Increasing the equity of Medicare’s payments within each post-acute care setting; and Assessing payment adequacy and updating payments for skilled nursing facilities

Carol Carter
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Concerns about Medicare’s current post-acute care payment systems

- Similar patients are treated in 4 PAC settings
  - Separate payment systems establish different payments for similar patients
- Lack of evidence-based guidelines to base decisions about PAC
- Current PPSs encourage providers to:
  - Furnish therapy services unrelated to care needs
  - Avoid medically complex patients
- Provider financial performance varies widely
An approach to increase the equity of payments within each setting

- A fully implemented PAC PPS would redistribute payments across conditions
- Prior to implementing the PAC PPS, use a blend of the setting-specific and unified PAC PPS relative weights to establish payments
- Within each setting, payments would be redistributed across conditions
- Total payments to each setting would remain at recommended level
Redistribute payments within each setting by blending current and PAC PPS relative weights

<table>
<thead>
<tr>
<th>Implementation period</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blend setting-specific and unified PAC PPS relative weights (2019 and 2020)</td>
<td>Redistribute payments within setting</td>
<td>Redistribute payments within setting</td>
<td>Redistribute payments within setting</td>
<td>Redistribute payments within setting</td>
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<tr>
<td>Transition to a unified PAC PPS (begins 2021)</td>
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Within each setting, blending relative weights would shift payments across conditions and providers

- Payments would shift across conditions
- Based on patient mix and therapy practices, payments would:
  - Increase to nonprofit and hospital-based providers
  - Decrease to for-profit and freestanding providers
- At current levels, aggregate payments to a setting remain well above the cost of care
Conclusions

- Possible to increase the equity of payments within each setting before implementing a unified PAC PPS

- Redistribution would begin to:
  - Correct the known biases of current PPSs
  - Increase the equity of payments across conditions
  - Give providers more time to adjust to changes needed to be successful under PAC PPS
  - Support recommendations that better align payments to the cost of care
Assessing payment adequacy and updating payments:
Skilled nursing facility services
Overview of the SNF industry in 2016

- Providers: ~15,000
- Beneficiary users: 1.6 million
- Medicare spending: $29.1 billion
- Medicare FFS share: 11% of days, 20% of revenues

Data are preliminary and subject to change.
Payment adequacy framework

- Access
  - Supply of providers
  - Volume of services
- Quality
- Access to capital
- Payments and costs
Access is adequate (2016 data)

- Provider supply is steady (about 15,000)
- 89% of beneficiaries live in a county with 3+ SNFs
- Occupancy rates remained high (85%, small decline from 2015)
- Service use declined from 2015
  - Admissions decreased 3.6%
  - Length of stay decreased 4.0%
  - Days decreased 6.5%

Data are preliminary and subject to change.
Service mix reflects biases of the PPS design

<table>
<thead>
<tr>
<th>Year</th>
<th>Share of days</th>
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<tbody>
<tr>
<td>2002</td>
<td>27%</td>
</tr>
<tr>
<td>2010</td>
<td>69%</td>
</tr>
<tr>
<td>2016</td>
<td>83%</td>
</tr>
</tbody>
</table>

- Payments driven by amount of therapy furnished
- Payments for therapy exceed the cost of these services

Data are preliminary and subject to change.
SNF quality measures:  Mixed performance

<table>
<thead>
<tr>
<th>Risk-adjusted rate</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to community</td>
<td>38.7%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Potentially avoidable readmissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the SNF stay</td>
<td>10.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Within 30 days after the SNF stay</td>
<td>5.0</td>
<td>5.8</td>
</tr>
<tr>
<td>Change in function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement in 1+ mobility ADLs*</td>
<td>43.6</td>
<td>43.6</td>
</tr>
<tr>
<td>No decline in mobility</td>
<td>87.1</td>
<td>87.1</td>
</tr>
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</table>

*Activity of daily living
Data are preliminary and subject to change.
Access to capital is adequate

- Access to capital is adequate and expected to remain so
- Buyer demand remains strong
- Some lending wariness reflects lower SNF use and investigations into therapy use
- Medicare continues to be a payer of choice
Freestanding SNF Medicare margins in 2016

- Medicare margin: 11.4%
- 17th year of margins above 10%
- Variation in Medicare margins
  - 25th percentile: 0.7%
  - 75th percentile: 20.2%
  - Nonprofit: 2.3%
  - For-profit: 14.0%
- Marginal profit = 19.6%

Data are preliminary and subject to change.
Relatively efficient SNFs in 2016: relatively low cost and high quality

- 970 SNFs (8%) met cost and quality criteria
- Efficient SNFs compared to other SNFs:
  - Community discharge rates: 26% higher
  - Readmission rates: 17% lower
  - Higher daily census (99 versus 81)
  - Standardized cost per day: 8% lower
  - Medicare payment per day: 10% higher
- Medicare margin: 18.2%

Data are preliminary and subject to change.
Medicare FFS rates are considerably higher than MA/managed care rates

- FFS per diem payment rates are higher than MA/managed care payment rates
- Characteristics of MA and FFS SNF users do not explain these payment differences
- Publicly traded companies report seeking managed care business, suggesting the payments are attractive
Projected 2018 Medicare margin

- Costs increased by market basket
  - Included costs to meet nursing home regulations
- Revenues increased by market basket minus
  - Productivity
  - Portion of value-based purchasing retained as savings

Data are preliminary and subject to change.
How should Medicare payments change for 2019?

- Broad circumstances have not changed
- The level of Medicare’s payments remains too high
- The PPS needs to be revised
- Wide variation in margins reflects differences in patient selection, service provision, and cost control