

# Rural Health Needs and Opportunities in the Maryland Mid-Shore Region

Rural Health Care Delivery Working Group  
November 1, 2016

The Walsh Center   
for Rural Health Analysis

NORC AT THE UNIVERSITY OF CHICAGO

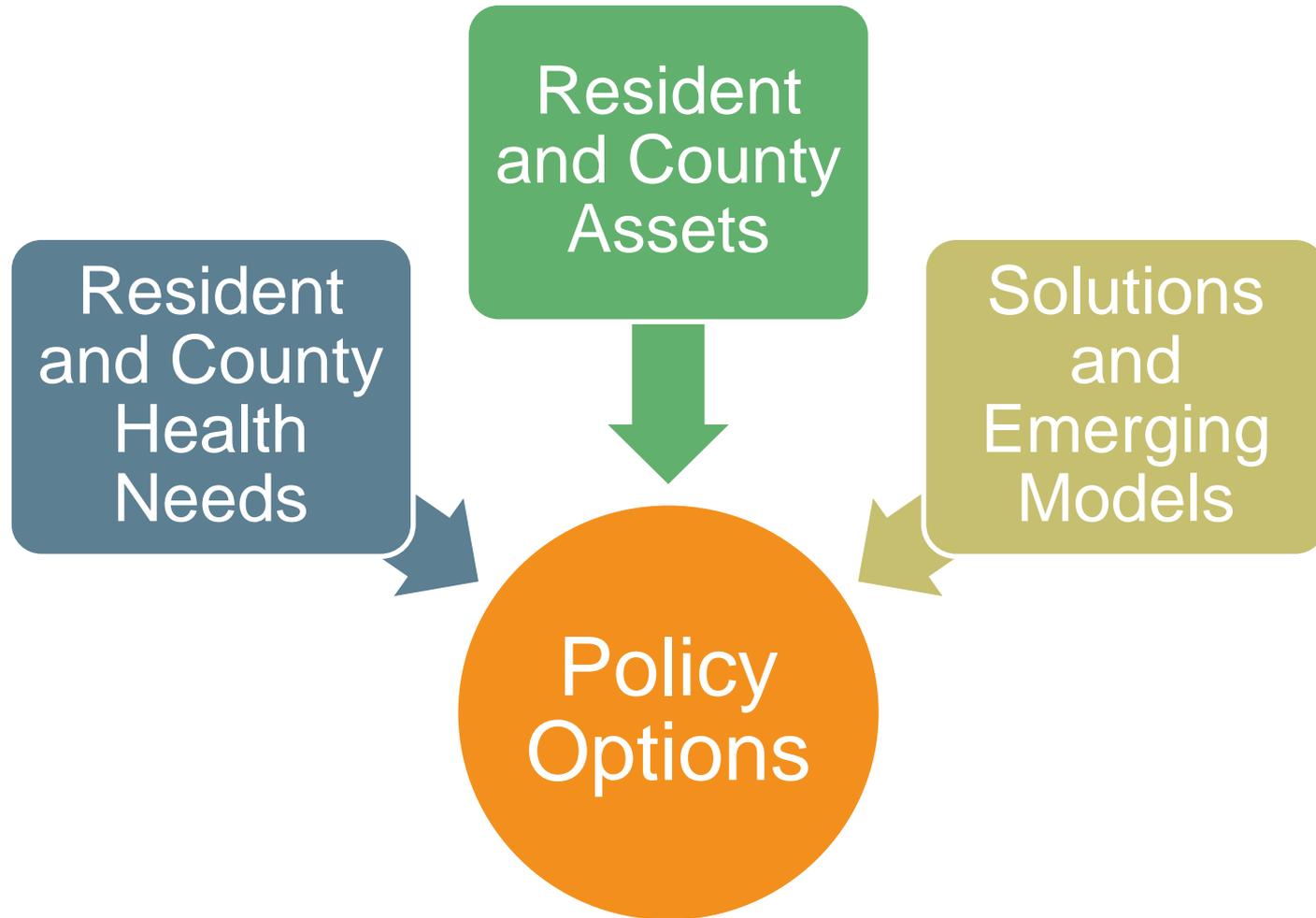


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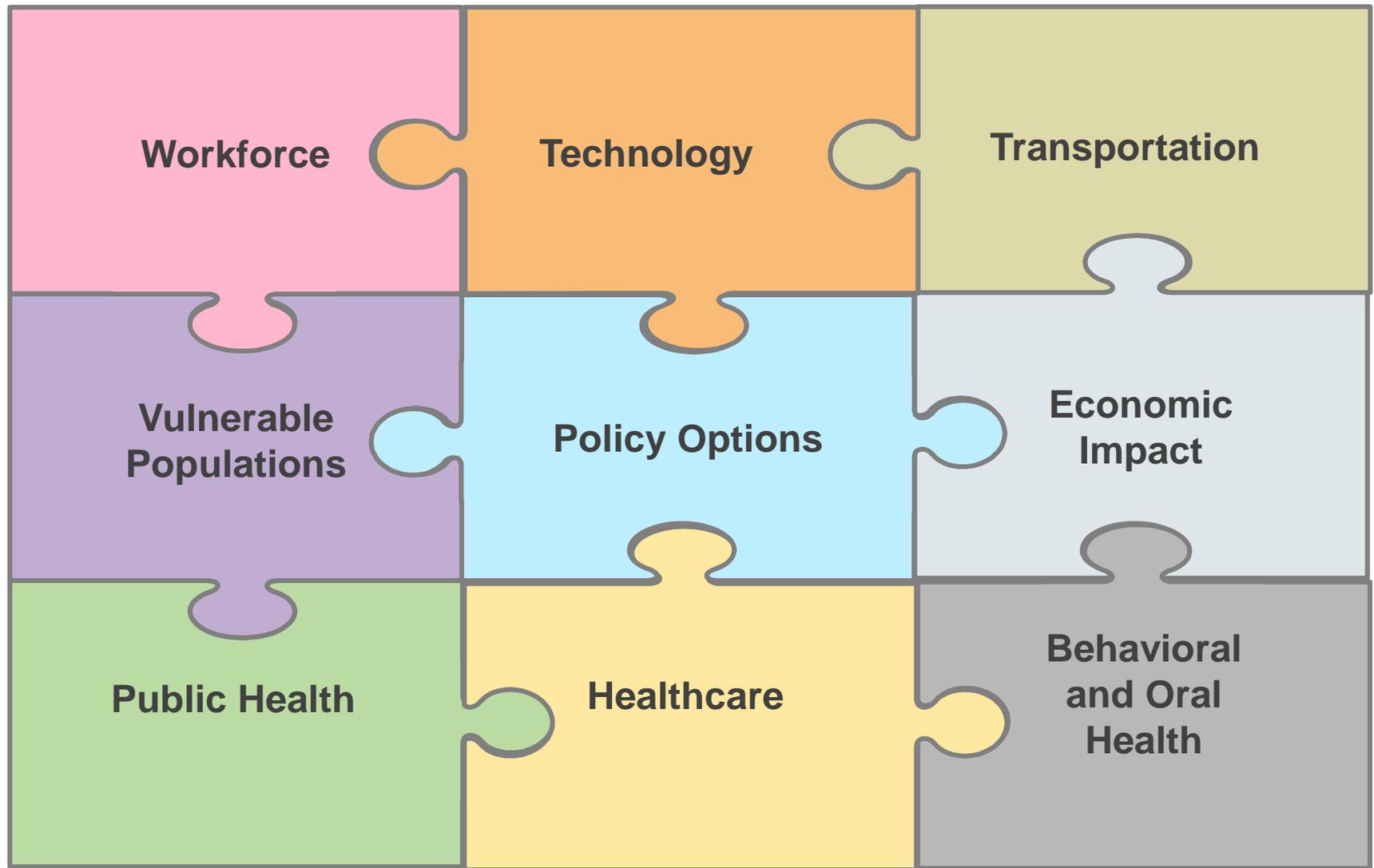
# Background

- Senate Bill 707 Freestanding Medical Facilities- Certificate of Need, Rates and Definition (SB 707)
  - Established the Rural Health Care Workgroup
    - oversees a study of healthcare delivery in the Middle Shore region
    - develops a plan for meeting the health care needs of the five counties -- Caroline, Dorchester, Kent, Queen Anne's and Talbot
  - Maryland Health Care Commission contracted with the University of Maryland School of Public Health and the NORC Walsh Center for Rural Health Analysis to conduct a study to develop rural health care delivery and payment options for the five counties.

# Study Framework



# Inter-related Issues



# Examine Challenges and Assets

Assess and integrate findings/recommendations of health improvement plans, existing task force reports and analyses of public health/social services

Obtain and analyze input from Residents and Stakeholders

- Conduct and analyze: Stakeholder Interviews (15) and Focus Groups (5)

Analyze Existing Data

Health care use patterns of primary, specialty, and acute services by:

- privately insured, Medicaid and Medicare residents,
- zip code, county and region, and
- vulnerable populations (frail and elderly; racial and ethnic groups, patients with persistent behavioral illness), and
- targeted analyses for behavioral health and prevention quality indicators

# Identification of rural health innovation models with capacity to scale up / apply to Mid-Shore Region

- Identify local and/or national models that address major challenges
- Develop a comprehensive systems-based framework, including key strategies, initiatives, targets and measures
  - Applicability of models in context of the Global Budget and other State initiatives
  - Other considerations - quality of care, population health impact, acceptance by residents, financial sustainability, workforce requirements, regulatory/statutory considerations, and governance structures
- Assess potential models against comprehensive framework
- Explore model capacity for engagement and alignment under new models including the perspective of residents, providers, business, and community leaders, and other partners who supply services to the 5 county area.

# Focus Issues, Examples of Potential Solutions and Considerations for Policy Options

Issue	Examples of Potential Solutions	Option Considerations
<p><b>Health care and services</b></p> <ul style="list-style-type: none"> <li>- Access to hospital care, to primary care and specialists</li> <li>- Providers shortage</li> <li>- Distance from providers</li> <li>- Physician acquisition by health systems</li> </ul>	<ul style="list-style-type: none"> <li>- Expand primary care focus</li> <li>- Develop community care with CHW and physician extenders</li> <li>- Diffuse Telehealth</li> <li>- Introduce Innovative transportation models</li> </ul>	<ul style="list-style-type: none"> <li>- Financial models need to align with limitations of practicing in rural areas</li> <li>- Meeting residents' needs</li> </ul>
<p><b>Technology: telehealth and telemedicine</b></p> <ul style="list-style-type: none"> <li>- Limited access to high speed internet on the Eastern Shore</li> <li>- Provider/Patient acceptance of telehealth</li> <li>- Med. Liability issues</li> </ul>	<ul style="list-style-type: none"> <li>- Expand CareFirst telehealth &amp; MHCC telehealth grants</li> <li>- Introduce innovative telehealth programs that have succeeded in the nation or rural areas</li> </ul>	<ul style="list-style-type: none"> <li>- Role of CRISP – MD's HIE</li> <li>- Development of IT systems</li> <li>- Financial investment for telehealth</li> <li>- Reimbursement for telehealth</li> <li>- Certification requirements</li> <li>- Treatment scope</li> </ul>
<p><b>Economic development</b></p> <ul style="list-style-type: none"> <li>- Potential impact of hospital reconfiguration on local economy and health care access</li> <li>- Desire to attract more industries and health systems</li> </ul>	<ul style="list-style-type: none"> <li>- Reengineer, redeploying healthcare workforce</li> <li>- Diversify local economy</li> <li>- Establish or expand Enterprise Zones</li> <li>- Use MD Depts of Commerce / Environment programs</li> </ul>	<ul style="list-style-type: none"> <li>- Support for economic development in Mid Shore counties</li> <li>- Relationship between health care sector &amp; other sectors</li> <li>- Collaboration among counties?</li> </ul>

# Focus Issues, Examples of Potential Solutions and Considerations for Policy Options

Issue	Examples of Potential Solutions	Option Considerations
<p><b>Workforce</b></p> <ul style="list-style-type: none"> <li>- Physician availability</li> <li>- Limited primary and specialty providers</li> </ul>	<ul style="list-style-type: none"> <li>- Enhance loan repayment programs</li> <li>- Recruit local young people</li> <li>- Create career ladder (e.g. CNA &gt; LPN &gt; RN)</li> <li>- Establish rural physician residency programs</li> <li>- Development of CHW</li> <li>- Expand scope of practice for non-traditional providers</li> </ul>	<ul style="list-style-type: none"> <li>- Sources of financing:               <ul style="list-style-type: none"> <li>- Federal</li> <li>- State</li> <li>- Local</li> <li>- Hybrid</li> </ul> </li> <li>- Department of Labor</li> <li>- Other</li> <li>- Financial Incentives for providers</li> </ul>
<p><b>Transportation</b></p> <ul style="list-style-type: none"> <li>- Transportation barriers to health care access               <ul style="list-style-type: none"> <li>- Limitations posed by distance</li> <li>- Barriers lead to delayed care</li> </ul> </li> <li>- Limited/no public transportation</li> <li>- Impact of tourism</li> </ul>	<ul style="list-style-type: none"> <li>- Rural Transit Assistance Program</li> <li>- Innovative programs               <ul style="list-style-type: none"> <li>- Uber for Medicaid patients</li> <li>- Mobile Integrated Community Health</li> <li>- Health Mobiles</li> </ul> </li> <li>- Oregon CCO</li> <li>- Partner with the VA</li> </ul>	<ul style="list-style-type: none"> <li>- Partnerships               <ul style="list-style-type: none"> <li>- Medicaid</li> <li>- VA</li> <li>- Local transport</li> <li>- EMS</li> </ul> </li> <li>- Linking specialists with PCP clinics to enhance access to telehealth</li> <li>- Financial incentives</li> </ul>

# Examples of Emerging Rural Specific Models and their Components

- Health Care Innovation Awards (ongoing)
  - Tests a wide range of innovative projects to deliver better health, improved care, and lower costs via Medicare, Medicaid and the Children's Health Insurance Program (CHIP), particularly for beneficiaries with the highest healthcare needs. Includes projects that serve rural populations. (CMMI)
- Rural Community Hospital Demonstration (ongoing)
  - Cost-based reimbursement for small rural hospitals too large to be Critical Access Hospitals. Examines the community benefits and financial impact for participating hospitals. (CMS)
- Frontier Extended Stay Clinics (demonstration complete)
  - An enhanced clinic model in frontier areas to address the needs of seriously ill or injured patients who cannot be transferred to a hospital, or who need monitoring and observation for a limited period of time. (CMS and FORHP)
- Frontier Community Health Integration Program (ongoing)
  - Developing and testing new models for the delivery of healthcare services in frontier areas through improving access to, and better integration of, the delivery of healthcare to Medicare beneficiaries. (CMS and FORHP)

Source: Rural Health Information Hub, <https://www.ruralhealthinfo.org/new-approaches>

# Financing Options: Payment and Delivery Models

## Quality Payment Program

### Advanced Alternative Payment Models (APMs)

- The list of care models each year that qualify for APM incentive payments will be put out by the Centers for Medicare and Medicaid Services (CMS)
- Clinicians who qualify will not receive a MIPS payment adjustment and will instead receive a 5% Medicare Part B incentive payment.
- Qualifying APMs must:
  - Be able to take on a certain amount of financial risk
  - Use comparable quality measures to those used in MIPS
  - Use certified electronic health record (EHR) technology
- Maryland will seek to CMS to designate the Global Payment Model as a qualifying APM

### Merit-Based Incentive Payment System (MIPS)

- MIPS combines Medicare Meaningful Use (MU), Physician Quality Reporting System (PQRS) and Value-Based Modifier (VBM) programs
- Payment adjustments are applied to Medicare Part B payments two years after the performance year
- The MIPS composite score includes:
  - Quality
  - Advancing Care Information
  - Clinical Practice Improvement Activities
  - Resource Use
- This composite score determines the eligible clinician performance (CPS). The CPS in a given performance year determines the MIPS payment adjustments in the second calendar year.

# Financing Options: Payment and Delivery Models

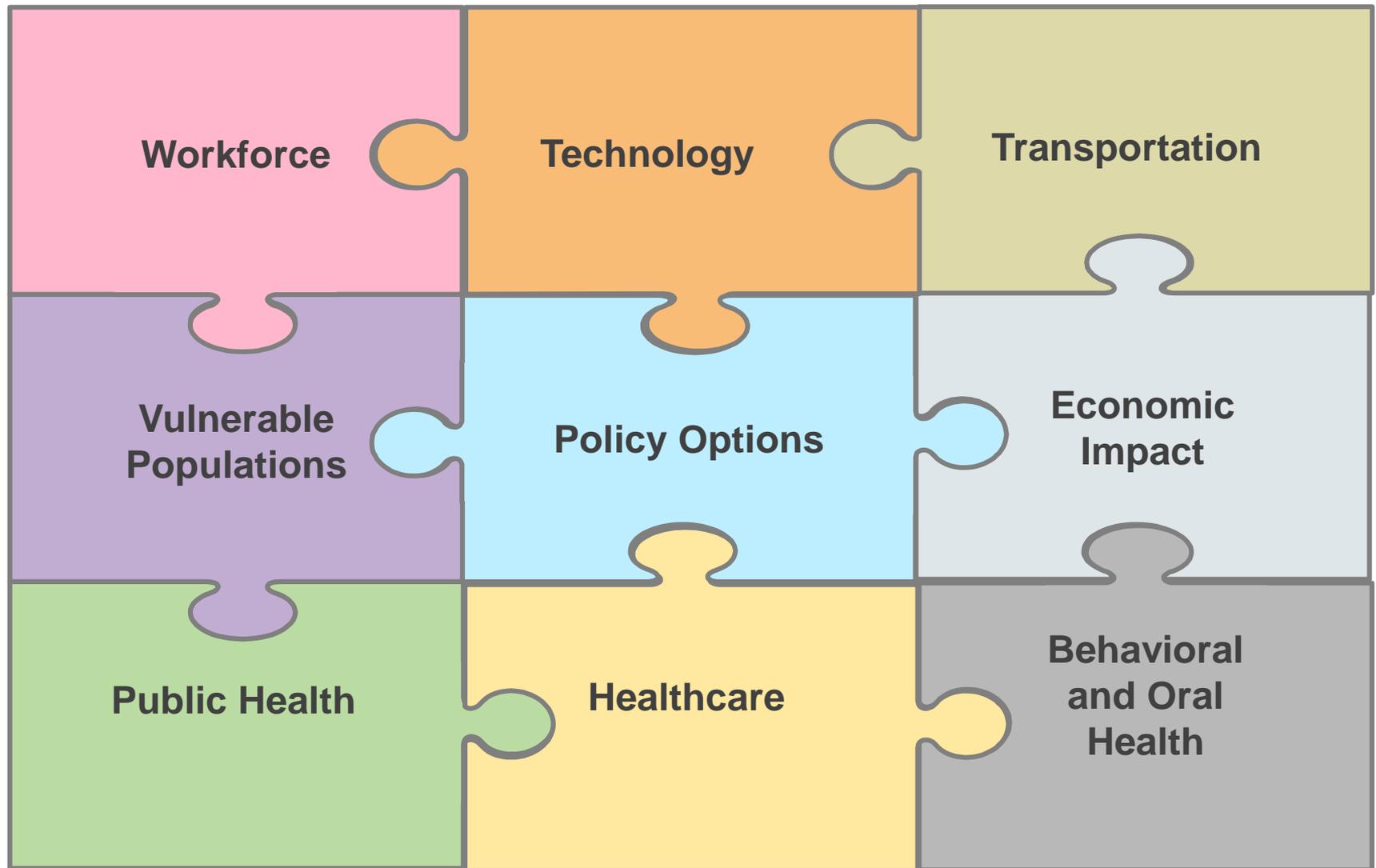
Accountable Care Organizations	Comprehensive Primary Care Plus (CPC+) Program	Global Payment Amendments
<ul style="list-style-type: none"> <li>- Groups of physicians, hospitals, and other health care providers, who comes together voluntarily to give coordinated high quality care to their Medicare patients.</li> <li>- Medicare ACO programs:               <ul style="list-style-type: none"> <li>▪ Medicare Shared Savings Program—a program that helps a Medicare fee-for-service program providers become an ACO. Apply Now.</li> <li>• Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program.</li> <li>• Pioneer ACO Model—a program designed for early adopters of coordinated care. No longer accepting applications.</li> <li>• <u>Maryland has &gt; 20 ACOs</u></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- National advanced primary care medical home model</li> <li>- Provides practices with a robust learning system with actionable patient-level cost and utilization data feedback, to guide their decision making</li> <li>• Payment under the Medicare Physician Fee Schedule:               <ul style="list-style-type: none"> <li>▪ Track 1: Bill and receive payment as usual.</li> <li>▪ Track 2: Continue to bill as usual, but the E&amp;M FFS payment is reduced to account for CMS shifting a portion of the Medicare FFS payments into capitated Comprehensive Primary Care Payments (CPCP)</li> <li>▪ Maryland is developing a CPC+ like model as part of its Phase 2 Global Budget Application</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Hospital Care Improvement Program (HCIP) will be implemented by hospitals and to improves efficiency and quality of inpatient episodes of care - by encouraging effective care transitions; encouraging effective management of inpatient</li> <li>• The Chronic Care Improvement Program (CCIP) will link the hospitals' efforts in managing the care of current high-utilizing patients and rising risk patients with the primary care providers' efforts to care for the same populations.</li> </ul>

# Global Budget Initiative: Commonwealth of Pennsylvania

- Proposal to implement a multi-payer global budget initiative in rural Pennsylvania
  - 2016 – 6 rural hospitals
  - 2019 – + 12 to participate
  - 2020 – 30 rural hospitals
  - Key aspects:
    - Focus on population health management
    - Role of telehealth
    - Value-based payment strategy



# Inter-related Issues



Alana Knudson, PhD

Email: [knudson-alana@norc.org](mailto:knudson-alana@norc.org)

Phone: 301-634-9326

Rebecca Oran, BA

[oran-rebecca@norc.org](mailto:oran-rebecca@norc.org)

301-634-9375

Dushanka Kleinman, DDS, M.Sc.D.

[dushanka@umd.edu](mailto:dushanka@umd.edu)

301-405-7201

Luisa Franzini, PhD

[Franzini@umd.edu](mailto:Franzini@umd.edu)

301-405-2470

Thank You!

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