How to Build and Pay for Home Based Palliative Care: The ProHEALTH Experience

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Overview

- Building a HBPC Program
  - From inpatient PC / ICU doc to running a HBPC program
  - Order a desk, tote bag and laptop
  - Hire and train the right people… off you go!
- Paying for Palliative Care - Find the financial alignment
  - Learn the vocabulary
  - Negotiate with health plans, C-suite
  - Risk, ACOs, MACRA and good old FFS

Audience Poll

- Are you currently working with a health plan to pay for your palliative care program?
  - Yes
  - No

Helping Frank and His Family

- Frank is an 87 year old man with dementia, heart failure and chronic kidney disease
- Frequent ED visits for weakness
- Admitted 2 times in 6 months for altered mental status
- His 86 year old wife and adult son overwhelmed

Before and After

- Usual Care
  - **3** calls to 911
  - **2** hospitalizations
  - Family distress
  - Progressive functional decline with each admission

- ProHEALTH Care Support
  - Disease management
  - 24/7 phone coverage
  - Virtual visits with son
  - Caregiver support
  - Dinner - Meals on Wheels
  - Friendly visitor program
  - **No 911 calls, ED visits, or hospitalizations in 9 months**

Building the Program

- Branding
- Design
- Staffing
- Services
- Population

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Program Design

- Co-management model
  - Supportive Oncology
  - Difficult patients
- Consultative model
- Assume full care

Staffing

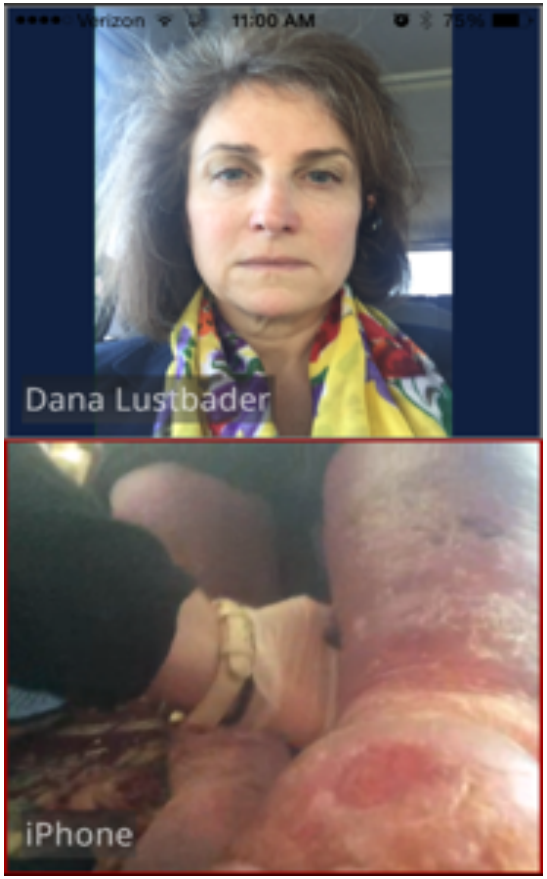
- RN/SW model with MD oversight
- 85 patients/RN
- Pod = 3 RNs/1 SW/1 MD per 275 patients
- Team meeting 1 hour 2x/week
- Weekly 1:1 meeting with RN:MD

Services

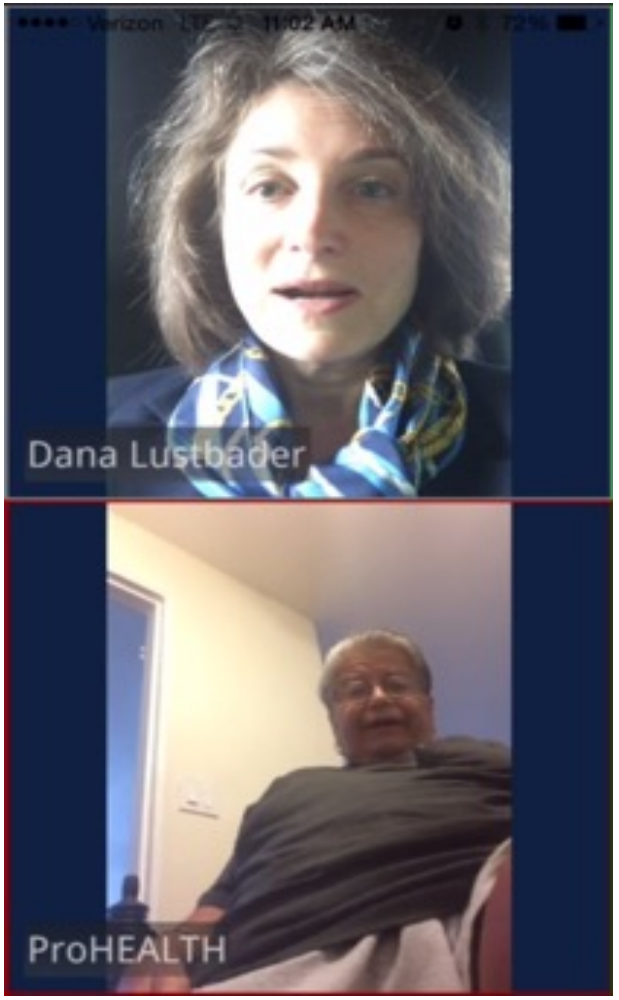
- House Calls
- Telephonic Support
- Volunteer Department
  - Reiki Massage
  - Friendly Visitors
- 24/7 Availability
- Telemedicine - “telepalliative care”

Telemedicine - Use Cases

Team Meeting



Urgent Issue



RAF or Routine Visit

Services

- Environmental Scan
- Medication Reconciliation
- Partnerships with Other Organizations
  - Home Health Agency, Hospices, MLTCs
  - Community Resources
- Care Transitions Post Hospital Discharge
- Risk Adjustment Factor (RAF) Lift for Medicare Advantage Programs

The ProHEALTH Care Support

Advanced illness care at home

- Two or more chronic conditions
- Frequent hospital admissions
- Advanced illness (e.g. heart failure, COPD, CVA)
- Progressive neuromuscular disease
- CKD with debility
- Stage IV cancer
- Frailty syndrome

Patient Population: Data Driven Referrals

- ACO High Risk High Need
- Health plan provided
  - Hot Spotter - Top 5% spend
  - ADK - #Admissions per 1000 members
  - Admits in prior 12 months
  - Future risk score, readmission predictive score

Patient Population: Provider Referrals

- Sometimes useful but can be an unreliable source
- Involve office based care coordinators
- Surprise Question - Would you be surprised if this patient died within the year? If no, consider for HBPC.

Patient Population

- ➔Sweet spot for optimal ROI
  - Mortality rate 25-50%
  - Some patients transferred back to usual care or case management
- ➔Claims and health plan provided data must be supplemented with tools to capture frailty and functional decline

HBPC Enrollment Tool	Yes=1, No=0
Age > 85	1
ADLs 3+ Dependence	0
Lives Alone, High Caregiver Burden, Social Factors	1
Progressive Functional Decline Over 6 Months	0
Hospital Admits in Past 6 Months	1
Most Recent Hospital LOS > 5 days	0
Metastatic Cancer	0
Home Oxygen Dependence	0
Prognosis < 1 Year	1
SCORE: > 2 Consider HBPC	4

HBPC Disenrollment Tool	Yes=1, No=0
Sees Multiple Doctors	1
Minimal or No Assist with ADLs	0
Gets Out of House	1
No Hospital Admits in Past 6 Months	1
No ER Visits in Past 6 Months	1
Prognosis > 1 Year	0
Strong Caregiver Support	1
SCORE: > 2 Consider Disenrollment	5

Paying for HBPC

- New Vocabulary Words
  - MACRA, MIPS, APM, ADK, MLR
- Methods
  - Fee for Service - FFS
  - Accountable Care Organization - ACO
  - Shared Savings - (e.g. MSSP ACP)
  - Per Member Per Month (PMPM) Rate
  - Risk

Leading up to Medicare Access and CHIP Reauthorization Act – MACRA

- 1997 Medicare Sustainable Growth Rate (SGR) - goal to rein in physician costs, formula set annual budget target not to exceed growth in GDP
- 2002 SGR yielded a whopping 5% cut in physician fees.
- Congress enacted 17 “doc fixes” over 12 years, freezing fees. In 2014 CMS paid $138 billion to physicians, or about 22% of Medicare spend.
- 2015 Congress repealed SGR through MACRA law as new payment system (passed 392-37 House; 92-8 Senate).

Medicare Access and CHIP Reauthorization Act – MACRA Law

- 2016-2018 Annual physicians fee increase of 0.5%
- 2019-2025 Physicians choose one of two newly designed payment models. Those not eligible to join an ACO or who fail to choose model will be automatically assigned to MIPS.

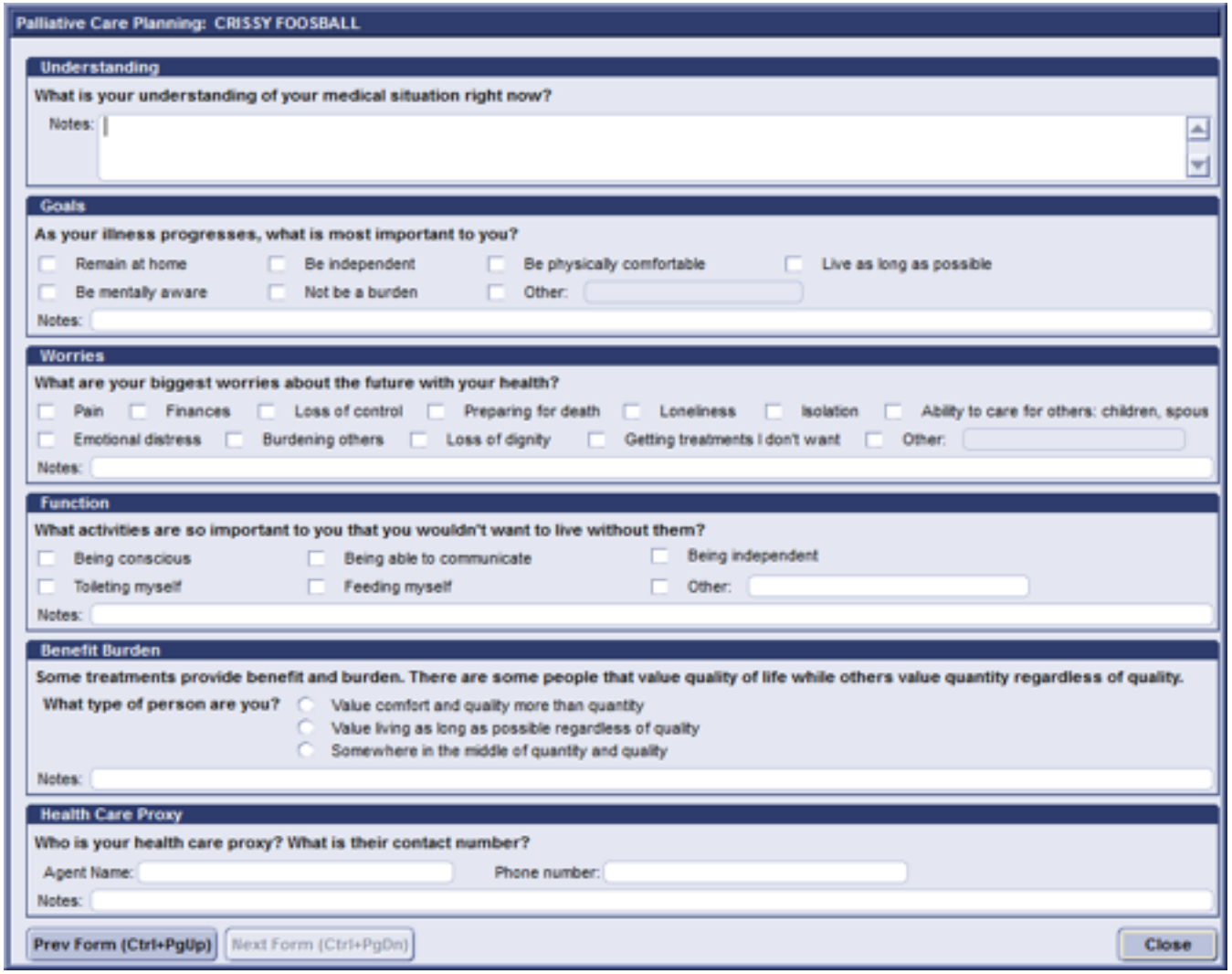
1. Merit Based Incentive Payment System (MIPS)

- Based on quality (30%), spend (30%), EHR (25%), performance improvement (15%)
- Max bonus and penalties 4% in 2019, 5% 2020, 7% 2021, 9% 2022 and beyond
- Physicians will be scored and publicly reported on these four metrics to be developed by Dept of Health and Human Services (HHS). “Exceptional performers" get part of $500M bonus pool

2. Advanced Alternative Payment Model (APM)

- Join a qualified Tier 2 or 3 ACO or Patient Centered Medical Home
- Annual 5% bonus 2019-2024
- Starting 2026, annual increase 0.75%

FFS-Advance Care Planning - 99497



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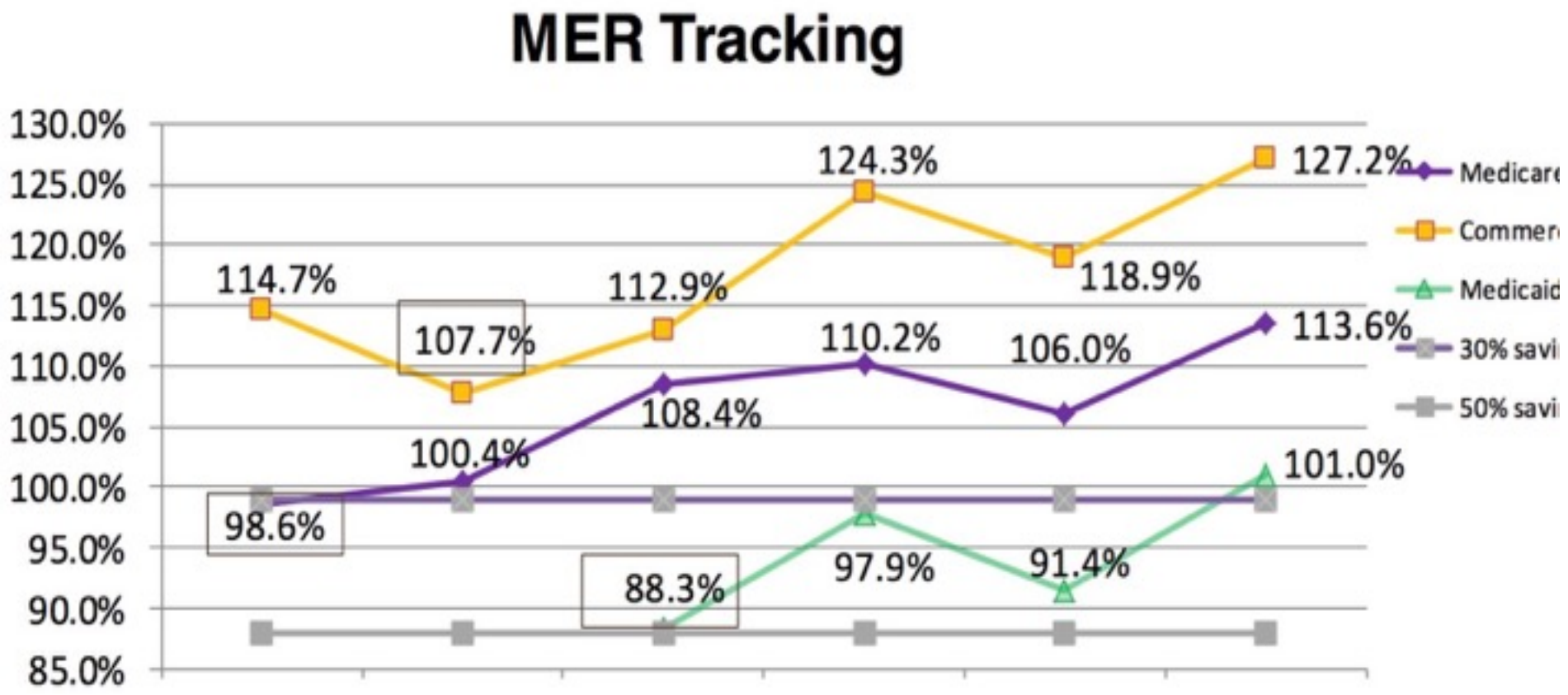
Vocabulary to Sit at the Big Girl Table - Know the Numbers

- ADK = Hospital admissions per 1000 members
  - Average is 200/1000 but our population may be at 3000/1000 or 3 admits/member in a year
- MLR - Medical Loss Ratio is amount spent on medical care over amount collected by health plan
  - Opportunity if MLR > 85%, Huge opportunity with MLR > 100%

Medical Loss Ratio (MLR or MER)
HiHo Healthplan



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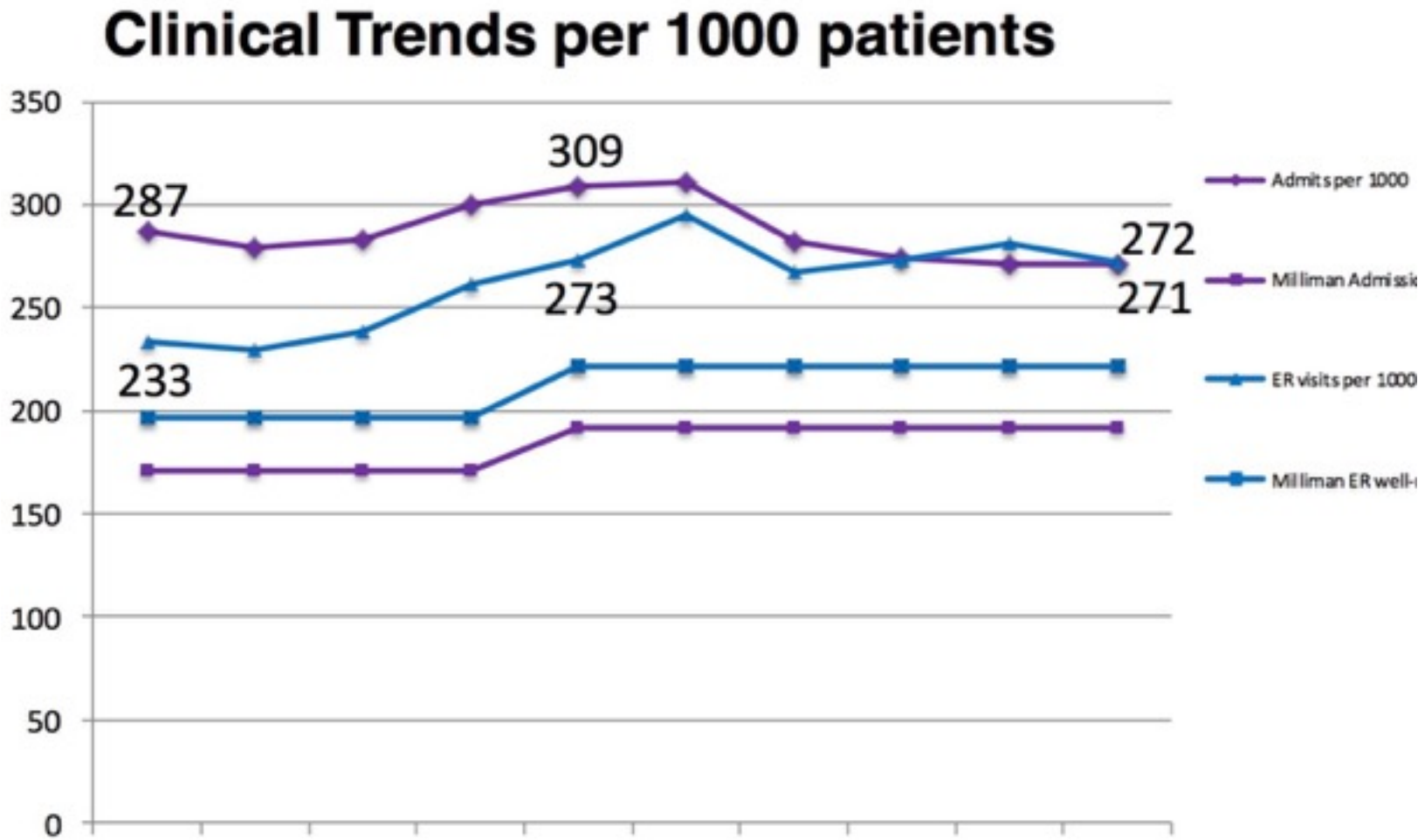
ADK and ER/1000 Members
HiHo Healthplan



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HBPC Can Help with ADK and ER Problem: 180 days Pre-Enrollment versus Post-Enrollment among Patients Receiving Home Based Palliative Care

	Pre HBPC Enrollment (N=236)				Post HBPC Enrollment (N=236)				Pre vs Post HBPC Enrollment	
Utilization	Events	Person-Days	Rate	95% CI	Events	Person-Days	Rate	95% CI	IRR	p
ER Visits	226	42,480	0.0053	0.0045 0.0062	120	31,352	0.0039	0.0031 0.0049	**0.73** **27% Reduction**	0.0178
Admits	187	42,480	0.0044	0.0037	71	31,352	0.0023	0.0018 0.0030	**0.52** **48% Reduction**	< 0.0001

(MSSP ACO 2015)

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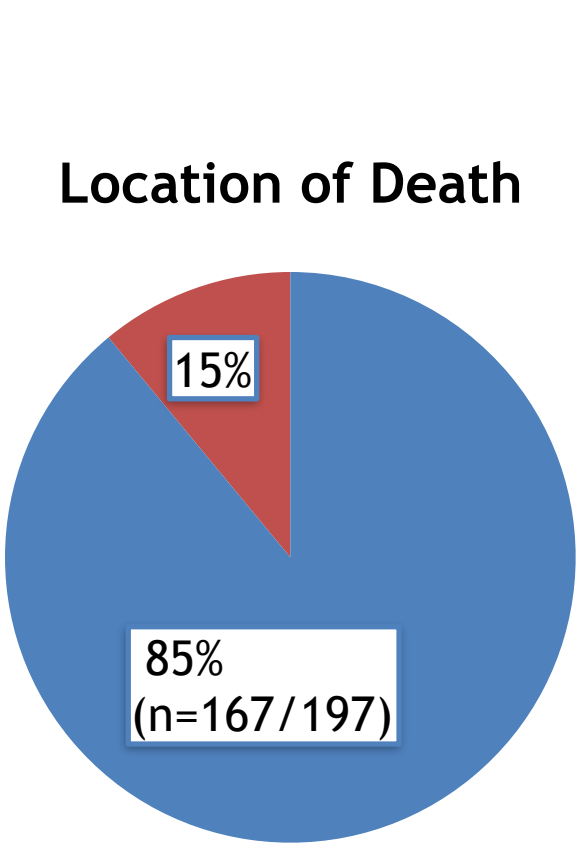
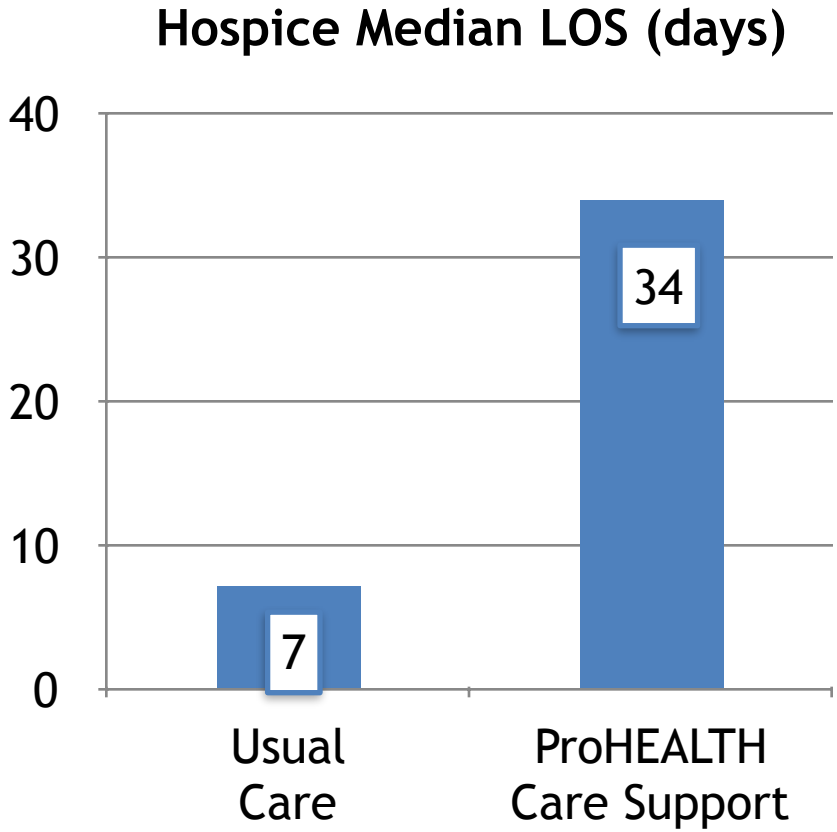
Impact of HBPC on Spend in ACO

Total Costs Medicare Part A,B,D $ PMPM	Home Based Palliative Care Patients (N=236)		
	Mean	95 % CI	p
90 days pre-enrollment	$3403		
90 days post-enrollment	$2157		
Mean difference	**$1245**	469, 2022	0.0018
180 days pre-enrollment	$3429		
180 days post-enrollment	$2336		
Mean difference	**$1093**	399, 1787	0.0021

ProHEALTH Care Support





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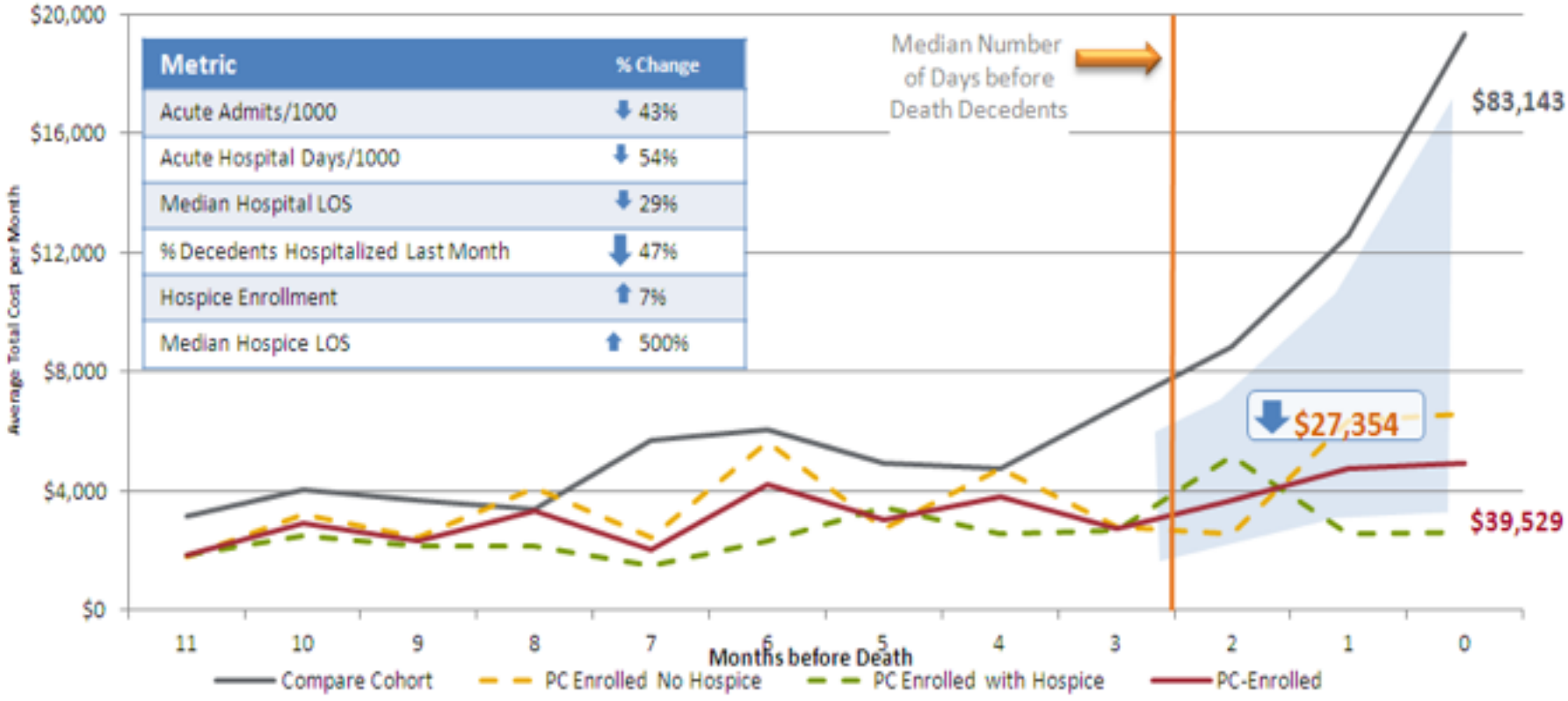
Final Month of Life

- HBPC associated with 48% reduction in spend in final month of life compared to usual care
  - $8,202 versus $15,903 ($p < 0.0002$)
- Location of death was home for 85% of decedents who received HBPC (versus 25% for usual care)

ProHEALTH Decedent Analysis



(MSSP ACO 2015)

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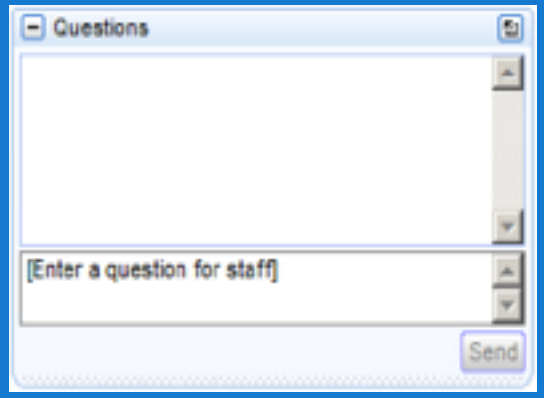
The “Secret Sauce”

1. Track the right metrics (e.g. hospital admits, ER visits, satisfaction)
2. “Red Zone” – Dosing of intervention
3. Family caregiver support
4. POLST/MOLST on the fridge
5. 24/7 availability

Questions and Comments

Do you have questions for the presenter?

Click the hand-raise icon on your control panel to ask a question out loud, or type your question into the chat box.



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