Partnership Strategy >> Industry Insights >> Trend Analysis

THE
Remington Report®

FOR BUSINESS GROWTH AND REVENUE OPPORTUNITIES

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VOLUME 27 ▪ ISSUE 2

Special Report

STRATEGIC PLANNING

7 Guided Questions

6 External Trends

10 Challenges Ahead

In pursuit of a predictable future

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TO THE POINT

By **LISA REMINGTON**

Strategic Planning: In pursuit of a predictable future

Seven guided questions for strategic planning. Six external trends for home care companies to keep an eye on. 10 challenges ahead for home care companies.

Developing short and long range strategic plans for home care companies can be complicated and complex by changes impacting the healthcare delivery system. Strategies for short and long-term plans can be accomplished by assessing clear trends that are driving a more predictable future in healthcare and developing a plan to keep ahead of evolving trends that impact the future. How can your organization create a plan of action around predictability to invest wisely in your future?

IDENTIFYING "PREDICTABILITY"

1. How the providers changing paradigm is accelerating value- based models.
2. How dynamics of provider relationships are creating a clearer roadmap.
3. How healthcare's infrastructure and payment reform support the move into value-based payments.
4. Why the acceleration of value- based payments is here … changing your future.

The evolving market signal for all providers is the movement from "siloed" care management to integration across the continuum. This requires a relationship based on risk-sharing, clinical integration and an increase in preferred provider relationships. The healthcare industry's common goals is for providers to partner on managing quality, cost, and outcomes.

The clear market signals represents a paradigm shift for home care companies to explore new ways to deepen the value of their services, optimize efficiencies, reduce the cost of care, invest in technology and focus on quality and patient outcomes. Participating in risk/reward models is key to future sustainability.

LISA REMINGTON is President of the Remington Health Strategy Group (RHSG) & Publisher of **The Remington Report**

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Special Report

Strategic Planning

In Pursuit of a Predictable Future

Insight
Analysis
What's Ahead

Survey

In Every Issue

SOURCE: Analyzed from Bureau of Labor Statistics

7.8 Million Direct Care Job Openings

Long-term care employers will need to fill 7.8 million total direct-care job openings from 2016 to 2026, according to a new analysis from PHI. The estimate includes 3.6 million workers who will leave the labor force, 2.8 million workers who will leave the field for other occupations, and 1.4 million new positions that will need to be created because of increasing demand, said Stephen Campbell, data and policy analyst with PHI.

INDUSTRY	GROWTH	% GROWTH	SEPARATIONS	TOTAL JOB OPENINGS
HOME HEALTH AIDES AND NURSING ASSISTANTS	414,000	56%	1,058,600	1,472,600
PERSONAL CARE AIDES	619,000	50%	2,149,000	2,768,000
HOME CARE	1,033,000	52%	3,207,600	4,240,600
NURSING HOMES	4,200	1%	674,100	678,300
OTHER INDUSTRIES	345,000	19%	2,514,300	2,859,300
TOTAL	**1,382,200**	**31%**	**6,396,000**	**7 ,778,200**

Strategic Planning

IN PURSUIT OF A PREDICTABLE FUTURE

IT'S IMPORTANT TO KEEP THIS IN MIND: How can your organization create a plan of action around predictable phases to invest wisely in your future?"

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP
PUBLISHER, THE REMINGTON REPORT

Developing short and long range strategic plans for home care companies can be complicated and complex by changes impacting the healthcare delivery system. Strategies for short and long-term plans can be accomplished by assessing clear trends that are driving a more predictable future in healthcare, and developing a plan to keep ahead of evolving trends that impact the future.

In this article, we explore how your organization can strategically plan based on predictability, and how your organization can respond effectively with flexible and agility to move quickly based on evolving trends. Important to both plans is an external and internal approach.

IDENTIFYING "PREDICTABILITY" FALLS INTO TWO BROAD AREAS:

1. **How healthcare's infrastructure and payment reform support the move into value-based payments.**

2. **How dynamics of provider relationships are creating a clearer roadmap.**

How Healthcare's Infrastructure and Payment Reform Support the Move Into Value-Based Payments

The roadmap transforming the healthcare delivery system takes shape with five key examples affecting home care company's future.

1/ Payment reform transitions to support value-based care models.

The healthcare infrastructure and payment reform is accelerating value-based care payment models from fee-for-service. Provider readiness for value-based care is across the industry. For example, the home care industry is preparing for payment reform that replaces therapy-driven payments, the reduction of 60-day episodes of care to 30-day episodes of care, and home health value-based purchasing. Physician reimbursement under Advanced Alternative Payment Models (APMs) is incorporating risk to drive lower costs and an increase in quality. The final rule for Medicare Shared Savings (ACOs) accelerates timeframes and shared risk and reward in the future. The talk of mandatory bundled payment models is back on the agenda. Medicare managed care is embracing alternative payment models, and more cost-effective payment models. Health systems are preparing for greater competition and more risk by expanding the scale of their organizations.

2/ Physicians moving into more risk/ reward payments.

The shift from voluntary participation to mandatory payment models under MACRA is here. In 2019, expect to see more

7
Guided Questions for Strategic Planning

6
External Trends for Home Care Companies to Keep An Eye On

10
Challenges Ahead for Home Care Companies

physicians participate in APM models. An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Examples of an APM are accountable care organizations, bundled payment programs, or patient centered medical homes.

MACRA and APMs are game changers. Medicare, Medicaid and managed care organizations are moving quickly to support APMs. 34% of total U.S. health care payments made in 2017 were tied to alternative payment models (APMs) such as shared savings, shared risk, bundled payments or population health payments.

It's important to keep this in mind: How can your organization create a plan of action around predictability to invest wisely in your future?

"The industry market signal for all providers is the movement from "siloed" care management to integration across the continuum. This requires a relationship based on risk-sharing, clinical integration, and an increase in preferred provider relationships. The industry is transforming for providers to work together to manage quality, cost and outcomes."

In a November 2018 study in the *New England Journal of Medicine* (NEJM), half of respondents say their organization participate in ACOs. Bundled payments follow closely among value-based organizations (see page 7).

3/ Population health models begin to accelerate.

Population health takes a broad look at the management of outcomes. Components include lifetime health, disease prevention, promoting health and wellness, and a focus on determinants of health. It's the model where all providers are at risk/reward and the true Rolls Royce of a value-based payment model where the patient is at the core of care.

4/ The changing "Care Continuum Ecosystem" for payors, providers, and insurers.

The playing field for payors, providers and insurers is leveling out. The common goals each have are indicators of how home care companies will be developing partnerships and how they will need to build their internal infrastructure to effectively respond.

1. Social determinants
2. Population health
3. Behavioral health
4. Wellness vs. illness
5. A revenue shift from inpatient to outpatient
6. Investments in technology
7. Shift to value-based payments and models
8. Building continuum of care models

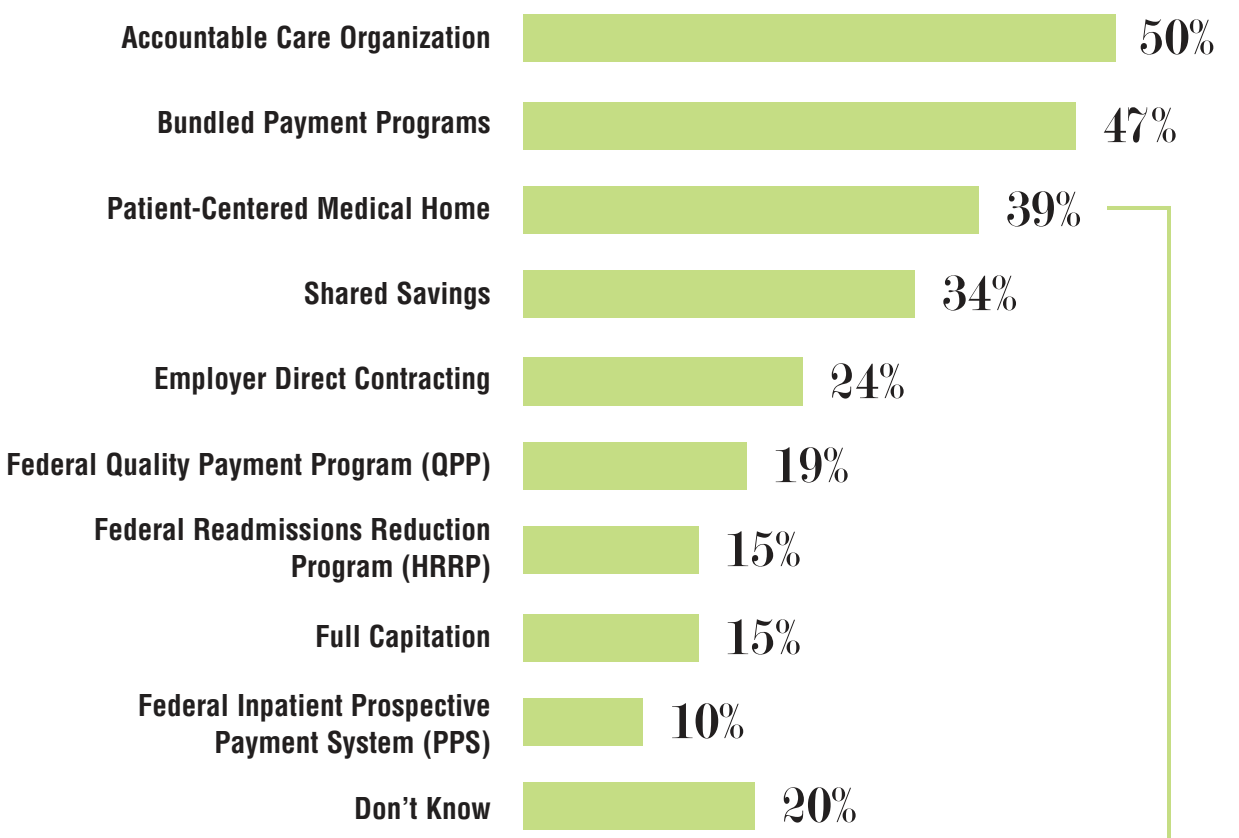
5/ Technology investments.

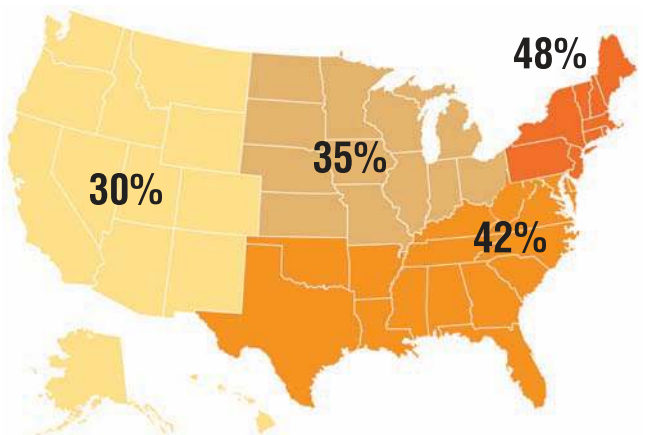
The "ecosystem" of value-based care is firming-up into four key areas. Behavioral health, social determinants, population health and managing the chronic care population. Technology investments in clinical support systems, predictive analysis, artificial intelligence, EHRs, data analytics, remote patient monitoring, digital technology, and complete suites of software solutions are important for home care organizations to consider.

Base: 522 (multiple responses)
NEJM Catalyst (**catalyst.nejm.org**) © Massachusetts Medical Society

Health Care Organizations Are Pursuing a Range of Value-Based Care Models

Which value-based care models is your organization actively pursuing?





Patient-Centered Medical Homes are more likely to be pursued in the Northeast (48%) and South (42%), than in the Midwest (35%) and West (30%).

Securing Your Future:

Effective Responses to the New Paradigm

FLEXIBILITY AND AGILITY RESPONSES

- **As other stakeholders transform their organizations into value-based care models, how flexible is your organization to respond?**
- **Do you have internal strategies in place to meet the new demand? Is the culture of your organization based on accountability?**
- **How can you "hedge" the workforce shortage by increasing technology?**
- **What is the plan to move into greater risk?**

HOW THE DYNAMICS OF PROVIDER RELATIONSHIPS ARE CREATING A CLEAR ROADMAP

The industry market signal for all providers is the movement from "siloed" care management to integration across the continuum. This requires a relationship based on risk-sharing, clinical integration, and an increase in preferred provider relationships. Providers will work together to manage quality, cost and outcomes. Here are a few examples.

1/ Payor and health system relationships.

Health plans are forging closer relationships with health systems to share risk and partner in value-based payments. In turn, this means health systems will need to have a strong continuum of care model.

The impact of a value-based model for health systems and physicians is a full "cradle to grave" care model within a fixed premium payment (eg: shared-risk, capitation, or global payments).

To better control outcomes, more focus will be on population health. The financial pressures of readmission penalties, ED visits, and managing length of stay requires a more intensive look at population health. At the top of the list is managing chronic illness, social determinants of health, and the shift from illness to wellness. Innovative partnerships will re-think how providers across the continuum can work together to manage quality, cost and outcomes.

2/ Payors and home care companies.

The blurred lines between payors and providers will continue in 2019. The deals we saw in 2018 were about market

7 Guided Questions for Strategic Planning

1. Is your organization prepared for risk-shared models? At the very top of the list is: does your organization understand the total cost of care per patient? You can't take on risk, if you don't know what your risk is.

2. Does your organization have the right technology solutions in place to evaluate your risk? Stakeholders that have increased risk will have expectations of working with organizations to partner on shared risk.

3. How is your organization responding to the changing landscape of value-based care? Is your organization prepared to partner with a changing care ecosystem?

4. Is there a conscious effort to stay small, or expand your geographic footprint? Scale/size matters. Value-based payments require scale to undertake quality initiatives that incorporate standardized clinical processes and to eliminate variations. It's a competitive move to future partnerships.

5. Are service lines and quality measures aligning with other stakeholders? Review your service lines. Are they in alignment with referral sources. Volume matters. Eliminate service lines that do not create enough volume.

6. How is your organization expanding value and new models of care to contract with payors? How are future partnerships based on risk-sharing, clinical integration, technology and data analytics. How is your organization "de-risking" the risk for payors? What's your value proposition?

7. Has your organization identified key technology investments in your strategic planning? For example, is your organization looking to invest in: clinical support systems, predictive analysis, data analytics, remote patient monitoring, EHR, digital technology, and complete suites of software solutions? This is the new era of technology for sustainability. What leading-edge technologies for population health, care coordination,data management and analytics will competitively drive your organization?

positioning for payors to either merge or acquire companies to develop a post-acute care continuum strategy. It was also a signal that payors are investing in population health management models especially in chronic care. Payors will continue to seek out home care companies as partners for Medicare Advantage strategies. Eighty-six percent of all healthcare spending is on people that have multiple chronic conditions, and payors understand a lot of those multiple chronic conditions can be cared for in sites that are outside of hospitals.

3/ ACOs and home care companies.

The recent rule for Medicare Shared Savings ACOs to take on more risk signals a few things for home care companies. ACOs will partner with more home care companies, or they will build-out their own care management models and sub-contract out home care company's services. Next Generation ACOs, the model at most risk, can use telehealth and post-discharge home visits. As the risk side accelerates for ACOs, a care continuum strategy to manage quality, cost and outcomes becomes a key strategy.

4/ Medicare Advantage Plans will continue to grow and provide greater supplemental benefits.

Over the next few years, expect to hear more announcements about expanded supplemental benefits under Medicare Advantage Plans. CMS's CMMI is testing hospice benefits, telehealth, and wellness and health care planning. This is driven by The Bipartisan Budget Act of 2018. (See timeframes for innovation on page 11.)

6 External Trends for Home Care Companies to Keep An Eye On

Included in your strategic planning are trends to keep an eye on. Here's are a few examples:

1. Expanded requirements/payment reform for social determinants
2. Mandatory bundles vs. volunteer
3. Greater supplemental benefits under Medicare Advantage
4. Alternative payment models (APMs) accelerating value-based payments
5. ACOs – expecting shared-risk models
6. Partnerships between payors and providers based on accountability and risk

10 Challenges Ahead for Home Care Companies

1. Workforce
2. Scalability
3. Shared-risk contracting
4. Market share and positioning
5. Performance improvement
6. A culture of accountability
7. Consolidation/mergers and acquisitions
8. The IMPACT Act
9. PDGM
10. Moving from fee-for-service to value-based care

The evolving market signal for all providers is the movement from "siloed" care management to integration across the continuum. This requires a relationship based on risk-sharing, clinical integration and an increase in preferred provider relationships. The healthcare industry's common goals is for providers to partner on managing quality, cost, and outcomes.

The clear market signals represents a paradigm shift for home care companies to explore new ways to deepen the value of their services, optimize efficiencies, reduce the cost of care, invest in technology and focus on quality and patient outcomes. Participating in risk/reward models is key to future sustainability.

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Medicare Advantage Plans Testing Hospice Benefit

Value-Based Insurance Design (VBID) provides future supplemental benefits for MA plans

By **LISA REMINGTON**

The Centers for Medicare & Medicaid Services (CMS) announced a broad array of Medicare Advantage (MA) health plan innovations that will be tested in the Value-Based Insurance Design (VBID) model for CY 2020.

Beginning in CY 2021, the VBID model will test the Medicare hospice benefit in Medicare Advantage. CMS will release additional information and guidance on this intervention for interested stakeholders in the coming months through the VBID model website, and through open-door forum type events.

Additionally, in order to be able to sufficiently evaluate the impact on cost and quality of these different approaches, CMS is extending the performance period of the VBID model by an additional three years, through 2024.

"Through VBID, CMS is testing how different service delivery innovations in telehealth can be used to both augment and complement an MA plan's current network of providers."

– LISA REMINGTON
PRESIDENT, REMINGTON HEALTH STRATEGY GROUP
PUBLISHER, THE REMINGTON REPORT

WHAT IS VBID?

The VBID model is being tested under the authority of the CMS Center for Medicare and Medicaid Innovation (CMMI). The model is designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, including dual-eligible beneficiaries, and improve the coordination and efficiency of health care service delivery. The changes to the VBID Model aim to contribute to the modernization of Medicare Advantage through increasing choice, lowering cost, and improving the quality of care for Medicare beneficiaries.

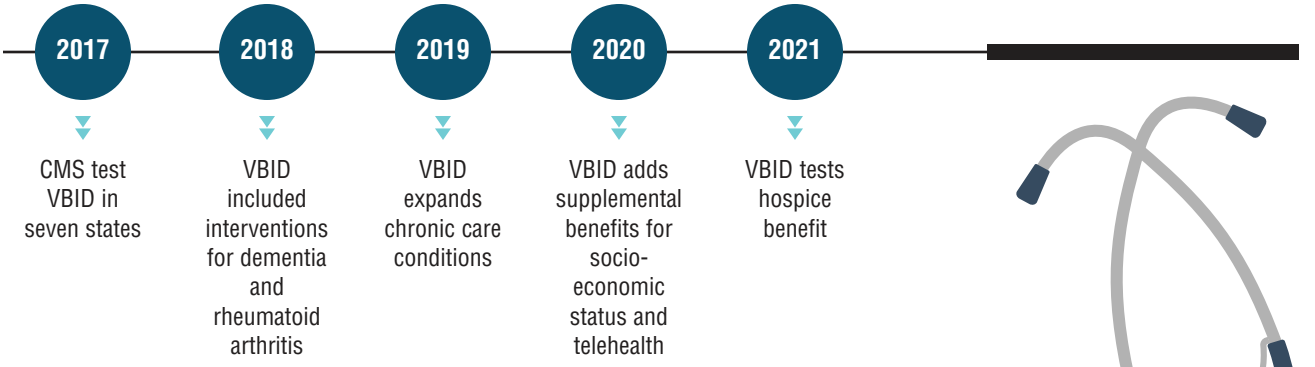
VBID MODEL FOR CY 2020 AND SUBSEQUENT YEARS

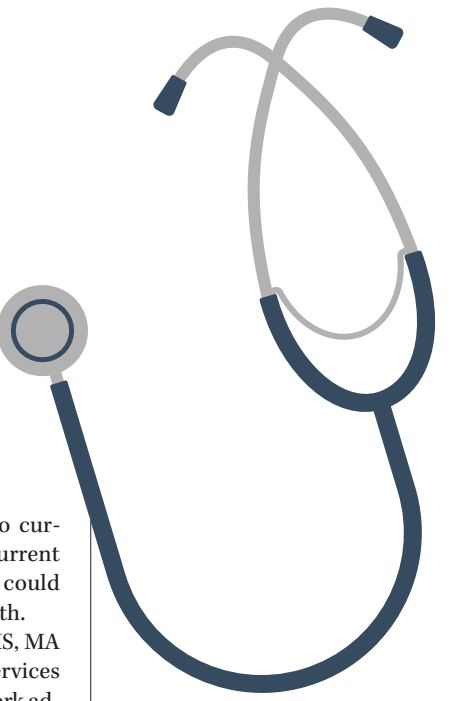
For CY 2020 and subsequent years, CMS is testing the following health plan innovations in Medicare Advantage through the VBID model. The new interventions described below represent a broad array of value-based approaches to service delivery in MA.

- **Value-Based Insurance Design by Condition and/or Socioeconomic Status**

Beginning in CY 2020, participating MA plans may propose offering reduced cost-sharing or additional supplemental benefits, including for "non-primarily health related" items or services, for enrollees based on chronic condition, socioeconomic status determined by qualifying for the low-income subsidy and/or having dual-eligible status, or both. Plans may also propose allowing addi-

VBID Model





tional "non-primarily health related" supplemental benefits for all enrollees by disease state, regardless of socioeconomic status.

• Rewards and Incentives

In order to enable more meaningful rewards and incentives that effectively influence healthy behaviors, CMS is testing the impact of permitting broadened Medicare Advantage and Part D Rewards and Incentives (RI) programs. Specifically, plans may propose RI programs with allowed values that more closely reflect the expected benefit of the health related service or activity, up to an annual limit, to better promote improved health, prevent injuries and illness, and promote the efficient use of health care resources.

Participating MA plans that offer a Prescription Drug Plan (MA-PDs) may also offer RI programs for enrollees who take covered Part D prescription drugs and who participate in disease state management programs, engage in medication therapy management with pharmacists or providers, receive preventive health services, and actively engage in understanding their medications, including clinically-equivalent alternatives that may be more cost-accessible.

• Telehealth Networks

Through this intervention, CMS is testing how different service delivery innovations in telehealth can be used to both augment and complement an MA plan's current network of providers, as well as how access to telehealth services may appropriately allow MA plans to expand their service area to currently underserved counties where current MA network adequacy requirements could not be met without the use of telehealth.

Where deemed appropriate by CMS, MA plans may propose using telehealth services in lieu of in-person visits to meet network adequacy requirements. Organizations must ensure that enrollee choice is preserved and that enrollee access to an in-person visit, if that is the enrollee's preference and choice, is maintained. CMS expects that this will provide MA plans with an opportunity to enter into underserved markets, including rural areas where there may be few to no MA plan choices. ▸▸

TWO DIFFERENT APPROACHES CMS IS TESTING ARE?

1. **How plans can use telehealth services to complement and augment their current network of providers, including proposals where telehealth networks may comprise up to one-third of the required in-network providers for a specialty or specialties; and**

2. **How the use of telehealth services allows MAOs to offer a broadened service area, including counties where the choice of an MA plan may not have previously been able to be offered.**

"Beginning in CY 2021, the VBID model will test including the Medicare hospice benefit in Medicare Advantage."

WELLNESS AND HEALTH CARE PLANNING

Organizations participating in VBID, working with their network of providers, will be required to offer enrollees improved, timely access to Wellness and Health Care Planning (WHP), including advance care planning. Each MA organization applying for the VBID model must submit its proposed approach to WHP for their enrollees as part of the application.

Through the VBID model, CMS will evaluate the impact on quality and cost of best practices for performing WHP in the Medicare Advantage population.

The VBID model began in January 2017 testing the impact of providing eligible Medicare Advantage plans the flexibility to offer reduced cost sharing or additional supplemental benefits to enrollees with select chronic conditions, focusing on the services that are of highest clinical value to them. The model tested whether providing this flexibility could improve health outcomes and reduce expenditures for Medicare Advantage enrollees.

In 2017, CMS tested the VBID model in seven states, Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee, and allowed testing of VBID interventions for the following disease states: diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), past stroke, hypertension, coronary artery disease, mood disorders, and combinations of these categories.

In 2018, CMS updated the model to include Alabama, Michigan, and Texas and also allowed for VBID interventions for dementia and rheumatoid arthritis.

For 2019, CMS updated the model to include organizations in fifteen additional states, California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia to apply and allowed participants to propose a methodology that either:

1. **Identifies enrollees with different chronic conditions than those previously established by CMS, or**
2. **Revises the existing approved CMS chronic condition category to focus on a broader or smaller subset of the existing chronic condition.**

The Bipartisan Budget Act of 2018 required that the model be revised to include all 50 states and territories by 2020. Consistent with these requirements, eligible Medicare Advantage health plans in all 50 states and territories may apply for the health plan innovations being tested under the VBID model for CY 2020.

+ REFER TO THE VBID CY 2020 REQUEST FOR APPLICATIONS FOR ADDITIONAL DETAIL ON 2020 INTERVENTIONS, AS WELL AS HOW TO APPLY AT https://innovation.cms.gov/ initiatives/vbid

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"As we seek to create a health care system that truly rewards value, we must consider the impact that factors beyond medical care have in driving up health costs. That's why many states are beginning to think about ways to better address the root cause of chronic illness. As part of this demonstration, North Carolina will implement a groundbreaking program in select regions to pilot evidence-based interventions addressing issues like housing instability, transportation insecurity, food security, interpersonal violence and toxic stress." – Seema Verma, CMS Administrator

Groundbreaking pilot to address social determinants to promote value and evidence-based interventions

By **LISA REMINGTON**

In October 2018, CMS approved North Carolina's 1115 waiver for a five-year demonstration period. The waiver provides the North Carolina Department of Health and Human Services (DHHS) authority to transition its fee-for-service delivery system to a managed care program and, as part of the transition, important flexibility to implement a groundbreaking pilot program in select regions to promote value through evidence-based interventions designed to address non-medical factors that drive health outcomes and costs.

North Carolina will launch "Healthy Opportunity Pilots" in two to four geographic areas of the state to test evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid beneficiaries.

This transition toward whole person care includes the authority to create Tailored Plans to serve people with intellectual/developmental disabilities (I/DD) or higher intensity behavioral health needs and a specialized behavioral health home model to ensure strong care management for those individuals. To support broader state efforts to combat the opioid crisis and improve access to treatment, DHHS received authority to implement new flexibilities that allow for treatment of substance use disorder in institutions of mental disease (IMD).

The federal government has authorized up to $650 million in state and federal Medicaid funding for the pilots over the five-year life of the waiver, including capacity-building funding in the early years to support the launch of the project. PHPs will implement the pilots in collaboration with a network of human service organizations (e.g., community-based organizations and social services agencies) established and overseen by Lead Pilot Entities (LPEs).

Pilot Services Offered to Improve Health

- Housing Modifications
- Improved Access to Healthy Foods
- Addressing Interpersonal Violence

"Over time, payments made for pilot services will be increasingly linked to improvements in enrollees' health outcomes."

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP, PUBLISHER, THE REMINGTON REPORT

CARE MANAGEMENT

North Carolina's Medicaid managed care plans, called PHPs, will be central to the Healthy Opportunity Pilots. PHPs will work closely with their communities and LPEs to operate the pilots and will be ultimately responsible for managing pilot enrollees' care – considering their physical, behavioral, social, and pharmacy needs. Having PHPs and their care managers own this responsibility will promote integrated, whole-person health. Many of the PHP

responsibilities will be shared with their designated care managers located in the community. Under NC Medicaid managed care, PHPs will delegate some care management functions to advanced medical homes and local health departments. Embedding the pilot activities within the PHP and their care management infrastructure will promote sustainability and facilitate statewide implementation when the five-year demonstration ends.

PHP and care manager key pilot-related responsibilities will include:

- **Identifying Eligible Beneficiaries.** PHPs will leverage their community-based care managers to identify those in need and determine beneficiary eligibility for initial and ongoing pilot services.
- **Assessing for Needed Services.** PHPs and their care managers will determine which services to provide to a pilot enrollee from a pre-defined set of cost-effective and evidence-based interventions. The services will be delivered by human services organizations.
- **Managing the Pilot Budget.** Each PHP will have a capped allocation of funding to spend on pilot services outside of its Medicaid managed care capitation rate. PHPs will be highly incented to spend pilot dollars wisely, as improvements in their enrollees' health and reductions in their health care costs will boost PHPs' performance. In addition, DHHS will establish parameters to ensure that dollars are spent on both services that are likely to result in decreased medical expenses in the short-term, but also on effective, evidence-based interventions that result in a financial return on investment over the longer-term.
- **Collecting and Submitting Data.** PHPs will be responsible for collecting and submitting data to DHHS to support real-time, rapid-cycle assessments; a summary evaluation of the demonstration's final outcomes; and ongoing program oversight.

Simple, cost-effective interventions like these can result in marked improvements in health for North Carolinians, while simultaneously reducing health care spending.

How DHHS Will Ensure Pilots Are Effective

To ensure accountability for state and federal dollars, North Carolina will:

- **Employ Rigorous Evaluation.** North Carolina will execute a formal summative evaluation on the final outcomes of the demonstration and conduct rapid cycle assessments to gain insights into pilot impact in as close to real time as possible. The findings from rapid-cycle assessments will help to identify which interventions are most and least effective, enabling North Carolina to shift pilot dollars to interventions with a demonstrated impact on cost and outcome.
- **Link Payments to Outcomes.** Over time, payments made for pilot services will be increasingly linked to improvements in enrollees' health outcomes.
- **Implement Course Corrections.** Throughout the demonstration, DHHS will modify or discontinue initiatives that are less effective and shift dollars to interventions with a demonstrated impact on cost and outcomes.

Medicaid cannot directly pay for additional services — that's outside the program's scope. But, The North Carolina experiment does represent a way for the state and federal health insurance program to encourage a more comprehensive approach to health care. North Carolina's pilot program could feed into CMS's larger goal of ultimately reducing Medicaid spending and enrollment.

IN 2017: 19 STATES REQUIRED MEDICAID MANAGED-CARE ORGANIZATIONS TO SCREEN PATIENTS FOR SOCIAL NEEDS AND/OR REFER THEM TO SOCIAL SERVICES.

Reducing hospitalizations using community-based health coaches

By **SCOTT W. PERKINS, ALEXSANDRA DAVIS, MPA, BSN, RN., PAUL R. NIELSEN, MD, MS., AMY S. JOLLIFF, MD**

Improving care of at-risk patients with chronic conditions

In the photo: far right – Scott Perkins, Health Coach, AlexSandra Davis, Director CCN, Amy Jolliff, MD and Paul Nielsen, MD, co-medical directors of the program.

CHRONIC DISEASE MANAGEMENT: CHALLENGING AND WIDESPREAD

Chronic diseases, including mental health conditions, are common and widely managed by family and primary care physicians. According to the National Center for Chronic Disease Prevention and Health Promotion, they are the leading cause of death and disability in the United States.[1] Additionally, chronic diseases such as heart disease, stroke, cancer, diabetes, arthritis, and Alzheimer's disease account for 86% of the United States' $2.7 trillion in annual health care expenditures, making them a serious public health concern.[2] Managing multiple chronic conditions can be challenging for patients and care providers, especially when patients are not medication compliant or have other complicating factors such as a low income, lack of education, or lack of a support system. The combination of multiple chronic conditions and complicating factors can lead patients to be at-risk for frequent emergency department usage, hospitalization or death.

Complicating factors cannot always be adequately addressed during a 10-minute doctor's office visit, making the role of a community health worker (CHW) valuable. The U.S. Bureau of Labor Statistics reports that community health workers (CHWs) can help individuals and communities adopt healthy behaviors by:

1 **Conducting outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health**

2 **Providing information on available resources**

3 **Providing social support and informal counseling**

4 **Advocating for individuals and community health needs**

5 **Providing services such as first aid and blood pressure screening**

6 **Collecting data to help identify community health needs**[3]

Community health workers have worked in underserved populations since the 1960s,[4] but have recently been the subject of interest due to their ability to serve as an extension of nurses and other care providers.[5] CHWs, under the supervision of medical professionals, make home visits, identifying complicating factors and providing the patient with additional help, resources, and support.

Unhealthy food in a patient's refrigerator, bottles of unused pills, or a foul smell in a patient's home can indicate poor nutrition, medication noncompliance, or a lack of cleanliness. After identifying these factors, a CHW can help the patient by either addressing these problems during a home visit, or by connecting the patient with appropriate resources such as a dietician or social worker.

In order to improve care of at-risk patients with chronic conditions, the Wooster Community Hospital of Wooster, Ohio, developed the Wooster Community Care Network (WCCN) in 2013. The WCCN uses college students as CHWs, and the structure, function, and preliminary outcomes of this program were previously reported.[6] After receiving a semester of training from the WCCN, students at The College of Wooster become "health coaches" and make weekly home visits to high-risk patients in the Wooster area, helping these patients manage their chronic conditions and reach health goals.

The WCCN serves as a community-clinical link, one element of population chronic disease management that the U.S. Centers for Disease Control and Prevention describe as "ensur[ing] that people with or at high risk of chronic diseases have access to quality community resources to best manage their conditions."[7] By serving as such a link, the WCCN assists primary care physicians in managing chronic conditions.

This type of program has the potential to improve the quality and effectiveness of chronic disease management by using college-student health coaches as extensions of primary care physicians. Based on the success of the WCCN, we believe that college-student CHWs can help primary care physicians better care for high-risk patients, particularly those with many chronic conditions and complicating factors. This article reports recent outcomes from the WCCN, which suggest that programs like the WCCN could provide significant cost savings to patients and health systems, reduce patient hospitalizations and emergency department visits, improve patient health, and improve the quality of care for high-risk patient populations.

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PROMISING RESULTS

From the December 2013 to July 2018, the WCCN admitted 289 patients and discharged 168. Patient reception of the program has been overwhelmingly positive, with only 1% of discharged patients reporting leaving due to dissatisfaction with the program. Several factors may contribute to high patient satisfaction.

Many patients appreciate the social interaction provided by a health coach visit. Not only do coaches provide medical coaching –

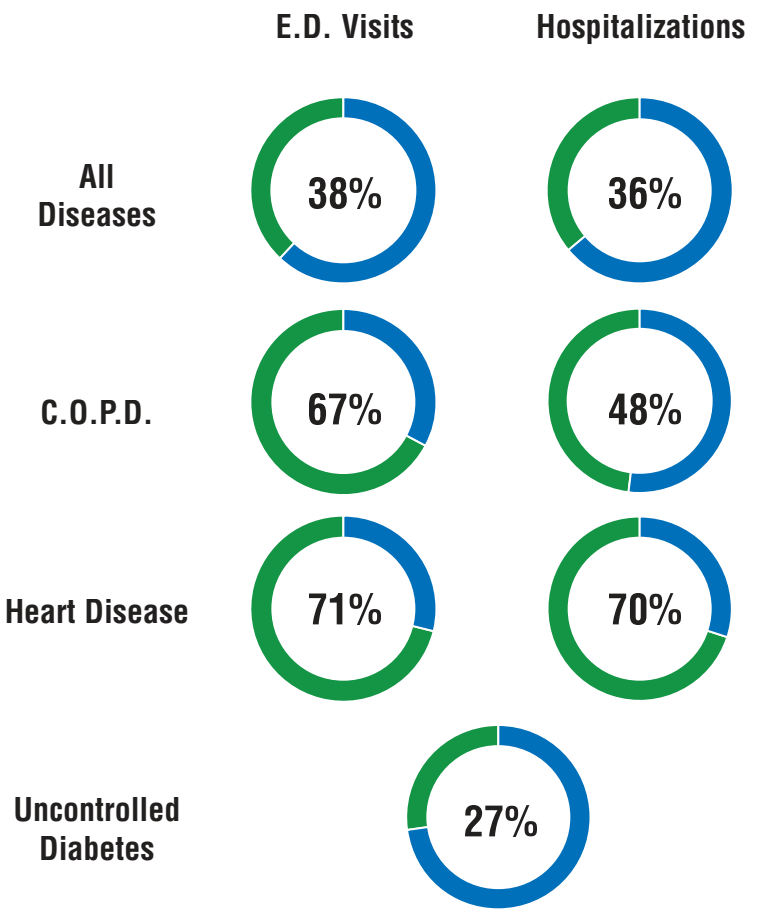

Fig. 1. Percent decrease in number of emergency department visits per year, number of hospitalizations per year, and rates of uncontrolled diabetes (HgA1C > 9) of WCCN patients.

they also provide company and conversation for patients who might otherwise not have much social interaction. This is not only gratifying for a patient, but also allows the primary care physician to use information collected by a health coach to obtain a more complete understanding of a patient's situation.

Patients also enjoy the personalized help and attention a heath coach provides. For patients who need it, a coach can help with tasks such as calling in medication refills, scheduling doctor appointments, and arranging transportation to and from the doctor's office. Patients appreciate and benefit from these services, which better enable them to manage their chronic conditions.

The remainder of discharged patients left the WCCN for a variety of reasons. Of all patients discharged:

1 **Thirty one percent needed more specialized care and moved to assisted living or hospice facilities. These patients had chronic conditions which progressed to the point where more skilled care was required, or needed more frequent attention as they aged.**

2 **Eleven percent met their health goals with the help of their health coach and no longer needed the program's support.**

3 **Eighteen percent died while in the program.**

4 **Thirty-two percent left due to personal circumstances such as moving out of the Wooster area or feeling a lack of need for the program's assistance, not due to program dissatisfaction.**

5 **Seven percent were dismissed by the WCCN due to patient refusal to cooperate with health coaches.**

It would be beneficial to increase the number of patients able to be discharged due to achieving health goals and no longer needing the assistance of a health coach. These discharge statistics show that the WCCN has been successful at supporting patients while they are in the program, but enabling patients to be self-sufficient has proved to be much more difficult. WCCN services have been well received by patients, and these services have helped patients improve their health while in the program.

Measurable Patient Health Improvements: Diabetes, COPD, Heart Disease, and Hospital Use

Among adults, diabetes is the leading cause of new cases of blindness, kidney failure, and lower-limb amputations other than those caused by injury.[8] Comparison of patient HgA1C data before and one year after enrolment in the WCCN shows a 27% reduction in the number of patients with uncontrolled diabetes (HgA1C > 9), which translates into greater health for patients, as well as reduced risk for more serious conditions in the future.

Patients enrolled in the WCCN also experienced (Fig. 1):

1. A thirty-eight percent decrease in number of emergency department visits annually

2. A thirty-six percent decrease in number of hospitalizations annually

3. A sixty-seven percent decrease in COPD-related emergency department visits

4. A forty-eight percent decrease in COPD-related hospitalizations

5. A seventy-one percent decrease in heart-related (chest pain, atrial fibrillation, congestive heart failure, and syncope) emergency department visits

6. A seventy percent decrease in heart-related hospitalizations

"This type of program has the potential to improve the quality and effectiveness of chronic disease management by using college-student health coaches as extensions of primary care physicians."

Percent decrease was determined by comparing numbers of patient hospitalizations and emergency department visits in one-year time periods before and after enrollment in the WCCN. This reduction in hospital utilization represents cost savings for the patient if the patient's insurance does not completely cover hospital or emergency department visits. This also indicates an increase in patient health and an increased stability of patient conditions. Reduced usage may be attributable to the ability of a health coach to notice warning signs and alert doctors before a patient requires emergency attention. Health coaches can also notice patient habits that could result in hospitalization, and work to help the patient make lifestyle changes before the habits cause more serious problems.

Conclusion

IMPROVING CHRONIC CONDITION MANAGEMENT FOR HIGH-RISK PATIENTS

The outcomes of the WCCN so far suggest that the program could be an important part of improving patient health and helping family practitioners effectively manage chronic conditions. Patients in the city of Wooster and the surrounding area have benefited from the individualized care and attention that the WCCN has provided, and decreased rates of uncontrolled diabetes and hospital and emergency department utilization have been observed. By using college students as health coaches, high-risk patients have been given assistance managing chronic conditions and risk factors, aiding primary care physicians and improving quality of care.

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The true spirt of home care

How a home health aide handled a bear in the bathtub

By **ELIZABETH HOGUE,** *Attorney*

Some of you may recall an account of what I call "the true spirit of home care," as follows:

A home health aide in Maine visited a patient in the dead of winter. The main room of the patient's home was heated by a wood stove while the doors to the remainder of the rooms were closed, including the door to the only bathroom. The aide prepared to give the patient a bath. When she entered the bathroom, she found a dead bear in the bathtub. This was not surprising to her because she knew that the bear was part of a source of food for the patient and family during the winter. But how was she going to give the patient a bath with a bear in the only bathtub?

The aide had a Hoyer lift that she used for the patient and quickly realized that she could use the lift for the bear, too. So she used the lift to remove the bear from the bathtub and move the patient into and out of the bathtub. Then she used the lift again to put the bear back in the bathtub where it "belonged."

Together EVERYONE ACHIEVES MORE!

And this, my friends, is part of the true spirit of home care! It's that "can do" attitude that says we will do whatever is necessary to meet the needs of our patients. "Whatever it takes" might be the motto of many home care providers. There is another aspect of the true spirit of home care that is equally important.

Recently, an agency needed an experienced staff member to assist with billing on a part-time basis, but wasn't having any luck identifying such a person. A competitor employed an experienced biller who worked only four days per week. When the competitor heard about the need for an experienced biller, the competitor volunteered its biller to the agency.

And this, my friends, is also what the true spirit of home care is all about: the willingness to assist fellow providers, even competitors, with crucial functions of agency operations.

Generosity of spirit; graciousness; value clearly placed on relationships with fellow providers and the success of the industry as a whole.

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C-level management opportunities to learn and freely problem solve with the same-sized organizations. Facilitated in a shared-learning environment, peer-to-peer mentoring incites strategy planning and accelerates change. **The goal:** to leverage strengths, increase tangible value, improve patient-centered care, and leverage core competencies.

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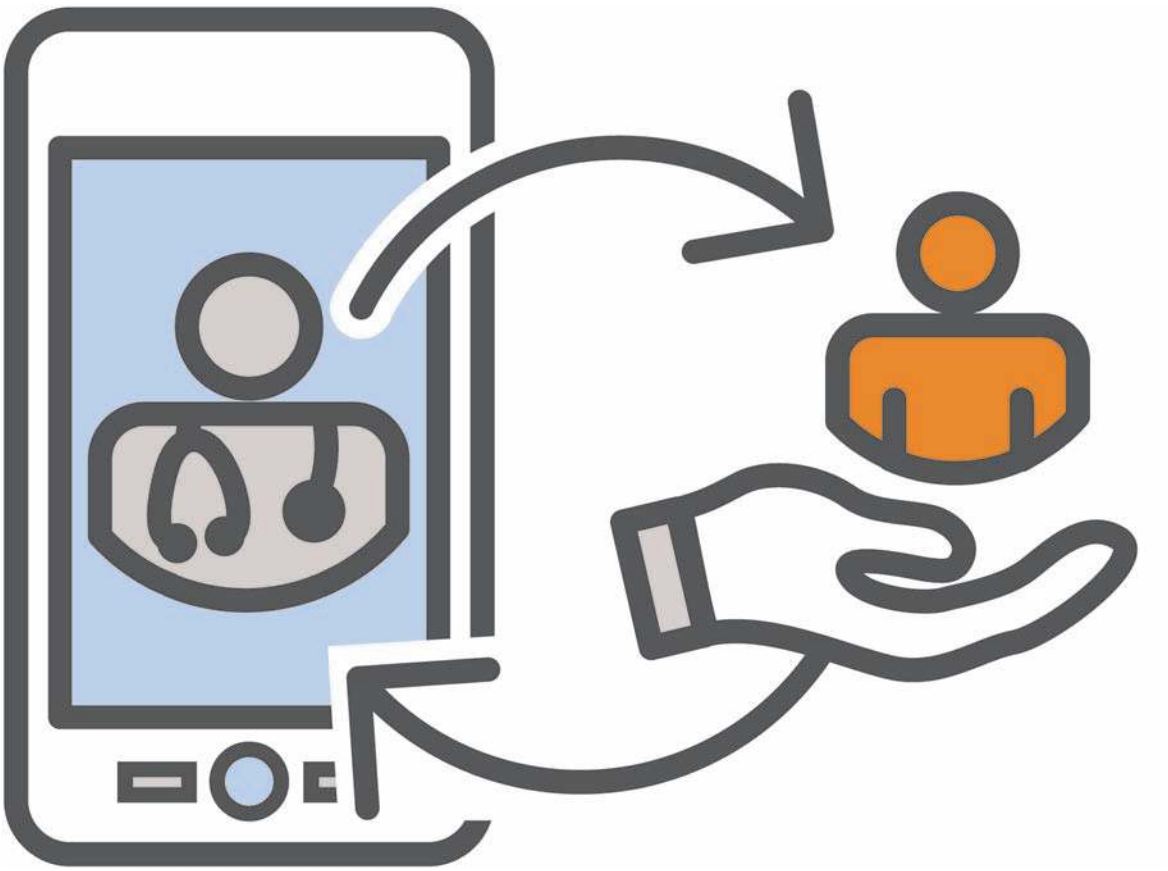
CaseStudy

Sustaining Telehealth in the Home Health Industry



THE STUDY SHOWED $318,500 IN SAVINGS BASED ON $2,818 AS THE AVERAGE RATE OF EMERGENCY CARE IN MAINE

By **MIA MILLEFOGLIE**

REMOTE PATIENT MONITORING: AN EVIDENCED BASED MODEL OF CARE

Evidence in support of remote patient monitoring (RPM) services is widespread. An extensive meta-analysis of studies by the Agency for Healthcare Research and Quality (AHRQ) focused on the use of RPM in the management of chronic cardiovascular and respiratory conditions and found "the most consistent benefit has been reported when telehealth is used for communication and counseling or remote monitoring in chronic conditions such as cardiovascular and respiratory disease, with improvements in outcomes such as mortality, quality of life, and reductions in hospital admissions."[1] Considering the broad scope of the study it would be safe to assume that RPM is a beneficial addition to normative care in most patients.

A California-based study looked into the 30-day, 90-day, and 180-day re-admission rates of patients with Chronic Obstructive Pulmonary Disease (COPD) and/or Heart Failure (HF) following an acute event. The researchers reported, "Program patients showed 50% reduction in 30-day re-admission and 13-19% reduction in 180-day re-admission compared with control patients. There was no significant difference in ED utilization. Patients were satisfied with telemonitoring services, and functional status improved by program end."[2] The significant (50%) reduction in 30-day re-admission rates shows that RPM administered immediately after hospital discharge is very effective reducing the rate of re-admission.

MAINEHEALTH CARE AT HOME: A CASE STUDY

MaineHealth Care at Home (MHCAH) is an early adopter of telehealth with more than seventeen years' experience with integrating technology in the delivery of home health care. For MHCAH, the state's demographic profile served as the initial catalyst to incorporate telehealth as a method to expand access to care across a large and predominantly rural service region that held the largest elderly population in any one region of Maine.

According to the US Census, Maine has the oldest population in the country, with a median age of 43 compared to 37 for the United States.[3] In Maine, healthcare challenges are compounded by adverse trends in chronic disease, a predominantly rural landscape, and significant levels of poverty. America's Health Rankings' 2017 annual report found that cardiovascular deaths in the state of Maine increased from 215.4/100,000 to 227.4/100,000 over three years, from 2014 to 2017. This increase, 12 persons per 100,000, is significantly greater than the reported increase in the nation's cumulative cardiovascular death total during these three years of 3.2 persons per 100,000.[4] These troubling figures provide evidence to support the fact that Maine communities are increasingly susceptible to cardiovascular events leading to death. Maine also is amongst the poorest states in the country. Maine seniors, ages 85 and older, have poverty rates 50 percent higher than younger Maine seniors.[5]

In 2001, MHCAH (formerly HomeHealth Visiting Nurses) launched southern Maine's first telehealth demonstration project with grant support from Rural Utilities Services-USDA. This project introduced interactive video monitoring units, augmented with traditional home health services, to patients diagnosed with advanced congestive heart failure in remote areas of Maine. Early results showed reductions in costly hospital re-admissions and high patient satisfaction rates; however, "buy-in" from clinician staff and the physician community presented challenges to expansion. Recognizing the need to secure engagement, the agency launched an outreach campaign to the medical community and migrated to a new platform that offered a simplified installation process, patient-friendly color touch monitors, and portals for the exchange of information with healthcare providers.

From 2007 through 2014, MHCAH sustained its telehealth efforts through grants from USDA-RUS and local foundations that provided funds to deploy telehealth units to more than a thousand patients with advanced chronic disease. Consistently, telehealth patients experienced significantly lower rates of hospitalization, lower rates of emergent care, and improved ability to manage their chronic conditions when compared to home health patients who did not receive telehealth. During this period, MHCAH collaborated in a pilot project with MaineHealth, a not-for-profit health system in Maine, on a Home Diuretic Protocol for Heart Failure. The project aimed to demonstrate that interventions to avoid

"MaineHealth Care at Home (MHCAH) is an early adopter of telehealth with more than seventeen years' experience with integrating technology in the delivery of home health care.

For MHCAH, the state's demographic profile served as the initial catalyst to incorporate telehealth as a method to expand access to care across a large and predominantly rural service region that held the largest elderly population in any one region of Maine."

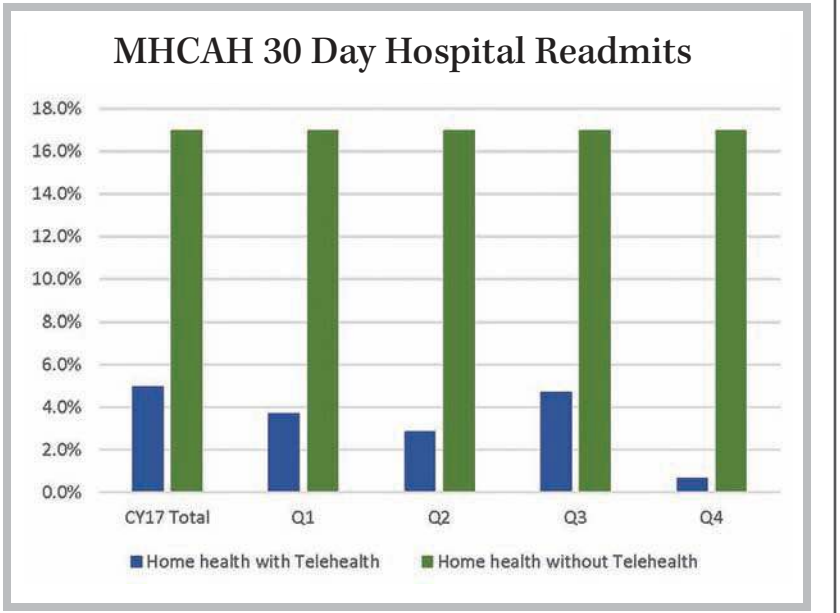
– MIA MILLEFOGLIE, VP DEVELOPMENT AND MARKETING, MAINE-HEALTH CARE AT HOME

hospitalizations could be delivered safely and effectively in the home. Interventions included home-based nursing care augmented with telemonitoring services and IV diuretic protocols. Pilot findings resulted in lower hospital re-admission rates from 20.5% to 10%.[6] Telehealth technology was central to the success of this program as it provided caregivers the ability to assess evidence of volume overload and unstable vital signs at the earliest juncture. This project also marked a milestone for solidifying a telehealth partnership between the agency and affiliated healthcare providers that mandated the provision of telehealth in its protocol.

In 2015, the agency experienced vendor and equipment challenges that led to an expedited vendor search and a transition to another solution partner. This platform utilizes an android tablet with 4G internet, wireless monitoring devices, self-assessment features, medication compliance modules, disease-specific educational video clips, and the ability for patients to quickly connect via voice or video to monitoring nurses. Caregivers and assigned family members can view the patient's activity in the program as a measure of engagement. To further advance its work on provider coordination and communication, MHCAH finalized an HL7 integration with MaineHealth's shared electronic medical record for the transmission of demographics and biometrics.

In its first year with our solution partner, the agency achieved a 75% reduction in overall 30-day hospital readmissions. Telehealth patients (N. 478) experienced an average rate of 4.2% for hospital readmissions compared to the state average of 16.6% for hospitalization within a thirty-day period. Primary diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes, and post-surgical cardiac patients. As a measure of engagement, patients spent an average of 24.6 minutes a day watching educational videos, answering teach-back questions, reviewing biometric data, participating in video calls, and accessing their personalized care plan.

In 2017, MHCAH expanded its telehealth efforts and enrolled 725 patients who realized 30-day hospital admissions in the range of .07% – 5% per quarter when compared to non-telehealth patients with 17% re-admission rates. In this cohort, the average daily adherence for patients taking biometric readings was 85%. Patient satisfaction scores were in ranges of 3.35 – 4.0 (four =highest) for responses related to ease of use, willingness to recommend and how telehealth is helping manage disease.



Although MHCAH did not conduct formal studies on its telehealth initiatives, internal comparisons were completed on hospitalization rates for two groups in 2017: Group A: All Medicare patients on traditional home health services and Group B: Medicare patients on traditional home health services supplemented with telehealth. Group A realized an average re-hospitalization rate of 17% within a 30-day period; Group B realized an average re-hospitalization rate of 2.3%. This comparison showed $475,000 in avoided hospitalization charges. In calculating savings for emergent care, MHCAH compared the agency's average rate for emergency care for all Medicare patients on home health services at 14.5% against the average rate of 2.3% for patients with traditional home health services supplemented with telehealth. This comparison showed $318,500 in savings based on $2,818 as the average rate of emergency care in Maine.[7]

Reimbursement Challenges and Opportunities for the Home Health Industry

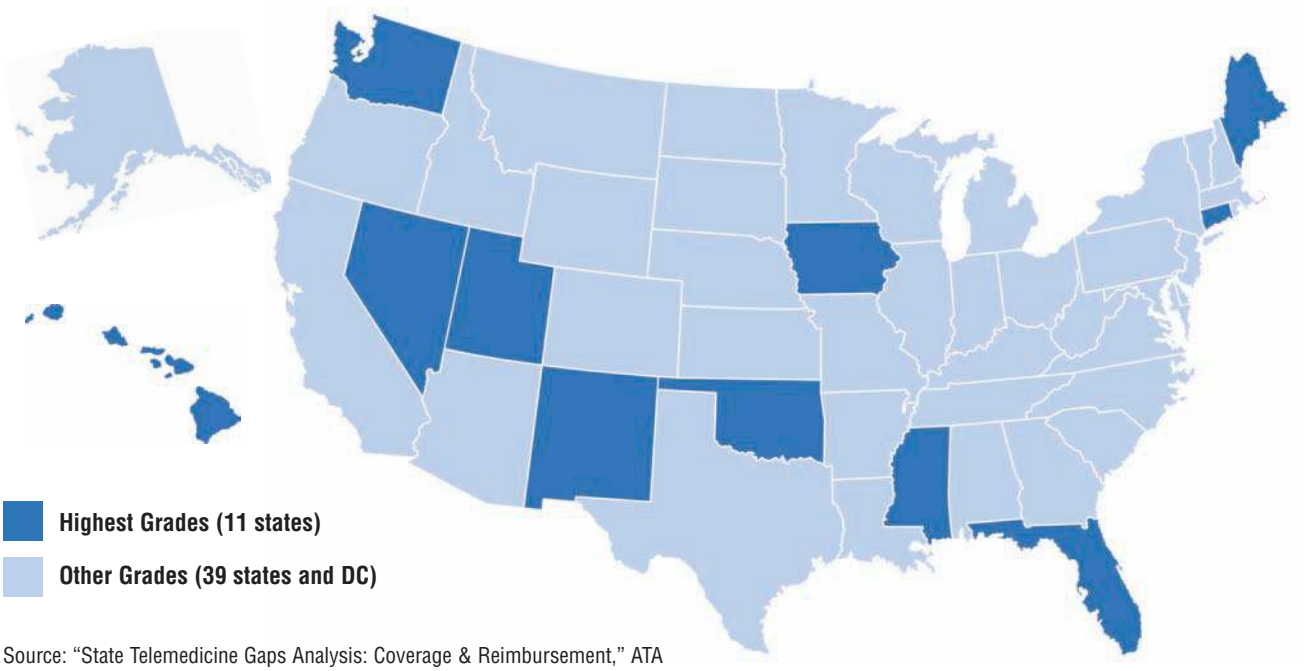
Despite the success and the opportunities for advancing telehealth, the limitation in reimbursement is a significant barrier for the home health industry. Among government payers, Medicare is the most restrictive and offers limited coverage for telehealth in the home health environment. In its payment policy, Medicare defines eligible telehealth services as "interactions between a healthcare professional and a patient via real-time audio-video technology."[8] Although Centers for Medicare and Medicaid (CMS) acknowledges "effective adoption and use of health information exchange and health IT tools will be essential ... [to] improve quality and lower costs," home health agencies were ineligible for incentive programs that allowed other healthcare providers to support the significant cost of deploying technology.[9] As a result, home health agencies absorb the associated costs in deploying telehealth, subsidize their efforts through federal and local grants, and/or offset costs through operations.

Proposed changes for 2019 indicate that the CMS landscape is changing and would offer significant opportunities for the home health industry. Currently, CMS recognizes RPM when it is a part of the home health plan of care and does not substitute for in-person care; however, the cost of RPM is not separately billable under the Home Health Prospective Payment System under Medicare. As a result of this restriction, the agency must subsidize RPM when independent of other care.[10]

A proposal for 2019 seeks to amend the regulations at 42 CFR 409.46 that would allow home health agencies to augment the care planning process with RPM and report these associated costs as part of operating expenses in the cost report. As such, RPM would not be considered a billable service itself, but would be part of the comprehensive service that is billable as a whole. This change would have important implications for assessing home health costs relevant to the Medicare payment model, as the cost-efficiency of RPM would now be more pronounced. >>

"This partnership launched Connected Care Clinics offering on-site, pre-scheduled video visits with a nurse to conduct multi-dimensional individual health/risk assessments to ascertain health challenges, goals, needs, and deficits including psychosocial/ behavioral health concerns."

Medicaid Coverage



Source: "State Telemedicine Gaps Analysis: Coverage & Reimbursement," ATA

Effective January 2018, CMS also began reimbursing providers for RPM services under CPT code 99091. This decision to directly subsidize RPM services on a monthly recurring basis signifies another shift in the way Medicare policy views this service. Although the application of the code only benefits physicians directly, the American Medical Association's Editorial Panel has determined that this code (CPT 99091) is outdated in its applicability to modern RPM technology and has begun working on an update or replacement.

STATE MEDICAID PROGRAMS

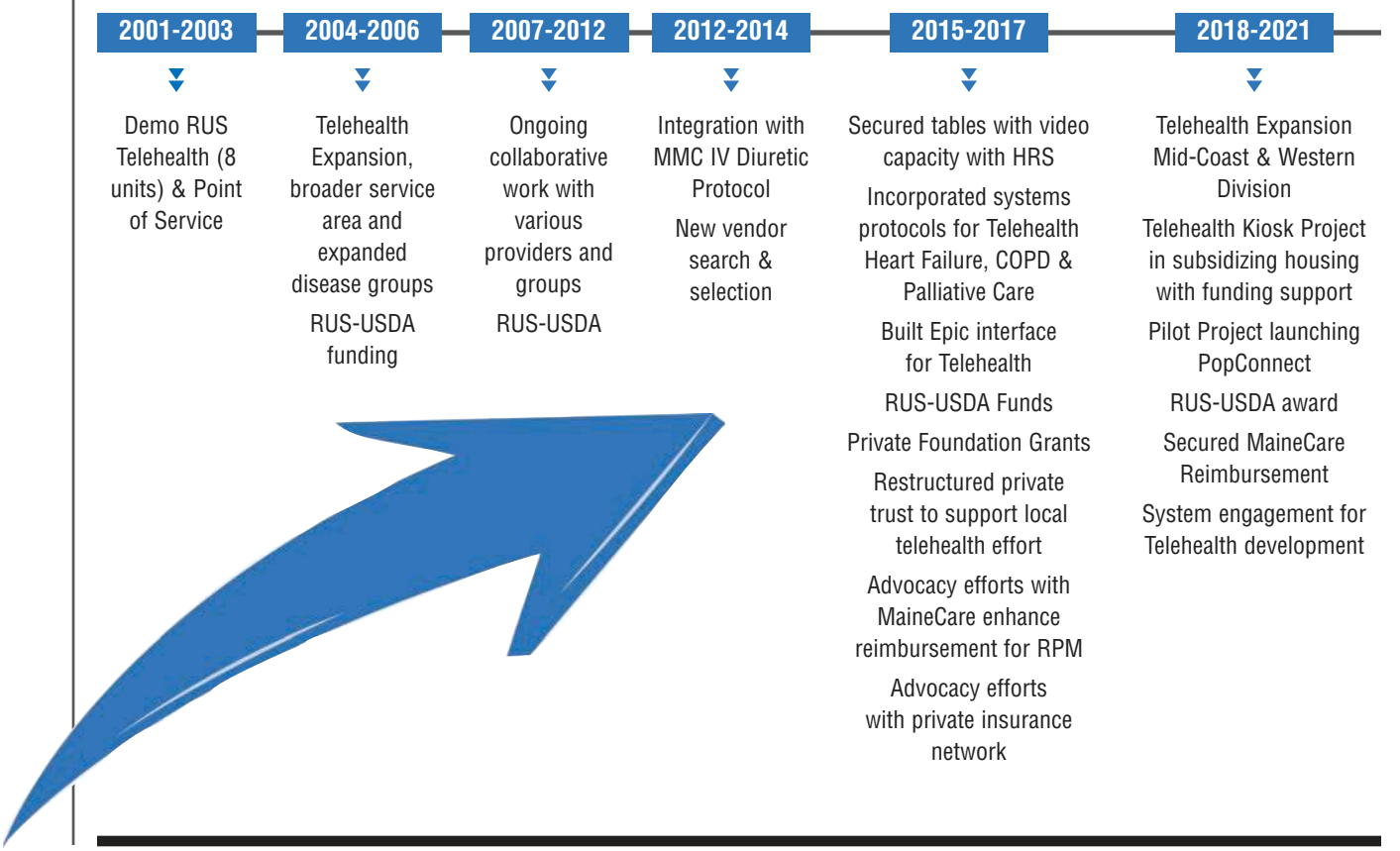
In reviewing reimbursement under Medicaid, the definition of telehealth and its coverage varies widely across the United States. In 2017, the American Telemedicine Association released an updated analysis of state-to-state coverage and reimbursement for telehealth services. States were assigned a letter grade, "A" through "F", for performance in meeting thirteen standards that included parity laws, telehealth coverage in employee health plans, reimbursement, eligible technologies, informed consent requirements, and eligible providers. Maine is included in the 11 states that were given an "A" grade for Medicaid coverage, as seen in the map (see page 25).[11]

"Despite the limitations of reimbursement, MHCAH has sustained its telehealth services primarily through grants and private donations."

Although reimbursement for telehealth services is relatively new and subject to qualifying criteria for home health agencies, MHCAH successfully submitted several claims for reimbursement and is completing a build in its electronic record to facilitate the reimbursement process.

In surveying the commercial market, 32 states have some sort of parity law requiring private insurers to cover telehealth services at reimbursement levels comparable to in-person services. Several large health insurers including Cigna, American Well, and Doctor on Demand are collaborating with third-

Funding and Development



party telehealth companies to offer interactive video care services primarily through physicians. Other insurance plans model their coverage similar to Medicare guidelines; therefore, excluding "store and forward" and restricting telehealth use only to live interaction between physician or practitioner at the distant site and the beneficiary at the originating site. Despite advances in the commercial market, the coverage provisions generally do not apply to home health agencies. Holland Hospital Home Health in Michigan and Catholic Health in Buffalo, New York are securing reimbursement for beneficiaries enrolled with BlueCross & Blue Shield. Our solution partner reports that among its clients, encompassing sixty home health agencies and several health networks with more than 15,000 patients, only two home health agencies are securing reimbursement for telehealth services. These clients have a high reliance on grant funds to support their efforts. With a mounting necessity to adopt new technology that aligns with the emerging value-based payment system, the lack of insurance coverage is an enormous obstacle for home health agencies.

MHCAH'S CURRENT MODEL OF SUSTAINABILITY

Despite the limitations of reimbursement, MHCAH has sustained its telehealth services primarily through grants and private donations. The graph (opposite) describes the course of funding and development of the telehealth program.

While the trajectory seems to indicate a smooth, gradual increase in funding that correlates to development and expansion of MHCAH's telehealth services; that is not the case. USDA-RUS grants – primary funding source for program – is a competitive proc - ess that requires frequent proposals that evaluate and score on measures related to need, rurality and poverty. Although low-income, rural populations benefit greatly from telehealth technology, RUS-USDA funds are not leveraged for those in non-rural areas who may present significant barriers to accessing healthcare. Securing grant funds required ongoing investment of resources that, at times, competed with other agency priorities. In addition, MHCAH experienced several years without new grant funds that diminished its scope and decreased the number of patients served through telehealth. What can be concluded is that organizations are likely to encounter obstacles when relying on granting foundations or government entities to maintain a successful telehealth program.

ADVOCACY

MHCAH believes that organizations need to engage a clinical team who is committed to expanding their role and developing their skills for optimal delivery of telehealth services. Equally important are advocacy efforts from senior leaders who can champion the value and benefits of telehealth to local, state, and national stakeholders. At a minimum, organizations who are leveraging the tools of telehealth should be active members of their state and national trade organizations.

Donna DeBlois, Chief Executive Officer for MHCAH, is the President of the Homecare and Hospice Alliance of Maine and actively participated in advocacy efforts with the Department of Health and Human Services to modify regulatory language allowing home health agencies to submit claims for remote monitoring. On a national level, she has advocated for the Fostering Independence through Technology bill sponsored by Senator John Thune from South Dakota. We advise agencies are to take advantage of the wealth of resources offered by organizations such as American Telehealth Association and National Consortium of Telehealth Resource Centers.

PARTNERSHIPS AND COLLABORATIONS

In June 2016, MHCAH collaborated with Avesta Housing and the Caleb Group – two housing organizations in southern Maine – in a partnership to improve the health and well-being of their elderly and disabled residents. An incentive program through Maine State Housing offers tax credits for housing projects that build the infrastructure and space for a telehealth office.

This partnership launched Connected Care Clinics offering on-site, pre-scheduled video visits with a nurse to conduct multi-dimensional individual health/risk assessments to ascertain health challenges, goals, needs, and deficits including psychosocial/

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behavioral health concerns. Nurses offer biometric screening, support implementation of current prescribed therapies and education, identify and support residents in reaching their self-management goals, educate on the use of telehealth, and provide education and coordination with community referral services. This project incorporates a telehealth kiosk that allows patients to monitor and transmit biometric data and voice/video chat with remote nurses at MHCAH seven days a week. The telehealth kiosk utilizes our solution partners monitoring platform located in a common area to ensure access with attention to protecting the user's privacy. The primary goal is to assist vulnerable seniors and disabled people with multiple chronic conditions and to improve their self-management skills and health status through access to on-site nursing and telehealth services. Services are negotiated and reimbursed through contractual agreement.

Considerations for Sustainability

Central to success in this environment, home health agencies are advised to align with affiliated healthcare providers in addressing the federal regulatory limitations for telehealth reimbursement, seek telehealth platforms that are flexible and scalable, advocate with state and industry leaders to champion provisions for telehealth reimbursement in the private insurance market, aggressively pursue federal, state, and private grant opportunities, develop fee-for-service initiatives with community providers, articulate the value proposition to its affiliated health system, and creatively engage a more diverse profile of patients to gain the benefits and access to health inherent with telehealth.

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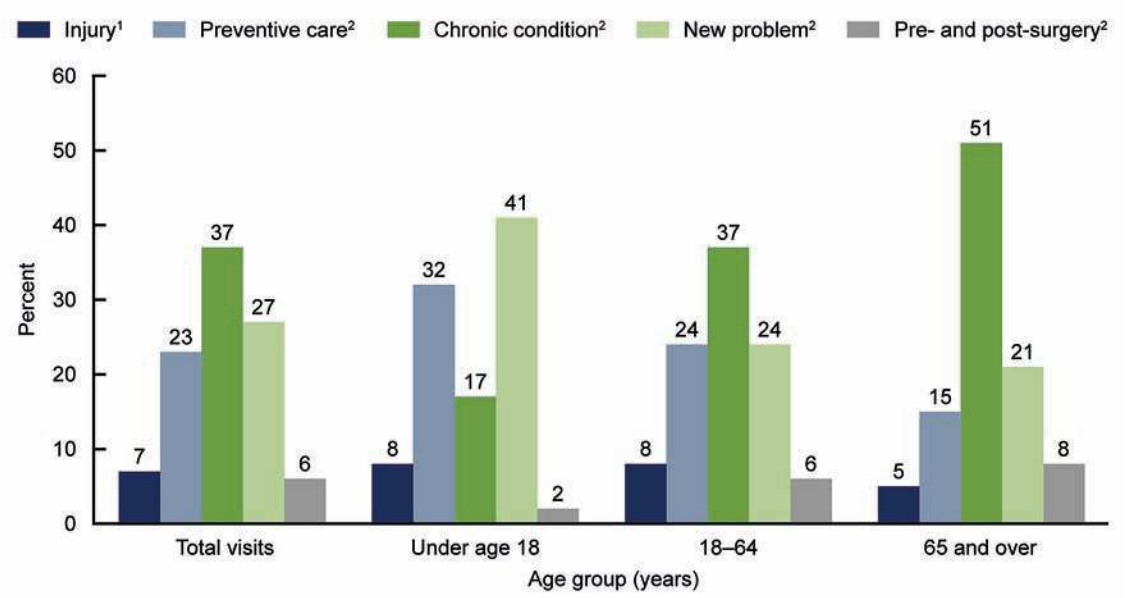
SOURCE: NCHS, National Ambulatory Medical Care Survey, 2016

WHAT WERE THE MAJOR REASONS FOR OFFICE-BASED PHYSICIAN VISITS, 2016?



A CHRONIC CONDITION was listed as the major reason for 37% of all office-based physician visits, followed by a new problem (27%), preventive care (23%), an injury (7%), and pre- or post-surgery care (6%).

BOTH CHRONIC CONDITIONS (17% among children under age 18 years, 37% among those aged 18-64, and 51% among those aged 65 and over) and pre- and post-surgery care (2% among children under age 18, 6% among those aged 18-64, and 8% among those aged 65 and over), as the major reason for visit, increased with increasing age.

BOTH PREVENTIVE CARE (32% among children under age 18 years, 24% among those aged 18-64, and 15% among those aged 65 and over) and new problem (41% among children under age 18 years, 24% among those aged 18-64, and 21% among those aged 65 and over), as the major reason for visit, decreased with increasing age.

INJURY was listed as the major reason for visit at a higher percentage of visits by children (8%) and adults aged 18-64 (8%) than adults aged 65 and over (5%).

Business

Industry News

By **PETE LEWIS**

MERGERS & ACQUISITIONS

Beaumont Health Transfers Seven-County Home Health and Hospice Agency: Beaumont Health sold a majority share and transferred operations of its seven-county home health and hospice agency to Alternate Solutions Health Network, a Kettering, Ohio-based for-profit home health company. Beaumont said "a growing need for home health and hospice services in Southeast Michigan has prompted Beaumont" and Alternate Solutions "to create a joint venture that will expand access to these critical services." Beaumont sold 90% of its home health company for an unspecified price, but said Beaumont retains certain "supermajority" reserved powers, two of five board seats and the right to buy back the business if various metrics aren't achieved.

Ensign Acquires Utah Skilled Nursing Facility: The Ensign Group Inc., the parent company of the Ensign™ group of skilled nursing, rehabilitative care services, home health care, hospice care and assisted living companies, acquired the real estate and operations of Bella Terra Cedar City, a skilled nursing facility with 120 skilled nursing beds in Cedar City, Utah. The acquisition brings Ensign's growing portfolio to 189 skilled nursing operations, 24 of which also include assisted living operations, 56 assisted and independent living operations, 22 hospice agencies, 24 home health agencies and seven home care businesses in 16 states. Ensign owns the real estate at 73 of its 245 healthcare operations.

LHC & LifePoint Purchase Two Home Health Companies: LHC Group and LifePoint Health® finalized two transactions to purchase and share ownership of home health service providers in Hickory, N.C., and Danville, Va. In Hickory, LHC Group and LifePoint purchased and will share ownership of Guardian Health Services. LHC Group has majority ownership and will assume management responsibility of the agency, which will continue to provide service from its current location under a new name: Guardian Home Health. Guardian Home Health will be affiliated with Frye Regional Medical Center, which is part of Duke LifePoint Healthcare. In Danville, LHC Group and LifePoint Health purchased and will share ownership of Commonwealth Home Health Care. LHC Group has majority ownership and will assume management responsibility of the agency, which will continue to operate at its current location under the same name. Commonwealth Home Health Care will be affiliated with Sovah Health – Danville, a LifePoint Health facility. LHC Group and LifePoint formed a joint venture in January 2017 to share ownership of home health and hospice providers across LifePoint's footprint in January 2017. In less than two years, the joint venture, which started with 20 home health and 10 hospice locations, has grown to 33 home health, 14 hospice, and one home and community based services locations.

Centerbridge Partners Acquires Civitas Solutions: Boston-based Civitas Solutions Inc. entered into a definitive merger agreement to be acquired by funds advised by Centerbridge Partners L.P. Under the terms of the agreement, Centerbridge acquired all outstanding shares of Civitas common stock for $17.75 in cash per share, resulting in an enterprise value of about $1.4 billion. The offer price represents a 27% premium to the 30-day volume-weighted average price as of Dec. 18, 2018. Civitas Solutions, Inc. is a national provider of home- and community-based health and human services to must-serve individuals with intellectual, developmental, physical or behavioral disabilities and other special needs. Founded 1980, Civitas has evolved from a single residential program to a diversified national network offering an array of quality services in 36 states.

PEOPLE ON THE MOVE

Jennifer Ramona Named VP at Homewatch CareGivers

Homewatch CareGivers, the international senior care brand, recently added a new VP-level executive whose entire focus is driving innovation int he relationship between health care and senior care. Jennifer Ramona, who is the VP of "Health Care Innovation and Strategy," is entirely focused on cutting through competition and lack of coordination between health care providers.

Humana Appoints Shrank Chief Medical Officer

Louisville, Ky.-based Humana Inc. appointed William Shrank, MD, MSHS, as its new Chief Medical Officer effective April 1. He will serve as a member of the

KUDOS

Humana Management Team and report to Humana president and CEO Bruce D. Broussard. Shrank will succeed Roy A. Beveridge, MD, who last year announced that he will retire from Humana in 2019. Beveridge will remain with Humana for several months after Shrank joins the firm. Shrank joins Humana from the University of Pittsburgh Medical Center, where he served since 2016 as Chief Medical Officer, Insurance Services Division.

LifePoint Appoints New Presidents for Eastern and Central Divisions

Brentwood Tenn.-based LifePoint Health® promoted two veteran company leaders to new roles. James (Jamie) Carter, who previously served as chief operating officer (COO) of LifePoint's former Eastern Group of facilities, has been promoted to Eastern Division president; and Cherie Sibley, who previously served as COO of the company's former Central Group of facilities, has been named Central Division president. As Eastern Division president, Carter is responsible for LifePoint's facilities in Michigan, North Carolina, Pennsylvania, South Carolina and Virginia, including all Duke LifePoint Healthcare facilities.

PETE LEWIS IS A CONTRIBUTING WRITER FOR THE REMINGTON REPORT®

CORPORATE MANEUVERS

CVS Launches MinuteClinic Video Visits in New Mexico and Wyoming: CVS Health in December introduced the company's retail medical clinic, MinuteClinic, new virtual health care offering in New Mexico and Wyoming. People in New Mexico and Wyoming with minor illnesses and injuries, skin conditions and other wellness needs now can seek care through MinuteClinic Video Visits, a telehealth offering. MinuteClinic Video Visits provide patients with access to care 24 hours a day, seven days a week from their mobile device or computer. Working collaboratively with a telehealth partner, patients can receive care via a MinuteClinic Video Visit, initiated through the CVS Pharmacy app and CVS.com. Patients who opt to seek care through a fully customized MinuteClinic Video Visit experience the same high-quality, evidence-based care they receive at traditional MinuteClinic locations inside select CVS Pharmacy and Target stores. A video visit can be used to care for patients ages two years and up who are seeking treatment for a minor illness, minor injury, or a skin condition. A MinuteClinic Video Visit costs $59, which is currently payable by credit card or debit card. Insurance coverage will be added to the experience in the coming months.

The service, first introduced in August 2018, is now available in 18 states and Washington D.C.

DON'T MISS THESE **KEY TRENDS**

Developing short and long range strategic plans for home care companies can be complicated by the many changes impacting the healthcare delivery system. Strategies for short and long-term plans can be accomplished by assessing clear trends that are driving a more predictable future in healthcare, and developing a plan to keep ahead of evolving trends that impact the future. **PAGE 4**

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP, PUBLISHER, **THE REMINGTON REPORT**

Reducing Hospitalizations Using Community-Based Health Coaches PAGE 16

Improving care of at-risk patients with chronic conditions

Medicare advantage plans test hospice benefit

Beginning in CY 2021, the Value-Based Insurance Design (VBID) model will test the Medicare hospice benefit. In CY 2020, offer supplemental benefits including for "non-primarily health related" items or services for enrollees based on chronic condition and socioeconomic status determined by qualifying for the low-income subsidy and/or having dual-eligible status, or both. PAGE 10

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