Meeting Summary
Rural Health Care Delivery Work Group

January 9, 2017

11:00am-3:30pm

Welcome and Introductions

The third Maryland Rural Health Care Delivery Work Group meeting was held January 9, 2017 in Chestertown, Maryland. The meeting began with a welcome from the Workgroup Co-Chairs Deborah Mizeur and Joe Ciotola. The meeting featured a presentation by the Health Services Cost Review Commission (HSCRC) on the Phase II Progression Plan for the Maryland All-Payer Model, as well as a presentation by the Maryland Deputy Secretary for Public Health on Maryland's Comprehensive Primary Care Model. The meeting also included a discussion of the planning process for the public hearings to be held in March and April of this year, as well as a facilitated discussion with the workgroup members on rural healthcare models and regulatory and other hurdles that must be faced. The final part of the workgroup meeting was reserved for comments by the public.

Plan Phase II Progression

Ms. Katie Wunderlich, Principle Deputy Director of HSCRC, presented highlights of the Maryland All-Payer Model and the future plans for this model. Ms. Wunderlich noted that the Phase II Progression Plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) in December of 2016, was the result of many months of hard work. She began the presentation by discussing the performance measures and targets of the All-Payer Model for the years 2014-2016. Prior to implementation of the model, hospital per capita revenues were growing at a high rate with limited incentives to control utilization. Today, hospital revenue is governed by global budgets. Ms. Wunderlich explained that the goals of the current model are to contain hospital costs and to improve health outcomes. Statewide, there has been a reduction in potentially avoidable utilization and readmission rates have declined.

Ms. Wunderlich then described the focus of the next phase of the Plan which is to extend the All-Payer Model to the total cost of care metrics, and to align efforts across providers and care settings. The Phase II Progression Plan focuses on improving care to reduce potentially avoidable utilization and providing care in the right setting. This next phase will also incorporate stakeholder input, as well as state initiatives such as implementation of the Primary Care Home Model in 2018, implementation of the Dual Eligible Accountable Care Organization (ACO) Model in 2019, and the updated Population Health Plan. The strategies, components and timeline of the Plan must also align with the Medicare Access and CHIP Reauthorization Act (MACRA) requirements.

According to Ms. Wunderlich, there are five key strategies of the Progression Plan. One strategy is to foster accountability of supporting providers for the care and health outcomes of groups of patients within a geographic area. Other strategies include aligning measures and incentives for providers to work together along with health care payers and consumers, and encouraging and developing the

transformation of payment and delivery systems. Finally, we must ensure the availability of tools to support providers in this transformation and devote resources to increase consumer engagement.

Ms. Wunderlich explained what the new Model may mean for the improvement of care delivery in rural areas of Maryland. This Model may help decrease avoidable hospitalizations and improve chronic care by increasing consumer engagement, strengthening local initiatives, and better managing chronic diseases. The Progression Plan builds on success of rural hospitals under Total Patient Revenue. It also supports several approaches for sustaining rural health care such as leveraging a Geographic Value-Based Incentive to address accountability for population health, and transforming primary care to support coordination of care with other services and resources.

Ms. Wunderlich then provided the workgroup with a potential timeline for the Progression Plan. Between 2017 and 2018 will be the time for care redesign and infrastructure development. This is the fourth year of the All-Payer Model. Care design will be completed in 2017 and amendments must be approved by CMS. The year 2018 will begin implementation of the Primary Care Model as well as development of phase two goals. The second phase of the Model begins in 2019.

In the final part of the presentation, Ms. Wunderlich described the implications of the Phase II Progression Plan for rural health care delivery as well as some of the solutions used by other states. She noted some of the challenges in rural health settings for adult women who have increased their morbidity rate in part due to increased opioid use and increased suicides. Rural hospitals have declining margins due to shrinking demand and many have closed over the past several years. This presents a problem for individuals in rural areas who use the hospital as their only source of health care. Although many states have looked to Maryland for solutions, we continue to look at the solutions developed by other states. Ms. Wunderlich described the rural health model of two of these states; Pennsylvania and Vermont. Pennsylvania has transitioned from an in-patient focus to an outpatient focus concentrating on population health. Vermont has an All-Payer system which encourages better care coordination and collaboration

Questions and Answers on the Plan Phase II Progression

Following the presentation, Ms. Wunderlich asked for any questions or comments on the progression plan. Deborah Mizeur said that she can appreciate getting people into the right setting and asked for examples of the Geographic Value-Based Incentive model. Ms. Wunderlich described the incentives for hospitals to work with providers in their community under MACRA to provide more cost-effective, outcomes-based health care. Dr. Ciotola asked about seed-funding for implementation of a Geographic Value-Based Incentive model. It was explained that the 2016 grant awards will be implemented in 2017. Gene Ransom, the CEO of MedChi, noted opportunities for investment from two programs; a hospital-based program and a community-based model the money does not count towards the global budget. HSCRC has been working with CMS in this area. Ben Steffen, the Executive Director of the MHCC described the waiver and the importance of public participation under the new model.

Maryland Comprehensive Primary Care Model

The second presentation on the Maryland Comprehensive Primary Care Model was presented by Dr. Howard Haft, the Deputy Secretary for Public Health for Maryland's Department of Health and Mental Hygiene (DHMH). Dr. Haft explained that he used to be a rural health care provider. He noted that it is not only important to know what is being done in the state, but also to know why it is being done. We want to improve the health of the residents in Maryland. Dr. Haft described the problem of shortages of primary care doctors in Maryland and nationwide. There is an increased demand for primary care services and decreased provider satisfaction due to increased patient volume. He noted that we must provide services more effectively and efficiently. Dr. Haft noted that the waiver has helped move Maryland from high volume fee for service to a value based model which has helped Maryland become a leader in the delivery of affordable care. He then described CMS innovation (MACRA), in changing provider payment structures (Merit-Based Incentive Payment System and Advanced Alternative Payment Models), the delivery of care, the distribution of information and the basis of the Comprehensive Primary Care Model. Two existing models that support responsibility for cost and outcomes of Medicare beneficiaries are Accountable Care Organizations (ACOs and a Medical Home Model).

Patient Centered Care Homes

Dr. Haft described the broad scope of the Patient Centered Home which is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it. This model takes the patient's needs into consideration. For example, he said, substance abuse and depression are real problems in Maryland. The Patient Centered Care Home Model brings resources to the primary care physician. This is especially important in rural areas where it is difficult to recruit primary care physicians. The basis of this model is joint decision- making and team-based care. Dr. Haft described possible members of this team in addition to the primary care physician which included: Community Health Workers, Physician Assistants, Pharmacists, and Nurse Practitioners. He also described the benefits of electronic health records and the health information exchange (CRISP) for this model.

Federal Government and State Timeline

Dr. Haft described the progression from fee- for- service Medicare to SGR and then to MACRA as well as some of the key elements of MACRA in terms of quality. He also described Maryland's progression from fee-for service hospital payments, to the All-Payer Model, to a Global Budget as well as some of the key features of the All-Payer Model. The Progression Plan for the All-Payer Model was submitted to CMS at the end of 2016. The State must now develop the incentive approach for implementation in 2017 and 2018 as well as begin to implement models that align with MACRA.

Questions and Answers on the Maryland Comprehensive Primary Care Model

Susan Johnson, the Vice President of Quality and Population Health for Choptank Health noted that Federally Qualified Health Centers (FQHC) are not included in adopting this type of a model. Dr. Haft stated that there are ongoing discussions with CMS to include FQHCs. Senator Middleton asked for specifics in regard to this question. It was noted that FQHCs have a different reimbursement

designation and are therefore exempt from a merit-based incentive payment system because of how they are paid.

Mark Boucot, the CEO of the Garrett Regional Medical Center, had a question about the Garrett County region which could not be answered specifically until the adoption of a model has been made. Ms. Mizeur asked about governing organizations needed to tailor to local needs. There was a brief discussion of Care Transformation Organizations (CTO) that followed. CTOs are designated private entities that will provide services to practices. The CTOs generate economies of scale in the provision of these services which are difficult for small physician practices to afford. The CTOs will also provide education and technical assistance to practices that are tailored to the needs of the community.

Public Hearing Planning

Following a short break, Ms. Erin Dorrien, the Chief of Government and Public Affairs for the MHCC, led the next discussion of the Public Hearing Planning. A public hearing rubric that was developed by MHCC staff was used for this discussion. The public hearings are mandated by Senate Bill 707 to gain community input regarding the health care needs in the five study counties. Ms. Dorrien told the group that the study that is required under Senate Bill 707 must also take into account the input that is gained through the public hearings. The public hearings will take place at the end of March and beginning of April of this year.

Ms. Dorrien noted that the public hearings would be held in three of the five study counties; Kent, Talbot and Dorchester. She then detailed various strategies for alerting the public to these hearings including a notice on the MHCC website and social media, notice in the Maryland Register, press release, and through a pamphlet that can be distributed by the local Health Departments and the public libraries. Ms. Dorrien then asked the workgroup members for additional suggestions for alerting the public, as well as additional information that would be good to distribute to the public prior to the hearings.

It was suggested that senior centers and all of the local newspapers in the five county region would be good sources for disseminating information. One workgroup member suggested that some of the acronyms that were used by health care professionals and the workgroup members could be confusing to the public. Ms. Dorrien noted that a list of acronyms and definitions would be posted on the MHCC website. Additional pre-hearing material such as the history of the workgroup, its purpose and charge as well as statistics regarding community health needs will also be available on the website.

Finally, Ms. Dorrien informed the workgroup members that we would need Public Hearing Officers (three for each public hearing) to answer any questions from the public and to take notes of the hearing. These Public Hearing Officers will then present a summary of the notes to the workgroup. She encouraged workgroup participation at the public hearings and stated that she will conduct a short survey to determine the availability of the workgroup members.

Facilitated Discussion (Jack Meyer)

Meeting facilitator Jack Meyer began the facilitated discussion by suggesting that the Work Group members offer their thoughts on how the Rural Health Work Group could both *learn from* Maryland's plans for Phase 2 of the All-Payer Model, with particular emphasis on primary care transformation, and at the same time *inform* the evolution of this model. In other words, how can we make this a two-way street, with the deliberations, findings, and recommendations of the Work Group incorporating the new, statewide approaches to delivery and payment system reforms, while also sensitizing Maryland's leaders to the special challenges in rural areas in general, and the Mid-Shore region in particular?

Joe Ciotola led off the discussion by asking how the CTOs would be funded. He expressed concern that this new set of institutional arrangements could turn into another layer of bureaucracy, overlapping with existing arrangements, and also about the adequacy of funding. He wondered whether the State has identified a sustainable source of funding for the CTOs.

Dr. Ciotola's concern was also expressed by other members of the Work Group, and in the broad context of the overall All-Payer Model. Gene Ransom, for example, asked how we would fund all these investments, and "whether dollars would go across the bridge," referring to the need for funding to reach into the five counties that comprise the purview of the Work Group. The Model seems to envision a number of investments in "infrastructure," both in terms of technology and human resources. Members wondered how all of this was going to be funded.

Over the course of the discussion, the following potential sources of funding were identified:

- Federal government funding from agencies including CMMI (which the State hopes will fund the new investments under the All-Payer Model); HRSA, which funds FQHCs; the Substance Abuse and Mental Health Services Administration (SAMHSA), providing grants for innovations in the treatment of substance use disorders and mental illness; the Centers for Disease Control and Prevention (CDC); and HUD, the federal housing and urban development agency that provides funding that can address unsafe housing and homelessness, and home visits for asthma and lead based paint abatement, factors that can contribute to poor health. Both the federal government and Maryland have loan forgiveness programs tied to commitments on the part of physicians and other providers to practice in under-served areas.
- Programs sponsored by hospitals, such as the one presented by Marc Boucot explained below, and numerous hospital-based initiatives aimed at reducing hospital admissions and readmissions.
- Initiatives of commercial payers intended to better manage chronic illnesses and reduce avoidable ED use and hospital admissions.
- City and county government programs.
- Private philanthropy, including both grant-making organizations such as the Robert Wood Johnson Foundation and corporate foundations.
- The business and labor communities.

Marc Boucot provided a thorough explanation of a Well Patient Program at Garrett County Memorial Hospital. This program is very consistent with the key tenets of the All-Payer Model and in particular, with the planned Primary Care Model. A key element is to shift resources into the community and to

both prevent and manage chronic conditions through early intervention and empowering people to manage their own health.

Initiatives in the Garrett County Memorial Wellness model include:

- ✓ Wellness blood screening including cholesterol, heart, liver, and kidney function, and blood sugar
- ✓ Wellness consultations
- ✓ Arthritis and fibromyalgia support groups
- ✓ Employer initiatives such as early detection through medical screening on the job site, and volunteer wellness opportunities, coordinated by a nurse and offered during work hours.

Mr. Boucot highlighted the savings attributed to this model, including a 7.8% decline in risk-adjusted inpatient hospital readmissions; a 2% drop in potentially avoidable utilization in one year; a decline in mortality; and a drop in hospital-acquired conditions. Further, surgical site infection rates are an impressively low 0.16%, compared to a more typical rate of 1.9%.

Participants discussed the importance of better addressing serious behavioral health problems in the five-county area. Holly Ireland reminded the group of the ongoing stigma that still holds many people back from seeking treatment. She also explained the need for doing a better job of spotting early symptoms of mental illness and not waiting until a crisis occurs. She noted promising models such as Assertive Community Training (ACT) and the need to combine behavioral health treatment with support for housing and social services and mentioned that the current behavioral health staff cannot handle a huge influx—there will need to be additional recruitment in that area as well. Transportation was also mentioned as a frequent barrier to behavioral health treatment, and it was noted that there is no mass transit in the five counties. There is a need for more linkages between primary care and behavioral health treatment. In some cases, co-locating services can be very helpful while in other cases, telemedicine can extend the reach of behavioral health providers. This is particularly important in rural areas.

Co-chair Deborah Mizeur stressed the importance of recognizing the differences across each community. Even within the five-county area encompassed by this Work Group, there is considerable variation not only from county to county, but across small towns within counties. We need "out-of-the-box" thinking to address and reduce the barriers to connection to needed services within these towns and neighborhoods. It is also important that Mid-Shore residents be empowered to be active participants in their health decisions and provide transparency about the real costs of health care.

Senator Middleton asked about whether there was some "low-hanging fruit" that he and his colleagues in the Maryland legislature could begin to address quickly, now that the legislature is in session. One suggestion was to work on updating and expanding work force programs such as loan forgiveness, tax credits and other ways to attract and retain physicians to the region, particularly primary care physicians. Other ideas can be found in the Policy Idea Working Document.

Public Comment

Q. Kay Macintosh, Economic Development/Economic Impact of Health System Transformation- What is the role of UMD, SPH and NORC?

A. Dr. Franzini- We are working with NORC together to address several tasks. We are looking at already collected data and reports to collate and summarize the information. We're doing focus groups and stakeholder interviews. We're also creating option models. We're looking at transportation, econometric development, workforce development, access to care, vulnerable populations, and behavioral health.

Ben Steffen, Executive Director Maryland Health Care Commission- Our strategy was contract with an organization that had a record of accomplishment for policy work. We have a team that brings together local and national perspectives. They will produce a report for the Workgroup to then act on. The Workgroup will have a report that will try to support some of their recommendations. We are and have been in negotiations to locate data and use data. DHMH is also providing reports available to them. We will be publishing that data as it is approved.

Q. Fred Harmmod, resident of Heron Point and member of the Maryland Continuing Care Residents Association- We'd like to see your timeline, or at least know where you are in your process of making recommendations.

A- Ms. Mizeur- We are on our 3rd meeting of 6. In March we'll hear about some models that have been implemented in other rural counties nationwide. The workgroup has until October to make recommendations.

Q- David Foster, engineer- We heard very little discussion and information that was specific on rural, the distinction that sets us apart from other counties. We are the oldest county, we have no mass transit, our institutions are small, and our healthcare systems are small. What are the real challenges?

Q- Barabra Reed, RSA – residential service agency, rural is important, because days like today, neighbors check on each other. Sometimes, we have to take our neighbors to doctor appointment because of transportation or family living in a distance. We have no real big employers. We need to keep that in mind. Rural is different but important.

Closing Comment

Next meeting will be March.