Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Washington Rural Health Access Preservation Pilot

Interim Status Report

Engrossed Substitute House Bill 2450; Chapter 31, Laws of 2016

December 1, 2018

Washington Rural Health Access Preservation Pilot

Interim Status Report

Preface

This report was developed in cooperation with the Washington State Health Care Authority and the Washington State Department of Health. The Health Care Authority shared this report with the Washington State Hospital Association for comment. The Hospital Association provided its own report (attached).

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Background

The Washington State Health Care Authority (HCA), in consultation with the Department of Health (DOH) and the Washington State Hospital Association (WSHA), is submitting this report to the Legislature as required by Engrossed Substitute House Bill (ESHB) 2450 (2016). This bill related to the establishment of the Washington Rural Health Access Preservation (WRHAP) pilot. WSHA submitted additional comments included as an attachment.

The WRHAP pilot is aimed at supporting the smallest and most remote Critical Access Hospitals (CAHs), which are at the highest risk of closing and threating access to care in rural communities. The pilot is one of the implementation steps from the New Blue 'H' Report[1]. This report recommended creating opportunities to restructure and strengthen the rural health care system in Washington State. The WRHAP pilot was created in fall 2014 by WSHA and DOH to design and implement improvements in payment and delivery of health care in Washington's smallest and most remote communities. HCA began working with the WRHAP pilot in 2016.

ESHB 2450 states that:

> The department of health, health care authority, and Washington state hospital association will report interim progress to the legislature no later than December 1, 2018, and will report on the results of the pilot no later than six months following the conclusion of the pilot. The reports will describe any policy changes identified during the course of the pilot that would support small critical access hospitals.

Passage of ESHB 2450 allows designated critical access hospitals that dropped their CAH licensure to participate in the WRHAP pilot to resume CAH payment and licensure in the future, if they choose to do so. This legislation was necessary because there is a moratorium on new CAH designations in Washington State.

During the 2017 legislative session, the Legislature expanded ESHB 2450 by passing Substitute House Bill (SHB) 1520. Under this bill, the Legislature mandates that the WRHAP pilot shall "develop an alternative service and payment system to the critical access hospital authorized under section 1820 of the social security act to sustain essential services in rural communities."

SHB 1520 directs HCA to create the WRHAP payment pilot based on an alternative, value-based payment methodology that "…adjusts payment amounts based on measures of quality and value, rather than volume…" Subject to budget appropriations, the payment methodology was to provide sufficient funding to sustain essential services, including emergency and primary care services. The Legislature also directed HCA to encourage additional payers to use the adopted payment methodology.

[1] Learn more about the New Blue 'H' Report at http://www.wsha.org/our-members/rural-hospitals/the-new-blue-h-report/

The Legislature provided $2.1 million in bridge payments to build capacity for value-based payment and systems transformations for WRHAP hospitals, for the 2018 and 2019 fiscal years. The appropriation is to be used to help WRHAP hospitals prepare to transition to a new payment methodology. The bill authorizes a three-year pilot period and extends additional appropriations through the entire three year period of the pilot.

Update on Activities and Implementation

Following the passage of SHB 1520, HCA worked with DOH, WSHA, and the 13 hospitals participating in WRHAP to design how the pilot's transitional funding could support readiness for a new payment methodology that met the legislative requirements of SHB 1520. The design HCA implemented focuses on underpinnings that will contribute to preserving and strengthening primary care and emergency services by:

- Building capacity for behavioral health services or care coordination services; or
- Linking quality performance to the implementation of those services.

Each participating hospital had the option to establish one of these two services aim at strengthening their capacity and readiness for value-based care. For those that elected to establish behavioral health services, supplemental funding has been linked to the hospital's performance on the clinical quality measure of depression screening. For those that elected to establish care coordination services, supplemental funding has been linked to the hospital's performance on the clinical quality measure of follow-up after an emergency department visit or hospital discharge.

HCA began communicating with the Centers for Medicare and Medicaid Services (CMS) in November 2017 to evaluate ways to obtain federal matching funds under the Medicaid program, and to explore the requirement that HCA encourage additional payers to use the adopted payment methodology. The Legislature's funding for the WRHAP pilot assumed the $2.1 million is matched by state and federal dollars.

The transitional funding provided has been implemented through HCA's Apple Health contract with Medicaid Managed Care Organizations (MCOs). HCA was able to structure these funds to meet federal guidelines for Medicaid matching dollars. Payments for the WRHAP hospitals are approved as "pass-through" payments.[2] Payments flow from HCA, through contracted MCOs, to WRHAP hospitals. MCOs will pay WRHAP hospitals based on their reported performance. Once this performance is reported to HCA, Milliman Inc. will retroactively adjust MCO contract rates to account for payments made to WRHAP hospitals.

Washington State did not receive final CMS approval until June 27, 2018.[3] Because WRHAP implementation was delayed, the Legislature's 2018 budget shifted implementation and payments entirely to the 2019 fiscal year.

[2] "Pass-through payments" are additional dollars paid on top of Medicaid's standard rates.
[3] The CMS approval process for HCA's alternative payment methodology for the pilot was lengthy because it relies on pass-through payments — which CMS is phasing out.

Based on the CMS approval letter, necessary Apple Health contract amendments were executed in July 2018. HCA executed a contract with WSHA on June 18, 2018 to provide technical assistance and oversight support to WRHAP hospitals. The hospitals submit quarterly progress reports to HCA.

WSHA's planning and implementation support includes technical assistance in:

- Staff hiring and training;
- Billing process review and reimbursement review;
- Alignment with other practice transformation supports and initiatives, such as transformation through the Accountable Communities of Health under the Medicaid Transformation waiver; and
- Technical assistance with a change of scope (CIS) filing as allowed under Washington's Medicaid State Plan.

These supports helped WRHAP hospitals to successfully establish new service lines to support greater access to primary care. Notably, CIS has strengthened reimbursement to the affiliated Rural Health Clinics (RHCs) owned by the WRHAP hospitals. Fiscal modeling of 2015 hospital cost data under WRHAP demonstrated that all WRHAP owned RHCs experienced significant losses, and on average, clinic revenues covered only about two-thirds of costs. As allowed under federal law, this filing for CIS increases service capacity for WRHAP-owned RHCs and may contribute to longer term sustainability.

Participating hospitals are required to report their performance to MCOs no later than December 31, 2018. MCOs are required to remit payment within 30 calendar days and report to HCA within 60 days. Payments to WRHAP hospitals are based on deliverables and reporting of participant performance. Installments will be distributed at regular intervals based on performance against targets set by HCA. Under the Apple Health contract language, each MCO will report to HCA on the WRHAP pilot hospital's performance and show proof of payment.

Lessons From WRHAP

The Washington State Legislature, HCA, DOH, and WSHA share the common goal and commitment of preserving access to quality health care in rural communities. With funding from the State Innovation Model (SIM) grant (which the state received from the Center for Medicare and Medicaid Innovation [CMMI]) and DOH Rural Hospital Flexibility Grant Program resources (received in 2016), HCA began working with DOH, WSHA, and the hospitals participating in the WRHAP pilot to evaluate current fiscal performance, and identify new models of payment and delivery. These models support continued access to high quality, essential health services in WRHAP pilot communities.

Evaluations included in-depth fiscal analyses and modeling based on WRHAP hospital costs, e.g. evaluation of profit and loss statements. These analyses identified payer and service line contribution to the WRHAP hospital's overall margin, and how those service lines impact the overall financial sustainability of the hospital.

These financial analyses identified losses in multiple service lines:

- At 30 percent, primary care offered through RHCs made up the largest percentage of overall deficits
- 80 percent of WRHAP hospitals experienced losses in their emergency department; 70 percent experienced losses on inpatient services
- Among WRHAP hospital districts that own either a nursing facility or an assisted living facility, all experienced losses
- All WRHAP hospital districts that own ambulance services experienced losses

While not the sole contributor to positive WRHAP hospital margins, laboratory services were profitable for all WRHAP hospitals. Laboratory service utilization consists of aggregate volumes from inpatient, outpatient, emergency department services, and long-term care services. Overall, WRHAP hospitals have sustained current operations based on WRHAP hospital Public Hospital District support, WRHAP hospital innovation, and legislative action (Medicaid expansion, Medicaid cost-reimbursement, funding under SHB 1520, etc.). Qualitatively, long-term projections under the financing system are not sustainable.

The rate of inpatient stays are consistently below the national average. Given small economies of scale, it is unlikely large savings could be borne from a reduction among unnecessary inpatient stays. This is in part due to shared costs across WRHAP hospital service lines and their contribution of revenue to the WRHAP hospital margin.

Costs and revenues are interwoven across service lines in WRHAP hospitals. Projected savings cannot be demonstrated from the direct elimination of a single service line without delivery system transformation. With staffing as the primary fixed cost, WRHAP hospital staff often work across cost centers. Staffing implications and the distributed costs among service lines — as well as their contribution to hospital margins — must be accounted for in any transformation effort.

Shortly after a proposed payment model developed for WRHAP was completed in January 2017, HCA shared this recommendation with CMMI for review and response. Based on CMMI input and Medicaid's desire to work with all rural hospitals in transformation efforts, HCA in June 2017 elected to pursue two work streams: (1) Seek direct implementation of the WRHAP proposal[4] and (2) expand rural health system transformation conversations to be inclusive of all rural providers and payers (including Medicare).

Subsequently, HCA solicited Milliman Inc. to review the WRHAP proposal to better understand the impacts on the Medicaid program and potential points of alignment with broader transformation interests. Pending additional details of the WRHAP proposal, qualitative analysis suggests there

[4] Based on the necessity to support WRHAP hospital transition to new model of payment and timeliness of available resources, HCA worked with WRHAP hospitals to implement transitional funding consistent with the intent of SHB 1520. A more comprehensive model must be implemented for longer-term WRHAP hospital sustainability.

may be added cost to the Medicaid program. This is representative of the necessity to transform the WRHAP hospital delivery system, and resourcing necessary to support such transformation.

Moving Toward a Broader-Based Payment Model for Rural Hospitals

Early on in WRHAP engagement, HCA, DOH, WSHA and the WRHAP hospitals identified that participation of Medicare and Medicaid — which accounts for 70 percent of WRHAP hospital revenues in some rural areas — and commercial health plans are essential to achieve sustainable payment and delivery system transformation.

Based on guidance from CMMI to ensure the state was developing a model that would include both Medicaid and Medicare, HCA engaged in a more inclusive process with a broader set of hospitals and payers in early 2018. This approach embraces a more comprehensive model that conforms to CMMI established guidance. HCA intends to move in this direction while being responsive to the urgent needs of WRHAP hospitals.

To meet the criteria for inclusion of Medicare, HCA is developing a broader multi-payer model that is available to all of the state's approximately 52 rural hospitals. HCA is engaged in discussions with a wider set of small and large rural providers, including CAHs, WRHAP hospitals, Sole Community Hospitals, and other non-specially designated rural hospitals. The agency is also engaging a wide array of payers. This larger group of rural providers varies in size, scope of services, and financial status. This diversity among provider participants is a core evaluation requirement for Medicare participation.

HCA plans to continue these payment discussions throughout 2018 and 2019 with the understanding that the smallest health systems represented by WRHAP are experiencing an urgent need for solutions to sustain access and support for transformation. These conversations will continue to place strong emphasis on identifying specific accommodations necessary for WRHAP participation in a new payment method and identifying similar supports that would make it possible for other financially stressed hospitals to participate in transformation. These new models of payment and care will build upon existing transformation investments made by the state and the health care delivery system, like the Medicaid Transformation Project. As these discussions occur, HCA will share additional information with the Legislature.

HCA is committed to working with all relevant stakeholders and partners to use the learnings from the WRHAP proposal and, where possible, fold key learnings into a more comprehensive approach that assures Medicare participation. Continued partnership with DOH, WSHA, and WRHAP hospitals will be essential during this development process.

Attachments

- **CMS Approval Letter**
- **Apple Health Contract Language–Washington Rural Health Access Preservation Project**
- **WSHA Project Planning Report**
- **WSHA Interim Report on HB 2450**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Division of Medicaid & Children's Health Operations

June 27, 2018

Susan Birch, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Performance Improvement Initiative for Critical Access Hospitals in the Washington Rural Health Access Preservation (WRHAP) Program

Dear Ms. Birch and Ms. Lindeblad:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Washington's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on May 10, 2018.

Specifically, the following proposal for delivery system and provider payment initiatives is approved:

- Performance improvement initiative established by the state for critical access hospitals in WRHAP for the rating periods covering July 1, 2018 through June 30, 2019.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

Note that this payment arrangement must be addressed in the applicable rate certifications. CMS is happy to provide technical assistance to states and their actuaries.

If you have questions concerning this letter, please contact CMS staff John Giles at John.Giles@cms.hhs.gov or (410) 786-1255, or Rick Dawson at Rick.Dawson@cms.hhs.gov or (206) 615-2387.

Sincerely,

David L. Meacham
Associate Regional Administrator

cc: John Giles, DMCP
Laura Snyder, DMCP

Contract Language – Washington Rural Health Access Preservation Projects

7.2.8 The Contractor shall make pay-for-performance payments to Critical Access Hospitals participating in the Washington Rural Health Access Preservation (WRHAP) Pilot created by the Legislature (Substitute House Bill 1520) (2017), upon the achievement by the hospitals of specified benchmarks on quality measures. The amounts and frequency of the payments shall be no less than the minimums specified below. Additional funds have been appropriated by the Legislature as part of the WRHAP Pilot to help the participating hospitals transition to a new payment methodology and will not extend beyond the anticipated 3-year pilot period. The total amount of additional funds available for the period of July 1, 2018 - December 31, 2018 to support this performance improvement initiative is $1,221,480. Each of the 13 participating hospitals, if it achieves all of the specified benchmarks, will need to receive a total of no less than $93,960 from all of the MCOs with which it has contracts in order to successfully implement the service changes needed to achieve the benchmarks. In order to accomplish this, the Contractor shall pay each hospital with which it has contracts amounts greater than or equal to the amounts listed in subsection 7.2.8.3 if and when the hospital achieves the specified quality benchmarks.

7.2.8.1 List of participating hospitals and service regions:

WRHAP CAHs	Public Hospital District	Region
Cascade Medical Center	Chelan County PHD #1	R1- North Central
Columbia Basin Hospital	Grant County PHD #3	R1- North Central
Dayton/Columbia County Health System	Columbia County PHD	R9-Greater Columbia
East Adams Rural Healthcare	Adams County PHD #2	R11-Spokane
Ferry County Memorial	Ferry County PHD #1	R11-Spokane
Forks Community Hospital	Clallam County PHD #1	R9-Salish
Garfield Co. Public	Garfield County PHD	R9-Greater Columbia
Mid-Valley	Okanogan County PHD #3	R11-Spokane
Morton General	Lewis County PHD #1	R15-Great Rivers
Odessa Memorial	Lincoln County PHD #1	R11-Spokane
Willapa Harbor	Pacific County PHD #2	R15-Great Rivers
North Valley	Okanogan County PHD #3	R11-Spokane
Three River	Okanogan-Douglas Counties PHD #1	R11-Spokane & R1-North Central

7.2.8.2 The Contractor shall contract with each participating Hospital District to make pay-for-performance payments based on the quality measures and benchmarks described in 7.2.8.2.1, 7.2.8.2.2 and 7.2.8.2.3. Each participating Hospital District (Participant) will indicate in its contract whether the majority of services it will deliver are (a) Behavioral Health services or (b) Care Coordination services. The Participant shall collect data for the quality measures using an EHR, registry, or manually collected data. When the Participant achieves one of the specified benchmarks, it must receive a payment equal to or greater than the applicable amount specified in 7.2.8.3 in addition to any other payments to which it may be entitled. The following are the quality measures and the benchmarks to be achieved during this contract period:

7.2.8.2.1 The Participant submits a report on the number of Medicaid beneficiaries who received the principal new service (either behavioral health or care coordination) during the first month the service was provided and a brief narrative report on the nature of the services delivered and any startup challenges experienced. This first benchmark is expected to be achieved by July 31, 2018, but no later than December 31, 2018.

7.2.8.2.2 If the Participant indicates that the majority of the new services delivered will be behavioral health services (including psychiatric collaborative care services), the Participant submits a report on the behavioral health quality measure (Patients Screened for Clinical Depression and Follow-Up Plan - NQF 0418/MIPS 134) for a three month period that shows that the Participant has met the benchmark for that period. For the second benchmark, the Participant shall have screened a minimum of 28 percent of total clinic patients during a three month period (this second benchmark is expected to be achieved by September 30, 2018 but no later than December 31, 2018) and for the third benchmark, the Participant shall have screened a minimum of 53 percent of patients during an additional three month period (the third benchmark is to be achieved by December 31, 2018). The measure shall be calculated by the Participant as follows:

Numerator: Number of Enrollees screened for depression on the date of the visit using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen that includes either a referral to a practitioner who is qualified to diagnose and treat depression, a pharmacological intervention, or another documented intervention.

Denominator: Number of Enrollees who visit the Participant's Rural Health Clinic or primary care clinic during the performance period. If there is no RHC or primary care clinic, the focus will be Enrollees who visit the Participant's Emergency Department. Enrollees with an active diagnosis of depression or bipolar disorder, who refuse to participate, or are in an urgent or emergent situation where time is of the essence and delaying treatment would jeopardize the patient's health status, or have limitations on functional capacity or motivation to improve that may impact the accuracy of results of standardized assessment tools are excluded from the program.

7.2.8.2.3 If the Participant indicates that the majority of the new services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7)

calendar days of ED or hospital discharge) for a three month period that shows the Participant has met the benchmark for that period. For the second benchmark, the Participant must make contact with a minimum of 30 percent of patients during a three month period (this second benchmark is expected to be achieved by September 30, 2018 but no later than December 31, 2018) and for the third benchmark, contact must be made with at least 40 percent of patients during an additional three-month period (the third benchmark is to be achieved by December 31, 2018). The measure shall be calculated by the Participant as follows:

Numerator: Number of Enrollees with a phone contact or face-to-face visit with the care coordinator or a primary care provider within seven (7) calendar days following discharge from the ED or the hospital where the Enrollee was admitted following the ED visit.

Denominator: Number of Enrollees who (1) are residents of the Public Hospital District, (2) visit the Emergency Department operated by the Public Hospital District, and (3) are discharged alive to their homes following the ED visit or following a hospital admission resulting from the ED visit during the performance period (calendar quarter).

7.2.8.3 The Contractor shall award a pay-for-performance payment to a Participant as soon as possible after they submit a report showing that they have achieved one of the benchmarks specified in subsection 7.2.8.2. The minimum amount to be paid to each Participant for each benchmark is listed below and is based on the number of MCOs the hospital has contracted with in the region. The Contractor has the discretion to make additional payments for higher performance on the quality measures and to make additional payments more frequently than quarterly.

WRHAP CAHs	Benchmark 1 Minimum Rate	Benchmark 2 Minimum Rate	Benchmark 3 Minimum Rate
Cascade Medical Center	$ 10,718	$ 6,386	$ 6,386
Columbia Basin Hospital	$ 8,574	$ 5,109	$ 5,109
Dayton/Columbia County Health	$ 8,574	$ 5,109	$ 5,109
East Adams Rural Healthcare	$ 8,574	$ 5,109	$ 5,109
Ferry County Memorial	$ 10,718	$ 6,386	$ 6,386
Forks Community Hospital	$ 8,574	$ 5,109	$ 5,109
Garfield Co. Public	$ 8,574	$ 5,109	$ 5,109
Mid-Valley	$ 8,574	$ 5,109	$ 5,109
Morton General	$ 8,574	$ 5,109	$ 5,109
Odessa Memorial	$ 8,574	$ 5,109	$ 5,109
Wilapa Harbor	$ 10,718	$ 6,386	$ 6,386
North Valley	$ 8,574	$ 5,109	$ 5,109
Three River	$ 8,574	$ 5,109	$ 5,109

7.2.8.4 Within thirty (30) calendar days of issuing payments to the Participants, the Contractor shall submit to HCA a written status report on the performance improvement project (including copies of documentation received from the hospital demonstrating successful completion of the measures) and proof of payment to the hospital. Capitation payments for the period to which these payments apply will be retroactively adjusted by HCA within sixty (60) calendar days following confirmation of payment.

WRHAP PROJECT PLANNING REPORT

June 30, 2018

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JacquelineB@wsha.org; TiannaF@wsha.org

Washington State Hospital Association

Washington State Hospital Association

Contents

Background:

The Washington Rural Health Access Preservation (WRHAP) project was created to design, test and implement improvements in payment and delivery of healthcare in Washington's smallest and most remote communities where Critical Access Hospitals (CAHs) are at risk of closing and threatening access to care. These hospitals, all operated by Public Hospital Districts, generally serve as the platform for a broad range of healthcare services in the community, from primary care to acute care and long-term care. Financial problems at the hospitals jeopardize both the health of the residents as well as the economies of the community. The goal of the WRHAP project is to develop ways to ensure continued access to high quality, essential health services in these communities and to align those services with the aim of delivering better health, better care, and lower costs. The WRHAP pilot authorized by HB 1520 is a voluntary pilot that seeks to sustain access to essential services in these vulnerable communities.

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

1.1 Participating Members and Contact Information:

Table 1. Contact Information of Hospital CEOs & Administrators

	CEO & Administrator			
Hospital Name	First Name	Last Name	Email Address	Phone
Cascade Medical Center	Diane	Blake	dianeb@cascademedical.org	(509) 548-3425
Columbia Basin Hospital	Rosalinda	Kibby	kibbyr@columbiabasinhospital.org	(509) 717-5207
Columbia County Health System	Shane	McGuire	smcguire@cchd-wa.org	(509) 382-2531
East Adams Rural Healthcare	Gary	Bostrom	gbostrom@earh.org	(509) 659-5402
Ferry County Memorial Hospital	Aaron	Edwards	aaron.edwards@fcphd.org	(509) 775-8242
Forks Community Hospital	Tim	Cournyer	timc@forkshospital.org	(360) 374-6271
Garfield County Hospital District	Julie	Leonard	jleonard@pomeroymd.com	(509) 566-4145
Mid-Valley Hospital	Alan	Fisher	fishera@mvhealth.org	(509) 826-7640

Morton General Hospital	Leianne	Everett	leverett@mortongeneral.org	(360) 496-3525
North Valley Hospital	John	McReynolds	johnmcreynolds@nvhospital.org	(509) 486-2151
Odessa Memorial Healthcare Center	Mo	Sheldon	sheldomp@omhc.org	(509) 982-2611
Three Rivers Hospital	Scott	Graham	jgraham@trhospital.net	(509) 645-3340
Willapa Harbor Hospital	Carole	Halsan	chalsan@willapa.net	(360) 875-4528

Table 2. Contact Information of Hospital CFOs

	Chief Financial Officer			
Hospital Name	First Name	Last Name	Email Address	Phone
Cascade Medical Center	Jim	Hopkins	jamesh@cascademedical.org	(509) 548-3429
Columbia Basin Hospital	Rhonda	Handly	handlyr@columbiabasinhospital.org	(509) 717-5200
Columbia County Health System	Cheryl	Skiffington	cheryls@cchd-wa.org	(509) 382-3200
East Adams Rural Healthcare	Gary	Bostrom	gbostrom@earh.org	(509) 659-5402
Ferry County Memorial Hospital	Brant	Truman	brant.truman@fcphd.org	(509) 775-3333
Forks Community Hospital	Paul	Babcock	paulb@forkshospital.org	(360) 374-6271
Garfield County Hospital District	Julie	Leonard	jleonard@pomeroymd.com	(509) 566-4145
Mid-Valley Hospital	Holly	Stanley	stanleyh@mvhealth.org	(509) 826-1760
Morton General Hospital	Richard	Boggess	rboggess@mortongeneral.org	(360) 496-5112
North Valley Hospital	Alan	Ulrich	alanulrich@nvhospital.org	(509) 486-3113
Odessa Memorial Healthcare Center	Annette	Edwards	edwardaj@omhc.org	(509) 982-2611
Three Rivers Hospital	Jennifer	Munson	jmunson@trhospital.net	(509) 645-3344
Willapa Harbor Hospital	Phil	Hjembo	phil@willapa.net	(360) 875-4508

1.2 WRHAP Members Pursuing Behavioral Health Integration Track

Cascade Medical Center
Columbia County Health System
Morton General Hospital
Odessa Memorial Healthcare Center

1.3 WRHAP Members Pursuing the Care Coordination Track

Columbia Basin Hospital
East Adams Rural Healthcare
Ferry County Memorial Hospital
Forks Community Hospital
Garfield County Hospital District
Mid-Valley Hospital
North Valley Hospital
Three Rivers Hospital
Willapa Harbor Hospital

1.4 Method of engagement:

Rural Program Manager
WSHA is currently recruiting and interviewing candidates for a Rural Program Manager (RPM) position to assist with implementation of this project (please see attachment 3 for RPM job description). The RPM will be responsible for targeted implementation support to WRHAP hospitals, including but not limited to assistance with SWOT analysis, identification of resources and assistance in data collection and submission. It is anticipated that much of this support will be provided in-person to the rural hospital. WSHA anticipates having the RPM hired by August 1, 2018.

Weekly WRHAP Calls
Since January 2018, the WRHAP group has held an implementation call Mondays from 10:00 am to 12:00 pm. This call is most often scheduled on a weekly, but not-less than bi-monthly basis. Calls have been suspended for the month of August to allow WRHAP hospitals time to focus on preparation for their first round of data submissions. WSHA will resume WRHAP group meetings in September, or sooner, if group-related implementation questions arise. WRHAP hospitals have requested a change in day and time for this call beginning in July 2018 but have endorsed the continued need for this time as a group, despite the significant amount of time involved. The WRHAP calls, facilitated by WSHA, are used to pass key project information to participating hospitals, identify progress and challenges in

implementation, provide a forum for feedback and shared learning, and discuss next steps. See attachment 1 for a sample call agenda.

Future Meetings and Progress Tracking

Through the established WRHAP group call and the addition of the RPM, WSHA anticipates remaining a driving force in tracking project success over time. The Rural Program Manager will actively engage with individual WRHAP hospitals and their identified WRHAP implementation teams to ensure submissions are occurring; helping to trouble shoot and resolve barriers to project implementation. This shall continue for the duration of the pilot period.

In-Person Meetings

The WRHAP hospitals meet quarterly for an in-person, all-day work session. These meetings are typically held in Ellensburg, WA as it is a relatively central location for the hospitals. Each session is facilitated by Harold Miller, President and CEO of the Center for Healthcare Quality and Payment Reform. The next in-person meeting is planned for August 2018, date TBD. We also plan a meeting around already scheduled WSHA events in September. Additional in-person meetings are anticipated for January and June of 2019 with the potential for additional meetings as the need arises. See attachment 2 for the agenda and meeting summary from the May 31, 2018 meeting.

1.5 Timeline

Table 3. Implementation Timeline

June 2018	Ongoing Weekly WRHAP Calls (anticipated through June 2019)
	Submit Initial Project Planning report
July 2018	First Data Submission
August 2018	In-person WRHAP Group Meeting
September 2018	In-person WRHAP Group Meeting
	Hospital data submission
	Third quarter report submission to HCA
October 2018	Fourth quarter report submission to HCA
December 2018	Hospital data submission
January 2019	In-person WRHAP Group Meeting
March 2019	First quarter report submission to HCA
	Hospital data submission
June 2019	In-person WRHAP Group Meeting
	Hospital data submission
	Final report submission to HCA

1.6 Support for Hiring and Training

WRHAP hospitals vary in ability to recruit new staff. For those who have not been able to bring a staff member on board to facilitate this work to date, and those who anticipate challenges in recruiting, existing staff will be used to complete work flows and processes until new staff can be brought on board. For status of hiring, please see sections 2.2 and 2.3.

Training is a key component for ensuring that care coordination and behavioral health integration are successfully implemented. WSHA has compiled a list of existing training methods/resources used by WRHAP hospitals who have begun implementation and shared this with the WRHAP group. Section 2.2 outlines the current set of training methods/resources being utilized by WRHAP hospitals. This list will be updated as WRHAP hospitals select the appropriate training program. As the RPM is brought on board, this person will assist hospitals in selecting the appropriate training program and ensuring it is completed. While WRHAP hospitals may only select one track for the purposes of funding via the 1520 allocation, multiple hospitals have expressed a desire to pursue care innovation in both care coordination and behavioral health. Assistance will be provided regardless of which track the hospital is formally enrolled.

1.7 Process for Project Alignment with ACHs

Once on board, the RPM will be responsible for monitoring and ensuring alignment with ACH activities. The RPM, in partnership with the Director of Rural Health Programs, will similarly monitor the progress of the rural multi-payer initiative for areas of overlap and alignment.

WRHAP Engagement and Workforce Development:

2.1 Summary of WRHAP Anticipated Engagements and Key Topics

A. Proposed In-person Meetings
   1. August 2018: Discuss implementation and data submission challenges; ensure hiring and training is planned or a mitigation strategy is in place.
   2. September 2018: Discuss implementation and data submission challenges; ensure hiring and training is planned or a mitigation strategy is in place; shared ining opportunities; discuss alignment with other Medicaid transformation initiatives. Folow up to August meeting.
   3. January 2019: Discuss progress towards quality benchmarks; identify challenge areas and assistance plan; discuss alignment with other Medicaid transformation initiatives.
   4. June 2019: Sustainability planning for service continuation post SHB 1520 funds.

B. Ongoing weekly calls
   1. Calls will be used to rapidly identify implementation challenges, target interventions and provide space for shared learning.

C. Supplemental documentation and support (already provided to hospitals)
   1. Overview of implementation detail and timeline for use with boards (see attachment 4)
   2. Data submission template for reporting via QBS (see attachment 4)

2.2 & 2.3 Status of Hiring for Behavioral Health or Care Coordination Staff

To meet the workforce needs of care coordination and behavioral health integration, many of the WRHAP hospitals plan to shift or expand the responsibilities of existing hospital employees. Those that will require new staff are actively recruiting but the timeline for successful hiring will vary. While this may work in the short-term, the extended responsibilities on existing staff may increase burn-out. Until new workforce is available, WSHA, through the RPM will aim to reduce reporting burden whenever possible.

Long-term sustainability remains a concern. Where possible, the RPM will work with hospitals to help facilitate the incorporation of these changes into standard work. We anticipate that the majority of clinics will apply for a change in scope for their rural health clinics. One clinic has already done so. Ultimately, sustainability of care transformation should be supported by an alternative payment model (outlined within HB1520).

Hospitals in the table below, without an identified method of training will be contacted by the RPM to assist in identifying training options appropriate to their selected track. The below information reflects an initial project plan and is subject to change as implementation progresses.

Table 4. Implementation Status

Hospital Name	Track	Hiring Status	Training Method	Notes
Cascade Medical Center	Behavioral Health	On board	Mountainview Consultant Group	
Columbia Basin Hospital	Care Coordination	On board	Transforming Clinical Practice Initiative	Also pursuing recruitment for Behavioral Health practitioner
Columbia County Health System	Behavioral Health	On board	University of Washington AIMS Center	Care Coordination training for staff also obtained through Clinical Health Coach Training via the Iowa Chronic Care Consortium
East Adams Rural Healthcare	Care Coordination	On board	Transforming Clinical Practice Initiative	
Ferry County Memorial Hospital	Care Coordination	On board		
Forks Community Hospital	Care Coordination	On board		
Garfield County Hospital District	Care Coordination	On board		
Mid-Valley Hospital	Care Coordination	On board		
Morton General Hospital	Behavioral Health	On board		Social worker on board as of June 1. Pursuing licensing.
North Valley Hospital	Care Coordination	Hired; On board July 2018		
Odessa Memorial Healthcare Center	Behavioral Health	Recruiting		
Three Rivers Hospital	Care Coordination	On board		
Willapa Harbor Hospital	Care Coordination	On board		

2.4 ACH Alignment

WRHAP hospitals are at the onset of implementation. As the RPM is brought on board and WRHAP hospitals begin to deliver services and collect data, the RPM will provide assessment of areas of overlap and alignment, as well as strategies for hospitals to leverage opportunities via the ACH to maximize impact.

Washington State Hospital Association

Attachment 1: Sample Call Agenda

Monday June 18, 2018

WRHAP Work Group Call

1-800-503-2899 passcode 2162519

- Recap Thursday's Multi-Payer Model meeting for those unable to attend (see attached materials from HCA)
- Discuss the documents previously sent for your review including implementation timeline and talking points
- Prep for meeting with state leaders at Chelan
- Discuss the AHA REMC model and applicability to small rural hospitals
- Check in on progress on implementation- We'll be joined by Andrea from our Decision Support Team to walk us through reporting for the WRHAP quality measures. Sample reporting dashboard and a list of reporters from your hospitals attached for review. Also attached is a timeline for your review.

Washington State Hospital Association

Attachment 2: Sample Agenda & Meeting Notes
May 31, 2018 In-person Meeting

Washington Rural Health Access Preservation (WRHAP)
Kittitas Valley Healthcare, Ellensburg
Thursday, May 31, 2018 9:00 a.m. – 4:15 p.m.
AGENDA

8:30 a.m. **Continental Breakfast Available**

9:00 a.m. **Welcome, Introductions, and Overview of Agenda**

9:05 a.m. **Strategy for Improving Payment for WRHAP Hospitals (Part 1)**
- Update on state & federal efforts to change payments for rural hospitals
- Likelihood of a Global Budget model for hospitals in Washington State
- Likelihood of state and federal support for a WRHAP-specific Payment Model
- Goals of WRHAP hospitals, state officials, and federal officials

9:45 a.m. **Finalizing the Primary Care Component of the WRHAP APM**
- Status of Scope of Service encounter rate changes
- Agree on essential and desired elements of a WRHAP primary care payment model
- Decide whether to pursue a WRHAP-specific payment model or modifications to APM4

10:45 a.m. **Break**

11:00 a.m. **Report on the May 30 "Global Budgeting Policy Academy"**
- Diane Blake, Eric Lewis, and Ben Lindekugel will call in with their report

11:15 a.m. **Finalizing the Total Cost of Care Component of the WRHAP APM**
- Agree on measures of spending used for accountability
- Agree on recommended targets and rewards for savings
- Identify the resources and information needed for success and how to obtain them

11:45 a.m. **Finalizing the ED Component of the WRHAP APM**
- Resolve any issues remaining following discussions on 5/14 and 5/21 calls

12:15 p.m. **Break for Lunch**

12:45 p.m. **Whether & How to Include Inpatient & SNF Services in the WRHAP APM**
- Discuss goals that hospitals and payers want to address
- Discuss options for payments for inpatient services
- Discuss options for payments for nursing facility/long-term care services
- Agree on preferred and acceptable options

2:15 p.m. **Break**

2:30 p.m. **Ensuring Successful Implementation of SHB 1520 Funds**
- Update on approval from CMS for matching funds
- Update on hiring and training behavioral health specialists and care coordinators
- Identify readiness and barriers to achieving and reporting on performance measures
- Agree on priorities for management assistance services supported by SHB 1520 funds

3:15 p.m. **Strategy for Improving Payment for WRHAP Hospitals (Part 2)**

- Decide whether to pursue a WRHAP Payment Model or modifications to an HCA-defined Global Budget model or both
- Agree on minimum essential elements of a successful model for WRHAP hospitals
- Agree on state and federal advocacy strategy

4:00 p.m. **Next Steps**

- Future meetings and calls

4:15 p.m. **Adjourn**

Washington Rural Health Access Preservation (WRHAP)
May 31, 2018 Meeting
Kittitas Valley Healthcare, Ellensburg
DRAFT SUMMARY

Summary of Follow-Up Items

The following are the key action items needed to follow up on the decisions at the meeting:

Engage with State and Federal Officials

- The WRHAP PHD CEOs will send a letter to Representative Eileen Cody and Senator Annette Cleveland requesting an opportunity for the WRHAP PHD CEOs to meet with the Joint Select Committee on Health Care Oversight as soon as possible
- WRHAP PHD CEOs should talk with HCA Director Sue Birch and Representative Eileen Cody at the Rural Hospital Leadership Conference in Chelan in June. Following that meeting, make a decision about additional meetings between the CEOs and HCA.
- Individual WRHAP hospital CEOs will contact their state legislators, Congressmen, and U.S. Senators to explain the problems facing the WRHAP PHDs and the payment model to address those problems, and to request state and federal support for implementing it.
- Briefings will be arranged in September in Washington, DC with congressional staff to help them understand the needs of rural communities similar to the WRHAP Public Hospital Districts and to gain their support to have Medicare participate in a new payment model.

Expand/Revise the WRHAP Alternative Payment Model

- The WRHAP APM should be reframed as a Rural Healthcare System Payment Model for very small rural communities.
- The details of a “hub and spoke” Inpatient Services Component should be developed.
- A request should be submitted to HCA to obtain data needed to enable the WRHAP PHDs to develop strategies for maintaining or reducing the total cost of care for Medicaid and Medicare beneficiaries.
- The Primary Care Clinic and ED Components of the WRHAP APM should be finalized.

Implementation of Behavioral Health and Care Coordination Services

- A determination should be made as to what additional actions are needed to assure that the WRHAP PHDs receive the SHB 1520 funds beginning in August.
- A standard data collection form should be developed that includes refined definitions of the performance measures.
- A system should be developed so that WSHA can collect performance measure data from the WRHAP PHDs and submit it to MCOs on their behalf.

WRHAP Group Website

- Each WRHAP CEO should review the draft website and suggest any improvements.

Attendees

Jacqueline Barton True, Washington State Hospital Association

Gary Bostrom, East Adams Rural Healthcare

Tim Cournyer, Forks Community Hospital

Aaron Edwards, Ferry County Hospital

Alan Fisher, Mid-Valley Hospital

John Flink, Washington State Hospital Association

Scott Graham, Three Rivers Hospital

Carole Halsan, Willapa Harbor Hospital

Pat Justis, Department of Health

Julie Leonard, Garfield County Hospital District

Stacy Linscott, Garfield County Hospital District

Shane McGuire, Columbia County Health System

John McReynolds, North Valley Hospital

Harold Miller, Center for Healthcare Quality and Payment Reform (Facilitator)

Jeannie Monk, Alaska State Hospital & Nursing Home Association

Claudia Sanders, Washington State Hospital Association

Mo Sheldon, Odessa Memorial Healthcare

Lindy Vincent, Department of Health

Eric Walker, East Adams Rural Healthcare

Washington State Hospital Association

Participating via conference call for a portion of the meeting:

Diane Blake, Cascade Medical Center

Madina Cavendish, Health Care Authority

Eric Lewis, Olympic Medical Center

Ben Lindekugel, Association of Washington Public Hospital Districts

I. Strategy for Improving Payment for WRHAP Hospitals

A. Information and Options for Defining a Strategy

The group held a lengthy discussion to determine what strategy would most likely be successful in obtaining changes in payments that would sustain the healthcare services in the WRHAP communities.

History and Prospects for State Support

Claudia Sanders reviewed the history of efforts in Washington State to sustain small rural hospitals, the origin of the WRHAP project, the lessons from the work done to date, and the activities the Washington Health Care Authority and legislators are currently pursuing to address the issues facing rural hospitals and clinics.

In addition to passing SHB 1520 in 2017, which required HCA to create a payment model for the WRHAP hospitals that would sustain clinic and ED services, in March 2018, the Washington Legislature passed Engrossed Substitute Senate Bill 6032 directing the Joint Select Committee on Health Care Oversight to "collaborate with the Health Care Authority and the Department of Health to develop a plan to restructure and strengthen the rural health care system" and requiring that "to the extent possible, the committee shall leverage findings of the Washington Rural Health Access Preservation Pilot."

Claudia and Jacqueline Barton True distributed a table showing that only a few of the legislators representing the WRHAP Public Hospital Districts hold key leadership positions in the Washington Legislature. Representative Joe Schmick, whose district includes East Adams Rural Healthcare and the Garfield Public Hospital District, serves on the Joint Select Committee and is the Ranking Member of the House Health Care & Wellness Committee. Representative Steve Tharinger and Senator Kevin Van De Wege, whose districts include Forks Community Hospital, are both members of the majority party and serve on the four key legislative committees in the House and Senate.

Claudia said that Representative Eileen Cody has been leading legislative efforts to address rural healthcare issues and co-chairs the Joint Select Committee on Healthcare Oversight, and so it will be important to have her support for any additional legislative actions that are needed. Claudia noted that Rep. Cody helped to recruit Sue Birch, the new

Director of HCA. She said that Rep. Cody has expressed interest in a "hub and spoke" approach to hospital services, although there were no details on what that means.

Claudia outlined three options for moving forward:

1. Finalize a WRHAP-specific payment model and advocate for implementation by HCA and CMS.
2. Wait for HCA to develop a payment model to support rural hospitals.
3. Help HCA to develop a payment model that incorporates elements that will address WRHAP hospital/clinic needs.

Prospects for Federal Support

John Flink discussed the likelihood of obtaining federal support for payment changes to sustain the WRHAP hospitals and clinics. He said the direction CMS would be taking on value-based payment models was unclear, so it was also unclear whether it would be possible to get support from the Trump Administration for a new method of paying for rural hospitals. He said that although several members of the Washington State Congressional Delegation held influential positions on the key health care committees in Congress and some had expressed interest in helping rural areas, it was not clear how quickly any action could be taken, and any proposal that involved higher appropriations would be much more difficult to pass.

Hospital Global Budgets

Diane Blake, Eric Lewis, and Ben Lindekugel joined the meeting by phone to report on their participation at the Global Budgeting Policy Academy in Baltimore the previous day (May 30). They said the members of the Washington State group agreed that the global budget approach used in Maryland would not work in Washington; the goal of global budgets in Maryland was to find a way to reduce inpatient utilization, and that was not a problem in rural areas in Washington State. The rural hospitals in Maryland are much larger than those in Washington State, and Maryland had no experience in implementing global budgets for very small hospitals or hospitals that had been losing money.

Diane Blake said that it was clear that the representatives from CMS and other agencies had no experience with very small rural hospitals and they had no understanding of the unique problems facing small rural hospitals and how to solve them.

Diane, Eric, and Ben said that they thought it was worthwhile to continue working with HCA to try and develop a mutually acceptable solution. The state leaders seem to recognize the urgency of the problems but simply do not know how to solve them. The only way to ensure that what they come up with would solve the WRHAP PHDs' problems would be for the WRHAP leaders to be at the table.

B. Strategy for Moving Forward

After a lengthy discussion, there was general agreement that the WRHAP Public Hospital Districts should pursue a strategy with the following three components:

1. **Expand/revise the WRHAP payment proposal** so that, to the extent possible, it also addresses the goals of key legislators, HCA, Congress, and federal agencies for value-based payment, rationalization of inpatient care, spending control, etc. while continuing to adequately address the key financial problems facing the WRHAP Public Hospital Districts.
2. **Work collaboratively with HCA to help it develop a payment model that will address both WRHAP and HCA goals** if, and only if:
   - HCA explicitly indicates that one of its goals is to ensure access to quality healthcare services in communities of the sizes served by the WRHAP Public Hospital Districts and to resolve the financial problems jeopardizing the delivery of such services; and
   - HCA commits to either provide a detailed initial draft proposal for review by the WRHAP PHDs in the near future or to use an expanded/revised WRHAP payment model as the starting point for an HCA proposal.
3. **Meet with Washington State legislators, members of the Washington Congressional delegation, and other local, state, and federal leaders** to:
   - educate them about the unique problems facing very small, very rural communities similar to the WRHAP Public Hospital Districts, why those problems are different from the problems facing larger communities, the rationale for the proposal developed by the WRHAP project, and why the WRHAP proposal is preferable to other proposals that have been proposed at the state and federal levels; and
   - request their support for implementation of the WRHAP payment proposal.

C. Communications with HCA, Legislators, and Congressional Delegation

The group agreed to the following next steps for communications and advocacy:

- The WRHAP PHD CEOs will immediately send a letter to Representative Eileen Cody and Senator Annette Cleveland requesting an opportunity for the WRHAP PHD CEOs to meet with the leaders and members of the Joint Select Committee on Health Care Oversight as soon as possible. The letter should say the purpose of the meeting is to:
  - Brief the legislators on the specific challenges that the WRHAP PHDs are facing and why their problems and the potential solutions are different from larger rural hospitals, including a briefing on the results of the detailed analyses the group has conducted over the past three years.
  - Describe the innovative, value-based payment model that the WRHAP PHDs have developed to address their problems, and show how it meets the requirements for the payment model required by SHB 1520 and how it addresses other state and federal goals;
  - Get feedback from the legislators on the proposed payment model and suggestions for improvements or alternative approaches; and
  - Discuss what additional steps need to be taken and a feasible timetable in order to address the hospitals' financial problems by 2019.
- The WRHAP PHD leaders feel it is also important to meet as a group with HCA Director Sue Birch in the near future to (a) ensure she understands why the needs of the WRHAP PHDs are different from other rural hospitals, and (b) determine whether there is a sufficiently strong commitment by HCA to address the needs of the WRHAP PHDs in order to justify continued

participation by the PHD CEOs in HCA's multi-payer payment model planning efforts.

However, it was decided that instead of sending a letter to Director Birch requesting such a meeting immediately, she will be cc'd on the letter to Rep. Cody and Sen. Cleveland. WSHA will continue working to arrange a meeting of a small group of hospital leaders with HCA Director Sue Birch and Representative Eileen Cody at the Rural Hospital Leadership Conference in Chelan in June. The group will include representatives of the WRHAP PHDs as well as other hospitals. Following that meeting, a decision will be made about what further steps to take with respect to meetings between the WRHAP CEOs and HCA.

- Individual WRHAP hospital CEOs will contact their state legislators, Congressmen, and U.S. Senators to communicate the following key messages:
  - the WRHAP PHDs are facing serious problems, and those problems and potential solutions to those problems are different from larger rural hospitals; and
  - the WRHAP PHDs have developed an innovative, value-based payment model to address their problems, and they need state and federal support to implement it.
- Briefings will be arranged in September in Washington, DC with congressional staff (both the office staff of the members of the Congressional Delegation and staff from the key Congressional Committees) to help them understand the needs of rural communities similar to the WRHAP Public Hospital Districts and to gain their support to have Medicare participate in a new payment model.

II. Design of the WRHAP Alternative Payment Model

Due to the time spent discussing overall strategy, there was not sufficient time at the meeting to discuss and finalize all elements of the WRHAP APM. The group decided to focus on determining what, if any, additional components or modifications to existing components were needed to make it more attractive to state legislators, HCA, and CMS.

A. Goal of the WRHAP APM

The group agreed that the primary goal of the WRHAP project should be defined as enabling the delivery of high-quality healthcare services to the communities served by the WRHAP Public Hospital Districts, not simply to eliminate deficits in specific service lines. The group felt that the WRHAP payment model's primary care and emergency services components would provide the necessary financial support for the two most important elements of a Rural Healthcare System, and that it would be both feasible and desirable to reframe the WRHAP APM as a Rural Healthcare Payment Model for very small rural communities.

Reframing the WRHAP APM as a Rural Healthcare Payment Model would require an explicit and compelling articulation of two things that are currently implicit in the APM proposal:

- **Definition of Eligible Communities.** A definition of "very small rural communities," that clearly distinguishes the WRHAP communities from larger rural areas;

- **Goals for Healthcare Delivery.** A statement of the goals for healthcare delivery in such communities, e.g., the ability to receive minimum emergency services within a specific period of time and to obtain high-quality primary care services in the community.

B. Inpatient Services Component

The group agreed that an inpatient services component of some kind would be desirable, since state and federal agencies and legislators have signaled that they are unlikely to support a Rural Healthcare Payment Model unless it addresses concerns about inappropriate and overly expensive inpatient services. Because Representative Cody has advocated for creation of a "hub and spoke" model, it would be desirable for the inpatient services component to have that type of structure, but only if it could be designed in a "win-win" way that benefited both the hub and spoke hospitals, rather than in a way that only benefited the hub hospital.

The group agreed to develop a new component for the WRHAP Rural Healthcare Services APM proposal that has the following elements:

- **Hospital Policies Regarding Appropriate Inpatient Admissions at Rural Hospitals.** Each hospital would adopt a policy defining (in terms of diagnoses, procedures, DRGs, or other characteristics) which patients would ordinarily be accepted for admission and which would ordinarily be transferred to other "hub" hospitals. Larger rural hospitals with appropriate equipment and staff could adopt policies to accept a broader range of patients, and potentially serve as local "hubs" for those types of patients.
- **Hospital Policies at Hub Hospitals Regarding Patients Accepted for Admission/Transfer.** One or more "hub" hospitals would need to adopt a policy committing to accept admissions or transfers of the patients that each rural hospital's policy defined as inappropriate for local admission.
- **Policies at Hub Hospitals for Return of Patients for Post-Acute Care.** Hub hospitals would also adopt policies to refer patients to post-acute care services delivered by the rural hospital where they live, assuming the rural hospital delivers high-quality post-acute care.
- **Population-Based Payment to the Rural Hospital for Appropriate Admissions.** The rural hospital would be paid differently to support the costs of caring for patients who were appropriate admissions: the hospital would receive an annual payment for each insured resident of the community that would cover the fixed costs of inpatient capacity, and it would receive an additional payment for each patient who was admitted, with the payment amount designed to cover the variable costs of an additional admission.
  - If an analysis indicated that it made sense for a rural hospital to serve as a local hub for patients who were costlier than average to care for, payers would provide higher payments for those patients.
  - If the rural hospital was forced to admit a patient because no hub hospital was willing or able to accept transfer of the patient, the rural hospital would receive a higher payment for the additional costs of caring for that patient.

- **Payment to Support Adequate Diagnostics at Spoke Hospitals.** Rural hospitals that adopt policies under which most patients would be transferred to hub hospitals would need sufficient payments to support adequate local diagnostic and/or telemedicine capabilities.
- **Revenue Sharing for Local Hub and Spoke Hospitals.** If two rural hospitals agreed that certain types of inpatient or outpatient services could be delivered more efficiently or with higher quality at one of the hospitals rather than at both of the hospitals, they would share the net revenue from those admissions.
- **Adequate Payment for Outpatient Services and Preservation of Hospital Status if Inpatient Services Are No Longer Delivered.** If, as part of hub and spoke arrangements, it made sense for a rural hospital to eliminate inpatient admissions entirely, payers would make appropriate changes in outpatient payment rates to adequately support the hospital's remaining services, and the Department of Health would make appropriate changes in regulations to enable the facility to retain its status as a "hospital."

Pat Justis noted that the Department of Health has statutory authority to create demonstration projects that might be helpful in implementing these types of approaches.

C. Total Cost of Care Component

The group agreed that it is important to include a component designed to address the full range of healthcare services needed and received by community residents. The current Total Cost of Care component in the WRHAP APM provides a financial incentive to maintain or reduce the total cost of care, but it will be difficult for WRHAP PHDs to actually impact the Total Cost of Care without a specific and feasible strategy for doing so, such as by focusing on services for a particular health condition, such as maternity care or back pain.

It is not clear what focus areas would make sense because the group does not have access to any detailed data on the types of services that the residents of the Public Hospital District are receiving outside of the District. Medicaid data that were made available to the group indicated that the majority of spending for most major categories of services went to providers other than the PHD, but there is no detail available on the specific types of services the residents receive or what conditions they are intended to address.

The group agreed to request that HCA provide more detailed data on total healthcare spending so that the WRHAP PHDs could try to develop a specific strategy for reducing avoidable spending.

D. Aging and Long-Term Care Services

The smallest WRHAP PHDs feel that they need to deliver home and institutional long-term care services in order for their communities to have the kind of healthcare system they need, whereas for some of the larger PHDs, an adequate level of services is being delivered by nursing homes and home health agencies. In addition, the major current funding streams for community long-term care services flow through different state and federal agencies. Consequently, the group agreed that a component for aging and

long-term care services should be developed as an option after agreement is reached on the other components of the model that apply to all of the WRHAP PHDs.

E. Clinic Services Component

There was not sufficient time to discuss the draft Primary Care Component of the WRHAP APM in detail. The group agreed to send comments on the draft document to Harold Miller, and any issues will be discussed on upcoming WRHAP calls.

F. ED Services Component

There was not sufficient time to discuss the draft ED Component of the WRHAP APM in any detail. The group agreed to send comments on the draft document to Harold Miller, and any issues will be discussed on upcoming WRHAP calls.

G. Transportation

Lack of access to emergency and non-emergency transportation services is a growing problem in several communities, and a component for this may need to be added to the WRHAP APM at some point.

III. Implementation of SHB 1520 Funds

A. Status of CMS Approval and MCO Contracts

Madina Cavendish from HCA joined the meeting by telephone and gave an update on the status of the process for making payments to the WRHAP PHDs for behavioral health and care coordination services using the funding appropriated by the Washington State Legislature in conjunction with SHB 1520. She said that the materials describing the use of funds and the quality measures were currently being reviewed by CMS; the initial CMS review was scheduled to be completed by May 31, and then any questions or comments from the federal review team would be sent to HCA early in the week of June 4. Although no problems are expected, it will be important for the WRHAP members to respond quickly if additional information or changes are needed.

The WRHAP PHD CEOs pointed out that they currently have nothing in writing assuring them that the payments will be made if they deliver the services. It is unclear whether any special contracts will be needed between the MCOs and the Public Hospital Districts to enable these payments to be made. Madina agreed to clarify what additional steps needed to be taken following CMS approval to ensure that the funding flowed from the Medicaid Managed Care Organizations (MCOs) to the WRHAP PHDs. Madina also agreed to arrange for this issue to be included on the next regular meeting between HCA and representatives of the MCOs.

B. Status of Local Implementation Activities and Reporting

All of the WRHAP PHDs in attendance reported that implementation is on track with respect to:

- hiring (or contracting with) appropriately trained staff by July; and
- carrying out the tasks needed to achieve the goals for the quality measures, i.e., either
  - having clinic providers screen clinic patients for depression, or
  - making follow-up contacts with patients who visit the ED, including those who are transferred from the hospital to other EDs or inpatient admissions.

It was agreed that the measure definitions should be clarified in the following ways:

- The measures should be reported just for Medicaid patients. For patients coming to the ED, the hospital should include patients whom it has reason to believe are Medicaid beneficiaries at the time.
- The depression screening would not be required to be done more frequently than every twelve months. If a patient had a clinic visit and had been screened at a previous clinic visit within the previous twelve months, the patient would be considered to have been screened for the purpose of the measure.
- If a care coordinator has made multiple efforts to contact a patient following an ED visit but has been unable to reach them, that patient should be excluded from the denominator of the measure.

It was agreed that a standard data collection form should be created that all of the hospitals/clinics can use to collect the information in a common way. (A hospital/clinic could use a different form or data system if it wished to do so, however.)

It was agreed that it would be desirable if WSHA would collect the numerators & denominators for the measures for each WRHAP PHD through the existing WSHA quality data collection system, submit that information to the MCOs on behalf of the PHDs, and monitor to ensure that the payments were made. WSHA will (1) circulate a description of how this process would work, and (2) work with HCA and the MCOs to obtain agreement to implement it.

IV. Communication and Organization

The group complimented and thanked Eric Walker for creating a website for the WRHAP Group. The group agreed to review the draft material on the website and provide feedback and suggestions to Eric for improvements and additional materials.

Washington State Hospital Association

Attachment 3: Rural Program Manager Job Description

Do you have experience working with hospital leaders in rural areas and driving forward initiatives to completion? Are you an excellent project manager? Would you like to work with a group of dynamic, dedicated, passionate people who are committed to transforming health care in the state of Washington?

If this sounds like something you would like to be part of, we want to talk to you about a career at WSHA – the Washington State Hospital Association.

WSHA has been in existence for over 80 years and continues to grow and evolve as the needs of Washington residents and our member hospitals change. We are located in beautiful downtown Seattle, surrounded by wonderful views of Puget Sound and the Olympic mountains with easy access to bus, rail or parking, and we are currently recruiting for a **Rural Program Manager**.

The Rural Program Manager position is a full-time position and is responsible for working with rural member hospitals and other stakeholders to implement programs and tactics that improve health and health care delivery in rural Washington State. This position will be responsible for coordinating work related to the State's Medicaid Transformation Waiver program. The Rural Program Manager works under the supervision of the Director, Rural Health Programs and works closely with the Senior Vice President, Strategic Planning and the Executive Director of the Association of Washington Public Hospital Districts (AWPHD); as well as with members of the Rural Implementation Group to assure the timely, coordinated and strategic deployment of relevant resources.

Specific duties of this position include, but are not limited to:

- In partnership with the Director, Rural Health Programs and the membership of the Rural Implementation Group, ensure the successful implementation of the Washington Rural Health Access Preservation (WRHAP) pilot.
- In partnership with the Executive Director of the Association of Washington Public Hospital Districts (AWPHD), manage and coordinate the AWPHD Medicaid Payment Program.
- Responsible for ensuring successful WRHAP program startup to enable behavioral health and care coordination services are effectively implemented in participating WRHAP hospitals. Assistance may include, but is not limited to:
    - Program implementation support
    - Gap identification
    - Linking hospitals to appropriate resources
- Responsible for tracking of milestones necessary for Medicaid Payment Program funds disbursement and assisting member hospitals in submitting necessary data to HCA and Health Plans.
- Facilitate education to ensure data flow to and from hospitals to ensure successful participation in the WRHAP and IGT Programs.
- Provide guidance and aid to rural health clinics completing applications for improved Medicaid payments.
- Identify and connect hospitals with resources related to performance improvement as appropriate.
- Interface with Medicaid managed care organizations on behalf of WRHAP hospitals to ensure payment for achieved performance measures.

- Establish effective relationships with State Health Care Authority staff responsible for rural transformation and the disbursement of Medicaid funds.
- Track and reconcile the disbursement of AWPHD Medicaid program funds. Coordinate flow of funding to participating hospitals.
- Identify and proactively pursue opportunities to use appropriate resources to support rural hospitals and facilitate service transformation.
- Facilitate and host meetings and phone calls for the WRHAP group and opportunities for rural innovation under Healthier Washington.
- With internal WSHA partners, align activities and agendas across the rural membership.
- Act as an educational and planning resource to local hospital boards and staff.
- Represent WSHA and AWPHD in and at appropriate forums, venues and conferences.
- Perform other duties as assigned.

Desired qualifications, skills, and abilities

- Bachelor's degree required, Master's preferred but not required.
- Minimum 2 years of experience working in healthcare required. Education may be substituted for experience.
- Some experience in fund tracking and disbursement and/or finance preferred.
- Familiar with clinical operations of rural health facilities a plus.
- to 5 years of strong project management experience
- Excellent organizational skills
- Proven ability to lead and facilitate dialog among hospital leaders and other community stakeholders
- Self-starter with strong analytical skills
- Ability to understand and clearly communicate complex concepts to diverse audiences effectively.
- Proven ability to connect and create effective partnerships with all levels of employees from CEOs to secretaries.
- Exceptional written and verbal communication skills, with the ability to connect effectively with diverse audiences.
- Comfortable learning new software platforms and systems.
- Effective time management skills and ability to manage multiple priorities successfully.
- Able to remain flexible and adaptable in a changing environment.
- Able to travel up to 10% within the State of Washington.
- Able to work effectively as a team member or independently.
- Maintains a high degree of professional excellence exhibiting sound independent judgement, initiative, and a high standard of ethics.
- Able to successfully manage multiple priorities and activities simultaneously.
- Proven ability to work effectively while producing high quality work in a fast-paced environment with firm deadlines.
- Strong computer skills, including but not limited to MS office suite, Outlook, Excel, Word, PowerPoint.

If you have the skills and abilities listed above, feel that you would be a good fit for this position and would like to be part of this exceptional organization, please apply through our career center using the link below for immediate consideration. LINK

Washington State Hospital Association

Attachment 4: Supplementary Supports Provided to WRHAP Hospitals

Please see the separate PDF attachment for supplemental materials.

Washington State Hospital Association

WSHA Interim Report on HB 2450

Background on Critical Access Payment and Delivery Pilot

WSHA and our smallest critical access hospitals[1] asked for and supported changes to critical access hospital payment and delivery to address a crisis in rural health care --- our smaller hospitals in isolated rural areas are having difficulty sustaining their operations. While many see only a few inpatients a day, they offer essential services to their community – primary care, emergency room care, swing bed and long- term care. Their patients are mostly Medicare and Medicaid. Neither Medicaid nor Medicare pays them fully for their costs of providing these essential services. If the hospital and its facilities close, it would have devastating impacts for residents, with a significant increase in travel time for vital services.

The original intent for these smallest hospitals involved in Washington Rural Health Access Preservation (WRHAP) was to allow the hospitals to close their inpatient units, but still be supported for the other services they provide. After a thorough examination of the hospitals' cost structures, we learned that closing inpatient beds did not produce cost savings. Staff for these units also staff the swing bed units or other units. Without the inpatient units, the costs would simply shift to these other areas. We also learned the patients being admitted were there for short stays, sometimes to be helped with rehydration or other simple acute care. Community members can receive this care locally.

There were several changes to the law, including HB 1520 in 2017. It directed the Health Care Authority (HCA) to develop an alternative payment model for the essential local services. The model needed to provide sustainable funding and focus on quality and value rather than volume. The legislature also gave transitional funding to help the hospitals move to a new system.

Status of Work to Date: WRHAP Payment Pilot

The WRHAP hospitals are three years into this work. WSHA and the WRHAP hospitals, initially with HCA support, drafted a new alternative payment proposal and forwarded it to legislative leaders and HCA (click here for proposal). This proposal would sustain the emergency departments and link hospital payments to the total cost of care for residents in their community. HCA has said they are unable to implement it. HCA is working instead with the Centers for Medicare and Medicaid Services on a model for all types of rural hospitals. The WRHAP hospitals have expressed doubt that the larger rural model will work in their facilities. As of this writing, many details on the HCA proposal have yet to be released. We know, however, that there are some basic elements in payment reform that must be different for the WRHAP hospitals.

Opportunities for efficiencies at these WRHAP facilities are not the same as with larger hospitals.

- These facilities cannot achieve savings by reducing the number of avoidable emergency room or inpatient visits in their hospitals. For example, there are no savings by redirecting a patient from

[1] **Cascade Medical Center**, Leavenworth**; Columbia Basin Hospital**, Ephrata**; Columbia County Health System,** Dayton; **East Adams Rural Healthcare**, Ritzville; **Ferry County Memorial Hospital**, Republic**; Forks Community Hospital**, Forks; **Garfield County Public Hospital**, Pomeroy**; Mid-Valley Hospital**, Omak; **Morton General Hospital**, Morton; **North Valley Hospital**, Tonasket**; Odessa Memorial Healthcare Center**, Odessa, **Three Rivers Hospital**, Brewster; **Willapa Harbor Hospital**, South Bend

the emergency room to the primary care clinic if the emergency room physician is in house and not seeing other patients. The hospital is still paying the physician for the time.

- These facilities are already operating at a deficit; the HCA initial proposal to base payment on their historic low costs would not provide sufficient funding to sustain their essential services.
- On the outpatient side, community health care needs may be too variable to be predictable from year to year. That is why the WRHAP model kept outpatient care under the current payment system. Moreover, it is important for these hospitals to have the flexibility to respond to immediate needs in their community.

The smaller hospitals in Washington remain in precarious financial shape. These hospitals need a solution. They are asking the legislature to help them with a path forward into the future.

Status of Work to Date: WRHAP Transitional Funding

Funds appropriated for HB 1520 gave transitional support to help hospitals prepare to move to a new payment model based on value. Many of these emergency departments are operating with a deficit from Medicaid. The deficits may grow if community care improvements drive fewer visits. These hospitals still incur high infrastructure costs whether they see additional patients.

WRHAP hospitals requested transition funds to offset these emergency department losses, as well as invest in care improvement. The legislature appropriated funding and Medicaid health plans began distributing payments this September for care coordination or behavioral health integration. WRHAP hospitals are eligible for funds if they meet quality performance benchmarks. HCA went through a protracted negotiation process to secure federal matching funds and provide about $90,000 per hospital each year.

Eight of the WRHAP hospitals have now hired staff for help with improved care coordination. A care coordinator makes follow up contact with patients who visit the emergency room or are discharged from an acute care hospital. This helps ensure the patients are following up with care needs and have appropriate visits scheduled with their primary care physician. In the first three months of this program, 1200 Medicaid patients have been contacted.

Five hospitals are receiving funds to hire staff to help with behavioral health integration. They are initiating depression screens and developing care plans for patients diagnosed with clinical depression for patients with primary care visits. In the first three months of the program, 700 Medicaid patients have been screened.

Legislative Requests

Even with passage of HB 1520, we still do not have a long-term solution for these fragile hospitals. The WRHAP hospitals have worked on this process for more than three years. Without a solution that addresses their problems, they remain in financial jeopardy and will continue to need transitional funding. The hospitals are asking the legislature to require HCA develop a workable new payment model and provide additional Medicaid funding to sustain their essential services until a new model is developed.

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