Partnering with MCOs, ACOs and Hospitals as New Payment Models Emerge in Post-Acute Care

16 Post-Acute Executives from Across the Nation Weigh In

Executive Roundtable
A sponsored provider event held at the American Healthcare Association Annual Convention
October 9, 2013
Executive Summary

The Challenge
Managed care and/or accountable care are reshaping the post-acute industry. As states look to find savings, Medicaid is one of the fastest-growing sectors of Managed Care.

In October of 2013, 16 post-acute executives came together at The American Healthcare Association (AHCA) Annual Convention in Phoenix for a Provider Executive Roundtable to share experiences, strategies, and advice when doing business with Managed Care Organizations (MCOs), Accountable Care Organizations (ACOs), and hospitals systems. These customers are all leading, high-quality providers and experienced negotiators; as such, they have high expectations.

The Bottom Line
In the long-term care (LTC) industry, a skilled nursing (SNF) and/or post-acute facility’s data-driven performance can jump-start a great relationship with the new payors. Medicare, and increasingly Medicaid, is shifting to contract-driven relationships. In urban and rural markets alike, quality is the new currency used to rank preferred care partners.

The Takeaway
Agile, post-acute players are reinventing their businesses and maneuvering as trusted partners vs. vendors. This paper summarizes the market transformation 16 executives are experiencing and what they are proactively doing about them. Top takeaways include:

- Opportunities are emerging in niches for those helping ACOs, MCOs, and hospital networks solve real business challenges.
- These niches require unconventional ways of partnering, packaging services, training staff, and measuring success.
- Three key metrics win business: 5-Star Ratings, Re-hospitalization Rates and Average Length of Stay (ALOS). Know them, measure them, and improve them.

“Nothing we do anymore is invisible.”

Naomi Prendergast, CEO, D’Youville Life and Wellness
Roundtable Participants

Fred Benjamin  COO, Medicalodges Inc.
Bill Bogdanovich  President & CEO, Broad Reach Healthcare/Liberty Commons
Steven Chies  Senior Vice President of Operations, Benedictine Health System
Garen Cox  President, Medicalodges Inc.
Brad Dalton  Senior Vice President of Business Development, American HealthCare, LLC
Joseph Donchess  Executive Director, Louisiana Nursing Home Association
Jim Gomez  President & CEO California Association of Health Facilities
Bill Hoover  CFO, Hillcrest Convalescent Center
Kenneth Lund  President & CEO, Shea Family
Michael Plausse  CFO, iCare
Naomi Prendergast  CEO, D’Youville Life and Wellness Community
Neil Pruitt Jr.  Chairman & CEO, UHS-Pruitt Corporation
Ted Smith  Administrator, Hillcrest Convalescent Center
Robert Van Dyk  President & CEO, Van Dyk Health Care Inc.
Jack Vetter  CEO, Vetter Health Services Inc.
Marilyn Wood  President, Opis Management Resources, LLC
Chris Wright  President & CEO, iCare

Moderators
Meg LaPorte, Managing Editor, Provider Magazine
Kenneth Lund, President & CEO, Shea Family
The “Big Three” Issues

This executive roundtable was a unique opportunity: it gathered together some of the top people in the LTC industry, on the cusp of one of the greatest periods of change in its history: the full implementation of the 2010 Affordable Care Act (ACA). More than anything, this meeting was marked by strong consensus on three core issues impacting today’s providers, together with a wealth of creative ideas and success stories – and more than a few strong warnings. Here are the “big three” issues these executives feel are driving the industry:

1. Fee-for-service is dead. Managed care is here.

The acute care facilities that transition patients to LTC facilities for focused post-acute care services are under increased financial scrutiny, including penalties for missing performance targets. This means that LTC’s future lies in partnering with ACOs and MCOs that band together to meet cost and quality targets.

2. You need to out-service and out-market your competition.

Those who succeed and flourish in this environment are finding ways to creatively boost service levels, for both patients and acute-care partners – through better training, communications, increased medical “bench strength,” increased marketing and value-added services across the patient lifespan.

3. Data matters – more than ever.

From now on, LTC facilities will live and die on metrics such as their 5-star quality ratings, average length of stay (ALOS) and rehospitalization rates. LTC facilities need to manage quality care services for their populations, and ACOs and MCOs hold the cards – and if your quality measures and positive clinical outcomes aren’t where they should be, you lose. For example, many provider groups today will not even consider a facility without at least 4 star ratings and strong, best-of-class metrics.

Read on and learn in detail what this group of 16 CEOs have to say about these and other related issues, as the long-term care environment of the 21st century begins to take shape.
What new payment models are emerging in your markets?

Key Discussion Points

- **Fee-for-service is quickly transitioning to contracts**

  There is a broad consensus that in the wake of the ACA, the traditional fee-for-service model of payment is fading into history in favor of capitation arrangements such as managed care and contracting with ACOs. This is often shifting the risk of care to LTC facilities: for example, one participant noted that Florida’s state legislature put in contingencies to protect these facilities in their recent transition to managed care, but only for one year.

  Conversely, this new model represents opportunities for those willing to negotiate around service and outcome levels. According to California Association of Health Facilities’ Jim Gomez, "I've been preaching the death of fee-for-service for 2-1/2 years. It's a matter of how soon and how fast. Part of our job is to get a sustainable Medicaid rate up so owners can survive. Floor rates are being established and you can negotiate above that."

- **Providers must find ways to say ‘yes’ faster**

  In an era of increased contracting, LTC providers must learn to think like a hospital, and wrap their service offerings around the needs of the hospital. This ranges from macro-level issues such as improving hospital readmission rates - cited as a big factor in getting in to managed care networks - to more tactical issues such as how much of a hospital's time you take up. D'Youville Life and Wellness Community's Naomi Prendergast sums it up by noting, "Nothing we do anymore is invisible. The ACOs' Nurse Practitioners and docs are in our buildings. This speaks to the importance of customer service." Shea Family's Ken Lund also points out that market forces are increasingly pushing hospitals from LTACs toward SNFs due to the breadth of services available in SNFs.

- **Cash flow is an issue as payment terms lengthen**

  Extended times for payments are increasingly becoming part of the current landscape according to Medicalodges’ Fred Benjamin, who notes that payment has slowed from 15 days to 45 days overall. He adds, “These are challenges, but we’re also focusing on opportunities. We want to take part in building a new model. We’re partnering with MCOs to create more favorable results.”
What do MCO/ACOs expect?

Key Discussion Points

- **Metrics that matter: 5-Star ratings, ALOS, rehospitalizations**

  Perhaps the most universal observation to emerge from this roundtable discussion was the link between performance metrics and future viability. UHS-Pruitt’s Neal Pruitt framed this in very blunt terms: “You must compete on the merits of your product. The harsh reality is, if you don’t, you’ll be out of business.” Expectations for ALOS often range from 12-15 days, and many MCOs won’t consider partners who have less than 4-5 star ratings or high rehospitalization rates.

  Opis Management Resources’ Marilyn Wood added that metrics have become important internal motivators as well. “Nurses are very visual people. We use visual scorecards on each unit for 5-Star Rating, readmit rate, etc. Frontline people now see them.” Others noted that these metrics can be managed successfully through staffing and quality measures.

- **Profitability is increasingly linked to data-driven quality**

  With quality now driving the equation, it was clear to participants that the industry is facing a competitive landscape chasing more patients and fewer days per person. According to Ken Lund, “Volume drives everything,” while D’Youville’s Naomi Prendergast adds, “In order to maintain census, we have to push up admissions. The sands shift daily.”

  Lund describes one health system where the MCO/ACO business went from 46 to 3 SNFs, and he is getting 95% of their patients with a readmit rate of 8-10%, a mortality rate less than 2% and nonexistent appeal rates – but still struggles to drive enough volume to maintain a needed replacement ratio of 3-4 to 1 (Note: For every patient referred by an ACO, SNFS need approximately 3-4 Medicare or private insurance patient’s admitted). Prendergast adds that, in Massachusetts, they are trying to cope by pushing for uniformity of contracts with ACOs.
What strategies are you implementing to be competitive?

Key Discussion Points

- Create co-operatives of niche services/products

  Today’s new environment of managed care and cost control requires out-of-the-box thinking and, in some cases, collaborative relationships between niche partners. Fred Benjamin recalls how hospitals 10-15 years ago, had a choice to react to rate changes by joining systems or becoming an apartment building, as he puts it, and lays out a similar challenge taking place now for LTC: “What about a co-op model? We don’t have to be victims. A dozen geographically well-placed facilities can create a network for selling into an MCO.” Jack Vetter of Vetter Health Services also shared his niche of partnering directly with an acute care provider, building next to a cardiac hospital and serving as its “inside operator.”

  Speaking of apartment buildings, Benjamin notes that this could be a valid brand extension for some facilities: “Have extra land? Create a low-cost senior apartment building. MCOs do not want to buy heads in beds. They have 12 different SNFs in their network to take care of – how can we reinvent our model and help them?” Jim Gomez of the California Association of Health Facilities echoes the need for innovation. “Fill needs and you position yourself to capture part of a new market. How about adding a geriatric physician practice in your building(s)? Home care?”

- Thinking like an insurance company – or a strategic partner

  Ken Lund points out that, LTC providers must start thinking like an insurance provider that manages cost and risk, versus a cost-based service provider, and advocates re-thinking your institutional mission in much broader terms. “We’ve tried to abolish the word, ‘discharge.’ We have an opportunity to provide services for a lifetime as patients transition from setting to setting. Be a strategic partner. Don’t let them think of you as a vendor.”

  Jim Gomez frames this issue in terms of economies of scale: “Bigger companies are going to integrate vertically and horizontally, and present a different picture than an independent operator who only presents skilled nursing.” He also notes there are areas where LTC can compete better on cost control. “There’s not enough food at the table, so you need to eat someone else’s lunch. Return-to-hospital rates from home care are 46%. MCOs should be sending patients to a SNF first instead of straight home, because it’s costing $5K per day to put those patients back in a hospital. A viable option is to continue the patient’s care by sending them to a post-acute setting so their ultimate return home is both safe and efficient.”
CMS has not caught up with emerging niches

iCare President Chris Wright pointed out that new service niches present a learning curve for payors. “Our niche is 6 behavioral health programs, in addition to short-stays and cardiology. The niche market is our base when Medicare fluctuates. It took the Department of Health several years to adjust and accept our behavioral health & recovery model.” Neil Pruitt adds that operators must work with CMS to refine regulations for niches, such as in their facilities with ventilators.
Your Top Challenges?

Key Discussion Points

- **Relationships are key**
  
  Van Dyk Health Care President & CEO Robert Van Dyk points out that relationships and education of families, as well as MCO staff in your facilities to help oversee quality protocols, are needed to help prevent readmissions. Neil Pruitt adds that this is particularly critical during the intake process. “We created a ‘Partnership in Caring’ program. For 72 hours after admission our full-time responsibility is to communicate with the family about goals and the next level of care, at every step of the process.”

- **Nurses need enhanced skills as complexity rises**

  Skills training for nurses is getting renewed attention as the scope of LTC services continues to expand. Steven Chies of Benedictine Health Systems shared that they received a grant to enhance competency training for RNs in conjunction with a local college, while Jack Vetter noted that Vetter Health Services was offering the Gero Nurse Prep certification program for nurses.

- **A greater medical presence in facilities**

  Pruitt notes that 24-hour coverage with RNs is increasingly becoming a requirement, particularly in rural markets where facilities are competing with hospitals – and he frames this as a competitive opportunity as hospitals reduce costs and benefits. Ken Lund adds at that MCOs have put teams in his buildings, stating that, “We’re going to rethink the traditional medical director role and redeploy as chief medical officer with teams.”
What the Future Holds

Key Discussion Points

- Re-balancing of Medicaid is shifting dollars to home care
  According to Jim Gomez, “You should consider in your state how long that rebalancing will take. In California, 55 cents of every Medicaid dollar goes to home care, while 45 cents goes to LTC. In Iowa, 30 cents goes to home care and 70 cents to LTC. MCOs want more home care and will force it.” Steven Chies added that, in Minnesota, hospital beds have declined by 35% over the past 30 years, and the trend for nursing home beds has tracked exactly the same.

- Strong messages are needed to communicate quality
  Joseph Donchess of the Louisiana Nursing Home Association points out that LTC operators need to continue to market their successes with public campaigns. “If the general public doesn’t know the job we’re doing, they will continue to think of us as old nursing homes. Strong PR messages are needed.”

- There’s opportunity to rethink what a nursing home is
  iCare’s Chris Wright closed the discussion around a challenging call to action: Can we call ourselves something other than nursing homes? One of the practicalities of this is that if this were to happen, the definition would need to be changed with CMS: as Fred Benjamin noted, the state forces some facilities to be called nursing homes. But as Robert Van Dyk summarized, “We focus on the customer. We focus on post-acute. It’s what the hospitals are looking for. That’s what we’ve become.”

About American HealthTech

American HealthTech is among the nation’s largest providers of financial and clinical solutions in post-acute care, connecting skilled providers to the healthcare continuum. Coast to coast, over a fifth of the nation’s skilled nursing providers depend on AHT daily for innovations that free hands to serve others. AHT is a wholly owned subsidiary of Healthland. More information is available at www.healthtech.net.

© October 2013, American HealthTech. All Rights Reserved.