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Data Analytics: Unlocking Growth and Enhancing Quality in Home-Based Medical Care

HCCIntelligence™ Community Webinar

September 2024

Agenda

Topic	Time (min)	Presenter
Welcome & Introductions	5	Jeff Fraler
Value-Based Care	15	Dr. Paul Chiang
Use of Data Analytics	30	Aaron Yao
Q&A/Discussion	5	Dr. Paul Chiang Aaron Yao
Conclusion	5	Jeff Fraler

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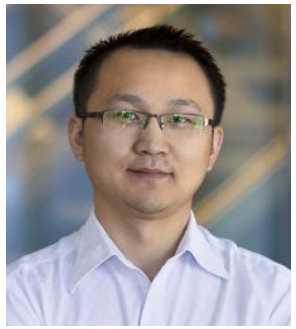
Faculty

Paul Chiang, MD

- Senior Medical and Practice Advisor, Home Centered Care Institute
- Medical Director, Northwestern Medicine HomeCare Physicians (HCP)



Nengliang (Aaron) Yao, PhD

- Research Director, Home Centered Care Institute

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Value Based Care

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Top 6 Components for Success in VBC:

- Patient identification
- Gaps in care/quality
- Managing cost of care
- Data and financial considerations
- Revenue capture in VBC model (HCCs)
- Payer negotiation

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?
- Do you have enough volume in your patient pool to have a realistic PMPM income?

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!

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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 vs. 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)

Types of Value Contracts

- Alternative Payment Models (APMs)
- Augmented FFS or FFS+
- Per Member Per Month (PMPM) or Per Enrollee Per Month (PEPM)
- FFS + Care Coordination
- Shared savings (e.g., ACO tracks)
- Quality bonus (paid for performance or P4P)
- Full risk/signification risk capitation
- Episode of care payments (Bundled Payments)
- ACO REACH model - counts NP practices and NP patients as part of the ACO pool

Use of Data Analytics

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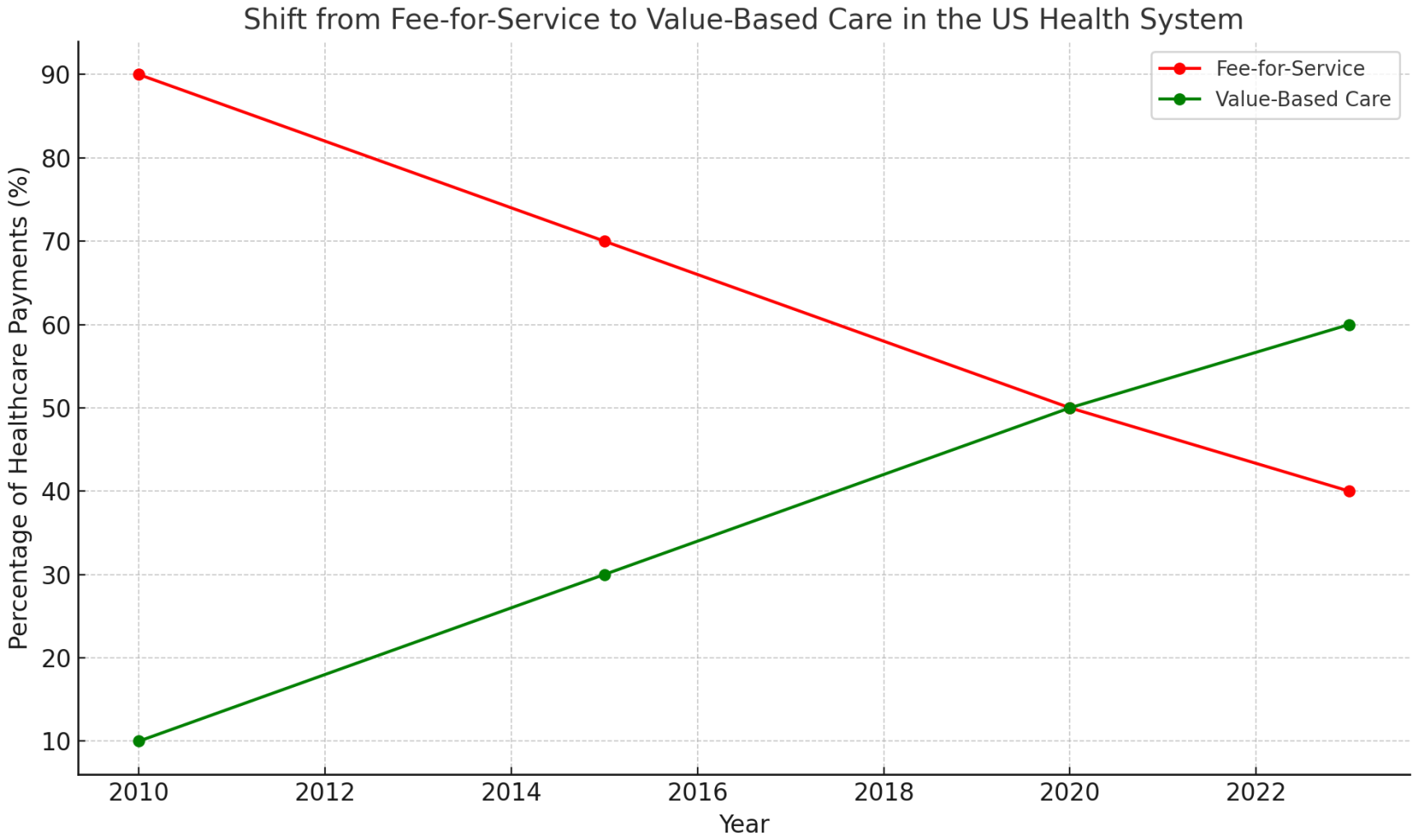
How Are You Using Data Analytics Now?

- Build or augment a medical care program
- Establish baseline for performance improvement
- Improve marketplace competitive advantage
- Succeed with managed care
- Transition to value-based care
- Other (please specify)
- None of the above … yet!

From FFS to Value-Based Care



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CMS Strategic Direction

"All Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030. The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030."

What is Value?

Source: CollaborateMD

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Risk-based Contracting

Source: a16z

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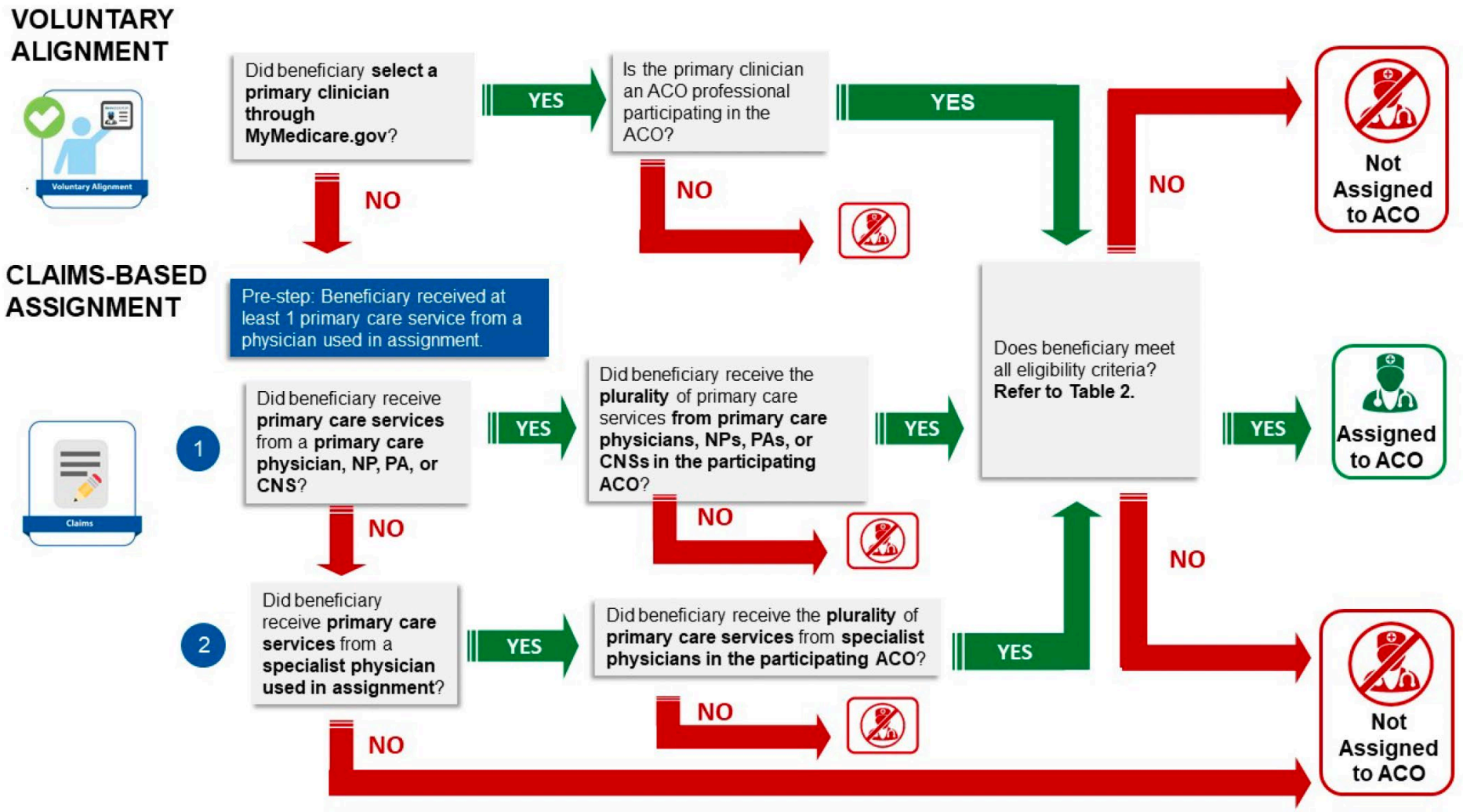
Risk-based Contracting

- Value-Based Care (VBC) is complex and requires a strong foundation in data and analytics readiness to succeed.
- You can start with a lower-risk model, such as the MSSP Level A one-sided risk model, which offers smaller rewards for good performance but imposes no penalties for underperformance.
- As your data capabilities and performance improve, you can 'glide' to riskier models, like the enhanced MSSP track or ACO REACH, and negotiate contracts with MA companies for greater rewards.*

*See the Risk-based Contracting chart at the end of this presentation for more detailed information.

Attribution



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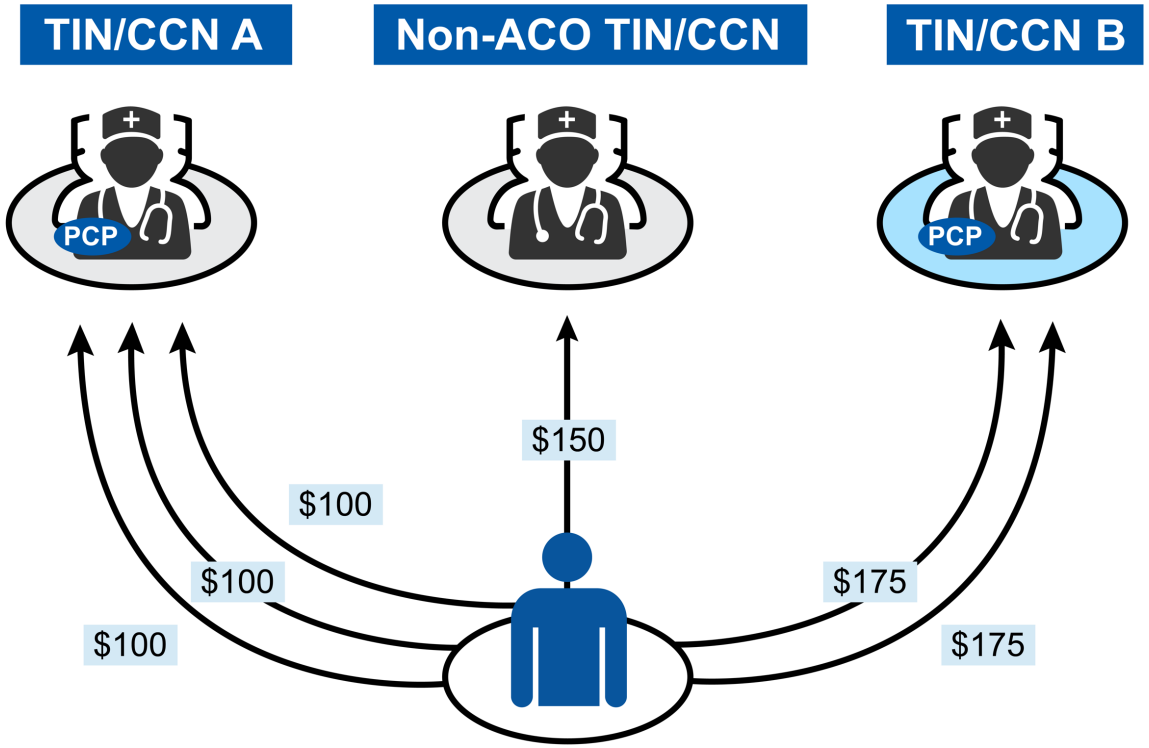

Plurality of primary care services is based on allowed charges

Plurality refers to a greater proportion of primary care services as measured in allowed charges within the TIN/CCN compared to primary care services outside the TIN/CCN.The plurality is determined by the total allowed charges for primary care services and can be less than a majority of the total number of primary care services provided. In this example, the beneficiary is assigned to TIN/CCN B, because TIN/CCN B provided the greatest amount of allowed charges.

Source: FastHSR and Source: Centers for Medicare and Medicaid Services

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	BY1: CY 2020	Jan 1, 2020–Dec 31, 2020	Oct 1, 2018–Sep 30, 2019	Through Sep 30, 2019	Jan 1, 2020–Dec 31, 2020

Source: Centers for Medicare and Medicaid Services

See the full Attribution chart at the end of the presentation for more detailed information

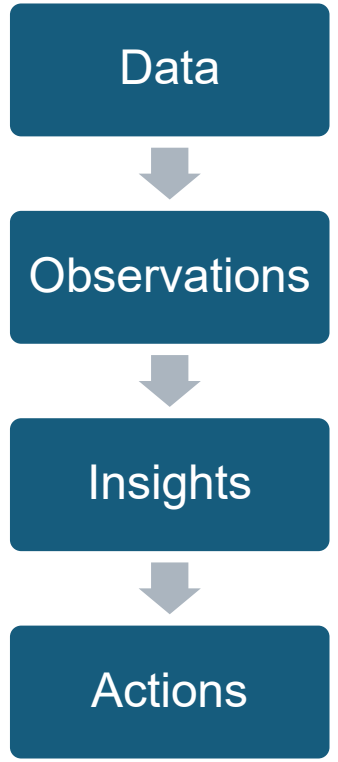
Understand Markets & Refine Strategies

- Benchmark performance against competition or to measure improvement
- Identify opportunities for improvement in quality and revenue
- Enhance clinician staffing and recruitment
- Gain insights into patient referral patterns and leakage
- Inform due diligence for practice acquisition
- Approach payer negotiations with more knowledge
- Support ACO network expansion with high-performing programs
- Prepare for industry transition to Value-Based Contracting
- AND MORE

Let’s do it Together

1. I show you the data and functions
2. You share your observations
3. We delve deeper into the insights
4. We discuss the practical applications
5. Questions

Example: McHenry County, IL or your county



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Market Share Data

- Market Analysis by Practice
- Market Analysis by Clinician
- Clinician Affiliations

Market Share Data

MSA	ALF Visits MSA	Home Visits MSA	County	ALF Visits County	Home Visits County	Name	% of Patients Who Are Longitudinal	ALF MSA Market Share	Home MSA Market Share	ALF County Market Share	Home County Market Share
Palatka, FL	252	395	Putnam County, Florida	252	395	CARITAS IN HOME PRIMARY CARE, LLC	69.77%	0.00%	64.05%	0.00%	64.05%
Crestview-Fort Walton Beach-Destin, FL	1867	1344	Walton County, Florida	434	248	PRIMARY CARE HOUSE CALLS PA	77.38%	14.52%	61.46%	10.60%	54.44%
Crestview-Fort Walton Beach-Destin, FL	1867	1344	Okaloosa County, Florida	1433	1096	PRIMARY CARE HOUSE CALLS PA	77.38%	14.52%	61.46%	15.70%	63.05%
Pensacola-Ferry Pass-Brent, FL	2587	3107	Santa Rosa County, Florida	879	916	PRIMARY CARE HOUSE CALLS PA	77.38%	40.39%	45.38%	34.58%	42.14%
Pensacola-Ferry Pass-Brent, FL	2587	3107	Escambia County, Florida	1708	2191	PRIMARY CARE HOUSE CALLS PA	77.38%	40.39%	45.38%	43.38%	46.74%
Lakeland-Winter Haven, FL	2175	3073	Polk County, Florida	2175	3073	MOBILE PHYSICIANS TEAM LLC	67.26%	0.00%	45.23%	0.00%	45.23%
Naples-Immokalee-Marco Island, FL	2242	5797	Collier County, Florida	2242	5797	RIZZI PSYCHIATRIC ASSOCIATES INC	81.33%	0.00%	42.00%	0.00%	42.00%

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Performance Data

- Scorecard of HBMC Practices
- Scorecard of HBMC Clinicians

Performance Data

Program/Practice Name	N of longitudinal patients	Median N of Visits per Patient	N of High Needs Patients	PMPM	Adjusted PMPM	ADK	Adjusted ADK
CENTRAL DUPAGE PHYSICIAN GR							
PARAGON CLINICAL LLC							
HANSA MEDICAL GROUPE, LLC							
MD @ HOME ILLINOIS, SC							
ADVOCATE HEALTH AND HOSPITA CORPORATION							

Program/Practice Name	sted ADK	EDK	Adjusted EDK	Readmission Rate	Adjusted Readmission Rate	Hospital Days per Patient	SNF Days per Patient	SNF Stays per 1000 Patients
CENTRAL DUPAGE PHYSICIAN GROUP	683	1,286	1,211	19.7%	19.5%	4.4	6.4	274
PARAGON CLINICAL LLC								
HANSA MEDICAL GROUPE, LL								
MD @ HOME ILLINOIS, SC								
ADVOCATE HEALTH AND HOSI CORPORATION								

Program/Practice Name	N of longitudinal patients	Normalized prospective HCC	Normalized concurrent HCC	Average Frailty Score	Average Patient Age	Average Dual Months	% of White Patients
CENTRAL DUPAGE PHYSICIAN GROUP	893	3.00	4.52	0.30	84.7	1.4	92.2%
PARAGON CLINICAL LLC	544	3.42	5.35	0.32	79.2	7.4	69.5%
HANSA MEDICAL GROUPE, LLC	1,350	2.31	3.47	0.32	86.2	0.8	93.8%
MD @ HOME ILLINOIS, SC	1,273	2.94	4.46	0.30	77.6	6.4	43.0%
ADVOCATE HEALTH AND HOSPITALS CORPORATION	388	3.25	5.11	0.32	84.3	2.1	77.6%

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Demand Data

- HBMC Penetration Rates
- Medicare Advantage Penetration
- Older Adults in the US, by Zip Code

Demand Data

High-Needs Patients not receiving HBMC and Their Plurality Office-Based Provider by County

The definition of a plurality provider comes from CMS.

Year
2023

State Abbr.
IL

County
(All)

N of high needs patients not receiving HBMC in County
11 — 102,356

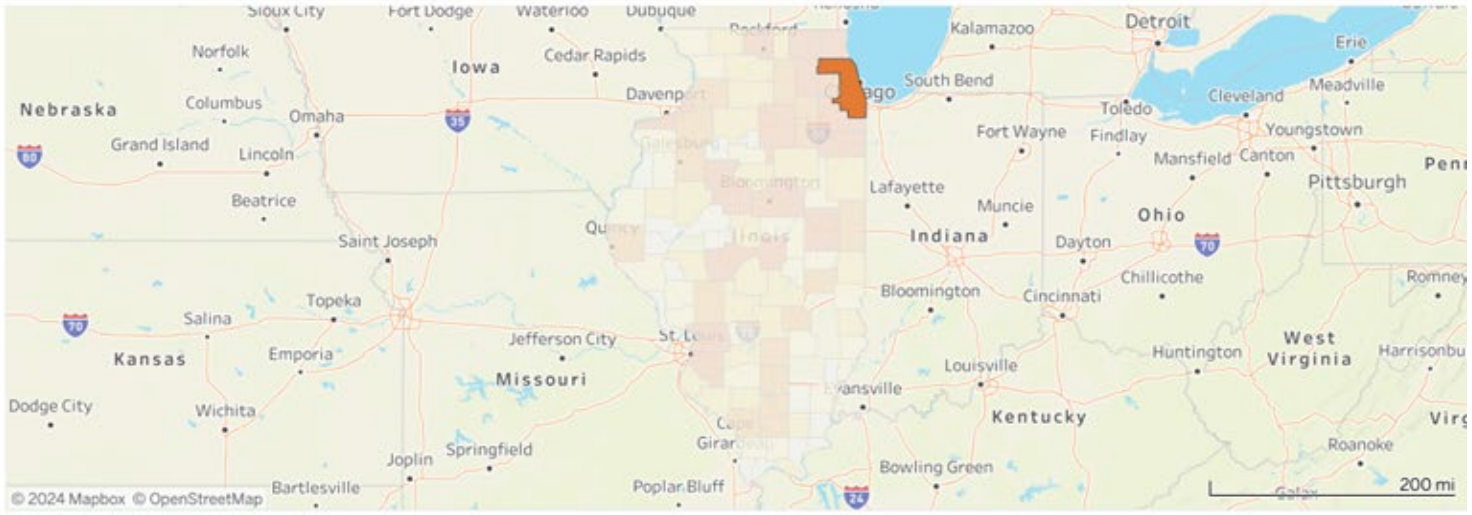
- <200
- 200-399
- 400-699
- 700-1700
- >1700

Provider Specialty
(All)

Provider Name
(All)

N of High Needs Patients Treated by this Provider
11 — 312

- <15
- 15-19
- 20-29
- 30-40
- >40



County	NPI	Provider Name	Specialty	Phone	N of High Needs Patients Treated by this Provider
Cook	1942684956	Yosef Seewald	Physician assistant	8007508616	312
Cook	1003077322	Simon Fensterszaub	Family practice/Family Medicine	7189646161	216
Cook	1376521773	David Chess	Geriatric medicine	2033778360	186
Cook	1952326019	Seema Elahi	Internal medicine	7735887733	171
Cook	1790718617	Jayesh Mehta	Hematology	3126959797	163
Cook	1639140403	Jaroslav Goldman	Internal medicine	7739736100	163

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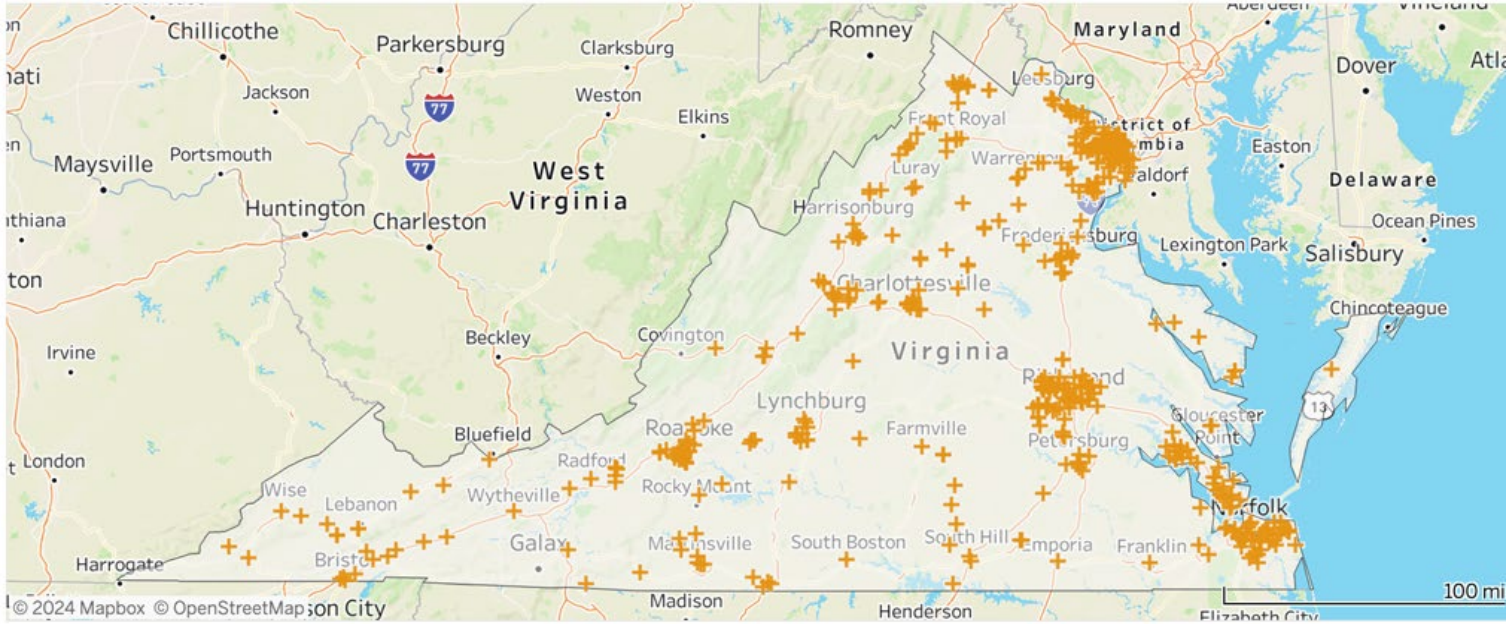
Partnership Opportunities Data

- Home Health Agencies
- Hospice Programs
- Assisted Living Facilities

Partnership Opportunities Data



Name	Address	Phone	Total Units
Goodwin House Bailey's Crossroads	3440 SOUTH JEFFERSON STREET, FALLS CHURCH, VA 22041	(703) 820-1488	500
The Virginian	9229 ARLINGTON BOULEVARD, FAIRFAX, VA 22031	(703) 385-0555	350
Vinson Hall	6251 OLD DOMINION DR., MC LEAN, VA 22101	(703) 536-4344	300
Assisted Living At Warwick Forest	860 DENBIGH BLVD., NEWPORT NEWS, VA 23602	(757) 886-2000	273
HERMITAGE RICHMOND operated by Pinnacle Living	1600 WESTWOOD AVENUE, RICHMOND, VA 23227	(804) 474-1800	257

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Q/A

HCCIntelligence™ Community Resources

Exclusive Member-Only Access

- Log in at https://www.hccinstitute.org/login/
- Go to "My Learning Hub," and scroll to "My Resources"

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HCCIntelligence™ Community Webinar Series

Expanding Home-Based Primary Care: Uncovering Referral Channels, Attracting New Patients, and Partnering with Providers

Objectives:

- Explain the process of identifying patient referral sources.
- Explore strategies for recruiting and communicating with potential new patients, including talking points and scripting examples.
- Outline key discussion topics for engaging with providers when reaching out to new referral sources.

November 20, 2024
3 pm - 4 pm CT

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Website

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Email

info@hccinstitute.org

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Conclusion

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Risk-based Contracting

CHARACTERISTIC	BASIC TRACK'S GLIDE PATH LEVEL A & LEVEL B (ONE-SIDED MODEL)	LEVEL C (RISK/ REWARD)	LEVEL D (RISK/ REWARD)	LEVEL E (RISK/ REWARD)	ENHANCED TRACK (RISK/ REWARD)
Shared Savings (once MSR met or exceeded)[158]	1st dollar savings at a rate of 40% if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is met; 1st dollar savings at a rate of 40% multiplied by the ACO's health equity adjusted quality performance score if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is not met but the ACO meets the alternative quality performance standard at § 425.512(a)(4)(ii); not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is met; 1st dollar savings at a rate of 50% multiplied by the ACO's health equity adjusted quality performance score if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is not met but the ACO meets the alternative quality performance standard at § 425.512(a)(4)(ii); not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is met; 1st dollar savings at a rate of 50% multiplied by the ACO's health equity adjusted quality performance score if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is not met but the ACO meets the alternative quality performance standard at § 425.512(a)(4)(ii); not to exceed 10% of updated benchmark	1st dollar savings at a rate of 50% if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is met; 1st dollar savings at a rate of 50% multiplied by the ACO's health equity adjusted quality performance score if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is not met but the ACO meets the alternative quality performance standard at §425.512(a)(4)(ii); not to exceed 10% of updated benchmark	1st dollar savings at a rate of 75% if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is met; 1st dollar savings at a rate of 75% multiplied by the ACO's health equity adjusted quality performance score if the quality performance standard established in § 425.512(a)(2) or § 425.512(a)(4)(i) is not met but the ACO meets the alternative quality performance standard at § 425.512(a)(4)(ii); not to exceed 20% of updated benchmark

Source: Centers for Medicare and Medicaid Services

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	BY1: CY 2017	Jan 1, 2017–Dec 31, 2017	Oct 1, 2015–Sep 30, 2016	N/A	Jan 1, 2017–Dec 31, 2017
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Source: Centers for Medicare and Medicaid Services