A Complex Care Wrap Around Model: What Can We Learn And Apply Elsewhere?

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COMPLEX CARE CASE

- Patient Case: 89M with dementia, hx DM, bed bound living at home, on chronic oxygen.
- Who can relate to having patient scenarios like this?
- How does it make you feel as a practitioner?
- What outcomes occur for the patients?

Tell us about your practice!

- Outpatient/Inpatient providers
- Private practice/University or Academic Practice/FQHC?
- Work with learners
- Work with Medicare Advantage or other full risk models?
    - System changes set-up for full risk/value patients?

OUTLINE

- Overview Complex Care model at Optum
- Understand MA as an entity including finances
- Understand differences between Complex Care, Medicare Advantage, general population
- Highlight care delivery sites in this model
- Overall outcomes
- Takeaways

SHOW ME THE MONEY

Traditional Fee for Service

Physician gets paid "X" amount for visit, procedure, or test.

Amount set by CMS or negotiated with insurer

Reimbursement not increasing with pace of inflation

Clinic hires MAs/RNs who increase physician/APC visits

RNs/MAs do not bill directly

Funding comes from provider visits or procedures

Not reimbursed well or at all: long visits, extensive work-ups, telephone, My-chart, etc.

Hospital and ED visits are paid separately to the institution

Value Based Care with full risk

Clinic gets paid "X" dollars/month for each patient

Amount per patient is based on patient's risk adjustment factors

Includes age, specific chronic conditions, BH, SDOH

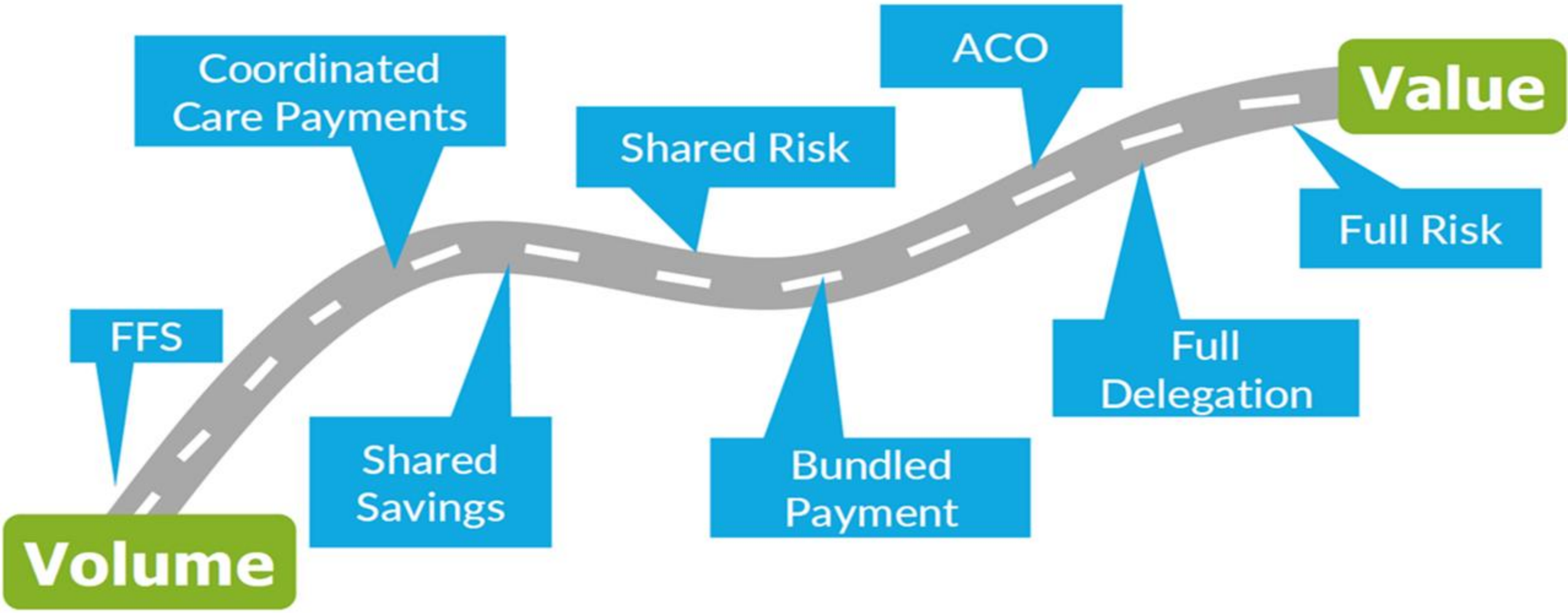
Clinic pays bills for patient's care (hospitalization, ED use, SNF, etc).

Documenting all of patient's conditions accurately allows investment in resources.

Population based payment allows clinic to invest in care managers, social workers, pharmacists etc.

Managing patients outside the hospital = funds for further investments

The road to value



Does payment model influence standard of care?

Traditional Fee-for-Service
Reactive approach – *Sickcare*

Delivering care in this **moment in time**

- **Episodic care**
- Rewards **number of visits**
- Most of care is provided **in the visit**
- **Encourages utilization** for reimbursement

Can drive **higher costs**

✗ A mild flu season ☹

✗ A snow day ☹

Population Health / Value Based Care
Reactive approach - *Wellcare*

Delivering care **throughout the year**

- **Prevention and early detection**; keeping the patient healthy
- Rewards **outcomes and quality**
- Much of care is provided **between visits**
- Patient's **diagnosis determines cost** of care and resources needed

Predicts cost and more **accurately reimburses** for complexity of care

✓ A mild flu season ☺

✓ A snow day ☺

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Medicare Advantage value-based payment model

Benchmark

Is the "average" spend for an "average" (1.0 RAF) person in a geographic area

Premium

If bid is less than benchmark, insurer may share the savings. If greater, pt pay in higher premiums.

Risk Adjustment

CMS "risk adjusts" the premium based on RAF

Medicare's evolving payment models

MSSP

- A patient is attributed to an organization by highest number of visits
- An average geographic spend is calculated for the area in question
- If we spend less than average to care for the population, we share in the savings
- Percentage of "shared savings" depends on quality scores.
- Highest percentage of shared savings is 33%
- There is no downside risk.

ACO Reach

- Partial cap model is used.
- An average geographic spend is calculated
- If we spend less than the benchmark we keep 100% of the difference. If we spend more then the benchmark we pay 100% of the difference.
- Quality threshold must be met
- Metrics include
  - screenings/vaccines
  - pt experience
  - Care coordination (readmits, post-d/c f/up, SDOH screen, med rec)

Finance Example: Edith (80 yo with dementia, bedbound, chronic O2, DM)

PMPM=$800 x 12 month = $9600

Risk Adjust (RAF): 0.6 + 0.4 + 0.1=1.1

(demographic + dementia + DM-II)

Total funding: = **$10,560**

Total one year cost: hospital + SNF + ER = $17,000+$900+9000 = **$26,900**

*****you owe $16,340*****

PMPM=$800x12months = $9600

RAF: 0.6+0.4+0.3+0.4+0.5=2.2

(demographics + dementia + DM w/comp + Chronic resp failure)

Total funding = **$21,120**

Total one year cost: home hospital + senior clinic + caregiver help = **$15,500**

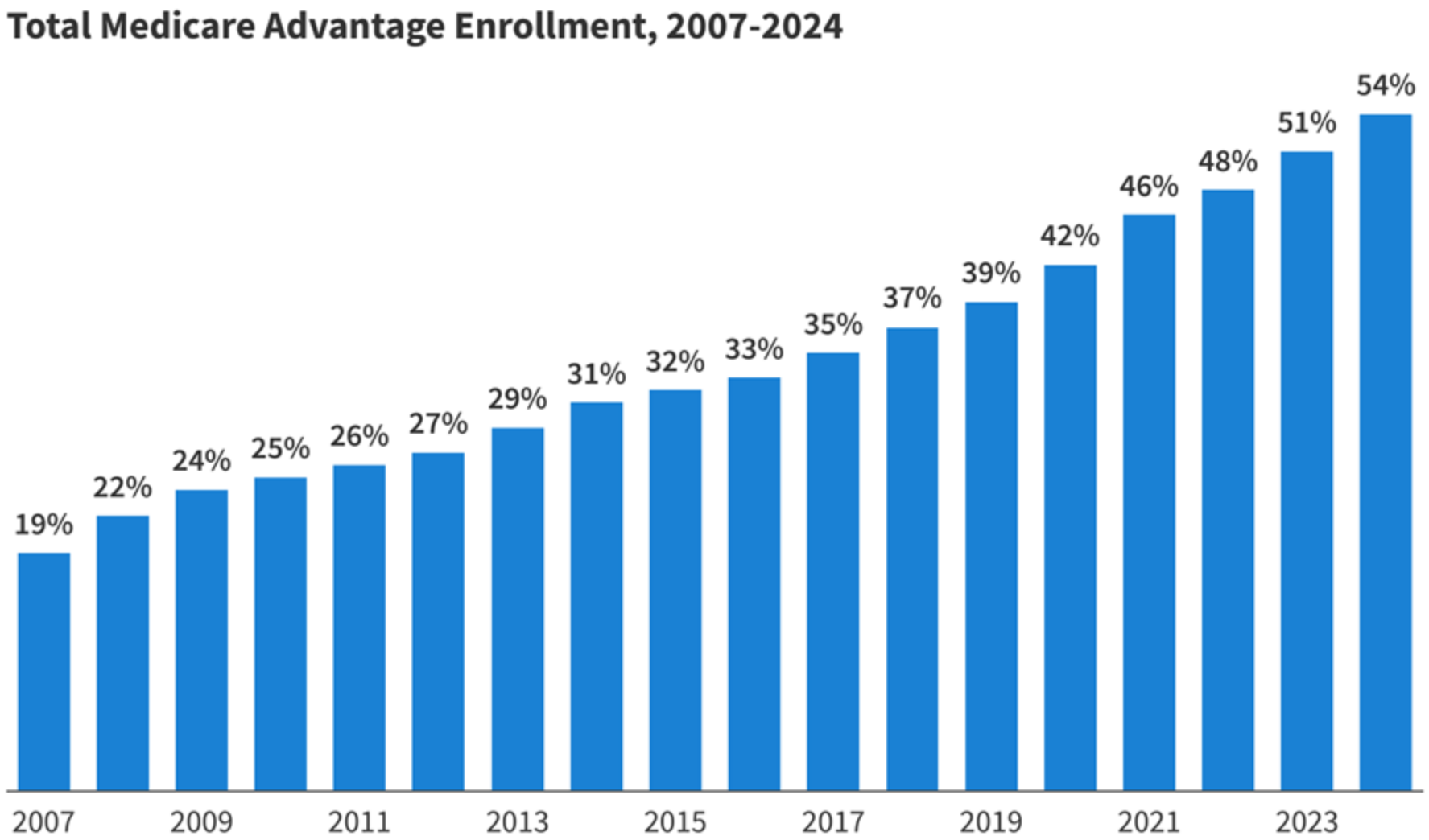
*****you keep $5620*****

PATIENT POPULATION

- Medical Complexity
  - High admission risk and/or health care utilization
- Insurance coverage and cost of care
  - Medicare Advantage and DSNP and Medicare*
- Demographics?
  - 12% DSNP (Medicaid)

WHAT IS MEDICARE ADVANTAGE?

- Medicare Part C - 1985 => Different from fee for service Medicare
- Capitated payment for insurers who accept risk (covering all costs of care for a patient for the year)
  - Month to month based on patient complexity
- Often include drug plan, may include other services and benefits
  - Vision, rides, OTC meds, food, dental
- Generally limits choice in where care can get covered
- Treatments and medications can require Prior Authorization

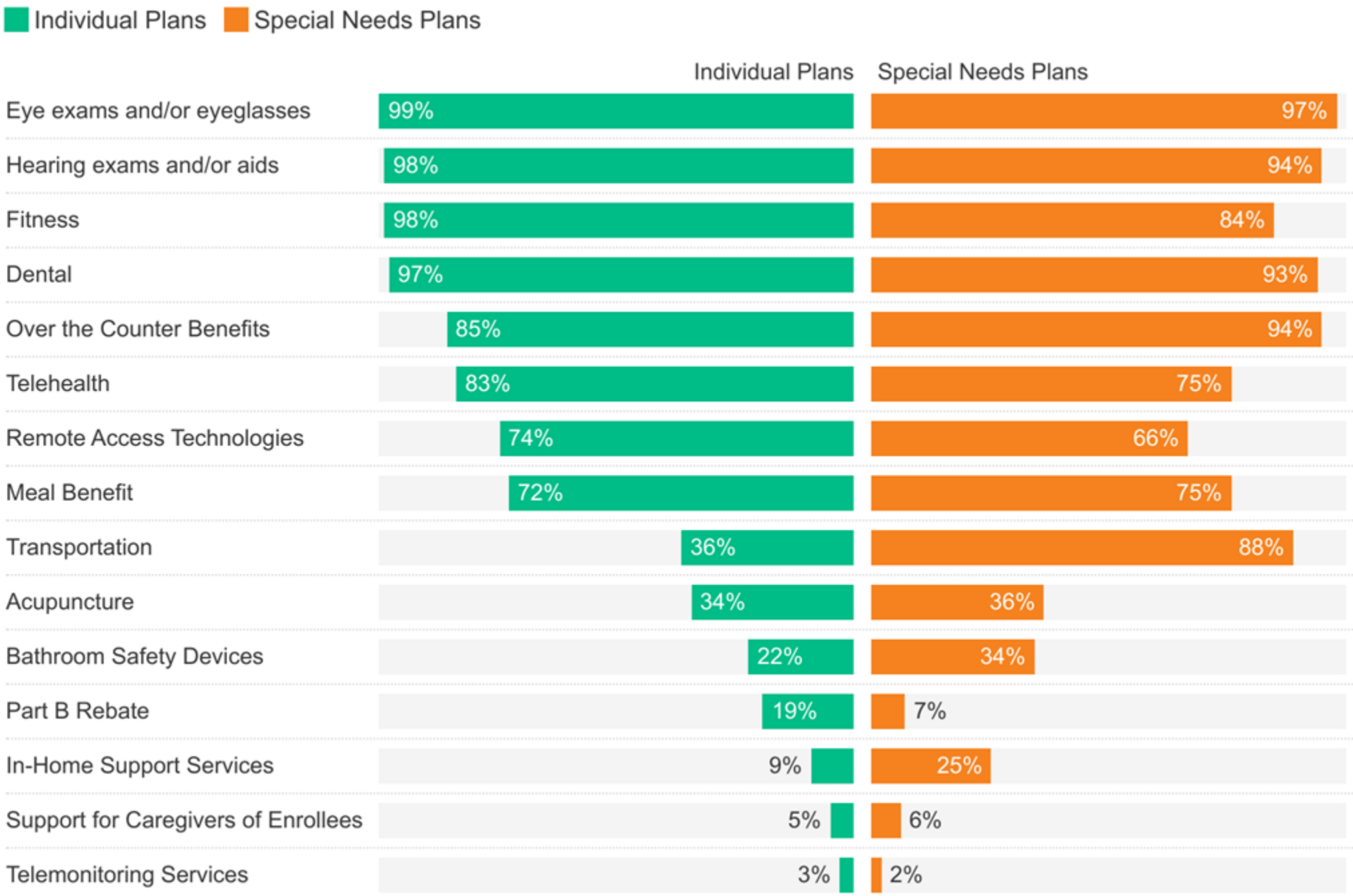


Increasing enrollment => 54% of eligible Medicare beneficiaries (33 million enrollees 2024)

Source KFF.org

Dual Eligible Special Needs Plans (D-SNP)

- For patients eligible for **Both** Medicare and Medicaid
- Specific Medicare Advantage plans where this is primary insurance, with Medicaid often covering premiums, other costs
- Often fewer prior authorizations
- Often have extra benefits (compared to MA)
- Demographics
  - Patients low income (or spend down)
  - Higher percentage people of color
  - Higher medical complexity and chronic conditions


Individual Plans
Special Needs Plans
Individual Plans
Special Needs Plans
Eye exams and/or eyeglasses
99%
97%
Hearing exams and/or aids
98%
94%
Fitness
98%
84%
Dental
97%
93%
Over the Counter Benefits
85%
94%
Telehealth
83%
75%
Remote Access Technologies
74%
66%
Meal Benefit
72%
75%
Transportation
36%
88%
Acupuncture
34%
36%
Bathroom Safety Devices
22%
34%
Part B Rebate
19%
7%
In-Home Support Services
9%
25%
Support for Caregivers of Enrollees
5%
6%
Telemonitoring Services
3%
2%

Challenges to Medicare Advantage

- Limitations in **care options**, **treatments** and **medications**
- Incentivizes maximizing patient medical complexity (Hierarchical Condition Category - HCC)
  - Increases healthcare costs
- Accessibility issues
  - Premiums, out of pocket maximum (is capped)
  - Easy to switch from, but hard to switch back to traditional Medicare
  - Cannot get Medigap coverage

CARE DELIVERY SITES

PERSONALIZED CARE TEAM

PALLIATIVE TEAM

SENIOR ADVANTAGE CLINIC

VALUE BASED TEAM @ HOSPITAL

ED DIVERSION SHIFTS

HOSPITAL AT HOME

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Personalized Care Team

- Patient Selection
  - Medicare Advantage OR Dual Eligible Special Needs Plans (DNSP) plans AND
  - High admission risk or health care utilization (calculated)
- High RN / Clinical Pharmacist / Social work staffing ratios with Care Management for patients
- **Daily** interdisciplinary team meetings to coordinate care, **regular panel management**
- Clinicians able to do home visits, longer visits, **small panels** (300 / 150)
- Same day access

PALLIATIVE CARE Integration

- Multidisciplinary Ambulatory team with Chaplain, RNs, ARNP
- Home visits and Linked visits with Personalized Care Team
- Goals of care focus
  - In terms of healthcare utilization AND patient satisfaction, the most impactful part of the Complex Care ecosystem
- Symptom management and support for patient and family

Benefits of Integration

- Getting lots of eyes and thoughts on challenging medical and social comorbidities
- Addressing big picture goals of care, heading off unwanted hospitalizations
- Identifying patients with limited life expectancy (that those of us in primary care sometimes greatly overestimate)

Value-Based Hospital Team & ED Diversion

- Hospitalist providers with training in MA model resources
- Track MA patients in ED, help with disposition when feasible
  - CUF nursing team to coordinate outpatient f/u or communication
- Admit directly to Hospital at Home
- Admit to observation status, bridge to Hospital at Home
- Admit to inpatient MA team
  - Designated Case Manager familiar with dispo resources
  - Lower census
  - HCC coding component (Clinovations)

Hospital at Home

- Patient selection
  - Medicare Advantage
  - Inpatient appropriate but NOT critical care level
  - Safe home environment
  - Hospitalist Reviews case
- Assessment in ER (or Same day by another acute care team) then return home
- Hospitalist team follows 24/7 with in home care by visiting RNs
- Able to do imaging, labs, IVs
- Outcomes at Optum: Shorter stays, higher satisfaction, very low SNF admission rate, low conversion to in-hospital care

Hospital at Home Literature

- Arsenault-Lapierre et al. Systematic Review & Meta-analysis, JAMA Netw Open
  - RCTs control in-hospital vs. hospital at home interventions
  - 9 studies including 959 patients
  - H@H: no difference in mortality, lower risk of readmission, length of treatment longer, lower risk of long-term care admission, lower depression and anxiety, no difference in functional status
- Conley et al. Systematic Review, JAMA IM
  - Meta-analysis 5 studies covering several clinical conditions, H@H saved on average $2000 per patient vs. inpatient management
- Report on AHCAH initiative, CMS.gov, Sept 30, 2024
  - https://qualitynet.cms.gov/acute-hospital-care-at-home/reports

Bringing it Together - Complex Care Ecosystem

Entity	2019	2020	2021	2022	2023	Program effects
ADK -TEC*	188	166	164	154	146	42/k reduction
ADK -TPC†	145	115	125	134	136	11/k reduction
EDK -TEC	220	215	213	207	225	5/k increase
EDK -TPC	207	175	248	264	268	61/k increase
SNF -TEC	33	29	26	26	31	2/k reduction
SNF -TPC	29	21	25	32	29	Stable

*The Everett Clinic
†The Polyclinic

Capitated payments and Complex Care

- Enables models that would not be feasible with fee for service
- Incentivizes different approaches to care
- Financial incentive ***can align*** with improvements in outcome
  - Patient goals often do Not include more hospitalization and ER visits!
  - Reduced healthcare utilization and admissions translates to profit

PROVIDER TAKEAWAYS

- Finances make this model possible
- High yield components:
  - Working as a team
    - IDT, shared in-basket, RN CM
  - Meeting patients where they are
    - Home-visits
    - Palliative care
    - Streamlined same day/urgent care
    - Hospitalization at Home
- *Are there high-yield processes you can support in your practice regardless of model?*

Thank you!!

Questions

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