Welcome!

2022 WEBINAR SERIES
"SPECIAL TOPICS IN RURAL HEALTH"

Sponsored by Representative Kathy L. Rapp
and Senator Michele Brooks

Coordinated by the
Pennsylvania Rural Health Association

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Pennsylvania Rural Health Model

Accelerating Health Care Innovation in Pennsylvania

Rural Legislative Summer Webinar

Transforming Rural Health Care in Pennsylvania through Innovation in Payment and Service

August 17, 2022

RHRC
RURAL HEALTH REDESIGN CENTER

A Federally Funded Program

Today's Conversation

- Rural Health Redesign Center (RHRC)
  - Introduction
  - Goals for its future
- An Overview of the Pennsylvania Rural Health Model (PARHM)
  - What it is and its overall goals
  - PARHM scale across the state of Pennsylvania
  - Economic impact of rural hospitals and the communities they serve
  - Disparities faced in participant communities
- The Value of the PARHM to Hospitals and the Communities Served
  - Improved Hospital Financial Trends
  - Utilization trends of participants compared to National Rural averages
  - Quality of care improvements by participants
- Next Steps in Program Continuance

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The Rural Health Redesign Center (RHRC) was created by PA Legislative Act 108 of 2019 and established in May of 2020 for the purpose of advancing rural health care and administration of the Pennsylvania Rural Health Model (PARHM).

RHRC Vision

To advance the overall health of rural communities within Pennsylvania and support the development of thriving communities.

RHRC Focus

Build solutions to drive financial sustainability while meeting the health care needs of each community

The RHRC is uniquely positioned to drive transformation building on the lessons learned in PA and Other States

- Technical services and capabilities developed to support the PA Program can be leveraged to other communities as shown in the Overall Program Management and Leadership Framework
- The RHRC can serve as a "learning lab" with significant expertise to assist other organizations that pursue value-based care models for rural communities building on lessons learned in Pennsylvania

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The RHRC has four primary strategic priorities in accordance with Act 108

Four Strategic Priorities Identified

Priority 1: Administrate effective governance and operational structures

Priority 2: Successfully execute the PARHM

Priority 3: Secure a next generation program to maintain access to care and advance population health

Priority 4: Effective management of stakeholder relationships to advance the RHRCA's mission

The RHRC is dedicated to supporting PARHM participants (hospitals and payers) and the high-risk communities they serve.

Goals Moving Forward…

- Continue to support the eighteen participant hospitals in serving the 1.3M individuals impacted by the program.
- Provide financial support to hospitals using global budgets, stabilizing the economic contributions of these facilities to their communities.
- Improve overall population health by improving access to care and social determinant of health measurements through community-based transformation goals.
- Transform the healthcare mindset from quantity of care to quality.

Hospitals are the backbone of many rural communities. By being a part of this initiative, participants will be able to witness long-term, lasting results related to the improvement in quality of care, positive impacts on population health, and overall transformation of their communities.

An Overview of the Pennsylvania Rural Health Model and the Communities Served

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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

- First of its kind program between the Centers for Medicare and Medicaid Innovation (CMMI) and the Commonwealth of Pennsylvania to test a new payment model specifically for rural hospitals as a potential solution to the nationwide problem
- Participation by hospitals and payers is voluntary:

18 Participant Hospitals		
PPS / Sole Community	CAH	
13	5	
6 Participant Payers		
Medicare FFS	4 PA MCOs (Highmark, UPMC, Geisinger, Highmark Wholecare)	1 National MCO (Aetna)
MCOs include Commercial Medicare Advantage and Medicaid Managed Care		

- Significant funding through CMMI to provide technical assistance to participant hospitals and payers:
  - Grant funds provide 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

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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

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

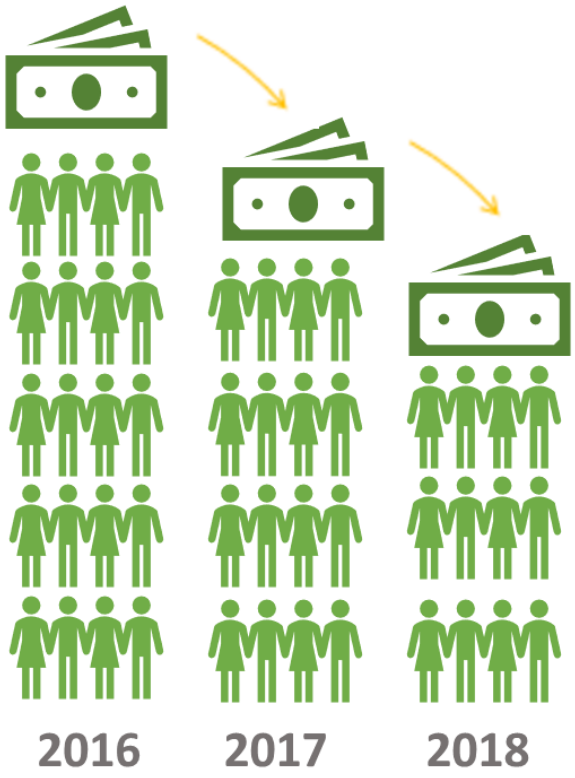
The Model stabilizes cash flow from all participant payers

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

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

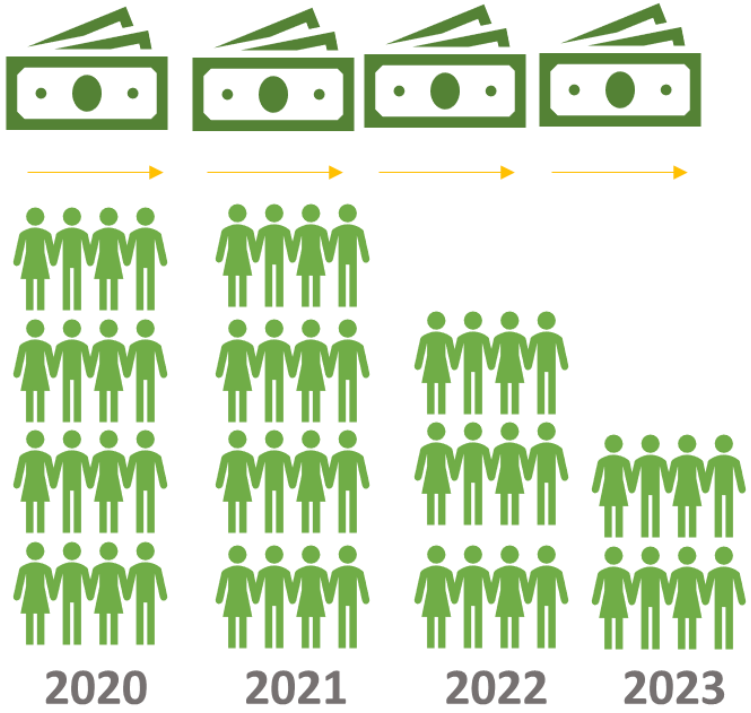
Fee for Service

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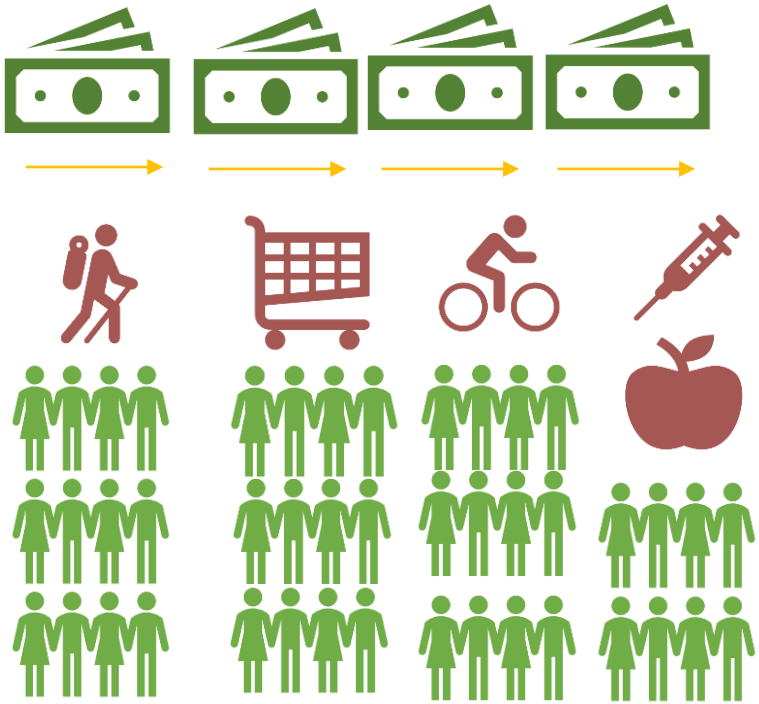
By retaining the revenue associated with the reduced PAU, the hospital can invest in services that promote community wellness

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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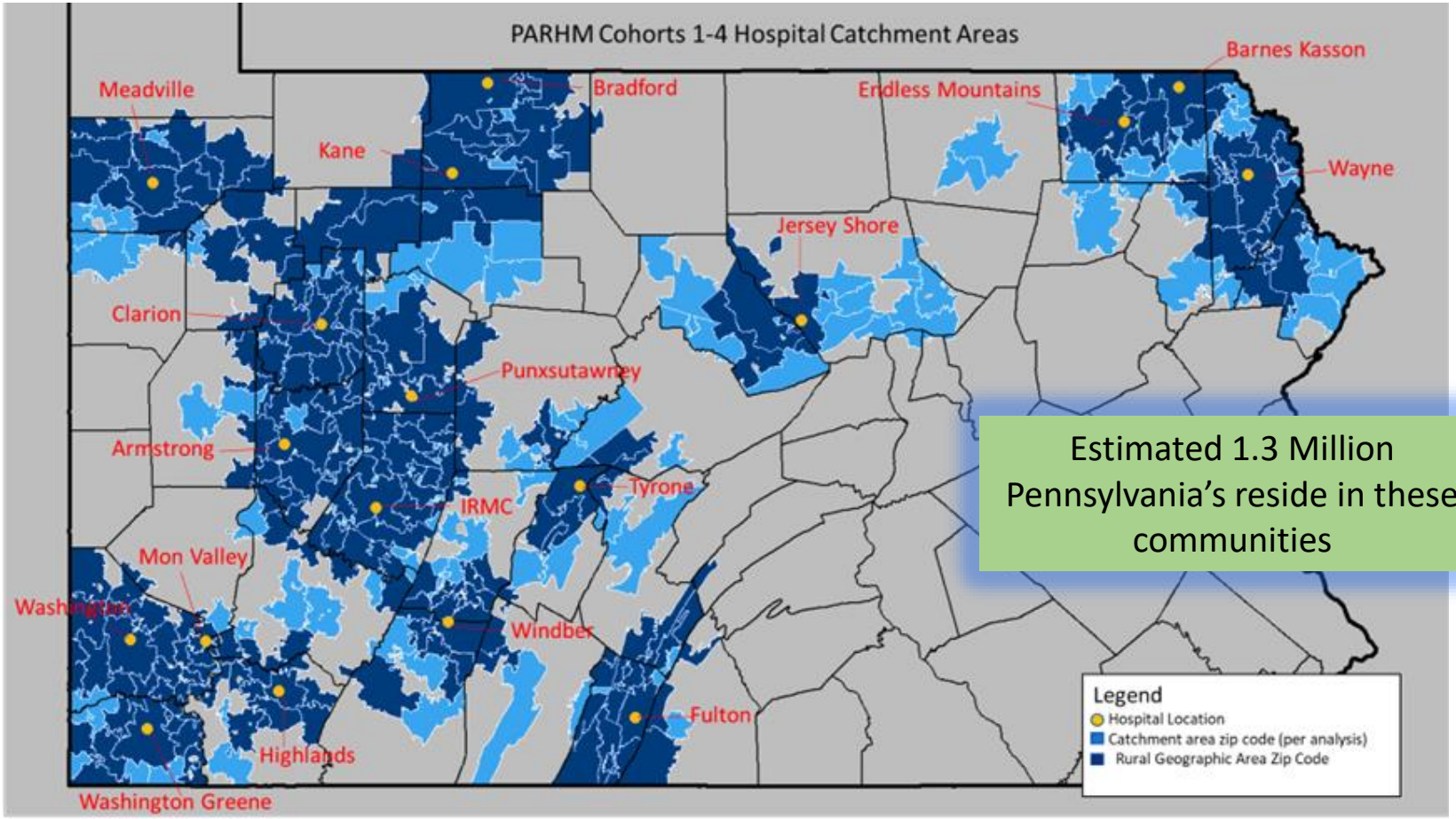
The PARHM has established significant program scale across the state of Pennsylvania.



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

Global Budget Revenue

$1.12 million of Net Patient Revenue in Global Budget (70% government)

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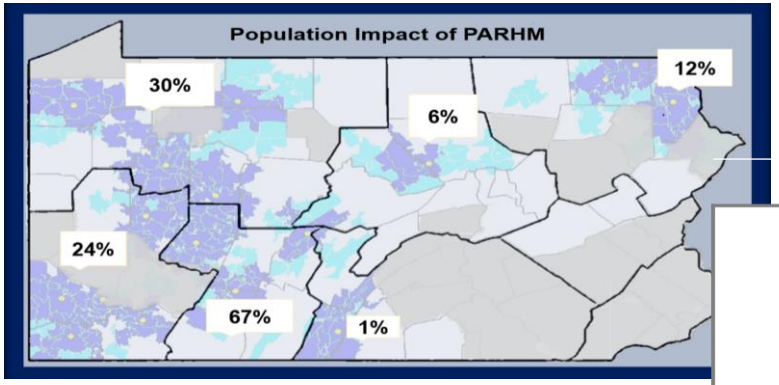
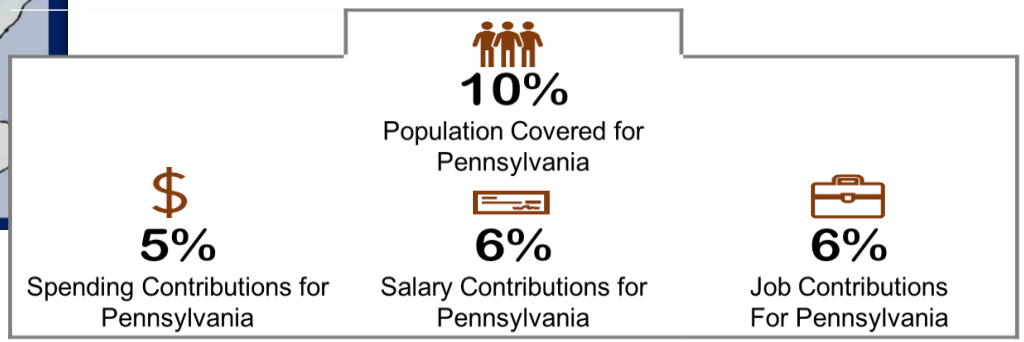
Based on this HAP study, the estimated regional economic impact of the hospitals in the PARHM is $2.4 billion which accounts for almost 18K jobs in these communities

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



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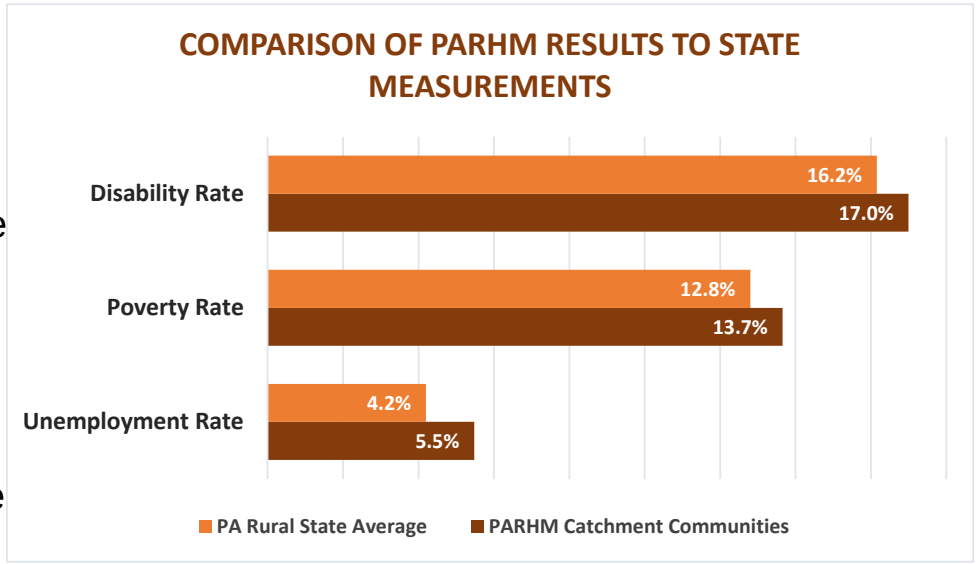
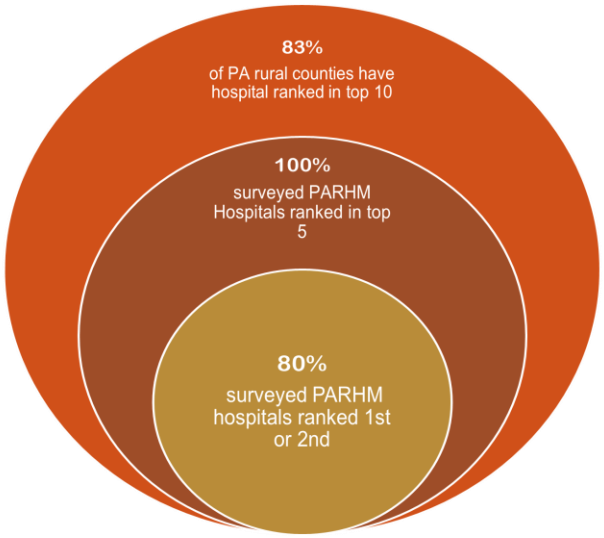
PARHM hospital communities are some of the most critical across the state. An analysis was conducted comparing the participant hospital community average health and economic needs to the state's rural averages.

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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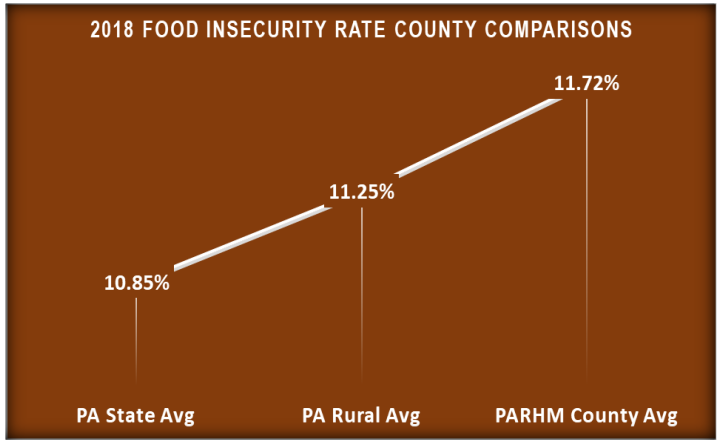
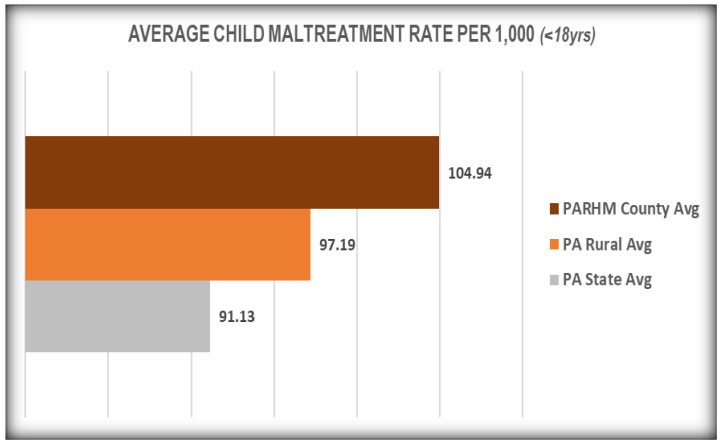
Poverty and food insecurity are two social determinant of health factors examined using DHS county level data. Data indicates that PARHM communities rank higher in both, compared to state and rural averages.



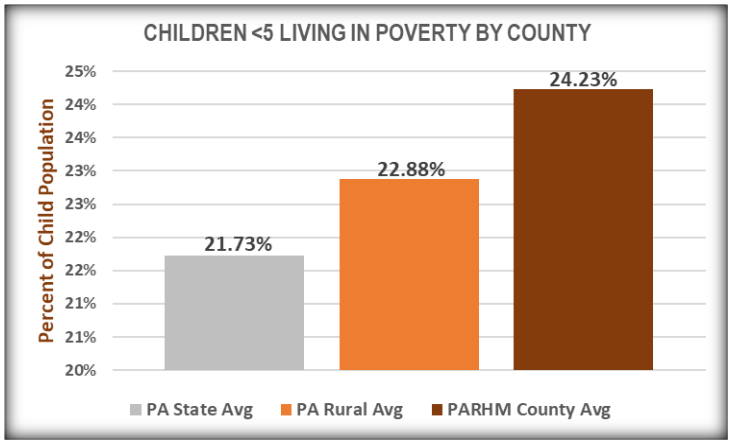
10 out of 15

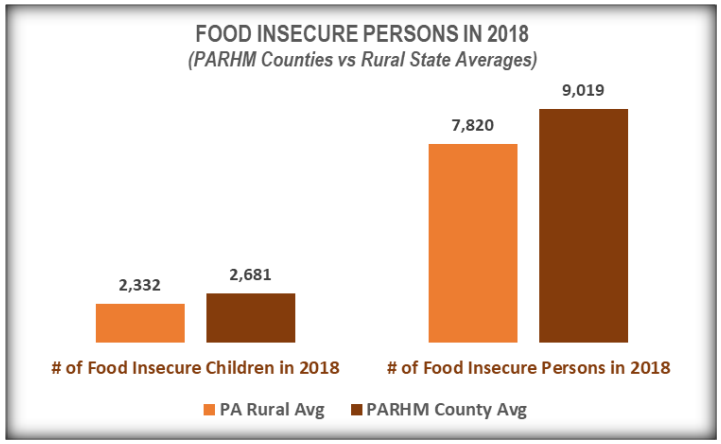
participant counties report a population poverty percentage above the rural state average.



11 out of 15

participant counties report a higher percentage of children under 5 living in poverty compared to the rural state average.





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

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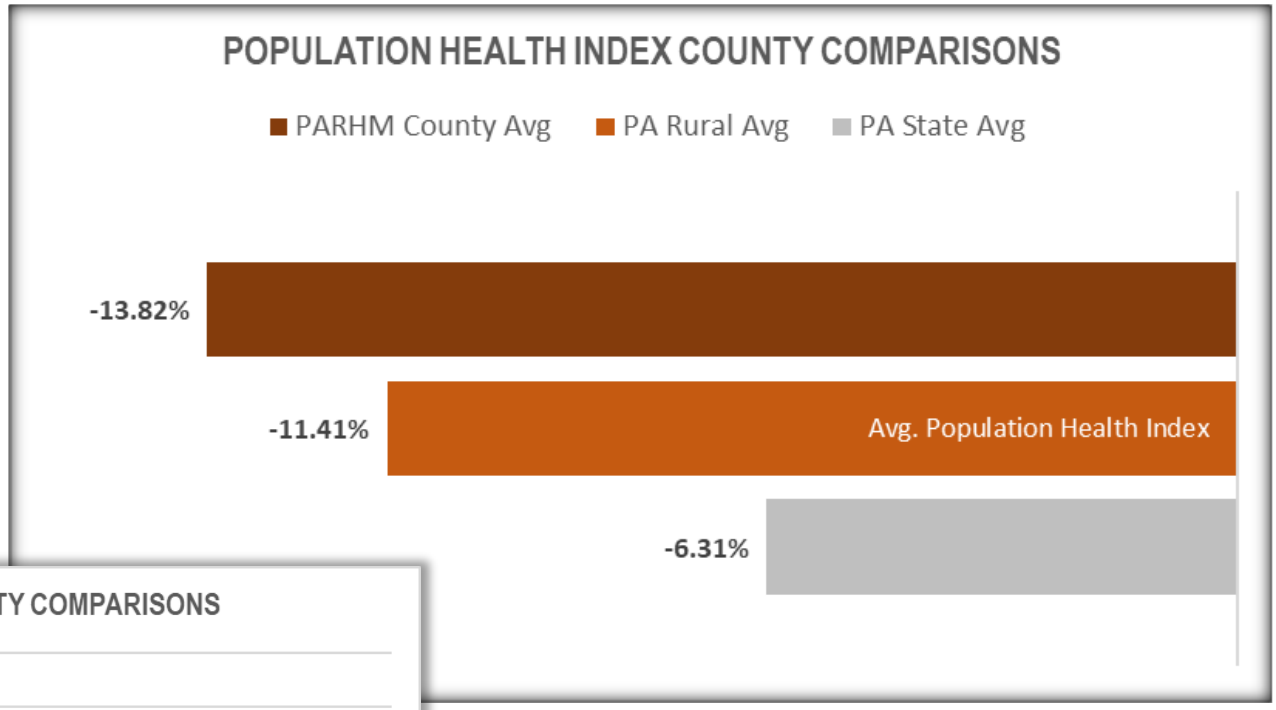
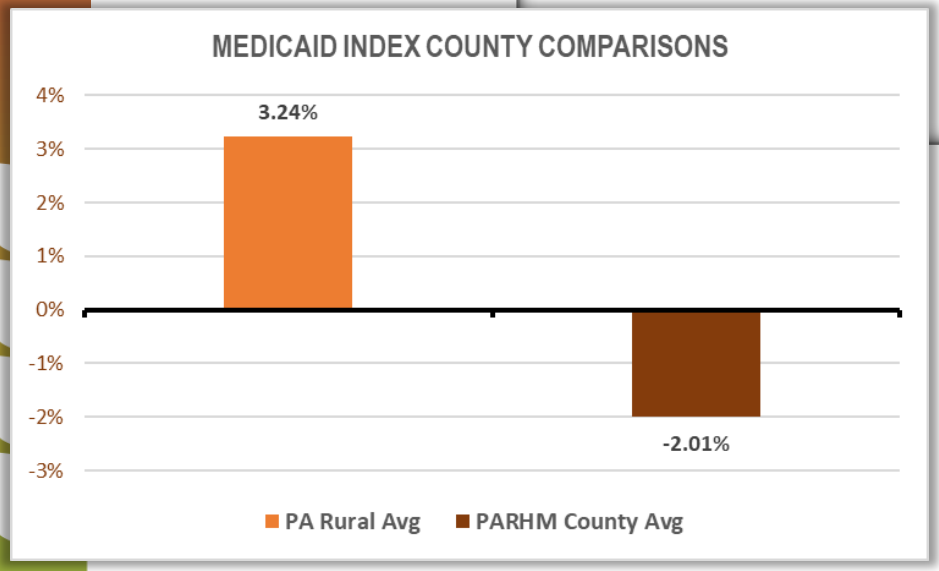
The PA Department of Human Services (DHS) dual index data identifies that PARHM participant counties face inequities in health outcomes compared to other areas of the state.





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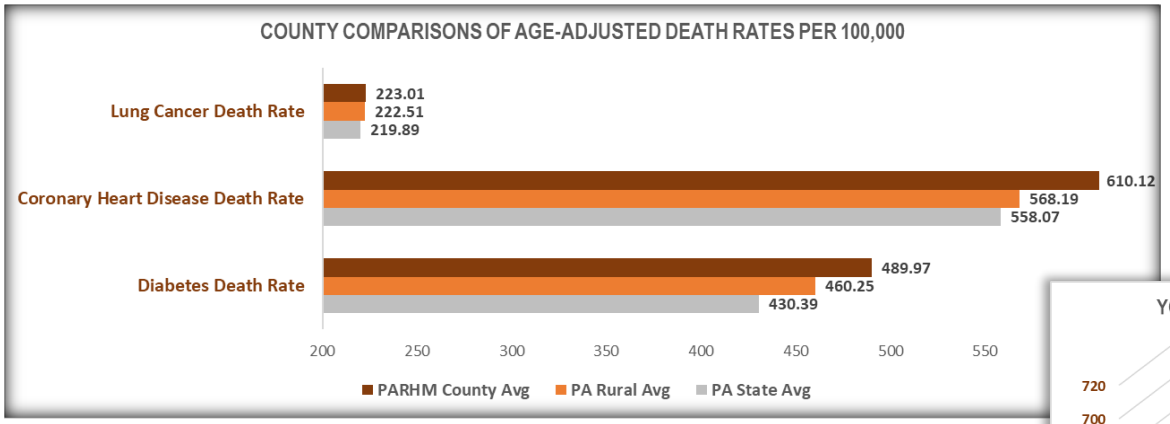
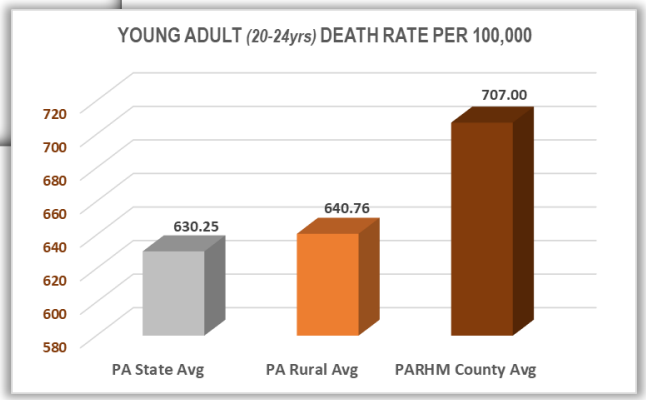
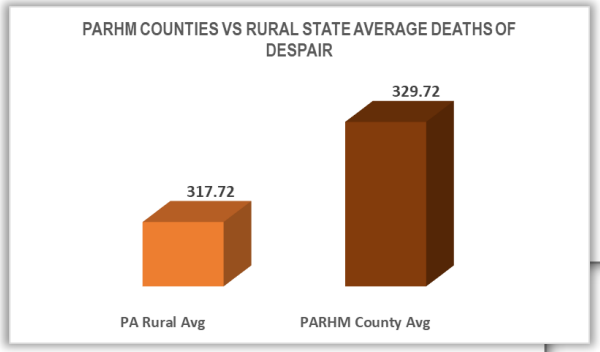
Using DHS health equity data, a variety of age-adjusted death rates were examined. The graphs below identify that PARHM participant counties have health inequities in all the represented categories compared to state and rural averages.



76%

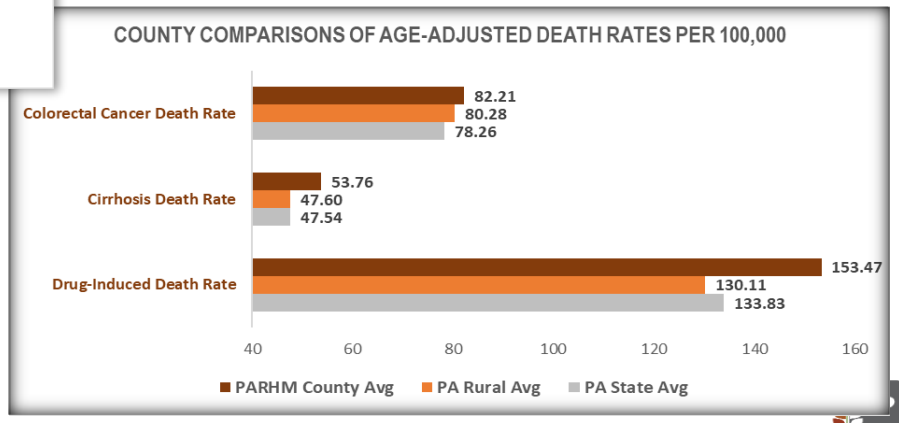
Of the population health metrics examined measured worse for PARHM counties compared to state total, urban & rural averages.





60%

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



60%

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

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

- With efforts of reducing inequities and disparities a major focal point of many agendas, the goal of providing everyone with equal 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.

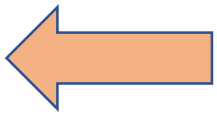
The Value of PARHM

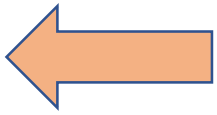
Based on audited financial statements of PARHM participants, there is improvement in the operating margin overall for all cohorts.

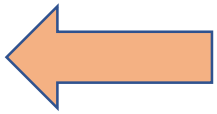
Consolidated Financial Position of PAHRM Participants

Financial Metrics by Cohort

Cohort 1	2018	2019	2020	2021
Operating Revenue	$ 180,254,722	$ 188,649,138	$ 200,728,764	$ 222,964,796
Operating Expenses	$ 187,759,506	$ 191,402,762	$ 193,032,365	$ 208,063,735
Operating Income/(Loss)	$ (7,504,784)	$ (2,753,624)	$ 7,696,399	$ 14,901,061
Operating Margin	-4.2%	-1.5%	3.8%	6.7%
Cash and Cash Equivalents	$ 7,025,406	$ 19,009,311	$ 39,841,477	$ 55,938,321
Current Assets	$ 48,265,001	$ 54,603,981	$ 73,214,858	$ 93,375,771
Total Assets	$ 236,157,693	$ 247,490,081	$ 277,618,529	$ 314,052,777
Cohort 2				
Operating Revenue		$ 652,711,451	$ 651,012,489	$ 700,889,807
Operating Expenses		$ 648,364,393	$ 644,428,384	$ 663,475,849
Operating Income/(Loss)		$ 4,347,057	$ 6,584,105	$ 37,413,958
Operating Margin		0.7%	1.0%	5.3%
Cash and Cash Equivalents		$ 44,917,308	$ 130,736,258	$ 98,638,456
Current Assets		$ 150,016,652	$ 228,653,075	$ 208,048,009
Total Assets		$ 685,507,044	$ 764,999,225	$ 794,362,461
Cohort 3				
Operating Revenue			$ 601,021,778	$ 654,151,445
Operating Expenses			$ 627,965,216	$ 651,273,924
Operating Income/(Loss)			$ (26,943,438)	$ 2,877,521
Operating Margin			-4.5%	0.4%
Cash and Cash Equivalents			$ 81,284,837	$ 107,245,019
Current Assets			$ 182,084,368	$ 193,289,591
Total Assets			$ 588,211,165	$ 652,238,309







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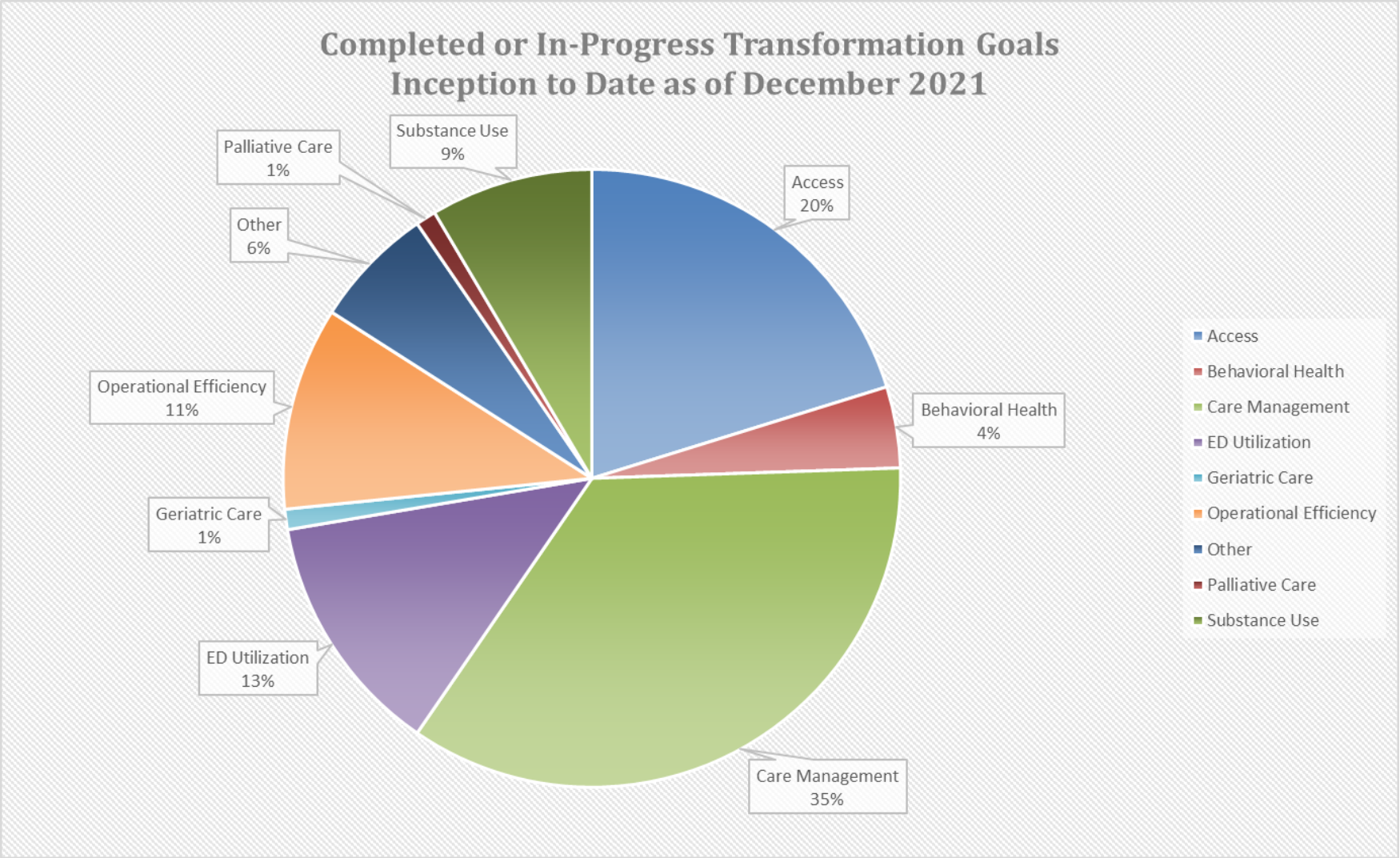
Between 2019 – 2021 there have been over 100 goals completed or are in progress across the program to drive delivery system reform.



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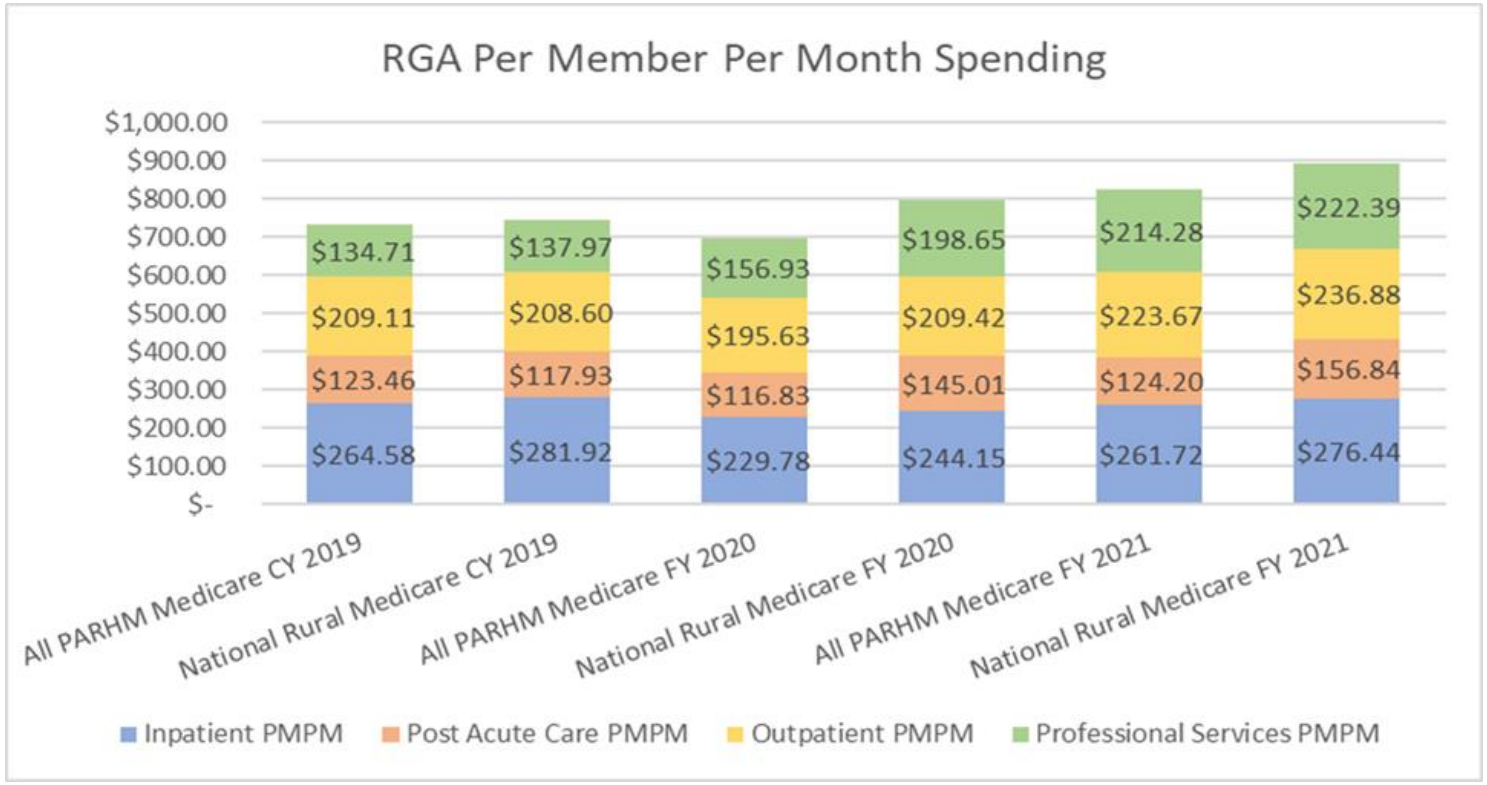
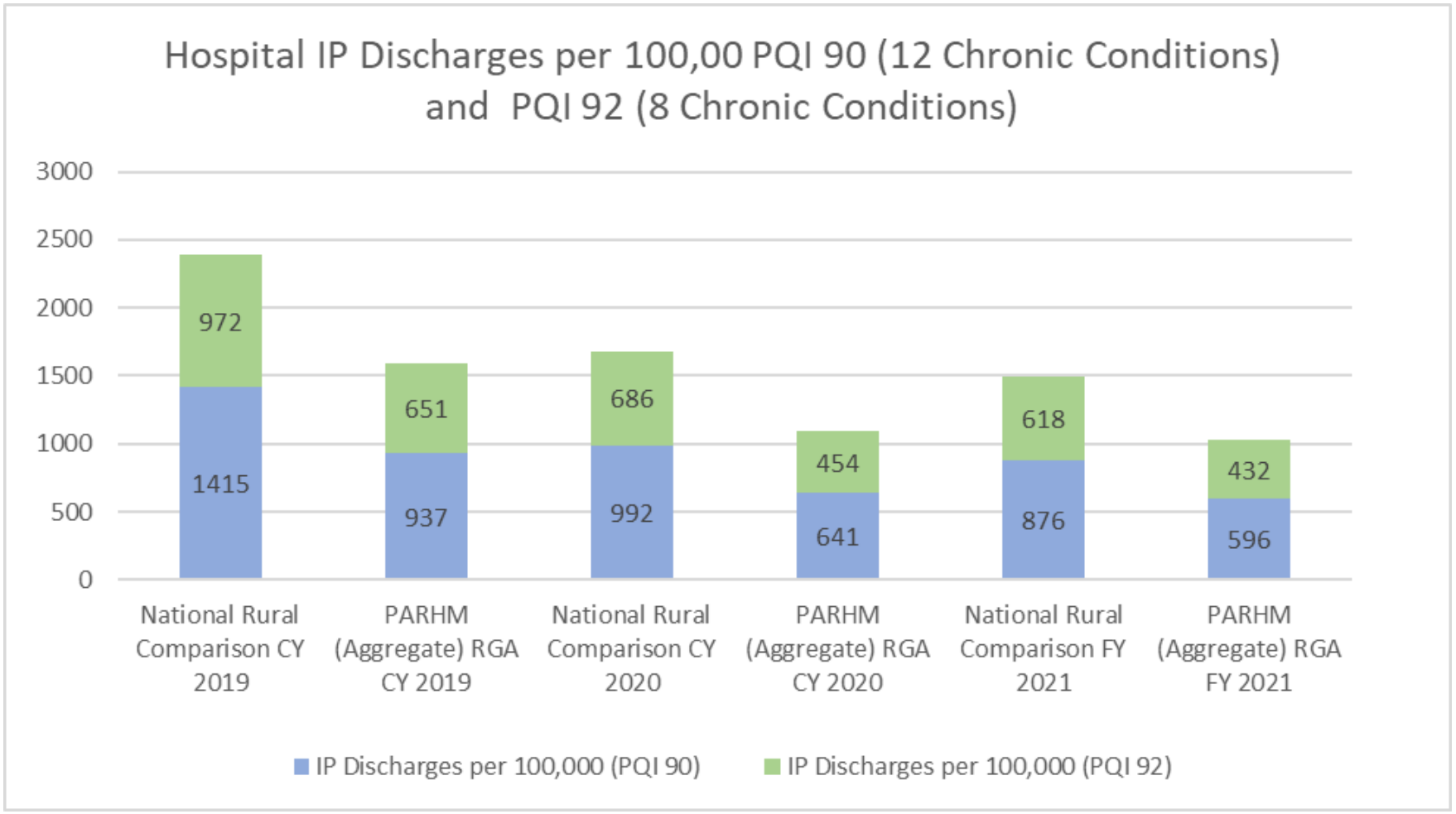
The rural communities served by the participant rural hospitals continue to receive more efficient healthcare services in comparison to national rural peers. This

PARHM vs. National Rural PMPM Spend



Medicare discharges per 100,000 by the PARHM participant hospitals continue to be below rural averages for all three program years.



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2021 Preliminary quality measure performance indicates PARHM is passing all measures.

Medicare

		Fiscal Year 2020		Fiscal Year 2021				
Measure	Measure_Name	National Rural w/o PA 2020 Benchmark	2020 MCO PARHM RGA	National Rural w/o PA 2021 Benchmark	2021 MCO PARHM RGA	National Rate of Change	PARHM Rate of Change	Status
AAP	Adults' Access to Preventive/Ambulatory Health Services	88.5%	88.2%	88.3%	88.0%	-0.2%	-0.2%	Pass
COU 15	Risk of Continued Opioid Use - 15 Day	15.2%	17.2%	14.3%	14.9%	-6.1%	-13.3%	Pass
COU 31	Risk of Continued Opioid Use - 31 Day	7.9%	8.4%	7.4%	7.2%	-6.0%	-14.4%	Pass
FMC	Follow-up After ED Visit for People With Multiple High-Risk Chronic Conditions	59.2%	59.6%	58.7%	59.7%	-0.7%	0.1%	Pass
NQF 1769	Hospital-Wide Unplanned Readmission (w/ risk adj)	23.1%	25.4%	21.9%	20.6%	-5.3%	-19.1%	Pass
NQF 3400	Use of Pharmacotherapy for Opioid Use Disorder	16.6%	16.6%	16.1%	16.0%	-3.2%	-3.3%	Pass
PCR	Plan All-Cause Readmission Rates	14.6%	13.7%	14.7%	14.0%	0.4%	2.1%	Pass
POD	Pharmacotherapy for Opioid Use Disorder	35.1%	35.5%	31.9%	49.5%	-9.3%	39.5%	Pass
PQI 92	Hospital IP Discharges per 100,000 PQI 92: (8 Chronic Conditions)	774	507	618	432	-20.1%	-15.0%	Pass

Commercial

Measure	Measure_Name	National Rural w/o PA 2020 Benchmark	2020 MCO PARHM RGA	National Rural w/o PA 2021 Benchmark	2021 MCO PARHM RGA	National Rate of Change	PARHM Rate of Change	Status
AAP	Adults' Access to Preventive/Ambulatory Health Services	88.5%	92.9%	88.3%	92.4%	-0.2%	-0.6%	Pass
COU 15	Risk of Continued Opioid Use - 15 Day	15.2%	9.0%	14.3%	7.5%	-6.1%	-16.6%	Pass
COU 31	Risk of Continued Opioid Use - 31 Day	7.9%	5.4%	7.4%	4.6%	-6.0%	-14.6%	Pass
FMC	Follow-up After ED Visit for People With Multiple High-Risk Chronic Conditions	59.2%	58.2%	58.7%	59.4%	-0.7%	2.2%	Pass
PCR	Plan All-Cause Readmission Rates	14.6%	9.1%	14.7%	8.8%	0.4%	-3.1%	Pass
POD	Pharmacotherapy for Opioid Use Disorder	35.1%	30.5%	31.9%	26.0%	-9.3%	-14.7%	Pass

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The RHRC's Value

The value of the RHRC is demonstrated through program results. It supports the participant rural hospitals and payers by providing a range of technical assistance through a highly trained team of experts with the continued goal of advancing rural health transformation.

Annual Operating Budget	Projected Annual Operating Cost ($)
Current RHRC Annual Operating Budget	$3.5 M
Regional Economic Impact to PARHM Communities Served	$2.4 Billion
Cost/Benefit Ratio of PARHM to the Commonwealth ($3.5 million annual cost / $2.4 billion annual regional economic impact)	**0.15%**

Cost/Benefit Ratio Demonstrates Significant Value Realized by the Commonwealth in supporting health care in rural communities across the state

To date, the RHRC has primary been funded by CMMI as part of the demonstration project with the assistance of some private grants. The RHRC is working to secure permanent funding solutions for long-term financial sustainability to ensure this work continues for years to come.

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The RHRC has identified a path forward to ensure program sustainability, and there are areas where legislative support would be helpful:

1.State Support
1. Assist with identifying appropriate educational forums at the state level to educate on program benefits

Federal Support
1. Assist with a federal legislative strategy to educate on programs' successes to ensure program continuance

Transition Support
1. Assist with the transition of government officials as a result of the 2022 elections, both governor and other elected officials

1.Financial Support
1. Budgetary consideration for the RHRCA given the identified economic benefit to Pennsylvania

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Questions

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Contact information:

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Gary Zegiestowsky, MBA, Executive Director

Rural Health Redesign Center (RHRC)

Email: gz@rhrco.org

Website: www.RHRCO.org

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"SPECIAL TOPICS IN RURAL HEALTH"

Mark you Calendars for the Final Webinar!

Tuesday, September 6, 2022 **9:00 am-10:00 am**

Cultivating Rural Health Professionals: How We Can Grow Our Own in Pennsylvania

Ben Fredrick, MD, Professor of Family & Community Medicine, Penn State College of Medicine and Program Director, Pennsylvania Area Health Education Center (PA AHEC), Hershey, PA