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Connecting Communities and Health Care

n4a

advocacy | action | answers on aging

ASA American Society on Aging

"Is My Organization Ready? Assessing CBO Capacity to Partner with Health Care Entities"

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Part of the Aging and Disability Business Institute Series- a collaboration of n4a and ASA

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The "Business Institute"

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

www.n4a.org/businessinstitute

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Partners and Funders

Partners:

- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence

Funders:

- Administration for Community Living
- The John A. Hartford Foundation
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Marin Community Foundation

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Impact of MACRA Legislation

- MACRA
  - Medicare Access and CHIP Reauthorization Act
  - Bipartisan bill passed separately from ACA
  - Requires increased participation in alternative payment models
  - APMs
    - Bundled Payment
    - ACOs
    - Risk-bearing contracts for Medicare populations
- Commercial Payers are adopting similar financial models to MACRA

Achieving the Triple Aim

- Framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance
- Institute for Healthcare Improvement Triple Aim
  - Population Health
  - Experience of Care
  - Per Capita Cost
- CBOs that can support the achievement of the Triple Aim will have increasingly important roles in the transforming healthcare market.

MACRA Early Impact (Cont.)

- Eligible Providers (EPs) will be subject to an initial 4% payment adjustment
- 2019, which grows to 9% in 2022 and later
  - Merit-based Incentive Payment System (MIPS)
  - EPs that meet the APM threshold are exempt and receive a lump sum incentive payment instead of being subject to a potential MIPS penalty

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MACRA Financial Incentives

- Eligible Providers that meet the required threshold for APM participation
  - 2017 – Transition Year to establish benchmark quality metrics
  - Eligible Providers (EPs) will be subject to an initial 4% payment adjustment
  - Receive a 5% lump sum incentive payment based on the estimated aggregate of Part B covered professional services for the preceding year
  - 2019 – 2020: EPs must have 25% of their payments through APMs
  - 2021 – 2022: EPs must have 50% of their payments through APMs

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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

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Physician Practices and the Risk Continuum

- Physician Practices, PCMHs, and FQHCs receive Medicare payments under the Part B program
  - Hospitals and Skilled Nursing Facilities bill Part A
  - Readmission penalties generally apply to Part A collections
- Increasing competition from hospitals, retail clinics, and urgent care centers
- 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

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Strategy: Community Integrated Health

- 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

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Steps to healthcare 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

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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 / Community Benefit Report

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.)
    - Care Transitions
  - 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

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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

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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 customer 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 Key decision makers
  - CEO
  - CFO
  - Population Health Director/Manager
  - Quality Improvement Director
  - 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?

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Alternative Payment Models: Points of Pain

- MedPac Report to Congress. June 2013. Pg 106
  - "There is concern that hospitals serving large shares of poor patients tend to have higher readmission rates and that hospitals serving these patients will be more likely to pay readmission penalties."
- MedPac Report to Congress. June 2013. Pg 107
  - "We found that hospitals with high shares of poor patients (as indicated by their share of Medicare patients on SSI) tended to have higher readmission rates and thus higher penalties."

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CMS Study of Socioeconomic Factors on Star Ratings

- Released September 8, 2015
- Beneficiaries with low socio-economic status assessed based on Low-Income Subsidy (LIS) receipt and/or Dual Eligible (DE)
- Study found that 12 out of the 16 Star measures have a statistically significant negative association with LIS/DE status
  - All Cause Readmissions
  - Medication Adherence
  - Diabetes/Heart Disease Measures

HEDIS and STAR Ratings

- Star Ratings are closely aligned with HEDIS measure performance.
- HEDIS – (Healthcare Effectiveness Data and Information Set
  - Tool used by more than 90% of health plans to measure performance
  - CMS report shows that the outcome of some health measures can be influenced by social determinants of health
    - CBOs that can address both health and social needs are increasingly important to addressing this requirement

Seize the Opportunity

- Stratify the population
- Identify the need of the consumer that matches your strengths
- Population that unanimously has been cited as a point of pain
  - Consumers with low socioeconomic status
  - Duals
  - Consumers eligible for Medicaid HCBS that are at risk for institutionalization

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Is Your Organization Ready?

Abigail Morgan
VP Planning & Quality Improvement

DIRECTION HOME AKRON CANTON
AREA AGENCY ON AGING & DISABILITIES

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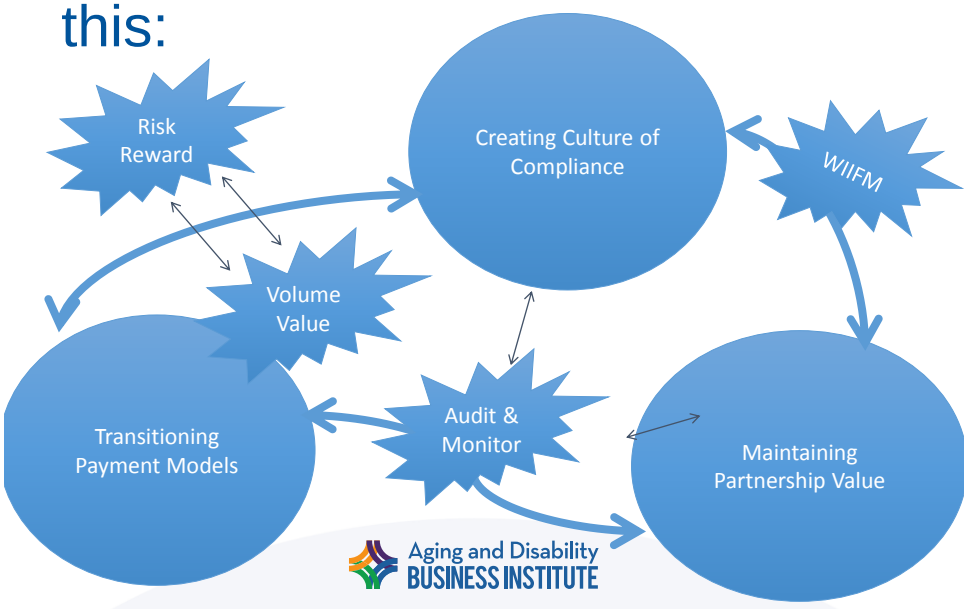
When your checklist feels like this:



Our Journey

- Transitioning payment models
- Maintaining our value as 'high-quality' partners
- Adopting a Culture of Compliance

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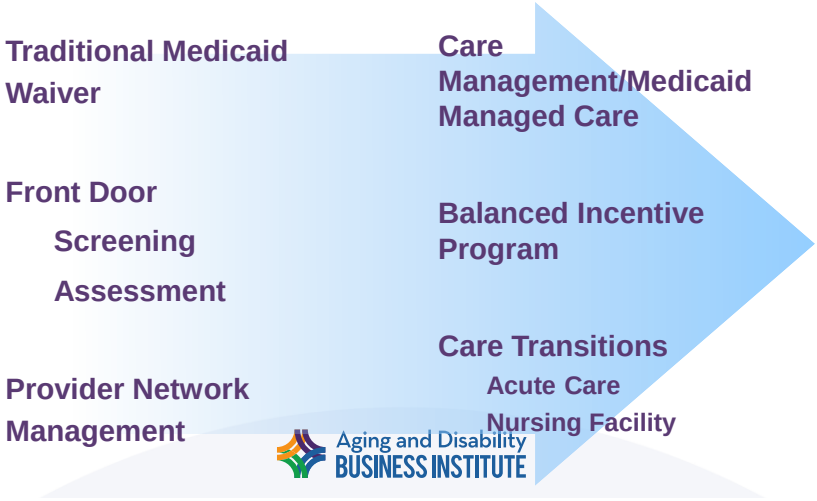
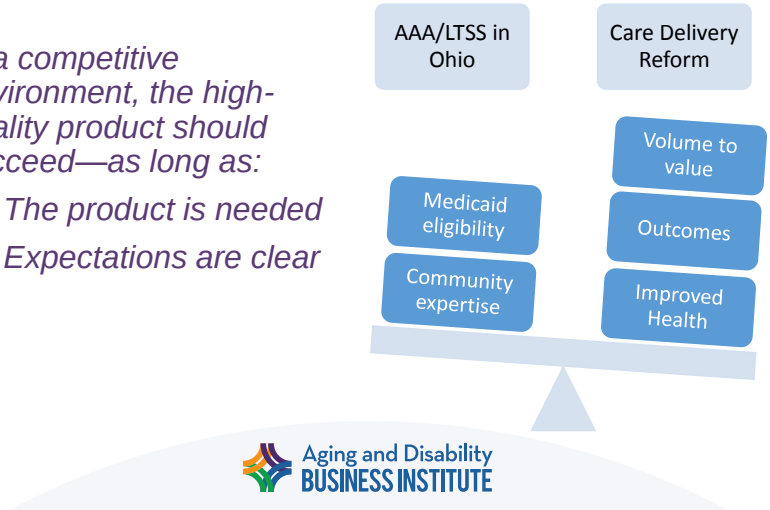
From Extension of State to Risk/Reward Business



Maintaining our Value as Partners

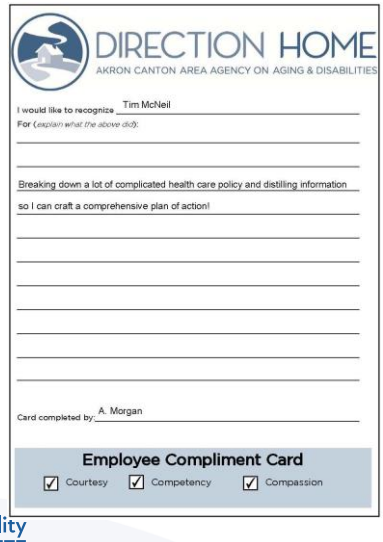
In a competitive environment, the high-quality product should succeed—as long as:

1. *The product is needed*
2. *Expectations are clear*



Clashing of Cultures—Adding Compliance

- Strong Corporate Culture
- "Line of Sight" performance metrics
  - roll up from staff to management, operational and strategic plans
  - Not necessarily tied to compliance
- Tied to extension of state government business
- Corporate culture based on **Customer** satisfaction



DIRECTION HOME
AKRON CANTON AREA AGENCY ON AGING & DISABILITIES

I would like to recognize Tim McNeil
For (*explain what the above did*):

Breaking down a lot of complicated health care policy and distilling information so I can craft a comprehensive plan of action!

Card completed by: A. Morgan

Employee Compliment Card

☑ Courtesy ☑ Competency ☑ Compassion

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Our Checklist

- ❑ Overall Strategic/Organizational Planning
- ❑ Care Management Processes
- ❑ Quality Assurance & Improvement
- ❑ IT Infrastructure
- ❑ Financial Planning

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Overall Strategic/Organizational Planning

- Examine and address organizational culture
- Plan for shift in customer focus
- Utilize Experience of Board
- Align long-term financial plan with strategic goals
- Consider new contract structures

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Care Management Processes

- Examine Care Management or Care Coordination Models
- Develop or assess internal training program
- Assess role of supervisors/oversight
- Review documentation procedures

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Quality Assurance & Improvement

- Be clear about performance metrics, data sources, definitions (include clinical staff in development)
- Plan for how to monitor/audit performance
- Develop organized quality improvement program and champions

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IT Infrastructure

- Complete HIPAA Gap or Risk Assessment or HITRUST Assessment
- Update policies & procedures
- Develop relationships with IT staff
- Plan for how data will be shared
- Test system compatibility

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Financial

- Educate payors on services, units of service
- Develop conservative staffing and multiple cost models
- Invest in systems to track individuals
- Don't say no to performance-based contracts

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Questions & Answers: Please Submit Using the "Questions" Box

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Please join us for future webinars in the Aging and Disability Business Institute Series

Expand Your Vision and Grow Your Mission! Driving Culture Change in Aging and Disability CBOs Looking to Work with Health Care Partners – January 9, 2017

Learn more and pre-register here:
http://www.asaging.org/series/109/aging-and-disability-business-institute-series

Questions about the Aging and Disability Business Institute?

Email us:

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