Changing Reimbursement in Rural Hospitals
The Oregon Experience
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Current Rural Themes

More Services

More Integration

Bend the Cost Curve
Current Rural Themes

Difficult to staff a rural hospital
- The right MDs and RNs to serve the community
- Educational resources are in the urban centers

Payers want rural hospitals to go “at risk” for reimbursement
- Difficult because of fixed costs and small populations

Consequences of failure are big
- Significant community resource
- Often the community’s largest and best paying employer
Presentation Roadmap

- Set The Table
  - Who and what are Oregon’s Rural Hospitals
- The Oregon Health Plan
  - Oregon’s history with Medicaid experimentation
- Coordinated Care Organizations
  - Oregon’s latest Medicaid demonstration
- Rural Oregon’s Response
  - The Rural Health Reform Initiative
- Outcomes
  - What was learned and next steps
Oregon’s Rural Communities are Diverse
Oregon’s Rural Hospitals by the Numbers

Rural Hospital Demographics
- 25 with 25 or fewer beds (range 6 – 25)
- Most with at least 50 miles to the nearest DRG
- Many are at least 2 hours by road from the nearest DRG

Outpatient Centered Care
- 42,004 inpatient discharges
- 312,434 ED Visits
- 1,975,325 Outpatient Visits

Most Have Some Level of Organizational Support
- 17 are part of a Hospital System
- 7 District Hospitals
- 8 Independent Rural Hospitals
Rural Hospital Politics of Oregon
Rural Hospital Politics of Oregon
History of Oregon Medicaid

- Oregon Health Plan (OHP) approved in 1993 by Medicaid waiver
  - Expanded Medicaid to the working poor by rationing benefits
- Created a prioritized list of covered services
  - Low cost – high value services at the top
- Legislature funded the OHP at a selected budget and eligibility
- DHS would draw the line on the Prioritized List to serve the eligible beneficiaries within that budget
- Rural Hospitals were paid at 100% of cost
History of Oregon Medicaid

- Expanded Medicaid beneficiaries by 50% to 360,000 individuals in the first year reaching nearly 500,000 by 2010
- Created two tiers of Medicaid coverage
  - OHP Plus covered children & eligible adults
  - OHP Standard covered uninsured adults not eligible for Medicaid
- As costs rose, new enrollment was closed in 2004
- Enrollment reopened in 2008 with 3000 new spots
  - Oregon Medicaid Lottery
  - Oregon Health Insurance Experiment
By 2010 DHS realized it had a problem
- Costs were increasing at an unsustainable rate
- Either cut services or cut beneficiaries

Needed a way to shift the risk of insuring Medicaid beneficiaries away from the State

New system goals:
- Budgets would be sustainable
- Communities would control services and utilization
- Oregon could afford to expand Medicaid eligibility
1115 Demonstration Waiver

- Significant Flexibility in how Medicaid dollars are spent
- CMS granted $1.9 billion to fund delivery and payment transformation
- Oregon cuts Medicaid’s rate of growth from a projected 5.4% a year to:
  - 4.4% in year 1
  - 3.4% in years 2-4
- Saving $3 billion in Medicaid spending over the 4-year period
How can Oregon guarantee growth reduction?

- Shift the Risk
  - From the state as a payer to private payers
- Reduce Waste
  - Eliminate unneeded care
- Integrate Care
  - Decreased ED and hospital utilization
- Increase the Risk Pool
  - Include all state beneficiaries

Safety Net Program | Healthcare Partner | Better Health Lower Costs
- Enabling legislation for Oregon Health Plan transformation
- Created the Oregon Health Authority
  - Puts all state health purchasing and regulating power into one agency
- Creates a new system for purchasing care for Medicaid beneficiaries called Coordinated Care Organizations (CCO)
- Gives the Oregon Health Authority and CCOs incredible flexibility and negotiating power when purchasing healthcare
What’s a Coordinated Care Organization (CCO)?

- Community run Medicaid insurer
- Operates in a specific geographic area of Oregon
- Receives a PMPM from the OHA for all each beneficiary
  - Inpatient/Outpatient Physical
  - Mental
  - Dental
- Owned & Operated by Communities, Providers, Hospitals, Health Districts, Health Plans
- 15 CCO’s have been approved by the OHA
HB 3650 did not provide for rural hospitals to be paid at 100% of cost

Rural hospitals must negotiate with their CCO just like everyone else

Rural Hospitals were able to add language allowing some to remain on CBR if the new payment model caused “significant financial risk”

More on this later!!!
The White Paper — Team Effort

- Written by a rural hospital CEO
- Proposed a joint effort by all rural hospitals in Oregon
- Must have 100% participation from rural hospitals
- Genesis for the Rural Health Reform Initiative (RHRI)
Goals of RHRI

- Sustaining rural hospitals and physician practices
  - Preserving access to local health care services for rural Oregonians through sustainable state and federal funding for rural hospitals and health systems.

- Prepare for the future
  - Take the steps necessary to design and implement new models of care delivery and reimbursement for rural hospitals.
RHRI Work Plan

- Bring consistent data, metrics, and benchmarking to Oregon’s rural hospitals
- Study the affects of cost-based Reimbursement on Oregon’s rural hospitals and Medicaid program
- Study the affects of alternative payment methodologies on Oregon’s rural hospitals & Medicaid program
- Determine if some or all rural hospitals must remain on CBR to survive
RHRI Data & Analytics

- **Triple Aim Dashboard**
  - Focuses all RHRI hospitals on the same metrics
  - Hospitals define what they do and how they do it to their constituents

- **Readmissions Analysis Tool**
  - Focuses all RHRI hospitals on one common goal of reducing unnecessary readmissions

- **Value-Based Metrics**
  - Starts the process of hospital management thinking about future pay for performance
Rural hospital beliefs:

- Rural hospitals provide care:
  - More efficiently
  - Less expensively
  - With higher quality

- The financial and human cost of transportation would outweigh any increased cost of care in a rural setting
The RHRI funded an analysis of cost, utilization, and quality in Oregon’s 32 rural hospitals.

Findings:
- Inpatient cost was much higher in the average rural hospital than the average urban hospital.
- Inpatient utilization was lower in the average rural hospital than the average urban hospital.
- Quality was very difficult to compare.

The cost of transporting patients to an urban hospital did not outweigh the extra financial cost of treating them in a rural hospital.
Alternative Payment Methodologies

- Remain on Cost-Based Reimbursement
  - 100% of cost

- Prospective Payment System with a Volume Adjustment
  - If volumes decrease, payments increase
  - If volumes increase, payments decrease

- DRG/APC system of the urban hospitals

The RHRI chose to study and compare all three
The RHRI created hospital-specific reports comparing revenues under the three proposed payment methodologies.

Cost-Based Reimbursement was the control.

Some hospitals would have little to know problem moving to the PPS with VAS:
- Larger hospitals

The hospitals already reimbursed by Medicare using DRG were most equipped to move to a Medicaid DRG system.
The OHA may allow hospitals to remain on CBR if they would experience “significant financial distress” from alternative payment methodologies.

OHA had no definition for “significant financial distress” and no benchmark or measurement to determine which of the 32 hospitals should not transition.

RHRI stepped up to offer a definition and measurement that would be acceptable to the rural hospitals and the OHA.
Proposed Risk Assessment

- Flex Monitoring Team/UNC - Modeling for Risk of Financial Distress
  - Critical Access/Rural Hospital specific
  - Peer Reviewed

- Cleverly + Associates Risk Assessment
  - OHA proposed

- Global Health Payments
  - Hospital proposed
Preliminary Risk Assessment Outcome

- Some rural hospitals must remain on CBR at this time
- Some will be able to successfully move to a new payment methodology
- How many and who has not been released at this time
- OHA is reviewing the methodology
Where does that put us now?

- Some rural hospitals have teamed up to have ownership in their CCOs
- Those in large systems are using their system resources to integrate care in their communities
- The once unified RHRI is fracturing a little
  - Hospitals that “know” they are losing CBR
  - “Bubble Teams”
  - Those that are “sure” they will remain on CBR
What did Oregon get from the RHRI spend?

- Increased understanding of how hospital care is delivered in rural Oregon
- In depth understanding of the financial strength of Oregon’s rural hospitals
- Oregon knows which rural hospitals are currently at risk of financial distress
- Oregon’s rural hospitals understand how changes in payment methodology will affect their future financial strength
Was it worth it the time and money spent?

- The Small and Rural Committee of the OAHHS decided to continue funding the RHRI
- There is continued work in:
  - Delivery Integration
  - Payment Methodologies
  - Quality Assessment and Benchmarking
- The RHRI has become the place to ask the difficult rural questions
Was it worth it the time and money spent?

- Oregon knows which hospitals should remain on Medicaid CBR
- Hospitals have well researched payment methodologies they can use when negotiating with their CCO or other payers
- Informed advocacy position
But...

- A group project cannot address every hospital’s specific needs
- Rural hospital data will always be “thinner” than desired
- A project moving at light speed will miss a few opportunities
Next Steps for Oregon

- OHA to determine the reimbursement status of rural hospitals
  - Do some remain on CBR?
  - Which ones?
  - Can the OHA mandate a type of PPS that CCOs must use with rural hospitals?
Next Steps for Oregon

- Rural hospital data collection system
  - Information Network for Oregon Hospitals (INFOH)
  - Program to collect previously uncollected outpatient & ED claims
  - Collect new kinds of Rural Hospital quality data

- Integration strategies for rural hospitals
  - Emergency Department Information Exchange (EDIE)
  - Program that lets providers and hospitals understand on a real-time basis how their patients are using the ED

- We will have clarity after July 1st
Questions?
Thank you!

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