Reforming Medicare's prospective payment system for skilled nursing facilities

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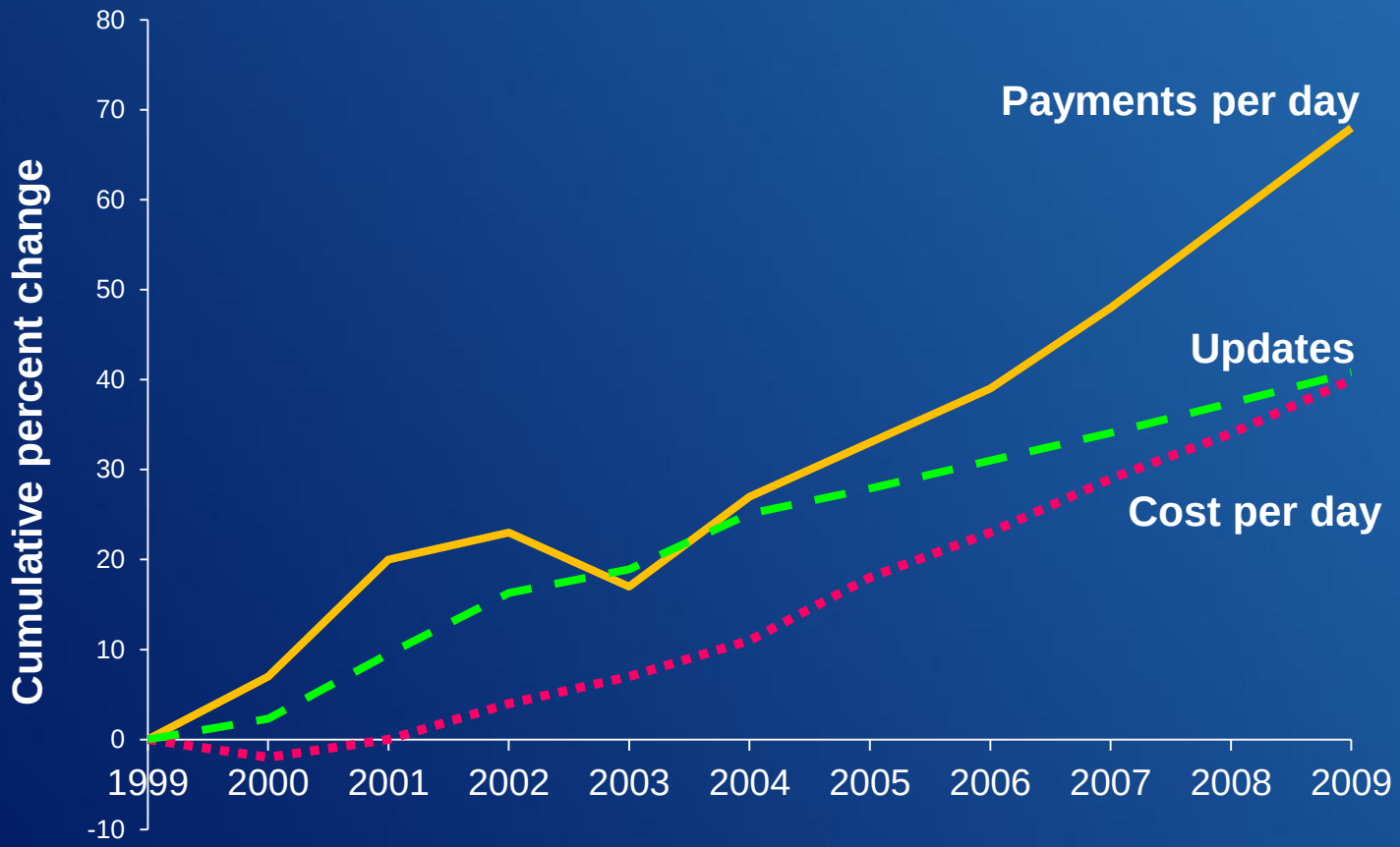
Why are reforms needed?

- Consistently high Medicare margins indicate payments are not aligned with costs
- No incentive to avoid unnecessary rehospitalizations and improve transition care

Medicare payments to SNFs need to be realigned with Medicare costs

- High margins since 2000
- Large variation in cost per day after adjusting for wages and case-mix
- Some providers have relatively low costs and relatively high quality, suggesting that payments can be lowered without compromising quality

Trends in Medicare payments to SNFs and SNF costs since 1999



Source: MedPAC analysis of freestanding SNF Medicare cost report data. Data are preliminary and subject to change.

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Medicare margins have been above 10 percent since 2000

Source: MedPAC analysis of freestanding SNF cost reports for 2009. Data are preliminary and subject to change.

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Cost growth between 1999 and 2009 not explained by service or patient mix

- Case-mix, wages, and beneficiary demographics do not explain differences in cost growth
- Cost managed by increasing length of stay, higher census, use of low-cost therapy modalities
- SNFs with highest cost growth had Medicare margins of over 14 percent
- In 2009, standardized costs vary 30 percent between 25th and 75th percentiles

Changes in revenue

- SNFs with highest growth in revenues had almost double the share of intensive therapy days, even though patient mixes were similar
- Changes in hospital lengths of stay and beneficiary frailty, age, and diagnoses were not commensurate with increases in therapy intensity
- Increased attention to the amount and timing of therapy provided

Efficient SNFs have relatively low costs, furnish relatively high quality, and have high margins

	Efficient SNFs (9%)	Other SNFs (91%)
Relative community discharge rate (2008)	1.29	0.97
Relative rehospitalization rate (2008)	0.84	1.02
Relative cost per day (2009)	0.91	1.01
Medicare margin (2009)	22.0%	18.3

Source: MedPAC analysis of freestanding 2009 SNF Medicare cost report data and 2008 DataPro data.

Medicare context for rebasing payments

- Recent payment reductions correct overpayments due to new case-mix system
- Freestanding SNFs with negative margins have standardized costs 30% above others
- Disparities in financial performance related to mix of patients would be narrowed with a revised PPS
- Rebasing should be accompanied with revising PPS

Estimated impacts of rebasing options with PPS revisions

Scenario	Medicare margin (%)	Percent change in payments
Actual	18.1%	na
5% reduction in payments	13.8	-5%
Payments set at 75th percentile cost per day	7.2	-12
Payments set at 70th percentile cost per day	4.8	-14

Source: MedPAC analysis of freestanding 2009 SNF Medicare cost report data. Data are preliminary and subject to change.

A revised PPS would shift payments across SNFs

SNF group	Percent change in payments
High share rehabilitation cases	-5%
Low share rehabilitation cases	13
High share intensive rehabilitation	-9
Low share intensive rehabilitation	26
High share special care cases	12
Low share special care cases	-4
Freestanding	-1
Hospital-based	27
Nonprofit	8
For profit	-2

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Source: Estimates from the Urban Institute of the impacts of a revised PPS. Data are preliminary and subject to change.

Policy option: Rebase SNF payments

- Rebase SNF payments to better align payments with the costs of an efficient provider AND
- Revise PPS to base therapy payments on patient and stay characteristics, establish a separate NTA component, and adopt an outlier policy

Discourage unnecessary rehospitalizations from SNFs

- Avoidable hospitalizations can result in poor quality of care and are costly
- SNFs have a financial incentive to rehospitalize high-cost beneficiaries
- High variation in risk-adjusted rates suggests opportunities to lower them
- Align hospital and SNF policies to improve transition care

Large variation in risk-adjusted rehospitalization rates

- Rates 60% higher at 75th percentile than at 25th percentile. Extremes varied almost 3-fold
- Hospital-based SNFs have rates half that of freestanding SNFs
- Facilities with high rates
  - Similar mix of medically complex days
  - Higher shares of dual-eligible beneficiaries
  - Disproportionately for-profit

Factors within a SNF's control that influence rehospitalization rates

- Transition care
- Drug mismanagement
- Hospice and advance directives
- Staffing and physician presence
- Financial incentive to rehospitalize
- Local practice patterns

A SNF rehospitalization policy

- Measure: potentially avoidable conditions
- Time period:
  - Initial: SNF stay
  - Future: SNF stay + 30 days after discharge
- Penalty:
  - Target above-average rates over 3 years
  - Mirror hospital policy (up to 3% of payments)
- Publicly report rates

Policy option: Rehospitalization policy for SNFs

- Reduce payments to SNFs with relatively high rehospitalization rates for select conditions
- Initial measure: risk-adjusted rates of potentially avoidable rehospitalizations during the SNF stay
- Expand measure to include 30 days after discharge from the SNF once a risk-adjusted measure is available

Discussion questions

- Do you have any questions about the rebasing and rehospitalization policies presented?
- Is there additional information you need to further develop these policies?
- Level of rebasing we should examine?