Flex Reverse Site Visit 2019

Washington Rural Health Access Preservation (WRHAP)

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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 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

- Hospital A ($2,543,150) ($2,656,149) ($2,758,124) ($2,747,653) ($10,705,076) 4.4% 3.8% -0.4% 8.0%
- Hospital B($1,527,800) ($1,882,479) ($2,389,999) ($1,562,504) ($7,362,782) 23.2% 27.0% -34.6% 2.3%
- Hospital C ($1,112,827) ($1,938,583) ($1,680,075) ($1,353,082) ($6,084,567) 74.2% -13.3% -19.5% 21.6%
- Hospital D($1,282,997) ($776,389) $656,894 ($2,599,300) ($4,001,792) -39.5% -184.6% -495.7% 102.6%
- Hospital E($686,459) ($279,172) ($762,467) ($515,865) ($2,243,963) -59.3% 173.1% -32.3% -24.9%
- Hospital F($4,704,956) ($3,166,315) ($4,974,292) ($4,263,391) ($17,108,954) -32.7% 57.1% -14.3% -9.4%
- Hospital G($233,606) ($781,674) ($941,407) ($1,360,823) ($3,317,510) 234.6% 20.4% 44.6% 482.5%
- Hospital H($2,247,763) ($2,797,119) ($922,576) ($2,237,899) ($8,205,357) 24.4% -67.0% 142.6% -0.4%
- Hospital J ($688,161) $522,747 $1,124,294 $378,569 $1,337,449 -176.0% 115.1% -66.3% -155.0%
- Hospital K($809,235) ($1,230,814) ($739,824) ($1,107,439) ($3,887,312) 52.1% -39.9% 49.7% 36.9%
- Hospital L($2,244,030) ($1,867,164) ($1,197,389) ($1,658,973) ($6,967,556) -16.8% -35.9% 38.5% -26.1%
- Hospital M($1,634,318) ($1,669,544) ($1,872,284) ($957,735) ($6,133,881) 2.2% 12.1% -48.8% -41.4%
- Total All Hospitals ($22,399,464) ($20,657,040) ($18,452,365) ($22,387,549) ($83,896,418)

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
- 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

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

<u>Harold Miller working with WHRAP</u>

- 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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