Overview of Global Hospital Budgeting in the State of Maryland

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June 2017

A CENTURY OF SAVING LIVES
MILLIONS AT A TIME

JOHNS HOPKINS
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Disclosure

Dr. Sharfstein is a consultant for Audacious Inquiry, a Maryland-based health IT company and with Sachs Policy Group, a healthcare consulting practice based in New York City.

Hospital Payment in Maryland

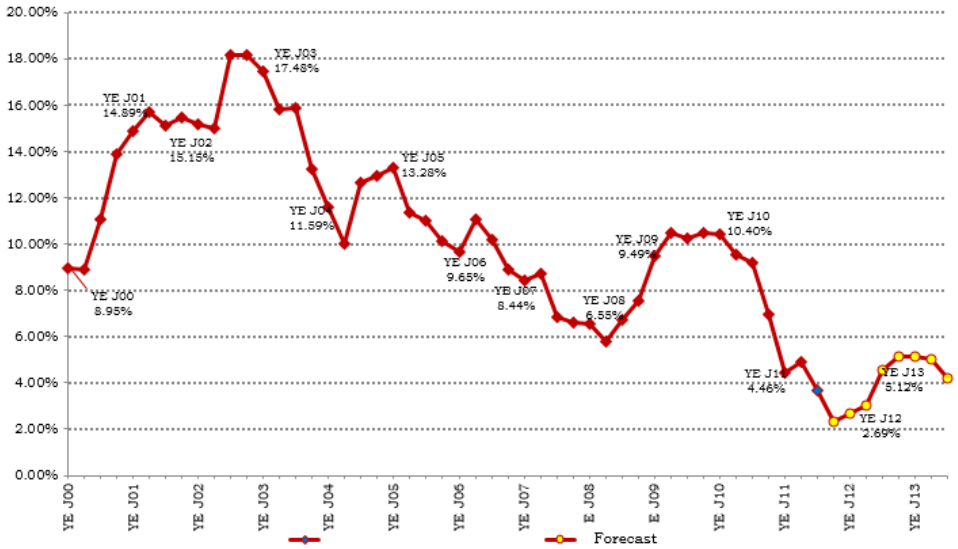
- Since the late 1970s, the Maryland's quasi-public Health Services Cost Review Commission sets inpatient and outpatient hospital rates for all public and private payers.

- Essentially, each hospital received a rate card, and all payers pay off of the rate card

- Over 35 years, Maryland's rate-setting system:
  - Eliminated cost-shifting among payers
  - Allocated cost of uncompensated care and medical education among all payers
  - Allowed usage of creative of incentives to improve quality and outcomes

2013: Crisis in the Maryland System

- Medicare participation required Maryland to keep rate of growth of prices below national trends

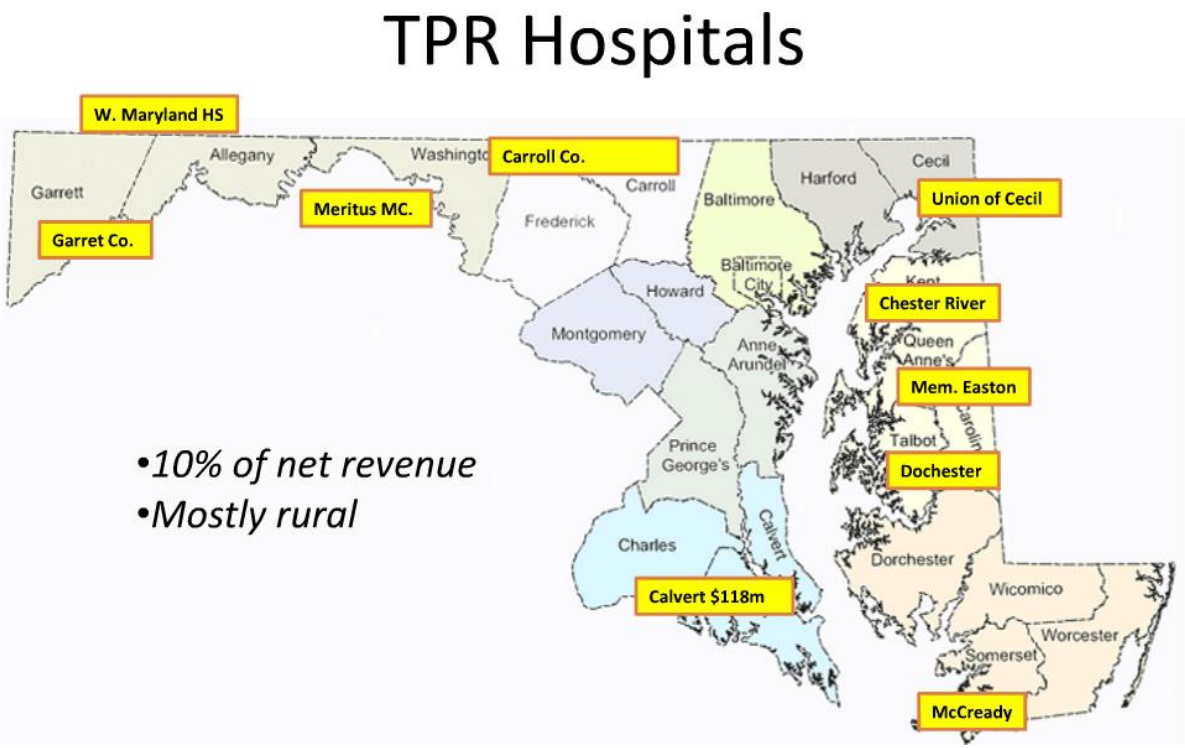


What to do?

- Crisis in healthcare costs = opportunity for health?
- Maryland had a unique opportunity to restructure hospital payment in order to control costs and incentivize prevention.

A Pilot: Total Patient Revenue, Meaning a Global Budget Across All Payers

Strong Incentive for Clinical Transformation



Concept: Move All Hospitals to Global Budgets

- Former Hospital Payment Model:
  - Volume Driven

Units/Cases

× **Rate Per Unit or Case (Updated for Trend and Value)**

↓

Hospital Revenue

- Unknown at the beginning of year
- More units creates more revenue

- New Hospital Payment Model:
  - Population Driven

Revenue Base Year

× **Updates for Trend, Population, Value**

↓

Allowed Revenue for Target Year

- Known at the beginning of year
- More units does not create more revenue

Source: HSCRC

Key Points

- Hospitals can use revenue to invest in prevention outside the walls
- Year-over-year adjustments in budgets based on:
    - Population changes
    - Market shifts
    - Quality
- Hospitals keep revenue as services decline, as long as no market shifts or quality problems
- Fewer preventable admissions = better bottom line

Western Maryland Health System

Facts About WMHS

- $330 Million in operating revenues for FY14
  - 11,805 adult admissions per year (Down from 15,521 in FY11)
  - 52,331 ED visits per year
  - 1,000 deliveries per year
- Over $300 million economic impact on the region annually
- $36.5 million in Community Benefit for FY2014

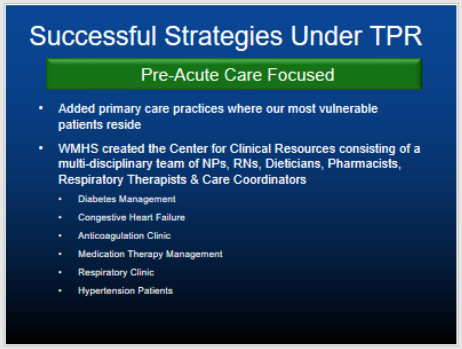
Source: WMHS

Managing Under TPR

Keys to Success

- Shift emphasis from volume to value
- Reduce admissions & re-admissions
- Provide care in the most appropriate location
- Create stronger patient engagement
- Reduce variation in quality
- Improve payment alignment with physicians
- Re-invest savings
- Educate employees, medical staff and community about changes
- Work collaboratively with community partners
- Focus on better community access
- Increase health & wellness activities on a regional basis
- Reduce utilization rates in ED, inpatient, observation and ancillary
- Improve chronic care delivery

Source: WMHS



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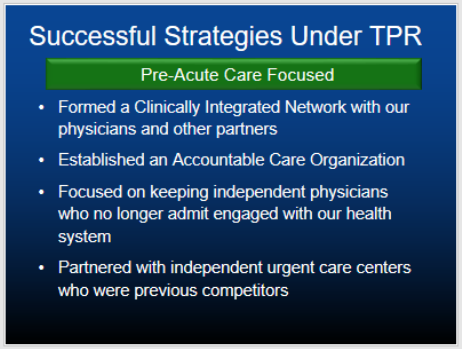

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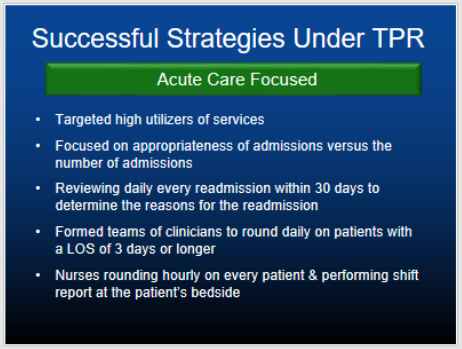

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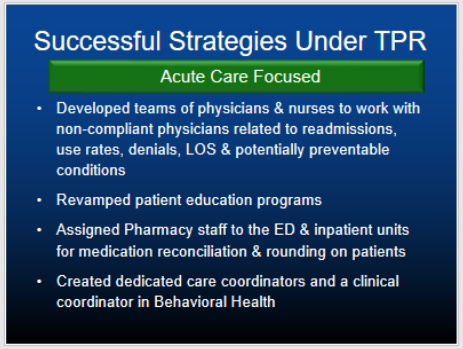

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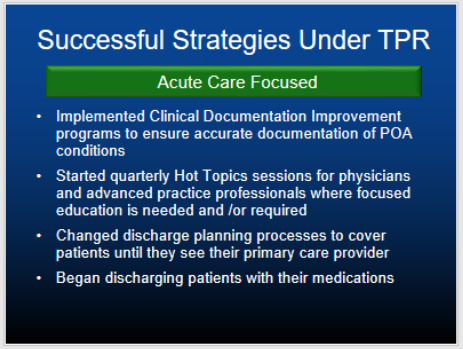

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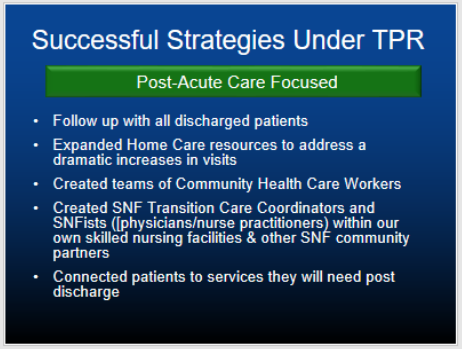

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Source: WMHS

Overall Results So Far

	FY2011	FY2015	Change
Inpatient Admissions	15,848	11,882	↓ 25%
Readmission Rate	14.54%	13.25%	↓ 8%
Inpt Behavioral Health Admissions	1,248	1,126	↓ 9.8%
Readmission Rate	20.9%	11.35%	↓ 46%
ED Visits	55,183	52,875	↓ 4.2%

Source: WMHS

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ECONOMIC SCENE

Lessons in Maryland for Costs at Hospitals

J.M. Eddins Jr. for The New York Times

Dawn Snyder, a registered nurse, runs a heart failure clinic at Western Maryland Health System.

By EDUARDO PORTER
Published: August 27, 2013

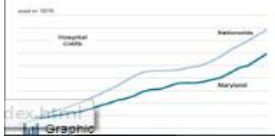
CUMBERLAND, Md. — This hardscrabble city at the base of the Appalachians makes for an unlikely hotbed of health care innovation.

Economic Scene

Eduardo Porter writes the Economic Scene column for the Wednesday Business section.

Author Bio »
Past Columns »

Multimedia



Graphic

Yet Western Maryland Health Systems, the major hospital serving this poor and isolated region, is carrying out an experiment that could leave a more profound imprint on the delivery of health care than President Obama's reforms.

Over the last three years, the hospital has taken its services outside its walls. It has opened a diabetes clinic, a wound center and a behavioral health clinic. It has hired people to follow up with older, sicker patients once they are discharged. It has added primary care practices in some neighborhoods.

The goal, seemingly so simple, has so far proved elusive

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Keys to Success (1)

- Community collaborations with physicians, nursing homes, and community organizations around primary, secondary, and tertiary prevention

Outside the Walls

School Health Program

At Meritus Health, we believe that all children are entitled to quality healthcare services and that good health helps support academic achievement. The Meritus Health School Health program serves the 22,000 students of Washington County Public School system in 27 elementary schools, eight middle schools and eight high schools. On average, our healthcare providers see 500 to 700 students each month in school health rooms.

Sinai Hospital and HealthCare Access Maryland Pioneer a New Program to Link Emergency Department Patients with Needed Services

Baltimore, MD – Sinai Hospital of Baltimore and HealthCare Access Maryland are piloting a groundbreaking program developed to proactively help patients, who frequently use the hospital's Emergency Department for non-urgent and chronic health conditions, better manage their own care, lead healthier lives, and in turn, save precious health-related resources.

Keys to Success (2)

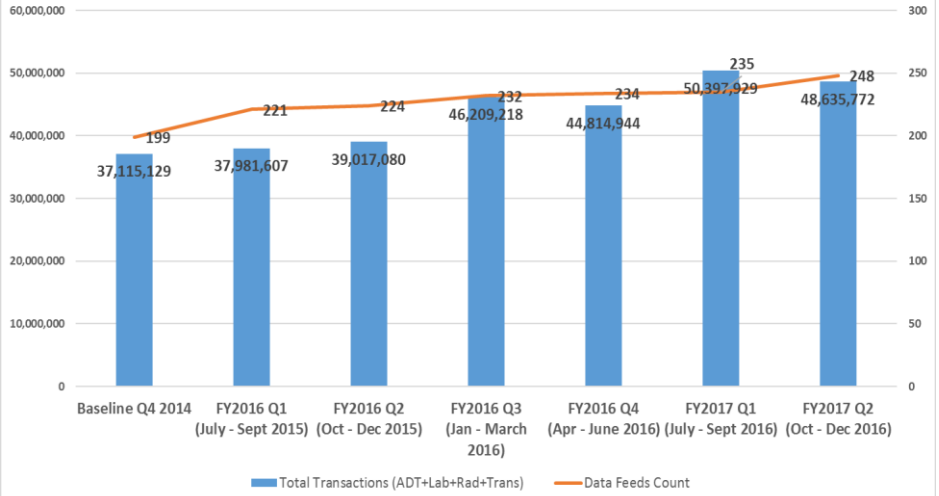
- Sharing and effective use of electronic health data

CRISP Core Services

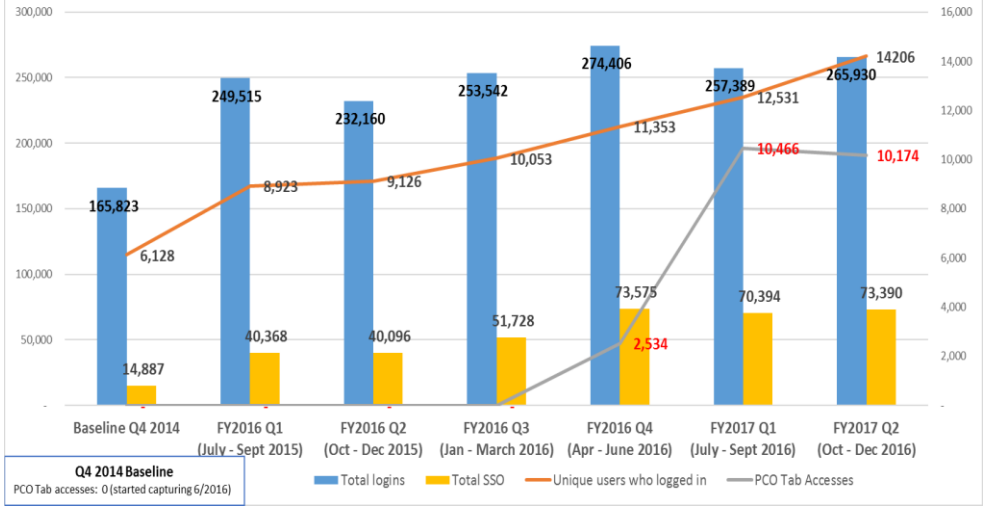
1. **POINT OF CARE: Clinical Query Portal**
   - Search for your patients' prior hospital records (e.g., labs, radiology reports, etc.)
   - Monitor the prescribing and dispensing of PDMP drugs
   - Determine who are the other members of your patient's care team
2. **CARE COORDINATION: Encounter Notification Service (ENS)**
   - Be notified when your patient is hospitalized in any MD, DC or DE hospital
   - Receive special notification about ED visits that are potential readmissions
   - Know when your MCO member is in the ED
3. **POPULATION HEALTH: CRISP Reporting Services (CRS)**
   - Use Case Mix data and Medicare claims data to:
     - Identify patients who could benefit from services
     - Measure performance of initiatives for QI and program reporting
     - Coordinate with peers on behalf of patients who see multiple providers

Key Performance Indicator Dashboard

Data Feeds

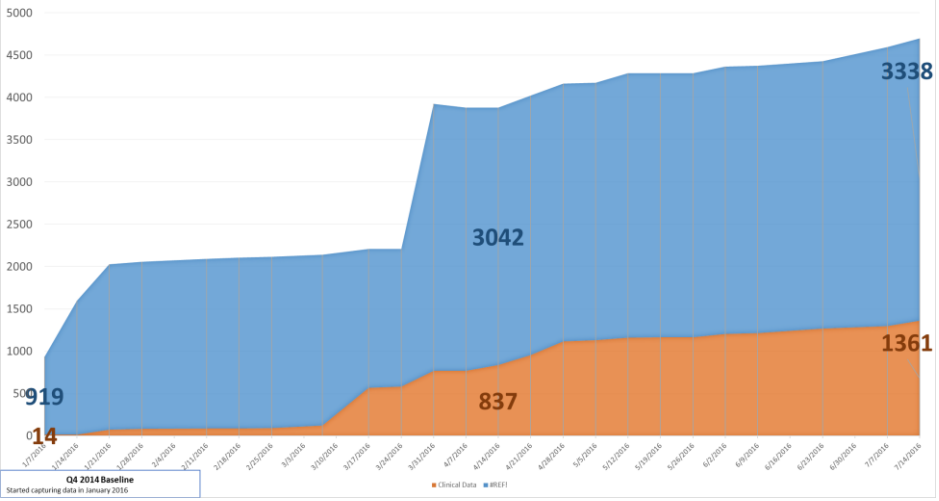


Query Portal Utilization



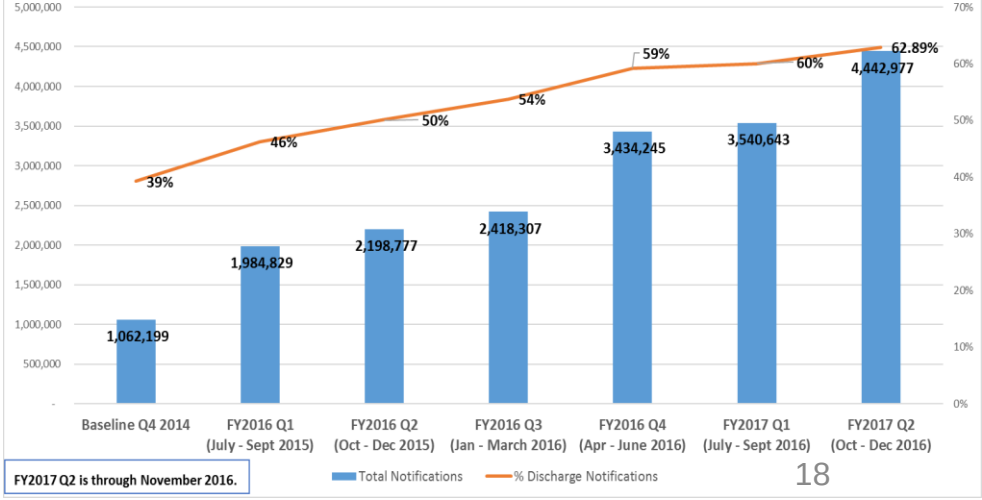
Q4 2014 Baseline
PCO Tab accesses: 0 (started capturing 6/2016)

AMBULATORY CONNECTIVITY NUMBER OF PHYSICIANS



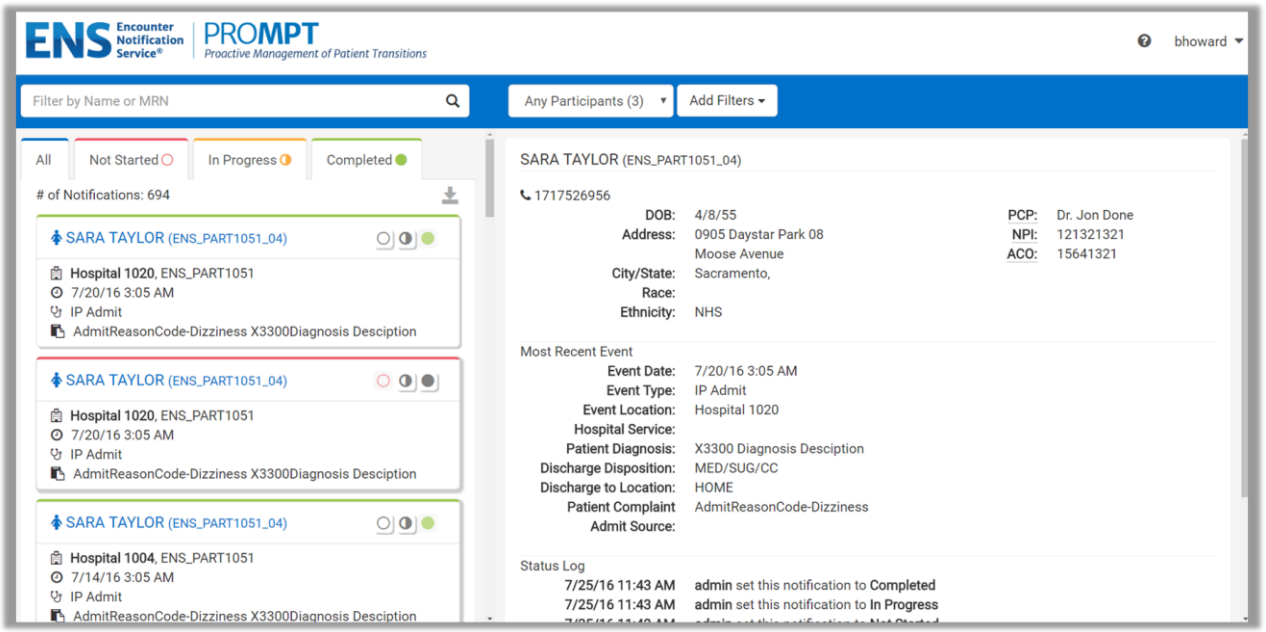
Q4 2014 Baseline
Started capturing data in January 2016

ENS Notifications



FY2017 Q2 is through November 2016.

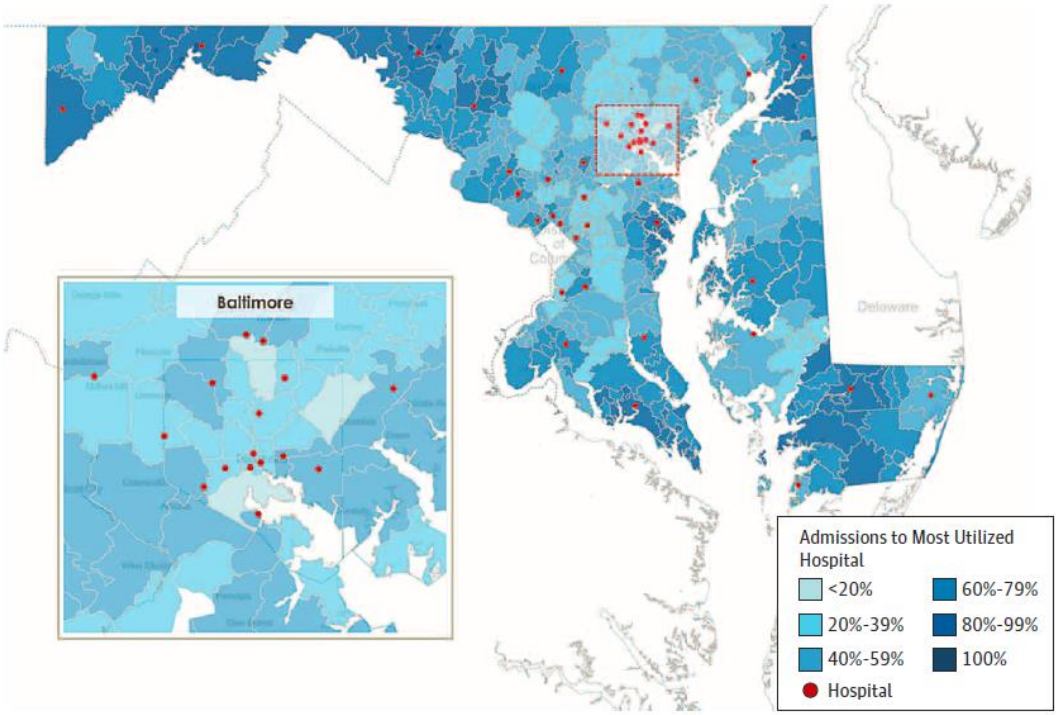
Encounter Notification Services



- Subscribers submit a patient panel to CRISP and identify which types of alerts they would like to receive
- Phase 1 notifications included only demographic information and the event types; Phase 2 included chief complaint and discharge diagnosis; Phase 3 includes a CCDA summary of care
- Hospitals can auto-subscribe to 30 day real-time readmission alerts
- CRISP has ADT exchange partnerships with DHIN in Delaware and ConnectVirgnia. Anytime a Maryland or DC resident arrives at a Delaware or Northern Virginia hospital CRISP receives the ADT and can route it to a subscriber.

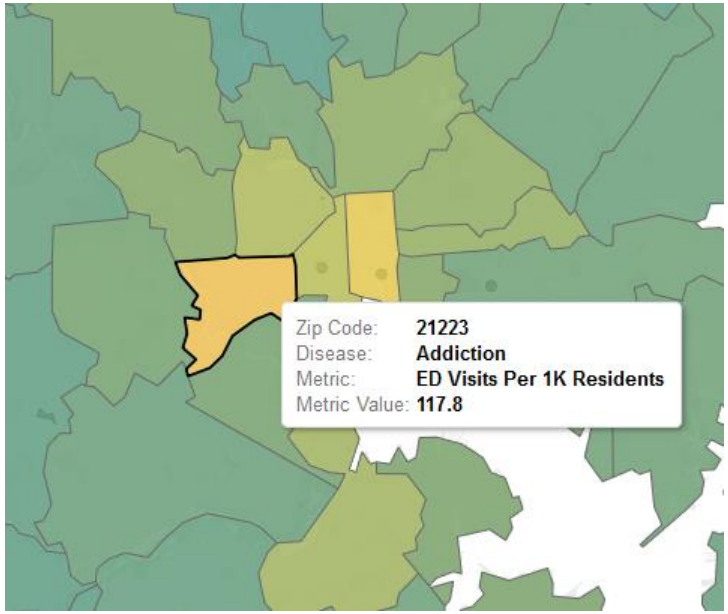
HIE: Natural Advantage over Individual Hospital Data

Figure. Concentration of Inpatient Care in Maryland, Shown as the Percentage of Admissions to Most Utilized Hospital by Zip Code

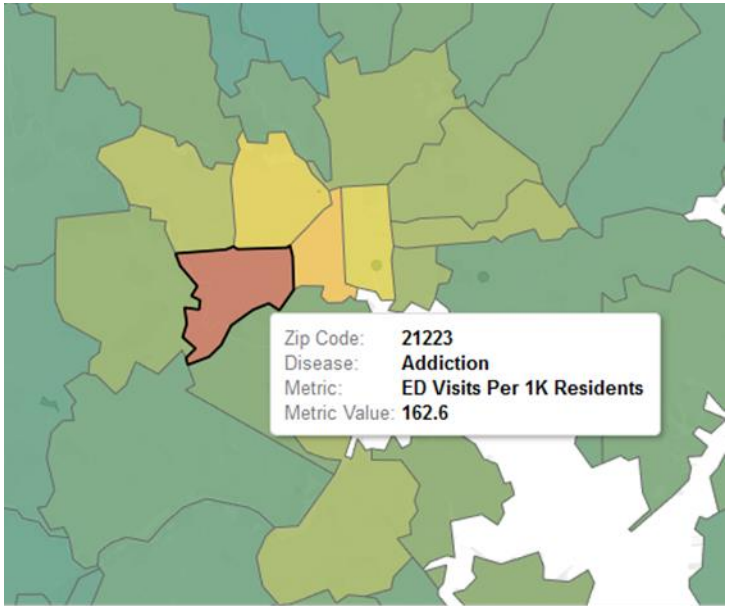


Horrocks D, Kinzer D, Afzal S, Alpern J, Sharfstein JM. The Adequacy of Individual Hospital Data to Identify High Utilizers and Assess Community Health. JAMA Intern Med. 2016 Apr 25.

Example: Overdose

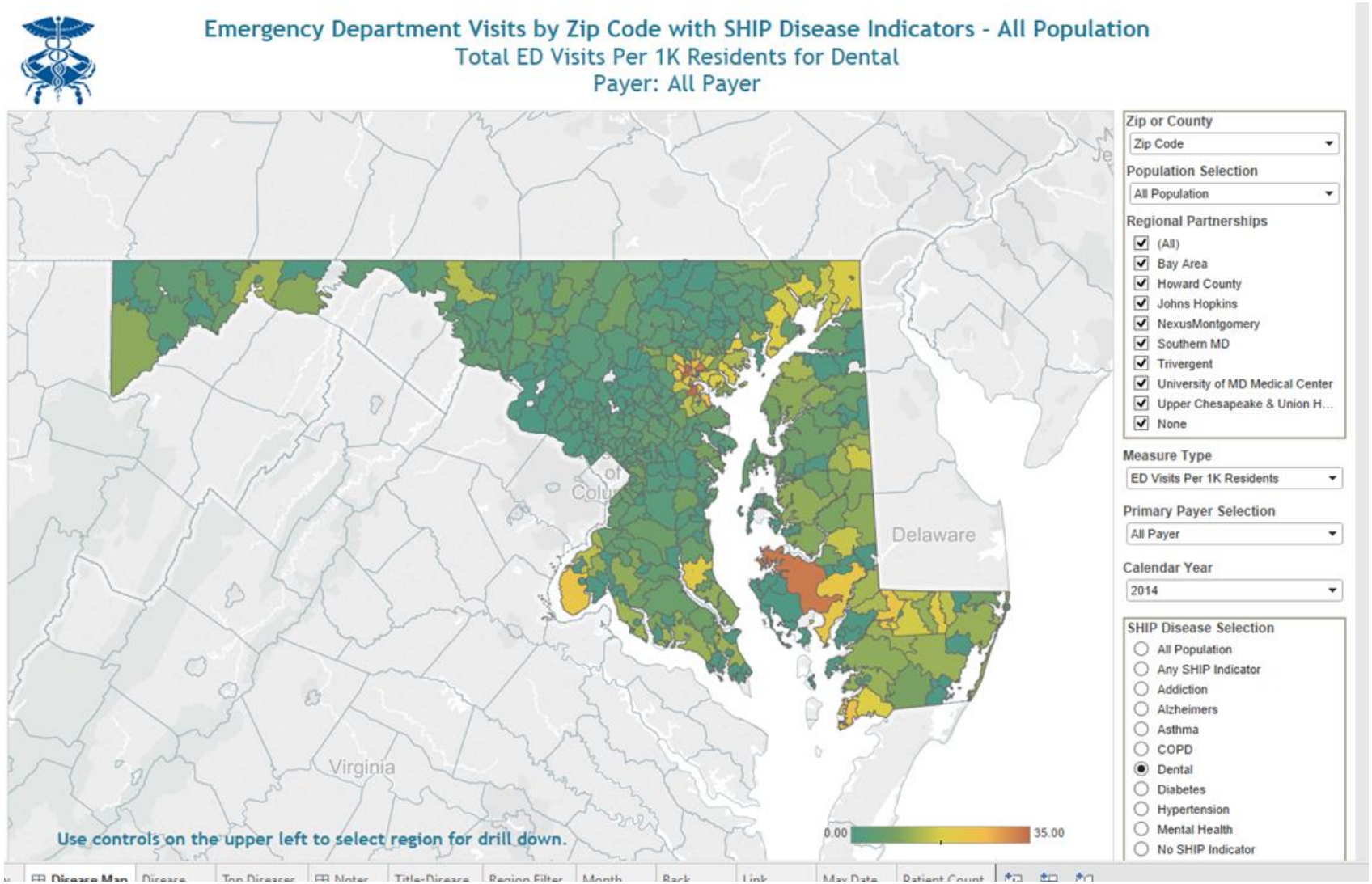


2012

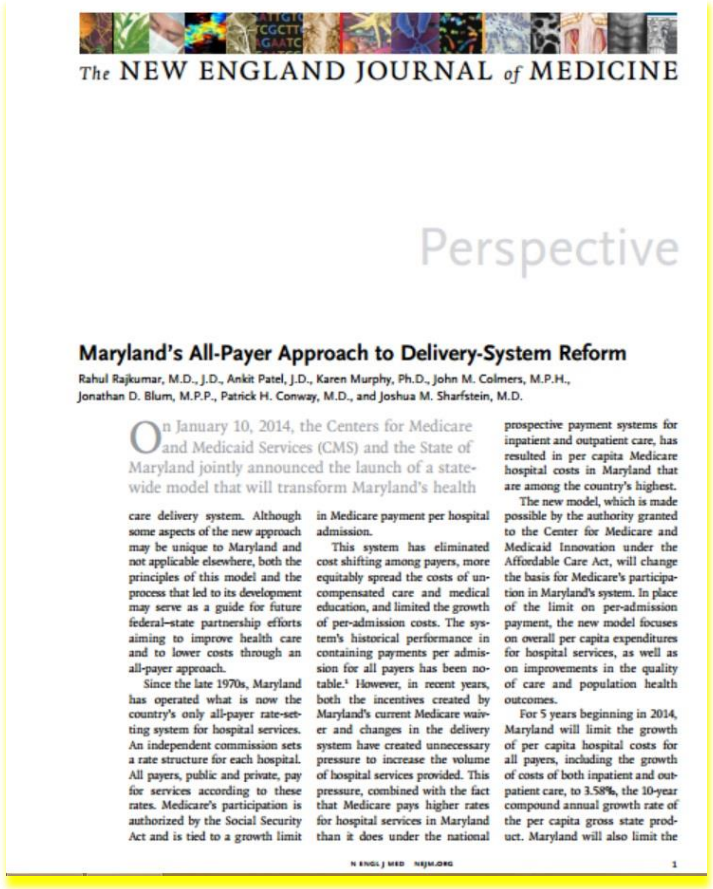


2014

Example: Dental



Maryland's Hospital Model



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Maryland's All-Payer Approach to Delivery-System Reform

Rahul Rajkumar, M.D., J.D., Ankit Patel, J.D., Karen Murphy, Ph.D., John M. Colmers, M.P.H., Jonathan D. Blum, M.P.P., Patrick H. Conway, M.D., and Joshua M. Sharfstein, M.D.

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) and the State of Maryland jointly announced the launch of a statewide model that will transform Maryland's health care delivery system. Although some aspects of the new approach may be unique to Maryland and not applicable elsewhere, both the principles of this model and the process that led to its development may serve as a guide for future federal–state partnership efforts aiming to improve health care and to lower costs through an all-payer approach.

Since the late 1970s, Maryland has operated what is now the country's only all-payer rate-setting system for hospital services. An independent commission sets a rate structure for each hospital. All payers, public and private, pay for services according to these rates. Medicare's participation is authorized by the Social Security Act and is tied to a growth limit in Medicare payment per hospital admission.

This system has eliminated cost shifting among payers, more equitably spread the costs of uncompensated care and medical education, and limited the growth of per-admission costs. The system's historical performance in containing payments per admission for all payers has been notable.[1] However, in recent years, both the incentives created by Maryland's current Medicare waiver and changes in the delivery system have created unnecessary pressure to increase the volume of hospital services provided. This pressure, combined with the fact that Medicare pays higher rates for hospital services in Maryland than it does under the national prospective payment systems for inpatient and outpatient care, has resulted in per capita Medicare hospital costs in Maryland that are among the country's highest.

The new model, which is made possible by the authority granted to the Center for Medicare and Medicaid Innovation under the Affordable Care Act, will change the basis for Medicare's participation in Maryland's system. In place of the limit on per-admission payment, the new model focuses on overall per capita expenditures for hospital services, as well as on improvements in the quality of care and population health outcomes.

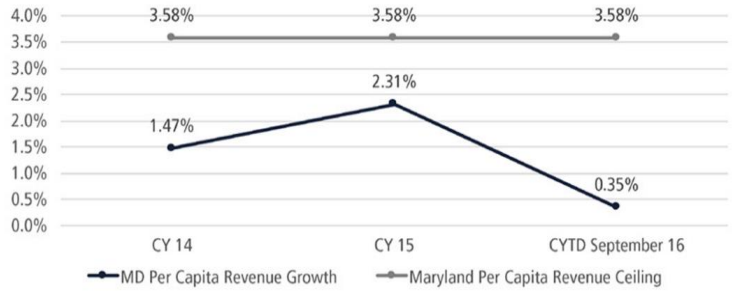
For 5 years beginning in 2014, Maryland will limit the growth of per capita hospital costs for all payers, including the growth of costs of both inpatient and outpatient care, to 3.58%, the 10-year compound annual growth rate of the per capita gross state product. Maryland will also limit the

"The boldest proposal in the United States in the last half century to grab the problem of cost growth by the horns."

– Professor Uwe Reinhardt, Princeton University

Health Affairs Blog, 1/17

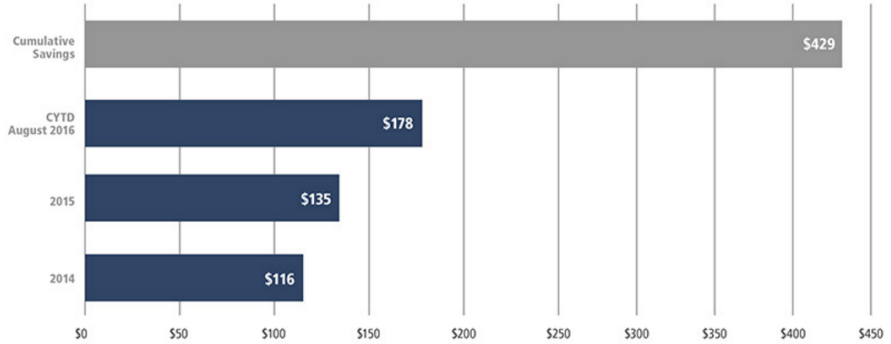
Exhibit 1: Maryland Hospital Revenue Growth (All Payers)



Source: Hospitals' monthly revenue and usage reports to Maryland Health Services Cost Review Commission (HSCRC). Year-to-date 2016 results compare hospital revenues for January-September 2016 to January-September 2015.

- $319 total cost of care savings
- 48% reduction in potentially preventable conditions
- Readmissions gap down by 57%

Exhibit 2: Maryland Medicare Hospital Savings Relative To National Medicare Per Capita Growth Rate (Millions Of Dollars)



Source: State of Maryland analysis of data from CMS. 2016 figures are for a partial year through August, and results for the full calendar year could vary from partial year results. Base year is 2013.

Acknowledgments

- Donna Kinzer, John Colmers, and Health Services Cost Review Commission
- Maryland Department of Health and Mental Hygiene
- Governor Martin O'Malley
- Maryland Hospital Association
- CRISP