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Contracting with Payers to Demonstrate the Value of Home-Centered Care

(Session 4 of 4)

Crossroads of Care: Managing Serious Illness in the Home

March 7, 2024 • Schaumburg, Illinois

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Advancing home-based primary care to ensure medically complex patients have access to high-quality care in their homes

EDUCATION | CONSULTING | RESEARCH | ADVOCACY

What We Do

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HCCIntelligence™ Resource Center

Hotline

Call 630.283.9222 or email Help@HCCInstitute.org
9:00 am-5:00 pm (CST)
Monday through Friday

Webinars

HCCI hosts free and premium webinars on topics relevant to Home-Based Medical Care. Visit the HCCIntelligence™ Resource Center for upcoming dates and topics.

Tools and Tip Sheets

Downloadable tools, tip sheets, sample forms and how-to guides on a variety of Home-Based Medical Care topics.

The John A. Hartford Foundation

HCCIntelligence™ is funded in part by a grant from The John A. Hartford Foundation.

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HCCI gratefully acknowledges support for this activity from:

Elea Institute is dedicated to advancing care for people with serious illness.

Learn more at eleainstitute.org.

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Review of Past Sessions

June 2023:

Bridging the Gap with Home-Based Primary Care

September 2023:

The Intersection of Home-Based Primary Care & Palliative Care

December 2023:

Optimizing Efficiency in House Call Operations

Today's Objectives

- List the various payer types relevant to home-based primary care (HBPriC) and home-based palliative care (HBPalC) and distinguish between the characteristics of each.
- Identify the key individuals to connect with when negotiating contracts.
- Demonstrate the value of your home-centered care services through presentation of quality of care metrics, utilization and outcomes data, and compelling patient stories.

Faculty

J. Cameron Muir, MD, FAAHPM

- Founder and Principal, Cameron Muir Consulting, LLC
- Chief Innovation Officer, National Partnership for Healthcare and Hospice Innovation (NPHI)

Amanda Tufano, MHA, FACHE, FACMPE

- Chief Executive Officer, Genevive
- Board Member, Minnesota American College of Healthcare Executives (ACHE); Minnesota Assn. of Geriatric Inspired Clinicians (MAGIC)

Paul Chiang, MD

Medical Director, Northwestern Medicine, HomeCare Physicians

Senior Medical and Practice Advisor, Home Centered Care Institute

- Boarded in Internal Medicine and Hospice/Palliative Medicine
- 37,000+ house calls to more than 3,600 patients

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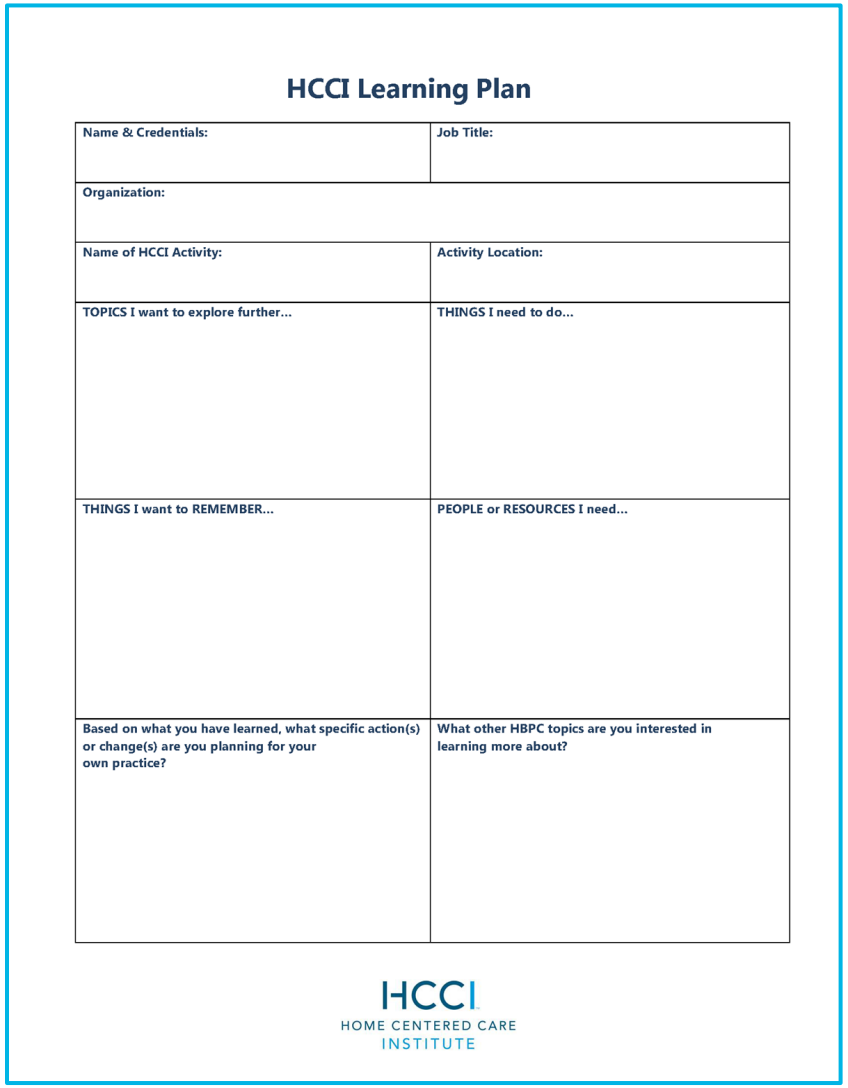
Your HCCI Learning Plan



HCCI Learning Plan

Name & Credentials:	**Job Title:**
Organization:	
Name of HCCI Activity:	**Activity Location:**
TOPICS I want to explore further…	**THINGS I need to do…**
THINGS I want to REMEMBER…	**PEOPLE or RESOURCES I need…**
Based on what you have learned, what specific action(s) or change(s) are you planning for your own practice?	**What other HBPC topics are you interested in learning more about?**

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Application Deadline: March 29

https://www.surveymonkey.com/r/6WXXB3J

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Ice Breaker

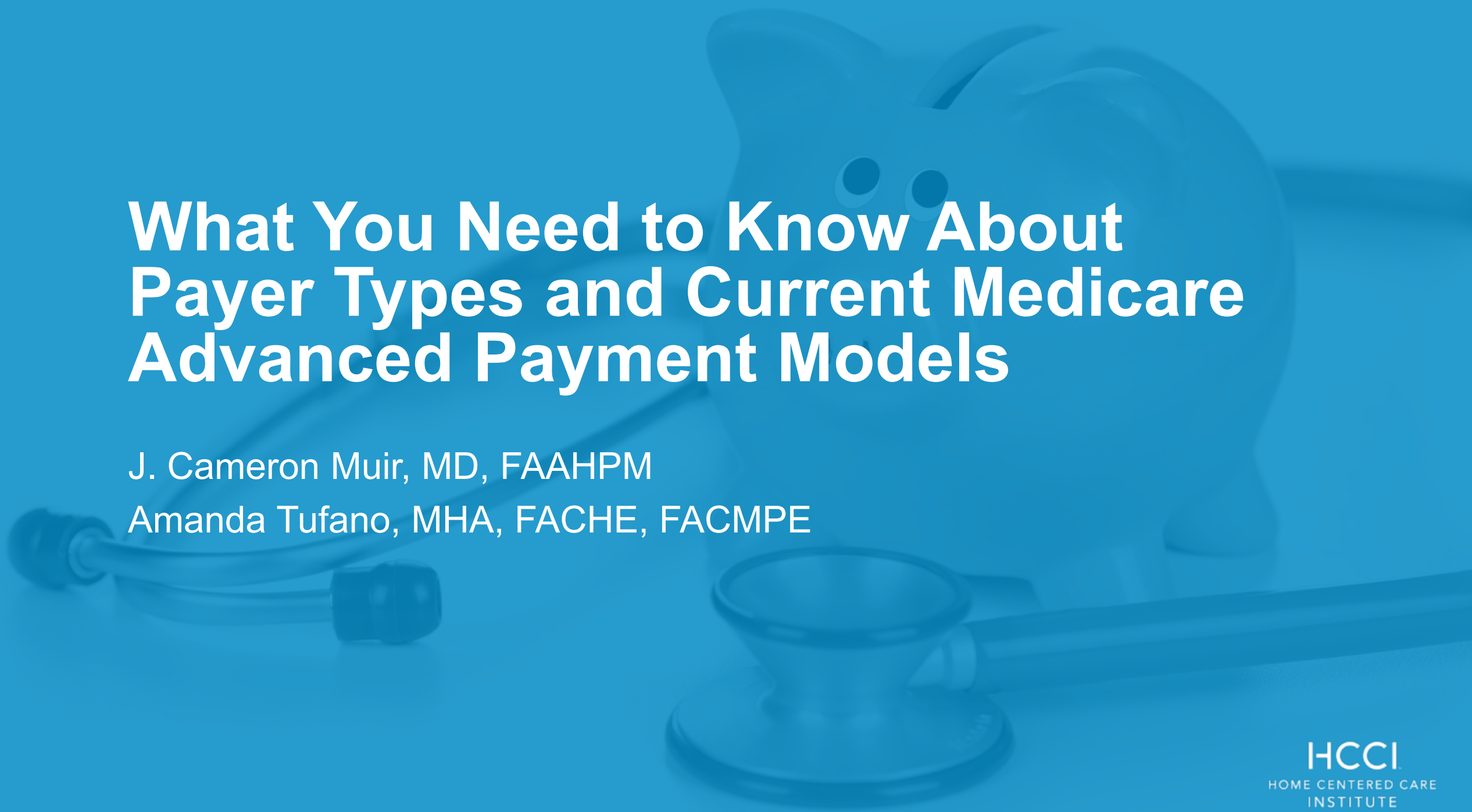
Please share with the group:

- Your Name
- Your Practice
- Your level of experience in home-based medical care
- One burning question you hope to get answered today, or something you hope to learn more about

What You Need to Know About Payer Types and Current Medicare Advanced Payment Models

J. Cameron Muir, MD, FAAHPM

Amanda Tufano, MHA, FACHE, FACMPE



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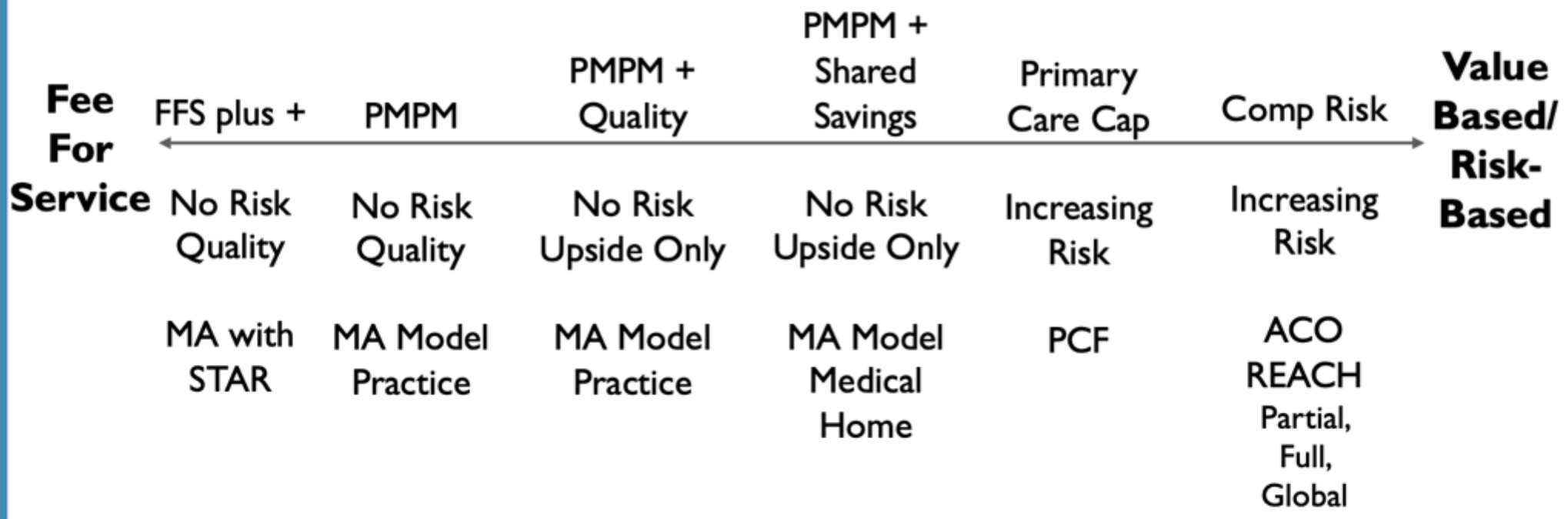
Objectives

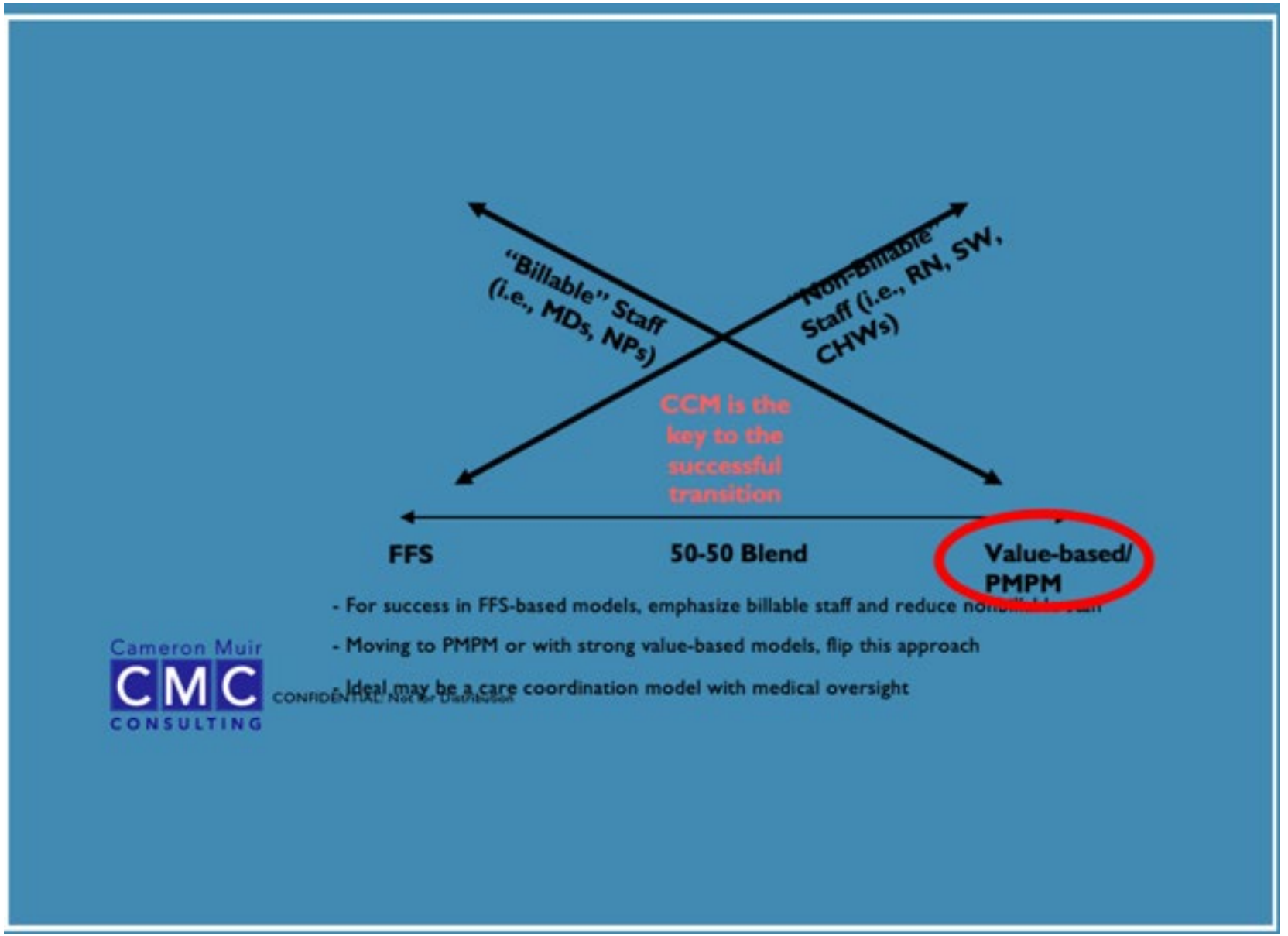
- List the various payer types relevant to home-based primary care (HBPriC) and home-based palliative care (HBPalC) and distinguish between the characteristics of each.
- Identify what value-based payment model opportunities exist today.
- Discuss the main attributes for model requirements.
- Share insight into how home-based practices can prepare themselves for value-based care transformation.

PAYMENT MODELS ARE CHANGING



https://www.humana.com/-/media/Humana/Tenants/HumanaCom-Tenant/HumanaCom/12-4-3-0-Value-Based-Care/Primary-Care-Value-Based-Continuum-LC16322ALL0222-.png

Consistent Care Modeling Toward Value



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Medicare Value-Based Care Overview

- Centers for Medicare and Medicaid Services (CMS) is run by the federal government
- Medicare is funded by the Trust Funds and administered by the Social Security Administration
- Medicare can create VBC programs in two ways:
  - Legislation, and
  - The Center for Medicare & Medicaid Innovation Center (CMMI) demonstration projects
- Medicare has announced its goal for all Medicare beneficiaries to be associated with an accountable care relationship by 2030

Five strategic objectives will guide the CMS Innovation Center's implementation of its vision.

https://innovation.cms.gov/strategic-direction

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Payment Models Today

ACO Realizing Equity, Access, and Community Health (REACH) Model

Creating a Health System that Achieves Equitable Outcomes through High Quality, Affordable, Person-Centered Care

GUIDE Model

Medicare Advantage (Part C)

Private health insurance plans approved by Medicare

Medicare Advantage plans combine Medicare Part A, Part B, and often Part D into one plan with a network of providers.

Boomer Benefits | We Speak Medicare | Talk to a Medicare Expert at 855-732-9055

Making Care Primary (MCP)

Medicare Shared Savings Program

Better Care for **Individuals.**

Better Health for **Populations.**

Lowering Growth in **Expenditures.**

PCF

Primary Care First

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Direct Contracting Transformation to ACO REACH

"Reaching" Beyond GPDC: ACO REACH Model Goals

GPDC	***ACO REACH***
 Empower beneficiaries to personally engage in their own care delivery.	**Promote health equity** and address healthcare disparities for underserved communities
 Transform risk-sharing arrangements in Medicare fee-for-service (FFS).	**Continue the momentum of provider-led organizations** participating in risk-based models
 Reduce provider burden to meet health care needs effectively.	**Protect beneficiaries and the model** with more participant vetting and monitoring and greater transparency

https://innovation.cms.gov/innovation-models/aco-reach

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ACO REACH: Entity Types

Model Participants

A REACH Accountable Care Organization (ACO) is generally comprised of health care providers and suppliers, operating under a common legal structure, which enter into an arrangement with CMS and accept financial accountability for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the entity.

Standard ACOs	ACOs that have experience serving beneficiaries in traditional Medicare program.
New Entrant ACOs	ACOs that have not traditionally provided services to a traditional Medicare FFS population and / or have not participated in FFS Medicare value-based arrangements. Beneficiaries may be aligned primarily based on voluntary alignment.
High Needs Population ACOs	ACOs that serve Medicare FFS beneficiaries with complex needs employing care delivery strategies similar to those used by Program of All-Inclusive Care for the Elderly (PACE) organizations.

ACO REACH Requirements

- Development and implementation of a health equity plan (progress reported to CMS annually)
- Beneficiary level adjustment for entities with an underserved population (encourages the collection of SDoH data)
- Participating providers must hold 75% of the governance structure with voting rights
  - Includes both a beneficiary representative and consumer advocate
  - Incentive: Additional Benefit Enhancement: NP scope of practice

ACO REACH Quality/Performance Metrics

Claims-Based Measures:

- Risk standardized all condition readmission
- All-Cause unplanned admissions for patients with multiple chronic conditions
- Days at home (High-Needs ACOs only)
- Timely follow-up after acute exacerbations of chronic conditions (Standard and new ACOs)

Patient Experience Measure:

- CAHPS Survey

Medicare Shared Savings Programs (MSSP)

Key Definitions

Accountable Care: A doctor, group of health care providers, hospital or health plan takes responsibility for improving quality of care, care coordination and health outcomes for a defined group of patients, thereby reducing care fragmentation and unnecessary costs for patients and the health system.

Accountable Care Organizations (ACOs): Groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs. ACOs may be in a specific geographic area and/or focused on patients who have a specific condition, like chronic kidney disease. (Source: Medicare)

Value-Based Care: Value-based care is paying for health care services in a manner that directly links performance on cost, quality and the patient's experience of care.

MSSP Overview

Voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an ACO to give coordinated, high-quality care to their Medicare beneficiaries. Aim to achieve:

- Accountability for a patient population
- Coordinate items and services for Medicare FFS patients
- Encourage investment in high quality and efficient services
- Assume risk for populations and offers alternate payment methodology

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about

Medicare Advantage

- AKA Medicare Part C
  - Wraps together Medicare Part A, Part B, and Part D in one product
- Medicare Replacement plans responsible for their member population Medicare benefits
- Premiums tied to overall risk score of their member population
- Held accountable for HEDIS measures and rated by CMS Star Ratings
  - 5 domains: effectiveness of care, access or availability of care, experience of care, utilization and relative resource use, and health plan descriptive information
- Ability to contract directly with providers and services to meet their population's needs

Special Needs Plans (SNPs)

- Medicare Part C program
- Three types of SNPs:
  - Institutional SNPs – for beneficiaries living in a nursing home or meet clinical criteria to live in a nursing home
  - Dual Eligible SNPs – for beneficiaries on Medicare and Medicaid
  - Chronic Condition SNPs – for beneficiaries with a one of 15 specific diagnosis (e.g., CHF, ESRD, Dementia)
- Work in a similar way to Medicare Advantage, but built for specific populations

Key Takeaways

- A lot of vehicles exist for Medicare contracting, including working directly with Medicare or as a delegated provider inside of a network.
- Continue to research the details in each product to find the best VBC contracting vehicle for your practice.
- CMMI will continue to create more vehicles for provider groups to be successful under VBC in the coming years.

Quantifying the Value of HBPC

Paul Chiang, MD
Amanda Tufano, MHA, FACHE, FACMPE

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Objectives

- Examine expenses against reimbursement to maximize capitated monthly payments.
- Assess the strengths, weaknesses, and readiness of your clinical model to perform well under a risk contract.
- Describe the steps in building relationships with payers and other potential partners and identify the key questions that must be addressed to demonstrate your practice's value.
- Review the various types of value-based contracts.

Case Study

Minerva

Refer to Handout

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Minerva

- Community Dwelling
- Long list of diagnoses, medications, hospitalizations, treatments = high utilizer of healthcare
- Dual eligible:
  - Medicare (80%)
    - Medical spend including hospitalizations, pharmacy, provider visits, potential Skilled Nursing Facility (SNF) stays
  - Medicaid (20%)
    - Elderly waiver services including Personal Care Assistant (PCA), Durable Medical Equipment (DME), potential meals

Minerva

How do you impact her clinically?

- Discuss goals of care
- Discuss main point of contact
- Reduce polypharmacy
- Provide correct home care support
- Discuss appropriate living situation
- Address medical and psychosocial concerns

How do you get paid?

- Likely fee-for-services (FFS)
  - $75-$124 per visit for subsequent home visit (national 2024)
- Potential FFS+

Value Based Contracting (VBC)

How do you get paid under a VBC contract?

- Capitated monthly payment for her care coordination
- Possible: fee-for-service for billable visits
- Risk/shared savings model for the pool of patients
- Could share in savings with ACO like model
- Could share in quality bonus initiatives with payer or health system

Sounds too good to be true?!
Make sure you're ready for it.

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Clinical Model is the Foundation

- Before you do anything else: is your clinical model ready?
- What are your strengths and weaknesses?
- Who do you need on-board before you're ready?

Signing a risk contract today and expecting a different outcome tomorrow = ?!

The Devil is in the Details

The ability to interpret the clinical model into a sustainable business model is key. Ask:

- What is your value proposition?
  - What can you prove? What are your strengths and weaknesses? BE HONEST WITH YOURSELF!
- How to think about your area within the larger healthcare system?
- How do you leverage that and with whom?
  - Who is willing to PARTNER with you?
- What data will you get from your partner?
  - What do you formalize around your partner relationship?

Building the Relationship

Building a relationship with payers and other potential partners takes time. You must:

- Have a persuasive champion on your team to lead the discussions on your behalf.
- Understand what the potential partner values.
  - What are their goals? Is it less days in hospital beds? If so, come prepared to demonstrate how you will impact that particular metric!
- Be able to speak directly to the gap or need you would be filling for them.
- Utilize connections to ensure you get in front of the right people to tell your story!

Maintaining the Relationship

Create an ongoing way to demonstrate performance and generate meaningful outcomes that matter to your partner.

- Consider creating a scorecard or dashboard for your practice
- Track the key metrics that highlight your value and are important to your partners/payers
  - Consider tracking your sickest patients- days at home and days in the hospital over time = financial savings!
- Extrapolate data from other home visit programs and apply savings to your model (e.g., reduction in hospitalizations if you don't have direct data)

Key Takeaways

- First, understand your **clinical model.**
- Evaluate your organization's **readiness for change** (not just interest).
- Find the **right partner** to take financial risk.
- Create a **meaningful relationship** that allows for growth and transparency.
- **Deliver** on results.

Defining the Value Proposition of HBPC

J. Cameron Muir, MD, FAAHPM
Amanda Tufano, MHA, FACHE, FACMPE

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Objectives

- Discuss the key individuals to connect with when negotiating contracts.
- Identify key quality metrics that demonstrate the value of home-based care.
- Demonstrate the value of your home-centered care services through presentation of quality-of-care metrics, utilization and outcomes data, and compelling patient stories.
- Discuss an approach for how to implement quality improvement efforts and leverage data for potential partnerships.

Key Quality Metrics

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MIPS Eligible Metrics:

National Quality Forum (NQF) Endorsed Metrics:

Cognitive Assessment and Plan of Care for Home-Based Primary Care and Palliative Care Patients

Percentage of actively enrolled home-based primary care and palliative care patients whose cognitive status was assessed at enrollment and annually and for whom a plan of care was described for those with cognitive impairment.

National Quality Strategy Domain: Patient Safety
Measure Type: Process
High Priority: Yes
Data Submission Methods(s): Electronic Measure, Registry Measure

Functional Assessment (Basic and Instrumental Activities of Daily Living [ADL]) for Home-Based Primary Care and Palliative Care Patients

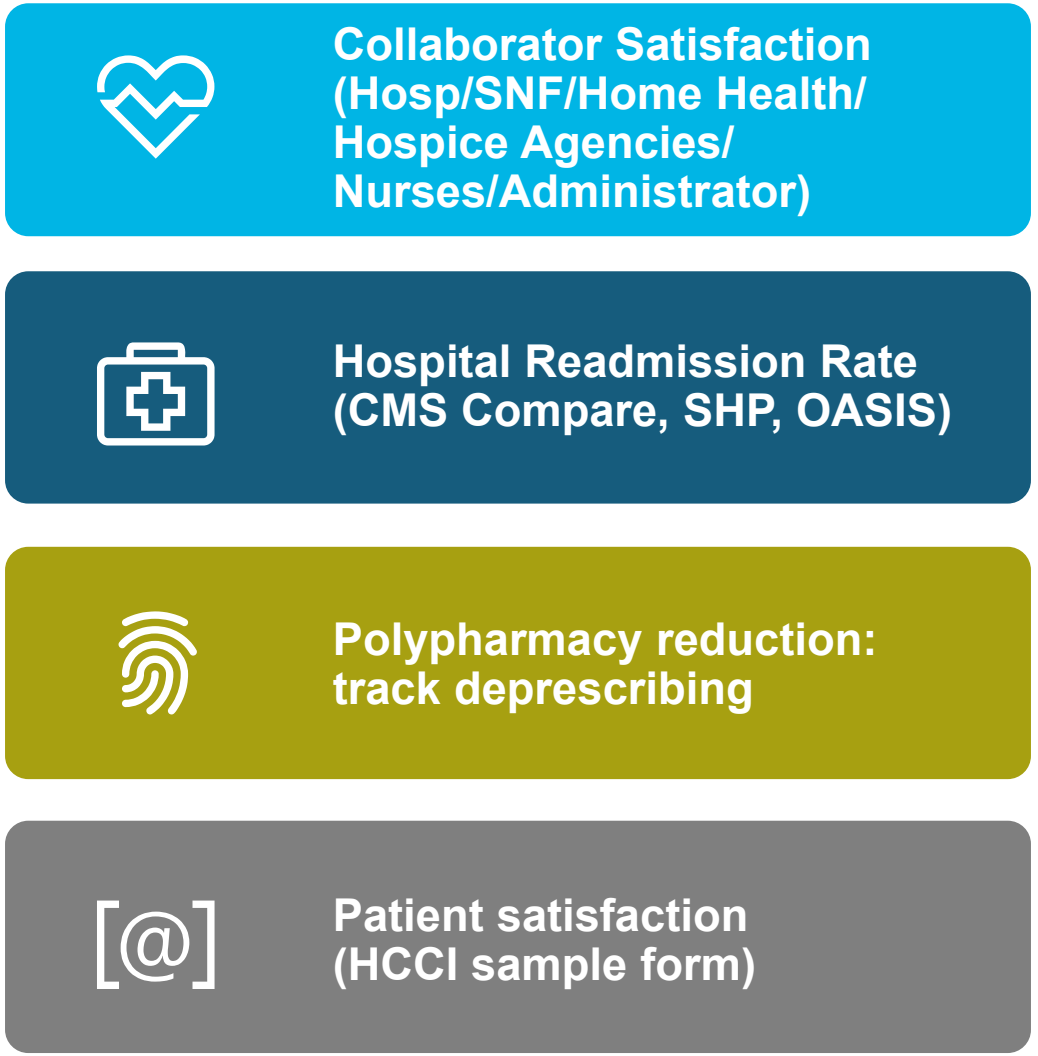
Percentage of actively enrolled home-based primary care and palliative care patients who are assessed for impairment of basic and instrumental activities of daily living (ADLs) at enrollment and annually.

National Quality Strategy Domain: Patient Safety
Measure Type: Process
High Priority: Yes
Data Submission Methods(s): Electronic Measure, Registry Measure

Meaningful Metrics to Consider

- Number of deaths at home vs. SNF, hospital and per zip code
- Incoming referrals per month per each source
- Number of visits per day and by month, per provider, and the practice as a whole
- Total number of deaths on hospice
- Hospitalization rate/100 beneficiary months
- ICU stays 30 days before death
- Hospitalizations 90 days before death
- Yearly census
- Time to first visit (average and mean wait days)
- Time to TCM visit (average and mean wait days)

Numbers Don’t Lie



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Confer Analytics™: 35+ Dashboards

CONFERANALYTICS™
Your Trusted Data Source For Home-Based Care

- **Home-Based Medical Care**
  - Demand
  - Supply and Performance
  - Partners, Referrals, and Billing
  - Medicare Advantage
- **Hospice**
- **Home Health**
- **Virtual Care**
- **Hospital at Home**

For more information, or to attend a demo, visit https://conferanalytics.com/

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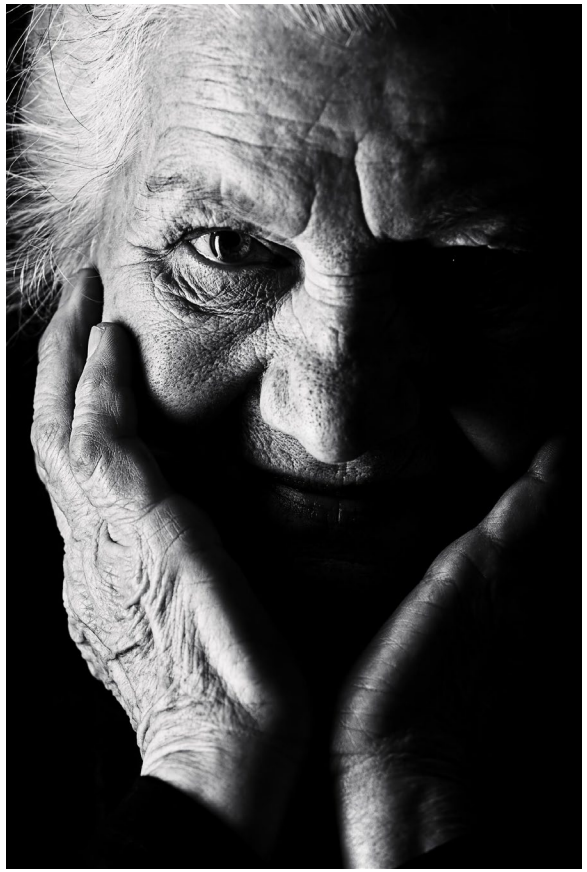
Don’t Forget About Patient Stories

- **65-year-old Female**
- **12 Chronic Medical Problems**
- **16 Medications**



Social History:

- Never Married
- 2 (uninvolved) Adult Children
- Meals: Frozen/Delivered meals

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Key Takeaways

- Use your quality measures to negotiate with payers and partners
- Utilize 3-5 meaningful measures that show quality impacts and directly link to cost
  - E.g., 5% lower readmissions resulted in X dollars saved by the system
- Find a mix of process and outcome-based measures if you have a system that is cumbersome
- Utilize Medicare reported data on your practice as well, if you have access
- Try to find HEDIS measures where you excel if you're working with a payer

Questions?

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Application Deadline: March 29

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Our gift to you: 5 Free Online Courses + 1 Video

1. House Calls 101: Introduction to Home-Based Primary Care
2. Patient Assessment in HBPriC
3. Managing Multicomplexity in the Homebound Patient
4. The Intersection of HBPriC and HBPalC
5. Diversity, Equity, and Inclusion for Home-Based Care; plus

- The Value of Home-Based Primary Care (video)

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