

Rural Multi-Payer Model provider presentation

September 7, 2018

Washington State Health Care Authority
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Context for this document

- This document is intended to be shared by HCA as an update on the rural multi-payer model
- This document is reflective of key aspects from an in-progress document with additional detail
- Details of the rural multi-payer model and this document are still being finalized by HCA

Goal of the model

Sustainable access to care in rural communities

Supporting hospitals through:

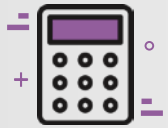
- Focus on health needs of rural communities
- Stable stream of revenue with monthly payments
- Tailored support for transformation planning
- Data analytics to support model implementation
- Infrastructure support to transform care

A global budget and care transformation support are the two pillars of the model

Fixed annual revenue (global budget)

The global budget is fixed annually and paid to hospitals monthly, providing a stable stream of revenue

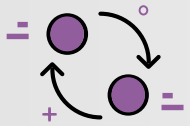
The objective of the global budget is to stabilize cash flow, allowing focus on investment and care quality



The global budget is calculated based on historic data adjusted for transformation-related annual service changes

Care transformation support

Tailored, end-to-end assistance at no cost to the hospital



The objective of support is to minimize the burden of transformation, allowing focus on successful implementation

Support across all transformation phases: data collection, plan creation, implementation progress

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Concept paper & Rural Multi-payer timeline

Current progress

Important milestone for rural hospitals

Model and concept paper development

July – September 2018

- Determine technical model parameters and high-level design through workshops
- Model high-level impact – economics, amount of care in rural communities addressed, ramp-up aspiration
- Codify model interdependencies and complementarities with existing programs
- Develop priority stakeholder list (including "shortlist" of providers) and engagement plans
- Engage payers and providers with "pitch deck"
- Create concept paper

Participant LOIs and State Agreement

October – December 2018

- Engage CMMI to refine model components and develop State Agreement
- Develop quality goals and relationship to existing measure sets
- Develop governance approach and required structures
- Engage interested providers and payers and develop stakeholder-specific tools to quantify value of participation
- Create transformation plan outline for providers
- Develop budget for model administration and technical assistance / transformation

Launch preparation with initial cohorts (Wave 1)

January – December 2019

- Use simulation tool to determine value creation opportunity for individual payers and providers
- Formal agreements with providers and payers participating in the model
- Provide technical assistance for transformation plan completion
- Determine technical requirements for data intake, reporting, and compliance
- Begin to collect data from providers and payers
- Finalize any legislation required for model launch

Initial cohort (Wave 1) launch and future cohort preparation (Wave 2 and beyond)

January – December 2020

- Go-live with Year 1 of model for payers and first wave of participating providers
- Launch governance model
- Determine next wave of hospital and provider participation

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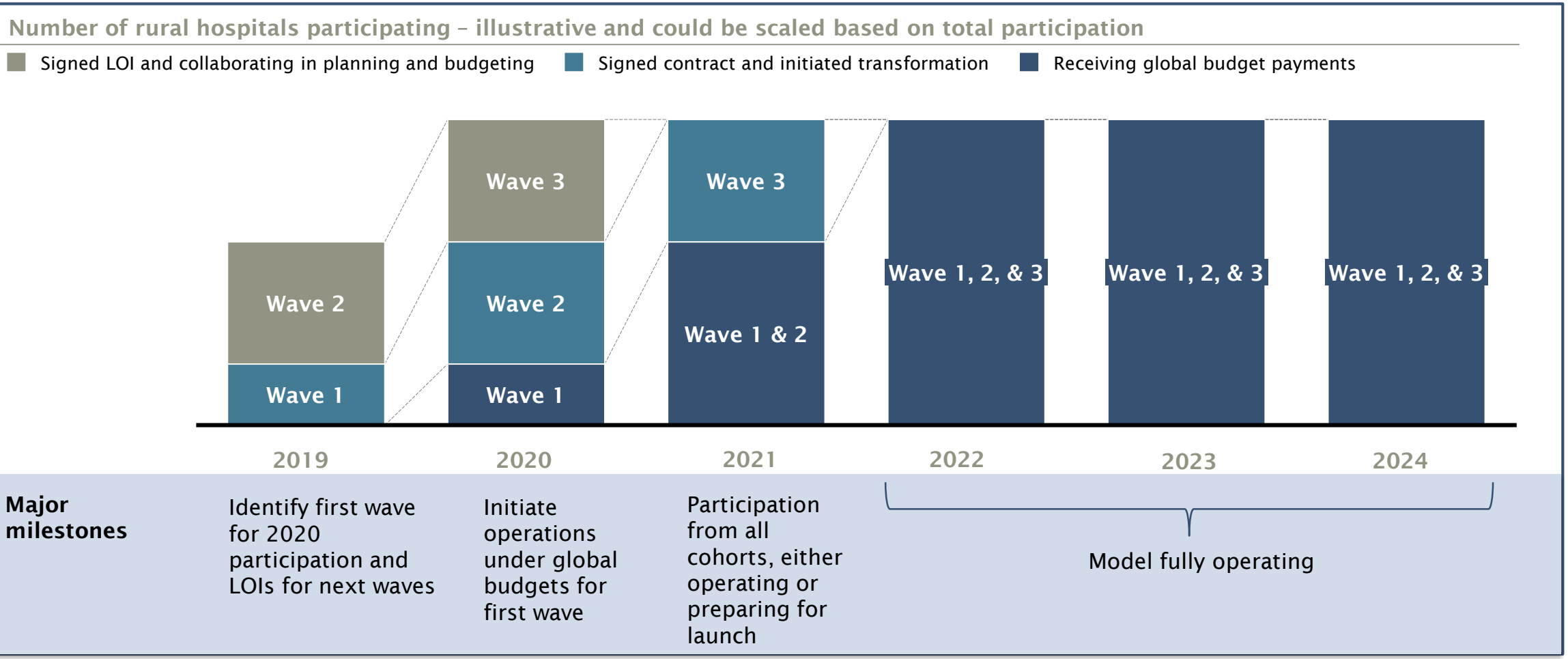
Ramp-up for rural hospital participation

Number of rural hospitals participating – illustrative and could be scaled based on total participation



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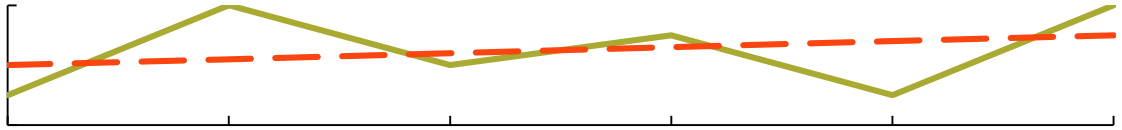
Global budget provides financial stability lacking under today's system and rewards population health focused transformation

Revenue in flows — Costs

Fee for service reimbursement creates hurdles

Unstable and unpredictable financials

- Decreasing revenues, increasing costs, and decreasing operating margins
- Outstanding payables, and unpredictable receivables



Healthier populations hurt bottom line

- Incentivized for inpatient admissions volume
- Dis-incentivized from investments without direct, substantial reimbursement (i.e., care management, outpatient/primary care, and healthier populations)

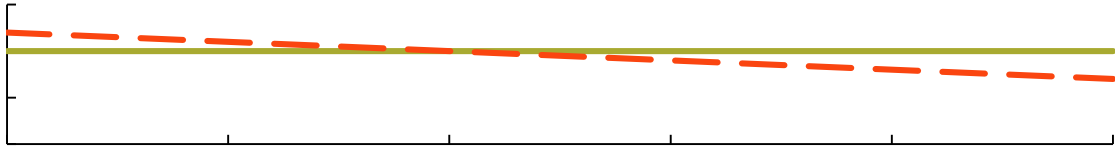
Investments in population health = Decreased utilization

Fewer profits overall

Global budget model corrects incentives

Predictable and stable cash flows

- Predictable, historically based annual revenues without in-year fluctuation
- Stable, dependable cash flows



Incentives to invest in population health

- Incentives to transform to meet community needs and keep populations healthy
- Rewards identifying lower cost, higher quality delivery options like primary, urgent, and tele-care

Investments in population health = Decreased utilization

More profits overall

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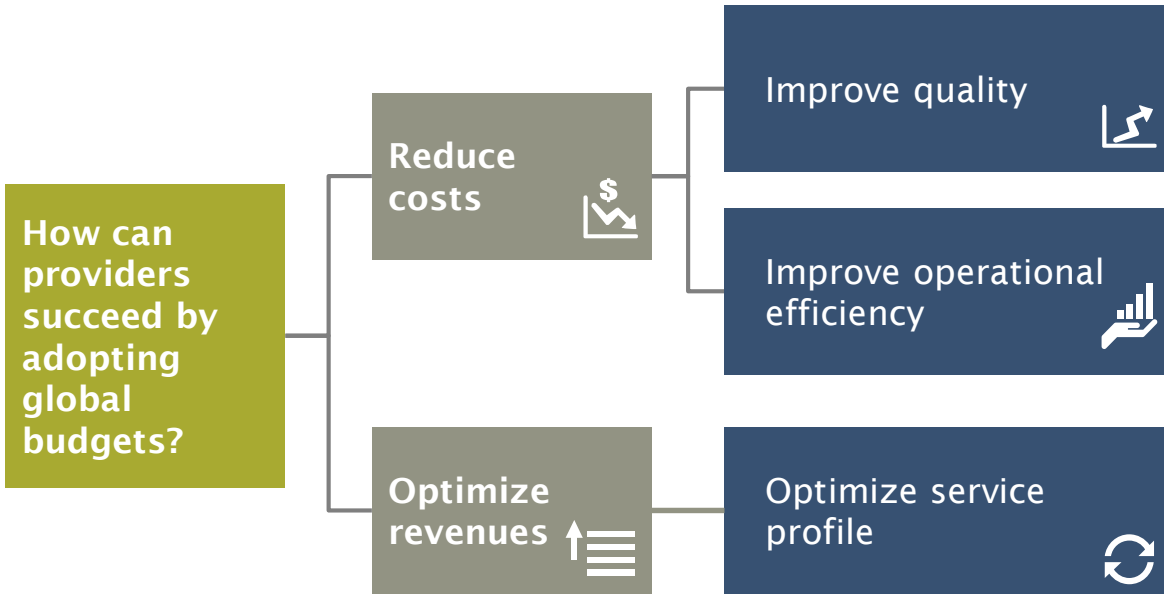
Hospitals can transform care, improve quality, and become financially stable under the model



Description

- Reduce hospital care (e.g., reduce # of readmissions, # hospitalizations, length of stay) that is unplanned and can be prevented through **improved quality, care management, coordination and clinical operations**
- **Improve hospital's ability to provide care in the most cost-effective manner** (e.g., reduce operating expenses per admission) by optimizing processes and capabilities
- Generate optimal revenue (e.g., by increasing appropriate outpatient and inpatient volume) from service lines and community programs that **align with hospital and population needs and improve the patient care experience**

Later in the process, while developing transformation plans, hospitals will analyze opportunities across:

- Quality (e.g., readmissions, community care)
- Care settings (e.g., pre-acute, acute and post-acute)
- Patient care journey (e.g., prevention, treatment and follow-up)
- Population groups (e.g., chronic conditions, behavioral health)

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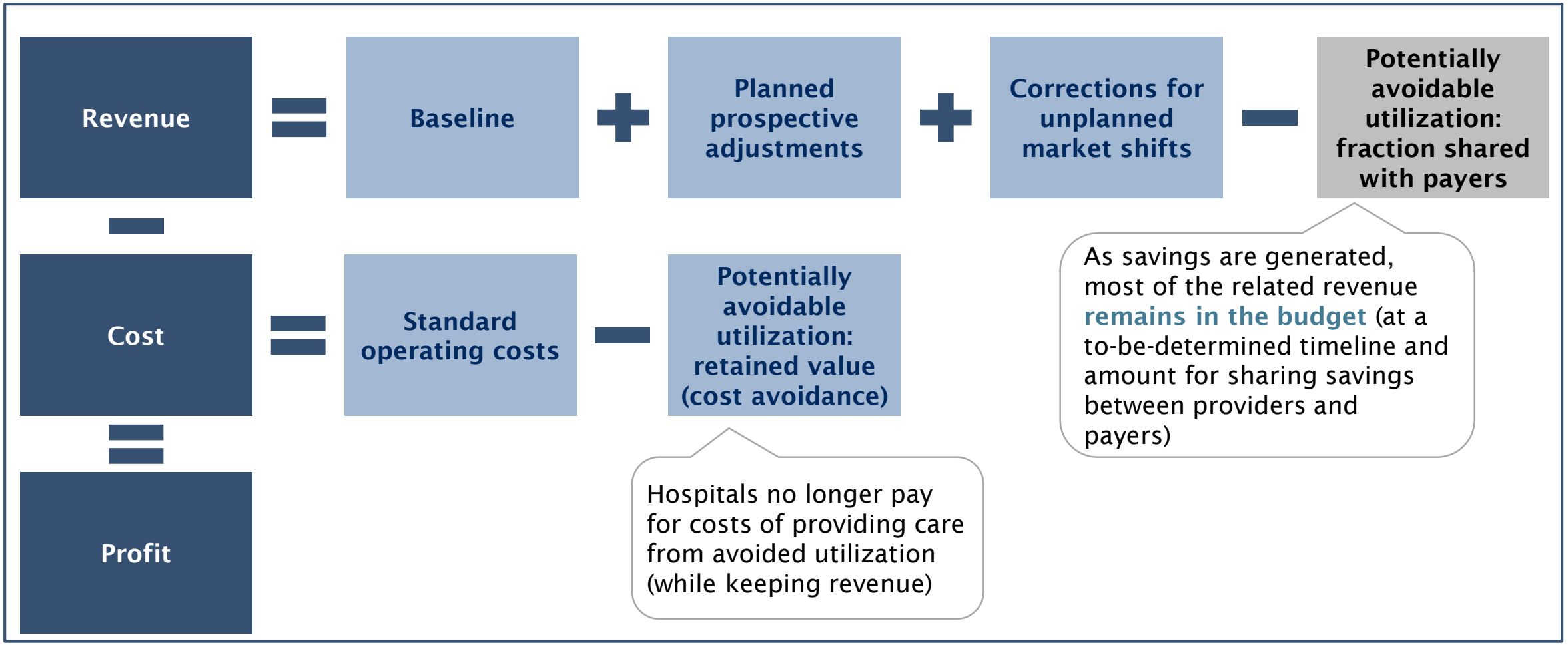
Profitability under global budget model



Outline of the rural multi-payer model

Model components	Decisions made
Technical requirements for model participation	• **All rural hospitals will have the opportunity to participate** in the model • The model should **include Medicare FFS and in-network Medicare Advantage, Medicaid FFS and MCOs, and large commercial payers** comprising a critical mass of the hospital's net patient revenue
Approach to setting baseline payment model	• The model will incorporate: – **Hospital inpatient (IP) and outpatient (OP) services** (professional fees billed on professional claims in IP/OP settings included) – **CAH swing beds** – **Employed primary care physicians (PCPs) in to-be-determine format**[1] – **Existing hospital-owned long-term care (LTC) and behavioral health (BH) services**, where applicable
Methodology for adjustments of planned and unplanned activities	• The model will include adjustments for: – **Potentially avoidable utilization (PAU)**, as the mechanism to share savings with payers and providers – **Planned service line changes** – **Unplanned market share shifts and emergent issues/exception** • **The model will not include adjustments for operational efficiencies achieved**
Approach to managing risk	• **The model will likely need to incorporate a Year 0** (likely 2019) during which status quo hospital budgeting remains in place and preparation and finalization of rural multi-payer model participation is advanced
Additional incentives	• The model will include **incentives related to quality, primary care, non-hospital providers (primarily PCPs)** • **The model will align with Accountable Communities of Health (ACHs)**

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1 Exact structure to be confirmed through further analysis and discussion

Under a value-based model, many internal processes will remain unchanged for providers

Internal processes remaining the same	
Claims processes	Maintained through the same process to later be utilized during reconciliation and future global budget calculations
Co-pay collection	Continued co-pay collection from patients, since co-pays not included within the global budget payments from payers to hospitals
Professional fees	Professional fees will not initially be included in the global budget
Payer contracts	Currently effective agreements will be maintained except for payment terms (e.g., quality metrics and reporting, negotiated inflation rates, etc. will remain constant as agreed upon in negotiated payer agreements)

HCA is working through elements of the model

Elements under consideration:

- How employed PCPs, including those in owned FQHCs and RHCs, will be incorporated
- Guardrails to be included
- Glide path for WRHAP and hospitals with average negative revenue joining the model
- Additional incentives and supports included
- Elements and structure of transformation plans
- How quality metrics will be harmonized between the rural multi-payer model and other state programs

HCA will continue to build out these aspects and incorporate input and suggestions.

Potential activities provided by HCA to hospitals to ensure readiness for global budget

Community & provider assessment

- Introduce the model
- Assist in internal or external benchmarking on operational performance, access, and quality
- Assist in understanding community needs by leveraging existing material

Exploration

- Familiarize hospitals with transformation areas/levers/ interventions
- Model the impact of provider and payer participation
- Provide examples of how to identify potential strategic priorities

Evaluation

- Assist in prioritization of strategic goals
- Provide examples to help define year 1 expectations and interventions
- Convene experts and communities for best practice sharing
- Provide template for high-level work plan

Plan

- Provide board-level briefing materials for consideration
- Provide a template for a transformation plan, including:
  - Community needs
  - Capabilities assessment
  - Strategic priorities (w/targets, financial plan etc.)
  - High-level action plan

Launch

- Launch global budget model
- Provide template for a change management plan
- Provide guidance on detailed action plan and execution

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Questions for group discussion

- What aspects of the model excite you the most?
- Where are your hospital's greatest opportunities in addressing community health needs today?
- What enhancements do you have underway in meeting these needs?
- How could the transition to a global budget help you expand your efforts?
- What primary challenges do you envision and how could these be addressed?
- What support would be most helpful in transitioning to a global budget and implementing a transformation plan?