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Global Budgets and the PA Rural Health Model: Lessons learned from a global budget demonstration program

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Today's Conversation

- An Overview of the Pennsylvania Rural Health Model (PARHM)
- Rural Health Redesign Center and its role
- PARHM participants, goals and model framework
- Impact of the Program - Results
- What's Next?

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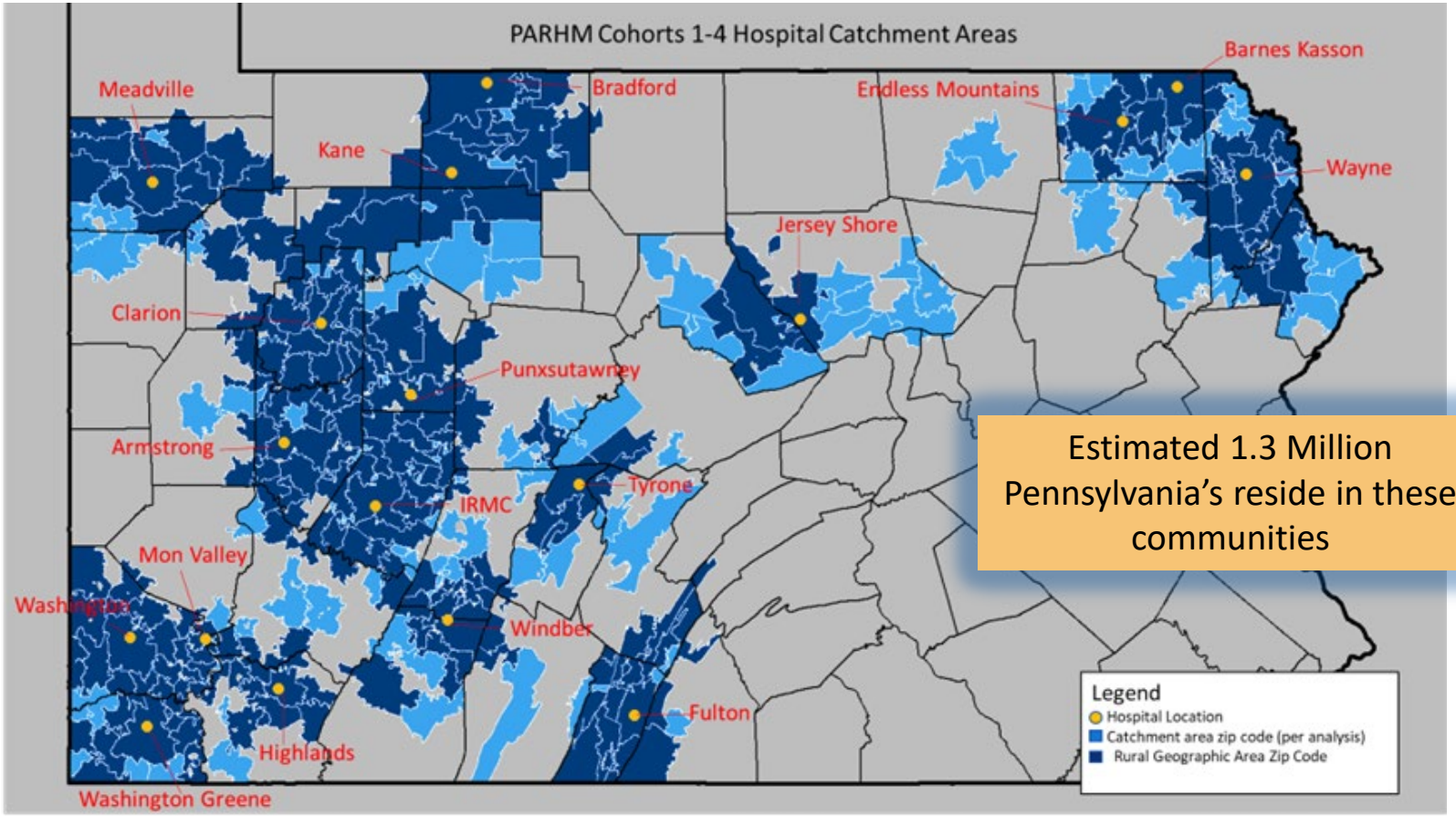
What is PA Rural Health Model?

The Pennsylvania Rural Health Model (PARHM) is an innovative alternative payment model created by the Centers for Medicare and Medicaid Innovation (CMMI). It is the first of its kind, aimed at transforming healthcare, specifically in rural communities. This Model was created to address the financial challenges faced by rural hospitals, transitioning them from fee-for-service to global budget payments.

- Began in 2018
- Current – transition years through 2027
- Rural Health Redesign Center was originally established as a government instrumentality to oversee recruit hospitals to the model and oversee it implementation.
- As the administrator of the program, the RHRC is responsible for overseeing the Global Budget Methodology, Transformation Planning process, and technical assistance provisions to participants.

The PARHM has established significant program scale across the state of Pennsylvania through 18 participant hospitals



Estimated 1.3 Million Pennsylvania's reside in these communities

Payer Covered Lives: 1.02M

Medicare: 125 K

Medicare Advantage: 192K

Commercial: 409K

Medicaid: 295K

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What the PARHM is trying to achieve and how success will be measured.

Outcome Measurements of Success

Financial position of the participant hospitals improve over time

Population health outcomes

- Increased access to care
- Improve chronic disease management and preventative screenings
- Reduction in substance abuse related deaths

Reduction in total cost of care

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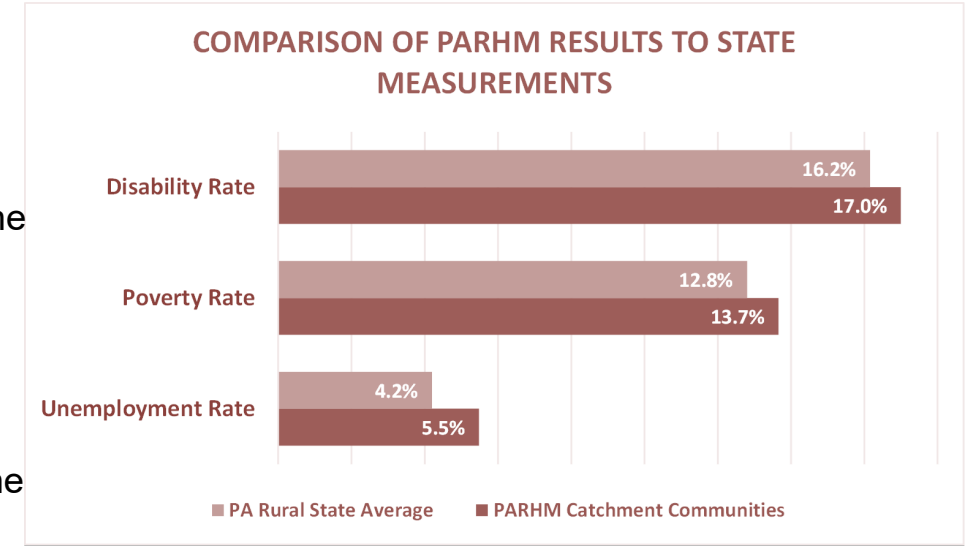
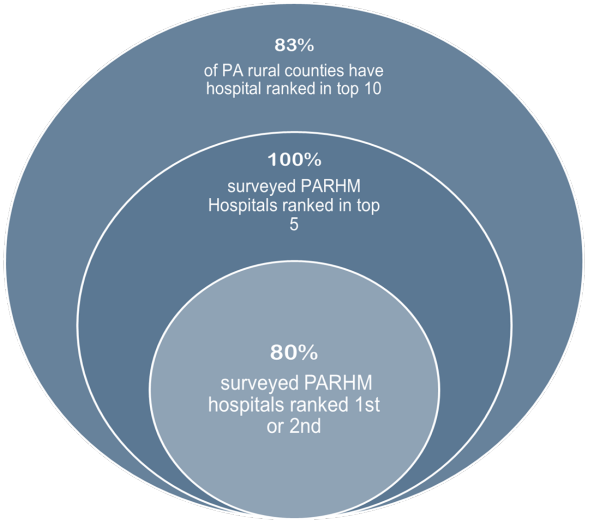
PARHM hospital communities are some of the most critical across the state. An analysis was conducted comparing the participant hospital community average health and economic needs to the state's rural averages.

Findings of this analysis concluded that:

- 100% of PARHM participant hospital communities have unemployment rates above the rural state average.
- 78% of PARHM participant hospital communities have disability rates above the rural state average.
- 67% have poverty rates above the rural state average.
- 50% of PARHM participant hospital communities have unemployment rates, poverty rates, and disability rates above the rural state average.





Despite the high unemployment rates, PARHM participant hospitals are some of the largest employers in the communities.

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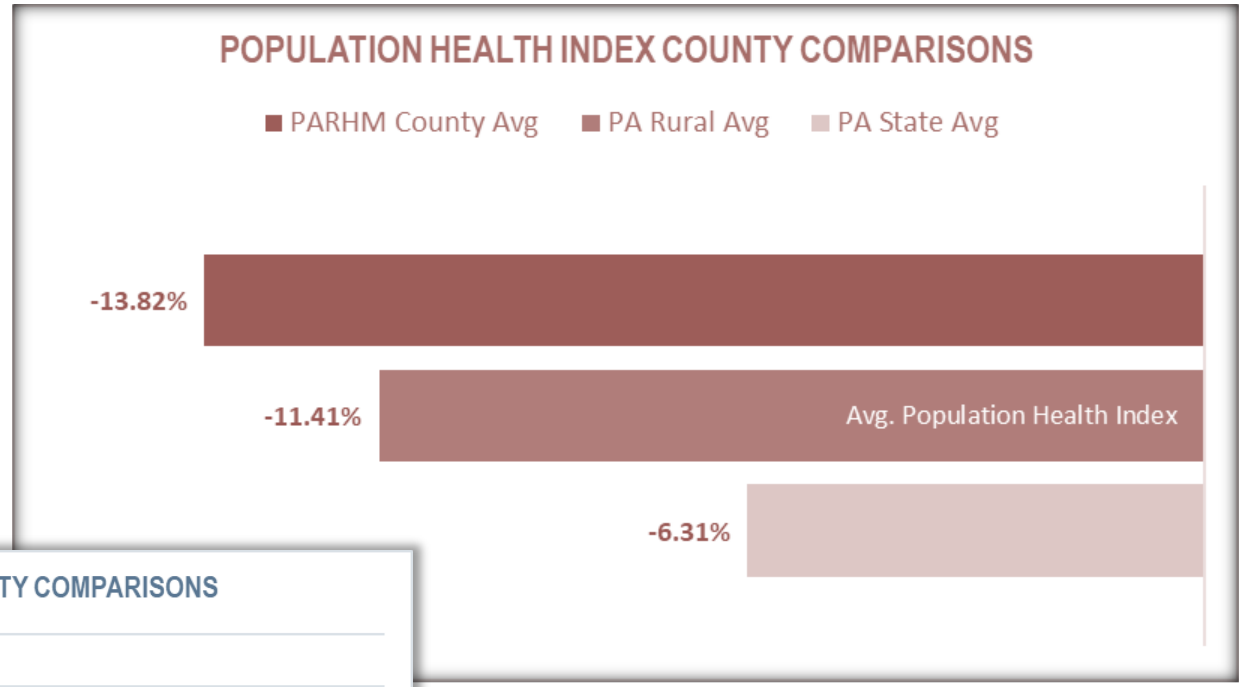
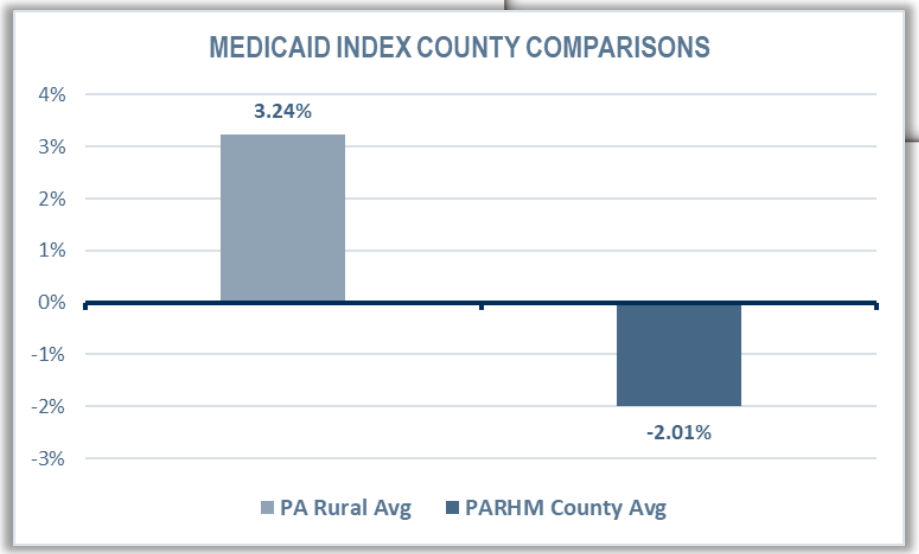
The PA Department of Human Services (DHS) dual index data identifies that PARHM participant counties face poorer health outcomes compared to other areas of the state.





It can be seen in these graphs that compared to state rural and total averages, PARHM communities have poorer values on both the Medicaid and Population Health indexes

Source: *PA DHS data organized by the Center For Rural PA's definition of "rural".*

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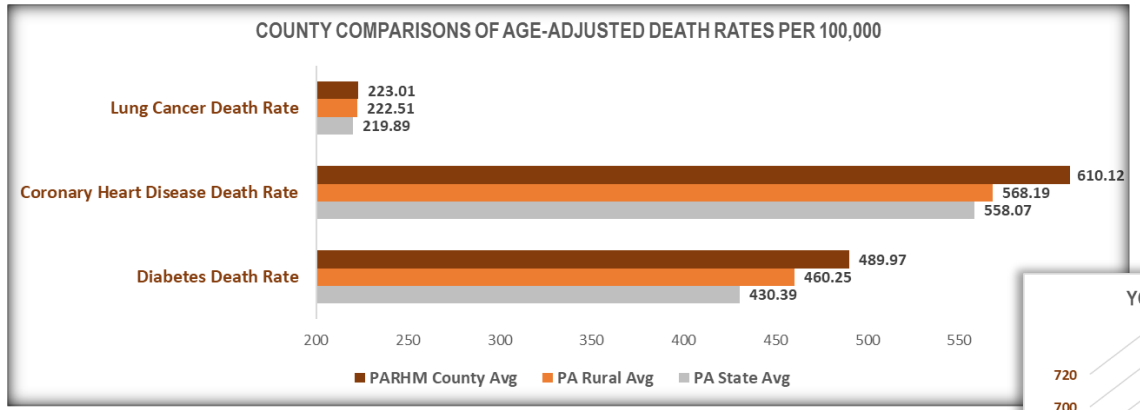
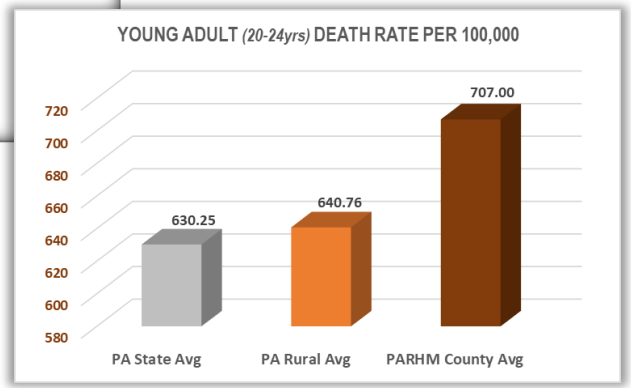
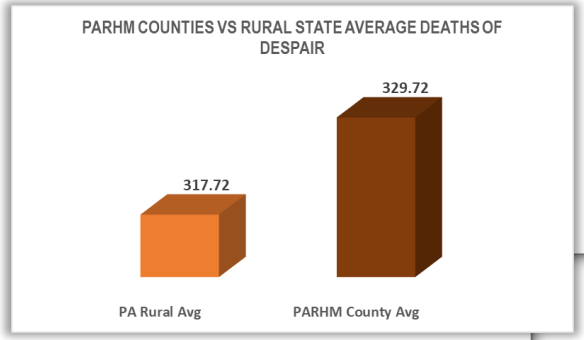
Using DHS health data, a variety of age-adjusted death rates were examined. The graphs below identify that PARHM participant counties have health inequities in all the represented categories compared to state and rural averages.



76%

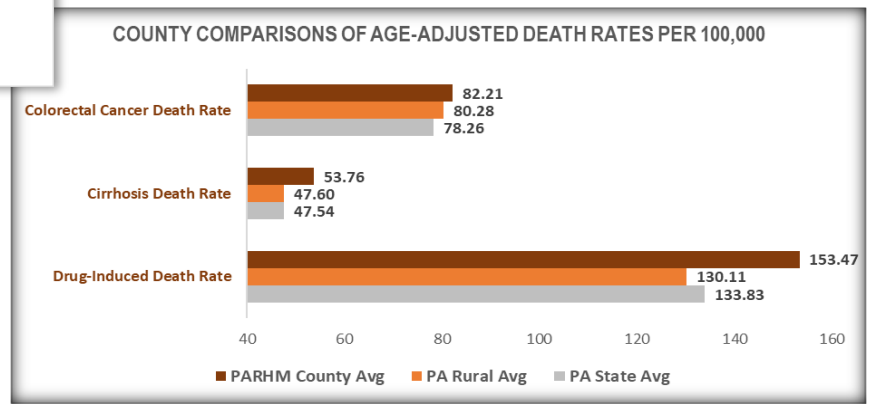
Of the population health metrics examined measured worse for PARHM counties compared to state total, urban & rural averages.





60%

Of participant counties report more deaths of despair than the rural state average.



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Data conclusions –hospitals remaining in these rural communities is essential.

- With efforts of reducing health disparities a major focal point of many agendas, the goal of providing everyone with improved access to care should be prioritized, and rural areas should be no exception.
- Hospitals are the backbone of many rural communities, not only in regard to providing healthcare but also in regard to economic contributions such as spending, salaries, and job opportunities.
- If the closing of these facilities were to occur, the following would be seen as a result:

As evidenced by data, all four of these measures are already inflated in PARHM communities.

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Specifics of the PARHM Model

The Model offers value propositions from a provider's perspective, but many align with payer community goals

	Current Scenario	*Desired End State*	*Model's Value Proposition*
1	Unpredictable revenue tied to FFS volumes	A predictable revenue stream	Model participation provides for a predictable revenue stream that is independent of the level of FFS volume provided within the hospital. It protects from sudden revenue downturns when providers leave and protects it for a period until providers can be recruited.
2	Significant volume driven by potentially avoidable utilization (PAU)	Reduce PAU through enhanced coordination of care efforts, such as care management, to improve community health	If a significant portion of a hospital's volume is driven by PAU, providers are financially rewarded for effectively managing and reducing PAU. Revenue associated with PAU is retained by the hospital, even though utilization decreases. The Model supports providers in reducing PAU by focusing on drivers in and outside of the hospital walls that effect it, such as service line optimization and community needs.
3	Utilization lost to tertiary centers	Bring appropriate utilization back into the community	The Model enables service line analysis and optimization, which aids in bringing appropriate utilization back into the community. It looks at macro-level market shifts and costs across service areas. To the extent more cost-effective care can be provided at the local level, the Model tracks, supports, and rewards providers for doing this.
4	Making significant investment in population health already	Slows the bleeding from the current FFS model that occurs when population health investments are made within the FFS model	By utilizing a "look-back" period, the Model recaptures NPR that may have decreased as a result of investments already made in the community, and allows the organization to retain it. This will slow the financial drain of the FFS model created by doing the right thing for the community.

The Model offers value propositions from a provider's perspective, but many align with payer community goals

	Current Scenario	*Desired End State*	*Model's Value Proposition*
5	The hospital may feel like an island unto itself for strategy development and securing funds for advancing strategies	Collaborative, impactful strategies that improve health outcomes for the local community	The Model provides the mechanism to collaborate with other participant hospitals to learn, problem solve and share best practices. Also, the Model provides a forum for a joint application process to apply for additional funding through competitive grants and possible foundation resources. In addition, it provides access to national rural-health experts as part of the collaboration experience.
6	Lack of technical resources (data analytics, clinical transformation, etc.) due to resource constraints	Robust technical support infrastructure to enable impactful community health outcomes	The Model provides access to technical support for financial and clinical transformation activities without additional cost to the hospital
7	Stifled innovation due to competing day-to-day operational needs, and at times regulatory barriers	Implementation of innovative solutions to meet the needs of the local communities	Model participation allows for: • Potential waivers to national and state policies and regulations that may present barriers to an organization's transformation • The hospital to act as the convener in the community to improve population health and potentially enhance its reputation • Partnerships with payers that establish a cooperative rapport • A potential alternative to the hospital's current state while advancing your community and hospital • Input into a new model of care that has national applicability to solve rural health challenges

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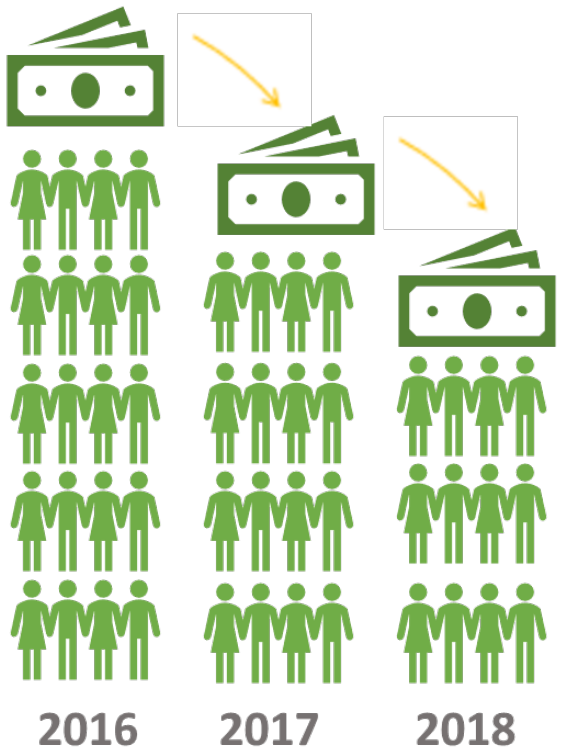
The global budget stabilizes hospital revenue compared to fee for service, which is imperative in rural communities where population is declining

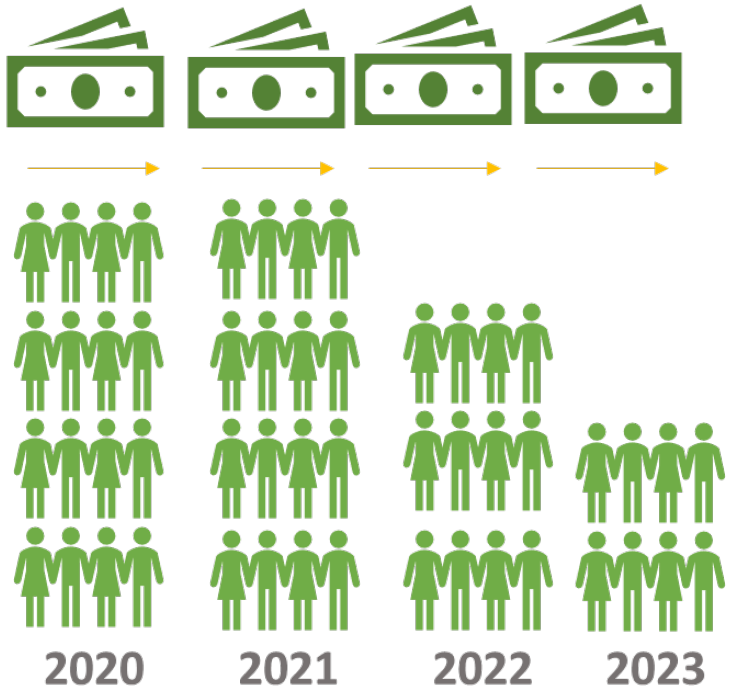
Fee for Service

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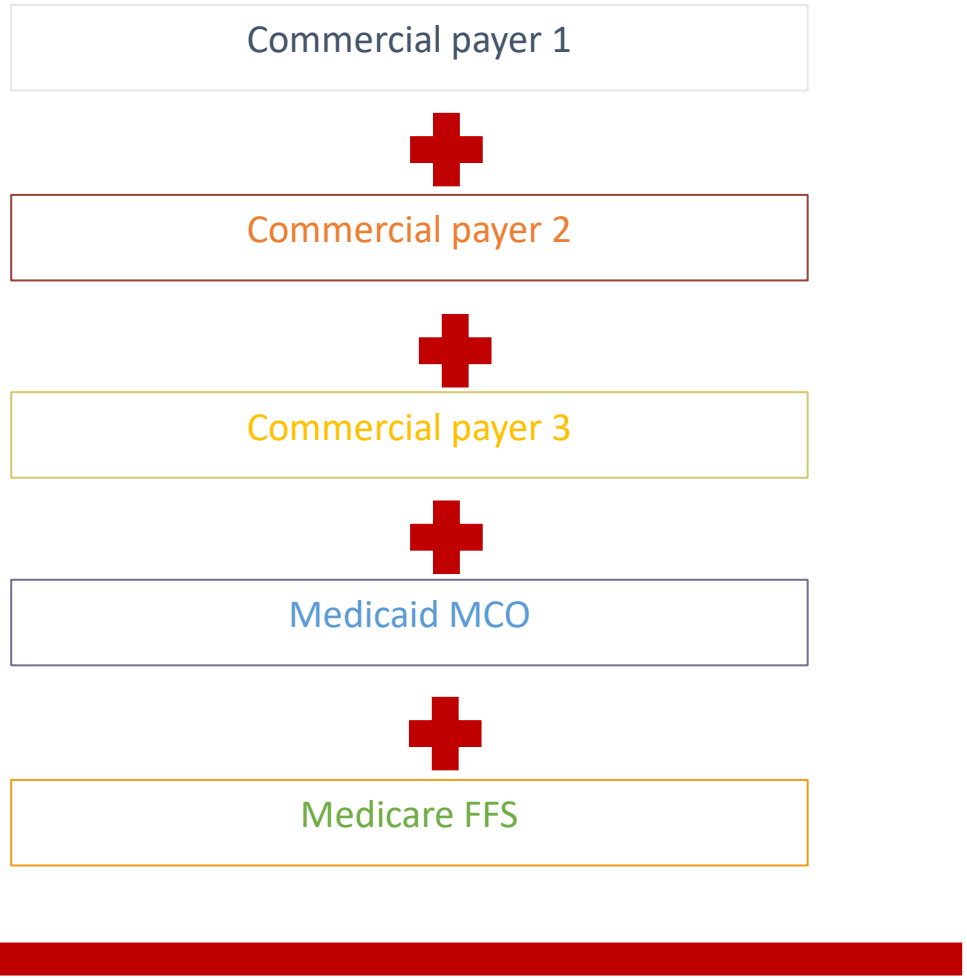
Hospitals and payers establish a budget with all payers using the same logic. Without a global rate setting function, the global budget must be set for each individual payer, and then summarized to arrive at the total global budget amount



Reconciliation and review processes exist to ensure a fair budget is maintained for each hospital

Semi-Annual:

- Payer mix – adjusts for changes in the number of lives covered for commercial insurance plans for services provided

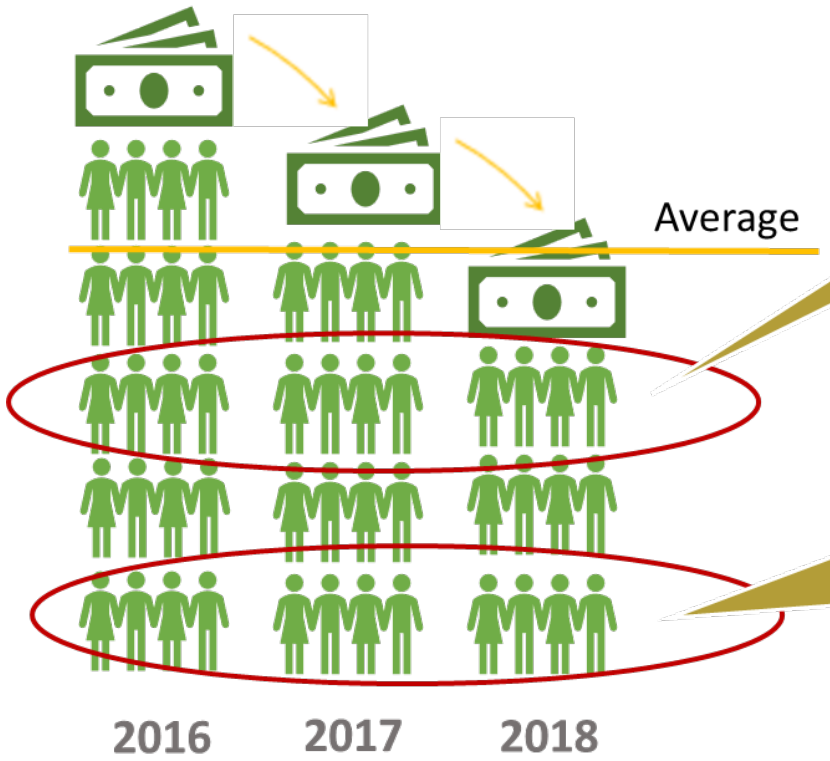
Annual as part of setting the following year's budget:

- Unit price changes
- Unplanned volume shifts - changes as the result of where people choose to receive their healthcare services
- Demographic shifts for Medicare – changes as a result of people leaving or entering the area
- Savings associated with providing the right care in the right setting (e.g. a primary care clinic vs. the emergency department)
- Other adjustments: Additional adjustments / exceptions may be made for exogenous changes (e.g., epidemics)

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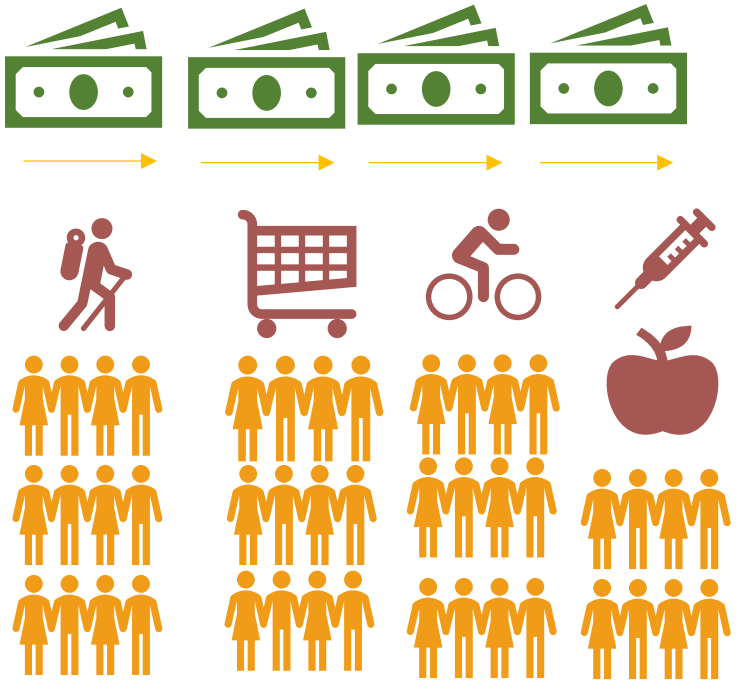
By retaining the revenue associated with the reduced PAU, the hospital can invest in services that promote community wellness

FFS

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

Global Budget

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



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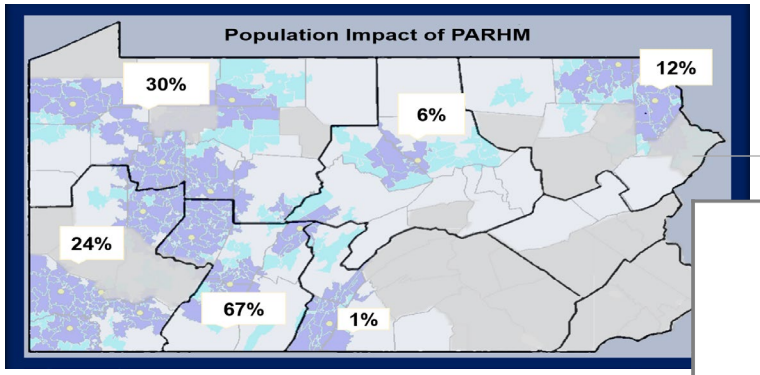
The Value of PARHM

Based on this HAP study, the estimated regional economic impact of the hospitals in the PARHM is $2.4 billion which accounts for almost 18K jobs in these communities

REGIONS	SPENDING CONTRIBUTIONS	SALARY CONTRIBUTIONS	JOBS PROVIDED
Northwest (5 hospitals)	$616M	$229M	4.4K
Southwest (5 hospitals)	$1.0B	$381M	7.7K
Altoona/Johnstown (3 hospitals)	$377M	$138M	2.7K
North and South Central (2 hospitals)	$141M	$57M	1.1K
Northeast (3 hospitals)	$226M	$82M	1.9K
TOTAL	**$2.4B**	**$886M**	**17.8K**

The PARHM participant hospitals can be estimated to impact 10% of the state population, contribute 5% of total spending, and produce 6% of salaries and job opportunities.



Provided by PARHM Catchment Zip Code Data

10%
Population Covered for Pennsylvania

5%
Spending Contributions for Pennsylvania

6%
Salary Contributions for Pennsylvania

6%
Job Contributions For Pennsylvania

SOURCE: *Hospital and Healthsystem Association of Pennsylvania's (HAP) 2020 analysis of FY 2019 data: Beyond Patient Care: Economic Impact of Pennsylvania Hospitals, coupled with the regional map of Pennsylvania provided by PHC4*

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Medicare PQI Data for participant communities indicate that favorable improvement is being realized as admission associated with PQIs has been reduced over the program's performance periods.

Medicare RGA Utilization by Top Diagnosis

PQI Description	YOY Change 2020-2019	YOY Change 2021-2020	YOY Change 2022-2021	Medicare MQI Improvement
Heart Failure Admission	(102)	190	(147)	(59)
Community-Acquired Pneumonia Admission	(258)	(54)	17	(295)
Urinary Tract Infection Admission	(169)	39	6	(124)
COPD or Asthma in Older Adults	(427)	(80)	(8)	(515)
Diabetes Long-Term Complications Admission	(158)	(5)	(8)	(171)
Lower-Extremity Amputation Among Patients with Diabetes	(19)	4	2	(13)
Hypertension Admission	(40)	(14)	(20)	(74)
Uncontrolled Diabetes Admission	(20)	2	(12)	(30)
Diabetes Short-Term Complications Admission	(25)	4	(1)	(22)
				(1,303)

Using data as provided for global budget calculations, it is clear there is positive impact on PAU rates at participant hospitals across the program.

All Payer ED PAU Trending

Cohort	Baseline Year	2019	2020	2021	Favorable Trend
Cohort 1	39.6%	38.6%	35.4%	30.3%	Yes
Cohort 2	39.3%		34.6%	24.5%	Yes
Cohort 3	38.7%			25.2%	Yes

All Payer Inpatient Re-Admit PAU Trending

Cohort	Baseline Year	2019	2020	2021	Favorable Trend
Cohort 1	6.5%	5.3%	5.1%	4.2%	Yes
Cohort 2	8.0%		5.4%	5.1%	Yes
Cohort 3	7.3%			5.9%	Yes

All Payer Inpatient ASC PAU Trending

Cohort	Baseline Year	2019	2020	2021	Favorable Trend
Cohort 1	20.3%	23.4%	18.3%	19.4%	Yes
Cohort 2	17.0%		16.4%	14.5%	Yes
Cohort 3	17.1%			14.2%	Yes

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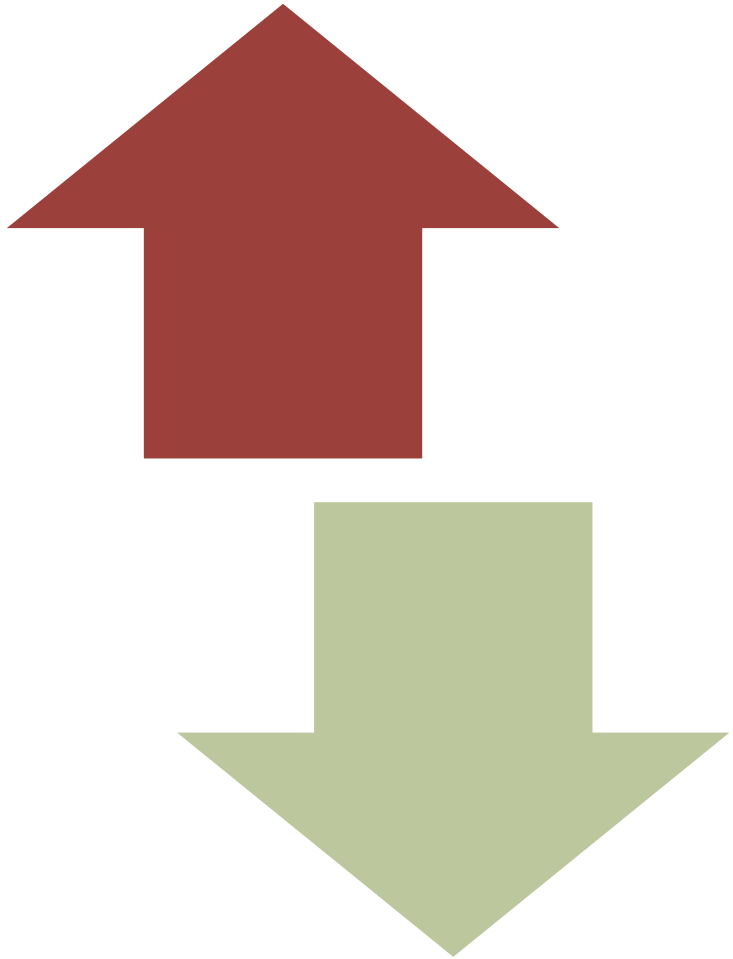
Data supports that the transformation planning processes are impacting avoidable utilization at the participant hospitals. As we continue to evolve the program, the goal is to continue this trend and impact TCOC beyond the walls of the participant hospital.



Increased transformation planning

Decreased avoidable utilization

What were the original goals of the PARHM?

Because the global budget stabilizes cash flow, hospitals are incentivized to invest in community health.

#1: Financial Stability

- Financial position of participant hospitals improve overtime.

#2: Population Health Outcomes

- Increased access to appropriate care
- Improve chronic disease management & preventative screenings
- Reduction in deaths related to substance use disorder

#3: Savings

- Reduction in total cost of care

No PARHM hospitals have closed since joining the Model, despite impacts of the COVID19 Pandemic

"The PARHM has helped us shift from providing sick-care to providing healthcare."
-PARHM Participant

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A few points to remember and lessons learned

Key Messages

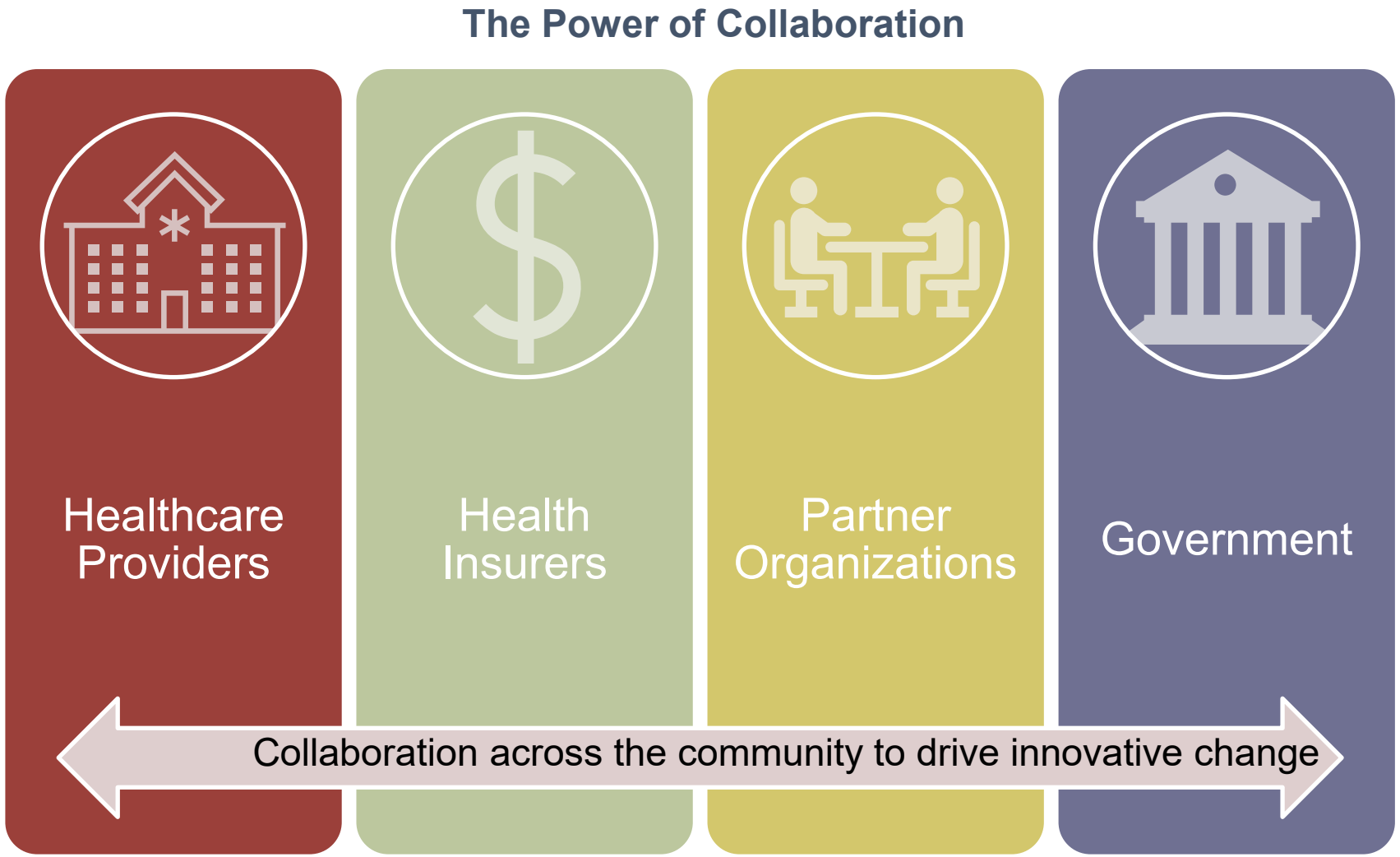
Change is hard -

- Even though the current environment isn't sustainable, adopting a new way of thinking is difficult for healthcare leaders, Board of Directors, clinicians, etc.
- The paradigm requires a different mindset – takes discipline to think differently
- Overcoming fear of the change takes time
- Even when rural leaders want to adopt the change, there are often other circumstances that prohibit them from doing so *(competing priorities, bandwidth issues, etc.)*

Data, Data, Data

- Timely Data is essential
- Lack of data will stifle innovation

Engagement with the broader community is needed to achieve the next level of success, and position all of us to sustain rural healthcare



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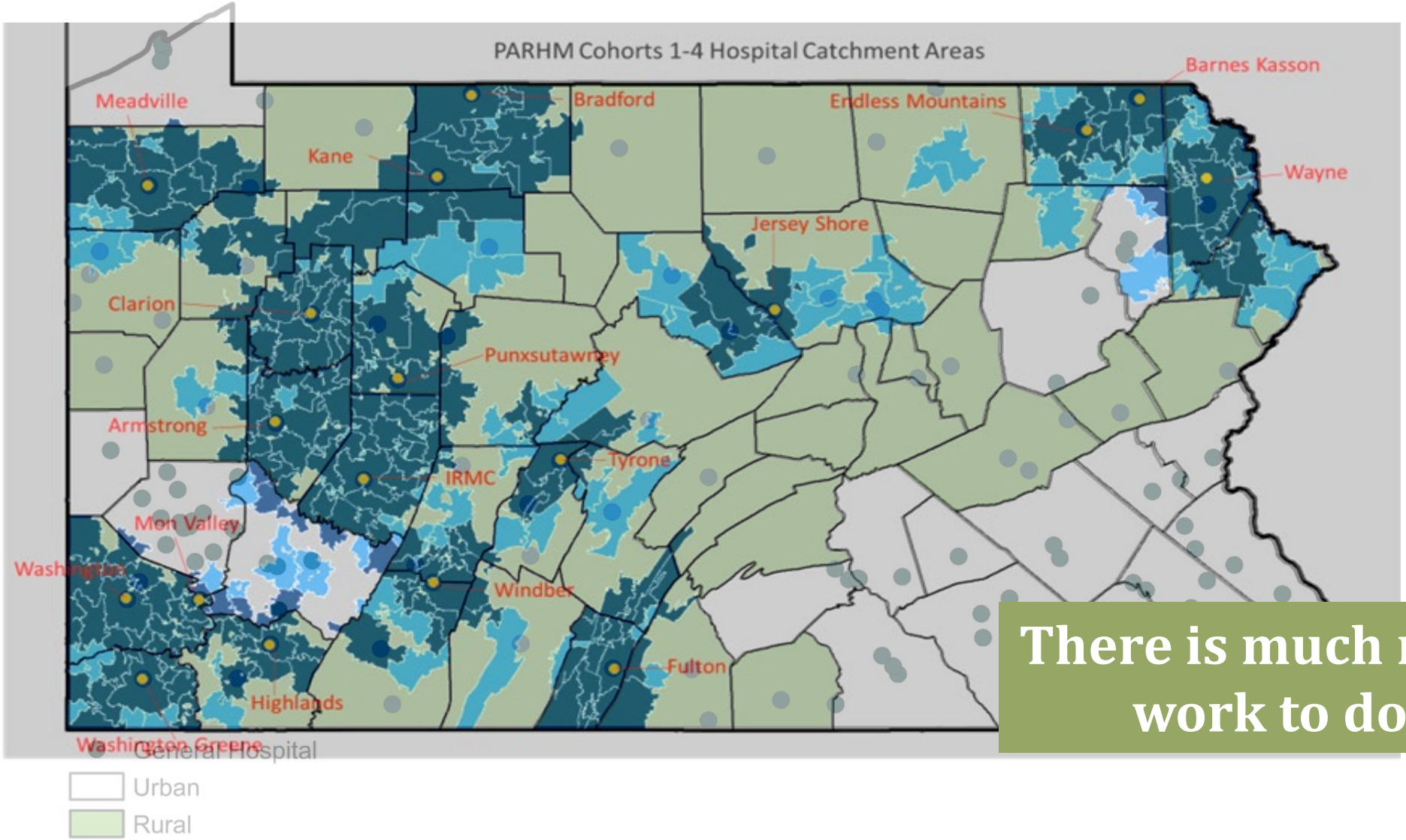
While the current program established significant scale across the state of Pennsylvania…



There is much more work to do.

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What's Next?

The RHRC, in coordination with current participants and other key stakeholders, is actively working to leverage the lessons learned through the PARHM to create a next-generation solution that will continue to provide high-quality healthcare to rural communities beyond the program's current sunset.

Questions
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