

Special Needs Plans: Considerations for Skilled Nursing Facilities

May 28, 2015

Managed Care is rapidly assuming a major role in skilled nursing facility (“SNF”) reimbursement. Traditional Medicare Advantage penetration is now 30% nationally, with many markets exceeding 60% enrollment. Participation continues to grow unabated, with overall enrollment doubling in the past seven years. Meanwhile, several states have moved to Managed Care for SNF Medicaid beneficiaries, and at least a dozen more are in various stages of adoption. Even the Medicare fee-for-service (“FFS”) program is implementing managed care principles through Accountable Care Organizations and the Bundling demonstration. The only remaining segment of the SNF business that remains almost exclusively FFS is Medicare (Part A and Part B) for the long-term care population, as these residents are generally not financially conducive to traditional Medicare Advantage. But now after more than 10 years in existence, Special Needs Plans (“SNPs”) are finally gaining traction in managing these beneficiaries as well.

The Medicare Modernization Act of 2003 established a Medicare Advantage coordinated care plan that was specifically designed to provide targeted care to individuals with special needs. SNPs offer the opportunity to improve care for three types of Medicare beneficiaries, primarily through improved coordination and continuity of care. Specifically, Congress identified the following special needs programs:

1. I-SNPs: Institutionalized beneficiaries (or individuals residing in the community with an institutional level of care) who are expected to need institutional care for at least 90 days (this is the program that applies to SNFs);
2. D-SNPs: Designed for dual eligible beneficiaries in the community;
3. C-SNPs- Individuals with severe or disabling chronic conditions as specified by CMS.

Since their inception, SNPs remained a very small Medicare benefit category. However Congress recently authorized an expansion to the program. This authorization, in addition to provider quality enhancement initiatives, is dramatically accelerating program adoption.

How the SNP Program Works (Operationally)

The SNF enters into a contract with the SNP. The SNP then coordinates enrollment within the skilled nursing facility. The residents who enroll are no longer in the FFS Medicare program, they are covered by the Medicare managed care plan (the primary payer of room and board – Medicaid or private funds – is not impacted by SNP enrollment). The SNP and SNF then work together to improve clinical outcomes in an effort to reduce program expenses. This is accomplished primarily by the placement of a Nurse Practitioner (“NP”) in the facility to help manage care. There is generally no “lock in” period for the SNF. If the program is not working as expected, enrolled beneficiaries revert back to FFS once the SNP/SNF contract is terminated.

How the SNP Program Works (Financially)

The SNP receives a fee from the CMS each month per enrollee. This is known as the “PMPM” (which stands for “per member per month”). The amount varies by geography and the acuity of the enrolled population. Acuity is measured by the Hierarchical Conditions Category (“HCC”) coding system, which in principal is similar to our own Case-Mix Index (“CMI”) system, with the goal of scoring residents at their highest severity to ensure appropriate reimbursement.

The health plan must cover all expenses out of the PMPM. These include medical costs (e.g. hospitalizations, Part B therapy, etc.) and administration, including the cost of the NP. While individual arrangements between SNP and SNF may vary considerably depending on resident population and facility risk tolerance, common recent agreements involve the SNF receiving a guaranteed monthly PMPM Medicare replacement payment in addition to “shared savings” (a percentage of the balance of the PMPM after all expenses are deducted). The shared savings represents the most exciting financial opportunity for the SNF.

The majority of Medicare spending for the institutional long-term care population is on hospitalizations. As such, the SNP’s primary goal is to keep long-term care residents from being discharged to costly hospital stays by maintaining health and improving the SNF’s clinical assessment and treatment capabilities. This allows residents who would otherwise be hospitalized to be cared for “in-place” within the SNF. This has nothing to do with “re-hospitalization” rates of the short-term population. Remember, we are discussing only long-term care residents (however, competencies gained by treating SNP members in place are transferable to the whole house).

The guaranteed payment and shared savings received by the SNF is “Medicare Replacement Revenue” (“MRR”). The obvious goal is to realize more MRR than would have been generated had enrollees remained FFS. Therefore, the SNP value proposition is assessed by comparing projected MRR against a facility’s historical FFS reimbursement. This is the tricky part, as providers must also take into account the additional Medicaid revenue that will be generated by adopting the program, as many days otherwise billed to Medicare will be covered by Medicaid instead (discussed later).

How the SNP Program Impacts Medicare Revenue

SNP enrollees are no longer FFS beneficiaries, so the traditional Medicare program is not billed for any services. The implications for Medicare Part A and Part B are very different.

Any SNP enrollee that is hospitalized and would otherwise qualify for a new Medicare Part A benefit period will not be placed on program. Instead, most SNPs pay a monthly fee (guaranteed revenue) to the SNF to cover the Medicare Part A benefit. For example, a SNP may pay the facility \$300 per month for each enrollee. So a SNF with 100 residents enrolled in the SNP would receive \$300 x 100, or \$30,000 per month in MRR to compensate for the loss of Medicare Part A revenue. Should a resident be hospitalized for three midnights and return both clinically and technically eligible for Medicare Part A, the SNF would not bill for these days. So the first part of the analysis is to determine how much FFS revenue the long-term care population has historically generated for a facility and compare it to the Guaranteed Payment being offered by the SNP.

In addition, there is typically a limited “Exceptional Payment Per Diem” for residents that require short-term intensive medical services who previously would likely have been hospitalized. These payments are often greater than the average Medicare per diem, but the benefit periods are short (usually three days or less). These days are not counted against the traditional Part A stay, and as such are unaffected by a patient that has utilized 100 days and might not be otherwise eligible for a skilled stay. Remember, these days are intended to encourage facilities to keep and treat patients who may have been hospitalized in the past.

The SNF can still bill for Medicare Part B covered services (to the plan), and those are considered medical expenses covered by the PMPM. Most SNPs pay the same amount as Medicare (80% of the fee screen), but some are offering a fixed monthly capitated fee, similar in concept to the Medicare Part A replacement payment.

A concern among providers is “losing” Part B therapy revenue. Therapy billing does tend to diminish somewhat after SNP implementation, but associated therapy costs come down as well. Moreover, if the therapy department is outsourced, most of that revenue is paid to the rehab provider anyway. Another positive is that the annual therapy limitations, exception requests and appeals also disappear, greatly relieving the department’s administrative burden.

The final component of SNP revenue is the shared savings. As previously stated, whatever is remaining from the PMPM after all medical and administrative costs (including SNF payments, hospitalizations, ancillaries, administration, NP, etc.) is available for distribution. Payments are typically issued quarterly, with the SNF receiving the pre-negotiated share.

This arrangement rewards a facility when it reduces its own direct revenue. While it may seem counterintuitive given the legacy of the FFS mindset, the goal is to maximize the shared savings component and improve the facility’s bottom line.

SNFs should be concerned with the associated risk the SNP agreement may present and ensure they are protected before contracting. Most notably, a high number of hospitalizations (or even one high cost outlier) can quickly exhaust any funds available for shared savings. The SNF must therefore establish its level of risk tolerance, as losses may be shared as well. Some programs are now securing re-insurance to cover the cost of expensive hospitalizations. But the associated premiums will also reduce available distributions.

How the SNP Program Impacts Medicaid Revenue

Medicaid is generally unaffected by the SNP initiative. CMI is not impacted by this program at all, and we have seen no evidence of CMI slippage after SNP implementation. In fact, CMI often increases as the SNF’s clinical capabilities are expanded to provide more intense services. Also, it should be noted that the increase in qualified visits by the NP will increase CMI in states that utilize the RUG-III system for Medicaid acuity-based payment.

Many SNFs also note an increase in Medicaid days due to the reduction in Medicare days generated by the enrolled population. For example, a FFS resident returning from a qualifying hospital stay would often be placed on Medicare for up to 100 days – Medicaid would not be billed for these days. However under the SNP model, that hospitalization would (hopefully) be avoided so no Medicare stay would ensue.

While the Medicare Part A FFS revenue is “lost,” returning long-term care residents are typically not captured in the highest paying RUG scores consistent with the short-term sub-acute population, so the sacrifice is not as significant as it may appear. The “loss” is further mitigated by the Medicaid revenue that would otherwise not be available. As such, facilities with higher Medicaid rates fare better under the SNP model. Additionally, the difference between net Medicare and Medicaid revenue is reduced as reimbursable bad-debt for Medicare Part A is phased down in coming years. Finally, Medicare Part A ancillary costs (e.g. drugs, diagnostics, etc.) are not incurred, and these can be costly. And of course, we cannot overlook the benefit to the resident of not having to endure a hospitalization and the associated maladies.

Is the SNP Program Right for Your Facility?

Zimmer Healthcare had been a longtime critic of SNPs – while we recognized the clinical benefits of the program, the “legacy” reimbursement models often favored remaining in FFS. However, regulatory and market initiatives have incentivized SNFs to reduce re-hospitalizations and improve care quality (the basic ingredients of a financially successful SNP initiative), and these efforts are carrying over to the long-term care population. Further, we are seeing evidence that insurance companies and health systems favor facilities with this program, as it demonstrates the commitment to quality our healthcare partners are demanding.

The bottom line is that in today’s rapidly evolving healthcare landscape, skilled nursing facilities should consider this model, as it improves resident care and is often financially beneficial to the provider.

Zimmer Healthcare is available to discuss Special Needs Plans in more detail and can conduct a comprehensive assessment to evaluate how the program would impact your facility’s revenue and operations. Email us at info@zhealthcare.com for details.

About Zimmet Healthcare Services Group, LLC

ZHSG is a full service reimbursement compliance support firm with SNF clients in nearly 30 states. ZHSG is also a member of Alpha Healthcare, a “Skilled Nursing Facility Cooperative” that provides clinical, administrative and network management for ISNPs through a risk sharing arrangement.

About the Author

Marc Zimmet has over 20 years of experience working in healthcare reimbursement compliance. His primary field of expertise is skilled nursing facilities and related companies, and he advises the firm’s diverse client base on navigating today’s complex regulatory/reimbursement landscape.

Marc is heavily involved in the next iteration of SNF reimbursement, assisting clients in positioning themselves within integrated delivery systems and properly “pricing” the care they provide under “fixed payment systems.” Mr. Zimmet is also heavily involved with advancing Medicare Advantage Special Needs Plans within SNFs to maximize their participation in shared savings resulting from quality improvement.

He is an active member of many state and national industry associations, and lectures extensively on topics relating to SNF reimbursement and compliance. He holds a degree in CPA Accounting from Syracuse University and an MBA in Healthcare Administration from Baruch College/Mount Sinai School of Medicine.