

TRANSFORMING RURAL HEALTH: RHTP AND VALUE-BASED PAYMENT (VBP)

Webinar Presentation through RHIHub

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Keith J. Mueller, PhD

Director, Rural Policy Research Institute (RUPRI)

College of Public Health, University of Iowa

VALUE OF VALUE-BASED PAYMENT



- Intrinsic appeal as a new payment design, ending incentives of fee-for-service and volume-driven care
- Intrinsic appeal to explicitly incorporate patient outcomes into payment design
- Benefit of potentially shift health spending to other priorities



THE COMMITMENT TO TRANSITION TO VBP



Not a one-time project



Requires a longer time-line: not likely to fully implement until end of 5 years and not see gains until after that time



“All in” will require all payers

AS AN ACTIVITY IN RHTP

- An incremental approach: one service line
- An incremental approach: Medicaid only, at least initially
- An incremental approach: pay-for-performance but without structural change
- As a major activity of the RHTP that in the end supports other efforts – the focus of this presentation

ACTIVITIES LINKED TO VBP

- **State RHTP plans** - at least 23 specifically chose the activity of value-based payment
- **Redesigning the health care delivery system** to achieve better patient outcomes at the same or lower cost
- **Use of technology** that supports delivery of local services to improve patient outcomes through enhanced access
- **Address health care workforce** with a comprehensive approach that includes occupations such as community health workers that address all circumstances affecting health outcomes; including prior to interaction with clinical care (upstream drivers) and after initial clinical care (managing chronic conditions, post acute care)

VALUE-BASED CARE AND VBP INITIATIVES IN VBP

- **Nevada Rural Value Acceleration Network** to reward providers for improved health outcomes and administrative efficiency
- **Colorado** exploring feasibility of shared savings, bundled payments and other approaches that reward prevention; finalizing contracts by end of Year 5
- **New Hampshire** to start with first cohort in 2027, second cohort in 2028 working with Medicaid VBP models to prepare rural providers for two-sided risk
- **Montana** exploring VBP for dual-eligible special needs plans and PACE model; VBC for nursing facilities

STATE EXAMPLE: KANSAS

- Operate a state-supported Accountable Care Organization (ACO) in partnership with a national ACO management company; open to rural providers not already in the Medicare Shared Savings Program or ACO REACH
- Incentive payments for participating rural providers
- Develop new Medicaid MCO contract requirements for provider incentive payments tied to care coordination services



GOALS IN THE KANSAS PROGRAM



- By 2031 all rural providers achieve improvements on pay-for-performance measures identified as foundational to clinical integration
- By 2031 all rural providers actively participate in clinically integrated networks

STATE EXAMPLE: LOUISIANA

01

Focus on risk-sharing VBP arrangements between providers serving high-need populations and plans/providers with quality incentives to improve care

02

Evolve to statewide VBP by starting by piloting innovative care models

03

Utilize community partnerships to serve hard-to-reach populations – mobile units in care deserts, correctional facility care, rural hospitals, rural pharmacy access

LOUISIANA TIMELINE

Needs assessment to identify priority interventions for innovate pilots, and develop criteria and selection process for pilots

Preparatory work toward partnerships

By Dec 2027 launch initial pilots; work on metrics and care coordination

Evaluation and preparation to spread pilots

Full implementation by Sept 2031

STATE EXAMPLE: SOUTH DAKOTA



VBP TRANSFORMATION
THROUGH MEDICAID REFORM
TO ALIGN FINANCIAL
INCENTIVES WITH HEALTH
OUTCOMES



AIM TO PROVIDE PREDICTABLE
REVENUE REWARDING
QUALITY



INCENTIVIZE PREVENTATIVE
CARE

SOUTH DAKOTA STAGES

- ❑ 0: define goals and identify needs
- ❑ 1: finalize roles and establish infrastructure funding
- ❑ 2: Select vendors, create model, quality reporting, bridge payments for FQHC/RHCs
- ❑ 3: staff, quality metrics set, payor alignment initiatives
- ❑ 4: final outcomes defined; model launched
- ❑ 5: quality and utilization analyzed, results inform budget and legislation

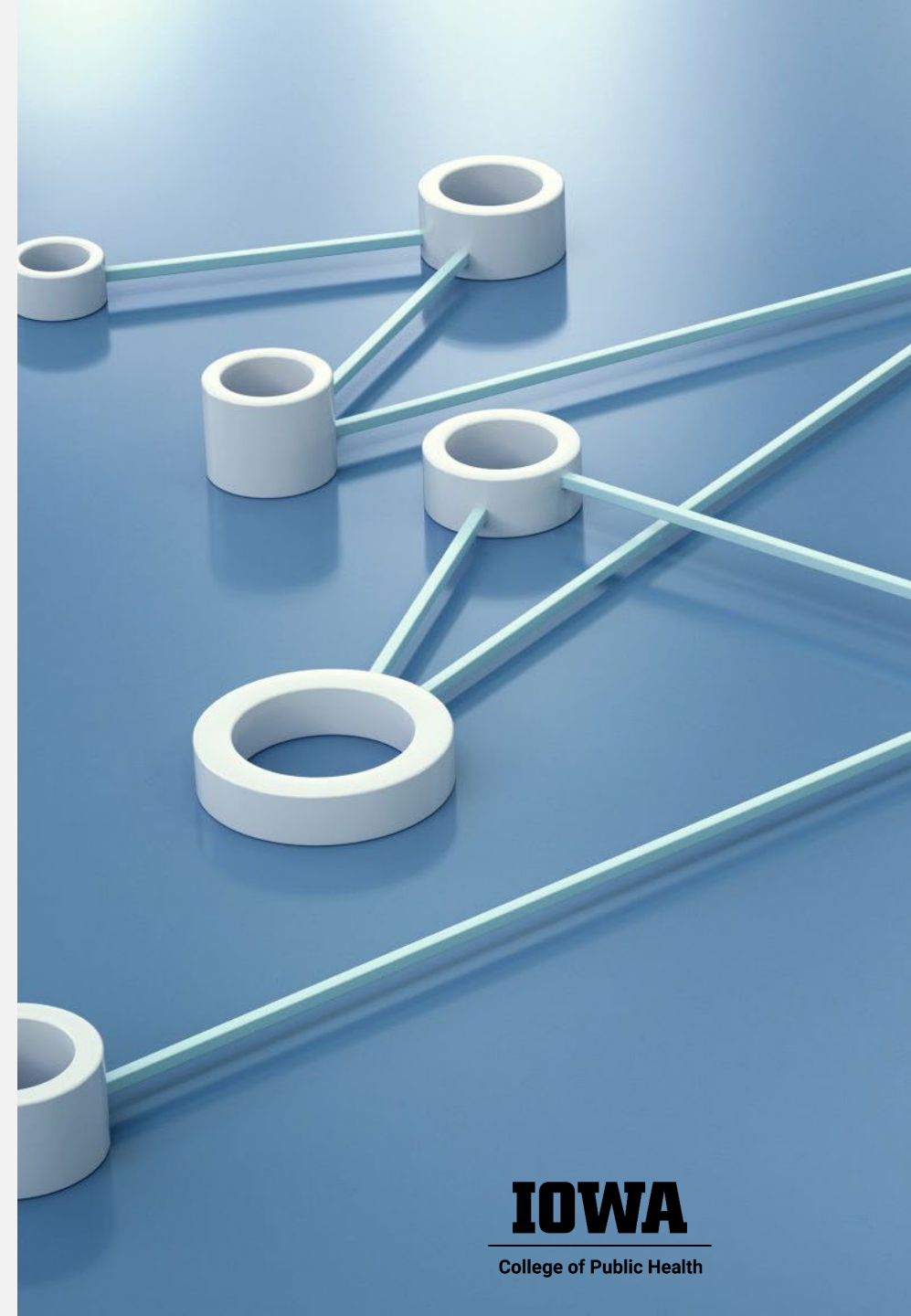


THEMES

- In early stages lay the groundwork: can be accelerated if there is already something in place (Missouri's use of networks developed in a Medicaid demonstration)
- Models as first step
- Scale varies from targeting providers or service lines, to comprehensive

RELATED INITIATIVES

- Establishing hub and spoke models: facilities other network development, building block to advanced care management accepting risk
- Population health initiatives pave the way for reducing utilization
- Implement uses of technology that improve effectiveness and efficiency



SYSTEM CHANGE: HUB AND SPOKE DESIGN

- **Missouri TORCH Program** expanded from current Medicaid pilot to statewide all payer model
- **Iowa using rural hubs as cancer care sites** working with local spokes; all are rural hospitals; also, a health hub model for other conditions, builds off cancer network and centers of excellence programs

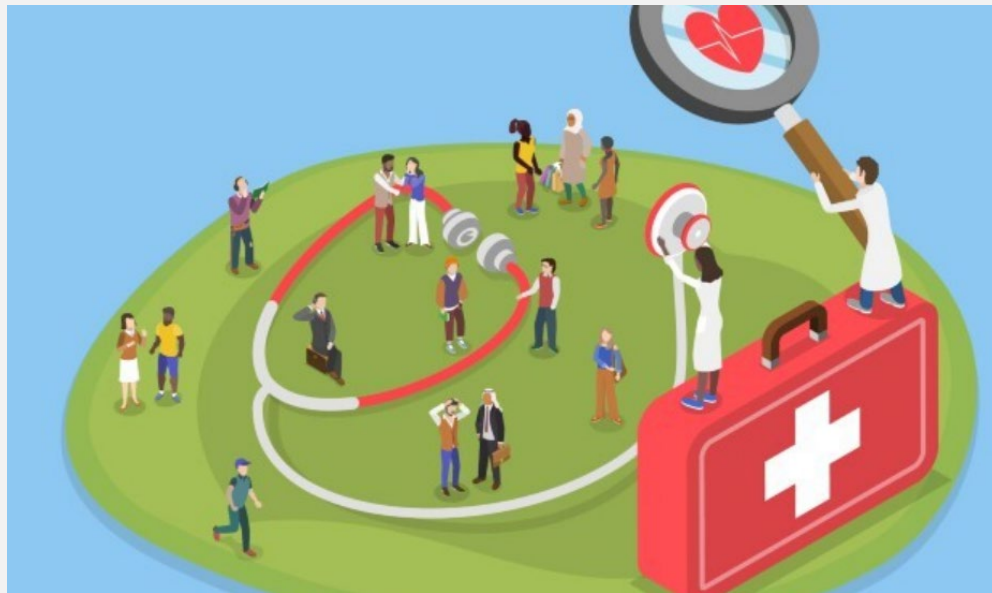


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North Carolina established **NC ROOTS Hubs** – six locally governed networks that coordinate medical, behavioral, and social services; tailors projects to regional needs; each hub must address prenatal health, chronic disease, prevention, cancer, and physical fitness

Ohio Rural Health Innovation Hubs – establish Clinically Integrated Networks and Regional Centers of Excellence; mission is to address rural residents' needs to close healthcare gaps

SYSTEM CHANGE: POPULATION HEALTH



- Screening activities, including wellness visits
- Preventative services
 - Primary
 - Secondary
 - Tertiary
- Addressing living conditions (upstream factors affecting health)
- CO: a specific focus on Population Health Outcomes
- FL: focus on health and lifestyle
- GA: addressing transportation needs

USE OF TECHNOLOGY



- Modernizing Health Information Exchanges (IN)
- Investing in telehealth
- Remote patient monitoring (LA)
- Population health management (KS)

WORKFORCE COMPOSITION



Pipeline program development



Includes community health workers



EMS training (OR)



Recruitment and retention initiatives

TRANSFORMATIONAL CHANGE

- Multiple initiatives
- Interacting initiatives
- Timeline across five years
- Consistent efforts to build to sustainability
- Sustainability requires building the change into the ongoing financing of health care services

RHV TOOLS AND RESOURCES: GENERAL LESSONS IN DESIGN

- [Rural Health Value Virtual Summit
Designing Rural Value-Based Care
for the Future, February 2026](#)
- [Rural Value-Based Care - The
Payer Perspective, Rural Health
Value Summit Report](#)

RHV TOOLS AND RESOURCES: GUIDES AND TOOLS

- [Value-Based Care Assessment Tool](#)
- [Rural Community Engagement Resource Guide](#)
- [Serving High Need/High Cost Patients in the Emergency Department](#)
- [Introduction to Rural Clinically Integrated Networks \(CINs\)](#)

RHV TOOLS AND RESOURCES: PROFILES

- [Rural Hospital Participation in Missouri HealthNet's Transformation of Rural Community Health \(ToRCH\) Program](#)
- [Rural Hospital Experiences in the Colorado Hospital Transformation Program \(CO HTP\)](#)
- [Iowa Community Health Centers and Value-Based Care](#)
- [Rural Health Value Summit: Driving Value Through Community-Based Partnerships](#)

For further information:

- **The RUPRI Center for Rural Health Policy Analysis**
<http://cph.uiowa.edu/rupri>
- **The RUPRI Health Panel** <http://www.rupri.org>
- **Rural Health Value** <http://www.ruralhealthvalue.org>

Keith J. Mueller, PhD

Gerhard Hartman Professor of Health Management and Policy
Director, Rural Policy Research Institute (RUPRI)

Department of Health Management and Policy

University of Iowa College of Public Health

145 Riverside Drive, CPHB

Iowa City, IA 52242

Office: 1-319-384-3832

keith-mueller@uiowa.edu