WRHAP
Washington
Rural Health
Access Preservation

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WRHAP ALTERNATIVE PAYMENT MODEL
A Value-Based Payment Model to Sustain and Expand High-Quality, Affordable Healthcare Services in Rural Communities in Washington State

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I. Statutory Authorization for the WRHAP Pilot

Substitute House Bill 1520 was passed unanimously by the Washington State Legislature and signed into law by the Governor in April 2017. It requires creation of an alternative, value-based payment methodology for Public Hospital Districts participating in the WRHAP Pilot. The legislation requires that the payment methodology provide sufficient funding to sustain essential services in the Public Hospital Districts, including (but not limited to) emergency and primary care services. It also requires that the payment methodology adjust payment amounts based on measures of quality and value, rather than volume.

Participation in the WRHAP Pilot is voluntary and Critical Access Hospitals that participate are permitted to return to the current cost-based payment system at any time. The law requires that the Department of Health (DOH), the Health Care Authority (HCA), and the Washington State Hospital Association (WSHA) identify the goals of the WRHAP Pilot before a hospital enters the pilot program, and the Health Care Authority is required to explain how the hospital could end its participation if the pilot is not working in its community. DOH, HCA, and WSHA are required to report interim progress to the Legislature by December 1, 2018.

The Legislature also passed Substitute Senate Bill 5883 on June 30, 2017, which appropriated funding to help hospitals participating in the WRHAP Pilot to transition to the new payment methodology. A total of $2,129,000 in state and federal funds were appropriated for the 2017-19 biennium, and additional funds are expected to be appropriated for the 2019-21 biennium.

II. Issues to Be Addressed in WRHAP Public Hospital Districts

A detailed analysis of the challenges facing the WRHAP Public Hospital Districts was conducted in 2015 and 2016 with financial and technical support from the Washington State Department of Health, the Washington State Health Care Authority, the Washington State Department of Social and Health Services, the Washington State Hospital Association, and the Association of Washington Public Hospital Districts, and with consulting assistance from the Center for Healthcare Quality and Payment Reform, Health Facilities Planning & Development, and Dingus, Zarecor & Associates.

A report on the findings of this analysis, *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*, was issued in January 2017. Findings included:

- The WRHAP Public Hospital Districts are experiencing significant deficits that threaten their ability to continue to deliver services. In some districts, the deficits have been as high as 35% of costs. The primary causes of the deficits in the WRHAP Public Hospital Districts are deficits in their primary care clinics and Emergency Departments.
- The deficits in the primary care clinics and Emergency Departments are occurring because Medicare, Medicaid, and commercial health plan payments are below the cost of visits. The staffing levels and costs of operating the primary care clinics are consistent with the volumes of visits they experience, and the staffing levels and costs of the Emergency Departments are necessary to provide adequate emergency services for the communities. However, because of the small populations of the communities, the cost per clinic visit and the cost per ED visit are higher than in larger communities.

- Current payment systems do not support the delivery of high-value primary care services in rural communities. Clinic payments are limited primarily to face-to-face visits with physicians and other clinicians, which prevents the clinics from providing telephone, email, and telemedicine services that are needed for good primary care in rural areas where long distances and travel challenges during bad weather make it difficult for residents to travel to a primary care clinic. In addition, payments are inadequate to support the costs of high-value services such as care managers/coordinators and behavioral health specialists.
- Current payments for Emergency Department services are based on the number of visits made to the ED. Consequently, improvements in primary care and other initiatives that reduce the number of ED visits will increase the already large deficits in the hospitals' Emergency Departments.

The report recommended implementation of an Alternative Payment Model for the WRHAP Public Hospital Districts by 2018 that would enable the Districts to sustain essential primary care and emergency department services and to deliver more comprehensive population health management services to the residents of their service areas.

III. Overview of the WRHAP Alternative Payment Model

The proposed Alternative Payment Model for Public Hospital Districts participating in the WRHAP Pilot would differ from current payment systems in three ways:

A. **Population-Based Payment for Primary Care Services.** Revenues for primary care services in the WRHAP Pilot Districts would no longer be based solely on the number of clinic visits. Each primary care clinic would receive a monthly payment for each enrolled patient that is adequate to cover the costs of delivering high-quality primary care in a small rural clinic and that gives the clinic the flexibility to deliver care in ways other than traditional office visits. Each clinic would also receive performance-based payments tied to key quality measures.

B. **Population-Based Payment for Emergency Department Services.** Revenues for Emergency Department services would no longer be based solely on the number of ED visits. Payments for ED visits by residents would be adjusted to ensure the hospital's total ED revenues would adequately cover the cost of meeting state and national standards for high-quality care in small rural emergency departments. Payments would also be adjusted based on the quality of care delivered in the ED and residents' utilization of EDs at other hospitals.

C. **Performance-Based Payment for Total Cost of Care.** A portion of the revenues for a Public Hospital District in the WRHAP Pilot would be based on its ability to control the total cost of care for its patients. In addition to the population-based payments for primary care and ED services and the current payments for inpatient and ancillary services delivered by the hospital, the WRHAP District would receive a performance-based payment from a participating payer if the payer's total healthcare spending for the patients enrolled in the primary care clinics operated by the District was significantly below the statewide average for that payer or if the per-patient spending had decreased significantly from the previous year.

A. Population-Based Payment for Primary Care

Primary care services in Public Hospital Districts participating in the WRHAP Pilot, whether they are delivered through one or more Rural Health Clinics operated by the Public Hospital District or through one or more provider-based clinics operated by or in collaboration with the Public Hospital District, would be paid for through a three-part payment model:

1. **Monthly Comprehensive Primary Care Services Payment for Enrolled Patients (CSP).** Each month, the clinic would receive a Comprehensive Primary Care Services Payment from a participating payer for each patient who is enrolled in the clinic (i.e., who has agreed to receive all primary care services there) or who has been formally assigned to the clinic by the payer. The clinic would no longer be paid separately for individual encounters (at a Rural Health Clinic) or evaluation and management services (at a clinic paid through a physician fee schedule) for these patients. (Ancillary services for clinic patients, such as laboratory testing and imaging studies, would continue to be paid for separately under current payment systems.) This monthly payment would give the clinic the flexibility to deliver care using visits with nurses and care coordinators and phone calls/emails with clinic providers and staff in addition to face-to-face visits with clinicians.
   - The CSP payment amounts for a particular clinic each year would be based on (a) the number and characteristics of individuals who are expected to be enrolled in or assigned to that clinic, and (b) a budget that is adequate to support the essential clinical staff and other costs needed to deliver primary care medical home services to patients at that clinic, including behavioral health and care coordination if the clinic offers those services.
   - Beginning in the third year of the pilot, the CSP payments would be stratified/tiered, with higher payment amounts paid for patients who have multiple chronic conditions, behavioral health problems, or significant health risk factors such as obesity.
2. **Visit-Based Payments for Non-Enrolled Patients.** The clinic would receive a payment for each encounter or visit to the clinic made by (a) patients who are not enrolled in or assigned to the clinic, and (b) patients whose insurance plan is not participating in the WRHAP Alternative Payment Model. These payments would be billed in the same way they are under current payment systems, but the amounts would be based on the cost of delivering visit-based services to patients who are not assigned to or enrolled in the clinic.
3. **Performance-Based Payment (PBP).** The clinic would receive a Performance-Based Payment annually based on its performance on a small set of primary care quality measures that are relevant to the majority of patients the clinic serves and that can be reliably measured for the number of patients who are being served by the clinic. A target performance level would be established for each measure based on what is achievable in small rural health clinics with the types of patients served by the WRHAP PHD clinics, and the clinic would receive a Performance-Based Payment if its performance during the year was equal to or better than the target level on a quality measure.

The CSP and visit-based payments would differ from clinic to clinic and from payer to payer because there would be differences in (a) the cost of operating each clinic based on the type of services being provided and the difficulty of attracting and retaining clinicians and other staff in the community, and (b) the numbers and characteristics of the individuals who live in the community, are insured by a particular payer, and use the clinic’s services. However, the payment amounts for each clinic and payer would be calculated using a standard methodology designed to ensure that the payments were adequate and appropriate.

B. Population-Based Payment for Emergency Department Services

ED services at WRHAP Pilot hospitals would be paid through a four-part payment model:

1. **Emergency Department Capacity Payment (ECP).** The hospital's total payments for ED visits from a participating payer would be no less than the amount of the ED Capacity Payment (ECP) calculated for that payer.
   - A Minimum ED Budget amount for the hospital would be calculated based on the estimated costs of the clinical and non-clinical staff and ED equipment required to deliver timely, high-quality emergency services that meet federal and state standards for hospital services and trauma care.
   - The ECP payment for a participating payer would be a percentage of the Minimum ED Budget based on the payer's proportion of the insured individuals who live within the Public Hospital District and for whom the ED is the closest emergency department.
   - The ECP payment would be paid to the hospital even if the payer's members do not make any visits to the hospital's ED.
2. **Charges for Individual ED Visits.** The hospital would continue to charge and be paid for all ED visits using Evaluation and Management visit CPT codes (CPT codes 99281-99285).
3. **Resident Discount on ED Visit Payments (RVD).** The hospital would provide a discount to participating payers on payments for ED visits made by residents insured by those payers.
   - The Resident Visit Discount (RVD) would be applied to charges for Evaluation & Management services in the ED for residents for whom the hospital is receiving ECP payments. The discounted amount would be lower than the payments made for visits by non-residents but higher than the average payment for a clinic visit. (Alternatively, for patients who pay cost-sharing, the cost-sharing amount for the ED visit could be adjusted to ensure it is higher than the average cost-sharing amount for a clinic visit.)
   - Other services delivered by ED providers (e.g., CPT codes for critical care services and procedures such as insertion of a central venous catheter), and ancillary services that ED patients receive, such as laboratory testing and imaging studies, would continue to be paid for under the current payment systems for those services (with no additional discount for residents).
4. **Performance-Based Payment Adjustments.** The ECP payment would be increased or decreased based on (1) measures of the quality of care delivered in the PHD's Emergency Department and (2) the rate at which the residents of the Public Hospital District utilize ED services at other hospitals for conditions that could have been treated in the PHD's Emergency Department.

The ECP and RVD amounts would differ from hospital to hospital and from payer to payer because there would be differences in (a) the cost of ED services at each hospital based on the level of ED services being provided, (b) the numbers of residents served by the ED in different Public Hospital Districts, and (c) the payers' standard fees or discounts on charges for visits. However, the ECP and RVD amounts for each ED and payer would be calculated using a standard methodology designed to ensure that the payments were adequate and appropriate.

C. Performance-Based Payment for Control of Total Cost of Care

In addition to the Performance-Based Payments for primary care services and the Performance-Based Payment Adjustments for emergency department services, Public Hospital Districts participating in the WRHAP Pilot could receive an additional Performance-Based Payment based on the total spending on healthcare services (other than outpatient prescription drugs) for the residents of the District who enroll in or are assigned to the PHD's primary care clinics.

The Public Hospital District would receive a Total Cost of Care Performance-Based Payment (TCPBP) from a payer if the risk-adjusted total spending per member for the payer's members who are enrolled in or assigned to the PHD's clinics either:

- is significantly below the statewide average for the payer's members; or
- has decreased significantly from the per-member spending in the prior year.

IV. Comparison to the Current Payment System

Service	Current Medicare CAH/RHC Payment	Current WA Medicaid CAH/RHC Payment	WRHAP Alternative Payment Model
PRIMARY CARE	Payment only for eligible encounters with providers or for eligible chronic care management or psychiatric collaborative care services; No payment for phone calls, emails, or visits with nurses, educators, etc.	Payment only for eligible encounters with providers or for eligible psychiatric collaborative care services; No payment for phone calls, emails, or visits with nurses, educators, etc.	Monthly payment for enrolled patients that allows flexibility to deliver non-face-to-face services and visits with other clinic staff in addition to traditional clinician encounters; Encounter/visit payments continue to be paid for non-enrolled patients
	An increase in clinic visits increases profits, and fewer visits causes losses	An increase in clinic visits increases profits, and fewer visits causes losses	A change in the number of visits for enrolled patients doesn't affect profits, but monthly payments are tiered so amounts are higher for higher-need patients
	Encounter payment is equal to 99% of actual eligible cost; not all costs are included, there is no margin to cover costs of care to uninsured patients, and payments are reduced if providers do not have a minimum number of visits	Encounter payment is equal to prior year amount increased by inflation, regardless of actual change in costs; Payments can be reset based on budgeted/actual costs when the scope of service changes; no margin to cover costs of care to uninsured patients	Payment amounts are set based on a budget that is adequate to cover the cost of high-quality primary care, with adjustments made if actual costs are significantly higher or lower than the budget.
	No reward or penalty based on quality of care	No reward or penalty based on quality of care	Bonus payments are paid for delivery of high-quality care
ED VISITS	Visit-based payments are equal to 99% of actual eligible costs; no margin to cover costs of care to uninsured patients	Visit-based payments are based on actual historical costs for all outpatient services, adjusted for inflation but with no reconciliation to actual current costs (for MCO clients); no margin to cover costs of care to uninsured patients	Cost-based payment per visit with discounts for residents; Total payments can be no less than a budget needed for essential staffing at achievable unit costs for the number of insured residents
	Reduction in ED visits through better primary care results in ED deficits; increase in ED visits increases profits	Reduction in ED visits through better primary care results in ED deficits; increase in ED visits increases profits	No impact on profits from changes in number of ED visits by residents because payment amount per visit is comparable to marginal cost per visit
	No reward for high-quality care; No penalty for avoidable transfers to other hospitals	No reward for high-quality care; No penalty for avoidable transfers to other hospitals	Bonuses and penalties based on quality of care and utilization of EDs at other hospitals
TOTAL COST OF CARE	No reward for keeping total cost of care for patients below state or national averages	No reward for keeping total cost of care for patients below state or national averages	Bonus payments for reducing total spending on patients and/or maintaining low spending levels

V. Comparison to Other Alternative Payment Models

A. Primary Care Component

	Primary Care Component of WRHAP APM	CMS Comprehensive Primary Care Plus (CPC+)	Washington HCA APM4 for FQHCs
Structure of Payment	• Monthly per-patient payment for enrolled or assigned patients instead of visit-based payment for encounter-eligible primary care services; • Visit-based payments for encounters/visits with patients not enrolled or assigned.	• Standard FFS payments for face-to-face visits; • Additional PMPM payments provided to support care management services; • For some practices, visit-based payments are reduced by ~50% and practice also receives a quarterly per-patient payment for attributed patients equal to 50% of prior visit-based revenue.	• Monthly per-patient payments for assigned patients instead of visit-based payments for encounter-eligible primary care services; • Visit-based payments for encounters with non-assigned patients.
Amount of Payment	• Monthly payments and visit-based payments vary by clinic; • Monthly payment amounts are set based on a budget designed to support adequate clinic staffing to deliver planned services. Revenue from monthly payments is adjusted at the end of the year based on actual costs incurred during the year.	• Visit-based payments are based on standard national fee-for-service rates for all clinics/practices; • Care management payments are established by CMS and are the same for all participating clinics/practices.	• Monthly payments and encounter payments vary by clinic; • Monthly payments are based on the clinic's current average revenue per patient from current encounter rates; • Payments are increased each year by inflation regardless of changes in cost. • If scope of services changes, new encounter rate is based on a budget, then reconciled to actual cost at the end of the year.
Difference in Payments for Higher-Need Patients	• Higher monthly payments for enrolled patients with multiple chronic diseases, behavioral health conditions, and/or significant health risks.	• Higher visit-based payments for more complex visits (higher-level E&M); • Additional FFS payments for visits if more visits are made; • Higher monthly care management payments for patients with higher HCC scores.	• Monthly payment is the same for all patients, regardless of need.
Value-Based Component	Quality bonuses are paid if performance is above target levels for: • access to care; • delivery of preventive services; • screening for depression; and • care coordination.	Additional performance-based payment is paid to the clinic and then all or part of the payment may be recouped if: • performance on 10 quality measures is poor relative to national averages; or • rates of ED visits and/or hospital admissions are high relative to national averages.	Monthly payments are reduced if performance on 9 quality measures is: • below average levels; or • below target levels and improvements are not made

B. Emergency Department Component

	ED Component of WRHAP Alternative Payment Model	Maryland Total Patient Revenue System (Global Budget)
Defining the Service Area	The Area of Essential Emergency Services is defined for each hospital by the Washington State Department of Health based on the drive time distance to the hospital compared to other hospitals with equal or higher level ED capabilities. The number of insured residents living in the area is then estimated.	The Virtual Patient Service Area is defined for each hospital by the Maryland Health Services Cost Review Commission based on the counties or zip codes where individuals who use the hospital's services live. The hospital is assigned a portion of the estimated population of the area based on the number of case-mix adjusted discharges in six age categories.
Defining the Budget	A Minimum Emergency Department Budget for the hospital is determined for each year based on: • recommendations for ED staffing and equipment developed by the Washington State Department of Health based on the trauma level designation for an ED, the size of the population served, and the plan for on-call vs. on-site staffing; and • the average projected unit costs (e.g., wage rates) for the next year at participating hospitals EDs as compiled by a CPA firm	An Approved Regulated Revenue amount (the "Global Budget") is established for the hospital each year, which defines the total revenue the hospital is permitted to receive from all services it delivers that are regulated by the state. The amount of the Global Budget is based on: • the prior year's Global Budget for the hospital; • a statewide percentage increase for the year determined by the state Health Services Cost Review Commission; • hospital-specific adjustments to the Global Budget based on actual revenues in the prior year compared to the Global Budget, changes in the size of the population in the community, changes in the utilization of hospital services by the population, changes in the proportion of services residents receive from other hospitals, and the hospital's performance on quality and utilization measures.
Defining the Payment Amounts for Individual Services	Residents pay less than non-residents for ED visits. The payment amounts are set before the beginning of the year: • Standard payment amounts for ED visits are set by the hospital based on the expected average cost per visit (ED Minimum Budget divided by the expected number of visits). • Residents insured by participating payers receive a Resident Visit Discount, which is set so that the net visit payment for a resident is equal to the greater of (a) the marginal cost of additional visits beyond the Minimum Budget (rather than the average cost of all visits) and (b) 125% of the amount paid for a primary care clinic visit.	All patients/payers pay the same amount for an ED visit, but payment amounts can vary during the course of the year: • Payment amounts for ED visits (and all other services) are set by the hospital at the beginning of the year but must be approved by the state Health Services Cost Review Commission to ensure they are consistent with the costs of services and the Global Budget. • The hospital can increase or decrease the payment amounts for each service by up to 5% during the year (up to 10% with state approval) in order to keep revenues within the Global Budget.

<table>
<tr><th></th><th>ED Component of
WRHAP Alternative Payment Model</th><th>Maryland
Total Patient Revenue System
(Global Budget)</th></tr>
<tr><td>Reconciling Revenues to the Budget</td><td>All payers pay for all ED visits when they occur, at the standard payment rate set at the beginning of the year.
On a quarterly basis, the ED visit payments from a participating payer are adjusted so that the payer’s total ED visit payments for residents of the Area of Essential Services are equal to the greater of:
• the ED Capacity Payment, which would be equal to the payer’s share of the Minimum ED Budget based on the proportion of residents of the community who are insured by that payer; and
• the discounted ED visit rate times the number of ED visits made by those residents.</td><td>All payers pay for all ED visits and other services at the standard rates in effect at the time the visits and services occur.
No adjustments are made to payments for services delivered during the current year regardless of whether the Global Budget is exceeded or if there is a shortfall in revenues. If, at the end of the year, the total revenues received by the hospital from all payers for all services differs from the Global Budget that was in effect for the year, the hospital’s Global Budget for the following year will be increased or decreased by the difference, and the payment rates for hospital services in the following year will be adjusted to match the new Global Budget.</td></tr>
<tr><td>Value-Based Component</td><td><u>Adjustments Based on Quality</u>:
• The ED Capacity Payment will be reduced if the hospital fails to meet minimum standards of performance achievable by rural hospital EDs on three quality measures:
➢ time from ED arrival to provider contact;
➢ % of patients who left without being seen; and
➢ time to ECG for potential AMI.
• The ED Capacity Payment will be increased if the hospital has better performance than target levels set for the measures.
<u>Adjustments Based on Utilization</u>:
• The ED Capacity Payment would be reduced or increased if the rate of ED visits made by residents to other hospitals increases or decreases</td><td><u>Adjustments Based on Quality</u>:
The hospital’s Global Budget is reduced by up to 2% or increased by up to 1% based on its performance relative to national averages and its improvement over time on several measures:
• patient experience (HCAHPS)
• all-cause inpatient mortality
• infection rates
• early elective deliveries
<u>Adjustments Based on Utilization</u>:
The increase in the hospital’s Global Budget from the prior year is based in part on the proportion of its revenue that is determined not to have resulted from:
• ambulatory care sensitive hospital admissions; and
• readmissions to the hospital (for either inpatient or observation stays)</td></tr>
<tr><td>Eligible Hospitals</td><td>Participation would be limited to small Critical Access Hospitals who voluntary agree to join the WRHAP Pilot. The median annual operating expenses for the WRHAP hospitals in 2016 was $16 million:
• The smallest WRHAP hospital is Garfield County Memorial Hospital, which had total operating expenses of $7.3 million in 2016.
• The largest WRHAP hospital is Mid-Valley Hospital, which had total operating expenses of $30.5 million in 2016.</td><td>All urban and rural hospitals in Maryland are required to participate. There are no Critical Access Hospitals in Maryland. The two smallest hospitals are:
• McCready Memorial Hospital, which had total operating expenses of $16 million in FY17 (and a $1 million operating deficit).
• Garrett County Memorial Hospital, which had total operating expenses of $47 million in FY17.</td></tr>
</table>

C. Total Cost of Care Component

	Total Cost of Care Component of WRHAP Alternative Payment Model	**Medicare Shared Savings Program (Track 1 ACOs)**
Patients Included	Patients assigned to or enrolled in Public Hospital District primary care clinics that are receiving Population-Based Payments for Primary Care.	Patients attributed to primary care providers that are affiliated with the ACO.
Spending Included	All medical spending for services delivered to the patient during the month in which the patient was assigned to or enrolled in the clinic, other than outpatient prescription drugs.	All Part A and Part B spending for services delivered to the patient during the month in which the patient was attributed to the ACO. Part D drug spending is not included.
Spending Measure	Average annualized risk-adjusted spending per patient during the year. Risk adjustment is based on Hierarchical Condition Category (HCC) codes for each patient. Spending amounts for outliers are truncated before computing the average.	Average annualized risk-adjusted spending per patient during the year. Risk adjustment is based on Hierarchical Condition Category (HCC) codes for each patient. Spending amounts for outliers are truncated before computing the average.
Spending Target(s)	Two alternative targets: • 90% of the statewide average risk-adjusted per-patient spending for the payer's members; or • 90% of the risk-adjusted average per-patient spending during the previous year for the payer's members assigned/enrolled in the PHD clinics.	96.1% of the weighted and trended average of the ACO's per-patient spending in the previous three years.
Payment When Target is Met or Exceeded	20% of the difference between the actual average risk-adjusted per-patient spending and the target	Maximum of 50% of the difference between the actual average per-patient spending and the target
Adjustment for Quality	Adjustments are made as part of the Population-Based Payments for Primary Care and Emergency Department Services, not the Total Cost of Care Component.	The shared savings payment is reduced based on the ACO's performance on a series of quality measures.\
Minimum Number of Patients for Participation	Minimum of 500 patients who are insured by the payer and assigned/enrolled in the primary care clinics receiving Population-Based Payments for Primary Care. If fewer than 500 patients per month are assigned/enrolled, the spending measure and targets are averaged over two or more years to increase reliability.	5,000 Medicare beneficiaries.