

# HOME BASED PRIMARY CARE KEY THEMES AND SECTOR DEVELOPMENTS

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Ziegler

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# INTRODUCTION

## *Back to the Future*

As recently as 1930, approximately 40 percent of primary care appointments were doctor visits into the home. This nearly forgotten practice was widely known as a “house call,” and it all but ended about 35 years ago. However, in recent years, innovative care models have emerged that are bringing back house call providers. Multiple factors including the rapid aging of America, emergence of value-based care models, and new government payment initiatives are leading to an environment in which the use of house calls will expand.<sup>1,2</sup> Additionally, COVID-19, which immediately led to significant loosening of regulations around telehealth and the increased ability of providers to see patients outside their offices, will likely be a major impetus for regulation aiding house call providers.

This paper will begin by addressing the market demand characteristics that create the need for Home Based Primary Care (HBPC). We will consider changing demographics that have led to the largest elderly homebound population in U.S. history as well as the push to the lowest cost of care settings that has already resulted in favorable conditions for Home and Community Based Services, including home health, hospice and personal care. Rapidly developing technology, including the pending ascent of telemedicine, and the consumerization of healthcare are additional factors setting the stage for Home Based Primary Care.

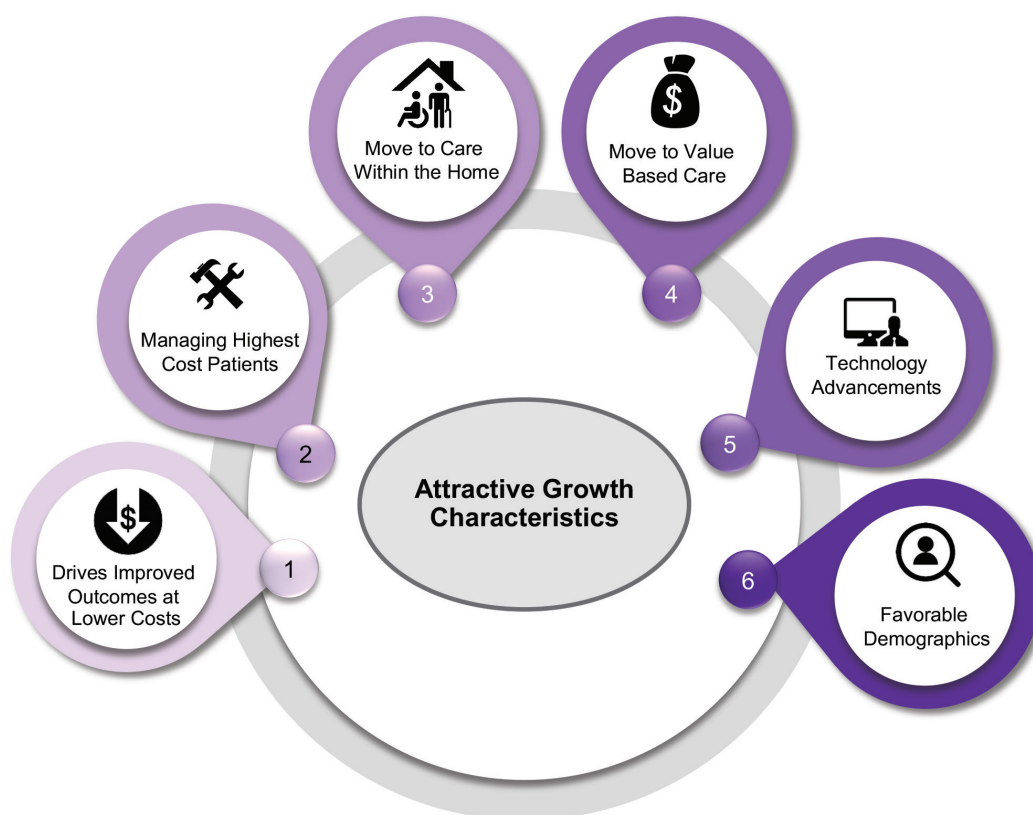
Following this discussion of market drivers, we will examine the successes and use cases of HBPC to date. Key demonstration projects, such as the Independence at Home project, have shown the usefulness of HBPC and Assisted Living has emerged as an early adopter.

Finally, we will look at some of the key payment initiatives, from increased reimbursement potential under Medicare’s Fee for Service codes to recent demonstration projects such as Primary Care First. HBPC operators have pursued unique paths to profitability, with most recognizing the longer-term future is within value-based arrangements to create alignment among key constituents and garner additional financial upside through improved care.

## Home Based Primary Care Overview

- HBPC is primarily care designed to prevent chronic conditions from worsening
- HBPC providers work in interdisciplinary teams including physicians, nurse practitioners, physician assistants, social workers, everyday medical technicians and pharmacists
- Often HBPC providers partner with health systems, accountable care organizations, managed care practices, and medical practices
- HBPC offers a proactive approach that takes account of the patient's environment, family, social stressors, and health conditions and helps the most vulnerable population stay in their homes
- HBPC is cost effective and eliminates readmissions, ED visits, avoidable complications, and medication errors
- HBPC can work in conjunction and provide a wide array of complementary services in the home with services including home health, hospice, personal care pharmacy, radiology, lab, etc.
- HBPC can utilize urgent house calls and paramedic services
- HBPC coordinates with remote technologies and telehealth

### Key Themes Promoting HBPC



# WHAT HBPC IS AND WHY NOW?

Home Based Primary Care programs provide care to patients in their home and can be particularly effective for high-risk and medically vulnerable seniors. HBPC providers, such as independent practices or hospital-based HBPC practices, are often small in size and partner with larger organization like health systems and ACOs to increase their reach. These HBPC provider partnerships can take many different forms and teams are composed of a variety of members including primary care physicians, nurses, nurse practitioners, triage nurses, physician assistants, LPNs, emergency medical technicians, pharmacists, social workers, and back-office support to run day-to-day operations, amongst others. These teams work in unison to provide the patient with the best care possible and team members will vary based on the patients' needs. This care team approach allows engagement with the patient by a provider operating at their highest and best use depending on the need being addressed.

The goal of HBPC is to make the patient feel comfortable in their home (personal residence, assisted living facilities, independent living facilities, etc.) while ill or dealing with chronic conditions, without compromising the quality of care. In order to provide the best possible care, successful HBPC programs aim to mirror the same offerings as traditional care practices. This includes:

- Improving the patient care experience
- Improving the overall health of diverse populations
- Reducing the per capita cost of care
- Leveraging portable medical technology to ensure exceptional quality of care is offered to home-based patients that is consistent with or exceeds care available in traditional care settings
- Offering on-call urgent care house calls and emergency medical care when needed
- Identifying and validating HBPC quality metrics as the foundation for value-based payment models

Ultimately, successful HBPC practices will demonstrate these attributes, which foster a long-term, trusting relationship between the patients, the patients' families, and the care providers.<sup>3</sup>

## Technology

There were important functions that could only be performed in physicians' offices which led to the decline in house call providers from the 1930s until recently, but new technologies are paving the way for home based primary care to greatly expand and become widely accepted. Traditional diagnostic technology, such as blood tests, electrocardiograms, X-rays, and ultrasounds, are office- or hospital-centered, so patients have had to go to the doctor's office or hospital to have them done. Modern technology enables these diagnostic tests to be done in the patient's home. Labs can be done via point-of-care testing or drawn in the home and spun down using a portable centrifuge that plugs into a car's auxiliary power outlet. Many areas now have services that offer portable X-ray and ultrasound in the home, and some large house call programs provide these ancillary services, which generate additional revenue.

Smartphone apps can assist care in the home by providing real-time monitoring capabilities, vision testing, drug databases, decision support, and much more. Finally, cloud-based electronic medical records allow access to patients' medical records virtually anywhere. All this enables the highest quality of medical care in the patient's home.<sup>4</sup>

In addition to these factors, telehealth, which has been gaining traction steadily, is ready to truly emerge in light of COVID-19 and the push to assist patients outside of traditional care settings. One of President Trump's first actions in response to COVID-19 was an \$8.3 billion funding bill that relaxed some Medicare restrictions on telehealth services, allowing for a wide range of healthcare providers to offer telehealth to Medicare beneficiaries. As this continues to play out, it can be a major benefit for house call providers, allowing for some of their services to be provided via remote technology.

COVID-19 has created a necessity for HBPC and also quickly educated the patient population on how to use tech and increased the comfort level with this care model so it will survive long after COVID passes.

## Why HBPC?

HBPC is an alternative solution to traditional hospital visits for aging patients that seek to receive primary care in their homes. HBPC often takes the form of preventative care and

closer monitoring to help avoid emergency room visits and hospitalizations that could have been prevented. Over time the patient begins to feel much more comfortable with their home-based physician than a traditional doctor's office, leading to improved patient satisfaction and minimizing the added mental stress that can arise from deteriorating health. Lastly, HBPC is generally cheaper than traditional health care as the patient is being monitored more closely and regularly by the same provider, allowing them to identify potential preventative actions and escalating care as needed. This leads to better results and reduced costs for the patient and their healthcare provider.<sup>3</sup>

In addition, HBPC provides great assistance to informal caregivers (i.e. family members). In many situations, unpaid caregivers are often the only reason a beneficiary is able to remain in the home setting. By bringing HBPC into the home setting, family members are relieved of the burden of transporting seniors to appointments, and the house call provider can more readily assess caregiver needs. This level of support saves the healthcare system billions annually over the cost of institutionalization if the caregiver suffers from "burnout" and cannot continue. HBPC also offers a homebound patient's caregiver the opportunity to receive their own healthcare in the home, saving them from having to arrange for care for their loved one.

Prevention is the best form of treatment. By consistently communicating with patients and monitoring their health conditions, HBPC providers are well positioned to prevent re-hospitalizations and emergency department services, which are some of health care's largest cost drivers. A Harvard Medical

School study published in the February 1, 2017 issue of the Journal of the American Heart Association found that health care costs were about \$5,000 less per year for people with the most heart-healthy factors compared to those with the least number of factors. The report noted if all Medicare beneficiaries followed "five of seven key heart-healthy" preventive habits to reduce cardiovascular disease, it would save more than \$41 billion a year in Medicare costs.<sup>5</sup>

Further, preventive medicine by a HBPC provider helps minimize the chance of patients developing chronic medical conditions as the providers can work closely with the patient to identify any emerging illnesses. An early prescription or behavior change allows time for mitigating major disease or health impairment later. Through developing a relationship with the patient, the provider can help save long-term healthcare costs while also keeping the patient's family informed of the condition, what medication management is required and how to optimize health and safety.<sup>6</sup>

Home Based Primary Care's proactive, preventative, patient-focused approach helps vulnerable patients remain in the comfort of their homes while still receiving the quality of care needed and reducing major healthcare costs such as readmissions, ER visits, and medication errors. These quality metrics are used to adjust provider payments based on their ability to meet baseline quality standards for various provider-preventable conditions. In certain circumstances, HBPC providers will be eligible for a bonus if they exceed and maintain their quality metrics.<sup>3</sup>

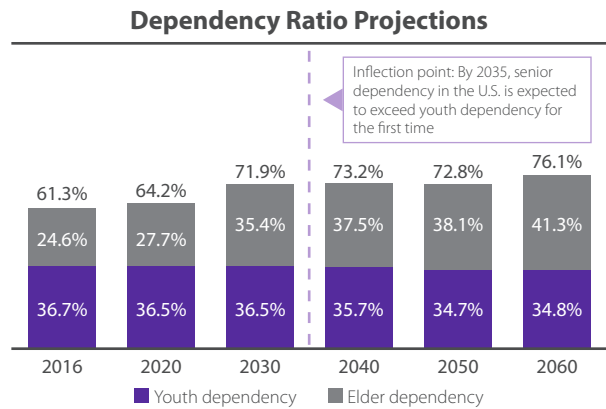
# MARKET DEMAND/DEMOGRAPHICS

Identifying the market demand for these services and key factors which will lead to their increase

Home Based Primary Care is an attractive and emerging sector due to numerous market activities and dynamics.

## The Aging of Society

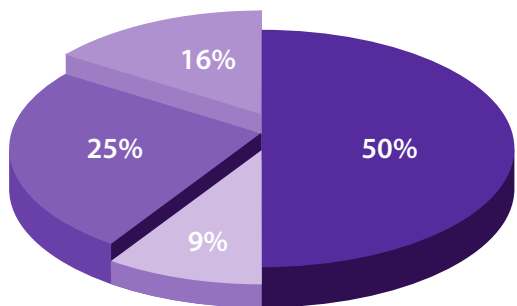
According to the U.S. Census Bureau's 2017 National Population Projections, by 2030, all baby boomers will be older than 65 years old. This means one in every five U.S. residents will be at retirement age. Adding to the generational shift: for the first time in U.S. history, older people are projected to outnumber children. The dependency ratio is the number of dependents in a population divided by the number of working-age people. Dependents are defined as those aged zero to 14 and those aged 65 and older. Working-age is from 15 to 64. As shown in the chart on the right, the dependency rate in the U.S. as of 2016 was 61.3% with the population age 65 and over equivalent to just under one quarter of the working age population. By 2030, dependency is expected to grow to 72.0% driven entirely by the age 65+



Source: U.S. Census Bureau; RBC Capital Markets

Approximately half of the population age 85 and over needs assistance with at least one activity of daily living; one-quarter needs help with two and one in six need help with three or more daily activities. This is an exploding homebound population. In 2011, 2 million individuals were homebound, and this population is expected to double over the next 20 years, which calls for adding HBPC experience to residency training.<sup>4</sup>

## Assistant Level of the 85 years and older Population



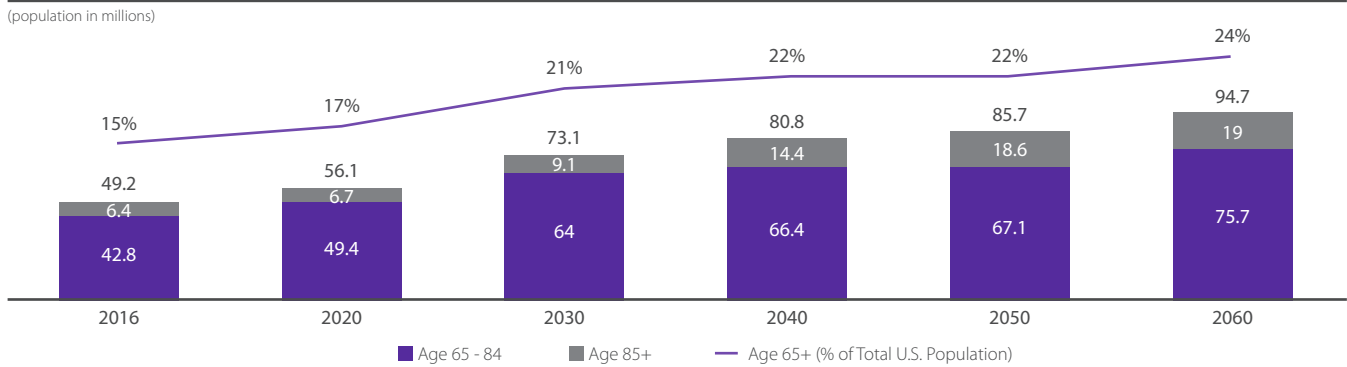
- 50% Needs assistance with at least one daily activity
- 25% Needs assistance with at least two daily activities
- 16% Needs assistance with three or more daily activities
- 9% Does not need any assistance with daily activities

cohort, which is expected to increase to over one-third the size of the working population. Importantly, by 2035 the population above age 65 is expected to dominate the U.S. dependent population for the first time in history. With expected dependency growth through 2060 driven entirely by the elderly, demand for elder care resources will only increase for the foreseeable future

Studies show that while approximately 2 to 4 million patients would benefit from HBPC, only 12% of these patients are receiving it.<sup>4</sup> There are at least two key factors for why HBPC leads to enhanced care for frail populations. First, transportation needs impair the ability to receive care until it is in response to an acute event. Those that are homebound are typically dependent on a member of their community or a family member to drive them to doctor appointments, reducing the frequency of their interactions with doctors and ability to effectively treat chronic conditions. Second, social determinants of health have been found to be critical to treating patients effectively, and seeing patients in their normal setting provides caregivers with a much more accurate picture of their patients' true situation. Patients' safety, diet, social interaction, hygiene, and other environmental factors play major roles in their overall health picture, and physicians and nurse practitioners can more effectively treat patients when they learn more about these factors.



## Expected Growth of the U.S. Elderly Population: 2016-2060

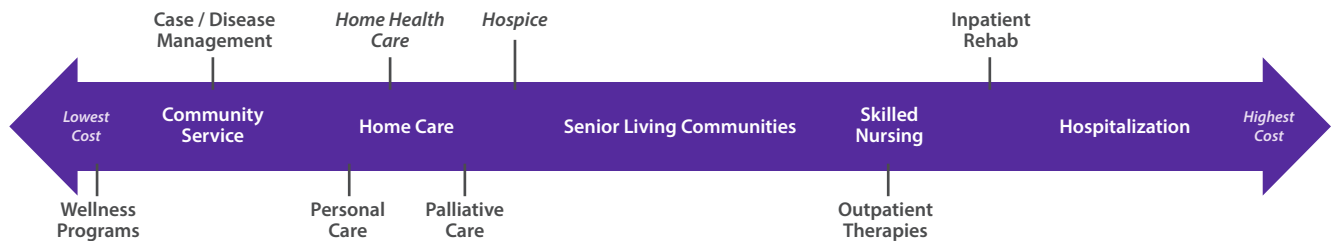


Source: U.S. Census Bureau

## Desire to Treat Patients in the Lowest Cost Setting and Rise of Value-Based Arrangements

Two major trends within the broader healthcare landscape are i. the desire to treat patients in the lowest cost setting and ii. the emergence of value-based payment models. These highly related trends significantly pave the way for Home Based Primary Care. Care has gradually moved to lower cost settings and away from hospitals. Patients have a preference for home-based care, which has driven the transition away from facility-based care. For example, an AARP study in 2018 showed that 77% of people agreed with the statement “I’d really like to remain in my community as long as possible”, but only 46% of people think they will be able to remain in their homes as they age. Therefore keeping patients in their homes aligns incentives of both seniors and those focused on lowering cost in the healthcare system. Additionally, care settings and acuity have been more accurately matched to patient needs, as enabled by monitoring and equipment.

## Home Care is Well Positioned on the Continuum of Care



Also, there has been a major shift from fee-for-service to value-based arrangements. Long-term, this is critical for HBPC. Instead of being paid for brief doctor-patient encounters which also involve drive time, providers will be compensated for their ability to keep patients out of more expensive care settings, leading to a much more significant share of overall care dollars. 34% of healthcare payments were value-based in 2017, up from just 23% in 2015, and roughly 80% of Americans had at least some value-based care in 2017. These numbers will only increase, as managed care programs with significant risk-based components such as Medicare Advantage continue to grow. Medicare Advantage plans had nearly half their healthcare dollars spent in value-based models (49.5%) while the commercial market plans has only 28.3% in these models.<sup>7</sup>

# MARKET APPLICABILITY

Home Based Primary Care has become a much more common way for the elderly to receive primary care as health care payments shifts from volume to value-based, realizing that the long-term savings from reduced hospitalizations, ER visits, transfers to skilled facilities, and other savings outweigh the costs of a home-based care provider. A demonstration project created by the Affordable Care Act, Independence at Home (IAH), tests whether providing HBPC to the most ill (and costly) patients improves outcomes and lowers fee-for-service Medicare spending. Practices that successfully lowered expenses for their patients are being rewarded with a portion of the savings. On average, participating practices saved 7.7% or \$3,070 per beneficiary in the first year.<sup>8</sup> Another study showed that hospitalizations fell by 23% and readmissions, which can be extremely expensive to the patient and provider, dropped by 27% over a two-year period. Hospitalizations for conditions that are amenable to effective ambulatory care fell 44%. Another IAH study had 15 HBPC providers serve 10,000 Medicare patients and saved over \$1,000 per patient compared to the national average spend for Medicare patients, largely attributable to fewer hospitalizations and emergency department services. According to CMS estimates, IAH practices saved over \$35 million during the first 2 years. National adoption of the IAH demonstration would result in \$10 - \$15B in savings over a 10-year period. All of these data points demonstrate that Medicare can save money and that home based primary care providers can earn more money by introducing shared savings programs for meeting HBPC quality metrics.<sup>3</sup>

IAH requires HBPC providers to be able to provide care 24/7 and to make in-home visits, including medication reconciliation, within 48 hours of hospital or emergency department discharge. Providers must meet three of the following six quality measures to qualify for the shared savings payment:

- Follow-up with the contact within 48 hours of a hospital admission, hospital discharge, or emergency department visit
- Provide medication reconciliation in the home within 48 hours of a hospital discharge, or emergency department visit
- Perform annual documentation of patient preferences

- Confirm all-cause hospital readmissions within 30 days
- Note hospital admissions for ambulatory care – sensitive conditions, defined as conditions that respond well to interventions deliverable in community-based healthcare settings
- Note emergency department visits for ambulatory care – sensitive conditions

Additional demonstration projects and successful use cases include:

- Analysis of the Veteran Administration's 2007 HBPC program (the largest in the country) found a nearly 60% reduction in hospital days, a 21% reduction in 30-day readmissions, and an 89% reduction in VA nursing home days. The program also had the highest patient and caregiver satisfaction of any VA program.<sup>9</sup>
- Comparing 700 HBPC to more than 2,000 controls over two years at MedStar Washington Hospital Center in Washington, DC, HBPC decreased hospitalizations by 9% and emergency room visits by 10%. This resulted in \$8,400 savings per patient and a total savings of \$6.1 million over the two-year period.<sup>10</sup>
- U.S. Medical Management (USMM, Troy, MI) operates the only HBPC accountable care organization (ACO) in the country. In 2016, its second year, USMM generated over \$44.5 million in shared savings on approximately 18,000 patients in 14 states, making it the fourth most financially successful ACO out of 472. USMM generated an average savings of \$2,450 per patient while achieving an overall quality score of 97%. In its third year, USMM saved \$45 million on 20,750 patients.<sup>12, 11</sup>
- Assisted living is a very strong use case for HBPC programs, as the next section describes.

## Use case within ALs

Assisted living (AL) has become an increasingly common housing option for elderly individuals, especially those with physical or mental impairment needing assistances with daily activities. Roughly one million Americans live in a senior living community, and that number is expected to double over the next 10 years as the “Baby Boomer” generation enters retirement age.<sup>12, 13</sup> To compete with institutional facilities, AL

communities must demonstrate the ability to provide quality care that reduces costs and the re-hospitalization of patients recently discharged from the acute care hospital.

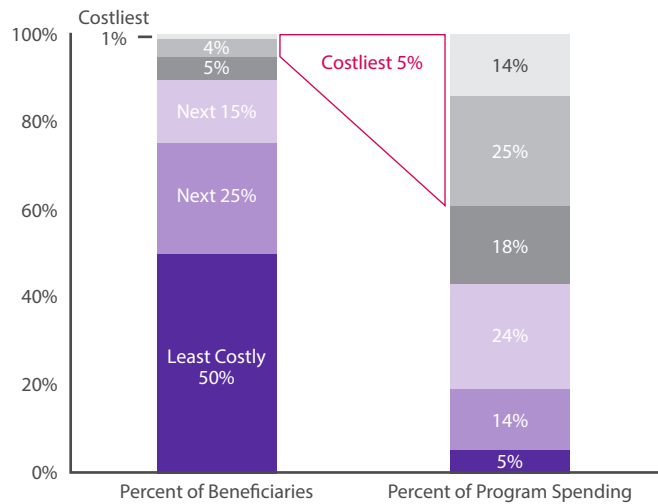
To provide higher value care, AL providers must address the medical needs of their residents, which will require them to embrace the “integrated” model of care.<sup>14</sup> Integrated health care is an approach characterized by a high degree of collaboration and communication among diverse health professionals, which often includes sharing of information amongst multiple providers to create a comprehensive treatment plan to address all needs of the patient.

This integrated care model is a complement to the “hospitality” or “social” model.<sup>14</sup> In addition to competing more effectively for referrals in the post-acute space, the evolution should also increase residents’ average length of stay (LOS), reduce their turnover, and improve occupancy.<sup>15</sup>

Medicare FFS spending is concentrated among a small number of beneficiaries. In 2016, the costliest 5 percent of beneficiaries accounted for 39% of annual Medicare FFS spending, and the costliest 25 percent accounted for 81%. By contrast, the least costly 50 percent of beneficiaries accounted for only 5% of FFS spending. Costly beneficiaries, who tend to include those that have multiple chronic conditions, use inpatient hospital services and get discharged into AL facilities. By addressing the health care needs of these high-cost Medicare enrollees, AL communities have the opportunity to significantly reduce costs incurred through reducing emergency department admissions, hospitalizations, and inpatient hospital services, among other costs. AL communities can be a key driver in improving the quality of care and delivering a better care model to help reduce costs across the healthcare system.

Assisted Living facilities can be lucrative targets for HBPC practices because providers can see numerous patients at one location. For patients in the home, some HBPC providers may charge a trip fee that is authorized by Medicare. HBPC practices have the opportunity to collaborate with AL facilities to provide a continuum of care offering a full suite of services including skilled nursing, PT, imaging, lab testing, and many other services, all on-site. AL facilities are highly incentivized to provide high quality care and avoid placing their patients back in the hospital.

### FFS Program Spending is Highly Concentrated in a Small Group of Beneficiaries



Source: Medicare Current Beneficiary Survey, 2018

When a patient is discharged from the hospital, the patient is typically first engaged in home based primary care within 48 hours of admittance to the AL facility. The provider assesses the patient’s medical condition and determines what care is the most appropriate. The provider and patient then set a schedule to monitor the patient’s condition as they begin their post-acute care.

HBPC providers aim to provide preventative care and make themselves accessible as often as necessary to ensure all medical needs are met. HBPC providers will only refer a patient to a skilled nursing facility or rehab facility if the patient requires 24-hour care. This greatly decreases the patient’s chances of being re-hospitalized and is only done if necessary.

## HOME BASED PRIMARY CARE BY THE NUMBERS



**50** MILLION

INDIVIDUALS IN THE U.S. THAT WILL BE 75 OR OLDER BY 2050



**2** MILLION

MEDICARE BENEFICIARIES WITH MULTIPLE CHRONIC CONDITIONS COULD BENEFIT FROM HBPC



**81%**

OF PEOPLE 65 AND OLDER THAT HAVE MULTIPLE CHRONIC CONDITIONS



**50%**

AMOUNT HBPC CUT HEART FAILURE READMISSIONS



**\$4,000**

ANNUAL HBPC SAVINGS/PATIENT



**30-40%**

RISK-SHARING HOME BASED PRIMARY CARE PROGRAM REDUCES AVOIDABLE UTILIZATION



**40%**

OF PATIENTS VISITS WERE IN-HOME IN 1930



**70/30%**

OF AMERICANS THAT PREFER TO DIE AT HOME VERSUS THOSE THAT DO



**5/39%**

TOP 5% OF PEOPLE ARE RESPONSIBLE FOR 39% OF HEALTH SPENDING

Sources: HCCI: Home-Based Primary Care's Perfect Storm; AAHCM: Home-Based Primary Care

# PAYMENT MODELS AND KEY DEVELOPMENTS

This section will look at historical and recent changes to the Medicare program that have helped increase the prevalence of HBPC. It will then explain the fee-for-service codes under which HBPC operators can currently bill, including several chronic care management codes. Finally, this section will explain the government initiatives and value-based approaches that operators are currently taking part in, and the potential revenue enhancements possible under these approaches.

## Higher Medicare Fee-for-Service Payments and Elimination of the Homebound Criteria

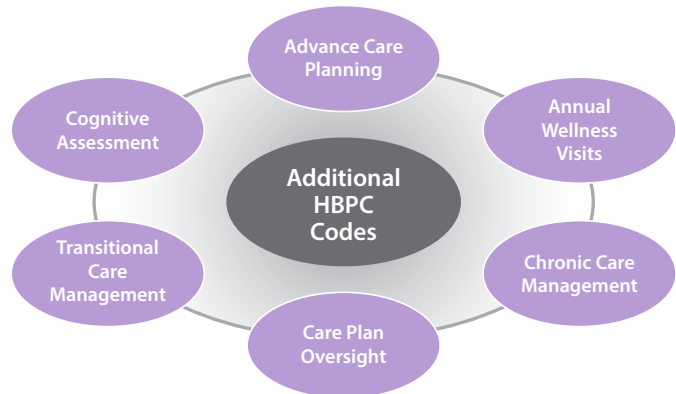
In 1998, Medicare created higher-level Current Procedural Terminology (CPT) codes for house calls and significantly increased its payments for HBPC. This resulted in increased use of HBPC services, as evidenced by a 43% increase in annual house calls from 1.4 million in 1998 to 2.1 million in 2004<sup>16</sup>, the first increase in a century. In 2006, Medicare added higher-level CPT codes for domiciliary visits (assisted living facilities and group homes) and more than doubled payments. This resulted in a marked increase in annual house visits from less than 1.3 million in 2006 to more than 3 million visits in 2016<sup>17</sup>. Medicare also added other CPT codes that support the work of HBPC providers, including care plan oversight for overseeing home health and hospice; certifications and recertifications for home health; chronic care management; advance care planning; and prolonged non-face-to-face service before or after direct patient care.<sup>4</sup>

In recent years, Medicare further expanded the potential for payment for HBPC by eliminating the homebound criteria in 2019, opening up HBPC to all traditional Medicare patients. Prior to this, HBPC providers had to document that the patient was homebound in order to bill for patient visits in the home under any Medicare code. This opens up the market to potentially any Medicare beneficiary that desires the convenience of having a provider come to his or her home. While in the near term, patients that can travel to providers are highly likely to continue doing this, over time as HBPC gains traction, this change dramatically changes the market potential for HBPC.

## Fee-for-Service Medicare Codes

In addition to basic Evaluation and Management visits, within the HBPC industry there is a broad offering of services such as Advance Care Planning (ACP), Annual Wellness Visits

(“AWV”), Chronic Care Management (“CCM”), Care Plan Oversight (“CPO”), Transitional Care Management (“TCM”), Cognitive Assessment (COG), Remote Patient Monitoring (RPM), and Behavioral Health Integration (“BHI”).



**Advance Care Planning (ACP)** is when a physician or other qualified health care professional discusses advance directives with a patient, family member, or surrogate.

**Annual Wellness Visit (AWV)** allows physicians/practices to gain patient information, including medical and family history, health risks, and specific vitals, in order to develop a personalized prevention plan. AWV are similar to a physical examination but also include a patient’s emotional and psychological well-being. These visits allow physicians/practices to improve quality of care, patient engagement, and optimize payment opportunities.

**Chronic Care Management (CCM)** is non-face-to-face care for part B Medicare beneficiaries with multiple chronic conditions. This group has a unique physician fee schedule service that applies to practices and patients not included in alternative payment models.

**Care Plan Oversight (CPO)** is provider supervision of patients under either the home health or hospice benefit. The patient must require complex or multi-disciplinary care with ongoing provider involvement and supervision by a physician or non-physician practitioner under the patient’s certified care plan, which is periodically re-certified by a physician.

**Transitional Care Management (TCM)** is the patient’s care between the inpatient and community setting. After a hospitalization or other inpatient facility stay, the patient may



earn a performance-based adjustment of up to 50% of revenue for meeting certain quality standards. If the practice fails to meet the quality standards, 10% of practice revenue is at risk.

A practice with 70% of revenue from primary care can participate in Primary Care First either for a general population, SIP, or both. For SIP, the payments and quality standards will reflect the complex health needs of the patient base.

Primary Care First model options are being offered in 26 regions for a 2021 start date. The application period for both practices applying to begin participation in the model and the payer solicitation period are now closed. Practice and payer selections will take place in Spring 2020 while the model will begin in January 2021. CMS is expected to focus on onboarding participating practices and payer partners to the model from July-December 2020, but it remains unclear how COVID-19 will affect these timelines.

**Direct Contracting** is another voluntary alternative payment model aimed at reducing expenditures and improving quality of care for Medicare fee-for-service beneficiaries. It consists of three voluntary model options where direct contracting entities (DCEs), like providers, payers, or other organizations, enter into full or partial capitated population-based payment (PBP) arrangements.

The three Direct Contracting model options build on principles of the Next Generation ACO Program:

1. **Professional PBP** is the lowest risk option. The DCE can have a minimum of 5,000 Medicare attributed lives with 50% shared savings or losses. The DCE will be paid through Primary Care Capitation equal to 7% Total Cost of Care for enhanced primary care services.
2. **Global PBP** is a higher risk option. As with Professional PBP, the DCE can have a minimum of 5,000 attributed Medicare lives, but takes 100% risk on the cost of care.

Global PBP DCEs will have a choice between Primary Care Capitation, like Professional PBP, or Total Care Capitation for all services.

3. **Geographic PBP** (*Under Development*) is the highest risk option with the most innovative model design. CMS plans to select at least two Geographic DCEs in each target region to promote competition. Each target region is required to have at least 75,000 Medicare lives. A Geographic DCE would be responsible for 100% of the cost of care for all Medicare fee-for-service beneficiaries in the defined geographic area. Geographic DCEs would have a choice between taking full financial risk with CMS processing Medicare fee-for-service claims or Total Care Capitation.

On November 25, 2019, the CMS Innovation Center released the Request for Applications (RFA) for only the Professional and Global options. The Geographic model remains on a longer development timeline, and the agency has not publicly indicated when stakeholders should expect to see an application for that model. The payment model options started in 2020 with an initial implementation period for organizations that want to align beneficiaries to meet the minimum beneficiary requirements. Five performance years will follow, beginning in April 2021. For the Professional and Global options, there are two application submission periods: one for applicants interested in participating in the Implementation Period and a second one for applicants wanting to start the model in the first performance year. The application for organizations interested in the Implementation Period closed February 25, 2020. The application for organizations interested in starting in the first performance year were due July 6th 2020. It remains unclear how COVID-19 will affect these timelines.

## KEY ELEMENTS OF PRIMARY CARE FIRST AND DIRECT CONTRACTING MODEL OPTIONS

Model	Eligibility	Payment	Other Details
<p><b>Primary Care First</b></p> <p>General or Seriously Ill Populations (SIP)</p>	<ul style="list-style-type: none"> <li>Minimum 125 attributed Medicare patients</li> <li>Primary care ≥ 70% practice revenue</li> <li>Can participate in one or both model options</li> <li>Located in one of 26 PCF regions</li> <li>SIP-only must have sufficient network to address complex health needs</li> <li>Claims-based attribution with voluntary alignment opportunity</li> </ul>	<ul style="list-style-type: none"> <li>Three parts:                             <ol style="list-style-type: none"> <li>Prospective capitated payment</li> <li>Flat fee for in-person visits</li> <li>Bonus for quality and avoidance of admissions</li> </ol> </li> <li>Bonuses can be up to 50% of practices revenue and losses up to 10%</li> <li>Specific PMPM and quality measure for SIP</li> </ul>	<ul style="list-style-type: none"> <li>Request for Applications (RFA) period is closed</li> <li>Payer solicitation expected to close Spring/Summer of 2020</li> <li>Model will begin January 2021</li> </ul>
<p><b>Direct Contracting</b></p> <p>Global or Professional</p>	<ul style="list-style-type: none"> <li>Contract with Direct Contracting Entity (DCE)</li> <li>Provider, payer, or other organization can be DCE</li> <li>At least 5,000 aligned Medicare lives</li> <li>Claims based or voluntary alignment (patients identify provider)</li> </ul>	<p>Population-Based Payments (PBP)</p> <ul style="list-style-type: none"> <li><b>Professional PBP:</b> <ul style="list-style-type: none"> <li>Primary Care Capitation, 7% TCOC, 50% savings/losses</li> </ul> </li> <li><b>Global PBP:</b> <ul style="list-style-type: none"> <li>Choice of Primary Care Capitation or Total Care Capitation, 100% savings / losses</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>CMS requires a Letter of Intent from organizations interested, non-binding</li> <li>RFA is now available</li> <li>Model will begin January 2021</li> <li>Benchmark:                             <ul style="list-style-type: none"> <li>Prospective blend of historical spending and adjusted MA regional expenditures</li> <li>Discount applied with potential quality bonus</li> </ul> </li> </ul>
<p><b>Direct Contracting</b></p> <p>Geographic <i>(Under Development)</i></p>	<ul style="list-style-type: none"> <li>In each region:                             <ul style="list-style-type: none"> <li>One or more DCEs</li> <li>DCEs responsible for all Medicare FFS spending</li> <li>Must have 75,000 Medicare beneficiaries</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><b>Geographic PBP:</b> <ul style="list-style-type: none"> <li>Choice of Total Care Capitation or full risk with FFS claims</li> <li>Either choice has 100% risk for DCE</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>CMS issued a request for information in 2019</li> <li>RFA timeline is unknown</li> <li>Proposed Benchmark:                             <ul style="list-style-type: none"> <li>One year historical FFS spend in target region trended forward with negotiated discount</li> </ul> </li> </ul>

Source: Caravan Health and Centers of Medicare & Medicaid Services

Additionally, Medicare Advantage programs are contracted to use house call programs to care for high-cost patients using per-member-per-month (PMPM) payment. House call programs have been found to reduce costs for patients as well as aid in important diagnoses used in risk adjustments that determine payments for Medicare Advantage. House call programs also help predict costs for ACOs and other shared savings programs. Capturing appropriate diagnoses shows the true disease burden of these homebound patients and can impact overall revenue and cost savings achieved by home based primary care. This program reduces gaps in care and achieves high patient satisfaction as well as improves quality scores and Medicare Advantage star ratings. Due to the benefits of this program, about 80% of ACOs reported using house calls for some of their patients<sup>18</sup>.



## | CONCLUSION

Home-based primary care offers a promising way to optimize care for many of the nation's sickest and frailest patients—those who are homebound or face functional limitations that prevent them from obtaining routine care in physicians' offices. The U.S. population age 85 and older is expected to quadruple by 2050; there are likely to be many more frail older adults who could benefit from home-based primary care. In addition, many younger adults, including those with disabilities and behavioral health conditions, could benefit from this approach.







The robust cost savings achieved by successful practices in the Independence at Home Demonstration suggest that extending the benefit to more Medicare beneficiaries, including those also eligible for Medicaid, could help reduce federal government spending. The experience of a risk-based medical group suggests another pathway for spreading home-based primary care through capitated Medicare Advantage plans, which are enrolling an increasing share of beneficiaries, or through integrated delivery systems working under value-based payment arrangements.






Ensuring success will require payment models that attract broader participation by medical practices and training opportunities that prepare primary care clinicians to work effectively in patients' homes. As the nation moves toward value-based purchasing of health care, policymakers and payers should consider the role home-based primary care can play alongside other effective models of interdisciplinary primary care in advancing a higher-performing health system.

# APPENDIX: STRIPS AND CASE STUDIES

As new generations push for more convenience and on-demand care, the nine-to-five scheduling seems to be a relic of the past. House calls and new health care models are gaining traction in metropolitan areas and dispersing to rural populations as well. Telehealth and telemedicine's emergence during the COVID-19 pandemic helped reveal the imminent realities of new health care models that are here to stay indefinitely and can provide improved care for patients. Below are companies making recent news.

## HOME BASED PRIMARY CARE COMPANIES

Company	Overview	Value Proposition	Recent Developments
	<p>A mobile clinic approach to provide care to patients where they are, including in residential and home-based settings. The care team is comprised of Bluestone medical providers, nurses and social workers collaborating with patients' other healthcare providers and families.</p>	<p>Bluestone's innovative integrated care model brings together primary care and care coordination offerings into a data-driven interdisciplinary care team</p>	<p>New initiatives include partnering with residential communities, homecare organizations and hospice to contract directly with payers for value-based care</p>
	<p>Offers on-demand mobile urgent care services within approximately 20 markets in the U.S.</p>	<p>Allows individuals to request care for acute injuries and illnesses, providing the same level and type of care provided at an urgent care center. It has partnered with leading health plans as well as traditional Medicare and Medicaid</p>	<p>Closed on \$136 million Series C growth capital financing in June 2020, with investors including Optum Ventures, Alta Partners, Questa Capital, Echo Health Ventures, Oak HC/FT and Humana. Previously closed on a \$33 million growth capital financing, led by Echo Health Ventures, a collaboration between Cambia Health Solutions and Mosaic Health Solutions</p>
(Echo Health Investors)			
	<p>Based in North Carolina, DMHC is one of the largest house call providers in the United States, providing approximately 200,000 visits per year mostly within senior living facilities</p>	<p>Becomes the primary care physician of choice within its base of ~200 AL centers (targets penetration over 50% with some facilities at almost 100% penetration). Emphasizes a flexible employment model and low volume and high complexity patient base that is attractive in physician recruitment</p>	<p>Interested in expanding its core base beyond North Carolina and becoming a regional and then a national leader</p>
	<p>Offer a full spectrum of post acute services to skilled nursing, LTACHs, rehab centers, and assisted / independent living centers in in Texas, North Carolina, South Carolina, Missouri, Kansas and Nevada</p>	<p>The Elite Patient Care Transitional Care Model was designed to promote the best possible outcomes for every patient by facilitating the transfer of information between facilities when necessary</p>	<p>In 2019, Lorient Capital announced an investment in Elite Patient Care to help pursue strategic growth initiatives</p>
(Lorient Capital)			
	<p>Founded in 2014 and based in North Carolina, Eventus provides physician-lead healthcare services within AL and SNF facilities</p>	<p>Offers an interdisciplinary team of primary care doctors, nurse practitioners and specialists to help the facilities reach their goals and ensure better patient outcomes</p>	<p>In 2019, Enhanced Healthcare Partners announced an investment in Eventus designed to help Eventus pursue strategic growth initiatives including expanding geographic footprint of its facility partnerships and M&amp;A opportunities</p>
(Enhanced Healthcare Partners)			
	<p>A technology focused company that provides same day medical housecalls for adults and children and currently is available to 75 million people in major markets including California, New York, Atlanta and the DC area</p>	<p>Heal uses technology to automate tasks including scheduling, billing and connecting with patients and physicians who are employed as independent contractors</p>	<p>In July 2020, Humana invested \$100 million, bringing the total capital raised to \$170 million. Raised \$20 million in 2018 from early stage Investors. Purchased Doctors on Call, a New York City-based housecalls provider in September 2019</p>

Company	Overview	Value Proposition	Recent Developments
 <p>(General Atlantic)</p>	<p>The nation's leading home based primary care group. Landmark provides 24/7 care to qualifying patients in their homes across 14 states, including California and New York, and serves 80,000 patients.</p>	<p>Integrated care model that includes medical, behavioral, social, and palliative care. It is focused on complex, chronic patients and collaboration between community-based organizations, primary care providers, specialists, patients and their families. The model has demonstrated 39% reduction in ER visits and 26% reduction in mortality.</p>	<p>In 2018, General Atlantic made a strategic investment to support its rapid growth and help it deliver better healthcare to chronically ill patients</p>
 <p>(Council Capital)</p>	<p>Founded in 2012, PHC is the leading provider of home-based primary care in Oklahoma and Kansas, and is rapidly expanding its current footprint in surrounding states</p>	<p>Innovative care model focused on providing coordinated preventative care for the highest risk patients in the home and AL settings. Well positioned to succeed under value-based payment models</p>	<p>Council Capital executed a majority recapitalization in March 2020 and is supporting Physician Housecalls in its geographic expansion while continuing its focus on quality of care and moving care to lower cost settings</p>
 <p>(Central Control)</p>	<p>Founded in 2009, PHS is a rapidly growing nurse practitioner (NP) care management company with 200 providers spread across southeast with presence in 400+ SNFs and 45+ALs</p>	<p>Strong focus on value-based care through contracted relationships with I-SNP partners and operates under 3 models: i) traditional model which deploys NPs to SNFs to support current MDs providing primary care ii) a value-based offering to I-SNPs, and iii) a hybrid offering of both services</p>	<p>PHS is involved in several CMS alternative payment models and grant-funded projects, and PHS serves in various consulting and practice capacities for multiple Institutional Special Needs Plans (ISNPs), with different models of care</p>
 <p>(Noro-Moseley Partners)</p>	<p>Based in Rhode Island, Upward provides physician housecall services with a focus on medical, behavioral, and social determinants of health</p>	<p>Upward has focused on partnering with payors to provide exceptional care for high-risk, high-cost members with a focus on reducing cost of care and improving outcomes</p>	<p>Upward received \$8 million in funding from Noro-Moseley Partners in 2019 and is focused on geographic expansion and the rollout of its Facilitated Virtual Care program</p>
 <p>(Centene)</p>	<p>Founded in 1993, VPA, an affiliate of USMM, is the nation's leader in house call medicine and geriatric home health care. VPA specializes in elderly care, serving over 50,000 home-based patients across 11 states</p>	<p>A physician-led model with 70% Physician Providers establishes close relationships with patients and a deep understanding of their social and clinical needs. Employs over 200 full-time Primary Care Providers (Physicians, Nurse Practitioners and Physician Assistants)</p>	<p>CMS announced that in the Fifth Performance Year of the seven-year Independence at Home (IAH) Demonstration, VPA achieved significant improvements in quality of patient care, while significantly reducing overall healthcare costs for homebound elderly patients with complex, chronic conditions</p>

Ziegler is well positioned within the Home-Based Primary Care industry. The team has completed over 25 home health and hospice deals in the last two years with 100% close rate. Also, the team has executed market-leading transactions such as Centene's acquisition of USMM and Council Capital's acquisition of Physician Housecalls. Please see case studies below.



In the sale to

**Council Capital**

**SELL-SIDE ADVISOR**

Physician Housecalls –  
Regional physician housecall  
provider

## Company Description

- Physician Housecalls (“PHC”) is the leading provider of home-based primary care in Oklahoma and Kansas, and is rapidly expanding its current footprint in surrounding states
- Founded in 2012, PHC deploys physicians, nurse practitioners, and physician assistants with primary care experience and serves the care needs of homebound patients, many with two or more chronic diseases
- Differentiated, broad offering of services including HBPC, annual wellness visits, chronic care management, care plan oversight, transitional care management, cognitive assessment and behavioral health
- Focused on serving patients within the lowest cost settings, the push to fee-for-value and participation in Primary Care First Medicare demonstration

## Strategic Goals

PHC was seeking a knowledgeable growth capital investor that could assist in:

- Regional expansion
- Technological advancements
- Acquisitions and M&A integration
- Providing executive level support

## Transaction Rationale

- PHC will use this investment to fund its platform and state expansion as well as gain access to Council’s sophisticated CEO Council Model, which has demonstrated considerable success driving growth for emerging growth healthcare companies
- Allows Council Capital to grow and generate returns by investing into companies that improve the patient experience while also reducing cost



In the sale of a majority interest to

**CENTENE**  
Corporation

**ADVISOR**

USMM – Leading provider of  
physician house calls and other  
ancillary in-home health services  
for complex populations

## Company Description

- U.S. Medical Management (USMM) is the national leader in integrated, physician-driven, house call medicine with comprehensive service offerings including primary care, health risk assessments, home health, hospice, podiatry, radiology, DME, lab and pharmacy
- USMM managed over 50,000 high-acuity patients with multiple chronic conditions, cognitive issues, functional impairments and psychosocial complications and participated in the Detroit Medical Center Pioneer ACO and the Independence at Home Demonstration Project
- USMM, directly or through managed affiliates, conducted over 400,000 physician house calls annually and over 2,500 face-to-face patient interactions with licensed health care professionals on a daily basis
- USMM operated 39 local offices across 11 states, including seven states in which Centene operated

## Strategic Goals

USMM was pursuing select managed care strategic relationships to:

- Engage in innovative contracting
- Develop targeted care management solutions
- Partner with entities looking to its differentiate offerings
- Deploy physician driven HCC risk scoring and HEDIS measuring initiatives

## Transaction Rationale

- Provides a continuum of high quality services that allows Centene to effectively manage the complex needs of its growing high acuity populations
- Allows Centene to offer quality healthcare services and programs for an aging, co-morbid population in the comfort of their own homes

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## ABOUT THE AUTHORS



**CHRIS HENDRICKSON**  
MANAGING DIRECTOR  
312 705 7286  
chendrickson@ziegler.com

Chris Hendrickson joined the corporate finance team at Ziegler in 2012. He has over 20 years of healthcare services experience focusing on mergers and acquisitions and capital raising for home health, hospice, pharmaceutical services, managed care, healthcare information technology, and chronic condition management entities. Chris has participated in the execution of over 75 healthcare transactions, totaling over \$30 billion.

Previously, Chris spent the last four years as a senior leader in Lazard Middle Market's healthcare services team. Prior to joining Lazard, he spent six years as a vice president at UnitedHealth Group in numerous roles including mergers and acquisitions, strategic development, national hospital and physician network development, and president of Ovations' home care and chronic condition management business unit. Prior to UnitedHealth Group, Chris was a vice president at RBC Capital Markets and a senior member in their healthcare and technology investment banking groups. In addition, he was a manager at Grant Thornton LLP and a senior associate at Coopers & Lybrand LLP.

Chris graduated from the University of Michigan Graduate School of Business where he received his M.B.A. with concentrations in strategy and finance. He received a B.A. in accounting from the University of St. Thomas. Chris is also a Certified Public Accountant.



**KEN BENTON**  
VICE PRESIDENT  
312 705 7287  
kbenton@ziegler.com

Ken Benton joined the corporate finance team at Ziegler in 2017. He specializes in mergers and acquisitions, strategic advisory and capital formation engagements for Ziegler's middle-market healthcare client base. Ken focuses on providers at all stages of the continuum of care as well as information technology and managed care entities.

Prior to Ziegler, Ken was a vice president at Hammond Hanlon Camp LLC (H2C), an independent, healthcare-focused strategic advisory and investment banking firm. Prior to H2C, Ken worked in the healthcare groups of boutique firms Scott-Macon Ltd. and Navigant Capital Advisors. In these roles, Ken advised on M&A, equity and debt capital raises and restructurings to middle-market healthcare clients with a particular focus on serving healthcare providers and payors, both for-profit and not-for-profit.

Ken earned a joint J.D./M.B.A. degree in finance from Emory University. He earned a B.A. degree from Williams College, where he majored in political economy. Ken holds Series 7, 63 and 79 securities licenses.



**FRANK UGBOH**  
SENIOR ANALYST  
312 705 7241  
fugboh@ziegler.com

Frank Ugboh joined the corporate finance team at Ziegler in 2019. He specializes in mergers and acquisitions, strategic advisory and capital formation engagements for clients in the healthcare services and healthcare information technology sectors.

Prior to Ziegler, Frank worked as an investment banking analyst at Wells Fargo Securities, performing and advising on mergers and acquisitions as well as capital raising transactions.

Frank received a B.B.A. in accounting and business honors with a minor in finance and economics from the University of Texas at Austin.

## ABOUT ZIEGLER CORPORATE FINANCE HEALTHCARE

*Ziegler has long lasting relationships with healthcare providers, information technology companies, financial sponsors and other thought leaders across the nation, giving us unique insight into emerging trends and the future direction of the healthcare industry.*

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Our team has an extensive track record of putting our client objectives above all else in closing transactions. As a result, we successfully deliver tailored merger & acquisition, capital raising, restructuring and corporate partnering solutions, helping organizations identify and capitalize on exceptional and differentiated opportunities.

Ziegler's team has an unwavering dedication to the healthcare industry and includes professionals with extensive healthcare investment banking, corporate development, operational, accounting and entrepreneurial backgrounds enabling us to deliver unmatched advisory services to our clients.

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- Physician Groups
- Virtual Care

## ZIEGLER HEALTHCARE SERVICES & TECHNOLOGY TEAM

### NEIL BORG

HEAD OF CORPORATE FINANCE HEALTHCARE,  
SENIOR MANAGING DIRECTOR  
nborg@ziegler.com  
301 828 1065

### ANDREW COLBERT

SENIOR MANAGING DIRECTOR  
acolbert@ziegler.com  
212 284 5422

### GRANT CHAMBERLAIN

MANAGING DIRECTOR  
gchamberlain@ziegler.com  
312 596 1550

### CHRIS HENDRICKSON

MANAGING DIRECTOR  
chendrickson@ziegler.com  
312 705 7286

### CHRIS ROGERS

MANAGING DIRECTOR  
crogers@ziegler.com  
615 982 7550

## ADDITIONAL LEADERS OF ZIEGLER'S HOME AND COMMUNITY-BASED TEAM

### JAYSON ZIRMAN

VICE PRESIDENT  
jzirman@ziegler.com  
(212) 284-5418

### WILL SIMSON

ASSOCIATE  
wsimson@ziegler.com  
(312) 705 7254

### BRIAN BRINK

SENIOR ANALYST  
bbrink@ziegler.com  
(312) 705 7288

### JONATHAN MAASHO

ANALYST  
jmaasho@ziegler.com  
(312) 705 7240

### PETER HEIMBOLD

ANALYST  
PHeibold@ziegler.com  
(312) 705 7251

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## | CONTACT US

### **ZIEGLER**

1 North Wacker Drive  
Suite 2000  
Chicago, IL 60606

**800 366 8899**

**[askziegler@ziegler.com](mailto:askziegler@ziegler.com)**



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