

CHAPTER

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**Skilled nursing facility services**

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**R E C O M M E N D A T I O N S**

**8-1** The Secretary should proceed to revise the skilled nursing facility prospective payment system in fiscal year 2020 and should annually recalibrate the relative weights of the case-mix groups to maintain alignment of payments and costs.

**COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0**

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**8-2** The Congress should eliminate the fiscal year 2020 update to the Medicare base payment rates for skilled nursing facilities.

**COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0**

# Skilled nursing facility services

## Chapter summary

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2018, about 15,000 SNFs furnished 2.3 million Medicare-covered stays to 1.6 million fee-for-service (FFS) beneficiaries. Medicare FFS spending on SNF services was \$28.4 billion in 2017, about 1 percent less than in 2016. Just over 4 percent of beneficiaries used SNF services.

## Assessment of payment adequacy

To examine the adequacy of Medicare’s payments, we analyze beneficiaries’ access to care (including the supply of providers and volume of services), quality of care, provider access to capital, and Medicare payments in relation to providers’ costs to treat Medicare FFS beneficiaries. Most indicators of the adequacy of Medicare’s payments are positive.

**Beneficiaries’ access to care**—Access to SNF services remains adequate for most beneficiaries.

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program has been stable. The vast majority (89 percent) of beneficiaries live in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds), and less than 1 percent live in a county without one.

## In this chapter

- Are Medicare payments adequate in 2019?
- How should Medicare payments change in 2020?
- Medicaid trends

Between 2016 and 2017, the median occupancy rate declined slightly but remained high (about 85 percent).

- ***Volume of services***—Medicare-covered admissions per FFS beneficiary decreased 2 percent between 2016 and 2017, consistent with a decrease in the number of admissions for hospital stays that last at least three days (required for Medicare coverage). Lengths of stay also declined by 2 percent. Both contributed to fewer covered days in 2017 compared with 2016. Lower SNF use reflects the growing presence of alternative payment models, not the adequacy of Medicare’s payments.
- ***Marginal profit***—An indicator of whether freestanding SNFs have an incentive to treat more Medicare beneficiaries—marginal profit—averaged 19.1 percent for freestanding facilities in 2017.

***Quality of care***—Since 2011, SNF quality measures have shown mixed performance. The average rate of discharge to the community increased and the average rate of readmission during the SNF stay improved, the average rate of readmissions after the SNF stay worsened, and the measures of mobility remained the same. Changes in the measures between 2016 and 2017 were similarly mixed.

***Providers’ access to capital***—Because most SNFs are part of nursing homes, we examine nursing homes’ access to capital. Despite relatively low total margins (a measure of the total financial performance across all payers and lines of business), lending and investment activities remain robust. Access to capital was adequate in 2018 and is expected to remain so in 2019. Lending wariness reflects broad changes in post-acute care, not the adequacy of Medicare’s payments. Medicare is regarded as a preferred payer of SNF services.

***Medicare payments and providers’ costs***—Medicare’s spending in 2017 decreased 1 percent to \$28.4 billion. In 2017, the average Medicare margin for freestanding SNFs was 11.2 percent—the 18th year in a row that the average was above 10 percent. Margins varied greatly across facilities, reflecting differences in costs and shortcomings in the SNF prospective payment system (PPS) that favor treating rehabilitation patients over medically complex patients.

Revisions to the PPS are still needed to improve the accuracy and equity of Medicare’s payments across different types of patients. CMS plans to revise the SNF PPS beginning in fiscal year 2020. The redesign will increase payments for medically complex patients and patients with high costs for nontherapy ancillary items (such as drugs), consistent with the Commission’s previously recommended designs for the SNF PPS and a unified post-acute care PPS.

The Commission recommends that the Secretary proceed with revising the SNF PPS and annually recalibrate the relative weights of the case-mix groups to keep payments aligned with the costs of care. The implementation of a revised SNF PPS will increase the equity of Medicare's payments across different conditions and narrow the disparities in financial performance across SNFs. The redesigned PPS is likely to alter the mix of cases treated in SNFs, providers' cost structures, and the relative costs of different types of stays. To keep costs and payments aligned across types of cases, CMS will need to regularly recalibrate the relative weights of the new case-mix groups.

The level of payments continues to be well above the cost to treat Medicare beneficiaries. Several factors indicate that the aggregate level of Medicare's payments remains too high. First, since 2000, the average Medicare margin has been above 10 percent; the marginal profit in 2017 was even higher (19 percent), suggesting that facilities with available beds have an incentive to admit Medicare patients. Medicare Advantage (managed care) payment rates to SNFs, considered attractive by many SNFs, are considerably lower than the program's FFS payments. The small differences between beneficiaries enrolled in Medicare Advantage and FFS who used SNF services in 2017 would not explain the large difference in payments. Costs varied widely for reasons unrelated to case mix and wages. The very high Medicare margin (18 percent) for efficient SNFs—those providers with relatively low costs and high quality—is further evidence that Medicare continues to overpay for SNF care.

Considering these factors, the Commission recommends that the Congress eliminate the fiscal year 2020 update to the Medicare base rates. While the level of payments indicates a reduction to payments is needed to more closely align aggregate payments and costs, the SNF industry is likely to undergo considerable changes as it adjusts to the redesigned PPS. Given the impending changes, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with cost while exerting pressure on providers to keep their cost growth low.

## **Medicaid trends**

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins. Medicaid finances most long-term care services provided in nursing homes, but also covers the copayments on SNF care for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities has declined slightly since 2013,

by less than 1 percent, but remains close to 15,000. CMS reports total FFS spending on nursing home services declined 1.6 percent between 2016 and 2017 but projects small increases for 2019.

In 2017, the average total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as hospice, ancillary services, home health care, and investment income)—was 0.5 percent, down from 2016 (0.7 percent). The average non-Medicare margin (which includes all payers and all lines of business except Medicare FFS SNF services) was -2.4 percent, the same as in 2016. ■

## Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include beneficiaries recovering from surgical procedures such as hip and knee replacements or from medical conditions such as stroke and pneumonia. In 2017, almost 1.6 million fee-for-service (FFS) beneficiaries (4.2 percent of Part A FFS beneficiaries) used SNF services at least once; program spending on SNF services was \$28.4 billion (about 7 percent of FFS spending) (Boards of Trustees 2018, Office of the Actuary 2018b). Medicare’s median payment per day was \$480, and its median payment per stay was \$18,121.<sup>1</sup> In 2016, about one-fifth of hospitalized beneficiaries were discharged to SNFs.

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least 3 days.<sup>2</sup> For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of the spell of illness. Beginning with day 21, beneficiaries are responsible for copayments for day 21 through day 100 of the covered stay. For fiscal year 2019, the copayment is \$170.50 per day.

The term *skilled nursing facility* refers to a provider that meets Medicare requirements for Part A coverage.<sup>3</sup> Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes (which typically provide less intensive, long-term care services). Thus, a facility that provides skilled care often also provides long-term care services that Medicare does not cover. Medicaid pays for the majority of nursing facility days.

The mix of facilities where beneficiaries receive skilled nursing care has shifted over time toward freestanding and for-profit facilities. In 2017, almost all facilities were freestanding (96 percent), and they accounted for an even larger share of revenue (97 percent; Table 8-1) than other types of facilities. Hospital-based SNFs made up a small share (4 percent or less) of facilities, stays, and spending. For-profit facilities accounted for 71 percent of all SNFs and 75 percent of revenues.

Medicare FFS–covered SNF days typically account for a small share of a facility’s total patient days but a disproportionately larger share of the facility’s revenues. In freestanding facilities in 2017, Medicare FFS beneficiary stays constituted 11 percent of total facility days but accounted for 19 percent of facility revenue, a decline from 2010 when FFS Medicare accounted for 23 percent of facility revenue (data not shown). The decrease in the FFS Medicare share of revenues reflects the growth in Medicare Advantage (MA) enrollment.

**TABLE  
8-1**

**Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, Medicare stays, and Medicare spending, 2017**

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total number	15,090	2,266,301	\$25.9 billion
Freestanding	96%	96%	97%
Hospital based	4	4	3
Urban	73	83	85
Rural	27	17	15
For profit	71	71	75
Nonprofit	23	24	21
Government	6	4	4

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding and missing values. The spending amount included here is lower than that reported by the Office of the Actuary, and the count of SNFs is slightly lower than what is reported in CMS’s Survey and Certification Providing Data Quickly system.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2017.

The most common hospital conditions of patients referred to SNFs for post-acute care are septicemia, joint replacement, heart failure and shock, hip and femur procedures (except major joint replacement), kidney and urinary tract infections, chronic obstructive pulmonary disease, renal failure, and pneumonia. In 2017, the top 10 diagnoses accounted for 43 percent of all SNF stays. Compared with other beneficiaries, SNF users are older; more frail; and disproportionately female, disabled, living in an institution, and dually eligible for Medicare and Medicaid (Medicare Payment Advisory Commission 2013).

### **SNF prospective payment system and its shortcomings**

Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.<sup>4</sup> Information gathered from a standardized patient assessment instrument—the Minimum Data Set—is used to classify patients into case-mix categories called resource utilization groups (RUGs).<sup>5</sup> Although the payment system is referred to as “prospective,” two features undermine how prospective it is: The system makes payments for each day of care (rather than a set payment for the entire stay), and it bases payments partly on the minutes of rehabilitation therapy furnished to a patient. Both features result in providers having some control over how much Medicare will pay them for their services.

Almost since its inception, the SNF PPS was criticized for encouraging the provision of excessive rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) items such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002). Over time, the accuracy of Medicare’s payments has steadily eroded: Payments for NTA services are unrelated to the cost of SNF care, and therapy payments have become less and less proportional to the costs of therapy services.<sup>6</sup> As a result, the PPS continues to advantage providers that furnish therapy services unrelated to a patient’s condition and avoid patients with high NTA costs (Medicare Payment Advisory Commission and The Urban Institute 2015). The Office of Inspector General (OIG) of the Department of Health and Human Services found that the profitability of therapy services increased as the amount of therapy provided per day increased (Office of Inspector General 2015).

In 2008, the Commission recommended revising the PPS to base therapy payments on patient characteristics

(not service provision); remove payments for NTA services from the nursing component; establish a separate component within the PPS that adjusts payments for NTA services; and implement an outlier payment policy (Medicare Payment Advisory Commission 2008). The Commission’s recommended revisions to the PPS would increase the equity of Medicare’s payments and result in considerable redistribution of payments, raising payments for medically complex patients and decreasing them for patients who receive intensive rehabilitation therapy that appears unrelated to their clinical conditions (Medicare Payment Advisory Commission and The Urban Institute 2015).<sup>7</sup> The revisions should increase access for patients requiring complex medical care or costly drugs. Based on the mix of patients and therapy practices, payments would increase for hospital-based facilities and nonprofit facilities and would decrease for freestanding facilities and for-profit facilities. The effects on individual facilities would depend on their mix of patients and current therapy practices.

Each year since 2008, the Commission has urged CMS to move forward with the much-needed reform and, since 2012, recommended revising and rebasing the SNF PPS to address both the distribution and level of payments (Medicare Payment Advisory Commission 2012). The Commission was not alone in calling for an overhaul of the SNF PPS. OIG recommended that CMS evaluate the extent to which therapy payments should be reduced, change the method for paying for therapy, adjust Medicare payments based on patient characteristics (not the amount of therapy furnished), and strengthen the oversight of SNF billing (Office of Inspector General 2015).

### **CMS plans to revise the SNF PPS beginning October 1, 2019**

CMS’s work on alternative designs for the SNF PPS began 13 years ago in response to a legislative requirement (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) to conduct research on potential refinements of the SNF PPS (Liu et al. 2007, Maxwell et al. 2003, Urban Institute 2004). In 2017, CMS issued an advanced notice of proposed rulemaking and sought comments on a redesign of the SNF PPS that it planned to implement in fiscal year 2019 (Centers for Medicare & Medicaid Services 2017). Considering stakeholder comments, CMS revised the design and delayed implementation until fiscal year 2020 (Centers for Medicare & Medicaid Services 2018b).

Consistent with the Commission’s recommended design for the SNF PPS, CMS’s patient-driven payment model will base payments on patient characteristics, not the amount of therapy services furnished to patients. There will be five components—nursing, physical and occupational therapy, speech–language pathology, NTA, and room and board—that will be summed to establish a daily payment. Except for the room and board component (which is uniform for every day of care), each component will have its own case-mix factors in which clinical characteristics play a considerably larger role compared with the current design. To reflect the declining average daily costs for physical and occupational therapy and NTA services over the course of a stay, the daily payments for these components will be lower for days later in the stay. So that individual therapy remains the dominant modality, group and concurrent therapy cannot make up more than 25 percent of total therapy minutes. Given the clinical focus of the redesign, SNFs are likely to evaluate the clinical and coding expertise of its staff and the presence of physicians and medical directors and to reassess their contracts with therapy vendors.

CMS estimates that the design will redistribute payments from patients assigned to the highest rehabilitation case-mix groups to medical patients, patients with high NTA costs, and patients requiring tracheostomy or ventilator services (Centers for Medicare & Medicaid Services 2018b). This redistribution is consistent with the Commission’s recommended designs for the SNF PPS and a unified post-acute care (PAC) PPS. CMS noted that the redesigned SNF PPS will bring the payment system closer to an eventual transition to a unified PAC PPS (Centers for Medicare & Medicaid Services 2018b). Although intended to be budget neutral, provider responses to the new PPS, including changes in the recording of patient diagnoses, will shape how spending will change. Because case mix, service provision, and cost structures are likely to change for many SNFs, CMS may need to recalibrate the relative weights of the case-mix groups to keep payments aligned with the cost of care.

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## **Are Medicare payments adequate in 2019?**

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To examine the adequacy of Medicare’s FFS payments, we analyze beneficiaries’ access to care (including the supply of providers and volume of services), quality of

care, providers’ access to capital, Medicare FFS payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compare the performance of SNFs that have relatively high Medicare margins and those with low Medicare margins, and we compare relatively efficient SNFs with other SNFs.

### **Beneficiaries’ access to care: Access is stable for most beneficiaries**

We do not have direct measures of access in part because the need for SNF care, as opposed to the need for a different PAC service or none at all, is not well defined. Instead, we consider the supply and capacity of providers and evaluate changes in service volume. We also assess whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve.

The number of SNFs participating in the Medicare program in 2018 was stable at 15,326 (Centers for Medicare & Medicaid Services 2018a). There was a handful of new facilities (73, the majority of which were for profit) and a number of terminations. There have been 69 terminations as of November 2018, most of which were at the facilities’ initiative. This number is greater than at the same point in 2017, when there were 51 terminations.

The SNF industry is highly fragmented and characterized by independent providers and local and regional chains. Of the 50 largest operators, most are privately held. The 25 largest nursing home chains in the country operate 19 percent of all facilities (IQVIA Institute for Human Data Science 2018). Single operators make up about 40 percent of the industry, small (often regional or religious) operators make up about one-quarter of facilities, with the remaining third run by large chains (Ritchie and Johnson 2017). The share of hospitals with financial links to SNFs has slowly increased as alternative payment models encourage hospitals to lower spending and improve clinical outcomes for services furnished in post-acute care. In 2015, 18 percent of hospitals had a financial link to a SNF, up from 11 percent in 2005 (Fowler et al. 2017). One study found that the integration of hospitals and SNFs increases Medicare payments for the hospital and PAC stays (combined) by extending the lengths of the SNF stays but also lowers rehospitalization rates (Konetzka et al. 2016).

In 2017, 89 percent of beneficiaries lived in counties with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds). Less than 1 percent of beneficiaries lived in a

**TABLE  
8-2**

**SNF admissions and days continued to decline in 2017**

Volume measure	2010	2013	2016	2017	Percent change 2016-2017	Percent change 2010-2017
Covered admissions per 1,000 FFS beneficiaries	73.0	69.3	65.9	64.6	-2.0%	-11.5%
Covered days per 1,000 FFS beneficiaries	1,972	1,872	1,693	1,623	-4.1	-17.7
Covered days per admission	27.1	27.0	25.7	25.1	-2.3	-7.4

Note: SNF (skilled nursing facility), FFS (fee-for-service). "FFS beneficiaries" includes users and non-users of SNF services. Data include 50 states and the District of Columbia.

Source: Centers for Medicare & Medicaid Services 2018c.

county without a SNF or swing bed facility, and another 11 percent lived in counties with one or two SNFs or swing bed facilities.

Between 2016 and 2017, median occupancy rates for freestanding SNFs declined slightly but remained high (84.7 percent). The lower occupancy rates reflect shorter stays and fewer admissions. Occupancy rates at hospital-based facilities were slightly lower (80.4 percent). There is wide variation in occupancy rates. In 2017, one-quarter of freestanding facilities had occupancy rates at or below 73 percent while another quarter had rates 91 percent or higher. This variation indicates that some markets have the capacity to accommodate more admissions while other markets do not. The median occupancy rates for freestanding SNFs in rural areas and those in frontier locations were lower than the average (77 percent and 71 percent, respectively).

**Between 2016 and 2017, SNF admissions decreased and stays shortened**

In 2017, 4.2 percent of FFS beneficiaries used SNF services, the same share as in 2016. Between 2016 and 2017, SNF admissions per 1,000 FFS beneficiaries decreased 2 percent (Table 8-2) (Centers for Medicare & Medicaid Services 2018c). We examine service use for only FFS beneficiaries because the CMS data on users, days, and admissions do not include service use by beneficiaries enrolled in Medicare Advantage (MA) plans. Covered days per 1,000 FFS beneficiaries in 2017 declined 2.3 percent to 25.1 days. The combination of fewer admissions and shorter stays resulted in 4.1 percent fewer days per 1,000 beneficiaries. Since 2010, SNF

use by FFS beneficiaries declined over 11 percent, and covered days per admission decreased almost 18 percent.

The declines in SNF use reflects several trends, including a growing presence of alternative payment models such as accountable care organizations (ACOs) and bundled payments that result in fewer beneficiaries referred to SNF care and shortened stays (Colla et al. 2016, Dummit et al. 2016, McWilliams et al. 2017). Two studies of CMS's mandatory bundling initiative found participating hospitals had lower use of institutional PAC but similar quality outcomes (Dummit et al. 2018, Finkelstein et al. 2018). The use of a narrower network of preferred SNFs has also resulted in shorter SNF stays (Dummit et al. 2018, Huckfeldt et al. 2018). Hospitals participating in the Comprehensive Care for Joint Replacement payment model have adopted several strategies that could enhance the care beneficiaries receive, including improved patient education; dedicated staff for coordinating care among the hospital, physicians, and PAC providers; earlier initiation of discharge planning; and wider use of standardized patient protocols (Dummit et al. 2018).

Some SNFs report negative experiences of pressure from ACOs and managed care organizations to shorten SNF stays. A study of 25 SNFs participating in managed care and ACOs reported increased paperwork and time spent negotiating longer stays for patients, instances of declining to admit patients who were likely to require long stays, and one instance of switching the attending physician to remove the patient from an ACO (Tyler et al. 2018). A survey of chief financial officers reported cumbersome processes that they said made it more difficult for patients to receive the care they needed (Ziegler 2018).

The decline in SNF admissions is also tied to the small decline in FFS per capita inpatient hospital stays that were three days or longer and therefore qualified beneficiaries for Medicare coverage of SNF care. Although total per capita inpatient admissions increased, hospital admissions for stays of at least three days decreased 0.6 percent. The expanded use of observation stays (during which a patient is observed and treated but not admitted to the hospital) by hospitals is another contributing factor to lower SNF use (Mendelson et al. 2018). Because a three-day hospital stay is required for Medicare coverage, some beneficiaries not meeting this requirement may continue to receive care that is not covered by Medicare or be discharged home.

### **Service mix reflects biases in PPS design**

Since the PPS was implemented, providers have responded to the incentives to furnish enough therapy to classify days into rehabilitation case-mix groups and, within those groups, into the highest payment groups. Between 2002 and 2017, the share of days classified into rehabilitation case-mix groups in freestanding facilities increased from 78 percent to 95 percent; days assigned to special care, clinically complex, and extensive services made up the other 5 percent of days. During the same period, the share of intensive therapy days (days assigned to the ultra-high and very high groups) as a share of total days rose from 27 percent to 83 percent. The share of days assigned to the highest rehabilitation case-mix groups (the ultra-high group) increased from 7 percent to 58 percent.

Changes in the frailty of beneficiaries at admission to a SNF do not explain the increases in therapy. Between 2012 and 2017, the average SNF user was the same age and had the same average risk score but by 2017 was slightly less able to perform activities of daily living (ADLs). The average Barthel index, a composite measure of a person's disability, was 5 percent lower, indicating less ability to perform ADLs. For the 10 ADLs we examined, the shares of SNF users requiring the most help decreased for 7 activities, remained the same for 1 activity, and increased for 2 activities.<sup>8</sup> Yet during this period, the amount of intensive therapy furnished to beneficiaries increased 15 percent. OIG found that SNFs had increased their billing for the highest levels of therapy even though beneficiary characteristics—including age and the reasons for and severity levels of the preceding hospital stay—remained unchanged (Office of Inspector General 2015). A study examining whether additional therapy improved patient outcomes (in this case, the likelihood of being discharged

home) focused on beneficiaries between 2000 and 2009 who were recovering from hip fracture (Jung et al. 2016). It found that patients with more therapy were more likely to be discharged home, but the benefit of additional therapy decreased as the therapy intensity increased, and there was no additional benefit for patients in the highest case-mix groups. The large growth in days assigned to the intensive therapy group raises the question of the value of these additional therapy services.

Facilities differed in the amount of intensive therapy they provided, though the differences by provider type and ownership have narrowed over time as all providers assigned a larger share of days to intensive rehabilitation case-mix groups. In 2017, there was a 16 percentage point difference between freestanding and hospital-based facilities in the share of days assigned to intensive therapy (83 percent in freestanding facilities, 67 percent in hospital-based facilities). There were smaller (2 percentage points) differences in case-mix between for-profit and nonprofit facilities (84 percent and 82 percent, respectively).

In 2017, the share of days assigned to medical case-mix groups or to extensive services case-mix groups was low (5 percent in 2017). Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex admissions. While making up 4 percent of facilities, hospital-based SNFs made up 8 percent of the SNFs with the highest shares (the top quartile) of medically complex admissions.

In 2018, the Department of Justice continued to enforce the False Claims Act by investigating fraud and abuse in SNFs' therapy billings. It reached agreements in four cases to settle allegations of improperly billing for intensive therapy services that were not reasonably or medically necessary (Department of Justice 2018a, Department of Justice 2018b, Department of Justice 2018c, Department of Justice 2018d). The department alleged that the defendant engaged in one or more of the following strategies: falsely reporting the minutes of therapy delivered, furnishing services that were medically unnecessary given the patient's clinical care needs, discouraging therapists from providing services beyond the minimum threshold minutes for a given case-mix group, pressuring therapists and patients to complete planned minutes of care even when patients were sick

or declined to participate in therapy, or presumptively assigning patients to the highest rehabilitation case-mix group regardless of each patient's individual care needs. Since 2013, the Justice Department has settled 16 cases involving allegations of improper provision of rehabilitation therapy services.

Medicare's case-mix groups may have a broader impact beyond Medicare-covered stays. One study of nursing homes in New York found that nursing home residents (whose care is not covered by Medicare) treated in for-profit facilities in the last month of life were more likely to receive intensive therapy than low or medium levels of therapy (Temkin-Greener et al. 2018). New York Medicaid bases its payments on an older version of the same case-mix groups that Medicare uses, which considers the amount of therapy in establishing payments.

Though access does not appear to be an issue in general, industry representatives and patient advocates report that some providers are reluctant to admit patients with high NTA costs (such as those who need expensive antibiotics). The design proposed by CMS should improve access for these patients because payments will increase for patients with high NTA care needs by an estimated 27 percent (Centers for Medicare & Medicaid Services 2018b). Providers may avoid patients who are likely to require long stays and exhaust their Medicare benefits because a facility's daily payments decline if the patient becomes eligible for Medicaid or the stay results in bad debt.

### **Marginal profit: A measure of the attractiveness of Medicare patients**

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.<sup>9</sup> For providers with available data, the marginal profit in 2017 was at least 19.1 percent. Because Medicare payments far exceed facilities' marginal costs, facilities with available beds have an incentive to admit Medicare patients, also signifying a positive indicator of patient access.

### **Quality of care: Measures indicate mixed performance**

The Commission tracks three broad categories of SNF quality indicators: risk-adjusted rates of discharge to the community, hospital readmission, and change in functional status during the SNF stay (see text box on measures of SNF quality, pp. 204–205). We use these measures because they reflect the goals of most beneficiaries: to return home, avoid a readmission, and improve or maintain function. Because of evidence that the function information reported by inpatient rehabilitation facilities (IRFs) and home health agencies (HHAs) may reflect financial considerations, the Commission is concerned that the function information may not be reliable. The readmission rate during the SNF stay measures how well the SNF detects, monitors, and furnishes adequate care to prevent readmissions. The postdischarge measure indicates how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home).

Changes in quality show mixed results: Some measures have improved since 2011 while others have not. The average rates of discharge to the community and readmission during SNF stays improved, the average rate of readmissions after discharge from the SNF worsened, and two measures of change in function were essentially the same over this period. The most recent changes (between 2016 and 2017) also indicate mixed progress.

### **Rates of community discharge and readmissions show uneven progress**

Since 2011, SNF outcome-based measures show mixed results; some measures improved while others worsened slightly (Table 8-3). The average risk-adjusted rates of discharge to the community steadily improved and reached 40 percent in 2017, up from 33.5 percent in 2011.<sup>10</sup> During the same period, the average risk-adjusted rate of potentially avoidable readmissions during the SNF stay also improved, declining from 12.4 percent to 10.9 percent in 2017. The average risk-adjusted rate of potentially avoidable readmissions during the 30 days after discharge from the SNF worsened. Changes between 2016 and 2017 exhibited a similar mixed pattern: an improved discharge to community rate, a worse rate of readmissions after discharge from the SNF, and no change in the rate of readmissions during the SNF stay. There is a low correlation between the during-stay readmission rates and the readmission rates during the 30 days after discharge from the SNF (0.16, which was statistically significant

**TABLE  
8-3**

**Mean risk-adjusted rates of community discharge and potentially avoidable readmissions, 2011-2017**

Measure	2011	2013	2015	2016	2017
Discharged to the community	33.5%	35.7%	38.8%	39.5%	40.0%
Potentially avoidable readmissions:					
During SNF stay	12.4	11.2	10.4	10.9	10.9
During 30 days after discharge from SNF	5.9	5.5	5.0	5.8	6.1

Note: SNF (skilled nursing facility). Higher rates of discharge to the community indicate better quality. Higher readmission rates indicate worse quality. Rates are the average of facility rates calculated for all facilities with 25 or more stays, except the rate of potentially avoidable readmissions during the 30 days after discharge, which is reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2017 Minimum Data Set and inpatient acute hospital claims data for fee-for-service beneficiaries.

given the sample sizes), confirming that the measures capture different dimensions of quality.

The general trend of lower readmission rates during the SNF stay since 2011 in part reflects the increased attention from hospitals and ACOs to avoid readmission penalties by partnering with SNFs that have low readmission rates. Some hospitals have established preferred provider networks with higher quality SNFs, hoping to lower their own readmission rates in exchange for increased referrals to SNFs. Two studies found that hospitals with more extensive collaboration efforts (such as transition care and visits by hospital staff to SNFs) had fewer readmissions (Rahman et al. 2018, Zhu et al. 2018). Another study found that hospitals with a network of preferred SNFs had lower readmission rates from their partnering SNFs (McHugh et al. 2017). While hospitals on average lowered their readmission rates between 2007 and 2013, hospitals affiliated with ACOs were quicker to lower them (Winblad et al. 2017). Because the ACO-affiliated hospitals were at greater financial risk, they may have had more effective discharge planning and information sharing with the SNFs they used. In addition to partnering with hospitals, many SNFs want to secure volume from MA plans, though there is some evidence that MA plans guide their enrollees to lower quality facilities (Meyers et al. 2018).

As part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing (VBP) policy that uses one measure—readmissions within 30 days of discharge from the preceding hospital stay.<sup>11</sup> The VBP program began adjusting payments to providers

in October 2018. The VBP program withholds 2 percent of payments; of the withheld amount, 60 percent will be returned to providers as incentive payments and 40 percent will be retained as program savings. On net, the program lowered net payments for the majority of SNFs (73 percent). These SNFs did not earn back some portion of the amount withheld, and about one-fifth of SNFs did not earn back any portion of the 2 percent withhold. For-profit facilities were overrepresented in the group of SNFs with the largest reduction. Net payments to over one-quarter of SNFs (27 percent) increased under the VBP; they earned back more than the 2 percent withheld. The largest increase (a net gain of 1.6 percent) was earned by 11 percent of SNFs, and for-profit facilities were underrepresented in this group.

In addition to the single VBP measure, CMS publicly reports SNF performance on six other measures. The three assessment-based measures are the share of patients with pressure ulcers that worsened, the share of patients experiencing one or more falls with major injury, and the share of patients with admission and discharge functional assessments and a care plan that addresses function. The three claims-based measures are the rate of successful discharges to the community (i.e., discharged to the community without deaths or unplanned readmissions within the 31 days after discharge), the rate of potentially preventable readmissions following discharge from the SNF, and Medicare spending per beneficiary. Since October 2018, providers that do not submit the necessary data to calculate the three assessment-based measures on

## Measures of skilled nursing facility quality

To assess skilled nursing facility (SNF) quality, the Commission examines risk-adjusted rates of readmission to the hospital, discharge to the community, and change in functional status during the SNF stay for beneficiaries in fee-for-service (FFS) Medicare.

The community discharge measure includes beneficiaries discharged to a community setting (including assisted living) and excludes beneficiaries discharged to an inpatient setting (e.g., an acute care hospital or nursing home) within one day of the SNF discharge. The measure also excludes beneficiaries who die within 1 day of the SNF discharge and beneficiaries who are readmitted to an acute care hospital within 30 days of admission to the SNF (Kramer et al. 2015). Beneficiaries who are discharged to a nursing home are not counted as community discharges.<sup>12</sup>

The readmission measures count patients whose primary diagnosis for rehospitalization was considered potentially avoidable; that is, the development of the conditions leading to the hospital admission typically could have been managed with appropriate care to avoid the hospitalization. The potentially avoidable conditions include congestive heart failure, electrolyte imbalance/dehydration, respiratory infection, septicemia, urinary tract or kidney infection, hypoglycemia and diabetic complications, anticoagulant complications, fractures and

musculoskeletal injuries, acute delirium, adverse drug reactions, cellulitis/wound infection, pressure ulcers, and blood pressure management. The count excludes readmissions that were likely to have been planned (e.g., inpatient chemotherapy or radiation therapy) and readmissions that signal a premature discharge from the hospital. We separately measure readmissions that occur during the SNF stay and those that occur within 30 days of discharge from the SNF because they measure different aspects of care—care furnished by the SNF and the SNF handoff to the next setting (or home). We do not use CMS’s measure (readmissions that occur within 30 days of discharge from the hospital) because it conflates the two dimensions of care.

The observed readmission and community discharge rates were risk adjusted for medical comorbidity, cognitive comorbidity, mental health comorbidity, function, and clinical conditions (e.g., surgical wounds and shortness of breath). The rates reported are the average risk-adjusted readmission rates for all facilities with 25 or more stays (20 stays for the postdischarge readmission measure). Demographics (including race, gender, and age categories except younger than age 65 years) were not important in explaining differences in readmission and community discharge rates after controlling for beneficiaries’ comorbidities, mental illness, and functional status (Kramer et al. 2014).<sup>13</sup>

*(continued next page)*

at least 80 percent of assessments will have their update for that year reduced by 2 percentage points.

### **Measures of changes in functional status were essentially unchanged**

Most SNF beneficiaries receive rehabilitation therapy, and the amount of therapy furnished to them has steadily increased over time. Yet patients vary considerably in their expected improvement during the SNF stay. Some patients are likely to improve in several ADLs during their

SNF stay, while others (such as those with chronic and degenerative diseases) may expect, at best, to maintain their function. We measure SNF performance on both aspects of patient function—improvement and no decline (see text box on SNF quality measures). The risk-adjusted rates consider the likelihood that a patient’s functionality will change, given the functional ability at admission. However, given the evidence in HHAs and IRFs that the reporting of functional status may be influenced by financial considerations, the Commission is increasingly

## Measures of skilled nursing facility quality (cont.)

Two risk-adjusted measures of functional change are used to gauge the share of a facility's stays during which patients' function improves (the rate of improvement in one, two, or three mobility measures—bed mobility, transfer, and ambulation) and the share of stays during which patients' functioning does not decline (including stays with improvement and stays with no change), given the prognosis of the facility's patients. Change is measured by comparing initial and discharge assessments. For patients who go on to use long-term nursing home care, the assessment closest to the end of Medicare coverage is used as long as it is within 30 days of the end of the SNF stay. Although the initial assessment often occurs toward the end of the first week of the stay, the Minimum Data Set information pertains to the number of times over the past week that assistance was provided rather than the recorded functional status at a single point in time. Therefore, measurement error due to the reliance on an assessment conducted at the end of the first week of the stay is unlikely and would not affect our ability

to examine quality trends over time, unless providers changed during the week the initial assessments were conducted.

The initial assessment conducted during each stay is used to assign the patient to 1 of 22 case-mix groups using 3 measures of mobility—bed mobility, transfer, and ambulation (Kramer et al. 2014). This classification system acts as a form of risk adjustment, differentiating patients based on their expected ability to perform the three mobility-related activities of daily living (ADLs). A patient's prognosis is measured using the patient's ability to eat and dress because these two ADLs encompass cognitive functioning and other dimensions of physical functioning that facilitate rehabilitation.

Risk-adjusted rates compare a facility's observed rates with its expected rates ((actual rate / expected rate) × the national average rate) based on the mix of patients across functional outcome groups. Each facility-level measure combines the functional status information for the three mobility measures. ■

wary of the accuracy of the provider-reported functional assessments because the data are generally obtained by observing the patient and are somewhat subjective. The Commission has work underway to examine the accuracy of these data.

The average risk-adjusted rates of functional change—rate of improvement in one, two, or three mobility ADLs (bed mobility, transfer, and ambulation) and the rate of no decline in mobility—were essentially unchanged between 2011 and 2017 (Table 8-4, p. 206). In 2017, 43.9 percent of stays had improvement in mobility, and 87 percent of stays had no decline in mobility. So, even though the program paid for more therapy over this period (the share of days assigned to the highest rehabilitation case-mix groups increased), the average functional status of beneficiaries did not improve.

### **Large variation in quality measures indicates considerable room for improvement**

Considerable variation exists across the industry in performance on the quality measures we track. We

found one-quarter of facilities in 2017 had risk-adjusted community discharge rates at or below 31.9 percent, whereas the best performing quarter of facilities had rates of 49.1 percent or higher (Table 8-5, p. 207). Similar variation was seen in readmissions during the SNF stay: The worst performing quartile had rates at or above 13.6 percent, whereas the best quartile had rates at or below 7.8 percent. Finally, rates of readmission in the 30 days after discharge from the SNF varied most—a twofold difference between the 25th percentile and the 75th percentile. The amount of variation across and within the groups suggests considerable room for improvement, all else being equal. There was less variation in the mobility measures, particularly the measure detecting no decline in mobility. The relatively high and fairly uniform rates could indicate that most SNFs are able to prevent declines for most beneficiaries.

Consistent with prior years, in 2017, nonprofit SNFs had higher rates of community discharges and fewer

**TABLE  
8-4****Mean risk-adjusted functional outcomes in SNFs were essentially unchanged between 2011 and 2017**

Composite measure	2011	2013	2015	2016	2017
Rate of improvement in one or more mobility ADLs	43.6%	43.7%	43.6%	43.6%	43.9%
Rate of no decline in mobility	87.2	87.1	87.1	87.2	87.0

Note: SNF (skilled nursing facility), ADL (activity of daily living). The three mobility ADLs include bed mobility, transfer, and ambulation. The rate of mobility improvement refers to the average rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. Stays with improvement in one, two, or three of these ADLs are counted in the improvement measure. The rate of stays with no decline in mobility is the share of stays with no decline in any of the three mobility ADLs. Rates are the mean of facility rates and are calculated for all facilities with 25 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2017 Minimum Data Set data.

readmissions (that is, better rates) during the SNF stay than for-profit facilities. Nonprofit SNFs on average had community discharge rates that were 10 percent higher and during-stay readmission rates that were 15 percent lower than for-profit facilities. The rates for readmissions during the 30 days after discharge were similar on average.

We also found differences in the performance of hospital-based and freestanding SNFs in 2017. Compared with freestanding facilities, hospital-based SNFs had, on average, higher rates of discharge to the community (18 percent higher) and lower during-stay readmission rates (27 percent lower). The average readmission rate during the 30 days after discharge was higher for hospital-based SNFs compared with freestanding facilities, indicating an opportunity for hospitals to improve their discharge planning, the handoffs of these beneficiaries to the next setting or home, and the quality of the providers to which they refer beneficiaries.

Medicare is increasingly focused on measuring the value of the care it purchases. In addition to implementing a VBP program in October 2018, CMS has improved the Nursing Home Compare website, a Medicare website that displays comparative information about SNFs and nursing homes to help beneficiaries select a provider. CMS expanded the number of short-stay quality measures reported in Nursing Home Compare to include measures that reflect the key goals of this post-acute care. The short-stay measures include improvement in function, readmissions, discharge to the community, patient experience with pain, presence of new or worse pressure ulcers, vaccination rates, and use of antipsychotic medications.

**Providers' access to capital was adequate in 2018**

The vast majority of SNFs operate within nursing homes; therefore, in assessing SNFs' access to capital, we look at the availability of capital for nursing homes. Medicare makes up a minority share of almost all facilities' revenues.

Access to capital was adequate in 2018 and is expected to remain so in 2019 (Kaufman 2018). Many investors and lenders remain optimistic about this sector because of its relatively low costs compared with other institutional PAC providers and the long-term demographics that will fuel demand. Capital markets are reported to be "robust," with "tremendous investor demand," even though facilities' total margins are low and occupancy rates have declined in recent years (Connole 2018, Flynn 2018). Improved state economies have also stabilized Medicaid payments for the long-term care portion of providers' businesses.

The Department of Housing and Urban Development (HUD) continues to be an important lending source. In fiscal year 2018, HUD financed 317 projects, with the insured amount totaling \$3.6 billion, a 6 percent increase from 2017 (Department of Housing and Urban Development 2018). During fiscal year 2018, both the number and size of the loans increased. Refinancing, rather than new construction or renovation, continues to make up most of HUD loans. HUD plays a smaller lending role than it has previously because low-cost borrowing and widely available capital sources have made it only one of many alternative lenders.

**TABLE  
8-5**

**SNF quality measures varied considerably across SNFs, 2017**

**Risk-adjusted rates**

Quality measure	Risk-adjusted rates			Ratio of 75th to 25th percentile
	Mean	25th percentile	75th percentile	
Discharged to the community	40.0%	31.9%	49.1%	1.5
Average mobility improvement across the three mobility ADLs during the SNF stay	43.9	35.8	52.0	1.5
Rate of no decline in mobility during SNF stay	87.0	82.5	92.6	1.1
Potentially avoidable readmissions during SNF stay	10.9	7.8	13.6	1.7
Potentially avoidable readmissions within 30 days after discharge from SNF	6.1	3.9	7.8	2.0

Note: SNF (skilled nursing facility), ADL (activity of daily living). Higher rates of discharge to community indicate better quality. Higher readmission rates indicate worse quality. “Mobility improvement” is the average of the rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. “No decline in mobility” is the share of stays with no decline in any of the three mobility ADLs. Rates are the average of facility rates and are calculated for all facilities with 25 or more stays, except the rates of potentially avoidable readmissions during the 30 days after discharge, which are reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2017 Minimum Data Set and inpatient acute hospital data.

Yet some lenders and investors are wary of this setting. Total margins for nursing homes across all lines of business and all patients are modest and have ranged between 0.6 percent and 3.8 percent since 2001. Because a “total margin” includes the mostly Medicaid-funded long-term care (the nursing home portion of the business), the overall financial performance of this setting is heavily influenced by state policies regarding the level of Medicaid payments and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need). The aggregate total margin for freestanding SNFs in 2017 remained positive (0.5 percent), slightly lower than the total margin in 2016 (0.7 percent).

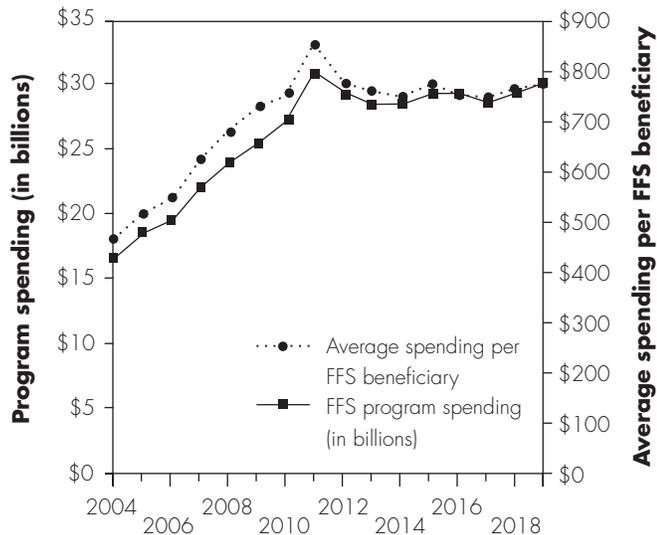
Some investors eye the slim total margins, declining occupancy rates, and increasing share of revenues from payers with lower rates and opt to pare back their investments or avoid the sector altogether. Reflecting these trends, the average price per bed decreased 18 percent between 2016 and 2017 (to \$81,350), though it remains the third highest price ever (Irving Levin Associates Inc. 2018). However, reluctance to invest in this setting does not reflect the adequacy of Medicare’s FFS SNF payments: Medicare remains a preferred payer.

As some of the larger national players (such as Kindred Healthcare and Sabra Healthcare REIT) exited or pared back their investments in the sector, smaller regional investors picked up the offerings, assisted by widely available capital. Although small regional operators are less able to spread their financial risks across diverse locations, they have greater familiarity with the local markets, referral patterns from hospitals, and individual facility performance that may offer them a competitive advantage (Spanko 2018). In contrast to reluctant lenders, these investors view the industry as remarkably stable, having the advantage of demographic trends and being a lower cost alternative to other institutional PAC.

The nursing home industry is increasingly dividing into providers that can expand their service lines and successfully participate in alternative payment models and providers that cannot. The transition from FFS to alternative payment models (including ACOs and bundled payments) and VBP will require SNFs to achieve good outcomes and communicate that performance to potential partners (hospitals and health systems) to secure volume. Some facilities have started to develop and market their “niche” clinical capabilities to hospitals, aiming to care for patients with special care needs, such as patients

**FIGURE 8-1**

**After declining in 2017, FFS program spending on SNF services is expected to increase in 2018 and 2019**



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year spending is shown. Data for 2018 and 2019 are estimates.

Source: Office of the Actuary 2018b.

on ventilators or dialysis, those requiring dementia or wound care, or those with respiratory or heart conditions. The revised PPS that CMS plans to implement will also exert pressure on providers to develop skilled nursing capabilities if they do not already have them. Some observers note that some small solo operators will opt to sell rather than transition to a new model of care, which will likely result in more consolidation in the industry.

Because Medicaid payments are lower than Medicare FFS payments, some representatives in the industry argue that high Medicare payments are needed to subsidize losses on Medicaid residents. The Commission does not support this policy for several reasons (see text box on not subsidizing other payments). It should be noted that while Medicare's payments are higher than Medicaid's, the programs pay for different levels of care. Medicare pays for skilled services after a hospitalization; Medicaid covers long-term care. Differences in the level of care are captured by the relative weights for the average Medicare beneficiary and Medicaid resident. The average therapy relative weight for

a Medicare-covered beneficiary was nine times higher than the relative weight for a Medicaid-covered resident (White and Zheng 2018). The average nursing relative weight was 40 percent higher for a Medicare-covered beneficiary compared with a Medicaid-covered resident.

### Medicare payments and providers' costs: Medicare margins remained high in 2017

In 2017, the aggregate Medicare margin for freestanding SNFs was 11.2 percent. Margins for individual facilities continue to vary depending on the facility's share of intensive therapy days, size, and cost per day. High-margin SNFs had higher shares of intensive therapy days and lower average costs per day compared with low-margin SNFs. Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. The 987 freestanding facilities defined as relatively efficient—providers with consistently low costs and higher quality care, in relative terms—had Medicare margins of 18 percent, indicating Medicare overpays freestanding facilities for this care. Some MA plans' payment rates were considerably lower than Medicare's FFS payment rates, and the disparity is unlikely to be explained by differences in patient mix.

### Trends in FFS spending and cost growth

In fiscal year 2017, Medicare FFS spending for SNF services was \$28.4 billion, about 1 percent lower than in 2016 (Figure 8-1) (Office of the Actuary 2018b). Between 2004 and 2010, the average increase in program spending was over 8 percent a year. In 2011, program spending was unusually high because rates for the new case-mix classification system included an adjustment that was too large for the mix of therapy modalities (i.e., individual versus group or concurrent) assumed in setting the rates. The industry took advantage of the new policies by quickly shifting its mix of modalities, and spending increased by over 14 percent in 2011. To correct for the excessive payment, CMS revised the adjustment downward in 2012, and total payments declined almost 8 percent in 2012. Although there was no significant overall change in program spending, annual changes have been highly variable, ranging from a 4.5 percent increase in 2015 to a 2.8 percent decrease in 2016. On a per FFS beneficiary basis, spending in 2017 (\$743) was slightly lower (–0.4 percent) than in 2016. The Office of the Actuary estimates that FFS spending has increased in 2018 and will further increase to \$29.9 billion in 2019.

## Medicare's skilled nursing facility payments should not subsidize payments from Medicaid or other payers

**M**edicare payments, which are financed by taxpayer contributions to the Part A Trust Fund, effectively subsidize payments from other payers, most notably Medicaid. High Medicare payments may also subsidize payments from private payers. Industry representatives contend that this subsidization should continue. The Commission believes such cross-subsidization is poor policy for several reasons. First, it results in poorly targeted subsidies. Facilities with high shares of Medicare beneficiary days receive the most in subsidies from higher Medicare payments, while facilities with low shares of Medicare beneficiary days—presumably the facilities with the greatest financial need—receive the smallest subsidies.

In addition, Medicare's subsidization does not differentiate among states with relatively high and low Medicaid payments. If Medicare raises or maintains its high payment levels, states could be encouraged to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates even more. Higher Medicare payments could also further encourage providers to select patients based on payer source or rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay. Finally, Medicare's high payments represent a subsidy from trust fund dollars (and taxpayer support) of the low payments made by states and private payers. If the Congress wishes to financially support certain nursing facilities (such as those with high Medicaid shares) efficiently, it could do so through a separate, targeted policy. ■

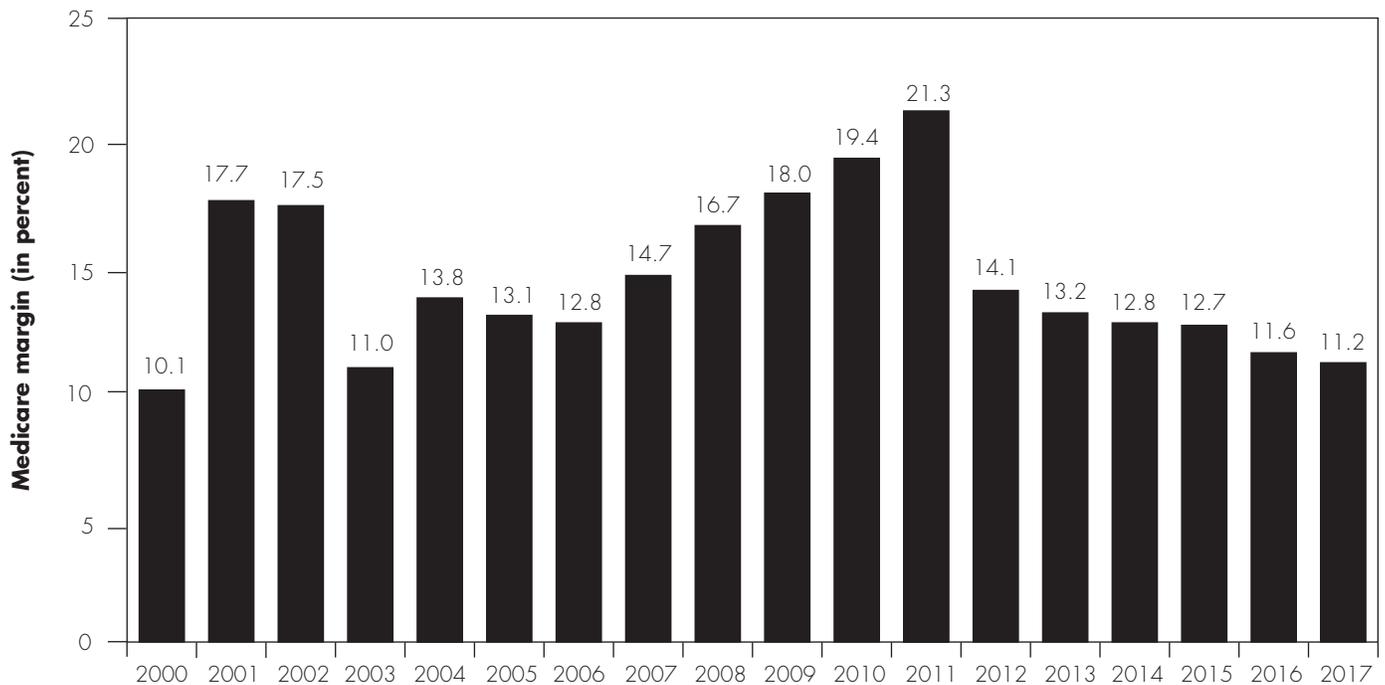
Between 2016 and 2017, SNFs kept the growth in the average cost per day below the market basket (2.3 percent compared with the market update of 2.7 percent). Costs increased more quickly for nonprofit SNFs compared with for-profit SNFs (3.0 percent compared with 2.2 percent, respectively). Cumulatively since 2012, the industry kept the growth in the average cost per day below the market basket (11.1 percent compared with the market basket of 12.3 percent). Over the same period, nonprofit SNFs had higher cost growth compared with for-profit SNFs (14.7 percent for nonprofit facilities compared with 10.1 percent for for-profit SNFs). In addition to higher cost growth, nonprofit facilities had average costs per day in 2017 that were about 10 percent higher than the cost per day in for-profit facilities. Differences in the level of cost per day by ownership have grown over time.

### SNF Medicare margins remain high

The Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's FFS payments with providers' costs to treat FFS beneficiaries. In 2017, the aggregate Medicare margin for

freestanding SNFs was 11.2 percent, the 18th consecutive year of Medicare margins above 10 percent (Figure 8-2, p. 210). Medicare margins declined slightly because, although SNFs kept their cost growth below the update to payments, the sequester has lowered payments by 2 percent each year since April 2013. SNFs have countered this reduction to the payment rate by keeping their cost growth low and assigning days to higher payment case-mix groups.

In 2017, hospital-based facilities (3 percent of program spending on SNFs) continued to have extremely negative Medicare margins (–68 percent), in part because of the higher cost per day reported by hospitals. Previous analysis by the Commission found that routine costs in hospital-based SNFs were higher, reflecting more staffing, higher skilled staffing, and shorter stays (over which to allocate costs) (Medicare Payment Advisory Commission 2007). However, hospital administrators consider their SNF units in the context of the hospital's overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their SNF beds, thus making inpatient beds available to

**FIGURE  
8-2****Aggregate freestanding SNF Medicare margins have been above 10 percent since 2000**

Note: SNF (skilled nursing facility). Medicare margin is calculated as the sum of Medicare payments minus the sum of Medicare's costs, divided by Medicare payments.

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2017.

treat additional inpatient admissions. As a result, hospital-based SNFs can contribute to the bottom-line financial performance of hospitals: Hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs.

### High and widely varying SNF Medicare margins indicate PPS reforms are still needed

The persistently high Medicare margins and their wide variation indicate that the PPS needs to be revised and rebased so that payments more closely match patient characteristics, not the services provided to them. In 2017, one-quarter of freestanding SNFs had Medicare margins of 20.2 percent or higher, while another quarter of freestanding SNFs had margins of 0.8 percent or lower (Table 8-6). Providers' case mix played a key role in shaping Medicare margins. In 2017, facilities with high shares of intensive therapy days had Medicare margins

that averaged 9 percentage points higher than facilities with low shares of these days (13.1 percent compared with 4.1 percent, respectively).

Medicare margins also reflect the economies of scale that larger SNFs are able to achieve. Small (25–50 beds) and low-volume facilities (bottom quintile of total facility days) had low average Medicare margins (–0.3 percent and 0.6 percent, respectively) compared with large and high-volume facilities (12.6 percent and 13.4 percent, respectively). SNFs with the lowest cost per day (SNFs in the bottom 25th percentile) had an average Medicare margin of 22.8 percent compared with 0.3 percent for SNFs with the highest cost per day (the top 25th percentile).

Since 2006, for-profit facilities' Medicare margins have averaged about 10 percentage points higher than nonprofit facilities' margins. Nonprofit facilities had an average

Medicare margin of 1.7 percent, while the average margin for for-profit SNFs was 13.7 percent. The disparity reflects differences in facilities' mix of patients, costs, size, and service provision. Nonprofit facilities tend to have higher costs per day (about 10 percent higher) and, since 2011, have had higher cost growth compared with for-profit facilities. The higher costs for nonprofit facilities partly reflect their smaller size. In 2015, the median nonprofit facility had 85 beds compared with 103 beds for the median for-profit facility, suggesting that the nonprofits may not be able to achieve the same economies of scale as larger facilities. As for revenues, nonprofits had somewhat lower shares of the more profitable ultra-high and very high therapy days compared with for-profit facilities (82 percent compared with 84 percent, respectively) and shorter stays, both lowering revenue.

The highest margin freestanding SNFs (those in the top quartile of the distribution of Medicare margins) appear to pursue both cost and revenue strategies (Table 8-7, p. 212). Compared with lower margin SNFs (those in the bottom quartile), high-margin SNFs had considerably lower daily total, routine, and ancillary costs and lower cost per discharge. Economies of scale play a role; high-margin SNFs were larger on average, with a higher occupancy rate, than lower margin facilities. Somewhat surprisingly, high-margin facilities had larger shares of dual-eligible beneficiaries, minority beneficiaries, and Medicaid days. It is possible that, given their larger Medicaid mix (and the lower payments typically made by Medicaid), these facilities keep their costs lower, which contributes to their higher Medicare margins.

On the revenue side, high-margin SNFs had revenues per day that were 15 percent higher, driven in part by having larger shares of intensive therapy days and, to a smaller extent, a lower mix of medically complex days. The differences in financial performance based on a provider's case mix illustrate the need to revise the PPS, such as using the design proposed by CMS. Differences in payments per discharge between high- and low-margin SNFs were even larger (43 percent higher) because of the longer lengths of stay.

Ownership of low-margin and high-margin facilities did not mirror the industry mix. Although for-profit facilities made up 71 percent of freestanding SNFs in 2017, they constituted a smaller share (57 percent) of the low-margin facilities and a higher share (86 percent) of the high-margin group. Similarly, high-margin SNFs were

**TABLE  
8-6**

**Variation in freestanding SNF Medicare margins reflects the mix of cases and cost per day, 2017**

Provider group	Medicare margin
All providers	11.2%
For profit	13.7
Nonprofit	1.7
Rural	9.7
Urban	11.5
Frontier	3.8
25th percentile of Medicare margins	0.8
75th percentile of Medicare margins	20.2
Intensive therapy: High share of days	13.1
Intensive therapy: Low share of days	4.1
Medically complex: High share of days	9.0
Medically complex: Low share of days	12.1
Small (20–50 beds)	–0.3
Large (100–199 beds)	12.6
Cost per day: High	0.3
Cost per day: Low	22.8
Cost per discharge: High	9.6
Cost per discharge: Low	12.2
Facility volume: Highest fifth	13.4
Facility volume: Lowest fifth	0.6

Note: SNF (skilled nursing facility). The margins are aggregates for the facilities included in the group. "Intensive therapy" days are those classified in the ultra-high and very high rehabilitation case-mix groups. "Low" is defined as facilities in the lowest 25th percentile; "high" is defined as facilities in the highest 25th percentile. "Frontier" refers to SNFs located in counties with six or fewer people per square mile. Facility volume includes all facility days.

Source: MedPAC analysis of 2017 freestanding SNF Medicare cost reports.

disproportionately urban, accounting for 79 percent of this group even though they make up a smaller share of freestanding SNFs (73 percent).

**Relatively efficient SNFs illustrate Medicare's payments are too high**

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The

**TABLE  
8-7**

**Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2017**

Characteristic	SNFs in the top margin quartile	SNFs in the bottom margin quartile	Ratio of SNFs in the top margin quartile to SNFs in the bottom margin quartile
<b>Cost measures</b>			
Standardized cost per day	\$271	\$399	0.68
Standardized ancillary cost per day	\$117	\$167	0.70
Standardized routine cost per day	\$152	\$224	0.68
Standardized cost per discharge	\$11,285	\$14,116	0.80
Average daily census (patients)	87	65	1.35
Occupancy rate (in percent)	86%	84%	1.02
<b>Revenue measures</b>			
Medicare payment per day	\$522	\$452	1.15
Medicare payment per discharge	\$22,470	\$15,714	1.43
Medicare length of stay (days)	42	35	1.21
Share of days in intensive therapy	88%	80%	1.10
Share of medically complex days	3%	4%	0.75
Medicare share of facility revenue	23%	13%	1.77
Medicaid share of days	66%	57%	1.16
<b>Patient characteristics</b>			
Case-mix index	1.41	1.32	1.07
Share dual-eligible beneficiaries	39%	26%	1.50
Share minority beneficiaries	14%	5%	2.80
Share very old beneficiaries	30%	35%	0.86
<b>Facility mix</b>			
Share for profit	86%	57%	N/A
Share urban	79%	70%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Top margin quartile SNFs (n=3,284) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n=3,283) were in the bottom 25 percent of the distribution of Medicare margins. "Standardized cost" refers to Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries. "Intensive therapy" days are days classified in ultra-high and very high rehabilitation case-mix groups. "Medically complex" includes days assigned to clinically complex and special care case-mix groups. "Very old beneficiaries" are 85 years and older. Figures in the first two columns are rounded, but ratios were calculated on unrounded data.

Source: MedPAC analysis of freestanding 2017 SNF cost reports and claims.

analysis informs the Commission's update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures.

The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on both cost and quality metrics (see text box on identifying relatively efficient SNFs, p. 214).

Second, performance has to be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission's approach is to develop a set of criteria and then examine how many providers meet them. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

**TABLE  
8-8**

**Financial performance of relatively efficient freestanding SNFs is a combination of lower cost per day and higher revenues per day**

Performance in 2017	Type of SNF		Ratio of relatively efficient to other SNFs
	Relatively efficient	Other SNFs	
Community discharge rate	50.3%	39.8%	1.27
Readmission rate	9.0%	10.9%	0.83
Standardized cost per day	\$297	\$324	0.92
Standardized cost per discharge	\$8,948	\$12,310	0.73
Medicare revenue per day	\$526	\$476	1.11
Medicare margin	18.0%	10.5%	1.71
Total margin	2.3%	0.6%	3.61
Facility case-mix index	1.44	1.36	1.06
Medicare average length of stay	30 days	38 days	0.79
Occupancy rate	87%	85%	1.03
Average daily census	100	79	1.27
Share ultra-high therapy days	66%	55%	1.21
Share medically complex days	4.2%	3.8%	1.09
Medicaid share of facility days	58%	63%	0.93
Share urban	84%	67%	N/A
Share for profit	79%	68%	N/A
Share nonprofit	15%	21%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). The number of facilities included in the analysis was 11,462. SNFs were identified as “relatively efficient” based on their cost per day and two quality measures (community discharge and readmission rates) between 2014 and 2016; their performance was evaluated in 2017 and is displayed in the table. Relatively efficient SNFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of three years and were not a facility under “special focus” by CMS. Costs per day and per discharge were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and readmission during the SNF stay for patients with potentially avoidable conditions. Quality measures were calculated for all facilities with at least 25 stays. “Ultra-high therapy days” includes days assigned to ultra-high case-mix groups. “Medically complex days” includes days assigned to clinically complex and special care case-mix groups. Table shows the medians for the measure. Figures in the first two columns are rounded, but ratios were calculated on unrounded data.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2014–2017.

To identify efficient SNFs, we examined the financial performance of freestanding SNFs with consistent cost and quality performance. To measure costs, we looked at costs per day that were adjusted for differences in area wages and case mix. The quality measures were risk-adjusted rates of community discharge and potentially avoidable readmissions during the SNF stay.

Our analyses found that many SNFs (987) had relatively low costs and provided relatively good quality care. Compared with other SNFs in 2017, relatively efficient

SNFs had community discharge rates that were 27 percent higher and readmission rates that were 17 percent lower (Table 8-8). Standardized costs per day were 8 percent lower than for other SNFs. The aggregate Medicare margin for efficient SNFs was high (18 percent), indicating that although these providers were relatively low cost and achieved relatively high quality, the program could get better value for its purchase if its payments were lower. The high margin for these providers underscores the need for the program to lower its payments to more closely align them with the costs of care.

## Identifying relatively efficient skilled nursing facilities

**W**e defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and good quality of care for three years in a row, 2014 through 2016. The cost per day was calculated using cost report data and was adjusted for differences in case mix (using the nursing component relative weights) and area wages. To assess quality, we examined risk-adjusted rates of community discharge and potentially avoidable readmissions that occurred during the SNF stay. Only facilities with at least 25 stays were included in the quality measures. To be included in the relatively efficient group, a SNF had to be in the best third of the distribution of at least one measure and not in the bottom third on any measure for three consecutive years. Another criterion was that SNFs not be part of CMS’s Special Focus Facility Initiative for any portion of time covered by the definition (2014 through 2016), which excluded five facilities from the pool of efficient providers.<sup>14</sup>

We found that almost 9 percent (987 of the 11,462 facilities that had all of the data items required for this

analysis) provided relatively low-cost, high-quality care—17 more facilities than last year. Less than half (44 percent) were identified as efficient last year. Relatively efficient facilities were more likely to be urban and for profit. Efficient SNFs were located in 44 states, including 2 in frontier locations.

The method we used to assess performance attempts to limit incorrect conclusions about performance based on poor data. Using three years to categorize SNFs as efficient (rather than just one year) avoids categorizing providers based on random variation or on one “unusual” year. In addition, by first assigning a SNF to a group and then examining the group’s performance in the next year, we avoided having a facility’s poor data affect both its own categorization and the assessment of the group’s performance. Thus, a SNF’s erroneous data could result in its inaccurate assignment to a group, but because the group’s performance is assessed with data from later years, these “bad” data would not directly affect the assessment of the group’s performance. ■

Similar to high-margin SNFs, efficient SNFs appear to pursue cost and revenue strategies. On the cost side, efficient SNFs achieved greater economies of scale, with a higher daily census compared with other facilities (100 compared with 79, respectively) and slightly higher occupancy rates. Since the efficient providers were also higher quality, their volume could reflect their success in attracting admissions. On the revenue side, efficient providers had higher shares of the most intensive therapy days that raised their daily Medicare payments relative to all SNFs. They also had lower Medicaid shares, which improved their total financial performance; efficient providers’ total margin was 2.3 percent compared with 0.6 percent for other SNFs. Efficient facilities had more complex case mixes (driven in part by higher therapy intensity) and much shorter stays.

### **FFS payments for SNF care are considerably higher than MA payments for three publicly traded nursing home companies**

Another indicator that Medicare’s payments under the SNF PPS are too high is the comparison of FFS and MA

payments. (We use “MA” as shorthand for all managed care payments since MA makes up the majority of rates reported as “managed care payments.”) We compared Medicare FFS and MA payments at three nursing home companies for which such information was publicly available. For these companies, Medicare’s FFS payments averaged 21 percent higher than MA rates (Table 8-9). We do not know whether the lower average daily payment reflects differences in service intensity (for example, fewer intensive therapy days), lower payments for the same service, or some combination. We also do not know how these rates compare with rates paid to smaller chains and independent facilities. It is possible that smaller companies have less leverage and do not negotiate similarly low rates. However, similar differences in payments were reported by the National Investment Center for Seniors Housing & Care, a nonprofit organization that supports access and choice for seniors’ housing and care, including nursing homes and assisted living. It found that for the 1,449 SNF properties included in its sample, FFS payments

**TABLE  
8-9**

**Comparison of Medicare fee-for-service and managed care daily payments in 2018 to three companies**

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	Managed care (MA)	
Diversicare	\$455	\$397	1.15
Ensign Group	616	462	1.33
Genesis HealthCare	525	458	1.15

Note: FFS (fee-for-service), MA (Medicare Advantage). MA makes up the majority of managed care payments. The Genesis rate is reported as “insurance,” which includes managed care but excludes Medicaid managed care and private pay.

Source: Third quarter 10-Q 2018 reports available at each company’s website.

per day were 21 percent higher than MA rates (National Investment Center for Seniors Housing & Care 2018).

We compared the patient characteristics of beneficiaries enrolled in FFS and MA plans in 2017 and found the differences are unlikely to explain the magnitude of the differences between FFS payments and payments typically made by MA plans.<sup>15</sup> Compared with FFS beneficiaries, MA enrollees were about the same age, had slightly higher Barthel scores (about two points, indicating slightly more independence), and had lower risk scores (5 percent lower, indicating fewer comorbidities). The considerably lower MA payments indicate that some facilities accept much lower payments to treat MA enrollees who may not be much different in terms of case mix from FFS beneficiaries. Some publicly traded firms report seeking managed care patients as a business strategy, indicating that the MA rates are attractive.

**Payments and costs for 2019**

To project the aggregate Medicare margin for 2019, the Commission considers the relationship between SNF costs and Medicare payments in 2017 as a starting point. To estimate costs for 2018 and 2019, we assumed a cost growth equal to the average for the past five years (slightly below market basket) and no behavioral changes. To estimate 2018 payments, we assumed payments in 2018 would increase by 1.0 percent, as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). For 2019, we assumed payments would increase by 2.4

percent, as required by the Balanced Budget Act of 2018. We also reduced 2019 payments by the portion of the VBP withhold that will be retained as program savings.

The projected Medicare margin for 2019 is 10 percent. The margin is expected to be lower than the 2017 margin because of the MACRA-mandated update in 2018 and program savings from VBP that will lower revenues in 2019.

**How should Medicare payments change in 2020?**

In considering how payments should change for 2020, we note that costs are estimated to increase 3.1 percent that year. The update to payments is estimated to be lower than 3.1 percent because productivity adjustments will lower the update by an estimated 0.5 percent, for a net update of 2.6 percent. The change in Medicare margins will depend on whether cost growth exceeds the growth in payments on a case-mix-adjusted basis.

In fiscal year 2020, CMS plans to make substantial changes to the SNF PPS. The Commission has called for a revised PPS since 2008 and urges the Secretary to proceed with the redesign. While CMS estimated the redesign to be budget neutral, provider responses to the new PPS may alter program spending and facilities’ cost structures and mix of cases. Thus, behavioral responses will dictate

whether rebasing and recalibration will be needed to keep payments aligned with the cost of care.

Regarding the level of payments, indicators of the adequacy of Medicare's payments are positive. The aggregate Medicare margin for SNFs has been above 10 percent since 2000 and is projected to be 10 percent in 2019. In 2017, the marginal profit was 19.1 percent, indicating facilities with an available bed have an incentive to admit Medicare patients. Relatively efficient SNFs had a median Medicare margin of 18 percent, further evidence that the level of payments is too high relative to the cost of care. Furthermore, FFS payments were considerably higher than the MA payments made to some SNFs, suggesting that some facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries. These factors show that the PPS continues to exert too little pressure on providers.

### RECOMMENDATION 8-1

**The Secretary should proceed to revise the skilled nursing facility prospective payment system in fiscal year 2020 and should annually recalibrate the relative weights of the case-mix groups to maintain alignment of payments and costs.**

### RATIONALE 8-1

After proposing to revise the SNF PPS and postponing the implementation, CMS refined its design and appears poised to implement a revised PPS in October 2019. The revisions will increase the equity in payments for different types of stays, increasing payments for medically complex stays and decreasing payments for stays that include intensive therapy unrelated to a patient's care needs. While the redesign would narrow the disparities in financial performance that result from the mix of cases facilities treat and therapy practices, it would not, and should not, address disparities that result from providers' inefficiencies.

The recommendation also calls for the Secretary to annually recalibrate the relative weights of the case-mix groups. The redesign may encourage many SNFs to change their mix of cases and their cost structures and thereby shift the relative costs of days assigned to the case-mix groups. To keep payments aligned with the cost of care for all types of days, CMS should recalibrate the relative weights of the case-mix groups on a regular schedule. Recalibration is administratively straightforward

and should become part of CMS's annual upkeep of the SNF PPS, just as it is part of the annual updates made to acute care hospitals.

As CMS noted in its final rule for updating rates for fiscal year 2019, the redesigned SNF PPS and the unified PAC PPS establish similar incentives for providers. SNFs will gain valuable experience under the revised SNF PPS that will ready them for an eventual transition to a PAC PPS.

### IMPLICATIONS 8-1

#### Spending

- Relative to current law, this recommendation would not change program spending. The recommendation is budget neutral to the current level of spending.

#### Beneficiary and provider

- A redesigned PPS and an annual recalibration of the relative weights would increase the equity of Medicare's payments for all beneficiaries, thereby helping to ensure access for all beneficiaries, including those with medically complex conditions and those with high NTA costs. We do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

### RECOMMENDATION 8-2

**The Congress should eliminate the fiscal year 2020 update to the Medicare base payment rates for skilled nursing facilities.**

### RATIONALE 8-2

Current law will increase base payments by a projected 2.6 percent (the market basket net of productivity) in fiscal year 2020. The aggregate Medicare margin in 2017 was 11.2 percent, indicating that the current level of Medicare's payment rates is more than adequate to accommodate cost growth and provide care to Medicare beneficiaries without an update to the base rate.

While the level of Medicare's payments indicates that a reduction to payments (i.e., not simply maintaining payment rates at current levels) is needed to align aggregate payments to aggregate costs, we expect the SNF industry to undergo considerable changes as it adjusts to the redesigned PPS. Given the impending changes, the Commission will proceed cautiously in recommending reductions to payments to more closely align them to costs. A zero update would begin to align

**TABLE  
8-10**

**The number of nursing homes treating Medicaid enrollees declined slightly from 2017 to 2018**

	2013	2015	2017	2018	Average annual percent change	
					2013-2017	2017-2018
Number of facilities	15,082	15,076	15,024	14,955	-0.1%	-0.5%

Note: The 2018 number is through November of that year; it does not include data from the full calendar year.

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2013-2018.

payments with costs while exerting pressure on providers to keep their cost growth low and to engage in practice patterns encouraged by alternative payment models. The Commission will monitor beneficiary access, quality of care, and financial performance and may consider future recommendations based on industry responses to the new payment system.

**IMPLICATIONS 8-2**

**Spending**

- Relative to current law, this recommendation would lower program spending by between \$750 million and \$2 billion for fiscal year 2020 and by between \$5 billion and \$10 billion over five years. Savings occur because current law requires market basket increases for 2020.

**Beneficiary and provider**

- We do not expect this recommendation to have adverse effects on beneficiaries' access to care. Given the current level of payments, we also do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

**Medicaid trends**

Section 2801 of the Patient Protection and Affordable Care Act of 2010 requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers with a significant portion of revenues or services associated with Medicaid. We

report nursing home spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2018).

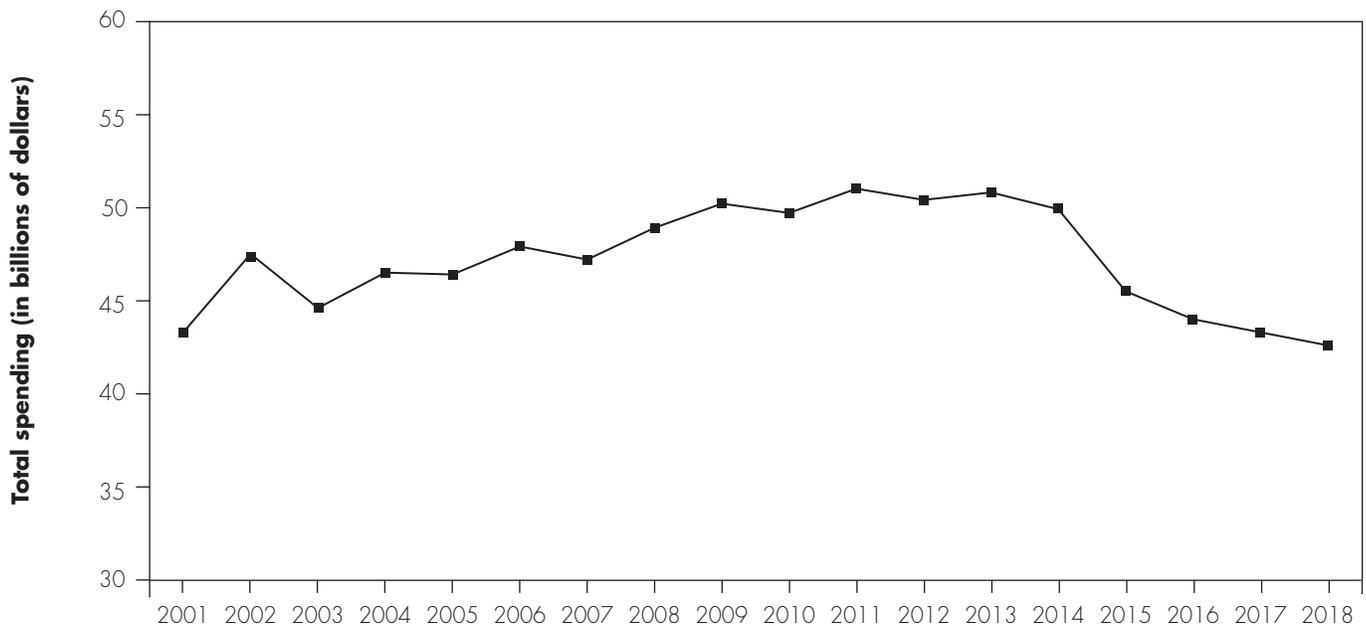
Medicaid covers nursing home (long-term care) and skilled nursing care provided in nursing facilities. Medicaid also pays for long-term care services that Medicare does not cover. For beneficiaries who are dually eligible for Medicaid and Medicare, Medicaid pays the Medicare copayments required of beneficiaries beginning on day 21 of a SNF stay.

**Count of Medicaid-certified nursing homes**

The number of nursing facilities certified as Medicaid providers has stayed relatively stable, with a small decline between 2017 and 2018 (Table 8-10). The decline may reflect the expansion in some states of home- and community-based services (HCBS), which allow more beneficiaries to remain in their homes rather than an institution. State HCBS waivers and federal initiatives have accelerated the trend toward HCBS. In fiscal year 2018, all 50 states and the District of Columbia expanded the number of beneficiaries served by HCBS, an increase from 47 states in fiscal year 2017 and 46 states in fiscal years 2015 and 2016 (Gifford et al. 2017). The reduced number of Medicaid providers may also reflect some facilities shifting their focus to the skilled care market.

**FIGURE  
8-3**

**Total Medicaid fee-for-service spending on nursing home services declined about 2 percent, 2001-2018**



Note: Spending does not include any managed care organization spending on nursing homes. Data for 2018 are projected.

Source: Office of the Actuary 2018.

## Spending

Spending on Medicaid-funded nursing home services (combined state and federal funds) totaled \$43.3 billion in 2017 (Figure 8-3) (Office of the Actuary 2018a). CMS estimates that FFS Medicaid spending on nursing home services decreased by 1.6 percent between 2017 and 2018 and that spending will increase by 0.45 percent in 2019. This trend of lower spending is in part due to an increased use of managed care organizations, whose spending is not included in these data. As of 2017, 24 states operated capitated managed long-term services and supports (Lewis et al. 2018). This number is a 50 percent increase from 2012, when only 16 states had such programs. Furthermore, total enrollment in these programs more than doubled between 2012 and 2017, from 800,000 beneficiaries to 1.8 million beneficiaries.

Analysis of Medicaid rate-setting trends found that 17 states restricted (froze or reduced) rates paid to nursing homes in 2018, while 34 states and the District of

Columbia increased rates (Gifford et al. 2018). More states increased rates to nursing homes in 2018 than in 2017 (only 34 states raised rates in 2017, and 15 states restricted rates) (Gifford et al. 2017). Furthermore, the National Investment Center for Seniors Housing & Care reported that Medicaid revenue per day has been increasing steadily since 2011 (National Investment Center for Seniors Housing & Care 2018). Rates will likely shift in 2019; 40 states and the District of Columbia have indicated that they will increase nursing home rates. Eleven states plan to restrict rates in 2019 (Gifford et al. 2018).

States continue to use provider taxes to raise federal matching funds. In fiscal year 2018, 44 states and the District of Columbia levied provider taxes on nursing homes to increase federal matching funds (Gifford et al. 2018).<sup>16</sup> States can use the augmented revenue to increase payments to providers or to mitigate reductions to payments for services to Medicaid patients (Kaiser Family Foundation 2017).

**TABLE  
8-11**

**Over the past 10 years, total margins remained positive in freestanding SNFs but non-Medicare margins were negative**

Type of margin	2008	2010	2012	2014	2016	2017
Total margin	2.2%	3.6%	1.8%	1.9%	0.7%	0.5%
Non-Medicare margin	-2.4	-1.5	-2.0	-1.5	-2.4	-2.4

Note: SNF (skilled nursing facility). "Total margin" includes the revenues and costs associated with all payers and all lines of business. "Non-Medicare margin" includes the revenues and costs associated with Medicaid and private payers for all lines of business.

Source: MedPAC analysis of Medicare freestanding SNF cost reports for 2008 to 2017.

### Total margins and non-Medicare margins in nursing homes

Total margins reflect all payers (including Medicare, Medicaid, private insurers, and managed care) across all lines of business (for example, nursing home care, hospice care, ancillary services, home health care, and investment income). In 2017, total margins were positive (0.5 percent) (Table 8-11). The median total margin was 0.6 percent, with margins at the 25th and 75th percentiles ranging from -5.3 percent to 5.5 percent, respectively (data not shown). Rural and urban freestanding SNFs had similar total margins (0.6 percent and 0.5 percent, respectively). Total margins have declined since 2013 (when the total margin was 1.9 percent), reflecting the impact of reductions to Medicare payments mandated by the Patient Protection and Affordable Care Act of 2010 and the growing share of managed care payments that are lower than Medicare's FFS payments. The aggregate non-Medicare margin (the profitability of all services except Medicare FFS SNF) in 2017 was -2.4 percent, the same as in 2016.

Total margins varied by ownership, though the differences were much smaller than the differences by ownership in Medicare margins. In 2017, the average nonprofit SNF total margin was 1.9 percent compared with 0.2 percent for the average for-profit facility. In 2016, the total margin was 0.8 percent for both nonprofit and for-profit providers. The diverging performances reflect differences in the changes in mixes of revenue and days by payer. Compared with for-profit providers, the share of Medicare revenue and days decreased less for nonprofit facilities and the share of non-Medicare revenues (the lower-payment revenue sources) grew at half the rate of for-profit facilities. (Note that Medicaid revenues are not reported on the Medicare cost report.) Reflecting differences in

payer mix, median facility payments increased 3.4 percent between 2016 and 2017 for nonprofit facilities compared with 2.1 percent for for-profit facilities. Differences in cost growth (median facility costs per day) did not explain the diverging performances. Consistent with the growth in Medicare cost per day (see p. 209), nonprofit facilities experienced higher cost growth compared with for-profit facilities.

The declines in the average total and non-Medicare margins reflect the lower average occupancy rates (which raises the average cost per day) and the lower volume of high-payment Medicare FFS patients. Beneficiaries receiving skilled nursing services are increasingly enrolled in alternative payment models (including bundled payments and ACOs) and MA plans, which typically seek to shorten stays or avoid this setting entirely. In addition, payments from MA plans are generally lower than Medicare's FFS rates (see p. 214). ■

## Endnotes

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- 1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay coverage is paid for by Medicare (Part A). Some beneficiaries who no longer qualify for Medicare coverage remain in the facility to receive long-term care services, which are not covered by Medicare. During long-term care stays, beneficiaries may receive care such as physician services, outpatient therapy services, and prescription drugs that are paid for separately under the Part B and Part D benefits. Services furnished outside the Part A–covered stay are not paid under the SNF prospective payment system and are not considered in this chapter. Except where specifically noted, this chapter examines FFS Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans. Some beneficiaries also qualify for Medicaid and are referred to as “dual-eligible beneficiaries.”
- 2 A spell of illness ends when there has been a period of 60 consecutive days during which the beneficiary was an inpatient of neither a hospital nor a SNF. Coverage for another 100 days does not begin until a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day hospital stay requirement.
- 3 For services to be covered, the SNF must meet Medicare’s requirements of participation and agree to accept Medicare’s payment rates. Medicare’s requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day, providing physical and occupational therapy services and speech–language pathology services as delineated in each patient’s plan of care, and providing or arranging for physician services 24 hours a day in case of an emergency.
- 4 The program pays separately for some services, including certain chemotherapy drugs; certain customized prosthetics; certain ambulance services; Part B–covered dialysis; emergency services; and certain outpatient services provided in a hospital (such as computed tomography, MRI, radiation therapy, and cardiac catheterizations).
- 5 The SNF *Payment Basics* is available at [http://medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_18\\_snf\\_final\\_sec.pdf?sfvrsn=0](http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_snf_final_sec.pdf?sfvrsn=0).
- 6 Payments for NTA services are included in the nursing component, even though NTA costs vary much more than nursing care costs and are not correlated with them.
- 7 We include patients who are assigned to the clinically complex and special care case-mix groups in our definition of medically complex. Clinically complex patients have burns, surgical wounds, hemiplegia, or pneumonia, or they receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while in a SNF. Special care patients are comatose; have quadriplegia, chronic obstructive pulmonary disease, septicemia, diabetes requiring daily injections, fever with specific other conditions, cerebral palsy, multiple sclerosis, Parkinson’s disease, respiratory failure, a feeding tube, pressure ulcers of specific sizes, or foot infections; receive radiation therapy or dialysis while a resident; or require parenteral or intravenous feedings or respiratory therapy for seven days. Intensive therapy days are classified in the ultra-high and very high rehabilitation case-mix groups. Rehabilitation groups are based on minutes of rehabilitation provided per week. “Ultra-high rehabilitation” includes patients who receive more than 720 minutes per week; “very high rehabilitation” includes patients who receive 500–719 minutes per week.
- 8 The share of SNF users requiring the most assistance dropped for transferring, walking in corridor, eating, performing personal hygiene, toileting, dressing, and bed mobility; remained the same for always being incontinent; and increased for help with bathing and always being bowel incontinent.
- 9 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:  
$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 10 The Commission’s measure of discharge to community captures a key goal of many beneficiaries: to go home. It measures the share of beneficiaries discharged home from a SNF. In contrast, CMS’s quality reporting measure gauges the share of beneficiaries who were discharged home, did not have an unplanned readmission within 31 days of discharge, and remained alive.
- 11 CMS’s VBP readmission measure differs from the Commission’s measures that separately track readmissions during the SNF stay and readmissions that occur within 30

- days after discharge. By including readmissions that occur within 30 days of discharge from the hospital, CMS's measure can include readmissions that occur during the SNF stay and after discharge, depending on the length of the SNF stay. For short SNF stays, CMS's measure includes readmissions after discharge from the SNF but still within 30 days of discharge from the hospital stay. For long SNF stays, the measure includes only readmissions that occur within the first 30 days of the SNF stay (assuming an immediate transfer from the hospital) and misses readmissions that occur later in the SNF stay.
- 12 Separate models (with their own covariates) are used to estimate expected community discharge rates for different discharge destinations (e.g., discharged home with home health care, discharged home without home health care, and discharged to a nursing home).
  - 13 With inclusion of the other covariates, age categories were not found to be significant in explaining variation in outcomes and were dropped from the models except for the model explaining differences in readmission during the 30 days after discharge for beneficiaries younger than 65 years residing in the community.
  - 14 The Special Focus Facility Initiative is a program to stimulate improvements in the quality of care at nursing homes with a history of serious quality problems. The initiative targets homes with a pattern over three years of more frequent and more serious problems (including harm or injury to residents) detected in their annual facility surveys. Facilities that improve and maintain those improvements can "graduate" from the program. Providers that do not improve face civil monetary penalties (fines) and eventual termination from Medicare and Medicaid.
  - 15 We compared the assessments conducted at the beginning of stays (the "day 5" assessment). MA plans are not required to submit these assessments, and we cannot determine what share of plans submits them or the possible bias in the assessments that are submitted.
  - 16 A provider tax works as follows: A state taxes all nursing homes and uses the collected amount to help finance the state's share of Medicaid funds. The provider tax increases the state's contribution, which, in turn, raises the amount of federal matching funds. The augmented federal funds more than cover the cost of the provider tax revenue, which is returned to providers. The provider tax is limited to 6 percent of net patient revenues.

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