

partners in care

Legal and Operational Considerations when Working with ACOs

By Rachael Maxwell-Jolly of Hanson Bridgett
and Todd Shetter of ActivCare Living



The Affordable Care Act implemented several incentive programs to encourage providers to align together, collaborate, and work to provide better quality and more cost-effective care.

Accordingly, the Centers for Medicare and Medicaid Services (CMS) approved three programs: the Medicare Shared Savings Program that helps a Medicare fee-for-service provider become an accountable care organization (ACO); the Advance Payment ACO Model, a supplementary incentive program for selected participants in the Shared Savings Program; and the Pioneer ACO Model, a program designed for early adopters of coordinated care.

Although formation of ACOs are limited to "ACO professionals" (defined under the law as physicians and hospitals), senior living providers can participate in the Shared Savings Program as ACO participants. There are strong incentives for hospitals and health care providers who are in ACOs and have a great

stake in cost savings and long term outcomes of their patients to partner with senior living communities. For example, Assisted Living providers can help hospitals contain costs by assisting them in reducing their readmissions rate. Herein lies the opportunity for Assisted Living providers.

ACOs To Date

In total, CMS has approved 220 ACOs participating in the Shared Savings Program, 17 of which are in California. Providers can find contact information for each ACO on the agency's website. Last year, CMS also approved 32 organizations to participate in the Pioneer ACO Model, which incorporates higher levels of risk and savings than the Medicare Shared Savings Program. Six of those organizations were in California.

Recent statistics from CMS indicate that the reforms are working. Earlier this year, the Medicare Trustees Report found that growth in Medicare spending has slowed, and spending is projected to continue growing slowly over the next several years. From 2010 to 2012, Medicare spending per beneficiary grew at 1.7 percent annually, more slowly than the average rate of growth in the Consumer Price Index, and substantially more slowly than the per capita rate of growth in the economy. In 2012, readmissions for Medicare patients dropped significantly, with an estimated 70,000 readmissions avoided due to a variety of new incentives for hospitals to keep patients well and avoid these costly events.

CMS recently announced the cost savings of the Pioneer ACO model to date. Overall, costs for the more than 669,000 beneficiaries aligned to Pioneer ACOs grew by only 0.3 percent in 2012, whereas costs for similar beneficiaries grew by 0.8 percent in the same period. Out of 32 pioneer ACOs, 13 produced shared savings with CMS, generating a gross savings of \$87.6 million in 2012 and saving nearly \$33 million to the Medicare Trust Funds. Pioneer ACOs earned over \$76 million by providing coordinated, quality care. Program savings were driven, in part, by reductions that Pioneer ACOs generated in hospital admissions and readmissions.

Only two Pioneer ACOs had shared losses totaling approximately \$4.0 million. These organizations are leaving the Pioneer ACO program entirely. Kaiser Health News reports that

CMS has identified one of the ACOs as Presbyterian Healthcare Services in New Mexico, but it has not yet identified the second program. Presbyterian apparently left because it did not save money in the program. Statements from Todd Sandman, vice president of strategy at Presbyterian, indicate that Presbyterian may not have had opportunities to cut costs because of the character of the New Mexico health market—it is already a low-cost and low-utilization environment—so there were no opportunities for additional savings.

Other changes to the market include the California Dual Eligibles Coordinated Care Demonstration (Cal MediConnect) to better coordinate care between seniors who qualify for both Medi-Cal and Medicare. Cal MediConnect is part of California's larger Coordinated Care Initiative (CCI). The CCI was enacted in July 2012 through SB 1008 and SB 1036. Beginning in April 2014, all beneficiaries in eight counties (Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, and San Bernardino) will be enrolled in Department-approved Managed Care Organizations to coordinate medical, behavioral health, long-term institutional care, and home-and-community-based services through a single health plan. Specific long term services and supports will only be available through a health plan in the CCI counties.

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Considerations for Future Partnerships

Given these significant changes in the market, how have Assisted Living providers succeeded in partnering with these ACOs? What are some considerations regarding partnerships with ACOs and other coordinated care models?

Q: Rachael Maxwell-Jolly:
What do you see as the biggest benefit of partnering with an ACO?

A: Todd Shetter:
As an ACO partner, an Assisted Living community could be a very appropriate discharge location for a senior versus the senior's home. Assisted Living communities can help residents manage medications and receive regular, healthy meals, and can monitor for changes of condition. The number one reason for hospital readmissions is failure to fill prescriptions or take medications as prescribed. We can solve that problem. A senior at home alone or with intermittent home health care might not be as successful.

Q: Rachael Maxwell-Jolly:
What do you see as the biggest challenge of partnering with an ACO?

A: Todd Shetter:
The biggest challenge—and we have already witnessed this during CALA Health Reform Task Force meetings—is explaining to hospital groups, physician groups, and insurance providers what Assisted Living is and what we bring to the table. The diversity of Assisted Living services, environments, and costs throughout California is one of our positive attributes, but can also be one of our biggest challenges when we are attempting to offer solutions to an ACO network. Each Assisted Living community in a certain area may offer different levels of service, accept and retain residents with different acuity levels, or charge different monthly rates. Therefore, it may take a network of multiple Assisted Living communities contracting as a group and offering a menu of programs in order to provide an alternative for an ACO network.

Q: Rachael Maxwell-Jolly:
Do you see a benefit in catering your current services to fit into an ACO model? Or do you see a benefit in developing new services that can better serve the ACO market?

A: Todd Shetter:
We re-structured our company and mission in 2010 to focus solely on providing purpose-built memory care communities licensed as private pay, specialty care RCFEs. Our interest and activity in pursuing an ACO network relationship would be to offer an appropriate, affordable, and effective dementia care solution outside of the traditional skilled nursing facility

model. The problem is, no one in the acute hospital or insurance communities have ever directly contracted with RCFEs. There is no pricing model to follow, so making progress and getting answers has been very difficult.

Q: Rachael Maxwell-Jolly:
In your experience, are traditional health care providers (specifically hospitals and physicians) aware of the billing issues, models of care, and challenges specific to senior care? How has their knowledge of your model of care helped or hurt your attempts to align with such providers?

A: Todd Shetter:
The learning curve for physician groups and hospital organizations I have spoken with has been very steep. In the past, they have had no reason to have Assisted Living on their radar screen. From a discharge standpoint, they know more about skilled nursing and returning to home with support services. Very few physicians have ever visited an Assisted Living community, so there are a lot of misperceptions about what these communities provide and their capabilities when it comes to caring for frail seniors.

Q: Rachael Maxwell-Jolly:
Medical record coordination is a big issue for ACOs. The group of doctors, hospitals, and other health care providers working together in the ACO will be able to read the medical records, along with other authorized office staff, to help coordinate care. What are the biggest challenges for transferring over to an electronic medical record system for Assisted Living providers? Is this something that providers have contemplated? Has this been an issue in any of your discussions with ACOs?

A: Todd Shetter:
It is just beginning to happen. We are seeing more eMARs (electronic medication administration record) and EHR/EMRs (electronic health record/electronic medical record) in Assisted Living communities. Some of the larger providers are beginning to roll out integrated medical records customized for Assisted Living documentation that can be transmitted to an acute hospital with historical data on the resident. We are looking at starting with eMARs that are tied in directly to our pharmacy provider. CALA has also kicked off a wonderful initiative this year to collect and tabulate hospital transfer, admission, and readmission data. Individual Assisted Living providers are submitting that data to CALA on a quarterly basis so

that we can build a database of admission, transfer, and readmission rates.

Q: Rachael Maxwell-Jolly:
As part of the integration into dual eligibility, have you explored the possibility of working with Medi-Cal managed care plans? Have you been contacted by managed care plans to initiate and develop relationships with local housing providers and community resources to assist beneficiaries with housing needs? What has your experience been working with these plans?

A: Todd Shetter:
We have had a couple of exploratory meetings with one contracted managed care plan. There is still a lot of work to do. For example, none of the current Medi-Cal billing codes or formulas provide any guidance on how to value and set rates for dementia care in a specialized Assisted Living community. A lot of these initiatives are exploring new territory. We know it makes sense—it is more affordable, more desirable for consumers, and can be replicated—but it really comes down to convincing an underwriter or plan administrator to expand their thinking from the models of care they have always used.

Q: Todd Shetter:
We are very interested in pursuing a partnership with one or more of the managed care organizations to provide care and services to dual-eligible dementia residents who may be better suited for our secured perimeter memory care communities than their current environment of a skilled nursing facility. What would your advice or cautions be when structuring a contractual relationship with any of these groups?

A: Rachael Maxwell-Jolly:
As we have discussed, hospitals, physician organizations, and insurance companies have not traditionally partnered with Assisted Living providers. Because the relationship is new, these traditional providers are not familiar with the regulations specific to Assisted Living providers and are not fully educated on what Assisted Living providers can and cannot do. Without this background knowledge, there is potential risk that the expectation for what Assisted Living can do is different from the reality. Providers may expect Assisted Living to provide more services than they are able. Taking on residents that are in compliance with the regulations and not beyond the level of care appropriate for the particular community is crucial.

In addition, providers must carefully structure their relationship with the ACO. CMS has indicated that specific arrangements of ACOs are waived from application of the Physician Self-Referral law, the federal anti-kickback statute, and certain civil money penalties. But there are several different kinds of waivers;

to qualify, the ACO must meet certain conditions, including specific requirements created by the Office of Inspector General (OIG). There are also certain anti-trust implications in joining an ACO. The Federal Trade Commission (FTC) has set forth guidance on these concerns, including establishing certain safety zones. ACOs that fall within the safety zone are highly unlikely to raise significant competitive concerns; ACOs outside the safety zone, however, do not necessarily present competitive concerns. Finally, tax-exempt organizations should be careful to avoid adverse tax consequences when entering a relationship with an ACO. The tax-exempt organization must ensure that participation in the ACO will not result in its net earnings inuring to the benefit of its insiders or in its being operated for the benefit of private parties in the ACO.

The regulatory environment is still evolving. As these relationships continue to form and prosper, new or updated regulations may change the landscape and dynamic of the relationships. Therefore, it is important for a provider to stay educated and get advice before entering into contracts if new regulations are issued.

Q: Todd Shetter:
As you know, Assisted Living is primarily private pay in California. As health care reform takes hold and more managed care organizations look to Assisted Living as a lower cost alternative with quality care outcomes, how do we protect ourselves against payment delays and defaults that are more common with institutional payer sources?

A: Rachael Maxwell-Jolly:
Ultimately, the payments will filter through those traditional providers who are allowed to structure an ACO independently. Assisted Living providers entering into a relationship with an ACO should be sure that the contract contains specific terms about payment, timing, reimbursement, and what happens if the provider is unable to get reimbursement for the particular event. Similarly, in Cal Medi-Connect, an Assisted Living provider contracting with a managed care company should require clear payment terms in the contract. Ultimately, as an Assisted Living provider, you will be wed to the specific health care provider who has the direct reimbursement relationship. Each Assisted Living provider should do their own due diligence to ensure that they are partnering with an organization that can manage that relationship in order to have security in the reimbursement structure.

Q: Todd Shetter:
If dual eligible partnerships come to fruition with Assisted Living, do you see risks associated with increased regulatory scrutiny (Department of Public Health, Department of Insurance, etc.) that Assisted Living providers are not currently subject to now?

A: Rachael Maxwell-Jolly:
 Yes. If the managed care organizations see that there is benefit to providing services in the “in-home” environment of an Assisted Living community, the managed care providers will certainly scrutinize the facility more carefully. Although we have not yet seen a lot of new regulations specific to Assisted Living, there has been some attempt for further regulation in related areas. For example, the Home Care Services Act of 2013 under consideration by the California legislature seeks to provide for the licensure and regulation of home care organizations.

New regulations and policies about how these relationships are structured are also likely. As I mentioned, the law provides that the relationships are specifically exempt from any fraud and abuse regulations. But as these relationships develop, the OIG may decide to put specific restrictions on them.

Q: Todd Shetter:
 What advice would you give Assisted Living providers who are looking to provide additional benefits to more residents?

A: Rachael Maxwell-Jolly:
 Strategies may include adding licensed nursing staff, increasing hospice waivers, and providing more clinical support to residents.

Again, the Assisted Living provider should take a close look at the community and what it has the

capacity to do. The Assisted Living provider should remain diligent about the regulations and constantly monitor its compliance. In addition, there may be opportunities to partner with organizations who have experience performing these services at home. This type of partnership is a viable option if it is too burdensome to bring the services, whether nursing, hospice, or the like, in-house.

Q: Todd Shetter:
 What other niches do you see developing for Assisted Living providers in California as the Accountable Care Act and health care reform take hold?

A: Rachael Maxwell-Jolly:
 Home health is an area that is expanding. I see a market for Assisted Living providers to have more adult day care or in-home services available. Assisted Living providers are uniquely qualified to care for seniors, and moving that care to less traditional models may allow for better coordinated and more cost-effective care. Ultimately, the federal and state governments are looking for models of care that are more cost effective while increasing quality—if Assisted Living providers are able to demonstrate their ability to participate in that kind of care model, it may set the stage for new programs, reimbursement models, and a new standard for long term senior care and housing. ■

Rachael Maxwell-Jolly is an associate at the law firm of Hanson Bridgett LLP in the Health and Senior Care Section. Todd Shetter is the CCO and partner of ActivCare Living, which specializes in residential memory care for those with dementia.

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