

A Federally Funded Program

# **Pennsylvania Rural Health Model**

*Accelerating Health Care Innovation in Pennsylvania*

*SLC Human Services & Public Safety Committee  
Virtual Program  
September 23, 2020*

*Presented by:*

*Gary Zegiestowsky, MBA, RHRC Executive Director  
Janice Walters, MSHA, RHRC Chief Operating Officer*

## Topics for today

1. Current landscape of VBC for rural communities
2. Introduce the Rural Health Redesign Center
3. Provide insight into Rural Pennsylvania:
  - a) Provide insight into rural Pennsylvania through statistics
  - b) Provide a brief history of the PA Rural Health Model (PARHM)
  - c) Provide a very brief overview of Model Concepts
4. Answer questions
5. Appendix
  - RHRCO Leadership
  - RHRCO Value Proposition

# Value Based Care for Rural Communities

## **CHART Announcement**

### **CMS Expands Focus of Alternative Payment Models with National Model for Rural Communities**

- Community Health Access and Rural Transformation (CHART)
  - CMS announcement on 8/11/2020 of National Model
  - Notice of Funding Opportunity(NOFO) released on September 15, 2020
- The Community Health Access and Rural Transformation (CHART) Model is a voluntary model that will test whether aligned financial incentives, operational & regulatory flexibility, and robust technical support will help rural providers transform care on a broad scale to achieve the following goals:
  - Improve access to care in rural areas
  - Improve quality of care and health outcomes for rural beneficiaries
  - Increase adoption of alternative payment models (APMs) among rural providers
  - Improve rural provider financial sustainability

CHART model builds on lessons learned from:

- Maryland Total Cost of Care Model
- Pennsylvania Rural Health Model

## State Medicaid Communication

### **CMS Letter to State Medicaid Directors Promotes Value-Based Payment Models with an Emphasis on Comprehensive All-Payer Models**

- CMS believes that value-based payment (VBP) is a key driver of value-based care (VBC):
  - Value is likely to improve across the healthcare system when provider incentives are aligned across payers
  - By advancing VBP in Medicaid, states have the opportunity to improve beneficiary health while reducing costs
  - Accepting value-based or capitated payments can enable providers to better weather fluctuations in utilization, and they can focus on keeping patients healthy rather than trying to increase the volume of services to ensure reimbursement
- Implementing VBP programs to the promote progression from traditional FFS models to population health-based payment models should focus on several key success drivers, including:
  - Multi-payer participation
  - Assessment of delivery system readiness
  - Robust health information exchange and technology
  - Stakeholder engagement
  - Quality measure selection
  - Sustainability

Comprehensive payment models are among the most innovative and effective ways to align incentives across payers and providers

# Rural Health Redesign Center Introduction

## ***RHRCO – Our Vision and Focus***

### Serving Rural Health Care Communities

**Vision:** The Rural Health Redesign Center is committed to addressing the challenges facing rural hospitals and communities in Pennsylvania and across the Nation building on three key strategies:

- Transforming health care delivery in rural communities to increase access and improve quality
- Improving the population health status in rural communities and reducing the total cost of care
- Creating health care services that match the needs of the community

**Focus:** The Rural Health Redesign Center (RHRC) has a dual focus to:

1. Build solutions for rural hospitals and communities across the country to drive financial sustainability while improving the health of the populations in these communities. This focus area is building on the experience and lessons learned in PA as well as elsewhere in the country to bring scalable, cost-effective solutions to rural communities.
2. Continue support of the Pennsylvania Rural Health Model (PARHM) to achieve the financial and health-related goals of the program of this CMMI Demonstration Project.



## **PARHM Accomplishments To Date – Reason to Celebrate**

### **Successful Payer-Provider Collaboration at Scale**

- We launched the first All-Payer Model of its kind and are in our 3<sup>rd</sup> performance year (Pre-implementation, PY1 and PY2)
  - In addition to Medicare, recruited the largest five commercial payers in the State to ensure critical mass of Net Patient Revenue (NPR) is included in the program.
  - Developed methodology to calculate global budgets, including the build-out of commercial methodology that is broadly accepted. This includes payer mix, unplanned volume shift adjustments, and PAU methodologies.
  - Developed a Quality Assurance process that reconciles payer and hospital data to agree on the starting point.
  - Worked with over 30 PA hospitals to:
    - Develop global budgets, which resulted in the successful recruitment of 13 hospitals with hopefully 4 more joining in October
    - Develop the transformation planning process to include plans for over 30 hospitals
  - Implemented the global budgets and are in the 2<sup>nd</sup> year of performance
  - Implemented a HEDIS quality reporting system outside of a State-based HIE or all-claims database to aid in program reporting.
  - Worked collectively to get legislation passed to establish the Rural Health Redesign Center Authority and supported the subsequent creation of its governing board.

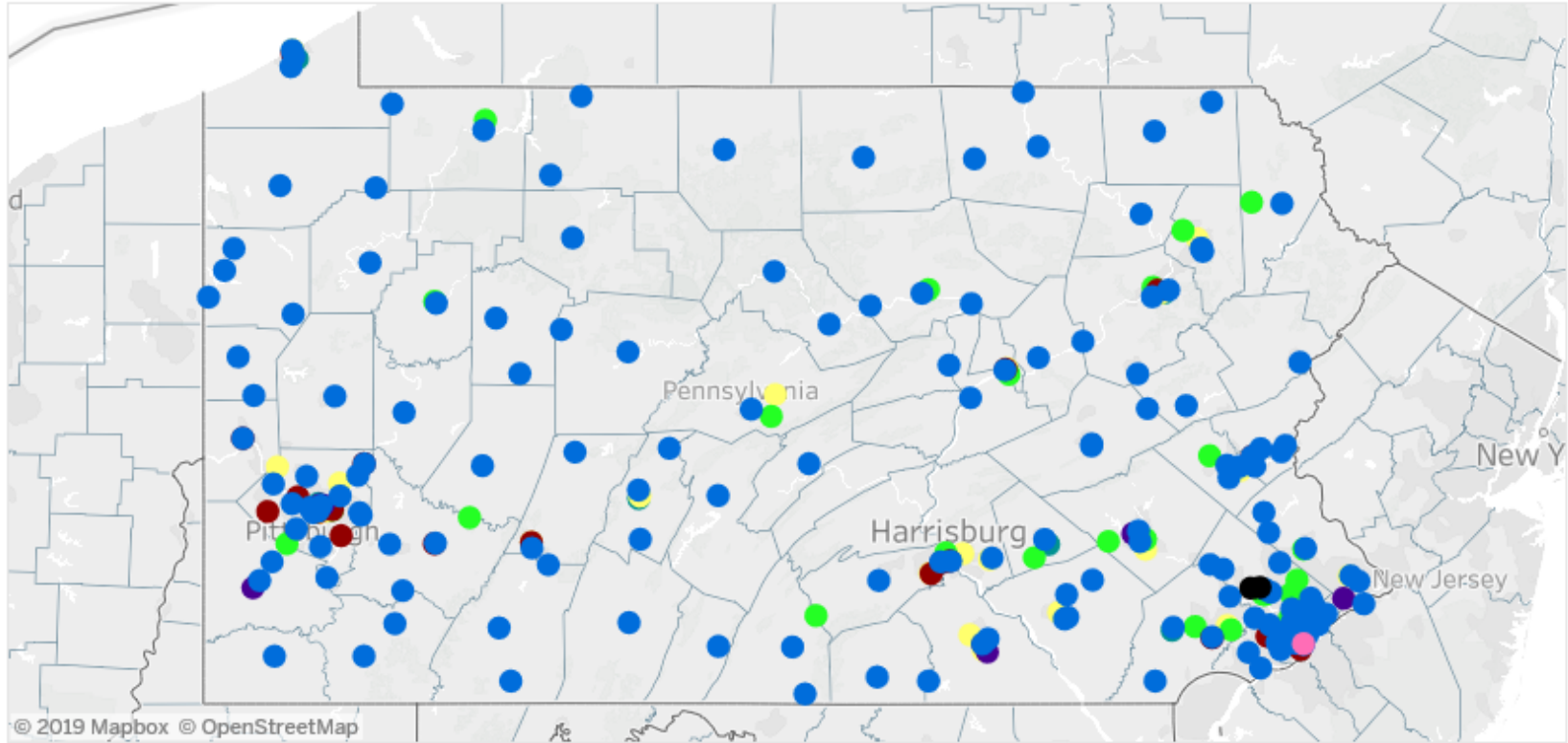


# Insight into rural Pennsylvania through statistics

Many leaders from other states are trying to assess the applicability of the PARHM as a potential solution for their state.

### All Pennsylvania Licensed Hospitals

Hospital Name



**Research and Data Analytics**  
 Latest Revision: August 1, 2018  
 Source: PA Dept of Health, HAP

**Type of Facility**

- Drug & Alcohol
- General Acute Specialty
- Psychiatric
- Eye, Ear, Nose & Throat
- Long-Term Acute Care
- Rehabilitation
- General Acute
- Maternity
- VA Hospitals

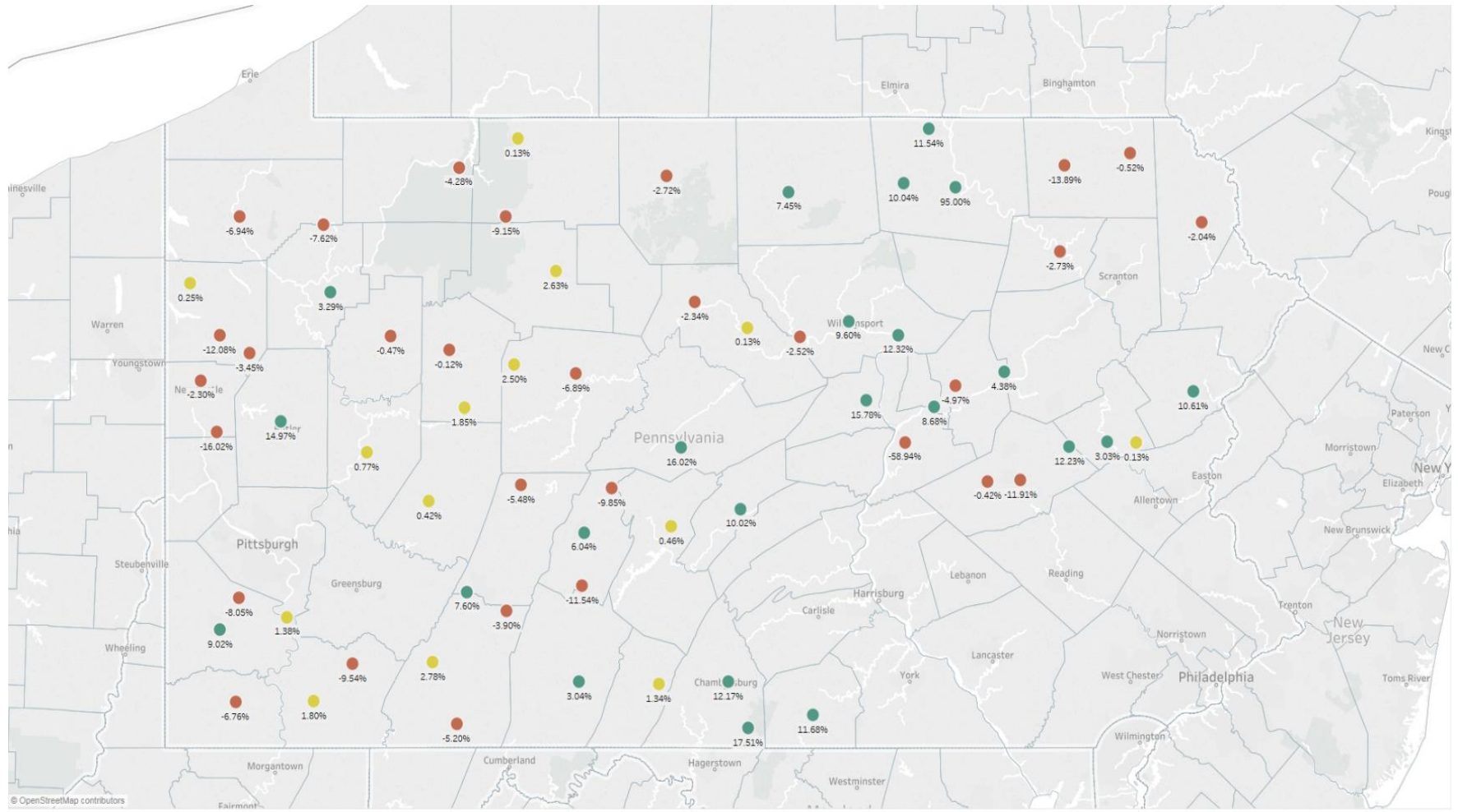


The Hospital + Healthsystem Association of Pennsylvania



Often PARHM leadership is asked “is PA really rural?”

## PA Rural Hospitals



# Rural Pennsylvania

## PA Statistics

- Geography statistics:
  - 67 total counties in PA
  - 41 deemed rural for the PARHM
- Hospital Statistics
  - 249 licensed hospitals
  - 67 eligible for PARHM
    - 13 CAHs
    - 54 Sole Community / PPS
- Professional Provider Statistics:
  - Approximately half of Pennsylvania's providers practice in one of three counties (Philadelphia, Montgomery, and Allegheny).
  - Based on 2015 estimates, HRSA has as identified portions of 65 of the 67 counties, both rural and urban, as federally designated Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs), that is, areas having too few primary care providers and services, high infant mortality rates, high poverty and/or a high elderly population.

# Rural Pennsylvania

## PA Statistics

- Population (2015 census data)
  - Estimated that there are 3.4 million rural Pennsylvania residents
  - 18% of the rural population was aged 65 years and above compared to 15% urban.
  - Average household income in rural Pennsylvania was \$61,993
  - Approximately 13% of rural households reporting incomes below the poverty level.

[https://www.rural.palegislature.us/demographics\\_about\\_rural\\_pa.html](https://www.rural.palegislature.us/demographics_about_rural_pa.html)

- Medicaid Statistics:
  - In June 2016, 21% of the rural residents were eligible to be enrolled in Medicaid Assistance
    - Pa is a Medicaid Expansion State

# Insights into Pennsylvania – the PA Rural Health Model (PARHM)

# *The Pennsylvania (PA) Rural Health Model (the “Model”)*

*The goal of PA Rural Health Model is to prevent rural hospitals, which ensure access to high-quality care and economic vitality in local communities, from closing*

- Partnership between CMMI and the Commonwealth of Pennsylvania to test a new payment model for rural hospitals
- Federally funded through CMMI to provide technical assistance to participant hospitals who join the Model
  - Grant funds for technical assistance to participant hospitals to help ensure success
  - Health insurers remain the source for hospitals’ net patient revenue streams
  - Model will be assessed based on rural hospitals financial performance and population health outcome measures
- Several key differences between Maryland Model and the PA Rural Health Model:
  - Impetus: retaining access to care and jobs vs. cost containment
  - No global rate setting function in PA - the underlying negotiated rates between payers and providers remain intact after the calculation of the baseline budget
  - No “all-claims” database in PA – we are identifying alternative means of getting data to calculate global budgets for all payers and to monitor quality outcomes

The Model provides protection from some of the most challenging issues facing rural healthcare leaders by minimizing several of the risks hospitals experience under FFS

FFS Risk	Model Benefit
Volume fluctuations	Predictable revenue stream
Provider resignations / recruitment challenges	Protects hospital revenue from the immediate impact of providers departure and provides stability until recruitment efforts are successful
Competition with tertiary centers for volume	Competition is no longer the driver of revenue
Investments in population health (right thing for the community, wrong thing for the bottom line)	Eliminates the concern as you are paid to keep people well
Regulatory barriers that prohibit innovation	Within the Model, opportunities exist to apply for waivers of regulations that may stifle innovation



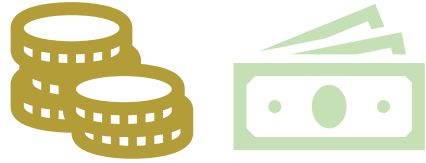
## Current state of the PARHM Program

- The model is in its 3<sup>rd</sup> performance year:
  - PY0 – Pre-Implementation
  - PY1 – 2019
  - PY 2 - 2020
- Current Model participants:
  - 13 hospitals currently participating, actively recruiting potentially 4 more
  - Six payers
    - Medicare FFS
    - 4 Pennsylvania based commercial insurers
      - Commercial, Medicare and Medicaid
    - 1 national payer
      - Commercial, Medicare and Medicaid
- Planned expansion
  - Continue to grow hospital participation through next year
  - Maintain payer participation to ensure critical mass of payment to hospitals is maintained within the program



# Insights into PARHM concepts

There are two core tenants that make the Model different from FFS that work in combination to create different incentives for hospitals



The Model stabilizes cash flow from all participant payers

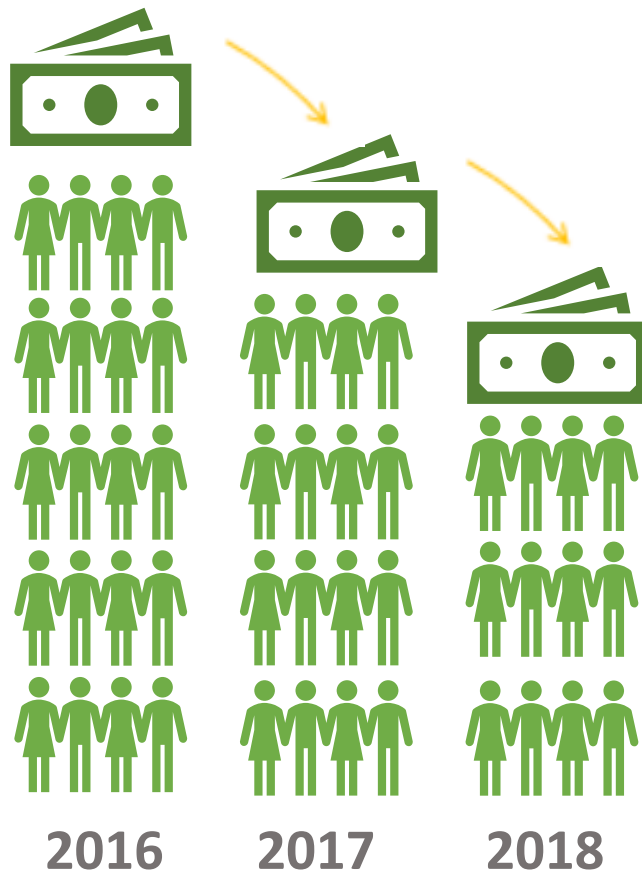


The hospital is incentivized to invest in community health to retain revenue

The global budget stabilizes hospital revenue compared to fee for service, which is imperative in rural communities where population is declining

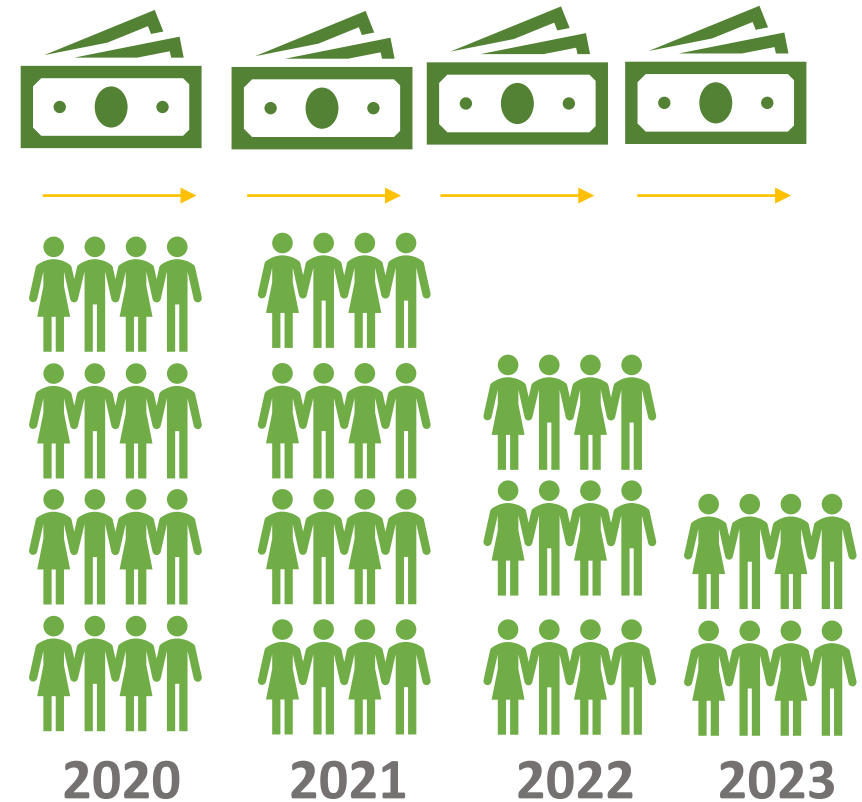
## Fee for Service

Hospital is paid for the # of healthcare resources consumed by the community, but as the community is getting smaller, so is revenue.



## Global Budget

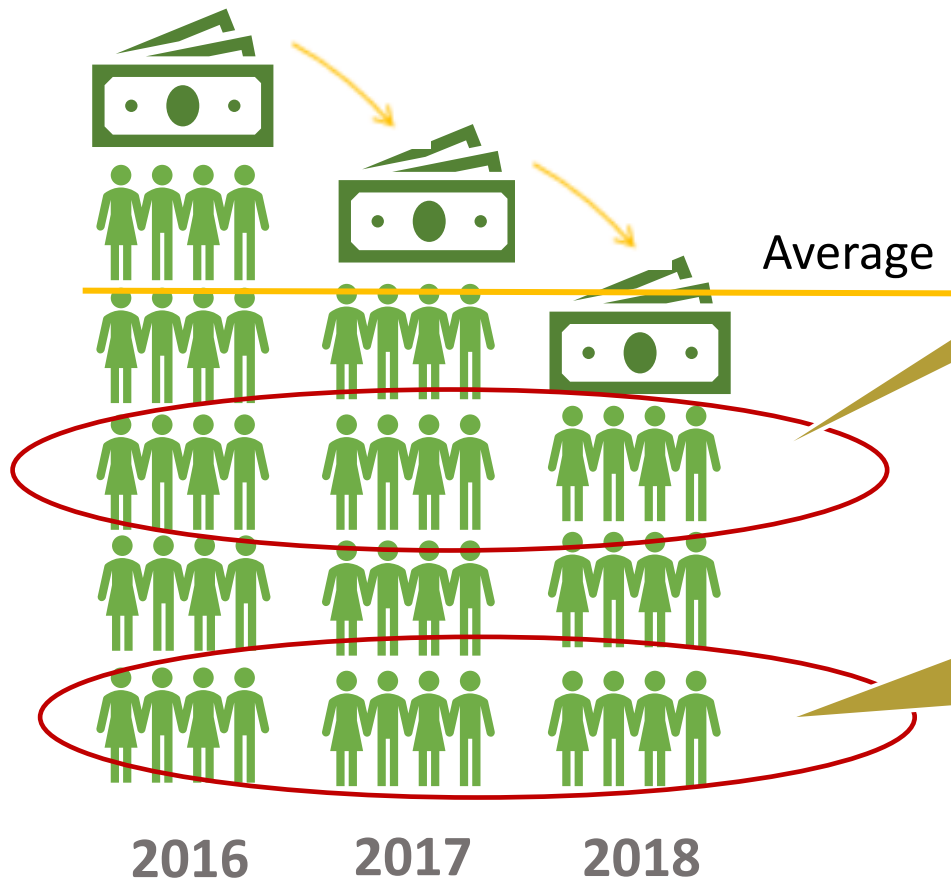
Hospital is paid the same amount of money as historic NPR regardless of how many resources are consumed by the community.



To the extent the hospital can reduce unnecessary utilization, they keep the historical revenue

### FFS Revenue

*Hospital is paid for the # of healthcare resources consumed by the community, but as the community is getting smaller, so is revenue.*



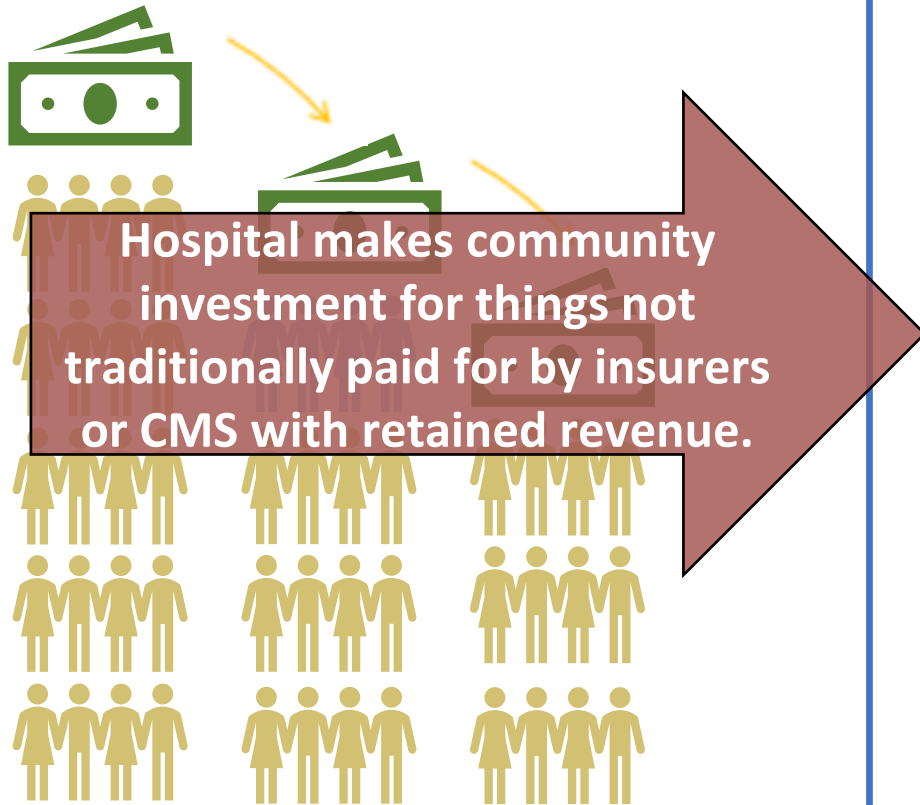
Each year a certain number of patients seek care in the ED that could have been furnished in a primary care office.

Each year a certain number of patients come back to the hospital within 30 days of a prior hospital stay due to breakdowns in how care was delivered to the patient.

By retaining the revenue associated with the reduced PAU, the hospital can invest in services that promote community wellness

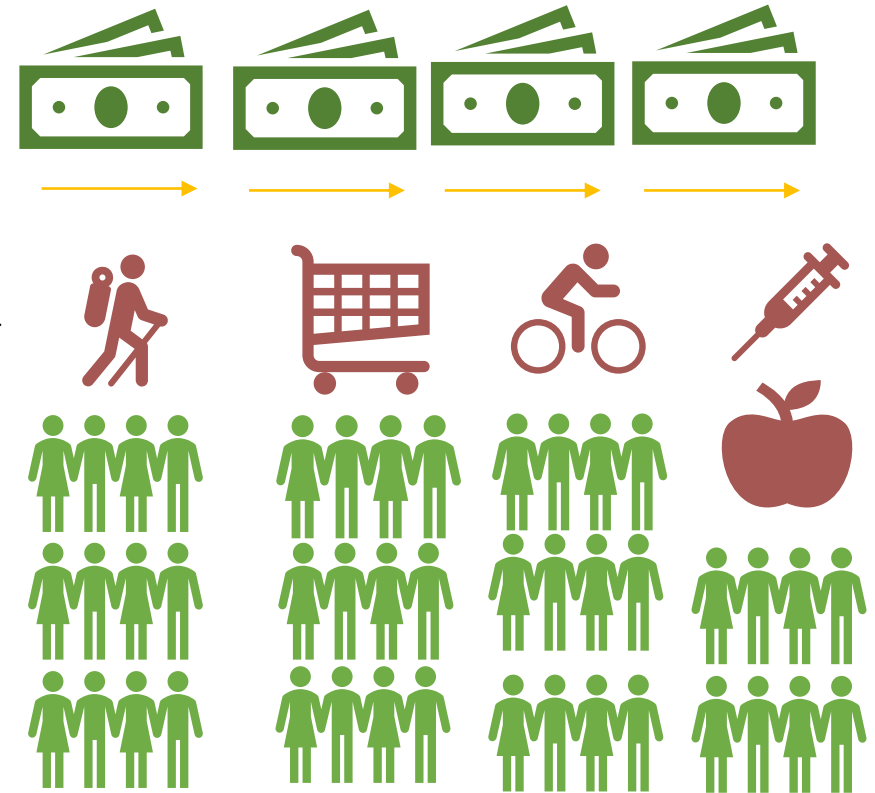
### FFS

*Hospital is paid for the # of healthcare resources consumed by the community, but as the community is getting smaller, so is revenue.*



### Global Budget

*Hospital is paid the same amount of money irrespective of how many resources are consumed by the community.*



# Q&A



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# Appendix

## **RHRCO – Our Leadership**

### **Experienced Health Care Executives Committed to Rural Health Care**

#### **RHRCO Executive Team:**

- Executive Director: Gary Zegiestowsky
- Chief Operating Officer: Janice Walters

#### **RHRCO Board members:**

1. Chairman: Thomas Kurtz, CEO, Windber Hospital
2. Vice Chairman: Glenn Pomerantz, SVP, Gateway Health
3. Secretary: Brock Slabach, SVP, National Rural Health Association
4. Treasurer: Lauren Hughes, MD, State Policy Director, Farley Health Policy Center, Colorado
5. Director: Lisa Davis, Director and Outreach Associate Professor of Health Policy and Administration, PA Office of Rural Health

RHRC leadership will capitalize on leveraging subject matter expertise combined with individuals bringing experience from across the country, including:

- RHRC Team members
- Hospital and Payer Executives with global budget expertise
- State leadership – Department of Health, Department of Human Services, Insurance Commission, etc.
- Academic Partners
- Community Partners

## ***The Rural Health Redesign Center's Value Proposition***

**Provide a “roadmap” to address the Health Care challenges faced in rural communities**

### Solving the Rural Health Care Challenge Outside of Pennsylvania

The Pennsylvania Rural Health Model (PARHM) is the only one of its kind in the country, and therefore provides unique opportunities to leverage “hands on” experience to provide a “roadmap” to success for other communities and states in the following areas:

- Stakeholder engagement
- Identification of data sources to support program administration
- Development of data infrastructure
- Hospital and payer recruitment
- Transformation plan development and implementation
- Provider and payer onboarding
- Operationalization of global budget methodology
- Performance management of overall program
- Development of community partnerships and other external resources
- Development of shared services to support rural hospitals

***The RHRC is a Learning Lab for the transformation of health care delivery in rural communities***