HEALTHCARE MORTGAGEE ADVISORY COUNCIL

Financing Seniors Housing for America

My Horse is Too Slow!

Tell Me How to Get

My Reimbursement

MY Horse is Too Slow! Tell me how to get my reimbursement!

Ritchie Dickey, CFA
Managing Director

WHITE OAK

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MY Horse is Too Slow! Tell me how to get my reimbursement!

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U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

HEALTHCARE MORTGAGEE ADVISORY COUNCIL

Financing Seniors Housing for America

HUD Hot Topics – Medicare

- Medicare Advantage payors
  - Lower operating margins
- Evaporation of PHE Medicare Waiver stays
  - Rebound to more traditional Medicare stays
- Staffing Requirements
  - Star rating calculation impacts

Medicare Trailing 12 Utilization

Month	Revenue	Days	Avg. Rate
9/2023	$22,024	66	$333.70
10/2023	$40,685	77	$528.38
11/2023	$53,748	101	$532.16
12/2023	$96,246	187	$514.68
1/2024	$136,262	263	$518.11
2/2024	$95,293	187	$509.59
3/2024	$100,984	198	$510.02
4/2024	$82,340	153	$538.17
5/2024	$118,650	224	$529.69
6/2024	$125,474	239	$525.00
7/2024	$123,581	247	$500.33
8/2024	$100,220	216	$463.98
Trailing 12 Months	$1,095,507	2,158	$507.65
Trailing 6 Months	$651,249	1,277	$509.98
Trailing 3 Months	$349,275	702	$497.54

Source: Compiled by JLL

Conversion of 2023 to 2024

Weighted Avg Rate Prior to 9/30/23		$333.70
Non Labor Portion (29%)		$96.77
Labor Portion (71%)		$236.92
2023 Wage Index	0.7255	
2024 Wage Index	0.7541	
Difference	1.0394	
Adjusted Labor		$246.26
Adjusted 23 Rate to 24 For Wage Index		$343.04
2024 Rate Increase		1.040
Adjusted 2023 Rate to 2024		$356.76
2023 Days		66
2023 Adj Revenue to 2024		$23,546

Source: Compiled by JLL

Estimated FY 2025 Medicare Rate

Adjusted 2023 Revenue		$23,546
2024 Revenue		$1,073,483
Total Trailing 12 Adj to 24		$1,097,029
Total Days		2,158
2024 Adjusted Rate		$508.35
Non Labor Portion (29%)		$147.42
Labor Portion (71%)		$360.93
2024 Wage Index	0.7541	
2025 Wage Index	0.8217	
Difference	1.0896	
Adjusted Labor		$393.29
Adjusted 24 Rate to 25 For Wage Index		$540.71
2025 Rate Increase		1.042
Adjusted 2024 Rate to 2025		**$563.42**

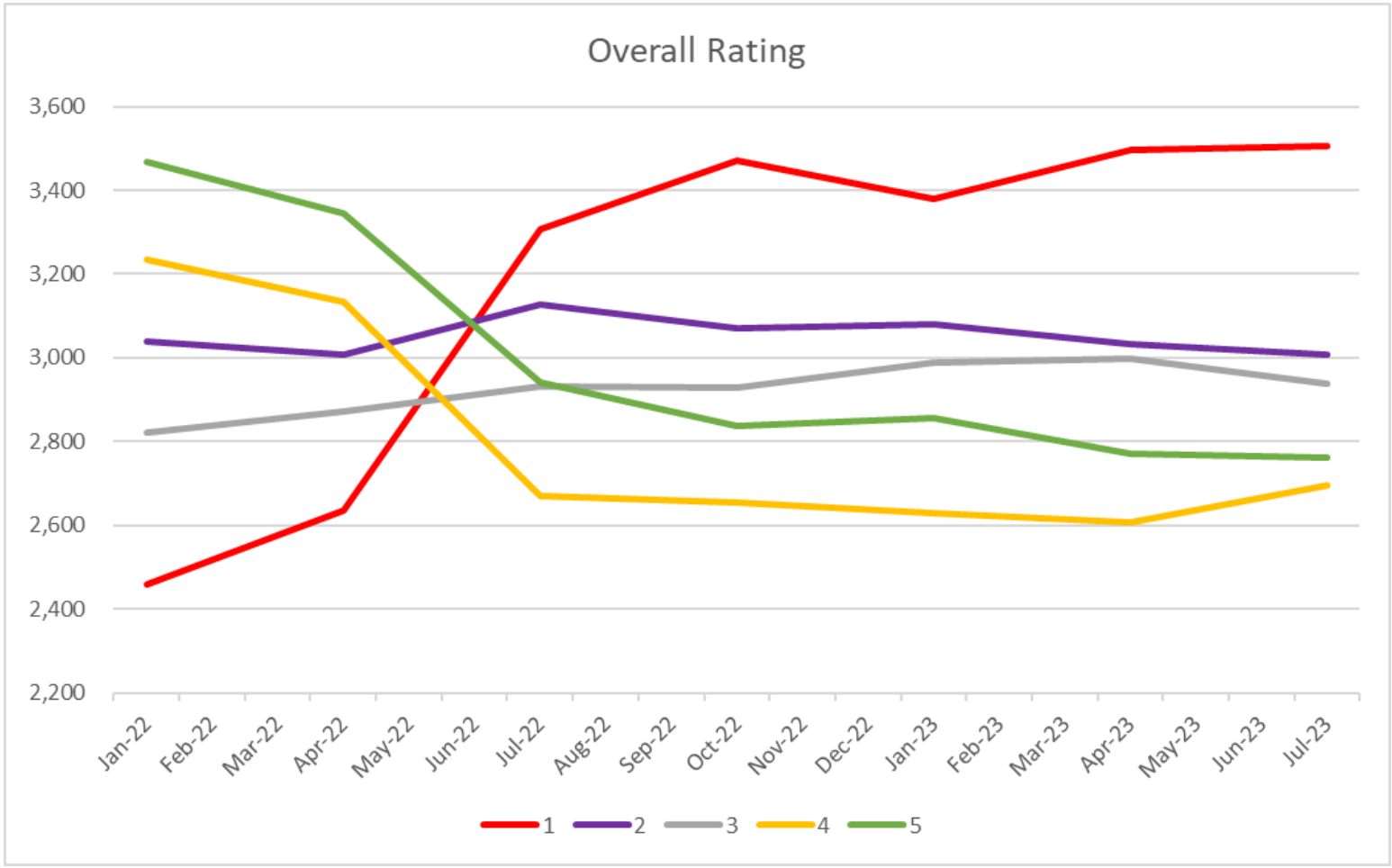
Source: Compiled by JLL

9.0%

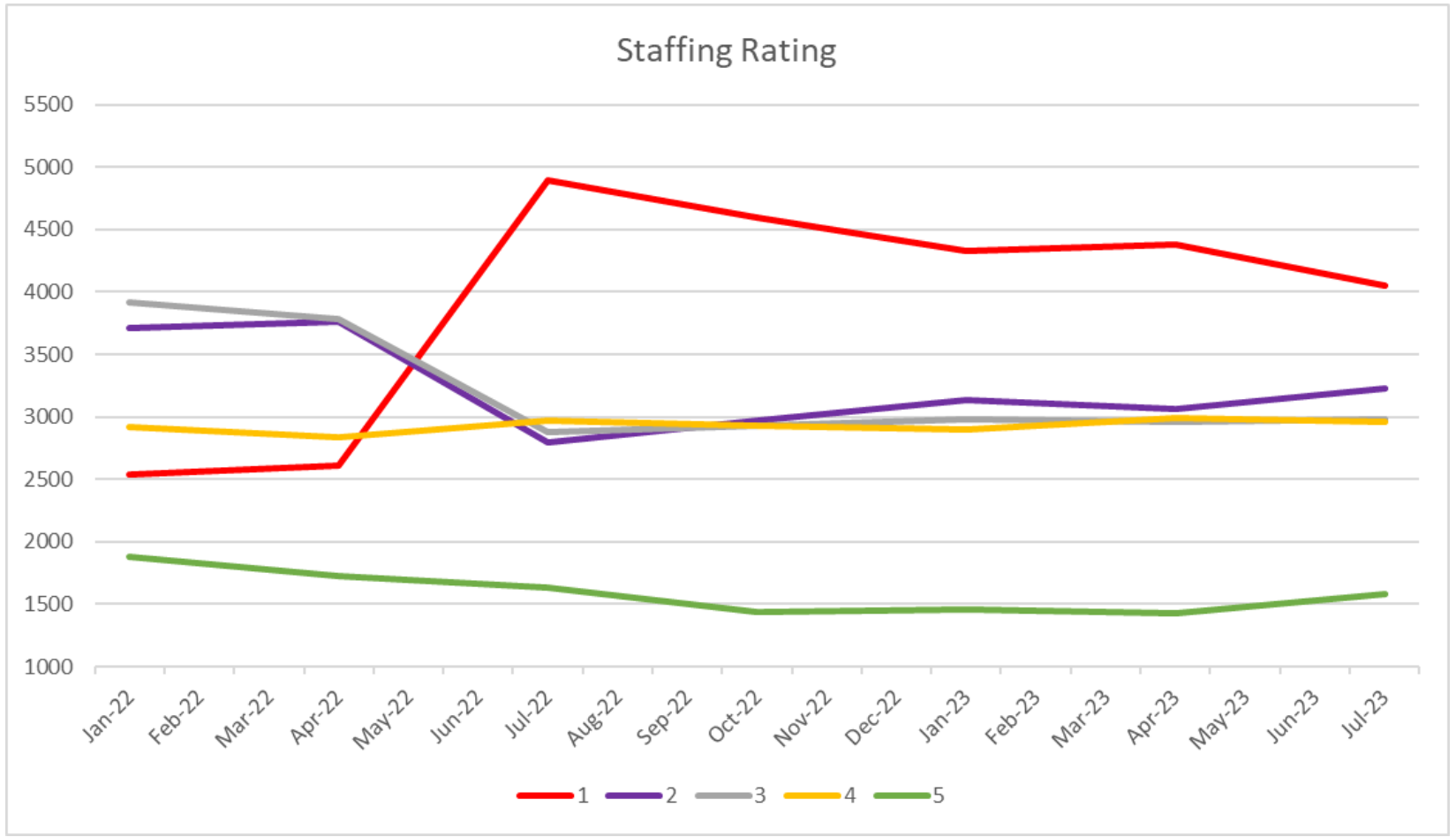
It All Starts With The Clinical Care

- In corporate strategy there is a term we use call “table stakes”
- Table Stakes:
  - Also called competitive necessities, these are the capabilities that every company must develop, simply to remain current in its industry
  - In SNF, these table stakes are high quality clinical care
- Without this:
  - No Revenue
  - No Residents
  - No Future
- Operators must focus on quality clinical care first. Everything else is second.

But What is Quality?



But What is Quality?



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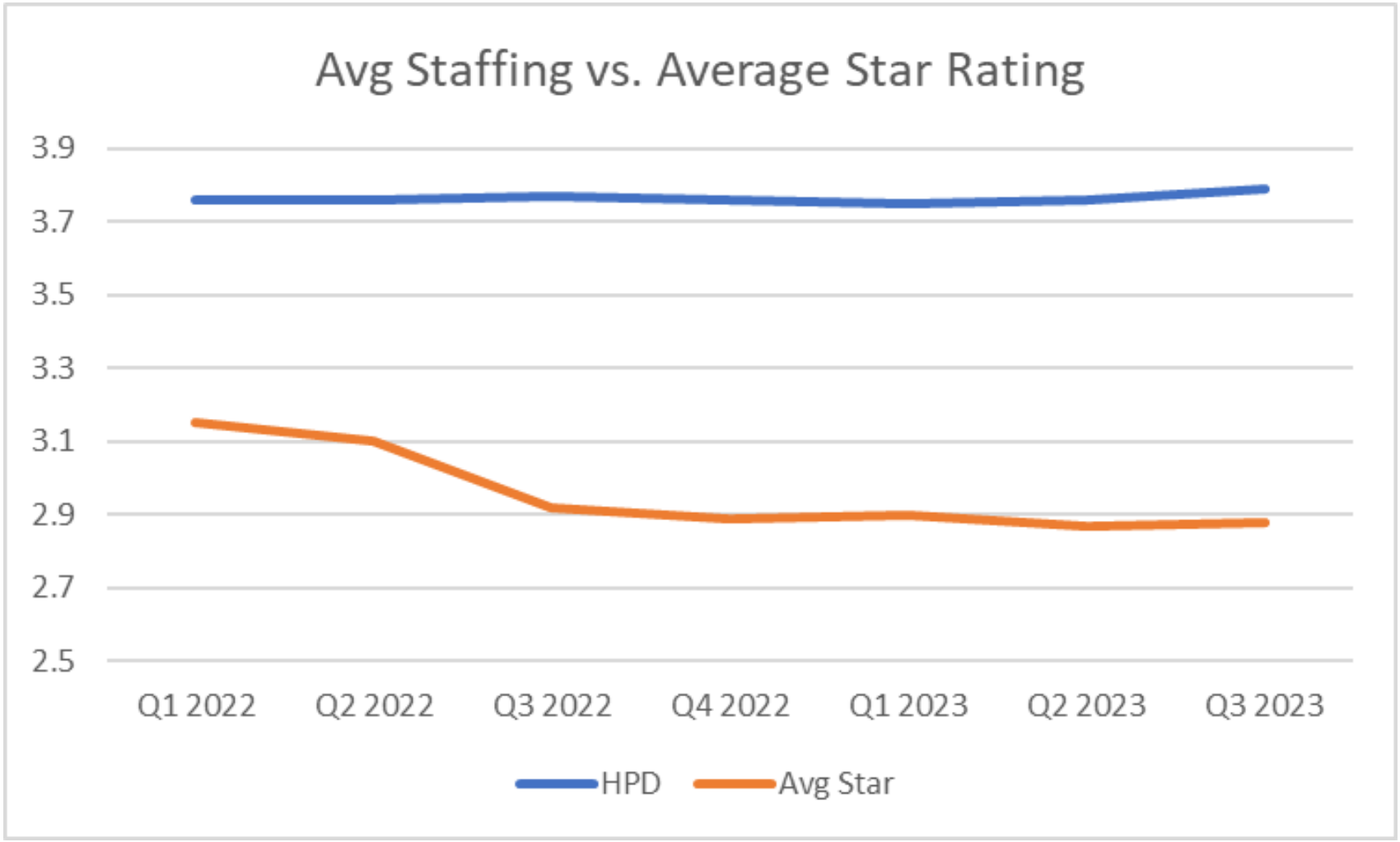
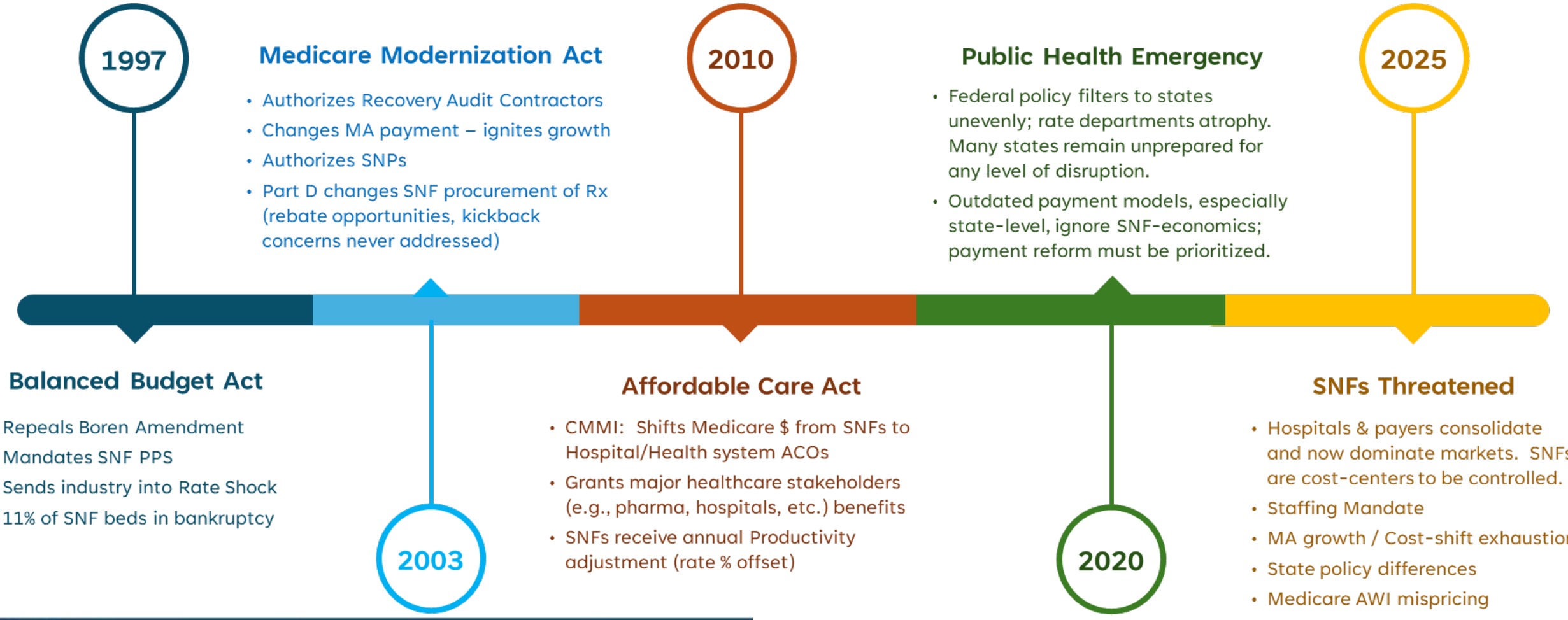


What is going on?

- NY reimbursement profile for Skilled Nursing Facilities has deteriorated since 2019.
  - Medicare Part A utilization decline (CMMI & Medicare Advantage)
  - Medicaid rate % increases trail most other states
  - Challenging Rate Construction Method
  - Poorly targeted funding enhancements
- How do successful SNFs make it?
  - Controlling costs
  - Economies of Scale
  - Optimizing Reimbursement
  - Capturing every dollar of their “SNF-Economy”

SNFscrimination in Healthcare Policy



One Size Fits None

Different Nursing Homes, but only one certification: "Skilled Nursing Facility".

Freestanding
Hospital-Based
State Specialty

Urban / Rural
CCRC
Large / Small

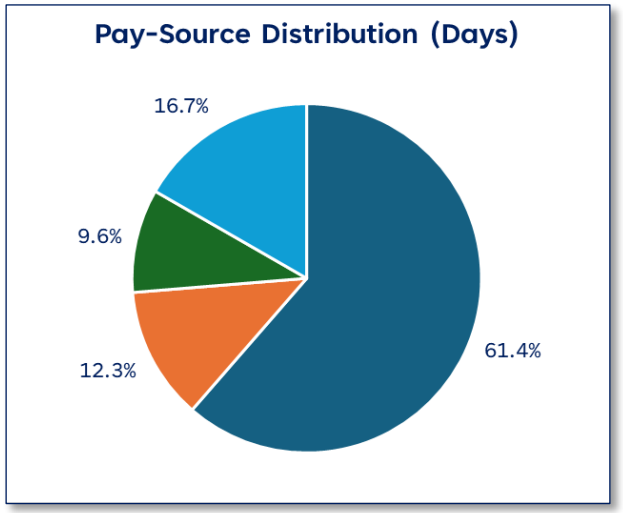
Short-Term/LTC
Dual-Eligible
CMMI

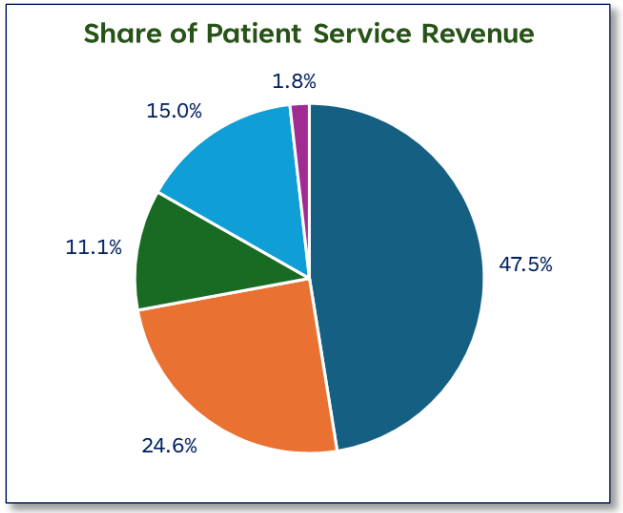
Pricing
Cost-Sharing
Market Dynamics

“SNFonmics”

- Skilled Nursing does not adhere to traditional economic principles.
- SNFs cannot impct pricing or demand.
- Inventory & Sales are measured per Inpatient Day of Care, but care is not a “product”; it cannot be scaled, standardized, automated, or outsourced.
- SNFs are “downstream” cost-centers; ACOs/insurers seek to limit utilization.
- Buyer sets prices that are inconsistent and inelastic; “**Mispricing**” is common.
- Most SNF expenses are “fixed/threshold”; true variable costs ~5% of total.
- High fixed costs, payer-mix, and capacity distort performance across markets.
- Size matters: High bed capacity SNFs generate largest Net Income & Loss.
- Outdated and inconsistent reporting makes comparing facilities difficult.

SNFonmics: Key Points (Generalizations)





Medicaid Medicare Part A MA Other Medicare Part B

- Medicare & Medicaid develop Reimbursement policy without consideration to interdependencies.
- Rates are constructed on faulty underlying data applied uniformly to all Providers under the system.
  - This causes "**Mispricing**" that imbalances the SNF-Economy.
- Few SNFs at 90% occupancy could survive with Medicaid as the only payer, but a "loss per Medicaid day" defies SNFonomics.
  - SNFs that lose money do so on every resident.
- Medicaid can be profitable for most SNFs when occupancy is high *and* residents are Dual-Eligible, yet breakeven becomes unachievable for more SNFs each year.
- Medicare has subsidized Medicaid for decades.
  - Medicaid Payer-mix has changed minimally over 10 years; acuity and expenses increased; Medicaid rates have not.
  - Decrease in Medicare FFS creates greater imbalance

SNFs can only perform as well as a market allows

Position

Potential

Performance

- ✓ Medicaid Rate Construction
- ✓ Medicare Area Wage Index
- ✓ Medicare Advantage %
- ✓ Medicare FFS Attrition Rate
- ✓ Provider/Payer leverage
- ✓ Payer-Mix (non-duals)
- ✓ State "Cost Sharing" (Dual-Eligibles)
- ✓ Market demand ("Rightsized")
- ✓ CMMI (ACOs)
- ✓ Medicaid-only (non-Dual)
- ✓ Bed complement / configuration
- ✓ Ancillary opportunities

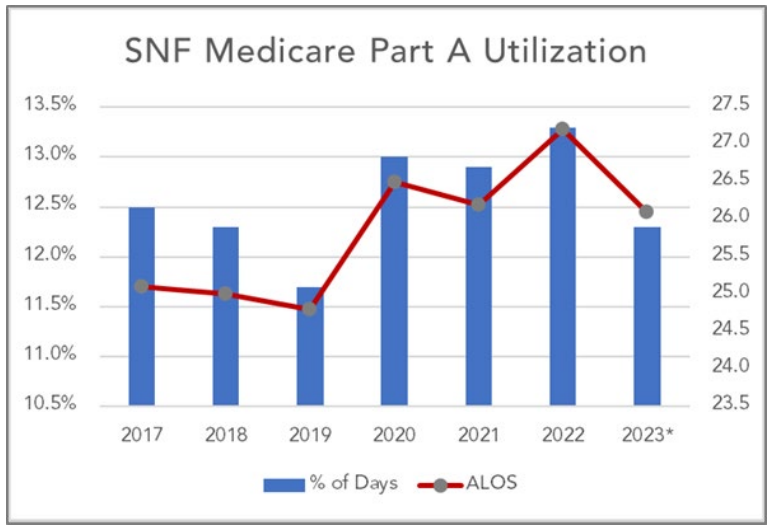
Mispricing ultimately destabilizes access and quality

SNF Reimbursement

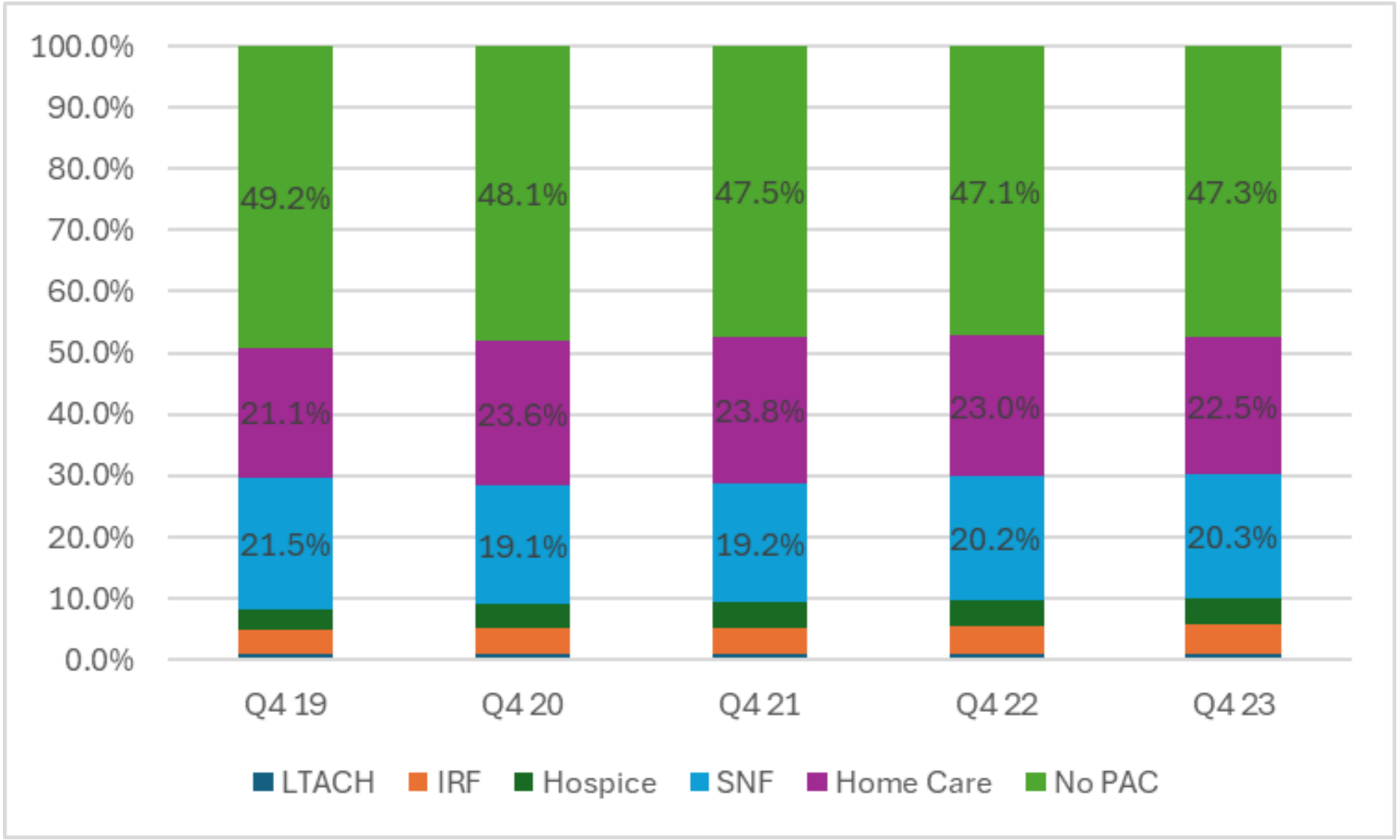
- Medicare Part A
- Medicare Part B
- Medicaid
- Medicare Advantage
- ISNP
- Medicaid Managed LTC

National Market Statistics

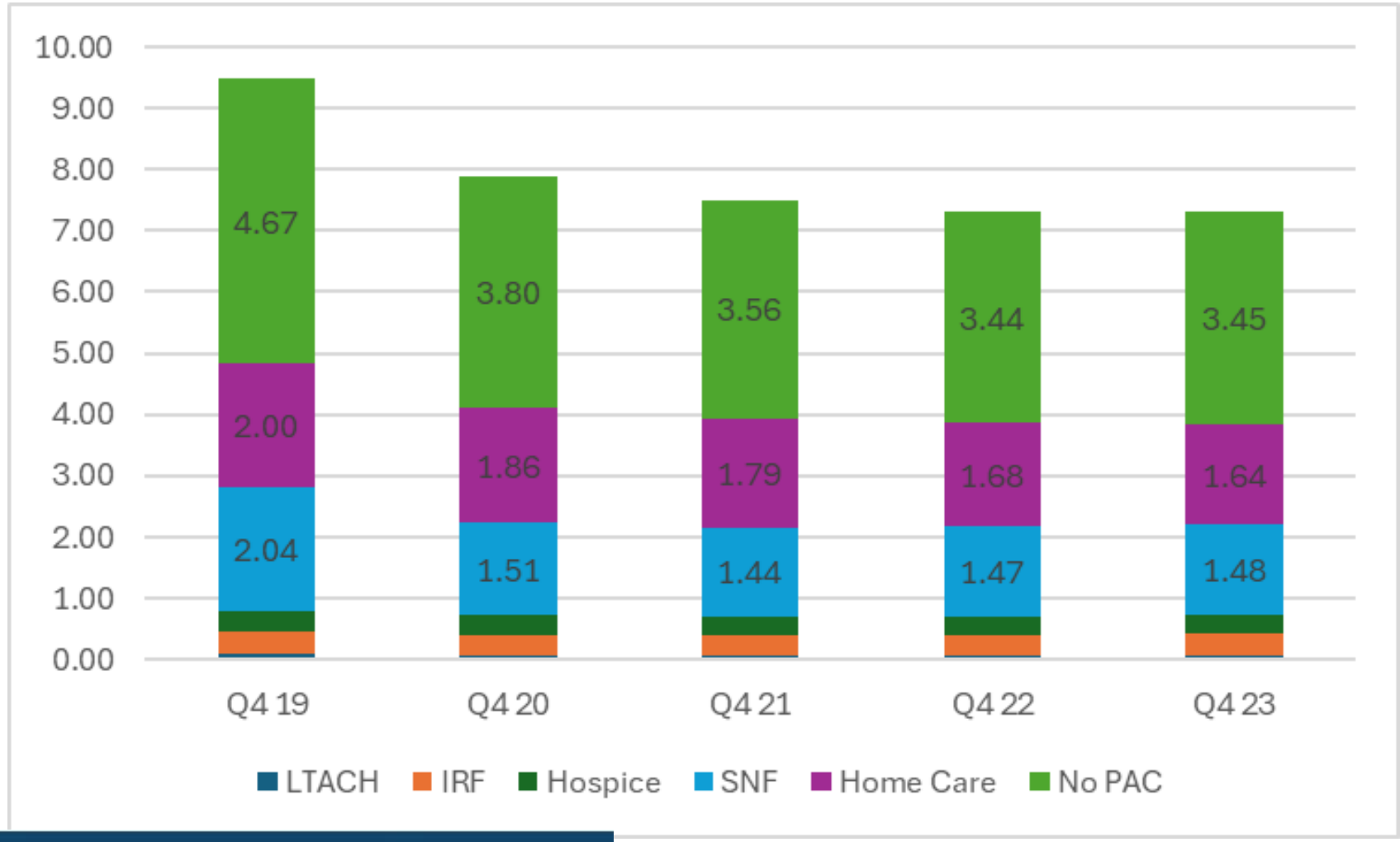
Variable	2017	2018	2019	2020	2021	2022	2023
Number of Certified SNFs	15,646	15,596	15,471	15,348	15,264	15,137	14,924
Licensed SNF Beds	1,661,184	1,655,027	1,643,567	1,634,737	1,624,102	1,610,957	1,603,952
SNF Occupancy %	80.4%	80.5%	80.7%	72.7%	69.8%	73.2%	75.7%
Relative Occupancy	-	80.2%	79.8%	71.5%	68.2%	71.0%	73.1%
Medicare Part A Share	12.5%	12.3%	11.7%	13.0%	12.9%	13.2%	12.0%
Medicaid Share	58.3%	57.2%	58.3%	58.4%	59.2%	58.0%	63.6%
Other Share	29.2%	30.5%	30.0%	28.6%	27.7%	28.3%	24.4%



Medicare Discharges



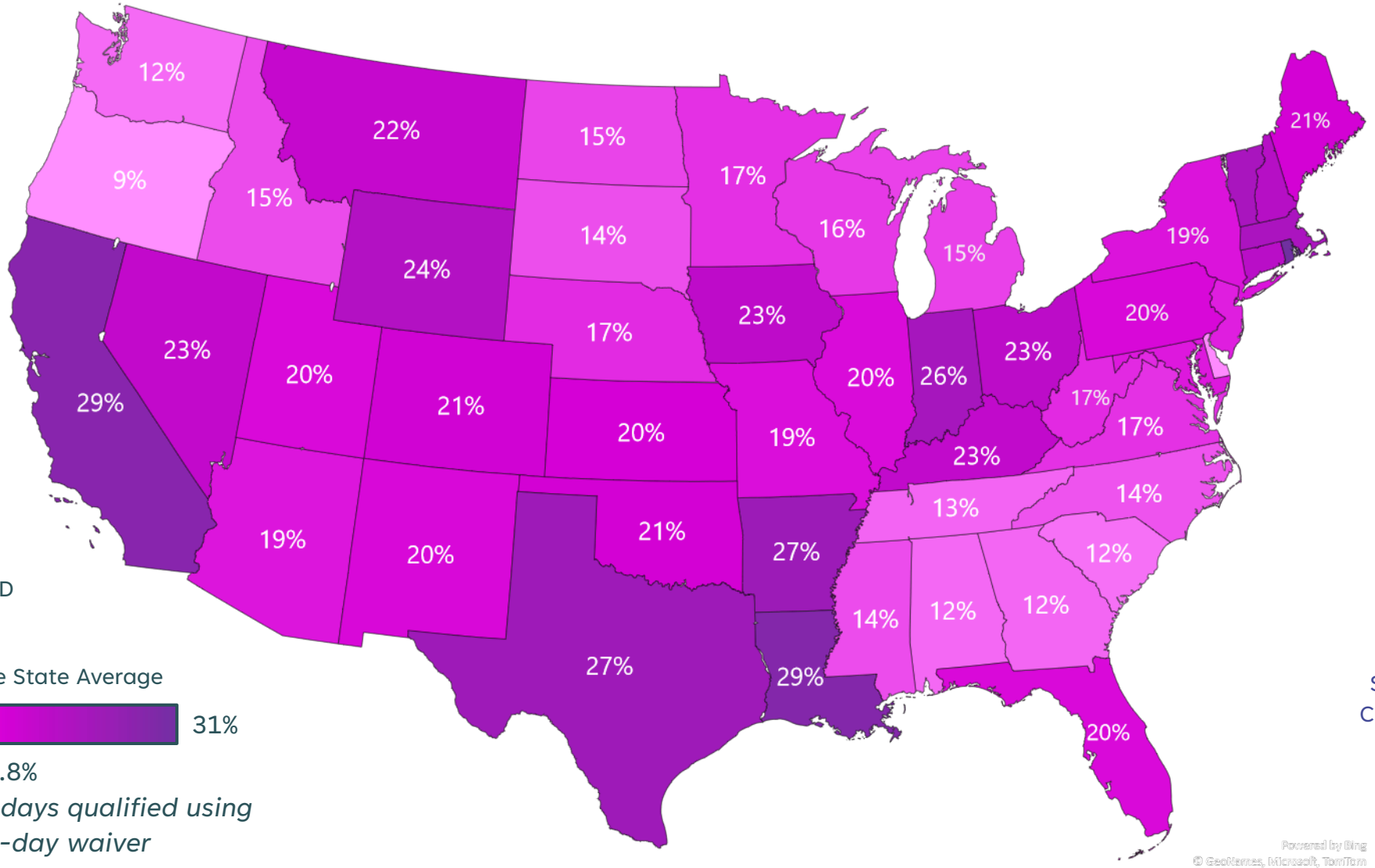
Medicare Discharges – In Millions



2022: PHE 1135 Waiver Share of Medicare Part A Days

Medicaid did not pay for 14 million waiver days and saved $3.5 billion in 2022.

The NET impact of SNF waiver days reverting to Medicaid = $4.3 billion (~$287,000 per SNF).



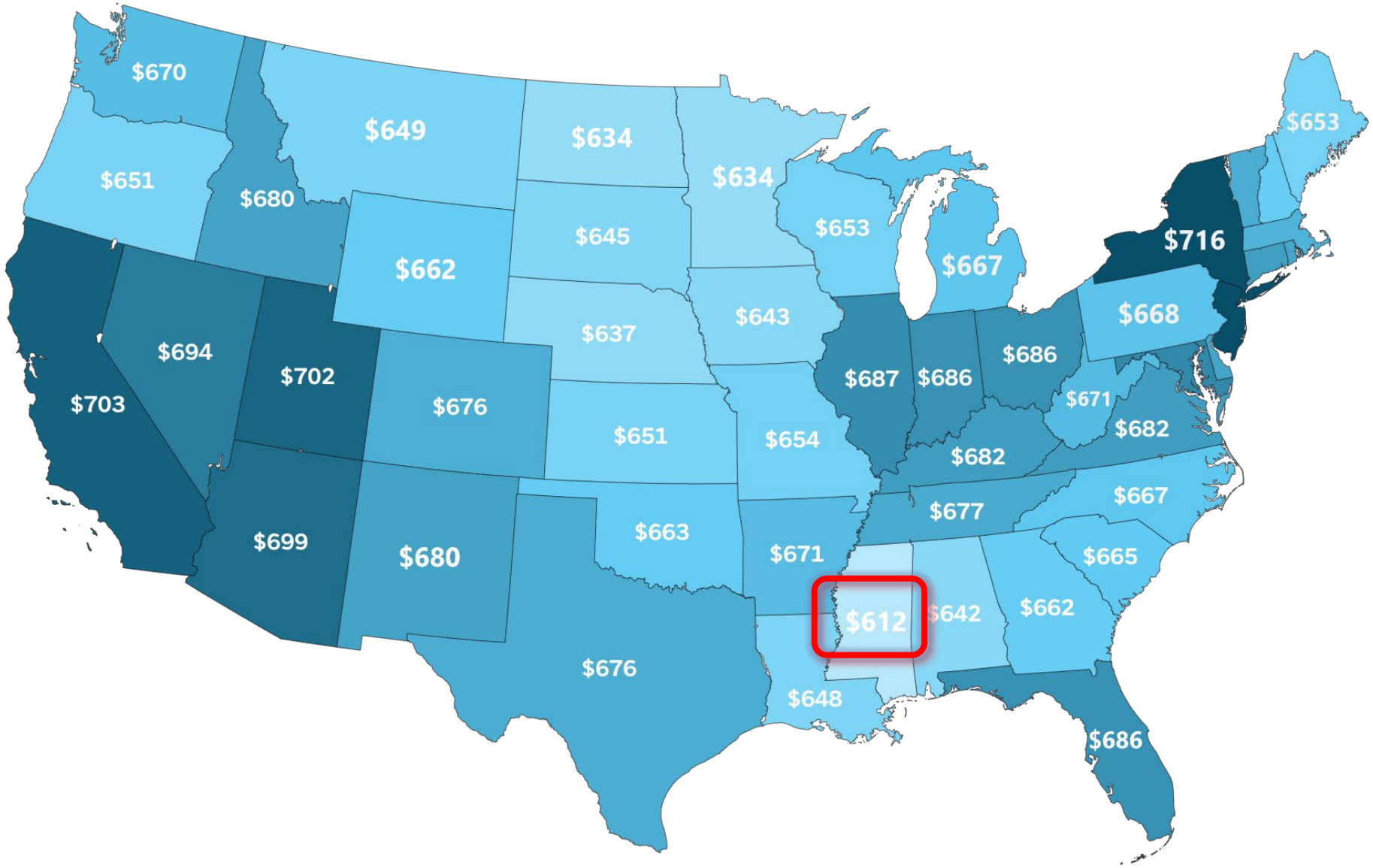
CT	24%
DC	10%
DE	10%
MA	25%
MD	19%
NH	24%
NJ	18%
RI	31%
VT	25%

Source: CMS LDS SAF
Contextualized by ZHSG

Care vs Capture

- The primary differentiator in payment rates within acuity-based systems is not acuity; it’s assessment management.
- Therapy is no longer the primary payment driver.
- Even when therapy is the reason for skilled care, PDPM scores are based heavily on Nursing, conditions, diagnosis, and non-therapy ancillary services.
- Not-for-profit SNFs average reimbursement rates are 10% below expected benchmarks.
- Medicare Part A, Medicaid CMI, Medicare Advantage

2023 Medicare Part A Rates*



CT	$681
DC	$677
DE	$679
MA	$674
MD	$689
NH	$662
NJ	$719
RI	$679
VT	$677

Source: LDS SAF
Contextualized by

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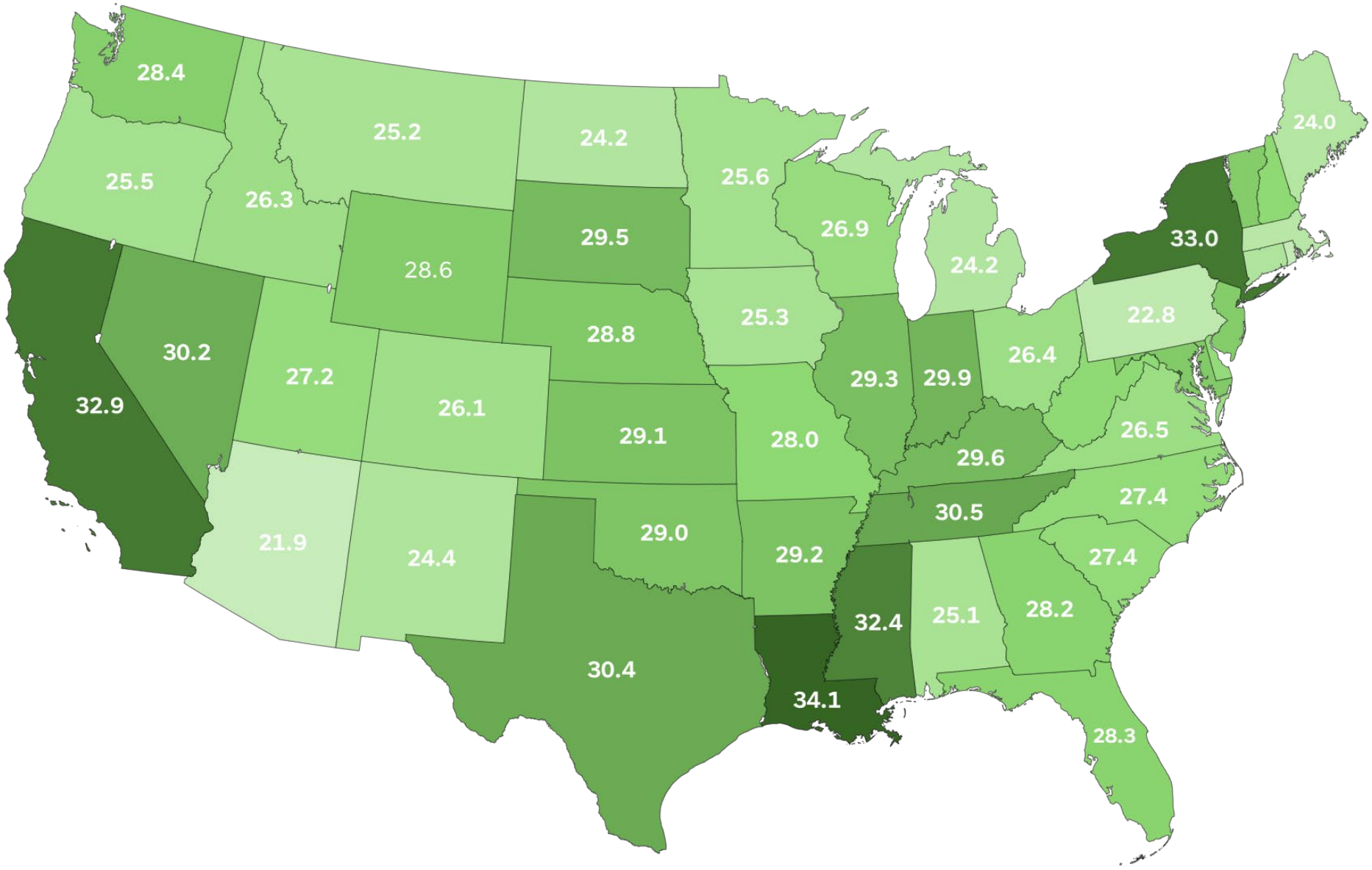
* All rates set to Urban Unweighted (AWI = 1.0) for comparative integrity.

2023 Medicare Part A ALOS*



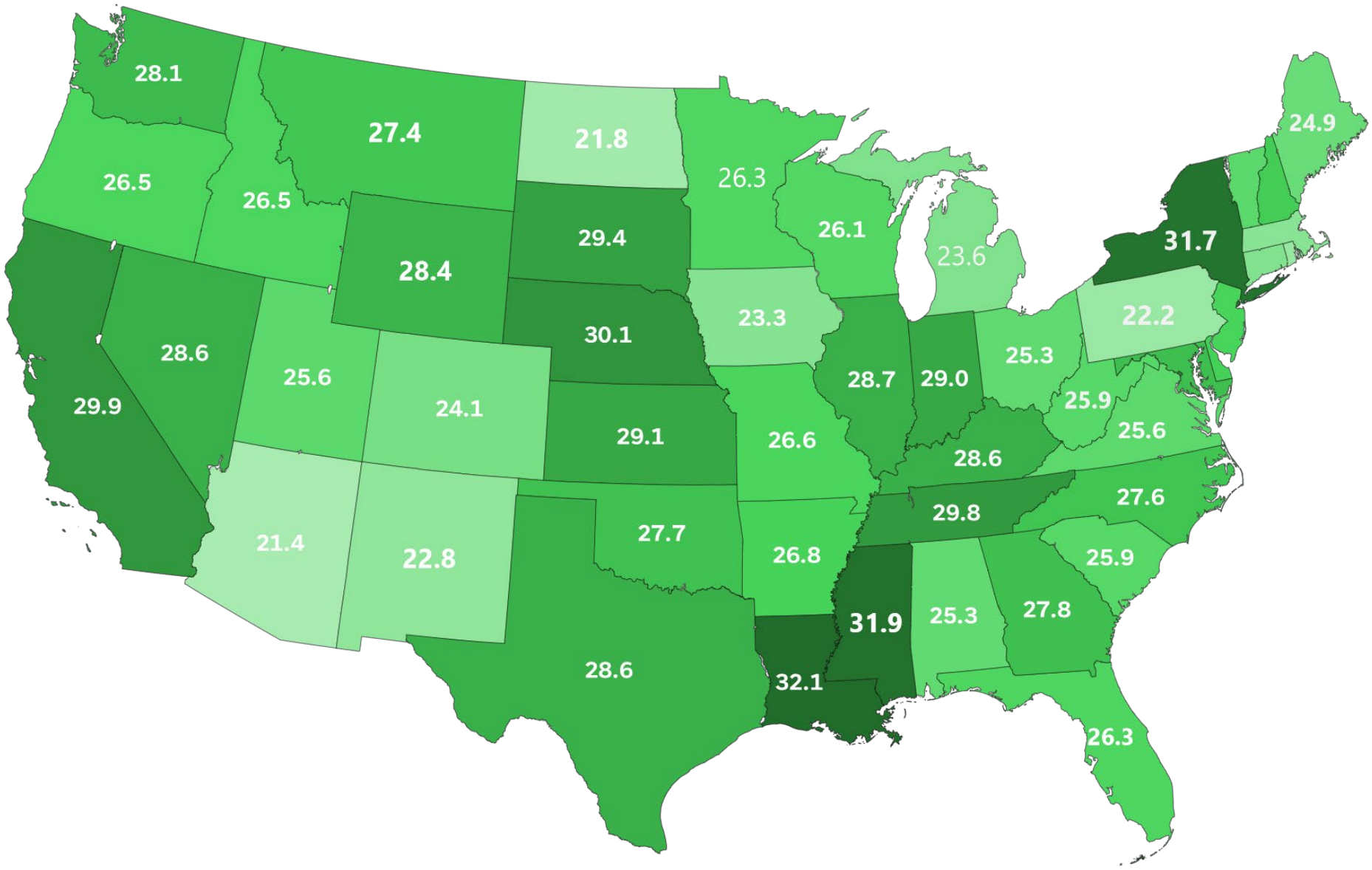
CT	24.3
DC	32.8
DE	27.2
MA	23.4
MD	28.7
NH	27.8
NJ	28.6
RI	22.2
VT	28.6

Source: LDS SAF
Contextualized by

ZIMMET HEALTHCARE SERVICES GROUP, LLC

* Readmission-returns are counted as new stays.

2022 Medicare Part A ALOS*



CT	23.5
DC	30.6
DE	26.9
MA	23.2
MD	27.9
NH	27.1
NJ	26.7
RI	22.3
VT	25.7

Source: LDS SAF
Contextualized by

ZIMMET HEALTHCARE SERVICES GROUP, LLC

* Readmission-returns are counted as new stays.

2023 Medicare Part A Rates

- Figures represent gross reimbursement based on CMS' LDS-SAF file.
- Neutralized for comparative integrity:
- Claims with dates of service October 1, 2022 – June 30, 2023 (2023 Q3 will be added by April 2024)
- Applied 2023 Urban rate set, Area Wage Index = 1.0000
  - Patient acuity does not explain the significant variance among states ($617 – $720 PPD). The difference is primarily reimbursement management. Nevertheless, when CMS "recalibrated" rates, 4.6% was applied to all states.
  - In other words, fixed Medicare funds were redistributed to high-performing states from low-scoring regions. The result is Reimbursement Inequality.
- ALOS: Shorter stays increase $PPD under PDPM
- Sequestration and VBP offsets not applied.
- Cost-sharing differs across state lines (copayment for Duals)

Revenue/Admission

Observations

Expressed as a simple average of state rates, Medicare rates increased from $656 to $670. The 2.1% rise is less than half the inflation factor. Lower Isolation capture explains the variance, but why did ALOS decline?

Medicare revenue per Admission varied significantly. A study last decade concluded PAC spending explained 73% of the variation per episode of care.

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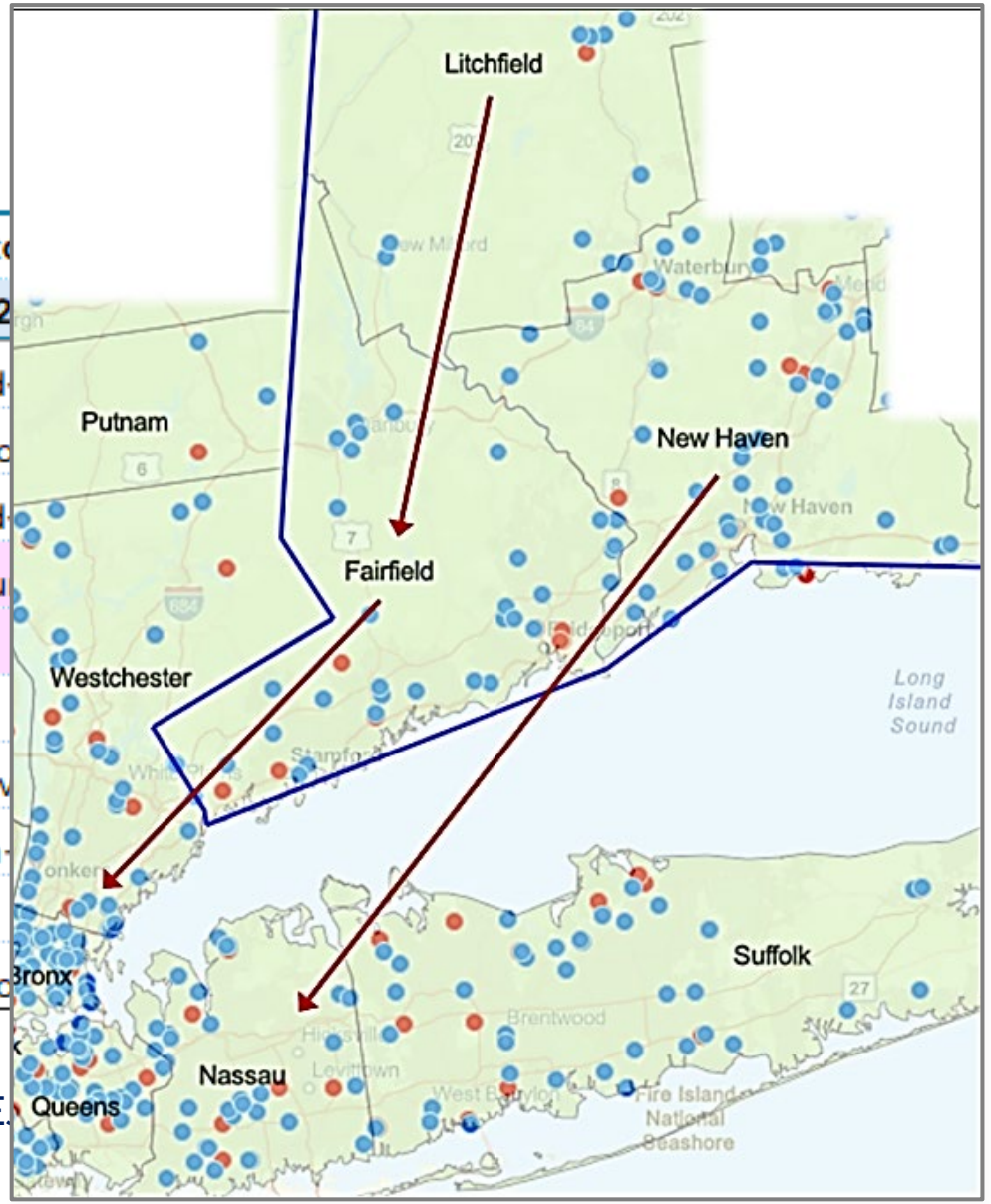
2022 Gross PDPM Revenue/Adm.					
1	NY	$22,338	26	ID	$17,552
2	LA	$20,655	27	MT	$17,463
3	DC	$20,577	28	HI	$17,456
4	CA	$20,250	29	UT	$17,412
5	TN	$19,644	30	OH	$17,055
6	IN	$19,520	31	MO	$17,023
7	NV	$19,274	32	WV	$16,983
8	MS	$19,245	33	VA	$16,979
9	IL	$19,235	34	VT	$16,938
10	TX	$19,083	35	OR	$16,934
11	KY	$19,010	36	WI	$16,805
12	KS	$18,806	37	SC	$16,796
13	NE	$18,785	38	MN	$16,276
14	MD	$18,700	39	CO	$15,973
15	NJ	$18,699	40	AL	$15,908
16	SD	$18,559	41	ME	$15,874
17	WY	$18,456	42	CT	$15,744
18	WA	$18,449	43	MI	$15,446
19	GA	$18,125	44	MA	$15,306
20	OK	$18,122	45	NM	$15,036
21	DE	$18,020	46	IA	$14,847
22	AR	$17,872	47	AZ	$14,559
23	NC	$17,867	48	RI	$14,545
24	FL	$17,641	49	PA	$14,450
25	NH	$17,634	50	ND	$13,692

2023 Gross PDPM Revenue/Adm.					
1	NY	$23,645	26	NH	$18,422
2	CA	$23,172	27	NE	$18,336
3	DC	$22,173	28	MO	$18,315
4	LA	$22,077	29	NC	$18,246
5	NV	$20,965	30	SC	$18,202
6	TN	$20,681	31	OH	$18,097
7	NJ	$20,589	32	VA	$18,092
8	TX	$20,560	33	ID	$17,875
9	IN	$20,486	34	CO	$17,646
10	KY	$20,188	35	WI	$17,592
11	IL	$20,158	36	HI	$17,195
12	MS	$19,861	37	NM	$16,616
13	MD	$19,798	38	OR	$16,597
14	AR	$19,565	39	CT	$16,583
15	FL	$19,397	40	MT	$16,333
16	VT	$19,361	41	IA	$16,274
17	OK	$19,264	42	MN	$16,259
18	WA	$19,072	43	MI	$16,152
19	UT	$19,069	44	AL	$16,147
20	SD	$19,049	45	MA	$15,781
21	KS	$18,963	46	ME	$15,664
22	WY	$18,950	47	ND	$15,370
23	GA	$18,684	48	AZ	$15,317
24	WV	$18,638	49	PA	$15,238
25	DE	$18,484	50	RI	$15,034

* All rates set to Urban Unweighted (AWI = 1.0)

AWI: Area Wage Insults

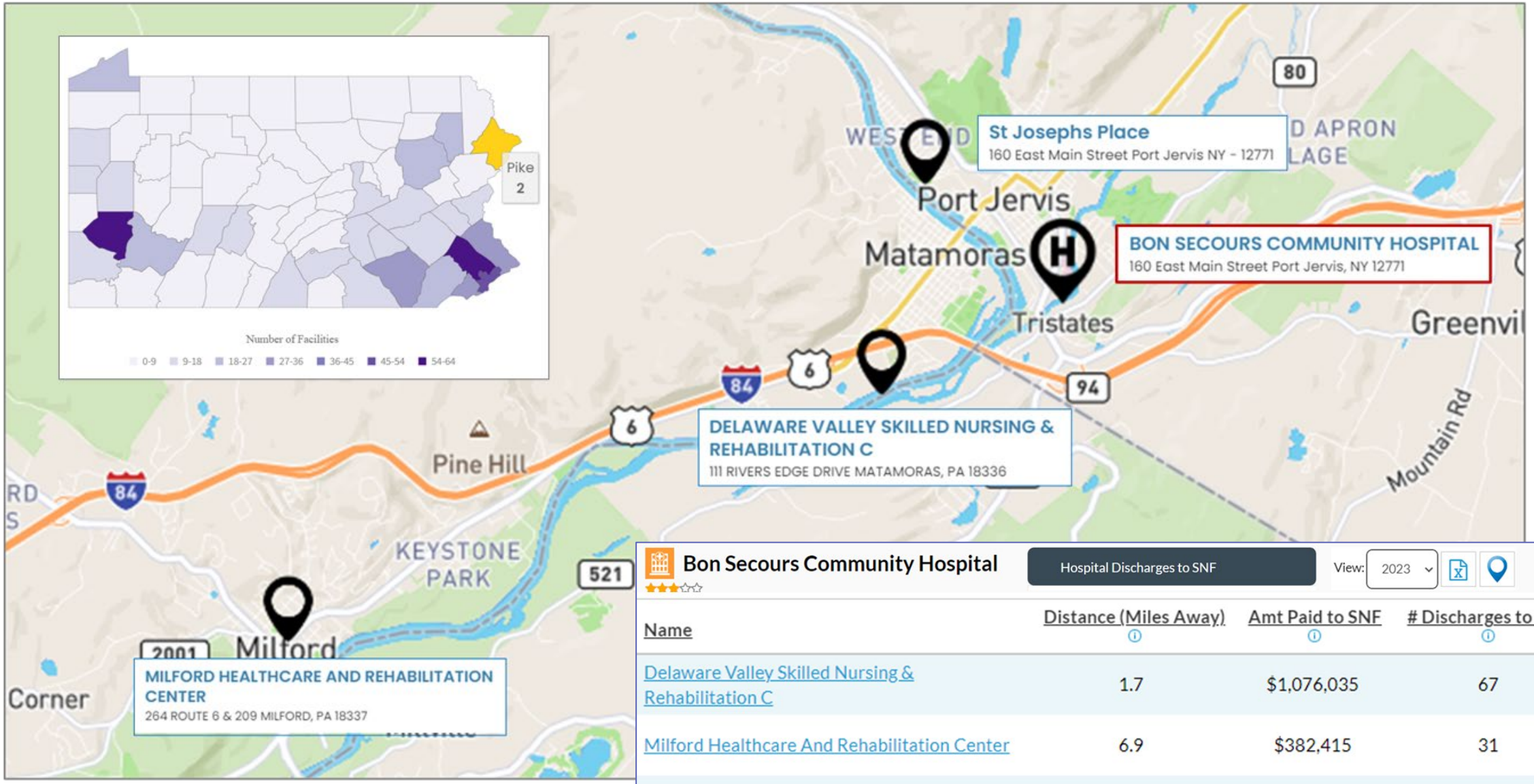
County	State	Core-Based Statistical Area 2024		Core-Based St 202	
CAPITOL	CT	25540	Hartford-East Hartford-I	25540	Hartford
GREATER BRIDGEPORT	CT	14860	Bridgeport-Stamford-Nc	14860	Bridgepo
LOWER CT RIVER VALLE	CT	25540	Hartford-East Hartford-I	25540	Hartford
NAUGATUCK VALLEY	CT	35300	New Haven-Milford, CT	47930	Waterbu
NE CONNECTICUT	CT	49340	Worcester, MA-CT	07	RURAL
NORTHWEST HILLS	CT	07	CONNECTICUT	07	RURAL
SOUTH CENTRAL CT	CT	35300	New Haven-Milford, CT	35300	New Hav
SOUTHEASTERN CT	CT	35980	Norwich-New London, C	35980	Norwich
STATEWIDE	CT	07	CONNECTICUT	07	RURAL
WESTERN CT	CT	14860	Bridgeport-Stamford-Nc	14860	Bridgepo



Impact relative to 2024's gross rate at 27-day ALOS at HIPPS KE
Copay, MBI. Values are approximate.

Declines capped at 5%. In other words, a 10% AWI reduction would be phased-in over two years.

Pike County, PA: 2024 – 2025



Bon Secours Community Hospital — Hospital Discharges to SNF — View: 2023

Name	Distance (Miles Away)	Amt Paid to SNF	# Discharges to SNF
Delaware Valley Skilled Nursing & Rehabilitation C	1.7	$1,076,035	67
Milford Healthcare And Rehabilitation Center	6.9	$382,415	31
St Josephs Place	1.4	$370,311	29

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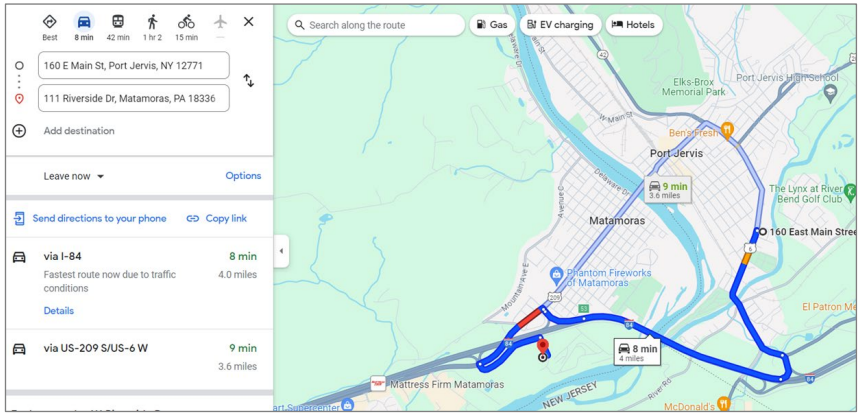
CMS 2025 SNF PPS Proposed Rule: AWI

HIPPS: KEKD, 27-days, Gross Rate			**AWI**		**Rate**	
CBSA: PIKE County, PA			**2024**	**2025**	**2024**	**2025**
35084	Urban	Newark, NJ-PA	**1.1288**	1.1049	**$771**	$791
39	Rural	Statewide	0.8021	**0.8757**	$631	**$696**
		Difference		**(0.2292)**	**(140)**	**($95)**
Analysis of Pike County competitors & of Rural Floor exclusion						
39	Urban	Orange, NY	1.2882	1.1942	$851	$838
38300	Urban	Armstrong, PA	0.8244	0.8396	$618	$651



- Delaware Valley is a 70-bed SNF, Medicare ADC = 18. New AWI pays $95 less/day ($624,000/year). The facility broke even in 2022.
- St. Josephs Place is an 8-minute drive. Rate in Orange County, NY is $142/day higher.
- In addition, NYS pays 100% of Medicare coinsurance (Cost Sharing) for Duals; PA pays zero. This disadvantages DV another $72/day for days 21 – 100.

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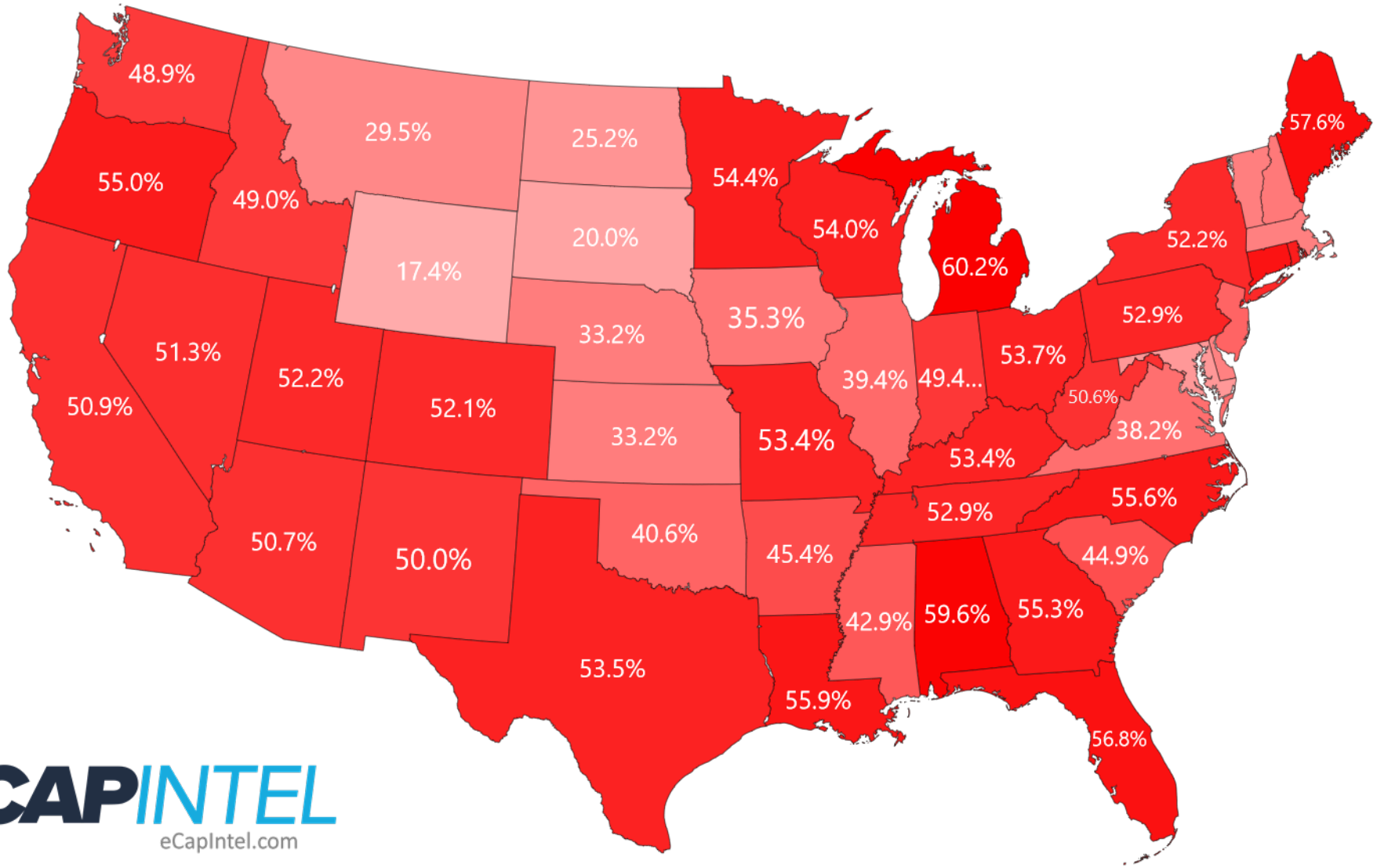
Medicare Advantage Penetration

As of July 1, 50.1% of Medicare beneficiaries are enrolled in a Medicare Advantage plan.
The simple state average, a much less meaningful figure, is 45.6%.



CT	56.4%
DC	33.0%
DE	31.9%
MA	32.3%
MD	24.0%
NH	34.6%
NJ	40.5%
RI	54.6%
VT	32.4%

Source: CMS
Contextualized by ZHSG for:

ECAPINTEL
eCapIntel.com

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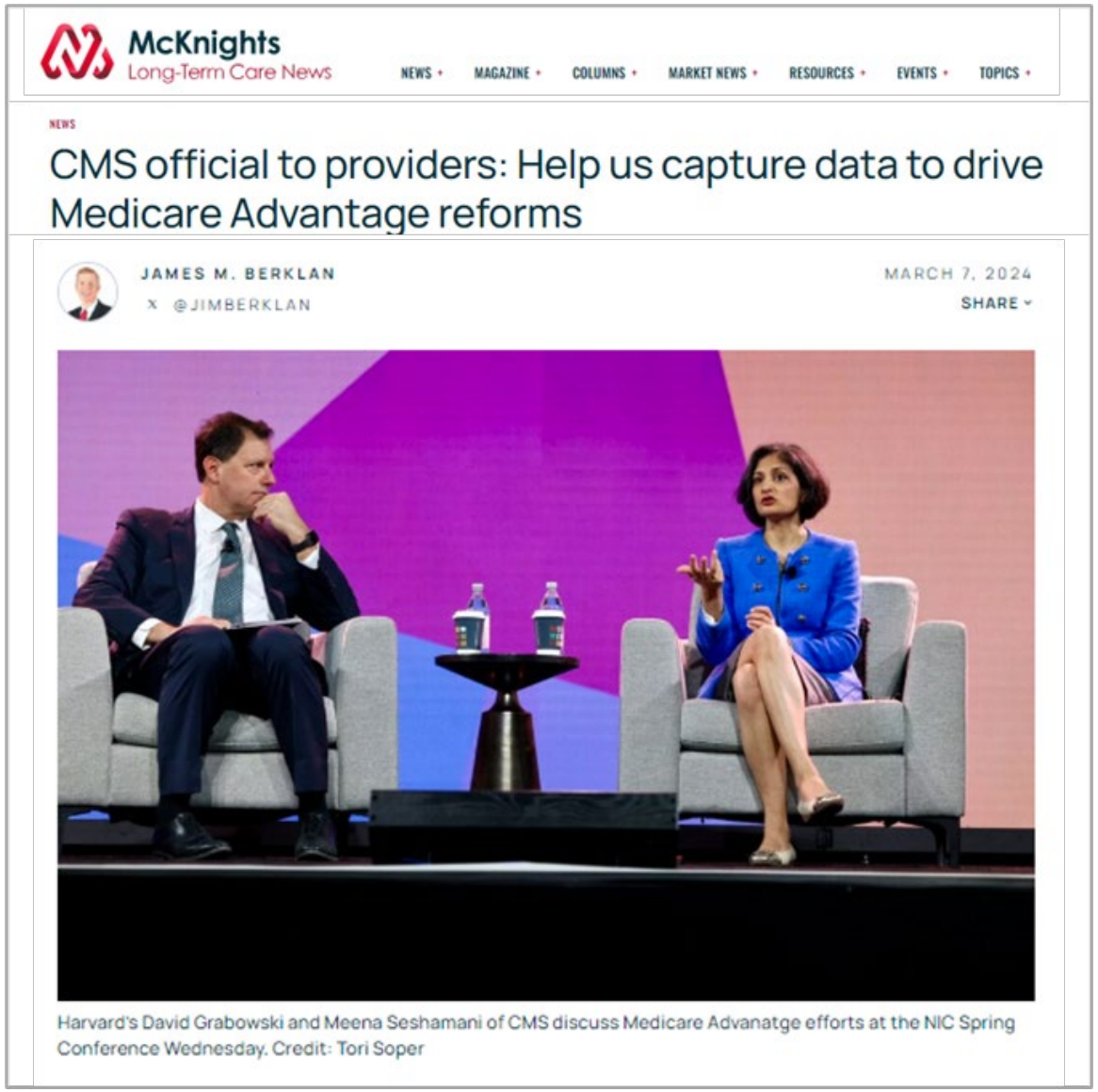
The Dataless Zone



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NEWS

CMS official to providers: Help us capture data to drive Medicare Advantage reforms

JAMES M. BERKLAN
X @JIMBERKLAN

MARCH 7, 2024
SHARE

Harvard's David Grabowski and Meena Seshamani of CMS discuss Medicare Advanatge efforts at the NIC Spring Conference Wednesday. Credit: Tori Soper

Unlike FFS claims, CMS does not make available (or properly collect) granular MA utilization data.

The most recent generalized utilization data from CMS dates to 2019.

ZHSG's findings are based on proprietary claims submissions from CORE Analytics.

PART I - STATISTICAL DATA

	Component	Number of Beds	Bed Days Available	Inpatient Days / Visits					
				Title V	Title XVIII	Title XIX	Other	Total	Tit V
		1	2	3	4	5	6	7	8
1	Skilled Nursing Facility	200	73,200		3,489	43,855	18,339	65,683	

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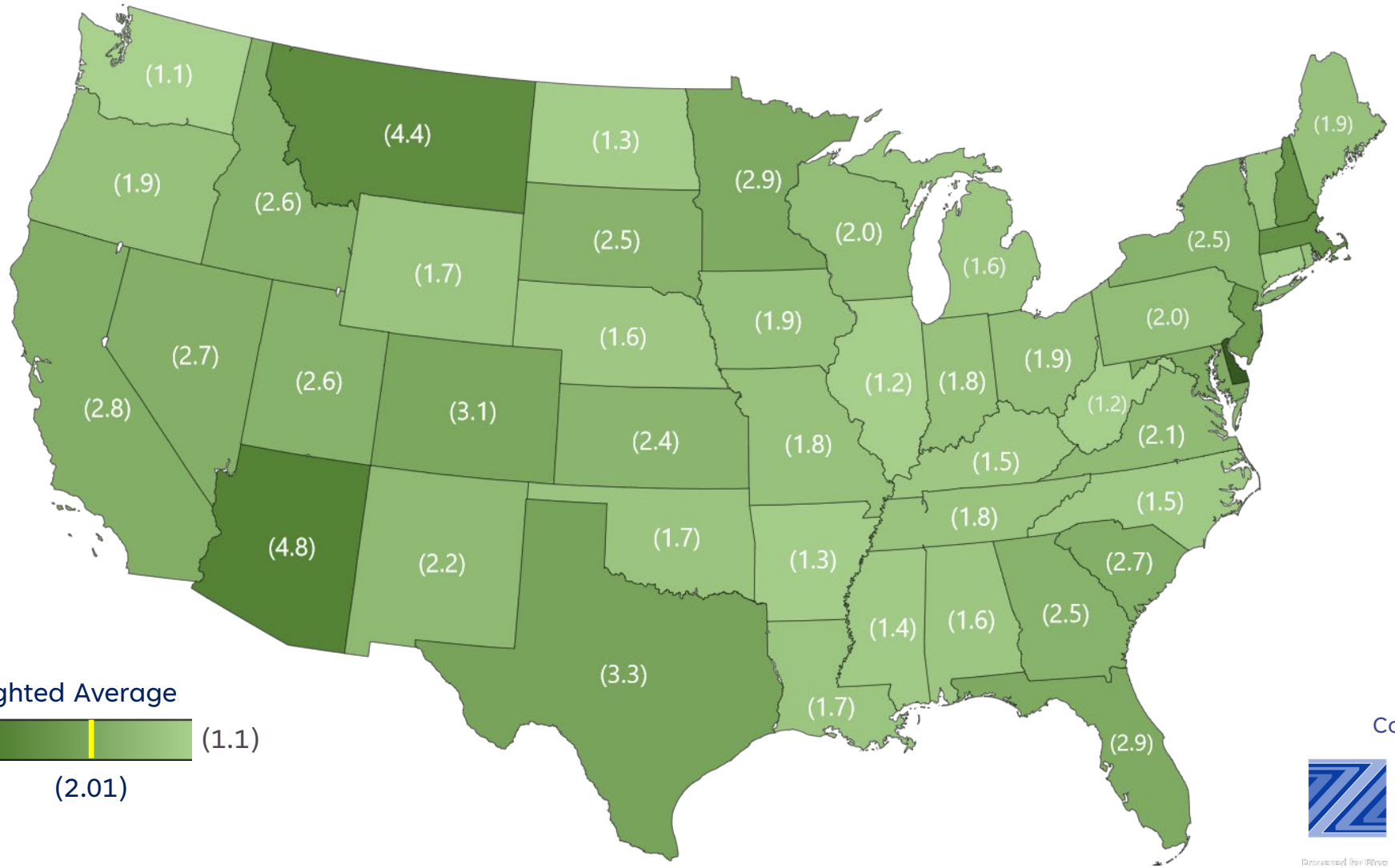
MA Update

- Applying FFS utilization to 2023 MA enrollment: $13.1B SNF revenue reduction (~$870,000/SNF average) by covering fewer SNF days at lower rates.
- 2023 CMS rule enforces coverage criteria and eases prior authorization restrictions, but $PPD is the problem.
- ZHSG data: Long stagnant MA rates now often trail Medicaid (net of ancillary expenses otherwise covered by Medicare Part B/D).

- SNF market is highly fragmented; providers lack negotiating leverage and prevents quantifying “Value”. Why continue to admit?
- SNFonomics: SNFs’ own demand for Contribution Margin.
- Ultimately, the burden of subsidizing Medicaid falls right back to the states.

2023 Annual Medicare Attrition Rate

MA growth relative to FFS decline in people, not %. Total Medicare grew by 1.4M in 2023, yet FFS declined by 1.3M (for every two electing MA, one FFS left the program or expired). 2023 was the first year FFS declined in every state [Delaware lost FFS the fastest with an MAR = (8.6); for every 10 electing MA, there were 86 fewer in FFS].



CT	(1.4)
DC	(1.1)
DE	(8.6)
MA	(4.0)
MD	(2.8)
NH	(4.0)
NJ	(3.6)
RI	(1.9)
VT	(1.8)

National Weighted Average

(8.6) (1.1)

Traditional FFS to MA only (2.01)

Source: CMS
Contextualized by ZHSG

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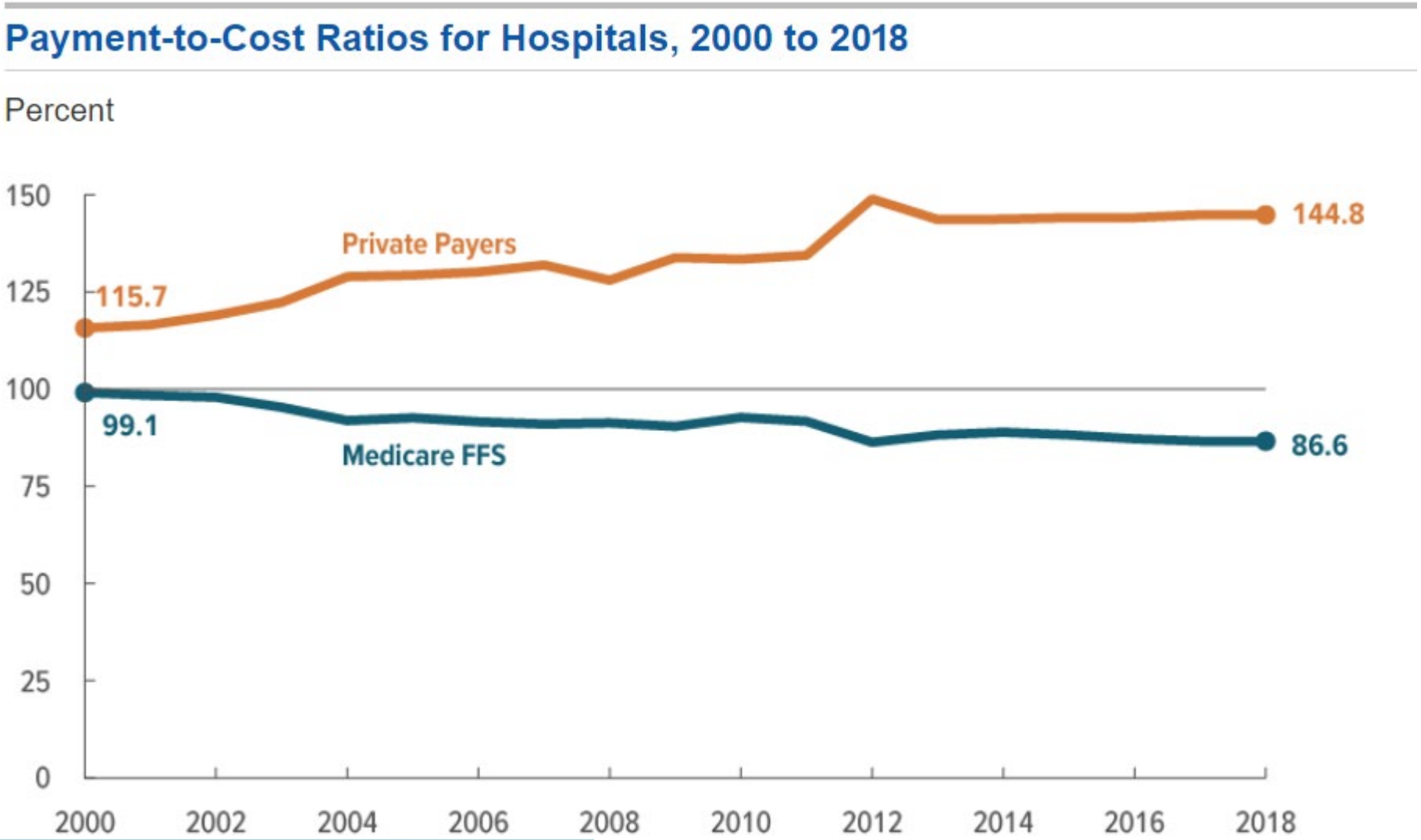
Medicare Advantage Hospital Cost Shifting



Medicare Advantage $PPD Relative to FFS

Urban Area	FFS	MA	MA/FFS Ratio	30-Day Re-H	ALOS
Nassau County-Suffolk County, NY	$796	$412	51.8%	18.6%	17.6
NYC-Jersey City-White Plains, NY-NJ	$810	$441	54.5%	21.8%	15.2
Miami-Miami Beach-Kendall, FL	$619	$342	55.2%	26.8%	17.5
Boston, MA	$740	$418	56.5%	6.6%	16.4
Cambridge-Newton-Framingham, MA	$681	$418	61.4%	12.6%	16.5
West Palm-Boca Raton-Delray, FL	$603	$374	62.1%	18.7%	16.9
Scranton-Wilkes-Barre-Hazleton, PA	$577	$360	62.4%	13.5%	17.0
Portland-South Portland, ME	$647	$564	87.2%	10.7%	17.2
Pittsburgh, PA	$577	$509	88.4%	21.1%	15.4
Manchester-Nashua, NH	$631	$560	88.8%	14.7%	17.9
Detroit-Dearborn-Livonia, MI	$597	$546	91.5%	21.0%	15.0
Chicago-Arlington Heights, IL	$672	$620	92.3%	22.3%	16.8
Warren-Troy-Farmington Hills, MI	$605	$571	94.4%	16.6%	16.2
Shreveport-Bossier City, LA	$577	$556	96.4%	14.1%	17.7

Source: CORE Analytics
Contextualized by ZHSG

simple.
a Netsmart solution

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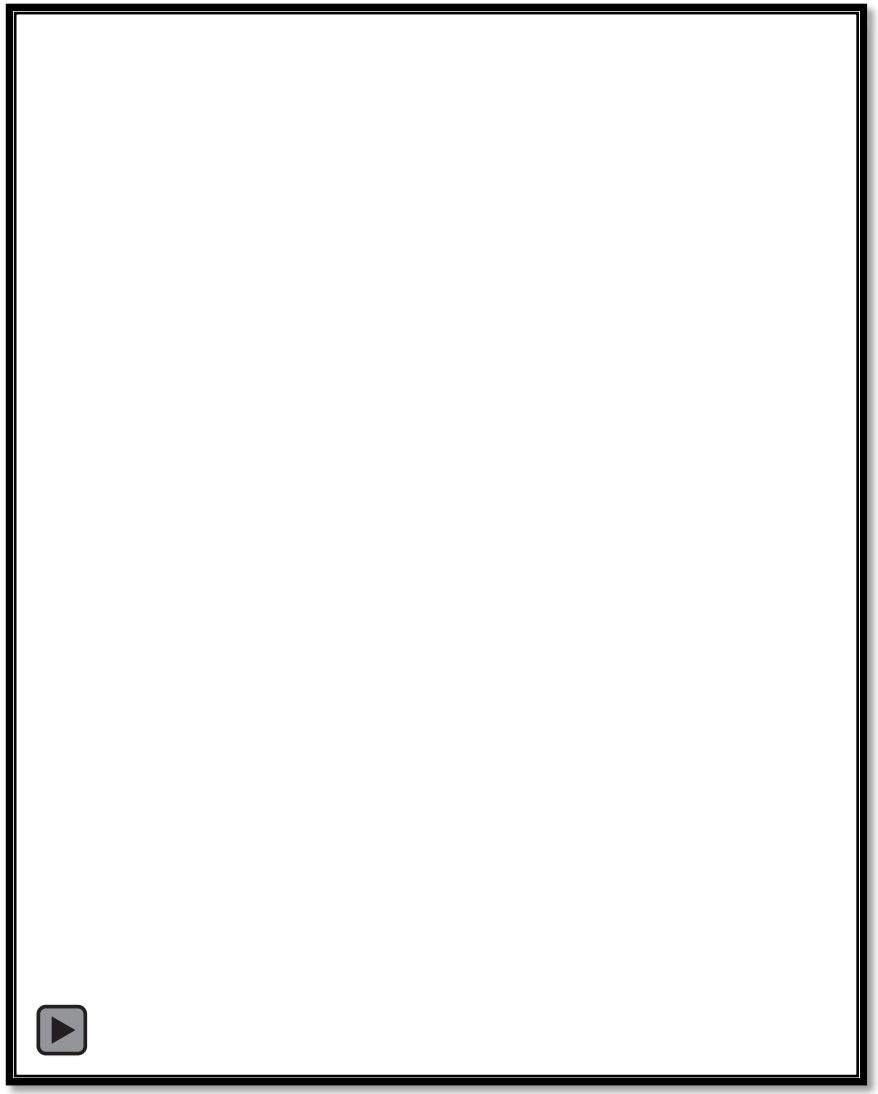
HUD Hot Topics – Medicaid

- State by State
  - Recent rate increases/new methods
  - Ward bed reductions
  - Other State initiatives
- Minimum Staffing Requirements
  - Federal & State roll outs of minimum staffing requirements
  - Star rating calculation impact
  - Staffing add-on rate incentives
  - Penalties for not meeting minimum requirements
- Expenses
  - Labor costs – staffing star rating nexus
  - Insurance premiums
  - Rate adjusted incomes without adjusting expenses

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



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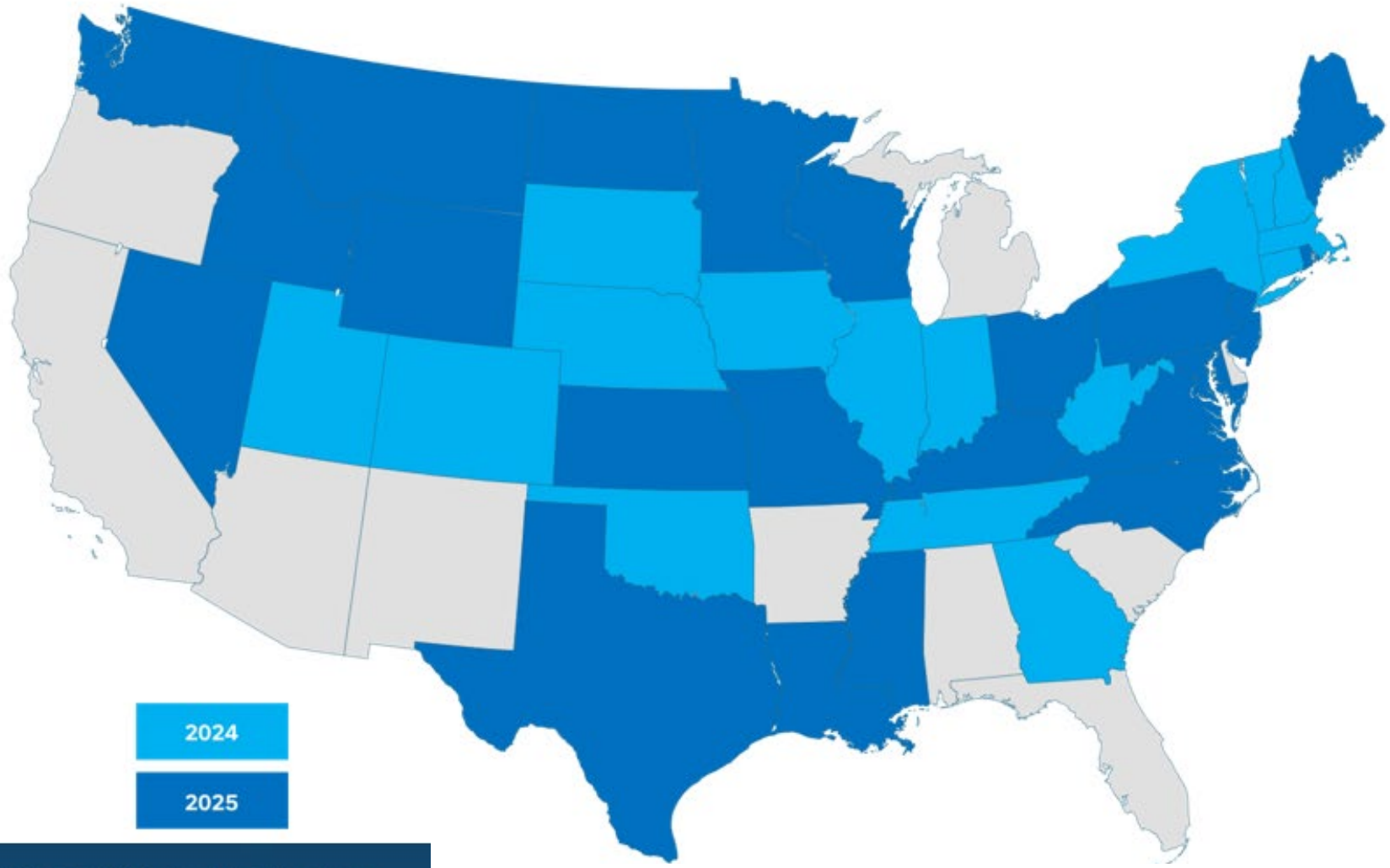
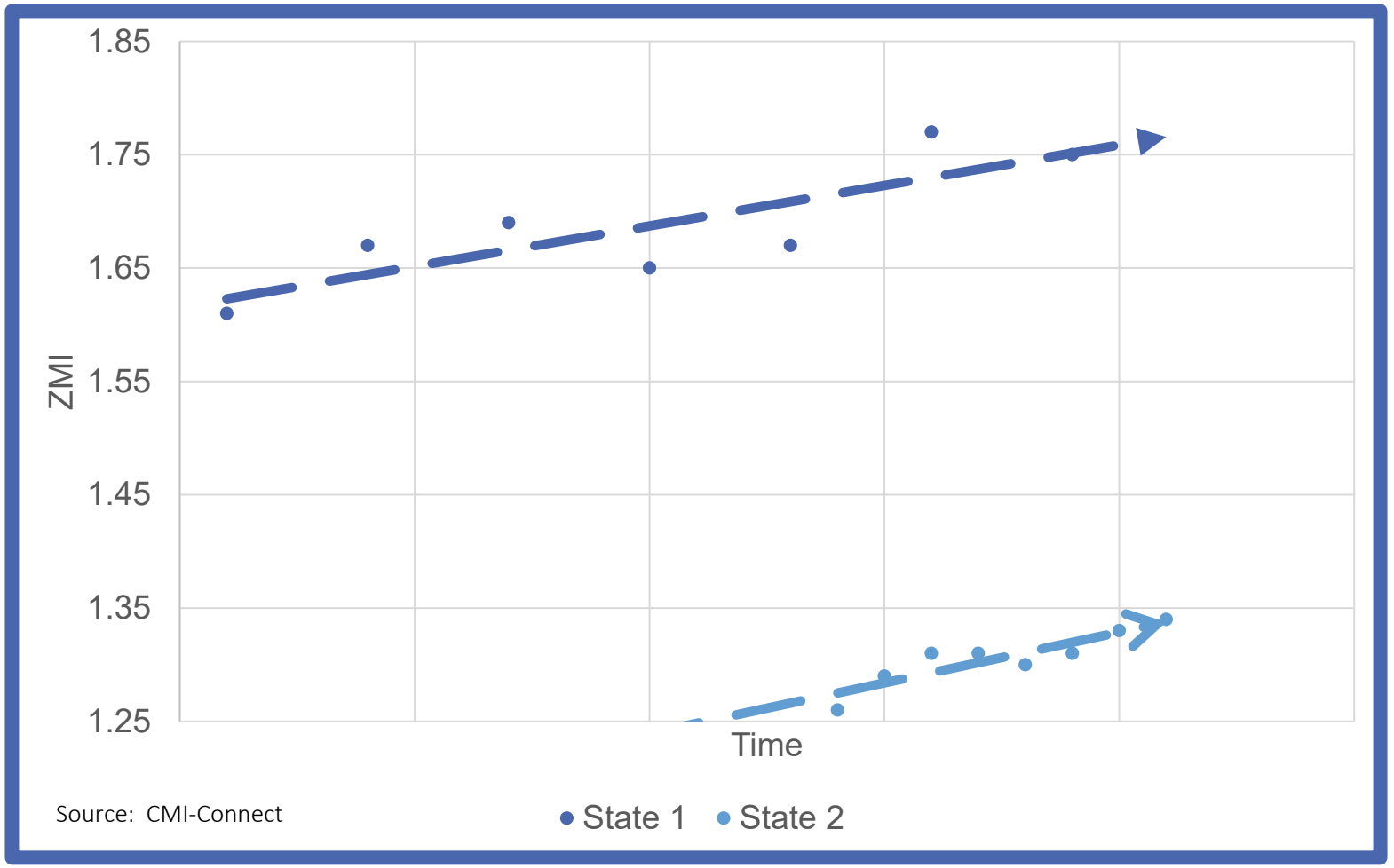
Medicaid PDPM Implementation

Timeline for state case-mix index (CMI) adjustment transitioning to PDPM.



Not All State Transitions Are Created Equal

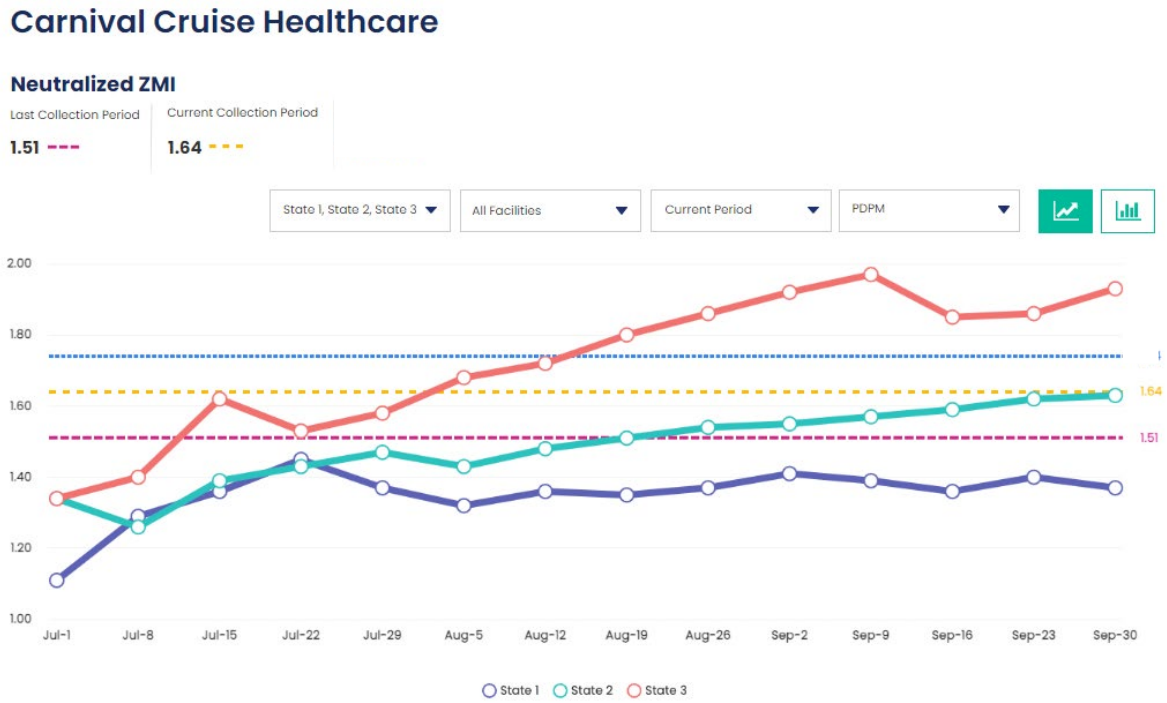


Source: CMI-Connect

Introducing the "ZMI"

Neutralized Case-Mix to Account for State CMI Differences

- For Medicare Zimmet Healthcare invented the "Z-Rate" at a neutralized wage index of 1.0
- Meet the "ZMI" a new measure for neutralized CMI to account for State system differences
- Allows operators to compare performance within a portfolio from State-to-State
- Offers industry standard metric for operators in one state or an individual SNF to compare
- Implications beyond CMI management include transactions and underwriting



CONNECT

Early ZMI Capture Trends

Provider Performance Varies Significantly

New York ZMI from 4/1/24 to 8/31/24 = 1.39

Category	Bottom Quartile	Average	Top Quartile
Neutralized "ZMI"	1.20	1.46	1.79
Extensive Services	0.0%	4.0%	12.5%
Special Care High	8.7%	27.5%	49.0%
Depression	0.1%	27.2%	58.8%
Physical Function	50.6%	33.4%	16.9%
GG Function Score "A"	41.0%	21.0%	5.0%

Source: CMI-Connect & PDPM-Connect

CONNECT

New York PDPM

Nursing Component Distribution

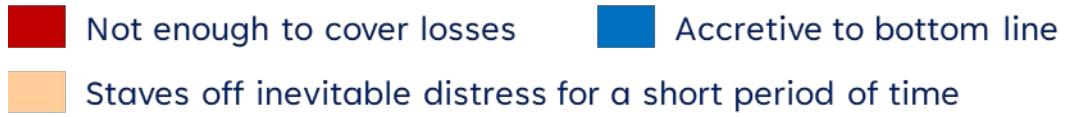
Nursing Category	Medicaid %
Extensive Services	1.0%
Special Care High	26.0%
Special Care Low	10.8%
Clinically Complex	14.4%
Behavioral	11.7%
Physical Function	36.1%
Depression	24.1%
Restorative Nursing	3.0%
Function Score "A"	21.4%

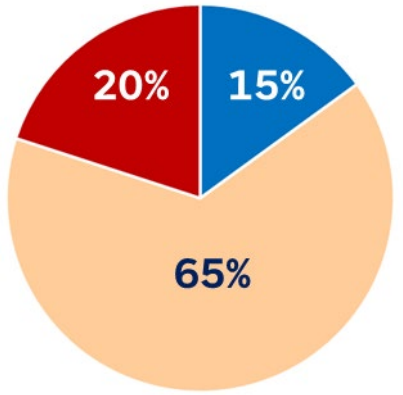
Medicaid in the SNF-Economy

- **Medicaid is the "Safety Net" payer for Beneficiaries *and* providers. For SNFs, Medicaid must ensure stability when non-Medicaid demand fails to cover operating expenses. Medicaid should not be a profit center but should not cause bankruptcy.**
- **Medicare subsidized Medicaid for decades.** "Cost-shifting" targets are declining due to Medicare Advantage and CMMI initiatives, while Medicaid updates trail inflation.
- Market-typical SNFs can **NOT** survive with Medicaid as the primary payer. Medicaid coverage w/o Medicare (non-Duals) is a growing problem as well.
- Rate models begin with cost reports. Stepdown accounting, CMI, adjustments, assign $PPD cost to payers. This exercise is repeated at "irregular" intervals.
  - Operating expenses are NOT directly identifiable to a specific patient or payer.
  - Payment is not targeted or aligned with provider-position or policy goals.
- Mispriced rates are then "corrected" with add-ons, adjustments, inflation, etc. more likely to enhance distortions, not correct them.

Medicaid in SNFonomics

- Recycling the same ideas will do nothing to correct the distortion.
- Well-intended "Quality" incentive payments are often regressive.
- Rebasing, new CMI, etc. serve only to perpetuate imbalances.
  - Budget Adjustment Factor / Recalibration transforms a "Reimbursement" system into "Relative Value Allocation" exercise.
- Once overhead is covered, Contribution Margin can exceed 90% of marginal revenue.
- Medicare Part B adds another potential profit center or penalty for SNFs with high Medicaid-only volume.
- Uniform % rate increases do not stabilize the industry:





ZHSG analysis of national trends.

Modern Reimbursement Theory

- Modern Reimbursement Theory posits that the Medicaid rate cannot be developed in a vacuum. Rates must be scaled/adjusted based on provider-specific position.

- **SNF-specific Medicaid rates must reflect SNFonomics.**
  - Flexible: Medicaid Rate Construction must be slowly transformed from a static formula to one responsive to provider "position" within changing market conditions.
  - Responsible: Avoids undue enrichment or burden. Phased-in with stop loss/gain provisions to avoid Rate Shock.
  - Targeted: Controlled payment incentives should align with state policy objectives.
  - Stabilizing: Ensure long-term care access for Medicaid beneficiaries.
  - Transparent: Clear understanding of data-driven payments based on facility need.

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:

$$\frac{\text{Patient Service Revenue}}{\text{Days}}$$

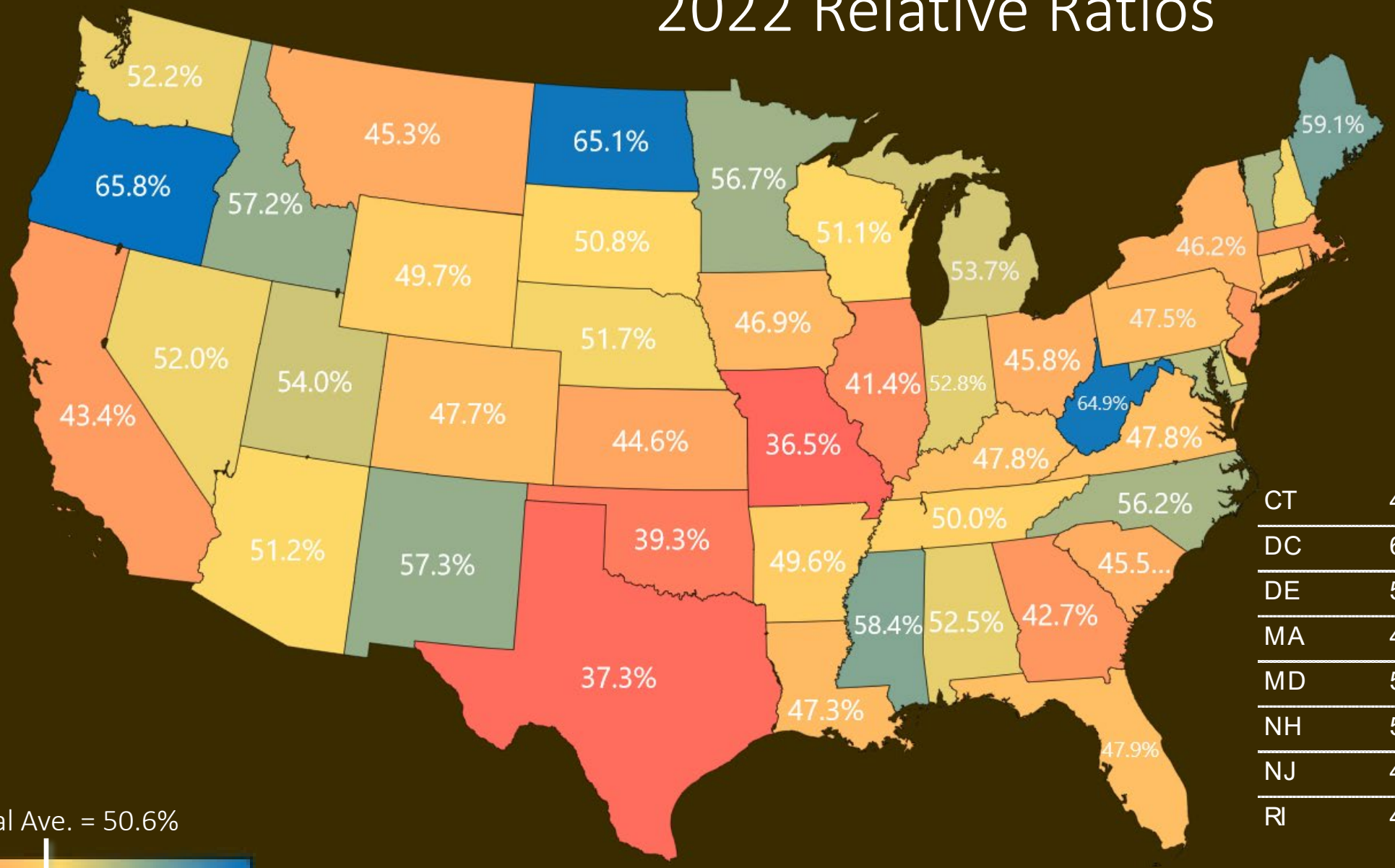
- Compares SNF performance against local peer group
- Identifies underlying favorability of state reimbursement environment

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

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%

Medicaid Systems to Discuss

- Tennessee
  - Reduction in Imputed Occupancy Penalty Drove rates up
- Pennsylvania
  - Budget Adjustment Factor & Rebasing.
  - “Drinking Your Milkshake”
- New York State
  - Residual Capital Reimbursement
- Missouri
  - Major Increases due to Case Mix but not universally adopted
- Georgia
  - “Unfrozen” base year coupled with PDPM nursing CMI improvement ratios

Future Positive Trends in Medicaid Reimbursement

1. Align payment with policy initiatives that reward providers for initiative and achievement, as opposed to punishing for noncompliance or failure to achieve unrealistic benchmarks. Quality Programs are almost always regressive and bad for High Medicaid providers.

   As importantly, neutralize metrics so that Medicaid does not pay for programs/services that do not benefit the Medicaid population:

   A. Direct Care staffing: Set staffing hour/day targets so that rates increase when thresholds are achieved, much in the way RUGs reimbursed for rehab, but on a facility-wide basis. Had nursing time been originally rewarded in this manner instead of therapy, we may not be having this discussion today.

   B. Single-bed rooms: Add a “Private Room Differential” payment for one-person occupancy, but only when rooms are reserved for Medicaid-covered residents.

Future Positive Trends in Medicaid Reimbursement

2. Account for efficiency limitations for smaller facilities.

3. Provide incentives for avoidable hospital mitigation programs such as ISNP or ISNP equivalent, which improve clinical quality but are difficult to measure with respect to net revenue for providers.

4. Neutralize distortion when calculating base rates for Indirect cost centers so that $PPD are not skewed across noncomparable providers. Specifically, Freestanding SNFs with 100% SNF-certified beds should not be averaged with CCRCs or Hospital-Based SNFs.

Future Positive Trends in Medicaid Reimbursement

5. Adjust for baseline differences in Direct Care based on ratio of short- v. long-term care census (this is often accomplished using respective CMI systems which lack sensitivity for such a nuanced calculation).

6. Capital reimbursement: Operators should have the incentive, and ability, to finance capital improvements. These payment mechanisms must not be regressive and should favor high Medicaid providers.
   a. Fair Rental Value vs. Actual Cost Based Systems

7. Create a Disproportionate Share pool to shift dollars to high Medicaid providers or those caring for patients without Medicare Part B supplemental coverage.

8. Study new forms of CMI adjustment, specifically the CMS-HCC used for Medicare Advantage to align acuity-measures across payers.

What's the Band-Aid Approach?

- Rationalized Non-Comps
- Quality??
- Add some differentials that align with state goals
  - Private Room
  - Disproportionate Share
- Clean up the "catch-up funding" on the bottom half of the rate sheet
- Stop the alphabet soup of the past and put in the rate
- Unfrozen Aribtrary Specialty Rates

Ohio Medicaid

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Direct Care Rates – HB 33 & Rebasing

- The statewide average Direct Care Rate increased $25.40, or 22%, from $117.76 as of July 1, 2022, to $143.16 as of July 1, 2023.
- Direct rates are provider specific and adjusted for Case Mix semi-annually

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Direct Care Rate				
Peer Group	July 1, 2022	July 1, 2023	Per Diem Increase	Percent Increase
1-L	124.55	155.43	30.88	25%
1-S	119.24	146.85	27.60	23%
2-L	118.59	145.39	26.80	23%
2-S	118.80	145.33	26.53	22%
3-L	114.89	134.35	19.46	17%
3-S	112.56	132.56	19.99	18%
FP	119.31	145.01	25.71	22%
NFP	111.98	135.86	23.88	21%
Gov	108.83	128.53	19.71	18%
SWA	117.76	143.16	25.40	22%

July 1, 2024
Ohio Medicaid Rates

July 1, 2024 Medicaid Rates

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- No change to prices
- Case-mix change, if provider did not opt to freeze CMI
- Facility quality points will be recalculated for July 1, 2024 based on most currently available data and new measures
- 5% rate reduction for licensed occupancy percentage less than 65%
- 3 quality points for licensed occupancy percentage greater than 75%
- Licensed occupancy based on 2023 Medicaid cost reports and any beds surrendered before July 1, 2024

Quality incentive program

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- Bottom twenty-fifth percentile excluded
- New facilities receive median quality incentive payment for SFY of initial provider agreement and immediately following fiscal year
- Change of ownership facilities after July 1, 2023 are excluded from quality incentive program until the earlier of the January 1 or July 1 that is at least six months after date of CHOP
  - CHOP 6/30/24 → Eligibility date 1/1/2025
  - CHOP 7/1/24 → Eligibility date 7/1/2025

Key Considerations for providers

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- Review licensed occupancy calculation and consider impact of bed reductions to meet 65% or 75%
- Case Mix, if not frozen
- Facility quality points will be recalculated for January 1, 2025 rate setting
  - 25th percentile will stay the same. Opportunity to improve above threshold if under in July
  - Data for frozen measures will not change for January recalculation due to timing

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Ohio Medicaid Quality Points

July 1, 2024 Quality Components

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- House Bill 33 modifies ORC 5165.26 to include four new measures as part of Ohio quality incentive program
  - Long-stay residents whose need for help with daily activities has increase
  - Long-stay residents experiencing one or more falls with major injury
  - Long-stay residents who were administered an antipsychotic medication
  - Adjusted total nurse staffing hours (from Payroll Based Journal Submissions)
- Scores for July 1, 2024 rate setting period will be set based on aggregate score for eight measures

July 1, 2024 Quality Points Data

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- April 2024 refresh includes data with measure period 2023Q1-2023Q4
- Frozen QMs continue with measure period 2022Q4-2023Q3
- Staffing data, updated quarterly, was frozen for April refresh due to transition to MDS 3.0 and conversion to PDPM rate. Most recent data for Adjusted Total Nurse Staffing is 2023Q3.

Quality Component Measurement Periods

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Quality Component	Measurement Period
Percentage of long-stay residents with a catheter inserted and left in their bladder	2023Q1-2023Q4
Percentage of long-stay residents with a urinary tract infection	2023Q1-2023Q4
Percentage of long-stay residents whose ability to move independently worsened	2022Q4-2023Q3
Percentage of high risk long-stay residents with pressure ulcers	2022Q4-2023Q3
Percentage of long-stay residents whose need for help with daily activities has increased	2022Q4-2023Q3
Percentage of long-stay residents experiencing one or more falls with major injury	2023Q1-2023Q4
Percentage of long-stay residents who were administered an antipsychotic medication	2023Q1-2023Q4
Adjusted Total Nurse Staffing (Hours per Resident per Day) from PBJ Data	2022Q4-2023Q3

Bottom Twenty-fifth percentile

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- The cut point is calculated and set each July 1. The cut point is used for the remainder of the state fiscal year.
- Individual nursing facility scores will be recalculated for January 1, 2025 rate setting. There is an opportunity to improve for providers below cut point at July 1, 2024.
- ***Estimated*** cut point for July 1, 2024 is 28.25 points.

Twenty-fifth percentile trending

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- The bottom twenty-fifth percentile cut point has risen from 23.25 points to 28.25 points over the past year; however, there was no increase from the prior quarter's data release to this release

Twenty-fifth Percentile Trending and Forecasting

Four Quarters Ending	**Q4 2022**	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2024**
Cut point	23.25	25.75	26.25	28.25	28.25
Increase by quarter		*2.5*	*0.5*	*2*	*0*

Distribution by measure

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- The table below shows the distribution for each quality measure. In determining scores and the twenty-fifth percentile cut point, the state aggregates all measures before calculations are made. The table below is for trending purposes only. Accordingly, the sum of each measure for the twenty-fifth percentile column will not foot to 28.25.

Measure	25th Percentile	Average	Median	75th Percentile	Maximum Points
Catheter	4.00	4.53	5.00	5.00	5.00
Urinary Tract Infection	4.00	4.21	5.00	5.00	5.00
Ability to Move Worsened	5.25	6.01	6.75	7.50	7.50
High Risk with Pressure Ulcers	2.00	2.96	3.00	4.00	5.00
Help with Daily Activities Increased	3.75	5.02	5.25	6.75	7.50
Falls with Major Injury	2.00	2.65	3.00	4.00	5.00
Administered Antipsychotic	3.00	4.46	4.50	6.75	7.50
Adjusted Total Nurse Staffing	0.00	1.67	2.00	3.00	5.00

Quality point value calculation

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- The value per quality point will be calculated by the Ohio Department of Medicaid based on ORC 5165.26. The point value is calculated as a quotient of funding available and average Medicaid point-days. The inpatient days to be used in the calculation for licensed occupancy and for Medicaid days will come from the 2023 Medicaid cost reports.
- As of today, the Ohio Department of Medicaid has not released the 2023 Medicaid cost report data. However, using the most currently available data, we have calculated the estimated value per quality point to be around $1.20. This is an estimate only and is not final.
- This estimate uses 2022 Medicaid cost report days and assumes that providers who received the occupancy add-on in SFY 2024 will receive the occupancy add-on in SFY 2025.

NF Private Rooms

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- $30 for category 1, $20 for category 2
- ODM still accepting applications
- The private room incentive payment will begin six months following approval by CMS or on the effective date of applicable Department of Medicaid rules, whichever is later
- Funding retroactive or not?
- Current updates

Kentucky Medicaid

Transition to PDPM

4/1/2024-6/30/2024 rates were frozen at rates effective 1/1/2024

Proposed to be effective 7/1/2024

7/1/2024-9/30/2024 and 10/1/2024-12/31/2024 rates were frozen also due to delay in implementation

Only Nursing PDPM CMI applied to case-mix adjusted rate components

PDPM Phase-In

Rate Effective Date	Percent PDPM CMI	Percent RUG CMI
7/1/2024	25%	75%
10/1/2024	50%	50%
1/1/2025	75%	25%
4/1/2025	100%	0%

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Calculation of 7/1/2024 CMI as proposed:

- 75% RUG CMI from 1/1/2024 rate sheet (final Q3 2023 roster)
- 25% PDPM CMI from final Q1 2024 roster

Calculation:

RUG CMI: _____ x 0.75 = _____ plus (+)

PDPM CMI: _____ x 0.25 = _____

_____ = Medicaid Average CMI

Kentucky Quality Program

- Provider tax add-on allowance will be reduced and instead the funding will be used to create the quality pool.
- Providers will earn quality per diem add-on using 4 quality measures and 2 non-quality measures
- Funds distributed based quarterly on provider performance and percentage of Medicaid days
- Scorecards to be issued by department through provider portal, which will show ranking and quality payment amount for subsequent quarter

Percentage of long-stay residents with a urinary tract infection	Percentage of high risk long-stay residents with pressure ulcers
Percentage of long-stay residents experiencing one or more falls with major injury	Percentage of long-stay residents who received an antipsychotic medication
Medicaid utilization	Occupancy Percentage

Kentucky Department for Medicaid Services
Quality Scorecard and Per Diem Calculation

Current Provider Information

DRAFT FOR DISCUSSION PURPOSES ONLY / INFORMATIONAL FOR SFY 2026 PAYMENTS

Facility Name:

Provider Number:

Quality Measures

Benchmarks and Facility QM Scoring

Data Published Q3 2024 [MDS Data from Q2 2023:Q1 2024]

Quality Measure	Kentucky Specific QM Benchmarks and Point Values						Percent of Residents	Points Assigned
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5			
	20	40	60	80	100			
	Maximum Value Allowed for Each Range							
Percentage of long-stay residents with a urinary tract infection (QM #407)	100.00%	4.52%	2.72%	1.60%	0.70%	WILL BE USED FOR DETERMINATION OF QUALITY SCORE	0.26%	100
Percentage of long-stay residents experiencing one or more falls with major injury (QM #410)	100.00%	5.14%	3.56%	2.46%	1.34%		4.07%	40
Percentage of high risk long-stay residents with pressure ulcers (QM #453)	100.00%	10.57%	7.83%	5.84%	3.77%		6.78%	60
Percentage of long-stay residents who received an antipsychotic medication (QM #419)	100.00%	20.39%	15.08%	11.37%	7.49%		16.71%	40
Occupancy Percentage	25.00%	60.00%	80.00%	90.00%	95.00%		85.23%	60
Medicaid Utilization	25.00%	60.00%	70.00%	80.00%	90.00%		56.68%	20
Percentage of long-stay residents assessed and appropriately given the pneumococcal vaccine (QM #415)	70.00%	80.00%	90.00%	95.00%	100.00%	INFORMATIONAL ONLY	100.00%	Info Only
Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine (QM #454)	70.00%	80.00%	90.00%	95.00%	100.00%		99.09%	Info Only
						TOTAL		320

**** There will be optional incentives related to Behavioral Health in near future. This topic is under discussion with CHFS and DMS.***

Proposed Quality Payment Per Diem Calculation ***(not effective until SFY 2026 with current data at time of rate setting)***		
Total Quality Score		**320**
Medicaid Days		25,430
Quality Adjusted Medicaid Days (320/600 * 25,430 Medicaid Days)		13,563
Total Statewide Quality Adjusted Medicaid Days		2,861,118
Percent of Statewide Medicaid Days (13,563/2,861,118)		**0.47%**
Total Annual Quality Metric Pool	$	8,000,000
Annualized Medicaid Days		25,430
Total Per Diem ($8,000,000 * 0.47%/25,430 Annualized Medicaid Days)	$	**1.49**

Impact of Medicaid Rate Changes

KY Rate Estimated Budget Impact is $382 Million

1/1/2024	$248.90
7/1/2024	$311.21
Difference	$62.31

	Annualized 7 Months Ending 7/31/2024	Adjusted Medicaid Rate Impact	Difference	Percentage Change
Total Beds	60	60		
Medicaid Days	15,087	15,087		
Medicaid Revenue	$3,877,659	$4,695,359	$817,699	
Average Rate	$257.01	$311.21	$54.20	21.1%
Effective Gross Income	**$4,969,009**	**$5,786,708**	**$817,699**	**16.5%**
Expenses	$4,363,115	$4,363,115		
Management Fee	$248,450	$289,335		
Total Expenses	$4,611,565	$4,652,450	$40,885	
Net Operating Income	$357,444	$1,134,258	$776,814	217.3%
Hypothetical Cap Rate	12.50%	12.50%		
Indicated Value	**$2,860,000**	**$9,070,000**	**$6,210,000**	**217.1%**
Value Per Bed	$47,667	$151,167	$103,500	217.1%

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Connecticut Bed Reduction

CT Rebalancing Plan

Reduce the reliance of institutional care

- Increase funding for community-based long-term care as of 2022 58% vs 42%
- Money Follows the Person (MFP)
- Nursing Home Diversification - grant money available for SNFs adding HBCS

Other Methods to reduce beds

- In 2019 - Removed the stop/loss provision for vacancy above 70%
- Medicaid minimum occupancy requirement of 90%
- Elimination of 3 and 4 beds by 7/1/26
- Proposal to cut rates further if a minimum average occupancy of 90% is not achieved

Connecticut Statistics

	2004	2013	% Diff	2023	% Diff
Licensed Beds	29,801	26,467	-11.2%	23,460	-11.4%
Residents	27,796	24,032	-13.5%	19,599	-18.4%
Occupancy	93.3%	90.8%	-2.5%	83.5%	-7.3%

Utilization of Beds per 1,000 Age 75 for 2022>

CT	84.1
OR	28.7

Source: CBRE Information Digest for the Skilled Nursing Industry

2012	2013	2014	2015	2020	2021	2022	2024
$227.03	$227.28	$227.11	$227.40	$246.92	$249.39	$275.68	$323.46

Average overall increase from 2022 $47.78