RURAL HEALTH REDESIGN CENTER

Written Testimony Submitted by:
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Thank you to the House Health Committee for hosting this subcommittee informational meeting on bolstering rural and independent hospitals. Thank you to Chair Frankle and Republican Chair Rapp for understanding the importance of our rural hospitals and their significance in not only ensuring access to healthcare in rural communities, but to the economic impact these hospitals have in their communities. I am honored to have been asked to provide testimony at this hearing and represent the significant work the Commonwealth has accomplished collectively in advancing rural health payment reform and the lessons we have learned in our journey together these past 6 years. It has been a privilege to lead the innovative efforts of the Pennsylvania Rural Health Model (PARHM), and support the creation of the Rural Health Redesign Center (RHRC) as its chief operating officer, and more recently its executive director.

Background – The RHRC and the PARHM

Through the legislative Act 108 of 2019, and subsequently Act 15 of 2023, the Rural Health Redesign Center Authority (RHRCA) was created to advance the mission of ensuring access to high-quality healthcare remains in rural Pennsylvania. The RHRCA has a governing board of directors comprised of hospitals, payers, government officials, and national rural health experts. The RHRCA was officially formed in May of 2020 and has been governing the Pennsylvania Rural Health Model (PARHM) since its inception. In addition to the Rural Health Redesign Center Authority (RHRCA), a supporting not-for-profit organization was also created, the Rural Health Redesign Center Organization (RHRCO), with the overall vision of supporting the RHRCA and becoming a long-standing resource to rural healthcare leaders and institutions. These two organizations, the RHRCA and RHRCO, are collectively known as the Rural Health Redesign Center (RHRC).

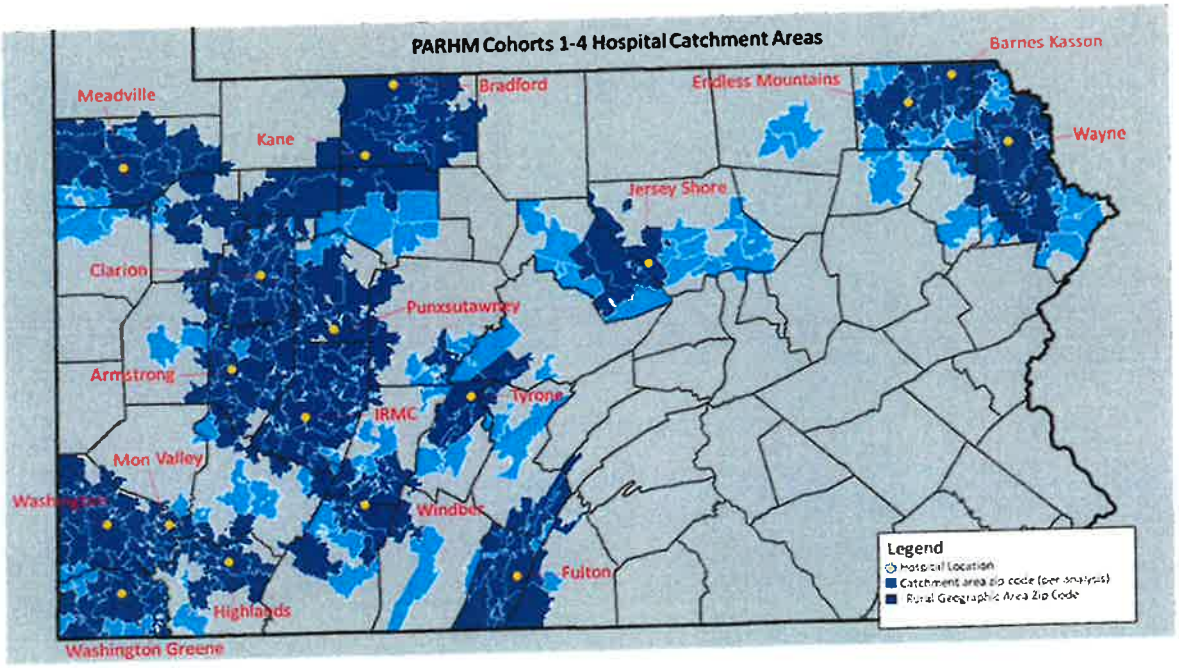
The PARHM was the first of its kind innovative demonstration program that is being administrated in partnership with the Centers for Medicare and Medicaid Innovation (CMMI) that is testing an alternative payment model specifically designed for rural hospitals. The PARHM was a seven-year demonstration program, beginning in 2018 with a pre-implementation year, followed by 6 performance years, 2019-2024. We are currently in the final program year.

RURAL HEALTH REDESIGN CENTER

The overarching goals of the program were to test the following: 1) if we fundamentally change how hospitals are paid (i.e., moving them to a global budget framework) can we improve their financial viability, 2) by stabilizing the revenue, can hospitals improve the health of the populations served within these communities, and 3) through a redesigned payment structure, can we reduce the total cost of care growth rate over time.

The RHRC has data that shows it is achieving the overarching objectives of the PAHRM. While the program is certainly not perfect, it has proven to be a robust learning laboratory for what works as well as what does not work well within rural health payment reform. Despite its imperfections, seventeen of the eighteen participant hospitals have improved operating margins during the program period, and quality indicators show improvement against national rural averages. In addition, RHRC data shows that the program is managing within its Total Cost of Care (TCOC) growth guardrails.

Through the first 4 performance years of the program (2019-2022), an additional $188M of revenue was paid to our participant hospitals by the participant payers. Participants in this program include eighteen hospitals as well as the predominant 3rd party payers in the Commonwealth. The payers included Highmark, University of Pittsburg Medical Center, Geisinger Health Plan, Aetna, and CMS / Medicare. The payers remain the source of payment of the global budgets to the participant hospitals which span across fifteen rural counties. The map below shows the footprint of this program.



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The participant hospitals include thirteen PPS hospitals including UPMC Kane, Bradford (Kaleida), Meadville, Independence Health Clarion, Punxsutawney, Armstrong, Indiana Regional, Washington (UPMC), Washington Greene (UPMC), Penn Highlands Monongahela Valley, Penn Highlands Connellsville (Highlands Hospital), Windber, and Wayne Memorial; and five critical access hospitals Endless Mountains, Barnes-Kasson (Wayne Memorial), Geisinger Jersey Shore, Fulton County, and Penn Highlands Tyrone. Participants are a mix of independent and system-owned hospitals. Seven of the eighteen hospitals were independent upon entry into the program but have either been subsequently acquired by a larger organization or are currently in the process of being acquired. This statistic alone would indicate that while there is data to support that the PARHM provided stability and improved operating margins for the participant rural hospitals over the course of the program, it was not enough to sustain these organizations as independent rural entities.

The work of the RHRC

The role of the RHRC specific to the PAHRM is to support both participant hospitals and payers within the program. This support includes providing the necessary technical assistance and infrastructure to facilitate both the global budgeting process, as well as the transformation planning and implementation process for hospitals. This includes activities such as developing shared learning platforms to advance population health initiatives and transformation planning, grant-writing research support, financial modeling for service line changes, and program reporting and monitoring. The RHRC's cost of providing robust technical support services for the PARHM is approximately $2.5MM per year, and to date has been funded by federal CMS dollars and private grant funds. Current funding for the RHRC's PARHM work is expected to expire by the end of calendar year 2024. However, it is believed that given its work to date, the RHRC remains ideally situated to continue to provide needed infrastructure to rural communities to advance payment reform, population health improvement, and improved efficiencies to rural and other safety net providers in need of assistance.

In addition to supporting the hospitals and payers within the PARHM, the RHRC also works with other distressed hospitals and offers a host of rural relevant expertise to rural healthcare providers beyond those listed above. In addition to the services mentioned already, services include rural relevant strategic planning including implementation and accountability processes, financial and data analysis, grant-writing services, compliance and regulatory support, performance improvement services, educational platforms, leadership development resources, organization culture assessments, project

management training, revenue cycle evaluations, and overall C-suite leadership support. These services are provided through RHRC staff as well as partnerships with other organizations with rural relevant expertise.

Key Lessons Learned

As mentioned, the PARHM created a robust opportunity to identify what works well with rural health payment reform and what did not work so well. To frame what worked, what didn't, and other key lessons, I will highlight several in each category for reference.

Things that worked well were:

1. The all-payer nature of the program: the predominance of hospital revenue as paid to our participant hospitals through the global budget included the majority of its revenue from all prominent payers in the state.
2. The level of technical assistance provided to the hospitals: Given the level of competing priorities and resource limitations of rural hospitals, leaders have stated that if it wasn't for the support the RHRC provided, they could not have participated in the program.
3. The RHRC's creation, and its subsequent governing board: Both payers and hospitals felt it essential to have an independent entity, outside of the governor's direct jurisdiction, governing the program to insulate it from the election cycle and subsequent priorities. All felt this work was too important to be tied to a specific administration's priorities. The work is governed by the key stakeholders, which has been essential for its success.
4. The commitment of the participants to stick with the program: This program was only successful because of the commitment of the parties to stick with it, even when the outcomes may not have been in the best interest of each individual entity. There was a level of commitment to the journey that is noteworthy, and deserves to be recognized for all participants, hospitals and payers alike.
5. The patience of the participants to be flexible during the PHE: When this program was launched, no one knew that there was going to be a global crisis a little more than a year into the performance years. As a reminder, the RHRC was created in May of 2020, and the commitment of the board members and their organizations to be patient to allow data to drive decisions was equally remarkable.
6. The transformation planning process: The RHRC built infrastructure to support hospitals in moving from volume to value strategies. This work required hospitals to think differently, and the RHRC built tools and frameworks to guide hospitals through this process.

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Things that did worked well:

1. The lack of data infrastructure: In order to administrate a program of this nature, robust data is needed. The work was stifled due to a lack of data infrastructure and data sharing within the program. In the absence of all-claims or other infrastructure, program administration had to rely on summary level data as individually submitted by the payers to administrate the program.
2. The methodology as developed was complicated: While the goal was to develop a fairly simple global budget framework, it became very complicated in order to meet the demands of the various stakeholders. As a result, we have a complicated methodology that is difficult for hospitals to understand and is resource intense to manage. The current program requires a lot of trust on the part of hospitals as they don't understand the "black box" calculations that occur within the frameworks and rely heavily on the RHRC to manage the budgets on their behalf.
3. The methodology as currently developed isn't as predictable for hospitals or payers as originally hoped: Due to the methodology as mentioned above, the global budget is not overly predictable due to some of the adjustments included within it. This creates challenges for both hospitals and payers each year as it relates to financial statement preparation.
4. The lack of timely, actionable data by which to advance population health initiatives: Data sharing is not as robust as it could be, or should be, to improve population health. If rural health care providers are being asked to manage within fixed payment arrangements, data sharing on the parts of all payers should be a requirement to ensure the providers can be successful.
5. Lack of RHRC funding in later performance years: As mentioned, the funding for the current PAHRM is reaching its end, and as a result the RHRC is having to cut back its support to the participant hospitals. There is more the RHRC could do with adequate funding.

Other Key Lesson:

Lesson 1: Change of this nature is hard, and it takes different skillsets and mindsets to be successful. There is a continued need to remind stakeholders of why we are doing this work together. It is easy to revert to the old way of thinking.
Lesson 2: Even when rural health leaders and payers know change is needed, often competing priorities and lack of resources do not allow them to adopt change.
Lesson 3: There is an element of fear that accompanies change. Recognizing this fear, understanding it, and mitigating it are fundamental keys to success.
Lesson 4: Trust is the essential element in order to make all of this work. Stakeholders must trust that there is aligned purpose to the work, and that everyone is working to achieve that desired outcome of ensuring access to care remains in rural communities.

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Lesson 5: Robust data infrastructure will be essential for a successful next generation program.

As we collectively begin to put pen to paper for a next generation strategy, considering all of the lessons learned will be part of that work.

Path Forward

It estimated that 1.3MM individuals reside within the Commonwealth communities that the RHRC currently supports. By keeping these hospitals open, as well as other providers that are in need of new strategies and solutions, we not only retain access to essential healthcare solutions, but also employment and broader economic benefit. We know that the hospitals the RHRC already works with accounts for approximately 18K jobs and $2.6B of economic benefit for their communities and the Commonwealth.

The current PARHM program is in its final performance year. For the traditional CMS Medicare portion of the program, the hospitals within the program have a two-year transition period which will allow them to continue to receive global budget through 2026 if the hospital chooses to do so. However, for the PA-based aspects of the program (commercial, Medicaid Managed, and Medicare Managed), the current program will terminate as of December 31, 2024.

Given the imminent need for a replacement program, and with the support and direction from the Shapiro Administration in follow-up to the Rural Health Roundtable held on January 18th, 2024, the RHRC has been tasked with leading the development of a next-generation replacement program proposal. The RHRC will be leading efforts in the coming months to develop a proposal with the goal of having this solution drafted by the end of 2024 for inclusion in the 2025 Governor's budget cycle. This timeline was identified by the Governor in his address at the January 18th Round Table. Development of this program will include broad stakeholder engagement across the Commonwealth, including hospitals, payers, Commonwealth agencies such as DOH, DHS, PID, the State Office of Rural Health, the Hospital and Health System Association of PA, and other partner organization. The collective goal is to not abandon our rural hospital participants but develop better and more refined methodologies using lessons learned from the current program.

There are many thoughts and ideas regarding what the next solution should contain, including what services are essential to rural communities, the funding strategies to be utilized to ensure rural healthcare remains viable, the infrastructure required for success,

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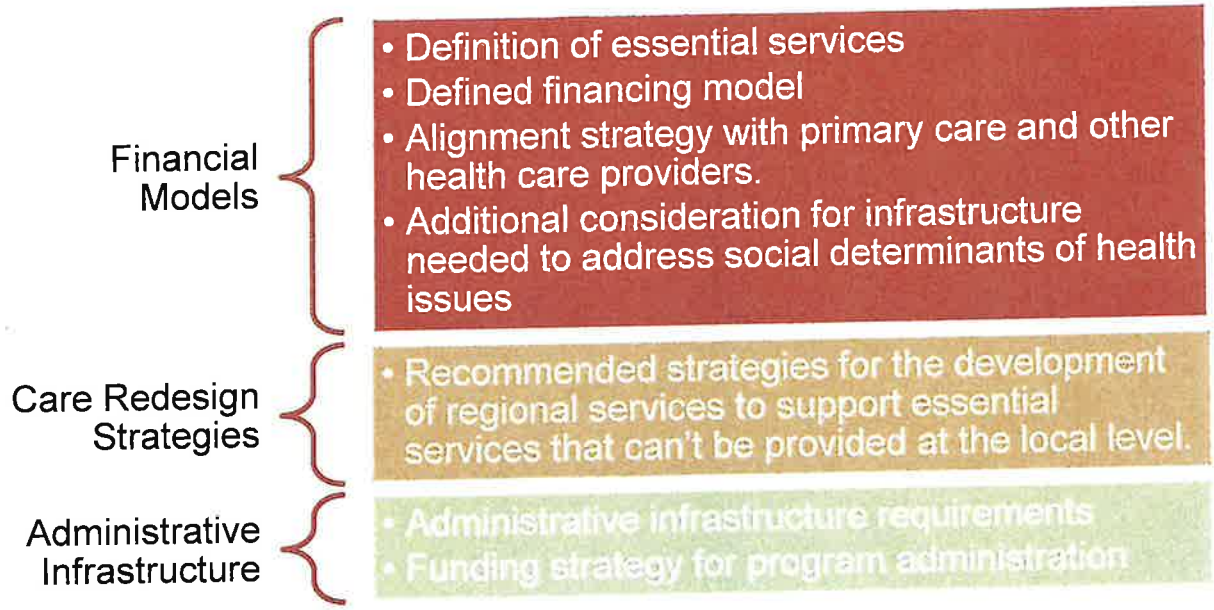
and Commonwealth budgetary considerations that may be needed to ensure a sustainable long-term solution. The work of the RHRC, in partnership with the Shapiro administration and the legislature, will be to develop a strategy that can be adopted as a Pennsylvania rural health solution. This next generation solution will be developed through robust stakeholder engagement over the course of the next several months. Our collective goal also includes ongoing dialogue with our federal partners at CMS / CMMI to determine what the federal replacement program will be in 2027 upon completion of the transition period. A summary of key objectives to be identified within the planning work are summarized in the diagram below:



Closing Remarks

The RHRC appreciates the ongoing interest in, and support of, the current Pennsylvania Rural Health Model as well as your interest and support for what comes next. The creation of a successful next generation strategy will require the ongoing support of all of you. The country has learned so much from our journey together and it continues to look to the Commonwealth to help inform and influence rural health policy in response to the ever-increasing rural health crisis. I look forward to the continued partnership with the legislature as we continue to advance innovative solutions to ensure access to care remains in our vulnerable communities. I firmly believe we have the knowledge as well as the fortitude within the Commonwealth to solve the challenging problems before us, and I look forward to the continued partnership as we move forward together.

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Thank you again to this committee and to the Chairman for this opportunity to provide testimony on this very important subject matter, and I look forward to continued conversation.

Respectfully submitted: *Janice Walters, Executive Director, RHRC*