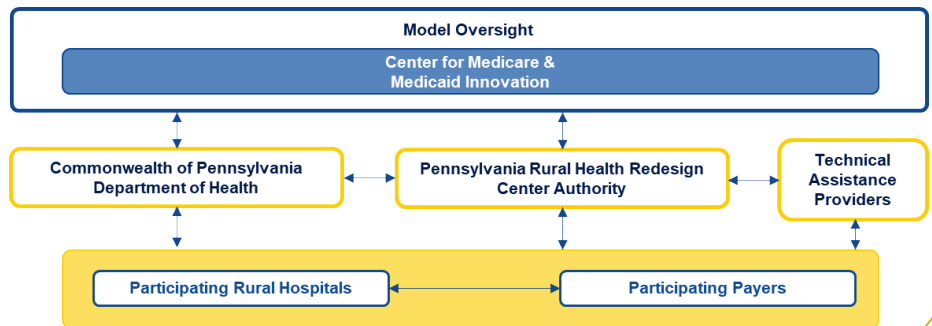


### MODEL OVERVIEW

The Pennsylvania Rural Health Model (PARHM) aims to improve population health outcomes, increase access to high-quality care, and improve the financial viability of acute care hospitals in rural Pennsylvania. Designed to reduce the risk of rural hospital closures, the Model seeks to stabilize participating hospitals' finances by providing a predictable revenue stream through global budgets. Global budgets are prospective, fixed payments paid by participating payers to cover hospital services in participating hospitals (adjusted each year based on several factors such as inflation, service line changes, and hospital performance).

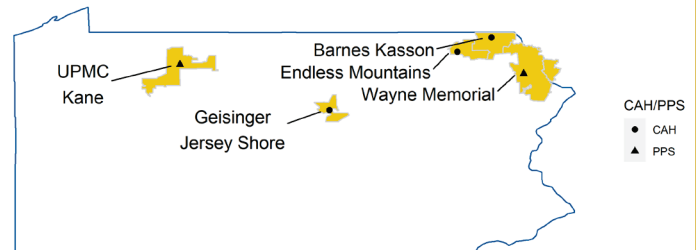
The PARHM also supports participating hospitals in identifying and implementing activities to transform care delivery by investing in prevention, quality improvement, and community-based services to improve quality of care and achieve population health outcome goals. This graphic illustrates the accountability and oversight structure for the Model design and implementation.



### COHORT 1 PARTICIPANTS

Five out of 67 eligible rural hospitals joined in performance year (PY) 1 (2019), including:

- Three critical access hospitals (two independent, one system owned)
- Two prospective payment system hospitals (one independent, one system-owned)



Five commercial payers developed global budget arrangements with PARHM participants, including:

- Geisinger, Highmark Blue Cross Blue Shield, University of Pittsburgh Medical Center, Aetna, and Gateway health plans
- All but Highmark also participate in one or both of the Commonwealth's Medicaid managed care programs

#### Motivating Factors for Cohort 1 Hospital Participation

- All hospitals valued the opportunity to transform care through the Model
- Hospitals reported that the prospective calculations and consistent cash flow were central to their decision to participate

#### Factors for Commercial Payer Participation

- Due to high rates of Medicare Advantage and Medicaid managed care enrollment in Pennsylvania, commercial payers are essential to attaining the Model's payer participation scale targets
- Commercial payers were motivated by a desire to stabilize and sustain rural hospitals but expressed reservations about hospital eligibility, global budget methodology, and accountability for transformation
- Three of the five Cohort 1 hospitals achieved the target of 75% of eligible net patient revenue covered under the global budget, with a fourth expected to meet the target after global budget reconciliation

### FINDINGS



#### Model Implementation

- Hospitals and payers generally assessed positively the technical assistance from the Commonwealth and technical experts, which included global budget support, support for the development of transformation plans, and bi-weekly meetings to facilitate communication among all stakeholders
- While some technical experts and commercial payers would like to see more movement in the transformation process, they recognize that meaningful transformation is a slow and iterative process; COVID-19 was a barrier to transformation progress in PY2
- Hospitals noted the need for funding to support staff time to implement transformation plans; hospitals struggled to have dedicated staff to manage and monitor transformation process
- At the time of the interviews, hospitals requested access to timely data and more clarity regarding quality measures; in collaboration with the Commonwealth, CMS updated the quality measures in the fall of 2020



#### Financial Status during Baseline Period

- The short- and long-term financial viability of the Cohort 1 participating hospitals worsened prior to the model's start. During the baseline period average total margins were -3.8% for participating CAHS and -2.5% for PPS hospital participants (2013-2018) —a potential motivating factor for their participation in the Model
- Declining inpatient volume and fixed costs may have negatively impacted financial status during the baseline period



#### Medicare Payments and Utilization Trends

- Biweekly payments under the global budget addresses variability due to seasonality and volume shifts

### KEY TAKEAWAYS

The approach to payment reform in this Model attracted a range of participants from a variety of hospital types (e.g., CAHs, PPS, independent, system-affiliated, and varying financial status). However, hospital participation has been lower than anticipated, resulting in challenges to achieving scale targets and a smaller share of revenue covered by the global budget. Medicare's fixed, biweekly payments helped participants manage fluctuations in volume and provided financial stability. Additionally, while the Model contributes to short-term financial stability, independent rural hospitals continue to struggle with long-term sustainability. Some hospitals opted for long-term financial stability through system acquisition and mergers. Large cost savings also may not be feasible in the Model due to the limited timeline to realize significant spending reductions and to the hospitals' tight operation margins.