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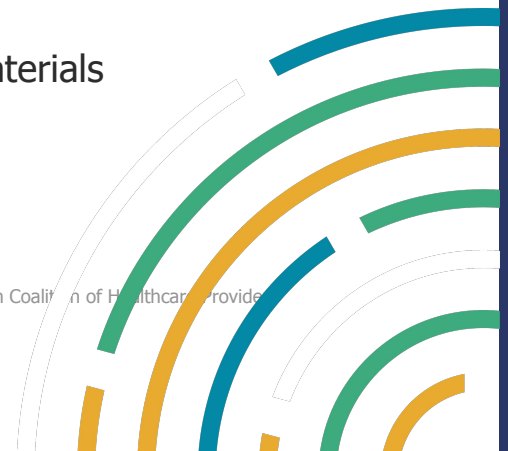

> We're all better off by accommodating those that really need to be in the emergency room, rather than those that are there because they don't have the support they need to stay out of the emergency room.

DAN GREEN, CFO Mercy Health Saint Mary's

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Introduction

While hospitals are required to serve all patients who need emergency department or inpatient services regardless of their ability to pay, the hospital's revenue for the same services can range dramatically. If the patient is uninsured or is covered by Medicaid, the hospital may actually lose money on the service, while hospitals fare better financially for patients covered by Medicare or commercial insurance. If you can reduce unnecessary utilization of those with the lowest reimbursement source, you will continue to generate buy-in and support from the organization for ongoing intervention and expansion of complex care. Taking this approach also allows you to prioritize equity by first serving those with the least resources.

Learning how your organization perceives the financial impact level of different populations helps you target and stage the populations you work with, generate buy-in and create financial sustainability for your program.

In this section, you will learn about different value-based payment concepts and how different payment structures and levels can influence your programs' financial impact and choice of population.

INSIGHTS FROM EXPERIENCE: BALANCING THE MARGIN AND MISSION POLARITY

As a clinician, it was my instinct to help everyone I could. After having intervened with a high-utilizing population, demonstrating double-digit reduction in utilization, and receiving a lukewarm response from the senior executives regarding the (negative) financial impact, the CFO clued me into a key secret of success in the business case: you can't help everyone at once. He taught me one of the best lessons: I had considered mission, but not margin. I had unintentionally reduced millions of dollars in hospital revenue for which the executives in my organization had to compensate. Depending on the financial goals of your institution: consider starting with a small population. After this feedback from the CFO, he became my partner in the work. Together, we identified which patients to work with first, and how to stage the populations for intervention in a way that prioritized **equity, need and mission** while balancing margin. This wasn't intuitive to me as a clinician. I never thought about segmenting patients by financial impact, but I realized that for the work to move forward, I had to consider it. If I had ignored the CFO's recommendation, I'm not sure the complex care program at the hospital would still exist years later. - **LAURAN HARDIN**

Moving to value-based payment

While the ACA has been subject to court battles and political threats since its passage in 2010, there is general consensus within both parties and health policy experts about the need to move from fee-for-service (FFS) to value-based payment (VBP). The pace of the transition from FFS to VBP varies dramatically by geography and provider type.

Created in 2010, the Center for Medicare and Medicaid Innovation (CMMI) was established to improve healthcare quality and reduce costs in the Medicare, Medicaid and CHIP programs. **CMMI** has introduced a steady stream of new payment models that seek to align financial incentives between payer and provider. The goal of VBP is to improve care for people and hold the healthcare system accountable for a "health" instead of "sick" outcome, improving quality at the same of lower costs. Models range from disease-specific bundled payments to population-level shared savings and direct payment programs. Many of these models originally retained some element of FFS, adding VBP incentives when payments were below the target.

Over time, models have required an increasing amount of risk, with providers taking downside *and* upside risk, and payments moving to fixed price (capitation).

Insurance companies and state Medicaid plans have also been adopting VBP models gradually for both public and privately financed coverage.

While the healthcare system transitions from FFS to VBP, the pace of that transition varies dramatically by provider type and geography. Recent studies estimate that the vast majority of physician practice revenue remains FFS as health systems are increasingly subject to VBP, and most revenue is earned in a hybrid structure. It is expected that the trend toward VBP will continue over the next decade, and that healthcare providers will strengthen their capacity to operate at risk.

Understand the VBP models in which your system participates by **accessing the CMS website** and asking your CFO. Many health systems participate in multiple ACOs and other arrangements with different payers. Financial leaders are often more supportive of complex care models if they feel it will help prepare the system to operate at greater risk.

UNDERSTANDING THE LANGUAGE

ACCOUNTABLE CARE ORGANIZATION (ACO)

Group of doctors, hospitals, and other providers who voluntarily cooperate to give coordinated high-quality care to a given population of patients

ALTERNATIVE PAYMENT MODEL (APM)

Claims reimbursement structure that rewards providers for high-quality, cost-efficient care

BUNDLED PAYMENT

Payment model in which a health system is paid a specified amount for an episode of care and required to fulfill certain quality measures rather than being paid separately for each individual service provided

DIRECT CONTRACTING

CMS payment model in which a set of providers participate in a variety of VBP arrangements for their Medicare FFS population

GLOBAL CAPITATION PAYMENT

Payment model in which providers receive a fixed amount to pay for the entire care of a participant or population (often paid on a per-member, per-month basis)

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA)

Medicare reimbursement tied to CMS for quality improvement and cost efficiency

SHARED SAVINGS

Payment model in which an ACO or other provider group earns a portion of the net reduction in cost calculated against the expected expenditure; the share of savings typically depends on achieving certain quality metrics

VALUE BASED PAYMENT (VBP)

A concept by which purchasers of healthcare (government, employers, and consumers) and payers (public and private) hold the health care delivery system at-large (physicians and other providers, hospitals, etc.) **accountable for both quality and cost of care**.

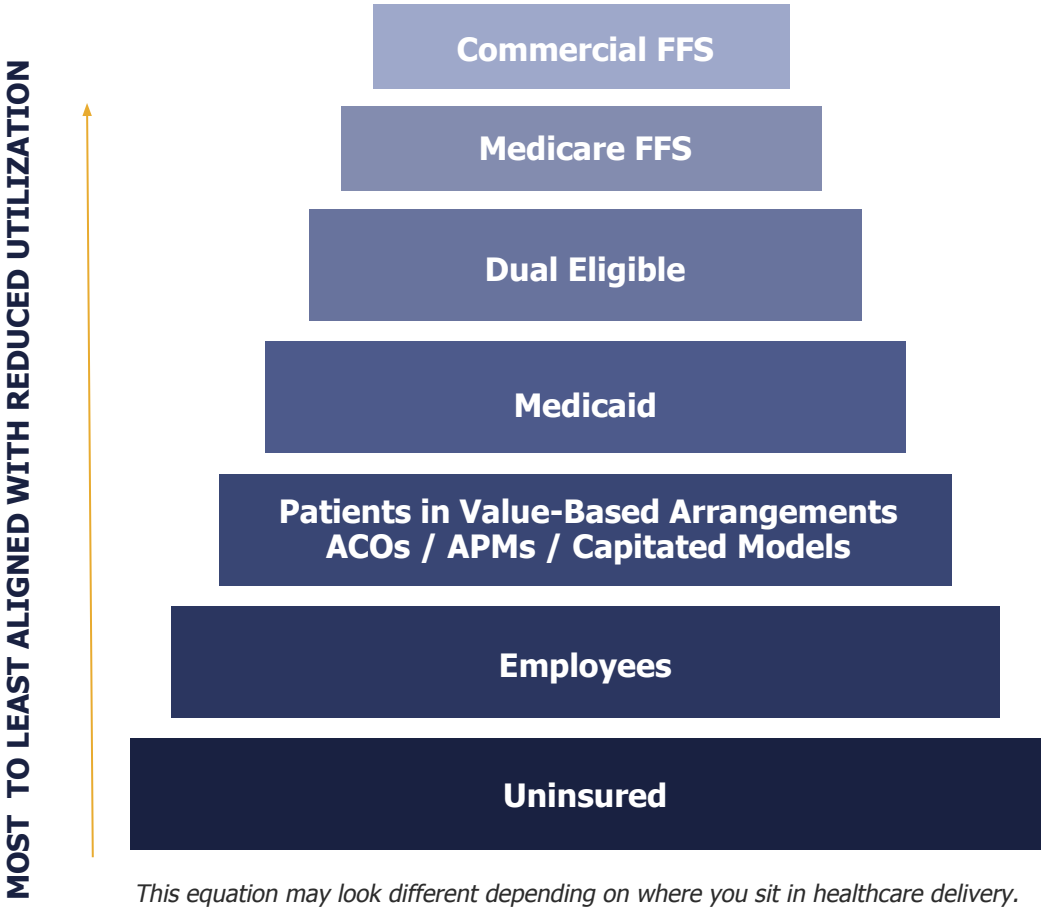
Scaffolding populations for impact

When thinking about which populations to work with first, in a mixed fee-for-service and value-based payment environment, it's important to consider prioritization. In the complex care model I operated, I served all populations and all payers. In order to balance the financial model, this meant working with 100% of the uninsured population with five or more visits annually, whereas the utilization threshold was higher for populations with more favorable reimbursement. This allowed me to address equity and vulnerability by caring for *all* populations with high utilization. Prioritizing those with the least resources (the uninsured) helped to balance the mission and margin polarity.

I therefore prioritized intervention based on the financial impact until the program grew enough to demonstrate a return on investment for multiple populations. This gave me time to grow the business case and organizational support across many populations. You will need to apply the lens of your organization to this equation. Examining your population through the lens of utilization and the associated costs provides a good starting point. **- LAURAN HARDIN**

DISTRIBUTION FOR MOST HEALTHCARE SYSTEMS

The graphic shows the populations by insurance type in which the health systems' financial outcome is aligned with reductions in utilization



This equation may look different depending on where you sit in healthcare delivery.

COST MAPPING TOOL

UNINSURED

Populations without a payer source can have a significant financial impact on a health system.

EMPLOYEES

You may not think of health system employees as a population at financial risk, but organizations directly bear the healthcare costs of their workforce. Improving care for this population impacts the company's financial health.

VALUE-BASED ARRANGEMENTS

Populations in value-based contracts like an ACO or capitated payment are ideally situated for a complex care program. The population has moved out of fee-for-service care, which incentivizes increasing volume of visits. In VBP, the focus is on reducing costs and utilization, and improving quality – often shifting care into the home and community.

DUAL ELIGIBLE AND MEDICAID

Depending on your market, reimbursement for Medicaid visits may be lower than the actual cost of delivering the care. You can ask your finance leader or care management leader about how this plays out in your organization. Improving care for the Medicaid population, and thereby reducing unnecessary utilization, is thus a priority from a financial perspective for most organizations. In addition, when hospitals are operating near capacity, reducing utilization of low reimbursement payers can improve revenue by freeing up a bed for a patient with more favorable coverage. Dual eligible populations have both Medicare and Medicaid which impacts cost and reimbursement in a similar fashion.

If we continued to complete the top of the scaffolding, the next tier up in terms of cost and impact to the system would be **Medicare Fee for Service (FFS)**, and then **commercial or private insurance FFS**.

SCAFFOLDING PATIENTS IS NOT ONE-SIZE-FITS-ALL

An important perspective about scaffolding patients is that depending on your setting and context, patients for whom reduced utilization is most beneficial who are may vary. For example, if the setting where you work is a clinic that receives payment by individual appointments, revenue is maximized by seeing a high volume of patient appointments. Therefore, from the perspective of clinic revenue, the most costly patients to the system are those who require the most time during appointments. So, it may be worthwhile to begin working with individuals who providers spend the most time with during appointments.

On the other hand, it may not be wise to begin working with privately insured patients paid on a FFS basis, and begin diverting them from coming to the clinic for appointments. Such a decision may negatively impact the clinic's financial revenue.

Over time, as the work of complex care builds momentum, the clinic may shift their strategy to include more equitable value-based payments which incentivize quality instead of volume of visits. This may then allow for you to work with all patients. The key point here is scaffolding the patient population to determine which patients are best to work with first to gain leadership buy-in and build support for the complex care work broadly.

TYING IT TOGETHER: SCAFFOLDING A PATIENT POPULATION

Let's revisit the utilization dashboard. Pictured on the right is your population. There are decision points built into this data that start conversations. Let's revisit some key lessons from the experts up to this point:

- Before broadly designing care pathways for a specific "population box," first understand the business case. What is the payer mix of the patients within these utilization boxes? If the hospital is consistently providing services to a group of patients and not receiving reimbursement, it may be helpful to start with those patients, because you'll be able to demonstrate cost savings. As hard as this is to accept clinically, designing care pathways that divert high-paying patients away from the hospital can forge a difficult road to gaining leadership support. By scaffolding the population, starting with patients in VBP or without payment, it can create an early win that gains attention and long term support.
- You don't have to solve this problem alone! What types of resources already exist in your local ecosystem? Start with the network you already have and partner with finance or your care management leadership to determine which patients you're most well-positioned to help.

<table>
<tr><th rowspan="2">ED visits</th><th colspan="5">Inpatient visits</th></tr>
<tr><th>0</th><th>1</th><th>2</th><th>3 to 4</th><th>5+</th></tr>
<tr><td>0</td><td colspan="2" rowspan="3">44,728 (85%) patients
• 5,210 Inpatient visits
• 63,489 ED visits
• $28,000,000 (50%) IP payment
• $25,800,000 (59%) ED payment</td><td rowspan="6">985 (2%) patients
• 1,856 IP visits
• 4,129 ED visits
• $10,000,000 (17%) IP payment
• $1,700,000 (4%) ED payments</td><td rowspan="6" colspan="2">503 (1%) patients
• 2,026 Inpatient Visits
• 4,144 ED Visits
• $10,900,000 (20%) in IP payment
• $1,700,000 (4%) in ED payment</td></tr>
<tr><td>1</td></tr>
<tr><td>2 to 3</td></tr>
<tr><td>4 to 5</td><td rowspan="4">4,961 (9%) patients
• 28,447 ED visits
• $11,500,000 (27%) in ED payment</td><td rowspan="4">1,563 (3%) patients
• 1,239 IP visits
• 6,962 ED visits
• $6,700,000 (18%) in IP payment
• $2,800,000 (6%) in ED payment</td></tr>
<tr><td>6 to 7</td></tr>
<tr><td>8 to 9</td></tr>
<tr><td>10 +</td></tr>
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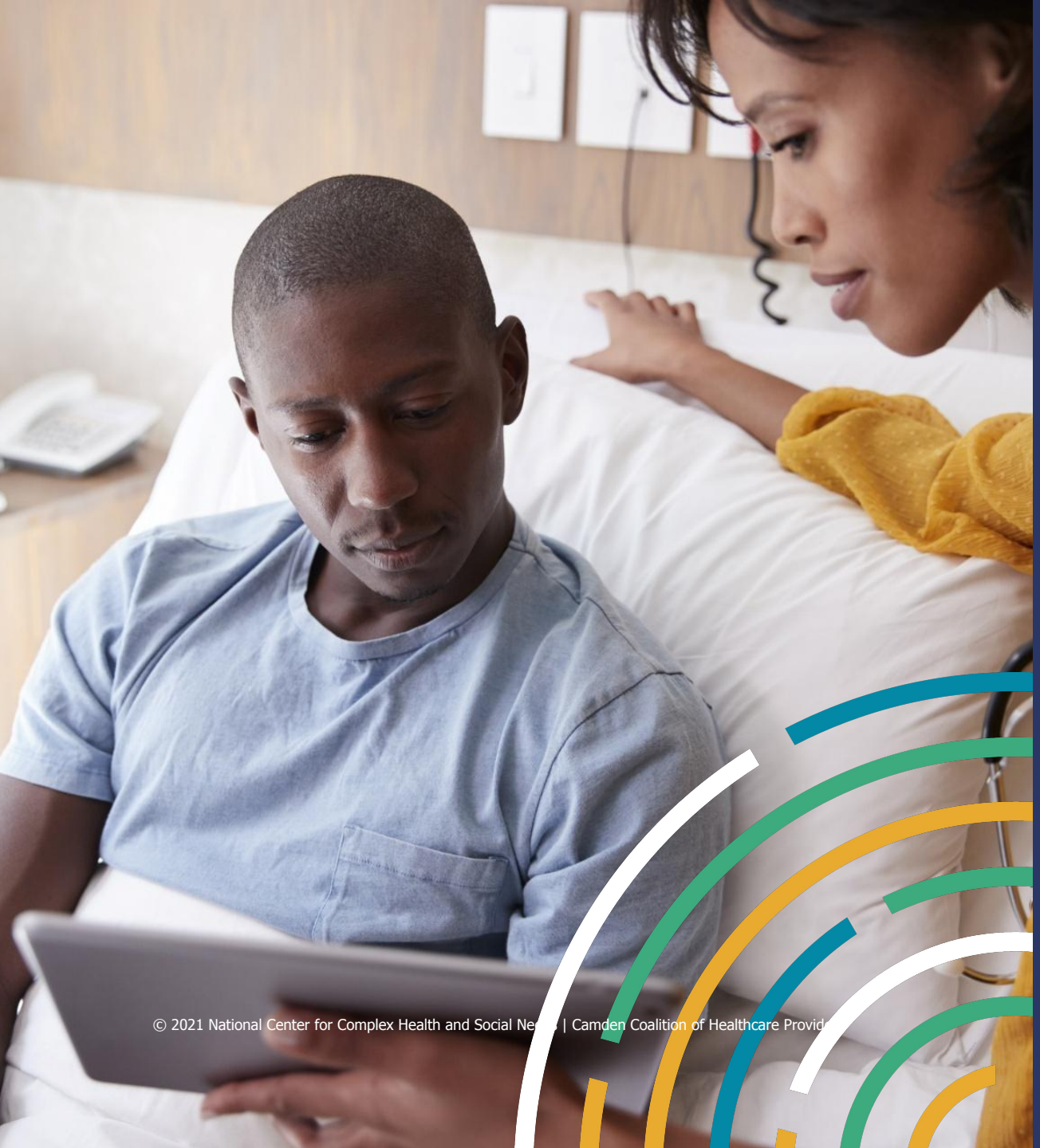

Key takeaways

- Based on your understanding of your organization's financial incentives, review the populations for whom reduced utilization is beneficial.
- Consider equity in your choice of populations to serve.
- Schedule time with leadership or CFO/financial analyst to discuss appropriate scaffolding of the population
- Consider adapting the population you start with first to those whose utilization is most impactful to your system.