March 7, 2022

Unfunded: *The Medicaid Rate Construction Crisis*

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The codependent Medicare/Medicaid duopsony can no longer balance the SNF financial equation. Medicare Advantage, Alternative Payment Models, and ill-conceived experiments with Managed Medicaid LTC created structural deficiencies the current economic model was not designed to absorb.

Skilled Nursing was saved from pandemic distress by emergency federal funding. Now, in the face of comprehensive reform, policymakers must fortify the industry's reimbursement foundation. Reliable data is essential for success; without it, a decades old incongruity threatens to destabilize the entire healthcare continuum.

FUNDING V. FUNDAMENTALS

SNF stakeholders cite inadequate Medicaid funding as long-term care's primary structural defect, noting the pandemic was more accelerant than catalyst. However, the methodology by which funds are allocated is nearly as important. A quarter-century ago, the Urban Institute issued an insightful policy brief on the relationship between financing and quality in long-term care. Upon review, we find little has changed in Skilled Nursing's revenue model since 1998:

> *The federal Balanced Budget Act of 1997 repealed the Boren amendment, giving states far greater freedom in setting nursing home payment rates. The nursing home industry warned that Medicaid reimbursement levels already are too low, and that further reductions would adversely affect quality of care. Indeed, poor quality nursing home care is gaining increasing attention.*
>
> *The question for state policymakers is whether and to what extent goals of quality assurance and cost control are compatible.*
>
> *Logic dictates that there is some minimal level of reimbursement below which it is impossible—or at least unacceptably difficult—to provide good-quality care. That assumption was the premise of the Boren amendment; the problem was that nobody could ever specify in any scientific way what that level of reimbursement was.*
>
> *Finally, although linking payment and quality of care would seem conceptually desirable, the technology to implement such systems at the state level is not currently available.*

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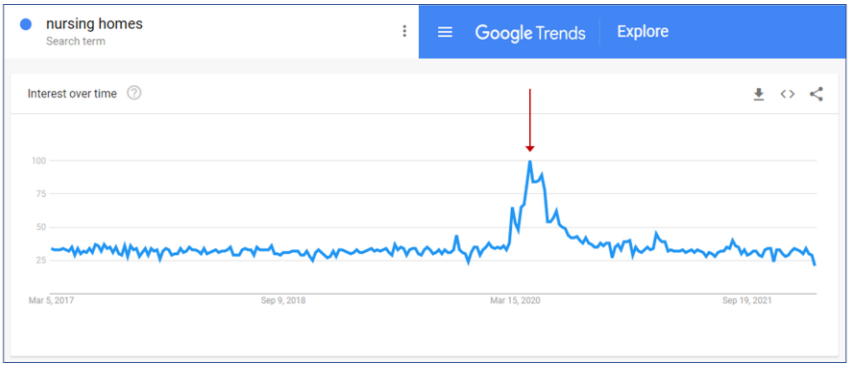
ANECDOTES V. ANALYTICS

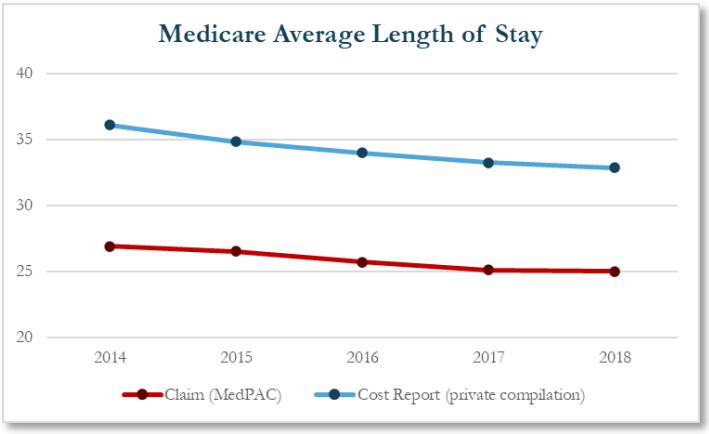
Skilled Nursing is burdened by a perception issue. SNFs enter public consciousness only at the industry's most challenging moments, as evidenced by Google search trends for "Nursing Homes" at the start of the pandemic:



While caregivers were rightfully praised for their health-emergency heroics, the "industry" was afforded no such goodwill. Rational reform, grounded in reliable data, would be welcomed by all stakeholders. We are concerned that performance measures will not be calibrated consistently or applied evenly, as policymakers struggle with even the most basic metrics in long-term care.

DATA V. DISTORTION

The datasets below are both sourced from CMS, yet Medicare cost reports and provider claims tell vastly different stories:

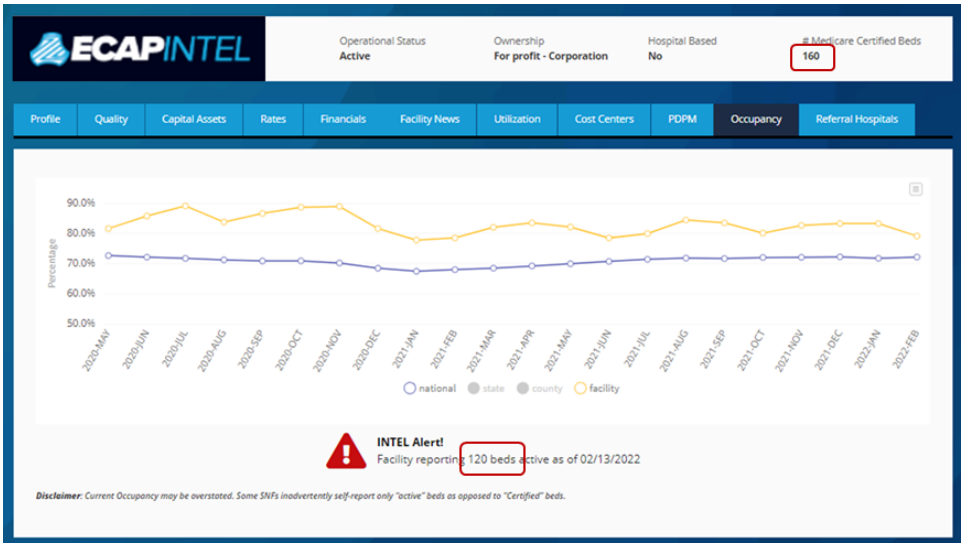


The difference is hardly a rounding error, so which dataset is correct? Good question.

Utilization discrepancies are especially relevant, given CMS' explicit intent "to promote single-occupancy rooms." Data reported to the National Healthcare Safety Network indicates SNF occupancy averaged 71.4% during February 2022, but this figure is misleading for two reasons. First, the calculation is based on provider-reported census & bed inventory.

Officially, there are approximately 1.6 million certified SNF beds nationally; unofficially, ZHSG estimates that up to 200,000 are, as a practical matter, not in service. Most three & four bed configurations have been downsized to semi-private, while many semi-private rooms now serve as single occupancy to meet market demand.

Analysis of NHSN reporting confirms this trend; SNFs are instructed to report total number of "certified beds," but many, like the facility represented below, now measure occupancy as a function of "Post-Pandemic Capacity," thus overstating the ratio of occupied beds.



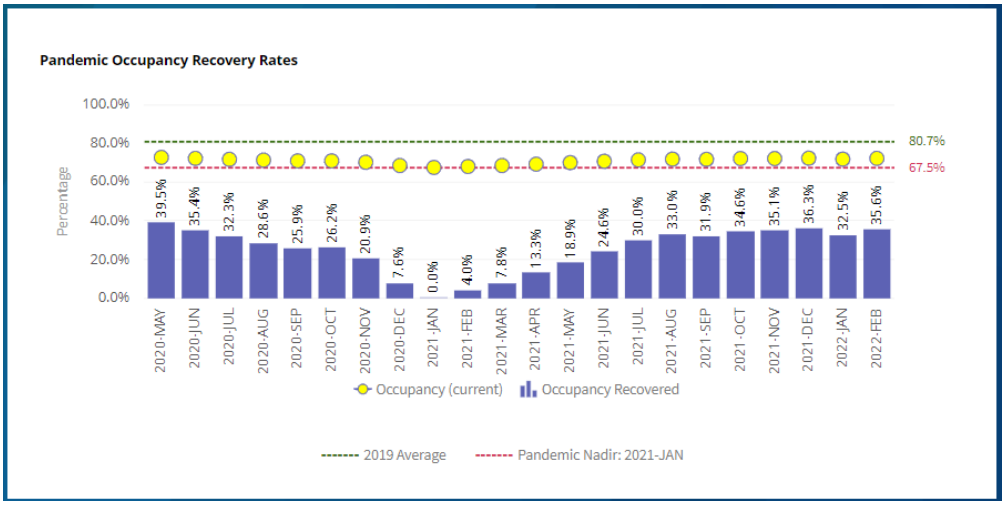
Certified beds carry intrinsic value; providers cannot be expected to voluntarily surrender hard assets regardless of market demand. Nevertheless, approximately 40,000 SNF beds have been decertified since 2015. This 2.4% decline is not evenly distributed across the country. Healthcare is a "local" business; each state must be considered independently. Kansas, for example, has lost 11% of its certified capacity during the same period.

Standard benchmarks are deceiving because they do not reflect changes in demand relative to supply. Occupancy is calculated by dividing current census by total beds, but inventory has steadily declined in recent years. eCapIntel expresses market conditions using "Relative Occupancy," calculated by dividing current census by the number of beds in a base year. As illustrated below, occupancy in Kansas dropped from 80.5% in 2015 to 72.6% last year, but 2021 SNF occupancy was only 64.4%, *relative to* 2015.

Kansas: Market Statistics & Trends — ECAPINTEL

Variable	2015	2016	2017	2018	2019	2020	2021
Number of Certified SNFs	344	340	336	334	337	327	323
Licensed SNF Beds	22,618	24,048	23,560	21,280	21,257	20,572	20,154
Saturation: Beds / 1,000 FFS Beneficiaries	19.3	18.1	18.5	20.5	20.5	21.2	21.6
SNF Occupancy %	80.5%	74.1%	74.4%	80.9%	80.4%	78.2%	72.6%
Relative Occupancy	-	78.8%	77.4%	73.5%	75.0%	71.1%	64.4%

Presenting current national occupancy at 71.4% (down from 80.7% pre-pandemic) as a measure of industry recovery is self-defeating. In reality, occupancy stands at ~68%, *relative to* periods preceding the public health emergency. Even more telling, SNFs have recovered only 35% of demand lost as measured from the pandemic-era nadir in January 2021.



NOTE: An independent investor-focused industry group regularly releases SNF occupancy benchmarks. This dataset is not representative of national performance and we recommend it be discarded. December 2021 national occupancy was 72.3% (before adjustment), not 76% as they recently reported.

OWNER V. OPERATOR

Gordon Gekko is not buying skilled nursing facilities. The term "Private Equity" brings to mind Wall Street raiders, "Hampton Hedge-funders" and sinister shell companies based in the Cayman Islands. The negative connotation should not apply to groups of individual (private) investors who believe in Skilled Nursing as an essential part of the healthcare ecosystem; they not only hold the mortgage, but also finance desperately needed capital improvements.

These investors helped "regionalize" Skilled Nursing when publicly traded national chains divested and exited long-term care. Irrespective of plant ownership, private investors are rarely the operators. In fact, they have created opportunity for dozens of new operating companies to enter the space. Contrary to recent rhetoric, private investor partners are overwhelmingly directed by LNHAs, not MBAs. Incidentally, private investors are not involved in every Skilled Nursing transaction, such as the recent sale of a large national chain by a pure-play, Private Equity company ***to*** a mission-driven, not-for-profit organization.

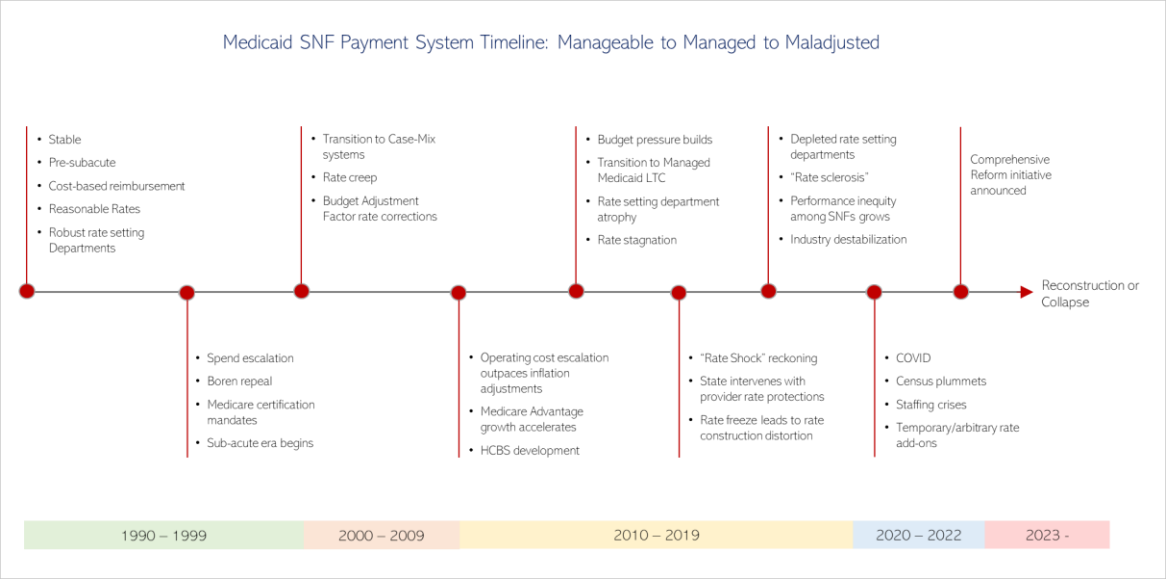
REFORM V. RELIEF

"Reform" is an iterative process subject to extensive debate, including how to pay for policy. While reimbursement was not mentioned in the official Fact Sheet, CMS may believe the initiative is already funded. Congress allocated untold billions in pandemic relief for administration at the local level; states may simply be expected to figure it out. Either way, operators and SNF residents are running out of time.

Our recent work with trade associations suggests states are prepared to provide relief, but only with assurances the funds be used to increase staffing, promote dignity, and in no way "unduly enrich" profitable operators. In the words of one association leader, "We can't just ask the state for $100 million no strings attached."

"Relief" is temporary and often not corrective. An arbitrary, evenly distributed funding allocation would further degrade the industry's long-term outlook. Emergency pandemic relief was delivered through temporary, uniform rate adjustments, set at a fixed value or percentage of SNF-specific rates. The reality of market position meant some facilities received largesse, but more often, aimless distribution fell far short of covering mounting provider obligations, especially for facilities with the highest Medicaid census. Making matters worse, early round CARES funding was "need-inverted" with respect to Skilled Nursing's payer-mix dynamic, as allocation was driven by Medicare utilization.

An innovative approach to Medicaid revenue distribution is desperately needed. Ideally, this would be a collaborative process between state and industry. Unfortunately, many state rate setting departments lack the experience and resources needed to balance uneven provider needs. How did we get here? In states like New Jersey, it went something like this:



REIMBURSEMENT EROSION V. RATE EXTENSION

Based on extensive analysis of Medicaid reimbursement methodologies, we designed a set of "Rate Extensions" that effectively deliver policy-specific relief to providers most in need of support.

Rate Extensions are not predicated on additional funding or enhanced federal match. They are customizable, self-correcting solutions that can be affixed to any rate setting methodology without risk to provider or payor. Additional payments are not standardized or automatic; dollars are made available to qualifying facilities based on Medicaid share of covered days and other predetermined metrics. The goal is to balance Medicaid allocation to promote clinical excellence, while advancing dignity and equality for all beneficiaries.

Rationalizing Medicaid rate construction may not mitigate all the challenges impacting long-term care, but the quality-payment incongruity can and should be addressed immediately. As noted in the 1998 Urban Institute policy brief:

> *"... although linking payment and quality of care would seem conceptually desirable, the technology to **implement such systems at the state level is not currently available**.*

Twenty-five years later, let's hope the systems are available now... the Rate Extensions are.

March 7, 2022

SNF Medicaid Rate Extensions

Quality Extensions

1. Direct Care Targeting
   DCT encourages SNFs to maintain appropriate staffing levels without "one size fits all" mandates. Providers will "staff-to-acuity" if rate adjustment is scaled to nursing HPPD, thus mitigating perverse incentives to reduce staffing. RUGs proved this approach works. The difference? Distorted rehab RUG weights encouraged too much therapy; it would be nice to complain about too much nursing care. This Extension is not resident-specific, but all incentives are aligned.

2. Direct Care Rating
   The SNF Five-Star system is often distorted, misleading and used against providers in negligence actions. An intuitive, consumer-facing score would enhance market competition based on rationally adjusted direct care HPPDs that include nursing and other licensed health care professionals. The score is expressed as a statewide ranking calibrated in fifteen-minute intervals (e.g., 5.25 HPPD is the "Top 20%" statewide). DCR would also serve as a powerful advertising tool, creating a "race to the top" of quality rankings.

3. HCC-RAF Acuity Indexing
   Acuity adjustment incentivizes providers to accept admissions requiring more intensive (and expensive) care. Most case-mix systems are based on highly flawed RUGs. Applying the CMS-HCC risk adjustment model for Direct Care rate adjustment would align clinical assessment standards between provider & payor. A slightly modified Risk Adjustment Factor (incorporating ADLs) allows for sustainable measures of LTC-chronic conditions designed for the long-term care population without rehab RUG distortion / duplicative payment by Medicare Part B.

4. ECCP-Equivalent
   Based on CMS' Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, SNFs are incentivized to adopt effective treat-in-place programs through partnerships with Enhanced Care Coordinator Provider / ISNP-equivalent organizations.

Social Equity Extensions

1. Medicaid Private Room Differential
   This provision balances CMS' desire for single-occupancy rooms against the reality of asset-value forfeiture and facility configuration. Making extension payments available to qualifying SNFs, based on Medicaid share of days and target average daily census of Medicaid beneficiaries in private rooms can be implemented independently or in conjunction with the "Deferred Decertification" Extension detailed within.

2. Cultural Enrichment Allowance
   Offsets provider cost of implementing programs that promote familiar homelike environments and amenities for designated culturally diverse populations.

3. Disproportionate Share
   Medicaid rates fail to cover SNF operating costs. Unlike hospitals, SNFs cannot offset inadequate government reimbursement by charging higher rates to private payors; Medicare FFS is Skilled Nursing's only cost-shift equivalent. SNFs with the highest Medicaid census, often located in disadvantaged communities, also carry the highest ratio of residents without Medicare Part B coverage. DSH supports providers without supplemental revenue opportunities through scaled distribution of encumbered funds.

EFFICIENCY & INFRASTRUCTURE EXTENSIONS

1. Deferred Decertification
   Three challenges prevent rightsizing the LTC market: Each certified bed is an asset that, once surrendered, is not easily reinstated, low census carries explicit & collateral imputed occupancy penalties, and bed shortages create access problems for patients. Enabling providers to officially flex bed capacity would improve efficiency while facilitating the market's ability to adjust capacity as demand changes.

2. Cost-Shift Relief
   Medicare Advantage (MA) is rapidly replacing the FFS population with fewer admissions at half the revenue. MA is an extremely lucrative enterprise, yet ultimately forces Medicaid to cover the resulting financial shortfall. In other words, Medicaid now subsidizes the insurance industry. States must require MA plans to pay reimbursement rates at (or near) the FFS benchmark. Doing so ensures high-value SNFs are measured by "quality," not "price" (i.e., the lowest contracted rate).

3. Provider Protections
   MA plans often pressure SNFs into contracts for other insurance products as a condition of network inclusion. Exposing providers to such coercion represents a risk to resident choice and model-of-care.

4. Medicaid Rate Corridor
   Boren's flaw was its failure to quantify "reasonable and adequate" reimbursement. A CMS-developed national formula, standardized but adjustable for market-specific benchmarks, would offer guidance to states on reasonable rate targets. To protect against defaulting to both floor & ceiling, the methodology must promote "rate elasticity" so that even SNFs caring exclusively for Medicaid-only beneficiaries are able to meet competitive standards of care, comfort, and equality.

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eCapIntel's mission is to improve data integrity by contextualizing and neutralizing SNF reporting distortions.

www.zhealthcare.com www.ecapintel.com