CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

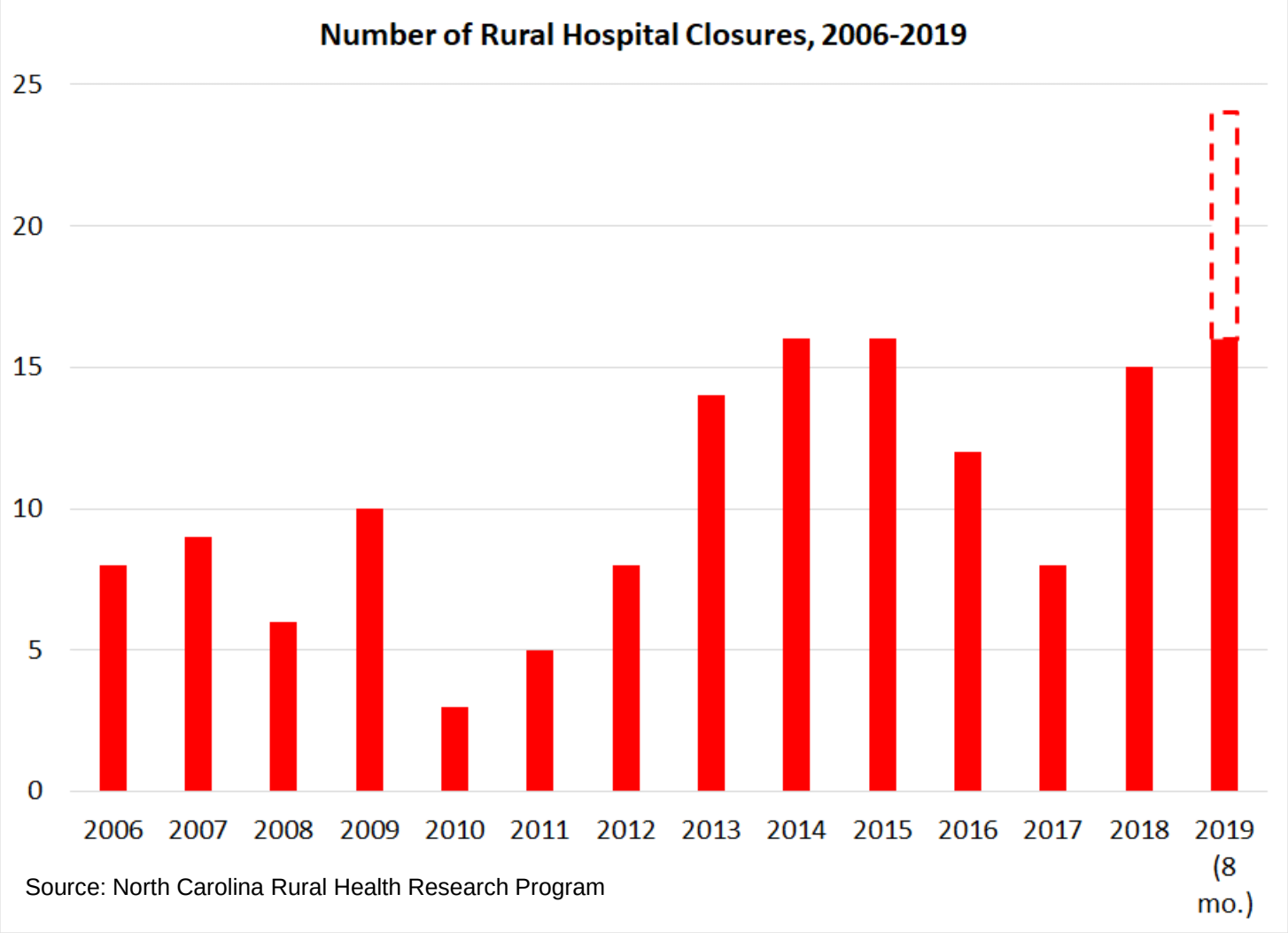
BETTER WAYS TO PAY RURAL HOSPITALS & PHYSICIANS

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



Growing National Awareness of the Issue

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February 20, 2019 12:00 AM

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

ALEX KACIK

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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 2,045 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 Cecil G. Sheps Center for Health Services Research.

As rural populations decline, inpatient admissions fall, more beds sit vacant, 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 DeBehnke, a Navigant managing director, co-author of the report and former CEO of the Omaha-based Nebraska Medicine system.

The New York Times

THE NEW HEALTH CARE

A Sense of Alarm as Rural Hospitals Keep Closing

ssociated

n. But hospital closings are rising,

unities are hardest hit," said Katy
University of Minnesota.

rby, hospital closings can exact
t to expand Medicaid as part of

estimate, hundreds of other rural

mmission found that of the 67
an 20 miles from the next closest

he University of Minnesota found
r study, published in Health
e pregnant women must travel

-risk, preterm births are more
stetric units without closing the

are maternity care deserts in
n and their babies at risk."

Rural hospital closings cause mortality rates to rise, study finds

Populations served by rural hospitals – which have limited access to health care and other services – saw mortality rates rise 5.9 percent after a hospital closed.

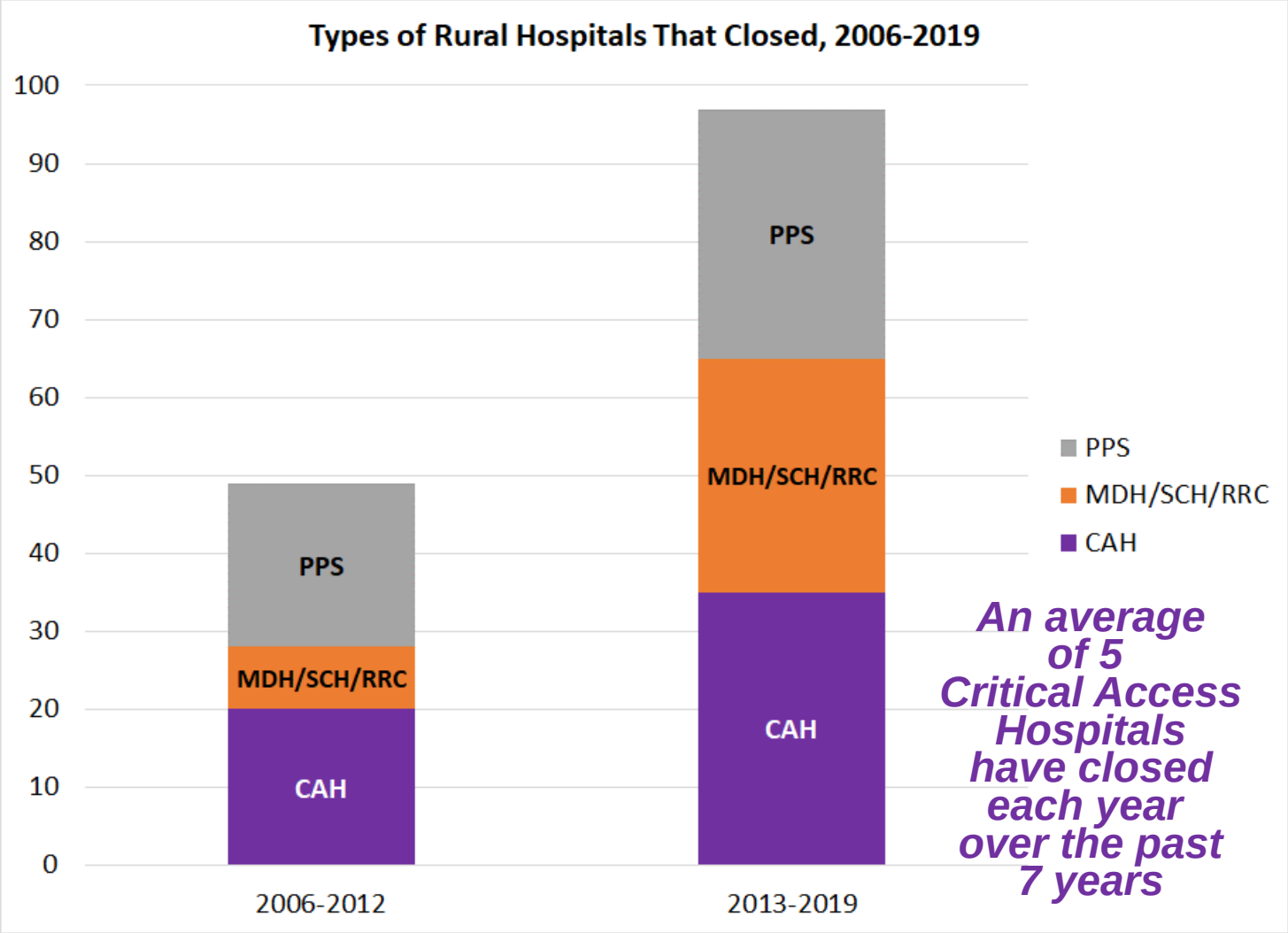
Mayor Adam O'Neal of Belhaven, N.C., leads a rally for rural hospitals in Washington on June 15, 2015.
Brendan Smialowski / AFP - Getty Images file

Sept. 6, 2019, 10:23 AM EDT

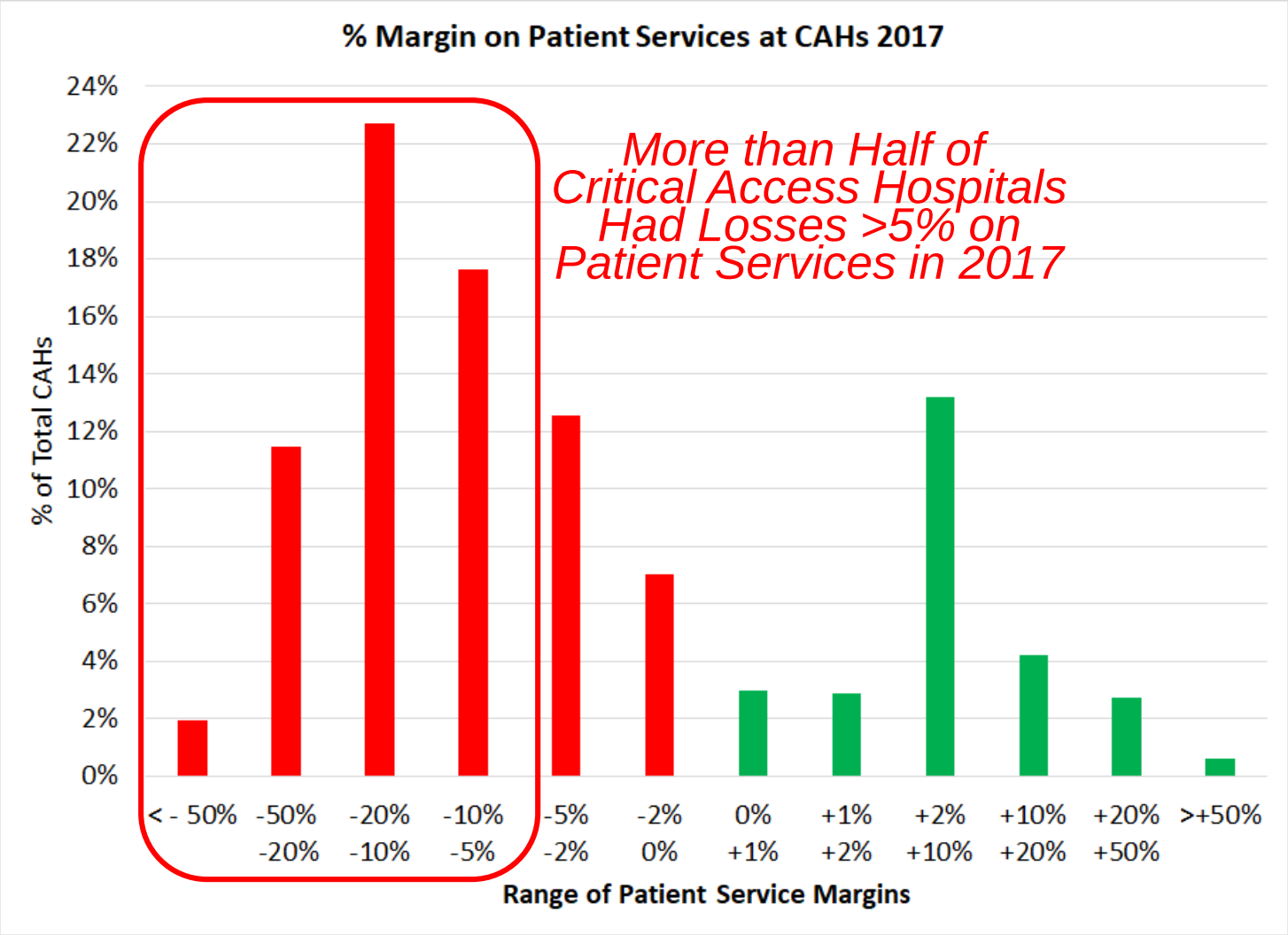
By Phil McCausland

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

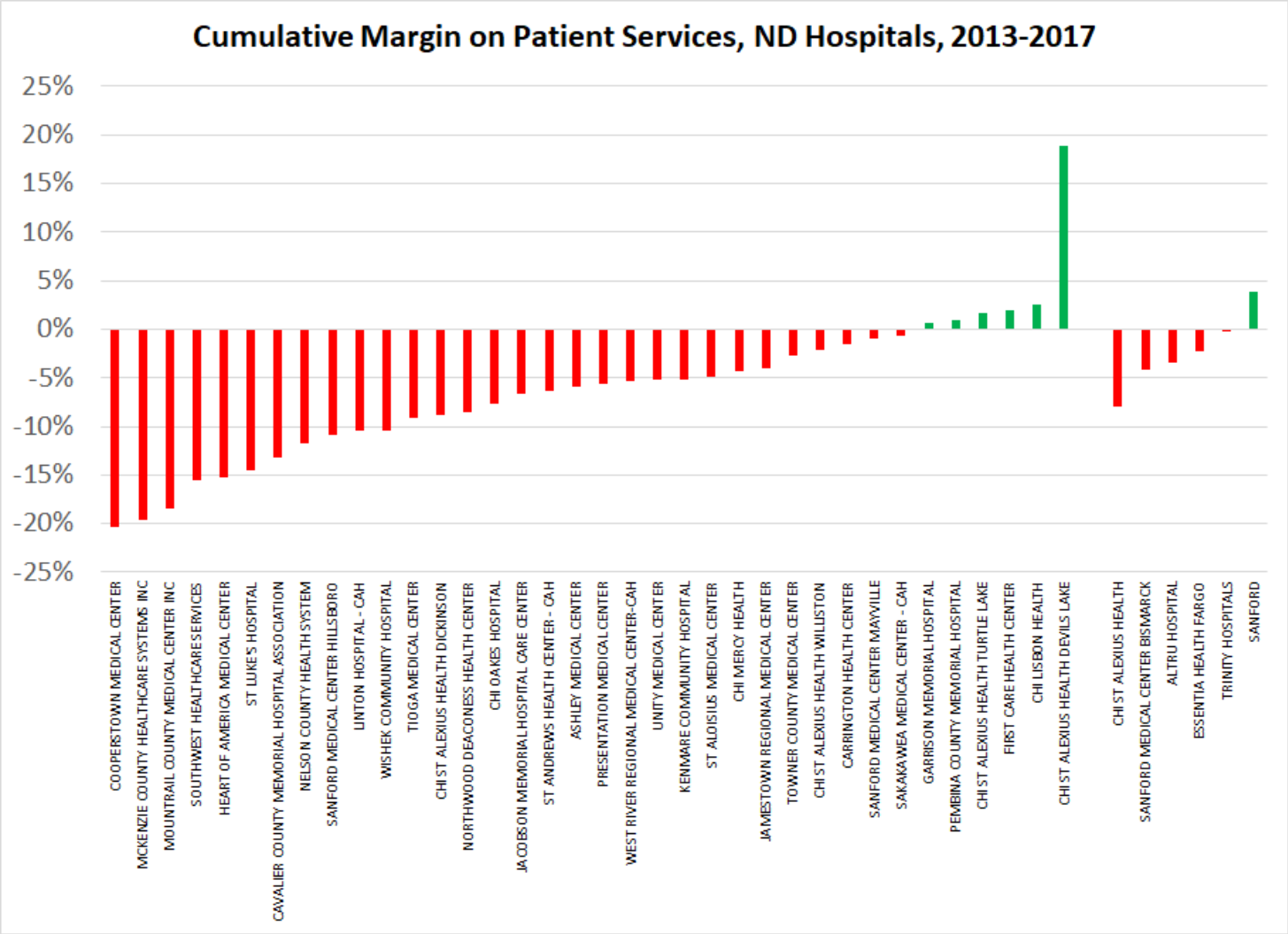


It's Surprising More CAHs Haven't Closed With So Many Losses



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

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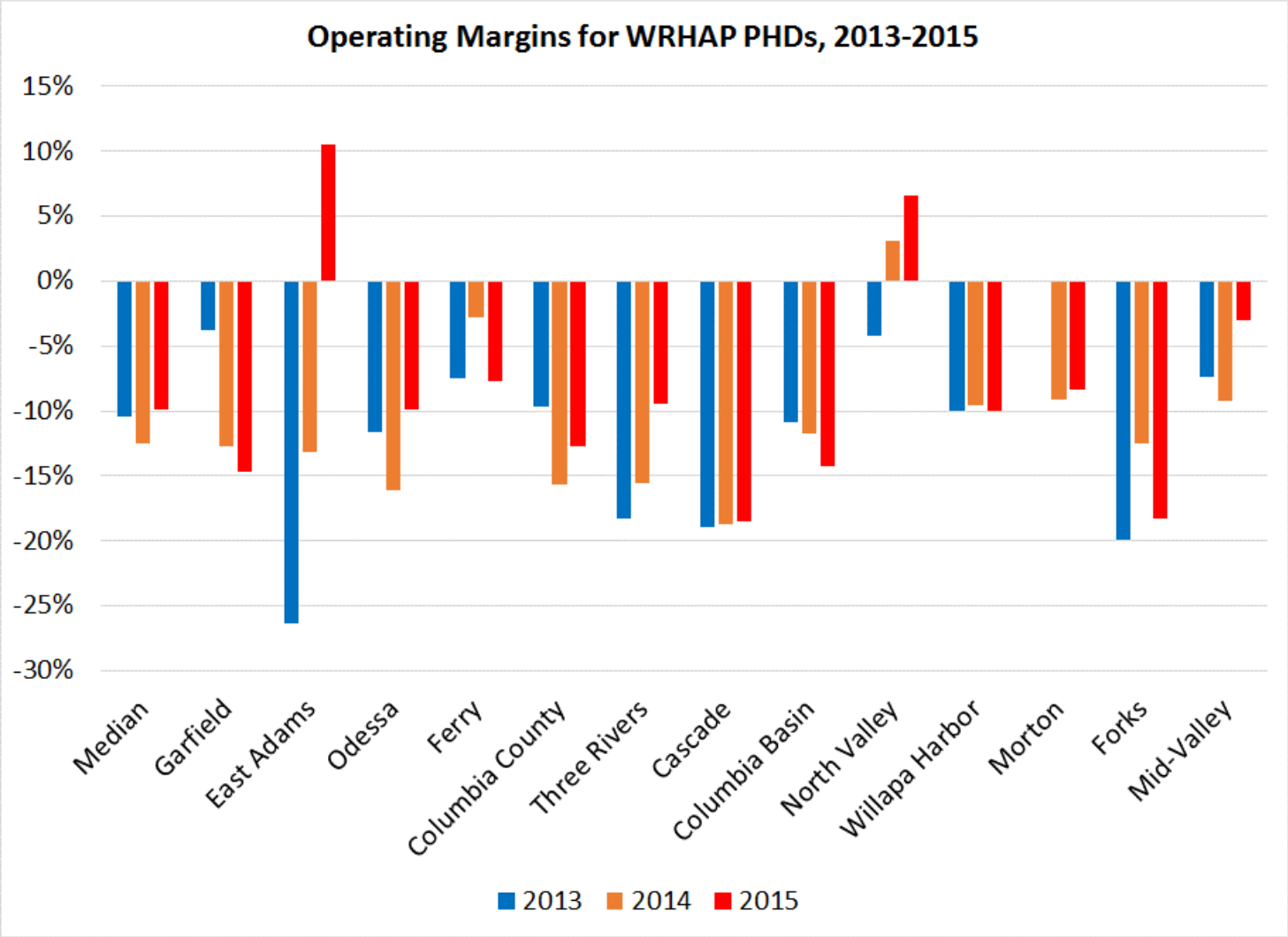
- **Data Obtained to Help Answer That Question**
  - 10 CAHs in Washington State provided more detailed information on net revenues by service line and by payer for 2015
    - "WRHAP" – Washington Rural Health Access Project
  - 3 CAHs in Alaska provided similar information for 2017

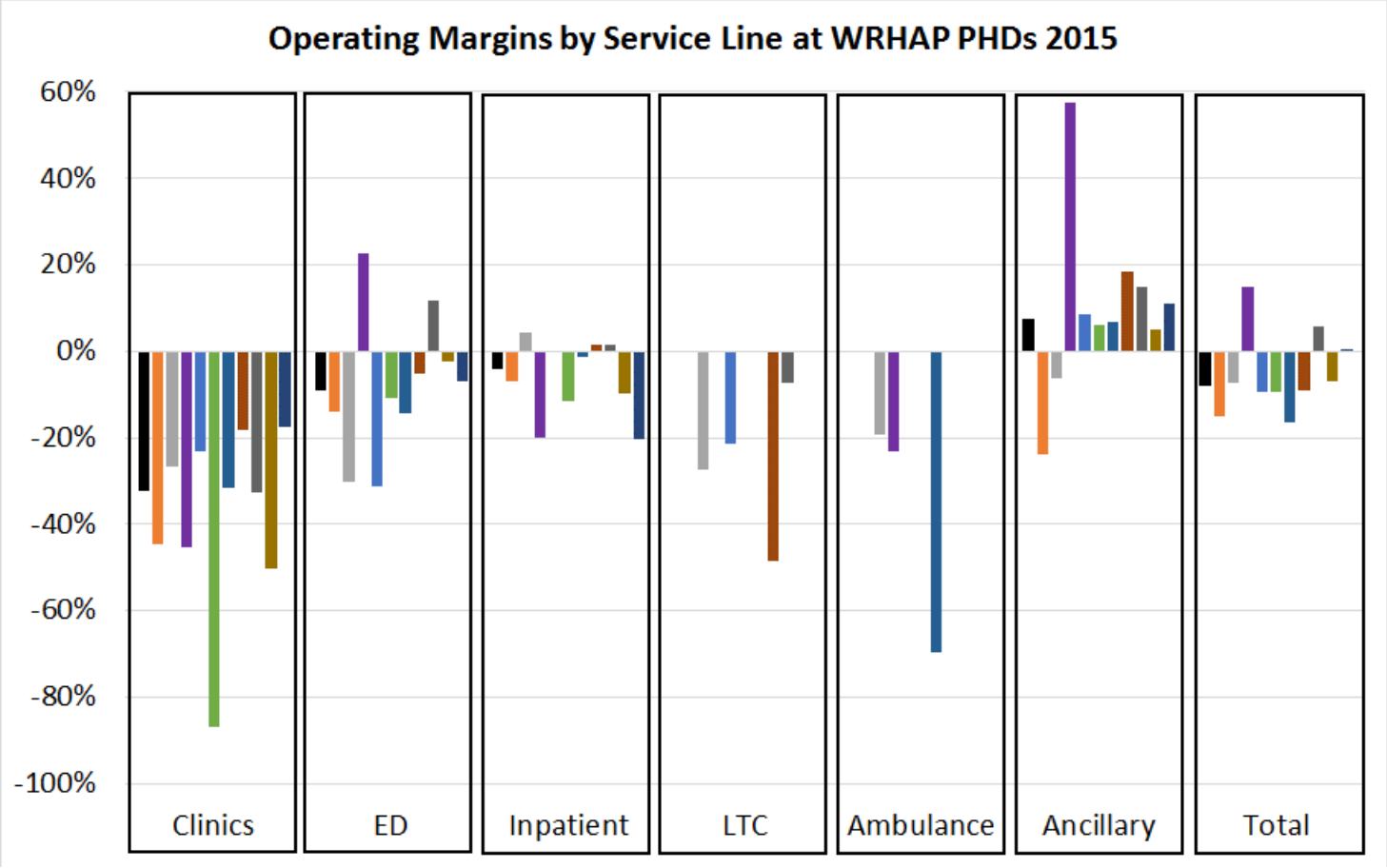
Large Annual Losses at WA CAHs That Provided Data



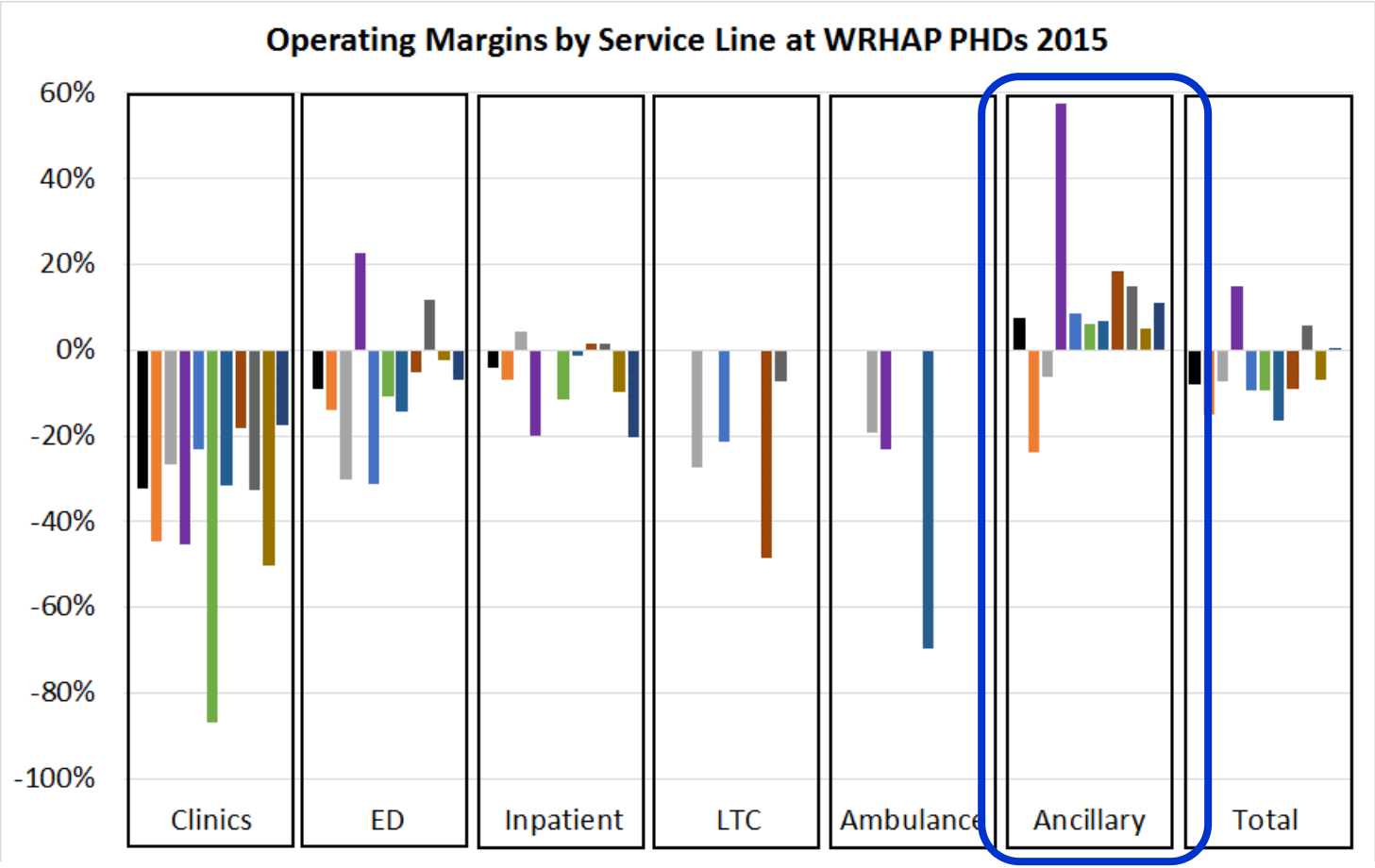
Findings: 5 Service Lines Cause Hospital Deficits

- **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

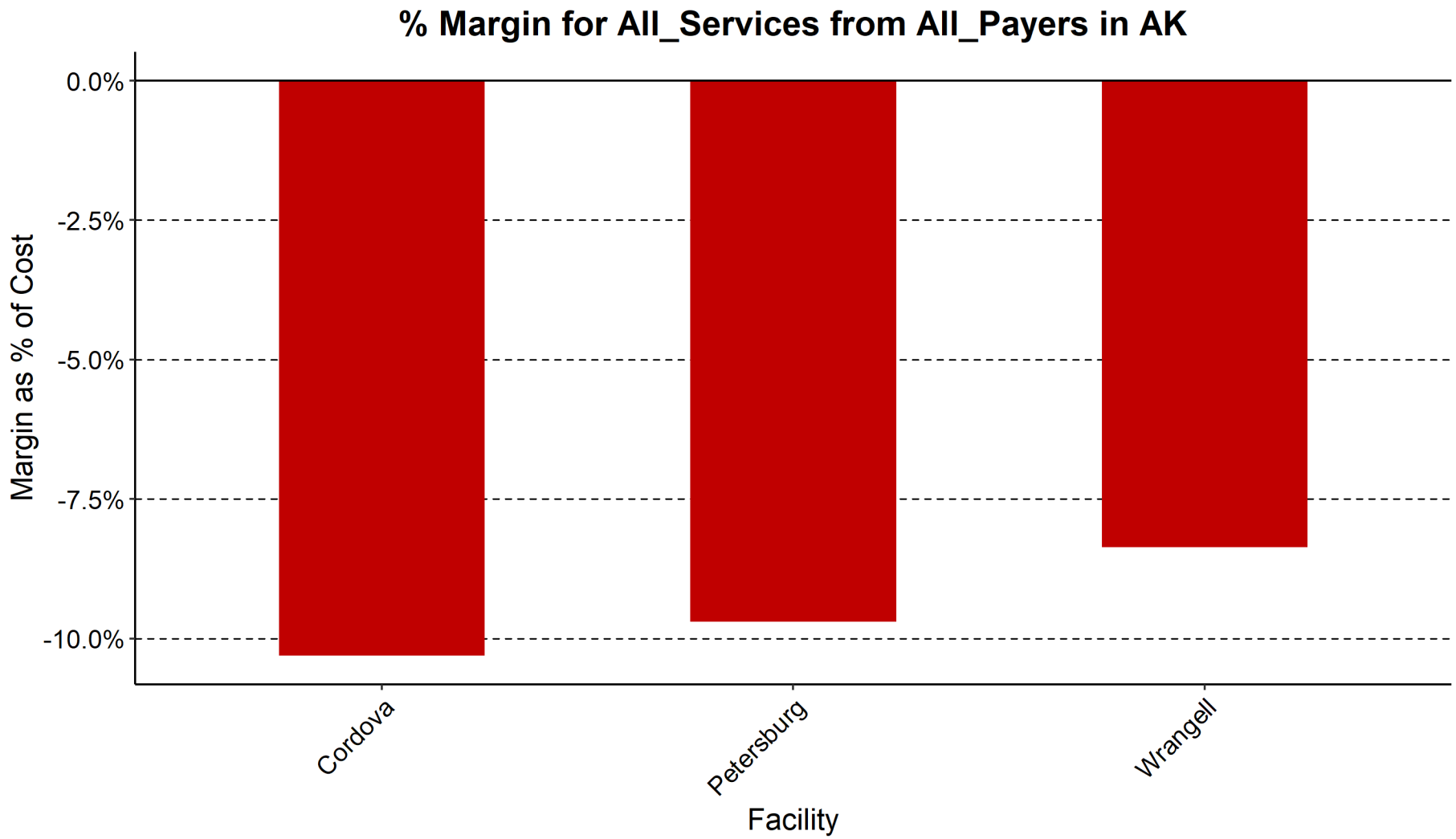
Operating Margins by Service Line



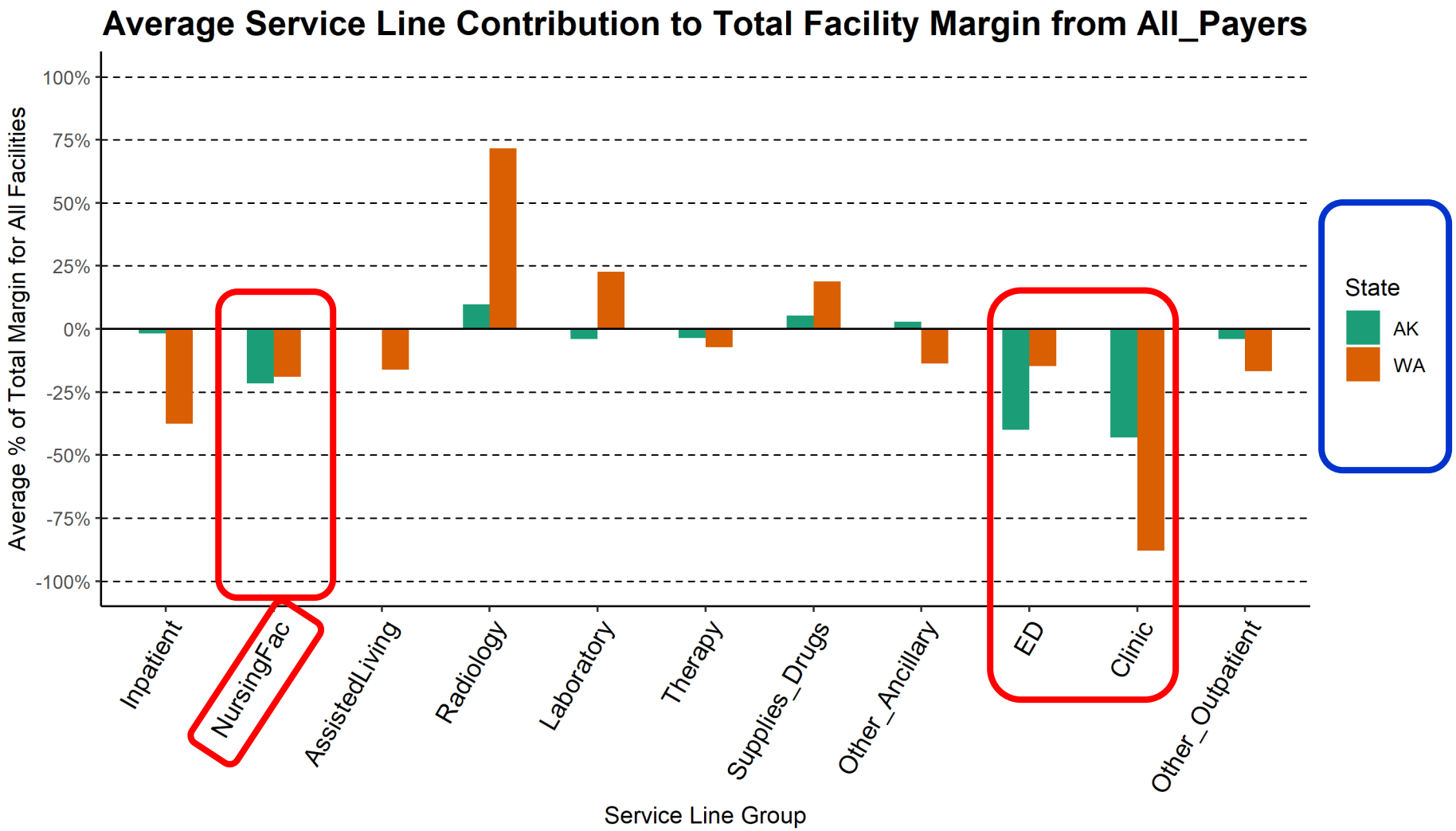
Profits on Ancillary Services Offset a Portion of Other Losses



8-10% Deficit in 2017 at the 3 Alaska Hospitals Analyzed



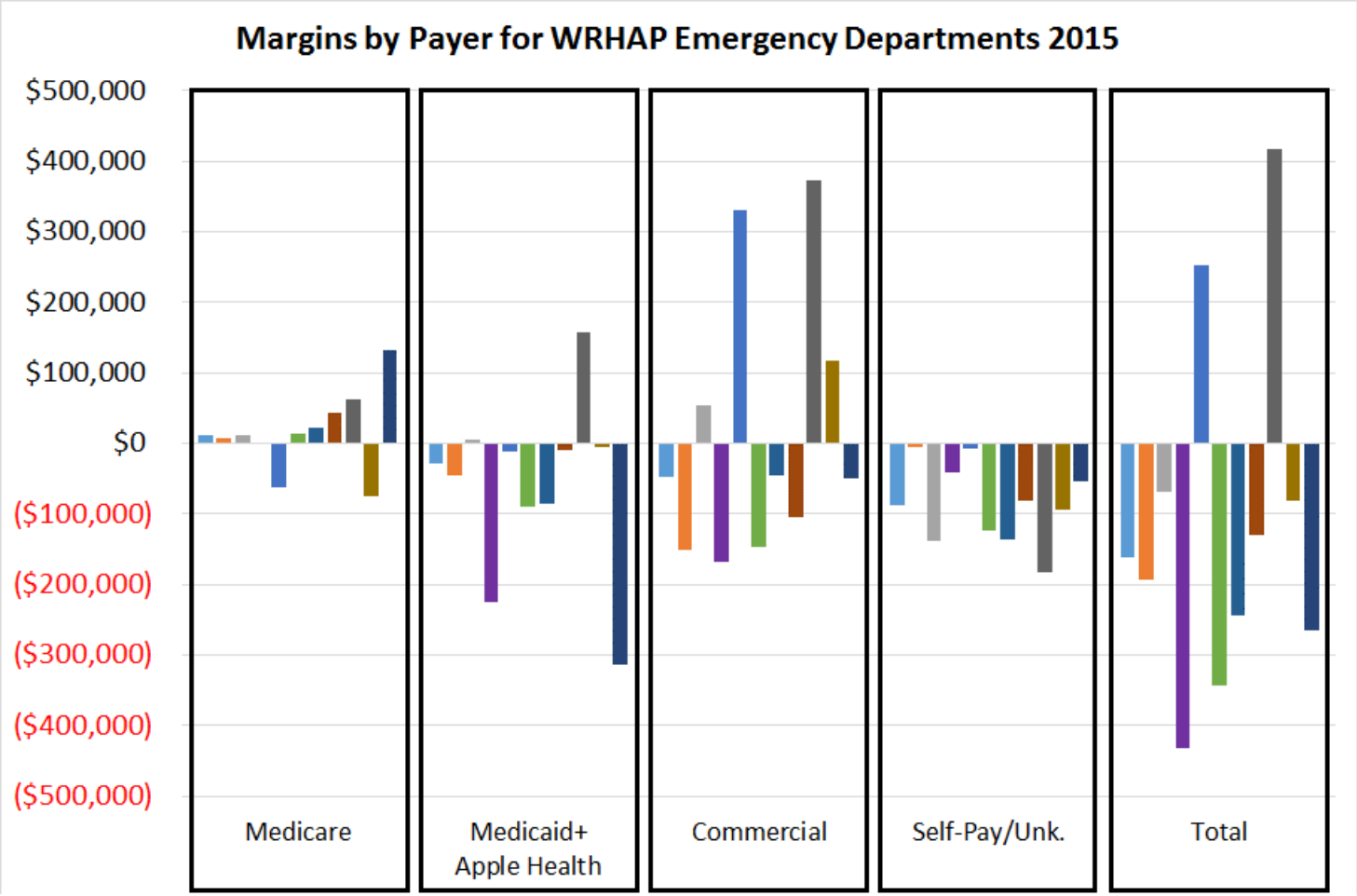
Clinic, ED, and Nursing Facilities Problems In Both WA and Alaska



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

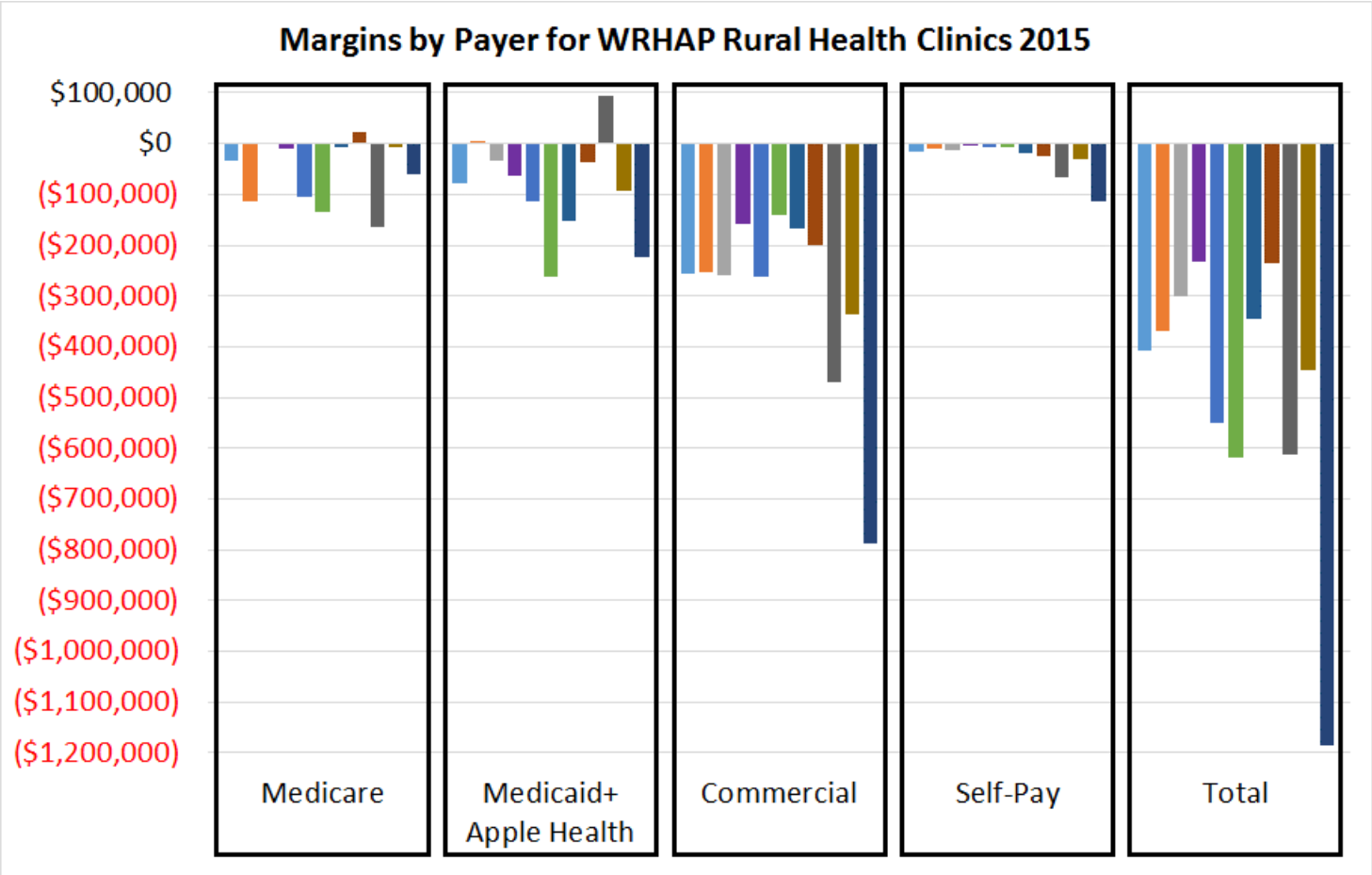
ED Visit Margins by Payer



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



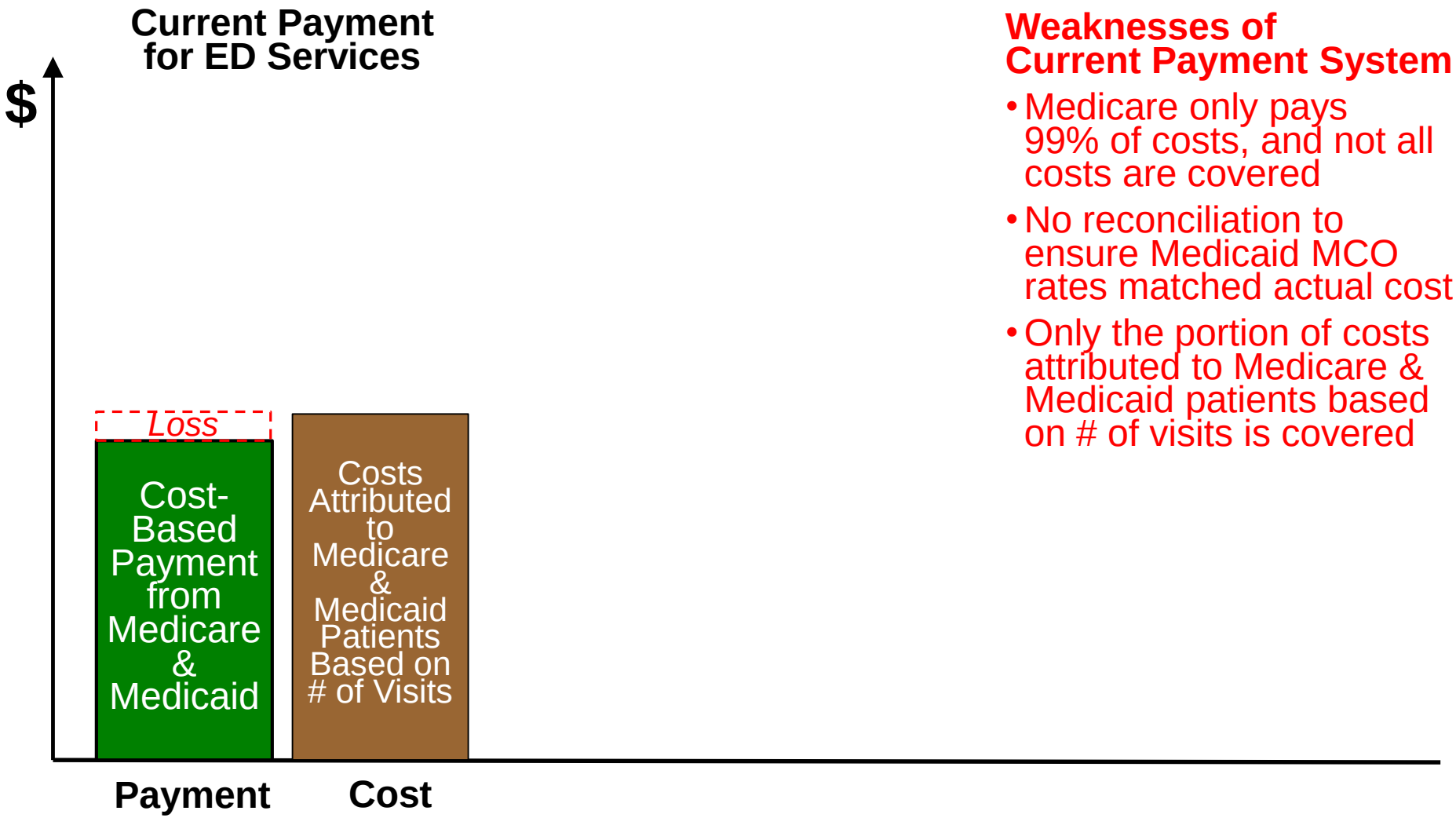
Causes of Deficits in Long-Term Care Services

- 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

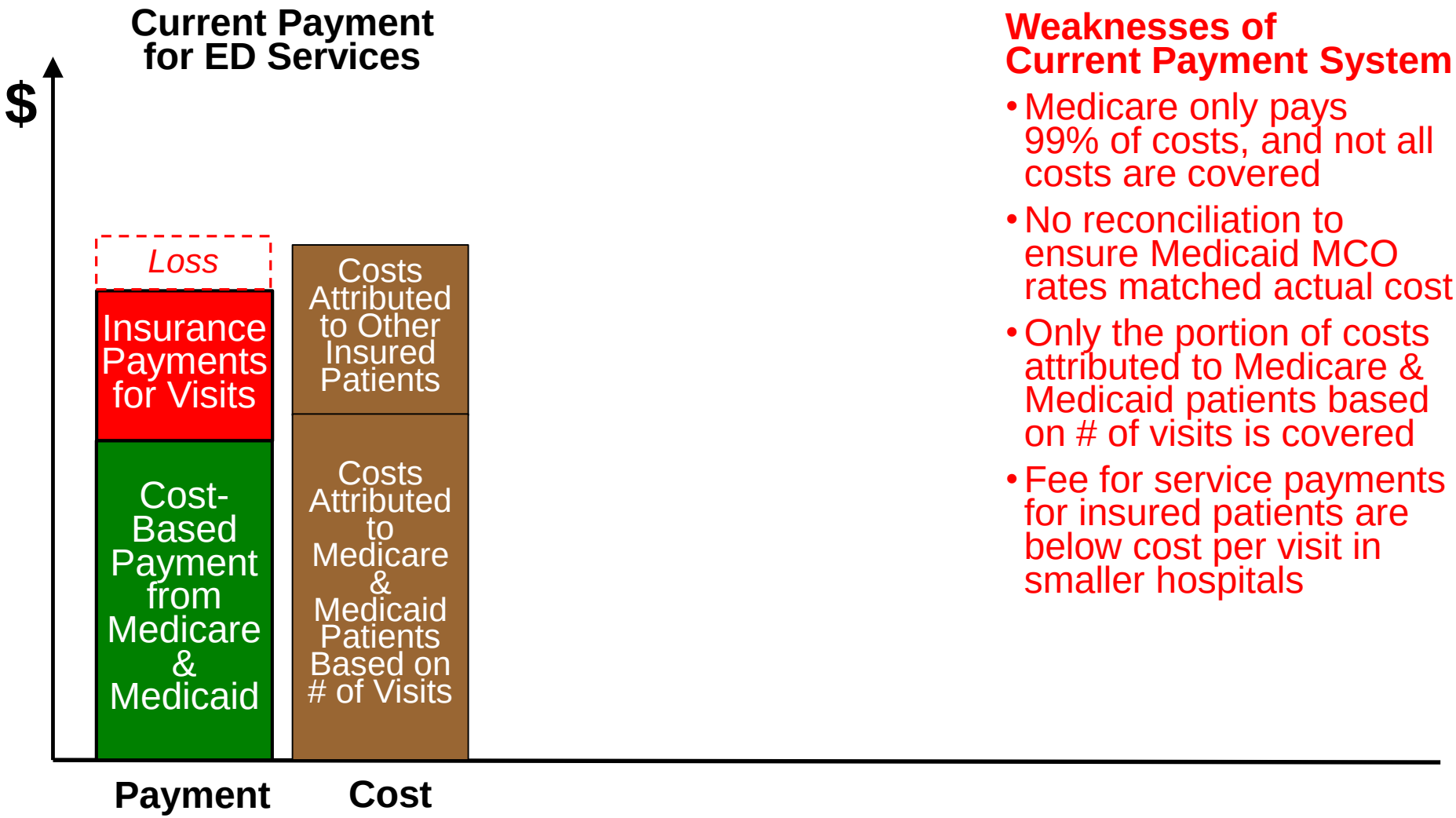
"Cost-Based Payment" Isn't As Good As It Sounds



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

Insurance Payments for Visits May or May Not Cover Cost



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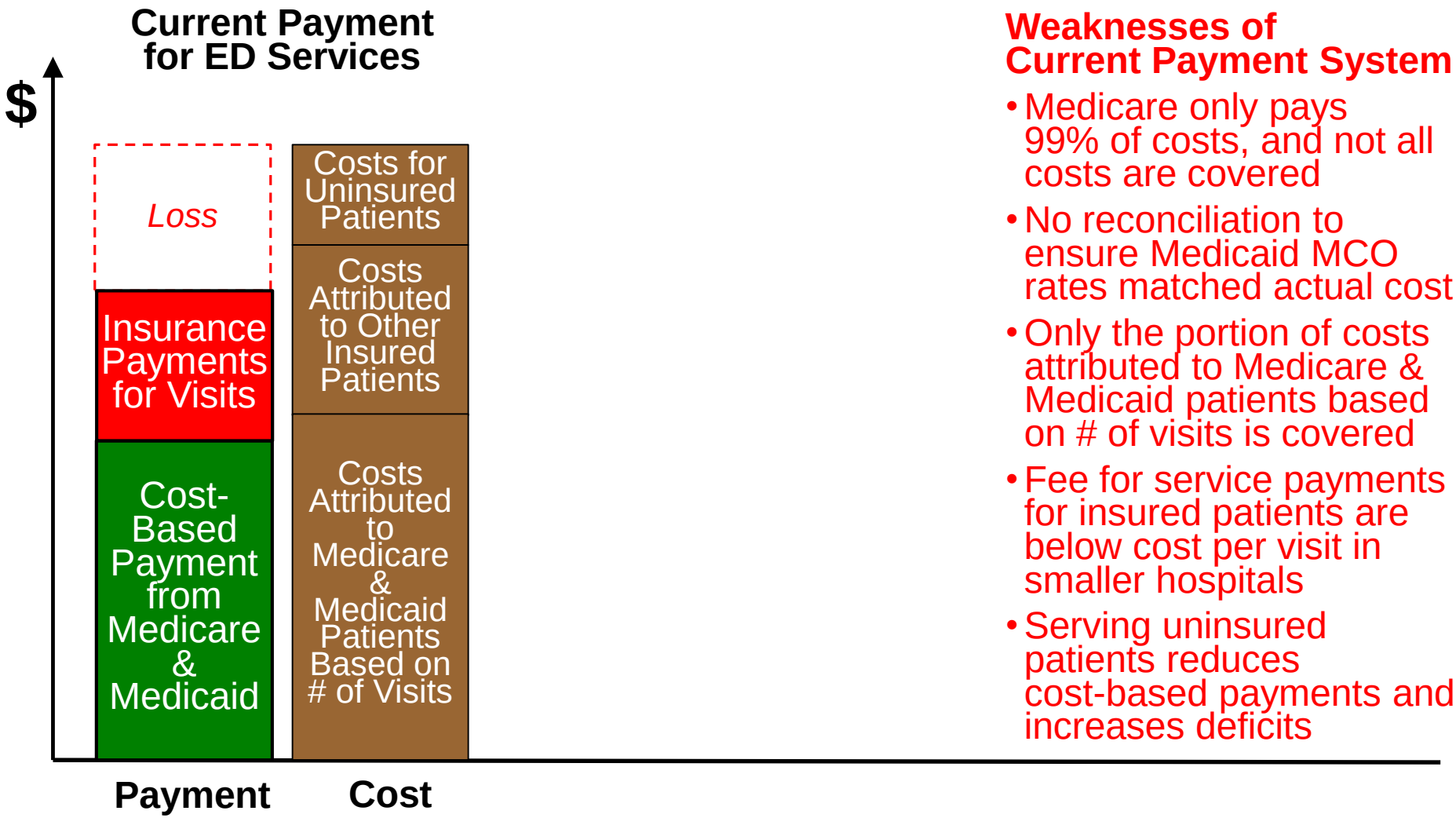
Nobody Covers the Cost Attributed to Uninsured Patients



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- Serving uninsured patients reduces cost-based payments and increases deficits

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"

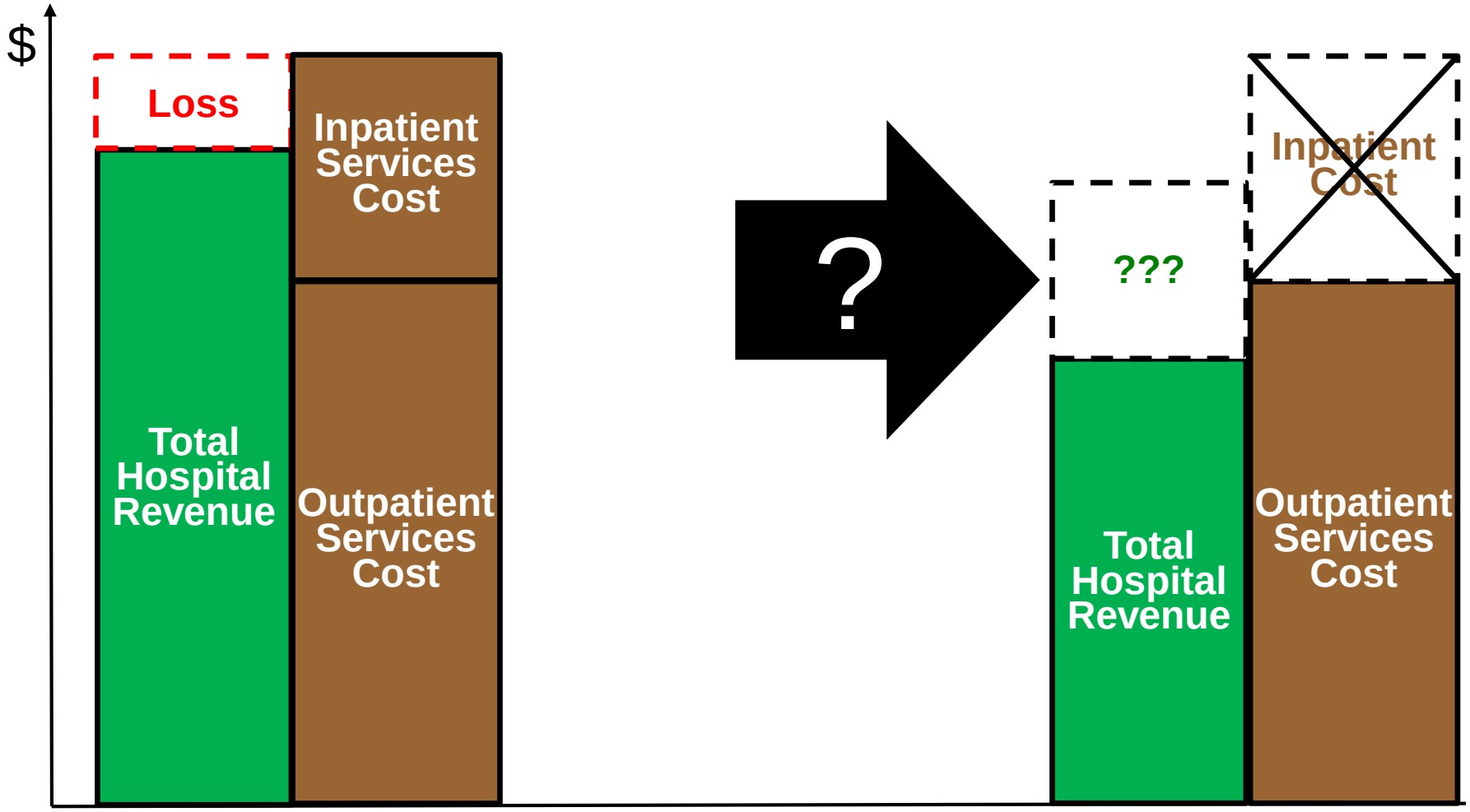
FIGURE 2–B1

Map of isolated low-volume hospitals, 2017

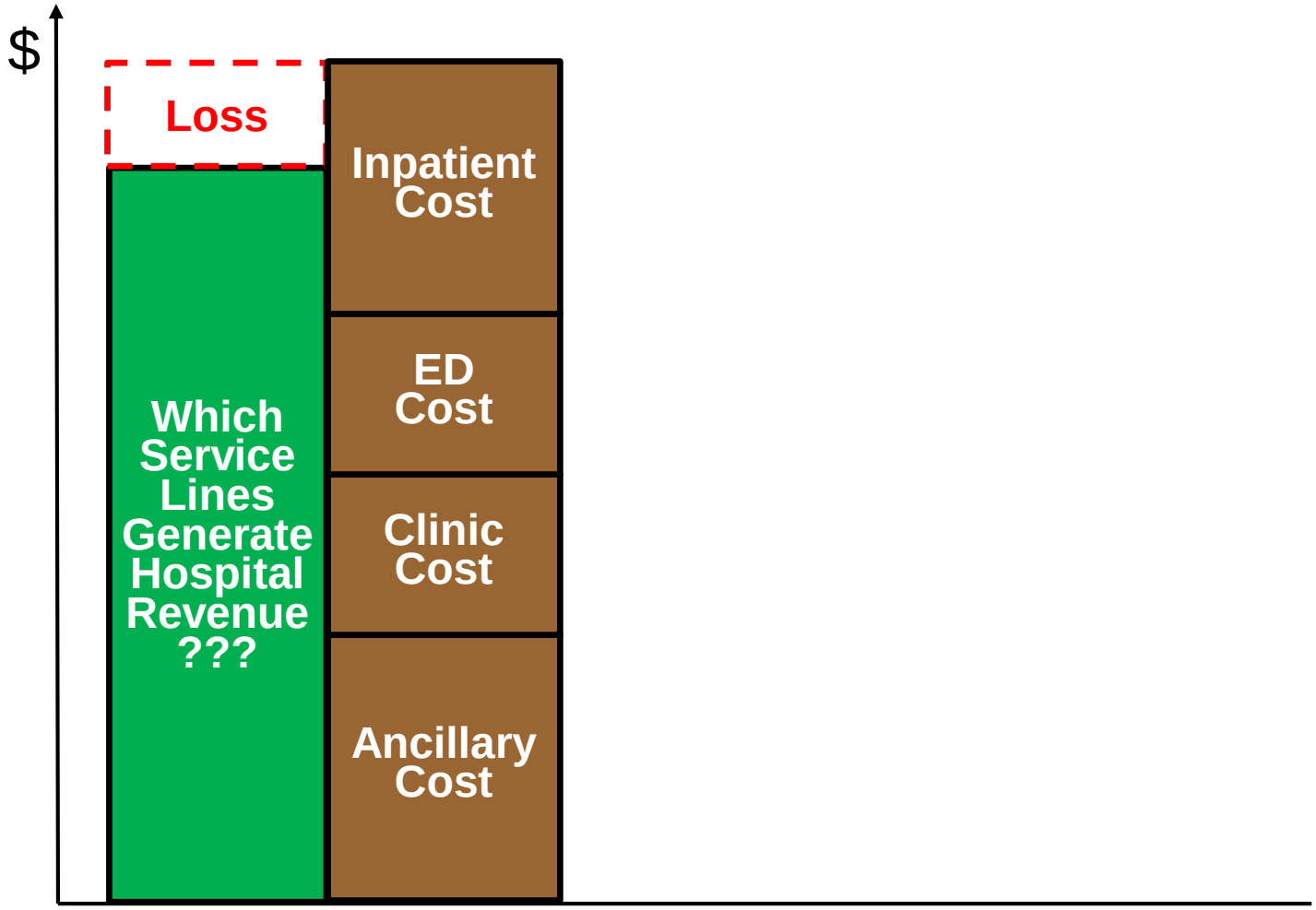
Source: MedPAC analysis of hospital closures from 2010 to 2017 and CMS inpatient claims files from 2016.

SOURCE:
MedPAC June 2018
Report to Congress
Appendix 2B

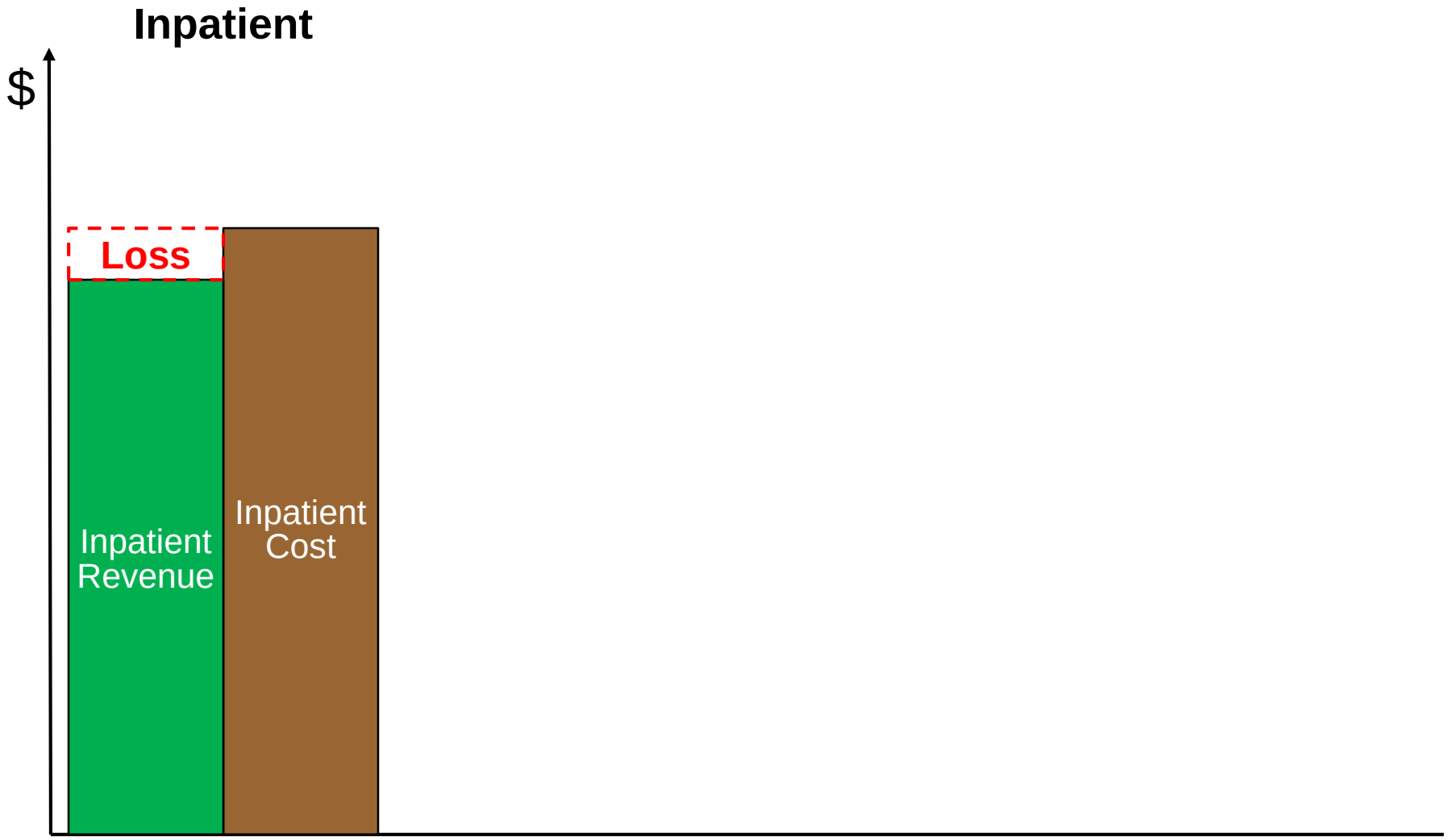
Would Rural Hospitals Be Better Off Without Inpatient Services?



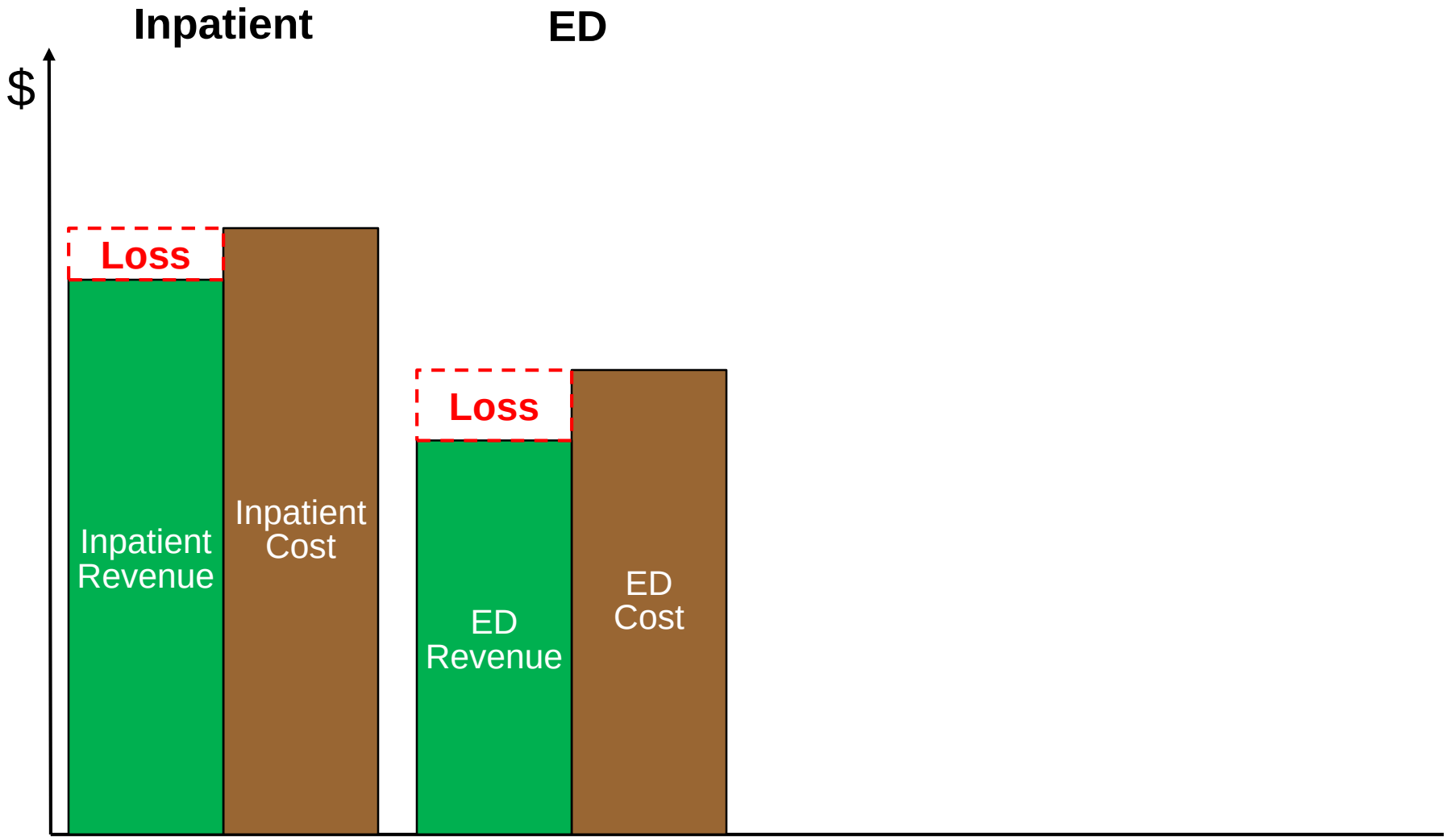
Would the Hospital Be Profitable On Outpatient Services Alone?



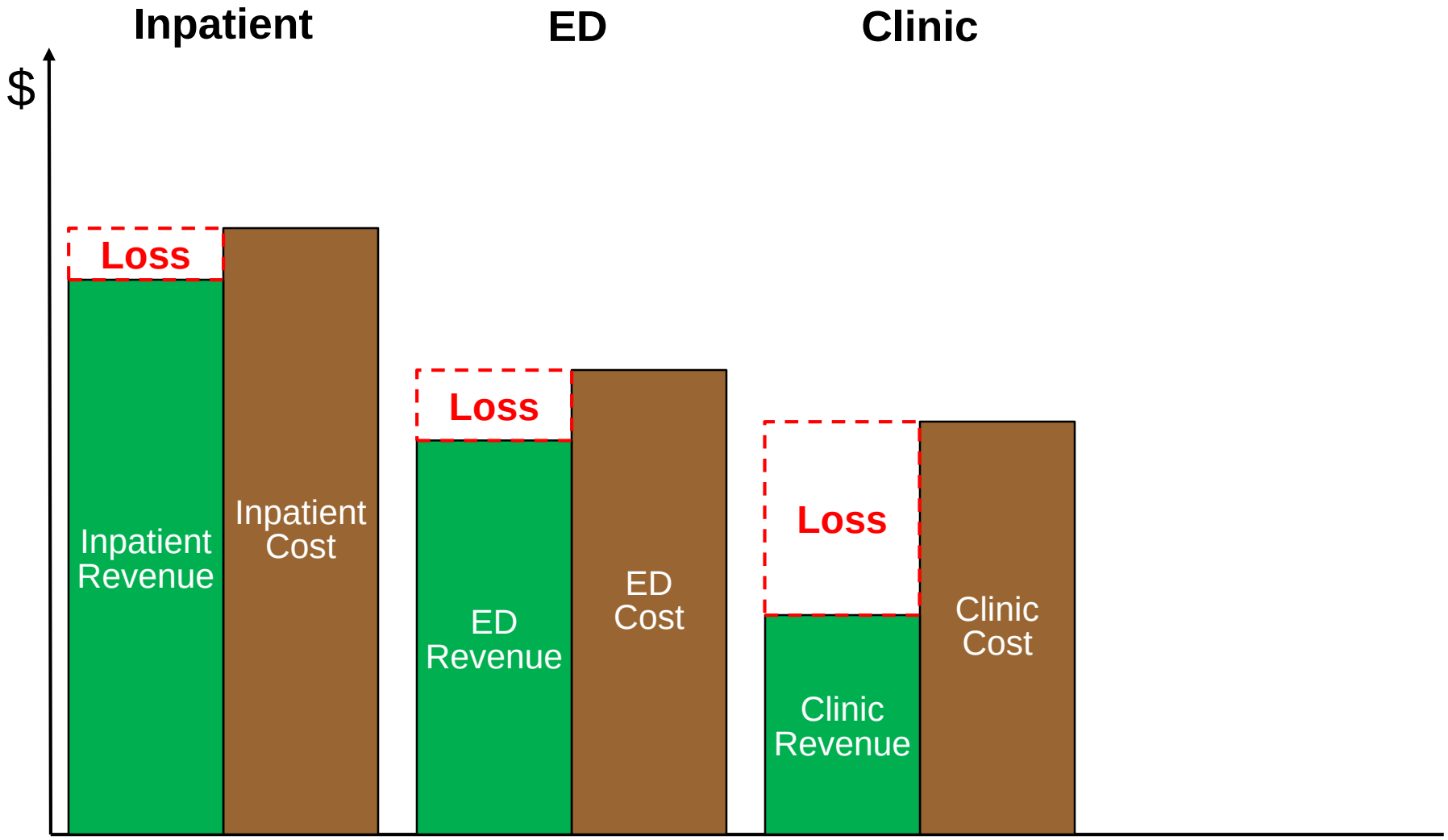
Findings: Inpatient Services Aren't Profitable at Small Hospitals



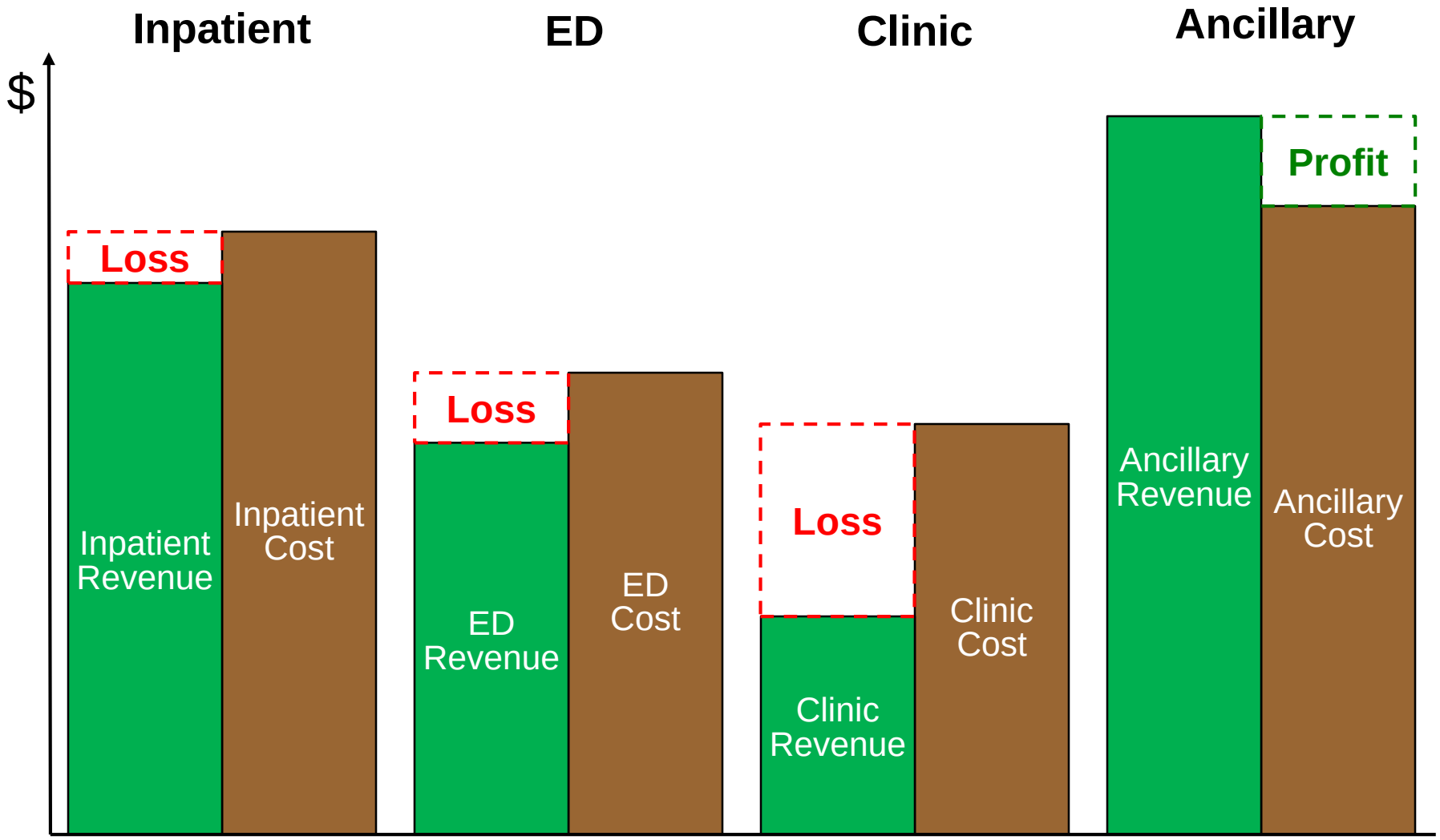
Findings: Rural Hospitals Lose More Money on Their EDs



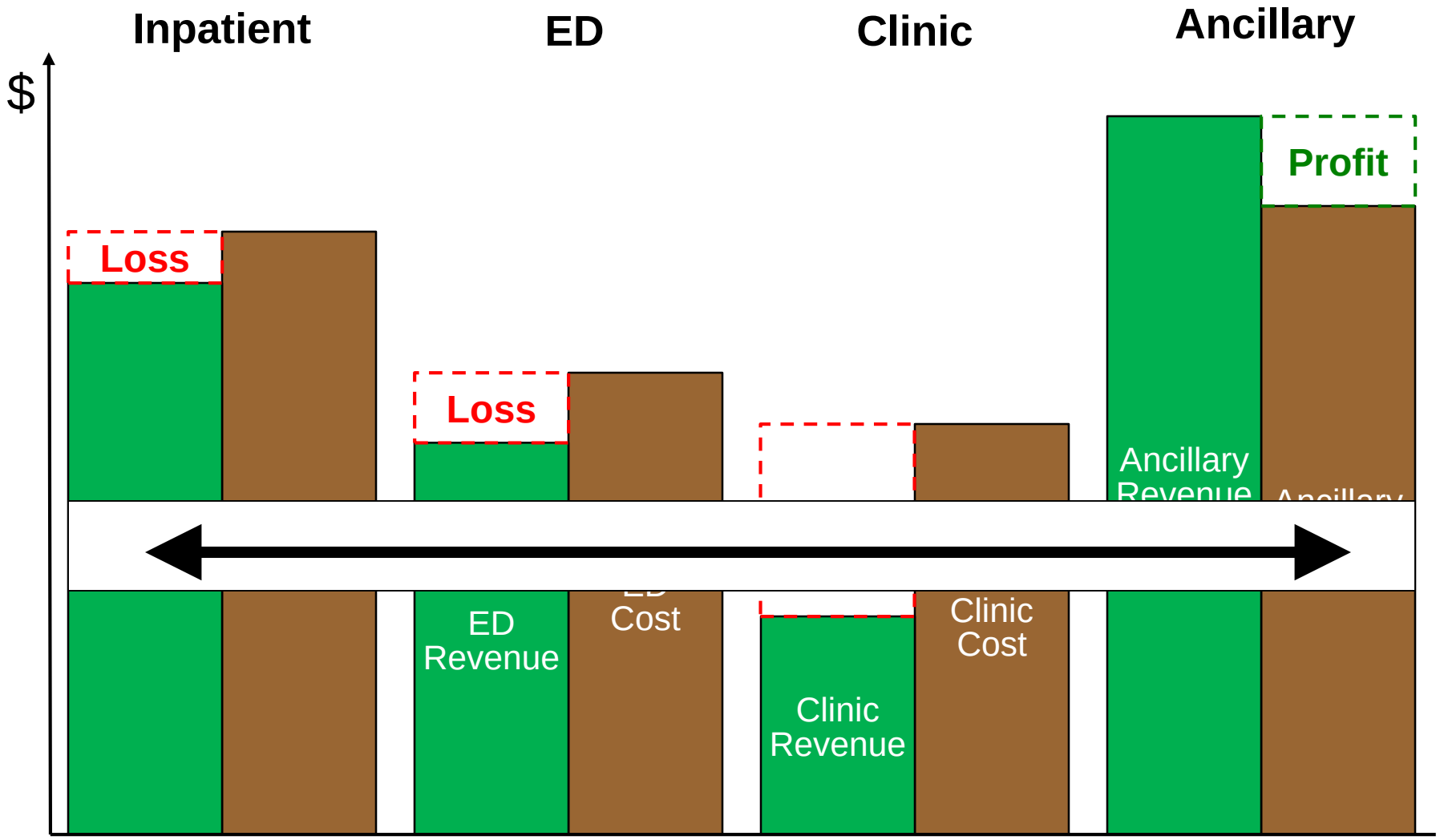
Findings: Rural Hospitals Lose More Money on their Clinics



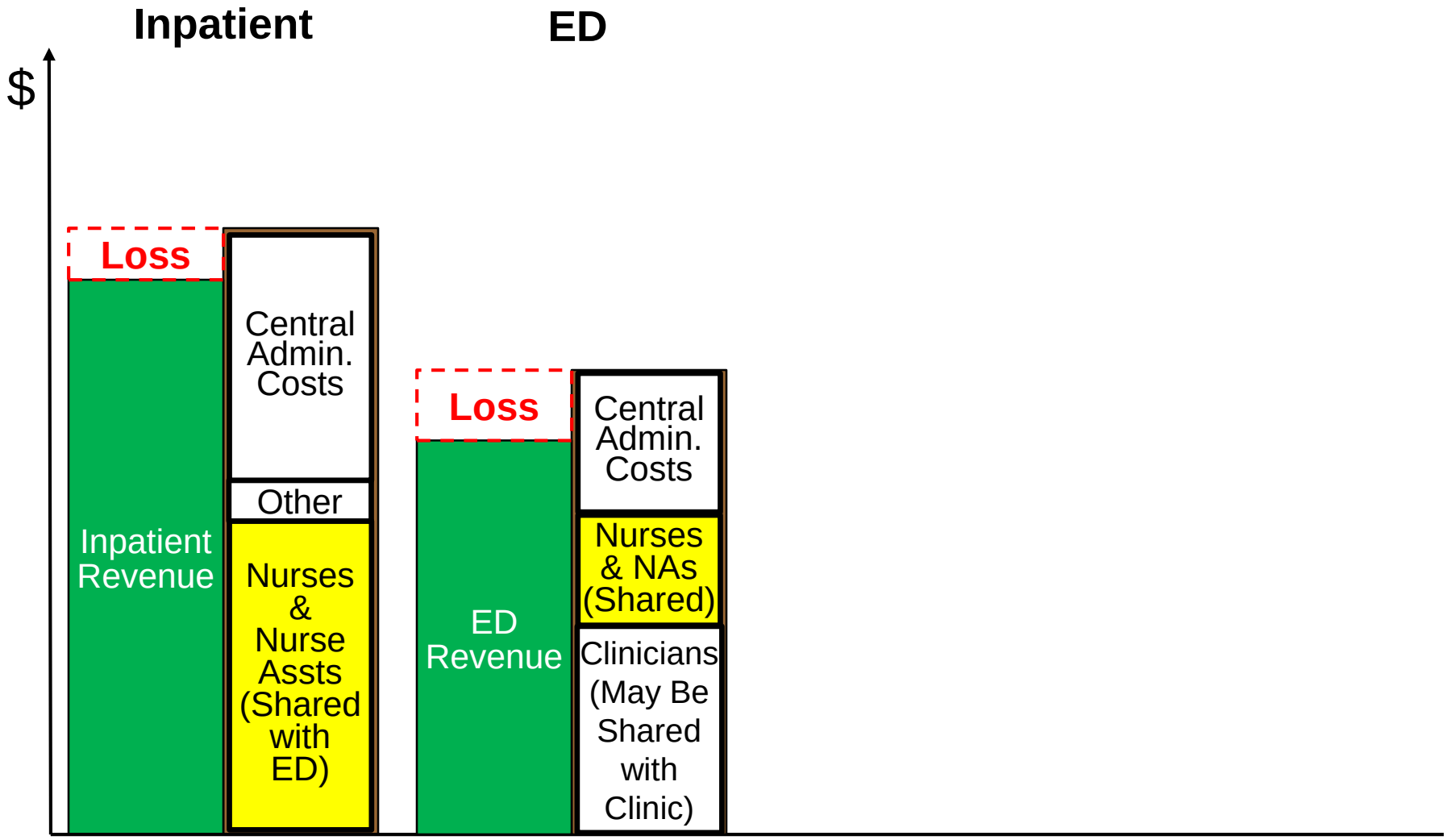
The One Thing That Helps Float the Boat is Ancillaries (Lab/Rad)



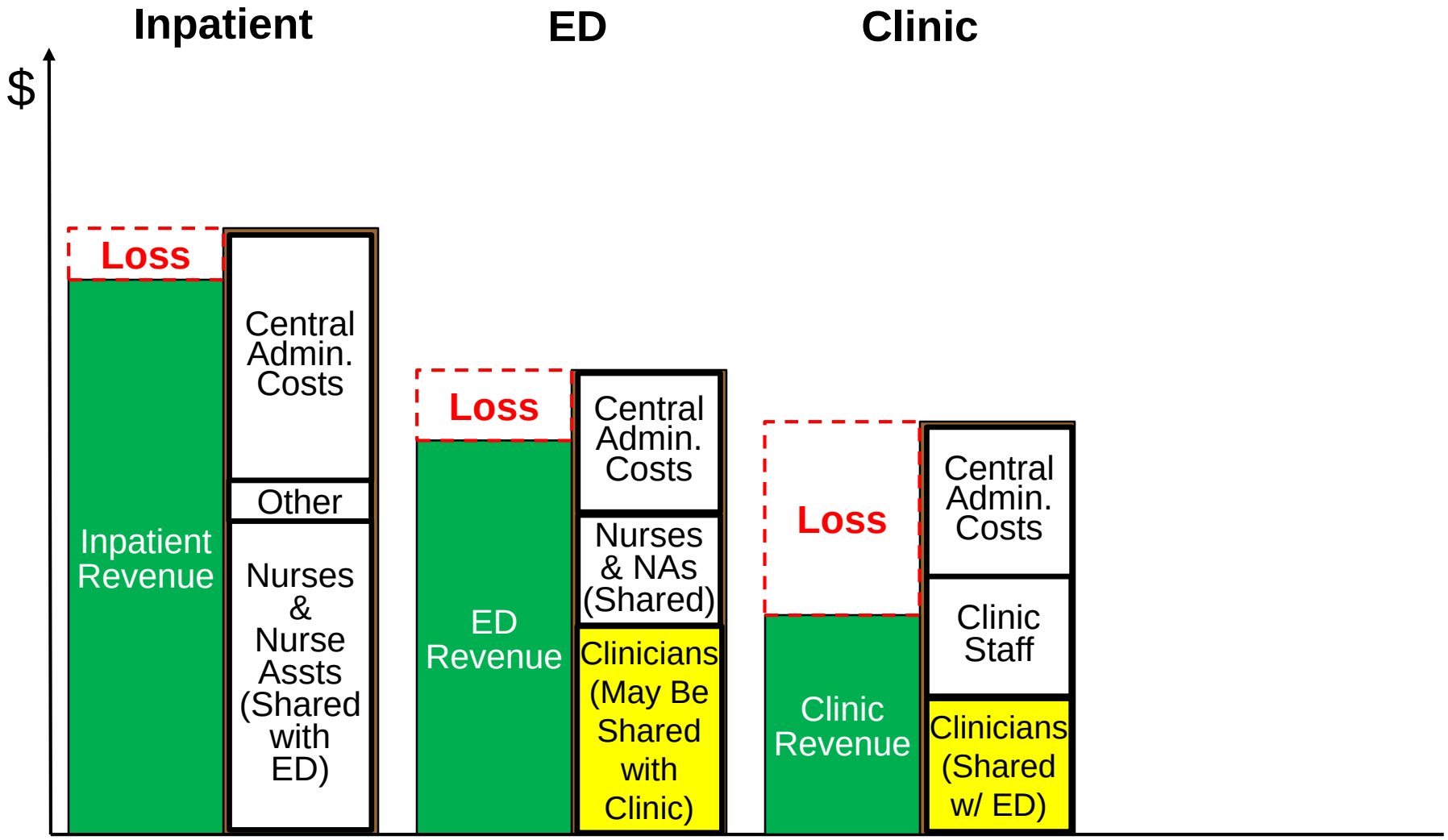
BUT ALSO: All of These Service Lines Are *Interdependent*



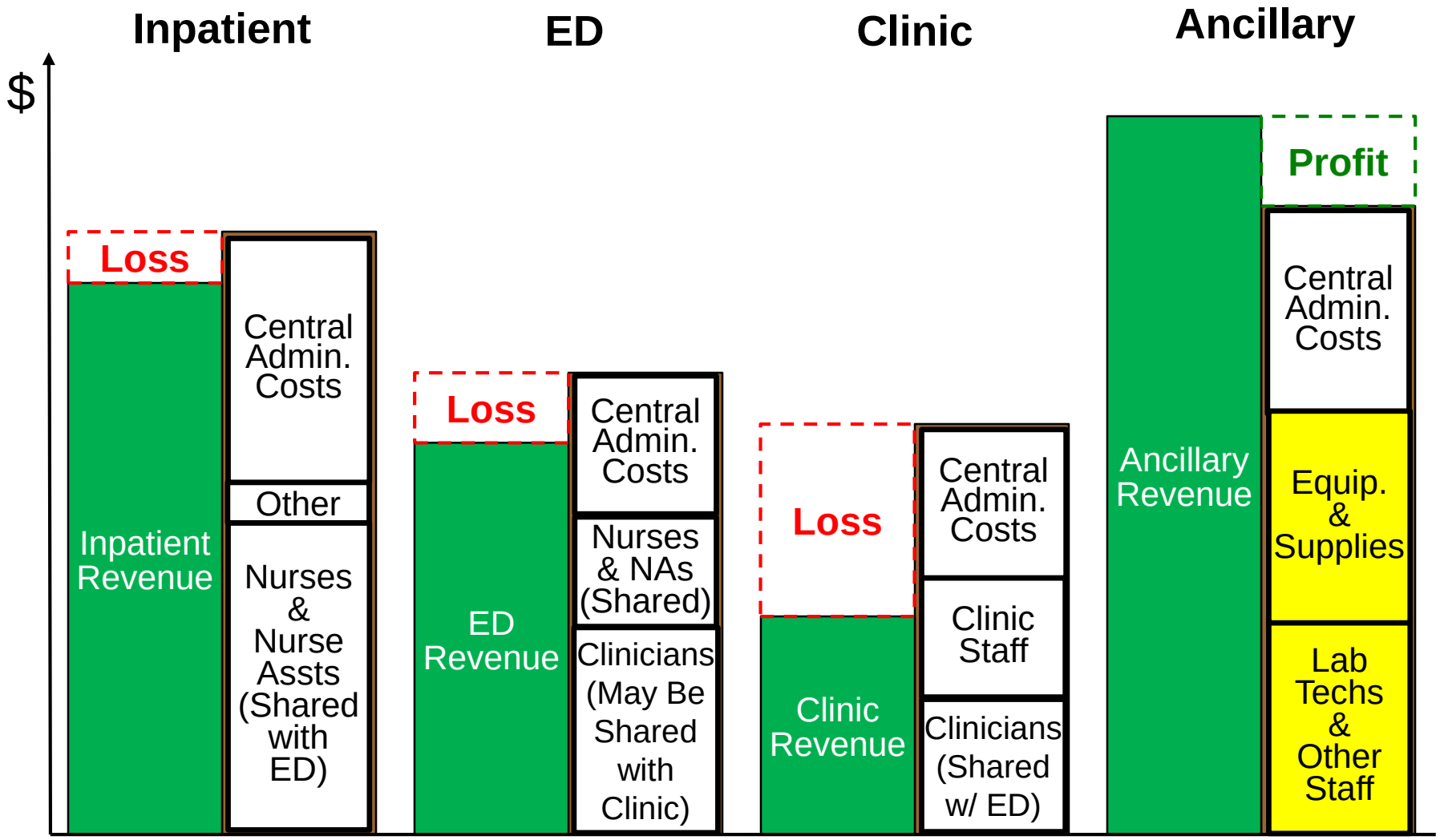
Inpatient Services Shares Nurses With the ED



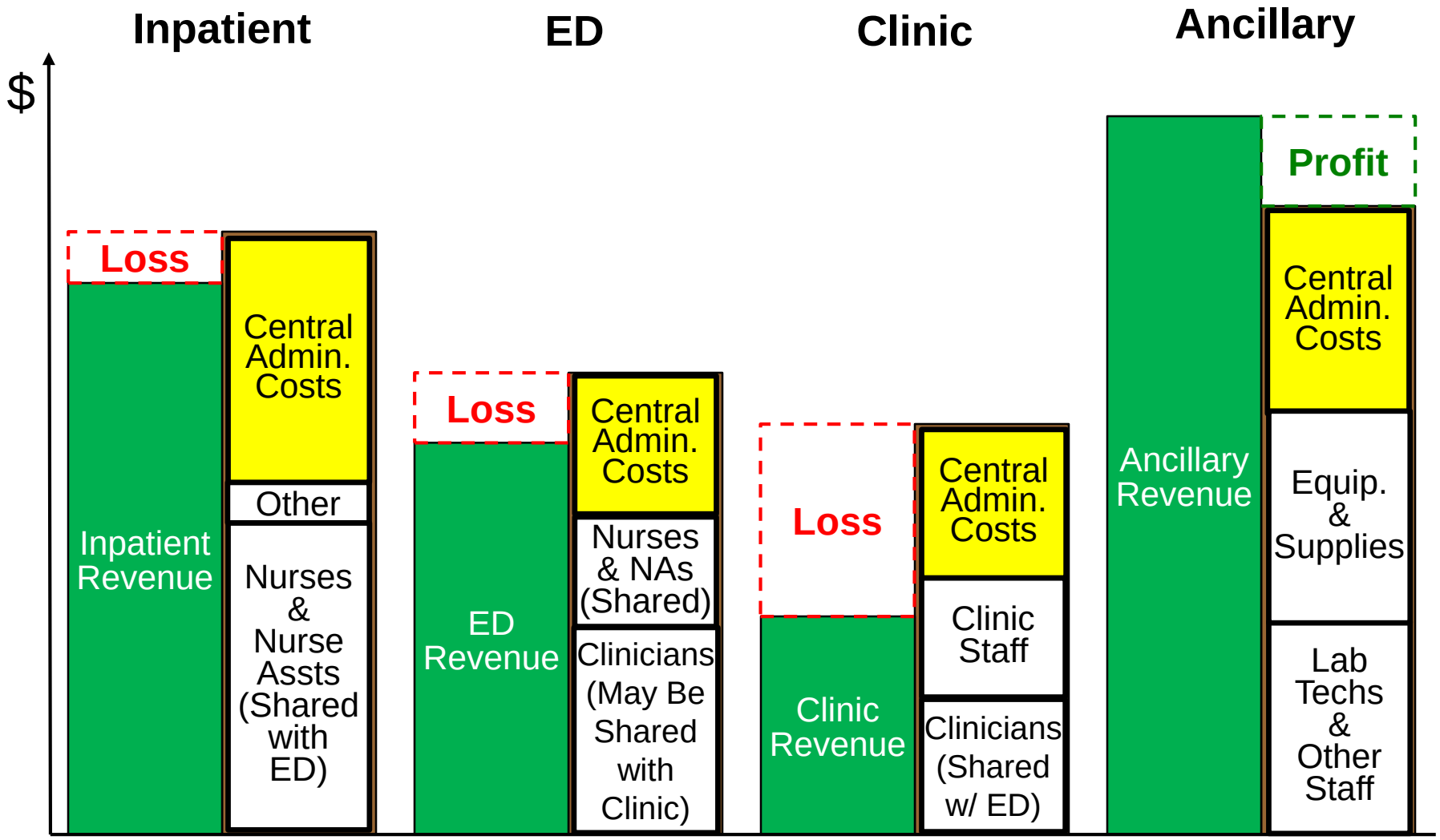
The Smallest EDs Share Clinicians With the Clinic



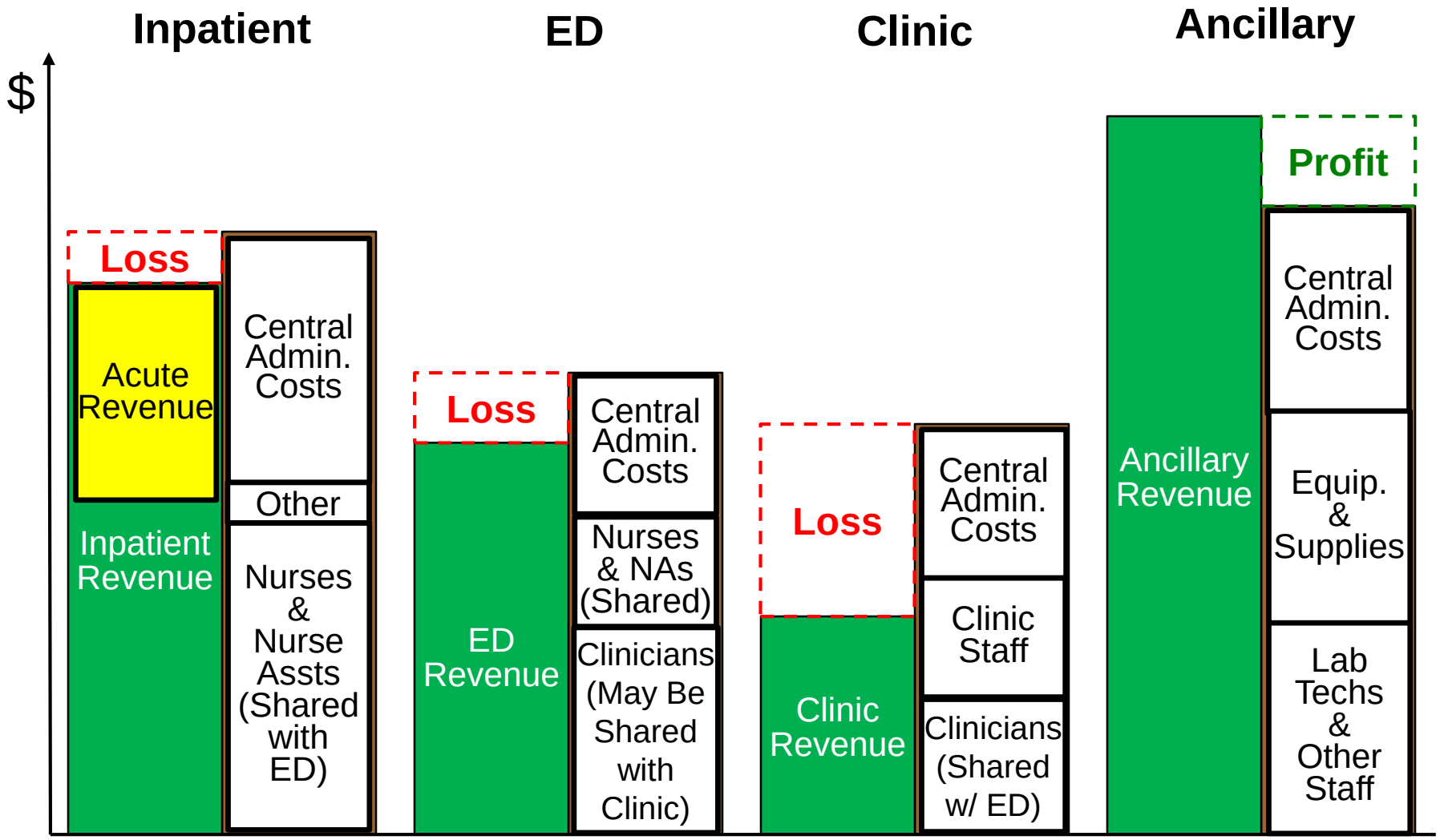
Ancillary Services Are Used for Inpatient, ED, & Clinic Patients



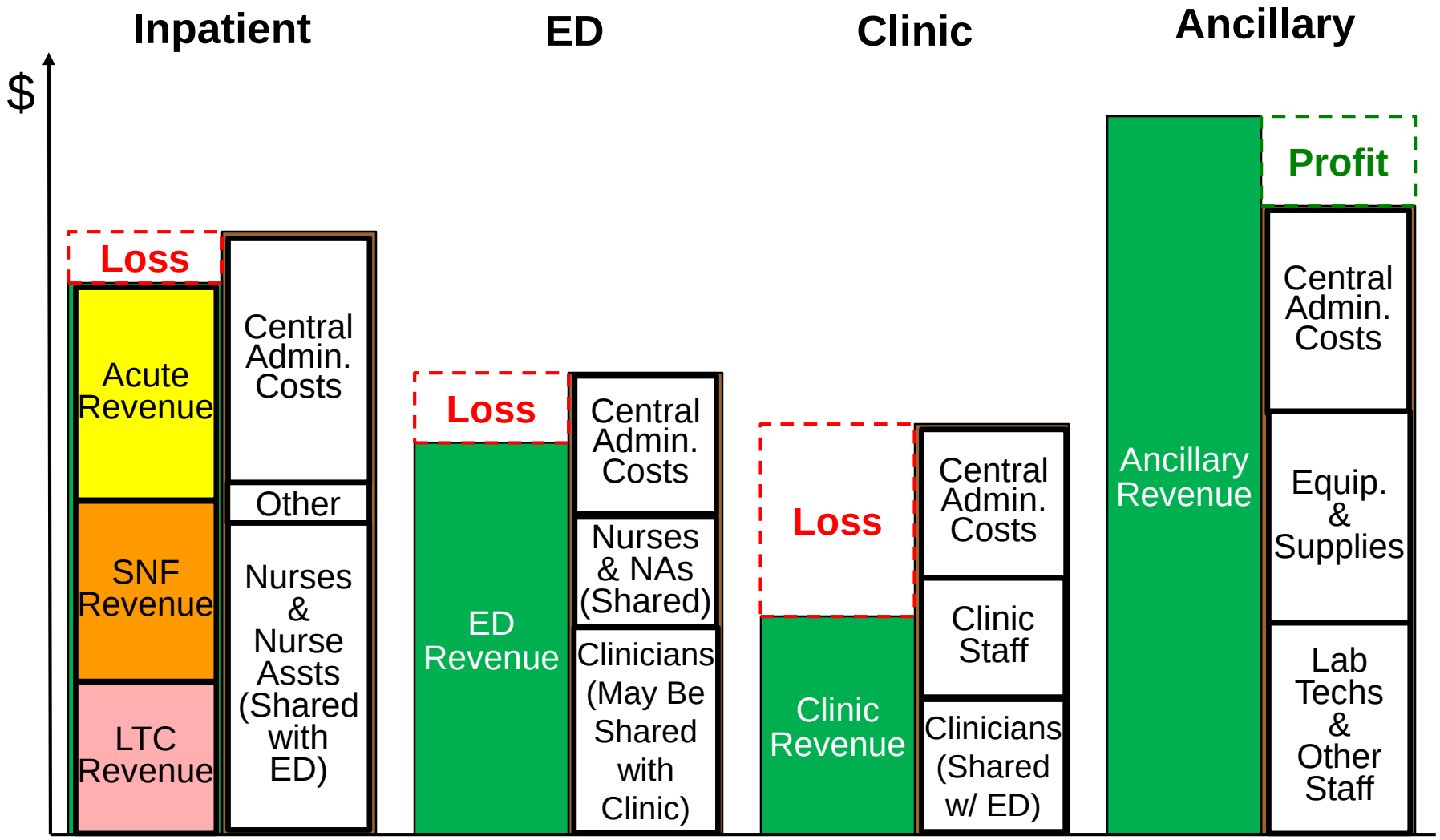
Hospital Overhead Costs Are Shared by All Service Lines



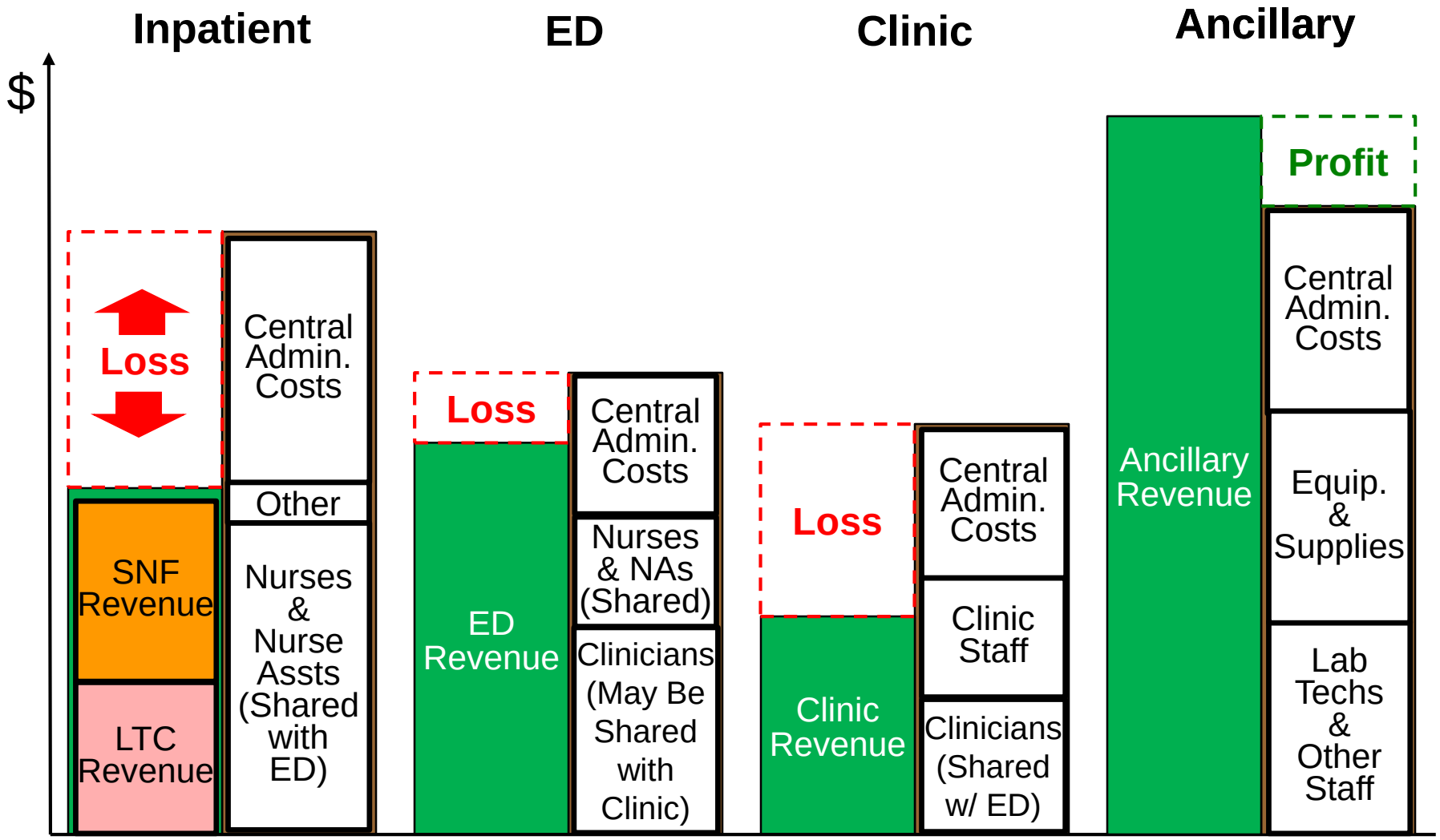
Inpatient Services Includes More Than Just Acute Admissions



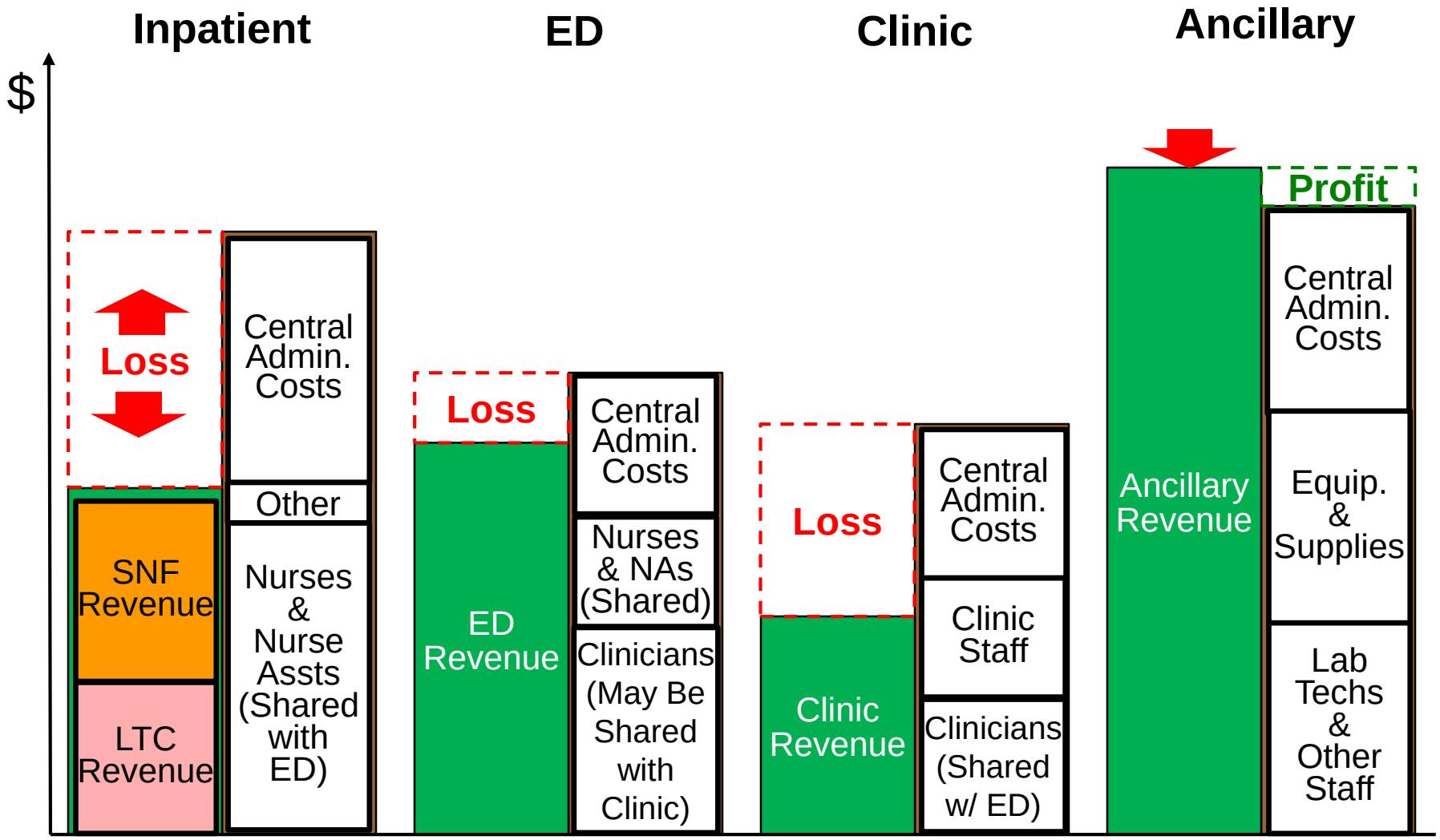
Inpatient = Acute + SNF + LTC



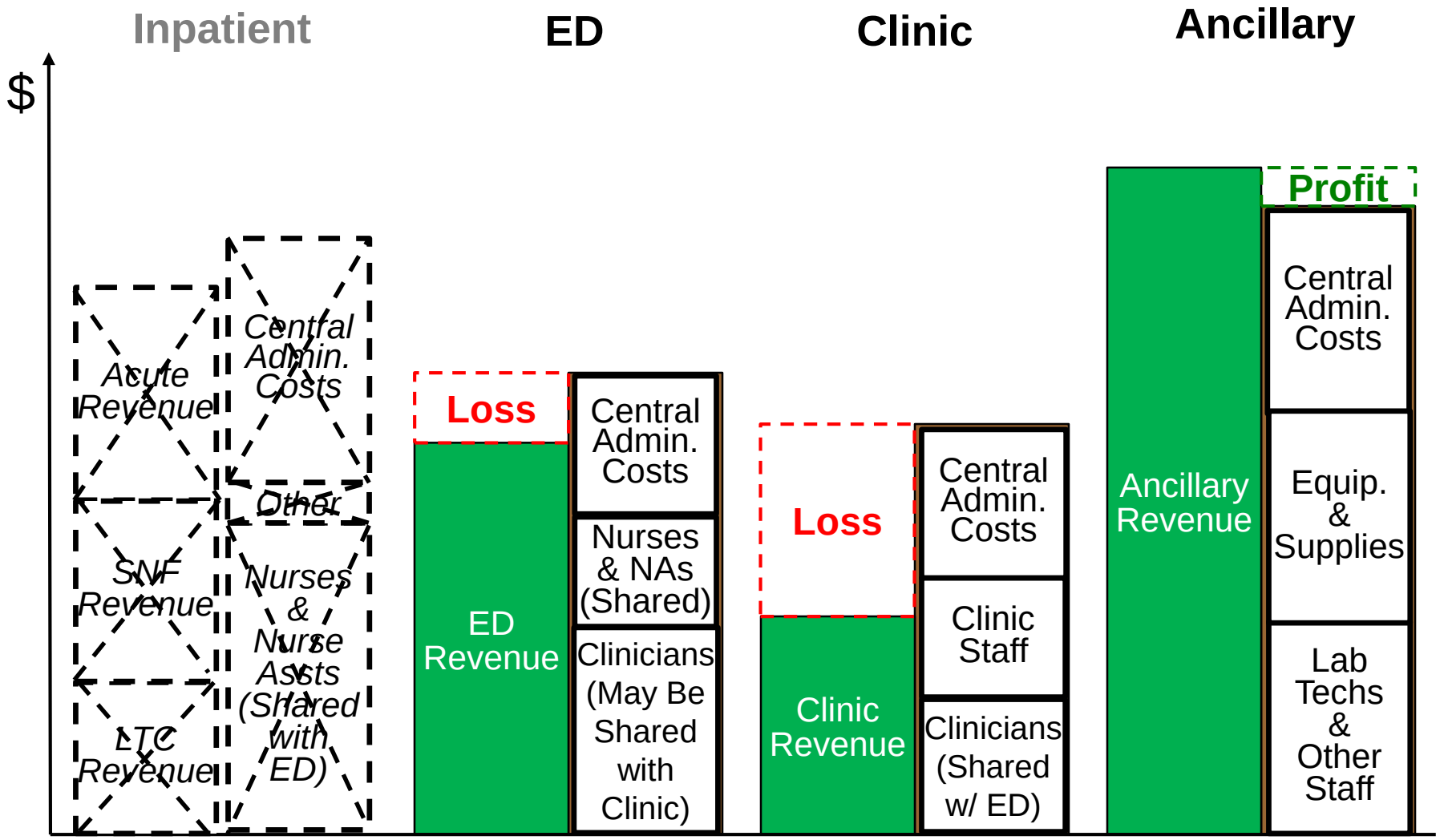
Without Acute Patients, Inpatient Losses Would Be Higher



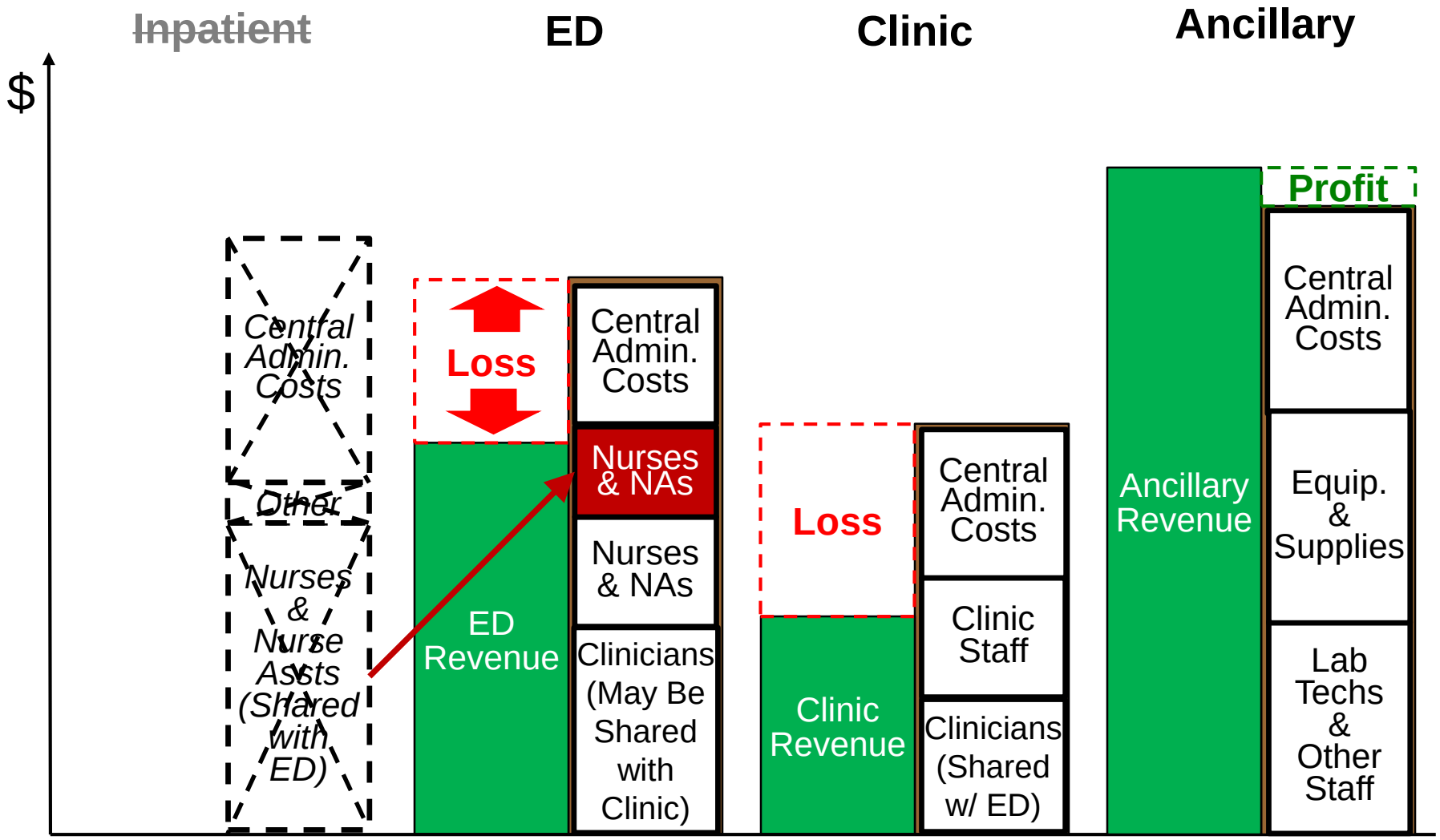
Without Acute Patients, Ancillary Profits Would Be Lower



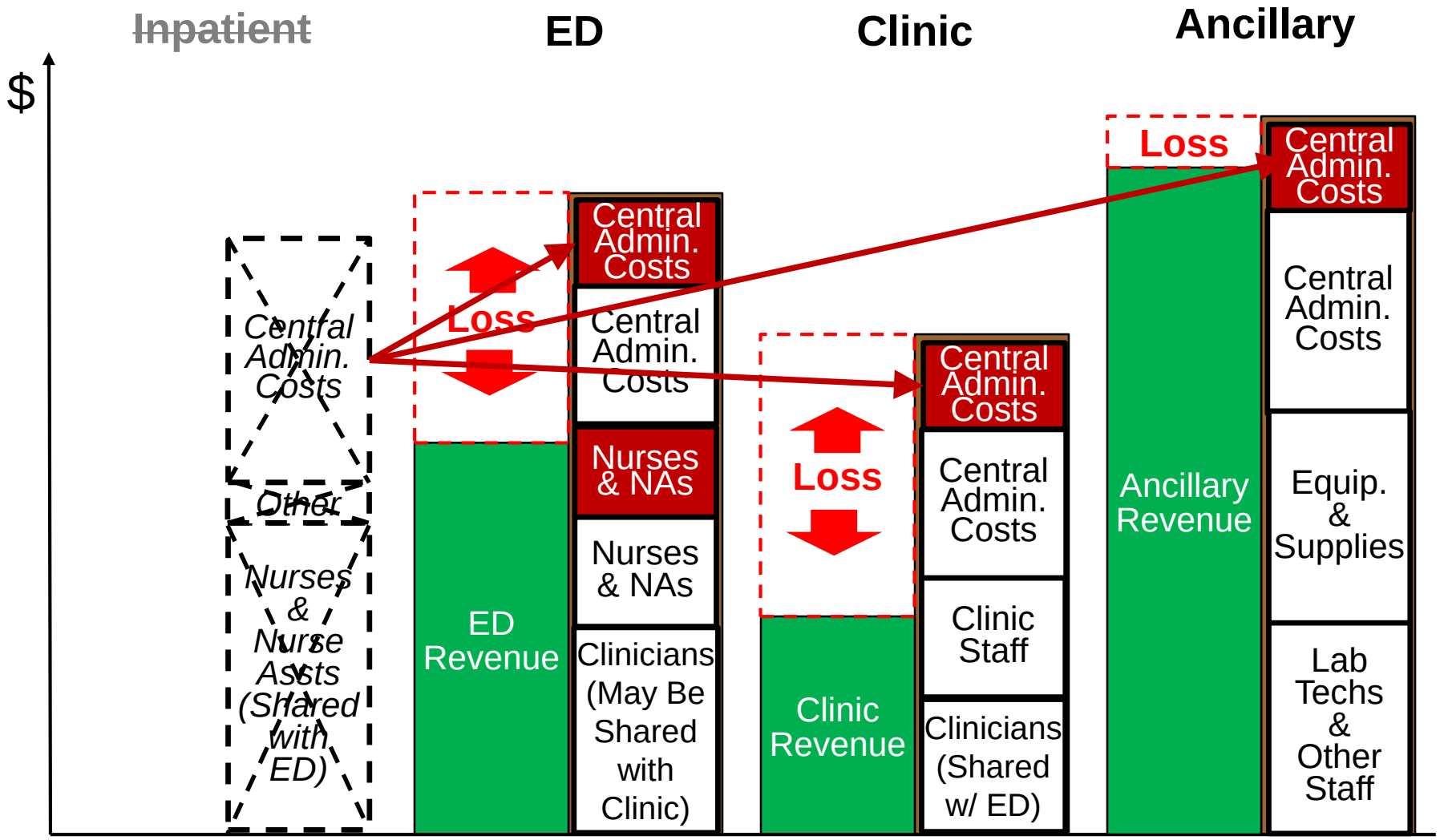
What If Inpatient Services Were Eliminated Entirely?



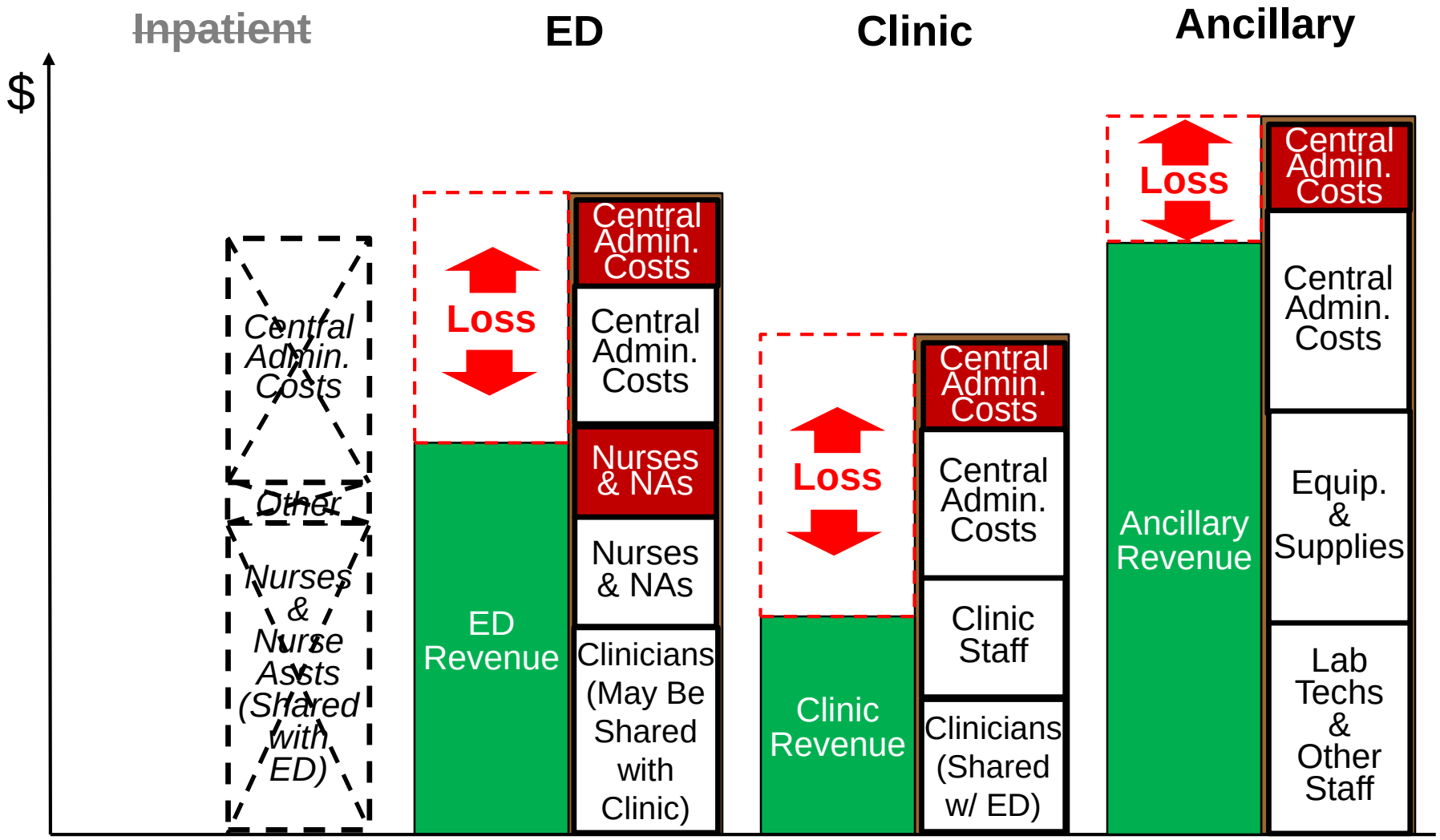
The ED Could No Longer Share Nursing Costs with Inpatient



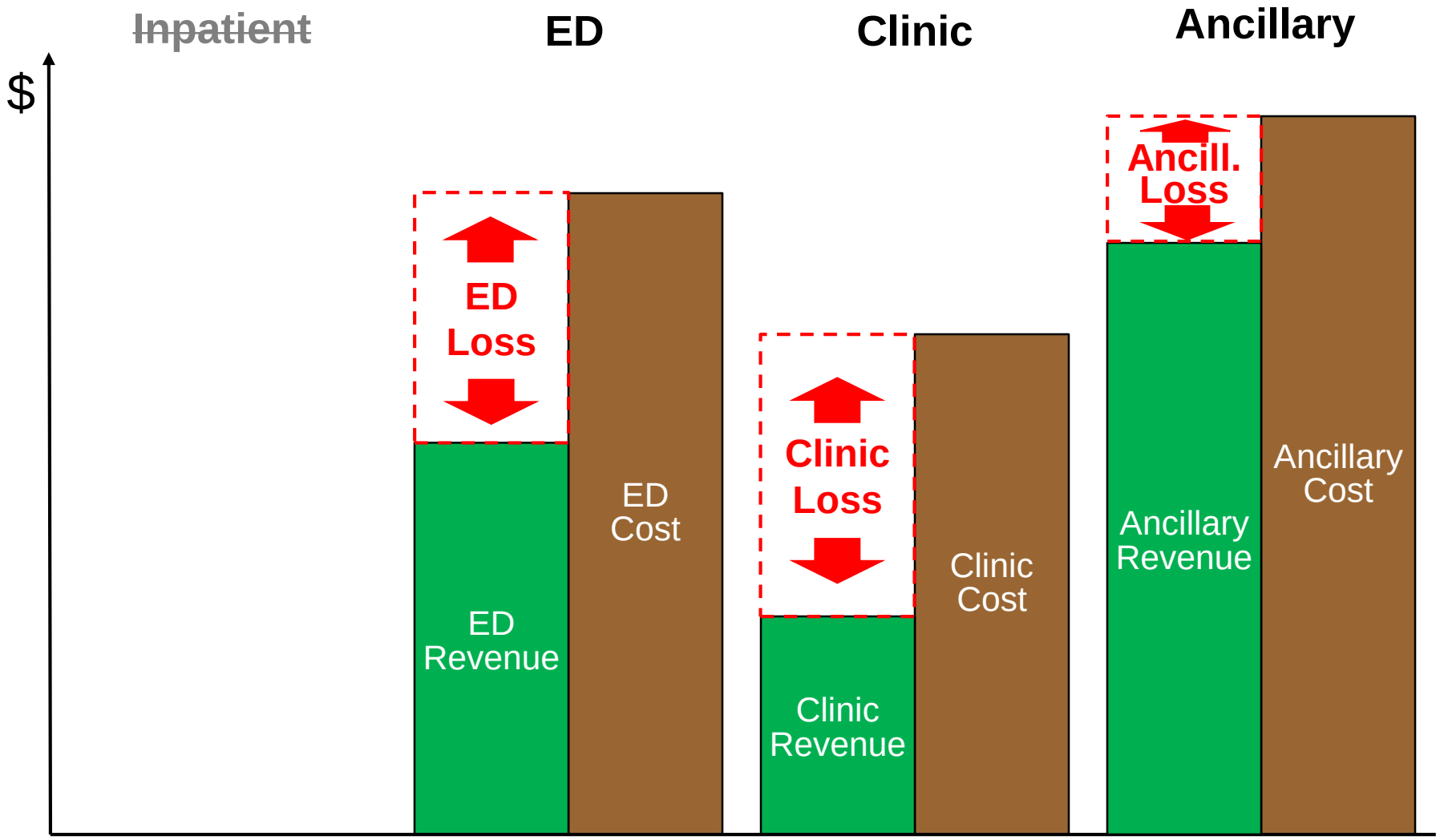
Other Service Lines Couldn't Share Overhead With Inpatient



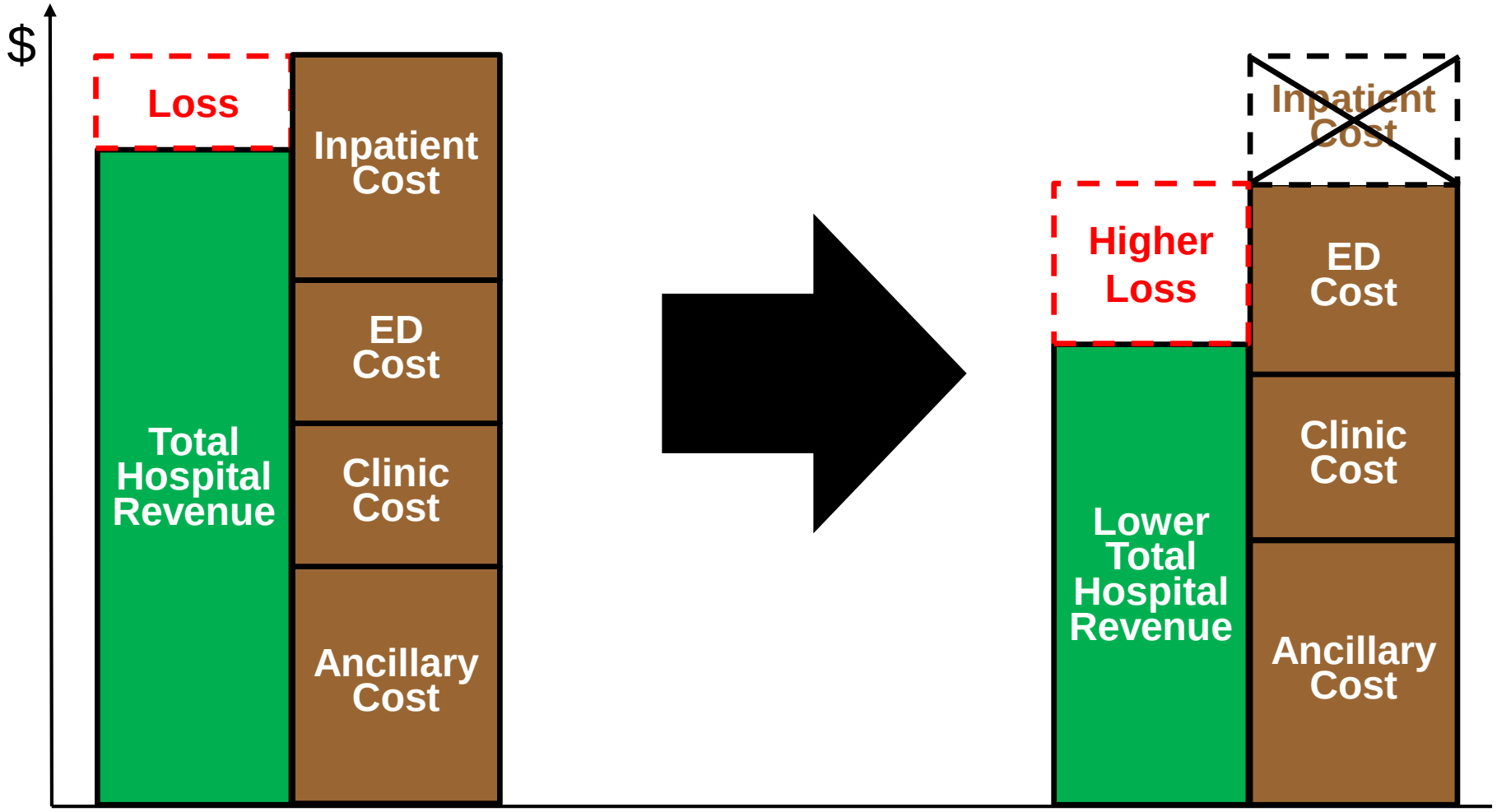
Revenue from Ancillary Services Would Decrease



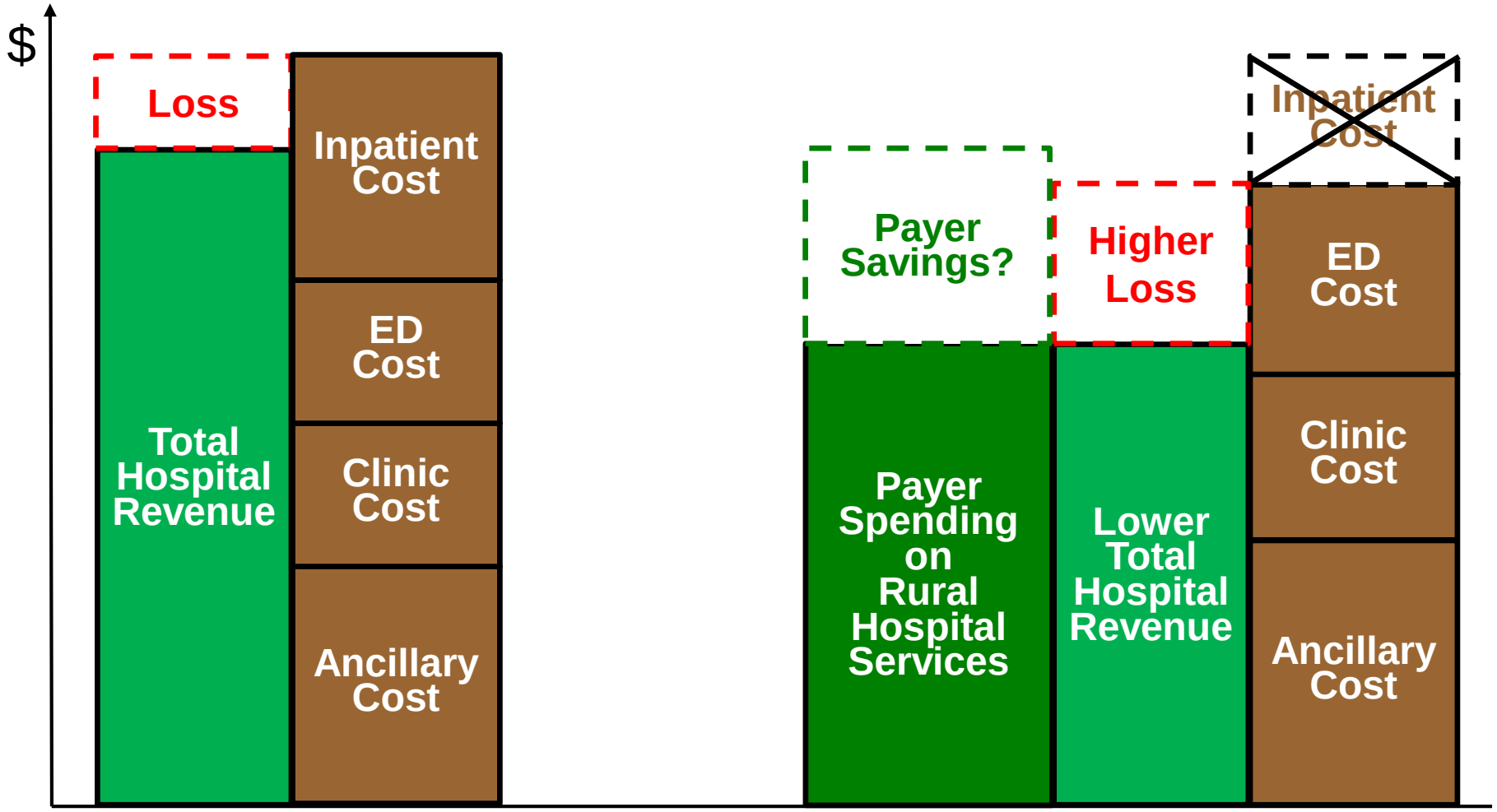
In Sum: Every Other Service Line Would Have Bigger Losses



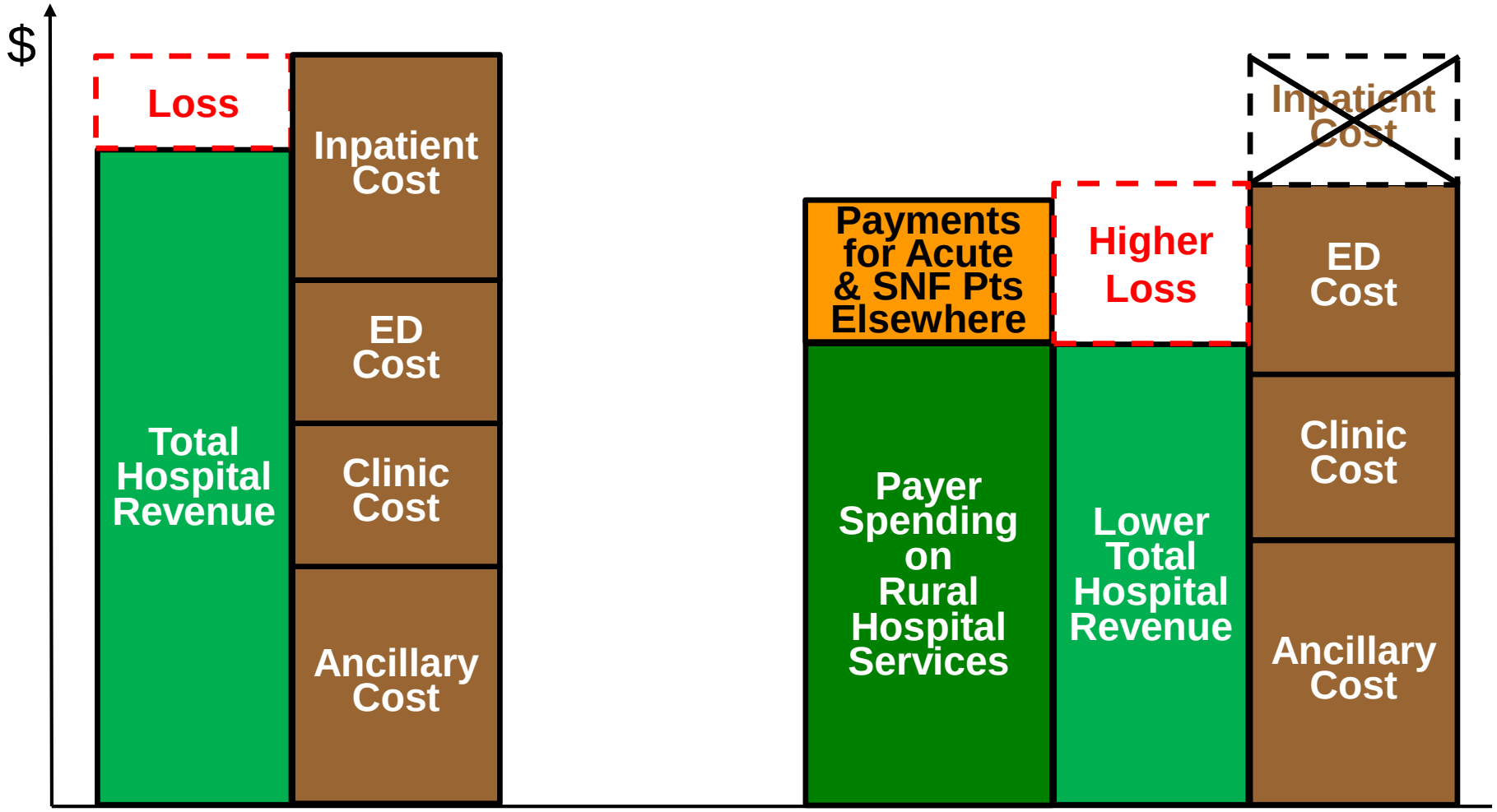
The Hospital As a Whole Would Be *Worse* Off



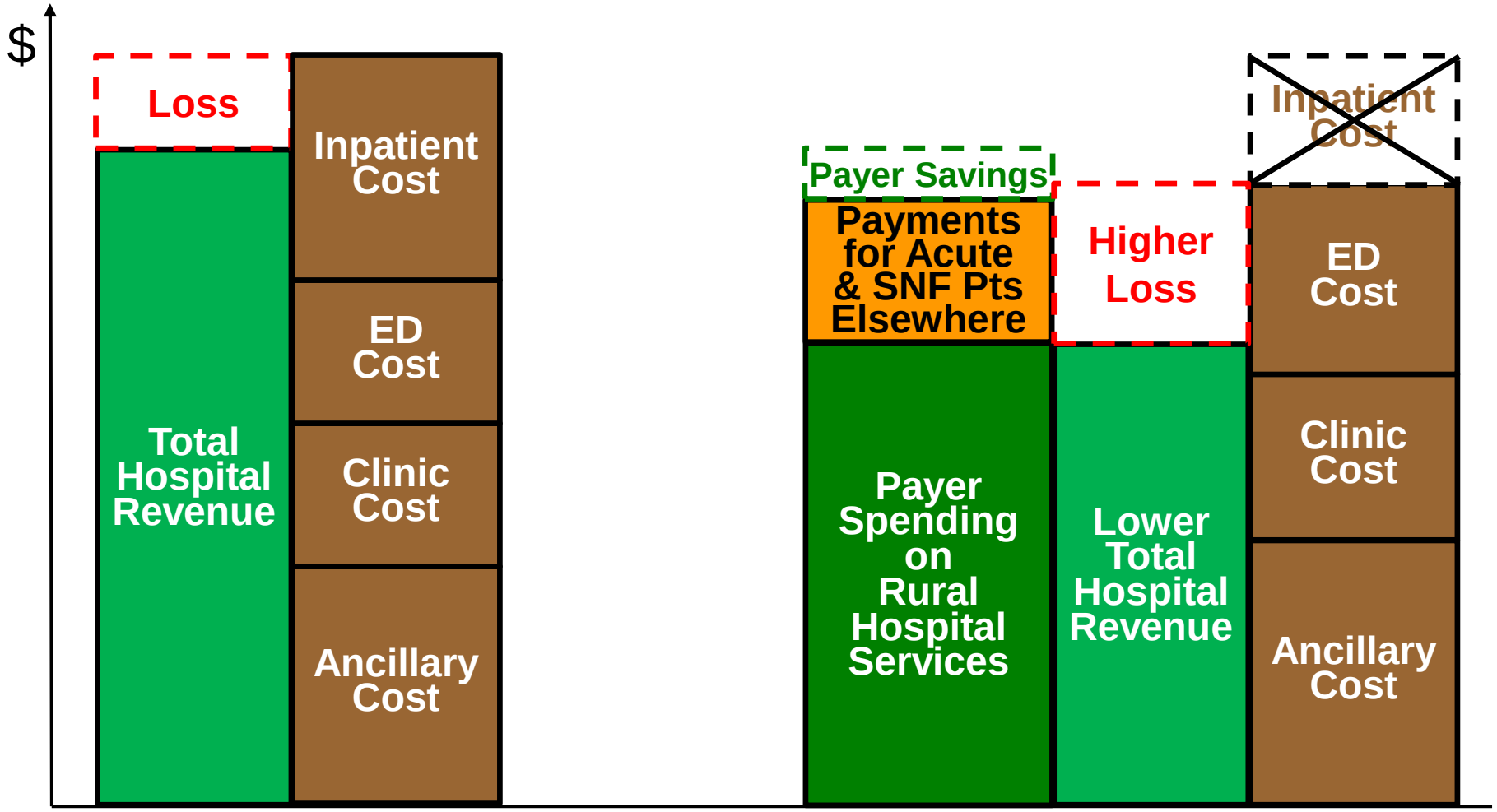
Would Payers Save Money?



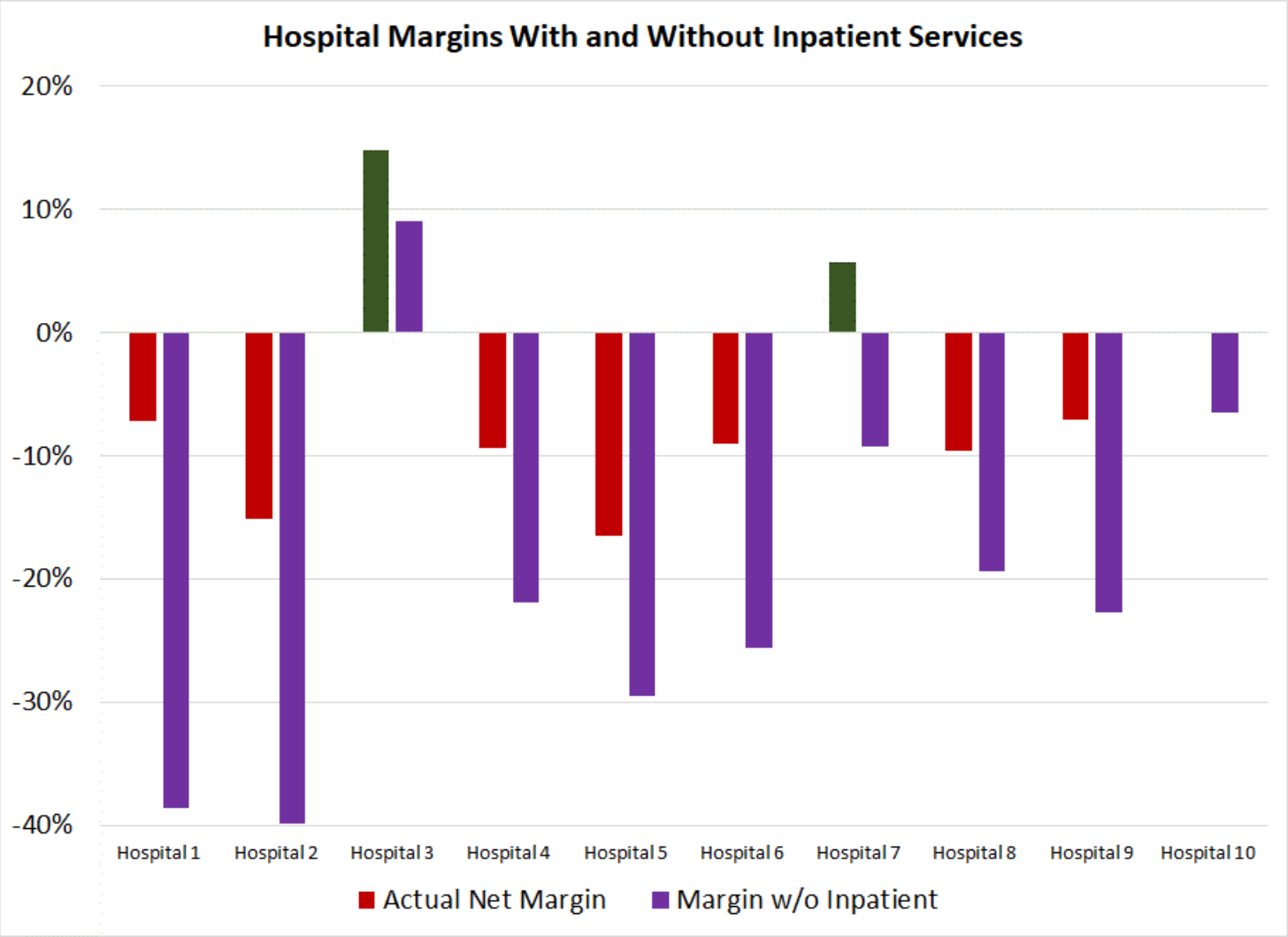
The Inpatients Still Need Care Somewhere & That Costs Money



So the Savings Will Be Much Smaller Than They Might Seem



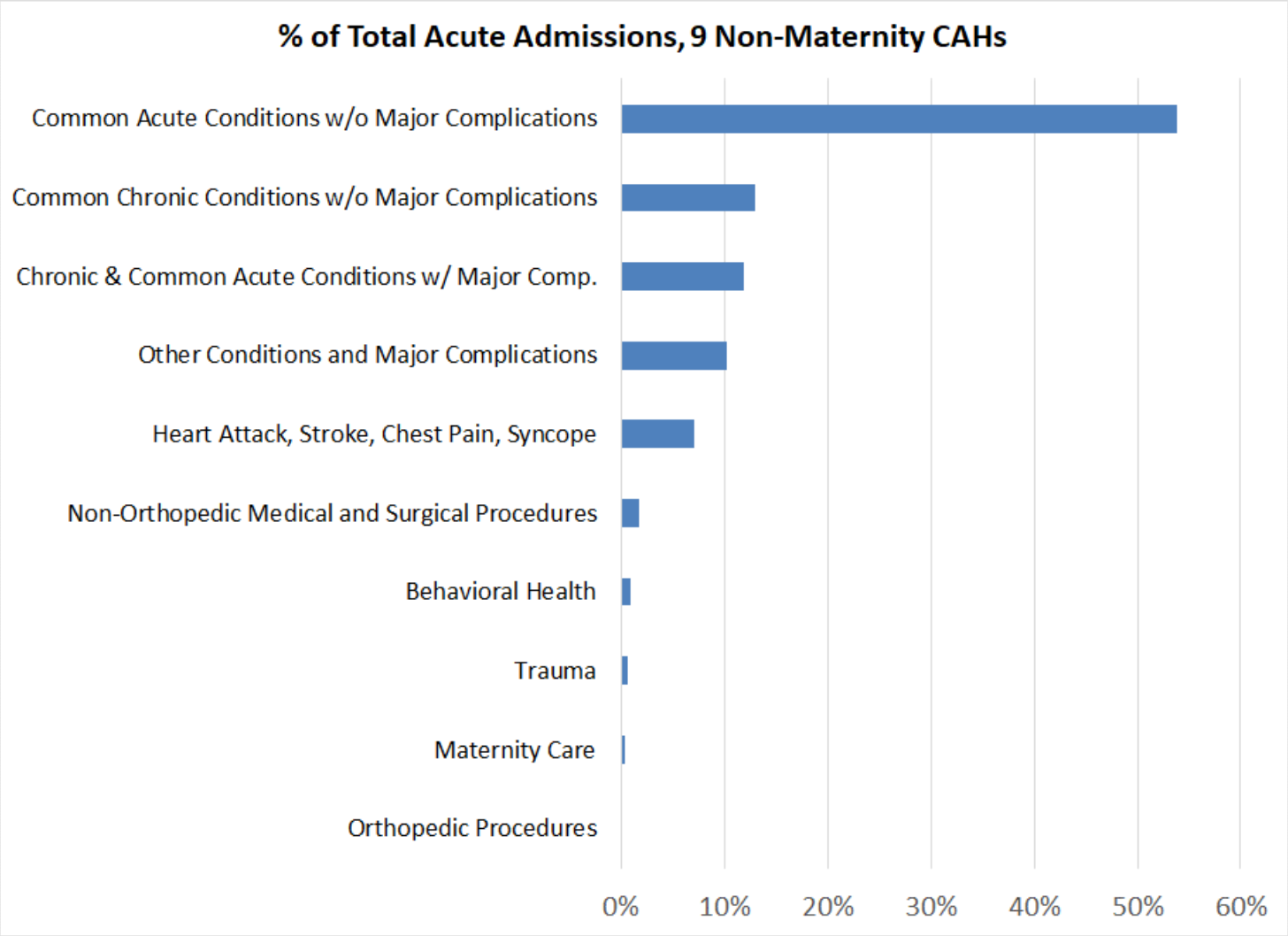
Small CAHs Would Lose $ If Inpatient Services Were Ended



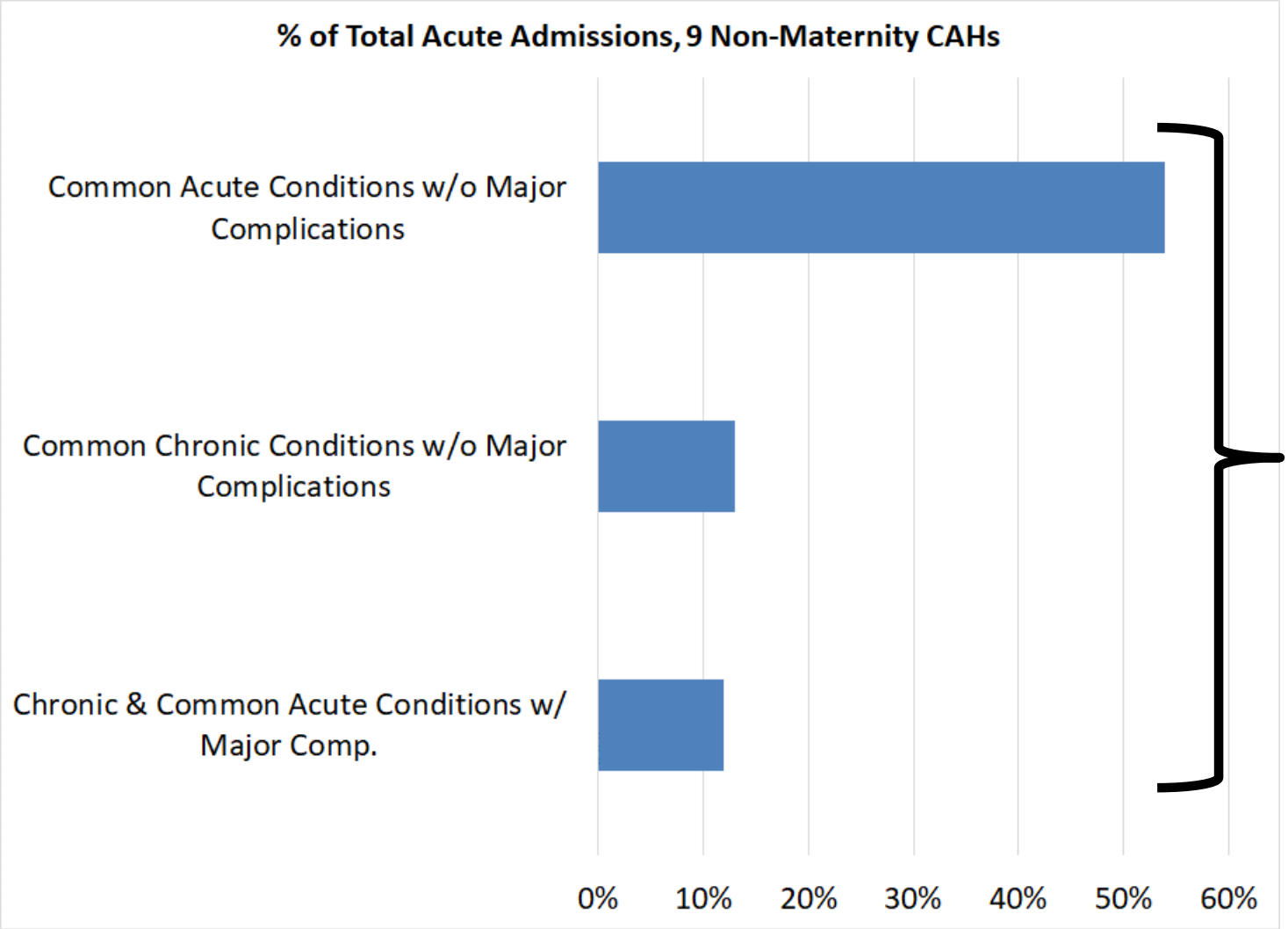
Who Gets Inpatient Care in Small Rural Hospitals?

- 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

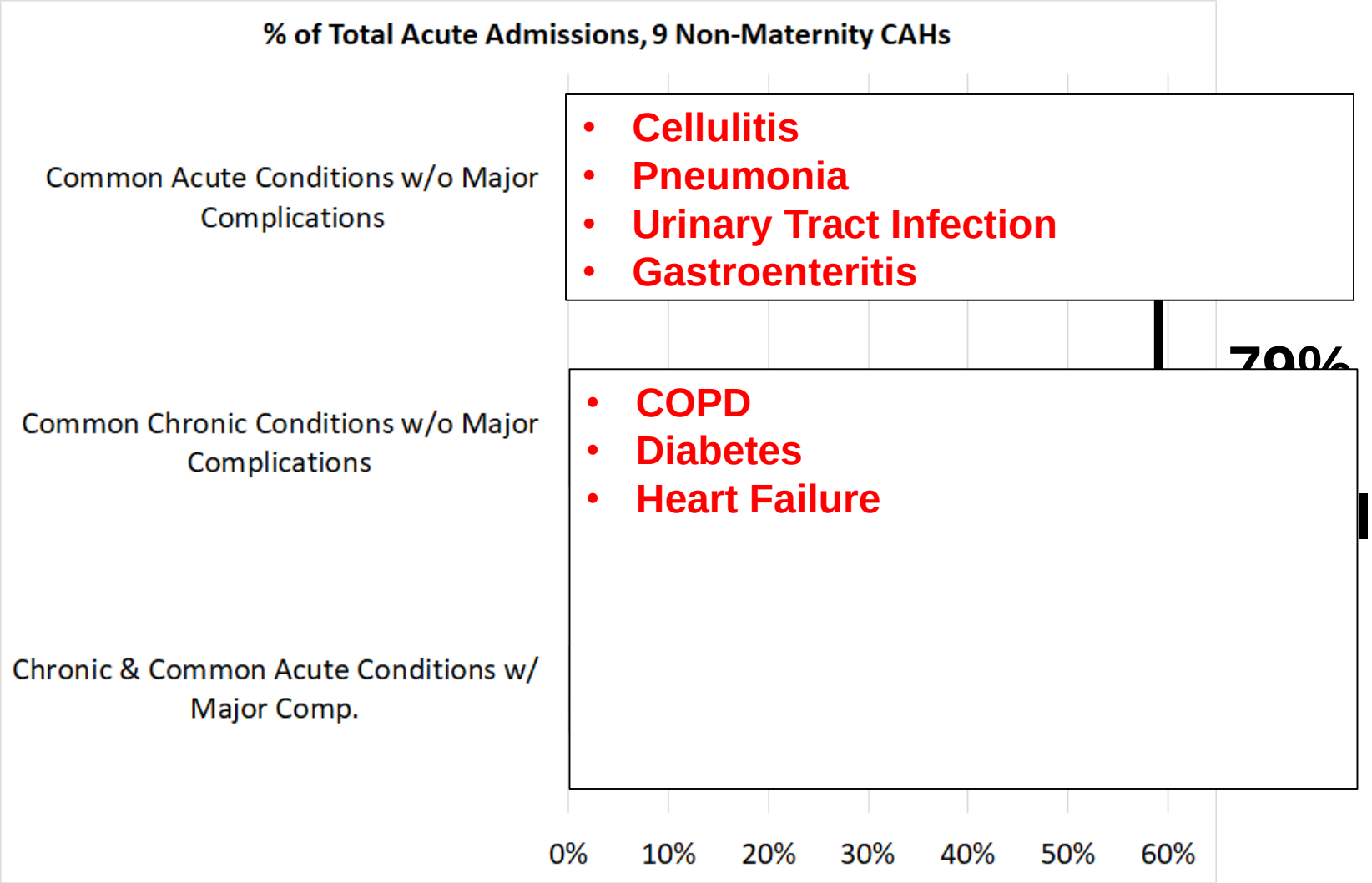
Most Acute Admits Are For A Narrow Range of Conditions



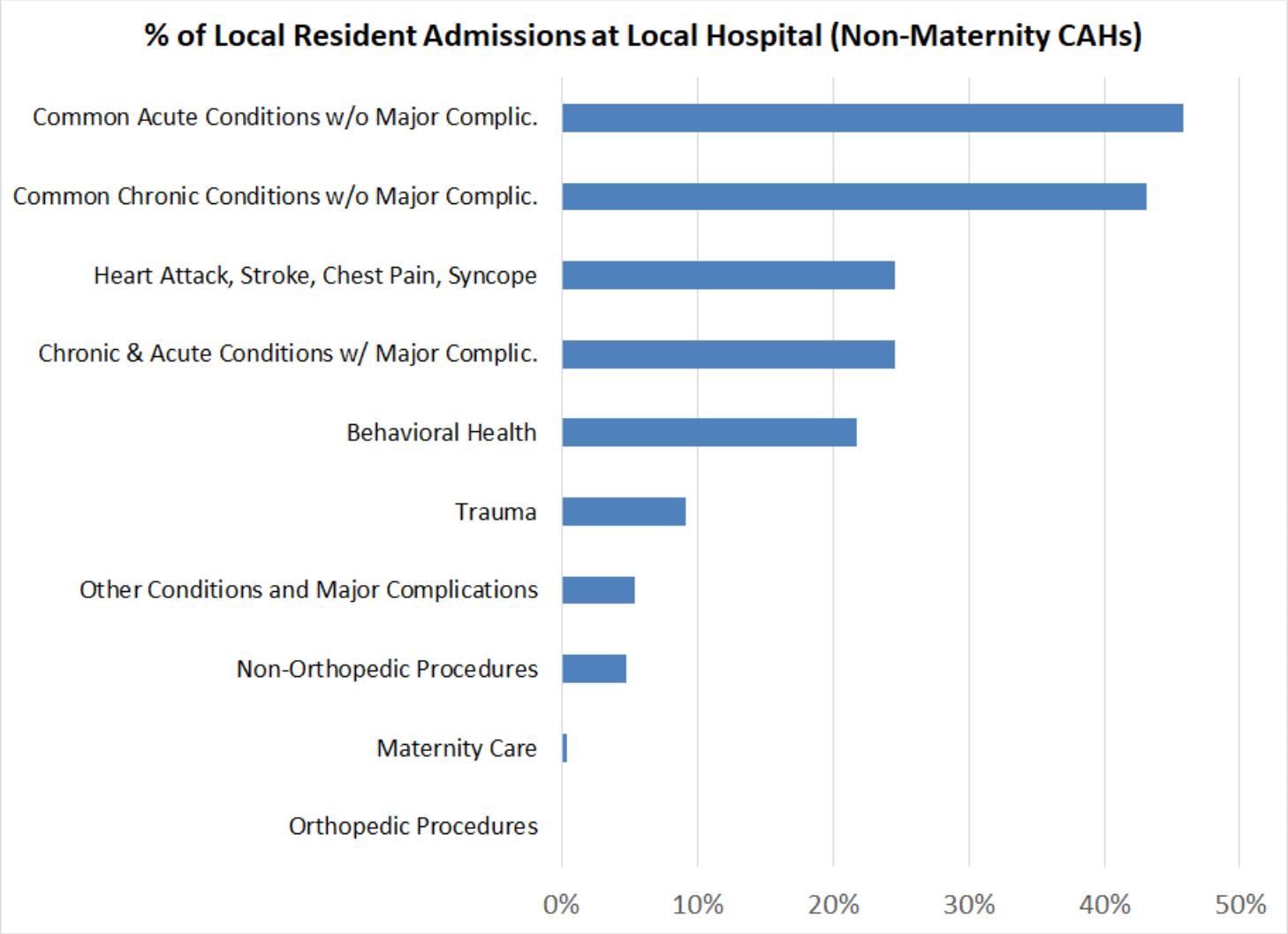
Most Acute Admits Are For Common Acute/Chronic Diseases



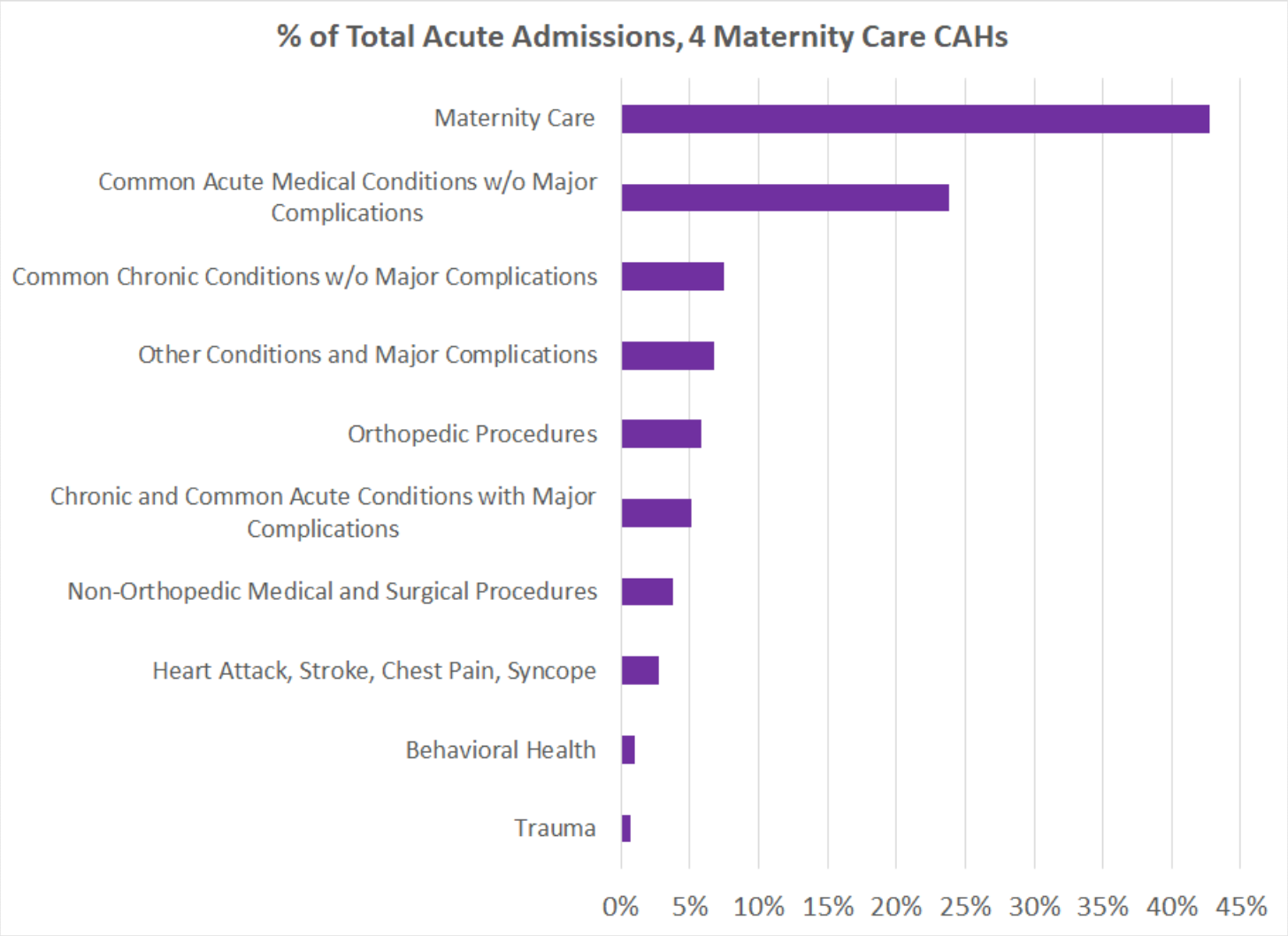
Most Acute Admits Are For Common Acute/Chronic Diseases



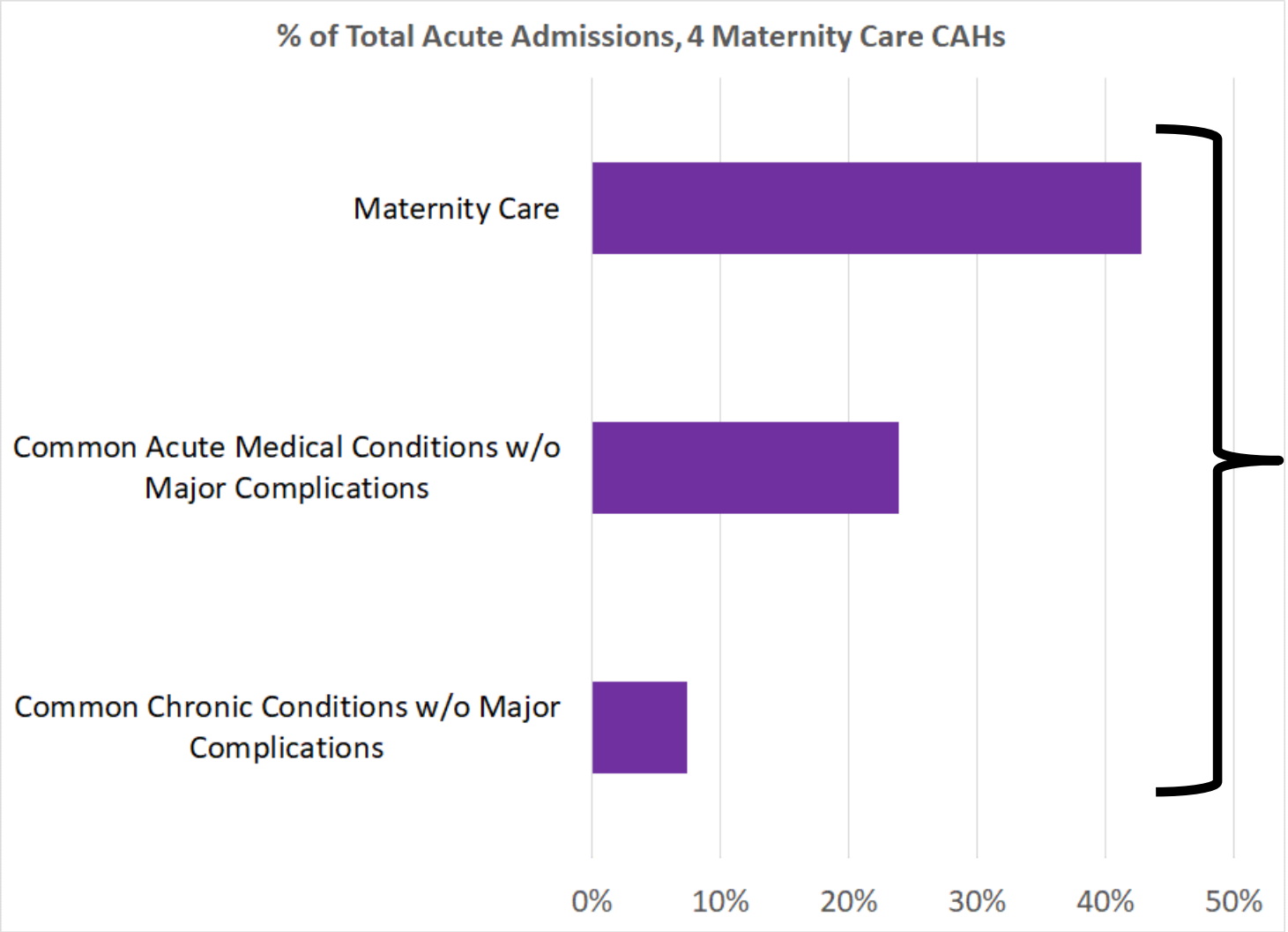
>40% of Admits for Acute/Chronic Conditions Are to Local Hospital



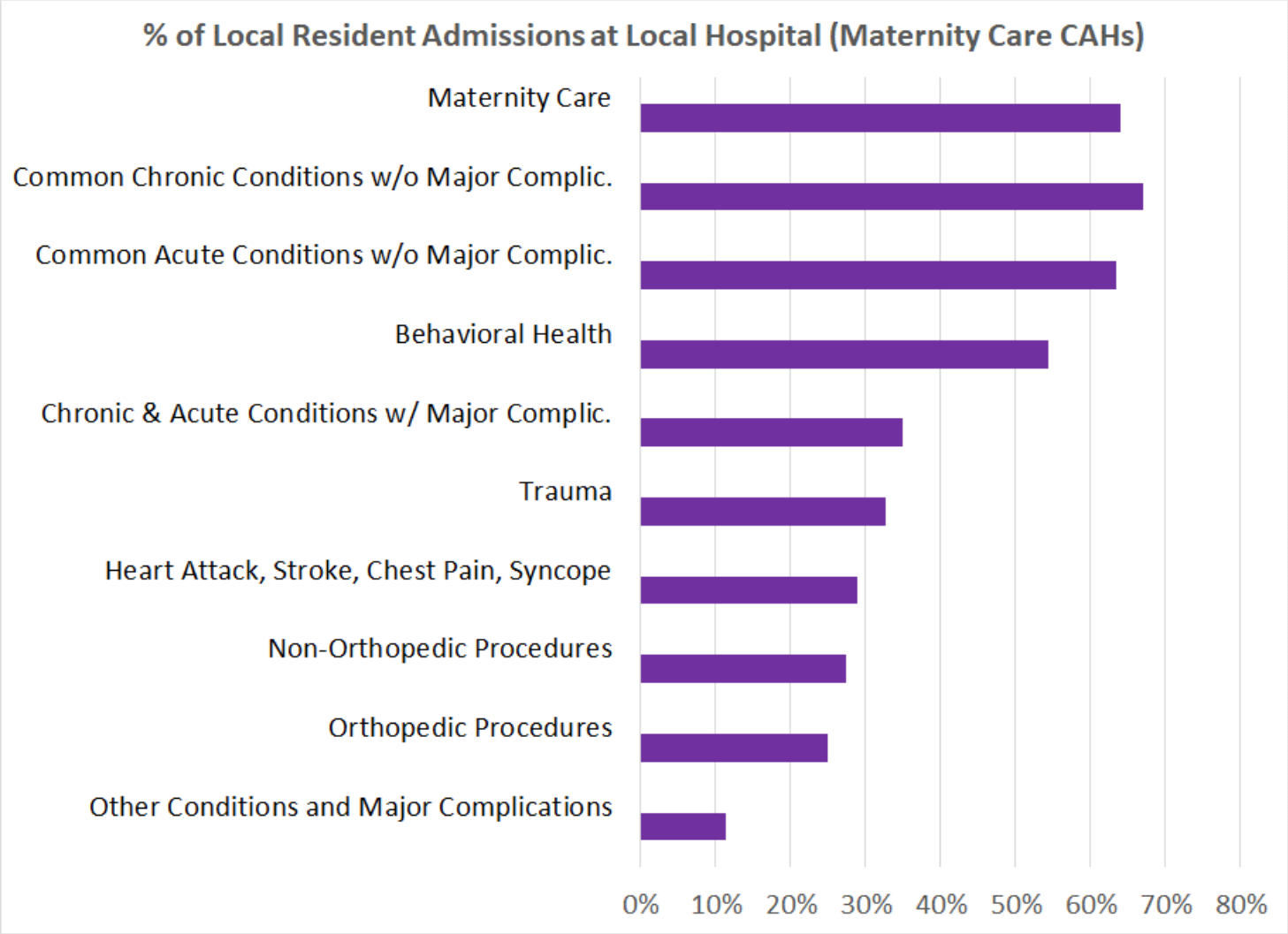
Some Larger Hospitals Also Deliver Babies



Most Admits Are Deliveries & Common Acute/Chronic Cond.



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



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

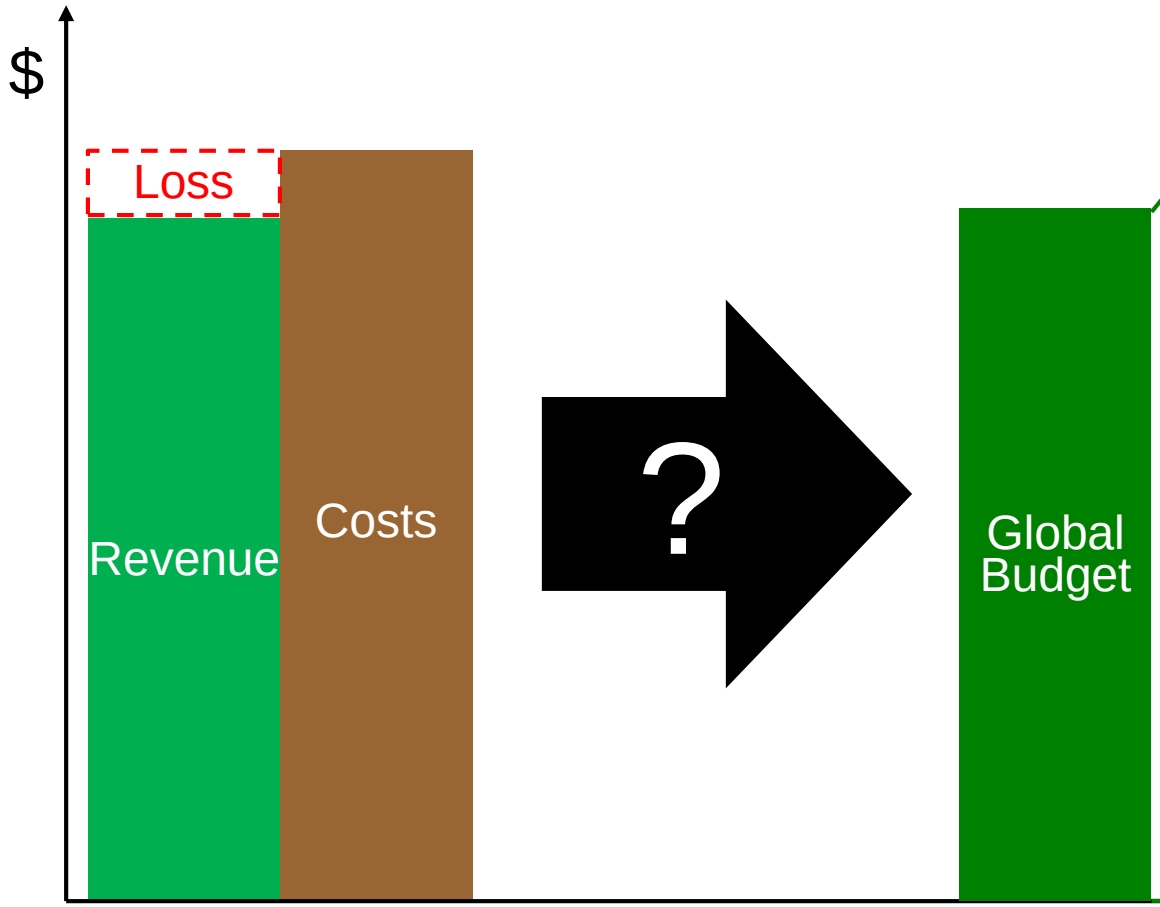
Impacts of Closing Inpatient Services in Small Rural Hospitals

- 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

Premise #1: Hospitals Deliver Avoidable Svcs

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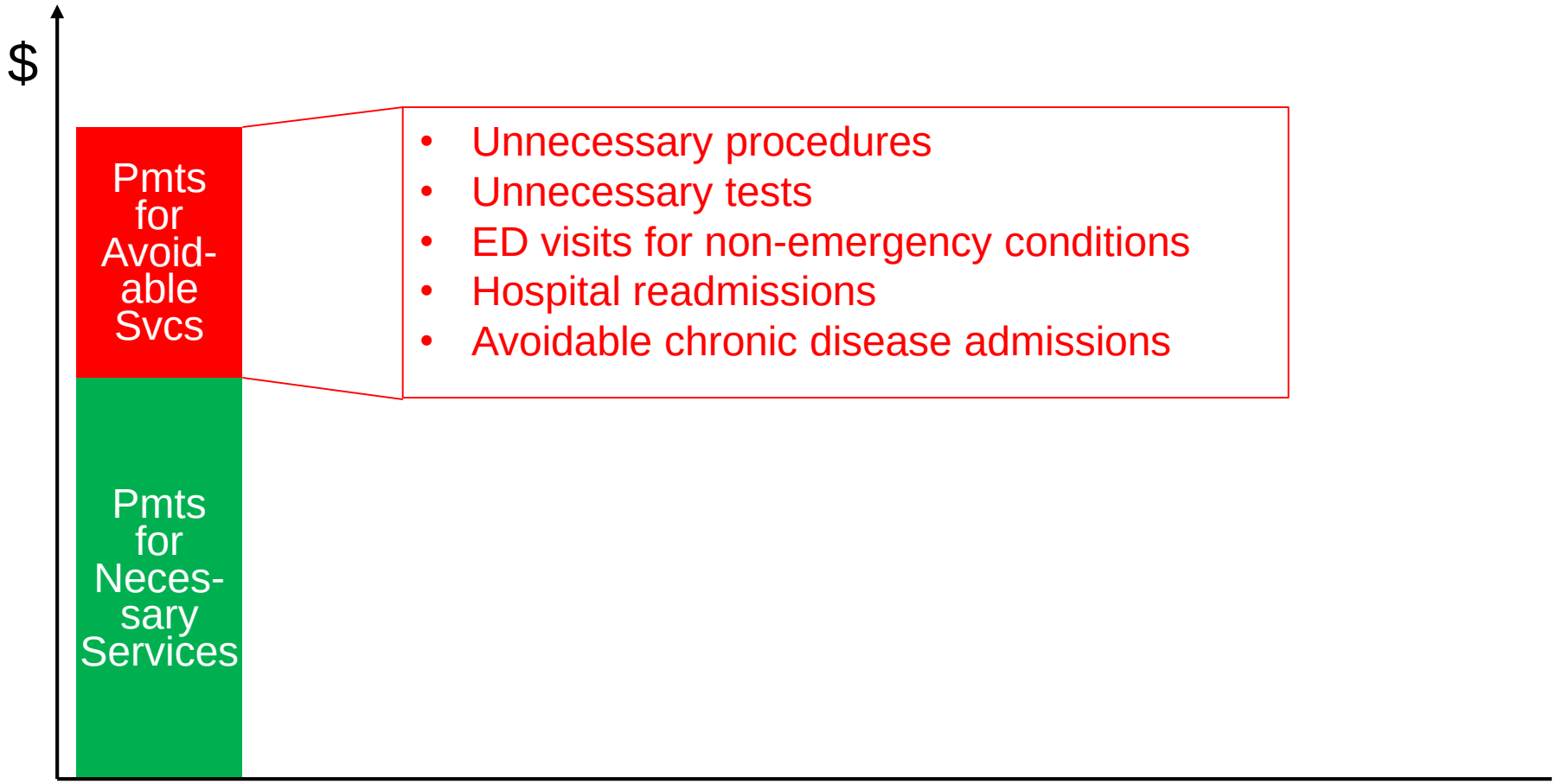
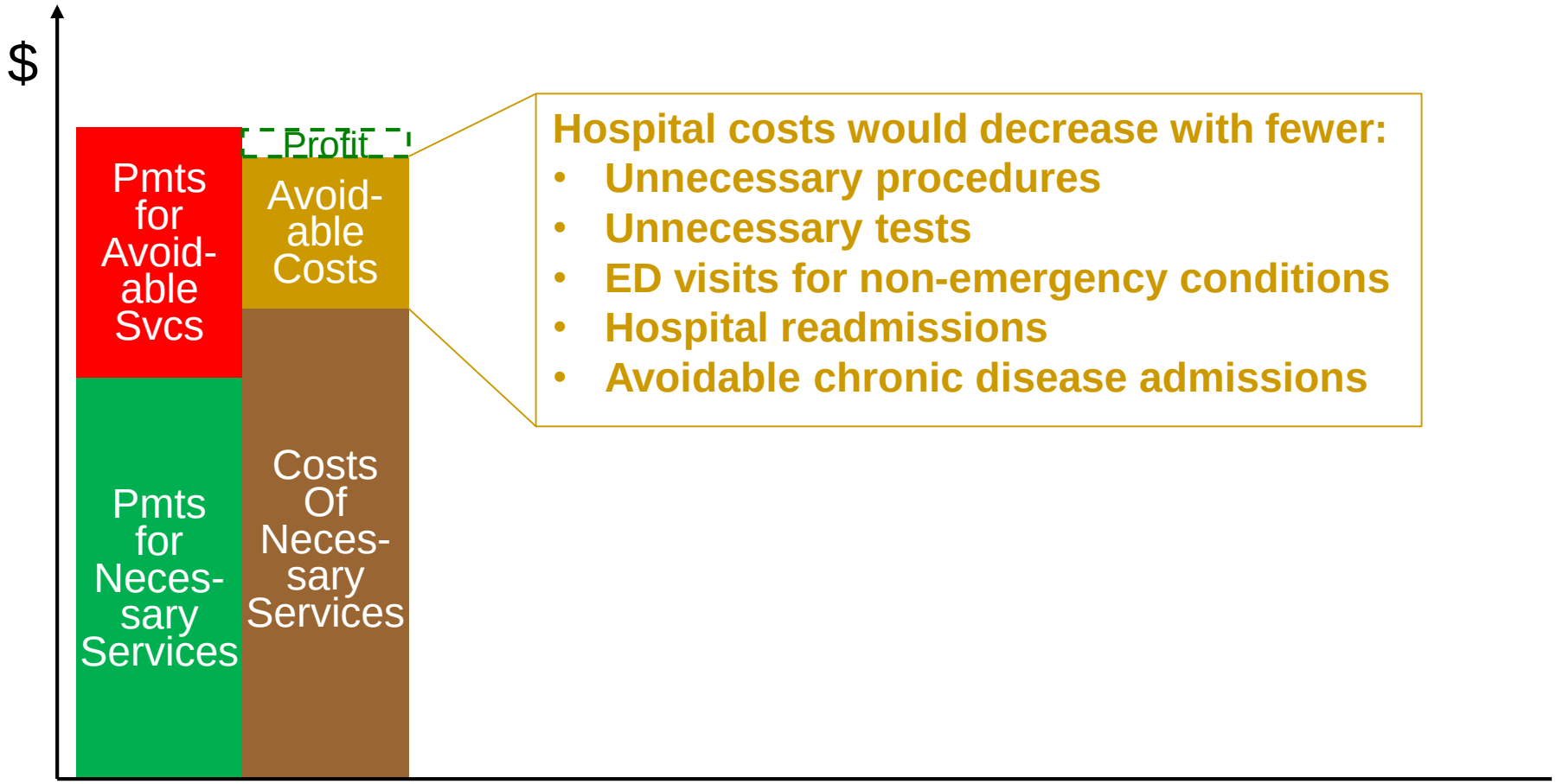


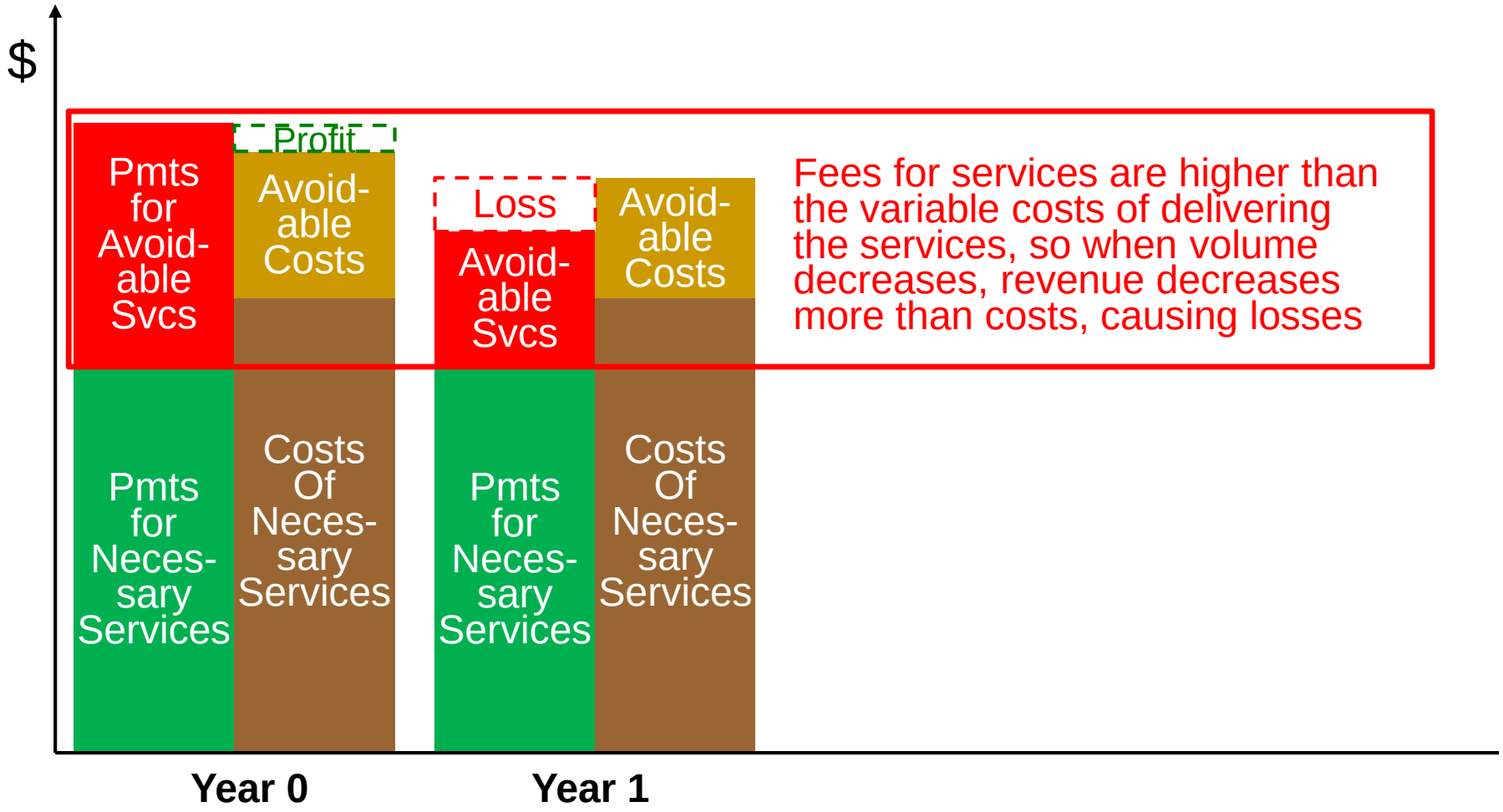
Premise #2: Fewer Services = Lower Costs



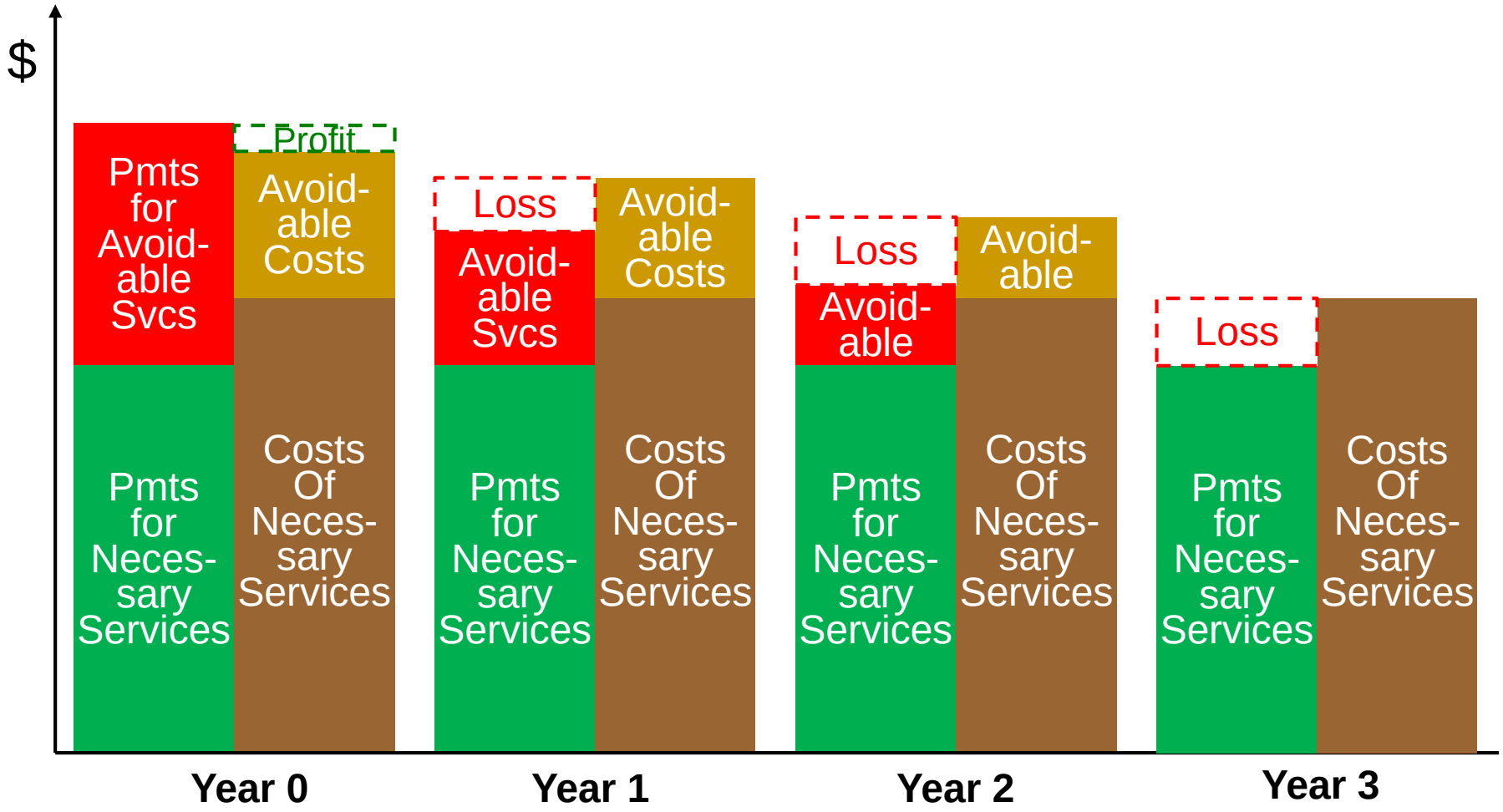
Hospital costs would decrease with fewer:

- **Unnecessary procedures**
- **Unnecessary tests**
- **ED visits for non-emergency conditions**
- **Hospital readmissions**
- **Avoidable chronic disease admissions**

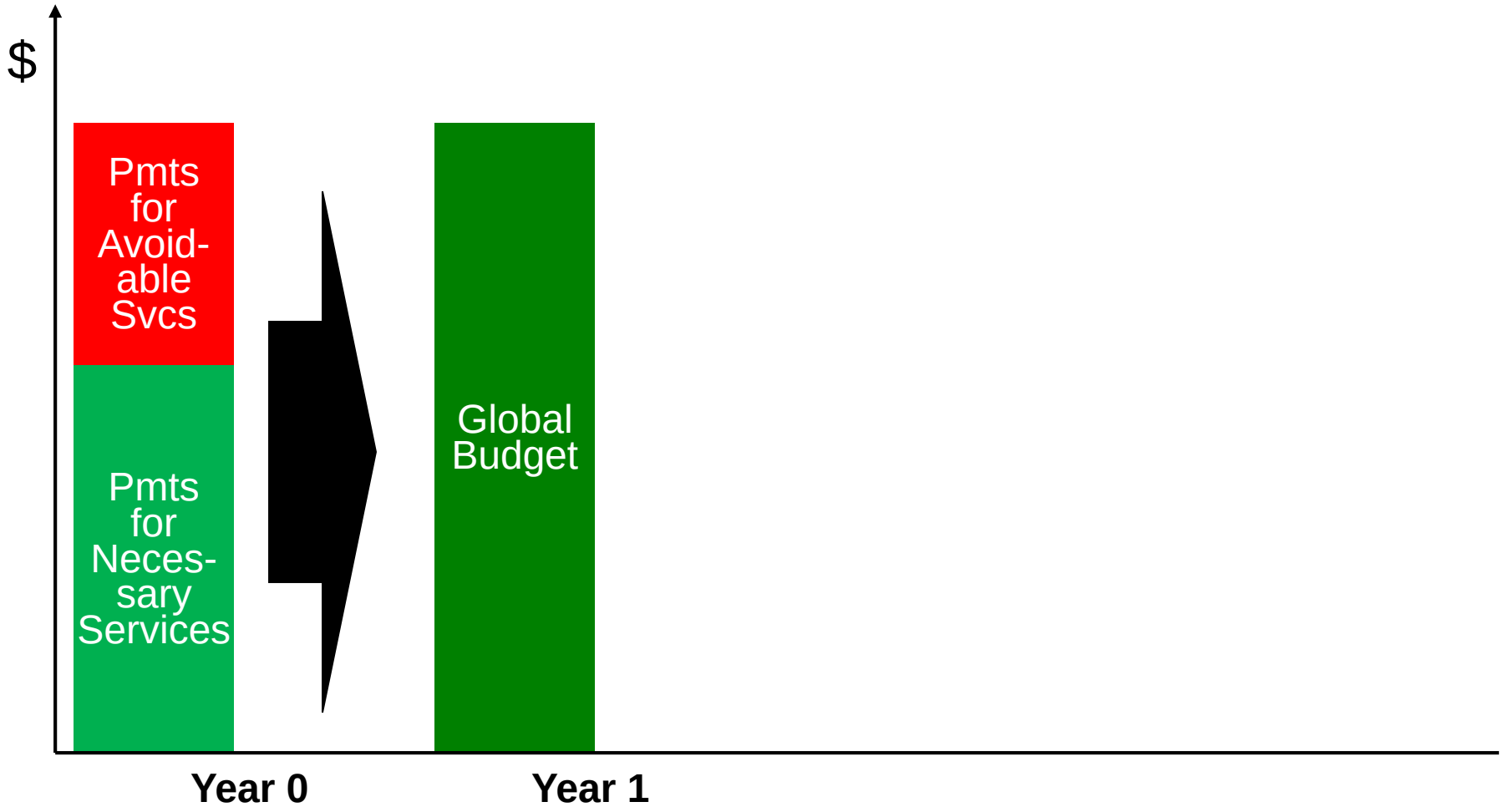
Premise #3: FFS Penalizes Reductions in Services



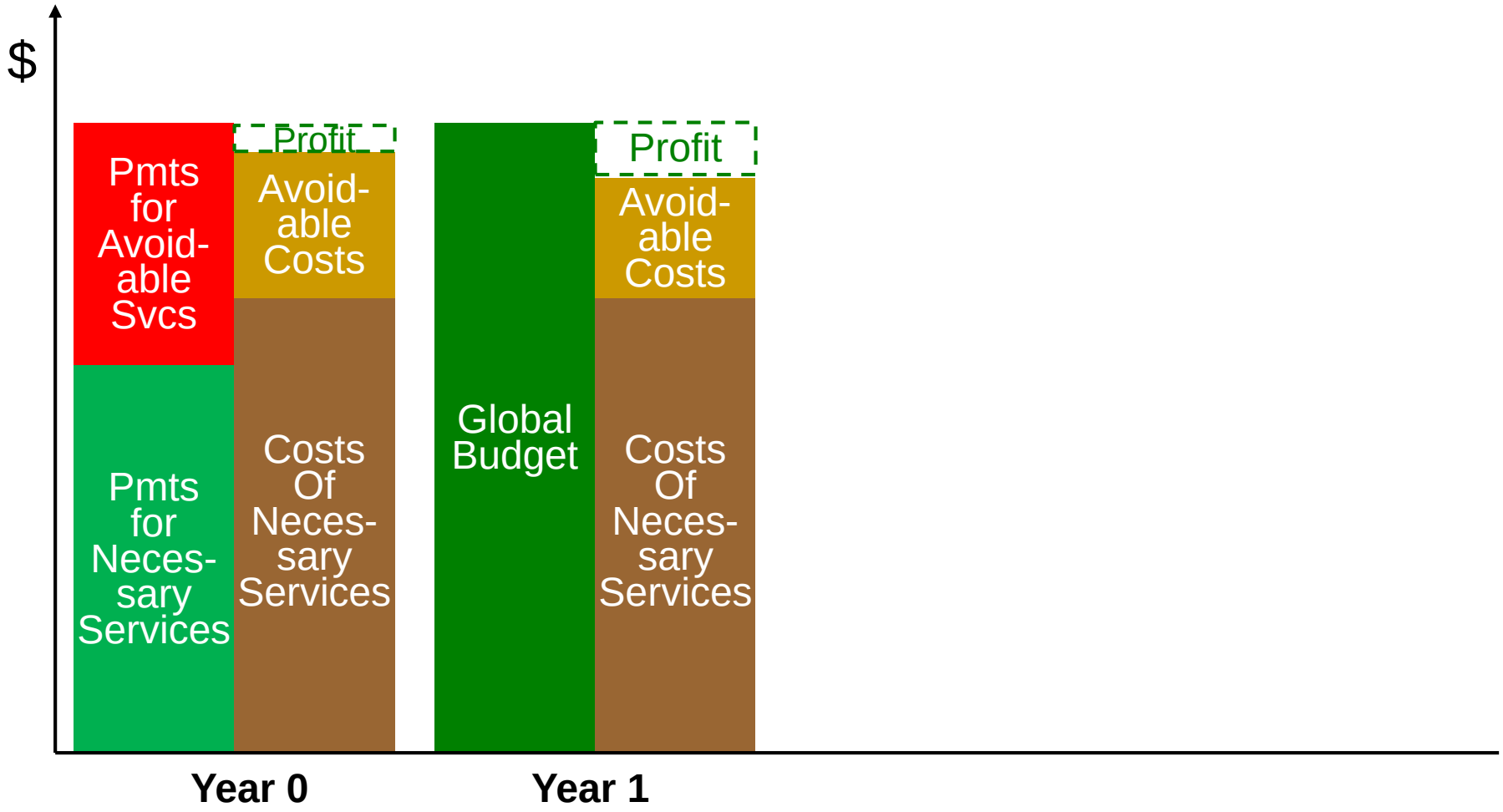
Losses Increase When Fewer Avoidable Services Are Delivered



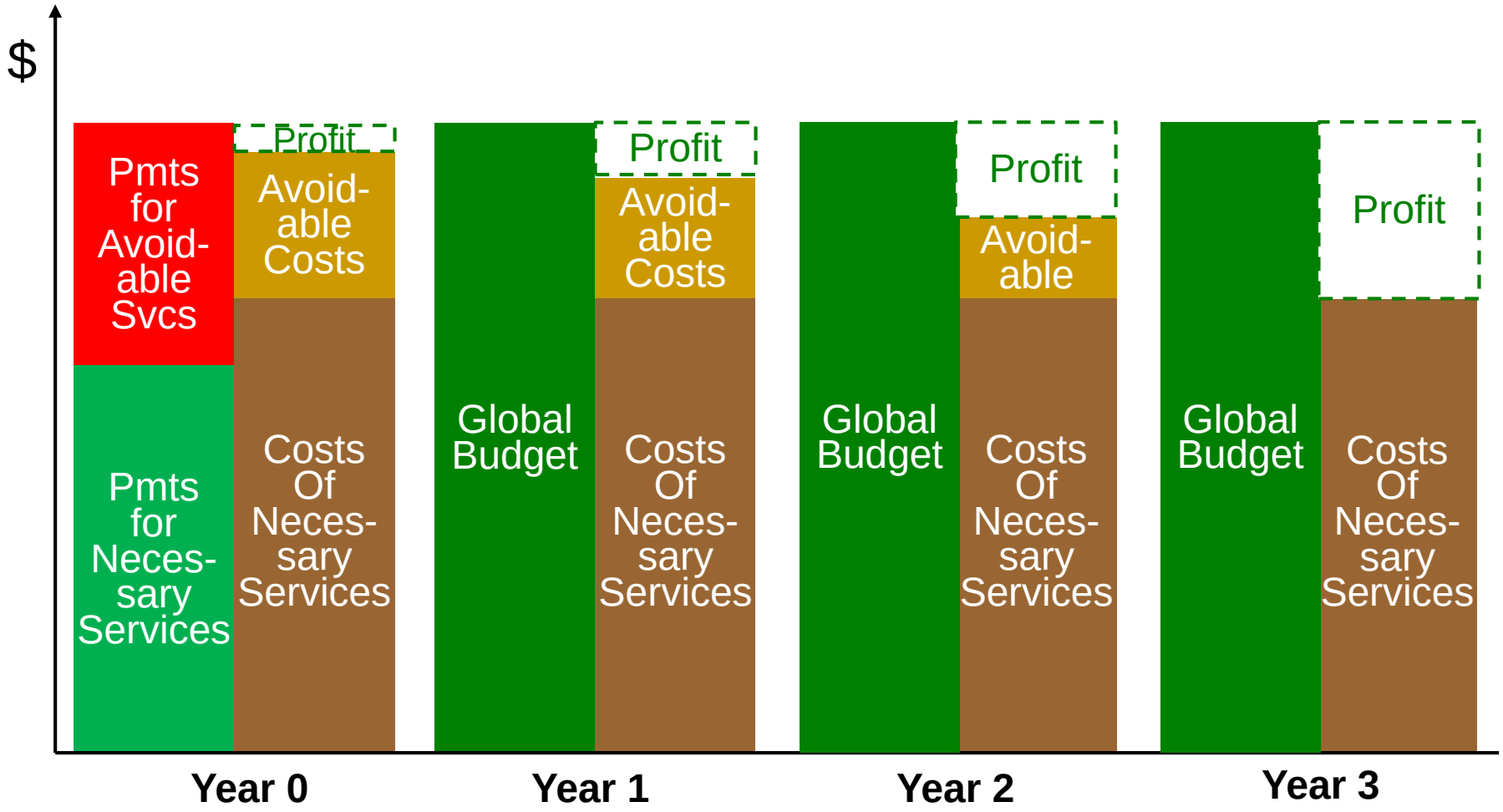
Under a Global Budget…



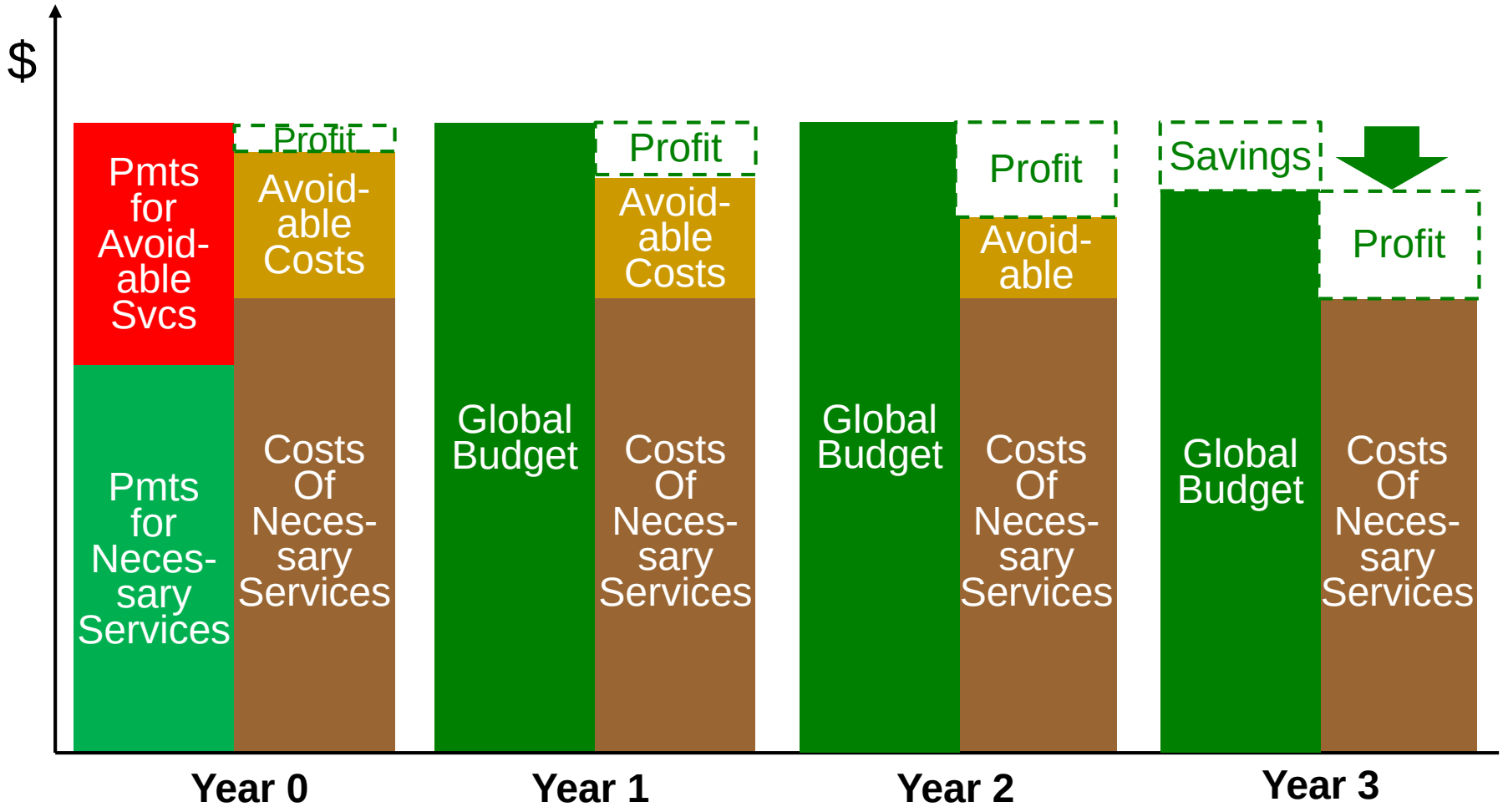
Revenue Does Not Decrease With Fewer Avoidable Services



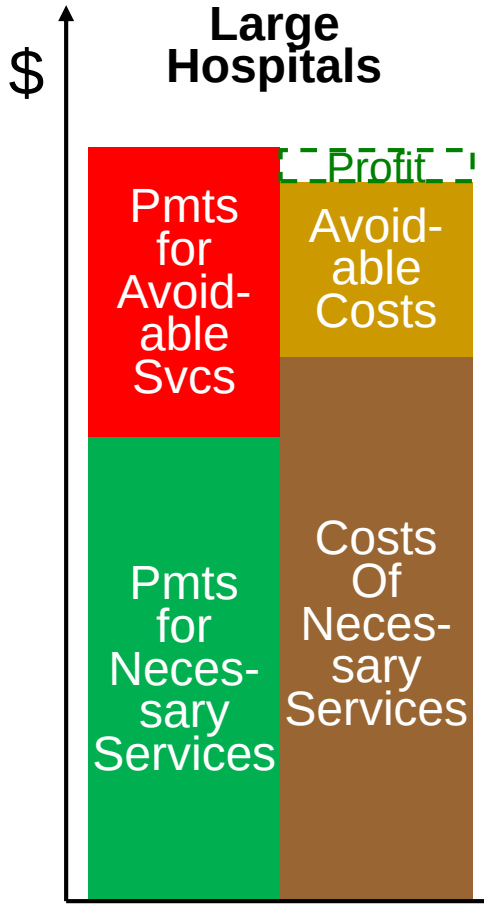
Reducing Avoidable Services Will Increase Hospital Profits



CMS Assumes Global Budget Can Be Reduced to "Share Savings"

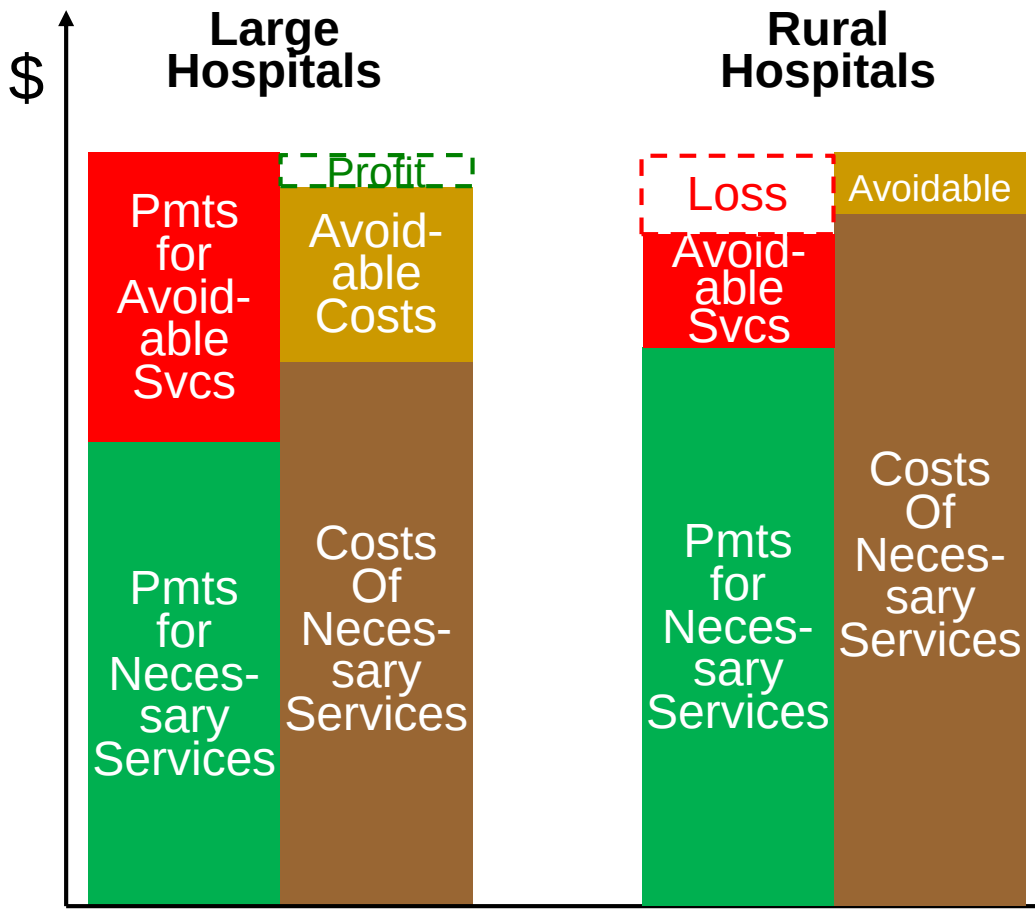


Premises of the Global Budget May Apply to Larger Hospitals



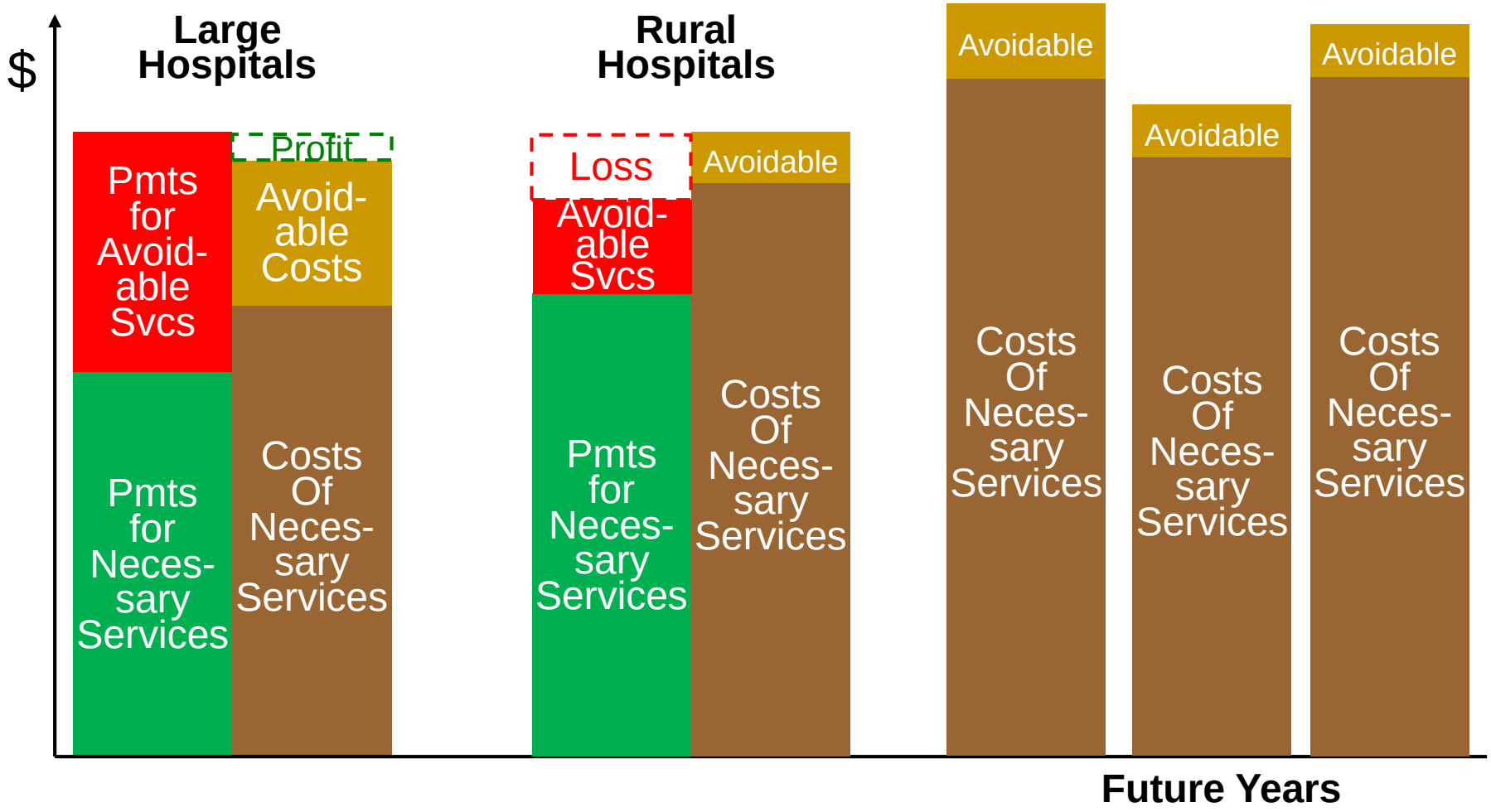
- Hospitals Deliver Many Avoidable and Non-Essential Services
- Costs Could Be Reduced if Fewer Avoidable Services Are Eliminated
- Unit Costs Are Fairly Stable Year-to-Year

…But Small Rural Hospitals Are Starting From a Different Place

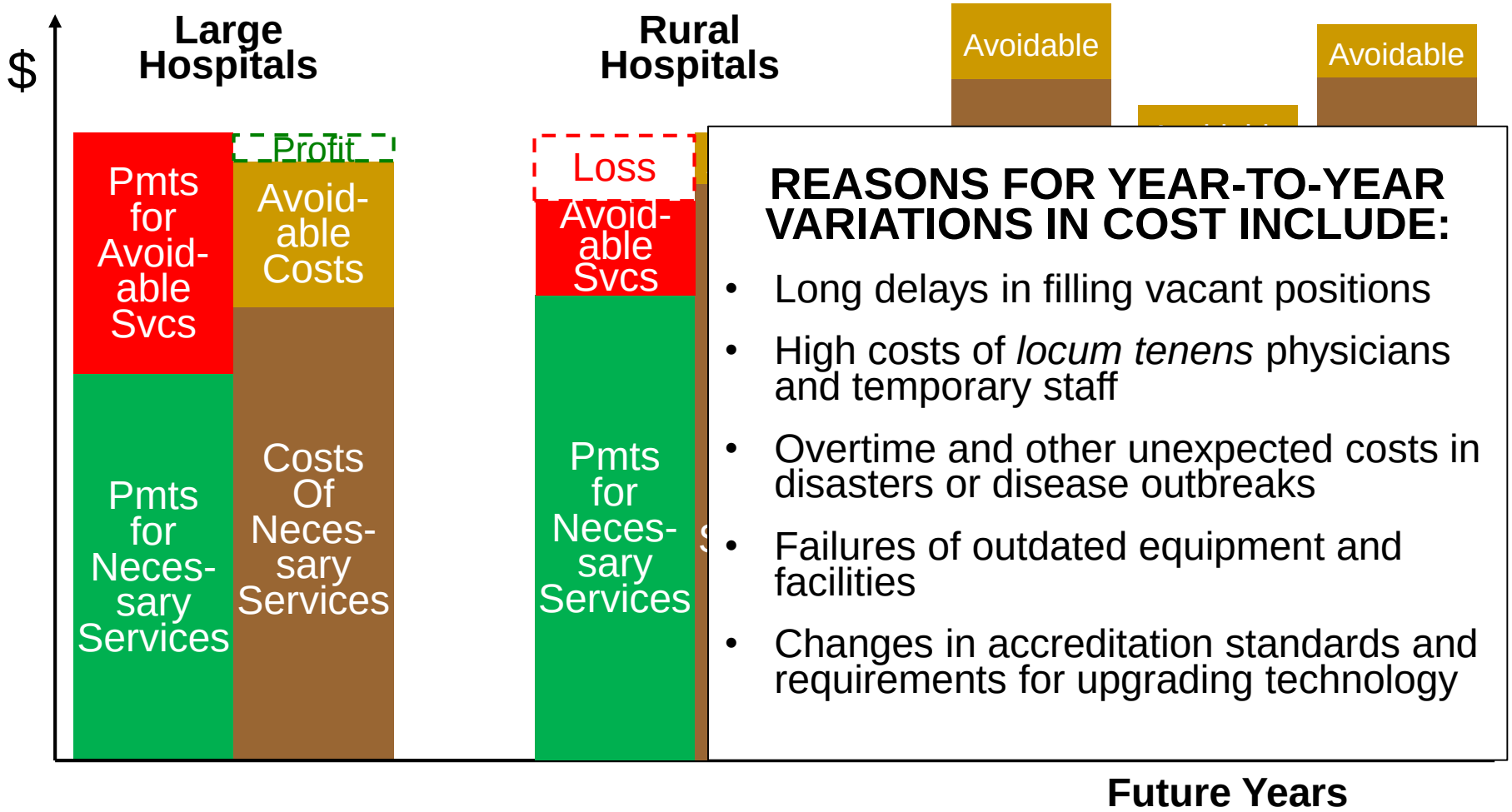


- Hospitals Have Large Operating Losses
- Hospitals Primarily Deliver Essential Services
- A High Proportion of Costs Are Fixed
- Unit Costs Are Highly Variable

Rural Hospital Costs Can Change With No Change in Volume



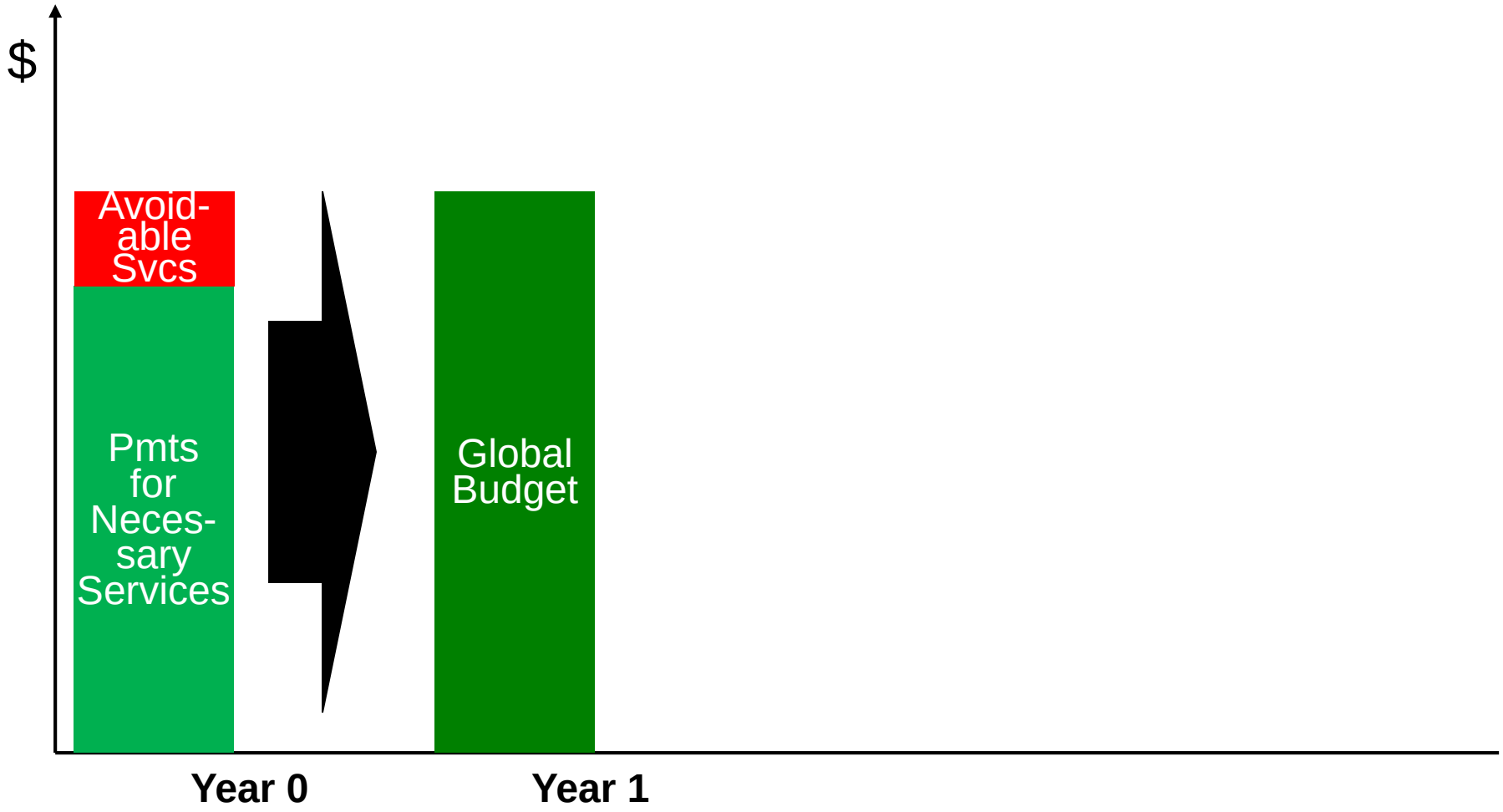
Rural Hospital Costs Can Change Significantly From Year to Year



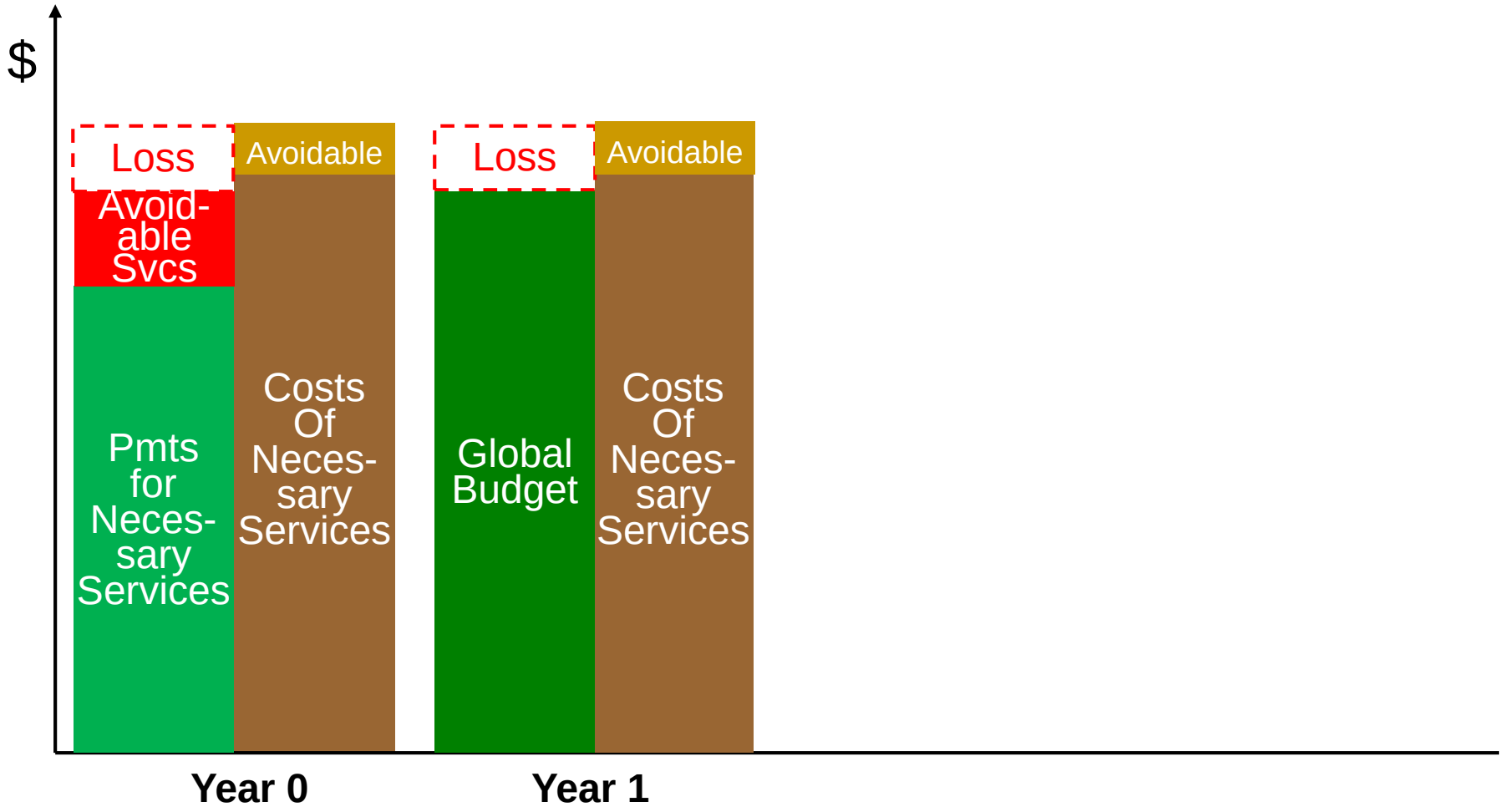
REASONS FOR YEAR-TO-YEAR VARIATIONS IN COST INCLUDE:

- 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

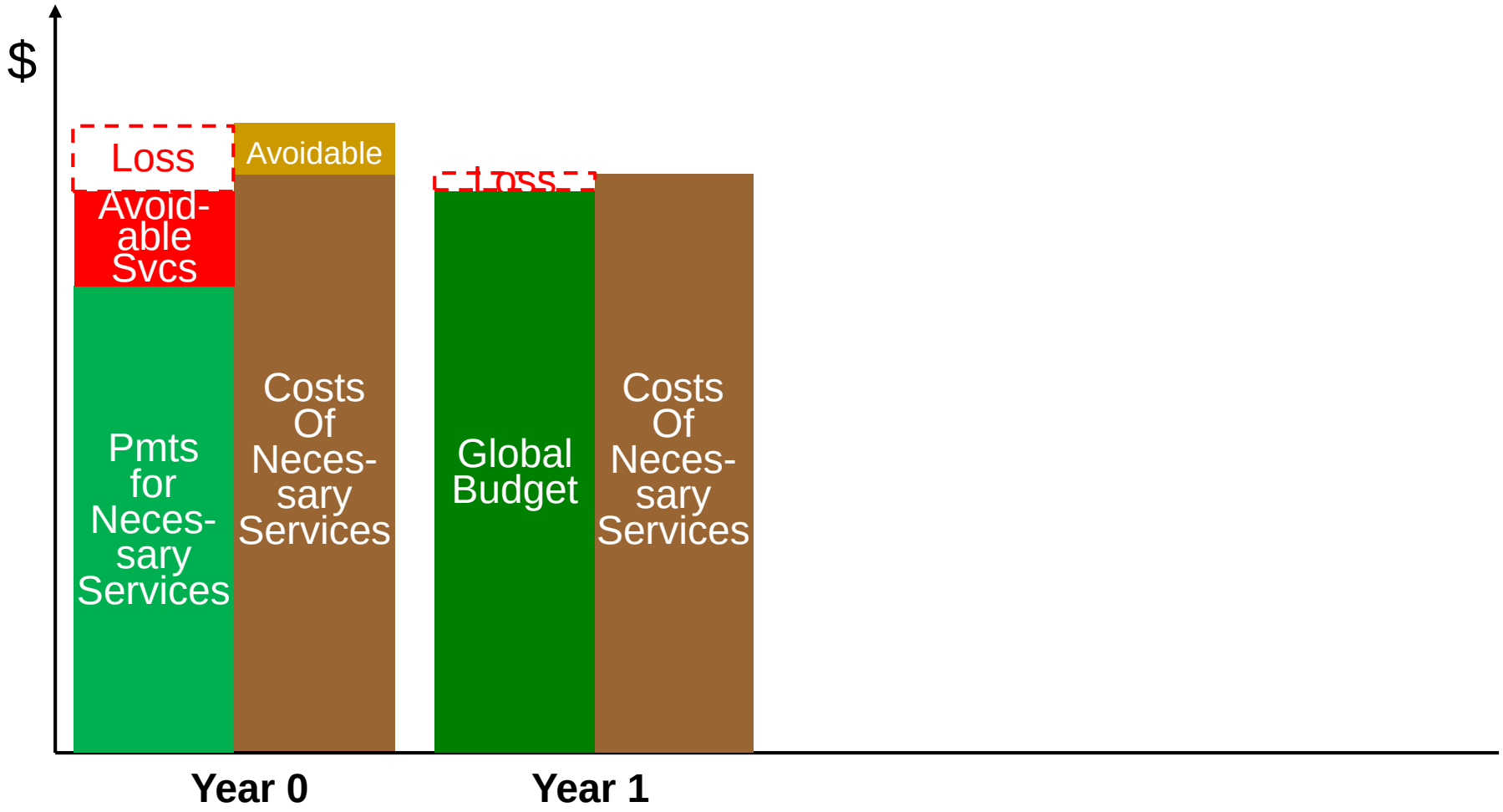
The "Global Budget" is Supposed to Start With *Current* Revenue…



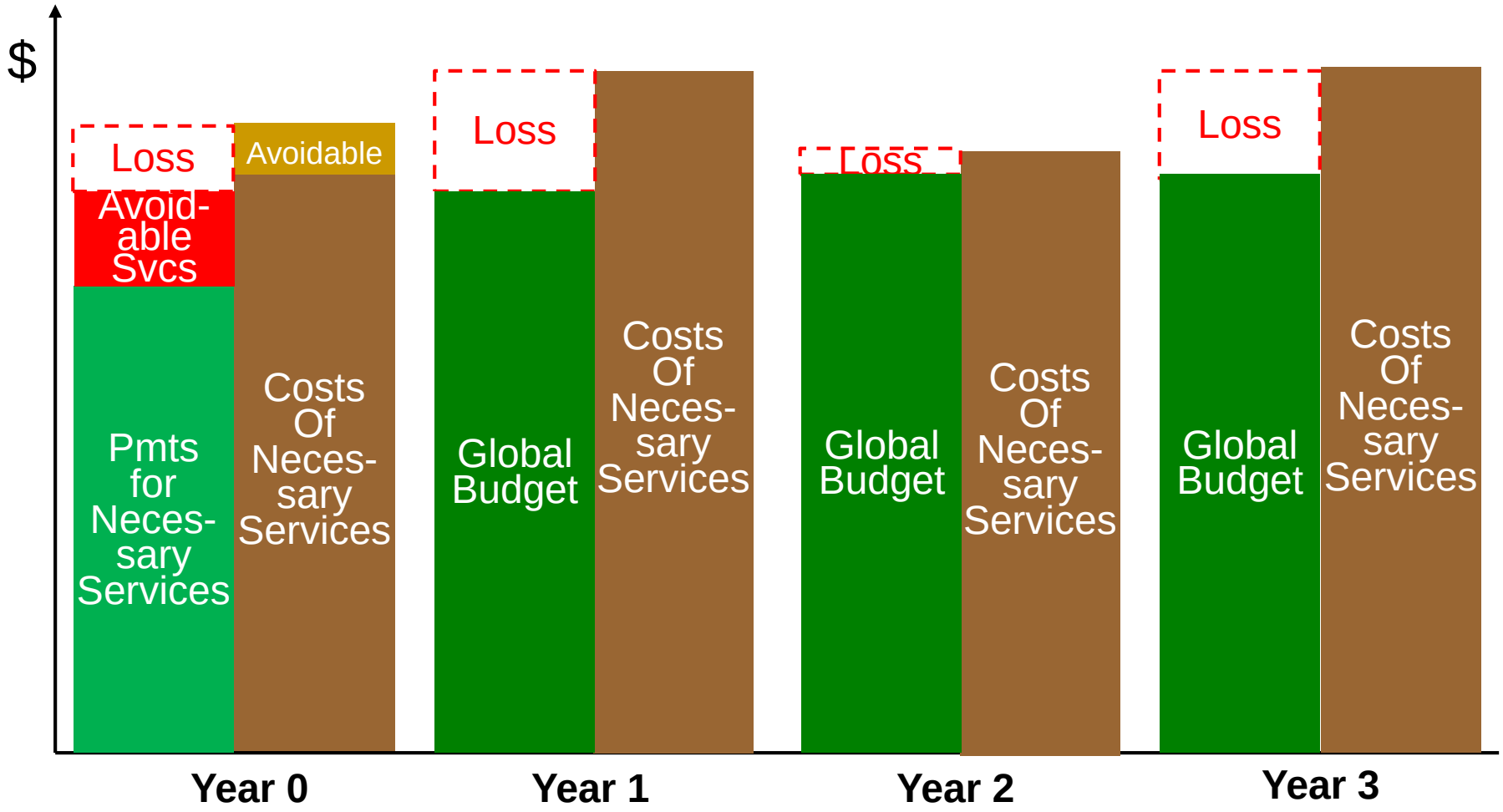
…But If Current Revenue Doesn't Cover Costs, It's Not a Solution



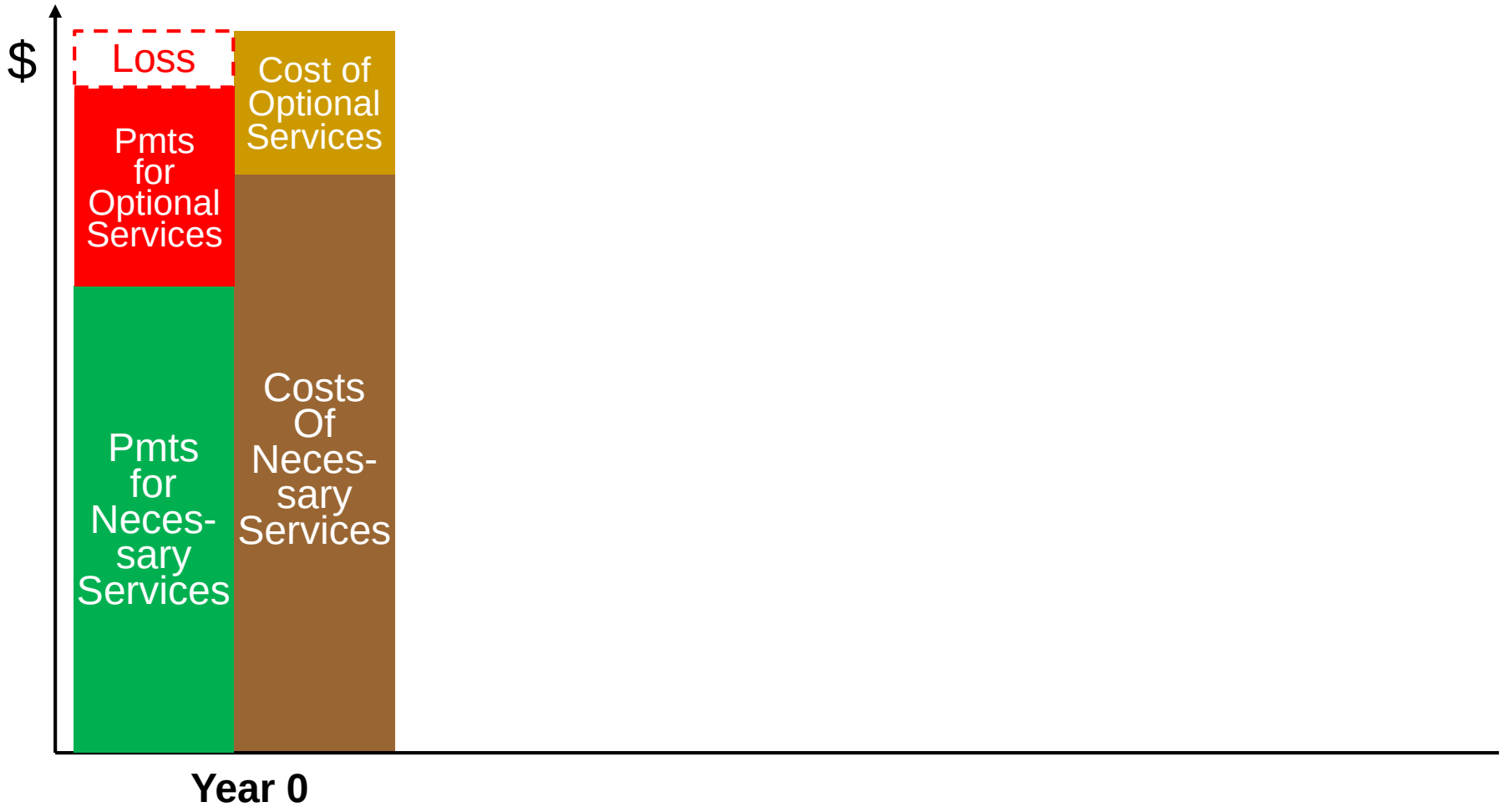
Reducing Avoidable Services Doesn't Reduce Costs Very Much



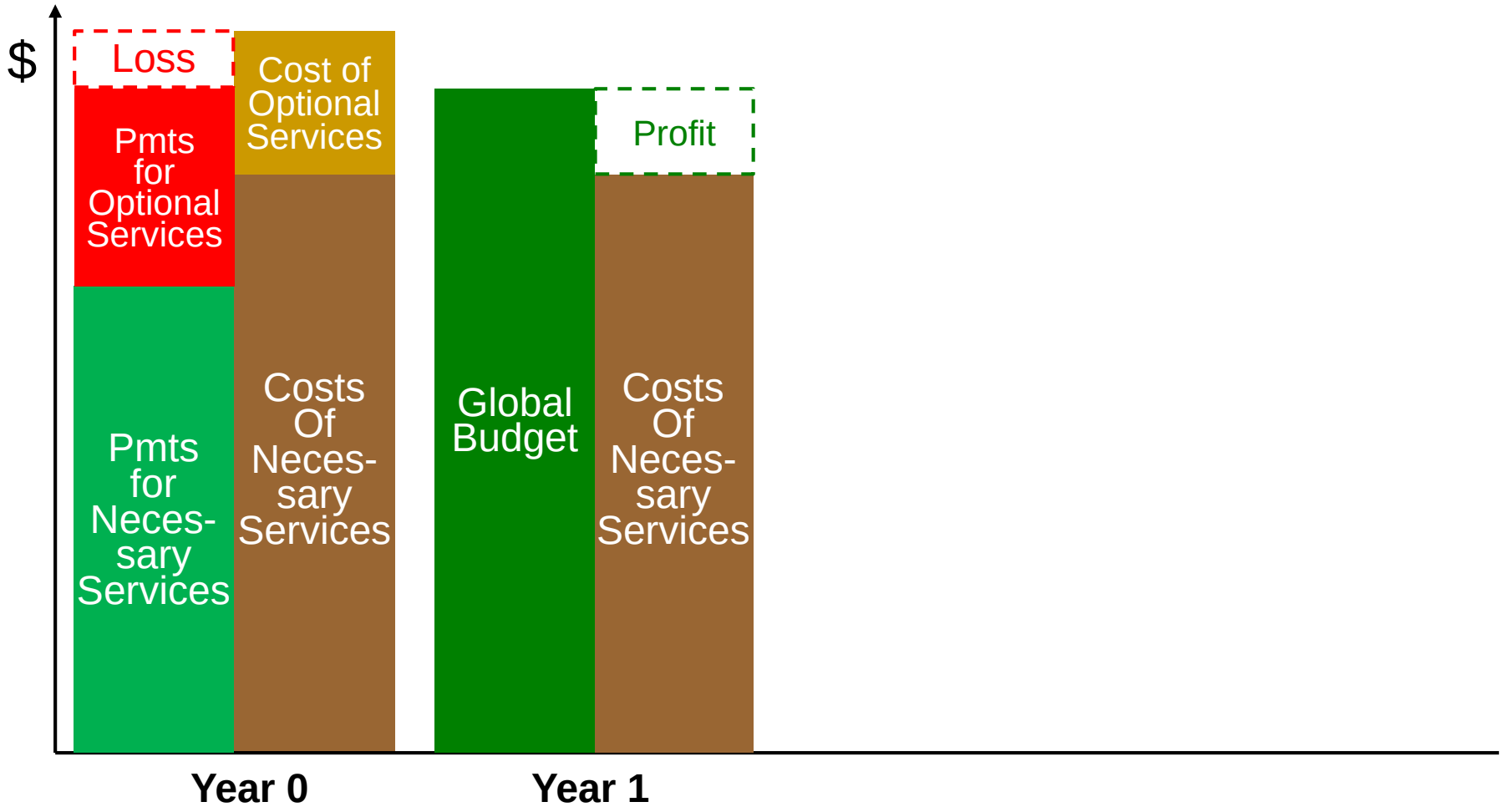
If Costs Increase But Global Budget Doesn't, Losses Increase



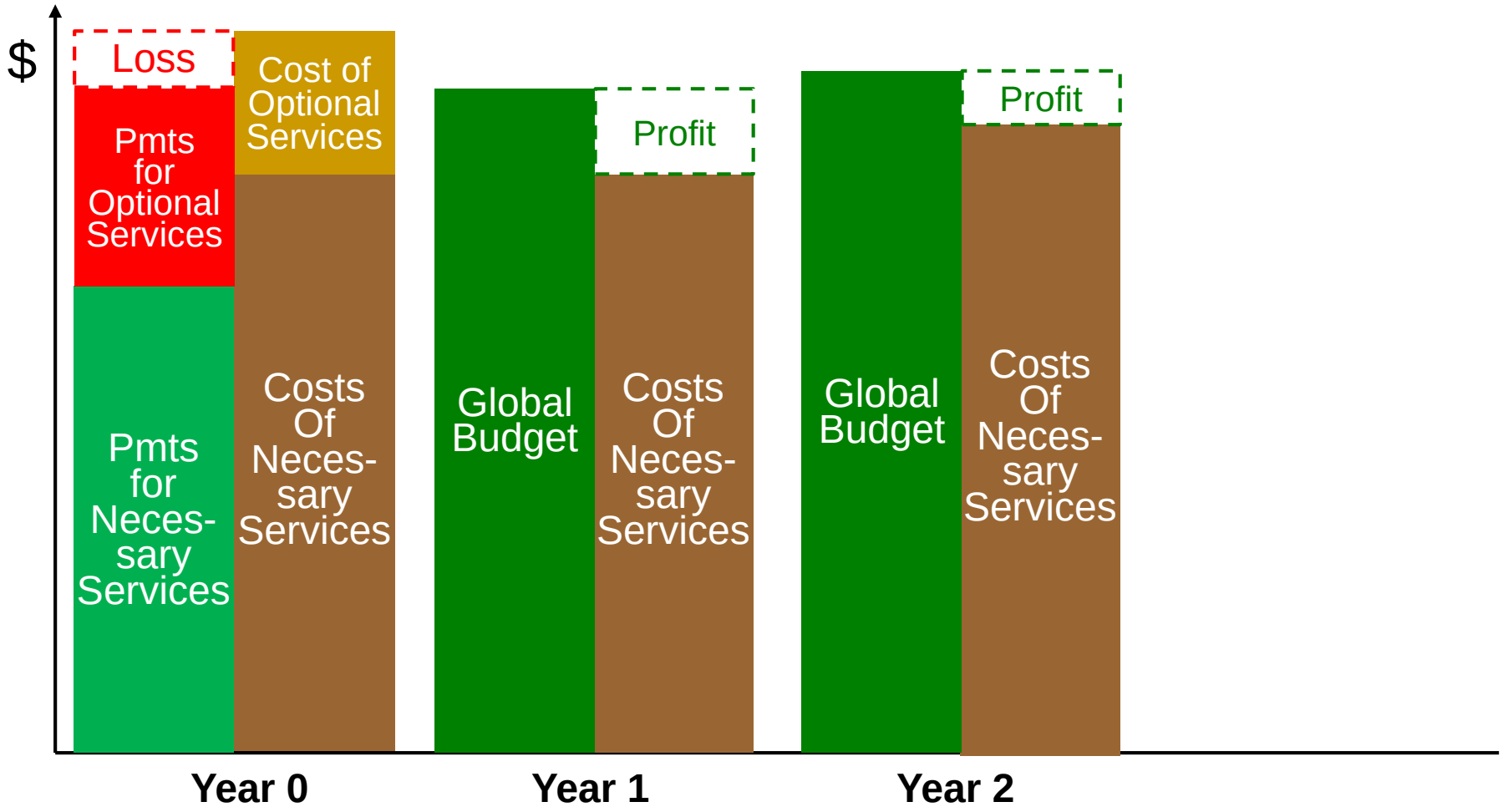
If Hospital is Delivering Non-Essential Services…



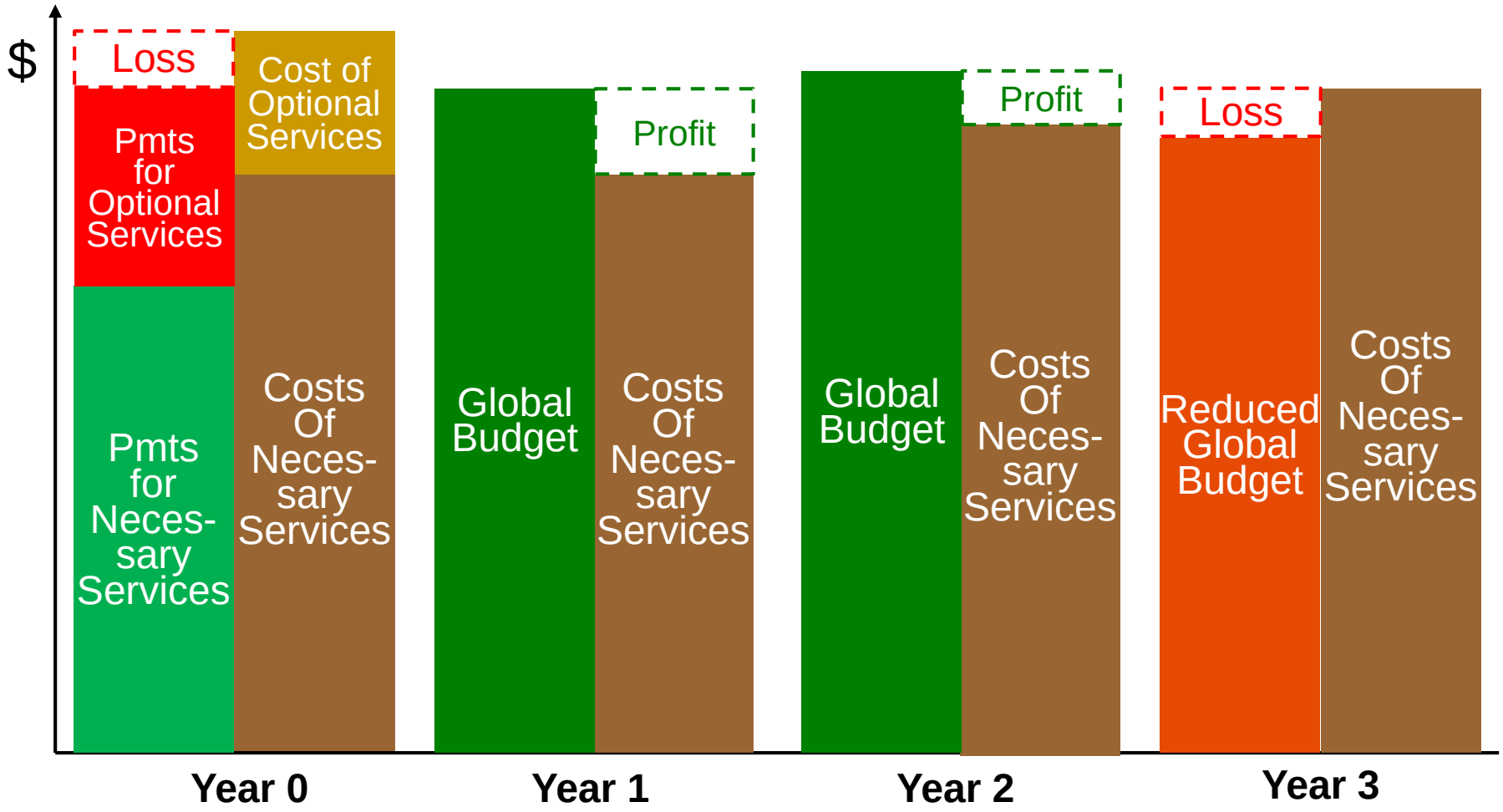
Global Budget Makes It Profitable To Eliminate Them…



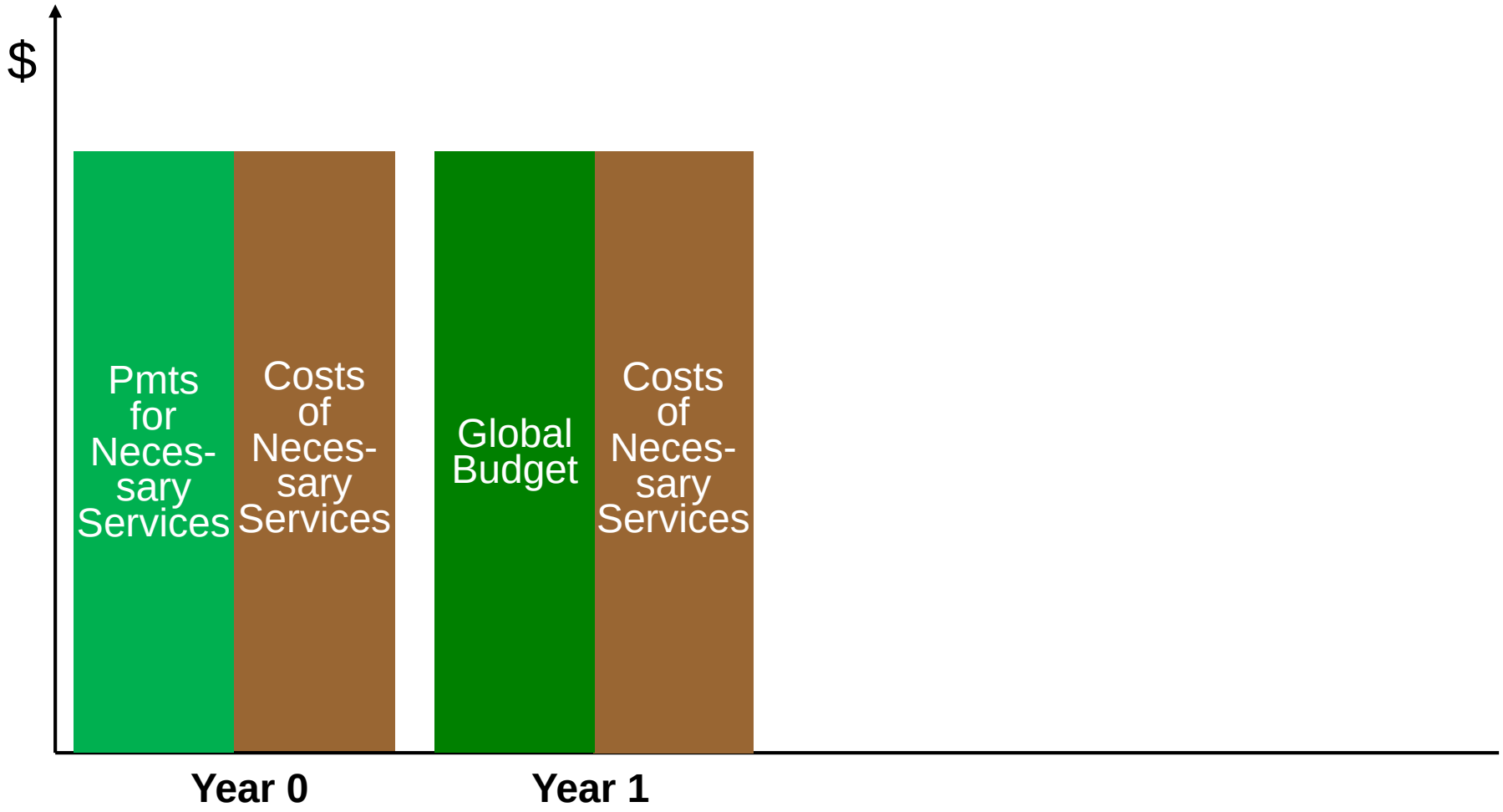
Increases in Budget May Cover Cost Growth in Essential Svcs



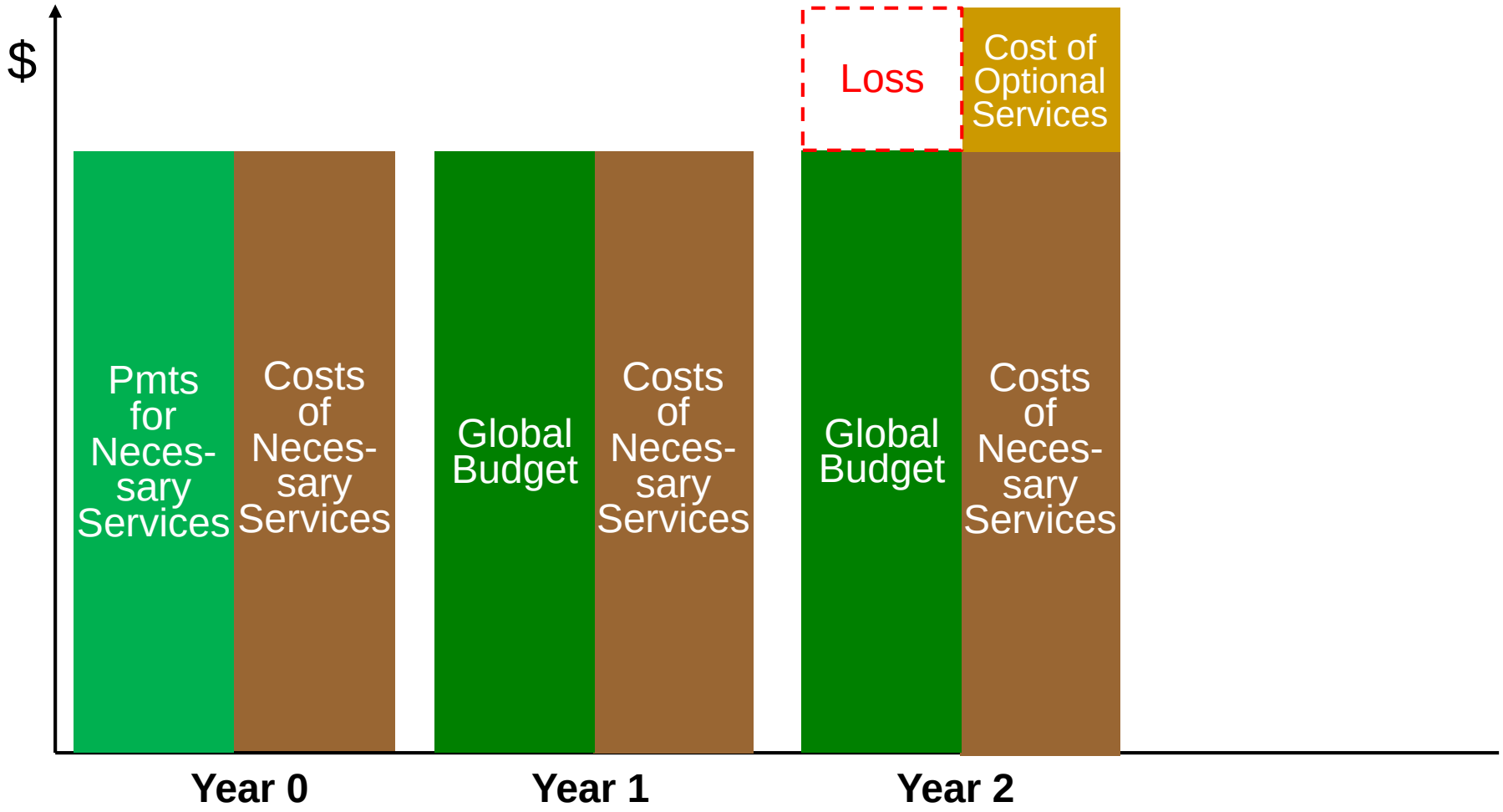
…But There is No Guarantee Global Budget Won't Be Cut



If Hospital is Only Delivering Minimum Services Today…



…Global Budget Prevents Adding New Services for the Community



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)

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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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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

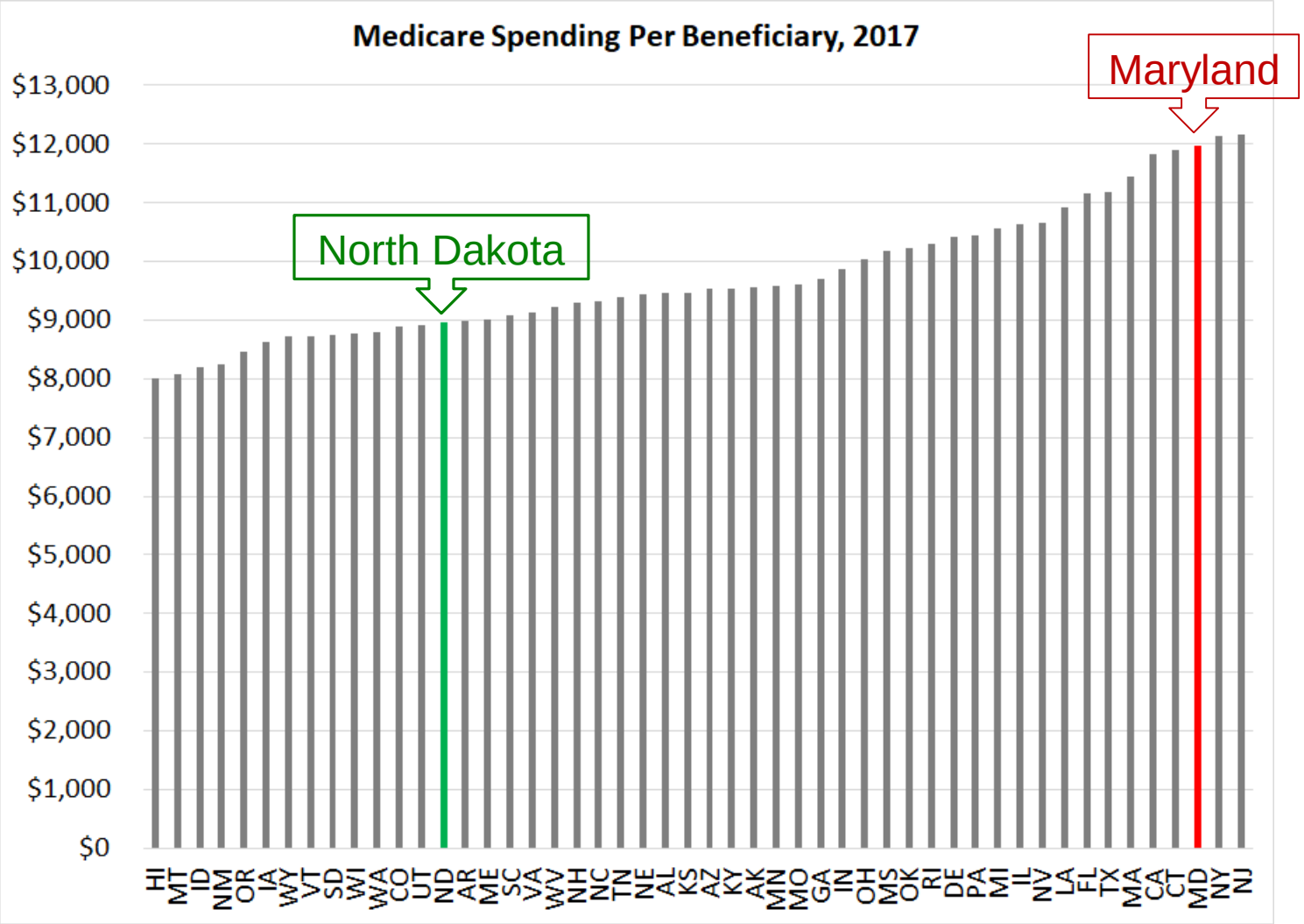
Maryland's System is Different From What CMMI is Promoting

	Maryland	CMMI/Pennsylvania Model
Determination of Annual Hospital Budget	Determined with a complex formula based on market share and community factors	Based on past revenues increased by an inflation factor
Adjustments to Budget When Costs Change	State agency with large staff experienced in evaluating hospital costs reviews hospital requests	New agency with a focus on helping hospitals redesign service delivery; unclear if or how budgets will be changed
Payer Participation in Model	State can mandate participation and payment amounts by all payers, including Medicare	Payer participation is voluntary; CMMI can change the rules at any time
Reliability of Payment	Hospital can adjust payment rates to ensure budget is met	Payers may or may not pay the full amount expected by hospitals

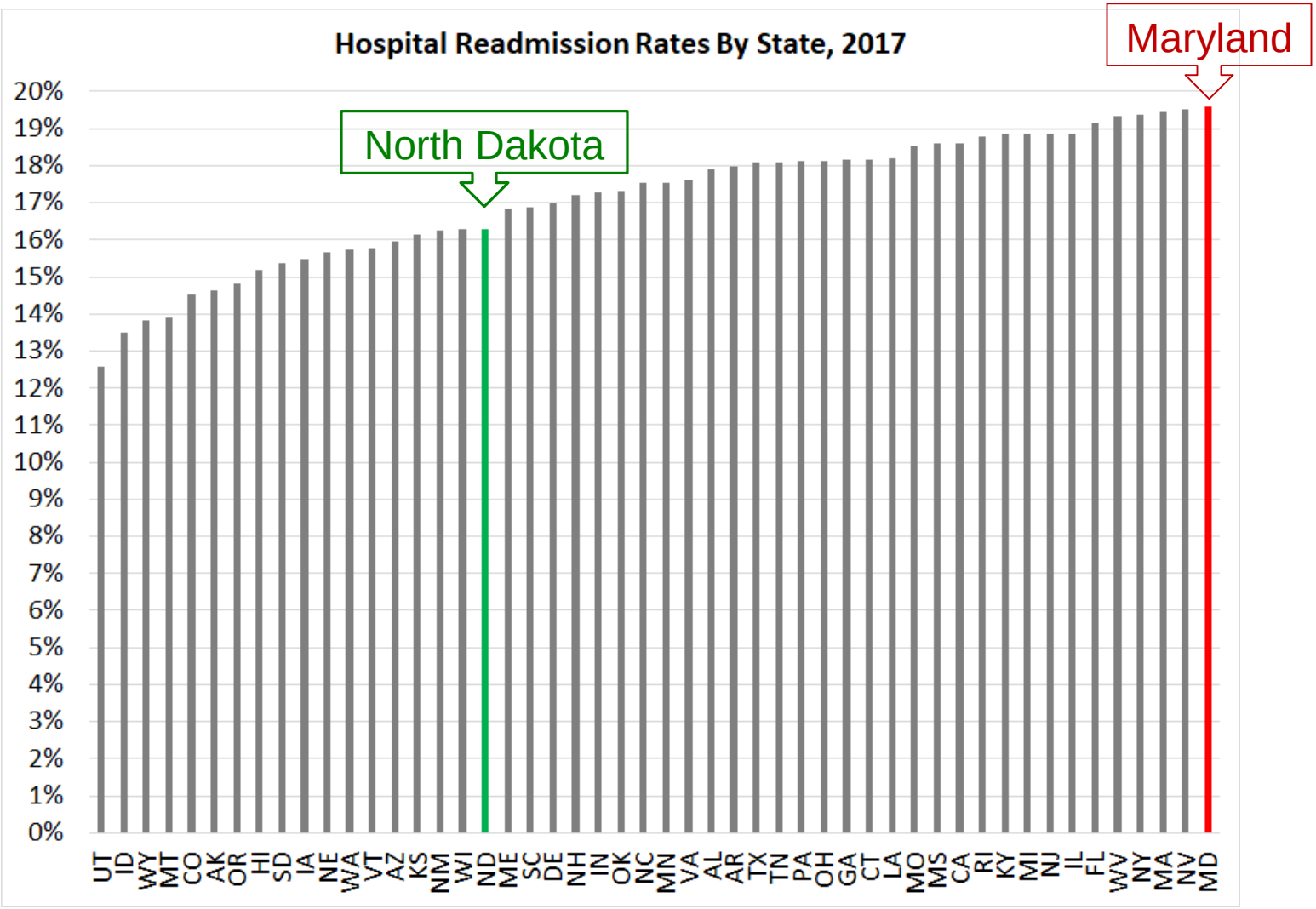
Maryland's Problems/Opportunities Are Different Than Rural States

- 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.



Global Budgets Haven't Reduced "Rural Hospital" Spending in MD

HOSPITALS

DOI: 10.1377/hlthaff.2018.0112
HEALTH AFFAIRS 37,
NO. 4 (2018): 644–653

By Eric T. Roberts, Laura A. Hatfield, J. Michael McWilliams, Michael E. Chernew, Nicolae Done, Sule Gerovich, Lauren Gilstrap, and Ateev Mehrotra

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

Eric T. Roberts (eric.roberts@pitt.edu) is an assistant professor in the Department of Health Policy and Management, Graduate School of Public Health, University of Pittsburgh, in Pennsylvania.

Laura A. Hatfield is an associate professor in the Department of Health Care Policy, Harvard Medical School, in Boston, Massachusetts.

J. Michael McWilliams is the Warren Alpert Foundation Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School.

Michael E. Chernew is the Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School.

Nicolae Done is a postdoctoral fellow at Boston University School of Medicine.

Sule Gerovich is a senior

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 isolate 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.

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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

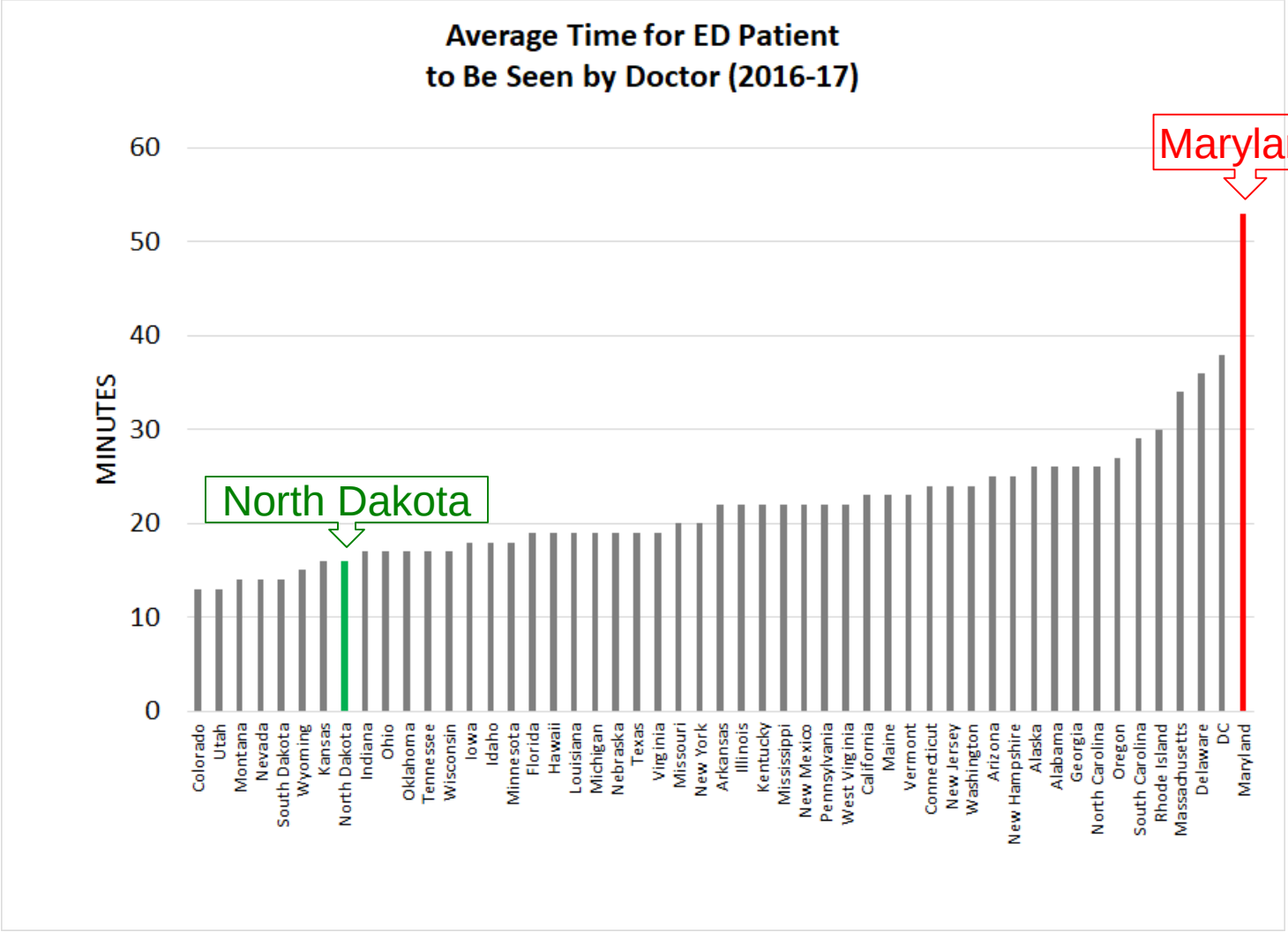
Share Article

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

An image from a YouTube video of a woman who was discharged from University of Maryland Medical Center in Baltimore and released into the cold night. Imamu Baraka/PMGVideos, via YouTube

The New York Times

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.

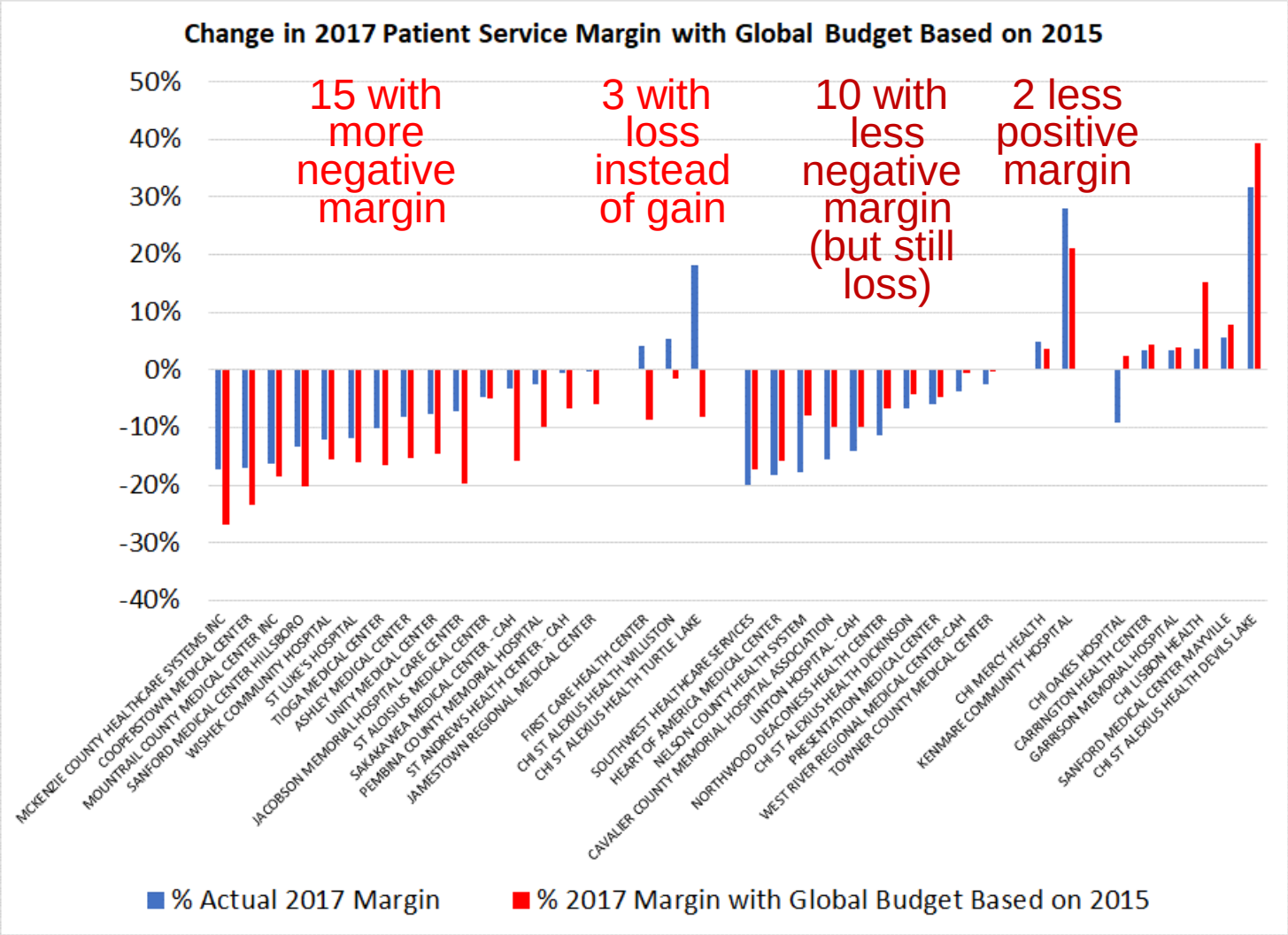
"This is disgusting that they would just leave her unattended on a bus stop, half naked," he said in the video. "And it's got to be at least 40 degrees, if not colder."

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."

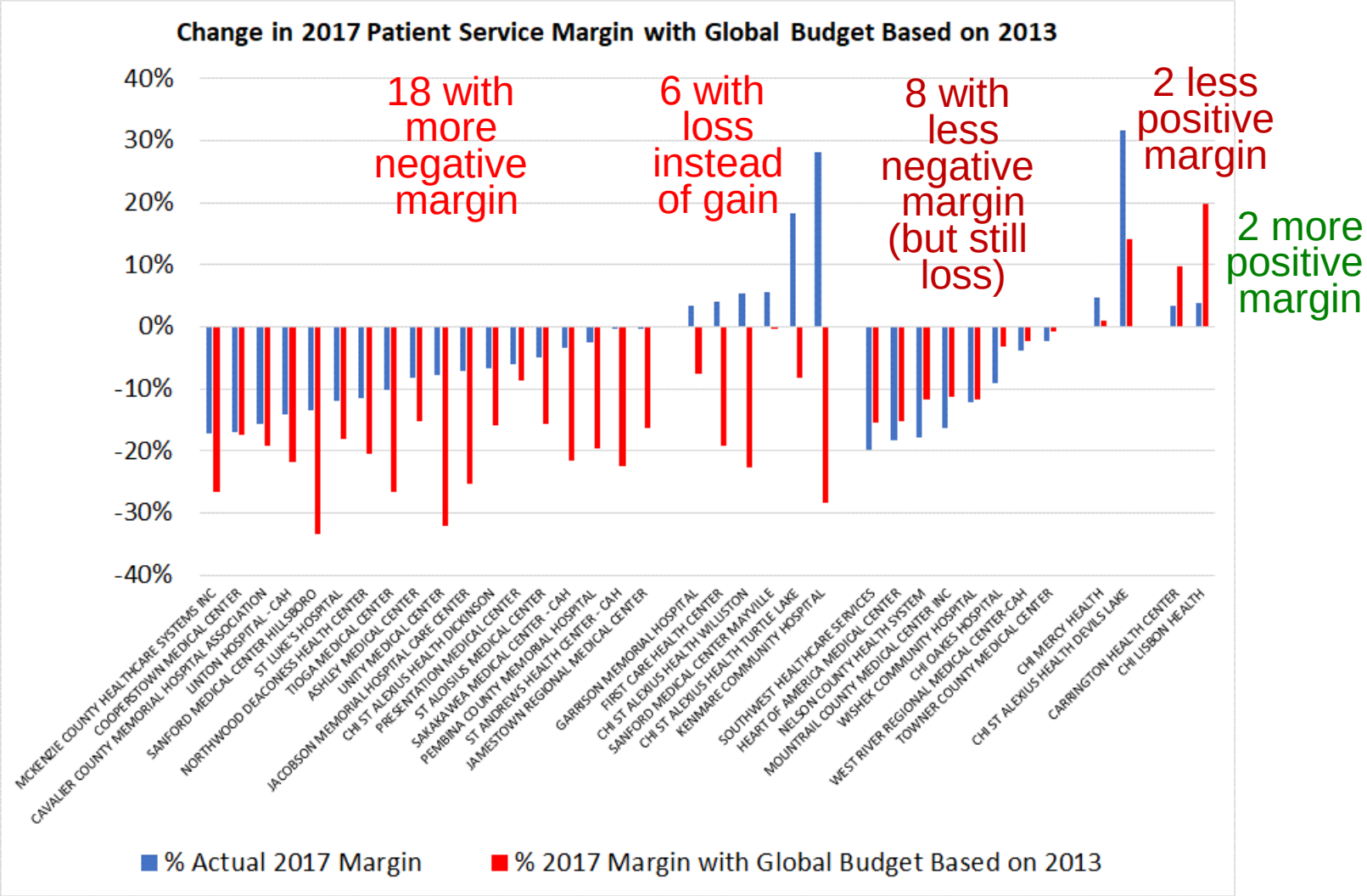
Most ND CAHs Would Do Worse Under a Global Budget



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

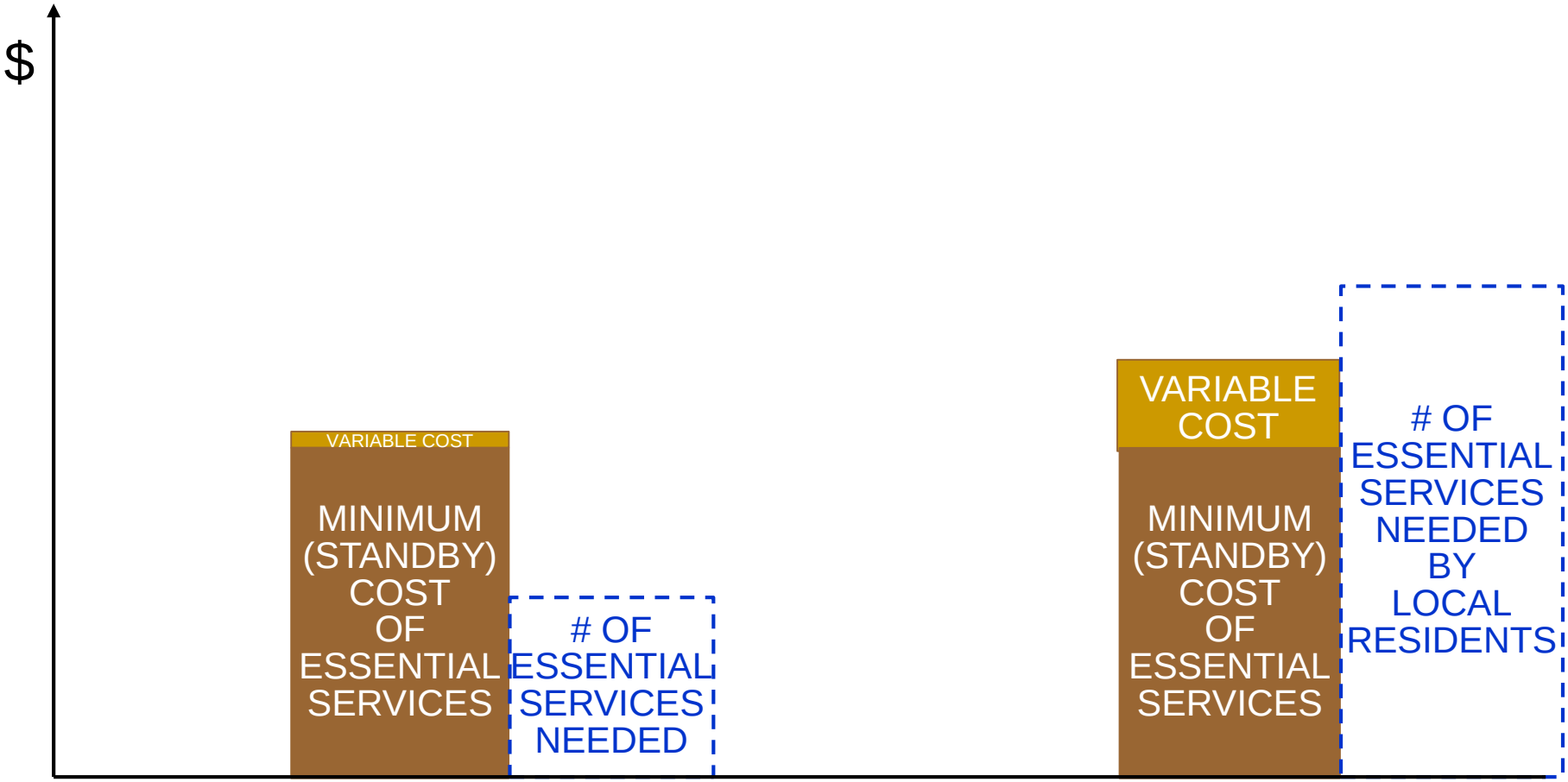


Is There a Better Way?

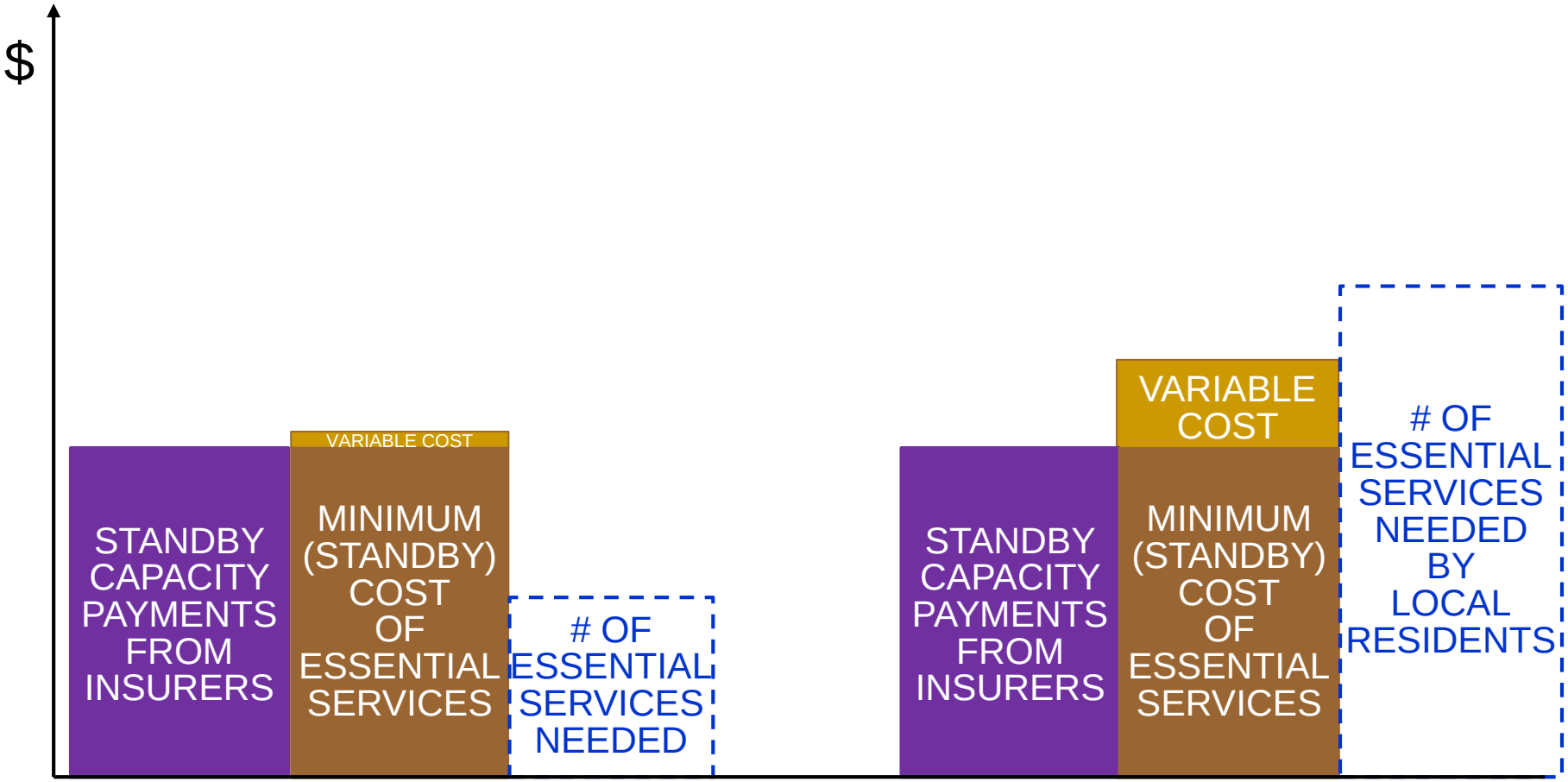
Rural Hospitals Deliver 2 Kinds of Services, But Only 1 is Paid For

- **Services delivered to patients – fees for services**
- **Readiness in case patients need services – no payment**

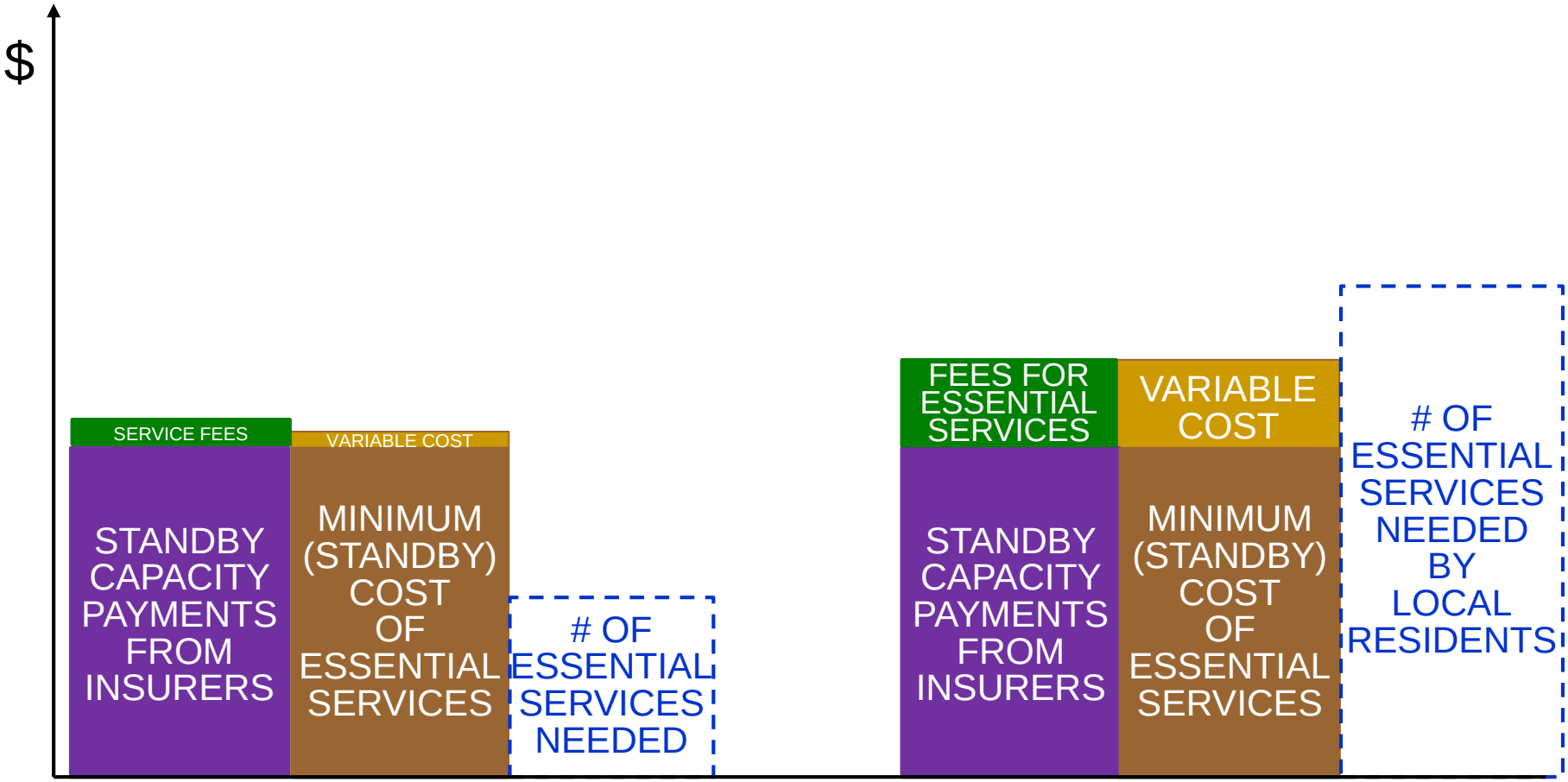
Minimum Cost is Incurred Even if Few Services Are Delivered



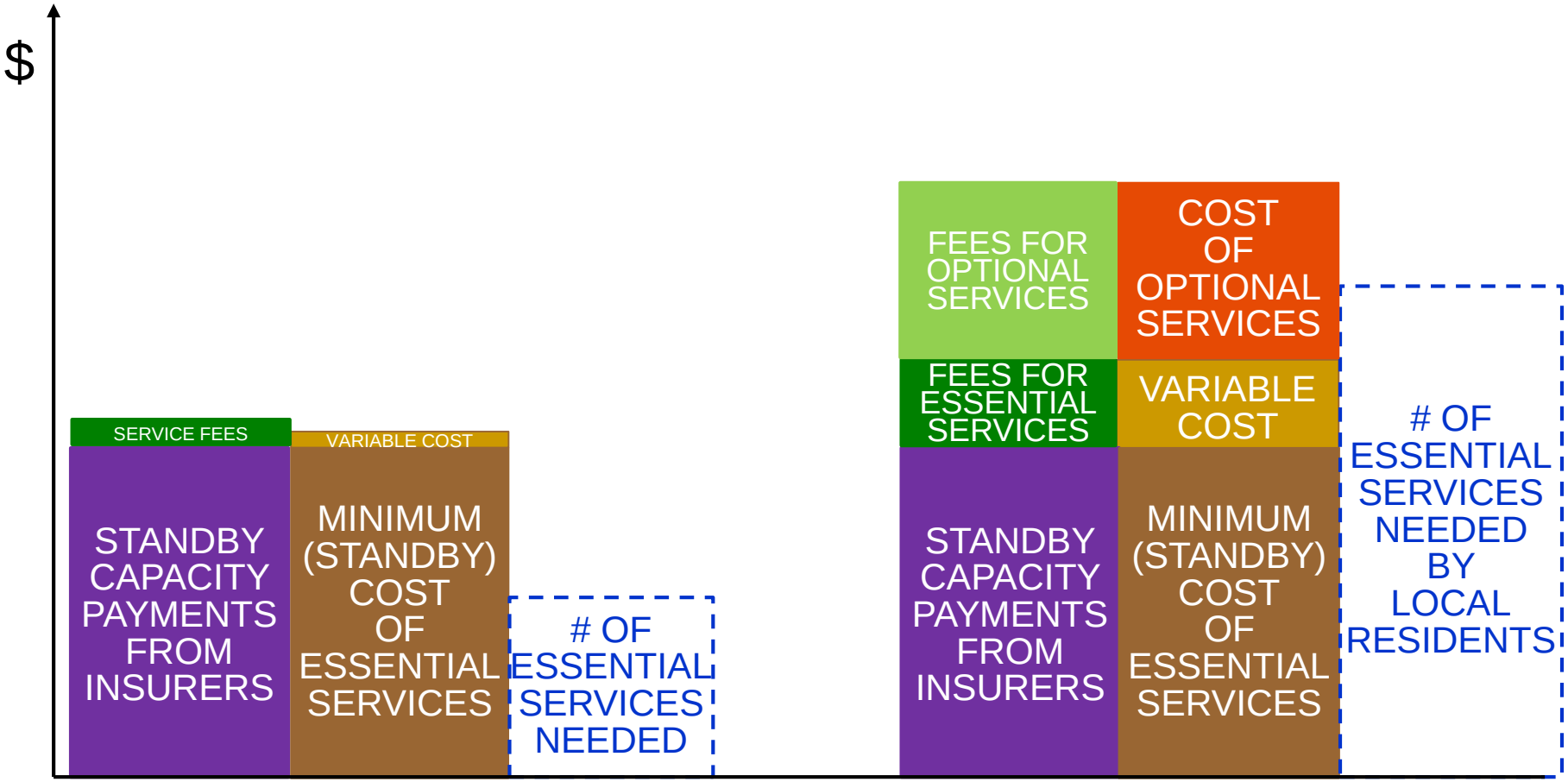
Payers Should Pay a "Standby Capacity Payment"



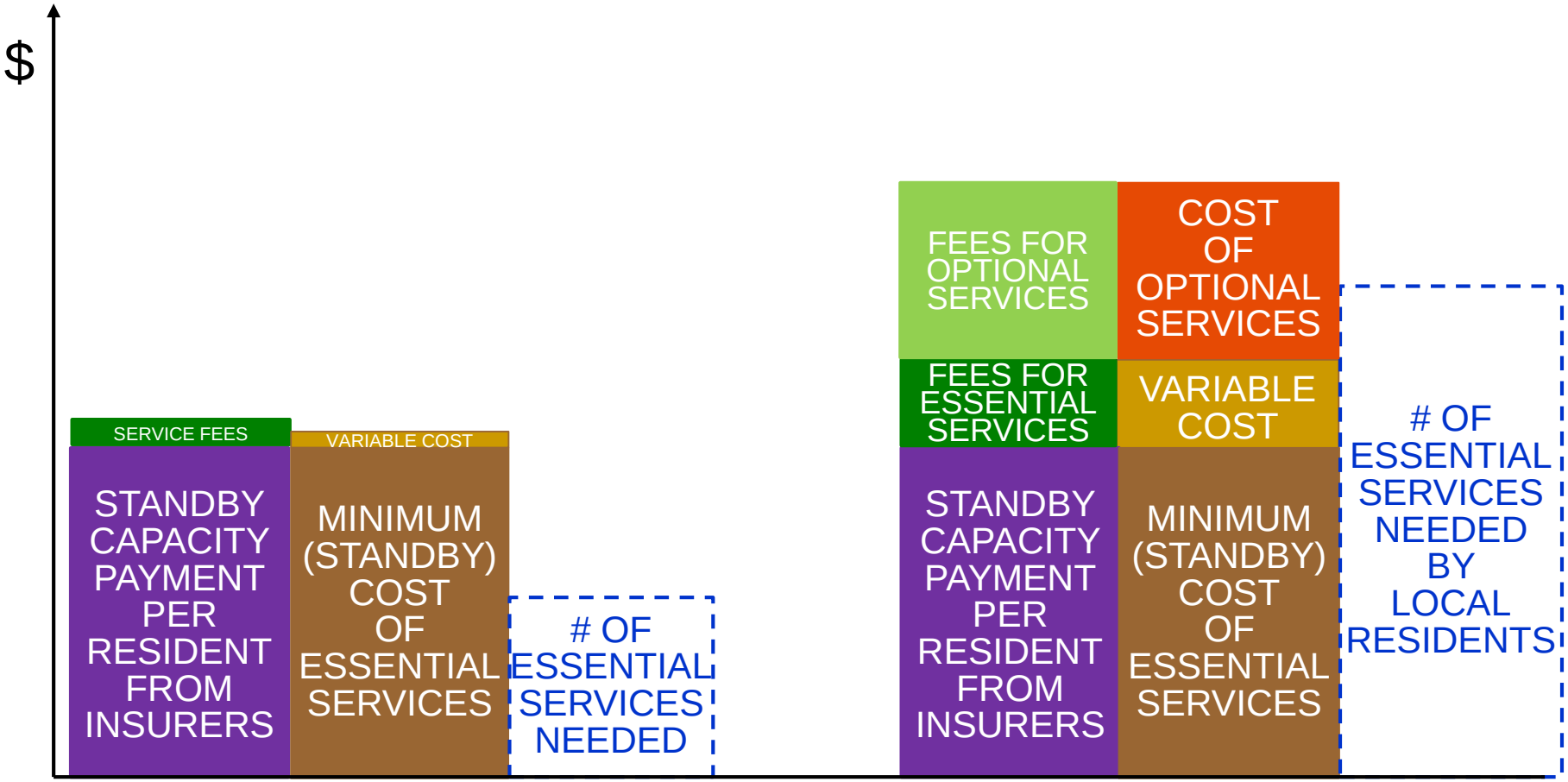
Fees Can Then Be Used to Cover the *Variable* Costs of Services



Fees Can Also Be Used to Cover Any Optional Services Delivered



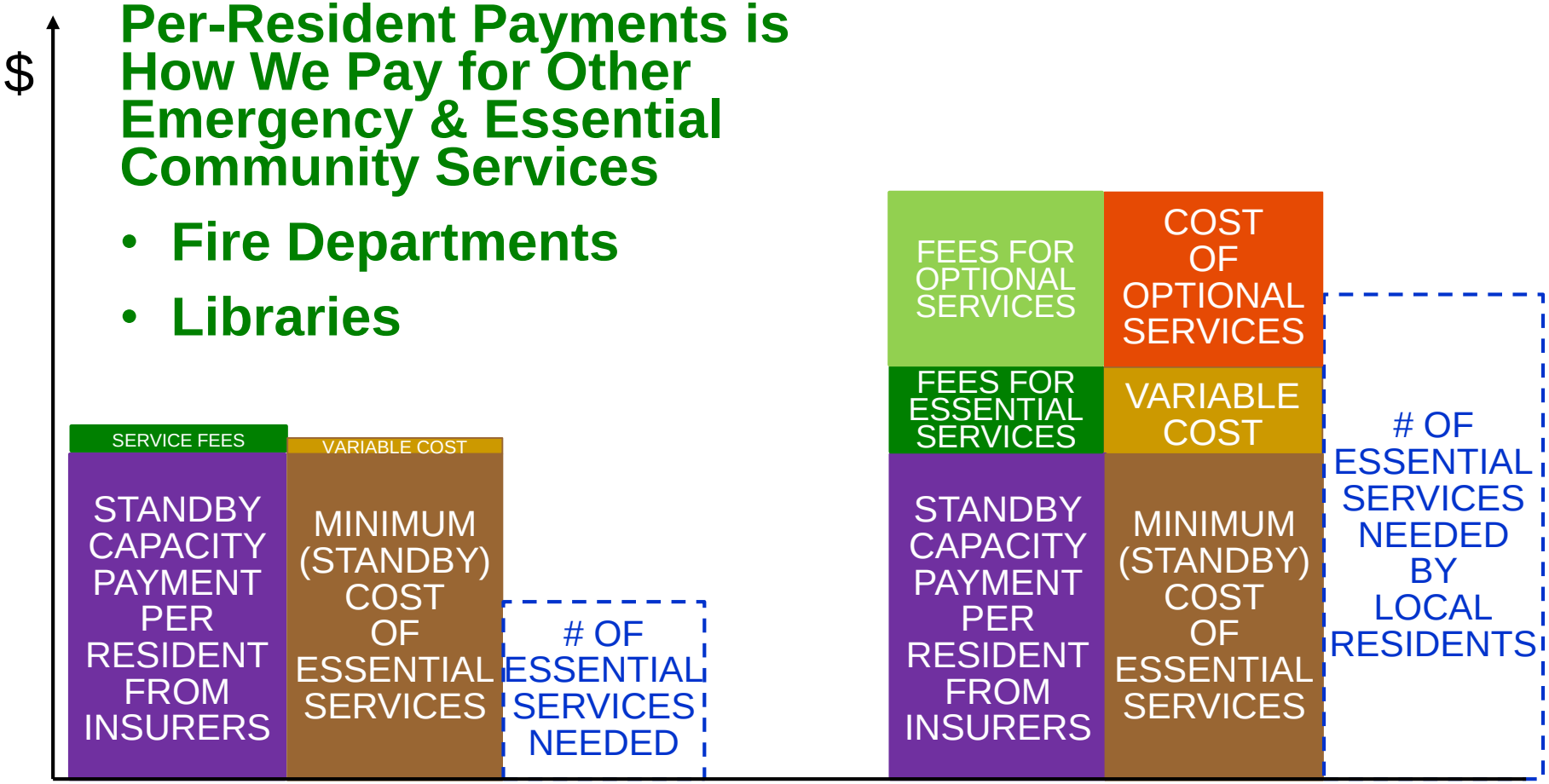
Standby Capacity Payments Should Be $ *Per Resident*



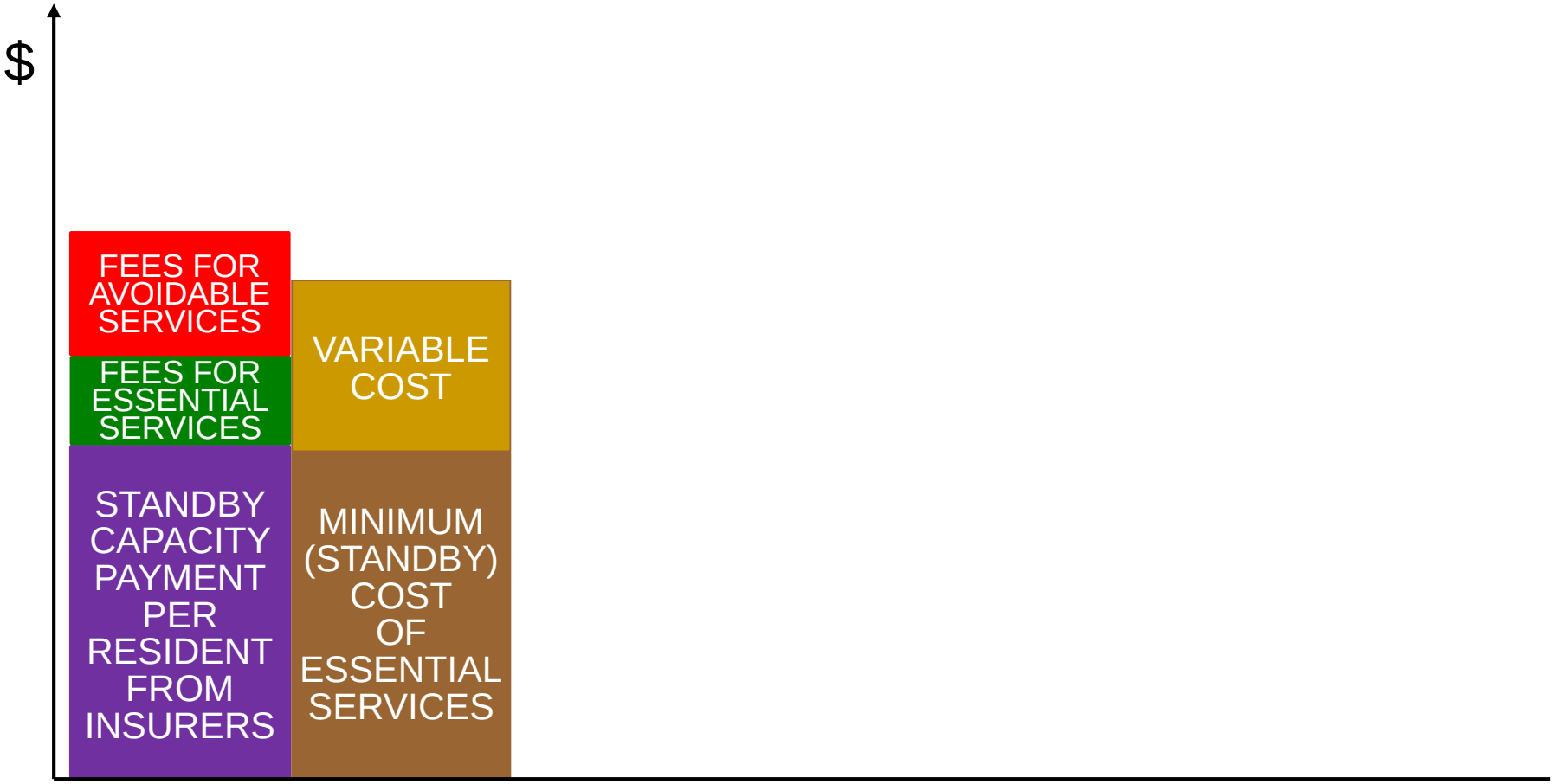
Standby Capacity Payments Should Be $ *Per Resident*

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

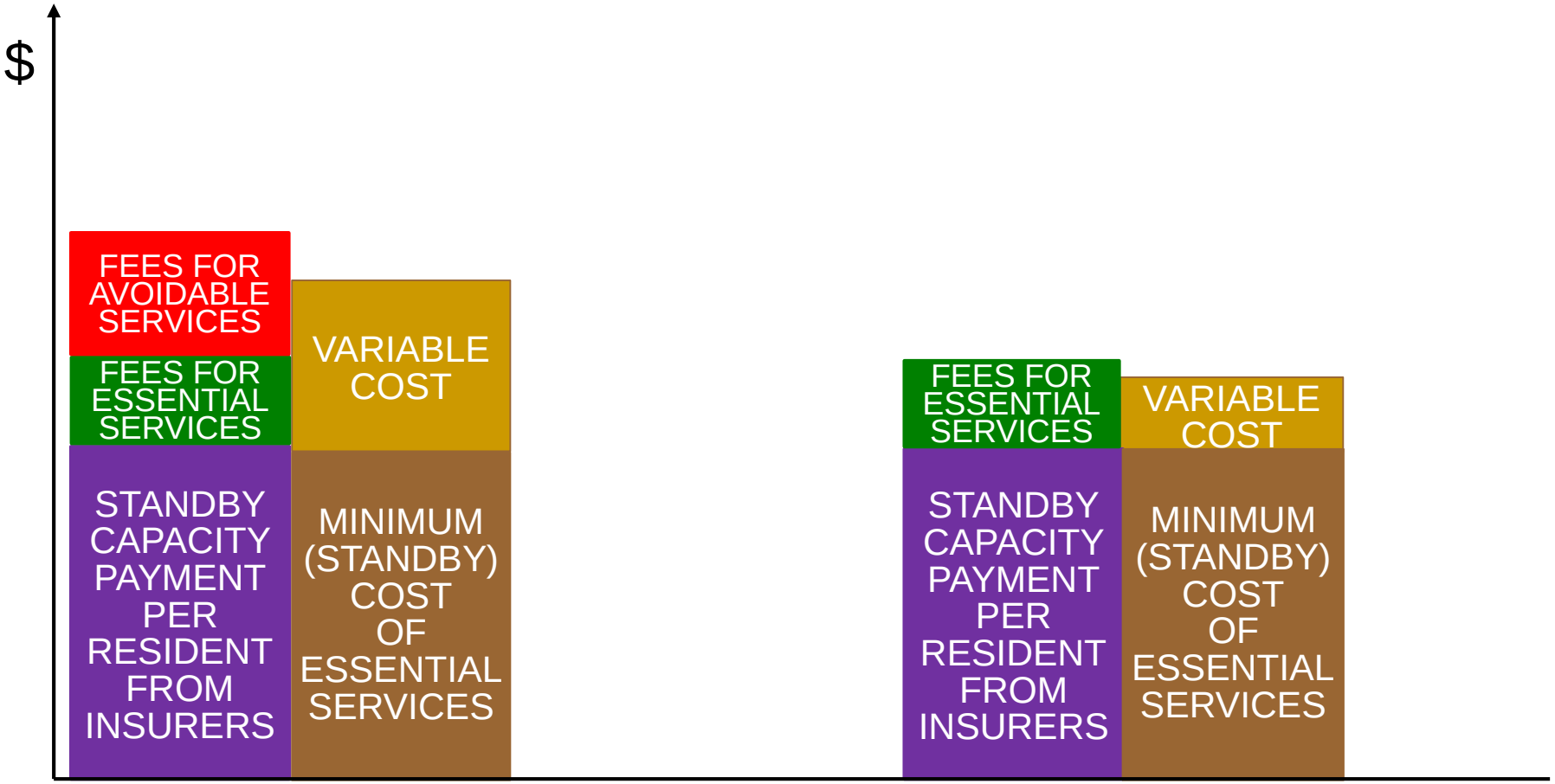
- **Fire Departments**
- **Libraries**



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

	Visits		
Total Visits	1,500		

- **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

	Visits		
Insured Visits	1,425		
Uninsured Visits	75		
Total Visits	1,500		

- **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

	Visits		
Insured Visits	1,425		
Uninsured Visits	75		
Total Revenues	1,500		
Costs	**FTEs**	**$**	**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

- **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		
Revenues	**Visits**	**$/Visit**	**Total $**
Per Visit Pmts	1,425	$540	
Uninsured Visits	75	$0	
Total Revenues	1,500		
Costs	**FTEs**	**$**	**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

- **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**
- **Hospital charges $540 per visit**

If All Payers Paid Adequately, ED Would Have a Positive Margin

	VISIT-BASED PAYMENT		
Revenues	**Visits**	**$/Visit**	**Total $**
Per Visit Pmts	1,425	$540	$769,500
Uninsured Visits	75	$0	$0
Total Revenues	1,500		$769,500
Costs	**FTEs**	**$**	**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%

- **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**
- **Hospital charges $540 per visit**
- **4% operating margin**

What Happens if ED Visits Are Reduced by 15%?

	VISIT-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	$540	$769,500	1,211			
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$769,500	1,275			-15%
Costs	**FTEs**	**$**	**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%				

Revenues Will Decrease in Proportion to Reduction in Visits

	VISIT-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	$540	$769,500	1,211	$540	$654,075	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$769,500	1,275		$654,075	-15%
Costs	**FTEs**	**$**	**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%				

Fixed Costs (Staffing) Will Not Change

	VISIT-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	$540	$769,500	1,211	$540	$654,075	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$769,500	1,275		$654,075	-15%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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				
Indirect (% Dir.)		40%	$212,184				
Total Costs			$742,644				
Margin			$26,856 +4%				

Small Amt of Variable Costs Will Decrease in Proportion to Visits

	VISIT-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	$540	$769,500	1,211	$540	$654,075	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$769,500	1,275		$654,075	-15%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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				
Total Costs			$742,644				
Margin			$26,856 +4%				

Total Costs Will Decrease, But Less Than Revenues Decrease

	VISIT-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	$540	$769,500	1,211	$540	$654,075	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$769,500	1,275		$654,075	-15%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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			$26,856 +4%				

The Emergency Department Now Has Significant Losses

	VISIT-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	$540	$769,500	1,211	$540	$654,075	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$769,500	1,275		$654,075	-15%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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			$26,856 +4%			($80,694) -11%	-400%

What Happens If ED Visits Increase by 10%?

	VISIT-BASED PAYMENT			INCREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	~~$540~~	~~$769,500~~	1,568			+10%
Uninsured Visits	75	$0	$0	83			
Total Revenues	1,500		$769,500	1,650			+10%
Costs	**FTEs**	**$**	**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

	VISIT-BASED PAYMENT			INCREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	$540	$769,500	1,568	$540	$846,450	+10%
Uninsured Visits	75	$0	$0	83	$0	$0	
Total Revenues	1,500		$769,500	1,650		$846,450	+10%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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	$41,250	+10%
Indirect (% Dir.)		40%	$212,184		40%	$213,684	
Total Costs			$742,644			$747,894	+0.7%
Margin			$26,856 +4%			$98,556 +13%	+267%

Is It Any Wonder Many Hospitals Encourage Use of the ER?

	VISIT-BASED PAYMENT			INCREASE IN VISITS			Chg
Revenues	**Visits**	**$/Visit**	**Total $**	**Visits**	**$/Visit**	**Total $**	
Per Visit Pmts	1,425	$540	$769,500	1,568	$540	$846,450	+10%
Uninsured Visits	75	$0	$0	83	$0	$0	
Total Revenues	1,500		$769,500	1,650		$846,450	+10%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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 (			,500				10%
Indirec			,184				
Total C			,644				0.7%
Margin			$26,856 +4%			+13%	67%

Is Cost-Based Payment Better or Worse?

	COST-BASED PAYMENT		
Revenues			**Total $**
Cost – Hospital			
Costs	**FTEs**	**$**	**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			

Not All Costs Are Covered By Cost-Based Payment

	COST-BASED PAYMENT		
Revenues	**Visits**	**$/%**	**Total $**
Cost – Hospital	625	99%	$278,216
Clinician Fees		$100	$62,500
Costs	**FTEs**	**$**	**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			

- **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

	COST-BASED PAYMENT		
Revenues	**Visits**	**$/%**	**Total $**
Cost – Hospital	625	99%	$278,216
Clinician Fees		$100	$62,500
Per Visit Pmts	800	$540	$432,000
Uninsured Visits	75	$0	$0
Total Revenues	1,500		$772,716
Costs	**FTEs**	**$**	**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			$30,072 +4%

What Happens When ED Visits Decrease?

	COST-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/%**	**Total $**	**Visits**	**$/%**	**Total $**	
Cost – Hospital	625	99%	$278,216	531			
Clinician Fees		$100	$62,500				
Per Visit Pmts	800	$540	$432,000	680			
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$772,716	1,275			
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**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			$30,072 +4%				

Most Costs are Fixed and Don't Change

	COST-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/%**	**Total $**	**Visits**	**$/%**	**Total $**	
Cost – Hospital	625	99%	$278,216	531			
Clinician Fees		$100	$62,500				
Per Visit Pmts	800	$540	$432,000	680			
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$772,716	1,275			-15%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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			$30,072 +4%				

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

	COST-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/%**	**Total $**	**Visits**	**$/%**	**Total $**	
Cost – Hospital	625	99%	$278,216	531	99%	$279,186	+0.3%
Clinician Fees		$100	$62,500				
Per Visit Pmts	800	$540	$432,000	680			
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$772,716	1,275			
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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			$30,072 +4%				

…Visit-Based Payment Decreases in Proportion to Visits…

	COST-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/%**	**Total $**	**Visits**	**$/%**	**Total $**	
Cost – Hospital	625	99%	$278,216	531	99%	$279,186	+0%
Clinician Fees		$100	$62,500		$100	$53,125	-15%
Per Visit Pmts	800	$540	$432,000	680	$540	$367,200	-15%
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$772,716	1,275			
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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			$30,072 +4%				

…Total Revenues Decrease More Than Costs Decrease…

	COST-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/%**	**Total $**	**Visits**	**$/%**	**Total $**	
Cost – Hospital	625	99%	$278,216	531	99%	$279,186	+0%
Clinician Fees		$100	$62,500		$100	$53,125	-15%
Per Visit Pmts	800	$540	$432,000	680	$540	$367,200	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$772,716	1,275		$699,511	-9.5%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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			$30,072 +4%				

…So the Hospital Still Loses Money With Fewer Visits

	COST-BASED PAYMENT			DECREASE IN VISITS			Chg
Revenues	**Visits**	**$/%**	**Total $**	**Visits**	**$/%**	**Total $**	
Cost – Hospital	625	99%	$278,216	531	99%	$279,186	+0%
Clinician Fees		$100	$62,500		$100	$53,125	-15%
Per Visit Pmts	800	$540	$432,000	680	$540	$367,200	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$772,716	1,275		$699,511	-9.5%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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			$30,072 +4%			($35,258) -5%	-217%

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

	COST-BASED PAYMENT			INCREASE IN VISITS			Chg
Revenues	**Visits**	**$/%**	**Total $**	**Visits**	**$/%**	**Total $**	
Cost – Hospital	625	99%	$278,216	688	99%	$277,569	-0.2%
Clinician Fees		$100	$62,500		$100	$68,750	
Per Visit Pmts	800	$540	$432,000	880	$540	$475,200	+10%
Uninsured Visits	75	$0	$0	110	$0		
Total Revenues	1,500		$772,716	2,200		$821,519	+6.3%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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	$41,250	
Indirect (% Dir.)		40%	$212,184		40%	$213,684	
Total Costs			$742,644			$747,894	+0.7%
Margin			$30,072 +4%			$733,625 +10%	+145%

Is There A Better Way?

	NEW PAYMENT MODEL		
Revenues			
	?	?	
	?	?	
	?	?	
	?	?	
Costs	**FTEs**	**$**	**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			>$0

The ED Needs to Be Available Whether Anybody Needs It or Not

	NEW PAYMENT MODEL		
Revenues			**Total $**
Total Revenues			$771,400
Costs	**FTEs**	**$**	**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			$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

	NEW PAYMENT MODEL		
Revenues	**#**	**$**	**Total $**
Per Resident	4,750	$162	$771,400
Total Revenues			$771,400
Costs	**FTEs**	**$**	**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			$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

	NEW PAYMENT MODEL		
Revenues	**#**	**$**	**Total $**
Per Resident	4,750	$130	$617,500
Per Visit	1,425	$108	$153,900
Uninsured Visits	75	$0	$0
Total Revenues	1,500		$771,400
Costs	**FTEs**	**$**	**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			$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?

	NEW PAYMENT MODEL			DECREASE IN VISITS			Chg
Revenues	**#**	**$**	**Total $**	**#**	**$**	**Total $**	
Per Resident	4,750	$130	$617,500				
Per Visit	1,425	$108	$153,900	1,211			-15%
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$771,400				
Costs	**FTEs**	**$**	**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			$28,756 +4%				

…Costs Don't Change Much Because Most Costs Are Fixed

	NEW PAYMENT MODEL			DECREASE IN VISITS			Chg
Revenues	**#**	**$**	**Total $**	**#**	**$**	**Total $**	
Per Resident	4,750	$130	$617,500				
Per Visit	1,425	$108	$153,900	1,211			-15%
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$771,400				
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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%				

…Visit-Based Revenues Decrease in Proportion to Visits…

	NEW PAYMENT MODEL			DECREASE IN VISITS			Chg
Revenues	**#**	**$**	**Total $**	**#**	**$**	**Total $**	
Per Resident	4,750	$130	$617,500				
Per Visit	1,425	$108	$153,900	1,211	$108	$130,815	-15%
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$771,400				
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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…

	NEW PAYMENT MODEL			DECREASE IN VISITS			Chg
Revenues	**#**	**$**	**Total $**	**#**	**$**	**Total $**	
Per Resident	4,750	$130	$617,500	~~4,750~~	~~$130~~	$617,500	0%
Per Visit	1,425	$108	$153,900	1,211	$108	$130,815	-15%
Uninsured Visits	75	$0	$0	64			
Total Revenues	1,500		$771,400				
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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%				

…Total Revenues Decrease by Only a Small Amount…

	NEW PAYMENT MODEL			DECREASE IN VISITS			Chg
Revenues	**#**	**$**	**Total $**	**#**	**$**	**Total $**	
Per Resident	4,750	$130	$617,500	4,750	$130	$617,500	0%
Per Visit	1,425	$108	$153,900	1,211	$108	$130,815	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$771,400	1,275		$748,315	-3.0%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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%				

…So Hospital Margin is Preserved

	NEW PAYMENT MODEL			DECREASE IN VISITS			Chg
Revenues	**#**	**$**	**Total $**	**#**	**$**	**Total $**	
Per Resident	4,750	$130	$617,500	4,750	$130	$617,500	0%
Per Visit	1,425	$108	$153,900	1,211	$108	$130,815	-15%
Uninsured Visits	75	$0	$0	64	$0	$0	
Total Revenues	1,500		$771,400	1,275		$748,315	-3.0%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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%			$13,546 +2%	-61%

Not Every Payer Will Participate

	NEW PAYMENT MODEL		
Revenues	**#**	**$**	**Total $**
Per Participant	3,800	$128	$486,400
Per Part. Visit	1,140	$108	$123,120
Non-Part. Visit	300	$540	$162,000
Uninsured Visits	60	$0	$0
Total Revenues	1,500		$771,520
Costs	**FTEs**	**$**	**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			$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

	NEW PAYMENT MODEL			DECREASE IN VISITS			Chg
Revenues	**#**	**$**	**Total $**	**#**	**$**	**Total $**	
Per Participant	3,800	$128	$486,400	3,800	$128	$486,400	0%
Per Part. Visit	1,140	$108	$123,120	969	$108	$104,652	-15%
Non-Part. Visit	300	$540	$162,000	255	$540	$137,700	-15%
Uninsured Visits	60	$0	$0	51	$0	$0	
Total Revenues	1,500		$771,520	1,275		$728,752	-5.5%
Costs	**FTEs**	**$**	**Total $**	**FTEs**	**$**	**Total $**	
Clinicians ($/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			$28,876 +4%			($6,017) -0.8%	-121%

Comparison of Approaches

SCENARIO	Current System	Global Budget	Standby Payment
Residents Need More Services	Higher margin	Lower margin	Stable margin
Residents Need Fewer Services	Lower margin	Higher margin	Stable margin

Comparison of Approaches

SCENARIO	Current System	Global Budget	Standby Payment
Residents Need More Services	Higher margin	Lower margin	Stable margin
Residents Need Fewer Services	Lower margin	Higher margin	Stable margin
Higher Wage Rates Required to Obtain Personnel	Lower margin	Much lower margin unless budget is adjusted	Stable margin if payment is adjusted for pay rates

Comparison of Approaches

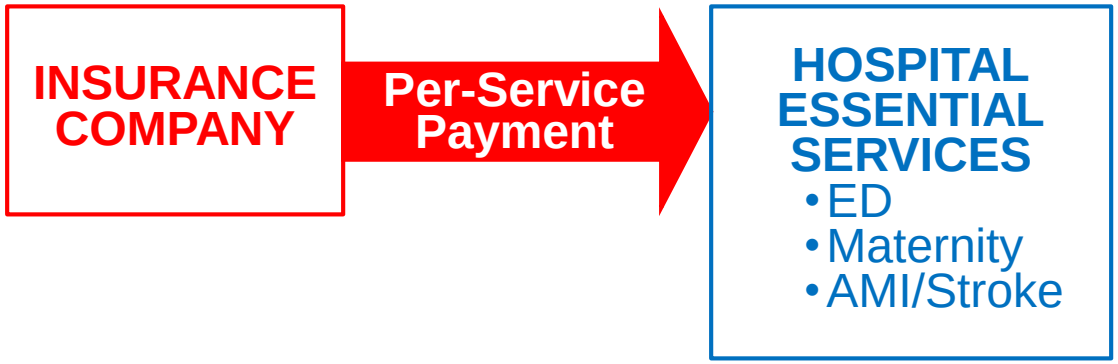
SCENARIO	Current System	Global Budget	Standby Payment
Residents Need More Services	Higher margin	Lower margin	Stable margin
Residents Need Fewer Services	Lower margin	Higher margin	Stable margin
Higher Wage Rates Required to Obtain Personnel	Lower margin	Much lower margin unless budget is adjusted	Stable margin if payment is adjusted for pay rates
Higher Costs Due to Inefficiency	Lower margin	Much lower margin	Much lower margin
Lower Costs Due to Efficiencies	Higher margin	Much higher margin	Much higher margin

Comparison of Approaches

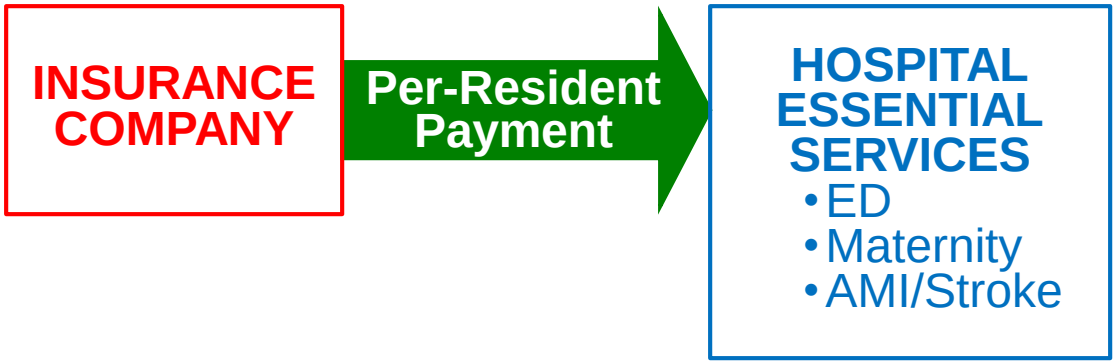
SCENARIO	Current System	Global Budget	Standby Payment
Residents Need More Services	Higher margin	Lower margin	Stable margin
Residents Need Fewer Services	Lower margin	Higher margin	Stable margin
Higher Wage Rates Required to Obtain Personnel	Lower margin	Much lower margin unless budget is adjusted	Stable margin if payment is adjusted for pay rates
Higher Costs Due to Inefficiency	Lower margin	Much lower margin	Much lower margin
Lower Costs Due to Efficiencies	Higher margin	Much higher margin	Much higher margin
Profitable New Service Line	Higher margin	Much lower margin	Higher margin

This Isn't as Radical a Change As It May Seem…

CURRENT SYSTEM



STANDBY CAPACITY PAYMENT



Today, Residents Pay an Annual Premium to an Health Plan…

CURRENT SYSTEM

COMMUNITY RESIDENT

Per-Resident Premium

INSURANCE COMPANY

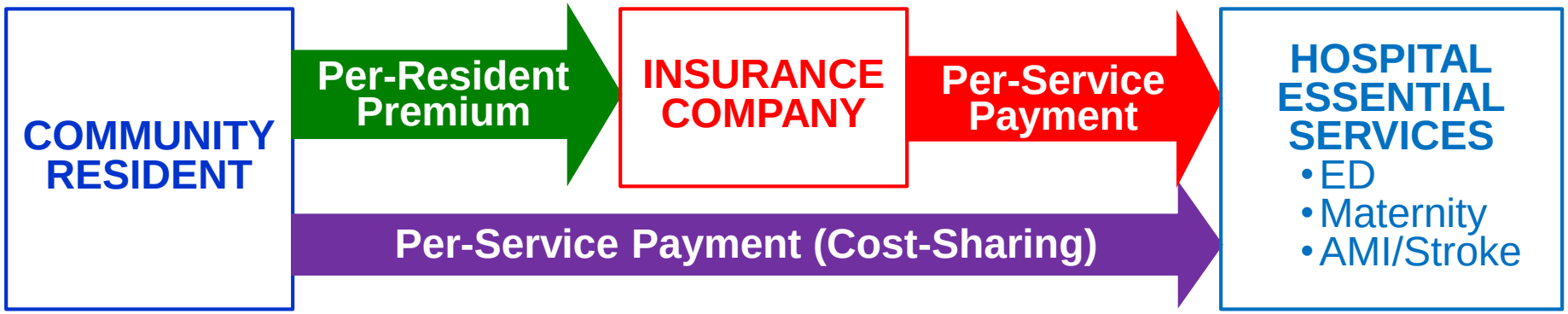
HOSPITAL ESSENTIAL SERVICES
- ED
- Maternity
- AMI/Stroke

…The Health Plan Converts the Premium Into Visit Payments…

CURRENT SYSTEM

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

CURRENT SYSTEM



Insured Residents Already Use a Per-Resident + Per-Visit System

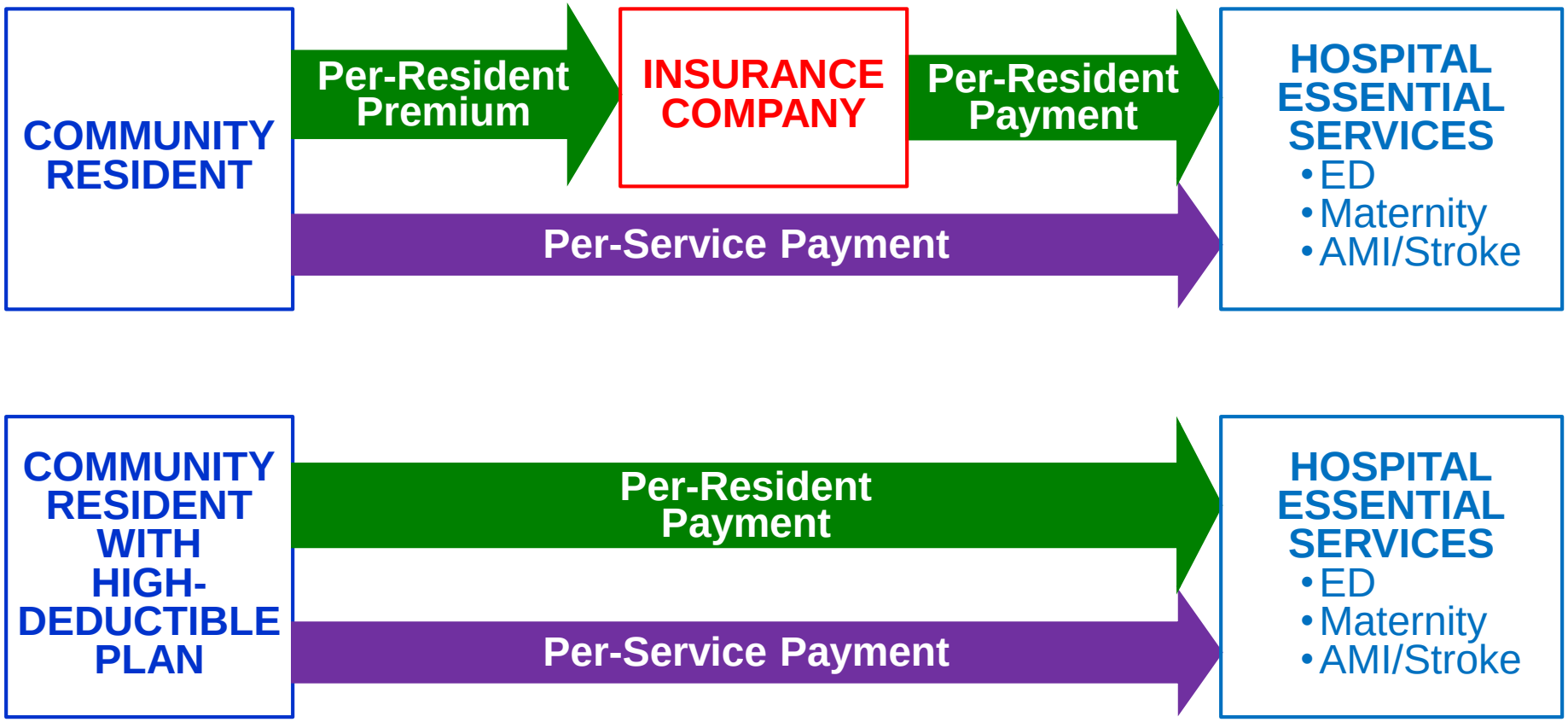
CURRENT SYSTEM

The Payer Just Needs to Give Part of the Premium to the Hospital

STANDBY CAPACITY PAYMENT

No Need for the Middle-Man in High-Deductible Health Plans

STANDBY CAPACITY PAYMENT



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

- **Define the Population Being Served by the Service**
  - What geographic area is being served?
  - How ma)?
  - Who ins
- **Determin vice Fees**
  - What is ce delivery?
  - Under w decrease?
  - How mu ivered?
  - How mu
- **Determin 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?

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

Determining the Amount of the Standby Capacity Payment

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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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  - No incentive to be efficient
- **Option 3: Based on national averages/percentiles of service line cost**
  - Similar to current CMS prospective payment models
  - Rewards more efficient hospitals, but penalizes those with unique situations
  - Requires a method of determining standby (minimum) proportion of costs

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  - Rewards more efficient hospitals, but penalizes those with unique situations
  - Requires a method of determining standby (minimum) proportion of costs
- **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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  - 3,000+ visits: 24/7 MD/DO
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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

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  - 1,000 – 3,000 visits w/o RHC: 24/7 MD/DO, NP, and/or PA
  - 3,000+ visits: 24/7 MD/DO
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- The CPA firm would calculate medians and percentiles for wage rates for each category of community size

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

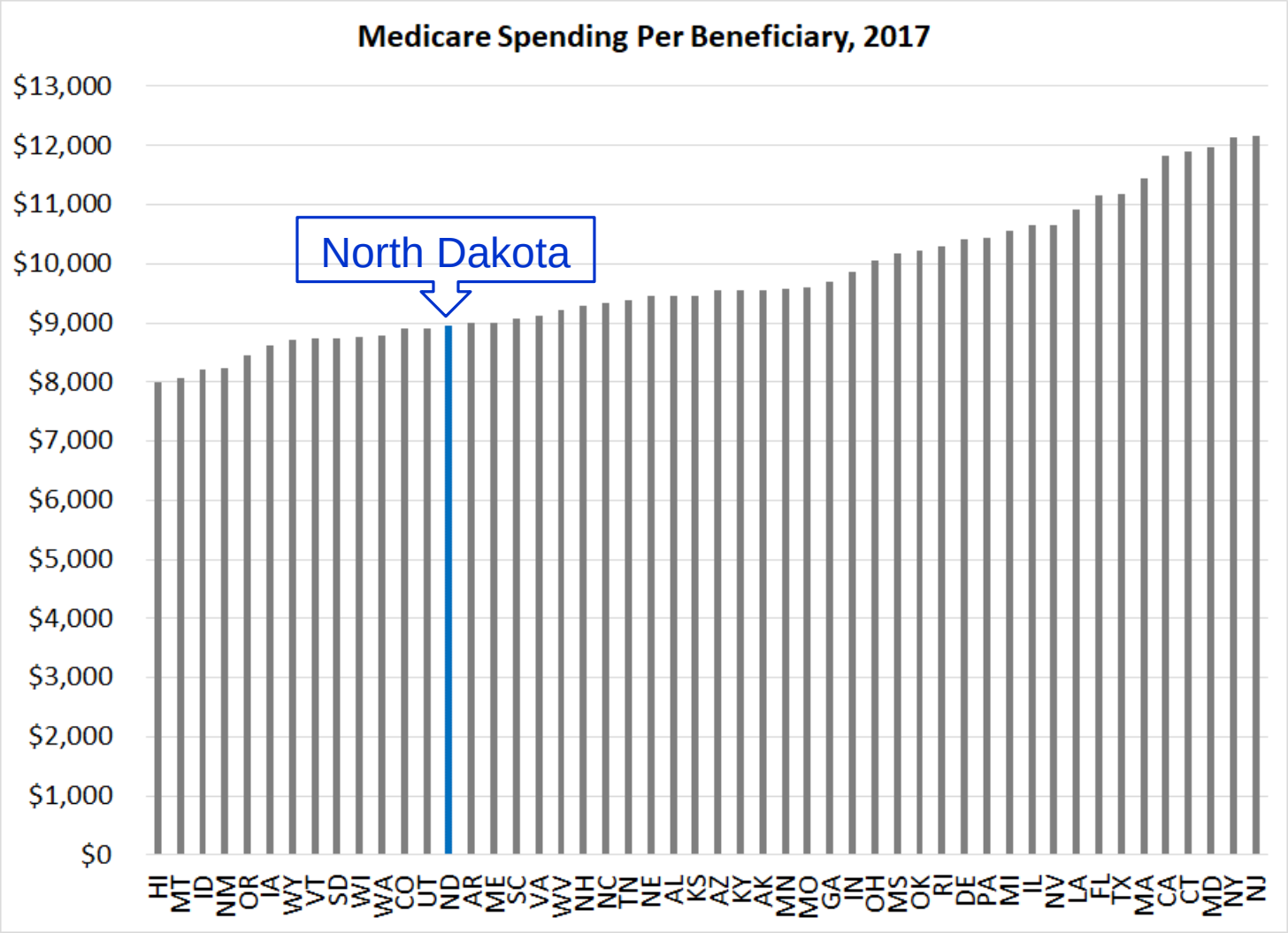
- **Quality:**
  - Reduce payment for an essential service line if quality measures that are meaningful/reliable at the volumes of those services delivered in rural areas fall below minimum standards
  - Example for ED:
    - MBQIP OP-20: Median time from ED arrival to provider contact < 30 min.
    - MBQIP OP-22: Patient left without being seen <1%
    - MBQIP OP-5: Median time to ECG for potential AMI < 7 min

Potential Value Components for Standby Capacity Payment

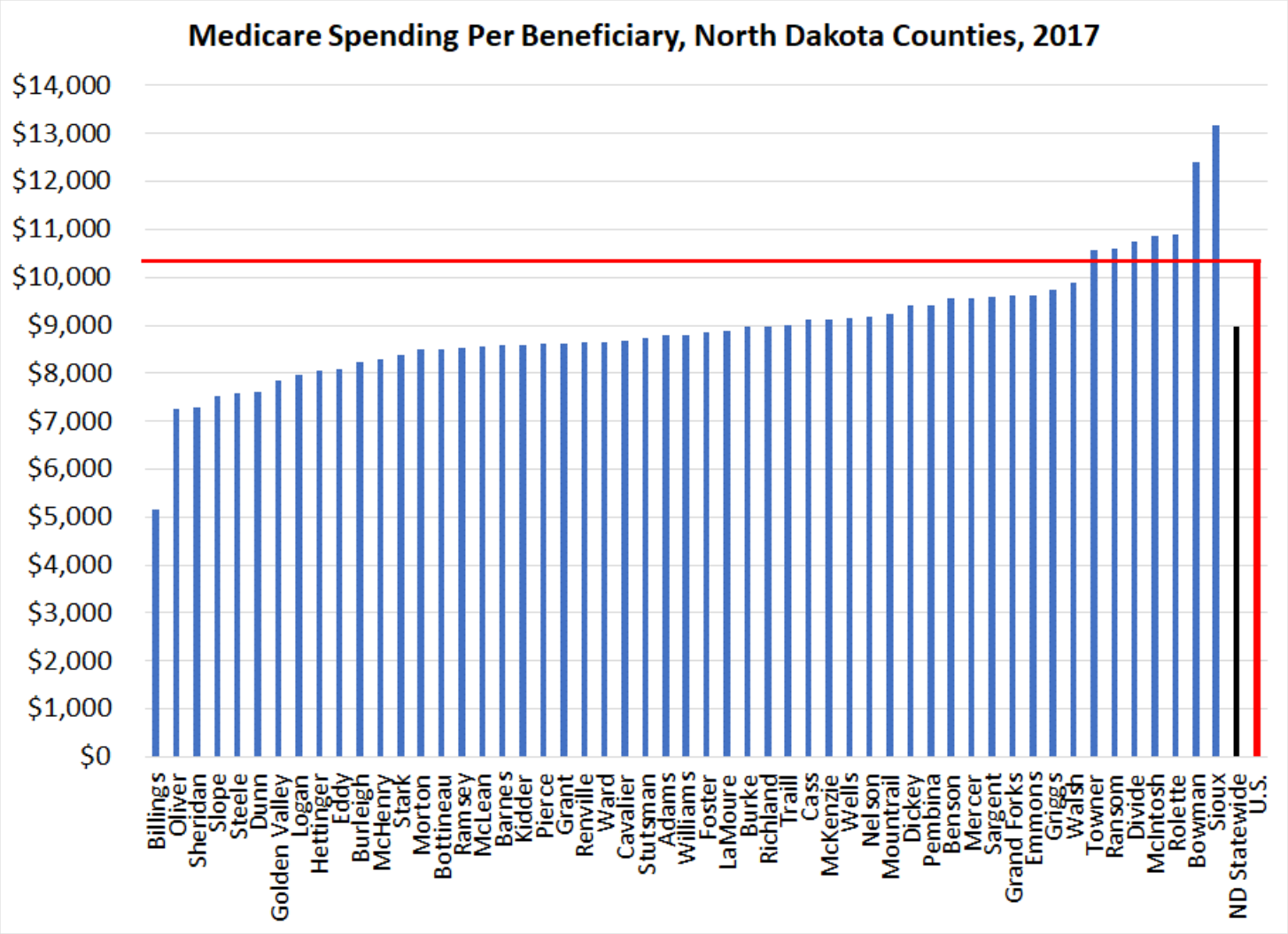
- **Quality:**
  - Reduce payment for an essential service line if quality measures that are meaningful/reliable at the volumes of those services delivered in rural areas fall below minimum standards
  - Example for ED:
    - MBQIP OP-20: Median time from ED arrival to provider contact < 30 min.
    - MBQIP OP-22: Patient left without being seen <1%
    - MBQIP OP-5: Median time to ECG for potential AMI < 7 min
- **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

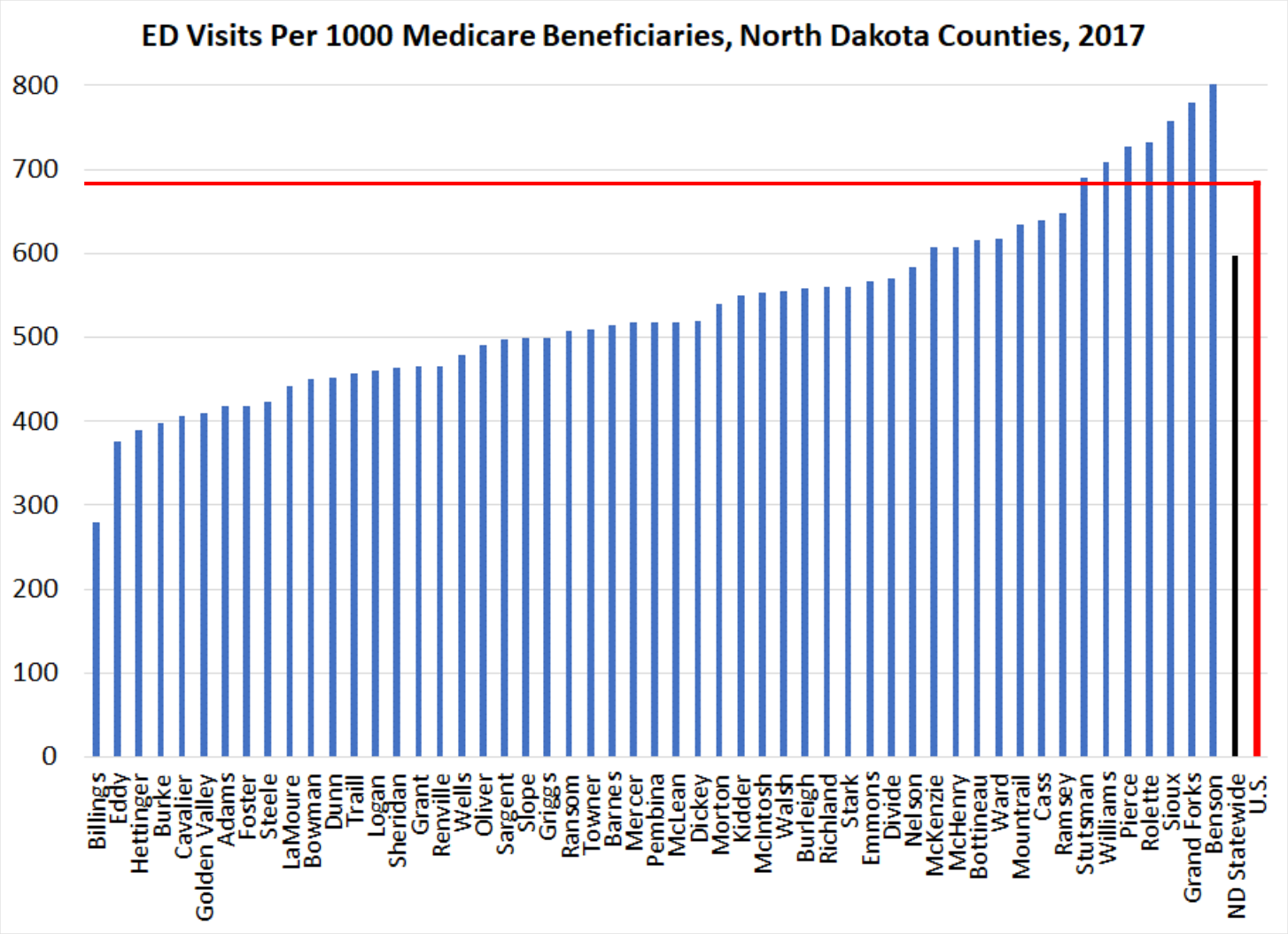
Medicare Spending in ND is Well Below Average



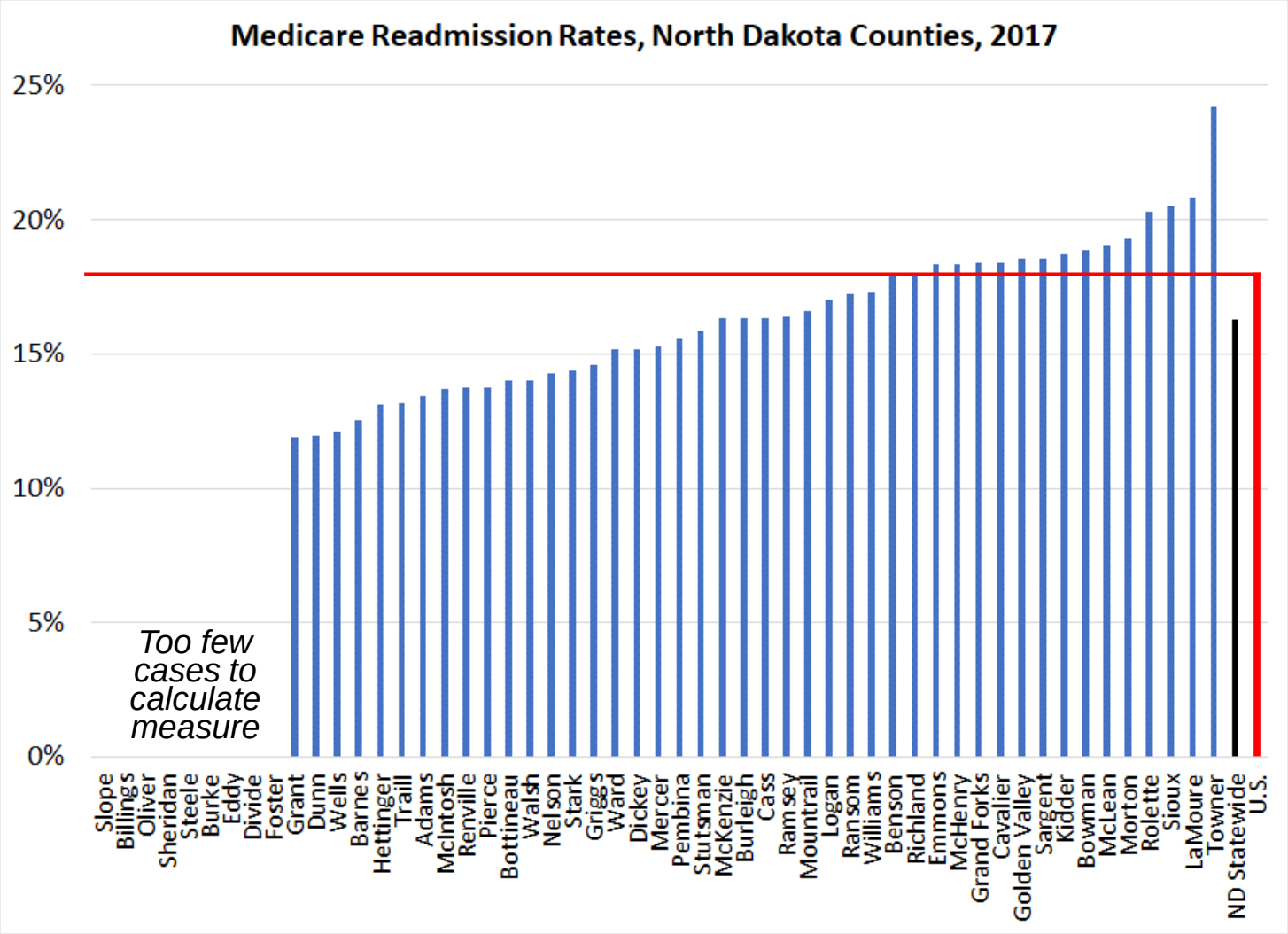
Medicare Spends Far Less in Most ND Counties Than U.S.



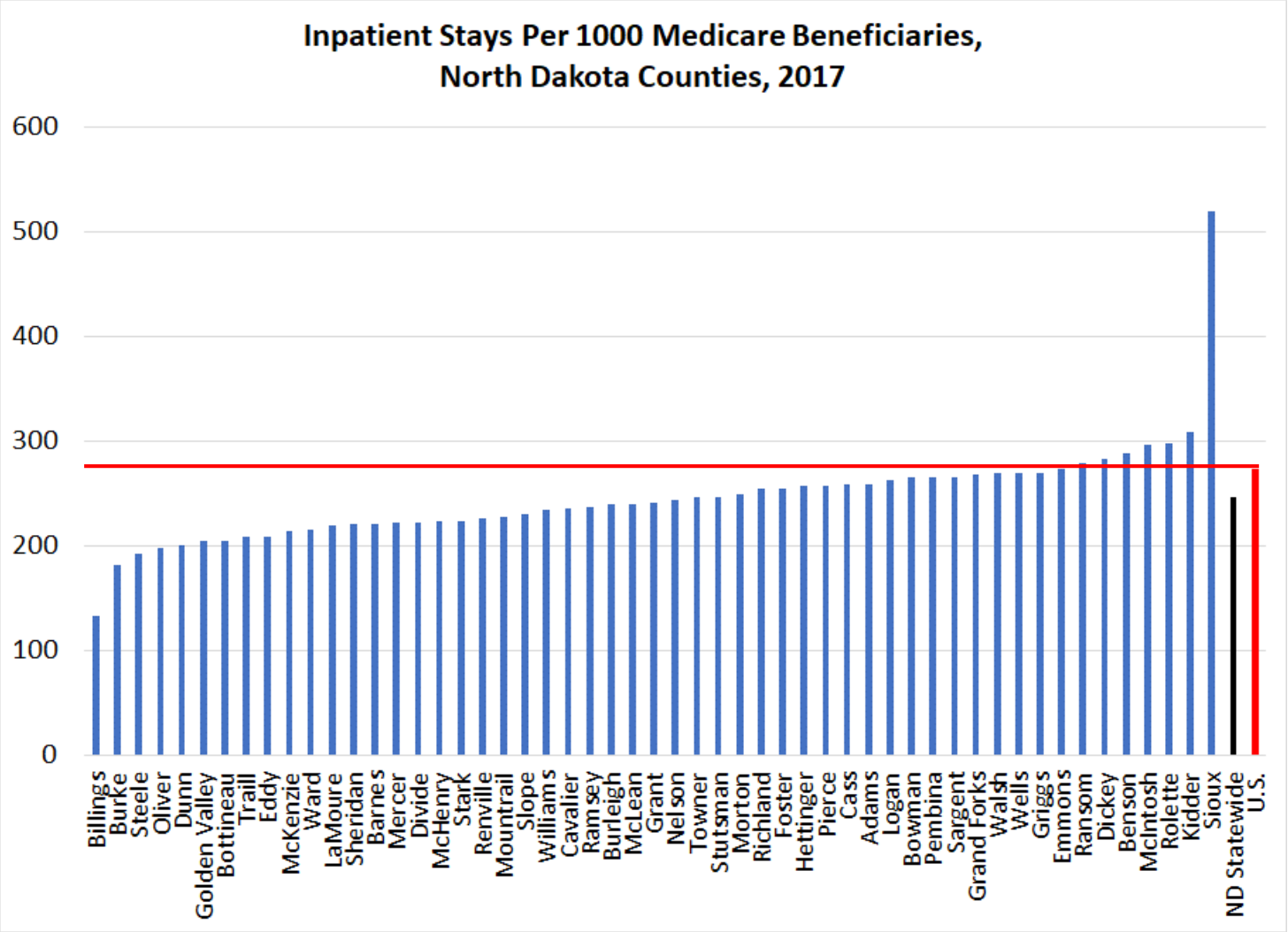
ED Visits in Most ND Counties Are Below National Average



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

RURAL HOSPITALS

3 Options for the Future of Rural Hospitals

RURAL HOSPITALS

PAYER-DEFINED
#1 "VALUE-BASED PAYMENT" SCHEMES

3 Options for the Future of Rural Hospitals

RURAL HOSPITALS

#1 PAYER-DEFINED "VALUE-BASED PAYMENT" SCHEMES

#2 LOSS OF SOME OR ALL RURAL SERVICES

3 Options for the Future of Rural Hospitals

RURAL HOSPITALS

#1 PAYER-DEFINED "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 PAYER-DEFINED "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 svcs
   - 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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   - Costs can vary dramatically from year to year for uncontrollable reasons

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   - Ways to reduce unnecessary visits, testing, and procedures at larger hospitals
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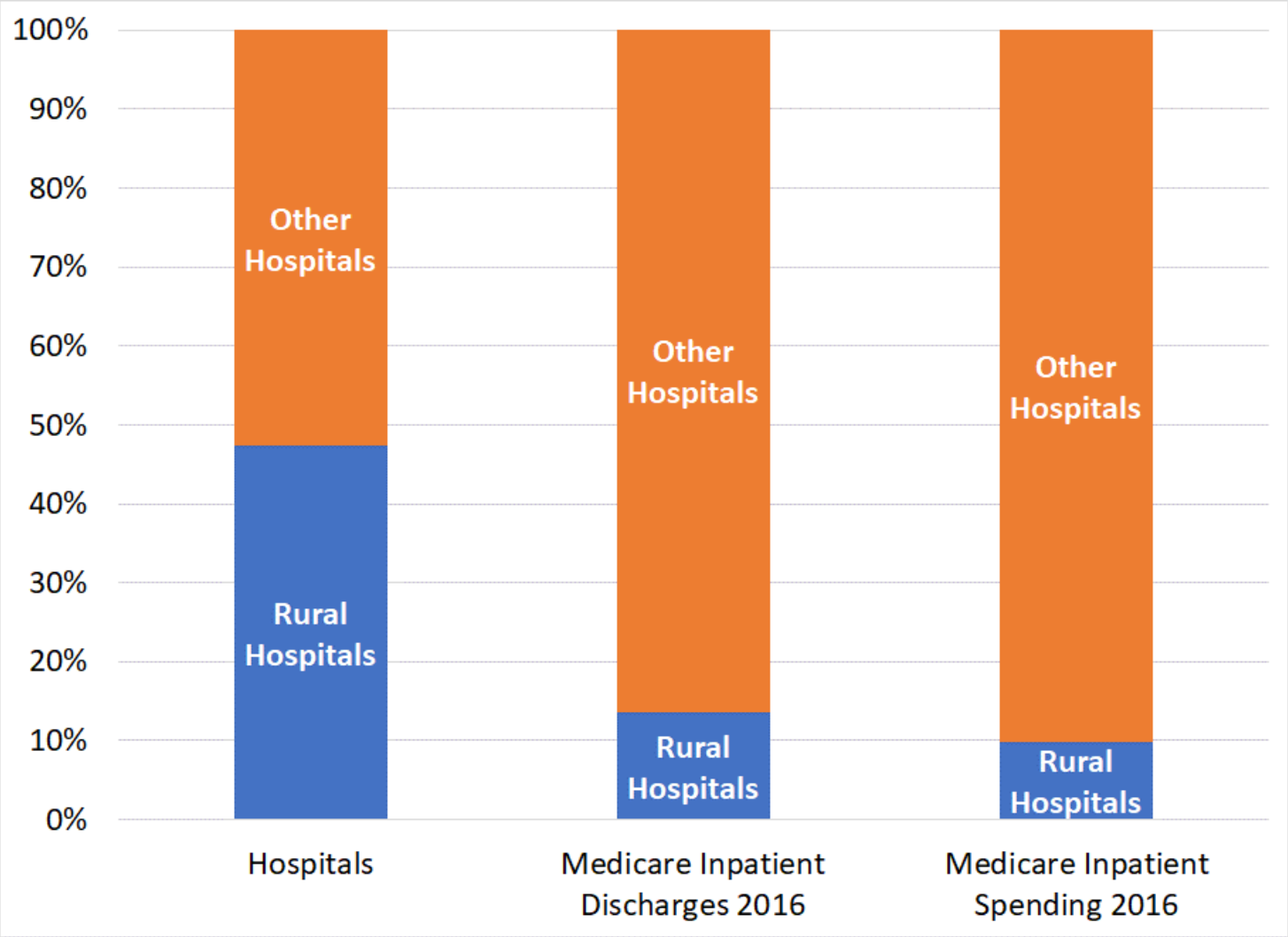
4. **Join with the essential small rural hospitals in other states to push for better payment solutions that address both hospital & payer needs**
   - Show why simplistic, top-down approaches and current VBP won't work
   - Propose a new payment model that sustains efficient essential services

Nearly Half of Hospitals Are Rural, Better Pay = Small % of Spending



Today's Slides Are Available Here

www.PaymentReform.org

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?

For More Information:

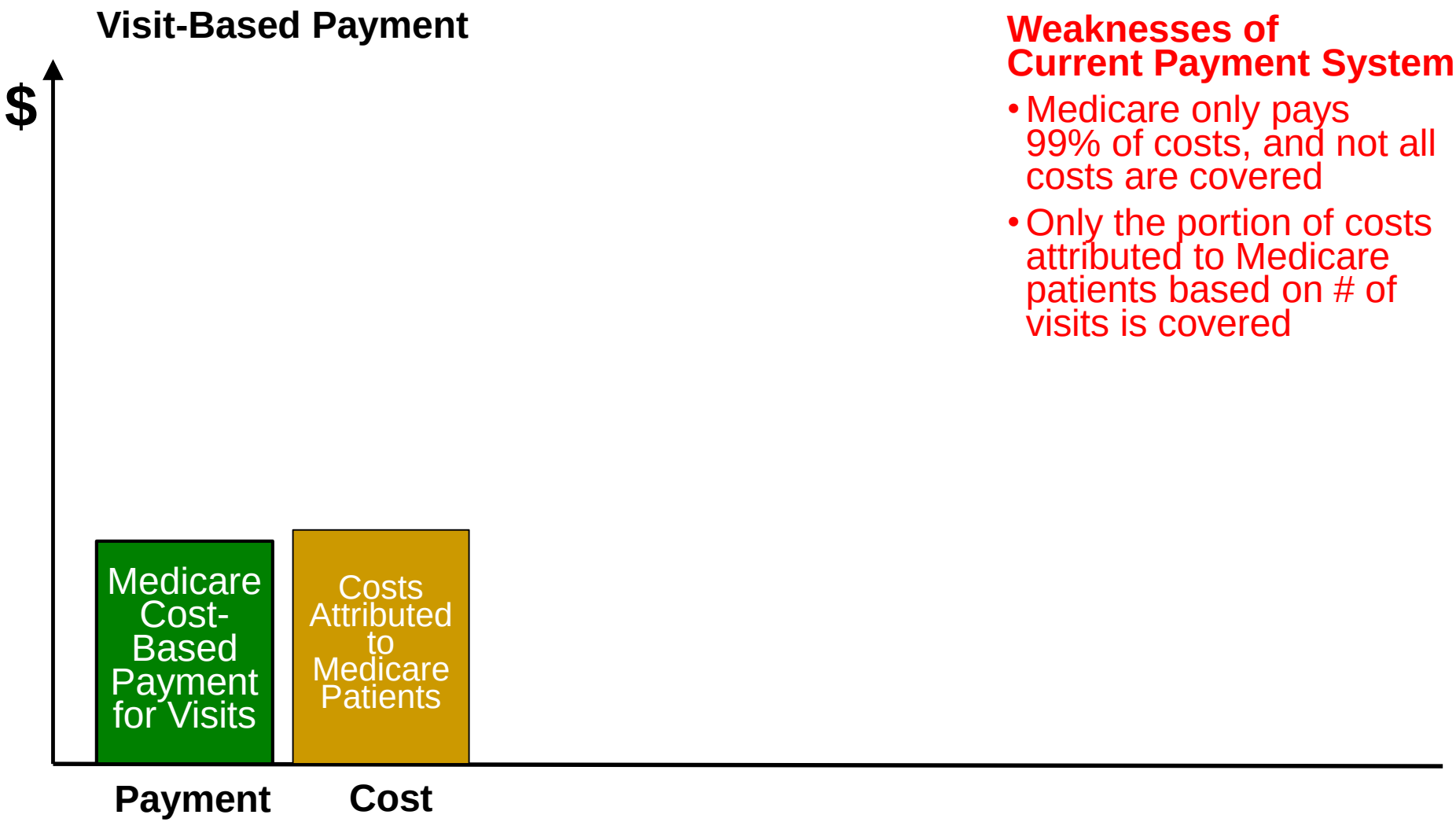
Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

Miller.Harold@CHQPR.org
(412) 803-3650
@HaroldDMiller

www.CHQPR.org
www.PaymentReform.org
@PaymentReform

APPENDIX
Improving Payments for Rural Health Clinics

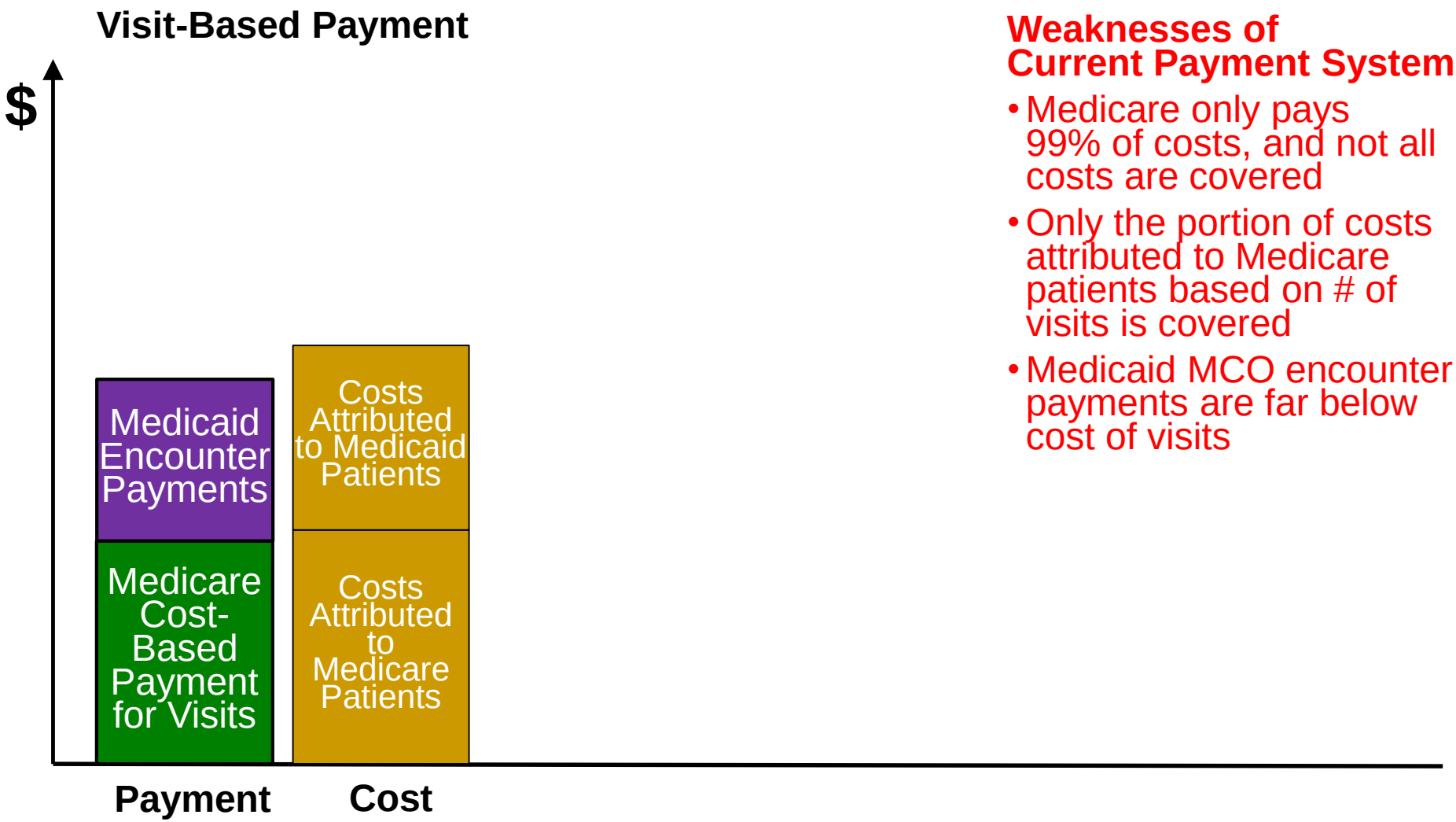
Current Visit-Based Payments for Clinic Services



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



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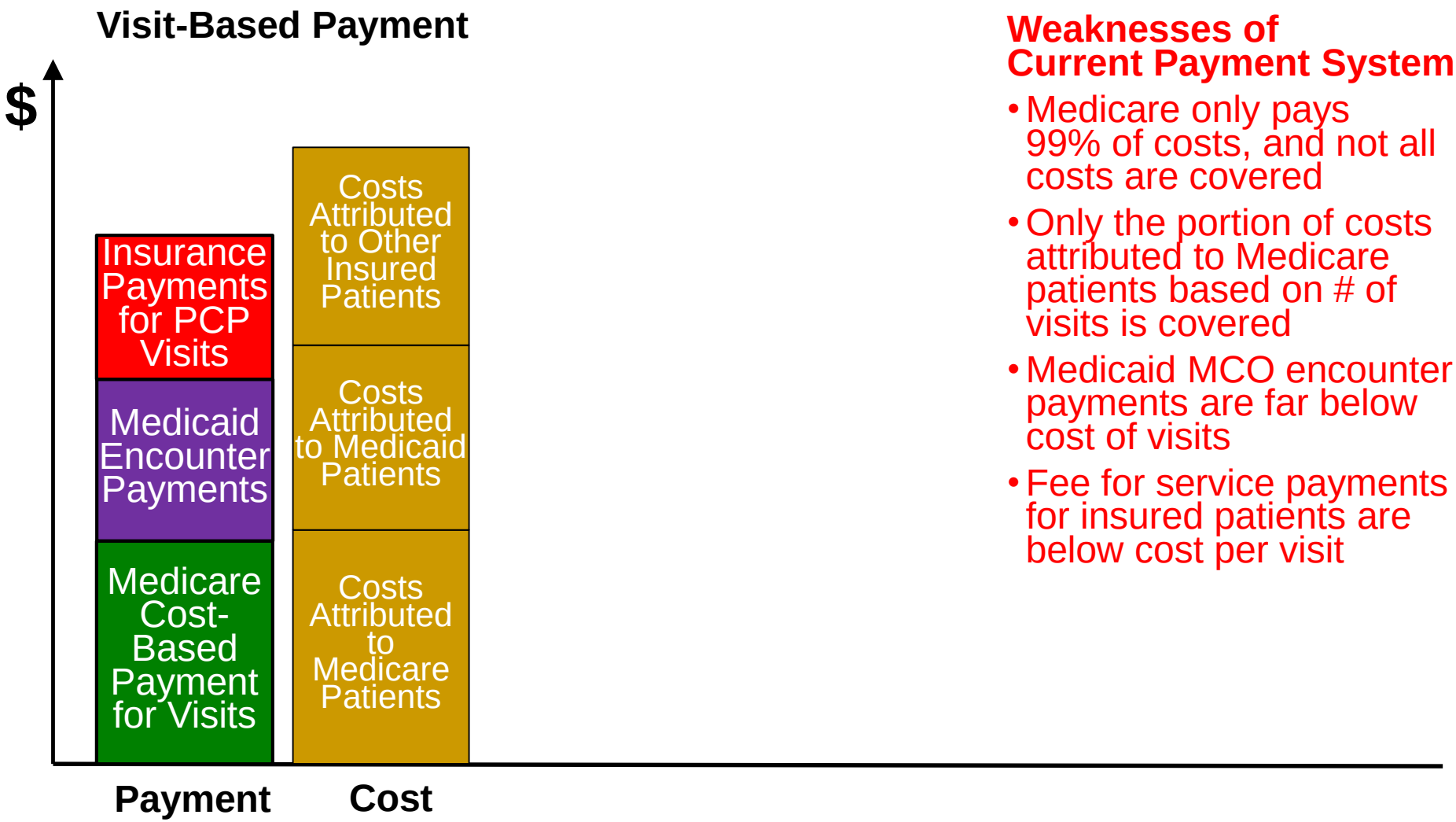

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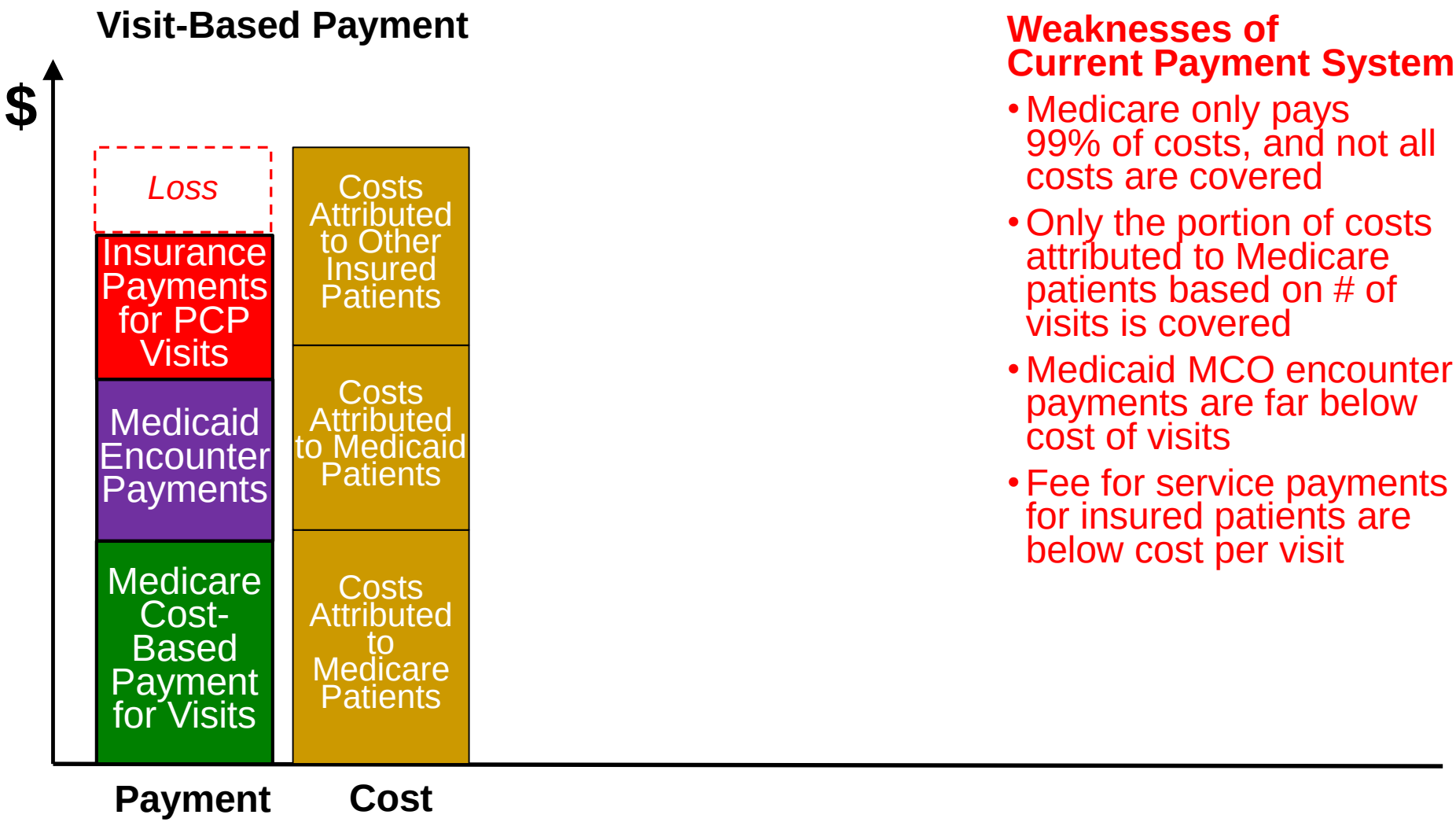
Current Visit-Based Payments Do Not Cover Costs of Clinic



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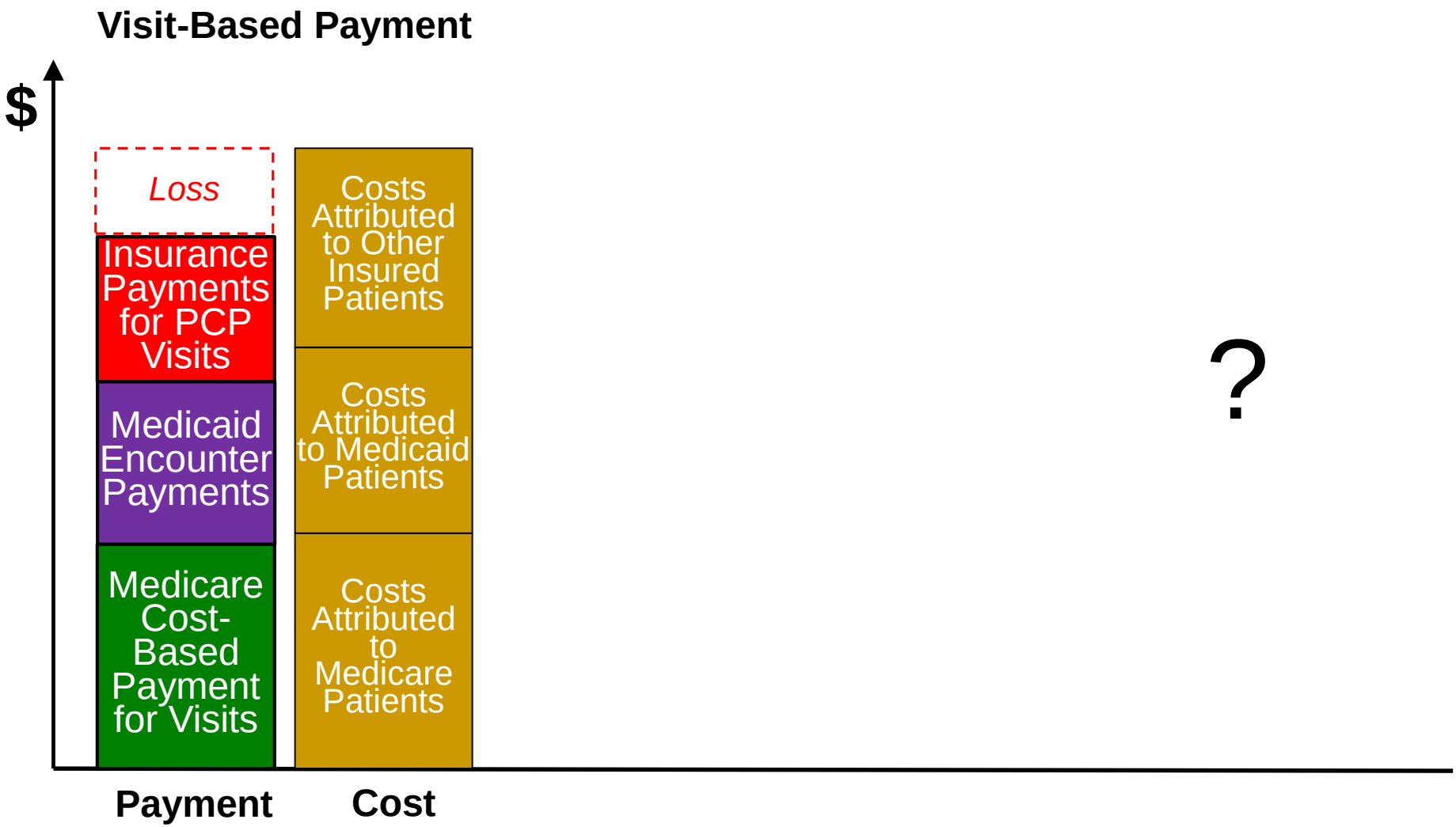
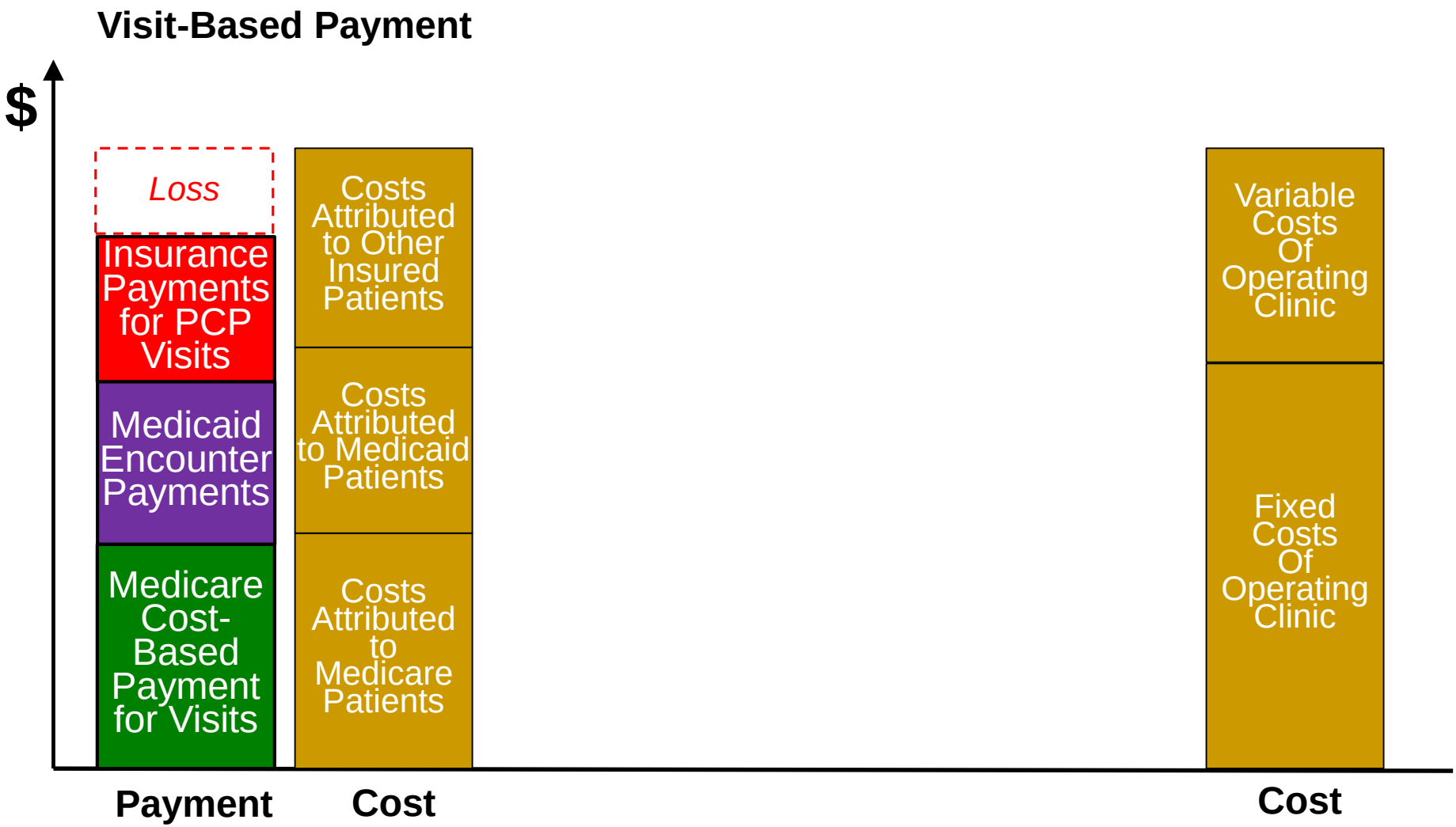
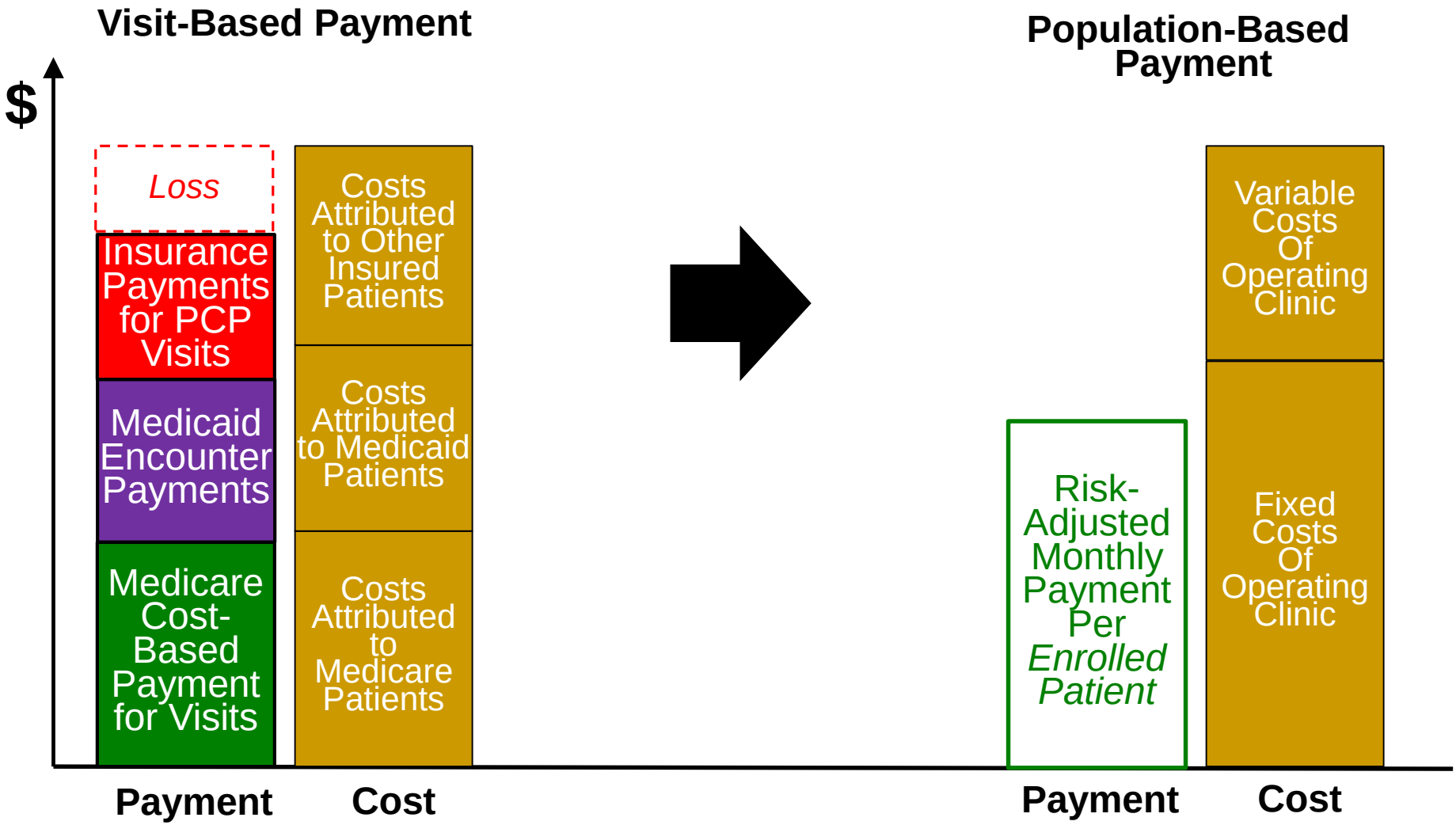
Is There a Better Way?



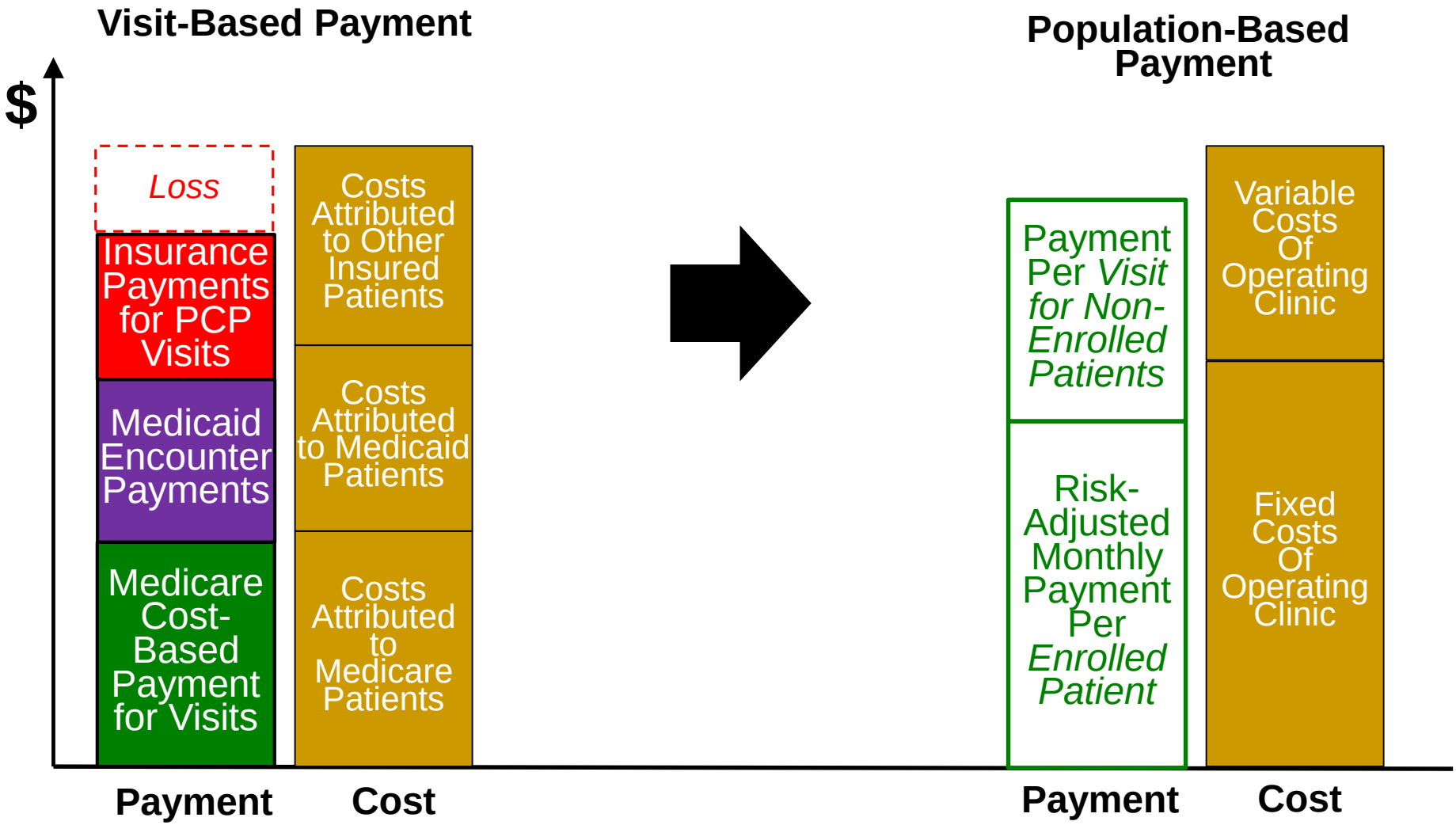
Most Clinic Costs Are Fixed Regardless of # of Visits



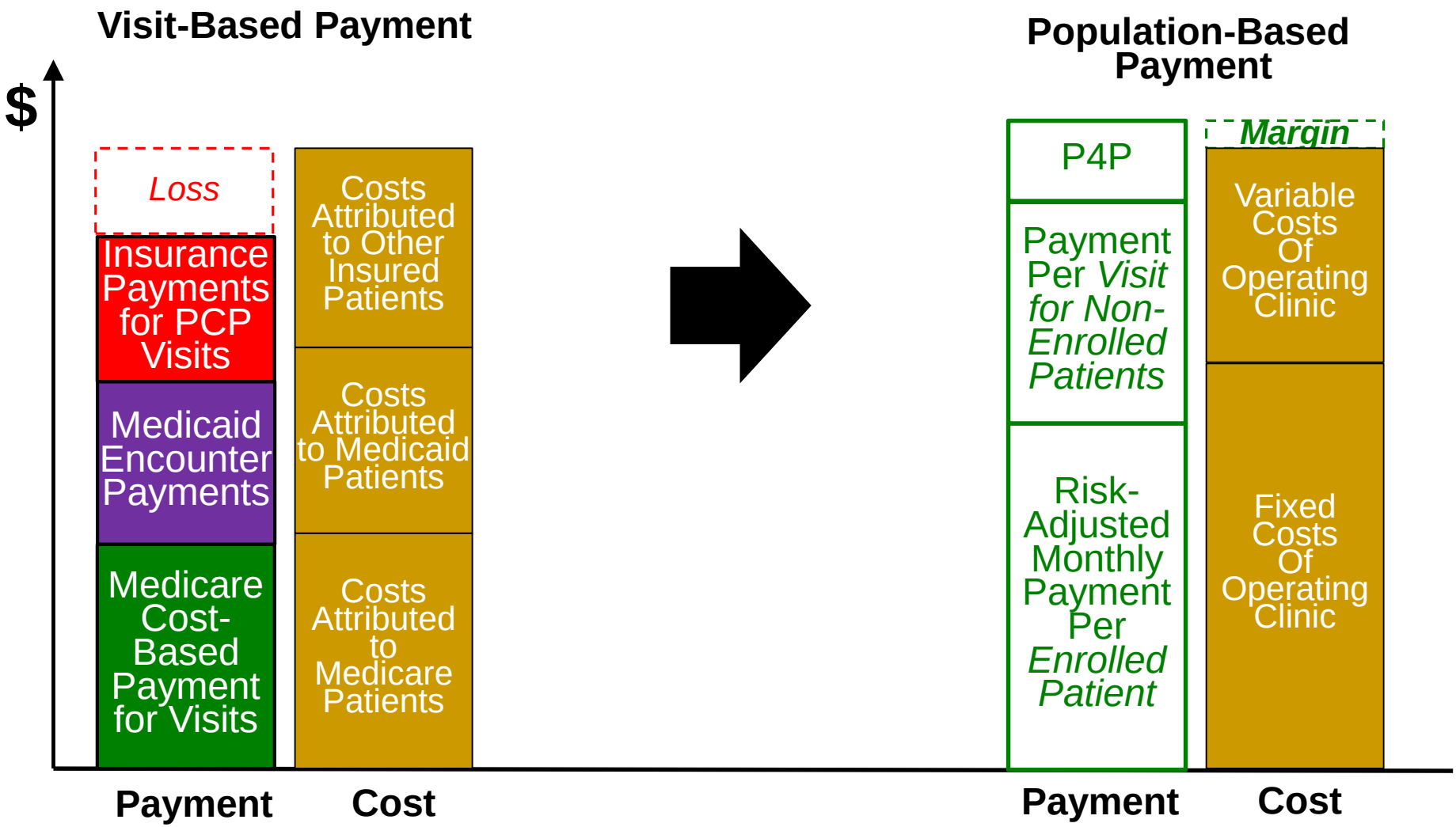
Pay a Predictable Amount to Manage Care for Regular Patients



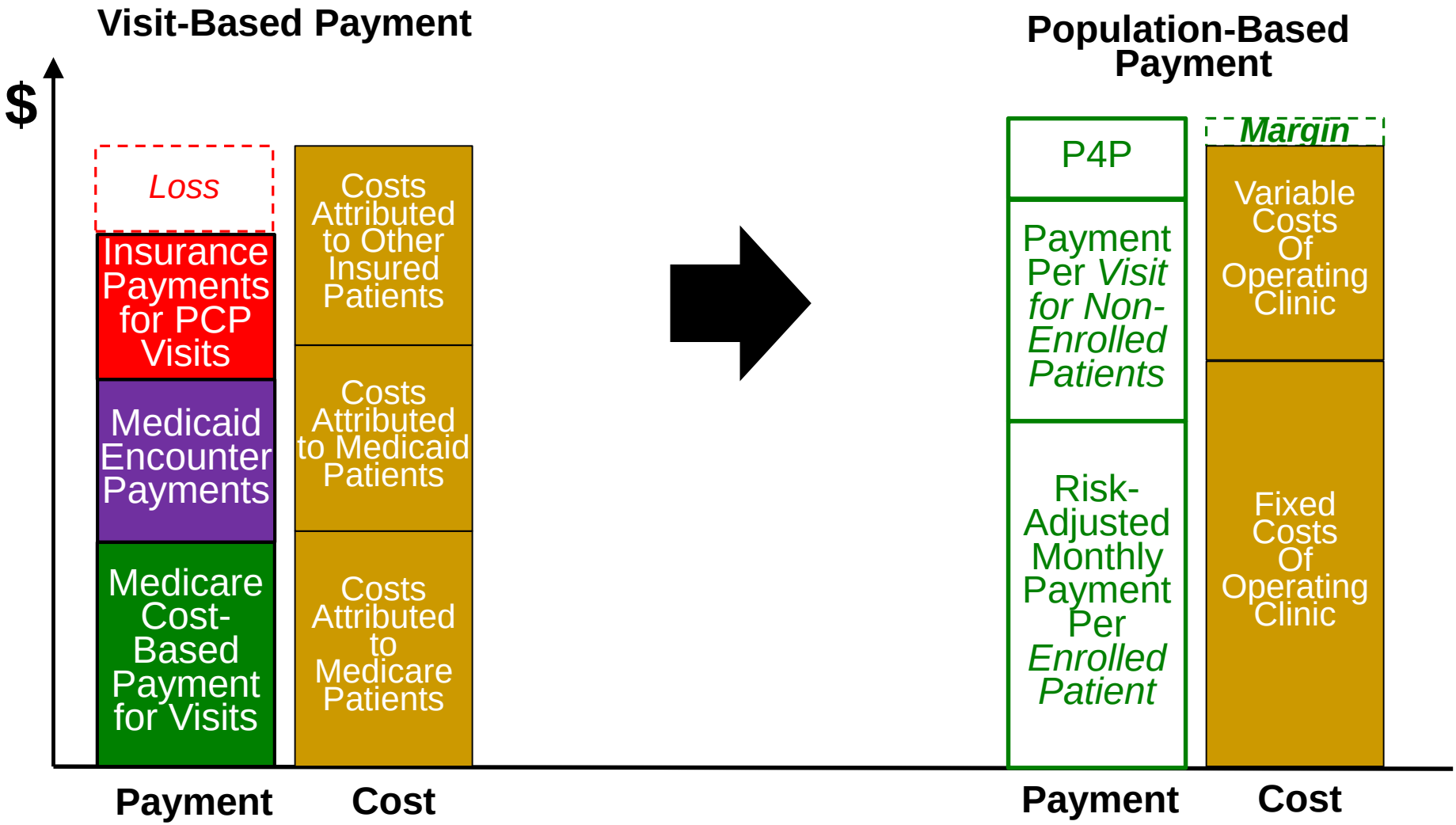
Pay Per Visit for Occasional Visitors



Base a Portion of Payment on Quality and Access



Population-Based Payment for Primary Care Clinic Services



Payment Model for Rural Health Clinics

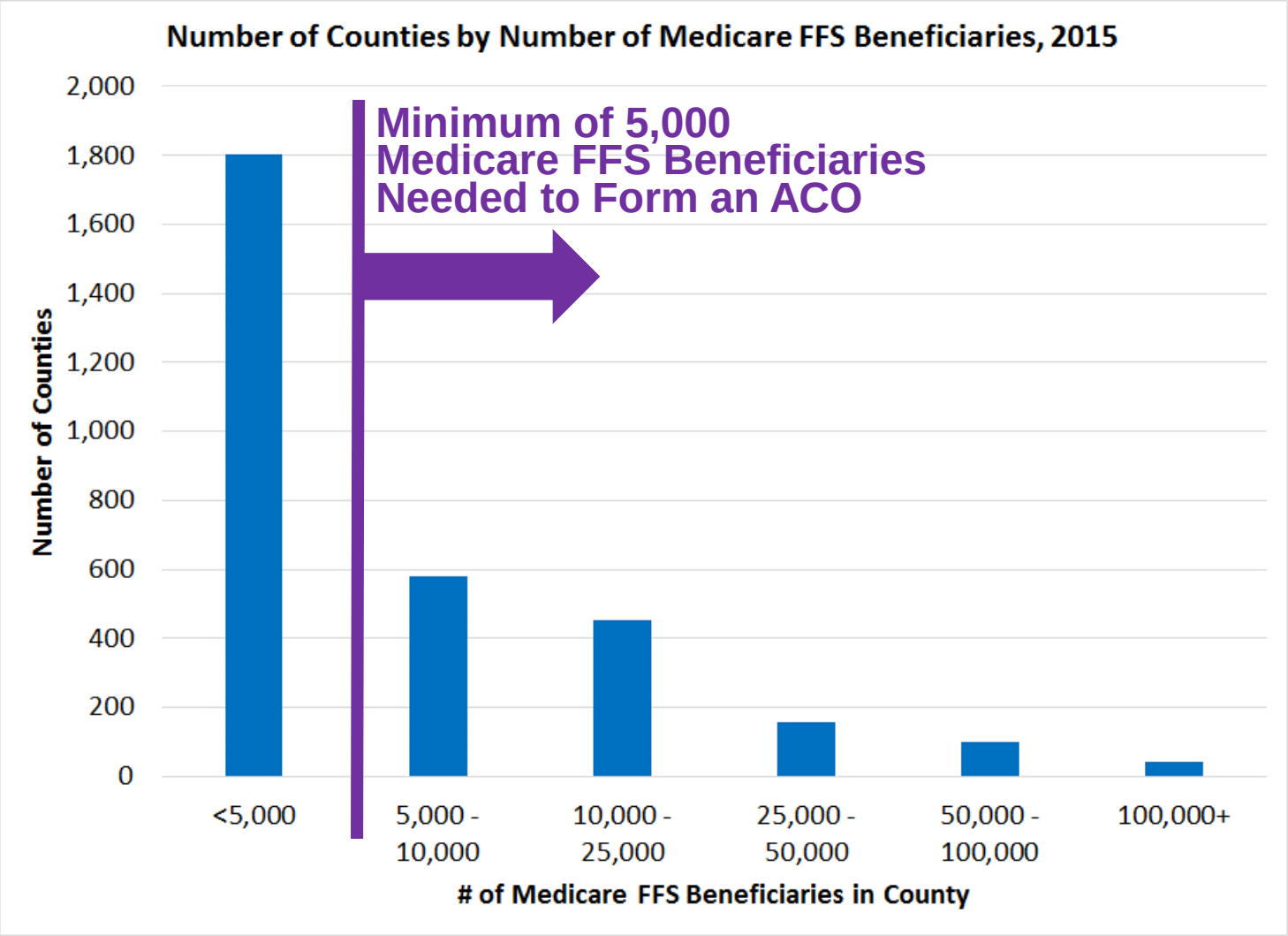
1. **Comprehensive Primary Care Services Payment (CPCSP)**
   - For patients formally enrolled with the practice, the clinic would receive a monthly, acuity-stratified payment for each patient that could be used to deliver a wide range of services, including services not currently billable or reimbursable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

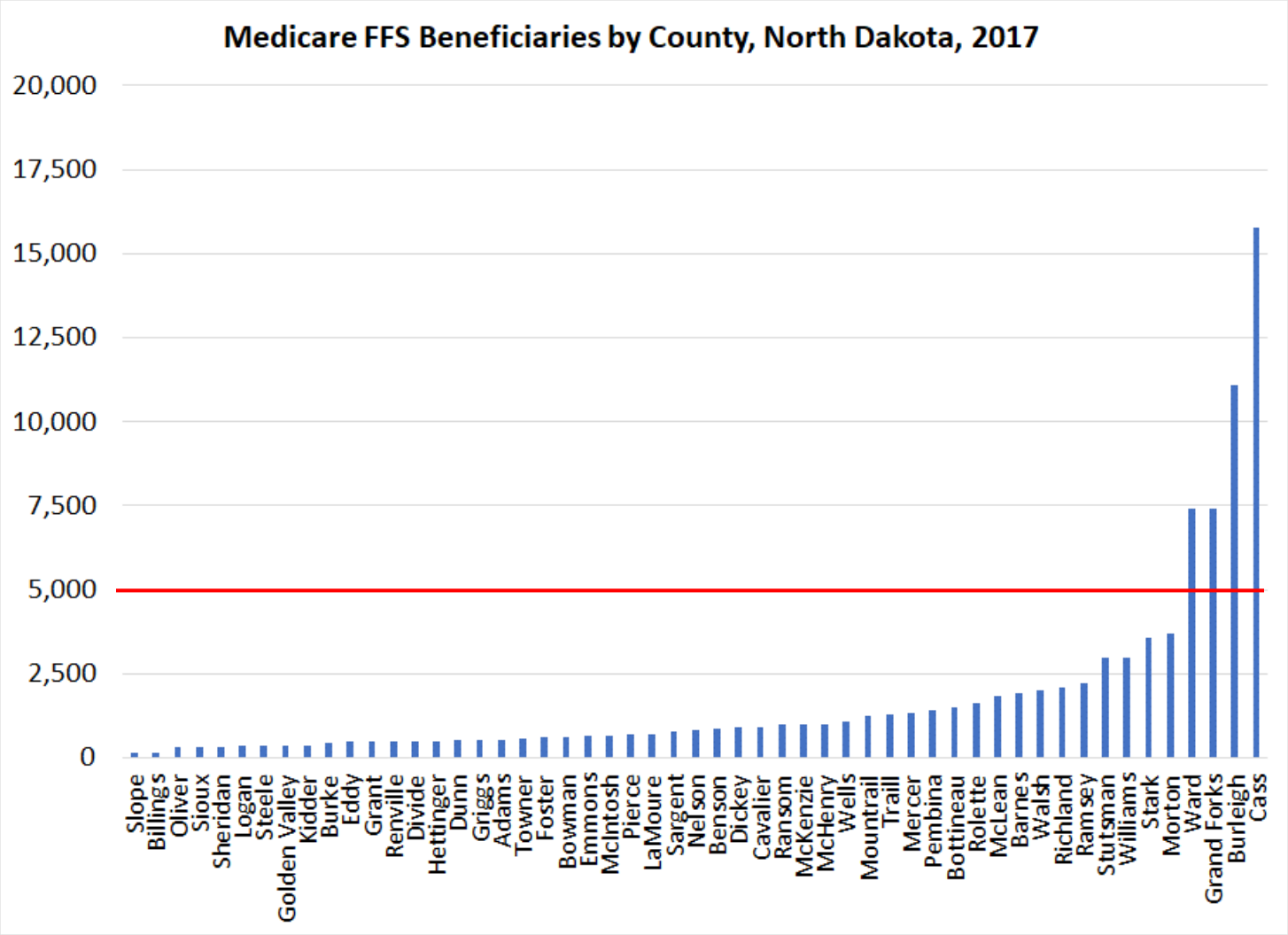
CMS Comprehensive Primary Care Plus	CAH Primary Care Clinic APM
Comprehensive Primary Care Payment: • Per-beneficiary per month payment for attributed patients • Payment amounts based on current average FFS payments per beneficiary to the practice, so practices with higher revenues under FFS continue to receive higher revenues **Care Management Fee:** • Five tiers of additional monthly payments per attributed beneficiary based on HCC risk scores and presence of dementia	**Comprehensive Primary Care Services Payment:** • Three tiers of monthly payment per enrolled member based on physical or behavioral health conditions and presence of serious risk factors
Performance Based Incentive Payment • Two components based on quality/utilization • Single per patient payment regardless of patient needs; reduced for poor performance	**Performance-Based Payment** • Two components based on quality/utilization • Payments increased or decreased based on good/poor performance • Payments based on patient need as well as performance level
Continued FFS Payments • Payments for all services to all patients but at 35%-60% of current rates	**Encounter-Based Payment** • Payment per visit only for patients who are not enrolled for monthly payment

APPENDIX:
Can ACOs
Sustain Rural Hospitals?

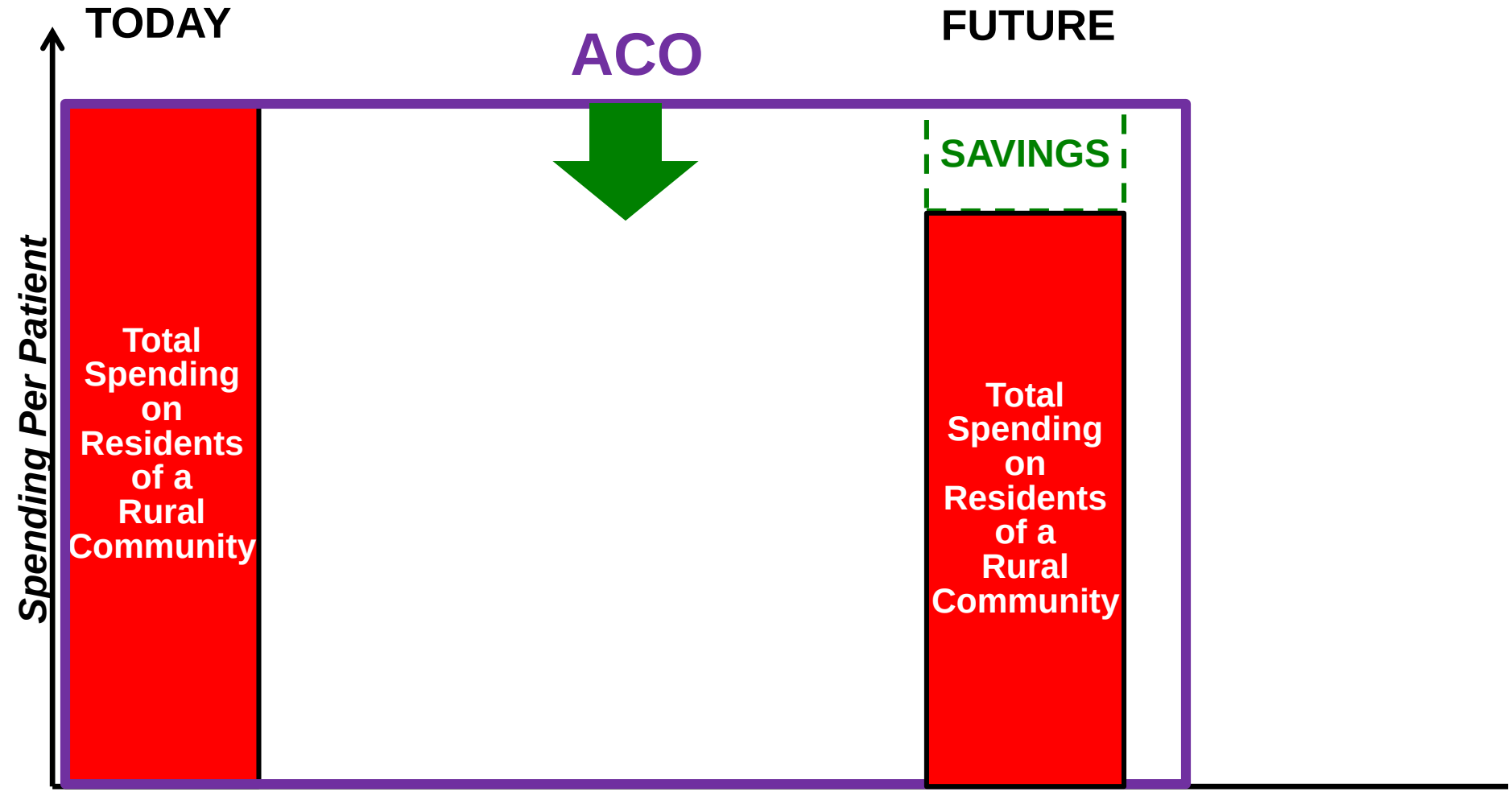
Most Counties Aren't Big Enough to Create a Medicare ACO



Most Counties in ND Have Far Fewer Than 5,000 Beneficiaries



ACOs Are Expected to Reduce the *Total* Cost of Care for a *Population*



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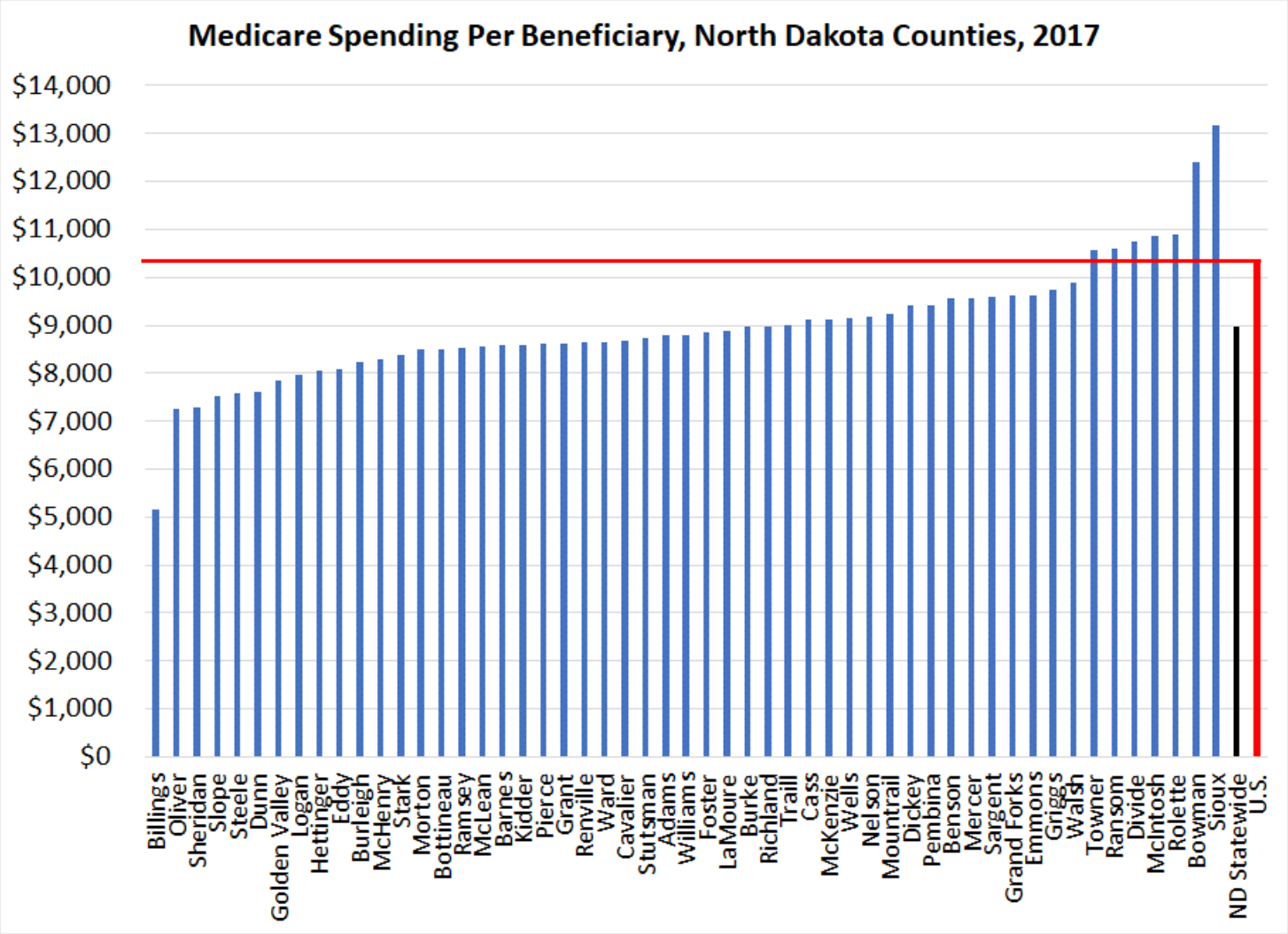
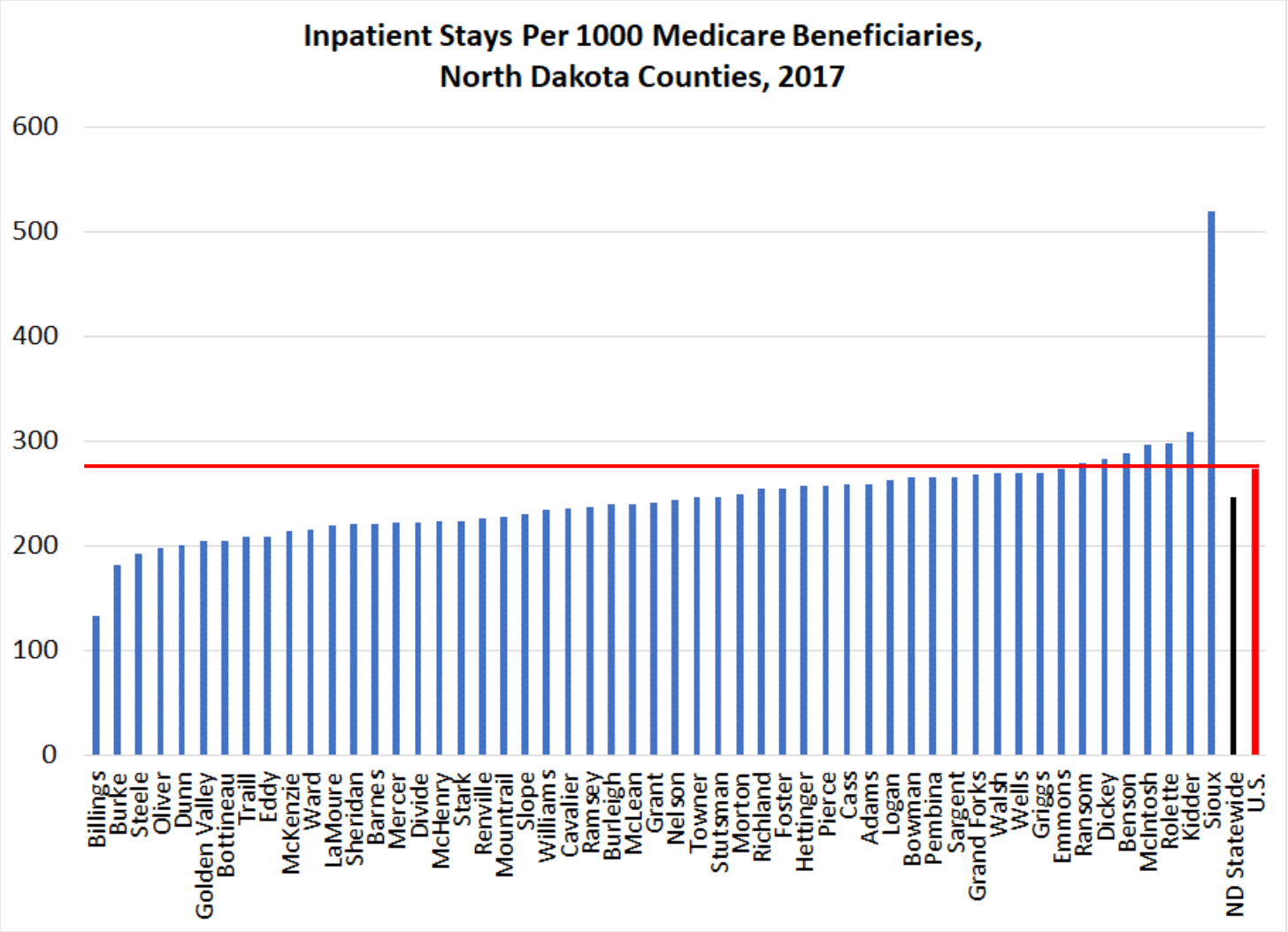
Payer Spending

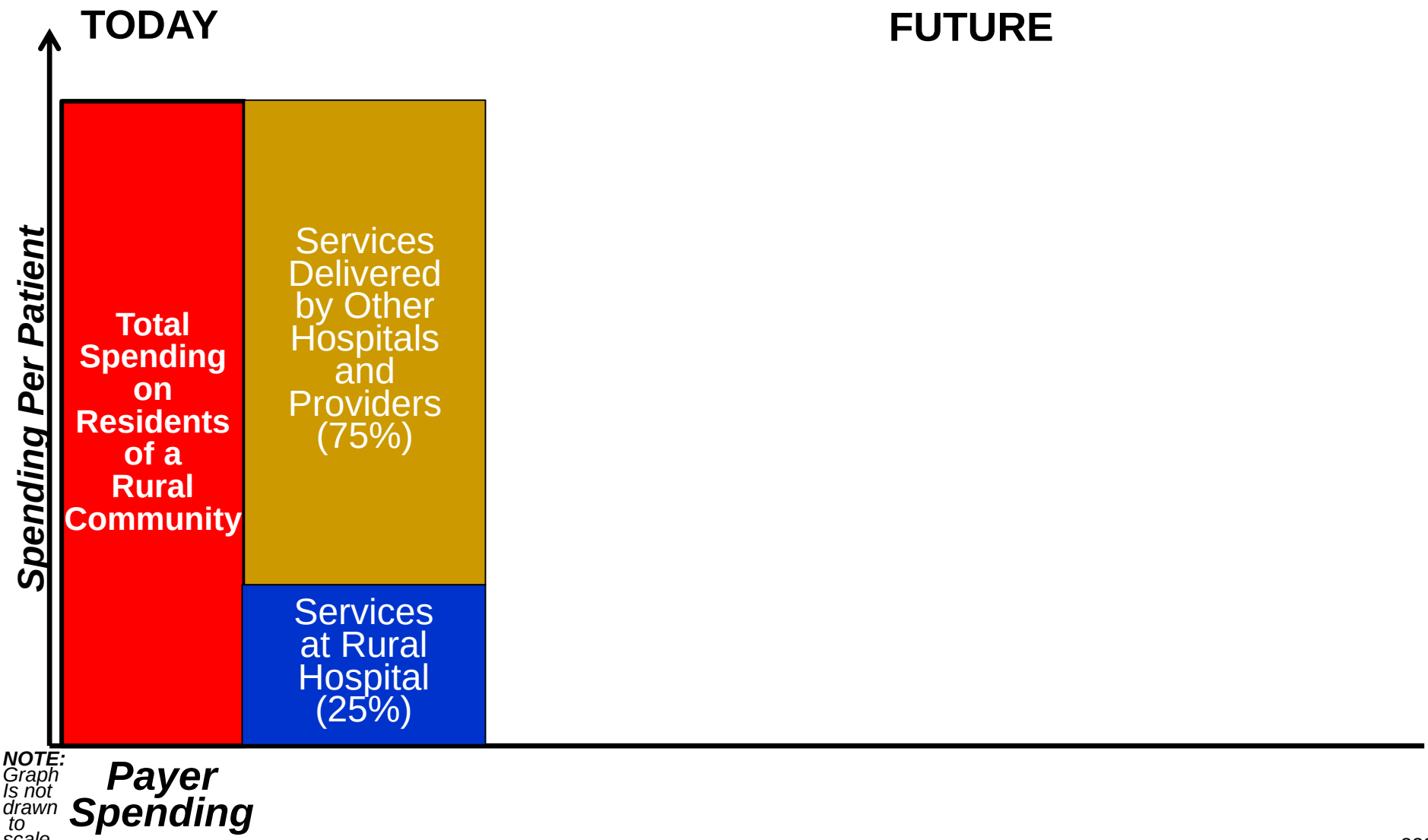
Medicare Spends Far Less in Most ND Counties Than U.S.



Less Opportunity to Reduce Spending Than Other States



Most Spending on Rural Patients Isn't From Rural Hospital Services



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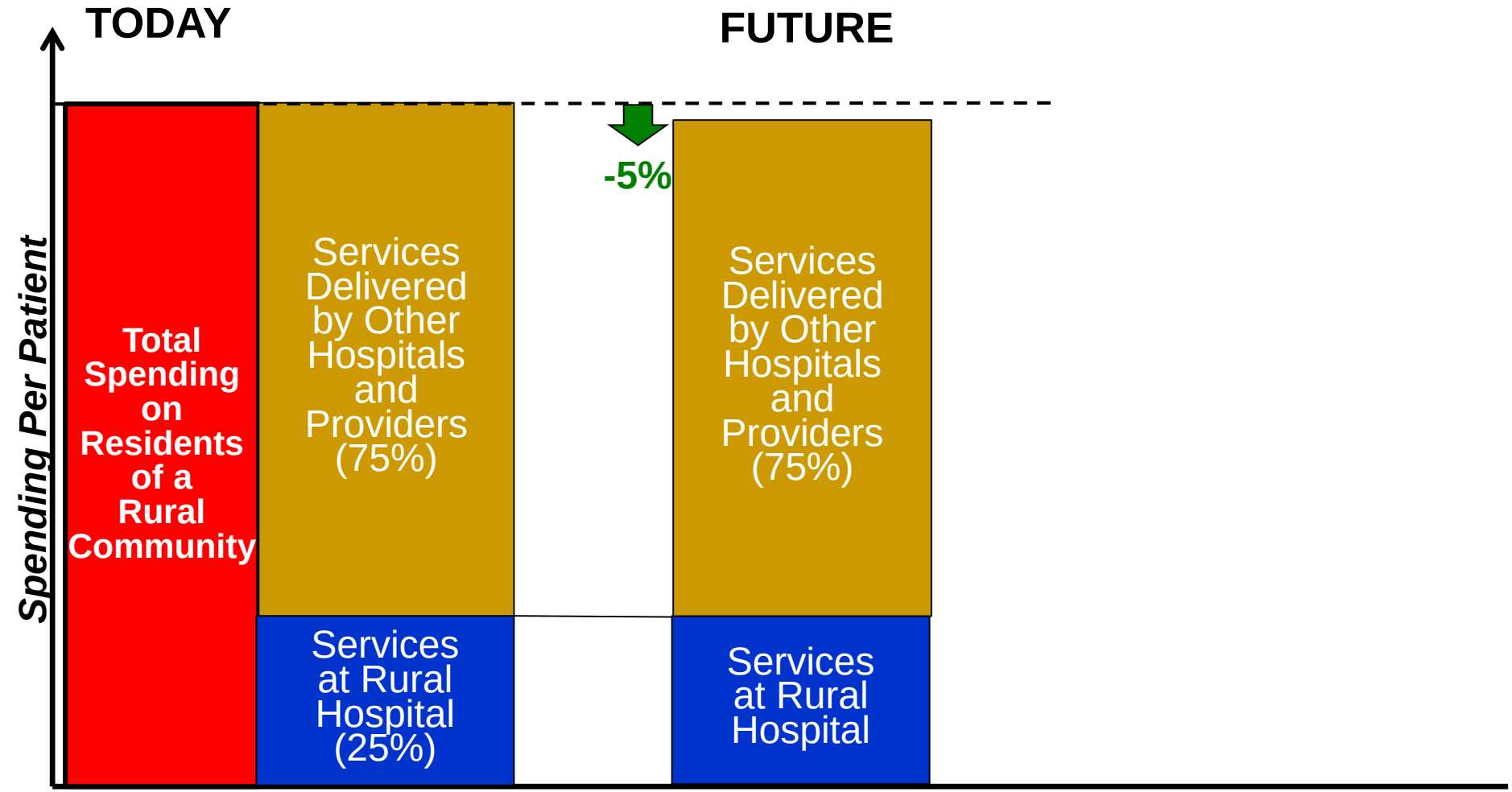
If Spending on Services Elsewhere Could Be Reduced…



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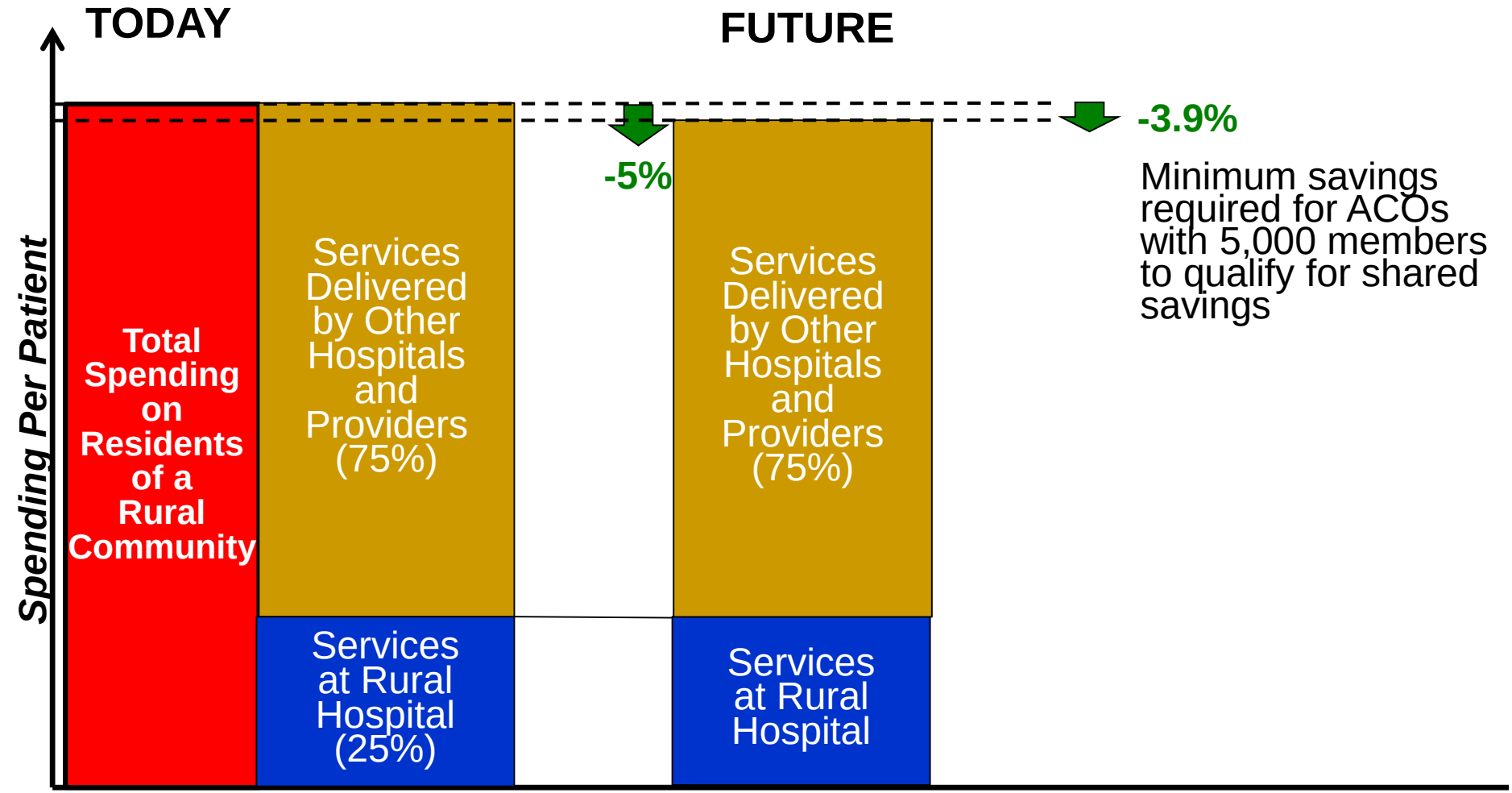
Payer Spending

…Enough to Meet the Minimum for Receiving Shared Savings…



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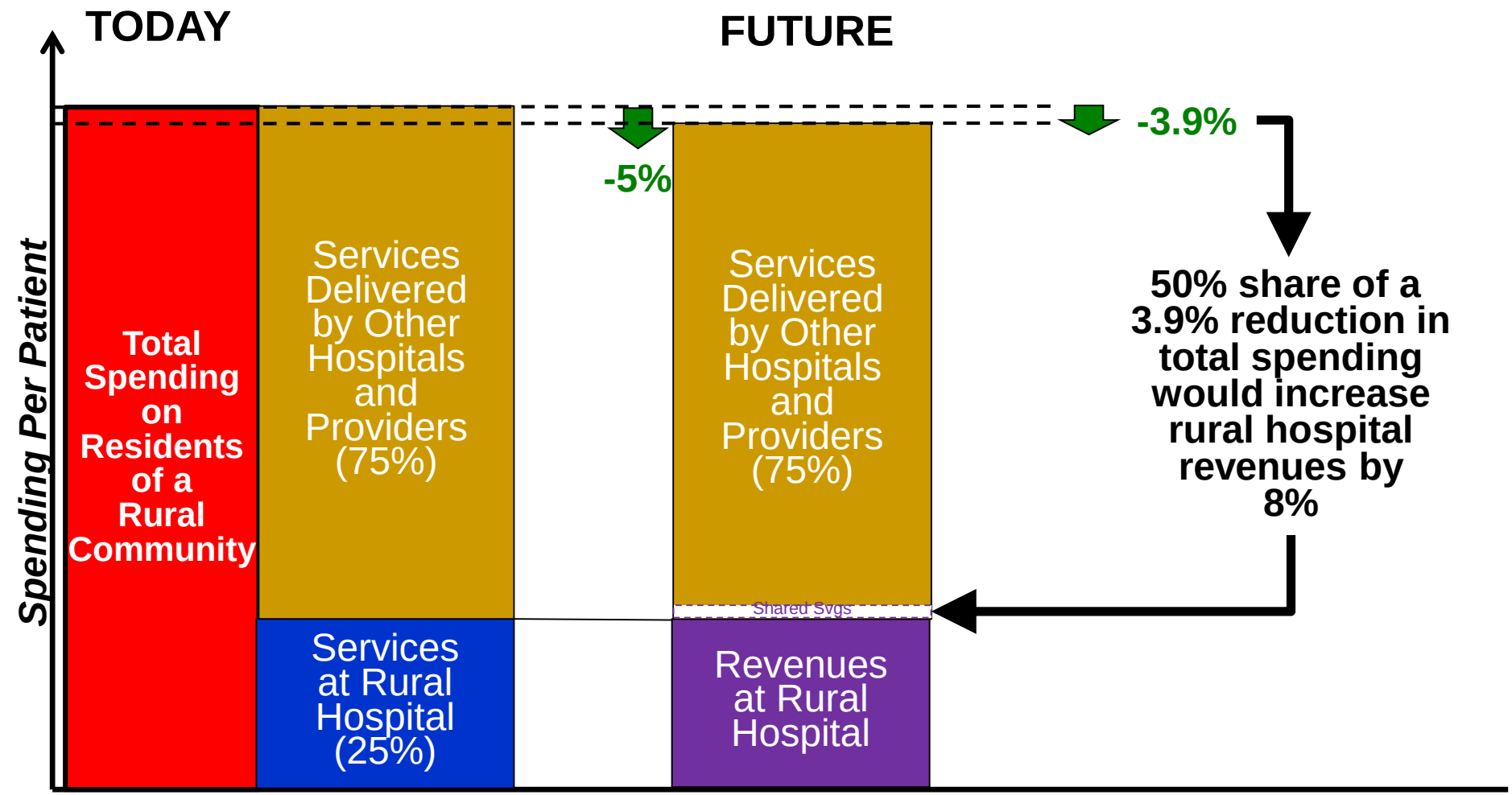
…Shared Savings Could Increase Revenue for the Rural Hospital



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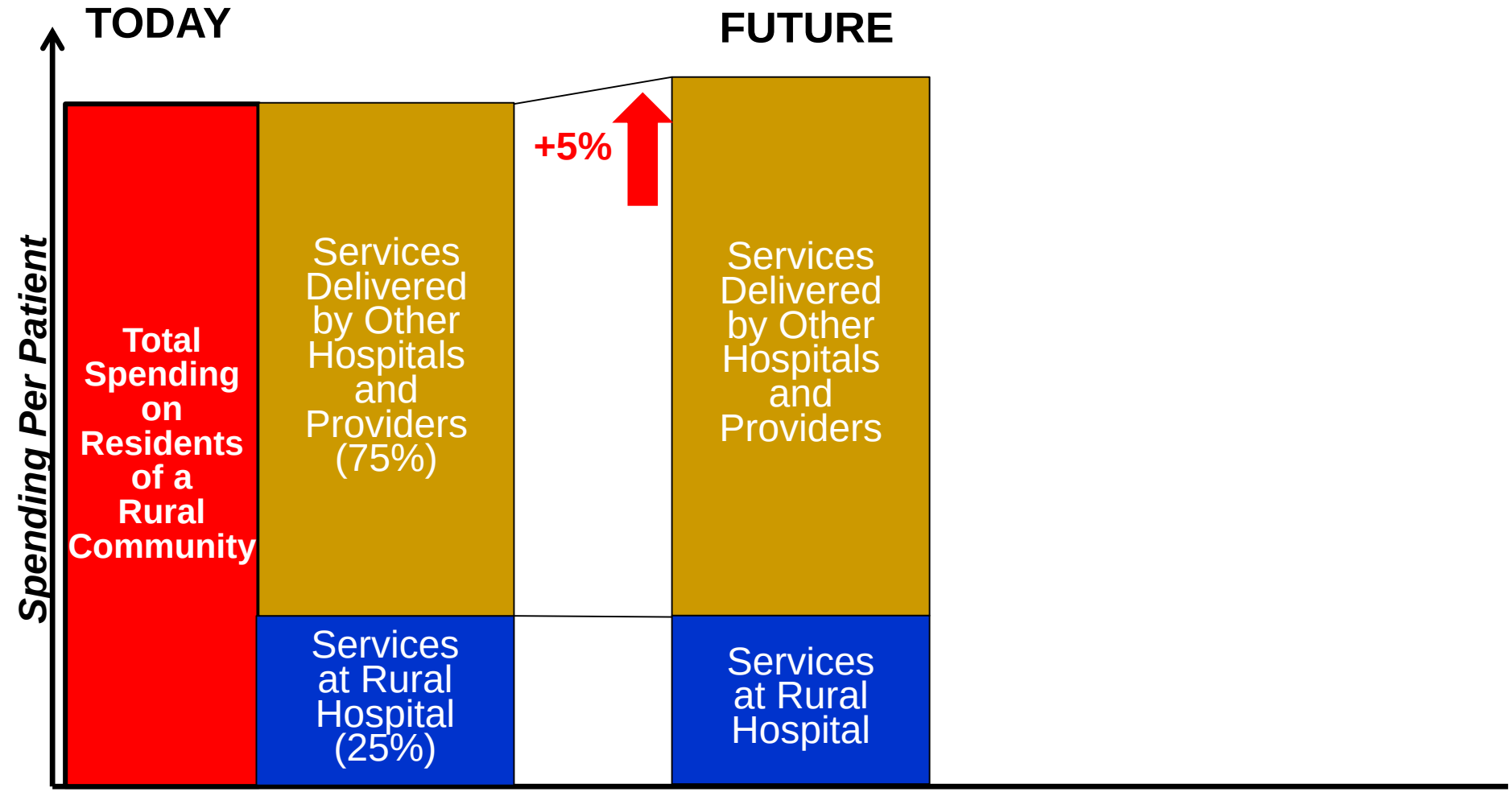
Payer Spending

But If Rural Hospital Can't Ensure Savings From Other Providers…



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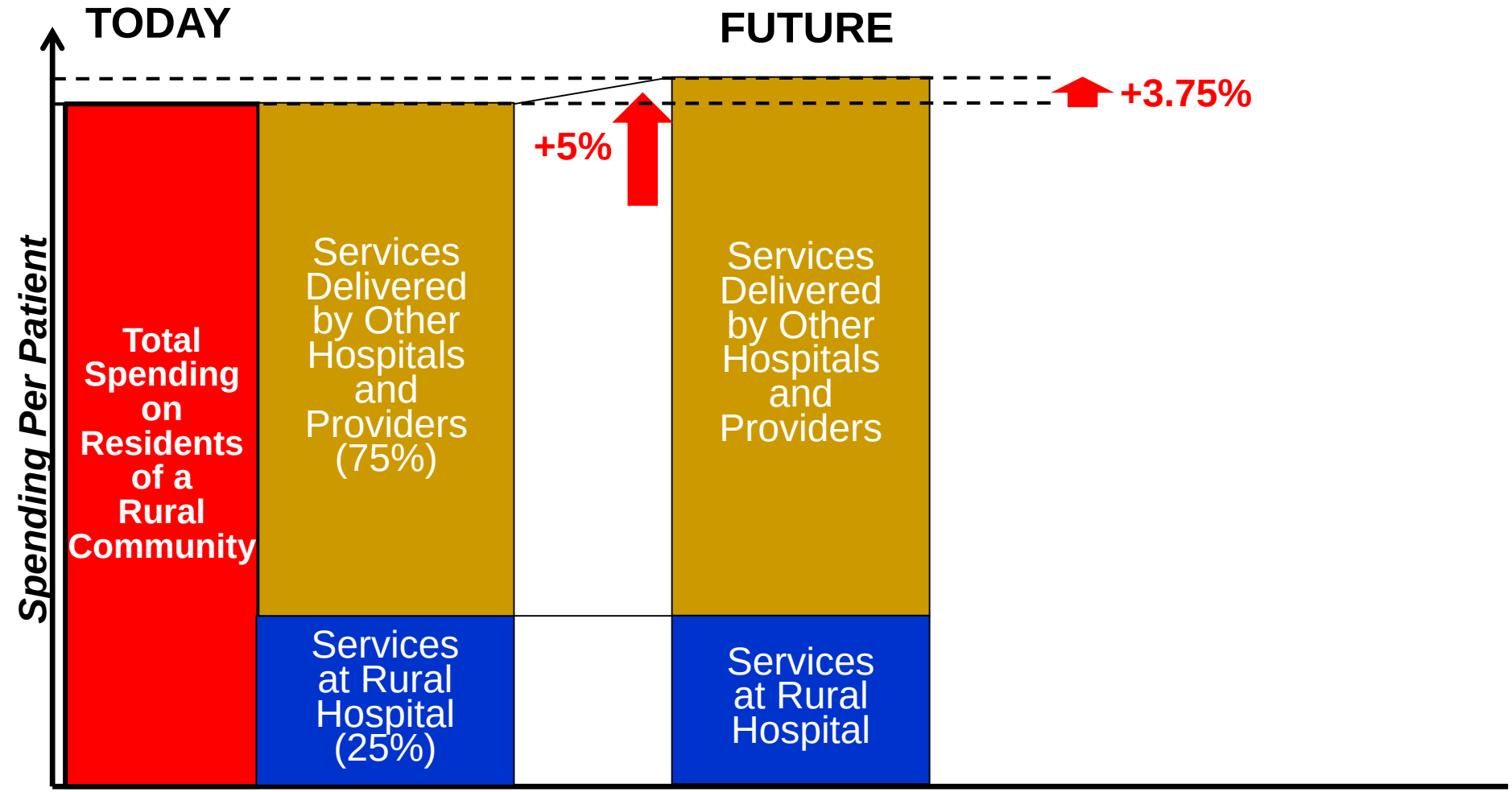
Payer Spending

…It Wouldn't Qualify for Shared Savings Payments…



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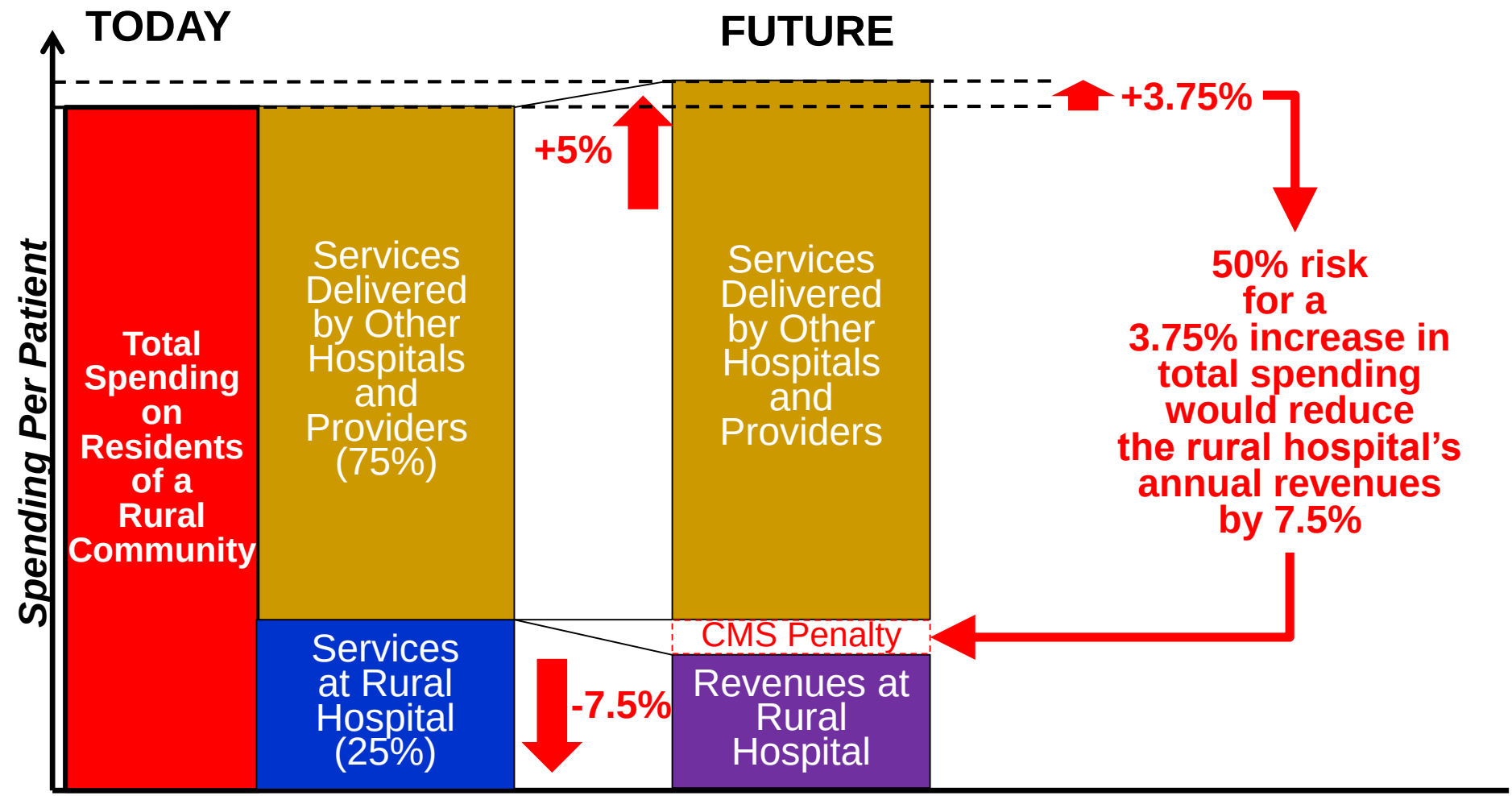
Payer Spending

…And Harm the Hospital if Downside Risk is Required



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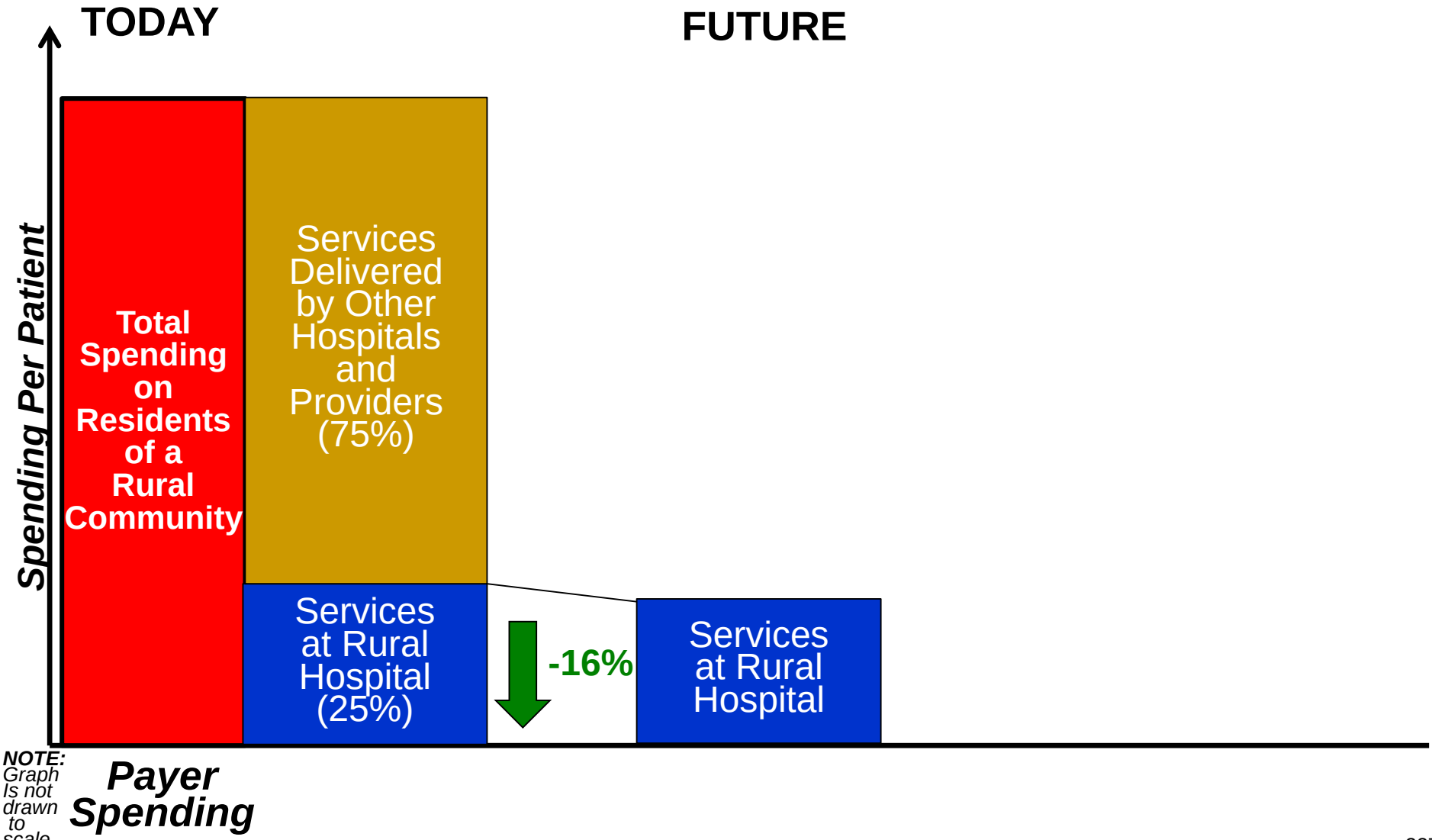
Payer Spending

Rural Hospital's Own Services Would Need Large Decreases…



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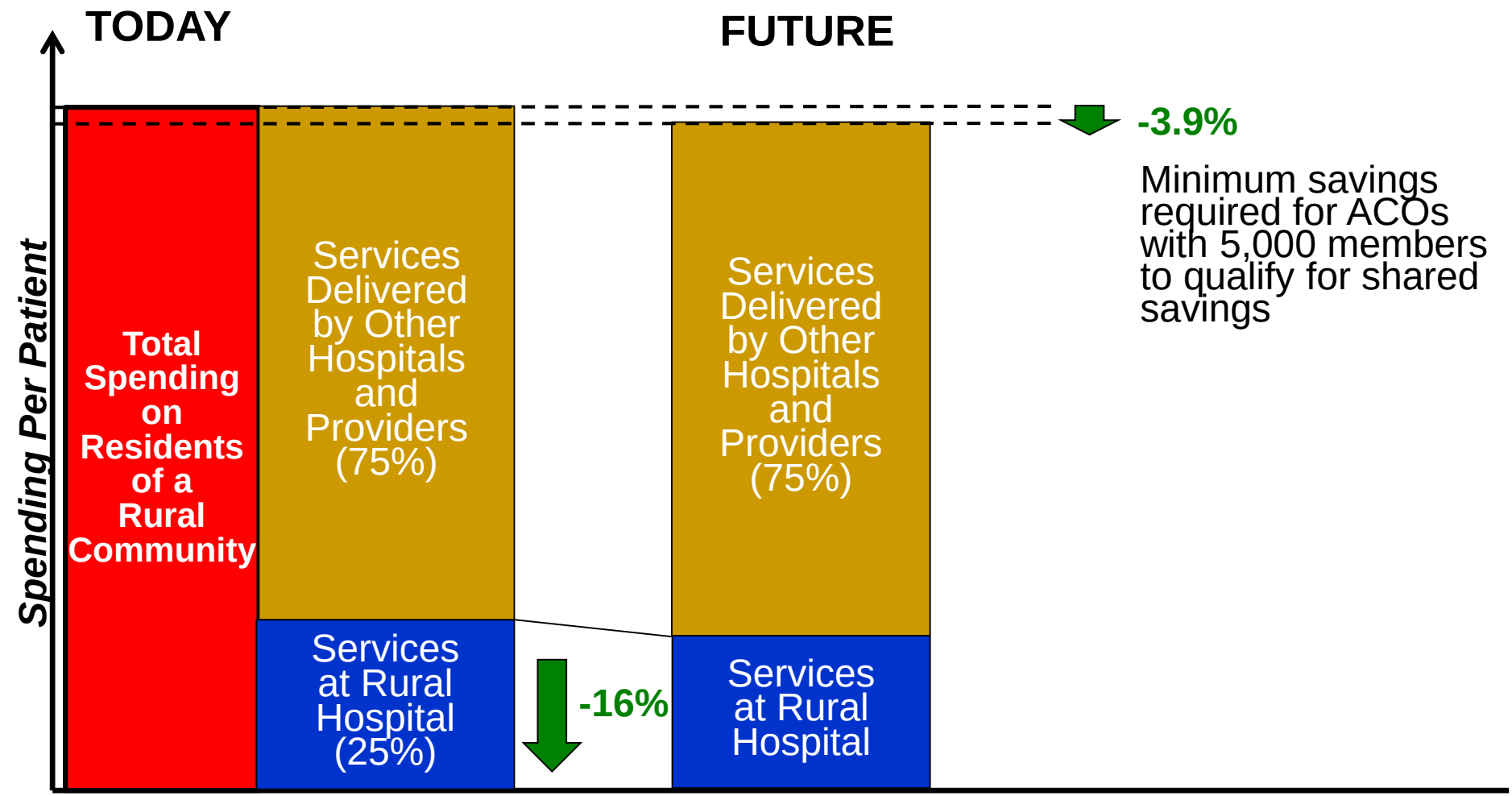
…To Achieve Minimum Savings Needed for Shared Savings…



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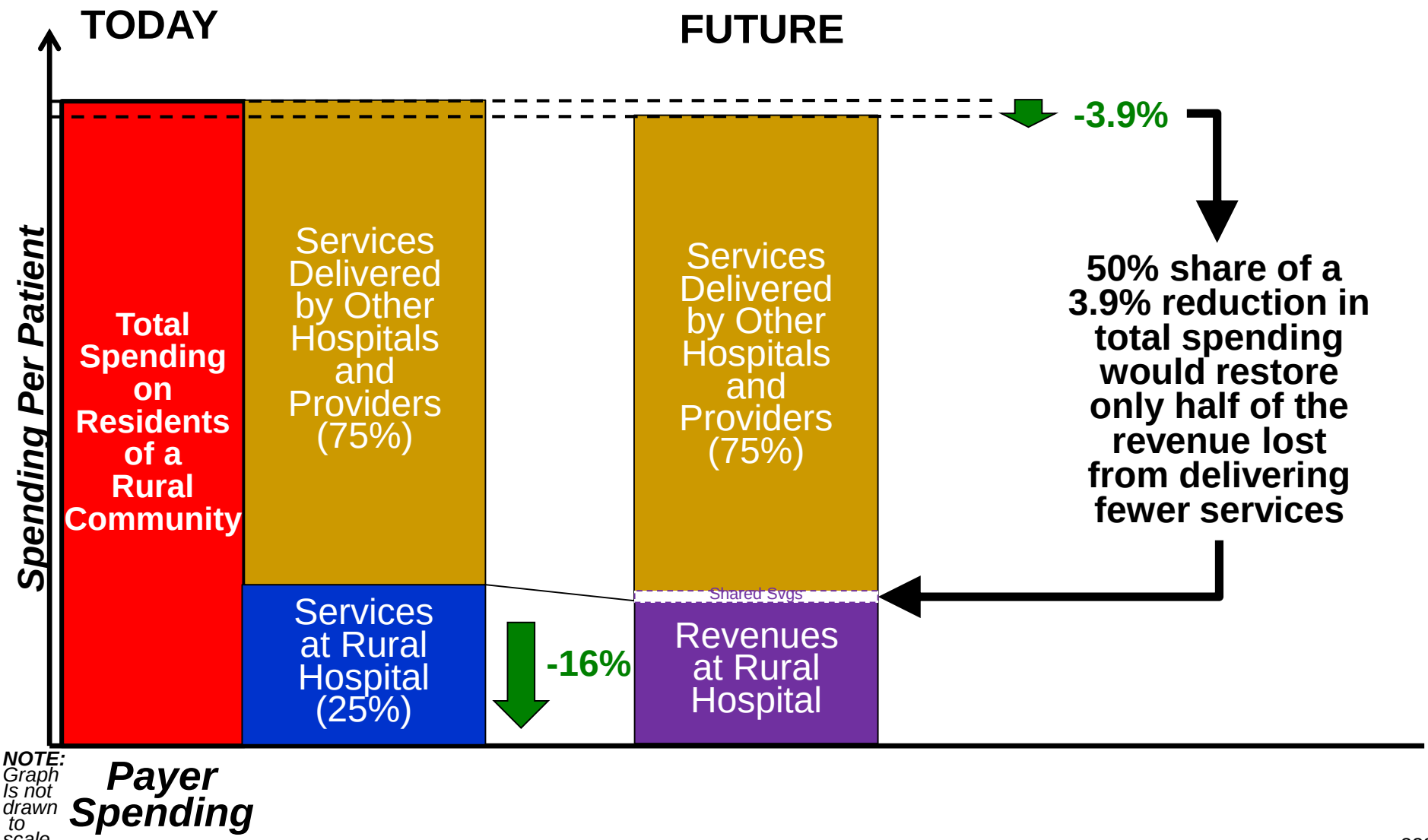
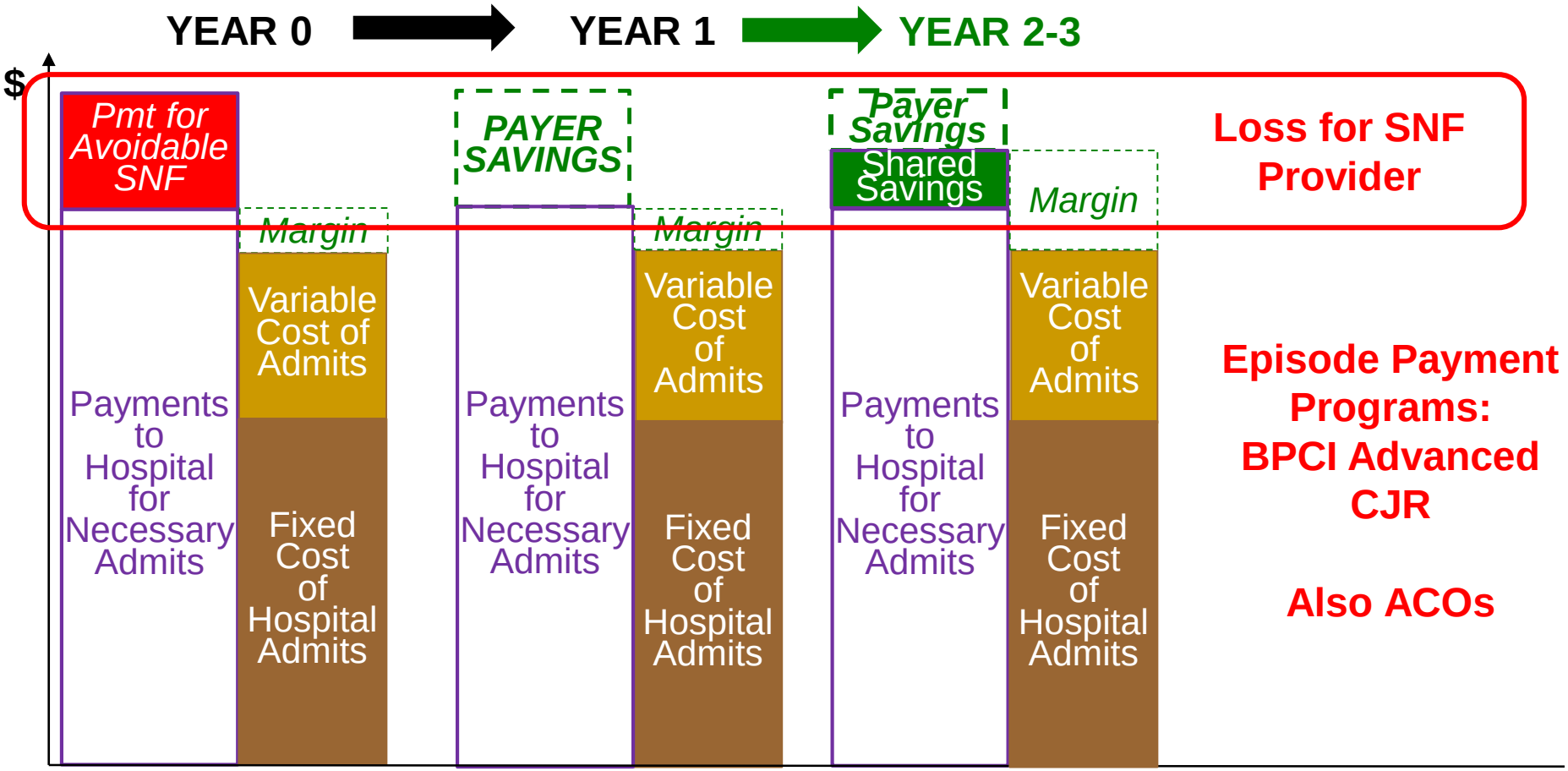
Payer Spending

…But Hospital Ends Up Worse Off Than It Started…



APPENDIX:
How CMS Episode Payments Could Harm Rural Hospitals

Expensive SNF Stays in Rural Hospitals = Savings for Others



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