



Transforming Rural Health: Models and approaches from Washington State, Pennsylvania, and Maryland

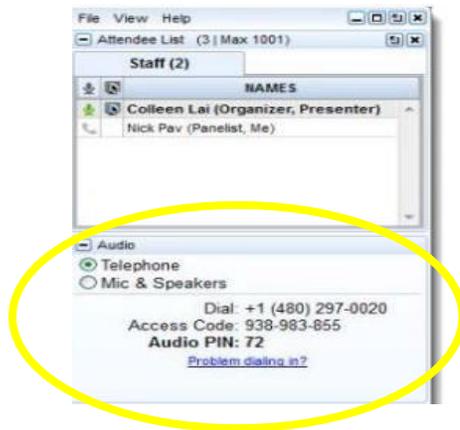
Webinar for Rural Providers and Accountable Communities of Health

June 18, 2019

Before we get started, let's make sure we are connected

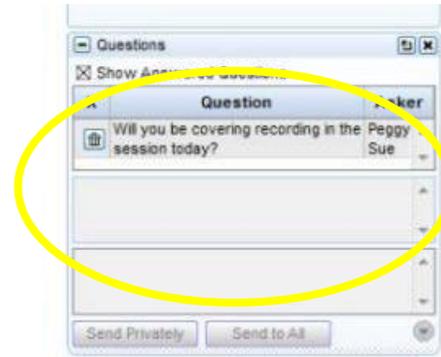
Audio Options

- Mic & Speakers
- Telephone: Use your phone to dial the number in the "Audio" section of the webinar panel. When prompted, enter your access code and audio pin.



Have questions?

Please use the "Questions" section in the webinar panel to submit any questions or concerns you may have. Our panelists will answer questions as they arise and at the end of the presentation.





Today's Presenters

Moderator: Mich'I Needham, Chief Policy Officer, WA Health Care Authority (HCA)

- Rivka Friedman, Center for Medicare and Medicaid Innovation
- Rachel Quinn, HCA
- Janice Walters, Rural health Redesign Office, Pennsylvania Department of Health
- Mike Robbins, Maryland Hospital Association
- Sule Gerovich, PhD, Senior Researcher, Mathematica

Overviewing CMMI partnerships with states to test novel all-payer models

The Innovation Center provides custom, state-specific Medicare flexibilities to test novel models in return for state accountability on both all-payer cost growth and population health measures.

All-payer model

Novel test

Medicare flexibility

State accountability



Maryland

Hospital global budgets to decouple hospital revenues from volume and incentivize prevention and wellness

Allow global budgets to determine Medicare payment amounts to Maryland hospitals



Vermont

ACOs at scale statewide to incentivize value and quality under the same payment structure throughout the delivery system

Provide a custom Medicare ACO model, based on CMMI's NextGen ACO model



Pennsylvania

Hospital global budgets for rural hospitals and a deliberate plan to improve quality and efficiency across services and service lines

Allow global budgets to determine Medicare payments to participating Pennsylvania rural hospitals

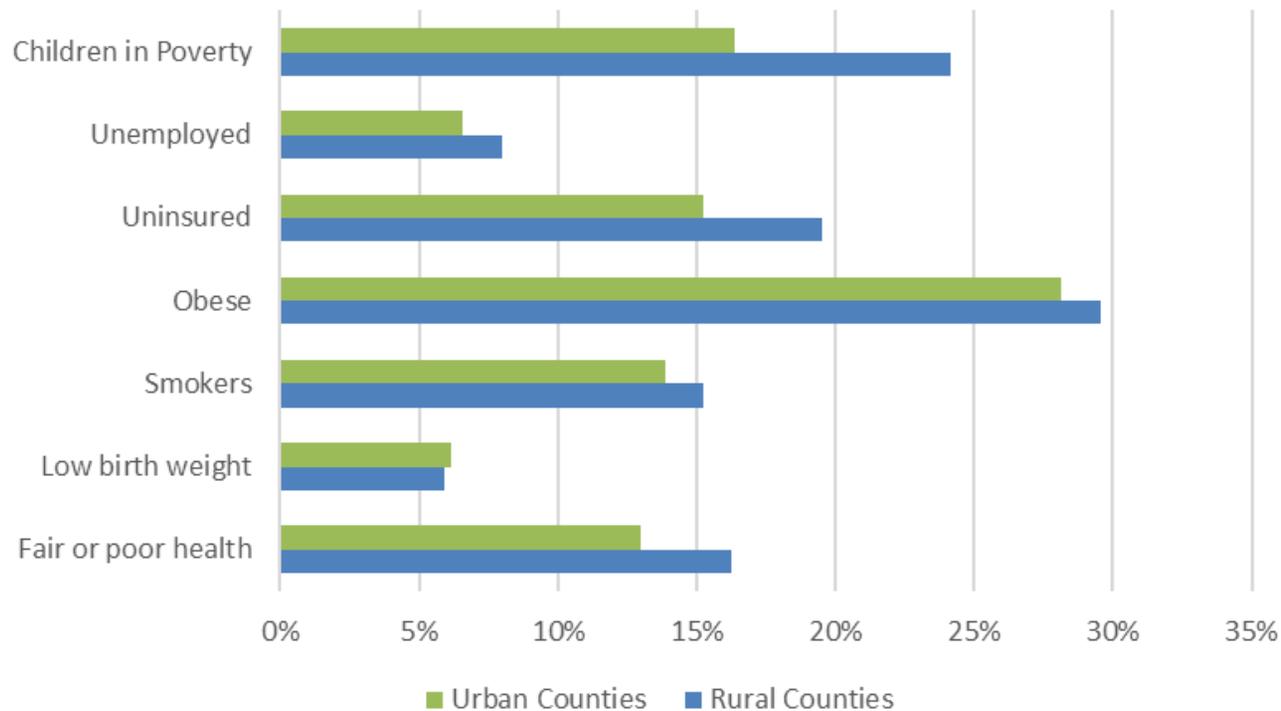
- **Scale targets** to disseminate reforms across states' payers and providers
- **All-payer financial targets** to ensure state's healthcare costs across payers grow at a sustainable level
- **Medicare financial targets** to maintain fiduciary duty to Medicare beneficiaries and the Trust Fund
- **Population health targets** to tie success to actual improvements in the health and quality of care for residents

Washington's Proposed Rural Multi-Payer Transformation Model

Why rural? Why now?



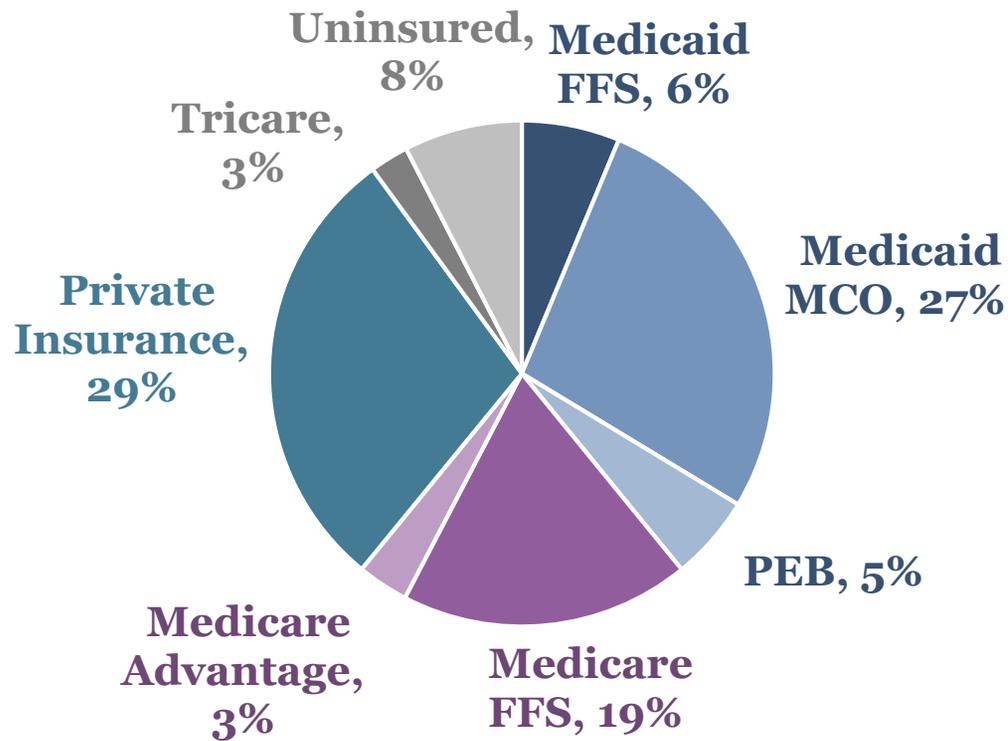
Rural residents may have even greater health care needs than urban residents.



Based on 2014 designation of all Washington state counties by OFM; 2016 County Health Rankings

Coverage Mix in WA Rural Counties

Percent of Lives by Coverage Option



HCA lives = 38%
of WA's rural
population

Source: HCA Estimates as of 4.4.19 based on latest available data



Rural Multi-Payer Transformation Model – Proposed Vision and Goals

Vision: By 2025, health care delivery in Washington’s rural communities will be reorganized and transformed to match the regional health, social and economic needs of their communities

Primary Goal: Sustain access to essential care in rural communities

Secondary Goals:

- Improve population health and well-being outcomes and quality of care for rural residents
- Incentivize rural health systems (hospitals, rural clinics, aging providers), Accountable Communities of Health, tribes, other rural providers, and community partners to redesign health and health care that meet the needs of their communities (in partnership with the state, federal gov’t and payers)
- Improve the financial state of participating rural hospitals by re-aligning incentives and through care coordination
- Decrease health and social disparities
- Reduce the growth of total expenditures across payers



Rural Multi-payer Transformation Model – **Proposed Approach**

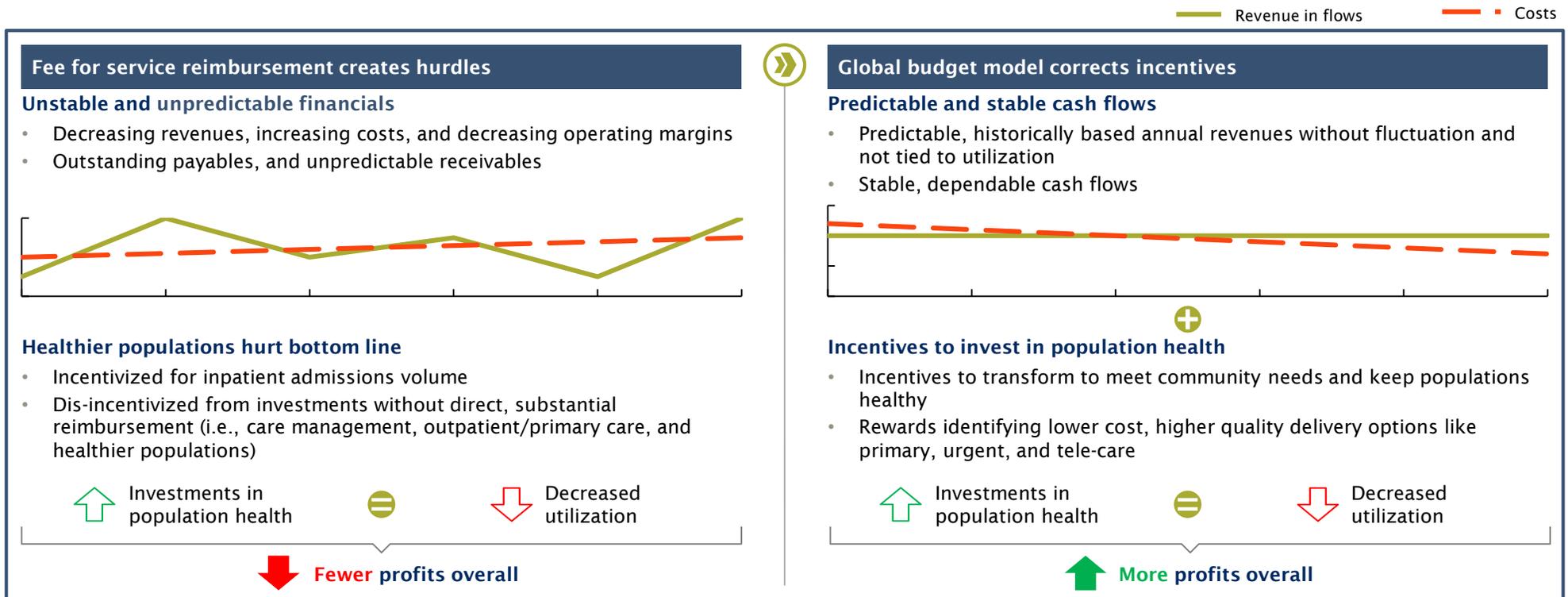
Proposed Approach – 3 components:

- 1) Alternative payment model (global budget) for all rural hospitals (52 eligible)
- 2) Community transformation plan and strategy
- 3) Quality metrics

Justification for approach:

- *Medicaid/Medicare participation is key* given its large presence in rural communities
- Budget approach brings stability and predictability for rural health systems
- Allows for customized approach for each community (created by and for each community)
- Opportunity to address state and federal regulatory barriers (e.g., workforce, scope of practice)
- Opportunity to tackle social determinants of health through the Accountable Communities of Health

Global budget provides financial stability lacking under today's system and rewards population health focused transformation



Rural Multi-payer model - Proposed

Model components	Decisions made
Technical requirements for model participation	<ul style="list-style-type: none"> All rural hospitals will have the opportunity to participate in the model The model should include Medicare FFS and in-network Medicare Advantage, Medicaid FFS and MCOs, and large commercial payers comprising a critical mass of the hospital's net patient revenue
Approach to setting baseline payment model	<ul style="list-style-type: none"> The model will incorporate: <ul style="list-style-type: none"> Hospital inpatient (IP) and outpatient (OP) services (professional fees billed on professional claims in IP/OP settings included) CAH swing beds Employed primary care physicians (PCPs) in to-be-determine format¹ Existing hospital-owned long-term care (LTC) and behavioral health (BH) services, where applicable
Methodology for adjustments of planned and unplanned activities	<ul style="list-style-type: none"> The model will include adjustments for: <ul style="list-style-type: none"> Potentially avoidable utilization (PAU), as the mechanism to share savings with payers and providers Planned service line changes Unplanned market share shifts and emergent issues/exception The model will not include adjustments for operational efficiencies achieved
Approach to managing risk	<ul style="list-style-type: none"> The model will likely need to incorporate a Year 0 (likely 2019) during which status quo hospital budgeting remains in place and preparation and finalization of rural multi-payer model participation is advanced
Additional incentives	<ul style="list-style-type: none"> The model will include incentives related to quality, primary care, non-hospital providers (primarily PCPs) The model will align with Accountable Communities of Health (ACHs)

Exact structure to be confirmed through further analysis and discussion



Community Participation Requirements

- Open to all rural hospitals and all health plans
- Partners include:
 - Patients
 - Affiliated and non-affiliated providers in community, including long-term care providers
 - Accountable Communities of Health
 - Public and private purchasers
 - Other community partners critical to transformation



Anticipated Timeline

- Multi-year (5-7 year model), phased approach with early adopters in first wave
- Engagement with Medicare and formal commitments from communities of hospitals and payers: Fall 2019
- Pre-implementation phase starts when Medicare agreement finalized: Early 2020
- Budget starts for participating hospitals: Mid 2020 or Jan 1, 2021

Next Steps



Next Steps

- **Share your feedback, complete email survey**
 - What are the biggest opportunities/challenges for your organization under this model?
 - What components/safeguards would you need to participate in a rural community transformation model (with other rural providers/clinics, payers, purchasers, ACHs, etc)?
 - What outstanding questions do you have?
- **Send comments and questions to ruraltransformation@hca.wa.gov**

A Federally Funded Program

Pennsylvania Rural Health Model

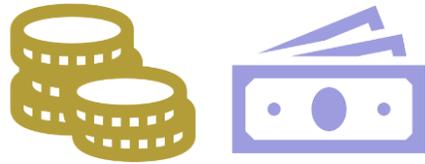
Accelerating Health Care Innovation in Pennsylvania

WA – HCA Webinar

June 18, 2019



There are two core tenants that make the Model different from FFS that work in combination to create different incentives for hospitals



The Model stabilizes cash flow from all participant payers

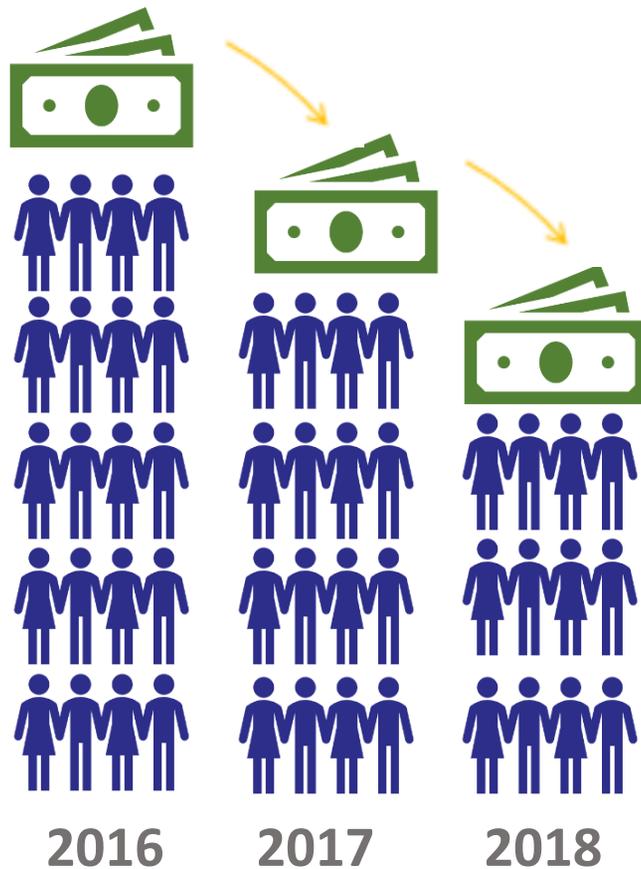


The hospital is incentivized to invest in community health to retain revenue

The global budget stabilizes hospital revenue compared to fee for service, which is imperative in rural communities where population is declining

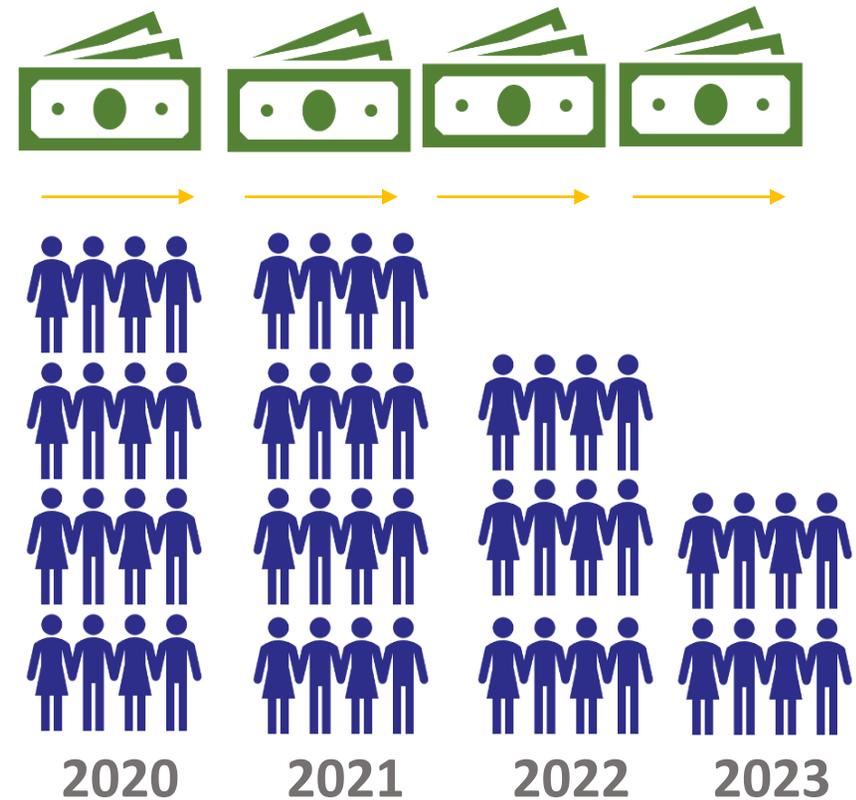
Fee for Service

Hospital is paid for the # of healthcare resources consumed by the community, but as the community is getting smaller, so is revenue.



Global Budget

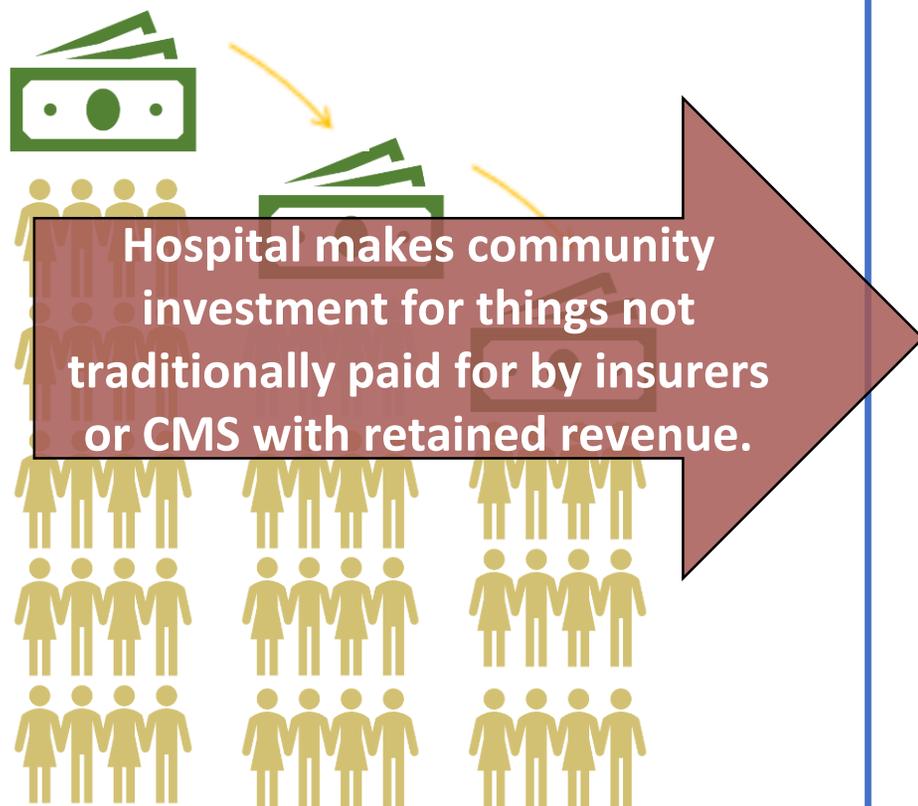
Hospital is paid the same amount of money as historic NPR regardless of how many resources are consumed by the community.



By retaining the revenue associated with the reduced PAU, the hospital can invest in services that promote community wellness

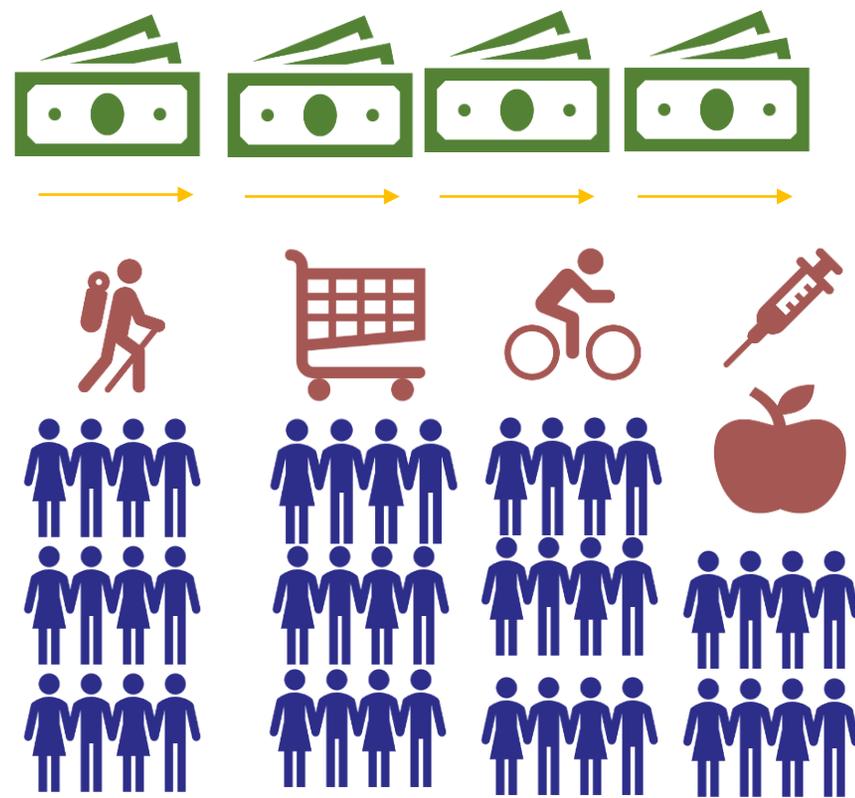
FFS

Hospital is paid for the # of healthcare resources consumed by the community, but as the community is getting smaller, so is revenue.

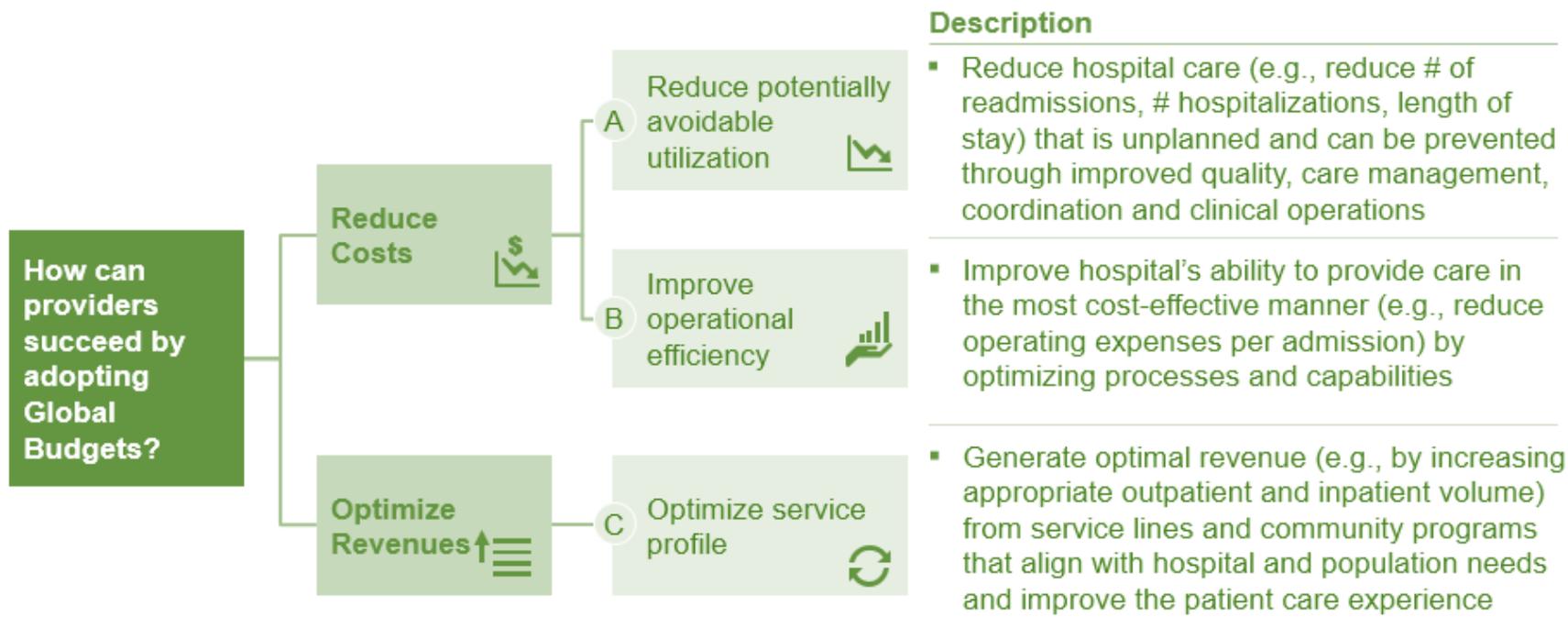


Global Budget

Hospital is paid the same amount of money irrespective of how many resources are consumed by the community.



Each provider defines its own transformation plan, leveraging three key opportunities to succeed under the model



In developing transformation plans, hospitals will analyze opportunities across:

- Population groups (e.g., chronic conditions, behavioral health)
- Care settings (e.g., Pre-acute, acute and post-acute)
- Patient care journey (e.g., prevention, treatment and follow-up)

Hospitals are taking similar approaches to achieve success in the Model; for those points of commonality, the SDOH strategy provides a platform to achieve program outcomes



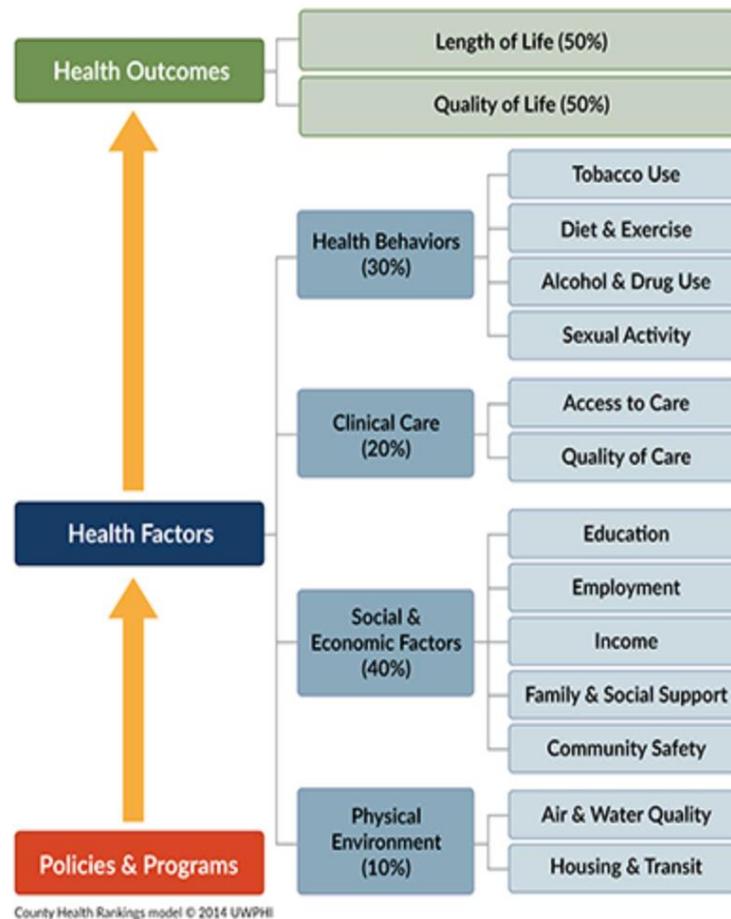
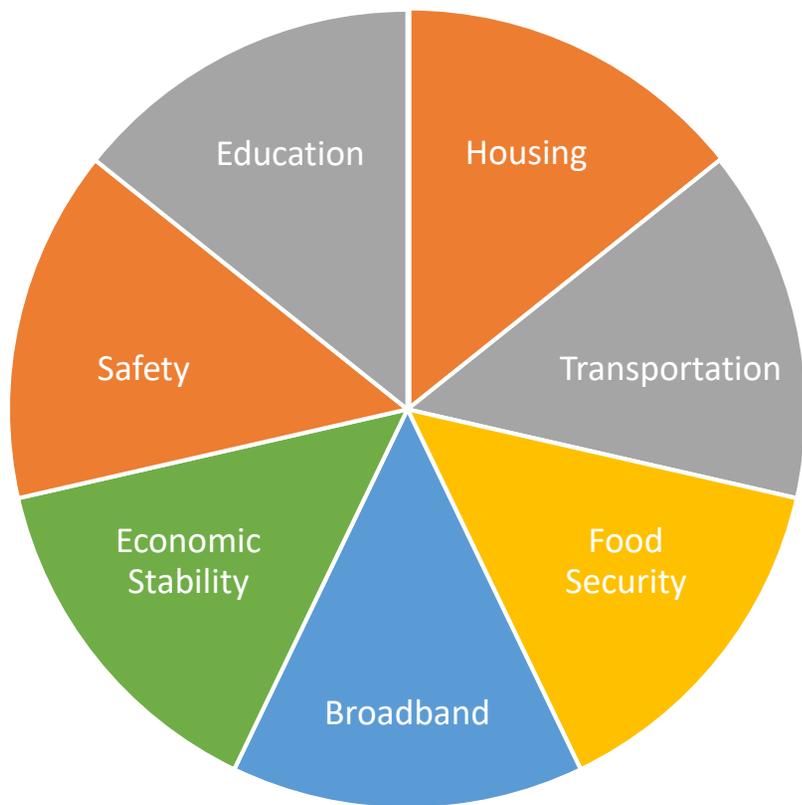
Population health outcomes, quality and access

Activities that will make the community healthier and enable financial success for the hospital

Combination of what will help us to meet CMMI measures in Years 3+ and make communities and hospitals successful

However, hospitals are also cognizant that to achieve success in the Model long-term, SDOH / population health must be addressed to retain shared savings

SDOH Overview



Hospitals succeed in the Model to the extent they help make their community healthier, and these factors are key to improving the health of rural PA residents.

Stakeholder Involvement

- The model formally launched in January 2019
- Key stakeholder engagement
 - CMMI
 - Governor's Office
 - Department of Health
 - Department of Human Services
 - Pennsylvania Insurance Department
 - Hospital Association
 - Office of Rural Health
 - Hospital Leaders
 - Commercial Payers
 - Legislators
 - Other trade associations

Current State

- Current Model participants:
 - Five hospitals
 - Five payers
 - Medicare FFS
 - 4 Pennsylvania based commercial insurers
 - Commercial, Medicare and Medicaid
- Planned expansion
 - Grow hospital participation to 30 over the course of the next two years
 - Increase payer participation to grow global budget revenue

Key considerations for hospital leaders:

- Change is hard, and will require a different mindset
- The current FFS structure isn't sustainable, and will continue to be targeted from a payment reform perspective.
- The current financial position of the organization – weighing the risks of early adoption versus waiting
- Understanding if there are other alternatives
- Leaderships attitudes toward population health
- Culture / readiness for change of the organization
- Competing priorities / ability to implement

The Model offers value propositions from a provider's perspective, but many align with payer community goals

<i>Current Scenario</i>	<i>Desired End State</i>	<i>Model's Value Proposition</i>
<p>1 Unpredictable revenue tied to FFS volumes</p>	<p>A predictable revenue stream</p>	<p>Model participation provides for a predictable revenue stream that is independent of the level of FFS volume provided within the hospital. It protects from sudden revenue downturns when providers leave and protects it for a period until providers can be recruited.</p>
<p>2 Significant volume driven by potentially avoidable utilization (PAU)</p>	<p>Reduce PAU through enhanced coordination of care efforts, such as care management, to improve community health</p>	<p>If a significant portion of a hospital's volume is driven by PAU, providers are financially rewarded for effectively managing and reducing PAU. Revenue associated with PAU is retained by the hospital, even though utilization decreases. The Model supports providers in reducing PAU by focusing on drivers in and outside of the hospital walls that effect it, such as service line optimization and community needs.</p>
<p>3 Utilization lost to tertiary centers</p>	<p>Bring appropriate utilization back into the community</p>	<p>The Model enables service line analysis and optimization, which aids in bringing appropriate utilization back into the community. It looks at macro-level market shifts and costs across service areas. To the extent more cost effective care can be provided at the local level, the Model tracks, supports, and rewards providers for doing this.</p>
<p>4 Making significant investment in population health already</p>	<p>Slows the bleeding from the current FFS model that occurs when population health investments are made within the FFS model</p>	<p>By utilizing a "look-back" period, the Model recaptures NPR that may have decreased as a result of investments already made in the community, and allows the organization to retain it. This will slow the financial drain of the FFS model created by doing the right thing for the community.</p>

The Model offers value propositions from a provider’s perspective, but many align with payer community goals

	<i>Current Scenario</i>	<i>Desired End State</i>	<i>Model’s Value Proposition</i>
5	The hospital may feel like an island unto itself for strategy development and securing funds for advancing strategies	Collaborative, impactful strategies that improve health outcomes for the local community	The Model provides the mechanism to collaborate with other participant hospitals to learn, problem solve, and share best practices. Also, the Model provides a forum for a joint application process to apply for additional funding through competitive grants and possible foundation resources. In addition, it provides access to national rural-health experts as part of the collaboration experience.
6	Lack of technical resources (data analytics, clinical transformation, etc.) due to resource constraints	Robust technical support infrastructure to enable impactful community health outcomes	The Model provides access to technical support for financial and clinical transformation activities without additional cost to the hospital
7	Stifled innovation due to competing day-to-day operational needs, and at times regulatory barriers	Implementation of innovative solutions to meet the needs of the local communities	<p>Model participation allows for:</p> <ul style="list-style-type: none"> • Potential waivers to national and state policies and regulations that may present barriers to an organization’s transformation • The hospital to act as the convener in the community to improve population health and potentially enhance its reputation • Partnerships with payers that establish a cooperative rapport • A potential alternative to the hospital’s current state while advancing your community and hospital • Input into a new model of care that has national applicability to solve rural health challenges

Contact information:

Janice Walters, Chief Operating Officer Consultant

Rural Health Redesign Office

Pennsylvania Department of Health

9th Floor West | Health & Welfare Building | Suite 903

625 Forster Street | Harrisburg, PA 17120-0710

Phone: 717.903.6895

Email: c-jawalter@pa.gov

Keara McKenna, Director of Rural Health Innovation Consultant

Office of Rural Health Redesign

Pennsylvania Department of Health

9th Floor West | Health & Welfare Building | Suite 903

625 Forster Street | Harrisburg, PA 17120-0710

Phone: 717.547.3094 (O) & 717.265.6164 (C) | Email: c-kemckenn@pa.gov



THE MARYLAND MODEL



A Bold Initiative to Control Cost Growth,
Improve Quality and Make People Healthier



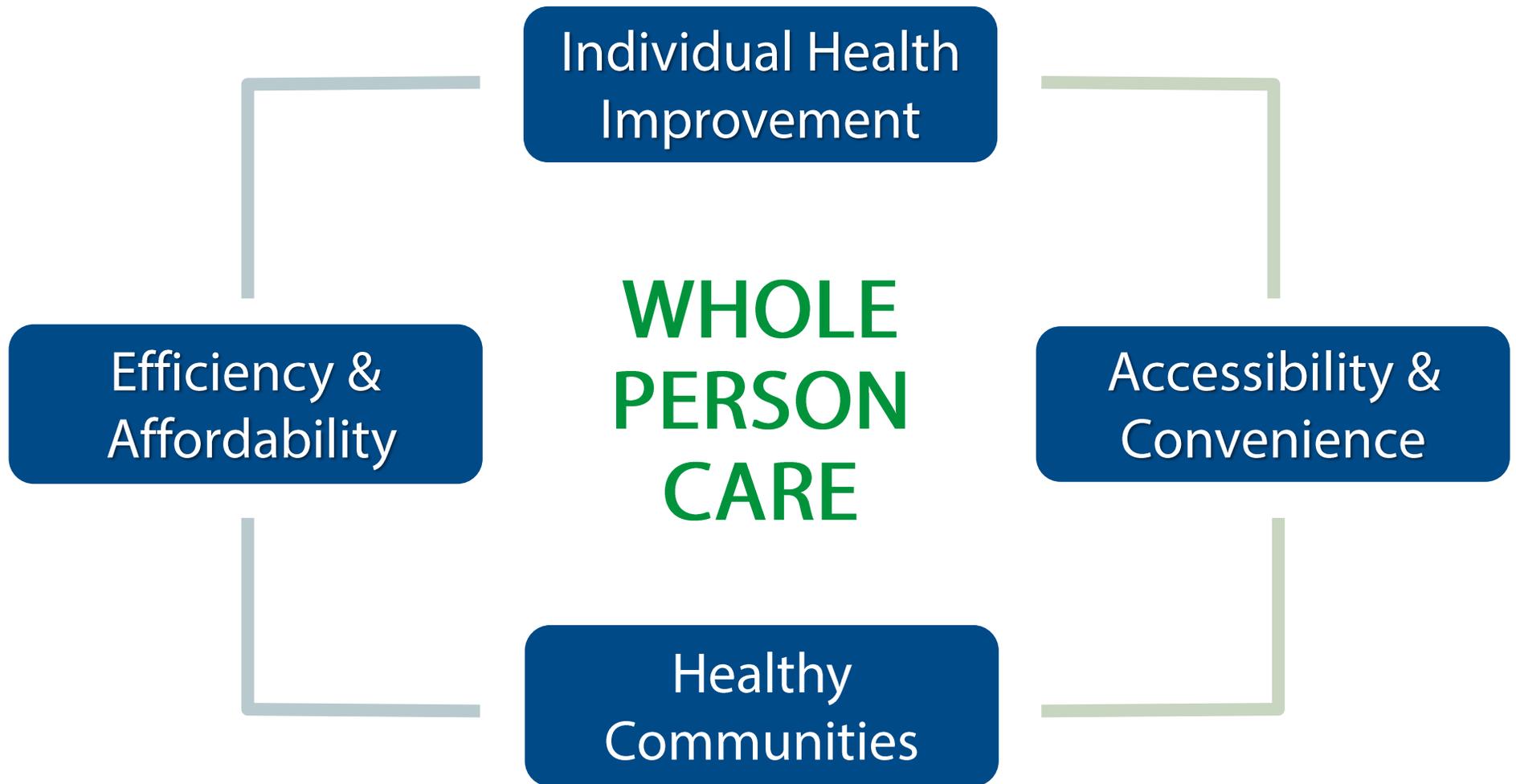
Maryland
Hospital Association

NEW MODEL IS **UNIQUE** TO MARYLAND



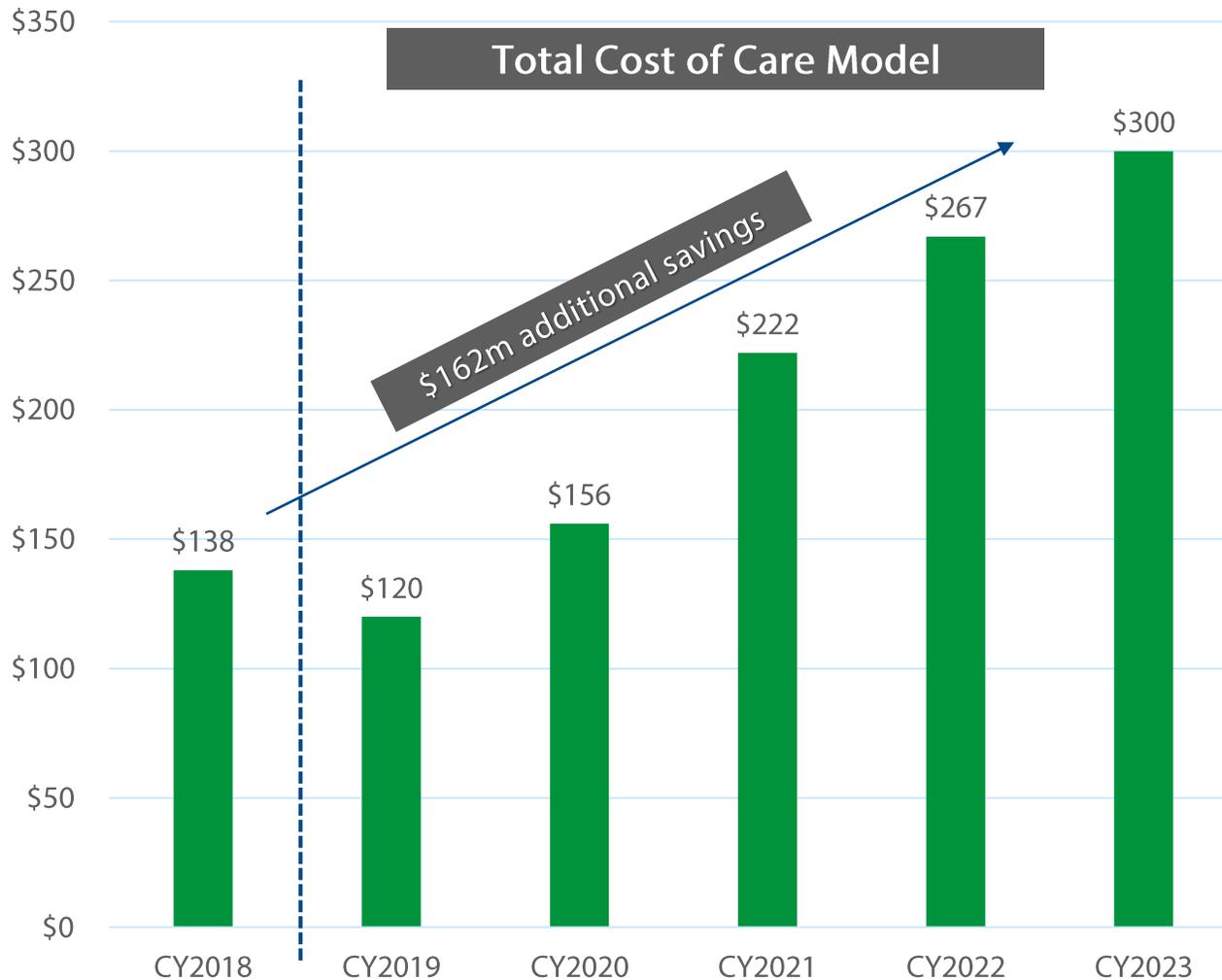
Healthier People &
Economically Sustainable
Health System

BIG GOALS: BETTER CARE, BETTER HEALTH



MODEL BRINGS AMBITIOUS TARGETS

Yearly Total Cost of Care Savings Targets



- State's hospitals at risk for total cost of care for 950,000 Medicare fee-for-service beneficiaries
- Plus, aggressive goals:
 - Quality improvement
 - Health gains

SIX KEYS TO UNLOCK VALUE

- 1** Global Hospital Budgets
No incentive to deliver more than needed care
- 2** All-Payer Hospital Rates
Cost burdens shared equitably by all payers
- 3** Total Cost of Care Accountability
Hospitals each responsible for attributed lives
- 4** Shared Provider Incentives
Programs designed to align all care partners
- 5** Population Health Goals
Care for communities, not just individuals
- 6** Quality of Care Incentives
Hospitals rewarded for hitting quality targets

1. GLOBAL BUDGETS REWARD EFFICIENCY

Preset annual hospital inpatient and outpatient revenue budget

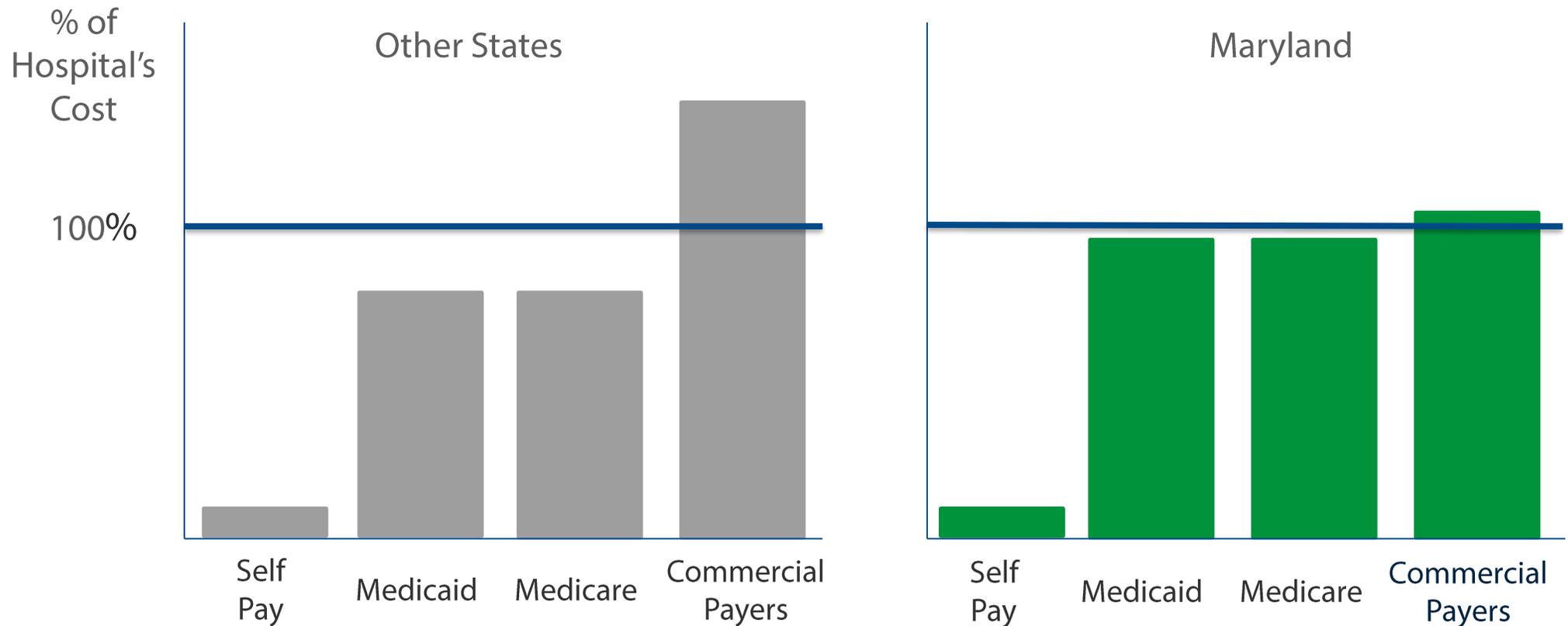
Incentivizes preventive care to avert hospital use

Hospitals may reinvest savings in prevention

Maintains quality controls to uphold performance

2. ALL-PAYER RATES ELIMINATE COST SHIFTING

Hospital Prices



Protect access in rural and vulnerable communities

Equitably share burden of uncompensated care

3. TOTAL COST OF CARE RISK

- Medicare FFS beneficiaries attributed to hospital
- Target aggregate spend for all Parts A and B services

Promotes keeping people – and populations – well

Encourages partnering for whole-person, longitudinal care

Drives care to most appropriate, least costly settings

4. SHARED INCENTIVES BOOST COLLABORATION

Finding Hospital Efficiencies

- Goal: Drive improvements and cost savings in hospital care
- Players: Hospitals and care partners practicing at hospitals
- Benefit: Physicians may share in efficiency gains

Hospital Care Improvement Program (eff. July 2017)

Connecting Providers to Treat Episodes of Care

- Goal: Align care across all settings, with focus on care post-discharge
- Players: Hospitals and care partners across the continuum
- Benefit: Hospitals may share incentives with efficient partners

Episode Care Improvement Program (eff. Jan. 2019)

Managing Patients with Chronic Illness

- Goal: Enhance care management and coordination
- Players: Hospitals and community-based providers
- Benefit: Shared resources and information improve quality and reduce costs

Complex & Chronic Care Improvement Program (eff. July 2017)

Primary Care Doctors Guiding Patients

- Goal: Restore focus on primary care
- Players: Primary care physicians and some specialists working with supportive organizations
- Benefit: Additional resources to support new modes of care delivery and performance improvement

MDPCP: Maryland Primary Care Program (eff. Jan. 2019)

5. POPULATION HEALTH – BEYOND ONE PATIENT

PREVENT CHRONIC CONDITIONS

- Diabetes
- Heart disease
- ...more

REDUCE WIDESPREAD HARMS

- Falls in elderly
- Opioid overdoses

Promotes hospital investments in community-based care

Motivates integration of physical & behavioral care

Demands attention to social determinants of health

6. INCENTIVES AIM TO RAISE QUALITY OF CARE

- Hospital incentives apply across all payers
- More than 7% of inpatient revenue at risk

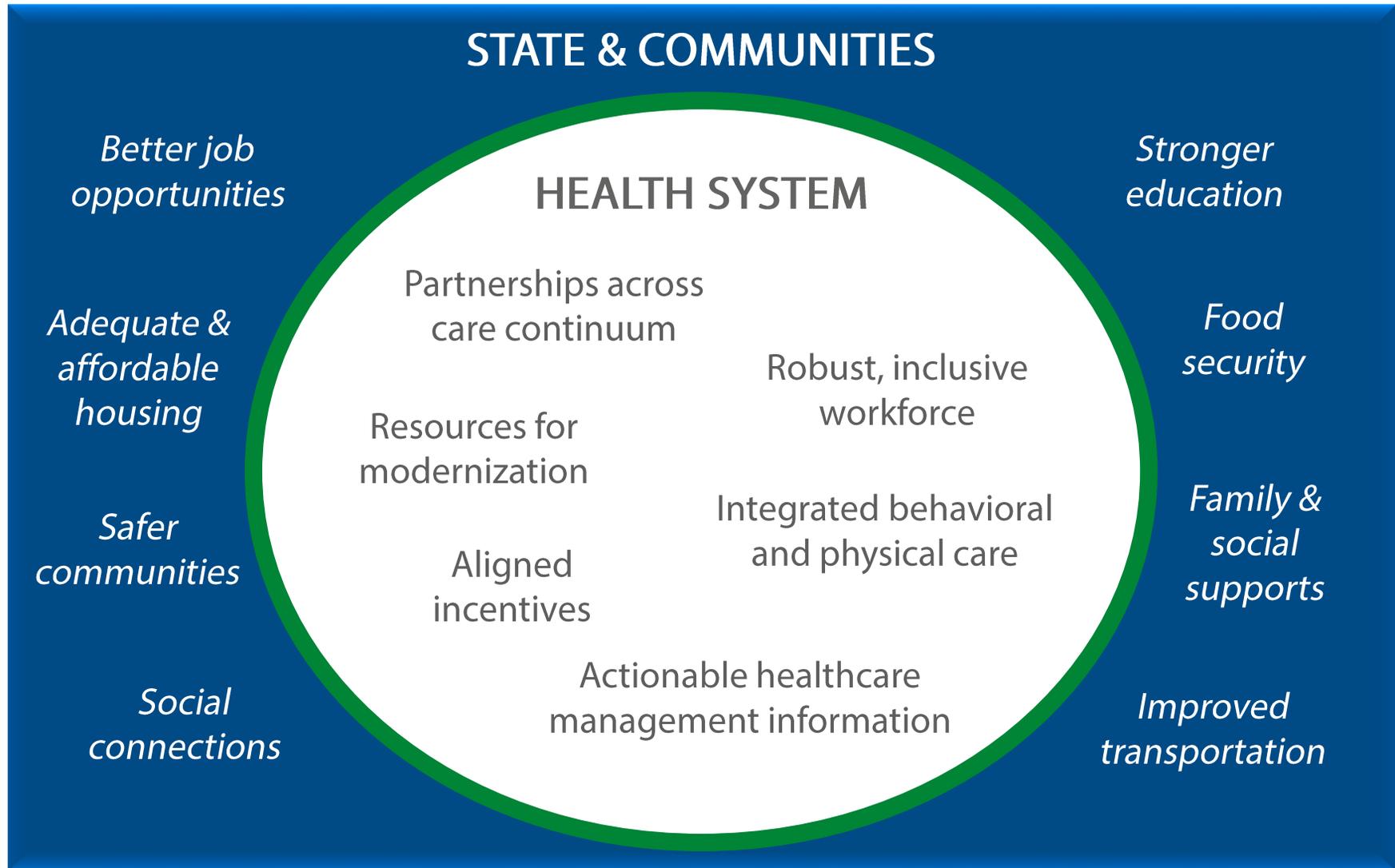
End patient harms occurring in health facilities

Reduce avoidable care ... for manageable conditions

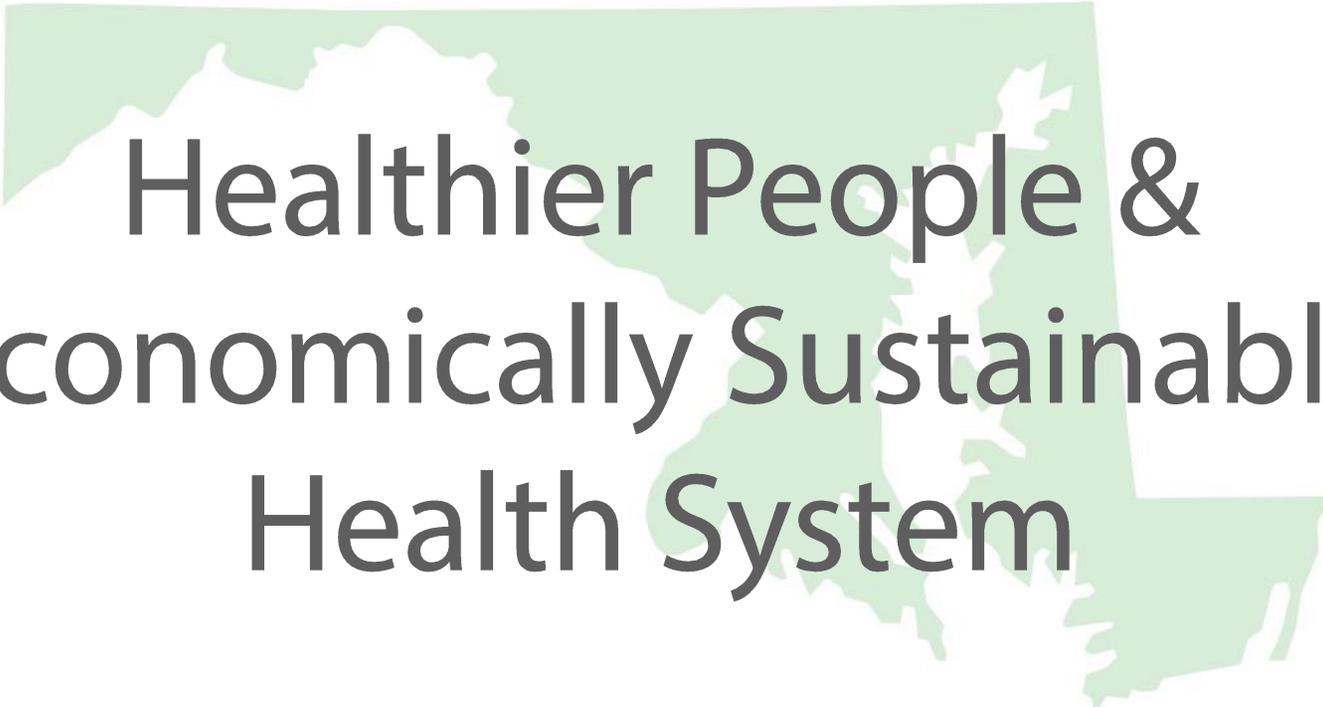
Enhance coordination across care settings, and beyond

Engage patients in improving care experience and health

A SYSTEMS APPROACH IS NEEDED



OUR SUCCESS DEMANDS
COLLECTIVE EFFORT



Healthier People &
Economically Sustainable
Health System



Question and Answers?



Thank you for watching the webinar

- Send comments and questions to ruraltransformation@hca.wa.gov
- Please complete survey you receive via email!