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 in 2014

- Providers: 15,000
- Beneficiary users: 1.7 million
- Medicare spending: $28.6 billion
- Medicare share: 12% of days
  21% 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: supply adequate and stable in 2014

Indicator	Change from 2013
▪ Supply	▪ Unchanged (about 15,000)
▪ Share of beneficiaries living in a county with multiple SNFs	▪ Unchanged (90% live in a county with 3+ SNFs)
▪ Occupancy rate	▪ Unchanged (86%) ▪ One quarter of SNFs have rates less than 76%

Data are preliminary and subject to change.

Decline in SNF use in 2014 consistent with reductions in inpatient hospital use

Indicator	Change from 2013
Admissions	Declined -1.4%
Days	Declined -1.5%
Length of stay	Unchanged

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Service mix reflects biases of the PPS design

% of days	2000	2013	2014
Intensive therapy	24	79	81
Moderate and low therapy	61	14	12
Medically complex	15	6	6

- Payments driven by amount of therapy furnished, not patient characteristics
- Therapy payments exceed therapy costs
- Payments for nontherapy ancillary services do not track these services' costs

Categories may not sum to 100% due to rounding.
Data are preliminary and subject to change.

SNF quality measures: Mixed performance

Risk-adjusted rate	2013	2014
Discharged to community	37.5%	37.6%
Potentially avoidable readmissions		
During the SNF stay	11.2	10.9*
Within 30 days after the SNF stay	5.5	5.6*
Change in function		
Improvement in 1+ mobility ADLs	43.7	43.5
No decline in mobility	87.2	87.1

** Difference in rates for 2013 and 2014 are statistically significant.*
Data are preliminary and subject to change.

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Access to capital is adequate

- Access to capital is adequate and expected to continue
- Some lending wariness about potential budget cuts, 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

- 2014 margin: 12.5 %
- 15th year of margins above 10%
- Margins vary 8-fold
  - 25th percentile: 2.4%
  - 75th percentile: 21.2%
  - Nonprofit: 3.9%
  - For-profit: 14.9%
- Marginal profit = 20%

Data are preliminary and subject to change.
Margins reflect the impact of the sequester.

High-margin SNFs pursue cost and revenue strategies

- Compared to low-margin SNFs, high-margin SNFs have:
  - 30% lower daily costs (after adjusting for wages and case-mix)
    - Higher average daily census
    - Longer lengths of stay
    - Lower routine and ancillary cost per day
  - 10% higher revenue per day
    - More intensive therapy days
    - Fewer medically complex days

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 rates
  - 4 publicly traded firms report FFS rates average 23% higher than MA/managed care rates
- Characteristics of MA and FFS SNF users do not explain these payment differences
- Publicly traded firms report seeking managed care business, suggesting the payments are attractive

Relatively efficient SNFs in 2014: relatively low cost and high quality

- 892 were relatively efficient (8%)
- Compared to the other SNFs, efficient SNFs had:
  - Standardized cost per day: 8% lower
  - Community discharge rates: 27% higher
  - Readmission rates: 16% lower
  - Were larger (120 versus 100 beds)
- Medicare margin: 20%

Data are preliminary and subject to change.

Projected 2016 Medicare margin

- Costs assumed to grow at market basket
- Revenues increased by market basket minus
  - Productivity and effect of sequester
  - For 2015, reduced payments to reflect changes in payments for bad debt
  - Forecast error correction in 2016

Data are preliminary and subject to change.

How should Medicare payments change for 2017?

- Broad circumstances have not changed
- PPS continues to favor therapy over medically complex care
- The level of Medicare's payments remains too high
- Wide variation in margins reflects patient selection, service provision, and cost control

Why revise the SNF PPS?

- Since recommendation in 2008, payments for therapy and NTA services are more inaccurate
  - Overpayments for therapy services are larger
  - Evidence of unnecessary therapy
  - Payments for NTA services are poorly targeted
- Large difference in Medicare margins partly reflects the systematic biases of the PPS that need to be corrected

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 have been above 10 percent since 2000. Medicare margin in 2014= 12. 5%
- Marginal profit in 2014= 20%
- Efficient providers (with relatively low cost and high quality) margin= 20%
- FFS payments are considerably higher than some MA/managed care payments

Lack of progress on changes to SNF PPS prompt considering an alternative approach

- Little movement from CMS and the Congress
- Last year, Commission expressed impatience
- Structure of our recommendation may contribute to the delays
  - Reform PPS first, then rebase level of payments to help protect low margin SNFs
- Alternative: Set small rebasing steps in motion while PPS is revised

Medicaid trends in nursing home use and spending

Number of facilities (2015)	Almost 15,000
Spending (estimate 2015)	$51 billion
Non-Medicare margin (2014)	-1.5%
Total margin (2014)	1.9%

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