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Pennsylvania Rural Health Model

Accelerating Health Care Innovation in Pennsylvania

Idaho Hospital Association

October 7, 2019

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Conflicts of Interest Disclosure

Janice Walters has no real or apparent conflict of interest(s).

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Goals

- Provide a brief history and overview of the Model
  - What it is and current state of the program
- Provide key concepts of the methodology
  - Global Budgets
  - Transformation planning
- Share a few lessons learned
- Answer questions

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Brief history and overview

2019

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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

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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

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Current state

- The model formally launched in January 2019
- Public announcement made March 5, 2019
- Current Model participants:
  - Five hospitals
  - Five payers
    - Medicare FFS
    - 4 Pennsylvania based commercial insurers
      - Commercial, Medicare and Medicaid
- Planned expansion
  - Grow hospital participation to 30 over the course of the next two years
  - Increase payer participation to grow global budget revenue

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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

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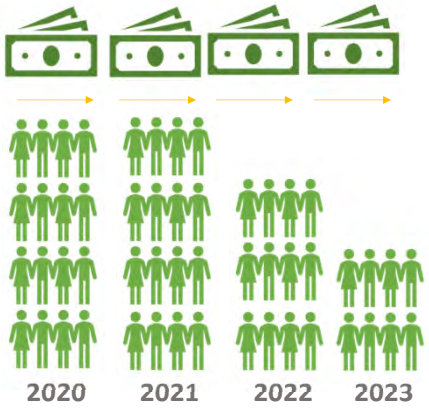
The global budget stabilizes hospital revenue compared to fee for service, which is imperative in rural communities where population is declining

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.



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Hospitals establish a budget with all payers using the same logic. Without a global rate setting function, the global budget must be set for each individual payer, and then summarized to arrive at the total global budget amount

- Commercial payer 1 → $x based on FY18 or FY16-18 average
- \+
- Commercial payer 2 → $x based on FY18 or FY16-18 average
- \+
- Commercial payer 3 → $x based on FY18 or FY16-18 average
- \+
- Medicaid MCO → $x based on FY18 or FY16-18 average
- \+
- Medicare FFS → $x based on FY18 or FY16-18 average

HOSPITAL'S TOTAL GLOBAL BUDGET

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In order for successful change, critical mass of net patient revenue must be paid differently. The Model contains payer participation targets to ensure enough revenue is included to allow for change in how care is delivered

2019 Goal: 75%

2020 Goal: 90%

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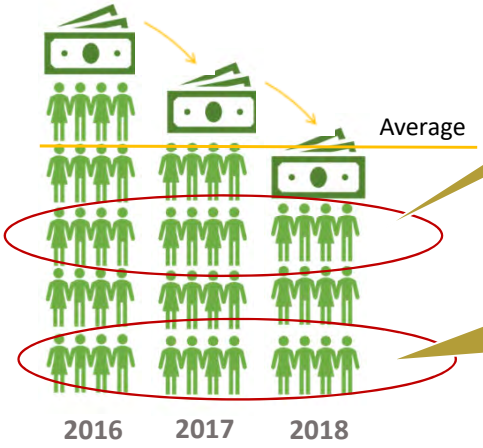
To the extent the hospital can reduce unnecessary utilization, they keep the historical revenue

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.

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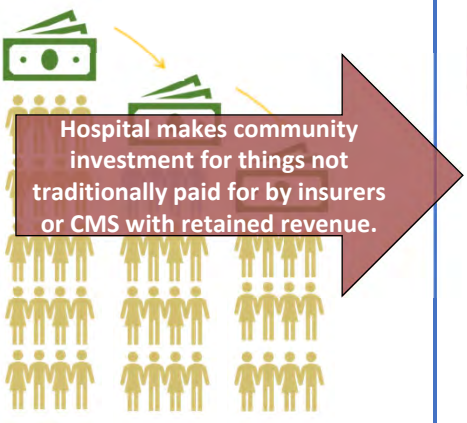
By retaining the revenue associated with the reduced PAU, the hospital can invest in services that promote community wellness

FFS

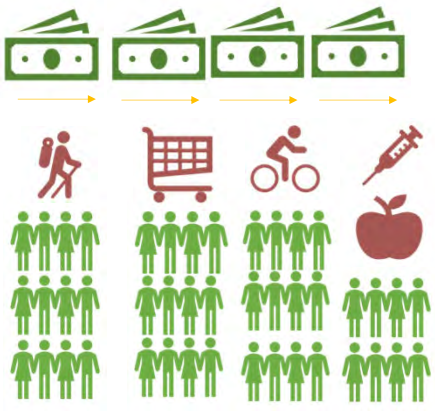
Hospital is paid for the # of healthcare resources consumed by the community, but as the community is getting smaller, so is revenue.



Hospital makes community investment for things not traditionally paid for by insurers or CMS with retained revenue.

Global Budget

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



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Hospitals are taking similar approaches to achieve success in the Model; for those points of commonality, the SDOH strategy provides a platform to achieve program outcomes

Population health outcomes, quality and access

Activities that will make the community healthier and enable financial success for the hospital

Combination of what will help us to meet CMMI measures in Years 3+ and make communities and hospitals successful

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Lessons learned

- Trust is the most important ingredient to make this work
- Broad stakeholder engagement is required for success
- Change is hard – even though the current environment isn't sustainable, adopting a new way of thinking is difficult
  - Perseverance is a must have
- Ensure accurate information regarding methodology is socialized in the hospital community
  - Understand misconceptions and control the message
- Having an organization outside of a governmental entity administrating this work is ideal –
  - Isolate from political volatility
  - Isolate from State procurement processes

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