Remington's Think Tank Leadership Exchange

Building Referral Relationships With Physicians and Specialists

Business Intelligence for Strategic Development

Presented by:
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President, Remington Think Tank Leadership Exchange
and Publisher, The Remington Report

April 11, 2024

Meet Lisa Remington

Lisa Remington, President
Remington's Think Tank
Leadership Exchange and
The Remington Report

Celebrating
30 Years
As A
Trusted
Advisor

Lisa is a growth and strategy advisor with extensive knowledge across the care continuum for three decades. She is well-known for her strategic analysis of payment, policy, and marketplace trends. She understands the challenges and opportunities facing leaders in home care and across the healthcare ecosystem.

As the publisher of The Remington Report, and president of the Think Tank Leadership Exchange, she has earned a trusted industry voice for her ability to navigate through disruption, identify new growth and revenue opportunities, position and expand home care's future, and define collaborative partnerships between hospitals, health systems, ACOs, payers, physicians, and home and community-based organizations.

Lisa has led C-suite education to over 10,000 organizations through a variety of platforms, including think tanks, strategic improvement programs, consulting, board retreats, executive leadership programs, and peer-to-peer networking groups.

Lisa has personally authored thousands of healthcare articles, forecasting reports, special industry market reports, and has maintained a track record of 100% accuracy in predicting emerging healthcare trends and value-based solutions. Her healthcare career began in hospital business operations and as a turn-around specialist in home care.

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Physician Market Signals

Market Intelligence to Build Referral Relationships

1. **Physician Market Future**
   Care, Management, Care Integration, and Community Connections
2. **Physician as Hub in Care Transformation**
   Examples: How Physicians Impact Care Transformation?
3. **Specialists**
   Future of Specialists
4. **Opportunities**
   Key Value Propositions

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01

Physician Clinical Models Focusing on Care Management, Care Integration, and Community Connections

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Roadmapping Primary Care's Future

1. **ACOs:** Integrating smaller physician groups into ACOs.

2. **Care Integration:** New models support primary care with specialists. Advance primary and specialty care coordination. Create financial incentives for ACOs to manage specialty care.

3**. Care Management:** Focused on chronic care.

4. **Incentives to participate in value-based payment models.** Increasing bundled payment models.

CMS Thought = MSSP has wide participation. High quality primary care drives shared savings success. Therefore, more investment in primary care and incentivizing participation from groups with characteristics of higher performing (in terms of % savings) low-revenue ACOs should save Medicare more $$$.

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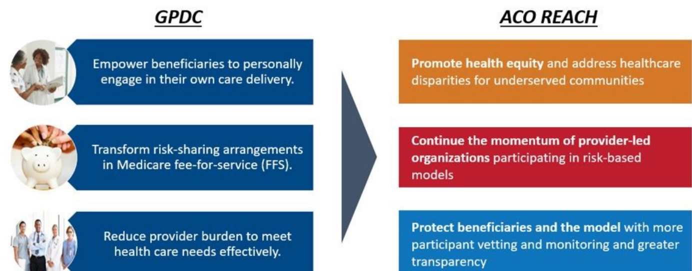
ACO Reach Model: Physician Capitation Payments

- Began January 2023: 132 ACOS and 131,772 healthcare providers and organizations providing are to 2.1 million beneficiaries

- ACO REACH model
  - doctors can accept either full or partial capitation as payment, with the goal of coordinating primary and specialty care for patients while giving access to additional benefits like telehealth visits.
  - implement a health equity plan and extend access in underserved communities, along with guardrails to increase provider governance
- Access to enhanced care coordination services, telehealth visits, home health visits
- ACO Reach model is committing to population-based models



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ACO Reach Model: Pilots Home Care Waivers

- **Testing and piloting home care waivers**
- **Aligning High Needs Population ACO**
- **Eligibility criteria for alignment to a high needs population ACO**
  - Eligibility criteria for alignment to a High Needs Population ACO will be expanded to include beneficiaries who have at least 90 Medicare-covered days of Home Health services utilization, or at least 45 Medicare-covered days in a Skilled Nursing Facility within the previous 12 months

There are two ACO REACH payment mechanisms

Total Care Capitation (TCC)	Primary Care Capitation (PCC)
•The capitated payment to the ACO applies to all services covered by Medicare Parts A and B that are provided to aligned beneficiaries by Participant and Preferred providers participating in TCC. •Providers will receive fee-for-service (FFS) payments only for the portion of claims that are outside the scope of the TCC	•The capitated payment to the ACO applies only to certain primary care services provided to aligned beneficiaries by Participant and Preferred providers participating in PCC •Providers will continue to receive FFS payment for non-primary care services that are outside the scope of the PCC payment. •An ACO electing PCC may also elect to receive reduced FFS payments for non-primary care services under the optional Advanced Payment Option (APO).

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ACO Primary Care Flex Model

- 5-year voluntary model – begins January 2025.
- Pilots under the Medicare Shared Savings Program
- Payment: One time advanced shared savings payment and population-based payments for primary care (replacing fee-for-service payments)
- Team-based approach to medical and social needs

ACO Primary Care Flex Model

2025-2030

The ACO Primary Care Flex Model (ACO PC Flex Model) is a voluntary model focused on improving funding and other resources to support primary care delivery in the Medicare Shared Savings Program. The model incentivizes the development of new, physician-led Accountable Care Organizations (ACOs), particularly those that will support underserved communities, and can help address health disparities.

Model Goals

- **Expand access** to high-quality, primary care
- **Improve the care experience** for people with Medicare
- **Strengthen primary care in accountable care organizations** and spur innovative approaches to care delivery
- **Reduce disparities** in health care outcomes
- **Lower costs** while preserving or enhancing the quality of care for individuals in the Shared Savings Program
- **Increase accountable care relationships** for people with Medicare, especially those in rural and underserved communities

Shared Saving Program

ACOs interested in participating in the model must first apply to the Shared Savings Program.

New ACOs
Indicate interest by **checking a box** on the Shared Savings Program application.

Renewing ACOs
Apply to the Shared Savings Program as a Renewal Applicant and **begin a new agreement period**.

For more information, visit the Application Types & Timeline webpage.

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Seven Specific Goals of ACOs

ACOs have found to be successful in reducing spending and improving quality

1. Working with physicians and specialists
2. Engaging beneficiaries to improve their own health
3. Managing beneficiaries with costly or complex care needs
4. Reducing avoidable hospitalizations and improving hospital care
5. Controlling costs and improving quality in skilled nursing and home healthcare
6. Addressing behavioral health needs and social determinants of health
7. Using technology to increase information sharing among providers

Align Your Organization's Value Propositions

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Examples of Clinical Models Transforming Physician Incentives

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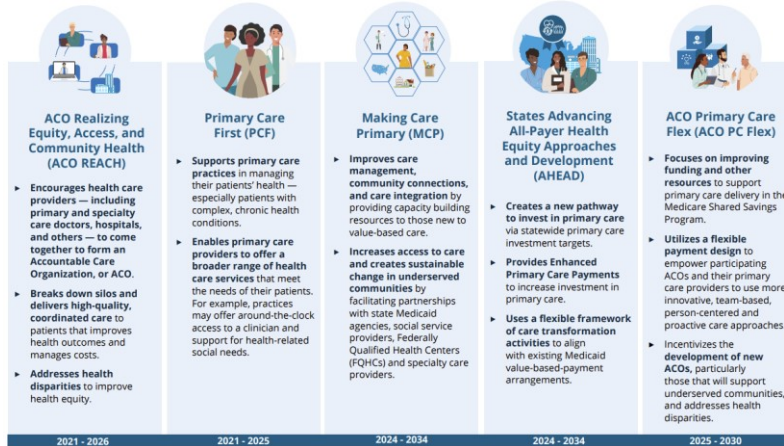
Primary Care Hub of Transformation



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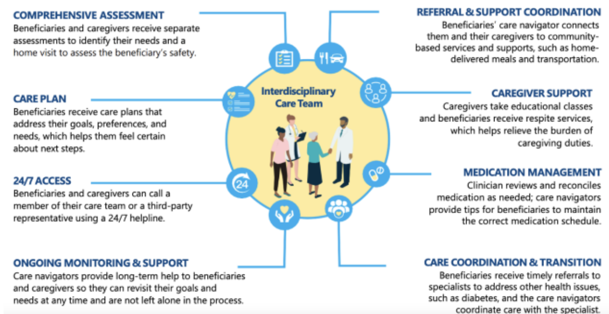
Guide Innovation Model

The Guiding and Improved Dementia Experience (GUIDE) model is care to people with dementia. Enables respite care for family caregivers to be paid for by Medicare fee-for-service.

Guiding and Improved Dementia Experience (GUIDE)

- **Begins July 2024 – 8-year pilot program**
  CMS' model purpose states physicians and other clinicians will deliver care through three domains:
- **Care management,** emphasizing diabetes, hypertension, and reducing unnecessary emergency department use.
- **Care integration**, strengthening connections with specialists and integrating behavioral health screenings.
- **Community connections**, identifying patient health-related social needs and connecting patients to community supports and services.

CMS Dementia GUIDE Innovation Model



Resource: What's Changing About Dementia Care Offered in Patient's Home?

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Accountable Care: Physician Model

Making Care Primary Model (MCP) – Create more coordinated care for rural and underserved populations

- Integrated, coordinated, person-centered, accountable primary care
- Gives smaller independent, rural, and safety-net primary care practices a way to enter value-based payment arrangements'
- Improves care quality while cutting cost
- Tools to form partnerships between primary care and specialists

Care Delivery: Three domains

1. Model Design: three progressive tracks
2. Multi-Payer Alignment
3. Payment Strategies: Health Equity

Resource: CMS's Making Care Primary Model Advances Primary Care into Value-Based Care

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CMS Physician Payment to Train Caregivers

Code	Definition	Service	Participants	Time
96202	Multiple-family group behavior management/ modification training for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/ caregiver(s); initial 60 minutes	Behavior management/ modification training	Multiple sets of caregivers (regarding different patients)	Entire 60 minutes
96203	each additional 15 minutes	Behavior management/ modification training	Multiple sets of caregivers (regarding different patients)	Entire 15 minutes
97550	(Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes),	Functional performance of ADLs	One or more caregiver (s) for a single patient	Entire 30 minutes
97551	each additional 15 minutes	Functional performance of ADLs	One or more caregiver (s) for a single patient	Entire 15 minutes
97552	(Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers).	Functional performance of ADLs	Multiple sets of caregivers (regarding different patients)	Not timed

Resource: CMS Proposes Payment to Physicians to Train Caregivers
September/October 2023 Issue

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2024 Physician Billing Codes

- New billing codes related to new clinical programs
  - Care coordination
  - Direct patient care services
  - Caregiver training
  - Assessment of health-related social needs
  - Coordination with community health workers
  - Care navigators
  - Support specialists
- Telehealth
  - Medicare: telehealth from any site
  - Added health and well-being coaching
  - Social determinants of health assessments
  - Qualified practitioner list expanded

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What to Expect in Home Care: Physician Transformation

1. Greater primary care coordination
2. Transitioning into value-based payments
3. Advances risk-based models
4. Greater need for home health, hospice, palliative care, private duty, in-home providers
5. New care transformation needs
6. Centers around care coordination, social determinants of health, and chronic care

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Specialty Care Transformation Bringing Opportunities to the Home Care Industry

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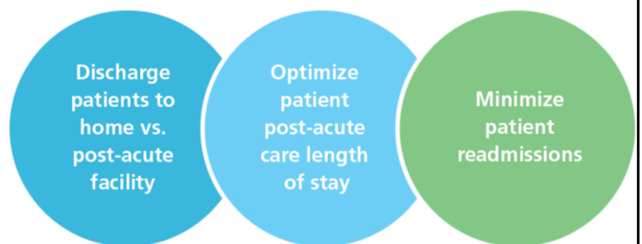
Market Signals: Ambulatory Care & Outpatient

1. Greater participation of specialists in value-based care
2. Reimbursement shift from inpatient to outpatient
3. Specialty clinical care models shifting to care at home



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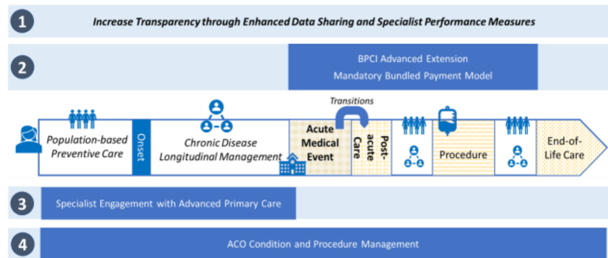
Roadmapping Specialists' Future



Resource: Physician MarketScan: Specialists Expanding Care in the Home. Remington Report May/June 2023

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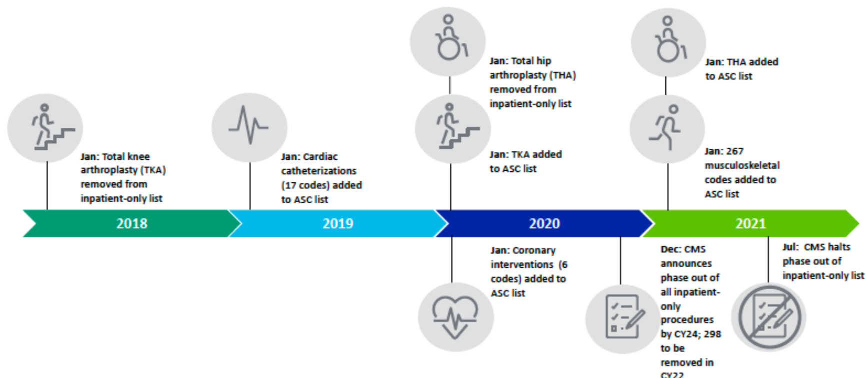
Site of Care Change Driven by Payment Change



Sources: CMS, Moody's Investors Service

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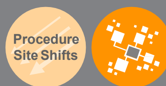
Sg2 ANALYTICS

Site of Care Shifts Continue Throughout the Decade



OP surgical volumes to grow **18%** by 2033

TOP SHIFTING PROCEDURES

- Total Joint Replacement
- Lumbar/Thoracic Spinal Fusion
- Revision Knee Replacement
- Prostatectomy
- Cervical Spinal Fusion
- Cholecystectomy
- Bariatric Surgery

Sources: Impact of Change®, 2023; Proprietary Sg2 All-Payer Claims Data Set, 2021; The following 2021 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2023; Sg2 Analysis, 2023.

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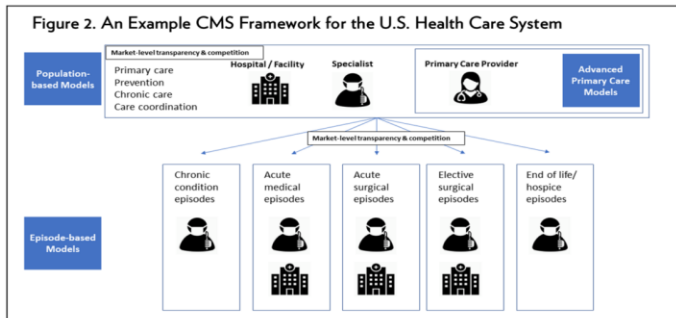
Clinical Models Expanding Care at Home

Groups of providers could be accountable for total cost of care (through population-based payment via a health system, an ACO, or another convener), with procedure-based specialists paid through bundled payments. Primary care providers could be paid under advanced primary care models that include capitated fees for care management activities



"Medicare Payment Reform's Next Decade: A Strategic Plan For The Center For Medicare And Medicaid Innovation," *Health Affairs Blog*, December 18, 2020. DOI: 10.1377/hblog20201216.672904

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Primary Care & Specialists

Value-based care adoption is highest in primary care but other specialties see meaningful and growing traction.

Value-based care (VBC) adoption by medical specialty,[1] nonexhaustive

HIGH ADOPTION ◄────────────────────► LOW ADOPTION

Specialty	Primary care	Nephrology	Oncology	Orthopedics	Women's health	Cardio-vascular	Behavioral health
Description	Enables primary care to act as the "quarterback" and take full responsibility for patient health	Enables nephrologists to succeed in CMS[4] and MA VBC[5] focused on reducing CKD/ESRD[6] costs	Enables oncologists to prescribe an appropriate drug for the patient while maximizing practice margin from prescription	Large spend area with significant employer focus and increase in penetration of episodes	Pregnancy episodes particularly in Medicaid and increasingly commercial	Large spend area, particularly in MA, driving high inpatient and emergency department utilization; site-of-care shift for procedures	Episode-based models for facilities with more innovative approaches involving PCPs on integration of BH[8]/physical health
Applicable CMMI model	Primary care first, MSSP,[2] ACO REACH[3]	Kidney care choices, ESRD treatment choices	Oncology care model, enhancing oncology model	Comprehensive care for joint replacement, BPCI[7]	n/a	BPCI	n/a

[1]Proportion of money in specialty at risk. [2]Medicare Shared Savings Program. [3]Accountable care organization Realizing Equity, Access, and Community Health (REACH) model. [4]Centers for Medicare & Medicaid Services. [5]Medicare Advantage value-based care. [6]Chronic kidney disease/end-stage renal disease. [7]Bundled Payments for Care Improvement initiative. [8]Behavioral health.
Source: Centers for Medicare & Medicaid Services Alternative Payment Models program data; expert interviews and discussions with payer and provider senior executives

McKinsey & Company

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Specialty Care Models: Value-Based

- Manage chronic care and complex illnesses
- Medically focused populations
- Goal: Shared savings: lowering utilization medial expenses

Physician population focus:

* Cancer
* Diabetes
* Dialysis
* Asthma
* Heart disease
*Opioid addiction
* Alzheimer's
* Depression

More than 2/3 of the chronic care population have at least one chronic condition

Care at home participation: Model requires care coordination across broader set of services

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Episode-Based Models

- Payment for entire episode of care (30-60-90 days)
- Single medical condition or surgical condition
  - Hip or knee replacement
  - Cardiac
  - Stroke
- Care at home participation:
  - Requires an advance care plan and coordination with acute, post-acute, and ambulatory partners
  - Care coordination: care managers, therapists, and community workers

Bundled payments have resulted in a 20.8% decrease in total spending per episode

Bundled payment relies on a certain level of risk. If providers can decrease the cost of the services below the bundled payment price, they can pocket the savings.

However, if the costs are higher, providers bear a financial loss.

Bundled payment arrangements present many opportunities to re-tool the types and mix of post-acute care, and materially improve patient care and lower costs

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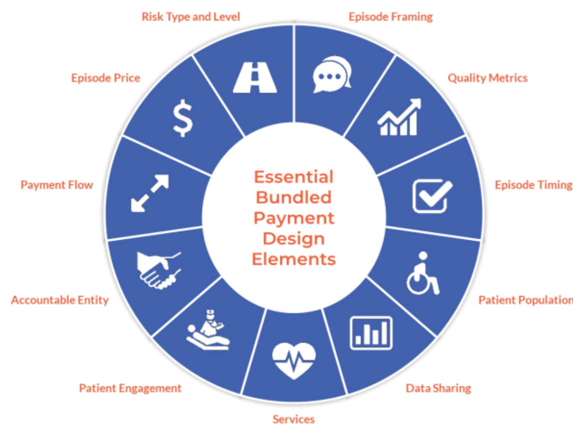
Bundled Payments: Next Level



Resource: Future Bundled Payment Program to Improve Care Transitions and Collaboration Across Patients' Care Journey
Remington Report Page 9 Sept/Oct 2023

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Opportunities to Build Your Business Case

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Physician Referral Frustrations

Working Through Physician Partnership Issues

The #1 frustration among referring partners was back-and-forth phone calls for medication coordination

- **40%:** Phone calls and phone tag. Back and forth phone calls cause dissatisfaction among patients and providers.
- **22%:** Inability for referring providers to see how their patients are progressing.
- **16%:** Inability to perform initial service in a timeline acceptable to the referral source.
- **10%:** Lack of knowledge about which payers are accepted by post-acute provider networks.

Source: MatrixCare Study

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Why Physicians Would Chose One Home-Based Care Organization Over the Other

Why Would A Referral Source Choose Another Provider?

Is Your Organization Losing Referrals?

- **74%** of referring physicians said they would switch to a new home care provider if that organization was able to accept electronic referrals and interoperate with them effectively.
  - * ***Home-Based Care****: 36% of home health and hospice organizations still use fax machines to receive referrals*.
  - * ***Home-based Care:*** *20% using the phone as a referral receipt*
  - * ***Home-Based Care:*** *Only 4% of care-in-the-home providers are using interoperability through technology such as an electronic medical record (EMR) to process orders today*
- ***96%*** reported they would send more referrals who have more advanced patient engagement capabilities

Source: MatrixCare Study

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Ambulatory Care Physicians: Frustrations

Working Through Physician Partnership Issues

1. No established relationships
2. Do not know where their patient is
3. Delayed communications
4. Lack of information

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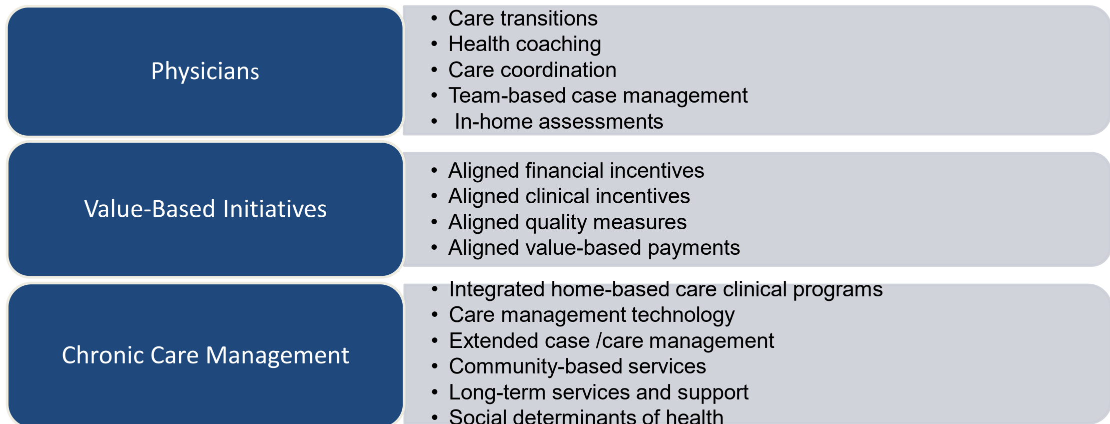
Make Your Business Care



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15 Physician Performance Metrics

1. Patient Satisfaction Scores	9. Patient Engagement
2. Patient Wait Times	10. Preventative Care Measures
3. Readmission Rates	11. Infection Rates
4. Length of Stay (LOS)	12. Diagnostic Accuracy
5. Mortality Rates	13. Relative Value Units (RVUs)
6. Complication Rates	14. Resource Utilization
7. Medication Error Rates	15. Cost Efficiency
8. Adherence to Clinical Guidelines	

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Help Improve Surgical Care Transitions

- Wound care education
- Supplies
- Pain control
- Approvals for non-home post discharge locations
- Follow-up plans for wounds, ostomies, and drains at discharge
- Challenges to surgical discharges:
    - Home environment
    - Caregiver availability
    - Team communication issues
    - Post discharge care coordination

Source: Mapping the Discharge Process After Surgery: JAMA Surgery

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Review Your Care Transition Tools

- **Competitive Tools to Improve Care Transitions with Your Referral Partners and Patients**
- 3 differentiation tools to overcome the challenges of efficient care transitions
- 4 care transition challenges faced by home-based providers
- 7 care transition referral-management capabilities you need to have
- 6 care transition solutions your intake team must have
- 6 ways to create a more satisfying care experience for patients, families, and caregivers
- 5 care transition capabilities to drive better outcomes
- 3 things referral partners want from home-based providers

4 Care Transition Challenges and How to Solve Them

https://remingtonreport.com/intelligence-resources/white-papers/4-care-transition-challenges-and-how-to-solve-them/

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Review Your Brand

What Do You Call A Hospice That Does More Than Hospice?

SAME EXPERTS.
NEW NAME.

Hospice of the Bluegrass is now Bluegrass Care Navigators.
Hospice care continues to be a focus, yet we now guide and provide expert care long before life's final months.

More ways to care.

- Extra Care – personalized home care
- Transitional Care – help with hospital to home
- Palliative Care – pain and symptom relief
- Hospice Care – for life's final months
- Grief Care – support during grief

To discuss the care that's right for you or your loved one, call 855.492.0812 or learn more at bgcarenav.org

Hello my name is
BLUEGRASS care navigators
Expert. Connected. Care.

Hello my name ~~is~~ was
Bluegrass Hospice

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BLUEGRASS care navigators
Expert. Connected. Care.

PASSION
Our passion is improving the life experience of the frail, seriously ill and their families by providing expert interdisciplinary care that allows life to be fully lived.

WHY?
TO HELP PEOPLE LIVE FULLY

HOW?
Interdisciplinary Team
Pain & Symptom Management
24/7/365
Personalized
Responsiveness
Compassion
Choices
Listening
Guiding
Teaching

WHAT?
Hospice Care
Palliative Care
Transitional Care
Extra Care
Grief Care
Adult Day Health Care
Home Primary Care

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SDOH Value Proposition

- Micro-social determinants of health (SDOH) assessment to address the needs of home care patients, readmission rates, drive care planning, and caregiver satisfaction
- Data-driven assessment tool identified the micro- social determinants of health impacting an individual
- Assessment score helps build a plan to overcome SDOH factors
- Uses a five-factor framework to analyze an individual's determinants. These factors include:
  - medical condition management,
  - activities of daily living function,
  - home safety,
  - caregiver burden, and
  - quality of life

An Annals of Internal Medicine study states a lack of non-medical support for older adults costs Medicare over $4 billion annually

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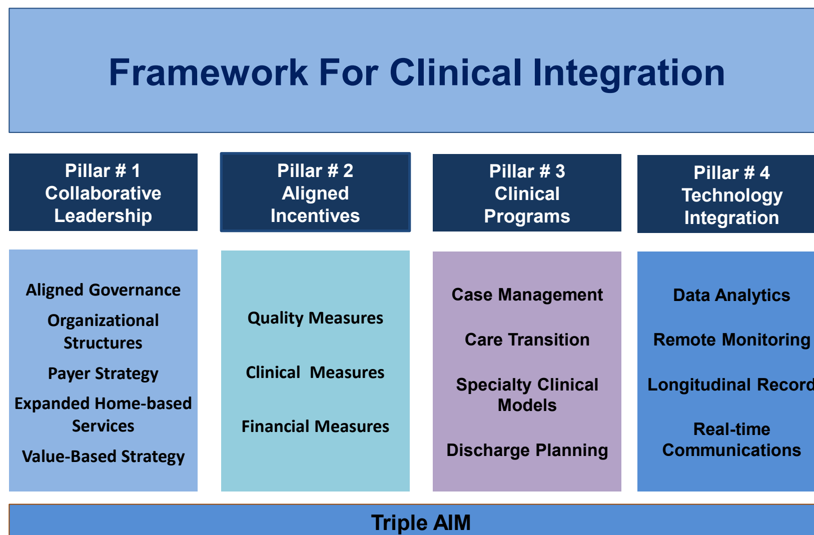
Physician Clinically Integrated Care Model



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Higher Engagement Opportunities

- **Care coordination and care transitions**. Collaborative and seamlessly connecting all providers along the care continuum.
- **Aligned Incentives.** Quality, financial, outcome improvement initiatives.
- **Clinical Protocols.** Consistent patient transfer, clinical protocols, and processes.
- **Data Integration and Data sharing**. Focus on analytics and more targeted interventions.
- **Real-time Communications**. Patient status
- **Population Health.** Managing chronic care, higher acuity patients
- **Correct Levels of Care.** Immediate and consistent access to high-quality home-based services, placing patients in the optimal levels of care, regardless of payer type
- **Readmissions and ED.** Reductions in readmissions and emergency department visits.
- **Discharge Planning.** Increased hospital throughput, a reduced average length of stay and a more efficient discharge process.

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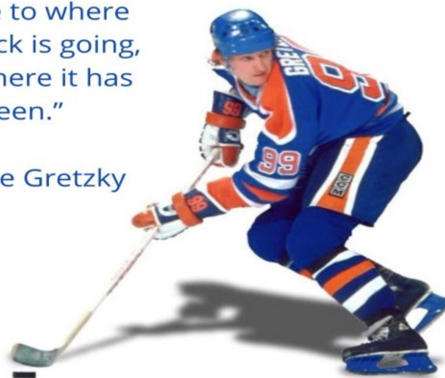
Get Ready For The Future

"Skate to where the puck is going, not where it has been."

~Wayne Gretzky



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Remington Think Tank Leadership Exchange
Upcoming Master Classes

May 16, 2024
Building Relationships with Hospitals and Health Systems
How Home Health, Hospice, Palliative Care, Private Duty, and In-Home Care Providers Can Craft Persuasive Value Propositions and Solve Critical Pain Points Through Home Care Solutions and Resources

June 6, 2024
Establishing Referral Partnerships Through Readmission Management
Opportunities for Home Health, Hospice, Palliative Care, Private Duty, and In-Home Care Providers to Decrease Readmissions, Collaborate, and Deliver Improved Outcomes

June 27, 2024
Building Referral Partnerships with Payers and Medicare Advantage Plans
Opportunities for Home Health, Hospice, Palliative Care, Private Duty, and In-Home Care Providers to Implement Effective Strategies and Foster Relationships

Live Recording Available
Building Referral Partnerships with ACOs
How Home Health, Hospice, Palliative Care, Private Duty and In-Home Care Can Create Team-Based Care
Received 5-Star Rating

Get the overview of all MasterClass Programs

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Additional Think Tank Resources

- Remington Report magazine
The Remington Report » Remington Report

- Remingtonreport.com: E-newsletter and Special Reports
https://remingtonreport.com/intelligence-resources/futurefocus/

- Email questions:
remington@remingtonreport.com

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