



Emerging Reimbursement Models: Preparing for What Lies Ahead for Skilled Nursing

An Executive Roundtable Discussion of Key
Post-Acute Care Executives

A special event hosted by *Provider* magazine
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payments and expect
the outcomes to be the
same as today.”*

Bill Levering
President and CEO,
Levering Management

Executive Summary

The Challenge

Medicare in the United States is turning 50 years old, an anniversary that is also ushering in new models for health care reimbursement. We are moving quickly towards payment models based on quality rather than quantity of care, which in turn will have a major impact for the entire long term care industry.

In October of 2015, 14 key executives from various segments of the post-acute care industry met in a roundtable discussion at the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) Annual Convention & Expo in San Antonio, TX for a *Provider Executive Roundtable* to share their observations and predictions for the future of long term care reimbursement models.

The Bottom Line

Traditional fee-for-service models are becoming a thing of the past for the long term care industry. Most panelists already participate in reimbursement models such as Accountable Care Organizations and bundled payments, and feel that surviving and flourishing in the future will require a new level of innovation, data sharing and collaboration with partners.

The Takeaway

Major players in the post-acute care profession are starting to adapt to newer payment models, but success requires changes in both process and strategy. This paper summarizes the view of current thought leaders in the market, with top takeaways including:

- › New payment models signify a shift towards increased accountability for patient care outcomes.
- › For many operators, their best prospects lie in better visibility through improved use of data.
- › Long term care’s profitability increasingly rests with collaborative relationships across the continuum of care.

Roundtable Participants

Dr. Harry Baum	President, C & H Healthcare
Chance Becnel	President and COO, Axiom Healthcare Services
Calvin Calloway	Administrator, Folsom Care Center
Teresa Chase	President, American HealthTech
Gerald Coggin	SVP, National HealthCare Corporation
Garen Cox	President and CEO, Medicalodges
Joey Haney	VP Finance, White Oak Management
Steven Hatlestad	SVP, Americare
Bill Levering	President and CEO, Levering Management
Stephen Marlow	VP/CFO, Care Initiatives
James Michel	Senior Director of Medicare Research and Reimbursement, American Health Care Association
David Norsworthy	VP Strategic Planning, Central Arkansas Nursing Centers, Inc.
Gail Polanski, RN	President, Tara Therapy LLC/Tara Cares
Tracey Schroeder	SVP Marketing, Healthland
Tammy Trasti	VP Managed Care, Golden Living

Moderators

Fred Benjamin	COO, Medicalodges
Joanne Erickson	Editor in Chief, <i>Provider</i> magazine

“As long as we focus continuing to care for our patients, we’ll be OK. Sadly, there’ll be winners and losers. Which one you will be will be up to you.”

Gerald Coggin,
SVP, National Healthcare
Corporation

Introduction and Background

In January of 2015, Health and Human Services (HHS) Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the *quality* rather than the *quantity* of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements, by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. *This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.*

HHS adopted a framework that categorizes health care payment according to how providers receive payment to provide care, framed around four categories:

- › Category 1: Fee-for-service with no link to quality
- › Category 2: Fee-for-service with links to quality
- › Category 3: Alternate payment models built on fee-for-service architecture, including ACOs, MCOs, and bundled payments.
- › Category 4: Population-based payment

This year’s executive roundtable once again gathered top executives and leaders in the LTC industry to discuss the state of the industry, this time focusing on the realities of new models for Medicare reimbursement. The consensus is that these are fundamental changes that will impact the LTC business paradigm, with key points including the following:

1: Fear is giving way to acceptance – and opportunity.

With growth in Medicare Advantage in most markets, a slower rollout of ACOs, and gradual moves toward bundled payments, LTC providers are starting to accommodate newer payment models. SNFs are adjusting to this, particularly larger ones, with some concerns for the future of smaller “mom and pop” operations. Strategies for the future range from having a role in preferred provider networks to dealing with greater acuity and increased volume.

2: Long term care needs a voice in this process.

The decline of fee-for-service models is placing more SNFs in a collaborative environment with other health care providers. Succeeding within this new strategy will require better communication and stronger negotiating skills.

3: Post-acute care is becoming more data-driven than ever.

New payment models have brought with them the need to have greater visibility than ever for operational metrics, at a higher level of granularity than in the past. These range from internal cost and clinical outcomes data to collaborative metrics such as re-hospitalization rates. Combined with expanding data reporting requirements, the importance of a strong technology infrastructure has become paramount.

Let’s look at what this group of 14 executives has to say about these and other topics in detail, as they discuss the state of the long term care payment landscape for 2015 and beyond.

“It is being on the forefront and knowing what those changes are. I can make those changes tomorrow before they want it ... If I’m not up front and not there then I will get run over.”

David Norsworthy
VP Strategic Planning,
Central Arkansas
Nursing Centers, Inc.

Where are you at today?

Key Discussion Points:

This roundtable discussion opened with the participants sharing where their own facilities stood in terms of participation in newer payment models such as accountable care organizations (ACOs), managed care organizations (MCOs), preferred partner agreements, and bundled payments – as well as how these models were working out for them to date.

Responses varied widely: MCOs are growing quickly with the continued expansion of managed Medicaid, while other models such as ACOs and bundled payments are ramping up more slowly. Specific participants commented as follows:

Joey Haney: I have seen a lot of change in the industry. We still have pretty limited experience with ACOs, while around 25% of the 2000 patients at our 15 nursing homes in North Carolina and South Carolina are under managed Medicare. We have seen mixed results so far, with gain shares good in summer, but not so good now. There has been some initial participation in the dual-eligible pilot in South Carolina, but things have been very slow to move forward.

Bill Levering: Not so much effort toward ACOs, but managed care is in full force. Bundling has not been occurring in Ohio, and it is something we do need to discuss.

Gerald Coggin: We are heavily immersed in managed care in Florida, and have seen an increased number of people under Medicare Advantage plans. Bundled three projects. Preferred provider in ACOs when have opportunity (more so in North than in South).

Stephen Marlow: MCOs will be implemented in Iowa on Jan. 1, 2016. Not much involvement yet, however I know of 2-3 ACOs developing in the area.

Harry Baum: It is a whole different ballgame for a single facility. Managed Medicaid is taking a long time to iron out in Kansas. We don't have the software for this, and it's a struggle.

Gail Polanski: We are seeing a lot of Medicare Advantage growth, but not a lot of ACOs.

Steven Hatlestad: We are seeing more private-pay clients, and trying to figure out what to do with our buildings. Our Medicare is hurting some. Residents for acute services have to go to bigger towns, and drive 30-40 miles to get there.

How do you set goals for the relationship with MCOs, and foster a relationship to focus on risk-sharing models, long- and short-term agreements?

Central Arkansas Nursing Centers' David Norsworthy frames this issue around being proactive: "It is being on the forefront and knowing what those changes are. I can make those changes tomorrow before they want it. It is a matter of staying up with education and understanding. If I'm not up front and not there then I will get run over."

Americare's Steve Hatlestad echoed a similar view, noting that, "It's all about planning and strategy. There is no one-size-fits-all strategy. I still believe that we are a small enough industry to react before someone else's failings become our failures."

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Fred Benjamin
COO, Medicalodges

Value-Based Programs and Bundling

Key Discussion Points:

Value-Based Programs as defined by CMS refer to a broad set of performance-based payment strategies that link financial incentives to providers’ performance based on a set of defined measures – all in an effort to drive improvements in quality and manage costs in health care spending.

As one example of this, 2015 marked the first mandatory test of a bundled payment program for select Medicare facilities, involving hip and knee replacement procedures. One recent article showed that with a bundled payment of \$24,770 for major joint replacement to a lower extremity, the shares for skilled nursing facilities and home care were \$4,660 and \$1,930 respectively.¹ Roundtable participants’ reactions to the move toward bundling showed caution and concern:

National HealthCare’s Gerald Coggin offered a perspective from being part of three bundled projects to date: “Look at precedence. Most orthopedic associates have precedence over us – we are not setting the hips and knees anymore, and referrals are dwindling. Because if they bundle, patients often go from hospital to home. Our home care offices are trying to benefit. We are still in transition, and we are finding that with third-party caregivers, there’s not really money to share.”

Bill Levering spoke to the mood of long term care operators in general by stating that, “Bundling is a very real concern. Bundling and value-based purchasing can all be merged over time. This is going to be a very difficult matter.” Harry Baum was more specific about concerns for smaller operators, noting, “How are independent owners going to get involved in bundled payments? Are those the ones that we’re going to allow to go by the wayside? What’s going to happen to rural communities? I don’t want those people to be left out of the mix. They need to have a voice in this. How do we move these people in AHCA? If we lose those we’d lose a large part of what LTC is really all about.”

¹ Evans, Melanie. Bundling risk: New demo program shows CMS’ eagerness to ditch fee for service.
Modern Healthcare, July 18, 2015.

Participants were of the consensus that episodic payments are inevitable, with Co-Moderator Fred Benjamin stating that this was an area of concern for the industry. He also shared that AHCA was working on its own model, noting that, "If everyone drinks at the same trough, we are all going to be thirsty."

How do we move from reimbursement to revenue cycle management – getting paid for the value you provide in health care services relationships?

Tammy Trasti of Golden Living in Texas noted that her approach is to be "payer agnostic": "Price is not based on cost – it is based on value. To increase this value, you have to listen to your market, improve your star ratings, and improve your value proposition." She recommends approaching the issue of value-based payments as a risk taker, piloting bundled payments, implementing true case management and care redesign, and educating and training your entire organization.

Bill Levering emphasized that operators needed to be proactive in structuring the relationship with bundled payment partners. "LTC has to be part of the handling of the payment. We simply can't be last in line for payments and expect the outcomes to be the same as today." And while he admits that this transition to more episodic payments sometimes keeps him awake at night, he expects that the next cycle of payment will be fair and operators will continue to thrive. "I don't believe that health care is an entitlement. It is society's responsibility. Managed care shouldn't be managed price."

The Role of Technology

Key Discussion Points:

Episode of care/bundled payment models and others such as Shared Savings involve a greater need for automation. Roundtable participants discussed their technology needs in areas including interoperability, data sharing, and reporting.

Participants noted that hospitals already have their data, using tools such as Medicare.gov's Nursing Home Compare website and CMS claims data. There was a consensus that both greater visibility and the ability to share data with care partners were important to leveraging the new era of shared payment models.

Bill Levering framed this issue as one that started with LTC facilities having better visibility: "Clinical data is going to help us. We need to be seen as a resource so patients see that effective care is given. AHCA's LTC Trend TrackerSM program can be the first exposure for facilities to a comprehensive system to help them understand where they stand."

Tara Cares' Gail Polanski echoed that they use Trend Tracker as well as the Interact Tracking tool as a strategic tool to manage readmission prevention. "We have seen an increase in cardiac rehab patients as well as respiratory patients, and this has helped us handle change. This is similar to what we saw with introduction of the Prospective Payment System. We need to have a strategy and plan accordingly."

American HealthTech's President Teresa Chase emphasized that interoperability was a key priority for vendors such as hers: "We have been talking about interoperability for years. Infrastructures are expensive – we need to follow standards, build packets of data and share that information back and forth between ourselves. This data has to move."

AHT has a new system planned for launch at the beginning of 2016 that is based around collaboration

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James Michel
Senior Director of
Medicare Research and
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Health Care Association

and coordination, and Chase notes that without this “you will find yourself nicked and dined to death.” She went on to say, “We have a vested interest in this. What we’re doing in health information technology is extremely important. This is your data. Push us. Let us know how you are engaging with physicians. We don’t have time anymore to just move forward with our heads in the sand, it is just not going to work. We have got to share the data, and interoperability is important.”

Healthland’s Tracey Schroeder echoed this sentiment, noting: “It’s coming fast. There’s no walking away from it this time. There’s no way back. It is a matter of how you can get through this. Interoperability is the toughest nut to crack.”

Looking to the Future

Key Discussion Points:

Looking to the next 2-3 years, how would you define success in navigating through the fast-paced nature and complexities of new reimbursement models?

There was a consensus that episodic payments and new reimbursement models were inevitable, and that success revolved around both learning to adapt and getting proactively involved, particularly with health care partners. According to AHCA’s James Michel, perspectives are changing from a fear of the unknown to acceptance and understanding, and moreover toward how to innovate. “Our goal is not only to prepare the overall industry... but to position our members ahead of our industry as well.”

What do you see as your greatest opportunities?

Participants in general saw new payment models as part of a greater opportunity to learn and reinvent their operations. Axiom Healthcare Services’ Chance Becnel

framed this around three areas: 1) Focus on clinical products — get really good at what we do, and good at the bedside; 2) Look at who we partner with in therapy, to combine resources and obtain valuable acute and post-acute data; and 3) Get executives to be at the table — much more of the future will be decided at the executive level. “Where we probably are going is decided on a much, much higher level.”

What do you see as your greatest challenges?

The greatest concerns revolved around changes to LTC business models, and how the economies of scale of new payment models would affect smaller operations. Tammy Trasti shared concerns, including “shorter lengths of stay, delayed admissions, payment denials, and additional staff required. Also, getting approval from MCOs when therapy isn’t delivered in time, because the hospital didn’t have time to get prior authorization.”

Gerald Coggin spoke frankly about the second issue: “It’s a shame that old mom-and-pop organizations are going out of business, because they provide quality care. Now some people will have to drive 100 miles to get service. The only endgame I see is taking control of our future.”

Coggin summed up a common position among Roundtable participants: “As long as we focus on continuing to care for our patients, we’ll be OK. The key is quality, quality, quality. Sadly, there’ll be winners and losers. We do have to accept this risk, because episodic payments are coming. I think we’re going to be OK, but things are going to change.”

About American HealthTech

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