Putting Care at the Center 2017

Building the Business Case for High-Need, High-Cost Patient Programs: Securing Support of Senior Leadership & Prospective Payers

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Speakers

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Learning Objectives Today

- Learned how other organizations are paying for HNHC programs
- Identified at least one effective HNHC model component to incorporate or strengthen in own care model.
- Formulated at least one action step to participate more fully in reimbursement strategies for HNHC programs
- Applied lessons from case example of building a business case for HNHC program.

Multiple Chronic Conditions

Behavioral Health

Frail Elderly

Healthy with Acute Event

Under 65 Years Disabled

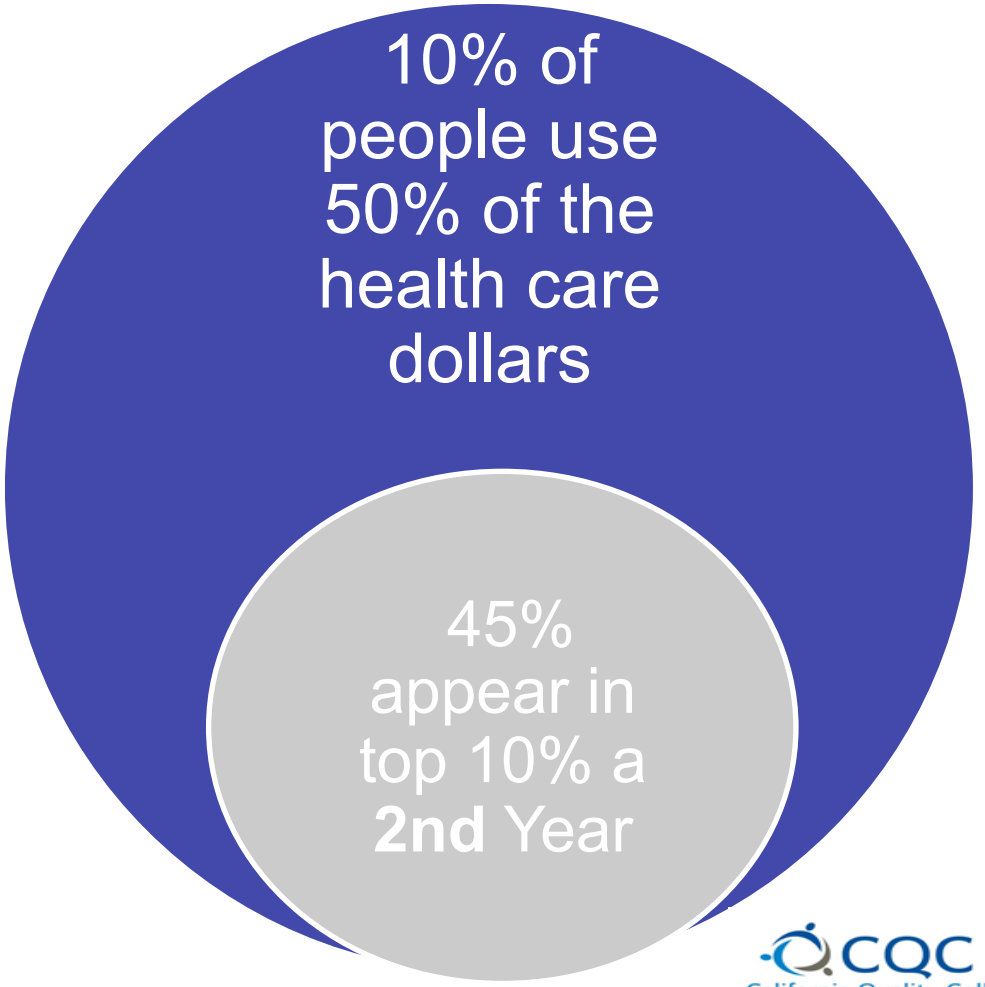
Children with Complex Needs

Socially Complex

Complex Chronic Conditions

Resulting Spending

- Signals of Unmet Needs:
- 45% of patients appear in top spending tier over 2 years
- 67% are under age 65
- 28% of Medicare Spending occurs in last 6 months of life



Response: Intensive Outpatient Care Program (IOCP)

- Built on successful pilots established for **commercial patients**:
  - ✓ Boeing (Seattle area)
  - ✓ PG&E and CalPERS (rural northern California)
- 2012 HCIA award to test spread across 23 delivery system in **5 states for 15,000 Medicare patients**
- 2016 Provided Technical Assistance for **Medi-Cal Health Homes program**
- **Building Care Solutions (BCS)** launch in 2017

IOCP: A Medically Complex Care Model

Patients	Services / "Guardrails"

Top 10-15% predicted high cost	▪ Longitudinal 1:1 relationship with warm handoff to support services
	▪ Minimum, two-way communication with care coordinator / patient 1x/month
	▪ Care coordinators host face-to-face "supervisit"
	  ▪ Assessment with PAM, PHQ-2; medication reconciliation
	  ▪ Support patients' Shared Action Plan
	▪ 24/7 access, communication to care coordinator next business day

Model Adaptations

- The ***Intensivist*** model versus ***Distributed***
  - **Intensivist** – Patient is referred to a specialist primary care practice with co-located care coordinators
  - **Distributed** – Patient remains in primary care practice and care coordinators travel

- **Care Coordinator ratios**
  - Panel size for Medicare: 80 – 120
  - Panel size for Commercial: 180 – 200
  - Medicaid: 25 - 80

Cost/Utilization	Clinical Outcomes	Patient Engagement
✓ Top 10-15% predicted high cost ✓ 55% decrease in emergency department visits for higher risk patients ✓ 21% decrease in total cost of care for higher risk patients	✓ Longitudinal 1:1 relationship with warm handoff to support services ✓ 33% improvement in depression symptoms ✓ 3.4% improvement in mental health functioning ✓ 4.1% improvement in physical health functioning	✓ 3.6% increase in patient engagement

Updated Model: New Considerations

Targeted Patient Identification & Engagement	Person-Centered Approach	Efficient Team Composition	Sustainability
(Appropriate patient identification, PC engagement, PCP referral)	(1:1 relationship with care coordinator, services beyond medical, such as behavioral health, face-to-face interaction)	(Use of non-licensed staff, triage, graduation criteria, panel size, leveraging external orgs, such as hospitals, community)	(Create business case, ROI)

Table Discussion

- With table, discuss how your buckets of HNHC care lined up with IOCP model? Is the IOCP model missing anything? Is your model?

HNHC Payment Models & Reimbursement

- No single model of HNHC care, no single method of reimbursement
- Pursuing reimbursement requires engaging leadership, regular/frequent discussions with payors, creativity and persistence
- Grant funding is not a long-term solution

Opportunities for Reimbursement

1. Full risk contracts (commercial and MA)
2. ACO contracts
3. Payor alignment
4. CCM/TCM Reimbursement
5. Health Home Programs

Full risk contracts

- Taking on upside and downside risk
- Questions to ask
  - Do you have enough data?
  - What kind of team do you have to manage the work?
  - What is organization's alignment with contract expectations?
  - What is compensation structure? FFS? Panel management?

ACO Contracts

- Contracts moving towards shared risk/savings; managing HNHC patients critical in achieving shared savings
- Questions to ask
  - What is shared savings distribution?
  - How is savings distributed? To what level of organization/ provider?
  - What is alignment across ACO contracts?
  - Do you know what ACO is measuring?
  - Do beneficiaries know that they are in ACO?

Payor Alignment

- Health plans reimburse for performance on certain measures, or less frequently, specific services
- Questions to ask
  - What HNHC services are covered?
  - How can performance on specific measures be leveraged to subsidize HNHC programs?
  - Can you negotiate with plans to add measures that support HNHC programs?

CCM/TCM Reimbursement

- CMS pays PMPM for some medically complex patients; requires electronic capture of complex data, as well as use of specific billing codes
- Questions to ask
  - Can your IT systems be set up to capture this data?
  - Do billing staff know correct coding?
  - Are eligible providers providing appropriate services?

Health Home Programs

- State and Federal funding combined to provide support to HNHC patients; need to provide specific set of core services
- Questions to ask
  - Does your state participate in HHP?
  - Are your medically complex patients participating?

Business Case: Real World Example