HACs)
  - Currently CMS targets 15 HACs, using MS-DRGs
  - Maryland targets 65 Potentially Preventable Conditions (PPCs) inclusive of the 15 CMS HACs
  - The Model will deliver a 30% reduction in hospital-acquired conditions across 65 PPCs
Approved Model Timeline

- Phase 1 (5 Year Model)
  - Maryland all-payer hospital model
  - Developing in alignment with the broader health care system

- Phase 2
  - Phase 1 efforts will come together in a Phase 2 proposal
  - To be submitted in Phase 1, End of Year 3
  - Implementation beyond Year 5 will further advance the three-part aim
Key Advantages of Model

- Fundamentally realigns hospital incentives to be consistent with three-part aim
- Aligns with other initiatives under way in Maryland
- Opportunities to test new ways to make progress on readmissions and hospital acquired conditions
  - Global hospital payments, hospital episodes with all-cause readmissions, broad based HAC program
- Phase I lays the groundwork for phase II application
Creates New Context for HSCRC

- Priority tasks: Transition to population/global payment models and patient-centered performance targets that are tied directly to payment
- Major data and infrastructure requirements

- Better care
- Better health
- Lower cost
Opportunities for Success

Model Opportunities

- Global revenue budgets providing stable model for transition and reinvestment
- Lower use—reduce avoidable utilization with effective care management and quality improvement
- Focus on reducing Medicare cost
- Integrate population health approaches
- Control total cost of care
- Rethink the business model/capacity and innovate

Delivery System Objectives

- Improved care and value for patients
- Sustainable delivery system for efficient and effective hospitals
- Alignment with physician delivery and payment model changes
Medical Education

Under the model, Maryland will convene medical schools and schools of health professionals to develop a five year plan that will serve as a blueprint on critical elements of improvement that will be needed to sustain transformation initiatives. The plan will be designed in a manner that is scalable and generalizable to other schools across the nation.
Measures

- In addition to quality and cost, Maryland will track a broad range of other measures related to the three-part aim, including:
  - Patient satisfaction
  - Potentially unnecessary use of radiology
  - Physician participation in Medicare and Medicaid
Challenges and Opportunities

- Integration of efforts
- Short-term challenges vs. long term investments
- Ability of health care system to align and come together
  - $15 million set aside for regional and statewide partnerships
- Coordination with public health
- Developing the Phase II proposal
  - Maryland would be the first state to assume control of total cost of care for all payers
Reason for Optimism: Partnerships

- School health in Washington County
- Outpatient mental health care in Frederick County
- Collaboration with long-term care in Baltimore City
Reason for Optimism: Health Enterprise Zones

- An initiative to address health disparities through focused investment in community health
- Investment based on a plan created by a governing community coalition, and may include:
  - Loan repayment
  - Hiring tax credits
  - Community health workers
  - Innovative health or social programs (loan bank, transportation route)
- Measurable health outcomes
- $4 million in annual state funding
- 5 initial sites: Hospitals involved in all 5, leaders in 3
Example: St. Mary’s County Zone

St. Mary's Hospital/"Greater Lexington Park" (20653, 20634, and 20667; Rural)

The St. Mary’s Hospital for the Greater Lexington Park HEZ seeks to improve public health outcomes in the Lexington Park, Great Mills, and Park Hall communities of St. Mary’s County, areas experiencing a dearth of primary care physicians, by creating a new community health care center in Lexington Park and adding five new primary care practitioners, one psychiatrist, and two licensed social workers in the Zone.

Innovative strategies contained in this proposal include the development of a “health care transportation route” to address barriers to accessing health care experienced in the underserved communities in this rural area of the state.
Acknowledgments

- Governor O’Malley and Lt. Governor Brown
- HSCRC Commissioners and Staff, including Chair John Colmers and Executive Director Donna Kinzer
- Center for Innovation at CMS, including Dr. Patrick Conway, Dr. Rahul Rajkumar, Karen Murphy, and Ankit Patel
- Dr. Laura Herrera, Department of Health and Mental Hygiene, and the public health team