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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1. Hospitals & Payment Reform
2. Steps to Hospital Contracting
3. Sample Business Case
4. Questions

Hospitals and the Risk Continuum

- 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

Discussion Topics

- 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

Alignment with Physician Transitional Care Management (TCM) / Chronic Care Management (CCM)

- 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

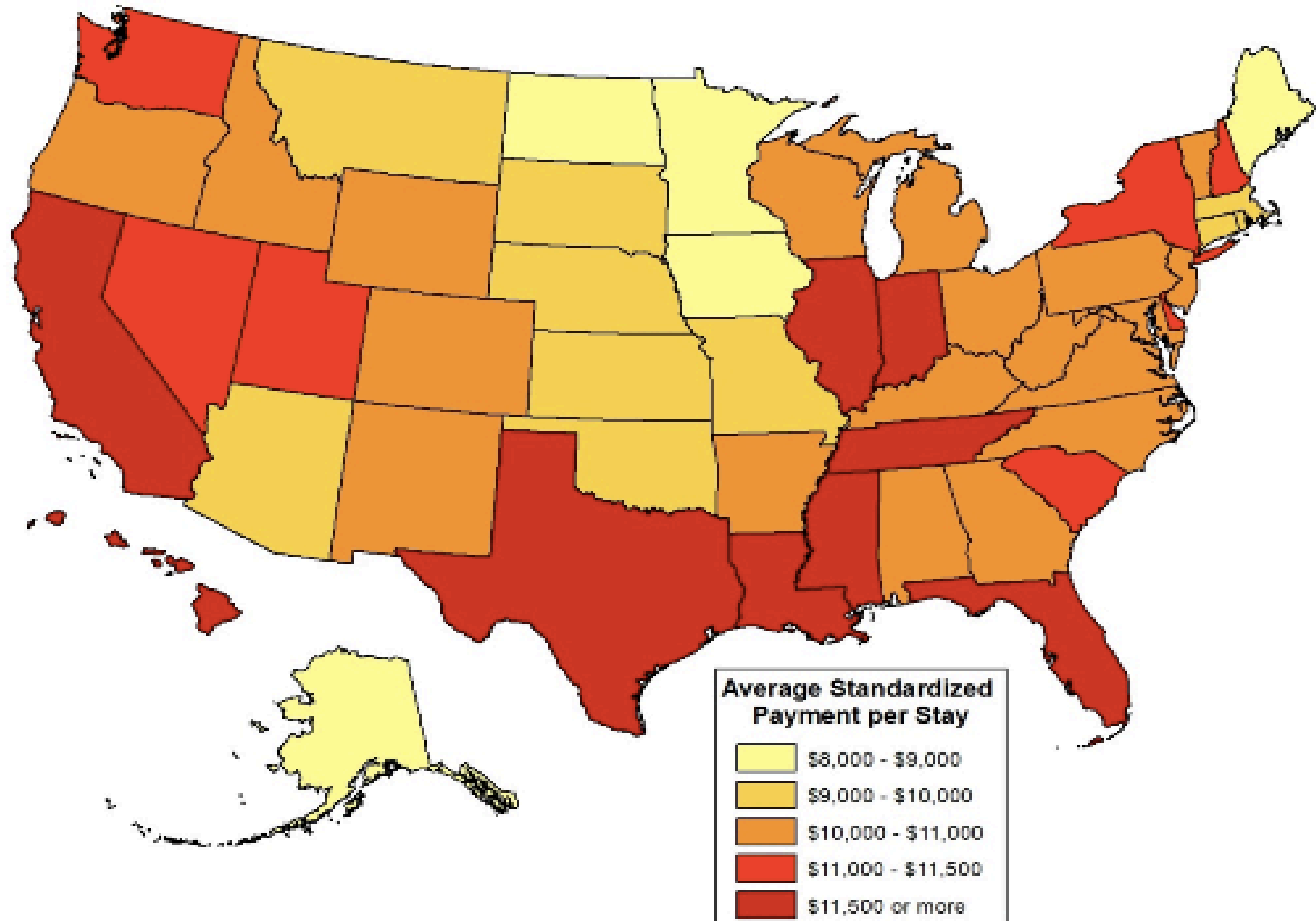
Home Health in Bundled Payment

- 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

Business Case

- 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 Tele-Health Waiver

- 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