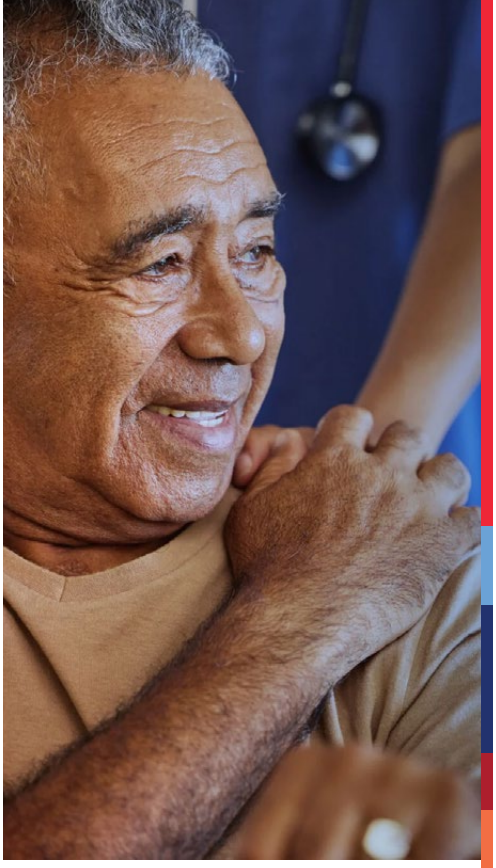
HOMECARE & HOSPICE
National Association for Home Care & Hospice

PAYER TIPSHEET

Developing Sustainable Relationships with Payers, Value-Based Organizations and Managed Care Organizations

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE



Home-based care providers are adapting to a reimbursement environment increasingly dominated by Medicare Advantage, managed Medicaid and Accountable Care Organizations, all looking to manage spend and quality. With CMS having a stated goal of getting 100% of Medicare beneficiaries into a value-based arrangement by 2030, interactions with payers and ACOs will only increase.

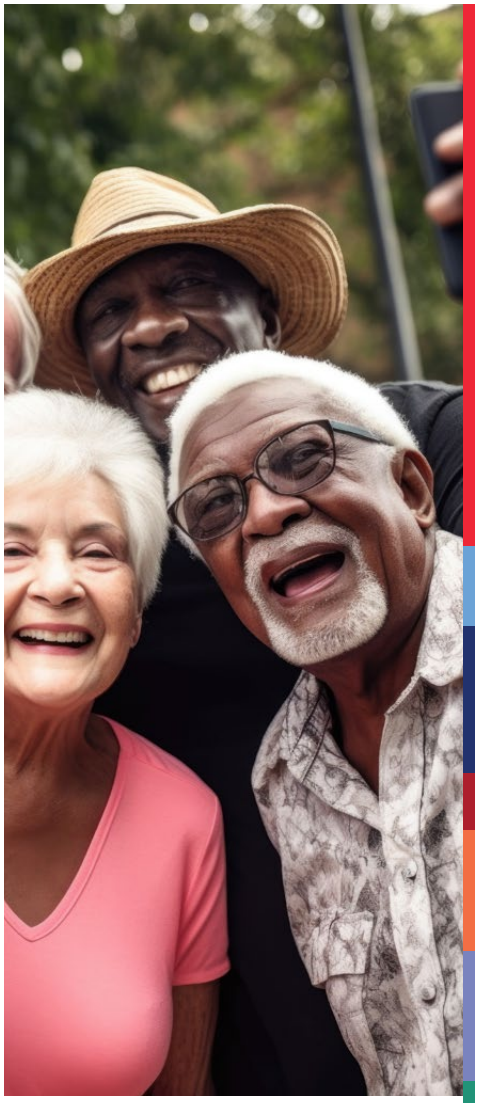
These changes present both challenges and opportunities. Care in the home is proven to save money while improving outcomes. While many payers seem fixated on rate setting, there are opportunities to educate and build the infrastructure to provide outcomes data that gain agencies a future seat at the table.

To help our members navigate this change, NAHC has compiled qualitative research to capture best practices on how to assess and navigate payer and risk-based organization mindsets and to develop mutually beneficial relationships that allow agencies to sustain their missions. We held in-depth focus groups with payers and contracting teams at home-based care organizations to compile these best practices.

This is part of a larger effort to invigorate public perception of home-based care as a dynamic and cutting-edge environment. With your help, we are working to give care in the home the place it deserves in the value-based care environment of the future.

Best Practices for Developing Mutually Beneficial Relationships with Payers and Value-Based Organizations

CHAOS IN THE MARKET, SILOED ORGANIZATIONS AND INCENTIVES ON PAYER SIDE



The relationships between payers and providers are rapidly changing. Home health organizations are struggling to gain meaningful footholds with payers in terms of the value they bring to insurers. Hospices see the Value-Based Insurance Design model being implemented as a portent to a carve-in to Medicare Advantage. Home care providers are struggling with patchwork payment systems via managed Medicaid, private pay and some Medicare Advantage supplemental benefit packages.

Agencies often see a disconnect between what payers say at a leadership level and the reality of negotiating for services or rates. While the aspirational goals of payers may be to lower total costs of care and increase quality, the incentives within their contracting departments are not yet aligned to these goals for home-based care. Of the organizations we spoke to, there were two key themes:

1. Home-based care is generally treated as a line item to be managed: Almost all discussions with payers are still focused on reducing payments, with little focus on quality or double-sided risk arrangements.
2. Some agencies are willing to enter risk-bearing arrangements, but the market has been slow to define these models, hampering meaningful progress.

Value-Based Care Will Continue to Expand:

CMS has a goal of

100%

fee-for-service patients

being covered by value-based arrangements

by 2030

Against this background, agencies and payers did provide some broad themes for thinking about how to interact with each other in ways that are mutually beneficial. These represent a general set of operating principles to guide agencies in the current climate.

BE TACTICAL: Hospital discharge planners are still home-based care stakeholders. Being able to accept patients from multiple payers can steer referrals to a quality home-based care agency. Calculated risks of entering contracts that allow you to accept patients from high-volume hospitals can help sustain operations while working to adapt to the new payer environment.

RELATIONSHIP DEVELOPMENT IS EVERYONE'S JOB: Payers aren't monolithic – they're evolving rapidly alongside the provider community. Working to map stakeholders at these agencies should be the responsibility of multiple team members at an agency. C-suite members should find ways to meet and connect with those who lead broad efforts at each state level. Marketing and community education teams should meet virtual case management clinicians for payers or Accountable Care Organizations, and contracting teams need to align with their counterparts. Logging these relationships over time will allow for deeper connection and multiple points of contact as turnover happens at payers.

THINK OUTSIDE THE BOX: Payers aren't viewing the fee-for-service paradigms as the benchmark. Agencies that constrain their positioning to hoping for traditional Medicare rates and rate structures will increasingly struggle to gain traction with payers.

KNOW WHEN TO WALK AWAY: Ultimately, agencies must have a good sense of what payments and rate structures they can sustain while providing high-quality care. Knowing your red lines before you negotiate a contract or service arrangement will help you focus on making a true impact where you can while allowing sustainability for your organization.

GOOD CONTRACTING TAKES TIME: Negotiating contracts with payers, especially for larger service areas or places of expected high volume, can easily take 12-18 months to arrange.

FIND YOUR LEVERAGE: The providers we spoke to advised working to find ways to have an advantage when going into negotiations.

HEALTH SYSTEM PARTNERS AND JOINT VENTURES: If your agency is a part of a hospital or health system, negotiating rates in concert with your larger partner can lead to more bargaining power for your home-based rates.

MARKET CONCENTRATION: If you can use data to show that you have a significant market share in a given community with high penetration of specific plans, you can often gain an advantage in being their favored contracted provider.

CLINICAL CAPACITY: With home-based care agencies having to decline referrals by double-digit percentages due to staffing shortages, being able to document your clinical capacity and acceptance rate is a factor that payers are taking into consideration as they develop networks for their members.

The Value-Based Insurance Design (VBID) Hospice Component:

WHEN SPEAKING ABOUT THE VBID PROGRAM WITH PAYERS, THEY MENTIONED SEVERAL KEY METRICS THAT THEY ARE TRACKING FOR HOSPICES:

LIVE DISCHARGES: Payers were mostly concerned about hospices with high rates of live discharge. They saw trends of programs that discharged patients for complex needs, who then were admitted to hospitals, then finally re-enrolled in hospice. Payers cited this as a key data point in their reviews.

ALL LEVELS OF CARE: Payers looked for hospices that had appropriate uses of all levels of care. However, we also heard from hospice contracting teams that some payers were not willing to pay for the Continuous Care (CC) level of hospice or were offering unsustainably low rates for CC.

AFTER-HOURS INFRASTRUCTURE: Having documented ways of providing care outside of the normal workweek, such as call centers or weekend triage, were seen as benefits to payers.

MANAGING UNRELATED COSTS: Hospices that worked to manage costs that were unrelated to the terminal prognosis gained an advantage. Programs were encouraged to have strong medication reconciliation programs or strive to help cancel recurring specialist visits for patients that no longer needed them.

VALUE PROPOSITIONS: Payers noted that some hospices they contacted were struggling to define themselves relative to their competitors. Leveraging data and sharpening a hospice's value proposition were seen as a skill yet to be mastered for the community.

ABILITY TO EDUCATE REFERRERS: Specifically, when it came to offering Transitional Concurrent Care (TCC) to patients (offering both curative and comfort care at the same time), VBID payers were interested in hospices who could help educate referral sources on what to look for and how to explain the TCC program to eligible patients.

Medicare Advantage Crossed

51%

of All Beneficiaries in 2023

The Payer and Value-Based Landscape Will Continue to Evolve

Payers and providers are merging, new models at the federal and state levels are coming online, and the larger structural and demographic landscape points to value-based care and contracting continuing to take on a larger role in home-based care. Providers are experiencing profound disruption and working to adapt to this evolution in payment systems.

While the landscape may be fractured and dynamic, the ultimate value proposition for home-based care is strong. People prefer care that is provided in the home. Home-based care also lowers costs and has strong quality and satisfaction ratings. NAHC is committed to raising the image of home-based care and working to ensure that providers have a seat at the table with payers and risk-based organizations. We are here to support our members and the larger care continuum with advocacy, training, best practices and support.

NAHC has also developed similar tip sheets for best practices in recruitment and retention of home-based care staff as well as materials for educating consumers on their options. **Please email marketing@nahc.org** or **click here** to view additional resources for our members.

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