



Flex Reverse Site Visit 2017

Washington Rural Health Access Preservation

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PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER COMMUNITY



Objectives

- Provide high level summary for WA State Flex Innovation for CAHs/RHCs
- Brisk review of payment model
- Describe a few key lessons learned relevant to other states

Numbers

- 39 Critical Access Hospitals, all but two in public hospital districts
- About 120 Rural Health Clinics
- 2/3 of RHCs provider based-hospital owned
- Of 39 counties, 31 are rural at county level definition and five are frontier.

High level background

- New Blue H report released 2014, new facility type highest priority
- Formed WA Rural Health Access Preservation aka WRHAP, Flex and WA State Hospital Association (WSHA)
- Summer 2015, linked to Healthier WA (SIM Grant)
“Payment Model 2”
- Added Health Care Authority (HCA) and Department of Social and Health Services

WHRAP CAHS

- 13 most at risk of 39, about a third doing well, a third doing okay, and this third at risk for closure, varying levels of imminence.
- Remote and/or serving smallest population base, typical under 1200 nearest town, FMT reports show trouble, mean avg daily inpt census of 0.5 to 1.5 patients per day
- CEOs with willingness, some forward vision

Funding the work on funding

- Flex and SORH in kind large time contribution
- WSHA in-kind contribution of time
- Flex funds for fiscal modeling tool development, data aggregation and analysis
- CMMI SIM grant funds through HCA

The first year

- Review of all national model demonstrations
- Assessment of state law and rule and Medicare COP
- Give up inpatient in defined essential services
- Dove into cost data detail
- Envisioning service delivery changes
- Seeking TA for calculating a value based payment system with incentives and with any luck, a transition fund.

The evolving model

Who's version?

- Vetted conceptual model
 - Test by service line: ED, primary care, LTC first, phase - in value payment complexity

ED version

1. Define minimum budget: Payers pay for capacity cost; calculated by DOH based on minimum staffing to meet regs and other fixed costs. Pay for percentage of covered lives in total payer mix- annual per member/resident \$. **PLUS**
2. Per visit payments- amount lower for pts who have a payer who contributes and higher for per visit only

Adjustments

1. 4 MBQIP measures for quality used for quality adjustments
 2. Adjustments based on utilization, incentivizing less ED use
- Per visit fees from non-residents receiving care at CAH
 - Adjust for PHD members who go outside district for care

The Health Care Authority

- Pennsylvania envy
- Budget neutral-“increased flexibility.”
- Global payment for Inpt, ED, outpatient services (not RHC) and swing, both skilled and LTC.
- Medicaid standard measure set* for quality incentives and penalties

*52 measures in set, 2 align with MBQIP

Many lessons learned... a few to discuss

- Go multi-payer from the gate
- Long term care and lack of community alternatives for aging are interwoven
- The less specific the more open to different understandings
- Who will decide? Does everyone know it up front?

A couple more lessons

- It is difficult to think of primary care/RHCs as completely separate; though this is Flex right now
- Models for larger rural hospitals including CAHs may not work for this subset of small hospitals with low populations, risk is also a problem with low volume as is tolerance and ability to flex resources
- Inpatient is interwoven throughout allocated costs and revenue streams

And...the lessons are many.

- A brain crunching-exciting -maddening ride for all the right reasons; tenacity beats apathy every time.



Next

- Other payers a must; Medicare primary
- Devil in the details
- CMMI request to apply to all WA CAHs, others have not had a voice to date
- Total cost of care outside public hospital districts?

Thank You

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