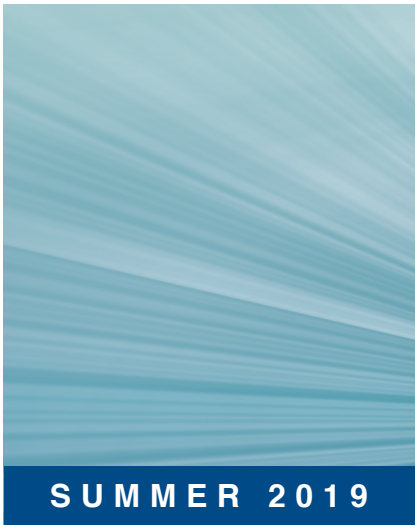
SPECIAL ISSUE

brief



POST-ACUTE CARE ENTERS A NEW ERA

Integrated Care Networks Unify the Continuum and Align Payors

Volume II

AMERICAN SENIORS HOUSING ASSOCIATION
Living Longer Better

GLENAIRE HEALTHCARE, LLC

TABLE OF CONTENTS

This is an expanded and revised update of a *Special Issue Brief* that was published by the American Seniors Housing Association in 2014. Volume I and Volume II of *Post-Acute Care Enters A New Era* were authored by Jim Bowe, Principal, GlenAire HealthCare.

POST-ACUTE CARE ENTERS A NEW ERA

Integrated Care Networks Unify the Continuum and Align Payors

Volume II

INTRODUCTION

Nine years after the enactment of the Affordable Care Act (ACA), the value-based care and reimbursement movement — an overarching, transformational force spanning the entire health care system — continues to lurch ahead in fits and starts.

The latest twist in this ongoing saga came from a surprise ruling in December 2018 by a Texas federal judge that struck down the entire law, declaring it unconstitutional. His decision was grounded in the 2017 repeal of the ACA individual mandate, which penalized those without health insurance.

The judge maintained that because Congress' ability to tax had been the basis of previous decisions upholding the mandate, by no longer enforcing the mandate it is rendered unconstitutional, and therefore the unconstitutionality of the individual mandate invalidates the entire ACA.

The decision has been appealed and may well end up in the Supreme Court, which upheld the ACA in 2012 and rejected another challenge to the law in 2015. Meanwhile, legal authorities uniformly question whether the most recent ruling will be upheld, and the ACA in the interim remains in effect pending appeal.

Amid all the uproar over the ACA's status, the Centers for Medicare and Medicaid Services (CMS) continues to refine and revamp the payment incentives and level of risk associated with accountable care organizations (ACOs), bundled payment programs, the patient-centered medical home model, and other value-based initiatives.

At the same time, integrated care networks with their focus on case management, cost, quality outcomes, and leverage through the use of narrow networks are advancing the principles of a value-based system by stressing wellness, prevention and oversight of entire episodes of care.

The value-based push, even in the face of CMS' overhauls and resets, is nevertheless gaining momentum. The agency met its goal to tie 30 percent of Medicare reimbursement to alternative payment models by the end of 2016, which was nearly one year ahead of schedule and up from 20 percent in 2014. For 2018, CMS projected that alternative payment models would represent 50 percent of all Medicare reimbursement.

Throughout all the ACA demonstration projects and new care delivery models that emerged during the last nine years, post-acute care has consistently stood out as a wild card with pronounced swings in utilization, quality and costs. According to the Institute of Medicine, post-acute care represents 73 percent of the Medicare spend variability in an episode of care.

These discrepancies have significant, far reaching implications, because when it comes to managing care episodes, post-acute care plays a major role within the new value-based payment paradigms. Medicare spends more than $59 billion on post–acute care, which has more than doubled since 2001, while discharges to post–acute care have increased nearly 50 percent during the past 15 years.

With 42 percent of Medicare beneficiaries who are hospitalized requiring post–acute care, this segment of the care continuum is a leading contributor to the costs of a care episode. The breakdown of all discharges to post-acute care shows 20 percent go to skilled nursing facilities, 17 percent to home health care, four percent to inpatient rehab facilities, and one percent to long-term care hospitals.

Given the degree to which integrated networks rely on post-acute care to manage episodes of care, as well as post-acute care's widespread variation in cost and performance outcomes, there clearly is an opportunity for participants in this sector of the care continuum that consistently deliver both reliable results and exceptional value following hospitalizations.

At the other end of the integrated care spectrum, those that demonstrate an aptitude for heading off costly inpatient care by overseeing value-added wellness, prevention and case management programs will be integral to networks' success.

ACCOUNTABLE CARE ORGANIZATIONS

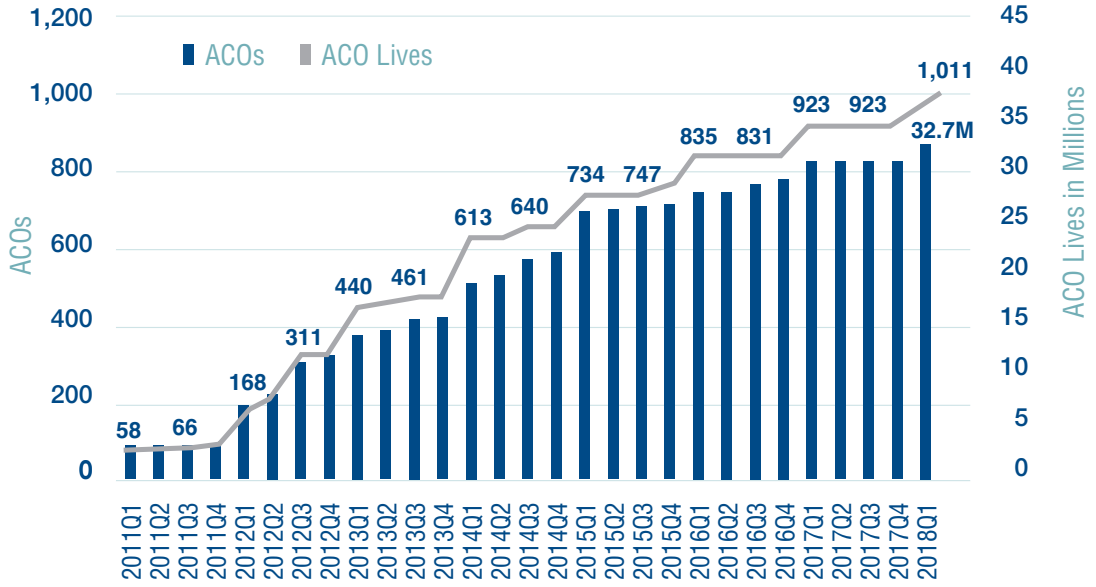
Accountable care organizations (ACOs) are networks of providers with financial incentives to control patients' health care spending while maintaining or improving quality of care. They are responsible for a defined population, care outcomes and the cost of services.

Three distinct elements of ACOs are:

- Shared savings. Providers typically receive bonuses if health care costs are below a projected amount. The sum of the payout depends, in part, on how much the ACO saves. In many cases, these bonuses are added to traditional fee-for-service payments
- Quality outcomes. Numerous quality metrics are tracked to gauge whether an ACO qualifies for shared savings and how much it earns from payors for its quality performance
- Patient choice. The Centers for Medicare and Medicaid Services (CMS) generally attributes Medicare beneficiaries to ACOs based on their primary care provider's affiliation with an ACO, but beneficiaries are free to seek services from any Medicare provider in or out of the ACO

CMS launched ACOs in 2012. About 10.5 million patients out of approximately 57 million Medicare beneficiaries in 2018 participated in the 561 Medicare Shared Savings Program (MSSP) ACOs, which had three tracks with various levels of risk. Another 1.4 million in 2018 were attributed to the 51 Medicare Next Generation ACOs, which assumed higher levels of financial risk and reward than were available under the Medicare Shared Savings Program.

Medicare, Medicaid, Commercial Insurance ACOs; Covered Lives Over Time



Source: Analysis of Leavitt Partners' accountable care organization (ACO) database.

Six years after rolling out the Medicare Shared Savings Program (MSSP) for ACOs, CMS announced in December 2018 that it will be replaced starting July 1, 2019 with the Pathways to Success program. New and existing ACOs must submit applications to participate.

The switch comes after CMS concluded that ACOs with "greater levels of risk show better results for cost and quality over time." The goal is to back away from the upside-only payment methodology that was prominent under the MSSP and require ACOs to shoulder more downside financial risk under the Pathways to Success program.

Key features of Pathways to Success include:

- Moving ACOs to two-sided risk more quickly
- Reducing shared savings for upside-only models from 50 to 40 percent
- Differentiating between low and high revenue ACOs and requiring high revenue ACOs to take on more risk more quickly
- Increasing access to telehealth and expanding the skilled nursing three-day rule waiver
- Allowing all ACOs to choose prospective beneficiary assignment or preliminary prospective assignment with retrospective reconciliation

Shared Savings Program Participation Options

	BASIC					ENHANCED
	LEVEL A	LEVEL B	LEVEL C	LEVEL D	LEVEL E	
Agreement Period	5 Years					5 Years
APM Status	MIPS APM	MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM
Shared Savings Rate	40%	40%	50%	50%	50%	75%
Maximum Savings	10% of Benchmark	10% of Benchmark	10% of Benchmark	10% of Benchmark	10% of Benchmark	20% of Benchmark
Shared Loss Rate	N/A	N/A	30%	30%	30%	40% to 75%
Maximum Losses	N/A	N/A	2% of Revenue capped at 1% of Benchmark	4% of Revenue capped at 2% of Benchmark	8% of Revenue capped at 4% of Benchmark	15% of Benchmark

Source: Health Catalyst

Pathways to Success has two participation options: The Basic track and the Enhanced track.

The Basic track has five levels that CMS characterizes as a glide path for ongoing participation with progressively higher levels of risk and reward. This track allows ACOs to start with a one-sided risk model, where they share savings with CMS, but don't owe the agency money if certain goals aren't met.

The glide path initially allows new ACOs under the one-sided model to share their savings with CMS for only two years, rather than the six years previously available to ACOs, before they must take on risk. After that, the Basic track moves to progressively higher levels of risk and potential rewards.

Under the upside-only payment methodology at the beginning of the glide path, ACOs share in no more than 40 percent of savings after meeting minimum savings rates. But further along the five-level glide path where downside financial risk is included, ACOs would be eligible for a 50 percent shared savings rate.

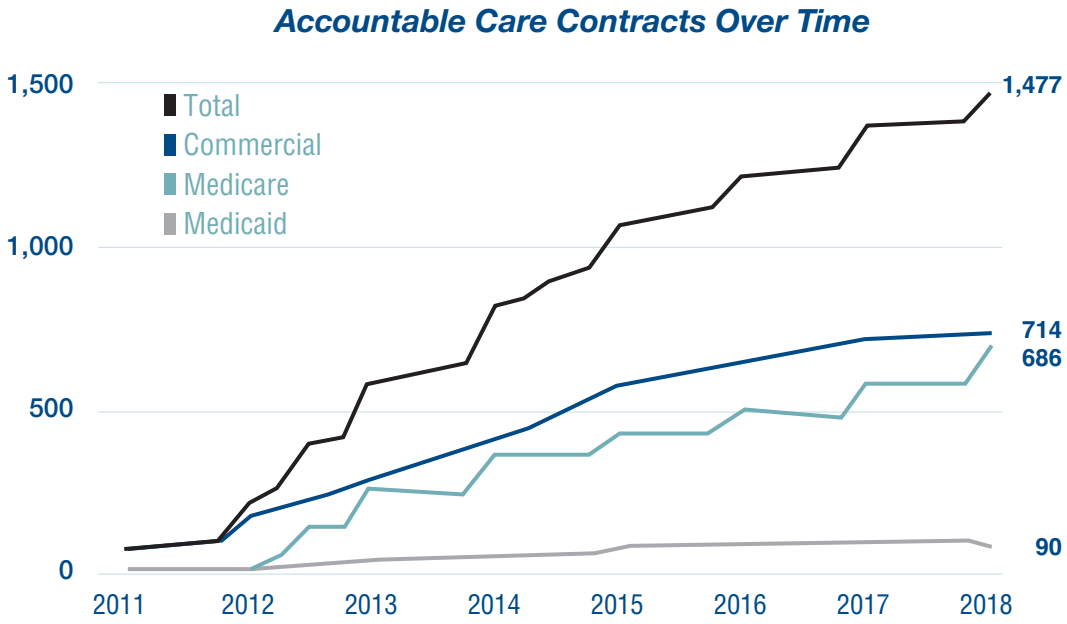
ACOs participating in the Enhanced track once the medical loss ratio is met or exceeded may earn up to 75 percent of shared savings or risk loss from 40 to 75 percent. Payment is capped at 20 percent of benchmark.

ACO patient populations fall under one of two classifications. The prospective assignment classification groups patients at the beginning of a performance period. With retrospective assignment, patients are assigned to ACOs at the end of the performance period.

Prospective assignment allows ACOs to identify their patient populations in advance. This approach gives the ACO and its providers the ability to target services and oversight within its overall patient population to select groups of patients that may have the highest costs and greatest needs.

But a prospective approach may result in some patients being assigned to an ACO who never receive any care from an ACO provider during the performance period, so the payer may need to use a reconciliation process at the end of the performance period to determine the exact patient population, adding an extra layer of administrative complexity and expense.

Some providers avoid retrospective assignment, because they cannot direct services to a select group of patients, such as those with the greatest needs who with early intervention and case management may generate the biggest return on investment. But a retrospective approach can provide certainty regarding an ACO's expenditures and savings or losses, because it holds the ACO accountable only for the patients seen during the performance period.



Source: Analysis of Leavitt Partners' accountable care organization (ACO) database

Medicare, Medicaid and commercial insurance ACOs in 2018 totaled 1,011, covering 32.7 million lives, according to Leavitt Partners and the Accountable Learning Collaborative. This represents about 10 percent of the U.S. population, an increase of about six percent from 2017.

Their data shows commercial ACO contracts covered slightly more than half of all ACO lives, while Medicare contracts represent 37 percent and Medicaid contracts accounted for 10 percent. Commercial contracts typically cover 24,300 lives compared to 17,500 lives for Medicare contracts, while Medicaid contracts average 43,500 lives.

How cost-effective are ACOs? The Medicare Shared Savings Program, CMS' largest value-based payment model, saved the agency $314 million or $35 per patient in 2017, the first year in which the program generated savings.

An analysis of the 2017 MSSP performance by Leavitt Partners and the Duke-Margolis Center for Health Policy found:

- Sixty percent of ACOs saved money compared to the expenditure targets set by Medicare, and a third had savings high enough to receive bonuses from CMS for saving substantial money while maintaining quality

- Organizations that had been in the program for longer were more likely to save money, as were organizations led by physician groups, as opposed to hospitals. MSSP ACOs with a history of participating in the program apparently made substantive changes in delivering care and are now improving financial performance
- The quality of health care delivered by the average ACO remained high, and was even higher in organizations led by physician groups, as opposed to hospitals

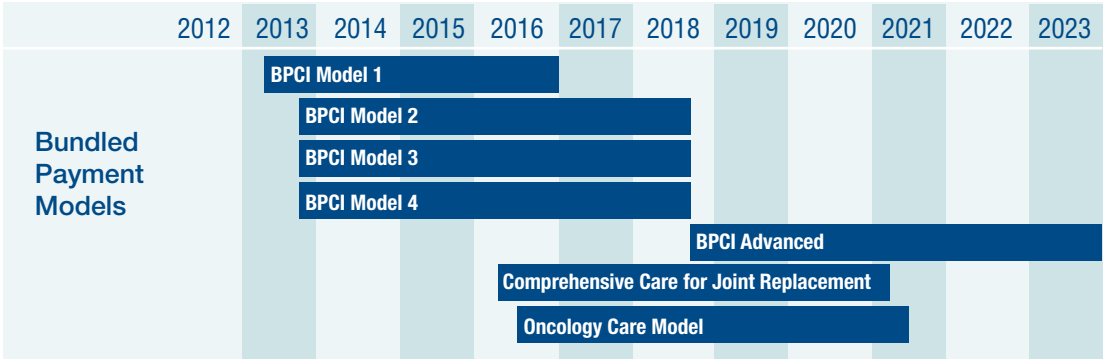
It takes time for ACOs to change the way they deliver care to become more efficient with higher quality outcomes. The average ACO's results jumped substantially after it was in the program for three years, according to Leavitt Partners and the Duke-Margolis Center.

BUNDLED PAYMENT

Whereas Medicare ACOs typically pool 5,000 lives or more in a population health/wellness management model funded on a per capita basis to cover the costs of virtually all services across the care continuum, Medicare's bundled payment program shifts risk to providers under a flat rate structure that reimburses for an entire episode of care by dividing a predetermined payment among service providers across the care continuum.

Bundling provides a single lump sum payment that is split among participating hospitals, physicians and other providers such as post-acute care operators. The goal is by coordinating care across the service delivery spectrum for a single episode of care, overall costs will decline, and participants will share in the savings.

Timeline: Bundled Payment Models



Updated January 11, 2018.The Henry J. Kaiser Family Foundation

Medicare's **Bundled Payments for Care Improvement (BPCI)** model was a voluntary episode payment initiative that began in 2013 and bundled up to 48 inpatient clinical episodes. CMS allocated a single, predetermined payment amount (bundle) for an episode of care under four different models.

Model 1 ended December 2016, while Models 2, 3 and 4 were terminated in September 2018. There were 1,191 BPCI participants representing 252 awardees and 939 episode initiators in late 2017. Episode lengths were 30/60/90 days, depending on the model/awardee selection.

Medicare's **Bundled Payments for Care Improvement Advanced** builds on the Bundled Payments for Care Improvement initiative and increases financial risk. Under this new model, CMS allocates a single retrospective payment amount (bundle) for up to 29 inpatient and three outpatient episodes.

Participants choose the clinical conditions they will engage in. The top three clinical episodes selected thus far are: Major joint replacement of the lower extremity; congestive heart failure; and cardiac arrhythmia.

Participants are paid a benchmark price and may keep the savings minus three percent. If they exceed the target, they are penalized up to 20 percent of costs. Savings payments are adjusted based on performance for seven quality measures.

It was implemented in September 2018, is voluntary and will run through December 2023. Participants make a five-year commitment to remain in the program. Nearly 1,300 Medicare providers are enrolled, including 715 hospitals and 580 physician practices.

Inpatient episodes constitute an anchor stay plus 90 days beginning day of discharge. Outpatient episodes represent an anchor procedure plus 90 days beginning on the day of completion of the outpatient procedure.

Medicare's **Comprehensive Care for Joint Replacement (CJR)** is a model implemented in 2016 for hospitals in 34 selected regions. CMS allocates a single, pre-determined payment amount (bundle) for hip and knee replacement episodes, including the inpatient hospital stay, post-acute care, and physician and other related services.

Participants may receive payments if total spending for an episode is below the target price. CJR is mandatory for hospitals in the 34 selected geographic areas and is active through December 2020. In 2017 there were 794 hospitals participating. The episode length is an anchor stay plus 90 days.

Under Medicare's **Oncology Care Model (OCM)**, physician practices receive monthly care coordination and management payment during episodes of care and are eligible for payments if they lower total Parts A, B, and some D Medicare spending and meet quality goals. Commercial payors participate in OCM in alignment with Medicare to create broader incentives for care transformation at the physician practice level. It was launched in 2016, is voluntary and will be active through June 2021. In 2017, 192 practices and 14 insurers participated. The episode length is six months.

Two evaluations of Medicare's Bundled Payments for Care Improvement initiative raise questions regarding bundling's ability to yield savings and improve outcomes.

A 2018 study published by the *New England Journal of Medicine* reviewed data from 2013 through 2015 for at least one of five common medical conditions included under BPCI:

- Acute myocardial infarction
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Pneumonia
- Sepsis

The researchers reported there was no statistically significant difference between the average Medicare payments to hospitals participating in BCPI and hospitals not participating in the program. They noted that hospital participation "in five common medical bundles under BPCI was not associated with significant changes in Medicare payments, clinical complexity, length of stay, emergency department use, hospital readmissions or mortality."

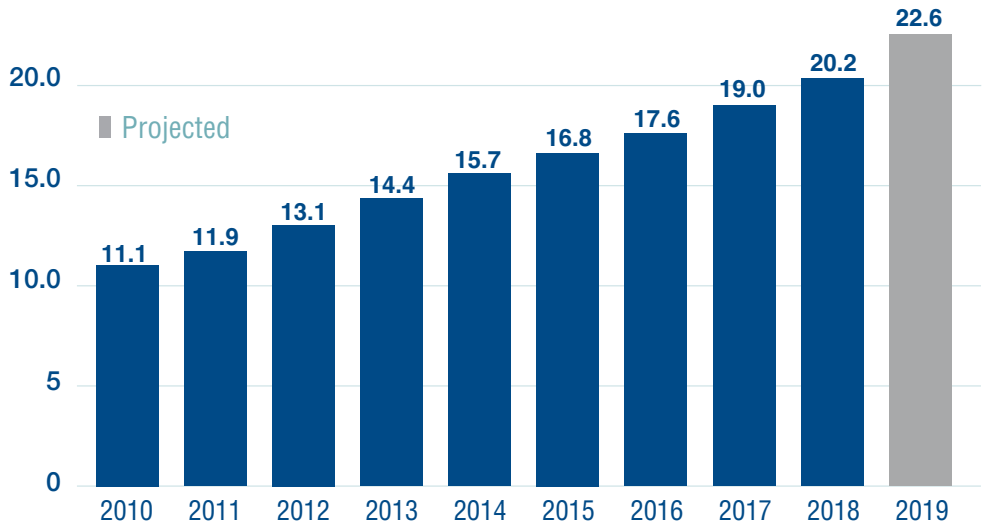
A 2018 report from the Lewin Group released by CMS concluded the Model 2 track under the Bundled Payments for Care Improvement initiative lost $202.1 million between 2013 and 2016, or $268 per event. The Model 3 track lost $85.2 million during that period, or $921 per episode. The report blamed the losses on the lack of downside risk under BCPI, which has been addressed by emphasizing two-sided risk in the new Bundled Payments for Care Improvement Advanced program.

MEDICARE ADVANTAGE

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive their Medicare benefits from private plans rather than from the traditional fee-for-service (FFS) program. Under MA plans, beneficiaries may receive additional benefits beyond those offered under traditional Medicare and could pay additional premiums for them.

Medicare pays plans a capitated rate for the 34 percent of beneficiaries enrolled in MA plans. Over 3,700 MA plans are available nationwide. MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and special needs plans (SNPs). United Healthcare, Humana and Aetna control just under half of the national enrollment.

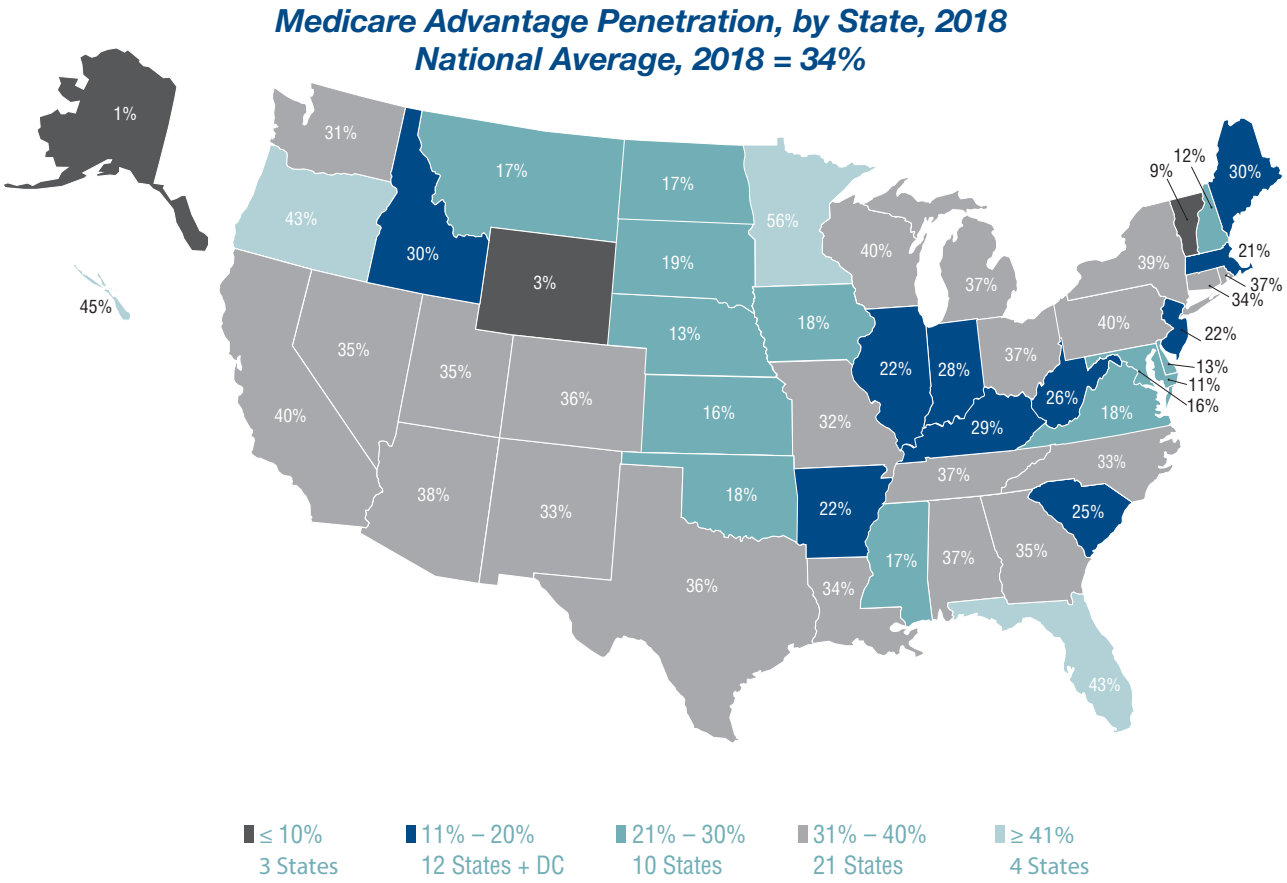
Medicare Advantage Enrollment, In Millions



Source: Kaiser Family Foundation; Centers for Medicare & Medicaid Services.

Under the MA program, Medicare buys insurance coverage for its beneficiaries from private plans with payments made monthly. The coverage must include all Medicare Part A and Part B benefits except hospice. All plans, except PFFS plans, must also offer an option that includes the Part D drug benefit.

Plans may limit enrollees' choices of providers more narrowly than under the traditional FFS program and supplement Medicare benefits by reducing cost-sharing requirements or providing coverage of non-Medicare benefits. Plans may charge a premium for these benefits.



Note: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.

Source: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2018.

Medicare Advantage plan networks include 51 percent of the hospitals and 46 percent of the physicians in enrollees' counties, on average. In 2015, more than one-third of Medicare Advantage enrollees (35 percent) were in plans with narrow physician networks.

Medicare Advantage enrollment varies widely across the U.S. In six states, 40 percent or more of Medicare beneficiaries are enrolled in a private plan (CA, FL, HI, MN, OR and PA). In three states (AK, VT and WY), fewer than 10 percent of all Medicare beneficiaries are in a Medicare Advantage plan.

For payment purposes, there are two different categories of MA plans: Local plans and regional plans. Local plans may be any of the plan types and may serve one or more counties. Medicare pays them based on their enrollees' counties of residence. Regional plans, however, must be PPOs and must serve all of one of the 26 regions established by the Centers for Medicare & Medicaid Services (CMS). Each region comprises one or more entire states.

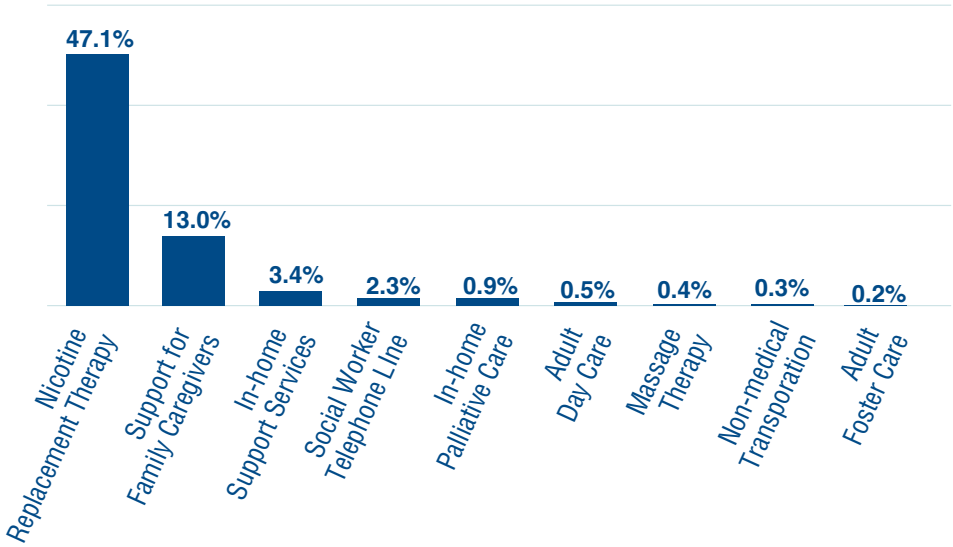
The scope of the MA benefit structure continues to grow. CMS announced additional supplemental benefits beginning in 2019 now allow insurers to include non-skilled, in-home care services in their coverage. And in 2020, MA plans have the option of offering telehealth services, a hospice benefit, and customized services that are not primarily health care-related and are based on chronic conditions and/or socioeconomic status.

The new 2019 non-skilled, in-home benefits for personal care must be "medically appropriate" and recommended by a licensed health care provider. Benefits may include: House calls by physicians or other health care providers, under certain conditions; a home health care aide for a limited number of hours to help with dressing, eating and other daily activities; and transportation.

CMS' 2020 rules for MA plans clear the way for benefits that "have a reasonable expectation of improving or maintaining the health or overall function" of beneficiaries with chronic conditions. The intent is to cover non-medical services that intervene in social determinants of health and can influence environmental factors to improve well being.

It's up to each Medicare Advantage plan to decide whether to offer these new supplemental benefits. For the most part, plans will sit out 2019 with rollouts pegged for 2020 while they work on the design for the new benefits and finalize pricing. According to CMS, about seven percent of MA plans will offer some of the new supplemental benefit options in 2019.

Percentage of MA Plans Offering New Supplemental Benefits in 2019



Source: AARP

One insurer, however, is committed to introducing this new coverage in 2019. Anthem, which is the largest for-profit managed health company associated with Blue Cross and Blue Shield, is expanding its MA benefits package.

Anthem's MA service packages may now include:

- Food Deliveries: Up to 16 delivered meals per health event, up to four events each calendar year (64 total)
- Transportation: Up to 60 one-way trips per year to health-related appointments or to obtain a service covered by the health plan
- Personal Home Helper: Up to 124 hours of an in-home health aide for respite care, home-based chores, and assistance with activities of daily living, as approved by a licensed care provider
- Assistive Devices: Up to a $500 allowance for safety devices such as ADA toilet seats, shower stools, hand-held shower heads, reaching devices, and temporary wheelchair ramps
- Day Center Visits: Up to one visit per week for adult day center services, in order to help older adults who need supervision and assistance
- Alternative Medicine: Up to 24 acupuncture and/or therapeutic massage visits each calendar year

The changes covered under the Medicare Advantage Value-Based Insurance Design (VBID) model that will be tested beginning 2020 include:

- Allowing plans to provide reduced cost sharing and additional benefits to enrollees in a more targeted fashion than has previously been allowed, including customization based on chronic condition, socioeconomic status, or both, and benefits not primarily related to health care, such as transportation
- Bolstering the rewards and incentives programs that plans can offer beneficiaries to take steps to improve their health, permitting plans to offer higher value individual rewards than were previously allowed
- Increasing access to telehealth services by allowing plans to use access to telehealth services instead of in-person visits, as long as an in-person option remains, to meet a range of network requirements, including certain requirements that could not previously be fulfilled through telehealth
- Beginning in the 2021 plan year, the VBID model will also test allowing Medicare Advantage plans to offer Medicare's hospice benefit. This change is designed to increase access to hospice services and facilitate better coordination between patients' hospice providers and their other clinicians

Many of these new MA services and enhancements mirror those provided in senior living communities. As more MA plans in the coming years expand their benefits, senior living operators may choose to contract directly with the insurers to deliver services, or they may also expand their relationships with ancillary service providers that have MA agreements.

While operators are quick to point out how their services can control costs and offer alternatives to other higher-priced segments of the care continuum, MA plans at this point are primarily focused on rates, rather than the bigger-picture value proposition.

REHAB OPENS NEW OPPORTUNITIES FOR ASSISTED LIVING

Rehab and recovery following a hospital or skilled nursing stay has long been regarded as an enticing niche for assisted living operators vying for a role in integrated care networks and Medicare Advantage plans, yet this is a proposition that has largely been more theoretical than tangible.

For the last three years, however, and going even further back to its formative stages, the Progressions Program at the 12 locations operated by Country Meadows Retirement Communities across Pennsylvania and Maryland has specialized in two- to eight-week rehab stays with:

- Seven days a week of therapy in on-site gyms and restorative support around the clock
- 24/7 access to nurses and regularly scheduled physician rounds
- Support with co-morbidities and chronic diseases
- Special medication, wound care and dietary support
- Coordination of care resources
- ADL assistance including two-person or mechanical lift transfers

Hershey, PA-based Country Meadows traces its lineage back to 1962 when former Pennsylvania governor George Leader founded a nursing home group with an emphasis on rehabilitation that eventually grew to 23 locations. After selling all but one of the nursing homes over 30 years ago, the Leader family made its mark in the independent living and assisted living business.

Progressions operates from specialized units at each community where staffing ratios run higher and clinical expertise with ongoing education and training is emphasized. While hospital referrals are prominent, skilled nursing referrals are dominant, often due to the expiration of the 20-day Medicare post-hospital stay benefit when the $170.50 daily co-pay kicks in.

The daily Progressions rate for stays up to eight weeks is $135. Costs are offset by partnering with Genesis Rehab Services for on-site outpatient therapy clinics, a physician group that maintains regularly scheduled office hours at each community, a pharmacy, and a network of home health care agencies. Each provider is Medicare certified.

Approximately half of those in the Progressions Program return home, while the remainder choose to reside in either Country Meadows' independent living or assisted living apartments.

Progressions incorporates 13 clinical management tools designed for chronic diseases with best practices for symptom exacerbation, rounding and charting. Dashboards track and analyze hospitalizations, re-hospitalizations, falls, wounds, medications and more to guide interventions and ensure quality improvement.

All the Progressions units have a dedicated manager and restorative coordinator to interact with the therapy team and other third-party providers to ensure continuity and oversee communication with the frontline staff, clients and their families. Admissions are accepted seven days a week. Restorative programming and restorative fitness are underway 24 hours a day to advance functional improvement beyond the therapy sessions.

"When people go home, we do a graduation ceremony and have a program to stay in touch with them," Meredith Mills, Country Meadows COO commented as she explained how post-Progressions outreach efforts often bring clients back as full-time residents. "We invite them to activities, fitness programs and back for meals. On some of our campuses where we've had a large volume of Progressions clients, we have special events just for the people who have gone home from that program.

"Some people continue their outpatient therapy on our site with the therapist they enjoyed during their stay. Genesis provides us with a modified Barthel Index for activities of daily living, which is a functional improvement scorecard. It shows where the patient started with their abilities and where they finished after their time with us.

"Genesis writes a story about the person and includes a picture, all with the permission obviously of the patient. We take that profile back to the discharge planner, and we started nice branded binders with clear sleeves. They have a whole book of success stories from our program that they show to people considering our program," she said.

As value-based reimbursement and integrated care networks gradually make headway, Country Meadows is looking ahead to become an indispensible partner in its region by assembling a turnkey post-acute care ensemble. Building networks up to this point has been a low priority for hospitals, so Country Meadows is stepping in.

"We have this extensive relationship with Genesis Rehab and have the same pharmacy across all our sites," Mills pointed out. "We formed preferred home health relationships across all our sites. We're starting to work with the same medical director group across all sites. And now we're launching our own hospice across all sites. We already have strong relationships with the SNFs. So we're saying we're going to form the whole post-acute network for you. If you want to be part of it, then here's the package with a nice bow on it."

Preliminary discussions have been underway with Medicare Advantage plans. "In Pennsylvania, it's about 50–50 traditional Medicare versus Medicare Advantage," she reported. "With the notice that came out from Medicare last April where they said Medicare Advantage can now cover some of these home-based services, the insurance companies are saying look, we've got 70 different irons in the fire right now. But send us your information, we'll put another iron in the fire.

"It's definitely on their radar, and we are one of the partners they would consider. One insurer wanted to see what a bundle would look like. We gave them the cost we would charge for the therapy, home health and the assisted living stay. The insurance would pay us a bundled fee and have us handle the payments for the therapy and the home health. We would be at risk.

"We are open to and actively researching both participation in and ownership in Medicare Advantage plans," Mills added. "We know that our industry is saving Medicare money through the strong clinical quality we have invested in. It's the right thing to do for our residents. However, at some point we would like to get financial credit for the work we are doing.

"While so much private equity is flowing into our industry, and many of our competitors are constructing new buildings," she continued, "we are building for the future by investing in wrap-around resources that will support our current clientele in the best possible way. We believe strongly that this focus will position us for future opportunities and also allow us to participate in the health care system in a more meaningful way."

LOOKING ACROSS THE CONTINUUM TO LEARN

Assisted living faces far more questions than answers at this point as it sorts through health care's rapidly changing landscape with its growing emphasis on capitated and risk-based reimbursement, case management, narrow networks, tracking outcomes, and promoting wellness and prevention.

To get a jump on weighing the innumerable risks and rewards tied to participating in this new health care paradigm, assisted living operators that are part of larger organizations with diversified service lines including Medicare-certified skilled nursing, home health care, and hospice are looking at their affiliates' experiences in navigating this interdisciplinary labyrinth of care delivery, reimbursement and contractual relationships.

Avamere is a fully integrated senior living group operating across the Pacific Northwest and beyond that is based outside Portland in Wilsonville, OR. Founded in 1995 with one nursing facility, it now operates independent living, assisted living, memory care, skilled nursing, and transitional care facilities.

Signature Healthcare At Home delivers home-based hospice, home health, provider services and palliative care. Infinity Rehab provides contract rehabilitation and wellness, and outpatient therapy. And its Signature CareConnect group specializes in network development, care coordination and episode management, and claims data management and analytics.

Avamere has been on the frontlines of the value-based reimbursement movement. Prior to CMS transitioning away from the Bundled Payments for Care Improvement model last year and moving to the Bundled Payments for Care Improvement Advanced program, Avamere was one of the largest provider-sponsored Model 3 Bundled Payment Convener in the country. It was responsible for approximately 2,000 90-day episodes annually across 46 of the 48 bundle groups.

A convener is an organization that brings together multiple independent parties (like physicians, hospitals and post-acute providers) that are involved in delivering care across an episode. The convener is then responsible for distributing the bonus or paying the penalty to the payer.

Before Model 3 was closed in September 2018, participating skilled nursing facility, inpatient rehab facility, long-term care hospital or home health agency providers chose the hospital patient discharges it would accept based on up to 48 different clinical condition episodes. The bundle included physicians' services, related hospital readmissions, and other Medicare Part B services such as clinical laboratory services, durable medical equipment, prosthetics, orthotics and supplies, and Part B drugs.

"Despite the potential downside risk, BPCI provided a tremendous amount of insight into actionable gaps in care, and a profound level of data for analytics," said Donna Mueller, Avamere's Executive Vice President, Strategy and Innovation. "We have a compelling story to tell about staying in our system, having a warm handoff, and ensuring continuity and a longitudinal journey of care."

An example of one of the assisted living opportunities that Avamere is investigating was working with a hospital's ACO program to care for comprehensive joint replacement patient discharges. The physicians preferred SNFs over home health care to oversee the transition from the hospital, but this was costly.

"I suggested an alternative placement, which is if the patients need five or seven days to recover, they could go to assisted living with 24-hour assistance and have daily home health care. The ACO would have to pay for the assisted living out of their bottom line, but that would ultimately drive down utilization costs," Mueller pointed out.

In another discussion with a physician group that participated in commercial insurance bundling, the focus was on the need to discharge outpatient surgery patients by midnight on the day of their procedures. For those who were unstable, they could be relocated to assisted living with support from a nurse with the physician practice.

Responding to the ongoing growth of Medicare Advantage and the leverage it holds over providers, Avamere is intently weighing the merits of sponsoring its own Institutional Special Needs Plan (I-SNP).

I-SNPs are designed for individuals enrolled in Medicare Advantage who reside in assisted living communities, nursing homes or other institutions. Special Needs Plans may provide care and coverage coordination services that are not offered by other types of Medicare Advantage Plans.

"In many markets, we have all the levers, so we can be nimble and help these upstream, risk-bearing providers get the right care in the right place at the right time. We have all the surrounding resources. This new role will come for assisted living, but our markets are not quite ready for it. It's a big cultural hurdle to get over," she observed.

To anticipate how integrated care networks and the value-based reimbursement movement may ultimately reshape the health care services at the four continuing care retirement communities (CCRCs) that Evergreen Senior Living operates across Texas, Senior Vice President of Operations David Henderson tracks emerging trends across the country.

Looking at Medicare Advantage, for example, Institutional Special Needs Plans (I-SNPs) for enrollees residing in contracted assisted living communities are drawing a lot of attention. These often incorporate nurse practitioners, who work with physicians, assisted living communities, members and members' families to coordinate care across settings.

Henderson referred to a hypothetical scenario to illustrate how the plans could interact with assisted living communities and their residents.

"Three or four assisted living facilities in a marketplace would partner with a skilled nursing facility. They create a mini-network that is contracted by the I-SNP. If the assisted living resident's condition begins to deteriorate, instead of going to the hospital, they would send them to a skilled facility where they could handle a higher level of acuity with more complex medical oversight than you typically would be able to deliver in assisted living, where you frequently have only one nurse on-site a day. This would be for someone who needed services beyond what a home health care agency could provide," he explained.

Another development that he is keeping an eye on is telemedicine. He previously worked with a hospital's emergency department to interact with physicians via videoconferencing.

"Instead of residents going to the hospital, you'd videoconference with a doctor so the nurse could explain the situation," Henderson recalled. "They could review the patient. They could see signs and symptoms. There was telemetry available for pulse and respirations and those sorts of things, so it was a pretty exciting program.

"If you connect someone to telemetry and interact with a doctor, this can reduce sending people back to the hospital, which is a huge improvement in the quality of life, and it costs less money," he pointed out.

CMS is finalizing policies that will allow Medicare Advantage beneficiaries to access additional telehealth benefits and eliminate geographical restrictions, starting in plan year 2020. Historically, Medicare Advantage plans were able to offer more telehealth services, compared to Original Medicare, as part of their supplemental benefits.

But with the new rule, it will be more likely that plans will offer additional telehealth benefits outside of supplemental benefits, expanding patients' access to telehealth services from more providers and in more parts of the country than before, whether they live in rural or urban areas. The MA plans will now have broader flexibility than is currently available in how they pay for coverage of telehealth benefits.

THE MEDICARE ADVANTAGE MOVEMENT

UnitedHealthcare, working in conjunction with its Optum affiliate, has Medicare Advantage Institutional Special Needs Plans (I-SNPs) designed for assisted living residents in Colorado, Oregon and Wisconsin.

At contracted assisted living communities where 30 percent or more of the residents must be enrolled, Optum assigns a nurse practitioner or physician assistant to coordinate access to services and benefits in conjunction with residents' primary care physicians.

"Our nurse practitioner is the point person in the whole care delivery model," explained Keith Rasimus, Director of Business Development in Wisconsin for the UnitedHealthcare I-SNP. "They're communicating with the building's staff, families, physicians, and all the ancillary providers like home health care, hospice and durable medical equipment groups.

"They're at the center point of putting all care delivery models together to try to maintain treatment in-place," he pointed out. "That treatment in-place is going to, first and foremost, reduce hospitalization, and then second, it reduces readmits. The family member has greater satisfaction, as well as the resident, because they're treated in-place."

If an assisted living operator would like to participate in the UnitedHealthcare I-SNP, Optum conducts an assessment of its residents and its clinical protocols. "We have a collaborative model when we do a facility assessment. We find out who all the primary care physicians are for every one of those residents, and 75 percent at a minimum of those doctors have to agree to collaborate," Rasimus said.

"Our medical director contacts those doctors and shares with them who Optum is, that we're not here to steal your patients, and this isn't going to affect your revenue. This is about adding value to the great care you're already providing. When that doctor says yes, what they're agreeing to is our nurse practitioner will be the first call for help," he continued.

"Our nurse practitioner does not bill Medicare. We pay our nurse practitioners through the plans that we sell. So the doctor still gets to bill. The doctor's nurse practitioner still gets to bill. And you still have the doctor or nurse practitioner seeing this patient, and that patient is not being charged any more for our additional services. This gives the doctor another nurse practitioner at no charge to follow his patients, and he doesn't get midnight calls," he observed.

For locations where approximately 70 or more residents participate in the Medicare Advantage plan, Optum assigns a full-time nurse practitioner. "At a larger assisted living community, they can have a full-time nurse practitioner on site at no cost. It's not going to hit their margins," he noted.

After an assisted living community agrees to participate, there is a 90-day period when residents have an opportunity to enroll. "Ninety days before we go live," Rasimus said, "we share what Optum is and the benefits of the United Healthcare Medicare Advantage plan. We'll go to resident council meetings. We'll send a mailing.

"As we're having these discussions, individuals might say after 60 days of interacting with them, yes, sign me up. Thirty days before going live, we can enroll them. And the longer we're in the building, the more the penetration rates grow, because of word of mouth.

"The most important factor in determining enrollee penetration is the relationship we have with the community," he commented. "Is the building championing a cohesive partnership?"

Rasimus noted that UnitedHealthcare's assisted living I-SNP typically offers broader coverage at a lower cost to beneficiaries compared to traditional Medicare Advantage plans.

"They're paying a lot less not just on the premiums, but also on the deductibles. If you're on our assisted living plan, for the first hundred days after a hospital stay, you don't pay a deductible for your skilled days. There's no co-pays for physical therapy and occupational therapy. The benefit also waives the three-midnight hospital stay requirement to qualify for the Medicare skilled nursing stay," he added.

One of assisted living's most prominent Medicare Advantage strategists has been a leader in charting the course to partner with the private insurance plans and is preparing to participate in an operator-sponsored MA Special Needs Plan.

Lynne Katzmann, Ph.D., is CEO of Bloomfield, NJ-based Juniper Communities, which has 23 communities in four states. Her communities have been at the forefront of preparing for capitated and risk-based reimbursement, thanks to Juniper's Connect4Life program.

Connect4Life provides on-site comprehensive therapy, primary care, pharmacy and lab services, which are integrated with other services using a "high-tech/high-touch" communications protocol that transfers information through an electronic health record (EHR) and coordinates care through a human navigator.

Data from the Connect4Life program points to the value of the model for managing population health, because of its ability to efficiently target integrated care interventions in the high cost, high-need Medicare population.

Launching an operator-sponsored MA I-SNP is another initiative underway at Juniper. Partnering with Christian Living Communities, Englewood, CO, and Ohio Living, Columbus, OH, under The Perennial Consortium banner, the group plans to go live with the network in 2021 and is positioned to expand with additional operator stakeholders.

Looking across the assisted living landscape and sizing up the potential for engaging with Medicare Advantage plans, she said "there are several potential ways to engage. In all cases, it will be important to adopt a new mindset and overlay a series of new protocols to integrate the work we traditionally do with other ancillary and acute paroviders. It's not simply, oh, I've got this hospitality model and now I've got older, sicker people, so I'll go with Medicare Advantage and get more money.

"One option is allowing a plan access to enroll residents in exchange for a modest monthly fee from the insurance company for any resident who signs up," she continued. "Assuming a large percentage of residents sign up, there is the potential for new revenue without significant new risk. It is important to know that the revenue is only associated with the residents who participate in the plan; the plan's contract is typically renewed annually so there is always the chance that the plan may change the terms — for the better or worse."

Another option is one where the risk reward ratio is different. "If you want more dollars, it usually will come from taking some risk and sharing in the 'quality gain' that you produce," Katzmann explained. "In order to do this, an operator needs not only to change their workflows but be able to produce data to show that what you're doing has positive impact, particularly on hospitalizations and re-hospitalizations.

"Finally, a senior living operator can choose to own a plan. This can provide the most reward both for residents and the company alike but with it also comes the greatest risk," she added.

Aligning with Medicare Advantage typically means an operator must "overlay a new set of workflows and communication protocols in order to integrate with ambulatory providers, notably primary care, and if needed acute care services. You must be able to collaborate. Not everyone has been dealing with a complex resident. For some it's a new endeavor. Your biggest push will be to add a new set of workflows

and systems to communicate among different, typically siloed provider groups," she explained.

"Early identification and early intervention are what we do in seniors housing, particularly for older, chronically ill people who are high utilizers," she continued."We need to manage lifestyle. We need to make sure people get their meds on time, that they have proper food, that they live in safe housing with supportive services. Where you call home and your behaviors are the first determinants of health. And curative care represents only about 10 percent of the determinants of health.

"Scale, having the right care model, and having the right preferred providers who buy into what we're doing are important, along with being able to stratify and identify completely someone's diagnostic situations," she added.

Katzmann's take on the future of Medicare Advantage in seniors housing revolves around "getting our share of the value we create. We're making a huge difference for the payer. Why can't we make a huge difference for ourselves? A lot of people are saying, oh, I've been approached by this insurer, that insurer. They're going to give me $150 a month per person, and isn't that great?

"But they're going to pull a lot more out of you than $150. So down the road, you're going to be losing out, and they will control your destiny. For me, this is about us getting a seat at the table and being an equal provider," she commented.

NOTES

ABOUT THE AUTHOR

Jim Bowe is Principal of GlenAire HealthCare, LLC, a strategic planning and business development firm that specializes in post-acute care and senior living engagements. GlenAire HealthCare partners with health care networks to help realign the continuum of care with an emphasis on rewarding quality outcomes and cost efficient operations. The firm advises and guides clients on how to optimally develop, expand and reposition post-acute care and senior living businesses.

AMERICAN SENIORS HOUSING ASSOCIATION
Living Longer Better

5225 Wisconsin Avenue, NW
Suite 502
Washington, DC 20015
(202) 237.0900
www.seniorshousing.org

GLENAIRE HEALTHCARE, LLC

25580 Waneta Way
Sturgis, MI 49091
(248) 904.6766
bowejp@att.net