*The Rime of the New World Mariner*

# Medicare Advantage & SNF Reimbursement

*It is a New World Mariner,*
*And he stoppeth wounded knee,*
*With long grey beard and rehab needs,*
*Now wherefore stopp'st thou he?*

***Data, data everywhere,***
***Still all our rates did shrink,***
***Data, data everywhere,***
***Yet all of it doth stink.***

*Oh Fee-for-Service Medicare,*
*How little hath we seen,*
*Advantage Plans lurk everywhere,*
*Such reimbursement fiends.*

*We searched for data, ne'er seen,*
*And round and round we flew.*
*Our Rates did split with a thunder-fit;*
*'Til MAPAX steered us through!*

CORE analytics

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**S.T. Coleridge may not have composed** *Rime of the Ancient Mariner* as an ode to Medicare, yet the sentiment rings true in the financial toll from Medicare Advantage (MA). The "Silver Tsunami" may indeed be the ironic metaphor that rescues skilled nursing, but only if we weather today's reimbursement storm.

We've all seen the numbers. The Medicare Modernization Act of 2003 revised the MA financial formula and enrollment never looked back. While penetration varies considerably across states and even counties, more than 40% of all beneficiaries nationally now surrender choice for a growing array of supplemental benefits. "Medicare Part C" was intended to control runaway healthcare costs, yet the program has never achieved a net savings for the Federal government (MedPAC). Specific to post-acute care, MA's rapid growth threatens to turn Skilled Nursing Facilities into Shipwrecked Nursing Facilities.

## DATA, DATA Everywhere

Researchers sail on oceans of information specific to the Medicare fee-for-service (FFS) program, while MA utilization metrics lay somewhere between Scylla and Charybdis in the great sea of healthcare analytics.

CMS releases a quarterly "Limited Data Set" file containing comprehensive Medicare claim submissions from providers across the healthcare continuum. Third-party vendors (including CORE Analytics) distill the LDS file into performance metrics – valuable tools that nevertheless fall short in two critical ways. The first is timeliness; healthcare evolves rapidly but we must wait up to a year for a complete record of utilization activity. Also, the LDS includes traditional Medicare patients only, a population that no longer represents the plurality of coverage in many markets.

There is no negotiating with the Medicare program. The federal government holds a monopsony in the FFS domain, an arrangement most SNFs embrace as Medicare revenue is essential for survival. MA is a different story.

In a competitive market, providers should *theoretically* be able to use superior quality and efficiency outcomes to their benefit. In *reality*, that does not seem to be the case. "Information asymmetry" has anchored this strategy in a port of darkness. Third-party applications market Medicare Advantage performance metrics, but these tools are as useful as a tattered sail. MA utilization data was simply unavailable… until now.

"… a definitive finding [on MA quality] is not possible with currently available data. … the data to compare MA with FFS are lacking… for measures that need to be risk adjusted, differences in coding between MA and FFS need to be taken into account." MedPAC

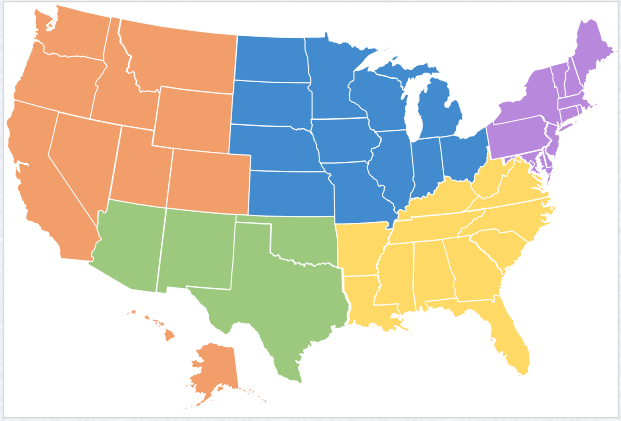

## MAPAX

The Medicare Advantage Post-Acute eXchange, launched by CORE Analytics in April 2021, delivers the industry's first claims-based intelligence on current SNF-MA revenue, outcomes & value-proposition.

CORE's database includes over 3,000 Skilled Nursing Facilities from 49 states that collectively submit over 30% of all SNF Medicare Part A claims nationally. To date, nearly 1,000 of these providers have also uploaded MA claims for SNF episodes completed between March 1, 2021 – August 31, 2021.

Benchmarking MA performance relative to the local peer group equips providers with market-based revenue & value metrics by payer and competitor. This previously nonexistent data levels the payer/provider information-imbalance, empowering quality operators to improve contract terms and manage opportunities for risk-based payment. MAPAX also enhances payer/provider alignment by supporting patient-specific risk-adjustment (HCC) capture & compliance using the same scoring system that CMS utilizes in its MA payment formula (an ongoing OIG concern for Plans).

Consistent with CORE's FFS platform, MAPAX delivers facility-specific LDS-style benchmarks using **current** claims (don't be misled by other applications that market their data as "most up to date," which refers to CMS' latest release of six- to nine-month-old FFS claims). The figures below represent average regional revenue and value data from MA claims for approximately 24,000 episodes during the six-months ended August 31, 2021.



| Region | SNF $PPD | ALOS | $ Per Admission | 30-Day Re-Hosp. | D/C to Comm. |
|---|---|---|---|---|---|
| NE | $444 | 18.1 | $8,036 | 16.9% | 46.1% |
| SE | $399 | 18.2 | $7,262 | 21.1% | 51.9% |
| MW | $496 | 15.9 | $7,886 | 19.1% | 43.8% |
| SW | $480 | 15.8 | $7,584 | 24.2% | 42.4% |
| W | $497 | 18.9 | $9,393 | 15.1% | 49.4% |
| FFS | $627 | 28.6 | $17,932 | 20.1% | 40.9% |

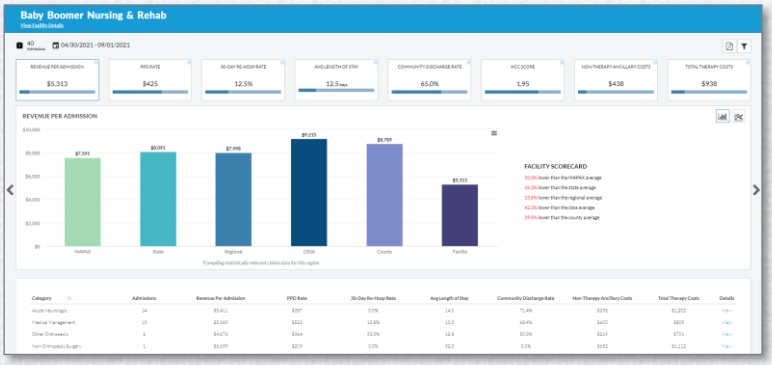
MA rates do not include charges for contract exclusions.

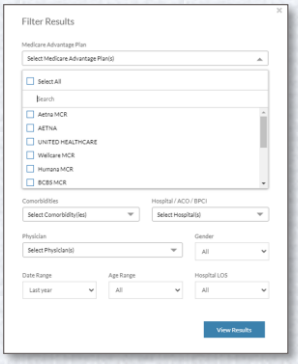
## Insights

Providers are painfully aware that MA revenue is significantly lower than the FFS equivalent. However, there is more to that story. The FFS data reported above represents the *neutralized* average rate for the entire CORE database during the same period. Facility-specific PDPM composite scores are priced using a wage index of 1.0 (urban) to allow for "apples-to-apples" comparisons across markets, but the MA figures reflect actual payments.

The variations become exceedingly useful at the county level, but broad scale analysis sets the tone. Note that the Northeast Region, which contributed 29.9% of MAPAX claims and is disproportionately populated by SNFs in downstate New York, New Jersey and the Philadelphia markets, trails only the Southeast's average per diem rate. For context, the $627 unweighted FFS rate translates to about $775 in New York City but only $597 in Miami. In other words, the NE's MA rate is 11% higher than the SE average, while the New York City FFS per diem is 30% greater than Miami's.

Those calculations may seem disingenuous coming from someone who has clamored for years against making exactly that sort of inconsistent comparison, but among MAPAX's most notable findings is that MA rates have far less variability across states than FFS. In fact, the most significant incongruity is that MA rates in high-cost cities are often less than those realized in surrounding counties. The most logical explanation for these rate inversions is greater provider competition in large markets – making comparable performance metrics that much more essential for success.




## Do Quality Outcomes & Value Matter?

In competitive markets, most MA claims were submitted by SNFs with at least a three-star rating, but in areas with less bed-saturation, two-stars were not uncommon. Further, there was no correlation between 5-Star rating and episodic revenue, while the 30-day hospital readmission rate explained less than 20% of payment variation.

These findings support what we've long known: Operators are not using data to improve MA performance. SNFs with the best outcomes and low costs should market their "value proposition" to Plans. Why aren't they? Because comparative MA data has been hidden at the bottom of the ocean… ***until now.***

For county-level Medicare Advantage metrics or to discuss how CORE Analytics can add wind to your competitive sail, please email support@zcoreanalytics.com.