

June 24, 2025

# What if Medicare Advantage was Paid by the Cost Report?

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# Agenda

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## What if Medicare Advantage was Paid by the Cost Report?

June 24, 2025

- 1 Traditional Medicare (TM) vs Medicare Advantage (MA) Plans
- 2 Transition or Rise in Medicare Advantage
- 3 Variances in Payment Methodology
  - Does MA Reimburse the Same?
  - What makes up difference?
  - How about the cost report impact of MA utilization?
- 4 Improvement Ideas!

*Disclaimer: The information provided in today's presentation is current as of June 24, 2025*

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# RECENT WSJ NEWS

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HEALTH | HEALTHCARE

## How Health Insurers Racked Up Billions in Extra Payments From Medicare Advantage

The Wall Street Journal's yearlong investigation into Medicare's private insurers relied on exclusive access to billions of records of Medicare services

By *Christopher Weaver* [Follow](#)

*Jan. 2, 2025 5:30 am ET*

Medicare Advantage are private plans that are typically more profitable than other segments of the health-insurance market. They have grown in popularity in recent years, and large insurers have rushed into the market to take advantage

# Medicare Advantage Impact on Rural HealthCare

## What's the Problem w Advantage Plans?

- Simply said – many of these MA plans do not pay what Traditional Medicare pays,.
- This includes CAH and is amplified under cost-based payment methodology.
- No bad debt payment on many contracts
- Some pay Swing Bed at RUGS rate and not CAH rate, and those that pay CAH rate, the contract is difficult.
  - If it is quoted as nursing home rate, that means RUG rate
- Traditional Medicare Pays CAH at cost-based rates. Medicare Adv. negotiate their own payment rates and may not offer rates equivalent to Trad. Medicare.

# Medicare Advantage Impact on Rural HealthCare

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## What's the Problem w Advantage Plans?

- Traditional Medicare (TM) Pays an average of 82% of Hospital cost on Medicare patients (AHA, 2022 study).
- Medicare Advantage pays an average of 88% of the Amount TM pays, or 72% of Cost, yet receives approx. 104% of the funding that traditional Medicare would have spent on these beneficiaries. (AHA, 2022 study)
- Hospitals in highest MA transition states are the most impacted.
  - Utah and Dakotas still have the lowest transition rate to MA and also have the least number of hospitals operating in negative margins, per capita.
  - Michigan has the highest transition rate at 63% of Medicare being Adv.

# Medicare (Dis)-Advantage Impact on Rural HealthCare

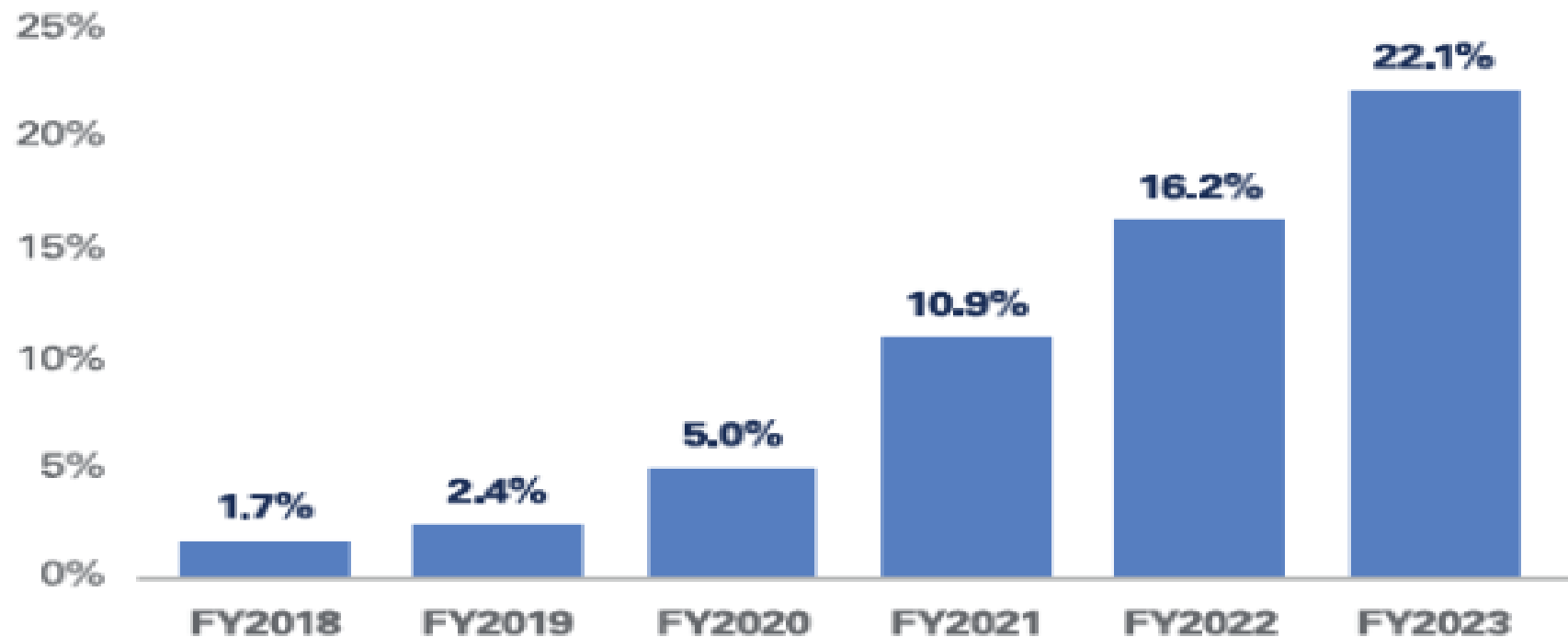
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- Confusing Contract terminology and Terms of Payment
- Enhanced Medical Claims Review and Claim Rejection / Denials
- Claims denials or delayed approval
- Delay in Rate Adjustment (especially with Rate Increases) and no settlement process.

# Medicare Advantage Growth of Medicare MA Market in Rural Hospitals

**Figure 1. Percentage of Rural Hospitals With More MA Inpatient Days vs. Traditional Medicare Has Seen Tenfold Growth**

*Percentage of Rural Hospitals with More MA Inpatient Days than Traditional Medicare, 2018 to 2023*



**Source:** AHA Analysis of Medicare Cost Report data between FY 2018 and FY 2023

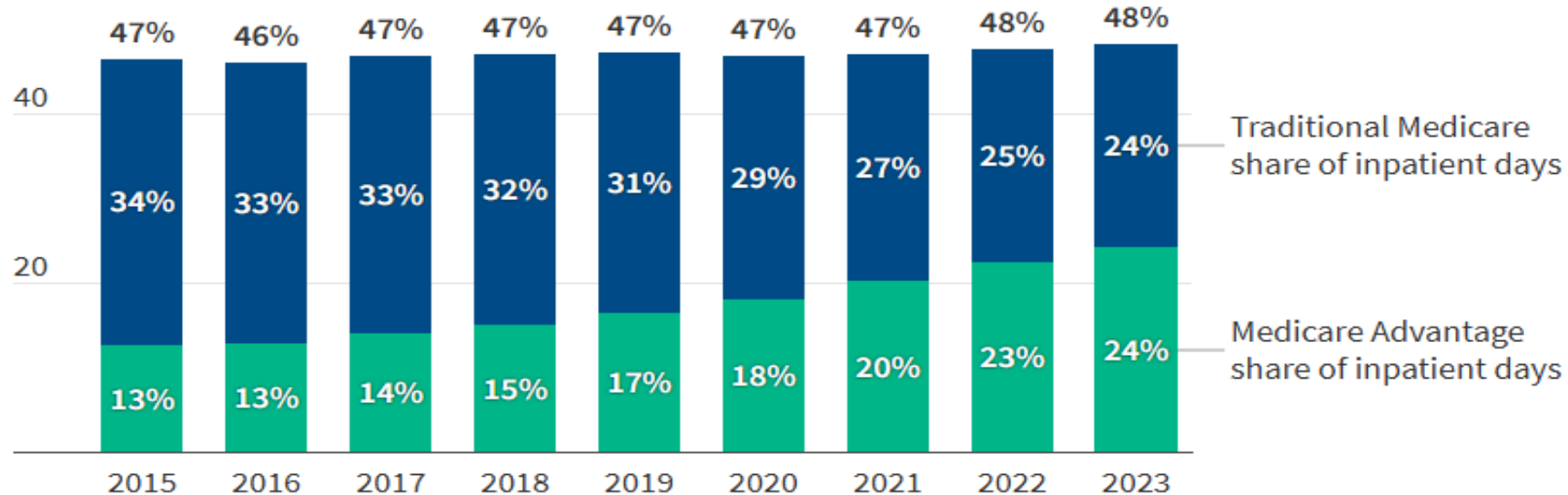
# COMBATING ADVANTAGE

Figure 24

## Medicare Advantage Steadily Increased As Share of Inpatient Days Between 2015 and 2023, While the Share Attributable to Traditional Medicare Decreased

Traditional Medicare and Medicare Advantage inpatient days as a percent of total inpatient days

60% of inpatient days



- Source: KFF (Kaiser Family Foundation) Healthcare Research

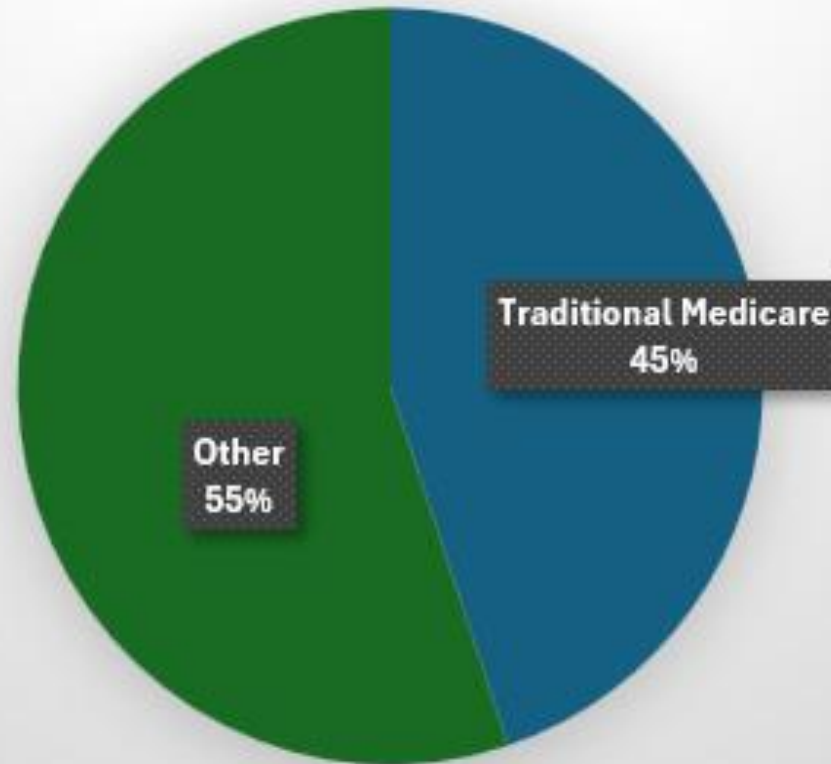
# Medicare Advantage - Growth of Medicare MA Market in Rural Hospitals

## Population Statistics

- In 2018 - 2020 – approx. 63M Americans were enrolled in Medicare
  - Approx 15-20% of those are in Rural US areas – 9.5M rural MC benefic.
    - Approx. 1,214,222 or about 12.75% of Medicare was enrolled in MA
- In 2024 – approx. 67M Americans were enrolled in Medicare
  - Approx. 50% (33.5M) Americans enrolled in MA plan
  - Approx 12% of those are in Rural areas – 7.8M rural MC Benefic.
    - Approx. 3.98M or about 51% of Medicare is enrolled in MA
- In 2025 - Texas has 4.9M Medicare benefic. and almost 20% in rural areas – 950,000 rural
  - Approx. 543,900 Texans enrolled in MA plan – 55.5% MA enrollees as of April 2025.

# Medicare Advantage Comparative Impact on Rural Healthcare – CAHs

## Pre-Advantage Scenario - 2011 FYE



## Mcr Payers Only

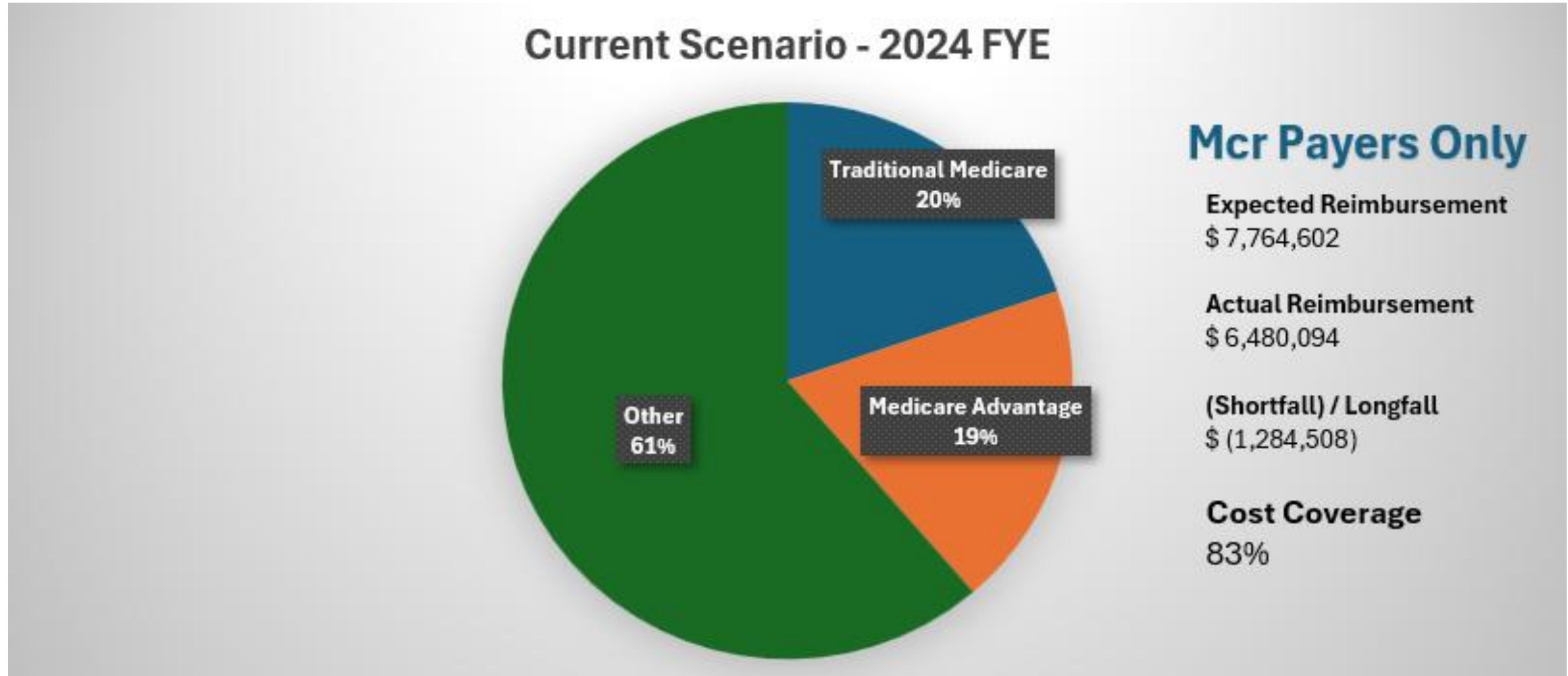
**Expected Reimbursement**  
\$ 3,087,885

**Actual Reimbursement**  
\$ 3,131,850

**(Shortfall) / Longfall**  
\$ 43,965

**Cost Coverage**  
101%

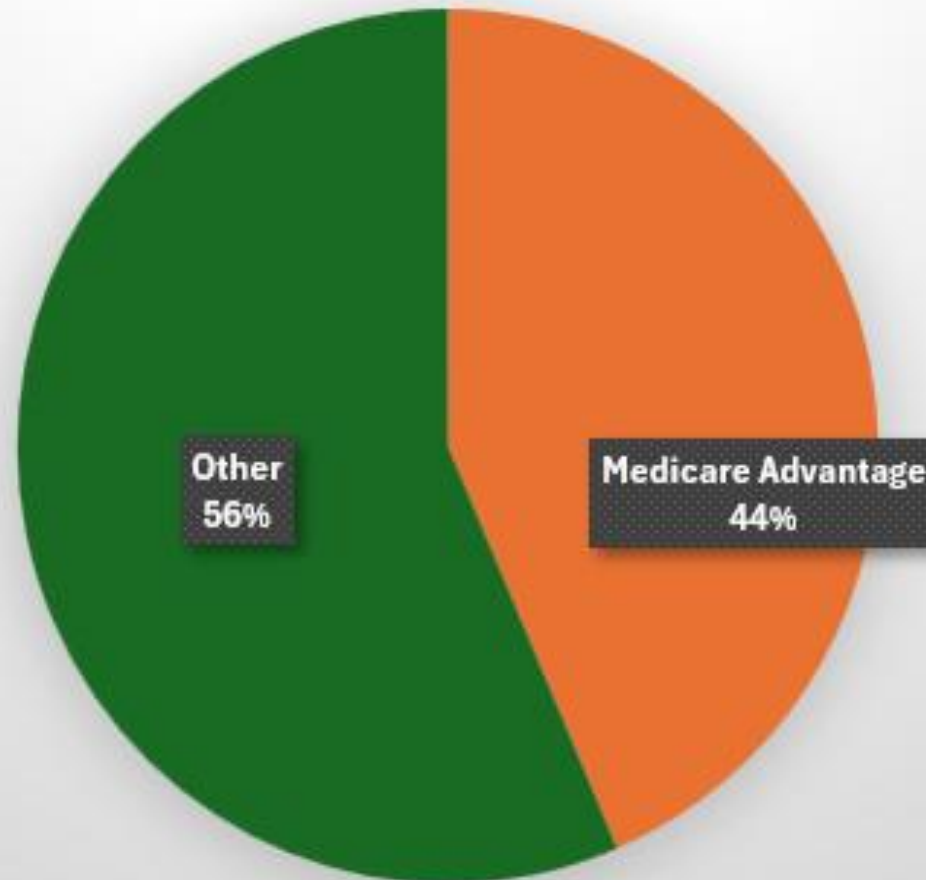
# Medicare Advantage Comparative Impact on Rural Healthcare – CAH



- Overall, CAH hospitals reviewed to this point, we know that a large amount of short-fall is denied claims.

# Medicare Advantage Comparative Impact on Rural Healthcare – CAH

## Future Advantage-Only Scenario - 2030 FYE



### Mcr Payers Only

**Expected Reimbursement**  
\$ 10,621,648

**Actual Reimbursement**  
\$ 7,141,488

**(Shortfall) / Longfall**  
\$ (3,480,160)

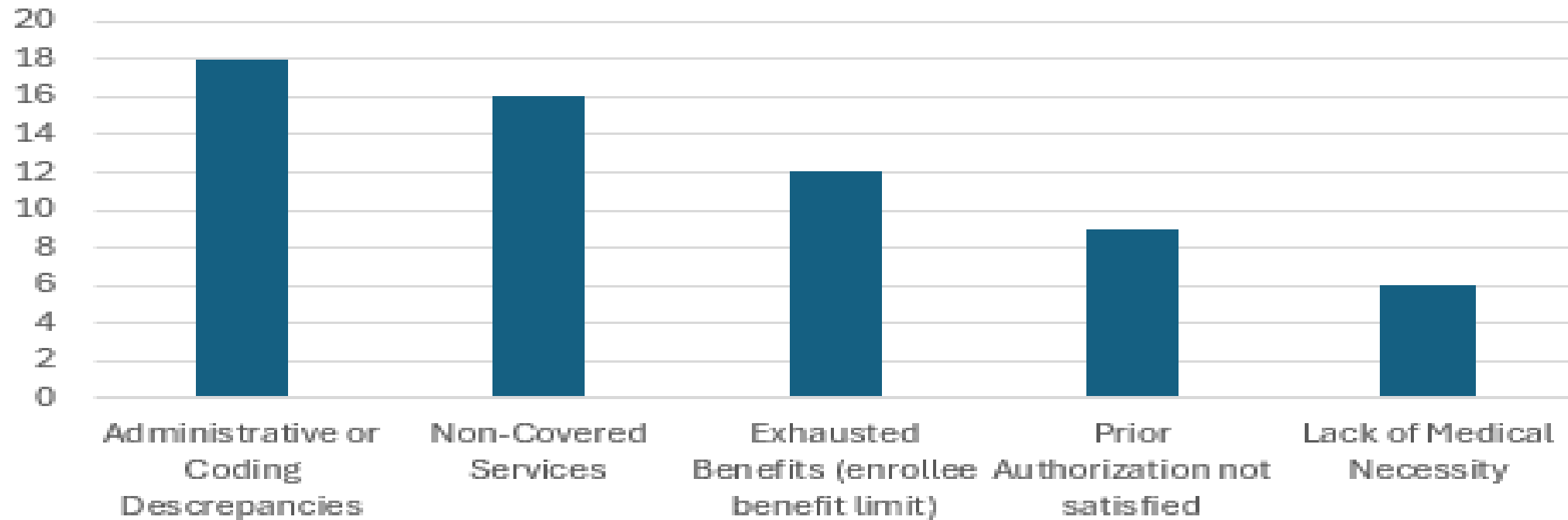
**Cost Coverage**  
67%

# Medicare Advantage Denial Rates

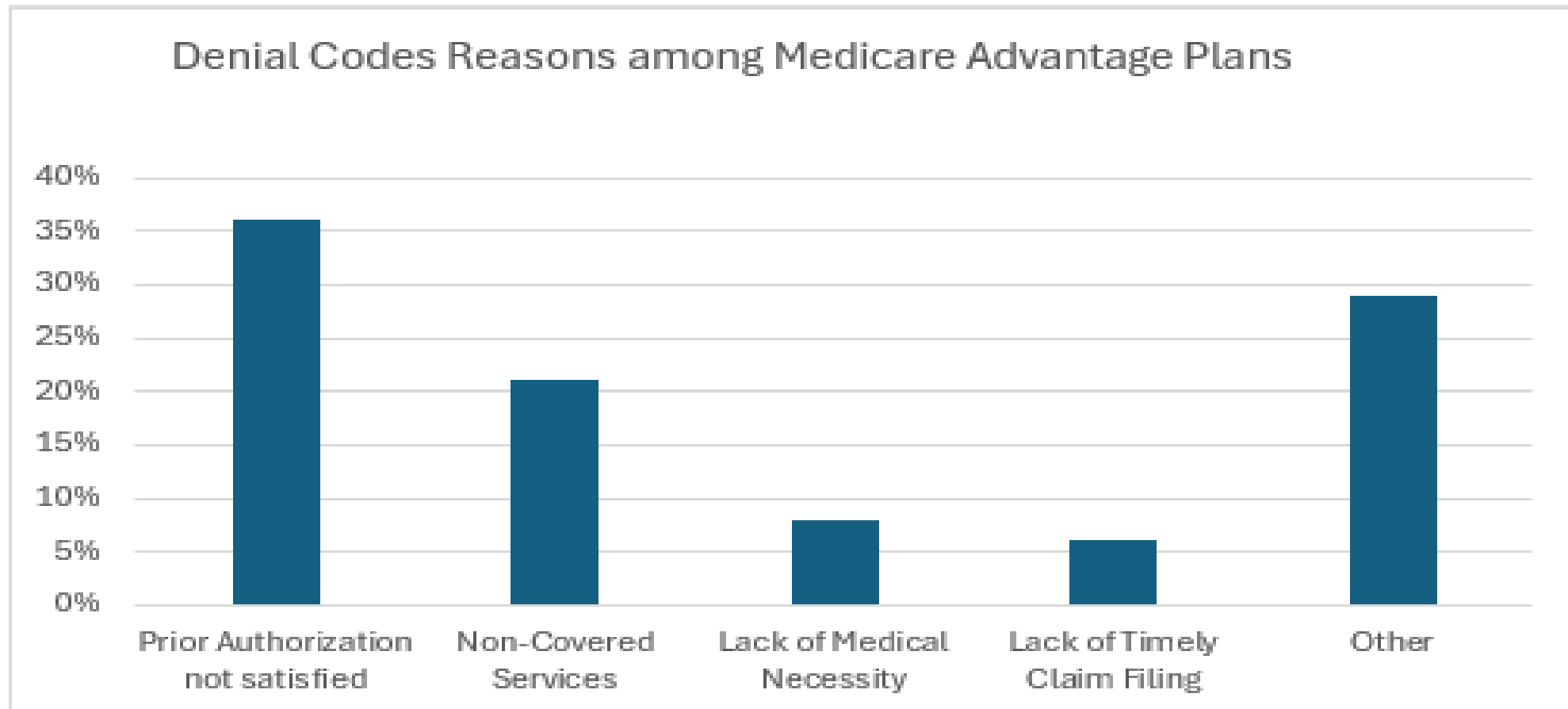
- **Overall MA plan denial Rate is approx. 17.7% of claims volume.**
  - Researcher examined 270M MA plan claims in 2023
  - Approx initial denials among MA plans = 46M claims
  - Inpatient claims = 17.3% denial rate
  - Outpatient (incl hospital and post-acute care) = 21.1% denial rate
  - Physician services (incl clinic) = 14.6% denial rate
- Traditional Medicare across the same spectrum has approx. a 5.8% claims denial rate.
- Denial Reasons among Medicare Payors vary, but matters with Prior Authorizations are significant for MA Plans.

# Overall Medicare Denial Rates (Inclusive of Traditional and MA Plans)

## Denial Codes Reasons among all Medicare Programs



# Medicare Advantage Denial Rates



# How does Medicare Advantage (MA) impact reimbursement in a CAH?

- Inpatient Acute Care Reimbursement
- Undercounting Medicare Cost – Medicare cost report methodology considers MA patient days as “commercial days” rather than Medicare days. This practice undercounts the overall Medicare cost and diminishes the value of cost-based reimbursement for traditional Medicare beneficiaries. (Source: Center for Medicare Advocacy)
- Medicare Adv plans typically require pre-authorization approval prior to cover certain services, particularly IP service areas.
- Impact on Cost / Charge Ratio
- Prior (Pre-)Authorizations lead to longer lengths of stay (more Adv days)
- Impact to the State Supplemental Funding

# How does Medicare Advantage (MA) impact reimbursement in a CAH?

- Swing Bed reporting and Reimbursement
- “The Cost Report methodology considers MA patient days as ‘Commercial days: rather than Medicare days....’”, except in the area of swing-bed (emphasis added).
  - Division of the days between Medicare and non-Medicare days for swing-bed services
  - The cost report instructions stipulate that all ‘covered’ (paid) Medicare days – Trad. and MA. – be included into the cost per diem calculation.
  - Watch the cost report to exclude non-Medicare days into the certified (SNF) swing-bed days. We are allowed to exclude non-Medicare (Medicaid, self-pay, other) from the ‘bucket’ of total swing-beds.

# How does Medicare Advantage impact reimbursement in a CAH?

## Outpatient Procedure Reimbursement

- Impact to the Cost / Charge Ratio
- Pre-Authorization Process and addressing denied or rejected or delayed pre-auth determinations
- Cost Report Reopening opportunities to correct charge structure for denied and rejected claims
- Certification review and provisions for clinic to ensure Medicare Adv contracts match traditional Medicare
- Clinic Provisions and services – negotiated rates and concentration on payment rates for consistency or close to the amount paid by traditional Medicare claims Fee Schedule vs Cost)

# How does Medicare Advantage impact reimbursement in a CAH?



## Observation Stay Reimbursement

- Observation equivalent Days inclusion
- Pre-Authorization Process and addressing denied or rejected or delayed pre-authorization determinations – delayed payment on pre-auth can be a big deal!
- Impact to the Cost / Charge Ratio
- Instructions to the Cost Reporting forms- CMS 2552-10 Section 4005.1
  - Observation – “Enter the total Observation bed days in column 8. Divide the total number of observation bed hours by 24 and round up to the nearest whole day.”

# What do we know!!

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- Center for Medicare Advocacy –July 18, 2024
  - “The Real Impact of Medicare Advantage....”
- MA Plans are funded approx. 22% more than what Medicare would have paid if MA enrollees were in traditional Medicare in 2024 alone. (paraphrased)
- “Paradoxically, despite those overpayments, MA plans spend 9% less on Medicare services the FFS Medicare spends for comparable enrollees.”
- The report also contest the idea that MA plans offer less expensive options for beneficiaries. The Center for Medicare Advocacy supports that the MA plan is the same cost or slightly more expensive than those beneficiaries in TM.

# COMBATING ADVANTAGE

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- How do we change the tide back to traditional Medicare
- Beckers cites that 15% of health systems have terminated Advantage, and that over 60% are looking at termination or limitation of plans.
- Join your local state advocacy group in initiative to vocalize the short-fall

# CONTRACT SOLUTIONS

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- Steps toward a better payment structure:
  - Inpatient and swing-bed admissions –
  - Renegotiate contracts:
    - Watch for lower of Cost or Charge clauses in contract, which contradicts the cost
    - Eliminate or reduce Medicare RUG rate or NF rate schedules – esp. CAHs
    - Target rates should be same as Traditional Medicare
    - Include Bad Debt Reimb Estimate
  - Continue to Appeal or contest denied claims volume
    - Kaiser Foundation states that only about 11.7% of denied claims are appealed, and more than 81% of appeals for denied claims are overturned.
    - Track and record claims denials and perform analysis on volume of payment reductions
  - CAHs need to update rates timely, as there is no settlement
  - Admission process verification and documentation

# What can you do?

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- How can you get your population to consider switching back to Traditional Medicare?
- Educate
  - As simple as brochures in the hospital, to
  - A coordinated community education program.
- Work through the complexities with refusing MA.
- Working on ideas with your local advocacy group.
- Join them: Medicare Plan Essential Hospital Payment

# Why do you need to continue to take Advantage?

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- You don't
- Modern healthcare has reported many rural hospitals dropping plans.
  - It actually restarts negotiations
- The plans are pushing back, suggesting legislation that mandates acceptance of plans and does not require network sufficiency.
  - Network regulations are already being relaxed.

# Medigap Plans

Medigap Benefit	Plan A	Plan B	Plan C	Plan D	Plan F*	Plan G*	Plan K	Plan L	Plan M	Plan N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓ <sup>***</sup>
Blood benefit (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	✗	✗	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible	✗	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible	✗	✗	✓	✗	✓	✗	✗	✗	✗	✗
Part B <u>excess charge</u>	✗	✗	✗	✗	✓	✓	✗	✗	✗	✗
Foreign travel emergency (up to plan limits)	✗	✗	80%	80%	80%	80%	✗	✗	80%	80%
Out-of-pocket limit <sup>**</sup>	N/A	N/A	N/A	N/A	N/A	N/A	\$7,060 in 2024	\$3,530 in 2024	N/A	N/A

# Supplement vs Advantage

- CMS has made Supplements or MediGap more cumbersome to de-incentivize
  - Require a separate decision on the Drug plan from the supplement
  - Complex rules
  - More confusing to the elderly population,
  - Much less marketing towards Supplements.
    - Follow the money
- Overall cost to the patient is not very different, but the marketing is.
- Marketing of the Advantage is much more aggressive
  - “Give Back” plans under Advantage actually give the enrollee more Social Security payments, but then take it back with more co-pays. It’s a marketing tool.
  - One Stop shopping
  - Less upfront cost, more copay, LESS CARE
  - Silver Sneakers and other small benefits
- Advantage sounds great, until you need the care.

# Medigap vs Advantage Comparison

	<u>TRS Plan</u>	<u>"G" Plan (Humana)</u>	<u>+ Drug Plan (AARP)</u>	<u>Total Supplement</u>
Premium	135 per month \$1,620	108 per month \$1,296	\$54.20 per month \$650	\$1,946
Deductible	\$400	\$240	0	\$240
CoPays	\$560	None		
Drug Copays	\$840		\$759	\$759
Cost-Plus Drug Mgt				
Affiliation Savings			(\$230)	(\$230)
	<hr/> \$3,420 <hr/>			<hr/> \$2,716 <hr/>

# LEGISLATIVE SOLUTIONS

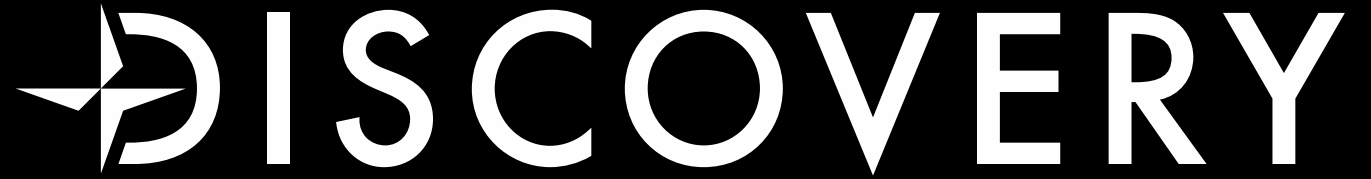
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## ● Current Legislation -

- Two Bills in Congress to address / assist with Medicare Advantage payment models
  - One dealing with Payment level review – Pre-authorization.
    - Texas Gold Card
- One dealing with increased level of price transparency in data for MA plans.
- None addressing improvement of payment criteria or accountability – including in the currently discussed H.R.1 (labelled the “Big Beautiful Bill”).
- MEDPAC did just issue a report to Congress in March



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