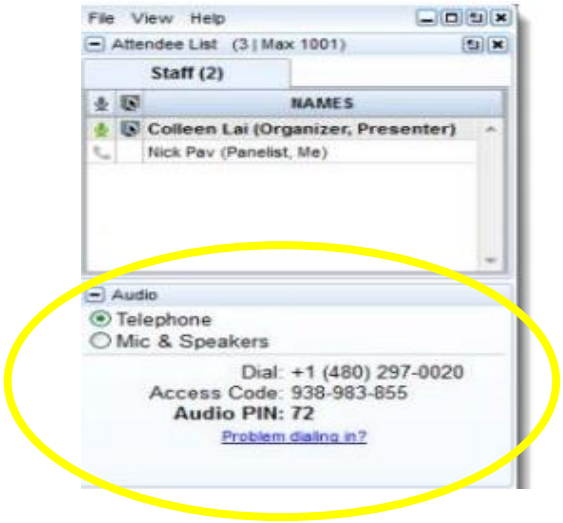
Before we get started, let's make sure we are connected

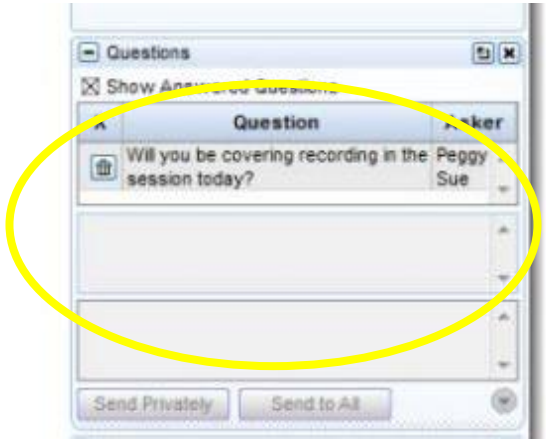
Audio Options

- 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.



Healthier WASHINGTON



Washington Rural Multi-Payer Model

November 29, 2017

Healthier WASHINGTON

Agenda

- Healthier Washington and value-based purchasing
- Rural healthcare financing and challenges
- Vision for rural health transformation
- Model overview
- Timeline

Healthier Washington

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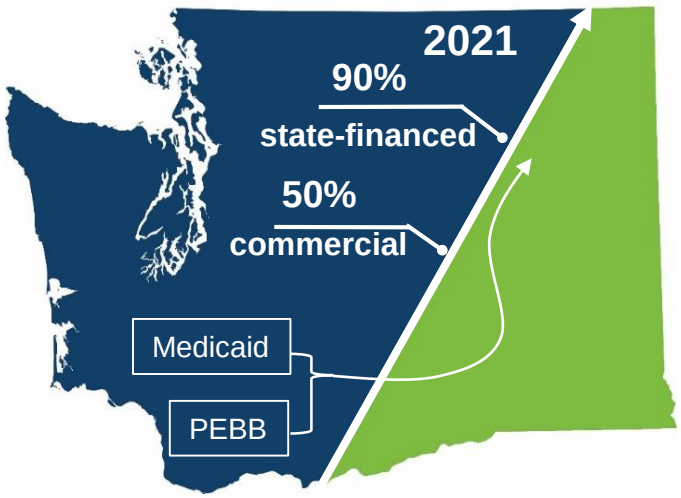
HCA: **purchaser**, innovator, convener

HCA purchases health care for over 2.2 million people; $10 Billion annual spend



Medicaid (Apple Health) – 1.9M clients

- 5 MCOs

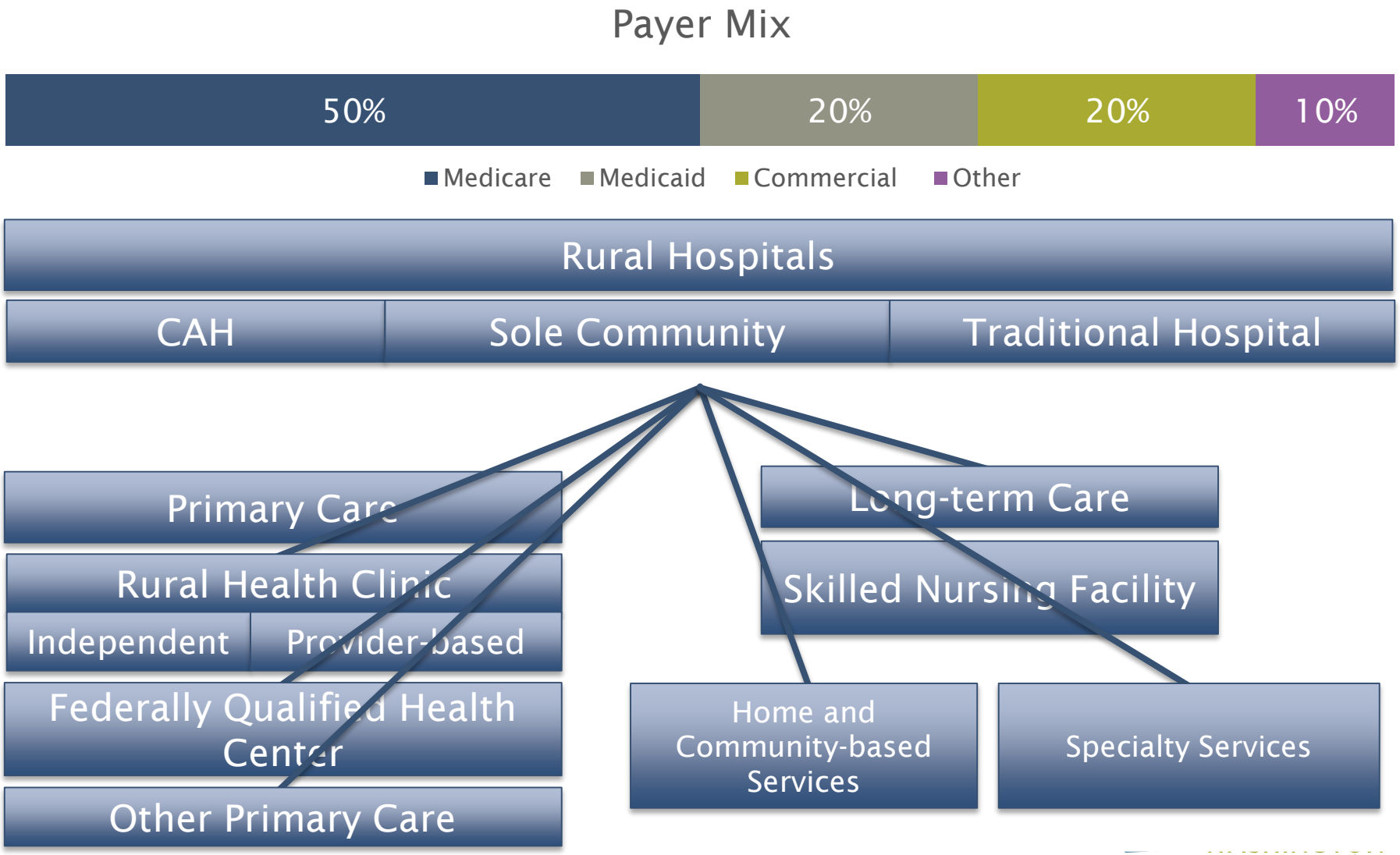
Public Employees Benefits (PEBB) – 370K covered lives

- 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:

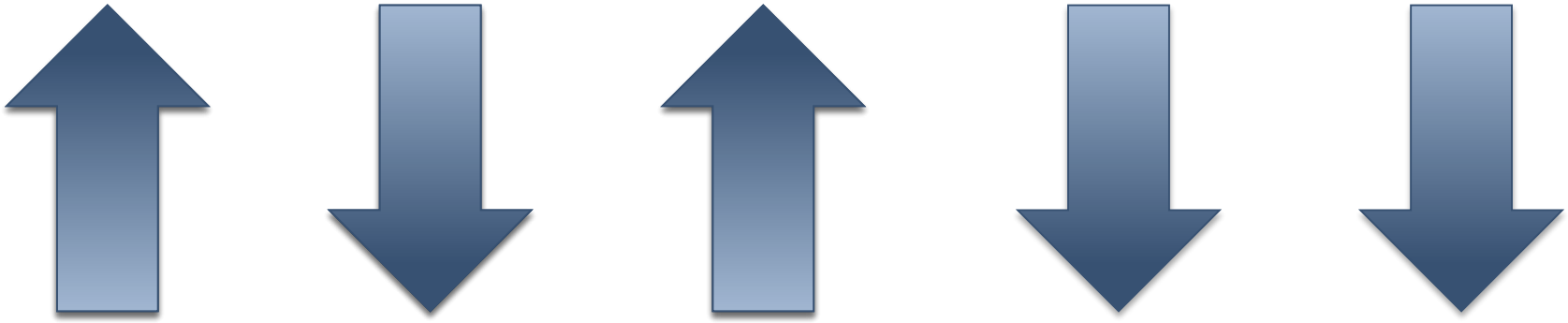
- 2014 Legislation directing HCA to implement VBP strategies
- SIM Round 2 grant, 2015-2019
- DSRIP Medicaid Transformation Demonstration Project, 2017-2021

Rural healthcare financing and challenges



Rural healthcare financing and challenges

Rural challenges



Risk of Morbidity and Morality

Access to PCP, Behavioral Health and Specialty

Older and Geographically Isolated

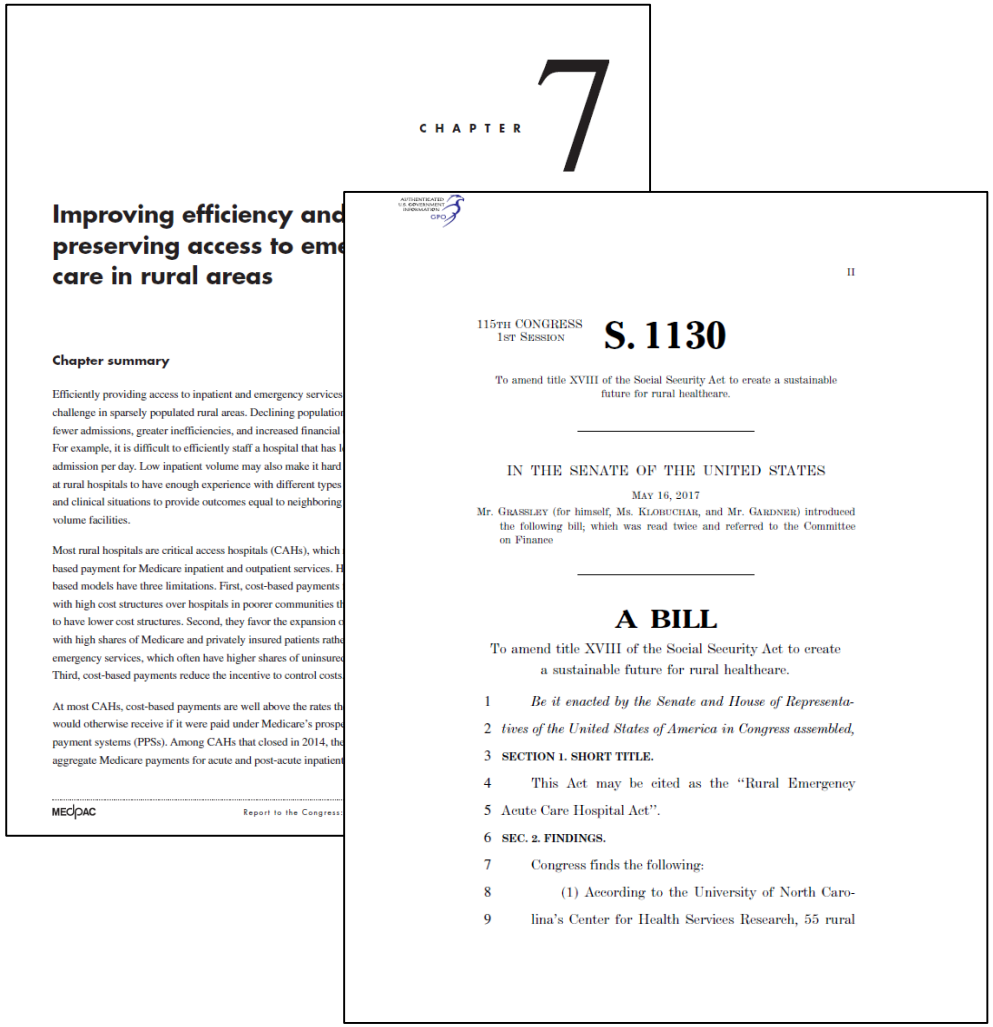
Utilization

Capitalization

Rural healthcare financing and challenges

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



CHAPTER 7

Improving efficiency and preserving access to eme care in rural areas

Chapter summary

Efficiently providing access to inpatient and emergency services challenge in sparsely populated rural areas. Declining population fewer admissions, greater inefficiencies, and increased financial For example, it is difficult to efficiently staff a hospital that has l admission per day. Low inpatient volume may also make it hard at rural hospitals to have enough experience with different types and clinical situations to provide outcomes equal to neighboring volume facilities.

Most rural hospitals are critical access hospitals (CAHs), which based payment for Medicare inpatient and outpatient services. H based models have three limitations. First, cost-based payments with high cost structures over hospitals in poorer communities th to have lower cost structures. Second, they favor the expansion o with high shares of Medicare and privately insured patients rathe emergency services, which often have higher shares of uninsured Third, cost-based payments reduce the incentive to control costs.

At most CAHs, cost-based payments are well above the rates th would otherwise receive if it were paid under Medicare's prospe payment systems (PPSs). Among CAHs that closed in 2014, the aggregate Medicare payments for acute and post-acute inpatient

MEDPAC Report to the Congress

II

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

Mr. 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

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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 (CRP)

- 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

WA Vision for rural health transformation

HILN – Rural Health Innovation Accelerator Committee:

"The sustainability of rural health care delivery depends on fundamental transformation and must consider the unique nature of rural and isolated constituents and scarce resources. The transformation must pragmatically embrace health resource availability and redesign the system with enhanced patient engagement, innovative health care interventions and population health strategies, all leveraging modern technology platforms."

https://www.hca.wa.gov/assets/program/RHIAC-report.pdf

WA vision for rural health transformation

System redesign:

- Multi-payer solutions
  - ***Medicare***, Medicaid and Commercial
- Consistent and predictable budgets
- Drive upstream in the care continuum and re-envision rural health delivery
- Provider level data providers can act on to improve health outcomes
- Reduce complexity and administration

- 2017 passage of SHB1520:
  - Seeks to support some of Washington's smallest hospitals and supports essential health services and moves toward value-based care.

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WA vision for rural health transformation

Washington's Rural Multi-Payer Model will provide:

- *Access to data*
  - *Population health management*
- *Flexibility*
  - *Re-orientation of services to meet changing community needs, and cross-collaboration across markets*
- *Predictability*
  - *Payer and provider predictable budgets*
- *Care transformation*
  - *Sustainability through value-based transformation*
- *Shared accountability*
  - *Payer and provider participation*
- *Incentive payments for quality*
  - *Shared interest in improving the health of the population*

WA vision for rural health transformation

- ***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.
- ***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.

WA vision for rural health transformation

- ***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.
- ***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.

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Model overview

- Minimum services included to start:
  - Inpatient, Observation, Swing-bed, ED, Outpatient, Ancillary, Primary Care
- Basic construct:
  - Multi-payer
  - Scalable to additional providers
  - Same basic structure for all participating providers with flexibility in performance and redesign efforts
  - Payment is linked to historical revenue, utilization, and/or costs in a budget neutral approach
  - Per-Resident payment:
    - The budget is set to a per-resident amount for attributed members for each participating payer

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Model overview

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)

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Model overview

- Per-member-per-month payment (PMPM)
  - The primary care entity will receive a PMPM rate that will be paid out based on the designated health service area (HSA). The PMPM will be adjusted on an annual basis by the Medicare Economic Index (MEI)

- Quality adjustment
  - The PMPM will be prospectively adjusted in future years based on the clinic's quality performance. The PMPM rate will be adjusted in future years based on the clinic's quality performance. Should the clinic's payment be adjusted downward due to poor performance, when the clinic is able to perform, they will have the ability to earn back the full benefit of their baseline PMPM as adjusted be MEI.

- Encounter-based payment
  - Those clients that do not fall within the HSA will be billed for under traditional billing mechanisms.

Model overview

- Total patient revenue
  - Establish a global budget based on total amount of net operating revenue (i.e., actual cash payments) that the hospital receives from participating payers for inpatient and outpatient services the hospital delivers during the coming year to the residents of the hospital's service area who are insured by the participating payers.

- Trending
  - The global budget would be adjusted annual for health care inflation.
  - The trend factor would be Washington specific and measure underling health inflation.
  - The factor would use existing indexes weighted to reflect the cost-profile of rural providers.

- Payer allocation
  - There will be a calculation for participating payer's percentage of the hospital's total billings during the year for eligible services delivered to eligible patients insured by all participating payers.
  - These percentages will be applied to the global budget established for the following year to determine each participating payer's share of the global budget.

Model overview

- Retrospective adjustments and reconciliation
  - The hospital will continue to bill each participating payer for individual services as it does today, and each payer will pay for those services as it does today.
  - At the end of each quarter, the hospital will determine whether the total billings it has submitted to a participating payer during the year are more or less than that payer's share of the global budget for the year.
  - The hospital will then either bill the payer for a supplemental payment in order to ensure the hospital receives the payer's full share of the global budget, or the hospital will repay the amount of revenue it had billed beyond the global budget.

- Prospective adjustments
  - The hospital's global budget for the coming year will be determined prior to the beginning of the year by adjusting the hospital's global budget for the prior year using the following factors:
    - changes in the participating payers;
    - changes in the total number of residents in the hospital's service area insured by participating payers;
    - changes in the costs of healthcare services nationally; and
    - the hospital's performance on quality measures.

- Encounter-based payment
  - Those clients that do not fall within the HSA will be billed for under traditional billing mechanisms.

Timeline

November 2017 – January 2018

- Develop complete model proposal with figures and proposed rates
- Engage payers and providers to review and refine
- Seek letter of intent from payers and providers
- Deliver complete proposal to CMMI for review

January 2018 – June 2018

- Negotiate terms and finalize model for approval with CMS
- Finalize details and negotiate final terms with providers/payers
- Establish final rates for implementation
- Early work for implementation
- Identify potential board members
- Early data needs – quality and fiscal
- Alignment with MTD

July 2018 – December 2018

- Work with providers and payers to set up data relationships
- Identify and contract auditing entity
- Establish administrative infrastructure for implementation
- Work with payers for any changes to payment systems

- HCA will be seeking payer and provider letters of intent to engage in discussions in January of 2018.

Timeline

December 2017:

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

- Presentation and engagement with providers

January 2018:

- Meeting with payers and providers on the model
  - Background and overview
  - Model discussion
  - Timeline and continued engagement

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