Oral Testimony of Karen M. Murphy, PhD RN
Chief Innovation Officer, Geisinger
United States Senate Committee on Finance
Washington, D.C.
May 24, 2018

Chairman Hatch, Ranking Member Wyden, and Members of the Committee, thank you for inviting me to testify today about rural hospitals. To provide context for my perspective, I would like to share my background. I started my career as a registered nurse in a community hospital in northeastern Pennsylvania. I held various positions at the hospital, ultimately serving as the President and Chief Executive Officer. Following my time at the hospital I spent two years at the Center for Medicare and Medicaid Innovation where I led the State Innovation Models Initiative. I then served for two and a half years in Governor Tom Wolf's cabinet as Secretary of Health. In 2017, I joined Geisinger as Chief Innovation Officer and Founding Director of the Steele Institute for Health Innovation. It was during my time with the state that I led the Pennsylvania Rural Health Initiative. Today, I'd like to share the development and evolution of this innovative payment and delivery model for rural hospitals.

I began my tenure as Secretary of Health assessing the status of the health care delivery systems in Pennsylvania. I was struck by the financial instability of the rural hospitals. An overwhelming majority of the 67 rural hospitals were not in a position to weather any financial challenge and had not invested in their facilities for many years. I found from my research that rural hospitals in other states faced the same challenges at those in Pennsylvania.

Today, rural hospitals provide essential health care services for 57 million people across the country, but achieving financial stability is difficult for most hospitals.[1] The reasons for the instability are multifaceted. Nationally, the number of inpatient admissions is declining, a trend that is also prevalent in rural hospitals. Rural hospitals also lack the financial and human resources to offer complex, highly specialized inpatient care that is required for most admissions today. In addition, reimbursement for rural hospitals remains predominantly fee for service, with public payers contributing a sizable percentage of the hospitals' revenue. The combination of declining inpatient admissions, resulting in decreased reimbursement, and a payer mix that yields a lower price per service has greatly contributed to the current crisis in rural hospitals.

The most recent statistics indicate that over the past seven years, 83 of 2244 rural hospitals in the United States have closed.[2] One analysis suggests that without intervention, an estimated 673 rural hospitals in the United States may also close over the next five years.[3] Individuals residing in rural communities tend to have poorer health outcomes compared with residents of urban areas. For example, opioid overdose deaths and the incidence of obesity, cancer, and cardiovascular disease are also more predominant in rural communities.[4]

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[1] 1. Gugliotta G. Rural hospitals, beset by financial problems struggle to survive.*Washington Post*. https://www.washingtonpost.com/national/health-science/rural-hospitals-beset-by-financial-problems-struggle-to-survive/2015/03/15/d81af3ac-c9b2-11e4-b2a1-bed1aaea2816_story.html. Published March 15, 2015.

[2] 2. The Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. 83 Rural hospital closures: January 2010-present. http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures.

[3] to closure, iVantage study claims. Healthcare Finance. http://www.healthcarefinancenews.com /news/more-200-rural-hospitals-are-close-closure-ivantage-study-claims. Published February 16, 2016. Accessed December 16, 2017.

[4] 4. Garcia M, Faul M, Massetti G, et al. Reducing potentially excess deaths from the five leading causes of death in the rural United States. *MMWR Surveillance Summ*. 2017;66(2):1-7.

Historically, federal and state governments have made unsuccessful attempts to stabilize rural hospitals by providing additional payments. Because the subsidies were largely based on fee-for-service and inpatient admissions, they provided little benefit.

After having worked on the Maryland All-Payer Model while at CMMI and seeing the impressive results, we decided to design a similar model for rural hospitals in Pennsylvania.

Pennsylvania has the third largest rural population in the United States,[5] and 67 of 169 hospitals are in rural communities.[6] More than 58% of the hospitals have mounting financial pressures resulting in break even or negative operating margins.[6]

We worked collaboratively with CMMI on designing the model. The design period was launched in January of 2017. The objectives of the model are to provide a path to improving health and health care delivery in rural communities. Rural health transformation promotes transition to higher quality, integrated, and value-based care. The model changes the way participating hospitals will be reimbursed by replacing the current fee-for-service system with a multi-payer global budget based on hospitals' historic net revenue. Like Maryland, the payment model in Pennsylvania is designed to include Medicare, Medicaid, and commercial payers. However, it was necessary to develop a new methodology since Maryland has the authority to establish hospital rates. Pennsylvania does not.

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5 US Census Bureau. 2010 Census urban and rural classification and urban area criteria. https://www .census.gov/geo/reference/ua/urban-rural-2010.html..

6 6. Pennsylvania Health Care Cost Containment Council. Financial analysis 2016: general acute care hospitals: an annual report on the financial health of Pennsylvania hospitals. http://www.phc4.org /reports/fin/16/docs/fin2016report_volumeone.pdf. Published April 2017.

The model moves rural hospitals from focusing on inpatient-centric reactive health care services to a greater focus on outpatient-centric health care services, with an emphasis on population health and care management. It replaces the current fee-for-service system with little emphasis on quality and safety to a payment model that includes direct incentives to improve quality and safety and eliminate sub-scale service lines.

Rural hospitals are encouraged to move from traditional care delivery model rendered directly by onsite health care providers to innovative care delivery models enabled by technologies such as tele-health, video conferencing, remote monitoring, and diagnostic scanning. The vision is that rural hospitals will invest in care coordination such as reaching out to patients who frequently use emergency services and connecting them with a primary care provider or guiding patients after hospital discharge to make sure they follow up with a physician. It also includes population health and preventative care services such as chronic disease prevention programs and behavioral health initiatives, including those targeting drug abuse and addiction, and the expansion of medical health homes to include medication-assisted treatment programs. Participating hospitals will have the ability to invest in social services that address community issues that lead to detrimental health outcomes – such as parenting classes and connections to social services for eligible benefits such as WIC. The model will be evaluated measuring improvements of health status and health care delivery in the participating rural communities.

Based on the global budget, participating hospitals are expected to develop a transformation plan that could outline an innovative approach to improving health and health care delivery. The hospitals are encouraged to work with community agencies, including United Way, Area Agencies

on Aging, and drug and alcohol treatment centers, to develop services based on their communities' needs. To provide participating hospitals with transformation support, Pennsylvania plans to create a Rural Health Redesign Center (RHRC). CMS has entered a cooperative agreement to provide Pennsylvania up to $25 million over 5 years to support the RHRC. The RHRC will provide a way to deploy capabilities to support all participating hospitals.

Pennsylvania is planning to engage six hospitals in the initial performance year, gradually expanding participation to include 30 rural hospitals across the state by the third performance year. At Geisinger, we are a participant in the initial phase. Dr. David Feinberg, Geisinger CEO, has been a staunch supporter of the initiative since its inception. The model builds on Geisinger's vision for building a health care delivery system that focuses on improving health and value creation for each community we serve. We are looking forward to working with the state on this important initiative.

The financial challenges of rural hospitals today are the result of a changing health care industry. Even though rural hospitals may not offer the same services as they did in the past, it is possible that they can be leveraged to improve the health of those residing in rural communities. This model, if it achieves better quality and lower costs, could potentially be scaled as a model for the nation for rural health care delivery.

Next week, I will be speaking at a Global Budgeting Summit at Johns Hopkins University. Twenty states have registered to participate. The federal government has the opportunity to engage additional states in the Pennsylvania Rural Health Model. Implementing the model

across diverse states gives the opportunity for it to evolve. Adding additional resources to the Rural Health Redesign Center would bring efficiency and an ability to disseminate best practices in rural health transformation across the United States.

Thank you for your interest in aiding rural hospitals. Rural communities deserve access to health care. We must continue to identify innovative approaches that offer a pathway to that goal.

Written Testimony of Karen M. Murphy, PhD RN
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Chairman Hatch, Ranking Member Wyden, and Members of the Committee, thank you for inviting me to testify today about rural hospitals. To provide context for my perspective, I would like to share my background. I started my career as a registered nurse in the Intensive Care Unit in a community hospital in northeastern Pennsylvania. I held various positions at the hospital, ultimately serving as the President and Chief Executive Officer. Following my time at the hospital I spent two years at the Center for Medicare and Medicaid Innovation (CMMI) where I led the State Innovation Models Initiative. I then served for two and a half years in Governor Tom Wolf's cabinet as Secretary of Health, before joining Geisinger as Chief Innovation Officer and Founding Director of the Steele Institute for Health Innovation. It was during my time with the state that I led the Pennsylvania Rural Health Initiative. Today, I'd like to share the development and evolution of this innovative payment and delivery model for rural hospitals.

As a cabinet member, I recognized that I had limited time in my role and wanted to be impactful. I began my tenure assessing the status of the health care delivery systems in Pennsylvania. I learned that, for the most part, hospitals in Philadelphia and Pittsburgh were doing well and did not need my help. However, I was struck by the financial instability of the vast majority of 67 rural hospitals. Their number of days cash-on-hand was very low, and their facilities' age-of-plant was well above benchmarks. This meant that the hospitals had little ability to weather any financial challenge and had not adequately invested in facilities for many years.

As I began to research rural hospitals in other states, I found that the challenges faced by rural hospitals across the country mirrored those in Pennsylvania.

Today, rural hospitals provide essential health care services for 57 million people across the country. However, the ability to achieve financial stability is difficult for most hospitals.[1] The reasons for the instability are multifaceted. Nationally, inpatient admissions are declining, a trend that is also prevalent in rural hospitals. Rural hospitals also lack the financial and human resources to offer complex, highly specialized inpatient care required for most admissions today. In addition, reimbursement for rural hospitals remains predominantly fee-for-service, with public payers contributing a sizable percentage of the hospitals' revenue. The combination of declining inpatient admissions resulting in decreased reimbursement and a payer mix that yields a lower price per service has been a large contributor to the current crisis in rural hospitals.

Over the past seven years, 83 of 2244 rural hospitals in the United States have closed.[2] One analysis suggests that without intervention, an estimated 673 rural hospitals in the United States may also close over the next five years.[3] Preserving health care in rural communities is imperative people living in rural communities tend to have poorer health outcomes compared with residents of urban areas. For example, opioid overdose deaths and the incidence of obesity, cancer, and cardiovascular disease are also more predominant in rural communities.[4] Given the financial

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[1] 1. Gugliotta G. Rural hospitals, beset by financial problems struggle to survive.*Washington Post*. https://www.washingtonpost.com/national/health-science/rural-hospitals-beset-by-financial-problems-struggle-to-survive/2015/03/15/d81af3ac-c9b2-11e4-b2a1-bed1aaea2816_story.html. Published March 15, 2015.

[2] 2. The Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. 83 Rural hospital closures: January 2010-present. http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures.

[3] to closure, iVantage study claims. Healthcare Finance. http://www.healthcarefinancenews.com /news/more-200-rural-hospitals-are-close-closure-ivantage-study-claims. Published February 16, 2016. Accessed December 16, 2017.

[4] 4. Garcia M, Faul M, Massetti G, et al. Reducing potentially excess deaths from the five leading causes of death in the rural United States. *MMWR*

pressure under their current fee-for-service reimbursement structure, rural hospitals are frequently unable to address the health of their communities. Economic instability is also more prevalent in rural communities. Poverty rates are higher. Hospitals are frequently the largest employer affecting the entire economy in the rural community.

While at CMMI I had the opportunity to work on the Maryland All-Payer Model. With this model, hospitals are reimbursed by a global budget based. The hospitals are accountable for the total cost and quality of care. Maryland began global budgeting for rural hospitals in 2010 with great success. Maryland extended the model to include all hospitals in January 2014 and has yielded positive results over the past four years. That provided the foundation of the Pennsylvania Rural Health Initiative.

Pennsylvania has the third largest rural population in the United States,[5] and 67 of 169 hospitals are in rural communities.[6] More than 58% of the hospitals have mounting financial pressures resulting in break even or negative operating margins.[6] Pennsylvania recognized the health and socioeconomic imperative involving rural communities. We estimated that over 27,000 people were employed by rural hospitals.

We began the work on the Pennsylvania initiative in the spring of 2015 and presented the initial concept to CMMI in the fall of 2015. We worked collaboratively with CMMI on refining the

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Surveillance Summ. 2017;66(2):1-7.

5 US Census Bureau. 2010 Census urban and rural classification and urban area criteria. https://www .census.gov/geo/reference/ua/urban-rural-2010.html..

6 6. Pennsylvania Health Care Cost Containment Council. Financial analysis 2016: general acute care hospitals: an annual report on the financial health of Pennsylvania hospitals. http://www.phc4.org /reports/fin/16/docs/fin2016report_volumeone.pdf. Published April 2017.

model. The design period was launched in January of 2017. The objectives of the model are to provide a path to improving health and health care delivery in rural communities. The model changes the way participating hospitals will be reimbursed by replacing the current fee-for-service system with a multi-payer global budget based on hospitals' historic net revenue. Like Maryland, the payment model in Pennsylvania is designed to include Medicare, Medicaid, and commercial payers. However, it was necessary to develop a new methodology since Maryland has the authority to establish hospital rates. Pennsylvania does not.

The model provides that the hospital budget will be prospectively calculated, and each month the hospital will be paid 1/12 of the total budget amount. This approach is expected
to provide rural hospitals with a predictable revenue stream. Most importantly, it could support the transformation of delivering health care services. The global budget is intended to incentivize rural hospitals to retain the established revenue base, regardless of hospital use. To achieve this, payers are expected to invest in the health of the population residing in rural communities. Annual adjustments are planned to account for changes in market share for the commercial payers.

Based on the global budget, participating hospitals are expected to develop a transformation plan that could outline an innovative approach to improving health and health care delivery. The hospitals are encouraged to work with community agencies, including United Way, Area Agencies on Aging, and drug and alcohol treatment centers, to develop services based on the communities' needs. Hospitals may choose to reconfigure or eliminate substandard or underused inpatient service lines and invest in community-facing interventions. Expanded care coordination, growth in behavioral health services with an emphasis on the opioid crisis, and increased access to

preventive services, such as colonoscopy and mammography, are examples of strategies that rural hospitals can execute to improve community health.

To support participating hospitals' transformation, Pennsylvania plans to create a Rural Health Redesign Center (RHRC). CMS has entered a cooperative agreement to provide Pennsylvania up to $25 million over five years to support the RHRC. The RHRC will provide a way to deploy scaled capabilities to support all participating hospitals. The RHRC will perform the following key functions throughout the Performance Period of the Model:

- Model Oversight: Provide oversight, approve Global Budgets and transformation plans. Advise on and approve changes to operational and payment mechanisms, and approve reasonable exceptions to agreed-upon payment algorithms and rules through an approved procedure.
- Global Budget Administration: Run algorithms for the defined payment model logic to determine Global Budget amounts, adjustments, and payer proportions.
- Data Analytics: Analyze and report to support model-specific goals. Provide stakeholders with regular reports to inform decision-making. Securely collect and store data from payers and providers. Clean data for performance reporting and budget calculation.
- Technical Assistance: Provide strategic and operational technical assistance to support care delivery transformation. Convene hospitals to share best practices. Change management.
- Quality Assurance: Provide an annual assessment of compliance with transformation plan and Global Budget targets. Recommend corrective action plans where needed. Contract with an independent outcome evaluation group to provide board and CEO with rigorous

evaluation of model's progress against population health, quality of care, and cost targets.

Engage stakeholders through an advisory panel for input on program policy and outcomes.

In addition, Pennsylvania has established savings goals for Medicare. Over the next five years, participating rural hospitals are expected to implement strategies that could save an estimated minimum of $35 million to Medicare over the life of the model. The plan stipulates that in the first two years, rural hospitals retain 100% of the realized savings. In the third year, the hospitals will retain 75% of the savings. In subsequent years, the payers and hospitals are expected to share an equal portion of the savings. Pennsylvania has also agreed to demonstrate improvement in access to health services, quality of care, and population health outcomes.

Pennsylvania is planning to engage six hospitals in the initial performance year, gradually expanding participation to include 30 rural hospitals across the state by the third performance year.

However, this initiative has clear challenges. While Maryland has experienced success using global budgets, as previously pointed out, a notable distinction is that Maryland is using its regulatory authority to establish inpatient hospital rates for all payers. Demonstrating success using multi-payer global payments in a non–rate setting state will be tested in the Pennsylvania model. In addition, the size of the state and the large number of commercial and Medicaid-managed care organizations will pose challenges. Also, the goal of the program is to stabilize the financial status of rural hospitals but at the same time reduce the cost to payers. Reconciling these two goals will be a challenge.

The lessons learned in developing this model could assist other states in this journey. The model requires strong support from the governor, state and federal legislators. In Pennsylvania, Governor Wolf was engaged early in the process and identified the model as one of his priorities. In Pennsylvania, the model engaged several state agencies in addition to the Department of Health. The Department of Agriculture, Department of Human Services and the Insurance Department all contributed to the work. The support of the Governor was critical in achieving an effective collaboration across state agencies.

States may require enabling legislation to execute the model. In Pennsylvania, state legislators were briefed early in the development of the model. The Department also engaged Senator Casey's office and the US Secretary of Agriculture, Tom Vilsak, throughout the design of the initiative.

This model is complex, requiring sophisticated data analytics and technical assistance. State agencies ordinarily do not have those internal resources or capabilities, and will require consultants with expertise in payment models and health care transformation to support the work.

Pennsylvania also worked with experts in Maryland in the design. The former Secretary of Health, Dr. Josh Sharfstein, and the Executive Director of the HRSC in Maryland, Donna Kinzer, were tremendous resources to Pennsylvania. Maryland's vast experience can be helpful in other states in designing global budgets.

The Pennsylvania Hospital Association was extremely helpful in supporting the model. They assisted the state in engaging hospital CEOs early in the process and throughout the design process. States will be required to collaborate with their state hospital association.

Engage rural hospitals early in the process is also essential. This model requires that each participating hospital have a CEO and Board of Directors with a vision and commitment for transformation. Hospitals need adequate time to develop effective transformation plans. The transition from fee-for-service reimbursement to a global budget requires a completely new paradigm moving from volume to value.

At Geisinger, we are a participant in the initial six hospitals. Dr. David Feinberg, Geisinger CEO, has been a staunch supporter of the initiative since its inception. The model builds on Geisinger's vision for building a health care delivery system that focuses on improving health and value creation for each community we serve. We are looking forward to working with the state on this important initiative.

CMS and Pennsylvania have demonstrated a strong interest in stabilizing health care in rural communities. Previous attempts to stabilize rural hospital by federal and state governments providing additional payments have been unsuccessful. These subsidies were largely based on fee-for-service and inpatient admissions, and therefore, provided little benefit.

The financial challenges of rural hospitals today are the result of a changing health care industry. Even though rural hospitals may not offer the same services as the past, it is possible they can be

leveraged to improve the health of those residing in rural communities. This model, if it achieves better quality and lower costs, could potentially be scaled as a model for the nation for rural health care delivery.

Next week, I will be speaking at a Global Budgeting Summit at Johns Hopkins University. Twenty states have registered to participate. The federal government has the opportunity to engage additional states in the Pennsylvania Rural Health Model. Implementing the test across diverse states gives the opportunity for the model to evolve. Additional resources to the Rural Health Redesign Center would bring efficiency and an ability to disseminate best practices in rural health transformation across the United States.

Thank you for your interest in aiding rural hospitals. Rural communities deserve access to health care. We must continue to identify innovative approaches that offer a pathway to that goal.