



**Oregon Association
of Hospitals and Health Systems**

RURAL HEALTH REFORM INITIATIVE

October 16, 2014



VISION OF RHRI (EST. 2011)

- Our overarching objective is to ***sustain***, ***prepare*** and ***advocate*** for rural hospitals in this time of uncertainty.
- We will do this by taking a ***balanced*** and ***measured*** approach using data to guide decision making.
- We will engage the best minds in rural health to guide us.

THREE TRACKS OF WORK

- **Phase 1: Resources and Tools**
 - Readmissions Analysis Tool
 - Hospital Triple Aim Dashboard
- **Phase 2: Alternative Payment Methodology**
 - Transition off of cost-base reimbursement
- **Phase 3: Transforming the Delivery System**



SHARED OBJECTIVE

- Guiding Principles
- Shared Interest: Preserve Access & Cost Reduction
- CCO Experience is one of a kind
- Multi-Dimensional, 3D Chess Game
 - All components work together
 - We have to know where we are going



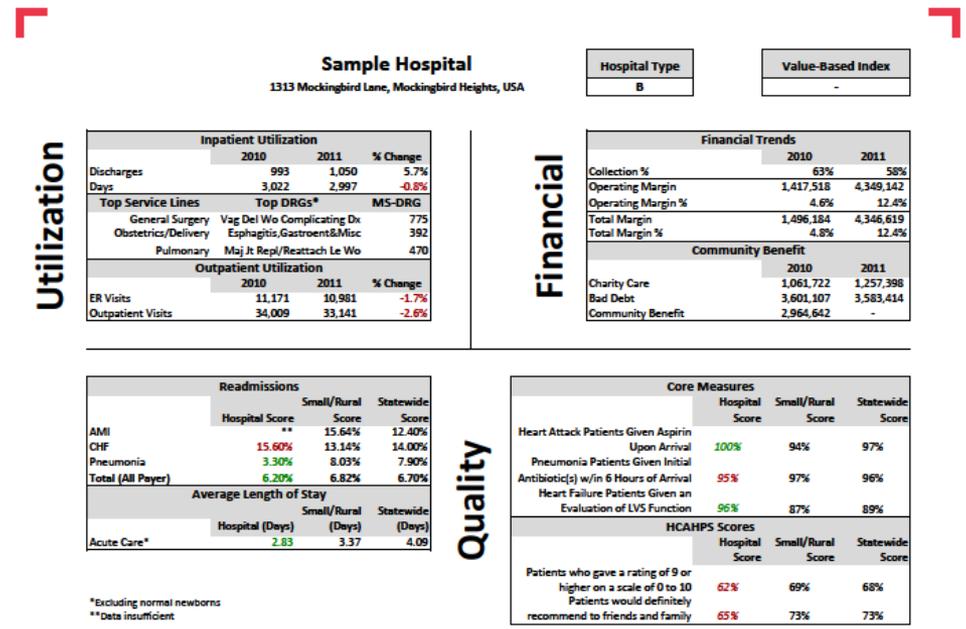
**Oregon Association
of Hospitals and Health Systems**

PHASE 1: RESOURCES AND TOOLS

October 16, 2014

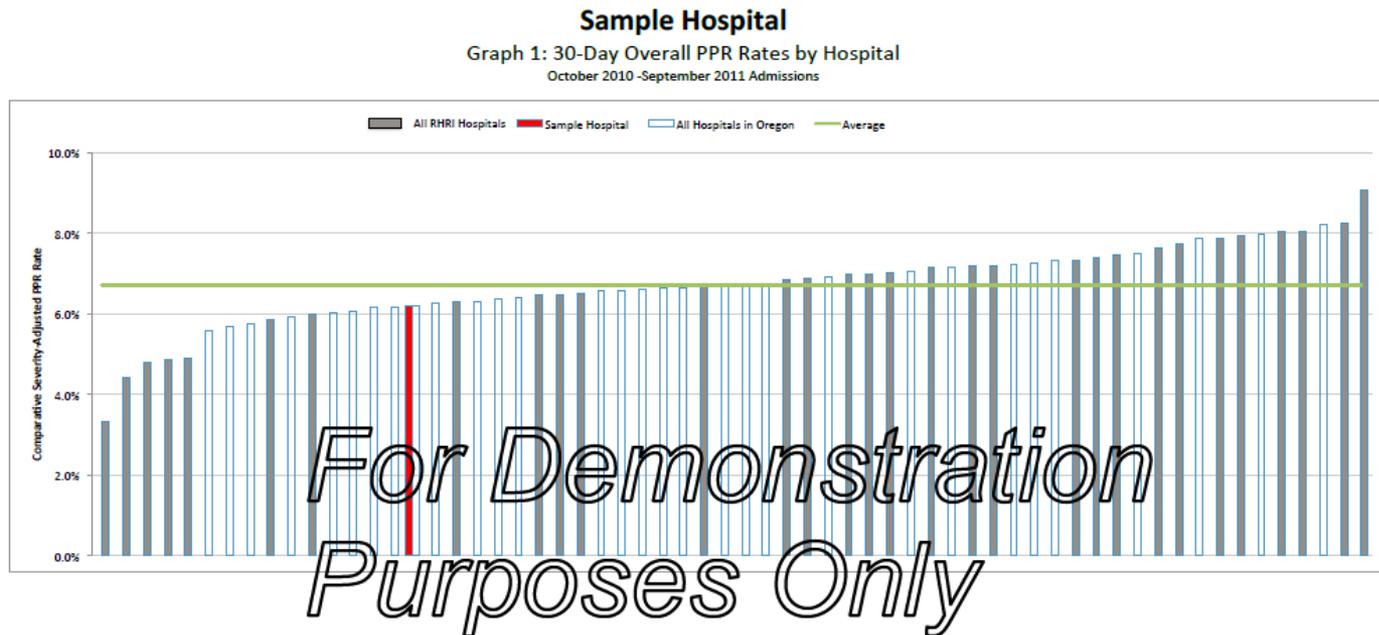
TRIPLE AIM DASHBOARD

- Every 90 days
- Tracks utilization, quality, and financial trends
- Will be updated Group by CCO and regions



READMISSIONS REPORTS

- Provided every 90 Days
- Uses statewide claims level data to capture all readmitted patients including those whose readmission is shared between two or more hospitals





Oregon  Association
of Hospitals and Health Systems

PHASE 2: ALTERNATIVE PAYMENTS

October 16, 2014

HB 3650 SECTION 5 (5)(C)

- Based upon an evaluation by an actuary retained by the authority, on and after July 1, 2014, the authority may, on a case-by-case basis, require a CCO organization to continue to reimburse a rural hospital determined to be at financial risk, fully for the cost of covered services based on cost-to-charge ratios.



RURAL OREGON HOSPITALS AT RISK

- As per statute, intent is to develop a *relative ranking* of Oregon rural hospitals at risk for financial distress.
- The risk analysis developed for alternative Medicaid payments will be the primary method for determining the ranking.
- Furthermore, findings will be overlaid with:
 - an overall hospital financial strength index analysis;
 - a demographic analysis.





HB 3650:
Actuary to identify
*hospitals to be at
financial risk*

Future
Payment
Models

- Forecast risk associated with new payment models
- Establish a hospital risk score for measuring variation
- Can a hospital move to PPS given the potential volume variation in Medicaid

Financial
Strength

- What are the current financial conditions for a hospital?
- Does their current financial position impact their ability to move to PPS?
- How does moving to a future payment model impact their overall book of business?
- How does a hospital's payer mix impact this ability to transition?

Demographic
Characteristics

- Do the demographic characteristics of a community hospital impact a hospital's ability to transition?
- What conditions outside of their control impact a hospital's ability to transition?

OHA RHRI ADVISORY GROUP

➤ Advisory group membership

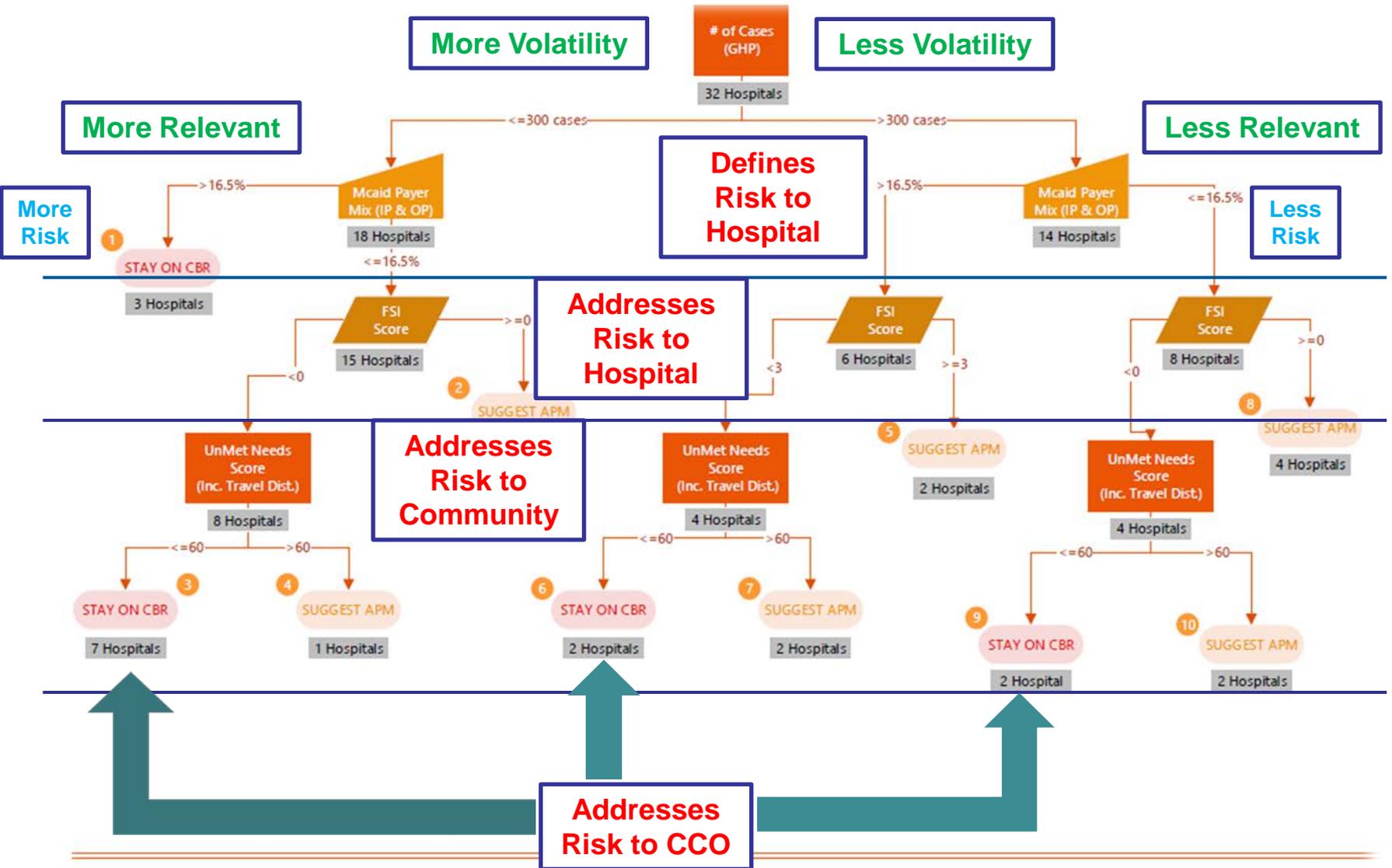
- OAHHS staff
- CCOs – Sean Jessup (Eastern Oregon CCO), Peter Davidson (PacificSource Comm. Solutions), Scott Clement (Columbia Pacific CCO), and Phil Greenhill (Western Oregon Advanced Health)
- Office of Rural Health – Scott Ekblad
- OHA – Kelly Ballas, Jeff Fritsche, DMAP, Actuarial Unit

➤ Charter/purpose

- Advisory workgroup to review the work performed by the consultants and ultimately develop a recommendation to OHA Administration.



Decision Tree



March 20, 2014

AREAS OF ALIGNMENT (STATE, HOSPITALS & CCOS)

- Success in **meeting the terms and limitations** of the State's Medicaid Demonstration with the Federal Government
- The need for more **predictable payment mechanisms** from an overall budgetary standpoint for CCOs (vs. cost-based which is less predictable)
- At the same time, a payment system that is **stable, predictable and adequate** for the hospitals involved
- The need for payment mechanisms incentivize hospitals to both increase **efficiency** and **at the same time support efforts at better clinical management** of care and thus better outcomes for patients
 - Note: better clinical management by definition would be promoted by incentives designed to reduce the use of unnecessary/margin hospital care
- Finally, avoidance of excessive financial disruption and diminishment of timely and convenient **access** by Medicaid Beneficiaries to necessary Hospital care



OUR PRIMARY GOALS IN DESIGNING THE APMS

- 1) A Cooperative approach emphasizing the Alignment of Interests and Incentives
- 2) Improved and aligned Incentives for better Cost Containment and Clinical Management of Care
- 3) Improved Stability and Predictability for both CCOs and the new PPS Hospitals
- 4) Adequate and appropriate payment levels for Hospitals that ensure continued financial viability to service their communities

We believe these goals comport with the Interests of the State and are Consistent with the Goals of the Demonstration



CHARACTERISTICS OF APM

- The Prospective “Discounted Charge” APM – sets Medicaid payment levels that are **initially** based on the hospital’s historical Base Year costs
- Under the APM, payments are also **“unhooked” from costs** and the hospital is now “at-risk” for managing unit costs
- The APM Discounted Charge approach differs from a conventional “Discounted Charge” approach in that a hospital’s payments do not automatically increase with increases in its charges
- The relationship to charges (on a discounted basis) remains – but allowed payment levels are trended forward on their own (per state global budget cap & the VAS) irrespective of how the hospital increases its charges
- If charges go up faster than costs, then the discount will increase (formulaically)



VOLUME ADJUSTMENTS & HOSPITAL/CCO ALIGNMENT

- **Risk of volume declines** was one of the risks facing hospitals under PPS
- Small/Rural Hospitals particularly vulnerable because of their high proportion of Fixed Costs
- A Volume Adjustment System (VAS) is a useful **“overlay adjustment”** to PPS because it can be structured to influence the incentives (and risk) facing a provider
- Most major rate making systems in the US have utilized volume adjustments
- Volume adjustments provide **appropriate incentives** (adjusts rates) with regard to service volumes (up and down)

KEY FEATURES OF A VOLUME ADJUSTMENT MECHANISM

- The Key Feature of the Volume Adjustment is it helps hospitals respond when volumes decline
- This feature helps remove hospitals' reluctance to support and promote volume declines and even encourages the hospital to initiate beneficial care management activities
- Should note, the adjustment is based on changes in the Hospital's **total volumes** (inpatient & outpatient across all-payers)
 - So the CCOs that reduces unnecessary Medicaid utilization can benefit
- It also works symmetrically (adjusts **rates down for volume increases**) to help align the incentive of the hospital with that of the CCO
- The key point is for the Volume adjustments to provide for better and **more aligned incentives**





Oregon  **Association
of Hospitals and Health Systems**

PHASE 3: DELIVERY REFORM

October 16, 2014