HEALTHCARE MORTGAGEE ADVISORY COUNCIL

Financing Seniors Housing for America

Medicare – We Can't Get No Satisfaction

Medicare - We Can't Get No Satisfaction

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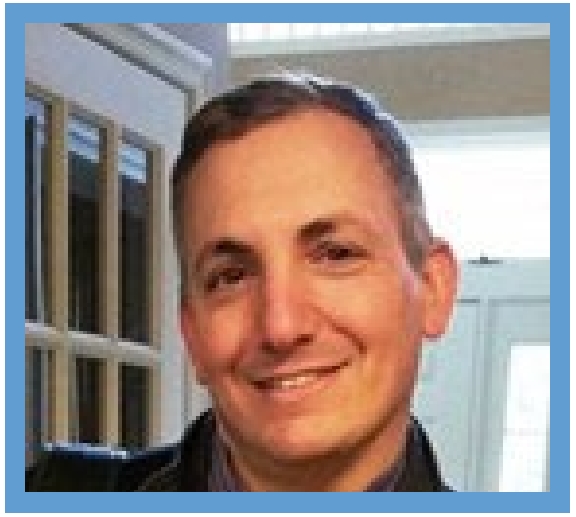

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HUD Hot Topics

- Staffing – déjà vu all over again
- What's in the mix?
  - Adjusting to PDPM, with added pandemic seasoning, just for fun
  - Evaporation of PHE Medicare Waiver stays
  - Stir in Medicare Advantage payors
  - Enough Medicare reimbursement flavor to support a healthy operation?

SNF Chains 1995-2003

- Publicly traded national chains dominated; at their height:

Beverly:	76	Kindred:	291
ExtndiCare:	163	Living Centers:	131
Manor Care:	292	Mariner:	266
Integrated HS:	238	Sun Healthcare:	272

- Equally dominant in Ancillary services
- Talk of capitating full PAC continuum, until…
- 11% of SNFs were in bankruptcy
- Driven by “Cost-Plus” Reimbursement

SNF*scrimination* in Healthcare Policy

Major healthcare legislation tilts negative for SNFs

- 1997: Balanced Budget Act
  Repeals Boren Amendment
- 2003: Medicare Modernization Act
  RACs, MA turbocharger, ISNPs
- 2010: Affordable Care Act
  "Innovation" (CMMI)
  Something for everyone (SNFs get "Productivity" Adjustment)
- Today: Irrational / inconsistent payment policies
  Single class provider status
  No protection from incidental policy yet disproportionate accountability
- Tomorrow: More of the same…
  Episode-Based Payment Model (RFI 7/18/23)
  Staffing mandate

Eight SNF Data Domains

SNF-Level Protected Health Information

FINANCIAL

Accounting/billing

MDS

CMS-JRAVEN

MEDICAL RECORD

Notes, orders, etc.

- Fragmented & Disconnected
- Inconsistent Data
- Cross-Contextualization required for meaningful insight

QUALITY

PBJ, Care Compare, etc.

UB-04

LDS-SAF claim data

COST REPORT

HCRIS database

CDC DATABASE

Nat. Health Safety Network

PROVIDER INFO

CMS file

SNF-level “Industry Data”

The SNF Reimbursement-Reality Cycle

- RATE ELASTICITY:
  - Amount SNF can impact its rate through normal operations.
- COMPONENT:
  - Rate Construction building block (Direct, Indirect, Capital, etc.).
- REBASING:
  - Process of updating baseline provider costs for rate-setting.
- TRANSITION:
  - Change in Rate Construction methodology (redistribution).

Medicaid Considerations: RUGs to PDPM

- October 1, 2023: None, PDPM, RUGs/OSA, CMI Freeze
- Component configurations differ: Nursing, PT/OT, SLP, NTA
- Structure: (MDS type, frequency, effective date, etc.)
- Resonance: SNF's "Data Profile"

Redistributive Impact:

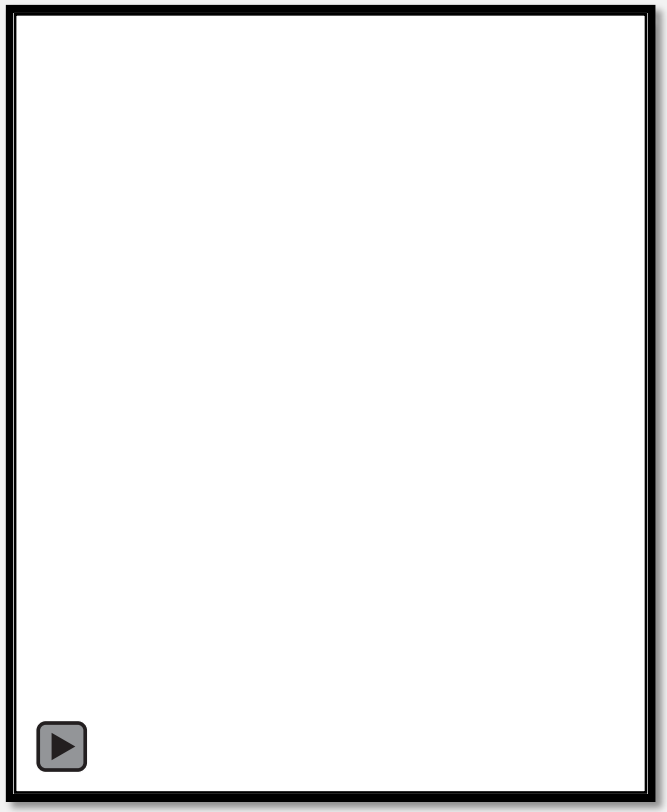
- Zero-Sum Game: Winners/Losers
  - Low-acuity Rehab (L)
  - Medicaid, No Part B (L)
- Cottage Industries
  - Depression, RT, "Boutique" IV fluids
  - Outsourced MDS

Rate-Elasticity:

- Cost Reporting Impact
- Understand the "Rate sheet"
  - Direct Care Component
  - Price- or Cost-Based
  - Full-House v. Medicaid-Only
  - Neutralization "Spread"

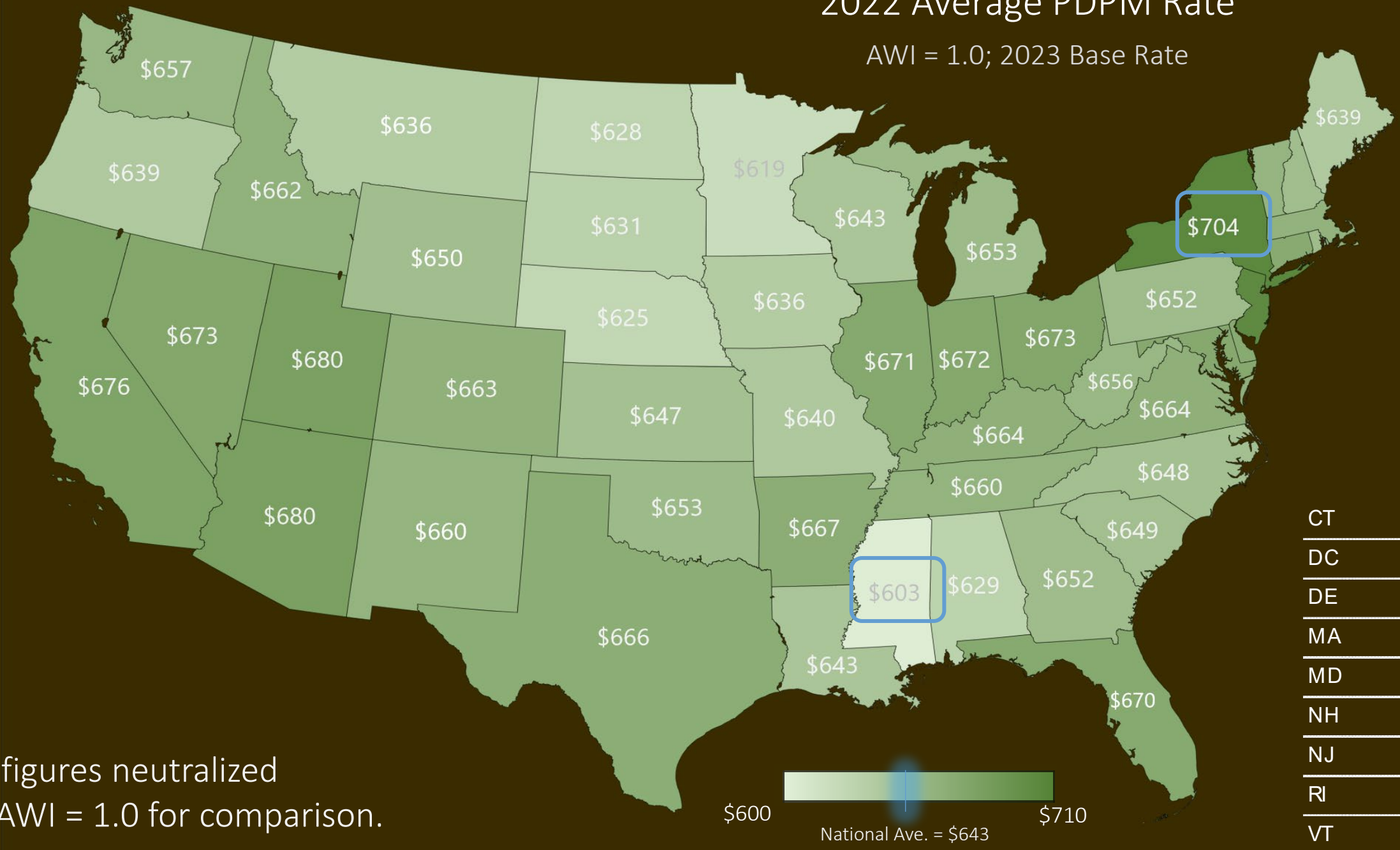
The Rate Elasticity Illusion

- Acuity-Based systems
  - Capture/Documentation
  - Aligned with policy-goals
  - The irony of Rehab RUGs
- Budgeted line-item = “Fixed-Funding”
  - Overages trigger equal offsets across all providers
  - BAF (Medicaid) or Recalibration (Medicare)
- Rate-Construction Politics:
  - Distinctions with no Difference
- “Quality” $ cannot meaningfully change Provider behavior
- The “Medicaid-only” penalty



2022 Average PDPM Rate

AWI = 1.0; 2023 Base Rate



CT	$669
DC	$672
DE	$669
MA	$661
MD	$671
NH	$650
NJ	$702
RI	$651
VT	$659

All figures neutralized
to AWI = 1.0 for comparison.

Medicaid Mispricing

- Accretive, poorly-targeted policy at the state-level perpetuates Mispricing
  - State Reimbursement dept atrophy
  - One-size fits all
  - Rate freeze
  - “Rate Shock”
  - Accretive Regs

NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF AGING SERVICES

2023!

RESPONDENTS.

Myers & Stauffer was contracted for cost report work. FY14 was the last year where rates were paid based on Cost Reports. Since 2014 DHS has abandoned the process of requiring nursing home Medicaid cost reports to be filed allowing individualized adjustments to nursing home rates from year to year. Instead, nursing homes in general have had their 2013 published Medicaid rate frozen in time due to the absence of staff and data collection used to set the underlying components of nursing home rates.

State-Specific Quality Incentive Programs

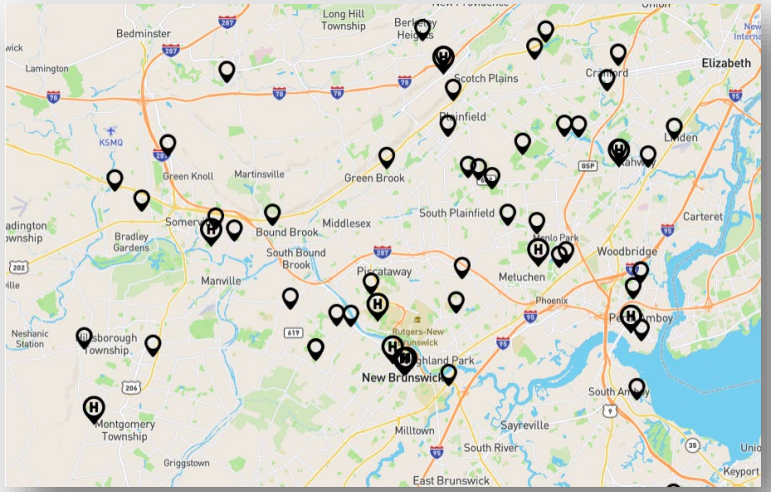
- Trend of state-specific quality programs that have material rate add-ons expected to continue
- Example #1: Illinois
  - $68M in funding allocated on an annual basis
  - Derived from long-stay MDS quality measures w/ additional dollars for staffing
  - 5-Star gets you another $8.65/day (tiered down from there) w/ 1-Star & SFF ineligible
- Example #2: Florida
  - $308M in funding allocated on an annual basis
  - Combination of long-stay MDS QMs, staffing, overall Five-Star rating & credentialing awards
  - Up to $56.35 per Medicaid day for top performers w/ bottom 20th percentile ineligible

A Tale of 3 Counties

Somerset, Union, Middlesex: Medicaid rates range by $47

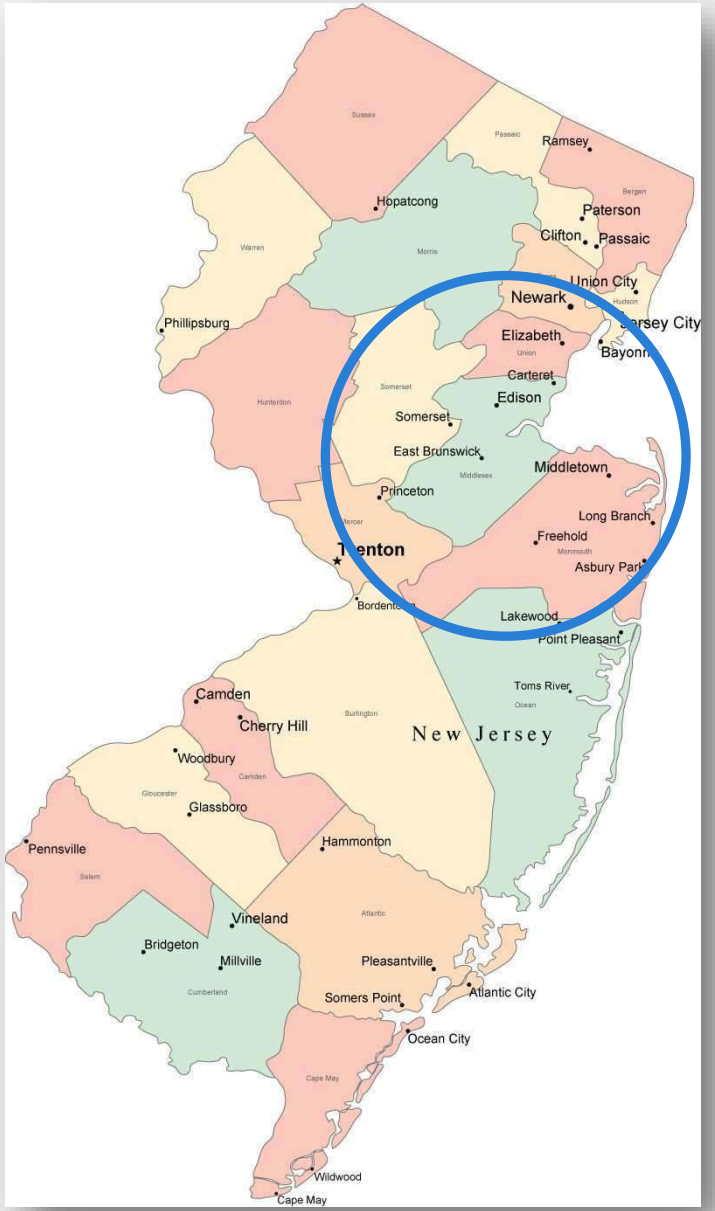
Rates frozen since 2014

County	SNFs	Beds	Average	High	Low
Middlesex	23	165.4	$243.10	$274.53	$221.54
Somerset	12	166.3	$242.86	$253.74	$226.22
Union	19	160.4	$236.88	$253.60	$220.06



2023 Medicare AWI

Middlesex:	1.0877
Somerset:	1.0877
Union:	1.0931



AWI: The October Suprise

- Major Mispricing from the Medicare Area-Wage Index
- Based on Hospital Cost Report data
- 2002: Congress instructed CMS to implement SNF-specific Index (CMS says it lacks resources to audit SNF cost reports)
- MedPAC: Recommends AWI system changes to benefit SNFs:
  - 5%+ change: 11% Decrease 27% Increase
- Hospital Geographic Reclass (66% in 2022; 40% in 2007)
  - SNFs excluded

2024 AWI: Arbitrary Wage Index

		AWI / Average $PPD			Change
		2022	2023	2024	2023 - 2024
CBSA/AWI	13380	1.2296	1.1777	1.2999	10.4%
Whatcom	**WA**	$729.99	$726.59	$814.06	**$87.47**
CBSA	39540	0.951	0.8814	0.9931	12.7%
Racine	**WI**	$606.74	$591.22	$667.71	**$76.48**
CBSA	28740	0.9708	0.996	1.0911	9.5%
Kingston	**NY**	$615.52	$643.57	$714.45	**$70.88**

Visit eCapIntel's AWI trend analysis here

2024 AWI: Arbitrary Wage Index

		AWI / Average $PPD			Change
		2022	2023	2024	2023 - 2024
CBSA	27060	1.0862	1.103	0.9288	-15.8%
Ithaca	**NY**	$666.56	$692.48	$637.03	**-$55.45**
CBSA	39740	0.9942	0.9929	0.8938	-10.0%
Reading	**PA**	$625.86	$642.18	$620.35	**-$21.83**
CBSA	16180	0.7743	0.8958	0.8248	-7.9%
Fort Knox	**KY**	$528.55	$597.80	$587.41	**-$10.38**

Visit eCapIntel's AWI trend analysis here

Medicare Part A PDPM Rate Update

Component	Top 10% of Providers	CORE Average	Bottom 10% of Providers	Difference Top-Bottom ($)	Difference Top-Bottom (%)	Change from Last Year
PT/OT	$177	$179	$176	$1	**0.6%**	-70.7%
SLP	$54	$46	$43	$11	**25.6%**	-4.1%
Nursing	$242	$206	$165	$76	**46.1%**	-0.6%
NTA	$155	$129	$107	$48	**44.5%**	-4.9%
NCM	$103	$103	$103	-	-	-
Total	**$730**	**$662**	**$594**	**$136**	**22.9%**	-4.5%

Source: CORE Analytics database; January 2023-June 2023; rates displayed at AWI=1

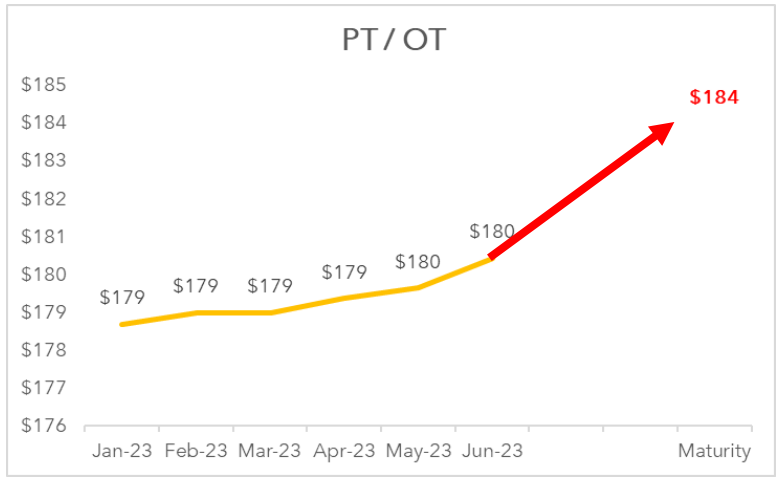
Medicare Rate Calculation - CBRE

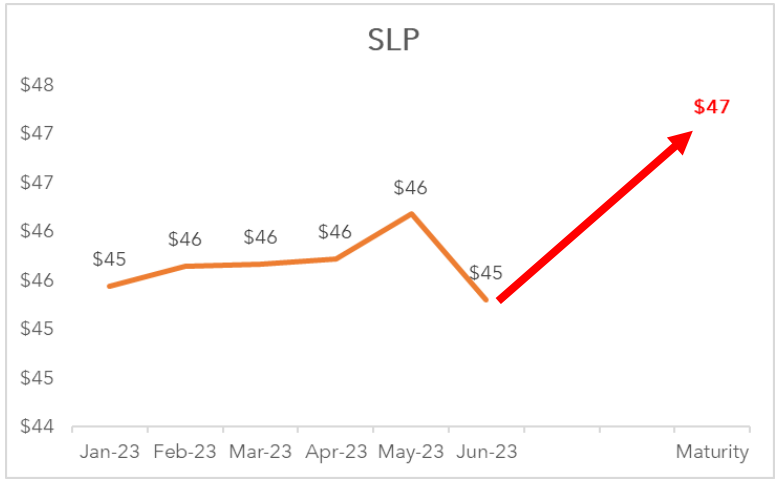
Monthly Medicare Rate											
Period	Revenue	Days	Rate	Labor %	Labor Rate	22 Wage Index	23 Wage Index	Difference	Adjusted Labor	Non Labor	Adjusted Rate
Jul-22	$767,298	1,097	$699.45	70.4%	$492.41	1.0939	1.0423	0.9528	$469.19	$207.04	$676.22
Aug-22	743,317	1,117	665.46	70.4%	$468.48	1.0939	1.0423	0.9528	$446.38	$196.98	$643.36
Sep-22	728,827	1,128	646.12	70.4%	$454.87	1.0939	1.0423	0.9528	$433.41	$191.25	$624.67
Oct-22	652,916	970	673.11	70.8%	$476.56	N/A	1.0423	1.0000	$476.56	$196.55	$673.11
Nov-22	538,201	802	671.07	70.8%	$475.12	N/A	1.0423	1.0000	$475.12	$195.95	$671.07
Dec-22	714,701	955	748.38	70.8%	$529.85	N/A	1.0423	1.0000	$529.85	$218.53	$748.38
Jan-23	703,801	1,043	674.78	70.8%	$477.75	N/A	1.0423	1.0000	$477.75	$197.04	$674.78
Feb-23	538,980	802	672.04	70.8%	$475.81	N/A	1.0423	1.0000	$475.81	$196.24	$672.04
Mar-23	710,043	1,048	677.52	70.8%	$479.69	N/A	1.0423	1.0000	$479.69	$197.84	$677.52
Apr-23	691,392	1,070	646.16	70.8%	$457.48	N/A	1.0423	1.0000	$457.48	$188.68	$646.16
May-23	598,768	884	677.34	70.8%	$479.56	N/A	1.0423	1.0000	$479.56	$197.78	$677.34
Jun-23	651,371	949	686.38	70.8%	$485.95	N/A	1.0423	1.0000	$485.95	$200.42	$686.38
Trailing 12-Months	$8,039,614	11,865	$677.59							T12 Mean	$672.59
Trailing 6-Months	$3,894,354	5,796	$671.90							T6 Mean	$672.37
Trailing 3-Months	$1,941,530	2,903	$668.80							T3 Mean	$669.96

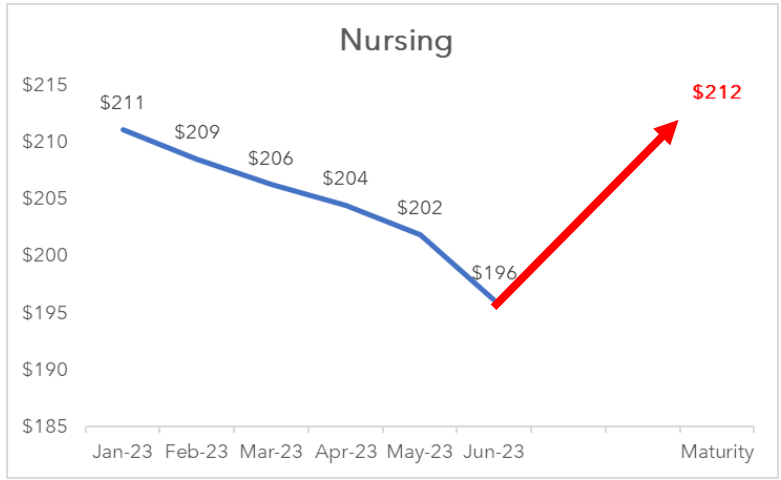
Medicare Rate Tables - CBRE

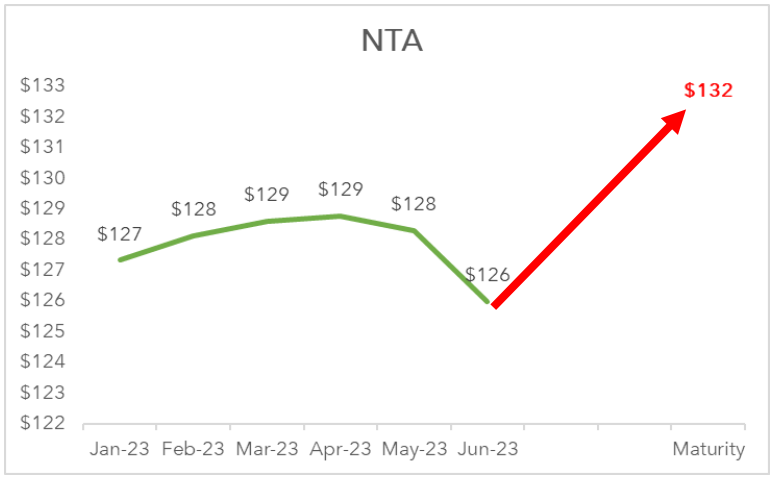
Medicare PDPM Revenue Analysis		
Jul-Sep 2022 Revenue		$2,165,075
Total Adjusted Revenue Before Oct 2022		$2,165,075
Plus FY 2023 Funding Increase		1.0280
Adjusted Revenue		$2,225,697
Revenue After 10/1/2022		5,800,172
Total Revenue After FY 2023 Funding Increase		$8,025,868
Divided by Total Days		11,865
Adjusted FY 2023 Medicare Rate		$676.43
FY 2023 Wage Index	1.0423	
FY 2024 Wage Index	1.0530	
Difference	1.0103	
Labor Portion of Rate (71.0% of total rate)	480.27	
Labor Portion of Rate Change	485.20	
Wage Index Difference		$4.93
Adjusted Rate for 2024 Wage Index		$681.36
2024 Funding Increase (4.0% Increase)		1.0400
Correlated Rate		**$708.62**

PDPM Rates Expected to Continue to Prosper



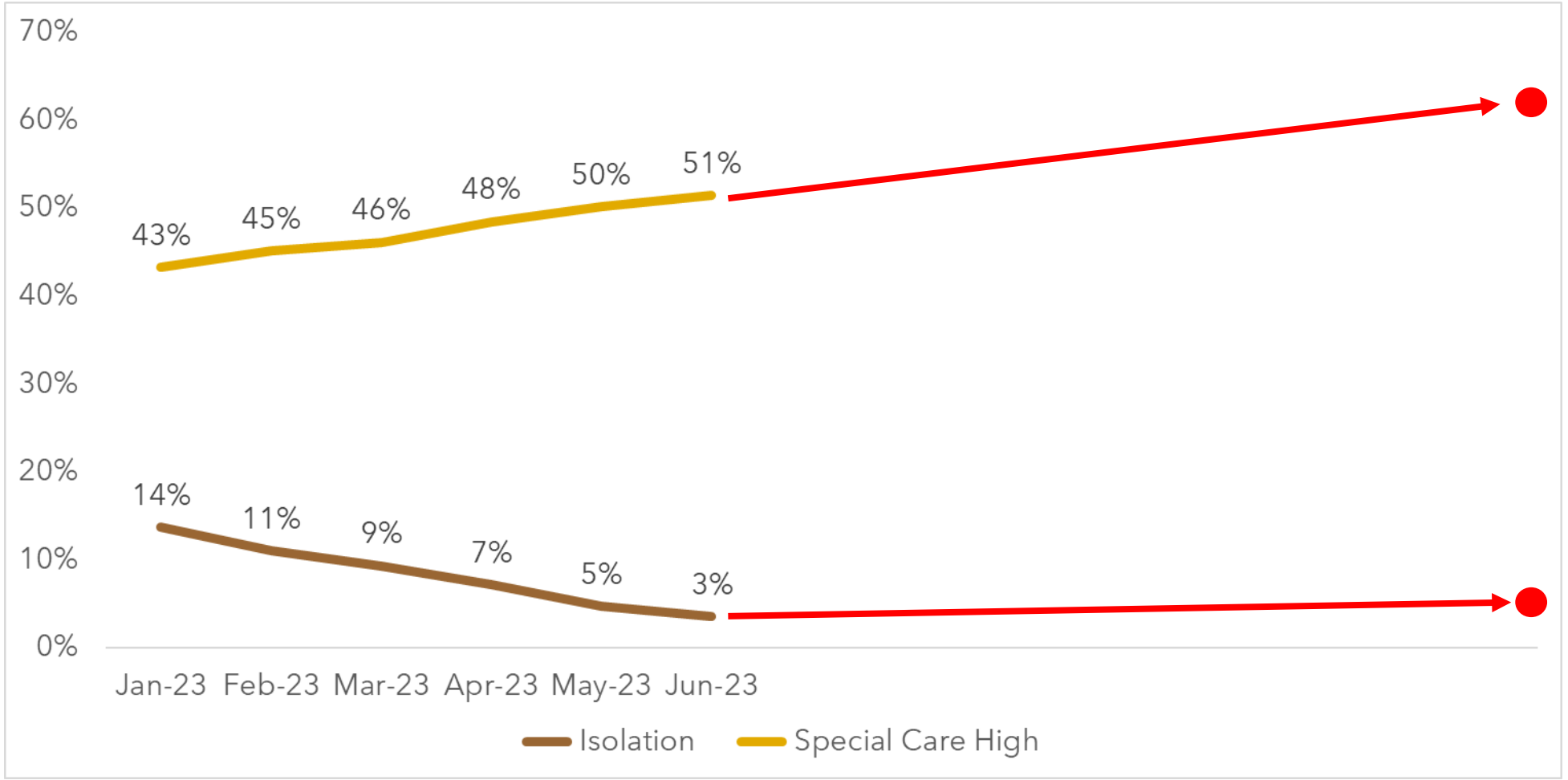




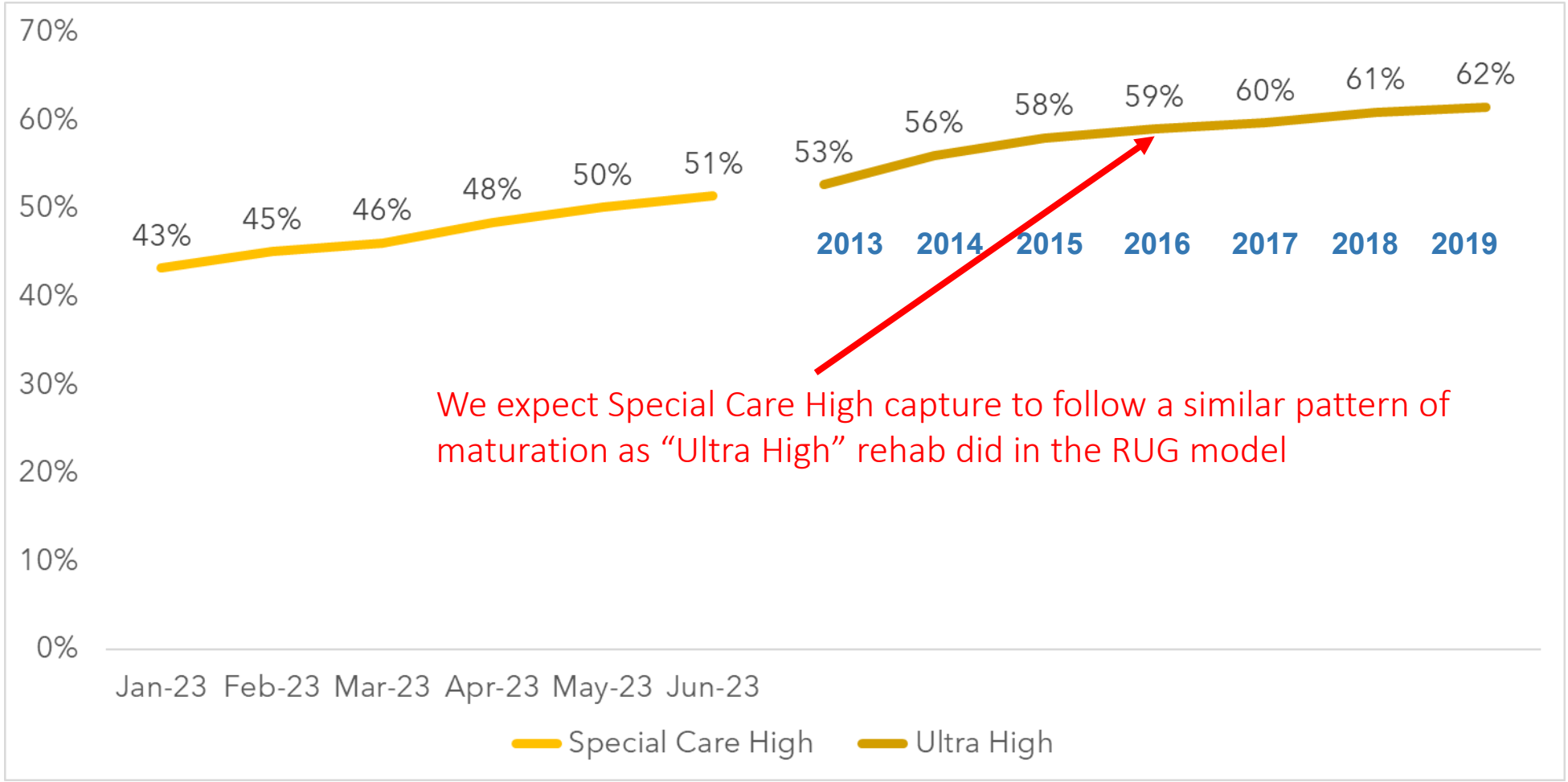


Source: CORE Analytics

Predicted Evolution of Nursing Component



History Repeats Itself?



Special Care High and Depression

Special Care High Capture

Depression Capture	20%	30%	40%	50%	60%	70%
0%	$170	$174	$179	$184	$189	$194
25%	$172	$178	$183	$189	$195	$201
50%	$174	$181	$188	$195	$202	$209
75%	$176	$184	$192	$200	$208	$216

PHQ-2 Leads to The Great Depression?

- ~29% current depression capture in t-6 (CORE)
- About 1/4 of facilities with 0% capture
- PHQ-2 changes take effect 10/1/23
- Simple LTC Analysis
  - About 2 million MDS assessments analyzed
  - 18.2% of current assessments capturing the depression end-split would be voided w/ the PHQ-2 change

The End of the 1135 Waiver

- COVID waiver in-place for 3+ years ended on May 11, 2023
- Preliminary data suggests 10-14% drop in Part A utilization
  - Not yet statistically valid sample (1,450-like facilities in April v. June 2023 billing)
  - Does not account for seasonal differences in Part A admissions or other causes
  - Will impact Part A rate projections as ~15% of recent waiver claims were for isolation
- End of the waiver will have significant implications across the ecosystem
  - Strong negative for operators as waiver days subsidized occupancy losses
  - Strong positive for ISNPs as provider pressure for skilled days is reduced
  - Slight positive for Medicaid case-mix as higher acuities to be captured
- Implications for future PDPM recalibration methodology & possible grouper changes

Medicare formula change to bring $14.8 million reimbursement boost for GLOW hospitals

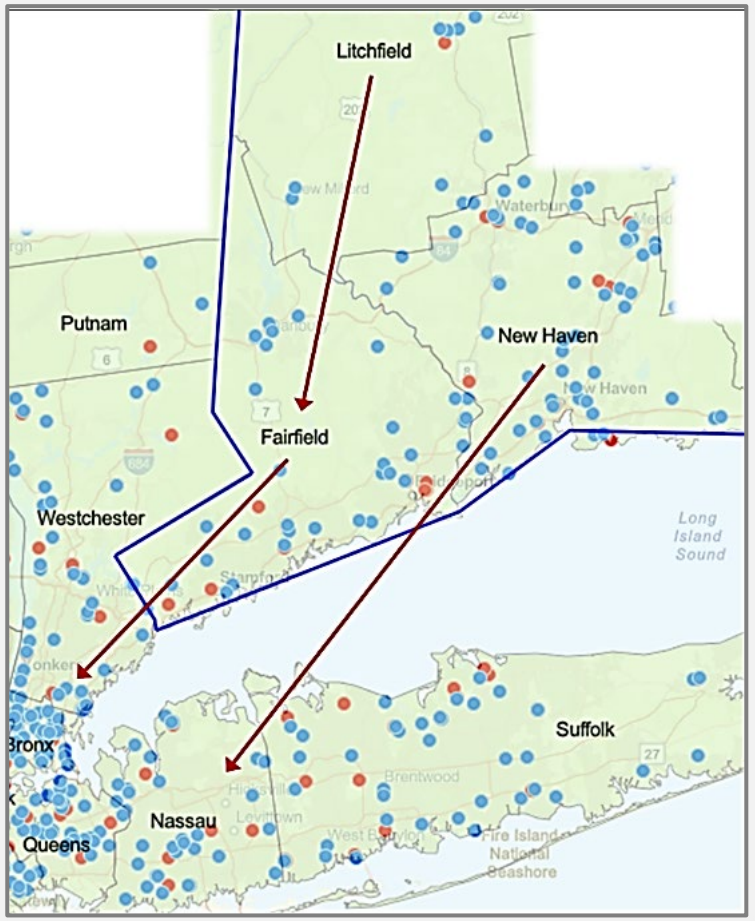
Rule change will reimburse $14.8M to GLOW region facilities

By JULIE ABBASS and BEN BEAGLE
news@batavianews.com May 8, 2023

Courtesy of Sen. Schumer's Office Sen. Charles E. "Chuck" Schumer, D-N.Y., speaks during an October 2022 appearance at Nicholas H. Noyes Memorial Hospital in Dansville.

A new federal rule in the works will give many GLOW region hospitals a major financial boost in the reimbursements they receive from Medicare for wage payments.

Litchfield:	1.0087
Fairfield:	1.1806
Fairfield:	1.1806
Bronx:	1.3755
New Haven:	1.1353
Nassau:	1.3354



Most CT Hospitals granted Reclassification exceptions; SNFs are ineligible.

Hospitals in upstate Rural NY receive special Congressional allowance to jump from 0.8476 to 1.2200 (the SNF equivalent of $641 to $785 PPD).

Is it even about Medicare anymore?

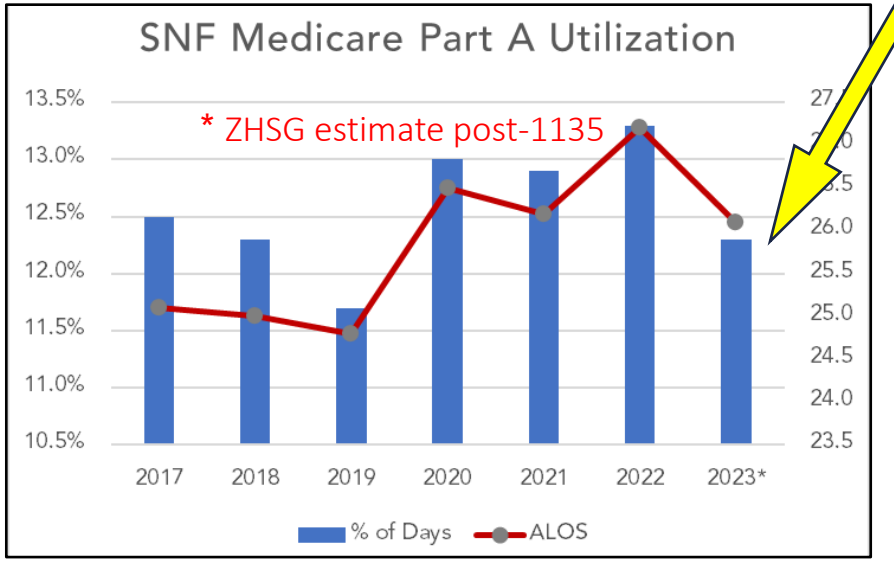
- 1135 Waiver extensive use
  - 18% of 2022 Medicare days
  - Differs by state
- Medicare is being cannibalized
  - Medicare Advantage
  - CMMI: ACOs, Bundles, LTC pilot
- Quality / VBP cannot spark meaningful provider behavior change without being self-defeating
- Fully-Integrated Dual-Advantage plans will likely emerge as the standard configuration

PHE-QHS-SNF Analysis

10/1/21 - 9/30/22

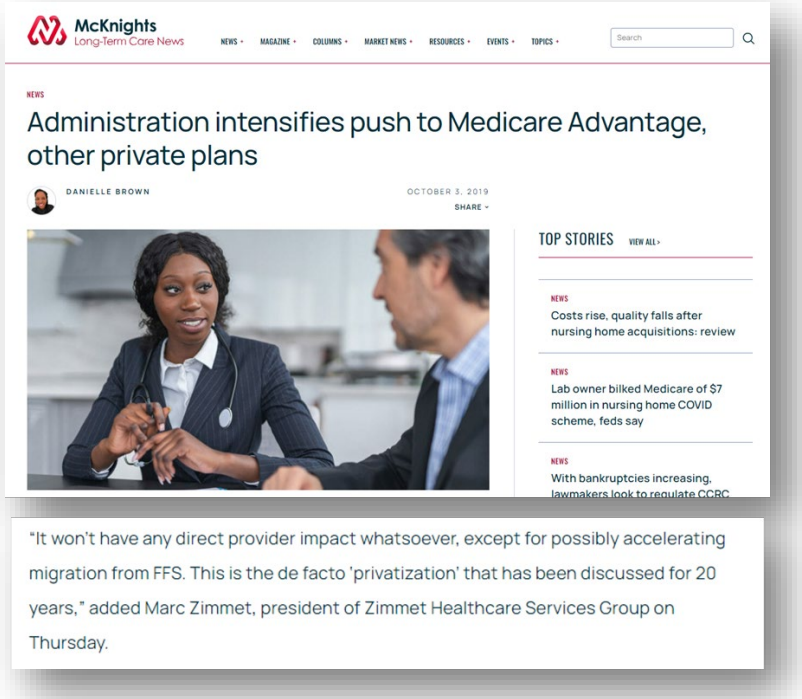
State	Utilization		Total	% of
	Admits	Days	SNF Days	Total
New Jersey	16,080	420,201	1,973,076	21.3%
Michigan	8,282	171,766	1,105,369	15.5%
Virginia	8,184	203,296	1,229,328	16.5%

Source: CMS LDS; provided by Simple; contextualized by Zimmet Healthcare/eCapIntel



Managed Care Derivatives / Privatization

- Medicare & Medicaid (MA, MMLTC)
- Politics, but coordinated benefit & RISK are inevitable



McKnights Long-Term Care News

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NEWS

Administration intensifies push to Medicare Advantage, other private plans

DANIELLE BROWN OCTOBER 3, 2019

SHARE

TOP STORIES VIEW ALL

NEWS
Costs rise, quality falls after nursing home acquisitions: review

NEWS
Lab owner bilked Medicare of $7 million in nursing home COVID scheme, feds say

NEWS
With bankruptcies increasing, lawmakers look to regulate CCRC

"It won't have any direct provider impact whatsoever, except for possibly accelerating migration from FFS. This is the de facto 'privatization' that has been discussed for 20 years," added Marc Zimmet, president of Zimmet Healthcare Services Group on Thursday.

Skilled Nursing News

MEDICARE ADVANTAGE

‘Medicare is Being Privatized’: Why Medicare Advantage May Make PDPM Irrelevant for Nursing Homes

By **Alex Spanko** | March 3, 2020

“It’s happening organically,”” Marc Zimmet, president of reimbursement consulting firm Zimmet Healthcare Services Group, said during a presentation at the eCap health care summit in Florida last month. “It’s happening: Medicare is being privatized by Medicare Advantage, any way you slice it.”

For instance, in Zimmet’s home state of New Jersey, total Medicare Advantage penetration sat at 28% in 2019, according to data from the Kaiser Family Foundation.

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MedPAC 2023: Medicare *DIS*-Advantage

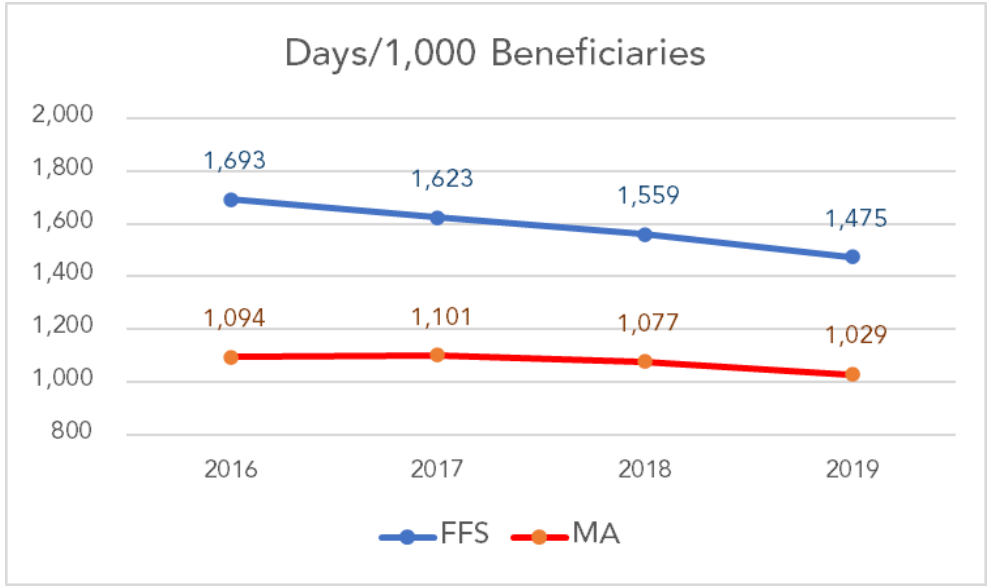
Over the 35-year history of private plan contracting in Medicare, benchmark policy has not attained an appropriate balance of benefits for enrollees, payment adequacy for plans, and responsible use of taxpayer dollars that fund the program. The current benchmarks that determine payments to Medicare Advantage plans have resulted in a very robust MA program with respect to plan participation, beneficiary enrollment, and the value of extra benefits provided to enrollees. But, in spite of the apparent relative efficiency of MA, no iteration of private plan contracting has yielded net aggregate savings for the Medicare program. The Commission estimates that Medicare currently spends 4 percent more for beneficiaries enrolled in MA than it spends for similar enrollees in traditional fee-for-service (FFS) Medicare.

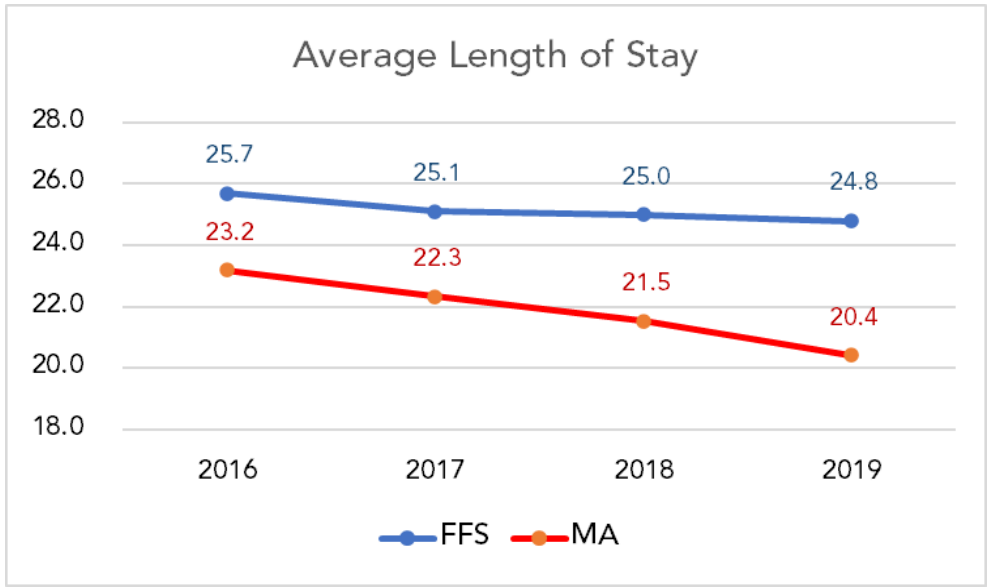
MA Reimbursement Analysis

CBSA	Market		PDPM PPD	MA PPD	Diff.
35614	NYC	NY	$779	$449	42.3%
45300	Tampa	FL	$575	$362	37.1%
37964	Philadelphia	PA	$675	$458	32.1%
31084	Los Angeles	CA	$764	$529	30.8%
35154	Monmouth	NJ	$654	$461	29.6%
26420	Houston	TX	$625	$507	18.9%
16984	Cook	IL	$645	$602	6.6%

- Plan consolidation
- Fragmented SNFs market; Empty beds
- No SNF industry leverage or protection

CORE analytics





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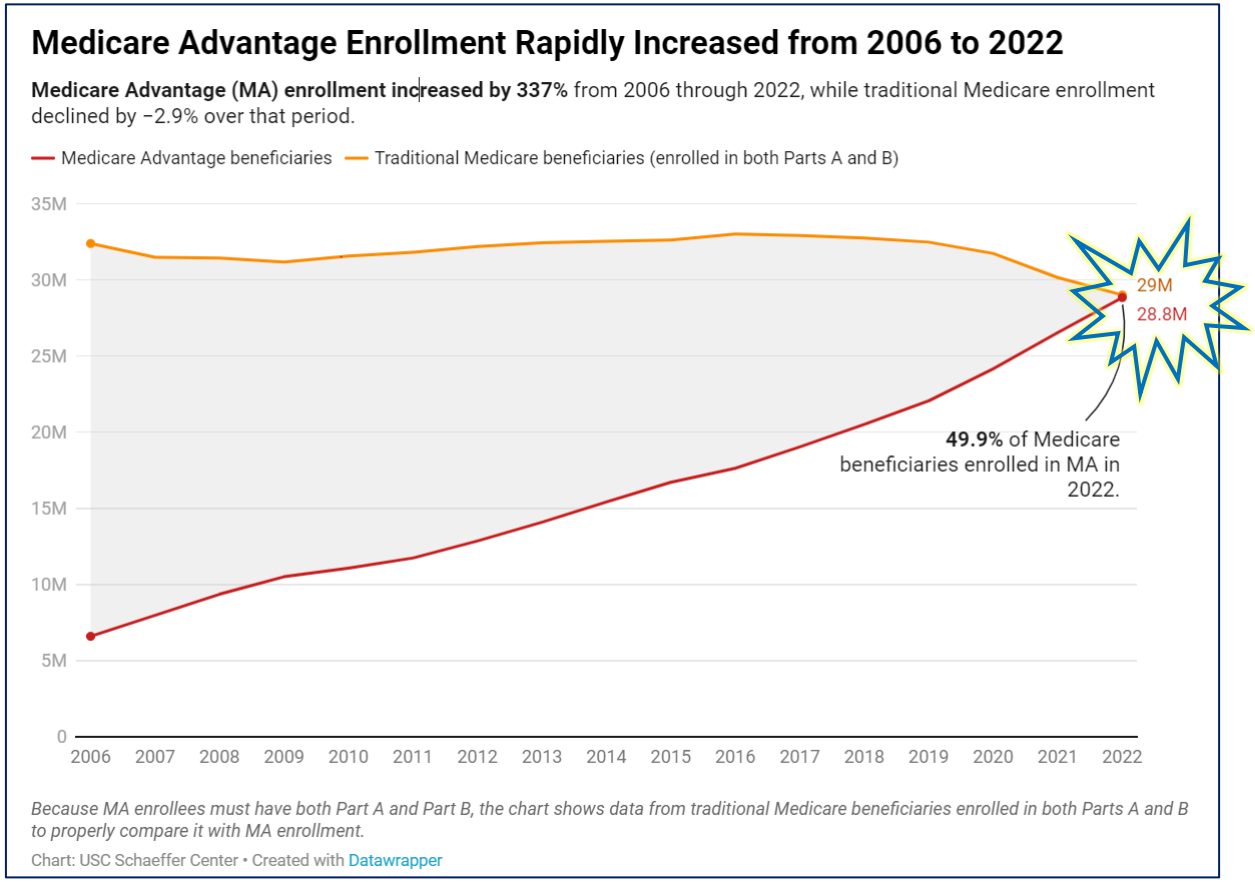
The Tipping Point

- 2002: “Medicare+Choice”
  Plans were exiting markets
- MMA (2003) changed Premium math
- FFS continued robust growth until 2019 (but some states sooner)
- “Medicare Attrition Rate”
  - Incoming Election, Natural Cycle, Established Bene Change
- Why it matters most to SNFs



“No MAs!”

- Fewer SNF admissions
- Lower ALOS & $PPD rate

1% share attrition = $275M annually

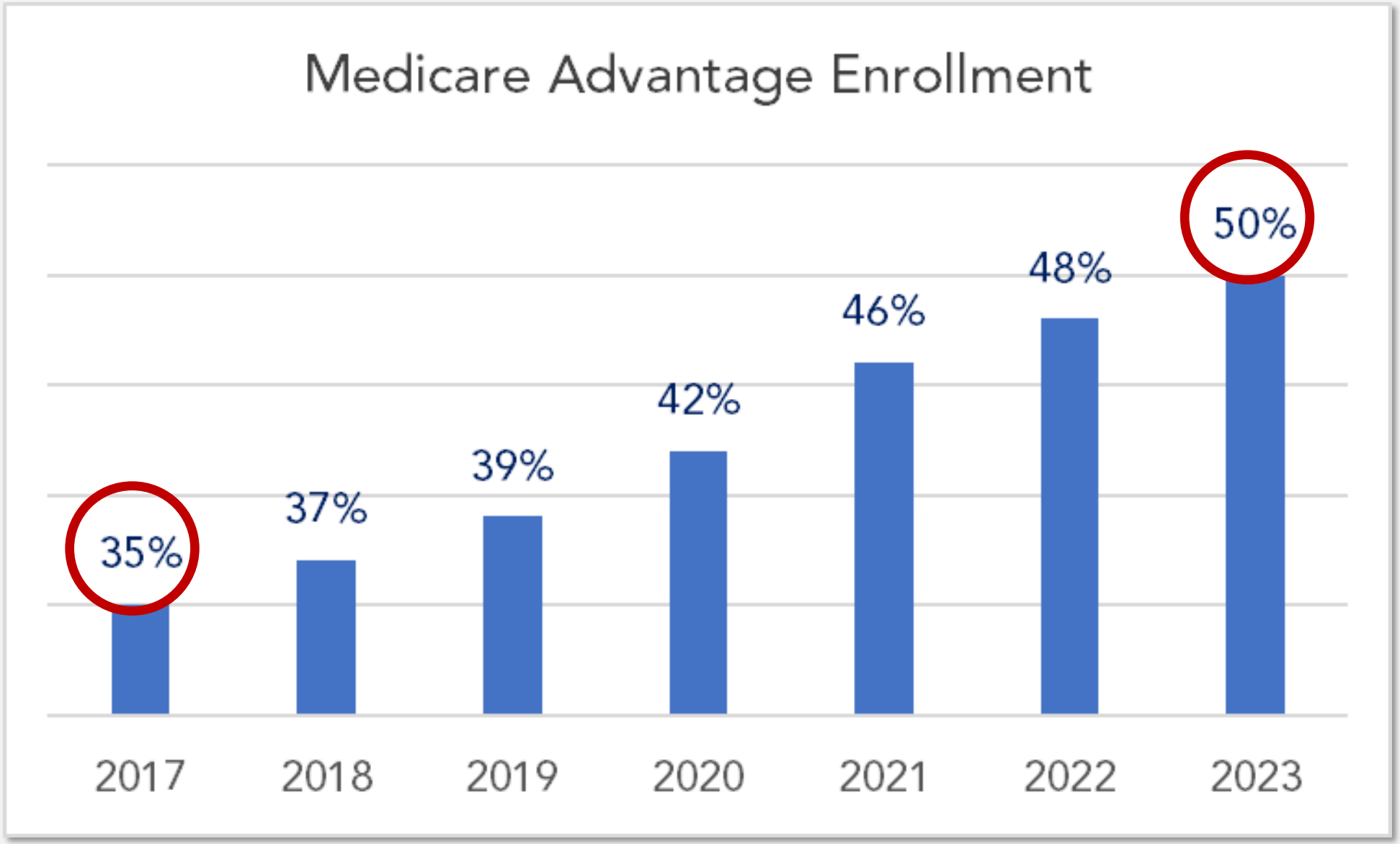
NEWS Gothamist A non-profit newsroom, powered by WNYC.

It's official: NYC inks deal with Aetna on new Medicare Advantage plan for 250K retirees

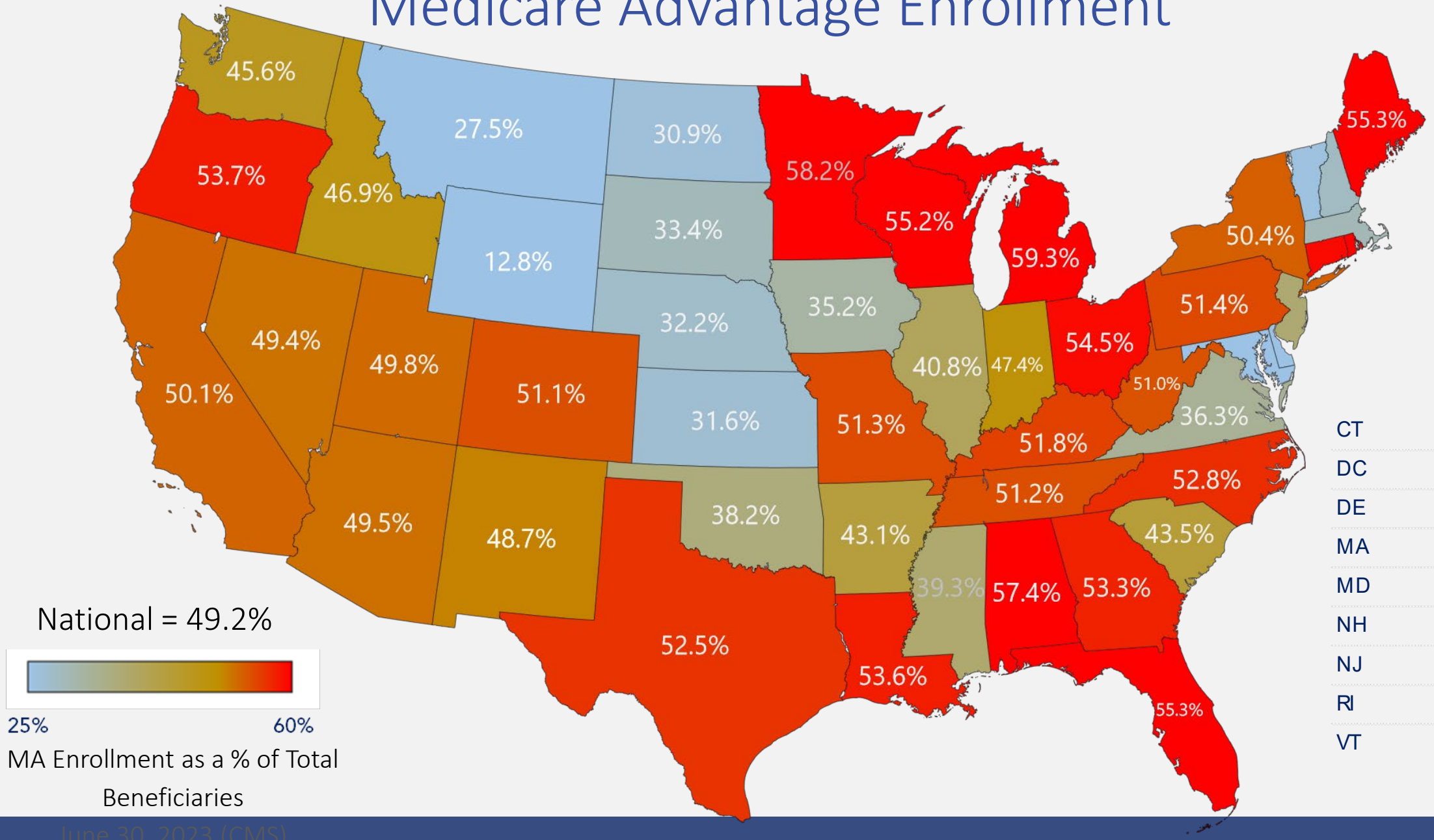
New York, NY		
Trended to 2024	$450	*2024 MBI*
Retirees Shifted	250,000	
SNF Loss / NYC Shift	**$106,250,000**	***per year***

2019 MA Utilization Analysis		
Variable	**FFS**	**MA**
Enrollment Share	37,898,471	22,314,992
SNF Covered Stays	2,069,107	1,150,964
ALOS (days)	24.6	20.4
Average Rate $PPD	$621	$425
SNF Revenue	$31.87B	$10.01B
$/Beneficiary	$841	$448
Spend Difference	**$393**	***Beneficiary per year***

Trended to 2023 Enrollment		
Spend Difference	$425	*MBI @ 2%/year*
2023 Beneficiaries	64,697,030	
1% Shift in Share	646,970	*(e.g., 48% - 49% MA)*
SNF Loss / 1% Shift	**$274,956,945**	***per year***


Medicare Advantage Enrollment
35%
37%
39%
42%
46%
48%
50%
2017
2018
2019
2020
2021
2022
2023

Medicare Advantage Enrollment



National = 49.2%

25% 60%

MA Enrollment as a % of Total Beneficiaries

June 30, 2023 (CMS)

CT	54.5%
DC	31.3%
DE	29.9%
MA	33.7%
MD	21.8%
NH	32.8%
NJ	39.0%
RI	57.6%
VT	30.5%

Medicare Attrition Rate ("MAR")

MAR quantifies MA growth v. FFS deterioration since 1/1/22. Lower values are bad for SNFs. For the 18 months ended June 30, 2023, Medicare grew by 1.72M beneficiaries, but FFS enrollment DECREASED by 1.34M

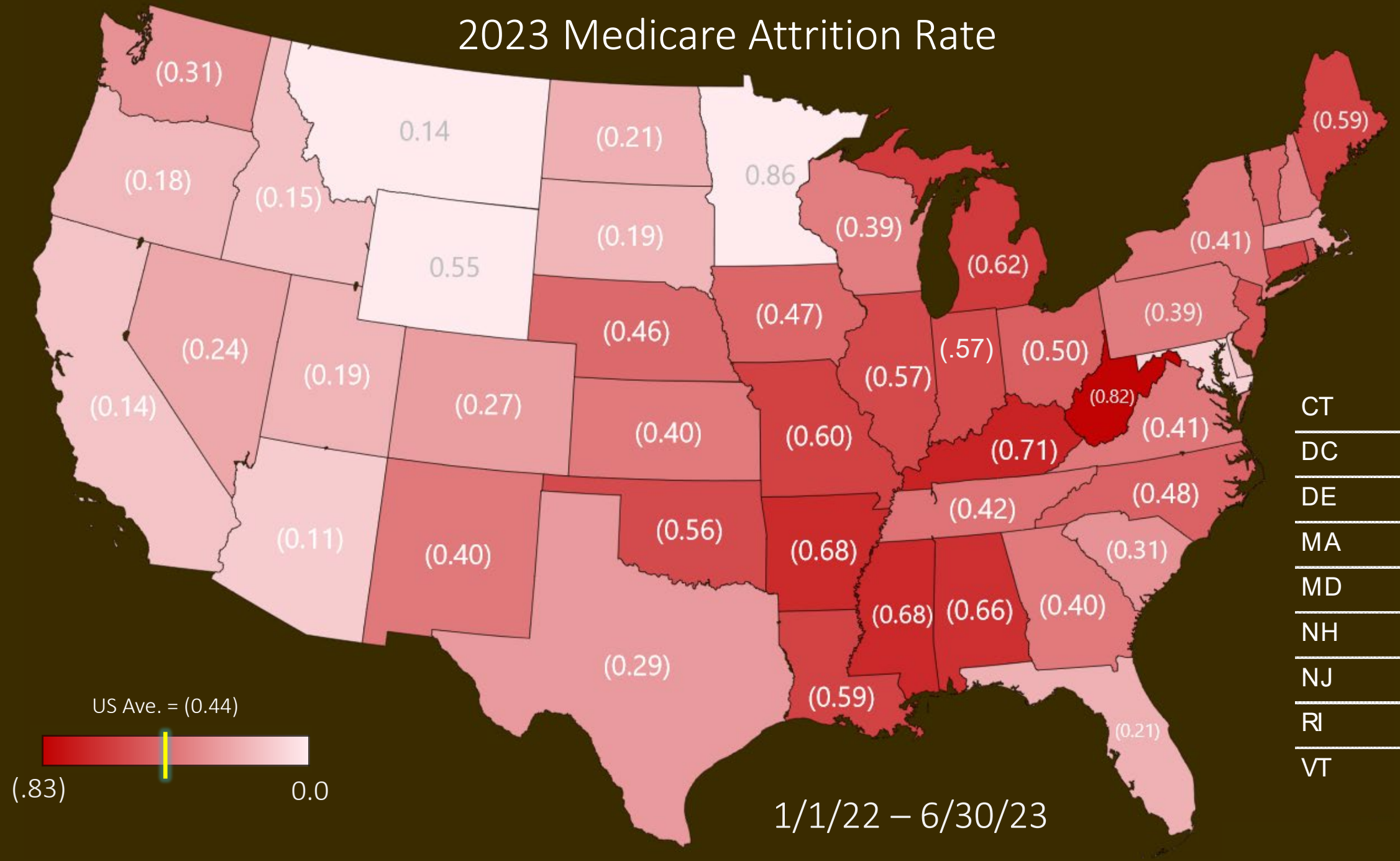
On a net basis, for every 100 new MA elections, FFS dropped by 44

	1/1/2022	6/30/2023	Change
Eligible	62,977,231	64,697,030	1,719,799
FFS	34,584,432	33,239,372	(1,345,060)
MA	28,392,799	31,457,658	3,064,859
MA Share	**45.1%**	**48.6%**	**7.8%**

Medicare Attrition Rate = FFS Change / MA Change

-1,345,060 / 3,064,859 = (0.44)

2023 Medicare Attrition Rate



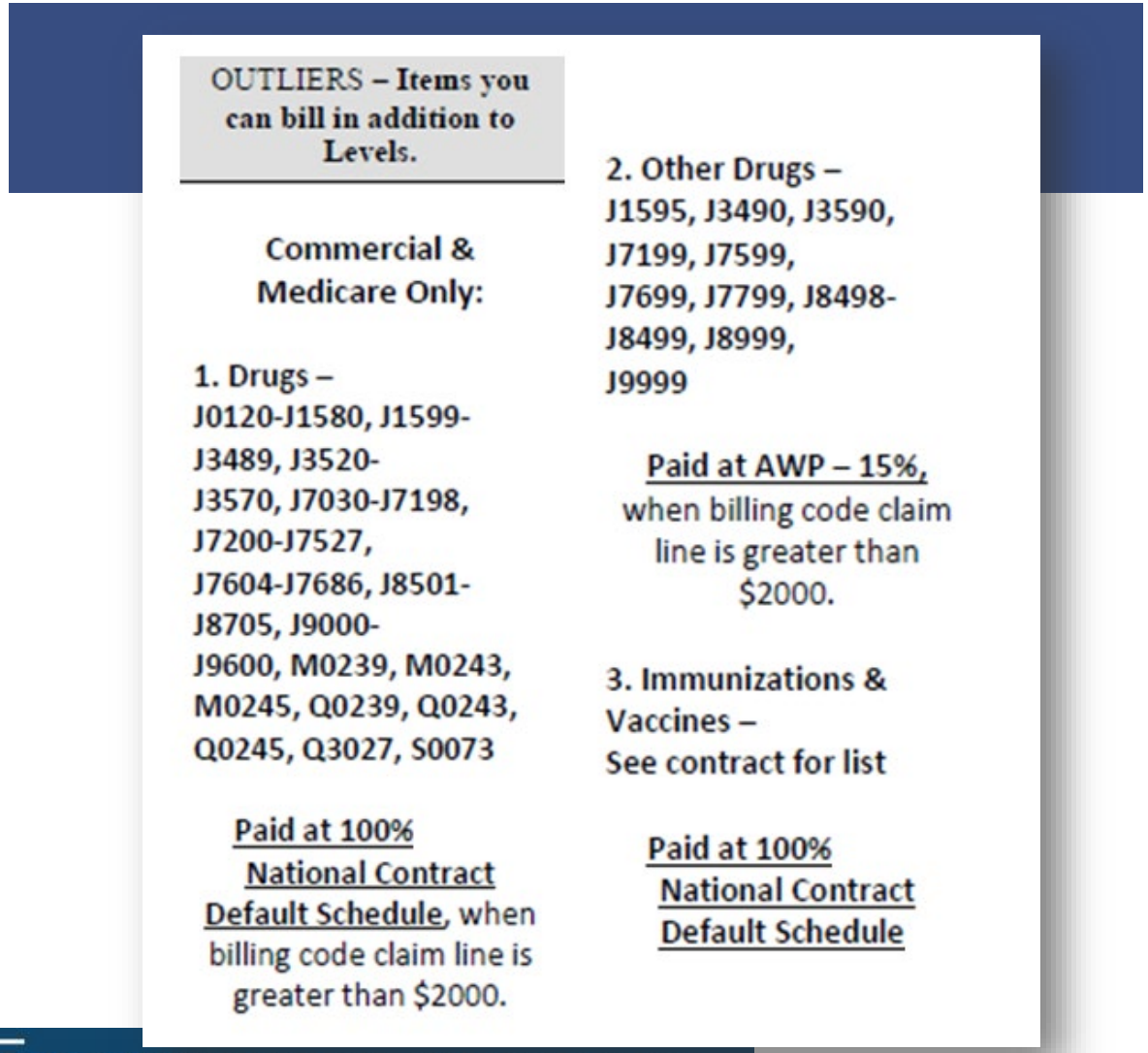
CT	(0.58)
DC	(0.75)
DE	(0.14)
MA	(0.26)
MD	(0.08)
NH	(0.38)
NJ	(0.53)
RI	(0.47)
VT	(0.46)

Medicare Advantage Level-Based Contracts

- Industry average Level 1 capture is 54% but it does not have to be…
  - Providers often “settle” for Level 1 due to lackluster case management process
  - Centralized case management average capture rate of Level 1 is 25-30%
  - Getting Level 2 over 1 equates to the revenue for two additional days
- Approximately 5% of Medicare Advantage admissions had a level increase mid-stay
  - Most common were Level 1 to 2, Level 2 to 3 & Level 1 to 3
  - Median increase of $80 per patient day when there is a level change mid-stay
  - ALOS for these types of admissions is 22.8 days (about 6 days longer than normal)
  - Most prevalent within the other ortho & acute neuro categories & Covid

Medicare Advantage - Carve-outs/Outliers

- Approximately 15% of MA admissions trigger for high-cost medications
- Each approved case generates an additional $1,250-$1,750 of carve-out payment (or $75-100/day in revenue)
- Approval varies based on individual insurance plan
- Proactive identification and authorization process must be in-place



CMI Management Operational Challenges

- Different states have a different approach to handling the transition to PDPM:
  - OSA to kick the can down the road
  - Transitional or phased-in approach to PDPM (forces two-system management)
  - “Frozen” rate period (which should be treated as “live” case-mix period)
  - Ignorance or apathy
- Cross-state CMI comparison has long been impossible:
  - Different payment systems & groupers (RUG, PDPM, Hybrid)
  - Different weighting methods (time-weighted, assessment-weighted)
  - Different case-mix numerical weights
  - Different assessment inclusion criteria

SNF Payment Changes & Impact on HCC RAF Scoring

- Risk adjustment method utilized by CMS to predict resource utilization & adjust payment
- PDPM was “birthed” by Acumen which utilized Part C and Part D risk adjustment models
- Direct correlation between PDPM & HCC RAF scoring for short-term population
- Expected long-term care increases in RAF scoring with state conversions to PDPM for CMI
- Wide-ranging implications for VBC, notably for provider-sponsored ISNP plans
- Providers should know their RAF profile for both short- and long-term populations
- Will most certainly be included within future SNF payment methodology

Broken from the SNF's perspective:

- Major Reimbursement Components
- These are NOT FUNDING issues:
  - Cost Report
  - Case-Mix Adj. ($ + expected staffing)
  - Area Wage Index
  - Medicaid Rate Construction
  - Medicare Advantage
  - Dual Eligible Cost-Sharing
  - CMS Innovation programs
  - Quality Rating Systems

Relative Reimbursement Analysis

Quantifies a SNF's or State's underlying reimbursement situation without distortion from Medicare Part A utilization

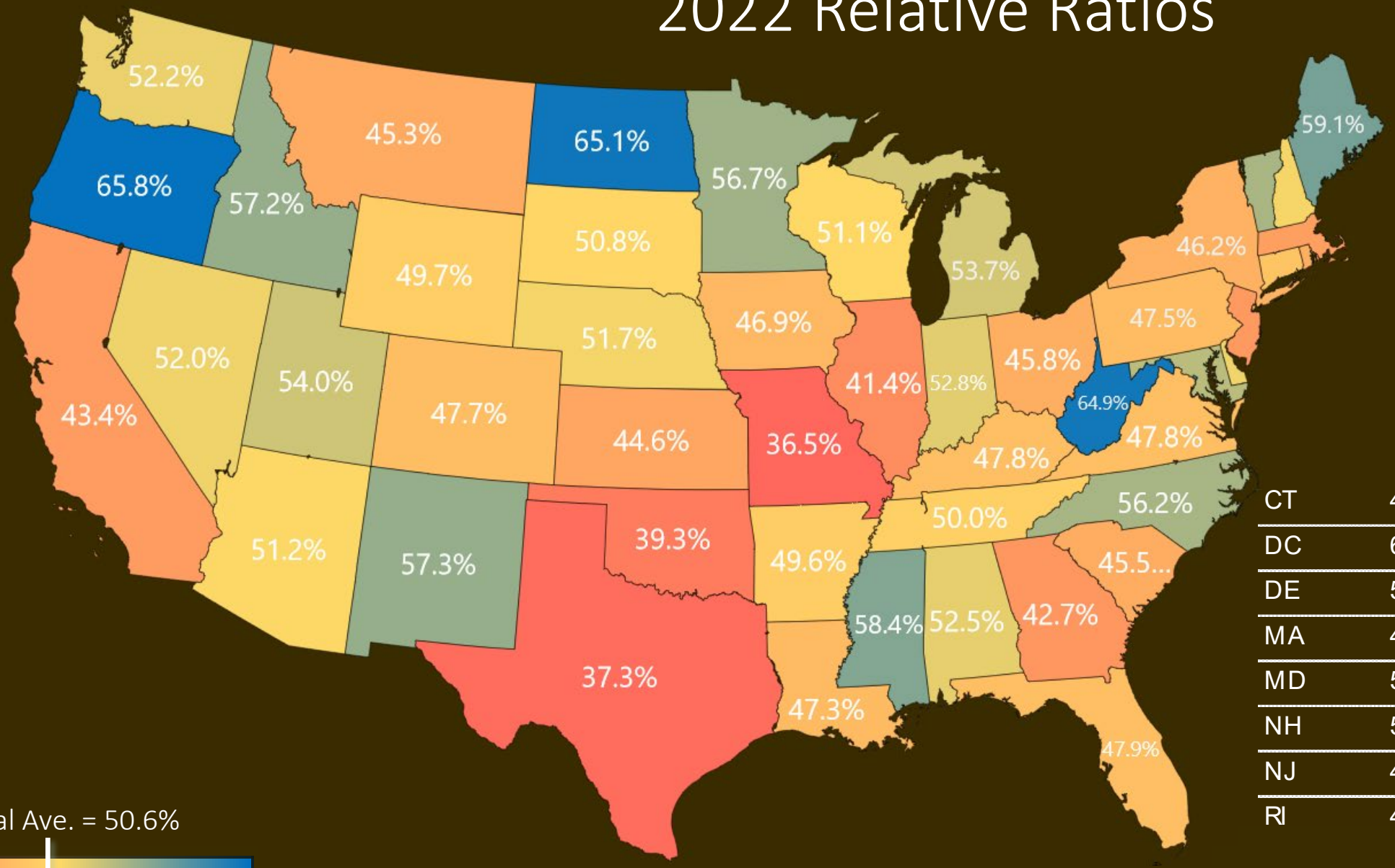
- Removes Medicare Part A from the average $PPD equation
  - Medicare subsidizes inadequate $ from other payers
  - FFS enrollment & utilization are in decline
- Subtract Medicare Part A $ & Days, then:
  - Patient Service Revenue / Days
- Compares SNF performance against local peer group
- Identifies underlying favorability of state R$ environment

Other Patient Service $: Medicaid, Medicare Part B, MA, ISNP, Dual Advantage, VBP, Quality, CMMI Gain Share, Hospice, etc.

MedPAC: Inadequacy of other payers is not CMS' problem, despite its role in Medicare Advantage and Medicaid regulation

2022 Relative Ratios

2022 Relative Ratio Ranking					
1	OR	65.8%	26	TN	50.0%
2	ND	65.1%	27	WY	49.7%
3	WV	64.9%	28	AR	49.6%
4	DC	62.8%	29	CT	48.6%
5	ME	59.1%	30	FL	47.9%
6	MS	58.4%	31	VA	47.8%
7	NM	57.3%	32	KY	47.8%
8	ID	57.2%	33	CO	47.7%
9	HI	56.8%	34	PA	47.5%
10	MN	56.7%	35	LA	47.3%
11	NC	56.2%	36	IA	46.9%
12	VT	56.1%	37	NY	46.2%
13	MD	55.1%	38	RI	45.8%
14	UT	54.0%	39	OH	45.8%
15	MI	53.7%	40	SC	45.5%
16	IN	52.8%	41	MT	45.3%
17	AL	52.5%	42	KS	44.6%
18	WA	52.2%	43	MA	43.9%
19	NV	52.0%	44	CA	43.4%
20	DE	51.9%	45	NJ	43.1%
21	NE	51.7%	46	GA	42.7%
22	NH	51.6%	47	IL	41.4%
23	AZ	51.2%	48	OK	39.3%
24	WI	51.1%	49	TX	37.3%
25	SD	50.8%	50	MO	36.5%
US Average = 50.6%					



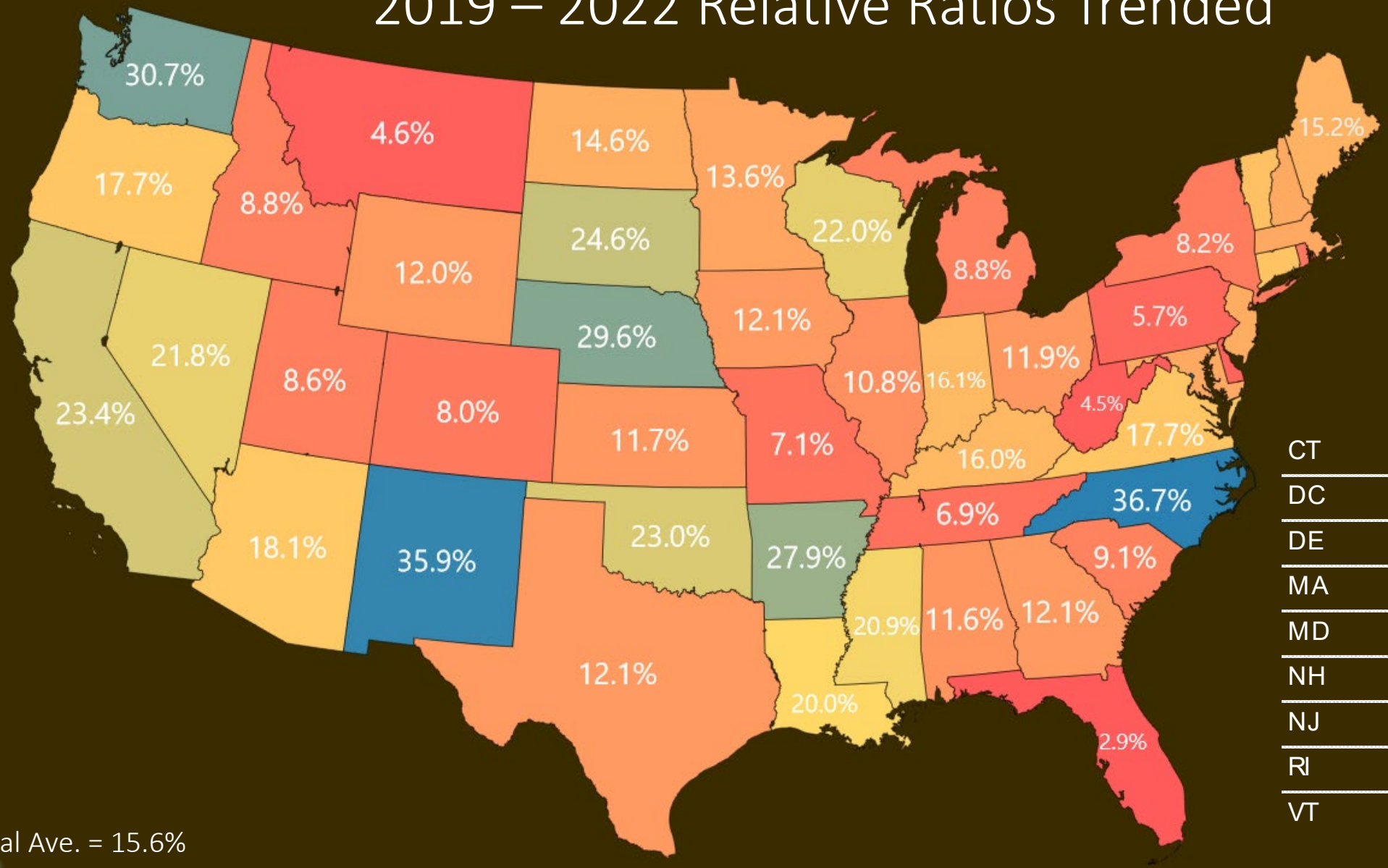
National Ave. = 50.6%

35% 70%

CT	48.6%
DC	62.8%
DE	51.9%
MA	43.9%
MD	55.1%
NH	51.6%
NJ	43.1%
RI	45.8%

2019 – 2022 Relative Ratios Trended

3-Year Relative Ratio Trend					
1	DC	37.3%	26	MD	14.1%
2	NC	36.7%	27	MA	13.9%
3	NM	35.9%	28	MN	13.6%
4	WA	30.7%	29	IA	12.1%
5	NE	29.6%	30	GA	12.1%
6	AR	27.9%	31	TX	12.1%
7	SD	24.6%	32	WY	12.0%
8	CA	23.4%	33	OH	11.9%
9	OK	23.0%	34	KS	11.7%
10	WI	22.0%	35	AL	11.6%
11	NV	21.8%	36	IL	10.8%
12	MS	20.9%	37	SC	9.1%
13	LA	20.0%	38	MI	8.8%
14	AZ	18.1%	39	ID	8.8%
15	OR	17.7%	40	UT	8.6%
16	VA	17.7%	41	NY	8.2%
17	CT	17.5%	42	CO	8.0%
18	HI	17.1%	43	RI	7.7%
19	VT	17.0%	44	MO	7.1%
20	IN	16.1%	45	TN	6.9%
21	KY	16.0%	46	PA	5.7%
22	ME	15.2%	47	DE	5.3%
23	ND	14.6%	48	MT	4.6%
24	NJ	14.5%	49	WV	4.5%
25	NH	14.1%	50	FL	2.9%
US Average = 15.6%					



CT	17.5%
DC	37.3%
DE	5.3%
MA	13.9%
MD	14.1%
NH	14.1%
NJ	14.5%
RI	7.7%
VT	17.0%

National Ave. = 15.6%

4% 40%

Notes & Observations on Performance

- General benchmarks differences not as severe as expected
- Financial performance differences are explained by imbalances discussed in this session

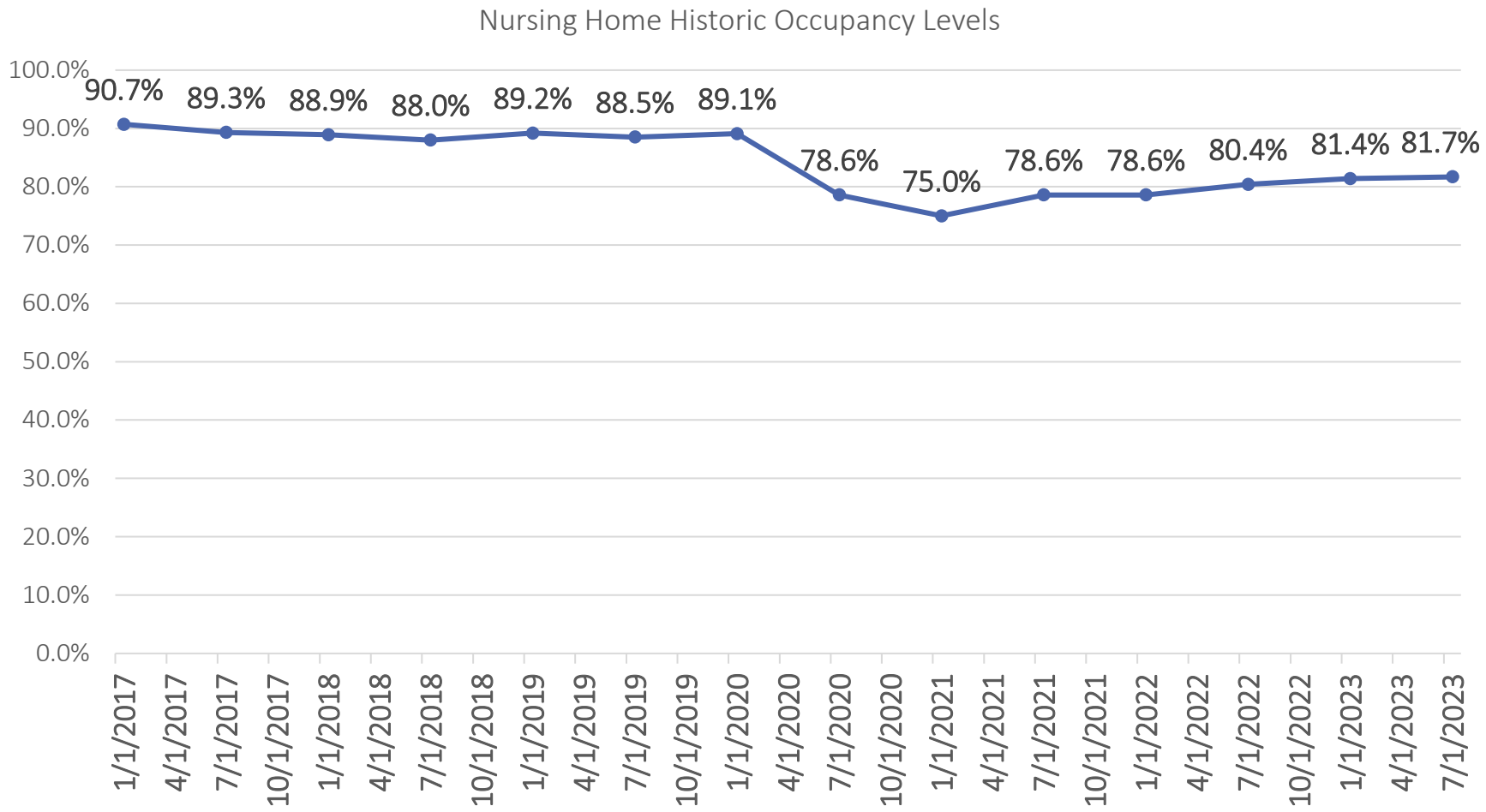
- Most profitable SNFs:
  - Size is most significant variable at high occupancy (but large, low occupancy SNFs also lost the most money)
    - Large enough for partial participation in CMMI, ISNP, etc.
  - Mispriced Medicare AWIs
  - Favorable state Medicaid policies (e.g., Cost Sharing)
  - Aggressive Medicare Part B therapy

Therapy-Driven Revenue

	Attributable Revenue per Minute	
	2019[1]	**2023[2]**
Medicare Part A	$2.50	$0.00
Medicare Part B	$2.10	$2.10
Medicaid CMI[3]	$5.30	$0.00
Managed Care	$1.60	$1.60
Attributable Revenue Per Therapist Caseload	$3.50	$1.45
Attributable Therapy Cost Per Minute	($1.00)	($1.00)
Net Attributable Revenue Per Minute	**$2.50**	**$0.45**

[1]Average caseload 50% Part A, 25% Managed Care, 25% Part B/Medicaid
[2]Average caseload 25% Part A, 25% Managed Care, 50% Part B/Medicaid
[3]Average value per CMI point = $1.00

Nursing Home Historic Occupancy Levels



Nursing Home Closures

- In 2022 AHCA estimated 1,103 nursing homes have closed since 2015.
  - While the pandemic is contributed to some of these closures, nursing facilities closing (especially in rural areas) was becoming an issue prior to the pandemic.
    - As of 2022, 776 nursing homes (400 rural facilities) have closed prior to the pandemic and 327 have closed since the pandemic.
    - Inadequate Medicaid reimbursement
      - Medicaid represents approximately 67% of nursing home patient volume and 50% of nursing home costs; however, on average nursing homes are only reimbursed 70% to 80% of their cost by Medicaid.
    - Operator consolidation
    - Cost of facility upkeep
    - Challenges since the COVID-19 pandemic
      - Loss of occupancy
      - Increased operating costs
      - Staffing shortages

Labor and Staffing Issues

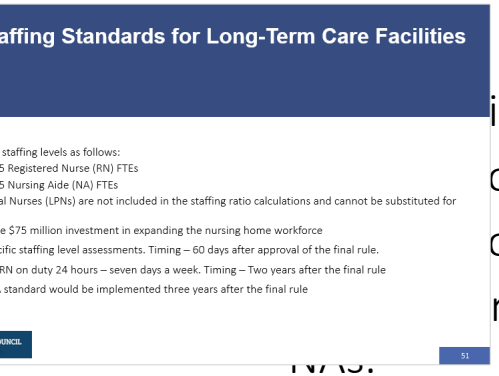
- The COVID-19 pandemic created a staffing crisis in nursing homes that is ongoing.
  - Based on data from the Bureau of Labor Statistics, from March 2020 to June 2022 nursing homes lost approximately 352,400 employees
- No segment of the healthcare industry has lost more employees than the nursing home industry
- AHCA estimated that in July 2022 60% of nursing homes in the US have to limit admissions due to lack of staff.
- Staffing levels did increase 2023. from July 2022 to September 2023 the Bureau of Labor Statistics estimated that nursing homes employment increased by 176,700 employees.
- In January 2023, AHCA estimated the following:
  - 45% of nursing homes indicated that their staffing situation was worse than it was in May 2022.
  - 84 percent are currently facing moderate to high levels of staffing shortages.
  - 96 percent find difficulty in hiring staff.
- Several states have enacted minimum wage increases, which has increased competitiveness with other industries for potential staff.
  - 97 percent of nursing homes surveyed by AHCA indicated that the lack of interested or qualified candidates is a major obstacle to hiring new staff.
- These issues have required nursing homes to adjust their staffing strategies.
  - More than nine out of 10 nursing home providers have increased wages and offered bonuses to try to recruit and retain staff.
  - To adjust for staffing shortages, 78 percent have hired temporary agency staff. This has also resulted in significant increases in staffing costs.

Minimum Staffing Standards for Long-Term Care Facilities

- On September 1, 2023, CMS introduced a proposed rule that would establish minimum staffing standards for long-term care facilities
- CMS Reasons
  - Concerns about the quality care
    - Belief that setting minimum staffing levels will increase the quality of care, prevent elder abuse and improve resident safety.
  - Concerns that high mortality rates during COVID-19 were partially the result of adequate staffing.
    - Recent study completed the National Academy of Sciences, Engineering and Medicine in 2022 stated the following:

    - *"The COVID-19 pandemic "lifted the veil," revealing and amplifying long-existing shortcomings in nursing home care such as inadequate staffing levels, poor infection control, failures in oversight and regulation, and deficiencies that result in actual patient harm."*

Minimum Staffing Standards for Long-Term Care Facilities


affing Standards for Long-Term Care Facilities

staffing levels as follows:
5 Registered Nurse (RN) FTEs
5 Nursing Aide (NA) FTEs
l Nurses (LPNs) are not included in the staffing ratio calculations and cannot be substituted for

e $75 million investment in expanding the nursing home workforce
ific staffing level assessments. Timing – 60 days after approval of the final rule.
RN on duty 24 hours – seven days a week. Timing – Two years after the final rule
standard would be implemented three years after the final rule

51

imum staffing levels as follows:
of 0.55 Registered Nurse (RN) FTEs
of 2.45 Nursing Aide (NA) FTEs
ractical Nurses (LPNs) are not included in the staffing ratio calculations and cannot be substituted for NAs.

- Bill would include $75 million investment in expanding the nursing home workforce

- Phase I - Facility-specific staffing level assessments. Timing – 60 days after approval of the final rule.
- Phase II – Requires a RN on duty 24 hours – seven days a week. Timing – Two years after the final rule
- Phase III – RN and NA standard would be implemented three years after the final rule

Minimum Staffing Standards for Long-Term Care Facilities

- The Comment period to CMS on the proposed legislation was from 9/6/24 to 11/6/24
  - As of 10/30/24 CMS has received nearly 20,000 comments on the proposed legislation
    - Comments from nursing facility associations and trade organizations are predominantly negative.
    - Congress and state leadership are divided on the issue
      - On October 20, 2023, a bipartisan letter from 91 members of congress was sent to President Biden asking his administration to reconsider the proposed legislation
      - On November 6, 2023, a letter from 15 State Attorney Generals and 12 U.S. Senators was sent to President Biden strongly supporting the proposed staffing legislation
    - It is currently unclear if the legislation will be implemented.

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