



The Future of Rural Value-Based Health Care and Surge Capacity

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For the past decade, the transition from volume-based health care to value-based health care has been strongly supported with new payment systems and demonstrations, including in rural America. However, healthcare service demands consequent to the COVID-19 pandemic have challenged preconceived rural value-based priorities such as inpatient-care reduction and just-in-time inventories. Thus, rural healthcare organizations may struggle with conflicting demands for surge-ready healthcare infrastructure and value-oriented business processes. As the COVID-19 pandemic spreads into rural America, implementing permanent adjustments to value-based care and payment systems is premature. Yet, as Donald Berwick points out, “Fate will not create the new normal, choices will.”¹ Informed choices about the future of rural value-based care begin with questions. This commentary outlines *questions for consideration* about the future of rural value-based care and payment.

Healthcare Value

Healthcare value implies the concurrent priorities of “better care for individuals, better health for populations, and lower cost.”² Seeking to lower cost, value-based payment systems tend to shift financial risk from payers to healthcare organizations through, for example, shared savings programs and global budget demonstrations. Rural healthcare organizations have responded by reducing inpatient care, implementing Lean management policies, utilizing just-in-time inventories, opening free-standing emergency departments, and shifting care to outpatient settings. New rural healthcare models, such as proposed in the REACH Act³, offer rural facilities with emergency and other services, but no inpatient beds.

COVID-19 Impact

COVID-19 has been the most impactful pandemic in a century. Lives lost and economic damage are unprecedented, and are now rapidly expanding to rural areas. Healthcare organization impact has been similarly significant, but in contrasting ways. Some healthcare organizations have experienced marked revenue loss as preventive services and elective procedures are delayed or abandoned. Revenue loss is particularly problematic for rural healthcare organizations already in financial distress. Conversely, some healthcare organizations have been overwhelmed with pandemic-related demand for care, or *surge*. This commentary considers rural healthcare organization *surge capacity*, that is, the personnel, equipment, infrastructure, processes, and policies necessary to deliver unforeseen and significantly increased healthcare services rapidly.

Surge Capacity

As rural healthcare organizations reduce underutilized infrastructure and inventory in the interest of cost reduction (a critical component of healthcare value), they become less capable of responding to unexpected surges in healthcare services demand. COVID-19 is the current cause for healthcare-services

surge, but other unanticipated events can suddenly increase demand such as antibiotic-resistant infectious diseases, natural and man-made disasters, terrorism, and healthcare infrastructure loss (eg, closure of a nearby hospital). Some of these healthcare service demands are localized, addressed by effective regional patient-transfer protocols, while others require local healthcare organization surge capacity. Surge capacity, especially for rural healthcare organizations, is a standby cost (a type of fixed cost). Fixed costs in low-volume healthcare organizations are often difficult to recoup within a fee-for-service healthcare payment system. Yet, the existing system requires all healthcare organizations to be self-sustaining. There is no financial return in surge-capacity investment for the possibility of a once-in-a-lifetime event.⁴ A 2018 survey of 400 hospital administrators found that hospitals had too many obligations to prepare for emerging infectious disease in the absence of a current threat.⁵

Not Just Hospitals

The response to surge is not just the responsibility of rural healthcare organizations, or any healthcare organization for that matter. Instead, the most effective response to pandemics and other disasters is coordinated and multi-sectorial. Depending on the scale of disaster, federal, state, and local governments have critical responsibilities. Due to its strong rural presence, primary care is best positioned to partner with public health to prevent and mitigate disaster impacts through activities such as “patient education, testing and reporting, contact-tracing, and low-acuity treatment and coordination.”⁶ And the National Guard, first responders (eg, emergency medical services, firefighting, and law enforcement), and service organizations may all play important disaster-response roles.

Current Regulatory Adaptations

Payers are currently modifying value-based payment programs and demonstrations in response to the COVID-19 pandemic. For example, the Centers for Medicare & Medicaid Services will exclude COVID-19 inpatient care episodes from accountable care organization (ACO) spending and give ACOs the option not to accept increased risk in 2021.⁷ Multiple telehealth rules have been relaxed, improving access to, and payment for, telehealth services. However, since these regulatory adaptations are temporary, they do not address changes necessary to develop surge capacity for a prolonged COVID-19 pandemic or the next disaster. Healthcare policy-makers and stakeholders should begin considering what healthcare system and organization changes should occur as a result of the COVID-19 pandemic. That consideration starts with *questions*.

Questions for Consideration

Reconciling the equally appropriate, but conflicting demands of value-based care and surge-capacity investment requires policy-maker and healthcare leader attention. As our nation and the world continue to experience the COVID-19 pandemic, it is tempting to design permanent solutions. But permanent solutions are premature because leadership attention is appropriately directed at addressing the pandemic *now*. And as COVID-19 expands into rural areas, there is still more to learn about COVID-19 impacts on rural healthcare organizations. Therefore, this commentary proposes a series of questions for consideration as a prelude to policy solutions that address rural healthcare organization surge capacity.

Demonstrations

- What are the quantitative and qualitative differences between rural healthcare organizations participating in value-based care demonstrations compared to nonparticipants during the COVID-19 pandemic?
- How will features of rural value-based care demonstrations change as a result of the COVID-19 pandemic?

- Will payers design new value-based care demonstrations, and will rural healthcare organizations participate in them, following the financial uncertainties caused by the COVID-19 pandemic?
- Considering the continuum of value-based payment systems and demonstrations from pay-for-performance to global budgets, how should each be modified so as to encourage, and not penalize, surge-capacity investment?

Payments

- How should healthcare payment systems recognize the need for efficiency, yet encourage healthcare organization investment in surge capacity and disaster planning?
- How should surge-capacity costs be separated from illness-care costs when considering rural healthcare organization performance in value-based payment systems?
- How should payers divide payment, and rural healthcare organizations divide resources, between illness care, preventive care, community/population health improvement, and surge capacity preparation?
- If financing surge capacity is incorporated into routine payment systems, how do payers avoid double-payments during surge-capacity utilization?

Partnerships

- How might rural hospital closures and healthcare organization affiliations impact surge capacity?
- How can separate funding streams which support health care, emergency preparedness, public health, and social services be leveraged and coordinated to support rural-community disaster readiness and pandemic planning?
- How should rural hospital leadership work with other organizations to prepare for demand surges (eg, designing regional equipment and personnel distribution policies)?
- How can rural primary care practices be incentivized to work closely with public health agencies for disaster prevention and mitigation?

Despite the horrors of the COVID-19 pandemic currently spreading to rural America, the pandemic serves as an opportunity to better address the next disaster through insightful questioning followed by informed policy action. The health and prosperity of rural Americans depends on leadership commitment to comprehensive, appropriately funded, and enduring disaster planning.

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