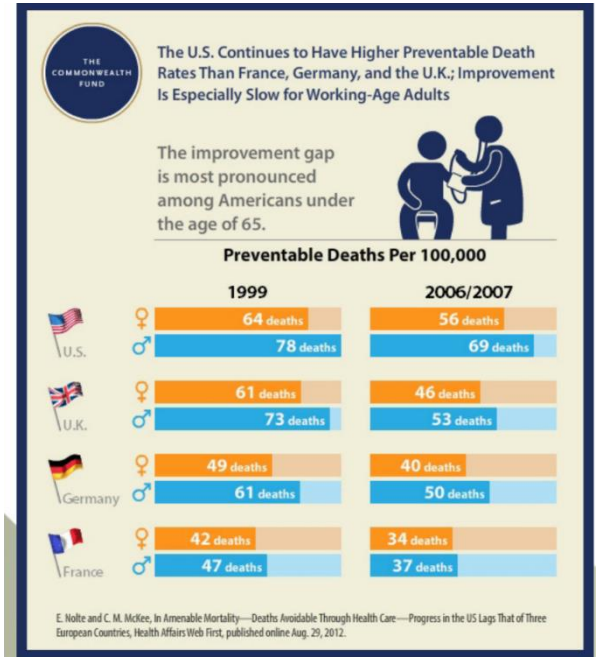
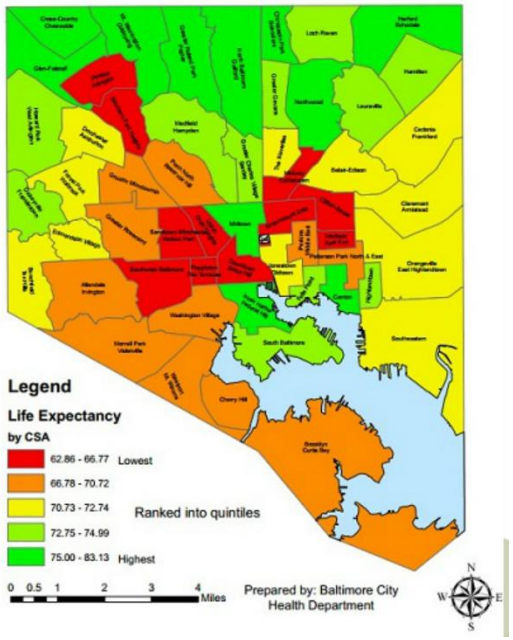
Improving Health with the Affordable Care Act in Maryland

Joshua M. Sharfstein, M.D.
Secretary
Department of Health and Mental Hygiene
May 16, 2014

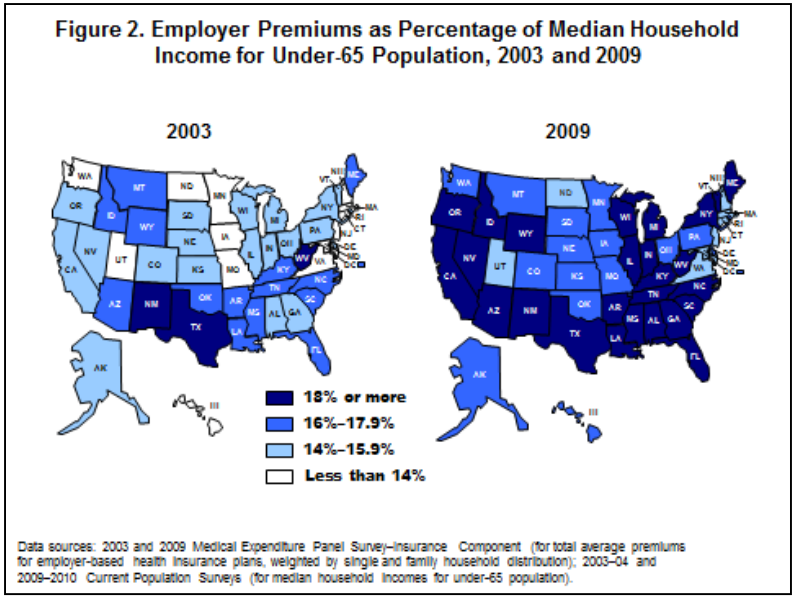
Background: Health Outcomes

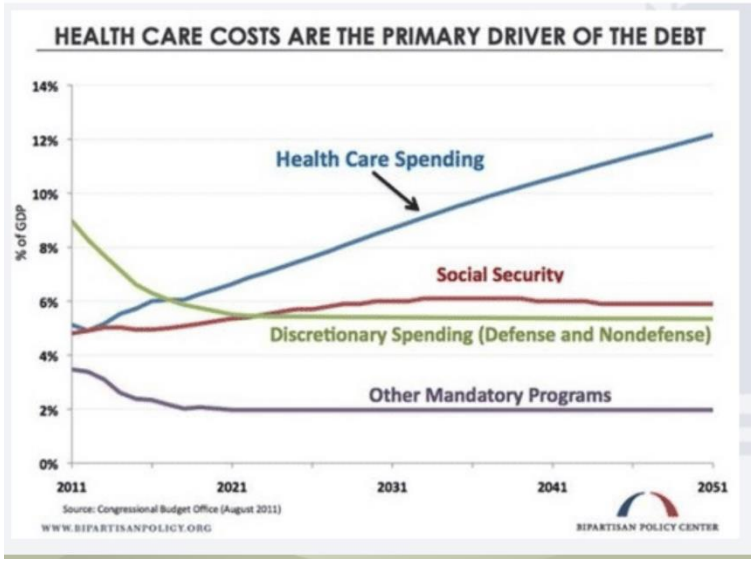


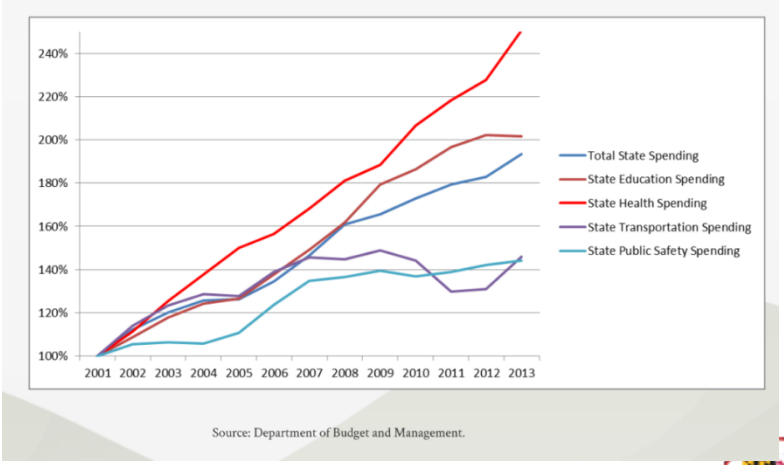


MARYLAND

Background: Health Costs







MARYLAND

Background: Quality

Figure 3.6: Medicare Hospital Readmissions Rates 2011

State	Rate	State Rank
DC	23.60%	1
MD	**21.37%**	**2**
NJ	21.14%	4
NY	20.72%	6
National	19.12%	
PA	19.07%	20
DE	17.86%	30

Source: Institute of Medicine's Geographic Variation Data Request (January 2013 Update)

MARYLAND

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

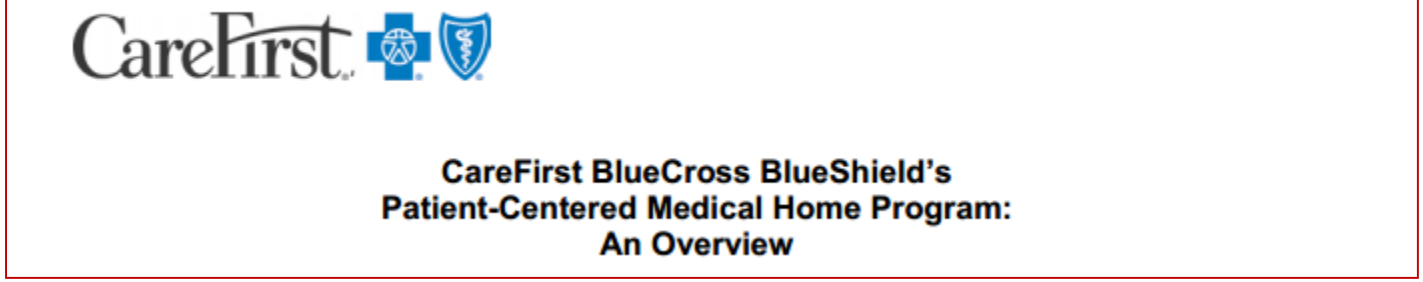
http://dhmh.maryland.gov/SHIP

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

Johns Hopkins Community Health Partnership



MARYLAND

Increased Payments in Medicaid Program

Nov 21, 2013, 4:03pm EST

Docs react positively to Maryland Medicaid boost, group says

Ben Fischer
Staff Reporter-
Washington Business Journal
Email | Twitter | LinkedIn

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.

Gene R

$73 million in funding FY2013-FY2015

MARYLAND

3. Population-based data analysis and planning

All-Payer Claims Database

- Allows tracking of resources, identification of outliers

Health Information Exchange

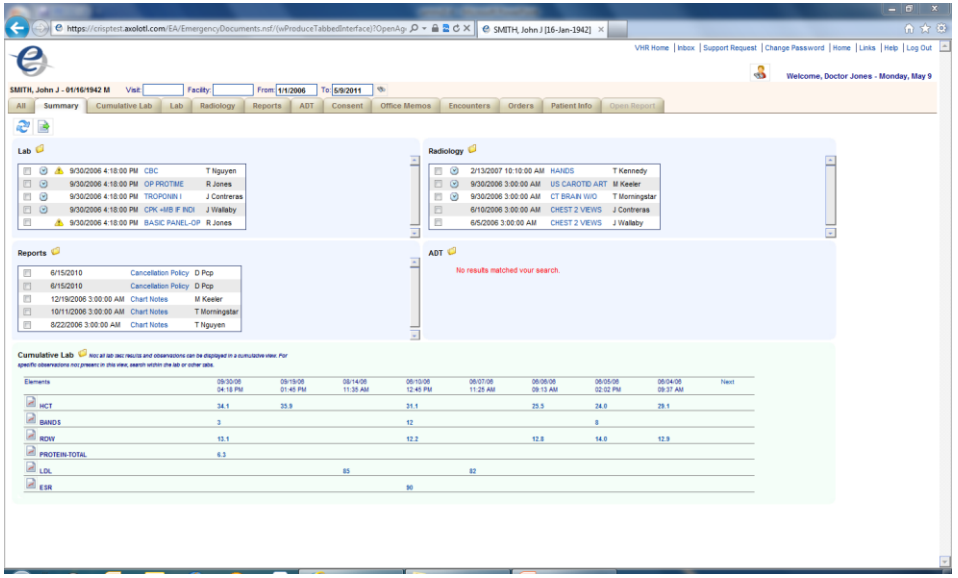
- Real-time reporting on aggregate hospital services, regional or community utilization, and trending analysis

CRISP

MARYLAND

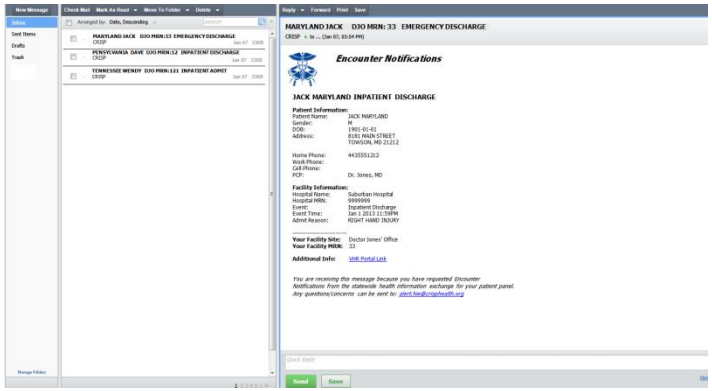
Maryland's Health Information Exchange

- 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

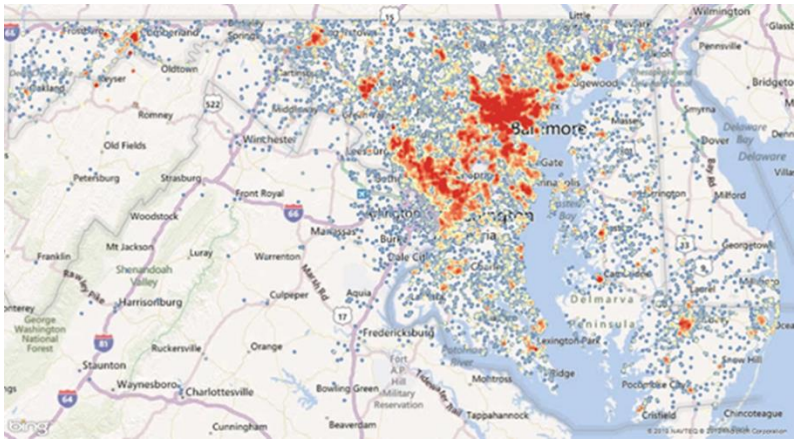
- Encounter Notification System (ENS) is a solution to notify a participant in real time when one of their patients has an encounter at any hospital in Maryland.
- Prescription Drug Monitoring Program
- Rapid readmission measurement across hospitals
- Provider database for Maryland Health Connection (https://providersearch.crisphealth.org)

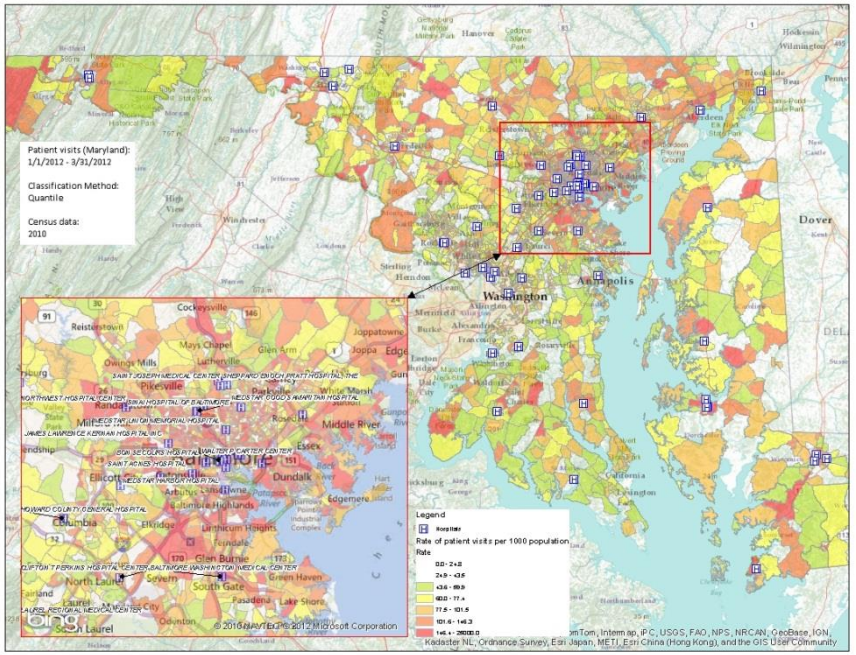


Mapping Capability

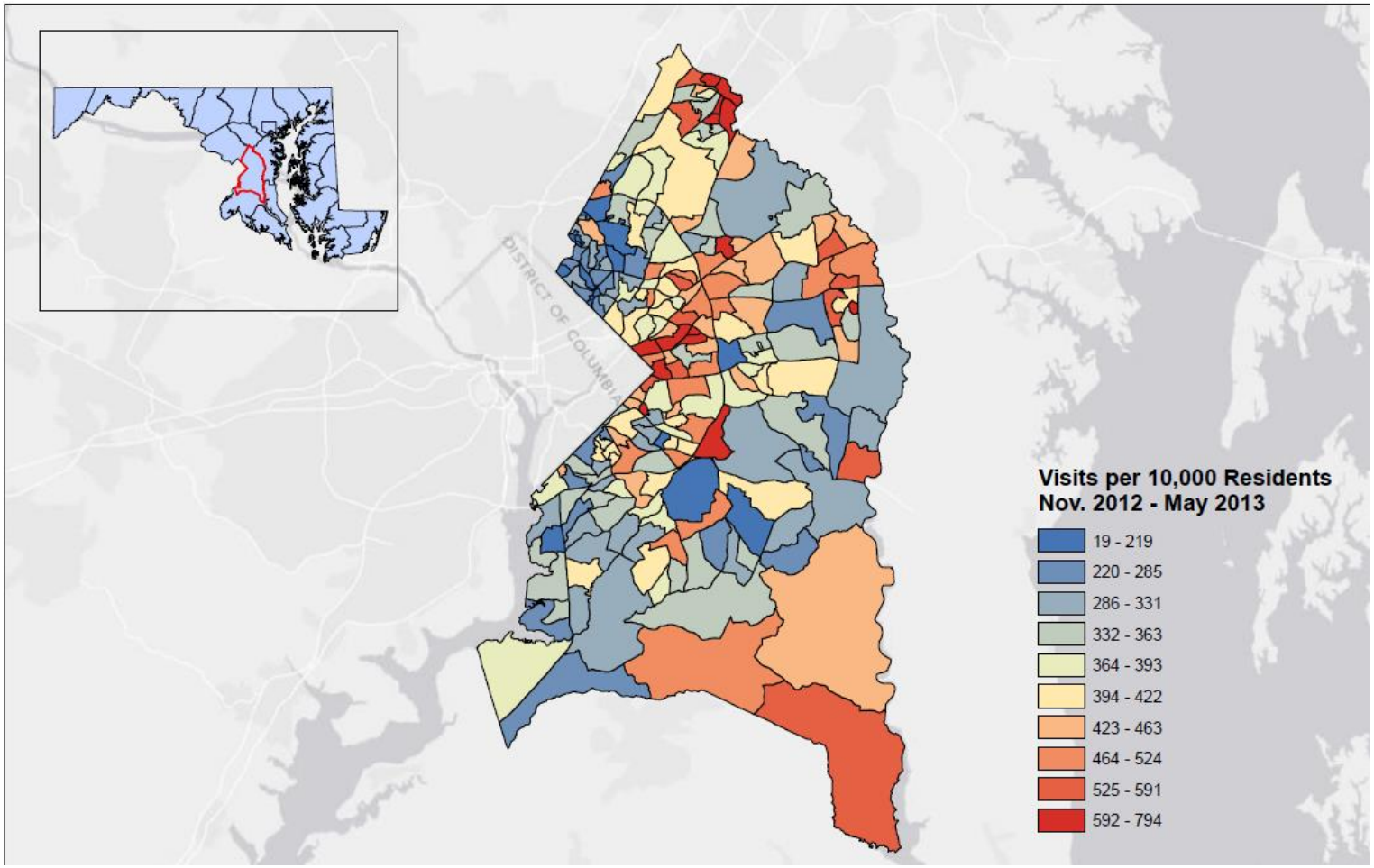
- Based on the indexed utilization information, Maryland's Health Information Exchange can produce visualizations of hospital utilization data in near real time.

- Community Integrated Medical Homes can leverage geographic data to better understand localized use of services and opportunities for targeted interventions.

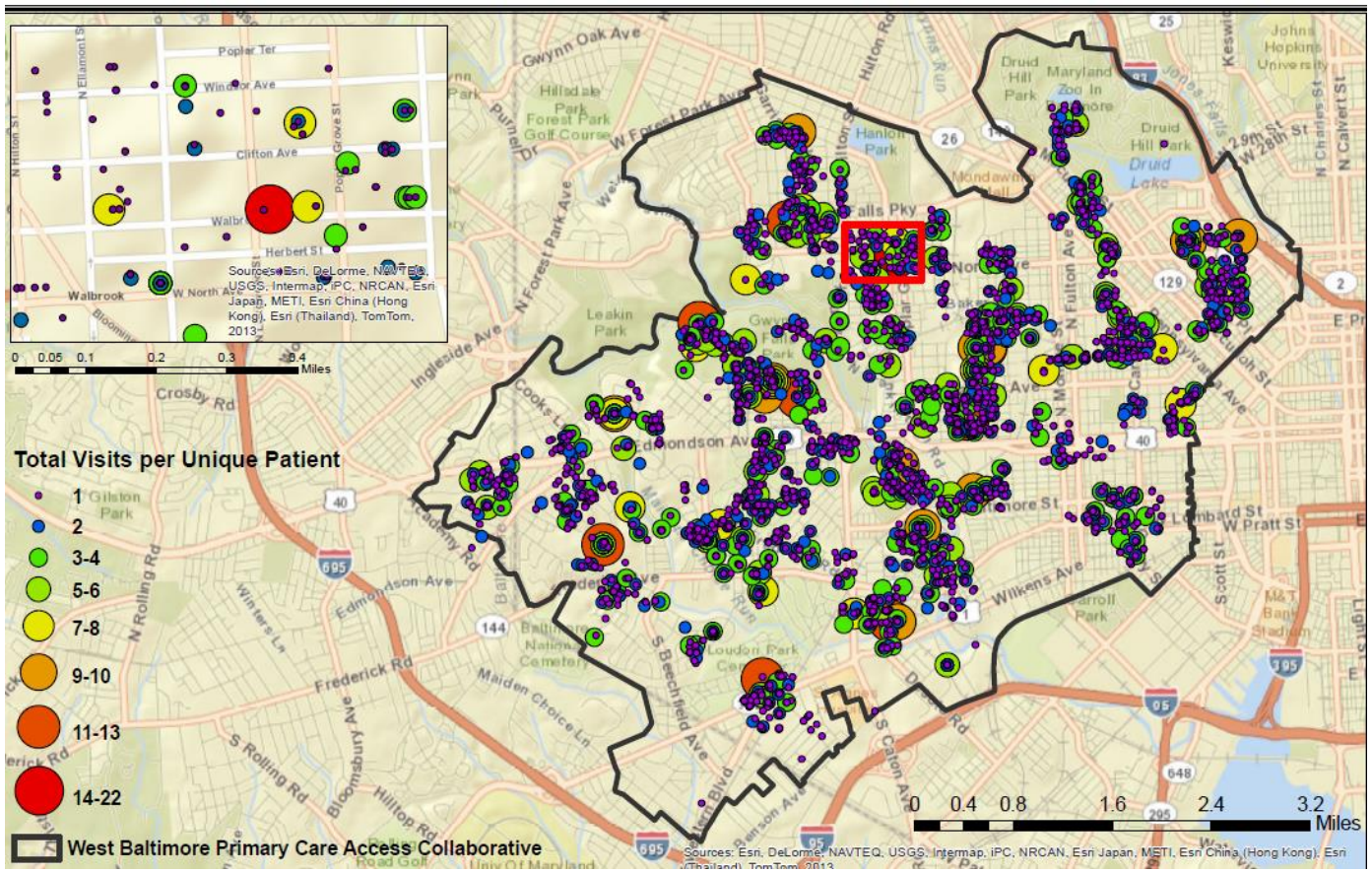




Example: Hospital Utilization by Census Tract – Prince George's County

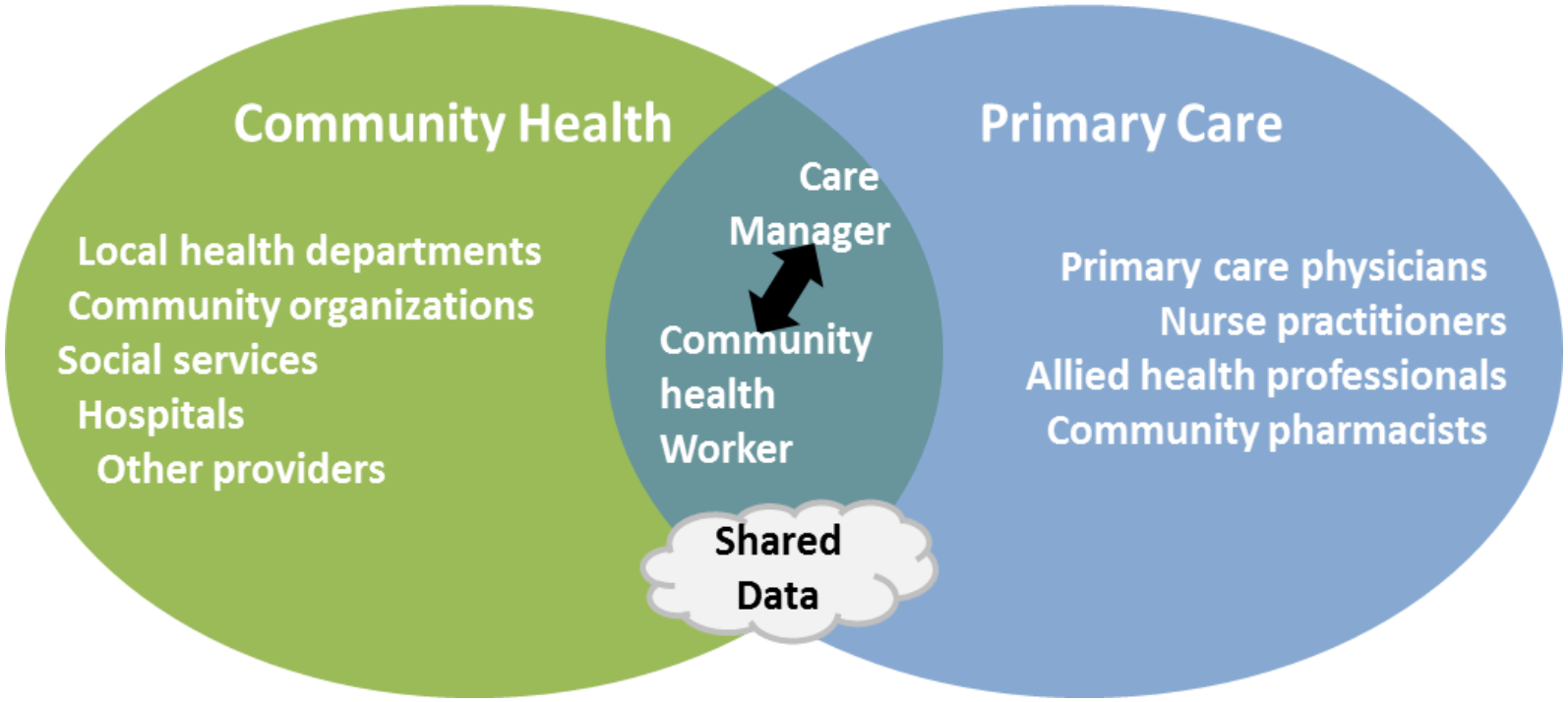


Example: Patient Level Hospital Utilization – West Baltimore



(not real data)

Planning for a New Model of Primary Care and Community Health



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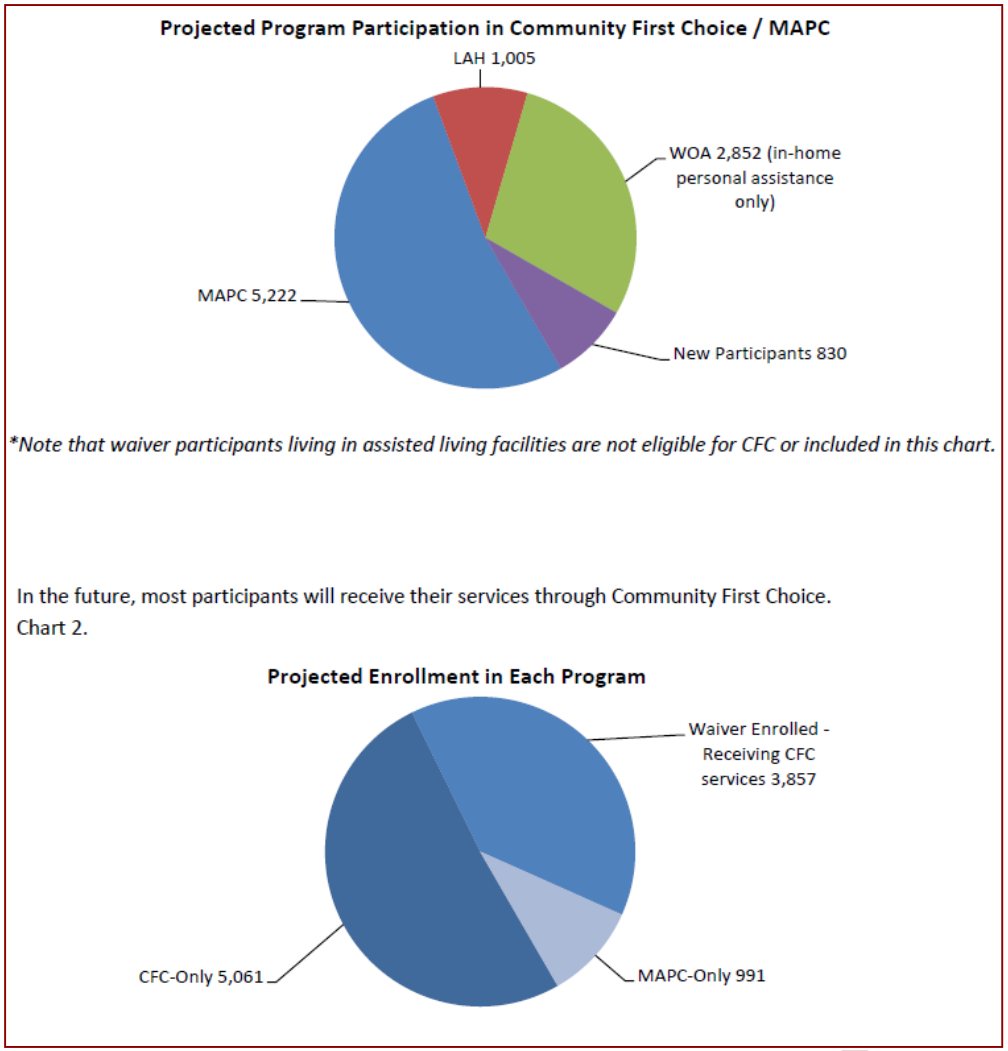
4. Long-Term Care Reform

- 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



Community Aging in Place—Advancing Better Living for Elders (CAPABLE)

National Institutes of Health R01 (4/1/2012 - 3/31/2017)

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 N. Gitlin, 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

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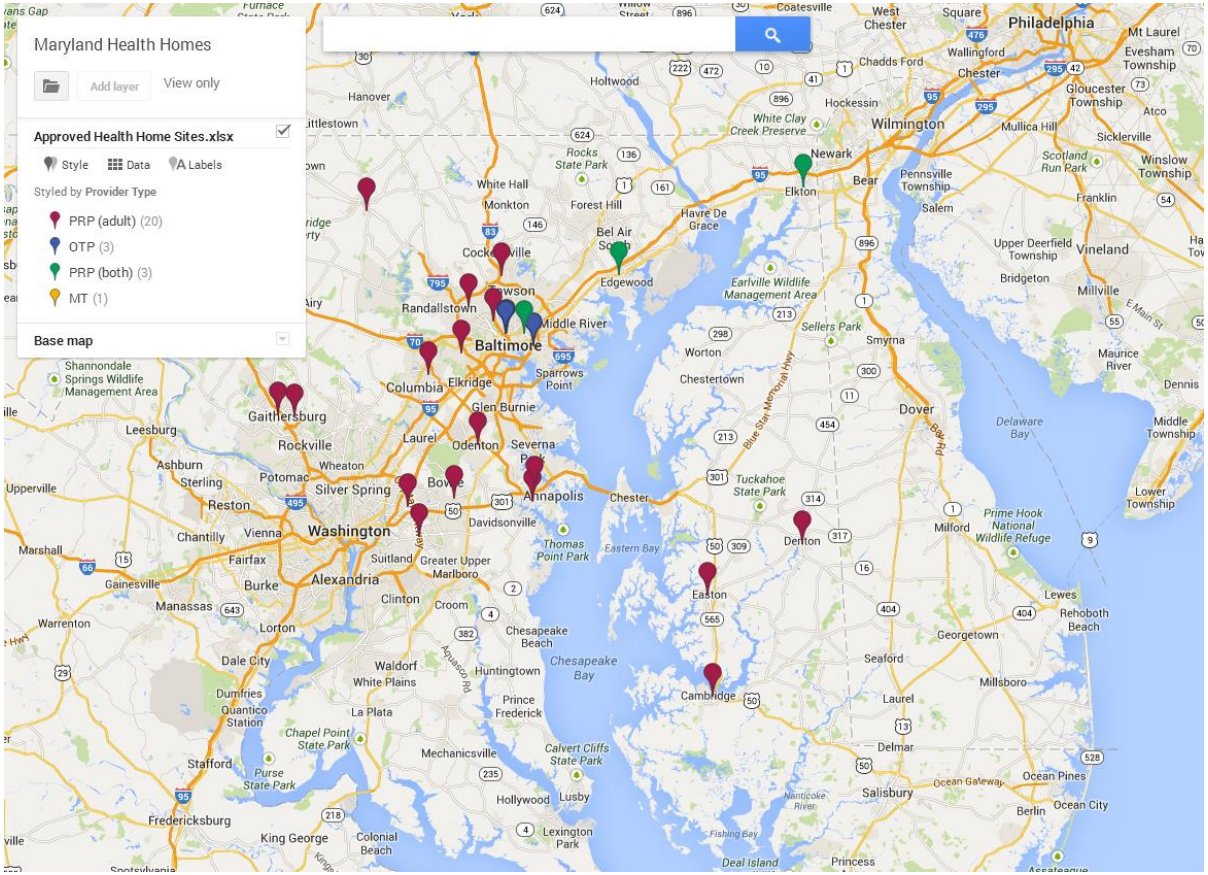
5. Behavioral Health Homes

- 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

Accountable Care Organizations

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

MARYLAND

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

COMMENTARY

Maryland's Hospital Cost Review Commission at 40

A Model for the Country

John A. Kastor, MD
Eli Y. Adashi, MD, MS

In 1971, the state of Maryland established the Health Services Cost Review Commission (HSCRC) to regulate the rates that hospitals in the state could receive from Medicare, Medicaid, and private insurers. Although other states once regulated hospital rates, only in Maryland does the practice continue. In this Commentary, we describe the Maryland system, discuss why regulation in other states failed, and suggest that other states should consider regulating hospital rates.

Several problems led to the creation of the HSCRC. Hospital costs per admission were significantly higher in Maryland than the average in other states and were increasing more rapidly each year, some hospitals were losing increasing amounts of money caring for uninsured patients, and several Maryland hospitals were denying care to patients with little or no health insurance.[1,2] The legislation creating the HSCRC gave it the power to set rates prospectively each year that all insurers would pay to the acute care hospitals in the state, making Maryland, in the local idiom, an "all-payer state." A federal waiver transferred hospital rate control over Medicare and Medicaid recipients to the HSCRC.

The HSCRC is governed by a 7-person voluntary board of commissioners appointed by the governor for 4-year staggered terms with 1 renewal. No more than 3 commissioners may be affiliated with "the management of policy of any facility,"[1] which includes hospital administrators, members of hospital boards, and physicians with admitting privileges. Operations are conducted by a full-time staff of 28 with experience in accou
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the commission of appro
hospitals, but because th
cost the payers ultimately
HSCRC. The state provi
insulating the HSCRC fr
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state legislatures. Since i
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all of which is available t

Annually, the commis
adjusted for the type of p

to a particular hospital. These rates differ among the hospitals depending on their missions and the amount of uncompensated care they provide. All payers must pay in accordance with that charge with only cost-adjusted discounts permitted. In 1976, when the system began full operation, the adjusted costs per admission in Maryland hospitals were approximately 26% higher than the national average.[3] Between 1977 and 2009, Maryland hospitals experienced the lowest cumulative increase in cost per adjusted admission of any state in the nation.[3] For fiscal year 2009, the average cost per admission at Maryland hospitals increased by only 2% compared with an estimated 4.5% increase for the rest of the nation.[3] Because the HSCRC regulates the amount hospitals can increase ("mark up") their charges, Maryland also has the lowest absolute charges of any state. Other data that contribute to overall health care costs, such as readmission rates, are not available.

Other provisions of the law establishing the HSCRC give it the responsibility to ensure access to hospital care for everyone and to make all parties, including hospitals and payers, accountable to the public.[1] The rates (ie, charges that ultimately result in reimbursements), as established by the HSCRC, enable hospitals that provide "efficient and effective" care (as defined by the commission) to operate in a solvent manner. (Six hospitals that could not meet these criteria closed.) Although uncompensated care is provided in different amounts by the hospitals, these costs are shared by all hospitals and are ultimately covered by the payers. Consequently, patients without the means to pay for their treatment are assured access to care because they can receive treatment in any Maryland hospital, including private community hospi-

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Health Policy Center

Independent research for better health policy and better health

Containing the Growth of Spending in the U.S. Health System

October 2011

John Holahan, Linda J. Blumberg, Stacey McMorrow,
Stephen Zuckerman, Timothy Waidmann, and Karen Stockley

Executive Summary

Health care costs have grown considerably faster than the economy for many years. Data from 2000 to 2010 show that national health expenditures (NHE) have increased at an average annual rate of 6.6 percent, while gross domestic product (GDP) has grown only 4.1 percent annually (table 1).[1] Although the rapid growth in U.S. health care spending and strategies for slowing it have become a focal point in debates over federal and state health care reform, strategies for slowing expenditure growth are more controversial, and evidence of their potential effectiveness is often elusive.

Research and analysis have focused in on four major and interrelated reasons for the persistent high spending growth: (1) overinsurance due to the tax treatment of employer-sponsored insurance, (2) the development and dispersion of medical technology, (3) an increasing prevalence of chronic disease, and (4) the consolidation of health care providers and insurers. All of these factors were addressed to some degree in the Affordable Care Act of 2010 (ACA). The law includes a new excise tax on high-cost health care plans, incentives to create competition among insurers in the health insurance exchanges, reductions in certain Medicare payments, and a broad range of pilot programs aimed at redesigning delivery systems, changing provider incentives, and improving care coordination (especially for patients with chronic conditions). The ACA also began to address the potential effects of medical malpractice on costs of care by providing grants for state demonstration projects to explore alternatives to settling malpractice cases, but many physicians would favor caps on the amount of noneconomic damages a jury can award.

There are approaches to cost containment that the ACA did not consider, as well as ways the provisions in the ACA could be strengthened. In this paper we consider a number of these options for containing the growth in U.S. health care spending and make our best estimates of possible savings.[2] Options include more aggressive limits on the tax exclusion for employer-based insurance, malpractice reform, targeted disease prevention policies, care coordination for those with chronic illnesses, lowering spending at the end of life, bundled payment mechanisms, strengthening the health insurance exchanges, the introduction of a public plan option in the health insurance exchanges, rate setting focused on the health insurance exchange markets, and all-payer rate setting.

In order to estimate potential savings from these cost containment policies, it was necessary to generate current law baseline estimates of spending, by payer and by service for the 10-year period 2014–2023. The Office of the Actuary (OACT) at the Centers for Medicare and Medicaid Services (CMS) produced aggregate spending projections by payer, reflecting the impacts of the ACA. The actuaries projected spending through 2019 for the following payers: Medicare, Medicaid/Children's Health Insurance Program (CHIP), employer-sponsored insurance (ESI), exchanges, and other private health insurance as well as other public, other private, and out-of-pocket (OOP) spending. In addition, since many of the cost containment policies being considered require targeted adjustments to spending by service category, we projected spending for hospitals, physicians, and prescription drugs. We also projected spending on "other services" and administrative costs. Because we use a 10-year window beginning in 2014 and CMS projected through 2019 only, we make additional projections for the years 2020–2023. For each payer (private, Medicaid, Medicare, and out-of-pocket) and each service (hospitals, physicians, drugs, other services, and administrative costs), we assume that the growth rate for 2019 continues annually through 2023. We then sum up all services and administrative costs, by payer, to get total expenditures for 2020–2023.

For each policy option, we generated estimates of the effects of the policy on the level and rate of growth of spending for targeted populations and services. Such estimates were based on the available literature as well as on, in some cases, reasonable and conservative assumptions. These effects were then applied to the baseline spending estimates to generate the expected

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October 2009

Issue Brief

State Hospital Rate-Setting Revisited

Graham Atkinson

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

ABSTRACT: In an attempt to control rapid growth in hospital costs, beginning in the mid-1970s several states implemented rate-setting programs to regulate hospital payments. In seven states, rate-setting was in effect for a substantial period of time (14 years or more). While most of these programs were discontinued by the mid-1990s, two are still active. In five of the seven states, the rates of increase in hospital costs were lower than the corresponding national rates during the periods in which the regulation programs were in place. Four of the states—Maryland, Massachusetts, New York, and New Jersey—had some of the lowest rates of hospital cost increases among all the states. This indicates that hospital rate regulation may be a useful approach in managing a major component of health care spending.

* * * * *

INTRODUCTION

From 1970 to 1975, spending on hospital services grew at an annual rate of 13.4
with the states of Connecticut, Maryland,
, Washington, and West Virginia enacted
s that established hospital rate-setting
perated by commissions established by
the state government. They set limits on
me use a formula-based approach, some
ividually, and some use a mix of these
pact of state rate-setting generally have
he growth of hospital costs.[2] However, in
ing emphasis on competition and man-
t of these state systems. Five of the seven
96, while two states—Maryland and West
programs.[3] This issue brief examines the

The Washington Post

In Annapolis, Lessons on 'Bending the Curve'

By Eli Y. Adashi
Friday, October 2, 2009

The search is on for tried-and-true methods to vanquish runaway health-care cost inflation, or to "bend the curve," as the effort has become known. Advisory, toothless constructs need not apply. Preference will be given to publicly accountable, enlightened curve-benders specializing in hard-nosed, data-driven cost containment. One such model exists in Annapolis.

Maryland's Health Services Cost Review Commission (HSCRC) is the small regulatory agency that could. Established in 1971 by an act of the legislature to set hospital-specific service rates for all payers, the HSCRC was to bring about hospital cost containment and unfettered patient access to care. Overseen by expert commissioners appointed by the governor, the modestly staffed HSCRC is an independent agency whose decisions are legally binding. The results are plain: Maryland residents receive hospital care regardless of ability to pay, but the state's hospital costs per admission dropped from 26 percent above the national average in 1976 to well below that national benchmark by the early 1980s. Costs per admission are controlled, and the annual admission growth rate (1 percent) is on a par with the national rate, according to an analysis by executive director Robert Murray of hospital reports filed with the agency through 2008.

Over three decades, the HSCRC (current annual budget: about $4.9 million) is estimated to have reduced state health-care bills by as much as $40 billion, a return on investment of about 2,500 to 1. Had a comparable national system been created to the same effect, the commensurate savings might have been $1.8 trillion.

Maryland's health-care market is largely free of dysfunctional (and discriminatory) hospital practices seen in many other states, such as indefensible cost markups and cost-shifting to patients. Building on its strong record, the HSCRC voted this year to approve an innovative pay-for-performance program focused on potentially preventable hospital-acquired complications and readmissions.

Consider the ingredients of Maryland's

MARYLAND

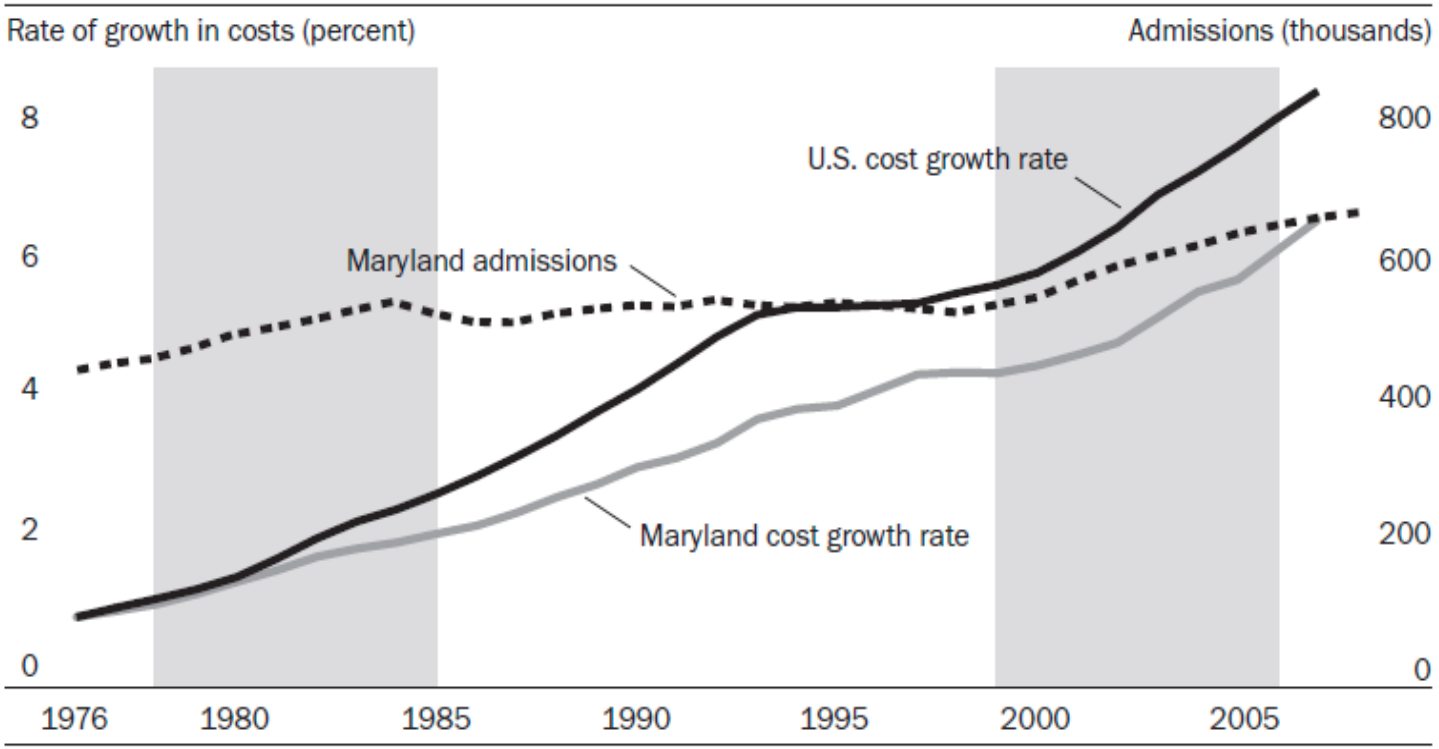
HSCRC Sets Hospital Rates for All Payers

- 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 in1976 to 2% below in 2007

Indexed Growth Rates In Hospital Cost Per Adjusted Admission, Maryland And United States, 1976–2007 (2008)



PAYMENT REFORM

By Uwe E. Reinhardt

DOI: 10.1377/hlthaff.2011.0813
HEALTH AFFAIRS 30,
NO. 11 (2011): 2125–2133

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?

Uwe E. Reinhardt (reinhardt@princeton.edu) is the James Madison Professor of Political Economy and a professor of economics and public affairs at Princeton University, in Princeton, New Jersey.

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."[1] 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 2000–09. 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 befalling 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.

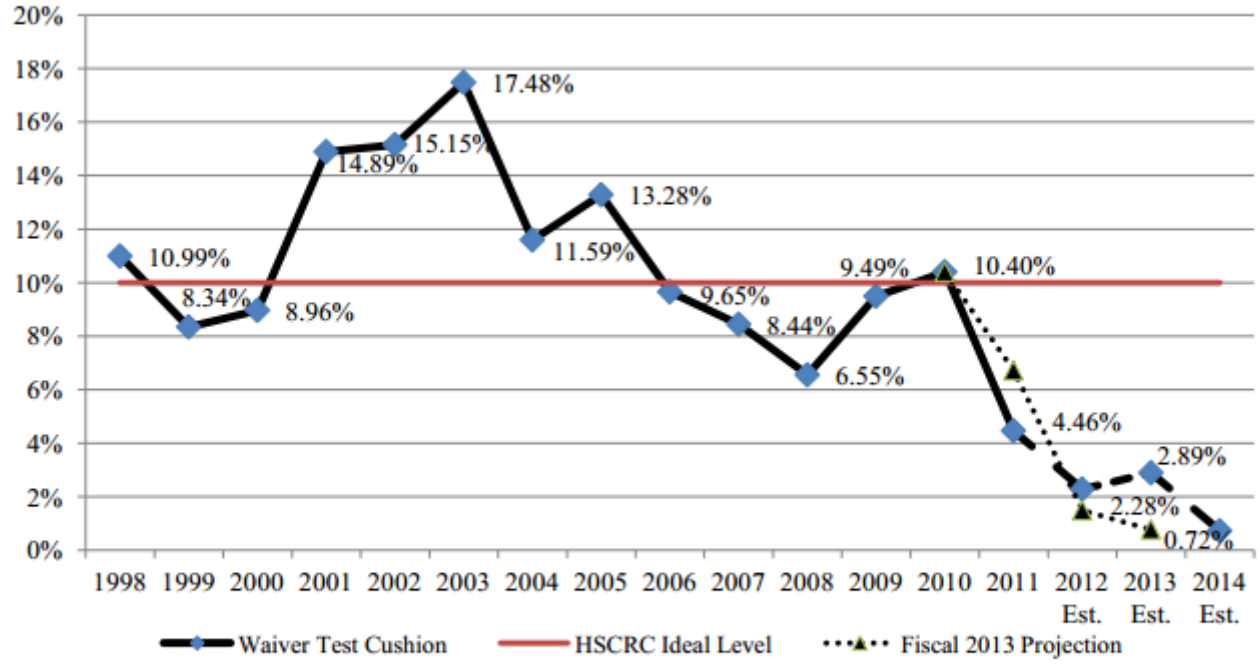
In this article I explore the question at greater length, beginning with a brief discussion of the most commonly advanced explanation: the cost-shift theory. According to this theory, private health insurers have no choice but to compensate health care providers for payment shortfalls

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 over all health care spending
- Not well fitted to innovations in health care

Diminishing "Waiver Cushion"

Exhibit 5
Medicare Waiver Cushion
Fiscal 1998-2014



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

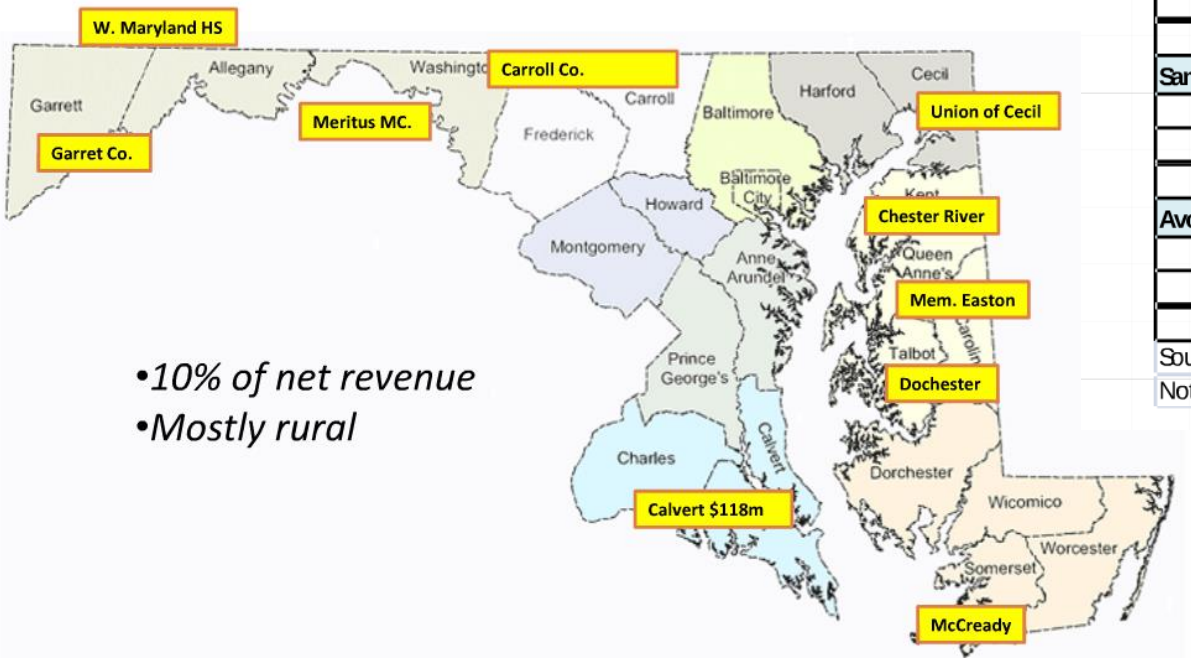
MARYLAND

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*

TPR versus non-TPR Hospitals: Before and After TPR Implementation in 2011

	TPR	Non-TPR
Inpatient Admissions		
FY2010	91,672	668,319
FY2013	75,478	608,166
% Change	**-17.7%**	**-9.0%**
Same Hospital Readmissions		
FY2010	9,530	64,842
FY2012	7,729	58,269
% Change	**-18.9%**	**-10.1%**
Avoidable Admissions (PQI90)		
CY2010	11,551	65,517
CY2012	9,593	57,148
% Change	**-17.0%**	**-12.8%**

Source: HSCRC, May 2013.

Note: FY2013 is based on 6 month data and annualized.

ECONOMIC SCENE

Lessons in Maryland for Costs at Hospitals

J.M. Eddins Jr. for The New York Times

Dawn Snyder, a registered nurse, runs a heart failure clinic at Western Maryland Health System.

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Published: August 27, 2013

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

Economic Scene

Eduardo Porter writes the Economic Scene column for the Wednesday Business section.

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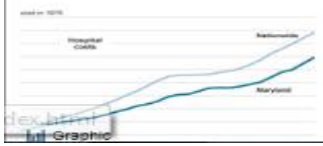
Multimedia



Graphic

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

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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.

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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

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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

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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

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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 blue print 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

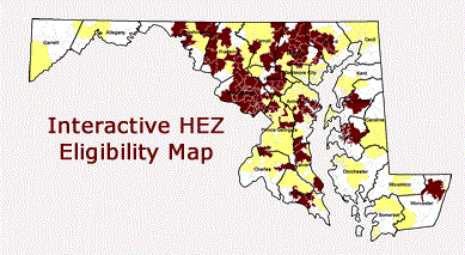
- Integration of efforts
- Short-term challenges vs. long term investments
- Ability of health care system to align and come together
  - $15 million set aside for regional and statewide partnerships
- Coordination with public health
- Developing the Phase II proposal
  - Maryland would be the first 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



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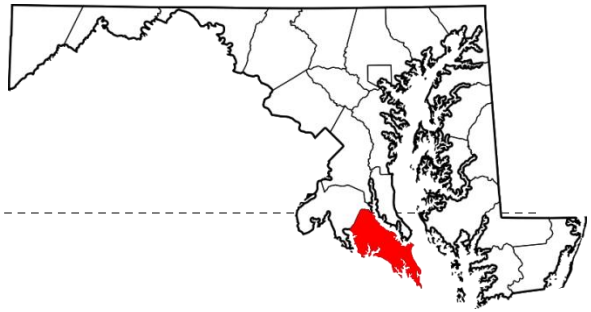

Example: St. Mary's County Zone

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

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