HOME CARE

Home Care Unhappy with the Medicaid Program

- Per Visit Payment Rates below Cost Levels = Program Lo$$e$
- Program Shifts to Managed Care
- Program Demands for Accountability = Investment in Technology
- Outcomes Based Reimbursement = Value-Based Purchasing Payment
Scarlett Overkill
As MEDICAID
“Doesn’t It Feel So Good to Be Bad?”

The MEDICAID Minions
Leads To Defeating OLD MEDICAID MODELS
(Played By Scarlett Overkill In An Oscar Winning Performance)

HOW TO DEVELOP NEW MODELS OF CARE FOR MEDICAID

INNOVATION

Innovative Use of Technology

HOW TO DEVELOP NEW MODELS OF CARE FOR MEDICAID
Innovative Use of Technology:

- Is the Underpinning of Survival
- Provides new methods to engage consumers (Yes, consumers have options regarding their health care!)
- WE as an Industry have adopted some new technologies, but are limited by lack of $ and legitimacy. Federal and State legislators may require education
- Requires regulatory change
- Technology = Data $\implies$ Information allows DATA DRIVEN DECISION-MAKING For Both Clinical and Business Decisions (We Can No Longer Separate Clinical From Financial!)

Innovative Use of Telehealth:

- Telehealth – monitors, phones, texts
- Videoconferencing
- Televisits with COWs
- Sensor chips for Monitoring Activities of Daily Living
- Pill boxes vs. Electronic Medication Management Systems
- Skype
**INNOVATION**

**Innovative Methods in Consumer Engagement**

**Align Strategy: Value v. Volume**

*Quality = A Focus on Output vs. Input*

- Data Driven Care
- Collaborative Care
- Innovative Care
- Transitions of Care
- Concierge Care…Patient Experience
- Preventative Care

**Consumer Engagement Goals**

Avoidable Care:

- Reduce Emergency Department Use
- Reduce Hospital Readmissions
- Limit 30-day Readmission Penalties:
  - Heart Attack
  - Heart Failure
  - Pneumonia
  - COPD
  - Cardiac Bypass
  - Stents
  - Other Vascular Conditions
Activate Rapid Response Clinical Navigator

Or

Significant Health Impairment → ED indicated

Development an Innovation Strategy:
- Adopt “Hospitalist Model at Home” – Doc-on-Call
- “AC” success for home care / community orders management
- Physician/NP Home Visit program
- Rapid response “Medication Bundle”
- Community Paramedicine – EMS partnership
- Laboratory Services at Home – Lab Shedding – draw, send, CXR, EKG
- Design program targeted at High Risk Management & Chronic Disease
- Enhance Palliative Care Transition Program - Hospice Partnerships
- EMR interoperability
- Sustainability: negotiate package with health plans

INNOVATION
In Engaging Consumers

Hospital-Home Care Collaboration

Rapid Responder/ED Navigator / “Care Activator” – On Call, 24/7:
- Admit only if clinically indicated… Alternate less costly level of care
- Discharge to home plan (from ED or abbreviated admission)… Activate Care Protocols
- Rapid Intervention: connect patient to primary care, home care, DME/Resp, Interactive Video telehealth install, (connect to NP, PharmD, MWW, RT, RD, palliative care, MD), prescrsions filled, med reconciliation, coordinate transportation, mobile radiology, mobile Lab, MD/home visits, schedule appts, refer to other projects, as indicated (behavioral health, smoking cessation, community linkages)

Interactive Video Telehealth – Connecting Clinical Experts to Patients – rapid install

INNOVATION
Population Health Management
NEW MEDICAID MODELS SHOULD BE BASED ON POPULATION HEALTH MANAGEMENT PRECEPTS

- Risk Stratification Based on Patient Centric Holistic Assessment
- Tiered Evidence-Based Best Practices Applied By Patient Level of Risk
- CARE TRANSITIONS IS MAJOR FOCUS

HOW TO DEVELOP NEW MODELS OF CARE FOR MEDICAID

INNOVATION

Population Health Management

THE FUTURE OF HEALTH CARE

- Home Health
- Telehealth
- RightHealth®

INNOVATION

Population Health Management

TRANSITIONS OF CARE

Focus on moving patients smoothly from one care setting to another

Transition from Fee for Service to Managed Care should:

- Be seamless
- Allow beneficiary to continue with existing provider for a period (minimum 6 months)
- Continue previously approved care plan until scheduled re-evaluation
- Minimize disruption in care due to rate changes

States Different, but Home Care must agree on common principles and advocate for models with:

- Adequate Networks and Out of Network Services for timely access
- Stakeholder Engagement and inclusion of all model types and providers
- Appeal Rights for Beneficiaries and Providers with anti-retribution provisions

HOW TO DEVELOP NEW MODELS OF CARE FOR MEDICAID
Bundled Payments

Medicaid Home Care Patient Characteristics:
- Often of Advanced Age
- Suffer Multiple Comorbidities
- Have Cognitive Deficiencies
  (especially Medicaid Long-Term Services & Supports MLTSS Patients)

Medicaid Patient Population: An AT RISK POPULATION
Compounded with ever increasing shift of Medicaid Programs to
Managed Care Models

MODELS THAT FOCUS ON TRANSITIONS OF CARE =
BEST CHANCE OF SUCCESS

HOW TO DEVELOP NEW MODELS OF CARE FOR MEDICAID
Bundled Payments

**Goal:** Produce VALUE = \( \frac{\text{Quality}}{\text{Cost}} \)

**Opportunity:** To Reward Coordination Among Healthcare Providers

- **BPCI Initiative:** Medicare is guaranteed a 3-4% savings through a Target Price for 30, 60 or 90 Day Episodes of Care
- **CMS** has other Initiatives that also involve “Bundled Payments”
- **Bottom-line** – Bundling is most likely the Payment Model of the Future

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### Medically “Bundled” Models of the Future

- “Partner” with States and/or MCOs
- Share Economic Savings and Economic Risks
- Require Patient Risk Stratification
- Require Care Redesign and High Collaboration AMONG Providers
- Maximize Technology
- Provide Performance Reporting for all Providers
- Effectively **Communicate, Communicate, Communicate** “Information” – Not RAW DATA, but Timely DATA Analysis
- Engage Physicians, Providers and Beneficiaries
- **Have Champions!!!**
INNOVATION

TRANSFORMATIONAL PROJECTS
CMS Has Approved 6 DSRIP States
Medicaid Reform

New York: A State of DSRIP
Delivery System Reform Incentive Payment Program (2014)

- Rewards providers for performance on delivery system transformation projects
- State divided into “Performing Provider Systems (PPS)
- PPS selects Transformative Projects
- Performance metrics cover 5 years

HOW TO DEVELOP NEW MODELS OF CARE FOR MEDICAID
New York: A State of DSRIP
Delivery System Reform Incentive Payment Program (2014)

What are the expectations? To:
- Reduce hospitalization by 25%
- Transform the state's Health Care System
- Bend the Medicaid Cost Curve
- Assure Access to Quality Care for all Medicaid members

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

INTERACT Adoption

INTERACT:
- A quality improvement program for residents in Skilled Nursing Facilities
- Designed to improve:
  - Early identification & assessment
  - Documentation & communication of changes in resident status

INTERACT: https://interact2.net/
GOAL of INTERACT:

- Improve care
- Reduce the frequency of potentially avoidable transfers to acute care hospitals (Transfers may result in numerous complications of hospitalization, with billions of dollars in unnecessary health care expenditures.)

INTERACT: https://interact2.net/

Innovative Uses of Interact

- Began in Skilled Nursing Facilities
- Now but being adopted by other organizations providing skilled care and “Hospital Without Walls” programs
- Potential for adoption by MCOs?

INTERACT: https://interact2.net/
Interact Adoption

Using the INTERACT Tools
In Every Day Care

- Advance Care Planning Tools
- New-Resident Admission/Resident Re-Assessment
- Change in Resident Status Noted
- CNL, Other Direct Care Staff, or Family Alerts LPN/RN
- LPN/RN Evaluation
- MD/NP/VA Notified
- Placement Checklist Envelope
- Meds
- Acute Care Transfer
- Quality Improvement Program
- Apply Learning to Improve Care Processes and Education

INNOVATION
Collaboration & New Partnerships
HOW TO DEVELOP
NEW MODELS OF CARE
FOR MEDICAID
PATIENTS

CONTACT
Colin Roskey, Esq., Alston & Bird, LLP, Washington, DC,
Executive Director, National Medicaid Action Council and Counsel to NAHC
Colin.Roskey@alston.com
Andrea Devoti, RN MSN
Co Chair, National Medicaid Action Council
President & CEO, Neighborhood Health Inc.
Devotia@VNACC.com
Ellen Bolch, RN MS
Co Chair, National Medicaid Action Council
President & CEO, THA Group Inc.
EBolch@NADgroup.org
Laurie Neander, MSN
President & CEO, At Home Care Inc.
LNeander@ahcnys.org