Washington State Hospital Association

Washington State Department of Health

Healthier Washington

WASHINGTON RURAL HEALTH ACCESS PRESERVATION

Enabling Rural Hospitals in Washington State To Survive and Thrive

WRHAP
Washington Rural Health Access Preservation

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

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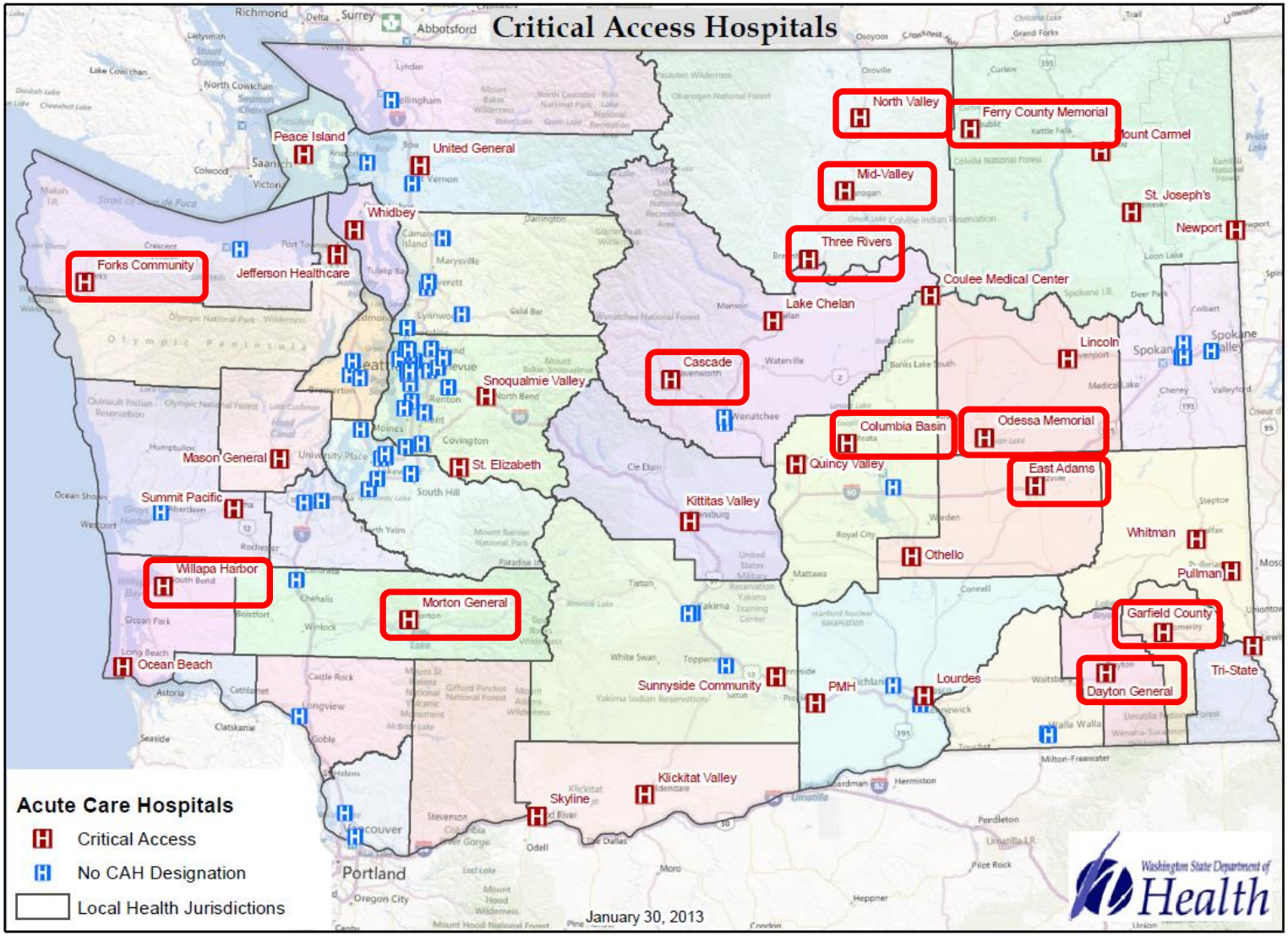
Focus: 13 Financially Vulnerable Critical Access Hospitals



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Public Hospital Districts Serving Small, Isolated Rural Communities

Hospital	Population Served	ED Visits/Day	Average Acute/Swing Census	Clinic Visits/Day
Odessa Memorial Hospital	1,300	1	23	16
Garfield County Hospital	2,250	1	21	19
East Adams Rural Healthcare	3,000	3	0.3	17
Ferry County Memorial Hospital	4,980	6	10	49
Dayton Hospital	5,600	4	10	43
Morton General Hospital	7,800	14	16	41
Willapa Harbor Hospital	8,300	11	2	12
North Valley Hospital	10,100	12	7	22
Forks Community Hospital	10,300	16	5	83
Cascade Medical Center	10,650	8	4	56
Three Rivers Hospital	14,400	9	3	5
Mid-Valley Hospital	15,500	26	7	0
Columbia Basin Hospital	15,600	13	15	56

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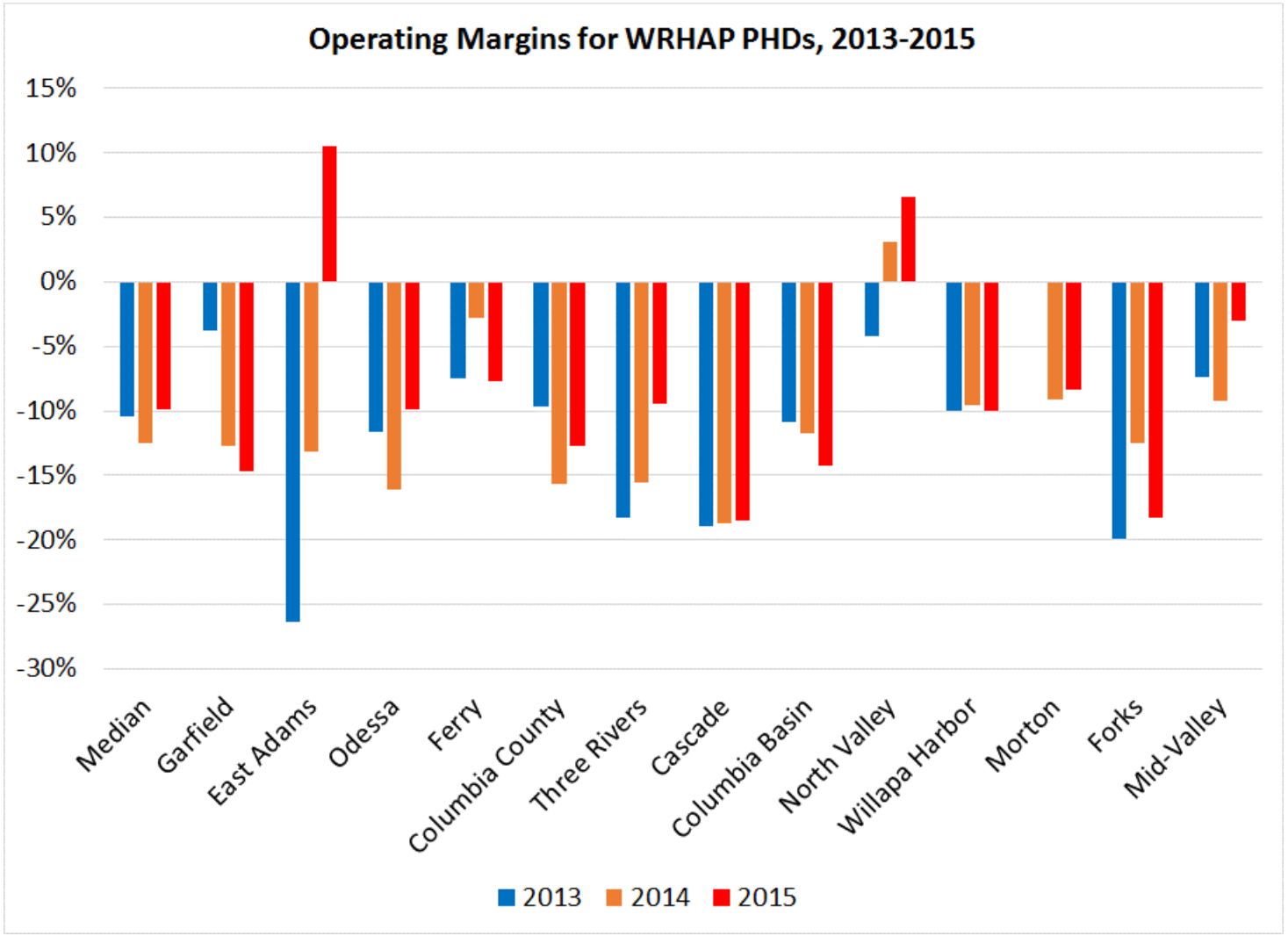
Significant, Persistent Financial Losses



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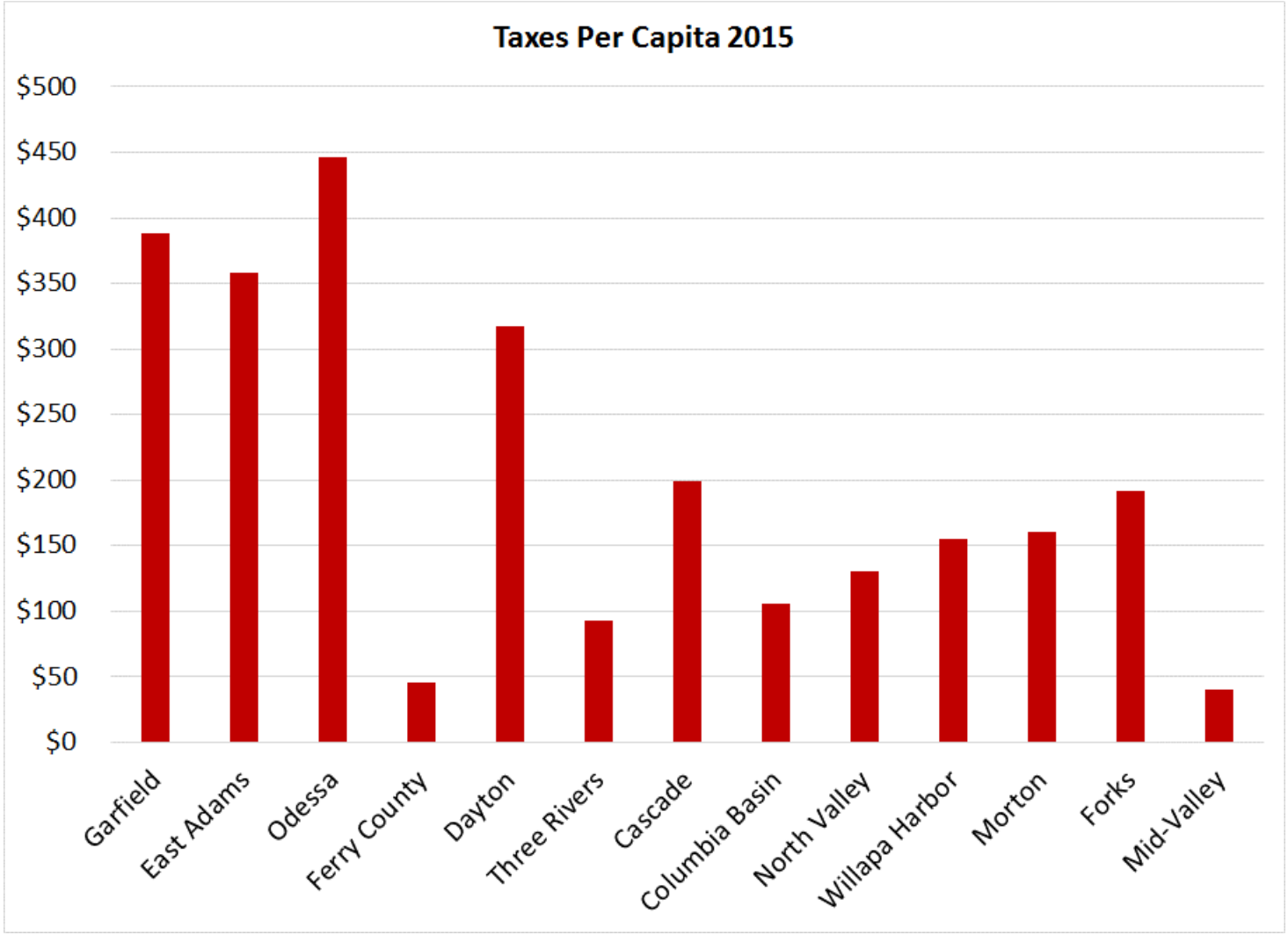
Losses Covered by Local Taxes, Highest Rates in Smallest PHDs



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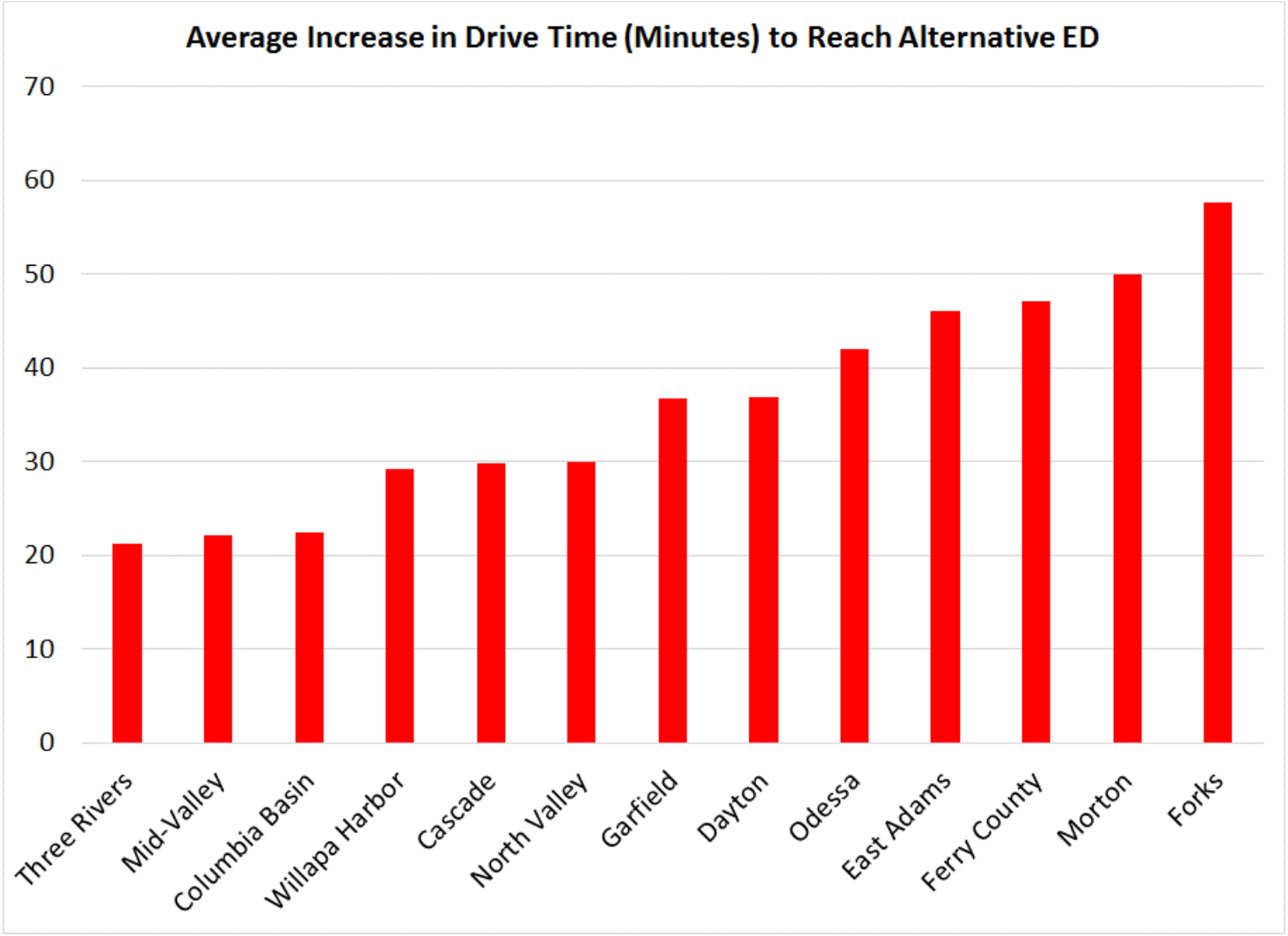
Travel Times Would Increase 20-60 Minutes if Hospital Closed



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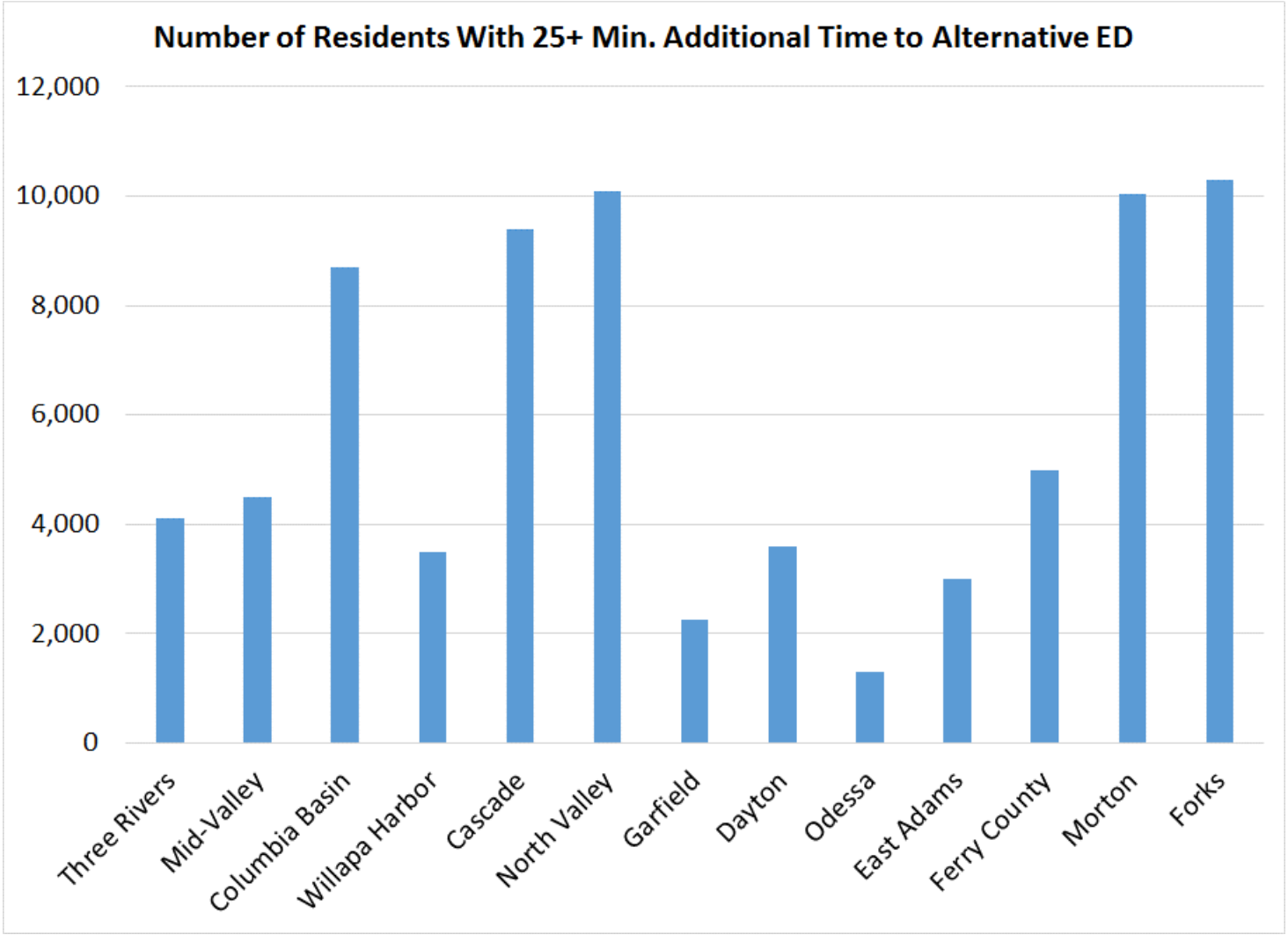
w/o Hospitals, Travel Time to ED Would Go Up 25+ Min. for 75,000



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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?

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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

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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

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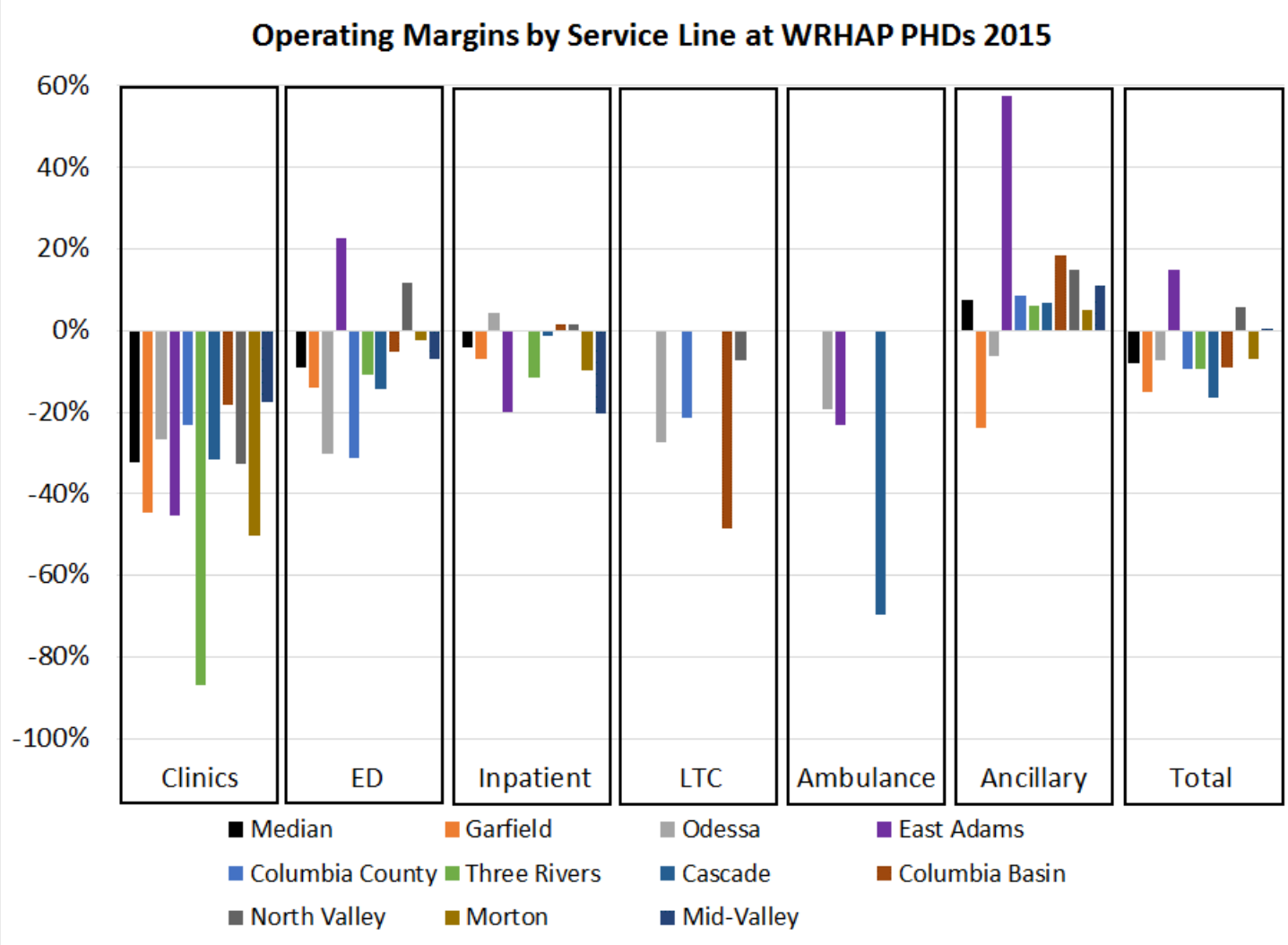
Operating Margins by Service Line



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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

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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

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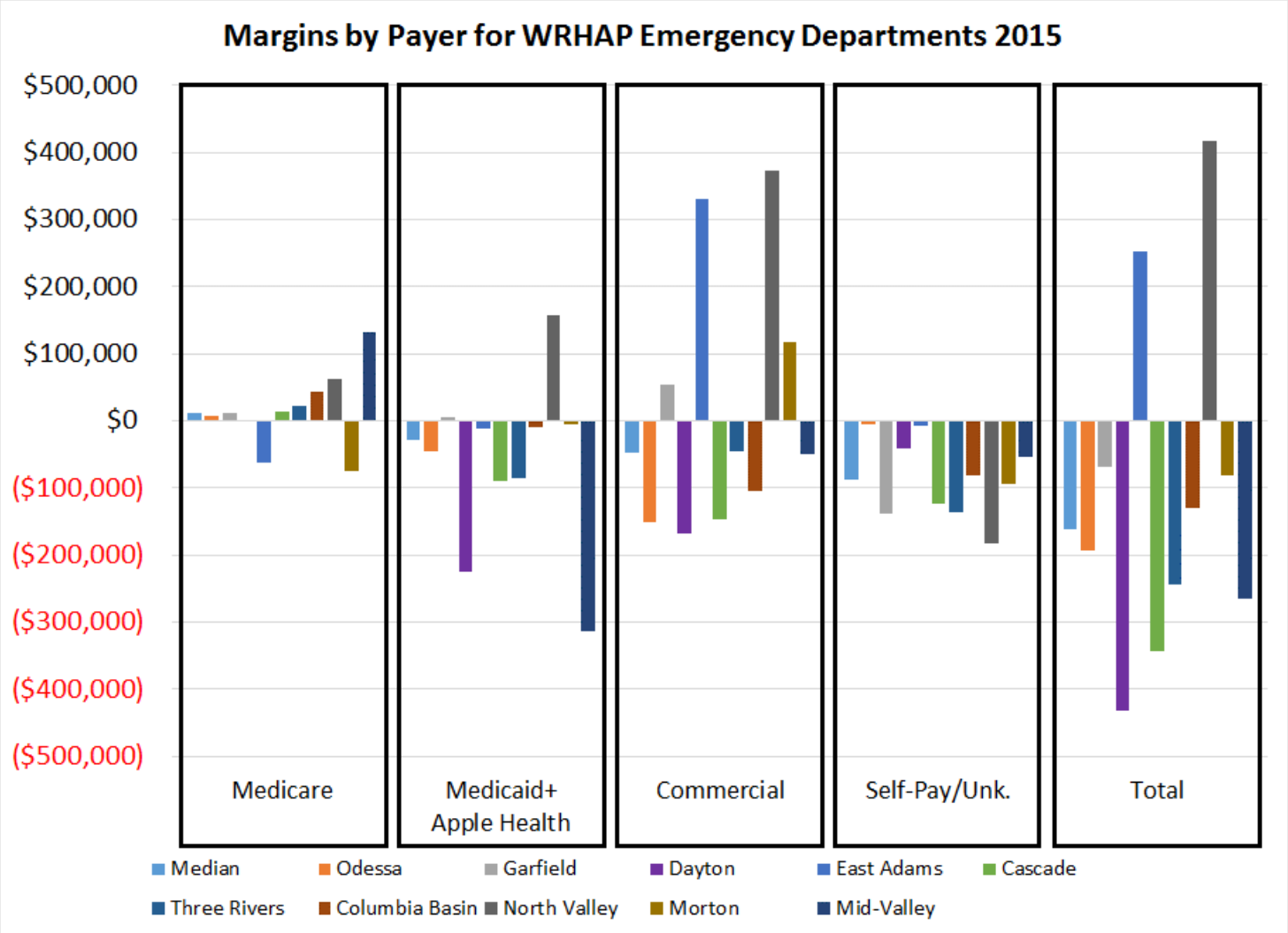
ED Visit Margins by Payer



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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

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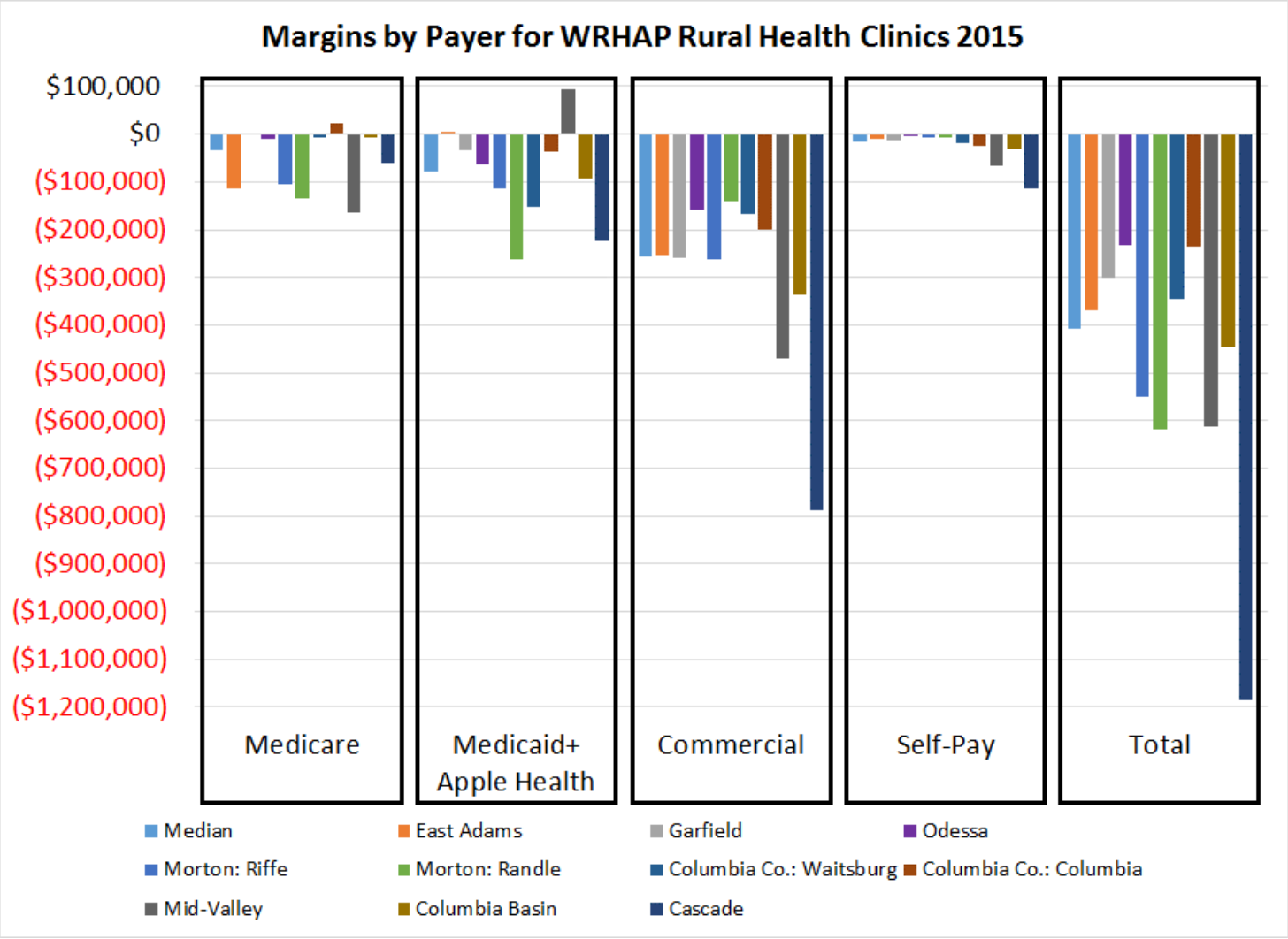
Clinic Margins by Payer



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Most ED and Clinic Patients are Medicaid/Medicare Beneficiaries

	ED Visits	Clinic Visits
Medicaid/MCO	36%	39%
Medicare	25%	29%
Medicare Advantage	3%	5%
Commercial	27%	23%
Self-Pay	8%	5%
Total	100%	100%

Average Distribution of Visits by Payer in 2015
for 6 WRHAP Hospitals

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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

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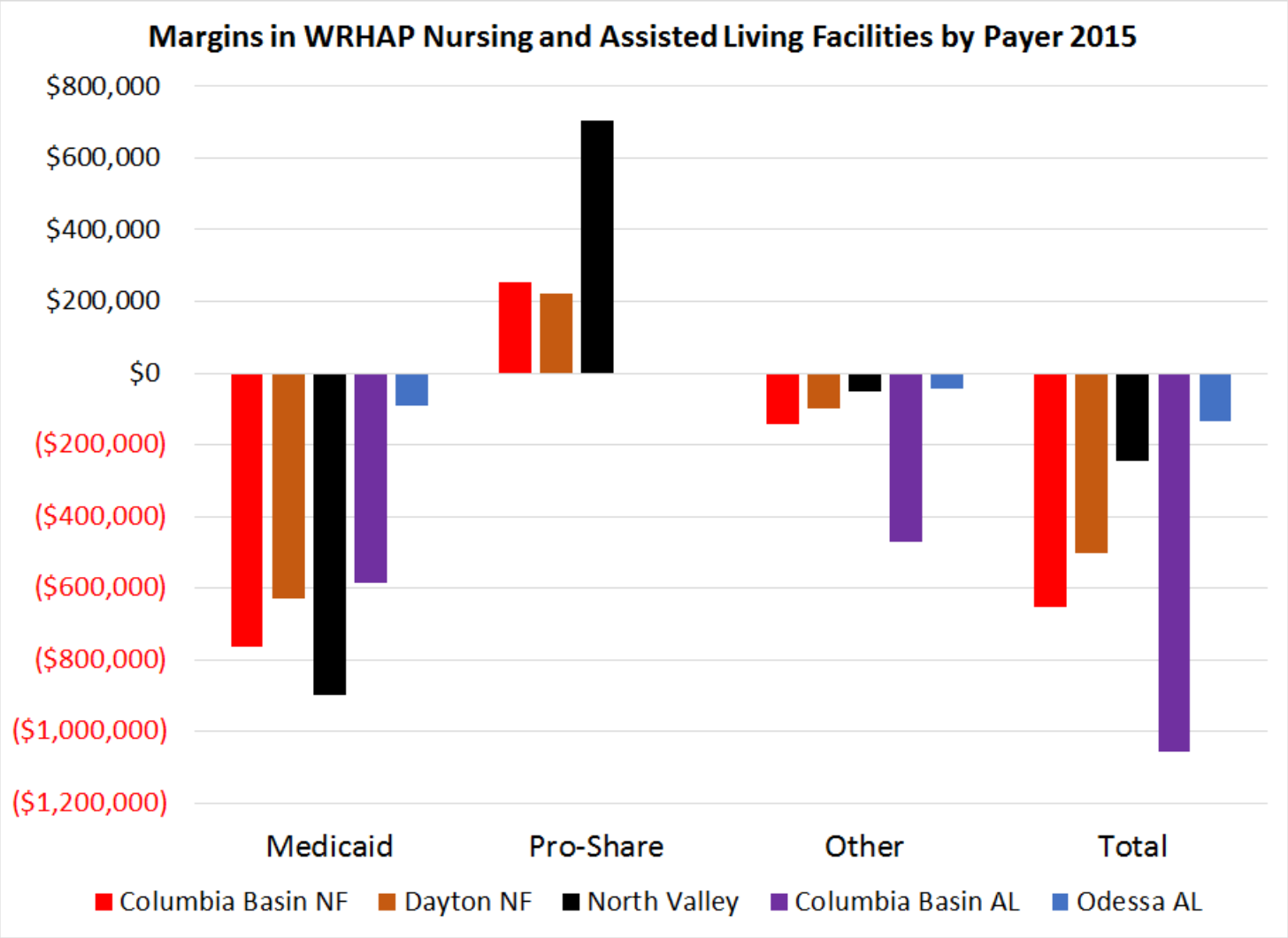
Nursing Care and Assisted Living Facility Margins by Payer



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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

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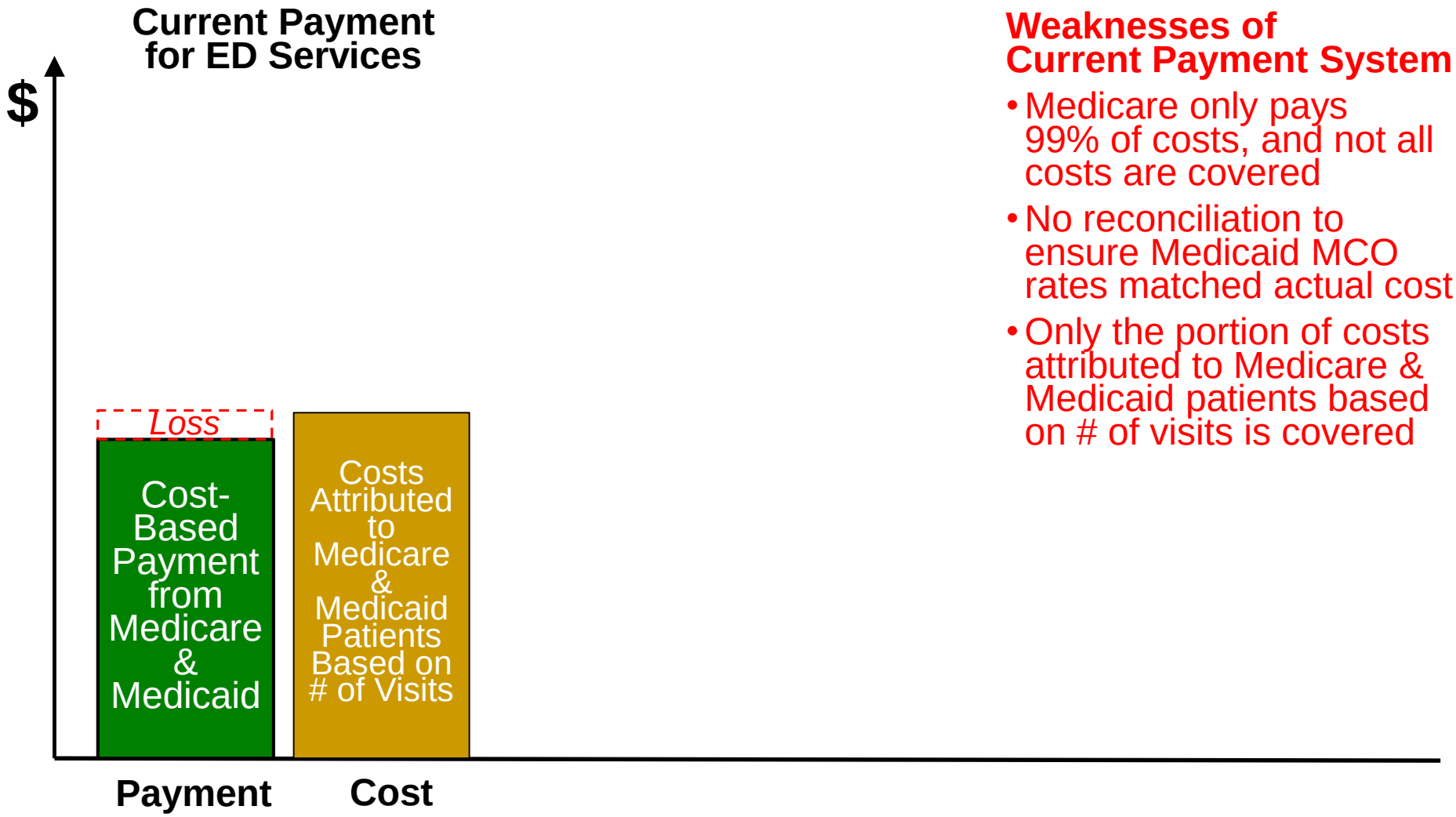
"Cost-Based Payment" Isn't As Good As It Sounds



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

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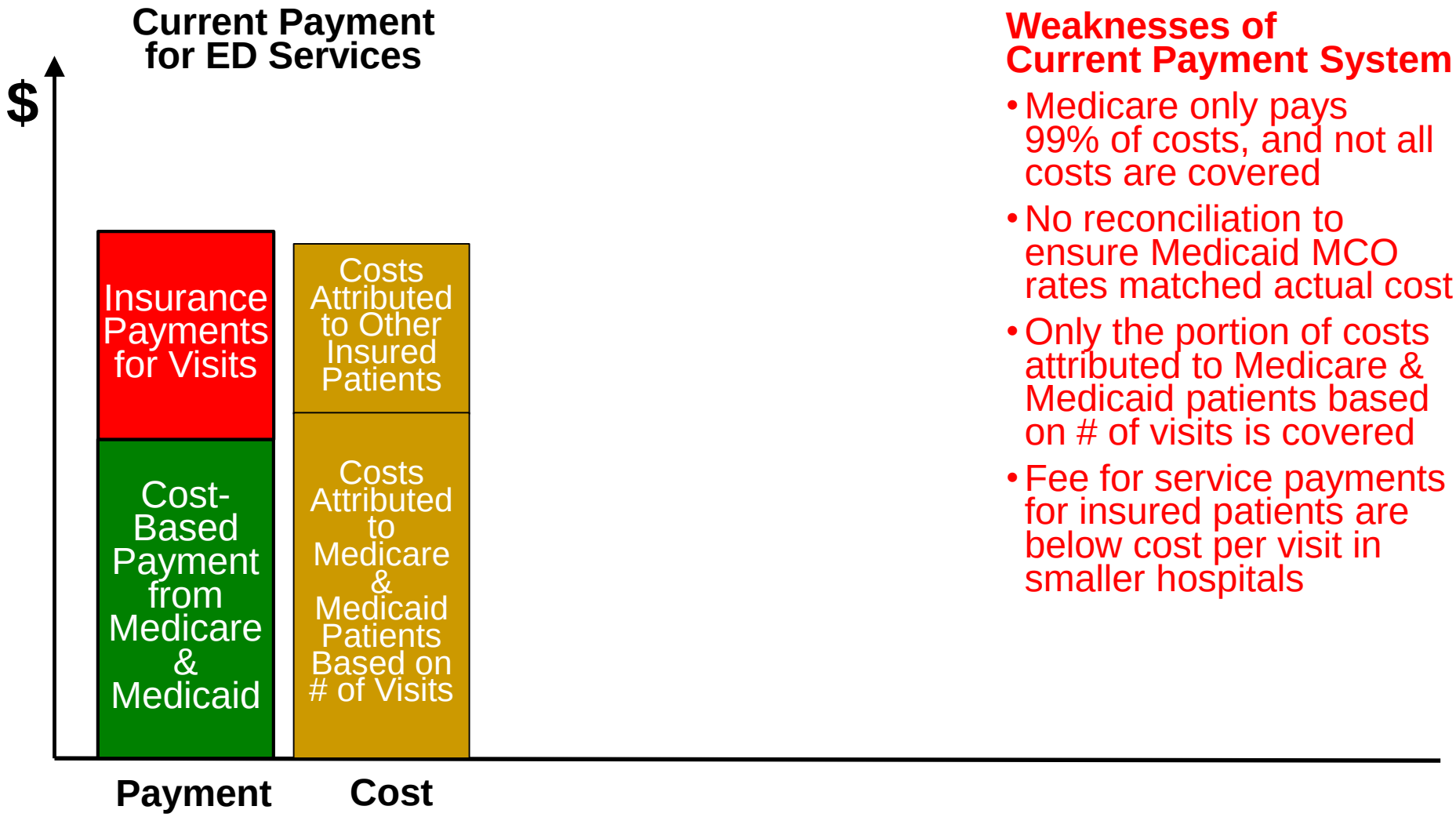
Insurance Payments for Visits May or May Not Cover Cost



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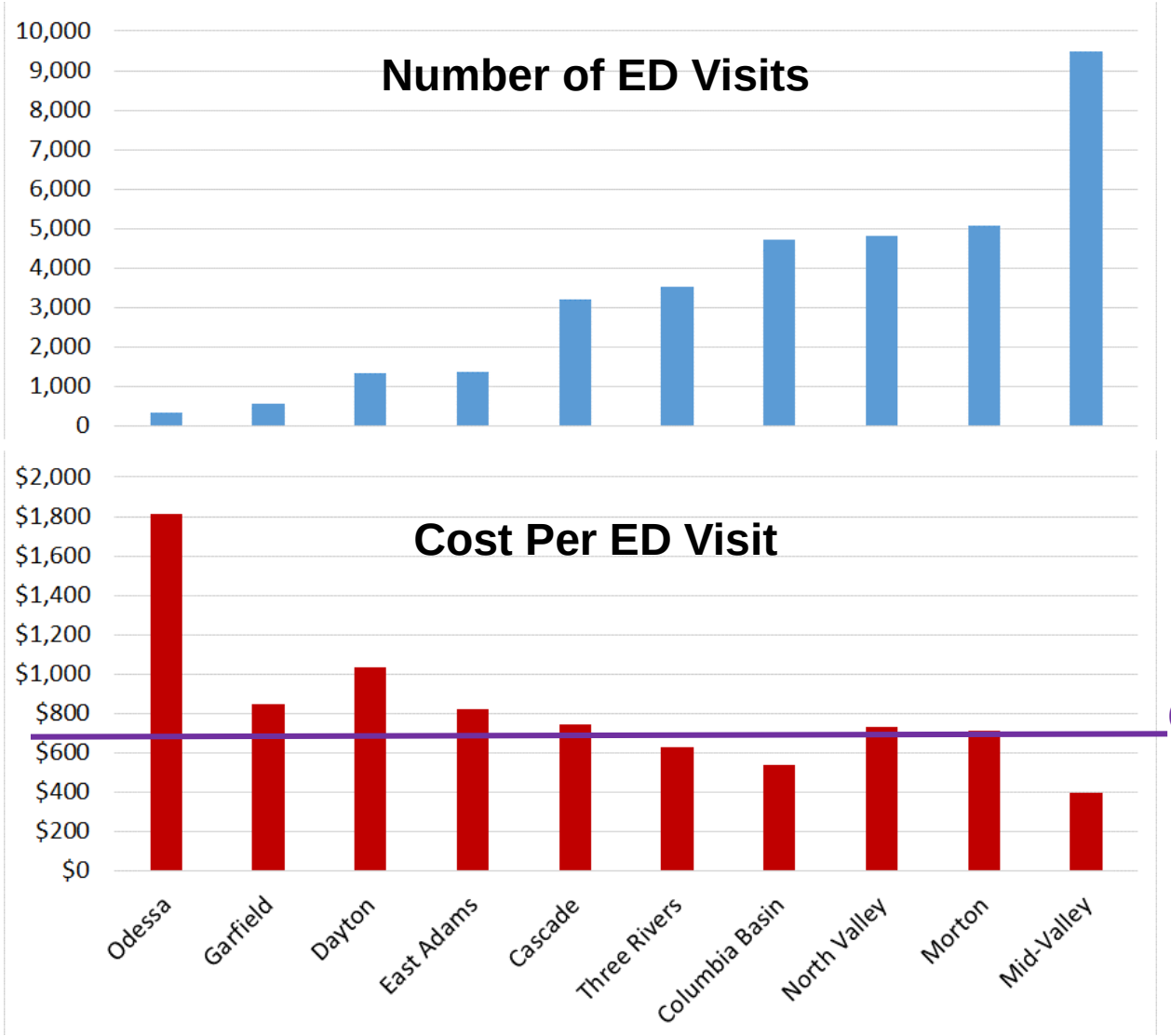
Lower Volume Hospitals Lose Money at Standard Payment Rates



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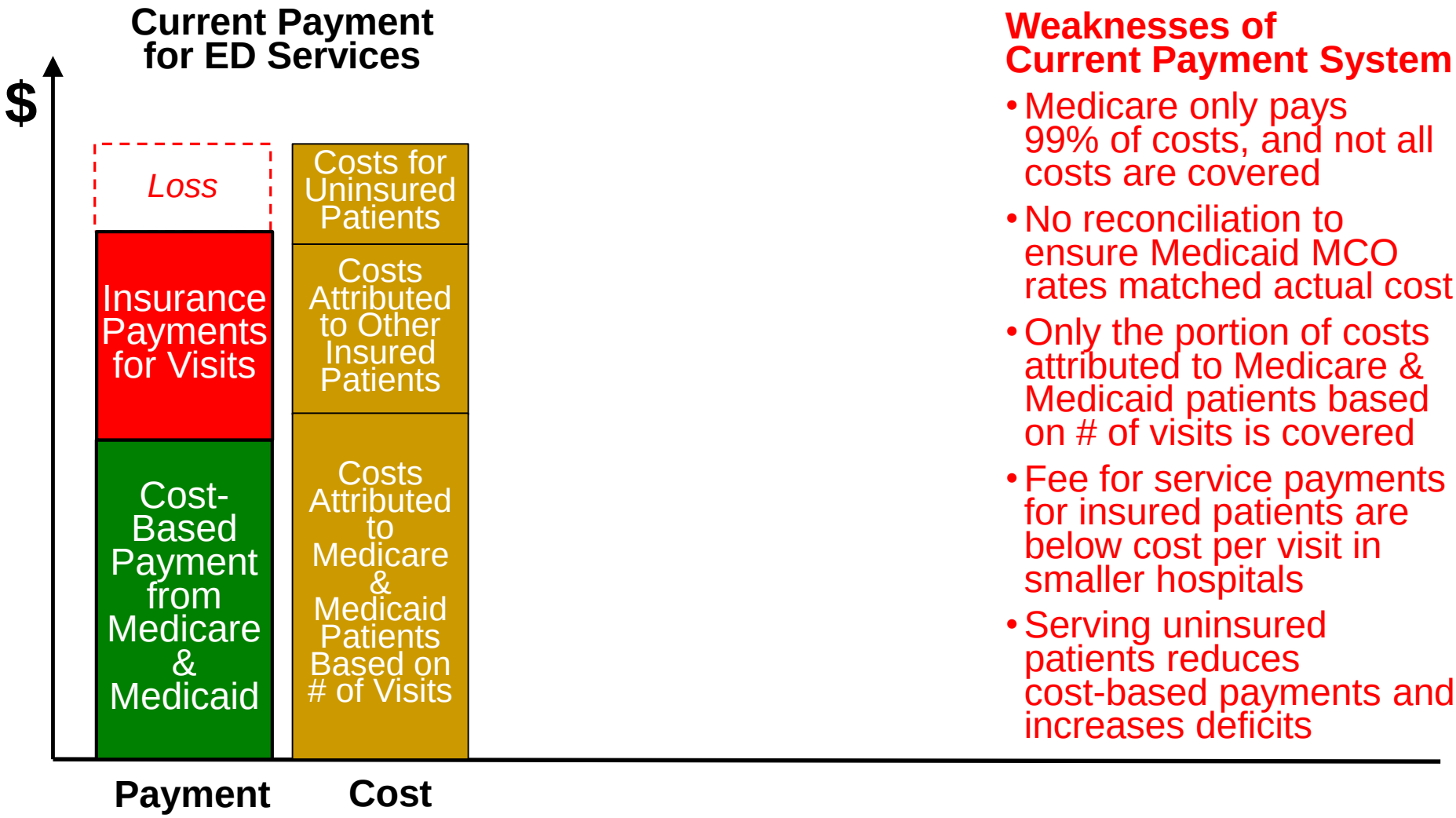
Nobody Covers the Cost Attributed to Uninsured Patients



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- Serving uninsured patients reduces cost-based payments and increases deficits

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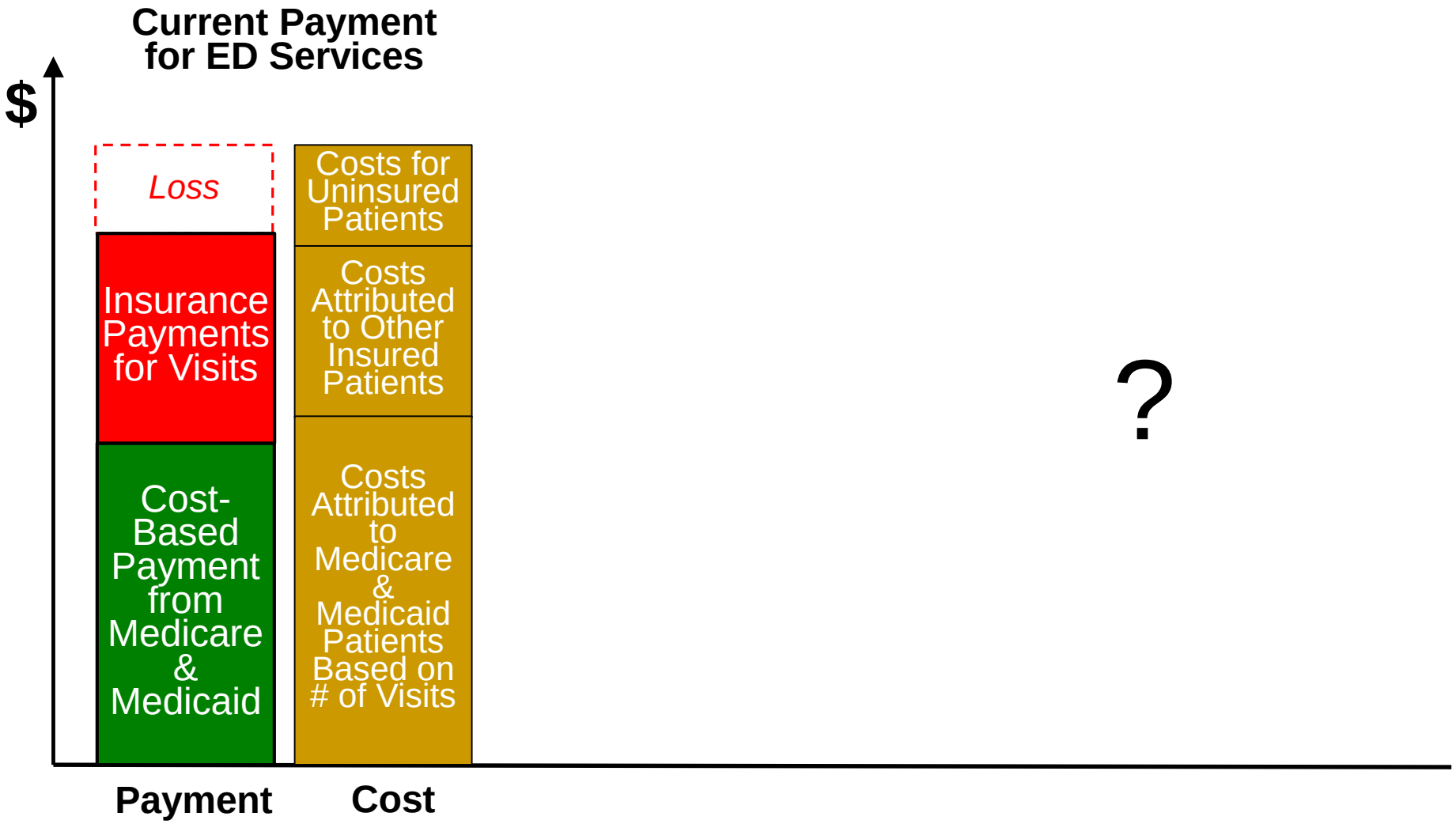
Is There a Better Way?



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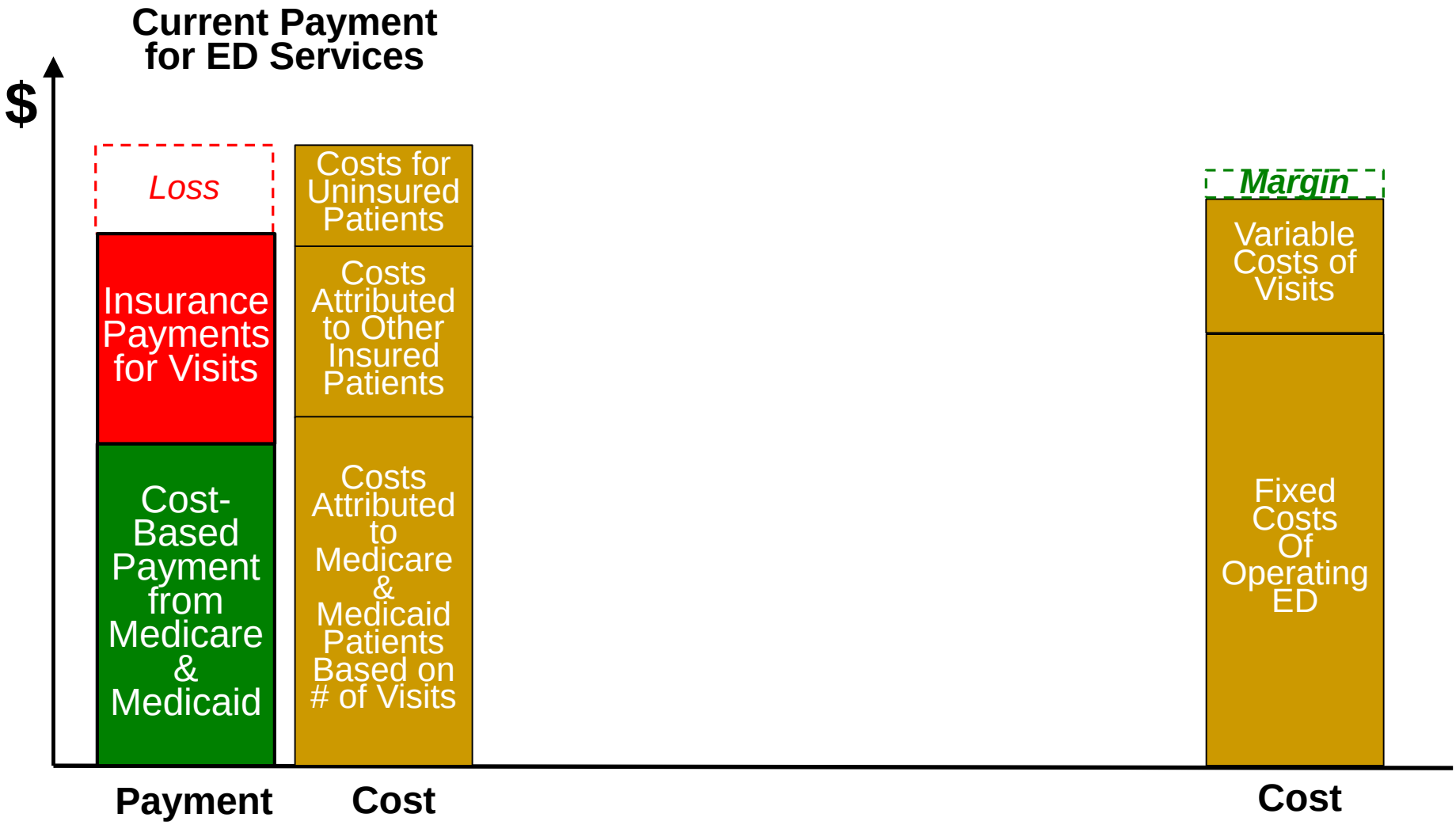
Recognize that Fixed Costs Continue Regardless of Visits



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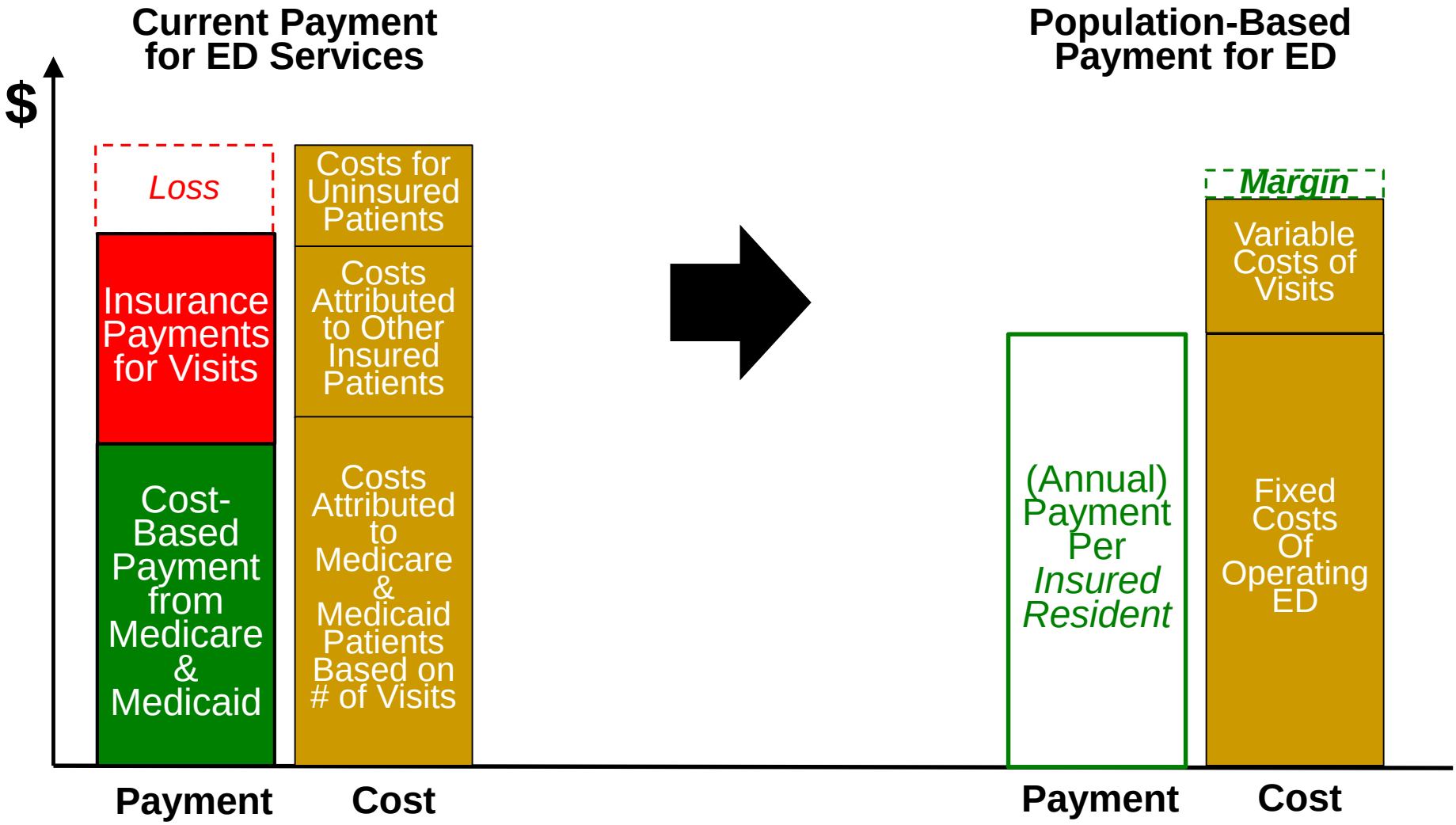
Pay for Fixed Costs With a Per-*Resident* Payment



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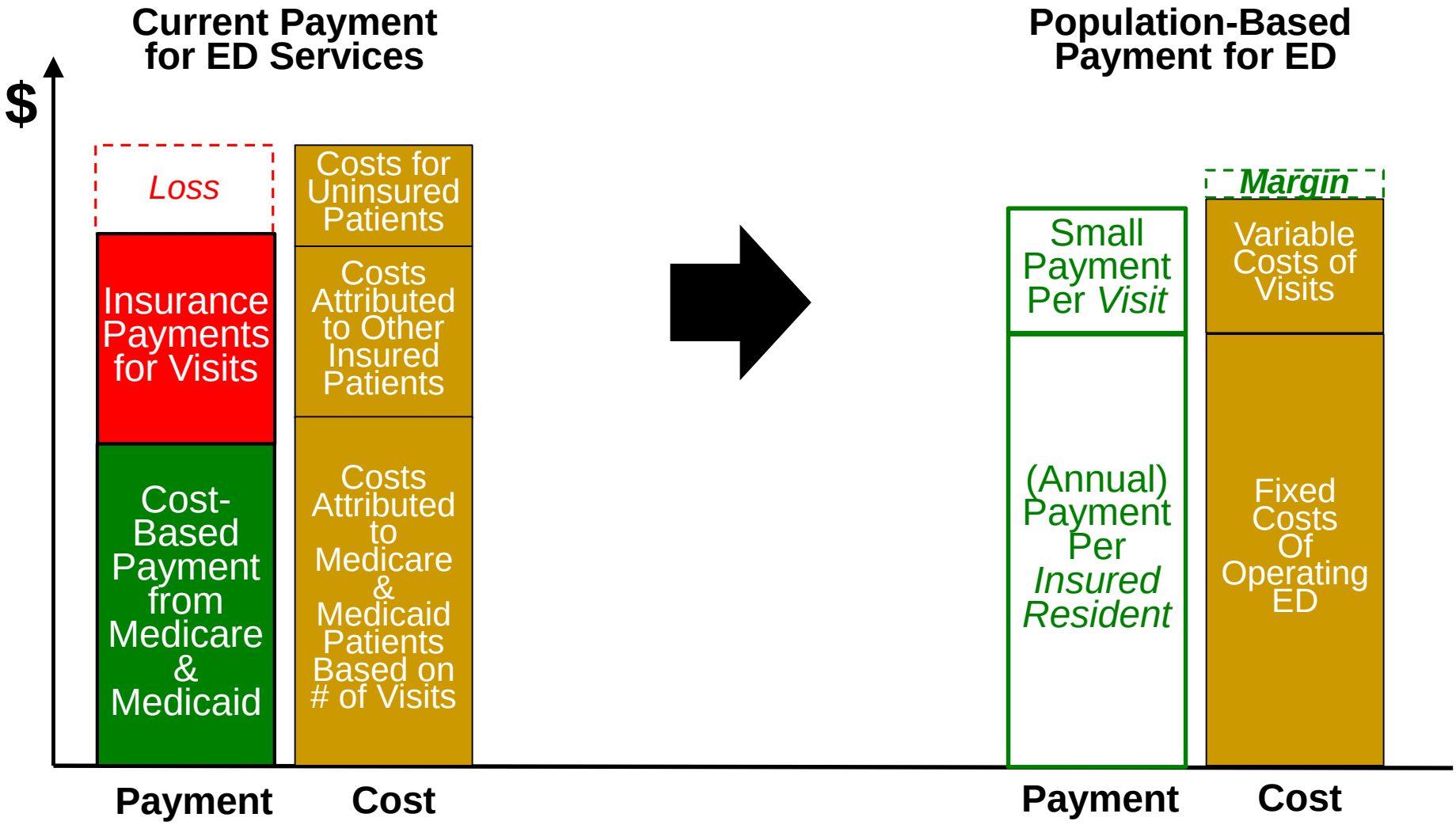
Pay Smaller Amounts Per Visit (Larger for Non-Resident Visitors)



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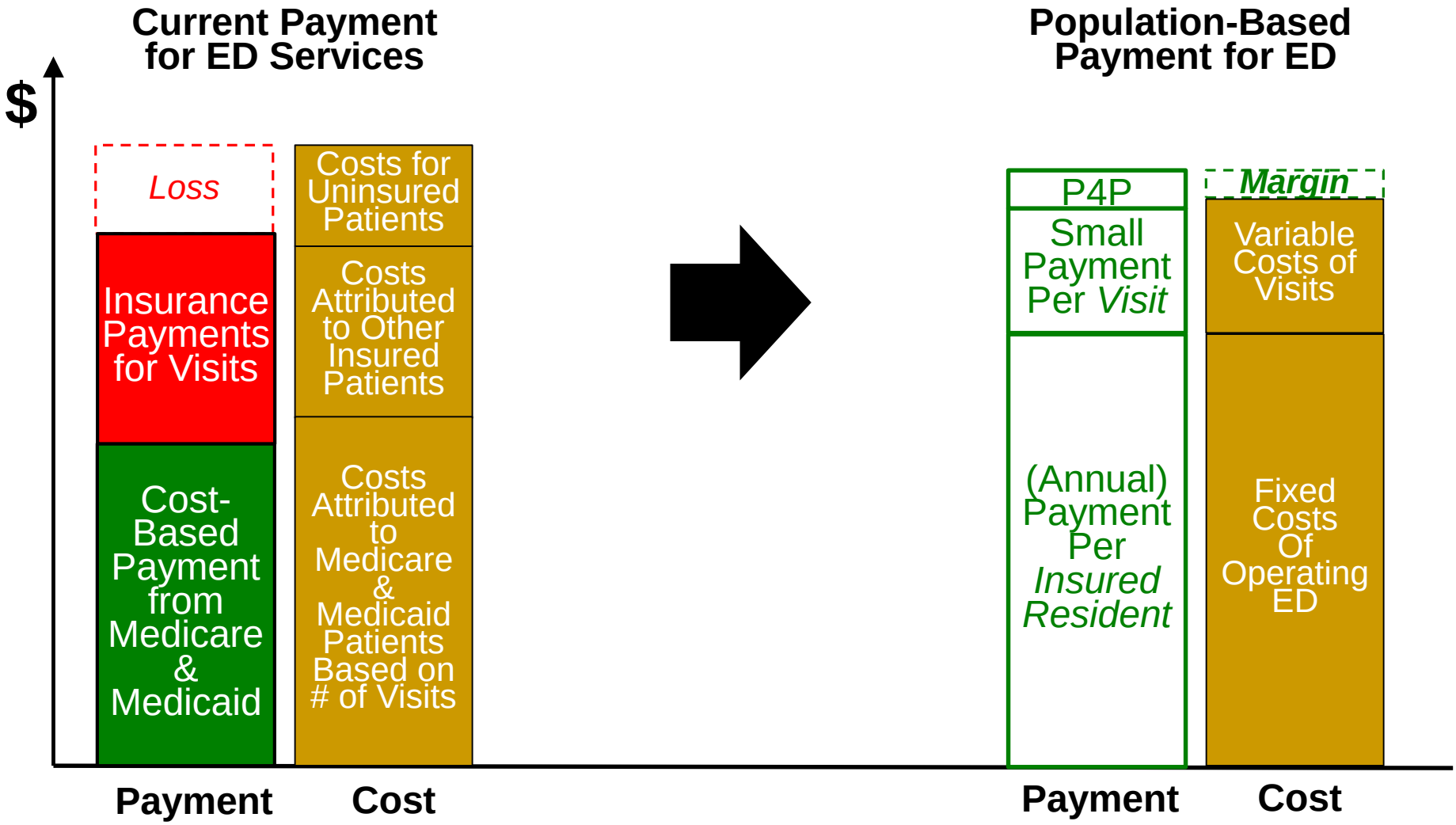
Performance-Based Payment to Ensure Quality & Access



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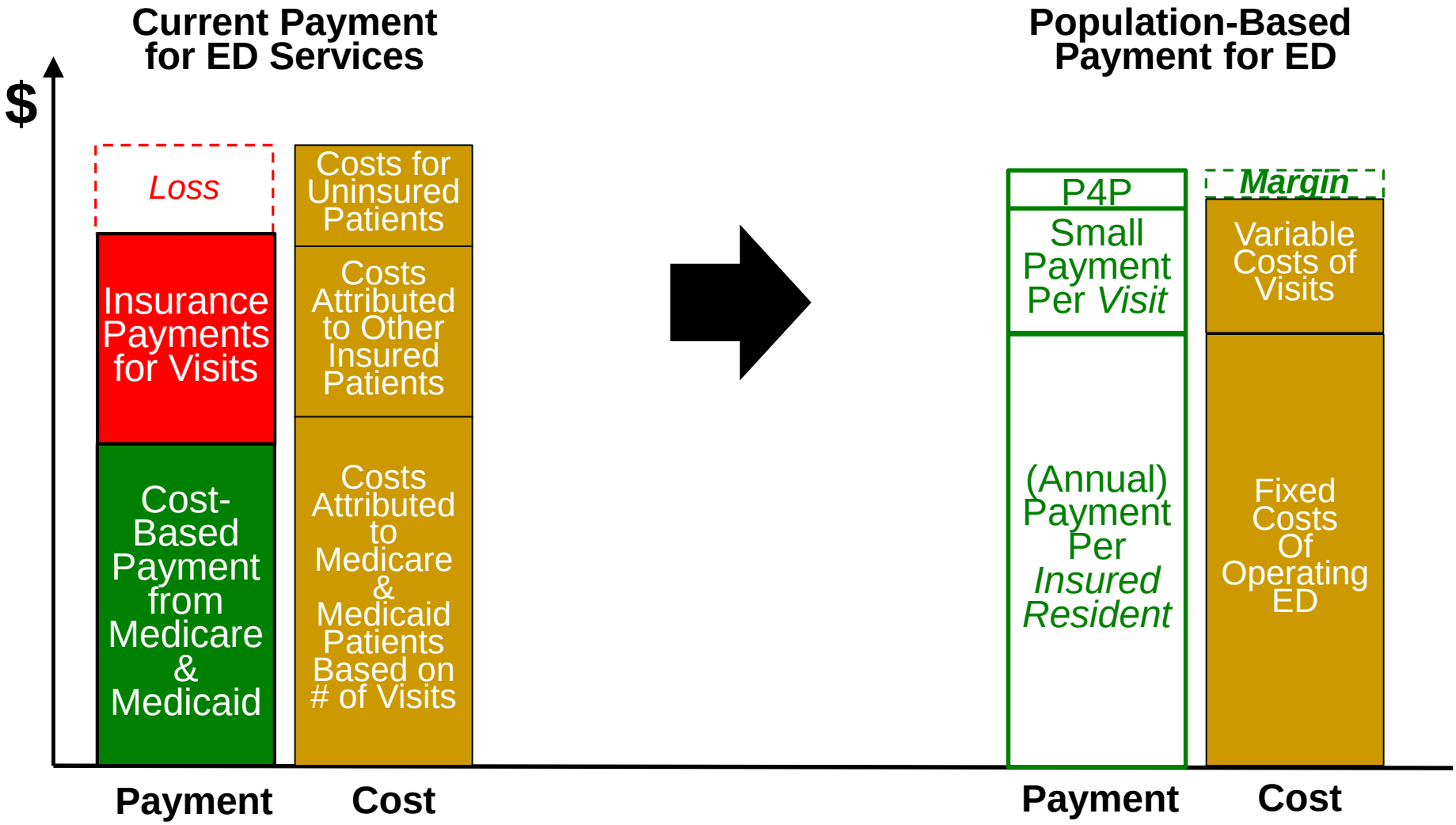
Population-Based Payment for Emergency Department Services



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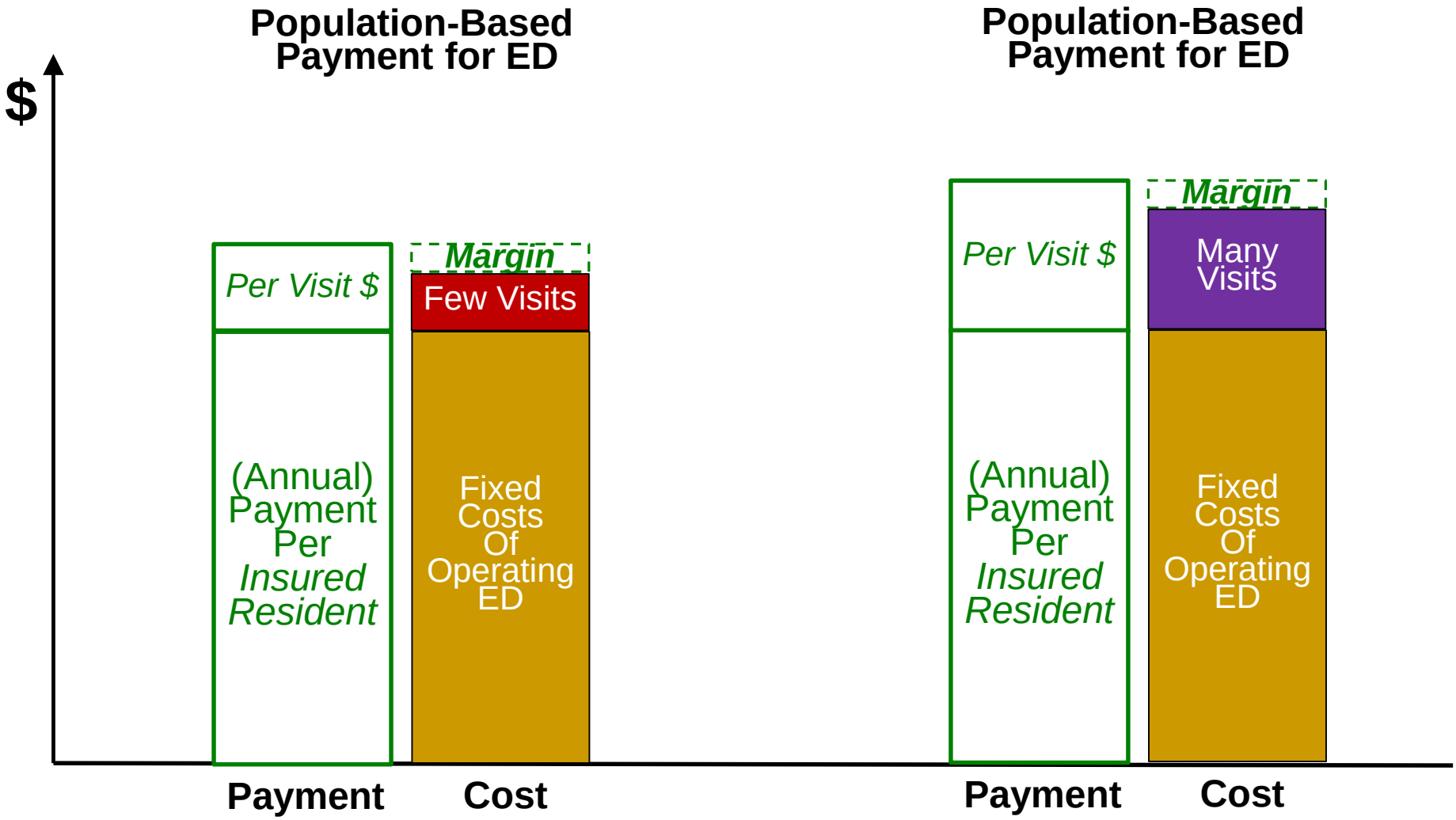
Fixed Costs of ED Are Sustained Regardless of Volume of Visits



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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

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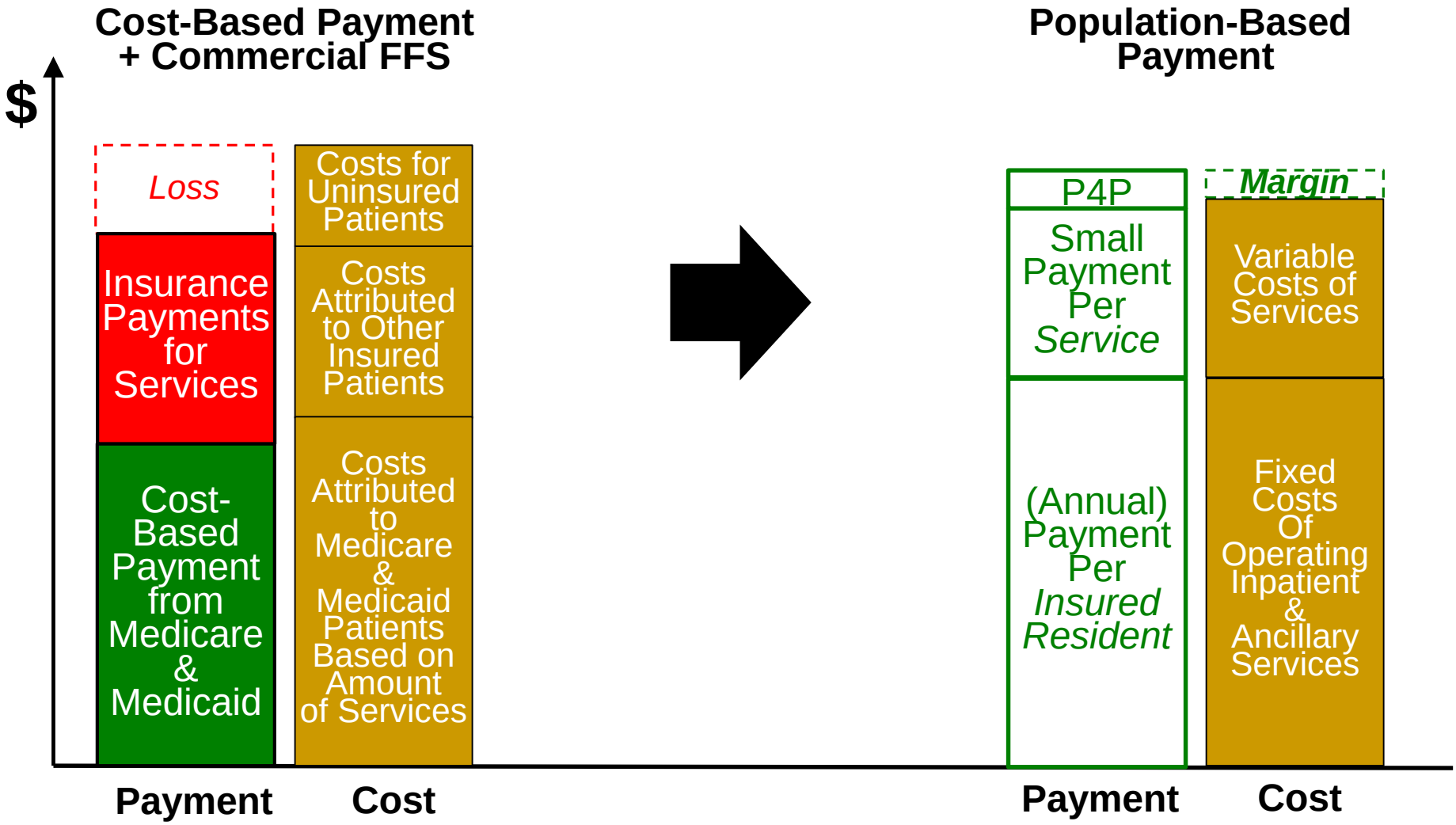
A Similar Approach Could Be Used for Inpatient & Ancillary Svcs



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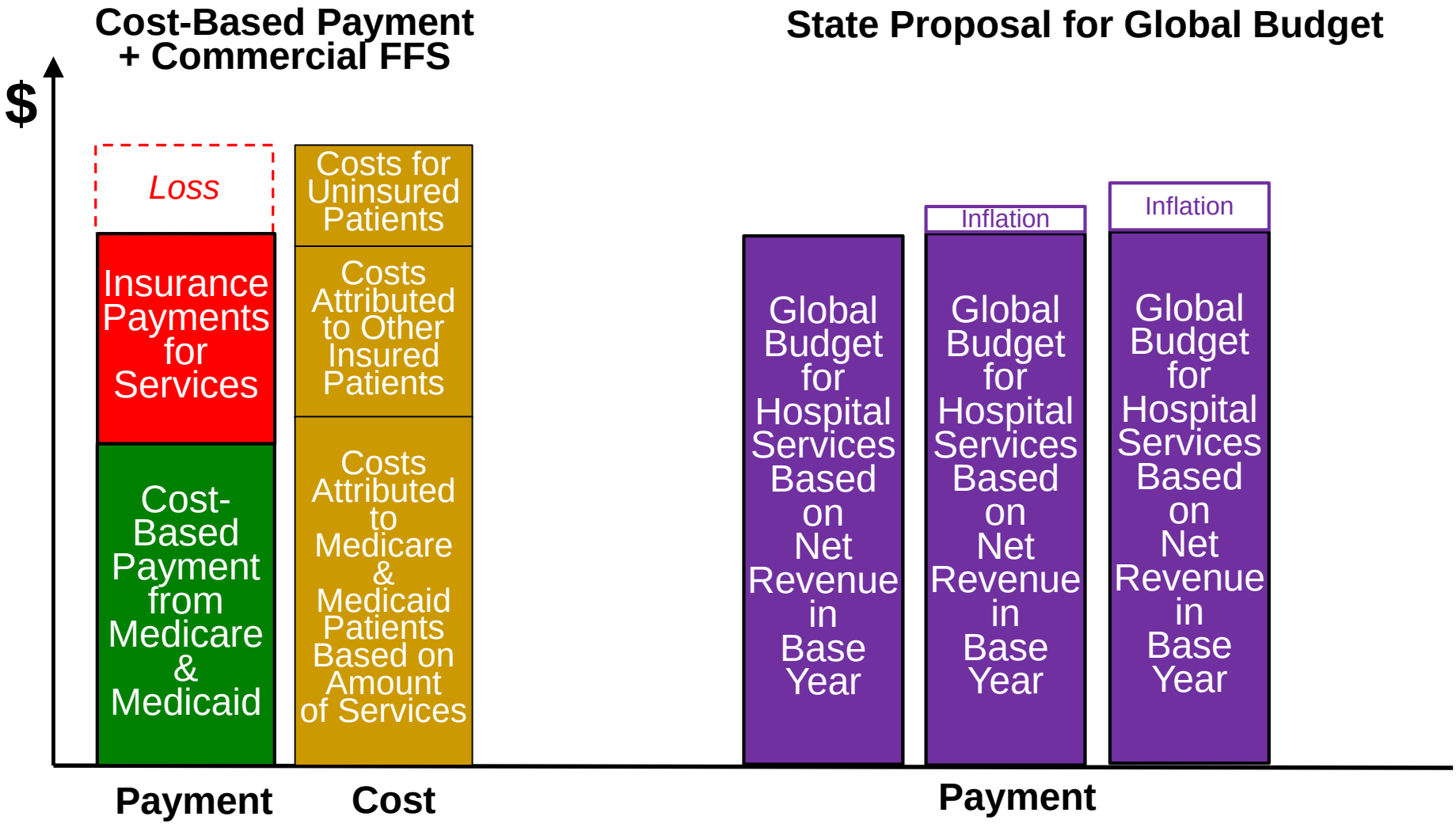
WA Health Care Authority Proposed a Trended Global Budget



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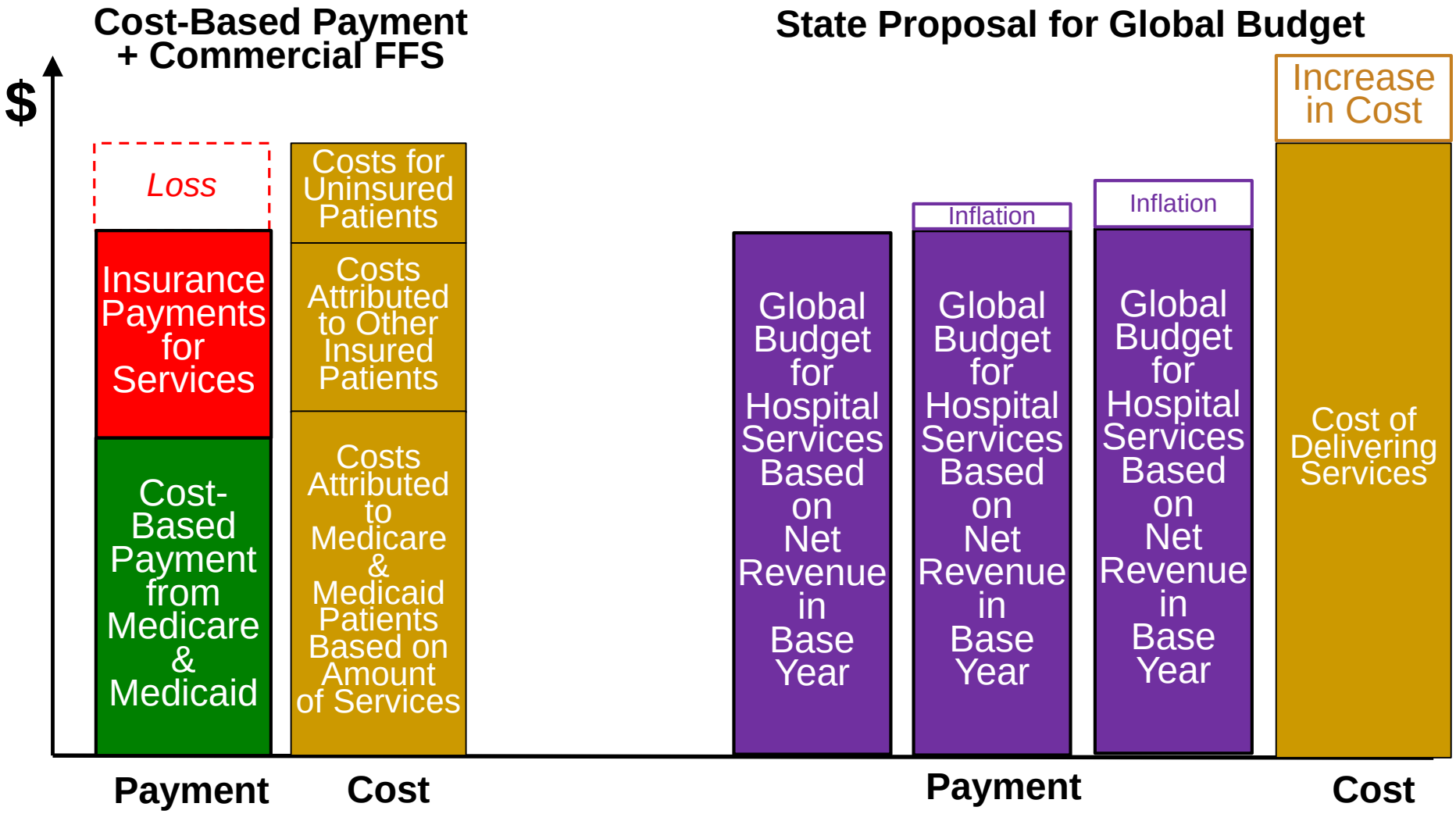
WRHAP Hospital Costs Have Increased More Than Inflation



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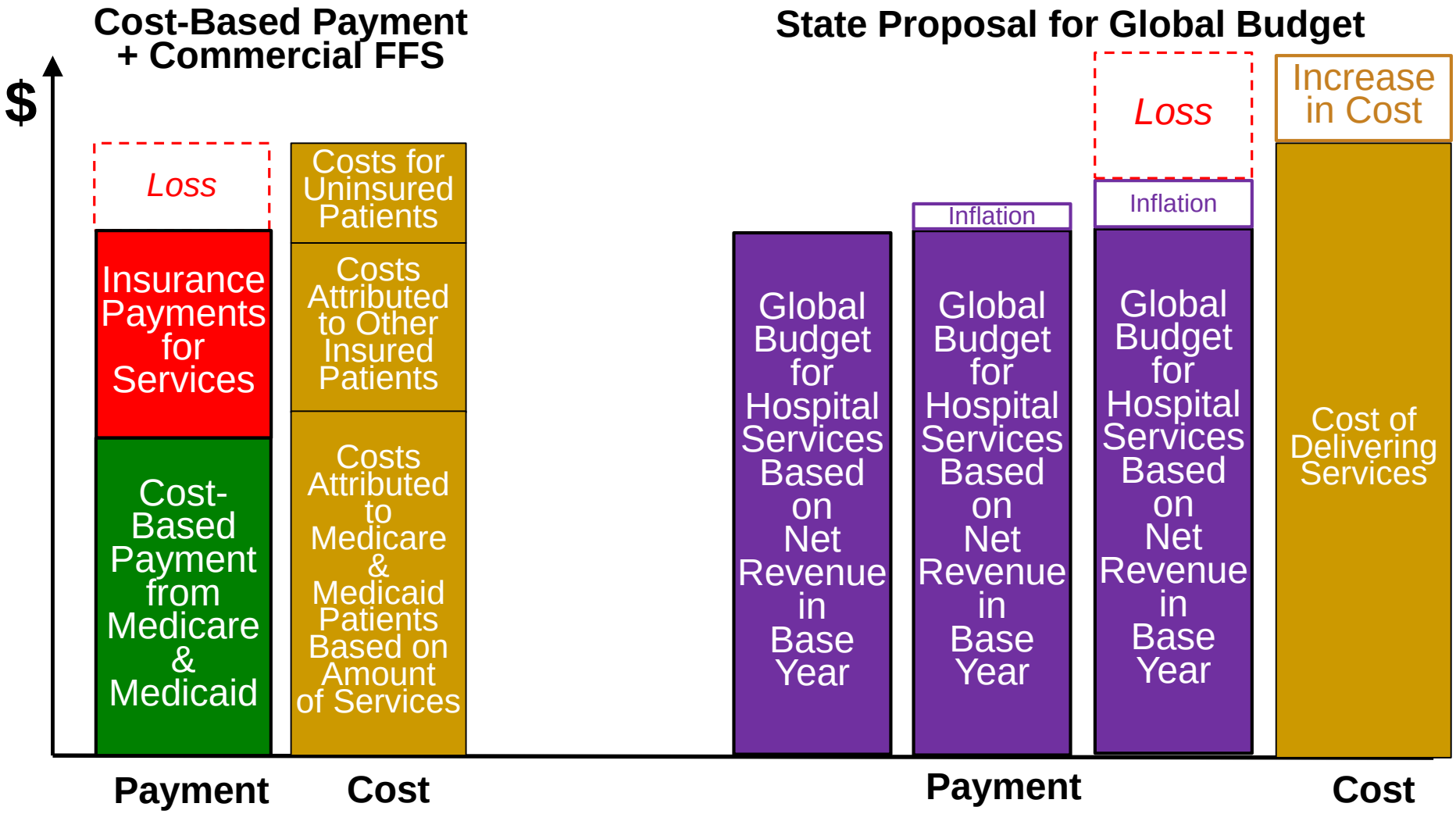
Budget Based on Past Revenues & Low Trend Would Increase Losses



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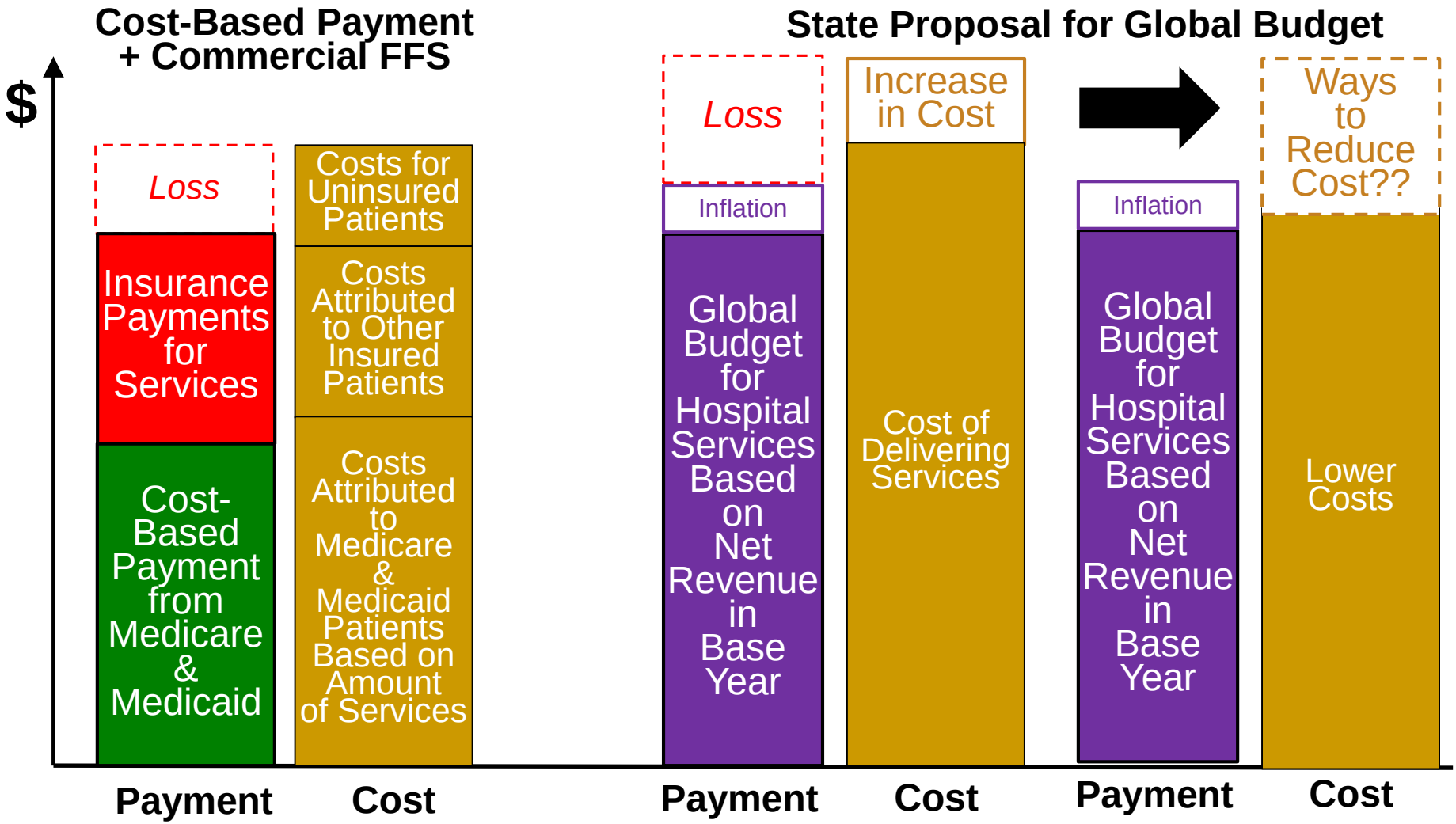
Payers Want to Encourage Efficiency in Care Delivery…



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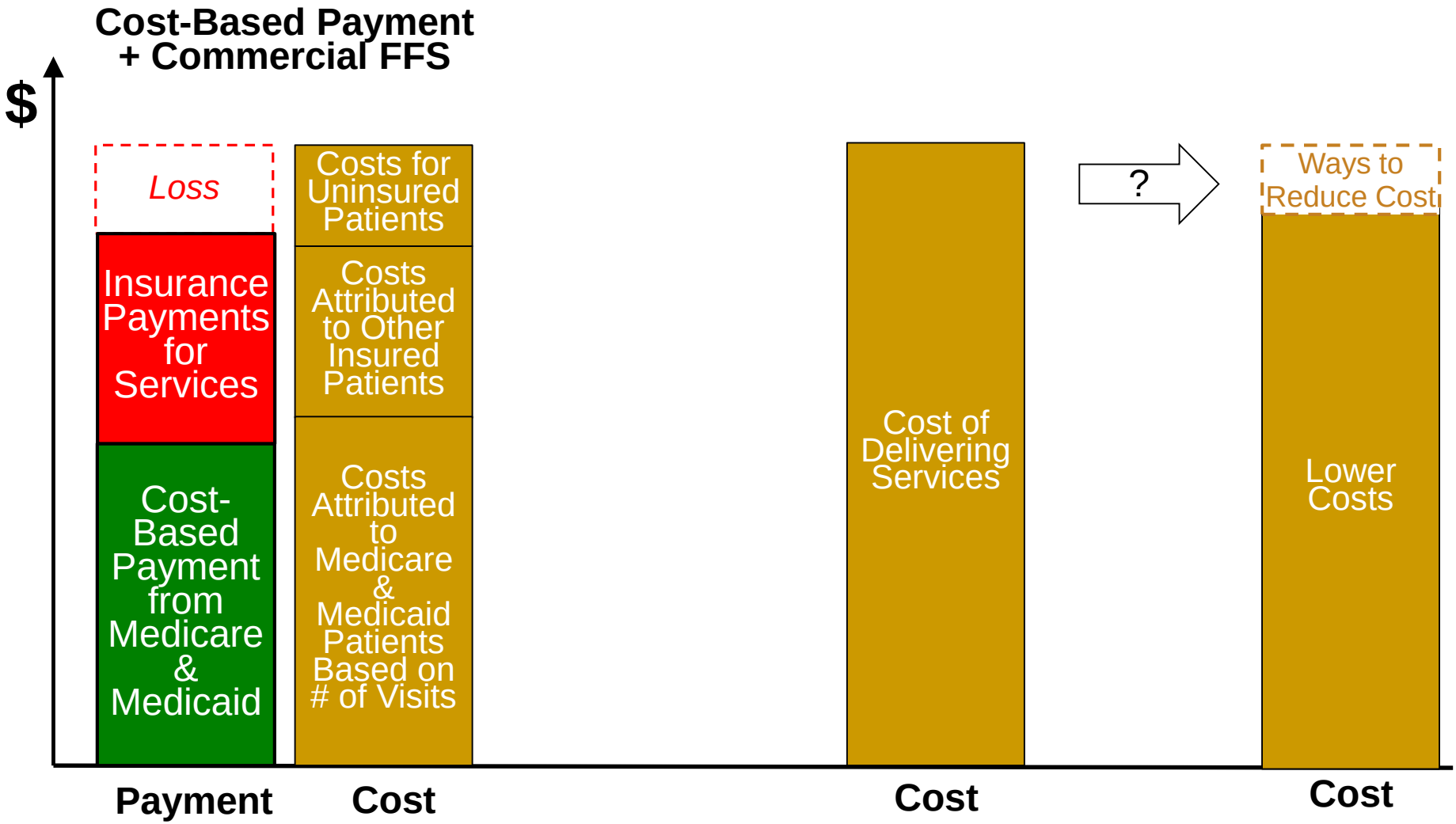
. . .So WRHAP PHDs Need to Show Costs Are As Low As Possible



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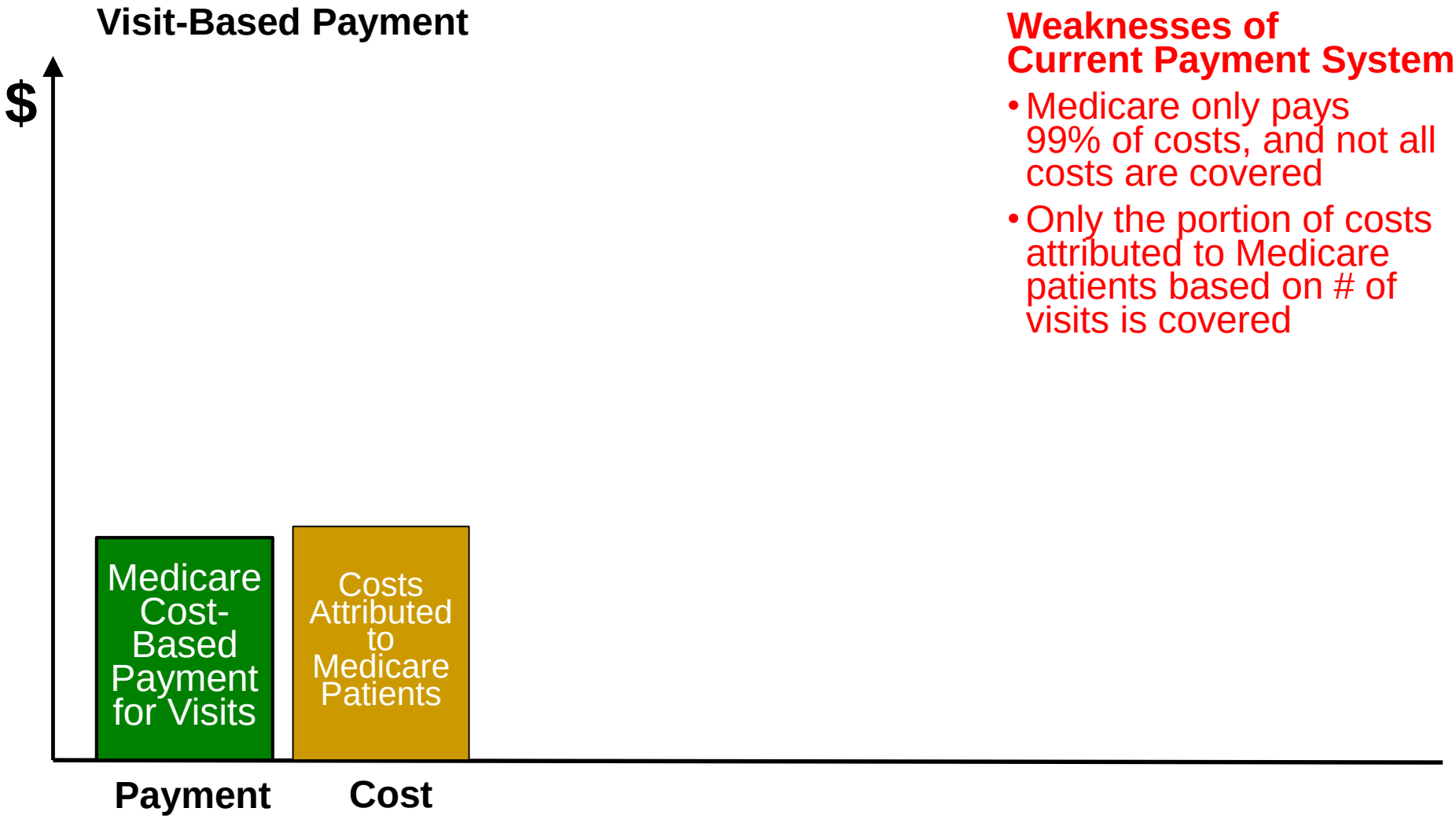
Current Visit-Based Payments for Clinic Services



Weaknesses of Current Payment System

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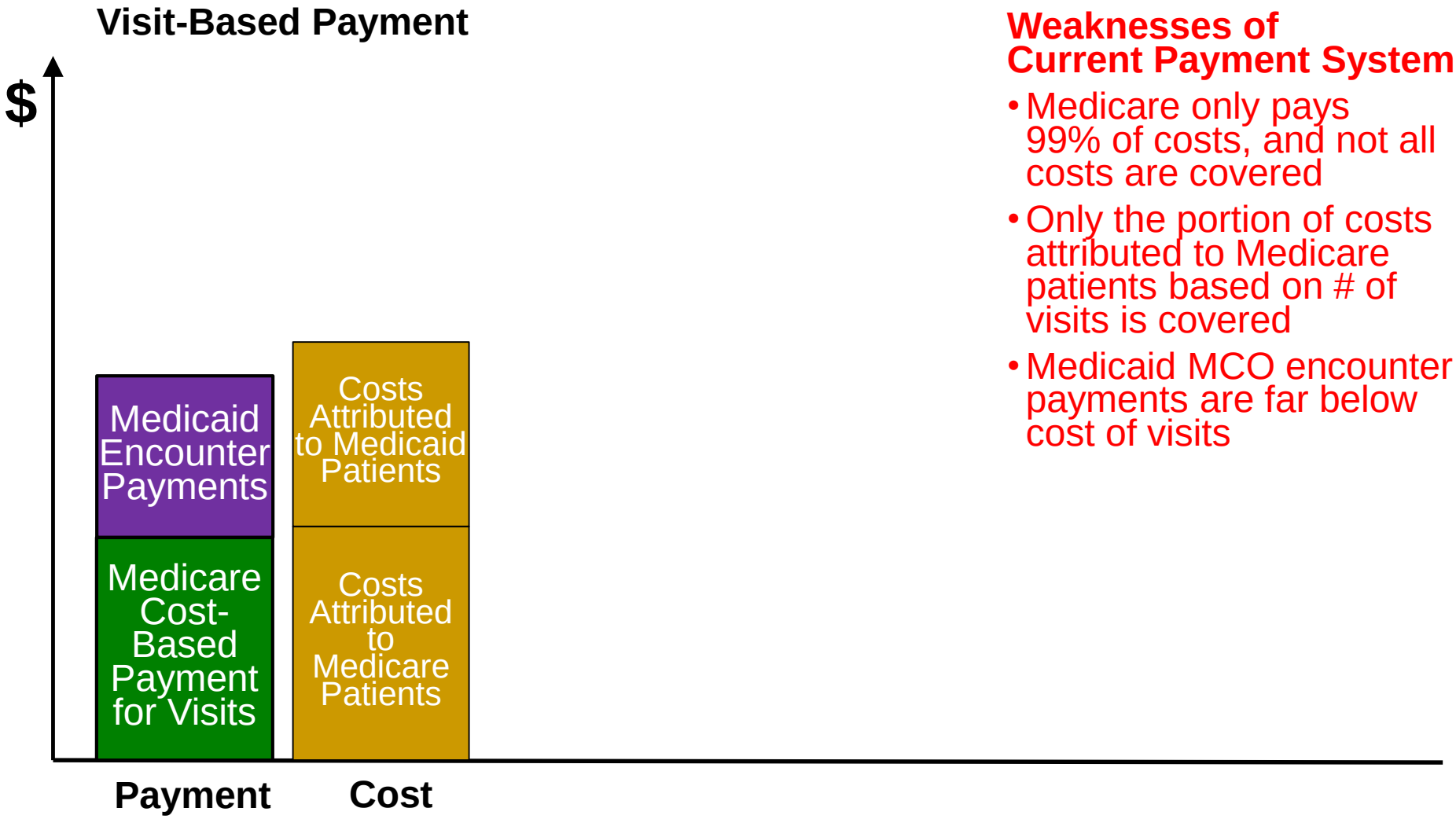

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- Medicaid MCO encounter payments are far below cost of visits

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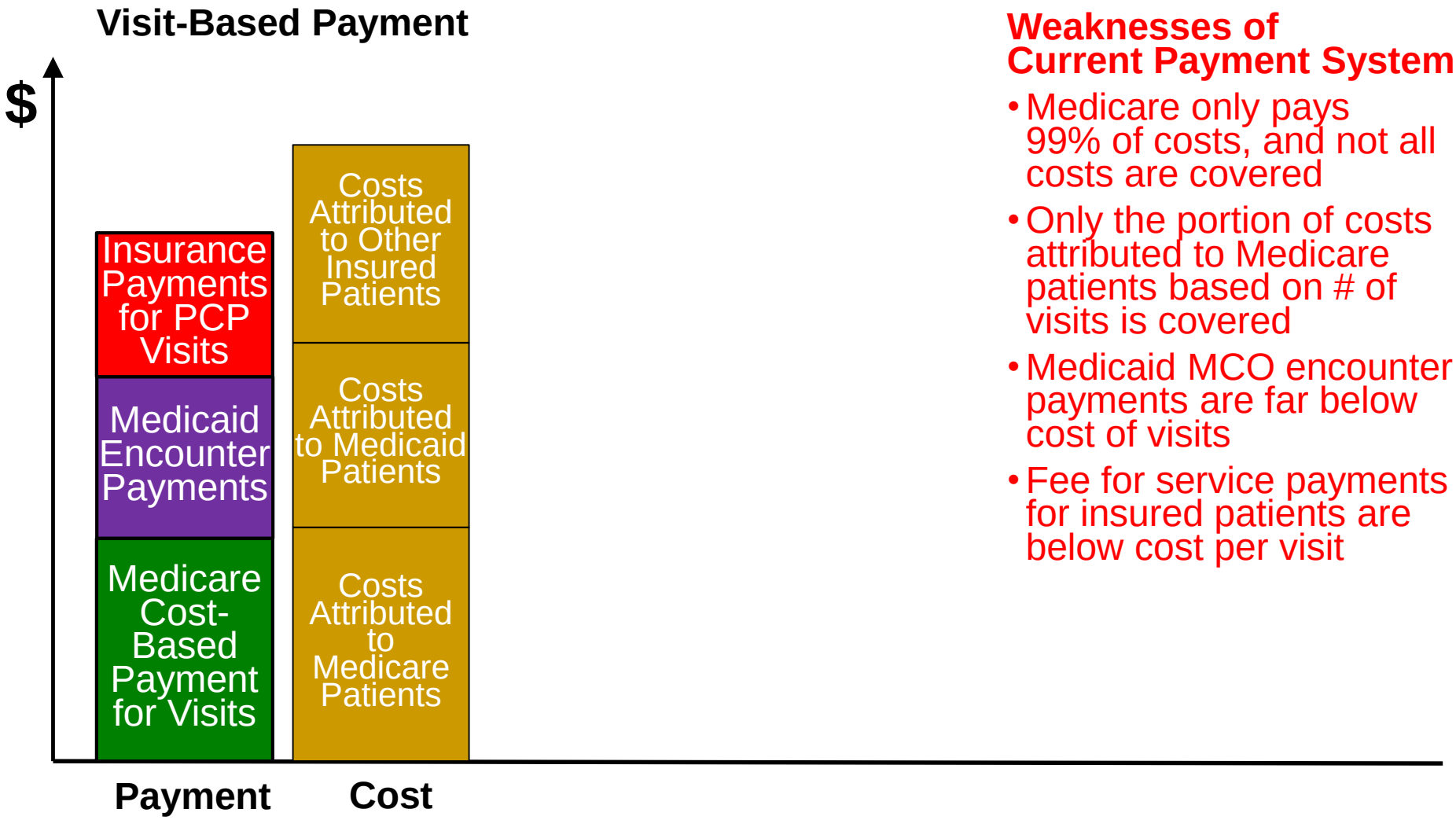

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- Fee for service payments for insured patients are below cost per visit

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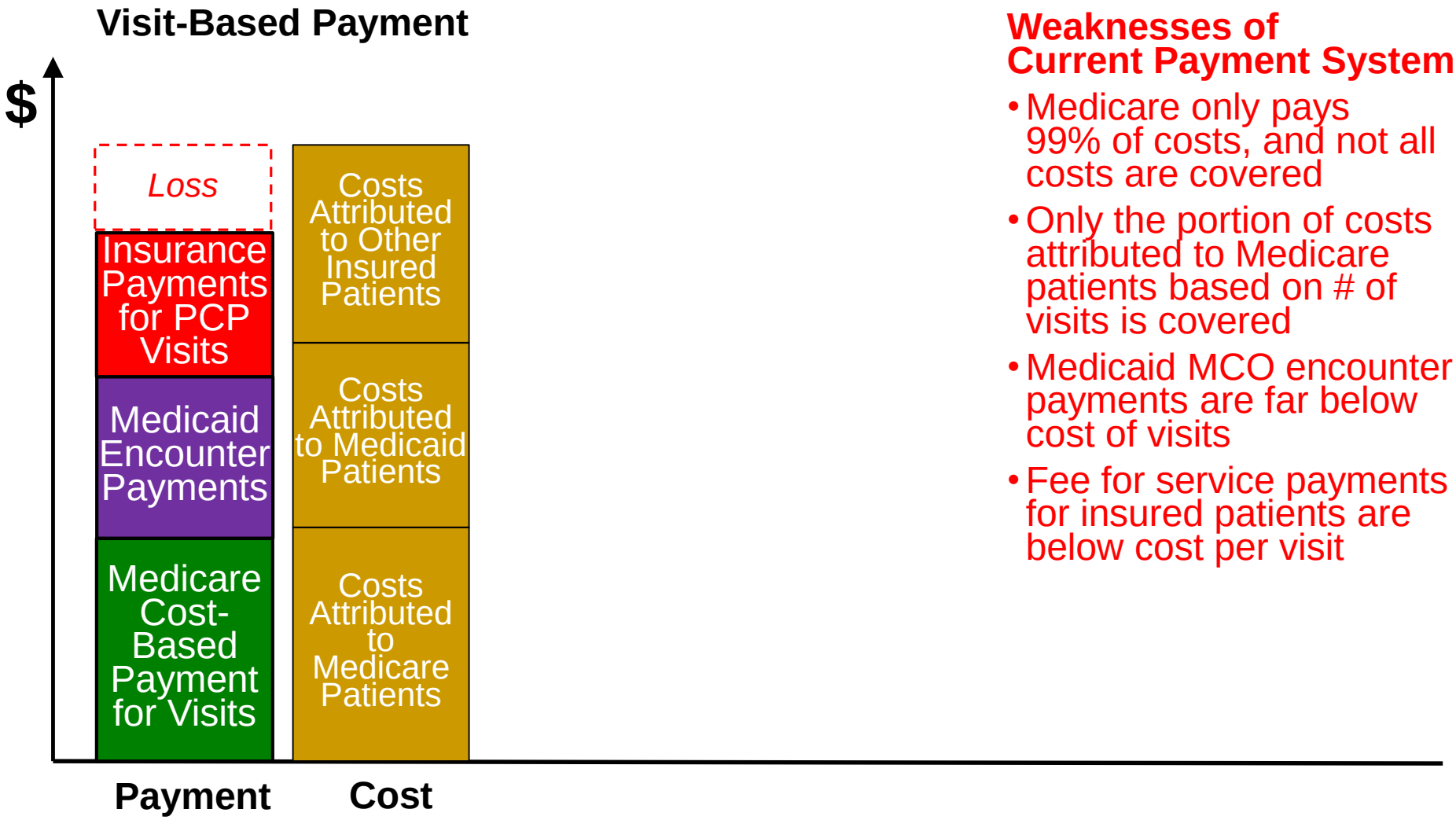
Current Visit-Based Payments Do Not Cover Costs of Clinic



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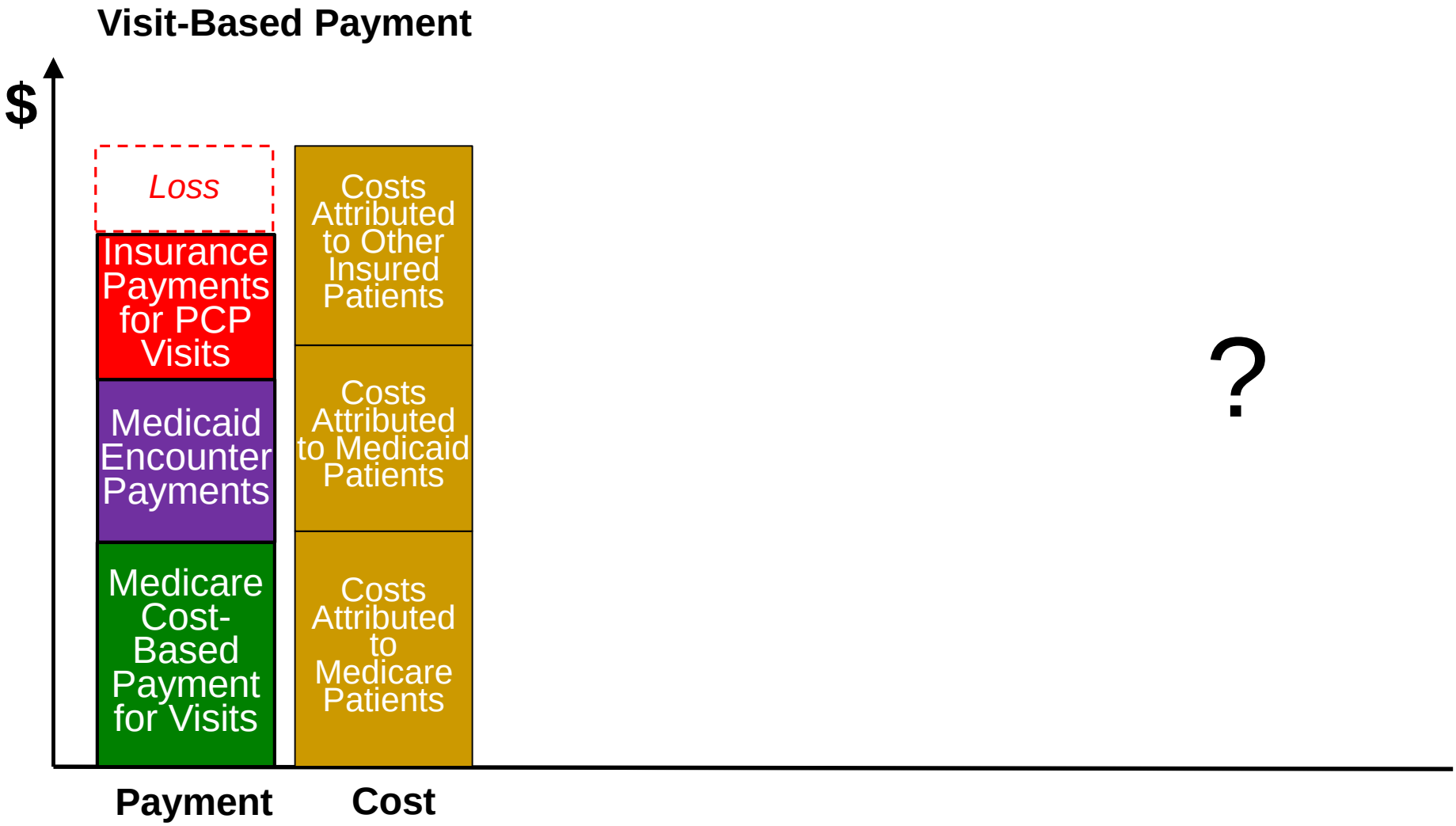
Is There a Better Way?



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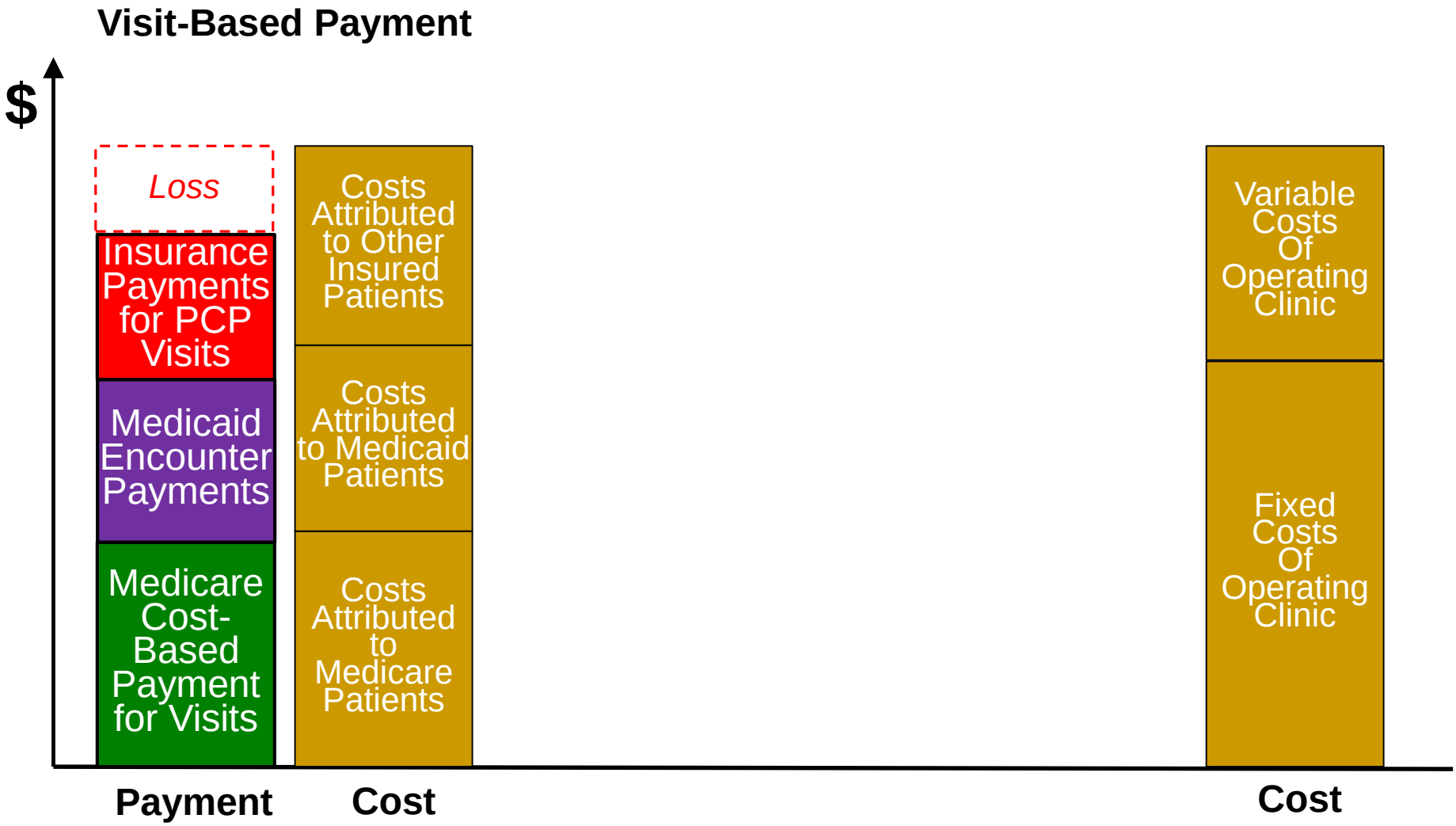
Most Clinic Costs Are Fixed Regardless of # of Visits



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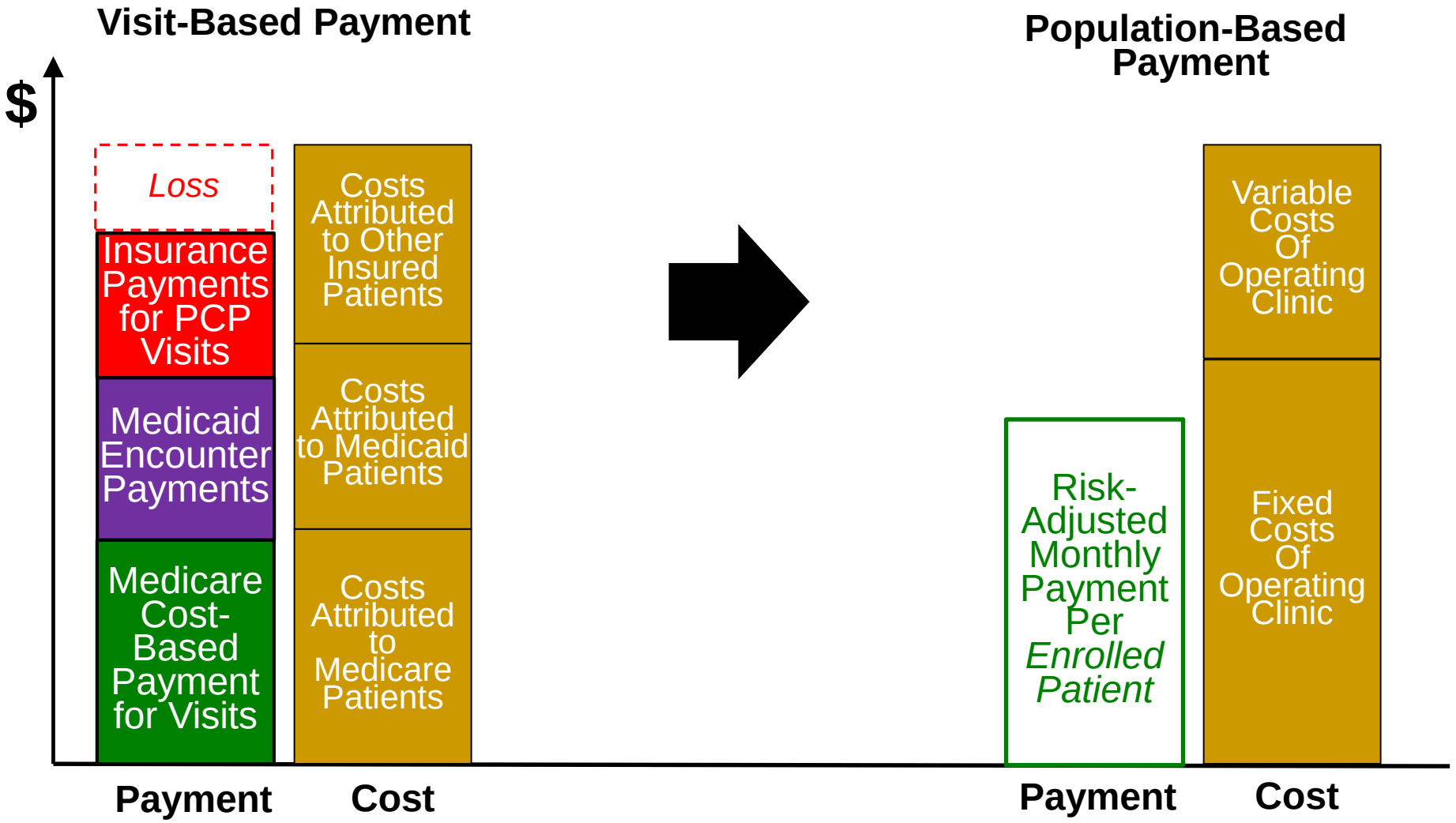
Pay a Predictable Amount to Manage Care for Regular Patients



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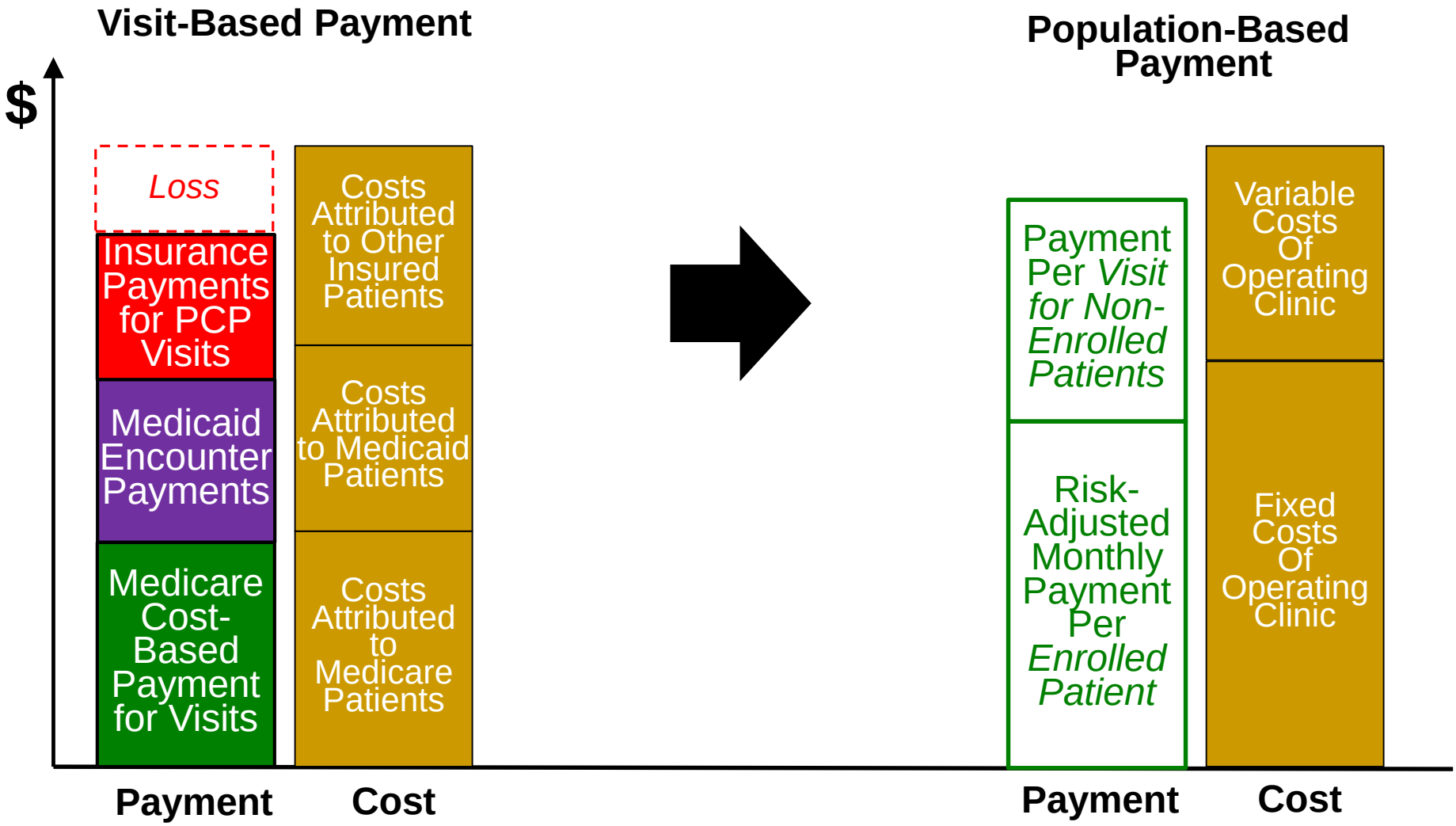
Pay Per Visit for Occasional Visitors



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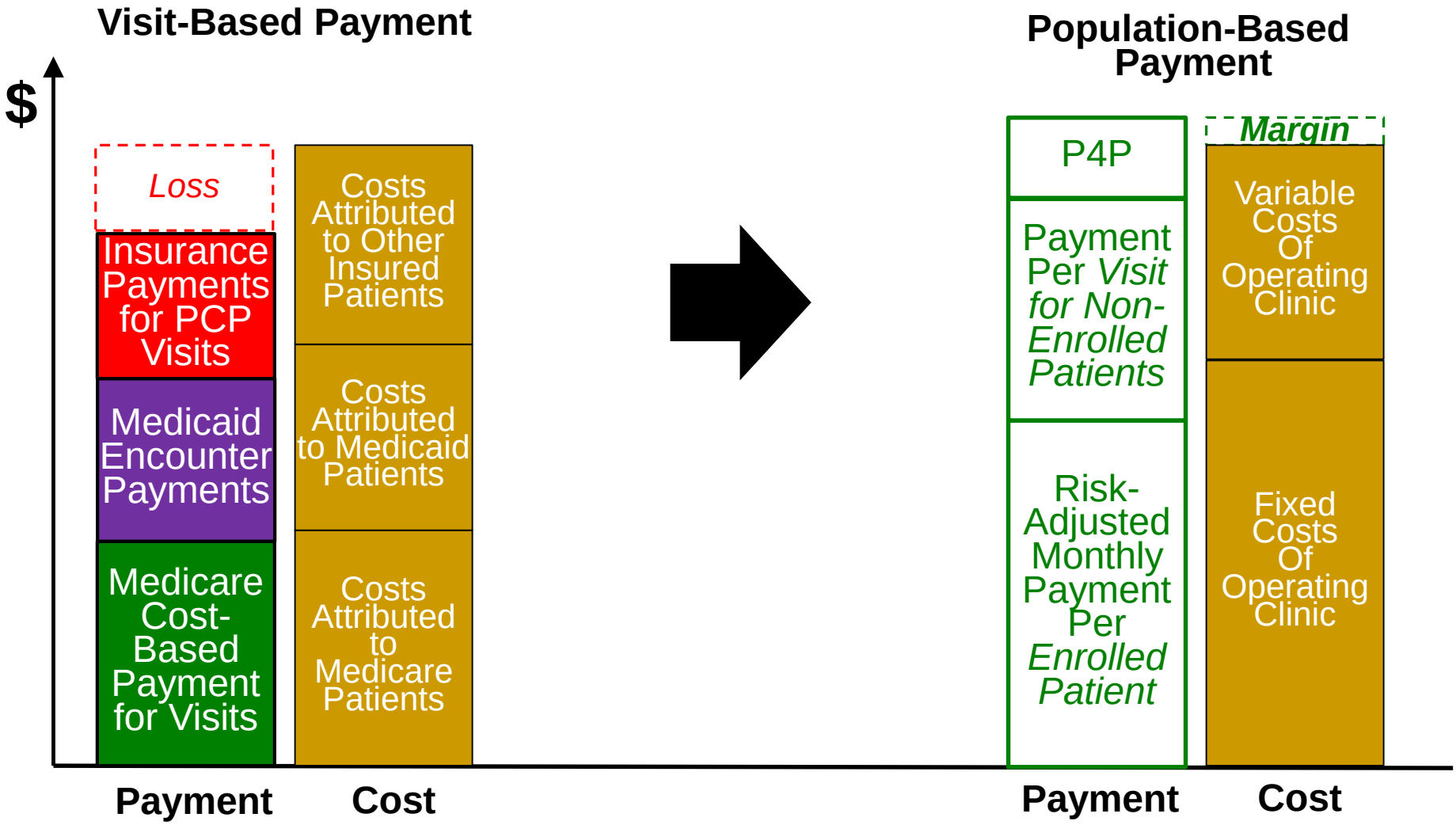
Base a Portion of Payment on Quality and Access



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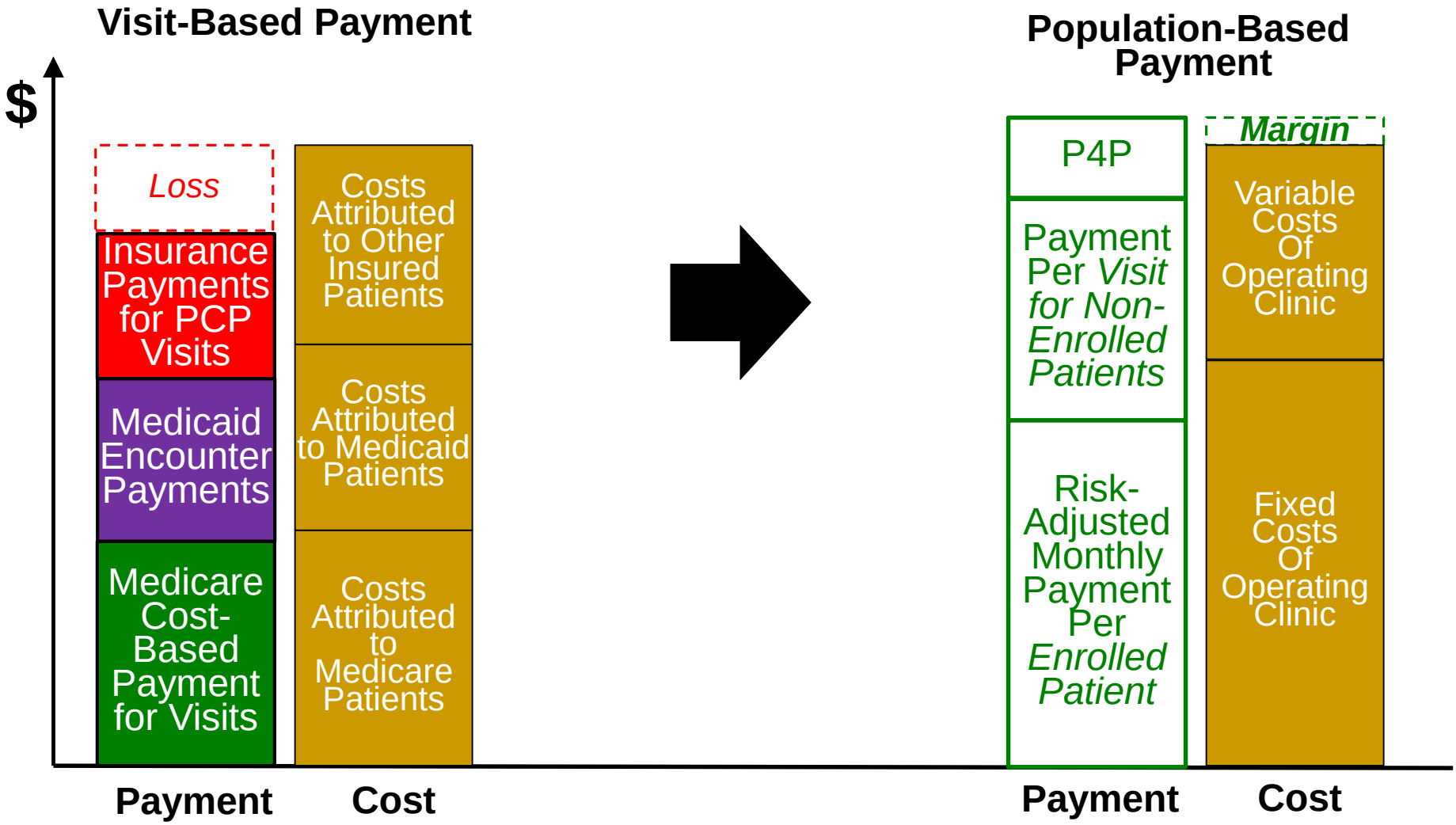
Population-Based Payment for Primary Care Clinic Services



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Proposed Payment Model for Rural Health Clinics

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

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Clinic Payment Model is Similar to Medicare Medical Home Pmts

Medicare Comprehensive Primary Care	WRHAP CAH Primary Care Clinic APM
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 **Care Management Fee:** • Five tiers of additional monthly payments per attributed beneficiary based on HCC risk scores and presence of dementia	**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
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

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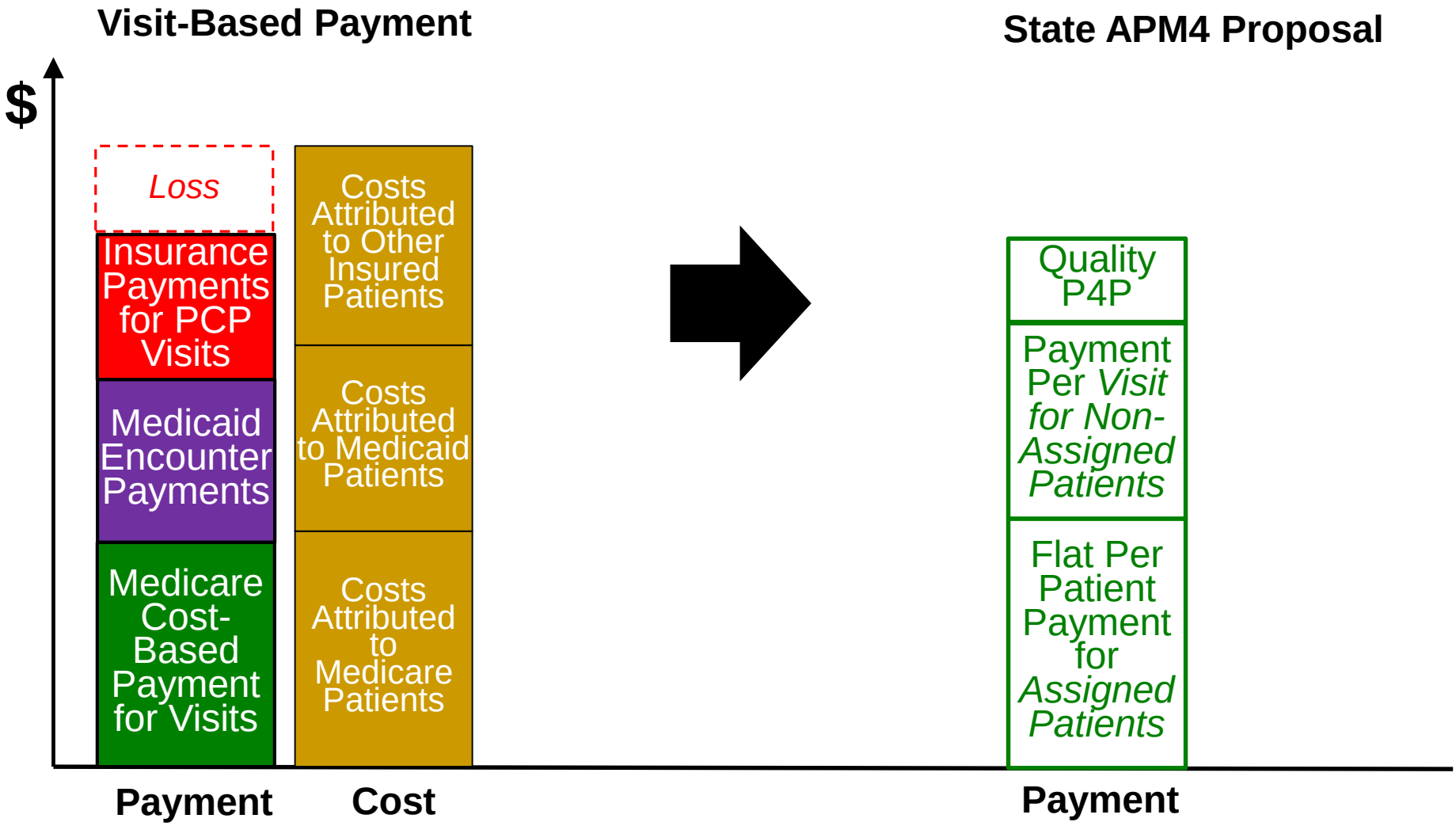
State APM4 Proposal



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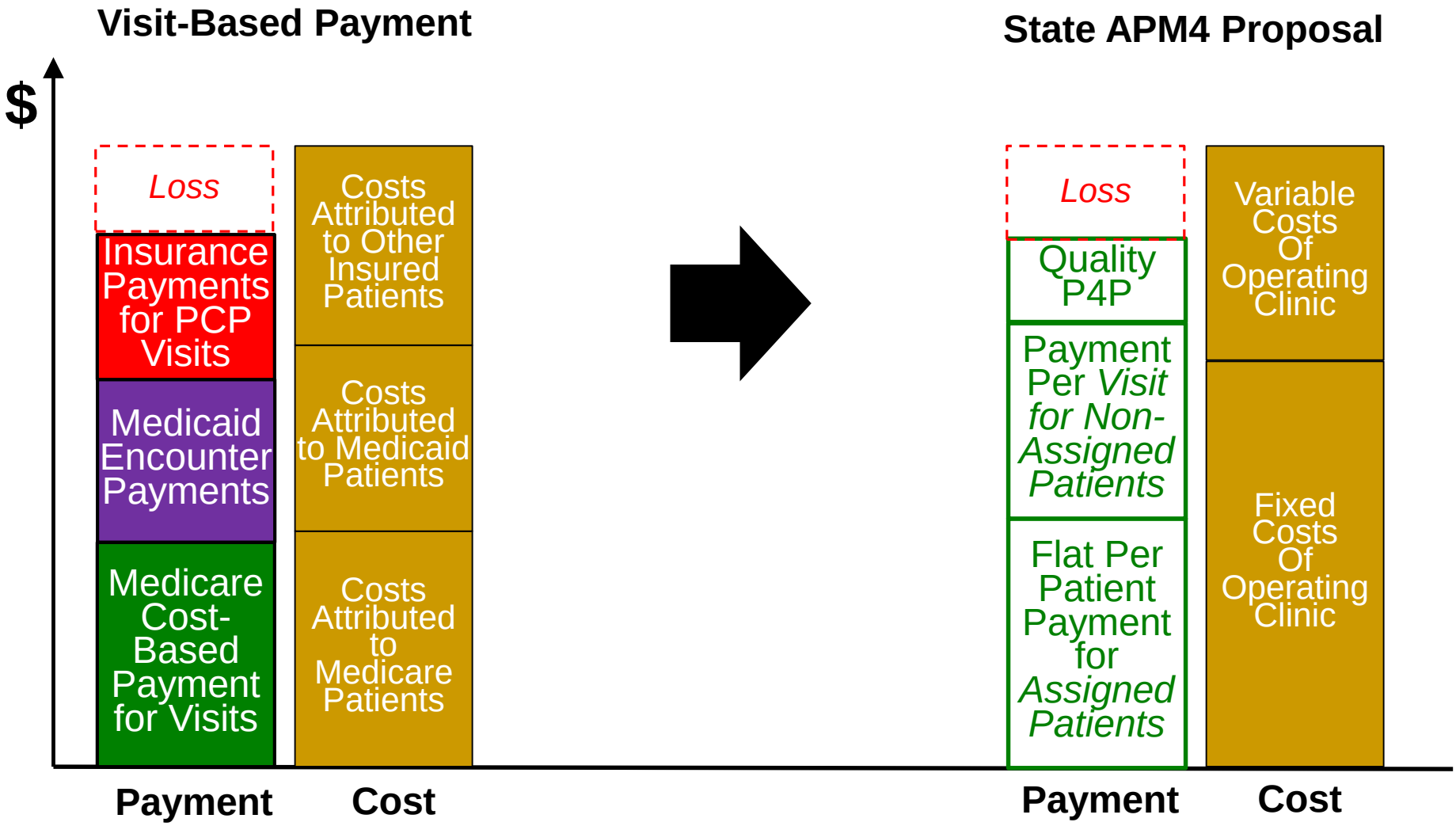
State APM4 Proposal Would Not Match Costs of Small Clinics



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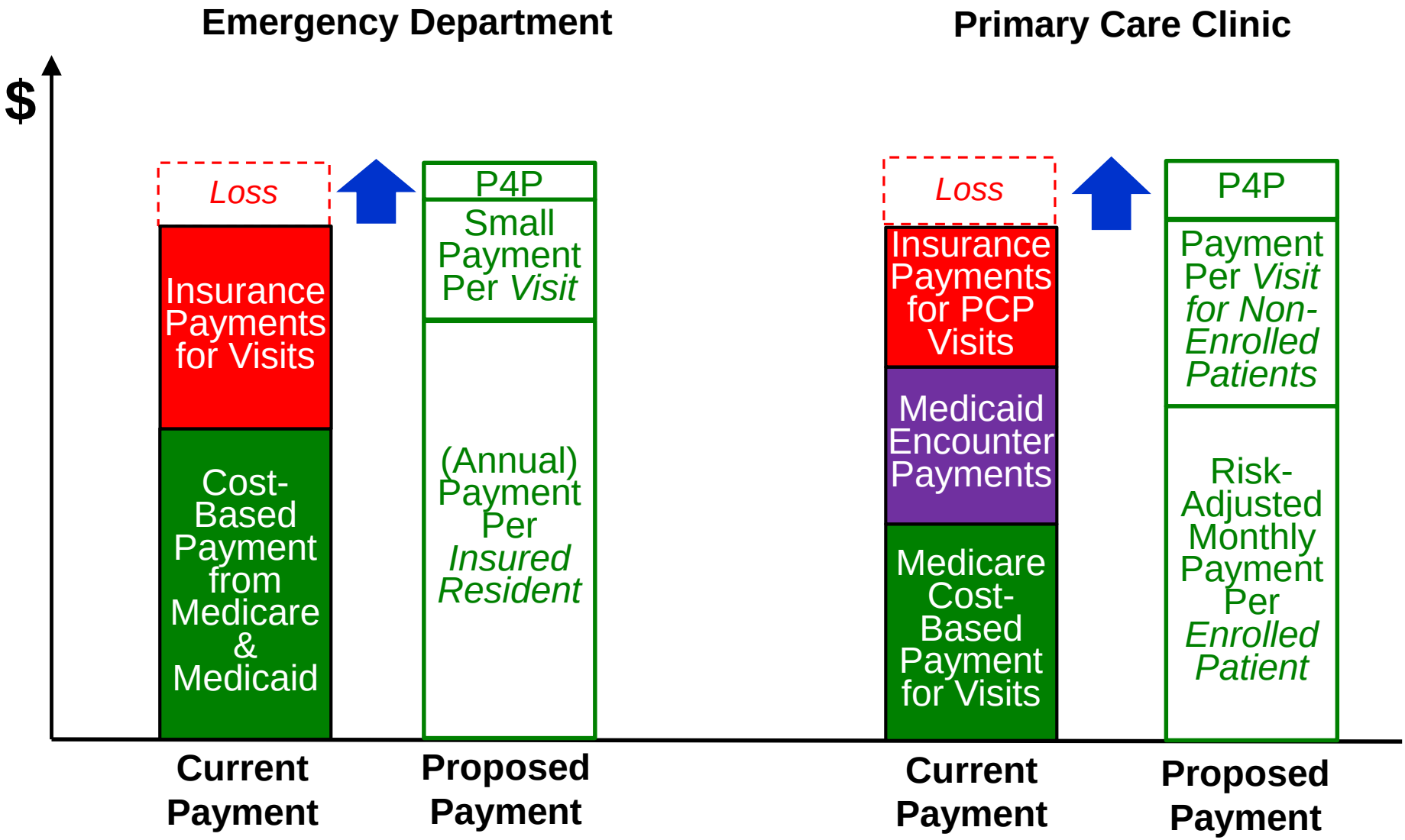
New Payment Models Need to Pay *More*, Not Just a Different Way



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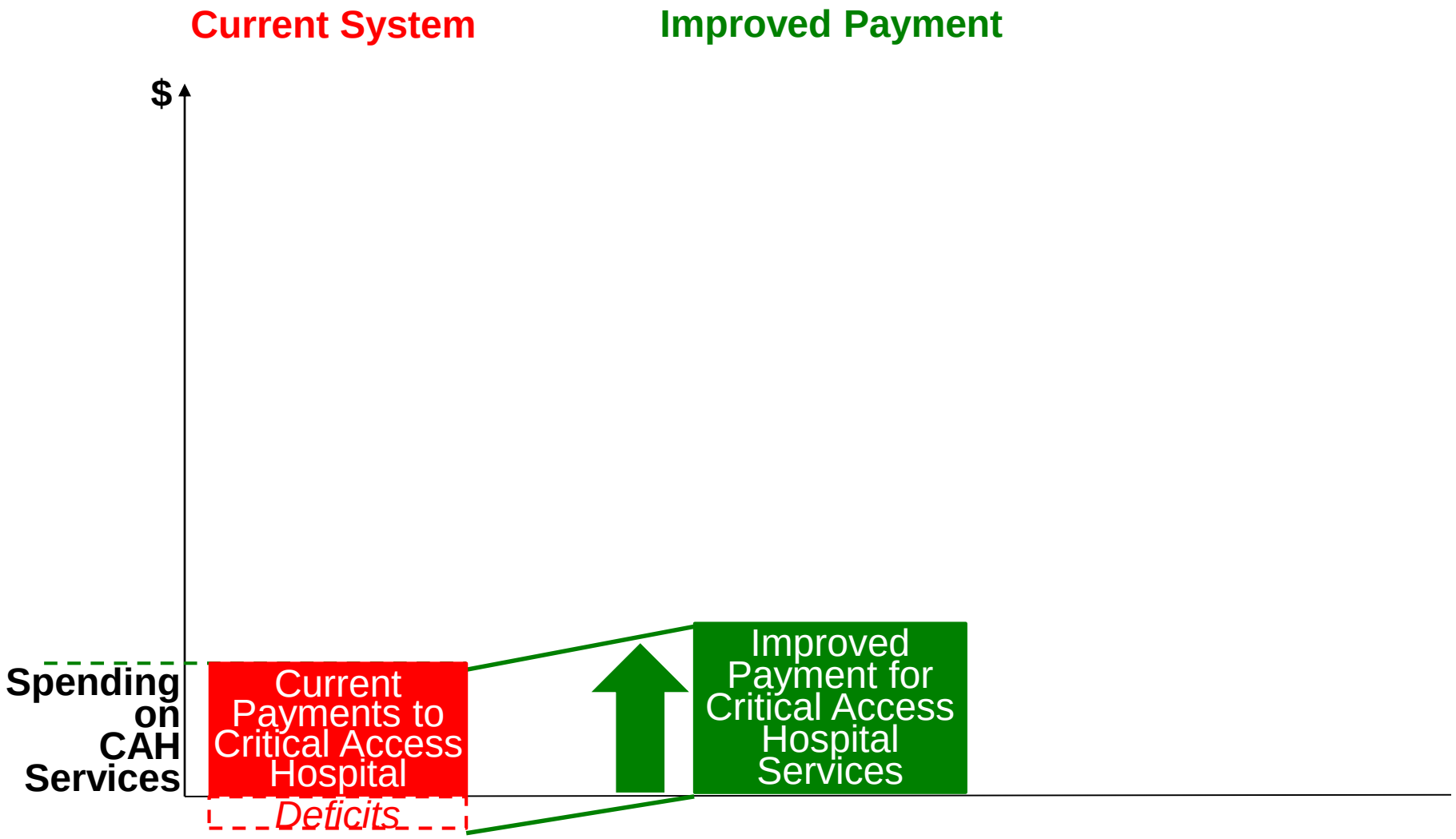
Can We Afford to Pay More for CAH Services?



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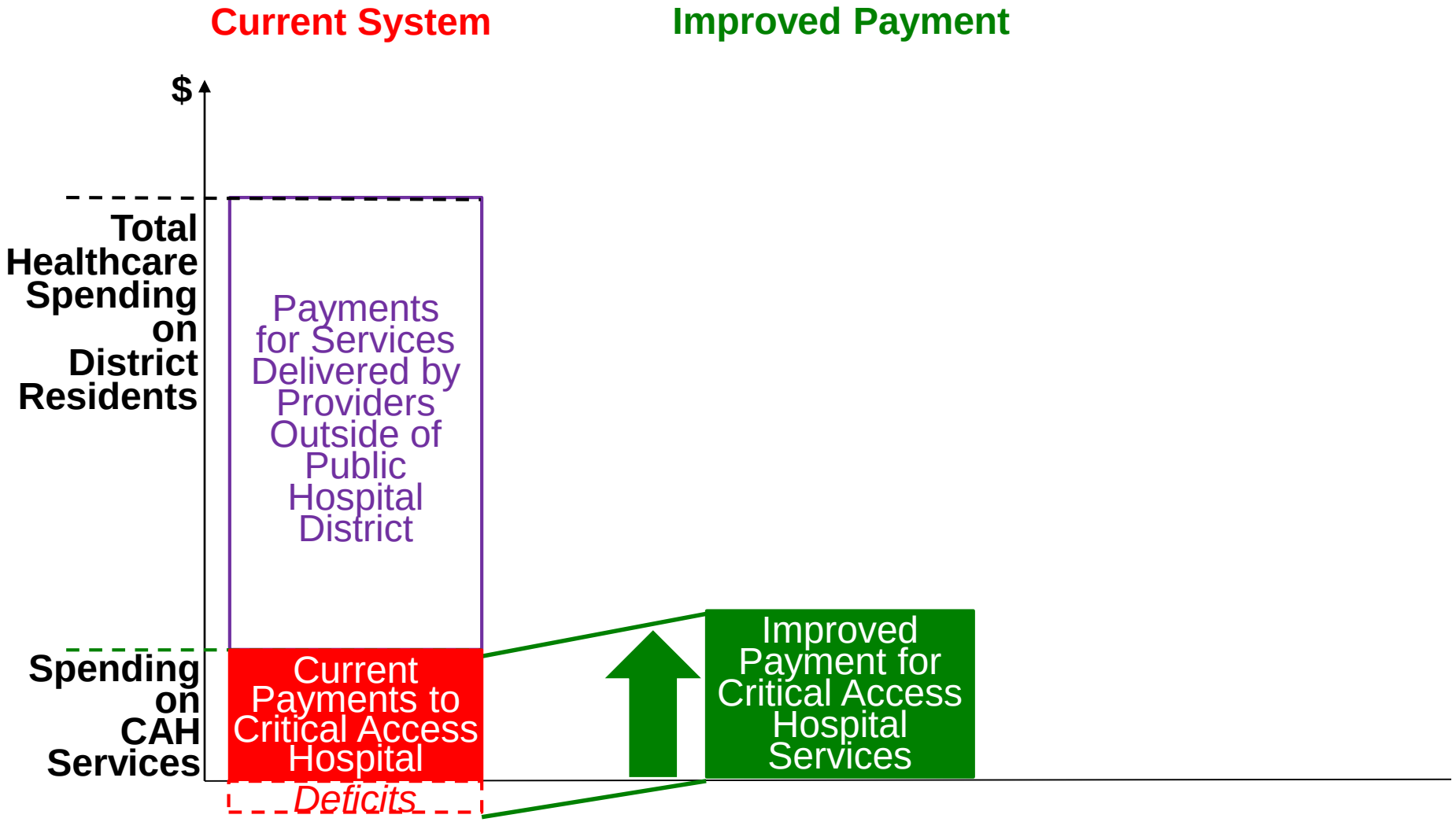
Most Spending for Residents of WRHAP PHDs Occurs Elsewhere



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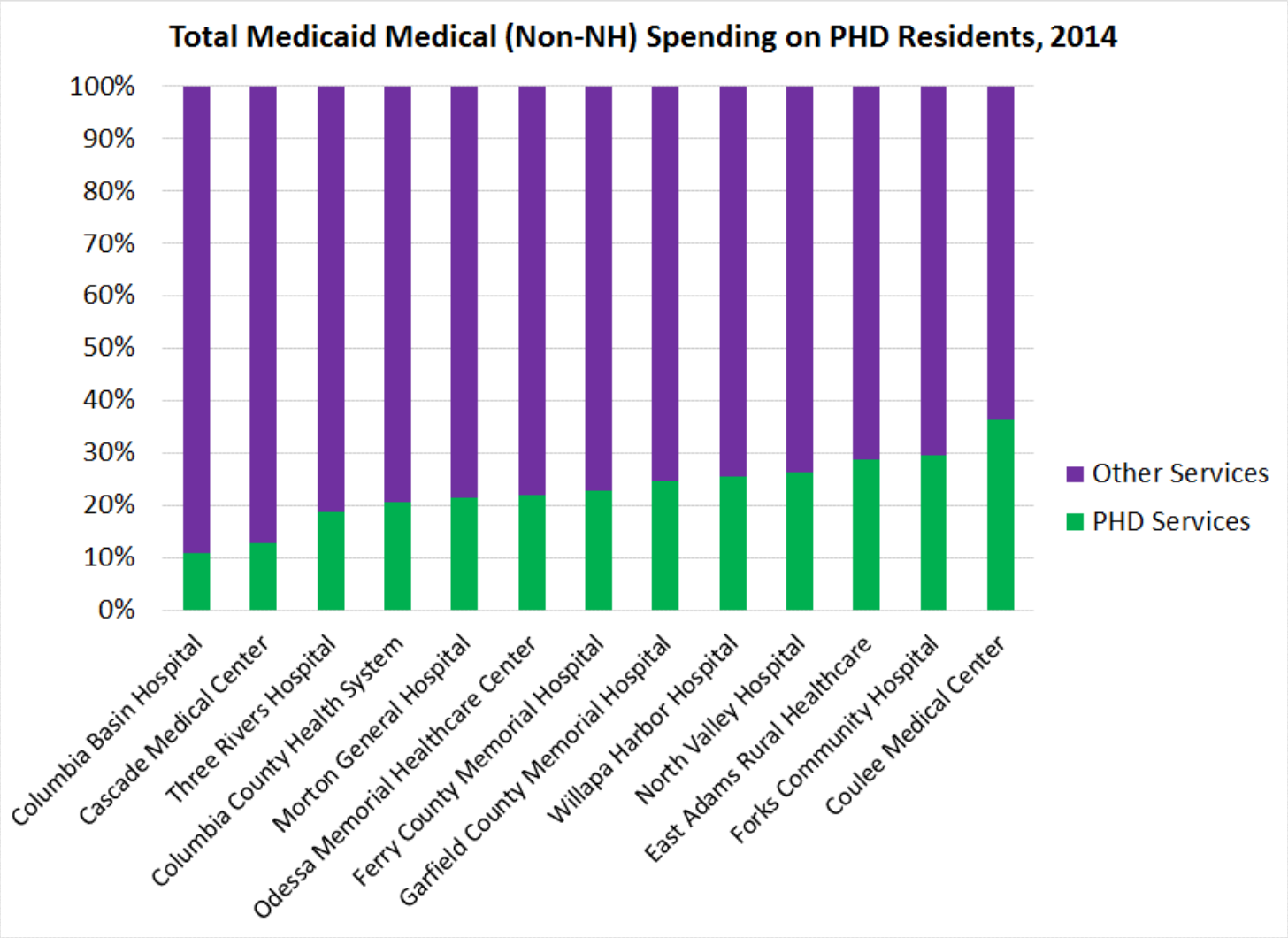
70-80% of Medicaid Spending Does Not Go to PHD Services



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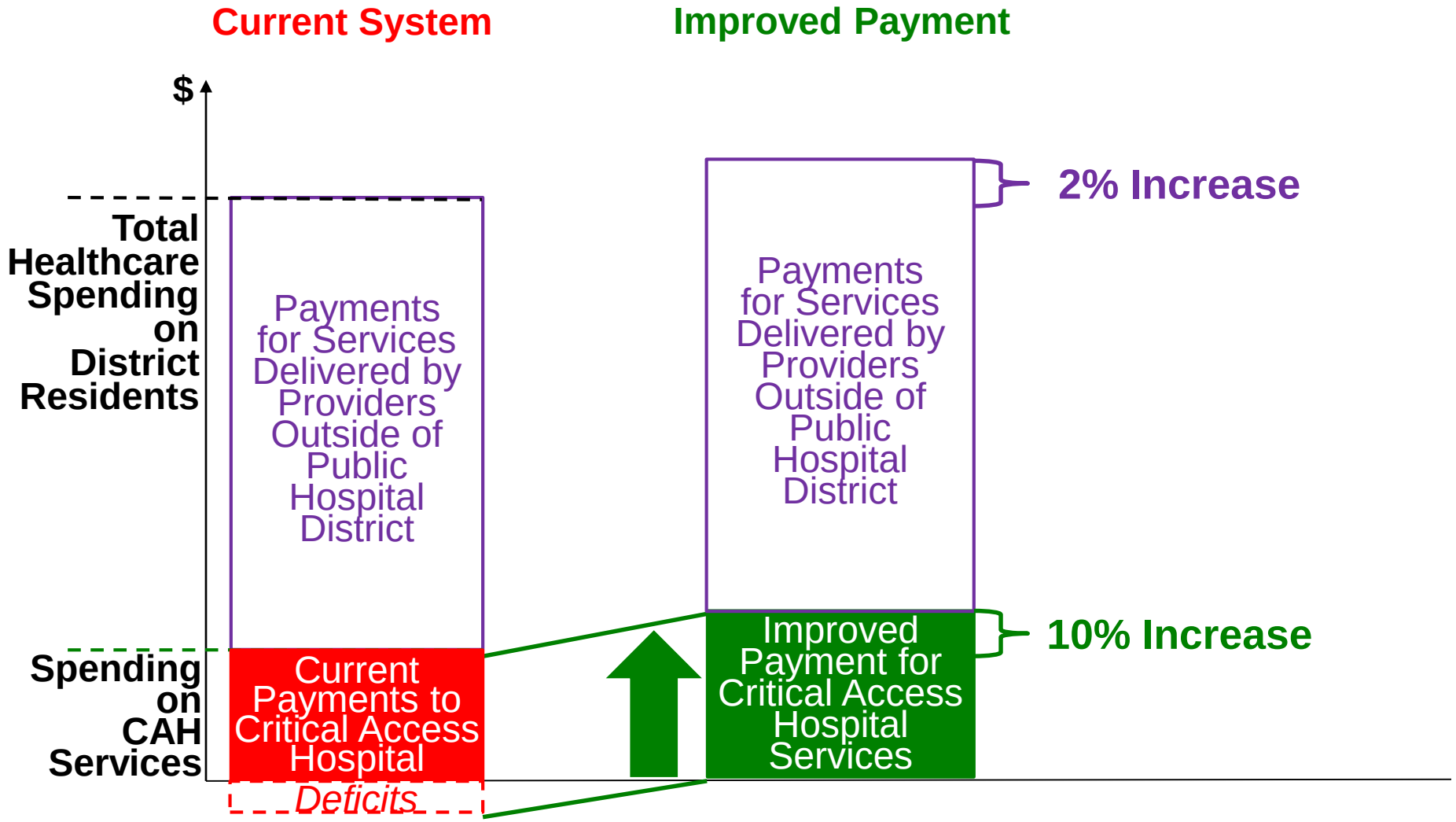
A *Big* Increase for CAH is a Much Smaller Increase in *Total* Spending



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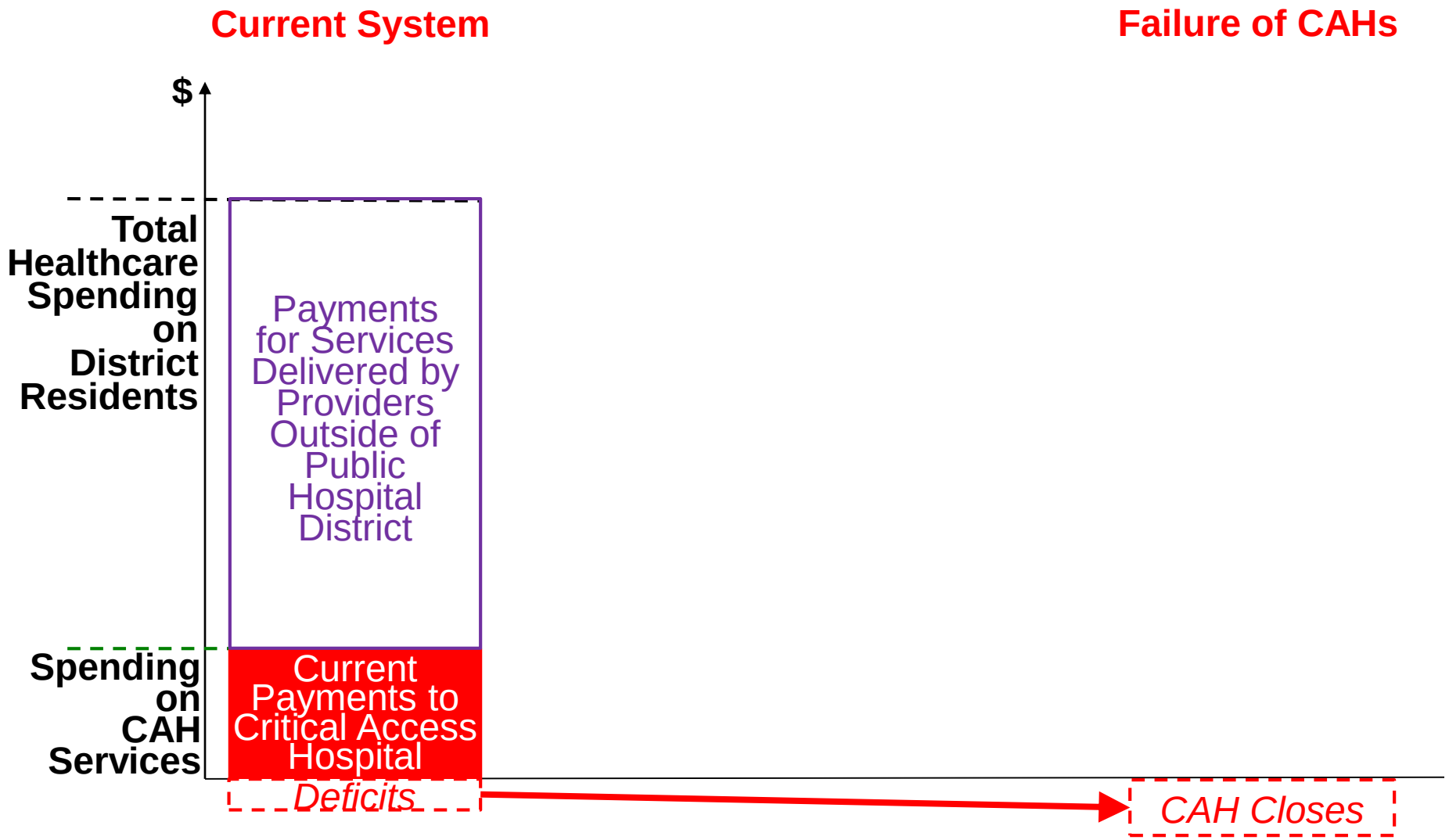
Loss of Local Services …



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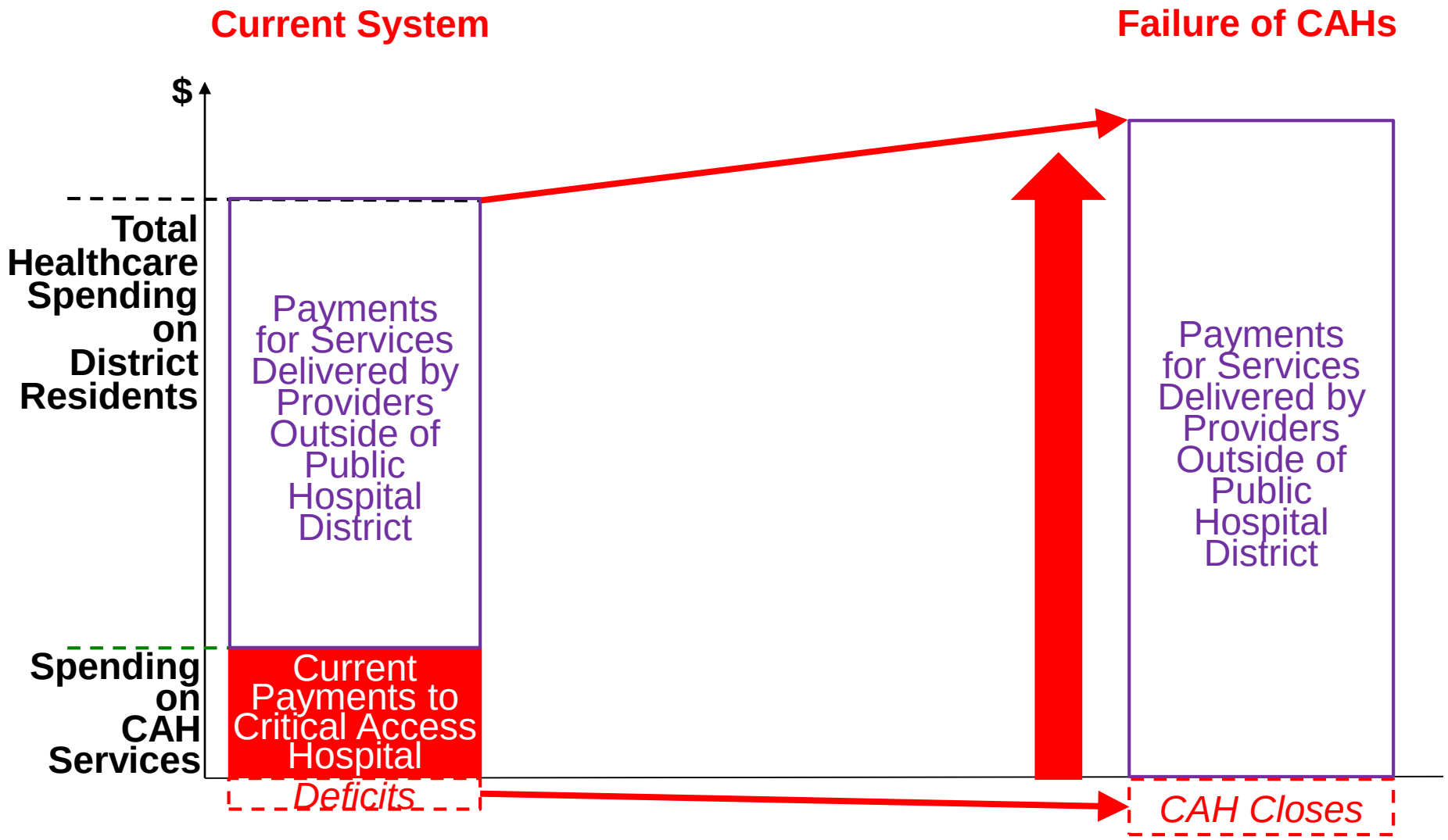
Loss of Local Services Could *Increase* Total Spending



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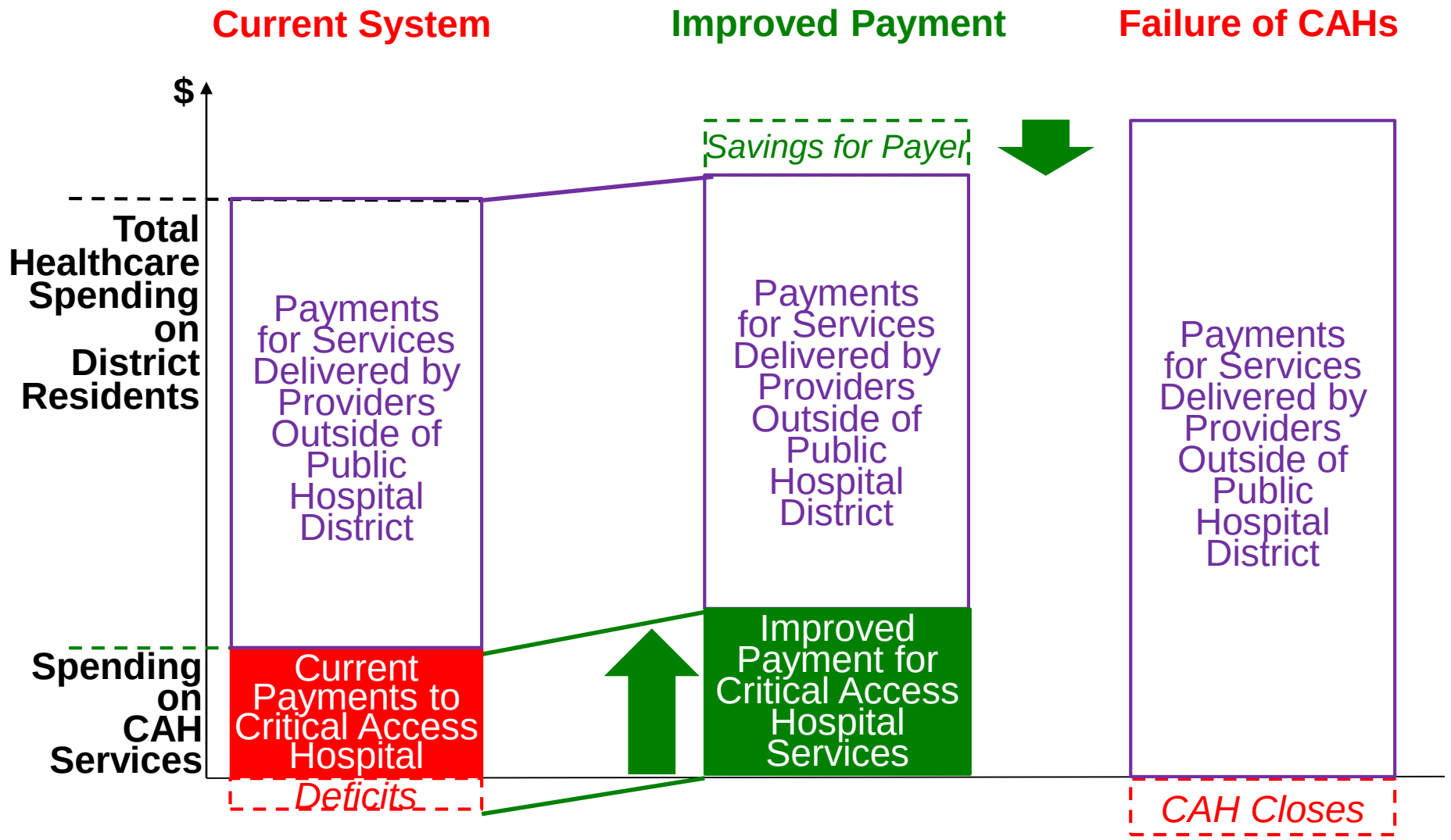
Better Payment May Save More vs. Doing Nothing



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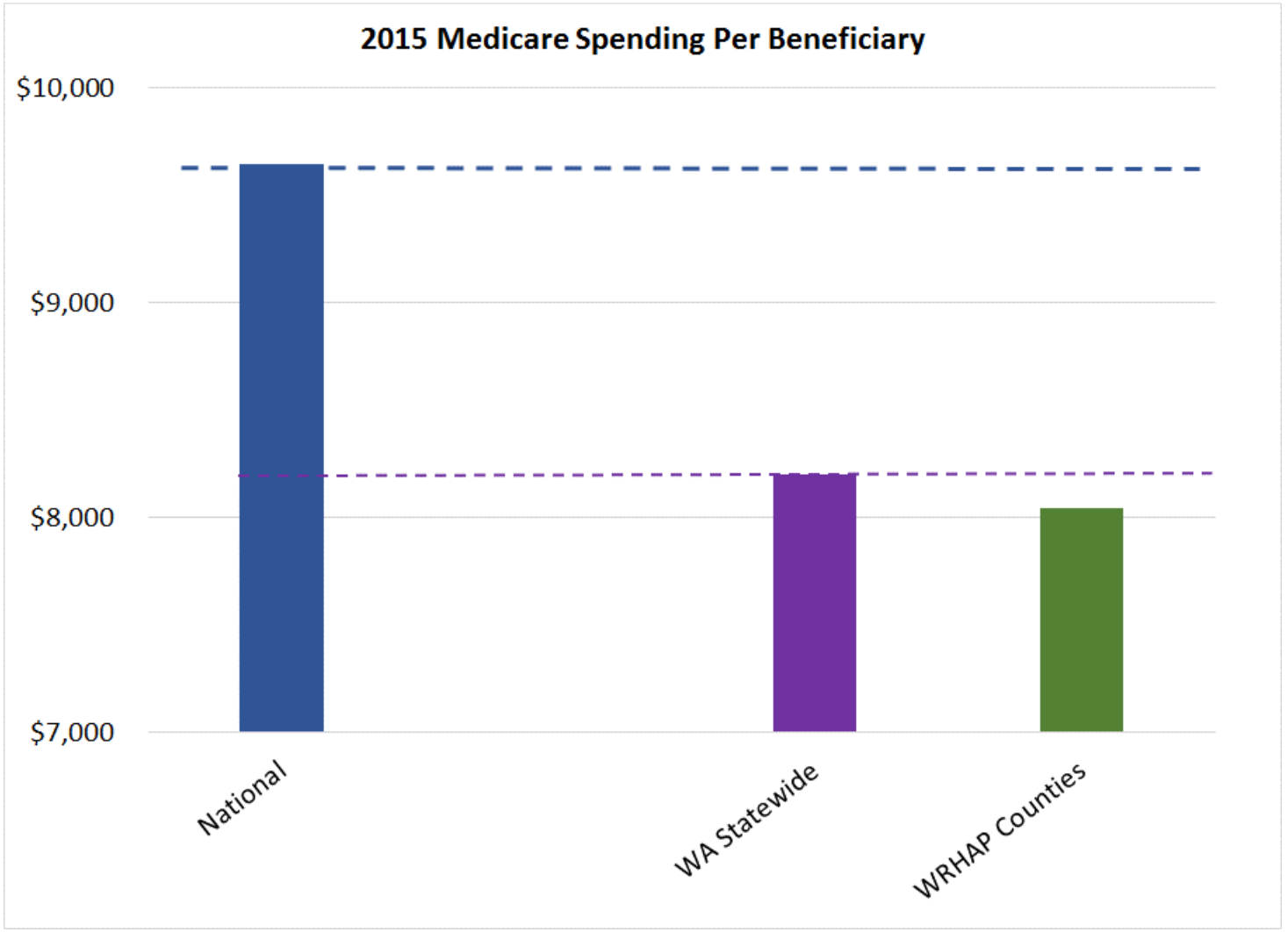
Medicare Spending in WRHAP Counties is Below State & U.S.



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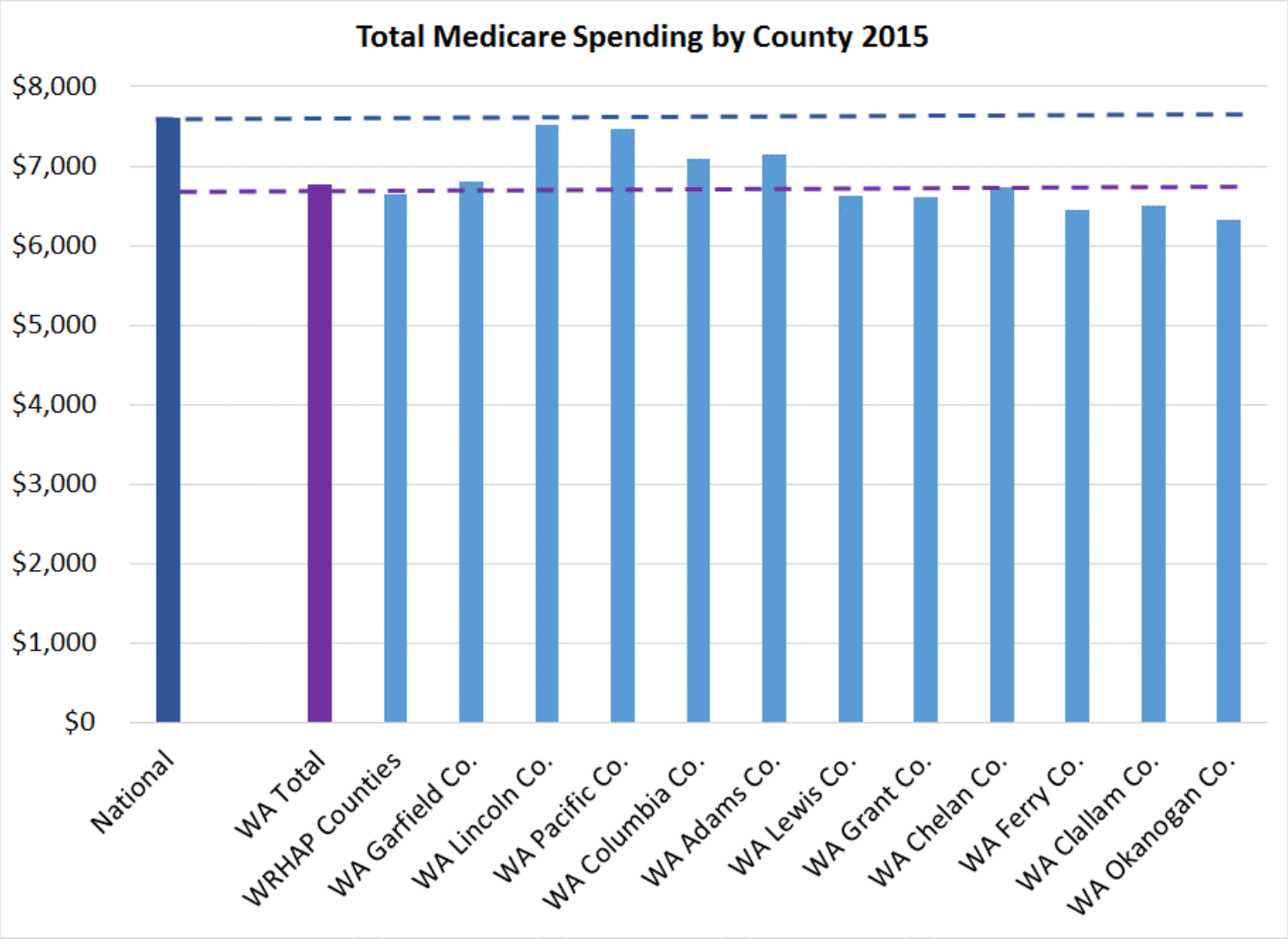
Medicare Spending for Residents of WRHAP Counties



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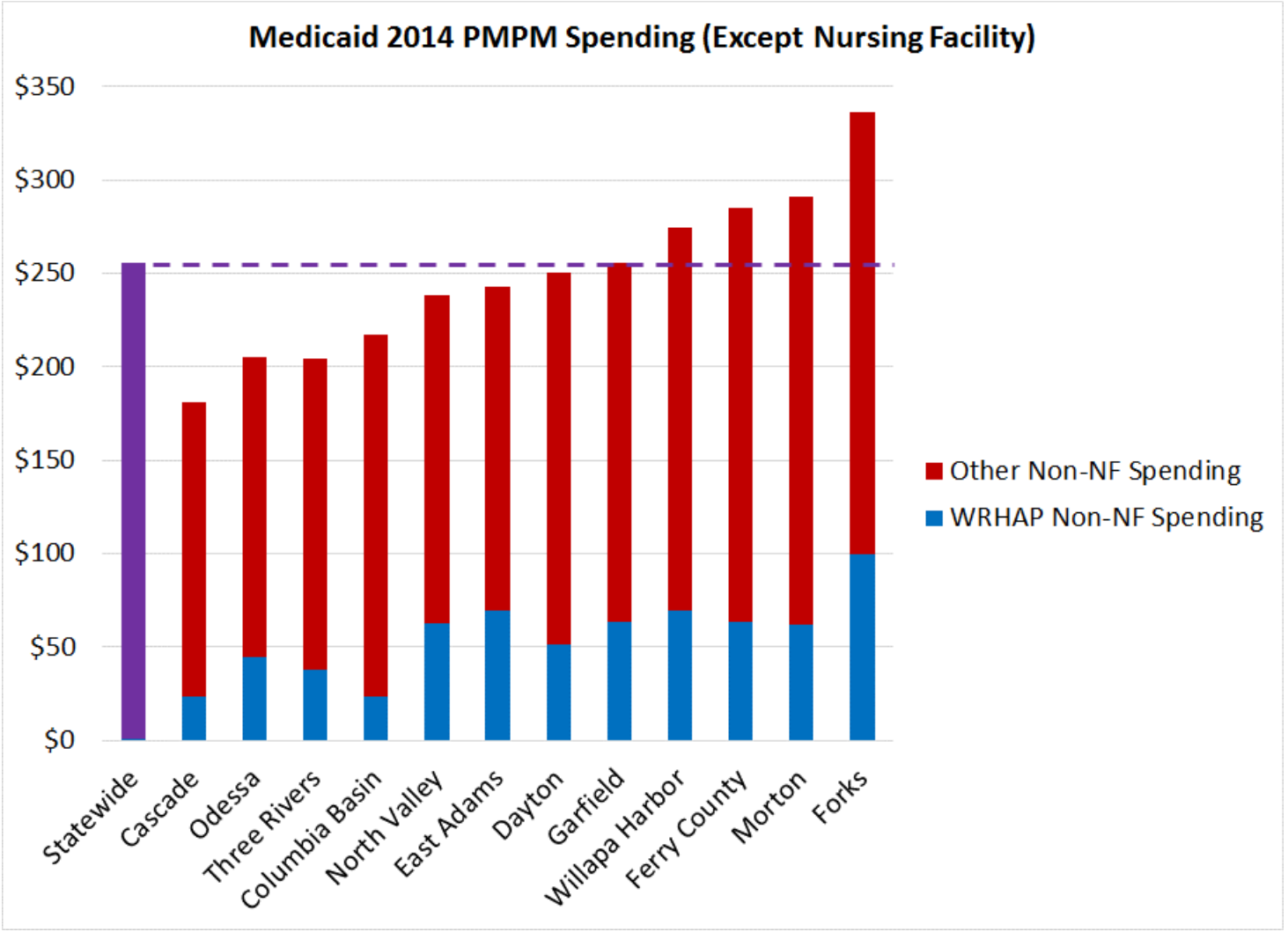
Medicaid Spending for Residents of WRHAP Districts



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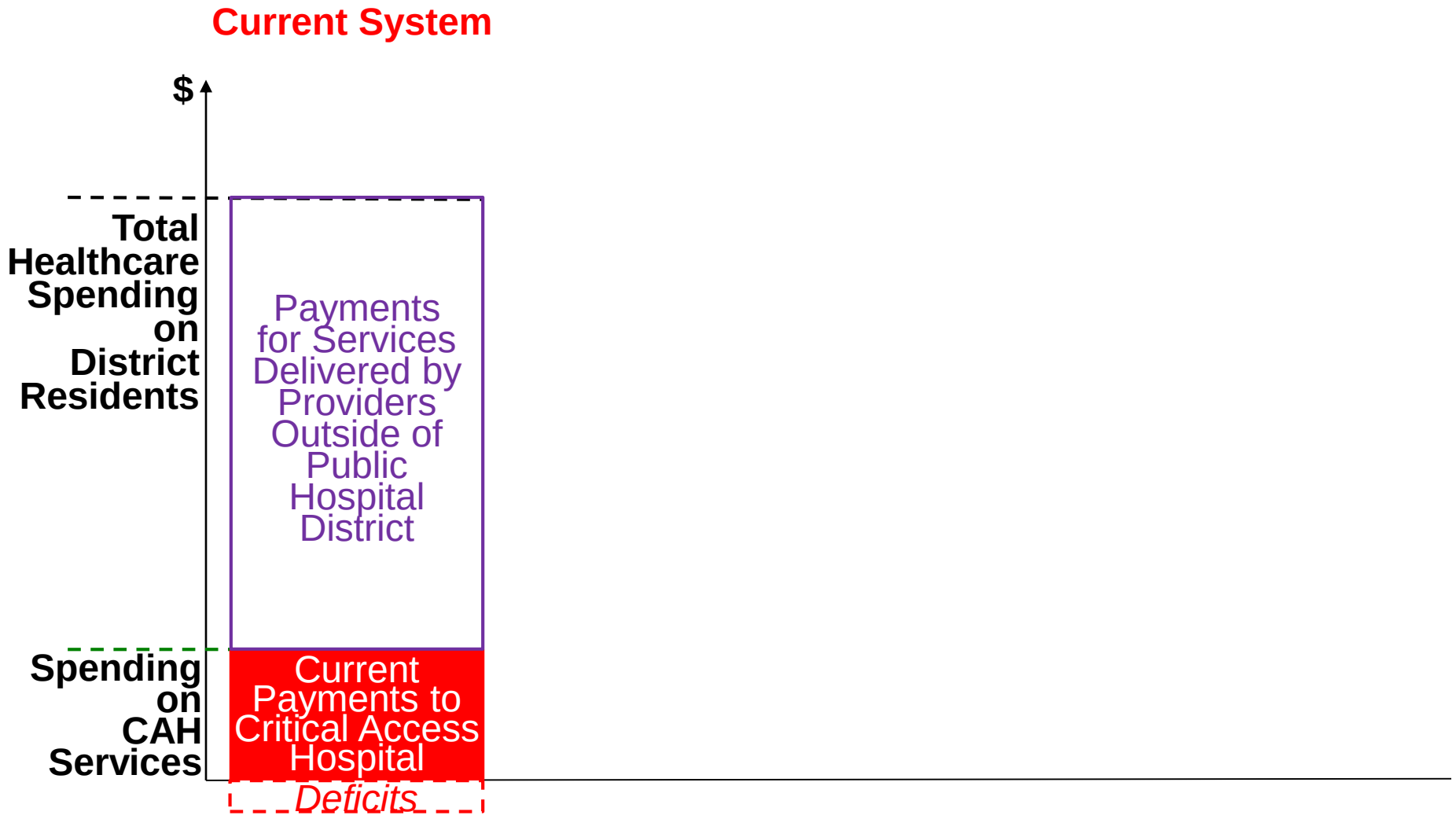
There May Be Ways to Create Savings to Offset Higher Payments



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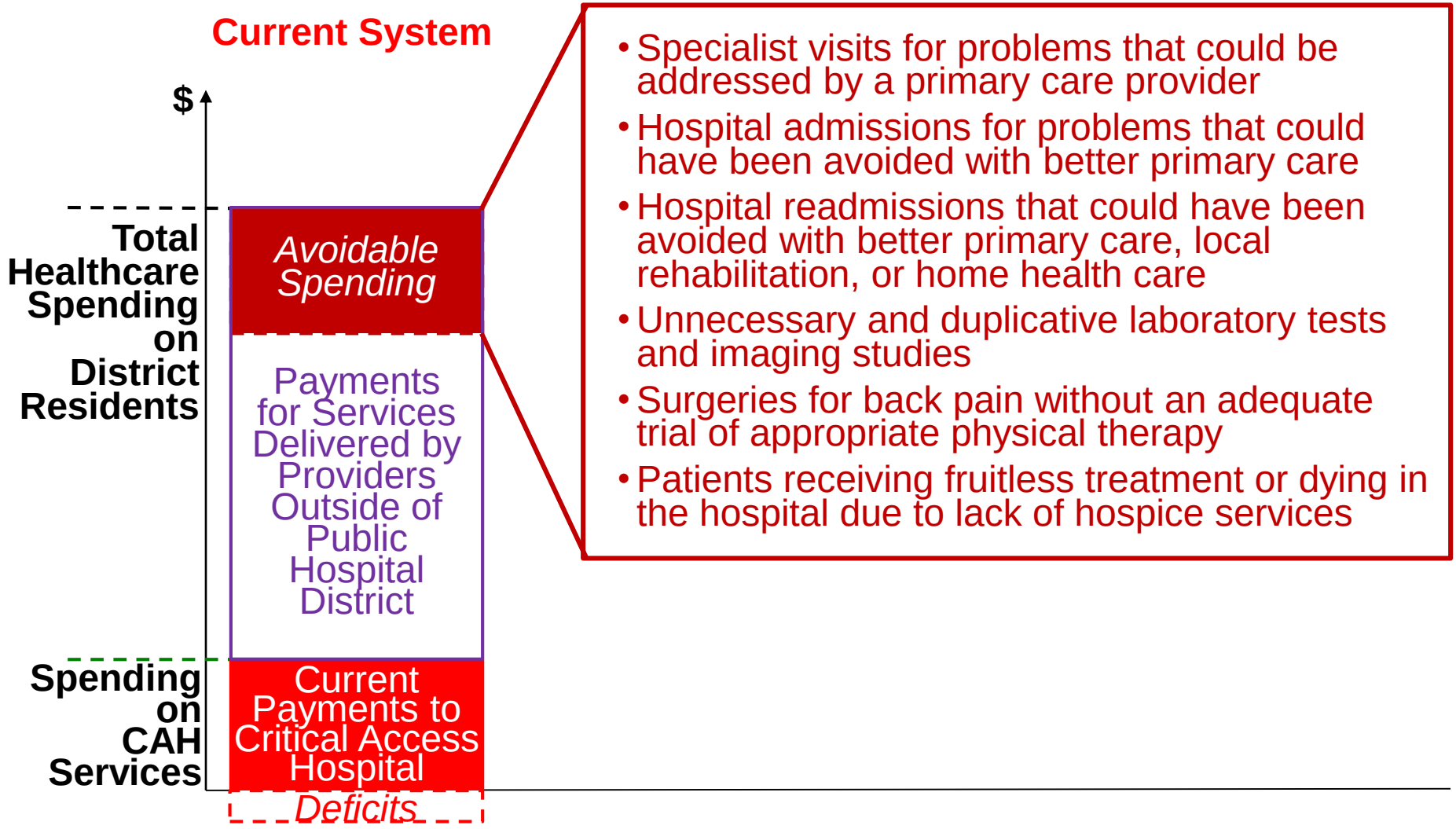
Many Examples of Potentially Avoidable Spending



- 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

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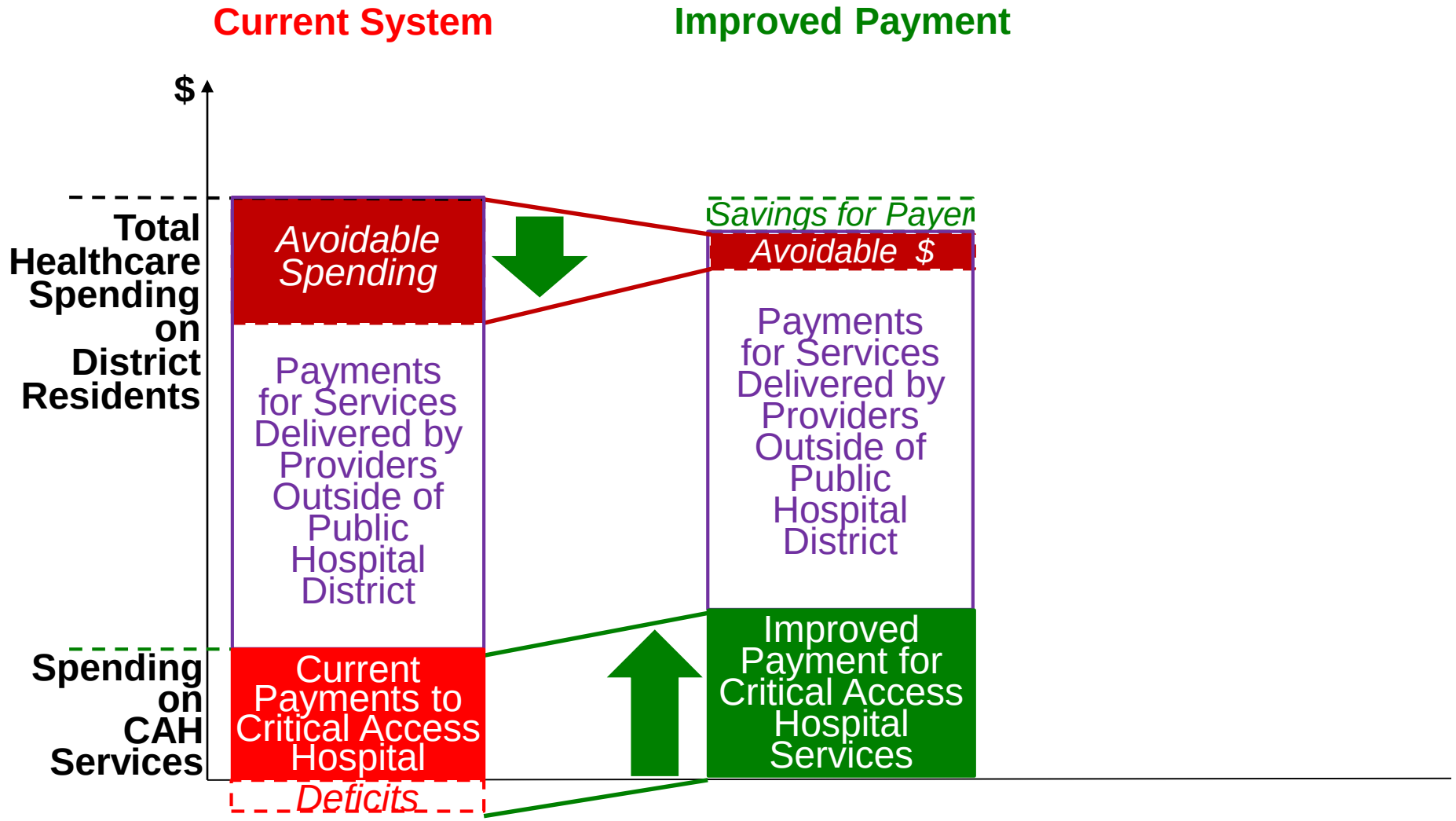
Better Payment for CAHs/RHCs Could Potentially Reduce Total $



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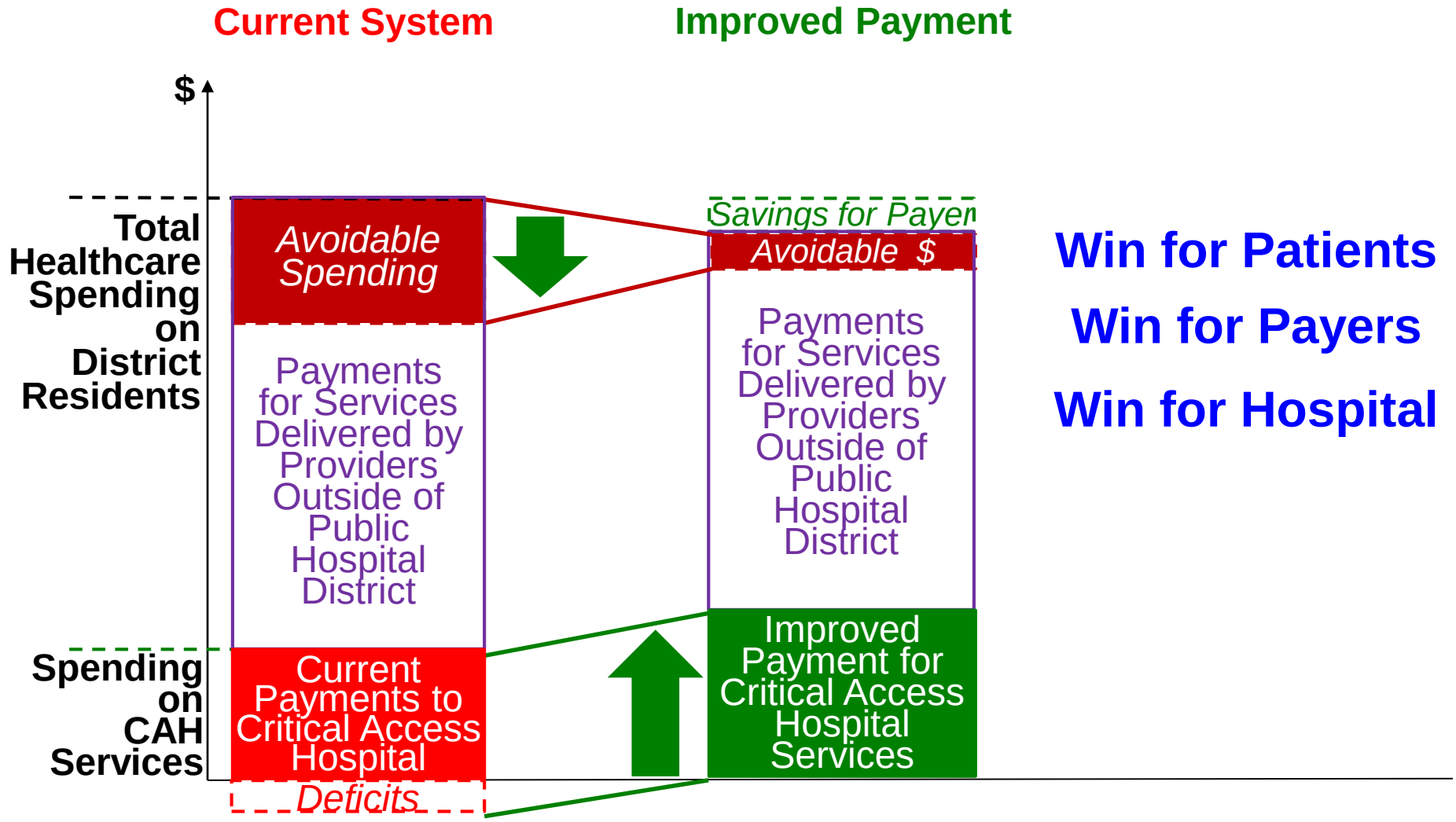
Win-Win-Win for Patients, Payers, and Hospital



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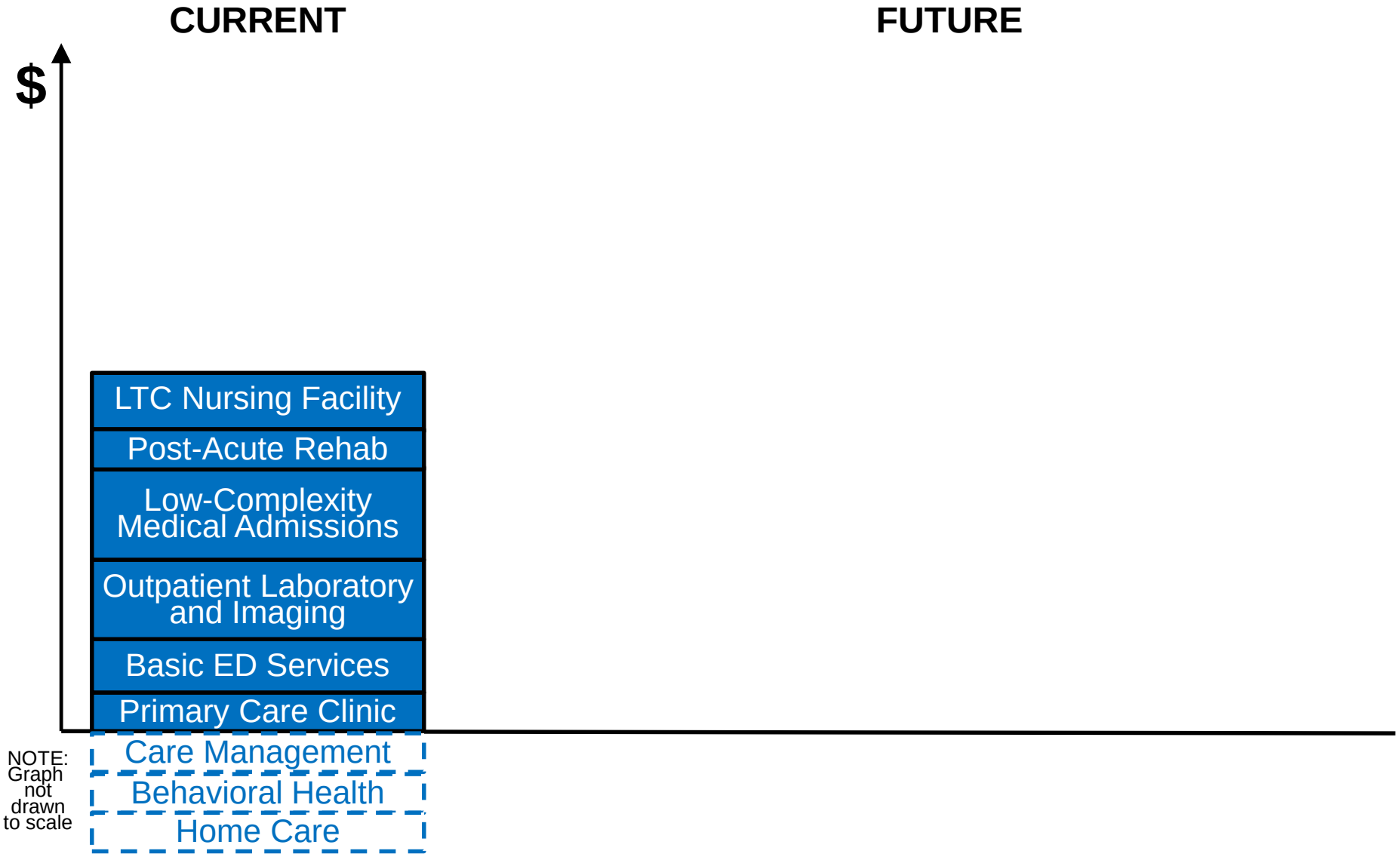
Instead of Viewing PHD as a Provider of Specific Services…



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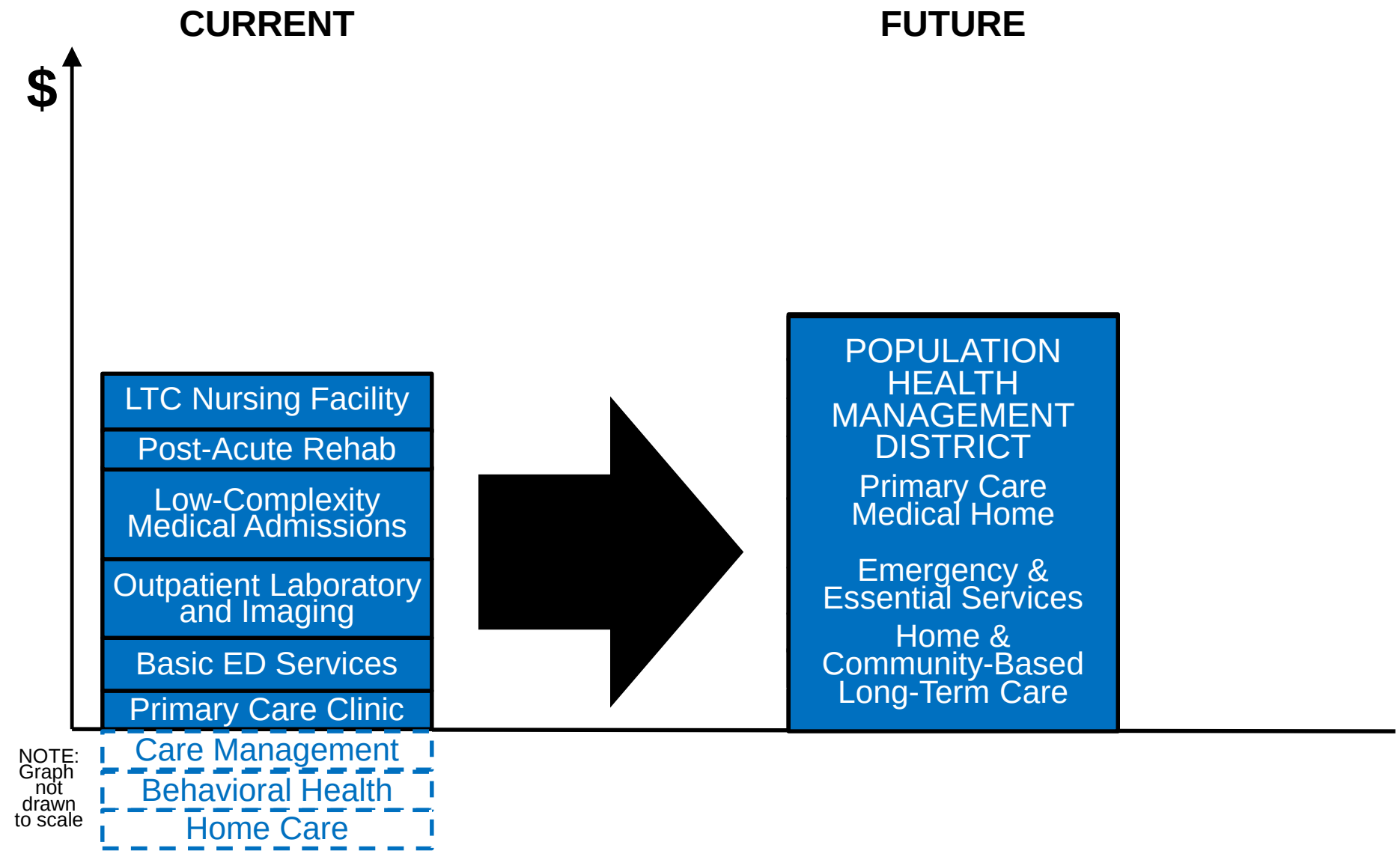
Give the PHD the Resources to Manage Population Health



NOTE: Graph not drawn to scale

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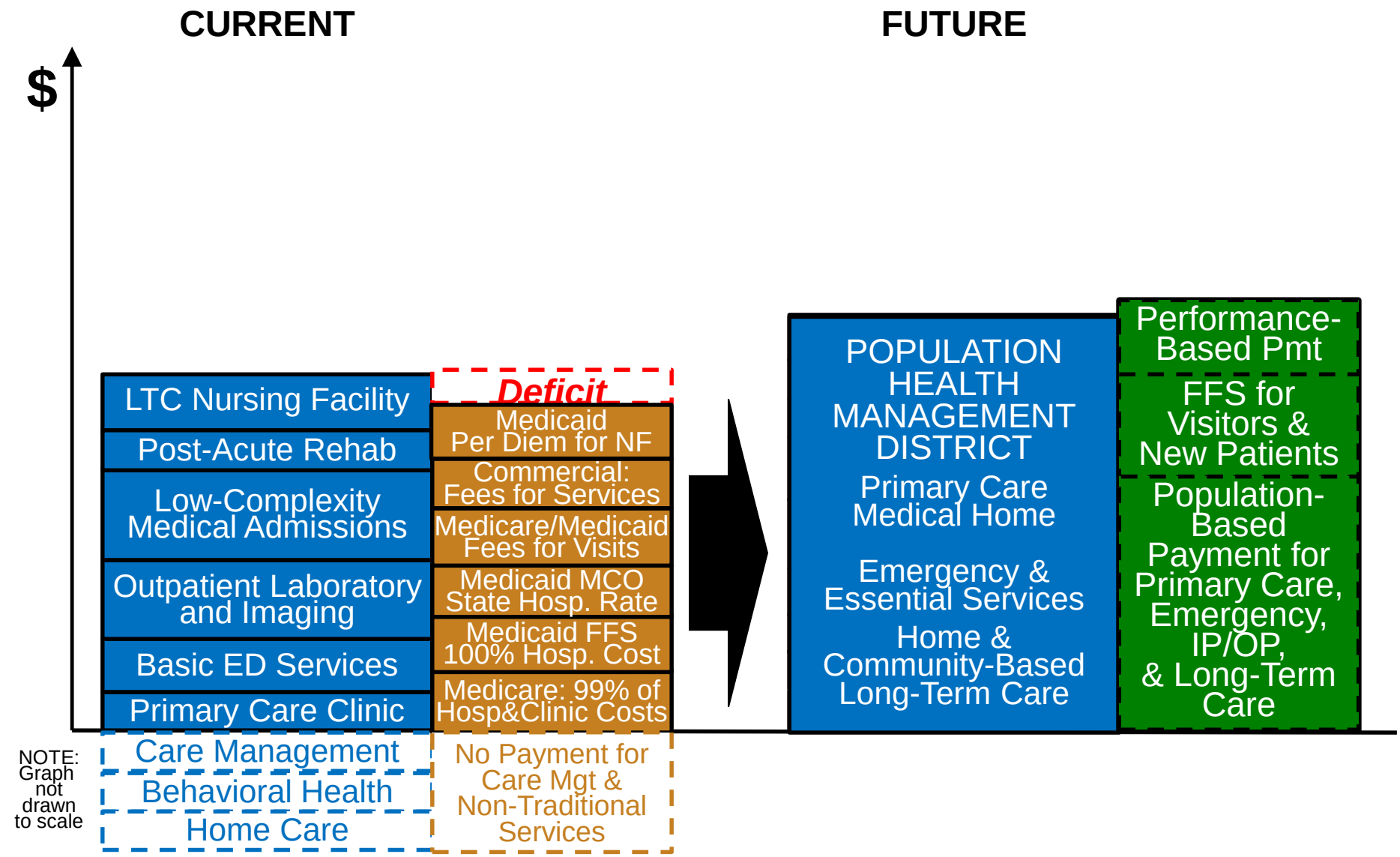
Replace Low, Complex Payments w/ a Simple, Value-Based System



NOTE: Graph not drawn to scale

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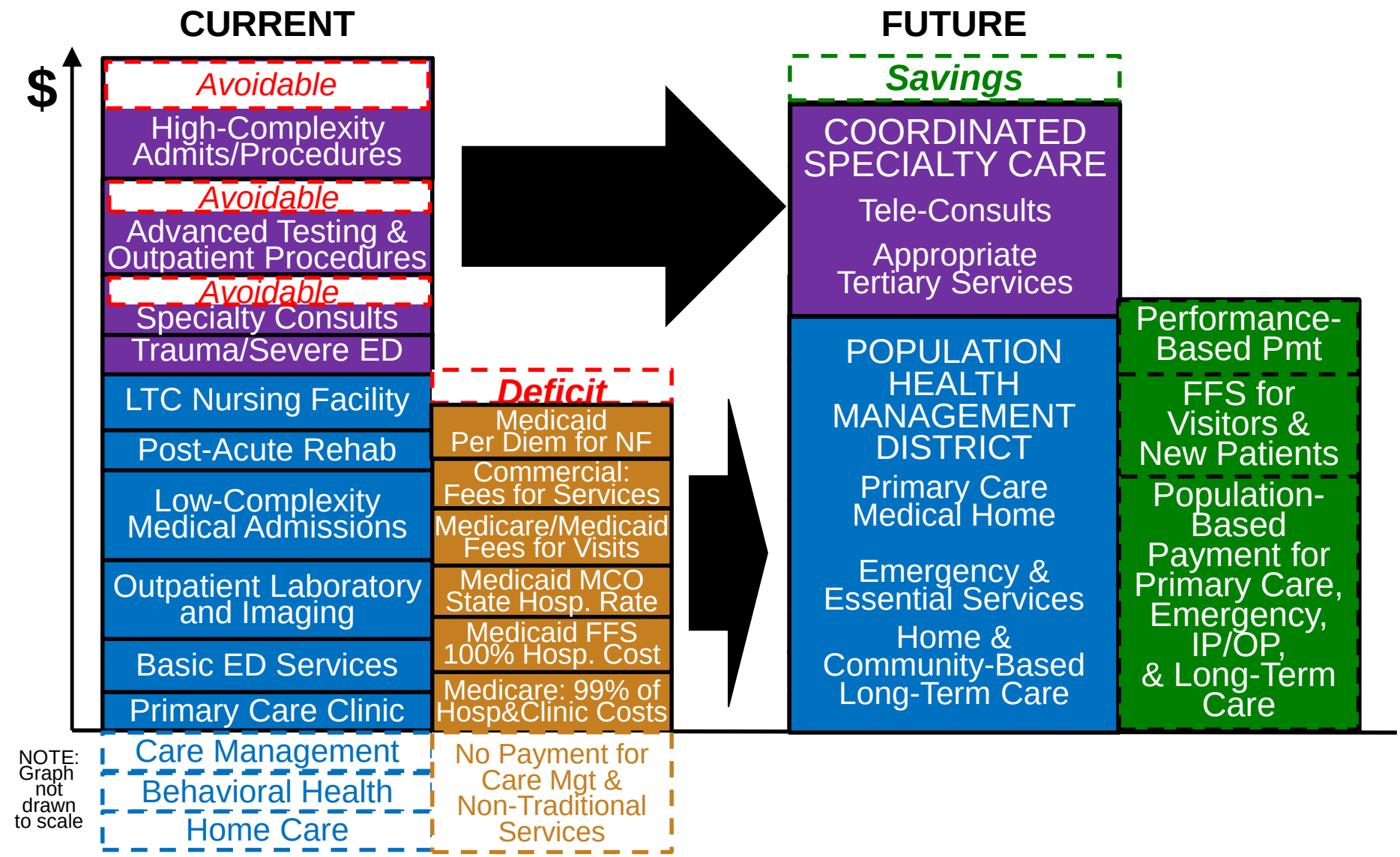
Reducing Avoidable Spending Outside the Community



NOTE: Graph not drawn to scale

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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