Maintain Your Edge

2025 Skilled Nursing Facility Medicare Benchmarking Report

Based on 2022–2023 data

plante moran | 100 years

Audit. Tax. Consulting. Wealth Management.

Contents

Introduction	3
Maintain your edge	4
Executive Summary	5
Data source & limitations	7
Definition of regions	8
Medicare & Medicare Advantage trends	9
Medicare SNF QRP & VBP programs	19
Medicare Accountable Care Organizations	22
Overall SNF profitability	25
Census & occupancy	28
Cost & wage trends	36
Appendix	46

Introduction

Our 2025 benchmark report provides essential and timely information on SNF industry trends for providers, investors, and other capital sources to ensure you maintain your edge.

For over 20 years, the Plante Moran Edge® Financial Report has provided a comprehensive comparison of Medicare-certified SNFs to key operating revenue and expense indicators, competitor facilities, and local, state, and national averages. Our report incorporates clinical and financial metrics associated with the Patient-Driven Payment Model for services provided to Medicare Part A beneficiaries, ensuring you have all the necessary information at your fingertips.

Our 2025 Maintain Your Edge: Skilled Nursing Facility Medicare Benchmarking Report represents 2022 and 2023 data trends for over 12,000 nursing facilities across the United States. It provides practical insights into the key trends influencing SNF operators and factors to consider when contemplating your organization's strategy. The trends highlighted throughout the report illustrate how this resilient industry continues to recover from the impact of the COVID-19 pandemic, empowering you to make informed decisions in a rapidly changing environment. Check out the 2024 Skilled Nursing Facility Medicare Benchmarking Report to compare what's changed.

Stay up to date on evolving reimbursement methodologies

This year, we're thrilled to bring you additional data points on emerging reimbursement methodologies. By staying informed on these topics, you'll gain valuable insights that can enhance your operations and improve patient care. Stay ahead of the curve and ensure you're equipped with the latest knowledge to navigate the evolving healthcare landscape effectively.

- **Value based purchasing (VBP) as part of state Medicaid reimbursement**
- **Medicare Advantage trends**
- **Payroll Based Journal**

Unlock the power of personalized insights with your custom Plante Moran Edge Report. Our team will collaborate with you to understand your unique needs and deliver a report that fits your specific requirements Reach out now to elevate your practice with actionable data!

Maintain your edge

As you review the benchmarking data, consider this. How does your average Medicare rate compare, are you missing revenue opportunities? Do you have a solid strategic plan in place to address decreased occupancy? How will you handle a shift to value based purchasing payment methodology while the acuity of your residents is increasing? Do you know how your cost and quality value proposition compares to your competitors, or how to quantify the operational efficiency?

A custom edge report can help.

Using our proprietary benchmarking process and analysis, our experienced senior care team will help you position for success. When you partner with us, you'll discover how to improve your market position, identify opportunities to improve your Medicare rate, and generate your desired financial results. Request your custom Edge report — your path to operational and financial stability is as easy as 1-2-3.

STEP 1
Gather data & make observations

We'll combine information from your cost reports with our observations of your market share; overall operations; diversity and innovation; and degree of collaboration.

STEP 2
Prepare reports

Plante Moran Edge SNF Market Integration Report:

- Analyzes the hospital referral relationships in your market and identifies important payers for you to contract with.
- Quantifies your market share and benchmarks your key performance indicators against peers and industry standards.

Plante Moran Edge Financial Analysis Report:

- Highlights opportunities to improve your bottom line.
- Uses information from Medicare cost reports to analyze cost and efficiency metrics, and then compares your organization to other facilities in your market.

STEP 3
Put insights into perspective

Based on the insights generated by these reports, we'll help you implement the changes that will have the most impact and best align you with your strategic plans. Action items could include case-mix optimization, bad debt, reimbursement, operational improvements, and billing and collections, among others. We're excited to help you take these next steps toward a stronger future.

Executive summary

2025 SNF industry trends highlight the urgency for facilities to innovate and adapt to a rapidly changing landscape. By aligning strategies with emerging opportunities and addressing persistent challenges, SNFs can remain resilient and deliver value to residents, staff, and stakeholders.

The skilled nursing facility (SNF) industry is navigating a period of significant transformation, as providers address evolving difficulties and opportunities in an increasingly complex healthcare environment. It's crucial for all stakeholders, including healthcare executives, SNF administrators, and policymakers, to understand how to combat challenges and take advantage of opportunities. Workforce shortages, shifting payment models, rising operational costs, and regulatory pressures continue to impact the sector, while demographic trends and market demands create opportunities for innovative solutions. With an estimated 20% of the U.S. population expected to be 65 and older by 2030, SNFs are experiencing increased demand for services. At the same time, many facilities are still operating in the red. This duality of growing demand and financial stress underscores the urgency for SNFs to adapt their strategies to remain viable.

State of the skilled nursing industry: Emerging trends for 2025

- **Increased emphasis on value based care.** The shift toward value based payment (VBP) models continues, requiring SNFs to demonstrate quality outcomes such as reduced hospital readmissions, improved patient satisfaction, and better long-term resident health to secure reimbursement.
- **Evolving trends in the Patient-Driven Payment Model (PDPM).** Providers are leveraging data and refining care delivery strategies to optimize reimbursements under PDPM, focusing on accurate resident assessments and aligning services with individualized care plans to appropriately capture reimbursement.
- **Expansion of managed care Medicare Advantage (MA) participation.** The growing penetration of MA plans is negatively impacting financial performance, pushing SNFs to negotiate favorable contracts, adapt workflows for preauthorization requirements, and maintain high-quality metrics to compete in an MA-driven landscape.
- **Enhanced scrutiny of Payroll-Based Journal (PBJ) reporting.** Increased oversight of PBJ submissions is prompting providers to ensure compliance with staffing minimums and accurate reporting. Leveraging technology to track staffing levels in real-time and proactively address gaps is becoming a critical operational priority.
- **Rising importance of diversified revenue streams.** Operators are expanding beyond traditional long-term care to include memory care, specialized clinical services, and short-term rehab to meet market demand and offset financial pressures.

Executive summary

This summary highlights the need for innovative approaches and policy advocacy to address both immediate and systemic challenges in the SNF industry. Here are the **key action items SNFs should prioritize to build a stronger, more sustainable foundation for the future:**

Focusing on improving quality of care and related outcomes benefits the residents and provides higher reimbursement through VBP reimbursement methodologies (Medicare VBP, SNF QRP), as well as the increasing trend in state Medicaid systems. Strong quality results make a SNF more attractive for accountable care organizations' participation or hospital partnerships.

Adapt to the expanding influence of MA, which often has shorter stays and lower payment rates than traditional Medicare. Providers with strong quality results and lower hospital readmissions are better able to negotiate higher contract rates, including Five-Star rating by demonstrating their value proposition.

Diversify revenue streams and improve quality outcomes by partnering with an I-SNP. These partnerships provide opportunities for a new revenue stream — both organizations and residents benefit from the clinical resources and protocols that I-SNP's offer.

The shift from traditional Medicare to Medicare Advantage combined with inadequate Medicaid funding has resulted in revenue not keeping pace with increased costs related to staffing challenges and inflation. Unfortunately, this has placed many providers in financial distress.

Data sources & limitations

The benchmarks are based on data compiled from 2022–2023 year-end Medicare cost reports provided by CMS.

Most facilities have all their beds certified for Medicare. As a result, the per diem costs, as reported on the Medicare cost report, represent the average cost for all patients. The actual per diem costs for Medicare patients are usually higher than average due to the staffing costs associated with elevated acuity for short-term patients. Additionally, SNF providers are responsible for ancillary costs such as pharmacy and therapy for Medicare patients as compared to private pay or Medicaid patients driving up Medicare per diem costs.

To facilitate success with MC and value based models, providers are encouraged to invest in accounting and information systems that can determine individual patient costs. Please note the 2022 data has been restated due to change in methodology of presenting costs and eliminating outliers.

The data represents

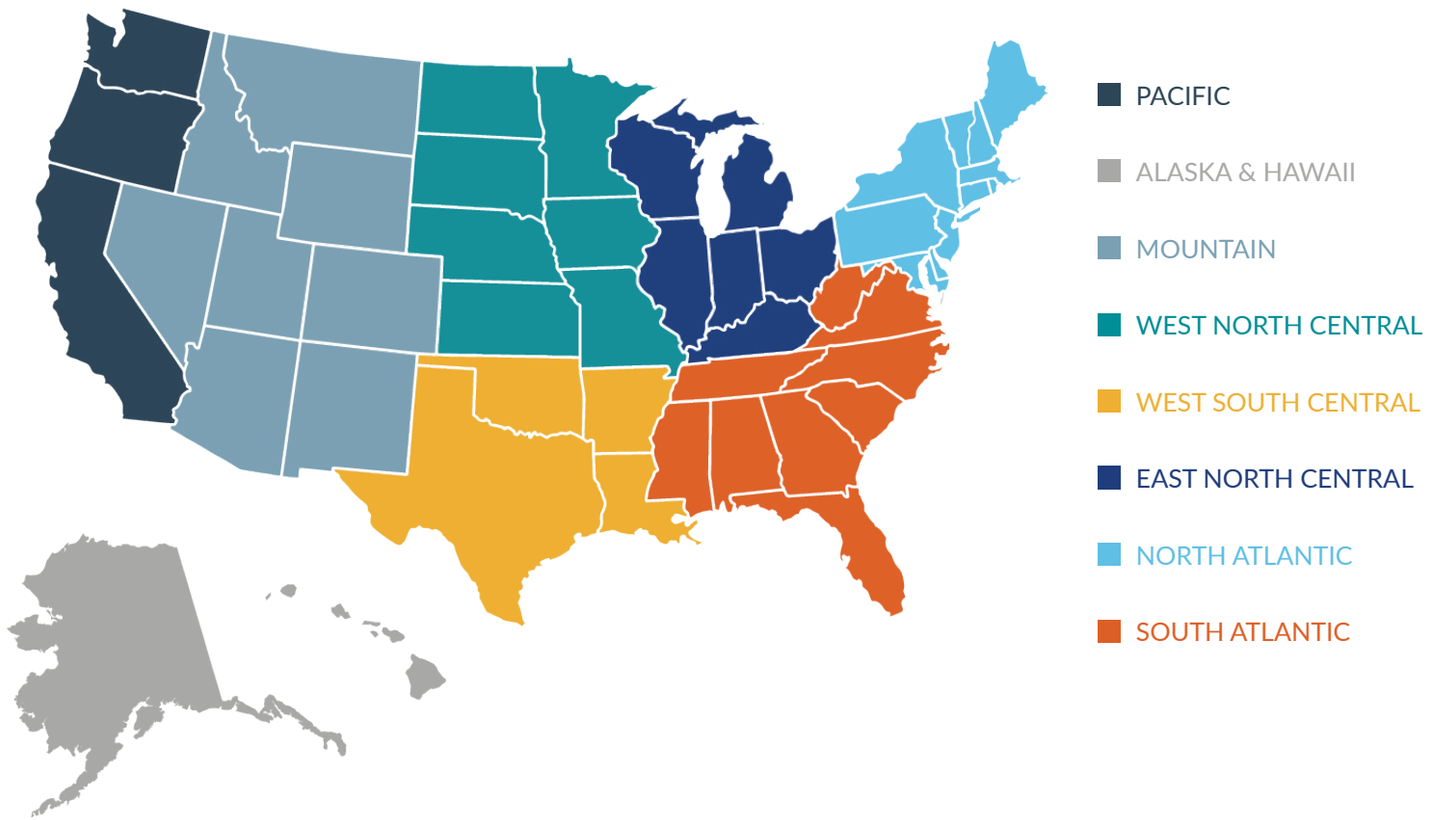
over 12,000 nursing facilities

across the United States.

MENU
SUBSCRIBE
CONTACT

Definition of regions

The benchmarks provided are based on regions of the United States. We have sectioned the United States into eight regions, which are defined below:



Medicare & Medicare Advantage trends

Medicare & Medicare Advantage trends

FY 2025 SNF PPS Final Rule payment provisions

The Centers for Medicare & Medicaid Services (CMS) updated the SNF market basket base year from 2018 to a new base year of 2022 for payment rates used under SNF PPS. The final rule includes a 4.2% increase to SNF PPS rates effective Oct. 1, 2024, with an estimated increase of $1.4 billion over FY 2024.

- SNF market basket of 3.0%
- +1.7% market basket forecast error adjustment
- -0.5% productivity adjustment

These figures exclude the SNF VBP reductions for certain facilities; SNF VBP reductions are estimated at $187.7 million for FY 2025.

Updates to CBSA & wage index

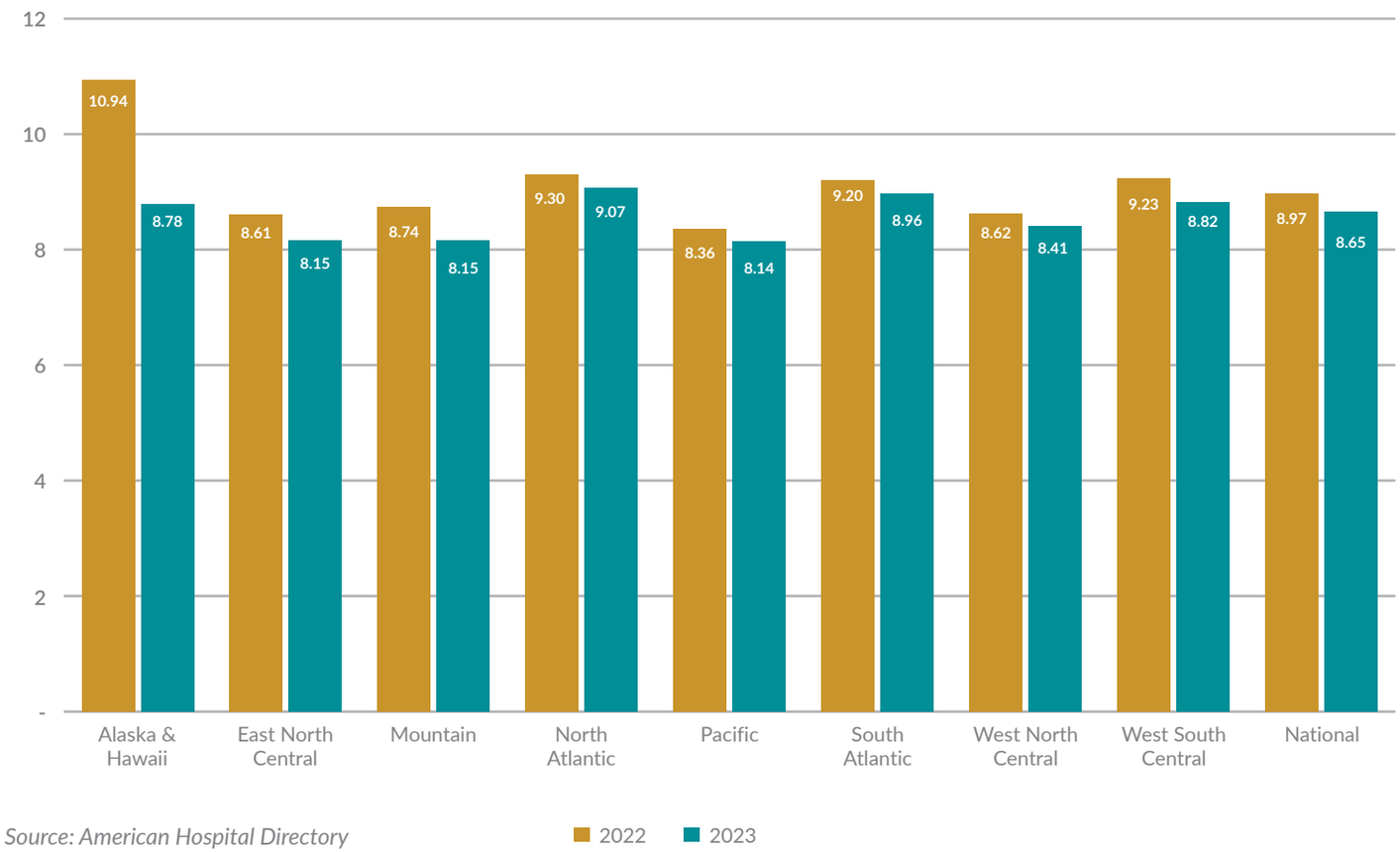
Provider experience will vary based on SNF wage index and labor adjustments, which continues to be based on hospital inpatient wage data.

The FY 2025 rule updates the SNF PPS wage indexes to use the core based statistical area (CBSA) defined within OMB Bulletin 23-01. This has resulted in certain county/county equivalents to change CBSA. This has also resulted in certain CBSA designations changing from “urban to rural” or from “rural to urban.”

Importantly, the FY 2023 SNF PPS Final Rule established a permanent 5% cap on decreases to a provider’s wage index from its wage index in the prior year.

Average hospital LOS for discharges to SNF

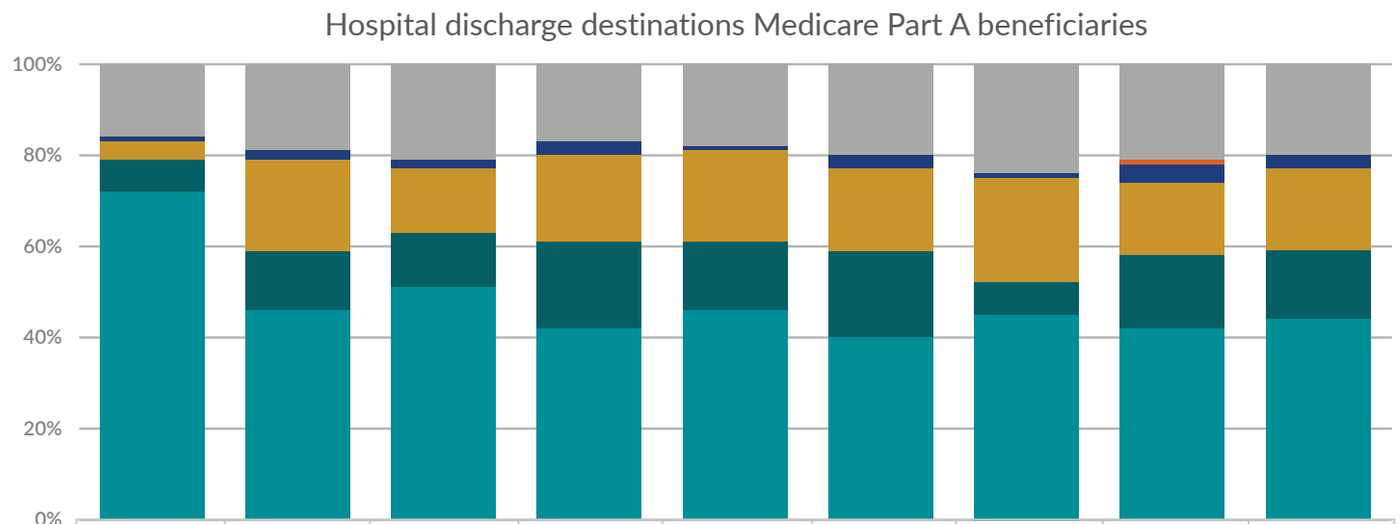
National average hospital length of stay for discharges to SNF decreased from 8.97 in 2022 to 8.65 in 2023.



Source: American Hospital Directory

Utilization of PAC services by Medicare beneficiaries in 2023

The utilization of post-acute (PAC) services by Medicare beneficiaries varies widely across regions. Hospital discharges to PAC services are highest in the South Atlantic region and lowest in the Alaska & Hawaii and Mountain regions. The national average discharge to SNF across regions was 18%, which is consistent to 2022. West North Central, East North Central, Pacific, and North Atlantic regions exceed the 18% national average.



	Alaska & Hawaii	East North Central	Mountain	North Atlantic	Pacific	South Atlantic	West North Central	West South Central	National average
Other discharges	16%	19%	21%	17%	18%	19%	24%	22%	20%
Discharge to LTAC	0%	0%	0%	0%	0%	0%	0%	1%	0%
Discharge to IRF	1%	2%	2%	3%	1%	3%	1%	4%	3%
Discharge to SNF	4%	20%	14%	19%	20%	18%	23%	16%	18%
Discharge to HHA	7%	13%	12%	19%	15%	19%	7%	16%	15%
Discharge to home	72%	46%	51%	42%	46%	40%	45%	42%	44%

Source: American Hospital Directory

1 in 5
Medicare beneficiaries are discharged to a SNF

1.8 million
covered stays in 2022[1]

29 billion
in payments to SNFs in 2022[1]

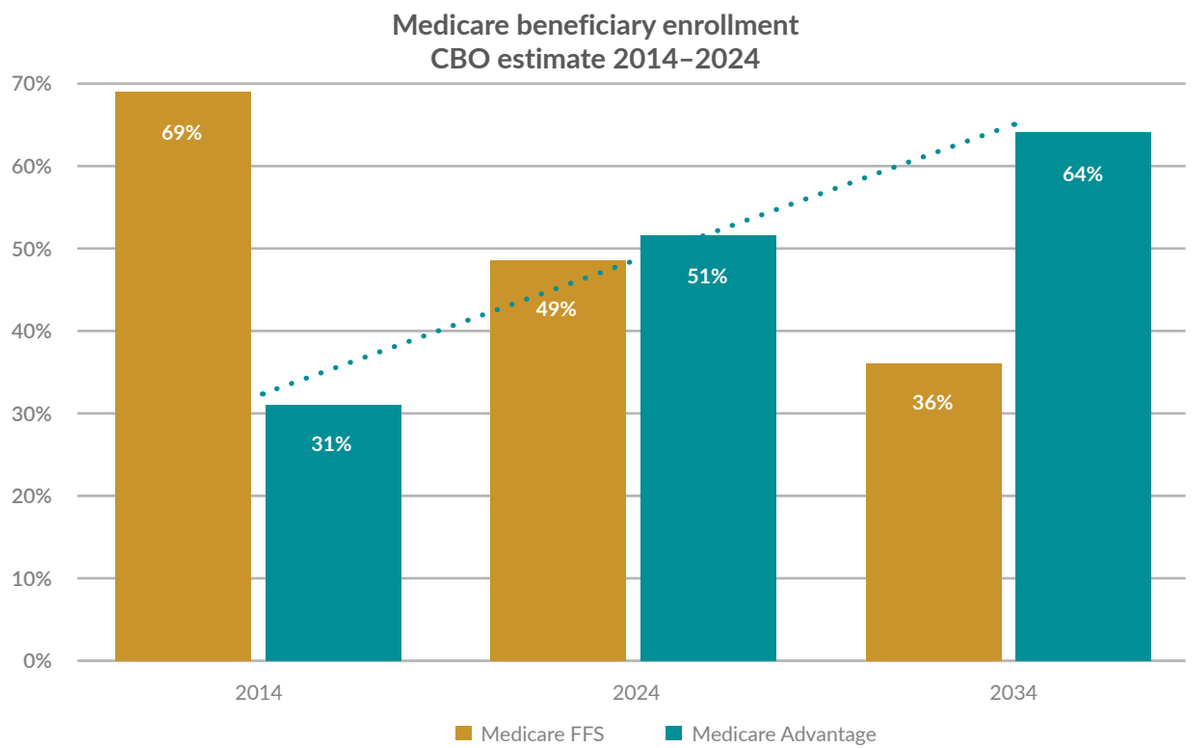
1. MedPac Report to Congress Medicare Payment Policy, March 2024

MA enrollment as of November 2024

MA penetration has surpassed traditional Medicare enrollment and is expected to keep climbing. SNF operators continue to see an increase in MA residents as compared to traditional Medicare Part A.

CMS continues to increase the flexibility of plans to provide additional benefits, and more than two-thirds offer dental, fitness, and vision benefits, while also controlling out-of-pocket expenses as compared to traditional Medicare — significant factors in consumer choice of these plans.

The Congressional Budget Office forecasts that, by 2034, 64% of all Medicare beneficiaries will be enrolled in MA plans. This would represent a 33% shift from traditional fee for service to MA over the span of 20 years.



As of November 2024, there are approximately 34 million MA beneficiaries distributed as shown below:

21%: Special needs plans (7M)

17%: Employer plans (6M)

62%: Open enrollment plans (21M)

Source: CMS Medicare Advantage Enrollment Files November 2024

MENU
SUBSCRIBE
CONTACT

MA enrollment as of November 2024

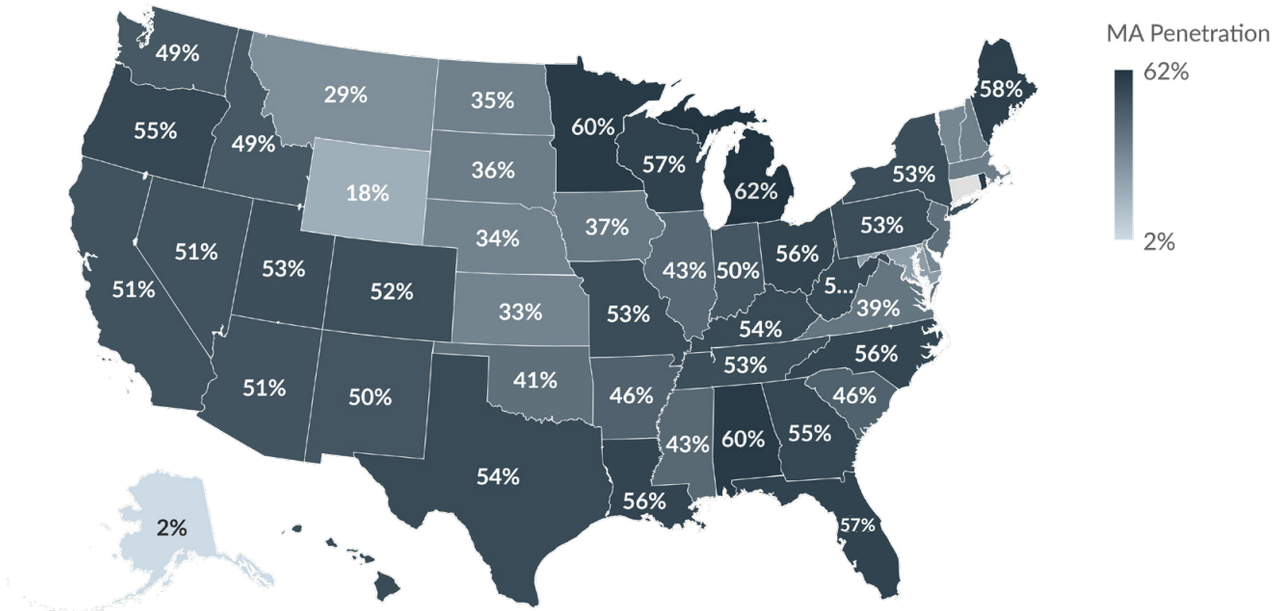
From a provider payment perspective, the spread between the MA rates and traditional Medicare Part A rates has widened over the past decade. This is resulting in significantly reduced margins on short-term rehab stays as MA plans, on average, can pay one quarter to one-third less than traditional Medicare Part A. However, MA typically results in additional burden for beneficiaries and providers due to the complex and delayed authorization process, admission denials, shortened length of stay, and overall reduced access to post-acute services for beneficiaries.

CMS doesn't have a required reporting for MA plans, so we're not able to share benchmarks similar to those included in this report under the Medicare program. MA enrollment continues to be concentrated among a small number of parent organizations.

MA enrollment by parent organization: November 2024	
UnitedHealth Group, Inc.	27%
Humana Inc.	18%
CVS Health Corporation	13%
Elevance Health	6%
Kaiser Foundation Health Plan, Inc.	6%
Centene Corporation	3%
Blue Cross Blue Shield	3%
The Cigna Group	2%
All Other	22%

Source: CMS Medicare Advantage Enrollment Files November 2024

Medicare Advantage Penetration by State
November 2024



Alaska & Hawaii		Mountain		North Atlantic		Pacific		West North Central	
Alaska	2%	Arizona	51%	Connecticut	63%	California	51%	Iowa	37%
Hawaii	54%	Colorado	52%	Delaware	32%	Oregon	55%	Kansas	33%
East North Central		Idaho	49%	Massachusetts	36%	Washington	49%	Minnesota	60%
Illinois	43%	Montana	29%	Maryland	24%	**South Atlantic**		Missouri	53%
Indiana	50%	New Mexico	50%	Maine	58%	Alabama	60%	North Dakota	35%
Kentucky	54%	Nevada	51%	New Hampshire	35%	Florida	57%	Nebraska	34%
Michigan	62%	Utah	53%	New Jersey	41%	Georgia	55%	South Dakota	36%
Ohio	56%	Wyoming	18%	New York	53%	Mississippi	43%	**West South Central**	
Wisconsin	57%			Pennsylvania	53%	North Carolina	56%	Arkansas	46%
				Rhode Island	60%	South Carolina	46%	Louisiana	56%
				Vermont	33%	Tennessee	53%	Oklahoma	41%
						Virginia	39%	Texas	54%
National average	51%					West Virginia	54%		

MENU
SUBSCRIBE
CONTACT

Medicare Advantage: Special needs plans

Special needs plans (SNPs) are designed to provide targeted care and limit enrollment to an institutionalized individual (I-SNP), a dual-eligible individual (D-SNP), or an individual with severe or disabling chronic condition as specific by CMS (C-SNP).

SNP enrollment has more than tripled over the past decade with the introduction of additional SNP plans. In 2024, D-SNPs represent 85%, C-SNPs represent 12%, and I-SNPs represent 2% of Medicare beneficiaries enrolled in SNPs.

	2014	2019	2024
Dual-eligible	1,720,000	2,720,000	6,030,000
Chronic or disabling condition	310,000	370,000	870,000
Institutional	50,000	100,000	130,000
Total SNP enrollment	2,080,000	3,190,000	7,030,000

Source: CMS Medicare Advantage Enrollment Files, November 2024

In response to reduced revenue associated with lower lengths of stay and payment transitions, many SNFs are exploring opportunities for new revenue streams by establishing SNPs. I-SNPs are for enrollees that meet institutional (nursing home) levels of care. IE-SNPs are for enrollees that require an institutional equivalent level of care but reside in the community setting (assisted living). D-SNPs are for dual-eligible enrollees. These plans require SNFs to assume risk related to hospitalization and other healthcare expenditures.

As of November 2024, there are 82 I-SNP contracts offering 177 plans in select counties of 43 states.

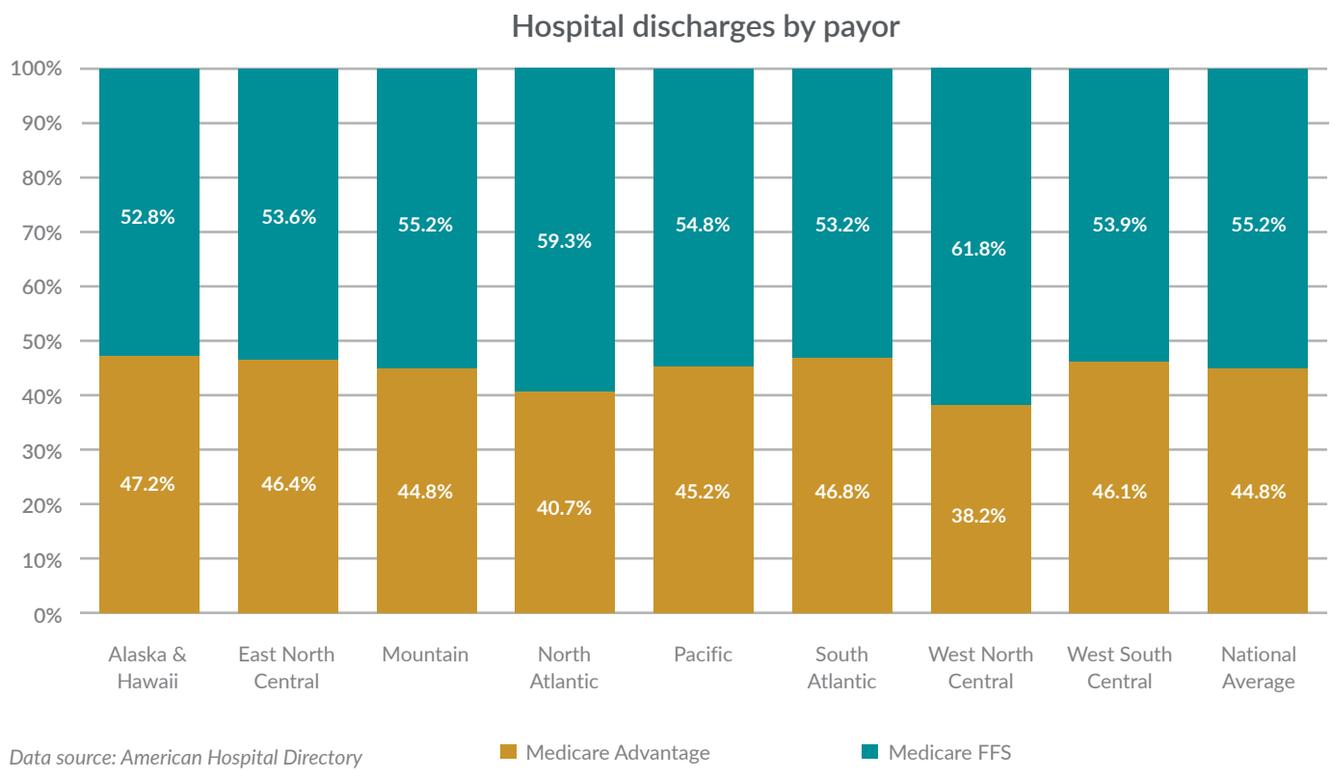
Industry trends to watch:

- In provider-owned I-SNPs and IE-SNPs
- Reimbursement increasingly being tied to quality outcomes

MA hospital discharges as a percentage of total Medicare eligible

In 2023, the national average for MA discharges as a percent of total Medicare eligible was 44.8%. This is a 2.7% increase from 2022.

Most MA health plans typically require authorization for SNF services and may limit beneficiaries' choice to preferred network providers. As such, SNF utilization tends to be lower for MA beneficiaries as compared to Medicare fee-for-service (FFS). A growing number of FFS beneficiaries are managed by accountable care organizations (ACOs) or under other risk-based models that may also result in reduced SNF utilization and shorter SNF length of stay.



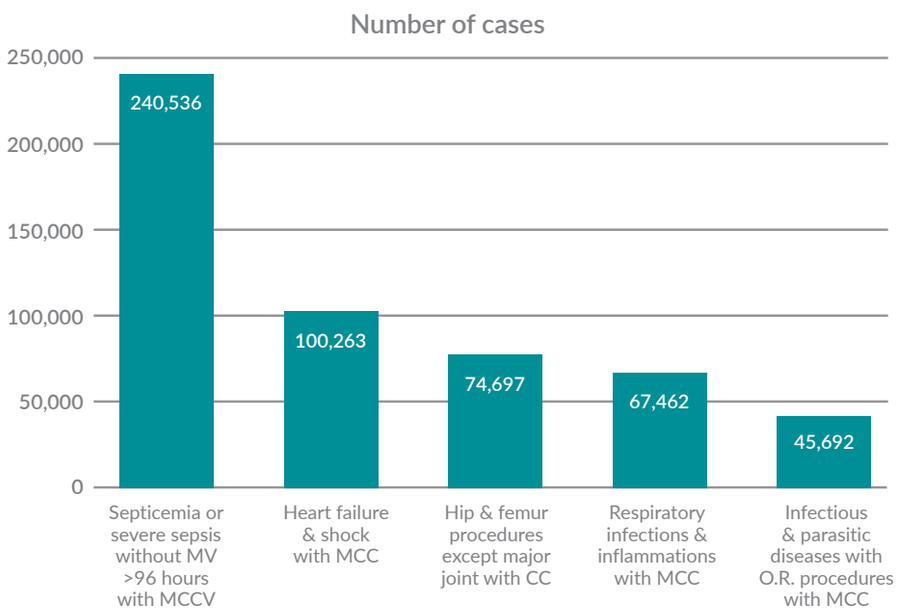
Data source: American Hospital Directory

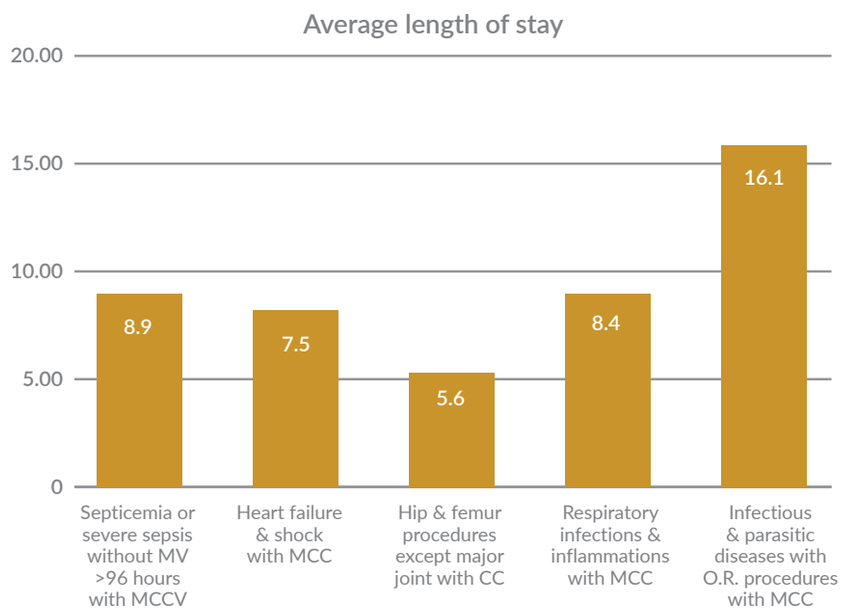
MA plans are having a growing influence on hospital referrals. Our market integration analysis provides market-specific data on MA enrollment and the flow of referrals in terms of the number of hospital discharges to individual SNFs.

MENU
SUBSCRIBE
CONTACT

Top five DRGs discharged to SNF and average length of stay in hospitals

The top five DRGs discharged to SNF remained the same for 2023, with septicemia as the top DRG. Heart failure and shock with MCC has moved up as the second DRG with an increase of nearly 7,000 cases from 2022 to 2023. Respiratory infections & inflammations with MCC decreased from the second highest DRG discharged to SNF in 2022 to the fourth highest DRG discharged to SNF in 2023 with a decrease of over 31,000 cases. The average length of stay has decreased for all of the top five DRGs by an average of 0.6 days.





MENU
SUBSCRIBE
CONTACT

Medicare SNF QRP & VBP programs

Medicare SNF QRP & SNF VBP

SNF quality reporting program (QRP)

Beginning with FY 2026, facilities must submit 90% or more of all assessments with 100% of the required MDS elements to be in compliance with SNF QRP requirements. If the required quality data isn't reported by each submission deadline, the SNF will be subject to a 2% reduction in their annual payment update (APU).

Collection time frames and submission deadlines for QRP are published on the CMS Nursing Home Quality Initiative webpage in the "Downloads" section. Data collected from calendar year 2023 will be the basis for the FY 2025 payment rate, and calendar year 2024 will be the basis for the FY 2026 payment rate, unless otherwise indicated.

For the most current updates to the actual quality measures, visit the CMS quality measures website.

SNF value based purchasing (VBP)

CMS withholds 2% of a SNF's Medicare FFS Part A payments to fund the SNF VBP. CMS redistributes 60% of the withhold to SNFs as incentive payments, and the remaining 40% of the withhold is retained in the Medicare Trust Fund. The SNF VBP adjustment is made when the claim is paid and is included with the contractual adjustment for each Part A claim on the Medicare remittance advice.

The SNF VBP score is calculated based on a SNF's performance on quality measures compared to national benchmarks and its own past performance. CMS compares a SNF's achievement score and improvement score for each measure; the higher of the two scores becomes the SNF's performance score for the measure.

The SNF VBP program has had one performance standard since inception: SNFRM-SNF 30-Day All-Cause Readmission Measure. This will continue through the FY 2025 program year from Oct. 1, 2024, through Sept. 30, 2025.

Due to the COVID-19 public health emergency, the FY 2022 and FY 2023 readmission rates for purposes of scoring and payment adjustments were suppressed. The information was still publicly reported but wasn't used to establish payment. During this time, SNFs earned back a flat 1.2% of their payment rate (VBP multiplier = 99.2%). Exceptions were made for low-volume facilities (SNFs with fewer than 25 eligible stays during the performance period) who earned back a flat 2% of their payment rate (VBP multiplier = 100%).

For the FY 2025 program year, the performance period was Oct. 1, 2022, to Sept. 30, 2023, and the baseline period was Oct. 1, 2018, to Sept. 30, 2019. SNFs will receive an incentive multiplier between 0.980256 and 1.018066 to their Oct. 1, 2024 PPS rates. The national average VBP incentive payment multiplier was 0.991145. This represents the national average of 10,533 SNFs included in the dataset. SNFs that didn't meet the SNFRM's case minimum were excluded from the SNF VBP program for FY 2025 and not publicly reported in the SNF VBP dataset.

Expansion of SNF VBP

Beginning with the FY 2026 program year, new measures will be adopted with a baseline period of FY 2022 and performance period of FY 2024. Additional measures will be added in FY 2027 program year. Beginning with FY 2028 program year, the SNFRM-SNF 30-Day All-Cause Readmission Measure will be replaced with the SNF Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure.

Future expansion of the SNF VBP program

Measure	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
SNFRM	Yes	Yes	Yes	Yes	
Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization			Yes	Yes	Yes
Total Nurse Staffing Hours per Resident Day			Yes	Yes	Yes
Total Nursing Staff Turnover			Yes	Yes	Yes
Discharge to Community — Post-Acute Care (DTC-PAC) Measure for SNFs				Yes	Yes
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)				Yes	Yes
Discharge Function Score for SNFs				Yes	Yes
Number of Hospitalizations per 1,000 Long Stay Resident Days				Yes	Yes
Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR)					Yes

SNF VBP program: December 2024 confidential feedback reports can be downloaded from iQIES. These reports will include facility-level results for the FY 2022 baseline period of the FY 2026 SNF VBP program. These results will be used for the FY 2026 SNF VBP program year scoring and incentive payment calculations taking effect Oct. 1, 2025. The data and results for the performance period for the FY 2026 SNF VBP program year should be included in the June 2025 quarterly confidential feedback reports.

Medicare Accountable Care Organizations (ACOs)

Medicare Accountable Care Organizations

*Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending healthcare dollars more wisely, it'll share in the savings it achieves for the Medicare program.**

The Center for Medicare and Medicaid Innovation (CMMI) has stated their strategic objective to drive accountable care by increasing the number of people in a care relationship with accountability for quality and total cost of care. Their objective is for all Medicare fee-for-service beneficiaries and most Medicaid beneficiaries to be in this type of care relationship by 2030.

ACOs aren't health separate health plans

While a Medicare beneficiary may be assigned to an ACO based on their primary care doctor, they're still free to seek services from any Medicare provider inside or outside of the ACO. An ACO's goal is to keep spending below a benchmark spending goal to potentially earn a percentage of the savings. Medicare providers still receive their regular fee-for-service reimbursements throughout the year and then may receive a bonus at the end of the year after a reconciliation process.

In 2024, the Medicare Shared Savings Program had 480 ACOs with 10.8 million assigned beneficiaries. This is the largest CMS ACO with 167 ACOs approved for a SNF three-day rule waiver and a total of 2,447 SNF affiliates.

The ACO REACH Model, (Accountable Care Organization Realizing Equity, Access and Community Health), a redesign of the GPDC model, which first began in 2021, had 122 ACOs with 2.6 million aligned beneficiaries. The ACO REACH model has three types of ACO structures:

- Standard ACOs. Experienced providers that serve Medicare population are aligned with beneficiaries through claims-based or voluntary alignment.
- New entrant ACOs. Depend more heavily on voluntary alignment.
- High needs ACOs. Specialize in complex care for vulnerable populations.

Source: CMS.gov

MENU
SUBSCRIBE
CONTACT

Medicare ACOs impact on SNF operations

ACOs may attempt to achieve savings by limiting short-stay SNF utilization. ACOs may attempt to incentivize SNFs to agree to discounted fee-for-service rates by promising an increase in referrals through the ACO's post-acute network. ACOs may partner with SNFs to increase their number of ACO beneficiaries. ACOs may attempt to enhance care management to lower emergency department visits and lower hospitalization rates.

SNF providers can participate in ACO arrangements as participant providers or preferred providers. Some ACOs may offer performance incentive payments based on key measures paid to/shared with the SNF if the ACO generates savings. Some ACOs may offer three-day stay waivers allowing long-term care facilities to "skill in place" for residents who require SNF level of care. Some long-term care focused ACOs will pay 100% of PDPM for their preferred provider partners.

Potential opportunities for SNFs:

- Generate additional revenue through bonus payments, skilling in place, potential referrals
- Access to additional clinical resources to support SNF care team

Potential downsides for SNFs:

- Disrupt existing relationships with other referral sources
- Resources and time to integrate ACO care team with existing SNF care team
- Opportunity cost of potentially better opportunities (MA I-SNP participation or joint ventures)

The ACO REACH is a model that aligns incentives between Medicare, physician groups, and institutions like SNFs to improve patient care. ACO REACH aims to incentivize SNFs and providers to deliver value based care, improve beneficiary access to SNF services, and support care management.

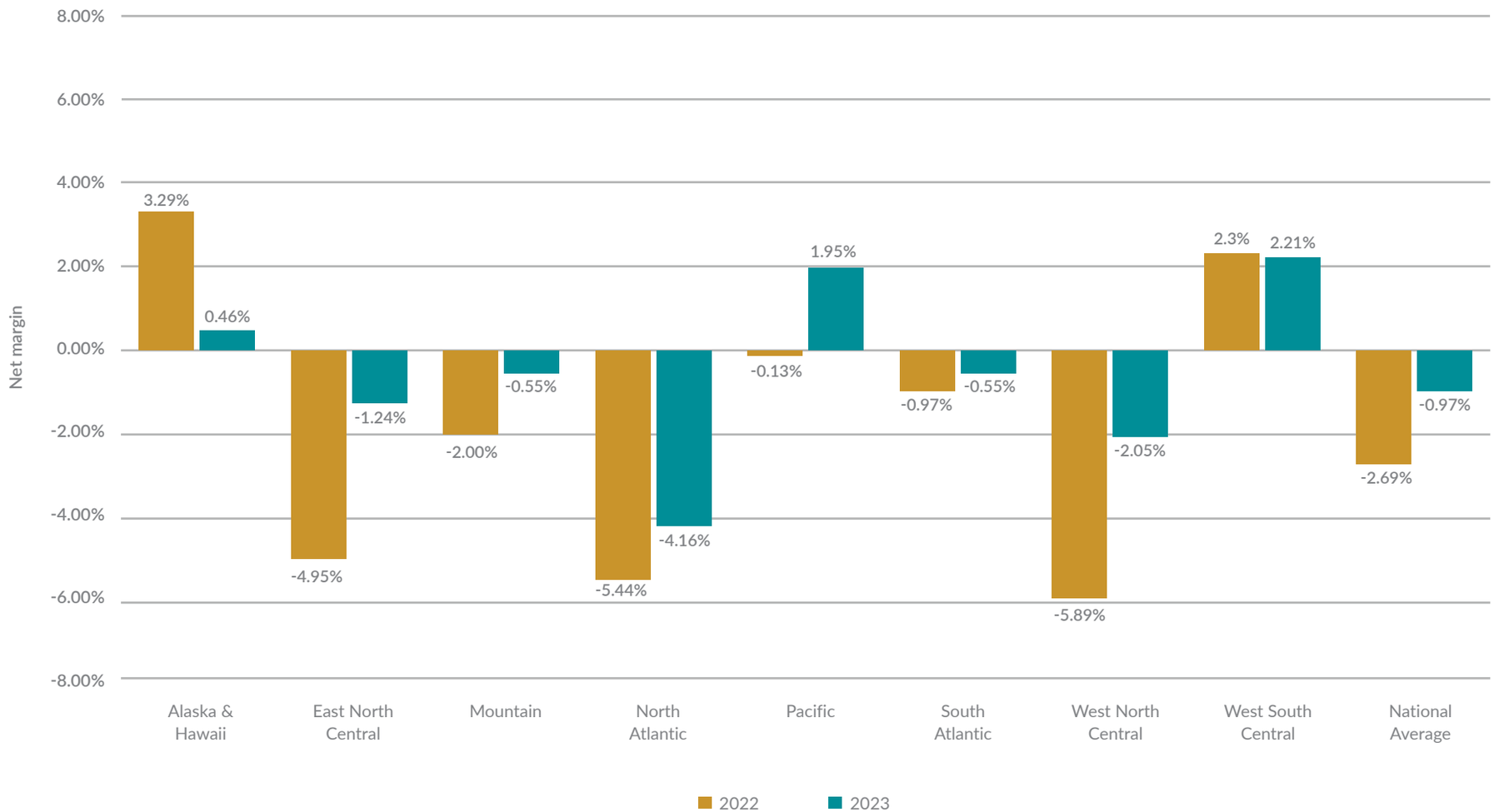
The ACO REACH is a great opportunity for SNF organizations to increase admissions, focus on improving quality and participate in a value based model.

MENU
SUBSCRIBE
CONTACT

Overall SNF profitability

Overall SNF profitability: Net margin

The net margin measures the overall profitability of a SNF by computing net income as a percentage of all revenue sources. This calculation includes COVID-19 Public Health Emergency (PHE) Provider Relief Funds recognized as revenue as reported by providers on their Medicare cost reports. The national average net margin increased by 1.7% from -2.69% in 2022 to -0.97% in 2023. -2.86%. These numbers are reflective of the continued financial distress the industry is experiencing.

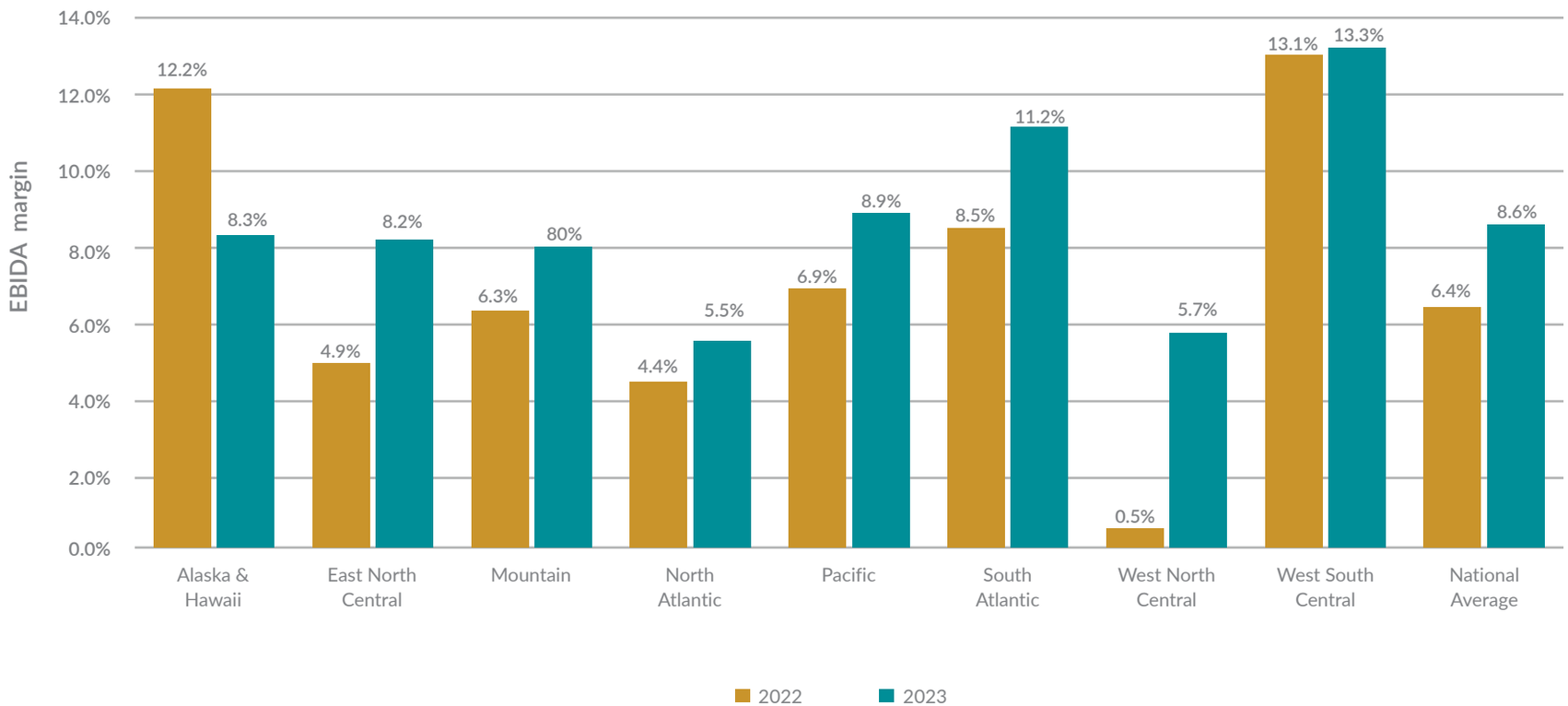


Overall SNF EBIDA margin

Earnings before interest, depreciation, and amortization (EBIDA) is a commonly used profitability measure that's an important driver of facility values. This calculation includes other income, including COVID-19 PHE funding as reported on Worksheet G-3 Line 24.5 on the Medicare cost reports. EBIDA margin is calculated as EBIDA divided by total revenue. Calculations presented below are averages.

Across the regions, there was a recovery of EBIDA in 2023 as compared to 2022. Importantly, the distribution of provider relief funding was reduced in 2022, while providers still experienced the hardships from the pandemic like inflation and staffing costs.

Low EBIDA margins are contributing to a lack of investment in physical plant. The age of plant is often measured by dividing accumulated depreciation by annual depreciation expense. A growing number of SNFs are owned by REITs or PEGs and operated by tenants that don't own the real estate. Therefore, they report rent expense, rather than depreciation on the annual cost report.



Census & occupancy

Census & occupancy

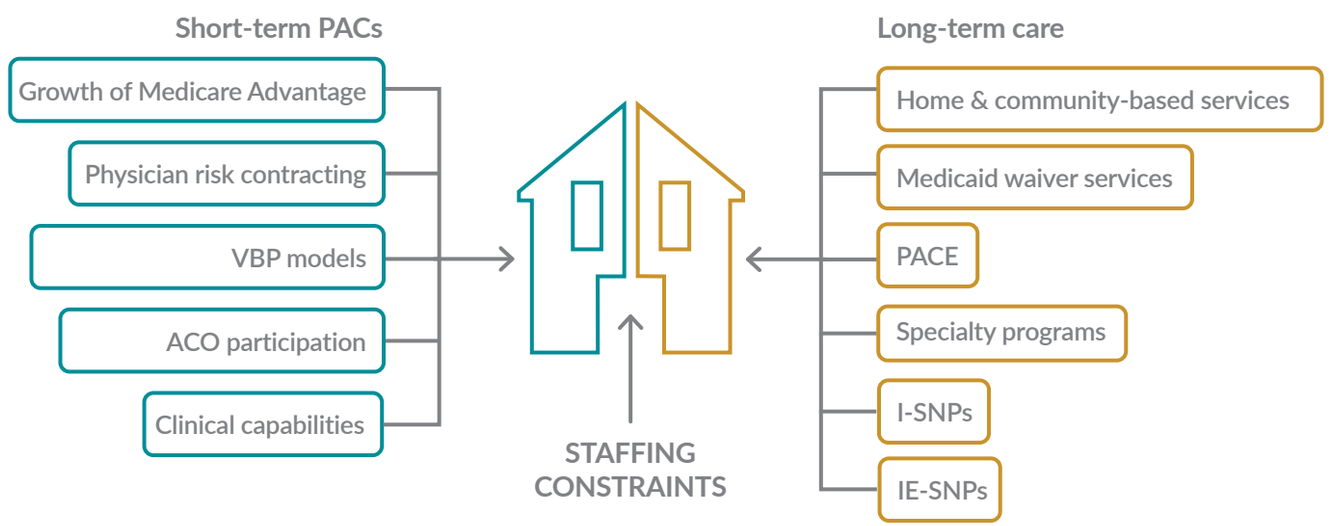
Occupancy is defined as the number of residents over the total number of beds available, as reported on Medicare cost reports.

The calculation doesn't take into account beds that may have been removed from service.

Average occupancy as reported on the Medicare cost report rose across all regions from 2022 to 2023.

The national average occupancy, as of June 30, 2024, according to PBJ reports is 77%, just three percentage points lower than the pre-pandemic average of 80%.

KEY INFLUENCES ON OCCUPANCY

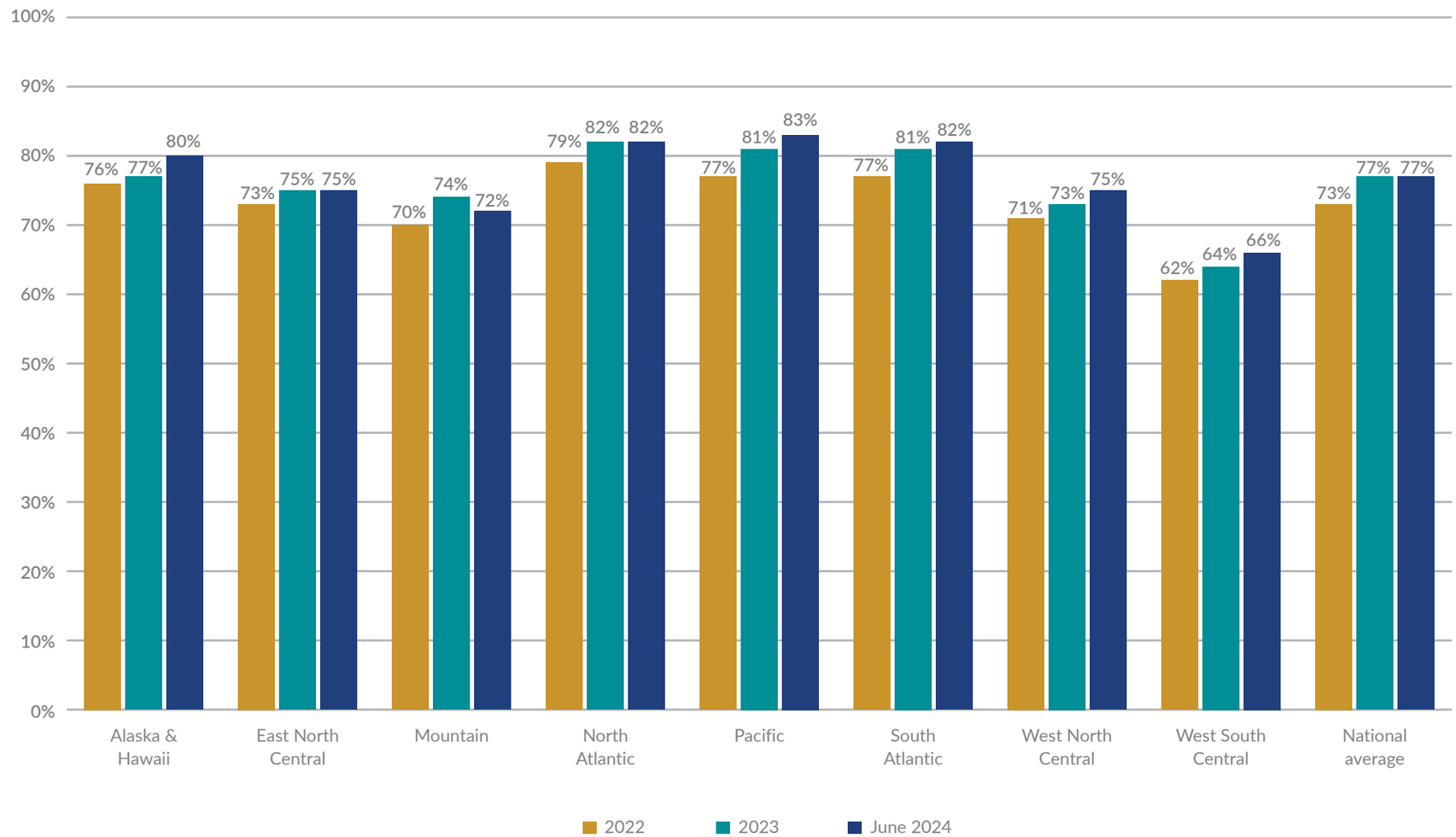


Consider clinical specialized services such as dialysis and ventilator services may generate new revenue streams. Evaluate a market study to determine need for memory care services.

MENU
SUBSCRIBE
CONTACT

Occupancy percentage

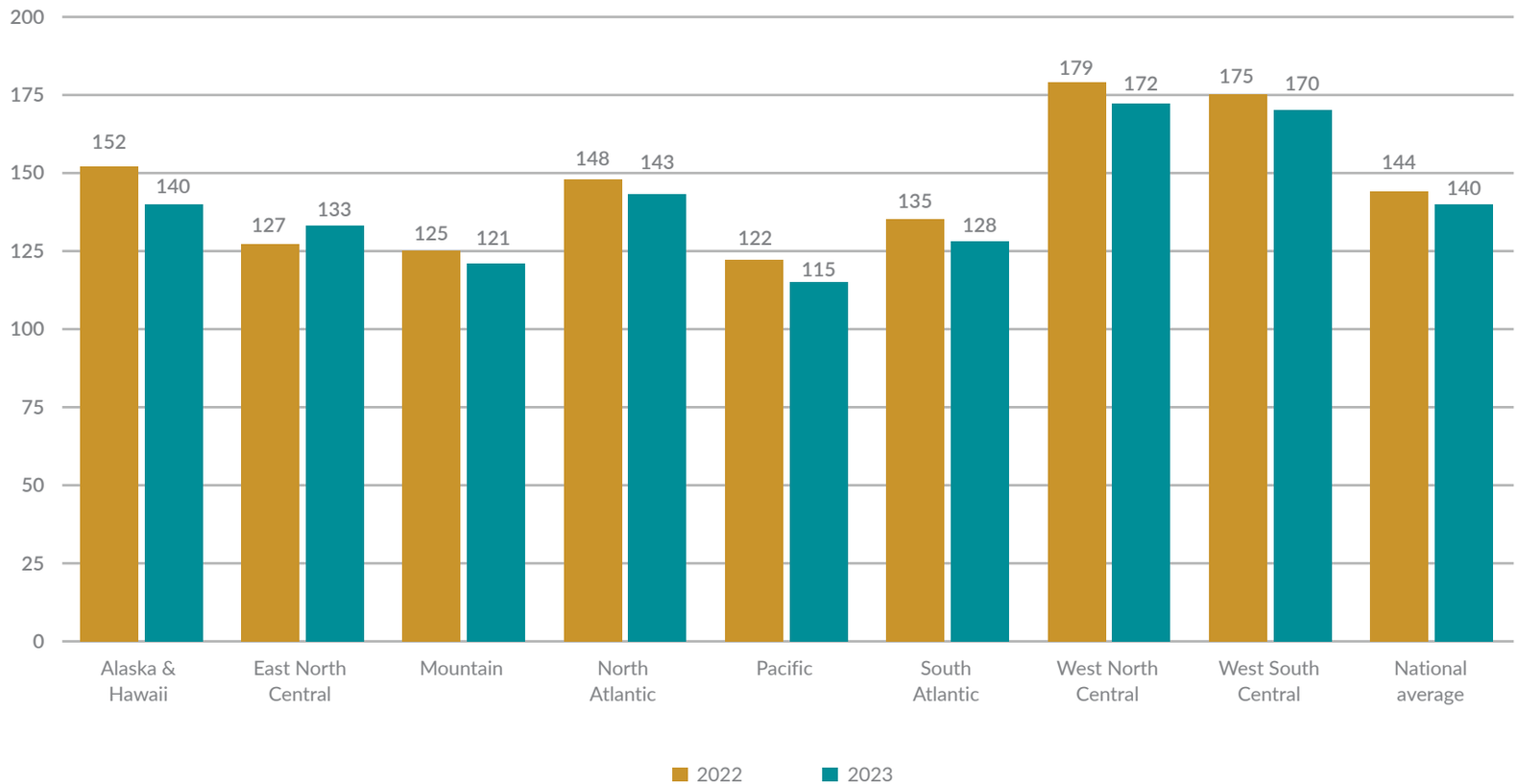
Occupancy percentages from 2022 through 2023 are shown as reported on the Medicare cost reports. The national average increased four percentage points from 73% in 2022 to 77% in 2023. As of June 2024, national average occupancy remains at 77% based on PBJ submission files for the second quarter of 2024.



MENU
SUBSCRIBE
CONTACT

Overall SNF average length of stay

Defined as all SNF days over all SNF discharges as reported on the Medicare cost report.

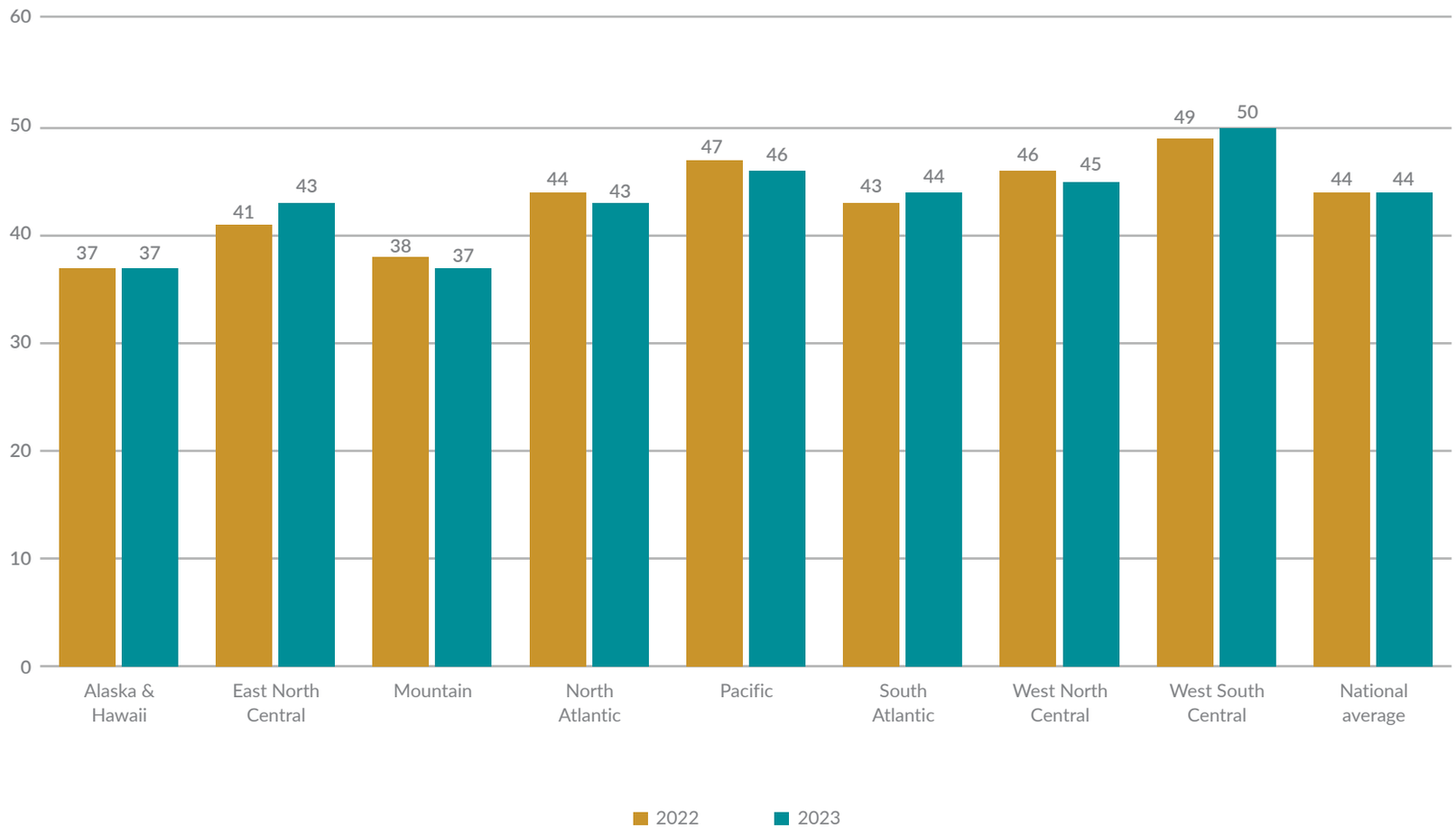


Slight decrease

The average LOS for all payors in a SNF declined by 4 days.

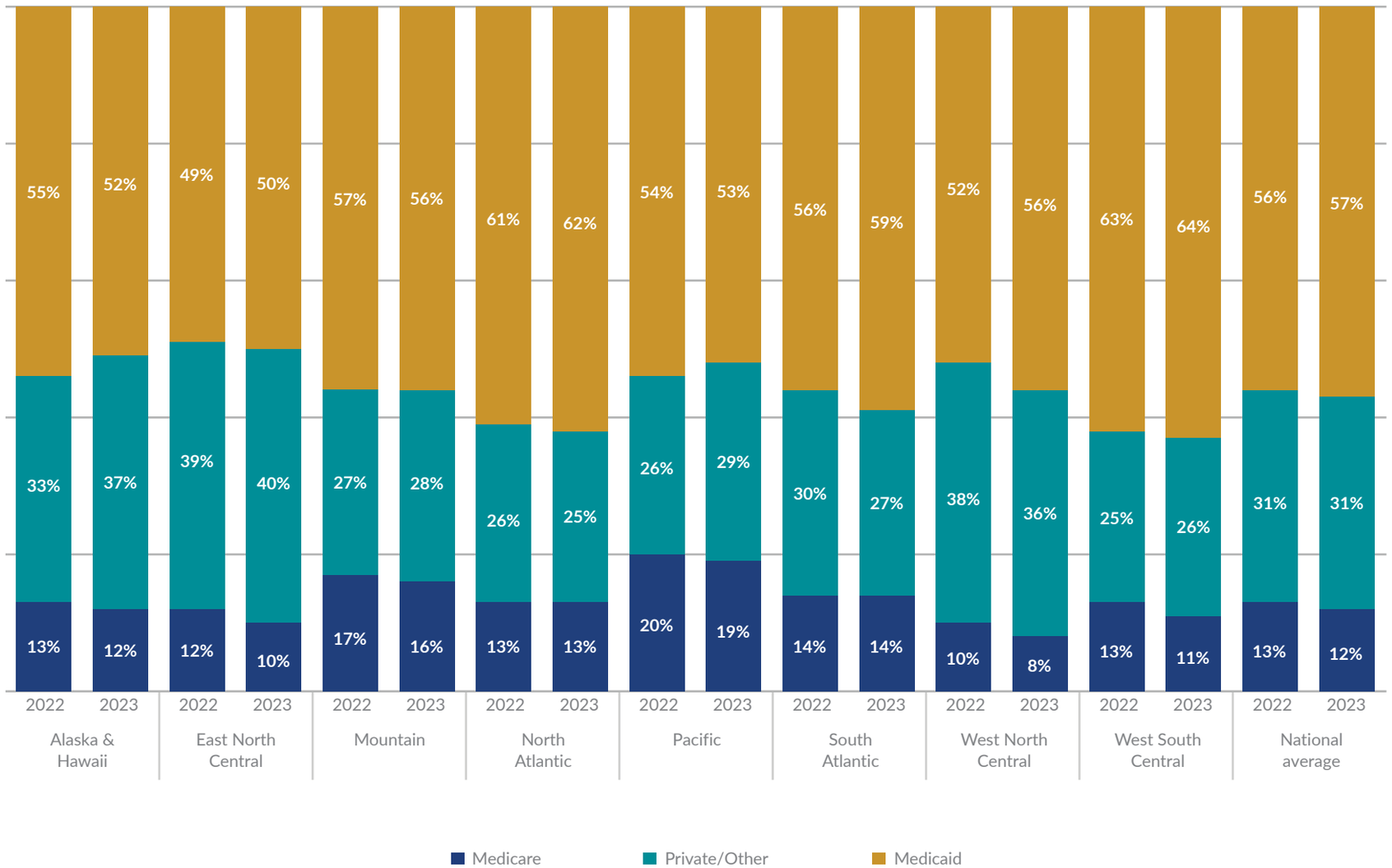
Medicare average length of stay

Defined as Medicare resident days over Medicare discharges as reported on the Medicare cost report. The Medicare average length of stay as reported on SNF Medicare cost reports held constant at 44 days.



MENU
SUBSCRIBE
CONTACT

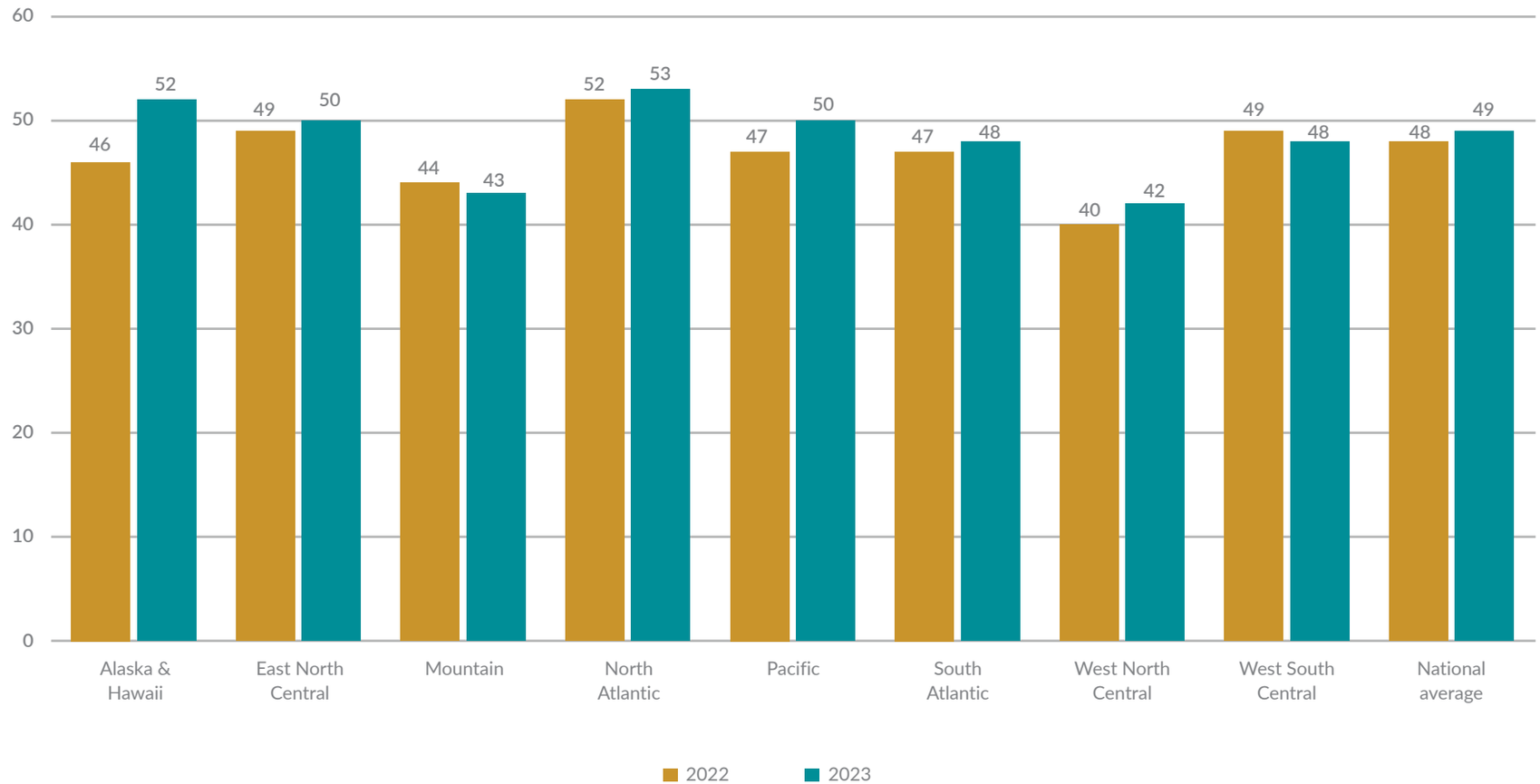
SNF payor mix



MENU
SUBSCRIBE
CONTACT

Days revenue in accounts receivable

Days revenue in accounts receivable (A/R) is calculated as (accounts receivable net of allowance/net patient revenues) x 365 days. This calculation is subject to the balance sheet reported on the Medicare cost report. We continued to see a slight increase in days in A/R, much of which is due to collection challenges related to MC plans.

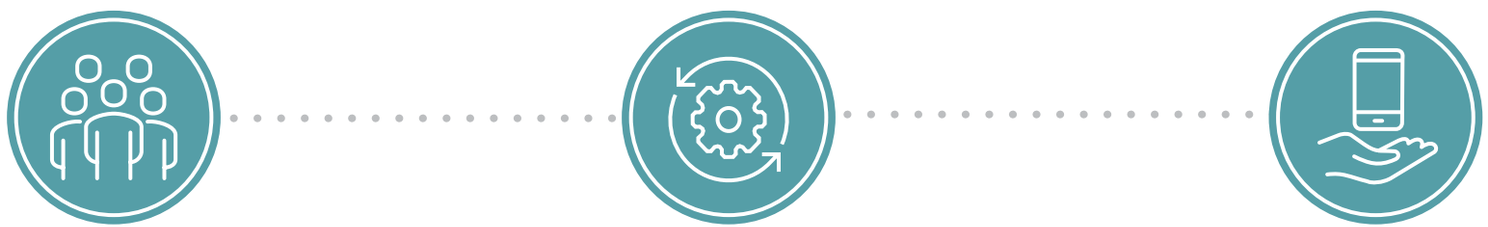


MENU
SUBSCRIBE
CONTACT

Growth of MC payors is driving up accounts receivable

MC plans continue to cause disruption to the industry both operationally and financially. The front-end authorization process and troublesome reauthorization process that may result in denial of admission or reduced length of stay for beneficiaries. There's significant variability in contract terms, authorization process, billing requirements, and post-payment review between MC plans. Organizations don't have the appropriate resources — resulting in growing accounts receivable balances. Occupancy challenges caused many facilities to relax preadmission financial assessment procedures. Organizations should establish targets for overall days in A/R that are determined based on consideration of the underlying payors and other local influences.

REVENUE CYCLE CONSIDERATIONS



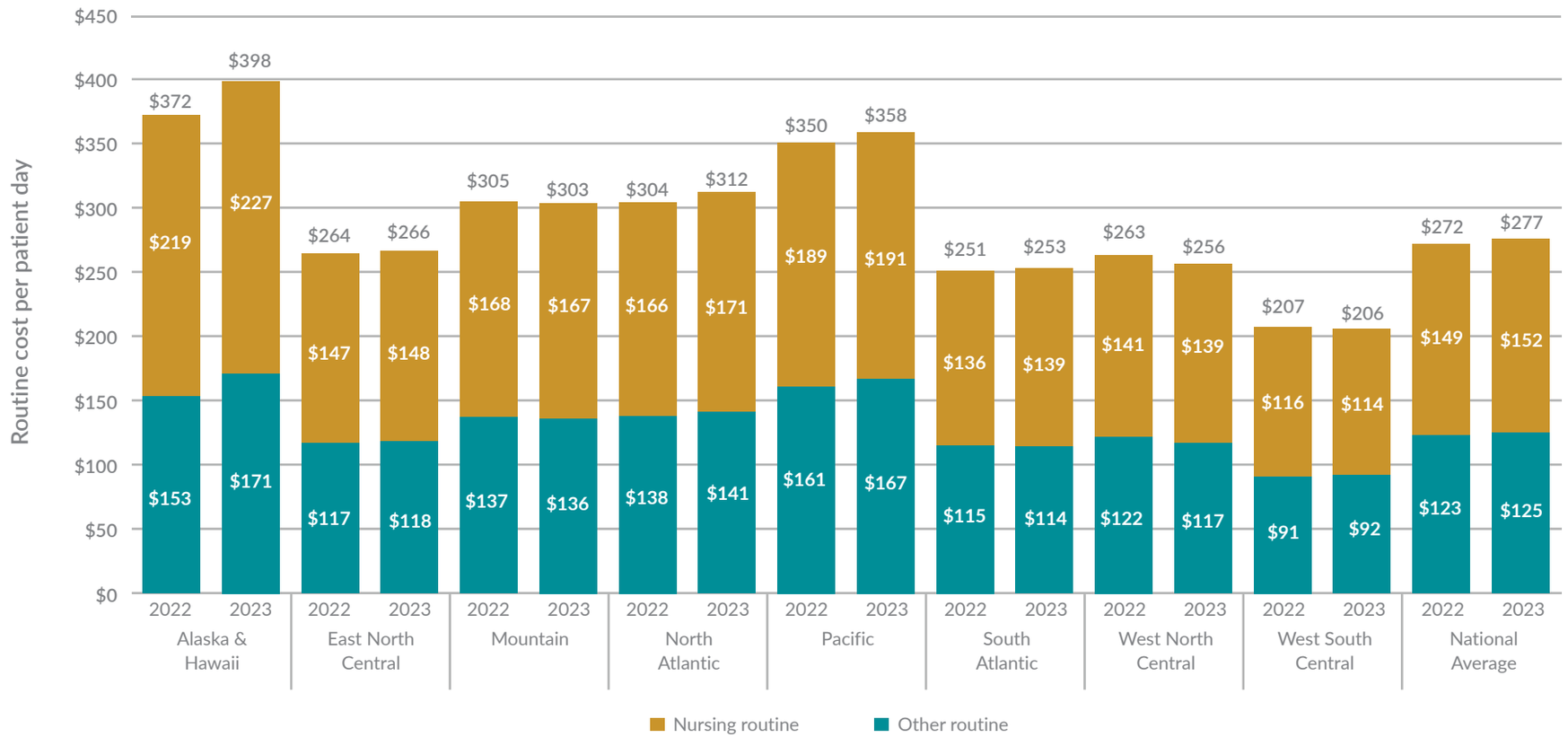
Red flags and warning signs:

- *+A/R balance*
- *+A/R over 120 days*
- *Unexplained shifts or variances in revenue or contractual allowance accounts*
- *+Bad debt expense*

MENU
SUBSCRIBE
CONTACT

Cost & wage trends

Routine cost per patient day



Direct nursing wage (excluding benefits) and supply costs represent 45% of the total routine cost of care. Nursing administration represents an additional 7%. Exploring creative and innovative ways to recruit and retain staff while eliminating agency usage is key.

Routine & capital cost (PPD)

Routine costs per day	Alaska & Hawaii	East North Central	Mountain	North Atlantic	Pacific	South Atlantic	West North Central	West South Central	2023 national average	2022 national average
Nursing	$171	$118	$136	$141	$167	$114	$117	$92	$125	$123
Employee Benefits	$29	$17	$16	$20	$20	$13	$14	$9	$16	$15
Administrative & General	$50	$29	$38	$35	$51	$27	$27	$26	$32	$31
Plant Operations	$20	$14	$14	$16	$15	$13	$14	$12	$14	$15
Laundry	$8	$5	$5	$6	$8	$5	$5	$4	$5	$5
Housekeeping	$12	$9	$9	$12	$11	$8	$8	$7	$9	$9
Dietary	$54	$37	$42	$43	$45	$36	$38	$30	$38	$37
Nursing Administration	$37	$17	$22	$20	$18	$22	$17	$15	$19	$19
Central Supply	$0	$4	$2	$3	$3	$3	$1	$2	$3	$3
Pharmacy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical Records	$4	$2	$3	$2	$4	$2	$3	$2	$2	$2
Social Service	$6	$8	$11	$6	$13	$7	$8	$5	$8	$8
Activities	$6	$5	$6	$7	$3	$3	$3	$2	$4	$4
Total Routine	$398	$266	$303	$312	$358	$253	$256	$206	$277	$272

Routine costs & capital	Alaska & Hawaii	East North Central	Mountain	North Atlantic	Pacific	South Atlantic	West North Central	West South Central	2023 national average	2022 national average
Routine	$398	$266	$303	$312	$358	$253	$256	$206	$277	$272
Capital	$35	$30	$33	$35	$32	$36	$22	$30	$31	$29
Routine and Capital	$433	$296	$337	$346	$390	$289	$279	$236	$308	$301

$5 routine

per patient day increase

Providers are working hard to manage costs while still dealing with staffing challenges

MENU
SUBSCRIBE
CONTACT

Medicare therapy cost per patient day

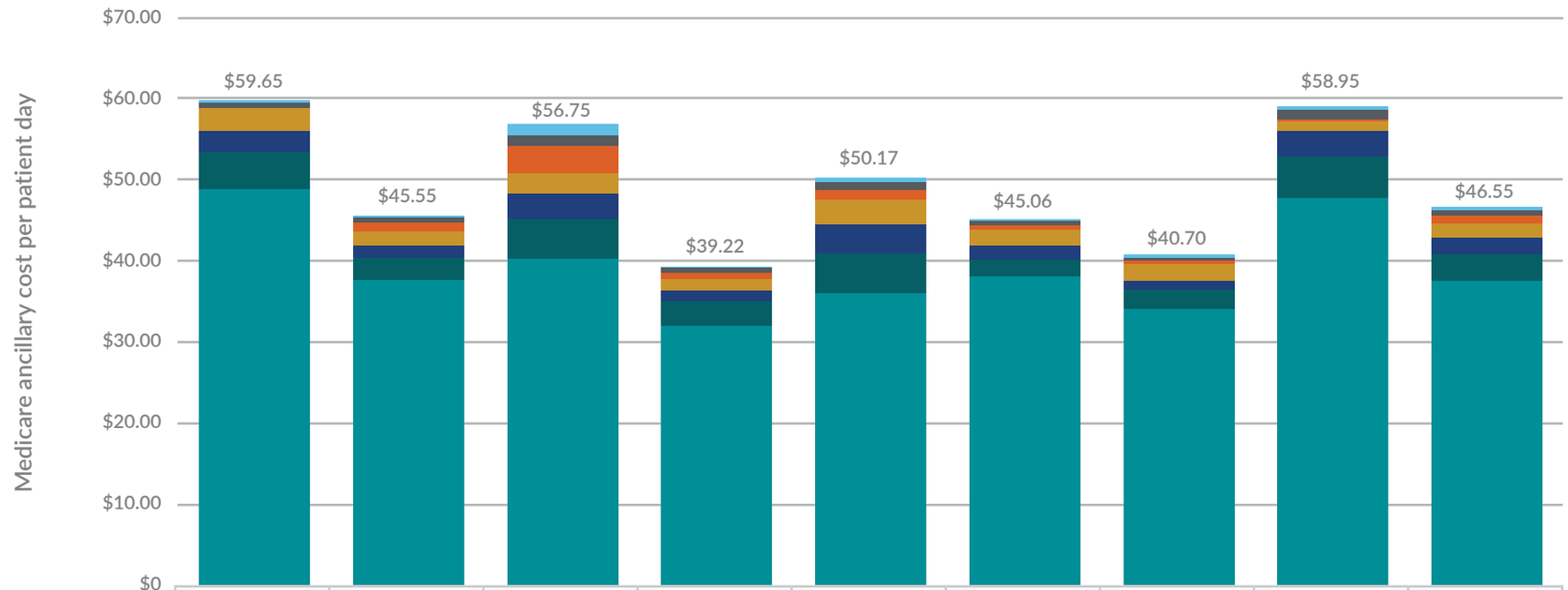
The Medicare cost report calculates Medicare Part A ancillary expense by imputing costs by using cost to charge ratio. Therefore, these costs are based on the Medicare Part A therapy charges that are reported on the Medicare cost reports.

With the transition to PDPM on Oct. 1, 2019, the national average Medicare therapy cost per patient day has declined from $139 in 2019 to $111 in 2023.

MENU
SUBSCRIBE
CONTACT

Medicare ancillary cost per patient day

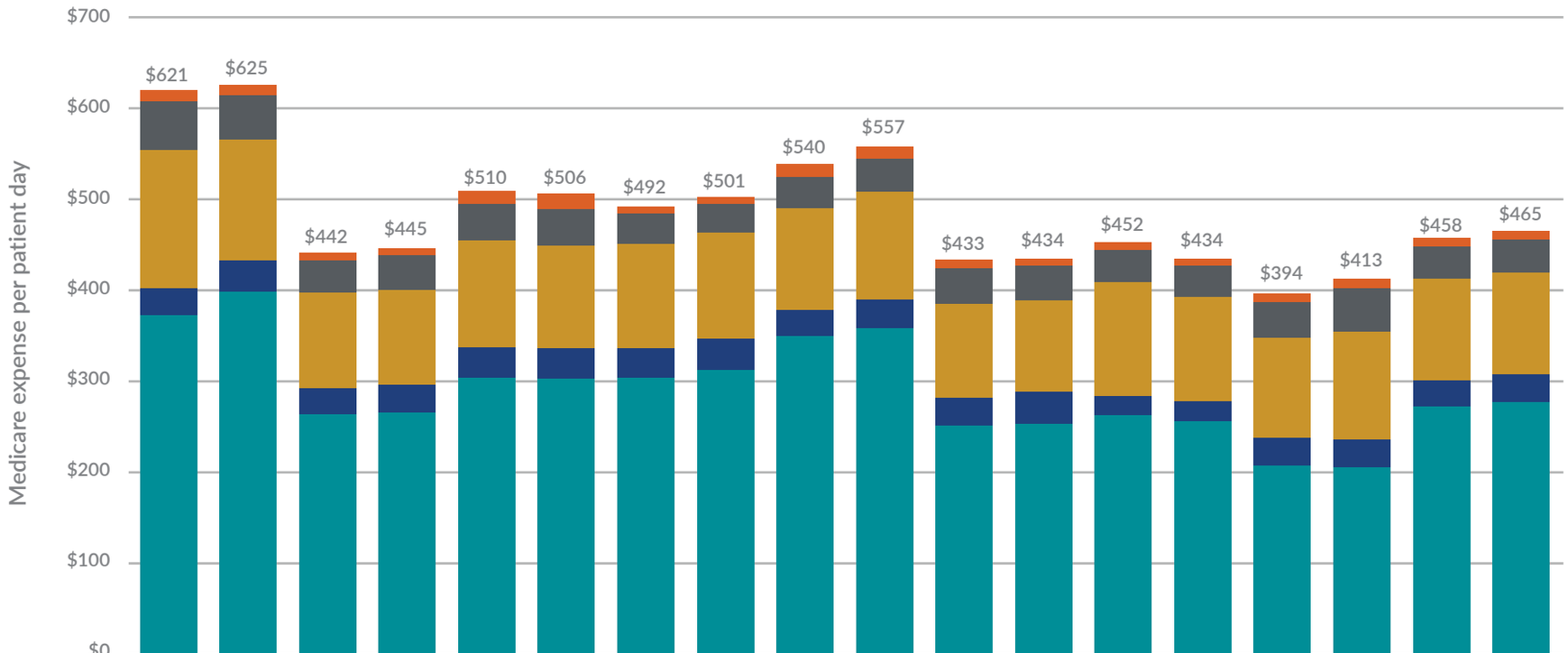
The Medicare cost report calculates Medicare Part A ancillary expense by imputing cost by cost-to-charge ratio. If providers don't include these ancillary charges on their Medicare Part A claims, then Medicare assumes no Medicare expense for that service. Providers are likely not including these costs on their claims, which drives down the ancillary costs on the cost report data.



	Alaska & Hawaii	East North Central	Mountain	North Atlantic	Pacific	South Atlantic	West North Central	West South Central	National average
Other	$0.37	$0.32	$1.37	$0.14	$0.59	$0.24	$0.35	$0.42	$0.37
Intravenous therapy	$0.57	$0.58	$1.29	$0.66	$0.89	$0.47	$0.38	$1.28	$0.71
Oxygen therapy	$0.09	$1.08	$3.34	$0.68	$1.28	$0.62	$0.42	$0.23	$0.88
Medical supplies	$2.71	$1.78	$2.57	$1.38	$3.00	$1.90	$2.05	$1.10	$1.83
Radiology	$2.62	$1.41	$3.07	$1.37	$3.53	$1.68	$1.09	$3.18	$1.96
Laboratory	$4.57	$2.80	$4.95	$2.99	$4.96	$2.14	$2.37	$5.06	$3.32
Pharmacy	$48.72	$37.58	$40.16	$32.01	$35.92	$38.02	$34.04	$47.68	$37.47

MENU
SUBSCRIBE
CONTACT

Total cost per Medicare patient day



	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023
	Alaska & Hawaii		East North Central		Mountain		North Atlantic		Pacific		South Atlantic		West North Central		West South Central		National average	
Other ancillary costs	$13	$11	$8	$8	$14	$17	$8	$7	$15	$14	$9	$7	$9	$7	$9	$11	$9	$9
Pharmacy costs	$53	$49	$36	$38	$40	$40	$33	$32	$34	$36	$39	$38	$36	$34	$39	$48	$36	$37
Therapy costs	$152	$132	$105	$104	$118	$113	$115	$116	$112	$118	$103	$100	$124	$115	$110	$118	$111	$111
Capital costs	$30	$35	$28	$30	$33	$33	$32	$35	$28	$32	$31	$36	$21	$22	$31	$30	$29	$31
Routine costs	$372	$398	$264	$266	$304	$303	$304	$312	$350	$358	$251	$253	$263	$256	$207	$206	$272	$277

MENU
SUBSCRIBE
CONTACT

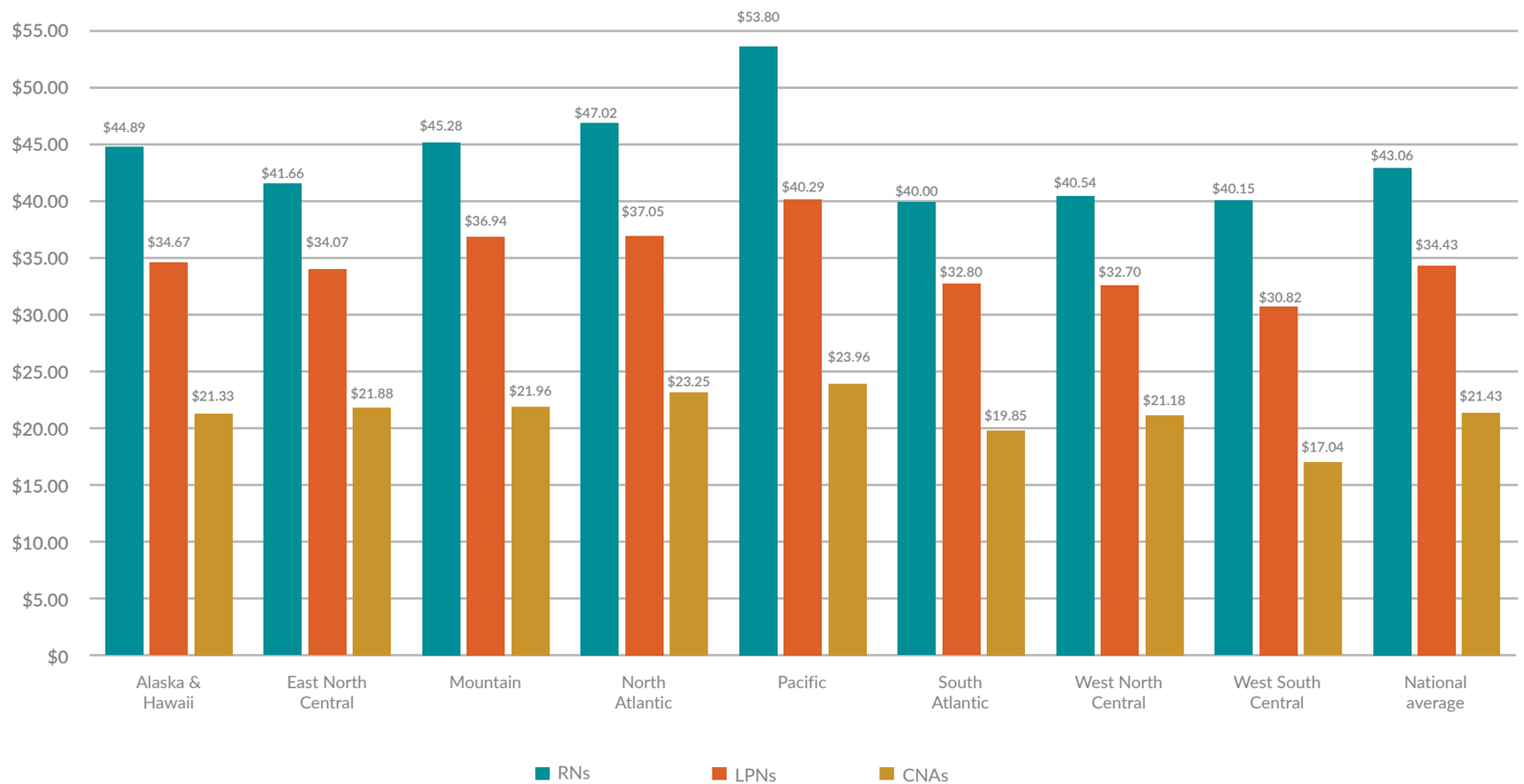
Wage rate trends

National median nursing wage rates as reported on Medicare cost reports

Nursing wage rates have increased 7–10% from 2022 to 2023.

MENU
SUBSCRIBE
CONTACT

2023 nursing wage rates as reported on Medicare cost reports



MENU
SUBSCRIBE
CONTACT

Support staff: Average wage rates

Average wage rates	Alaska & Hawaii	East North Central	Mountain	North Atlantic	Pacific	South Atlantic	West North Central	West South Central	2023 national average	2022 national average
Employee benefits	$28.49	$29.28	$25.59	$35.55	$33.31	$28.00	$27.55	$29.62	$30.73	$29.65
Administrative	$36.21	$33.33	$34.77	$36.77	$40.54	$34.42	$33.84	$32.74	$34.95	$33.27
Plant operations	$23.97	$24.25	$24.88	$25.65	$26.75	$23.83	$23.59	$22.85	$24.50	$23.56
Laundry	$17.10	$15.68	$16.41	$17.05	$17.91	$14.80	$15.38	$12.44	$15.60	$14.86
Housekeeping	$17.76	$15.83	$16.97	$17.38	$18.32	$15.36	$15.88	$13.35	$16.06	$15.38
Dietary	$20.61	$17.80	$19.12	$19.85	$21.16	$17.28	$17.52	$15.27	$18.21	$17.42
Nursing admin	$44.64	$45.40	$48.67	$49.62	$55.42	$43.63	$43.35	$43.45	$46.53	$45.03
Central supply	$24.14	$21.34	$21.88	$21.46	$22.70	$19.96	$20.34	$19.87	$21.19	$20.11
Pharmacy*	-	$46.05	$59.25	$40.56	$53.08	$50.32	-	-	$43.77	$41.72
Medical records	$25.16	$21.73	$23.56	$22.65	$26.97	$21.76	$22.21	$20.86	$22.74	$21.74
Social services	$27.31	$25.16	$26.84	$30.56	$26.88	$25.70	$24.47	$26.47	$26.54	$25.56
Activities	$20.59	$18.46	$20.02	$20.39	$21.60	$19.28	$19.18	$18.38	$19.45	$18.75
Average	$28.21	$25.93	$27.80	$28.48	$29.98	$25.64	$24.90	$23.01	$26.35	$25.21

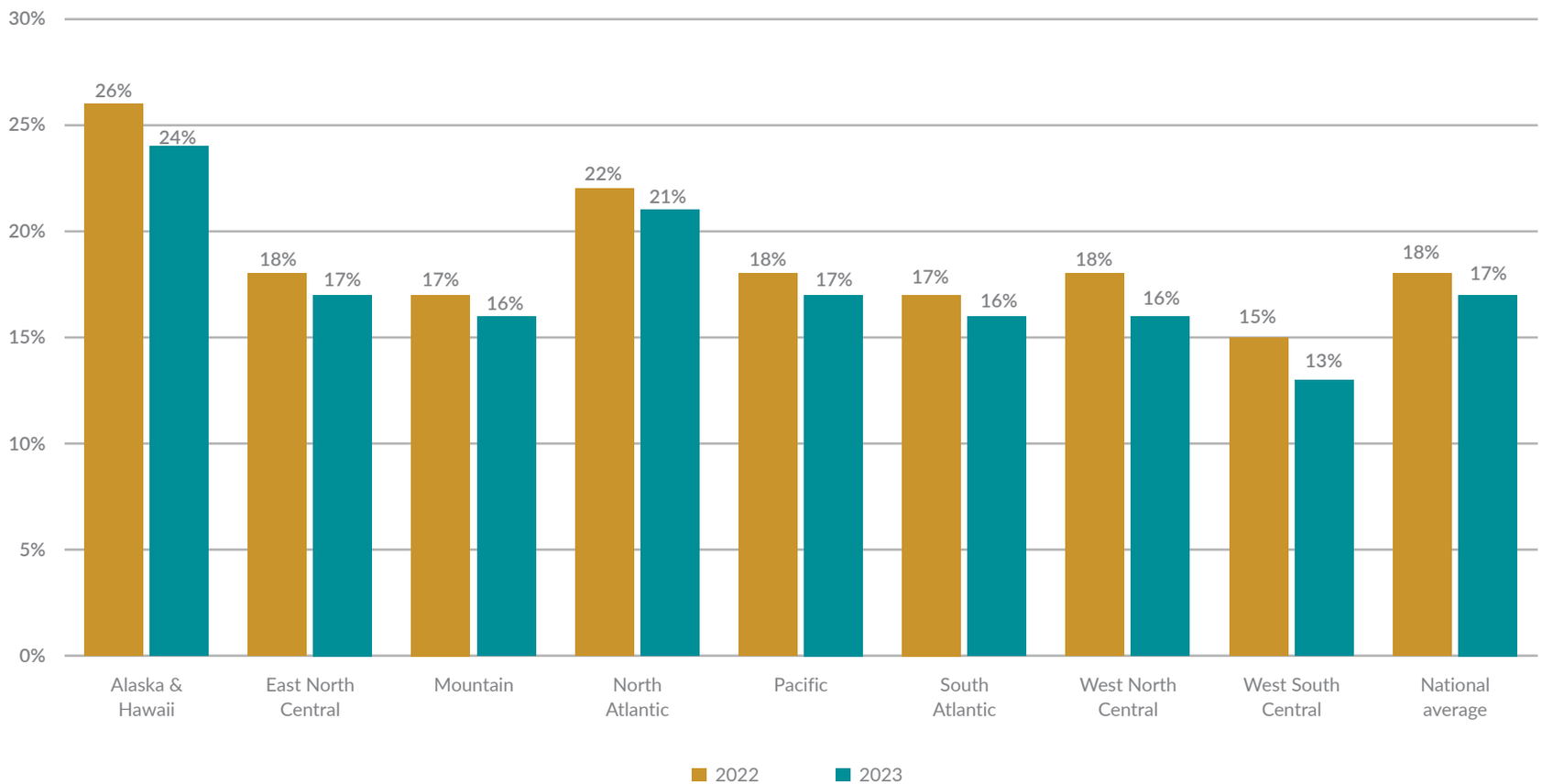
No data points for 2023 for Alaska & Hawaii, West North Central, or West South Central

Facility average wage rates have increased on average 4–5% from 2022 to 2023.

MENU
SUBSCRIBE
CONTACT

Benefits as percentage of wages

Benefits includes payroll taxes, worker's compensation, and fringe benefit expenses.



MENU
SUBSCRIBE
CONTACT

Appendix

- PDPM in state Medicaid programs
- CMS Five-Star program
- PBJ & related trends
- Growth in state Medicaid value based purchased
- Our senior care & living experience
- About Plante Moran

PDPM in state Medicaid programs

The transition from resource utilization group (RUG) III or IV models has begun in state Medicaid programs across the country with the majority of states expected to be utilizing the PDPM in 2025. With the removal of MDS Section G, replaced by Section GG effective Oct. 1, 2023, states that continued to use RUG case-mix systems were required to use optional state assessments through Oct. 1, 2025.

Seventy percent of states have a case-mix system in place for Medicaid reimbursement of SNFs. As of the end of 2024, around half of the states using a case-mix system have transitioned to PDPM, with more expected to follow this year.

The move away from RUGs to PDPM for the long-stay population represents a significant shift with implications to each state's reimbursement model. Each state transition is different. Some states have implemented a phase-in period for transitioning into PDPM for case-mix reimbursement. Some states have utilized only the nursing component CMI from PDPM, while other states have used a blended index including one or more of the additional components.

As always, this transition should be met with increased focus on MDS documentation and accurate assessments. Additionally, nursing facility providers will need to be aware of key drivers that impact payment under PDPM as compared to previous systems. Understanding the components that impact your specific state reimbursement system and adapting to change will continue to be critical for providers.

States currently utilizing PDPM

Colorado	Kentucky	Tennessee
Georgia	Massachusetts	Utah
Hawaii	Missouri	Vermont
Illinois	Nebraska	Washington
Iowa	New Hampshire	Wisconsin
Kansas	South Dakota	West Virginia

States implementing PDPM in 2025

Idaho: July 1	Mississippi: October 1	Ohio: July 1
Maine: January 1	New York: January 1	Rhode Island: October 1
Maryland: January 1	North Dakota: January 1	Virginia: October 1
Minnesota: October 1		Texas: September 1

Nursing home Five-Star trends

What changed for Five-Star staffing with the July 2024 refresh?

In September 2023, CMS announced an update to the staffing domain in the Five-Star system to transition to the PDPM concurrent with the transition to MDS 3.0. Beginning in April 2024, the staffing measures were frozen for one-quarter while data was collected for this transition. On July 31, 2024, CMS began posting nursing home staffing measures based on the new PDPM case-mix adjustment methodology.

As part of the implementation of the new staffing-level case-mix adjustment methodology, CMS revised the staffing rating thresholds with the intent to maintain the same overall distribution of points for affected staffing measures. However, CMS indicated individual provider scores may change due to a few reasons, including:

- The updated staffing level case-mix adjustment methodology.
- Changes in number of staffing hours reported by facilities from one-quarter to the next.
- Other revisions to the staffing turnover methodology, described below.

In addition to implementing the new case-mix adjustment methodology, effective with the July 2024 refresh, CMS has modified the number of days during which no work hours are reported for defining staffing turnover from 60 to 90 days, now allowing employees who take full parental leave allowed under the Family Medical Leave Act to not be considered for the turnover measures.

MENU
SUBSCRIBE
CONTACT

Recent changes to nursing home Five-Star/care compare

The six components to the CMS Five-Star staffing measure are listed below. While all six components are recalculated quarterly, the turnover measures use a 12-month period rather than a single quarter.

QUARTER AVERAGE:

1. Case-mix adjusted RN hours per resident day — 100 points
2. Case-mix adjusted total nursing hours per resident day — 100 points
3. Case-mix adjusted total nursing weekend hours per resident day — 50 points

12-MONTH PERIOD:

4. RN turnover — 50 points
5. Total nursing turnover — 50 points
6. Administrative turnover — 30 points

*Turnover measures require six consecutive quarters of PBJ data. For the turnover measures, nursing homes that fail to submit or submit erroneous staffing data for one or more of the quarters used in the turnover calculation will receive the lowest possible score for the corresponding measure.

The cut points for all staffing measures were updated with the July 2024 Care Compare refresh, except for administrator turnover. The new ranges for point values can be found in Table A2 of the Five-Star Quality Rating System: Technical User's Guide.

PBJ trends

October 2024 refresh: Representing second quarter of 2024

Region/State	Average Certified Occupancy	Average Quality Score	Average Staffing Score	Average Case Mix Adjusted RN HPRD	Average Case Mix Adjusted Total Nurse HPRD	Average Case Mix Adjusted Weekend Nurse HPRD	Average RN Turnover	Average Total Nurse Turnover	Average Administrator Departures
Alaska & Hawaii	80%	4.3	4.2	1.70	5.40	4.72	36%	39%	0.4
Alaska	88%	3.9	4.7	2.24	7.49	6.47	42%	47%	0.3
Hawaii	79%	4.5	4.0	1.45	4.46	3.93	34%	36%	0.4
East North Central	75%	3.5	2.5	0.68	3.56	3.11	46%	50%	0.6
Illinois	71%	2.9	2.0	0.65	3.12	2.73	48%	49%	0.7
Indiana	72%	3.9	2.2	0.58	3.31	2.87	44%	51%	0.6
Kentucky	83%	2.8	2.5	0.71	3.74	3.24	44%	50%	0.6
Michigan	77%	3.7	3.1	0.79	4.10	3.56	46%	50%	0.6
Ohio	81%	4.0	2.3	0.59	3.55	3.13	47%	52%	0.6
Wisconsin	69%	3.3	3.3	0.96	4.04	3.56	43%	50%	0.6
Mountain	72%	3.8	2.9	0.86	3.97	3.45	49%	53%	0.6
Arizona	71%	4.1	2.8	0.69	3.93	3.45	47%	48%	0.5
Colorado	74%	3.8	3.0	0.89	3.97	3.49	52%	55%	0.8
Idaho	69%	4.1	3.2	0.86	4.14	3.48	43%	49%	0.4
Montana	60%	3.0	3.2	0.97	4.45	3.84	52%	60%	0.7
New Mexico	78%	3.2	2.5	0.71	3.79	3.30	57%	54%	0.7
Nevada	81%	3.5	2.8	0.90	3.92	3.46	41%	46%	0.4
Utah	66%	4.4	2.8	1.03	3.63	3.13	47%	57%	0.8
Wyoming	67%	3.0	3.3	1.03	4.39	3.73	44%	54%	0.4
North Atlantic	82%	3.5	3.0	0.75	3.86	3.40	43%	45%	0.6
Connecticut	83%	3.2	3.2	0.73	3.88	3.46	40%	39%	0.5
Delaware	81%	4.1	3.7	1.06	4.63	4.09	44%	48%	0.6
Massachusetts	79%	3.2	2.8	0.65	3.88	3.45	49%	44%	0.6
Maryland	83%	3.4	2.9	0.82	3.83	3.36	45%	44%	0.7
Maine	83%	2.9	3.7	1.01	4.38	3.90	46%	53%	0.5
New Hampshire	80%	3.0	3.1	0.76	3.99	3.52	45%	48%	0.7
New Jersey	80%	4.3	2.8	0.70	3.76	3.29	43%	44%	0.7
New York	87%	3.7	2.6	0.66	3.57	3.07	41%	42%	0.5
Pennsylvania	79%	3.3	3.2	0.83	4.00	3.58	42%	48%	0.7
Rhode Island	84%	3.1	3.4	0.84	3.96	3.47	42%	46%	0.6
Vermont	78%	2.6	2.9	0.80	4.16	3.61	48%	62%	0.8
National Average	77%	3.4	2.7	0.67	3.89	3.40	46%	49%	0.6

MENU
SUBSCRIBE
CONTACT

PBJ trends

October 2024 refresh: Representing second quarter of 2024

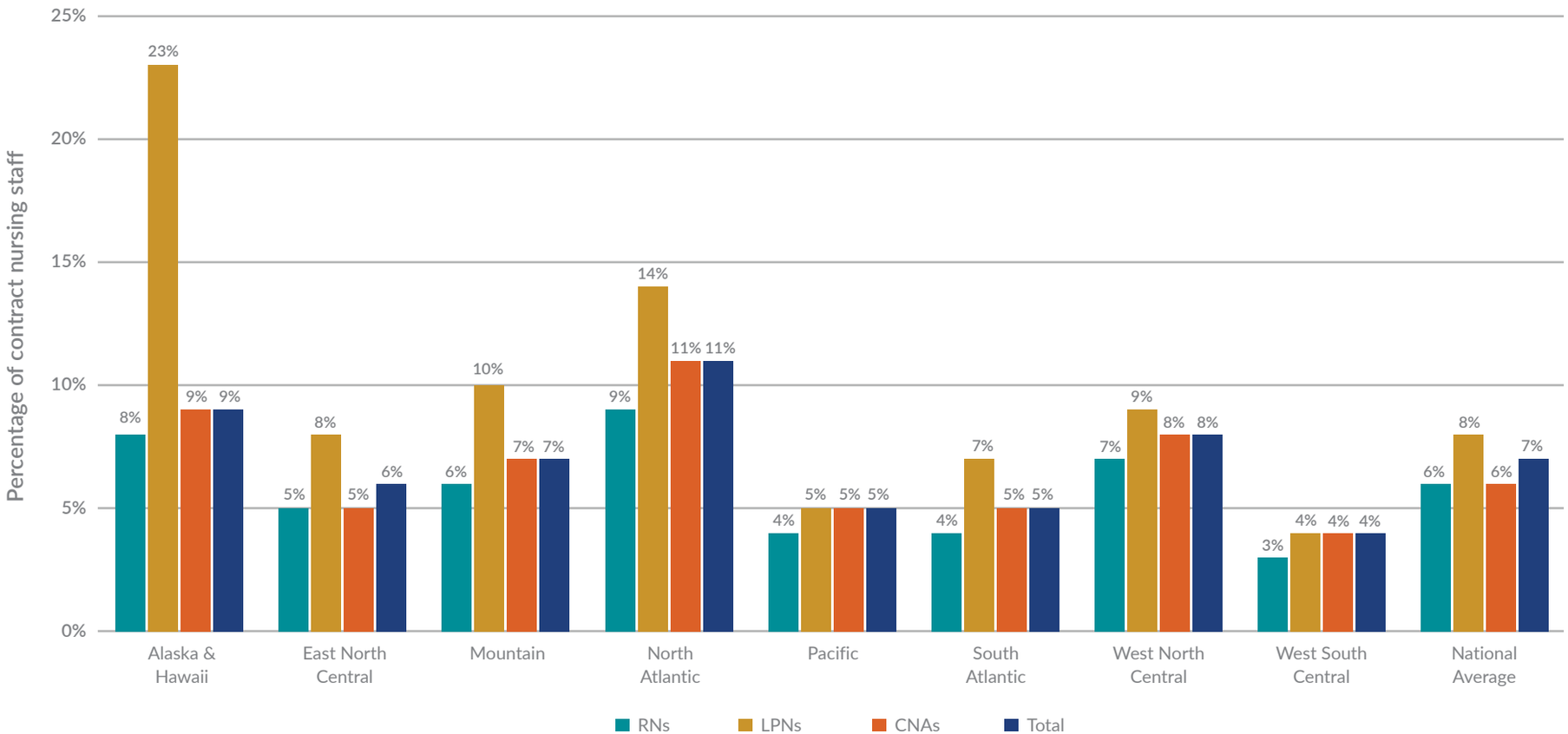
Region/State	Average Certified Occupancy	Average Quality Score	Average Staffing Score	Average Case Mix Adjusted RN HPRD	Average Case Mix Adjusted Total Nurse HPRD	Average Case Mix Adjusted Weekend Nurse HPRD	Average RN Turnover	Average Total Nurse Turnover	Average Administrator Departures
Pacific	83%	4.1	3.0	0.59	4.21	3.76	44%	43%	0.6
California	86%	4.2	2.9	0.54	4.12	3.72	42%	41%	0.6
Oregon	63%	3.3	3.4	0.68	5.12	4.53	53%	50%	0.8
Washington	73%	3.7	3.2	0.86	4.13	3.56	48%	51%	0.7
South Atlantic	82%	3.2	2.7	0.64	3.88	3.36	46%	49%	0.7
Alabama	81%	3.0	3.2	0.66	4.24	3.51	42%	49%	0.5
Washington, D.C.	82%	4.1	4.1	1.49	4.67	4.14	33%	32%	0.9
Florida	87%	3.9	3.1	0.74	3.98	3.60	48%	45%	0.9
Georgia	78%	2.6	2.1	0.47	3.51	2.99	45%	50%	0.6
Mississippi	84%	2.0	3.4	0.67	4.57	3.77	39%	46%	0.5
North Carolina	79%	2.9	2.5	0.59	3.86	3.37	47%	53%	0.7
South Carolina	82%	3.1	2.8	0.66	3.96	3.41	45%	49%	0.4
Tennessee	71%	3.2	2.3	0.56	3.55	3.02	43%	50%	0.5
Virginia	85%	3.5	2.3	0.65	3.69	3.19	50%	51%	0.7
West Virginia	89%	2.7	2.5	0.71	3.72	3.17	40%	48%	0.8
West North Central	75%	3.0	3.1	0.80	4.27	3.69	45%	51%	0.6
Iowa	74%	3.2	3.4	0.84	4.22	3.66	45%	48%	0.6
Kansas	80%	3.0	3.2	0.80	4.48	3.90	44%	51%	0.6
Minnesota	81%	3.4	3.9	1.14	4.69	4.08	42%	45%	0.5
Missouri	69%	2.7	2.0	0.48	3.73	3.25	55%	58%	1.0
North Dakota	90%	3.1	4.0	1.03	5.12	4.30	32%	47%	0.2
Nebraska	70%	3.2	3.2	0.75	4.34	3.71	45%	52%	0.4
South Dakota	83%	2.8	3.4	0.88	4.17	3.52	35%	50%	0.3
West South Central	66%	3.1	2.1	0.41	3.81	3.31	50%	53%	0.7
Arkansas	73%	3.4	2.9	0.45	4.46	3.75	47%	52%	0.6
Louisiana	72%	1.9	2.2	0.33	4.03	3.42	40%	49%	0.6
Oklahoma	61%	2.7	2.4	0.39	4.27	3.87	54%	57%	0.7
Texas	64%	3.4	1.9	0.43	3.53	3.08	51%	53%	0.7
National Average	77%	3.4	2.7	0.67	3.89	3.40	46%	49%	0.6

MENU
SUBSCRIBE
CONTACT

PBJ trends

October 2024 refresh: Representing second quarter of 2024

Percentage of contract nursing staff by position



PBJ trends

October 2024 refresh: Representing second quarter of 2024

Alaska & Hawaii		Mountain		North Atlantic		Pacific		West North Central	
Alaska	12%	Arizona	5%	Connecticut	6%	California	3%	Iowa	6%
Hawaii	9%	Colorado	10%	Delaware	11%	Oregon	12%	Kansas	6%
East North Central		Idaho	6%	Massachusetts	9%	Washington	7%	Minnesota	9%
Illinois	7%	Montana	16%	Maryland	10%	**South Atlantic**		Missouri	6%
Indiana	3%	New Mexico	7%	Maine	16%	Alabama	1%	North Dakota	15%
Kentucky	5%	Nevada	5%	New Hampshire	12%	Florida	3%	Nebraska	12%
Michigan	3%	Utah	5%	New Jersey	13%	Georgia	6%	South Dakota	10%
Ohio	6%	Wyoming	5%	New York	11%	Mississippi	7%	**West South Central**	
Wisconsin	10%			Pennsylvania	13%	North Carolina	10%	Arkansas	2%
				Rhode Island	6%	South Carolina	7%	Louisiana	5%
				Vermont	30%	Tennessee	5%	Oklahoma	3%
						Virginia	6%	Texas	4%
National average	**7%**					West Virginia	6%		

MENU
SUBSCRIBE
CONTACT

VBPs in state Medicaid programs

States are incorporating VBPs as part of their nursing facility Medicaid payment systems in different ways. While a few states have voluntary programs, the majority of states require mandatory participation as the payments are included in the nursing facility Medicaid per diem. Below are examples from a few states across the country on various value based payment programs.

Ohio Medicaid includes a quality incentive payment as part of the SNF Medicaid per diem payment rate. The quality payment is based on seven MDS long-stay measures that are used in the CMS Five-Star program, and the case-mix adjusted total nurse staffing hours per patient day as reported in CMS PBJ submissions. Points are aggregated for the eight measures of each nursing home on a semiannual basis. SNFs don't receive points for quality scores in the bottom quintile/decile based on CMS Five-Star ranges. Additionally, the providers whose total quality points are below the statewide bottom 25th percentile of nursing homes are excluded from receiving quality points from these eight measures. Nursing facilities with licensed occupancy greater than 75% receive three quality incentive points. As of July 1, 2024, Medicaid rates, the statewide average quality incentive payment of $33 represents around 12% of the overall average Medicaid rate of $272. Therefore, if a provider is in the bottom 25th percentile and doesn't receive any quality funding, this is a significant impact to their Medicaid rate often leading to financial distress.

Ohio Medicaid implemented a private room incentive payment that began with dates of service Dec. 18, 2024. Nursing facilities will receive an add on of $30 or $20 for Medicaid residents in approved category one (private bath) or category two (shared bath) private rooms. The private room incentive payment is subject to a statutory spending limit as appropriated in the FY 2025 budget.

Florida Medicaid includes a quality incentive payment as part of the SNF Medicaid per diem payment rate. The quality payment is based on process measures, outcome measures, structure measures, and credentials. The measures use data as reported in the CMS Five-Star program, staffing as reported on the Medicaid cost report, and data from CMS PBJ submissions. Credential measures include CMS Five-Star rating, Nursing Home Gold Seal Award, Joint Commission Accreditation, and AHCA National Quality Award. Performance for each measure is evaluated based on the state distribution. Points are aggregated for all measures for each nursing facility. To quality for the quality incentive payment, providers must exceed the 20th percentile. As of Oct. 1, 2024, Medicaid rates, the statewide average quality incentive payment of $22 represents around 8% of the overall average Medicaid rate of $284*.

**Florida statewide average Medicaid rates are subject to budget adjustment factors.*

Nebraska Medicaid includes a quality incentive payment as part of the SNF Medicaid per diem payment rate. The July rate period per diem add on is based on CMS Quality Measures Rating as of the previous May 1. Nursing facilities without a rating, one star, or two stars receive don't receive an add on. Nursing facilities with a three-star rating receive $3.50. Nursing facilities with a four-star rating receive $6.75. Nursing facilities with a five-star rating receive $10. The January rate period per diem add on is updated based on CMS Quality Measures Rating as of the previous November 1.

Tennessee Medicaid includes a quality incentive payment as part of the SNF Medicaid per diem payment rate. The quality payment is based on QuILTSS evaluation report of 14 measures, including satisfaction, culture change/quality of life, staffing/staff competency, and clinical performance measures. The measures use a variety of sources, including survey assessments, CMS Five-Star, and other documentation submitted by providers. Points are aggregated for all measures for each nursing facility and facilities are put into one of three payment tiers. As of July 1, 2024, Medicaid rates, the statewide average quality incentive payment of $17 represents around 6% of the overall average Medicaid rate of $286*. A nursing facility's quality payment tier based on total points earned, also informs other components of the Medicaid per diem rate: statewide direct care noncase-mix adjusted price multiplier, direct care spending floor percentage, and fair rental value rental rate percentage.

** Tennessee statewide average Medicaid rates are subject to budget adjustment factors.*

Colorado Medicaid utilizes a pay-for-performance (P4P) supplemental payment to Class I nursing facilities that complete and have verified/audited applications on annual basis. The program includes 23 performance measures (not including submeasures) in the quality of life and quality of care domains. New in 2024 and continuing into 2025, nursing facilities with substandard deficiencies in the previous calendar year are eligible to participate in the P4P program and receive half of their calculated payment. The supplemental payment is determined by multiplying a P4P per diem rate by Medicaid patient days. The per diem amounts have historically been $0, $1, $2, $3, or $4 based on the respective point ranges: 0-20; 21-45; 46-60; 61-79; and 80-100. With the passage of HB 23-1228, effective with SFY 2024-25, the P4P payments will increase to 12% of total supplemental Medicaid payments. With this change, the department is revising the per diem add-ons to be allocated as multipliers that will set the dollar amounts each year based on available funding.

Massachusetts Medicaid utilizes a quality adjustment factor to the nursing standard payment at each PDPM nurse case-mix category and operating standard payment rates. Beginning Oct. 1, 2024, a nursing facility may be eligible for a quality adjustment equal to the sum of the percent increase or decrease assessed for performance on each measure. The measures include: quality achievement based on CMS score (June 2023 overall); quality improvement based on CMS score (look back to June 2022 overall); quality achievement based on DPH score (July 1, 2023); and quality improvement based on DPH score (look back to July 1, 2022).
The achievement measures have adjustment percentages from –1% to 1%.
The improvement scores have adjustment percentages from –3% to 2%.
The aggregate quality adjustments can range from –8% to 6%. The dollar impact to a nursing facility payment from the quality adjustment factor will depend on the resident-specific PDPM nurse case-mix category that sets the nursing standard payment rate.

New York Medicaid Nursing Home Quality Initiative (NHQI) comprises three components. First is the quality component, which is based on a set of 14 measuring criteria, which accounts for a potential of 70 out of the 95 total quality points available to nursing facilities. Eleven of the 14 measures are quality-based, and the other three are more staffing-related and include percent of agency staff used, staffing hours per patient day, and total nursing turnover, and each of the measures are worth a maximum of 5 points each.

The second component is the compliance component, which focuses on the compliance specifically with reporting of timely submissions of employee influenza immunization data and also uses the New York state regionally adjusted Five-Star Quality Rating for health inspections, and compliance of reporting in these areas account for a potential of 15 out of the possible 95 total quality points.

The third component is the efficiency component, which focuses on the number of potentially avoidable hospitalizations of nursing facility residents, and accounts for a potential of 10 of the possible 95 total quality points available.

Other states have implemented value based payments separate from the Medicaid per diem rate. Texas, California, and Colorado have voluntary programs in which providers enroll to participate.

Texas Medicaid has a voluntary Quality Incentive Payment Program (QIPP) open to nonstate governmental-owned (NSGO) and private-owned nursing facilities serving residents enrolled in STAR+PLUS Medicaid. To participate, privately owned nursing facilities are required to meet a 65% Medicaid utilization threshold. The value based payment components vary based on facility ownership type.

Texas QIPP is a state directed payment that uses intergovernmental transfers (IGTs) for the nonfederal share of funding. A portion of the QIPP payments made to NSGO nursing facilities are shared back with county hospital and hospital district partners through intergovernmental transfers.

For SFY 2024, the program utilized four components: quality assurance and performance improvement (QAPI) (NSGO only), RN coverage and workforce development, core MDS long-stay quality measures, and infection control and antibiotic stewardship/MDS vaccination quality measures (NSGO only). Nursing facilities have been required to submit data and documentation to Health and Human Services on varying timelines with payments being made on a monthly or quarterly basis depending on the component. Monthly, quarterly, and adjustment period QIPP scorecards are posted to Texas HHSC website detailing facility results, payments by MCO, and adjustments by state fiscal year. Under related documents for each state fiscal year files may be included related to intergovernmental transfer data.

Effective with the SFY 2025 the pool size has been set at $1.75 billion, an increase from SFY 2024 of $1.1 billion. The structure of the program has been modified. The four components are: hospital partner MDS measures (NSGO only), workforce development, Texas priority MDS measures, and resident focus MDS measures (NSGO only). All components are structured as pay for performance and include nationally recognized quality measures. For SFY 2025, the program doesn't require nursing facilities to report data or documentation to Health and Human Services. All component funds will be measured and distributed quarterly in SFY 2025.

California's Workforce and Quality Incentive Program (WQIP) succeeds the former Quality and Accountability Supplemental Payment (QASP) program. WQIP provides performance-based directed payments to nursing facilities and is intended to incentivize workforce and quality in Freestanding Skilled Nursing Facilities Level-B and Adult Freestanding Subacute Facilities Level-B.

The metrics used to evaluate the quality of care in nursing facilities consist of three categories: workforce metrics, clinical metrics, and equity metrics. The measurements used in the workforce category are acuity-adjusted staffing hours and staffing turnover and this component makes up 50% of the total score.

In the clinical category, the metrics include a combination of three MDS measures and three claims-based measures, and this component makes up 40% of the total score, and the equity category uses Medi-Cal disproportionate share and racial and ethnic data completeness measures and makes up the remaining 10% of the total score.

The program began with a budgeted pool of $280 million, and DHCS establishes a baseline, uniform per-diem by dividing the $280 million by the total number of WQIP-eligible days. Then DHCS applies a linear curve by multiplying each facility's overall score by the curve factor and then divides by 100 to get to the facility's curved WQIP score, which is formatted as a percent.

Once the curved WQIP score is calculated, DHCS/HSAG calculates the final WQIP payments using the following equation:

WQIP-Eligible Days X Curved WQIP Score X Uniform Per Diem Rate

The weighted per-diem rate that's calculated using the above methodology, is then multiplied by the total number of WQIP-eligible days per participating facility, and the result is paid to providers on an interim basis. The average per diem rate paid to participating providers is approximately $10.43/day but ranges from zero to $28.90 per day.

Our senior care & living experience

Our experts are ready to consult with you on the best way to navigate policy and achieve your strategy, financial, and operational priorities.

WE SERVE:

1,000+ post-acute care providers

400+ Not-for-profit post-acute care clients served

20+ of the top 150 Not-for-profit senior care and living providers in the nation served

INCLUDING:

- life plan communities and continuing care retirement communities (CCRCs)
- home health and hospice agencies
- skilled nursing facilities
- independent and assisted living facilities
- PACE organizations

225+ staff who specialize in healthcare

OUR EXPERIENCE

80+ years in the healthcare industry as a firm

26+ years of experience possessed by our healthcare partners on average

About Plante Moran

Plante Moran is among the nation's largest certified public accounting and business advisory firms.

We provide clients with audit, tax, business consulting, and wealth management services. Whether you have a single, specific need or require comprehensive services on a worldwide scale, we have the knowledge, experience, and resources to meet your goals. Our professionals specialize by industry. This means our clients benefit from the expertise and advice of teams that know their specific challenges and how to combat them. We bring the full resources of the firm to every client.

Firm at a glance

1924
year founded

50
states

24
offices in the United States and abroad

150+
countries where we've serve clients

3,800+
professionals

20,000+
clients

Your one-stop shop

Our audit, tax, and consulting professionals have a deep understanding of the risks, trends, and growth strategies impacting senior care and living providers today. Our clients benefit from our experience serving organizations of all sizes and structures all across the healthcare continuum.

60+ years of experience in the healthcare industry as a firm

400+ trained professional staff who specialize in healthcare

26 average years of healthcare industry experience per partner

2,500+ senior care and living providers across the continuum


AUDIT

TAX


CONSULTING


DEVELOPMENT

plante moran | 100 years

Audit. Tax. Consulting. Wealth Management.

Please contact us with any questions.

Denise Leonard, CPA
Partner
denise.leonard@plantemoran.com
216-274-6514

Christy VanDeWater, CPA
Principal
christy.vandewater@plantemoran.com
614-222-9056

Mitch Dreisbach, CPA
Manager
mitch.dreisbach@plantemoran.com
614-222-9017

Jon Lanczak
Principal
jon.lanczak@plantemoran.com
248-223-3569