Maryland’s Hospitals: Transforming Patient Care

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Agenda

• About Maryland’s Hospitals

• Maryland’s All-Payer Model (“Waiver”)

• Care Coordination: A Path to Population Health

• What’s Next?
About Maryland’s Hospitals

- 47 acute care hospitals
- Employ 106,000 people
- Provide care to all, including an estimated 389,000 uninsured Marylanders, totaling $712 million last year, nearly $2 million a day
About Maryland’s Hospitals

- $1.6 billion in community benefits, including outreach services and programs aimed at specific community health needs
- 614,045 admissions
- 73,598 babies delivered
- 2.4 million ER visits
All Payer Model Background

• Maryland waiver in place since the 1970s
• Modernized in January 2014
• Formalized shift from volume to value and is in line with health care’s Triple Aim
“The boldest proposal in the United States in the last half century to grab the problem of cost growth by the horns.”

Uwe Reinhardt
Princeton University health care economist

IHI Triple Aim
All Payer Model Requirements

- **Three financial metrics:**
  - Annual hospital spending cap – 3.58% per capita
  - Medicare savings target - $330 million over five years
  - Growth in Maryland spending (hospital and non-hospital spending) cannot exceed the nation

- **Two quality metrics:**
  - Reduce 30-day readmissions to national average
  - Reduce complications by 30% in five years
How Things Have Changed

OLD
- Fee-for-service
- Inpatient only
- Fragmentation

NEW
- Global budgets
- Population health
- Care coordination
Global Budgets
### Maryland Waiver Performance Dashboard

#### Cumulative Performance – Years 1 and 2

<table>
<thead>
<tr>
<th>Metric</th>
<th>Maryland Performance</th>
<th>Cumulative Target</th>
<th>Period</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All-Payer Hospital Spending Growth Per Capita</strong>&lt;br&gt;(compared to base year Maryland - CY 2013)</td>
<td>3.82% spending growth</td>
<td>7.29% spending growth or below</td>
<td>Jan ’14 - Dec ’15 vs. 2015 ceiling</td>
<td>HSCRC monthly financial data</td>
</tr>
<tr>
<td><strong>Medicare Hospital Spending Growth Per Beneficiary</strong>&lt;br&gt;(compared to national)</td>
<td>$251 million in savings</td>
<td>$49.5 million cumulative savings at year 2</td>
<td>Jan ’14 - Dec ’15 vs. 2015 target</td>
<td>CMS data¹</td>
</tr>
<tr>
<td><strong>Medicare All Provider Spending Growth Per Beneficiary¹</strong>&lt;br&gt;(compared to national)</td>
<td>-0.84% spending difference (MD growth rate was 1.46%)</td>
<td>0% no more than above national growth rate (national growth rate was 2.50%)</td>
<td>Jan ’14 - Dec ’15 vs. CY 2015 target</td>
<td>CMS data²</td>
</tr>
<tr>
<td><strong>Medicare Readmission Rate</strong>&lt;br&gt;(compared to national)</td>
<td>-3.96% decrease</td>
<td>-2.71% decrease or more</td>
<td>Jan ’14 - Dec ’15 vs. 2013 base year</td>
<td>CMS data, V. 3²</td>
</tr>
<tr>
<td><strong>Maryland Hospital Acquired Conditions Rate</strong>&lt;br&gt;(compared to base year Maryland - CY 2013)</td>
<td>-33.04% decrease</td>
<td>-13.31% decrease or more</td>
<td>Jan ’14 - Dec ’15 vs. 2013 base year</td>
<td>HSCRC data</td>
</tr>
</tbody>
</table>

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¹ All provider spending growth limited to 1 percent above the nation in a single year, and cannot rise above the national growth rate for two consecutive years. In CY 2015, Maryland was higher than the nation by 0.71 percent

² Data contain summaries provided by the federal government that have been prepared for Maryland, but are not official federal data. Data are preliminary and contain lags in claims. There may be material differences in results when final data are received.
Financial Targets in Waiver

- 3.58% annual, all-payer per capita growth limit
- Cumulative ceiling is now at 11.13%
Financial Targets

Financial Targets in Waiver

- $300M in savings
- Over half a billion in Medicare hospital savings

Hospital Savings Resulting from Difference Between Maryland and National Hospital Spending Growth per Medicare Beneficiary (Dollars in Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings (in Millions)</th>
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<tbody>
<tr>
<td>1</td>
<td>$117</td>
</tr>
<tr>
<td>2</td>
<td>$135</td>
</tr>
<tr>
<td>3</td>
<td>$282</td>
</tr>
<tr>
<td>4</td>
<td>$533</td>
</tr>
</tbody>
</table>
Financial Targets

Financial Targets in Waiver

- Maryland’s Medicare per beneficiary total cost growth rate cannot exceed the national average by more than 1 percentage point

Annual Medicare All Provider Spending Growth per Beneficiary: Total, Hospital and Non-Hospital

Maryland is doing well on this metric – national growth exceeds growth in Maryland by 1.18%
How Are We Doing - Readmits

Maryland Readmissions Rates versus Nation, Medicare Unadjusted

Source: CMS

We must close this gap by the end of 2018

Maryland: 14 percent
Nation: 6 percent

Readmissions Reductions, 2011-2016
How Are We Doing – PPCs

Potentially Preventable Complications, 2013-2016

48% Reduction

Source: HSCRC monthly inpatient case-mix data with 3M PPCs, final data
All Payer Model Created New Incentives

Changes how hospitals are paid to reward the right things – global budgets

- Success under the new rules requires:
  - cost reduction
  - care coordination outside the hospital
  - care in lower cost, community setting
  - reduce unnecessary care
  - improve clinical effectiveness

- The key: **population health management**
Population Health Management

Changes How Hospitals Think

- Do more to earn more ➔ Rewards for efficiency and quality
- Care for an individual patient ➔ Care for an entire population
- Acute care ➔ Ambulatory care ➔ Community care
- Competition ➔ Collaboration
- Hospital care ➔ Health care
### What does it mean?

#### Examples of change

<table>
<thead>
<tr>
<th>Patients</th>
<th>Partnerships</th>
<th>Population health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedside prescription delivery</td>
<td>Close collaboration with SNFs</td>
<td>Wellness initiatives</td>
</tr>
<tr>
<td>Health “coaches”</td>
<td>Transport to primary care appointments</td>
<td>Predictive data analytics</td>
</tr>
<tr>
<td>In-home post-discharge visits</td>
<td>Physician education/partnerships</td>
<td>Mental health/substance abuse clinics</td>
</tr>
<tr>
<td>Nurse hotlines</td>
<td>Sharing of data</td>
<td>Mobile health clinics</td>
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</table>
Non-hospital spending growth in Maryland continues to outpace the nation

Source: CMS data, see disclaimer
*Substance Abuse and Mental Health Services Administration data not included
Regional and Local Efforts Focus on…

• Delivery system changes, including:
  ▪ Chronic disease supports
  ▪ Integration and coordination across care continuum
  ▪ Case management and other supports for high needs and complex patients
  ▪ Episode improvements, including quality and efficiency improvements
  ▪ Clinical consolidation and modernization to improve quality and efficiency
Care Redesign in Maryland

- Care Redesign Amendment
  - Approved Fall 2016

- Initial two programs:
  - Hospital Care Improvement Program (HCIP)
  - Complex and Chronic Care Improvement Program (CCIP)
Care Alerts

• Partnership with CRISP

• Value: operate functionally to share information on high needs Medicare patients

• Learning Collaborative
Regional Transformation Partnerships

- Regional Collaborations
  - Analytics
  - Targeted services based on patient and population needs
  - Plan and develop care coordination and population health improvement approaches

- 8 Awards, $2.5M
  - Additional implementation grants
Regional Transformation Partnerships

- **Nexus Montgomery; $7.6 M**

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<th>Hospital Partners</th>
<th>Primary Community Partners</th>
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<tr>
<td>Adventist HealthCare Shady Grove</td>
<td>Primary Care Coalition</td>
</tr>
<tr>
<td>Shady Grove Adventist Hospital</td>
<td>The Coordinating Center</td>
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<tr>
<td>Washington Adventist Hospital</td>
<td>Cornerstone Montgomery</td>
</tr>
<tr>
<td>Holy Cross Hospital</td>
<td></td>
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<tr>
<td>Holy Cross Germantown Hospital</td>
<td></td>
</tr>
<tr>
<td>Med Star Montgomery Medical Center</td>
<td></td>
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<tr>
<td>Suburban Hospital</td>
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**Patient Focus:** Medicare beneficiaries and dual eligible individuals residing in senior housing and senior care facilities
Regional Transformation Partnerships

- **Baltimore City Regional Partnership**

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<tr>
<td>The Johns Hopkins Hospital</td>
<td>Health Care for the Homeless</td>
</tr>
<tr>
<td>Johns Hopkins Bayview Medical Center</td>
<td>Sisters Together And Reaching</td>
</tr>
<tr>
<td>University of Maryland Medical Center</td>
<td>Esperanza Center</td>
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<tr>
<td>University of Maryland Midtown</td>
<td></td>
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<tr>
<td>Mercy Medical Center</td>
<td></td>
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<tr>
<td>Anne Arundel Medical Center</td>
<td></td>
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<tr>
<td>Greater Baltimore Medical Center</td>
<td></td>
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<tr>
<td>Medstar Harbor Hospital</td>
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**Patient Focus:** More than 50 percent of residents living in surrounding zip-codes are recipients of Medicare, Medicaid, dual eligible, lack health insurance and experience the major barriers to health.
Provider Alignment

- Barriers to collaboration in state law
- Legislation to allow new value-based compensation arrangements
- Stakeholder process included multiple state agencies, Physicians, Insurance Companies
After years of hard work…
Focus on Patients

A Breath of Fresh Care

Thanks to a commitment by Maryland’s hospitals, in 2014 Maryland became one of the first states in the nation to implement a NEW proactive, community-based health care model. The vision: to help you get health and stay healthy for life.
What’s Next?

- Phase 2 “strategic plan” submitted Dec 31 to:
  - Incentivize providers to address Medicare total cost of care
  - Transform payment and delivery through new models:
    - Care redesign amendment
    - Primary care model; MACRA compliance
    - Post acute & long term care models
    - Dual eligibles (Medicare/caid) model
  - Begin to develop other new models: geographic
- Model details under negotiation
Maryland’s Strategic Transformation Roadmap

State-Level Infrastructure (leverages many other large investments)
- Create and Use, Meaningful, Actionable Data
- Develop Shared Tools (Patient Profiles, Enhanced Notifications, Care Needs, Others)
- Connect Providers

Alignment
- Medicare Chronic Care Management Codes/Medical Homes
- Gainsharing & Pay for Performance
- Integrated Care Networks & ACOs Including Dual Eligibles
- Accelerating All-Payer Opportunities Moving Away From Volume

Care coordination & integration (locally-led)
- Implement Provider-Driven Regional & Local Organizations & Resources (Requires Large Investments And Ongoing Costs)
- Support Provider-Driven Regional/Local Planning
- Technical Assistance

Consumer Engagement
- State & Local Outreach Efforts
- Develop Shared Tools For Engaging Consumers

Source: HSCRC Public Meeting. May 13, 2015
What’s Next?
Questions