Alternative Payment Structures Equate to **Rapid Changes** and **Significant Risk** to Post Acute Providers

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State and federal funding sources for nursing facilities and home health agencies are in the midst of a tsunami. Payments that were fee for service are becoming a thing of the past. Alternative payments are managed care negotiated rates and models that include capitation, risk share, shared savings, value based services and preferred provider networks. Nursing facilities and home health providers that are not prepared to demonstrate their ability to meet the expectation of these payors and payment models need to quickly adapt or face serious consequences.

Whether you are a county that operates a nursing facility or you or a family member is a consumer or potential consumer of a hospital, nursing home or home health provider, this article will assist with finding the right resources to help navigate this uncharted territory. Also outlined is background information that will help put the alternative payment structures into perspective. Also provided is information on Medicaid, Medicare and other insurance payors; all of which will or have already made the change at various levels to a new payment model that requires nursing facilities to perform at certain standards. The standards have a similar theme for all the models which include but are not limited to performance in readmissions to hospitals, reduced length of stay, effective discharge plans to home, use of technology and enhancing partnerships with other post-acute services.

RANKINGS IMPROVE

In the 1990's, the State of Pennsylvania was ranked 49th out of 50 for the amount of funds spent on institutional care versus Home and Community Based Services (HCBS). This was an undesirable position due to the cost of institutional based care the majority of which was skilled nursing. The Department of Public Welfare (DPW) at the time, and currently the Department of Human Services (DHS), rolled out "nursing home diversion programs" to redirect care to HCBS but these programs were only marginally successful.

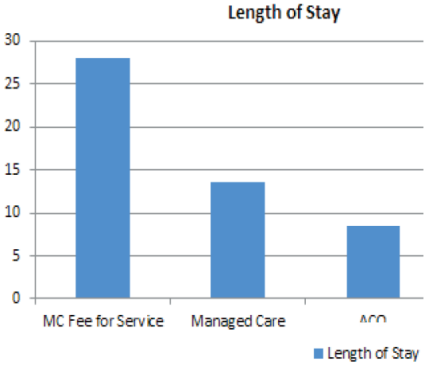
Recently, the State of Pennsylvania reports the ranking has improved to 42nd out of 50 and 50.9 percent of the consumers are served in HCBS as opposed to nursing homes. Governor Tom Wolfe's Community Health Choices (CHC) has the potential to make a more rapid shift to HCBS than previous programs.

AFFORDABLE CARE ACT

The Affordable Care Act (ACA) has created a financial penalty for hospitals if too many of their patients are returning to the hospital within 30 days of discharge. Most every initiative that has an impact on hospitals has a direct impact on nursing facilities in which they refer patients. In order to avoid hospital penalties there is pressure put on post-acute providers to avoid patients being sent back to the hospital after discharge. Hospitals discharge a large percentage of their patients to either skilled nursing or home health. Both skilled nursing and home health have had to change their practices to effectively care for the patient with a higher level of skill to avoid being sent back to the hospital. If these providers are not proactive to put measures in place to accommodate more services in house there are serious consequences.

Additionally, the ACA includes provisions to improve nursing home transparency, care and quality. This includes transparency and accountability of ownership, providing detailed information about staffing, improvement to Nursing Home Compare and other survey and enforcement requirements. The most recognizable of these initiatives for the consumer and for county commissioners and other boards with responsibility for oversight of a nursing facility is the five star rating system. Nursing Home Compare, found at Medicare.gov, ranks nursing facilities from a one to a five star based on multiple metrics including Department of Health Surveys, Staffing and Quality Measures. Many nursing home operators are not pleased with the five star rating system for many reasons and there is no dispute that the system has its flaws. Regardless of the providers view on this system, it is and will be used in various ways to determine some level of nursing facilities reimbursement and a gain or loss in referrals of patients. Because of this fact, operators need to embrace the system and strive for an average or above average star rating. This is no easy task.

Nursing Facility Length of Stay Medicare Compared to Alternative Payments



CMS INNOVATION

The Centers for Medicare and Medicaid Services (CMS) have developed the CMS Innovation Center. It is at the core of these models. The Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. Additionally, Congress has defined, both through the ACA and previous legislation, a number of specific demonstrations to be conducted by CMS. Most recently CMS has announced a new program, Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.

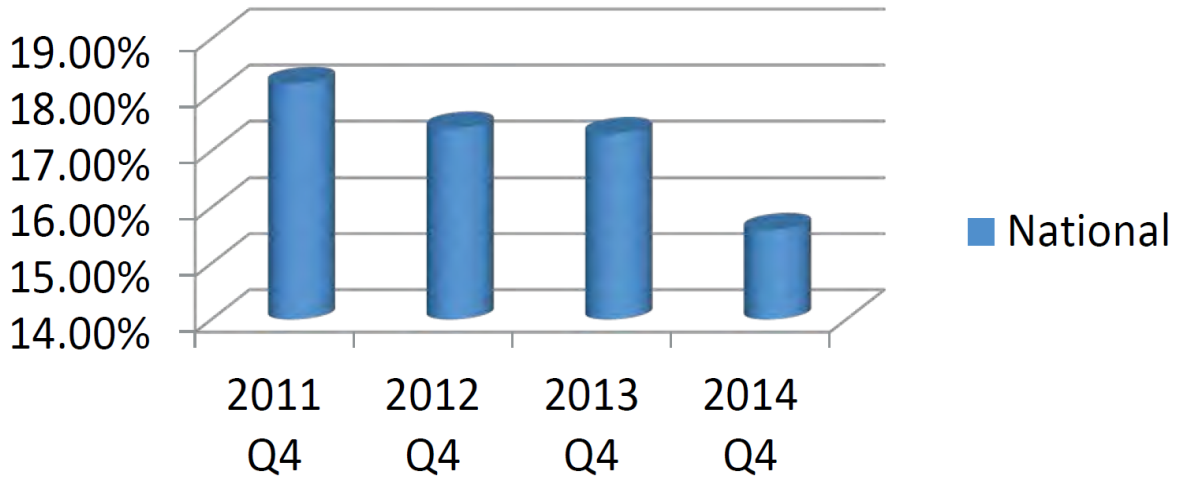
The most immediate issue that took effect January 2016 and prior is the payors that are narrowing their networks. In particular, Highmark and Geisinger have eliminated providers from their networks. The impact on providers is monumental, particularly those in Western Pennsylvania. These payors are determining which nursing facilities and home health providers will be eligible to provide services to those that have their insurance. Prior to this movement, most all nursing facilities participated in payments from Highmark whereas Geisinger is more closed. The patient had a choice of any facility they chose and the insurance would provide payment for skilled services to that provider. Highmark is now notifying providers that do not meet their criteria; they are no longer eligible to participate. They have established a score card ranking for nursing facilities and home health to select the quality providers and eliminate others. What this means for a patient is simple. If they have Highmark insurance and require skilled care, they can only go for treatment to preferred providers or pay out of pocket.

WHAT DOES THIS ALL MEAN?

For nursing facilities, Medicaid payments, DHS has issued an RFP for private insurance companies to administer the traditional Medicaid program. CHC and Long –Term Services and Support (LTSS) is managed care organizations that coordinate care. Providers such as Aetna, Cigna, and United Health Care to name a few are bidding on this opportunity. This means nursing homes will be negotiating rates with several different companies which is much different than the current system of billing Medicaid. With the new program, costs fall on outside entities that have incentives to manage care, improve collaboration and provide access to more options. There is an emphasis within LTSS on HCBS with a particular focus on Living Independently for the Elderly or LIFE programs. LIFE programs are paid capitated rates for nursing home eligible residents to keep them healthy to avoid hospitalization and nursing home placement or a nursing home diversion program. The 2016/2017 budget contains funding for five (5) additional LIFE Centers in PA bringing the total count to 40.

Medicare Alternative Payment models include the Mandatory Comprehensive Care for Joint Replacement Payment Model (CJR) which is a Bundled Payment effective April 1, 2016 and voluntary Accountable Care Organizations (ACO's). CJR requires hospitals to be accountable for the cost and quality of the patient for a 90-day episode of care which creates financial risk and reward for hospitals. This episode of care includes post-acute providers. Hospitals will need to partner with providers to control cost including length of stay. This pilot project through CMS is currently in the Pittsburgh, Harrisburg/Carlisle MSA and a small representation in the Scranton area. CJR is specific to joint diagnosis or DRG's including hips and knees. For example, if a patient has a hip replacement surgery in Harrisburg and the patient is discharged to a post-acute care provider

30 Day Risk-Adjusted, Hospital Readmission Rates for Skilled Nursing Facilities



in Chambersburg, the Harrisburg hospital is held accountable for the entire payment which includes the payments to post-acute care after the surgery. If the cost is over the established capitated rate the hospital loses money and if it is under the capitated rate they are incentivized. This model creates a sense of urgency to partner with nursing facilities and other providers that have success in achieving shorter lengths of stay and a low percentage of readmissions to the hospital. Sound familiar? Additionally, Nursing Homes have an opportunity to have the three day hospital stay requirement waived if the patient goes from the hospital to the nursing home but only if the nursing home has a three star status or above seven out of 12 months. Without the three star status, the nursing home is not eligible for the waiver. This requirement is slated to begin in 2017.

If the patient choses a facility that does not have the waiver and they did not meet the qualifying stay, the patient would have to pay for care out of pocket. This means significant dollars in lost revenue to nursing facilities that do not qualify because patients are not going to choose a location that they would be responsible to pay out of pocket. If a nursing facility does not qualify and they typically care for six rehab hips or knees per day paid by traditional Medicare for skilled care, the loss of revenue could reach more than one million dollars annually. On a positive note, certain facilities could have increased referrals and increased or stabilized revenues if they are considered quality providers and qualify for the waiver. According to McKnight's Long Term Care News, some experts estimate that the CJR model could cause 25% of one and two star facilities to close over the next five years as hospitals seek partnerships with high quality post-acute care providers.

ACCOUNTABLE CARE ORGANIZATIONS

Accountable Care Organizations (ACO's) are voluntary programs. ACO's can be groups of doctors, hospitals and other health care providers, who come together to voluntarily give coordinated care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding duplication of services. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for Medicare. ACO's can establish rules as approved by CMS. These rules can and do include the nursing facilities to meet certain key metrics. Star ratings, readmission to hospital rates, reduced length of stay, use of telehealth and effective discharge planning can be a part of that scorecard. The ACO's are reporting Average Lengths of Stay of 8.5 days in skilled care compared to fee for service of 28 days. ACO's establish what they call preferred providers. If a post-acute provider is a preferred provider there is a similar arrangement that increases referrals. This is a very favorable position. If they are not a preferred provider, there is cause for grave concern. As with the above, CJR and narrowing of provider networks, there is a potential for significant loses for providers that are not preferred.

On January 1, 2016, Highmark eliminated 16 nursing homes as providers for services. In July they will be eliminating more providers. They have established a "score card" measuring the expectations for nursing homes and home health providers. The score card includes similar key metrics outlined above. If a provider is not chosen to be in the Highmark network, the patient selecting that provider would pay out of pocket. Being eliminated from the Highmark network could easily amount to over 1 million dollars of annual revenue to nursing facilities. If a post-acute care provider is in the network and is deemed a quality provider and a competing facility is not in the network, it is a favorable position and would produce an increase in referrals.

The end equation is this: costs will and are already being reduced in both acute and post-acute care. The rate of the cost savings is dependent on the geographic trends and mandates. Pennsylvania currently is on an aggressive path for cost reductions. The theme is consistent among the various initiatives. There have already been notable trends of decreasing readmissions to the hospital on both a state and national level among other trends to reduce costs. There is great exposure for post-acute care providers that are unable to meet the expectations and demonstrate their abilities. There is also benefit to those that do meet the criteria and expectations.

Nursing homes will be negotiating rates with several different companies which is much different than the current system of billing Medicaid.

WHAT TO DO

I have been an operator and consultant in long term care for 30 years. We have seen a lot of change in this industry but nothing to trump the impact of Alternative Payments. There are criteria that providers have to meet or they can and will be unsustainable. If you have not properly aligned your organization to fit into today's environment you must act quickly. This is not a future initiative to be preparing for; it is the current reality. Ask your nursing home operators for their scorecard. Make sure the data is set forth exactly as the payors want to see it. You must remember that they already have your data. They retrieve the data from public sites. There is nothing you can hide nor should you. Transparency is only going to increase with the implementation of the new regulations. Have an action plan of what to do if your statistics are not within the established benchmarks. If you don't have the data, make arrangements to quickly gather your information and analyze it. Evaluate what it means to your organization and your County. Don't be caught in an unexpected tsunami.