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Advancing Value-Based Payment Policies Relevant to Rural Areas – Continued Challenges and New Opportunities

EXECUTIVE SUMMARY

Lessons from the recent public health emergency, rising health care costs, improved quality measurement, and innovative technologies are driving the health care transition from volume-based payment (i.e., fee-for-service with no connection to value) to value-based payment (VBP). Since the December 2020 Rural Health Value (RHV) report titled "How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report,"[1] important federal VBP policy advances have occurred. In 2021, the Center for Medicare & Medicaid Innovation (Innovation Center) released the *Innovation Center Strategy Refresh*. The purpose of Strategic Direction 1 is to drive accountable care: "All fee-for-service Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030." In 2022, the Centers for Medicare & Medicaid Services (CMS) *Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities* includes Priority 6: Drive Innovation and Value-Based Care in Rural, Tribal, and Geographically Isolated Communities.

Recent CMS and the Innovation Center policies in support of rural transitions to VBP are encouraging. For example, the Medicare Shared Savings Program (Shared Savings Program) includes a new payment option (Advance Investment Payments) to encourage health care providers in rural and underserved areas to join and form accountable care organizations. A prior Innovation Center demonstration, the ACO Investment Model (AIM), provided similar upfront payments for rural ACOs and informed this Shared Savings Program change.

Despite laudable CMS and Innovation Center emphases on VBP, the transition from health care volume to value has been slower in rural America than in urban areas. Rural health care organizations (HCOs) deserve equal opportunities to participate in the volume-to-value transition. Selected opportunities listed herein (categorized by the following seven VBP model themes) reflect RHV Team assessment of policies still needed to:

- Expand rural-appropriate opportunities to shift health care payment gradually but persistently from volume-based to value-based.
- Create rural-urban parity in implementing VBP to achieve the Triple Aim of better patient care, improved community health, and smarter spending.
- Address disparities in quality, access, affordability, and VBP experience between rural and urban providers.

- Consider cost growth control, not simply pure savings, when defining program and model cost "savings" within the context of CMMI's legislative charge to test innovative payment and service delivery models to reduce program expenditures.[2]

The RHV Team recommends that CMS and the Innovation Center consider the following:

1. Rural-Oriented Design

- Provide a clear path to HCO financial stability and sustainability during model design and implementation so as not to jeopardize access to care through health care organization insolvency.
- Employ rural health experts (e.g., practicing clinicians, CEOs, and accountants) to help design models rather than relying exclusively on requests for information and listening sessions to gather rural perspectives.

2. Transitions from Fee-for-Service to Value-Based Payment

- Design new payment systems that provide the stability of cost-based reimbursement and all-inclusive rates but help Critical Access Hospitals (CAHs) and Rural Health Clinics transition to VBP.
- Adjust CAH payment not simply based on CAH designation, but instead on fixed-to-total-cost ratios that recognize the value of standby costs (a form of fixed costs) that ensure access to care.

3. Innovation Center Model and CMS Program Alignment

- Design and adjust Innovation Center models so cross-participation with other CMS programs is possible and encouraged.
- Encourage early development of value-based care (VBC) opportunities for new provider types, such as the Rural Emergency Hospital designation, that would allow these facilities to support VBC delivery and community health improvement.

4. Upfront Infrastructure Investment

- Provide comprehensive and timely data analysis that results in quality and profit improvement to increase the likelihood of participant clinical and financial success.
- Fund technical assistance for transitions from fee-for-service to VBP.

5. Rural-Relevant Planning and Care Delivery

- Account for disparities (geographic and other) in value-based payment policy.
- Design telehealth care policies that support local health care, not supplant local health care.

6. Flexibility and Timing

- Extend model duration and the time allowed to achieve cost reduction.

- Incorporate yearly model assessments that are rapidly reported to model participants and specifically identify model changes to be implemented to improve the likelihood of participant success.

7. Information Technology and Data

- Pay for Z-code reporting to support data collection and eventual payment risk-adjusted for social determinants of health or health-related social needs.
- Deploy systems to combine and disseminate timely quality and cost data so clinicians can make value-based clinical and referral decisions that facilitate care coordination among health care organizations.

RURAL VALUE-BASED PAYMENT URGENCY

The COVID-19 pandemic and the associated public health emergency accelerated the momentum to change the way rural health care is delivered and financed. Inherent weaknesses in the long-standing fee-for-service (FFS) payment model with no connection to value were exposed during the first two years of the pandemic. Standby capacity had been reduced, making it difficult to respond to surges in demand due to infection hot spots. Demands for inpatient and Intensive Care Unit (staffed) beds, ventilators, and medical personnel skyrocketed. Additionally, demand for an active presence in community-based efforts to slow the infection spread created more rural health care organization stress. Paradoxically, system dependence on patient revenues from FFS suffered as resources had to be shifted to COVID-19 patients. Many health care organizations (HCOs) did not have resources to continue services that previously resulted in FFS payment, threatening financial viability. Fortunately for rural HCOs, the COVID-19 relief funds provided by the federal government through three successive infusions more than compensated for lost revenue and stabilized finances in the short term. However, the special payments are best seen as a delaying action. Long-term sustainability of the rural health care system, as well as prospects for achieving the Triple Aim (i.e., better patient care, improved community health, smarter spending), will not be achieved by continued reliance on a payment system as inflexible as FFS.

Simultaneously, the pandemic highlighted the breadth and depth of health disparities (including geographic disparities), many of which are exacerbated by current payment policies and systems. The pandemic has brought longstanding challenges into sharp focus as rural health care organizations and communities strive to create a high-performing rural health system. The disproportionate impact of the pandemic on historically underserved and underrepresented populations exposed inequities, some related to how health services were organized, delivered, and financed. Other inequities, such as housing and employment opportunities, are not as causally related to health services delivery, but meeting the aims of better patient care and improve community health is not possible without addressing those inequities. Completing the transition to value-based payment would create incentives and revenue to address health care system and community needs.

NEW VALUE-BASED PAYMENT POLICIES

Lessons from the recent public health emergency, rising health care costs, improved quality measurement, and innovative technologies are driving the health care transition from volume-based payment (i.e., FFS with no connection to value) to value-based payment (VBP). VBP is payment for health care that delivers one or more parts of the Triple Aim. Although limited VBP programs existed prior (including pay-for-performance programs and the Physician Group Practice Transition Demonstration[3]), the Patient Protection and Affordable Care Act of 2010 (PPACA) jump-started federal VBP efforts by creating the Center for Medicare & Medicaid Innovation (Innovation Center).[4] As the Centers for Medicare & Medicaid Services (CMS) stated

in a recent Request for Information about a new model: "In accordance with section 1115A of the Social Security Act, the Innovation Center tests models that are expected to improve or maintain quality of care while reducing or maintaining program expenditures."[5]

Since the December 2020 Rural Health Value (RHV) report titled "How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report,"[6] important federal VBP policy advances have occurred. In the 2021 *Innovation Center Strategy Refresh*, the Innovation Center stated that the purpose of Strategic Direction 1 is to drive accountable care, "All fee-for-service Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030." And "The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030."[7] Furthermore, the Innovation Center aims to advance health equity by engaging "providers who have not previously participated in value-based care and ensure that eligibility criteria and application processes do not inadvertently exclude or disincentivize care for specific populations, including patients in rural and underserved communities."[8] In 2022, CMS released the *Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities* which includes Priority 6: Drive Innovation and Value-Based Care in Rural, Tribal, and Geographically Isolated Communities. Key supporting activities for Priority 6 include:

- "Incorporate equity principles in the design of models and demonstrations to test and scale innovations in rural health delivery.
- Ensure inclusion of health care providers serving rural, tribal, and geographically isolated communities in CMS models, programs, and quality improvement initiatives.
- Support State Medicaid and CHIP agencies and other state and local agencies to prepare for and respond to public health emergencies, disasters, and threats in rural, tribal, and geographically isolated communities."[9]

Despite laudable CMS and Innovation Center emphasis on VBP, the transition from health care volume to value is less advanced in rural America compared to urban areas. Understandably, the Innovation Center's challenge is to accomplish national goals in rural areas and among rural HCOs; and thus, may lack the flexibility to focus solely on rural-specific models and goals. Many rural HCOs are paid differently than urban HCOs. Low rural patient numbers and service volumes make it more difficult to demonstrate statistically significant quality improvements. And underdeveloped rural value-based care capacities (and thus crucial investments) may preclude short-term financial savings. Nonetheless, rural HCOs deserve equal opportunity to participate in the volume-to-value transition.

The purpose of this RHV paper is to build on RHV's "How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report" and suggest potential policy opportunities for Innovation Center model design and CMS program inclusion to serve the stated priorities of

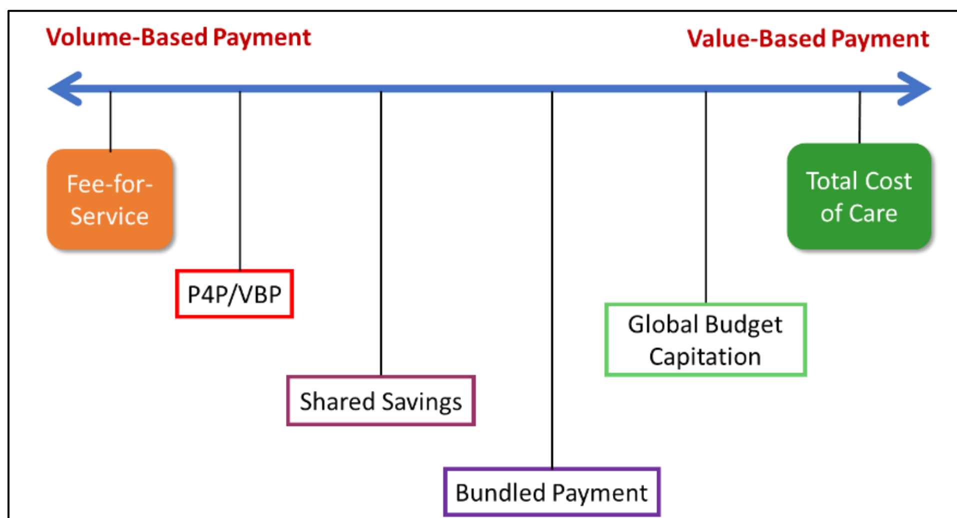
the *Innovation Center Strategy Refresh* and the *CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities*.

VALUE-BASED PAYMENT CONTINUUM

Health care payment may be considered along a continuum from volume-based payment (i.e., FFS) to value-based payment (e.g., total cost of care). Although VBP is simplistically payment for delivering the Triple Aim, the term *value* is complex and nuanced. The definition of health care value depends on one's perspective. Patients, physicians, employers, and payers may weigh the Triple Aim's three aims differently, or include other priorities such as tax burden, worker productivity, or administrative ease.[10] This paper will define *value-based care* (and consequent VBP) as delivering one or more aims of the Triple Aim without weighting. Similarly, rural has multiple definitions. In this rural VBP overview, *rural* will refer to non-metropolitan statistical areas,[11] although much more definitional precision could be applied.

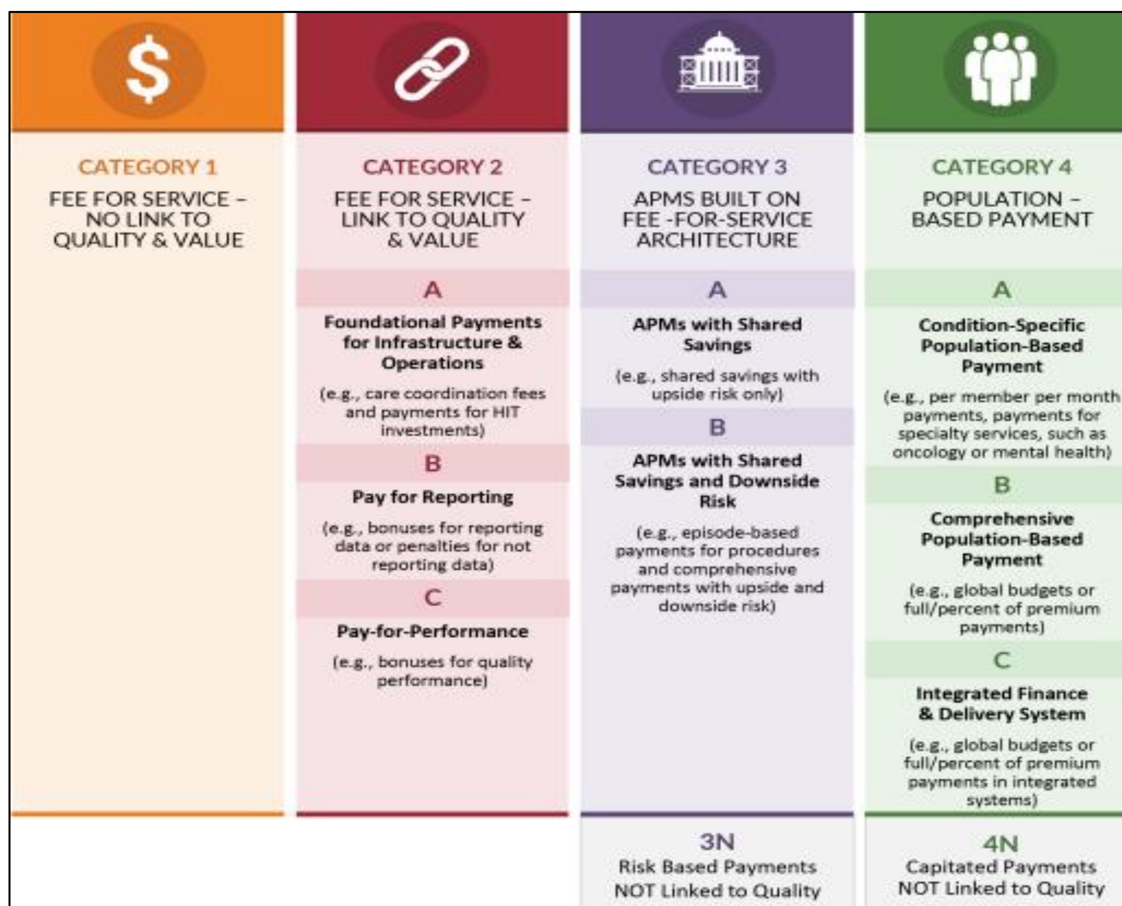
Despite the distinction between *volume*-based payment and *value*-based payment, most new payment systems and models fall along a payment continuum and are a blend of the two. For example, shared savings programs are based on FFS payments, but payers reward clinical-quality and cost-savings performance by sharing savings (if any) with participating HCOs. HCOs may participate in more than one VBP system. For example, a hospital may participate in a Medicare bundled payment plan and a commercial payer shared savings plan. In general, a greater degree of value-based payment implies greater financial risk for the HCO (Figure 1).

Figure 1: The Health Care Payment Continuum



Similarly, the Health Care Payment Learning and Action Network (HCP-LAN) developed the Alternative Payment Model (APM) Framework. The APM Framework outlines four health care payment categories that describe a continuum from FFS (with no link to quality and value) to population-based payment (Figure 2).[12]

Figure 2: HCP-LAN Alternative Payment Model (APM) Framework



VALUE-BASED POLICY THEMES

Recent CMS and the Innovation Center policies in support of rural transitions to VBP are encouraging. For example, the Medicare Shared Savings Program (Shared Savings Program) includes a new payment option (Advance Investment Payments) to encourage health care providers in rural and underserved areas to join and form accountable care organizations (ACOs).[13] A prior Innovation Center demonstration, the ACO Investment Model (AIM),[14] provided similar upfront payments for rural ACOs and informed this Shared Savings Program change. Yet, some VBP models and programs remain challenging for, or even unavailable to, rural HCOs. For example, the recent Making Care Primary (MCP) Model[15] is a positive step supporting VBP including in rural areas, but the model is unavailable to Rural Health Clinics (RHCs) – a prevalent rural primary care delivery site. Rural HCOs are frequently under-resourced to deliver value-based care (e.g., absent population health and financial management processes), and rural people often suffer from health and geographic inequities.

Thus, VBP model and program challenges and policy opportunities remain, particularly regarding rural participation in model design, implementation, and operation. Policy

opportunities presented herein are pertinent to rural HCOs and areas, but some rural and urban overlap exits. The RHV Team suggests that policies are still required to:

- Expand rural-appropriate opportunities to shift health care payment gradually but persistently from volume-based to value-based.
- Create rural-urban parity in implementing VBP to achieve the Triple Aim.
- Address disparities in quality, access, affordability, and VBP experience between rural and urban providers.

VBP rural challenges and policy opportunities are categorized by seven VBP model policy themes. Themes are based on input from the field in 2020 and updated based on experiences with the models. A summary of challenges and policy opportunities are provided for each theme.

Value-Based Payment Policy Themes

- Rural-Oriented Design
- Transitions from Fee-for-Service to Value-Based Payment
- Innovation Center Model and CMS Program Alignment
- Upfront Infrastructure Investment
- Rural-Relevant Planning and Care Delivery
- Flexibility and Timing
- Information Technology and Data

1. Rural-Oriented Design

Rural Challenges

To "drive innovation and value-based care in rural, tribal, and geographically isolated communities," models must be designed to facilitate HCO participation and success in those areas. Many small and rural HCOs (particularly hospitals and nursing homes) are fiscally fragile. Rural-oriented model designs must not jeopardize access to care by threatening the solvency of rural hospitals and other facilities. Low volumes and diseconomies of scale often make model participation, compliance, and evaluation difficult (e.g., quality, cost, and other assessments). Geographic model limitations, such as limiting the MCP Model availability to only eight states, excludes many rural, tribal, and geographically isolated communities. Disallowing participation by certain HCOs in value-based payment models perpetuates the silos of care and payment that are already counterproductive in U.S. health care. For example, again in the MCP Model, RHCs (a very prevalent rural clinic type) and practices participating in the Shared Savings Program are excluded from model participation. On the other hand, Federally Qualified Health Centers may participate in the MCP. The Pennsylvania Rural Health Model does not include physician practices. Furthermore, separating payment for medical care and health-related social needs artificially divides and segregates health care that most all people require. This may be particularly problematic in areas of low population density where access to both medical care and social services is at risk.

Policy Opportunities

- Consider providing a clear path to HCO financial stability and sustainability during model design and implementation so as not to jeopardize access to care through health care organization insolvency.

- Consider defining *access to care* prior to model implementation to ensure access is not compromised by the model.
- Consider allowing creative joining of test populations and HCO participants to spread infrastructure and evaluation costs. Alternatively, consider providing risk corridors for HCOs with smaller populations. (e.g., provide an onramp to increased financial risk for HCOs with smaller populations, such as what was done in MCP and the Shared Savings Program).
- Consider making models geographically broad, opening opportunities for participation. For example, establish a plan to rapidly expand the MCP Model to additional states.
- Consider including prevalent rural provider types – for example, CAHs, RHCs, Federally Qualified Health Centers (FQHCs), and private practices – during model design to encourage rural participation and collaboration.
- Consider expanding comprehensive systems of care and payment, such as FQHCs and state Medicaid programs, that specifically target medical and social needs and thus break down silos of care.
- Consider employing rural health experts (e.g., practicing clinicians, rural hospital CEOs, and accountants) to help design models rather than relying exclusively on requests for information and listening sessions to gather rural perspectives. Having rural health experts engaged with design will ensure that the nuances of rural provider payments (e.g., the RHC all-inclusive rate) are taken into consideration.

2. Transitions from Fee-for-Service to Value-Based Payment

Rural Challenges

Rural HCOs are challenged by the apparent legislative requirement that Innovation Center models reduce program expenditures. Given small numbers in rural settings, how “savings” are defined can have direct implications on the viability of a given model in a rural setting.[16] Achieving the goal that “all fee-for-service Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030” demands particular attention to HCOs serving beneficiaries who are least likely to participate in such a relationship now. But legacy payment systems and the financial challenges imposed by diseconomies of scale thwart movement away from FFS. CBR and the AIR were implemented to address the challenge of profitability in low-volume situations common in CAHs and RHCs. While initially beneficial, these payment systems, combined with budget neutrality concerns (and Innovation Center program expenditure reduction requirements), have unintentionally made conversion to value-based payments more difficult. Furthermore, service volumes are indirectly correlated with fixed-to-total-cost ratios; as service volumes decline, fixed-to-total cost ratios increase.[17] This means that in low-service-volume hospitals such as small rural hospitals, new models that reward volume reduction (e.g., emergency department visit or readmission reductions) will reduce costs proportionally less than in larger HCOs with higher volumes. Therefore, value-based payment models will be less likely to generate appreciable

savings for low-volume hospitals. Although not a value-based payment program, the Rural Emergency Hospital (REH)[18] payment system provides an opportunity to increase rural hospital financial stability by having a monthly facility payment in addition to claims reimbursements. Shared Savings Program Advance Investment Payments (AIPs)[19] provide interest-free loans to new and small accountable care organizations (ACOs). But due to the limited applicability of REHs and AIPs, impacts will not be widespread.

Policy Opportunities

- Consider cost growth control, not simply pure savings, when defining program and model cost "savings" within the context of CMMI's legislative charge to test innovative payment and service delivery models to reduce program expenditures.
- Consider designing new payment systems that provide the stability of CBR and AIR but help CAHs and RHCs transition to VBP. Initially, VBPs may need to be add-ons to current payments.
- Consider adjusting CAH payment not simply based on CAH designation, but instead on fixed-to-total-cost ratios that recognize the value of standby costs (a form of fixed costs) that ensure access to care.
- Consider a CAH tripartite payment system that includes payment based on (1) volume production (FFS), (2) quality performance (pay-for-performance), and (3) population health (risk-adjusted capitation).[20] Payment systems can gradually shift from volume-based to value-based payment (as in MCP Model and Shared Savings Program). Percentages of each of the three payment categories can be adjusted as systems mature (e.g., risk- and disparity-adjusted panel size, quality measurement, telehealth visit parity).

3. Innovation Center Model and CMS Program Alignment

Rural Challenges

To optimize model participation, it would be helpful for Innovation Center models to align with CMS programs. If inappropriately rewarding an HCO for participating in multiple models or programs (AKA "double dipping") is disallowed, participation in a model ideally would not exclude participation in other regular Medicare FFS programs. For example, RHCs and Shared Savings Program participants are ineligible to participate in the MCP Model, significantly limiting rural participation opportunity. Despite CMS emphasis on accountability for quality and cost, the new CMS Rural Emergency Hospital designation does not provide value-based payment or require value-based care. Conversely, the current CMS request for information regarding the Episode-Based Payment Model does address model and program alignment.[21] Although a question of policy priority rather than alignment, the recent pandemic-related public health emergency demonstrated the tension between efficiency ("just in time") and standby surge capacity (e.g., to address pandemics and disasters). This tension occurs in rural hospitals regularly as the struggle between closing unprofitable services and maintaining access to

services. FFS causes prioritization of services not necessarily in the community's best interest (e.g., orthopedics versus obstetrics). VBP could change that. For example, the number of hospitals providing obstetric services in rural areas has declined since 2014. As of 2018, over half of rural counties did not have a hospital that provided obstetric services.[22] In those rural counties providing obstetric care, much of that care is delivered by primary care providers. Furthermore, primary care is the predominant care in many rural communities. The U.S. Department of Health and Human Services (HHS) has requested public comment regarding its *Initiative to Strengthen Primary Health Care*.[23]

Policy Opportunities

- Consider designing and adjusting Innovation Center models so cross-participation with other CMS programs is possible and encouraged. For example, during the next iteration of the MCP Model, consider adjusting the model such that RHCs and Shared Savings Program participants become eligible.
- Consider updating regulations to encourage the development of value-based care (VBC) opportunities in the Rural Emergency Hospital designation to support VBC delivery and community health improvement to be eligible for the additional facility payment.
- Consider making definitive policy decisions that support the cost of standby surge capacity and/or essential service maintenance.
- Consider ensuring that Innovation Center models support the tenets of the HHS *Initiative to Strengthen Primary Health Care,* the HHS *Action Plan to Strengthen Primary Health Care*, and the National Academies of Sciences, Engineering, and Medicine report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*.[24]

4. Upfront Infrastructure Investment

Rural Challenges

As noted previously, many small and rural HCOs are fiscally fragile. Even relatively minor interruptions of revenue or increases in costs can threaten HCO solvency and jeopardize access to care. Many small and rural HCOs do not have well-developed infrastructure (e.g., population-health and financial-risk management people and processes) to deliver value-based care and thus receive VBP. The transition from volume to value can be expensive and beyond the reach of some rural HCOs. Furthermore, additional personnel and data collecting/reporting to administer models is costly. The Shared Savings Program offers interest free loans (but not grants) through Advance Investment Payments to help certain small ACO startups.

Policy Opportunities

- Consider minimizing data collection and reporting burden to reduce the upfront cost for engaging in value-based care yet continue accountability for quality and cost.

- Consider providing comprehensive and timely data analysis that results in quality and profit improvement to increase the likelihood of participant clinical and financial success.
- Consider funding technical assistance for transitions from fee-for-service to VBP – for example, financial analysis, population health management, coding (for risk-adjustment), and leadership-driven culture change (volume to value).
- Consider emulating services for new ACOs that are provided by accountable care organization aggregators (e.g., risk mollification through aggregation, data analysis, and practice transformation).

5. Rural-Relevant Planning and Care Delivery

Rural Challenges

Rural people and places (and the HCOs that serve them) may be underserved communities. "The term 'underserved communities' refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life areas…"[25] Thus, rural people often endure dual disparities of rural residence and more. Virtual health care (or telehealth care) rapidly expanded during the public health emergency and served an important function to provide care when patients and providers could not travel. However, virtual health care should support, not supplant, local health care. Rural HCOs are at risk from distant providers delivering virtual services that are not coordinated with, or supportive of, local health care services. New care models rightly emphasize team-based care as an important path to value-based care. "Working in effective teams improves clinical outcomes, increases professional satisfaction and provides crucial peer support."[26] Yet, due to small practice size, autonomous practice styles, FFS payments, and other factors, team-based care may be underdeveloped in rural areas.

Policy Opportunities

- Consider expanding use of the health equity adjustment, such as the Area Deprivation Index (used in a few models), to integrate social determinants of health with treatment and prevention.[27]
- Consider ensuring that the Area Deprivation Index (or other similar health equity adjustment process) adequately captures geographic, weather, transportation, and other rural access barriers.
- Consider designing telehealth care policies that support local health care, not supplant local health care.
- Consider providing technical assistance and payment models that incentivize team-based care, including small teams in rural places.

6. Flexibility and Timing

Rural Challenges

Due to underdeveloped infrastructure, fiscal fragility, lack of experience, and other challenges, rural HCOs may require more time to fully engage and realize success in new VBP models. Expectations for rapid model ramp up and financial success may be unrealistic for many rural HCOs. Although rapid assessments of model success or failure suggest limited model durations, limited model duration may not allow rural success. Models are often held static throughout the duration of the model so more informed assessments can be completed. But such inflexibility does not allow continuous learning and model adjustments that would make models more feasible and participant success more likely.

Policy Opportunities

- Consider extending model duration. Current examples are the MCP Model, duration of 10.5 years, and the 2023 ACO rule that allows new and inexperienced entrants up to seven years in a one-sided risk arrangement.
- Consider extending the time required for achieving cost reduction, at least to the lifetime of the model.
- Consider incorporating gradual increase in financial risk or distinct levels of risk such as included in the MCP Model and ACO REACH.[28]
- Consider incorporating yearly model assessments that are rapidly reported to model participants and specifically identify model changes that could be implemented to improve the likelihood of participant success. Then adjust the model accordingly.

7. Information Technology and Data

Rural Challenges

As noted above, rural dual disparities exist and challenge the delivery of health care. The impact is even worse when payment risk-adjustment systems do not adequately recognize rural disparities. For example, social determinants of health (documented with Z-codes) are not well captured in hospital data systems in part because they are currently not linked to payment. Possibly as an unintended consequence of CBR, CAHs submitted significantly fewer hospital diagnosis codes than non-CAHs.[29] Thus, risk-adjustment with hierarchical condition category coding may be incomplete for rural providers This challenge may extend to RHCs due to historic payment with the AIR that is not adjusted for diagnosis or type of service. Many rural HCOs have underdeveloped data analysis capacity. Medicare and Medicaid claims data are not regularly shared with HCOs except in the Shared Savings Program. However, even in the Shared Savings Program, CMS does not analyze quality data and cost data together to present value-based evaluations, thus requiring expensive data analysis services unavailable to many rural HCOs. Finally, limited electronic health record (EHR) interoperability limits care coordination, population health, and other patient care management opportunities.

Policy Opportunities

- Consider paying for Z-code use to support data collection and eventual payment that is risk-adjusted for social determinants of health or health-related social needs.
- Consider providing technical assistance and automated systems to advance accurate risk-adjustment.
- Consider deploying systems to combine and disseminate timely quality and cost data so clinicians (e.g., primary care teams) can make value-based clinical and referral (e.g., for ancillary and specialty care) decisions that facilitate care coordination among HCOs.
- Consider recommending EHR interoperability protocols that allow data sharing (with appropriate patient confidentiality safeguards) that facilitate care coordination among HCOs.

POLICY IMPLICATIONS

The health care volume-to-value transition will continue, if not accelerate. VBP in Traditional Medicare, Medicare Advantage, and Medicaid (state-managed plans or Medicaid managed care) is growing. The Innovation Center continues VBP model testing; and CMS has announced the goal that all beneficiaries (rural and urban) will be in a relationship accountable to cost and quality by 2030. Commercial health insurance plans are increasingly using VBP contracts in negotiations with HCOs. Diseconomies of scale, differing payment systems, underdeveloped resources, and other challenges have made rural HCO participation in the volume-to-value transition less prevalent than in urban areas. To achieve CMS's 2030 accountability goal, additional CMS and Innovation Center policy efforts to engage rural HCOs in VBP will be valuable. Payment system and model design should address rural HCO challenges (e.g., low volumes and fiscal fragility), develop rural HCO strengths (e.g., primary care and community engagement), include all payers (government and commercial), and recognize that today's investments in a VBP future may require years to realize a return.

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