

How leadership and the value of home health aides can secure positive payer outcomes

By CHRISTY JOHNSTON, MPH



This is the second article in series to discuss how to promote the growth of in-home community-based organizations and accelerate relationships with payers.

The first article published in the Remington Report's July/August issue, pages 4-8, focused on the home health aide workforce: [How Real Time Actionable Data Leverages New Value For Home Health Aides and Stakeholders.](#)

A six web-based Signature Education series provided by The Remington Report and Premier Home Health Care Services is being offered to support company-wide training in the areas of:

- **The Changing Healthcare Landscape: The New Role of the Home Health Aides**
- **How to Expand Payer Partnerships and Meet Their Goals**
- **How to Expand the Role of Aides to be Part of an Interdisciplinary Team Member**
- **How to Target Interventions to Improve Outcome**
- **How to Size-up Your Organization for Cultural Change**
- **How to Boost Quality Scores and Performance Improvement**

See details on pages 22-23.

In this article, we provide insights to how organizations can identify common goals, common language, and the importance of remaining flexible.

- **Understanding the payer perspective:**
What the payer/stakeholder needs. Talking their language, and understanding their issues.
- **Emerging programs, changes in reimbursement and methodologies:**
Differences in incentives vs. penalties.
- **The value of conversations between leadership, home health aides and payers:**
Talking their language, understanding their issues.
- **Identifying alternative approaches to meet payer's needs:**
How to stay flexible.

Trying to keep up with the alphabet soup of acronyms that identify emerging healthcare reimbursement models has been both challenging and exciting at Premier. Challenging because of the evolving changes that must be understood and incorporated into home and community-based care models, and exciting because of all the solutions that home and community based care providers have to offer. In order to survive and thrive in the fast pace of health-care system change, all health care providers, including home and community-based care, must be informed, creative, and nimble partners with payers and other relevant stakeholders.

Understanding the Payer Perspective

The acronyms and new models in different healthcare sectors – Accountable Care Organizations (ACOs,) Managed Care, Physicians, Hospitals, Skilled Nursing Facilities (SNFs) – may be more than anyone wants to keep up with, but in the midst of the changing healthcare landscape it is critically important that home and community-based care providers know what is important to payers and post-acute care partners. It is particularly crucial to understand the financial incentives they are seeking and the penalties they are avoiding, because that is where the funding streams are heading.

Over the past decade, the reimbursement mechanisms for the delivery of many health care services has changed dramatically. We now find ourselves increasingly removed from a predictable Fee for Service (FFS) payment structure and are navigating a health-care environment that is operating under Alternative Payment Models (APMs).

These new Alternative Payment Models (APM) paradigms (see Table 1, page 19) offer financial incentives and rewards for higher quality, lower cost care. It is in everyone's best interests to deliver the type of care and put systems in place that help achieve these outcomes and incentives. Conversely, APMs may result in lower reimbursement and penalties for payers when outcomes are less favorable or preventable facility readmissions occur. These newer reimbursement models, which may be structured as Value Based Payment (VBP) arrangements with upside/downside risk, take us farther away from the FFS volume model and require everyone to make changes and think differently.

While there are many variations in newer payment models, most require great attention to quality measures (QMs), readmission rates by diagnosis, potentially avoidable hospitalization (PAHs) rates, and other related measures. Funding under most of these models is distributed using the proverbial carrot and stick approach – payment incentives and penalties – and QMs, PAHs, and other readmission rates are critical to understanding what helps a payer reach the incentives and what can help prevent the penalties. In order for home and community-based care providers to interact effectively with payers and stakeholders, it is vital that we understand the payer's perspective and how funding, incentives, and penalties are allocated.



“Too often we fall into the trap of knowing what we want to present and forgetting to listen to the feedback, or to even solicit the needs and thoughts of the payers/stakeholders.”

– CHRISTY JOHNSTON, MPH IS VP OF GOVERNMENTAL & MANAGED CARE SERVICES FOR PREMIER HOME HEALTH CARE SERVICES, INC.

THE VALUE OF CONVERSATIONS BETWEEN LEADERSHIP, HOME HEALTH AIDES AND PAYERS

As healthcare funding mechanisms began to change in earnest a number of years ago, Premier recognized that in order to get to the conversation with payers about what we brought to the table, we needed to understand the system entirely from the payer perspective. We needed to know what was important to the payer – how their reimbursement methodology worked, what metrics impacted payment levels, how incentives were paid out and what triggered penalties. Our goal became to better understand and sit in the seat of the payer/stakeholder so we could identify how we could best support them in achieving their goals.

Once the reimbursement models of the payers/stakeholders were better understood, it was time to listen to what the payers/stakeholders were saying. Too often we fall into the trap of knowing what we want to present and forgetting to listen to the feedback, or to even solicit the needs and thoughts of the payers/stakeholders.

Regardless of whether you are meeting with:

- Medicare Advantage plans working on implementing new supplemental, in-home support benefits;
- Physician groups launching a Primary Care First (PCF) model;
- ACOs seeking to reduce readmissions for their most problematic diagnoses, *or*
- Managed Long Term Services and Supports (MLTSS) plans required to enter into a Value-Based Payment (VBP) risk arrangement.

It is important to plan in advance and determine what information you want and need from them to understand how you can

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Additional Information

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make a valuable contribution. Before meeting with a payer/stakeholder, taking the time to understand their programs and the likely reimbursement structure intricacies and trying to find any publicly available data that paints a picture of their member population, readmission rates, or other demographics is well worth the investment.

In a recent conversation with a health system, we were reminded of the value of an open conversation. We talked with the health system about ways we thought home care services could support their efforts based on what we knew about ACOs, readmissions by diagnoses, and social determinants of health, but they still were not sure how in-home services fit.

So, we began to ask them questions:

- What were the particular challenges they were trying to solve as a health system overall or in specific programs?
- Were there costly diagnoses that they were concerned about or that would trigger penalties?
- What were the characteristics of their complicated populations?
- How do social determinants of health impact their populations?
- What data could they share about their populations to help us better understand the landscape?

As the conversation moved beyond our presentation and shifted to the questions we thought would be helpful to have answered by the payer, it became clear that they were not used to having an in-home service provider asking them these types of questions or probing them about what they needed. At that point, the conversation shifted. The health system started to realize that we were exploring things from their perspective and working to identify how we could assist them in achieving their objectives – rather than simply talking to them about our programs and services. It became a collaborative process and the conversation remains ongoing.

IDENTIFYING ALTERNATIVE APPROACHES TO MEET PAYER'S NEEDS

It also is important to remain flexible in what we are able to offer payers/stakeholders and

to be prepared to adapt services and programs to find the right solutions to meet their needs. Potential partners are not looking for a “one size fits all” program. Payers/stakeholders need solutions that can be adapted to meet the needs of their particular populations or programs. They also are looking for provider partners that are flexible enough to make program adjustments along the way as the needs of their populations change.

Premier makes every effort to structure programs and services with as much flexibility as possible to adapt to different partners' needs. When we speak to payers/stakeholders, we know we need to be nimble enough to figure out how to change and adapt the model to meet the needs of those on the other side of the table.

For instance, some of our programs were originally developed with Managed Long Term Services and Supports (MLTSS) quality and satisfaction measures in mind. Watching the changing environment, we have adapted to fit into the transitional care models that are of interest to ACOs and other payers trying to keep members from being readmitted to hospitals, and the chronic care or supplemental in-home support models in development by Medicare Advantage plans. Remaining adaptable in a healthcare environment that no longer looks the same from program to program or payer to payer is imperative.

STAYING FLEXIBLE TO CHANGE

Home and community based care providers need to keep in mind that we are experts in what we have to offer payers/stakeholders, but must remain flexible. If payers/stakeholders do not understand how we fit into their healthcare puzzle, we must be prepared to pivot, ask for more information on the challenges that they are trying to solve, and come back again with a puzzle piece that fits.

Fortunately, home care providers have so much to offer in both post-acute and long term care environments. Payers/stakeholders are beginning to realize the valuable contributions and results they can achieve by including in-home support services in their models. In order to even begin to tell our story, we first need to understand the payers' stories and what they need help with to achieve their goals. |

Table 1

2019 Advanced Alternative Payment Models (APMs)
In Performance Year 2019, the following models are Advanced APMs:

Advanced APM	Overview
Bundled Payments for Care Improvement (BPCI) Advanced	The Bundled Payments for Care Improvement (BPCI) initiative is a model of care, which links payments for the multiple services beneficiaries receive during a clinical episode of care.
Comprehensive ESRD Care (CEC) – Two-Sided Risk	The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD).
Comprehensive Primary Care Plus (CPC+)	Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.
Medicare Accountable Care Organization (ACO) Track 1+ Model	The Medicare ACO Track 1+ is a time-limited model for Track 1 Medicare Shared Savings Program (Shared Savings Program) ACOs. The Shared Savings Program is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an ACO to provide coordinated, high-quality care to their Medicare patients. Track 1+ Model ACOs assume limited downside risk (less than Track 2 or Track 3).
Next Generation ACO Model	Building upon experience from the Pioneer ACO Model and the Shared Savings Program, the Next Generation ACO Model offers a new opportunity in accountable care – one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.
Medicare Shared Savings Program – Tracks 2 and 3	The Shared Savings Program is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an ACO to provide coordinated, high-quality care to their Medicare patients. Track 2 and 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs. Track 3 ACOs take on the greatest amount of risk but may share in the greatest portion of savings if successful.
Oncology Care Model (OCM) – Two-Sided Risk	Under the Oncology Care Model (OCM), physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.
Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)	The Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR).

Table 1. 2019 Advanced Alternative Payment Models (APMs)

Advanced APM	Overview
<p>UPDATED: Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)</p>	<p>The Vermont All-Payer Accountable Care Organization (ACO) Model is the Centers for Medicare & Medicaid Services' (CMS) new test of an alternative payment model in which the most significant payers throughout the entire state – Medicare, Medicaid, and commercial health care payers – incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the state's care delivery system and transform health care for the entire state and its population.</p>
<p>UPDATED: Comprehensive ESRD Care (CEC) Model</p>	<p>The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Through the CEC Model, CMS partners with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care.</p>
<p>UPDATED: Maryland All-Payer Model (Care Redesign Program)</p>	<p>The Care Redesign Program (CRP) is a voluntary program within the Maryland All-Payer Model that advances efforts to redesign and better coordinate care in Maryland. The CRP provides hospitals participating in the Maryland All-Payer Model the opportunity to partner with and provide incentives and resources to certain providers. In exchange, suppliers offer activities and processes that aim to improve quality of care and reduce the growth in total cost of care for Maryland Medicare beneficiaries.</p>
<p>UPDATED: Maryland Total Cost of Care Model (Maryland Primary Care Program)</p>	<p>The Maryland Total Cost of Care Model builds on the success of the Maryland All-Payer Model by creating greater incentives for health care providers to coordinate with each other and provide patient-centered care, and by committing the State to a sustainable growth rate in per capita total cost of care spending for Medicare beneficiaries.</p>
<p>UPDATED: Maryland Total Cost of Care Model (Care Redesign Program)</p>	<p>The Care Redesign Program (CRP) allows hospitals to make incentive payments to non-hospital health care providers who partner and collaborate with the hospital and perform care redesign activities aimed at improving quality of care. A participating hospital may only make incentive payments if it has attained certain savings under its fixed global budget and the total amount of incentive payment made cannot exceed such savings.</p>

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