New Rural Payment Models

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Challenges to rural hospitals

High fixed cost

Reductions in population and/or admissions

Smaller financial margins than urban hospitals

Smaller patient volume -> variability in revenue flow

Supplies/equipment expensive

Challenges in recruiting/retaining physicians

Four new models

Vermont	All-payer Accountable Care Organizations (ACOs)
Maryland	All-payer model with global budgets (focus on cost containment)
Pennsylvania	Multi-payer global budgets for rural hospitals with deliberate plan to transform care (focus on retaining jobs and access to care)
Washington	Rural Multi-Payer Transformation Model **under way**; plan for global budgets for hospitals and community transformation

Pennsylvania Rural Health Model

6-year demonstration w/CMS providing $25M

Global budgets for hospitals (>90% net revenue after year 2)

Spending growth rate targeted at 3.38%

Performance incentives for

1. increasing access to primary and specialty care
2. improved chronic disease management and preventive screenings; and
3. decreasing deaths from substance use disorder

Rationale

Global budget -> stability and predictability

Hospitals can focus on keeping patients healthy (and out of hospital)

Communities can customize according to needs

Opportunities to address social determinants of health

Opportunity to address state and federal regulatory barriers (e.g., workforce, scope of practice)

Transformation possibilities

Opportunity to capitalize on expansion of telehealth

Over time, communities can reassess needs

Replace existing hospital with freestanding emergency departments, emergency medical centers, other services that meet need and retain jobs.

Considerations

All payer/multi payer (need at least 80% of revenue in global budget)

Engagement of Medicare

Inclusion of physician services in global budget

Mandatory vs. voluntary?

Need for quality/access measures

Need for community transformation plan