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Members of VHCA

- Nursing Facilities / Skilled Nursing Facilities (SNF)
- Residential Care Homes (RCH)
- Assisted Living Residences (ALR)

These providers all offer forms of residential long-term care, and some offer short- term rehabilitation care.

Each have different considerations for who they serve, what services they offer, how they are regulated, and how they are paid.

Some important distinctions

- Although these providers serve mostly a 65+ demographic, their primary public payer is Medicaid (not Medicare).
- Skilled Nursing Facility regulations are set primarily by the federal government with states performing inspections under federal contract.
- Residential Care and Assisted Living regulations are set primarily by the state government – and these rules are being updated on April 1, 2025, for the first time in almost 25 years.
- Skilled Nursing Facility payments have a regular re-calculation as part of statute; Residential Care and Assisted Living do not. (This does not mean SNF Medicaid payments cover the cost of services).
- We need more nurses in general – shortages in LNAs and LPNs are particularly acute for our providers, which rely on these licensure levels as the backbone of residential nursing care.

More important distinctions

- Almost none of our providers directly employ physicians – primary care & specialty services are provided by external medical groups.
  - Residents in RCH / ALR need to have their care services secured within the region before admission.
  - One exception is facilities owned by hospital networks, which include a medical group.
- Unlike some forms of hospital & primary care services, there is a *strong* regulatory emphasis on not accepting referrals if a LTC provider cannot guarantee an ongoing ability to provide the services in the individual care plan. This leads to many denials.
- Because we are discussing residential care, there are also rooming logistics to consider in accepting any referrals. These logistics have become more complicated as we adopt new precautions against spreading infectious diseases.

Capacity Is A Big Issue

There are multiple dimensions to "capacity"

- Number of beds available
- Location of those beds relative to home communities / care teams
- Number of beds with basic staffing
  - Nursing & direct care worker shortages have restricted this number
- Access to workforce for more complex needs
  - This may be clinical staff – for example psychiatrists, pharmacists, OT/PT
  - This may be other staff – for example in memory care or SLP
- Availability of qualified providers to perform admissions reviews
- Other specialized considerations
  - MissionCare
  - Equipment – for example ventilator units (equipment & staff)

Some Basic Capacity Metrics to Track

Number of beds available – this number may decline even if number of facilities stays the same, especially in a workforce crunch.

- ~2,900 SNF
- ~2,120 RCH
- ~1,220 ALR

Number of beds occupied

- The goal in SNFs is not 100% occupancy
- ~90% is a better target, average now is around 80% - with a large split between highest and lowest occupancy

Ratio of available SNF beds to age demographics: 75+ and 85+

- Risk of needing SNF placement at some point in the next year goes up significantly at 75+ and goes up *dramatically* after 85

Policy Requests You Will Hear from VHCA

Fully implement the increases for Enhanced Residential Care (ERC) described in the state's 2023 rate study.

- This is a Medicaid payment for "enhanced" services beyond the basic bundle of services in ALR / RCH settings.

Continue to support workforce development initiatives.

Provide adequate reimbursement for SNFs.

- VHCA supports the Administration's BAA Request
- Some changes to base reimbursement were made in SFY2025
- We still have work to do on capacity with certain clinical risk factors and on how Medicaid payment keeps pace with changing costs
- Medicare Advantage is highly disruptive