ZIMMET HEALTHCARE SERVICES GROUP, LLC

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The "Great Transition": Medicaid Rate Construction Reform

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Skilled Nursing has a reimbursement problem. The provider community cites inadequate state Medicaid funding[1] as the root cause of quality and market instability. Appeals for rate relief must filter through policymakers wary of unduly enriching a perpetually maligned industry. This narrative may never change, but state governments and SNF advocates must recognize that funding is, at most, only half the Reimbursement equation. The other half is Rate Construction. Quality improvement initiatives cannot be effectuated until this imbalance is corrected.

Skilled Nursing Facilities continue to shutter, with at least 500 fewer SNFs operating today than before the pandemic. To be clear, the SNF "industry" is not facing imminent collapse. Instead, Zimmet Healthcare's analysis finds an alarming number of isolated and clustered facilities that cannot cover operating expenses, even at full practical occupancy. To remove questions of obfuscation, our calculations *add back related-party profits as SNF income*. Without Rate Construction reform, the SNF industry becomes the "SCNF" industry – Swiss Cheese Nursing Facilities defined by gaping holes on the provider map. Hospital backlogs stress the healthcare continuum; they are unsustainably expensive and excruciatingly sad, forcing families to travel long distances to visit loved ones. The insidious data-driven reality is that we can identify[2] facilities that won't make it, or more accurately, can't make it, long before the beds are gone.

Due to changing market dynamics, fewer SNFs can cover operating costs each year. We can blame the pandemic's occupancy challenges, but when well-managed facilities cannot achieve financial break-even in a stable occupancy-environment, that's a red flag that will not self-correct, especially when similar providers only miles away manage a profit. Variances are not driven by census, rent, quality, or case-mix. It distills down to Medicaid Rate Construction and deterioration of the overriding SNF reimbursement environment. Those red flags glow neon.

The SNF-Economy

Skilled Nursing does not follow normal economic principles. Demand cannot be spurred, prices cannot be raised or lowered, high fixed costs cannot be rescaled, the product cannot be automated or outsourced. Operating expenses, save for certain ancillaries, are not directly identifiable or allocatable to a specific patient or payer.

As a business, SNF sales are measured in patient days. Calculating cost on a SNF unit of inventory is a slippery slope. Traditional Medicaid payment systems apply step-down accounting and acuity-adjustment to align Medicaid rates with provider expenses attributable to Medicaid patients. This approach ignores fundamental realities of SNF-economics that, left unattended, exacerbate the uneven, inequitable distribution of resources now rotting Long-Term Care's financial stability.

A confluence of events has prompted many states to update their respective Medicaid rate setting methodology – the "Great Transition" – an unprecedented opportunity to rationalize reimbursement on a national scale. Unfortunately, states are recycling the same ill-conceived constructs that will do nothing to address systemic mispricing across the country. I have studied and modeled SNF reimbursement for 30 years; states must approach rate setting differently, or no amount of funding will correct the problem.

"Cost Shifting"

The sentiment that Medicaid rates do not cover the cost of care is a relative truth. Forget the "Underfunding per Medicaid day" rhetoric because that statistic is oversimplified and unactionable. SNF-economics don't work that way. The math is simple enough: Nearly every SNF, operating at the pre-pandemic benchmark occupancy of 80.7%, funded only by respective per diem Medicaid rates, would close, but Medicaid does not exist in a vacuum. This has long been the case, yet we still have a serviceable, if recovering, industry. What drives the urgency today?

Medicaid covers more than 60% of Skilled Nursing's population and pays rates that objectively fail to cover the cost of care. Medicaid has for years shifted the financial burden of patient care to other payers; private-pay and Medicare effectively sustained (subsidized) the Medicaid underpayment model. This is known as cost-shifting. As providers generate more non-Medicaid revenue, tolerance to Medicaid rate shortfalls increases. The growing problem with Medicaid's cost-shifting reimbursement model, what has brought us to this inflection point, is that essential cost-shifting targets have atrophied and can no longer meet the required subsidy for a growing number of providers. The Medicaid model of paying for long-term care no longer works. It's like a dinner party at an expensive restaurant; the deep pockets have left the table and Medicaid is awkwardly pretending it doesn't notice the check has arrived.

Cause of Erosion

Private-pay patients abandoned SNFs for Assisted Living and homecare decades ago; Medicare Part A has been Skilled Nursing's lifeblood ever since. Medicare utilization, artificially inflated by the 1135 three-day waiver for two years, has quickly regressed to its pre-pandemic downward trendline. Medicare Advantage ("MA") is the primary culprit, removing nearly $14 billion from SNF topline revenue per year. Not only are there more MA beneficiaries, the absolute number of FFS beneficiaries is falling (remarkably fast in some markets). CMMI initiatives (Accountable Care Organizations and BPCI), while still technically under the auspices of Fee-for-Service, temper utilization on much of the remaining FFS population.

Mathematically, the net effect of these pressure points leaves Medicaid subsidizing private insurance company profits while CMS orchestrates the ACA's legacy of transferring Medicare funds from one provider class (SNFs) to another (Hospitals and Health Systems). Shared Savings that were dangled as carrots to the SNF provider-community were never shared by the controlling health systems favored to run the show, while the "backfill" promise of favored network status came with hard core pressure to reduce FFS utilization. Adding a touch of irony, shorter SNF stays drove average PDPM rates higher which fueled a recalibration inexplicably based on average rate instead of neutralized spend. In any event, SNFs receive less revenue while acuity rises and expenses climb. At a certain point, SNFs find themselves in "Positionally Disadvantaged" markets[3]. We're not talking about remote rural outposts either; these markets can be anywhere.

Example, not Anecdote

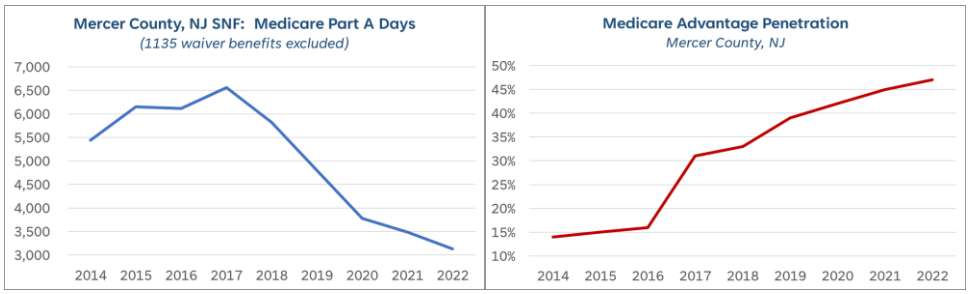
The weakest arguments are based on anecdote; I offer New Jersey as an example. Mercer County is a difficult place to run a SNF, as evidenced last month when a 119-bed facility abruptly closed after a fully predictable decline. The media coverage was typical, the industry's response was rational but ignored. The Star Ledger pondered, "It's unclear why (SNF) was failing in a field where others are profitable." The answer is complex but clear and explains why nearly one-in-ten (and growing) SNFs nationally are fast-tracked to the same fate if states do not change Medicaid payment policy to match the evolving SNF-economy. The Mercer County SNF was Positionally Disadvantaged; it had long been quality-comparable to area providers until it wasn't, and toward the end, as Medicare days waned, it became mathematically impossible to generate enough revenue to cover expenses. Here are the reasons:

1. Area Wage Index ("AWI"): Mercer's Medicare rates are significantly below neighboring counties despite drawing from the same labor pool. Competing SNFs just a few miles away are paid $50 per day more for the same patients under PDPM. Adding insult to injury, Mercer County hospitals are eligible for Medicare geographic reclassification, a process that increases acute-care reimbursement to the higher neighboring wage index.

2. Cost-Sharing: Because New Jersey's "cost-sharing" policy is to pay $0 toward Medicare coinsurance, the SNF wrote off $26/day last year as non-reimbursable Medicare bad-debt for its dual-eligible beneficiaries. This issue does not get the attention it deserves.

3. Medicare Advantage: Mercer's irrational AWI empowers insurance companies to lowball contract rates in a county with the highest Medicare Advantage penetration in Central New Jersey (NJ SNFs lose on average $750,000/year to Medicare Advantage).

For context, the closed SNF's Medicare Part A utilization is graphed below, next to Mercer County, NJ's Medicare Advantage penetration over the same period. Traditional Medicare days decline as Medicare Advantage grows in each market.



4. Scale: The shuttered SNF had fewer licensed beds than local competitors, and therefore fewer days to spread Skilled Nursing's high fixed-cost burden. Larger SNFs simply have different economics at play. "Rebasing" rates without adjustment can perpetuate the uneven distribution of limited Medicaid funds across the provider-community.

5. "Medicaid-Only": Medicare Part B supplements Medicaid's inadequate reimbursement. Caring for residents without coverage can dramatically impact a provider's revenue and expenses. This issue takes on greater significance as managed long-term care initiatives for dual-eligible beneficiaries gain traction across the nation.

6. CMMI: In addition to Medicare Advantage, NJ ACOs are especially aggressive in efforts to reduce covered days; like all variables discussed within, the impact is highly localized.

7. Arbitrary Medicaid Rate: Medicaid rate setting is where New Jersey shines as a beacon of reimbursement policy-dysfunction in that rates are effectively arbitrary. Medicaid utilization was 65% at the shuttered SNF, so cost-shift tolerance was compromised even before factoring in low Medicare rates. Its Medicaid rate was as much as $30/day below its competitors. New Jersey's current rates were promulgated eleven years ago then frozen in time; adjustments have been limited to token inflation bumps and poorly targeted rate add-ons. There is no "Rate-Elasticity" – rates are locked regardless of patient acuity or provider costs, as the state explains in response to a recent, unrelated matter:

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Myers & Stauffer was contracted for cost report work. FY14 was the last year where rates were paid based on Cost Reports. Since 2014 DHS has abandoned the process of requiring nursing home Medicaid cost reports to be filed allowing individualized adjustments to nursing home rates from year to year. Instead, nursing homes in general have had their 2013 published Medicaid rate frozen in time due to the absence of staff and data collection used to set the underlying components of nursing home rates.

In plain English, the state tells providers it doesn't care where you are, who you treat, what you spend, or how sick your patients are, your rate is frozen based on conditions from the first Obama Administration – before the Affordable Care Act was in effect. Have a nice day.

Consider how SNF patient acuity has increased over the last decade, then circle back to the Star Ledger's comment about why this facility couldn't make it. The provider was Positionally Disadvantaged compared to its nearest competitors – Freestanding SNFs with similar quality scores, staffing patterns, and expenses, fighting for admissions from the same hospitals, yet they generated up to $200/day more Patient Service Revenue than the closed facility. Such discrepancies trigger a Quality Death Cycle that ultimately dooms a facility to operational failure. This type of imbalance is happening in pockets across the country. Keep an eye on parts of Pennsylvania, New York State, and, apropos to the AHCA conference venue, Colorado, to name a few "at-risk" markets.

Modern Reimbursement Theory

Correcting for cost-shift erosion is challenging at the state level because effects are localized. This is why the soundbite about statewide underfunding per day is dangerous. It suggests increasing every provider's rate by the shortfall will fix the problem when in fact, it would make things worse. Evenly distributed increases would drop directly to the bottom line of a handful of SNFs, but they won't be enough for most. States have proposed solving for undue enrichment by mandating a set percentage of a provider's revenue be spent on Direct Care. That would be an unmitigated disaster and I sincerely hope we never hear of it again.

The Budget Adjustment Factor

Medicaid funding for SNF care is typically a fixed item in state budgets; if the rate setting formula drives aggregate provider reimbursement beyond the initial benchmark, a Budget Adjustment Factor is applied, and every facility's rate is reduced by the same percentage to restore fiscal balance and effectively perpetuate the illusion the provider has a modicum of control over its reimbursement. This is the same principle that triggered CMS' Medicare PDPM "recalibration".

Put another way, at a certain point, every additional dollar a SNF generates above the state budget, for example by raising CMI, gets clawed-back from the entire provider community, meaning operators compete for a limited resource. This is why certain case-mix systems in a fixed-budget environment can be problematic. Facilities meticulously document to ensure proper acuity capture, always with the specter of retrospective audit, only to have whatever gains recouped when the state calculates the final overage. CMI distills down to a relative value allocation measure, not a reimbursement system. CMI increases are akin to running up a down-escalator; a SNF's rate does not necessarily increase if acuity increases – the reported acuity increase must also be greater than the state average increase.

The "Great Transition"

This brings us to the "Great Transition" of Medicaid's migrating from RUGs to PDPM. States underestimate new case-mix scores because baselines are established prior to implementation – before SNFs had incentive to manage Medicaid PDPM capture. The low-baseline model portends significant rate increases that Operators use for budgeting, but without additional funds, phantom-revenue is clawed back, and we end up exactly where we were under the old system (this principle drove Medicare's 2012 and 2023 recalibrations). Invariably, operators with high scores in one system have the highest scores in the new one, as CMI is often as much about reimbursement management as it is patient acuity. When all is said and done, the state wasted valuable resources implementing a new system and providers wasted valuable resources preparing, all to rearrange the same deck furniture. I asked this question when CMS effectuated the PDPM recalibration: ***What was the point?***

Conclusion

Skilled Nursing's reimbursement problem is not going away. Medicare days that subsidized inadequate Medicaid rates have atrophied to unsustainable levels. Funding must increase, but even if states suddenly offered to cover the industry's "Medicaid shortfall per day", the payment would do nothing to correct fundamental deficiencies in the SNF revenue model. Funding is only half the equation; the other half is Rate Construction. We are amid an unprecedented "Great Transition" wherein states are updating Medicaid reimbursement systems, but poorly targeted payment policy will leave many SNFs sinking. Medicaid must stop playing the role of helpless observer; the program was conceived to be the Coast Guard[4].

Technical considerations for Medicaid Rate Construction are detailed in the next section.

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1. *This commentary does not address funding adequacy or the direct care staffing mandate, which for all intents and purposes, are redundant expressions (labor availability notwithstanding). Staffing is otherwise relevant here only because it will dominate policy discussions for years at the expense of addressing the immediate, critical need for Rate Construction reform.*
2. *We created a measure called Relative Reimbursement that is useful in identifying at-risk providers.*
3. *I am not ignoring the qualitative impacts of healthcare policy. This discussion is specific to the financial ramifications of national policy.*
4. *"Bon Voyage Reimbursement" embarks from Port Mohegan Sun, CT July 16, 2024.*

Considerations for Medicaid Rate Construction

These updated "Rate Extensions" are based on the paper we released last year. Rate Extensions are customizable calculations that can be affixed to any rate methodology to effectively deliver policy-specific relief to Positionally Disadvantaged providers. Dollars are made available to qualifying facilities using scheduled adjustments that reflect evolving market conditions and promote quality improvement, while advancing dignity and equality for all beneficiaries.

1. Align payment with policy initiatives that reward providers for initiative and achievement, as opposed to punishing for noncompliance or failure to achieve unrealistic benchmarks. As importantly, neutralize metrics so that Medicaid does not pay for programs/services that do not benefit the Medicaid population. Examples include:
    a. Direct Care staffing: Set staffing hour/day targets so that rates increase when thresholds are achieved, much in the way RUGs reimbursed for rehab, but on a facility-wide basis. Had nursing time been originally rewarded in this manner instead of therapy, we may not be having this discussion today.
    b. Single-bed rooms: Add a "Private Room Differential" payment for one-person occupancy, but only when rooms are reserved for Medicaid-covered residents.
2. Account for efficiency limitations for smaller facilities.
3. Provide incentives for avoidable hospital mitigation programs such as ISNP or ISNP-equivalent, which improve clinical quality but are difficult to measure with respect to net revenue for providers.
4. Neutralize distortion when calculating base rates for Indirect cost centers so that $PPD are not skewed across noncomparable providers. Specifically, Freestanding SNFs with 100% SNF-certified beds should not be averaged with CCRCs or Hospital-Based SNFs.
5. Adjust for baseline differences in Direct Care based on ratio of short- v. long-term care census (this is often accomplished using respective CMI systems which lack sensitivity for such a nuanced calculation).
6. Capital reimbursement: Operators should have the incentive, and ability, to finance capital improvements. These payment mechanisms must not be regressive and should favor high-Medicaid providers.
7. Create a Disproportionate Share pool to shift dollars to high Medicaid providers or those caring for patients without Medicare Part B supplemental coverage.
8. Study new forms of CMI adjustment, specifically the CMS-HCC used for Medicare Advantage to align acuity-measures across payers.

9. Address imbalances caused by policy initiated at the federal level:
    a. Collect detailed utilization and rate data relating to Medicare Advantage.
    b. Consider MA Provider Protections such as rate floors to mitigate the state's subsidy of insurance companies.
    c. Address payment cliffs for providers in mispriced AWI counties and state variation regarding coinsurance bad-debt.
    d. Assess and resolve the impact of CMMI initiatives that now effectively shift Medicare funds to hospitals from SNFs.

Note: see Relative Reimbursement for a primer on market-specific reimbursement conditions.

Feedback is appreciated. Please submit comments to info@zhealthcare.com.

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Numbers are not data. Context matters.