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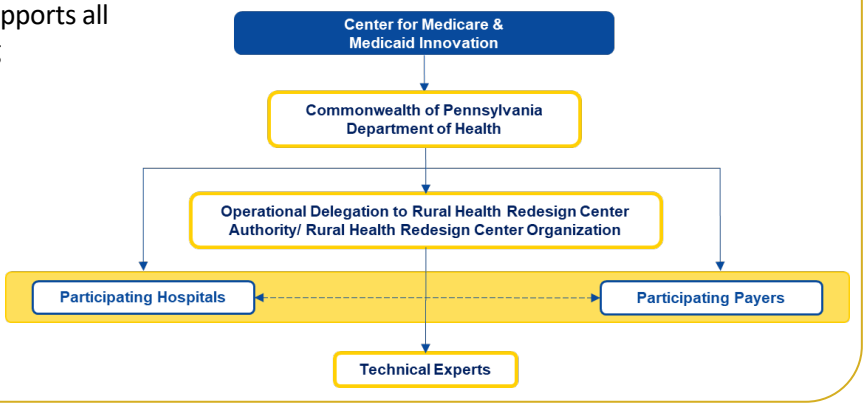
Findings at a Glance

Pennsylvania Rural Health Model (PARHM)

Evaluation of Performance Years 1-2 (2019-2020)

MODEL OVERVIEW

The Pennsylvania Rural Health Model (PARHM) aims to increase access to high-quality hospital services and improve population health in underserved rural communities. To ensure the financial viability of participating rural hospitals, the Model seeks to stabilize all participating hospitals' finances by providing a predictable revenue stream through global budgets. Global budgets are prospective payments paid by participating payers and are based on historical net patient revenue for inpatient and select outpatient hospital services at participating hospitals (adjusted each year based on several factors such as inflation and service line changes). The PARHM also supports all participating hospitals in identifying and implementing activities to transform care delivery by investing in prevention, quality improvement, and community-based services to improve quality of care, achieve population health outcome goals, and advance health equity. This graphic illustrates the implementation structure for the Model. In Performance Year 2 (PY2, 2020), Model components were refined (i.e., global budget methodology and reconciliation) and flexibilities were provided during COVID-19.



MODEL PARTICIPANTS

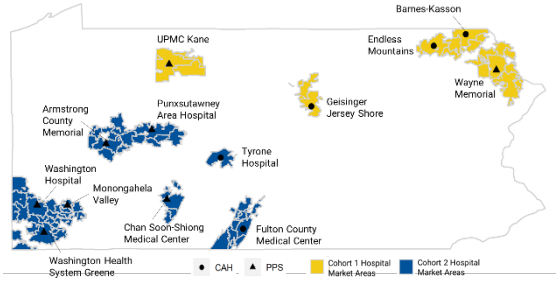
Eight hospitals joined the Model in PY2 (2020), bringing the total to 13 participating hospitals, including:

5 critical access hospitals

3 independent | *2 system-owned*

8 prospective payment system hospitals

5 independent | *3 system-owned*



Payer participation increased in PY2 (2020):

- Geisinger, Highmark Blue Cross Blue Shield, University of Pittsburgh Medical Center, Aetna, Gateway health plans including Medicare Advantage, and Medicare FFS

- The percentage of eligible net patient revenue covered by global budgets for participating hospitals increased from 59% in PY1 (2019) to 76% in PY2 (2020)

Motivation to Participate

- Financial stability was central to hospitals' decision to participate; the global budget was more appealing to independent hospitals lacking the financial resources of a hospital system affiliation
- Cohort 2 hospitals were slightly less financially distressed than Cohort 1 hospitals, which may have contributed to their delayed participation
- Participating payers sought to maintain access to hospital services in rural areas

Recruitment in PY2 (2020)

- The COVID-19 pandemic created challenges for payer and hospital recruitment efforts
- The pace of hospital mergers and acquisitions in rural Pennsylvania was a recruitment barrier, with the percentage of system-affiliated rural hospitals increasing from 27 percent to 77 percent between 2015 and 2020

This document summarizes the evaluation report prepared by an independent contractor. All findings presented are reported by participating hospitals, commercial payers, and implementation partners. To learn more about PARHM and to download the Second Annual Evaluation Report, visit https://innovation.cms.gov/innovation-models/pa-rural-health-model.

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FINDINGS

Model Implementation

- Pennsylvania established the Rural Health Redesign Center Authority (RHRCA), an independent center to facilitate Model implementation, in PY2 (2020) enabling increased participant engagement and helped build trust among participating hospitals, payers, and implementation partners
- Hospital and payer participants found technical experts helpful as a neutral intermediary

Hospital Transformation

- Transformation plans addressed rural health disparities and high costs through robust chronic disease management, improved care coordination, and PAU reduction
- Hospitals made progress on transformation activities, including providing patient and staff education, assessing patient social needs, developing registries of high-risk patients, and implementing new post-discharge follow-up processes
- Hiring dedicated care coordination staff facilitated transformation in PY2 (2020)
- Transformation barriers included lack of upfront funds and limited staff capacity during the COVID-19 pandemic

Global Budgets

- Hospital participants appreciated the financial stability provided by global budgets throughout the COVID-19 pandemic; fixed biweekly payments generated predictable cash flow for participating hospitals
- Some commercial payers perceived that the Model increased their exposure to financial risk in PY2 (2020) during the COVID-19 pandemic
- Despite satisfaction with final PY1 (2019) reconciliation process, Cohort 1 hospitals were cautious about transformation investments due to potential global budget adjustments
- Differences between the global budget payment and reported costs resulted in larger than usual variability in settlement adjustments during the reconciliation period

KEY TAKEAWAYS

Although the COVID-19 pandemic complicated Model implementation in PY2 (2020) for participating hospitals, it also provided an opportunity for providers and commercial payers to redouble efforts to shift away from FFS to value-based payment to meet the health care needs of rural residents. The Commonwealth retained all PY1 (2019) and PY2 (2020) participating hospitals and commercial payers—a notable accomplishment in the context of the pandemic. Hospital transformation activities gained traction and the Model reportedly helped some participating hospitals attain greater financial stability. Some commercial payers noted the administrative burden to adapt to global budget methodology changes. It is unknown how COVID-related utilization fluctuations and emergency supplemental funding will be accounted for in the reconciliation process.