Assessing payment adequacy: Skilled nursing facilities

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Skilled nursing facilities: providers, users, and Medicare spending

- Providers: 15,161
- Beneficiary users: 1.7 million
- Medicare spending: $28 billion
- Medicare share: 12% of days
  23% of revenues

Payment adequacy framework

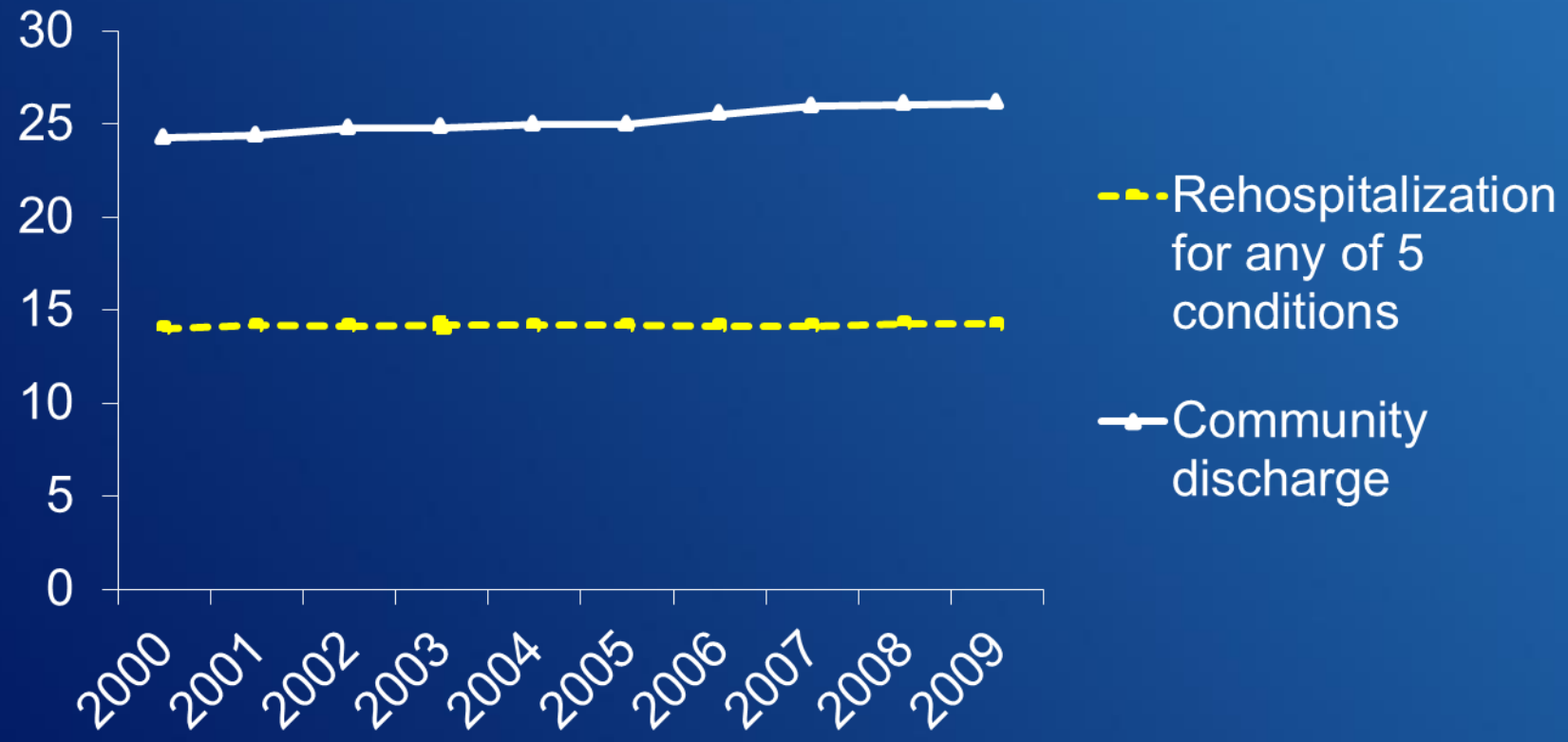
- Access
  - Supply of providers
  - Volume of services
- Quality
- Access to capital
- Payments and costs

Access indicators

Indicator	Change
Supply	2010: 15,207 2011: 15,161
Bed days available	No change 2009-2010
Occupancy rates	Stable at 88%
Covered admissions	-1.4 percent 2009-2010
Covered days	-1.3 percent

Data are preliminary and subject to change.

Quality measures show little improvement since 2000



Source: MedPAC analysis of DataPro data. Data are preliminary and subject to change.

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Access to capital

- Adequate this year.
- Lending and borrowing expected to be slow in 2012, reflecting state and Medicare uncertainties.
- Medicare shares used to gauge the financial health of facilities.

2010 freestanding aggregate SNF Medicare margins

SNF type	Medicare margin
All	18.5 %
Urban	18.5
Rural	18.4
25th percentile	9.4
75th percentile	26.6
For-profit	20.7
Nonprofit	9.5

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

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Relatively efficient providers have lower cost and higher quality

Compared to other SNFs, relatively efficient providers had:

- Costs per day: 10 percent lower
- Community discharge rates: 38 percent higher
- Rehospitalization rates: 17 percent lower

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

Rural SNF payment adequacy

Medicare margins			
Micro-politan	Adjacent to urban	Nonadjacent	Frontier
18.6%	18.4%	18.0%	15.2%

- Volume at rural facilities was not strongly related to Medicare margin.

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

Why rebase Medicare payments?

- Medicare margins above 10 percent since 2000
- Variation in Medicare margins are not explained by differences in patient mix
- Cost differences are unrelated to wage levels, case-mix, or beneficiary demographics

Why rebase Medicare payments? (continued)

- Relatively efficient providers show it is possible to have low costs and high quality
- Evidence that some MA payments are considerably lower than FFS payments
- Industry responded to the level of payments
  - Cost growth exceeded market basket every year since 2000
  - Revenues grew even when rates were lowered

Differences in Medicare margins highlight need to revise PPS

- Uneven financial performance partly reflects shortcomings of PPS
- Need to implement recommended changes to PPS
  - Establish a separate component for nontherapy ancillary services
  - Base therapy payments on care needs not service provision
  - Add an outlier policy

A budget-neutral revised PPS would shift payments across providers

SNF group	Percent change in payments
Intensive therapy days-- high share	-10%
Special care days-- high share	17
Freestanding	-1
Hospital-based	27
Nonprofit	8
For-profit	-2

Data are preliminary and subject to change.
Source: Impacts estimated by the Urban Institute 2011

Medicaid trends in nursing home use and spending

Number of facilities	15,000 (2011)
Days (000s)	252,090 (2010)
Spending	Almost $50 billion (2010)
Non-Medicare margin	-1.2 percent (2010)
Total margin	3.6 percent (2010)

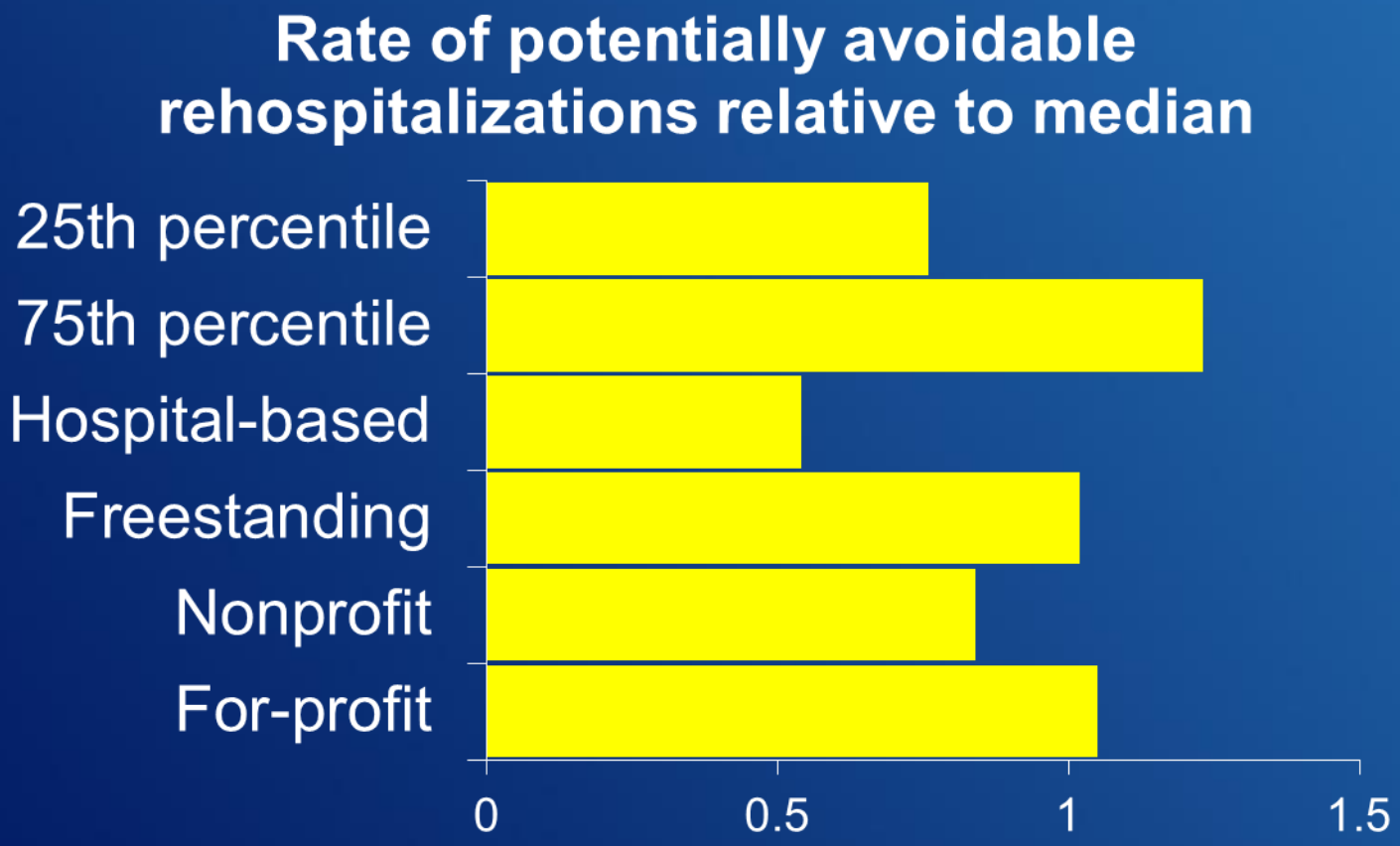
Subsiziding Medicaid through Medicare payments is poor policy

- Poor targeting of funds
  - Payments go to facilities with high Medicare days, not necessarily those with high Medicaid days
  - Subsidizes payments even in states with relatively high Medicaid payments.
- Could encourage states to lower their payments
- Payroll taxes that finance the Trust Fund subsidize low Medicaid payments

A policy to discourage unnecessary rehospitalizations from SNFs

- Avoidable rehospitalizations can result in poor quality of care and are costly
- Align hospital and SNF policies to improve transition care
- Some factors that influence rehospitalizations are within a provider's control; others are not

Widely varying risk-adjusted rates suggest opportunities to lower them



Source: MedPAC analysis of 2009 data from DataPro . Data are preliminary and subject to change.

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Design of a rehospitalization policy

Measure definition	• Potentially avoidable conditions • All cause
Time period	• Initial: SNF stay • Future: SNF stay + window after discharge
Penalty	• Based on rates, not individual stays • Rates over multiple years