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2023 ANNUAL CONFERENCE

MAY 17-19, 2023

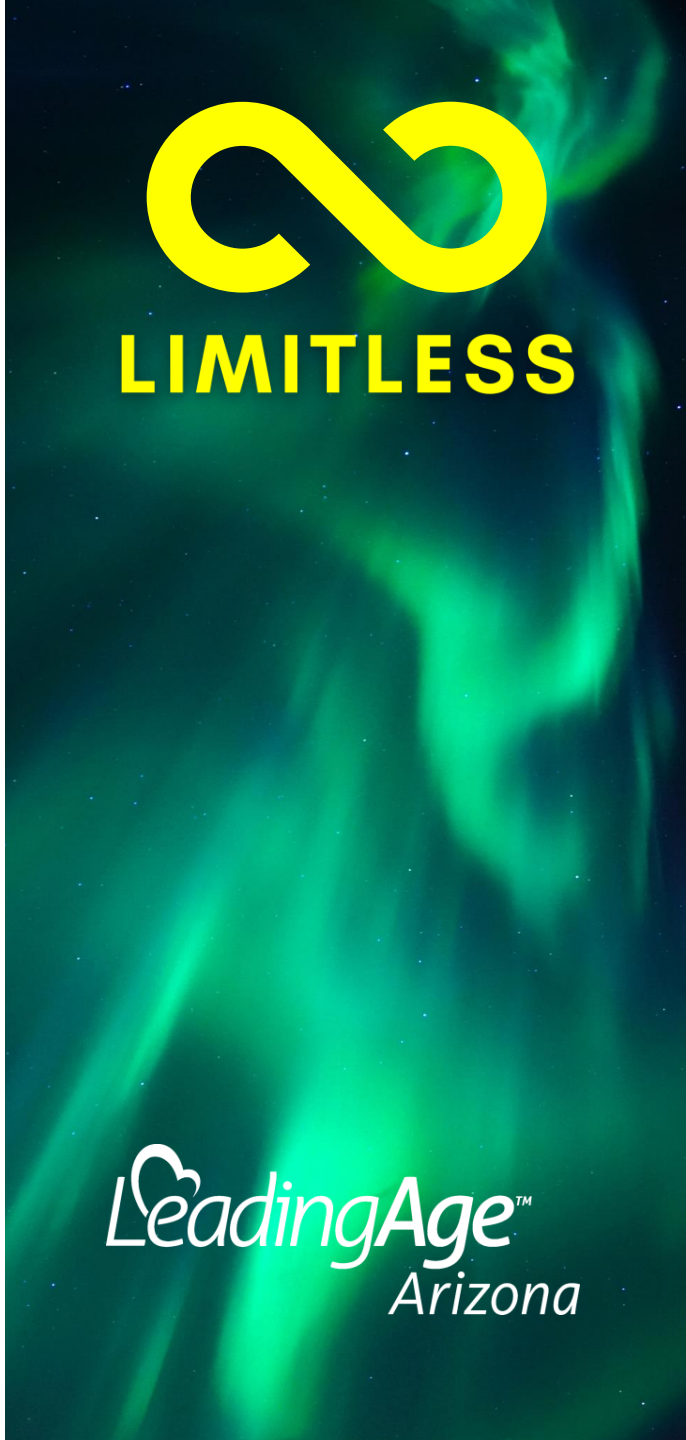
We-Ko-Pa Conference Center • Scottsdale, Arizona

ArizonaLeadingAge.org

Forecasting, Financials + Foundations: Finding Stability Amidst Uncertainty

Objectives

- Understand the financial impact of resident acuity trends and identify the proper occupancy to fiscal balance for community success
- Take away key strategies for changing the system in order to optimize revenues with a new outlook on admissions + IDT processes
- Leverage alternative solutions, harnessing present expertise + resources, in order to achieve sustainability + success



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State of the Union: PAC Evolution + Occupancy Impact

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No Shortage of Challenges!

Rising Acuity

Increase in **Daily Business Costs**

Increase in **HCBS**, Aging in Place

Overcoming the **Fear Factor**

Need to **Rebuild ST + LT Census**

Work Force **Shortages**

Clinical **Competencies**

Provider **Collaboration**

Required Shift in **Mindset**

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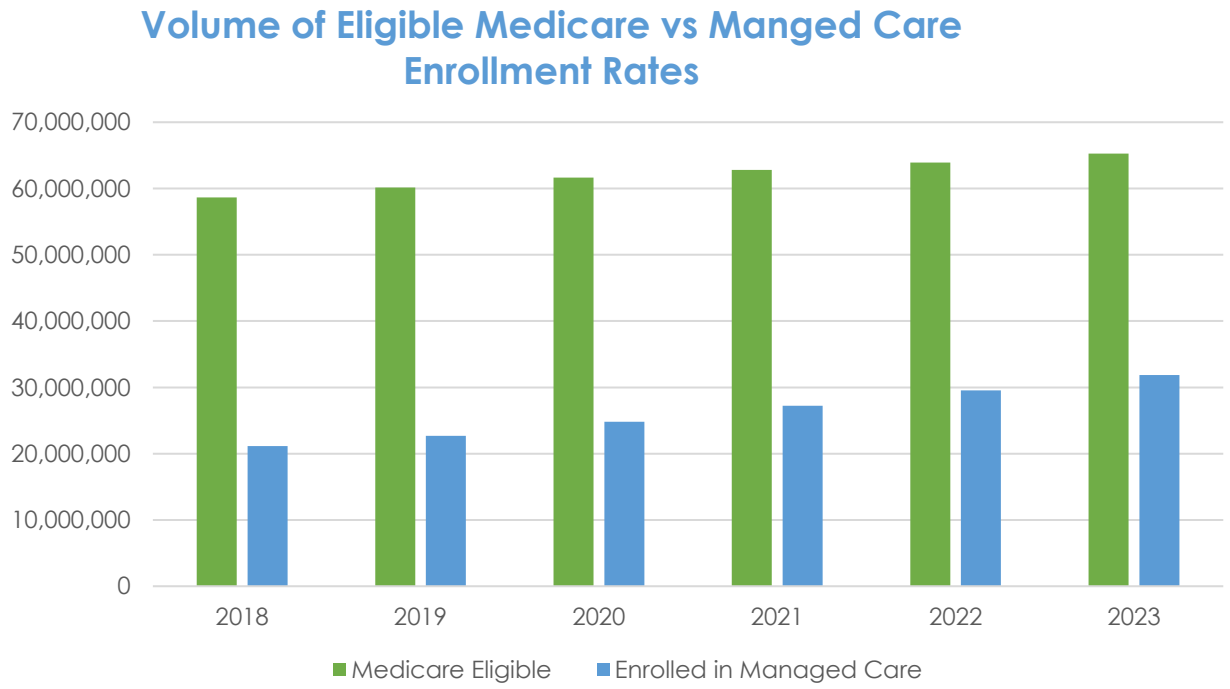
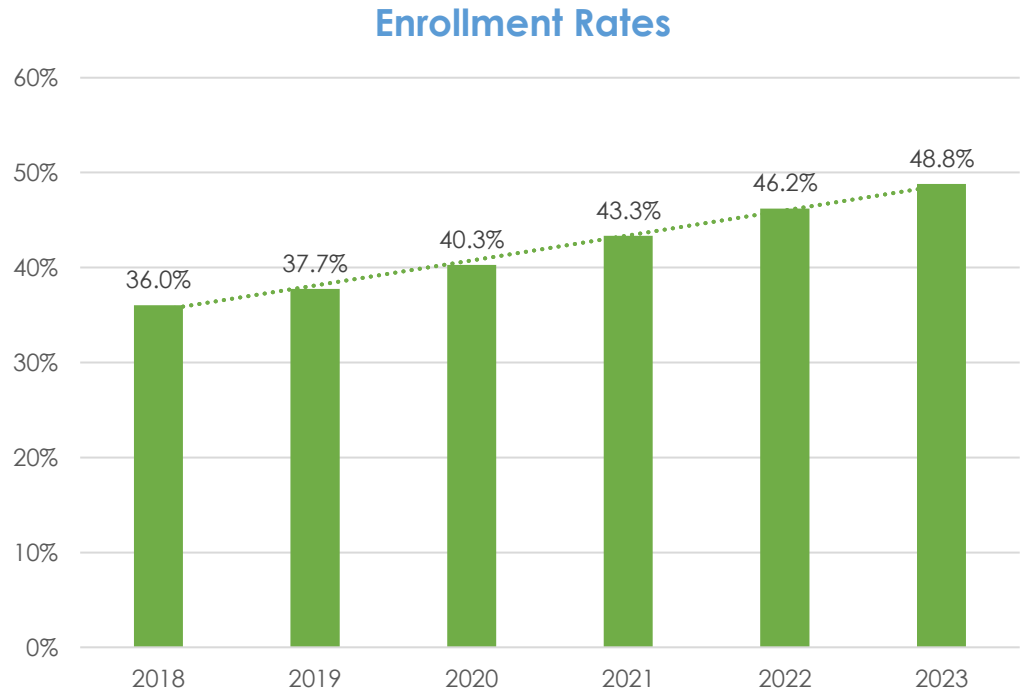
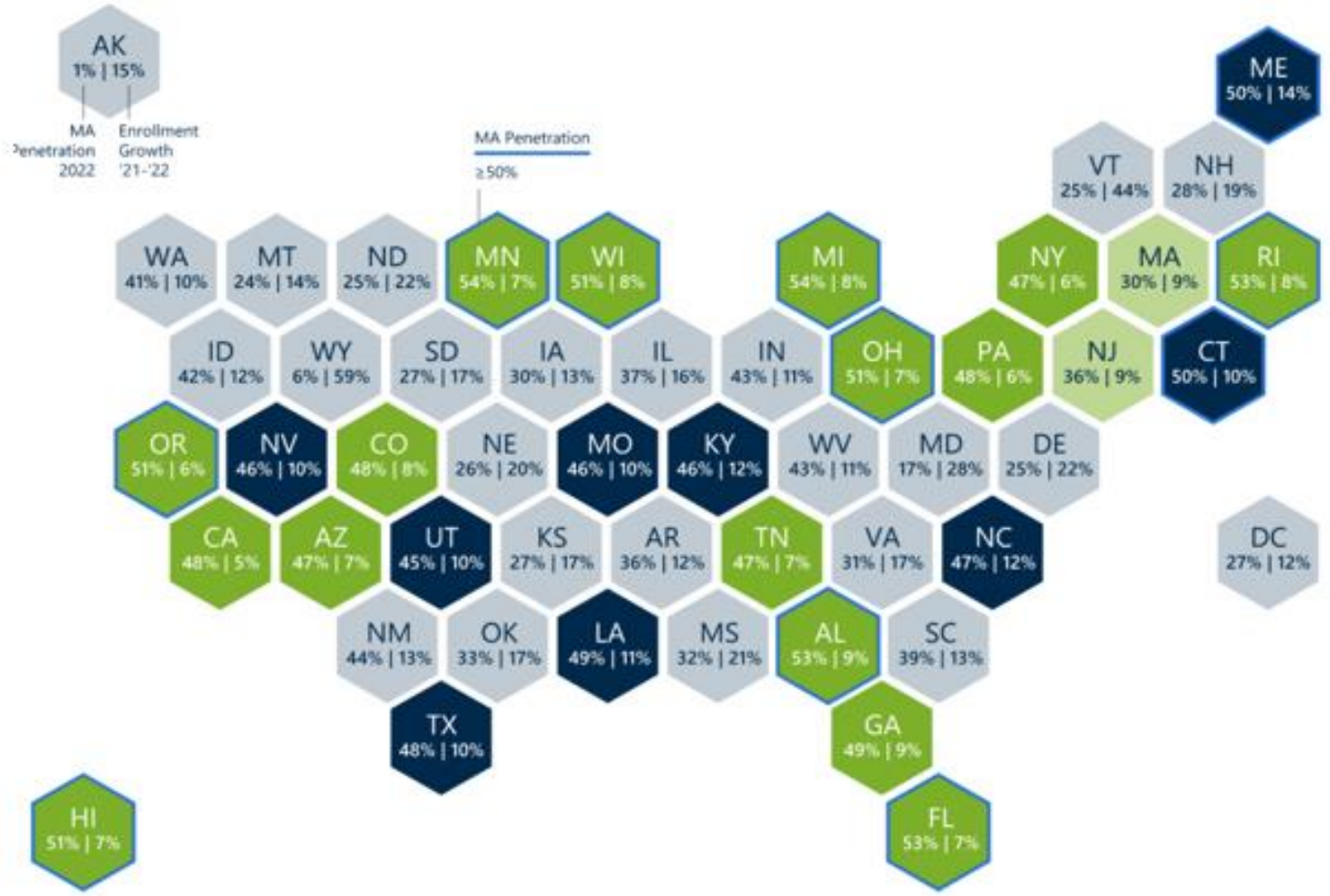
Managed Medicare Growth Over Time





Managed Medicare By State and Growth Rate



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Cross Continuum Impacts

Public Health Emergency

- **The three-day hospital waiver**
- Hospitals + case management taking a back seat to discharges
- **57%+ of hospital discharges going home without PAC**
- **High + Very High Acuity readmissions sky rocketing**
- Telehealth Impact + Physician Reach

Home Health

- **VBP Program:**
  Need for SNF partners to leverage direct admissions to lower risk of readmission and penalty & quality Senior Living
- **Choose Home Care Act:**
  SNF at Home. High acuity in the home who may not be able to be successful; without institutional care for a short period of time. What is the SL role?
- **Quality Measures and Competitive Standing:**
  Need for SNF partners and Senior Living to help prevent readmissions

Assisted Living

Short Stay Respite Considerations:

- Choose Home Care Act + SNF at Home
- Leveraging physicians and surgical centers for lower acuity patients who cannot go home
- Option with Home Health to skip SNF
- 1135 Waivers –direct admit AL/IL and Home into the SNF to initiate Med A benefit
- SNF/ALF partnership opportunities

Top 25 Managed Medicare Health Plans

These are the major parent companies and there enrollments across all states.

Parent Company	Number of Enrollments
UnitedHealth Group, Inc.	6,592,516
Humana Inc.	4,136,859
CVS Health Corporation	2,956,942
Kaiser Foundation Health Plan, Inc.	1,709,858
Elevance Health, Inc.	730,265
Blue Cross Blue Shield of Michigan Mutual Ins.	665,209
Centene Corporation	508,023
The Cigna Group	476,366
Highmark Health	348,904
MHH Healthcare, L.P.	217,834
Aware Integrated, Inc.	207,089
Guidewell Mutual Holding Corporation	185,805
Lifetime Healthcare, Inc.	167,721
UPMC Health System	165,838
Medica Holding Company	145,336
BlueCross BlueShield of Tennessee	142,869
Cambia Health Solutions, Inc.	136,394
EmblemHealth, Inc.	110,413
Independence Health Group, Inc.	108,312
UCare Minnesota	108,033
Blue Cross and Blue Shield of North Carolina	105,876
Point32Health, Inc.	102,408
Health Care Service Corporation	96,502
Clover Health Holdings, Inc.	79,602
Bright Health Group, Inc.	76,958

National Managed Care Trends

Figure 1

Total Medicare Advantage Enrollment, 2007-2022

Medicare Advantage Penetration | **Medicare Advantage Enrollment**

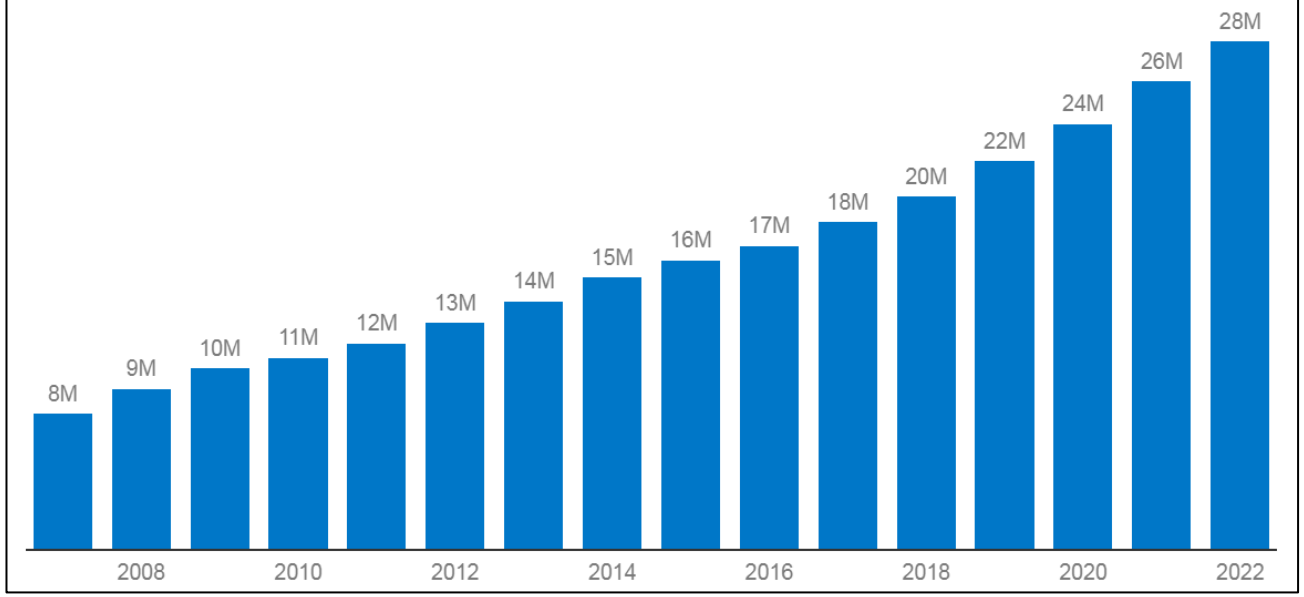
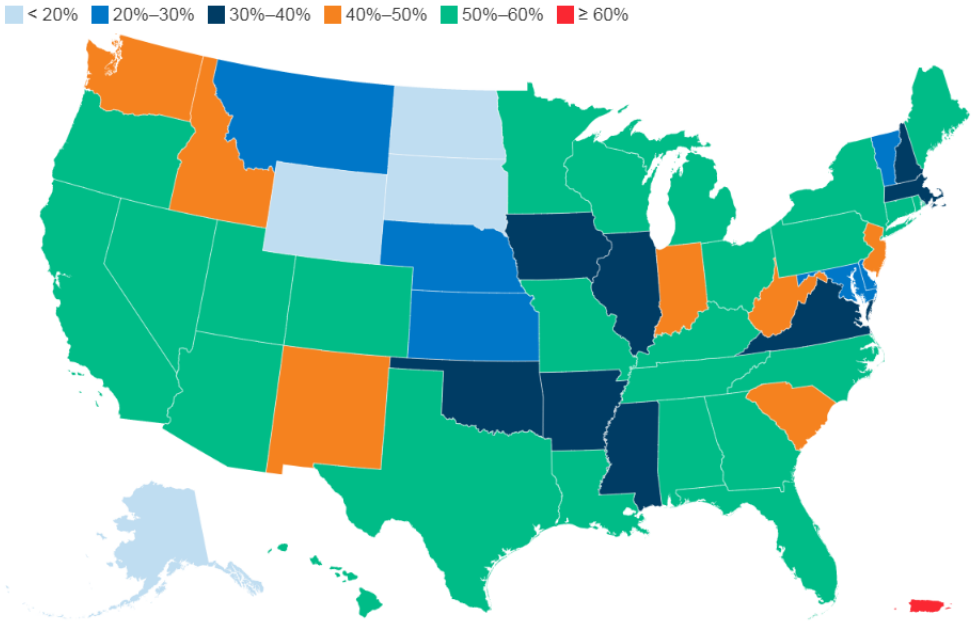


Figure 6

Share of Beneficiaries Enrolled in Medicare Advantage in 2022, by State



NOTE: Includes only Medicare beneficiaries with Part A and B coverage.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022 and March Medicare Enrollment Dashboard, 2022 • PNG

KFF

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MA enrollment as a share of the eligible MCR population has **more than doubled from 2007 to 2022** (19% to 48%)

The Congressional Budget Office projects the share of all MCR beneficiaries enrolled in MA plans will rise to **61% in 2032!**

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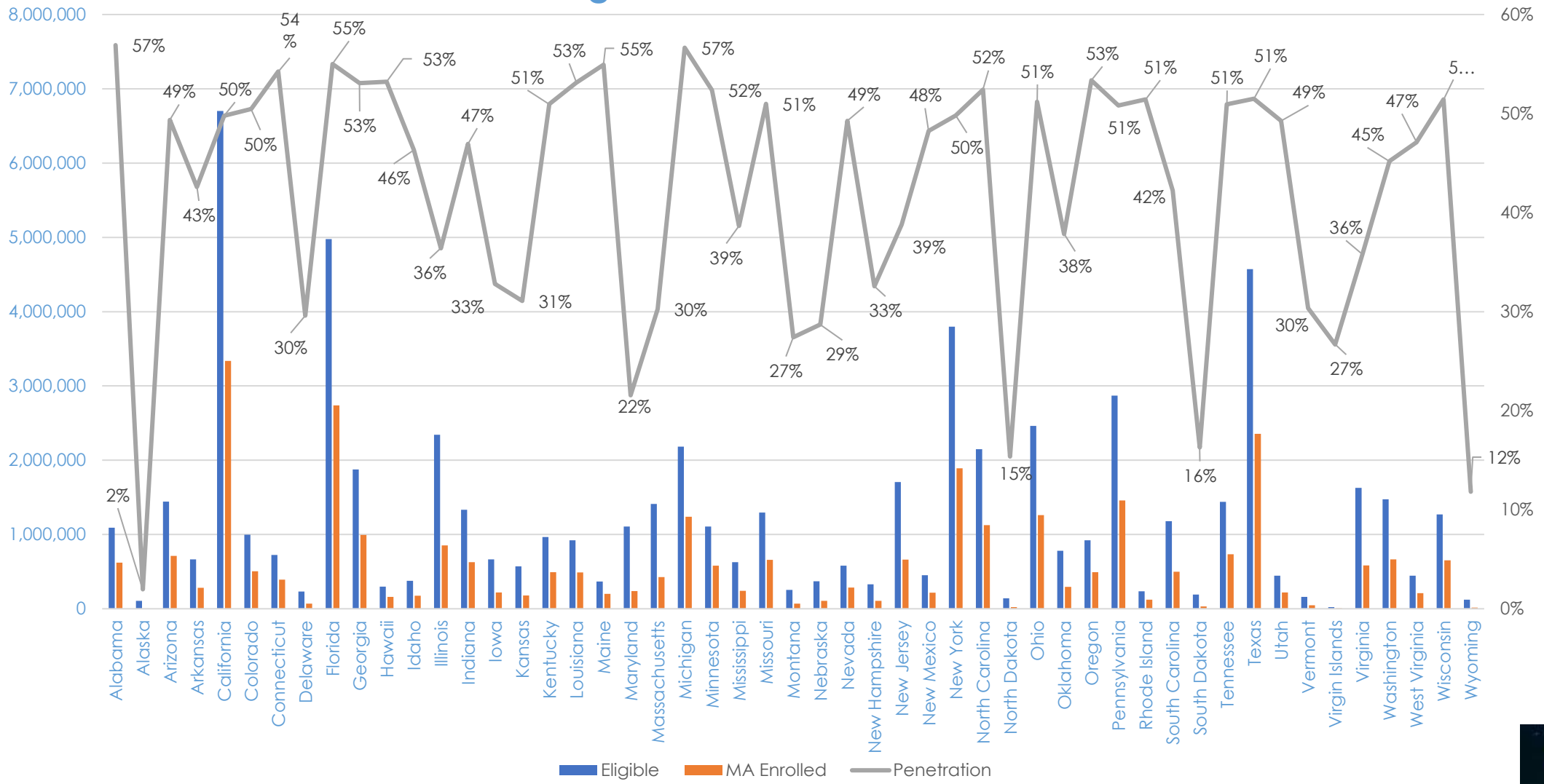
Manged Medicare Penetration



Data from CMS.gov released 4.2023

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Disruptive Innovations to Senior Living

HEALTHCARE TO HEALTH

- Accept it to survive
- New ways of meeting consumer needs
- Like Uber wrecked the taxi
- Reframing Aging and Age
- Reframing Health around wellness
- Reframing Senior Care – bye bye model of dependence

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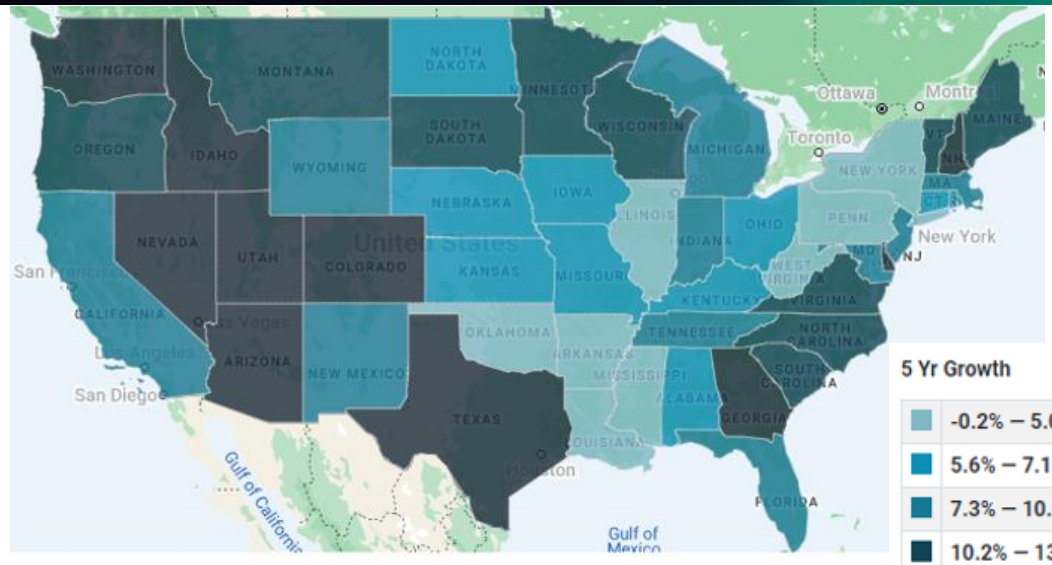

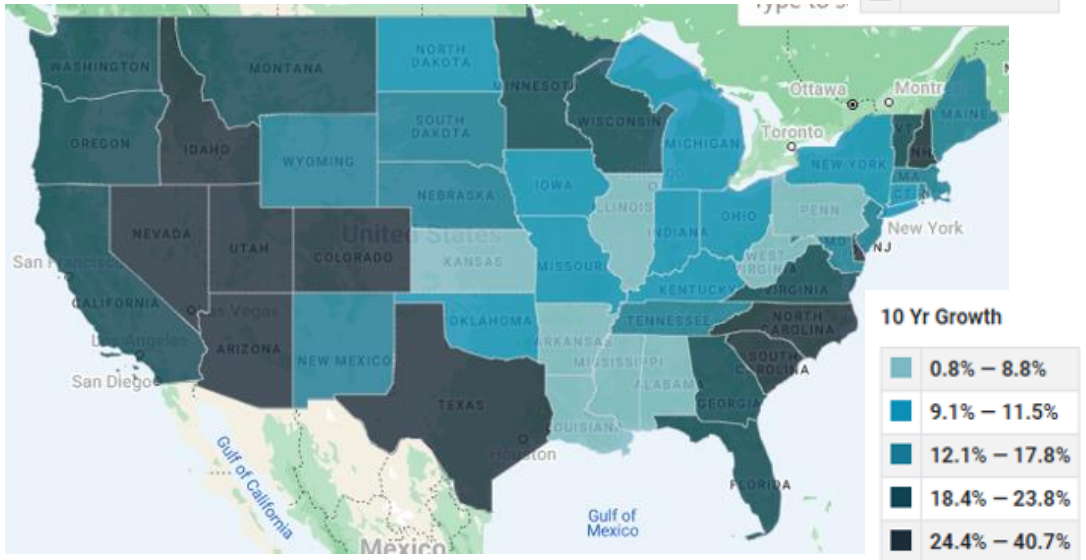

Intentional Disruption

Key Concepts That Will Define Senior Care

Concept of Home

Value + Partnerships

Risk Tolerance

Data Driven Solutions

Tech + Capital

Consumers + Policy

envision everything
with HealthPRO Heritage

"Innovators are more focused on the **vision** than the obstacles that stand in the way."

-Simon Sinek

Take a Few Minutes…

Reflect on the Tangible Takeaways + Thought Provoking Questions Thus Far.

- What new ideas struck a chord?
- Where do I want to grow?
- Am I thinking bigger + bolder? Where can I push the limits?
- Where should I take risks? What does that look like?
- Am I set up for long term sustainability + success?

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Acuity Trend + Opportunity Analysis

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Rising Acuity Levels: Opportunity!

Home Health & PCP Partnerships

Site of Service	Provider	HCC Tier	Encounter Volume	LOS	30-Day Readmission Rates	90-Day Readmission Rates	Average HCC Risk Score
HH	National	Low	1,587,300	14.70	03.93%	8.17%	1.18
HH	National	Mid	1,250,391	18.51	11.37%	21.75%	2.88
HH	National	High	566,640	20.01	21.93%	38.95%	4.84
HH	National	Very_High	283,170	21.47	32.77%	54.20%	7.65
SNF	National	Low	337,449	27.08	5.2%	12.10%	1.49
SNF	National	Mid	701,276	26.79	13.67%	26.39%	2.94
SNF	National	High	420,597	25.16	26.35%	44.85%	4.88
SNF	National	Very_High	255,313	23.68	39.95%	61.70%	7.73
SNF	AZ	Low	5,436	20.66	4.7%	11.44%	1.50
SNF	AZ	Mid	10,773	20.97	13.79%	26.79%	2.94
SNF	AZ	High	6,081	20.75	27.25%	46.40%	4.87
SNF	AZ	Very_High	3,509	21.85	38.38%	62.21%	7.64

LOW RISK PATIENTS (HCC Score: 0-2)

MEDIUM RISK PATIENTS (HCC Score: 2-4)

HIGH RISK PATIENTS (HCC Score: 4-6)

ACUTE RISK PATIENTS (HCC Score: 6+)

Acuity Financial Case Study

Maricopa, AZ WGI .9757 – Non-Case Mix $ 101.35/day

$71.68/ day variance

Low Medically Complex #1	PT/OT CMG	SLP CMG	Nursing CMG	NTA CMG
CMGs	TK	SA	PBC1	NF
$/Day Days 1-3	-	-	-	$179.31
$/Day Days 4-20	$186.73	$16.00	$124.49	$59.77
Total $ over 14 day LOS	**$5,909.67/ ($488.34/day) 537.93**			

Neuro High Acuity #2	PT/OT CMG	SLP CMG	Nursing CMG	NTA CMG
CMGs	TM	SK	CDE2	ND
$/Day Days 1-3	-	-	-	$330.45
$/Day Days 4-20	$156.65	$87.25	$205.97	$110.15
Total $ over 14 day LOS	**$7,151.57/ ($560.02/day)**			

Census: Heads in Bed versus Acuity

Budgeted Revenues versus Census Numbers

Low Acuity Case Study #1 $353.89/day	
20 short term census ADC	50 total beds – 30 LTC ADC
42 admissions	Needed every month with a 15 day LOS
$445,901.40	Rough average Medicare revenues per month

Neuro High Acuity Case Study #2 $518.82/day	
15 short term census ADC	5 open beds – 50 beds in total with 30 LTC ADC
32 admissions	Needed every month with a 15 day LOS – 10 less than low acuity
$498,067.20	Rough average Medicare revenues per month

Less staff and supplies necessary, but a higher competency required for high acuity.
Expenses like high cost meds come into play

Embracing Higher Acuity: A Balancing Act

- Increased per diems
- Carve outs or additional payment for hard to place residents
- Employee engagement, growth + retention
- Physician partnership opportunities: increased frequency + the role of telehealth

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- Requires increase in competencies
  - Return demonstration + intentional trainings
  - Clinical + Ops leadership rounding – trust by verify!
  - Leverage hospital partners
  - Infection control + prevention
  - Survey readiness
- Focus on nursing assessment to proactively ID risks + warning signs
- Redesign your clinical meeting and expand IDT responsibilities
- Focus on revenue cycle management

Achieving Occupancy to Fiscal Balance

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Shifting Mindsets

“What got us here, won’t get us there.”

–Marshall Goldsmith

- Consideration of your risk capacity is essential for sustainability + stability. Quality care of acute residents is needed!
- Assess fiscal risk impact vs heads in beds. How have you adjusted to the PDPM structure?
- Referral + admission process must adapt to meet the needs of the market. Cherry picking admissions is no longer a sustainable practice
- Expansion of IDT roles + establishment of downstream partnerships directly impact occupancy efforts

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Alternative Staffing Strategies

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Outsourced Services

Therapy

Activities/Wellness

Focused recruiting on clinical

Redesign Wellness

Scheduling

Increased engagement

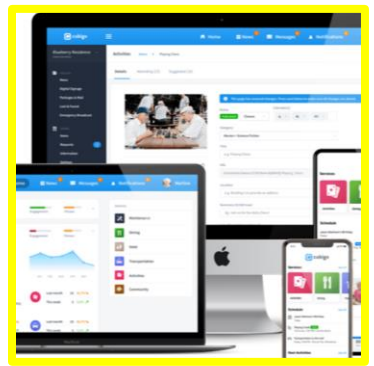
Close the back door

Leverage Telehealth

TeleMental Health

Hospital MD/NP collaboration

Bluetooth capable tech



Leverage Technology

Wellness

Communication/Information

Proactive Falls AI

Evolution of IDT Roles

Roles	Then	Now
Admissions	Waiting for referrals from previously established partnerships, esp. hospital DC planners. Gravitating towards Medicare Part A + low acuity residents.	Tracking + analyzing admission + referral data, leveraging predictive analytics. Seeking out proactive relationships with upstream AND downstream partners. Data driven pursuance of diverse payer streams and patient acuities.
Marketing	Providing brochures and "traditional" printed materials. In-person community events + drop in hospital visits.	Anticipating the needs of consumers + partners, tailoring materials based on identified needs (ex: infection prevention, changes in admissions, clinical capabilities, etc.). Highlighting specific outcomes + differentiators, updating regularly. Creative networking opportunities, including virtual with diverse upstream + downstream providers.

Evolution of IDT Roles Continued

Roles	Then	Now
NHA	Operate on traditional, predictable budgets + trends. Oversee all components of standard nursing facility operations + culture.	Strategic analysis and redesign to strike the occupancy to fiscal impact balance. Embracing nursing facility redesign + paradigm shifts to include payer diversification of short and long term census.
DON	Selecting most optimal residents for skilled nursing care.	Advancing clinical capabilities to meet diverse market needs. Competency based trainings with frequent verification rounding. Collaboration with IDT re: competencies, allowing for timely referral responses + network expansion.
DOR	Operating department based on volume-based care.	Active IDT participant with focus on risk mitigation + value-based care. Facilitate functional objectives while maintaining competitive market metrics.
MDS	Relying on rehabilitation to drive reimbursement.	IDT collaboration to support reimbursement. QM + QRP monitoring with direct impact on networks.
Social Services	Maintaining standing downstream relationships.	Downstream relationship keepers. Transitional Care Management champions. Ability to foster growth in mutually beneficial, quality partnerships.

Revenue Cycle Management

Questions Worth Asking

Who should be involved?

Who should be at the helm?

Do you check your aging report?

How clean is it?

Can you identify the sources?

Do you know how to remedy the origin of the issues?

Where are the missed opportunities?

Revenue Cycle Management

Do NOT Leave Money on the Table

CLEAN CLAIMS:

Ensure Triple Check Process in place and effective for accurate billing and ensure authorizations are in hand

ROOT CAUSE ANALYSIS:

Proactively investigate and adjust systems/process for the root cause of claims denials and payment irregularities

PATIENT BILLING

Capturing and billing of consolidated billing exclusions

Accurate MDS coding

MANAGED CARE GROWTH:

Understanding your contracts versus service delivery

Therapy, Medications, Nursing Care

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Managing Managed Care

Navigating Pre-Authorizations

Costly Medications

Carve Outs

Managing Treatment Provision

Requesting Appropriate LOC

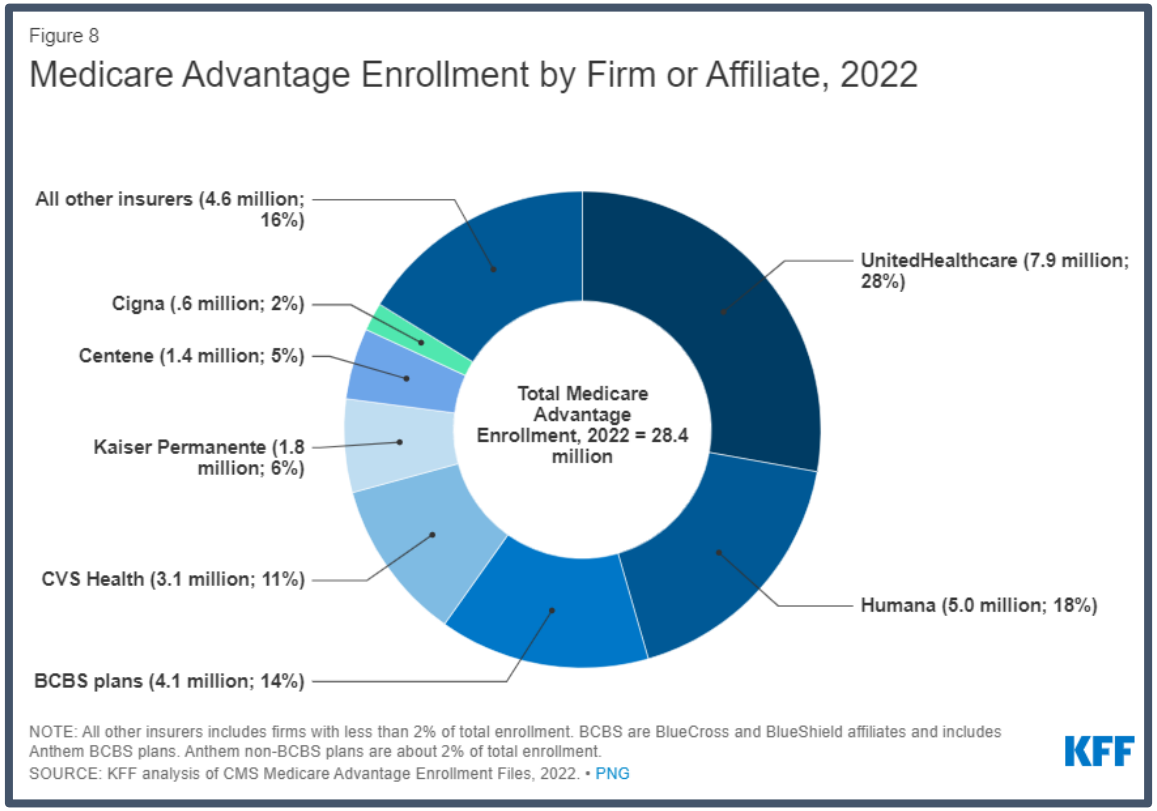
Update Fee Schedules

Billing Copays

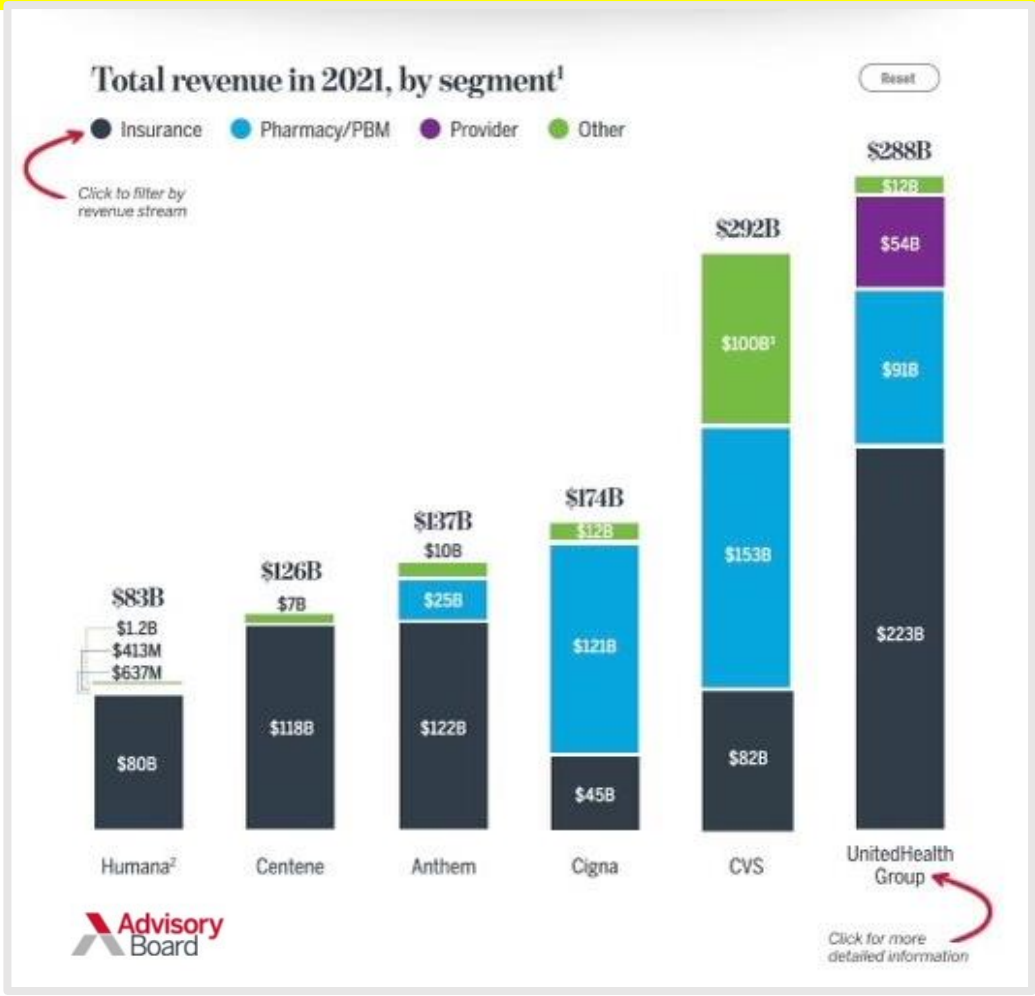
Managing LOS

Managed Care Payer Distribution + Diversification

Insurers have pursued service expansion resulting in diversified revenue streams. Per Advisory Board these traditional insurers are becoming, "diversified health solutions companies."



UnitedHealthcare + Humana account for 46% of all MA enrollees nationwide. In nearly a third of counties (945) they account for at least 75% of MA enrollment.



Episodic or Capitated Payment

ACO REACH MODEL – SNFs and ALFs Opportunity

Episodic case rate over 17 days

Reimbursed at 90% of Medicare FFS rate

Quarterly reconciliation

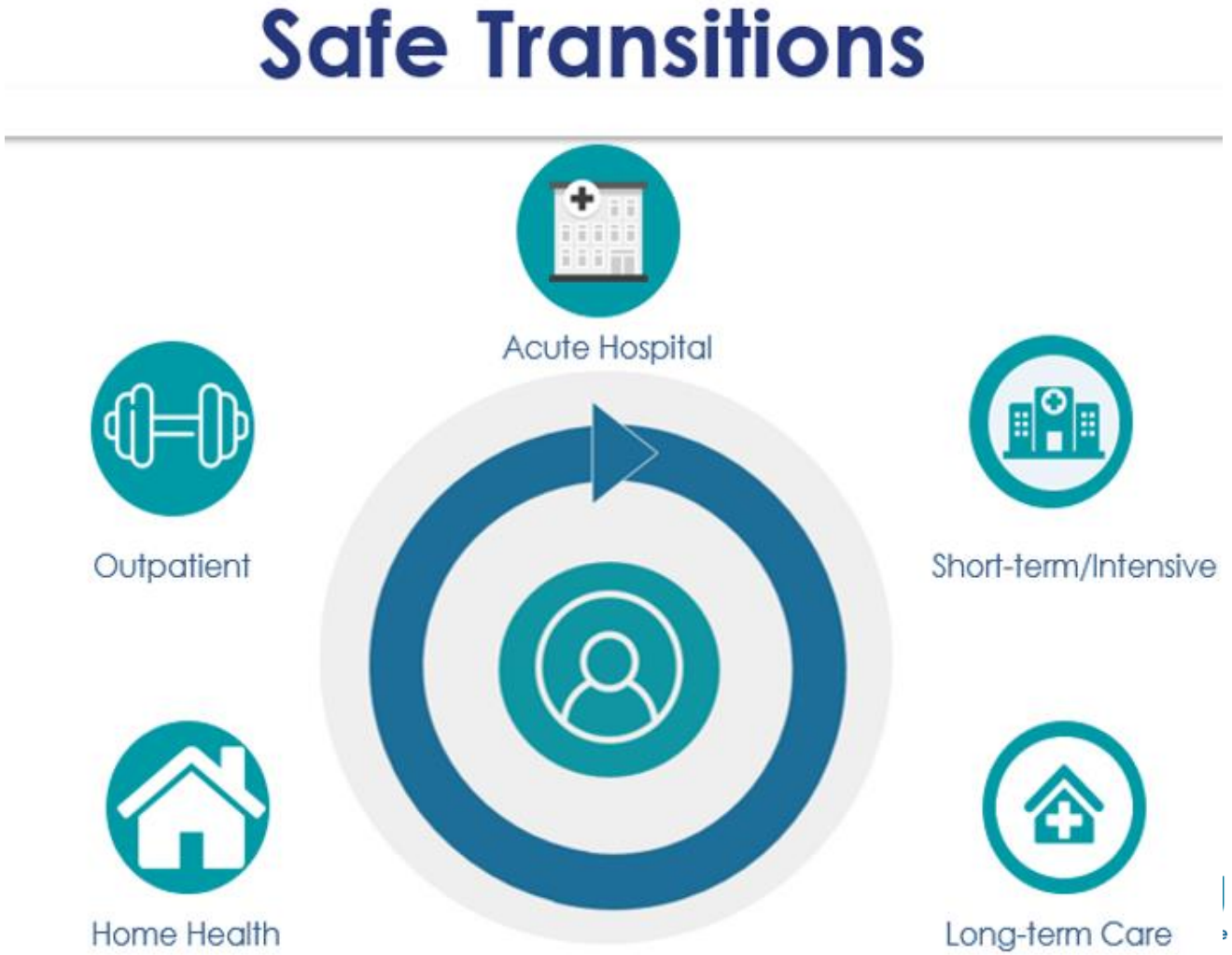
Shortfall payment

Surplus pay back

14 day LOS Target

Top Preferred Providers ranked by 90-day Readmission Rate for incentive compensation up to 105% of the Medicare Fee For Service rate

Managed Care levering predictive analytics today



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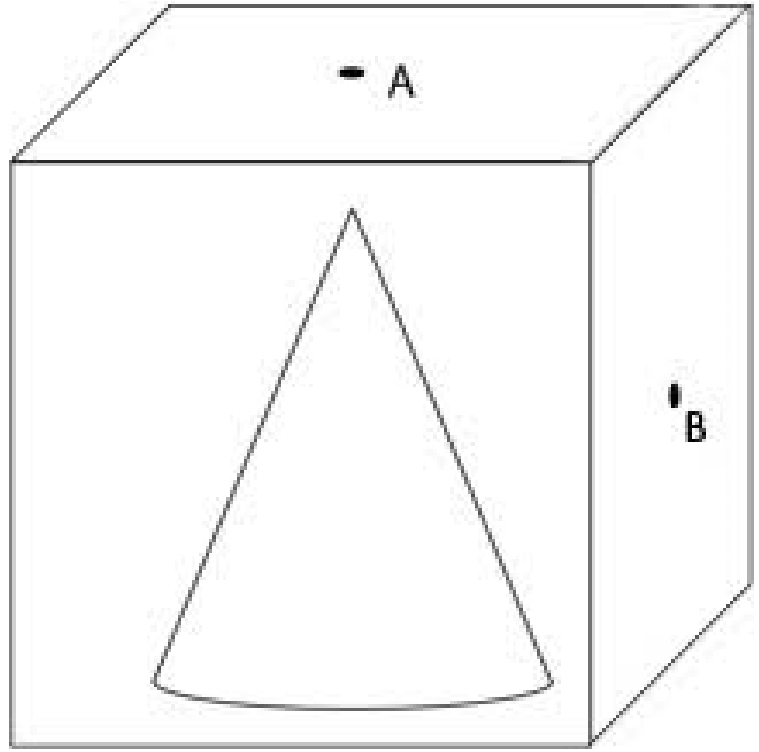
Cultivating Change

The Cone in a BOX

Involvement of all perspectives yields fresh, emergent solutions

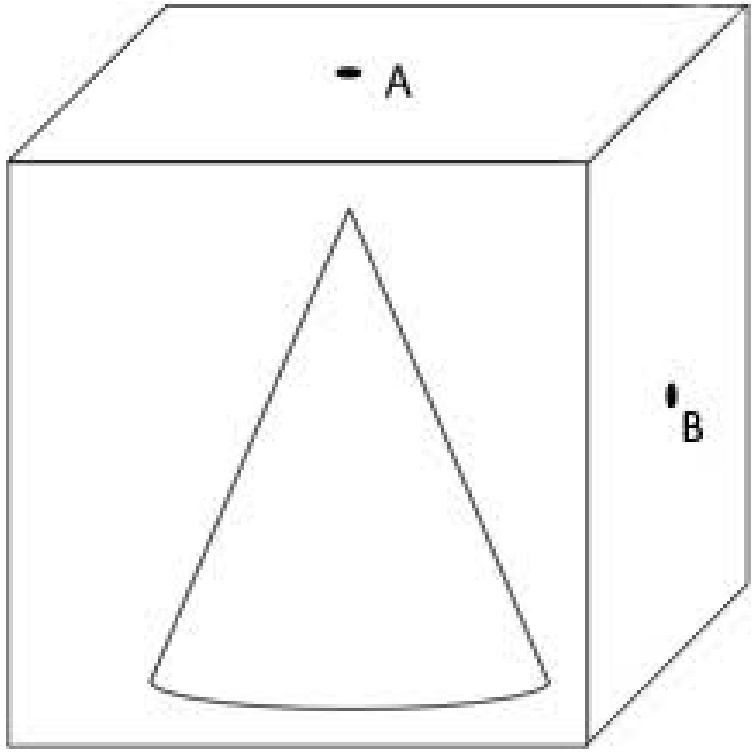
Exploring multiple perspectives requires time, respectful dialogue, and a safe space

Open discussion increases awareness and understanding



This is how it looks from my perspective, how does it look from yours?

Cone in a Box Activity



Optimists – Positive Responses

How do you leverage this energy? Opportunity to create a champion or program leader?

Big picture vs. details

Who are these people in your organization?

How to you cultivate growth of these responses in your organization

The WHY – risk + reward

Skeptics – Challenging Responses

How is the information shared?

Is there a ripple effect?

Opportunity for perspective to play a role?

Challenge to be solution oriented?

Who are these people in your organization?

How do you acknowledge + address questions, leading to understanding and collaboration?

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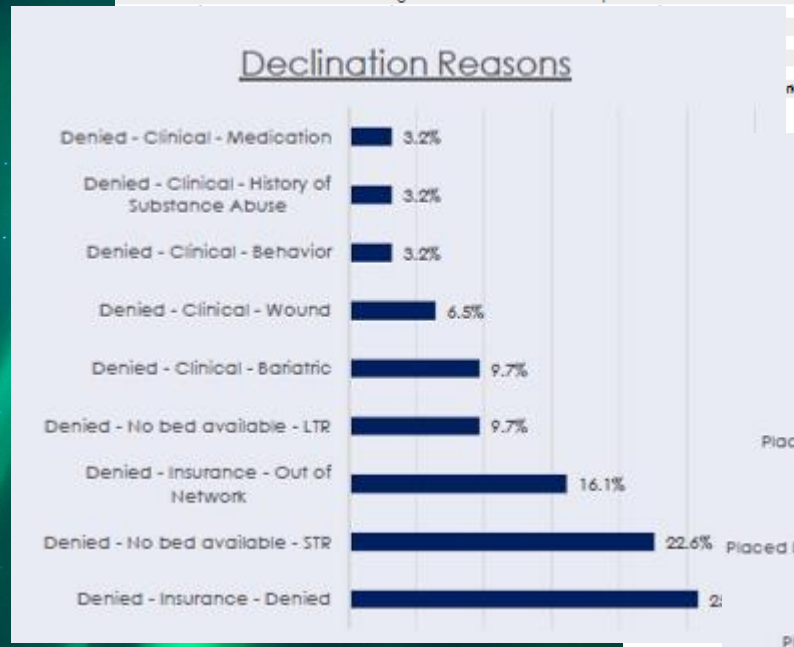
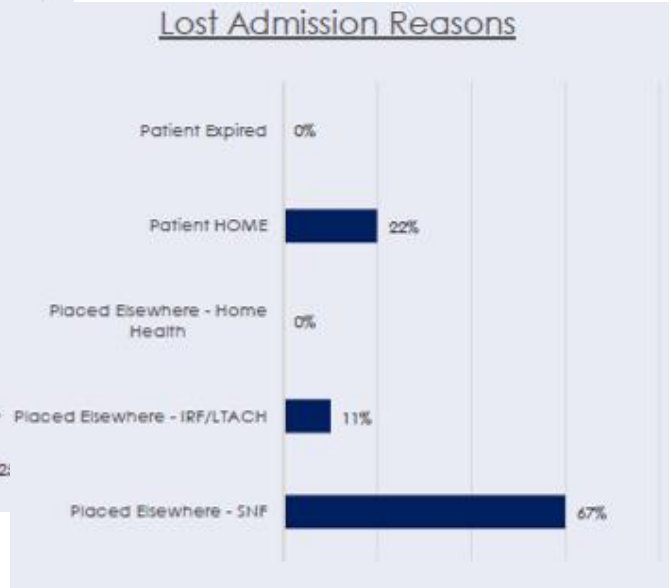
Data at Your Fingertips: Referral + Admission Trends

Client Name
Referral and Admission Tracker CY2021

Referral Source	Payer	Accepted / Denied with Reason	Admitted	Reason NOT Admitted
Debs Med Center	Medicare A	Accepted Patient	Yes	
Debs Med Center	Medicare B	Accepted Patient	No	Placed Elsewhere - SNF
Erins Hosp	Medicaid	Denied - No bed available - STR	No	
Shawns Rehabilitation	Private Pay	Denied - Insurance - Denied	No	
Kristy's House of Care	Commercial	Accepted Patient	Pending	
Tylers health hut	Managed Medicare	Denied - No bed available - STR	No	
Other - Not Listed	Managed Medicaid	Accepted Patient	No	Patient HOME
			No	Patient HOME
			Yes	
			No	
			No	
			No	
		rk	No	





Opportunity for collection of detailed data

Insight into real time market needs + census stream trends

Monitor trends – where do the opportunities lie? Allows for targeted risk expansion

Leverage data to facilitate strong upstream + downstream partnerships

Admission Acuity Analysis: A Case Study

Sender Name	Encounter Volume	ALOS	Medicare Spend Per Encounter	30-Day Readmission Rate	90-Day Readmission Rate	Avg HCC Risk Score	Spend Per 90-Day Episode	Healthcare Days Per 90-Day Episode
FACILITY A	140	24.3	$10,847	18.4%	35.2%	3.66	$43,372	56.7
FACILITY B	63	24.8	$12,523	Less than 11	Less than 11	2.44	$29,386	44.1
FACILITY C	174	25.6	$12,098	14.1%	28.6%	3.11	$43,340	61.4
FACILITY D	144	25.8	$12,161	13.3%	31.8%	3.21	$39,960	52.2

SOS_1	PRVDR_1_STATE_CD	Encounter Volume	ALOS	Readm_30	Readm_90	Avg_HCC_Score	Avg_ Episode_ $	Avg_ Episode_ Days
SNF	-National-	1824654	26.15	21%	36%	3.76	$ 51,517.14	58.03
SNF	State	26621	26.41	22%	36%	3.62	$ 44,990.83	59.75

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LOW RISK PATIENTS (HCC Score: 0-2)

MEDIUM RISK PATIENTS (HCC Score: 2-4)

HIGH RISK PATIENTS (HCC Score: 4-6)

ACUTE RISK PATIENTS (HCC Score: 6+)

The Power of Predictive Analytics

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PROFILITY

Patient Prediction

General:

Prediction Subject	Current	Potential
ADL Improvement	Limited assistance	High
Walking Improvement	Limited assistance	High
Independent ADL	Limited assistance	Very High
Independent Walking	Limited assistance	High
Independent Transfer	Limited assistance	Very High

General:

Prediction Subject	Current	Risk
Readmission		Low
Fall	No	Very Low
New or Worsened Pressure Ulcer	No	Medium
New or Remaining Delirium	No	Very Low

Patient Score Card

General:

	Facility	Market	State
LOS	27 days	39 days	33 days
Readmission	24%	32%	29%
Cost	$18K	$21K	$18K

Primary Reason:

	Facility	Market	State
LOS	N/A	40 days	33 days
Readmission	N/A	40%	26%
Cost	N/A	$20K	$16K

PDPM: Non Surgical Orthopedic/Musculoskeletal

	Facility	Market	State
LOS	29 days	42 days	36 days
Readmission	30%	26%	25%
Cost	$11K	$21K	

Drive Increase in Admission Acuity ● Impact Admission Efficiency ● Fuel Accurate Financial Capture ● Promote Safe Transitions ● Reduce RRs

Evolve the Care Coordination Process

Introducing…RISK ASSESSMENT!

Pre-admission to admission

Project BOOST 8Ps

Care Plan based on Risk an DC needs

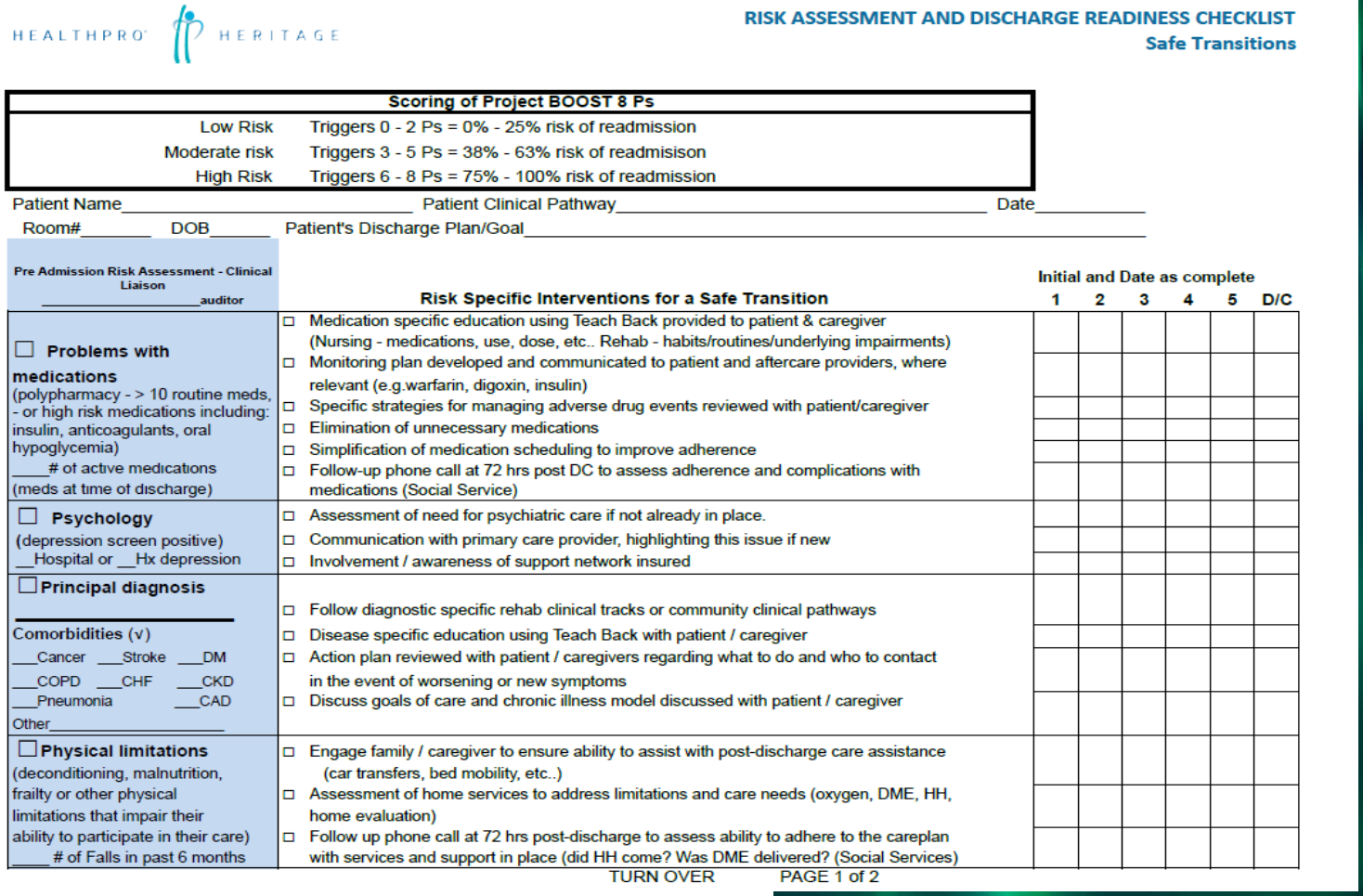
Assess all barriers & progress ongoing prior to DC

Round + review based on risk

High

Moderate

Low



HEALTHPRO HERITAGE

RISK ASSESSMENT AND DISCHARGE READINESS CHECKLIST
Safe Transitions

Scoring of Project BOOST 8 Ps	
Low Risk	Triggers 0 - 2 Ps = 0% - 25% risk of readmission
Moderate risk	Triggers 3 - 5 Ps = 38% - 63% risk of readmisison
High Risk	Triggers 6 - 8 Ps = 75% - 100% risk of readmission

Patient Name_____ Patient Clinical Pathway_____ Date_____

Room#_____ DOB_____ Patient's Discharge Plan/Goal_____

Pre Admission Risk Assessment - Clinical Liaison _____auditor	Risk Specific Interventions for a Safe Transition	Initial and Date as complete 1	2	3	4	5	D/C
☐ **Problems with medications** (polypharmacy - > 10 routine meds, - or high risk medications including: insulin, anticoagulants, oral hypoglycemia) ____# of active medications (meds at time of discharge)	☐ Medication specific education using Teach Back provided to patient & caregiver (Nursing - medications, use, dose, etc.. Rehab - habits/routines/underlying impairments) ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g.warfarin, digoxin, insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hrs post DC to assess adherence and complications with medications (Social Service)						
☐ **Psychology** (depression screen positive) __Hospital or __Hx depression	☐ Assessment of need for psychiatric care if not already in place. ☐ Communication with primary care provider, highlighting this issue if new ☐ Involvement / awareness of support network insured						
☐ **Principal diagnosis** _____ Comorbidities (√) ___Cancer ___Stroke ___DM ___COPD ___CHF ___CKD ___Pneumonia ___CAD Other_____	☐ Follow diagnostic specific rehab clinical tracks or community clinical pathways ☐ Disease specific education using Teach Back with patient / caregiver ☐ Action plan reviewed with patient / caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient / caregiver						
☐ **Physical limitations** (deconditioning, malnutrition, frailty or other physical limitations that impair their ability to participate in their care) ____# of Falls in past 6 months	☐ Engage family / caregiver to ensure ability to assist with post-discharge care assistance (car transfers, bed mobility, etc..) ☐ Assessment of home services to address limitations and care needs (oxygen, DME, HH, home evaluation) ☐ Follow up phone call at 72 hrs post-discharge to assess ability to adhere to the careplan with services and support in place (did HH come? Was DME delivered? (Social Services)						

TURN OVER PAGE 1 of 2

Partnership Checklist

Systems & Supportive Partners are Crucial to Success

- **Telehealth & Physicians:**
  Mental Health; Emergent On Call Assessment + Treatment; Transitional Care Management
- **Therapy Programming and Quality Outcomes & Wellness**
- **Collaborative, Quality Home Health Partner**
- **Artificial Intelligence & Technology Integration**

LIMITLESS

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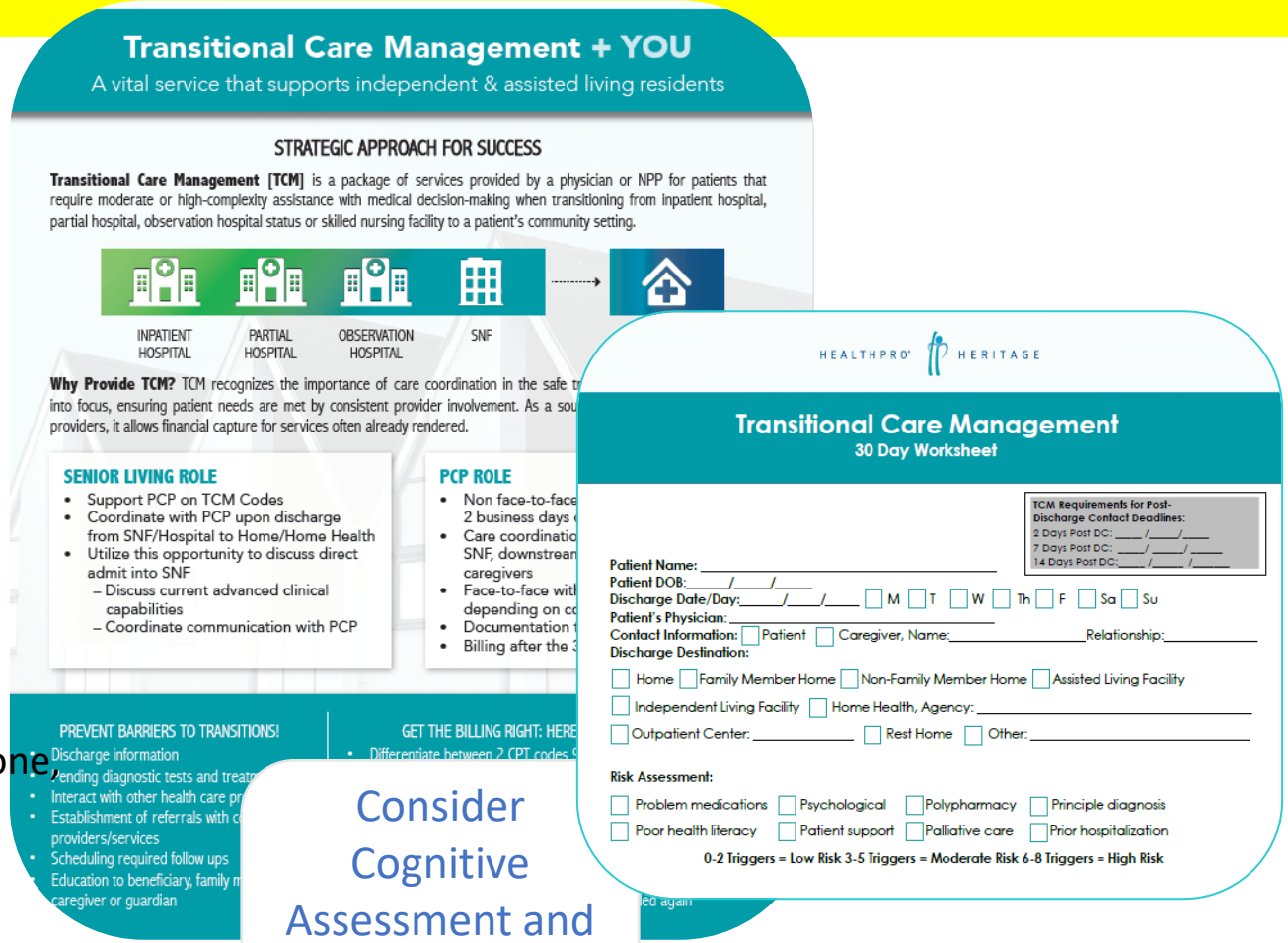
Transitional Care Management

Advantages

- Increased Care Coordination
- Provider Services Revenue Boost
- Physician Driven Program supported by IDT
- Consistent Provider Involvement
- Collaborative Discharge Planning Process
- Marketing Tools
- Reduced Hosp Readmission Rates
- Safe transition throughout the Continuum

CMS Promotes

- + Communication with patient or caregiver (phone, e-mail or in person) within 2 business days of discharge
- PFS Final Rule expands concurrent billing codes; reduced from 57 to only 29 codes



Consider Cognitive Assessment and Care Plan Services

Technology Solutions

Facilitating Proactive Risk Identification + Promoting Advanced Mitigation Strategies

TELEHEALTH

Hospital MD/NP collaboration

TeleMental Health

Specialist Access

High Presence MD/NP model onsite and via tech

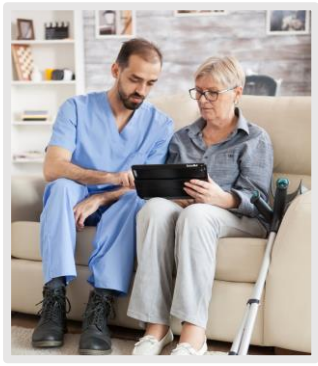
Increase accessibility, reduce RRs

RPM

Monitor vital functions with increased frequency (continuous or episodic)

Provider Involvement

Resident safety + staffing efficiency



ENHANCING OUTCOMES

Fall Reduction

Interactive HEP with carryover

Holistic care solutions

HOME SAFETY +TRAINING

Environmental assessment

Pt/family/CG engagement

Health literacy

LIMITLESS

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Proactive QAPI Approach

Lower Cost

- Right-size LOS
- Decrease SNF Readmissions
- Select Quality Downstream Partners

Increase Outcomes

- Decrease 90-day Readmissions
- Prevent Infections
- 5-Star Quality/QRP Measures
- Increase in Discharges to the Community
- Participation in Therapeutic Activities/Wellness

Increase Satisfaction

- Person-Centered Care
- Increase Communication + Beneficiary Involvement in Care

The Rule of Six

Challenge Yourself. Broaden Your Horizons.

- Write down a problem you're experiencing
- Write down six solutions – they must be realistic!
- Think big. Don't stop until you get ALL SIX

"Turn your obstacles into opportunities and your problems into possibilities."

-Roy T. Bennett

Leveraging Industry Change to Envision Everything

LIMITLESS

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How to Envision Everything

Implement Proactive Frameworks +

Put solid **replicable systems** in place

Change Activities from Leisure to **Proactive Wellness** & Leisure Across the Spectrum

Leverage your current **QAPI** to move you towards **Proactive**/Value Based Care

Initiate **Competency** Based Intentional Training for Clinical Teams **Increasing overall acuity** levels and admissions

Set up Reimbursement **IDT systems** and follow through – Payment for the Services Provided

Partners are changing – **up and downstream are crucial** today

THANK YOU

www.healthpro-heritage.com

Elisa Bovee MS OTR/L
VP of Clinical Strategies + Consulting
ebovee@healthpro-heritage.com

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