CAH Payment Reform: Defining Value and Sustainability

MN Rural Health Conference
June 20, 2016
Minnesota’s CAH Landscape

- 143 Hospitals / 132 General Acute Hospitals
- 17 Health Systems with 44 CAHs
- 78 Minnesota Critical Access Hospitals:
  - 3rd largest by number of CAHs
  - 1st based on CAH Medicare inpatient payments
- 8 CAHs are greater than 35 miles from another hospital
  - 20 CAHS are less than 15 miles from another hospital
MHA/MDH CAH Payment Reform
Task Force 2014 - 2015

Toby Freier, Chair
New Ulm Medical Center, Allina Health

Mark Schoenbaum
Minnesota Department of Health

Randy Anderson
Sanford Health

Nathan Blad
RC Hospital & Clinics, Olivia

David Borgert
CentraCare Health

Rick Breuer
Community Memorial Hospital, Cloquet

Brian Carlson
Sanford Thief River Falls Medical Center

Deb Fischer-Clemens
Avera

Kerri Gordon
Allina Health

Kathy Johnson
Johnson Memorial Health Services, Dawson

Michael Mahoney
Essentia Health

Jennifer Mallard
Mayo Clinic

Keith Okeson
LifeCare Medical Center, Roseau

Todd Sandberg
Ridgeview Sibley Medical Center

John Solheim
Cuyuna Regional Medical Center, Crosby

Mary Ellen Wells
CentraCare Health - Monticello
Reasons for Beginning Our Discussion

- Proposed cuts to CAH payments program
  - Eliminate CAH status based on distance
  - Across-the-board cuts (e.g., sequestration)
  - Site-neutral provider-based clinic payments
  - Site-neutral swing bed payments (e.g., OIG report)
  - Death by 1,000 regulations
    - Direct supervision of outpatient therapeutic services
    - 96-hour rule
    - 2-Midnight rule
MHA’s Principles & Recommendations

- Advocate for payment models that protect access for residents in rural communities

- Evaluate reform proposals against the goals of the Triple Aim

- Favor reforms that appropriately account for variation in communities’ needs and capacity
Projected Financial Impacts on MN’s CAHs (in millions)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Impact (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% Cut</td>
<td>($5.50)</td>
</tr>
<tr>
<td>Swing bed RUGs cap</td>
<td>($28.70)</td>
</tr>
<tr>
<td>Lose CAH at 15 miles</td>
<td>($50)</td>
</tr>
<tr>
<td>Lose CAH at 25 miles</td>
<td>($145.40)</td>
</tr>
<tr>
<td>Lose CAH at 35 miles</td>
<td>($169.60)</td>
</tr>
</tbody>
</table>
Potential Impacts on Access for MN’s Residents

* Based on population of areas that make up 85% of CAHs service utilization (MHA data)

High to Extreme Performance Risk assumes negative margins and < 1x Debt Service Coverage after impacts considered using 2013 HAR data as base year

* Images of pie charts showing population demographics today and converting to strict enforcement of 35 mile rule.

- **Today**
  - Low: 1,094,115
  - Moderate: 703,469
  - High: 177,997
  - Extreme: 123,716

- **Converting to strict enforcement of 35 mile rule**
  - Low: 543,941
  - Moderate: 360,940
  - High: 1,061,109
  - Extreme: 133,307
CMS’ Drive Towards “Value” is Clear

- CAHs cannot avoid shift to value
  - Accountable Care Organizations
  - Bundled payments
  - PPS Value Based Purchasing
  - PPS Readmissions
  - MD Value Modifier
  - MD Merit-based Incentive Payment System (MIPS)
  - MD Alternative Payment Models
  - PAC options under consideration
Minnesota’s Context & Experience

2011 to 2014 trends

- Adjusted operating costs/day +22%; Adjusted net revenue/day +18%
- Inpatient admissions -15%
- Swing bed admissions -4%
- Births -12%
2013 Medicare Costs/Day Variance

Medicare Cost per Day
Using Cost Report data

Average  $2,917
Median  $2,766
Min  $1,526
Max  $5,106
Std Deviation  $732

Reflects data from 62 CAHs that provided electronic file of report.
# Minnesota CAHs Case Mix Trend

<table>
<thead>
<tr>
<th>Hospitals by Expense Category</th>
<th>CMI_2010</th>
<th>CMI_2011</th>
<th>CMI_2012</th>
<th>CMI_2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHs $0 - $9.9 million</td>
<td>.5310</td>
<td>.5340</td>
<td>.5448</td>
<td>.5638</td>
</tr>
<tr>
<td>CAHs $10.0 - $19.9 million</td>
<td>.5326</td>
<td>.5426</td>
<td>.5566</td>
<td>.5667</td>
</tr>
<tr>
<td>CAHs $20.0 - $49.9 million</td>
<td>.6188</td>
<td>.6017</td>
<td>.6140</td>
<td>.6358</td>
</tr>
<tr>
<td>CAHs $50.0 - $149.9 million</td>
<td>.6056</td>
<td>.6194</td>
<td>.6341</td>
<td>.6348</td>
</tr>
<tr>
<td>All Other PPS Hospitals</td>
<td>1.0376</td>
<td>1.0545</td>
<td>1.0709</td>
<td>1.1009</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1.0000</td>
<td>1.0169</td>
<td>1.0361</td>
<td>1.0657</td>
</tr>
</tbody>
</table>

Based on MHA UB all-payer Claims data
Uses APR-DRG Version 30 Case Mix Index
Swing Bed Rates

- Swing Bed rates per day are variable and are significantly higher than SNF rates
- A cap at the 75th percentile would save Medicare around $2.3 million in MN

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Max</td>
<td>$ 3,932</td>
<td></td>
</tr>
<tr>
<td>75th %</td>
<td>$ 2,579</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>$ 2,118</td>
<td></td>
</tr>
<tr>
<td>25th %</td>
<td>$ 1,793</td>
<td></td>
</tr>
<tr>
<td>Min</td>
<td>$ 1,299</td>
<td></td>
</tr>
</tbody>
</table>

- Medicare RUGs-IV rates set for rural MN for FFY2015 range from $181 - $746 by comparison
Larger, system-affiliated CAHs generally have stronger operating margins.

More than 25% of small, independent and public CAHs show 3-year losses.

50% of public CAHs have less than 1% margins over 3 years.
Public CAHs have slightly higher Medicare and Medicaid dependency.

CAHs with total expenses below $20 million tend to have lower Medicaid.

For most CAHs, Medicare and Medicaid comprise well over 50% of payer mix.
Medicare Advantage in MN

- Minnesota has the highest concentration of Medicare Advantage (MA) plans covering 53% of Medicare Beneficiaries; US average is 31%.
- Each county has from 20 – 30 MA offerings according to the CMS website.
- The dominate market share leaders are: BCBSMN 29%, Medica 27%, UCare 22%, HealthPartners 11%, Humana 8%
Examples of Reform Concepts
MHA/MDH Task Force Explored

- Inpatient payment caps
- Swing bed payment caps
- Chronic care medical home
- Inpatient and/or outpatient bundled payments
- Readmissions (penalty only or symmetrical risk)
- Value Based Purchasing
- Accountable Care Organizations (scaled, regional or virtual)
Recommend symmetrical +/-2% incentive
- Inpatient only
- Favored closer alignment with existing VBP program

Range of statewide impacts based on 2013 data
- **Financial:** +$1.08 million to -$0.77 million
- **Percentage:** +1.7% to -1.5%
- Individual hospital impacts vary
Modeling Caveats & Disclaimers

- Limited quality data
  - Several PPS VBP measures that many CAHs do not report publicly
  - Some PPS VBP measures relate to services CAHs do not provide or do not provide in sufficient volumes

- No comparable CAH efficiency data
  - Proxy: Dartmouth Atlas total costs of care per Medicare beneficiary

- Outcomes will vary with different performance year, different measures
Penalty up to -2% if hospital’s performance ranks in bottom half of CAHs’ readmission rates

**Reward up to +2%** if hospital’s performance ranks in top half of CAHs’ readmissions rates

Used all-cause readmissions for modeling to better align with PPS readmissions program, although MHA would prefer CMS to use avoidable/preventable for evaluating hospital performance

Range of statewide impacts based on 2013 data

- Financial: +305,000 to -$355,000
- Percent: +0.39% to -0.9%
1. Develop a value-based purchasing program for CAHs, and
2. Develop a readmissions reduction program for CAHs
Projected Aggregate Impacts on MN’s CAHs (in millions)

<table>
<thead>
<tr>
<th>Impact</th>
<th>Value (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% Cut</td>
<td>($5.50)</td>
</tr>
<tr>
<td>Swing bed RUGs cap</td>
<td>($28.70)</td>
</tr>
<tr>
<td>Lose CAH at 15 miles</td>
<td>($50)</td>
</tr>
<tr>
<td>Lose CAH at 25 miles</td>
<td>($145.40)</td>
</tr>
<tr>
<td>Lose CAH at 35 miles</td>
<td>($169.60)</td>
</tr>
<tr>
<td>VBP</td>
<td>$1.10</td>
</tr>
<tr>
<td>Readmissions adjusted</td>
<td>$0</td>
</tr>
</tbody>
</table>
What Other States are Working On

- Washington: Federally Qualified Health Clinic (FQHC)-like, cost-based global payment
  - Hoping to negotiate with CMS for state to receive all inpatient, outpatient, pharmacy data
  - Expecting to have a global payment approach similar to FQHCs for total-cost-of-care for rural community
Kansas: Testing 12- and 24-hour outpatient models

- Modeling demonstrated viability, with many caveats
- Unable to produce reliable financial projections because it is limited to calculating inpatient revenue loss, not revenue/expense of new models
What Other States are Working On

- Illinois: “Rural relevant” quality measure set
  - Efficiency measure (25%)
    - CAH cost/patient day; ‘Tweener’ 90-day bundle
  - Process measures (10 - 25%)
    - Initial antibiotic selection for CAP in immuno-suppressed patient (VBP)
    - Assessed and given flu vaccine (VBP)
    - Follow-up appointment with medical home scheduled before discharge (NQF)
    - Door to Doc (NQF)
    - Transition record with specific elements received by discharged patients (NQF)
    - Advanced care plan (NQF)
What Other States are Working On: Illinois Continued

- Outcome measures (40%)
  - 30-day mortality rate (converted to survival rate for VBP)
  - CAUTI (VB/NHSN)
  - MRSA/VRE (IDPH/NHSN)
  - C-diff (IDPH/NHSN)
  - Accidental puncture/laceration (AHRQ Claims-based)
  - Post OP DVT (AHRQ Claims-based)
  - Falls with injury (NQF)
  - Stage 3 or 4 hospital acquired pressure ulcers (AHRQ Claims-based)
  - SSI – all surgeries (NQF)
  - ED return within 72 hours (NQF)
What Other States are Working On: Illinois Continued

• Patient experience measures, including inpatient, swing and observation beds (10-25%)
  o Communication with nurses (HCAHPS)
  o Communication with doctors (HCAHPS)
  o Responsiveness of staff (HCAHPS)
  o Pain management (HCAHPS)
  o Communication about medicines (HCAHPS)
  o Hospital cleanliness and quietness (HCAHPS)
  o Discharge information (HCAHPS)
  o Overall rating (HCAHPS)
Next Steps

- Development of more rural-relevant measures is critical to perceived fairness of results (e.g., National Quality Forum initiative)
- Share with other state hospital associations working on complementary CAH and rural PPS reforms
- Inform AHA’s Task Force on Vulnerable Communities
- Reach out to other rural health advocates
- Begin discussions with MEDPAC, CMS and Legislators working on rural health policy issues
Questions/Discussion

Contacts

John Solheim, FACHE, CEO
Cuyuna Regional Medical Center
jsolheim@cuyunamed.org

Joe Schindler, Vice President of Finance
Minnesota Hospital Association
jschindler@mnhospitals.org