Senior Care & Housing Report Cards: Understanding How Quarlity Healthcare Delivery is Impacting ROI

Anne Tumlinson:

All right. Well, we'll go ahead. I think we can get started. I'm not seeing a massive rush to come in the door now. Anyway, welcome and thank you for coming at 4:30 in the afternoon. We're delighted to be here. We're going to be talking about senior care and housing, and specifically the role of housing in helping to manage the healthcare needs of senior living residents.

Anne Tumlinson:

I just want to start first just to do a little bit of a summary of what we're going to be talking about. I think, we're going to be presenting some new data and reacting to it and reflecting on it and what it means for the industry.

Anne Tumlinson:

The data basically says something that will be of no surprise to anybody in this room, but the senior living population, meaning those in independent living, assisted living, are a particularly frail, complex care population more so than ever, they use a lot of healthcare. There are a lot of organizations now as a result of a variety of changes that have been made over the last 10 years that are now at risk for that healthcare spending of the residents in senior living buildings.

Anne Tumlinson:

So the utilization of these, they're becoming an increasingly important issue to entities that are part of your ecosystem and your market. Like health plans, insurers, hospitals, health systems are taking risks.

Anne Tumlinson:

So as an industry, we to have to start to think about what our role is in all of this. I think a particular interest to me is new data that we've just released today that shows that about 30% of residents in independent living, 30% of residents in assisted living are enrolled in Medicare Advantage plans today, and we expect that to increase over time.

Anne Tumlinson:

So we're really excited to talk to you about the opportunity to offer value to these risk-holders, to offer value to your organization, to your residents. I'm really extremely lucky to be here today to be co-speaking, facilitating this panel.

Anne Tumlinson:

So we have, sitting here to my left, Larry Leisure, who's with the Chicago Pacific Founders, and Ken Segarnick, who's with Brandywine Living. So, again, we'll let them tell you a little bit more about their organizations and their perspective and their experience as we go.

Anne Tumlinson:

But first, so I'm just going to lead off with ... You're going to be inundated with data. But the first thing that I want to start with is the first part of the analysis that my firm ... So I'm with a company called ATI Advisory. We are a research and consulting firm that's based in Washington, DC. We do a lot of research on the industry and work with operators who are looking to find ways to integrate with healthcare and

coordinate healthcare for the residents. We ask the question: what is the level of care needs of this population today?

Anne Tumlinson:

So this is 2017 data on the Medicare population. We created these analytic categories looking at people who are living in housing that doesn't have services attached to it, we call that retirement housing on the slide, independent living, assisted living, and nursing homes.

Anne Tumlinson:

The first question that we asked of the data was what is the level of functional impairment, functional needs and cognitive impairment, in these different populations? How do they compare to each other? I'm just going to point out a couple of things here and then let Ken and Larry react to this and tell you a little bit more about their organizations.

Anne Tumlinson:

But one of the things I want to point out in particular is if you look in the assisted living column and you see that 63.2%, that's the percentage of people who live in assisted living today who need assistance from another person with two or more activities of daily living. I think everybody in this room probably knows what those are. I don't have to explain what ADLs are, but bathing, eating, dressing, that kind of thing, 63.2%. Steven Littlehale's here so I'm going to feel embarrassed. So I'd say you can contradict me later if you disagree with this statement.

Anne Tumlinson:

But I tend to think of the two-plus ADL level of need as being a nursing home level of need. When you think about what it takes to be qualified to live in a nursing home and be paid under the Medicaid program, I think a two-plus ADL as being a proxy for that nursing home level of need.

Anne Tumlinson:

So in my mind, we've got 63.2% of the assisted living facility population today that probably has something like a nursing home level of need, that they would qualify for nursing home, if they were to try to seek Medicaid reimbursement for that. So that's a pretty high percentage.

Anne Tumlinson:

Then the other two things I just want to point out is that the independent living residents are obviously less ... They have less of that really high level of functional decline that's represented by the two-plus ADLs. But you see the beginning kind of twice the rates of early functional decline in those instrumental activities of daily living, that 40.2%.

Anne Tumlinson:

Then also a doubling of the rate relative to housing without services in the share that have cognitive impairment. This data comes from a nationally representative sample survey that the CMS does on Medicare beneficiaries every year called the Medicare Current Beneficiary Survey.

Anne Tumlinson:

I just am absolutely fascinated by the degree to which that acuity or frailty, I guess, jumps up when you go from independent living to assisted living. Maybe I'll start first with you, Larry, because I think it would be really helpful for everyone in the room to hear your perspective not just on the data, but what your role is in senior living and your organization as a whole.

Larry Leisure:

Sure. Well, first of all, let me comment. I'm not particularly shocked by the data because it's kind of my life. As was mentioned, I'm a partner in Chicago Pacific Founders. We're a private equity firm based in Chicago and San Francisco. We're investing in a thesis based on the move from fee-for-service to pay for value. So that's part of our underlying philosophy, but also the aging population.

Larry Leisure:

We touched this issue from a multitude of directions first and foremost under the leadership of my partner, John Rijos, who's very active in this organization. But John delivers senior living services independent assisted memory across 15 states. We have some 46 facilities that we own, another 14 that we manage. So we're experiencing this as an operator.

Larry Leisure:

Secondarily, we deliver direct primary care, at-risk primary care to Medicare populations through a provider group that we have based in Las Vegas called P3, another one in Tampa, Florida, and a third called WellBe Senior Care, which delivers primary care, fully cap, for the most frail senior population. So that's another part of what we do.

Larry Leisure:

We also operate in Medicare Advantage plans, so in the Medicare Advantage business as well. Then, last, we aren't technology investors, but we did invest, with John Rijos' encouragement, in a company called iN2L, which delivers a technology platform that really supports the engagement of populations in memory care. So how do we improve the lives of people who are in memory care facilities?

Larry Leisure:

And so, we touched this from a number of different dimensions. One of the things that's been particularly interesting about this conference is the disparate points of view of the attendees in this conference, and really understanding how we can all work more effectively together to impact this population, because if we can deliver against this population effectively, we have a happier, healthier population that stays in the senior living facilities and we don't see the churn.

Larry Leisure:

So if we can effectively service the needs of this population makes a big difference. But as people who are at risk for care delivery in that population, if we can keep them healthy, obviously we have very aligned incentives.

Larry Leisure:

So this is a really important topic for us and I appreciate the opportunity to be here and learn more about how different entities are working to solve this problem from different dimensions.

Anne Tumlinson:

Oh, that's great.

Ken Segarnick:

Hi. Ken Segarnick. I also want to say thank you for inviting me to be on this panel and having the opportunity to work with you and Larry. You guys are both experts in your field and you also bring such incredible insights.

Ken Segarnick:

Brandywine Living is an owner/operator of assisted living and memory care communities, independent living, in the mid-Atlantic. We have 29 operating communities and our thirtieth one is about to open in Potomac, Maryland. That'll be our seventh state of operation. We're headquartered just outside of Philadelphia.

Ken Segarnick:

As I look at these statistics, I'm also not super surprised by them, Anne. I think I want to focus on a point that you made in your opening remarks. You took a moment to correct yourself and distinguish between the term "acuity" and "frailty".

Larry Leisure:

Yeah.

Ken Segarnick:

I want to take a moment and just think about that for a second, because acuity implies ... A derivative of the word "acute", which implies some sort of focused, concentrated need that's driven by an event. It could be a stroke or a cardiac event or something like that. "Frailty" is more of a part and parcel of the aging process.

Ken Segarnick:

What we've seen at Brandywine, and we take care of 2500 residents a day, and I would say on average you'll see a third to 40% of those residents turnover in the ordinary course every year. So we're touching the lives of 4,000 residents and their families throughout the course of every year.

Ken Segarnick:

We've been in business for over 23 years. I've been with the company for 18. I'm a principal and the chief corporate officer. And I will say that this isn't like Darwinism where we've seen evolution occur over centuries. I've seen in a relatively short period of time an uptick in the age of the move-in of the resident and I've seen an uptick in the frailty, and that shouldn't come as a surprise to the operators in the audience.

Ken Segarnick:

What I find particularly opportunistic here is, to benefit from Larry's insight, is how you see this as being the investment environment from all sides of the horizon. These are the facts. They're not going anywhere. Now we need to think about this session and about investment opportunity in the paradigm of this reality. The residents are moving in at an older age and they're moving in at a higher level of frailty.

Anne Tumlinson:

Right.

Larry Leisure:

That's interesting.

Anne Tumlinson:

Yeah. What you may also not be surprised to see is that this is a population that is also using a lot of healthcare. So just to take a really huge step back and pull up to the highest possible level, just in case you didn't know this, if you're serving the over age 65 population, then pretty much everybody who lives in your building is a Medicare beneficiary.

Anne Tumlinson:

Medicare spends ... We're spending between six ... Gee, every year it goes up so fast I can't even keep track, $600 billion, $700 billion a year on this population, and the federal government's focused like a laser beam on how we can reduce per capita utilization, which is basically a function of how much service use each person has and how much those service units cost. So that's their focus because they can't do anything about the number of people that we're multiplying that by.

Anne Tumlinson:

So they're focused like a laser beam on that, and the primary strategy, I would say, or at least what I think is the primary strategy, is to essentially ask the providers and insurance companies that operate in this country to take on some of the risk of this growing healthcare liability that the government faces.

Anne Tumlinson:

So, to Larry, the investment thesis is like we are interested in investing in organizations that are contributing to improving the value of what we deliver, which is about a higher level of efficiency and a higher level of quality.

Anne Tumlinson:

So what you're seeing in this data are hot inpatient admission rates and emergency room visit rates. These rates are again calculated for each of the populations that live in these different settings.

Anne Tumlinson:

I think maybe just to bound this for you all a little bit, I want to just ... So what do you mean by inpatient admission rates? This is the rate at which individuals go to the hospitals and are admitted. In the population that does not live in senior living, so this is everybody else including healthy people, if the rate of hospital admissions is about 230 per 1000, or 0.23, at the farther end of the spectrum, long-stay nursing home residents were looking at a rate of about 680 per 1000, or 0.68.

Anne Tumlinson:

So assisted living is substantially lower than nursing homes at 430 per 1000, but one of the things that I find really interesting about the data is that the rate of ER visits is about the same. So what I would surmise from that, or just deduce, is that one of the challenges that assisted living facility providers face in particular is that revolving door with the emergency room, because what's happening is you're

sending people to the emergency room as frequently as a nursing home, but fewer of them are actually being admitted for an inpatient stay. That means that probably they're just being sent right back or they're being admitted under observation or some other kind of mechanisms.

Anne Tumlinson:

I live really, really just right down the road from an assisted living facility, and I will just report that there's a lot of ambulances kind of ... Like a revolving door situation. I interact with a lot of my friends who are now at the stage where their parents are in assisted living, and they talk all about how often their parents go to the emergency room.

Anne Tumlinson:

In another just benchmark point, or something to just keep in mind in terms of what's possible, is that Juniper Communities, and many of you are familiar with Lynne Katzmann's work to integrate healthcare into housing model. She gets an inpatient admission rate of about 300 per 1,000 and her population is very frail in the assisted living facility category.

Anne Tumlinson:

So I think assisted living's actually doing pretty well with inpatient admissions really relatively speaking given the frailty of the population. It could do better. Certainly when it comes to ER rates, there's also a lot of opportunity here.

Anne Tumlinson:

So, Ken, I want to just go directly to you because I know that the reason I invited you to be on this panel is Brandywine is aware of this phenomenon and doing things to address the rate of transfers to emergency rooms and the use of a hospital. And so, I'd love to hear you talk a little bit about that.

Ken Segarnick:

Sure. I thought you invited me for my charm and charisma.

Anne Tumlinson:

There was that, too.

Ken Segarnick:

But, okay, whatever will do it. I think, look, when you say that you have friends who are the adult children of residents in assisted living and they are experiencing visits to the ER, how many of them tell you that in a positive way?

Anne Tumlinson:

Not any of them.

Ken Segarnick:

None one, zero.

Anne Tumlinson:

Yeah.

Ken Segarnick:

Look, I think we have to recognize that you'll have a whole constituency of people saying that the emergency room is the most expensive from a healthcare system and cost standpoint. It's the worst environment for someone to go to unless they actually truly need to be in the emergency room, and it's the last place people want them to go.

Ken Segarnick:

Then you'll have the assisted living operators who would love to avoid an eventual inpatient hospitalization, which will sometimes ensue from an ER visit. But most importantly, from Brandywine's perspective, you have a consumer, the resident themselves and their adult child, who the last thing they want is to see their loved one or themselves wind up in the emergency room.

Ken Segarnick:

So we find that there's great opportunity to invest in the mechanisms that will help reduce reliance upon ER visits. That investment for us, for example, includes 24-hour on-site nurses, third shift nurse on-site. Now a lot of operators in this industry will have a third shift nurse on call and not on-site. The key difference between the two is a significant financial investment.

Ken Segarnick:

Now for us, and this can't be said for every operator in the business, but for us our experience has been that many of the accidents that precipitate an ER visit happen in the middle of the night. A resident is ... The things that you don't want to happen happen in the middle of the night. They get out of bed to go use the facilities or something like that and they trip, they fall. If you don't have a nurse on site to help coordinate the interaction with the physician, you may very well have no choice but to 911 the call.

Ken Segarnick:

I think the point that I want to emphasize is there's a great alignment of interests between all the stakeholders here, and it's not just centered around the costs to the healthcare system. It's centered on delivering a significant value proposition, and a value proposition that can be passed along in terms of a private pay charge to the residents.

Ken Segarnick:

This is not something that we give away at no additional cost. The cost of living in a Brandywine, because of our holistic value proposition, is going to be more expensive. Some people will choose to buy into that value proposition because they think these types of security or mitigants for going to the emergency department are worth the investment. And so, that would be one example of an investment that we've made to try to reduce the impact of those statistics.

Larry Leisure:

Yeah, let me come at it from a slightly different direction. I'm going to put my Medicare Advantage hat on for a second and that of an at-risk provider. Also, I should disclose I don't want to say my bias, but the context. I'm from Southern California, the land of managed care and the land of Medicare Advantage.

Larry Leisure:

But if you look at a typical Medicare population across all of these categories, you would typically experience about 1500 days per thousand hospital utilization. 1500 days of hospital utilization. But if you looked at a well-

Anne Tumlinson:

Days. Days.

Larry Leisure:

Days of hospital ... Yeah, okay. Thank you. If you looked at a well-managed population, say, one, if you look at the stats for, say, healthcare partners in Southern California, that number is south of 800 days per thousand.

Larry Leisure:

By the way, the economic benefit to that group from managing the ER visits and managing days per thousand can produce between $2,000 and $3,000 of profitability for Medicare Advantage members. So highly profitable. So by effectively managing population, they're demonstrably reducing savings and their participation in those savings.

Larry Leisure:

One of things that groups like HealthCare Partners and Monarch, which is another significant group in Southern California, both coincidentally are now owned by United Health Group, just another observation, but one of things that they've been doing for years is they've been working closely with senior living in Southern California.

Larry Leisure:

So, for example, Leisure World, no relation, down in Laguna has a very close relationship with Monarch, which is the largest medical group there. By working effectively with Monarch, Monarch and Leisure World, they've been able to effectively improve the care and the services to those senior members, but directly benefit from that increased coordination and lower cost. Leisure World in Laguna has a similar relationship with Healthcare Partners, and the result is better care, happy residents, demonstrably ower costs.

Larry Leisure:

A more current example of where that model is being applied is The Villages in Central Florida. I assume everybody's familiar with it. It's 100,000 residents and 40 square miles. The Villages operate something called Villages Health, which is the equivalent of a Monarch or Healthcare Partners, but again brings accessible care, better care, better coordination, and again realizes the benefits of that.

Larry Leisure:

So as we think about it as operators, we're both the senior living operator, but we're also the investor in delivering care to those communities. We see lots of opportunities to do better care coordination, not necessarily delivering care in our senior living facilities but improving care coordination, which will produce the benefits of both sides.

Larry Leisure:

If the resident stays in the facility and doesn't churn, obviously that produces a real significant benefit to the operator. Likewise, the person who's responsible for managing the care, if they do an effective job in keeping them out of the hospital, they have happier, healthier, and more profitable members.

Larry Leisure:

So as we see this phenomenon, we see that there's going to become this better coordination on both sides, which will produce, I think, meaningful economic benefits for both parties, for all parties.

Ken Segarnick:

I just want to reiterate, I mean I think Larry does an excellent job in identifying the Venn diagram of the overlapping interests between, let's say, in this case, the operator and the at-risk insurer. What's in the middle of that Venn diagram is the resident's interests.

Larry Leisure:

Absolutely, thank you. Thank you, yeah.

Ken Segarnick:

What's the great news here, though, is that the customer is totally aligned the. I remember when my oldest child was born ... This will date me a little bit. But my wife and I tried to figure out a way that if she went to the hospital a certain time, we'd get an extra day in the hospital. We were like, "Oh, it'd be great if we went in there ... "

Ken Segarnick:

We actually want to stay in the hospital another day thinking that that was the better, safer course of action. Times have changed, and my son's not that old and neither am I. But times have changed. Staying in the hospital longer is not considered to be a protective benefit.

Larry Leisure:

It's a very unhealthy place.

Ken Segarnick:

Yeah. And so, as a result, it's very important to recognize that there's a unique investment opportunity, where not only does it align with the insurers' interests and the operators' interest in reducing cost and finding increased profitability, but it's exactly what the customer wants. I want to keep that in mind as we think about the ways in which we're going to develop this investment thesis.

Anne Tumlinson:

Yeah, and just a further emphasis on that point, our company also runs an organization for caregivers called Daughterhood.org. It's really valuable to us because we interact with basically the family caregivers of the folks that we're trying to improve the delivery and financing of care for.

Anne Tumlinson:

But I will tell you that one of the things we hear so often is when it comes to assisted living, it's like, "I'm paying $75,000 a year," "I'm paying $60,000 a year," whatever it is, "Why am I at the ER so often?" or, "Why am I still in charge of everything? Why is it my responsibility?" essentially to quarterback this very intensive set of care needs.

Anne Tumlinson:

It's not fair to operators because these expectations are out of alignment, but to me it points to an opportunity. I think that whenever I give this talk or I evangelize on this in any way, shape, or form, I feel like I lose half the audience within 15 seconds, because the presumption is that I'm suggesting that you should ... I mean Brandywine's made a big investment. I'm not necessarily suggesting that everybody has to go out and hire an extra resource or to take full responsibility for care coordination or figure out a way to pay for a nurse practitioner. It's really more about finding organizations in your market potentially that you can align with, who, like you said, have the same interests.

Ken Segarnick:

Right, and I think as we get deeper into your analysis here, we're going to probably end up thinking through ... And everyone here is going to walk away with a wide array of models and mechanisms to accomplish the overarching objectives. Some people are going to coalesce at the, "Look, I'm comfortable in this very low level of coordination and involvement and investment. I've got my hands full with just doing what I'm doing." Then you're going to have others like your Juniper Partner who's going to say, "Look, I'm all in."

Anne Tumlinson:

Right.

Larry Leisure:

That's a different business, too.

Ken Segarnick:

Right. It's a different business model, and I think people need to find where on the continuum they are. If I could just take one second-

Anne Tumlinson:

Yeah, please.

Ken Segarnick:

... as a footnote and put a plug in here for the NIC's Future Leaders Council has put together a survey that basically asks a series of questions. It's a very easy, user-friendly, interactive survey that asks a series of questions on basically where you would identify your organization, whether you're an assisted living, independent living, skilled nursing, whatever type of provider you are, where you would identify yourself on this continuum.

Ken Segarnick:

They're going to aggregate this data and they're going to share it as part of a published report. So if you're interested in taking the survey and you're an operator, please go to seniorcaresurvey@nic.org and request a copy of the survey. Seniorcaresurvey@nic.org.

Anne Tumlinson:

One more time, that's ...

Ken Segarnick:

I think NIC could only produce the data that it has access to. So if we could provide the data, they'll do some really interesting reporting on it. [crosstalk 00:28:34].

Anne Tumlinson:

Yeah. Somebody was raising their hand, and I was going to say, "Oh, let's wait until the end and take questions." But no, but then I changed my mind because this isn't such a huge group that we couldn't actually entertain questions as we go.

Male:

[inaudible 00:28:45].

Speaker 5:

[inaudible 00:28:45] are tricky. Then I look at these ER visit numbers and I think all the assisted living and nursing homes have the option of losing their license if they fail to take someone to the ER [inaudible 00:28:57]. Similarly, yes, people hate going to the ER, but they're [inaudible 00:29:03].

Anne Tumlinson:

I think that's a really, really, really important point. So consumers are fickle and tricky and hard to please because on the one hand they're annoyed, on another hand they're relieved. Yeah, so no question about.

Larry Leisure:

Yeah. I just have a question. I think when somebody goes in the ER frequently, that's a failure. It's a failure in the system. I don't disagree. Absolutely, when somebody needs to go to the ER, they go to the ER. But it's not stopping somebody going to the ER that should be going to the ER. It's understanding what the needs of that resident are, anticipating and avoiding the acute event that led to the ER visit.

Ken Segarnick:

Or even in the event of an acute situation, not all of them necessitate an ER visit. There are other mechanisms for coordination with physicians that would eliminate the need without the operator taking on the license risk of saying, "I made this determination." A nurse can communicate with the physician, a physician can order checks throughout the course of the night that may, at a minimum, defer the period of time for further assessment from the middle of the night to the morning. That in and of itself starts to become a benefit for the families. So I absolutely think this gentleman makes a great point, though-

Larry Leisure:

It's a really great point.

Ken Segarnick:

... that there is only so much risk tolerance that a licensed provider who doesn't have physicians on their staff can make. And so, coordination in terms of making the decisions is a big distinction from ownership. Just because you coordinate with care doesn't mean you own the care. You have to be careful about who you coordinate with and that sort of risk paradigm.

Anne Tumlinson:

I do want to just take this opportunity to say something about this setting that makes ... And this is a good lead in to the next data point I'm going to show you, which is just that we've been talking about the opportunity here in the context of like these are high rates and if you bring them down, we can save money.

Anne Tumlinson:

But it's much easier ... Not easier, but it's much more efficient to address this kind of high utilization in the context of senior living for multiple reasons, but mostly because the way you avoid an ER visit is that you notice a changing condition far in advance of it becoming an urgent issue that requires that trip, just to Larry's point.

Anne Tumlinson:

You're actually in a much better position to do that in assisted living than you are if somebody's in a single family dwelling out in the suburbs somewhere living alone. Unless they have great remote patient monitoring and telehealth and have a case manager and a nurse practitioner calling on them all the time, their likelihood is that they're going to go to the emergency more often than if you apply a similar model in assisted living.

Anne Tumlinson:

So there's a lot of real value, and we'll emphasize this again as we go, but there's a lot of value in the setting for organizations that might be in fact wanting to intervene to reduce these rates, because it's conducive to the intervention in a much more efficient way.

Anne Tumlinson:

So it's a good segue to the most exciting data finding, I think, exciting to me as a geek, data geek, which is that ... Again, just to take a step back, for those of you who aren't familiar with what Medicare Advantage is. So Medicare Advantage is an option for every single Medicare beneficiary for them to get their Medicare benefit, the Medicare benefits to which you are entitled under the law, from a private insurance company.

Anne Tumlinson:

You might be asking yourself, "Why would anybody ever choose to do that?" The very quick answer is that because it's much less expensive. Medicare fee-for-service has a lot of gaps. It has a lot of high cost-sharing.

Anne Tumlinson:

The only way to fill those gaps and fill that cost-sharing to buy private insurance, like fee-for-service insurance, from Medicare supplemental insurance providers, and those premiums are high. Then you have to buy dental, then you have to buy ... Everything has to be patched together, and it's expensive. Or you can go to a private insurer that's bundled it all up for you in the Medicare Advantage program.

Anne Tumlinson:

Because of the rising cost of healthcare and the rising liability for these out-of-pocket costs, more and more people have been enrolling in Medicare Advantage. If anybody here operates a skilled nursing facility, you're like, "I know, I know."

Anne Tumlinson:

So compared to 10 years ago, I think the Medicare Advantage penetration rate was like, I don't know, 5% or 10%. Now it is almost 40%. In the overall population, 34%, 40% depending on what data set you're using. We expect it to continue to grow. I expect to see Medicare Advantage penetration rates of 50%, 60% within the next five years.

Anne Tumlinson:

What I was shocked to learn is that the Medicare Advantage penetration rate in independent living and assisted living facility settings is actually just slightly lower than the average in the overall population. It's coming in around 30%. That means 30% of residents in independent living, 30% of residents in assisted living are in fact enrolled today in a Medicare Advantage product of some kind. Again, we fully expect that to increase as time goes on.

Anne Tumlinson:

There are private insurers who are at risk and paying for these hospitalizations. United is making a payment to the hospital every single time your resident goes, or to the ER, and there are in fact quite a few people enrolled in these plans in your buildings.

Anne Tumlinson:

So here we are starting to see these things start to come together. You're running a housing, a hospitality model on the one hand, but with the population that needs a lot of healthcare and is in fact enrolled in Medicare Advantage. So somebody's at risk for it.

Larry Leisure:

Yeah, one thing I'll just comment is there's a lot of geographical variations. So, for example, in California, these numbers are significantly higher. You look at Florida, they're significantly higher.

Larry Leisure:

Then there's also an age phenomenon here is that the younger seniors have grown up in managed care, and many of them are just aging into these managed care plans. So they're not necessarily electing, "I want a Medicare Advantage plan." They're in Kaiser, they like Kaiser. They get to 65, they're enrolled in the Medicare Advantage plans.

Larry Leisure:

So we're going to see these numbers move up dramatically as they age in and become a resident. So we're going to see that phenomenon.

Larry Leisure:

The other thing is as there's greater penetration, they're going to be outreaching through their at-risk provider groups, because all these Medicare Advantage plans contract with providers, increasingly the providers they contract with are these at-risk providers.

Larry Leisure:

And so, as those numbers go up, they're going to be increasingly focused on reaching the patients wherever they are. So they're going to be finding you as senior living operators and they're going to say, "How can we more effectively integrate with you and take advantage of the footprint you have?"

Larry Leisure:

I mean a lot of us are thinking about, well, how do we reach out to them? Don't worry, they're finding you. I mean it's not surprising that there's people here in this conference from Humana and United Healthcare and others, it's because this is where the patients are. They see these numbers. They're looking for opportunities.

Larry Leisure:

They've also seen the case studies where by effectively integrating, coordinating ... I guess I would use the term "coordinating", not integrating, but better coordinating, they're achieving better results and the operators are seeing the benefits. But they're seeing the very direct benefits from that integration.

Larry Leisure:

So I think this is a positive trend. I like the fact that they are at risk, because if that patient ends up using a lot of care because they aren't well-managed, they get burned. Likewise, as operators, when you have people who you're losing to sniffs or you're losing them as residents, you lose. And so, I like the fact there's very clear shared incentives to keep that patient population. Your residents happy, healthy, and out of the hospital and the ER to the extent they can be.

Larry Leisure:

If they need care, the worst thing you can do is defer care for a patient that needs care. So there was, I know for a long time, this fear that these big HMOs like Kaisers were denying care. That's the last thing they want to do because all that does is exacerbate the problem. So I like the aligned incentives all the way around.

Anne Tumlinson:

Yeah, definitely.

Ken Segarnick:

Look, I think it answers the age-old question that we used to ask at these conferences: are we healthcare or are we hospitality? I mean I think the answer is-

Larry Leisure:

Yes.

Ken Segarnick:

... resoundingly both. If you were wondering whether or not you had a seat at the healthcare table, the table's coming to you. I mean the data supports the fact that you have not only an increased frail population, but now you have more at-risk ancillary companies that are aligned with the infrastructure that we've created, which is a low-cost center for providing services and care, and they are very interested ... As you said, they are at this conference. They're very interested in identifying ways to optimize everyone's interests.

Ken Segarnick:

I think it's a very significant reality. I think the fact that it's a Medicare Advantage population is an interesting statistic in terms of the evolution of the program itself, and I think that's a story that's still being written. But in terms of just what does an operator need to think about in terms of driving growth at its own business. It's really not a question of how much risk you want to take on. It's really a question of how are you going to align yourself with those that are at risk, because that's happening inside your system.

Ken Segarnick:

So I'm not an advocate for becoming a risk-bearing entity for a private pay senior housing operator [inaudible 00:39:54] becoming a risk-bearing entity. I'm an advocate for having eyes wide open for what's happening in the communities and all the stakeholders that are interested and involved.

Anne Tumlinson:

Right, right.

Larry Leisure:

One more comment about the Medicare Advantage players. It is interesting, they're pretty innovative. Centene, Humana, United, just to name three, are running all sorts of experiments. So they're trying stuff and they're looking for partners. So how can we use telehealth more effectively? United's got a real interest in remote patient monitoring or things that we can do with passive monitoring.

Larry Leisure:

There's an example of something that United's been working closely with, which is a simple ... It looks like a bandaid that you can just put on your chest here and it'll measure respiration, heart rate, body temperature, 3D motion, and has a speaker. Has a speaker. That's probably a little scary. It has a six-week battery life. But the point is doing something for a patient pre and post-op ... This is not that funny.

Anne Tumlinson:

Sorry. Well, the whole Ken and you together, it's like-

Ken Segarnick:

Well, I think it's neat. It's not invasive. I think it's neat that you have the benefit through your fund and your partnership with John, you have the benefit of converging technologies and things that were

developed without necessarily the purpose of implementation inside of a senior housing community, but just for the elderly population.

Ken Segarnick:

And so, this works anywhere, but what you're pointing out is something that is potentially low invasiveness, high efficacy. It could do a lot of different things. One, it could enhance consumer outcomes and protective measures. Two, it could better align the infrastructure of a senior housing community with these at-risk companies. Three, there's probably a lot of embedded data opportunity that exists in a technology like this.

Ken Segarnick:

I'm not saying that this is the first time I've seen this, which is why I was having a little fun with it. But I'm very well aware of these types of developments and how they're going to play a role in our ecosystem.

Larry Leisure:

Yeah, I've actually seen John here. We met with folks from Bose, for example. They're developing some very low profile things that allow you more effective hearing aids or hearing systems and talking about doing a demonstrably lower price point. Not $4,000, not $5,000, $400 or less. But bringing capabilities, technologies like that.

Larry Leisure:

So there's lots of those kinds of experiments that are going to be available. If you're open to trying stuff in your facilities, there's lots of people that are going to be willing to do things or try things. You don't have to jump all in. You can test these approaches.

Ken Segarnick:

Can I just make one comment about that? I think it's very important because when you're making the selection to partner with either a technology provider or a health provider, any selection that you make in partnership, brand is a very important component of this, because recognize that the population that we're servicing, this is their homes. We're not trying out technology in an institutional setting. You're doing it in their homes.

Ken Segarnick:

So even the name Bose, it evokes a sense of high-end, luxury, and, frankly, of residential product that most people here are accustomed to seeing in their homes. So if Bose can deliver a sound amplification system that really meaningfully makes an impact on the quality of residents' lives and it's not ...

Ken Segarnick:

Look, residents at any age, people are vain. They don't want to look like they're walking around with big cans on and things like that. If there's a way that they can do it that increases the quality of life, and you can align yourself with a brand like Bose, it makes a lot of sense.

Anne Tumlinson:

So two things I want to empathize on what you all just said. One is quality of life. I mean a few years ago, when NIC first started emphasizing this theme of collaboration in order to drive value in healthcare, we had this visualization where we had the resident in the middle.

Anne Tumlinson:

And you think about we're not just talking about managing healthcare so that we can get a higher degree of value of healthcare. We're talking about you really want to have an engaged resident who's having a high quality of life, to just set healthcare aside as something that's tangential to that, is you're missing an opportunity to really ..... I mean because quality of life is about health and wellness. If you are the resident who's going to the emergency room every other day, you're not having good quality of life.

Anne Tumlinson:

But the other thing, I wanted to just then flip back to something a little bit more tactical here, is because we're getting ready to shift gears a little bit and I just want to plant a seed in everybody's head, we were talking about Medicare Advantage plans, and one of you, maybe it was Larry, made this point about a lot of these plans are now delegating risk to provider groups.

Anne Tumlinson:

This is just a really important point because you may not necessarily have United Healthcare or Humana traipsing into your building wanting a partnership, but they have essentially delegated or deployed these physician groups like CareMore, like Optum, like Landmark Health, others under some delegated risk, to essentially go out and find and manage high cost lives in a really efficient way.

Anne Tumlinson:

So that's your connection point is through these what we call.... I'm gonna use the term medical services organizations. You're going to see that term again in a minute. Anyway, I just want you to be thinking about this is.... It has a lot of dimensions to it the way in which this is all going to come together and everyone's going to be engaged and in partnership with each other.

Anne Tumlinson:

So to that point, in my firm, we've been working with a wide variety of organizations, including a couple of organizations that were interested in financial analysis around what would it take to deliver in a community with private houses, a model that is similar to what you could do in assisted living?

Anne Tumlinson:

In other words, it's a clinic. How could we create a clinic-based model that has adult daycare or sends doctors into people's homes, and then create a Medicare Advantage, what we're calling an IESNIP in the community around all that. So it's not something that's actually been tried in nature yet. They just wanted to do some financial analysis.

Anne Tumlinson:

Anyway, I'm saying all this just to say one of the things that we learned pretty quickly was it is really hard to stretch the premium dollar when you have to deliver services in individual family homes, and you don't have any other source of financing for any care services for those people at all.

Anne Tumlinson:

I think when I compare that financial analysis to the analyses that we do for ISNIPs in senior living or nursing homes and the resources that we have to budget for, it's much lower. So we're budgeting for care management, we're budgeting for primary care.

Anne Tumlinson:

In the community setting, we've got to build a clinic, we've got to have office managers, we've got to have staff. This is on the right-hand side of the slide. There's like a very elaborate web of support that has to revolve around that person and live in this clinic setting in order to make all of that work.

Anne Tumlinson:

I had this aha moment where I thought, "Golly, this is a lot of value" the senior living is essentially delivering to the Optums and the CareMores and United because they can essentially come and have an enormous impact, perhaps some arbitrage impact that's already there just by virtue of the fact that the senior living services are there. They don't have to actually create a clinic. They've got eyes on these people all the time. They've got care aides, nurses, and nutrition. It's all built in.

Anne Tumlinson:

So I created this slide because I thought I just wanted to tee this up for discussion in this context, and especially to get Larry and Ken's reaction to it, because it got my mind thinking like are there ways in which, are there NOI opportunities here above and beyond the classic model that you're operating in today. And so, Ken, I want you to react to that especially.

Ken Segarnick:

Sure, yeah. I mean I think this is a great slide because it reinforces the fact that we have a very leverageable infrastructure. So I'm talking about the senior housing communities. You could say the same for skilled nursing and for independent living, but I'm going to think specifically in the context of Brandywine.

Ken Segarnick:

We've got a very leverageable infrastructure. Everything you said in terms of the wide array of services that are provided, the physical plant, the safety and security, the opportunities that come in in terms of how to align with the interests of the people who've entrusted us with their safety and security and of those ancillary providers that work with them.

Ken Segarnick:

I'm going to make a point about the industry at large that aligns with your point about the NOI. When you think about where we are today as an industry, NIC has been reporting occupancies across the assisted living industry in the mid to upper 80% range. So you're seeing 87%, 88% occupancy is being considered to be today's norm. Some of that's actually after reporting what people are hoping was the bottom and they're seeing this slight uptick.

Ken Segarnick:

It was only a few years ago that we would scoff at an upper 80% occupancy and we were in the low 90s, and it was 91%, 92% occupancy. The difference, the delta, between that 500 or 600 basis points of occupancy is huge for the operators in the room.

Ken Segarnick:

What has driven that? Well, there's a multitude of factors, but one of the things that we've seen is a lot of growth in new supply coming on. Everybody has been developing and a lot of new supply coming in. In the highest barrier to entry markets, there's a ton of supply coming in. That has put a lot of pressure on operators.

Ken Segarnick:

What I think operators need to do now is focus on ways to drive an optimize organic NOI growth. We're not going to be able to build ourselves out of this occupancy challenge. We're going to have to just focus on delivering a more diverse array of products and services and to find ways to leverage our infrastructure to be more relevant, and that means increased occupancy and that means increased lengths of stay and that means increased rates.

Ken Segarnick:

And so, when you think about this infrastructure as an operator, it's not enough just to focus on what we can do for these ancillary at-risk insurers or health systems, but also to think about ways in which it's going to help drive value organically at the community level, because it's incumbent on us to get ahead of this challenge that we're in right now.

Anne Tumlinson:

Right, great.

Larry Leisure:

Yeah. The only thing I was going to add, it's interesting, as you talk about additional revenue streams, as you build a tighter coordinated model with the providers, or provider partners, I think there's an opportunity to collect a care coordination fee. I really think it's possible.

Larry Leisure:

I'm not talking about delivering care. I'm not suggesting the operators deliver care. I'm just saying to the extent that you create that integration point, not even integration, coordination point. I think there's an opportunity to monetize that value, because to the extent that you are more effectively coordinated, there is going to be better care delivered to your residents. There's a value created and I think there's a value trade opportunity.

Larry Leisure:

We're exploring that now with one of our companies to really push on that idea. But I think it would create an added incentive for you as operators to really think about doing that, because to build it just on this notion that we think it'll drive these benefits, I mean that would drive meaningful revenue now. So I think there's an opportunity.

Ken Segarnick:

Yeah, there is opportunity. I want to just emphasize again. The details of some of the words that we're using, the differentiation, you used, acuity and frailty, earlier, and I honed in on that, and you keep purposefully using the word coordination. I think it's a very important word because I think it's differentiated from full-blown integration and it's also differentiated from what we've seen in this industry historically as collocation.

Anne Tumlinson:

[crosstalk 00:52:32].

Ken Segarnick:

It's somewhere right in the center point. So let me explain collocation. When you go to a Target and you see Starbucks there, you have a fantastic collocation of amenities and services, and it inures to the benefit of the consumer. Trust me, my daughter will tell you. She loves both, the Target visit and a venti latte.

Ken Segarnick:

But the reality is that, for a long time, these two brands came together and said, "Hey, this is a leverageable big box environment and we can provide services." But that's all it is as a collocation and as an amenity. What you're saying, Larry, and, Anne, I think you're trending the same way, is what's the next step-

Larry Leisure:

Click.

Ken Segarnick:

... or click above that? When we think about coordination, I want to explain what I hear as the distinction. I think if an operator, especially if you're going to charge a fee as in a coordination fee, I think there's great opportunity to provide value to the customers, a concierge-level coordination of care.

Ken Segarnick:

You mentioned earlier that one of the biggest struggles that adult children have is I pay all this money and yet I still feel like I'm at the vortex of all this health care administrative stuff. So there's a way to satisfy that burden. There's a way to monetize that and drive NOI growth. Equally as important is to be purposeful and intentional to find out what we can do to help drive more favorable outcomes to the resident.

Ken Segarnick:

There's going to have to be a true investment. The person who's on the coordination team is not a ticket-taker. That person has to be someone who's really invested in understanding what the services are, what the array of services that are being delivered, and how effective we are in delivering good quality outcomes.

Anne Tumlinson:

Yeah, that's a really good point.

Larry Leisure:

Yeah.

Anne Tumlinson:

Yeah.

Male:

Can I ask a quick question for Ken, actually? A question earlier, which I think you just answered, but I'm going to ask it [inaudible 00:54:19].

Anne Tumlinson:

Oh, you know what? So let me say this. Sorry.

Larry Leisure:

The box.

Anne Tumlinson:

Before you go further, we'll have you ask this question. We have a box for people to ask their questions into. Has everybody seen one of these before? They freak people out when it's their first time with one, but they're cool.

Larry Leisure:

If you don't get the right answer, you're going to whack us with it.

Anne Tumlinson:

Exactly.

Ken Segarnick:

[crosstalk 00:54:41].

Anne Tumlinson:

We have two more slides. We're just going to keep talking until we're supposed to be done. But I would just want to invite everybody to ask questions from this point forward. So there you go.

Joe:

So just because I have a clear understanding of how the Brandywine Living model works, is what you just described the way that you would bridge the selling proposition that you have now, which is a lifestyle, to being able to meet the innate healthcare needs of the population that is clearly going to be coming to your door? Because that's what it sounded like I heard.

Ken Segarnick:

It could be. I mean I think what I would say, Joe, in answer to your question, is that there's been a high degree of stratification of the level of service that gets offered in this industry, whether you're in a primary market or a secondary or tertiary market, whether you're the Ritz Carlton or you're the Hilton

Garden Inn or you're the Motel 6. I mean there's a broad array of different products and services that are available to the consumer today.

Ken Segarnick:

As you know, Brandywine operates in markets in a model that's very high end. So the bridge that you're referring to, yes, I believe would be part of a concierge-level type of service that I think would meet the needs of the customer, and they'd be willing to pay a part of the increased cost to have that added value proposition.

Ken Segarnick:

For others, it may be a different type of bridge. It may be a bridge to stay very relevant to referral sources. It may be a bridge to align yourself with a single referral source like collocating with a hospital on campus. Or if you're in a secondary MSA, you may say, "It's the only way I'm going to get residents in here." So there's not a one-size-fits-all answer to what that bridge looks like, but, yes, it's a bridge.

Anne Tumlinson:

I don't think it has to be a bridge just for high end. In fact, if anything, I think we're going to end up in the next two to three years in, I think, even WellTower is starting to hint at this already, which is we're going to start to see experimentation with housing that is more affordable in conjunction with Medicare Advantage products, which have a lot of flexibility, pay for a lot of things that are embedded in the rates for services that you all are already offering today, transportation, med administration.

Anne Tumlinson:

Medicare Advantage plans can now pay for personal care services as a supplemental benefit. They can pay for all kinds of technology care coordination. So lots of the things ... meals. Medicare Advantage plans can pay for meals now.

Ken Segarnick:

And WellTower's model is doing that at a much more attainable price point.

Anne Tumlinson:

Right.

Ken Segarnick:

So to your point, yeah.

Anne Tumlinson:

Because I mean you could start to begin to see some subsidization of some of those things that we would otherwise drive through a private pay fee within the context of the Medicare Advantage premium because of the opportunity to reduce hospitalizations-

Larry Leisure:

Absolutely.

Anne Tumlinson:

... to the point where you've created that room there. We figured out a way to do it in the community in that model I was referring to earlier. You can definitely do it in senior living.

Anne Tumlinson:

And so, we just put together, the three of us on the phone, we were prepping for this. First, we were talking about like boil it down. There are four entities, stakeholders that have to work together in some way, shape, or form to really drive the value that we're talking about.

Anne Tumlinson:

So it's that medical services organization I was referring to earlier, which is your primary care and case management, care management. There's the real estate itself, the fact that you have this building here.

Anne Tumlinson:

It's some entity taking healthcare risk, because only when you take healthcare risk essentially do you create the flexibility and the funding source in order to pay for the enhanced primary care. So if you want to have a nurse practitioner answer a call at 8:00 on a Friday night, you have to pay that person differently than you could ever do under fee-for-service Medicare.

Anne Tumlinson:

So Medicare Advantage creates that platform essentially. Then, of course, technology, which enables really all kinds of value enhancement in that setting, and coordination of information and things like that.

Anne Tumlinson:

I think we talked about earlier today at least trying to present a few more ideas of value opportunities. But before we do, I do want to take a quick pause and see if there's anybody else in the audience right now who wants to ask a question. I always find that the second I'm like, "Oh, okay. No one ... Oh, right. There you go." All right. Well, we will ... Okay.

Bob:

Okay. Ken, you in particular have tried to stress there a lot of options for how you can play in this, so to speak, depending upon both the level of risk you want to take all the way to becoming your own plan, do you own the medical services that are going to get provided in your building, are you providing the real estate setting, so on and so forth.

Bob:

I guess the question I would have, because I think you both commented in essence that the healthcare plans are going to find you. They're going to come to you. If that's the case, what would each of you say the senior care providers here need to do to get ready? In other words, what's going to make you a preferred provider versus, "Why in the world would we want to work with you? We don't like your numbers at all. We really want to go to your competitor across the street because what we see in hospitalization rates or ED usage or whatever is so much lower."

Bob:

I guess my question to each of you is, all right, maybe they're going to come knocking on my door, but what do I have to do to be ready?

Larry Leisure:

By the way, that's a really, really good question and I thought a fair amount about it. One comment is, and this is for NIC actually, I think there's a real need to chronicle, to really build case studies. So what are the examples we can look to very specifically and see what's been successful? I've talked about Leisure World, I've talked about The Villages. There's probably 20 or 30 use cases. I think we really need to go deep on those use cases.

Larry Leisure:

What were the level of services? What was the level of integration? What were the economic benefits that were produced? How are they potentially shared? What are potential synergies that could be realized by better coordination with the senior living provider?

Larry Leisure:

I think we need to do some homework, because the worst thing you can do is guess. I think the more evidence you have, the more you can point to specific examples, the far more compelling you're going to be as you decide what you want to do based on the level of risk, as you mentioned, you want to undertake.

Larry Leisure:

I think that that homework hasn't been done. I think, at this session, it's been interesting. There's been several speakers talking very specifically to their model. Oak Street, I thought, did a really good job this morning. Juniper, the presentation, I thought, was fabulous. But it didn't speak specifically, "So I worked with this senior living community in this way, with this level of integration or coordination, and this is how that worked and this is what it entailed. This was the investment that was made. This were the returns."

Larry Leisure:

I think we've got to do some homework. I mean I think that when we know that, we'll be better informed. I mean it's fine if you just want to experiment, but not knowing the knowable seems kind of dumb from my perspective.

Ken Segarnick:

Well, I think I like Larry's comments. He's cautioning operators don't have the free cash flow to invest in experimental measures, so you want people to be very pensive and look at models that may or may not have been successful.

Ken Segarnick:

But, Bob, I've got a slightly different answer, which may not be the one that is the most enjoyable to everybody. But this is, I think, an unavoidable truth in healthcare today.

Ken Segarnick:

I think one thing that's missing from this slide and one thing that addresses your question, Bob, is scale. The reality is that there's so much consolidation that's going on in healthcare in general, health systems, health insurers-

Anne Tumlinson:

Health plans, for sure.

Ken Segarnick:

... health plans, that I think that if you intend on being a small boutique operator of a single, two communities, the answer may be different than if you're a scaled operator in a market, in a region. You don't necessarily have to be national, but you have to have a brand platform and presence that I think is scalable and leverageable to meet the needs of a highly consolidating industry. Otherwise, I think you're going to be nipping at it on the periphery, and that's going to alter the investment decisions that you're going to make.

Larry Leisure:

Sure.

Anne Tumlinson:

Yeah, yeah. I definitely agree with that. All right, we've got another question here.

Speaker 8:

I've got to come at this from a different angle. Your previous slide talked about having a medical practice with 200 covered lives down there at the bottom of it. All right. I'm from upstate New York, Rochester, New York, heavy Medicare penetration, managed care at 70%.

Anne Tumlinson:

Wow!

Speaker 8:

We have one payer in town, Blue Cross Blue Shield, that has 80-plus percent of the market. They don't want to deal with any kind of provider association. We run everything from assisted living to skilled independent housing. We own part of a medical practice. We miss the partner that's willing to take the risk. How do you attract somebody into a very complicated market that is willing to do that?

Speaker 8:

So you mentioned earlier United Healthcare. Yes, they do the Optum program for the dual eligibles in the nursing home. They don't want to touch New York State because of the regulations on the assisted living side. Any advice?

Anne Tumlinson:

Oh, boy.

Speaker 8:

We need that payer to make our model work. It's costing us a fortune to run a medical practice. We're only two years into it.

Anne Tumlinson:

Yeah. Are you getting fee-for-service right now? Are you billing them, just billing them on a fee-for-service basis?

Speaker 8:

We're just billing, but-

Anne Tumlinson:

They won't do a value-based contract with you?

Speaker 8:

Yeah. There no value in it. There's two hospital systems in town, and all of the primary care is attributed to them. So anyone that comes into any of our independent and assisted living, they're already accounted for in a value-based product with one of the hospital systems.

Anne Tumlinson:

How many lives are you serving today?

Speaker 8:

We have about 1,000.

Anne Tumlinson:

Okay. So I have some ideas, which I'll talk to you about afterwards.

Speaker 8:

Okay.

Anne Tumlinson:

Can I just take a quick [crosstalk 01:06:12]?

Larry Leisure:

No, this is yours.

Anne Tumlinson:

Okay.

Larry Leisure:

Go for it.

Anne Tumlinson:

So I say this with a lot of respect. What I'm about to say sounds really hard. But what you've just described is the reason why there are in fact assisted living facility providers and nursing homes forming their own Medicare Advantage plans, because they simply cannot get the attention and the leverage that they need.

Anne Tumlinson:

Going back to the Optum product for just a minute, the Optum model was we're going to go into a nursing home, we're going to bring our nurse practitioner. So Optum has a nurse practitioner. They're the medical services organization.

Anne Tumlinson:

United Healthcare has a Medicare Advantage plan. Optum takes the risk. Any money that they make, and they make a lot because they get that 680 per 1000 down to 250 per 1000 or something like that, all of those savings go right back into that medical services organization and weren't being shared at all with the nursing homes. So what happened was the nursing homes got fed up and they've started to form their own plans. Now the Optum model's starting to change.

Anne Tumlinson:

It's not easy. It's not fun. I will say there are probably more provider-led ISNPS in the state of New York than any other state in the country. There may even be some that would be willing to let you use their back-office apparatus to offer their plans.

Anne Tumlinson:

So Hebrew Home in New York City has a great plan. There's a bunch of great providers doing really innovative things, and I would team up with them and just disenroll everybody in your buildings from Blue Cross Blue Shield, enroll them in your product. I'm making it sound simpler than it is, but-

Larry Leisure:

[inaudible 01:07:52].

Anne Tumlinson:

... yeah, that's what I recommend.

Larry Leisure:

Translation: Anne says get a bigger hammer.

Anne Tumlinson:

Yeah, you need more-

Larry Leisure:

You need a bigger hammer. Leverage matters.

Anne Tumlinson:

You've got to create your own, get yourself to the top of the ... Yeah.

Speaker 8:

Just related to that, there are examples in other states where when providers got together, all of a sudden the [inaudible 01:08:12].

Anne Tumlinson:

Totally. 100%.

Larry Leisure:

What a shock. What a shock.

Anne Tumlinson:

Yeah, they got the value-based contracts after they started to-

Speaker 8:

I mean basically one of the lessons of what's happened with healthcare payment reform is that nobody is going to voluntarily offer you part of the savings, period. That's a total illusion.

Larry Leisure:

By the way, there's two parts of it. One is you have to identify what the savings is. You have to know the measures. So what's the pie? Then you have to leverage. That's where leverage comes in. Well, how do we apportion the pie based on who's creating that value? But to your point, just identifying the value without leverage doesn't mean they're necessarily going to share it with you. Actually [crosstalk 01:08:54].

Speaker 8:

Well, I think a lot of operators, that's been a shock, because they walked in to say, "Here's all the dollars I've saved you." "The good news is, well, you can continue to be in our network." But wait a second. I'm saving you all these dollars." "Well, you get rewarded. We haven't kicked you out of our network. Aren't you happy?"

Anne Tumlinson:

Thank you very much for that.

Speaker 8:

And so, the issue of leverage is a key issue.

Male:

It's huge.[crosstalk 01:09:20].

Speaker 8:

Whether it's for-profit nursing home providers in Alabama, whether it's not-for-profits at a number of states like Ohio and so forth, either banding together or even just the threat that you're going to band together suddenly makes folks open up to the idea that maybe there's some way we can let you participate in this. But if you don't have leverage, they will never voluntarily move to do it.

Anne Tumlinson:

Yeah. I just want to say ... Because as soon as we start talking about forming a Medicare Advantage plan and getting involved in shared savings, again I always feel like we lose half the audience.

Anne Tumlinson:

One thing I would end on, I see I have 29 seconds, is that the theme is that this is ... We've got to have a whole conference about this rather than just one session, which is that, getting back to your case study, your use case, there are so many different ways to seize opportunities in the context of healthcare, whether it's just ... Not just, but whether it's collocating or-

Larry Leisure:

Coordination.

Anne Tumlinson:

... coordination or-

Larry Leisure:

Full integration.

Anne Tumlinson:

... integration, owning some part of the risk, getting some part of the shared savings. There's really a very wide variety of ways in which you can participate in this. But leverage is a key, key part of how you make the decision about where you want to be.

Anne Tumlinson:

All right. Do we have any other burning, urgent questions that ... Okay. All right. Well, thank you very much for coming.

Male:

Thank you.

Male:

[inaudible 01:10:58]. That was good. Here, let me give you the ...