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2017 Webinar Series

The presentation will begin shortly.

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2017 Webinar Series

Global Budgets as a Pathway to Ensuring Access

November 1, 2017

Speakers:

- Priya Bathija, Senior Associate Director, Policy Development, American Hospital Association
- Mike Robbins, Senior Vice President, Maryland Hospital Association
- Joshua Sharfstein, MD, Associate Dean for Public Health Practice and Training and Professor of the Practice in Health Policy and Management, Johns Hopkins Bloomberg School of Public Health
- John Chessare, MD, President and CEO, GBMC HealthCare
- Moderator: Jay Bhatt, DO, Senior Vice President and Chief Medical Officer, American Hospital Association; President, Health Research & Educational Trust

Task Force on Ensuring Access in Vulnerable Communities

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TASK FORCE BACKGROUND

Confirm the **characteristics and parameters** of vulnerable rural and urban communities by analyzing hospital financial and operational data and other information from qualitative sources where possible;

Identify **emerging strategies, delivery models and payment models** for health care services in rural and urban areas;

Identify **policies/issues at the federal level** that impede, or could create, an appropriate climate for transitioning to a different payment model or model of care delivery, as well as identify policies that should be maintained.

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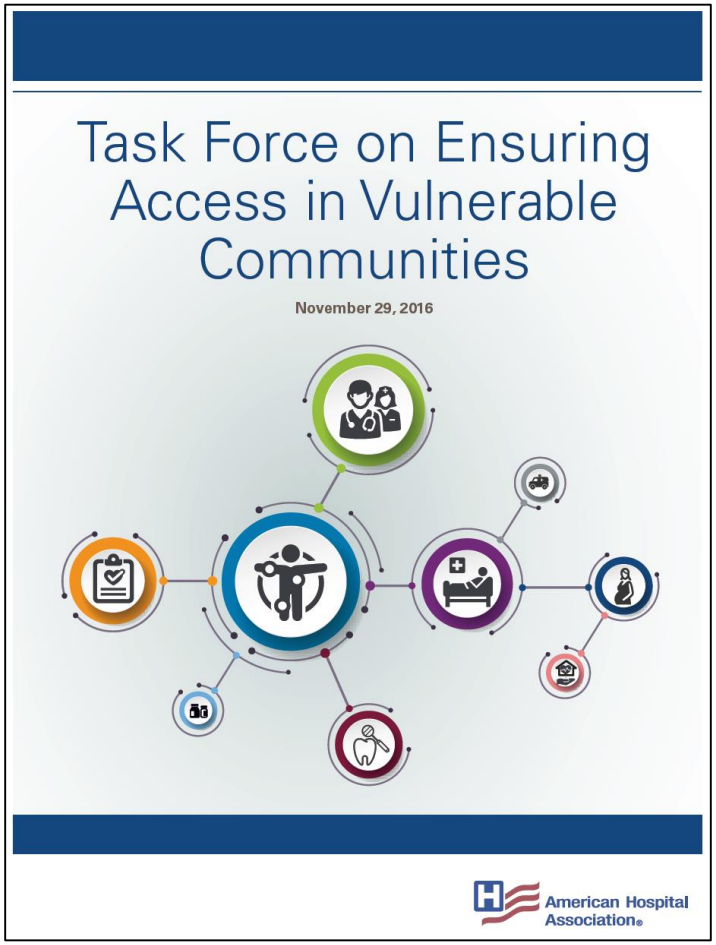
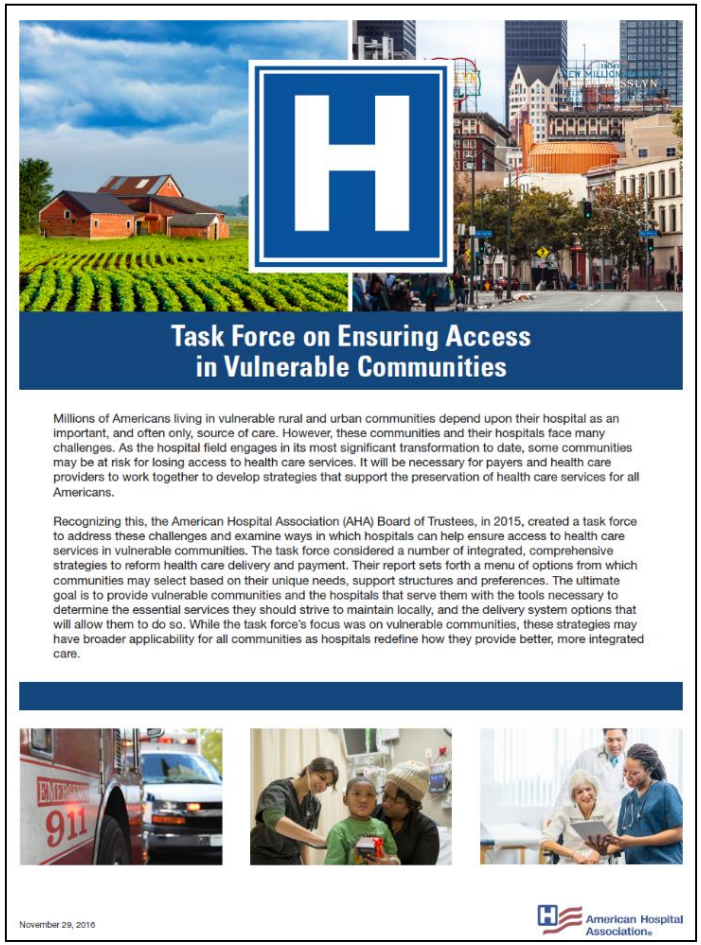
TASK FORCE REPORT

To learn more about the work of this AHA Task Force, please visit www.aha.org/ensuringaccess.





THEMES IN THE REPORT

- The task force focused on preserving access to essential health care services.
- The characteristics and parameters of vulnerable communities were similar for rural and urban areas.
- The task force focused on communities.
- There is no single or one-size fits all solution; as a result, the task force recommended nine strategies.
- There are many federal and state barriers that must be addressed before these models may be implemented successfully.

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EMERGING STRATEGIES

Virtual Care Strategies

Social Determinants

Inpatient/Outpatient Transformation

Urgent Care Center

Rural Hospital-Health Clinic

Emergency Medical Center

Global Budgets

Frontier Health System

Indian Health Services

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AHA GLOBAL BUDGET STRATEGY

1. **Fixed reimbursed over a fixed period of time and for a specified population**
2. **Each provider is able to create a unique plan to meet mandated budgets**
3. **Many factors must be considered –**
   - Payments must be predictable, stable and sufficient
   - Timing and structure of payments
   - Ability to adjust for factors outside a hospital's control
   - Selection of appropriate quality measures
   - Types of health care providers and services included
   - The payers that are willing to participate
   - Access to claims and quality metric data

AHA STRATEGY

ADVANCING HEALTH IN AMERICA
THE PATH FORWARD

Our vision: A society of healthy communities where all individuals reach their highest potential for health.

Our commitment:

1 **Access:** Access to affordable, equitable health, behavioral and social services

2 **Value:** The best care that adds value to lives

3 **Partners:** Embrace diversity of individuals and serve as partners in their health

4 **Well-being:** Focus on well-being and partnership with community resources

5 **Coordination:** Seamless care propelled by teams, technology, innovation and data

Our role: The '**H**' of the future = **H**ospitals, **H**ealth systems, and **H**ealth organizations that are:

- → Partnering and leading in our communities
- → Striving toward the vision to advance health in America
- → Helping our communities beyond the four walls of the hospital
- → Creating new models of care, services and collaborators

Our Mission

To advance the health of individuals and communities. The AHA leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement.

Driving Forces

- → Affordability
- → Coverage
- → Consumerism
- → Payment for Value
- → New Technologies
- → Chronic Care Management
- → Consolidation
- → Community Benefit

Strategic Priorities

- → Performance Improvement
- → Payment and Delivery Reforms
- → Shaping Future Workforce
- → Advocating for Access and Coverage
- → Telling the Story

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AHA STRATEGY

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AHA ASSISTANCE STRATEGY

Discussion Guide for Health Care Boards and Leadership

AHA President & CEO Rick Pollack spoke at a Washington, D.C. press event to unveil this report. From left: AHA Chairman Jim Skogsbergh, president & CEO of Advocate Health Care, IL; Bob Hankal, president & CEO of Ascension Healthcare, MO; Christina Campos, administrator of Guadalupe County Hospital, NM, & Karen Tafalbaum, president & CEO of Sinai Health System, IL.

The questions below can be used to guide discussion about the vulnerable populations your health care organization serves and steps your board and leadership can take to ensure ongoing access to health care services.

Use of this discussion guide can be tailored for your board's needs as part of the agenda for a board education session, leadership retreat, or strategic planning session. The executive staff and all board members should be prepared to address local examples/information as part of this discussion.

1. The report defines a vulnerable community as "a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions" and page 2 of this summary lists characteristics that may make a community vulnerable. ***Which of the populations or communities we serve could be considered vulnerable? And why?***
2. The essential health care services identified in Table 2 below, should be available in every community. ***Which, if any, of these services are not available in the vulnerable communities our organization serves?***
3. ***Which of the vulnerable communities we serve are less likely to have access to or are not likely to utilize one or more of these essential health care services?***
4. ***Which of the emerging strategies identified on page 3 are most likely to further improve access to essential health care services for the vulnerable populations our organization serves?***
5. ***What are the implications of implementing these strategies in our organization and community?*** Some areas to consider include strategic compatibility, financial, clinical, workforce, technology, partnerships with other community organizations, and legal and regulatory compliance.
6. Several barriers to implementation are identified in the Task Force Report and many are listed on page 4. ***Which of these barriers is our organization most likely to encounter? How can we as a board and as an organization advocate to overcome them?***
7. ***What role(s) should our board play in gaining input, buy-in and acceptance from the community to implement new strategies for ensuring access?*** Some examples include:
   - facilitate community conversations,
   - be prepared to respond to questions from community members, and
   - invite community leaders and organizations to provide input into our organization's strategic planning process.
8. ***What assistance, such as education, tools, training and other resources, will our board need to effectively fulfill its community liaison role(s)?***

Table 2: Essential Health Care Services

Primary care	Psychiatric & substance use treatment services	ED & observation care
Prenatal care	Transportation	Diagnostic services
Home care	Dentistry services	Robust referral structure

Please contact Priya Bathija at *pbathija@aha.org* to provide feedback about your board and leadership discussion.

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Ensuring Access in Vulnerable Communities

Community Conversations Toolkit

American Hospital Association

Emerging Strategies to Ensure Access to Health Care Services

Inpatient/Outpatient Transformation Strategy

The AHA Task Force on Ensuring Access in Vulnerable Communities examined ways in which the access to and delivery of care could be improved. The inpatient/outpatient transformation strategy (IOTS) addresses two recent challenges faced by hospitals – the declining volume of inpatient services and increasing volume of outpatient services. The IOTS would capitalize on these challenges, allowing hospitals to more closely align the services offered with those needed by their communities.

Reduce Inpatient Capacity and Shift Resources to the Delivery of Outpatient Care

To implement this strategy, hospitals need to conduct a detailed assessment of the level of inpatient and outpatient services needed in their community. They should then take these three steps to achieve better alignment:

1. **Reduce inpatient capacity** to a level that closely reflects the need of the community for acute inpatient beds;
2. **Shift resources** to enhance outpatient and primary care services offered to the community; and
3. **Continue providing** emergency services.

Once this transition takes place, hospitals would continue to be subject to all federal statutory and regulatory requirements that apply to hospitals, including, but not limited to, quality reporting requirements, the Medicare Conditions of Participation and other requirements related to the volume and type of inpatient services provided by the hospital.

Strategies to Facilitate Successful Implementation

While the IOTS does not require changes to federal statutory or regulatory provisions to be implemented, there are certain strategies that will allow hospitals to more successfully implement this model.

- **Community engagement.** Partnership, buy-in and acceptance from the community will be a key driver for success as hospitals consider this strategy. Hospitals should start by engaging their boards in conversations related to the amount and type of services currently offered by the hospital to the community. Hospitals may utilize *AHA's Discussion Guide for Health Care Boards and Leadership* to assist with these conversations. Then, hospitals should determine what services they should be providing based on the health needs of the community. This includes proactively fostering relationships with community organizations focused on improving the community's health. In addition, hospitals may work with community health partners, including local county governments, health departments, churches and schools to coordinate care and increase the community's focus on health and wellness. Hospitals also may use *resources* developed by the AHA to consider ways to engage with their communities as they complete their Community Heath Needs Assessment.
- **Resource allocation.** In order to transition to this strategy, like others included in the task force report, hospitals will need to invest time, effort and financial resources. In many cases, hospitals will need to make facility renovations or improvements to restructure how and where it offers its services. Additional resources from local, state and federal governments would allow hospitals to more successfully implement the IOTS. Hospitals may visit AHA's *website* for more information on grant funding opportunities.

April 28, 2017

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TASK FORCE REPORT

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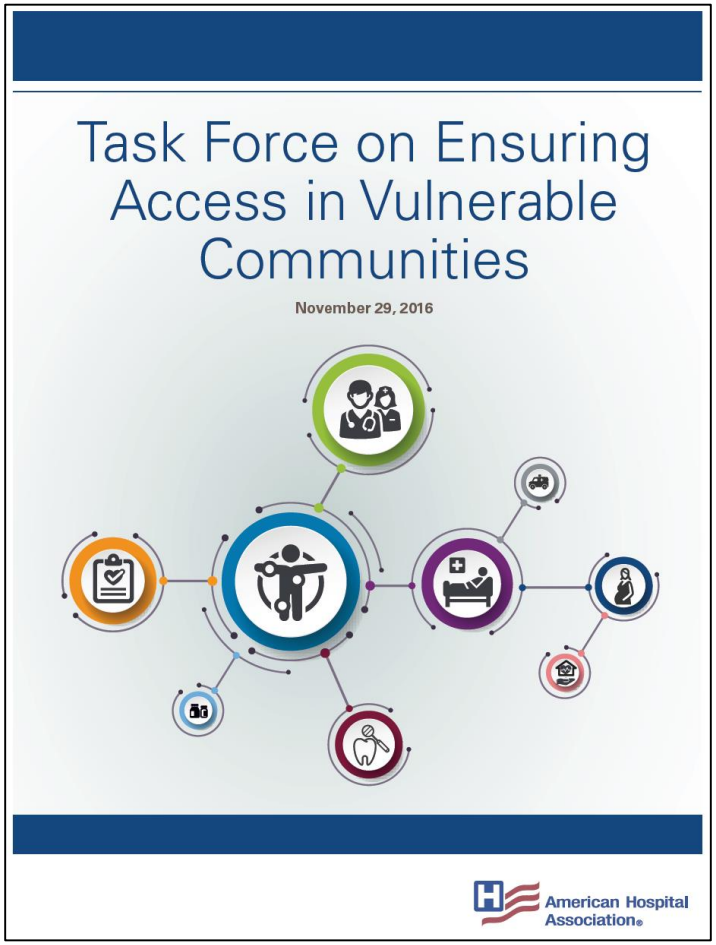

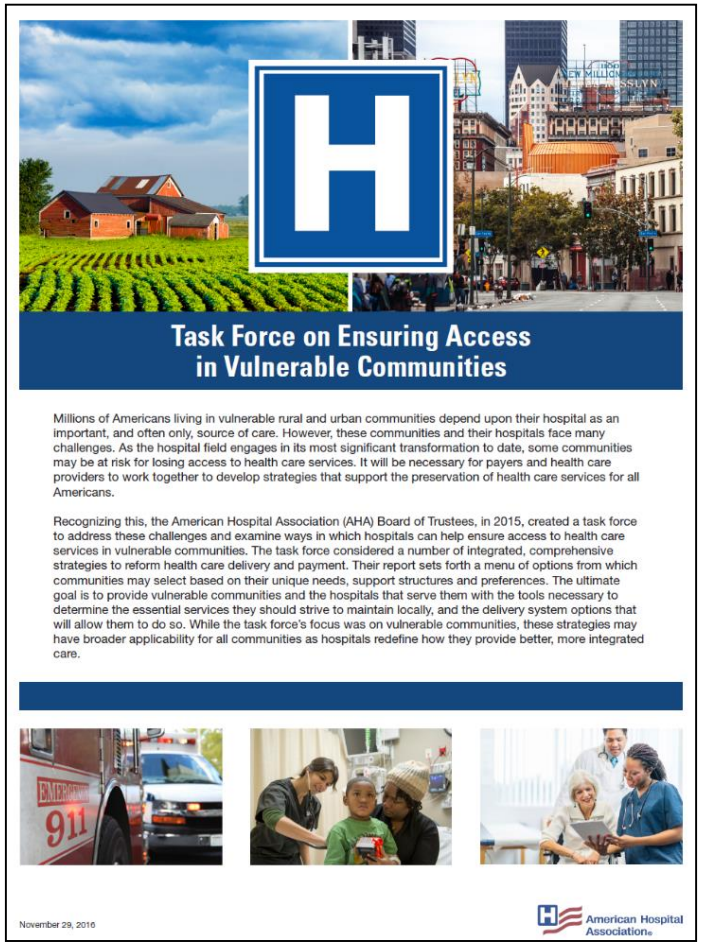

Paying for Value: Maryland's Global Budget Experiment

Michael Robbins, Senior Vice President

Maryland Hospital Association

Background

- On October 10, 2013, the State of Maryland applied to the Center for Medicare and Medicaid Innovation (CMMI) for a demonstration project to improve outcomes, to enhance patient experience and to control costs.
- The application was approved effective January 1, 2014
- The resulting All-Payer Model ("the Model") shifts the focus from historic price per encounter controls to a focus on overall revenue growth, including price and use.

Background

- The New Model includes the following provisions:
  - **Annual all-payer, per capita, total hospital cost growth limited to 3.58%**
  - **Maryland's Medicare per beneficiary total hospital cost growth rate must be below the national Medicare per beneficiary average, resulting in $330m of Medicare savings over five years**
    - 80% of Maryland hospital revenue shifted into value-based payment models by year 5
  - **Maryland's Medicare per beneficiary total cost growth rate cannot exceed the national average by more than 1 percentage point in any year, and must be no more than the national growth rate in at least one of every two years.**

Background

- The New Model includes the following provisions (cont.):
  - **Maryland will reduce its 30-day Medicare readmission rate to the national average in five years**
  - **Annual Potentially Preventable Complication (PPC) reduction of 6.89%, for a cumulative 5 year reduction of 30%.**
  - Maryland will propose a model extension at the start of Year 4 (submitted for federal clearance in May 2017)
    - If the Model is not extended, or terminated early, Maryland hospitals will transition to the national Medicare payment systems.

HSCRC Policy Impacts

- To achieve success under the Model, HSCRC Staff have taken several actions, including:
  - Negotiating either a Global Budgeted Revenue (GBR) or Total Patient Revenue (TPR) agreement with almost every hospital in the State.
  - Implementing a series of workgroups and committees to assist with implementation
    - Overall Advisory Council that identified guiding principles
    - Other workgroups to address critical success factors (physician alignment, performance improvement, etc.)
    - Sub-workgroups to address certain technical issue's (transfer policy, demographic adjustment, etc.)
  - Establishing policies to address the quality measures (PPC's and readmissions)

Hospital Global Budgets: How They Work

- The GBR agreements establish a fixed amount of regulated charges for each hospital. The cap was based on FY2013 experience, with certain adjustments and allowances for infrastructure investments for reducing avoidable utilization and investing in population health management

Hospital Global Budgets: How They Work

- Under GBR, hospitals receive annual adjustments for:
  - Inflation
  - Change in markup (payer mix and UCC via the UCC pool)
  - Population/Demographics
  - Impact of Commission's Quality-Based Payment Programs
- There are no explicit adjustments for changes in:
  - Volume (I/P or O/P)
  - Case Mix/Severity
  - Adjustments are made for "categoricals," transfers, and market share changes
  - Hospital billing: Fee for service, unit rates are adjusted up or down based on ability to change PAUs within total global budget

Hospital Global Budgets: How They Work

- Global Budget Model
  - Provides fixed revenue base on an annual basis for inpatient and outpatient regulated revenue
  - Changes the long-standing incentives that have been in-place regarding volume
  - Maintains long-standing commitment to access to care through equitable funding of uncompensated care
  - Forces hospitals to rethink, and redesign, strategic and operating plans

Hospital Global Budgets: Policy Questions

- How do you recognize changes in volume due to changes in population demographics?
- How do you adjust budgets for changes in market share and movement to unregulated services?
- How do you measure efficiency on a per capita basis?
- What limits, if any, do you place on unit rate increases within global budgets?

Hospital Global Budgets: Policy Questions

- How do you fund capital within a global budget environment?
- How do you address unforeseen adjustments, such as extraordinary inflation, a flu epidemic, or ACA-related volume growth (or today, potential loss of coverage), within the global budgets?
- How do you align global budgets with other payment models (ACOs, PCMH)?
- How do you align global budgets with providers still under volume-driven incentives?

Hospital Global Budgets: Policy Questions

- How do you fund infrastructure investments needed outside of hospitals to invest in population health, to reduce avoidable hospital care, and to reduce the total cost of care?

Hospital Public Reporting

- Disclosure of Information and Performance
  - High degree of availability
    - Maryland system is based on most comprehensive and timely information available
  - Multiple reporting requirements of Hospitals
    - Monthly revenue and utilization, All-payer and Medicare
    - Annual filings
    - Community Benefit Report
    - Reporting by payer and in-state vs. out-of-state
    - New data tape submission requirements – now monthly
  - Access to Medicare data to monitor total cost of care and implement care transformation activities

Paying for Value: Maryland's Global Budget Experiment

Michael Robbins, Senior Vice President

Maryland Hospital Association

All-Payer Global Budgets for Hospital Systems

Joshua M. Sharfstein, M.D.

November 2017

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Fee-for-Service Incentives

Public and private insurers and managed care companies paying separately for each admission

Indirect Medicaid revenue based on inpatient volume

Hospitals need to keep beds filled to be successful

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All-Payer Global Budget Incentives

Prospectively set budget for all inpatient and hospital outpatient care

Hospitals need to prevent illness to be successful

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Going Global

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A Vision for Transformation

- Assess community health challenges
- Understand limitations of current financial model in addressing them
- Develop promising community health investments to succeed under global budget
- Establish clear metrics for success

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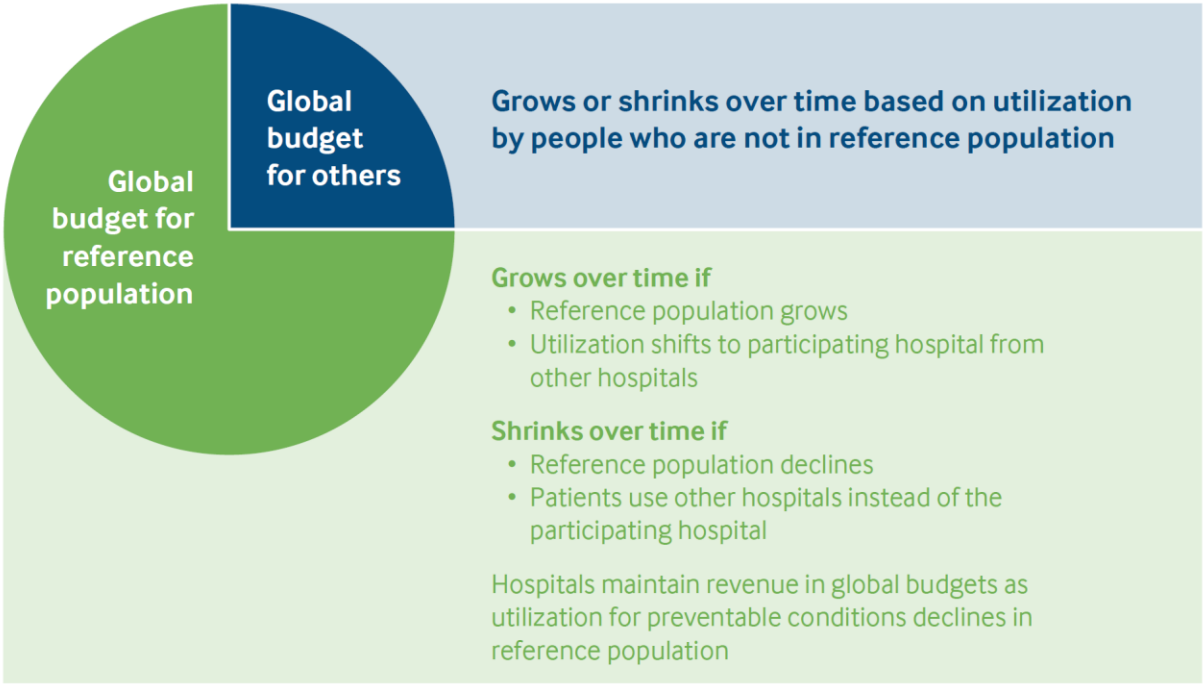
An Operational Strategy

Exhibit 1. Addressing Changes Over Time



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Establishing a Credible Governance Structure

- Credible, with key public and private partners
- Transparent, fair methodologies
- Can handle capital investments differentially from other cost, penalize inappropriate behaviors

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How Payers Participate

- Payers contribute to global budgets based on assignments by administering agency
- Medicare, Medicaid, private insurers
- Medicaid contribution includes indirect public payments
    - Disproportionate Share Hospital payments
    - Upper Payment Limit

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An Environment Conducive to Success

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Local Hospital Environments

- Ideally neighboring hospitals will also use global budget
- A “regional ecosystem” facilitates:
  - Elimination of danger that other hospitals seek volume to grow their revenue
  - Incentive for collaboration in addressing needs of high-need patients
  - Additional synergy with local public health agencies interested in defined geographic populations

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Engagement of the State and Federal Governments

- Federal support through innovation waivers and Medicaid plans or waivers
- State formal authority & strong leadership support can lead to necessary health system alignment

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Availability of Technical Assistance

- Administering agency must access:
  - High quality data on hospital utilization
  - Tools for identifying opportunities for health systems to improve outcomes and lower costs
- Other sources of funding may include:
  - Private philanthropy
  - Foundations
  - Global budgets themselves- pre-set to provide additional room for population health investments

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Summary: How to Begin

1. Describe the challenge: finding flexible funding to transform for better health at lower cost.
2. Draft a vision for transformation.
3. Propose an operational strategy for global hospital budgeting.
4. Discuss with policymakers.
5. Develop a governance structure.

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The Hospital Global Budget: A Tool To Help Build a System of Care That Drives Value for the Patient And Payer

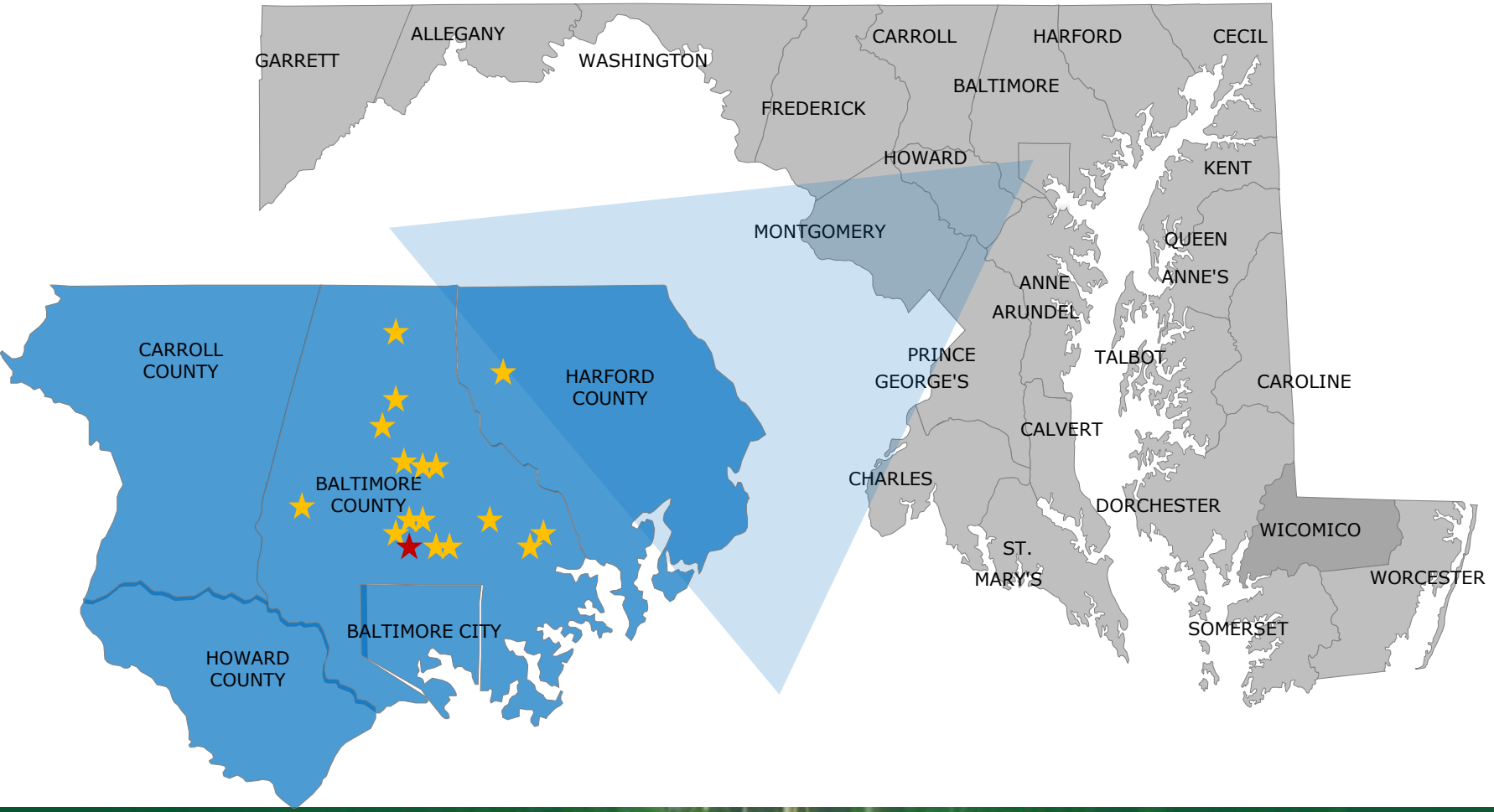
November, 2017

John B. Chessare MD, MPH
President and CEO
GBMC HealthCare System
Baltimore, Maryland

The GBMC HealthCare System

- **Greater Baltimore Health Alliance (GBHA)**
  - Private practicing physicians
  - Greater Baltimore Medical Associates (GBMA)
- **GBMC Medical Center (250 beds)**
- **Gilchrist**
  - Elder Care
  - Hospice (850 patients/day)
  - Counselling and Bereavement Support

GBMC HealthCare System



Our Vision Statement 2011-2018

In order for GBMC to maintain its status as a provider of the highest quality medical care to our community, in the context of an evolving national healthcare system, we must transform our philosophy and organizational structure, and develop a model system for delivering patient-centered care.

We define patient-centered care as care that manages the patient's health effectively and efficiently while respecting the perspective and experience of the patient and the patient's family. Continuity of care with a focus on prevention and ease of navigation through a full array of services will be the rule. Our professional staff will be able to say with confidence that the guidance and medical care they are providing mirrors what they would want for their own family.

We will create the organizational and economic infrastructure required to deliver evidence-based, patient-centered care and for holding ourselves accountable for that care. This new organization will be defined by collaboration and continuous improvement. Physicians will lead teams that will manage patient care.

We are moving into the future with renewed energy and increasing insight. We look forward to building relationships with both community-based and employed physicians that will form the foundation of the Greater Baltimore Health Alliance. We welcome all those who share our vision of health care as it is transformed to meet the needs of our community and nation in the 21st century.

Vision Phrase:

To every patient, every time, we will provide the care that we would want for our own loved ones.

What do we want for our own loved ones?
The GBMC HealthCare *Quadruple* Aim

1. The **Best *Health* Outcomes**
2. The **Best *Care* Experience**
3. Lowest Cost (**Least *Waste***)
4. With the **Most *Joy*** for those providing the care

The Global Budget is Liberating

- The global budget allows us to apply hospital resource to create a true system of care.
  - Adding nurse care managers and addiction specialists.
  - Paying primary care providers to drive value rather than visits.
- We no longer lament “not enough widgets sold”.
  - If the ED is not full and only has patients with true emergencies this is a success.
  - Declining abdominal CT scans is probably a good thing.

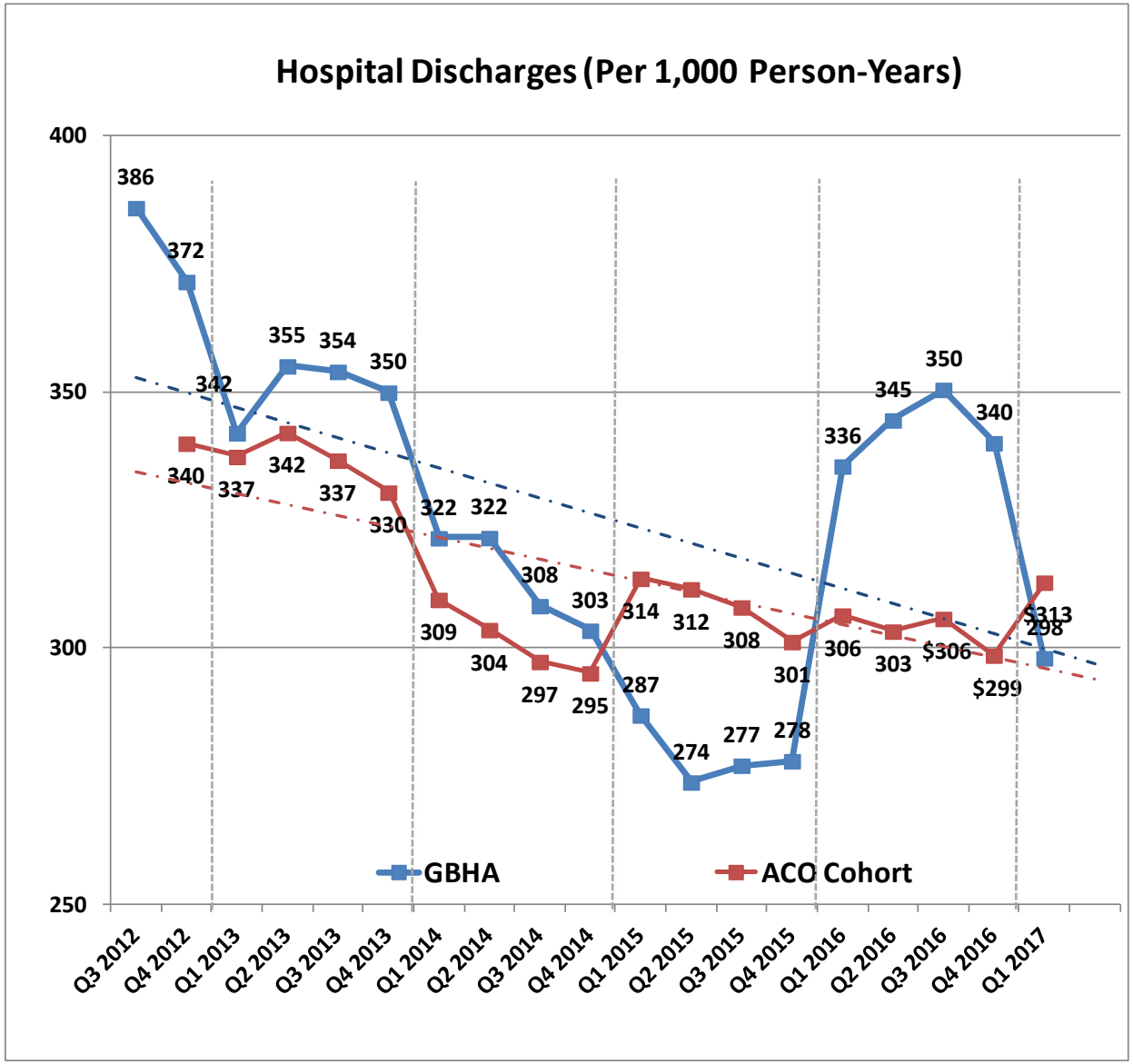
Developing a Model System for Delivering Patient-Centered Care

- **The Patient Centered Medical Home**
  - 15 practices within GBHA (GBMA=10)
  - Also called advanced primary care.
  - It's not about the visit. It's about a relationship of trust and accountability but access is critical.
  - Physician leaders and Practice Managers working with nurse care managers and care coordinators working to maximize health even without a visit.
  - Using disease-state registries and valuing care coordination and prevention.
  - Embedded behavioralists, addiction specialists and psychiatrists.
  - How are we doing?

Managing the Health of a Population
Some Results

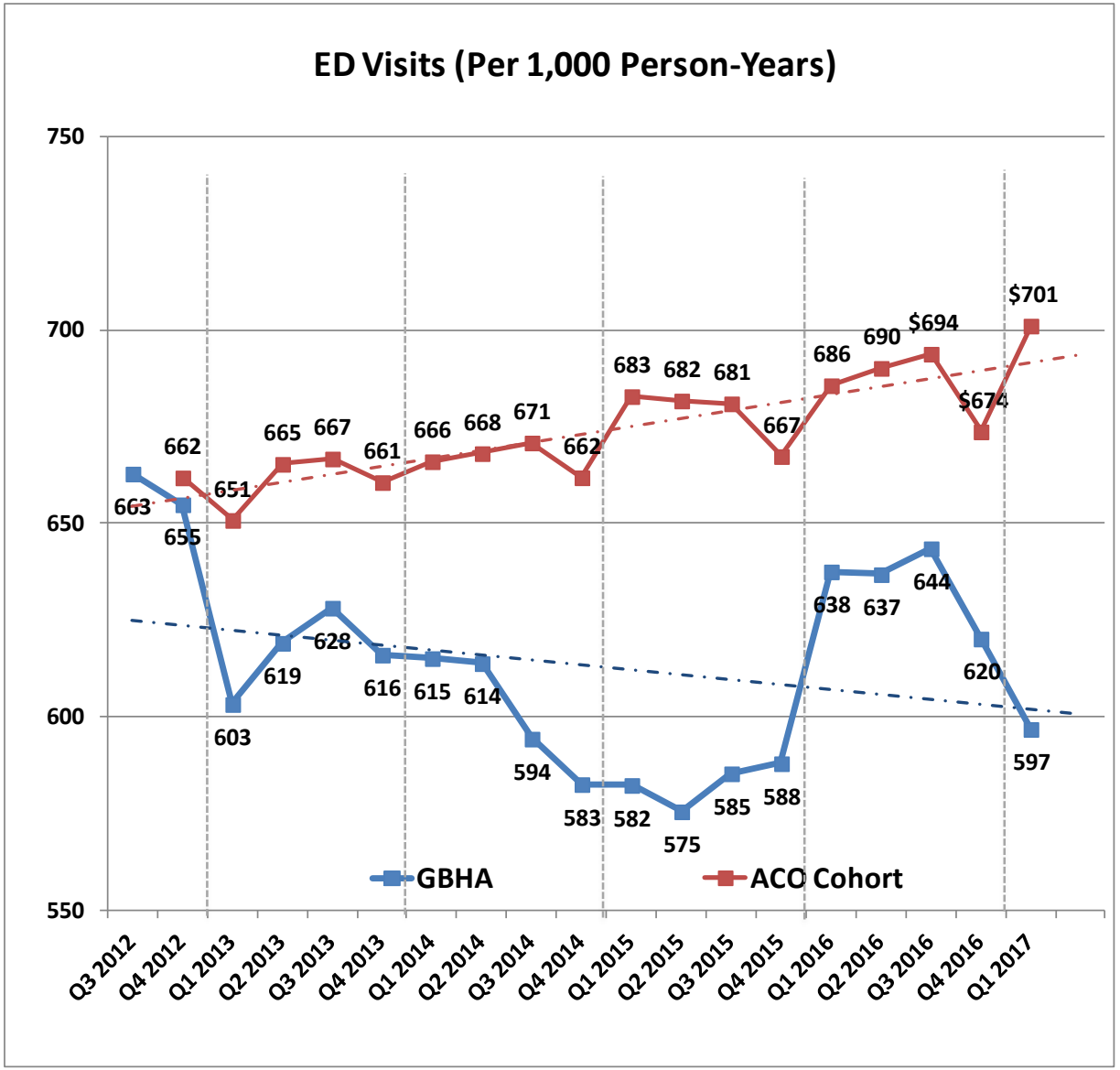
MSSP Expenditures/Utilization – Trends

Hospital Discharges
GBHA – 22.77% Decrease (Δ 88)
ACO Cohort – 7.98% Decrease (Δ 27)



MSSP Expenditures/Utilization – Trends

ED Visits
GBHA –9.97% Decrease (Δ 66)
ACO Cohort – 5.93% Increase (Δ 39)

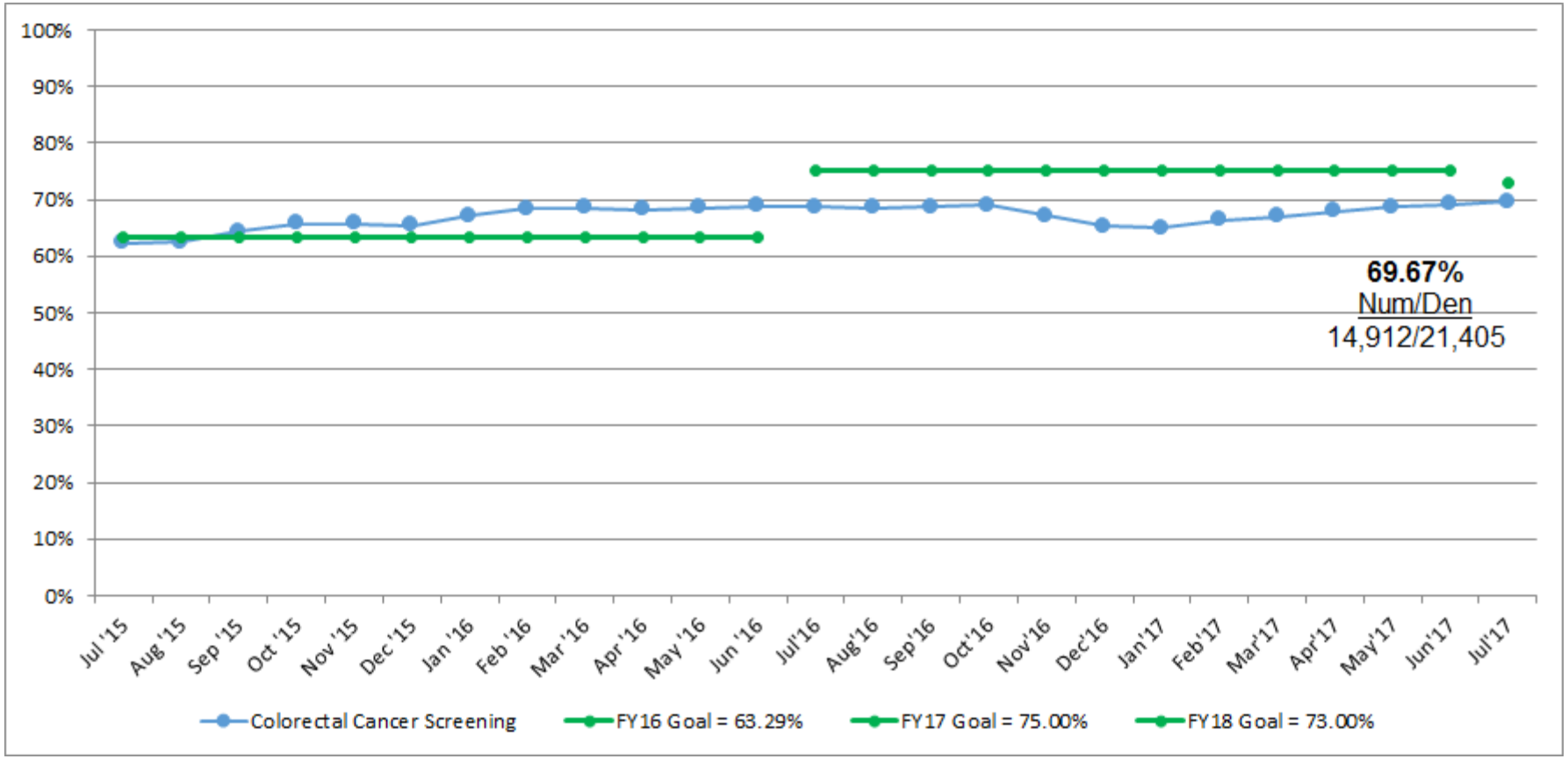


Best Health Outcomes

Higher is Better

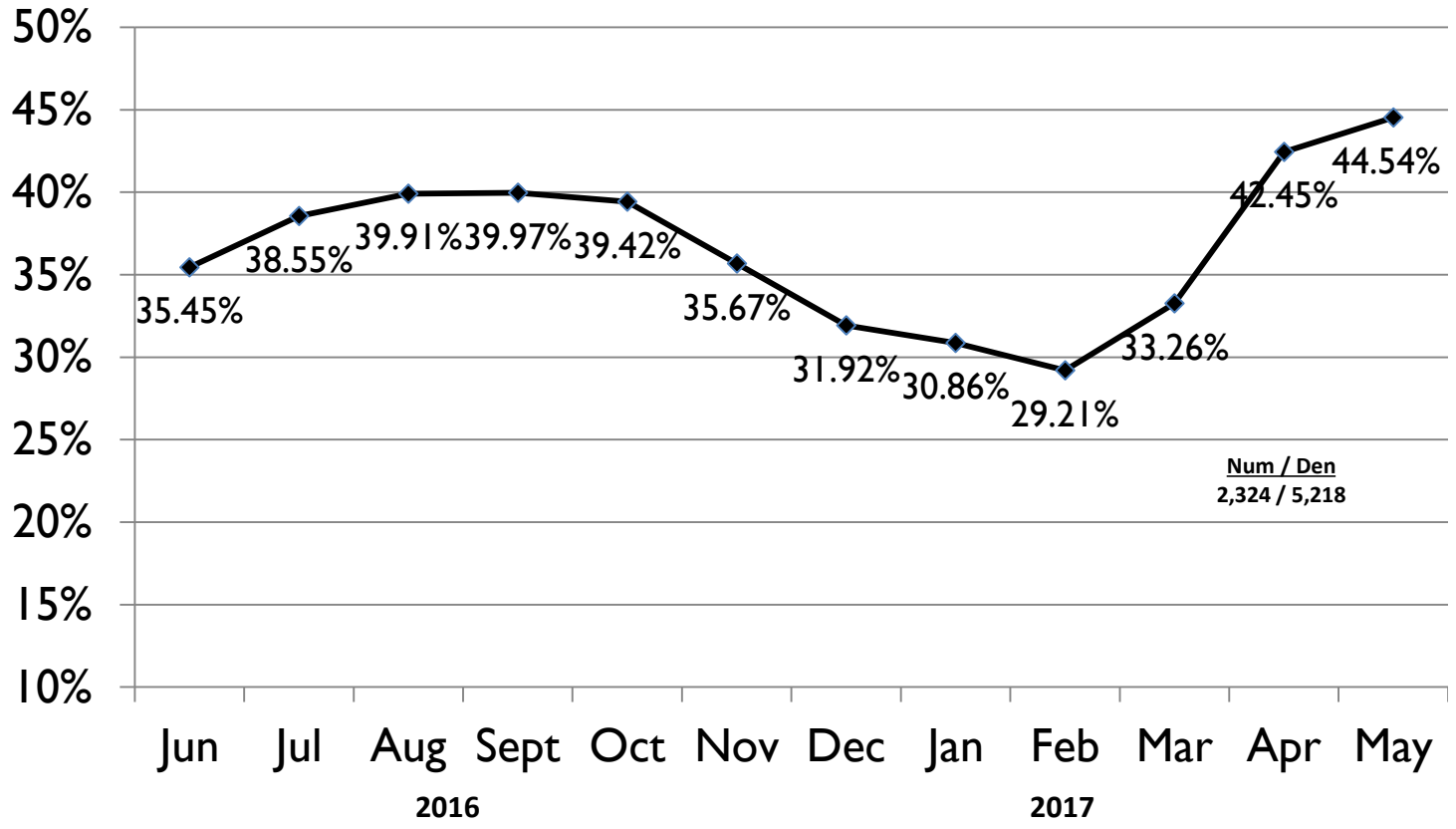
Improve Population Health as measured by Colorectal Cancer Screening

GBMA Group Practice Reporting Measure. Percent of patients with documented colorectal cancer screening



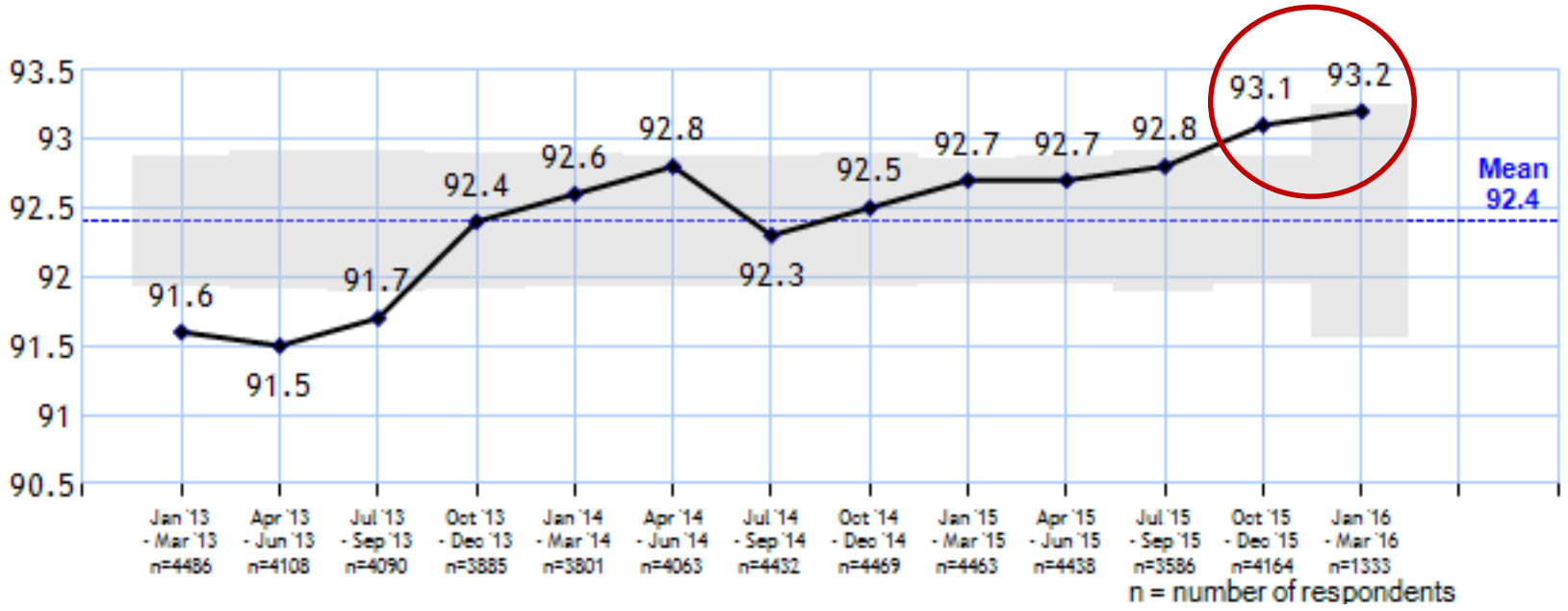
Best Health Outcomes

Evidence-Based Diabetic Eye Exam



GBMA – Overall Satisfaction Score

85th National Percentile

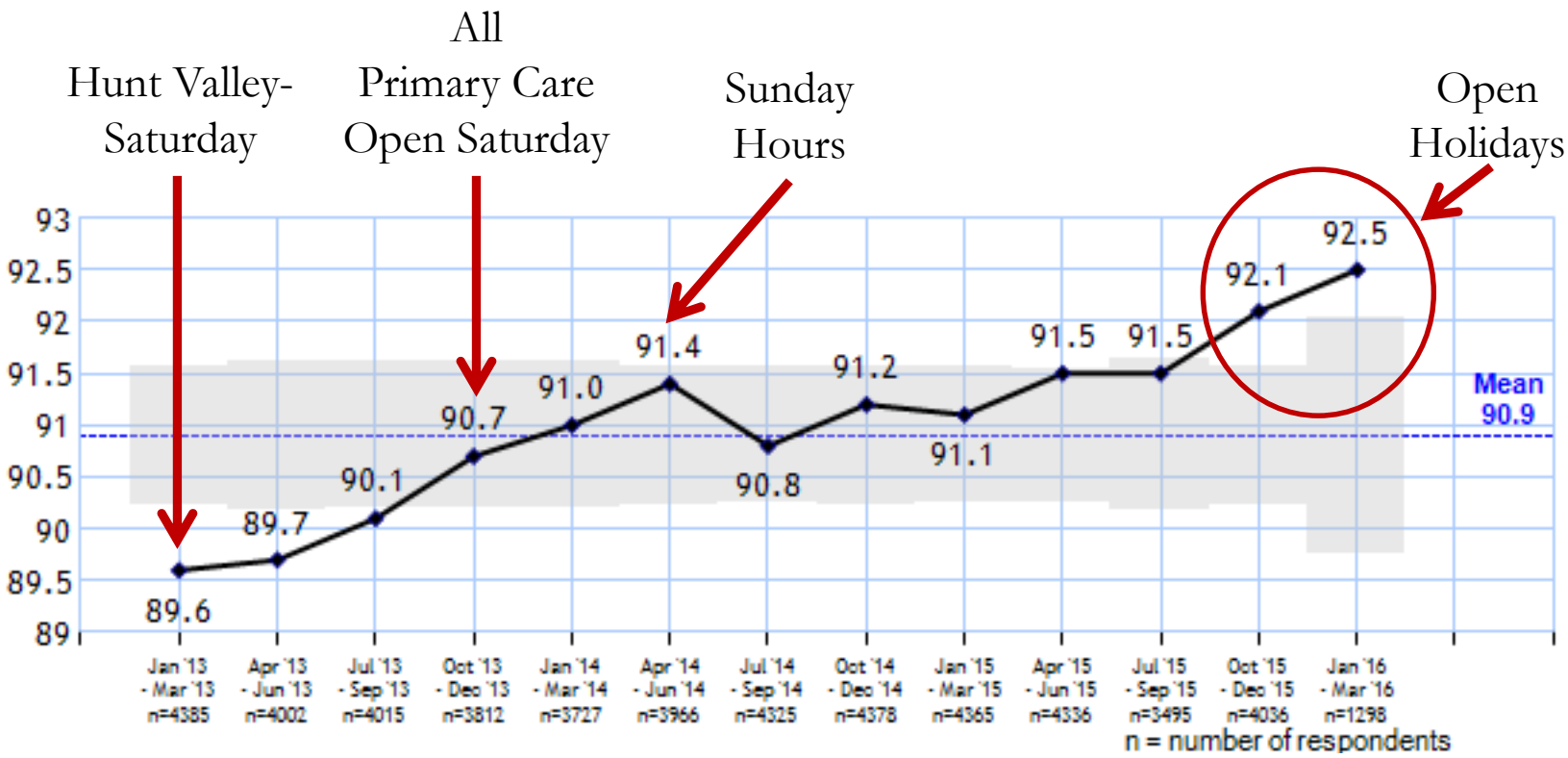


All My Sites

Higher is Better

GBMA – Convenience of our Office Hours

92nd National Percentile



Higher is Better

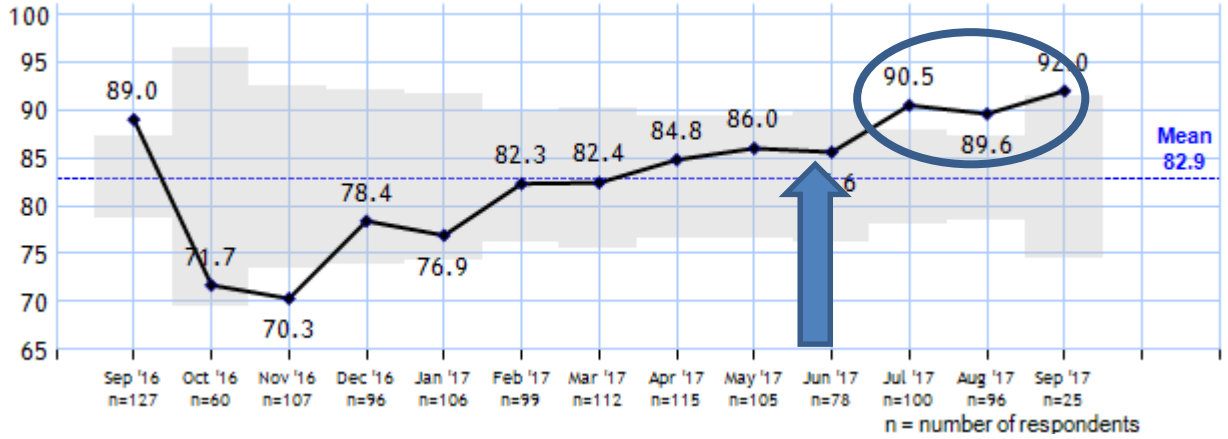
Best Care Experience

Mean Trends

Medical Practice

Hunt Manor GBMC

Question - Ease of getting clinic on phone



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Upcoming Webinar

Transportation and the Role of Hospitals

November 17, 2017

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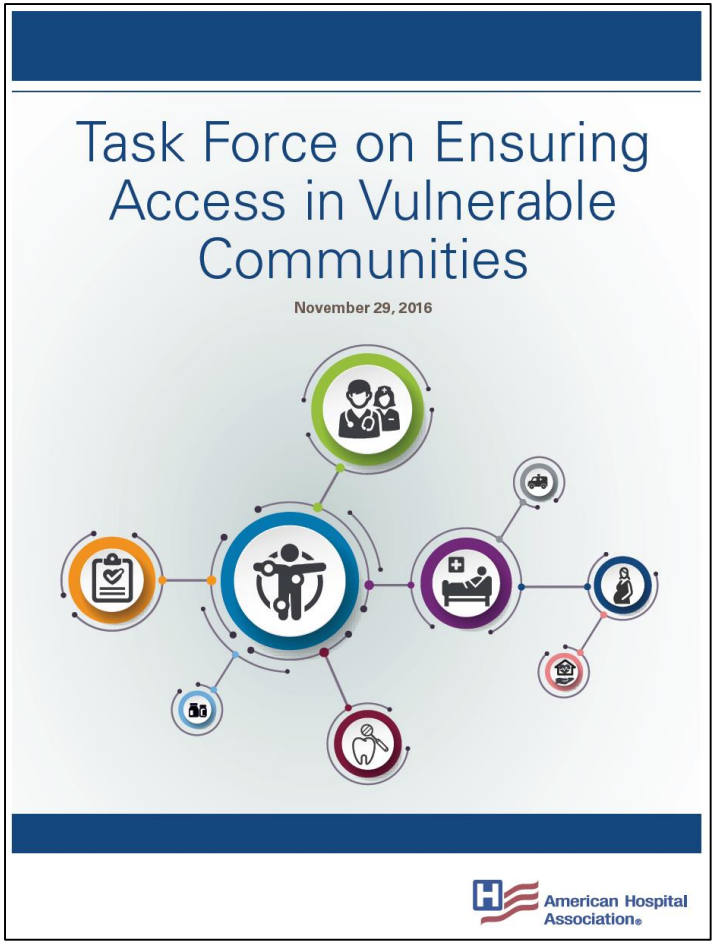
Visit www.aha.org/ensuringaccess to learn more about AHA's Task Force



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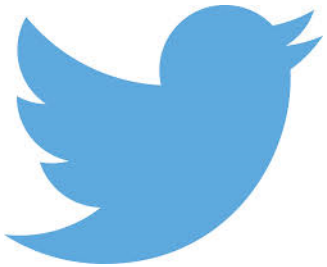

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