Assessing payment adequacy and updating payments: Skilled nursing facility services

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Outline of presentation

- Overview of the SNF industry
- Analysis of payment adequacy
- Medicaid trends

Skilled nursing facilities: providers, users, and Medicare spending

- Providers: 15,000
- Beneficiary users: 1.7 million
- Medicare spending: $29 billion
- Medicare share: 12% of days
  22% of revenues

Payment adequacy framework

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

Access: supply adequate and stable in 2013

Indicator	Change from 2012
▪ Supply	▪ Unchanged (15,000)
▪ Share of beneficiaries living in a county with multiple SNFs	▪ Unchanged (3/4 live in a county with 5+ SNFs)
▪ Occupancy rate	▪ Small decrease (from 87% to 86% in 2013) ▪ One quarter of SNFs have rates less than 72%

Data are preliminary and subject to change.

Decline in SNF use in 2013 consistent with reductions in inpatient hospital use

Indicator	Change from 2012
Admissions	Decreased 2.2%
Days	Decreased 1.4%
Length of stay	Small increase 2.2%

Data are preliminary and subject to change.

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Service use reflects shortcomings of the PPS design

% of days	2002	2011	2013
Any therapy	78%	92%	93%
Intensive therapy	29	74	79
Medically complex	15	7	6

- Amount of therapy drives therapy payments
- Therapy payments exceed therapy costs
- Payments for nontherapy ancillary services are not based on these services' costs or patient characteristics

Data are preliminary and subject to change.

Small improvement in rates of community discharge and potentially avoidable rehospitalizations

Risk-adjusted measure	2012	2013
Discharged to community	35.6%	37.5%
Potentially avoidable rehospitalizations:		
During SNF stay	11.5	11.1
Within 30 days after discharge from SNF	5.6	5.5
Combined	15.5	15.1

Source: Analysis of MDS data conducted by Kramer et al.. 2015. Data are preliminary and subject to change.

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Essentially no change in functional status between 2012-2013

Risk-adjusted rate	2012	2013
Percent of stays with improvement across 3 mobility measures	43.6%	43.7%
Percent of stays with no declines in mobility	87.2	87.2

Source: Analysis of MDS data conducted by Kramer et al. 2015.
Data are preliminary and subject to change.

Wide variation in risk-adjusted quality measures indicate opportunities to improve

Risk-adjusted rate	25th	75th
Discharged to the community	29.2%	46.6%
Rehospitalized during SNF stay	8.0	13.9
Rehospitalized within 30 days of discharge from SNF	3.4	7.2
Improved mobility	35.6	52.5

Source: Analysis of MDS data conducted by Kramer et al. 2015.
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Access to capital is adequate

- Access to capital is adequate and expected to continue
- Some lenders are reluctant due to uncertainties about lower volume and future Medicare policies
- Reluctance is not a reflection of the adequacy of Medicare's payments: Medicare continues to be a payer of choice

Freestanding SNF Medicare margins

- 2013 margin: 13.1 percent
- 14th year of margins above 10 percent
- Margins vary 6-fold
  - 25th percentile: 3.7%
  - 75th percentile: 21.7%
- High-margin facilities have lower standardized costs per day and higher payments per day

Data are preliminary and subject to change.

Relatively efficient SNFs in 2013: relatively low cost and high quality

- 524 were relatively efficient (7% of SNFs in the analysis)
- Compared to the average, efficient SNFs had:
  - Costs: 7% lower
  - Community discharge rates: 20% higher
  - Rehospitalization rates: 18% lower
- Medicare margin: 20.6%

Data are preliminary and subject to change.

Previous Commission recommendation has two parts

- Year 1: the prospective payment system for SNFs should be revised. No update.

- Year 2: payments should be lowered by an initial 4 percent. Subsequent reductions over an appropriate transition until payments are in better alignment with provider costs.

Why revise the SNF PPS?

- Uneven financial performance partly reflects shortcomings and biases of PPS
- Payments for therapy and NTA services have gotten more inaccurate since 2006
  - Overpayments for therapy services are larger
  - Payments for NTA services are unrelated to their costs
- Longstanding recommendation to revise PPS

A budget-neutral revised PPS would shift payments across providers

SNF group	Percent change in payments
High share of all days that are:	
Intensive therapy	-7%
Clinically complex & special care	5 to 7
Hospital-based	21
For-profit	-1
Nonprofit	4
Rural	4

Source: Impacts relative to current policy estimated by the Urban Institute 2014.

Why rebase Medicare payments?

- Medicare margins above 10 percent since 2000
- Industry responses to policy changes
- Variation in Medicare margins is related to amount of therapy furnished and cost differences
- FFS payments are considerably higher than some MA plan payments

Medicaid trends in nursing home use and spending

Number of facilities (2014)	Almost 15,000
Users (2011)	1.6 million
Spending (estimate 2014)	$52 billion
Non-Medicare margin (2013)	-1.9%
Total margin (2013)	1.9%

Data are preliminary and subject to change.

Subsiziding Medicaid through Medicare payments is poor policy

- Poor targeting of funds
- Could encourage states to lower their payments
- Diverts Medicare Trust Fund dollars to subsidize Medicaid and private payments