CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Findings at a Glance

Pennsylvania Rural Health Model (PARHM)

Evaluation of Performance Years 1-4 (2019-2022)

MODEL OVERVIEW

The Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS) developed the Pennsylvania Rural Health Model (PARHM or model) with the Commonwealth of Pennsylvania to maintain access to essential health care services in rural communities. The model aims to achieve the following goals in rural Pennsylvania over six performance years (2019-2024):

- Improve population health outcomes
- Increase access to high-quality care
- Strengthen the financial viability of rural acute care hospitals
- Reduce the growth of hospital expenditures across payers (i.e., Medicare fee-for-service [FFS], Medicare Advantage, commercial, Medicaid; detailed in 'Participation')

Two key mechanisms are used to achieve the model aims:

1) **Hospital global budgets** are prospectively set payment amounts for hospital services. Medicare FFS provides fixed biweekly payments to hospitals.
2) **Hospital transformation plans** describe activities that participating hospitals will implement to address community health needs, attain financial sustainability for the hospital, and achieve savings/budget neutrality for payers.

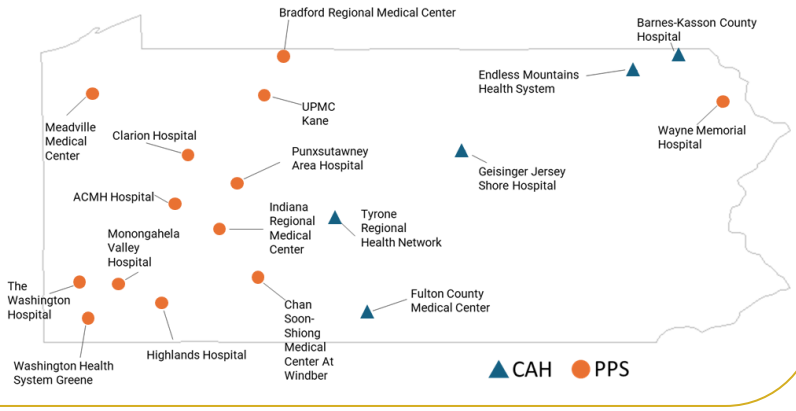
Participation

The 18 participating hospitals in PY3 (2021) all maintained participation in PY4 (2022):

- 5 critical access hospitals (CAHs)
- 13 Prospective Payment System (PPS) hospitals

Payer participation remained consistent in PY4 (2022):

- Geisinger, Highmark Blue Cross Blue Shield, University of Pittsburgh Medical Center, Aetna, Highmark Wholecare, and Medicare FFS



KEY TAKEAWAYS

- PARHM aimed to support innovation and system transformation, and advance healthy equity in rural Pennsylvania.
- The model provided the impetus for participating hospitals and payers, implementation and community partners, and other state entities to convene and innovate, advancing hospitals' and the Commonwealth's transformation goals. For example, three participating hospitals partner with local organizations to provide on-site case management and recovery support services to improve access to treatment for substance use disorder.
- The model's biweekly payments and focus on care transformation provided some financial stability and a fiscal buffer to hospitals, though the reconciliation process did create uncertainty.
- Greater financial predictability could be ensured through enhanced technical assistance, simplicity and transparency in the global budget and reconciliation methodology, guardrails around the magnitude of settlement payments, and alignment of financial incentives with concurrent value-based care initiatives. Improved predictability could enable better forecasting of funds available for transformation.
- Engagement and upfront investment from other health plans, private sector, state and local entities, and philanthropic organizations can enhance transformation sustainability.

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 Fourth Annual Evaluation Report, visit https://innovation.cms.gov/innovation-models/pa-rural-health-model.

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KEY FINDINGS

Experiences with the Global Budget and Reconciliation

- Overall, average global budget payments to PPS hospitals consistently exceeded the FFS value of services rendered.
- Prospective Medicare FFS global budgets were adjusted upwards for PPS hospitals and downwards for CAHs in the second year of participation.
- Hospitals and commercial payers reported that the global budget's reconciliation process did not eliminate year-to-year financial unpredictability.
- Unplanned volume shift (UVS) adjustments were a substantial component of Medicare FFS reconciliation payments for most hospitals. Participating hospitals attributed negative UVS adjustments to clinician losses and market competition.
- While participating hospitals appreciated the stable cash flow, they cited lack of allocated funds and concern about potential paybacks resulting from future reconciliations as barriers to investing in care transformation. Participating hospitals made incremental changes to improve the quality of care and population health.

Behavioral Health Transformation

- The development of specific, actionable hospital transformation goals served as a catalyst for participating hospitals to address behavioral health needs at the patient and community levels.
- Participation in the model motivated hospitals to partner with local primary care providers, counseling services, and social service organizations.
- Market areas of participating hospitals had higher rates of follow-up after ED discharge among Medicaid patients for substance abuse disorder (SUD) compared to market areas for similar hospitals and to national benchmarks. However, adherence to pharmacotherapy remains low and even decreased in areas served by PARHM hospitals.
- While participating hospitals noted that model participation encouraged investment in medication-assisted treatment (MAT), barriers to local treatment persist, including resistance from providers and clinical directors to providing MAT services (such as liability concerns, lack of time, and staff turnover).

Interactions/Alignment between the Model and Other Value-Based Care Programs

- Some participating hospitals participate in concurrent value-based care programs such as the CMS Medicare Shared Savings Program (SSP). In 2022, nine participating PPS hospitals had market areas where 30% or more of Medicare FFS patients were assigned to an SSP accountable care organization.
- While PARHM and concurrent value-based care programs share some similarities in overarching program goals, hospitals noted challenges participating in multiple programs with different patient populations, quality metrics, and payment mechanisms.
- When concurrent value-based care programs have complementary approaches to care delivery transformation, it may create efficiencies and increase value in participation.