

State	What Were the Drivers of Initiative?	What are the Payment Approaches?	Date started and updates?	Who are the Focused Population Segments?	Who are the Focused Provider Segment(s)?	Goal(s)	Funding Source(s)	What is the Governing Structure?	What are the Gov. Structure Responsibilities?
Pennsylvania	1). Hospital Stability especially CAH, 2). Medical cost containment	Global Budget based on hospital baseline revenues	January, 2019	Medicare, Medicaid, 5 Commercial payers	Rural Hospitals and CAH	Stabilizing CAH, delivery system transformation.	CMMI Grant for technical staffing support; Medicaid, Medicare and voluntary payers	Rural Health Design Center, (RHRC), Independent authority to administrate the Model designated by legislative action - started as DHW; Included McKinsey as consultant to process and data analysis	Oversees implementation of Rural Health Model; connect participants to resources; facilitate identifying targets that initially have high impact to critical mass; develop frameworks, toolkits, and implement best practices; convene SMEs
Maryland	1. Cost containment, 2. Hospital stability	Global rate setting and Budget based on hospital historical revenues	2014-2018 - all payer model, 2019 - 2026 - Pivoting to TCOC model based on hospital global budget.	Medicare, Medicaid, All Commercial payers	All Hospitals and CAH	cost containment, system transformation, improve quality of care.	Medicare, Medicaid, All commercial payers required	HSCRC empowered by the state; 7 commissioners and about 40 staff	HSCRC - regulating quality and cost of hospital services; leads transformation of delivery system
Oregon	1).Cost containment, 2). Medicaid Expansion, 3) prevent benefit, provider reimbursement, eligibility cuts and tapping other financial sources	Global budget - cost based reimbursement to Type A hospitals, RHCs and FQHC; Enhanced PCP payment with shared savings; Re-investment in service area communities- Community Benefit Initiative Grant Program and Transformation Community Benefit Grant Program.	2007 - legislation for structure and plan. 2009 legislation new gov. structure with responsibility for action plan 2011 responsibility for operation plan and global budget	Medicaid, and Medicaid Expansion	PCP, Hospitals and network providers	Cost containment, Managing Medicaid, improve quality of care	Medicaid and expansion only; Value based bonus and enhanced PMPM payments; State funding to start governing/ administrative body. Additional grant to support community transformation.	Oregon Health Policy Board, (OHPB) oversees plan: Easter Oregon Coordinated Care Organization, (EOCCO) - Legislated to implement with accountability consist of 9 joint network owners; 17 member Governing Board; Community Advisory Councils and Clinical Advisory Panel	EOCCO - implementation, meeting cost targets and achieving performance measures accountability;

State	What legislation to govern or guide the value based approach.	Who has the Budget Performance Accountabilities?	Provider Level Alternative Payment approach(s)	Presence of VB Approaches - shared savings; enhance PMPM; Global budget; withholds; down-side risk	Source(s) for Community Transformation Investment(s)	What were the results- financially and quality performance?	What are the Lessons Learned from model?
Pennsylvania	Department of Health and Welfare; now broken off to an independent entity, (RHRC) to avoid conflict with Medicaid policy.	Hospital focused;	Hospitals are paid same amount based on historical revenues during the year. Need critical mass of net patient revenue to hospital for successful change- at least 75%	Global budget; no down side risk to start.	hospital incentivized to invest into community services/processes to retain revenue and achieve savings from decrease ER and inpatient hospital .Philosophy of developing a "seamless system of services" to address SDOH	Too early in pilot.	Important to focus on the area that has the biggest impact on Potentially Avoidable Utilization, (PAU) (high cost/high volume) to achieve efficiency in system and savings. Increase access to PCP; need community partnership. Data and transparency important to implementation and development of trust
Maryland	Established the Health Services Cost Review Commission,(HSCRC) focus to regulate hospital prices and health plan rates and the Center for Payment Reform and Provider Alignment,(PRPA), to manage the Global Budget Revenue, (GBR) approach	Primary -Provider Level -Hospitals with secondary Governing Body HSCRC to CMS targets.	paid monthly installments based on budgeted amount. Hospitals had the flexibility to dial up charges up or down so by the need of the year they attained their GBR.	Moved from Charge per case - DRGs to Total Patient Revenue to Global/Episodes to Global/Total Cost of Care, (TCOC).	Savings achieved funneled to targeted interventions to address SDOH associated with targeted area that has an impact of total cost; analysis of utilization and cost ,(e.g. diabetes care in Maryland)	achieved \$135 million in 2017; limit all payer hospital revenue per capita at 3.58%	Applications to states without Maryland structure: annual hospital revenue by payer for base year, increase by X% based on historical factors; payers cuts check to hospitals; CMMI to get Medicare involvement; CMS will determine savings target; leakage and market shifts need to monitored and addressed; Have an entity that sets guidelines for annual rate updates/adjustment and necessary data to support - detailed monthly hospital case mix, financial data and analytic capacity to capture Market Shifts. FFS system still in play but hospital change prices to hit Global Budget amount - how does this effect non- insured purchasers of services? Engaging non-hospital providers in care transformation and TCOC responsibility; target specific population health goals and interventions.
Oregon	Senate Bill 329 - established Oregon Health Fund Board, (OHFB) charged with developing the strategic plan. Changed to the Oregon Health Policy Board, (OHPB) - charge with developing action and implementation plan House Bill 2009 and 3650	Providers within the EOCCO were responsible financial and quality performance.	2014-2015 -Shared savings - quality bonus to PCPs; Enhanced PMPM payments; 2015-2016 no down side risk in shared savings model and no withhold or full capitation w/o withhold; 2017-2018 bonus payments partially based on performance and significant increase month payment to certified PCMH; 2018-2019 - PCP capitation, quality bonus with participation in shared savings model	shared savings for providers; global budget for entire provider network.	10% reinvestments into services areas Health Transformation community Benefit Initiative Grants	Decrease ER, specialist and inpatient utilization; increase PCP visits.	

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Topic



REIMBURSEMENT NEWS

AHA: Global Budget Payments Help to Treat Vulnerable Communities

Global budget payments give providers the flexibility to treat patients, particularly in vulnerable communities, and CMS should consider more models, AHA stated.



(https://revcycleintelligence.com/images/site/article_headers/_large/Doctor%2C_money_stack.jpg)

Source: Thinkstock



By **Jacqueline LaPointe** (<mailto:jbelleveau@xtelligentmedia.com>)

January 11, 2018 - Global budget payments support providers treating patient populations in vulnerable communities by granting them the flexibility to address the health needs of their community, the American Hospital Association (AHA) recently **stated** (<http://www.aha.org/content/18/task-force-global-budget-2018.pdf>).

Millions of individuals live in communities considered vulnerable, the hospital group's Ensuring Access to Care in Vulnerable Communities **explained** (<http://www.aha.org/content/16/ensuring-access-taskforce-exec-summary.pdf>). These communities lack access to primary care services, have high uninsurance or underinsurance rates, exhibit cultural differences, report low education or health literacy levels, and experience environmental challenges. Vulnerable communities also have a poor economy, high unemployment rates, and limited economic resources.

These communities exist in rural areas with declining and aging populations and business closures, as well as urban communities with high disease burdens and limited access to basic life needs of residents.

Individuals in vulnerable communities depend on local hospitals for care. But unfavorable economic conditions and growing disease burdens challenge hospitals as they try to stay open during the healthcare industry's shift to value-based care.

The AHA identified global budget payments as an emerging strategy for hospitals to preserve patient access to care.

WHAT ARE GLOBAL BUDGET PAYMENTS?

READ MORE: Key Capabilities for Population-Based Alternative Payment Models

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Global budget payments offer providers a fixed reimbursement amount for a fixed period for a specific patient population. Providers receive the payment regardless of case volume or intensity of services delivered, the hospital association explained.

The fix payment structure gives providers flexibility to deliver tailored care to patient populations as long as total care costs do not exceed the reimbursement total for that population. Providers also know they will be paid regardless of the services they provide to patients, such as follow-up calls and comprehensive **chronic disease management** (<https://healthitanalytics.com/news/examining-the-challenges-of-medicare-chronic-disease-management>).

Several payers have implemented or are considering global budget payments for hospitals, including two states.

Maryland's healthcare system operates under an all-payer global budget program known as the **Maryland All-Payer Model** (<https://revcycleintelligence.com/news/maryland-all-payer-apm-reduces-medicare-hospital-costs-by-429m>). The state reimburses all hospitals a prospectively set budget that covers inpatient and outpatient services provided to residents within a year regardless of the patient's insurance carrier.

State health officials adjust each hospital's budget each year for inflation, payer mix changes, population and demographics, and the impact of value-based reimbursement programs.

READ MORE: Understanding the Top 10 Terms of Value-Based Purchasing (<https://revcycleintelligence.com/news/understanding-the-top-10-terms-of-value-based-purchasing>)

A 2017 *Health Affairs* study (<https://revcycleintelligence.com/news/maryland-all-payer-apm-reduces-medicare-hospital-costs-by-429m>) uncovered that the all-payer global budget model reduced Medicare hospital costs by \$429 million, exceeding the expectation that the model would save \$330 million over five years.

Maryland hospitals also reduced potentially preventable complications by 48 percent and lowered the all-cause readmission rate to just 3.4 percent above the national rate, accounting for a 57 percent improvement.

Pennsylvania is heading down a similar path by partnering with CMS to implement an **all-payer global budget program** (<https://revcycleintelligence.com/news/all-payer-alternative-payment-model-targets-pa-rural-hospitals>) for acute care and critical access hospitals in rural areas. CMS intends to provide \$25 million in funding over four years to help the state implement the model in early 2017.

ELEMENTS OF A SUCCESSFUL GLOBAL BUDGET PAYMENT STRATEGY

The AHA called on Congress and CMS to consider similar global budget payment systems for vulnerable rural and urban communities. The programs should include four key elements.

First, global budget payment programs should have “predictable, stable” reimbursement. Hospital payments should cover the cost of care, as well as the expenses incurred to build the infrastructure and capabilities needed to redesign care delivery.

READ MORE: Best Practices for Value-Based Purchasing Implementation
(<https://revcycleintelligence.com/features/best-practices-for-value-based-purchasing-implementation>)

Hospitals in vulnerable communities may need global budget payments that exceed historical payment levels to cover all the expenses of delivering improved care, the hospital group noted.

Payers should also consider the timing and structure of payments, as well as adjustments for factors beyond the hospital’s control, such as natural disasters or epidemics.

Second, broad provider participation in the program will help to improve care quality while decreasing costs.

“Provider participation, which could be limited to hospitals or could include a broader set of providers. Increased participation could result in better alignment between and more accountability from healthcare providers for the quantity and quality of services offered,” the report stated. “The types of services included in or excluded from the global budget also must be defined.”

Third, health plan participation is also key to global budget payment program success. The program should include private and public payer participation. Otherwise, hospitals would be simultaneously operating under fee-for-service and global budget payment models.

Finally, health leaders should choose appropriate quality measures, AHA advised.

“The implementation of measures that hold providers accountable for their quality of care is essential,” the hospital association wrote. “Payers also must provide timely access to actionable information related to care, payment and cost to allow providers to make necessary decisions regarding care delivery.”

Additionally, the AHA urged CMS and Congress to ensure global budget payment programs “account for the different sizes and types of hospitals, acknowledging that each of which may be at very different points in the transformation process.”

Hospitals must redesign care delivery and financial processes to succeed under global payment programs. While some organizations have started on the value-based reimbursement journey, other hospitals, like small, rural organizations, may be further behind with this process.

CMS should create payment policies that “bridge the gap” between fee-for-service or cost-based reimbursement and global budget payments. The **risk versus reward** (<https://revcycleintelligence.com/features/exploring-two-sided-financial-risk-in-alternative-payment-models>) equation should also encourage hospitals to assume additional financial risk without penalizing them for needing additional time and experience to fully participate.

The AHA also advised policymakers to waive **fraud and abuse laws** (<https://revcycleintelligence.com/features/how-providers-can-detect-prevent-healthcare-fraud-and-abuse>), such as the Physician Self-Referral Law and the Anti-Kickback Statute. Hospitals will need to forge financial relationships under global budget payments that could violate certain laws.

Participating hospitals should also be exempt from certain Medicare reimbursement policies to allow providers to move patients throughout the care continuum with ease. Current discharge planning requirements stop hospitals from sharing post-acute information and the skilled nursing facility “3-Day Rule” and inpatient rehabilitation facility “60-Percent Rule” prevent hospitals from discharging to post-acute care providers of their choice.

Hospitals should have the flexibility to discharge patients to high-value **post-acute care** (<https://revcycleintelligence.com/news/importance-of-post-acute-alignment-integration-to-value-based-care>) facilities under global budget payment models.

The AHA concluded that global budget payments are not widely available in healthcare markets right now. But hospitals should prepare for the alternative payment model as the industry seeks new ways to reimburse providers in vulnerable communities under value-based reimbursement.

Providers can find more information on how to prepare for and implement global budget payments, as well as how to preserve care access in these areas, by visiting the Ensuring Access to Care in Vulnerable Communities Task Force’s **website** (<http://www.aha.org/advocacy-issues/accesscoverage/access-taskforce.shtml>).

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A Federally Funded Program

Pennsylvania Rural Health Model

Accelerating Health Care Innovation in Pennsylvania

Idaho Critical Access Hospital Work-Group

January 23, 2020



Goals for the conversation today:

- Provide a brief history and overview of the PA - RHM
 - Its inception
 - Current state of the program
- Review key concepts of the methodology
 - Global Budgets
 - Transformation planning
- Share a few lessons learned
- What States should be thinking about
- Answer questions

Brief history and overview

2020

The Pennsylvania (PA) Rural Health Model (the “Model”)

The goal of PA Rural Health Model is to prevent rural hospitals, which ensure access to high-quality care and economic vitality in local communities, from closing

- Partnership between CMMI and the Commonwealth of Pennsylvania to test a new payment model for rural hospitals
- Federally funded through CMMI to provide technical assistance to participant hospitals who join the Model
 - Grant funds for technical assistance to participant hospitals to help ensure success
 - Health insurers remain the source for hospitals’ net patient revenue streams
 - Model will be assessed based on rural hospitals financial performance and population health outcome measures
- Several key differences between Maryland Model and the PA Rural Health Model:
 - Impetus: retaining access to care and jobs vs. cost containment
 - No global rate setting function in PA - the underlying negotiated rates between payers and providers remain intact after the calculation of the baseline budget

Current state

The model formally launched in January 2019

- *5 payers, 5 hospitals*

2020 saw significant growth:

13 Participant Hospitals	
5 CAHs	8 PPS Hospitals

6 Participant Payers	
Medicare FFS	Geisinger Health Plan
Highmark	UPMC Health Plan
Aetna	Gateway

Goal is to increase participation for hospitals and payers for 2021

Methodology Overview

2020

The Model provides protection from some of the most challenging issues facing rural healthcare leaders by minimizing several of the risks hospitals experience under FFS

FFS Risk		Model Benefit
Volume fluctuations		Predictable revenue stream
Provider resignations / recruitment challenges		Protects hospital revenue from the immediate impact of providers departure and provides stability until recruitment efforts are successful
Competition with tertiary centers for volume		Competition is no longer the driver of revenue
Investments in population health (right thing for the community, wrong thing for the bottom line)		Eliminates the concern as you are paid to keep people well
Regulatory barriers that prohibit innovation		Within the Model, opportunities exist to apply for waivers of regulations that may stifle innovation

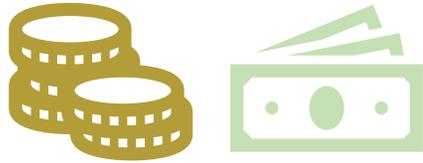
The Model offers value propositions from a provider's perspective, but many align with payer community goals

<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

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

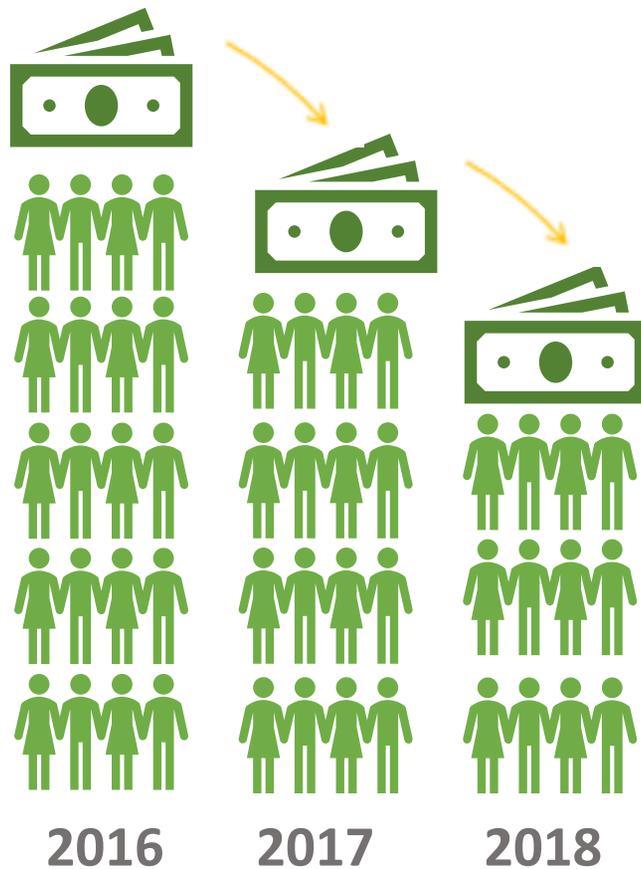


The hospital is incentivized to invest in community health to retain revenue

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

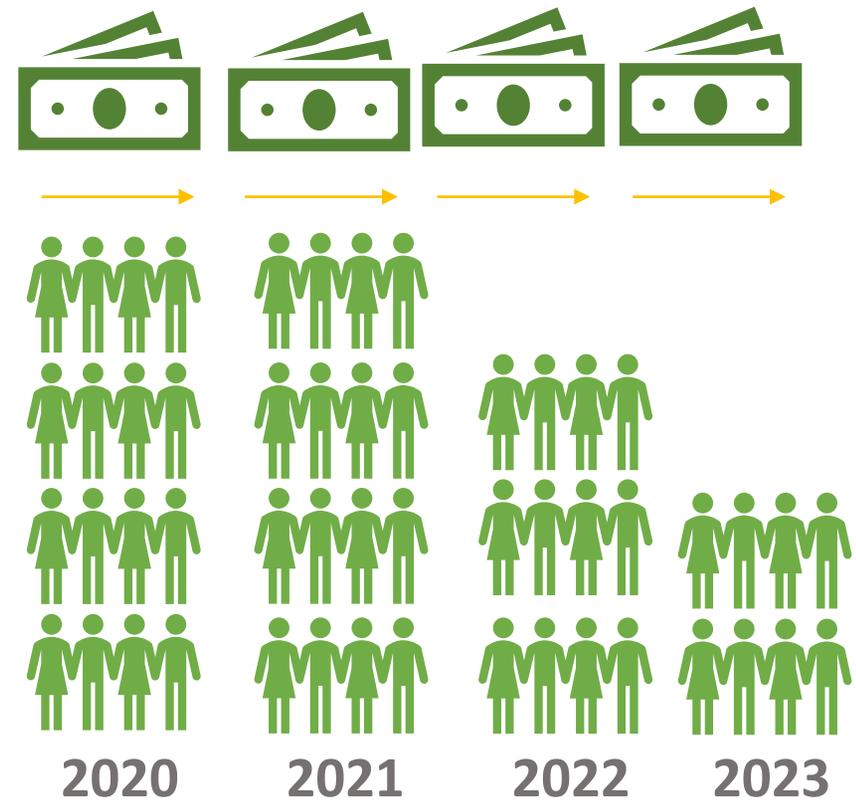
Fee for Service

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



Global Budget

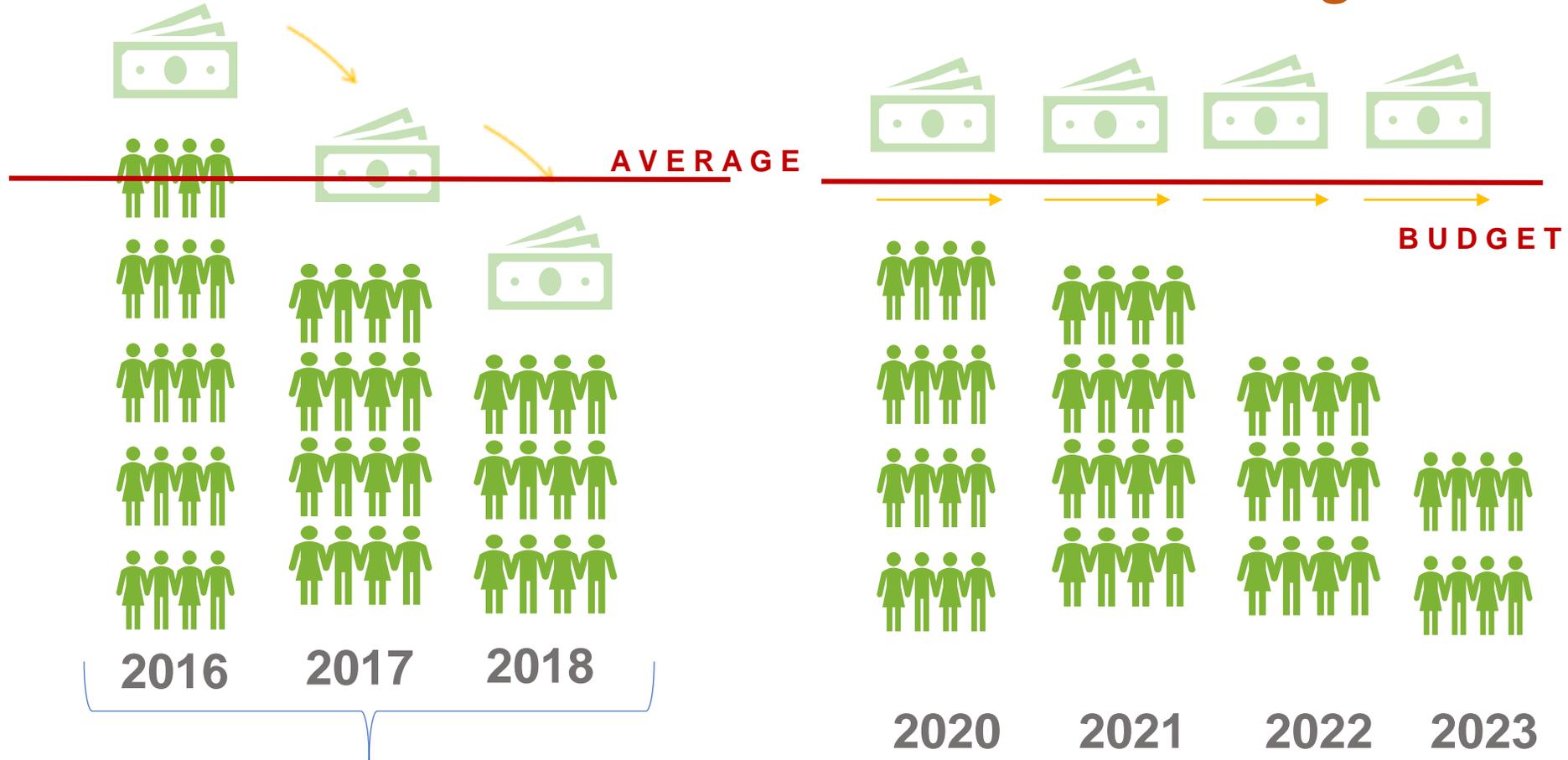
Hospital is paid the same amount of money as historic NPR regardless of how many resources are consumed by the community.



The budget is determined based on historic net patient revenue, which is used to set the prospective budget

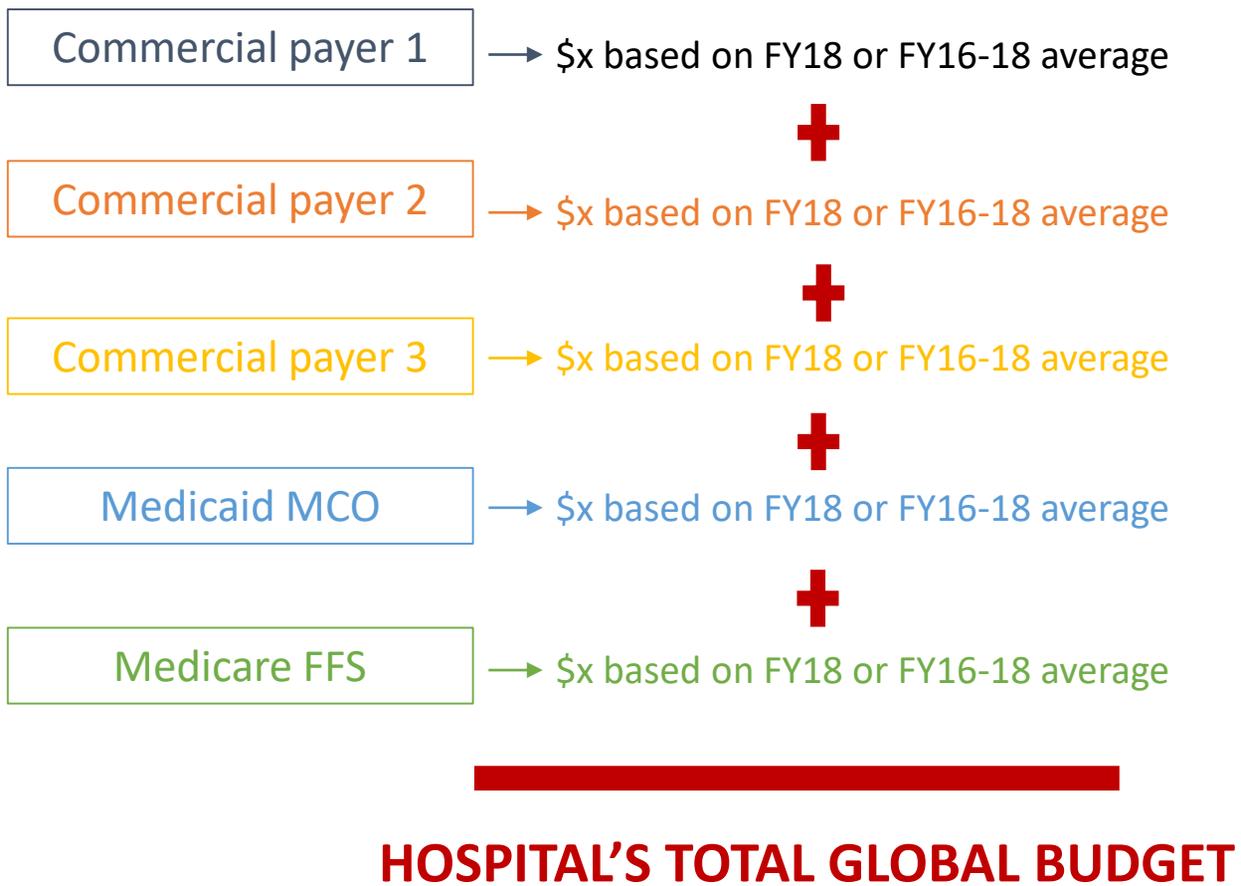
Fee for Service

Global Budget



For 2020, baseline budget is set at the greater of 2018 or the average of 2016 – 2018. It includes inpatient services, outpatient services such as labs and imaging, emergency services, and swing bed for the CAH

Hospitals establish a budget with all payers using the same logic. Without a global rate setting function, the global budget must be set for each individual payer, and then summarized to arrive at the total global budget amount



In order for successful change, critical mass of net patient revenue must be paid differently. The Model contains payer participation targets to ensure enough revenue is included to allow for change in how care is delivered

2019 Goal: 75%

2020 Goal: 90%

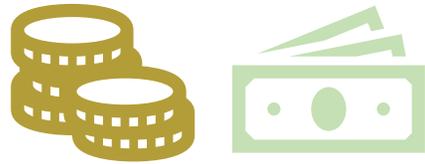


Question – what is the magic number to incentivize providers to change?

Reconciliation and review processes exist throughout the year to ensure a fair budget is maintained for each hospital

- **Quarterly:**
 - Payer mix – adjusts for changes in the number of lives covered for commercial insurance plans for services provided
- **Annual as part of setting the following year’s budget:**
 - Unit price changes
 - Unplanned volume shifts - changes as the result of where people choose to receive their healthcare services
 - Demographic shifts for Medicare – changes as a result of people leaving or entering the area
 - Savings associated with providing the right care in the right setting (e.g. a primary care clinic vs. the emergency department)
 - Other adjustments: Additional adjustments / exceptions may be made for exogenous changes (e.g., epidemics)

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

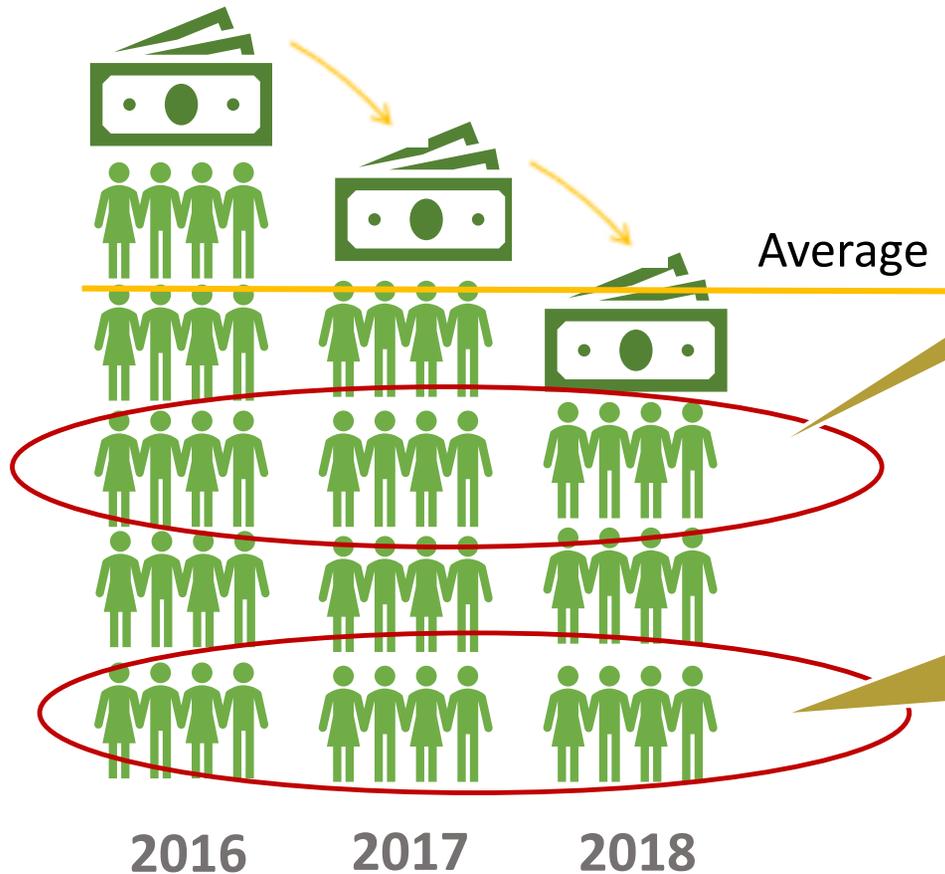


The hospital is incentivized to invest in community health to retain revenue

To the extent the hospital can reduce unnecessary utilization, they keep portions of the historical revenue and share some with payers

FFS Revenue

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



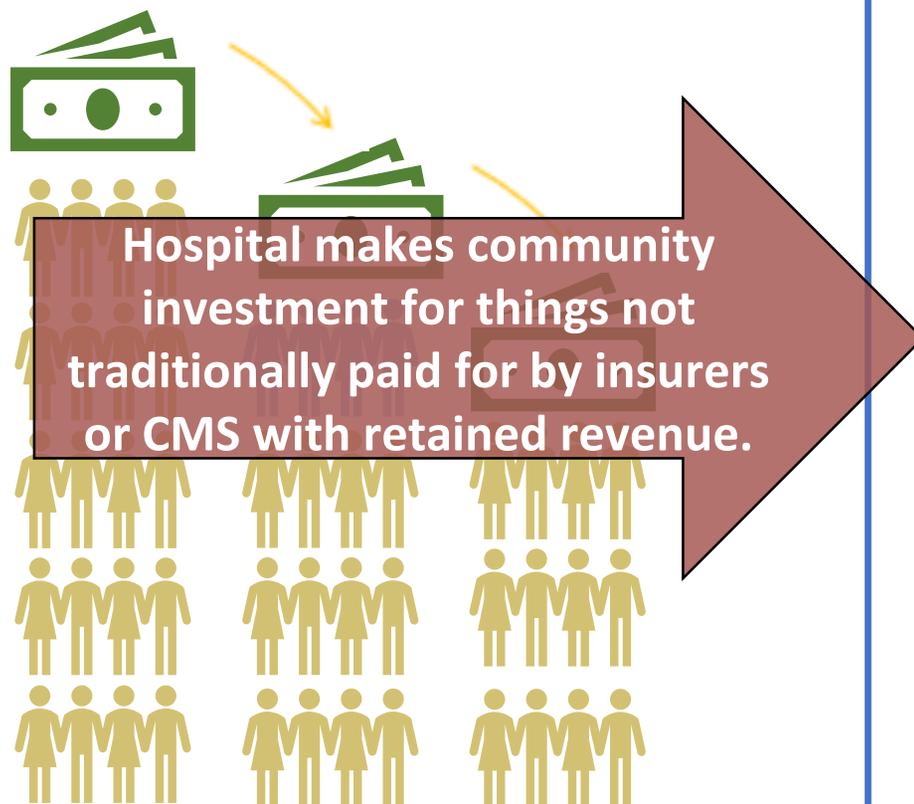
Each year a certain number of patients seek care in the ED that could have been furnished in a primary care office.

Each year a certain number of patients come back to the hospital within 30 days of a prior hospital stay due to breakdowns in how care was delivered to the patient.

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

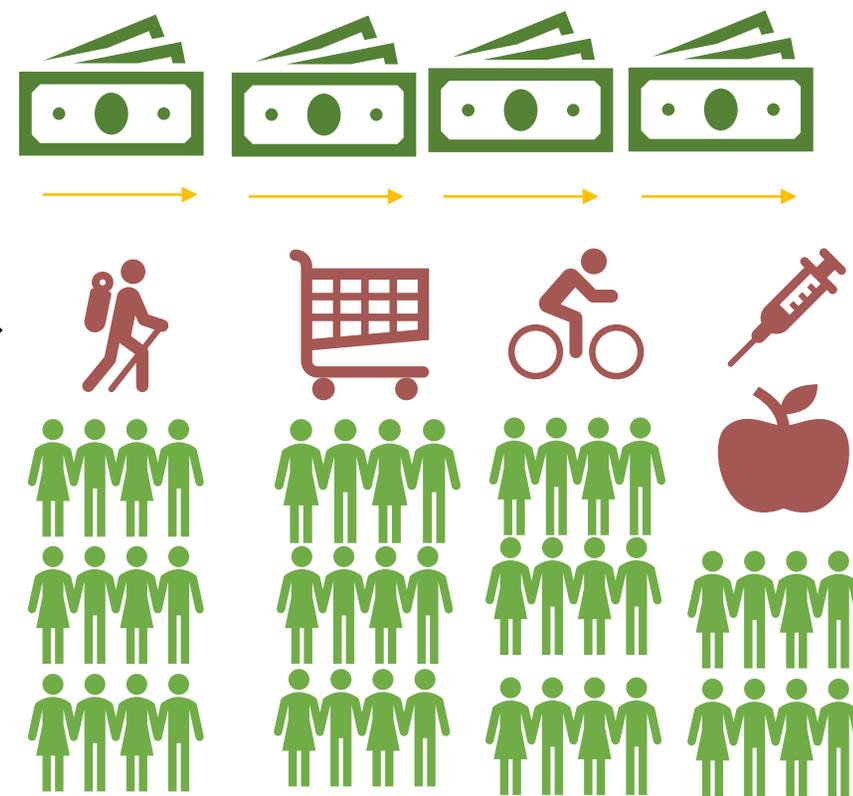
FFS

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



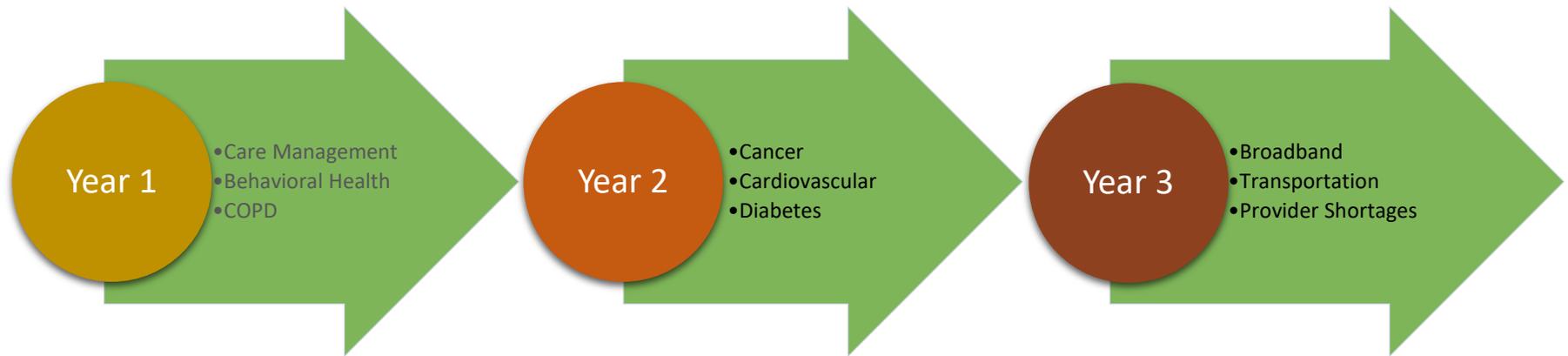
Global Budget

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



In future years, the SDOH strategy will expand and focus more on what is outside of hospital walls; but, for now, hospitals will focus on areas for immediate impact

Multi-Year SDOH Strategy



Communities are encouraged to tackle these important determinants as the need arises in their community, but all recognize the need for interagency support for solutions to achieve long term success

Lessons learned and considerations

2020

A few lessons learned

- Trust is the key ingredient needed to make this work -
 - Trust between the federal government, state government, payers, providers, community partners, legislators, etc.
 - Everyone has to have faith that the best interest of our rural communities is the key driver behind the change
- Establish achievable / realistic targets –
 - Participation targets (hospital, payers)
 - Outcome measures (financial metrics, population health metrics)
- Change is hard –
 - Even though the current environment isn't sustainable, adopting a new way of thinking is difficult
 - We are programmed to function in the environment of the known
 - The paradigm requires a different mindset – takes discipline to think differently
- Change of this magnitude takes time -
 - Overcoming fear of the change takes time
 - Even when leaders want to adopt the change, there are often other circumstances that prohibit them from doing so (competing priorities, bandwidth issues, etc.)
 - “Big think” innovation may take time
 - This is a marathon, not a sprint – this requires an appreciation for the long view
- Access to data, and timely data, is key to program success
 - Current infrastructure and lack of access to information is a barrier to innovation

Key considerations for States

- First step in engagement is education and shared vision setting
 - Begin the conversation regarding the needs of the various stakeholders and desired outcomes
- Key stakeholder engagement (not exhaustive)
 - Hospital Leaders - essential if participation is voluntary
 - Local Boards
 - Corporate leadership
 - Commercial Payers – essential if an “all-payer program”
 - CMMI / CMS – essential if beyond a state initiative
 - Governor’s Policy Office
 - Department of Health
 - Department of Human Services
 - State Insurance Department
 - Hospital Association
 - Office of Rural Health
 - Other trade associations
 - Community providers – essential as true transformation occurs outside of the hospitals

Key considerations for States

- This is a journey:
 - PA has been at this for several years
 - Resiliency is key
- What current value based work is already underway and how this can be leveraged in the program

Key considerations for hospital leaders considering transformation:

- The paradigm requires a different mindset – takes discipline to think differently
- What are the opinions and attitudes about the current FFS structure and its sustainability
- The current financial position of the organization - weighing the risks of early adoption versus waiting
- Understanding if there are other alternatives
- Leadership's attitudes toward population health and its commitment to it
- Culture / readiness for change of the organization
- Competing priorities / ability to implement

Idaho questions and answers

2020

Questions provided in advance:

- Can you describe the types of waivers you received? Are the waiver documents available?
 - General statements in the agreement between CMMI and Pennsylvania
 - Determining necessary waivers was an exercise in partnership – CMMI instrumental in identifying what was needed
- What are the building blocks needed to develop this model?
 - Identify desired outcomes (overall vision of what is to be accomplished) with stakeholder engagement
 - Prioritize the vision and be specific
 - Establish framework based on the vision
 - Example, is this just a financial model, or transformation model
 - Is this just about controlling cost or ensuring access to care
 - How much oversight regulation do you to establish
- Did PA respond to a CMMI funding opportunity announcement or work with CMMI directly?
 - Worked with CMMI directly
- Do you include physician, stakeholder, and board education and engagement in your project and resources for participants?
 - Yes, this is where I spend a significant amount of time, educating and working with stakeholders

Additional Questions

