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MARYLAND CITIZENS' HEALTH INITIATIVE

Encouraging Multi-Hospital Collaboration to Reduce Potentially Avoidable Utilization

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I. In a multi-hospital area, it makes little economic sense for a hospital acting on its own to lower community-wide utilization

Some of the most important potential reductions in hospital costs require community-wide interventions, outside hospital walls. Some interventions might improve care management for chronically ill consumers to lower hospitalization rates for ambulatory-care-sensitive conditions. Others could strengthen primary care infrastructure and connect consumers to primary care providers, thereby reducing non-emergency use of emergency departments.

Steps like these can make economic sense to a total patient revenue (TPR) hospital that serves all residents in its community. Secretary Sharfstein has thus cited TPR hospital investments in community asthma clinics that lowered asthma hospitalization levels, generating financial returns for the hospital. The same hospital making the investment reaped all the rewards.

In an area served by multiple hospitals, the situation can be quite different. A global budget revenue (GBR) hospital has inherent incentives to reduce utilization at that particular hospital. But those incentives do not apply in the same way to a single intervention that simultaneously lowers potentially avoidable utilization (PAU) at many hospitals.

Suppose, for example, that a GBR hospital in a multi-hospital service area opens a community-based asthma clinic that reduces asthma admissions for all of the region's hospitals. Unlike the above example of the TPR hospital, the hospital that pays the entire cost of the investment realizes only some of the resulting gains. Its competitors are "free riders," enjoying many if not most of the financial benefits. This example illustrates a "market failure" inherent in global budgets: *When a rational GBR hospital acts alone, it will underinvest in measures that lower utilization at multiple hospitals.*

In theory, a region's hospitals could address this free rider problem by entering into a compact to jointly invest in community infrastructure. Unfortunately, such joint initiatives have not occurred very often. One factor inhibiting collaboration may be the perception that, collectively, hospitals have excess capacity. As a result, many hospitals remain competitively focused on maximizing market share to optimize their position in the face of long-term pressures on hospital infrastructure. Realistically, obtaining desired levels of hospital collaboration around reducing area-wide PAU may require HSCRC to create incentives and regional structures that supplement individual hospital global budgets.

II. How HSCRC and other state agencies could effectively encourage multi-hospital collaboration to lower community-wide utilization

A two-part approach could address the problems described above:

1. **Incentives**—in a community served by multiple hospitals, reward each hospital if community-wide utilization declines, and provide direct incentives for each hospital to contribute to collaborative efforts aimed at reducing such utilization; and
2. **Facilitation**—create effective mechanisms to facilitate hospitals' collaboration with each other and with others in their communities.

A. Incentives for collaboration to lower hospitalization throughout hospital service areas

1. Reward each hospital within a multi-hospital service area when PAU drops throughout the service area

To encourage hospitals to focus, not just on their own PAU, but also on PAU levels within their service areas, HSCRC could take the following approach:

1. HSCRC will divide the state into areas that are served by multiple hospitals and those that are served by a single hospital.¹
2. Currently, each hospital's rehospitalization incentive reflects a combination of (1) hospital-specific and (2) *statewide* performance. By contrast, the approach suggested here will base each hospital's incentive amount on (1) hospital-specific rehospitalization performance and (2) rehospitalization performance in the *hospital's service area*.
3. For each hospital within a service area, its global payment amount will be adjusted based on the *entire service area's* performance on Prevention Quality Indicators (PQI), not the individual hospital's PQI.² PQI is a measure developed by the Agency for Healthcare Research and Quality to define hospitalization rates for conditions that can often be prevented by ambulatory care.³
4. For each hospital within a shared service area, its otherwise applicable Unit Rates will increase by a uniform percentage to the extent that overall utilization within the total service area (not otherwise reflected in other incentive payments) declines by a more than a target amount set by HSCRC. The amount of the Unit Rate increase will be set so the savings resulting from the decline in utilization, beyond the target amount, are shared between hospitals and payors.

This new approach will create incentives for hospitals to cooperate in lowering utilization throughout their shared service area:

- If area-wide hospitalization declines by more than the target amount, each hospital will receive higher payments per case. Accordingly, hospitals will have an incentive to lower overall hospitalization levels throughout the service area—for example, by working to change local physician culture to reduce the use of costly, hospital services that have not been shown to improve health; or by agreeing to a “mutual disarmament treaty” that shifts clinic outpatient services from each hospital into the community.
- Each hospital's rehospitalization incentive will be based on two factors: its own rehospitalizations and those within its service area. Because of the latter, hospitals will have an incentive to cooperate in reducing regional rehospitalization levels—for example, by establishing supports in severely underserved communities that help newly discharged, low-income patients stay out of the hospital, regardless of which hospital they left.⁴
- Hospitals will benefit financially if PQI declines within their service area. This will provide incentives to prevent hospitalizations for ambulatory-care-sensitive conditions by, for example, funding care coordination programs for Medicare patients with chronic illness. Note that if PQI performance measures were instead made specific to individual hospitals—

- Each hospital would have a strong incentive to avoid low-income patients, who have high levels of ambulatory-care-sensitive conditions. Applying PQI incentives to entire service areas avoids this risk, since all hospitals in each area will be equally affected.
- The incentive would be hard to apply, since PQI is a population measure, based on hospitalization rates per thousands of residents within a given geographic area. Applied to all residents of a service area, PQI will be more usable.

2. Encourage hospitals to join collaborative efforts reducing community-wide PAU

The above policies would encourage hospitals to focus on improving area-wide PAU, but they would only partially solve the “free rider” problem and other obstacles to partnership. One hospital could remain on the sidelines and still benefit from other hospitals’ efforts that lower hospitalization rates throughout a shared service area. To avoid such free riding and encourage all area hospitals to aid collaborative efforts from which all such hospitals benefit—and which all can help shape—HSCRC could create two additional incentives.

1. Target a specific amount of funding from global budgets. HSCRC could increase a hospital’s global budget based on the amount that it contributes towards collaborative efforts to lower community-wide PAU, subject to several limitations:

- Such increases would be capped at a specified percentage of the hospital’s budget (such as 0.5 percent); and
- For the first year or two, such increases may require offsetting reductions to hospitals’ baseline global budgets, statewide, to keep total spending below the waiver’s ceilings.⁵

Of course, hospitals could invest amounts beyond these targeted levels if, in the hospitals’ judgment, such investments appeared likely to yield favorable returns in the form of further PAU reductions. But those additional investments would not further increase global budget totals.

2. Limit regional rewards for non-collaborating hospitals. If a hospital contributes less than the targeted percentage of its budget towards collaborative efforts to reduce community-wide PAU, any financial gains it receives from such reductions would be reduced proportionately. For example, suppose that: (1) area-wide PQI improvements should qualify a hospital for \$10 million in incentive payments; (2) reduced area-wide hospitalizations should increase the hospital’s base rates by 2%; but (3) the hospital invested only 0.4 percent of its budget, rather than the specified 0.5 percent, in an area-wide, multi-hospital initiative to reduce shared PAU. The hospital would obtain only 80 percent ($0.4/0.5=80\%$) of what it could have collected. As a result, it would receive \$8 million rather than \$10 million in incentive payments, and a 1.6% instead of a 2% increase to its base rates.

Hospitals may decide that the likely return from area-wide PAU reductions justifies investing additional resources beyond the amount funded through an increase to their global budgets. If so, the above incentives will have done their job by “priming the pump.”

B. Mechanisms to facilitate collaborative arrangements

1. Local forums for reaching agreement sponsored by public agencies

For hospitals to take action most effectively on these incentives, the Department of Health and Mental Hygiene (DHMH) or another state or local public agency could convene and oversee multi-hospital discussions in each service area to develop local, community-focused initiatives that reduce PAU. With HSCRC staff providing advice and assistance, such an approach could yield several advantages:

- By invoking the State Action Doctrine, it could shield hospitals from potential antitrust liability.⁶
- Holding these events in a public forum, with knowledgeable public agencies playing an active role, would limit risks of problematic methods to lower multi-hospital utilization.
- Other community stakeholders could engage with hospitals around effective strategies for reducing hospital utilization. Developing gain-sharing or shared savings arrangements between hospitals and other providers under public leadership would limit anti-trust risks for both sets of providers. Public sector leadership could also provide a vehicle for addressing other legal obstacles to implementing innovative arrangements that advance the Triple Aim.

These collaborations must go beyond “feel good” exercises. Their goal is maximizing hospitals’ return on investment (ROI). To achieve that goal, HSCRC or DHMH should compile a list of documented best practices to guide hospital decisions about the community interventions most likely to yield significant PAU reductions. Of course, local conditions vary, and optimal interventions could likewise vary in different parts of Maryland. Moreover, promising innovations could be pilot-tested in particular areas and rigorously evaluated for ROI. That said, some practices have proven more effective than others, and hospital choices should be informed by the best available evidence.

2. Connecting these forums to implementation of community health needs assessments and other regional processes

Under the ACA, each non-profit hospital is obliged, as a condition of its tax-exempt status, to conduct a community health needs assessment (CHNA) that identifies and prioritizes the significant health needs of the community it serves. For each significant health need that it identifies, the hospital must develop an implementation strategy that either (1) describes how it plans to address the need or (2) explains why it does not intend to address it.⁷

The kind of multi-hospital collaboration discussed here could overlap significantly with implementing the CHNA process. For example, community health needs could be addressed while PAU is reduced through efforts that coordinate care for seniors and people with disabilities in underserved communities; or that improve primary care access in underserved communities, thereby reducing the need for non-emergency use of emergency rooms.

For this synergy to prove effective, it will be important for CHNA participants to be invited to join the above-described multi-hospital discussions in each service area. Other important regional efforts currently under way in Maryland likewise have components that address PAU and could intersect with the kind of forum discussed here. Examples include implementation of

the state's Community Integrated Medical Home (CIMH) innovation model; Local Health Improvement Coalitions; and Health Enterprise Zones. Smoothly integrating these processes with efforts to expedite multi-hospital collaboration around area-wide PAU reductions will require accommodating several competing concerns, including the following:

- Efficiently leveraging existing publicly-run processes, rather than creating potentially redundant new processes;
- Avoiding the need for hospitals and other stakeholders to attend multiple meetings with similar purposes; while
- Keeping requests for hospital intervention and investment tightly focused on practices that are known to produce a solid ROI in reducing PAU.

The Maryland Health Care For All! Coalition, representing hundreds of faith, community, labor and business organizations from across the state, would be delighted to assist in organizing these events.

III. Conclusion

Global budgets alone are unlikely to lead most GBR hospitals to collaborate around community initiatives to reduce PAU at multiple hospitals. The approach suggested here would directly incentivize such collaboration by rewarding a hospital, not just for its own reduced PAU, but also for lower PAU throughout its service area. To qualify for its full reward, a hospital would need to spend at least a targeted amount of its global budget on collaborative investments in lowering area-wide PAU. DHMH would further encourage collaboration by sponsoring forums at which hospitals and other local stakeholders can develop arrangements, including gain-sharing and shared savings agreements, to reduce PAU by improving community-based care, including through investing in care coordination, perhaps starting with chronically ill Medicare patients. If successful, this approach will further integrate Maryland's new hospital financing system with the delivery system and financing reforms that are taking place outside the state's hospitals, synergistically strengthening innovations in both realms to help accomplish the Triple Aim.

Stan Dorn, consultant to Health Care for All and the Maryland Citizens Health Care Initiative Education Fund, Inc., was the primary author of this White Paper.

Notes

¹ To present its basic concepts clearly, this paper implicitly characterizes hospitals' shared service areas as identical and overlapping. In reality, hospitals' service areas have much more complex relationships. The basic approach discussed in this paper may therefore need to be refined in practice. For example: (1) HSCRC could designate "shared investment areas" where hospital Virtual Patient Service Areas (VPSAs) overlap to a significant degree and where economies of scale could be realized investing in regional PAU-reduction initiatives, such as those involving care coordination. VPSAs used to calculate demographic adjustments could be modified, for this purpose, to include, as heavily weighted, a significant geographic area adjacent to each hospital. That modification would limit hospitals' ability to qualify for regional PAU reduction incentives by seeking to change their patient mix. (2) Each hospital's regional incentive payments would be based on rehospitalization levels, PQI, and total hospital utilization within its modified VPSA. (3) A

hospital's investment in multi-hospital collaborative efforts to reduce PAU in any shared investment area within its modified VPSA could be used to determine whether it met its global budget target for such collaboration. (4) To avoid the imposition of unrealistic expectations for collaboration on relatively isolated hospitals, the global budget percentage target for collaboration could be reduced for a particular hospital to the extent that, within its VPSA, shared investment areas comprise less than the statewide median proportion among all Maryland hospitals.

² This paper does not discuss how to structure incentive payments around PQI—for example, to what extent incentives should reflect absolute PQI performance or improved PQI performance; how PQI should be risk-adjusted to reflect socio-economic status; etc. It simply makes the point that PQI-related incentive payments should be based on community-level, rather than hospital-specific PQI.

³ The proposed community-based approach to PQI incentives would have one exception. If a hospital proves that its specific investment in community-based services led to a particular PQI improvement, that hospital, rather than all hospitals within the service area, would receive the resulting financial benefit.

⁴ Such supports would supplement efforts by a hospital targeting its own discharged patients, including those living in underserved areas, to prevent rehospitalization—for example, through home visits by “Grand-Aides,” community health workers, or other trained non-physician personnel. See, e.g., Arthur Garson. “New Systems of Care Can Leverage the Health Care Workforce: How Many Doctors Do We Really Need?” *Academic Medicine*, December 2013, 88(12):1817–1821.

⁵ After that first year or two, the reductions in PAU resulting from this initiative could make such offsetting reductions unnecessary.

⁶ State Quality Improvement Institute, AcademyHealth. *Navigating Antitrust Concerns in Multi-Payer Initiatives*. Washington, DC: AcademyHealth, September 2010. The Maryland Health Care Commission already takes this approach in overseeing implementation of a multi-payer patient-centered medical home initiative.

⁷ Molly Berkery, JD, MPH, Public Health Law Program, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention, “Community Health Needs Assessments: Aligning Hospital Investments and Public Health Outcomes,” March 26, 2014.