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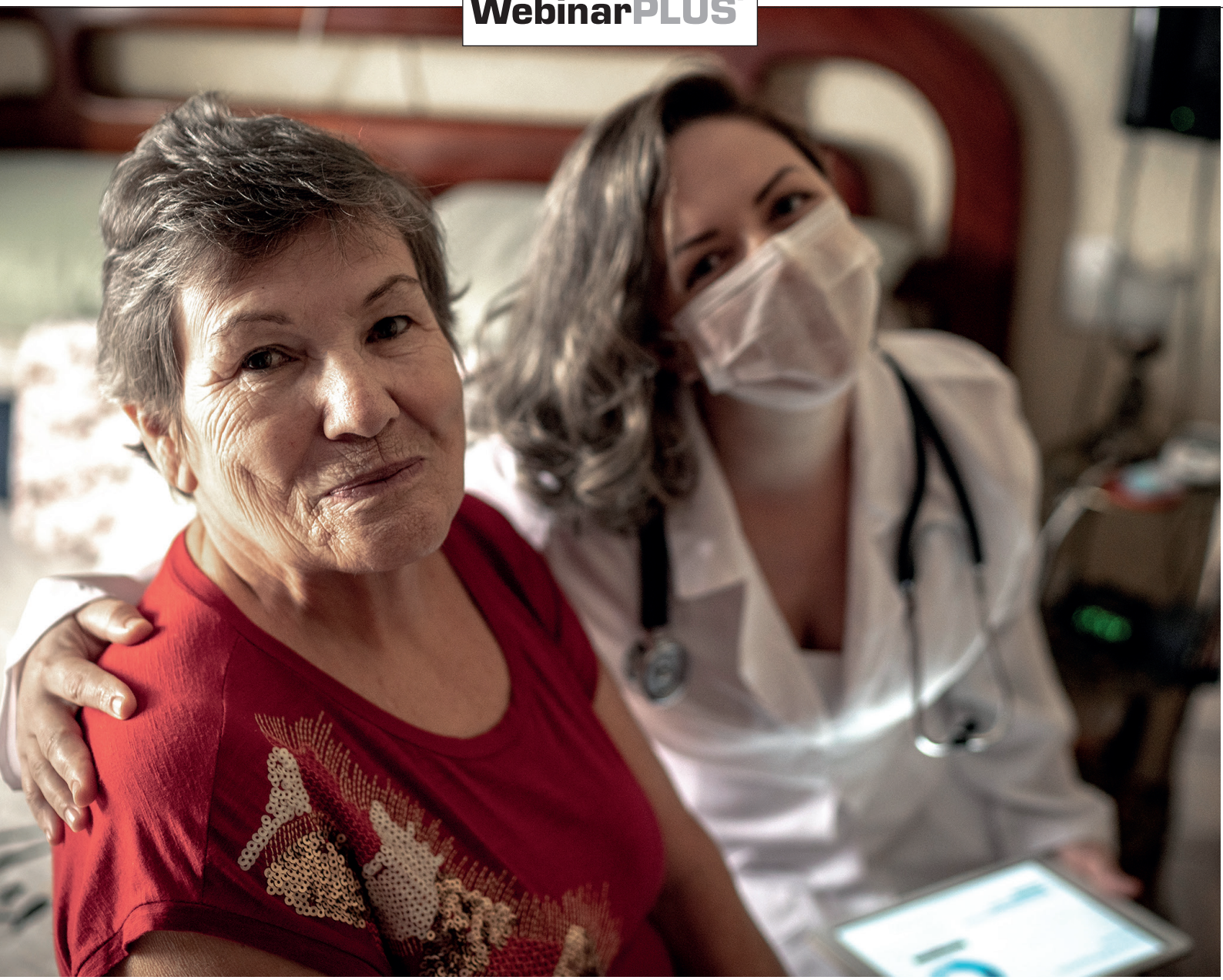

THE CASE FOR CONTRACT THERAPY

COST, COMPLIANCE AND OUTCOMES SET CONTRACT THERAPY APART FROM IN-HOUSE, MANAGED THERAPY MODELS

AN E-BOOK BY

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Reliant® REHABILITATION

The objective of this eBook is to assess the relative operational, clinical, and financial differences between adopting a Management Agreement Model (Advisor) contrasted with an outsourced Full-Service Contract Rehabilitation Model (Partner). Getting right to the point, the substantive difference between the two models centers around ***accountability***.

Management-only Agreement models are simply advisors with limited authority or incentive to control costs, performance standards and clinical compliance because they don't employ or directly manage the therapists. The therapists are employees of the SNF provider and all costs and clinical results are ultimately borne by the provider. The therapy team knows they do not really answer to the Advisor and therein lies the problem as the following illustrates:

Inherent Conflict of Interest: Since Advisors (Management-only Model) don't employ the therapists they are reluctant to enforce operational and clinical standards/protocols for fear of upsetting the therapists and putting the contract at risk with the SNF provider. The Advisor's leverage and leadership is constrained with respect to implementing care pathways or corrective action in order to avoid complaints by the clinician to their employer. The therapy team, in return, knows they have this power over the Advisor and that they can willingly disregard the guidance of the Advisor.

Inflated Costs: The Advisor has no incentive to manage productivity or control wage rates associated with recruiting staff because they want to keep the therapists happy as noted above. All associated premium labor costs are a pass through to the SNF provider resulting in excessive staff, reduced inefficiency and higher labor costs. Furthermore, there are a number of hidden infrastructure costs (as outlined in this eBook that are included in a full-service pricing model) not typically disclosed in an Advisor proposal that the SNF provider should be aware of in objectively comparing a management versus full-service agreement.

No Skin in the Game: The Advisor will not stand behind their product by indemnifying the SNF operator for claims rejected and unsuccessfully appealed; nor do they typically have the staff, expertise or resources necessary to successfully handle this labor-intensive task on behalf of the SNF provider. The financial risk to the SNF provider associated with third-party appeals, audits and investigations associated with this arrangement is exacerbated and compromised by the lack of clinical standards enforcement already noted above.

The absence of management authority in holding therapists accountable results when therapists are not employed by, and therefore do not answer to, an outside Advisor. This exposes the SNF to excessive individual therapist discretion and variation in patient care treatment. The operational and financial risks are mitigated through indemnification by the Full-Service Contract Rehabilitation Model. A shared risk model with a national Full-Service Contract Rehabilitation Provider creates intense hands-on oversight with the objectivity and authority necessary to optimize efficiency, reduce cost, and provide evidence-based care with above average outcomes.

Chris Bird
Chief Executive Officer
Reliant Rehabilitation

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THE CASE FOR CONTRACT THERAPY

Among the benefits of contract therapy: more accountability and better patient outcomes, according to the national Gravity study.

One large skilled nursing facility's in-house therapy program operated for more than 20 years before a perfect storm of reimbursement and regulatory change prompted it to switch to a contract services provider. An internal audit revealed that residents had not been screened in over three years. Productivity was at 50% and the in-house program was hemorrhaging an average of $33,000 a month.

But after six months under appropriate oversight, margins averaged more than $40,000 a month, productivity had risen to 75%, and resident outcomes and satisfaction had soared.

"What we've been finding is appropriate leadership that's able to hold therapists accountable can make a vast improvement in quality and margins while maintaining approximately the same staff," said Melissa Brown, COO of Gravity Healthcare Consulting. She talked about the SNF as part of a study conducted by Gravity that compared in-house, management and contract therapy services models.

Brown and two veteran long-term care providers, Lane Bowen, chief strategy officer of Avalon Health Care Group and former president and chief operations officer of Sava Senior Care, and Tara Roberts, vice president of rehabilitation and wound care services for Nexion Health, offered their perspectives on contract therapy in the webinar, "Hidden Costs of Managed and In-house Therapy Models." Reliant Rehabilitation sponsored the program.

Brown acknowledged that knowing whether to provide rehabilitation in-house or through a contracted third party can be confusing for most SNFs, if only because of the massive regulatory changes that have swept the therapy sector the past few years. While therapy models seem to have the potential to offer greater internal oversight at reduced expense, there are downsides. Hidden costs inherent in these models can present a great deal of risk, produce lower patient outcomes and usually cost more thancontract therapy, with results from the study showing a difference of only $1,557 between contract costs and just staffing for management programs, Brown told the large webinar audience in late October.

In general, Brown and her colleagues concluded that management and in-house therapy models typically have lower patient outcomes and reimbursement, higher compliance risk, conflict of interest issues, a lack of accountability, inefficiencies and treatment inconsistencies and inflated wages.

MOTIVES TO SWITCH

During the study, many providers who reported considering the shift away from contract services told Brown they were motivated by a need to gain more control over their department and the delivery of services, and focus better on resident-centered care. All of this makes sense, especially under the Patient Driven Payment Model.

Discussions revealed a minefield of misconceptions and flawed projections.

"I've been called into organizations that use contract therapy and asked to complete an analysis of what the anticipated cost, reimbursement and final SNF

THE CASE FOR CONTRACT THERAPY

"HR, EMR AND COMPLIANCE COSTS FOR THERAPY DEPARTMENTS CAN BE SIGNIFICANT."

—Melissa Brown, Gravity Healthcare Consulting

provider margins would be under a shift in in-house and management agreements, and our analysis is usually quite a bit different in terms of internal projections by the facility," Brown said.

"These often-inaccurate home-grown projections may appear positive for the provider and demonstrate potential for increased therapy margins," she added.

However, she said, many providers often fail to predict the true costs and margins associated with this shift. Costs are usually higher than projected when therapy HR, EMR, salaries and compliance costs are included. Additionally in the study, revenue declined by 29.7% for management agreements and decreased by 44% for in-house models, as compared to contract rehab

Another huge unseen cost is therapy-specific compliance training and education. "Often for an in-house or management agreement, a director of rehab and/or management personnel will have to receive additional training and digest the information, create education materials and then provide training to therapy associates," Brown said. "Without the support of a large peer review team available at a typical contract therapy company, this associate training is often insufficient to meet the training and compliance.

In the Gravity study, providers who used contract therapy had the largest SNF provider margins. Providers with the management model saw 60% less SNF margins, and in-house models fared worse with a 71% decrease in SNF margins.

"When in-house programs are audited, even with their management agreements in place, they are often well outside therapy standards in just a few years of transitioning from a contract rehab model and they demonstrate multiple compliance liabilities," Brown added.

Costs pertaining to other items like recruitment also have expanded a great deal.

"The recruiting costs for therapy departments can be significant. Many management companies charge full recruitment fees, and additional fees for permanent placement, which can be anywhere from $3,000 to $10,000 or higher," she added.

THE ELEPHANT IN THE ROOM

Although therapy minutes are no longer prescribed under the Patient Driven Payment Model (PDPM), providers still assume risk if therapy minutes are slashed, regardless of who made the decision. Essentially, therefore, "CMS program integrity is still focused on therapy minutes," said Brown, who noted that CMS PDPM lead John Kane warned that "providers with poor outcomes and outlier minutes will be targeted."

This has encouraged some SNFs to begin considering taking their therapy programs in-house or with an oversight management agreement.

"Providers will still want to make sure residents' needs are still served through clinically appropriate levels of therapy services," Brown said. "They fear therapy companies will slash minutes to target margins rather than focus on residents' goals and outcomes. There were projections everywhere in the pre-PDPM era that therapy companies would extensively cut therapy minutes under PDPM, but the data just doesn't bear that out."

"IN ORDER TO GET A HIGH-QUALITY REHAB PROGRAM, I NEEDED TO GO OUTSIDE AND HAVE SOMEBODY ELSE ADMINISTRATE IT."

— Lane Bowen, Avalon Health Care Group

THE CASE FOR CONTRACT THERAPY

Expenses can quickly mount with in-house or management therapy.

The majority of therapy companies have made only a 10% to 20% cut in therapy minutes, according to Gravity. And studies show that this level of change is not correlated with a significant change in functional outcomes.

There are a number of challenges for management and in-house therapy models. In any model, decisions around therapy minutes are at the therapist's discretion. But there are a number of unique challenges for management and in-house therapy models. These therapists are more likely to make decisions based on mood or personal needs, versus clinical data. Outside input from therapy oversight is needed to examine all relevant aspects.

POINTERS TO PONDER

Brown's advice for long-term care providers considering switching the way they provide therapy services includes:

- Use an independent third-party to analyze your options.
- Acknowledge that every provider and therapy department is unique.
- Internal projections are often incorrect, so look for outside numbers.
- Residents come first. Quality and therapy yield outstanding outcomes, appropriate reimbursement, optimized margins and protected denial-resistant revenue.

Bowen and Roberts also offered insightful perspective.

"There are no cookie-cutter solutions," noted Avalon Health Care Group's Bowen. "No [one] size fits all. There's no right or wrong and no perfect answer, particularly in an environment where we have lots of change going on."

"WE BOTH (NEXION AND RELIANT) HAD TO BELIEVE IN THE ECONOMICS AND UPSIDE OF VALUE-ADDED SERVICES THAT WOULD REACH MUTUAL BENEFITS."

— Tara Roberts, Nexion Health

Roberts, of Nexion Health, said she's learned a great deal in her 18 years with Nexion, which began with time as a physical therapist and includes area manager for a rehab vendor.

"Early on, Nexion benefited from numerous stratified approaches, but as payment models changed and administrative burdens quadrupled on the operations side, it became increasingly important to decide whether to continue with its rehab vendor model," she explained.

"We decided we could leverage that relationship experience and create a unique fully vendored model for our facilities," she added.

"There were three very important things we needed to make sure were considered to be successful," Roberts continued. "Have an aligned mission, vision and philosophy, have contracting flexibility, and a mutual belief in the economics and that value-added services would reap mutual benefit. This is how a rehab vendor and operator must be aligned to execute these intangibles." ■

The webinar,"Hidden Costs of Managed and In-house Therapy Models," was sponsored by Reliant Rehabilitation. Click here to view the webinar.

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THE CASE FOR CONTRACT THERAPY

Q&A

During the McKnight's webinar, the following questions were posed by participants.

Q **Who commissioned this study? Was Gravity Healthcare Consulting paid for this study?**

A Reliant Rehabilitation commissioned Gravity Healthcare Consulting to conduct an independent, third-party research study on the costs and margins with the various models. The goal of the study was to determine how SNF providers fared under the various models, considering a wide array of indicators. Gravity completed the study independently, and then provided the final results to Reliant Rehabilitation.

Q **Is Gravity related to Reliant?**

A Gravity is an independent consulting firm based out of Cumberland, MD that has no relationship to Reliant. Gravity has multiple therapy vendor clients, and does not solely collaborate with Reliant.

Q **Why do therapy contract companies push so hard for Part B?**

A Therapists have a responsibility to serve all residents in their care, practicing at the top of their license. It is not that therapy companies push for Part B caseload, but rather they encourage and mentor their teams to holistically screen and assess all of the resident's therapy needs. The regulations state that the threshold for completing a therapy evaluation and course of treatment is that the therapist believes there is greater than 50% chance that their interventions will benefit the resident. In other words, it is more likely that therapy services can help a resident than not. So good therapy oversight educates, supports, and challenges their clinicians to tackle any appropriate therapy needs that could benefit the resident, reduce pain, increase function and/or improve quality of life, etc.

Q **Why do contract therapy companies negotiate for a large portion of the therapy revenue?**

A Contract therapy companies, like many SNFs and Life Plan Communities, are struggling to see any margins after all expenses. Recent data from CMS showed that SNFs see a 0.5% margin on average, and therapy companies fare no better in many cases. If you dive into the research conducted by CMS for PDPM, you will see that they intended that all of the reimbursement for therapy under PDPM went to therapy, because they only intended to pay for the actual cost of therapy. However, most therapy contracts are for less than 50% of the therapy per diems, some as low as 18%! In actuality, the SNF provider usually recoups a larger portion of the reimbursement, while the contract therapy provider has to carry the majority of costs through staff salaries and corporate management overhead.

Q **How many management and inhouse models did this study include? How many contract companies were included? Are these results reflecting only three buildings?**

A The study included data and statistics compiled from over 100 facilities. However, for certain elements of the study, Gravity carefully selected 3 facilities to directly compare that were exactly matched for census, payor mix, and CCRC size. Additionally, they were selected within the same geographical location with the same wage index. The results were similar to additional sites analyzed in a variety of geographical locations all over the United States.

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THE CASE FOR CONTRACT THERAPY

Q What timeframe was the study referencing?

A The Gravity study was conducted in 2020 using data from December 2019 through February 2020, and annualized to reflect pre-COVID data in each facility.

Q Did Melissa get to choose the facilities or was Gravity directed on who to pick?

A Gravity conducted completely independent research and Melissa chose all of the buildings that were included in the study independently. The buildings in the study include both Reliant Rehabilitation buildings, as well as those with other contract therapy companies, management companies and in-house arrangements.

Q What are your thoughts around giving restorative to the contract therapy provider?

A This can be an excellent solution if you are struggling to find success with your Restorative Program. Therapists understand how to appropriately manage RNP minutes, and can help your team with RNP oversight and clinical direction. Remember that you will still need an RN or LPN to oversee the program internally, and to add RNPs to the EMR, write orders, etc.

Q Why no statistics on long term care minutes?

A We were not able to present everything from the comprehensive study during this webinar. However, the full study does address therapy minutes for residents in long term care and notes that the research showed that contract therapy provided increased minutes for long term care residents, consistent with the appropriate levels of care for evidence-based practice. In contrast, in house and management models tended to under-deliver care to long term care residents, both in minutes and frequency.

Q The Gravity study states improved outcomes...how were those defined?

A These are based upon both the functional outcomes obtained through the Business Intelligence platforms of the therapy EMRs, along with Section GG results from the MDSs and therapy evaluations/discharges.

Q How was the Part B revenue factored in the presentation Therapy Dept Reimbursement?

A The reimbursement reflects the SNF provider's perspective on the amount of reimbursement the SNF provider would receive for Part B therapy services under the various models.

Q If you have not been gathering outcomes data with past utilization, how do you suggest developing clinical ranges for CMI groups?

A If you don't have this outcomes data, consider partnering with a consulting firm who can provide you with national data from their clients, and assist you with developing these clinical treatment ranges. Alternatively, this is one of the key reasons to consider partnering with a contract rehab vendor, as they would complete all of this analysis on your behalf and drive the clinical approach.

Q Where can I find these standards of delivery of care you spoke about. Are these like "pathways"?

A These standards of care are usually developed by contract therapy vendors and are proprietary to each vendor. The use of these types of evidence-based practice approaches is one of the reasons to consider partnering with contract therapy. However, some consulting firms also offer critical and clinical pathways that can be purchased for use in your community.

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THE CASE FOR CONTRACT THERAPY

Q **Increasing revenue is easy with Rehab if company gives 30 minutes of treatment no matter what DX and require staff to be 95-97% [productive]... but how about the patients? How about the quality of care? Some say that therapy vendors are just "greedy" and "in house is much better for a facility that cares about the patient and not just about reimbursement."**

A While we appreciate your perspective, we are sorry to hear that anyone has had that experience. None of the contract rehab vendors, or any of the therapy departments in our study had productivity standards that high. Nor did any of the contract therapy vendors dictate skilled or long term care minutes, or require the same amount of therapy regardless of diagnosis. Neither of these approaches is recommended or adopted by either Gravity or Reliant. While many communities chose to go or stay in-house because they believe that it will improve resident outcomes and quality of care, the results of the study showed otherwise. The best outcomes, resident satisfaction and highest discharge to home rates were seen in the communities with a quality contact therapy vendor. Additionally, long term care residents served by contract therapists received improved therapy services as evidenced by the outcomes obtained for the residents in this study.

Q **Aside from the disadvantages you are saying about in-house did you see any advantages to the "in-house" format versus the contractors?**

A Probably the one main advantage we found with in-house and management agreement communities was that some therapists reported increased job satisfaction with the in-house model. However, this is not surprising given the above market salaries they receive, and the significantly reduced productivity standards that are often required.

Q **Screens for long term residents, IDT meetings covering falls, PDPM daily meetings - how is this covered [under contract therapy]? What I've found is that rehab vendors want to charge more for these type of services which changes your analysis figures. Most facilities like in house rehab because they feel the therapists become part of facility/team. How do you analyze these type situations/scenarios?**

A These types of meeting costs, if they were charged by the contract therapy company, were included in the analysis figures. While there can be a benefit to the therapy team being a part of the facility team, good contact therapy vendors integrate into the very fabric of the building and are seen as part of the facility staff. Every facility is unique, and the solution that is best for each facility is based upon a variety of factors. This is why Gravity recommended that providers receive an independent, third party analysis of their risks and benefits of using the various models. The ultimate goal is providing quality therapy to the residents and achieving best-in-class outcomes.

Table 1: Salary Costs for Therapy Department

Therapy Department Labor Costs	Contract Rehab Model	Management Agreement Model	In-House Model	Approximate cost per FTE annually
Director of Rehab Salary	Included in therapy contract	$135,900	$140,900	N/A
Physical Therapist Salary	Included in therapy contract	$100,057	$104,169	N/A
PTA Salary	Included in therapy contract	$57,982	$71,401	N/A
Occupational Therapist Salary	Included in therapy contract	$84,232	$87,519	N/A
COTA Salary	Included in therapy contract	$61,207	$63,400	N/A
Speech Language Pathologist Salary	Included in therapy contract	$96,507	$100,559	N/A
Therapy Tech/ Medical Records Salary	Included in therapy contract	$33,077	$34,500	N/A
Operational Oversight (Regional Manager)	Included in therapy contract	Fulfilled by management agreement	$150/hour; 10 hours per month	At least $1,500 (would increase for teams less than 10 FTE)
Compliance Officer and Oversight	Included in therapy contract	Fulfilled by management agreement	$150/hour; 15 hours per month	At least $2,250 (would increase for teams less than 10 FTE)
PRN hiring, training and management	Included in therapy contract	Management company may assist but facility expense at $250/month	$400/month	$480/FTE
PRN labor cost	Included in therapy contract	Average is $55/hour	Average is $55/hour	$10,000/FTE annually (includes some coverage for increased census)
Agency Contractor hiring, training and management	Included in therapy contract	Management company may assist but contractor fees at $50-60/hour	Contractor fees of $50-60/hour	$2,880/FTE
Total additional annualized cost per FTE (not including salaries)				$17,110

Table 2: Risks, Liabilities, Indemnification Costs for Therapy Department

Liability/ Risk/ Indemnification Costs	Contract Rehab Model	Management Agreement Model	In-House Model	Approximate annual cost per FTE
Therapy ADR/ Denials Lost = Indemnification	Covered by therapy contract and indemnified by therapy	100% of risk/loss is maintained by the provider	100% responsible – average loss is $19,115/ year	$1,911/FTE
Therapy ADR/ Denials Processing and Management	Therapy company provides assistance to existing onsite team	Management company may provide some consulting for therapy specific items, but all processing and management is up to the provider: 1 day per month at $50/hour: $400/month	1 day per month at $50/hour if able to manage with onsite denial staff: $400/ month	$480/FTE
Total additional annualized cost per FTE				$2,391

Table 3: HR Costs for Therapy Department

Therapy HR Items	Contract Rehab Model	Management Agreement Model	In-House Model	Approximate annual cost per FTE
Annual therapist licensure and credential maintenance	Included with therapy contract model	$250/therapist plus $100/ therapist per year of HR costs to track and log information	$250/therapist plus $100/therapist per year of HR costs to track and log information	$350/FTE
Annual HR Retraining/ Orientation	Included with therapy contract model	8 hours per employee; requires PRN coverage	8 hours per employee; requires PRN coverage	$440/FTE
Benefits including healthcare and liability insurance	Included with therapy contract model	20% annual compensation per FTE: $17,905/FTE	20% annual compensation per FTE: $20,501/FTE	$17,905 to $20,501/FTE
Recruiting	Included with therapy contract model	May have some assistance from Management Company, but at least $300/month	$300/month	$360/FTE
Clinical Education and CEUS	Included with therapy contract model	Provider supplies cost of CEUs, plus travel	Provider supplies cost of CEUs, plus travel	$2,000/FTE
Computers and IT support	Included with therapy contract model	5 hours of IT support plus 2 replacement devices per year	5 hours of IT support plus 2 replacement devices per year	$425/FTE
Total additional annualized cost per FTE				$21,630 to $24,046/FTE

Table 4: EMR Costs for Therapy Department

Therapy EMR	Contract Rehab Model	Management Agreement Model	In-House Model	Approximate cost for entire department (fixed and does not reduce with less FTE)
Cost for therapy EMR	Included with contract rehab	$500/year (Some management companies cover this cost)	$500/year	$500/year
Administration of EMR	Included with contract rehab	10 hours per month, plus annual attendance at EMR conference	10 hours per month, plus annual attendance at EMR conference	$10,500/year
Billing Support	Included with contract rehab	Completed by provider associates	Completed by provider associates	$6,000/year

Table 5: Average Aggregate Costs for Therapy Services for 10 Therapist Department

Therapy Department Expenses Annualized: 10 Therapists	Contract Rehab Model	Management Agreement Model	In-House Model
Therapy salary costs	No additional costs beyond Therapy Contract	$971,083	$1,019,085
Therapy Risk/ Indemnification costs	No additional costs beyond Therapy Contract	$23,910	$23,910
Therapy HR costs	No additional costs beyond Therapy Contract	$216,300	$240,460
Therapy EMR costs	No additional costs beyond Therapy Contract	$17,000	$17,000
Total costs outside of contract	$0	$1,228,293 (plus management fee)	$1,285,155

Table 6: Average Aggregate Costs for Therapy Services for 20 Therapist Department

Therapy Department Expenses Annualized: 20 Therapists	Contract Rehab Model	Management Agreement Model	In-House Model
Therapy salary costs	No additional costs beyond Therapy Contract	$1,900,513	$2,020,443
Therapy Risk/ Indemnification costs	No additional costs beyond Therapy Contract	$47,820	$47,820
Therapy HR costs	No additional costs beyond Therapy Contract	$432,600	$480,920
Therapy EMR costs	No additional costs beyond Therapy Contract	$17,000	$17,000
Total costs outside of contract	$0	$2,397,933 (plus management fee)	$2,566,183

Table 7: Average Aggregate Costs for Therapy Services for 5 Therapist Department

Therapy Department Expenses Annualized: 5 Therapists	Contract Rehab Model	Management Agreement Model	In-House Model
Therapy salary costs	No additional costs beyond Therapy Contract	$573,518	$603,748
Therapy Risk/ Indemnification costs	No additional costs beyond Therapy Contract	$11,955	$11,955
Therapy HR costs	No additional costs beyond Therapy Contract	$108,150	$120,230
Therapy EMR costs	No additional costs beyond Therapy Contract	$17,000	$17,000
Total costs outside of contract	$0	$707,623 (plus management fee)	$752,933

Table 8: Final comprehensive costs, margins and revenue for 10 therapist department in 3 models. Data was taken from actual facilities from December 2019 to February 2020 (pre-COVID-19 in all facilities) and annualized to provide relevant PDPM comparison data.

	Contract Rehab Model	Management Agreement Model	In-House Model
Cost of therapy contract	$1,226,736	N/A	N/A
Cost of management agreement (per facility)	N/A	$120,000 ($10k/month/facility)	N/A
Additional annualized provider staffing costs	N/A	$1,228,293	$1,285,155
Total costs	$1,226,736	$1,348,293 (increase of 9.9% of costs compared to contract rehab)	$1,285,155
Therapy department revenue	$2,317,252	$1,786,048 (decrease of 29.7% of revenue compared to contract rehab)	$1,607,443 (decrease of 44% of revenue compared to contract rehab)
Final actual therapy department margins	$1,090,516	$437,755 (60% reduction as compared to contract rehab)	$322,288 (71% reduction as compared to contract rehab)

Table 9: Management model expense compared to outsourced

Average Full-Service/Outsourced Monthly Expense	**$47,732**
SNF Therapy Monthly Payroll	
Therapy Salaries	$32,000
Additional Payroll (10% increase due to inhouse inefficiency)	$3,200
Wage Escalation (5%, common with inhouse staffing)	$1,760
Taxes/Benefits (25%)	$9,240
SNF Overhead Expense @ 5% (HR/Payroll/Compliance)	$1,848
Total SNF Inhouse Expense	**$48,048**
Management Fee *	$10,000
Total SNF Inhouse + Management Fee Expense	**$58,048**
Increased SNF Expense with Inhouse/Management (month)	$10,316
Increased SNF Expense with Inhouse/Management (annualized)	**$123,792**
Additional SNF Expenses: Services Previously Provided by National Therapy Provider	
RAC-CT medical reviewers processing ADRs/appeals (avg. per month)	$500
Opportunity Cost: ADRs/appeals less than 94% successful (avg. per month)	$500
Financial benefit of shared regulatory liability/risk sharing	TBD

* Range is $7,000-15,000

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Reliant Rehabilitation, a leading provider of therapy services

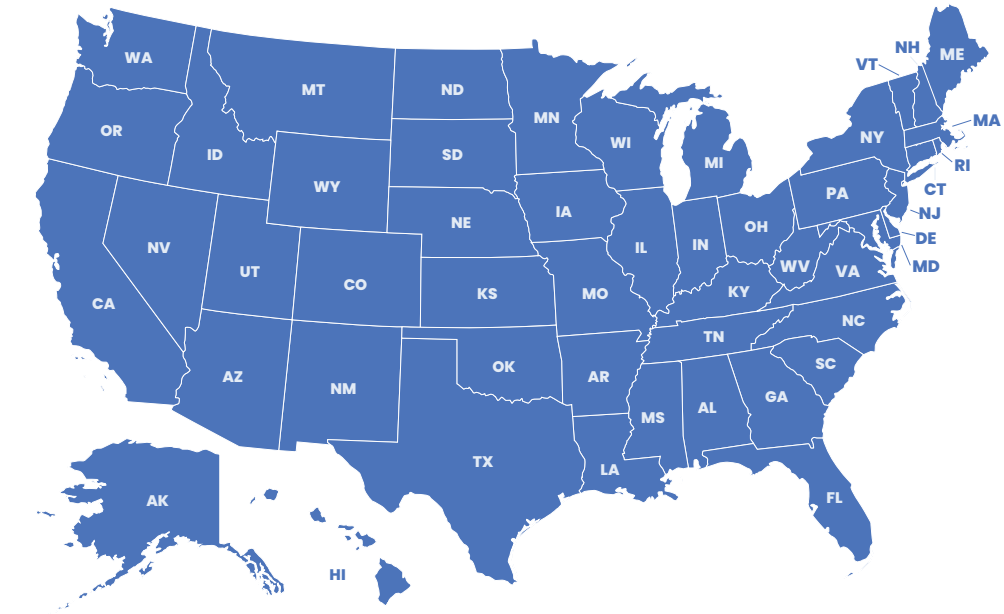
Who is Reliant?

Reliant Rehabilitation provides outcomes-driven physical, occupational and speech therapy to approximately 900 skilled nursing and senior living communities in 40 states. Reliant has a solid reputation of providing high quality, outcomes-driven therapy services to their skilled nursing partners.

900
Facilities

8000
Therapists

40+
States



Why Reliant?

Reliant Rehabilitation has developed a strong reputation for creating professional partnerships built on the pillars of integrity and transparency. Reliant's provider partnerships date back to the start of the organization. This long-standing tenure speaks for itself in a highly competitive space. Reliant prides itself on providing the highest level of patient outcomes in a compliant and efficient manner, bringing value to all stakeholders- patients, providers, payers and referral sources.

Census Development Programs

Reliant is your partner for establishing strong relationships with your referral sources. Our custom marketing programs will set your communities apart from the competition. Offerings include patient success stories/outcomes reports, analysis of referral data, A Year of Wellness®, and a co-branded marketing collateral.

No Patient Left Behind

NPLB is Reliant's proprietary program to ensure that all residents, regardless of payer type, receive the therapy intervention they need. This program includes caregiver and nursing training for the early identification of declines. Reliant therapists are equipped with condition-specific screening protocols to ensure "No Patient is Left Behind".

Do the right thing®

Do The Right Thing is Reliant's best-in-class compliance and medical review program. Our approach includes an automated multi-tier auditing process, on-going clinical education, and a team of clinicians who are RAC-C certified reviewing denied claims and processing every appeal.

Care+

Due to changes with reimbursement and direct care staffing challenges, Reliant has developed a skilled therapy "step-down" model to assist our partners with Restorative Nursing programs. Reliant therapists work with facility nursing staff to provide training, oversight, and support. We also provide a fully outsourced Restorative model when appropriate and requested.

Care+ Wellness

Reliant's holistic approach to wellness moves beyond solely the physical aspects of well-being. Emotional, spiritual, and intellectual wellness are just as important elements to assist our residents have a happy and healthy life. Reliant has developed this program to ensure each element is met for every resident.

Technology

Reliant utilizes technology throughout our programs and service offerings. These include MDS support through claims analytics software, VR gaming systems for engaging, outcomes-driven therapeutic interventions, a proprietary portal giving transparency to auditing and KPIs, a family engagement app that facilitates communication between the facility and family members, and a fully integrated EMHR system customized with Reliant's proprietary clinical pathways.

Why Now?

- The COVID-19 pandemic has caused serious declines in residents' physical and mental well-being. These declines require a sophisticated therapy partner to work with your nursing team to identify and address these concerns quickly. Reliant's No Patient Left Behind Program has a proven track record for exactly this type of resident need.
- Census declines challenges due to the pandemic and other competition required a systematic approach that leverages strong therapy outcomes. Reliant has an entire department dedicated to partnering with your business development teams to grow your census together.
- Third party contract therapy helps avoid the hidden costs of inhouse and managed therapy treatment models which include lower patient outcomes, lower reimbursement, compliance risk and treatment inconsistency. In the spirit of a true partnership, Reliant has designed a billing model that aligns our reimbursement methods with the payers. There are no hidden fees or surprises on your invoice.

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The Hidden Costs of Managed and Inhouse Therapy

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