Flex Reverse Site Visit 2019

Washington Rural Health Access Preservation (WRHAP)

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WA State Office of Rural Health
Objectives

- Provide high level summary for WA State Flex Innovation for critical access hospitals (CAHs)/rural health clinics (RHCs)
- Brisk review of payment model
- Describe a few key lessons learned relevant to other states
Numbers

- 39 CAHs, all but two in public hospital districts
- About 110 RHC
- 2/3 of RHCs provider based-hospital owned
- Of 39 counties, 31 are rural at county level definition and five are frontier.
# Net Revenues 2013-2016; RED INK

## Income from Patient Services

<table>
<thead>
<tr>
<th>Hospital</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>4-Year Avg.</th>
<th>5-Year Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>($2,543,150)</td>
<td>($2,656,149)</td>
<td>($2,758,124)</td>
<td>($2,747,653)</td>
<td>($10,705,076)</td>
<td>4.4%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Hospital B</td>
<td>($1,527,800)</td>
<td>($1,882,479)</td>
<td>($2,389,999)</td>
<td>($1,562,504)</td>
<td>($7,362,782)</td>
<td>23.2%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Hospital C</td>
<td>($1,112,827)</td>
<td>($1,938,583)</td>
<td>($1,680,075)</td>
<td>($1,353,082)</td>
<td>($6,084,567)</td>
<td>74.2%</td>
<td>-13.3%</td>
</tr>
<tr>
<td>Hospital D</td>
<td>($1,282,997)</td>
<td>($776,389)</td>
<td>$656,894</td>
<td>($2,599,300)</td>
<td>($4,001,792)</td>
<td>-39.5%</td>
<td>-184.6%</td>
</tr>
<tr>
<td>Hospital E</td>
<td>($686,459)</td>
<td>($279,172)</td>
<td>($762,467)</td>
<td>($515,865)</td>
<td>($2,243,963)</td>
<td>-59.3%</td>
<td>173.1%</td>
</tr>
<tr>
<td>Hospital F</td>
<td>($4,704,956)</td>
<td>($3,166,315)</td>
<td>($4,974,292)</td>
<td>($4,263,391)</td>
<td>($17,108,954)</td>
<td>-32.7%</td>
<td>57.1%</td>
</tr>
<tr>
<td>Hospital G</td>
<td>($233,606)</td>
<td>($781,674)</td>
<td>($914,407)</td>
<td>($1,360,823)</td>
<td>($3,317,510)</td>
<td>234.6%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Hospital H</td>
<td>($2,247,763)</td>
<td>($2,797,119)</td>
<td>($922,576)</td>
<td>($2,237,899)</td>
<td>($8,205,357)</td>
<td>24.4%</td>
<td>-67.0%</td>
</tr>
<tr>
<td>Hospital J</td>
<td>($688,161)</td>
<td>$522,747</td>
<td>$1,124,294</td>
<td>$378,569</td>
<td>$1,337,449</td>
<td>-176.0%</td>
<td>115.1%</td>
</tr>
<tr>
<td>Hospital K</td>
<td>($809,235)</td>
<td>($1,230,814)</td>
<td>($739,824)</td>
<td>($1,107,439)</td>
<td>($3,887,312)</td>
<td>52.1%</td>
<td>-39.9%</td>
</tr>
<tr>
<td>Hospital L</td>
<td>($2,244,030)</td>
<td>($1,867,164)</td>
<td>($1,197,389)</td>
<td>($1,658,973)</td>
<td>($6,967,556)</td>
<td>-16.8%</td>
<td>-35.9%</td>
</tr>
<tr>
<td>Hospital M</td>
<td>($1,634,318)</td>
<td>($1,669,544)</td>
<td>($1,872,284)</td>
<td>($957,735)</td>
<td>($6,133,881)</td>
<td>2.2%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Total All Hospitals</td>
<td>($22,399,464)</td>
<td>($20,657,040)</td>
<td>($18,452,365)</td>
<td>($22,387,549)</td>
<td>($83,896,418)</td>
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</tr>
</tbody>
</table>
High level background

• CMMI is the only part of CMS that has legislative authority to issue demonstration projects.
• 2016 Formed WA Rural Health Access Preservation aka WRHAP, Flex and WA State Hospital Association (WSHA)
• Summer 2015, linked to Healthier WA (State Innovation Model (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, Flex Monitoring Team (FMT) reports show trouble, mean average 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 State Office of Rural Health (SORH) in-kind large time contribution
• WSHA in-kind contribution of time
• Flex funds for fiscal modeling tool development, data aggregation and analysis
• Centers for Medicare and Medicaid Innovation Center (CMMI) SIM grant funds through HCA
The first year

- Review of all national model demonstrations
- Assessment of state law and rule and Medicare Conditions of Participation (COP)
- Give up inpatient in defined essential services
- Dive 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

HB 1520

• 2017 HB 1520 authorized an alternative payment methodology to stabilize WRHAP hospitals

• Provided needed funding for care transformation until a new system was in place

• HCA continues to develop the multi-payer payment model for rural hospitals
The Third Year
A Tale of Two Models

Harold Miller working with WHRAP

• Three part payment:
• PMPM for each plan in proportion to their percentage share of the population in payer mix for basic capacity cost
• Per visit payments- amount lower for pts who have a payer who contributes to per-member-per-month (PMPM) and higher payers who do not contribute.
• Quality Incentives
• Per service line models
The Third Year
A Tale of Two Models, Continued

Health Care Authority (HCA) proposal

• Single global budget across multiple service lines; inpatient, Emergency Department (ED) and primary care.
• Based on previous year’s net revenue
• Adjustments for unforeseen factors
• Quality incentives
• Budget neutral means: you can only lose, not gain
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?
Next

- CMMI has requested that the Health Care Authority not pursue further authorization for a new global payment model.
- Instead, wait until the Pennsylvania model is rolled out and active for a year to see if there are parts to replicate.
Thank You

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