Advising the Congress on Medicare issues

Post-acute care: Steps towards broad payment reforms

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The need for PAC reform

- Medicare has four separate payment systems for post-acute care (SNF, HHA, IRF and LTCH)
- PAC silos frequently provide similar services to similar patients, but payment can vary significantly
- SNF, IRF and home health have unique patient assessment tools; no required assessment tool for LTCH
- Each silo's tool uses different definitions, scales, time periods, and method of assessment

History of developing common assessment tool for Medicare post-acute care providers

- 1999 MedPAC recommended the Secretary collect a core set of patient information across settings
- 2005 DRA required the Secretary to conduct a demonstration to develop and test a common tool
- 2011 CMS reported on demonstration's findings, including common tool (CARE)

Demonstration results suggest the viability of common assessment approach

- Continuity Assessment Record and Evaluation (CARE) tool developed and tested for validity and inter-rater reliability
- CARE data could predict resource use (nursing and therapy)
- Limited differences in outcomes (changes in function and readmissions)

Key elements of a common PAC patient assessment tool

	Measure key to predicting:		
	Resource use	Change in function	Readmission
Age	X	X	X
Diagnoses & comorbidities	X	X	X
Functional status	X	X	X
Cognitive status	X	X	X
Special services (e.g. vent)	X	X	
Pressure ulcers (severe)	X	X	
Physical impairment (e.g. ability to see)	X	X	
Prior functioning before hospitalization		X	

Current CMS activities regarding the common assessment (CARE) tool

- Evaluate the use of CARE elements in PAC PPSs over next 2 years
- Develop CARE-based outcome measures for IRFs and LTCHs
- No timeframe for final implementation of a common tool

Benefits of a common patient assessment tool for PAC

- Better understanding of costs and outcomes across settings
- Improved information to guide PAC site selection for beneficiaries
- Prepare FFS for possible consolidation of some PAC silos

Chairman's draft recommendation

- The Congress should direct the Secretary to implement a common assessment tool for use in home health agencies, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term care hospitals by 2016.

Phased approach to implement a common assessment instrument

- Begin in 2016
  - A core set of items with others added over time
  - Append initial domains' questions to existing assessment tools (for HHAs, SNFs, and IRFs)
- In 2017
  - Use common assessment tool elements in existing PPSs for HHA, SNF, and IRF
  - Begin 3-year transition to use common tool

Implications

- Spending: May raise administrative costs for Medicare in the short term.
- Beneficiaries and providers: Beneficiaries will have better information about the quality of providers and to select the site of PAC. Providers will have better data to improve transition care, and tie outcomes to core processes. Providers may incur costs to implement tool and train staff.

Assessing payment adequacy and updating payments: 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: 15,000
- Beneficiary users: 1.7 million
- Medicare spending: $29 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: supply adequate and stable in 2012

Indicator	Change from 2011
Supply	Unchanged (15,000)
Share of beneficiaries living in a county with multiple SNFs	Unchanged (3/4 live in a county with 5+ SNFs)
Bed days available	Increased 1%
Occupancy rates	Unchanged (87%)

Data are preliminary and subject to change.

Decline in SNF use in 2012 parallels reductions in inpatient hospital use

Indicator	Change from 2011
▪ Admissions	Decreased 4.5%
▪ Days	Days decreased 3.8%
▪ Length of stay	Small increase 0.7%

Data are preliminary and subject to change.

Small improvement in rates of community discharge and potentially avoidable rehospitalizations

Risk-adjusted measure	2011	2012
Discharged to community	29%	30.8%
Potentially avoid. rehospitalizations		
During SNF stay	11.8	11.0
Within 30 days after discharge from SNF	5.5	5.4
Combined	14.7	14.0

Source: Analysis of MDS data conducted by Kramer et al.. 2014. Data are preliminary and subject to change.

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Functional status was maintained but not improved between 2011-2012

Risk-adjusted rate	2011	2012
Average share of stays with improvement across 3 mobility measures (bed mobility, transfer, and walking)	28.0%	28.2%
Share of stays with no declines in mobility	89.2	89.4

Source: Analysis of MDS data conducted by Kramer et al. 2014. Data are preliminary and subject to change.

Wide variation across SNFs in risk-adjusted quality measures

- Comparison of 25th and 75th percentiles

Risk-adjusted rate	25th	75th
Discharged to the community	23.5%	38.6%
Rehospitalized during SNF stay	7.7	13.9
Improved mobility	20.6	34.9

Data are preliminary and subject to change.

- Large opportunities to improve beneficiary care, realize program savings, and increase value of the program's purchases

Access to capital is adequate

- Access to capital is adequate and expected to continue
- Some lenders are reluctant due to uncertainties reflecting federal budget policies

Freestanding SNF Medicare margins

- 2012 margin: 13.8 percent
- 13th year of margins above 10 percent
- Margins vary 4-fold between 25th and 75th percentiles
  - 25th percentile: 4.8%
  - 75th percentile: 23%
- Projected 2014 margin : 12 percent

Data are preliminary and subject to change.

Relatively efficient SNFs: relatively low cost and high quality

- 11% of SNFs
- Compared to the average, efficient SNFs had:
  - Costs: 3% lower
  - Community discharge rates: 16% higher
  - Rehospitalization rates: 11% lower
- Medicare margin: 17%

Commission's 2012 SNF recommendation 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 recommended revising PPS in 2008

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

Why rebase Medicare payments?

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

How should payments change in 2015?

- Circumstances have not changed
- Re-run 2012 recommendation
  - 2015: No update while a revised PPS is implemented
  - 2016: Begin rebasing with a 4 percent reduction in payments

Medicaid trends in nursing home use and spending

Number of facilities (2013)	Almost 15,000
Users (2010)	1.5 million
Spending (estimate 2013)	$51 billion
Non-Medicare margin (2012)	-2.0%
Total margin (2012)	1.8%

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 Trust Fund dollars to subsidize Medicaid and private payments

Chairman's proposal: Re-run MedPAC's 2012 SNF update recommendation

The Congress should eliminate the market basket update and direct the Secretary to revise the prospective payment system for skilled nursing facilities for [2015]. Rebasing payments should begin in [2016], with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare's payments are better aligned with providers' costs.