1

A BIT ABOUT ME…

Betty Rambur holds an endowed chair at University of Rhode Island & is a former member of Vermont's Green Mountain Care Board. She is active in many service and reform efforts, including the RI Cost Trend Steering Committee, a Trustee at South County Health, and as a member of the Medicare Payment Advisory Commission. Certified as an FNP in 1982, she led the development of the first NP program in western North Dakota. In the 1990s, she led the ND health reform effort that shaped omnibus legislation inclusive of direct reimbursement for APRNs, removal of gender as an insurance rating factor, and community rating, among other things. She served as an academic dean at University of Vermont from 2000-2009.

- All views are hers, and do not necessarily represent the views of any of her affiliations.

2

AND……..

- North Dakota Native
- Born at St. Alexius…Educated in ND
- Former Chair, University of Mary Nursing
- Former Chair, ND Health Task Force

3

HEALTHCARE STRUCTURAL CHANGE INCLUDING VALUE AND IMPACT ON PROVIDERS/NURSES

4

REIMBURSEMENT

Shapes what we focus on!

Fosters or impedes what we are able to do!

Largely determines where we land!

5

A PERFECT MARRIAGE? VALUE AND RURAL HEALTH

Why? Because Volume-based care is poorly suited for regions with low volumes!

6

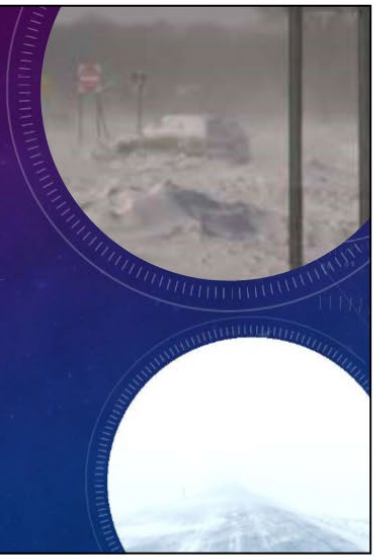
THE RURAL PENN EXPERIENCE

- Kurtz, cited in Brady, noted that the drop in revenue secondary to the decline in elective procedures during COVID-19 would have "wreaked havoc" on their system in the fee-for-service world yet did not because they had joined the fixed revenue reimbursement model.

7

BUT FIRST…THE SPECIAL CHALLENGES OF RURAL DELIVERY AND RURAL LIFE

- CONTEXT…1 in 5 American's live in rural areas
- Average travel time to a facility WAS 34 minutes by car, but with hospital closures, this time is increasing
- The "average" time does not easily factor in weather
- The "average" time does not easily reflect the supports needed to travel



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RURAL HOSPITAL CHALLENGES

- Declining inpatient admissions
- Patients traveling to urban areas for care
- Older & often sicker populations than urban counterparts
- Payer mix--Large number of uninsured and in some states Medicaid, Medicare…including "very old" elderly
- Provider shortages—physicians, nurses, others
- Less cash, yet equipment is expensive and quickly obsolete
- Operating expenses

The urban bias in education

9

IN THE US, RURAL PEOPLE, IN GENERAL

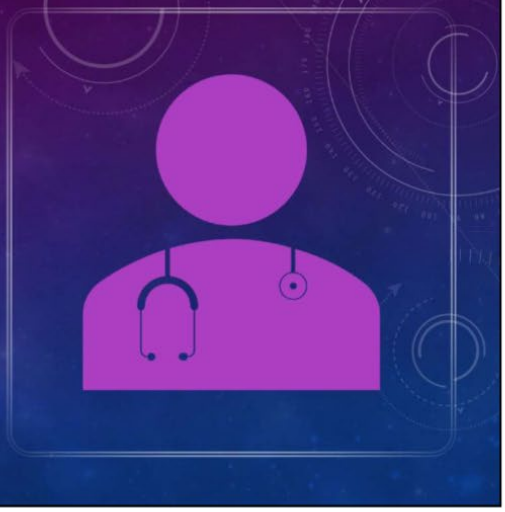
- Have less wealth, lower incomes and more poverty
- Lower educational attainment
- Less stable labor markets
- Worse health status
- "Opportunity Gap"

- "Health," defined as the ability to work

10

HEALTH-RELATED FACILITIES MAY BE AMONG THE LARGEST EMPLOYER

YET PEOPLE BYPASS THEIR LOCAL FACILITY



11

CRITICAL NEED FOR TRAUMA SERVICES & OTHER SELECTED SERVICES

- Challenges of retaining cutting edge competence in low volume procedures/conditions
- Expertise may be only one layer deep.—creates particular challenges with retirements, illness, time off, call coverage etc.

12

RURAL EMERGENCY HOSPITAL DESIGNATION

- "Designed to maintain access to critical outpatient hospital services in community that may not be able to support or sustain a Critical Access Hospital or small rural hospital".
- Offers greater Medicare reimbursement. The glitch? Shutters inpatient services, thus, a solution for the very few.

13

THE TRADITIONAL MYTH ON WHY RURAL HOSPITALS CLOSE

- What I would call the traditional myth is that the reason why small rural hospitals lose money is because they're providing inpatient care to a very small number of patients. Therefore, if you could somehow relieve them of that responsibility, then everything would be fine," "**The problem is that's not necessarily true**....
- ... if hospitals eliminate their inpatient unit, they usually can't recoup all of the costs that are associated with it, but they do miss out on its revenue. For example, a nurse working in the inpatient unit at a small rural hospital will typically also tend to the emergency department. So, even if inpatient care is eliminated, the hospital still needs that nurse.

"That means they would lose money by closing their inpatient unit as well as not providing the service that the community needs," Miller said. (Harold Miller, Washington Post, January 2023, https://www.washingtonpost.com/politics/2023/01/17/rural-hospitals-say-they-stuck-between-rock-hard-place/)

14

HOW TO SURVIVE??

- Mergers and acquisitions
- Convert to different type of facility
- Is there a better solution?

15

VALUE- BASED PAYMENTS FOR CREATES VALUE- BASED CARE!

VALUE=OUTCOMES/COSTS

$$\text{Patient Value} = \frac{\text{Health Outcomes}}{\text{Cost}}$$

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

16

FOCUS IS ON OUTCOMES

- Immediate AND long-term
- Patient satisfaction and their values are factors with fresh attention
- The "measure set" influencing payment matters!

17

VALUE-BASED PAYMENTS

01

Incentivize upstream proactive thinking and action

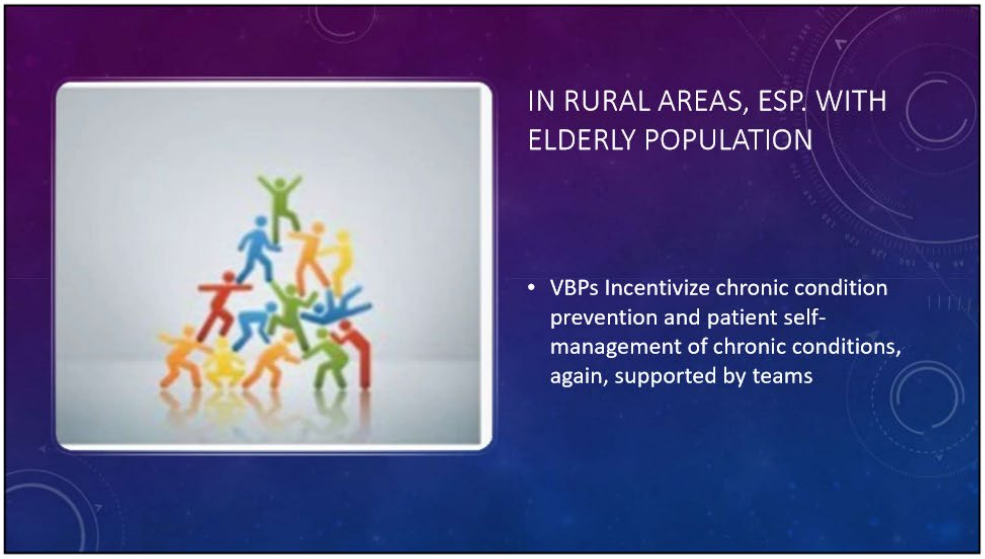
02

Incentivize team-based care with the patient and their family in the center

03

Require sophisticated data collection, reporting and analytics

18


IN RURAL AREAS, ESP. WITH ELDERLY POPULATION
• VBPs Incentivize chronic condition prevention and patient self-management of chronic conditions, again, supported by teams

19


Payment Models
RISK
The Move Away From Fee For Service to Value
Reimbursement Linked to Outcomes
Patient Centered Medical Homes
"Upside only" ACOs
Reimbursement Linked to Outcomes & Cost
Two-sided ACOs
Bundled payments
Global Budgets/Fixed Revenue Total Cost of Care
Financial risk creates tremendous opportunities IF we know how to seize them.
20

20

Accountable Care Organization Reimagined to Achieve Equity and Community Health model, better known as…

ACO REACH

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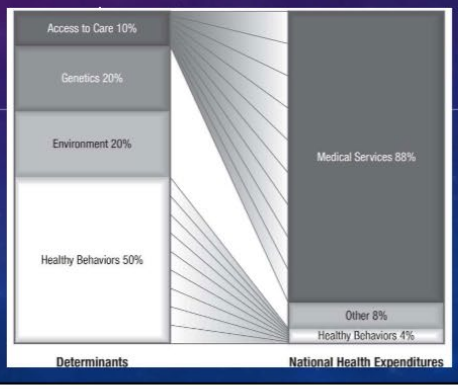
WHY VALUE-BASED CARE?

Our reimbursement strategies fuel care that is not well aligned with societal need

- Mismatch between spending @ value



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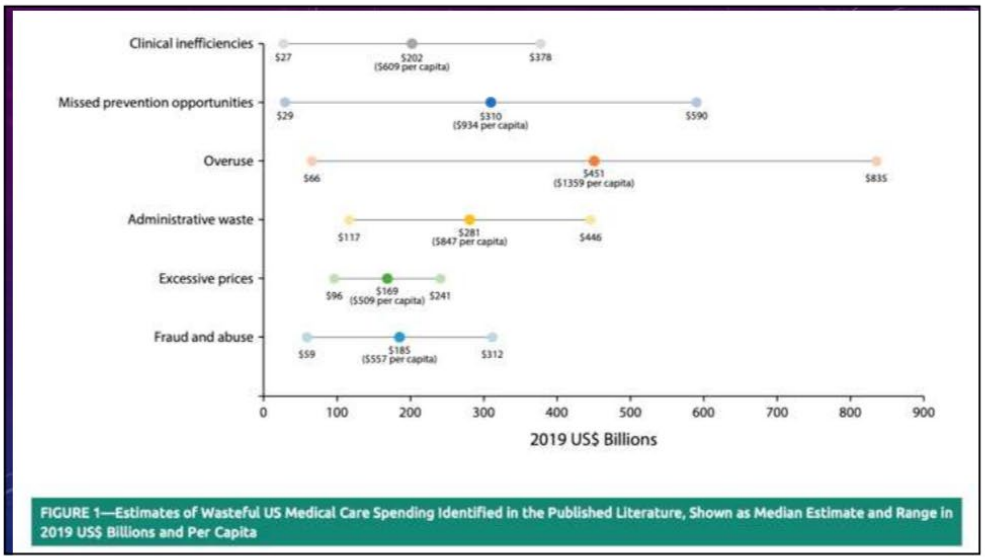

FIGURE 1—Estimates of Wasteful US Medical Care Spending Identified in the Published Literature, Shown as Median Estimate and Range in 2019 US$ Billions and Per Capita

23

LOW VALUE CARE HARMS PEOPLE AND POCKETBOOKS

- Waste, low value care, high rates of error
  - 2/3 of low value care has high potential for cascades of unnecessary care; half creates harm (Ganguli et al, 2022).
  - Unequal harm risks: Black and Latino patients more likely to receive low value care (Schpero et al 2017)

24

CAN WE REDIRECT THAT LOW VALUE CARE/OVERTREATMENT TO THINGS THAT REALLY MATTER?

25

WE KNOW THE "WHAT"…VALUE BASED CARE AS A "HOW"

- CMS recently called for all Medicare beneficiaries to be in a risk bearing value-based arrangement by 2030.
- Reid and colleagues (2022) found that volume-based compensation remains the most common, with value-based payment arrangement averaging less than 10%
- Likely, it takes 60-80% value-based arrangements to fully change provider behavior and redesign care delivery

YET….

26

THE STATE OF VALUE BASED PAYMENTS

"40.9 percent of US healthcare payments, representing approximately 238.8 million Americans and over 80 percent of the covered population, stemmed from value-based reimbursement models last year. These models included upside and downside risk arrangements, as well as population-based payments.

Additionally, almost a fifth (19.8 percent) of all healthcare payments made last year were in some way tied to value or quality of care while still being based in fee-for-service. The remaining 39.3 percent of payments were strictly fee-for-service (2021, para 1-2).

https://revcycleintelligence.com/features/the-state-of-value-based-reimbursement-financial-risk-in-healthcare#:~:text=Additionally%2C%20almost%20a%20fifth%20(19.8,in%20fee%2Dfor%2Dservice.

27

BENEFITS AND CHALLENGES TO PAYING RURAL SYSTEMS FOR VALUE

BENEFITS

Creates income stability and predictability

Accelerates ability to spend on things that improve health

Allows the system to align with true community need

Administrative simplicity (optimally)

Adapted from Firth, 2019

28

CHALLENGES!

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GLOBAL BUDGETS AS A FORM OF VALUE-BASED CARE…WHAT ARE THEY?

- "A fixed amount of funding for a fixed period of time for a specific population, rather than payment for individual services or cases"
- The types vary: A facility – based global budget: gives hospital clear incentives to manage provision of care within a defined budget constraint and also the hospital (or health system) more flexibility to allocate resources (Firth, 2019, p4).

30

MICRO EXAMPLES--

- PACE
  - BISMARCK
  - DICKINSON
  - FARGO
  - MINOT

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MARYLAND

- Decade of experience, building on its longstanding rate setting framework
- Is hospital focused—higher proportion of ambulatory surgery centers in the nation
- Hospitals have real-time information on admissions and readmissions
- MD has no CAH

- Population density=245 people per sq mile

32

PENNSYLVANIA

- Differs from Maryland. Is prefixed upfront and voluntary

Population density=286 people sq mile

33

VERMONT

- All payer rate setting model, like a risk bearing Next-Gen ACO
- Designed to be all payer, all settings

- Population density-68 people/sq mile
- North Dakota—population density=9.7 per square mile & many frontier counties

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INCENTIVES MATTER!

Fixed Revenue Model Incentives

- Reduce unit costs, for example, blood tests or imaging
- Eliminate unnecessary or low value texts or procedures
- Reduce admissions/readmissions

Fee-for-service Incentives

- Maximize unit costs
- Use tests and procedures liberally
- Expand admissions
- Expand readmissions outside of the 30 days.

LESSONS FROM THE SHIFT FROM RETROSPECTIVE REIMBURSEMENT TO PROSPECTIVE (DRGS)

35

HOW DO THEY FIXED-REVENUE VALUE BASED MODELS USUSALLY WORK?

- USUALLY BASED ON HISTORIC ALL-PAYER REVUENUE AS A BASELINE AND THEN TRENDED FORWARD BY A FACTOR REFLECIVE OF INFLATION AND OTHE FACTORS
- NOTE…THIS IS A SIMPLE SENTENCE BUT A HUGE ISSUE…THE BASE AND TREND MATTER

36

WHERE DO THEY WORK BEST?

- "HOSPITALS/HEALTH SYSTEMS THAT ARE DOMINANT N A PARTUCUYAR REGION AND HAVE POPULATIONS WHO ARE NATURALLY MAPPED TO THEIR HOSPITALS….PARTICULARLY RURAL FACILITES WITH EASILY IDENTIFABLE *REFERENCE POPULATIONS* "(GLOBAL HEALTH PAYMENT LLC, 2018, P 30)
- ALL PAYER/ALL SETTING ENVRIONMENTS

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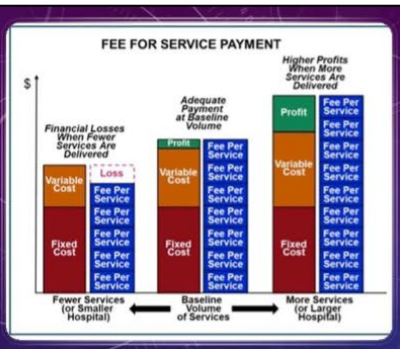

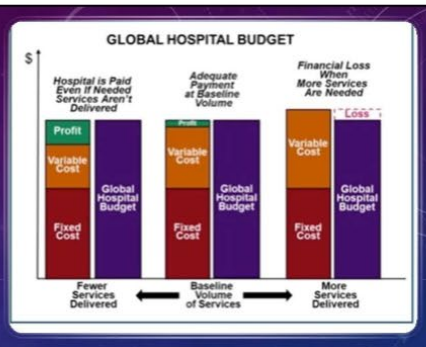

CONVERSELY

THE CENTER FOR QUALITY AND PAYMENTT REFORM ARGUES AGAINTS FIXED REVENUE "GLOBAL BUDGETS" AND FEE FOR SERVICE.

Source: https://chqpr.org/downloads/Better_Way_to_Pay_Hospitals.pdf

38

STRATEGIES

"STANDBY CAPACITY PAYMENTS? "

"STOP LOSS?"

39

THE FLEX MODEL!!!!

- STRATEGIC PROCESS 2.5—VALUE BASED PAYMENT PROJECTS.
- OUTPUTS-# and % of CAHs participating in value-based payment projects
- Self-Assessment for Transition Planning completed and result shared
- CAHs can effectively implement strategies to being the transition to value-based care

40

OUTCOMES

1. # and % of CAHs making changes in systems to prepare for participation in value-based payment programs
2. CAHS are prepared for future models of healthcare
3. Value-Based Payment program Ready to Implement

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IMPACT

- "High quality healthcare is available to rural communities and *aligned* with community need (emphasis added)
- High value healthcare is delivered to patients and communities, resulting in healthier rural people"
- (https://www.ruralcenter.org/sites/default/files/2023-01/Flex%20Program%20Logic%20Model%20-%20Financial%20%26Operational.pdf

42

CONTEXT IS EVERYTHING

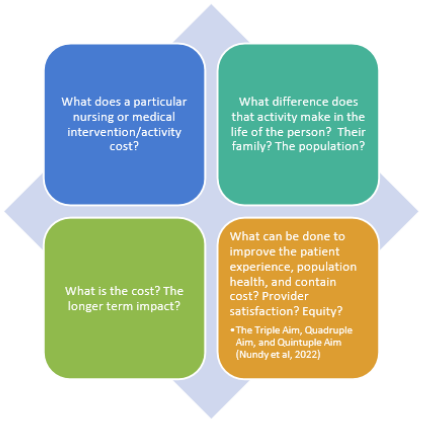
- NOTE: This model specifically recognizes that contextual factors will influence the shape and contours of the program, reflecting social, cultural, political, policy, legislative/regulatory, economic and physical environments for each program.

43

CULTURE…INCLUDES AND IS SHAPED BY WHAT WE SAY…AND DON'T SAY…WHAT WE DO AND DO NOT!

44

VALUE-BASED MODELS BEGIN TO ASK, WHAT DIFFERENCE DOES OUR CARE MAKE?



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SKILLS NEEDED IN THE ERA OF VALUE-BASED CARE

- Value-informed practice
- Care coordination
- Care process reengineering
- Team-based care
- Continuous performance improvement
- Use of data and metrics
- Waste reduction
- Innovation

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LET'S TALK ABOUT TEAMS

- RN (not APRN) led team inclusive of pharmacists highly effective in care of people with diabetes (Herges et al 2022).
- Provider teams (NPs, PAs and MDs) outperformed solo providers (Pany et al, 2021)
- Value based payment removes fee-for-service distinctives for team-based care

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VALUE-INFORMED PAYMENT → VALUE-INFORMED PRACTICE

Decisions on resource use are made every day by all providers

Are we considering de-implementation of things that don't work?

Are we reviewing rigid standing orders?

Are nursing and medical schools deeply informing students on value?

IMPORTANT because studies have found that graduates will adapt themselves to the environment they are practicing in

48

WHY MOVING AWAY FROM FEE-FOR-SERVICE OFFERS NURSES OPPORTUNITIES--EXAMPLES

Recall, in FFS, staff nurses are cost centers, physicians are revenue generators

Solution to childhood asthma in fee-for service? Hire more pulmonary physicians

Solution in fixed revenue models? Have nurses do home visits to address mold, animal exposure, etc.

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Public Trust in Groups to Improve the US Health Care System

Commonwealth Fund/Harvard School of Public Health, 2019 Survey Americans' Values & Beliefs about Health Insurance Reform

'A great deal' of public trust in…	
Nurses	58
Doctors	30
Hospitals	18
Labor unions	14
State governments	6
The federal government	6
Congress	5
Business leaders	5
Health insurance companies	4
Pharmaceutical companies	4

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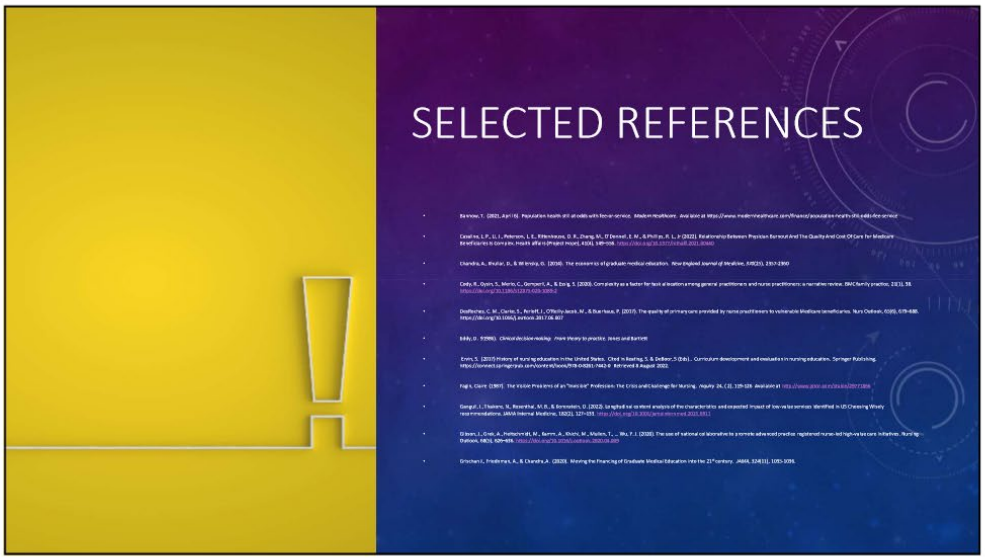
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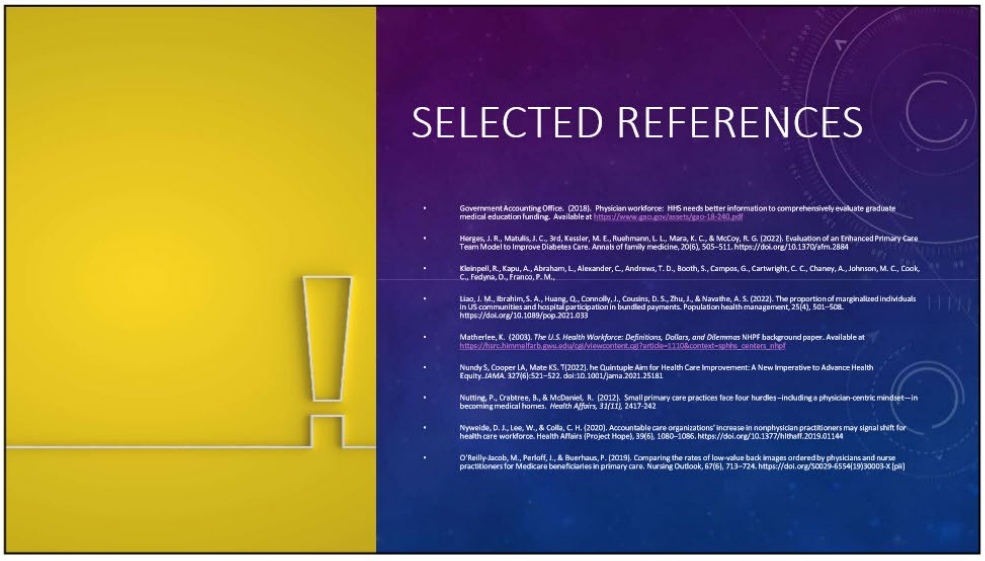
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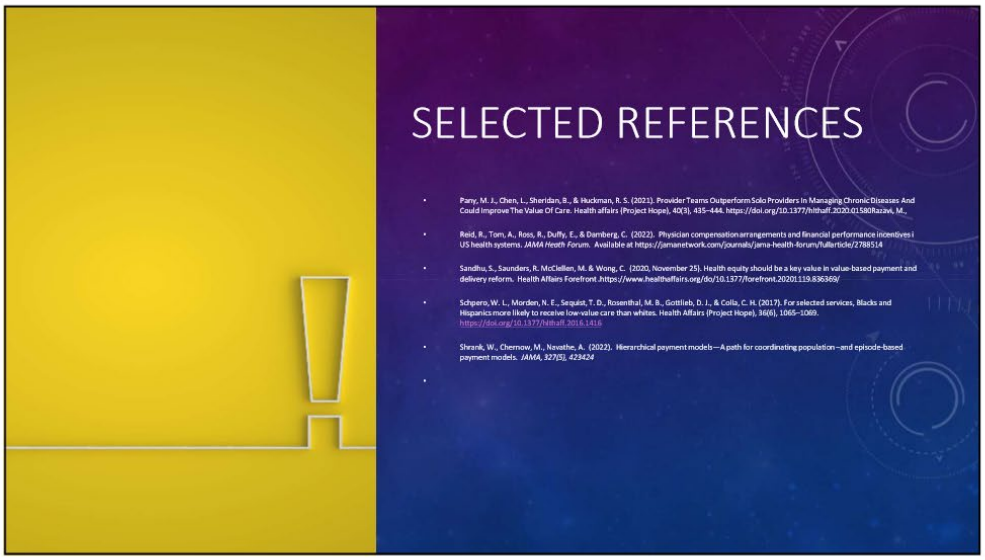
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Any Suggestions?
WHAT IS NEXT?
Questions?
Thoughts?
Suggestions? Criticism and Critique Welcome!

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