Building Back Better:
Leveraging Value-Based Payment to Build a More Resilient Health Care System

An interview with **Rachel A. Roiland, RN, PhD**

Q. Please define resilience, especially what it means for healthcare systems. Any comments on robust system (ability to return to equilibrium point) vs resilient system (ability to re-set equilibrium point based on changes)?

A. Resilience means being able to respond to and recover from challenges and leverage lessons learned during a challenge to build back better and more prepared for the future. Robust, as described above, implies being able to respond to a challenge, but with a focus on returning to "normal" (i.e., the way things were before the challenge). In the context of COVID-19, health care providers and the U.S. health care system as a whole can't afford a return to the way things were before the pandemic. The challenges we've seen around accessing personal protective equipment[1], preventing and managing the virus in high-risk populations (e.g., nursing home residents[2]), and addressing the pandemic's financial impact on health care providers[3] reveal some of the key areas of dysfunction in our health care system that need to be addressed.

Chief among these dysfunctions is the fee-for-service (FFS) payment system upon which much of our health care system remains

reliant. This payment per service approach means a provider's payments are driven by the volume of services they deliver. When service utilization dropped dramatically in the early days of the pandemic[4], payments to health care systems and providers dropped dramatically, too. Many providers, particularly primary care, pediatric, and rural providers, had to cut costs by implementing layoffs, furloughs, and skipped or deferred salaries.[5] While some utilization levels have returned to or near pre-pandemic levels[6], the occurrence of another surge of COVID-19[7] means utilization and provider payments will likely decline again as elective procedures are reduced[8] and individuals hesitate to visit clinics or hospitals as the number of COVID-19 cases rises.

If we are to have a more resilient health care system, we need to learn from the failures of FFS. This means moving away from FFS and toward payment models capable of supporting providers and ensuring patients' access to care during times of crisis. Our team found providers operating under value-based payment (VBP) arrangements were better situated to respond to the pandemic.[9] They could quickly pivot their resources to both respond to the demands of the pandemic (e.g., implement screening and testing) and maintain continuity of care for their patients (e.g., implement telehealth quickly). Value-based payments made this possible because they are focused on paying providers for delivering high-quality care and achieving desired outcomes, not just individual services.

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This value-approach to payment not only protects providers financially from dramatic drops in service utilization but it also encourages them to develop capabilities – data infrastructure, care coordination workforce, telehealth platforms – that can help them achieve their cost and quality goals. These same capabilities, it turns out, are also useful during times of crises. Our work shows providers leveraged these capabilities to reach out to individuals at high-risk for COVID-19, coordinate with other providers and community partners to address individuals' non-medical needs, and expand telehealth services to ensure continuity of care for patients.

Q. Have groups previously revised plans based on lessons learned from the history of epidemics and pandemics – e.g., SARS (2003), MERS (2012), Zika, etc.?

A. After each of those outbreaks, there were efforts to identify lessons learned and make recommendations for how those lessons could inform preparations for future outbreaks. For example, the National Academies convened a workgroup after the SARS epidemic in 2003 and identified a number of a lessons learned related to early detection, containment approaches, and other areas of response.[10] Places like Hong Kong and Singapore acted on many of those lessons and built up their public health surveillance systems in response. Assessing lessons learned and acting on those lessons are key to building up resilience. COVID-19 is a very different challenge from SARS and MERs given differences in transmission, but that model of taking stock of what we've learned and acting on that information is one we should follow in figuring out how to respond to and rebuild from COVID-19.

Q. What are the key areas we should be considering when looking to identify the lessons we can learn from our COVID-19 response?

A. In addition to the issues mentioned above related to how providers are paid, other areas we should examine include ensuring the availability and distribution of resources needed to respond to a pandemic (e.g., PPE), supporting health care providers ability to coordinate and collaborate with public health agencies, the appropriate collection and sharing of data related to an outbreak, and preventing future outbreaks from disproportionately affecting vulnerable individuals (e.g., older adults in nursing homes) or communities of color.

Roles of Players in Resilience Policies

Government: Funding and Coordination

Q. How can the government promote or advance resilient overall healthcare policy and oversight of healthcare equity, delivery, insurance, reimbursement, safe therapies?

A. Congress, with additional funding, could provide the resources the health care system needs to not only respond go the pandemic but to also rebuild itself. Future funding should be structured in such a way as to support both the COVID-19 response that is needed now and the development of resilience that is needed for the future. Our Center, along with partner organizations Families USA and US of Care, have proposed the COVID-19 Health Care Response and Resilience Program[11] as a possible approach the government could take for future funding. In this proposal, we describe how future financial relief from the government could help health care providers invest in capabilities (e.g., data and telehealth infrastructure) that can support effective COVID-19 response *and* facilitate transition into VBP arrangements over the next few years. This kind of proposal – focused on learning from the challenges of this pandemic and developing ways to address them moving forward – is what we need to build a health care system that is more resilient moving forward.

Agencies can also play a huge role in promoting resilience. The Centers for Medicare and Medicaid will have an important role given it will likely be charged with operationalizing the distribution of any additional funds to providers caring

for patients on Medicare and/or Medicaid. Through this role, the agency can help ensure the process for applying and receiving funds is not overly burdensome and that the funds are distributed equitably and used appropriately to support the delivery of COVID-19 tests, therapies, and vaccinations as well as investment in the capabilities (e.g., data infrastructure, telehealth platforms) that will enable a more robust response to future crises.

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Business: Resilient Economic Models

Q. What are the major changes needed in healthcare business and economic models to be more resilient, especially for insurance and reimbursement (e.g., emergency funding set-asides)?

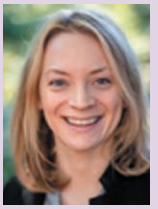
A. More movement away from FFS and toward VBP arrangements is really key to building our health care system's resilience and making it more effective at meeting the needs of individuals. Not only do these payment models better support providers during challenging times, they support the redesign of care so that it is more coordinated and patient-centered. Under VBP arrangements, providers can often employ staff to help coordinate care across providers and settings and deliver services and supports to address a wide set of patient needs.

More advanced VBP arrangements, meaning those involving prospective payments to providers for each of their patients, are particularly promising in their ability to address not only the medical needs of individuals but also needs related various social determinants of health (e.g., nutrition, transportation). Models such as Oak Street Health[12] and ChenMed[13] are very successful models for how advanced VBP models can support the delivery of comprehensive primary care to older adults with multiple chronic conditions and oftentimes many social needs. If our health care system is to be really effective in improving the health and well-being of individuals, payment models that support providers' ability to address the many factors that affect health are needed.

Hospitals and healthcare centers

Q. One can foresee "knock-on" effects of a whole-sale transition to VBP models across and within health care industries. As a specific example, how would a VBP model filter throughout a care center or hospital to teams that directly treat patients and make these teams more resilient?

A. It's important to note that changing payment is an important reason for implementing VBP, but it's not the only one. VBP is also meant to enable changes in the way providers in care centers, hospitals, or other settings deliver care. VBP can help organizations develop capabilities (e.g., care coordination, data infrastructure, partnership with community-based organizations) that give providers the tools and resources they need to better meet the needs of their patients. With access to data about one's patient population, providers can proactively identify individuals at high-risk for complications and prioritize them for outreach. With staff and workflows dedicated to care coordination, providers can effectively and efficiently communicate across providers and settings to ensure a patient is receiving necessary services. With these capabilities at hand, providers and their teams are able to respond to patient needs both in normal times and times of crises. Having the ability to respond in either context is what makes a team more resilient. JoPM



Rachel Roiland, RN, PhD

Rachel is a Research Associate in Payment and Delivery Reform at the Duke-Margolis Center for Health Policy. In this role, she leads projects on value-base care and payment and most recently led the development of the COVID-19 Health Care Response and Resilience Program proposal mentioned in this article. Prior to joining the Center, Dr. Roiland was a Director at the National Quality Forum, where she directed NQF's Serious Illness Initiative, and contributed to multiple efforts focused on quality measurement and shared decision making. A former Health Aging Policy Fellow, Dr. Roiland is trained in geriatric nursing and earned her doctorate in nursing from the University of Wisconsin-Madison School of Nursing.

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