PARTNERING IN THE NEW HEALTHCARE PARADIGM

Mike Tawater
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Question of the day...

What the heck is happening to our industry?
Truth.

Nursing Homes are under greater scrutiny than ever before in the history of the industry.
Timeline

2010: The Affordable Care Act

2011: First U.S. baby boomers retire

2012: First 32 ACOs implemented

2014: Managed Care

2015: Medicare Shared Savings

2015: Value Based Purchasing

2016:
- 10/1/2016: Notice ACT
- 10/1/2016: Impact ACT
- First mandated bundled payment system implemented (CJR)

2016:
- 10/1/2016: PAMA Protecting Access to Medicare Act

2017:
- 7/1/2017: Penalties will begin hitting HALF of the hospitals in the US. Total withheld amount will exceed $525 million
- 5/2017: 5 star changes
- 10/1/2018: Protecting Access to Medicare Act begins

2018: Mandatory bundled payments for heart attack treatment and bypass surgery — 98 markets
Know the industry, Be well read, Take action

Do regular research, know what they see (medicare.gov, etc)

Be well read. (McKnights, Provider, Modern Healthcare get info emailed to you)

Take action, you’ve got to do something
Know Your Industry

Hospitals are narrowing networks
Why is it happening
What criteria are they using
What can providers do to ensure success

Managed Care Companies being more selective

Insurance companies are weighing in
Be well read.

Ripped from the headlines...
CMS Finalizes Mandatory Hip and Knee Bundling Program

Today CMS finalized a new rule establishing the Comprehensive Care for Joint Replacement (CJR) program, a mandatory bundled payment program for hip and knee replacement procedures affecting providers in 67 defined Metropolitan Statistical Areas (MSAs) throughout the country.

CJR Program Summary

Under this model, the hospital in which the hip or knee replacement procedure takes place will be accountable for the costs and quality of related care from the time of the surgery through 90 days after hospital discharge -- what is called an "episode" of care. Depending on the hospital's quality and cost performance during the episode, the hospital will either earn a financial reward or, beginning with the second performance year, be required to repay Medicare for a portion of the spending above an established target. This payment structure gives hospitals an incentive to work with physicians, home health agencies, skilled nursing facilities, and other providers to manage costs across providers and settings as well as make sure beneficiaries receive the coordinated care they need.
Bundled payment demo has nursing homes seeing stars

By Melanie Evans | November 21, 2015

Hospitals in more than five dozen metropolitan areas will soon have no choice but to take bundled payments from Medicare for hip and knee replacements. And the skilled-nursing facilities that do business with them face a stark reality of their own.

Medicare will give hundreds of hospitals more flexibility in letting patients recover from such procedures in brief nursing home stays, which are significantly less expensive than hospital care. But only nursing homes that rank average or better on national quality scores will qualify for a waiver. That will exclude 1 out of 3 nursing homes in the 67 chosen areas from getting referrals for services covered in the payment bundles, according to an analysis of the markets, and the latest scores on Medicare's five-star quality ratings. In some areas, as many as 80% of nursing homes will be disqualified.
Yesterday, FHCA staff and Alan Davis representing FHCA President Joe Mitchell held a meeting with Michael Lawton, the CEO for United Healthcare Florida, and Paul Norman his general counsel. We have heard from several members that UHC was cancelling contracts with centers that are rated one star; terminating contract negotiations; and cancelling select contracts not fully completed. Michael stated that UHC was looking at terminating contracts with approximately 15 one star facilities because of concern that the quality being delivered reflected poorly on the UHC brand of services offered. FHCA staff discussed the deficiencies of the one star system and the need to look at other quality measures when making these decisions. FHCA offered, and UHC accepted, to begin dialogue between the UHC clinical team and the FHCA Quality Foundation Senior Clinician Council.

FHCA also raised the issue of UHC terminating select contracts with our member companies or ending negotiations. Michael responded that the one year “any willing provider” clause in law has expired, and UHC is contracting its network to meet the needs of its members. UHC believes it does not need to contract with every nursing center. In addition to one star facilities, UHC is looking at ending relationships with facilities that have not signed agreements with it. FHCA staff responded that clear criteria is lacking when you look at the centers being left out of the UHC network. He responded that if there is a case why a center should remain in their network, that center should make the case to the contracting officer.
Common Response: Network Formation
Reasons for NOT Being Selected

- Poor Satisfaction ratings
- Less than 5-Star Rating
- High Readmission Rates
- Poor Outcomes
- Not Providing Data
How Hospitals Are Choosing Post-Acute Partners.
Continued Network Formation

Hospitals and health systems are looking for post-acute partners that can provide:

- More efficient care
- Improved outcomes
- Top notch measurables
How do we do that?
Use systems PROVEN to work