Waiver 101

Maryland Hospital Association

The Basics

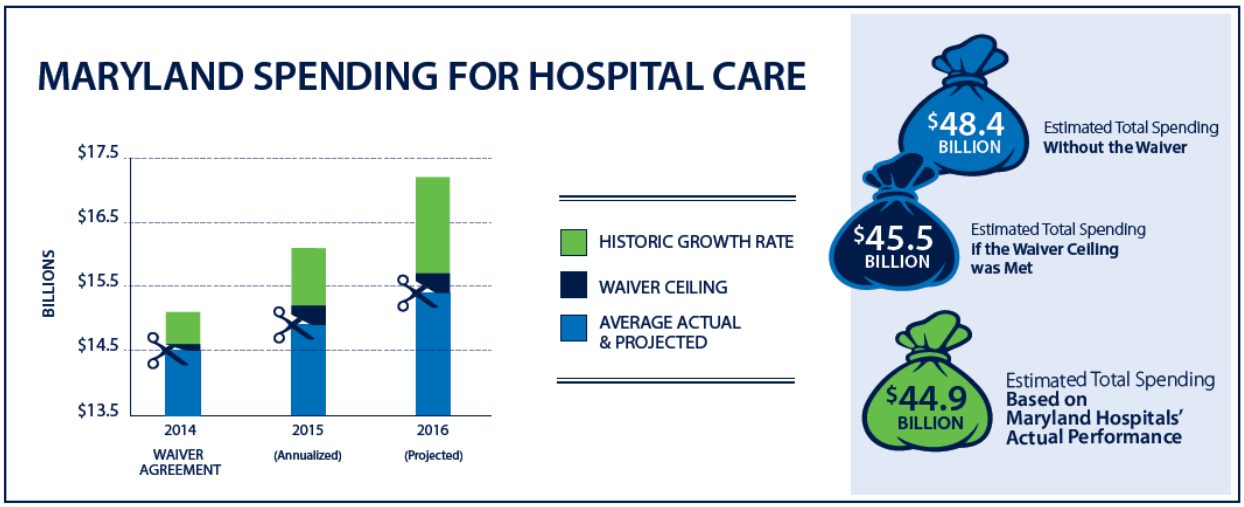
- Maryland is the only state in the nation that sets the rates hospitals can charge for their services. In our system, rates are the same for all patients for the same service in the same hospital, whether they have Medicare, Medicaid, private health insurance, or pay out of their own pocket.
- The system, begun in 1977, is known as the Maryland "Medicare waiver" because the federal government agrees to waive federal Medicare payment rules so that Medicare pays the rates set by the state. This brings the state an additional $1.5 billion annually.
- Since its inception, Maryland's system has lowered spending on hospital care from 25 percent above the national average to 4 percent below, and saved Maryland $45 billion through lower costs and lower health insurance premiums.
- Because the system began in another era of health care, it badly needed an update.

The Turning Point

- In January 2014, the Maryland "Medicare waiver" was modernized to better reflect the current state of health care – a trend toward more outpatient care and prevention, and less inpatient care. The new waiver agreement aligns with the goals of the Triple Aim of Health Care — less expensive care, better experiences for patients, and healthier communities.
- The new agreement requires hospitals and the state to achieve five specific targets:
  - Limit hospital spending per person to 3.58 percent annual growth
  - Reduce total Medicare hospital spending by $330 million over five years
  - Limit total Medicare spending per beneficiary to no more than national growth
  - Reduce the rate of hospital readmissions to the national average within five years
  - Reduce infections and other complications by 30 percent within five years
- This modernization has been praised by state and federal leaders and national health care experts as a revolution in health care that could be a model for the nation – all eyes are on Maryland!

The Results

- All of Maryland's hospitals now operate under fixed annual budgets shifting incentives from volume to value. This is a model where hospitals are not rewarded based on how many patients they treat, but rather on how successful they are in keeping their patients and communities healthy.
- The result: hospitals are keeping costs down by trimming unnecessary use of hospital services, improving quality, and working to keep members of their communities healthier and out of the hospital.
- To do this, hospitals have moved care beyond their walls and into communities by expanding preventive care and collaborating with others to make sure care does not stop after a patient leaves the hospital.
- Innovations generated by this shift include highly practical solutions like bedside prescription delivery, health "coaches" for patients after discharge, and comprehensive chronic disease management programs.
- The results are impressive. In the first year, hospitals have: saved Medicare more than $100 million; decreased unnecessary hospital use by more than 6 percent; held spending growth to less than 1.5 percent per person; reduced the readmissions rate faster than the nation; and reduced hospital complications by 26 percent.



Hand Hygiene

Compliance with hand-best practices has increased from 71 percent in 2010 to 90 percent in 2014.

Care Transitions

The rate at which patients discharged from the hospital were readmitted dropped 4.3 percent.

Illnesses Acquired in Hospitals

Preventable complications in hospitals dropped last year by 26 percent.

Infections

There were fewer urinary tract infections caused by catheters reported in April than in any of the previous 12 months. And 92 percent of units reporting data have had zero infections related to central line IVs in a 12-month period.

Unnecessary Hospital Use

Avoidable utilization of hospital services declined more than 6 percent.