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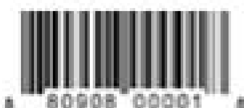

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COVER STORY

BY JACLYN BOROWSKI

Timothy Penn-el, 59, tries on donated shoes at Health Care for the Homeless. Connecting patients to outside resources like Health Care for the Homeless will be key in hospitals reducing their readmissions and their costs.

THE NEXT HEALTH REFORM

Waiver impact felt beyond hospitals

BY SARAH GANTZ
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Maryland is betting big on its next health care experiment. The state's Medicare waiver has long been a linchpin in the state's health care system. This one policy has created a unique hospital industry where costs do not vastly differ from one hospital to another and hospitals that treat high numbers of poor and uninsured patients are able to stay in business. In every other state, patients with private insurance pay more for care to make up for low Medicare payments. People who are uninsured get hit the hardest.

All that is at stake while Maryland tries out an ambitious, five-year pilot to completely change the way this policy works and pay hospitals differently. The system hangs on being able to keep growth in annual hospital revenue to just 3.58 percent, or roughly $600 million.

The target is in line with the annual growth hospitals here have experienced recently. But years ago revenue grew at a faster rate.

BY JACLYN BOROWSKI

Western Maryland Health System is testing out a new payment system.

"Is it sustainable? This is the entire gamble of the Maryland Medicare waiver," said Carmela Coyle, CEO of the Maryland Hospital Association.

If it works, Maryland residents will get better care at lower cost. The state will be a success story for controlling costs in a way that has only been talked about in the U.S.

With the new system, the game stays the same, but the rules are changing. Hospital revenue will still be regulated by the state's Health Services Cost Review Commission and Maryland must still show it is saving Medicare money in the long run.

But the factors that determine how much hospitals should get paid and the benchmarks they must meet as conditions of the federal deal will be drastically different.

EDITOR'S NOTE:

Sarah Gantz wrote this story as part of a yearlong Reporting Fellowship on Health Care Performance sponsored by the Association of Health Care Journalists and supported by the Commonwealth Fund.

Instead of getting paid by the number of patients who walk in the door, hospitals will have to live within a budget set by the state. Hospitals will also be on the hook for reducing readmissions, infections and accidents. To do that, hospitals will need to get more plugged in to the health care community outside their own walls.

What this means is that a policy that used to be about paying hospitals is about to bleed out into the rest of the health care industry.

If you think this all is just a hospital or Medicare policy that doesn't affect you, you're wrong. Hospitals are a $15 billion industry in Maryland, making them one of the state's largest economic sectors. If you're one of the tens of thousands of Marylanders employed by a hospital or among the hundreds of local companies that do business with them, your livelihood is on the line.

Beyond the health care sector, health insurance premiums are among the largest expenses for any business and rising costs are a constant concern for employers.

Hospital costs are a big part of health insurance premiums and if all goes according to plan, hospital costs should go down. That means (in theory, at least) your company's health insurance premiums should eventually stop increasing at such a quick clip. And if they don't, you should be informed enough to ask why.

At the very least, you will – regardless of how healthy you are – be a patient some day.

This seemingly arcane policy directly impacts your choice of doctors and hospitals, the quality of the service they provide and how much it all costs.

COVER STORY

A PATIENT'S STORY

How one man's care shows need for major change

Timothy Penn-el knew he needed to get to a hospital. Fast. Two of his fingers had big blisters – frostbite from being outside too long on a particularly cold night. Penn-el, 59, is homeless and didn't realize how cold he was because he had been drinking.

Doctors at Mercy Medical Center, near the Baltimore shelter where Penn-el sometimes stays, gave him gauze and ointment. They told him he should make a visit to the burn unit at Johns Hopkins Bayview Medical Center, across town.

Penn-el took "should" as a suggestion and didn't go, and in a matter of days his fingers turned black. When he finally made that visit to Bayview, doctors told him amputation was the only option.

Penn-el's experience is a clear example of what doesn't work in the health care system.

If someone had checked in on Penn-el after he left the hospital or helped him schedule an appointment at the burn unit, his fingers might have been spared.

But in the U.S., hospitals are paid per service – per service provided within their four walls. Their responsibility for patients typically ends when they are discharged.

Maybe that sounds harsh. But think about it. Hospitals are businesses. When was the last time your favorite clothing store called to see if that sweater you bought had lost its shape yet? Or your mechanic checked in to see why you hadn't been by for an oil change in a while?

Like any business, hospitals do what they get paid to do. Spend too much time and resources on services they're not getting paid for and hospitals risk cutting in to their bottom line and being unable to care for anyone.

That's why Maryland regulators want to change the rules about what hospitals get paid to do.

Under the new payment model, hospital budgets will be capped. Fewer patients will mean less strain on the budget. One way hospitals could reduce the patient counts is to make sure patients get the right follow up care when they leave. That way they don't end up sicker and back at the hospital.

"The thing that most helps reduce readmissions is good follow-up care, a good medical safety net that a patient is tied in with," said Dr. Scott Spier, senior vice president of medical affairs at Mercy.

Make the follow-up phone call or home visit. Help schedule appointments and order prescriptions.

Mercy doctors already do these things, or try to, for every patient who walks in the door, Spier said. Spier could not speak to specific patients, so he did not know why Penn-el fell through the cracks.

"We can always do more," Spier said. "But we can never do 100 percent."

– Sarah Gantz

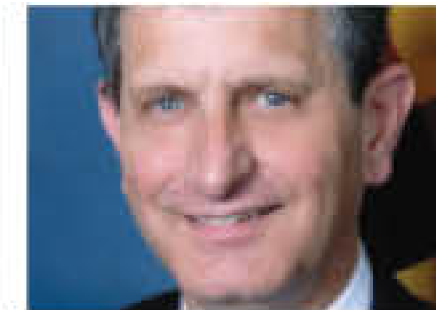
▸ POWER PLAYERS

MEET THE PEOPLE, AGENCIES BEHIND THE WAIVER

Here's who helped develop Maryland's new hospital regulation experiment and are now overseeing its rollout.

DR. JOSHUA SHARFSTEIN
Secretary, Maryland Department of Health and Mental Hygiene

▸ Sharfstein was largely responsible for drafting Maryland's proposal to the federal Centers for Medicare and Medicaid Services. He led the state's negotiations with CMS.



JOHN COLMERS
Chairman, Health Services Cost Review Commission

▸ Along with Sharfstein, Colmers played a leading role in developing the framework for the new system.

DONNA KINZER
Executive Director, Health Services Cost Review Commission

▸ The HSCRC is responsible for fleshing out the details of how the new system will operate. Kinzer is heading up those efforts.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

▸ Maryland really wanted to keep its Medicare waiver, which meant CMS had a lot of bargaining power. With Maryland essentially over a barrel, CMS made big demands for cost savings and quality improvements. At the end of the day, Maryland needs to impress this federal agency.

CARMELA COYLE
CEO, Maryland Hospital Association

▸ Without hospitals, the state's plan for tackling health care costs won't work. And Coyle represents all of them. Dissent from hospitals and other stakeholders nearly derailed negotiations at one point, which shows the association's strength.

GENE RANSOM III
CEO, MedChi

▸ Figuring out a way to better align the way doctors get paid with the new method for paying hospitals is among the challenges hospitals say is most important to address. Doctors still get paid per patient. As CEO of the association that represents doctors, Ransom has pull to shape a new agreement — and one that benefits doctors.

▸ GLOSSARY

If you want to keep up with health policy, you need to speak the language.

1. **GLOBAL BUDGET:** A method for controlling rising health care costs. Entities subject to a global budget, in our case hospitals, are given a set amount of money for the year and must care for their patients within that budget.

2. **ALL-PAYER SYSTEM:** A type of financing system for health care in which services cost about the same price, regardless of who is paying. Maryland's hospital payment system is an all-payer system. The state sets hospital rates and Medicare, Medicaid and private insurance companies (all payers) are expected to pay those rates to hospitals for services.

3. **READMISSION:** When a patient returns to the hospital shortly after being discharged. Readmissions are often seen as an indicator of how well a hospital is caring for patients.

4. **FEE-FOR-SERVICE:** Doctors, hospitals or other health care providers are paid per service. This model gives doctors and hospitals incentive to admit more patients, run more tests and order more procedures because they are paid for every service.

5. **POPULATION HEALTH MANAGEMENT:** The idea of approaching care broadly, by looking for ways to improve the health of an entire community. Instead of focusing on single episodes of care, for example treating a patient for a heart attack, health care providers would also look at where that patient goes after their heart attack treatment — what resources are available in the community. Social and economic factors that may have contributed to the problem are also part of the discussion.

– Sarah Gantz

COVER STORY

A primer on how Maryland hospitals get paid

Here's how the state gets from a wonky health policy to lower costs and better quality care in hospitals – at least in theory.

WHAT IS THE MEDICARE WAIVER?

Maryland and the Centers for Medicare and Medicaid Services have an official agreement, called the Medicare waiver. Under the agreement, Maryland hospitals are exempt — or waived – from regular Medicare rules.

late 1970s Medicare waiver is created.

Maryland is the only state with this agreement.

WHAT IT DOES

That sets up Maryland's unique hospital payment system, which is regulated by the Health Services Cost Review Commission.

HSCRC'S MAJOR ROLE

The HSCRC's charge is to figure out how much hospitals should get paid, while making sure the state stays within the rules of its Medicare waiver agreement.

HOSPITAL RATES

Every year, the HSCRC updates hospital rates. Hospital rates are the price a hospital gets paid for treating a patient.

EVERYONE PAYS THE SAME

The rates set by the HSCRC apply to all payers — private insurers, Medicare, Medicaid and uninsured patients who pay their own bills. Everyone pays about the same price for any given service at any given hospital.

IN OTHER STATES

Each hospital must negotiate with each insurer. Medicare and Medicaid pay lower rates. To make up the difference, hospitals charge private insurers and uninsured patients more.

THE RULES

The big one under the new system is making sure hospital revenue does not grow by more than 3.58 percent, or about $600 million, a year. (The actual formula is a little more complicated, but that's the basic idea.)

$330 million The amount Medicare will save over the next five years.

Hospitals must meet targets to reduce re-admissions, hospital injuries and infections.

OUT WITH THE OLD

Hospitals' revenue was previously based on the amount of money they got paid per service. The more services they provided, the more money they could make.

IN WITH THE NEW

Under the new system, each service will still have a price tag. But there will be a limit to how much money hospitals can earn from the services they provide.

The set budget is supposed to slow the growth of health care costs.

HOW IT WORKS

The price a hospital gets paid for each service will go down if patient volume increases, to keep hospitals in their set budget. The price paid for each service will go up if hospitals reduce the number of people coming in.

LOWER COSTS

Hospitals will want to reduce the number of patients they treat.

WHO IS AFFECTED

Hospitals should target what are called avoidable admissions: Patients who come to the hospital when they didn't really need to; who require treatment for a hospital mistake that could have been avoided; who return to the hospital shortly after discharge because they did not get the right follow-up care.

Opponents fear that instead, hospitals will ration health care and turn away patients to make budget.

IMPROVING QUALITY

To lower readmissions the right way, hospitals need to pay more attention to what happens when patients are discharged, by helping them schedule appointments, checking on their progress, helping order prescriptions.

COMMUNITY PARTNERSHIPS

Hospitals won't be able to do it all on their own. They will need to forge stronger partnerships with the other places people get care, such as nursing homes, rehabilitation facilities and primary care doctors offices.

COVER STORY

A TEST CASE

Allegany hospital sees results with payment plan tryout

Barry Ronan

Lofty health policy ideas like "making hospitals more accountable for patients' overall health" and "working more closely with community organizations to improve patients' transition out of hospitals" can be difficult to visualize.

In Maryland, a handful of hospitals have already been testing out a model that resembles the state's vision.

Western Maryland Health System in Cumberland is among the 10 hospitals in the so-called Total Patient Revenue program showing the most significant results.

Western Maryland has lowered its readmission rate from 17 percent, a little below average for Maryland, to 9 percent.

Overall, admissions to the hospital are down 32 percent over the past three years. Hospital emergency room visits due to diabetes complications (obesity is a serious problem in the area) are down 22 percent. And they did it while staying within a set budget – very little wiggle room.

That's how the Total Patient Revenue program works. The Health Services Cost Review Commission decides how much money each of the participating hospitals needs for the year and the hospitals figure out a way to care for all their patients within that budget.

The idea is that if hospitals know they have only a set amount of money to provide care, they will look for ways to reduce the amount of care their patients need.

When it comes to improving care, there are so many things a hospital could do. But they all cost money. The key – especially for hospitals whose budgets are limited – is to invest in high impact changes.

"A lot of times you sit there and look for the big things," said Chief Financial Officer Kim Repac. "What we found is little things that have such a cause and effect. You take care of the big things, of course, but it's all the little things, the social issues that are huge drivers."

For example, elderly patients with several health conditions tended to bounce between the hospital and a nursing home.

About 36 percent of patients discharged to a nursing home were being readmitted, which was high compared to the hospital's overall readmission rate of 17 percent.

So Western Maryland administrators made the rounds to the area's biggest nursing homes, explained their case, and together developed a system for passing on more information about each patient and bringing more medical care to the nursing homes. Now, about 22 percent of nursing home patients are readmitted.

The change wasn't easy.

Western Maryland began this experiment about three and a half years ago and started seeing consistent improvement only in the last six or eight months.

The hospital struggled in the second year of the program. A number of factors contributed but the constricted budget did not help.

Since the program started, Western Maryland has eliminated about 100 positions. Most were vacant positions, but about 34 people lost their jobs. The hospital needed to cut staff as it downsized less necessary departments.

Decisions were difficult – Western Maryland is also the area's largest employer.

"Quite honestly it was scary making this change and us saying, 'Did we make the right decision?'" said CEO Barry Ronan.

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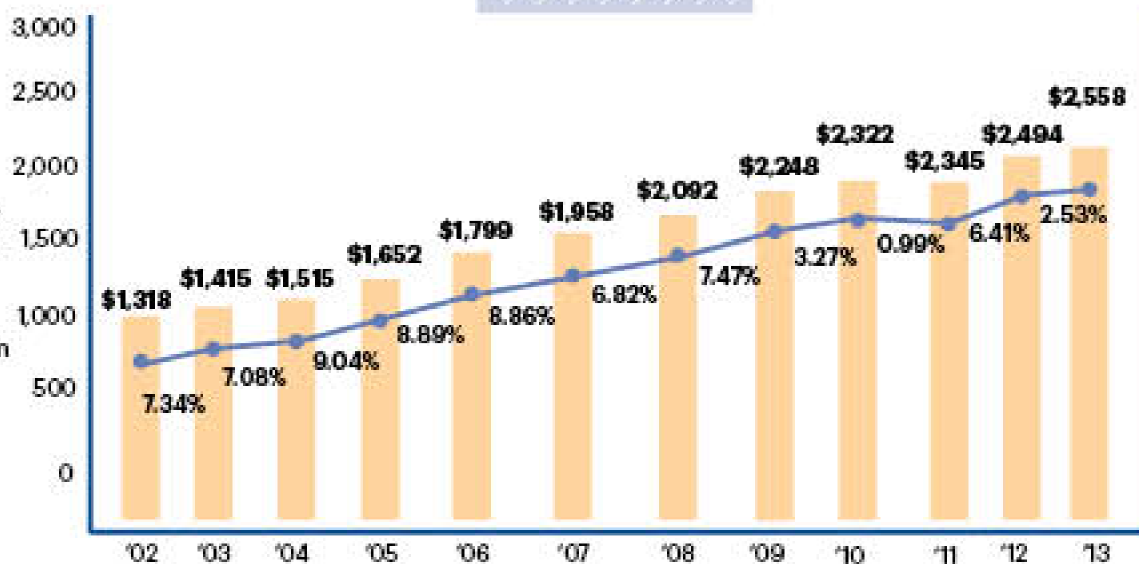
COVER STORY

PER CAPITA HOSPITAL REVENUE

Total hospital revenue per capita is the amount of money hospitals earned per Maryland resident. Year-to-year growth in per capita revenue is the number regulators will be paying attention to. The new system limits growth in per capita revenue to 3.58 percent a year. Hospitals would have passed the test in 2013, when revenue grew 2.53 percent, but not in 2012, when the growth rate was 6.41 percent.



TOTAL REGULATED HOSPITAL REVENUE

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▸ COMPARISON

BEFORE AND AFTER

The most important aspect of Maryland's Medicare waiver has not changed – the state will still have unusual control over hospital payment. But that's about all that's staying the same. Here are some of the biggest changes.

BEFORE

▸ Hospitals are paid on a fee-for-service basis, or per service.

AFTER

▸ Hospital revenue is capped to 3.58 percent. Revenue growth is tied to state economic growth.

BEFORE

▸ Hospitals have an incentive to admit more patients, order more tests and perform more procedures.

AFTER

▸ Hospitals have an incentive to reduce the number of patients treated by improving the care they receive in the hospital and after discharge.

BEFORE

▸ Hospitals' responsibility for patients is primarily while they are in the hospital.

AFTER

▸ Hospitals will stay involved in patients' care after they're gone. Doing so will make sure they follow care instructions.

BEFORE

▸ Hospitals compete with other care centers, such as clinics and ambulatory care facilities for patients, or business.

AFTER

▸ Hospitals will collaborate with other health care businesses to treat patients.