ZIMMET HEALTHCARE SERVICES GROUP, LLC
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Spotlight on…

Medicare Advantage: Avoiding Common Pitfalls

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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.

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Outdated rate structures: Many MA contracts include rate escalation provisions, yet the average "age" of per diem rates is over four years old. We found that many SNFs had not discussed rate increases with the MA plans; unlike FFS, private companies do not publish annual rate increases.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

No case management/prior authorization on 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.

Medicare Advantage Pitfalls (continued)

Part B payments: Some MA residents remain in the facility after the short-term benefit expires. Because MA is a "full replacement product," the plans are responsible for everything Part B covers for a long-term resident. Too often, the SNFs received nothing for these services.

Failure to manage non-reimbursable co-pay/bad debt: Unlike FFS, MA bad debt may not be claimed on the Medicare cost report, and every dollar not collected by the SNF is a dollar lost. Unfortunately, we identified considerable "lost" revenue associated with MA co-insurance.

Given that Medicare Advantage penetration is expected to continue its growth unabated, it is imperative that skilled nursing facilities have robust internal systems to manage these complex cases and ensure they receive every dollar to which they are entitled.

If you are interested in having ZHSG conduct an assessment of your Medicare Advantage processes and performance, feel free to call our office anytime at (732) 970-0733 or send an email to info@zhealthcare.com.

Medicare Advantage plans pay less than 80% of fee-for-service rates, and that's only the beginning of the problem.

Inefficiencies in the provision of therapy: Most clients provide the same treatment protocols to MA residents as they do to FFS beneficiaries – specifically "one-on-one" therapy that was mandated by the 2011 SNF PPS final rule. Yet most MA contracts do not specify this requirement, meaning "concurrent" therapy could be a cost-effective alternative to the FFS requirement. Additionally, over a quarter of the cases we audited found treatment minutes in excess of the level authorized by the MA plan, often corresponding to the FFS thresholds (e.g. 500 minutes per week).