

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

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# Concerns about Medicare's current post-acute care payment systems

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- 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

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- 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

Implementation period	HHA	SNF	IRF	LTCH
Blend setting-specific and unified PAC PPS relative weights (2019 and 2020)	<i>Redistribute payments within setting</i> 	<i>Redistribute payments within setting</i> 	<i>Redistribute payments within setting</i> 	<i>Redistribute payments within setting</i> 
Transition to a unified PAC PPS (begins 2021)	<i>Redistribute payments across settings</i> 			

Within each setting, blending relative weights would shift payments across conditions and providers

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- 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

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- 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

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- 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

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- Access
  - Supply of providers
  - Volume of services
- Quality
- Access to capital
- Payments and costs

# Access is adequate (2016 data)

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- 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%

# Service mix reflects biases of the PPS design

Share of days assigned to intensive therapy case-mix groups

2002

27%

2010

69%

2016

83%

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

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# SNF quality measures: Mixed performance

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

*\*Activity of daily living*

*Data are preliminary and subject to change.*

# Access to capital is adequate

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- 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

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- Medicare margin: 11.4 %
- 17<sup>th</sup> year of margins above 10%
- Variation in Medicare margins
  - 25<sup>th</sup> percentile: 0.7%
  - 75<sup>th</sup> 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

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- 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%



# Medicare FFS rates are considerably higher than MA/managed care rates

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- 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

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- 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?

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- 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