With the overhaul of healthcare delivery and payments, what changes are needed to meet new quality standards?

Those who manage data best will be the big winners

By Tom Coble
Founder and CEO,
Elmbrook Management Co.

I think of the sea change occurring in the healthcare delivery system in terms of the building of the American West in the mid- to late 1800s.

The providers who are willing to take risk and change their business models will be very successful, while those who don't will be put out of business.

At the center of this evolution is risk. Providers must capture and utilize their data to mitigate this risk. New payment systems are using quality measures to determine reimbursement and network participation. Providers who embrace data will be the kings of the West.

The industry is Balkanized by misunderstandings

By Blake Gillman
Vice President and Director
of Post-Acute Care Services, LCS

The biggest change is confusion. Providers are scrambling to achieve alignment, although they are not always fully aware of what they are aligning to do or what the outcome may be in the end.

As a result, the industry as a whole continues to be working in compartments and not as a complete delivery system due to the changing paradigm never before seen in the medical delivery system.

Quality has always been on the minds of the providers, but now they are working on alignment to make sure they are paid for the quality service they render.

Technology is a crucial investment

By Adam Heavenrich
Managing Director,
Heavenrich & Company

As managed care moves into the assisted living and memory care sector, we are beginning to see operators compete for post-acute resident stays and the Medicaid waiver program. This is pushing operators into direct interaction with managed care organizations and their high standards for data tracking and reporting and best practices requirements.

The shift makes it especially challenging for the mom-and-pop operators who must invest in a new layer of infrastructure.

Thus, hardware and software systems are gaining popularity along with chief technology officers.

Good teams drive good results

By Matt Monson
Vice President of Acquisitions and
Business Development,
Mainstreet

The biggest changes we're seeing today require operators to focus on solving care delivery complexities and lowering costs through partnerships and consumer satisfaction, all of which require an investment in people and systems.

Operators that report evidence-based outcomes showcase their effectiveness and provide the data necessary to establish preferred-provider partnerships. This drives the operator's reimbursement rates and census.

But the ability to report accurate results requires an investment in a team that can navigate complex case management and a robust IT infrastructure.

Medicare, Medicaid put responsibility on operators

By Jim Bowe
Principal, GlenAire HealthCare LLC

Managed care, thanks to Medicare Advantage's 31 percent share of all 17.6 million Medicare beneficiaries, is tightening its grip on post-acute care operators by hitting them with a double whammy: tighter reimbursement and shorter lengths of stay.

Meanwhile, dual-eligible demonstration projects and the rise of third-party Medicaid managed care companies that control nursing home utilization are putting additional pressure on the bottom line for long-term care operators.

Given the incredibly complex and costly nature of post-acute and long-term care, Medicare and Medicaid are ramping up to more aggressively offload their administrative responsibilities as the capitation rates, provider networks, quality standards, utilization reviews and contract negotiations that are so prevalent throughout the rest of healthcare begin to envelop post-acute care.

Reward doctors who hit their benchmarks

By Jason Greis
Partner, McGuire Woods

As we move from fee-for-service to alternative payment systems, the provision of care is increasingly being tied to objective benchmarks for quality improvement. Various models have failed but have yielded important lessons.

Models likely to succeed will achieve a new triple aim of aligning financial and care incentives among physicians, payors and healthcare institutions.

This will happen by significantly rewarding physicians who focus on providing preventive care management and value-based interdisciplinary care across multiple settings to prevent readmissions; by providing payors with big data needed to address poor outcomes and systemic fraud and abuse; and by encouraging institutions to adopt outcomes-based medicine approaches.

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