The Daily Provider

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Medicare SNF Rate Cut: $56/day! Disadvantaged Communities Hit Hardest

CMS announced significant reductions in Medicare SNF daily rates, but not all providers will feel the pain. Wealthy areas are spared, while underserved, disadvantaged communities bear the brunt of the payment reductions. MedPAC supports this action.

When asked for justification about unfairly penalizing Skilled Nursing Facilities in struggling areas that need help the most, one official is on record saying, "It's not Medicare's job to subsidize providers based on demographics in their neighborhood." *Ouch…*

The Daily Provider is satire, of course. No, CMS is not targeting disadvantaged communities with a fiendish rate cut, but strange things happen when federal policy is filtered through state regulations and local market dynamics; there is a hint of quantifiable truth to this headline. The banner was inspired by MedPAC's March 2022 Report to Congress. The Commission tacitly acknowledged that robust Medicare margins are essential for Skilled Nursing Facility ("SNF") survival, but at the same time recommended CMS reduce payments because "*cross-subsidization is poor policy*."

As you read on, remember this is only one of many incongruities plaguing the fragmented and dysfunctional SNF reimbursement model.

THE INEQUITY OF MEDICARE COPAYMENT is a structural deficiency in the SNF revenue-cycle unrelated to the Patient Driven Payment Model, which establishes patient-specific per diem rates across a Medicare Part A Benefit Period (up to 100 days). Medicare pays providers 100% of the PDPM rate for days 1 – 20, then applies a $200/day coinsurance reduction to the remaining (up to) 80 days. Beneficiaries without a supplemental Medigap policy must pay coinsurance out-of-pocket, which providers are required to pursue.

"Dual-eligible" beneficiaries are enrolled in both Medicare and Medicaid. Medicare Part A is the "primary" payer for qualifying SNF short-term care; Medicaid, as "secondary" insurer, is charged the $200/day coinsurance (Medicaid assumes primary-payer status after the Medicare benefit is exhausted). Federal Medicare policy is consistent across the nation; Medicaid is administered at the state level, with payment rules so variable they perversely distort the Medicare benefit Medicaid is designed to support.

As a matter of policy, states must "cover" Medicare associated expenses for dual-eligible beneficiaries ("cost sharing"), but "*cover*" is not synonymous with "*pay*." Many states maintain a "*Lesser of*" policy wherein Medicaid makes a provider whole, but only up to the respective SNF's Medicaid rate. The chasm between Medicare and Medicaid reimbursement is so pronounced, states often pay no coinsurance at all. For example, assume a dual-eligible beneficiary is covered by Medicare Part A for a full 100-day Benefit Period:

Dual-Eligible Analysis *(simplified for discussion)*

Average Medicare Rate (PDPM)	$630
Coinsurance (days 21 – 100):	-$200
Medicare Rate (net)	**$430**

Medicare pays the $630 PDPM rate through day 20, then applies coinsurance and payment drops to $430 effective on the 21st day. In *"Lesser of"* systems, Medicaid pays nothing unless the facility's Medicaid rate is at least $430/day. If the Medicaid rate is $500, Medicaid pays $70 coinsurance; at $800/day, Medicaid would pay the full $200. This facility is hypothetical, but Medicaid rates that high are not even theoretical. In other words, Medicaid effectively denies the copayment.

The provider isn't totally out of luck; unpaid Medicaid coinsurance is reported as "Allowable Bad Debt" on the annual Medicare Cost Report. Medicare eventually pays 65% of Allowable Bad Debt through its "Reimbursable Bad Debt" allowance, but the process is taxing, and audits are routine. When finally settled a year or more later, the Medicare rate across the entire 100-day Benefit Period has effectively been slashed by $56/day.

Coinsurance / day:	$200	Allowable Bad Debt:	$16,000
Coinsurance days:	80	Reimbursable (65%):	$10,400
Total Coinsurance:	$16,000	Bad Debt Write-off	$5,600
Medicaid Copayment:	**$0**	**Average (100 days)**	**$56**

Relative Distortion

CMS adjusts PDPM rates for local economic variables such as labor and general expenses; "Local" is defined by Core-Based Statistical Area wage indexing. CBSAs often include multiple counties across state lines, but beneficiaries generally gravitate to facilities in their "home state." As a result, a SNF in one state may receive full coinsurance for dual-eligible patients while a peer group facility realizes up to $56/day less for identical care "priced" at the same PDPM rate.

Things get surreal at the macro level as coinsurance is $200/day everywhere; this harms providers and patients in low wage-index markets, as illustrated by two CBSAs at opposite ends of the "Area-Wage Index" spectrum:

County	AWI	Rate*	Copay	%	Dual Loss	Rate %
Santa Clara, CA	1.9356	$1,093	$200.00	18.3%	$70.00	6.4%
Knox, TN	0.7211	$527	$200.00	38.0%	$70.00	13.3%

** average PDPM rate*

CMS accounts for cost-of-living differences through wage-indexing. As a percentage of Medicare's "cost of care," patients in Knox County are responsible for 38% of the bill (if paying out-of-pocket), while Santa Clara admissions pay less than half that ratio. Perhaps Silicon Valley and Quinten Tarantino's hometown are too comparatively extreme. I write this paper from my home office in Essex County, NJ (AWI = 1.0931), where the average PDPM rate is $701/day. I'm ordering lunch from my favorite deli in Passaic County (AWI = 1.3310, average rate, $830). Delivery time is 24 minutes; do I tip more because the sandwich is coming from a higher CBSA? Incidentally and inexplicably, the average Medicaid rate is $3 ***higher*** in Essex County than Passaic; this is what I mean by the term, "*irrational reimbursement system*."

Dual-eligible beneficiaries pay nothing either way, but providers in lower-wage markets are further disadvantaged in *"Lesser of"* states. Knox rates are effectively reduced 13.3% for each dual-eligible coinsurance day. Comparatively, Santa Clara providers lose "only" 6.4%. Meanwhile, SNFs in "Full payment" states receive the entire PDPM rate for every Medicare covered day. Irrespective of geography, Skilled Nursing Facilities everywhere will be subject to the same cost burden of minimum staffing requirements, without deference to how states satisfy their financial obligations.

Dual-eligible beneficiaries in *"Lesser of"* states generate up to $56/day less revenue for providers than "Medicare-only" admissions. At scale, low-income, disadvantaged markets are home to outsized shares of dual-eligible beneficiaries, who "continue to be disproportionately… of minority race/ethnicity, compared to other Medicare beneficiaries." Lower reimbursement means less money for staffing, amenities, and services. Quality is outside the scope of this analysis, but a $56 rate cut inadvertently targeted to the most vulnerable beneficiary class is not a recipe for success, especially when not all states impose the "*Lesser of*" penalty.

Addressing the Disparity

MedPAC intimates that Medicare policy exists in a vacuum; it doesn't. Despite this myopia, there may be hope, with rumblings CMS will soon address Medicaid reimbursement shortfalls in a rational, consistent manner. With so many structural compression points to relieve, eliminating the inequitable *"Lesser of"* limitation is a good place to start.

Quick Thoughts…

- Short-term stays (20 days or fewer) are not impacted by *"Lesser of"* penalties. Anecdotally, shorter stays are associated with higher admission volume. SNFs most at risk admit (or readmit) patients who remain long-term. This makes for interesting ISNP analysis.

- MedPAC is fond of spotlighting SNF "Medicare Margins." I've attempted to reengineer the Commission's logic but cannot ascertain how MedPAC accounts for unpaid dual-eligible coinsurance, among other specific concerns. More broadly, the Medicare Cost Report doesn't work that way. There are no "Distinct Parts" for direct costing; no consistency of expense allocation. How can MedPAC put forth such a discrete calculation without considering occupancy efficiencies? The Medicare Margin is a clumsy soundbite that should be retired. MedPAC and CMS must rationalize Skilled Nursing's entire data profile immediately.

- States have aggressively transitioned Medicaid recipients into mandatory Managed Care. While Medicare beneficiaries cannot be compelled to forgo Fee-for-Service coverage, fully-integrated plans explain why Medicare Advantage now represents the plurality of beneficiaries in many markets. In other words, counties with the most dual-eligible beneficiaries tend to have the highest share of Medicare Advantage. Notwithstanding the promise of improved outcomes through coordinated benefits, a byproduct of Dual-Advantage is driving another SNF reimbursement imbalance…

But those are stories for another time.

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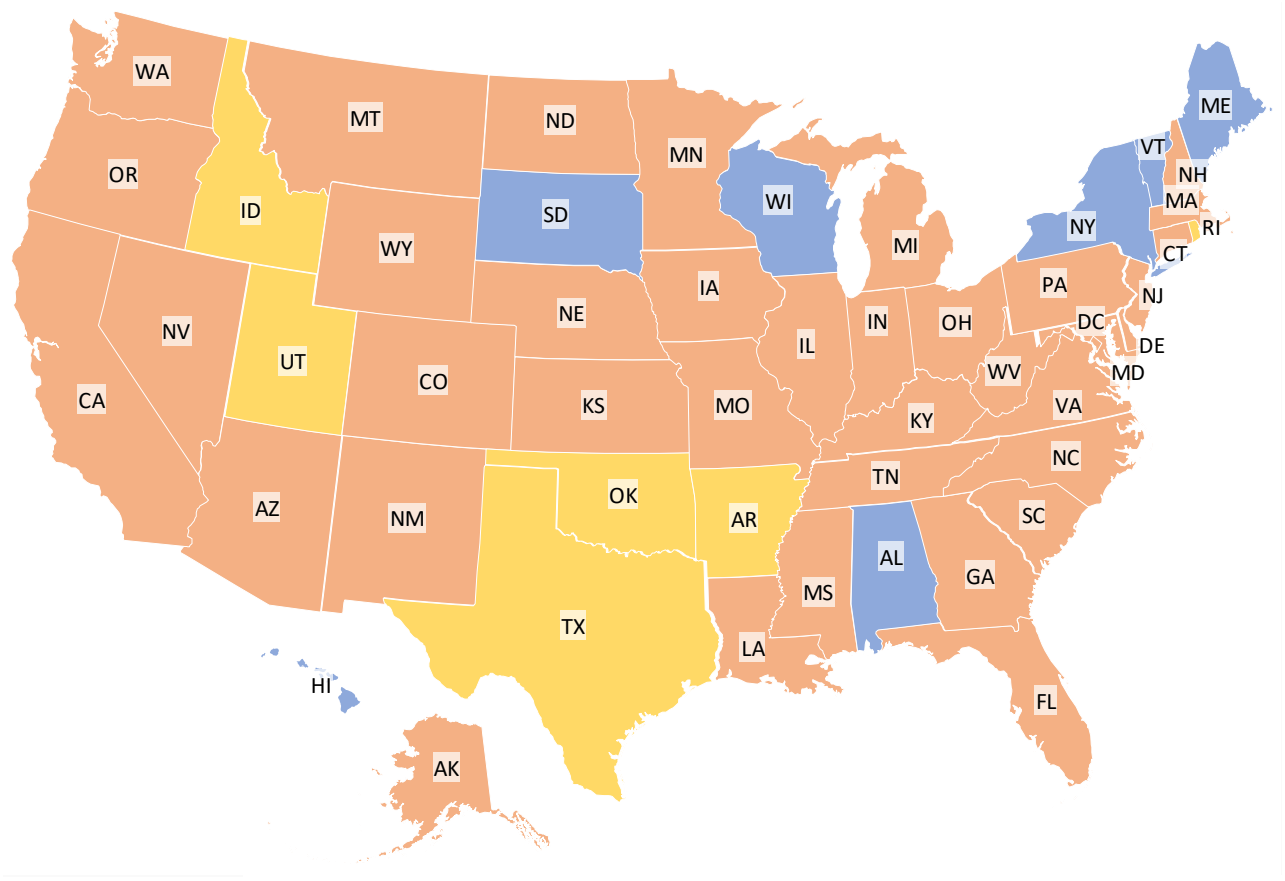
Medicaid Cost-Sharing SNF Payment Policy by State

visit eCapIntel.com for state-specific information and underwriting considerations



"Lesser of"	Other	Yes ("Full")
usually $0	*Partial; situational; recently changed*	*100%*

eCapIntel updated MACPAC's 2018 cost-sharing compilation through independent research, as of October 1, 2022. Information is reliable but not suitable for underwriting. eCapIntel is not responsible for third-party use of this resource.

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Numbers are not data. Context matters.

State Medicaid Payment Policy Summary:

SNF Medicare Cost Sharing

eCapIntel updated MACPAC's 2018 cost-sharing compilation through independent research, as of October 1, 2022.

Information is reliable but not suitable for underwriting. eCapIntel is not responsible for third-party use of this resource.

State	Source	Policy
Alabama	http://medicaid.alabama.gov/content/Gated/7.6.1G_Prov	Full payment
Alaska	http://manuals.medicaidalaska.com/hospital/hospital.ht	Lesser of
Arizona	https://www.azahcccs.gov/Shared/Downloads/ACOM/P	Lesser of
Arkansas	https://www.sos.arkansas.gov/uploads/rulesRegs/Arkans	Other (QMB/SLMB)
California	http://law.onecle.com/california/welfare/14109.5.html	Lesser of
Colorado	https://www.colorado.gov/pacific/hcpf/billing-manuals	Lesser of
Connecticut	https://www.cga.ct.gov/2016/rpt/pdf/2016-R-0240.pdf	Lesser of
Delaware	https://dhss.delaware.gov/dmma/files/dchip_section_08	Lesser of
D.C.	https://www.dc-medicaid.com/dcwebportal/providerSpe	Lesser of
Florida	http://flsenate.gov/Laws/Statutes/2018/409.908	Lesser of
Georgia	https://www.mmis.georgia.gov/portal/PubAccess.Provid	Lesser of
Hawaii	https://medquest.hawaii.gov/en/plans-providers/fee-for-	Full payment
Idaho	https://doi.idaho.gov/wp-content/uploads/ID/2051.pdf	Other (Full QMB)
Illinois	https://www2.illinois.gov/hfs/info/Brochures%20and%2	Lesser of
Indiana	https://www.in.gov/medicaid/providers/about-ihcp-prog	Lesser of
Iowa	https://dhs.iowa.gov/sites/default/files/1803-MC-FFS_M	Lesser of
Kansas	https://portal.kmap-state-ks.us/Documents/Provider/Pro	Lesser of
Kentucky	https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/nursing	Lesser of
Louisiana	http://www.doa.la.gov/Pages/osr/lac/books.aspx	Lesser of
Maine	http://www.maine.gov/sos/cec/rules/10/ch101.htm	Full payment
Maryland	http://www.dsd.state.md.us/COMAR/subtitle_chapters/	Lesser of
Massachusetts	http://www.mass.gov/courts/case-legal-res/law-lib/laws-	Lesser of
Michigan	https://www.mdch.state.mi.us/dch-medicaid/manuals/M	Lesser of
Minnesota	https://www.medicaid.gov/sites/default/files/State-resou	Lesser of
Mississippi	https://medicaid.ms.gov/wp-content/uploads/2020/07/Pr	Lesser of
Missouri	https://dss.mo.gov/mhd/providers/pdf/bulletin30-53_20	Lesser of

State	Source	Policy
Montana	https://rules.mt.gov/gateway/ruleno.asp?RN=37.83.802	Lesser of
Nebraska	https://www.medicaid.gov/sites/default/files/State-resou	Lesser of
Nevada	http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/	Lesser of
New Hampshire	https://nhmmis.nh.gov/portals/wps/portal/BillingManua	Lesser of
New Jersey	http://www.lexisnexis.com/hottopics/njcode/	Lesser of
New Mexico	https://www.hsd.state.nm.us/wp-content/uploads/FileLi	Lesser of
New York	https://www.hcrapools.org/medicaid_state_plan/DOH_P	Full payment
North Carolina	https://www.nctracks.nc.gov/content/public/providers/pa	Lesser of
North Dakota	https://www.nd.gov/dhs/services/medicalserv/medicaid/	Lesser of
Ohio	https://codes.ohio.gov/ohio-administrative-code/rule-51	Lesser of
Oklahoma	https://oklahoma.gov/ohca/policies-and-rules/xpolicy/m	Other (to Lesser of)
Oregon	https://www.oregon.gov/oha/HSD/OHP/Policies/141-35	Lesser of
Pennsylvania	http://www.pacode.com/secure/data/055/partIIItoc.html	Lesser of
Rhode Island	https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/	Other
South Carolina	https://www.scdhhs.gov/internet/pdf/manuals/Provider%	Lesser of
South Dakota	https://dss.sd.gov/medicaid/recipients/costsharing.aspx	Full payment
Tennessee	https://publications.tnsosfiles.com/rules/1200/1200-13/1	Lesser of
Texas	https://www.medicaid.gov/State-resource-center/Medica	Other (Full MCO)
Utah	https://medicaid.utah.gov/medicare-cost-sharing-progra	Other
Vermont	https://humanservices.vermont.gov/sites/ahsnew/files/do	Full payment
Virginia	https://vamedicaid.dmas.virginia.gov/vamed/download-	Lesser of
Washington	https://apps.leg.wa.gov/WAC/default.aspx?cite=182-502	Lesser of
West Virginia	http://www.dhhr.wv.gov/bms/Pages/Manuals.aspx	Lesser of
Wisconsin	https://docs.legis.wisconsin.gov/code/admin_code/dhs/1	Full payment
Wyoming	https://www.medicaid.gov/State-resource-center/Medica	Lesser of

Link to 2018 MACPAC compilation (outdated): eCapIntel.com

Definitions: QMB (Qualified Medicare Beneficiary); SLMB (Specified Low-income Medicare Beneficiary); QI (Qualifying Individual).

State policies listed as "Full payment", "Lesser of", or "Other". "Full payment" indicates Medicaid pays 100% of Medicare cost-sharing amount. "Lesser of" indicates Medicaid pays cost sharing only up to SNF's respective Medicaid rate. If net Medicare payment exceeds Medicaid rate, Medicaid pays nothing towards coinsurance. "Other" indicates differential policy that should be reviewed.

Link to MedPAC / MACPAC 2022 Dual-Eligible Data Book