Reforming Maryland's All-Payer Approach to Delivery-System: An Opportunity for Hospital and FQHC Collaboration

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Maryland continues to regulate the nation's only all-payer hospital rate regulation system through its Independent Health Service Cost Review Commission. The system exempts Maryland from the Inpatient Prospective Payment System and Outpatient Prospective Payment System, allowing the state to set its own rates for services. Waiver provisions keep all third parties payments equal, permitting Maryland to mitigate the rate of hospital cost increases compared to other states.

In January 2014, CMS approved a plan that would update Maryland's rate regulation system to focus more on preventive care and re-admission reduction, goals initiated by ACA. The plan works by changing the way hospitals are reimbursed, providing hospitals with funds to ensure population health instead of linking payments to admissions. Policy provisions require hospitals to make notable changes in quality improvement regarding Maryland hospitals' 30-day hospital readmissions rate and hospital acquired condition rates, calling for adherence to a reduction in 30-day readmissions and a 30% decrease in the occurrence of 65 preventable conditions over five years. The primary objective of the reform is to promote cost-effective measures that will increase patient health outcomes.

THE PROBLEM

While the reform should provide cost savings for Maryland, the transition may prove costly for hospitals. Hospitals will be required to pay the full cost of treatment for patients who remain high utilizers of emergency services and who are readmitted prior to the 30-day mark. Consequently, hospital leaders are looking for ways to reduce re-admissions, opting to purchase off-site primary care clinics in order to treat patients with illnesses that do not require hospitalization. However, these clinics may not provide whole-person needs required by patients who greatly utilize emergency services. These individuals are generally low-income uninsured, and underserved. Primary care alone will not suffice – patients within this demographic require the service of a patient-centered medical home (PCMH) that ties together primary and specialized care, allowing patients to receive comprehensive care in one facility where they can return for follow-up visits. PCMH facilitates care in a way that emphasizes care coordination and communication to transform primary care into what patients want it to be. PCMH facilities can lead to higher quality care and lower costs simultaneously improving patients' and providers' experience of care.

PROMISING PRACTICE

As an alternative to purchasing off-site primary clinics, hospitals can establish a partnership with federally qualified health centers (FQHC), helping to alleviate the cost burden of avoidable emergency visits. FQHCs receive federal funding under the Federal Health Center Program (Section 330 of Public Health Service Act), serving high need communities and work with clients who suffer from chronic health conditions. Fees are adjusted based on patients' ability to pay, opening the doors to care for patients who are uninsured. Many FQHCs are PCMH-recognized or are in the process becoming recognized, meaning that they offer (or will soon offer) a standard of care that ensures patients receive essential care when and where they need it, in a manner they can understand. Within the PCMH model, providers and allied health professionals build a sustainable relationship with patients, offering them points of contact in which to schedule follow-up care visits. FQHC-available services such as case management, peer support, translation, and transportation, tie together the coordination of care stressed by PCMH. These elements work together to prevent avoidable ER visits, anchoring patients to their local health centers for comprehensive, non-emergent care.

Collaboration with FQHCs will allow hospitals to maximize reimbursement for primary care through the FQHC site of service differential. With a strong relationship in place, hospitals may exit the primary care market, leaving the patient population and financial resources to FQHCs partners to expand care services to meet the demand, reducing avoidable ER use and reallocating hospital funds into preventative care channels.

EFFECTIVE MODELS

Evidence shows how successful collaboration between hospitals and FQHCs may work to reduce avoidable ER visits. In 2007, the St. Louis Integrated Network established the Community Referral Program in order to increase access for underserved and uninsured patient to integrated health services, decrease avoidable use of the ER, strengthen, build relationships between providers who serve underserve and uninsured patients.[1] Referral coordinators employed by IHN work within participating hospitals to connect nonemergent ED patients with FQHC clinics for

[1] Hospital and FQHC Collaboration: Findings and Opportunities. (2012).

primary, follow-up, or preventative care. Currently, coordinators serve patients across seven partner hospitals.

Since the program began in 2007, almost 72,000 patients have been encountered by IHN Referral Coordinators. More than 8,000 patients have been connected with a health center since 2008 and fewer than 15% of patients encountered by IHN Referral Coordinators experienced readmission into the ER.[2] Overall, the program has successfully reduced the number of patients using avoidable emergency services.

A similar program shines light onto the effectiveness of cooperation between FQHCs and hospitals. In Spokane, Washington, Holy Family Hospital works in collaboration with the Community Health Association of Spokane (CHAS). CHAS partners work alongside Providence Holy Family Hospital to reduce avoidable ER visits by connecting patients with ER liaisons. The liaison's primary function is facilitation of a "warm handoff" from ER to health center.[3] Patients are identified as they are discharged from the ER and are given the liaison's contact information for follow-up appointment. This program continues to provide success for both the hospital and partner FQHCs, delivering necessary appointments to patients who are dependent on ER services for conditions handled more appropriately in a clinic setting. Since January 2010, the liaison program has provided over 600 patients leaving the ER with referrals to FQHCs and has increased new patient census by 250 individuals. The ER diversion program has reduced annualized ER visits an average of approximately 50%.[4] ER practitioners and staff have shown immense support for the program, sympathetic to the needs of their most vulnerable patients.

Collaborations between hospitals and FQHCs have already taken shape within Maryland communities, especially in Baltimore where the concentration of hospitals and health centers is greater. Health Care for the Homeless, Inc. provides health-related services, education and advocacy to reduce the incidence and burdens of homelessness. Their emergency department diversion/referral program targets people experiencing homelessness in Baltimore City who utilize hospital emergency departments in high rates, establishing a patient-centered medical

[2] St. Louis Integrated Health Network. (n.d.). Retrieved May 6, 2015, from http://www.stlouisihn.org/

[3] Browne, John. "Bending the Health Care Cost Curve: Community Collaboration for Appropriate Emergency Department Care" Presentation.

[4] Browne, John. "Bending the Health Care Cost Curve: Community Collaboration for Appropriate Emergency Department Care" Presentation.

home for these individuals to receive comprehensive care. Total Health Care, another FQHC in Baltimore, places Outreach Coordinators in Maryland General Hospital's ER during peak usage hours to educate patients on appropriate ER use while connecting them with a primary care provider. Between 2007 and 2008, Total reported a reduction in ER visits to Maryland General Hospital by 8 percent. Recognizing the value of health centers as partners instead of competition opens the doors to decreasing costs per capita while improving population health.

RECOMMENDATIONS

Establishing a long-term collaborative relationship between hospitals and FQHCs provides a cost-effective method for adhering to the new Medicare waiver reform. Pressure from declining reimbursements and growing increase in uncompensated care from avoidable ER visits require hospitals to find innovative approaches to reduce costs. Collaboration with FQHCs will not only help to reduce hospital costs, it will also benefit uninsured and underserved patients who are chronic utilizers of emergency services. Directing patients to FQHCs will increase of revenue for health centers, supplying them the funds necessary to expand care to vulnerable populations, lifting the health status of a community. Hospitals that partner with FQHCs will play a valuable role in strengthening communities.