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Pennsylvania Rural Health Model

Accelerating Health Care Innovation in Pennsylvania

Idaho Forum on Value-based Application to Rural Health Systems

October 2019

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Part 1:

- Provide a brief history and overview of the Model
  - Its inception
  - Current state of the program
  - Model governance
- Provide key concepts of the methodology
  - Global Budgets
  - Transformation planning
- Share a few lessons learned
- What States should be thinking about
- Answer questions

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Brief history and overview

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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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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 by 2021
  - Increase payer participation to grow global budget revenue

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A key design component of the Model is the creation of an independent authority to administrate the Model. This entity will be created by the PA legislature.

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- The Model Administrator is currently the PA Department of Health

- Planned future Model Administrator is the Rural Health Redesign Center (RHRC):
  - An independent authority established through legislative action with a governing board
  - Legislation introduced in both the House and Senate

- Vision for the RHRC is oversight of PA Rural Health Model, and potential resource to other states interested in implementing global budgets.

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Methodology Overview

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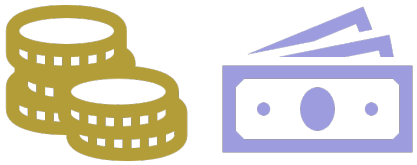
There are two core tenants that make the Model different from FFS that work in combination to create different incentives for hospitals



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

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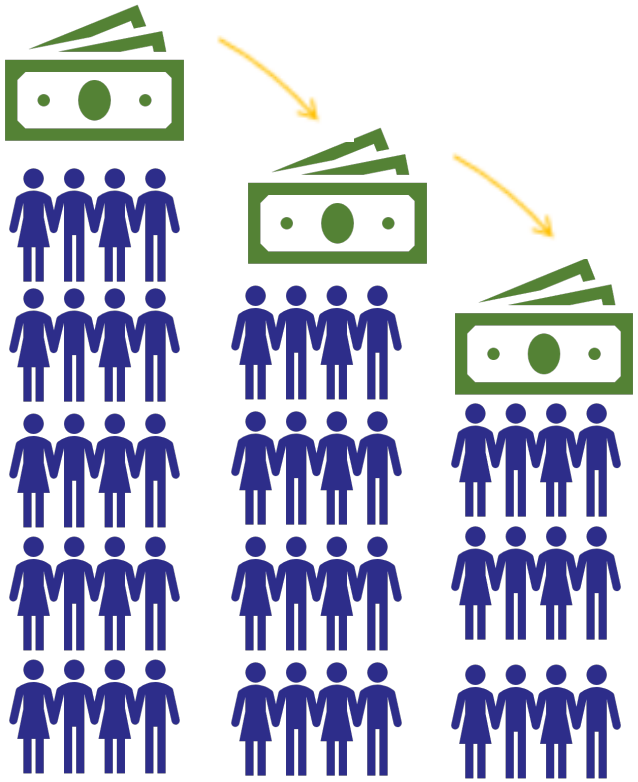
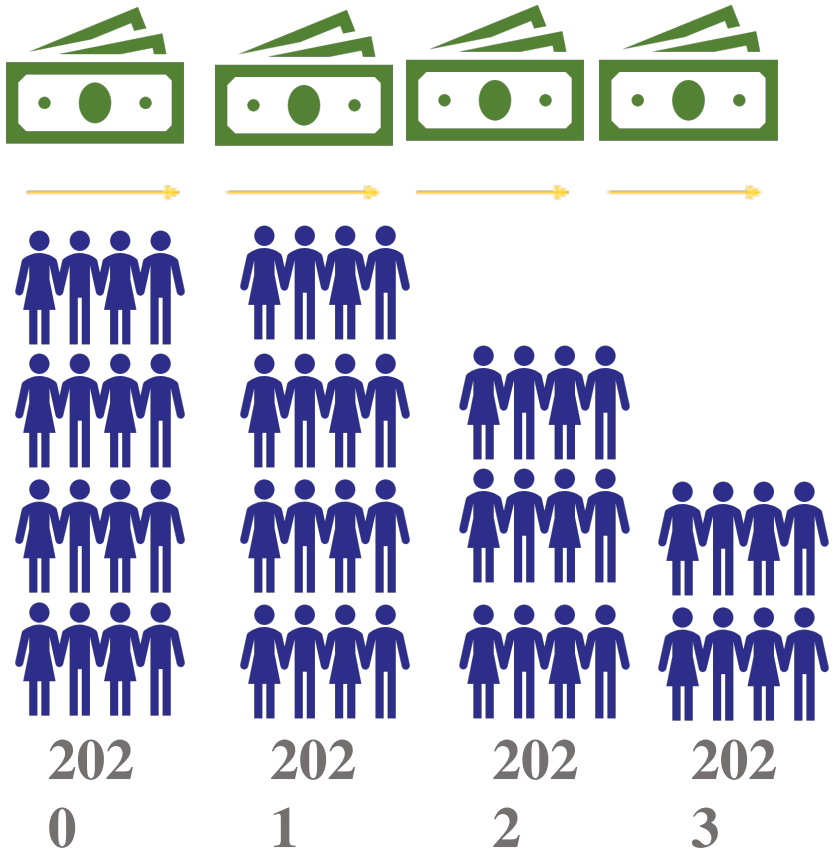
Fee for Service

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

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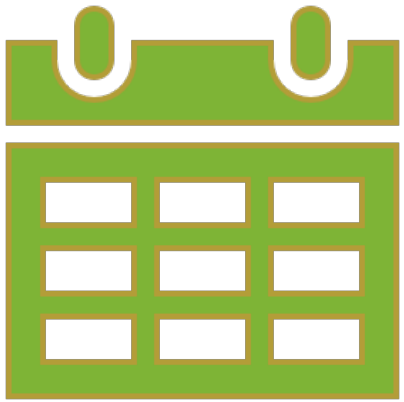
2019 Goal: 75%

2020 Goal: 90%



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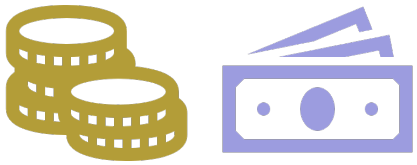

The Model stabilizes cash flow from all participant payers

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

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

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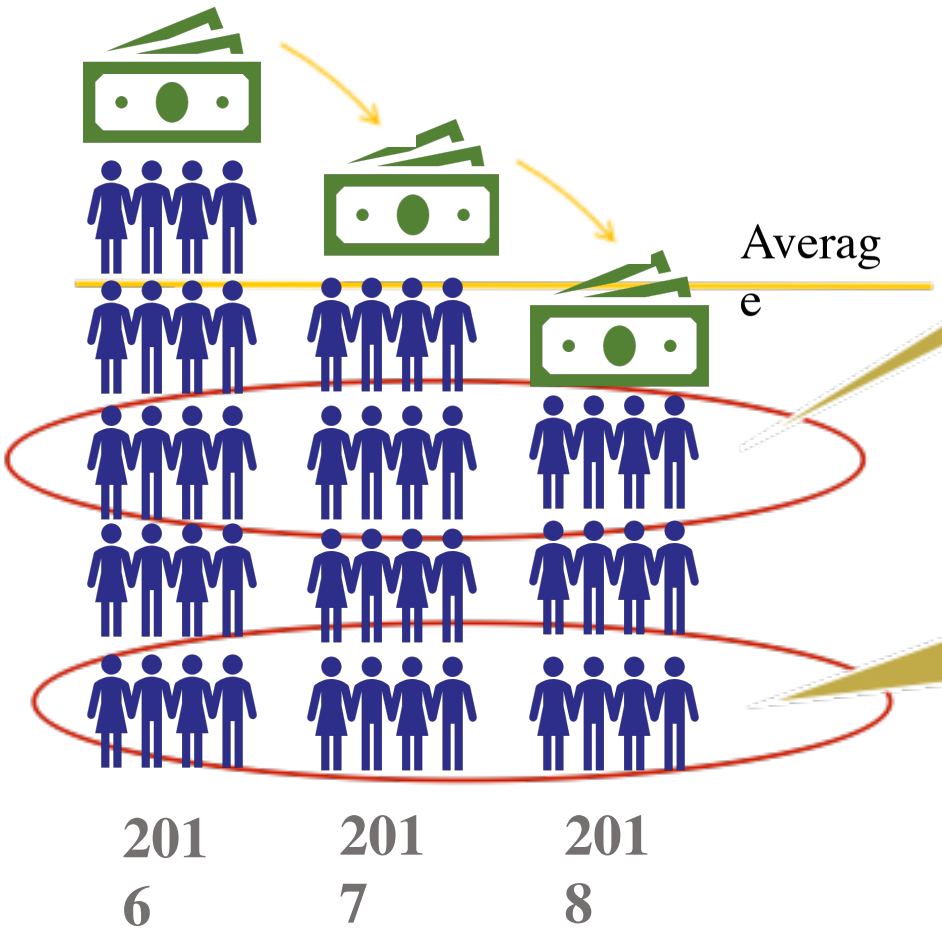
FFS Revenue

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 o 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

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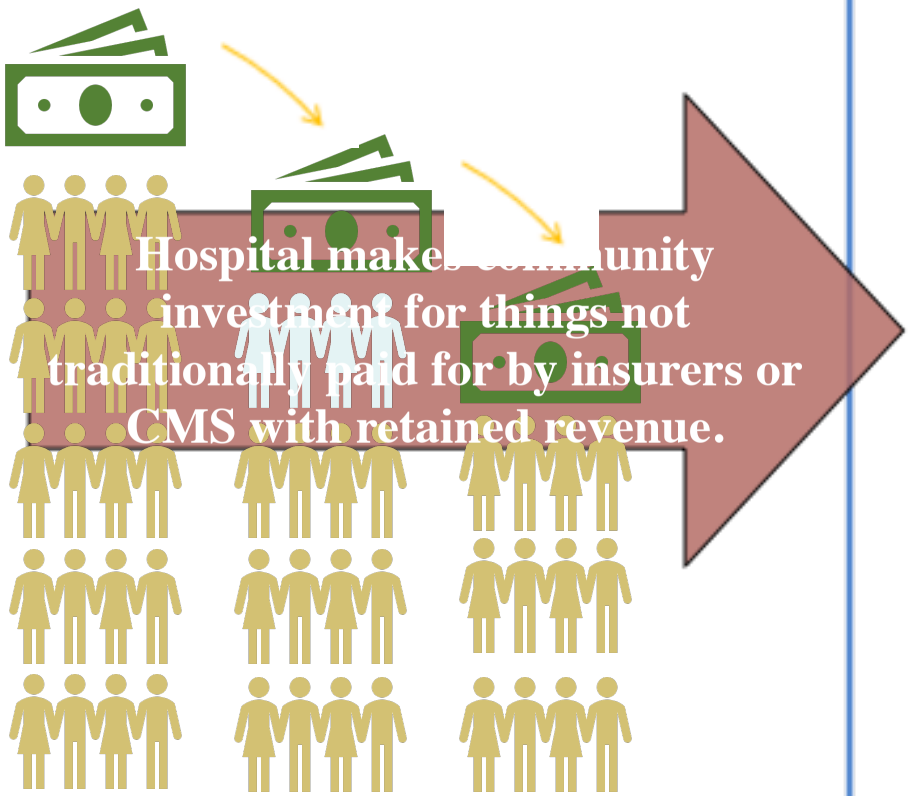

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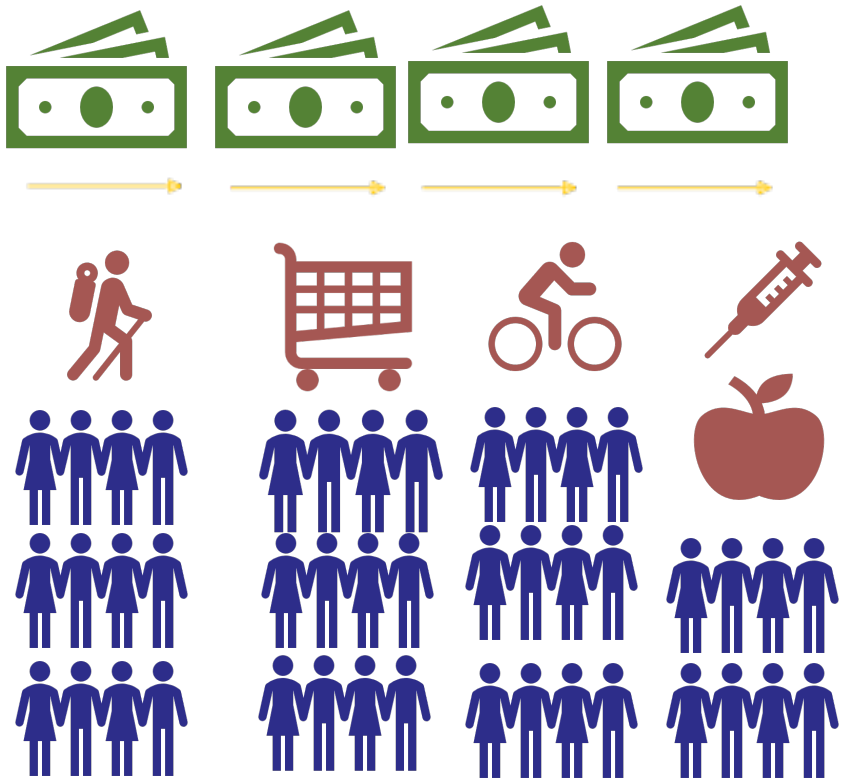

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In looking across hospital and community priorities, there are many opportunities for collaboration among hospitals and the need to develop a multi-year strategy

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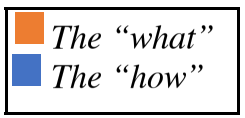
Clinical and SDOH Strategy Drivers



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In Year 2+, the SDOH strategy will expand and focus more on what is outside of hospital walls; but, for now, hospitals will focus on areas for immediate impact

Multi-Year SDOH Strategy

Communities are encouraged to tackle these important determinants as the need arises in their community, and the DOH/RHRC will work to connect them with resources. Yet, the strategy will target areas of high-impact that have a critical mass of hospitals interested the participate. We will work as a cohort to develop frameworks, toolkits, and implement best practices, and the DOH/RHRC will focus on bringing resources to bear for these topics.

Lessons learned and considerations

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A few lessons learned

- Trust is the key ingredient needed to make this work
- Identify who will serve as the Model Administrator
  - Having an organization outside of a governmental entity administrating this work is ideal
- Change is hard – even though the current environment isn't sustainable, adopting a new way of thinking is difficult
- Basis for payment has to be changed first, before we can ask people to think innovatively, especially in rural settings
- Access to data, and timely data, will be key to program success.
- Keep transformation goals to a few so hospital can experience early wins
- Broad stakeholder engagement is required for success

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Key considerations for States

- Key stakeholder engagement (not exhaustive)
  - Hospital Leaders
  - Commercial Payers
  - CMMI / CMS
  - Governor's Policy Office
  - Department of Health
  - Department of Human Services
  - Pennsylvania Insurance Department
  - Hospital Association
  - Office of Rural Health
  - Other trade associations

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Key considerations for States

- This is a journey:
  - PA has been at this for several years
  - Resiliency is key
- Begin the conversation regarding the needs of the various stakeholders and desired outcomes
- What current value based work is already underway and how this can be leveraged in the program

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A Hospital's Perspective

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Contact information:

Janice Walters, Chief Operating Officer Consultant

Rural Health Redesign Office

Pennsylvania Department of Health

9th Floor West | Health & Welfare Building | Suite 903

625 Forster Street |Harrisburg, PA 17120-0710

Phone: 717.903.6895

Email: c-jawalter@pa.gov

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