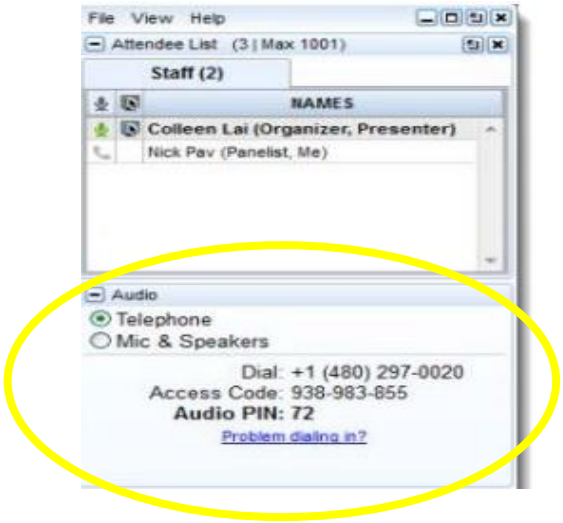
Before we get started, let's make sure we are connected

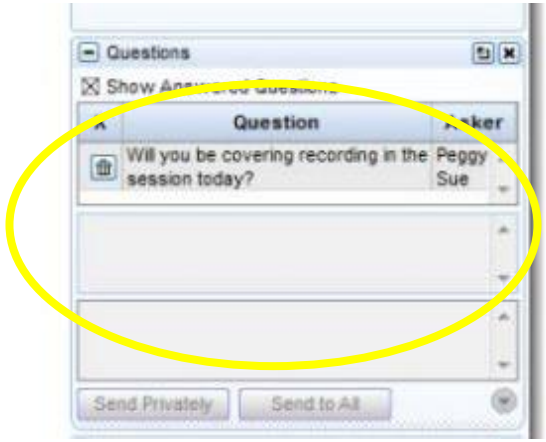
Audio Options

- Mic & Speakers
- Telephone: Use your phone to dial the number in the "Audio" section of the webinar panel. When prompted, enter your access code and audio pin.



Have questions?

Please use the "Questions" section in the webinar panel to submit any questions or concerns you may have. Our panelists will answer questions as they arise and at the end of the presentation.





Washington Rural Multi-Payer Model

December 14, 2017

Provider challenges in rural regions

Providers face

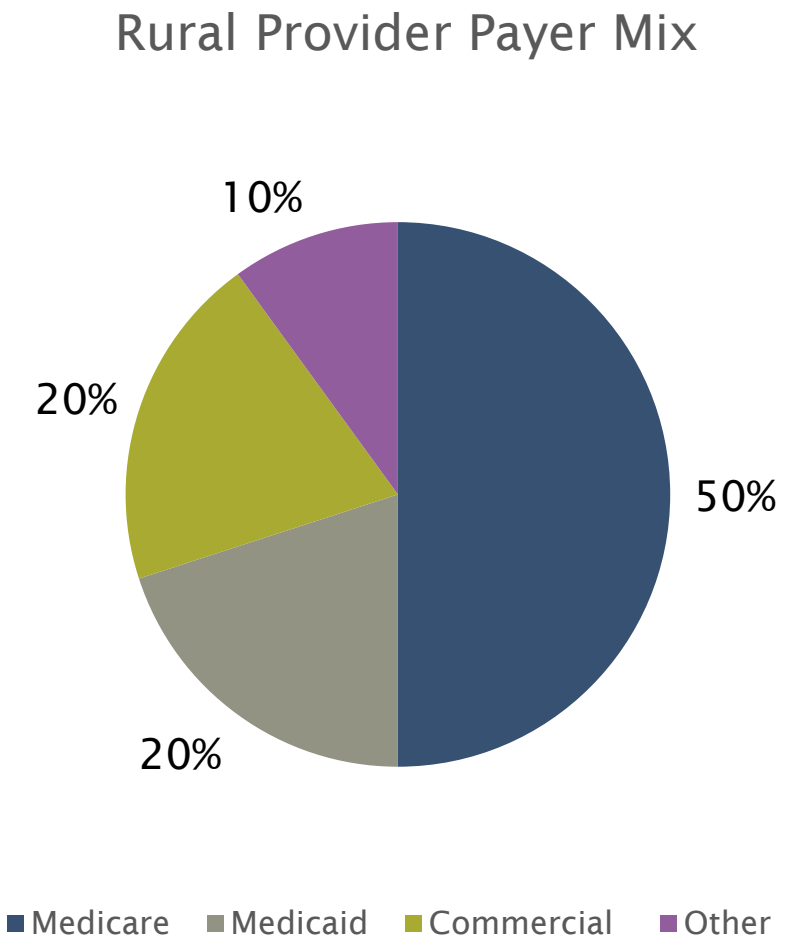
- Recruitment and retention
- Sicker, older populations
- Operating margins are low
- Relationships with larger systems have not benefited rural providers…

Low utilization and challenges faced under cost-based reimbursement will be exacerbated as the system moves to value-based purchasing.

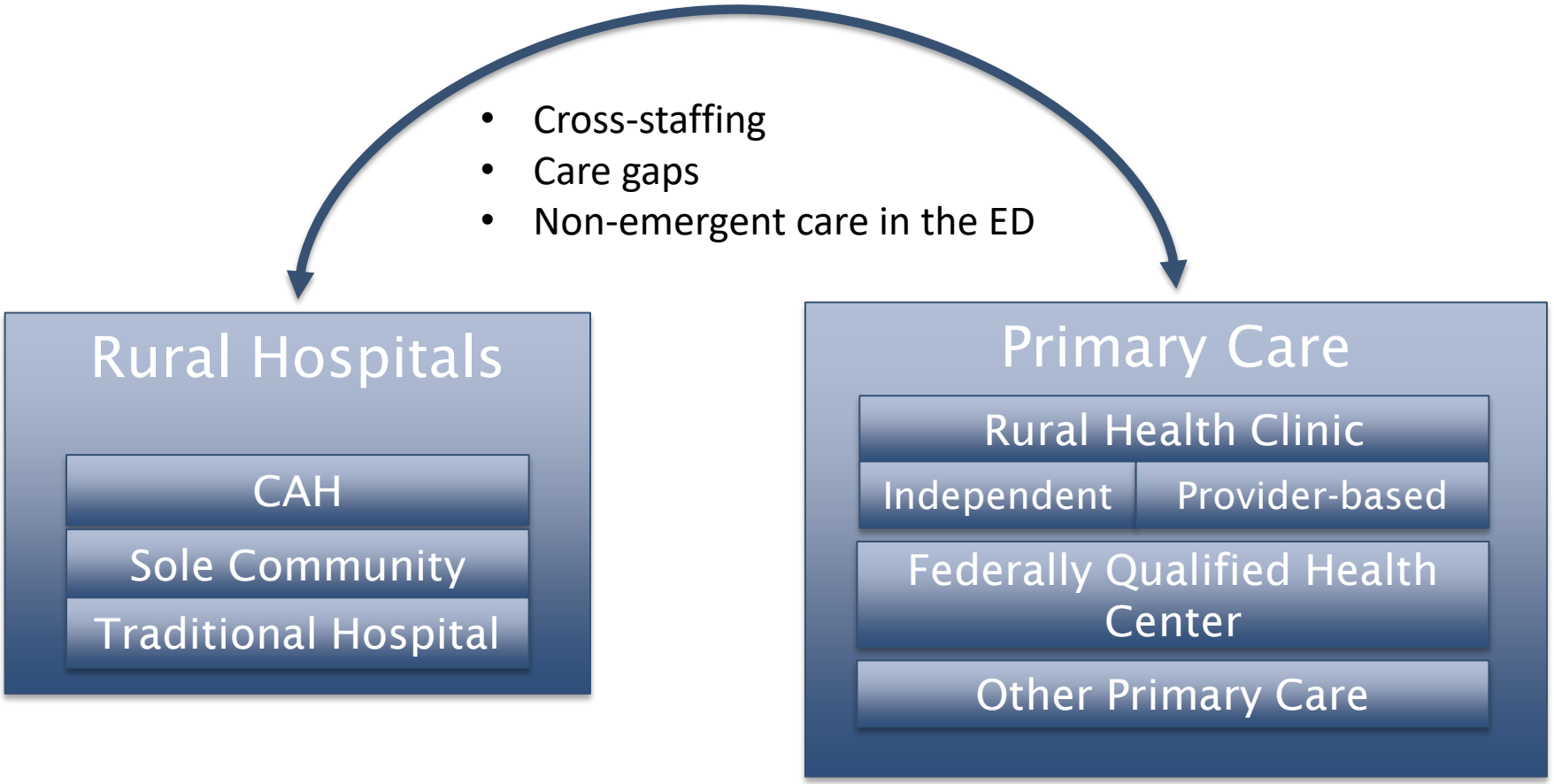
Is there a better way?

Healthier Washington

Provider challenges in rural regions



Provider challenges in rural regions



Provider challenges in rural regions

Rural hospital summary:

Inpatient care:

- 20% occupancy of available beds
  - Average daily census ≈ 4 patients per day
  - Admits per day ≈ 1.4 patients
  - Lower case-mix

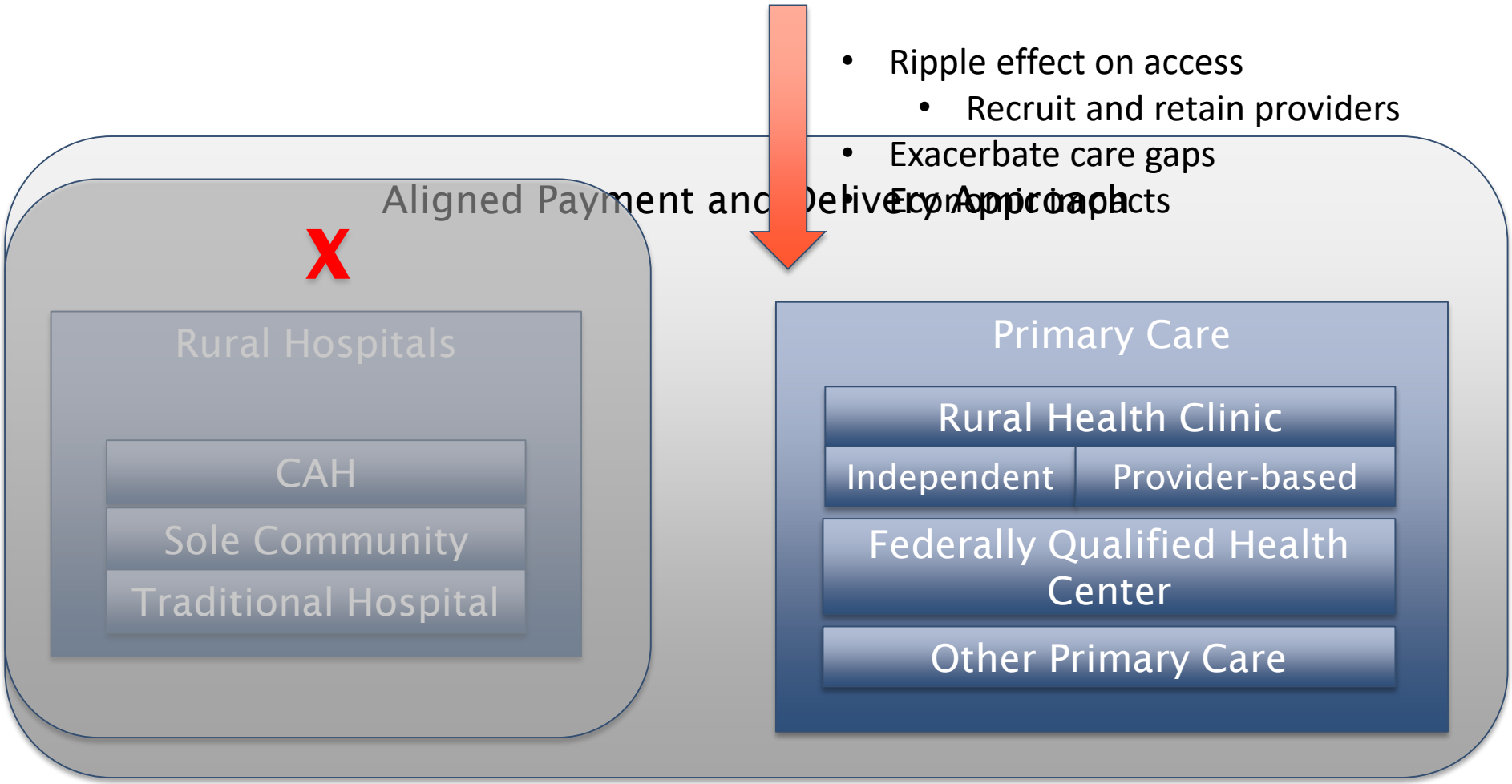
Outpatient care:

- Average outpatient visits per day ≈ 58 visits
- 70% of gross revenue is from outpatient services

Source: DOH Hospital Financial Data
https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalFinancialData

Provider challenges in rural regions

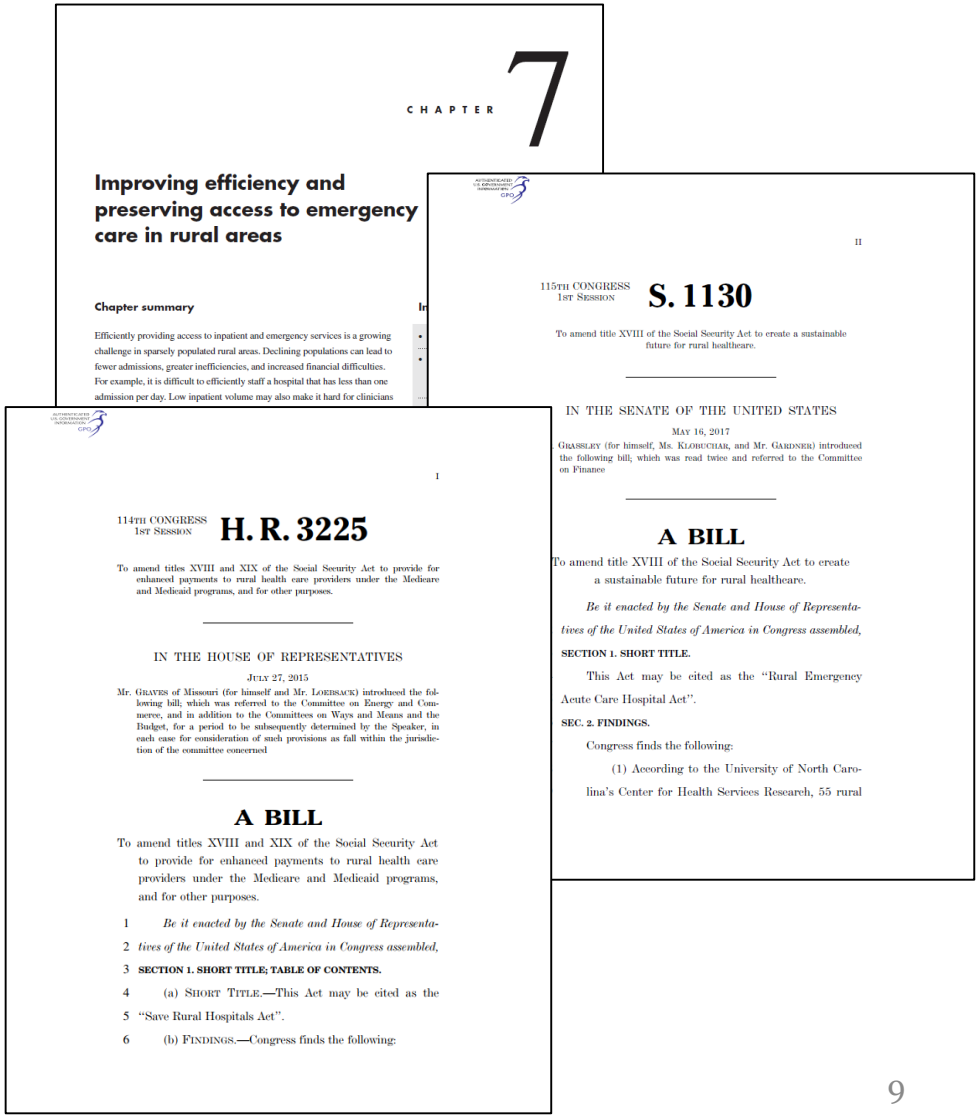
- Ripple effect on access
  - Recruit and retain providers
- Exacerbate care gaps
- Economic impacts



Provider challenges in rural regions

National interest:

- **Between 2005-2016**
  - **123 rural hospitals closed**
  - **48 CAHs closed**
- MedPAC 2016 Report to Congress
  - 24/7 ER
  - Primary Care model
- Rural Emergency Acute Care Hospital Act (REACH Act)
  - Removes acute care inpatient services
  - Increases cost-based reimbursement
- Save Rural Hospitals Act
  - Removes sequester cuts
  - Increases payments for low-volume/Medicare-dependent hospitals



CHAPTER 7

Improving efficiency and preserving access to emergency care in rural areas

Chapter summary

Efficiently providing access to inpatient and emergency services is a growing challenge in sparsely populated rural areas. Declining populations can lead to fewer admissions, greater inefficiencies, and increased financial difficulties. For example, it is difficult to efficiently staff a hospital that has less than one admission per day. Low inpatient volume may also make it hard for clinicians

115TH CONGRESS 1ST SESSION **S. 1130**

To amend title XVIII of the Social Security Act to create a sustainable future for rural healthcare.

IN THE SENATE OF THE UNITED STATES

MAY 16, 2017

GRASSLEY (for himself, Ms. KLOBUCHAR, and Mr. GARDNER) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to create a sustainable future for rural healthcare.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Rural Emergency Acute Care Hospital Act".

SEC. 2. FINDINGS.

Congress finds the following:

(1) According to the University of North Carolina's Center for Health Services Research, 55 rural

114TH CONGRESS 1ST SESSION **H. R. 3225**

To amend titles XVIII and XIX of the Social Security Act to provide for enhanced payments to rural health care providers under the Medicare and Medicaid programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 2015

Mr. GRAVES of Missouri (for himself and Mr. LOEBSACK) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend titles XVIII and XIX of the Social Security Act to provide for enhanced payments to rural health care providers under the Medicare and Medicaid programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Save Rural Hospitals Act".

(b) FINDINGS.—Congress finds the following:

Opportunity for rural health systems

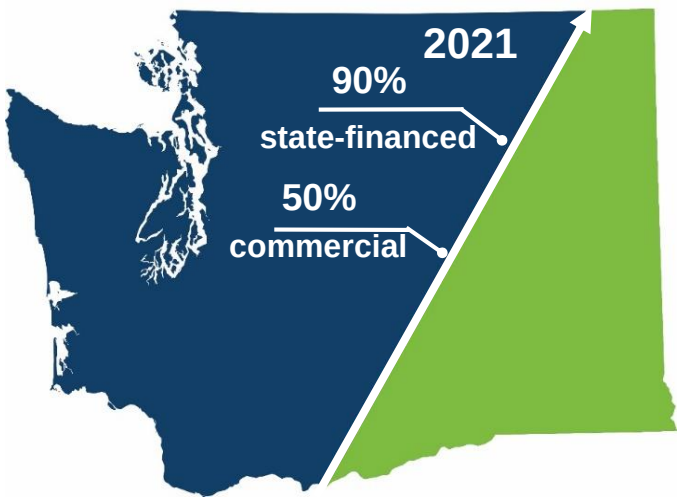
Status Quo (Volume-based) System	Transformed (Value-based) System
Fragmented clinical and financial approaches to care delivery	Integrated systems that pay for and deliver whole-person care
Uncoordinated care transitions	Coordinated care and transitions
Variations in delivery system performance (cost and quality) with no ties to clinical accountability and transparency	Standardized performance measurement with clinical and financial accountability and transparency for improved health outcomes
Unengaged members left out of own health care decisions	Engaged and activated members who are connected to the care they need and empowered to take a greater role in their health
Independent organizations competing for market share based on volume	Aligned organizations competing with other organizations for covered lives based on quality and value

Defining Value-Based Payments using the CMS Alternative Payment Model Framework

https://hcp-lan.org/groups/apm-fpt/apm-framework/

HCA: **purchaser**, innovator, convener

HCA purchases health care for over 2 million people; $10 Billion annual spend



Medicaid (Apple Health) – 1.8 million clients

- 5 MCOs

Public Employees Benefits (PEBB) – 370,000 covered lives

- Two carriers:
  - Regence TPA, self-insured plan: PPO, CDHP, accountable care options
  - Kaiser WA, Kaiser NW, fully insured plan: HMO and PPO options

Tools to accelerate VBP and health care transformation:

- 2014 legislation directing HCA to implement VBP strategies
- SIM Round 2 grant, 2015-2019
- DSRIP Medicaid Transformation Project, 2017-2021

Rural multi-payer innovations nationally

CMMI Models:

- Maryland All-Payer Model
  - Limit annual all-payer per capita total hospital cost growth to 3.58%
  - Care Redesign Program
- Vermont All-Payer ACO Model
  - Limit the annualized per capita health care expenditure growth for all major payers to 3.5 percent
  - Focus on achieving health outcomes and quality of care (substance use disorder, suicides, chronic conditions, and access to care)
- Pennsylvania Rural Health Model
  - Prospectively sets global budget for each participating rural hospital, based primarily on hospitals' historical net revenue for inpatient and outpatient hospital-based
  - Rural Hospital Transformation Plans

https://innovation.cms.gov/initiatives/index.html#views=models

Opportunity for rural health systems

HCA is interested in exploring ways to transform the rural health delivery system

Under a new model, collectively, we can:

Collaborate and **transform** the delivery system to leverage:

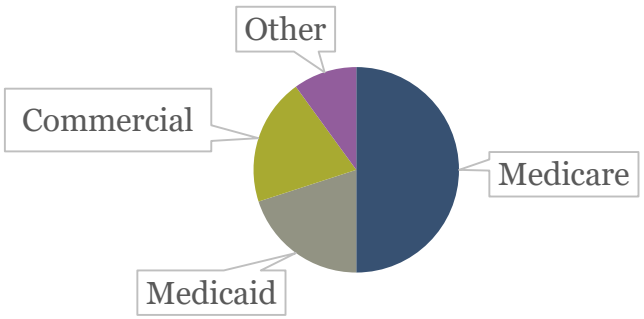
- Budgeted payment approaches
- Practice transformation

Rural Multi-Payer Model

Rural multi-payer goals

- **Value-based payment reform**
  - Patient-centered solutions that reward rural providers for the value of care delivered, not for the volume of care delivered, and incent rural providers to improve outcomes for patients and populations.

MCOs/Payers **AND** *Providers*



Rural multi-payer goals

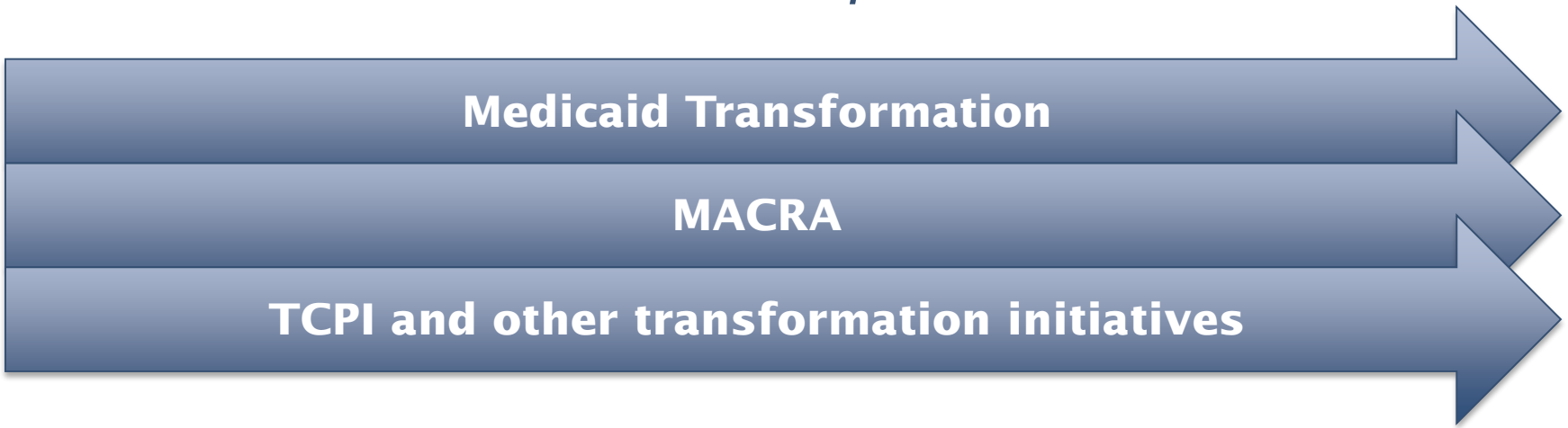
- **Sustainable solutions for maintaining and increasing access**
  - Address the unique challenges of rural health delivery, and help to maintain and increase access to essential health services.

MCOs/Payers **AND** *Providers*

Rural multi-payer goals

- **Delivery system transformation**
  - Incent delivery system integration and seek to redefine primary care for rural populations. This includes aligned payment systems, cross-cutting incentive structures and regulatory flexibility.

Practice Transformation



Rural multi-payer goals

- **Patient engagement**
  - Deliver the right care, at the right place, at the right time, and ensure that each patient is engaged with the local health care delivery system.

Population health management

  - Members are empowered with tools to be active in their health
  - Engagement with the care team
  - Coordinate care back to local delivery system
  - Patient engaged care plans

Rural multi-payer model

Potential model structure

Total cost of care pool (TCOC)	
Primary Care (RHCs and PCP related services)	• Per-member-per-month (PMPM) • Prospective quality adjustments • Encounter based payments (EBP)
Hospital Services (IP/OP, including ER, observation, ancillary, swing-beds)	• Baseline budget – Total patient revenue (TPR) • Trending of the budget • Payer allocation of the budget • Retrospective adjustments and reconciliation of the budget • Prospective adjustments of the budget • Encounter-based payments (EBP)

Timeline

December 2017 - January 2018:

- Individual meetings with payers for input and review
  - Discuss the model
  - Identify concerns
  - Provide additional details

- Presentation and engagement with providers

February 1, 2018:

- Meeting with MCOs, commercial payers and providers on the model
  - Background and overview
  - Discussion on the vision
  - Potential models
  - Timeline and continued engagement

Questions?

Federal Notice: The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

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