Health Reform in Maryland: An Overview

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Sinai Hospital
Pediatric Grand Rounds
September 13, 2011
Outline

• Background: Maryland Insurance Coverage and Markets

• The Affordable Care Act

• Delivery System Reform
Most Marylanders Have Group Insurance Coverage

Maryland 2009 Population by Source of Insurance Coverage

- Group: 60%
- Individual: 12.6%
- Medicaid/CHIP: 12%
- Medicare: 12.3%
- Other Public: 3%
- Uninsured: 1%
Large Groups (51+)

Insured Groups
- Carrier bears risk if claims exceed premiums
- Subject to insurance laws and mandated benefits
- 950,000 individuals

Self-Insured Groups
- Group bears the risk if claims exceed premiums
- Not subject to state insurance laws/oversight
- Nearly 2 million individuals
Markets Under Insurance Regulation

Individual Market
- Buy directly from carrier (vs. Association)
- Subject to state insurance laws and mandated benefits
- Medical underwritten
- 160,000 covered lives

Small Group Market*
- 2-50 employees
- Guaranteed issue
- Modified Community Rating
- Standard plan w/ riders
- 47,000 businesses (410,000 covered lives)

*Oversight by Maryland Insurance Administration and Maryland Health Care Commission
High Risk Pool

- Established 2002, administered by CareFirst, self-insured by the state
- Covers 20,000 people unable to obtain insurance in individual market
- MHIP + subsidizes coverage for low income residents
- MHIP Federal opened Sept. 2010
How are we doing?
Trend in Uninsured Rate in Maryland, 2004 through 2009

Uninsured Rate (%)

* Differs significantly from the 2007 & 2009 estimates using a 90% C.I.

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


Figure 4. Premiums for Family Coverage, 2003, 2009, 2015, and 2020

Health insurance premiums for family coverage

- 2003
- 2009
- 2015
- 2020

- U.S. average
- Lowest state
- Highest state


Medicaid

Exhibit 13
Fund Sources
Fiscal 2008–2012
($ in Billions)

Source: Department of Legislative Services; Department of Budget and Management; and Department of Health and Mental Hygiene
FY 2012 Maryland Budget

- Health
- Elementary and Secondary Education
- Public Safety
# REPORT CARD

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<th>Grade Average</th>
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<td>Attendance:</td>
<td><strong>Present</strong>: 40, <strong>Absent</strong>: 0, <strong>Tardy</strong>: 1</td>
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A = Excellent • B = Good • C = Satisfactory • N = Needs Improvement
U = Unsatisfactory • I = Insufficient / Incomplete

Student: ____________  Grade: ______  Year: ______
Barriers to Performance

• Weak primary care infrastructure, poorly connected to tertiary care
• Health care system generally pays for volume, not value
• Few incentives for high quality care
Efficiency

Test Results or Medical Records Not Available at Time of Appointment, Among Sicker Adults

Percent reporting test results/records not available at time of appointment in past two years

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<thead>
<tr>
<th></th>
<th>2005</th>
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<tr>
<td>CAN</td>
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International Comparison

AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.


Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008
### EFFICIENCY

**Medicare Admissions for Ambulatory Care-Sensitive Conditions, Rates and Associated Costs, by Hospital Referral Regions**

<table>
<thead>
<tr>
<th>Rate of ACS admissions per 10,000 beneficiaries</th>
<th>Costs of ACS admissions as percent of all discharge costs</th>
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<tr>
<td>2003</td>
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<tr>
<td>National mean</td>
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<tr>
<td>771</td>
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<td>526</td>
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</table>

**Percentiles**

- National mean
- 10th
- 25th
- 75th
- 50th

*Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008*

See report Appendix B for complete list of ambulatory care-sensitive conditions used in the analysis.

Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.
Medicare Hospital 30-Day Readmission Rates

Percent of Medicare beneficiaries admitted for one of 31 select conditions who are readmitted within 30 days following discharge.

* See report Appendix B for list of conditions used in the analysis.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% inpatient data.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008
March 23, 2010: The Affordable Care Act
Health Reform has many implications in Maryland and nationally.

- Changes to Medicaid
- Changes to private insurance
- Establishment of new Insurance Exchanges
- New State information technology needs
- Affects other parts of the public health and health care delivery systems
  - Long-term services and supports
  - Health care workforce
  - Preventive services and public health
On March 24, 2010, by Executive Order, Governor O’Malley created the Health Care Reform Coordinating Council.

- The HCRCC is a cross-agency and cross-branch entity
- Analysis conducted for the HCRCC projects that health insurance coverage will be expanded to an additional 350,000+ Marylanders by 2020
- Maryland’s uninsured rate will be cut in half, from 14.0% in 2010 to 6.7% in 2017
- The state is expected to realize more than $850 million in savings over 10 years as current state-funded safety net programs move into federally-subsidized coverage
Affordable Care Act Anticipated to Reduce Maryland Uninsured by Half

- **Uninsured**
  - 2010: 14.0%
  - 2017: 6.7%

- **Medicaid**
  - 2010: 14.1%
  - 2017: 14.3%

- **Private**
  - 2010: 59.4%
  - 2017: 64.0%

- **Medicare**
  - 2010: 12.5%
  - 2017: 15.0%

2010 (5.8 million Marylanders)
2017 (6.2 million Marylanders)
Four Key Elements of ACA

1. Strengthens insurance coverage
2. Expands access to health care
3. Makes coverage more affordable
4. Promotes cost control, quality, and prevention
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Smart Consumer Protections

• Young adults can stay on their parents coverage until age 26.

In effect now
Protects Families from Bankruptcy

- No exclusions for children with pre-existing conditions.

In effect now
Support in Case of Illness

• No pre-existing condition exclusions for chronically ill adults.

2014
Private insurance reforms influence both the individual and group insurance markets.

- Adopt adjusted community rating rules
- Adopt consumer protection reforms, e.g.:
  - No annual or lifetime caps
  - No pre-existing condition exclusions
  - Minimum Loss Ratios
- Phase-in of small business tax credits
- Establishment of new federally-funded high-risk pool
- Temporary reinsurance programs for early retirees
- Range of new options/considerations for states
Four Key Elements of ACA

1. Strengthens insurance coverage
2. Expands access to health care
3. Makes coverage more affordable
4. Promotes cost control, quality, and prevention
Expands Access to Health Care

- Establishes incentives and requirements to have coverage in order to avoid adverse selection and spread risk
Expands Access to Health Care

• Creates transparent, competitive exchanges where individuals and small businesses can go to purchase private insurance coverage.

2011 2012 2013 2014
Timeline for Health Insurance Exchanges

2011: Administration legislation establishes framework for an independent governmental entity to run the exchange.

2012: After study and initial recommendations, possible legislation to refine exchange.

2013: Final adjustments and launch of Exchange.

2014: Exchange operational.
Example
Looking for health coverage?

You have options.

Connect2Coverage works with insurers and public programs to offer the health coverage that you need. Select the best description of your needs below.

- Apply for no or low cost public health coverage
- Purchase health insurance and pay your own premiums
- Explore all available options

The information you provide will be used to determine the lowest cost health coverage and other public benefits for which you may be eligible. You will be provided the option to select other health coverage options if you choose to.
Example
On April 12, 2011, Governor O’Malley signed the Maryland Health Benefit Exchange Act into law.

- Established Maryland’s Exchange, effective June 1
- Framework and governance
  - Independent public entity to blend advantages of nonprofit (nimble operations, competitive salaries, etc.) with advantages of traditional executive branch agency (public transparency, accountability, etc.)
  - Exchange Board: nine members: Secretary of DHMH, head of MIA, head of MHCC, three members appointed by Governor with technical expertise, three members appointed by Governor to reflect individual, small employer, and public health
  - The Board has met five times, and among things approved bylaws, a procurement policy, an initial staffing plan, a job description for the Executive Director, and the recruitment and selection of the Executive Director who will start on September 12
Maryland’s Exchange has received over $30 million in federal grants for its planning and development start-up costs.

- $6.2 M federal Early Innovator Grant (awarded late 2010)
  - Supports prototype system for a subsection of federal Exchange IT system requirements

- $27 M federal Exchange Establishment Grant (awarded August 2011)
  - Supports implementation of ACA-compliant front-end and back-end eligibility and enrollment systems
Four Key Elements of ACA

1. Strengthens insurance coverage
2. Expands access to health care
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With premium tax credits and Medicaid Expansion, by 2014, all individuals under 400% FPL will be eligible for financial assistance.
Medicaid Expansion under ACA greatly affects Medicaid eligibility and payment structure.

- Expansion of Medicaid eligibility
  - Full federal financing for the new expansion eligibility category from 2014-2016, decreasing annually until the federal government contributes 90% funding for 2020 and beyond
- Sweeping changes in how Medicaid eligibility is determined
  - New IRS-based income eligibility known as the “Modified Adjusted Gross Income”, or MAGI
  - MAGI eligibility is expected to affect 200,000+ Medicaid eligibles
  - MAGI will require real-time eligibility determinations, including web-based, with a real-time connection to federal data (IRS, HHS, SSA, Homeland Security)
Support for Maryland Businesses

✓ Small business tax credits 35% (2010) – 50% (2014)
✓ Visit smallbusinesstaxcredits.org
✓ Or text HEALTH to 877877
Four Key Elements of ACA

1. Strengthens insurance coverage
2. Expands access to health care
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State Health Improvement Process

• [http://dhmh.maryland.gov/SHIP](http://dhmh.maryland.gov/SHIP)
Saves Money While Making People Healthier

✓ Invests in prevention

✓ Encourages high quality and efficient provision of care, with leadership by doctors and hospitals

✓ Supports ongoing efforts in health information technology
Health Care Delivery Reform
Goal is the “Triple Aim”

1. Improving individual experience of care
2. Reducing per capita health care costs
3. Improving the health of the population
ACA Opportunities (1)

• Patient-centered medical homes
  – 24/7 care management and support
  – Interdisciplinary teams
  – Coordinate care through care planning
  – Collect data on outcomes and cost
ACA Opportunities (2)

• Accountable Care Organizations
  – Vertically integrated units that share savings with payers
  – Must handle at least 5000 patients and commit for 3 years
  – If meet quality measures, get to share savings below benchmark per capita costs
  – Medicare to certify in 2012
ACA Opportunities (3)

• Pilot programs for bundled payments, readmissions reduction, and reduction in hospital-acquired conditions.
  – Limited to Medicare
Delivery Reform Workgroup

• 25 members
• Goal of identifying innovation in Maryland
  – Financial mechanisms
  – Clinical innovation
  – Integrated programs
Welcome

In this time of rising health care costs and tight budgets, Maryland’s consumers, hospitals, clinicians, insurance plans and community groups are working together to develop creative programs that enhance patient care, improve population health and cut costs.

About the database:
The health care projects featured in this database are already delivering care in the state of Maryland. Search below to learn more about the future of Maryland’s health care, and some of the innovative tools that will get us there.
Better health for Marylanders requires innovative community strategies that prevent illness, complications, and reduce health care cost through approaches to supporting patients. Click on the approaches below for more information and to see who is seeking to achieve these goals:

- Community-Based Chronic Disease Management
- Electronic Medical Record Networks
- Evidence-Based Clinical Practice Support
- Health Information Exchanges
- Home Health Support Services
- Integrated Hospice Care
- Integrated Primary, Mental and Behavioral health care
- Intensive Case Management
- Maximized Support Network for High-Risk Patients
- Patient Centered Medical Homes
- Patient Navigation from ED to Primary Care
- Post-Discharge Care Transitions Program
- Remote Monitoring
- Telemedicine
Patient-Centered Medical Home

A Patient-Centered Medical Home is a team-based model of care that provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH team typically consists of physicians, nurse practitioners, nurses, social workers, nutritionists, and other allied health professionals working together to provide preventive services, treatment of acute and chronic illness, and social support.

Here are some of the Maryland providers putting the PCMH model into use. Click on the links for more information:

**Stand-Alone Medical Home Projects:**
- Maryland Medical Home Plus Project
- The Memory and Alzheimer's Treatment Center
- The Sickle Cell Infusion Center

**Integrated Medical Home Projects with Supportive Financing:**
- Maryland Multi-Payer Patient-Centered Medical Home
- CareFirst Primary Care Medical Homes Program
- Adventist Patient-Centered Medical Home Pilot
Financing Better Health

Restructuring the way we pay for care plays an important role in promoting the kind of preventive and coordinated care that keeps patients healthy. These approaches to paying for care support better outcomes at lower cost.

- Bundled Payments
- Global Budgets
- Incentives for Reducing Preventable Hospital Readmissions
- Shared Savings
- Self-Insurance
Financing Better Health

Maryland Total Patient Revenue

What They're Doing: Global Budgets that cover all inpatient and outpatient services provided by participating rural hospitals with protections against reductions in volume.

Financing Mechanism: Total Patient Revenue is a three-year pilot program to test a voluntary alternative healthcare financing program for rural hospitals run by the Maryland Health Services Cost Review Commission (HSCRC). Participating hospitals receive a global budget that covers all inpatient and outpatient services provided by the hospital. The payment is calculated based on the hospital's charges from the prior fiscal year's with an annual rate update that is adjusted for performance on specific quality (both process and outcome) measures. This budget is used to determine the rate that the hospital can charge Medicare, Medicaid and private insurers for each service. If the hospital can increase efficiency, control costs or reduce avoidable ED visits, admissions and readmissions, it gets to keep 100% of the savings. If the costs increase beyond the allotted amount, then the hospital bears the financial risk. However, there is protection for hospitals to ensure that they do not lose revenue if volume decreases.

Evaluation Plan: HSCRC will review the number of hospital readmissions and how hospitals score on various quality (both outcome and process measure) before and after the program. Additionally, hospitals must submit any clinical innovations implemented in response to the program to the HSCRC.

Outcomes: Not available at this time. Pilot results expected end of 2013.

Target Population: Rural Hospitals in Maryland (10 hospitals currently participating)

Date of Implementation: July 2010
Contact: Steve Ports at the Maryland Health Services Cost Review Commission (HSCRC) sports@hscrc.state.md.us.
Multimedia: pending
Where to learn more: pending

Learn how Maryland hospitals are implementing Clinical innovations with support from Total Patient Revenue below:

Calvert Memorial Hospital
Integrated Programs

Organizations across Maryland are combining clinical innovations with supportive financing to meet the goals of the Triple Aim: enhancement of patient care, improvement of population health and reduction of cost.

Click on the examples below to learn more about how these programs mobilize cost-saving financial mechanisms to improve care:

**Adventist Patient-Centered Medical Home Pilot**
Medical Home for High-Risk Patients supported by Self-Insuring

**CareFirst Primary Care Medical Homes Program**
Medical Home project supported by Enhanced Provider Fee Rates, Provider Incentives for Coordinated Care and Shared Savings

**Johns Hopkins ElderPlus**
All-Inclusive Care supported by Global Budgets

**Maryland Multi-Payer Patient-Centered Medical Home**
Medical Home Project supported by Shared Savings

**Shore Wellness Partners**
Intensive Case management supported by Total Patient Revenue
Integrated Programs

Maryland Multi-Payor Patient-Centered Medical Home

What They’re Doing: State-wide Medical Home initiative supported by Shared Savings

Clinical Innovation: Creation of Maryland Learning Collaborative to support primary care practices in their transformation into Patient-Centered Medical Homes. These practice models emphasize integrated care coordination teams and individualized care plans, offering a uniquely flexible and responsive care centers for patients, and featuring 24/7 phone access, same-day appointments, and email communication options.

Financing Mechanism: Maryland law requires the five major insurance carriers and Medicaid to participate, and several other public employee plans have voluntarily joined in. Each practice enrolled in the program receives a transformation loan to finance costs associated with technology adaptation to moving to the medical home structure of care. A standard fee-for-service model per payer applies thereafter, with an annual reconciliation process where current year costs are compared to historical baseline and savings are shared equally between the plan and provider.

Evaluation Plan: Evaluation will be conducted by a third party and will focus on measures of quality, cost, patient/provider satisfaction surveys, and impact on health disparities.

Outcomes: No results available at this time.

Target Population: Currently 53 practices participating from across the state.

Date of Implementation: Learning collaboratives launched May 2011, practices operational July 2011.

Contact: Susan Myers

Multimedia: pending

Where to learn more: http://mhcc.maryland.gov/pcmh
Integrated Programs

Johns Hopkins ElderPlus
Program of All-Inclusive Care for the Elderly

What They're Doing: **All-Inclusive Care** supported by **Global Budgets**

**Clinical Innovation:** All-inclusive coordination of preventive, primary, acute, and long-term care services for a nursing home-eligible population, allowing them to remain living independently while maximizing support services and reducing the need for hospitalization.

**Financing Mechanism:** Global payment system where Medicare and Medicaid provide risk-adjusted up-front monthly payments for each patient, incentivizing wellness promotion, prevention, and avoidance of unnecessary hospitalization.

**Outcomes:**
- A rate of hospitalization equal to that of the general Medicare population, despite a sicker nursing home-eligible population at baseline.
- 96% of patients are able to remain living independently
- 95% of participants would recommend the program to a family member or friend

**Target Population:** High-risk nursing home-eligible elderly population living at home.

**Date of Implementation:** January 1996

**Contact:** Nicki McCann, nmccann4@jhu.edu

**Multimedia:** Pending

**Where to learn more:** www.hopkinsbayview.org/hopkinselderplus
Conclusions

• Tremendous challenges facing health system
• Health care reform is a tremendous opportunity
• To succeed, must control costs and improve outcomes.
For More Information

HealthReform.Maryland.Gov