PA Rural Health Model

Accelerating Health Care Innovation in Pennsylvania
April 2018
Rural hospitals provide essential health care services and are pillars of their communities, but many are struggling to stay open.

**Republican Herald**

**April 22, 2012**

Saint Catherine’s demise ends 130 years of health care legacy

“The closing … leaves a gap in local health care in the northern Schuylkill County”

“The bankruptcy and closure left about 160 employees out of a job, with many still owed for up to six weeks in back pay.”

**Republican Herald**

**April 30, 2014**

Mid Valley Hospital to stop acute care and emergency room services

“It’s a tremendous blow,” [said Lori Williams, M.D., president of the Lackawanna County Medical Society.] The Scranton hospitals are fantastic, but in an emergency, it’s right here. … People always chose to go there, instead of waiting an hour or two at one of the Scranton hospitals.”

“Chet Potoski, 60, … was concerned with the longer drive to an ER now, but said the closing was a sign of the times, based on “economics.””

**Politico Magazine**

**October 3, 2017**

Rural Hospitals Are Dying and Pregnant Woman Are Paying The Price

“At least 81 rural hospitals have shut down across the country since 2010”

“Three years ago, Lucia Parker gave birth … and the nurses attending her were family friends. … But this February, when her second baby is due … she plans to drive an hour-and-a-half … on mountain roads that could be slick with ice and snow, to give birth in a room with nurses and staffers who are strangers. “I have no idea how that’s actually going to work,” she says. “I am not gonna know anybody when I have this baby.”
Pennsylvania rural hospitals face poor operating margins

The majority of rural Pennsylvania hospitals report low and declining operating margins.

Rural hospitals operating margin breakdown: 2016

Percent of hospitals

- <0: 34
- 0-3: 21
- >3: 45

Nearly half of rural hospitals reported negative operating margins in 2016, with 66 percent reporting operating margins of 3 percent or less.

SOURCE: Pennsylvania Health Care Cost Containment Council
Rural hospitals are facing challenges due to financial instability and a system that dis-incentivizes visionary transformation.

Rural hospitals are essential to their communities...

1. Provision of vital services to local communities, enabling lower transport times to the ER and closer access to general healthcare needs for a population.

2. Personal and familiar to members of the community, including many pre-existing relationships between patients and healthcare providers.

3. Economic pillars of the community as a significant employer in most communities and an anchor for local goods and services.

...but are facing two primary challenges.

- Lacking financial stability and predictability.
- Dis-incentivized to transform to meet community needs.
Rural hospitals are challenged for many reasons

- Patients tend to be older, sicker, and have more chronic diseases.
- There are a larger number of uninsured patients.
- Equipment is very expensive.
- Specialists are difficult to recruit.
- There are significant physician shortages.
- Operating expenses continue to increase.
- Patients may travel to urban areas for health care services.
- There is a national trend of declining inpatient admissions.
Pennsylvania’s response is focused on ensuring access to quality care and improving health outcomes in rural communities

Guiding principles in developing response

1. Utilize latest promising practices in meeting rural health community needs

2. Engage communities, payers, providers, private sector, and national thought leaders to bring best solution forward

3. Pursue models that are nationally scalable

4. Ensure stability for rural communities and care providers through a public-private partnership

5. Direct investments toward transformational solutions, including achieving a budget-neutral rural health care delivery system over time
The pillars of the PA Rural Health Model—the global budget and transformation support—address these core challenges

**Current challenges for rural hospitals**

- **Lacking financial stability and predictability**
  - Fixed annual revenue (global budget)
    - The global budget is fixed annually and paid out by the payers to hospitals monthly, providing a stable stream of revenue
  - The global budget is calculated based on historic net patient revenue data, adjusted for transformation-related annual service changes
  - Volume-independent, stable cash flow will allow investment in care quality and population health

- **Dis-incentivized to transform for community needs**
  - Incentives and support for transforming to meet community needs
    - Model incents provision of lowest-cost quality care, encouraging hospitals to focus on innovative population health strategies
    - DOH will provide tailored, end-to-end assistance at no cost to enable hospitals to focus on successful transformation
    - Support across all transformation phases: data collection, plan creation, implementation progress

Solutions within the model
The Model provides financial stability lacking under today’s system and incentives population health focused transformation

Fee for service reimbursement creates hurdles

- Unstable and unpredictable financials
  - Decreasing revenues, increasing costs, and decreasing operating margins
  - Outstanding payables, and unpredictable receivables

Global budget model corrects incentives

- Predictable and stable cash flows
  - Predictable, historically based annual revenues without in-year fluctuation
  - Stable, dependable cash flows

Revenue in flows
Costs

Healthy populations hurt bottom line

- Incentivized for inpatient admissions volume
- Dis-incentivized from investments without direct, substantial reimbursement (i.e. care management, outpatient/primary care, and healthier populations)

Incentives to invest in population health

- Incentivized to transform to meet community needs and keep populations healthy
- Rewarded for identifying lower cost, higher quality delivery options like primary, urgent, and tele care

Investments in population health
Decreased utilization

Less profits overall

Investments in population health
Decreased utilization

More profits overall
And each provider will define its own transformation plan, leveraging three key opportunities to succeed under the model

**Description**

- Reduce hospital care (e.g., reduce # of readmissions, # hospitalizations, length of stay) that is unplanned and can be prevented through improved quality, care management, coordination and clinical operations.

- Improve hospital's ability to provide care in the most cost-effective manner (e.g., reduce operating expenses per admission) by optimizing processes and capabilities.

- Generate optimal revenue (e.g., by increasing appropriate outpatient and inpatient volume) from service lines and community programs that align with hospital and population needs and improve the patient care experience.

**How can providers succeed by adopting Global Budgets?**

- **Reduce Costs**
  - Reduce potentially avoidable utilization
  - Improve operational efficiency

- **Optimize Revenues**
  - Optimize service profile

In developing transformation plans, hospitals will analyze opportunities across:

- Population groups (e.g., chronic conditions, behavioral health)
- Care settings (e.g., Pre-acute, acute and post-acute)
- Patient care journey (e.g., prevention, treatment and follow-up)
The RHRC is critical to support the Model

The Rural Health Redesign Center (RHRC) will …

- Be created through legislative action
- Provide crucial support to rural hospitals through quality assurance, data analytics, and other forms of technical assistance
- Provide support for hospitals to engage and work with rural community partners (i.e., employers) to improve local health status
- Help rural hospitals identify solutions for critical challenges, including access to broadband, transportation, and behavioral health services
The RHRC will help PA become a leader in rural health

The RHRC will provide the opportunity to develop **concentrated expertise** in rural health care delivery, including financing, population health, research, rural health transformation, and economic vitality.

The RHRC will provide **free technical assistance** and **consistent support** to participant rural hospitals that otherwise would be extremely difficult for these hospitals to access.

PA is increasingly being recognized as a **leader in rural health**

- First state to administer the **Rural Health Model**
- The Model could be expanded across the country
- Other states are looking to PA for rural health care solutions
Model participants will be supported by multiple stakeholders

1 CHNA provides initial baseline
Anticipated timeline of model rollout

- **Collaborating in planning and budgeting**
- **Signed contract and initiated transformation**
- **Receiving global budget payments**

**Target of 30 hospitals, but may accept more**

<table>
<thead>
<tr>
<th>Year</th>
<th>Program</th>
<th>Pilot hospital</th>
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</thead>
<tbody>
<tr>
<td>2017</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>2018</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>2019</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>2020</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>2021</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td>2022</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td>2023</td>
<td>30</td>
<td>12</td>
</tr>
</tbody>
</table>

**Program Timeline**
- **2018**
  - Preparation phase incl. budget calculation initial transformation plan development
- **2019**
  - Global budget goes live on Jan 1\(^{st}\) 2019
- **2023**
  - 5-year global budget program
    - 100% PAU savings retained in 2019, 2020
    - 75% in 2021
    - 50% thereafter
We are providing a range of technical assistance to support transformation planning for interested providers.

<table>
<thead>
<tr>
<th>Community &amp; provider assessment</th>
<th>Comparative assessment</th>
<th>Exploration</th>
<th>Evaluation</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Introduce model and commitment</td>
<td>• Aligning on transform-</td>
<td>• Familiarize hospitals with transformation</td>
<td>• Prioritize “strategic priorities”</td>
<td>• Develop a transformation plan, including:</td>
</tr>
<tr>
<td>• Assessment of community health</td>
<td>tion vision</td>
<td>areas/ levers/ interventions (Playbook)</td>
<td>• Definition of year 1 expectations and interventions</td>
<td>• Community needs</td>
</tr>
<tr>
<td>needs and hospital performance on</td>
<td>• Sharing synthesis of</td>
<td>• Produce shortlist of opportunities</td>
<td>• Develop high-level work plan</td>
<td>• Capabilities assessment</td>
</tr>
<tr>
<td>key levers through</td>
<td>capability assessment and benchmarking</td>
<td></td>
<td>with targets, milestones, responsibilities, timeline, etc. for strategic priorities</td>
<td>• Strategic priorities (w/ targets, financial plan etc.)</td>
</tr>
<tr>
<td>— Data request</td>
<td>• Sharing transformation plan template</td>
<td></td>
<td></td>
<td>• High-level action plan</td>
</tr>
<tr>
<td>— Self-assessment</td>
<td>• Provide example of how to identify potential strategies</td>
<td></td>
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<table>
<thead>
<tr>
<th>Main touchpoint</th>
<th>Support provided</th>
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</thead>
<tbody>
<tr>
<td>• Individual call/e-mail to provide timeline and introduce data request and self-assessment</td>
<td>• Template and self-assessment tool</td>
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<tr>
<td>• Workshop (half day)</td>
<td>• Facilitation; Opportunity identification</td>
</tr>
<tr>
<td>• Hospital check-in call (~1-2 hrs with follow-ups as needed)</td>
<td>• Intervention playbook; technical assistance</td>
</tr>
<tr>
<td>• Workshop / working session</td>
<td>• Facilitation; Templates; Financial simulation</td>
</tr>
<tr>
<td>• Regular working sessions/calls</td>
<td>• Drafting of some transformation plan elements; technical assistance as needed</td>
</tr>
</tbody>
</table>

In progress with initial set of interested hospitals.
The Model allows hospitals to create new visions

Rural hospital CEO goals for transformation

- “I want to create a hospital without walls”
- “We want to see more nights patients sleep in their own beds”
- “Our hospital will manage population health rather than just provide health care services”

Specific goals hospitals want to pursue

- Expand behavioral health and substance use disorder services
- Offer certified community health worker education programs
- Combine emergency medical services with neighboring areas to increase coverage when needs arise
“The PA Rural Health Model will open the door to new and innovative solutions for PA citizens who live in rural communities to have greater access to health care closer to home.”

– Adam Dimm, CEO of JC Blair Memorial Hospital, Huntingdon County PA
Questions?
Profitability under global budget model

1. **Revenue**
   - Baseline

2. **Planned prospective adjustments**

3. **Corrections for unplanned market shifts**

4. **Potentially avoidable utilization: fraction shared with payers**
   - As savings are generated, most of the related revenue remains in the budget (100% in years 1 and 2, 75% in year 3, 50% thereafter)
   - Hospitals no longer pay for costs of providing care from avoided utilization (while keeping revenue)

Profit

Baseline + Planned prospective adjustments + Corrections for unplanned market shifts = Profit

Illustrations available
What is included in Net Patient Revenue (NPR) when calculating the global budget is based on type of facility and type of service

**Included facilities¹:**
- Acute care hospitals
- Critical access hospitals (CAH)

**Included services²:**
- **Inpatient hospital services**
  - ED
  - Lab
  - Imaging
  - E&M services
  - Same day surgery
  - Other OP services
- **CAH swing bed services**

**Excluded facilities:**
- Post-acute care institutions (e.g. skilled nursing facility)
- Dialysis facility
- Ambulatory surgery centers or other special facilities

**Excluded services include:**
- Professional services (inpatient and outpatient)
- Dental services
- Durable medical equipment
- Home health services
- Swing bed services (at acute care hospitals)
- Clinic services (incl. rural health clinic, community mental health clinic, federally qualified health centers)

- The Global budget excludes operating revenue outside of NPR such as existing earned quality, pay-for-value, or value-based payments or other supplemental payments (e.g., DSH)
- Behavioral health inpatient admissions or outpatient services at acute hospitals or CAHs are included in the global budget; however, those at stand-alone BH facilities (e.g. CMHCs, psych hospitals) are excluded

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1. Identified using taxonomy codes 282N00000X and 282NC0060X
2. Identified using type of bill codes with 1st 2 digits 11 or 41 for IP and 13 or 85 for OP
Understanding how to measure success can drive the transformation

<table>
<thead>
<tr>
<th>Metric description</th>
<th>Preferred outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case-adjusted average length of stay</strong></td>
<td>• Prefer <strong>lower numbers</strong> as it indicates fewer patient days spent in the hospital, therefore saving utilization</td>
</tr>
<tr>
<td>Determined by multiplying the case mix index (CMI) by the average length of stay, which is calculated by dividing the sum of all inpatient days in adults &amp; pediatrics, CCU, ICU, nursery, and burn, surgery and special care ICUs by total hospital admissions. CMI * Inpatient days Total hospital admissions</td>
<td></td>
</tr>
<tr>
<td><strong>Readmissions rate</strong></td>
<td>• Prefer <strong>lower numbers</strong> as it indicates fewer hospital visits resulting in lower utilization</td>
</tr>
<tr>
<td>Risk-adjusted estimates of unplanned readmission to an acute care hospital within the 30 days after discharge from a hospitalization (all-cause).</td>
<td></td>
</tr>
<tr>
<td><strong>Potentially avoidable inpatient spend (and admissions)</strong></td>
<td>• Prefer <strong>lower numbers</strong> as it indicates that hospitals are expending fewer resources on preventable conditions</td>
</tr>
<tr>
<td>The amount spent on preventable quality indicators (PQI) divided by total amount spent on any acute admission. PQI admissions include one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection. Spend on preventable quality indicators (PQI) Spend on acute admission</td>
<td></td>
</tr>
<tr>
<td><strong>Potentially avoidable portion of ED spend (and admissions)</strong></td>
<td>• Prefer <strong>lower numbers</strong> as it indicates that hospitals are expending fewer resources on avoidable care</td>
</tr>
<tr>
<td>The NYU Algorithm⁴: The sum of not emergent, ED primary care treatable, and ED care needed preventable and/or avoidable care divided by total ED spend. These classifications are determined by an algorithm created by the NYU Center for Health and Public Service Research. Not emergent + ED primary care treatable + ED care needed preventable Total ED spend</td>
<td></td>
</tr>
</tbody>
</table>

How do you calculate your current performance compared to the metric descriptions?

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1 Calculated using data provided by the hospital in the data request
2 Self-reported based on data request
3 Further described in McKinsey’s technical specification for rural hospital global budget
4 SOURCE: AHRQ, Hospital Compare, CMS, NYU Center for Health and Public Service Research
Although changing to a value-based model, many internal processes will remain unchanged for providers

### Internal processes remaining the same

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims processes</td>
<td>Maintained through the same process to later be utilized during reconciliation and future global budget calculations</td>
</tr>
<tr>
<td>Co-pay collection</td>
<td>Continued co-pay collection from patients since co-pays not included within the global budget payments from payers to hospitals</td>
</tr>
<tr>
<td>Professional fees</td>
<td>Professional fees not included in the global budget. In later years of the model, participating hospitals can explore options for enhanced alignment</td>
</tr>
<tr>
<td>Payer contracts</td>
<td>Currently effective agreements will be maintained except for payment terms – e.g. quality metrics and reporting, negotiated inflation rates, etc. will remain constant as agreed upon in negotiated payer agreements</td>
</tr>
</tbody>
</table>