DHA 6113-26923: Healthcare Public Policy
Final Paper
Value-Based Healthcare (VBHC)
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I. CONTENT

Despite the United States being one of the highest-ranking countries in terms of how much is spent on healthcare, we continue to rank among the lowest countries in healthcare outcomes. [23] Value-based healthcare was formally introduced in the United States in 2006 by Michael Porter and Elizabeth Olmsted Teisberg to improve the value of care for patients by coordinating care, enhancing quality measures, reducing costs, and improving patient experience. With the passage of the Affordable Care Act in 2010, organizations increasingly focused on integrating value-based care into their missions to help individuals better manage their health and achieve personal health goals. [6, 8, 10]

The goal of this value-based care policy is to provide equitable care to all patient populations. It examines the organizational capabilities and infrastructure investments healthcare organizations need to participate successfully in a value-based healthcare program through modifications to the recently enacted One Big Beautiful Bill's Rural Health Transformation Program.[1,8,10, 39]

Scope and Nature of Value-Based Care

With patient centered care being the primary focus under a value based health system where the patient and their functional, physical, and emotional health now becomes an integral part of their care and care decisions, healthcare providers must look for other ways to deliver quality care to not only the patients they are currently servicing who may be frequent and preventable visitors to physician offices and emergency departments, but also extend their services to provide care to marginalized populations in their service areas in order to improve the overall health of the community. [10, 12, 14, 16, 19]

Innovative care delivery methods such as partnerships with community organizations, more effective care coordination between providers and ancillary services, and the adoption of patient-centered technologies, including telemedicine, electronic health records, and digital health registries, are increasingly essential and a core feature of the Rural Health Transformation Program.[18, 39] The delivery of this care may take non-conventional forms, as patients may not be able to commute to a clinic due to distance or time constraints and will rely on mobile clinics or web-based services. [11]

Rapid technological advancement over the past two decades has made integrated, community-oriented care increasingly achievable. Beyond the original Porter-Teisberg vision of condition-specific clinics, today's value-based models are expanding into virtual care, supported by trusted community health partners embedded in underserved communities. [6, 7, 8, 12]

II. PROCESS/ POLICY:

A. Policy Objectives and Proposed Solutions

This policy brief proposes policy changes to the One Big Beautiful Bill's Chapter 4 – Protecting Rural Hospitals and Providers and the Rural Health Transformation Program to provide more direct funding guidance to rural areas of need through technology improvements and community partnerships.

1. **Strengthen Fund Eligibility** – Under the current language of the Rural Health Transformation Program, rural adjacent communities may be eligible for funding to support their own health initiatives. Fund distribution rules should be clarified to allow funds to be distributed only to rural adjacent health care providers that have a partnership agreement and a specific initiative with a rural provider documented through a Memorandum of Understanding or Letter of Intent. Oversight of programs and fund distribution would be administered by state-designated healthcare agencies such as the Agency for Healthcare Administration (AHCA). Provisions should be made to allow RHTP funds to be used only in conjunction with providing care to rural areas, through Memos of Understanding and Letters of Intent between hospitals in rural areas and hospitals in rural adjacent areas with greater access to resources.

   By restricting fund distribution to rural health providers or to partnerships between rural and larger providers in rural adjacent areas, it ensures that RHTP funds are used exclusively to provide healthcare assistance to rural populations.

2. **Development of Regional Networks** – Through state health agencies, such as the Agency for Health Care Administration (AHCA) provide funding for the provision of partnerships between smaller rural hospitals or systems of care and larger hospitals or systems of care in rural adjacent areas for shared services, value-based purchasing agreements, community outreach, and quality and best practice initiatives particularly in projects whose goals are to reduce or manage chronic diseases such as diabetes and cardiovascular disease in rural and underserved areas.

   Allowing for the distribution of funds to regional networks of care encourages partnerships between agencies who already have infrastructures, process, procedures, and care plans in place to care for underserved or neglected communities within rural areas who may be struggling to keep up with financial and quality demands imposed upon them by other aspects of the One Big Beautiful Bill such as the loss of Medicaid funding.

3. **Recruitment, Training, and Retention of Practitioners** – Through the Department of Education, amend the OBBB to provide funds to train and place recent graduates or soon-to-be physicians, physician assistants, nurse practitioners, registered nurses, and other mid-level practitioners in rural areas as part of clinical training and rotation. This would require some of these professions to be redesignated as professional degrees. As part of their service in these areas, new graduates would be eligible for student loan forgiveness for each year spent in a rural or underserved community. Additionally, the amendment would also allow non-physician providers to practice at

the top of their license in rural areas. Funds would be allocated to provide additional or refresher training, as needed, particularly for practitioners re-entering the workforce after an extended absence.

Since many rural communities lack staff to build and maintain IT infrastructures, recruitment, retention, and training of IT professionals will also be critical components and eligible for the same student loan forgiveness benefits as their clinical counterparts.

Funding training for healthcare practitioners, placing practitioners in rural areas to gain experience, and expanding mid-level practitioners' ability to practice at the top of their license, helps provide qualified, professional care in rural areas where there may be a shortage of qualified providers.

4. **Technology Improvements** – Amend the existing RHTP policy to allow funds to be distributed not only for the improvement or upgrade of existing IT infrastructures and electronic health record systems, but also for the purchase of new systems when existing systems are obsolete or incapable of being upgraded to communicate with partner agencies or providers.

   By amending the policy to not limit the use of funds for distribution for the improvement of existing systems, it allows for a greater ability for community partnerships to better align data sharing between systems, which do not have the ability to talk to each other rather than potentially incur increased costs to make systems work together which are currently incapable of two-way sharing of data between community partners. Oversight of technology would be provided by the Office of the National Coordinator for Health Information Technology (ONC) through each state's designated health agency.

B. Process

1. Regulatory Pathways

Since the One Big Beautiful Bill was passed through budget reconciliation and did not include public comment before its passage in July 2025, public comment and rule-making are currently taking place as part of the implementation phase. Public comment is coordinated through the Internal Revenue Service, while rulemaking for the Rural Health Transformation Program has been delegated to the individual states by Health and Human Services through the Centers for Medicare & Medicaid Services.

2. Agency Roles and Responsibilities

Since Health and Human Services and the Centers for Medicare & Medicaid Services have delegated authority to individual states to establish, regulate, and monitor their own rules for implementing the Rural Health Transformation Program. Each state will determine which state agency will have RHTP oversight. Each state's designated agency will be responsible for:

- Providing oversight and coordination of Rural Health Plans, which will include focusing on improving care models and care sustainability.
- Administering funds, monitoring performance, and ensuring that plans align with CMS requirements and priorities submitted by each state to CMS for fund distribution.
- Provide workforce access and development by recruiting and retaining healthcare providers in rural areas by strengthening community partnerships.
- Submittal of annual reports to CMS on approved state programs outcomes and spending.

3. Evaluation and Modification

The effectiveness of implementing value-based care through the Rural Health Transformation Program as part of the One Big Beautiful Bill's can be achieved using implementation science principles. The principles can be used to evaluate the effectiveness of each state's individually adopted programs, determine the barriers and catalysts for success, such as a willingness to develop community partnerships and identification of technology gaps. Success can also be evaluated by assessing the sustainability of new programs verses existing programs. Implementation science principles can also determine whether federal and state funded Medicaid programs should be phased out, maintained, or increased to support rural community hospitals.

The Centers for Medicare & Medicaid Services and each state's designated health agency can provide feedback on the four One Big Beautiful Bills funding cycles in conjunction with the proposed state programs to determine if quality outcomes are achieved based on the number of patients served through improved access to care as well as measurable health outcomes in the form of reduced hospital admissions and decreases in the number of cases of chronic conditions.

Since there are four individual fiscal-year funding cycles within the One Big Beautiful Bill, each state's proposed program can be evaluated after each fiscal cycle, and modifications can be made through supplemental rulemaking and stakeholder engagement.

The four funding and evaluation cycles can benefit a state's proposed program by allowing changes to be made annually rather than being locked into a four-year cycle. This can also be a hindrance, since state-level rules may require reapplication for funding on an annual basis and result in the loss of funding should outcomes not meet annual goals.

III. ACTORS

A. Stakeholder Groups and Potential Collaborators

1. Group A - Patients

Patients fall into two categories: 1) community members who are evaluating healthcare options with an emphasis on cost, efficiency, and available services; and 2) those currently receiving treatment, focusing on their care experience and health outcomes. [4, 16]

Patients are more likely to have a high level of support for a value-based health system established as part of the RHTP, as they will benefit from receiving quality, patient-centered care that helps them achieve their personal health goals at a fair price. While patients have a high level of support, as individuals, they also have a low level of influence on advancing these new value-based systems. From a group perspective, their level of influence can increase support for choosing value-based bundled care over a fee-for-service model. [25,33]

Patients and those considering care look for providers they trust and can communicate openly with, while also feeling as though they are receiving their fair share of time with the provider. For some, value means care close to home; for others, it is timely service or manageable costs. Simplified billing can also add value by offering a single source for transactions. In many rural and low-income communities, seeking healthcare can be overwhelming, but a value-based health system that connects care directly to the community through partnerships may reduce barriers and encourage preventive services.[7]

2. Group B - Healthcare Providers

Providers include doctors, nurse practitioners, lab and imaging staff, community health partners, and social workers. They work in the community to coordinate care, follow up with patients, provide social support, and help with employment or housing needs. These stakeholders care about efficient, successful health outcomes.[16] For providers, value-based health care can cut costs, improve outcomes, and make care more efficient. As the system grows, providers become trusted partners, helping patients reach their personalized health goals while respecting their preferences for care.[24] In value-based healthcare, shifting from fee-for-service to outcome-based payment means a patient's health success is also the provider's success.[24]

For healthcare providers, becoming part of a system of care and collaborating with other stakeholders promotes an environment of continuous learning and fosters a culture of sharing. By participating in a value-based system, providers can now stand out from the competition by promoting quality, patient-centeredness, and innovation.[24]

Under a value-based system, the financial risk of achieving successful outcomes becomes more burdensome for the providers, potentially reducing their level of support from high to medium. Funding from the Rural Health Transformation Program can help cover initial startup costs, alleviating the initial burden on rural providers. Providers who see the long-term value in reducing unnecessary costs, spending more quality time with patients, resulting in better outcomes, will have a higher level of support and influence in switching from a fee-for-service model.[25, 34]

In the initial implementation phase, providers may lose income and market share while building their network of partners. They may also struggle adapting to new technologies; however, once a strong network of community partners and technology aided by RHTP funding is in place, providers will see a reduction in administrative costs and their own burnout, since they will now have a network with which to collaborate for patient care. [34]

3. Group C - Technology Developers

Technology is a key component of value-based healthcare and the Rural Health Transformation Program. Early technology primarily included the use of electronic health records. Today, technology includes telemedicine for patients who can't visit clinics and for rural areas that need specialists. It also covers web applications for monitoring vital signs, making appointments, and delivering care. Technology stakeholders include developers who build these tools and IT staff who keep them running.

Developers and IT staff are responsible for creating seamless, compliant digital workflows that meet health information and privacy standards. Tech developers need to incorporate data security and privacy concerns for patients, providers, and insurers when developing systems to share data with all stakeholders who require access. Effective electronic medical records and digital applications strengthen patient experiences, speed up care delivery, and allow efficient tracking of health outcomes. For all stakeholders, a robust data infrastructure streamlines claims and billing processes.[8]

When health outcomes are digitally tracked, it can better aid a health care system in determining which areas of the community and areas of care to invest additional resources[13, 18, 21, 22]. Digitally tracking outcomes and costs can better determine the true quality and value of care.[2]

Since technology developers will be in high demand to create or improve health care providers' digital infrastructure to improve efficiency, reduce waste, and analyze data to track outcomes, they are both highly supportive of a value-based care system and a major influencer in its implementation. Technology companies that are unable to improve their existing products run the risk of being abandoned in favor of new products that can integrate with other platforms and incorporate artificial intelligence. [35,36]

As a key component of the RHTP, spending caps and restrictions on how funds can currently be utilized need to be revised to secure stakeholder buy-in from this critical source. Other technology infrastructure improvements may also be needed beyond software upgrades and development. Some rural areas in need of Rural Health Transformation Program funding may also be lacking robust broadband capabilities to support modern electronic medical record systems and patient-facing web applications, which would exceed the One Big Beautiful Bill's Rural Health funding allowance.[39]

4. Group D - Insurers

Insurers, or payers, may take the form of traditional sources, such as private insurance, or public programs, such as Medicare and Medicaid. Payers may also include hospital systems, which fund portions of community care through their community benefit or community care budgets. Insurance companies and payers benefit from a value-based health care system by using a single bundled negotiated price paid to a single source, which is then distributed to all parties participating in a patient's care. Having a continuum of pre-determined sources of care eliminates the need to negotiate rates with multiple sources on behalf of the patient.[16, 22] The current Rural Health Transformation Program language does not allow for the reimbursement of services to providers as a payer source for medical procedures provided to individuals or group plans.[39]

Payers are incentivized to achieve cost savings in the care their clients receive, while ensuring that appropriate and effective levels of care are provided[25]. Under a value-based healthcare system, insurers would make coverage decisions based on evidence from data collected from patients and care providers to reduce unnecessary high-cost, low-value care.[25]

Payers' support for and influence in implementing a value-based system is high due to their desire to manage risk and control costs. Insurers that do not support a value-based system will ultimately see fewer enrollees seeking plans with better coordinated care among providers in their market area.[37]

5. Collaborations Between Stakeholder Groups

Potential for collaboration exists between healthcare providers, technology developers, and insurers to develop more robust electronic health records and telemedicine software with the goal to reduce long-term administrative costs, streamline operations and billing, and provide better access to care to lower-income and rural communities.

B. Policy Positions and Arguments

American consumers are becoming more focused on access to care, equity, and value rather than on a more-is-better approach. When considering health care options, a patient's perspective will differ slightly from that of a consumer who does not currently need a specific health care service.[25]

1. Access to Care

Through value-based care systems providers are better able to deliver preventive care and educational resources in areas where care was once unavailable, using technology and community partnerships. Access to care can be achieved through partnerships with community organizations close to a patient's home, where they feel more comfortable interacting with providers. Health access can range from preventive education to reduce the incidence of chronic conditions such as diabetes and poor cardiovascular health to specialist care through telemedicine. Access to care becomes

part of a holistic approach that focuses on keeping people healthy rather than just treating them when they are sick.[4,11,18,19]

2. Health Equity

Health equity can be achieved when medical treatment is no longer based on fees for specific services prescribed, but rather on outcomes achieved. Payment is equitably distributed amongst the providers involved in a patient's care, and medical care is now distributed equitably amongst those who utilize resources, rather than just to patients who can afford to seek care.[5] Since care is no longer based on fee-for-service, providers can spend more quality time with patients instead of feeling the need to reach volume metrics to meet revenue goals.

Care is now based on interventions, technologies, and resources that deliver successful outcomes rather than those with the highest reimbursement rates. There is no longer a temptation to overuse services, but rather to reduce their misuse to an appropriate level of care. Ultimately, the distribution of healthcare resources becomes fairer and more efficient.[24]

To achieve health equity, data analysis is used to determine the areas of greatest need, comorbidities, and chronic conditions among at-risk populations, enabling the implementation of screenings and preventive education to reduce the long-term cost of care.[22]

3. Defining the Value - What is the True Cost of Value-Based Health Care?

When implementing value-based policies such as the RHTP, a successful system will focus on the appropriateness and effectiveness of care rather than just costs for providers and patients. If a treatment or intervention is the most effective, it should be considered based on overall effectiveness and not on cost alone[25]. The needs of the patient come first, above short-term cost savings. Cost-cutting rather than quality improvement may negatively affect a provider's practice and patient experience.

Providers can stand out from the competition by promoting quality care and innovation.[24] While patients seek to reach their health goals at a reasonable price, they do not necessarily think they need more health care to achieve their goals. Value-based care will not be successful if cost is the only factor. Patients and consumers are not necessarily going to shop around for the best cost in making their decisions, but rather on quality of care, convenience, and patient experience.[25]

4. Social Effects of Value-Based Health Care

Value-based care programs such as the RHTP can impact a community by improving school and work attendance and performance, as well as the overall physical, mental, and social health of a community.[25]

Through partnerships and continuous learning, a culture of sharing and cooperation among stakeholders can result in patients feeling more comfortable seeing providers

when they are sick because they have built trust through preventive care and education when they are well.

When patients are at the center of care, care is no longer about physical well-being but also about functional, mental, and community well-being.

C. Trade-offs in Developing a System of Value-Based Health Care

1. Preventive vs. Acute Care

Under a value-based health system, care shifts from traditional care for the community when they are sick to a model of preventive care. This new model emphasizes proactive preventive care and the reduction of the impact of chronic conditions through holistic, whole-person care rather than reactive, high-cost, intrusive care when the condition becomes hard to manage or life-threatening. By shifting services to preventive care such as screenings, education, and vaccine clinics, providers like hospitals compromise by giving up high-revenue activities, such as inpatient procedures and emergency room visits, which may also lead to fewer overnight hospital stays. To successfully transition from a fee-for-service model to a value-based system, hospitals and other care providers must invest in technology upgrades and data analytics to identify frequent flyers in the emergency room and at-risk patient populations, to offer screenings and education to reduce high-cost visits. Over time, providers will experience lower readmission rates and better outcomes at lower costs, while patients receive better care at lower costs.[10,12,14,16,19]

2. Short-Term Costs vs. Long-Term Gains

Instituting a value-based care system will entail higher administrative and infrastructure costs to build a comprehensive system of care. During this transition, administrators and clinicians must compromise—accepting higher workloads and reduced short-term margins to build foundations for better care. Administrators invest in technology and workforce, while care teams adapt to new workflows, with the shared goal of sustainable rewards in quality and efficiency, even at the cost of reduced immediate financial gain. This initial investment in technology, workforce, and non-traditional care settings may skew net operating margins compared to fee-for-service models, which encourage the use of care interventions that generate higher short-term revenue. In shifting to a value-based model, during the transition from acute to preventive care, health care providers will also see a shift in revenue streams from high-revenue tests and procedures to other revenue centers, such as wellness centers. A greater burden will be placed on the administrative team to collect, analyze, and report data, as well as to develop new revenue centers and care pathways, which may lead to administrative burnout. Long-term gains may include stable revenue from the new shared-team approach, more predictable revenue, better population health, and reduced readmission rates from the new revenue centers created to deliver care through a preventive model.[1-15, 18,21,22]

3. Evolving Workforce Dynamics

With an emphasis on better care coordination, health systems will become more reliant on a team of caregivers led by primary care providers and nurse navigators to

better coordinate patient care and community resources. This new team approach with shared decision-making may be difficult for some providers to adjust to, as the shifting of workforce responsibilities will require training, a new way of considering care pathways, and potentially reallocating human capital from traditional to non-traditional care settings, resulting in a transition from higher quick-turn revenue streams to lower long-term revenue streams. When population health is achieved, a community may see a reduction in reliance on emergency and urgent care, with an emphasis on screenings and education.[4,10,12,14,16,19]

Shifting focus from acute to preventive care, short-term costs to long-term gains, and developing a different workforce dynamic all share the same positive long-term impact: better care efficiency, lower costs, reduced admission and readmission rates, and reduced emergency room visits, which can heavily tax a workforce on a seasonal basis. They also share the same negative impacts of loss of quick, high-revenue streams and short-term staff burnout while developing and transitioning to a value-based system. However, the result of improved efficiency, better outcomes, and reduced overuse of services such as invasive procedures and testing will eventually outweigh the short-term negative impacts.

IV. CONTEXT

The application of value-based health care as a model for containing costs, improving patient experience, and enhancing quality outcomes remains open to interpretation and evolving definitions of 'value'. It is a model in which success in any one of the three components may not show immediate positive results. The real value in value-based care is the long-term improvement that can be realized when community partnerships are formed outside of the walls of the hospital and extend into the community to assist with the non-medical determinants of health, such as housing, spiritual life, mental health, and preventative care through education and training.[12, 19]

Success can only be achieved when all stakeholders are willing to commit to a bipartisan, long-range plan that spans multiple political administrations. Organizational alignment and robust infrastructure are indispensable.[4] To build an effective value-based system, organizations must strategically refine their referral networks, empower patients in their health decision-making, streamline education and follow-up, and leverage regulatory and technological advancements.

A successful value-based, community-focused program starts with a leadership team willing to make an investment in the time, talent, and physical resources to develop a continuum of care to support and improve the health of a community.[2]

Providing education and training to healthcare providers on the cost of care and work to streamline the referral process, including non-medical sources of care and follow-up care to improve mental and social well-being, should also be included in organizational planning. Healthcare education to patients and prospective patients on a wide variety of topics should be hosted in non-clinical settings such as community centers and places of worship, where citizens and patients are more comfortable and accepting of what is being provided, and can become more knowledgeable about how to manage their care at home and when to seek medical treatment to reduce emergency room visits.[4,16]

The analysis of hospital and community health data helps avoid hospital readmissions, manage complex care costs, and facilitate information sharing. Analyzing electronic medical records and community health data enables coalitions among hospitals, physicians, and social services to address recurring admissions for chronic diseases and place patients at the center of value-based care. [22]

Social Determinants of Health: Shaping Value-Based Care

The social determinants of health that may have an impact on developing and maintaining a value-based health care system, and by extension, programs created through the RHTP might include:

1. **Community Structure, Education, and Health Equity:** Residents of higher-income neighborhoods, supported by robust employment and educational resources, are more likely to seek timely medical care.[14] Access to reliable transportation, whether public or private, underpins access to care and impacts whether individuals seek medical attention or delay treatment, sometimes burdening emergency services. Community demographics that may affect whether a citizen feels comfortable or able to seek medical care include age, gender, sexual orientation, and ethnicity. Communities with lower education levels and poorer quality school systems will have a greater propensity to have chronic conditions such as diabetes and cardiovascular disease due to the lack of education and support programs in the community for preventative and ongoing care.[4] Lower-income, more diverse communities will have a difficult time attracting healthcare providers, such as primary and specialty care, unlike middle-class communities and areas of affluence.[9, 12] Community partnerships within a rural and underserved community, as well as from neighboring areas of greater wealth and resources, are vital to overcoming structural iniquities.
2. **State of the Economy:** The state of the economy will directly impact a patient's ability to seek medical services, where they choose to receive care, whether they can pay for services, and how they pay for them. Low-income and unemployed households will seek alternative care at emergency rooms, community-based clinics, and federally qualified health centers.[12] With cost a main driver of seeking or not seeking care, the value proposition of the level of care (health outcomes) and patient experience becomes more important in healthcare decisions.[17] Low-cost, high-quality care, provided through community partnerships developed as part of the Rural Health Transformation Program, may ease the burden of Medicaid cuts; however, budget cuts should be revisited at the conclusion of the 2030 policy period to adjust budgets and policies based on overall outcomes.
3. **Social Support:** Patient-centered care is more than treating the physical condition. Value-based care approaches patient care holistically, also taking into account the mind, body, and spirit. Having adequate access to services to support a citizen's mental and spiritual health is equally important as taking care of physical health. Utilizing social services to supplement the physical and medical care needs of a community is vital to its long-term health, particularly when these services support racial and gender equality.[19] Uniform definitions of healthcare providers at the federal level, as part of the One Big Beautiful Bill's Rural Health Transformation Program, can alleviate ambiguity about

which programs can be funded by each state and ultimately lead to successful outcomes in serving underserved and rural populations.

Importance of the Health Policy Issue

In the context of the COVID-19 pandemic and its aftermath, there is a pressing need at every level (local, national, and global) to reevaluate systems of care to improve patient outcomes and the delivery of care as stated in the United Nations health goals, "ensure healthy lives and promote well-being."

Both patients and care providers are essentially two sides of the same coin - quality care, with the best possible experience, at the lowest cost. All three cannot be achieved overnight [2].
For the patient, it is better care at a lower cost. For the provider, it is a better experience at a lower cost. Improving just one aspect of the triple aim can be considered an impressive local short-term goal. From a global perspective, value-based health care and programs like the Rural Health Transformation Program are an investment in a health system and the community's future, ensuring that all citizens can access other wellness services, with the long-term goal of achieving all three aspects to improve and enhance health and eradicate chronic conditions.[1-15]

Investing in organizational improvements and infrastructure is important for ensuring a successful, long-term, value-based health system that creates a continuum of care with the patient's goals and experience at the center.[20]

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