Assessing payment adequacy: Skilled nursing facility services

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Roadmap

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

Skilled nursing facilities: providers, users, and Medicare spending

▪ Providers:	14,935
▪ Beneficiary users:	1.7 million
▪ Medicare spending	$32 billion
▪ Medicare share:	12% of days
	23% of revenues

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Payment adequacy framework

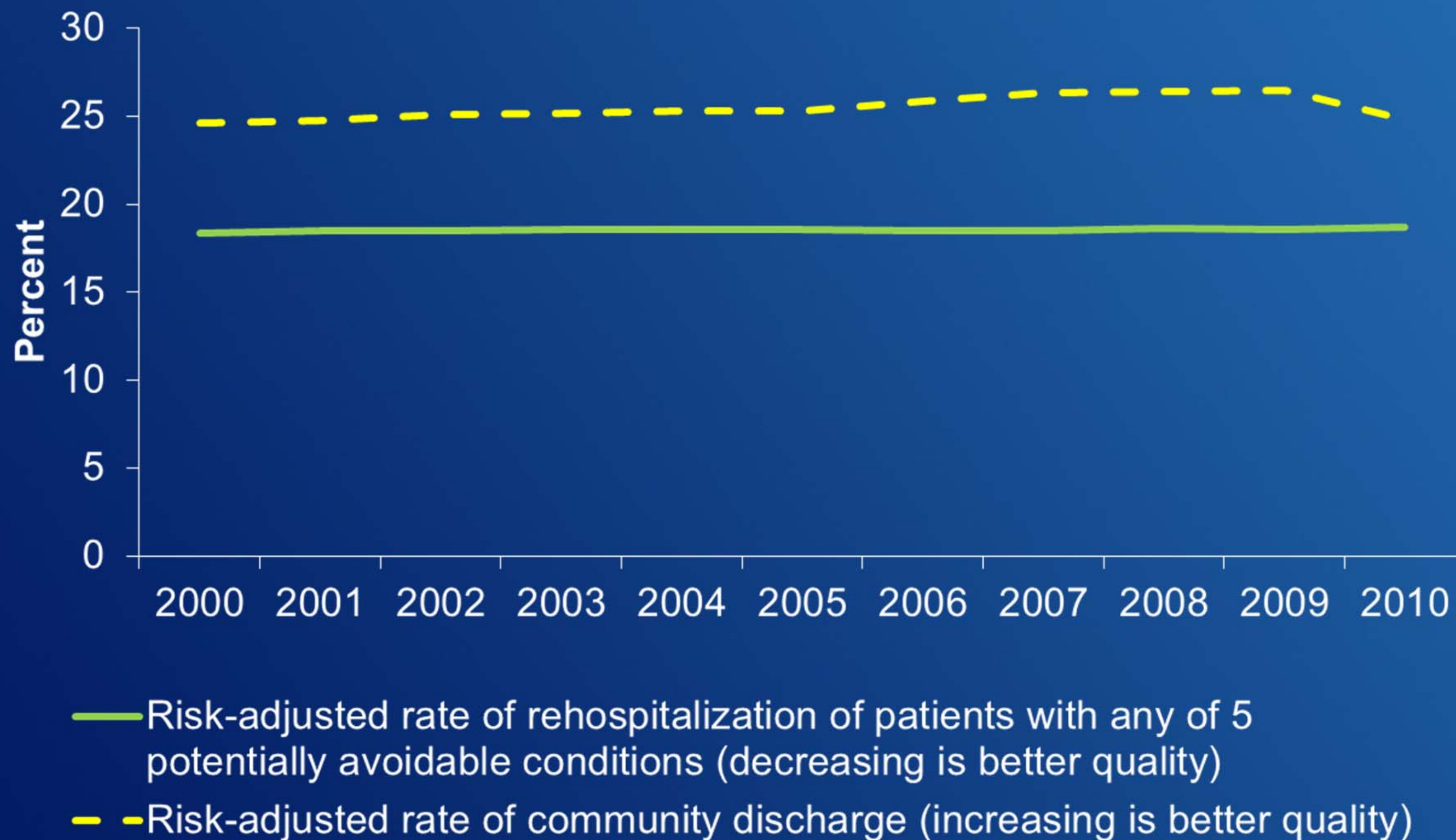
- Access
  - Supply of providers
  - Volume of services
- Quality
- Access to capital
- Payments and costs

Access: adequate and stable

Indicator	Change
Supply	Slight increase 2010- 2011
Admissions	Unchanged 2010-2011
Days	Unchanged 2010-2011
Bed days available	Unchanged 2009-2010
Occupancy rates	Unchanged 2009-2010

Data are preliminary and subject to change.

SNF quality shows little improvement over 10 years



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

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SNF rehospitalization policy

- Commission recommended a rehospitalization policy to align hospital and SNF incentives
- Measure should include rehospitalizations during and after a SNF stay
- Combined, during and after SNF stay, 28% of beneficiaries with any of 5 potentially avoidable conditions are rehospitalized

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Access to capital

- More lending in 2012 than 2011.
- HUD-financed projects increased 68 percent over 2011 and expected to maintain same level of activity for 2013.
- Non-HUD lending expected to keep pace with 2012 levels. Some uncertainties reflecting federal and state policies.
- Medicare shares are used to gauge the financial health of facilities.

Estimated freestanding SNF Medicare margins

- Estimated 2011: 22 to 24 percent
- In prior years, margins varied more than 3-fold
- Relatively efficient providers had lower costs per day and higher quality measures, and had high margins

Data are preliminary and subject to change.

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Last year's SNF recommendation (for FY 2013) had 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 of PPS
- Correct known shortcomings of PPS
  - Base therapy payments on care needs not service provision
  - Establish a separate component for nontherapy ancillary services
  - Add an outlier policy
- MedPAC recommendation in 2008

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A budget-neutral revised PPS would shift payments across providers

SNF group	Percent change in payments
Intensive therapy days—high share	-10%
Clinically complex/ special care—high share	17 to 18
Freestanding	-1
Hospital-based	27
For-profit	-2
Nonprofit	8

Source: Impacts relative to current policy estimated by the Urban Institute 2012

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Why rebase Medicare payments?

- Medicare margins above 10 percent since 2000
- Variation in Medicare margins is related to amount of therapy furnished not differences in patient mix
- Cost differences are unrelated to wage levels, case-mix, or beneficiary demographics

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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 2001
  - Revenues grew even when steps taken to lower payments.

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Medicaid trends in nursing home use and spending

Number of facilities (2012)	14,986
Users (2009)	1.6 million
Spending (estimate 2012)	$50.3 billion
Estimated non-Medicare margin (2011)	-1.2 to -3.2 percent
Estimated total margin (2011)	3.8 to 5.5 percent

Data are preliminary and subject to change.

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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 are diverted to subsidize Medicaid and private payments