

MOMENTUM
2022 Annual Conference and Trade Show - August 30 - September 1, 2022

LeadingAge
Ohio

Ensuring Enterprise Fiscal Success in 2022 & Beyond

Your Fiscal Strategy

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M₃I₁N₁D₂S₁E₁T₁

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Objectives

- Understand evolving models of care and payment systems and how pervasive & quickly our industry is evolving from FFS to VBC + risk based payment models
- Identify your organization's capacity for risk tolerance in order to prepare for alternative contracting models
- Understand how to balance immediate cash flow needs with upside and downside of risk arrangements
- Leverage reimbursement and industry changes to your advantage by envisioning everything

State of the Union in Post-Acute Care + It's Evolution

envision everything
with CLARITY and PURPOSE

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Challenges Ahead for Senior Care



Rising Acuity

Aging in Place Populations

Boomer expectations + non-negotiables



Work Force Shortages

Culture / Mind-set



Clinical Competencies

Provider **Collaboration**

Over-Comeing the **Fear Factor**



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Cross Continuum Impacts

Public Health Emergency	Home Health	Assisted Living
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 SNF role? Quality Measures and Competitive Standing: Need for SNF partners and Senior Living to help prevent readmissions 	<p>Short Stay Respite Considerations:</p> <ul style="list-style-type: none"> Choose Home Care Act + SNF at Home Leveraging physicians and surgical centers for lower acuity patients who cannot go home Options with Home Health to skip SNF 1135 Waivers – direct admit AL/L and Home into the SNF to initiate Med A benefit SNF/ALT partnership opportunities

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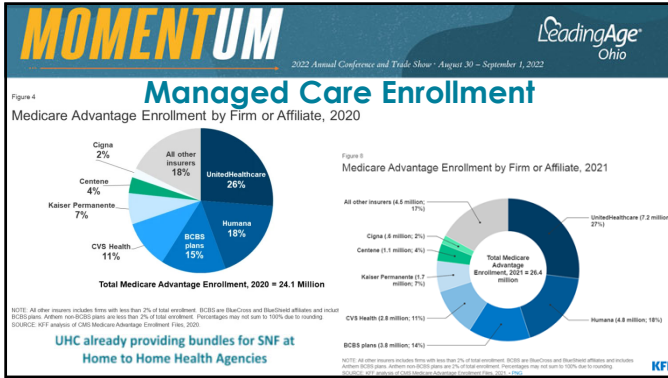
Accountable Care

- CJR
- BPCI-A
- Next Gen ACO
- LTC ACO
- DCE to ACO REACH
- Unified Post-Acute Payment System



Risks & Rewards

- **Participation:** The SNF as a part of the shared savings program
 - preferred provider versus participation
- **Contracting:** Episodic or Per Member Per Month Payments
- **Innovation** in Assisted + Independent Living with Managed Payers



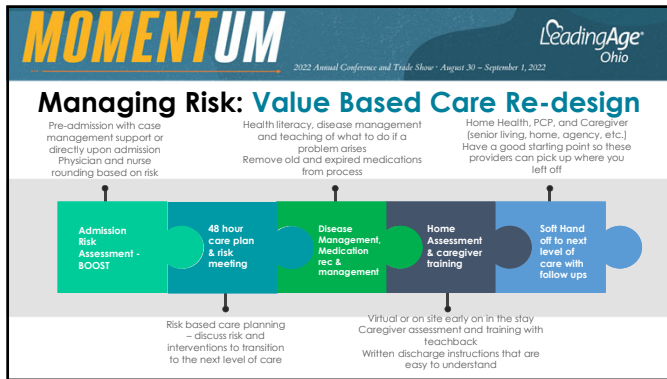
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Huge Opportunity for Downstream Partners
OH with over 43,000 Medicare Beneficiaries going home and with 61% returning within 90-days

Encounter Type	HCC Tier	Encounter Volume	ALOS	Medicare Reimbursement Per Encounter	30-Day Readmission Rate	90-Day Readmission Rate	30-Day Mortality Rate	90-Day Mortality Rate	Special Pay 90-Day Episode	Healthcare Days Per 90-Day Episode
SNF	Low	7,713	24.9	\$11.06	6.9%	15.8%	3.8%	8.8%	\$26.96	38.8
SNF	Mid	21,763	24.1	\$11.06	14.9%	29.2%	9.4%	14.8%	\$34.7%	44.8
SNF	High	14,833	27.4	\$11.06	18.3%	40.8%	8.8%	23.3%	\$47.96	52.8
SNF	Very_High	9,327	29.8	\$11.06	42.8%	85.8%	9.8%	29.8%	\$67.96	62.7
Patient Home	Low	63,718	8.6	\$0.0	0.7%	15.8%	0.4%	1.2%	\$13.7%	5.9
Patient Home	Mid	50,805	8.6	\$0.0	15.2%	30.1%	2.2%	6.1%	\$21.3%	12.2
Patient Home	High	27,023	8.6	\$0.0	27.4%	48.2%	4.8%	13.4%	\$33.9%	20.2
Patient Home	Very_High	10,547	8.6	\$0.0	58.1%	81.1%	10.1%	18.4%	\$45.4%	29.6
SNF	Low	9,242	11.3	\$2.51	5.7%	12.5%	0.4%	1.5%	\$19.2%	10.8
SNF	Mid	9,036	14.5	\$2.51	10.9%	20.9%	2.0%	6.4%	\$26.4%	20.3
SNF	High	5,380	14.8	\$2.51	20.5%	47.8%	4.8%	14.8%	\$35.6%	32.3
SNF	Very_High	2,897	19.8	\$2.51	41.1%	82.2%	6.4%	20.7%	\$51.1%	38.3

LOW RISK PATIENTS (HCC Score: 0-2) MEDIUM RISK PATIENTS (HCC Score: 3-4) HIGH RISK PATIENTS (HCC Score: 5-6) ACUTE RISK PATIENTS (HCC Score: 7-9)

*Data from Advisory Board Company 12 month ending Q1 2022



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Clinical Competency + Revenues

Opportunity: Acuity Is Rising!

- Let's Talk Rising Acuity: A Balancing Act
- Increase competency required
 - Return demonstration + intentional training required
 - Leverage hospital partners
- Increased per diems
- Carve outs or additional payment for hard to place residents
- Clinical + Ops Leadership rounding - Trust but Verify staff competency
- Redesign your clinical meeting and IDT responsibilities
- Focus on Nursing assessment and early warning of signs or symptoms of adverse effects
- Get Physician partnerships and increase frequency: **High presence models of care:**
 - In person high presence rounding
 - Telehealth to support Nursing assessment

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Survival of the SNFist

Will only the high acuity survive?

- What do we do in a **hospital-less** system?
- Primary Care** + Home Health become upstream referral sources; **Choose Home legislation**
- Diversification of SNF offerings with increased clinical capabilities are a **MUST + outcomes & quality matter**
- Managed Care growth** drives occupancy + payment (OptumCare, Humana, Aetna)


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Partnership Checklist

Systems & Supportive Partners are Crucial to Success







Telehealth & Physician:
Mental Health; Emergent On Call
Assessment + Treatment



Therapy Programming and Quality
Outcomes & Wellness



Quality and Collaborative Home
Health Partner



Artificial Intelligence & Technology

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Alternative Staffing Strategies



Outsourced Services

Therapy
Activities/Wellness
Focused recruiting on
clinical
Concierge Services



Redesign Activities

Scheduling
Increased engagement
Decreased caregiver
burden




Leverage Telehealth

TeleMental Health
Hospital MD/NP
collaboration
Bluetooth capable tech



Leverage Technology

Manual Workflows
Given the complexity, required
expertise and time-consuming
nature of reimbursement, the
process is too reliant upon
people.
Reimbursement -
Medasync
Proactive Falls AI



Balance Immediate Cash Flow

envision everything
with cognitive technology

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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

Acuity Financial Case Study \$186.86/
day
variance

Columbus, OH WGI .9469 – Non-Case Mix \$ 94.40/day

Low Medically Complex #1	PT/OT CMG	SLP CMG	Nursing CMG	NTA CMG
CMGs	TK	SA	PBC1	NF
\$/Day Days 1-3	-	-	-	\$171.78
\$/Day Days 4-20	\$178.61	\$15.35	\$119.12	\$57.26
Total \$ over 14 day LOS	\$6,849.94/ (\$489.28/day)			

Neuro High Acuity #2	PT/OT CMG	SLP CMG	Nursing CMG	NTA CMG
CMGs	TM	SK	CDE2	ND
\$/Day Days 1-3	-	-	-	\$317.34
\$/Day Days 4-20	\$149.98	\$83.52	\$197.13	\$105.78
Total \$ over 14 day LOS	\$9,466.02/ (\$676.14/day)			

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Census: Heads in Bed versus Acuity

Budgeted Revenues versus Census Numbers

Low Acuity Case Study #1
\$489.28/day

20 short term census ADC 50 total beds – 30 LTC ADC

42 admissions Needed every month with a 14-15 day LOS

\$293,568 Rough average Medicare revenues per month

Neuro High Acuity Case Study #2
\$676.14/day

15 short term census ADC 5 open beds – 50 beds in total with 30 LTC ADC

32 admissions Needed every month with a 14-15 day LOS – 10 less than low acuity

\$304,263 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

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Safe Transitions

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 leveraging predictive analytics today

Outpatient Acute Hospital Short-term/Intensive Long-term Care Home Health

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Census: Heads in Bed versus Acuity

Capitated Opportunity

Neuro High Acuity Case Study #2
\$676.14/day

\$11,494.38 Negotiated 17 day capitated payment
90% of Medicare FFS paid \$10,344.94

\$821.03/day Actual per diem at a 14 day LOS

\$\$\$\$ Incentives aligned with 90 day Readmissions and shortfall payment upon reconciliation

Your focus is on care integration and transitions to the next level of care effectively

Same revenue for a 14 day LOS as a 17 day LOS

Less staff and expense

Do it right and you even have the opportunity for an incentive based on the contract

VBC is setting us up for payment for NOT having someone in the SNF

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The Power of Predictive Analytics

PROFITLY

Ⓢ 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	No	Low
Fall	No	Very Low
New or Worsened Pressure Ulcer	No	Medium
New or Worsening Delirium	No	Very Low

Ⓢ Patient Score Card

General:

	Facility	Market	State
LOS	27 days	30 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

PRIM: Non-Surgical Orthopedic/Neurological

	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




Leveraging Industry Change
to Envision Everything

envision everything
with HealthPRO Technology

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"What got us here, won't get us there."
-Marshall Goldsmith

Shifting
Mindsets

▶ 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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How to
Envision
Everything

Put solid **replicable systems** in place

Move from a **REACTIVE** model to a **PROACTIVE** Model

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



Kristy Yoskey

SVP of Clinical Strategies

724.914.9945

kyoskey@healthpro-heritage.com

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