



**DELIVERING
HIGH-VALUE HEALTHCARE SERVICES
IN RURAL AREAS
OF WASHINGTON STATE**

**Phase 1 Findings and Recommendations
of the
Washington Rural Health Access Preservation
(WRHAP)
Project**

January 2017

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Phase 1 Findings and Recommendations of the
Washington Rural Health Access Preservation (WRHAP) Project

EXECUTIVE SUMMARY

Goals and Structure of the WRHAP Project

The Washington Rural Health Access Preservation (WRHAP) was created to design and implement improvements in payment and delivery of health care in fourteen of Washington's smallest and most remote communities, where Critical Access Hospitals (CAHs) are at risk of closing. These hospitals, all operated by Public Hospital Districts, generally serve as the platform for the full range of healthcare services in their communities, from primary care to acute care to long-term care, so financial problems at the hospitals jeopardize both the health of the residents as well as the economies of the communities. These hospitals are:

- Cascade Medical Center (Chelan County Public Hospital District #1)
- Columbia Basin Hospital (Grant County Public Hospital District #3)
- Columbia County Health System (Columbia County Public Hospital District)
- Coulee Medical Center (Douglas-Grant-Lincoln-Okanogan Counties Public Hospital District #6)
- East Adams Rural Healthcare (Adams County Public Hospital District #2)
- Forks Community Hospital (Clallam County Public Hospital District #1)
- Ferry County Memorial Hospital (Ferry County Public Hospital District #1)
- Garfield County Memorial Hospital (Garfield County Public Hospital District)
- Mid-Valley Hospital (Okanogan County Public Hospital District #3)
- Morton General Hospital (Lewis County Public Hospital District #1)
- North Valley Hospital (Okanogan County Public Hospital District #4)
- Odessa Memorial Healthcare Center (Lincoln County Public Hospital District #1)
- Three Rivers Hospital (Okanogan-Douglas Counties Public Hospital District #1)
- Willapa Harbor Hospital (Pacific County Public Hospital District #2)

The WRHAP project has received financial and technical support from the Washington State Hospital Association, the Washington State Department of Health, the Washington State Health Care Authority, the Washington State Department of Social and Health Services, and the Association of Washington Public Hospital Districts, with consulting assistance from the Center for Healthcare Quality and Payment Reform, Health Facilities Planning & Development, and Dingus, Zarecor & Associates.

Problems in Delivering Health Care in WRHAP Communities

The WRHAP Public Hospital Districts (PHDs) have experienced significant operating deficits in recent years. Detailed analyses conducted for ten of the fourteen WRHAP PHDs showed that the deficits primarily result from four types of services:

- **Primary Care Clinics.** All of the WRHAP PHDs analyzed had significant losses on their clinics in 2015. On average, clinic revenues only covered 2/3 of the costs of operating the clinics. For most of the WRHAP PHDs, the clinics were the largest contributor to the overall deficits, representing 30% or more of the total PHD deficit.
- **Emergency Department (ED).** Eight of the ten WRHAP PHDs analyzed had losses on their Emergency Departments. The shortfalls in the EDs were smaller than those in the clinics, averaging 9% of costs.
- **Inpatient Services.** Seven of the ten WRHAP PHDs had losses on their inpatient services. These shortfalls were smaller than the deficits for the Emergency Departments, averaging about 4% of costs.
- **Nursing Facility and/or Assisted Living Facility.** Four of the ten WRHAP PHDs operate separate long-term care nursing facilities and/or assisted living facilities. All of these facilities have significant operating deficits, and these deficits significantly increase the overall operating deficits for the PHDs that operate them.

These deficits are currently being covered primarily by revenues raised through local tax levies, but the current levels of these tax levies may not be sustainable. The Emergency Department, primary care clinics, and long-term nursing care are essential services for the WRHAP communities, and failure to resolve the deficits for those services would have serious negative impacts on residents:

- **Emergency Departments.** Average travel times to an alternative emergency department would be 30 minutes or more longer than today if WRHAP EDs were no longer available, which could result in higher mortality rates and poorer outcomes for patients with heart attacks, strokes, or trauma. Moreover, residents and businesses would be less likely to locate or remain in the community if timely access to an emergency department were no longer available.
- **Primary Care Clinics.** On average, the counties in which WRHAP PHDs operate have 29% fewer primary care physicians per capita than Washington State as a whole, and half of those counties are in the bottom third among Washington State counties in terms of primary care access. In the smallest communities, it is likely that the WRHAP Rural Health Clinics provide the majority of primary care services to the residents. As a result, access to primary care would be seriously harmed if the clinics were no longer available.
- **Long-Term Nursing Care.** In the communities where WRHAP PHDs are providing long-term nursing care services, there are no other long-term nursing care facilities available. The closest alternative facilities are generally a half hour or more away; moreover, it is unlikely that the closest facilities could care for all of the residents of the WRHAP PHD nursing care beds if those beds were no longer available.

Although there is an urgent need to resolve the deficits in order to preserve these essential services, merely eliminating the deficits will not give the WRHAP PHDs adequate resources to deliver high-quality coordinated care to the residents of their service areas. Other problems the WRHAP PHDs face include:

- Lack of resources to support the delivery of high-value primary care and Patient-Centered Medical Home services, including care coordination and behavioral health support;
- Financial penalties for reducing avoidable emergency department visits and hospitalizations; and
- Lack of home health, hospice, and other home care services that could help avoid the need for expensive inpatient and nursing facility care.

Causes of Deficits for Essential Services

The reasons for the deficits in the clinics, Emergency Departments, and nursing and assisted living facilities operated by the WRHAP Public Hospital Districts are complex. The patient service revenues that the WRHAP PHDs use to support their operations come from multiple payers, each of which uses a different payment system. Although the Medicare and Medicaid payment systems for Critical Access Hospitals and Rural Health Clinics are supposed to cover the costs of the services, they do not do so for a variety of reasons. Commercial health plans generally pay below the costs of services, particularly in the smallest hospitals.

- **Emergency Departments:** The biggest funding shortfalls are associated with uninsured patients, Medicaid clients, and commercially insured clients, but their relative importance varies significantly from community to community. Although Medicare is the largest payer for most of the Emergency Departments operated by the WRHAP PHDs, it is only a significant contributor to the current deficits at one of the ten hospitals analyzed.
- **Primary Care Clinics:** Low payments from commercial payers are the largest contributor to the deficits at all of the WRHAP PHD clinics analyzed. Medicaid payment rates below costs also cause 20% or more of the deficits at six of the ten WRHAP Rural Health Clinics analyzed. Medicare is also a significant cause of the current deficits at four of the ten clinics analyzed.
- **Long-Term Nursing Care:** Most of the current long-term nursing care patients are supported by Medicaid payments, and because those payments are well below costs, Medicaid represents the biggest contributor to the current operating deficits.

Recommended Solutions

All of the services delivered by the WRHAP Public Hospital Districts are highly interconnected. Addressing the problems in only one service line, or selecting options to address each service line independently, could have unintended consequences and achieve less overall impact than a comprehensive approach. In addition, because no one payer represents the majority of the patients or revenue in the WRHAP PHDs, all payers – Medicare, Medicaid, and commercial health plans – must participate in resolving the current deficits and creating the kind of payment systems that will enable the WRHAP PHDs to deliver high-quality, affordable services to their communities.

The participants in the WRHAP project recommend that no later than 2018, WRHAP Public Hospital Districts should have the opportunity to be paid for primary care, emergency department services, and long-term care services under alternative payment models that would enable them to sustain these essential services and to support delivery of a more comprehensive, population health management approach to health care for the residents of their service areas. The recommended payment models should be phased in over a four-year period.

RECOMMENDED PAYMENT SYSTEMS FOR WRHAP PUBLIC HOSPITAL DISTRICTS

	PHASE 1 2018	PHASE 2 2019-2020	PHASE 3 2021+
Emergency Department	Minimum ED Payments	Population-Based Payment for ED Services	Comprehensive Payment Model to Sustain All Essential Services and Support Effective Population Health Management in WRHAP Public Hospital Districts
Rural Health Clinic/ Primary Care Services	Monthly Per-Patient Payments for Clinic Services AND Additional Payments for Enhanced Services AND Payment Bonuses for Quality and Spending	Comprehensive Population-Based Payment for Primary Care Services	
Long-Term Care Services	Increased Per Diems or Minimum Payments for Essential Long- Term Nursing Care	Alternative Payment Model for Long-Term Care Services	
Inpatient and Other Outpatient Services	Identify Payment and Delivery Changes Needed for Other Outpatient and Inpatient Services	Design and Pilot Alternative Payment Model(s) for Other Outpatient and Inpatient Services	

Detailed designs for these alternative payment models should be developed in 2017 through a collaborative process involving, at a minimum, the WRHAP Public Hospital Districts, the Washington State Health Care Authority (HCA), the Department of Health (DOH), the Department of Social and Health Services (DSHS), the Washington State Hospital Association (WSHA), and the Association of Washington Public Hospital Districts (AWPHD). **The State of Washington will need to implement these payment models in the Medicaid program and through its other purchasing arrangements, and it will need to encourage participation by Medicare and by all health plans.**

In addition, during 2017, the WRHAP Public Hospital Districts should examine the other types of healthcare services that they deliver and that the residents of their service areas need in order to determine which existing services are essential to deliver, whether any additional services would be necessary to achieve population health management goals, and what payment systems would best sustain those services. This work would form the basis for more comprehensive payment reforms for the WRHAP PHDs that should be implemented no later than 2021.

Ideally, a subset of WRHAP PHDs could serve as pilot sites to begin implementing some or all of the 2018 changes in mid-2017, and those sites or others could begin implementing the 2019 changes in 2018. In addition, beginning in 2017, those WRHAP Public Hospital Districts that make a formal commitment to implement the alternative payment models for essential services and to examine ways to improve the delivery and payment of other services should receive financial and technical assistance to implement the initial payment reforms and to redesign the way they deliver care.

If there are delays in implementing the improved payment systems that would result in significant deficits for essential services during 2018 for some or all of the WRHAP PHDs, changes in payment amounts should be made in the current payment systems in order to reduce or eliminate these deficits.

I. OVERVIEW OF THE WRHAP PROJECT

In response to concerns about the challenges rural communities were facing in delivering high quality healthcare services to their residents, the Washington State Hospital Association (WSHA) and the Washington State Department of Health (DOH) jointly facilitated an examination of the issues and potential solutions. *The New Blue H* report (<http://www.wsha.org/newblueH.cfm>) published in 2014 outlined specific steps to be taken by WSHA and DOH to create opportunities to restructure and strengthen the rural health care system in Washington State. One of the implementation steps was the formation of the Washington Rural Health Access Preservation (WRHAP) project by WSHA and DOH in the fall of 2014.

WRHAP was created to design and implement improvements in payment and delivery of healthcare in Washington's smallest and most remote communities, where Critical Access Hospitals (CAHs) are at risk of closing. These hospitals generally serve as the platform for the full range of healthcare services in the community, from primary care to acute care to long-term care, so financial problems at the hospitals jeopardize both the health of the residents as well as the economies of the communities. The goal of the WRHAP project is to develop ways to ensure continued access to high-quality essential health services in these communities and to align those services with the Triple Aim (i.e., better health, better care, and lower costs).

The WRHAP project organizers identified fourteen Critical Access Hospitals in Washington that had low patient census, were 30 miles or more from the next closest facility, and were deemed at risk of closure based on the financial monitoring conducted through the Medicare Rural Hospital Flexibility Program (Flex Program). All of these hospitals are operated by Public Hospital Districts. The leaders of the fourteen Public Hospital Districts agreed to participate in the WRHAP project in order to better understand the causes of the financial problems the Districts were facing and to develop ways of solving those problems. These hospitals are:

- Cascade Medical Center (Chelan County Public Hospital District #1)
- Columbia Basin Hospital (Grant County Public Hospital District #3)
- Columbia County Health System (Columbia County Public Hospital District)
- Coulee Medical Center (Douglas-Grant-Lincoln-Okanogan Counties Public Hospital District #6)
- East Adams Rural Healthcare (Adams County Public Hospital District #2)
- Forks Community Hospital (Clallam County Public Hospital District #1)
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- Odessa Memorial Healthcare Center (Lincoln County Public Hospital District #1)
- Three Rivers Hospital (Okanogan-Douglas Counties Public Hospital District #1)
- Willapa Harbor Hospital (Pacific County Public Hospital District #2)

Concurrent with the formation of the WRHAP project, the Healthier Washington initiative led by the Washington State Health Care Authority (HCA) identified a need to transition from encounter-based payment to value-based contracting and to provide support for practice transformation in order to improve the health status of residents of rural Washington. In early 2015, HCA contracted with WSHA to help develop demonstration projects for changes in both payment systems and care delivery that would help ensure access to high value care in WRHAP communities.

This report describes the findings and recommendations developed during Phase 1 of the WRHAP project. The work began with an all-day strategic planning meeting in Wenatchee on Sunday, June 21, 2015 that was attended by thirty Public Hospital District Commissioners, District CEOs, and other District staff from the fourteen WRHAP Public Hospital Districts, and by senior staff from the Washington State Health Care Authority, the Washington State Department of Health, the Washington State Hospital Association, and the Association of Washington Public Hospital Districts.

Following that initial meeting, the CEOs of the participating Public Hospital Districts worked collaboratively with senior staff from the Washington State Health Care Authority, the Washington State Department of Health, the Washington State Department of Social and Health Services, and the Washington State Hospital Association over the following eighteen months to (1) collect and analyze data on the problems facing the hospital districts and (2) develop meaningful solutions that both the WRHAP Public Hospital Districts and the state agencies could support and implement. The group held five additional all-day in-person meetings (in Spokane on December 16, 2015, in Chelan on June 26, 2016, in Wenatchee on August 9, 2016, and in Ellensburg on October 6, 2016 and December 7, 2016) plus several conference calls in order to discuss findings and options for solutions.

The Washington State Hospital Association provided overall coordination for the work. Harold D. Miller, President and CEO of the Center for Healthcare Quality and Payment Reform facilitated the meetings, provided analytical support, and prepared this report. Consulting assistance was provided by Jody Carona, Principal, Health Facilities Planning & Development and Tom Dingus, Owner, Dingus, Zarecor & Associates. Financial support for the work was provided by the Washington State Health Care Authority using federal funding received from the Center for Medicare and Medicaid Innovation as part of a State Innovation Model (SIM) grant awarded to the State of Washington, by the Washington State Department of Health using federal funding received through the Medicare Rural Hospital Flexibility (Flex) Program, and by the Washington State Hospital Association.

The following individuals (listed alphabetically) from the hospital districts, state agencies, state associations, and consulting firms participated in one or more of the WRHAP meetings, and most of them have devoted many hours of time to this work over the past two years:

- Nancy Betschart, Board Chair, Ferry County Memorial Hospital
- Debbie Bigelow, Former CEO, Coulee Medical Center
- Michael Billing, CEO, Mid-Valley Hospital
- Diane Blake, CEO, Cascade Medical Center
- Scott Bond, President and CEO, WSHA
- Gary Bostrom, CEO, East Adams Rural Healthcare
- Mary Beth Brown, Director, Practice Transformation Support Hub, Department of Health

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- Bob Campbell, Former Interim CEO, Morton General Hospital
 - Jody Carona, Principal, Health Facilities Planning & Development
 - Helen Casey, Board Chair, North Valley Hospital
 - Tim Cournyer, CFO, Forks Community Hospital
 - Maria Courogen, Washington State Department of Health
 - Beverly Court, Research Manager, Department of Social and Health Services
 - Andrew Craigie, Former CEO, Garfield County Public Hospital District
 - Tom Dingus, Owner, Dingus, Zarecor & Associates
 - Aaron Edwards, CEO, Ferry County Memorial Hospital
 - Jody Etter, Chair, Governing Board, Columbia Basin Hospital
 - Leianne Everett, CEO, Morton General Hospital
 - Brian Fink, Commissioner, Odessa Memorial Healthcare Center
 - Roger Gantz, Critical Access Hospital Reimbursement Project, Department of Social and Health Services
 - J. Scott Graham, CEO, Three Rivers Hospital
 - Carole Halsan, CEO, Willapa Harbor Hospital
 - Rhonda Handly, CFO, Columbia Basin Hospital
 - Matthew Hanson, Chair, Board of Commissioners, Garfield County Hospital
 - Lee Holter, CFO, Columbia County Health System
 - Jim Hopkins, CFO, Cascade Medical Center
 - Pat Justis, Director, State Office of Rural Health, Department of Health
 - Kim Kelley, Former Critical Access Hospital / FLEX Program Coordinator, Department of Health
 - Rosalinda Kibby, CEO, Columbia Basin Hospital
 - Don Lawley, Commissioner, Forks Community Hospital
 - Kelly Leslie, CFO, Ferry County Memorial Hospital
 - Sandy Libsack, Board Secretary/Vice Chair, Odessa Memorial Healthcare Center
 - Ben Lindekugel, Executive Director, Association of Washington Public Hospital Districts
 - Scott McDougall, Chair, Governing Board, Willapa Harbor Hospital
 - Shane McGuire, CEO, Columbia County Health System
 - Danielle Messier, Critical Access Hospital Quality Improvement Coordinator, Department of Health
 - Harold D. Miller, President & CEO, Center for Healthcare Quality and Payment Reform
 - Gary Oestreich, Chair, Governing Board, Mid-Valley Hospital
 - Ron O'Halloran, CEO North Valley Hospital
 - Vicki Orford, Board Chair, Three Rivers Hospital
 - Jonathan Owens, CEO, Coulee Medical Center
 - Brenda Parnell, Interim CEO, Garfield County Public Hospital District, and Former CEO, Ferry County Memorial Hospital
 - Ted Paterson, Board Chair, Columbia County Health System
 - Marc Provence, Medicaid Transformation Program Manager, Health Care Authority
 - Claudia Sanders, Senior Vice President, Policy Development, WSHA
 - Steve Saxe, Director, Office of Community Health Systems, Department of Health
 - Mo Sheldon, CEO, Odessa Memorial Healthcare Center
 - Jon Smiley, Former CEO, Garfield County Hospital and Columbia County Health System

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- Jerry Snyder, Board Chair, East Adams Rural Healthcare
 - Holly Stanley, CFO, Mid-Valley Hospital
 - Terry Stone, Assistant Administrator/Compliance Officer, Willapa Harbor Hospital
 - Gary Swan, Payment Redesign Model Analyst, Office of Health Innovation and Reform, Health Care Authority
 - Jacqueline Barton True, Rural Project Manager, WSHA
 - Helen Verhasselt, CFO, North Valley Hospital
 - Lindy Vincent, Critical Access Hospital / FLEX Program Coordinator, Department of Health
 - Carol Wagner, Senior Vice President, WSHA
 - Eric Walker, Commissioner, East Adams Rural Healthcare
 - Mike Zwicker, Former CEO, North Valley Hospital

II. PROBLEMS IN DELIVERING HEALTH CARE IN RURAL COMMUNITIES

A. Financial Deficits in WRHAP Public Hospital Districts

In most of the WRHAP Public Hospital Districts (PHDs), the revenues received for services delivered to patients are insufficient to cover the costs of delivering those services. In the three years from 2013 through 2015, all of the WRHAP PHDs had an operating deficit in at least one year, and most had deficits in all three years. On average, the revenues for the patient services delivered by the WRHAP PHDs only covered 90% of the costs of the services. In some districts, the deficits were as high as 18% of costs.

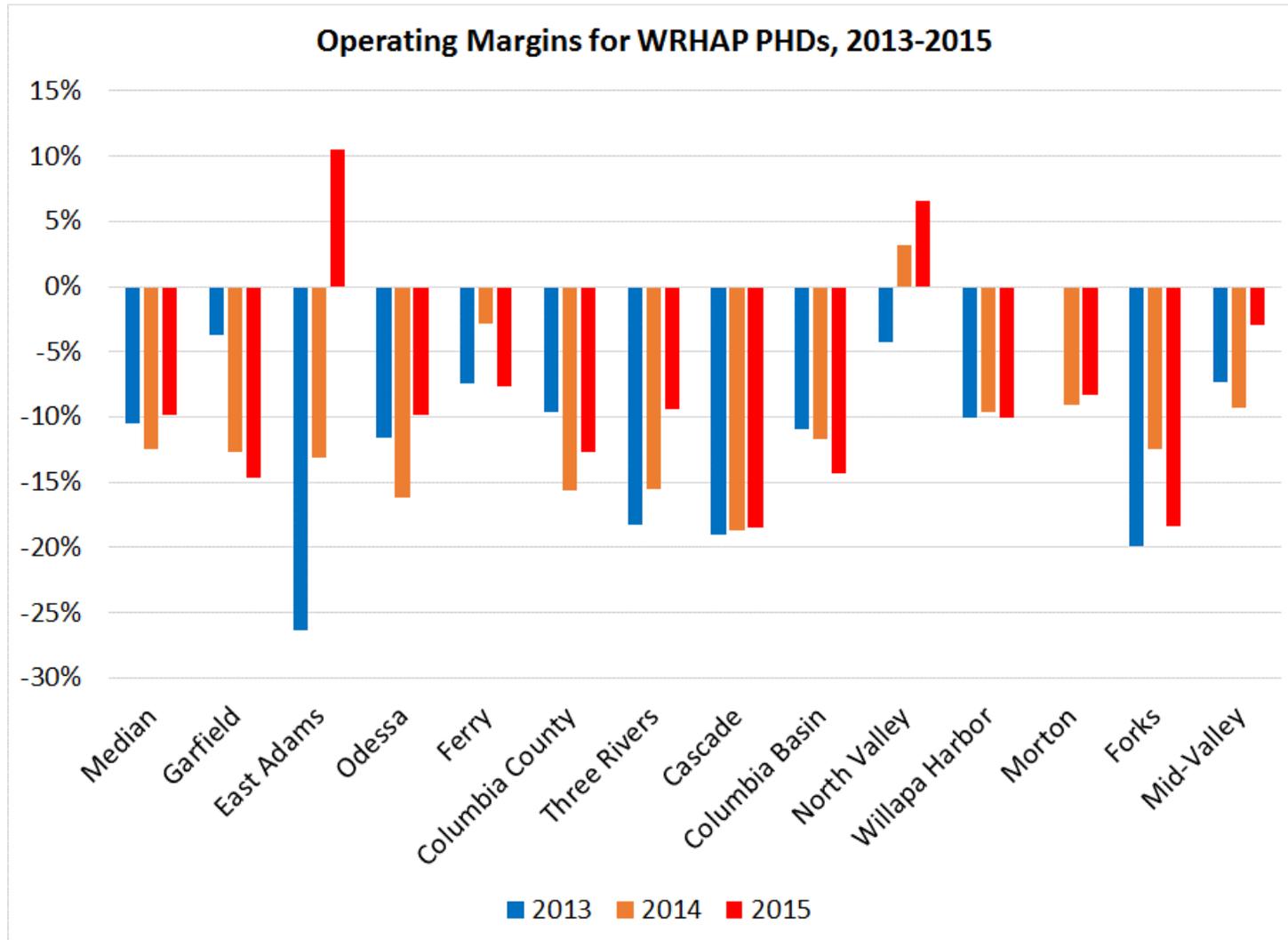
These deficits are currently being covered primarily by revenues raised through local tax levies. Property tax revenues raised by WRHAP PHDs in 2015 averaged approximately \$159 per resident and were as high as \$446 in some districts. If the hospitals were not operated by Public Hospital Districts with the ability to collect tax revenues, they would likely have had to close, and the tax levies currently being used to subsidize the losses may not be sustainable.

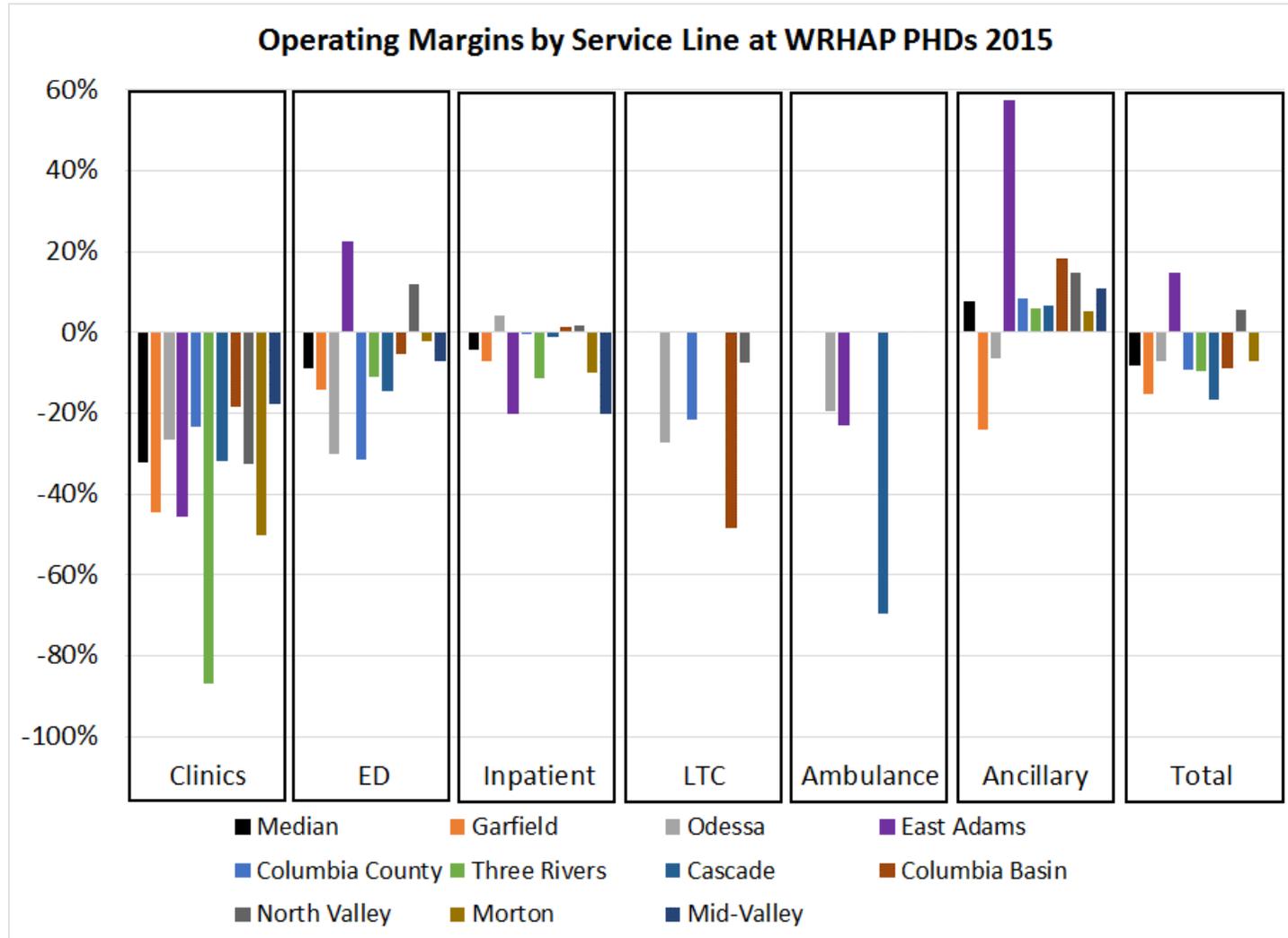
Detailed data on 2015 revenues and costs provided by ten of the fourteen WRHAP PHDs show that the deficits primarily result from four types of services operated by the hospitals:

- **Primary Care Clinics.** All of the WRHAP PHDs had significant losses on their clinics in 2015. On average, clinic revenues only covered 2/3 of the costs of operating the clinics. For most of the WRHAP PHDs, the clinics were the largest contributor to the overall deficits, representing 30% or more of the total PHD deficit.
- **Emergency Department (ED).** Eight of the ten WRHAP PHDs had losses on their Emergency Departments. The shortfalls in the EDs were smaller than those in the clinics, averaging 9% of costs.
- **Inpatient Services.** Seven of the ten WRHAP PHDs had losses on their inpatient services. These shortfalls were smaller than the deficits for the Emergency Departments, averaging about 4% of costs.
- **Nursing Facility and/or Assisted Living Facility.** Four of the ten WRHAP PHDs operate separate long-term care nursing facilities and/or assisted living facilities. All of these facilities have operating deficits, and these deficits significantly increase the overall operating deficits for the PHDs that operate them.

In most (but not all) of the WRHAP PHDs, radiology and laboratory testing services are profitable and help to offset losses in the other service lines and reduce the need for tax levies.

The reasons for the deficits in the clinics, Emergency Departments, inpatient units, and nursing and assisted living facilities are complex. The patient service revenues that the WRHAP PHDs use to support their operations come from multiple payers, each of which uses a different payment system. Although the Medicare and Medicaid payment systems for Critical Access Hospitals and Rural Health Clinics are supposed to cover the costs of the services, they do not do so for a variety of reasons. Commercial health plans generally pay below the costs of services, particularly in the smallest hospitals. In addition, the mere fact that every payer uses a different method of payment increases the complexity and cost of administrative services for small Public Hospital Districts.





B. Causes of Deficits in Emergency Departments

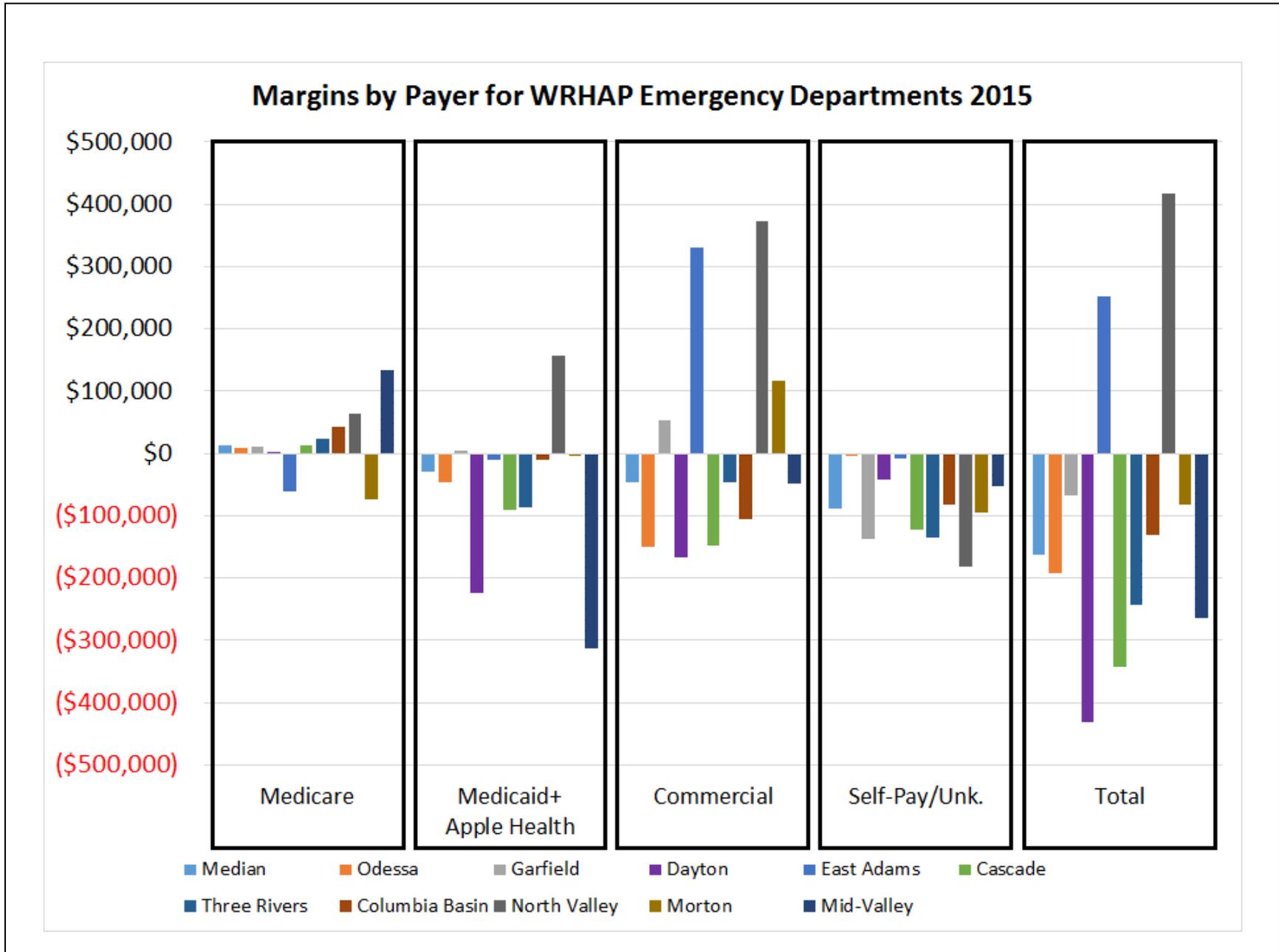
The participants in the WRHAP project agreed that it was essential to preserve access to the WRHAP PHD Emergency Departments for the residents of their service areas, and to do so, the financial problems facing the EDs needed to be resolved. In order to understand the causes of Emergency Department deficits, analyses of the revenues and costs of Emergency Departments were carried out using detailed data provided by ten of the WRHAP hospitals.

The following are the conclusions from those analyses:

- **Emergency Department visits are more expensive in WRHAP communities than in larger communities because of the lower volume of visits in sparsely populated rural areas, not because of inefficiencies in the delivery of care.** The staffing levels and costs of operating the WRHAP Emergency Departments are consistent with minimum standards for Critical Access Hospitals or stand-alone EDs based on the volumes of visits they experience, and it does not appear that staffing levels or costs could be reduced significantly without jeopardizing the quality and timeliness of emergency care provided. Moreover, the rate of ED visits from community residents is similar to state and national norms in most of the WRHAP PHD service areas. However, because of the small populations of the WRHAP communities, their total volume of ED visits is lower than the maximum number of visits that the ED could safely handle, which means that the cost per visit will be higher in WRHAP communities than in larger communities with higher volumes of visits.
- **The amounts that commercial health plans pay for Emergency Department visits are below the cost of the visits at the smaller hospitals.** In the larger communities, the average cost per ED visit ranges from \$300 to \$750, depending on volume, and the amounts that commercial insurance companies pay are similar to those costs – about \$400 to \$800 per visit. However, in the smallest communities, the average cost per ED visit is much higher – \$800 to \$1,800 – because of the smaller number of visits relative to the fixed costs of the ED, but in most cases, commercial insurance companies pay the same amounts in these communities as they do in larger communities. Since commercially insured patients represent more than one-fourth of the total number of visits to the EDs, large differences between payments and costs contribute to significant deficits in the small EDs.
- **In some WRHAP communities, large numbers of individuals visit the ED who do not have health insurance and cannot pay the full cost of the visit.** In three of the ten communities analyzed, 8-10% of the ED visits were made by patients without insurance, and in two of those communities, the payments from the patients averaged \$300 or less, which was less than half of the cost of the visits.
- **Under Federal law, Medicare pays less than the total cost of ED visits by Medicare beneficiaries.** All of the WRHAP hospitals are designated as Critical Access Hospitals. Although the Social Security Act requires the Centers for Medicare and Medicaid Services (CMS) to pay Critical Access Hospitals 101% of the costs of services delivered to Medicare beneficiaries, not all costs are considered reimbursable. In addition, federal budget sequestration has reduced the payment by 2%, so that it now only covers 99% of costs. Moreover, this cost-based reimbursement is only based on the *proportion* of

allowable costs allocated to Medicare beneficiaries; this means that the larger the number of non-Medicare beneficiaries who visit the ED, the smaller the Medicare payment will be, even though the other patients may be uninsured or have an insurance plan that pays less than the cost of an ED visit. (Only the portion of the cost of the physician/clinician that is considered to be “on call” is paid by Medicare in this way. Actual visits with patients are paid through a per-visit payment. Analyses indicate that for eight of the ten WRHAP hospitals analyzed, the visit-based payments are more than sufficient to cover the cost of the portion of the clinicians’ time spent in seeing patients.)

- **The rates that Medicaid Managed Care Organizations (MCOs) in Washington pay for ED visits at Critical Access Hospitals are based on a complex formula that may not cover the cost of the visits.** Each year, the Washington State Health Care Authority (HCA) establishes the percentage of each Critical Access Hospital’s charges that the state Medicaid program and Medicaid MCOs will pay for ED visits and other outpatient services delivered by that hospital. The percentage of charges paid for ED visits is based on the average cost-to-charge ratio for *all* outpatient services in the hospital, even though the cost-to-charge ratio for an ED visit is typically much higher than the ratio for other outpatient services. This means that the amount a Medicaid MCO will pay for an ED visit will generally be lower than the cost of the visit. For the same reason, the amount the MCO pays for other outpatient services will be higher than the cost of those other services. Since the percentages of charges were based on historical costs plus projected increases in those charges and costs over time, the net result may or may not be a payment that is sufficient to cover the current costs of the ED services. State law requires that the hospitals be paid based on their costs, and the state reconciles the payments in the Medicaid FFS program so they cover the actual costs incurred for services to the patients enrolled in that program. However, there is no reconciliation for payments made by Medicaid MCOs to ensure they cover the actual costs of ED visits or other services their patients receive. (In 2015, the total Medicaid MCO payments for both ED and outpatient services fell short of the total costs of those services for five of the ten hospitals analyzed, and the five with deficits were the smallest of the ten.)
- **The profits on radiology and laboratory tests for patients visiting the ED offset the ED deficits for some, but not all, hospitals.** The deficits described above for Emergency Departments are based solely on the costs of operating the Emergency Department and the revenues received for the visit to the ED. In addition to the visit with the emergency department physician or clinician, many patients who come to the Emergency Department will have laboratory tests or imaging studies ordered. The costs of these tests and studies, and the revenues associated with them, are assigned to the laboratory and radiology service lines, not the ED. As noted earlier, these service lines are profitable for most (but not all) of the WRHAP hospitals, so the total margin associated with caring for ED patients depends not only on the costs and revenues for the ED visit but also on the costs and revenues for these other services. Analysis showed that on average, total charges for patients visiting the ED were about 70% higher than for the ED visit alone. After factoring in the revenues and costs for all of the services the patients received, five of the ten WRHAP PHDs analyzed still experienced deficits for their ED patients, although most of those deficits were smaller than considering only the ED revenues and costs alone. For the other five, total revenues from patient visits to the ED appeared to exceed the total costs of the services delivered.



C. Causes of Deficits in Primary Care Clinics

All fourteen of the WRHAP Public Hospital Districts deliver some type of primary care services. Twelve of them do so through one or more Rural Health Clinics, and since the Medicare and Medicaid payment systems for Rural Health Clinics (RHCs) differ from the payment systems used for other primary care practices and clinics, the analyses carried out as part of the WRHAP project focused on the sizes and causes of deficits for RHCs. However, most of the problems described below also apply to Public Hospital Districts that bill for primary care services under the Medicare Physician Fee Schedule and the Medicaid fee schedule, not just those that are designated as Rural Health Clinics.

Financial data were analyzed for the ten separate Rural Health Clinics operated by eight of the WRHAP PHDs. The following are the conclusions from these analyses:

- **Visits to small primary care clinics in rural areas are more expensive than visits to primary care practices in larger communities because of the low volume of visits in sparsely populated rural areas.** The staffing levels and costs of operating the WRHAP Rural Health Clinics are consistent with the volumes of visits they experience, but because of the small populations of the communities, the total volume of visits is lower than the number of visits that the physicians/clinicians staffing the clinic could manage. This means that the cost per visit will be higher in these clinics than in primary care practices in larger communities. The WRHAP clinics have 4,000 to 6,000 visits per year, whereas a physician in a primary care practice in an urban area might have 6,000 to 7,000 visits per year.
- **The amounts that commercial health plans pay for Rural Health Clinic visits are below the cost of the visits.** The average cost per clinic visit is about \$200 in the WRHAP PHD clinics analyzed. However, commercial insurance payments for these visits are less than half of this amount, and in some cases are less than 25% of costs. Since commercially insured patients represent about one-third of the total number of visits to the clinics, those large shortfalls contribute to significant deficits in the clinics.
- **Medicaid payments for clinic visits at most of the WRHAP clinics fall far short of the cost of the visits.** Under state regulations, a Rural Health Clinic (RHC) is supposed to receive an Encounter Rate payment for each visit by a Medicaid beneficiary that is based on the clinic's cost per visit. However, the Encounter Rates in 2015 were below the average cost of visits for eight of the ten WRHAP Rural Health Clinics. In five of the clinics, the Medicaid Encounter Rates were 35% to 46% below costs, which contributed to significant overall deficits at those clinics. The deficits vary by clinic because of significant variation in the Medicaid Encounter Rates. Although the cost per visit ranged from \$161 to \$245 among the ten clinics, with a median cost of \$196, the Medicaid Encounter rates ranged from \$110 to \$295, with a median rate of only \$151.
- **The Medicaid payment system also creates significant administrative burdens for the state and the WRHAP Rural Health Clinics.** Not only are the Medicaid payments below the costs of the services in most of the clinics, they are paid through a very complex three-step process:
 - First, the patient's Medicaid Managed Care Organization (MCOs) pays the clinic an amount for each visit made by one of that MCO's members; these payments are often

based on Medicaid fee-for-service payments for physician visits and are well below the cost of visits in the WRHAP clinics.

- Second, each month, the Washington State Health Care Authority pays an additional “Enhancement” payment to the clinic that is intended to make up the difference between the MCO payments and the clinic’s Encounter Rate. However, this Enhancement payment is based on (1) the total number of Medicaid beneficiaries who have been assigned to the clinic by the MCOs and (2) an *estimate* of the rate at which these beneficiaries will visit the clinic, not on how often the beneficiaries *actually* visited the clinic. This means that the total payments may or may not be equal to the total Enhancement payments that are owed based on the actual number of visits that month.
- Third, a reconciliation process is conducted after the end of the year to ensure that the total payments received by each clinic from both the MCOs and HCA are equal to the clinic’s Encounter Rate times the number of visits Medicaid beneficiaries actually made to the clinic. The Public Hospital District must then pay for an audit to verify that it has received the correct amount; if not, it will either receive a supplemental payment from the state or it will be required to repay the excess amount it received.

This process is very burdensome for both the state and the clinics and it also makes it difficult for anyone to understand how payments actually relate to costs. In 2015, the payments received by the WRHAP clinics were 26% lower on average than their Medicaid encounter rates, forcing the clinics to wait for over a year to receive the balance of those payments. This 26% shortfall in cash flow, combined with the shortfall in the encounter rate itself, caused even greater short-term deficits for the clinics.

- **Under Federal law, Medicare pays less than the total cost of clinic visits by Medicare beneficiaries.** Although the Social Security Act requires the Centers for Medicare and Medicaid Services (CMS) to pay Rural Health Clinics operated by Critical Access Hospitals 101% of the costs of services delivered to Medicare beneficiaries, not all costs are included, and federal budget sequestration has reduced that payment by 2%, so that it only covers 99% of the eligible costs. Moreover, since this cost-based reimbursement is only based on the proportion of costs allocated to Medicare beneficiaries, the larger the number of non-Medicare beneficiaries who visit the clinic, the smaller the Medicare payment will be, even though the other patients may have insurance plans that pay less than the cost of a clinic visit.
- **Small Rural Health Clinics that employ physicians may have their Medicare payments reduced if the clinicians staffing the clinic do not have a minimum number of total visits in the clinic during the year.** CMS reduces payments to the clinic if the total number of visits with clinicians drops below the productivity standards it sets. CMS requires a minimum of 4,200 visits per year for physicians and 2,100 visits per year for a nurse practitioner or physician assistant. Since most WRHAP clinics have about 4,000 to 6,000 visits per year, clinics that employ a physician as well as a Nurse Practitioner or Physician Assistant may be financially penalized simply because the community is too small to support the required minimum number of visits per clinician.

D. Causes of Deficits in Nursing Care and Long-Term Care Services

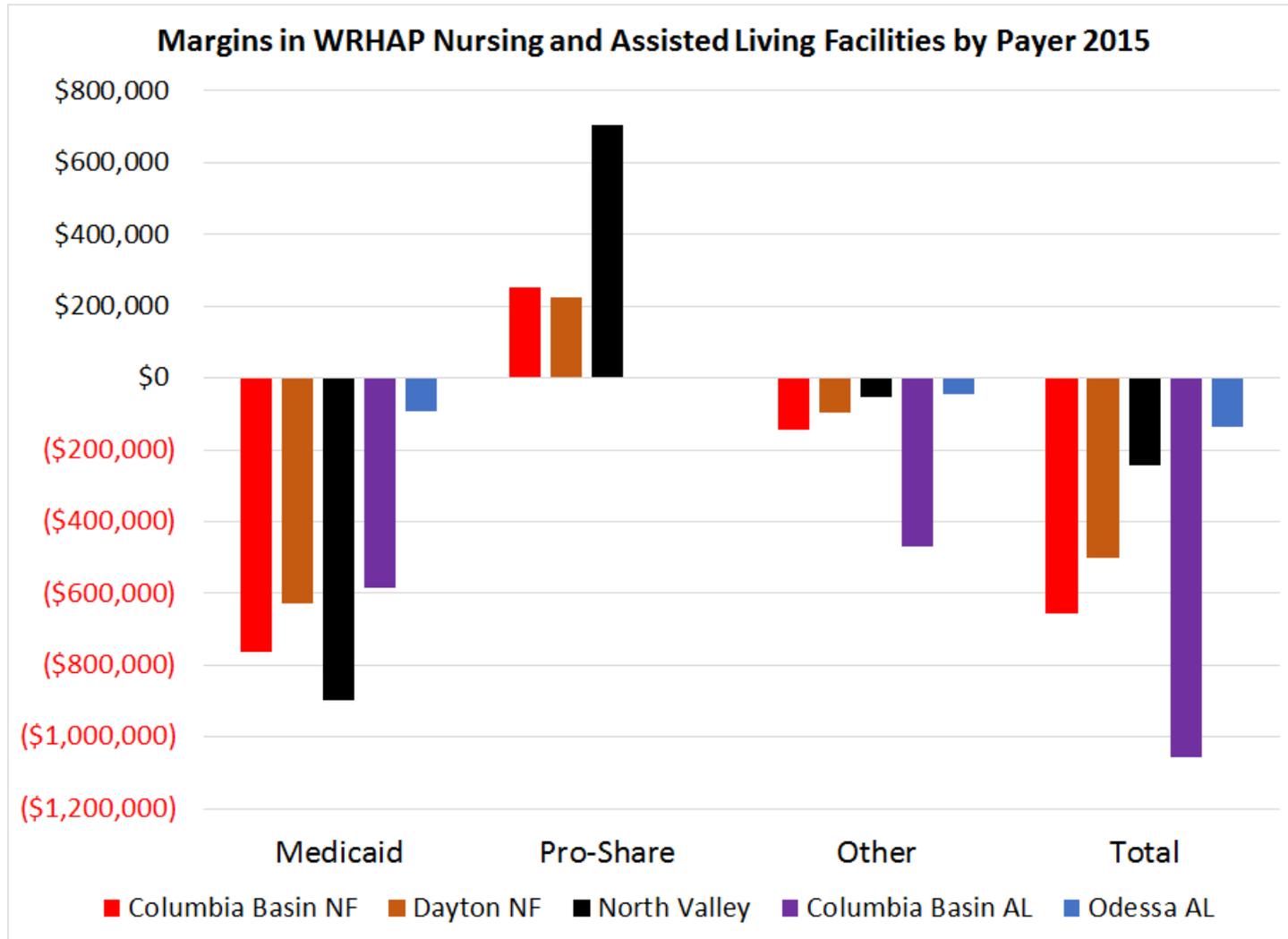
Many of the WRHAP Public Hospital Districts provide some type of long-term nursing care services, and that care is viewed as an essential service by the residents of their communities. Most of the WRHAP PHDs deliver at least some of these services in the hospital inpatient unit (through “swing beds”). In these cases, the staffing and other costs for nursing care patients are shared with staffing and costs for inpatient acute care, observation care, short-term skilled nursing rehabilitation services, and in some cases, emergency department services. Four of the WRHAP PHDs deliver long-term skilled nursed services through “separate part” nursing homes that are licensed and staffed separately from the hospitals themselves. Two of the WRHAP PHDs also operate assisted living units or facilities that use a less intensive level of staffing than a licensed nursing facility or inpatient unit would provide.

In order to determine the causes of deficits in nursing care services, some analyses of the revenues and costs of operating those services were carried out using detailed data provided by ten of the WRHAP hospitals, but a full analysis has not yet been completed. The following are the preliminary conclusions from the initial analyses:

- **Medicaid payments for long-term nursing care and assisted living services are significantly lower than the costs of delivering services.** In the three separate WRHAP long-term care nursing facilities analyzed, costs ranged from \$200 - \$400 per day, but Medicaid payments were only \$150-\$170 per day. The majority of the long-term nursing care patients are on Medicaid, so these shortfalls in payment rates are the primary source of deficits. In the two assisted living facilities analyzed, costs were \$120-\$180, but Medicaid payments were only \$60-\$65. Medicaid patients represented 27-40% of the residents of the assisted living facilities, and the Medicaid payment shortfalls were the primary sources of deficits there as well.
- **ProShare Supplemental Payments reduce the deficits for long-term nursing care but do not eliminate them.** Through the state’s ProShare program, the WRHAP Public Hospital Districts are able to receive supplemental federal Medicaid payments as a match for the local funds the WRHAP PHDs use to cover the deficits in state payments for long-term nursing care to Medicaid recipients. However, because PHD funds must be used as match and the combined payments cannot exceed the cost of the services, the ProShare program cannot eliminate the deficits in caring for Medicaid patients in long-term nursing care facilities.
- **Some communities have been able to make provision of long-term nursing care services to Medicaid patients more financially viable by providing care in swing beds instead of separate facilities, but this may not be sustainable.** WRHAP hospitals with small numbers of acute admissions, skilled nursing patients, and observation stays have been able to use their available swing beds to provide long-term nursing care services. That can be a more efficient way of serving small numbers of both hospital and nursing care patients than operating separate facilities. In addition, if Medicare beneficiaries receive acute care and rehabilitation services in swing beds, the Medicare payments to the hospitals for these services are calculated in a way that compensates for the shortfall in Medicaid payments for long-term care patients in swing beds. However, this requires that at least one Medicare beneficiary be receiving inpatient care (either an acute hospitalization or a skilled nursing facility stay) in the swing beds. Because the

hospitals receiving these subsidies have very few inpatient days, these subsidies could vanish if there are no Medicare inpatient days during the year. In addition, the shortfall in Medicaid payments for the long-term care patients makes the hospital falsely appear to have very high per-diem costs for inpatient care to Medicare beneficiaries, and that could inappropriately discourage use of these PHDs for inpatient care and post-discharge rehabilitation services under Medicare value-based payment systems and alternative payment models.

- **Many self-pay patients cannot afford the cost of nursing home and assisted living services without financial assistance.** Commercial health insurance plans and the Medicare program do not cover long-term nursing care or assisted living services, so patients who do not qualify for Medicaid must pay out of pocket. Although the payments from self-pay patients for nursing care and assisted living services are higher than Medicaid payments, they are still below the average cost of the service, and this also contributes to the deficits.



E. Causes of Deficits in Inpatient Services

Phase 1 of the WRHAP project focused primarily on the causes of and solutions to the deficits in the Emergency Departments, clinics, and long-term care services at the WRHAP PHDs.

Although some analyses were carried out to identify the factors causing the deficits in inpatient services and the preliminary findings are described below, additional analyses are needed and are planned for Phase 2 of the WRHAP project.

The WRHAP PHDs generally provide four different types of services in their inpatient units:

- acute inpatient admissions;
- skilled nursing stays in the subset of the unit designated as “swing beds;”
- long-term nursing care services in those swing beds; and
- observation stays.

In small hospitals, most of the costs of the inpatient units will not vary depending on the types of services the patients occupying the beds are receiving, but the payment rates will differ significantly depending on the type of service and the payer. This means that the profitability of the inpatient unit will depend heavily on the types of patients in the unit and the type of health insurance, if any, they have.

- **Most inpatient services are not acute admissions, and payments generally appear to cover the costs of these services.** On average, only about 25% of the net revenues for inpatient services are associated with acute admissions, and acute admissions represented the majority of net revenues in only two of the ten hospitals analyzed. In general, the payments received by WRHAP PHDs for acute admissions from most payers appear to be higher than the average costs for patients in the inpatient unit.
- **The majority of inpatient revenues are associated with skilled nursing or long-term nursing services delivered in swing beds, and these services generally break even.** Payments for skilled nursing services generally appear to cover costs. Medicaid payments for long-term nursing care services delivered on inpatient units do not cover costs, but the Medicare cost-based payments for swing bed services cover these shortfalls.
- **Losses on inpatient units appear to stem primarily from observation stays.** Even though an observation stay is an overnight stay in the hospital and the care is often indistinguishable from an acute admission, it is classified as an outpatient service and the reimbursement under Medicaid and commercial payment systems is much lower than for an inpatient admission. At the WRHAP hospitals, on average, the payments for observation stays are only about half of inpatient costs.
- **When payments for ancillary services to inpatients are considered, inpatient services at most WRHAP PHDs are profitable.** Patients on inpatient units receive a variety of radiology, laboratory, therapy, and other ancillary services which are paid for separately from the payments for the inpatient nursing care the patients receive. A preliminary analysis indicates that the combined revenues for both inpatient stays and the ancillary services the patients receive during those stays offset the combined costs of the services for seven of ten hospitals, making inpatient stays profitable for them overall.

F. Barriers to Delivering Higher-Quality, Lower-Cost Care

Even if payments for emergency department, clinic, long-term care, and inpatient services at WRHAP PHDs were large enough to eliminate the current deficits, the overall payments to the WRHAP PHDs would still be inadequate to provide the care that rural residents need. WRHAP PHDs face several barriers to delivering high-quality coordinated care to the residents of their service areas, and that is likely causing payers and patients to spend more in total on healthcare services than would otherwise be necessary. The major barriers are:

- **Current payment systems do not support the delivery of high-value primary care and Patient-Centered Medical Home services in rural communities.** There is growing recognition nationally that primary care, particularly when delivered in accordance with Patient-Centered Medical Home principles, can improve the health and productivity of individuals, reduce their need for expensive specialty care and hospital admissions, and thereby reduce total healthcare spending. However, the current payment systems for the WRHAP PHD primary care clinics do not enable them to deliver that type of high-value care, for several reasons:
 - **Current clinic payments are primarily based on face-to-face visits with physicians and other clinicians.** National studies have shown that proactive outreach to patients by phone can improve patient outcomes, and that in many cases, a health problem can be addressed equally or more effectively through a telephone, email, or telemedicine linkage rather than through a face-to-visit with a clinician. This is particularly true in rural areas, where long distances and travel challenges during bad weather make it difficult for residents to travel to a primary care clinic. However, under the payment systems used by Medicaid and commercial health plans, the clinic only receives payment for a face-to-face visit with a physician, nurse practitioner, or physician assistant, and telemedicine visits can only be delivered under limited circumstances. Although Medicare payments to Rural Health Clinics are based on the cost of operating the clinic, if the number of total visits (for all patients) falls below Medicare productivity standards, the clinic's payments will be reduced.
 - **Most payers do not support the costs of high-value services such as care managers/coordinators and behavioral health specialists.** National studies have shown that quality can be improved and overall costs can be reduced by embedding appropriately trained care managers/coordinators and behavioral health specialists who can help the clinic coordinate care for patients and deliver integrated behavioral health and physical health services. However, the WRHAP PHDs cannot deliver these services because many commercial health plans do not pay for these services and because Medicare and Medicaid payments are below the current costs of operating the clinics. (A portion of the costs could potentially be supported through Medicare cost-based payment in a Rural Health Clinic, but that would not be sufficient to cover the full costs of the services unless they were delivered exclusively to Medicare patients.)
- **Under current payment systems, improvements in primary care and other initiatives that reduce the number of ED visits will increase deficits at Critical Access Hospitals.** All payers – Medicare, Medicaid, and commercial insurance – base their payments for Emergency Department services in some way on the number of visits made by individuals insured by the payer, and so a reduction in the number of visits will reduce the amount of revenue the hospital receives to support the ED. However, the

Emergency Department will still need to be staffed at the same levels in order to respond to emergencies, so improving patients' health and delivering services through primary care rather than the Emergency Department will increase hospital deficits.

- **Current payment systems financially penalize WRHAP PHDs for reducing inpatient admissions.** Most of the inpatient admissions in WRHAP PHD hospitals are for ambulatory care-sensitive medical conditions such as heart failure, COPD, and pneumonia. In addition to reducing ED visits, improved primary care services will also likely reduce the number of these inpatient admissions. However, in most of the hospitals, the low volume of admissions means that staffing is likely already at minimum levels, so reductions in admissions will not allow reductions in the total cost of operating the inpatient unit. Since payments for inpatient admissions are based directly or indirectly on the number of admissions, fewer admissions will result in greater deficits for the WRHAP PHD. The hospitals most at risk of having no Medicare admissions are the very smallest hospitals, and loss of Medicare payments for inpatient admissions would create significant deficits for long-term nursing care delivered in swing beds.
- **Residents of WRHAP PHD service areas have limited access to home health, hospice, and other home care services that could help avoid the need for expensive inpatient and nursing facility care.** Although only anecdotal information is available, WRHAP PHDs report that it is difficult for residents of their service areas to obtain home health and hospice services. The WRHAP PHDs cannot fill this gap because (a) Medicare prohibits cost-based payment for these services unless no home health agency exists, and (b) other payers generally do not pay enough to cover the higher costs of delivering home care services in rural areas where long travel times are required to reach patient homes. Many patients may be forced to receive inpatient services instead, either at WRHAP PHDs or other facilities, because adequate home care services are not available. Since the populations served by the WRHAP PHDs are aging, these problems will worsen in the future.
- **Reductions in ED visits and admissions will also reduce margins generated on laboratory testing and imaging.** In most (but not all) of the WRHAP PHDs, radiology and laboratory testing services are profitable and thereby help to offset losses in the other service lines and reduce the need for tax levies. However, a significant portion of the patients receive these services in conjunction with an Emergency Department visit or an inpatient admission. This means that the margins generated on ancillary services would decrease if ED visits and admissions decreased, further exacerbating financial problems.
- **High cost-sharing amounts for patients can discourage patients from receiving preventive care and from obtaining services at WRHAP hospitals.** The higher charges per service required to cover the higher costs at WRHAP PHD hospitals and clinics mean that Medicare beneficiaries and commercially insured patients will pay higher cost-sharing amounts for primary care and outpatient services than they would at larger hospitals and clinics. That can discourage patients from obtaining preventive care services and/or cause them to delay receiving early treatment for a condition, both of which can lead to the need for more expensive services later. In addition, if patients travel to other hospitals or clinics in order to obtain services at a lower cost, it will reduce volume at the WRHAP PHD hospital or clinic, increasing the cost per service even more.

III. OPTIONS FOR ADDRESSING THE PROBLEMS

A. Options for Emergency Departments

Several options for addressing the problems facing the WRHAP PHD Emergency Departments were identified and analyzed:

- Close the Emergency Department
- Reduce the level of staffing in the Emergency Department
- Increase the amounts paid for ED services
- Establish a minimum total ED payment from each payer
- Create a population-based payment for ED services

Option A-1. Close the Emergency Department

Although closing the Emergency Department would eliminate the need for a WRHAP PHD to incur the direct costs associated solely with staffing and operating the ED, this would not eliminate the deficits that the hospitals are currently experiencing and it could actually increase the hospitals' deficits, for several reasons:

- **Shift in indirect costs to other service lines.** Payments for ED visits are generally adequate or more than adequate to cover the *direct* costs of the EDs, particularly in the larger hospitals, but they are not adequate to also cover the *indirect* costs that must be allocated to the ED. If the ED were to be closed, the profits on the direct costs would be lost, while most of the indirect costs would remain and would have to be reallocated to other service lines, which would simply increase deficits elsewhere. The combined effect would likely be an increase in the hospitals' overall deficits.
- **Shift in direct costs to other service lines.** In the smallest hospitals, the ED is staffed by physicians and nurses who also deliver clinic and/or inpatient services. That means that even if the ED were closed, the hospital would not be able to eliminate all of its direct costs associated with the ED; instead, costs and deficits in the other service lines would simply increase. (To the extent that patients would seek care from the PHD primary care clinic, the revenue from those visits could offset a portion of the loss of revenue from fewer ED visits.)
- **Loss of other outpatient revenues.** Closure of the ED would result in the loss of the license to operate as a hospital, which would reduce the amount the PHD would be paid for other outpatient services. Moreover, a significant proportion of the outpatient laboratory and imaging services delivered by the hospitals is associated with patients who are seen in the Emergency Department, which means that closure of the ED would likely result in the loss of some of that revenue. Those patients who would have come to the ED for minor acute care might seek care from the PHD primary care clinic or another local primary care provider instead, in which case any needed laboratory testing and imaging might continue to be delivered by the hospitals, but those who went to another hospital ED would receive all or most of any testing and imaging at that other hospital.

- **Loss of inpatient revenues.** Under current licensing rules, closure of the ED would result in the loss of the license to operate as a hospital, which would eliminate the PHD's ability to deliver inpatient services. Moreover, since a significant proportion of the inpatient admissions to the hospital originate in the ED, shifting ED visits to other hospitals would likely reduce the number of inpatient admissions at the WRHAP hospital even if it retained its license.

In addition to not solving the financial problems, closing the ED would have negative impacts on the community:

- **Delays in receiving emergency care.** In each of the WRHAP Public Hospital Districts, closure of the PHD's ED would mean that between 1,000 and 10,000 people would have to travel an additional 25 minutes or more to reach an emergency department in the case of an emergency. In the majority of the districts, one-third of the population would have to travel an additional 40 minutes or more, and in four districts, all of the residents would have to travel 40 minutes or more if the local ED were closed. Since a significant portion of the visits to the ED are for serious issues such as chest pain, potential stroke, or trauma, that delay could result in higher mortality rates and poorer outcomes for local residents and visitors.
- **Loss of community residents and businesses.** Some individuals and businesses would be less likely to locate or remain located in the service area if timely access to an emergency department were not available.

Option A-2. Reduce the Level of Staffing in the ED

A second option would be to reduce the cost of operating the ED by reducing the level of staffing. Three approaches to this would be:

1. Replace emergency physicians or primary care physicians who are currently staffing the ED with nurse practitioners or physician assistants;
2. Provide only on-call coverage by off-site clinicians during evenings and weekends; and/or
3. Replace on-site/on-call physicians, nurse practitioners, and/or physician assistants with trauma-trained nurses and telemedicine support from an off-site emergency physician.

The first two approaches could still meet state hospital licensure standards and conditions of participation for Medicare payment, but the third option would require revisions to state licensure requirements and Medicare conditions of participation.

Each of these approaches could have some of the same negative impacts described for Option A-1, since under any of the approaches, some patients might not receive timely or adequate care from a physician with the necessary training and skill.

No estimates have been made of the potential savings from any of these approaches. Each of the WRHAP hospitals is staffed differently and has different volumes and types of ED visits, so a special analysis of the savings and other impacts would have to be performed for each individual hospital.

Option A-3. Increase the Amount of Payments for ED Services

A third option would be to increase payments from each payer so they are adequate to cover the costs of the visits. Since each payer pays differently, this would require a somewhat different approach for each:

Medicare

- The cost-based payment from Medicare could be increased from 101% of costs to at least 102% of costs, so that with the 2% sequestration reduction, the hospital would receive at least 100% of its costs. This could either be applied to all hospital services or it could be targeted just to ED visits.
- Alternatively, Medicare could pay the hospital a new per-visit payment for ED visits, either in addition to or instead of the current cost-based payment for the hospital and the current clinician visit-based payment.

Medicaid

- The Health Care Authority could revise its regulations to require Medicaid MCOs to make cost reconciliation payments either for all outpatient services or just for ED services. State law requires that Critical Access Hospitals be paid based on their costs, and the Health Care Authority already carries out a cost reconciliation process for the payments it makes for Medicaid FFS services, so this same process could be required for Medicaid MCO payments.
- Alternatively, the Health Care Authority could modify its regulations and procedures to calculate a separate cost-to-charge ratio for ED visit charges, rather than the single blended ratio based on both ED visits and all other outpatient services that is used today. This ED-specific ratio would then be used by Medicaid MCOs and HCA to pay for ED visits at Critical Access Hospitals. Because the ratio would still be calculated based on an estimate of costs and charges, this approach would not assure that the payments for ED visits matched costs. However, it would likely close the gap between actual costs and payments for the Emergency Department, reducing the additional amount that would need to be paid if cost reconciliation was also required. This change in procedure would also result in a decrease in the payments for other outpatient services such as laboratory tests and radiology services, but because the payments currently exceed costs in most cases, this would simply better align payments with costs.
- A third alternative would be for the Health Care Authority to seek legislative approval to make supplemental federal Medicaid payments to Emergency Departments operated by WRHAP Public Hospital Districts through a new Certification of Public Expenditure (CPE) program. The WRHAP Public Hospital District would identify the funds that it is currently using to cover the gap between current ED payments and its costs of services for Medicaid patients, and the Health Care Authority would then obtain Federal Financial Participation (FFP) funding based on the PHD's spending. Based on Washington State's 50% FFP rate, this could reduce the ED losses on Medicaid patients by 50%, but it would not eliminate the losses entirely because the PHD would have to certify that it was covering the local share. Washington State uses a similar approach for supplemental payments for nursing facilities and for ground ambulance services. The Centers for Medicare and Medicaid Services (CMS) would need to approve this new CPE program as

part of Washington's State Plan Amendment; however, CMS has indicated that it will not be approving new CPE programs that are used as pass-through payments through Medicaid Managed Care Organizations.

- A fourth alternative would be for the state to make it easier for hospitals with a high volume of ED visits by migrant workers to access funding from the state Alien Emergency Medical Program (WAC 182-507-0115).

Commercial Insurance

- Hospital contracts with commercial insurance plans could specify payment of a higher percentage of the hospital's charges for ED visits than they do today. The simplest approach would be for the hospital to set its charge for a visit at a level sufficient to cover the average cost of the visit plus a margin to cover capital replacement costs, and for all insurance plans to pay 100% of that charge. Setting charges based on costs could also reduce cost-sharing amounts for Medicare beneficiaries (since Medicare beneficiaries must pay 20% of the hospital's outpatient charges, not 20% of Medicare's cost-based payment).

There are two disadvantages of trying to solve ED deficits merely by increasing the payment amounts for visits to match costs:

- **ED payments would remain tied to visits.** All ED payments would still be tied to the number of visits made to the ED, so the hospital would be financially penalized if the clinic services and other programs reduce the need for ED visits, and the hospital's operating margin would increase if the number of avoidable ED visits increased.
- **There would be no direct source of revenue for uninsured patients who cannot pay the full cost of a visit.** Payments and charges tied closely to the average cost per visit would still result in deficits if an Emergency Department had large numbers of uninsured patients, since payments tied to costs allow no margin to cover losses on patients who cannot pay the full cost of care. This could be addressed indirectly by increasing the charges and the cost-to-charge ratios used for payment; however, higher charges penalize the patients who pay for themselves, and payments higher than costs increase the financial penalties for reducing avoidable ED visits.

Option A-4. Establish a Minimum Total ED Payment from Each Payer

A fourth option would be to establish a floor on the total amount of payment that a payer would make each year to support the ED. This would leave all current payment systems in place, but ensure that the Emergency Department would have sufficient funds to cover its costs regardless of how many visits were made. Creating such a minimum payment would require four steps:

1. **Establish a Minimum ED Budget.** The minimum amount of money needed to sustain adequate hospital ED services in a hospital's service area during the year would be determined by the hospital and/or an independent entity.
2. **Calculate Each Payer's Share.** Each payer would identify the number of its members or beneficiaries who live in the hospital's service area during the year. The proportion of the total insured residents of the service area who are insured by that payer would be calculated

and applied to the minimum amount determined in step 1 to determine that payer's share of the minimum budget.

- 3. Calculate the Shortfall in Visit-Based Payments.** Each payer would continue to pay for ED services the way it does today; the cumulative amount of those payments during the year would be tabulated for the payer and compared to the payer's share of the Minimum ED Budget.
- 4. Make Supplemental Payments to Cover Any Shortfall.** If the total visit-based payments from a payer fall short of the payer's share of the Minimum ED Budget, the hospital would bill the payer an additional amount to cover the shortfall. (In order for a commercial payer to assign the appropriate portion of that amount to its self-insured accounts, it could increase the ED visit payments that were billed to each account by the shortfall percentage.)

The advantage of this option is that the hospital would no longer be financially penalized for reducing avoidable ED visits because the payments would no longer be based totally on the number of visits. However, disadvantages of this option include:

- **Continued incentives to increase the number of visits.** Although the hospital would no longer be financially penalized for reducing avoidable ED visits, it would still be rewarded for increasing the number of visits.
- **Reduced incentives to provide timely, patient-responsive care.** Because the hospital would receive the minimum budget amount regardless of how many patients were seen, there would likely be concerns that the hospital emergency departments would have less incentive to provide high-quality, timely care. However, the same concerns could be raised about the current cost-based payment systems, since the hospital will receive higher payments per ED visit if it sees fewer patients.

Implementation of this approach would require a method for determining an appropriate minimum budget amount. This could be done by combining (1) the requirements established in minimum standards for licensure or accreditation of emergency departments with (2) estimates of the costs of the emergency department personnel, equipment, etc. needed to meet those standards. To assure payers that the calculations and budgets were reasonable, the process would likely need to be supervised by a state agency or an independent multi-stakeholder body. Requiring local taxpayers to pay a percentage of this minimum amount through a tax levy could also help convince federal, state, and private payers that the minimum budget amount was not unreasonably high.

Option A-5. Create a Population-Based Payment for ED Services

A fifth option is to move even farther away from payments based on visits, to a payment system that is based primarily on the population of the area the ED serves and the quality of care delivered rather than the number of visits actually made to the ED. This approach would have three basic components:

- 1. Annual Per-Resident Payments from Each Major Payer.** Most of the cost of operating an Emergency Department is a fixed amount that does not change based on the actual volume of visits. That is particularly true in small EDs like those in the WRHAP communities, where the volume of visits is such that there is little or no extra staffing to

deal with higher-than-minimum numbers of visits. Since each resident of the community benefits from having that “standby” service available whether they use it or not, it would be more logical to pay for the cost through a fixed annual payment for each resident in the community (similar to supporting a fire department through an annual budget rather than based on the number of fires it responded to). The per-resident payment could be paid directly by each payer (Medicare, Medicaid, or a commercial health insurance plan) for each of its covered members. Residents who do not have insurance or whose insurance plan does not participate could pay the annual per-resident payment themselves in order to benefit from lower per-visit payments when needed. The amount of the per-resident payment would be established through a methodology similar to what is described in Option A-4, after adjusting for the visit-based payments that the hospital would still receive.

2. Payments for Visits. The ED should continue to also receive some amount of payment for each visit to the ED, for four reasons:

1. Many visits to the ED will be made by people who are not residents of the service area, particularly in areas with high levels of tourism and transient workers, and it would be unfair to local residents to make them pay the full cost of maintaining the ED and to charge nothing to non-residents who benefit from the ED’s services.
2. Not every health plan may be willing to make per-resident payments, particularly those plans with very few members living in a community, and there needs to be a way of charging for services their members receive.
3. The hospital would need a way to obtain the additional funding needed to address the costs associated with unpredictable sudden increases in ED volume, such as when a disaster, disease outbreak, or major tourist event occurs.
4. Community residents whose payers did pay the per-resident payment would be likely to overuse the ED for minor issues if they did not have to pay anything to visit the ED. This would make the ED less able to respond appropriately to true emergencies. However, the per-visit payments for this last group should be much lower than for the other two groups; their per-visit amounts could be set at an amount somewhat higher than the amount the hospital would receive for a visit to the primary care clinic, but less than the amount charged to non-residents.

3. Performance-Based Payment. The ED and payers would measure the Emergency Department’s performance on a set of quality measures relevant to the types of patients seen in the ED. The WRHAP Emergency Departments are already collecting and reporting a series of quality measures as part of the Medicare Beneficiary Quality Improvement Project (MBQIP) under the Medicare Rural Hospital Flexibility (Flex) Program. However, they currently receive no additional payments to cover the costs of collecting the measures and improving performance. Initially, the ED could receive a bonus payment if its performance on these measures was above the statewide or national average for patients with similar characteristics. In later years, payments could also be reduced if performance was below minimum standards.

Because the majority of the payments would no longer be based on the number of visits, and because the visit-based payments for those living in the hospital’s service area would be much lower than they are today, the hospital would no longer be financially penalized for reducing avoidable ED visits for local residents. In addition, spending on emergency department services

would be more predictable for payers, since the payments would be based more on the number of the payer's members living in the community rather than the number of ED visits those members make.

Challenges in implementing this option would include:

- **The need for a method of determining the budget for the per-resident payment.** The same approach described in Option A-4 for establishing the minimum payment amount could be used to establish the per-resident amount. Requiring local taxpayers to pay a percentage of this budget through a tax levy would help to convince federal, state, and private payers that the budget was not excessive.
- **Continued incentives to increase the number of visits.** Although most of the hospital's revenues would no longer be based on the number of visits, if the per-visit payments are set at amounts that are higher than the marginal cost of a visit, the hospital would still benefit financially by increasing the number of visits.
- **Reduced incentives to provide timely, patient-responsive care.** Since the hospital's revenue would be reduced if fewer patients visited, the hospital would still have an incentive to deliver patient-responsive care, although smaller per-visit payments would reduce this incentive compared to the current payment system.

It is important to recognize that this "population-based payment" is simply a different way of paying for *emergency department services* based on the number of people living in the community. It is *not* a "global" or "capitated" payment intended to cover all of the patients' healthcare needs or to place the WRHAP Public Hospital District at financial risk for the costs of services delivered by other providers.

Although the population-based payment described above would need to be designed to provide sufficient funds to cover the *expected* costs of operating an Emergency Department in a WRHAP Public Hospital District, the payment amounts would not be tied explicitly to the *actual* costs of operating the ED, so amendments to current state law would likely be needed to implement this option in the Medicaid program. Similarly, because federal law requires cost-based payments to Critical Access Hospitals, implementing this option in Medicare would require a waiver or demonstration project from the Centers for Medicare and Medicaid Services.

B. Options for Rural Health Clinics

Several options for addressing the problems facing the WRHAP PHD primary care clinics were identified and analyzed. These options would be applicable both to Rural Health Clinics and to primary care practices operated by Public Hospital Districts that are not structured as Rural Health Clinics.

- Close the clinic
- Increase the amount of payments for clinic services
- Increase payments for clinic services based on performance on quality and spending measures
- Create additional payments for enhanced services
- Create a population-based payment for clinic services
- Create a comprehensive population-based payment for clinic services

Option B-1. Close the Clinic

Closing the clinic would eliminate the need for a WRHAP PHD to incur the costs associated solely with staffing and operating the clinic, but that would not eliminate the deficits that the WRHAP PHDs are currently experiencing and it could actually increase the PHDs' deficits, for several reasons:

- **Shift in indirect costs to other service lines.** Payments for clinic visits are generally adequate or more than adequate to cover the *direct* costs of the clinics, but they are not adequate to also cover the *indirect* costs that must be allocated to the clinics. If the clinics were closed, the profits on the direct costs would be lost, and most of the indirect costs would remain and would have to be reallocated to other service lines, which would simply increase deficits there. The net impact could be to increase the hospital's deficit.
- **Increase in ED deficits in small hospitals.** In the smallest WRHAP PHDs, the Emergency Department is staffed by the same physicians who deliver clinic services. If the clinic were closed, the hospital would have to continue to employ some of the same physicians or other clinicians but with all of their time charged to the ED, and that would increase the direct cost of the ED in addition to the increase in indirect costs. Some of the patients who had visited the clinic would likely continue to seek care in the ED and the payments for those visits would be higher than if they had been seen in a clinic, offsetting some of the loss from eliminating the clinic revenue. However, it is likely that the combination of effects would still increase ED deficits in smaller PHDs.

In addition to not solving the financial problems, closing the clinic would have negative impacts on the community and on payers:

- **Reduced access to primary care services.** Adequate data are not available to assess whether there are other primary care providers located in or near the WRHAP PHD service areas that have sufficient capacity to care for all of the current patients managed by the WRHAP PHD clinics. However, in the smallest communities, the WRHAP PHD clinics appear to provide the majority of the clinic services that are delivered by rural

health clinics or FQHCs to the Medicaid recipients who live in their service area, so loss of the clinic would likely have a significant negative impact on primary care access in those communities, and that could make the community a less attractive place for people to live.

- **Increased spending on other healthcare services.** Those individuals who no longer can receive primary care would be more likely to develop health problems and to have visits with specialists, Emergency Department visits, and hospital admissions that could have been avoided, which would increase total healthcare spending for those individuals.

Option B-2. Increase Amount of Payments for Clinic Services

A second option would be to increase payments from each payer so the payments are adequate to cover the costs of the clinic services. Since each payer pays differently, that would require a different approach for each:

Medicare

- The cost-based payment from Medicare could be increased from 101% of costs to at least 102% of costs, so that even with the 2% sequestration reduction, the clinic would receive at least 100% of its costs.
- Alternatively, Medicare could pay a new per-visit payment for clinic visits, either in addition to or instead of the current cost-based payment.

Medicaid

- As required by WAC 182-549-1400(7)(d), the Health Care Authority could rebase the encounter rates paid for clinic visits using the data from RHC cost reports and other relevant sources so that the payments cover the current costs for clinic services.
- An alternative approach would be for the Health Care Authority to seek legislative approval to make supplemental federal Medicaid payments to rural health clinics operated by a Public Hospital District through a new Certification of Public Expenditure (CPE) program. The Public Hospital District would identify the funds that it is currently using to cover the gap between current clinic payments and its costs of services for Medicaid patients, and the Health Care Authority would then obtain Federal Financial Participation (FFP) funding based on the CPE spending. Based on Washington State's 50% FFP rate, this could reduce the clinics' losses on Medicaid patients by 50%, but it would not eliminate the losses entirely because the PHD would have to certify that it was covering the local share. Washington State uses a similar approach for supplemental payments for nursing facilities and for ground ambulance services. The Centers for Medicare and Medicaid Services (CMS) would need to approve this new CPE program as part of Washington's State Plan Amendment; however, CMS has issued new regulations indicating that it will not approve new CPE programs that are used as pass-through payments through Medicaid Managed Care Organizations.

Commercial Insurance

- The amounts that commercial health plans pay for rural health clinic services could be increased to better reflect the cost of services. The standard amounts that commercial health plans pay for visits with primary care providers are typically only about half of the

cost per visit in a small rural health clinic, so payments would need to be doubled to cover costs.

The disadvantage of increasing payments for clinic visits is that clinic payments would remain tied to visits. If the payments were increased sufficiently to enable the clinic to not just cover its current costs but to offer additional services, such as care coordination or integrated behavioral health support, the fact that the higher payments were tied to visits would make the clinic's finances even more vulnerable to initiatives that deliver services outside of traditional visits and to initiatives that successfully improve patients' health.

Option B-3. Increase Payments for Clinic Services Based on Quality and Spending

A third option would be to increase payments to WRHAP PHD clinics if they demonstrate they are delivering high-quality care and/or reducing the use of avoidable services by their patients. In order to fully address the challenges described in Section II, such increases would have to be large enough to eliminate the clinics' deficits or to provide the resources needed to deliver enhanced services to patients.

Challenges and disadvantages with this option include:

- **Difficulties in identifying reliable performance measures.** Many of the quality and cost measures used in pay-for-performance programs today have low statistical reliability, especially for small practices. That means that small WRHAP clinics could be penalized or fail to receive an increased payment simply because of small-sample-size random variation in the measures used, not because of true problems in performance.
- **Lack of equitable performance benchmarks.** Higher payments would depend not only on the measures used, but on the standards used to determine whether performance was sufficient to achieve a bonus. Because the types of patients and the challenges in caring for patients differ between rural areas and urban areas and even among different rural areas, it would be necessary to develop equitable performance standards before payments to rural health clinics could be adjusted based on their performance on the measures.
- **Increases in costs to achieve high performance.** For many types of quality measures, improvements can only be made by investing in additional or different services. Since quality bonuses are paid only after improvements are achieved, it will be difficult for rural clinics to cover the upfront costs of the services needed to improve quality, and unless the increased revenue provided through the quality bonuses is higher than the costs incurred to achieve them, clinic deficits may increase even if bonuses are received.
- **Exacerbation of deficits if both penalties and bonuses are used.** A growing number of pay-for-performance programs do not increase payments for higher-performing providers without also reducing payments for lower-performing providers. For example in the Merit-Based Incentive Payment System (MIPS) created under the federal Medicare Access and CHIP Reauthorization Act of 2015, payments to primary care physicians will be increased by up to 4% in 2019 and up to 9% beginning in 2022 based on their performance on quality measures, cost measures, and EHR usage, but those increases will only be made if other physician practices receive reductions in payments of 4%-9%. Using a "budget neutral" approach for rural health clinics would mean that help for some

would come at the expense of others, exacerbating the deficits at those that received penalties.

- **Payments remain tied to visits.** Since a pay-for-performance system would not change the underlying payment structure, it would at best increase the amount of payments for visits, but it would not resolve the barriers discussed in Section II-F that are created by a visit-based payment system.

An alternative approach would be to combine this option with Option B-2, so that the clinic receives an increase in revenues, but a portion of the increased revenue is tied to performance.

Option B-4. Create Additional Payments for Enhanced Services

A fourth option would be to create additional payments to the clinics for services other than face-to-face visits with physicians, nurse practitioners, and physician assistants. These payments could be directed specifically to supporting the kinds of services identified as gaps in Section II-F, such as:

- **Care management or care coordination services** to educate patients about their health problems, make referrals and schedule needed services that the clinic/hospital do not offer, avoid duplicative testing, imaging, and medications, etc.
- **Behavioral health services** to help patients who have depression, anxiety, or substance-abuse disorders as well as physical health problems to receive “one-stop” care in the clinic.
- **Home visits and home care services** for patients who cannot easily travel to the clinic or who need extra support in order to avoid an inpatient stay.

Three key challenges that would need to be addressed in creating such payments for WRHAP PHD clinics are:

- **Determining the right payment amounts.** The combination of small numbers of patients, variations in patient needs across communities, and difficulties in recruiting and retaining skilled personnel to rural communities will make it difficult to predict exactly how much will be needed to support a particular kind of service.
- **Determining the methodology for payment.** The payments could be made either on a per-service basis (e.g., the clinic would bill each time a patient met with a behavioral health counselor or for the time a care coordinator spent arranging care for a patient), or the payments could be made in order to support creating a particular staff position (e.g., the clinic would receive a monthly payment from the payer to support having a care coordinator or behavioral health counselor available to the payer’s members). A monthly payment to support delivery of the service, without tying the payment to any particular staffing arrangement, would provide the kind of flexibility and predictability needed by a small clinic.
- **Defining the performance expectations for the services.** In order to justify paying more for more services, payers will need to know what benefits the additional services will provide. Ideally, services such as care management and behavioral health support could generate enough savings in other areas to offset the higher costs, but it may take

time to achieve this performance and the challenges in defining appropriate measures and performance standards described for Option B-3 will also apply.

Option B-5. Create a Population-Based Payment for Clinic Services

A fifth option would be to pay for clinic services based on the number of patients whose care is being managed by the clinic rather than the number of visits those patients make to the clinic. “Per member per month” (PMPM) payments could be made on a monthly basis for each patient who enrolls with the clinic or who is assigned to the clinic by their health plan. Although this payment model has traditionally been referred to as “primary care capitation,” it is now often referred to as “direct primary care” by many primary care practices who are implementing it on their own. (Some of these practices are charging patients directly for the service rather than billing health plans for payment.)

PMPM payments have two key advantages over visit-based or encounter-based payments:

- They provide **greater flexibility** to the clinic to deliver services to patients through a wide variety of means other than just face-to-face visits with physicians and other clinicians.
- They create **greater predictability** in revenues for the clinic, since the number of patients they care for is more stable than the number of visits, and fixed monthly payments better support the fixed monthly costs that clinics incur for personnel, utilities, etc.

However, there are several challenges involved in designing and implementing population-based payments:

- **Determining the patients to whom it applies.** It would not make sense to pay on a monthly basis for a patient who merely comes to the clinic for a one-time service, however, there are currently not formal mechanisms in Medicare or non-HMO commercial health plans for patients to indicate that they want a particular clinic or practice to provide their care on an ongoing basis. Consequently, many payers are using statistical “attribution” methodologies to retrospectively assign or “align” patients with particular providers. However, those methodologies typically are based on the number of visits the patient makes to a provider, which defeats the goal of moving away from visit-based payment. Patients who are enrolled with Medicaid MCOs are assigned to clinics, but concerns have been raised about how effectively that process is functioning and whether it can be used to support a PMPM payment approach. Ideally, each patient would make a proactive designation as to whether they wanted the PHD clinic to provide their care; if they did, the clinic could receive a PMPM payment for them, and if not, the clinic could continue to receive visit-based payments.
- **Setting the appropriate PMPM payment amount.** A common approach to setting PMPM payment amounts is to calculate the average amount of visit-based payments per patient the clinic has received in the past. However, this can result in very different payment amounts to different clinics based on how many visits the clinics asked their patients to make as well as differences in the needs of the patients. In addition, the needs of patients may change over time, and a PMPM amount that is adequate today may not be adequate in the future. These issues could be addressed by using a stratified or risk

adjusted PMPM, i.e., paying a higher PMPM amount to clinics that have patients with higher needs.

- **Ensuring that patients still have adequate access to care.** Some primary care capitation programs in the past have been terminated because the primary care practices and clinics were not providing adequate access for patients when those patients needed care. Because the PMPM payment does not depend on visits, it does not create any financial incentive to see as many patients as possible. To some extent, that can be addressed by quality and utilization measures; for example, if a clinic's patients are making frequent visits to an Emergency Department for primary care-treatable conditions, the primary care practice or clinic is likely not providing adequate access, so the rate of ED visits can serve as a measure of the extent to which clinics are using the flexible payments to improve, rather than reduce, access for patients.

Option B-6. Create a Comprehensive Population-Based Payment for Clinic Services

A sixth option would be to use a combination of Options B-2, B-3, B-4, and B-5 to support primary care services in the WRHAP PHD clinics. This could be structured as follows:

1. **Comprehensive Primary Care Services Payment (CPCSP).** The WRHAP PHD clinic would receive a fixed payment each month for each patient who has been formally assigned to or enrolled in the clinic. The clinic would no longer bill the payer for individual visits delivered to those patients; the CPCSP would be the only payment for all visits and other contacts (such as phone calls, emails, etc.) with the patient during the month. (Other outpatient services delivered to patients, such as laboratory testing and imaging studies, could still be billed separately.)
 - **Calculation of Payment Amount.** If the payer had been paying for visits at rates at or above the clinic's costs, the amount of the CPCSP payment from each payer would be based on the average or median visit-based payments the clinic had received during the prior year for assigned/enrolled patients insured by that payer. If the payer had been paying below the clinic's costs, the CPCSP payment would need to be increased enough to overcome the shortfall in the visit-based payments. Eligible costs would include the costs of replacing capital assets, recruiting personnel, etc. as well as the day-to-day operating costs of the clinic.
 - **Enrollment/Assignment of Patients.** For payers that do not require a designated primary care provider, the PHD clinic would encourage the patient to formally enroll in the clinic, meaning that the patient would agree to obtain their primary care services through the clinic. For health plans that do assign patients to primary care providers, the monthly payment would be made for each plan member assigned to the clinic. Ideally, the health plan should assign residents of the community to the PHD clinic unless the resident requested a different assignment or the PHD clinic did not have the capability to meet their needs.
 - **Stratification of Payments.** Initially, the payment amount could be the same for each patient assigned/enrolled at a particular clinic, but the payment amount would differ from clinic to clinic depending on the payer's average payment per patient per month at that clinic during the prior year and the cost of visits at a clinic of that size. After the initial year or two, the CPCSP payment would need be stratified, i.e., there would be multiple (e.g., three) levels of the payment, with higher payments made

for patients with chronic conditions or serious risk factors. This would ensure that the clinic continued to receive an appropriate amount of revenue as the needs of its patients changed.

- 3. Supplemental Payments.** Three additional payments could be phased in over time to enable PHD clinics to provide additional services beyond those they can deliver with current visit-based payments.

 - **Care Coordination Payment (CCP).** In addition to the monthly CPCSP, the PHD primary care clinic could receive an additional payment each month for patients who had significant health problems, such as major chronic diseases (COPD, diabetes, heart failure) or major risk factors (e.g., obesity). The amount of this payment would be based on the cost of hiring or sharing the costs of one or more care coordinators at the clinic relative to the number of eligible patients at the clinic.
 - **Behavioral Health Services Payment (BHSP).** The clinic could receive an additional monthly payment to support the delivery of integrated behavioral and physical health services. The amount of this payment would be based on the cost of hiring or sharing the costs of one or more behavioral health specialists who are either on-site at the clinic or available through telemedicine linkages and also the cost of obtaining telephone support from psychiatrists. The clinic would need to demonstrate that it could provide the necessary behavioral health services in order to receive the payment. The payment could also be used to pay a separate behavioral health services agency to deliver services in the clinic.
 - **Home-Care Services Payment (HCSP).** The clinic could receive an additional monthly payment to support the delivery of home health, home-care, and palliative care services. The amount of this payment would be based on the cost of hiring or sharing the costs of home health nurses and home-care aides needed to provide services to patients who meet criteria for risk of hospitalization or nursing home admission. (The clinic would not be required or expected to deliver the full range of services provided by a home health agency under the Medicare home health benefit or hospice services under the hospice benefit.)
- 3. Encounter-Based Payment (EBP).** For patients who visit the clinic but are not assigned to or enrolled in the clinic, and for patients of non-participating payers, the WRHAP PHD primary care clinic would receive a payment for each visit to the clinic based on the average cost of a visit to the clinic.
- 4. Performance-Based Payment (PBP).** The WRHAP PHD primary care clinic and payers would measure the clinic's performance on a small set of primary care quality measures and measures of avoidable utilization relevant to the types of patients cared for by the clinic. There is growing national agreement that while quality measurement is important, only a small number of measures should be used, the measures should be relevant to the kinds of patients the clinic serves, and the measures should be appropriately risk-adjusted to reflect differences in patient characteristics that affect costs and outcomes. To the extent that (a) eligible primary care measures for the Merit-Based Incentive Payment Program under the CMS Quality Payment Program or (b) measures being reported for primary clinics statewide through the Washington Health Alliance meet these criteria, they could receive priority consideration. To ease the reporting burden on clinics, appropriate claims-based measures should be used unless the clinic's

EHR system has the capability to report clinical quality measures. A clinic should be deemed to be performing adequately on a measure if the clinic did not have a sufficient number of patients in the denominator of the measure to meet reliability standards, although measures for small clinics could be calculated over a multiple-year period. Initially, the PHD primary care clinic should receive a bonus payment if its performance on these measures was above the statewide average for patients with similar characteristics. In later years, payments could also be reduced if performance was below pre-defined standards.

This structure is similar to what the Center for Medicare and Medicaid Innovation (CMMI) is now testing in its Comprehensive Primary Care Plus (CPC+) Initiative. “Track 2” of the CPC+ Initiative has four components:

- A per-beneficiary-per-month Comprehensive Primary Care Payment (CPCP).
- Continued fee-for-service payments at 40% to 65% of current rates.
- A five-tier Care Management Fee (CMF) averaging \$28 per beneficiary per month.
- A \$4 PMPM Performance-Based Incentive Payment based on performance on quality and utilization measures.

It is important to recognize that this “population-based payment” is simply a different way of paying for *primary care services* based on the number of people living in the community. It is *not* a “global” or “capitated” payment intended to cover all of the patients’ healthcare needs or to place the WRHAP Public Hospital District at financial risk for the costs of services delivered by other providers.

C. Options for Nursing Care and Long-Term Care

There was not sufficient time in the Phase 1 work to conduct a detailed analysis of options for addressing the financial problems and other challenges involved with delivering long-term nursing care and other community long-term care services. Many of the options described earlier for improving payment for emergency departments and rural health clinics could be adapted to address needs for nursing facility care and community long-term care services, and many of the same challenges and disadvantages identified for EDs and clinics would also apply to nursing services and long-term care. Potential options include:

Option C-1. Close the Nursing Facility

The WRHAP PHDs that operate separate nursing facilities do so because the facilities are viewed as an essential service in the communities. Closing the facilities would have a negative impact on the residents of the WRHAP PHD communities, since the next-closest nursing facilities are generally a 30 minute or more longer drive. For WRHAP PHDs that provide long-term nursing care in swing beds, no longer accepting these patients may or may not reduce the direct costs involved, depending on the size of the swing bed unit and the other services it provides, and many of the indirect costs would simply be shifted to other service lines and would increase deficits there.

Option C-2. Increase Medicaid Payment Amounts for Small Nursing Facilities

Increased Medicaid payments for patients in separate nursing facilities would reduce deficits and have a positive impact on the overall finances of the WRHAP PHDs that operate separate facilities. Although the state's ProShare program is significantly reducing the size of the deficits in the WRHAP PHD nursing facilities, it cannot eliminate them (because the federal funds are predicated on the PHD paying for a portion of the costs), and an increase in Medicaid payments from the state would be needed to eliminate the deficits.

On the other hand, increasing Medicaid payments would provide no benefit to PHDs that care for those patients in swing beds because the higher Medicaid payments would be offset on a dollar-for-dollar basis by reduced cost-based payments from Medicare. However, the current Medicare subsidies for those patients will only continue as long as there are Medicare beneficiaries receiving inpatient or short-term skilled nursing services in the swing bed, and the current high cost of those subsidies may discourage use of the hospitals for post-acute care services under Medicare bundled payment initiatives, so there would be longer-term benefits from improving Medicaid payment rates.

Option C-3. Create a Minimum Payment for Essential Nursing Facility Capacity

Similar to Option A-4 for emergency department services, if a long-term nursing care facility (including a portion of a swing bed unit used for long-term nursing care) is operated by a Public Hospital District because there is insufficient long-term nursing care capacity available in its service area, a minimum could be established on the amount of Medicaid revenue it receives for long-term care in order to ensure there is sufficient revenue to support the costs of operating the facility or unit when the amount of per diem payments and/or the number of patients is low. As with a minimum payment for an ED, a mechanism would need to be established for determining

that the long-term nursing care beds are essential for the service area and for determining the minimum budget and Medicaid payment level needed to sustain the beds.

Option C-4. Create a Population-Based Payment for Long-Term Care Services

Rather than paying for inpatient nursing home services on a per diem basis, the state Medicaid program could pay WRHAP PHDs a monthly amount based on the number of individuals in the community who have health problems and/or functional limitations that would qualify for long-term nursing care. As with emergency department and clinic services, the costs of operating a small long-term nursing care service (either in swing beds or a separate facility) are mostly fixed, so basing the payments on the size of the population in need would provide more stable funding for the facility and more predictable spending for the Medicaid program.

If these payments were permitted to be used not just for facility-based long-term care services, but also for community-based long-term care services, including home care, hospice, and assisted living services, the WRHAP PHD might be able to keep more patients at home or in the community, thereby reducing overall nursing facility utilization by the residents of the community. This could reduce overall Medicaid spending and support state goals for controlling Medicaid costs through greater use of community-based services. However, controlling demand for this type of broader population-based payment could be challenging, and it is much more expensive to deliver home-based services in rural areas than in urban areas, so the level of need and the costs of meeting those needs in a particular community would have to be carefully analyzed before implementing this option.

D. Inpatient Services and Other Outpatient Services

There was not sufficient time in Phase 1 of the WRHAP project to examine all of the issues associated with inpatient services and other outpatient services.

In addition to the information in Section II describing the likely causes of deficits in inpatient services, an analysis was conducted to determine whether the costs of inpatient services at the hospitals were too high. This analysis concluded that:

- **The primary reason that Medicare payments for inpatient admissions and SNF stays at the smallest hospitals are very high is that the hospitals provide long-term care services in swing beds and receive payments for those services that are below cost.** For example, at one very small hospital, the average cost per day in 2015 for inpatient services to all patients in inpatient/swing beds was \$451, but the Medicare payment per day for Medicare acute admissions and SNF patients was \$4,398, because 94% of the patients were long-term nursing care patients and Medicaid payments were only \$184 per day.

A preliminary examination of two options related to inpatient and other outpatient services was conducted.

Option D-1: Eliminate Acute Admissions

Some federal proposals would provide financial assistance only for rural emergency departments in hospitals that no longer accept acute admissions. However, preliminary analyses indicate that elimination of acute admissions at WRHAP PHDs would increase operating deficits, particularly at the smallest hospitals. At the smallest hospitals, the direct costs as well as the indirect costs of inpatient services are shared with other service lines, so eliminating acute admissions would increase the costs of other service lines while reducing inpatient revenues, leading to higher deficits.

Option D-2: Create a Population-Based Payment for All Outpatient and Inpatient Services

The fact that hospitals are paid for inpatient services on a per-admission basis and for outpatient services on a per-service basis creates problematic financial uncertainties and incentives similar to those that are created by visit-based payments for Emergency Departments. Most of the costs of inpatient care, laboratory services, and imaging services in small hospitals are fixed costs that do not vary significantly based on volume. Consequently, a population-based payment structure for inpatient and all outpatient services could provide more stable funding and eliminate financial penalties that would otherwise result from reducing avoidable services to patients.

This payment could be structured similarly to what is described for Emergency Departments in Option A-5 along with a performance-based component to ensure accountability for quality and total spending.

1. **Per-Resident Payment.** The insurance plan for each resident of the Public Hospital District's service area would pay a monthly or annual payment to the hospital based on an annual budget designed to support essential inpatient and outpatient services. Residents

without insurance could make that payment themselves in order to receive services at lower charges.

- 2. Payments for Visits and Services.** The Public Hospital District would continue to charge fees for individual visits and services, but for residents who have paid the per-resident payment, those fees would be much lower than they are today and much lower than the fees charged to visitors to the community and residents who have not paid the per-resident payment.
- 3. Performance-Based Payment.** The Public Hospital District and payers would measure the hospital's performance on a set of inpatient and outpatient quality and utilization measures relevant to the types of patients receiving services. The quality measures would be designed to ensure that the services delivered by the hospital were of high quality, and the utilization measures would be designed to ensure that as many services as appropriate were being delivered by the Public Hospital District rather than other providers. The Per-Resident Payments and Payments for Visits and Services would be adjusted up or down based on performance on these measures compared to other rural hospitals.

This “population-based payment” would be a different way of paying for *the WRHAP PHD services* based on the number of people living in the community. It is *not* a “global” or “capitated” payment intended to cover all of the patients’ healthcare needs or to place the WRHAP Public Hospital District at financial risk for the costs of services delivered by other providers. Under this structure, payers would continue to pay separately for services that residents of the Public Hospital District service area receive from hospitals and physicians in other communities, but the Performance-Based Payment would require the Public Hospital District to take partial accountability for controlling utilization of those outside services.

IV. PRINCIPLES FOR SELECTING AND IMPLEMENTING OPTIONS

In addition to considering the relative advantages and disadvantages of the individual options discussed in Section III, there are a number of overarching principles that should be used in selecting the best combination of options that will both address the challenges facing WRHAP PHDs and enable them to deliver high-value healthcare services in the areas they serve.

A. The Need to Sustain Essential Emergency, Primary Care, and Long-Term Care Services

It is essential for all communities, including rural communities, to have adequate access to emergency services, primary care, and long-term nursing care services. The ED, clinic, and long-term care nursing beds operated by the WRHAP Public Hospital Districts are necessary to provide adequate access to those services for the residents of their districts:

- **Emergency Departments.** For most of the residents in each WRHAP PHD service area, the travel time to an Emergency Department would be unacceptably high if the WRHAP PHD Emergency Department was not available. Average travel times to an alternative emergency department would be 30 minutes or more longer than today if WRHAP EDs were no longer available, which could result in higher mortality rates and poorer outcomes for patients with heart attacks, strokes, or trauma.
- **Primary Care Clinics.** On average, the counties in which WRHAP PHDs operate clinics have 29% fewer primary care physicians per capita than Washington State as a whole, and half of those counties are in the bottom third among Washington State counties in terms of primary care access. In the smallest communities, it is likely that the WRHAP Rural Health Clinics provide the majority of primary care services to the residents. As a result, access to primary care would be seriously harmed if the clinics were no longer available.
- **Long-Term Nursing Care.** In the communities where WRHAP PHDs are providing long-term nursing care services, there are no other long-term nursing care facilities available. The closest alternative facilities are generally a half hour or longer drive away; moreover, it is unlikely that the closest facilities could or would be able to care for all of the residents of the WRHAP PHD nursing care beds if those beds were no longer available.

The financial challenges that are described in Section II threaten the continued operation of these essential services, so it is essential to have better payment systems that will sustain them.

Although there is clear agreement that the emergency departments, rural health clinics, and long-term nursing care services currently operated by the WRHAP Public Hospital Districts are essential for their communities, that does not mean that other services the PHDs operate are *not* essential. However, additional analysis is needed to determine which of the other types of inpatient and outpatient services that are currently being delivered are essential for the communities and the best way to sustain those services.

B. The Need for a Comprehensive, Patient-Centered, Value-Based Approach to Payment and Delivery Reform

As described in Section II, the Emergency Departments, the primary care clinics, and the long-term nursing care facilities each have their own unique problems that must be adequately addressed in order to sustain those essential services. However, in the WRHAP Public Hospital Districts, these services are also highly interconnected to each other and to the other services operated by the PHD. Addressing the problems in only one service line, or selecting options to address each service line independently, could have unintended consequences and achieve less overall impact than a comprehensive approach. In particular, improving the delivery of primary care services could have serious negative financial impacts on the emergency department unless changes are made in the way payers support the ED, and protecting the hospital against reductions in ED volume may be inadequate without also making payment changes that address the potential ripple effects on other outpatient and inpatient services.

Moreover, the mission of Public Hospital Districts is to provide effective care for the residents of their service areas, not just to deliver the minimum essential services or the kinds of services that happen to be supported by the current fragmented systems of payment. Ideally, the payment and delivery reforms that are implemented for both essential services and other services should be designed to enable the WRHAP PHDs to function as “Population Health Management Districts” rather than just “hospital districts,” with adequate resources and sufficient flexibility to deliver the best combination of preventive care and treatment services that will help the residents of their service areas stay healthy, receive prompt and effective treatment for health problems, and live and work productively in their communities.

C. The Need for Both Structural Payment Reforms and Adequate Payments

Although it may seem easier to address deficits or encourage improved care using options that simply increase payment rates or adjust current payment amounts based on measures of performance, changes in payment amounts alone will not address the structural problems in current delivery and payment systems that are causing operating deficits for hospitals and driving spending increases for payers. Changes will be needed in both the fee-for-service and cost-based payment systems that are currently used by Medicare, Medicaid, and commercial payers in order to successfully remove the barriers those current systems create to higher-quality, more affordable care delivery. The higher-numbered options in each subsection of Section III do more to address the problems in current payment systems than the lower-numbered options, but that also makes them more complicated to implement for both payers and the WRHAP PHDs.

Conversely, although structural reforms in payment are essential in order to restructure care delivery, simply changing the method of payment will not be sufficient if the amounts paid are still inadequate to cover the minimum costs of delivering services in small communities. It is unreasonable to expect small rural hospital districts to transform care when they are struggling to cover large financial deficits.

D. The Need to Set Realistic Goals for Quality and Savings in Payment Models

It will be difficult to convince payers to pay more for rural healthcare services or to make significant changes in payment methodologies without assurances that quality will improve, spending will decrease, or both. It was not possible during the Phase 1 effort to obtain detailed data regarding either the quality of care delivered by WRHAP Public Hospital Districts or regarding the total healthcare spending by all payers on the residents of their service areas. Consequently, it was not possible to estimate the magnitude of the opportunities for improving the quality of care delivery and to reduce avoidable spending. The limited data that were available suggested that while there are likely opportunities to reduce avoidable utilization in the WRHAP communities, overall levels of healthcare spending in many of the communities is already at or below state and national averages for both Medicare and Medicaid. This means that while some reductions in current spending may be possible, it is not reasonable to expect large amounts of savings.

However, even a small reduction in the total healthcare spending on the residents of WRHAP PHD service areas may be sufficient to offset the costs of the additional resources that the PHDs need to resolve current deficits and deliver enhanced services. For example, state data indicate that Medicaid payments for services delivered by WRHAP Public Hospital Districts to residents of their service areas represent only 23% of total Medicaid spending on those residents. Most of the potentially avoidable expensive services those residents receive are likely delivered by other physician practices and hospitals. Thus, a mere 3% reduction in spending on those other services would offset a 10% increase in payments to the WRHAP PHDs, and if improved care could achieve greater reductions in avoidable spending, it would reduce total Medicaid spending on the beneficiaries living in the WRHAP PHD service areas.

These are *underestimates* of the true savings opportunities, however, because it is misleading to estimate “costs” and “savings” by comparing future spending levels to *current* spending levels. If current deficits are not resolved, the existing services delivered by the WRHAP PHDs may not be sustainable. If some or all of the current services were reduced or eliminated, it is likely that total spending on healthcare services would increase, since residents of the communities would delay primary care and they would travel to other communities for services where the services may be more expensive. Consequently, any estimates of costs and savings from changes in payment structures should be based on comparisons to the level of spending needed to sustain adequate services.

It is also important to ensure that essential services will be delivered in a high-quality way, particularly if higher payments are needed to sustain those services, and to ensure that any savings are not being achieved at the expense of quality. This will require identification of quality measures that are appropriate for the types of services the WRHAP PHDs are delivering and for the number and types of patients who are receiving those services. Many of the quality measures currently being used in quality reporting and pay-for-performance programs for health plans or large hospitals or physician groups are not statistically reliable for healthcare providers with the small numbers of patients that WRHAP hospitals and clinics serve. There is also growing recognition across the country of the costs and time burdens involved with reporting

many quality measures and the high cumulative burdens created by use of large numbers of measures, and these burdens can be unaffordable for small rural hospitals and clinics.

It will also be necessary to select targets for performance on measures that are feasible for rural hospitals and clinics to achieve and that adequately reflect the characteristics of the populations being served. What is achievable in individual rural communities may be different than what can be achieved in other communities for the same level of healthcare spending, and so rural-appropriate performance standards as well as rural-appropriate measures will be needed. There is now national recognition that the social and economic characteristics of patients influence the quality of care and health outcomes that healthcare providers can achieve, and that failure to adjust for differences in these characteristics can penalize healthcare providers that serve people facing social and economic challenges, as the WRHAP PHDs do.

Consequently, special efforts should be made to identify or develop an appropriate set of quality and spending measures and performance targets that the WRHAP PHDs can reasonably be expected to collect and monitor and for which they can be held accountable in conjunction with better methods of payment.

E. The Need for Multi-Payer Payment Reform

It is impossible for any healthcare provider to make significant changes in the way care is delivered if the necessary changes in payments are only made for a subset of the provider's patients. Physicians and hospitals cannot and should not treat their patients differently based on the types of insurance they have, but when payment systems are only changed for a subset of patients, both existing and new methods of care delivery will create financial problems for the provider.

The analyses conducted for this project show that no single payer provides the majority of revenues that the WRHAP Public Hospital Districts use to support the three essential services identified to date – the Emergency Department, one or more primary care clinics, and long-term care nursing services. Moreover, the responsibilities of the payers for the current funding shortfalls differ across communities and among the different services.

- **Emergency Departments:** Although Medicare is the largest payer for most (but not all) of the Emergency Department services at the WRHAP PHDs, it is only a significant contributor to the current ED deficits at one of the ten hospitals. The biggest funding shortfalls for the EDs are associated with uninsured patients, Medicaid clients, and commercially insured clients, but their relative importance varies significantly from community to community.
- **Rural Health Clinics:** For most of the WRHAP PHD Rural Health Clinics, Medicare is again the largest payer, but it is also a significant cause of the current deficits at four of the clinics for reasons described in detail in Section II. Low payments from commercial payers are the largest contributor to the deficits at all of the WRHAP PHD clinics. Medicaid payment rates below costs also cause 20% or more of the deficits at six of the ten WRHAP Rural Health Clinics.
- **Long-Term Nursing Care:** Most of the current long-term nursing care patients are supported by Medicaid payments, and because those payments are well below costs,

Medicaid represents the biggest contributor to the current operating deficits. Although Medicare does not pay for long-term nursing care in separate facilities, its cost-based payment for hospital services enables many of the WRHAP PHDs to offer these services through swing beds.

Because the largest contributors to deficits across these three service lines are Medicaid and commercial health plans, any solution to the current shortfalls in funding for essential services will require support from the Medicaid program and commercial payers. State support and assistance will be necessary, not only to address the shortfalls from the Medicaid program, but also to encourage commercial payers to pay adequately for these essential services.

However, while it is clear that *higher payments* will be necessary from Medicaid and commercial health plans will be needed in order to adequately solve the current deficits, it is also important that *better payment methodologies* be established that will support the transition to higher-value care and population health management. It will also be important that the payment systems used by different payers be as similar as possible. Differences in payment methods, amounts, and administrative requirements increase costs and create conflicting incentives for all healthcare providers, but they are particularly burdensome for small, rural healthcare providers.

Since Medicare is the largest overall payer, a new payment methodology will not be successful unless Medicare participates. State support will be needed to encourage participation by Medicare.

F. The Desirability of Aligning With Other Payment Reform Initiatives – If They Adequately Address Rural Needs

It is not easy for payers to make significant changes in healthcare payment systems, and it is particularly difficult to change the structure of payment systems for only a small number of healthcare providers. Consequently, to the maximum extent possible, it will be desirable to choose payment options and to structure the details of those options in ways that align with payment changes that purchasers and payers are making or planning to make for other providers. In particular, it would be desirable if payment changes for WRHAP PHDs could align with the following major initiatives that are being pursued for Medicare, Medicaid, and commercial payments both in Washington State and other states:

- **Healthier Washington.** Improving payment systems in ways that reward quality over quantity is a key element of Washington State's strategy for supporting a healthy population and better, more affordable care. The payment reform options in Section II would help advance this goal, and state support will be important for successfully implementing those options.
- **Washington State's APM 4 Initiative for FQHCs and RHCs.** The payment model that is currently being considered for implementation in this state initiative would convert a portion of the current visit-based payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for Medicaid patients to a monthly payment for assigned Medicaid patients. Although details of APM 4 have not yet been finalized, the concept is similar to Option B-5 and to portions of Option B-6 in Section III.

- **Washington State’s Medicaid Waiver Initiatives.** Under Washington State’s federal Medicaid waiver application, funding will be available to support transformation initiatives in care coordination, behavioral health integration, and community long-term care services. The goals of these initiatives would be similar to what could be achieved through Options B-4, B-6, and C-4 in Section III.
- **Medicare’s Comprehensive Primary Care Plus Demonstration and Commercial Patient-Centered Medical Home Initiatives.** Both CMS and many commercial and Medicaid health plans are pursuing payment reform initiatives that convert visit-based payments to monthly payments, provide supplemental payments to support new services, and make performance-based payments based on quality, utilization and spending. There are many similarities between the elements of these initiatives and Options B-3, B-4, B-5, and B-6.
- **Hospital Global Payment Initiatives in Maryland and Other States.** The State of Maryland has implemented a global payment model for hospitals that bases payment for both inpatient and outpatient services on the size of the community served and the types of services offered rather than the number of services delivered. CMS is participating in this initiative and it has recently announced plans to implement a similar model in Pennsylvania. Options A-5 and D-2 are similar to this approach.

However, alignment with other payment reform initiatives is desirable only if the resulting changes actually address the challenges facing the WRHAP Public Hospital Districts described in Section II and if the changes are feasible for the PHDs to implement. There is growing recognition nationally that many current value-based payment programs and alternative payment models do not work well for small and rural physician practices and hospitals.

To the maximum extent possible, all payers should use the same quality measures in their payment systems for the services delivered by the WRHAP PHDs. As noted earlier, the measures used must be appropriate for the types of services delivered by the WRHAP PHDs, statistically reliable when applied to the volumes of patients served, and adjusted appropriately for the needs and other characteristics of those patients. To the extent that appropriate measures are included in the Washington Statewide Common Measure Set, preference should be given to using those measures in order to increase alignment with other state programs as well as alignment among all payers. However, if measures appropriate to small rural communities do not currently exist, alternative approaches to measuring quality and to collecting and reporting measures should be developed that can achieve the goals of quality measurement while minimizing burdens on the WRHAP PHDs.

G. The Need for Immediate Action and a Multi-Year Transition

It will take time to implement the kinds of payment and delivery reforms that would meet the above goals. It will likely take one to two years for all payers to implement true reforms in multiple payment systems and it will likely take two to five years for WRHAP Public Hospital Districts to make all of the possible improvements in the way they deliver care when payment systems give them the ability to do so.

However, the WRHAP Public Hospital Districts cannot wait for two or more years to address the significant financial challenges they are facing. Moreover, the residents of their service areas

and other patients should not face the risk of losing current services nor be forced to wait to receive improved care. The state and other payers are also anxious to move quickly to reduce healthcare spending wherever possible.

The need for rapid action and an adequate transition could be addressed by defining a multi-year process for implementing payment and delivery systems in the following way:

- To the extent that some but not all aspects of the alternative payment models can be implemented immediately, the ready-to-go components could be implemented with an explicit commitment by payers and the WRHAP Public Hospital Districts to design and implement the remaining components within a defined timetable and to make special provisions to avoid unintended consequences during the interim. For example, if appropriate performance benchmarks or adequate risk adjustment systems are not currently available, changes in payments to support enhanced services could be implemented without those components while work is undertaken to develop them, with temporary processes used to ensure that payment amounts are adequate, that quality care is delivered, and that neither the WRHAP Public Hospital Districts nor the clinicians who deliver care in the clinics, hospital, or nursing facilities are placed at inappropriate financial risk.
- If the desired reforms that can be implemented immediately do not address an urgent problem, a temporary solution to that problem could be implemented with the explicit understanding that it will be replaced with a permanent solution within a defined timetable. For example, current operating deficits could be addressed through temporary increases in visit-based payments or special one-time payments while an alternative payment system is being designed and implemented.
- If payment changes that can be implemented immediately for one set of services would create undesirable consequences in other areas that will ultimately be addressed when payment changes are made in these other areas, temporary solutions could be created to protect against those consequences. For example, immediate payment changes that support improved primary care could create financial losses in hospital EDs until an alternative payment system is created for ED services; this could be addressed by creating a temporary floor or hold-harmless for total ED payments, again with an understanding that this will be replaced when a more permanent solution is ready.

H. The Need for Transitional Support for Public Hospital Districts

Even if payment system structures and amounts provide adequate financial support for the desired PHD services in the long run, they may not provide adequate support during the transition process. Hospitals and clinics will need to redesign their workflows, hire and train new personnel, retrain existing personnel, reconfigure space and equipment, reprogram information and billing systems, etc. Those changes will cause short-term increases in costs and reductions in productivity and performance that will not be directly supported by payment systems and may even be penalized by them. For example, primary care practices across the country that have transformed into patient-centered medical homes have experienced short-term financial losses in the process.

The time and costs involved in the transition will be particularly challenging for WRHAP Public Hospital Districts because of their small size and financial problems. Unlike large health systems, they do not have capital reserves that can be used to pay for transition costs and they do not have management staff capacity to plan and manage major changes in multiple service lines. Small and rural healthcare providers all across the country are facing similar problems in making the transition to new payment systems; for example, a December 2016 report from the United States Government Accountability Office entitled *Medicare Value-Based Payment Models: Participation Challenges and Available Assistance for Small and Rural Practices* identified a number of problems that small and rural physician practices have faced in implementing Medicare payment models and the kinds of assistance they need to address those challenges.

Consequently, the WRHAP PHDs will need financial and technical support over the next several years in order to plan and implement all of the changes involved in making this transition. This might be done by establishing a dedicated pool of funds that the WRHAP PHDs could collectively use to cover short-term costs and losses, purchase technical assistance, etc. Since all of the WRHAP PHDs would be implementing many similar changes, there would likely be opportunities to share various kinds of costs and services. One source of these funds could be the federal funds provided to the state as part of its new Medicaid waiver.

V. RECOMMENDED APPROACH

Based on the principles in Section IV, a three part approach is recommended to address the challenges described in Section II.

A. Make Improved Payment Systems for Essential Services Available to WRHAP Public Hospital Districts Beginning in 2018

Beginning no later than 2018, WRHAP Public Hospital Districts should have the opportunity to be paid for primary care, emergency department services, and long-term care services under alternative payment models that would enable them to sustain these essential services and to support delivery of a more comprehensive, population health management approach to health care for the residents of their service areas. Specifically:

1. Alternative Payment Model for the Emergency Department

- By 2018, Medicare, Medicaid, and commercial payers should make a payment model similar to Option A-4 (Minimum ED Payments) available to WRHAP PHDs.
- By 2019, Medicare, Medicaid, and commercial payers should make a payment model similar to Option A-5 (Population-Based Payment for ED Services) available to WRHAP PHDs.

2. Alternative Payment Model for Rural Health Clinics/Primary Care Services

- By 2018, Medicare, Medicaid, and commercial payers should make one or more payment models available to WRHAP PHDs similar a combination of Option B-3 (Payment Bonuses Based on Quality and Spending), Option B-4 (Additional Payments for Enhanced Services), and Option B-5 (PMPM Payments for Clinic Services)
- By 2019, Medicare, Medicaid, and commercial payers should make a payment model similar to Option B-6 (Comprehensive Population-Based Payment for Primary Care Services) available to WRHAP PHDs.

3. Alternative Payment Model for Long-Term Care Services

- By 2018, Medicaid should make a payment model similar to Option C-3 (Minimum Payment for Long-Term Care Nursing Services) available to WRHAP PHDs.
- By 2019, Medicaid should make a payment model similar to Option C-4 (Population-Based Payment for Long-Term Care Services) available to WRHAP PHDs.

This transition process is summarized in the Table.

Detailed designs for these alternative payment models should be developed in 2017 through a collaborative process involving, at a minimum, the WRHAP Public Hospital Districts, the Washington State Health Care Authority (HCA), the Department of Health (DOH), the Department of Social and Health Services (DSHS), the Washington State Hospital Association (WSHA), and the Association of Washington Public Hospital Districts (AWPHD). The State of Washington would need to implement these payment models in the Medicaid program and through its other purchasing arrangements, and it would need to encourage participation by Medicare and by all health plans.

Ideally, a subset of WRHAP PHDs could serve as pilot sites to begin implementing some or all of the 2018 changes in mid-2017, and those sites or others could begin implementing the 2019

changes in 2018. In addition, beginning in 2017, those WRHAP Public Hospital Districts that make a formal commitment to implement the alternative payment models for essential services and to examine ways to improve the delivery and payment of other services should receive financial and technical assistance to implement the initial payment reforms and to redesign the way they deliver care.

B. Create Temporary Solutions to Financial Deficits in Essential Services During the Transition to Alternative Payment Models

If there are delays in implementing the improved payment systems that would result in significant deficits for essential services during 2018 for some or all of the WRHAP PHDs, the following changes should be made to the current payment systems in order to reduce or eliminate the deficits. The actions needed to achieve this will differ by payer:

1. Medicaid

- Rebase Medicaid Encounter Payments for PHD Rural Health Clinics to reflect costs
- Create separate Medicaid payment rates for ED services and other outpatient services in Critical Access Hospitals to better reflect the costs of individual services
- Provide easier access to funding from the State Alien Medical Program for hospitals with a high volume of ED visits by migrant workers
- Increase per diems for small long-term care nursing facilities

2. Commercial Payers

- Increase visit-based payments for primary care services in Rural Health Clinics
- Increase visit-based payments for Emergency Department Services

3. Medicare

- Modify the productivity requirements for primary care physicians in the Medicare payment formula for Rural Health Clinics to avoid inappropriately financial penalties to clinics located in low population density communities

C. Examine the Need for Additional Payment and Delivery Reforms for Other WRHAP PHD Services

During 2017, in addition to refining the details of the payment models described in Section V-A, the WRHAP Public Hospital Districts should examine the other types of healthcare services that they deliver and that the residents of their service areas need in order to determine which existing services are essential to deliver, whether any additional services would be necessary to achieve population health management goals, and what payment systems would best sustain those services. This should be done through a collaborative process involving the WRHAP PHDs, HCA, DOH, DSHS, WSHA, and AWPHD using an analysis and planning process similar to what was used during 2016 to develop recommendations for payment reforms to support Emergency Departments, clinic services, and long-term care services. This work would form the basis for more comprehensive payment reforms for the WRHAP PHDs that could be implemented no later than 2021.

**PHASE-IN OF ALTERNATIVE PAYMENT MODELS
FOR WRHAP PUBLIC HOSPITAL DISTRICTS**

	PHASE 1 2018	PHASE 2 2019-2020	PHASE 3 2021+
Emergency Department	Minimum ED Payments (Option A-4)	Population-Based Payment for ED Services (Option A-5)	Comprehensive Payment Model to Sustain All Essential Services and Support Effective Population Health Management in WRHAP Public Hospital Districts
Rural Health Clinic/ Primary Care Services	Monthly Per-Patient Payments for Clinic Services (Option B-5) AND Additional Payments for Enhanced Primary Care Services (Option B-4) AND Payment Bonuses for Quality and Spending (Option B-3)	Comprehensive Population-Based Payment for Primary Care (Option B-6)	
Long-Term Care Services	Increased Per Diems or Minimum Payments for Essential Long-Term Nursing Care (Options C-2 or C-3)	Alternative Payment Model for Long-Term Care Services (Option TBD)	
Inpatient and Other Outpatient Services	Identify Payment and Delivery Changes Needed for Other Outpatient and Inpatient Services	Design and Pilot Alternative Payment Model(s) for Other Outpatient and Inpatient Services (Option TBD)	