BETTER WAYS TO PAY
RURAL HOSPITALS & PHYSICIANS
Value-Based Payments that
Sustain Essential Services in
Rural Communities

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

www.CHQPR.org
More Rural Hospital Closures in 2019 Than Prior Years

Number of Rural Hospital Closures, 2006-2019

Source: North Carolina Rural Health Research Program
Growing National Awareness of the Issue

Nearly a quarter of rural hospitals are on the brink of closure

More than a fifth of the nation’s rural hospitals are near insolvency, according to a new report.

Twenty-one percent of rural hospitals are at high risk of closing, according to Navigant’s analysis of CMS data on 2,465 rural hospitals. That equates to 430 hospitals across 43 states that employ about 150,000 people and generate about $21.2 billion in total patient revenue a year.

Hospitals are often the economic drivers of rural communities. Per capita income falls 4% and the unemployment rate rises 1.6 percentage points when a hospital closes, a related study found. Ninety-seven rural hospitals have closed since 2010, according to the University of North Carolina. Public Citizen.

As rural populations decline, inpatient admissions fall, and the number of people covered by government-sponsored plans rises, these communities are left to grapple with the ramifications of losing a hospital, said Dr. Daniel DeFiore, a Navigant managing director, co-author of the report and former CEO of the Omaha-based Nebraska Medicine system.

Rural hospital closings cause mortality rates to rise, study finds

Population served by rural hospitals—which have limited access to health care and other services—saw mortality rates rise 19 percent after a hospital closed.

Mayor Adam O’Neal of Robeson, N.C., leads a rally for rural hospitals in Washington on June 15, 2018.

Brendan Smialowski / AFP - Getty Images file

More than 100 rural hospitals have closed in the United States since 2010 and another 430 are at risk of closing, which a new study says could have life-or-death implications for rural communities.
Medicare Payment Systems Aren’t Preventing Closures

An average of 5 Critical Access Hospitals have closed each year over the past 7 years.
It’s Surprising More CAHs Haven’t Closed With So Many Losses

More than Half of Critical Access Hospitals Had Losses >5% on Patient Services in 2017

Source: 2017 CMS Cost Reports
Most CAHs and Non-CAHs in ND Lose Money on Patient Services

Source: 2013-2017 CMS Cost Reports
What’s Causing the Losses?

• **Why are rural hospitals losing money?**
  – Are costs too high?
  – Are payments too low?
  – Which payers are underpaying for services?
  – Which service lines are causing the financial problems?
What’s Causing the Losses? What Would Solve the Problem?

• Why are rural hospitals losing money?
  – Are costs too high?
  – Are payments too low?
  – Which payers are underpaying for services?
  – Which service lines are causing the financial problems?

• What would solve the problem?
  – Changes to Medicare wage index
  – ACOs
  – Subsidies if rural hospitals eliminate inpatient services
    • Rural Emergency Medical Center Act of 2018
  – Global budgets for rural hospitals
    • CMMI Pennsylvania Rural Health Model
  – Other payment models
Why Are Rural Hospitals Losing Money?

• **Challenges in Determining the Causes of Losses**
  – Net revenue by service line is not available in standard financial reports
    • Total charges by service line are available, but deductions from revenue are only shown in aggregate
  – Service line margins by payer are not available in standard reports
    • Different payers pay different amounts that may or may not cover costs
  – Medicaid and commercial payers pay differently in different states
Why Are Rural Hospitals Losing Money?

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- **Data Obtained to Help Answer That Question**
  - 10 CAHs in Washington State provided more detailed information on net revenues by service line and by payer for 2015
    - “WRHAP” – Washington Rural Health Access Project
  - 3 CAHs in Alaska provided similar information for 2017
Large Annual Losses at WA CAHs That Provided Data

Operating Margins for WRHAP PHDs, 2013-2015

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Findings: 5 Service Lines Cause Hospital Deficits

• **Rural Health Clinics**
  – 100% of CAH RHCs analyzed had significant clinic losses
  – On average, clinic revenues only covered 2/3 of clinic costs
  – Clinics are largest contributor to overall deficits (30% or more of total)

• **Emergency Department**
  – Most CAHs had losses on ED visits
  – Payments for ancillary services during ED visits reduced losses, but
    half of CAHs with losses on visits had losses even with ancillary revenues

• **Nursing Home/Assisted Living**
  – Almost all CAH-operated nursing and/or assisted living facilities had losses

• **Ambulance**
  – All CAH-operated ambulance services had significant deficits

• **Inpatient Services**
  – Most, but not all, CAHs had losses on inpatient services
  – Payments for ancillary services during admissions reduced losses, but
    some CAHs had losses even with ancillary services
Operating Margins by Service Line

Operating Margins by Service Line at WRHAP PHDs 2015

- Clinics
- ED
- Inpatient
- LTC
- Ambulance
- Ancillary
- Total

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Profits on Ancillary Services Offset a Portion of Other Losses
8-10% Deficit in 2017 at the 3 Alaska Hospitals Analyzed
Clinic, ED, and Nursing Facilities Problems In Both WA and Alaska
Causes of Deficits for ED Visits

- **Costs are high because of low volume, not inefficiency**
  - CAH EDs average 1-26 visits per day, even though providers at most of the hospitals could handle as many as 60-70 visits per day
  - Hospital must pay providers to be on call regardless of # of visits, so cost of staffing the ED is fixed and average cost per visit is high

- **Visit payments are below cost**
  - **Commercial Health Plans:** Payments are below cost per visit in smaller hospitals
  - **Uninsured:** Some communities have large number of uninsured patients who use the ED for care but cannot afford to pay full cost
  - **Medicare:** Pays only 99% of the costs of ED visits
  - **Medicaid:** Payment amounts are intended to cover costs, but MCO payments are not reconciled to actual costs
ED Visit Margins by Payer

Margins by Payer for WRHAP Emergency Departments 2015

- Medicare
- Medicaid + Apple Health
- Commercial
- Self-Pay/Unk.
- Total
Causes of Deficits for Rural Health/Primary Care Clinics

• Costs are high because of low volume, not inefficiency
  – CAH RHCs have 4,000-6,000 visits per year, whereas a primary care physician in an urban area may have 6,000-7,000 visits per year
  – Hospital must pay to have providers staff the clinic regardless of the # of visits, so the cost per visit is high

• Visit payments are below cost
  – Commercial health plans: payment rate for primary care visits is below average cost of delivering a visit
  – Medicaid MCOs: Payments are below the average cost of a visit, and the encounter rates have not been rebased to costs in years
    • In 5 of 10 clinics, encounter rates were 35-46% lower than cost in 2015
  – Medicare: Pays only 99% of allowable costs for Rural Health Clinics, and it reduces payments further if physician visits are below productivity standards which may be impossible to meet in rural areas
Clinic Margins by Payer

Margins by Payer for WRHAP Rural Health Clinics 2015

- Medicare
- Medicaid + Apple Health
- Commercial
- Self-Pay
- Total

$100,000
$0
($100,000)
($200,000)
($300,000)
($400,000)
($500,000)
($600,000)
($700,000)
($800,000)
($900,000)
($1,000,000)
($1,100,000)
($1,200,000)
Causes of Deficits in Long-Term Care Services

• Medicaid payments for long-term nursing care and assisted living services are lower than the cost of delivering care
  – Costs at CAH-run nursing and assisted living facilities averaged $200-$400/day, but Medicaid payments were only $140-$170 per day

• Medicare does not pay for long-term nursing care services in separate facilities, but Medicare does indirectly pay for a portion of the cost of long-term nursing care services if they are delivered in a swing bed and if the hospital also has Medicare acute inpatients or skilled nursing facility (SNF) patients during the year
Inadequate Support for Rural Health Services

• Current Rural Health Clinic and primary care payments do not support delivery of Patient-Centered Medical Home services
  – No payment for phone/email contacts or services delivered to patients by nurses that could avoid need for a clinic or ED visit; payment is only made for face-to-face visits with physicians, nurse practitioners, and physician assistants
  – No payment for care management/coordination to help ensure patients get the services they need and avoid duplication, medication conflicts, etc.
  – No payment for behavioral health services delivered directly in clinic in coordination with physical health services

• Helping patients avoid Emergency Department visits or inpatient admissions would increase the hospital’s deficit
  – ED and inpatient admission payments are based on the number of visits/admits or the payer’s share of total visits/admits, so revenue decreases if visits/admits decrease, but cost of staffing ED and inpatient unit does not change
  – Payments for ancillary services would also decrease if visits/admits decrease

• Inadequate payment and regulatory barriers limit access to home health services that could avoid admissions & nursing facility stays
  – Payment rates do not support in-home services in sparsely-populated areas and hospitals/clinics cannot provide cost-based services unless there is no home health agency
“Cost-Based Payment” Isn’t As Good As It Sounds

Weaknesses of Current Payment System

• Medicare only pays 99% of costs, and not all costs are covered
• No reconciliation to ensure Medicaid MCO rates matched actual cost
• Only the portion of costs attributed to Medicare & Medicaid patients based on # of visits is covered

Current Payment for ED Services

| Loss | Cost-Based Payment from Medicare & Medicaid | Costs Attributed to Medicare & Medicaid Patients Based on # of Visits | Payment | Cost |
Insurance Payments for Visits May or May Not Cover Cost

Weaknesses of Current Payment System

- Medicare only pays 99% of costs, and not all costs are covered
- No reconciliation to ensure Medicaid MCO rates matched actual cost
- Only the portion of costs attributed to Medicare & Medicaid patients based on # of visits is covered
- Fee for service payments for insured patients are below cost per visit in smaller hospitals

Current Payment for ED Services

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<td>Costs Attributed to Other Insured Patients</td>
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<td>Cost-Based Payment from Medicare &amp; Medicaid</td>
<td>Costs Attributed to Medicare &amp; Medicaid Patients Based on # of Visits</td>
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Loss
Nobody Covers the Cost Attributed to Uninsured Patients

Weaknesses of Current Payment System

- Medicare only pays 99% of costs, and not all costs are covered
- No reconciliation to ensure Medicaid MCO rates matched actual cost
- Only the portion of costs attributed to Medicare & Medicaid patients based on # of visits is covered
- Fee for service payments for insured patients are below cost per visit in smaller hospitals
- Serving uninsured patients reduces cost-based payments and increases deficits

Current Payment for ED Services

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Federal Proposals to Help Rural Hospitals

- Subsidies if Rural Hospitals Eliminate Inpatient Services
- “Global Budget” for Rural Hospitals
Federal Proposals to Help Rural Hospitals

• **Subsidies if Rural Hospitals Eliminate Inpatient Services**
  – MedPAC June 2018 Recommendations
    • Subsidy for 24/7 ED if hospital ends inpatient services & cost-based pmt
  – Rural Emergency Medical Center Act of 2018
    • No acute inpatient services
    • Facility fee + OPPS for emergency services
    • 105% of ambulance payments for emergency transport
    • 110% of SNF payments for extended care

• “Global Budget” for Rural Hospitals
Target for Proposed Assistance: “Isolated Low-Volume Hospitals”

SOURCE: MedPAC June 2018 Report to Congress Appendix 2B

Map of isolated low-volume hospitals, 2017

Isolated hospitals (35 miles or more from other providers)
- Closed hospital
- Low-volume hospital (less than 1 admission per day)

Would Rural Hospitals Be Better Off Without Inpatient Services?

Total Hospital Revenue

Outpatient Services Cost

Inpatient Services Cost

Loss

Unknown

Total Hospital Revenue

Outpatient Services Cost

Inpatient Cost
Would the Hospital Be Profitable On Outpatient Services Alone?

Which Service Lines Generate Hospital Revenue ???

- Loss
- Inpatient Cost
- ED Cost
- Clinic Cost
- Ancillary Cost

$
Findings: Inpatient Services Aren’t Profitable at Small Hospitals

Inpatient Revenue

Loss

Inpatient Cost
Findings: Rural Hospitals Lose More Money on Their EDs

Inpatient

Inpatient Revenue
Inpatient Cost
Loss

ED

ED Revenue
ED Cost
Loss
Findings: Rural Hospitals Lose More Money on their Clinics

Inpatient

- Inpatient Revenue
- Inpatient Cost
- Loss

ED

- ED Revenue
- ED Cost
- Loss

Clinic

- Clinic Revenue
- Clinic Cost
- Loss
The One Thing That Helps Float the Boat is Ancillaries (Lab/Rad)

Inpatient
- Inpatient Revenue
- Inpatient Cost
- Loss

ED
- ED Revenue
- ED Cost
- Loss

Clinic
- Clinic Cost
- Clinic Revenue
- Loss

Ancillary
- Ancillary Revenue
- Ancillary Cost
- Profit
BUT ALSO: All of These Service Lines Are Interdependent
Inpatient Services Shares Nurses With the ED

- Inpatient Revenue
  - Loss
  - Central Admin. Costs
  - Other
  - Nurses & Nurse Assts (Shared with ED)

- ED Revenue
  - Loss
  - Central Admin. Costs
  - Nurses & NAs (Shared)
  - Clinicians (May Be Shared with Clinic)
The Smallest EDs Share Clinicians With the Clinic

- **Inpatient Revenue**
  - Loss
  - Central Admin. Costs
  - Other
  - Nurses & Nurse Assts (Shared with ED)

- **ED Revenue**
  - Loss
  - Central Admin. Costs
  - Nurses & NAs (Shared)
  - Clinicians (May Be Shared with Clinic)

- **Clinic Revenue**
  - Loss
  - Central Admin. Costs
  - Clinic Staff
  - Clinicians (Shared w/ ED)
Ancillary Services Are Used for Inpatient, ED, & Clinic Patients

- **Inpatient Revenue**
  - Central Admin. Costs
  - Other
  - Nurses & Nurse Assts (Shared with ED)
- **ED Revenue**
  - Central Admin. Costs
  - Nurses & NAs (Shared)
  - Clinicians (May Be Shared with Clinic)
- **Clinic Revenue**
  - Central Admin. Costs
  - Clinicians (Shared w/ ED)
- **Ancillary Revenue**
  - Central Admin. Costs
  - Equip. & Supplies
  - Lab Techs & Other Staff

- **Loss**
  - Nurses & Nurse Assts (Shared with ED)
  - Clinicians (May Be Shared with Clinic)
Hospital Overhead Costs Are Shared by All Service Lines

- **Inpatient**: Revenue - Costs = Loss
  - Central Admin. Costs
  - Other
  - Nurses & Nurse Assts (Shared with ED)

- **ED**: Revenue - Costs = Loss
  - Central Admin. Costs
  - Nurses & NAs (Shared)
  - Clinicians (May Be Shared with Clinic)

- **Clinic**: Revenue - Costs = Loss
  - Central Admin. Costs
  - Clinic Staff
  - Clinicians (Shared w/ ED)

- **Ancillary**: Revenue - Costs = Profit
  - Central Admin. Costs
  - Equip. & Supplies
  - Lab Techs & Other Staff

All service lines share the overhead costs, resulting in losses for each section.
Inpatient Services Includes More Than Just Acute Admissions

- **Inpatient Services**
  - Includes:
    - Acute Admissions
    - Other Services
      - Nurses & Nurse Assts (Shared with ED)

- **ED Services**
  - Includes:
    - Central Admin. Costs
    - Other Costs
    - Nurses & NAs (Shared)
      - May be shared with Clinic

- **Clinic Services**
  - Includes:
    - Central Admin. Costs
    - Clinicians (Shared w/ ED)

- **Ancillary Services**
  - Includes:
    - Central Admin. Costs
    - Equip. & Supplies
    - Lab Techs & Other Staff

**Profit**

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Inpatient = Acute + SNF + LTC

- Acute Revenue
- SNF Revenue
- LTC Revenue
- Central Admin. Costs
- Nurses & Nurse Assts (Shared with ED)
- Other
- ED Revenue
- Loss
- ED Costs
- Nurses & NAs (Shared)
- Clinicians (May Be Shared with Clinic)
- Clinic Revenue
- Loss
- Central Admin. Costs
- Clinic Staff
- Clinicians (Shared w/ ED)
- Ancillary Revenue
- Central Admin. Costs
- Equip. & Supplies
- Lab Techs & Other Staff
- Profit

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Without Acute Patients, Inpatient Losses Would Be Higher

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>ED</th>
<th>Clinic</th>
<th>Ancillary</th>
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<tbody>
<tr>
<td>SNF Revenue</td>
<td>Central Admin. Costs</td>
<td>Central Admin. Costs</td>
<td>Ancillary Revenue</td>
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<tr>
<td>LTC Revenue</td>
<td>Other</td>
<td>Nurses &amp; NAs (Shared with ED)</td>
<td>Equip. &amp; Supplies</td>
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<td>Loss</td>
<td>Central Admin. Costs</td>
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<tr>
<td></td>
<td>Loss</td>
<td>Nurses &amp; NAs (Shared)</td>
<td>clinic</td>
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<td></td>
<td>Loss</td>
<td>Clinicians (May Be Shared with Clinic)</td>
<td>Clinicians (Shared w/ ED)</td>
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<td></td>
<td>Loss</td>
<td>Clinic Staff</td>
<td>Profit</td>
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<td>Clinicians</td>
<td>Ancillary Costs</td>
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<td></td>
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<td>(Shared w/ ED)</td>
<td>Central Admin. Costs</td>
</tr>
</tbody>
</table>

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Without Acute Patients, Ancillary Profits Would Be Lower

- **Inpatient**
  - SNF Revenue
  - LTC Revenue

- **ED**
  - Central Admin. Costs
  - Other
  - Nurses & Nurse Assts (Shared with ED)
  - ED Revenue
  - Loss

- **Clinic**
  - Central Admin. Costs
  - Nurses & NAs (Shared)
  - Clinicians (May Be Shared with Clinic)
  - Clinic Staff
  - Clinicians (Shared w/ ED)
  - Clinic Revenue
  - Loss

- **Ancillary**
  - Central Admin. Costs
  - Equipt. & Supplies
  - Lab Techs & Other Staff
  - Ancillary Revenue
  - Profit
What If Inpatient Services Were Eliminated Entirely?

- **Inpatient**
  - Acute Revenue
  - Central Admin. Costs
  - Other
  - Nurses & Nurse Asst. (Shared with ED)

- **ED**
  - ED Revenue
  - Loss
  - Central Admin. Costs
  - Nurses & NAs (Shared)
  - Clinicians (May Be Shared with Clinic)

- **Clinic**
  - Clinic Revenue
  - Loss
  - Central Admin. Costs
  - Clinicians (Shared w/ ED)

- **Ancillary**
  - Ancillary Revenue
  - Profit
  - Central Admin. Costs
  - Equip. & Supplies
  - Lab Techs & Other Staff

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The ED Could No Longer Share Nursing Costs with Inpatient

Inpatient | ED | Clinic | Ancillary

- ED Revenue
- Loss
- Central Admin. Costs
- Nurses & NAs (Shared with ED)
- Clinicians (May Be Shared with Clinic)
- Central Admin. Costs
- Nurses & NAs
- Central Admin. Costs
- Clinic Staff
- Clinicians (Shared w/ ED)
- Central Admin. Costs
- Equip. & Supplies
- Lab Techs & Other Staff

Profit
Other Service Lines Couldn’t Share Overhead With Inpatient

- **Inpatient**
- **ED**
- **Clinic**
- **Ancillary**

- **Central Admin. Costs**
- **Nurses & NAs** (Shared with ED)
- **Clinicians (May Be Shared with Clinic)**
- **Clinic Staff**
- **Clinicians (Shared w/ ED)**

- **Loss**
Revenue from Ancillary Services Would Decrease

- ED: Revenue - Costs
  - Central Admin. Costs
  - Nurses & NAs
  - Clinicians (May Be Shared with Clinic)
  - Loss

- Clinic: Revenue - Costs
  - Central Admin. Costs
  - Clinic Staff
  - Clinicians (Shared w/ ED)
  - Loss

- Ancillary: Revenue - Costs
  - Central Admin. Costs
  - Equip. & Supplies
  - Lab Techs & Other Staff
  - Loss

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In Sum: Every Other Service Line Would Have Bigger Losses

- ED
  - ED Cost
  - ED Revenue
  - ED Loss

- Clinic
  - Clinic Cost
  - Clinic Revenue
  - Clinic Loss

- Ancillary
  - Ancillary Cost
  - Ancillary Revenue
  - Ancillary Loss
The Hospital As a Whole Would Be Worse Off

- Total Hospital Revenue
- Inpatient Cost
- ED Cost
- Clinic Cost
- Ancillary Cost

- Loss

- Higher Loss
- Lower Total Hospital Revenue
- ED Cost
- Clinic Cost
- Ancillary Cost
Would Payers Save Money?

- **Total Hospital Revenue**
  - Inpatient Cost
  - ED Cost
  - Clinic Cost
  - Ancillary Cost

- **Loss**

- **Payer Savings?**
  - Payer Spending on Rural Hospital Services

- **Higher Loss**
  - Lower Total Hospital Revenue
  - ED Cost
  - Clinic Cost
  - Ancillary Cost

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The Inpatients Still Need Care Somewhere & That Costs Money

<table>
<thead>
<tr>
<th></th>
<th>Inpatient Cost</th>
<th>ED Cost</th>
<th>Clinic Cost</th>
<th>Ancillary Cost</th>
<th>Payments for Acute &amp; SNF Pts Elsewhere</th>
<th>Higher Loss</th>
<th>Total Hospital Revenue</th>
<th>Payer Spending on Rural Hospital Services</th>
<th>Lower Total Hospital Revenue</th>
<th>ED Cost</th>
<th>Clinic Cost</th>
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So the Savings Will Be Much Smaller Than They Might Seem

Paid Savings

Payments for Acute & SNF Pts Elsewhere

Payer Spending on Rural Hospital Services

Lower Total Hospital Revenue

ED Cost

Clinic Cost

Ancillary Cost

Inpatient Cost

Clinic Cost

Ancillary Cost

Inpatient Cost

Higher Loss

Total Hospital Revenue

Cost

Loss

Payments for Acute & SNF Pts Elsewhere

Payer Spending on Rural Hospital Services

Lower Total Hospital Revenue

ED Cost

Clinic Cost

Ancillary Cost

Inpatient Cost

Higher Loss

Total Hospital Revenue

Cost

Loss

Payments for Acute & SNF Pts Elsewhere

Payer Spending on Rural Hospital Services

Lower Total Hospital Revenue

ED Cost

Clinic Cost

Ancillary Cost

Inpatient Cost

Higher Loss

Total Hospital Revenue

Cost

Loss

Payments for Acute & SNF Pts Elsewhere

Payer Spending on Rural Hospital Services

Lower Total Hospital Revenue

ED Cost

Clinic Cost

Ancillary Cost

Inpatient Cost

Higher Loss

Total Hospital Revenue

Cost

Loss

Payments for Acute & SNF Pts Elsewhere

Payer Spending on Rural Hospital Services

Lower Total Hospital Revenue

ED Cost

Clinic Cost

Ancillary Cost

Inpatient Cost

Higher Loss

Total Hospital Revenue

Cost

Loss

Payments for Acute & SNF Pts Elsewhere

Payer Spending on Rural Hospital Services

Lower Total Hospital Revenue

ED Cost

Clinic Cost

Ancillary Cost

Inpatient Cost

Higher Loss

Total Hospital Revenue

Cost

Loss

Payments for Acute & SNF Pts Elsewhere

Payer Spending on Rural Hospital Services

Lower Total Hospital Revenue

ED Cost

Clinic Cost

Ancillary Cost

Inpatient Cost

Higher Loss
Small CAHs Would Lose $ If Inpatient Services Were Ended
Who Gets Inpatient Care in Small Rural Hospitals?

- 70-85% acute inpatient cases are Medicare beneficiaries
- What kinds of conditions are they admitted for?
  - Washington State’s hospital discharge database was used to evaluate the types of health problems for which people were admitted to small CAHs
Most Acute Admits Are For A Narrow Range of Conditions

% of Total Acute Admissions, 9 Non-Maternity CAHs

- Common Acute Conditions w/o Major Complications
- Common Chronic Conditions w/o Major Complications
- Chronic & Common Acute Conditions w/ Major Comp.
- Other Conditions and Major Complications
- Heart Attack, Stroke, Chest Pain, Syncope
- Non-Orthopedic Medical and Surgical Procedures
- Behavioral Health
- Trauma
- Maternity Care
- Orthopedic Procedures
Most Acute Admits Are For Common Acute/Chronic Diseases

% of Total Acute Admissions, 9 Non-Maternity CAHs

- Common Acute Conditions w/o Major Complications: 79% of Total
- Common Chronic Conditions w/o Major Complications
- Chronic & Common Acute Conditions w/ Major Comp.
Most Acute Admits Are For Common Acute/Chronic Diseases

- Cellulitis
- Pneumonia
- Urinary Tract Infection
- Gastroenteritis

- COPD
- Diabetes
- Heart Failure
>40% of Admits for Acute/Chronic Conditions Are to Local Hospital
Some Larger Hospitals Also Deliver Babies
Most Admits Are Deliveries & Common Acute/Chronic Cond.

% of Total Acute Admissions, 4 Maternity Care CAHs

Maternity Care

Common Acute Medical Conditions w/o Major Complications

Common Chronic Conditions w/o Major Complications

74% of Total
>60% of Deliveries & Other Svcs Are at Rural Hospitals

![Bar chart showing the percentage of local resident admissions at local hospitals (maternity care CAHs).](chart)

- Maternity Care
- Common Chronic Conditions w/o Major Complic.
- Common Acute Conditions w/o Major Complic.
- Behavioral Health
- Chronic & Acute Conditions w/ Major Complic.
- Trauma
- Heart Attack, Stroke, Chest Pain, Syncope
- Non-Orthopedic Procedures
- Orthopedic Procedures
- Other Conditions and Major Complications
Who Gets Inpatient Care in Small Rural Hospitals?

- 70-85% acute inpatient cases are Medicare beneficiaries
- What kinds of conditions are patients admitted for?
  - Common acute medical conditions without major complications
    - Cellulitis, Pneumonia, UTI
  - Chronic disease exacerbations
    - COPD, Diabetes, Heart Failure
  - Labor and delivery at hospitals that offer maternity care
- 40-60% of patients with these conditions are admitted to their local hospital
- Most patients with more serious conditions go to or are transferred to larger hospitals
  - Heart attack, stroke, major trauma
  - Major surgical procedures
Impacts of Closing Inpatient Services in Small Rural Hospitals

• Hospital financial losses would likely increase

• Outpatient services would become even more expensive
  – Additional Medicare subsidies for outpatient services may offset the higher cost for Medicare patients, but not for other payers

• Community residents, particularly seniors, who have an acute condition or chronic disease exacerbation and who cannot safely be sent home would have to be transported to a hospital in a distant city, away from family and community supports

• Pregnant women and babies would be less likely to have a safe and healthy delivery
Will Proposed Solutions for Rural Hospitals Work?

• Subsidies if Rural Hospitals Eliminate Inpatient Services

• “Global Budget” for Rural Hospitals
  – Maryland All-Payer Rate Regulation/Total Patient Revenue System
    • CMMI-Maryland All-Payer APM
    • CMMI-Maryland Total Cost of Care Model
  – CMMI-Pennsylvania Rural Health Model
    • Just started in 2019 with 5 hospitals
Would Rural Hospitals Be Better Off With a “Global Budget?”

- Each participating payer pays the hospital a fixed amount for all of the care the hospital delivers to the payer’s patients, regardless of how many services are actually delivered.
- The payment amount is equal to (1) the payer’s total payments to the hospital in the year(s) prior to the global budget, and (2) an annual increase to reflect inflation.
The Global Budget Concept is Based on Several Premises

Revenue | Costs
Premise #1: Hospitals Deliver Avoidable Svcs

$\begin{array}{c}
\text{Pmts for Necesssary Services} \\
\text{Pmts for Avoidable Svcs}
\end{array}$
Premise #1: Hospitals Deliver Avoidable Svcs

- Unnecessary procedures
- Unnecessary tests
- ED visits for non-emergency conditions
- Hospital readmissions
- Avoidable chronic disease admissions
Premise #2:
Fewer Services = Lower Costs

Hospital costs would decrease with fewer:
- Unnecessary procedures
- Unnecessary tests
- ED visits for non-emergency conditions
- Hospital readmissions
- Avoidable chronic disease admissions
Premise #3: FFS Penalizes Reductions in Services

Fees for services are higher than the variable costs of delivering the services, so when volume decreases, revenue decreases more than costs, causing losses.
Losses Increase When Fewer Avoidable Services Are Delivered

- Pmts for Avoidable Services
- Avoidable Costs
- Costs Of Necessary Services

Year 0

Year 1

Year 2

Year 3
Under a Global Budget…

Under a Global Budget, the payments for necessary services decrease in Year 1 compared to Year 0, while the payments for avoidable services remain consistent. The global budget then accounts for the combined payments for both services.
Revenue Does Not Decrease With Fewer Avoidable Services

- Year 0
  - Pmts for Necessary Services: Green
  - Costs of Necessary Services: Brown
  - Pmts for Avoidable Svcs: Red
  - Avoidable Costs: Yellow

- Year 1
  - Global Budget: Green
  - Costs of Necessary Services: Brown
  - Avoidable Costs: Yellow

Profit does not decrease because revenue does not decrease with fewer avoidable services.
Reducing Avoidable Services Will Increase Hospital Profits

- Pmts for Avoidable Svcs
- Costs of Necessary Services
- Profit

Year 0:
- Pmts for Necessary Services
- Costs of Necessary Services
- Global Budget
- Profit

Year 1:
- Global Budget
- Costs of Necessary Services
- Profit

Year 2:
- Global Budget
- Costs of Necessary Services
- Profit

Year 3:
- Global Budget
- Costs of Necessary Services
- Profit

Profit $
CMS Assumes Global Budget Can Be Reduced to “Share Savings”
Premises of the Global Budget May Apply to Larger Hospitals

- Hospitals Deliver Many Avoidable and Non-Essential Services
- Costs Could Be Reduced if Fewer Avoidable Services Are Eliminated
- Unit Costs Are Fairly Stable Year-to-Year
…But Small Rural Hospitals Are Starting From a Different Place

- Hospitals Have Large Operating Losses
- Hospitals Primarily Deliver Essential Services
- A High Proportion of Costs Are Fixed
- Unit Costs Are Highly Variable
Rural Hospital Costs Can Change With No Change in Volume

Future Years

Large Hospitals

- Pmts for Avoidable Svcs
- Pmts for Necessary Services
- Avoidable Costs
- Costs Of Necessary Services
- Profit

Rural Hospitals

- Loss Avoidable Svcs
- Pmts for Necessary Services
- Avoidable
- Costs Of Necessary Services

Avoidable

Avoidable

Avoidable

$
Rural Hospital Costs Can Change Significantly From Year to Year

REASONS FOR YEAR-TO-YEAR VARIATIONS IN COST INCLUDE:

- Long delays in filling vacant positions
- High costs of *locum tenens* physicians and temporary staff
- Overtime and other unexpected costs in disasters or disease outbreaks
- Failures of outdated equipment and facilities
- Changes in accreditation standards and requirements for upgrading technology

Large Hospitals

- Pmts for Necessary Services
- Pmts for Avoidable Svcs
- Profit

Rural Hospitals

- Pmts for Necessary Services
- Pmts for Avoidable Svcs
- Loss

Avoidable Costs

Costs Of Necessary Services

Avoidable Svcs

Future Years

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
The “Global Budget” is Supposed to Start With *Current* Revenue…

<table>
<thead>
<tr>
<th>Year 0</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidable Svcs</td>
<td>Global Budget</td>
</tr>
<tr>
<td>Pmts for Necessary Services</td>
<td></td>
</tr>
</tbody>
</table>

$
…But If Current Revenue Doesn’t Cover Costs, It’s Not a Solution
Reducing Avoidable Services Doesn’t Reduce Costs Very Much

<table>
<thead>
<tr>
<th>Year 0</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs Of Necessary Services</td>
<td>Costs Of Necessary Services</td>
</tr>
<tr>
<td>Global Budget</td>
<td>Global Budget</td>
</tr>
<tr>
<td>Pmts for Necessary Services</td>
<td>Pmts for Necessary Services</td>
</tr>
<tr>
<td>Avoidable Svcs</td>
<td>Avoidable Svcs</td>
</tr>
<tr>
<td>Loss</td>
<td>Loss</td>
</tr>
</tbody>
</table>

© Center for Healthcare Quality and Payment Reform www.CHQPR.org
If Costs Increase But Global Budget Doesn’t, Losses Increase

- Costs of Necessary Services
- Avoidable Services
- Global Budget

Year 0
- Pmts for Necessary Services
- Costs of Necessary Services
- Loss
- Avoidable Services

Year 1
- Global Budget
- Costs of Necessary Services
- Loss

Year 2
- Global Budget
- Costs of Necessary Services
- Loss

Year 3
- Global Budget
- Costs of Necessary Services
- Loss
If Hospital is Delivering Non-Essential Services…

<table>
<thead>
<tr>
<th>Year 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
</tr>
</tbody>
</table>

- **Loss**
- **Pmts for Optional Services**
- **Pmts for Necessary Services**
- **Cost of Optional Services**
- **Costs Of Necessary Services**
Global Budget Makes It Profitable To Eliminate Them…

<table>
<thead>
<tr>
<th>Year 0</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pmts for Necessary Services</td>
<td>Global Budget</td>
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<tr>
<td>Cost of Necessary Services</td>
<td>Profit</td>
</tr>
<tr>
<td>Pmts for Optional Services</td>
<td>Cost of Optional Services</td>
</tr>
</tbody>
</table>

Loss
Increases in Budget May Cover Cost Growth in Essential Svcs

- Year 0: Loss - Costs for Necess. Services - Costs of Optional Services
- Year 1: Profit - Global Budget - Costs of Necess. Services
- Year 2: Profit - Global Budget - Costs of Necess. Services
…But There is No Guarantee Global Budget Won’t Be Cut
If Hospital is Only Delivering Minimum Services Today…

<table>
<thead>
<tr>
<th>Year</th>
<th>Pmts for Necessary Services</th>
<th>Costs of Necessary Services</th>
<th>Global Budget</th>
<th>Costs of Necessary Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 0</td>
<td>Green</td>
<td>Brown</td>
<td>Green</td>
<td>Brown</td>
</tr>
<tr>
<td>Year 1</td>
<td>Green</td>
<td>Brown</td>
<td>Green</td>
<td>Brown</td>
</tr>
</tbody>
</table>
…Global Budget Prevents Adding New Services for the Community

Year 0
- Pmts for Necessary Services
- Costs of Necessary Services

Year 1
- Global Budget
- Costs of Necessary Services

Year 2
- Global Budget
- Costs of Necessary Services

Loss
- Cost of Optional Services
Winners and Losers Under a Global Budget

• **Winners:**
  – Hospitals with formerly profitable service lines that are no longer financially viable and not essential for the community
  – Hospitals in communities experiencing or expecting significant population losses
  – Hospitals with salaried staff and low turnover rates

• **Losers:**
  – Hospitals receiving insufficient payments to deliver the minimum essential services for the community
  – Hospitals in communities with aging populations likely to need more services than in the past
  – Hospitals with high turnover rates among providers and/or staff and heavy reliance on temporary staff/providers
  – Hospitals that want to establish new service lines to reduce the need for residents to travel for care
Are Global Budgets Helping Rural Hospitals in Other States?

Maryland:

- Maryland has no Critical Access Hospitals
- Smallest hospital: Somerset County (pop. 26,000, 83 residents per sq. mile)
- Second smallest hospital: Garrett County (pop. 30,000, 47 residents per sq. mile)
Are Global Budgets Helping Rural Hospitals in Other States?

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Pennsylvania Rural Health Model:
- 5 hospitals began participating in 2019, 3 are CAHs
- Counties: 41,000 – 114,000 residents; 42 - 93 residents per sq. mile
- Hospital budgets in 2017: $19 million - $90 million
- Inpatient census in 2017: 5 – 25 patients/day
“Rural” is Very Different in Other Parts of the Country

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• Inpatient census in 2017: 5 – 25 patients/day

North Dakota Critical Access Hospitals:
• All but 4 counties have population < 20,000, most have fewer than 10,000 residents
• Population density in almost all counties is less than 10 residents per sq. mile, and most have less than 5 residents per sq. mile
• Most have annual budgets under $15 million
• Most have inpatient census less than 3 patients/day

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Maryland’s System is Different From What CMMI is Promoting

<table>
<thead>
<tr>
<th>Determination of Annual Hospital Budget</th>
<th>Maryland</th>
<th>CMMI/Pennsylvania Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determined with a complex formula based on market share and community factors</td>
<td>Based on past revenues increased by an inflation factor</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjustments to Budget When Costs Change</th>
<th>Maryland</th>
<th>CMMI/Pennsylvania Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>State agency with large staff experienced in evaluating hospital costs reviews hospital requests</td>
<td>New agency with a focus on helping hospitals redesign service delivery; unclear if or how budgets will be changed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payer Participation in Model</th>
<th>Maryland</th>
<th>CMMI/Pennsylvania Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>State can mandate participation and payment amounts by all payers, including Medicare</td>
<td>Payer participation is voluntary; CMMI can change the rules at any time</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reliability of Payment</th>
<th>Maryland</th>
<th>CMMI/Pennsylvania Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital can adjust payment rates to ensure budget is met</td>
<td>Payers may or may not pay the full amount expected by hospitals</td>
<td></td>
</tr>
</tbody>
</table>
Maryland’s Problems/Opportunities Are Different Than Rural States

- Much higher spending levels
- Much higher rates of avoidable services
Maryland Has Third Highest Medicare Spending in U.S.
Maryland Has Highest Hospital Readmission Rates in U.S.

Maryland

North Dakota
Global Budgets Haven’t Reduced “Rural Hospital” Spending in MD

Hospitals

Changes In Hospital Utilization Three Years Into Maryland’s Global Budget Program For Rural Hospitals

By Eric T. Roberts, Laura A. Hatfield, J. Michael McWilliams, Michael E. Chernew, Nicolas Derr, Tara Schreiner, Lauren Glazier, and James Melnick

Abstract In a substantial shift in payment policy, the State of Maryland implemented a global budget program for acute care hospitals in 2010. Goals of the program include controlling hospital use and spending. Eight rural hospitals entered the program in 2010, while urban and suburban hospitals joined in 2014. Prior analyses, which focused on urban and suburban hospitals, did not find consistent evidence that Maryland’s program had contributed to changes in hospital use after two years. However, these studies were limited by short follow-up periods, may have failed to identify impacts of Maryland’s payment change from other state trends, and had limited generalizability to rural settings. To understand the effects of Maryland’s global budget program on rural hospitals, we compared changes in hospital use among Medicare beneficiaries served by affected rural hospitals versus an in-state control population from before to after 2010. By 2013—three years after the rural program began—there were no differential changes in acute hospital use or price-standardized hospital spending among beneficiaries served by the affected hospitals, versus the within-state control group. Our results suggest that among Medicare beneficiaries, global budgets in rural Maryland hospitals did not reduce hospital use or price-standardized spending as policy makers had anticipated.

Our results suggest that among Medicare beneficiaries, global budgets in rural Maryland hospitals did not reduce hospital use or price-standardized spending as policy makers had anticipated.
What Happens If the Budgets Aren’t Big Enough?

Maryland ER wait times are the worst in the nation

BY: Mallory Sofastaii
POSTED: 6:00 AM, Feb 2, 2017
UPDATED: 11:21 PM, Feb 2, 2017

Share Article

BALTIMORE, Md. - In emergency rooms across the state, doctors and nurses are working around the clock to treat their patients but getting checked out by one is taking more time.

Maryland has the longest ER wait in the country, according to data by the Centers for Medicare & Medicaid Services. Patients waited an average of 53 minutes in Maryland before they were seen by a health care professional. The national average is 22 minutes.

There are a lot of varying thoughts as to what may be causing the gridlock but there's agreement that fixing this problem is as urgent as the patients requiring treatment.
ED Wait Times in Maryland are 3 Times as Long as North Dakota
Global Budgets Require Strong Quality Assurance

Baltimore Hospital Patient Discharged at Bus Stop, Stumbling and Cold

By Jacey Fortin
Jan. 11, 2018

A woman who appeared to be wearing nothing but socks and a hospital gown was discharged from a Baltimore hospital on a cold winter night and left alone at a bus stop.

A passer-by filmed the woman late Tuesday evening and posted several videos on Facebook shortly after midnight. In them, people in dark uniforms can be seen walking into the University of Maryland Medical Center’s Midtown Campus with an empty wheelchair, leaving the woman alone on the sidewalk.

The woman appears to have trouble keeping her balance and communicating. She barely speaks during the videos, which total about 11 minutes. But she does scream, and her breath condenses in the cold air in front of her.

The man filming, Imamu Baraka, finds her belongings in plastic bags at the bus stop and encourages her to sit down.

“This is disgusting that they would just leave her unattended on a bus stop, half naked,” he said in the video. “And it’s got to be at least 40 degrees, if not colder.”

Mr. Baraka, who did not immediately respond to requests for comment, stopped filming and called emergency responders. An ambulance eventually arrived to take the woman back to the hospital.

“We share the shock and disappointment of many who have viewed the video showing the discharge of a patient” from emergency care, a hospital spokeswoman said in an emailed statement on Thursday. “This unfortunate event is not representative of our patient-centered mission. For this, we are truly sorry.”

She added that a review was underway to evaluate “the appropriate response, including the possibility of personnel action.”
Most ND CAHs Would Do Worse Under a Global Budget

Source: CMS Cost Reports, Global Budget Increase Based on Annual IPPS Increases
Negative Impact of Global Budget Would Grow Worse Over Time

Source: CMS Cost Reports, Global Budget Increase Based on Annual IPPS Increases
Is There a Better Way?
Rural Hospitals Deliver 2 Kinds of Services, But Only 1 is Paid For

• Services delivered to patients – fees for services
• Readiness in case patients need services – no payment
Minimum Cost is Incurred Even if Few Services Are Delivered

$VARIABLE COST$

MINIMUM (STANDBY) COST OF ESSENTIAL SERVICES

# OF ESSENTIAL SERVICES NEEDED

$MINIMUM (STANDBY) COST OF ESSENTIAL SERVICES

# OF ESSENTIAL SERVICES NEEDED BY LOCAL RESIDENTS
Payers Should Pay a “Standby Capacity Payment”

- STANDBY CAPACITY PAYMENTS FROM INSURERS
- VARIABLE COST
- MINIMUM (STANDBY) COST OF ESSENTIAL SERVICES
- # OF ESSENTIAL SERVICES NEEDED

- STANDBY CAPACITY PAYMENTS FROM INSURERS
- VARIABLE COST
- MINIMUM (STANDBY) COST OF ESSENTIAL SERVICES
- # OF ESSENTIAL SERVICES NEEDED BY LOCAL RESIDENTS
Fees Can Then Be Used to Cover the *Variable* Costs of Services
Fees Can Also Be Used to Cover Any Optional Services Delivered
Standby Capacity Payments Should Be $ Per Resident
Standby Capacity Payments Should Be $ Per Resident

Per-Resident Payments is How We Pay for Other Emergency & Essential Community Services

- Fire Departments
- Libraries
Now, If The Hospital Is Delivering Avoidable Services…
…Reducing Avoidable Svcs Doesn’t Harm $ for Essential Svcs
Show Me Some Numbers!
A Simple Financial Model for an Emergency Department

<table>
<thead>
<tr>
<th>Visits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Visits</td>
<td>1,500</td>
</tr>
</tbody>
</table>

- 5,000 residents of a community served by a single hospital
- 300/1000 of the residents visit the ED annually (1,500 annual visits)
A Simple Financial Model for an Emergency Department

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<thead>
<tr>
<th>Visits</th>
<th></th>
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<tbody>
<tr>
<td>Insured Visits</td>
<td>1,425</td>
</tr>
<tr>
<td>Uninsured Visits</td>
<td>75</td>
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- 5,000 residents of a community served by a single hospital
- 300/1000 of the residents visit the ED annually (1,500 annual visits)
- 5% of visits are uninsured
A Simple Financial Model for an Emergency Department

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<table>
<thead>
<tr>
<th>Costs</th>
<th>FTEs</th>
<th>$</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians ($/Hr)</td>
<td>3.2</td>
<td>$60</td>
<td>$399,360</td>
</tr>
<tr>
<td>Other Staff</td>
<td>1.0</td>
<td>$45</td>
<td>$93,600</td>
</tr>
<tr>
<td>Other ($/Visit)</td>
<td></td>
<td>$25</td>
<td>$37,500</td>
</tr>
<tr>
<td>Indirect (% Dir.)</td>
<td>40%</td>
<td></td>
<td>$212,184</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$742,644</td>
</tr>
</tbody>
</table>

- 5,000 residents of a community served by a single hospital
- 300/1000 of the residents visit the ED annually (1,500 annual visits)
- 5% of visits are uninsured
- Hospital uses clinic providers + on-call providers to staff ED
- Total annual cost of ED is $742,644
First, Assume a Purely Visit-Based Payment System

### VISIT-BASED PAYMENT

<table>
<thead>
<tr>
<th>Revenues</th>
<th>Visits</th>
<th>$/Visit</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Visit Pmts</td>
<td>1,425</td>
<td>$540</td>
<td></td>
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<tr>
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- 300/1000 of the residents visit the ED annually (1,500 annual visits)
- 5% of visits are uninsured
- Hospital uses clinic providers + on-call providers to staff ED
- Total annual cost of ED is $742,644
- **Hospital charges $540 per visit**
If All Payers Paid Adequately, ED Would Have a Positive Margin

<table>
<thead>
<tr>
<th>VISIT-BASED PAYMENT</th>
<th></th>
<th></th>
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Margin

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- 300/1000 of the residents visit the ED annually (1,500 annual visits)
- 5% of visits are uninsured
- Hospital uses clinic providers + on-call providers to staff ED
- Total annual cost of ED is $742,644
- Hospital charges $540 per visit
- 4% operating margin
What Happens if ED Visits Are Reduced by 15%?

<table>
<thead>
<tr>
<th>VISIT-BASED PAYMENT</th>
<th>DECREASE IN VISITS</th>
<th>Chg</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Visit Pmts</td>
<td>1,425 USD/Visit</td>
<td>1,211 USD/Visit</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>1,500 USD/Visit</td>
<td>1,275 USD/Visit</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinicians (USD/Hr)</td>
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<td>1.2 USD/Visit</td>
</tr>
<tr>
<td>Other Staff</td>
<td>1.0 USD/Visit</td>
<td>0.6 USD/Visit</td>
</tr>
<tr>
<td>Other (USD/Visit)</td>
<td>0.25 USD/Visit</td>
<td>0.15 USD/Visit</td>
</tr>
<tr>
<td>Indirect (% Dir.)</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Total Costs</td>
<td>742,644 USD</td>
<td>742,644 USD</td>
</tr>
<tr>
<td>Margin</td>
<td>$26,856 USD</td>
<td>$26,856 USD</td>
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</tbody>
</table>

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Revenues Will Decrease in Proportion to Reduction in Visits

<table>
<thead>
<tr>
<th>VISIT-BASED PAYMENT</th>
<th>DECREASE IN VISITS</th>
<th>Chg</th>
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<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
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<tr>
<td>Per Visit Pmts</td>
<td>1,425</td>
<td>$540</td>
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<tr>
<td>Clinicians ($/Hr)</td>
<td>3.2</td>
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<tr>
<td>Other Staff</td>
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<td>$45</td>
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<tr>
<td>Other ($/Visit)</td>
<td></td>
<td>$25</td>
</tr>
<tr>
<td>Indirect (% Dir.)</td>
<td>40%</td>
<td>$212,184</td>
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<td>$742,644</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
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</table>
Fixed Costs (Staffing) Will Not Change

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<th>DECREASE IN VISITS</th>
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<tr>
<td><strong>Costs</strong></td>
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<td></td>
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<td>$60</td>
</tr>
<tr>
<td>Other Staff</td>
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<tr>
<td><strong>Margin</strong></td>
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Small Amt of Variable Costs Will Decrease in Proportion to Visits

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<td>$540</td>
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<tr>
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<tr>
<td>Total Revenues</td>
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<tr>
<td>Revenues</td>
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<tr>
<td>Uninsured Visits</td>
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<td>Total Revenues</td>
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<th>FTEs</th>
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<th>Total $</th>
<th>FTEs</th>
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<tbody>
<tr>
<td>Clinicians ($/Hr)</td>
<td>3.2</td>
<td>$60</td>
<td>$399,360</td>
<td>3.2</td>
<td>$60</td>
<td>$399,360</td>
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<tr>
<td>Other Staff</td>
<td>1.0</td>
<td>$45</td>
<td>$93,600</td>
<td>1.0</td>
<td>$45</td>
<td>$93,600</td>
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Margin

$26,856
+4%
Total Costs Will Decrease, But Less Than Revenues Decrease

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<thead>
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<tr>
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<tr>
<td>Per Visit Pmts</td>
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<td>$540</td>
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<td>$769,500</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
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<tr>
<td></td>
<td>FTEs</td>
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<tr>
<td><strong>Margin</strong></td>
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The Emergency Department Now Has Significant Losses

### VISIT-BASED PAYMENT

<table>
<thead>
<tr>
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<th>$/Visit</th>
<th>Total $</th>
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</thead>
<tbody>
<tr>
<td>Per Visit Pmts</td>
<td>1,425</td>
<td>$540</td>
<td>$769,500</td>
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<tr>
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<td>75</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Total Revenues</td>
<td>1,500</td>
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<td>$769,500</td>
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### DECREASE IN VISITS

<table>
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<tr>
<th></th>
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<th>$/Visit</th>
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<td>$654,075</td>
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<td>Total Revenues</td>
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<td>$654,075</td>
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### Costs

<table>
<thead>
<tr>
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<th>FTEs</th>
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<tbody>
<tr>
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<td>$399,360</td>
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<tr>
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<td>$45</td>
<td>$93,600</td>
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<tr>
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<td></td>
<td>$25</td>
<td>$37,500</td>
</tr>
<tr>
<td>Indirect (% Dir.)</td>
<td>40%</td>
<td>$212,184</td>
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</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$742,644</td>
</tr>
</tbody>
</table>

### Margins

- **Revenues**: +4%
- **Costs**: -1.1%
- **Margin**: $26,856 (+4%)  
  ($80,694) (-11%)  
  -400%
What Happens If ED Visits Increase by 10%?

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<th>Chg</th>
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<tbody>
<tr>
<td><strong>Revenues</strong></td>
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<td>+10%</td>
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<tr>
<td><strong>Per Visit Pmts</strong></td>
<td>1,425</td>
<td>$540</td>
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<tr>
<td><strong>Uninsured Visits</strong></td>
<td>75</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>1,500</td>
<td>$769,500</td>
</tr>
</tbody>
</table>

| **Costs** | | |
|**FTEs** | **$** | **Total $** | **$** | **Total $** |
|Clinicians ($/Hr) | 3.2 | $60 | $399,360 | |
|Other Staff | 1.0 | $45 | $93,600 | |
|Other ($/Visit) | | $25 | $37,500 | |
|Indirect (% Dir.) | 40% | $212,184 | | |
|Total Costs | | | $742,644 | |

**Margin** | $26,856 | +4% |
# Profits for the ED Soar

<table>
<thead>
<tr>
<th>VISIT-BASED PAYMENT</th>
<th>INCREASE IN VISITS</th>
<th>Chg</th>
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<td><strong>Revenues</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Visits</strong></td>
<td><strong>$/Visit</strong></td>
<td><strong>Total $</strong></td>
</tr>
<tr>
<td>Per Visit Pmts</td>
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<td>$540</td>
</tr>
<tr>
<td>Uninsured Visits</td>
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<td>$0</td>
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<tr>
<td><strong>Total Revenues</strong></td>
<td>1,500</td>
<td>$769,500</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Costs</strong></th>
<th><strong>FTEs</strong></th>
<th><strong>$</strong></th>
<th><strong>Total $</strong></th>
<th><strong>FTEs</strong></th>
<th><strong>$</strong></th>
<th><strong>Total $</strong></th>
<th><strong>Chg</strong></th>
</tr>
</thead>
<tbody>
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<td>3.2</td>
<td>$60</td>
<td>$399,360</td>
<td>3.2</td>
<td>$60</td>
<td>$399,360</td>
<td>0%</td>
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<tr>
<td>Other Staff</td>
<td>1.0</td>
<td>$45</td>
<td>$93,600</td>
<td>1.0</td>
<td>$45</td>
<td>$93,600</td>
<td>0%</td>
</tr>
<tr>
<td>Other ($/Visit)</td>
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<td>$25</td>
<td>$41,250</td>
<td>+10%</td>
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<tr>
<td>Indirect (% Dir.)</td>
<td>40%</td>
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<td>$212,184</td>
<td>40%</td>
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<td>$213,684</td>
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<td>$747,894</td>
<td>+0.7%</td>
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| **Margin** | | |
| **Total** | | |
| **Visits** | | |
| **Per Visit Pmts** | | |
| **Uninsured Visits** | | |
| **Total Revenues** | | |
| **FTEs** | | |
| **Clinicians ($/Hr)** | | |
| **Other Staff** | | |
| **Other ($/Visit)** | | |
| **Indirect (% Dir.)** | | |
| **Total Costs** | | |
| **Margin** | | | $26,856 | +4% | $98,556 | +13% | +267% |
Is It Any Wonder Many Hospitals Encourage Use of the ER?

<table>
<thead>
<tr>
<th>VISIT-BASED PAYMENT</th>
<th>INCREASE IN VISITS</th>
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<tbody>
<tr>
<td><strong>Revenues</strong></td>
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<tr>
<td>Visits</td>
<td>Per Visit Pmts</td>
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<tr>
<td></td>
<td>Uninsured Visits</td>
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<tr>
<td></td>
<td>Total Revenues</td>
<td>1,500</td>
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<tr>
<td><strong>Costs</strong></td>
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</tr>
<tr>
<td>FTEs</td>
<td>Clinicians ($/Hr)</td>
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<tr>
<td></td>
<td>Other Staff</td>
<td>1.0</td>
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<tr>
<td></td>
<td>Other ($/Visit)</td>
<td>1.0</td>
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<tr>
<td></td>
<td>Indirect (% Dir.)</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td></td>
<td>$742,644</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
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<td>$26,856</td>
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</table>

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Is Cost-Based Payment Better or Worse?

<table>
<thead>
<tr>
<th>COST-BASED PAYMENT</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td></td>
</tr>
<tr>
<td>Cost – Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
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<table>
<thead>
<tr>
<th>Costs</th>
<th>FTEs</th>
<th>$</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians ($/Hr)</td>
<td>3.2</td>
<td>$60</td>
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<tr>
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<td>$93,600</td>
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<tr>
<td>Other ($/Visit)</td>
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<td>$25</td>
<td>$37,500</td>
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<tr>
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<td></td>
<td>$212,184</td>
</tr>
<tr>
<td>Total Costs</td>
<td></td>
<td></td>
<td>$742,644</td>
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</tbody>
</table>

Margin
Not All Costs Are Covered By Cost-Based Payment

<table>
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<tr>
<th>COST-BASED PAYMENT</th>
<th>Visits</th>
<th>$/%</th>
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</thead>
<tbody>
<tr>
<td>Revenues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost – Hospital</td>
<td>625</td>
<td>99%</td>
<td>$278,216</td>
</tr>
<tr>
<td>Clinician Fees</td>
<td></td>
<td>$100</td>
<td>$62,500</td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Costs</td>
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<td></td>
<td>$742,644</td>
</tr>
</tbody>
</table>

- Only the share of cost attributable to Medicare patients (assumes 25% of visits are Medicare)
- Only 99% of costs paid
- Not all costs are covered
- Clinician time seeing patient isn’t cost-based
Hospital Is Still Paid by the Visit for Non-Medicare Patients

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<td>$742,644</td>
</tr>
</tbody>
</table>
| **Margin**         |         |          | $30,072  
|                    |         |          | +4%      |
### What Happens When ED Visits Decrease?

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Most Costs are Fixed and Don’t Change

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…Cost-Based Payment Increases Based on Higher Cost Per Visit

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| Costs                                   |                    |     |
| Clinicians ($/Hr)                       | 3.2                | $60  | $399,360 |
| Other Staff                             | 1.0                | $45  | $93,600  |
| Other ($/Visit)                         |                    | $25  | $37,500  |
| Indirect (% Dir.)                       |                    | 40%  | $212,184 |
| Total Costs                             |                    | $742,644 |
| Margin                                  |                    | $30,072 | +4% |

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...Visit-Based Payment Decreases in Proportion to Visits…

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...Total Revenues Decrease More Than Costs Decrease...

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…So the Hospital Still Loses Money With Fewer Visits

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...and the Hospital Is Still Better Off With More ED Visits

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### NEW PAYMENT MODEL

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Margin >$0
The ED Needs to Be Available Whether Anybody Needs It or Not

### NEW PAYMENT MODEL

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**Margin**                       $28,756  
                                 +4%

- 5,000 residents of a community served by a single hospital
Per Resident Contribution Needed Is Less Than Cost of One ED Visit

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**Margin**

$28,756
+4%

- 5,000 residents of a community served by a single hospital
- 95% with insurance
Residents Who Use the ED Should Pay More Than Those Who Don’t

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<td></td>
<td></td>
<td>$742,644</td>
</tr>
</tbody>
</table>

Margin $28,756
+4%

- 5,000 residents of a community served by a single hospital
- 95% with insurance
- 300/1000 of the residents visit the ED annually (1,500 visits, 1,425 insured)
### What Happens if the Number of ED Visits is Reduced?

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<tr>
<td>Per Resident</td>
<td>4,750</td>
<td>$130</td>
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<tr>
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<td>1,425</td>
<td>$108</td>
<td>$153,900</td>
<td>1,211</td>
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<tr>
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<td>75</td>
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<tr>
<td>Total Revenues</td>
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<tr>
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© Center for Healthcare Quality and Payment Reform www.CHQPR.org
Costs Don’t Change Much Because Most Costs Are Fixed

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<td>Other Staff</td>
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-15%
Visit-Based Revenues Decrease in Proportion to Visits…

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<tr>
<td>Total Revenues</td>
<td>1,500</td>
<td>$771,400</td>
</tr>
</tbody>
</table>

| **Costs** | **FTEs** | **$** | **Total $** | **FTEs** | **$** | **Total $** | **Chg** |
| Clinicians ($/Hr) | 3.2 | $60 | $399,360 | 3.2 | $60 | $399,360 | 0% |
| Other Staff | 1.0 | $45 | $93,600 | 1.0 | $45 | $93,600 | 0% |
| Other ($/Visit) | $25 | | $37,500 | | $25 | $31,875 | -15% |
| Indirect (% Dir.) | 40% | $212,184 | | 40% | $209,934 | | |
| Total Costs | | $742,644 | | $734,769 | -1.1% |
| **Margin** | | $28,756 | +4% | | | |
...Per-Resident Payments Don’t Change...

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<td>$108</td>
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<td>$</td>
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<td>$734,769</td>
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<tr>
<td>Margin</td>
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...Total Revenues Decrease by Only a Small Amount...

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<td>$399,360</td>
<td>3.2</td>
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<td>$399,360</td>
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<td>$45</td>
<td>$93,600</td>
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<td>40%</td>
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<td><strong>$734,769</strong></td>
<td>-1.1%</td>
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<td>+4%</td>
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…So Hospital Margin is Preserved

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<td><strong>Margin</strong></td>
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<td>+4%</td>
<td>+2%</td>
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# Not Every Payer Will Participate

## NEW PAYMENT MODEL

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**Margin**: $28,876 +4%

- 5,000 residents of a community served by a single hospital
- 95% with insurance
- 20% of non-Medicare payers don’t participate
- 300/1000 of the residents visit the ED annually (1,500 visits, 1,425 insured)
- Non-participating payers are charged full amount per visit ($540)
If Most Payers Participate, Loss From Fewer Visits Is Limited

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| Margin            |       | $28,876 | +4% |
|                   |       | ($6,017) | -0.8% |

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## Comparison of Approaches

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<th>Global Budget</th>
<th>Standby Payment</th>
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<td>Stable margin</td>
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<tr>
<td>Residents Need Fewer Services</td>
<td>Lower margin</td>
<td>Higher margin</td>
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<tr>
<td>Higher Wage Rates Required to Obtain</td>
<td>Lower margin</td>
<td>Much lower margin unless</td>
<td>Stable margin if payment is</td>
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<tr>
<td>Personnel</td>
<td></td>
<td>budget is adjusted</td>
<td>adjusted for pay rates</td>
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<td>Residents Need More Services</td>
<td>Higher margin</td>
<td>Lower margin</td>
<td>Stable margin</td>
</tr>
<tr>
<td>Residents Need Fewer Services</td>
<td>Lower margin</td>
<td>Higher margin</td>
<td>Stable margin</td>
</tr>
<tr>
<td>Higher Wage Rates Required to Obtain Personnel</td>
<td>Lower margin</td>
<td>Much lower margin unless budget is adjusted</td>
<td>Stable margin if payment is adjusted for pay rates</td>
</tr>
<tr>
<td>Higher Costs Due to Inefficiency</td>
<td>Lower margin</td>
<td>Much lower margin</td>
<td>Much lower margin</td>
</tr>
<tr>
<td>Lower Costs Due to Efficiencies</td>
<td>Higher margin</td>
<td>Much higher margin</td>
<td>Much higher margin</td>
</tr>
<tr>
<td>Profitable New Service Line</td>
<td>Higher margin</td>
<td>Much lower margin</td>
<td>Higher margin</td>
</tr>
</tbody>
</table>
This Isn’t as Radical a Change As It May Seem…

CURRENT SYSTEM

INSURANCE COMPANY → Per-Service Payment → HOSPITAL ESSENTIAL SERVICES
• ED
• Maternity
• AMI/Stroke

STANDBY CAPACITY PAYMENT

INSURANCE COMPANY → Per-Resident Payment → HOSPITAL ESSENTIAL SERVICES
• ED
• Maternity
• AMI/Stroke
Today, Residents Pay an Annual Premium to an Health Plan…

CURRENT SYSTEM

COMMUNITY RESIDENT → Per-Resident Premium → INSURANCE COMPANY → HOSPITAL ESSENTIAL SERVICES

• ED
• Maternity
• AMI/Stroke
...The Health Plan Converts the Premium Into Visit Payments...

**CURRENT SYSTEM**

<table>
<thead>
<tr>
<th>COMMUNITY RESIDENT</th>
<th>Per-Resident Premium</th>
<th>INSURANCE COMPANY</th>
<th>Per-Service Payment</th>
<th>HOSPITAL ESSENTIAL SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• ED</td>
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<td></td>
<td></td>
<td>• AMI/Stroke</td>
</tr>
</tbody>
</table>

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…And the Resident Pays for Cost-Sharing on the Visit

CURRENT SYSTEM

COMMUNITY RESIDENT

Per-Resident Premium

INSURANCE COMPANY

Per-Service Payment

Per-Service Payment (Cost-Sharing)

HOSPITAL ESSENTIAL SERVICES
• ED
• Maternity
• AMI/Stroke
Insured Residents Already Use a Per-Resident + Per-Visit System

CURRENT SYSTEM

COMMUNITY RESIDENT

Per-Resident Premium

INSURANCE COMPANY

HOSPITAL ESSENTIAL SERVICES
- ED
- Maternity
- AMI/Stroke

Per-Service Payment (Cost-Sharing)
The Payer Just Needs to Give Part of the Premium to the Hospital

STANDBY CAPACITY PAYMENT

COMMUNITY RESIDENT

Per-Resident Premium

INSURANCE COMPANY

Per-Resident Payment

Per-Service Payment

HOSPITAL ESSENTIAL SERVICES
• ED
• Maternity
• AMI/Stroke
No Need for the Middle-Man in High-Deductible Health Plans

STANDBY CAPACITY PAYMENT

COMMUNITY RESIDENT

Per-Resident Premium

INSURANCE COMPANY

Per-Resident Payment

Per-Service Payment

COMMUNITY RESIDENT WITH HIGH-DEDUCTIBLE PLAN

Per-Resident Payment

HOSPITAL ESSENTIAL SERVICES
• ED
• Maternity
• AMI/Stroke

Per-Service Payment

HOSPITAL ESSENTIAL SERVICES
• ED
• Maternity
• AMI/Stroke
Standby Capacity Payment Uses Concepts Promoted by Payers

• “Population-Based Payment”
  – Payment based on the number of beneficiaries/members in the community or population served, not the number of services received

• Supporting standby capacity
  – MedPAC: “If standby emergency and primary care capacity are the desired services, then Medicare should subsidize the cost of facilities’ standby capacity with an annual fixed payment rather than increased payments per inpatient day.” (Report to Congress, June 2018)
Same Approach Could be Used for Most Essential Services

- **Essential Ancillary Services**
  - Radiology, Laboratory, PT/OT
  - Most community residents will need these services at some point
  - Lack of access could result in poor preventive care, missed diagnoses, inability to work or function properly
  - Standby Capacity Payment could support minimum level of services needed, with optional services supported by fees if volume is high

- **Inpatient Acute & Observation Care**
  - Older patients and patients with chronic diseases are hospitalized relatively frequently for conditions a small hospital can handle well
  - Standby Capacity Payment could be supported primarily by Medicare
  - Medicaid & commercial payers could support labor & delivery capacity

- **SNF**
  - Patients who need a SNF stay after surgery at a distant hospital should be able to stay as close to home as possible
  - Standby Capacity Payment could be supported by Medicare and other payers
Similar Payment Models for Other Essential Services

• **Primary Care/Rural Health Clinic**
  – Monthly payment for each resident enrolled in the clinic
  – Provides stable revenue to cover monthly provider/staff salaries
  – Provides flexibility to deliver care by phone, email, etc. rather than only through face-to-face visits with providers in the clinic

• **Long-Term Care**
  – Per resident payments directly from residents (e.g., through taxes) to support capacity for a community long-term care system
  – Provides stable revenue to support a nursing facility and/or assisted living facility
  – Provides flexibility to deliver home care services rather than facility services
Operationalizing Standby Capacity Payment

• Define the Population Being Served by the Service
  – What geographic area is being served?
  – How many people live there (or are potential service users)?
  – Who insures those people?

• Determine the Standby Capacity Payment & Service Fees
  – What is the minimum amount that will support quality service delivery?
  – Under what circumstances should that amount increase or decrease?
  – How much does cost increase when more services are delivered?
  – How much should be paid for an individual service?

• Determine How the Hospital Should Obtain the Payments
  – Should the hospital bill for both types of payments?
  – Should the Standby Capacity Payment be paid annually, or more frequently, and at the beginning or end of the time period?
Operationalizing Standby Capacity Payment

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All of These Same Issues Would Have to Be Addressed in a Good “Global Budget” Payment Model
Determining the Amount of the Standby Capacity Payment

- **Option 1: Based on payments made in the past for the service line**
  - Similar to approach CMMI wants to use in global budgets
  - Locks in deficits if past payments have been too low
  - Rewards hospitals with high historical costs and payments
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• **Option 2: Based on each hospital’s actual service line costs**
  – Similar to current cost-based payment
  – Methods exist to ensure that ineligible and unreasonable costs aren’t included
  – Allows all unique individual circumstances to be considered
  – No incentive to be efficient
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- **Option 3: Based on national averages/percentiles of service line cost**
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  - Rewards more efficient hospitals, but penalizes those with unique situations
  - Requires a method of determining standby (minimum) proportion of costs
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- **Option 4: Based on minimum required staffing levels for service + averages of actual provider and staff wage rates**
  - Wage rate component conceptually similar to current CMS Wage Index
  - Requires a method of determining minimum required staffing levels
  - Allows automatic adjustments for changes in care standards & labor markets
Potential Method of Determining ED Standby Capacity Payments
Potential Method of Determining ED Standby Capacity Payments

Step 1: Define Minimum Staffing Plans for Rural EDs

- A national expert panel would develop recommended minimum staffing levels
- Staffing levels would differ based on community size & other services, e.g.,
  - < 1,000 ED visits: part-time and on-call MDs/Dos, NPs, and/or PAs
  - 1,000 – 3,000 visits with RHC on site: part-time and on-call providers
  - 1,000 – 3,000 visits w/o RHC: 24/7 MD/DO, NP, and/or PA
  - 3,000+ visits: 24/7 MD/DO
- Hospitals would be free to staff differently than the recommended level
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Step 2: Determine Achievable Wage Rates for Providers/Staff
- Hospitals would annually report their contracted wage rates for each type of provider (MD, NP, PA) and staff (RN, MA, etc.) to a CPA firm
- The CPA firm would calculate medians and percentiles for wage rates for each category of community size
Potential Method of Determining ED Standby Capacity Payments

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Step 3: Determine Achievable Wage Rates for Providers/Staff

- The CPA firm would apply the wage rates to the recommended staffing levels to determine minimum costs of staffing EDs in different size communities
- These minimum costs would be the basis for the Standby Capacity Payments
Payers Want “Value-Based Payments”

- **Quality:**
  - Tie payments to the quality of care
  - Current value-based payments for hospitals don’t pay more for high quality care, they just cut payments for low quality care

- **Utilization/Spending:**
  - Hold providers accountable for total spending on their patients
  - “Upside only”: “shared savings” bonus if total cost of care is reduced
  - “Downside risk”: bonus if savings achieved, penalty if costs increase
Value Concerns About Rural Hospital Reforms

• Quality Concerns About Standby Capacity Payment or Global Budgets for Rural Hospitals:
  – **Current**: Hospital will be paid regardless of quality of services
  – **New**: Hospital will be paid even if it fails to deliver a needed service

• Spending Concerns About Standby Capacity Payment or Global Budgets for Rural Hospitals:
  – **Current**: Cost-based payments can subsidize inefficient care
  – **New**: Hospital could encourage patients to get fee-based services elsewhere with no reduction in the hospital’s payment
Potential Value Components for Standby Capacity Payment

• Quality:
  – Reduce payment for an essential service line if quality measures that are meaningful/reliable at the volumes of those services delivered in rural areas fall below minimum standards
  – Example for ED:
    • MBQIP OP-20: Median time from ED arrival to provider contact < 30 min.
    • MBQIP OP-22: Patient left without being seen <1%
    • MBQIP OP-5: Median time to ECG for potential AMI < 7 min
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• Utilization:
  – Reduce payment for an essential service line if there is a significant increase in the proportion of patients receiving the service elsewhere
  – Example for ED:
    • Increase in proportion of ED visits made to other hospitals for conditions that can be managed by the rural hospital
Preserving the Value That Already Exists in Rural Health Systems
Medicare Spending in ND is Well Below Average
Medicare Spends Far Less in Most ND Counties Than U.S.
ED Visits in Most ND Counties Are Below National Average
Readmits in Most ND Counties Are Below National Average
Admit Rates in Most ND Counties Are Below National Average
Preserving the Value That Already Exists in Rural Health Systems

- Rural health care costs less than care in urban areas

- If the rural hospital closes, it will cost far more to transport patients to expensive hospitals in distant cities than to care for them in their own communities

- If the rural hospital closes, and good preventive care and basic treatment services aren’t available in the community, it will cost far more to treat health problems after they progress to more severe stages

- Spending may increase far more if rural hospitals close than it will cost to keep them open
3 Options for the Future of Rural Hospitals
3 Options for the Future of Rural Hospitals

PAYER-DEFINED #1 “VALUE-BASED PAYMENT” SCHEMES

RURAL HOSPITALS
3 Options for the Future of Rural Hospitals

1. "VALUE-BASED PAYMENT" SCHEMES

2. LOSS OF SOME OR ALL RURAL SERVICES
3 Options for the Future of Rural Hospitals

#1 "VALUE-BASED PAYMENT" SCHEMES

#2 LOSS OF SOME OR ALL RURAL SERVICES

#3 PAYMENT MODELS THAT SUSTAIN ESSENTIAL SERVICES
3 Options for the Future of Rural Hospitals

What Should You Do If You Don’t Like Options 1&2??

#1 "VALUE-BASED PAYMENT" SCHEMES

#2 LOSS OF SOME OR ALL RURAL SERVICES

#3 PAYMENT MODELS THAT SUSTAIN ESSENTIAL SERVICES
Four Things
Rural Hospitals Need to Do
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1. Educate policy-makers, payers, and patients about what rural hospitals do and the need to preserve essential services
   – What is an essential service
   – What happens when a community doesn’t have it
   – What hospitals shouldn’t be forced to do to cover the costs of essential services
   – The importance of rural communities to the national economy
Four Things Rural Hospitals Need to Do

1. Educate policy-makers, payers, and patients about what rural hospitals do and the need to preserve essential services
   - What is an essential service
     • Primary care
     • ED visits
     • Observation stays
     • Multi-day stays for chronic disease exacerbations and uncomplicated acute illnesses for patients who can’t safely go home right away
     • Labor and delivery
     • SNF and long-term care services
   - What happens when a community doesn’t have it
     • Higher costs due to delayed prevention, diagnosis, and treatment
     • Disability and death due to delays in accessing immediate care
   - What hospitals shouldn’t be forced to do to cover the costs of essential svcs
     • Unnecessary testing and imaging
     • Hip and knee replacement surgery
   - The importance of rural communities to the national economy
     • Where will people get their food if no one is willing to work on farms and ranches because there is no healthcare available?
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   - What is an *essential* service
   - What happens when a community doesn’t have it
   - What hospitals shouldn’t be forced to do to cover the costs of essential svcs
   - The importance of rural communities to the national economy

2. Show that essential services are being delivered as efficiently as possible, and that costs are high because of low volume and difficulties in recruiting clinicians and staff
   - Small hospitals are delivering services at minimum levels of staffing, so fewer services doesn’t mean lower cost
   - Costs can vary dramatically from year to year for uncontrollable reasons
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3. Identify opportunities to reduce avoidable problems and services for community residents and work with physicians and other providers to take accountability for achieving the savings if payment is adequate
   - Ways to reduce unnecessary visits, testing, and procedures at larger hospitals
   - Enhancements needed to local primary care and preventive services
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   - Ways to reduce unnecessary visits, testing, and procedures at larger hospitals
   - Enhancements needed to local primary care and preventive services

4. Join with the essential small rural hospitals in other states to push for better payment solutions that address both hospital & payer needs
   - Show why simplistic, top-down approaches and current VBP won’t work
   - Propose a new payment model that sustains efficient essential services
Nearly Half of Hospitals Are Rural, Better Pay = Small % of Spending
Questions for Me and Questions for You

• Are there different challenges facing rural hospitals in North Dakota than those I’ve described?

• Do you feel that inpatient services in rural hospitals should be preserved or not?

• Which approach to payment makes the most sense to you?

• If a Standby Capacity Payment or a Global Budget were to be used, how should the “right” amount be determined?
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@PaymentReform
APPENDIX
Improving Payments for Rural Health Clinics
Current Visit-Based Payments for Clinic Services

Weaknesses of Current Payment System
• Medicare only pays 99% of costs, and not all costs are covered
• Only the portion of costs attributed to Medicare patients based on # of visits is covered
Current Visit-Based Payments for Clinic Services

Weaknesses of Current Payment System

- Medicare only pays 99% of costs, and not all costs are covered
- Only the portion of costs attributed to Medicare patients based on # of visits is covered
- Medicaid MCO encounter payments are far below cost of visits

<table>
<thead>
<tr>
<th>Payment</th>
<th>Cost</th>
<th>Medicaid Encounter Payments</th>
<th>Medicare Cost-Based Payment for Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Costs</td>
<td>Costs</td>
<td>Costs Attributed to Medicaid Patients</td>
</tr>
<tr>
<td></td>
<td>Attributed</td>
<td>Attributed</td>
<td>Attributed to Medicare Patients</td>
</tr>
</tbody>
</table>
Current Visit-Based Payments for Clinic Services

Visit-Based Payment

- CostsAttributed to OtherInsured Patients
- CostsAttributed to MedicaidPatients
- CostsAttributed to MedicarePatients

Weaknesses of Current Payment System
- Medicare only pays 99% of costs, and not all costs are covered
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- Medicaid MCO encounter payments are far below cost of visits
- Fee for service payments for insured patients are below cost per visit

Payment Cost

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Current Visit-Based Payments Do Not Cover Costs of Clinic

Weaknesses of Current Payment System

- Medicare only pays 99% of costs, and not all costs are covered
- Only the portion of costs attributed to Medicare patients based on # of visits is covered
- Medicaid MCO encounter payments are far below cost of visits
- Fee for service payments for insured patients are below cost per visit
Is There a Better Way?

Visit-Based Payment

- Insurance Payments for PCP Visits
- Medicaid Encounter Payments
- Medicare Cost-Based Payment for Visits

Costs Attributed to Other Insured Patients
Costs Attributed to Medicaid Patients
Costs Attributed to Medicare Patients

Loss

Questions?
Most Clinic Costs Are Fixed Regardless of # of Visits

Visit-Based Payment

- Medicare Cost-Based Payment for Visits
- Medicaid Encounter Payments
- Insurance Payments for PCP Visits

Costs Attributed to Other Insured Patients
Costs Attributed to Medicaid Patients
Costs Attributed to Medicare Patients

Variable Costs Of Operating Clinic
Fixed Costs Of Operating Clinic

$
Pay a Predictable Amount to Manage Care for Regular Patients

Visit-Based Payment

- Loss
- Insurance Payments for PCP Visits
- Medicaid Encounter Payments
- Medicare Cost-Based Payment for Visits

Costs Attributed to Other Insured Patients
Costs Attributed to Medicaid Patients
Costs Attributed to Medicare Patients

Population-Based Payment

Variable Costs of Operating Clinic
Fixed Costs of Operating Clinic

Risk-Adjusted Monthly Payment Per Enrolled Patient
Pay Per Visit for Occasional Visitors

Visit-Based Payment

- Insurance Payments for PCP Visits
- Medicaid Encounter Payments
- Medicare Cost-Based Payment for Visits
- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicaid Patients
- Costs Attributed to Medicare Patients

Population-Based Payment

- Payment Per Visit for Non-Enrolled Patients
- Risk-Adjusted Monthly Payment Per Enrolled Patient
- Variable Costs Of Operating Clinic
- Fixed Costs Of Operating Clinic

Payment, Cost, Payment, Cost
Base a Portion of Payment on Quality and Access

Visit-Based Payment

- Costs Attributed to Other Insured Patients
- Costs Attributed to Medicaid Patients
- Costs Attributed to Medicare Patients

Population-Based Payment

- Risk-Adjusted Monthly Payment Per Enrolled Patient
- Payment Per Visit for Non-Enrolled Patients

Loss

Payment

Cost

Variable Costs Of Operating Clinic

Fixed Costs Of Operating Clinic

P4P Margin
Population-Based Payment for Primary Care Clinic Services

Visit-Based Payment

- Loss
  - Insurance Payments for PCP Visits
  - Medicaid Encounter Payments
  - Medicare Cost-Based Payment for Visits

Costs Attributed to Other Insured Patients

Costs Attributed to Medicaid Patients

Costs Attributed to Medicare Patients

Population-Based Payment

- P4P Payment Per Visit for Non-Enrolled Patients
  - Risk-Adjusted Monthly Payment Per Enrolled Patient
  - Variable Costs Of Operating Clinic
  - Fixed Costs Of Operating Clinic

Payment

Cost

Margin

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Payment Model for Rural Health Clinics

1. **Comprehensive Primary Care Services Payment (CPCSP)**
   - For patients formally enrolled with the practice, the clinic would receive a monthly, acuity-stratified payment for each patient that could be used to deliver a wide range of services, including services not currently billable or reimbursable under existing payment systems, such as care management and non-face-to-face visits.

2. **Encounter-Based Payment (EBP)**
   - For patients who are not formally enrolled for ongoing care but come to the clinic for specific services, the clinic would receive a per-visit payment.

3. **Performance-Based Payment**
   - The amounts of the CPCSP and EBP payments would be increased or decreased based on the clinic’s performance in delivering quality care and on controlling total healthcare spending.

4. **Optional Additional Monthly Payments**
   - Care Coordination/Management
   - Behavioral Health Services
   - Home Care Services
Clinic Payment Model is Similar to Medicare Medical Home Pmts

<table>
<thead>
<tr>
<th>CMS Comprehensive Primary Care Plus</th>
<th>CAH Primary Care Clinic APM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Primary Care Payment:</strong></td>
<td><strong>Comprehensive Primary Care Services Payment:</strong></td>
</tr>
<tr>
<td>- Per-beneficiary per month payment for attributed patients</td>
<td>- Three tiers of monthly payment per enrolled member based on physical or behavioral health conditions and presence of serious risk factors</td>
</tr>
<tr>
<td>- Payment amounts based on current average FFS payments per beneficiary to the practice, so practices with higher revenues under FFS continue to receive higher revenues</td>
<td></td>
</tr>
<tr>
<td><strong>Care Management Fee:</strong></td>
<td></td>
</tr>
<tr>
<td>- Five tiers of additional monthly payments per attributed beneficiary based on HCC risk scores and presence of dementia</td>
<td></td>
</tr>
<tr>
<td><strong>Performance Based Incentive Payment</strong></td>
<td><strong>Performance-Based Payment</strong></td>
</tr>
<tr>
<td>- Two components based on quality/utilization</td>
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</tr>
<tr>
<td>- Single per patient payment regardless of patient needs; reduced for poor performance</td>
<td>- Payments increased or decreased based on good/poor performance</td>
</tr>
<tr>
<td><strong>Continued FFS Payments</strong></td>
<td><strong>Encounter-Based Payment</strong></td>
</tr>
<tr>
<td>- Payments for all services to all patients but at 35%-60% of current rates</td>
<td>- Payment per visit only for patients who are not enrolled for monthly payment</td>
</tr>
</tbody>
</table>
APPENDIX: Can ACOs Sustain Rural Hospitals?
Most Counties Aren’t Big Enough to Create a Medicare ACO

Minimum of 5,000 Medicare FFS Beneficiaries Needed to Form an ACO
Most Counties in ND Have Far Fewer Than 5,000 Beneficiaries
ACOs Are Expected to Reduce the Total Cost of Care for a Population

NOTE: Graph is not drawn to scale.
Medicare Spends Far Less in Most ND Counties Than U.S.
Less Opportunity to Reduce Spending Than Other States

Inpatient Stays Per 1000 Medicare Beneficiaries, North Dakota Counties, 2017
Most Spending on Rural Patients Isn’t From Rural Hospital Services

TODAY

Payer Spending

Spending Per Patient

Total Spending on Residents of a Rural Community

Services at Rural Hospital (25%)

Services Delivered by Other Hospitals and Providers (75%)

FUTURE

NOTE: Graph is not drawn to scale

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If Spending on Services Elsewhere Could Be Reduced…

**TODAY**

Total Spending on Residents of a Rural Community

- Services at Rural Hospital (25%)

**FUTURE**

Services Delivered by Other Hospitals and Providers (75%)

- Services at Rural Hospital

NOTE: Graph is not drawn to scale

Payer Spending

Spending Per Patient

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...Enough to Meet the Minimum for Receiving Shared Savings...

**TODAY**

- **Total Spending on Residents of a Rural Community**
  - Services Delivered by Other Hospitals and Providers (75%)
  - Services at Rural Hospital (25%)

**FUTURE**

- Services Delivered by Other Hospitals and Providers (75%)
- Services at Rural Hospital

-5%

Minimum savings required for ACOs with 5,000 members to qualify for shared savings

**NOTE:** Graph is not drawn to scale
...Shared Savings Could Increase Revenue for the Rural Hospital

NOTE: Graph is not drawn to scale

TODAY

- Total Spending on Residents of a Rural Community
  - Services at Rural Hospital (25%)
  - Services Delivered by Other Hospitals and Providers (75%)

FUTURE

- Services Delivered by Other Hospitals and Providers (75%)
- Revenues at Rural Hospital

-5% reduction in spending

-3.9% reduction in total spending

50% share of a 3.9% reduction in total spending would increase rural hospital revenues by 8%
But If Rural Hospital Can’t Ensure Savings From Other Providers…

**TODAY**

- Total Spending on Residents of a Rural Community
  - Services Delivered by Other Hospitals and Providers (75%)
  - Services at Rural Hospital (25%)

**FUTURE**

- Services Delivered by Other Hospitals and Providers
- Services at Rural Hospital

+5%

NOTE: Graph is not drawn to scale
...It Wouldn’t Qualify for Shared Savings Payments...

TODAY

Total Spending on Residents of a Rural Community

Services at Rural Hospital (25%)

Spending Per Patient

FUTURE

Services Delivered by Other Hospitals and Providers (75%)

+5%

Services at Rural Hospital

+3.75%

Services Delivered by Other Hospitals and Providers

NOTE: Graph is not drawn to scale
...And Harm the Hospital if Downside Risk is Required

TODAY

<table>
<thead>
<tr>
<th>Spending Per Patient</th>
<th>Payer Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Spending on Residents of a Rural Community</strong></td>
<td>Services Delivered by Other Hospitals and Providers (75%)</td>
</tr>
<tr>
<td><strong>Services at Rural Hospital (25%)</strong></td>
<td><strong>CMS Penalty</strong></td>
</tr>
<tr>
<td><strong>Revenues at Rural Hospital</strong></td>
<td>+3.75%</td>
</tr>
</tbody>
</table>

FUTURE

- 50% risk for a 3.75% increase in total spending would reduce the rural hospital’s annual revenues by 7.5%
Rural Hospital’s Own Services Would Need Large Decreases…

Today

- Total Spending on Residents of a Rural Community
- Services Delivered by Other Hospitals and Providers (75%)
- Services at Rural Hospital (25%)

Future

- Services at Rural Hospital
- 16% Decrease

NOTE: Graph is not drawn to scale.
...To Achieve Minimum Savings Needed for Shared Savings...

NOTE: Graph is not drawn to scale

Minimum savings required for ACOs with 5,000 members to qualify for shared savings

- Total Spending on Residents of a Rural Community
- Services Delivered by Other Hospitals and Providers (75%)
- Services at Rural Hospital (25%)
- Future Services Delivered by Other Hospitals and Providers (75%)
- Services at Rural Hospital

-16% 

-3.9%
…But Hospital Ends Up Worse Off Than It Started…

Graph is not drawn to scale.

50% share of a 3.9% reduction in total spending would restore only half of the revenue lost from delivering fewer services.
APPENDIX:
How CMS Episode Payments Could Harm Rural Hospitals
Expensive SNF Stays in Rural Hospitals = Savings for Others

YEAR 0  YEAR 1  YEAR 2-3

Payer Savings

Loss for SNF Provider

Episode Payment Programs:
BPCI Advanced
CJR
Also ACOs

Chart Not Drawn to Scale