Rural Focus

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# Lessons for Rural Hospital Boards about Value-Based Care

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**As the American healthcare system makes the transition from reimbursement based on volume to reimbursement based on value, rural hospital boards are at a decision point.** The question that needs to be answered is not whether to adopt value-based payment; hospitals must move forward and will need to choose among the available options and have a plan for success. In any value-based payment model, a critically important factor is dependable revenue streams, both from population health services and from programs specific to safety-net facilities, such as the 340B drug discount program.

In its recent 10-year anniversary strategy refresh, the Centers for Medicare and Medicaid Services Innovation Center (CMMI) announced a goal of getting all Medicare lives and most Medicaid lives into accountable care or other total-cost-of-care arrangements by 2030. In order to meet that goal, all providers will need to participate in value-based contracts of one form or another. Rural hospital boards should consider joining an accountable care organization and adopting a team-based approach to preventive care as a solid way to get a foothold in value-based payment.

## When a Rural Hospital Closes

Rural health challenges are serious and getting worse. According to the Government Accountability Office, more than 100 rural hospitals have closed over the last 10 years and the circumstances of the pandemic threaten to prolong this crisis.[1] In a fee-for-service world, providers are at the mercy of the ebbs and flows of procedure volume. When volume plummeted during the pandemic, many providers faced the possibility of closure. While volume has rebounded, we are not out of the woods with COVID-19 and rural providers' revenue streams continue to be volatile.

1 "Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services," U.S. Government Accountability Office, December 22, 2020.

When a rural hospital closes, the entire community feels the effects, which go beyond the availability of health services. The loss of a hospital means that rural residents, who according to the Centers for Disease Control and Prevention have a greater risk of death from serious health conditions than other communities, will have to travel farther for care.[2] This creates a real risk that those patients will simply forgo care, worsening the trend of poor health in rural communities.

Rural facilities are also struggling with job churn and a shortage of healthcare professionals.[3] Successful accountable care organizations are rooted in team-based care focused on prevention and keeping people healthy. Participating in an ACO can introduce new clinical workflows and make sure that no one staff person is overwhelmed.

## Medicare Is Making Strides in Helping Rural Safety-Net Facilities

Medicare program officials have long been supportive of rural safety-net facilities' participation in value-based payment models. From 2016 to 2018, CMS provided start-up loans to small, mostly rural ACOs in the ACO Investment Model (AIM). This program became the most successful CMMI model ever launched, with ACOs paying back more than $380 million in shared savings over the life of the model.

The time is right to consider how to continue this success and encourage more rural safety-net facilities to embrace value-based payment. In 2020, the Trump

### → Key Board Takeaways

- Value-based care is in the future and you must prepare now.
- Don't reinvent the wheel—learn from the rural ACOs that have already succeeded.
- Team-based care delivery can save you from staff burnout.
- Organized advocacy can help encourage programs like AIM that make value-based payment workable.
- Don't overlook your 340B program—that money could make a huge difference.

2 Centers for Disease Control and Prevention, "About Rural Health."
3 Aallyah Wright, "Rural Hospitals Can't Find the Nurses They Need to Fight COVID," The PEW Charitable Trusts, September 1, 2021.

Administration announced a set of rural-focused value-based payment models, called Community Health Access and Rural Transformation (CHART). One of the two tracks would have borrowed heavily from the success of AIM by offering another round of start-up loans to rural ACOs. Unfortunately, the program has had a rocky start, with the AIM-like funding track eventually being eliminated from the model.

In March 2022, at the request of the House Committee on Ways and Means, the Medicare Payment Advisory Commission (MedPAC) discussed how Medicare can support safety-net facilities. It is encouraging to see Congressional authorizing committees elevating the concerns of safety-net facilities to this influential commission. In its discussion, MedPAC pointed to the challenge of balancing support for rural providers with fiscal obligations and explored ways to target payments rather than increase payment across the board.

The Biden Administration has continued to support rural providers as they seek an entry point to value-based payment. The cancellation of the CHART ACO track was a disappointment, but the new ACO Realizing Equity, Access, and Community Health (REACH) model is very promising. REACH will create ACOs that assume higher risk and offers providers greater flexibility in the way of benefit enhancements and beneficiary incentives to deliver patient-centered care. This new program gives all providers, including rural hospitals and safety-net facilities, another viable value-based option.

## 340B Drug Discounts Create Financial Stability

Many rural hospitals are safety-net facilities eligible for the federal 340B drug discount program. 340B is critical to the financial security of safety-net hospitals and boards should be aware of how much this program can help. These significant prescription drug discounts can be a lifeline for providers serving low-income and vulnerable populations.

For nearly 30 years, the 340B program has enabled safety-net hospitals and other providers serving vulnerable communities to stretch scarce federal resources by offering significantly reduced prices for prescription drugs. Pharmaceutical manufacturers are required by law to provide these discounts, typically about 50 percent on brand-name drugs, to health facilities that make up the safety net, including critical access hospitals, disproportionate share hospitals, sole community hospitals, and federally qualified health centers. Collectively, these facilities are known as 340B covered entities.

The revenue from drug discounts becomes even more important in the shift away from traditional fee-for-service to value-based payment. Those discounts can allow the covered entity to hire more staff, see more patients, and provide more care. By increasing the use of community pharmacies and ensuring that patients and providers are eligible participants, a covered entity can maximize 340B savings to expand and maintain its services to the community. This kind of systematic 340B planning can make the difference between surviving a public health emergency such as the COVID-19 pandemic and closing forever.

Many rural hospital boards have tried to calculate the risks and rewards of value-based payment. In AIM, CMS calculated all participants' ACO expenses and found an average expense of $87 per participant per year, which was offset by the average shared savings amount. Maximizing participation in the 340B program by finding and documenting referral claims and building a contract pharmacy network, could make the difference between a healthy ACO and a value-based care failure.

Rural providers have unique challenges and opportunities in value-based payment. Value-based payment can help maximize revenue while retaining services locally. Programs like AIM can help build on what rural hospitals do best while helping the transformation to new ways of delivering care. Rural hospital boards could advocate for an additional round of AIM-like funding to support rural ACOs and give those providers a real chance to succeed in value-based payment.

*The Governance Institute thanks Lynn Barr, Chief Innovation Officer at Signify Health, for contributing this article. She can be reached at lbarr@signifyhealth.com.*