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Optimizing Operational and Financial Performance

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OPTIMIZING OPERATIONAL AND FINANCIAL PERFORMANCE

The increased focus on improvement in the quality and delivery of health care, balanced with the goal of reduction in health care spending, requires providers to develop and execute operational strategies that result in the optimization of operational and financial performance. This optimization is not only crucial to providers, but for partners and payors for whom value is also created. Strategies to create and maintain value include revenue drivers such as volume growth, rate optimization, service line expansion, clinical program development and expansion, as well as ancillary payor and external provider partnerships. In addition to these revenue drivers, operational efficiencies for health care cost reduction may include developing new staffing models based on alignment of staffing to acuity, evaluating ancillary service expenses, and creating partnerships with material suppliers.

Making Success a Reality!

Every market and care network is different; however, the measures addressed in this article have been proven to optimize operational and financial performance. When SNF providers effectively integrate fiscal stewardship and resident advocacy in tandem, their strategic activities provide secured operations to navigate the daily challenges of skilled operations.

The Changing Landscape of Reimbursement

Though the basic structure of the prospective payment system (PPS) remains intact, the Centers for Medicare and Medicaid Services (CMS) has made many revisions to the system, which fall into three broad categories:

1. Refinements to case-mix classification system
2. Shifting of dollars towards nursing care and away from therapy care
3. Basing payments on costs of care provided to residents

Skilled nursing facilities (SNFs) can achieve positive financial outcomes when they understand and monitor care related to revenue drivers during the course of a resident's stay, including resident activities of daily living (ADL) end splits and minimum data set (MDS) coding.

Resident ADLs can affect a SNF's daily rate of reimbursement by as much as 30 percent for a traditional Medicare patient. It is important to note that coding ADLs not only drives payment—it also drives critical care plans and care decisions.

In MDS coding for behavior, mood, extensive services, rehabilitation, and other care areas related to clinical complex and special care, it is necessary that MDS staff be well educated in coding elements and how they relate to both payment and resident care.

Managing Payor Contract Terms

Many internal and external metrics drive SNF operations. A SNF must have a well-defined strategic plan to manage payors. Well-documented shortcomings in the design of Medicare's payment system for SNFs have prompted CMS to make many revisions, including shifting payments from therapy care towards nursing care. As alternative payment models surface, such as bundling, Medicare, and Medicaid Advantage programs, providers must be prepared for care delivery to adapt to both payor and resident needs, and must become fiscal stewards and resident advocates in tandem.

Commercial health plans are aggressively entering into the Medicare replacement plan scope of business. Medicare Advantage plan contracts will continue to be primary payors, and managed care or Medicare/ Medicaid Advantage contract terms must be adhered to. Understanding the terms of the contract is necessary for fiscal responsibility. Medicare Advantage/managed care payors have varying rules, some requiring preauthorization and others requiring authorization. Appointing a key individual at the SNF to oversee payor contracts to ensure that contracts are current is critical in securing a sound revenue stream. All payor contracts should be reviewed on an annual basis and included in the facility's budgeting process.

Best Practice Strategies for Successful Payor Contracts and Revenue Management

- Meet annually with payor organizations. Discuss payor initiatives and partner capabilities, provide reports related to clinical and financial outcomes, request annual cost-of-living adjustments, and discuss high-cost care outliers through case studies.

- Communicate contract terms with nursing and therapy staff.

- Facility case manager/admissions coordinator should be prepared to discuss the following areas with payors on a weekly basis:

    - Level of care changes or resource utilization group (RUG) payment changes
    - High cost outliers such as medications, wound care, and supplies
    - Discharge disposition, emergency department (ED) visits, and rehospitalization
    - Facility case manager/admissions coordinator should attend weekly Medicare meetings and end-of-month triple check meetings and communicate information with staff
    - Preauthorization and authorization requirements

Adapting to All Customer Demands – Speed is Survival

To account for the length of stay (LOS) reduction, SNF providers must be equipped to accept more admissions with shortened LOSs.

Focus on Admissions Process

It is imperative that skilled providers begin to place an increased emphasis on their admissions processes. Based on market trends, it is apparent that LOS patterns are changing. Alternative payment models, care networks, and the Bundled Payment for Care Improvement Initiative (BPCI) are requiring shortened LOSs, better outcomes, and avoidance of rehospitalization. CMS is expecting to find ways to reduce SNF spending, including reducing LOS in SNFs.

Efficient Admissions Process and Clear Communication with Resident and Family

The admissions process begins with a referral. SNF providers must act promptly on admissions decisions and carefully review a resident's physical, mental, and psychosocial levels of care during the referral inquiry. High cost care outliers should be reviewed in terms of medications, treatments, and labor needs. In the event high cost care outliers are identified, conversations and negotiations should take place related to payor contract terms, as well as Medicare or Medicaid payments. The admissions process should be streamlined and should involve both the director of nursing (DON) and therapy staff. Nursing staff should be well trained on performing the initial admissions assessment, which should include a well-organized review of the resident's medication history, care schedule needs, and an immediate assessment of the resident's and family's ability to self-manage care post-discharge.

During this process, SNF staff should be gathering data related to discharge disposition and educational needs of the resident and family. The SNF must uncover barriers that relate to the resident's and family's willingness to self-manage care needs post-discharge. This allows the staff to clearly understand discharge plans; it also identifies outliers early in the stay so that education and training, as well as necessary care and services, can be provided to the resident and family to enable an expedited and successful discharge.

Deployment of Cost Saving Strategies

Strategic Labor Analysis

The American Health Care Association (AHCA) has conducted many studies on staffing, which have found that satisfied and well-trained staff tend to be committed staff; providers see increased retention rates ultimately contributing to better overall performance of the SNF. The more consistent and dedicated the staff is, the more they understand and are able to effectively respond to each resident's care needs—reinforcing the long-term care profession's commitment to delivering person-centered care. As labor costs continue to increase, staffing is a primary area of cost for operations. SNF providers need to be accountable for labor spending and need to be in touch with their labor force. Labor forecasting should be a continuous project.

Following are recommendations for labor management:

- Design recruitment selection and retention programs
- Educate nurse management on staffing to regulatory requirements and to resident acuity
- Convert staffing model to electronic staffing solution
- Implement policies and procedures related to staffing, hiring, discipline, and termination practices
- Conduct weekly reviews on overtime and position vacancies
- Education and training: develop your staff, e.g., MDS coordinators, nursing staff
- Perform staff satisfaction surveys
- Career ladder integration
- Annual labor study
- Design labor plan for human resources department, nursing, and administration
- Meet daily

Negotiating Better Partnership Arrangements

As Medicare and other payor changes become a reality, skilled nursing providers should not be assuming all of the risk. SNF providers can take on a defensive role by becoming sound operational stewards by seeking and securing strategic partnerships.

Rehabilitation Provider Contracts

Keys to a successful contracted rehabilitation provider relationship include understanding the terms and conditions of the contract, making sure all charges are spelled out, and ensuring the contract includes provisions for compliance audits.

It is important to know your payor's expectations. As accountable care organizations (ACOs) are monitoring rehospitalization, they are also tracking outcomes related to rehabilitation and are expecting that residents receiving therapy in SNFs are provided two disciplines of treatment six days per week. Therefore, your rehabilitation provider should be available seven days per week to meet resident needs. Look for opportunities for shared risk when in an ACO payment arrangement.

To make sure the rehabilitation provider contract is meeting expectations, you must understand how the rehabilitation department is operating; ensure that managed care authorizations are reconciled to the therapy services provided and actual charges. Review rehabilitation therapy contracts annually and adjust as your business changes.

Pharmacy Contracts

When reviewing pharmacy contracts, it is necessary to understand the payor and resident markets the SNF is serving. Pharmacy contracts must adapt to the new payor environment. Areas to consider include the following:

Pharmacy Cost versus Price

Be aware of pharmacy carve-out costs affiliated with high-cost medications such as IV antibiotics and anticoagulants. Medication dispensing practices should be reviewed for labor time and ease of dispensing.

Pharmaceutical Waste

Compare real-time charge versus retrospective billing for Medicare Part A, Medicare Part D, and Medicare Advantage programs. If your facility is currently contracted utilizing a per-diem payment structure, after day 15, your facility will most likely experience increased drug waste. When drugs are returned to the contracted pharmacy, the facility will incur dispensing fees and restocking fees, not to mention costs for nursing labor involved in the preparation of drug return.

The contract should provide for conversion of prn medications from 30-day supply to 3-day supply to avoid waste and unnecessary charges. Review the process for reconciliation of returned drugs and assignment of appropriate credits to correct resident accounts.

Enhancement of Medicare Part A to Medicare Part D Continuity

Facilities can minimize costs by avoiding non-covered drugs as residents roll from Medicare Part A to Medicare Part D, and as the facility becomes responsible for all non-covered drugs. By starting residents on optimal drug therapies under Medicare Part A that are most likely to be covered under Medicare Part D, pharmacies can help increase continuity for the resident and reduce non-covered costs for the facility.

Reporting

Pharmacy vendors should supply monthly compliance audits that determine medication errors and dispensing compliance reports. Quarterly dispensing and utilization reports should also be supplied which detail antibiotic, narcotics, and anti-psychotropic drug usage.

Electronic Medical Record (EMR) – Clinical Care Informatics Provider Agreements

As technology is driving business, a SNF must select an EMR provider that has the ability to interface both clinically and financially, and offer administrative ease in pulling census, staffing, and other operational reports. Suggestions for interface include:

- 24-hour census to daily census reporting
- Nursing documentation to MDS, e.g., ADL to section G coding
- MDS coding to billing
- Incident reporting to resident care plan
- Clinical metrics to quality assurance program improvements (QAPI)
- Daily census to nurse staffing compliance

Optimizing Revenue Cycle Outcomes

Oftentimes, we may overlook the activities in the business office and fail to fully understand that the business office is ultimately responsible for tracking revenues that end up on financial statements. The business office manager (BOM) plays a critical role in operational success and overall compliance with billing and collection regulations. Administration should ensure that the BOM is collecting all required documentation to support billing for Medicare Part A, Medicare Part B, Medicaid and Medicaid Advantage programs, and other managed care and payor contracts. Documentation to support billing starts with the inquiry and preadmission documents. The BOM must be checking the common working file (CWF) or HIPAA Eligibility Transaction System (HETS) for eligibility, obtaining payor authorizations, doctors' orders to support skilled care, and Medicare Secondary Payor (MSP) completion. The BOM must be a good scholar of the payor contracts and must be aware of each payor's policy/plan for obtaining preauthorization or precertification, as well as the details for plan notification of residents who are admitted to the facility.

The BOM should participate in weekly Medicare meetings to keep track of resident billable days, and end-of-month triple check meetings to validate billing rates, diagnosis coding, and other areas related to billing compliance. In addition, the BOM is responsible for emailing vendors the SNF's daily census to ensure accuracy in vendor billing.

Clinical Program Development

Design clinical pathways according to resident, payor, and market needs as payor shifts are occurring. Recommendations for branding a SNF's services and enabling the SNF to be clinically competitive are provided below:

- Develop and execute clinical pathways that produce replicative outcomes with management-to-outcome approach
- Develop clinical pathways to ACO, MA, and bundled payment condition variables
- Develop and implement true-case management and care design clinical infrastructure based on partnerships and payor initiatives
- Educate clinical staff on clinical pathways and care design with focus on customer experience and transition readiness
- Launch customer-driven workflow process and supporting documentation
- Obtain clinical data/dashboard to review associated outcomes
- Practice interdepartmental data sharing and clinical incorporation of messaging
- Integrate outcomes to organization's QAPI process
- Dissect clinical versus marketing personnel
- Empower clinical leadership to be spokesperson

Physician relationships are extremely important on the pathway to designing and developing all clinical programs. Now, more than ever, is the time to partner with your physicians. Identify coordinated care activities the physicians are involved in, ACOs they may be participating in, and how they can help market your brand or assist in design of a clinical pathway in which their practice area is involved. Include physicians in facility strategic planning discussions to enable clinical program forecasting.

Developing Your Unique Value Proposition

Health care is undergoing an immense state of disruption with its delivery models and reimbursement. As a result, we are seeing an emergence of commercial health plans entering into the Medicare replacement scope of business. CMS is considering alternative payment methods for all post-acute providers. Hospitals are being penalized for performance issues of post-acute providers. Ultimately, our business will be dependent upon an aggressive value proposition that we can sustain and advance with all of the aforementioned partners.

A facility's value proposition should include four primary concepts:

1. Hospital and Health System Alignment.

This can be achieved by case-managing residents prior to admission, early and active resident engagement, education and training on self-management, providing clear and comprehensive discharge instructions and post-discharge follow-up, obtaining data on hospital readmission, and performing root cause analysis to determine transition process failure cause.

It is also critical that facilities pay particular attention to health system leakage. Oftentimes, patients get lost in the shuffle from health system discharge to skilled nursing admission. Providers need to be accountable to both upstream and downstream provider networks to secure census and care collaboration efforts for bundled payment ACOs and managed care payors, both to ensure that care delivery is seamless and to address the initiatives of these organizations. When organizations track their patients' transitions of care, they are better equipped in turning raw information flows—such as patient admission, discharge, and post-discharge follow-up—into actionable monthly claim and quarterly reconciliation reports that drive transparency and performance. Staying well-informed of patient transitions can prevent leakage in the provider network and allow for care coordination and real-time patient outcome controls.

2. Employee and Customer Satisfaction

This can be achieved through obtaining feedback from residents, families, and employees while the residents are in your facilities and post-discharge through a survey platform. Employee engagement is a critical factor in customer satisfaction. When working with coordinated care initiatives or with payors, it is imperative that lines of communication are open and data is available to support your internal corporate resident and staff satisfaction outcomes.

3. Coordinated Care Alternatives

Seek opportunities for ACO partnerships, Advanced Care, or Bundled Payments for Care Improvement (BPCI) opportunities that are strategic in a mission and clear delineation of a coordinated care model.

4. Regulatory Compliance

Continually review and monitor adherence to federal regulations and conditions of participation. Implement compliance processes around evolving rules related to care transitions and proposed updates to 42 CFR 483.15 – Quality of Life. The focus will be to ensure a documentation system is in place that will address discharge and discharge planning requirements and Comprehensive Person-Centered Care Planning (42 CFR 483.21), and implementation of the 2014 IMPACT Act for comprehensive discharge planning including resident/family engagement and requirements for post-discharge follow-up.

Taking Command of Your Five-Star Quality Ratings

The CMS Five-Star rating system will have direct and indirect effects for facility census and occupancy outcomes. In April 2016, CMS will begin posting data for six new quality measures on Medicare.gov Nursing Home Compare.

1. Percentage of short-stay residents who were successfully discharged into the community
2. Percentage of short-stay residents who have had an outpatient emergency department (ED) visit
3. Percentage of short-stay residents who were rehospitalized after a nursing home admission

4. Percentage of short-stay residents who made improvements in function
5. Percentage of long-stay residents whose ability to move independently worsened
6. Percentage of long–stay residents who received an antianxiety or hypnotic medication

Of the six measures, only five will be used in the calculation of CMS Five-Star Quality Ratings. Antianxiety/hypnotic medication measures will not be used in star ratings due to concerns about its specificity and appropriate thresholds for star ratings.

In order to attract payors or alternative payment partners, SNFs must be prepared to have systems in place to ensure successful discharges and prevent rehospitalization; also, the clinical competencies of skilled nursing staff should be such that short-stay residents are monitored closely and changes in condition are assessed and acted upon quickly to avoid ED visits. Payors in bundled payment arrangements, ACOs, or managed care will be watching and monitoring the SNF's Five-Star Quality Ratings when contracting. The better the Five-Star rating, the more opportunity the SNF will have for contracting and census development.

Making Success a Reality

As time goes on, skilled nursing providers are searching for solutions to assist in securing their business portfolios. SNFs will be challenged to brand their services and operations to attract customers and payors alike.

SNF providers must begin to mobilize their operations with plans of collaboration, partnership, and activities that drive care transformation, care continuums, and resident transition plans.

Every market and care network is different; however, the measures addressed in the article are proven to optimize operational and financial performance. When SNF providers effectively integrate fiscal stewardship and resident advocacy in tandem their strategic activities provide secured operations to navigate the daily challenges of skilled operations.

Health Dimensions Group provides skilled nursing facility providers with solutions to achieve their optimal operational and financial performance. Please contact Darrin Hull, vice president of senior care solutions at darrinh@hdgi1.com or call 763.537.5700.

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