Welcome to TIM Talks: Business Acumen
“Community Based Organizations (CBOs) Developing Meaningful Partnerships with Hospitals”

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Developing Meaningful Partnerships with Hospitals

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Hospitals and Providers will be participating in more risk-based contract models / Alternative Payment Models

As providers take on more risk, the more likely they are to engage in a different care delivery model

Success with APMs will require a redesign of standard care

- There will be a shifting towards the greater utilization of home and community-based services
- Prevention of disease and disease-complications are increasingly important
Strategy: Community Integrated Health (CIH)

- Meaningful partnerships with hospitals require the CBO to clearly define their role in an overall Community Integrated Health Strategy
- Assess the impact of market changes on the hospital and incorporate key items into your CIH strategy
  - August 2016 Report provides key information about the challenges and needs of hospitals.
  - Use the report along with market data to develop your strategy for establishing your hospital partnership
Evaluation of Bundled Payment Programs

- Publicly available market research
- CMS Bundled Payment for Care Improvement (BPCI) Initiative Models 2 – 4: Year 2 Evaluation & Monitoring Annual Report
- Released August 2016
- Available for download:
  - https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf
Bundled Payment for Care Improvement (BPCI) Initiative

• Initiative designed to test linking payments for all providers in an episode of care (generally 90 days after admission)
• Voluntary for hospitals to participate
• Program began October 2013
• Model 2
  – Includes a triggering hospital stay
  – Individual providers are paid on a fee-for-service basis
  – Total episode payments are reconciled retrospectively against the target price
Key Takeaways from Evaluation Report

- 130 participating hospitals
- 60,000 episodes of care
  - Primary episode major joint replacement of the lower extremity
  - Congestive Heart Failure
  - COPD
  - Pneumonia
- Largest savings occurred in joint replacement episodes
  - $864 (3%) reduction in total episode costs
  - Few achieved savings for cardiac care models
Challenges for Hospitals

• Success requires a targeted strategy to reduce OR eliminate Institutional Post-Acute Care
  – Almost all savings attributed to reducing institutional PAC
• No Model 2 participants used the telehealth or home visit waivers
• No statistically significant difference in readmission rates and ED visits within 90 days of hospitalization
• Managing patient expectations related to PAC use
• Challenges with establishing relationships with PAC providers
Few BPCI participants reported that they actively managed the care for patients after the PAC decision (HH vs SNF).

Savings was all created by shifting from Institutional PAC and expanding Home Health.

BPCI success requires limiting SNF use.

- SNF loss of revenue is contrary to the initiative goals.
Steps to hospital contracting

• Study your customer
• Identify potential points of pain
• Develop a pitch that outlines how your services can impact their point of pain
• Brand your intervention (ex. Community Integrated Health transition program)
• Outline the ROI for your intervention (Price vs Benefit)
• Practice your pitch
• Meet with hospital decision makers / stakeholders
Step 1: Study Your Customer

- Assess hospital participation in Alternative Payment Models
  - ACOs
  - Bundled Payment for Care Improvement
  - CJR
  - 2017 – SHFFT, Cardiac Care, Oncology Care
- Value-Based Payment Programs
  - MACRA
  - Physician Value-Based Payment Modifier
  - Length of Stay / Readmissions
- Community Needs Assessment
Step 2: Identify Potential Point(s) of Pain

• Determine how your services align with their potential needs
  • Need to Reduce Institutional PAC
    – HCBS
    – Duals (Waiver, MLTSS, etc.)
  • Experience with high-risk populations
  • Ability to provide evidence-based interventions
    – Diabetes Self-Management Training
    – Fall Prevention
    – Depression Risk Interventions (PEARLS)
Step 3: Develop Your Pitch

- Community Integrated Health Strategy
- Targeted Services
- Target Population / Geographic area
- Capacity
- Price
- Incorporation of the intervention in the reimbursement model (budget neutral)
- Documentation
  - Shared Care Plan
  - Outcome Reporting
Step 3: Develop Your Pitch (cont.)

- Presentation
  - About Us
  - Need
  - Why we are best to meet the need
  - How we will meet the need
  - Cost / ROI
  - Next Steps
Step 4: Brand Your Intervention

- Who will provide the intervention?
  - One agency
  - Lead agency
  - New organization formed by a group of collaborating providers

- Name the intervention

- Develop a presentation and baseline proposal
  - Example: Community Integrated Health Transition Program
Step 5: Outline the ROI

- What is the price?
- What is the financial benefit as compared to the price?
- Can the intervention be incorporated into the reimbursement model and be budget neutral?
  - TCM
  - CCM
  - Behavioral Health Integration (BHI)
- How will the intervention address the potential hospital points of pain?
Step 6: Practice Your Pitch

- Meet with key stakeholders and practice your pitch
  - Case Managers
  - Community Referral Sources
  - Board Members
  - PAC providers
  - Community members that have used hospital services
Step 7: Meet with Key Decision Makers

- Identify hospital decision makers
  - CEO
  - CFO
  - Population Health Director/Manager
  - Director of Case Management

- Schedule a meeting to make a presentation
  - You may have to make multiple presentations as you move up the hospital chain of command
Step 7 Continued

- Be prepared to make an oral presentation and leave a written proposal
- Discuss next steps at the end of your presentation
  - Pilot test the model
    - Define the purpose of the pilot
    - Purpose should not be to prove the effectiveness of the intervention
    - Target population / geography
    - Explicitly outline that the intervention has a cost
      - Why buy the cow if you can get the milk for free?
Case Study

• AAA wishes to work with local hospital
• Hospital in various APMs
  – ACO
  – Bundled Payment
• Market has MLTSS / Waiver services
  – Potential for expanded HCBS for Duals
• We acknowledge that other Part B providers are attempting to deliver TCM and CCM
  – CMS notes that 2/3 of the total Medicare population would be eligible for CCM
    • Total Medicare Population = 55M
    • Eligible for CCM: 36M
  – From Jan, 2015 – May 2016: Total # of beneficiaries receiving CCM nationwide – 275,000 (although 36M were eligible)
  – TCM has had an even smaller impact on outcomes due to low utilization
• Community-Integrated Health strategy is to target hard-to-reach populations that are not currently served by provider hospital care management programs in the community
Barriers to TCM/CCM Physician Model

- **Transitional Care Management**
  - Initial Contact within 48 hours of discharge
  - Service CANNOT be billed by Hospitalist or Part A Hospital
  - Face-to-Face within 7 – 14 days of hospital discharge
  - Co-Insurance requirement
  - Development and sharing of a care plan with the entire care team
    - PCP
    - Specialists
    - Hospital/Hospitalists

- **Chronic Care Management**
  - Must make direct contact with beneficiary every month
  - Service CANNOT be billed by a home health agency
  - Co-Insurance requirement
  - Development and sharing of a care plan with the entire care team
• 100% of the costs of Home Health attribute to the bundled payment episode payment (90 days)

• Home Health is reimbursed on a DRG-based prospective payment system
  – CY 2016 National standardized 60-day episode payment = $2,938.37

• Home Health 60-Day DRG Payment ($2,938.37) services
  – Most consumers have an initial assessment followed by limited home health aide services
  – Services conclude in 60-days or less, while the bundled payment episode extends for 90 days
  – Full DRG-based payment attributed to bundled payment expense
CBO Intervention + Home Health will provide a lower cost alternative to institutional PAC

Home Health DRG Payment: $2,938.37 for a 60-day episode

TCM / CCM Reimbursement
- Avg. TCM rate = $275.00
- Avg. CCM rate = $46.00 / mo.
- Total for 90 days = $367.00

Avg. Medicare payment for SNF episode of care
- $12,239

Avg. Medicare daily rate for SNF care
- $492/day
Map 1. Skilled Nursing Facility Average Standardized Payment per Stay, by State, 2013
Bundled Payment Home Visit Waiver

- Home Visit Waiver
  - HCPCS G-Code for Post-Discharge Home Visit – G9490
  - CJR allows for reimbursement for up to nine (9) post-discharge home visits
    - Performed by a RN or LPN in the home
    - G9490 Avg. Reimbursement = $84
    - Less than 20% of the impacted population receives this benefit
    - Available when HH benefit expires
    - Two home visits = $168
      - HH DRG payment covers RN/LPN assessment, home health aide services and medical social work
Bundled Payment has a Tele-Health Geographic Waiver

- Billable Medicare encounter can occur in the home or place of residence, of the consumer, as the originating site
- Higher rates require an auxiliary person in the home
- CBO Health Coaches can facilitate a tele-health encounter with the physician in bundled payment
- Physician bills for outpatient tele-health encounter
- CBO costs off-set by TCM / CCM
- Increases outpatient encounters at a significantly reduced cost as compared to other post-acute care alternatives
Total Cost Comparison for Bundled Payment Episode

- Home Health DRG-Based Payment = $2,937.37
- Budget Neutral CIH Intervention
- Avg. SNF Medicare Payment = $12,239
- CIH + Home Health Savings to the Bundled Payment Participant vs SNF placement for rehab
  - $12,239.00 (SNF) - $3,304.37 = $8,934.63
Multi-Payer Strategy

- TCM / CCM are both Medicare Part B benefits
- TCM / CCM are mandatory benefits of every Medicare Advantage plan.
- Multi-Payer Strategy
  - Provide targeted TCM along with community-based chronic care management (CCM) services for community-dwelling Medicare beneficiaries
  - Expand care transitions services to Medicare Advantage and Special Needs Plans (SNPs)
    - TCM / CCM for MA population
  - Contract with Medicaid RCOs and Health Homes to provide care transitions and chronic care management services for Medicaid
    - TCM / CCM for Medicaid only population
Questions