FEATURE

An Interview with Kim Saylor

Addressing the Growth in Medicare Advantage Plans

In the April edition of *The Capital Issue*, we detailed the recent growth in Medicare Advantage (MA) plans and examined how long-term care facilities are dealing with the changes. Given the attractiveness and the increasing prevalence of MA plans, operators will have no choice but to proactively manage their resident population to mitigate the risks of lower reimbursement and shorter average lengths-of-stay.

To gain more insight into this important issue, we present a Q&A with Kim Saylor, vice president of Concept Rehab, a rehab services provider in Toledo, Ohio. Saylor has seen operators effectively manage these risks and will share a variety of insights and strategies that can be considered when adapting to the changing reimbursement environment.

Q: What do you think is attracting enrollees to MA plans?

A: From our conversations and observations, we feel the primary drivers of MA growth are aggressive marketing, attractive low-cost Part D options, and beneficiary inexperience with insurance coverage comparison. Many MA plans offer lower monthly out-of-pocket premiums for beneficiaries, specifically in regards to Part D (medication) components. Some seniors have shared that they were able to save over $400 a month. This amount of savings can lead to many fixed-income beneficiaries changing from traditional Medicare to an MA plan. Although the short-term savings are attractive, it's important to keep in mind that with them comes limited in-network choices and/or stricter case-managed care for other health care needs, such as skilled nursing facility (SNF) services. As with typical consumer behaviors, you should compare and purchase based on current use and needs versus long-term considerations. This scenario, coupled with lower premiums and aggressive marketing efforts (e.g., print advertising, direct mail, television commercials, telemarketing, digital marketing and door-to-door sales), has created a swift and significant shift in payor mix for SNF operators.

Kim Saylor of Concept Rehab, which provides a full continuum of customized contract rehab services to skilled nursing facilities, senior housing and home care agencies.

Q: Do you believe the surging enrollment trend is likely to continue?

A: Yes. From our vantage point, we have seen rapid escalation in MA plans. In 2017, we saw a 42% increase in the amount of managed care treatment minutes we delivered nationwide.

Q: Going forward, how can SNF operators proactively manage the risk of increasing MA census and continue to position themselves for future growth?

A: It is unlikely that a SNF can avoid the shift of managed care utilization. Therefore, we are working with our partners to answer the question: "Under what conditions can my SNF mitigate risk and create success under the new reality of managed care?" Our key success drivers focus on the areas of **volume capacity**, **contract negotiation**, **case management**, **system redesign** and **demonstrating value**.

In regards to **volume capacity**, SNFs must know the budgetary allowance for managed care/MA volume. Specifically, operators must know the average daily census limitations by payor mix.

As for **contract negotiation**, it is important to remember that when establishing initial contracts and rate setting, you must negotiate. We are surprised by the number of SNF operators who do not challenge the value of their services and negotiate

for higher rates. Through our work with a significant number of providers across the nation and in densified geographical areas, we know with absolute certainty that variability exists between provider contractual rates. To negotiate effectively, you must be able to demonstrate your value with outcomes and cost data.

When considering **case management**, it is important to keep in mind that these payors require a different procedural approach. Key considerations include pre-certifications, certifications and update approvals. Many operators have found success inviting managed care case managers to have a seat at the interdisciplinary table. This helps create alignment on care needs, discharge planning, barriers to success, and community-based needs. Additionally, we recommend that the SNF create a specific clinical role for internal managed care case management. Key functions of this position include obtaining authorizations, submitting updates on time, obtaining correct clinical and reimbursement levels, and tracking exclusions to ensure additional charges are not incurred. Too often, these functions are marginalized as administrative and as means to control costs, and are thus filled by non-clinical personnel. This approach can be very short-sided and can jeopardize significant revenue dollars.

In regard to **system redesign**, operators are encouraged to create new processes and systems to meet the requirements and yield margins within the context of managed care. The age-old adage "information is power" still rings true. Far too often, we find struggling providers are eager and/or desperate to sign agreements with managed care providers, that they never fully understood the contractual terms, they never completed proformas/projections, and they didn't communicate requirements to those actually admitting patients and managing the services delivered. This lack of information sharing can cause contract violation risk and erode profit. We encourage every SNF provider to have a matrix that is updated and shared routinely with all vested personnel that outlines the contractual requirements of service delivery, reimbursement value, exclusions, and process requirements. This should be referenced daily and be used as a guideline for providing patient needs. Certain medications, treatments, and services can qualify for additional reimbursement or level changes. However, the facility must serve as their own advocate and ask for these allowables, as a managed care provider will not automatically identify or offer them. Finally, they should be certain to include their vendors (therapy, pharmacy, etc.) and encourage transparency. True business partners will help you succeed under constraint.

Lastly, when considering **demonstrating value**, we start by remembering that most SNF operators are experiencing census strain. Therefore it is important to embrace the emergence of managed care. However, this can be restrictive or competitive in some markets. A SNF must be able to demonstrate expertise and alignment with managed care goals. The initial criteria in many markets is the requirement of a three-star or higher rating in the CMS five-star system. Beyond that, benchmarked success in the areas of cost-per-episode, length-of-stay (LOS), and readmission rates are critical to the conversation. Finally, clinical outcomes, ease of admission process, patient engagement, and customer experience are all contributing factors to in-network selection.

Q: What challenges or opportunities are different for a transitional care/short-stay facility in this environment versus a traditional SNF?

A: The biggest difference we are seeing in regard to the growth of managed care is the LOS impact and required response. Generally, managed care organizations are driving down the LOS to 12 to 15 days, even eight days for uncomplicated orthopedic episodes. The typical SNF episode has been approximately 24 days for the last several years. In 2017, SNF census dipped to 83% nationally. The variables of managed care growth with related condensed LOS and overall census challenges are creating a new challenged coined "bed churn." The patient resources needed to backfill open beds is an increased pressure and reality. The need to compress LOS and assure preventable hospital readmissions remains low, requires evidenced-based clinical pathways, strong up-stream and down-stream partnerships, and post discharge follow-up protocols. SNF operators should consider vendor partnerships, company alliances and cross-company clinical protocols to demonstrate value and innovation to managed care providers.

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