Hospital Strategies Under Global Budget Revenue Models

March 3, 2014
Key Points of Presentation

1. Overview
2. Readmission Strategies
3. MHAC Strategies
4. Medicare Saving Strategies
5. Unit Cost Considerations
6. Role of Continuum of Care
**Historical Waiver Test**

- **“Waiver Test”**
  - Cumulative rate of growth in inpatient Medicare payments to Maryland hospitals compared to the cumulative rate of growth in inpatient Medicare payments to hospitals nationally over the same time period (January 1, 1981 to December 31, 2013)

- **Key Waiver observations**
  - Maryland inpatient regulated acute and chronic Medicare payments only
  - Maryland data based on actual claims data (CMS Region 3 calculation)
  - Did not include outpatient payments
  - Did not adjust for changes in case mix over time
  - Did not include physician or post acute costs
  - Due to delays in obtaining national Medicare payment data, actual test results lagged by approximately 15 to 18 months
Historical Waiver Test

• Since the inception of the Medicare Waiver 36 years ago the delivery of healthcare has changed significantly

• The focus of the current waiver on inpatient cost per case no longer aligns with the current focus on population health

• Recent HSCRC initiatives to improve quality of care and reduce hospital costs have resulted in erosion of the current waiver
  – Total Patient Revenue (“TPR”) Budget
  – Readmission Reduction Initiatives
  – Reduction in One Day Stay cases
Benefit of Medicare Waiver

- If Maryland lost the Medicare Waiver
  
  **Loss of $1.6 billion**

  **Two-year transition to PPS system**

  Maryland must repay excess payments

  **Rate setting for non-governmental payers remains in effect unless repealed**
Maryland Financial Conditions

- Maryland hospitals have experienced declines in financial performance due to update factors significantly less than inflation
Modernized Medicare Waiver

- The New Maryland waiver aligns with CMS’s Three Part Aim initiatives

- The formal application was announced on January 10th 2014
Modernized Medicare Waiver

• The New Waiver is effective January 1, 2014

• New model emphasizes a population health approach to rate regulation
  – Performance will be measured on hospital regulated payments per capita
  – Incentives under this approach are radically different than in the current environment where increased encounters and per case efficiency is emphasized

• Payment per capita emphasizes efficient utilization

• Current system incentivizes volume growth
  – The per capita approach will present challenges and opportunities for hospitals
  – Requires new payment models to ensure success
Modernized Medicare Waiver

- The basic constructs of the Modernized Waiver are:
  - Effective 1/1/2014
  - Term 5 years
  - Limit growth in Hospital Gross Patient Revenue (inpatient and outpatient) to 3.58% per capita
  - $330 million over 5 years in Medicare savings
  - Total Medicare healthcare spend constraint
    - Year 1: Cannot exceed the Nation by more than 1%
    - Years 3 thru 5: Must below the National growth rate for a two year period
  - Reduce MHACs by 30% over 5 years
  - Reduce rate of readmissions to the National average

- Renewal after 5 years with favorable performance and expansion to include physician and post acute services; if not renewed, revert to the national system
Modernized Medicare Waiver

- For 2 out of the past 5 years growth in Maryland Gross Revenue (inpatient and outpatient) per capita has been below the 3.58% Waiver target
Goal of Global Budget Revenue Models

GLOBAL BUDGETS
- Medicare Growth Rate
- Per Capita Payment Monitoring
- Unit Cost Analysis

BEGINNING TO BRIDGE THE GAP
- Quality Measurement & Improvement
- Clinical Analytics
- Reduce Variation & Redesign

Readmissions
PQIs
MHACs
High Utilizers
Resource Use
SNF Admission

Rate Tiering
Per Capita
ROC
Per Beneficiary

Patients / Episodes / Populations
- Healthy
- At Risk
- Chronic
- Acute
Global Budget Model

• The key aspects of the Global Revenue Budget are as follows:

  – Fixed revenue base for 12 month period with annual adjustments

  – Retain revenue related to avoidable volumes (readmissions, ED visits, avoidable admissions, MHACs) and reduced utilization

  – Annual Update Factor (Hospitals electing to stay on current methodology most likely will receive a lower update factor)
Global Budget Model (continued)

– Age adjusted population adjustments as determined by HSCRC policy

– Efficiency adjustment to be determined by HSCRC policy

– Adjustments for market share changes as determined by HSCRC policy
  • Excluding potentially avoidable volumes

– “Routine” annual adjustments including payer mix differential, changes in assessments, price variances etc.
Readmission Strategy

- Reduction in readmissions accomplishes multiple objectives under the new Waiver
  - Constrain all payer growth per capital growth to 3.58% annually
  - Achieve Waiver requirements for Maryland to beat National RA Rate by year 5 (2018)

<table>
<thead>
<tr>
<th></th>
<th>Maryland CY 2012</th>
<th>United States CY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td>46,917</td>
<td>1,912,227</td>
</tr>
<tr>
<td>Total Discharges</td>
<td>236,591</td>
<td>10,633,197</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>19.83%</td>
<td>17.98%</td>
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</tbody>
</table>
Readmission Strategy

• Intrahospital readmission charges have declined by $82.7 million in 2013 compared to 2012
  – FY 2012 $1,145 million
  – FY 2013 $1,063 million

• Medicare comprises $539.6 million of intrahospital readmission charges and therefore represents a significant opportunity for readmission reductions.
Readmission Monitoring

- Hospitals under the Global Budget model will require more robust data reporting specifically related to quality indicators such as readmissions.
Maryland Hospital Acquired Conditions

- Maryland Hospital Acquired Conditions is another key area of focus
- Hospital should focus on high volume high dollar MHACs to maximum opportunity
- Hospitals will be benefit under the Global Budget for reducing hospital acquired conditions:
  - Achieve requirement of reducing MHACs by 30%
  - The majority of MHACs are Medicare patients (58%) therefore reduction contribute to achieving the required Medicare savings
  - Hospitals will still be subject to rate adjustment related to Quality measures
    - New policy may be more punitive than current scaling methodology
Maryland Hospital Acquired Conditions

- MHAC charges have declined by $117.3 million in 2013 compared to 2012
  - FY 2012 $502.6 million
  - FY 2013 $385.3 million
- Medicare comprises $224 million of MHAC charges and therefore represents a significant opportunity for MHAC reductions
Maryland Hospital Acquired Conditions

- Below are the top 20 MHACs based on volume and revenue

<table>
<thead>
<tr>
<th>Rank</th>
<th>Condition</th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td>Acute Pulmonary Edema and Respiratory Failure without Ventilation</td>
</tr>
<tr>
<td>4</td>
<td>Acute Pulmonary Edema and Respiratory Failure with Ventilation</td>
</tr>
<tr>
<td>5</td>
<td>Pneumonia &amp; Other Lung Infections</td>
</tr>
<tr>
<td>6</td>
<td>Aspiration Pneumonia</td>
</tr>
<tr>
<td>7</td>
<td>Pulmonary Embolism</td>
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<tr>
<td>9</td>
<td>Shock</td>
</tr>
<tr>
<td>14</td>
<td>Ventricular Fibrillation/Cardiac Arrest</td>
</tr>
<tr>
<td>16</td>
<td>Venous Thrombosis</td>
</tr>
<tr>
<td>24</td>
<td>Renal Failure without Dialysis</td>
</tr>
<tr>
<td>28</td>
<td>In-Hospital Trauma and Fractures</td>
</tr>
<tr>
<td>31</td>
<td>Decubitus Ulcer</td>
</tr>
<tr>
<td>35</td>
<td>Septicemia &amp; Severe Infections</td>
</tr>
<tr>
<td>37</td>
<td>Post-Operative Infection &amp; Deep Wound Disruption Without Procedure</td>
</tr>
<tr>
<td>38</td>
<td>Post-Operative Wound Infection &amp; Deep Wound Disruption with Procedure</td>
</tr>
<tr>
<td>40</td>
<td>Post-Operative Hemorrhage &amp; Hematoma without Hemorrhage Control Procedure or I&amp;D Proc</td>
</tr>
<tr>
<td>42</td>
<td>Accidental Puncture/Laceration During Invasive Procedure</td>
</tr>
<tr>
<td>49</td>
<td>Iatrogenic Pneumothrax</td>
</tr>
<tr>
<td>54</td>
<td>Infections due to Central Venous Catheters</td>
</tr>
<tr>
<td>65</td>
<td>Urinary Tract Infection without Catheter</td>
</tr>
<tr>
<td>66</td>
<td>Catheter-Related Urinary Tract Infection</td>
</tr>
</tbody>
</table>
Opportunities to Reduce Medicare Costs

• Unit Rate Opportunities:
  – Review cost allocations in Annual Filing
  – Evaluate opportunities for tiering of rates based on cost justification

• Utilization reduction opportunities:
  – Readmissions
  – MHACs
  – Prevention Quality Indicators
  – Clinical Variation
  – Opportunities for lower cost of care
  – Improve continuum of care
Monitor Cost of Care

• Under the Global Budget Revenue model hospitals will be able to retain savings related to reduced utilization
  – Patients receiving care will pay more to compensate for lost volumes
  – Savings can be used to fund:
    • Population health initiatives
    • Offset rate increases below inflation
  – Savings may need to be shared in the future therefore hospitals will need to address cost structure

• Hospitals still need to monitor cost of care to ensure rates are:
  – Reasonable to its peers
  – Outpatient services remain competitive with the market
    • Hospital based vs. freestanding
Collaboration is Critical to Success

Adapted from Figure 6: Population Health Requires Partnership to Improve Outcomes in Managing Population Health: The Role of the Hospital, Health Research & Educational Trust, Chicago: April 2012. Accessed at www.hpone.org
Partnerships to Improve Outcomes

- Partner with **SNFs and home health agencies** to:
  - Expedite discharges to appropriate post-acute care services;
  - Better manage care transitions; and
  - Establish protocols for referrals back to acute care

**Who:** Care Coordination Network (CCN) at Summa Health System, Akron, Ohio

**Outcomes:** Summa was seeing lower quality outcomes, longer hospital stays, and higher rates of readmissions for patients transferred to and from SNFs.

**Factors:** Impractical transfer forms, area SNF competition, and the complex patient population all led to ineffective communication and unnecessary hospital readmissions.

**Interventions:** Summa collaborated with 37 SNFs to create the CCN to streamline patient transitions. They worked to create an electronic referral process, an easy-to-use form, and encouraged regular meetings among the parties to encourage collaboration.

**Impact:** Analysis has shown fewer readmissions from SNFs, reduced length of stay, improved schedule adherence, and better volume distribution at SNFs.

Partnerships to Improve Outcomes

- Partner with **urgent care centers** and/or use care managers to:
  - Encourage appropriate use of the ER;
  - Refer patients to primary care centers/medical homes

**Who:** University of Chicago Medicine and UCM’s Clinics, Chicago, Illinois

**Outcomes:** About 40% of the more than 55,000 visits to the adult emergency department at UCM were either preventable, low acuity and treatable in a different setting, or both.

**Factors:** Lack of patient knowledge and of familiarity with accessible health centers to manage chronic illnesses.

**Interventions:** UCM created the Southside Healthcare Collaborative, a partnership to encourage patients to find a medical home. Patient advocates were placed in the emergency department to refer low-acuity patients to high-quality care faster or to help find a primary care physician for follow-up visits.

**Impact:** The number of unnecessary ED visits decreased by 10% in the first year of the program (2005–2006). More than 5,600 patients gained a medical home, and the number of clinic appointments increased by 40% in the same period (2006–2010).
Partnerships to Improve Outcomes

- Partner with *physicians* to:
  - Improve patient health and stability of chronic conditions
  - Reduce potentially avoidable admissions/prevention quality indicators (PQIs)

**Who: Billings Clinic, Billings, Montana**

**Outcomes:** Billings had a large diabetes population not following typical care protocols.

**Factors:** Diabetes care is challenging in rural areas where there can be a limited number of primary care physicians. These physicians typically have limited resources, and patients have fewer local educational opportunities to better manage their chronic diseases outside of physician visits.

**Interventions:** Billings enrolled patients, regardless of insurance status, in its disease management program, emphasizing the physician’s role to achieve compliance with clinical guidelines. PCPs are provided with data profiles on diabetes patients before appointments, including real-time reminders on various diabetes health outcome measures to facilitate necessary discussions.

**Impact:** More than 7,000 diabetes patients are enrolled in this program, and physician compliance has increased significantly.

Partnerships to Improve Outcomes

• Partner with *community resources* to:
  – Improve access to care
  – Involve social services and resources
  – Transportation
  – Access to healthy food options

**Who:** Rush University Medical Center, Chicago, Illinois

**Outcomes:** Humboldt Park had a 14% type 2 diabetes rate, two times the national rate.

**Factors:** A predominantly uninsured and underinsured population, the neighborhood population also has difficulties accessing care due to low health literacy and language barriers.

**Interventions:** RUMC partnered with other local hospitals, the Puerto Rico Cultural Center, and the Greater Humboldt Park Community of Wellness to create the “Block by Block” program. Captains conduct door-to-door diabetes screenings, connecting residents to community PCPs and other resources available through the newly established Greater Humboldt Park Community Diabetes Empowerment Center. The center has a test kitchen that offers discussions of healthy food options, educational programs, and is staffed by nurses and clinicians who answer clinical questions.

**Impact:** RUMC committed to accept diabetes patients from Humboldt Park for ongoing care. More than 1,000 residents have been connected to a health care provider to discuss their diabetes risk.

Partnerships to Improve Outcomes

- Partner with *community resources* to:
  - Improve access to care
  - Involve social services and resources
  - Transportation
  - Access to healthy food options

**Who:** Healthy San Francisco, a partnership between the Department of Public Health and 30 hospitals and community clinics

**Outcomes:** The city had a growing number of uninsured residents, leading to high ED usage.

**Factors:** Uninsured and underinsured populations have reduced access to necessary health care services.

**Interventions:** The participating hospitals and clinics created Healthy San Francisco, a safety-net consortium of providers for the uninsured coordinated by SFDPH. Emphasis lies on improved care coordination and early treatment utilizing the medical home model for primary care. Enrollment is offered in a subsidized health care system. The consortium provides services through a network of clinics that meet medical, dental, and vision needs.

**Impact:** Since its inception, HSF has enrolled 100,000 uninsured residents (85% of the analyzed uninsured). Data for 2010–2011 suggest that HSF beneficiaries utilize primary care at the same rate as the national Medicaid population (3 office visits per year), go to the ED for avoidable conditions at half the state rate (9% versus 18%), and have a hospital readmission rate at half the national rate (9% versus 18%).

Implications for Health Systems

• **Successful hospital under a modernized waiver**
  – High quality, efficient and effective care while strategically maintaining market share
  – Partners with physician practices, urgent care and post acute care to effectively impact population health
  – Performance improvement to reduce clinical utilization in addition to cost efficiency
  – High quality with reduced clinical utilization will be the most successful
Implications for Health Systems

• **Role of Physicians**
  – Proposed State model does not apply to physicians directly
  – Population health emphasis implies need for physician involvement
    • Physician employment has increased
      – Preserve market share
      – Improve care coordination
    • Current population payment models do not align hospital and physician incentives
      – Physicians are still paid fee-for-service rates generally
    • ACO models to align hospital and physician incentives
Questions
David Krajewski

David H. Krajewski, Sr. Vice President/CFO, LifeBridge Health, Inc.
President, LifeBridge Investments

- David was promoted from Vice President of Finance to Chief Financial Officer in April 2013. He is responsible for financial planning and reporting, strategic capital planning, treasury management, revenue cycle operations, business development, managed care contracting, supply chain management and the for-profit Commercial Division.

- David has served as a member or Chair of various task forces with the Maryland Hospital Association, including Chair of MHA’s Financial & Technical Issues Task Force and as a member of the Healthcare Financial Management Association.

- David received his Bachelor of Science degree in accounting from Towson State University in 1986 and earned his CPA in the same year. He worked for Arthur Andersen from 1986 –1992 in the audit/consulting division. David served as an auditor and consultant for numerous healthcare providers until assuming the position of Controller at Northwest Hospital Center. In 1993 he was promoted to Assistant Vice President and given responsibility over the supply chain management functions. In 1998 he was promoted to Chief Financial Officer of Northwest Hospital Center. Subsequent to the formation of LifeBridge Health, Inc. he assumed the position of Vice President, Finance, LifeBridge Health, Inc.
Jeanette Cross

Jeanette Cross, CPC, FHFMA, CPC, Director Berkeley Research Group

• Jeanette has over 20 years of experience working with hospitals and health systems. She is involved in healthcare payment reform including analytics related to statewide all-payer bundling initiative for readmissions and currently the development of global revenue budgets. She has auditing, consulting and hands-on work experience as a hospital financial and reimbursement director including cost accounting, budgeting, billing compliance, coding and charge master review and standardization.

• Ms. Cross advises clients regarding HSCRC rate matters as well as coding and billing matters. She has also provided certificate of need assistance and developed business plans. She has also led engagements for charge description master reviews, severity-based coding audits, clinical documentation improvement programs for hospitals and integrated delivery systems, ICD-10 implementation planning, and coding and documentation risk assessments.