Increasing the equity of Medicare's payments within each post-acute care setting; and Assessing payment adequacy and updating payments for skilled nursing facilities

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Concerns about Medicare's current post-acute care payment systems

- Similar patients are treated in 4 PAC settings
  - Separate payment systems establish different payments for similar patients
- Lack of evidence-based guidelines to base decisions about PAC
- Current PPSs encourage providers to:
  - Furnish therapy services unrelated to care needs
  - Avoid medically complex patients
- Provider financial performance varies widely

An approach to increase the equity of payments within each setting

- A fully implemented PAC PPS would redistribute payments across conditions
- Prior to implementing the PAC PPS, use a blend of the setting-specific and unified PAC PPS relative weights to establish payments
- Within each setting, payments would be redistributed across conditions
- Total payments to each setting would remain at recommended level

Redistribute payments within each setting by blending current and PAC PPS relative weights

Implementation period	HHA	SNF	IRF	LTCH
Blend setting-specific and unified PAC PPS relative weights (2019 and 2020)	*Redistribute payments within setting*	*Redistribute payments within setting*	*Redistribute payments within setting*	*Redistribute payments within setting*
Transition to a unified PAC PPS (begins 2021)	*Redistribute payments across settings*			

Within each setting, blending relative weights would shift payments across conditions and providers

- Payments would shift across conditions
- Based on patient mix and therapy practices, payments would:
  - Increase to nonprofit and hospital-based providers
  - Decrease to for-profit and freestanding providers
- At current levels, aggregate payments to a setting remain well above the cost of care

Conclusions

- Possible to increase the equity of payments within each setting before implementing a unified PAC PPS
- Redistribution would begin to:
  - Correct the known biases of current PPSs
  - Increase the equity of payments across conditions
  - Give providers more time to adjust to changes needed to be successful under PAC PPS
  - Support recommendations that better align payments to the cost of care

Assessing payment adequacy and updating payments: Skilled nursing facility services

MEDPAC

Overview of the SNF industry in 2016

▪ Providers:	~15,000
▪ Beneficiary users:	1.6 million
▪ Medicare spending:	$29.1 billion
▪ Medicare FFS share:	11% of days
	20% of revenues

Data are preliminary and subject to change.

Payment adequacy framework

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

Access is adequate (2016 data)

- Provider supply is steady (about 15,000)
- 89% of beneficiaries live in a county with 3+ SNFs
- Occupancy rates remained high (85%, small decline from 2015)
- Service use declined from 2015
  - Admissions decreased 3.6%
  - Length of stay decreased 4.0%
  - Days decreased 6.5%

Data are preliminary and subject to change.

Service mix reflects biases of the PPS design

Share of days assigned to intensive therapy case-mix groups		
2002	2010	2016
27%	69%	83%

- Payments driven by amount of therapy furnished
- Payments for therapy exceed the cost of these services

Data are preliminary and subject to change.

SNF quality measures: Mixed performance

Risk-adjusted rate	2015	2016
Discharged to community	38.7%	39.5%
Potentially avoidable readmissions		
During the SNF stay	10.4	10.8
Within 30 days after the SNF stay	5.0	5.8
Change in function		
Improvement in 1+ mobility ADLs*	43.6	43.6
No decline in mobility	87.1	87.1

**Activity of daily living*
Data are preliminary and subject to change.

Access to capital is adequate

- Access to capital is adequate and expected to remain so
- Buyer demand remains strong
- Some lending wariness reflects lower SNF use and investigations into therapy use
- Medicare continues to be a payer of choice

Freestanding SNF Medicare margins in 2016

- Medicare margin: 11.4 %
- 17th year of margins above 10%
- Variation in Medicare margins
  - 25th percentile: 0.7%
  - 75th percentile: 20.2%
  - Nonprofit: 2.3%
  - For-profit: 14.0%
- Marginal profit = 19.6%

Data are preliminary and subject to change.

Relatively efficient SNFs in 2016: relatively low cost and high quality

- 970 SNFs (8%) met cost and quality criteria
- Efficient SNFs compared to other SNFs:
  - Community discharge rates: 26% higher
  - Readmission rates: 17% lower
  - Higher daily census (99 versus 81)
  - Standardized cost per day: 8% lower
  - Medicare payment per day: 10% higher
- Medicare margin: 18.2%

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Medicare FFS rates are considerably higher than MA/managed care rates

- FFS per diem payment rates are higher than MA/managed care payment rates
- Characteristics of MA and FFS SNF users do not explain these payment differences
- Publicly traded companies report seeking managed care business, suggesting the payments are attractive

Projected 2018 Medicare margin

- Costs increased by market basket
  - Included costs to meet nursing home regulations
- Revenues increased by market basket minus
  - Productivity
  - Portion of value-based purchasing retained as savings

Data are preliminary and subject to change.

How should Medicare payments change for 2019?

- Broad circumstances have not changed
- The level of Medicare's payments remains too high
- The PPS needs to be revised
- Wide variation in margins reflects differences in patient selection, service provision, and cost control