Value-Based Care and North Dakota

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Rural Health Value

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Rural Health Value

- RHV Goals
  - To facilitate rural health care organization and community transitions from volume-based to value-based health care and payment.
  - To engage and educate payers regarding *rural* value-based health care and payment perspectives.
- RHV Work
  - Convene parties/groups interested in rural value-based care and payment.
  - Develop tools and resources to support rural value-based care.
  - Interpret health policy related to rural health care value.
  - Disseminate rural best practices adopting value-based care.
  - Share rural experiences delivering value-based care.
- **www.ruralhealthvalue.org**

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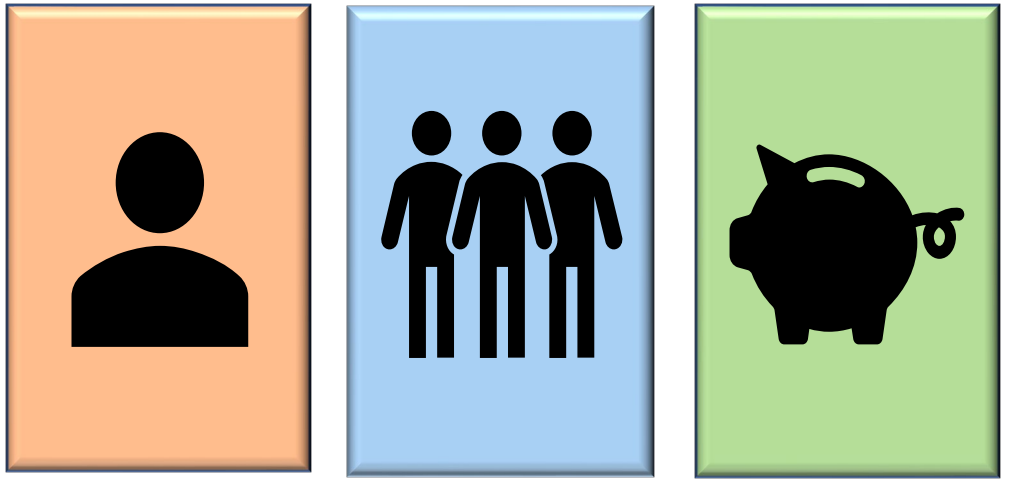
Rural Health Value – North Dakota

- A federally funded (CDC) project sponsored by the University of North Dakota **Center for Rural Health**.
- Over-arching goal is the Triple Aim – better care, improved health, and smarter spending.
- Designed to assist rural North Dakota Critical Access Hospitals prepare for value-based care and payment.



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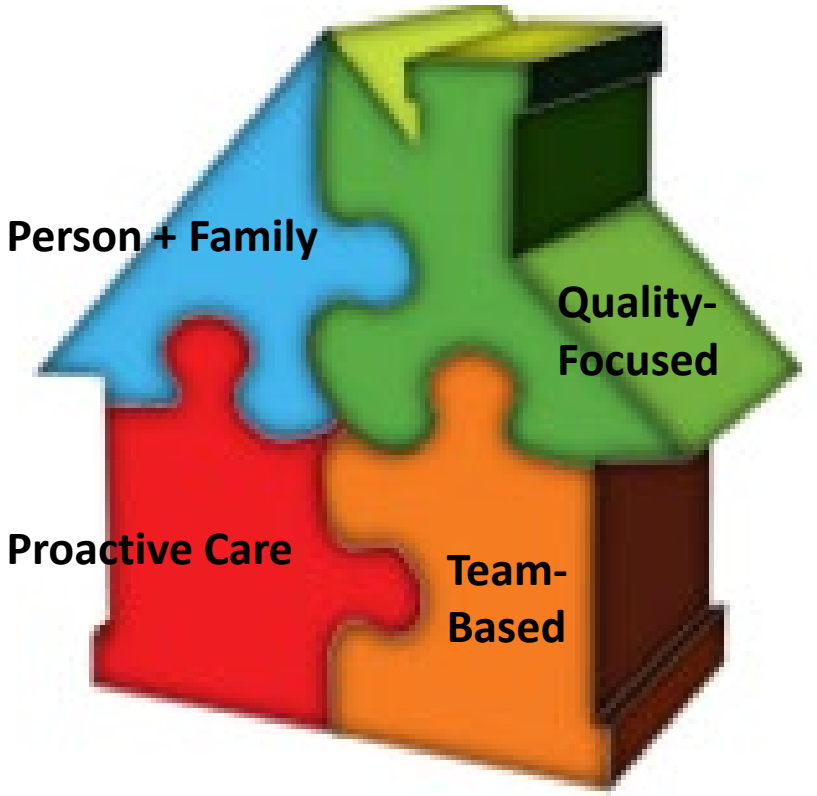
"Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it."

- A. A. Milne

Value-Based *Care*

- Value-based care provides better care, improved community health, and smarter spending.
- Value-based care prioritizes high-quality, person-centered, and efficient care.
- Value-based care does NOT prioritize the volume of services provided.
- **Robust primary care** practices are an essential ingredient (as in rural person-centered health teams).
- But we have a problem…



The Value Conundrum

You can always count on Americans to do the right thing – after they've tried everything else.

- Fee-for-service
- Full capitation
- Market-based
- Single payer

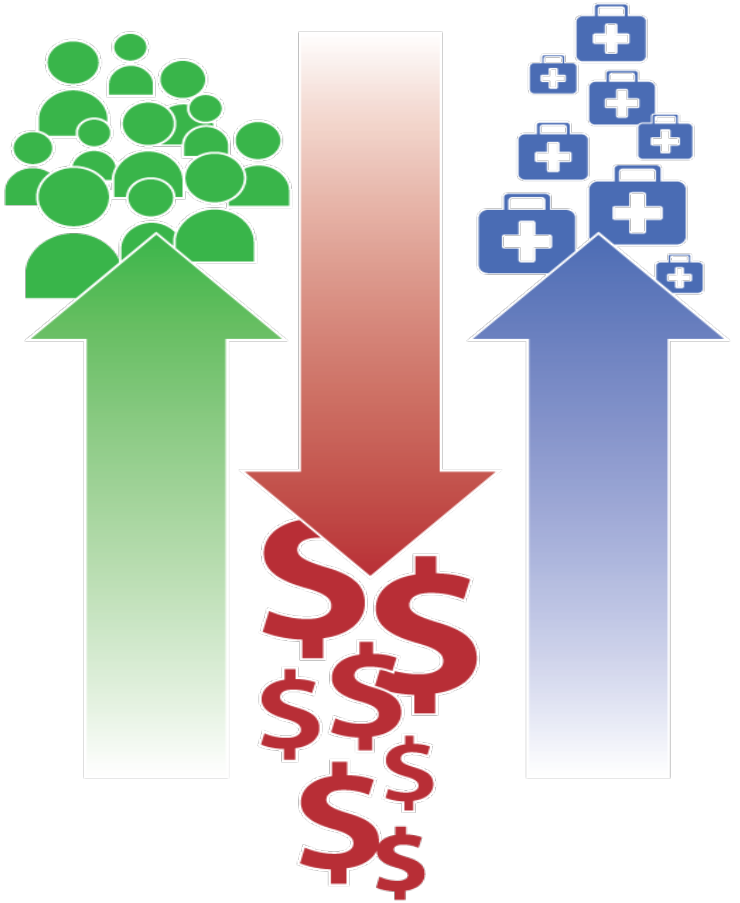
- What about paying for **health care value**?

Form Follows Finance

- How we *deliver* care depends in part on how we are *paid* for care.
- New alternatives are changing <u>both</u> payment and delivery.
- Payment supplies fuel for the Volume → **Value** transition.

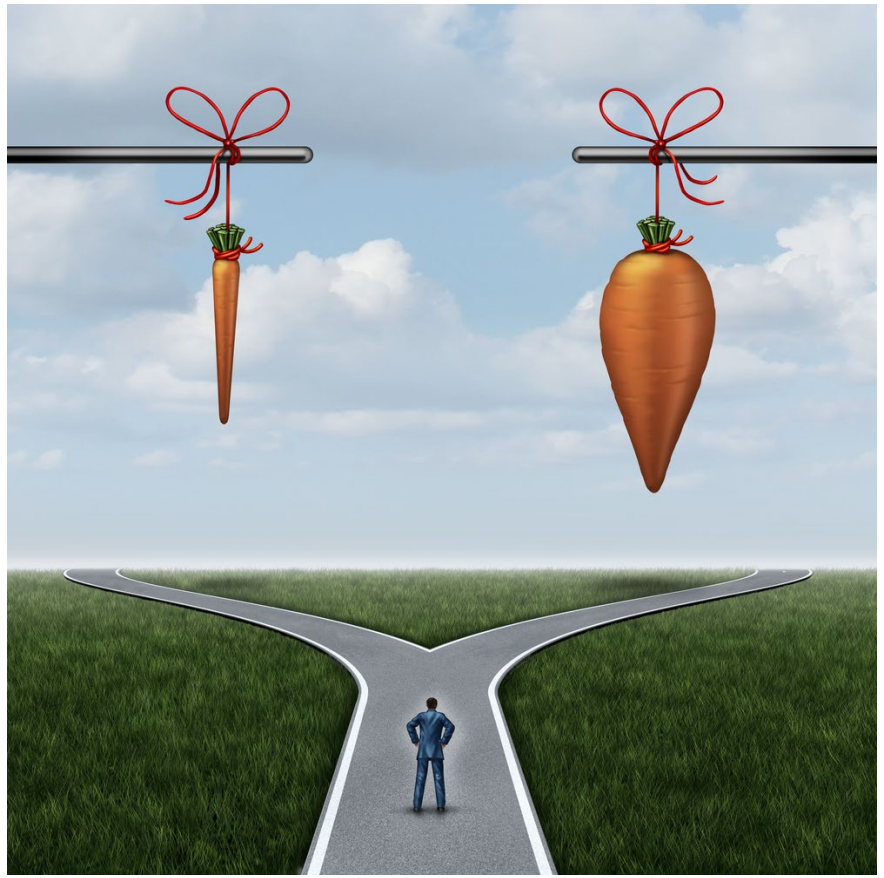
Value-Based *Payment*

- **Payment** for one or more parts of the Triple Aim
  - Better patient care
  - Improved community health
  - Smarter spending
- Pays for what people want and need.
- Not payment for a "service," that is, NOT fee-for-service.
- To *receive* value-based payment, we must *deliver* value-based care.

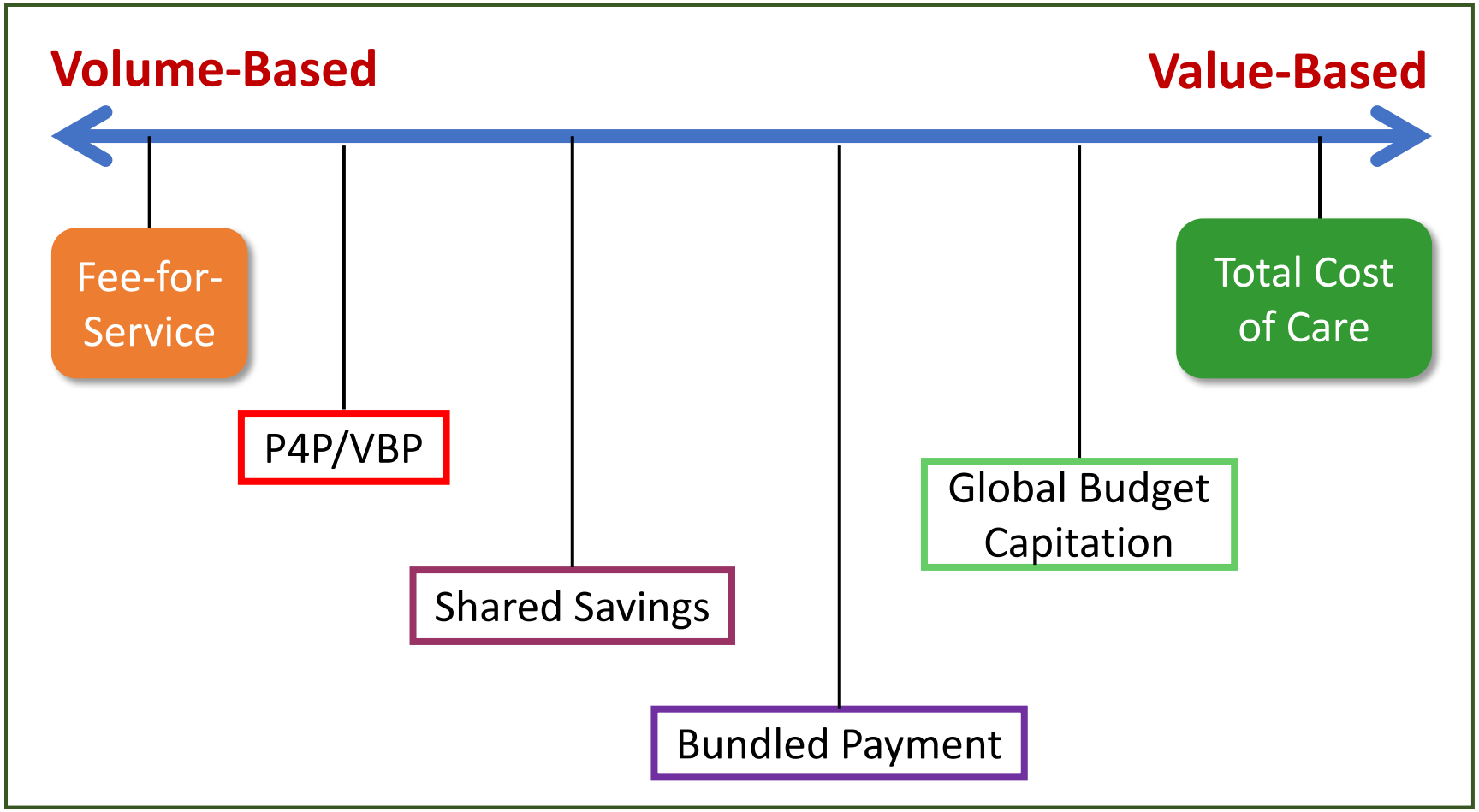


Why discussing payment, not care?

- Career as a rural family doc, yet…
- Money is a medium of exchange.
- Incentives drive behavior.
- Not all incentives are financial, but finance remains important.
- Let's incentivize the Triple Aim.
- Make it easy to do the *right* thing for our patients and communities.

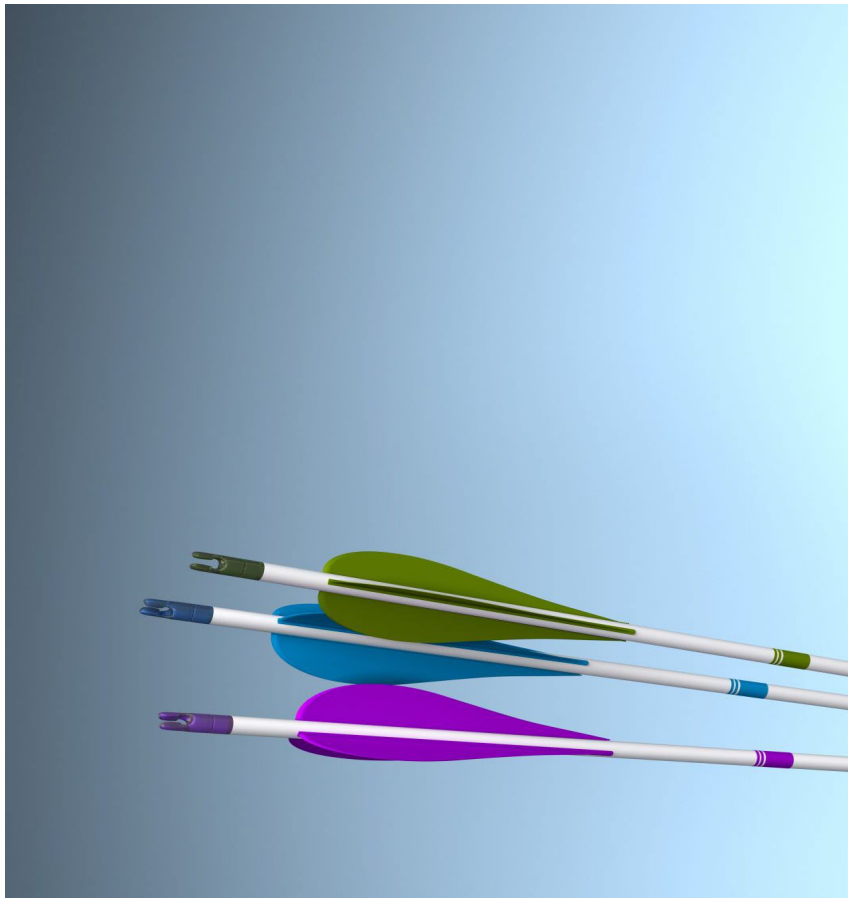


Payment Continuum



Changing Focus in National Payment Policy

- Is continued health care cost growth that exceeds inflation acceptable?
  - Assume no: Can we achieve savings aim by simply squeezing the fee-for-service turnip?
- Are we close to achieving optimum health for all community members?
  - Assume no: How do we improve health but not accelerate the cost curve?
- National focus: new payment systems and investments to achieve the Triple Aim.



CMS's 2030 Goal

- 100% of Traditional Medicare beneficiaries are in accountable care arrangements by 2030; and the vast majority of Medicaid beneficiaries.
- Testing new payment systems: global budgeting (hospitals) and per capita payments (primary care)
- In addition to payment change, two critical components
  - Primary care delivered through person-centered health teams
  - Focus on *health*, including health-related social needs
- Financial model must move resources to where needed *in each community.*

CMS.gov

What Volume-to-Value Portends

- Recall CMS's 2030 accountability goals.
- Gradual devaluation of fee-for-service.
- Payment for delivering better care, improved health, and smarter spending.
- Requires, *and rewards*, strong primary care participation.
- An opportunity to better deliver our health care mission.

Project Overview

RHV-ND Value-Based Care and Payment Project

Environmental Scan	Technical Assistance	Statewide Education
• ND demographics • ND health status • ND health system • Public policy	• Five selected CAHs • VBC assessment • Community engagement • Three financial scenarios	• VBC landscape • VBC survey tool • Community engagement • Financial modeling

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Technical Assistance

Provided to five *core* CAHs

1. Value-Based Care Assessment Tool
2. Community Engagement
3. Financial Analysis

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North Dakota Core Critical Access Hospitals

- **First Care Health Center** (Park River)
- **Linton Regional Medical Center** (Linton)
- **Mountrail County Medical Center** (Stanley)
- **SMP Health – St. Kateri** (Rolla)
- **Towner County Medical Center** (Cando)

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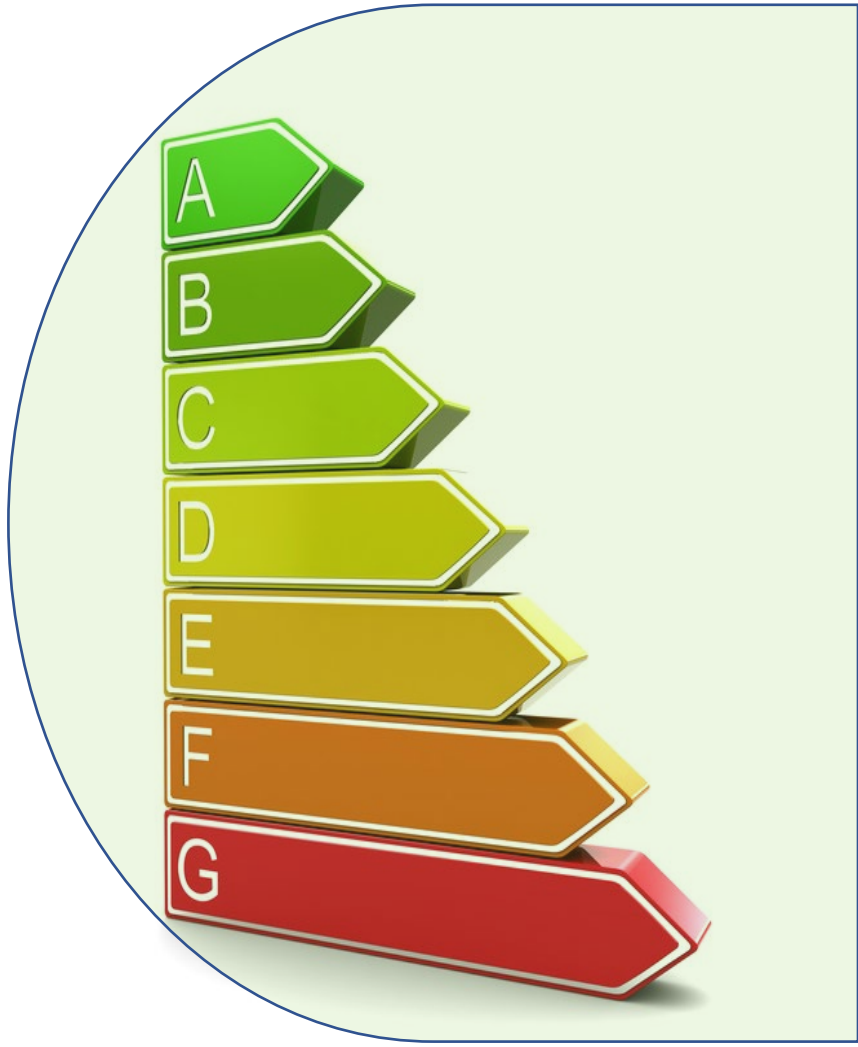
1. Value-Based Care Assessment

- A free online assessment tool
- Assesses 80 value-based care capacities in eight *categories*
    1. Governance and Leadership
    2. Care Coordination
    3. Clinical Care
    4. Community Health
    5. Patient and Family Engagement
    6. Performance Improvement and Reporting
    7. Health Information Technology
    8. Financial Risk Management



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2. Community Engagement

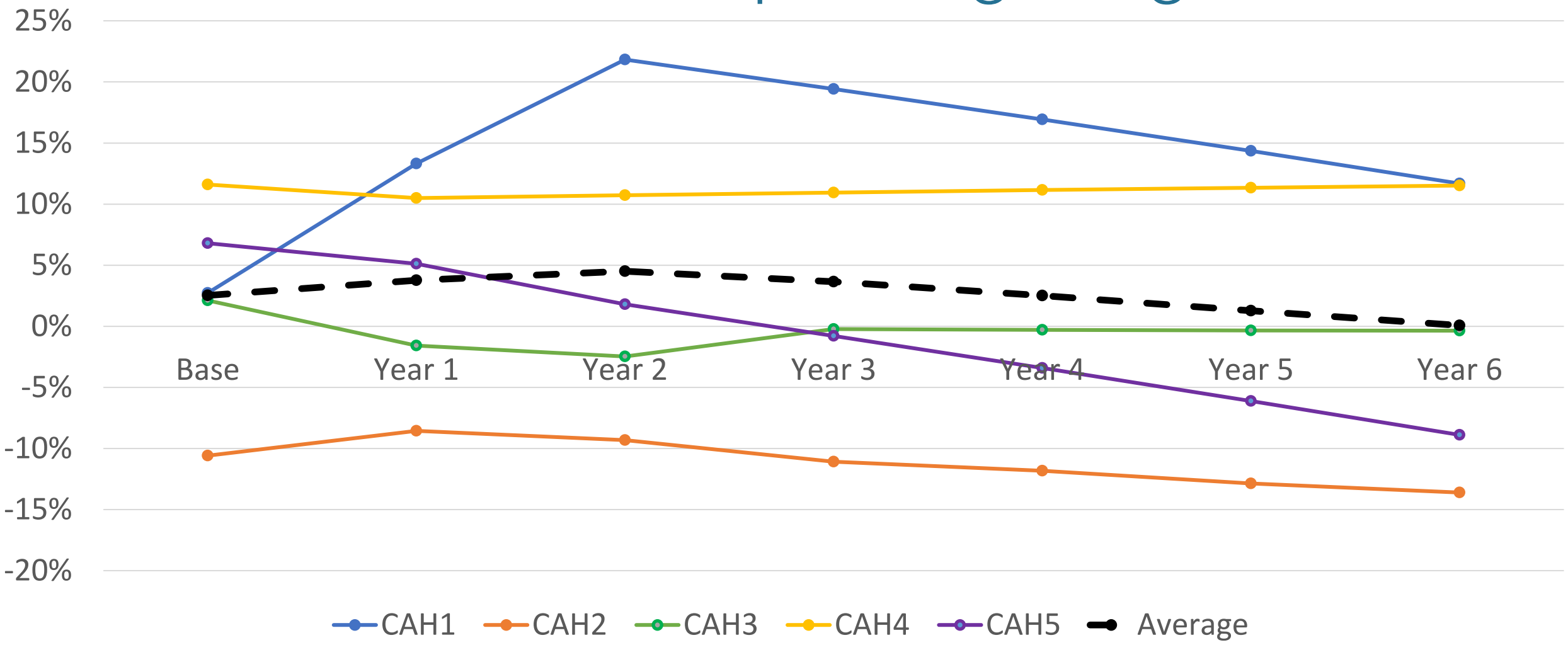
An **intentional** approach to working **collaboratively** with partners and people in the community to address issues and improve health.

- Formal coalitions
- Informal networks
- Individual relationships

3. Financial Analysis

- High level financial analysis based on organization assumptions, not an in-depth review of the general ledger.
- A *general direction* of financial performance and impact.

Status Quo Operating Margin



Financial Analysis Summary

- Status quo revenue and expense trajectories eventually will be unsustainable.
- Significant unit price increases (from payers) or volume increases (in rural areas) are unlikely.
- Value-based payment represents a new revenue source but is associated with financial risk.
- Value-based payment requires fundamental operational changes; that is, transitioning to volume-focused care to value-based care.

Healthy CAHs and Rural Communities

Thank You! Contact Information:

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R² Rough Rider Network