Global Budgeting for Rural Hospitals

• March 6, 2018

Logistics

- Lines are muted – we will unmute lines at the end of the call
- Feel free to ask questions using the Q&A box on the lower right hand side of webinar window
- Slides and a recording of the webinar will be available at www.shvs.org

Welcome

Chris Koller
President, Milbank Memorial Fund

Welcome

Heather Howard
Director, State Health and Value Strategies

About State Health and Value Strategies

- Technical assistance program supported by the Robert Wood Johnson Foundation
- Provides direct technical assistance to states, publishes late-breaking issue briefs, convenes states for peer-to-peer learning
- More information and library of resources available at www.shvs.org

Why the Policy Academy?

- Access to experts
- State teams can focus on topics
- Information sharing among and between states
- To learn more and apply, visit www.shvs.org

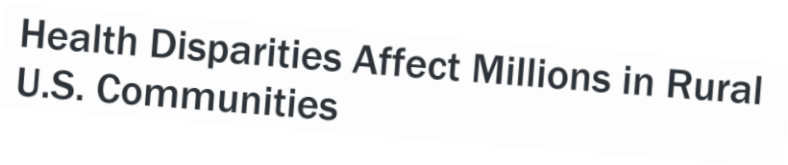
All-Payer Global Budgets for Rural Hospitals

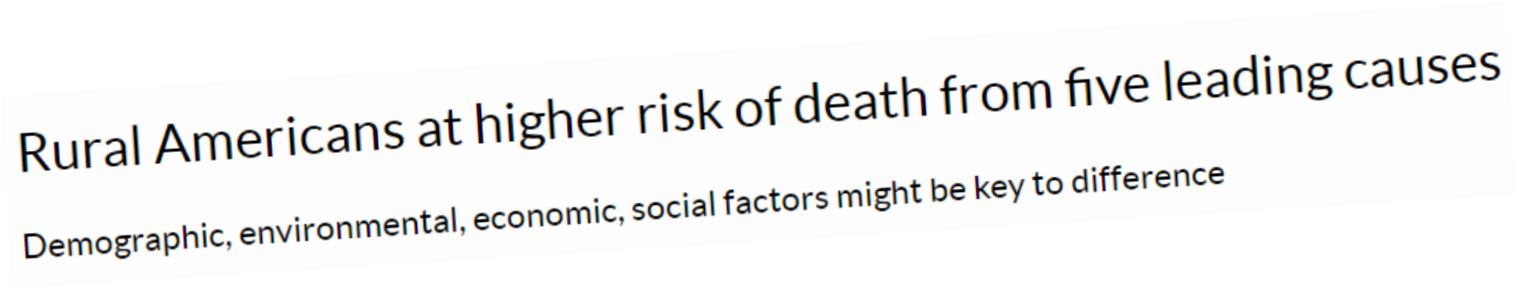
Joshua M. Sharfstein, M.D.
Professor of the Practice

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

US Struggling with Health Outcomes

- 2015 and 2016 showed declines in US life expectancy
- Substantial disparities, with rural health lagging





Rural Hospitals in Crisis

- Rural hospitals are closing at an increased rate[1]
- More than 80 rural hospitals have closed since 2010[2]
- An 673 additional facilities are vulnerable and could close, representing more than one-third of rural hospitals nationally[3]

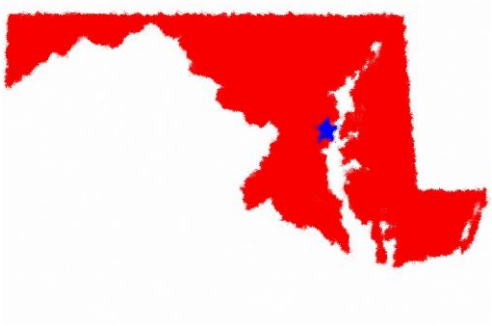
[1] Kaufman BG, Thomas SR, Randolph RK, Perry JR, Thompson KW, Holmes GM, Pink GH. The Rising Rate of Rural Hospital Closures. 2016; The Journal of Rural Health, 32: 35–43. doi:10.1111/jrh.12128.
[2] http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
[3]https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2017/Vulnerable-Hospital-Closure-Impact.pdf

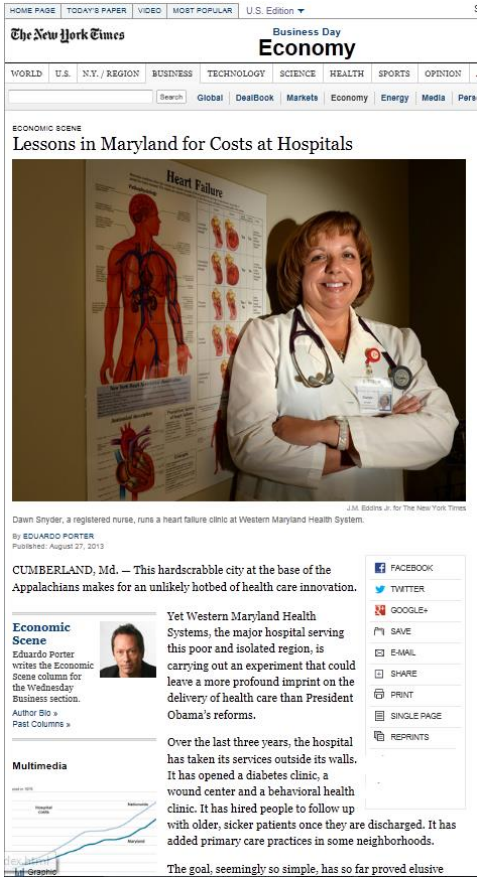
Challenge: Hospital revenue depends on patient volume…

- … And patient volume is declining in many areas
- Result #1: Hospitals teetering on brink of insolvency
- Result #2: Incentive to grow volume, even when health suggests need for prevention
    - Can lead to pressure to offer services best left to referral hospitals … with negative effect on community health
- Solutions that rely on greater fee-for-service reimbursement do not resolve the fundamental tension.

A Different Approach: All-payer Global Hospital Budgets

- A global budget assures hospitals of annual revenue for inpatient and hospital outpatient care, independent of volume
- Incentive rewards better management of chronic illness and prevention
- Improved hospital balance sheet aligned with enhanced community health





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ECONOMIC SCENE

Lessons in Maryland for Costs at Hospitals

J.M. Eddins Jr. for The New York Times

Dawn Snyder, a registered nurse, runs a heart failure clinic at Western Maryland Health System.

By EDUARDO PORTER
Published: August 27, 2013

CUMBERLAND, Md. — This hardscrabble city at the base of the Appalachians makes for an unlikely hotbed of health care innovation.

Economic Scene

Eduardo Porter writes the Economic Scene column for the Wednesday Business section.

Author Bio »
Past Columns »

Multimedia

Yet Western Maryland Health Systems, the major hospital serving this poor and isolated region, is carrying out an experiment that could leave a more profound imprint on the delivery of health care than President Obama's reforms.

Over the last three years, the hospital has taken its services outside its walls. It has opened a diabetes clinic, a wound center and a behavioral health clinic. It has hired people to follow up with older, sicker patients once they are discharged. It has added primary care practices in some neighborhoods.

The goal, seemingly so simple, has so far proved elusive

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Western Maryland Regional Medical Center

Cumberland, Maryland

Carroll Hospital Center
Westminster, Maryland

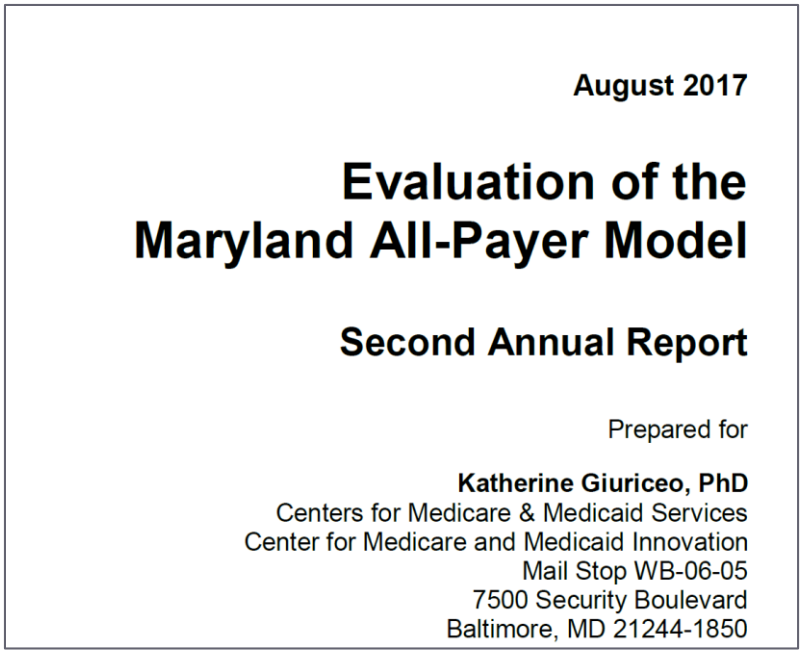
Meritus Hospital Center
Hagerstown, Maryland

Example Metrics for Success

- Financial viability of the safety net health system itself
- Improvements in community health outcomes, such as overdose and chronic disease measures
- Improvements in quality of care
- Reduced preventable hospital utilization

Early Maryland Results

- Maryland has met or exceeded key goals for hospital expenditures and complication rates, and readmission rates have fallen relative to national average.
- Independent evaluation found >$400 million in Medicare savings compared to control populations, reductions in preventable admissions, and reductions in readmissions.
- Hospital balance sheets improved



August 2017

Evaluation of the Maryland All-Payer Model

Second Annual Report

Prepared for

Katherine Giuriceo, PhD
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
Mail Stop WB-06-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Key Steps to Global Budgeting

1. A vision for transformation
2. An operational strategy
   - How budgets are set
   - How payers participate
   - Governance
3. An environment conducive to success
   - Federal and state support
   - Technical assistance and IT

Interested in Learning More?

- Consider the policy academy for states in Baltimore, Maryland on May 30, 2018.

- Hear from Rural Hospital CEOs, CMS and state leaders, and academic experts to participate.

- Apply to join the policy academy here: http://tiny.cc/policyacademy

Medicare Participation in State-Based Multi-Payer Models

Rivka Friedman

Director, Division of All-Payer Models

State-Level Alignment Can Reduce Provider Burden

The Innovation Center partners with states to align payment and delivery system reforms across payers in order to reduce burden on providers

Initiatives

ACOs
PCMH
Bundled Payments

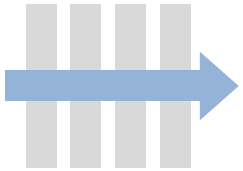
Payers

Medicaid
Commercial Payers
Medicare

States can drive multi-payer alignment across initiatives for:

Goals
Incentives
Targets
Metrics

The State Innovations Group (SIG) supports state efforts to transform delivery and payment

Our Approach		Our Strengths
Offer **flexibility and support** for states in a variety of environments—meet states where they are		**Strong relationships** with state partners allows SIG to support states to maximize the unique strengths of each state
Amplify national efforts by supporting state adoption of successful models		**Collaboration within HHS** enables SIG to help states integrate varied federal efforts
Customize existing models to meet states' unique needs		**Multi-payer participation** ensures transformation efforts at scale and alignment reduces provider fatigue

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Currently, three partnerships with states 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
 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

State accountability

- **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

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Maryland All-Payer Model has seen early successes using hospital global budgets

Maryland All-Payer Model design

State determines the total, all-payer revenue target (global budget) for each hospital to decouple hospital revenue from volume and incentivize prevention

Preliminary actuarial results of first two years demonstrate reduced Medicare cost growth

- **Medicare has saved $300M* in hospital expenditures,** driven by 3% decline in inpatient admissions and a large reduction in outpatient expenditures
- **Incentivized to prevent avoidable utilization, hospitals have engaged in several activities:**
  - Improved care continuity and management, discharge planning, and treatment adherence
  - Enhanced focus on behavioral health
  - Changed hospital administrative and organizational structures
  - Shifted service sites
  - Enhanced clinical staff management

*Based on actuarial results from HSCRC. More information available at: http://healthaffairs.org/blog/2017/01/31/marylands-all-payer-model-achievements-challenges-and-next-steps/

The PA Rural Health Model aims to improve financial viability and reduce health disparities

Payment model and scale	Rural hospitals will receive global budgets for all inpatient and outpatient services, to produce lower revenue but higher margin ▪ Global budgets will cover 90% of each hospital's revenue by year 2 ▪ 30 hospitals will participate by year 3 (45% of all rural PA hospitals) ▪ Payers will include Medicare FFS, Medicaid managed care, and commercial payers (including Medicare Advantage)
Care delivery redesign	Hospitals will redesign their delivery system based on local health needs ▪ Hospitals will build partnerships with other providers through care coordination and referral patterns to promote population health ▪ Hospitals may also reduce excess beds, change service delivery lines, or transition to become an outpatient centers ▪ The state will review the hospital plans to ensure access and quality
Financial targets	▪ At least $35M in Medicare rural hospital savings ▪ No more than 3.38% all-payer rural hospital cost per capita annualized growth rate
Pop. health targets	▪ Increase access to primary and specialty services ▪ Reduce deaths related to substance use disorder (SUD) and improve access to opioid treatment ▪ Improve chronic disease management and preventive screenings in target areas: cancer, cardiovascular disease, and obesity/diabetes

The Pennsylvania Rural Health Model is in its first year and will conclude in 2023.

New guidance explores future Medicare participation in state-based models

2015 Guidance → *2017 Updated Guidance*

Two tracks for Medicare participation:

- Customized model with unique quality and cost accountability ("Transformation")
- State aligns Medicaid and private payers to existing CMS model ("Alignment")

Six principles used to assess alignment proposals:

1) Patient-centeredness
2) accountability for total cost of care
3) Scope of transformation
4) Breadth of participating payers and providers
5) Feasibility of implementation
6) Feasibility of evaluation

New Information for states:

- More detailed descriptions of each of the six principles
- Specific requests re: scale, stakeholder engagement, HIT capabilities, analytics
- Detail on each step of model proposal and design processes
- Timelines based on model design and clearance experience
- Information on QPP and APM qualification criteria

State Policy Academy: Agenda and Application

Joshua M. Sharfstein, M.D.
Kathryn Foti, MPH

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

State Policy Academy

What: A day devoted to helping you figure out if global budgeting for rural hospitals is right for your state

When: May 30, 2018

Where: Baltimore, MD

How: Apply online by March 30, 2018

http://tiny.cc/policyacademy

Agenda

- Overview of global budgeting for rural hospitals
  - Introduction to global budgeting, how it works and results to date
  - Presentations and Q&A with rural hospital administrators from Maryland and Pennsylvania who will share their experiences
  - Federal and state considerations for global budgeting for rural hospitals
- Networking lunch
- Tailored state team sessions
- Closing remarks by CMS leadership

Application

- Propose a state team
- Provide a brief state narrative explaining your potential interest

State team

- Up to 5 state teams will be chosen
- State teams may have up to 5 people, including:
  - Team leader: Senior state government official (eg, Medicaid Director, Health Commissioner, Governor's Office)
  - Hospital executive: CEO of a rural hospital or executive leadership of state hospital association
  - Optional: 1-3 other public and private health leaders

Participant travel expenses will be covered.

State narrative

Tell us **briefly**:

- Why you are interested in learning more about global budgeting for rural hospitals in your state?
- Who is on your team and what are their roles as it relates to global budgeting?
- Who would you like to meet with during the policy academy?

Questions?

Email:

Publichealthpractice@jhu.edu

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Thank You