National Church Residences

EXCELLENCE THAT TRANSFORMS LIVES

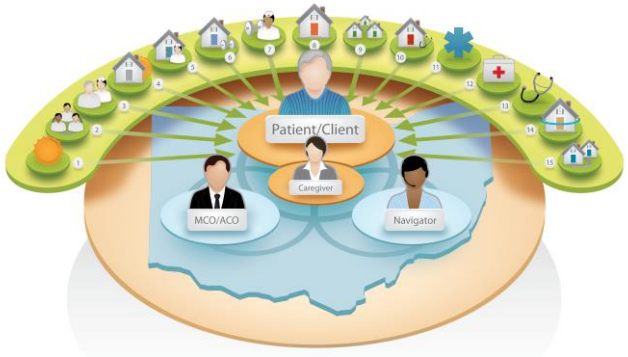
Joint Medicaid Oversight Committee

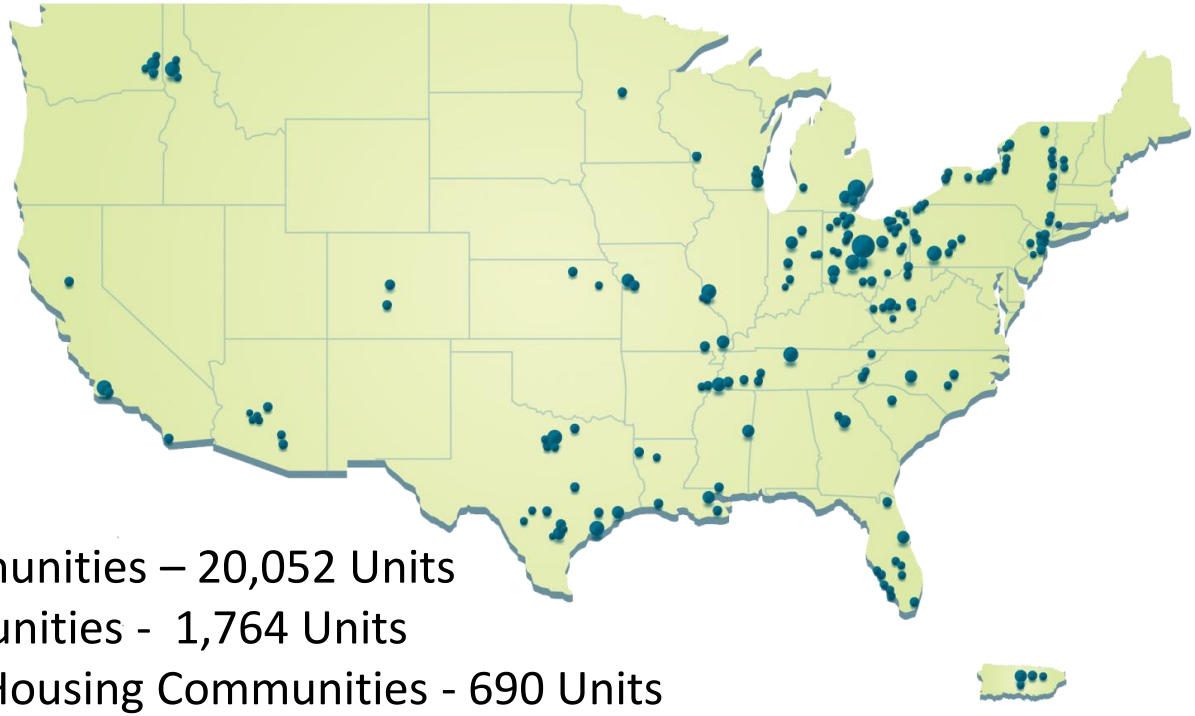
Katie Colgan

Vice President of Government & Payor Relations

June 16, 2016

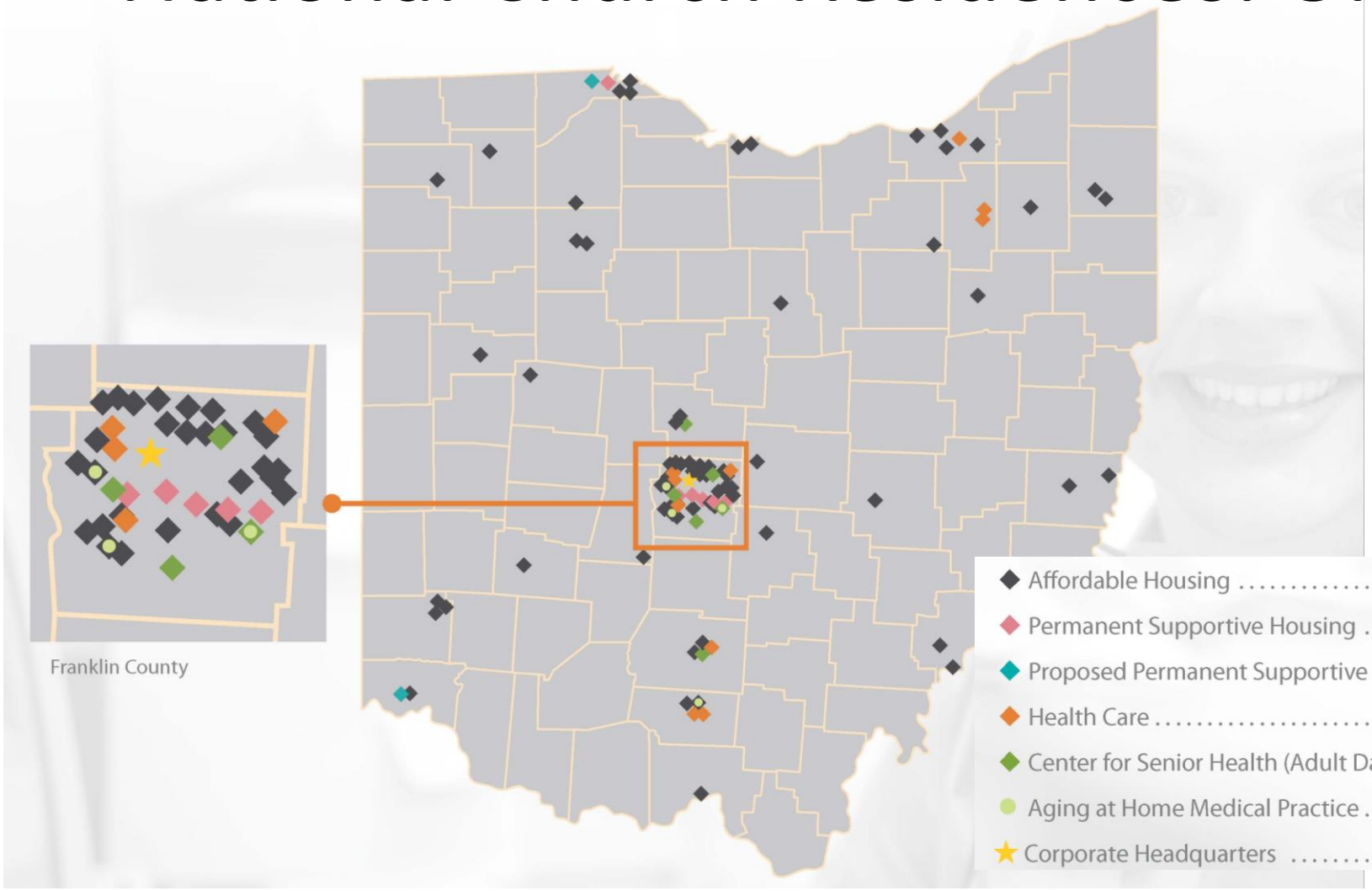
NATIONAL CHURCH RESIDENCES
PERSON-CENTERED CARE SYSTEM



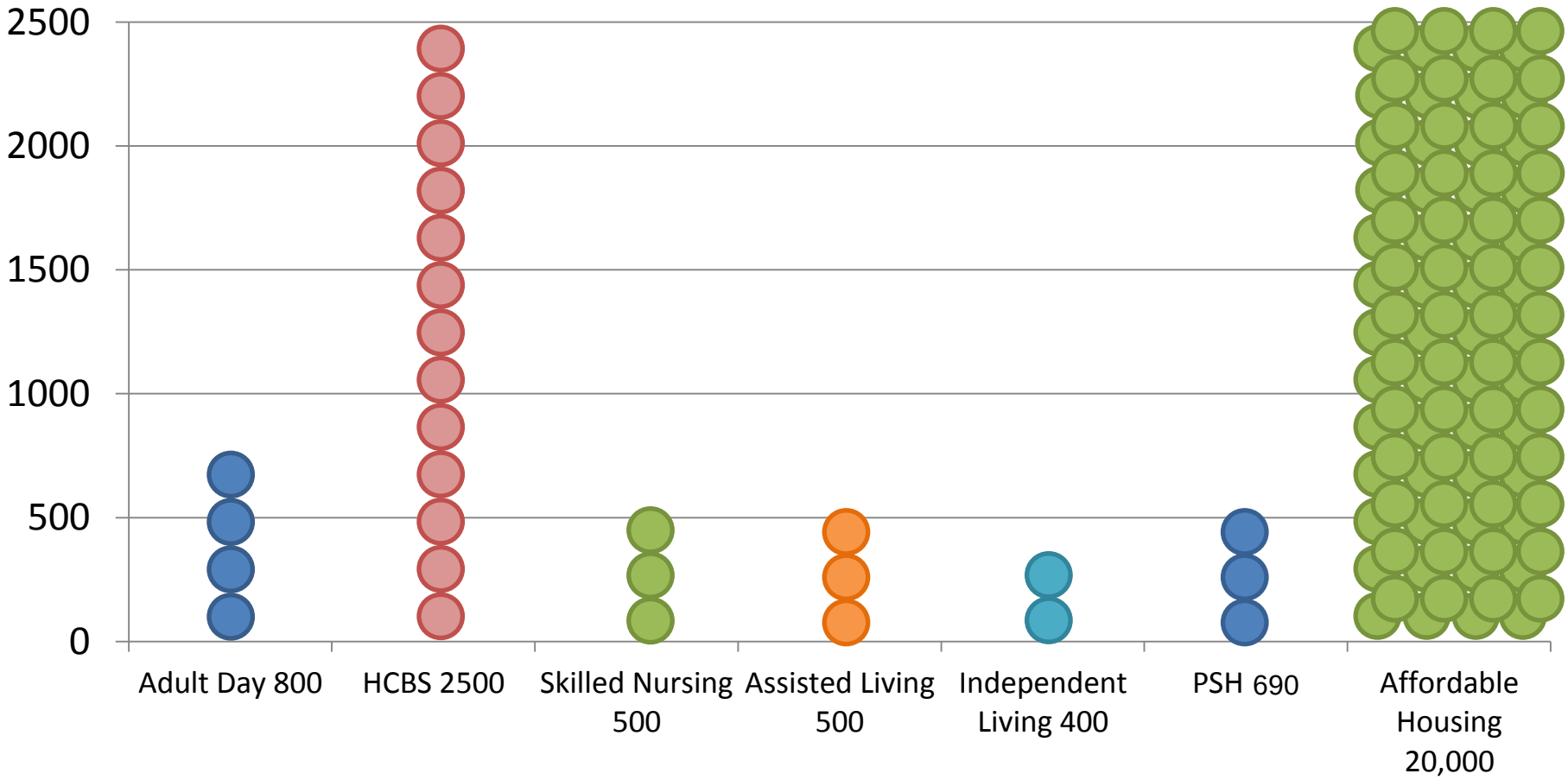


- 308 Senior Housing Communities – 20,052 Units
- 16 Family Housing Communities - 1,764 Units
- 9 Permanent Supportive Housing Communities - 690 Units
- 1 Student Housing Community - 60 Units
- 8 Assisted Living/5 Skilled Nursing Facilities
- 3 Home & Community Based Service Agencies/serving 3,561 clients
- 5 Adult Care Centers/serving 834 clients
- 10 Residential Health Care Communities

National Church Residences: Ohio



Who Do We Serve?



Mission

Originating from a Christian commitment of service, our mission is to provide high quality care, services and residential communities for all seniors.

Vision

Advance better living for all seniors enabling them to remain home for life.

Dublin, Ohio

National Church Residences

Atlanta, GA


5710
National Church Residences
Panola Gardens
A Senior Residential Community

Johnstown, Ohio

Pittsburgh, PA

National Church Residences

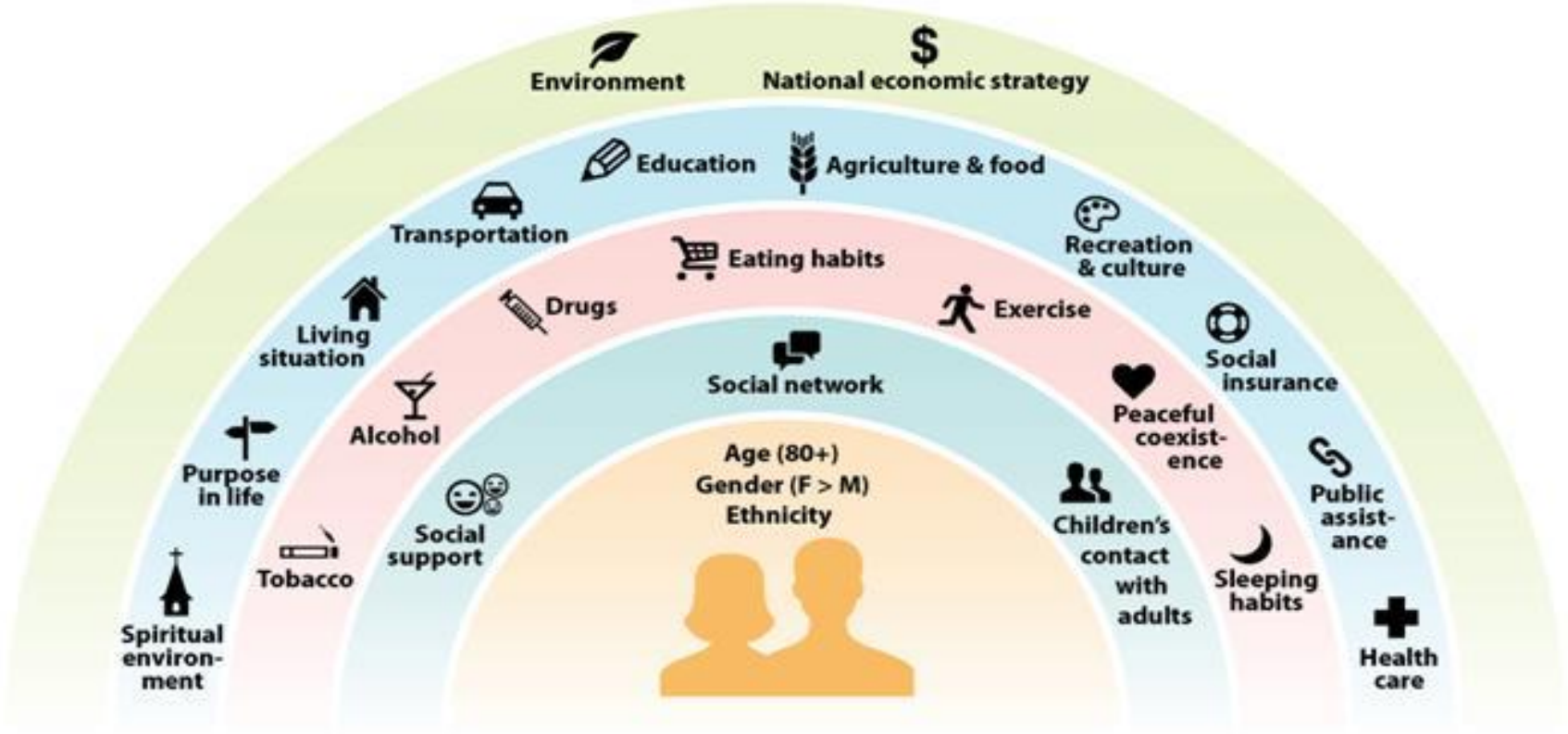
PARKSIDE MANOR MEDICAL SUITE

How Do We as Senior Pre- and Post-Acute Care Providers Bring Value?

- 2015 Study comparing HHS (US Health and Human Services) and HUD (US Housing and Urban Development) data:
  - 43% vs. 55% have 5+ chronic conditions
  - Medicare Cost is 16% higher
  - Medicaid Cost is 32% higher
  - ED visits are 13% higher

Picture of Housing and Health: Medicare and Medicaid Use Among Older Adults in HUD-Assisted Housing, The Lewin Group, March 2015

Social Determinants of Health



National Church Residences

HOME FOR LIFE[SM]

Home is wherever a senior chooses to live...

HOME FOR LIFE is National Church Residences' progressive plan for helping seniors remain healthy and happy wherever they call home — whether that is an apartment, house, or an independent setting in Senior Living or Affordable Housing.

NEW MODEL OF PROACTIVE RESIDENT ENGAGEMENT

ENHANCED SERVICE COORDINATION

A CARE MANAGEMENT TOOL FOR ASSESSING RESIDENT NEEDS

CARE GUIDE

PARTNERSHIP OPPORTUNITIES FOR HOUSING & HEALTH CARE

PREFERRED PROVIDER for health care services

PROMOTES RESIDENT HEALTH & SOCIALIZATION

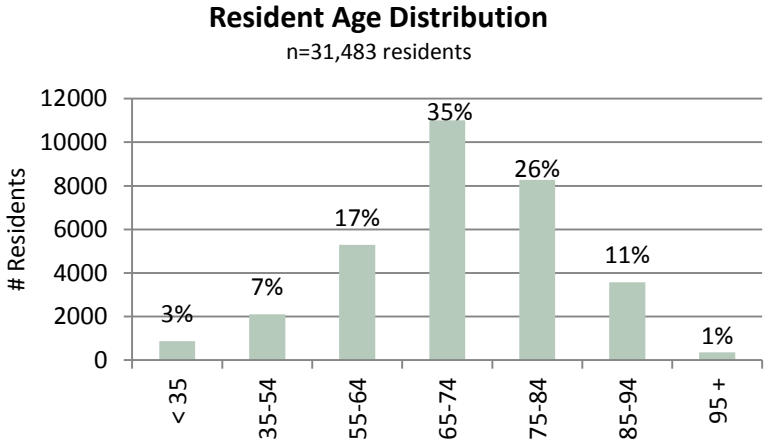
SOCIAL EVENT PROGRAM of events and activities

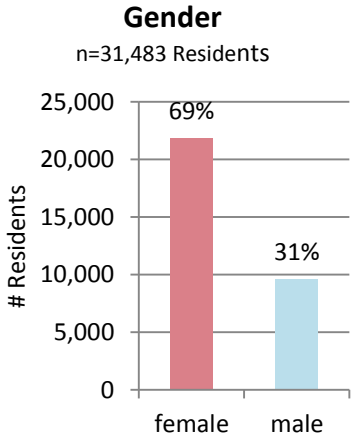
National Church Residences
HOME FOR LIFE

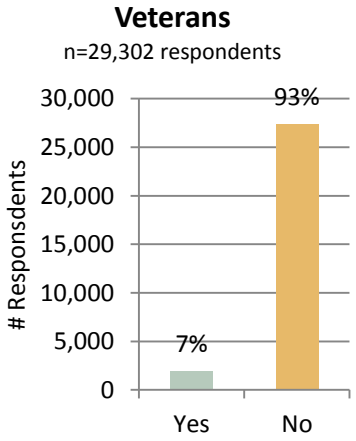
Outcomes:

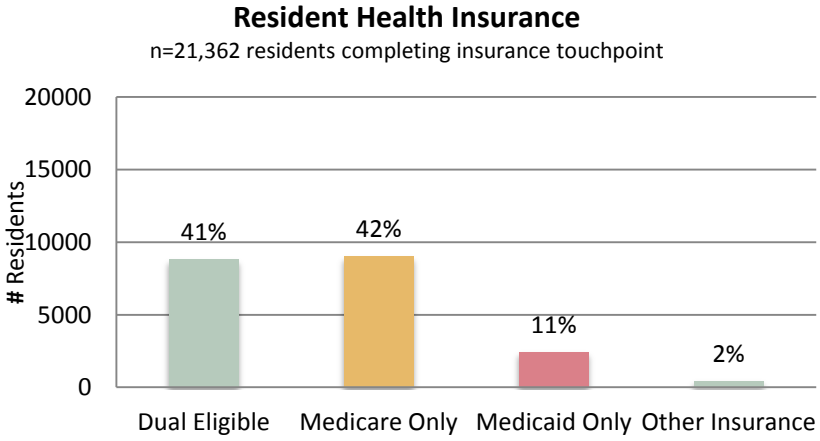
1. Reduce move outs to higher levels of care
2. Increase primary care visits
3. Reduce hospitalization, rehospitaliztion, and ER visits

Care Guide Dashboard March 2016





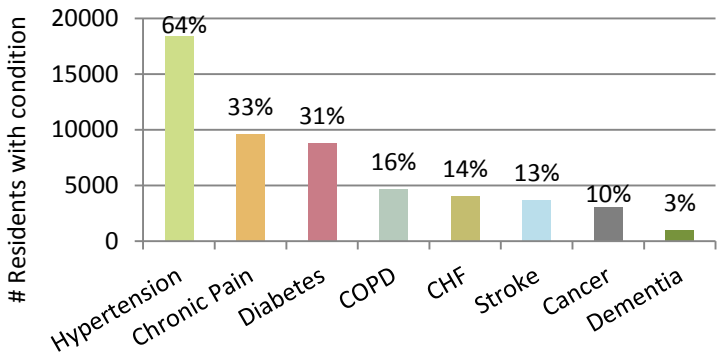




National Church Residences

Residents with Chronic Health Conditions

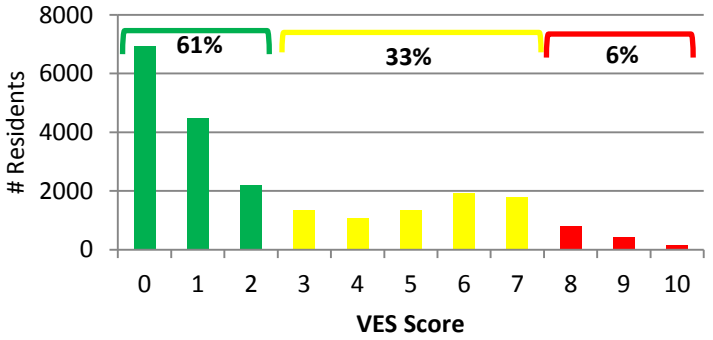
n= 28,658 residents completing health history



Values do not total to 100% because residents may have multiple conditions.

Resident Vulnerability

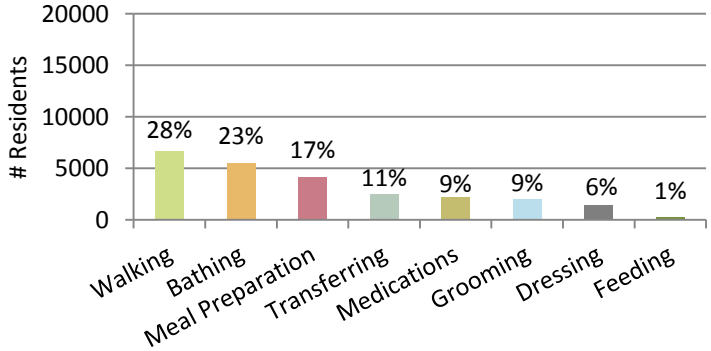
n=22,407 residents completing VES assessment



VES Vulnerability Categories: Low (0-2); Moderate (3-7) ; Severe (8-10) In the national sample of elders used to test the VES-13, a score of 3+ vs. 0-2 on the screener identified 32% of individuals as vulnerable. This vulnerable group had four times the risk of death or functional decline when compared to elders scoring 3 or less.

Resident ADL Needs

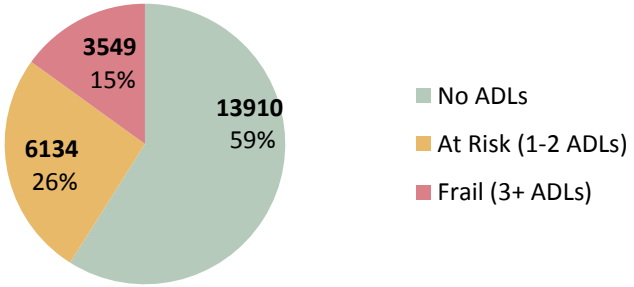
n=23,593 residents completing ADL assessment



ADL = Activities of Daily Living, indicating categories where residents need assistance.

% Residents with Multiple ADL Needs

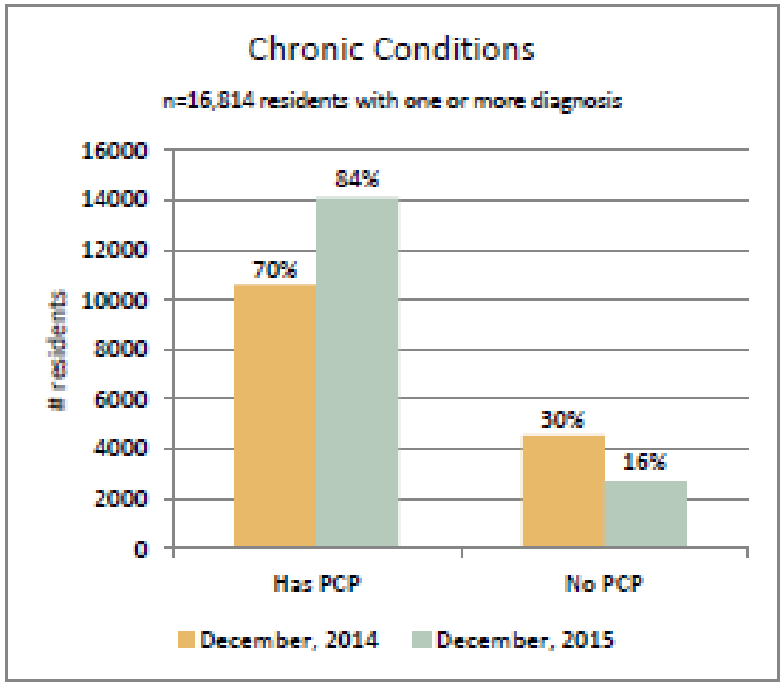
n=23,593 residents completing ADL assessment

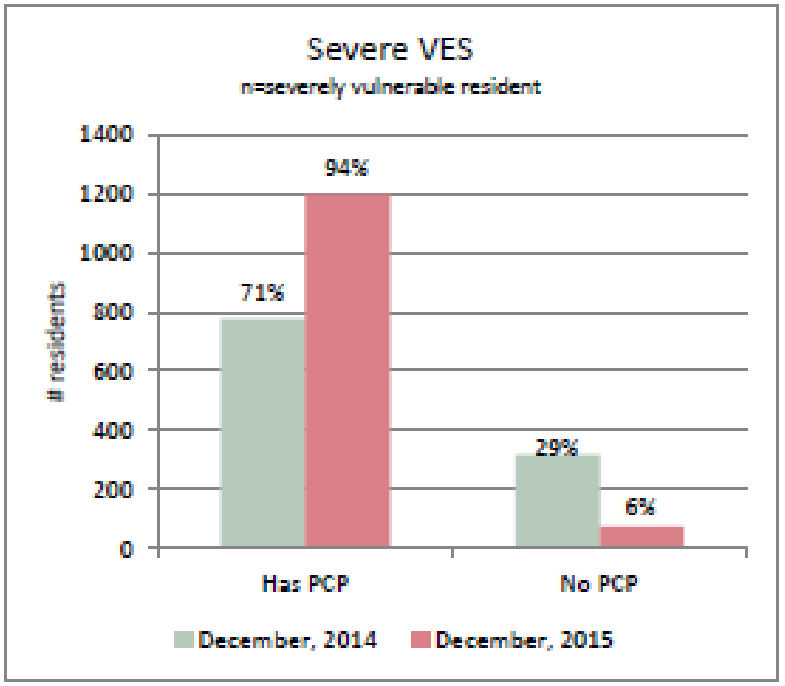


"At Risk" and "Frail" are the ADL categories defined by HUD.

National Church Residences

Outcomes: Access to Primary Care Physician

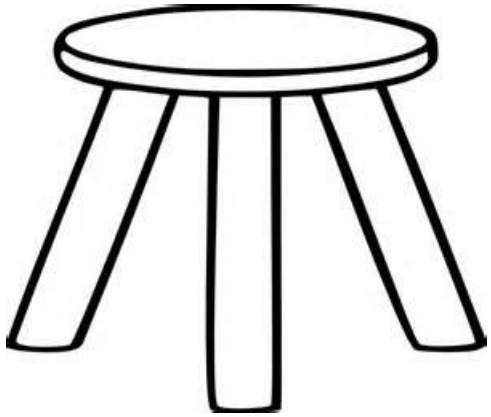




National Church Residences

Medicaid Value Based Contracts: Dual Eligibles

- Joint Venture with large independent primary care provider
- Collaboration between health plan, Primary Care provider, and housing and home and community services provider
- Goal: reduce higher levels of care including hospitalization
- Creating new interventions and care plans around vulnerable high cost “hot spot” patient



Primary Care Provider	National Church Residences	Payor
• Primary Care services • Diagnostic services • Hospitalist care • Medical practice management • Coordinated care/integration • Education	• Proactively identify members at risk • Person centered care planning • Track interventions and outcomes • Transition of care with service coordinator and nurse liaison • Management of chronic diseases • SNF, Home Care, Hospice, Adult Day Care, and other services as identified	• Care Management • Claims data • PCMH report and analysis

Preparing to enter Value Based Contracts

- Understanding our costs, revenue and loss through payor mix
  - Medicaid
  - Commercial and Medicare Advantage
  - Medicare
- Changing our Business Model
  - Reducing or limiting low cost payors
  - Reducing Skilled Nursing Beds
  - Expanding services that make margins such as Private Duty aid services
  - Increasing wages to living wage
  - Partnering with other like-minded providers, such as primary care
- Increasing our Value to Payors
  - Shortening length of stay in Skilled Nursing Facilities
  - Decreasing hospitalizations, rehospitalizations, and ER visits
  - The right service at the right time – quickly admitting home care patients to receive care, right setting across continuum
  - Care coordination, particularly in transitions of care

Medicaid Hurdles

- Commitment from payor partners to pay for value by avoiding higher future costs
  - Predicting the savings value proposition
  - Ensuring against duplication of care management
  - Attribution by address rather than by Primary Care provider; changing organizational mechanisms
  - Bringing a primary care partner to the table with us
- Reimbursement for Home and Community Services
  - PASSPORT
  - Assisted Living Waiver
  - Adult Day Care Services
- Creating new care paths and interventions that utilize the entire continuum of care
- Paying for “non-medical” services that address barriers within social determinants of health, such as housing

Recommendations

- Strong requirements or incentives to share savings with downstream providers
- Investment in home and community services
- Reward models that address social determinants of health like housing, particularly for low income senior population
  - Pennsylvania moving to MLTSS (Managed Long Term Services and Supports, currently procuring contracts with health plans
  - Michigan Duals Demo in Wayne and Macomb Counties
- Share claims or savings data with downstream providers
- Center episodes of care in pre- or post-acute settings