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All Roads Lead to Value (Part 3)

Making Inroads in Rural America

Market Corner Commentary
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[Readers' Note: This is the third of four articles on the transition to value-based care models for providers. Risk-based (also known as value-based) payment models, pro-market regulations, new competitors, technology advances and rising consumerism are combining to place enormous pressure on the healthcare industry to deliver better outcomes at lower costs with better customer experience. This article examines the unique character of rural healthcare and explores strategies for enhancing care delivery in under-served rural American communities.]

In *The Hospital: Life, Death, and Dollars in a Small American Town*, journalist Brian Alexander profiles Community Hospital and Wellness Centers (CHWC)[1], a century-old community hospital in northeast Ohio. Though vital to its small town as an employer and source of care, CHWC struggles to remain independent while still meeting the needs of a patient population challenged by widespread chronic illness, addiction and poverty.

Long-serving CHWC CEO Phil Ennen's heroic efforts to balance mission and margin feel futile in the face of such challenges. As Alexander describes Ennen's thoughts:

> ***"America was sick and getting sicker and dying earlier with every passing year.... Could a hospital, even a financially secure one, intervene in any meaningful way?"***

The answer, it turns out, is that CHWC and other hospitals in its position have not been able to make meaningful progress on these challenges. Like most of American healthcare, CHWC devotes much of its budget to high-cost specialists and acute procedures. It lacks the resources and capabilities to treat the root causes of chronic illness, mental health and substance abuse disorders before they cause serious harm or death.

This profound mismatch between the services that local hospitals like CHWC offer and those services local residents need is a major contributing factor to declining health status and life expectancy in much of rural America. Under Fee for Service (FFS) medicine, efforts at CHWC to address those challenges go unrewarded and weaken the hospital's already fragile bottom-line. That's a conundrum rural hospitals in economically challenged communities confront daily.

Value-based payment models (paying for outcomes not services) offer a powerful tool for reversing the fortunes of rural health providers and the people they serve. To improve individual health and well-being, providers must integrate primary-care, virtual-care, chronic-care and behavioral-health services with social-care services. Such cohesive, holistic care delivery is beyond the scope of most rural hospitals and provider networks today.

Nevertheless, efforts to bring value-based care to rural America are progressing. State governments are experimenting with global budget programs and other initiatives that support value-based care provision. Several innovative risk-enabling companies, including Aledade and Main Street Health, have emerged to help facilitate value-based care delivery for physician groups in difficult markets. Giant retailers, including Walgreen's, Walmart and Dollar General, are positioning themselves and investing heavily to provide primary-care and chronic-care management at scale in rural communities.

This article explores promising public and privately funded initiatives that seek to overcome the complex challenges of implementing better primary and comprehensive care to rural populations through value-based arrangements. These programs and service offerings align the interests of providers and patients in pursuit of better, more cost-effective care outcomes. They offer hope for improving health and quality of life for millions of Americans living in medically underserved rural communities.

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MARKET CHALLENGES IN RURAL COMMUNITIES

In rural America, market dynamics for healthcare providers are exceptionally challenging. Many rural communities are sparsely populated and have only one commercial health insurer. Most local hospitals are resource constrained and face significant staffing shortages exacerbated by the pandemic. Many are failing. Residents struggle disproportionately with poverty, addiction, obesity, chronic illness and cigarette smoking.[2, 3]

Transition to value-based care requires overcoming these significant obstacles:

Poorly equipped providers. Most regional hospitals lack the resources, capital, technology, care-delivery channels and social-service partners to deliver the holistic and preventive care needed to achieve quality outcomes. Under FFS, they primarily deliver acute care, not preventive or chronic care services.

Payers without financial incentives to take risk. The lack of capable provider partners, the lack of competition with other plans and the limited risk pool reduces motivation and feasibility to change current payment methodologies.

Suboptimal patient/member engagement. Rural populations are disproportionately low income, in poor health, and may lack the capacity, interest or fundamental belief in preventive care to arrange for vital care services and social support even when they are available.

Given these challenges, it is not surprising that a 2021 Drexel University report found that rural community enrollment in and satisfaction with Medicare Advantage (MA) programs has generally been uneven and disappointing.[4] While MA continues to experience high growth rates nationally[5], has produced better health outcomes, and has demonstrated success meeting consumer preferences, rural MA members choose to switch to traditional FFS Medicare at twice the rate of urban MA members.

Nearly 20 percent of rural beneficiaries cited their difficulty in accessing care as a reason for switching.[6] Others likely switched because poor health leads to higher out-of-pocket expenses otherwise covered by Medicare.

The Drexel report's authors recommended improving access by financially incentivizing providers to deliver targeted care services wanted by their rural MA members.[7] This is what innovative governments and companies are beginning to do.

PUBLIC INITIATIVES IN RURAL COMMUNITIES

To succeed in value-based care models, rural community hospitals need the support of primary care physicians that can deliver preventive and chronic care and help reduce acute care utilization and overall care costs. Yet, like the majority of rural hospitals, most independent-practice primary-care providers also lack the capabilities, resources and scale to provide adequate preventative services, let alone participate in value-based care models.

Care coordination and case management are particularly challenging without programmatic support.

Independent primary-care physicians (both rural and non-rural) often struggle to get information on patient activity from their local hospitals or emergency clinics. Most lack the interoperable, workflow-friendly applications needed to stay ahead of expensive patient events and avoid readmissions. They also need better data to understand underlying clinical conditions, apply accurate risk coding, measure progress and outcomes, identify gaps in care, make sound investments in the right services and appropriately document all care activities.

These limitations compromise the ability of rural healthcare providers to initiate and sustain high-value care delivery. In response, several state governments are experimenting with new payment mechanisms to advance value-based care. Combined with advances in technology platforms, tools and data-analytics capabilities, these new payment models target medically-underserved rural communities.

The **Community Health Access and Rural Transformation (CHART) Model**[8], sponsored by CMS and launching in 2021, supports rural healthcare providers with up-front investments and predictable capitated payments for quality and outcomes. Applying waivers that remove regulatory burdens, they enable rural providers to offer additional services that meet social-determinant-of-health (SDoH) needs like food and housing.

For example, Pennsylvania and Vermont are using **All-Payer Global Hospital Budgets** to provide financial support for rural safety net hospitals embarking on value-based care.

In 2017, **Pennsylvania** became the first state in the country to design and implement a global budget payment model to help rural hospitals invest in population health services. This enables hospitals to redesign their overall services and embrace outpatient and behavioral health services.

The global budget is specific to each hospital and based on historic net revenue. Five rural hospitals and five payers participated in the initial performance year. Eight new hospitals joined in January 2020 along with Aetna as a commercial payer. Five additional hospitals will likely join the program by the end of 2021.[9]

Vermont's All Payer Model, launched in 2016, enables ACOs to receive payments from Medicare, Medicaid and commercial insurers with aligned incentives and quality measures. All 14 Vermont hospitals and half the primary-care providers in the state participate in the program. Unfortunately, that program fails to align financial interests seamlessly. Hospitals bear the financial risk for the program while participating primary-care providers can choose to operate under FFS or VBR, and specialists continue to operate under FFS.[10]

PUTTING VALUE INTO PRACTICE

Several innovative venture-capital or private-equity-backed companies are also investing in strategies to improve rural healthcare. These companies have the scale, resources and know-how to support physician groups in transitioning to value-based care delivery. They include smaller, recently launched ventures and a number of national retail chains.

Private Equity and Venture-Backed Operators

Aledade Health[11]
Founded in 2014, Aledade helps independent family practices and larger primary-care groups enter into value-based arrangements by building and operating Accountable Care Organizations (ACOs). Aledade currently supports 7,800 providers in 31 states, across dozens of value-based contracts representing more than 1 million patient lives. Co-founder and CEO Farzad Mostashari was former national coordinator for health information technology at the Department of Health and Human Services.

In 2020, Aledade launched a multiyear, value-based collaboration with Regence BlueCross BlueShield of Oregon to deliver better, simpler and more affordable health care for rural members. The emphasis is on transitioning providers to value-based contracts while enabling more effective chronic care for rural populations. 40 percent of Regence health plan member claims currently flow through value-based arrangements.[12]

Caravan Health[13]
Kansas City-based Caravan Health offers value-based care arrangements for rural providers with limited resources by assuming full risk on their behalf through Caravan's own ACO programs. Caravan currently serves 250 community health systems and 25,000 clinicians.

iLumed[14]
Florida-based iLumed participates exclusively in CMS' new Direct Contracting Program (DCE). The company has selectively targeted some rural geographies to bring the benefits of the DCE program to underserved communities.

Main Street Health[15]
Recently launched, Nashville-based Main Street Health focuses exclusively on bringing value-based solutions to rural America. Through its Extra Access program, Main Street Health partners with rural primary-care physicians, pharmacists and urgent-care clinics to provide seniors with personalized assistance for their healthcare needs, making it easier for them to navigate the healthcare system. Founder and CEO Brad Smith was director of the Center for Medicare and Medicaid Innovation (CMMI).

National Retailers

Walmart
Walmart launched its first Walmart Health Center in 2019, offering customers primary care, imaging services, lab work, dental care, optical care, health-insurance education / enrollment, and community services like nutrition and fitness.

Walmart Health Centers accepts all forms of insurance, not just value-based arrangements. However, Walmart offers many services at very low prices, including many generic pharmaceuticals for $4. Recently, Walmart developed its own insulin product, which costs 58% to 75% less than branded insulin.

Walmart acquired MeMD, a telehealth provider specializing in primary care, urgent care and behavioral health, to expand its reach. Given that Walmart has over 5,000 stores in the U.S. and extensive experience integrating omnichannel retail services, the retail giant has the potential to bring primary and care management services to all regions of the country, including rural communities.[16]

Dollar General
Dollar General has 17,000 stores, mainly in rural communities. In July 2021, it hired its first Chief Medical Officer signaling its strategy to bring healthcare services to rural America. It also has new partnerships with online pharmacy Genius Rx and telehealth provider Babylon.[17]

CONCLUSION:
THE EXPANSION OF BETTER CARE IN RURAL AMERICA

America cannot achieve its overall goals for better health outcomes and lower healthcare costs without improving care access and coordination across payers, providers (particularly primary-care physicians) and social-services organizations in rural communities.

Governmental, nonprofit and for-profit organizations are pursing promising initiatives that align payment with desired improvements in access and health outcomes. Through skillful collaboration, these organizations are creating broad-based programming that enables rural residents to engage in their own care more actively and make healthier lifestyle choices.

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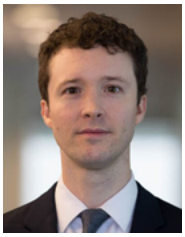

Colby Kittrell is a Director focused on mergers/acquisitions and capital raising for physician groups and multisite service clients. Colby joined Cain Brothers in 2013 and has over 10 years of experience in a variety of M&A, capital raising, and capital markets transactions. Select and notable transactions include the sale of CareMount Medical to Optum/UnitedHealth Group, the merger of Summit Medical Group and CityMD, the sales of Retina Group of Florida and Retina Consultants of Houston to Retina Consultants of America, the merger of Empress Emergency Medical Services with Patient Care Logistics Solutions, the investment by Blue Cross of Idaho in Primary Health Medical Group and the sale of Renaissance Imaging Medical Associates to Radiology Partners.

Prior to joining KeyBanc Capital Markets, Colby was an Associate at Jefferies in their Healthcare Group where he focused on supporting M&A advisory and public equity and debt capital transactions for clients in the healthcare services sector. Colby's prior experience also includes working for Deloitte Financial Advisory Services.

Colby earned a BA in Economics and an MBA from the University of Rochester.

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