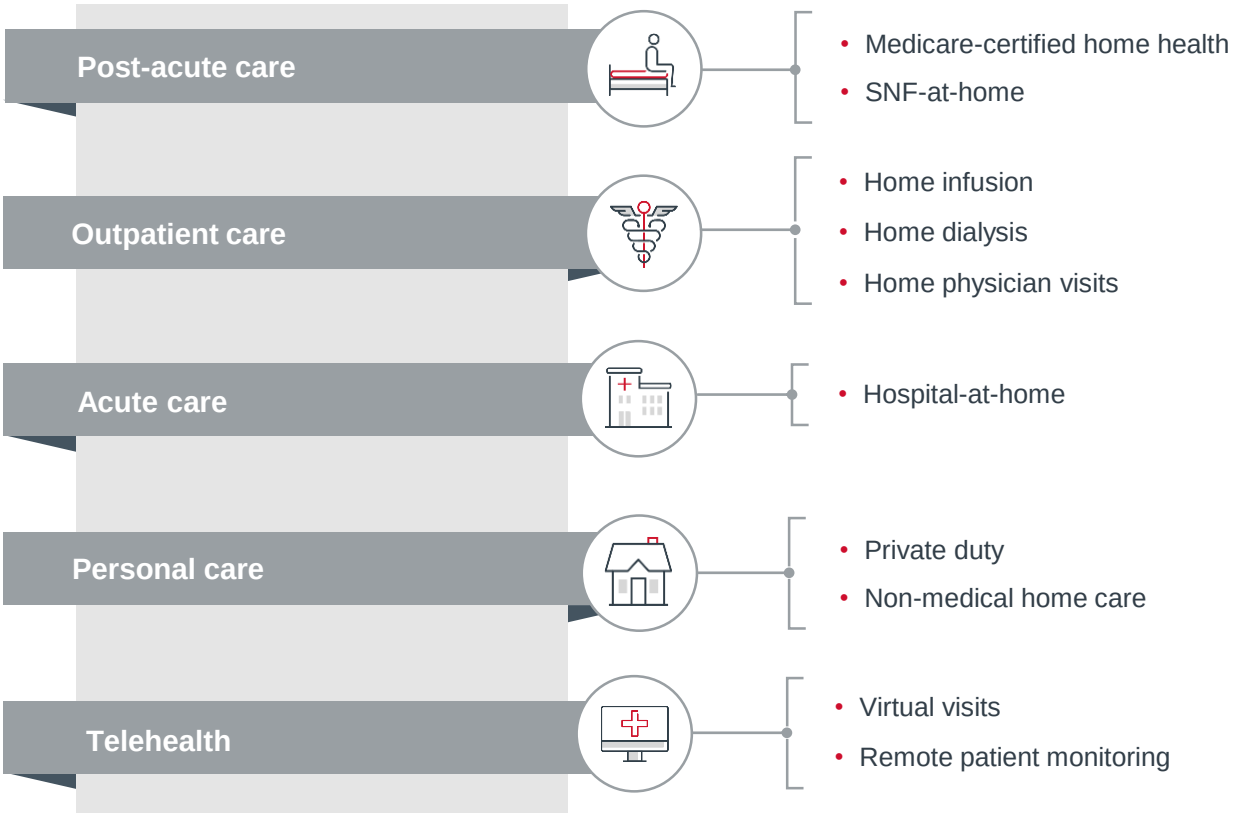
Key takeaways from a panel discussion on home-based care under Medicare Advantage

Home-based care has experienced increasing interest and growth during the Covid-19 pandemic from hospital-at-home to home-based primary care.

Emerging range of home-based care options



With all this growth comes questions around scalability, reimbursement, quality of care, and workforce. To address these questions and more, we convened a group of home-based care experts to discuss the future of home-based care under Medicare Advantage. This group included:

- Michael Johnson, Practice President Bayada, Home Health Care
- Nick Loporcaro, Chief Executive Officer, Landmark Health
- Travis Messina, Co-Founder and Chief Executive Officer, Contessa Health
- Greg Sheff M.D., Chief Medical Officer, Home Solutions, Humana

Read on for the five key takeaways from the discussion.

Source: Advisory Board interviews and analysis.

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Key takeaway #1: Scaling home-based care, while challenging, can be overcome through four primary mechanisms.

1. **Picking business partners** who already have a presence in markets you want to expand to makes scaling easier.
2. **Technology** allows an organization to take what they're doing and recreate it in a new geography.
3. **Training and standardization** is crucial to successful scaling. For instance, Landmark operates a "delta team" to recruit and train providers in new markets as a central part of their strategy to scale the model.
4. **Reimbursement** can make or break an organization's ability to scale. Historically, hospital-at-home models only operated in grant or pilot formats which are hard to scale. Once Contessa found a reimbursement model that worked, they were able to expand their hospital-at-home model.

Further, panelists noted that as these mechanisms are put into practice, they create a new infrastructure which makes it easier to continue expanding.

Key takeaway #2: Reimbursement must be structured uniquely for each home-based service and align with existing contracts in the market.

There is no one-size-fits all reimbursement model for all the different types of home-based care. Episodic interventions like Contessa's hospital-at-home programs rely on an episodic payment model, while Landmark's longer term home-based primary care model makes more sense with a full risk arrangement. However, when multiple providers take on risk in a market, this brings the challenge of who owns what portion of the risk. As such, final reimbursement methods must be determined in each market on a provider-specific basis.

> "If I have a value-based primary care group taking full cap on members, how do I then have hospital-at-home make sense and fit in, because that risk is already falling somewhere else."
>
> **Dr. Greg Sheff, CMO**
> Humana Home Solutions

Key takeaway #3: Working with MA payers is all about being an active partner.

Panelists emphasized the importance of approaching partnership with an MA payer based on that plan's challenges or pain points. For example, a provider might be excited about their outcomes or an innovative care delivery model, but without enough MA plan beneficiaries in that market, it is not as meaningful to the payer. Thus, providers should first learn a payer's challenge(s) and align solutions accordingly.

Additionally, panelists noted the importance of approaching payers with solutions that are budget neutral, before asking for shared savings or additional reimbursement. They have found this approach is the best way to open the door with payers.

Finally, it may seem obvious, but a commitment to regular communication and meetings is vital to a successful sustained partnership.

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Key takeaway #4: Outcomes metrics are essential, but don't forget about process metrics!

When pitching a program to a payer, organizations should come prepared with their outcomes data—and should expect those outcomes to be greeted with skepticism. Payers will likely want to test the outcomes in their own pilots, but still want to see the organization's data.

In addition, providers must articulate the specific interventions and process metrics that indicate a program is on track to achieving desired outcomes (which may take longer to achieve). For example, if an intervention's goal is to reduce readmissions by encouraging patients to see a nephrologist earlier in their care, providers must track that intervention and share it with the payer as a leading indicator.

Lastly, readmission rates and clinical/cost data tend to receive outsized attention, but providers should not forget that patient experience and activation metrics also matter to payers. This is particularly true for Medicare Advantage plans given CMS's push for Consumer Assessment of Healthcare Providers and Systems® (CAHPS) scores to have an increased impact on Star Rating.

Key takeaway #5: Recognize the home setting as a unique care environment—with distinct benefits and limitations.

For providers and tech vendors looking to enter the space, panelists emphasized the importance of understanding the realities of the home, including the benefits and limitations.

Panelists agreed that one of the most meaningful advantages of delivering care in the home is getting visibility into the patient's life. For example, a provider can ask a patient if their home and stairs are safe for them, but until the provider sees them in person, it is difficult to see what the patient is dealing with.

Furthermore, when patients return home from a rehabilitation facility, they tend to have a slight decline at first because they're learning how to do things at home rather than in the facility. One benefit of providing care in the home is that you don't have that issue.

On the flip side, interventions like remote patient monitoring will not be effective if you don't understand both the realities of the patient's home—something as simple as bad Wi-Fi can disrupt the model—as well as how the device can lead to an intervention. Panelists noted that technologies geared toward the home setting are often designed to predict or identify escalations—at which point a corresponding infrastructure must be in place intervene. As such, technology is well-positioned to extend home-based care teams but is unlikely to act as a direct substitute.

> "We all need to remember every other setting of healthcare outside of the home is fake. SNF and hospital stairs don't look like stairs in anyone's home."
>
> Michael Johnson,
> Practice President
> BAYADA Home Health

Source: Advisory Board interviews and analysis.

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