
# Assessing payment adequacy and updating payments: Skilled nursing facility services

Carol Carter

December 18, 2014

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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

- Providers: 15,000
- Beneficiary users: 1.7 million
- Medicare spending: $29 billion
- Medicare share: 12% of days
  22% 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 2013

| Indicator | Change from 2012 |
|---|---|
| ▪ Supply | ▪ Unchanged (15,000) |
| ▪ Share of beneficiaries living in a county with multiple SNFs | ▪ Unchanged (3/4 live in a county with 5+ SNFs) |
| ▪ Occupancy rate | ▪ Small decrease (from 87% to 86% in 2013)<br>▪ One quarter of SNFs have rates less than 72% |



*Data are preliminary and subject to change.*

# Decline in SNF use in 2013 consistent with reductions in inpatient hospital use

| Indicator | Change from 2012 |
| --- | --- |
| Admissions | Decreased 2.2% |
| Days | Decreased 1.4% |
| Length of stay | Small increase 2.2% |

*Data are preliminary and subject to change.*

# Service use reflects shortcomings of the PPS design

| % of days | 2002 | 2011 | 2013 |
|---|---|---|---|
| Any therapy | 78% | 92% | 93% |
| Intensive therapy | 29 | 74 | 79 |
| Medically complex | 15 | 7 | 6 |

- Amount of therapy drives therapy payments
- Therapy payments exceed therapy costs
- Payments for nontherapy ancillary services are not based on these services' costs or patient characteristics

*Data are preliminary and subject to change.*

# Small improvement in rates of community discharge and potentially avoidable rehospitalizations

| Risk-adjusted measure | 2012 | 2013 |
|---|---|---|
| Discharged to community | 35.6% | 37.5% |
| Potentially avoidable rehospitalizations: | | |
| During SNF stay | 11.5 | 11.1 |
| Within 30 days after discharge from SNF | 5.6 | 5.5 |
| Combined | 15.5 | 15.1 |

*Source: Analysis of MDS data conducted by Kramer et al.. 2015. Data are preliminary and subject to change.*

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# Essentially no change in functional status between 2012-2013

| Risk-adjusted rate | 2012 | 2013 |
|---|---|---|
| Percent of stays with improvement across 3 mobility measures | 43.6% | 43.7% |
| Percent of stays with no declines in mobility | 87.2 | 87.2 |

*Source: Analysis of MDS data conducted by Kramer et al. 2015. Data are preliminary and subject to change.*

# Wide variation in risk-adjusted quality measures indicate opportunities to improve

| Risk-adjusted rate | 25th | 75th |
|---|---|---|
| Discharged to the community | 29.2% | 46.6% |
| Rehospitalized during SNF stay | 8.0 | 13.9 |
| Rehospitalized within 30 days of discharge from SNF | 3.4 | 7.2 |
| Improved mobility | 35.6 | 52.5 |

*Source: Analysis of MDS data conducted by Kramer et al. 2015. Data are preliminary and subject to change.*

# Access to capital is adequate

- Access to capital is adequate and expected to continue
- Some lenders are reluctant due to uncertainties about 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

- 2013 margin:  13.1 percent
- 14th year of margins above 10 percent
- Margins vary 6-fold
  - 25th percentile: 3.7%
  - 75th percentile: 21.7%
- High-margin facilities have lower standardized costs per day and higher payments per day

*Data are preliminary and subject to change.*

# Relatively efficient SNFs in 2013: relatively low cost and high quality

- 524 were relatively efficient (7% of SNFs in the analysis)
- Compared to the average, efficient SNFs had:
  - Costs:  7% lower
  - Community discharge rates:  20% higher
  - Rehospitalization rates: 18% lower
- Medicare margin: 20.6%

*Data are preliminary and subject to change.*

# Previous Commission recommendation has 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 and biases of PPS
- Payments for therapy and NTA services have gotten more inaccurate since 2006
  - Overpayments for therapy services are larger
  - Payments for NTA services are unrelated to their costs
- Longstanding recommendation to revise PPS

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

# Medicaid trends in nursing home use and spending

| | |
|---|---|
| Number of facilities (2014) | Almost 15,000 |
| Users (2011) | 1.6 million |
| Spending (estimate 2014) | $52 billion |
| Non-Medicare margin (2013) | -1.9% |
| Total margin (2013) | 1.9% |

*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 Medicare Trust Fund dollars to subsidize Medicaid and private payments