



## Short Commentary

# How the Creation of Healthcare Preparedness Measures Can Improve Community Medicine: The Link Between Healthcare Payment Policy and Disaster Preparedness

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### Abstract

The Covid-19 pandemic highlighted the need to better understand the relationship between value-based payment programs and hospital disaster preparedness, especially since these programs are increasingly supplanting fee-for-service models throughout the healthcare payment system. A 2021 report by RAND Health Care not only identified three key dimensions to consider for future VBP policy, but also shared real-world interactions with VBP models during the Covid-19 pandemic. The following commentary shares the highlights from this timely report and outlines the importance of a bottom-up development approach to preparedness measures to avoid the dilemma of translating federal guidance to local level application.

**Keywords:** Disaster Preparedness; Healthcare Payment Policy; Healthcare Preparedness Measures; Healthcare Standard of Preparedness

### Introduction

In June 2021, RAND Health Care submitted a report to the Office of the Assistant Secretary for Planning and Evaluation (“ASPE”) at the Department of Health and Human Services (“DHHS”) that examined the connection between value-based payment (“VBP”) models

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and healthcare system preparedness. As noted in its summary, “the Covid-19 pandemic highlighted the need to better understand the relationship between VBP programs and disaster preparedness, response, and resilience (“PRR”)” [1]. The relevance of this relationship is made more acute given that “VBP increasingly supplants fee-for-service (“FFS”) payment throughout the healthcare payment system” [2]. The lessons learned and proposed policy directions presented in this report were the result of an extensive literature review and 12 semi-structured discussions with experts in health care payment, VBP programs, and health system PRR.

Covid-19 placed an enormous and unforeseeable strain on the healthcare system on multiple fronts, including staffing, supplies, and capacity. RAND Health Care (2021) identified a potential weakness in the current payment model, notably that “[t]he more we incentivize maximum efficiency in health care delivery’s day-to-day operations, the less incentive and ability providers may have for maintaining excess capacity and investing in infrastructure that would prepare for emergencies” [2,3]. RAND Health Care (2021) further noted that there is existing tension between FFS and VBP models as “neither are designed to incentivize and fund preparedness activities” [1]. “FFS models incentivize higher volume of services and disincentivize activities or investments that do not support the delivery of reimbursed services,” while VBP models tie “provider payments to performance based on cost and quality metrics, with the goal of improving the quality of care and efficiency” [1].

### Key Dimensions Between VBP Models and Healthcare PRR

Policy tension notwithstanding, the paneled experts identified three key dimensions that should guide future exploration of VBP programs and healthcare PRR. These include 1) the type, scope, and duration of the disaster; 2) the type of VBP model being considered; and 3) the type of healthcare provider responsible for preparing for and responding to the disaster [1]. Under the first dimension, there was a consensus that the disaster’s type (e.g., pandemic, hurricane, wildfire, tornado, etc.), scope (whether localized or nation-wide), and duration (short-term versus long-term) will each uniquely influence how VBP programs are utilized to support PRR [1]. These variables demand specific response capabilities to effectuate an effective response. As such, VBP models should be adaptable. The second dimension noted that variations in VBP policy can greatly impact decisions “about whether and to what extent a provider organization invests in preparedness, as well as decisions made during a disaster response” [1]. For example, RAND Health Care (2021) explained that “without changes in reimbursement policy, the shift to telehealth during the response to the Covid-19 pandemic would not have been as substantial” [1]. Provider characteristics, identified as the third key dimension, emphasized the fact that providers “have varying degrees of exposure to risk in VBP models and, as a result, have different incentives for both preparing for and responding to a disaster” [1]. For instance, primary care providers were viewed to have more flexibility to offer telehealth or reschedule visits, whereas hospitals and long-term care providers must continue to provide emergency care and care for hospitalized patients [1]. Furthermore, healthcare providers who are part of a large system have a significant advantage over smaller

organizations and those in rural communities who do not have access to many resources. In combination, the report recommended that these dimensions guide future VBP policy development. Now let's review three positive interactions between VBP models and PRR that experts experienced during response to the Covid-19 pandemic.

## Lessons Learned with VBP Models During Covid-19 Response

### VBP models with some degree of capitated population-based payments provided some revenue stability during the initial phases of the pandemic

"In addition to providing a financial cushion that allowed providers to continue to be paid and stay in operation," RAND Health Care (2021) explained that the capitated population-based payments "gave providers time and flexibility to pivot and implement Covid-19 mitigation strategies to safely provide in-person care for those patients in most need of it" [1]. As a result of this flexibility, "providers improved their medium-term (2-3 months) response to the pandemic once more elective appointments were permitted and improv[ed] resilience in the long-term, including their ability to restore total visit volume to near pre-pandemic levels" [1].

### Building flexibility into VBP models that would kick in when a disaster strikes would make healthcare providers more agile and better able to respond to and recover from a disaster

According to RAND Health Care (2021), "the Medicare Advantage and Part D Star Ratings have a 'disaster policy' that predated the Covid-19 pandemic and allowed plans to use the prior year measure performance if a certain percentage of their membership live in an area designated for Individual Assistance" [1,4]. In addition, "these Star Rating programs were adjusted to eliminate some data collection requirements, acknowledging that providers were operating in 'extraordinary circumstances'" [1,4]. Essentially, incorporating flexibility into VBP policies tailored to disaster PRR could help provide the financial and administrative support that may be missing in many healthcare emergency management programs.

### VBP models can foster a culture that rewards quick thinking and creative problem solving

Throughout the duration of the Covid-19 pandemic, healthcare providers across the nation scrambled to find creative ways to provide life-saving care in the face of goliath-sized obstacles, such as severe shortages in staffing, supplies, and capacity. Possible creative avenues may include "aligning incentives for various providers, offering flexibility with scheduling or use of telehealth, relying on ongoing or previous collaboration between departments or facilities, and using a population health lens to think about care to be delivered" [1,5]. However, VBP models should take into consideration the unavoidable limitations that smaller organizations face and find a reasonable balance to ensure these organizations are rewarded comparatively.

## Development of Preparedness Measures Should Utilize a Bottom-Up Approach

One of the possible policy directions RAND Health Care (2021) included in its report is to "incorporate preparedness or resilience measures into existing VBP models that hold providers accountable

for performance on a set of measures" [6]. However, "no readily usable preparedness measures exist in the database maintained by the National Quality Forum" [1]. While attempts have been made to craft standardized metrics for hospital disaster preparedness ("HDP") at the federal level through programs such as the Hospital Preparedness Program ("HPP") and the Public Health and Emergency Preparedness Program ("PHEP"), the undervalued assessment for a science and evidence base for healthcare and public health preparedness has rendered the capacity to measure preparedness "severely deficient" [7-9].

Another obstacle in preparedness measure development is the difficulty in translating federal guidance to local application. Gibson, Theadore, and Jellison (2012) highlighted this concern, explaining that, "The issue with using federal frameworks is that they are at the federal level—the broadest level there is. [...] A baseline described at the federal level cannot also be equally applied at the local level because the scope, intent, and implementing actors are vastly different" [10]. In response to such a dilemma, this author proposes consideration of a bottom-up approach to preparedness measure development. By eliciting input and expertise from hospitals who are on the "front lines" of disasters, researchers will not only eliminate the need to translate federal guidance, they may also garner more support for local implementation.

While the absence of recognized measures for HDP is a formidable obstacle, a bottom-up research approach for their development is ongoing with hopes of forging new pathways towards achieving a recognized standard for healthcare disaster preparedness [11,12]. As a Ph.D. Candidate, I am actively interviewing hospital representatives within the State of Florida with the goal of identifying factors that could influence a healthcare standard of preparedness. Relevant to this approach, RAND Health Care (2021) proposed a first step in this effort is to "convene experts from the fields of health care delivery, disaster preparedness, and measure development to develop a prioritized list of measure concepts" [1]. At the conclusion of my research, I have proposed to follow a translational science approach, which prescribes the next step is to introduce the results of my study to Delphi experts to reach a consensus [11,13]. Coordination of research efforts with the ASPE and other interested organizations may help to achieve the desired consensus. Ultimately, the goal is to lessen the financial burden on the healthcare delivery system, and thereby improve affordability of care and patient access.

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