Urban Hospital Experience Under the Maryland Medicare Waiver

Thomas R. Mullen
President & CEO
Mercy Health Services
Baltimore, Maryland
Friday, May 30th, 2014
BRIEF OVERVIEW OF MERCY HEALTH SERVICES
Mercy Health Services Background

- Founded in 1874 in Downtown Baltimore.
- High-quality, Independent Community Hospital affiliated with the University of Maryland School of Medicine.
- Mission-driven health system sponsored by the Sisters of Mercy.
- High-value provider compared to urban peers & Academic Medical Centers.

MISSION STATEMENT

Like the Sisters of Mercy before us, we witness God’s healing love for all people by providing excellent clinical and residential services within a community of compassionate care.
MHS: A Patient-Centered, Regional Health System

Mercy Health Services
4,700 Employees
$600 Million Revenue

Mercy Medical Center
238-bed Acute Care Hospital
3,100 Deliveries
67,000 ED visits
19,000 Admissions/Obs.
Downtown Primary Care Access
FQHC Coordination

Saint Paul Place Specialists
100+ employed Specialist Physicians

Maryland Family Care
70 Primary Care Providers
221K PCP visits
PCMH @ Hubs

Stella Maris
412-bed Nursing Home, Subacute-Rehab, Inpatient and Home Hospice

Mercy Ridge
Retirement Community
455 units (Joint Venture)

May 30, 2014
Mercy Medical Center Service Area

Quick Facts – Total Market
✓ Total population = 1.1M
✓ Forecast growth 2013-2018 = 1.0%

Hospital Key
1. Johns Hopkins Bayview
2. Medstar Harbor Hospital
3. Johns Hopkins Hospital
4. Medstar Union Memorial
5. UMMS Medical Center
6. UMMS Midtown Campus
7. Bon Secours Hospital
8. Sinai Hospital (Lifebridge)
9. St. Agnes Hospital (Ascension)
10. Medstar Good Samaritan
11. Greater Baltimore Medical Center
12. UMMS St. Joseph Medical Center
13. Medstar Franklin Square

May 30, 2014
MHS Transformation Timeline

Mercy is one of only a handful of non AMC urban hospitals in the nation to recapitalize itself.

Phase I - Building Financial Strength
- Mercy Ridge 2001

- Women's Health COE 1994

Phase II- Rebuilding Core Facilities
- Weinberg Ambulatory Center 2003
- Orthopedics COE 2002

- Mercy Ridge Phase II 2004
- Cancer COE 2006

- Replacement Garage and Tower Enabling Project 2007-2008
- Digestive Health COE 2008

Phase III Expanding Our Reach
- Bunting Acute Care Center 2010

- Lutherville Ambulatory Site 2011

- Maternal Child Health Center 2012

- Mercy Ridge Phase II 2004

- $118 MM

- $50MM

- $25MM

- $400MM

- $15MM

- $27MM

June 10, 2014

National Health Policy Forum - Washington D.C.
Mercy’s Centers of Excellence (COEs) support market share growth and institution's strong financial performance.

53.6% of COE revenue originates from outside PSA/SSA.

55% of MMC Total

52% of MMC Total

51% of MMC Total

48% of MMC Total

Neurosurg
Urol
Vasc Surg
Colon-Rectal
GI
Women's Svcs
Cancer Ctr
Ortho

* FY14 annualized using data through November, based on FY13 revenue patterns.
Successful Operation Supports Mercy’s Mission

- Mercy devotes 12% of its operating budget to benefit the community, compared to 10% state average.
- $49 Million in uncompensated care in FY2013.
- Clinical Staff support of Healthcare for the Homeless.
- Sexual Assault Forensic Examination Program (SAFE).
- Occupational Health Provider for City Police, Firefighters, Teachers, and other employees. Expanded to Baltimore County in 2013 (45,000 workers combined).
- Inpatient Detoxification Unit (1,200 patients annually).

Community Benefit Service Area

- 187,714 population (represents 30% of all City residents)
- 21% of households are below the poverty level
- 67% minority

Sister Helen Amos, RSM, Executive Chair of the Board of Trustees of Mercy Health Services
Mission: Baltimore City’s Largest Obstetrics Care Provider

- Baltimore’s largest birthing hospital.
- About 22% of all city births.
- More than 65% are Medicaid-insured patients.
- FQHC Coordination and Provider Staffing.
- Increasing maternal health literacy (Baby Basics).
- Maryland achieved significant reduction in infant mortality—especially among African Americans.
Senator Barbara Mikulski speaks at a press conference to announce Maryland’s new Medicare Waiver

National Health Policy Forum

MARYLAND MEDICARE WAIVER

URBAN HOSPITAL EXPERIENCE
Global Budget Revenue (GBR) Agreements

- **HSCRC Implementing Waiver**
  - 92% of revenue is GBR/TPR.
  - Balanced update 3.3% less 0.6% UCC.
  - New policies for quality reimbursements.

- **State Hospital Revenue Growth = 0.2% (1st Qtr March)**
  - Similar result for Medicare.
  - Developing system “Dashboard” to track.

- **Conservative – Early in Implementation**

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<table>
<thead>
<tr>
<th>Avg GBR Update (90%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflation</td>
</tr>
<tr>
<td>Volume</td>
</tr>
<tr>
<td>Infrastructure</td>
</tr>
<tr>
<td>Shared Savings</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
</tr>
<tr>
<td>Uncompensated Care</td>
</tr>
<tr>
<td>Average Update</td>
</tr>
</tbody>
</table>
Hospitals and physicians have differing incentives.

- Will be critical to internally align incentives.
- Productivity requirements will demand that we grow patient base or right-size service offerings.

What Does GBR Volume Incentive Mean?

Population Health Incentives

<table>
<thead>
<tr>
<th>Mercy Medical Center</th>
<th>Primary Care</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Managed volume growth – reduce unnecessary volume</td>
<td>• Payer incentives to control cost (PCMH)</td>
<td>• Payer-directed volume for cost-effective performance</td>
</tr>
<tr>
<td>• Cost incentive – living within the revenue cap</td>
<td>• Referrals to low-cost hospital and specialists</td>
<td>• Supply cost controls and ability to participate in gain-sharing</td>
</tr>
<tr>
<td></td>
<td>• Expand services at hubs to reduce system cost</td>
<td>• Create cooperation agreement between competitors to share physician capacity</td>
</tr>
</tbody>
</table>
### High-Value Providers Critical to Controlling Costs

#### Adjusted Charge Over (Under) Per Case MMC

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Adjusted Charge</th>
<th>Over (Under)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Maryland</td>
<td>$ 18,619</td>
<td>49.3%</td>
</tr>
<tr>
<td>Johns Hopkins Hospital</td>
<td>17,628</td>
<td>41.4%</td>
</tr>
<tr>
<td>Johns Hopkins Bayview</td>
<td>14,072</td>
<td>12.9%</td>
</tr>
<tr>
<td>Maryland General</td>
<td>13,708</td>
<td>9.9%</td>
</tr>
<tr>
<td>Sinai</td>
<td>13,541</td>
<td>8.6%</td>
</tr>
<tr>
<td>Harbor Hospital</td>
<td>13,397</td>
<td>7.4%</td>
</tr>
<tr>
<td>Union Memorial</td>
<td>13,219</td>
<td>6.0%</td>
</tr>
<tr>
<td>Franklin Square</td>
<td>12,769</td>
<td>2.4%</td>
</tr>
<tr>
<td><strong>Mercy Medical Center</strong></td>
<td><strong>12,468</strong></td>
<td><strong>0.0%</strong></td>
</tr>
<tr>
<td>St. Agnes</td>
<td>12,351</td>
<td>-0.9%</td>
</tr>
<tr>
<td>St. Josephs</td>
<td>10,952</td>
<td>-12.2%</td>
</tr>
<tr>
<td>GBMC</td>
<td>10,878</td>
<td>-12.8%</td>
</tr>
<tr>
<td>Competitor Average</td>
<td>$13,634</td>
<td>10.4%</td>
</tr>
<tr>
<td>Comp Avg (Excl. AMCs)</td>
<td>$12,736</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

#### Compared MMC high volume procedures to peer group & AMC’s

<table>
<thead>
<tr>
<th>Procedure</th>
<th>MMC</th>
<th>Academics</th>
<th>PG (excl AMCs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery</td>
<td>$7,571</td>
<td>$12,927</td>
<td>$7,485</td>
</tr>
<tr>
<td><em>C-Section</em></td>
<td>$9,630</td>
<td>$16,106</td>
<td>$8,949</td>
</tr>
<tr>
<td><em>Vaginal</em></td>
<td>$6,457</td>
<td>$11,398</td>
<td>$6,672</td>
</tr>
<tr>
<td>Hip Repl.</td>
<td>$24,144</td>
<td>$37,014</td>
<td>$24,710</td>
</tr>
<tr>
<td>Knee Repl.</td>
<td>$22,901</td>
<td>$40,013</td>
<td>$23,762</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>$2,258</td>
<td>$2,406</td>
<td>$2,100</td>
</tr>
</tbody>
</table>

Average Charge per Procedure
Waiver Readmissions Reduction Target will require increased collaboration among Hospitals

New methodology includes inter-hospital

- Medicare Readmissions: Mercy is slightly higher than the national average but below state average.

- 40% of Mercy readmissions go to other hospitals.

- While Hospitals will continue to compete for surgery/procedure market share, they must collaborate to reduce readmissions.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Discharges</th>
<th>Readmits</th>
<th>% Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland General</td>
<td>2,166</td>
<td>559</td>
<td>25.8%</td>
</tr>
<tr>
<td>UMMC</td>
<td>7,991</td>
<td>2,057</td>
<td>25.7%</td>
</tr>
<tr>
<td>JH Bayview</td>
<td>6,668</td>
<td>1,538</td>
<td>23.1%</td>
</tr>
<tr>
<td>Johns Hopkins</td>
<td>11,216</td>
<td>2,551</td>
<td>22.7%</td>
</tr>
<tr>
<td>Sinai</td>
<td>8,540</td>
<td>1,850</td>
<td>21.7%</td>
</tr>
<tr>
<td>Harbor</td>
<td>2,884</td>
<td>610</td>
<td>21.2%</td>
</tr>
<tr>
<td>Franklin Square</td>
<td>8,424</td>
<td>1,758</td>
<td>20.9%</td>
</tr>
<tr>
<td>St Agnes</td>
<td>6,739</td>
<td>1,387</td>
<td>20.6%</td>
</tr>
<tr>
<td>Union Memorial</td>
<td>5,514</td>
<td>1,048</td>
<td>19.0%</td>
</tr>
<tr>
<td>Mercy Medical Center</td>
<td>4,508</td>
<td>818</td>
<td>18.1%</td>
</tr>
<tr>
<td>St Josephs</td>
<td>6,595</td>
<td>1,126</td>
<td>17.1%</td>
</tr>
<tr>
<td>GBMC</td>
<td>6,133</td>
<td>989</td>
<td>16.1%</td>
</tr>
<tr>
<td>Competitor Avg</td>
<td>77,378</td>
<td>16,291</td>
<td>21.1%</td>
</tr>
<tr>
<td>Statewide Avg</td>
<td>223,672</td>
<td>43,280</td>
<td>19.3%</td>
</tr>
</tbody>
</table>

Source: HSCRC Performance Measurement Workgroup, FY2013 Data

Nat’l Avg = 17.7%
**Definition:** “Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health.”

23% of all IP Medicare spending statewide is “Potentially Avoidable”

**Examples:**
- 30-Day Readmissions.
- Preventable Admissions (AHRQ Prevention Quality Indicators).
- Maryland Hospital Acquired Conditions (Potentially Preventable Complications).
- Nursing home residents: Reduce conditions leading to admissions and readmissions.
- Improved care coordination: High needs/frequent users, involvement of social services.

*Excludes Kernan*
Mercy Response: Align Corporate Priorities with Waiver Goals and MHS Strategic Plan

Maryland Waiver Model

- All-Payer Total Hospital Cost Growth Ceiling
- Medicare Savings Target
- Medicare Readmissions Reductions
- Hospital Acquired Conditions Reductions

Global Budget Model Incentives

- Reduce Avoidable Utilization
- Improve Operating Performance Margin
- Targeted COE market share growth
- Increase patient base/physician network
- Quality Programs (MHAC, ARR, QBR)
- Medicare Savings

Corporate Priorities

MHS Transformation
- Clinical Redesign
- Medicare Savings
- Epic Ambulatory Optimization
- Community Health Initiatives

Quality, Safety, Patient Experience
- Hospital Acquired Conditions (MHACs)
- Readmissions
- Patient Experience (HCAHCPs)

Strategic Growth
- COE Volume & Reach
- Hub Specialist Visits
- Maryland Family Care
- Business Health

Stewardship
- Productivity
- EBIDA
- Subsidiary Performance

Mercy Goals/Initiatives under the “New Normal”

- **Clinical Redesign**—Achieve savings with clinical redesign by reducing potentially avoidable utilization.
- **Medicare Savings**—Hold growth in Medicare charges per beneficiary to 0%.
- **Readmissions**—Continue to focus on readmissions with a goal to achieve a 7% reduction in readmission rates. Collaborate with other City Hospitals.
- **Quality**—Improve performance on the HSCRC’s Hospital Acquired Conditions program (MHAC)
- **Population Health**
  - Integrate MHS Primary Care Physicians with PCMH. Hubs are located in geographic areas with high density of Medicare beneficiaries (CareFirst Medicare PCMH Pilot).
  - Significantly increase coordination with Community Health Centers (FQHCs).
  - Implement strategic community benefit initiatives to support more appropriate utilization of health services and improve health of populations.

Maryland Waiver

Better Care
Better Health
Lower Cost

May 30, 2014
National Health Policy Forum - Washington D.C.
A Closer Look: Mercy’s FQHC Coordination & Support

We view FQHCs as key collaborators in population health. FQHC’s also help Mercy to address 5 CHNA focus areas.

- **B’more for Healthy Babies & “Baby Basics”:** Prenatal education. Free Resource books for every expectant mother receiving care at partner FQHCs. Training for staff and providers.

- **Mercy’s Family Violence Program:** Training all FQHC staff and providers to recognize signs of domestic violence.

- **Homeless Services:** Hired a patient navigator to improve care coordination. Supported new Mobile Clinic. Pilot focused on coordination for 25 most frequent users of Mercy’s ED.

- **Clinic Expansion:** Mercy is working on real estate deal to enable Total Health Care to expand.

- **Leadership** Mercy managers now volunteer on the Boards of all five FQHC partners.
Thank you.

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Appendix: List of Acronyms

- AMC – Academic Medical Center
- AOI – Area of Interest
- AHRQ - Agency for Healthcare Research and Quality
- ARR - Admission-Readmission Revenue Program
- CMA – Case Mix Adjusted
- CMI – Case Mix Index
- CPE – Charge Per Episode
- COE – Center of Excellence
- CRISP - Chesapeake Regional Information System for our Patients
- FQHC – Federally-Qualified Health Center
- GBR – Global Budget Revenue
- GBMC – Greater Baltimore Medical Center
- HSCRC – Maryland Health Services Cost Review Commission
- MHAC – Maryland Hospital Acquired Conditions Program
- MMC – Mercy Medical Center
- PAU – Potentially Avoidable Utilization
- PCMH – Patient Centered Medical Home
- PSA – Primary Service Area
- RSM - Religious Sisters of Mercy
- SSA – Secondary Service Area
- TPR – Total Patient Revenue
- QBR – Quality Based Reimbursement
- UMMC – University of Maryland Medical Center