Senior living industry trends, reimbursement and operational considerations

PACAH 2023 Fall Summit

Meet your presenters

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Agenda

- Industry update
- Reimbursement considerations
- Operational considerations
- Contact information
- Questions

Industry update

Census

Workforce

SNF stressors

Consolidation drivers

Strategic planning

Mergers, acquisitions and affiliations

Financial impact

Key performance indicators

Refocus

Operational considerations

Reimbursement

Outlook

Census

- Impacted all levels of care within a senior living organization:
  - Skilled nursing (SNF)
  - Assisted living (AL)/personal care (PC)
  - Independent living (IL)
- Staffing shortages
- Access to staffing

Workforce

- Workforce challenges
- Staff burnout
- Wage and bonus competition
- Nurse agency utilization
- Increase in hours per patient day (HPPD) requirements
- Enhanced focus on recruitment/retention

SNF stressors

- Aging nursing homes
- Private room needs
- Occupancy
- Workforce shortages
- Technology needs
- Reimbursement

Consolidation drivers

- Leadership turnover
- Financial pressures
- Complexities of healthcare
- Ability to attract and retain talent
- Access to capital
- Technology demands

Strategic planning

- Perform SWOT analysis
- Identify culture/mission
- Engage board and committee members
- Strategic considerations:
  - ✓ Campus repositioning and right-sizing analysis
  - ✓ Evaluate services lines for expansion/contraction
  - ✓ Engage with referral sources and narrow networks

Mergers, acquisitions and affiliations

- Consider all opportunities
- Engage in internal discussions
- Identify opportunities to partner with other providers
- Process takes considerable time and effort
- Evaluate and include considerations as part of the strategic planning process

Financial impact

- Weakening balance sheets
- Inflation and inflationary factors
- Negative operating margins
- Debt covenant violations
- Volatility of the market and investment portfolios

Key performance indicators

- Days cash on hand
- Days in accounts receivable
- Bad debt expense as a percent net resident revenue
- Debt service coverage
- Operating margin
- Average daily PDPM rate
- Nurse agency cost per day

Refocus	Operational considerations
• Sunsetting of Government Funding • Sunsetting of Public Health Emergency Waivers • Challenging operating environment • Financing challenges • State level reimbursement changes • Regulatory requirements • Benchmarking Analysis	• Focus on building census and revenue drivers: ✓ Evaluate daily rates ✓ PDPM analysis ✓ Focus on controlling expenses: ✓ Evaluate all departments ✓ Nurse agency/contracted labor ✓ Value based/group purchasing

Reimbursement

- Medicare Managed Care/Advantage:
  - Rapidly increasing
  - Financial Impact
  - Length of Stay
  - Administrative Requirements
  - Audit Volume
  - Trending impact
  - Policy considerations
  - Rate protection
  - Availability for participation

Reimbursement

- FY24 SNF PPS final rule:
  - Prospective payment system FY 2024
  - Net increase of 4.0% (includes a 2.3% reduction for PDPM parity adjustment this is being phased in over a two-year period)
  - Changes in PDPM ICD-10 code mappings
  - Changes to SNF quality reporting program
  - Changes to SNF value-based purchasing program
  - Minimum staffing requirements …?

Outlook

- Hot topics and greatest focus areas:
  - Nursing in Life Plan Communities
  - Aging in Place
  - Labor
  - Senior Living Options
  - Demographic Growth
  - Technology
  - Consolidations/Affiliations
  - Cost of Capital

Outlook

- Hot topics and greatest focus areas:
  - Strategic Planning
  - Market Assessment
  - Consumer Research
  - Creative Business Models
  - Hospital & Post-Acute Relationships
  - Skilled Nursing Disruption
  - Revenue and Expense Pressures
  - Market infiltration of Managed Care

Reimbursement considerations

Reimbursement considerations

Medicare is expected to begin denying claims in a similar manner to Managed Care denials.

This news comes as CMS is rolling out the 5 claim probes (which we have not yet seen).

- MAC did not accept interview responses that were coded directly onto the MDS
- mechanically altered diet that was in a nurse's notes
- Interview PHQ-2 to 9, BIMS

These denials will occur after medical reviews and are focused on medical necessity, LOS and signatures/dating by physician.

However, they have added the following areas that if not completed, inaccurate or unsupported will result in denials:

- Section GG
- Section I active diagnosis
- NTA items not supported
- Mechanically altered diet
- Swallowing disorders
- Skin conditions
- BIMS not completed timely

Reimbursement considerations

Reimbursement considerations

Medicare advantage scrutiny of the Patient-Driven Payment Model (PDPM)

- Cost containment
  - Controlling length of stay (LOS)
  - Using Medicare's PDPM with regular post-payment reviews and payment take-backs
  - **Post-payment reviews focused on select minimum data set (MDS) areas:**
    - **Section GG (resident function)**
    - Active diagnosis (diagnosis)
      - NTA items not supported (diagnosis / clinical conditions)
    - Skin conditions (clinical conditions)
    - BIMS not completed timely (resident interview responses)
    - PHQ-9

Reimbursement considerations

Reimbursement considerations

Function

Coding instructions and GG0130 (Self-care) and GG0170 (Mobility)

- “Assess… based on direct **observation**, incorporating resident **self-reports** and **reports** from qualified clinicians, care staff, or family **documented in the resident’s medical record during the assessment period.** CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.”
  - *-CMS’s RAI Version 3.0 Manual CH 3: MDS Items [GG] October 2023 Pages GG-15 (self care) GG-43 (mobility)*
- “USUAL PERFORMANCE”

Reimbursement considerations

Nursing functional score

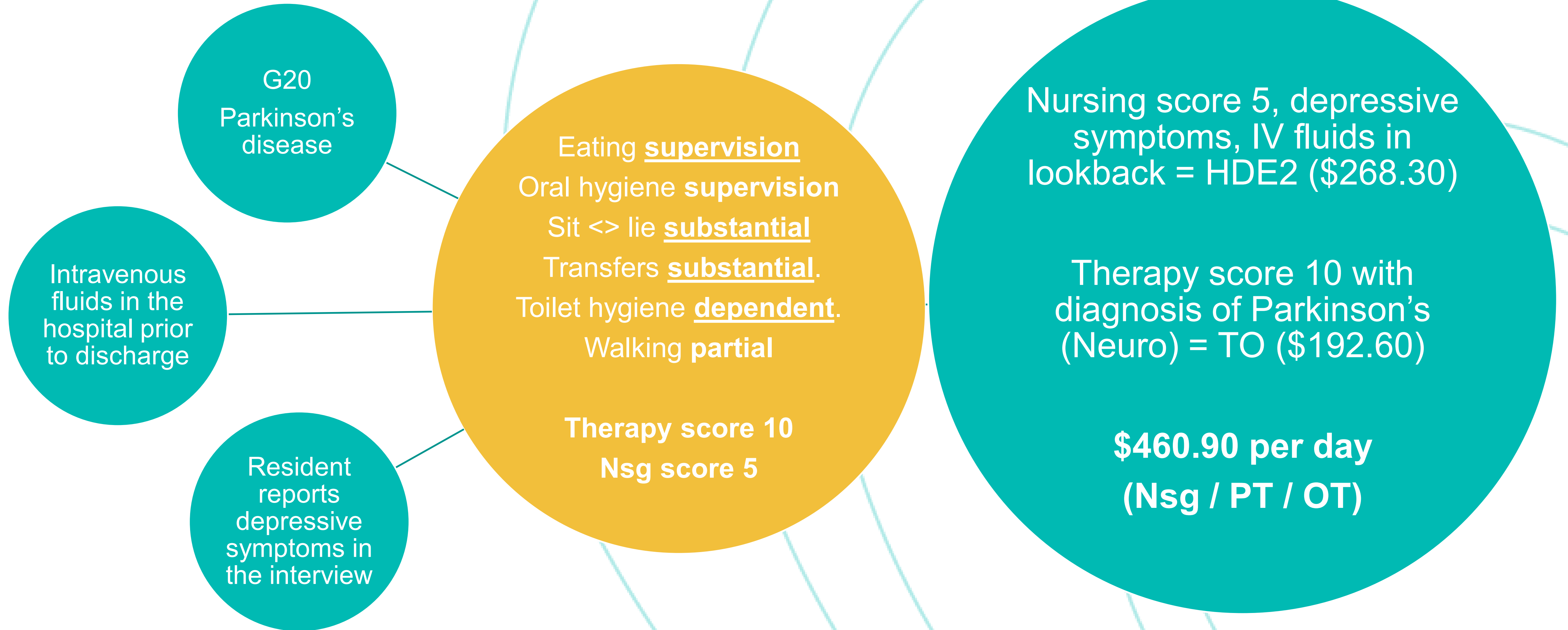
- “Usual performance” of late-loss ADLs, **MDS Section GG**
  - Bed mobility: Lie to sit, sit to lying position
  - Transfers: Sit to stand, chair/bed to chair, and toilet transfers
  - Eating
  - Toilet hygiene

Therapy functional score

- “Usual performance” of the nursing ADLs used for the score, and:
  - Oral hygiene
  - Walking: 50’ with 2 turns, 150’

POST-PAYMENT TARGET AREAS

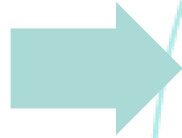
Reimbursement considerations



Reimbursement considerations

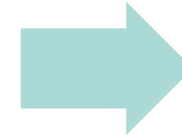
RESIDENT functional performance

- Not in dispute by interdisciplinary team – all agree.
- Therapy evaluations day four
- Assessment added into medical record on day four to support MDS coding.



Supporting documentation concerns

- *Variety of performance levels*
- *No documentation of performance coding decision in the lookback*
- *Documentation dated after the lookback*



Assessment encoding at risk

- PT payment
- OT payment
- Nursing payment

Reimbursement considerations

G20
Parkinson's disease

Intravenous fluids in the hospital prior to discharge

Resident reports depressive symptoms in the interview

Function Default
Therapy score 24
Nursing score 16

Nursing score 24, depressive symptoms, IV fluids in lookback = CA2 ($122.06)

Therapy score 0 with diagnosis of Parkinson's (Neuro) = TP ($134.54)

TAKEBACK

$204.30 per day

Reimbursement considerations

Medicare advantage scrutiny of the Patient-Driven Payment Model (PDPM)

- Cost containment
  - Controlling LOS
  - Using Medicare's PDPM with regular post-payment reviews and payment take-backs
  - **Post-payment reviews focused on select minimum data set (MDS) areas :**
    - **Section GG (resident function)**
    - **SLP-related resident function**
    - Active diagnosis (diagnosis)
      - NTA items not supported (diagnosis / clinical conditions)
    - Skin conditions (clinical conditions)
    - BIMS not completed timely (resident interview responses)
    - PHQ-9

Reimbursement considerations

Resident diagnosis:

G20 Parkinson’s

Swallowing problems,

Mechanically altered diet

Resident response to interview:

BIMS score 10

Function: Cognition, Swallowing

G20 Parkinson’s (Neuro)

BIMS score 10 (impaired cognition)

Mechanically altered diet

Swallowing problems

SLP – SI ($84.58)

Reimbursement considerations

C0100: Should brief interview for mental status be conducted

- Coding tips
  - Attempt to conduct the interview with ALL residents. **This interview is conducted during the look-back period** of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
    - *-CMS's RAI Version 3.0 Manual CH 3: MDS Items [K] October 2023 Page C-2*

K0100: Swallowing/nutritional status

- Coding tips:
  - Do not code a swallowing problem when interventions have been successful in treating the problem and **therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur** during the 7-day look-back period.
  - Code **even if the symptom occurred only once** in the 7-day look-back period.
    - *-CMS's RAI Version 3.0 Manual CH 3: MDS Items [K] October 2023 Page K-2*

K0520: Nutritional approaches

- DEFINITIONS
  - MECHANICALLY ALTERED DIET A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and **thickened liquids**. A mechanically altered diet should not automatically be considered a therapeutic diet.
- Coding instructions
  - Check **all nutritional approaches performed** after admission/entry or reentry to the facility and within the 7-day look-back period.
    - *-CMS's RAI Version 3.0 Manual CH 3: MDS Items [K] October 2023 Page K-11*

Reimbursement considerations

RESIDENT functional performance

- BIMS interview completed
  - Encoded direction onto the MDS
  - Z0400 dated for data entry date
- **Resident coughing** during fluid intake
  - SLP referral
    - Documents coughing
  - Nursing initiating **thick liquids**

Supporting documentation concerns

- *Interview performed*
  - *No note of this during the lookback.*
- *Information obtained by discussing resident condition with care staff.*
- *Note by MDS nurse after the ARD*
- *SLP daily notes not sent with information request*

Assessment encoding at risk

- SLP Payment items
  - Mechanically altered diet
  - Swallowing problem
  - Impaired cognition

Reimbursement considerations

Resident diagnosis:

G20 Parkinson's

Swallowing problems,

Mechanically altered diet

Resident response to interview:

BIMS score 10

Denied:

Cognition,

Swallowing,

Mechanical diet

G20 Parkinson's (Neuro)

~~BIMS score 10 (impaired cognition)~~

~~Mechanically altered diet~~

~~Swallowing problems~~

~~SLP – SI ($84.58)~~

SD ($35.02)

TAKEBACK

$49.56 per day

Reimbursement considerations

Medicare advantage scrutiny of the Patient-Driven Payment Model (PDPM)

- Cost containment
  - Controlling LOS
  - Using Medicare's PDPM with regular post-payment reviews and payment take-backs
  - **Post-payment reviews focused on select minimum data set (MDS) areas:**
    - **Section GG (resident function)**
    - **SLP-related resident function**
    - **Active diagnosis (diagnosis)**
      - **NTA items not supported (diagnosis / clinical conditions)**

Reimbursement considerations

Primary diagnosis:
M86.172 Other acute osteomyelitis, left ankle and foot

Nursing:
M1040C foot infection with
Dressing to foot

NTA:
Foot infection (+1)
Bone (osteo) infection (+2)

Active diagnosis

PT / OT orthopedic category
TG ($205.40)
Nursing: LBC1 ($160.06)
NTA Category (3 points)
ND ($336.24, $112.08)

$701.70, $477.54
(PT/OT, NSG, NTA)

Reimbursement considerations

I: Active diagnoses in the last seven days

- **Active diagnoses**
  - **Physician-documented** diagnoses in the **last 60** days that have a direct **relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death** during the 7-day look-back period.
    - *CMS's RAI Version 3.0 Manual CH 3: MDS Items [I] October 2023 Page I-7*
  - Recent onset or acute exacerbation of the disease or condition indicated by a **positive study, test or procedure, hospitalization for acute symptoms** and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include **radiological reports, hospital discharge summaries, doctor's orders, etc**.
    - *CMS's RAI Version 3.0 Manual CH 3: MDS Items [I] October 2023 Page I-11*

Reimbursement considerations

Active diagnosis:
-Osteomyelitis

- Hospital discharge summary includes diagnosis
- Nursing documents care for surgical wound
- Resident remains on antibiotics for infection

Supporting documentation concerns

- *Nursing notes document surgical area of foot*
- *Physician after the ARD, references osteomyelitis of the foot, antibiotics, post-surgical care and therapy.*
- *Discharge summary from hospital not sent in information request.*

Assessment encoding at risk

- PT payment
- OT payment
- Nursing payment
- NTA payment

Reimbursement considerations

Primary diagnosis:
M86.172 Other acute osteomyelitis, left ankle and foot

Nursing:
M1040C foot infection with
Dressing to foot

NTA:
Foot infection (+1)
Bone (osteo) infection (+2)

Denied:
Foot infection
Osteomyelitis

~~PT / OT: TG ($205.40)~~
~~Nursing: LBC1 ($160.06)~~
~~NTA Category (3 points)~~
~~ND ($336.24, $112.08)~~

PT/OT (Medical): TK ($190.00)
Nursing PBC1: ($126.67)
NTA NF: ($182.45, $60.82)

$202.58 (Days 1-3) lost
$100.05 (day 4-20) lost

Reimbursement considerations

Significance of takebacks

- Physical function: $150 / day
- Cognitive and swallowing function: $50 / day
- Active diagnosis: $100 - $200 / day

Potentially up to $400 per day in the examples above

Medicare – Started five claim reviews in June 2023

- Not much information out there on these yet…
- Interviews denied
- Mechanically altered diet denied

Reimbursement considerations

PEPPER clues to focus

- **PT/OT HIPPS**: C, D, F, G, J, K, N, or O = scores 6-23 (except D = MJ, 24)
  - Function
  - Diagnosis
- **Nursing HIPPS**: A, B C, D, H, or L (ES3, ES2, ES1, HDE2, LDE2, CDE2)
  - Function
  - Clinical factors
  - Diagnoses
  - Resident interview response
- **SLP HIPPS**: C, F, I, or L (BOTH Swallowing d/o and mechanically altered diet)
  - Clinical factors
  - Diagnoses
  - Resident interview response
- **Length of stay / readmission timing**

Operational considerations

Operational considerations

Skilled nursing facility 5-Claim Probe and Educate Review

- The Centers for Medicare & Medicaid Services (CMS) has recently announced the start of the SNF (skilled nursing facility) 5 Claim Probe and Educate Review program. As part of the effort to lower the SNF improper payment rate, Medicare Administrative Contractors (MACs) will be reviewing a small number of claims from every Medicare-billing SNF in the country. The SNF will then be offered education to address any errors identified, helping them to avoid future claim denials and adjustments.

Operational considerations

Skilled nursing facility 5-Claim Probe and Educate Review

- The proposed 5 claim strategy will extend the broadest reach to all SNFs. Similar to the current Targeted Probe and Educate (TPE) medical review strategy, the SNF 5 Claim Probe and Educate Program will include one on one provider education at the completion of a small sample of claim reviews. However, instead of the 1-3 rounds of review a provider receives through TPE, each SNF will undergo only 1 round of review.
  - MACs will review 5 claims from each SNF.
  - MACs will complete one (1) round of probe and educate for each SNF, not the potential three (3) rounds that may occur in the traditional TPE program.
  - Education offered will be individualized based on the claim review errors identified in the probe. Review results letters will detail the denial rationales for each claim, as appropriate.
- The SNF 5-Claim reviews commenced on June 5th, 2023 and will affect claims for services furnished after Oct. 1st, 2019. Claims containing the COVID-19 diagnosis will be excluded from the review.

Operational considerations

Skilled nursing facility 5-Claim Probe and Educate Review

- SNF 5-Claim Probe and Educate Review Frequently Asked Questions (FAQs)
  1. Why did CMS develop the SNF 5-Claim Probe and Educate Review?
  2. Where can providers access resources related to the PDPM?
  3. What is the look-back period for the SNF 5-Claim Probe and Educate Review?
  4. What happens if an SNF is currently undergoing Targeted Probe and Educate (TPE)?

Operational considerations

Federal compliance – Medicare and Medicare advantage

- Triple check process – Part A and Part B claims
  - Who is a part of the process?
  - Checklists
  - Retention of the results should be part of the compliance program
- Third-party medical record and claim audits
  - More common
  - Occur in "bunches"
  - Time sensitive
  - Results are at times not communicated

Operational considerations

PEPPER (Program for Evaluating Payment Patterns Electronic Report)

Target area	Target area definition
High PT and OT case mix (new as of the Q4FY21 release)	Numerator: count of SNF claims where the first character of the Health Insurance Prospective Payment System (HIPPS) code, representing the physical and occupational therapy component, is one of the following: C, D, F, G, J, K, N, or O Denominator: count of all SNF claims
High speech language pathology case mix (new as of the Q4FY21 release)	Numerator: count of SNF claims where the second character of the HIPPS code, representing the speech language pathology component, is one of the following: C, F, I, or L Denominator: count of all SNF claims
High nursing case mix (new as of the Q4FY22 release)	Numerator: count of SNF claims where the third character of the HIPPS code, representing the nursing payment group, is one of the following: A, B C, D, H, or L Denominator: count of all SNF claims

Operational considerations

High nursing case mix (new as of the Q4FY22 release)	Numerator: count of SNF claims where the third character of the HIPPS code, representing the Nursing payment group, is one of the following: A, B C, D, H, or L Denominator: count of all SNF claims
20 days	Numerator: count of episodes of care ending in the report period with a length of stay (LOS) of 20 days Denominator: count of episodes of care ending in the report period
90+ days	Numerator: count of episodes of care ending in the report period with a LOS of 90+ days Denominator: count of all episodes of care ending in the report period
Three-to-five day readm	Numerator: count of readmissions within three to five calendar days (four to six consecutive days) to the same SNF for the same beneficiary (identified using the Health Insurance Claim number) during an episode that ends during the report period Denominator: count of all claims associated with SNF episodes ending during the report period, excluding patient discharge status code 20 (expired); (See Appendix 1 in the SNF PEPPER User's Guide for how readmissions are identified)

Operational considerations

Federal compliance – Medicare and Medicare advantage

- The Centers for Medicare & Medicaid Services (CMS) has recently announced the start of the SNF (skilled nursing facility) 5 Claim Probe and Educate Review program. As part of the effort to lower the SNF improper payment rate, Medicare Administrative Contractors (MACs) will be reviewing a small number of claims from every Medicare-billing SNF in the country. The SNF will then be offered education to address any errors identified, helping them to avoid future claim denials and adjustments.

Operational considerations

Compliance in billing

- Risk areas associated with billing have been most frequent subjects of investigations and audits by the OIG
  - Criminal sanctions
  - Monetary penalties
  - Medicare payments suspended
  - Excluded from Medicare program participation
- Organizations must continually reassess its billing procedures and policies for both Federal and State programs

Operational considerations

Key performance indicators (KPIs) for reimbursement

- Census
- Payer mix
- Days cash on hand
- Average PDPM rate
- Average Medicaid rate
- Days in accounts receivable
- Bad debt expense as a percentage of net resident revenue

Operational considerations

Current reimbursement challenges

- Workforce staff/turnover
- Lack of SNF billing experience
- Implementation of new billing software
- Lack of accounts receivable monthly meeting
- Increase in accounts receivable (AR) balances
  - Limited claim follow-up
  - Lack of clear policy for collections
  - Resident/families not cooperative in application process

Operational considerations

Current reimbursement challenges

- Unheard of staffing shortages in nursing home billing offices are leading to billing lapses and major uncollectible or 'bad' debt amounts
- Bad debt is debt that cannot be collected from payers largely because claims were not filed or resolved in a timely manner. In the case of nursing homes, this typically involves Medicare, Medicaid or managed care plans
- Fewer people and less institutional knowledge are combining to create extensive and problematic delays
- Federal Medicare claims must be made within a year, and the same is true for most state Medicaid programs, but managed care plans are getting "sneaky," some plans now expect to be billed within 30 to 90 days.

Operational considerations

- Accounts receivable report (example: 100-bed SNF)

Payer type summary	Outstanding balance	Sep.	Aug.	July	June	May	Apr.	Mar.	Feb.	Jan.	Dec.	Nov.	Oct.	≥Sept.
Commercial insurance	192.498.08	33,242.1	14,173.5	2,737.87	7,605.05	18,700.6	15,781.1	31,247.5	14,612.5	12,592.1	12,410.6	6,519.75	5,820.90	17,054.24
Like Medicare Part A	704,393.45	26,943.7	88,306.6	11,814.03	44,286.3	35,971.4	39,674.0	76,770.3	57,875.5	63,790.8	29,372.9	46,889.9	44,850.8	137,846.7
Like Medicare Part B	173,814.26	14,310.6	25,227.2	22,600.29	11,197.82	3,552.86	15,116.53	8,203.61	3,348.33	8,345.67	6,726.41	6,128.67	8,138.89	40,917.28
Medicaid (state)	706,294.22	179,190.4	185,248.1	70,007.12	60,813.53	19,871.91	20,069.01	5,276.11	15,243.07	11,161.56	12,164.04	6,706.40	(19,312.79)	139,855.6

Operational considerations

- Accounts receivable report (example: 100-bed SNF)

Payer type summary	Outstanding balance	Sep.	Aug.	July	June	May	Apr.	Mar.	Feb.	Jan.	Dec.	Nov.	Oct.	≥Sept.
Medicare Part A	339,635.97	148,780.8	76,443.23	10,978.31	17,151.51	24,881.44	23,695.94	12,046.74	(15,050.20)	3,297.48	35.18	(2,132.26)	3,892.16	35,615.61
Medicare Part B	66,741.06	12,726.43	4,005.74	3,790.08	2,771.97	4,197.77	3,177.08	2,029.86	2,737.21	3,799.09	331.61	1,335.74	1,110.82	24,727.66
Private	1,346,887.33	68,350.37	73,817.25	66,337.64	44,804.72	23,707.80	16,506.12	19,012.03	32,461.77	41,926.75	17,976.56	25,846.03	40,078.55	876,061.74
Payer type total	3,530,264.37	483,544.6	467,221.7	188,265.34	188,630.96	130,883.90	134,019.8	154,586.27	111,228.19	144,913.53	79,017.35	91,294.26	84,579.42	1,272,078.93

Operational considerations

Accounts receivable aging report

- Each payer will have different rules for review based on time limits
- Chargemaster reviews – based on payer contracts
- Monthly posting and variance tracker
- Payer critical time limits
  - MA: 180 days
  - Medicare: 365 days
  - Medicare advantage: Based on contract with the facility (could be 30 to 90 days)

Operational considerations

SNF monthly billing cycle timing

- Example of timelines for payers and monthly follow-up
  - Private pay
  - Medicaid
  - Part B
  - Part A
  - AR meeting and collection follow-up

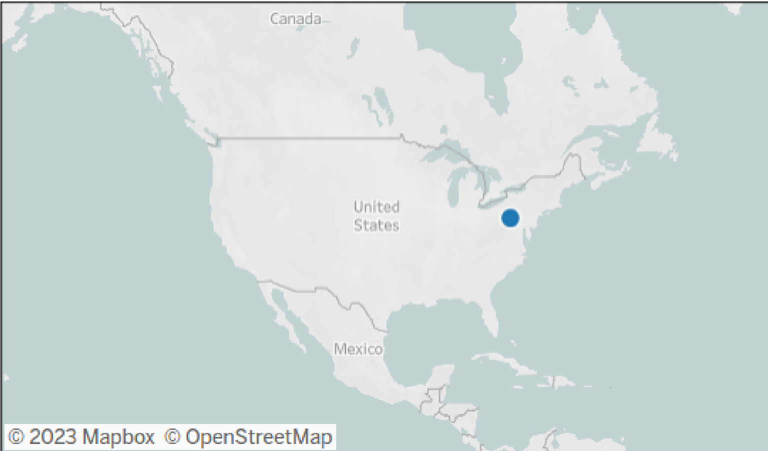
Operational considerations

- Accounts receivable monthly meeting is critical!
- Communication is important for claims review
- Billers, AR manager, facility staff, etc.
- Claims that have been denied/rejected – follow-up on claims from last month’s meeting
- Monthly action items on claim follow-up
- Follow-up, follow-up, follow-up!

Operational Considerations

Medicare Cost Report Benchmarking

Provider Name			Day of Cost Report Period End
			December 31, 2021
State	**City**	**County**	**CBSA**
PA			11020



Number of Providers

CBSA		State		National
11020	9	PA	646	14,061

Medicare Profitability

Provider Specific	
Total Medicare Per Diem Reimbursement	$522.12
Total Medicare Per Diem Cost	$477.18
Total Medicare Per Diem Profit or (Loss)	$44.94
Profit (loss) as a % of Per Diem	8.61%

CBSA Medians	
Total Medicare Per Diem Reimbursement	$533.79
Total Medicare Per Diem Cost	$460.66
Total Medicare Per Diem Profit or (Loss)	$73.12
Profit (loss) as a % of Per Diem	13.70%

State Medians	
Total Medicare Per Diem Reimbursement	$561.11
Total Medicare Per Diem Cost	$445.08
Total Medicare Per Diem Profit or (Loss)	$116.03
Profit (loss) as a % of Per Diem	20.68%

National Medians	
Total Medicare Per Diem Reimbursement	$566.44
Total Medicare Per Diem Cost	$418.01
Total Medicare Per Diem Profit or (Loss)	$148.43
Profit (loss) as a % of Per Diem	26.20%

-Provider specific information represents information only for the facility
-Medicare Per Diem Reimbursement, Cost and Profit (loss) as a % of Per Diem are medians for CBSA, State and National geographic definitions

Operational Considerations

Medicare Cost Report Benchmarking

Provider Name	Day of Cost Report Period End	State	City	County
[redacted]	December 31, 2021	PA	[redacted]	[redacted]

Number of Providers

CBSA	
11020	9

State	
PA	646

National
14,061

Other Statistics

Provider Specific	
Co Insurance	$143,206.00
Reimbursement Bad Debt	$0.00
Reimbursement Bad Debt Dual Eligible	$0.00
Vaccine	$0.00

CBSA Medians	
Co Insurance	$125,027.00
Reimbursement Bad Debt	$46,924.50
Reimbursement Bad Debt Dual Eligible	$46,739.00
Vaccine	$1,332.00

State Medians	
Co Insurance	$165,652.00
Reimbursement Bad Debt	$58,343.00
Reimbursement Bad Debt Dual Eligible	$51,784.50
Vaccine	$2,600.00

National Medians	
Co Insurance	$233,359.00
Reimbursement Bad Debt	$26,318.00
Reimbursement Bad Debt Dual Eligible	$63,438.00
Vaccine	$1,600.50

-Provider specific information represents information only for the facility
-CBSA, State and National metrics represent medians across geographic definitions for cost reporting timeframe

Operational considerations

Takeaways

- Reminder - billing is an important part of corporate compliance
- Continue to focus on your KPIs to identify outliers
- SNF Days in accounts receivable
- SNF bad debt expense as a percent of net resident revenue
- SNF accounts receivables reserves and allowances
- SNF AR aging
- Monthly AR meetings
- Private pay collections process
- Monthly evaluation of write-offs and reasons
- Follow-up is key to success!

Thank you!

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