November 9, 2022

Medicare Advantage ("MA") enrollment represents 50% of eligible beneficiaries, while another milestone commands far less attention. Despite MA's rapid growth, the absolute number of individuals within the Medicare Fee-for-Service ("FFS") population had also expanded; we now see FFS declining in a growing number of metropolitan areas. The trend cannot be distilled down to a single dollar value. As we explore the severity of structural deficiencies in the Skilled Nursing Facility ("SNF") revenue-cycle, remember that Medicare Advantage is simply one example of how provider-burden differs from market to market.

Traditional Medicare subsidizes inadequate Medicaid payment; in fact, FFS is the only payer keeping many providers afloat. Medicare Advantage reimbursement for short-term care exceeds Medicaid rates, but MA pays SNFs far less than FFS for the same patients the "private option" replaces (what we call the "FFS Attrition Ratio"). MedPAC argues SNFs' willingness to accept MA's discounted rates justifies reducing FFS payment. The problem with their logic is that lowering FFS rates would further destabilize the SNF economic model that CMS created, even as MA plans increasingly deny SNF covered benefits.

Zimmet Healthcare and eCapIntel analyzed Medicare Advantage reimbursement for SNF services, relative to FFS benchmarks. The data in the table below is sourced from CORE Analytics (now part of Simple, a Netsmart solution) from markets with at least 1,500 admissions during 7/1/21 – 6/30/22.

				Daily Rate Analysis			*Revenue Per Admission Analysis*			
CBSA	FY 2022 AWI	Z-RAF Score	County	PDPM PPD*	MA PPD	MA Discount	PDPM $/Admit^	MA ALOS	MA $/Admit	MA Discount
35614	1.3388	1.43	New York City	$779	$449	42.3%	$21,033	15.9	$7,143	66.0%
45300	0.8826	1.47	Tampa	$575	$362	37.1%	$15,525	16.3	$5,900	62.0%
37964	1.1073	1.63	Philadelphia	$675	$458	32.1%	$18,225	14.6	$6,692	63.3%
31084	1.3046	1.71	Los Angeles	$764	$529	30.8%	$20,628	17.4	$9,201	55.4%
41180	0.9583	1.82	St. Louis	$609	$422	30.7%	$16,443	14.7	$6,204	62.3%
36740	0.9003	1.70	Lake	$583	$404	30.6%	$15,741	17.7	$7,157	54.5%
35154	1.0578	1.41	Monmouth	$654	$461	29.6%	$17,658	15.1	$6,956	60.6%
19124	0.9699	1.38	Dallas	$615	$448	27.2%	$16,605	17.5	$7,840	52.8%
28140	0.9237	1.82	Kansas City	$594	$440	25.9%	$16,038	13.6	$5,990	62.7%
47894	1.0202	1.69	Arlington, DC	$637	$482	24.4%	$17,199	16.1	$7,756	54.9%
12060	0.9508	1.89	Atlanta	$606	$471	22.2%	$16,362	15.7	$7,401	54.8%
26420	0.9925	1.67	Houston	$625	$507	18.9%	$16,875	16.2	$8,212	51.3%
16984	1.0372	2.01	Cook	$645	$602	6.6%	$17,415	15.9	$9,567	45.1%

* Day-4 adjusted rate for respective Area Wage Index

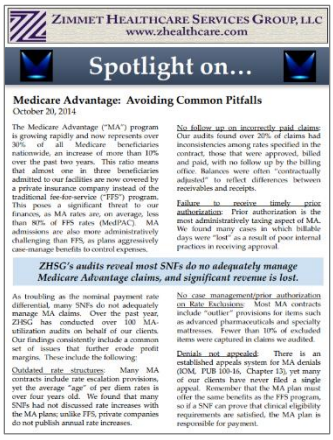
^ Uniform 27-day FFS ALOS used to mitigate local distortion

Key Takeaways:

- MA reimbursement is *significantly* below the FFS benchmark in all markets analyzed*.
- There is no correlation between MA reimbursement and SNF Five-Star rating or patient/population acuity (measured by eCapIntel's z.RAF scoring system).
- The *FFS Attrition Rate* (MA payment shortfall, relative to FFS) in each market is explained by two factors: (a) the number of SNF beds and (b) MA enrollment penetration. In other words, greater bed-supply and MA market share increase the plans' *leverage* to reduce SNF reimbursement.
- Within markets, SNFs that centralize or outsource case management functions realized 9% - 12% greater MA reimbursement than providers case-managing with facility-based staff (most of whom were not fully dedicated to Medicare Advantage case management).

Zimmet Healthcare first quantified the "*FFS-Attrition Ratio*" (how much less MA pays relative to FFS) in 2001. Around that time, MA enrollment growth had slowed and even reversed in many markets before the Medicare Modernization Act of 2003 changed the program's payment structure and trajectory.

Fast forward to 2014, ZHSG repeated the analysis and found most providers struggling with the Medicare Advantage revenue-cycle. The financial equation continued to deteriorate for SNFs; the OIG finally took notice this year and quantified the extent to which plans prevent beneficiaries from accessing care and burden Skilled Nursing Facilities with unfounded claim denials. Meanwhile, Medicare Advantage, per MedPAC, has never achieved a net savings for the Federal government.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Spotlight on…

Medicare Advantage: Avoiding Common Pitfalls
October 20, 2014

The Medicare Advantage ("MA") program is growing rapidly and now represents over 30% of all Medicare beneficiaries nationwide, an increase of more than 10% over the past two years. This ratio means that almost one in three beneficiaries admitted to our facilities are now covered by a private insurance company instead of the traditional fee-for-service ("FFS") program. This poses a significant threat to our finances, as MA rates are, on average, less than 80% of FFS rates (MedPAC). MA admissions are also more administratively challenging than FFS, as plans aggressively case-manage benefits to control expenses.

No follow up on incorrectly paid claims: Our audits found over 20% of claims had inconsistencies among rates specified in the contract, those that were approved, billed and paid, with no follow up by the billing office. Balances were often "contractually adjusted" to reflect differences between receivables and receipts.

Failure to receive timely prior authorization: Prior authorization is the most administratively taxing aspect of MA. We found many cases in which billable days were "lost" as a result of poor internal practices in receiving approval.

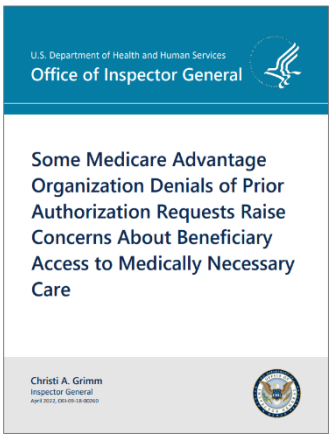
ZHSG's audits reveal most SNFs do no adequately manage Medicare Advantage claims, and significant revenue is lost.

As troubling as the nominal payment rate differential, many SNFs do not adequately manage MA claims. Over the past year, ZHSG has conducted over 100 MA-utilization audits on behalf of our clients. Our findings consistently include a common set of issues that further erode profit margins. These include the following:

Outdated rate structures: Many MA contracts include rate escalation provisions, yet the average "age" of per diem rates is over four years old. We found that many SNFs had not discussed rate increases with the MA plans; unlike FFS, private companies do not publish annual rate increases.

No case management/prior authorization ors Rate Exclusions: Most MA contracts include "outlier" provisions for items such as advanced pharmaceuticals and specialty mattresses. Fewer than 10% of excluded items were captured in claims we audited.

Denials not appealed: There is an established appeals system for MA denials (IOM, PUB 100-16, Chapter 13), yet many of our clients have never filed a single appeal. Remember that the MA plan must offer the same benefits as the FFS program, so if a SNF can prove that clinical eligibility requirements are satisfied, the MA plan is responsible for payment.


U.S. Department of Health and Human Services
Office of Inspector General

Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care

Christi A. Grimm
Inspector General

** Absent formal statistical analysis, we believe findings serve as a reasonable proxy for benchmarking.*

CMS Indifference

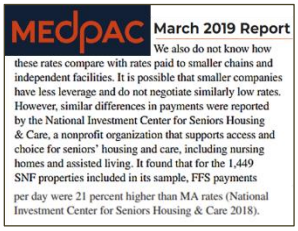
Inexplicably, CMS does not collect MA-SNF utilization data, despite Medicare Advantage enrollment now exceeding the number of FFS beneficiaries nationally. This is outrageous. The data can easily be collected using the annual Medicare Cost Report, but CMS has neglected the CMS 2540-10 (Cost Reports have atrophied to little more than a mechanism to report reimbursable bad debt). Case in point, detailed below is SNF payer mix, as reported in the Cost Report's Worksheet S:

SNF Medicare 2540-10 Cost Report Worksheet S-3 Part I		Number of Beds	Bed Days Available	Inpatient Days / Visits				
				Title V	Title XVIII	Title XIX	Other	Total
Component		1	2	3	4	5	6	7
1	Skilled Nursing Facility	120	43,800		2,245	8,351	25,518	36,114

The Cost Report recognizes only four payer classifications. "Title XVIII" is Medicare, "Title XIX" is Medicaid, "Other" includes Private Pay, Medicare Advantage, VA, and, well, "Other." The fourth option is "Title V" which, per the Social Security Administration, covers "Maternal and child health." In 30 years of cost reporting, I've never seen a single day reported under this benefit. "Title V" is a vestige from a bygone era; it's time to replace this field with "Medicare Advantage" utilization data.

Why it Matters

MedPAC cites provider willingness to accept lower Medicare Advantage rates as "evidence" FFS payments should be reduced, yet the Commission admits it has no data on which to support this argument. Instead, MedPAC references NIC's quarterly "benchmark" report, which, as I've repeatedly warned, is absurd and dangerous. This defies logic.


MEDPAC March 2019 Report

We also do not know how these rates compare with rates paid to smaller chains and independent facilities. It is possible that smaller companies have less leverage and do not negotiate similarly low rates. However, similar differences in payments were reported by the National Investment Center for Seniors Housing & Care, a nonprofit organization that supports access and choice for seniors' housing and care, including nursing homes and assisted living. It found that for the 1,449 SNF properties included in its sample, FFS payments per day were 21 percent higher than MA rates (National Investment Center for Seniors Housing & Care 2018).

Medicare Advantage plans reimburse Skilled Nursing Facilities less than half the amount paid by Fee-for-Service, with utilization and rate reductions highly variable across markets. CMS must consider provider protections and local area adjustments based on reliable data before subjecting providers to irrational reimbursement policy. MedPAC must recognize CMS' role in fostering a dysfunctional SNF economic model and recommend Congress pass meaningful legislation to correct these imbalances.

Marc Zimmet