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Session #:

Operating in a Post-Pandemic Climate; Strategies for SNF Success

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Objectives:

- *Utilize benchmarking data provided, both revenue and expense to drive operations under PDPM and post-pandemic landscape*
- *Be able to assess current clinical and financial outcomes to determine if opportunity for enhancement exists*
- *Understand different therapy contract methodologies and delivery patterns to determine your current cost per minute and decide if this model works for you*

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OCCUPANCY & CENSUS CHALLENGES

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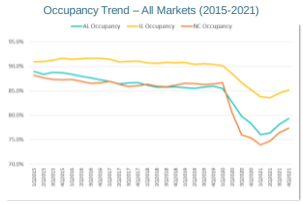
Occupancy and Census Challenges



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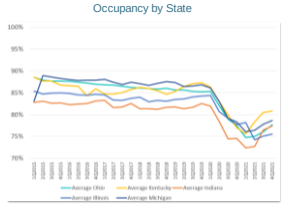
Occupancy and Census Challenges



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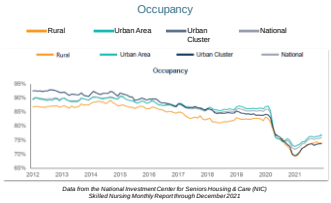
Occupancy National Trends



Data from the National Investment Center for Seniors Housing & Care (NIC)
Skilled Nursing Monthly Report through December 2021

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Occupancy Trends

NIC MAP VISION	Seniors Housing			Nursing Care
	Overall	Majority IL	Majority AL	Majority NC
Source: NIC MAP Data powered by NIC MAP Vision.	Market Fundamentals 4Q21			
Occupancy	81.0%	83.6%	78.3%	77.2%
Annual Rent Growth	2.3%	2.2%	2.4%	2.0%
Annual Absorption	3.0%	2.0%	4.1%	2.0%
Annual Inventory Growth	2.4%	1.9%	3.0%	-0.5%
Construction vs. Inventory	5.2%	5.0%	5.4%	0.3%
Rolling 4-Quarter Starts vs. Inventory	2.4%	2.4%	2.9%	0.2%
	Capital Markets 3Q21			
Transaction Volume (millions)	$4,308.1			$870.6
Rolling 4-Quarter Price Per Unit	$171,559			$94,425
Rolling 4-Quarter Cap Rate	4.9%			9.0%

* Overall Seniors Housing combines Majority IL and Majority AL Properties
Source: NIC MAP® Data, powered by NIC MAP Vision
Data for the Market Fundamentals is representative of the Top 31 Primary metropolitan markets.
Data for the Capital Markets is representative of all U.S. property transactions of at least $2.5 million.

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MANAGED CARE

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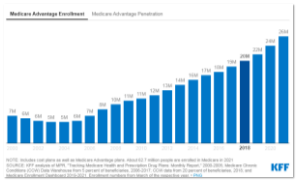
Medicare Advantage Enrollment

Figure 1
Total Medicare Advantage Enrollment, 2000-2021



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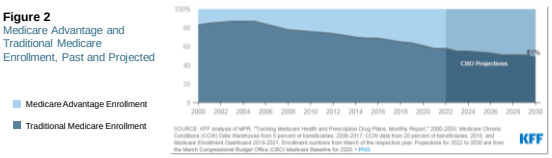
Medicare Advantage Enrollment

Figure 2
Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



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Managed Care Impact

Recent MedPAC study showed that Medicare fee for service payments were 27% higher than Medicare Advantage payments.

Year	Average Rate	Average Expense	PM Average Margin
2020	$422	$454	($32)
2019	$382	$386	($4)

Margins based on PM client sample

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PDPM & MEDICARE

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2020 Average PDPM Rates

State	PT & OT Rate	SLP Rate	Nursing Rate	Non-Therapy Ancillary	Total Rate
Indiana	$169.71	$38.50	$268.03	$108.78	$585.01
Kentucky	$159.81	$42.51	$237.44	$98.69	$538.45
Michigan	$169.24	$38.01	$259.09	$114.50	$580.84
Ohio	$156.76	$36.07	$254.26	$107.61	$554.70

Based on calendar year 2020 Medicare Claims Data

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MedPac suggested 5% cut in Skilled Nursing Rates

- Calculated a 25% profit margin in Medicare payments to justify proposal.
- Goal of cut would be to bring Medicare payment structure to budget neutrality.
- Proposal comes during a massive employment shortage for Nursing facilities all over the country.
- From February 2020 to December 2020, 'analysis of Medicare payments and SNF costs showed average costs per day increased 2.1% while staffing decreased by 9.6%. Therapy costs have been reduced under PDPM.

Source: Amy Stulick, Skilled Nursing News

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Temporary Suspension of Sequestration

- May 1, 2020 – March 31, 2022, sequestration was eliminated for ALL Medicare providers
- April 1, 2022- Sequestration adjustment will be 1%
- July 1, 2022- Sequestration adjustment will return to 2%

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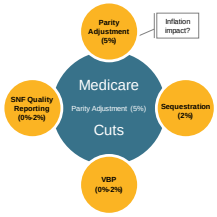
Medicare Rate Reductions



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December 2021 Key Indicators per NIC Map

	National	
Total SNF Occupancy	76%	
	Patient Mix	Average Rate
Medicaid	66.3%	$248
Medicare	11.5%	$580
Managed Medicare	7.3%	$451
Private	8.1%	$299

https://www.nic.org/senior-housing-investment-nic-map

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Staffing

- 2020 to 2021 wages increased significantly based on HCS Nursing Home Salary & Benefits Report based on 1,613 nursing homes
- Nurse Aide wages increased 7-8%
- Directors of Nursing increased 3.09%
- Turnover for CNAs jumped from 40% in 2020 to 51.4% in 2021
- All employee turnover went from 35.4% in 2020 to 38.7% in 2021

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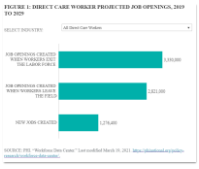
Senior Living Industry in a Post-Covid World

Critical Actions – Labor Market Challenges & Opportunities



In September 2020, the Bureau of Labor Statistics (BLS) released new employment projections—and once again, the outlook on the direct care workforce is daunting.

From 2019 to 2029, this workforce is projected to add nearly 1.3 million new direct care jobs, including one million home care jobs, 163,000 residential care jobs, and 119,000 direct care jobs in other industries, like hospitals, vocational rehabilitation services, and more. This dramatic workforce growth will be offset slightly by the loss of 10,000 nursing assistant jobs in nursing homes.

While the projected number of new jobs is astoundingly high, these figures alone offer an incomplete picture of the nation's full direct care workforce needs. **The long-term care sector will also need to fill an additional 6.2 million direct care job openings between 2019 and 2029** as workers leave the field for a new occupation or leave the labor force altogether due to retirement, disability, or some other reason. Combining these departures and new jobs, there will be a projected **7.4 million total direct care job openings in the decade ahead**. (See Figure 1.)

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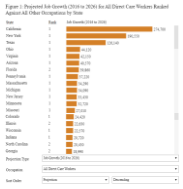
Senior Living Industry in a Post-Covid World

Critical Actions – Labor Market Challenges & Opportunities

From 2016 to 2026, the direct care workforce will **add the greatest number of new jobs** (as compared to other occupations) in 38 states—and by 2026, it will be the largest workforce in 21 states (see Figure 1). In California, Minnesota, New Mexico, and Vermont, personal care aides *alone* will be the largest single occupation in 2026.



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Strategies

Evaluate market
- Competition
- Demographic factors, age, income, etc.
- Service offerings

Repositioning
- Bed composition
- Private rooms
- Capital improvements

Operational assessment
- Room rates
- Staffing levels, wages
- Contract reviews

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IMPACTING CHANGE THROUGH MDS OPTIMIZATION

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MDS Impacts

CLINICAL OUTCOMES
- Quality Measures
- CMS 5 Star Rating
- SNF Quality Reporting Program
- PDPM Optimization
- Care Planning

COMPLIANCE
- Survey Readiness
- Meeting Federal/State Requirements
- Documentation Compliance
- Legal Risks

FINANCIAL OPTIMIZATION
- PDPM Optimization
- Case Mix Initiatives
- Managing Managed Care
- Quality Incentive Programs

CENSUS REGROWTH
- Care Compare Results
- Managing Managed Care
- CMS 5 Star Rating

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MDS Roles & Duties


MDS TASK MANAGEMENT
Wiechers Daily, Weekly, Monthly & Quarterly Tasks

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MDS Roles & Duties

ADDITIONAL TASKS COMPLETED BY AN MDS NURSE:

- On-call rotation
- Weekend manager
- Work the floor
- Back-up DON
- Update acute care plans
- Physician rounding
- Admission paperwork
- Quarterly assessments (Braden, fall risk, etc.)
- Wound Nurse
- Clerical duties (Filing records, thinning charts, uploading documentation)
- ICD-10 Coding
- Discharge planning
- Care conferences
- Monthly change over
- COVID testing
- Infection control tasks
- Restorative Nurse

Your MDS Nurse is your only revenue generating Nursing position.

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MDS Roles & Duties

WHO DOES YOUR MDS NURSE REPORT TO?

Administrator

Pros:
- Oversees facility financial and clinical quality of care
- Less likely to be pulled into additional Nursing tasks
- Better continuity of IDT members involved in coding MDS

Cons:
- Lack of understanding of clinical coding requirements
- Not viewed as part of clinical team

Director of Nursing

Pros:
- Continuity of clinical services

Cons:
- Pulled into additional Nursing duties
- Does not have a role in facility financial performance
- Conflict of capturing Quality Measures vs. Reimbursement
- Viewed as Nursing support when staffing issues arise

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MDS Accountability

MEETING MANAGEMENT

Are the following meetings taking place, and is your MDS Nurse taking an active role?

1. **Daily PPS or 3 Day Huddle**
   - Is the primary diagnosis being chosen by IDT to reflect optimized codes?
   - Does the team discuss GG usual performance?
   - Is the ARD carefully chosen based on documentation from the hospital? (Not always using day 8)
   - Are measures being put in place for "documentation compliance" leading up to the ARD?
   - Are all team members coming prepared? (GG information, swallowing info, BIMS, PHQ9 from first few days)
2. **Weekly UR/Medicare**
   - Are all team members coming prepared?
   - Are IDT conversations ongoing pertaining to DC planning?
3. **Monthly Triple Check**
   - Is there a large number of discrepancies between billing and MDS information?
   - Does MDS Nurse take an active role in validating information on the UB04?
4. **Weekly Case Mix Review**
   Does the IDT meet weekly to discuss current LTC population and potential case mix opportunities?
   Does the MDS Nurse keep a list of current lower scoring CMI residents to discuss?
5. **Monthly Quality Measure Review**
   Does the MDS Nurse understand what MDS items drive Quality Measure Scores?
   Does the team actively move ARD's as needed to improve Quality Measures?
   Does the team understand the impact of Quality Measures on Quality Incentive Payment programs?
6. **Quarterly SNF Quality Reporting Program Review**
   Does the MDS Nurse review the Review and Correct Report to validate coding is accurate?

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3-Day Huddle Meeting

- Skilled Residents
- Completed day 2-3 after admission (day 1 too soon)
- Predicting PDPM HIPPS Score based on info collected
- Information gathering for MDS process
- Opportunity- complete additional interviews, talk with physician for clarification on diagnoses, start triple check process
- Most important meeting you can have for skilled residents

As a result of this meeting:

- Additional measures put in place to collect data (ex: SOB while lying flat)
- Additional interviews conducted
- Additional clarification from hospital records and physician
- Discussion with resident/family (ex: diabetic retinopathy)

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Impact of Quality on Reimbursement

Value Based Purchasing Program

- FY 2023 – Proposal to continue flat 0.8% VBP reduction
- FY 2024 – Return to previous methodology including hospital readmission rate
- FY 2025 – Continue previous methodology
- FY 2026 – Add Total nurse staffing and health care-associated infections requiring hospitalization
- FY 2027 – Add discharge to the community

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Impact of Quality on Reimbursement

Ohio Quality Incentive Programs

- "Old" Quality Incentive
  - Long stay and short stay pressure ulcers
  - Long stay and short stay anti-psychotics
  - Unplanned weight loss
  - Staff retention
  - Customer satisfaction survey
- "New" Quality Incentive
  - Percentage of residents whose ability to move independently worsened
  - UTIs
  - Catheters
  - High-risk residents with pressure ulcers

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Retaining Top-Tier MDS Talent

- Include MDS Self-Assessment in annual performance reviews
  - Develop goals based on results
- Labor Analysis to ensure adequate time to complete MDS Tasks
- Eliminate additional duties not pertaining to MDS
- Provide support and encouragement for additional training/resources
- Consider alternative MDS staffing models

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MDS Accuracy & Audits

Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status.

- CMS RAI Manual v1.17.1 page 1-16

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MDS Accuracy & Audits

CMS/Ohio Department of Health Annual and Complaint Surveys

- F636 – Comprehensive Assessments & Timing
- F637 – Comprehensive Assessment After Significant Change
- F638 – Quarterly Assessment Every 3 Months
- F641 – Accuracy of Assessments
- F656 – Develop/Implement Comprehensive Care Plan
- F657 – Care Plan Timing and Revision
- Use of CAAs to validate citations in other areas

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MDS Accuracy & Audits

Ohio Department of Medicaid Exception Reviews

Intent

Identify any patterns or trends related to resident assessments submitted in accordance with rule 5160-3-43.1 of the Administrative Code that could result in inaccurate case mix scores used to calculate the direct care component of the nursing facility per diem rate

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2021 Commonly Unsupported Items – Per Myers and Stauffer

- ADL Documentation
- Mood/Depression Interviews
- BIMS Interviews
- Diagnosis Codes
- Respiratory Therapy
- Isolation

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MDS Accuracy & Audits

RAC Audits (Recovery Audit Program)

Intent

The Recovery Audit Program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.

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Common Unsupported RAC Audit Items

- Primary Diagnosis
- Section GG
- Diagnoses to support the Nursing and NTA categories
- Interview timing
- Medical Necessity of Skilled Care

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Managed Care Audits

- Audits continue, even if the score was approved by the insurance case manager
- Common unsupported items are similar to RAC Audit unsupported items, but there is increased emphasis placed on connecting coding elements to the reason for hospitalization
  - Example: Denial of COPD diagnosis, although it fits CMS RAI guidelines, due to the reason for hospitalization was a hip fracture
  - Is your MDS team prepared to state their case?

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Managed Care Audits

- Claims are frequently unsupported due to lack of information sent to the reviewer, or incorrect information sent
  - Make sure to send all information needed to support medical necessity and the HIPPS score
  - There is sometimes a difference between what the insurance reviewer asks for, and what they really need
  - Organization of the file is a key factor to ensure the reviewer is able to locate all needed information

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EVALUATING THE IMPACT OF THERAPY ON SNF VIABILITY

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Market Dynamics

Understanding today's market shifts will allow for greater organizational success in the future. This Market Dynamics Report outlines key market drivers impacting therapy, includes insights specific to your region, and pin-points action items across business, labor, reimbursement and market dynamics.

Business Dynamics
One size does not fit all in the therapy market. Evaluating pricing models, financial impact and key value-ads will allow you to make an informed decision on the health of your current partnership.

Market Dynamics
Understanding market trends and outcomes of your competitors as well as your referral sources enables SNF providers to build programming, develop strategic plans and be an attractive network partner.

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Business Dynamics – Pricing Variables

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Business Dynamics – Pricing Estimates

NATIONWIDE ESTIMATED PRICING MATRIX

PRICING METHOD	LOW RANGE	AVERAGE RANGE	HIGH RANGE
Part A % of Therapy CMG	29% - 33%	34% - 36%	37% - 40%
Part B % of Fee Screen	<70%	70% - 75%	76% - 80%

VARIABLES THAT IMPACT LOW/MID/HIGH RANGES:

- Urban vs Rural Location
- Volume of Business
- Therapist Availability
- Therapist Wages
- Caseload Volume
- Caseload Payer Mix
- Skilled vs Non-Skilled Trade-Offs
- Densification of Managed Care

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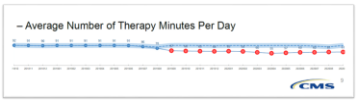
Business Dynamics – Utilization Trends

CMS FINDINGS

Patient-Driven Patient Model (PDPM) increased payments to nursing homes by about 5% in fiscal 2020, for a total gain of $1.7 billion.

A 30% drop from 91 minutes per day in fiscal 2019 to 62 minutes per day
- 91 minutes per day = 637 minutes per week
- 62 minutes per day = 434 minutes per week

Group and concurrent therapy services, which had historically accounted for 1% of total therapy minutes, ballooned to 29% and 32% in October 2019 respectively



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Business Dynamics – Utilization Trends

MINUTE DELIVERY IMPACT:

- Clinical/Quality
  - Outcomes
  - QRP/VBP
- Compliance
  - Audit Risk
- Referral
  - Consumer/Family/Physician Satisfaction
- Financial
  - Revenue
  - Cost
  - Partnership/trust impact

AVERAGE MINUTES PER WEEK	AVERAGE MINUTES PER DAY	DAILY COST FOR FACILITY	EFFECTIVE COST PER MINUTE
625	89	$82.50	$0.93
600	86	$82.50	$0.96
550	79	$82.50	$1.04
500	71	$82.50	$1.16
450	64	$82.50	$1.29
400	57	$82.50	$1.45
350	50	$82.50	$1.65

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Business Dynamics – Pricing is Complex and Facility Specific

GEOGRAPHIC LOCATION	WAGE INDEX	LOW PRICE RANGE % THERAPY COMPONENT 29%	33%	AVERAGE PRICE RANGE % THERAPY COMPONENT 34%	38%	HIGH PRICE RANGE % THERAPY COMPONENT 37%	40%
CA - Bay Area	1.849	$ 109.66	$ 124.78	$ 128.56	$ 136.13	$ 139.91	$ 151.25
Per Minute @ 60/Day		$ 1.83	$ 2.08	$ 2.14	$ 2.27	$ 2.33	$ 2.52
Per Minute @ 90/Day		$ 1.22	$ 1.39	$ 1.43	$ 1.51	$ 1.55	$ 1.68
CA – Los Angeles	1.3119	$ 83.35	$ 94.85	$ 97.72	$ 103.47	$ 106.35	$ 114.97
Per Minute @ 60/Day		$ 1.39	$ 1.58	$ 1.63	$ 1.72	$ 1.77	$ 1.92
Per Minute @ 90/Day		$ 0.93	$ 1.05	$ 1.09	$ 1.15	$ 1.18	$ 1.28
CA - San Diego	1.2833	$ 82.19	$ 93.53	$ 96.36	$ 102.03	$ 104.86	$ 113.36
Per Minute @ 60/Day		$ 1.37	$ 1.56	$ 1.61	$ 1.70	$ 1.75	$ 1.89
Per Minute @ 90/Day		$ 0.91	$ 1.04	$ 1.07	$ 1.13	$ 1.17	$ 1.26
Oh – Cincinnati	0.9122	$ 65.16	$ 74.14	$ 76.41	$ 80.93	$ 83.20	$ 89.97
Per Minute @ 60/Day		$ 1.10	$ 1.24	$ 1.28	$ 1.35	$ 1.40	$ 1.51
Per Minute @ 90/Day		$ 0.73	$ 0.83	$ 0.86	$ 0.91	$ 0.93	$ 1.01
Oh – Dayton	0.9253	$ 65.51	$ 74.54	$ 76.80	$ 81.32	$ 83.58	$ 90.36
Per Minute @ 60/Day		$ 1.09	$ 1.24	$ 1.28	$ 1.36	$ 1.39	$ 1.51
Per Minute @ 90/Day		$ 0.73	$ 0.83	$ 0.85	$ 0.90	$ 0.93	$ 1.00
Oh – Cleveland	0.8934	$ 63.48	$ 72.24	$ 74.43	$ 78.81	$ 81.00	$ 87.56
Per Minute @ 60/Day		$ 1.06	$ 1.20	$ 1.24	$ 1.31	$ 1.35	$ 1.46
Per Minute @ 90/Day		$ 0.71	$ 0.80	$ 0.83	$ 0.88	$ 0.90	$ 0.97

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Business Dynamics – Pricing Shifts

METHODOLOGIES

- Many providers are looking to transition away from a "Percent of Therapy/Total" and shift to a Flat Fee Per Day. This allows for ultimate predictability in costs versus each patient having a variable cost for therapy services dependent on clinical variables and length of stay.

PRICING ADJUSTMENTS

- Since the inception of PDPM in 2019, rates in most parts of the country have decreased. Partnerships have been right-sized after 2 years of operating under this new model to be more fairly-balanced.

Review value-add service extensions for various service extensions that should be included in therapy partnerships

- Staffing collaborations
- Marketing assistance
- Census partnership
- MDS support
- Niche programming
- Administrator & nursing education
- Data insights
- Clinical & financial outcomes optimization tools

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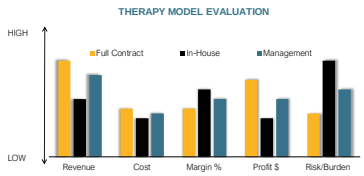
Business Dynamics – In House Considerations

The high costs of COVID and the impetus of PDPM have given SNF executives pause when determining what therapy business model is the best strategic fit. Leaders must consider not just revenue and costs but also focus on margin, profit, cash flow and risk when making these decisions.



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Business Dynamics – In House Considerations

Therapy Joint Venture Risks

On November 17th, the Office of the Inspector General issued an advisory opinion regarding joint ventures for the delivery of therapy services concluding that it would constitute grounds for sanctions under the Federal anti-kickback statue. With the growth of this model, for providers who are currently or are exploring entering a joint-venture in therapy, it's important to be aware of the inherent risks.

Click here to read the full report.

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THANK YOU!

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