Maryland's Health After Implementation of Health Care Reform

Presentation to the
League of Women Voters of Maryland
by Barbara Brookmyer, MD, MPH
Frederick County Health Officer
May 21, 2016

Objectives

- Define relevant terms
- Review key components of the PPACA
- Describe unique Maryland hospital funding structure
- Review status of health of Marylanders post PPACA
- Identify possible future issues of interest

Definition of Health

Health is a state of complete physical, mental and social well-being and *not merely the absence of disease or infirmity.* - World Health Organization

- The definition has not been amended since 1948.

What is Public Health?

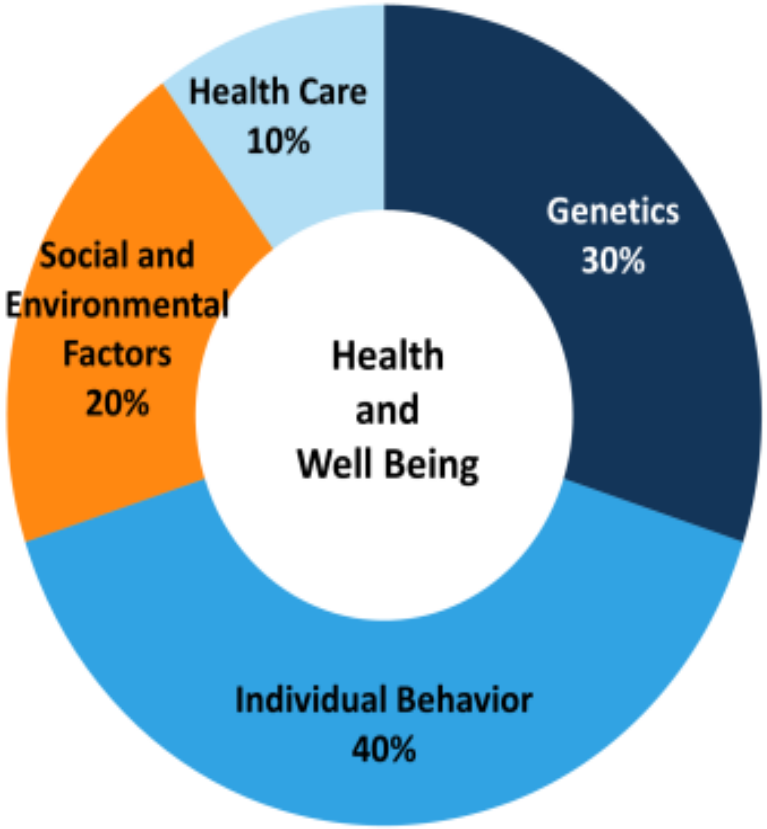
- Public health connects us all

- Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases.

- Public health professionals try to prevent problems from happening or recurring through implementing educational programs, recommending policies, administering services and conducting research.

Figure 1

Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

THE HENRY J. KAISER FAMILY FOUNDATION

Health Disparity

A health difference that is linked with **social, economic, and/or environmental** disadvantage.

Health disparities adversely affect groups of people who have experienced greater obstacles to health based on:

- racial or ethnic group
- religion
- socioeconomic status
- gender
- age
- mental health
- geographic location
- cognitive, sensory, or physical disability
- sexual orientation or gender identity
- or other characteristics historically linked to discrimination or exclusion.

PPACA Objectives

Access to Coverage – Expansion of Medicaid and commercial insurance through state level insurance Exchanges for individual and small business purchasers

Quality –Encourage use of evidence based care that improves outcomes, pay for performance, improve communication and safety

Cost – Improve the value of care provided per episode of treatment, test new models of payment that encourage innovation and collaboration, eliminate duplication, reduce fraud and abuse

Maryland's Unique Hospital Funding System

- When it comes to healthcare, Maryland is different from the rest of the nation.
- Maryland operates under a Medicare waiver program that guarantees hospital payments.
- The Maryland waiver has provided billions of extra dollars to Maryland hospitals, but as it has evolved it has created new challenges to the system

Adapted from MedChi

Challenges Faced by Maryland's All-Payer System for Hospitals

- Maryland has received a waiver from CMS to transition its "all payer" hospital payment system, under which all insurers pay the same fees, to a global budget system, effective January 1, 2014.
- The goal is to reduce overutilization of inpatient care and shift resources to more appropriate settings.
- The effort, led by the Maryland Health Services Cost Review Commission, is just getting under way. Details may be found at www.hscrc.maryland.gov .
- From the Physicians for a National Health Program "Whether it will control costs or just, in the absence of a single payer that can slash bureaucracy, restrict access to care, is unclear." http://www.pnhp.org/news/2014/june/data-update-summer-2014-newsletter

AMERICA'S ANNUAL REPORT
HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

Maryland

2015 EDITION

RANK: 18

Declined from 2014

2014 Rank: 16
Declined: 2

TOP FIVE HEALTHIEST STATES:
1. Hawaii
2. Vermont
3. Massachusetts
4. Minnesota
5. New Hampshire

America's Health Rankings®

United Health Foundation

Strengths:

- Low prevalence of smoking
- Low percentage of children in poverty
- Ready availability of primary care physicians

Challenges:

- Large disparity in health status by education level
- High levels of air pollution
- High violent crime rate

Highlights:

- In the past year, drug deaths increased 10% from 12.2 to 13.4 per 100,000 population.
- In the past year, physical inactivity decreased 15% from 25.3% to 21.4% of adults.
- In the past 2 years, lack of health insurance decreased 31% from 13.1% to 9.0% of the population.
- In the past 5 years, public health funding decreased 31% from $109 to $75 per person.
- Since 1990, cancer deaths decreased 15% from 221.1 to 188.0 per 100,000 population.

Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition
commonwealthfund.org http://www.commonwealthfund.org/publications/fund-reports/2015/dec/aiming-higher-2015

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Dimension and Indicator	State Rate	U.S. Average	Best State Rate	Rank	State Rate	U.S. Average	Actual Change in State Rate	Compare to other States
Access	2015 Scorecard Performance			5	Baseline Performance		Change in Rate	
Adults ages 19–64 uninsured	11%	15%	5%	12	14%	19%	-3	COMPARE
Children ages 0–18 uninsured	4%	6%	2%	6	5%	7%	-1	COMPARE
Adults who went without care because of cost in past year	10%	16%	7%	7	13%	15%	-3	COMPARE
Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	1%	16%	10%	1	N/A	N/A	N/A	COMPARE
At-risk adults without a routine doctor visit in past two years	7%	14%	6%	2	10%	14%	-3	COMPARE
Adults without a dental visit in past year	15%	15%	11%	20	13%	15%	2	COMPARE
Prevention & Treatment	2015 Scorecard Performance			14	Baseline Performance		Change in Rate	
Avoidable Hospital Use & Costs	2015 Scorecard Performance			42	Baseline Performance		Change in Rate	

D. McCarthy, D. C. Radley, and S. L. Hayes, Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition, The Commonwealth Fund, December 2015.

Avoidable Hospital Use & Costs	2015 Scorecard Performance			42	Baseline Performance		Change in Rate	
Hospital admissions for pediatric asthma, per 100,000 children	137	113	28	32	132	110	5	COMPARE
Hospital admissions among Medicare beneficiaries for ambulatory care–sensitive conditions, ages 65–74, per 1,000 beneficiaries	28	26	13	31	29	28	-1	COMPARE
Hospital admissions among Medicare beneficiaries for ambulatory care–sensitive conditions, age 75 and older, per 1,000 beneficiaries	66	64	36	25	69	69	-3	COMPARE
Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	43	30	10	49	49	34	-6	COMPARE
Short-stay nursing home residents readmitted within 30 days of hospital discharge to nursing home	22%	20%	13%	32	26%	21%	-4	COMPARE
Long-stay nursing home residents hospitalized within a six-month period	17%	17%	7%	24	20%	18%	-3	COMPARE
Home health patients also enrolled in Medicare with a hospital admission	17%	16%	13%	37	17%	16%	0	COMPARE

D. McCarthy, D. C. Radley, and S. L. Hayes, Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition, The Commonwealth Fund, December 2015.

US Health Care Expenditures

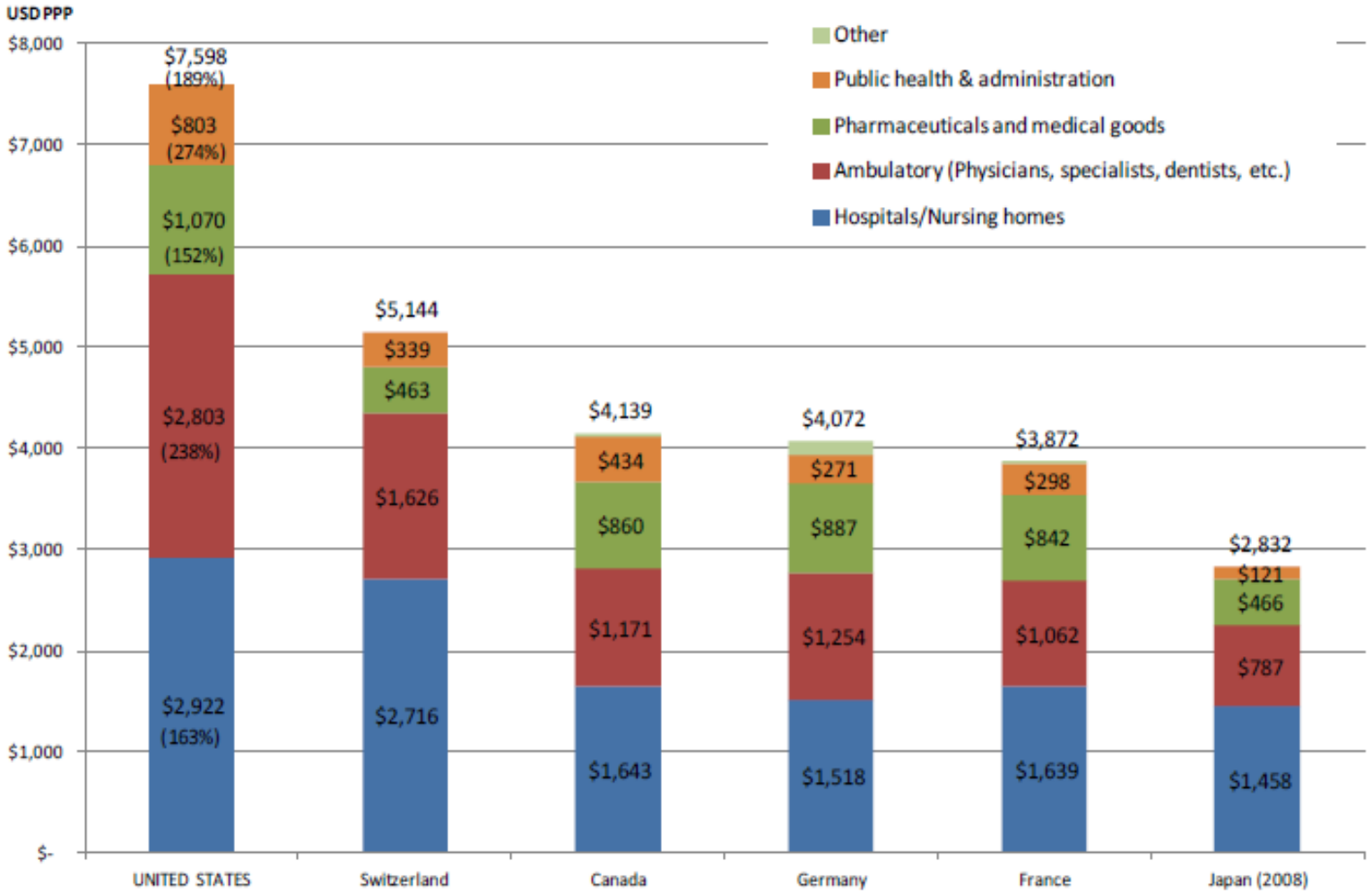
- Per capita national health expenditures: $9,523 (2014)
- Total national health expenditures: $3.0 trillion (2014)
- Total national health expenditures as a percent of GDP: 17.5% (2014)

Source: Health, United States, 2015, table 93 [PDF - 9.8 MB](http://www.cdc.gov/nchs/data/hus/hus15.pdf#093)

- Percent of national health expenditures for hospital care: 32.1% (2014)
- Percent of national health expenditures for nursing care facilities and continuing care retirement communities: 5.1% (2014)
- Percent of national health expenditures for physician and clinical services: 19.9% (2014)
- Percent of national health expenditures for prescription drugs: 9.8% (2014)

Source: Health, United States, 2015, table 94 [PDF - 9.8 MB](http://www.cdc.gov/nchs/data/hus/hus15.pdf#094)

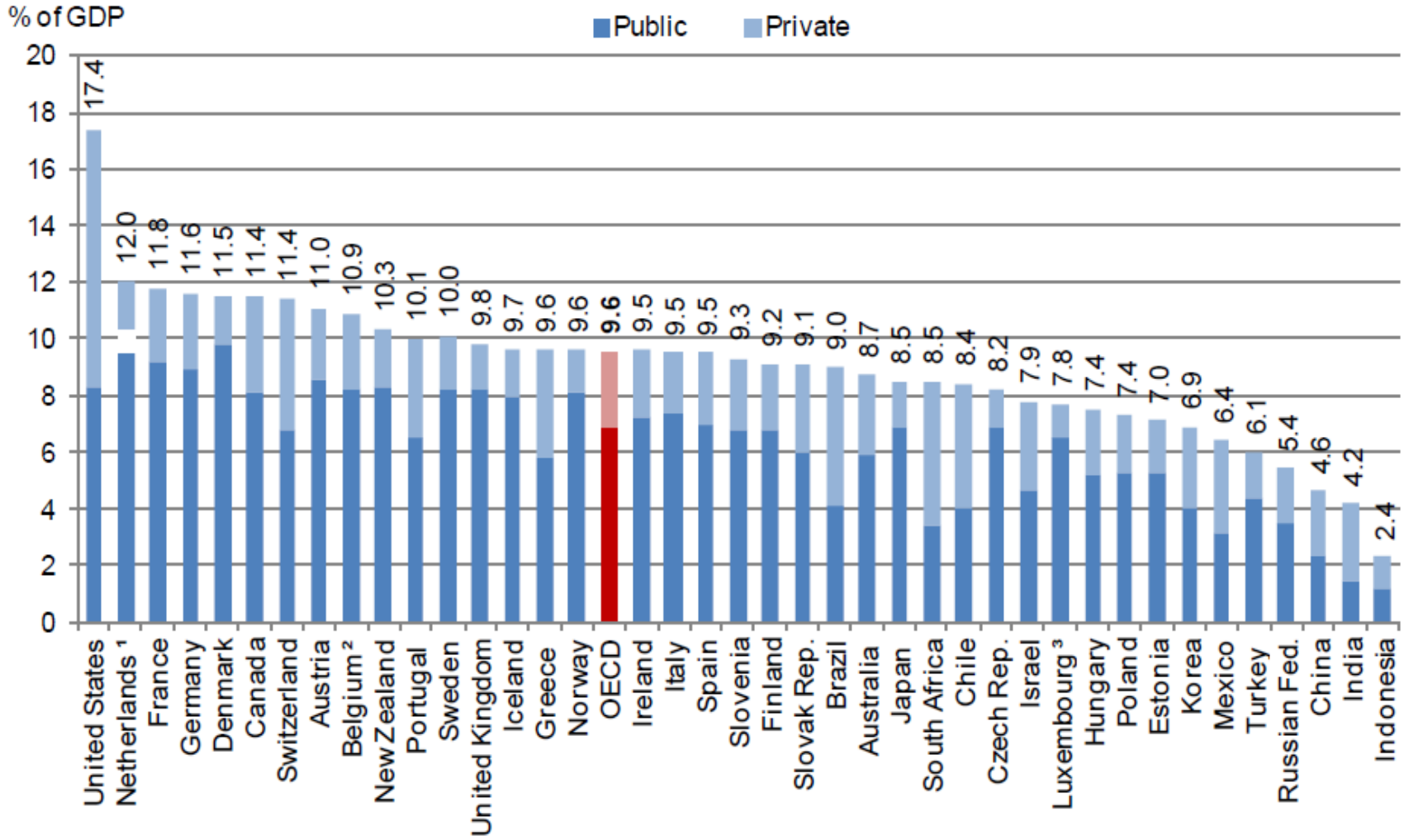
Chart 4: Health spending per capita by category of care, US and selected OECD countries, 2009



Note: Health spending excludes investments. The percentages in the US bar indicate how much more the US spends per category compared with the average of the five other OECD countries.
Source: OECD Health Data 2011.

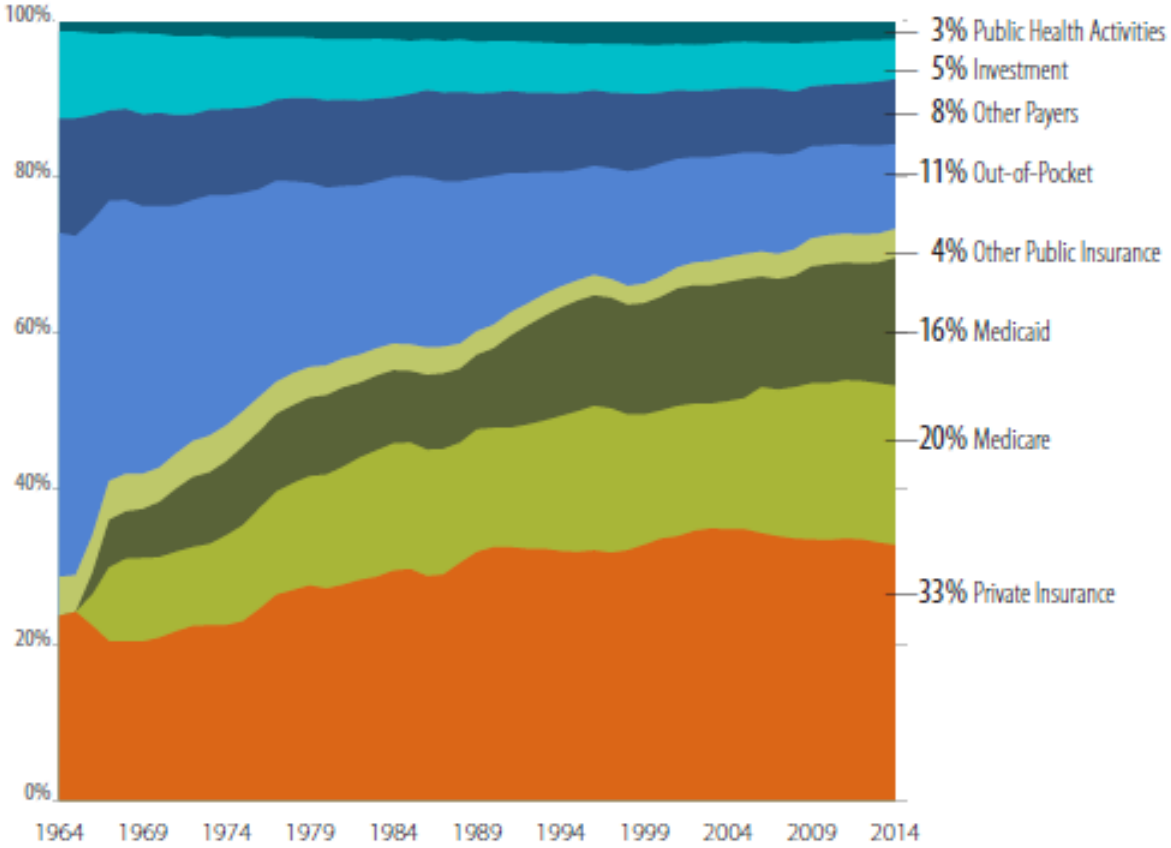
https://www.oecd.org/unitedstates/49084355.pdf

Chart 2: Total health expenditure as a share of GDP, 2009 (or nearest year)



Source: https://www.oecd.org/unitedstates/49084355.pdf

Payment Sources
United States, 1964 to 2014



Note: Health spending refers to national health expenditures.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2015, www.cms.gov.

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Out-of-pocket spending, as a share of all health spending, has shrunk dramatically over time as the share of spending by Medicare and Medicaid has expanded.

PAYER DEFINITIONS

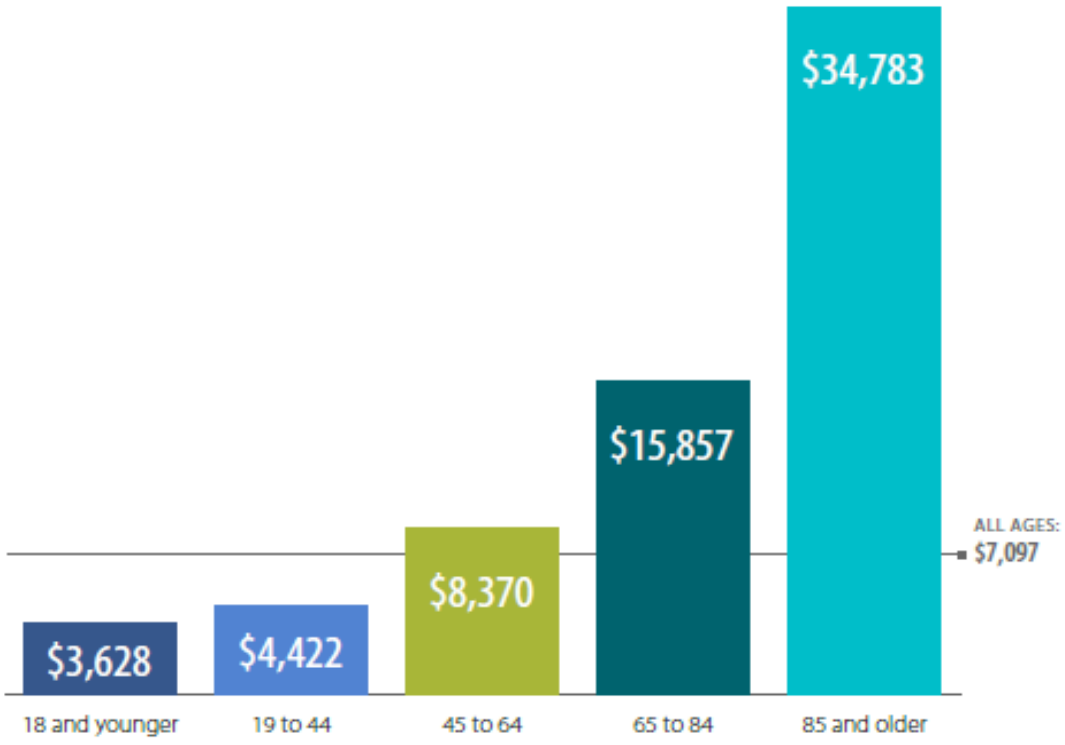
Other payers includes worksite health care, Indian Health Services, workers' compensation, maternal and child health, and vocational rehabilitation.

Other public health insurance includes Departments of Defense and Veterans Affairs health care and the Children's Health Insurance Program (CHIP).

Out-of-pocket includes consumer spending on copays, deductibles, and goods and care not covered by insurance; it does not include premiums.

Source:
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20H/PDF%20HealthCareCosts16.pdf

Personal Health Care Spending per Capita
by Age Group, United States, 2010



Notes: Personal health care spending excludes net cost of health insurance, government administration, public health activities, and investment. Per capita spending for all people age 65 and older was $18,424. See Appendix B for spending category detail by age group and gender.

Source: National Health Expenditure Data, Historical, 1960-2014, Centers for Medicare & Medicaid Services, 2014, www.cms.gov.

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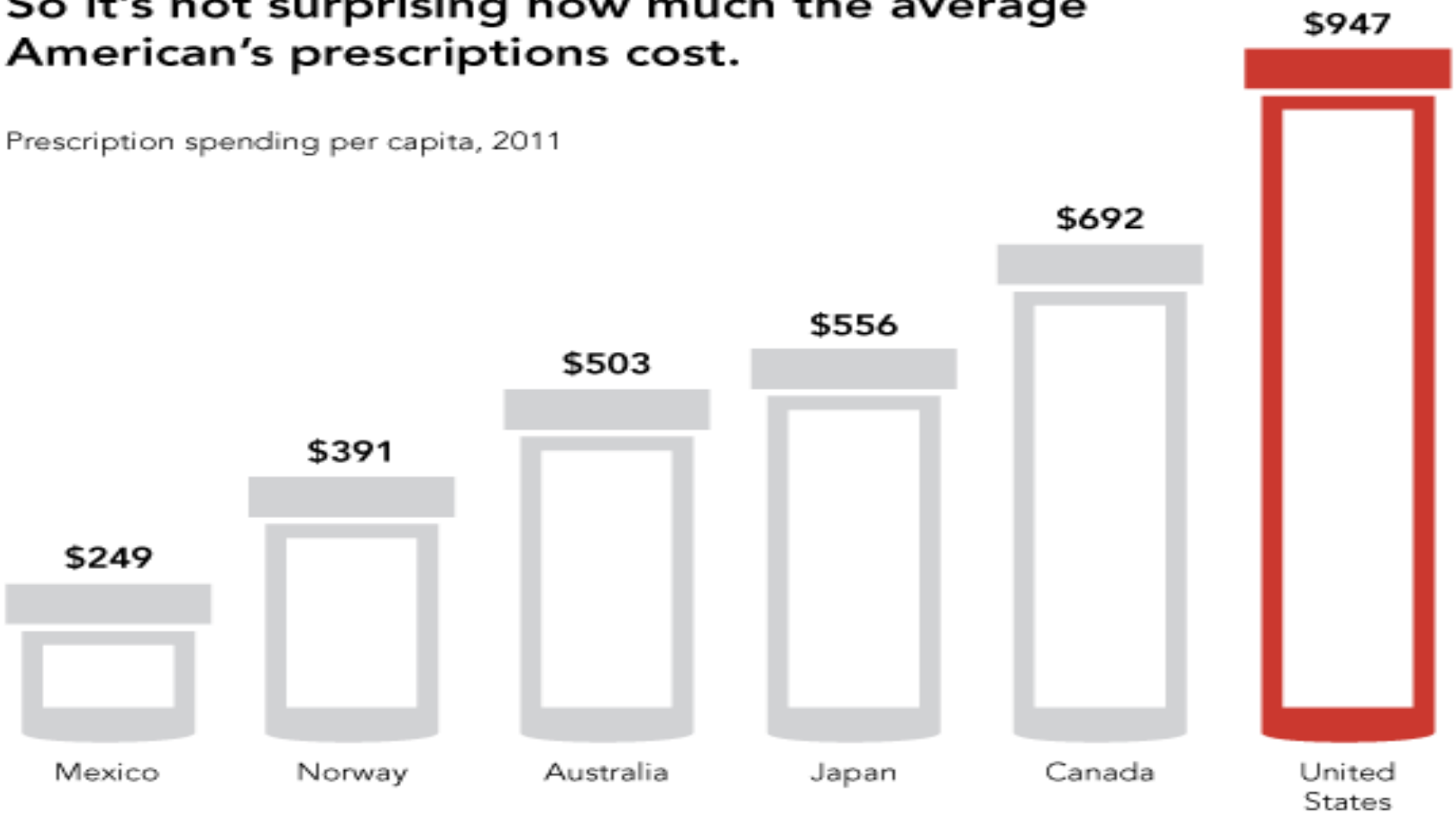
Per capita spending illustrates the relationship between health spending and age. Young working-age adults (19 to 44) spent $4,422 per person in 2010 on personal health care, 20% more than children, but half as much as older working adults. Those age 85 and over spent nearly $35,000 per person.

Source: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20H/PDF%20HealthCareCosts16.pdf

So it's not surprising how much the average American's prescriptions cost.



Notes: Numbers from Mexico and Norway cannot be separated and include medical non-durables. Data is from 2011 or nearest year.
Source: OECD Health Data 2011

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The Future

- Required to only maintain Medicaid and CHIP eligibility levels for children until 2019
- After 2016 feds pay states less than 100% for Medicaid
- Federally set* Medicaid rates for primary care providers to go back down
- Medicare bonus for primary care providers and general surgeons through 2015
- Maryland hospitals seek to reach Medicare savings targets

Maryland is doing something unique and *you are a part of it.*

- There is an agency that sets the rates hospitals are paid. *Concept: Hospitals do not* have the freedom to set their own pricing.
- Transformation of the health care delivery system should help you to get the right , in the right place, at the right time.
- Your health. Your life. – Your hospital is here to help you be as healthy as possible.
  - o Prevention is the most affordable care - see your doctor, eat healthy, live well.
  - o Teamwork among hospital and in the community, will make it easier for you to get care.
  - o Know where to get the care that best meets your needs (you might pay more if you get care in the wrong setting).
  - o Make good decisions by being informed about the cost of your health care and your financial responsibility
  - o Shop for health care that meets your needs.
  - o Shop for health care quality; high cost does not always equal high quality care.
  - o You can control who sees your health information.
  - o Use the tools that are available to help make health care decisions that are best for you.

Source: http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/ce/09-02/CETF-Commission-Report-FINAL.pdf p. 30

Maryland Waiver Performance Dashboard

Cumulative Performance – Jan 2014 to Most Recent Data Available

* 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

Watch List

- Medicaid eligibility changes to reduce expenses
- Medicaid reimbursement rates for primary care providers
- Medicaid network adequacy especially for behavioral health services
- Donut hole for prescription expenses in Medicare Part D
- Value prevention by paying for it
- Maryland hospital readmission reduction success
- Out-of-pocket expenditures – premiums, deductibles, medicines, and etc.
- Health in All Policies adoption

Health in All Policies

Health in All Policies is a **collaborative approach to improve health** by incorporating health considerations into decision-making across sectors and policy areas.

A Health in All Policies approach **identifies the ways in which decisions in multiple sectors affect health and how better health can support the goals** of these multiple sectors.

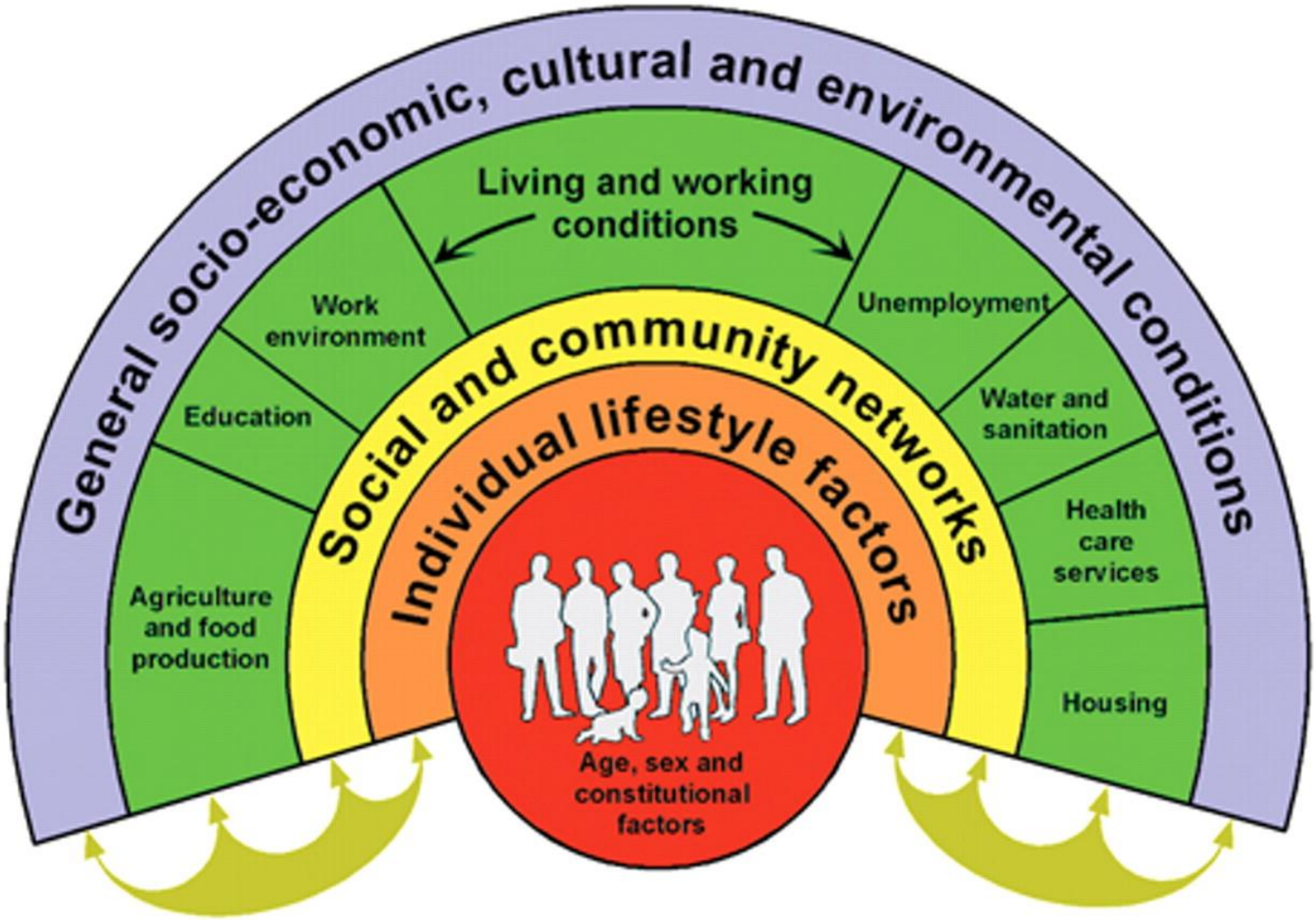
It **engages diverse partners and stakeholders to work together to promote health, equity, and sustainability, and simultaneously advance other goals** such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, and improved educational attainment.

Source: "Health in All Policies: A Guide for State and Local Governments," American Public Health Association and Public Health Institute, 2013, https://www.apha.org/topics-and-issues/healthy-communities/health-in-all-policies


EQUALITY


EQUITY

So


General socio-economic, cultural and environmental conditions
Living and working conditions
Work environment
Unemployment
Education
Water and sanitation
Social and community networks
Individual lifestyle factors
Agriculture and food production
Health care services
Housing
Age, sex and constitutional factors

Thank You!

Barbara A. Brookmyer, MD, MPH
Health Officer
Frederick County Health Department
350 Montevue Lane
Frederick, Maryland, 21702

bbrookmyer@FrederickCountyMD.gov

www.FrederickCountyMD.gov/health