WASHINGTON RURAL HEALTH ACCESS PRESERVATION

Enabling Rural Hospitals in Washington State To Survive and Thrive
Origin and Goals of WRHAP Project

• WSHA/DOH New Blue H Project
  – Identified issues threatening sustainability of healthcare in rural areas
  – Organized the Washington Rural Health Access Preservation Project
  – Identified most vulnerable hospitals

• Healthier Washington Initiative
  – Goal of improving healthcare and moving to value-based payment
  – Payment Model 2: Payment Reform for Rural Communities
  – Federal State Innovation Model (SIM) grant providing financial support to develop payment reforms for rural healthcare providers

• Initial WRHAP Meeting in June 2015
  – WSHA, DOH, HCA, Commissioners and CEOs/CFOs of PHDs
  – Discussed and prioritized problems
  – Identified potential solutions
  – Hospitals agreed to participate in a planning process
Focus: 13 Financially Vulnerable Critical Access Hospitals
# Public Hospital Districts Serving Small, Isolated Rural Communities

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Population Served</th>
<th>ED Visits/Day</th>
<th>Average Acute/Swing Census</th>
<th>Clinic Visits/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odessa Memorial Hospital</td>
<td>1,300</td>
<td>1</td>
<td>23</td>
<td>16</td>
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<tr>
<td>Garfield County Hospital</td>
<td>2,250</td>
<td>1</td>
<td>21</td>
<td>19</td>
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<tr>
<td>East Adams Rural Healthcare</td>
<td>3,000</td>
<td>3</td>
<td>0.3</td>
<td>17</td>
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<td>Ferry County Memorial Hospital</td>
<td>4,980</td>
<td>6</td>
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<tr>
<td>Dayton Hospital</td>
<td>5,600</td>
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<td>43</td>
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<td>Morton General Hospital</td>
<td>7,800</td>
<td>14</td>
<td>16</td>
<td>41</td>
</tr>
<tr>
<td>Willapa Harbor Hospital</td>
<td>8,300</td>
<td>11</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>North Valley Hospital</td>
<td>10,100</td>
<td>12</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Forks Community Hospital</td>
<td>10,300</td>
<td>16</td>
<td>5</td>
<td>83</td>
</tr>
<tr>
<td>Cascade Medical Center</td>
<td>10,650</td>
<td>8</td>
<td>4</td>
<td>56</td>
</tr>
<tr>
<td>Three Rivers Hospital</td>
<td>14,400</td>
<td>9</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Mid-Valley Hospital</td>
<td>15,500</td>
<td>26</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Columbia Basin Hospital</td>
<td>15,600</td>
<td>13</td>
<td>15</td>
<td>56</td>
</tr>
</tbody>
</table>
Significant, Persistent Financial Losses
Losses Covered by Local Taxes, Highest Rates in Smallest PHDs

![Taxes Per Capita 2015 Graph]

- Garfield
- East Adams
- Odessa
- Ferry County
- Dayton
- Three Rivers
- Cascade
- Columbia Basin
- North Valley
- Willapa Harbor
- Morton
- Forks
- Mid-Valley
Travel Times Would Increase 20-60 Minutes if Hospital Closed
w/o Hospitals, Travel Time to ED Would Go Up 25+ Min. for 75,000
Focus of Work Over Past 2 Years

• Why are WRHAP hospitals having financial difficulties?
  – Which service lines are causing financial problems?
  – Are costs too high?
  – Are payments too low?
  – Should services be delivered in different ways?

• What are the problems with the current payment systems?
  – Do they support or penalize high-quality care?
  – Do they support or penalize efficient care delivery?

• Which alternative payment models would better support high-quality health care services in small rural communities?

• Are there ways to provide better/higher payment to rural hospitals without increasing overall healthcare spending?

• How can we explain all of this to policy-makers & payers and convince all payers to participate?
Data Collection Required to Enable Detailed Analysis

• Challenges
  – Net revenue by service line is not available in standard financial reports
    • Total charges by service line are available, but deductions from revenue are only shown in aggregate
  – Service line margins by payer are not available in standard reports
    • Different payers pay different amounts that may or may not cover costs
  – Multiple payment systems with complex rules for each one
  – Cost and utilization in one service line affects staffing and costs allocated to other service lines

• Solutions
  – 10 WRHAP hospitals provided more detailed information for analysis
    • Cascade, Columbia Basin, Dayton, East Adams, Garfield, Mid-Valley, Morton, Three Rivers, North Valley
  – Simulation models developed to estimate impacts of changes in costs, utilization, and alternative payment models
Findings: 5 Service Lines Cause Hospital Deficits

- **Rural Health/Primary Care Clinics**
  - 100% of WRHAP PHDs analyzed had significant clinic losses in 2015
  - On average, clinic revenues only covered 2/3 of clinic costs
  - Clinics are largest contributor to overall deficits (30% or more of total)

- **Emergency Department**
  - 80% of WRHAP PHDs had losses on ED visits
  - Payments for ancillary services during ED visits reduced losses, but 40% of WRHAP PHDs had losses even with ancillary revenues

- **Nursing Home/Assisted Living**
  - 100% of WRHAP PHDs with nursing and/or assisted living facilities had losses

- **Ambulance**
  - 100% of WRHAP PHDs with ambulance services had significant deficits

- **Inpatient Services**
  - 70% of WRHAP PHDs had losses on inpatient services
  - Payments for ancillary services during admissions reduced losses, but 30% of WRHAP PHDs had losses even with ancillary services
Operating Margins by Service Line

Operating Margins by Service Line at WRHAP PHDs 2015
Three Services Identified as Priorities for Payment Reform

• Emergency Department Services
  – Emergency services are essential for retaining/attracting businesses & residents in small communities

• Rural Health Clinic Services
  – Access to primary care is essential for promoting health of residents and reducing overall spending on healthcare
  – Communities cannot attract/retain independent primary care providers and need hospital-based clinics

• Nursing and Long-Term Care Services
  – Needed to enable elderly residents to return home from the hospital and to remain in the community
  – Communities currently lack access to home health & hospice services
Causes of Deficits for ED Visits

• Costs are high because of low volume, not inefficiency
  – WRHAP EDs average 1-26 visits per day, even though providers at most of the hospitals could handle as many as 60-70 visits per day
  – Hospital must pay providers to be on call regardless of # of visits, so cost of staffing the ED is fixed and average cost per visit is high

• Visit payments are below cost
  – Commercial Health Plans: Payments are below cost per visit in smaller hospitals
  – Uninsured: Some communities have large number of uninsured patients who use the ED for care but cannot afford to pay full cost
  – Medicare: Pays only 99% of the costs of ED visits
  – Medicaid: Payment amounts are intended to cover costs, but MCO payments are not reconciled to actual costs
ED Visit Margins by Payer

Margins by Payer for WRHAP Emergency Departments 2015

- Medicare
- Medicaid + Apple Health
- Commercial
- Self-Pay/Unk.
- Total

Key:
- Median
- Odessa
- Garfield
- Dayton
- East Adams
- Cascade
- Three Rivers
- Columbia Basin
- North Valley
- Morton
- Mid-Valley
Causes of Deficits for Rural Health/Primary Care Clinics

- **Costs are high because of low volume, not inefficiency**
  - WRHAP clinics have 4,000-6,000 visits per year, whereas a primary care physician in an urban area may have 6,000-7,000 visits per year
  - Hospital must pay to have providers staff the clinic regardless of the # of visits, so the cost per visit is high

- **Visit payments are below cost**
  - **Commercial health plans:** payment rate for primary care visits is below average cost of delivering a visit
  - **Medicaid MCOs:** Payments are below the average cost of a visit, and the encounter rates have not been rebased to costs in years
    - In 5 of 10 clinics, encounter rates were 35-46% lower than cost in 2015
  - **Medicare:** Pays only 99% of allowable costs for Rural Health Clinics, and it reduces payments further if physician visits are below productivity standards which may be impossible to meet in rural areas
Clinic Margins by Payer

Margins by Payer for WRHAP Rural Health Clinics 2015

- Medicare
- Medicaid + Apple Health
- Commercial
- Self-Pay
- Total

Payers:
- Median
- East Adams
- Morton: Riffe
- Morton: Randle
- Garfield
- Odessa
- Columbia Co.: Waitsburg
- Columbia Co.: Columbia
- Mid-Valley
- Columbia Basin
- Cascade
**Most ED and Clinic Patients are Medicaid/Medicare Beneficiaries**

<table>
<thead>
<tr>
<th>Payer</th>
<th>ED Visits</th>
<th>Clinic Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/MCO</td>
<td>36%</td>
<td>39%</td>
</tr>
<tr>
<td>Medicare</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Commercial</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Average Distribution of Visits by Payer in 2015 for 6 WRHAP Hospitals
Causes of Deficits in Long-Term Care Services

• Medicaid payments for long-term nursing care and assisted living services are lower than the cost of delivering care
  – Costs at WRHAP facilities averaged $200-$400/day, but Medicaid payments were only $140-$170 per day

• Pro-Share Supplemental Payments reduce the deficits for nursing care but do not eliminate them

• Medicare does not pay for long-term nursing care services in separate facilities, but Medicare does indirectly pay for a portion of the cost of long-term nursing care services if they are delivered in a swing bed and if the hospital also has Medicare acute inpatients or skilled nursing facility (SNF) patients during the year
Nursing Care and Assisted Living Facility Margins by Payer

Margins in WRHAP Nursing and Assisted Living Facilities by Payer 2015

- Medicaid
- Pro-Share
- Other
- Total

- Columbia Basin NF
- Dayton NF
- North Valley
- Columbia Basin AL
- Odessa AL
Inadequate Support for Rural Health Services

- Current Rural Health Clinic and primary care payments do not support delivery of Patient-Centered Medical Home services
  - No payment for phone/email contacts or services delivered to patients by nurses that could avoid need for a clinic or ED visit; payment is only made for face-to-face visits with physicians, nurse practitioners, and physician assistants
  - No payment for care management/coordination to help ensure patients get the services they need and avoid duplication, medication conflicts, etc.
  - No payment for behavioral health services delivered directly in clinic in coordination with physical health services

- Helping patients avoid Emergency Department visits or inpatient admissions would increase the hospital’s deficit
  - ED and inpatient admission payments are based on the number of visits/admits or the payer’s share of total visits/admits, so revenue decreases if visits/admits decrease, but cost of staffing ED and inpatient unit does not change
  - Payments for ancillary services would also decrease if visits/admits decrease

- Inadequate payment and regulatory barriers limit access to home health services that could avoid admissions & nursing facility stays
  - Payment rates do not support in-home services in sparsely-populated areas and hospitals/clinics cannot provide cost-based services unless there is no home health agency
“Cost-Based Payment” Isn’t As Good As It Sounds

Weaknesses of Current Payment System

- Medicare only pays 99% of costs, and not all costs are covered
- No reconciliation to ensure Medicaid MCO rates matched actual cost
- Only the portion of costs attributed to Medicare & Medicaid patients based on # of visits is covered
Insurance Payments for Visits May or May Not Cover Cost

Current Payment for ED Services

<table>
<thead>
<tr>
<th>Payment</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Payments for Visits</td>
<td></td>
</tr>
<tr>
<td>Cost-Based Payment from Medicare &amp; Medicaid</td>
<td></td>
</tr>
<tr>
<td>Costs Attributed to Other Insured Patients</td>
<td></td>
</tr>
<tr>
<td>Costs Attributed to Medicare &amp; Medicaid Patients Based on # of Visits</td>
<td></td>
</tr>
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Weaknesses of Current Payment System

- Medicare only pays 99% of costs, and not all costs are covered
- No reconciliation to ensure Medicaid MCO rates matched actual cost
- Only the portion of costs attributed to Medicare & Medicaid patients based on # of visits is covered
- Fee for service payments for insured patients are below cost per visit in smaller hospitals
Lower Volume Hospitals Lose Money at Standard Payment Rates

Number of ED Visits

Cost Per ED Visit

Average Commercial ED Visit Payment
Nobody Covers the Cost Attributed to Uninsured Patients

Weaknesses of Current Payment System

- Medicare only pays 99% of costs, and not all costs are covered
- No reconciliation to ensure Medicaid MCO rates matched actual cost
- Only the portion of costs attributed to Medicare & Medicaid patients based on # of visits is covered
- Fee for service payments for insured patients are below cost per visit in smaller hospitals
- Serving uninsured patients reduces cost-based payments and increases deficits
Is There a Better Way?

Current Payment for ED Services

- Loss
- Insurance Payments for Visits
- Cost-Based Payment from Medicare & Medicaid
- Costs for Uninsured Patients
- CostsAttributed to Other Insured Patients
- CostsAttributed to Medicare & Medicaid Patients Based on # of Visits

?
Recognize that Fixed Costs Continue Regardless of Visits

Current Payment for ED Services

$\text{Loss}$

- Insurance Payments for Visits
- Cost-Based Payment from Medicare & Medicaid

Costs for Uninsured Patients

- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicare & Medicaid Patients Based on # of Visits

$\text{Margin}$

- Variable Costs of Visits
- Fixed Costs Of Operating ED

Based on # of Visits
Pay for Fixed Costs With a Per-Resident Payment

Current Payment for ED Services

- Loss
- Insurance Payments for Visits
- Cost-Based Payment from Medicare & Medicaid
- Costs for Uninsured Patients
- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicare & Medicaid Patients Based on # of Visits

Population-Based Payment for ED

- (Annual) Payment Per Insured Resident
- Variable Costs of Visits
- Fixed Costs Of Operating ED

Margin
Pay Smaller Amounts Per Visit (Larger for Non-Resident Visitors)

Current Payment for ED Services

- Costs for Uninsured Patients
- Costs attributed to other insured patients
- Cost-based payment from Medicare & Medicaid

Loss

- Insurance Payments for Visits

Population-Based Payment for ED

- Small payment per visit
- Margin
  - Variable costs of visits
  - Fixed costs of operating ED

Payment: Costs for Uninsured Patients
Payment: Costs attributed to other insured patients
Payment: Cost-based payment from Medicare & Medicaid
Cost: Margin
Cost: Variable costs of visits
Cost: Fixed costs of operating ED
Performance-Based Payment to Ensure Quality & Access

Current Payment for ED Services

- Loss
- Insurance Payments for Visits
- Cost-Based Payment from Medicare & Medicaid
- Costs for Uninsured Patients
- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicare & Medicaid Patients Based on # of Visits

Population-Based Payment for ED

- P4P Small Payment Per Visit
- (Annual) Payment Per Insured Resident
- Margin
- Variable Costs of Visits
- Fixed Costs Of Operating ED

Payment | Cost
--- | ---
Population-Based Payment for Emergency Department Services

Current Payment for ED Services

- **Loss**
  - Insurance Payments for Visits
  - **Cost-based Payment from Medicare & Medicaid**

- **Costs**
  - Costs for Uninsured Patients
  - Costs attributed to other insured patients
  - Costs associated with Medicare & Medicaid patients based on # of visits

Population-Based Payment for ED

- **P4P** Small Payment Per Visit
  - (Annual) Payment Per Insured Resident

- **Margin**
  - Variable Costs of Visits
  - Fixed Costs of Operating ED

**Payment**  |  **Cost**
Fixed Costs of ED Are Sustained Regardless of Volume of Visits

Population-Based Payment for ED

<table>
<thead>
<tr>
<th>Payment</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Per Visit $</td>
<td>Fixed Costs Of Operating ED</td>
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<tr>
<td>(Annual) Payment Per Insured Resident</td>
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Population-Based Payment for ED

<table>
<thead>
<tr>
<th>Payment</th>
<th>Cost</th>
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</thead>
<tbody>
<tr>
<td>Per Visit $</td>
<td>Fixed Costs Of Operating ED</td>
</tr>
<tr>
<td>(Annual) Payment Per Insured Resident</td>
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</tbody>
</table>

Margin

Few Visits

Many Visits
Proposed Three-Part Alternative Payment Model for ED

1. Population-Based Payment
   - Medicare, Medicaid, and major commercial payers pay the hospital an annual “membership fee” for each of their insured residents living in the community to support access to the Emergency Department
   - Payment amount is based on the proportion of the residents of the community insured by the payer and the estimated cost of staffing an ED to meet the expected volume of need for the community
   - Achieves a result similar to the Maryland global payment model without requiring a full rate regulation system

2. Per-Visit Payment
   - Patients/payers who do not reside in the community or participate in the population-based payment continue to pay for each visit but at a much lower rate than today

3. Performance-Based Payment (P4P)
   - Population-Based Payment and Per-Visit Payments are adjusted based on the hospital’s performance in delivering quality care and addressing residents’ emergency service needs locally rather than in other EDs
A Similar Approach Could Be Used for Inpatient & Ancillary Svcs

Cost-Based Payment + Commercial FFS

- Loss
- Costs for Uninsured Patients
- Costs for Services from Medicare & Medicaid
- Costs for Services from Medicare & Medicaid for Services

Payment | Cost
---|---
Insurance Payments for Services | Costs for Services to Medicare & Medicaid Patients
Costs for Services Based on Amount of Services | Costs for Services to Other Insured Patients

Population-Based Payment

- Small Payment Per Service
- (Annual) Payment Per Insured Resident
- Variable Costs of Services
- Fixed Costs of Operating Inpatient & Ancillary Services

Payment | Cost
---|---
Small Payment Per Service | (Annual) Payment Per Insured Resident
Variable Costs of Services | Fixed Costs of Operating Inpatient & Ancillary Services
WA Health Care Authority Proposed a Trended Global Budget

- Cost-Based Payment + Commercial FFS
- Costs for Uninsured Patients
  - Insurance Payments for Services
  - Costs for Other Insured Patients
    - Costs Attributed to Medicare & Medicaid Patients Based on Amount of Services
- Loss
- State Proposal for Global Budget
  - Global Budget for Hospital Services Based on Net Revenue in Base Year
    - Inflation
  - Global Budget for Hospital Services Based on Net Revenue in Base Year
    - Inflation
  - Global Budget for Hospital Services Based on Net Revenue in Base Year
    - Inflation
WRHAP Hospital Costs Have Increased More Than Inflation

Cost-Based Payment + Commercial FFS

- Loss
- Insurance Payments for Services
- Cost-Based Payment from Medicare & Medicaid
- Costs for Uninsured Patients
- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicare & Medicaid Patients Based on Amount of Services

State Proposal for Global Budget

- Global Budget for Hospital Services Based on Net Revenue in Base Year
- Global Budget for Hospital Services Based on Net Revenue in Base Year
- Global Budget for Hospital Services Based on Net Revenue in Base Year
- Inflation
- Inflation
- Increase in Cost

Cost of Delivering Services
Budget Based on Past Revenues & Low Trend Would Increase Losses

Cost-Based Payment + Commercial FFS

- Costs for Uninsured Patients
- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicare & Medicaid Patients Based on Amount of Services

State Proposal for Global Budget

- Global Budget for Hospital Services Based on Net Revenue in Base Year
- Global Budget for Hospital Services Based on Net Revenue in Base Year
- Global Budget for Hospital Services Based on Net Revenue in Base Year

Increase in Cost

- Inflation
- Inflation
- Cost of Delivering Services

Loss

Insurance Payments for Services

Cost-Based Payment from Medicare & Medicaid

Cost

Payment

Cost

Payment

Cost
Payers Want to Encourage Efficiency in Care Delivery…

Cost-Based Payment + Commercial FFS

- Loss
  - Insurance Payments for Services
  - Cost-Based Payment from Medicare & Medicaid
  - Costs for Uninsured Patients
  - Costs attributed to Other Insured Patients
  - Costs attributed to Medicare & Medicaid Patients Based on Amount of Services

State Proposal for Global Budget

- Global Budget for Hospital Services Based on Net Revenue in Base Year
- Increase in Cost
- Loss
- Inflation

Ways to Reduce Cost??

- Global Budget for Hospital Services Based on Net Revenue in Base Year
- Cost of Delivering Services
- Inflation
- Lower Costs

Payment  Cost  Payment  Cost  Payment  Cost
So WRHAP PHDs Need to Show Costs Are As Low As Possible

Cost-Based Payment + Commercial FFS

- Loss
- Insurance Payments for Services
- Cost-Based Payment from Medicare & Medicaid
- Costs for Uninsured Patients
- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicare & Medicaid Patients Based on # of Visits
- Cost of Delivering Services
- Lower Costs

Ways to Reduce Costs
Current Visit-Based Payments for Clinic Services

Weaknesses of Current Payment System

• Medicare only pays 99% of costs, and not all costs are covered

• Only the portion of costs attributed to Medicare patients based on # of visits is covered
Current Visit-Based Payments for Clinic Services

Weaknesses of Current Payment System

• Medicare only pays 99% of costs, and not all costs are covered
• Only the portion of costs attributed to Medicare patients based on # of visits is covered
• Medicaid MCO encounter payments are far below cost of visits
**Current Visit-Based Payments for Clinic Services**

**Weaknesses of Current Payment System**
- Medicare only pays 99% of costs, and not all costs are covered
- Only the portion of costs attributed to Medicare patients based on # of visits is covered
- Medicaid MCO encounter payments are far below cost of visits
- Fee for service payments for insured patients are below cost per visit
Current Visit-Based Payments Do Not Cover Costs of Clinic

Weaknesses of Current Payment System
- Medicare only pays 99% of costs, and not all costs are covered
- Only the portion of costs attributed to Medicare patients based on # of visits is covered
- Medicaid MCO encounter payments are far below cost of visits
- Fee for service payments for insured patients are below cost per visit
Is There a Better Way?

Visit-Based Payment

- **Loss**
  - Insurance Payments for PCP Visits
- **Medicaid Encounter Payments**
- **Medicare Cost-Based Payment for Visits**
  - Costs Attributed to Medicare Patients
  - Costs Attributed to Other Insured Patients
  - Costs Attributed to Medicaid Patients

?
Most Clinic Costs Are Fixed Regardless of # of Visits

Visit-Based Payment

- **Loss**
  - Insurance Payments for PCP Visits
  - Medicaid Encounter Payments
  - Medicare Cost-Based Payment for Visits

- **Costs**
  - Costs Attributed to Medicare Patients
  - Costs Attributed to Medicaid Patients
  - Costs Attributed to Other Insured Patients

- **Variable Costs of Operating Clinic**
- **Fixed Costs of Operating Clinic**
Pay a Predictable Amount to Manage Care for Regular Patients

Visit-Based Payment

- Insurance Payments for PCP Visits
- Medicaid Encounter Payments
- Medicare Cost-Based Payment for Visits

Costs
- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicaid Patients
- Costs Attributed to Medicare Patients

Loss

Population-Based Payment

- Variable Costs Of Operating Clinic
- Fixed Costs Of Operating Clinic

Risk-Adjusted Monthly Payment Per Enrolled Patient

Payment  Cost

Payment  Cost
Pay Per Visit for Occasional Visitors

Visit-Based Payment

- Loss
- Insurance Payments for PCP Visits
- Medicaid Encounter Payments
- Medicare Cost-Based Payment for Visits

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Costs Attributed to Other Insured Patients</td>
<td></td>
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<tr>
<td>Costs Attributed to Medicaid Patients</td>
<td></td>
</tr>
<tr>
<td>Costs Attributed to Medicare Patients</td>
<td></td>
</tr>
</tbody>
</table>

Population-Based Payment

- Variable Costs Of Operating Clinic
- Risk-Adjusted Monthly Payment Per Enrolled Patient

<table>
<thead>
<tr>
<th>Payment</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Per Visit for Non-Enrolled Patients</td>
<td></td>
</tr>
<tr>
<td>Fixed Costs Of Operating Clinic</td>
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</tbody>
</table>

Payment and Cost

- Medicare Payment
- Medicaid Encounter Payments
- Insurance Payments for PCP Visits

47
Base a Portion of Payment on Quality and Access

Visit-Based Payment

- **Loss**
  - Insurance Payments for PCP Visits
  - Medicaid Encounter Payments
  - Medicare Cost-Based Payment for Visits

Costs Attributed to Other Insured Patients
Costs Attributed to Medicaid Patients
Costs Attributed to Medicare Patients

Population-Based Payment

- **P4P**
  - Risk-Adjusted Monthly Payment Per Enrolled Patient

- **Margin**
  - Variable Costs Of Operating Clinic
  - Fixed Costs Of Operating Clinic

Payment
Cost

Payment
Cost
Population-Based Payment for Primary Care Clinic Services

Visit-Based Payment

- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicaid Patients
- Costs Attributed to Medicare Patients

Population-Based Payment

- P4P Payment Per Visit for Non-Enrolled Patients
- Risk-Adjusted Monthly Payment Per Enrolled Patient

Payment Components

- Insurance Payments for PCP Visits
- Medicaid Encounter Payments
- Medicare Cost-Based Payment for Visits

Cost Components

- Variable Costs of Operating Clinic
- Fixed Costs of Operating Clinic

Loss

- Costs attributed to other insured patients
- Costs attributed to Medicaid patients
- Costs attributed to Medicare patients

Payment

Cost
1. **Comprehensive Primary Care Services Payment (CPCSP)**

   - For patients formally enrolled with the practice, the clinic would receive a monthly, acuity-stratified payment for each patient that could be used to deliver a wide range of services, including services not currently billable or reimbursable under existing payment systems, such as care management and non-face-to-face visits.

2. **Encounter-Based Payment (EBP)**

   - For patients who are not formally enrolled for ongoing care but come to the clinic for specific services, the clinic would receive a per-visit payment.

3. **Performance-Based Payment**

   - The amounts of the CPCSP and EBP payments would be increased or decreased based on the clinic’s performance in delivering quality care and on controlling total healthcare spending.

4. **Optional Additional Monthly Payments**

   - Care Coordination/Management
   - Behavioral Health Services
   - Home Care Services
Clinic Payment Model is Similar to Medicare Medical Home Pmts

<table>
<thead>
<tr>
<th>Medicare Comprehensive Primary Care</th>
<th>WRHAP CAH Primary Care Clinic APM</th>
</tr>
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| **Comprehensive Primary Care Payment:**  
  - Per-beneficiary per month payment for attributed patients  
  - Payment amounts based on current average FFS payments per beneficiary to the practice, so practices with higher revenues under FFS continue to receive higher revenues | **Comprehensive Primary Care Services Payment:**  
  - Three tiers of monthly payment per enrolled member based on physical or behavioral health conditions and presence of serious risk factors |
| **Care Management Fee:**  
  - Five tiers of additional monthly payments per attributed beneficiary based on HCC risk scores and presence of dementia |  

| Performance Based Incentive Payment  
  - Two components based on quality/utilization  
  - Single per patient payment regardless of patient needs; reduced for poor performance | **Performance-Based Payment**  
  - Two components based on quality/utilization  
  - Payments increased or decreased based on good/poor performance  
  - Payments based on patient need as well as performance level |
|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| **Continued FFS Payments**  
  - Payments for all services to all patients but at 35%-60% of current rates | **Encounter-Based Payment**  
  - Payment per visit only for patients who are not enrolled for monthly payment |
State APM4 Proposal

Visit-Based Payment

- Medicare Cost-Based Payment for Visits
- Medicaid Encounter Payments
- Insurance Payments for PCP Visits

Costs Attributed to Medicare Patients
Costs Attributed to Medicaid Patients
Loss

State APM4 Proposal

- Quality P4P
- Payment Per Visit for Non-Assigned Patients
- Flat Per Patient Payment for Assigned Patients

Payment
Cost
Payment
State APM4 Proposal Would Not Match Costs of Small Clinics
New Payment Models Need to Pay More, Not Just a Different Way

<table>
<thead>
<tr>
<th>Emergency Department</th>
<th>Primary Care Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Payment</strong></td>
<td></td>
</tr>
<tr>
<td>Cost-Based Payment from Medicare &amp; Medicaid</td>
<td></td>
</tr>
<tr>
<td>Loss Insurance Payments for Visits</td>
<td></td>
</tr>
<tr>
<td><strong>Proposed Payment</strong></td>
<td></td>
</tr>
<tr>
<td>P4P Small Payment Per Visit</td>
<td></td>
</tr>
<tr>
<td>(Annual) Payment Per Insured Resident</td>
<td></td>
</tr>
<tr>
<td><strong>Current Payment</strong></td>
<td></td>
</tr>
<tr>
<td>Risk-Adjusted Monthly Payment Per Enrolled Patient</td>
<td></td>
</tr>
<tr>
<td>Loss Insurance Payments for PCP Visits</td>
<td></td>
</tr>
<tr>
<td>Medicaid Encounter Payments</td>
<td></td>
</tr>
<tr>
<td>Medicare Cost-Based Payment for Visits</td>
<td></td>
</tr>
<tr>
<td><strong>Proposed Payment</strong></td>
<td></td>
</tr>
<tr>
<td>P4P Payment Per Visit for Non-Enrolled Patients</td>
<td></td>
</tr>
</tbody>
</table>
Can We Afford to Pay More for CAH Services?

Current System

Improved Payment

Current Payments to Critical Access Hospital

Improved Payment for Critical Access Hospital Services

Deficits

Spending on CAH Services

$
Most Spending for Residents of WRHAP PHDs Occurs Elsewhere

Current System

Improved Payment

Total Healthcare Spending on District Residents

Spending on CAH Services

Payments for Services Delivered by Providers Outside of Public Hospital District

Current Payments to Critical Access Hospital

Improved Payment for Critical Access Hospital Services

Deficits
70-80% of Medicaid Spending Does Not Go to PHD Services

Total Medicaid Medical (Non-NH) Spending on PHD Residents, 2014

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>PHD Services</th>
<th>Other Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbia Basin Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cascade Medical Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three Rivers Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Columbia County Health System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benton General Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ferry County Memorial Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willapa Harbor Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Valley Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Adams Rural Healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forks Community Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coulee Medical Center</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A Big Increase for CAH is a Much Smaller Increase in Total Spending

Current System

Total Healthcare Spending on District Residents

Current Payments to Critical Access Hospital

Spending on CAH Services

Deficits

Improved Payment

Payments for Services Delivered by Providers Outside of Public Hospital District

Payments for Services Delivered by Providers of Critical Access Hospital Services

2% Increase

10% Increase
Loss of Local Services …

Current System

- Total Healthcare Spending on District Residents
- Spending on CAH Services

Failure of CAHs

- Current Payments to Critical Access Hospital
- Payments for Services Delivered by Providers Outside of Public Hospital District
- Deficits

CAH Closes
Loss of Local Services Could *Increase* Total Spending

- **Current System**
  - Total Healthcare Spending on District Residents
  - Spending on CAH Services
    - Current Payments to Critical Access Hospital
  - Deficits
    - Payments for Services Delivered by Providers Outside of Public Hospital District

- **Failure of CAHs**
  - Payments for Services Delivered by Providers Outside of Public Hospital District

CAH Closes
Better Payment May Save More vs. Doing Nothing

Current System

- Payments for Services Delivered by Providers Outside of Public Hospital District
- Current Payments to Critical Access Hospital
- Deficits

Improved Payment

- Improved Payment for Critical Access Hospital Services
- Savings for Payer

Failure of CAHs

- Payments for Services Delivered by Providers Outside of Public Hospital District
- CAH Closes
Medicare Spending in WRHAP Counties is Below State & U.S.
Medicare Spending for Residents of WRHAP Counties

Total Medicare Spending by County 2015
Medicaid Spending for Residents of WRHAP Districts

Medicaid 2014 PMPM Spending (Except Nursing Facility)

- Other Non-NF Spending
- WRHAP Non-NF Spending
There May Be Ways to Create Savings to Offset Higher Payments

Current System

- Total Healthcare Spending on District Residents
- Spending on CAH Services
- Payments for Services Delivered by Providers Outside of Public Hospital District
- Current Payments to Critical Access Hospital Deficits
Many Examples of Potentially Avoidable Spending

- Specialist visits for problems that could be addressed by a primary care provider
- Hospital admissions for problems that could have been avoided with better primary care
- Hospital readmissions that could have been avoided with better primary care, local rehabilitation, or home health care
- Unnecessary and duplicative laboratory tests and imaging studies
- Surgeries for back pain without an adequate trial of appropriate physical therapy
- Patients receiving fruitless treatment or dying in the hospital due to lack of hospice services
Better Payment for CAHs/RHCs Could Potentially Reduce Total $

Current System

- Avoidable Spending
  - Payments for Services Delivered by Providers Outside of Public Hospital District

Improved Payment

- Savings for Payer
  - Avoidable $
  - Payments for Services Delivered by Providers Outside of Public Hospital District

- Improved Payment for Critical Access Hospital Services

Total Healthcare Spending on District Residents

Spending on CAH Services

Deficits
Win-Win-Win for Patients, Payers, and Hospital

**Current System**
- Avoidable Spending
  - Payments for Services Delivered by Providers Outside of Public Hospital District

**Improved Payment**
- Improved Payment for Critical Access Hospital Services
  - Savings for Payer
  - Avoidable $ Payments for Services Delivered by Providers Outside of Public Hospital District

Win for Patients
Win for Payers
Win for Hospital
Instead of viewing PHD as a provider of specific services...

<table>
<thead>
<tr>
<th>CURRENT Services</th>
<th>FUTURE Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Clinic</td>
<td></td>
</tr>
<tr>
<td>Basic ED Services</td>
<td></td>
</tr>
<tr>
<td>LTC Nursing Facility</td>
<td></td>
</tr>
<tr>
<td>Low-Complexity Medical Admissions</td>
<td></td>
</tr>
<tr>
<td>Outpatient Laboratory and Imaging</td>
<td></td>
</tr>
<tr>
<td>Post-Acute Rehab</td>
<td></td>
</tr>
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NOTE: Graph not drawn to scale
Give the PHD the Resources to Manage Population Health

Current

- Primary Care Clinic
- Basic ED Services
- LTC Nursing Facility
- Post-Acute Rehab
- Low-Complexity Medical Admissions
- Outpatient Laboratory and Imaging
- Primary Care Clinic
- Care Management
- Behavioral Health
- Home Care

Future

- POPULATION HEALTH MANAGEMENT DISTRICT
  - Primary Care Medical Home
  - Emergency & Essential Services
  - Home & Community-Based Long-Term Care

NOTE: Graph not drawn to scale.
Replace Low, Complex Payments w/ a Simple, Value-Based System

CURRENT

- LTC Nursing Facility
- Post-Acute Rehab
- Low-Complexity Medical Admissions
- Outpatient Laboratory and Imaging
- Basic ED Services
- Primary Care Clinic
- Care Management
- Behavioral Health
- Home Care

FUTURE

- POPULATION HEALTH MANAGEMENT DISTRICT
  - Primary Care Medical Home
  - Emergency & Essential Services
  - Home & Community-Based Long-Term Care

Medicare: 99% of Hosp & Clinic Costs
Medicaid: 100% Hosp. Cost
Medicaid MCO State Hosp. Rate
Medicaid FFS Per Diem for NF
Commercial: Fees for Services
Medicaid/Medicaid Fees for Visits

NOTE: Graph not drawn to scale
Reducing Avoidable Spending Outside the Community

**CURRENT**

- Avoidable: High-Complexity Admits/Procedures
- Avoidable: Advanced Testing & Outpatient Procedures
- Avoidable: Specialty Consults
- Avoidable: Trauma/Severe ED
- LTC Nursing Facility
- Post-Acute Rehab
- Low-Complexity Medical Admissions
- Outpatient Laboratory and Imaging
- Basic ED Services
- Primary Care Clinic
- Care Management
- Behavioral Health
- Home Care

**FUTURE**

- **Savings**
  - COORDINATED SPECIALTY CARE
    - Tele-Consults
    - Appropriate Tertiary Services

- POPULATION HEALTH MANAGEMENT DISTRICT
  - Primary Care Medical Home
  - Emergency & Essential Services
  - Home & Community-Based Long-Term Care

**Deficit**

- Medicaid Per Diem for NF
- Commercial: Fees for Services
- Medicare/Medicaid Fees for Visits
- Medicaid MCO State Hosp. Rate
- Medicaid FFS 100% Hosp. Cost
- Medicare: 99% of Hosp & Clinic Costs
- No Payment for Care Mgt & Non-Traditional Services

**NOTE:** Graph not drawn to scale

- Performance-Based Pmt
  - FFS for Visitors & New Patients
  - Population-Based Payment for Primary Care, Emergency, IP/OP, & Long-Term Care

**CURRENT**

- Medicare: 99% of Hosp & Clinic Costs

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Next Steps

- Try to develop a proposal that meets the needs of both the WRHAP hospitals and the state and other payers
- Determine which hospitals are willing to participate as voluntary pilot sites
- Refine the details for phased implementation beginning as early as 2018