Overview of Global Hospital Budgeting in the State of Maryland

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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*

TPR Hospitals

- 10% of net revenue
- Mostly rural
Concept: Move All Hospitals to Global Budgets

**Former Hospital Payment Model:**
- Volume Driven
  - Units/Cases
  - Unknown at the beginning of year
  - More units creates more revenue
  - Rate Per Unit or Case (Updated for Trend and Value)

**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
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 & readmissions
- 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
Successful Strategies Under TPR

Pre-Acute Care Focused

- Added primary care practices where our most vulnerable patients reside
- WMHS created the Center for Clinical Resources consisting of a multi-disciplinary team of NPs, RNs, Dieticians, Pharmacists, Respiratory Therapists & Care Coordinators
- Diabetes Management
- COPD/Asthma Management
- Cardiac Risk Management
- Renal Failure Management
- Infection Prevention Management
- Renal Failure Management
- Hypertension Management

Successful Strategies Under TPR

Acute Care Focused

- Formed a Clinically Integrated Network with our physicians and other partners
- Established an Accountable Care Organization
- Focused on keeping independent physicians who no longer admit engaged with our health system
- Partnered with independent urgent care centers who were previous competitors
- Targeted high utilizers of services
- Focused on appropriateness of admissions versus the number of admissions
- Removing daily every readmission within 30 days to determine the reasons for the readmission
- Formed teams of clinicians to round daily on patients with a LOS of 3 days or longer
- Nurses rounding hourly on every patient & performing shift report at the patient’s bedside

Successful Strategies Under TPR

Post-Acute Care Focused

- Developed teams of physicians & nurses to work with non-compliant physicians related to readmissions, use rates, denials, LOS & potentially preventable conditions
- revamped patient education programs
- Assigned Pharmacy staff to the ED & inpatient units for medication reconciliation & rounding on patients
- Created dedicated care coordinators and a clinical coordinator in Behavioral Health
- Implemented Clinical Documentation Improvement programs to ensure accurate documentation of POA conditions
- Started quarterly Hot Topic sessions for physicians and advanced practice professionals where focused education is needed and/or required
- Changed discharge planning processes to cover patients until they see their primary care provider
- Begun discharging patients with their medications
- Follow up with all discharged patients
- Expanded Home Care resources to address a dramatic increases in visits
- Created teams of Community Health Care Workers
- Created SNF Transition Care Coordinators and SNF Labs (physician/advance practitioners) within our own skilled nursing facilities & other SNF community partners
- Connected patients to services they will need post discharge

Source: WMHS
## Overall Results So Far

<table>
<thead>
<tr>
<th>Category</th>
<th>FY2011</th>
<th>FY2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Admissions</td>
<td>15,848</td>
<td>11,882</td>
<td>25%</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>14.54%</td>
<td>13.25%</td>
<td>8%</td>
</tr>
<tr>
<td>Inpt Behavioral Health Admissions</td>
<td>1,248</td>
<td>1,126</td>
<td>9.8%</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>20.9%</td>
<td>11.35%</td>
<td>46%</td>
</tr>
<tr>
<td>ED Visits</td>
<td>55,183</td>
<td>52,875</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Source: WMHS
Lessons in Maryland for Costs at Hospitals

CUMBERLAND, Md. — This hard-scrabble city at the base of the Appalachian makes for an unlikely hotbed of health care innovation.

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.
Keys to Success (1)

• Community collaborations with physicians, nursing homes, and community organizations around primary, secondary, and tertiary prevention
Outside the Walls

Meritus Health

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
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
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 ConnectVirginia. 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

Example: Overdose

2012

Zip Code: 21223
Disease: Addiction
Metric: ED Visits Per 1K Residents
Metric Value: 117.8

2014

Zip Code: 21223
Disease: Addiction
Metric: ED Visits Per 1K Residents
Metric Value: 162.6
Example: Dental

Emergency Department Visits by Zip Code with SHIP Disease Indicators - All Population
Total ED Visits Per 1K Residents for Dental
Payer: All Payer

Use controls on the upper left to select region for drill down.
Maryland’s Hospital Model

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


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

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