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.”

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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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 to 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 dumb 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 59% 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.”