The recipe for payment success? Just deliver the best care at the lowest cost — and prove it

By Elizabeth Newman

Evolving payment structures will challenge skilled care operators to balance two seemingly contradictory objectives. The first: deliver quality care. The second: cut costs so you can charge less than the competition.

There's no question that "incentives are changing dramatically," says Leonard Russ, Bayberry Health Care principal partner and American Health Care Association immediate past board chairman.

Lengths of stay are disincentivized by virtue of bundled payment models, he says.

There are plenty of potentially ominous implications for long-term care providers.

"The patient is being downstreamed from hospital to skilled nursing facility, to home care to provide the maximum amount of quality and best outcomes with the least amount of cost," Russ explained during a *McKnight's* panel discussion at PharMerica's Annual Educational Symposium in June in Dallas.

The session, "Thriving on payment reform," gave operators clearer insight into the dust clouds churning around them.

Skilled providers are grappling with fluid financial incentives, noted Holly Harmon, RN, MBA, LNHA, and AHCA's senior director of clinical services. Pursuing high quality "really is not an option" but rather an understood imperative.

"[The industry is] moving toward these alternative payment models, and to be successful in that, we have to redesign the processes and systems that we have in place," she explained, "That's a big implication of these payment reforms."

Russ, shaking his head, added, "What we're seeing is not so much the rewarding of quality but the penalizing of the lack of quality."

Photos: Richard Dalton

From left to right:

Leonard Russ, Bayberry Health Care

Holly Harmon, AHCA

Robert Kramer, NIC

Fred Bentley, Avalere Health

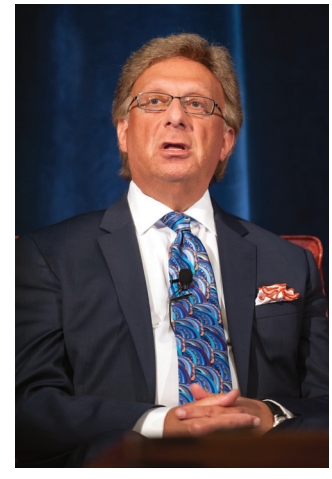
Measurable quality results will rule whether a provider is accepted by an accountable care organization or becomes a preferred provider in a network or a Medicare Advantage Plan. It's critical to "show them the numbers," in other words.

"If you don't," Russ explains, "there will be penalties as far as not being able to participate, number one. And number two, you will get financial penalties eventually taken out of your rate if you don't measure up to certain qualities."

Payments are "more disincentives than positive incentives in the short term," agreed Robert Kramer, CEO of the National Investment Center for Seniors Housing & Care.

"I think very few skilled nursing providers are really going to get recognized and reimbursed for the value they're really contributing over the next several years for several reasons. Right now, I do think cost is the primary driver, not quality," he said.

While Kramer agreed with Harmon that quality matters, he



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also told the audience, "You're not going to be rewarded for that in the short term. For skilled operators, you have to have a short-term survival strategy and a long-term strategy for success."

While clinical staff may be pushing quality initiatives, other sections of the long-term care community may remain focused on increasing census, developing a strategic plan or garnering capital.

For example, senior living board members are talking about quality, but are still "very much fixated on the financial piece of this, which obviously, is important," said Avalere Health Vice President Fred Bentley.

"[Boards] have to be good stewards of the organization, but to the extent that you can get them up to speed on understanding quality, performance and the data to back that up is going to be significant," he explained.

Who decides?

Beyond the quality debate, there also is the question of who is — and who should be — in charge. "Who's going to be calling the shots? We've got hospitals. We've got docs. We have SNFs. That's the question," said *McKnight's* Editor James M. Berklan, who co-moderated the panel discussion with *McKnight's* Editorial Director John O'Connor.

At the moment, "no one" is stepping forward, Kramer responded.

"That leads to confusion, honestly," he added, noting it is ultimately up to the federal government to push down spending per beneficiary, while also spreading out risk.

"[CMS] wants to drive certain things because they have a strong mandate," Kramer said. "I don't think that's really going to change, no matter what bizarre thing happens with November elections, because the realities of entitlement numbers are not going to change."

Providers may breathe a sigh of relief that no major legislation is expected to pass this year, but they also should question whether they're cognizant of all the changes happening concurrently, Russ noted.

"I don't think anything in recent history mirrors quite what's happening now with respect to the multiple changes that are going on with respect to referrals," he said, "with respect to the kinds of patients we're going to see, with respect to the regulatory structure, and with respect to the payment incentives and disincentives."

Minding the changes

There is no question providers need to pay close attention to marketplace movement, noted PharMerica CEO Greg Weishar earlier in the symposium.

"With the shift to value-based reimbursement and bundled payments, providers need to differentiate their performance to succeed," Weishar said. "Our clients are increasingly looking for cost-effective solutions they can quickly plug and play to improve their operations."

Winning in this turbulent period requires not only gathering data, but also understanding what statistics drive the market. Data has to demonstrate quality and that a SNF is the lowest-cost setting for a particular resident, Kramer said.

"Revenue maximization is very different from managing costs and quality," he said. "When you're managing cost and quality, that's where data becomes critical. You can claim it, but if you don't have the data, people aren't going to listen to you."

As a corollary, operators must zero-in on which other healthcare entities they want to be partnered with, whom they want to avoid and how they make their case. They also need to know how they should approach new players in the market.

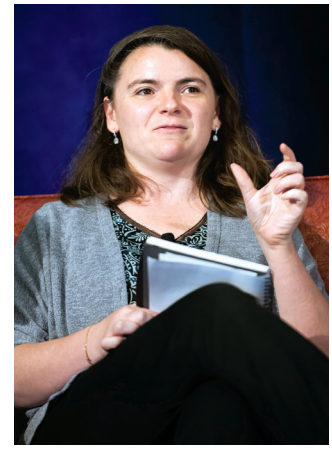
"You don't want it to be a game of musical chairs where suddenly you're left out," Kramer advised. "Do the research now. Don't wait until all of a sudden something happens."

But the reconnaissance work is only half the picture, Russ argued. The future may belong to those who can exchange data and have integrated models, assuming there are more safe harbor laws with respect to liability.

Double duty

Currently, a provider may receive a resident from a hospital partner. The hospital likely already has done a battery of tests, X-rays and lab work on the day of discharge, Russ explained.

"What happens when the patient comes to us? We repeat all of those tests again. Now, why do we need to do that? The fear is that if you don't gather your own data to justify the treatment plan



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you're going to recommend, you have a vulnerability that you've now depended on someone else's data, which may have been flawed because you didn't take ownership or do it yourself."

Harmon agreed that some providers are giving care through a process with "unnecessary tasks, unnecessary procedures, unnecessary hospitalizations, unnecessary services that isn't smarter spending." Better health arrives when providers understand negative consequences that result from that inefficiency. Silos preventing smooth transitions have to be broken down, she said.

Bentley said he expected that some cases, such as high-acute patients currently in inpatient rehab, will soon move to SNFs. But in turn, some traditional SNF placements will be moved down stream into home settings.

"I do anticipate that as these payment models advance and providers assume greater levels of risks, particularly ACOs and health systems, that they are going to be pushing that shift, and so the SNFs are going to be taking some of the higher-acuity cases," he said.

Getting a leg up

In another example, Kramer discussed knee surgery, which traditionally would have meant up to a week's stay in a hospital followed by a long rehab stay.

Now, some patients can have surgery at a specialized medical office building, spend a few days at a rehab center and then go home.

"Many of the boomer joint replacements aren't going to happen in hospitals in the future at all," Bentley forecast. "The hospital is going to get completely bypassed, unless they're the ones that own the [medical office building], and so many of them are therefore looking at that. But the question is everyone's seeking what's the right setting to provide this."

Younger, healthier boomers will probably go directly home after a knee replacement, while more complex patients will land in a SNF.

"It's the ones who have the comorbidities that are going to more likely fall on our shoulders, and that's going to be a more challenging population for us to manage," Kramer said.

While boomers are living longer, they aren't necessarily living healthier. For all the talk of the "silver tsunami," there's wide belief boomers won't start moving into SNFs en masse until around 2030.

"They're going to have multiple chronic conditions and multiple functional limitations, so the opportunities in institutional or skilled settings are going go be huge … but there's a question of timing. It's not right now," one audience member told the panel.

Monied interests

Providers fighting through this struggle also should recognize that data matters to investors, Kramer said. NIC has developed a skilled nursing data initiative "to educate investors," he noted.

"If we don't develop a new way for capital to think about your buildings and what's going on in your buildings, you're for the most part having dumber capital that just gets you overleveraged," he warned.

Playing to strengths

He also noted SNFs have to define what they are good at, whether it's orthopedics or chronic obstructive pulmonary disease, for example, and then promote it strongly.

Indeed, success partially relies on "capitalizing on the strengths within your own centers," Harmon pointed out.

"But also recognize where the gaps are, and look to your partners to help with that," she advised.

As providers narrow in on their specialties, Bentley said, they shouldn't forget how complex some residents' care has become.

The system is looking for providers who can manage patients with four or five conditions, he reminded.

"It's a little more nuanced," he observed.

Bentley also advised providers to examine Medicare Advantage's expansion.

"In most markets it's growing, and in some markets it is set to grow dramatically," he said. "A lot of that growth is being driven by the boomers, but also because they're managing more complex patients or beneficiaries.

"They're looking for creative ways to help those beneficiaries age in place and get the most appropriate care."

What that leads to, Bentley has noticed, is innovations where Medicare Advantage plans partner with senior housing or with "hospital at home" models.

By 2016, roughly 30% of beneficiaries had a Medicare Advantage plan. The number enrolled in private plans had more than tripled, from around 5 million in 2004 to 17.6 million in 2016.

Large geographic variations exist. For example, there are 55% of beneficiaries enrolled in Minnesota and under 1% in Alaska, according to the Kaiser Family Foundation.

Regardless, for many providers, those MA plans and whom they choose to partner with rely on quality measures.

"You've got to deliver those quality metrics," Russ concluded, "in order to maintain your stature and your position in the marketplace." ■