Orcas Island Health Care District
Assessment of Entity Options
Strategic Issues

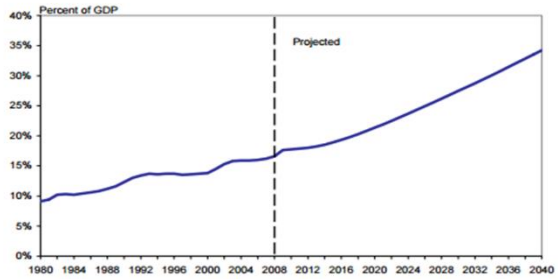
The Orcas Island Health Care District has issued a scope of work to determine an organizational structure to provide medical services on the island. In addition to 9 – 5 clinic operations, the District is interested in enhanced services including after hours care. The District provides financial support to a Rural Health Clinic (Family Center) and a Medical Clinic (operated by UW Neighborhood Clinics). The amount of financial support requested by both clinics has increased to the point where it may exceed the financial capacity of the District's taxing ability.

The District has identified several avenues for increasing rates & resulting cashflow thereby reducing requirements from the tax base:

- Rural Health Clinics
- Federally Qualified Health Centers
- Affiliation with hospital districts

Health care profitability is under fire from many sources currently. Healthcare costs have a strong upward trend overtime for cost increases which come from a variety of influences. The cost of equipment, personnel and documentation are primary drivers. As an example, the shortage of providers in rural settings was identified 40 years ago requiring higher pay for professionals to live outside of urban areas. The utilization of health care services has also increased amongst the population placing increasing demand for medical services and therefore raising the cost of running a clinic. National health care costs are projected to increase to 40% of all federal spending by 2037.

Figure 1: National Health Expenditures as a Share of GDP, 1980-2040



Source: CEA calculations.

The revenue stream for providers is undergoing a significant change under the provisions in the Affordable Health Act (ACA). These sections deal with how health care will be provided over time. The current model is generally based upon a piece rate called "Fee for Service" where the more a patient is seen, the greater the revenue for the provider. The end game for the ACA is to have providers take the risk for providing health care under a payment system called "Capitation". Capitation pays a provider a certain fee on a monthly basis to manage the health of a given patient. Generally, the capitation amount reflects the degree of expected health resources needed for the particular patient based upon demographic and claims utilization experience. Capitation was attempted in Washington state in the late 1990's. In order to protect profits, the management was controlling costs through denying services. This was capitation without quality controls and known occasionally as "Managed Death". Assuming risk under capitation means the provider can increase profitability or incur significant losses based upon how well the assigned population is managed. In the last decade, providers have formed Accountable Care Organizations as a method to manage the risk based upon the new reimbursement strategy. Many of these startups have failed due to losses.

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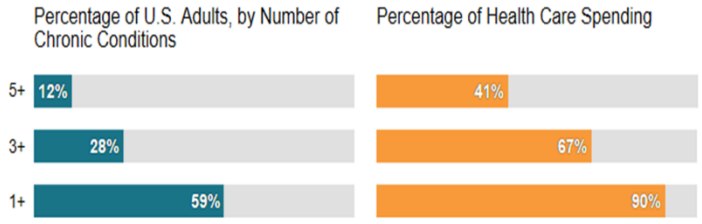
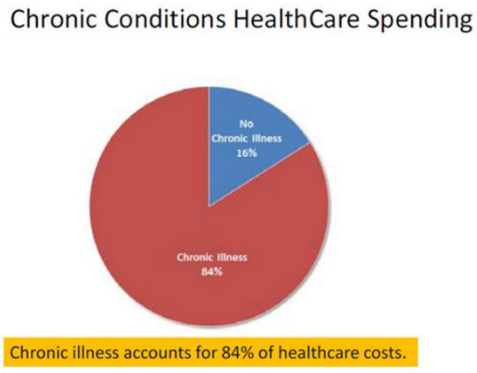
This time, the Centers for Medicare and Medicaid Services is tying payments to quality measures. Payments for Fee for Service claims are being reduced with the difference being kept in reserve. The Measures have been created based upon claims and/or encounters (claims with zero payment) that providers must meet to achieve a portion of the reserve amount. The measures are based on evidence-based practices known to reduce the consumption of expensive medical services. For example, providers who see diabetics 4 times a year and measure A1c levels experience a reduction in diabetes onset medical expenses such as vision degradation, loss of limbs and others. Providers that meet the measure requirements receive "Bonus" payments. The downside is the increased level of administrative work by physicians, reducing available capacity and leading to burnout. State Medicaid systems are in the process of increasing the amount of withholding into reserves each year. Many smaller clinics are finding it problematic to meet the reporting requirement, thereby leaving cash on the table at the end of the year. The expected date for implementing capitation is now 2025. It has been steadily slipping backwards over the last 5 years as the medical community adapts.

The ACA recognizes the 80/20 rule applies to the demand for health care services. The rule applies in many ways depending on how one cuts the data. Essentially, 20 percent of the population has more than one medical issue (comorbidity) which chews up a large chunk of health care demand. In the example to the right, 12% of the population has 5 or more chronic conditions that account for 41% of health care spending.



Folks who have chronic conditions account for over 80% of health care spending. Without integrated care of the whole person, chronic conditions are not resolved resulting in a life time of treatment



Often the issues are beyond the skill sets of medical providers. An example is a 300-pound diabetic who suffers from depression and doesn't have stable housing. The three-legged stool will not provide an avenue out of the high costs of treating this patient. If any one of the legs are missing, the stool will fall. The ACA is calling for the integration of care between providers of the three services. Medical and Behavioral Health providers may be paid on a fee for service basis, however, they tend not to communicate well between disciplines. Most of the time different provider groups use different Electronic Medical Record (EMR) systems that don't talk to each other. In many cases medical providers would rather not have mental health patients in their waiting rooms disrupting their medical patients. The provider of housing services is normally paid by grants & donations, and not tied in with the other two provider groups. There is little incentive for integrated care of the whole person although there are many evidence-based studies that demonstrate significant savings. The use of Emergency Rooms can drop by 50% with the use of integrated care teams.

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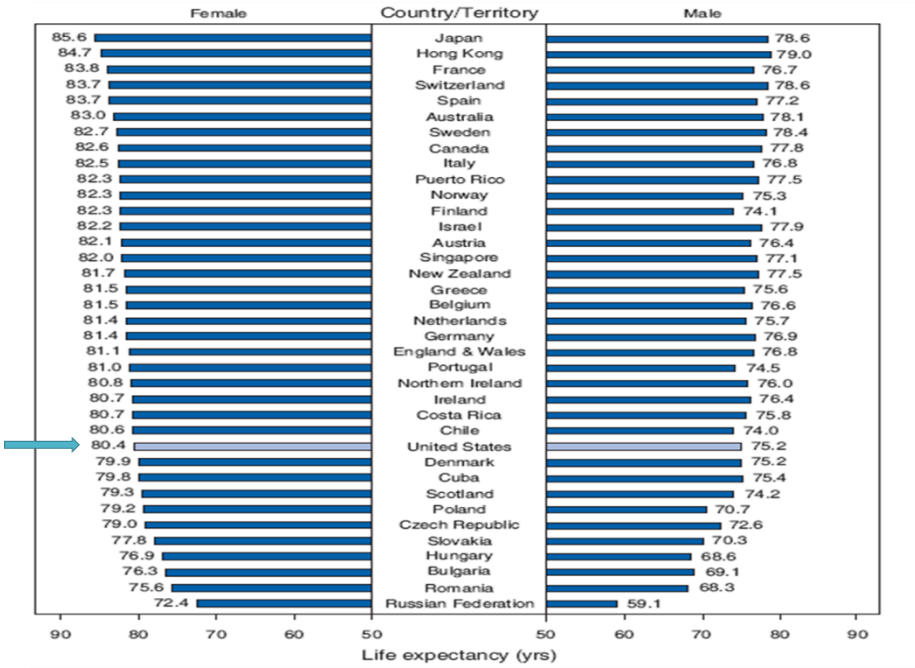
The U.S. is the most expensive health care system in the world, yet depending on the source, we are in the mid 80% in terms of effectiveness. It is recognized the current approach is producing sub optimal results. The ACA & CMS are pushing for innovation in the integrated treatment of the whole person. Many organizations are being funded to conduct pilot projects to develop methods for managing complex patients requiring more than medical care. Services that have not been paid for by Medicaid dollars in the past will receive funding if a significant cost savings can be demonstrated. The integrated approach will be driven by data for services and outcomes.



Medicaid & HRSA through states has been providing grants for smaller providers to build the necessary infrastructure over the last few years. New Grants appear through the states regularly. In some cases, they are for building infrastructure or performing research on how to solve integrated service issues.

The last several paragraphs are included as examples of the amount of change that is expected in the next few years making the decision on the best route to provide health care more complex than picking a payment path. It must be clear that the solution is not just increasing revenue but optimizing operations to increase effectiveness while reducing costs.

Rural Health Clinics and Federally Qualified Health Centers are primarily concerned with providing safety net services to venerable populations. Both certifications provide increased rates and require different level of services to be provided. A recommendation would require an analysis of population demographics and claims submissions to determine total cost of care. Relying strictly on historical utilization data will under estimate increased usage of some options under consideration. This is a process conducted by major insurance companies to set rates for various products and changes in regulatory environments.

The routes to lessen the load on the District are different where more than one can be pursued. In terms of rural clinics and FQHC's, application for both can occur simultaneously with FQHC's requiring multiple years to successfully execute. An option is to become an FQHC look alike entity which establishes an entity able to bill at higher rates before officially defined as an FQHC.

There are many requirements to be balanced against each other. Is the entity to be based only to serve Orcas Island residents? Generally, with the reporting and data requirements, more patients are better to spread the cost. However, to qualify, the Medicaid or underserved population must be significant. In

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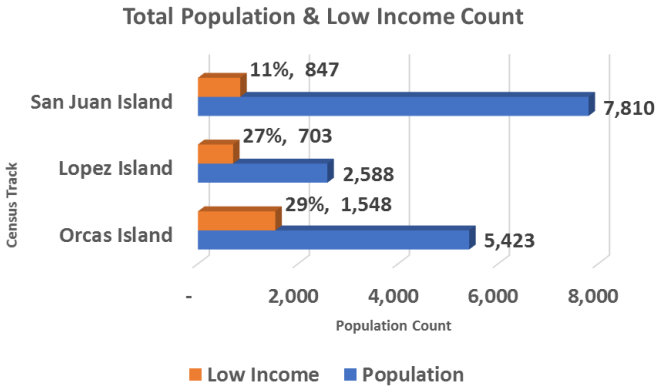
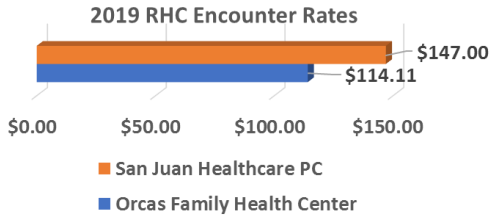
a conversation with a board member, it was estimated that this population is around 50%. HRSA believes the population is around 29%. Combining Lopez and San Juan districts, the safety net population is 20%. Normally the lower number would reduce opportunities to form an entity to service San Juan County. All the islands have rural status.



The regulations call for the enhancement rates to be adjusted annually based upon costs incurred in the previous year. Although San Juan has a lower concentration of low-income population, its Enhancement Rates are higher.

Provider Name	2019.Q3 Enhancement Rate
Anacortes Family Medicine	$47.24
Island Family Physicians	$25.00
Orcas Family Health Center	$16.33
San Juan Healthcare PC	$26.54
Sea-Mar Community Health Center	$30.88
Whidbey Health Primary Care - Freeland	$24.08
Whidbey Health Womens Care	$24.08

The rural Encounter Rates are also different for San Juan and Orcas. San Juan receives $33 more on average more than Orcas. A review of rural health annual submissions is recommended.



The choices the District will be considering are unfortunately not linear. There are many ways to make any of the paths successful. However, they require different levels of skill, capital investment and management skill to take advantage of programs and the ever-changing world of reimbursement.

At this point the recommended path to a decision is:

1. Conduct a work session with District key personnel, sometimes called “Stakeholders” to establish:
   - A review of Medical Service reimbursement trends and future strategies
   - a solid vision
   - a set of service priorities or trade-offs
   - entity tactical path preferences
   - timelines
   - budgets
   - a rank order of potential strategic alliance partners.
2. Review historical total cost of care (claims) data for use in modeling pricing and cost alternatives
3. Engage Washington State resources and associations to establish a 5-year view of expected policy changes that would differ from the federal level.

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4. Produce a recommended approach increased medical outcomes and net revenue enhancement including:
    - Resource capacity (provider) requirements
    - Financial ROI (econometric) analysis of potential options
    - Implementation timelines
    - Capital requirements
    - Working Capital requirements
    - Funding sources
    - Rate structures
    - Administrative requirements
    - Population to be served
    - Services to be offered
    - Implementation budgets