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POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

Guidance for Medical Directors Series

Value-Based Healthcare in PALTC: Opportunities for the Medical Director

This paper focuses on how medical directors serving post-acute and long-term care (PALTC) facilities have opportunities to work with their facilities and the companies that operate them to be successful in value-based healthcare programs. PALTC facilities ("facilities") refer to nursing homes providing care to skilled/rehab/post-acute patients, long-term/custodial care patients, or a combination of both.

Key Highlights:

Medical directors should consider engaging with their facilities and the companies that operate them to evaluate any alternative payment models being considered for adoption. In some cases, the medical director may already be participating in or have indirect ties to such models. The medical director should be aware of the key quality and financial outcome metrics for each model and assist the facility in evaluating and improving their performance toward achieving targeted outcomes.

A medical director's role in value-based healthcare may vary based on the type of program their facility is aligned with. The medical director can assist the facility in evaluating, understanding, and deploying the model, monitoring clinical and financial outcomes, directing quality and performance improvement projects to achieve the desired value-based, financial, and quality metrics, and ensuring patient-centered care and safety throughout. The medical director should include these responsibilities and time commitment toward reimbursement for their work in their contracts.

Medical directors may engage in VBC endeavors by:

- Attending, alongside the facility's leadership team, meetings hosted by value-based healthcare programs.
- Reviewing the proposed contract with the facility leadership and/or the company that operates them, to help everyone align with the outlined quality and financial metrics, data collection, outcome measurements, and potential financial and network incentives and disincentives.
- Helping the facility navigate the value-based care programs they are considering aligning with and highlighting the similarities and differences between these programs- so that the facility and its partners can make an informed decision.
- Helping the facility understand value-based care and how its care delivery models and reimbursement structures align with the facility's priorities, financials, staffing, and operations.

- Adding a qualified clinical voice to the ongoing discussion of the care and services the facility delivers to its residents and the medical director's oversight over all medical practitioners in the facility.
- Evaluating specialized care needs that value-based care programs may require in their post-acute care networks (e.g., respiratory therapy services, intravenous medications, dialysis, etc.)
- Engaging with and oversight of all providers offering services on behalf of the value-based care programs in the facility.
- Reviewing care delivered by providers in the facility related to quality, cost, and clinical outcomes, and providing ongoing feedback for improvement.
- Advocating for the delivery of the right care, at the right time, at the right place, and optimizing the use of medications and supplies as medically appropriate.
- Helping the facility understand which patients in the facility could be attributed to or enrolled in value-based care programs and how that process occurs.
- Ensuring that all eligible patients are offered enrollment opportunities in an equitable fashion.
- Providing clinical and ethical oversight to all value-based care engagements to ensure that the delivery of the highest quality clinical care is prioritized.
- Assisting the facility in the development of QAPI (Quality Assurance/Performance Improvement) plans and Performance Improvement Projects (PIPs) to ensure that they align with the objectives of the value-based care initiatives to meet specified clinical//quality outcome measures.
- Assisting the facility in the development of systems and processes to track outcomes to help track real-time measures of success and collaborate with staff to improve performance.
- Reviewing the facility's performance and outcomes on an ongoing basis and assisting in the timely generation of reports submitted to the value-based care programs to ensure that the facility communicates clearly and in formats and terminology understood/required by the programs.

Introduction:

The U.S. medical system has been primarily based and funded on a fee-for-service reimbursement model since pre-colonial days. Doctors and other clinical practitioners were paid a per-event monetary amount or through a barter system when caring for patients. The fee-for-service model became further entrenched as the primary reimbursement system for our nation's healthcare when the Medicare and Medicaid Act was signed into law in 1965. This resulted in almost all health insurance companies reimbursing medical care on a fee-for-service basis.

Rising healthcare costs and increased utilization were quickly identified as a limitation to the fee-for-service system. This led to some early alternative payment models, such as health maintenance organizations (HMOs) and capitated fee arrangements, which gained popularity with some commercial and private health insurance companies starting in the 1970s. In the early 1990s, discussions highlighted the need to not only reduce healthcare

costs but also to improve health outcomes in order to improve value. In the late 1990s, Medicare Advantage programs were made available to Medicare beneficiaries, providing capitated per-member-per-month reimbursement to at-risk entities, and became a widely utilized model of value-based healthcare. This type of managed care benefit model has expanded substantially in recent years, in part due to low premiums and copays and aggressive marketing. The Affordable Care Act in 2010 set in motion the creation of many value-based healthcare initiatives, including Accountable Care Organizations (ACOs), Medical Homes, Value-Based Purchasing, and Bundled Payment Programs.

These alternative care delivery models and payment structures have grown over the last decade and a half. In 2023, 60% of physicians who worked in a practice model were part of an ACO, and 34% of physicians were aligned with a Medical Home model. Nonetheless, fee-for-service remains the most prevalent payment arrangement for physicians in the United States. Of all physician practices, 86.4% have some fee-for-service reimbursement, and 70% of provider revenue comes through fee-for-service payments. This is due in large part to the complexity and the pace at which these programs change and evolve. [2,3]

Value-based healthcare models have typically centered on hospitals, physician practices, and insurers. Long-term care communities such as nursing homes, assisted living communities, and other congregate living settings have traditionally been excluded from direct participation in these alternative payment programs. Since post-acute care settings are an integral part of the overall healthcare network and can be associated with high healthcare costs, it is important that medical directors working in the field are well-informed about value-based care.

It is uncommon for nursing homes to engage their medical director in their day-to-day operations and financial planning. In large chains, decisions are often made at the corporate level. Medical Directors should let it be known that their input can be vitally important to the success of value-based care initiatives. Medical directors should be engaged with their facilities and the companies that operate them to know which alternative payment models the facilities are participating in or have indirect ties to. The medical director should be aware of the key quality and financial outcome metrics for each model and assist the PALTC facility in evaluating its performance toward achieving targets and outcomes. Medical directors are able to add valuable clinical insights into which metrics are tracked and the plans to achieve them.

Medical directors, facilities, and the professional organizations that represent them should be active in advocacy efforts to include all long-term and post-acute care settings in all future value-based care and alternative payment models and initiatives.

Hospitals and Health Systems:

Hospitals and health systems are the primary referral networks for post-acute care settings. It is important for a medical director to know the referral streams of the facilities they serve. It is critical to understand which value-based models these referral entities participate in and how they manage/prioritize those models, preferred provider networks, and facility/provider engagement to achieve the desired clinical quality and cost metrics.

Most hospitals and health systems participate in multiple value-based care payment models. Each of the models will typically have its own post-acute/long-term care preferred provider network, set of criteria for admission into the network, and clinical/financial outcome metrics to gauge success and ongoing participation. Facility administrators, directors of nursing, and admissions personnel may struggle to understand the various hospital models, how their facility's care and capabilities fit into the larger picture of optimizing quality and cost, and how to advocate for their participation in a network. The facility's leadership may struggle to incorporate these metrics and goals into the facility's QAPI program and to track their outcomes and incremental improvement. This is where the medical director should be able to communicate, collaborate, and commit to the overarching goal of improving quality of clinical care and outcomes for all residents at the facility.

Accountable Care Organizations:

ACOs are groups of doctors, hospitals, and other healthcare providers that come together voluntarily to provide coordinated, high-quality care to the Medicare patients they serve. When an ACO succeeds in both delivering high-quality care and spending healthcare dollars more wisely, it will share in the savings it achieves for the Medicare program.[4]

As of the writing of this paper, long-term care facilities cannot directly form an ACO. Typically, it is a physician's practice, a group of physician practices, a network of physicians employed or aligned with a health system, or a similar entity that will form an ACO. If the company that owns and operates the facility employs the physicians who work in the post-acute setting, then the physician practice can create an ACO. However, the business of operating the facility remains outside of the ACO.

Patients are attributed to an ACO through the care they receive from their physicians, most specifically their primary care physicians. A patient who is attributed to an ACO continues to hold their traditional Medicare benefits, may not elect to be part of an ACO, and often may not even be aware that they are participating in an ACO. The ACO typically does not provide additional medical or other benefits to an attributed patient beyond what is covered under traditional Medicare. However, the ACO may voluntarily provide care coordination benefits as a method to improve the quality and efficiency of care and to reduce healthcare costs.

ACOs that are composed of hospital-based and outpatient physician practices will typically utilize a preferred provider network model to manage the utilization of post-acute care among their attributed members. In this instance, medical directors can follow some of the recommendations for engagement noted in the section on hospitals and health systems.

With the advent of dedicated post-acute care physicians and providers, some have merged into larger post-acute care provider practices and have created their own ACOs. There are also a few larger ACOs that encourage solitary post-acute practitioners to align with their ACOs. In these scenarios, all patients who are attributed to the ACO are receiving their care in a PALTC facility. These ACOs have started to recognize the benefits

of engaging the PALTC facility in addition to their contracted or employed medical providers in order to improve both quality and cost outcomes.

Some ACOs are starting to contract with facilities and offering them a percentage of the shared Medicare savings the ACO earns.

Institutional Special Needs Plans:

Institutional Special Needs Plans (I-SNPs) are medical insurance programs, specifically Medicare Advantage, that restrict enrollment to Medicare Advantage-eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility (SNF), an LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or an inpatient psychiatric facility.[5]

An I-SNP has traditionally been an insurance program sponsored by one of the major insurance companies that also offer Medicare Advantage programs. In recent years, nursing home companies, physician practices, and other entities have begun creating their own I-SNPs. In order to do so, they must create an authorized insurance company and meet Medicare requirements for participation.

An I-SNP will typically contract with the facility and provide incentives for participation and quality outcomes. These incentives may include capitated monthly payments, shared profits, or quality performance bonuses. Plans may try to save money through utilization review, case management, and narrow networks. Many I-SNP plans focus on the prevention of costly hospitalizations for their primary cost-saving initiative. Medical Directors should provide guidance to their facility to ensure that these approaches do not impede or compromise appropriate care. I-SNPs, like other Medicare Advantage plans, can also provide coverage for goods and services that would typically not be covered by traditional Medicare. These additional services often include transportation, hearing aids, dentures, select medical equipment, etc. Some I-SNPs will build additional provider coverage into their medical models, such as nurse practitioner services or telehealth visits.

Patients eligible for an I-SNP must voluntarily elect to enroll in the program. Typically, they can enroll during any month, and enrollment will become active on the first day of the following month. In doing so, they forfeit prior medical insurance coverage, such as their traditional Medicare or Medicare Advantage enrollments. If they are dually eligible and qualify for Medicare and Medicaid, they maintain their Medicaid coverage. Facilities that are contracted with I-SNP programs can make their residents aware of the availability of an I-SNP in the facility, but cannot directly sell to or enroll a patient. Patients who are interested in an I-SNP for themselves or for a patient for whom they are the legal representative would be referred by the facility to an insurance agent working for the I-SNP for an explanation of benefits and possible enrollment.

In recent years, some corporations that own/operate facilities have started their own I-SNPs. In doing so, they assume the role of an insurance company licensed to offer their I-

SNP product to Medicare beneficiaries. As an insurance provider, they must have financial reserves to protect the policyholders that they cover. Being the I-SNP provider allows the corporation to have all the financial gain of the I-SNP but also puts them at risk for all the potential losses. The board of directors and leadership of the insurance company may overlap with the leadership of the corporation operating the facilities. It can be difficult for a medical director with multiple relationships to discern how to act in the best interest of the facility and its residents while also acknowledging the role of the corporate facility as the insurer. Regardless, medical directors should always act in the best interests of the residents.

State-Specific Value-Based Care Initiatives:

Many states have begun to create quality incentive programs through their Medicaid programs. Some states have developed a system that defines quality measures and a calculation to allow long-term care facilities to earn an increase in their Medicaid payments. Often, these programs use data points that are already collected, such as the CMS quality measures. These programs vary from state to state, and their ability to improve the quality of care to Medicaid residents remains to be studied/validated. These programs tend to change frequently due to fluctuations in state budgets and politics.

A medical director should be aware if their facility is participating in any of these programs. The medical director can assist the facility in understanding the model, monitoring clinical outcomes, directing quality improvement projects to help achieve the desired outcomes, and ensuring resident care remains at the forefront.

Conflicts of Interest:

Medical directors contracted with and serving facilities need to be aware of potential and actual conflicts of interest that may arise related to value-based care reimbursement programs. It is important for medical directors to recognize these potential conflicts of interest, bring them to light when they exist, and know when to recuse themselves from participating in discussions as needed. The medical director may consult the compliance officer for their practice, independent legal counsel, ethics/compliance officers for the facility, and/or the company that operates the facility.

Examples of Conflicts of Interest:

- A patient has been on skilled rehabilitation for 10 days following a prolonged hospitalization. After reviewing her clinical status, therapy progress, and comorbid conditions, the Medical Director determines that the patient would clinically benefit from an extension in her skilled rehabilitation stay—likely an additional 7 to 10 days—to safely achieve mobility goals and reduce the risk of rehospitalization. However, the facility participates in a facility-owned I-SNP, which also serves as the patient's Medicare Advantage insurance plan. The I-SNP issues a last covered day determination despite the Medical Director's clinical judgement.

Reducing the length of a patient's skilled stay translates into direct financial savings for the I-SNP through lower medical utilization costs. Because the I-SNP is owned by the same company that operates the facility, these savings may ultimately flow back to the facility in the form of increased profits or be used to fund bonuses for staff leaders based on cost containment. The Medical Director faces a conflict: advocating for a longer skilled stay aligns with the patient's clinical needs but goes against the facility's insurer's determination—and may be viewed as opposing the facility's financial interests.

- A frail long-term care resident with multiple comorbidities develops an acute and serious change in condition overnight. The nurse practitioner employed by the facility-owned I-SNP, who has requested to be the "first call" for any changes in condition, is called and elects to treat in place because of the I-SNP's intense focus on reducing hospitalizations. Tragically, the resident's condition worsens, and he suffers a bad outcome because of the delay in appropriate higher-level care.

  The Medical Director, upon learning of the situation, believes that hospital transfer was clearly warranted and wishes to raise concerns about the systemic pressure discouraging hospital transfer. However, because the I-SNP is owned and operated by the same corporation as the facility, the Medical Director feels constrained, especially as the facility emphasizes "alignment" with its vertically integrated value-based care model. There is no clear avenue for neutral peer review nor quality assurance outside of the facility-owned ecosystem.

  This situation illustrates how financial pressures to avoid hospitalization—even when well-intentioned under the guise of 'treating in place'—can lead to suboptimal or unsafe clinical decisions. It also highlights how a Medical Director's ability to advocate for patient-centered care may be suppressed when oversight and accountability structures are embedded within a single corporate entity.

- A medical director or providers in a facility may be employed by group practices, hospital systems, or other entities that are also engaged in value-based payment models. This may make it difficult to separate the interests of a practice or hospital system from those of the facility. This should not prevent a medical director or provider from acting in the best interests of the residents of the facility they serve.

  Residents may have opportunities to enroll in value-based care programs that their providers may have some or no financial alignment with. This can potentially create a conflict if the patient or their responsible party were to ask the provider for their recommendation. For instance, a provider might have variable competing incentives depending upon whether a patient is attributed to an ACO, an I-SNP, or other Medicare Advantage enrollment. Transparency will always be the first and appropriate response to these situations.

- Some medical directors may serve more than one facility as medical director and/or attending physician. These facilities may be operated by different corporations that

could also be working to become a part of similar value-based care networks or negotiating similar contracts.

Medical directors may engage with their facilities in contract negotiations and review. If they are involved with other facilities that are also negotiating such contracts, they should be transparent about those relationships and may need to recuse themselves when there is a conflict, as their knowledge of specific contract terms, either financial or related to quality metrics, could bias the negotiations.

Medical directors or practitioners who are engaged with multiple facilities may be tempted to steer patients and referral volume to facilities where they stand to gain from the presence of a value-based care program. For example, if a provider is aligned with an ACO or I-SNP, they may steer their patients to facilities that maximize their financial benefit. Any such conduct that is not in the best interest of patients would be unethical and illegal.

- Sometimes a medical director might be made aware of utilization patterns or care costs that need to be addressed as part of their participation in a value-based program, but that action may also result in lost revenue to their medical practice.

  Some value-based care programs will share information on the total health care costs or average costs per member per month, etc. It may be difficult to address the value of frequent provider visits if that discussion could reduce the provider's fee-for-service billing.

  As with most aspects of medical practice, transparency and ethical conduct that is focused on patients' best interests should be the guiding spirit for all practitioners.

Medical directors, attending physicians and APPs all share the fiduciary responsibility to provide appropriate and necessary care to PALTC residents. Perceptions of financial incentives should not influence or distract practitioners and medical directors from making ethical and appropriate care decisions. There is an abundance of experience and literature that has demonstrated that person-centered, evidence-based care will often be cost-effective. The medical director has a moral and ethical responsibility to always put the delivery of appropriate and necessary medical care to PALTC residents above all other conflicting factors.

References:

1. *What Is Value-Based Healthcare? | NEJM Catalyst (1/2/2025)*
2. *What is value based medical care | American Medical Association (1/2/2025)*
3. *Nearly 60% of doctors work in a practice that's part of an ACO | American Medical Association (1/2/2025)*
4. *Accountable Care Organizations (ACOs): General Information | CMS (1/2/2025)*
5. *Institutional Special Needs Plans (I-SNPs) | CMS (1/2/2025)*
6. *Assignment of Beneficiaries to Accountable Care Organizations Participating in the Medicare Shared Savings Program | CMS (1/2/2025)*