KHCA DON Boot Camp 2026

Shannon Lager RN, BSN
Medicalodges, Inc.
Executive Vice President and Chief Operations Officer

smlager@medicalodges.com

Agenda

- Objectives
- Why You Need to Know
- Definitions
- Payer Types
  - Private
  - Medicaid
  - Medicare A, B, C & D
  - Medicare Supplemental
  - Hospice
  - VA
  - ACOs
- Questions
- Resources

Objectives

- At the end of this presentation participants will
  - Be able to identify the various resident payer types
  - Be able to identify clinical considerations for each payer type
  - Be able to identify the financial considerations of different payer types

Why You Need to Know

- When you became DON your responsibilities are not just for clinical performance, but for overall performance of your department
- The decisions you and the clinical staff you supervise make have a significant impact on the operational performance of the facility
- The decisions you and the clinical staff you supervise may have a significant financial impact on the resident and their family

Why You Need to Know

- When you became a nurse, how much did you learn about the different ways a provider is paid for their services?
- Was anyone told in your nursing program, you did not need to know how a patient was paying for services? That this may bias your decisions in caring for the patient?
- Anyone with hospital experience as a nurse? Did you ever look at what the patients pay source was?

Why You Need to Know

- The clinical decisions made by you and the staff you supervise have a financial impact
- You must have the basic knowledge of how your facility is paid for the services provided, and
- Have an awareness of the potential impact of the decisions made
  - Admissions accepted
  - Treatment & services offered/provided
  - Equipment ordered
  - Medications
- And, have an awareness of why a resident or family make the decisions they make regarding treatment and services offered

Definitions

- **PREMIUM** is the amount paid to the insurance company to have insurance
- **COPAY** is a set rate you pay for prescriptions, doctor visits, and other types of care
- **COINSURANCE** is the percentage of costs you pay after you've met your deductible
- **DEDUCTIBLE** is the set amount you pay for medical services and prescriptions before your insurance company pays anything and before coinsurance kicks in fully

Payer Type—Private

- Private Pay
  - Resident pays 100% of the daily rate and any ancillary charges
  - Different rates may be charged for different room types/units
    - Private or semi-private room
    - Dementia or memory care unit
- Kansas private rates are published twice annually when Medicaid rates are published
  - Highest daily rate $877.00
  - Lowest daily rate $188.00
  - Median daily rate $308

Payer Type—Private

- Clinical Considerations
  - Does your facility charge for ancillary services and what is the process to capture charges?
    - Different levels of care
    - Transportation
    - Hair care
    - OTCs from stock medications
    - Oxygen, nebulizer, treatment, wound, blood glucose checks and other supplies/equipment
  - Does the resident have sufficient financial resources
  - Clinical decisions have an impact on the resident's finances
    - Copays, coinsurance, deductibles
    - Equipment rentals, medications, lab, x-ray, hospitalizations, therapies, ambulance transport
  - Do they have Medicare Part B, Part D, Medicare Advantage

Questions

©DESIGNALIKIE

Payer Type—Medicaid

- Medicaid
  - General health care, hospitalization, medication, long term care coverage
  - Can have both Medicaid and Medicare
  - Some residents may only have Medicaid
    - Never signed up or not eligible for Medicare part A, B, D
  - Eligibility requirements—disabled or 65 and older who meet specific income and asset limitations
  - Kansas has a managed Medicaid program (KanCare) administered by private health insurance companies (MCOs)
    - Sunflower
    - Blue Cross Blue Shield Healthy Blue
    - United Health Care

Payer Type—Medicaid

- KS rates are adjusted and published in January and July
  - Highest daily rate $492.68
  - Lowest daily rate $147.56
  - Median daily rate $316.41
- Rates are based on facility costs, resident acuity (CMI) and incentive factors
  - Medicaid rate incentive factor earned can be $0 up to $7.50
  - An additional $3.00 can be earned through the PEAK 2.0 incentive

Payer Type—Medicaid

- Facility costs
  - Cost reports are submitted annually and include
    - Operating costs
    - Indirect health care costs
    - Direct health care costs
- Resident Acuity (CMI)
  - Resident acuity (CMI) is reported quarterly
  - Acuity (CMI) based on PDPM as of July 2024
- Incentive Factors
  - Case mix adjusted nurse staff ratio up to $3.00
  - Staff retention up to $2.50
  - Occupancy at or above 65%--$0.75
  - Quality Measures at or above 75th percentile--$1.25
  - PEAK up to $3.00
  - Survey adjustment *reduction* 100% "H" or higher, 50% "G" corrected within 30 days

Payer Type—Medicaid

- Clinical Considerations
  - Resident MDS data is used to determine the acuity used in setting your facility's Medicaid rate
    - Is documentation complete? Accurate?
    - MDS Section O Special Treatments, Procedures & Programs, While a Resident?
  - Facility expense for some services can be captured for cost reporting purposes
    - Transportation
    - Therapy

Payer Type—Medicaid

- Clinical Considerations
  - Does the resident also have Medicare part A? part B?
    - If the resident does not have Medicare Part B, the facility may pay the costs of any therapy provided
      - Kansas Medicaid does not cover therapy services
  - The facility is responsible for covering the expense of equipment, basic supplies, OTC medications
    - Does your facility have an OTC formulary?
  - Specialists/providers accept Medicaid?

Questions

©DESIGNALIKIE

Payer Type—Medicare

- The majority of enrollees are 65 years and older, some are younger than 65 with disabilities
- Most have paid for Medicare through payroll taxes during working years or they receive coverage based on the payroll taxes paid by a spouse
- Medicare includes Part A, Part B, Part C and Part D
- Does not cover elective procedures—cosmetic surgery
- Most individuals will have a deductible and some out of pocket expenses even when services are medically necessary
- Most individuals will not pay a monthly premium for Part A

Payer Type—Medicare A

- In general, Medicare Part A covers
  - Inpatient hospital care
  - Acute inpatient rehabilitation care
  - Inpatient skilled nursing facility care
  - Hospice benefit
  - Home health
- Medicare Part A does not cover long term custodial care or assisted living care

Payer Type—Medicare A

- Medicare Part A Skilled Nursing Benefit
  - Must have had a qualifying hospital stay
    - 3 midnights in the hospital or,
      - Admitted, not observation days
    - Within 30 days from hospital discharge
    - Care received at the SNF must be related to the care received in the hospital
    - There must be a skilled need or service being provided
  - Most services provided to the resident during the SNF stay are covered under consolidated billing in a per diem (daily) rate paid to the facility (PT, OT, SLP, medications, equipment, supplies, lab, x-ray)

Payer Type—Medicare A

- Medicare rates paid to the facility are based on case mix classification called the Patient Driven Payment Model or PDPM
- PDPM includes 5 case-mix adjusted components
  - PT
  - OT
  - SLP
  - NTA (non-therapy ancillary)
  - Nursing

Payer Type—Medicare A

- The PT, OT and Nursing components include a function score based on MDS section GG
- PT and OT component includes clinical category classifications based on diagnosis codes falling into 4 categories
  - Major joint replacement or spinal surgery
  - Other orthopedic
  - Medical management
  - Non-orthopedic surgery and acute neurologic
- SLP component is based on the presence or absence of
  - Acute neurologic condition
  - SLP related comorbidities
  - Swallowing disorder or mechanically altered diet

Payer Type—Medicare A

- Nursing categories
  - Extensive services
  - Special Care high/low
  - Clinically complex
  - Behavior Symptoms/Cognition
  - Reduced physical function
- Presence of depression is a factor for Special care high/low and Clinically complex categories
- Presence of 2 or more restorative nursing programs is a factor in Behavior Symptoms/Cognition and Reduced physical function categories

Payer Type—Medicare A

- Non-Therapy Ancillary (NTA)
  - A variety of conditions or treatments that are thought to have increased expense in providing care and services
  - Each item has a point level ranging from 8 to 1, higher points is indicative of higher resident acuity/expense and is factored into the Medicare rate
- PT, OT, SLP, Nursing, NTA and Non-case mix base rate are totaled to establish the per diem Medicare Part A rate

Payer Type—Medicare A

- The per diem rate is variable and adjusted over the course of the SNF stay
  - PT & OT is adjusted down every 7 days starting on day 21
  - The NTA component has an adjustment factor of 3 for days 1-3

Payer Type—Medicare A

- Clinical Considerations
  - Cost of providing care vs per diem reimbursement
    - Does the patient have costly medication, equipment, lab or other items that would be included under consolidated billing
  - Documentation
    - Section GG is coded based on usual performance, is your documentation accurate?
    - Who is completing the documentation for Section GG, do you have a process?
  - Do you have a good/consistent restorative nursing program?
  - Are your interviews for depression being conducted correctly and accurately?

Payer Type—Medicare A

- Clinical Considerations
  - Obtain as much information from the hospital stay as possible
    - Some items can be coded on the MDS if they occurred in the hospital prior to admission to the SNF and the reference date is set to capture
    - Active diagnoses in the last 7 days
    - Nutritional approaches (parenteral IVs, feeding tube/PEG tube mechanically altered or therapeutic diets)
    - Medications (injections, not limited to insulin)
    - Special treatments/procedures in last 14 days (chemo, radiation, vent, trach care, oxygen, isolation)

Payer Type—Medicare A

- What is the expected length of stay?
  - Does the resident have resources to cover the coinsurance or have a supplemental coverage plan?
    - Medicare Part A does pay 100% for the first 20 days, then 80% for the remaining 80 days
  - Does the resident and family understand the SNF benefit is not an automatic 100 days, there must be participation and continued progress?
  - What is the plan for discharge? If they are unable to return to the community, do they have resources to cover long term care?

Questions

©DESIGNALIKIE

Payer Type—Medicare B

- In general Medicare Part B covers most non-institutional medical expenses
  - Physician and other health care providers' services
  - Durable medical equipment
  - Outpatient care (Home health, PT,OT, SLP)
  - Some preventive services (immunizations, screenings, mammograms)

Payer Type—Medicare B

- Most individuals do enroll in Medicare Part B when they enroll in Part A, but some do not
  - Medicare Part B does have a monthly premium (based on income) and an annual deductible
  - If not enrolled when eligible there is a monthly late enrollment penalty which goes up the longer they wait to enroll
- Medicare Part B generally covers 80% of the cost of covered services, the individual is responsible for the remaining 20% (coinsurance)
  - Medicare supplemental plans may cover a portion of the coinsurance

Payer Type—Medicare B

- Clinical Considerations
  - Not all residents will have Part B so you must be conscientious of procedures and services
    - Private pay resident, will be out of pocket expense
    - Medicaid only resident, may be an expense for the facility
  - Even with Part B there is a coinsurance expense for the resident for some services (therapy)
    - Does the resident have a Medicare supplemental plan?
  - Part B does not cover certain services or items for individuals in a nursing facility—DME, insulin syringes

Questions

©DESIGNALIKIE

Payer Type—Medicare C

- Medicare Advantage, also referred to as Medicare Part C, Medicare + Choice
- Bundles Parts A, B and generally D coverage into one plan
- To enroll, must have both Part A & Part B
- Individuals enrolled in a Medicare Advantage plan cannot purchase a supplemental plan
- Plans are offered by private insurance companies under very specific rules established by Medicare
- Premiums, deductibles, copays and coinsurance vary by plan
- Plans differ greatly based on location but are required to cover all the same benefits as Medicare A & B, most offer additional benefits such as vision, dental and hearing

Payer Type—Medicare C

- Some Medicare Advantage plans tailor benefit packages for special groups or to treat specific conditions—called special needs plans
  - Institutional special needs plan (I-SNP): designed for individuals who have or are expected to need the level of services provided in long term care
    - Some extra benefits for the institution such as reimbursement for 1:1 care, transportation, case management and NP/PA visits
  - Dual Eligible special needs plan (D-SNP): designed for individuals who are entitled to both Medicare and Medicaid
    - Extra benefits may include coverage of transportation for health care visits or pharmacy trips, monthly credit for OTCs, healthy food, utilities
  - Chronic Condition special needs plan (C-SNP): designed for people who need extra support/management due to an eligible chronic or disabling condition (CHF, Diabetes, COPD)

Payer Type—Medicare C

- Clinical Considerations
  - Residents are generally required to use health care providers in the Advantage plan's network—is your facility considered "in-network"?
  - Admission to a SNF often requires prior authorization even when in network
    - If prior authorization is not obtained, your facility will likely not be paid for the services you provide
  - Visits to specialists often require prior authorization, usually obtained or initiated by the facility
  - Some special needs plans do not require a qualifying hospital stay in order to use the skilled benefit

Payer Type—Medicare C

- Clinical Considerations
  - What is your facility contract with the Medicare Advantage plan?
    - PDPM based payment? MDS assessments are completed, but not submitted to CMS
    - Level of care based payment? What is covered at each level of care?
    - Are there carve outs for high cost medications?
  - Often required to communicate routinely with a plan case manager who determines continuing coverage and level of care
  - Length of stay on skilled services under an Advantage plan is often much shorter than with traditional Medicare
    - Is the resident and family prepared for discharge or for continued stay in the facility?

Payer Type—Medicare C

- Clinical Considerations
  - Medicare Advantage special needs plans may have a shared savings plan—if the facility meets specific clinical quality benchmarks, they are eligible to receive additional dollars from the plan
    - Preventative services-immunizations
    - Hospital admissions
    - 5 Star ratings
    - Quality Measures
    - Adherence to standard medical management protocols (statins in patients with CV or diabetes, beta blocker following MI, osteoporosis treatment following FX)
  - Some Medicare Advantage special needs plans pay a capitated rate—a fixed dollar amount paid in advance to be used by the facility to deliver services
    - The facility manages how & when those dollars are utilized in providing care

Questions

©DESIGNALIKIE

Payer—Medicare Part D

- Part D is the Medicare prescription drug plan
  - Individuals enroll at same time as Medicare A & B
  - If not enrolled when eligible there is a late enrollment penalty
  - Premiums and deductibles vary by plan and are based on income
  - Plans are administered by private insurance companies
    - Aetna, Humana, Wellcare, United Healthcare, Cigna

Payer—Medicare Part D

- Clinical Considerations
  - Medicaid residents are automatically enrolled in a Part D plan
  - Facility personnel may need to assist in determining the best plan for the resident based on their prescribed medications
  - Covered medications vary by plan and some medications may require prior authorizations
    - Potential delays in receiving ordered medications
    - What is your facility process to follow up on prior authorizations?
  - Residents or responsible parties may change the Part D plan during open enrollment
    - Are they letting you know of changes?
    - Would a different plan cover the resident medications better?
  - The facility may be responsible for the expense of Medicare Part D non-covered medications

Questions

©DESIGNALIKIE

Payer Type—Medicare Supplemental

- Medicare Supplemental Plans
  - Also called Medigap plans, extra insurance purchased from private insurance companies that helps pay the portion of costs (deductibles, copays, coinsurance) for services covered by Part A & B
  - Individuals must also be enrolled in both Medicare Parts A & B
  - There is a one-time enrollment where they cannot be denied due to pre-existing health problems
  - If they do not enroll they may not be able to purchase a supplemental plan or may pay more for a plan
  - Premiums are based on the plan purchased

Payer Type—Medicare Supplemental

- For those who have original Medicare and a Medicare supplemental plan, Medicare pays its share for a covered cost, and then the supplemental plan pays its portion
- All supplement plans are standardized and are required to provide the same basic coverage
- Plans are required to cover Medicare Part A's coinsurance and hospital costs at 100%.
- Most plans, but not all cover Part B's coinsurance or copayment at 100%
- Supplemental plans are not available to those enrolled in Medicare Advantage plans
- Medicaid residents may have a supplemental plan

Payer Type—Medicare Supplemental

- Clinical Considerations
  - Residents and responsible parties are generally more agreeable to offered services knowing in advance they will have limited out-of-pocket expense
  - The facility can bill the supplemental plan for deductibles, coinsurance the resident would have been obligated to pay if there were no supplemental plan

Questions

©DESIGNALIKIE

Payer Type—Hospice

- Hospice
  - Hospice is a Medicare Part A benefit
  - Resident must have a terminal diagnosis or expected to live less than 6 months as documented by a physician, recertified every 6 months
  - Private Pay hospice—the resident continues to pay the facility daily rate, the hospice agency is paid by Medicare
  - Medicaid hospice—the hospice agency pays the facility daily rate, the agency is paid by Medicare and Medicaid
  - Hospice Respite—short term admission, hospice agency pays the facility
  - There must be a contract between the facility and the hospice, or an individual contract specific to the resident

Payer Type—Hospice

- Clinical Considerations
  - Hospice contracts frequently pay less than the facility Medicaid rate but this can (and should) be negotiated
  - All care and services provided by the hospice are **in addition** to what the nursing facility provides
    - Bathing is not just the responsibility of the hospice aide-surveyors really like asking staff about who bathes the resident
  - Care is to be coordinated between the facility and hospice
    - Hospice nurse invited to and attending Care Plan meetings
  - Hospice care plan must address what hospice is providing:
    - Equipment & supplies, do they meet your facility standards?
    - Medications, antipsychotics often prescribed by hospice at end of life, still impact your antipsychotic quality measure, are they really necessary?
    - The facility must have a copy of Hospice's care plan

Payer Type—Hospice

- Clinical Considerations
  - Hospice RN, CNA visits
    - If you have a significant number of residents with the same agency, their staff may be helpful for staffing and providing care for their hospice residents (treatments, bathing, feeding)
  - Hospice 1:1
    - Hospice staff can and should provide 1:1, especially when a resident is actively dying, they have performance measures regarding all deaths being attended by hospice staff
    - Hospice volunteers can provide 1:1 for increased supervision/behavioral issues
  - Hospice respite
    - Requires all the same admission documentation, MDS entry and discharge, initial care plans as a full admission

Questions

©DESIGNALIKIE

Payer Type—VA

- Community Care Network (CCN)
  - Contract vehicle for VA to purchase community care for Veterans
  - 5 regional networks administered by either Optum or TriWest
  - Facility must be credentialed and in-network
    - Covers short term rehab care only
    - Pays the same as traditional Medicare (PDPM)

Payer Type—VA

- Veterans Care Agreement (VCA)
  - Preferred method of contracting, especially for long term care
  - Facility must be credentialed
  - Covers both long and short term care
  - Pays based on PDPM
    - Days 1-100 PT, OT & SLP case mix adjustment factor of 0.93
    - Days 101+ PT, OT SLP adjustment factor of 0, nursing and NTA adjustment factor of 1.25
    - Prior authorization is required for PT, OT, SLP on days 101+

Payer Type—VA

- Clinical Considerations
  - The VA must refer the veteran for services under each type of contract/arrangement
    - The facility should have the VA referral/authorization in hand prior to accepting or admitting the resident
  - Care is coordinated with a VA representative
  - The facility must maintain an overall CMS star rating of 3 to obtain/maintain the contract

Payer Type—VA

- Clinical Considerations
  - The facility is required to submit claims on behalf of the physician
    - Which means the facility pays the physician for seeing the VA resident
  - The VA conducts their own surveys and may issue citations and request a plan of correction. The VA must be notified of state survey results.

Questions

©DESIGNALIKIE

ACOs

- Accountable Care Organizations (ACO)
  - An ACO is a groups of doctors, hospitals and other healthcare providers who come together to provide high quality care to Medicare patients and to lower the cost of care
    - Sharing of information about the patient to coordinate and prevent duplication of services
    - Patient involvement in decision making and treatment plans
  - Cost savings are distributed back to the ACO providers
  - ACOs are not health plans and only those with traditional Medicare can be aligned/assigned to an ACO

ACOs

- Clinical Considerations
  - The facility may be asked to provide information about a resident who is aligned/assigned to an ACO
  - Some providers participating in an ACO may be approved to send a patient for skilled nursing care without a qualifying hospital stay
  - Residents can opt out of information sharing with other providers in the ACO
  - Resident choice in providers is not limited, they still have a right to visit any doctor, hospital or provider that accepts Medicare

Questions

©DESIGNALIKIE

Resources

- Caring.com
- https://www.caring.com/medicare/#medicare-basics:-parts-and-coverage
- Medicare.gov
- https://www.medicare.gov/basics/costs/medicare-costs
- https://www.medicare.gov/health-drug-plans/health-plans/your-health-plan-options
- https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP
- VA.gov
- https://www.va.gov/GERIATRICS/pages/Community_Nursing_Homes.asp
- https://www.va.gov/COMMUNITYCARE/programs/veterans/CCN-Veterans.asp#:~:text=The%20VA%20Community%20Care%20Network,network%20to%20its%20full%20potential.
- https://www.va.gov/COMMUNITYCARE/providers/Veterans_Care_Agreements.asp
- CMS.gov
- https://www.cms.gov/priorities/innovation/innovation-models/aco