CHAPTER 7

Skilled nursing facility services

RECOMMENDATION

7 The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2012.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

(For additional recommendations on improving the skilled nursing facility payment system, see text box on p. 165.)

CHAPTER 7

Skilled nursing facility services

Chapter summary

Skilled nursing facilities (SNFs) furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. Most SNFs are part of nursing homes that furnish long-term care, which Medicare does not cover. In 2009, 15,068 SNFs furnished covered care to just under 5 percent of fee-for-service (FFS) beneficiaries (1.6 million). In fiscal year 2010, Medicare spent $26.4 billion on SNF care.

Assessment of payment adequacy

Most indicators of payment adequacy for SNFs are positive.

Beneficiaries' access to care—Access to SNF services remains stable for most beneficiaries, though minorities use SNF services less than other beneficiaries. We have not gathered empirical information on the reasons for these differences.

- ***Capacity and supply of providers***—The number of SNFs has increased gradually since 2001. Three-quarters of beneficiaries live in a county with five or more SNFs, and less than 1 percent live in a county without one. Available SNF bed days increased 4 percent between 2008 and 2009. However, since 2004, the share of SNFs admitting medically complex patients decreased. As a result, some beneficiaries may have to wait to be placed in a SNF that will take them.
- ***Volume of services***—Days and admissions on a per FFS beneficiary basis decreased slightly between 2008 and 2009, reflecting fewer hospital

In this chapter

admissions (a prerequisite for Medicare coverage). Still, use rates were higher in 2009 than in 2006. Admission rates in 2009 for minority beneficiaries were lower than for white beneficiaries, though the difference was smaller than in 2008.

***Quality of care*—**SNF quality of care in 2008 was basically unchanged from the prior year. Two indicators of quality in SNFs are the rates at which patients are discharged to the community within 100 days of admission and the rates at which patients are rehospitalized for conditions that potentially could have been avoided. Since 2000, measures show mixed results; the percent discharged to the community increased (indicating improved quality), while the percent rehospitalized exhibited almost no change. Risk-adjusted quality outcomes did not vary by race.

***Providers' access to capital*—**Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital; it improved over last year but some investors are wary of the impact of states' budget difficulties. Any uncertainties in lending do not center on the adequacy of Medicare payments; from all accounts, Medicare remains a sought-after payer.

***Medicare payments and providers' costs*—**Increases in payments between 2008 and 2009 outpaced increases in providers' costs, reflecting the continued concentration of days in the highest payment case-mix groups. In 2009, the average Medicare margin for freestanding SNFs was 18.1 percent.

Financial performance continued to differ substantially across the industry—a function of distortions in the prospective payment system and cost differences of providers. Compared with SNFs with relatively low margins, SNFs with the highest margins had greater shares of days in intensive rehabilitation case-mix groups and smaller shares of days in the medically complex groups. We found that freestanding SNFs with low Medicare margins had standardized costs per day (adjusted for differences in wages and case mix) that were 41 percent higher than SNFs with high Medicare margins. We also examined relatively efficient SNFs and found that it is possible to have costs well below average, above-average quality, and more than adequate Medicare margins.

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid utilization, spending, and non-Medicare margins—in the absence of information on Medicaid margins. Medicaid finances mostly long-term care services provided in nursing homes but also covers copayments for dual-eligible beneficiaries who stay 21 or more days in a SNF. The number of Medicaid-certified facilities decreased between 2000 and 2009 but Medicaid-covered days and spending increased during this period. Non-Medicare margins (for all lines of business) were negative between 2000 and 2009, but total margins (for all payers and all lines of business) were positive. ■

TABLE 7–1

A growing share of Medicare stays and payments go to freestanding SNFs and for-profit SNFs

	Facilities		Medicare-covered stays		Medicare payments	
Type of SNF	**2005**	**2009**	**2005**	**2009**	**2005**	**2009**
Total number	15,001	15,068	2,444,796	2,369,016	$18.2 billion	$24.1 billion
Freestanding	92%	94%	87%	92%	93%	96%
Hospital based	8	6	13	8	7	4
Urban	67	70	79	81	81	83
Rural	33	30	21	19	19	17
For profit	68	69	66	69	72	74
Nonprofit	28	26	30	26	25	22
Government	5	5	4	4	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding and missing values.

Source: MedPAC analysis of the Provider of Services, Medicare Provider Analysis and Review files, and Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system for 2001–2009.

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 those recovering from surgical procedures, such as hip and knee replacements, or from medical conditions, such as stroke and pneumonia. About 1.6 million fee-for-service (FFS) beneficiaries (or about 5 percent) used SNF services at least once in 2009 and program spending totaled an estimated $26.4 billion in fiscal year 2010.

Medicare covers up to 100 days of SNF care after a medically necessary hospital stay of at least three days. Of the beneficiaries who use post-acute care (defined as home health, inpatient rehabilitation, long-term care hospital, or SNF services after a hospitalization), 29 percent use SNF services. For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment rate for the first 20 days of care. Beginning with day 21, beneficiaries are responsible for copayments. For calendar year 2011, the copayment is $141.50 per day.

Most SNFs are parts of nursing homes that treat patients who generally require less intensive, long-term care services than the skilled services required for Medicare coverage. The term "skilled nursing facility" refers to a provider that meets Medicare requirements for Part A coverage.[1] The vast majority (more than 90 percent) of SNFs are dually certified as a SNF and as a nursing home. Thus, a facility that provides skilled care often also furnishes long-term care services that Medicare does not cover. In 2009, there were 15,068 facilities that were certified as Medicare providers, Medicaid providers, or both. Medicaid is the predominant payer in nursing homes, accounting for 65 percent of days. The Patient Protection and Affordable Care Act of 2010 required the Commission to examine nursing home spending, utilization, and financial performance trends under the Medicaid program (p. 164).

The vast majority of SNFs are freestanding, with 6 percent being hospital based (Table 7-1). Between 2005 and 2009, freestanding facilities and for-profit facilities accounted for growing shares of Medicare stays and spending. For example, in 2009, 69 percent of SNFs were for profit and treated about the same share of stays but accounted for almost three-quarters of Medicare payments.

Medicare-covered SNF patients are typically a small share of a facility's total patient population but a larger share of the facility's payments. At the median in 2009, Medicare-covered SNF days made up 12 percent of total patient days in freestanding facilities but 23 percent of facility revenue.

TABLE 7–2 **Broad case-mix groups used for payments before fiscal year 2011**

Patient group	Types of patients included in group
Broad resource utilization groups	
Clinically complex	Patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy.
Extensive services	Patients who have received intravenous medications or suctioning in the past 14 days, required a ventilator/respirator or tracheostomy care, or received intravenous feeding within the past 7 days.
Special care	Patients with multiple sclerosis, surgical wounds, skin ulcers, or cerebral palsy; those who receive respiratory services seven days per week; or those who are aphasic or tube fed.
Rehabilitation	Groups based on minutes of rehabilitation per week: Ultra high: patients received over 720 minutes Very high: patients received 500–719 minutes High: patients received 325–499 minutes Medium: patients received 150–324 minutes Low: patients received 45–149 minutes
Rehabilitation plus extensive services	Patients received enough rehabilitation services to qualify them for a rehabilitation case-mix group and they received one or more extensive services.
Groups used in MedPAC analyses	
Medically complex	Clinically complex and special care cases. Extensive service groups are excluded from this definition because days can be assigned to them based on services furnished before admission to the skilled nursing facility. CMS found that services provided during the prior hospital stay were not an accurate proxy for medical complexity (Centers for Medicare & Medicaid Services 2009).
Intensive rehabilitation	Ultra high rehabilitation, ultra high rehabilitation plus extensive services, very high rehabilitation, and very high rehabilitation plus extensive services cases.

Note: Table reflects the resource utilization groups (RUGs), version III. In October 2011, CMS implemented revised case-mix groupings, RUG version IV. These broad groupings remain intact with the RUG–IV groups.

SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay for each day of service.[2] 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). RUGs differ by the services furnished to a patient (such as the amount and type of therapy furnished and the use of respiratory therapy and specialized feeding), the patient's clinical condition (such as whether the patient has pneumonia), and the patient's need for assistance to perform activities of daily living (such as eating and toileting).

The Commission has previously made recommendations related to three shortcomings of the SNF PPS (Medicare Payment Advisory Commission 2008b). First, the PPS does not adequately adjust payments to reflect the variation in providers' costs for nontherapy ancillary (NTA) services (for most patients these services are predominantly drugs). Payments for NTA services are tied to the nursing component, even though NTA costs

do not necessarily vary with, and are much more variable than, staff time. The Commission recommended that a separate payment component be established to pay for NTA services so that payments are targeted to patients with high NTA care needs. This past year, we explored alternative designs that met the criteria laid out for this component by CMS (Wissoker and Garrett 2010).[3] The revised models retained most of their ability to predict the variation in NTA costs but are simpler and would be easier to implement than the original design. The Commission and CMS staff have discussed these results, but to date CMS has not taken action to correct this problem.

A second shortcoming is that because payments increase with the provision of therapy, SNFs have a financial incentive to furnish these services. The Commission recommended replacing the existing therapy component with one that bases payments on patient characteristics so that payments vary with care needs, not service provision. CMS has not corrected this problem.

A third shortcoming is that the SNF PPS does not have an outlier policy to help defray the cost of exceptionally high-cost stays. CMS does not have the authority to establish an outlier policy.

CMS's revisions to the SNF PPS

CMS has taken steps to enhance payments for medically complex care but more work remains. In 2010, CMS revised the case-mix classification system (to RUGs version IV) by redefining many of the groupings, adding 13 case-mix groups (to 66 groups) for medically complex patients (see Table 7-2 for definitions), and tightening the definitions of the extensive services groups. At the same time, CMS shifted program dollars away from therapy care and toward medically complex care (Centers for Medicare & Medicaid Services 2009).[4] These changes will make treating medically complex patients more financially attractive. However, because payments for NTA services continue to be tied to the nursing component, payments may not match a patient's NTA care needs. CMS needs to establish separate payments for NTA services so that patients with high NTA care needs are not disadvantaged by the PPS.

To control therapy provision, CMS modified the way it counts therapy services furnished concurrently (when a therapist supervises multiple patients at the same time and patients are engaged in different therapy activities). To accurately capture the fewer resources required to furnish therapy concurrently, patients who receive therapy services concurrently will qualify for less intensive rehabilitation case-mix groups than under the previous counting rules. Using the same logic, CMS should revise the way it counts group therapy minutes. Group therapy occurs when a therapist supervises multiple patients at the same time and patients are engaged in the same therapy activities. In a letter to CMS, the Commission urged CMS to make similar changes to the way group therapy services are counted (Medicare Payment Advisory Commission 2010). Without this change, providers have a financial incentive to furnish therapy in groups, even though the modality may not provide the most benefit to the patient.

Even with more accurate counts of minutes, the provision of therapy will continue to drive Medicare's payments to SNFs. The Commission supports basing payments on care needs, not service provision. To date, CMS has not addressed this fundamental problem in the PPS.

Are Medicare payments adequate in 2011?

Indicators of payment adequacy are positive for SNFs. To make this assessment, we analyzed access to care (including the supply of providers and volume of services), the quality of care, provider access to capital, Medicare payments in relation to costs to treat Medicare beneficiaries, and changes in Medicare payments and costs. We also compared the performance of SNFs with relatively high and low Medicare margins.

Beneficiaries' access to care: Access is stable for most beneficiaries

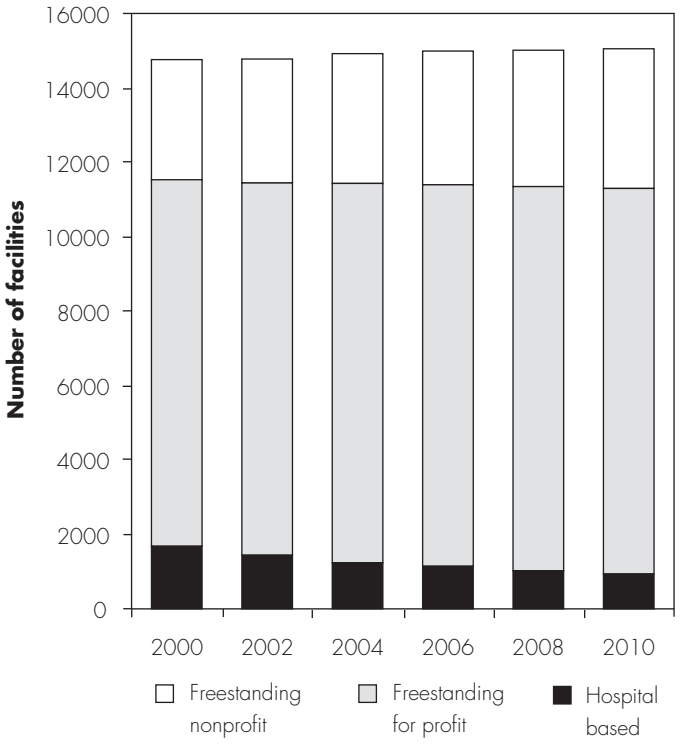
We do not have direct measures of access. Instead, we consider the supply and capacity of providers and evaluate changes in volume. Since 2000, the number of SNFs and bed days available increased, including the recent period between 2008 and 2009. After steadily increasing between 2006 and 2008, admissions and days per 1,000 FFS beneficiaries declined between 2008 and 2009. This decrease is likely due to the decline in hospital admissions, a prerequisite for Medicare coverage.

Capacity and supply of providers: Supply remains stable

Since 2000, the number of SNFs participating in the Medicare program slowly increased from 14,778 to 15,070 in 2010 (Figure 7-1, p. 152). Between 2009 and 2010, 97

FIGURE 7–1

The number of SNFs grew slightly since 2000, but the mix has shifted toward freestanding facilities



Note: SNF (skilled nursing facility). Counts do not include swing beds.

Source: MedPAC analysis of data from the Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system for 2000–2010.

facilities began participating in the program, all but one were freestanding, and almost two-thirds of them were for profit.[5] One hospital-based unit began participating in the Medicare program in 2010, but many more stopped, so there were 30 fewer hospital-based facilities by the end of 2010. Less than 1 percent of SNFs stopped participating in the Medicare program last year and most of those terminations were voluntary.

Most beneficiaries live in counties with multiple SNFs. Three-quarters of beneficiaries live in counties with 5 or more SNFs, 59 percent live in counties with 10 or more, and less than 1 percent of beneficiaries live in a county without a SNF.

The ownership mix has been stable since 2005, with for-profit facilities composing 69 percent of the industry. In 2010, hospital-based units made up 6 percent of the industry, the same share as in 2009. Since 2000, there has been a very small increase in the share of freestanding facilities that are nonprofit, from 25 percent to 27 percent.

Other measures of capacity include the number of SNF beds available during the year and occupancy rates. SNF bed days available (the days available for occupancy after adjusting for beds temporarily out of service due to, e.g., renovation or patient isolation) increased 4 percent between 2008 and 2009 in freestanding facilities. Since 2001, the increase in bed days available averaged 7 percent a year. In 2009, the average occupancy rate was 83 percent, slightly down from 2005.

While supply remains stable, the number of SNFs that treat medically complex patients (for definitions, see Table 7-2, p. 150) continues to decline. Between 2004 and 2008, the number of facilities admitting clinically complex and special care patients decreased (by 6 percent and 5 percent, respectively), even though the number of SNFs remained about the same (Figure 7-2). As a result, the distributions of medically complex admissions were more concentrated in fewer SNFs compared with rehabilitation admissions.[6]

There was wide variation in the share of facility admissions classified into medically complex case-mix groups. In 2008, although the median share of medically complex admissions to a facility was 2 percent, there were 149 facilities with at least 31 percent of their admissions in these groups.[7] These 149 facilities were disproportionately:

- ***Rural.*** Rural SNFs made up 48 percent of this highest share group compared with one-third of the industry. Rural SNFs located in the least populated counties (those with less than 2,500 population and not adjacent to a metropolitan area) made up less than 2 percent of all SNFs but 10 percent of SNFs with the highest shares of medically complex admissions.
- ***Nonprofit.*** Nonprofit SNFs made up 26 percent of the industry but one-third of this highest share group.
- ***Hospital based.*** Hospital-based SNFs made up 6 percent of the industry but more than one-quarter of facilities with the highest shares.

The decline in the number of SNFs willing or able to treat special care and clinically complex patients may reflect many factors. First, the relative attractiveness of the payments for rehabilitation case-mix groups may encourage some SNFs to furnish enough therapy

services to medically complex patients so they qualify for higher payment rehabilitation case-mix groups (rather than the special care or clinically complex case-mix groups). Second, certain medically complex care (such as ventilator, tracheostomy, and wound care) requires specific facility and staffing capabilities that are not available at all SNFs. These service offerings may meet some facilities' missions or complement other services they provide. Third, some areas of the country lack inpatient rehabilitation and long-term care hospitals so that patients who might be placed in these alternative facilities are treated in SNFs.

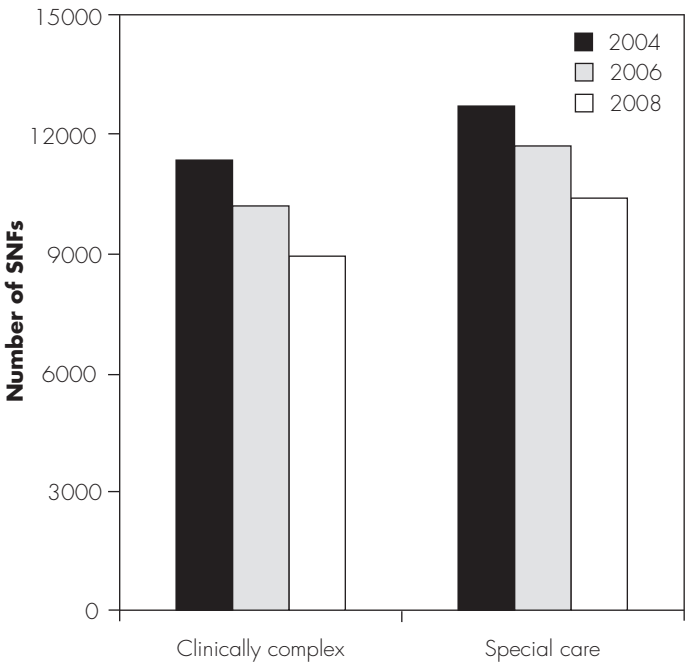
Before the revisions to the SNF PPS in 2011, SNFs had a financial advantage to treat rehabilitation patients over medically complex patients. As a result, some medically complex patients could experience delays in being placed in a SNF. Because racial minorities make up a disproportionate share of medically complex admissions, minority beneficiaries may have been more likely to experience delays in being transferred to a SNF or to be placed in SNFs further from their homes compared with other beneficiaries.[8] Beginning in 2011, the expanded number of case-mix groups for medically complex patients and the increased payments for the nursing component of the daily payment (see discussion on p. 151) may encourage some facilities to admit these patients.

Volume of services: After steady increase, small declines between 2008 and 2009

In 2009, the share of FFS beneficiaries who used SNF services remained at just under 5 percent. We examine utilization on a FFS beneficiary basis because the counts of users, days, and admissions do not include service use by beneficiaries enrolled in Medicare Advantage (MA) plans. Because MA enrollment continues to increase, changes in reported utilization could reflect a declining number of FFS beneficiaries rather than reductions in service use.

After increasing between 2006 and 2008, SNF volume per FFS beneficiary declined between 2008 and 2009 (Table 7-3, p. 154). Between 2008 and 2009, admissions went down 1.6 percent, while covered days were 0.7 percent lower. The small decline in admissions is expected because inpatient hospital stays, which are required for Medicare coverage of SNF services, also declined. Despite the reduction, use levels were higher in 2009 than they were in 2006.

FIGURE 7–2 **The number of SNFs that admitted clinically complex and special care cases decreased between 2004 and 2008**



Note: SNF (skilled nursing facility). Category based on admitting case-mix group assignment. The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or those who are aphasic or tube fed.

Source: MedPAC analysis of DataPro data from CMS.

SNF use is uneven among beneficiaries of different races, raising concerns about minorities' access to care (Figure 7-3, p. 155). In 2009, admissions per 1,000 FFS beneficiaries were 16 percent higher for whites than for beneficiaries of other races. Although admission rates were lower, lengths of stay for beneficiaries of other races were longer than those for white beneficiaries, perhaps reflecting differences in case mix. We have not examined these racial differences to know, for example, whether minority beneficiaries use other post-acute services instead of SNF care or whether minority beneficiaries are less likely to be hospitalized for conditions that typically require subsequent SNF care. Other studies have found that racial differences in SNF use have narrowed over time and that racial groups differ in their use of post-acute care services (Konetzka and Werner 2009). White beneficiaries are more likely than minorities to use assisted living

TABLE 7–3 **Small decline in SNF volume between 2008 and 2009**

	2006	2007	2008	2009	Percent change 2006–2009	Percent change 2008–2009
Volume per 1,000 fee-for-service beneficiaries						
Covered admissions	71	72	73	72	1.4%	–1.6%
Covered days (in thousands)	1,874	1,921	1,977	1,963	4.7	–0.7
Covered days per admission	26.4	26.7	27.0	27.3	3.4	0.9

Note: SNF (skilled nursing facility). Data include 50 states and the District of Columbia.

Source: Calendar year data from CMS, Office of Research, Development, and Information.

facilities and racial minorities are more likely to use home health care and informal home care.

Growth in the number and intensity of rehabilitation days

Rehabilitation days continued to grow as a share of all Medicare SNF days, though the pace has slowed. In 2009, rehabilitation days accounted for 92 percent of Medicare SNF days, up from 83 percent in 2005 (Figure 7-4). The nine case-mix groups for days that qualify for both rehabilitation plus extensive services (for definitions, see Table 7-2, p. 150) accounted for 39 percent of days, up from 34 percent in 2007. The large number of rehabilitation plus extensive services days may reflect providers' coding improvements to record extensive services provided by the SNF or during the previous hospital stay to obtain higher payments associated with these case-mix groups.[9] The growth also reflects specific strategies by some providers to maximize profits. Annual reports filed by publicly traded companies state that attracting Medicare patients and furnishing intensive therapy are business strategies they pursue (Extendicare 2008, Extendicare 2009, Extendicare Real Estate Investment Trust 2009, Kindred Healthcare 2010, Skilled Healthcare Group 2010, Sun Healthcare Group 2009, Sun Healthcare Group 2010, Wells Fargo Securities 2010).

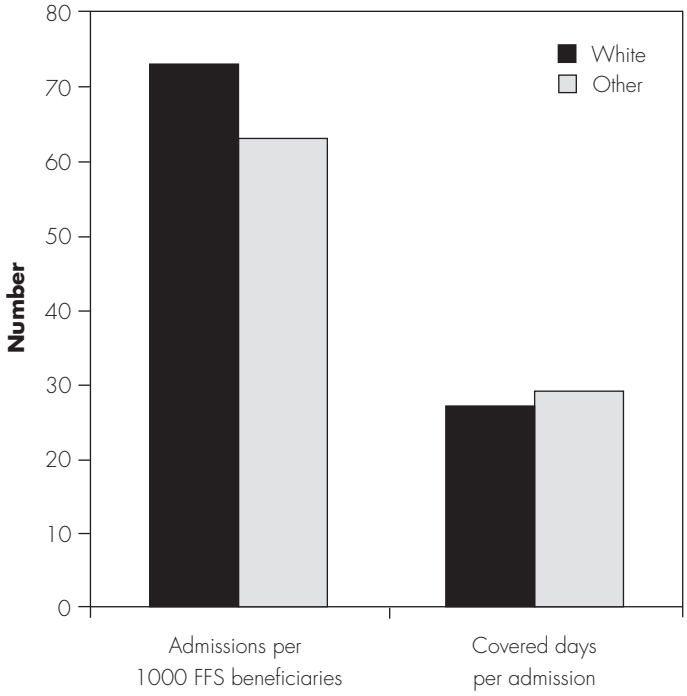
Within the rehabilitation case-mix groups, the distribution of days continued to shift toward the highest intensity, and therefore highest payment, therapy groups. Between 2006 and 2009, the share of ultra high and very high rehabilitation days grew from 56 percent to 71 percent of all rehabilitation days. However, growth in the volume of ultra high and very high days has slowed. It is unlikely that these increases reflect a change in patient care needs. At admission, there were small declines between 2006 and 2008 in patients' ability to conduct activities of daily living at admission (as measured by the Barthel score) and cognitive function (3 percent and 2 percent, respectively); during this period, total therapy days increased 16 percent.

Some of the shift in rehabilitation days may be explained by a shift in site of service from inpatient rehabilitation facilities (IRFs) to SNFs as IRFs comply with a rule requiring that at least 60 percent of IRF patients must have 1 of 13 specified conditions. Under this rule, only a subset of patients recovering from major joint replacement, the largest category of IRF admissions in 2004, count toward the threshold. Between 2004 and 2009, the share of beneficiaries who had a major joint replacement and were discharged from a hospital to a SNF increased by 4 percentage points (from 33 percent to 37 percent), the share discharged to home health care increased by 10 percentage points (from 21 percent to 31 percent), while the share discharged to an IRF decreased by 15 percentage points (from 28 percent to 13 percent).

Quality of care: SNF quality virtually unchanged from prior year

The quality of care furnished to patients during a Medicare-covered SNF stay continued to show mixed results (Table 7-4, p. 156). Since 2000, one outcome measure (the risk-adjusted rate of discharge to the community) showed slight improvement and the other (the risk-adjusted rate of rehospitalization for any of five care-sensitive conditions) exhibited almost no change.[10] Both measures showed almost no change between 2007 and 2008.[11]

FIGURE 7–3 **SNF admission rates and covered days per admission vary by race, 2009**



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

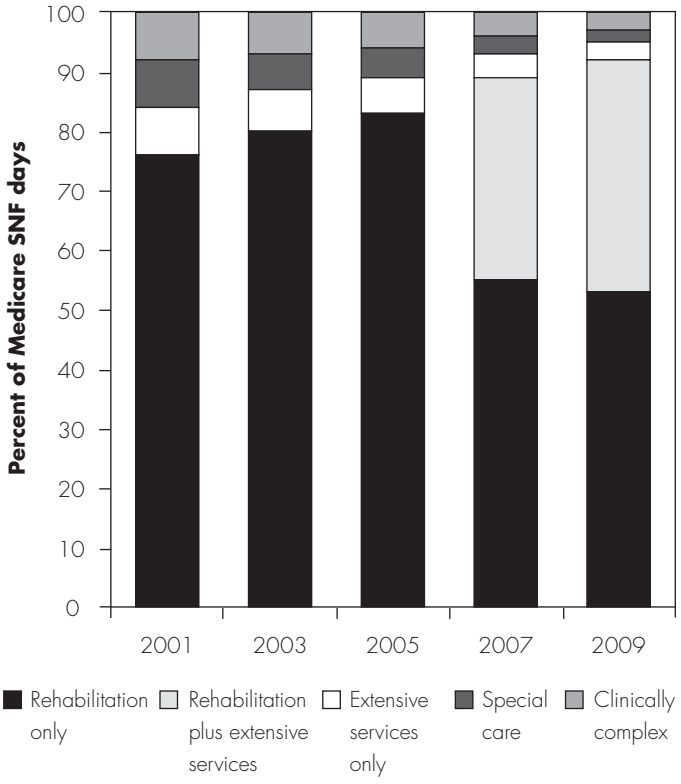
Source: Calendar year data from CMS, Office of Research, Development, and Information.

In 2008, the most recent year for which data are available, the risk-adjusted rate at which SNFs discharged patients to the community within 100 days—36 percent—was essentially the same as in the prior year. Since 2000, the rate has increased 2.7 percentage points, indicating improved quality. Nonprofit facilities and hospital-based facilities had higher risk-adjusted community discharge rates than other SNFs, and urban facilities had slightly higher community discharge rates than rural facilities.

In 2008, the risk-adjusted rate at which Medicare-covered SNF patients were rehospitalized for potentially avoidable causes was 13.9 percent, almost the same as in 2007. The risk-adjusted rate of potentially avoidable rehospitalization within 100 days for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) has increased only slightly since 2000, indicating almost no change in quality.

Across facilities, risk-adjusted quality measures varied considerably (Table 7-5, p. 157). Facilities with the highest community discharge rates (90th percentile, or almost 1,200 facilities) discharged more than 52 percent of SNF patients to the community within 100 days; facilities with the lowest rates (lowest 10th percentile) discharged only 16 percent or less. Rehospitalization rates varied less but still more than twofold. Facilities with the lowest rates (the best) rehospitalized 8.5 percent of their SNF patients, while facilities with the highest rates rehospitalized more than 20 percent. In 2008, the Commission recommended

FIGURE 7–4 **Case mix in freestanding SNFs continued to shift toward rehabilitation plus extensive services RUGs and away from other broad RUG categories**



Note: SNF (skilled nursing facility), RUG (resource utilization group). The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or are aphasic or tube fed. The extensive services category includes patients who have received intravenous medications or suctioning in the past 14 days, have required a ventilator/respiratory or tracheostomy care, or have received intravenous feeding within the past 7 days. The rehabilitation plus extensive service case-mix groups were implemented in 2006 and therefore are not seen in the mix of days between 2001 and 2005. Days are for freestanding SNFs with valid cost report data.

Source: MedPAC analysis of freestanding SNF cost reports.

TABLE 7–4 **Risk-adjusted SNF quality measures show mixed results since 2000**

Measure	2000	2002	2004	2006	2007	2008	Percentage point change 2000–2008
Percent discharged to community	33.3%	34.0%	34.4%	35.3%	35.9%	36.0%	2.7
Percent rehospitalized for any of 5 conditions	13.7	13.8	13.8	13.8	13.8	13.9	0.2

Note: SNF (skilled nursing facility). Increases in rates of discharge to community indicate improved quality. The five conditions include congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance. Increases in rehospitalization rates for the five conditions indicate worsening quality. Rates are calculated for all facilities with 25 or more stays.

Source: Rates calculated for MedPAC by the Division of Health Care Policy and Research University of Colorado at Denver and Health Sciences Center (Fish et al. 2011).

that SNF payments be tied to quality and noted that these measures could be part of a starter set of measures.

The Commission has discussed the need to synchronize the payment policies for hospitals and post-acute care providers. One way to make these policies parallel is to penalize SNFs that have high readmission rates, similar to the policy now in place for hospitals. If aligned, hospitals and SNFs would both have incentives to prevent premature discharge from hospitals, ensure good care transitions to SNFs, and furnish appropriate care in the SNF to prevent potentially avoidable rehospitalizations. Over the next year, we plan to examine policy options for lowering the number of rehospitalizations from SNFs.

We also examined observed rates of outcome measures by race. Despite differences in observed rates, once beneficiaries' characteristics—such as ability to perform activities of daily living, cognitive function, and comorbidities—were accounted for, the outcome differences by racial group were not statistically significant.

Providers' access to capital: Available but uncertainties persist

A vast majority of SNFs operate within nursing homes; therefore, in assessing SNFs' access to capital we look at access for nursing homes. Capital is more available now than last year, although the uncertainties of states' budgets give some lenders and borrowers pause. Hesitation in lending is not an indicator of the adequacy of Medicare payments: The program continues to be a highly valued payer. Because most operators make their bottom line using Medicare profits, lenders and owners use Medicare payer mix as one metric of a facility's financial health.

The volume of mergers and acquisitions is one measure of the availability of capital. Although the number of publicly announced mergers and acquisitions of long-term care providers (nursing homes and assisted living facilities) declined (from 96 in 2008 to 90 in 2009), the dollar value more than doubled (Irving Levin Associates Inc. 2010). For homes that sold, the median price paid per nursing home bed increased 18 percent between 2008 and 2009 (Irving Levin Associates Inc. 2009, Irving Levin Associates Inc. 2010). This increase reflects the fact that well-run facilities, especially those with a high Medicare patient mix and located in markets close to hospitals, are a steady investment. Many providers do not make money on Medicaid even in "good" years but will wait out the current fiscal crisis facing many states. Despite uncertain reimbursement and the general health of the economy, the sector remains remarkably resilient (Irving Levin Associates Inc. 2010).

Lending by the Department of Housing and Urban Development (HUD) continues to be an important source of funds. Since 2008, HUD's lending dramatically increased as a result of an overhaul of its federally insured mortgages program for nursing homes under Section 232/222.[12] Between 2009 and 2010, the number of HUD-financed projects increased 45 percent (to 369 projects) and HUD's insured mortgage amounts increased to $3.2 billion in 2010 (Department of Housing and Urban Development 2010). Most funded projects refinance existing loans. Less than 15 percent of the projects are new construction or major renovation. HUD reports 327 projects in its queue as of October 2010, making it the sector's busiest lender.

TABLE 7–5 **Considerable variation in risk-adjusted quality measures across SNFs, 2008**

Measure	Percentile		
	10th	50th	90th
Percent discharged to community	16.0%	35.2%	52.3%
Percent rehospitalized for any of 5 conditions	8.5	14.1	20.4

Note: SNF (skilled nursing facility). Increases in rates of discharge to community indicate improved quality. The five conditions include congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance. Increases in rehospitalization rates for the five conditions indicate worsening quality. Rates are calculated for all facilities with 25 or more stays.

Source: Rates calculated for MedPAC by the Division of Health Care Policy and Research University of Colorado at Denver and Health Sciences Center (Fish et al. 2011).

With implementation of the new case-mix groups, some providers plan to renovate their facilities to accommodate medically complex patients who require ventilator or cardiac rehabilitation. Market analysts noted that delayed implementation of the new case-mix groups and changes to the counting of concurrent therapy minutes created some added risk to this sector (Wells Fargo Securities 2010). As providers focus on higher acuity patients, lenders have increased their attention on facilities' operations, focusing on the quality of care furnished, patient census, and cash on hand (Williamson 2010).

Medicare payments and providers' costs: Medicare margins continue to increase

Between 2008 and 2009, Medicare payments increased faster than Medicare costs, resulting in an aggregate 2009 Medicare margin of 18.1 percent. Medicare margins continued to vary more than twofold across ownership groups. Examining the range in financial performance, we found that high-margin SNFs had considerably lower costs and, to a smaller extent, higher payments than low-margin SNFs. We also found that some SNFs consistently furnished relatively low-cost, high-quality care and had substantial Medicare margins.

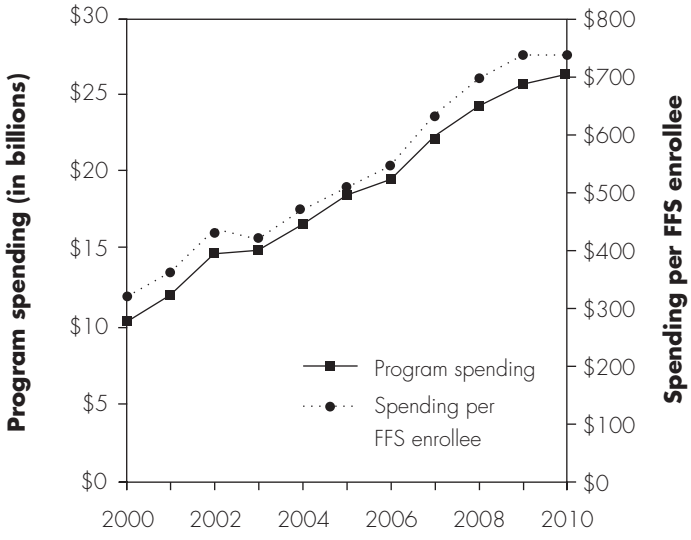
Program spending in 2010 topped $26 billion

In fiscal year 2010, spending for SNF services was $26.4 billion, up 2.3 percent from 2009 (Figure 7-5), the smallest increase since 2002. This lower growth rate reflects a slowdown in the growth in the volume of days classified into the highest payment case-mix groups. Spending on a per beneficiary basis declined slightly, reflecting an increase in the number of FFS beneficiaries between 2009 and 2010 that outpaced the growth in total spending.

SNF Medicare margins continue to grow

The Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's payments with the costs to treat beneficiaries. A total margin, in contrast, reflects the financial performance of the entire facility across all lines of business (such as ancillary and therapy services, hospice, and home health care) and all payers. Total margins are presented as context for the Commission's update recommendation.

FIGURE 7–5 **Slower growth in program spending on skilled nursing facilities**



Note: FFS (fee-for-service). Years are fiscal years. FFS counts include all beneficiaries enrolled in FFS Medicare.

Source: CMS, Office of the Actuary, 2010.

TABLE 7–6 **Freestanding SNF Medicare margins continue to increase**

	2003	2004	2005	2006	2007	2008*	2009*
Number of freestanding cost reports	10,941	11,252	11,301	11,379	11,625	12,549	12,827
Margin, by type of SNF							
All	10.9%	13.7%	13.0%	13.3%	14.7%	16.6%	18.1%
Urban	10.3	13.2	12.6	13.1	14.5	16.3	18.0
Rural	13.8	16.1	15.2	14.3	15.5	17.9	18.7
For profit	13.3	16.2	15.2	15.7	17.2	19.1	20.3
Nonprofit	1.6	3.6	4.6	3.5	4.2	7.1	9.5
Government**	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: SNF (skilled nursing facility), N/A (not available).
*CMS reports that an increased number of SNFs filed cost reports. This increase is attributed to the consolidation of audit operations at Medicare Contractors that resulted in a change in the number of cost reports being filed by "low utilization" facilities. As a result, more SNFs met the Commission's data screens to be included in the analysis.
**Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of freestanding SNF cost reports, 2003–2009.

SNF aggregate Medicare margins continued to increase, reflecting the continued concentration of days in the highest paying case-mix groups. In 2009, the aggregate Medicare margin for freestanding SNFs was 18.1 percent, the ninth consecutive year with a margin above 10 percent (Table 7-6).

Since 2006, Medicare payments per day have increased faster than costs per day, resulting in growing SNF margins. From 2008 to 2009, Medicare payments per day grew 6.1 percent, while Medicare costs per day grew 4.3 percent.

The financial performance of freestanding SNFs continued to vary widely. Consistent with previous years, in 2009, rural SNFs had slightly higher Medicare margins than their urban counterparts. Facilities in the most rural areas (nonmetropolitan areas not adjacent to an urban area, with populations less than 2,500) had an aggregate Medicare margin of 19.2 percent. The disparity between for-profit and nonprofit facilities was large but has declined since 2007. The Medicare margin for for-profit SNFs was 20.3 percent, compared with 9.5 percent in nonprofit facilities. One-half of freestanding SNFs had Medicare margins of 18.7 percent or more, while one-quarter of them had Medicare margins at or below 8.8 percent, and one-quarter had Medicare margins of 26.7 percent or higher (Table 7-7).

Thirteen percent of freestanding SNFs had negative Medicare margins in 2009 and more than half of them also had negative Medicare margins in 2007 and 2008. Facilities with negative Medicare margins in 2009 on

TABLE 7–7 **Freestanding SNF Medicare margins vary considerably in 2009**

	Percentile				
Measure	**10th**	**25th**	**50th**	**75th**	**90th**
Medicare margin	–4.1%	8.8%	18.7%	26.7%	34.2%

Note: SNF (skilled nursing facility). Values shown in the table are the margin at the percentile cutoff.

Source: MedPAC analysis of freestanding SNF cost reports for 2009.

Should Medicare's skilled nursing facility payments subsidize payments from other payers?

Industry representatives contend that Medicare payments should subsidize payments from other payers, in large part Medicaid. However, the Commission believes such cross-subsidization is not advisable for several reasons. First, on average, Medicare payments account for less than a quarter of revenues to freestanding skilled nursing facilities. A cross-subsidization policy would use a minority share of Medicare payments to underwrite a majority share of states' Medicaid payments. Second, raising Medicare rates to supplement low Medicaid payments would result in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from the higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies. Third, increased Medicare payment rates could encourage states to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates. In addition, a Medicare subsidy would have an uneven impact on payments, given the variation across states in the level and method of paying for nursing home care. In states where Medicaid payments were adequate, the subsidy would add to excessive payments. Last, higher Medicare payments could further encourage providers to select patients based on payer source or to rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay. ■

average were smaller and had shorter Medicare stays, which resulted in costs per day that were one-third higher than in other facilities. They also had much smaller shares of patients in ultra high and very high rehabilitation case-mix groups, which lowered their average payments per day relative to other SNFs. However, they had positive non-Medicare margins and only slightly negative total margins (–0.5 percent). Compared with the industry as a whole, SNFs with negative Medicare margins were more likely to be nonprofit. While nonprofit facilities made up 26 percent of freestanding facilities, they made up 37 percent of SNFs with negative Medicare margins. The mix of rural and urban facilities with negative Medicare margins was similar to that of the industry as a whole. Although every state had at least two facilities with negative Medicare margins, some states (Colorado, Maryland, Michigan, New Jersey, New York, Pennsylvania, and West Virginia) were overrepresented in the group of facilities with negative Medicare margins, while other states were underrepresented (Georgia, Illinois, Indiana, Iowa, Louisiana, Minnesota, Missouri, North Carolina, and Texas).

The aggregate total (all payer, all lines of business) margin for freestanding SNFs in 2009 was 3.5 percent, with one-quarter of facilities having total margins at or below –1.2 percent and one-quarter with total margins equal to or greater than 8.3 percent. Total margins are driven in large part by low Medicaid payments. This industry's overall financial health is shaped 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). There are many reasons why using Medicare payments to cross-subsidize Medicaid payments is ill-advised (see text box). An additional factor in a facility's total financial performance is the share of revenues from private payers (generally considered favorable) and other lines of business (such as ancillary, home health, and hospice services) that contribute to a facility's total financial performance.

On average, SNFs with the highest Medicare margins had relatively high total margins, while those with the lowest Medicare margins had low total margins (Table 7-8, p. 160). The Medicare margins for SNFs in the top quartile of Medicare margins averaged 32.6 percent and their total margin averaged 6.9 percent. Conversely, those in the bottom quartile of Medicare margins had Medicare margins of –0.7 percent and a total margin of 0.1 percent. Although the facilities' proportion of Medicare days did not vary much across quartiles (not shown), the Medicare shares of payments were quite different. Facilities in the bottom quartile of Medicare margins had 16 percent of their revenues from Medicare, while the Medicare share in facilities with the highest Medicare margins was 26

TABLE 7–8 **Characteristics of freestanding SNFs by Medicare margin quartile in 2009**

	Quartile of Medicare margin			
Measure	**Bottom**	**2nd**	**3rd**	**Top**
Medicare margin	–0.7%	14.5%	22.6%	32.6%
Total margin	0.1	2.7	4.5	6.9
Medicare share of facility revenues	16	23	25	26
Share of intensive rehabilitation days	54	63	67	69
Medicaid share of days	61	61	61	63
Medicare payments per day	$395	$412	$420	$427
Medicare costs per day	406	355	325	284

Note: SNF (skilled nursing facility). All values are medians for the quartile. Share of intensive rehabilitation days is the share of Medicare-covered days classified into ultra high and very high rehabilitation case-mix groups.

Source: MedPAC analysis of freestanding SNF cost reports for 2009.

percent. These differences were driven by the proportion of intensive rehabilitation days, which varied from 54 percent in the bottom quartile facilities to 69 percent in the top quartile facilities. Average Medicaid shares of facility days did not vary substantially across quartiles. SNFs in the top quartile of Medicare margins had higher payments and much lower daily costs. While average daily payments for SNFs in the top quartile of margins were considerably higher (8 percent) than SNFs in the bottom quartile, the cost differences were even larger. SNFs in the top quartile of Medicare margins had daily costs that were 30 percent less than those of SNFs in the bottom quartile.

Hospital-based facilities (6 percent of facilities) continued to have very negative margins (–66 percent), in large part reflecting their higher daily costs and shorter stays (averaging less than half the length of stay in freestanding facilities). Their higher costs are a function of higher staffing levels and a staff mix more heavily weighted toward professional staff. They also have higher ancillary costs, which may indicate that physicians view SNF stays as an extension of the inpatient stay and may not fully adjust their practice to the fact that the patient has moved into a lower intensity, post-acute setting. Our recommended changes to the SNF PPS would increase payments to hospital-based facilities by an estimated 20 percent, given the mix of patients they treat.

The Commission has examined hospital-based SNFs and their impact on the hospital's financial performance. Administrators consider the SNF units in the context of the hospital's overall business model and the SNF's impact on the inpatient margin, inpatient length of stay, and freeing up inpatient capacity to treat additional acute care patients. Our analysis of 2009 hospital cost reports found that SNF services contributed to the bottom line financial performance of the hospitals. Hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs.

Comparing SNFs with high and low margins

To help evaluate the range in SNF margins, we compared the characteristics of freestanding facilities with high and low Medicare margins (Table 7-9). We found that lower daily costs and higher payments contributed to the differences in financial performance between SNFs with the lowest and highest Medicare margins (those in the bottom and top 25th percentiles of Medicare margins). Compared with high-margin SNFs, low-margin SNFs had case-mix-adjusted costs per day that were 41 percent higher ($324 versus $229), ancillary costs per day that were 35 percent higher, and routine costs that were 40 percent higher. The higher daily costs of the low-margin SNFs are explained partly by their lower average daily census (with fewer economies of scale) and shorter stays

TABLE 7–9 **Freestanding SNFs in top quartile of Medicare margins in 2009 had much lower costs**

Characteristic	Top quartile margin	Bottom quartile margin	Ratio of bottom to top quartile
Costs per day			
Total	$229	$324	1.4
Ancillary	$100	$134	1.3
Routine	$131	$184	1.4
Administration and general cost (overhead)	$29	$38	1.3
Average daily census (patients)	87	70	0.8
Length of stay (days)	44	38	0.9
Medicare payment per day	$427	$395	0.9
Share of days in ultra high and very high rehabilitation case-mix groups	69%	54%	0.8
Medicare share of total facility revenues	26%	16%	0.6
Share of SNFs, by type			
Percent for profit	89%	59%	
Percent urban	71%	73%	

Note: SNF (skilled nursing facility). Values shown are medians for the quartile. Top margin quartile SNFs (n = 3,205) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n = 3,205) were in the bottom 25 percent of the distribution of Medicare margins. Costs per day have been adjusted for differences in area wages and case mix (using the nursing component's relative weights).

Source: MedPAC analysis of freestanding SNF cost reports, 2009.

(over which to spread their fixed costs) compared with high-margin SNFs. Unmeasured differences in patient mix could also explain some of the cost differences.

On the revenue side, low-margin SNFs had average Medicare payments per day that were 7 percent below those for high-margin SNFs. Low-margin SNFs had smaller shares of days in the ultra high and very high rehabilitation case-mix groups (54 percent compared with 69 percent) that reflect the current distortions in the PPS. Our previous work found that as therapy costs increase, payments rise even faster (Medicare Payment Advisory Commission 2008). Low-margin SNFs had smaller shares of their total revenues made up by Medicare.

Ownership of low-margin and high-margin facilities did not mirror their industry mix. Although for-profit facilities make up two-thirds of SNFs, they comprised a smaller share (59 percent) of the low-margin facilities. Conversely, they were overrepresented in the high-margin group.

High margins achieved by relatively efficient SNFs

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. We examined the financial performance of freestanding SNFs with consistent cost and quality performance (for definitions, see text box, p. 162). To measure costs, we looked at costs per day that were adjusted for differences in area wages and case mix. To assess quality, we examined risk-adjusted rates of community discharge and potentially avoidable rehospitalizations.

Our analyses found that SNFs can have relatively low costs and provide a good quality of care, while maintaining high margins (Table 7-10, p. 163). Compared with the average, relatively efficient SNFs had community discharge rates that were 29 percent higher, rehospitalization rates that were 16 percent lower, and costs per day that were 10 percent lower. In contrast, other SNFs had below-average community discharge rates,

Identifying relatively efficient skilled nursing facilities

We defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and reasonably good quality care between 2005 and 2007.[13] The cost per day was adjusted for differences in case mix (using the nursing component relative weights) and wages. Quality measures were risk-adjusted rates of community discharge and rehospitalization for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Quality measures were calculated for all facilities with at least 25 stays. To be included in the group of relatively efficient SNFs, a SNF had to be in:

- the best third of the distribution of one measure, and
- not in the bottom third on any measure for three consecutive years (2005 through 2007).

According to this definition, 9 percent of SNFs provided relatively efficient care. ■

above-average rehospitalization rates, and slightly higher costs per day. Compared with other SNFs, relatively efficient SNFs were more likely to be rural and nonprofit.

Although relatively efficient SNFs had shorter stays than other SNFs, we did not find differences between relatively efficient and other SNFs in their facility occupancy rates or bed turnover rates (nursing home and SNF days per bed). Yet, compared with other SNFs, relatively efficient SNFs had higher Medicare and total margins. Looking at growth trends since 2001, relatively efficient facilities were slightly more likely to have experienced low cost growth (in the bottom third of the distribution of growth in cost per day) and high revenue growth (in the top third of the distribution of growth in revenue per day) than other facilities.

We recognize that a SNF may appear to be efficient in providing care but may not be when considering a patient's entire episode of care. For example, SNFs that discharge patients to other post-acute services may be efficient in their own practice but raise total program spending. In the future, we plan to examine the total costs of the episode of care to assess the SNFs' practice patterns in a broader context.

Payments and costs for 2011

In assessing payment adequacy for 2012, the Commission considers the estimated relationship between Medicare payments and SNF costs in fiscal year 2011. To estimate 2011 payments, the Commission considers policy changes that went into effect in 2010 and 2011 and the legislated SNF market basket increases.

- For fiscal year 2010, CMS lowered payments to account for overpayments that had resulted from implementation of new case-mix groups in 2006. As background, whenever changes to a classification system are introduced, CMS uses the best available data to make an across-the-board adjustment so that payments under the "new" case-mix groups are the same as payments would have been under the "old" case-mix groups. CMS's analysis of 2006 case-mix data found that it substantially underestimated the impact of the new groups and that the new groups resulted in 3.3 percent overpayments, or about $1 billion (Centers for Medicare & Medicaid Services 2009). To ensure parity between the old and new case-mix groups, CMS lowered payments to account for the overpayment. The reduction is partly offset by the market basket increase for 2010, so that payments on net were reduced by 1.1 percent, or $360 million. We factored this reduction in payments into our estimate of 2010 payments.
- In 2011, there were no other policy changes to consider besides the projected market basket increase and a forecast error correction, which CMS makes to SNF payments when forecast errors are larger than 0.5 percent in either direction. In this case, the error was –0.6 percent, so CMS lowered the update by 0.6 percent.
- The SNF market basket, which measures price inflation for the goods and services SNFs use to produce a day of care, increased Medicare payments by 2.2 percent in 2010 and by 2.3 percent in 2011.

Our modeling of future year costs also considers recent observed cost growth for freestanding SNFs. Between 2008 and 2009, costs per day (unadjusted for case mix) grew 4.3 percent.

In 2011, we project the aggregate Medicare SNF margin to be 10.9 percent. This estimate may be conservative for two reasons.

- First, it assumes that costs will increase at the actual average cost growth over the past five years (4.6 percent) and not at the market basket rate, which is lower. If costs grow more slowly than the recent average rate because of the condition of the economy, costs will be overstated and the margin estimate will be understated.
- Second, we have not assumed any changes in the distribution of days across the case-mix groups. However, if the three-year average shift in the distribution of days to higher payment case-mix groups continues for 2010 and 2011, the projected margin for 2011 will be considerably higher. Under one reasonable set of assumptions regarding a shift in the mix of days, the estimated Medicare margin for 2011 will be almost 3 percentage points higher. In this scenario, we assume a shift in the mix of days for 2010 but not for 2011. In 2010, the PPS and its incentives were unchanged and the mix of cases is likely to shift consistent with historical trends (the mix of cases alone raises payments by more than 3 percent a year). In 2011, CMS made many revisions to the case-mix system, and it is difficult to estimate how they will affect the distribution of days. Therefore, we did not assume any change for 2011. Assuming a shift in days for 2010 but not for 2011 will raise the estimated Medicare margin to 13.6 percent instead of 10.9 percent. If providers in 2011 continue to focus on classifying days into the highest payment groups, the shift in distribution of days could increase payments, which would raise the projected 2011 margin above 13.6 percent.

TABLE 7–10 **Relatively efficient SNFs maintained high Medicare margins**

Measure	Relatively efficient SNFs	Other SNFs
Percent of SNFs	9%	91%
Performance in 2008		
Relative to the national average:		
Community discharge rate	1.29	0.97
Rehospitalization rate	0.84	1.02
Cost per day	0.90	1.01
Median:		
Medicare length of stay (in days)	35	41
Medicare margin	21.8%	17.4%
Performance in 2009		
Cost per day relative to the national average	0.91	1.01
Median:		
Medicare length of stay (in days)	34	39
Medicare margin	22.0%	18.3%
Total margin	5.3%	3.9%
Medicaid share of facility days	58%	62%
Trends in performance, 2001–2009		
Percent with low cost growth	11%	89%
Percent with high revenue growth	11	89

Note: Skilled nursing facility (SNF). Efficient SNFs were defined by their cost per day and two quality measures (community discharge and rehospitalization rates) for 2005 through 2007. Efficient SNFs were those in the lowest third of the distribution of one measure and not in the bottom third on any measure. Costs per day 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 rehospitalization for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Increases in rates of discharge to the community indicate improving quality; increases in rehospitalization rates for the five conditions indicate worsening quality. Quality measures were calculated for all facilities with at least 25 stays. Low cost growth included facilities in the lowest third of the distribution of cost growth between 2001 and 2009. High revenue growth included facilities in the highest third of the distribution of growth in revenues between 2001 and 2009. The number of facilities included in the analysis was 8,916.

Source: MedPAC analysis of quality measures for 2005–2008 and Medicare cost report data for 2001–2009.

How should Medicare payments change in 2012?

The update in current law for fiscal year 2012 is the forecasted change in input prices as measured by the SNF market basket offset by a productivity adjustment. The market basket for SNFs in 2012 is projected to be 2.6 percent and the productivity adjustment is estimated to be 1.3 percent, but CMS will update both before establishing payments for 2012. SNFs should be able to accommodate cost changes in fiscal year 2012 with payments held at 2011 levels.

Update recommendation

RECOMMENDATION 7

The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2012.

RATIONALE 7

The evidence indicates that Medicare beneficiaries continue to have access to SNF services, capital is available, and Medicare payments far exceed Medicare costs. Under policies in law for 2010 and 2011, we project the Medicare margin for freestanding SNFs to be 10.9 percent in 2011. SNF payments appear more than adequate to accommodate cost growth with payments held at 2011 levels.

IMPLICATIONS 7

Spending

- This recommendation would lower program spending relative to current law by between $250 million and $750 million for fiscal year 2012 and by between $1 billion and $5 billion over five years. Savings occur because current law requires a market basket increase (estimated to be 2.6 percent) and, as required by the Patient Protection and Affordable Care Act of 2010, a productivity adjustment (which would lower payments by an estimated 1.3 percent).

Beneficiary and provider

- We do not expect an adverse impact on beneficiary access, nor do we expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

Since 1995 (the year used to establish prospective payments), the mix of patients treated in SNFs and the services furnished have changed substantially. For example, the use of concurrent and group therapy was minimal when the PPS was implemented but these modalities (which lower the cost of rehabilitation therapy) made up about one-third of therapy services in 2009 (Centers for Medicare & Medicaid Services 2009). Over the coming year, we plan to examine the issue of rebasing SNF payments to reflect current costs and practice patterns.

Previous Commission recommendations would improve the accuracy of payments

The Commission considers the update recommendation to be part of the package of SNF recommendations that together consider the level and distribution of payments (see text box on previous recommendations). The payment update can help control overall spending, while other recommendations can improve the accuracy of payments and their distribution across facilities. Of particular relevance to the update discussion are two recommendations that have not been acted upon by the Congress or by CMS:

- Revise the PPS by adding a separate NTA service component, replacing the therapy component with one that establishes payments based on predicted care needs (not service provision), and adding an outlier policy.
- Establish a pay-for-performance program.

Basing payments on the care needs of patients and the outcomes they are able to achieve would narrow the disparities in financial performance across facilities. Although CMS has made progress in improving the SNF PPS, more work remains. The Commission urges the Congress to implement all three recommendations so that spending increases are limited and payments are distributed equitably across all types of cases and the facilities that treat them.

Medicaid trends

Section 2801 of the Patient Protection and Affordable Care Act of 2010 requires the Commission to examine spending, utilization, and financial performance under the Medicaid program for sectors with a significant portion of revenues or services associated with the Medicaid program. This year we report on spending and utilization trends for Medicaid and the financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports.

Medicaid covers nursing home (long-term care) and skilled nursing care furnished in nursing facilities. Medicaid pays for long-term care services that Medicare does not cover. For beneficiaries who are dually eligible for Medicaid and Medicare, Medicaid pays for the

Previous Commission skilled nursing facility recommendations

The Commission made several recommendations aimed at improving the accuracy of Medicare's payments, linking the program's payments to beneficiary outcomes, and increasing the ability to assess the value of Medicare's purchases (Medicare Payment Advisory Commission 2008a, Medicare Payment Advisory Commission 2008b). Recommendations that have not been acted upon include:

The Congress should require the Secretary to revise the skilled nursing facility (SNF) prospective payment system (PPS) by:

- **adding a separate nontherapy ancillary (NTA) component,**
- **replacing the therapy component with one that establishes payments based on predicted patient care needs, and**
- **adopting an outlier policy.**

Compared with the existing PPS, the revised design would better target payments to stays with high NTA costs, more accurately calibrate therapy payments to therapy costs, and offer some financial protection to SNFs that treat stays with exceptionally high ancillary costs.

The Congress should establish a quality incentive payment policy for SNFs in Medicare.

Linking payments to beneficiary outcomes could help improve SNF quality and redistribute payments from low-quality to high-quality providers. Measures such as rehospitalization rates would encourage providers to improve their coordination of care across sites. The Patient Protection and Affordable Care Act of 2010 requires the Secretary to develop an implementation plan for value-based purchasing for SNFs by October 1, 2011.

To improve quality measurement for SNFs, the Secretary should add the risk-adjusted rates of potentially avoidable rehospitalizations and community discharge to its publicly reported post-acute care quality measures.

The Secretary should direct SNFs to report more accurate diagnostic and service-use information by requiring that claims include detailed diagnosis information and dates of service.

Better information would improve payment accuracy and enable policymakers to assess the value of SNF care. ■

Medicare copayments required of beneficiaries beginning on day 21 of a stay in a SNF.

Utilization

There were more than 1.6 million users of Medicaid-financed nursing home services in 2007, more than a 3 percent decline from 2001 (Centers for Medicare & Medicaid Services 2010). Fewer users reflect many states' efforts to divert nursing admissions to community-based services.

The number of nursing facilities certified as Medicaid providers declined 5 percent between 2001 and 2009 (Table 7-11, p. 166). A vast majority of nursing home facilities are certified as Medicare and Medicaid providers.

During this same period, Medicaid-covered days (both nursing home level and SNF level) increased 12.9 percent (Table 7-12, p. 166). More recently, between 2008 and 2009, Medicaid-covered days increased slightly (0.6 percent). Medicaid-covered days make up an average 65 percent of nursing facility days.

Spending

In 2009, Medicaid spent more than $50 billion on nursing homes (Table 7-13, p. 167). Spending averaged a 2 percent increase annually between 2001 and 2009, though

TABLE 7–11 **Small decline in Medicaid-certified nursing home facilities 2001–2009**

	2001	2003	2005	2007	2009	Percent change, 2001–2009
Number of facilities	15,590	15,388	15,121	14,990	14,915	–5.4%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2001–2009.

spending changes were quite variable, increasing in some years and decreasing in others. Between 2008 and 2009, spending increased 2.5 percent, and it is projected to increase slightly for 2010 (to $50.5 billion).

On a per user basis, Medicaid spending per nursing home resident averaged $28,511 in 2007.

Medicaid per day payment levels vary twofold across states. In 2004, 11 states' payments were 20 percent (or more) below the national average ($132 per day), while 8 states paid 20 percent or more above it (Grabowski et al. 2008). The levels of Medicaid's and Medicare's payments are sometimes compared. Although Medicare's payments are much higher than Medicaid's, the acuity of the average Medicare beneficiary is higher, as reflected in the average nursing and therapy case-mix indexes for Medicaid and Medicare patients. In 2008, the Medicare nursing case-mix index was 36 percent higher and the therapy index was almost 13 times that for Medicaid patients (Plotzke and White 2009). At Medicare's payment rates, the average-acuity Medicaid patient would have been paid $212, compared with $380 for the average-acuity Medicare patient.

States grappling with budget deficits have pursued three policies to control their spending on nursing homes. First, states have shifted their long-term care spending away from institutional care and toward home health care and community-based services. Between 2000 and 2007, Medicaid spending on home health, personal, and community-based services more than doubled, while nursing home spending increased 19 percent. Second, fewer states are raising provider payments. The number of states that raised payments to nursing homes has steadily declined since 2008, while the number of states reducing or freezing payments for fiscal year 2010 outnumber those that increased them (Kaiser Commission on Medicaid and the Uninsured 2009). Third, more states (for a total of 37 states in 2010) adopted provider taxes for nursing homes as a way to raise the states' share of matching funds, and 7 states increased the size of the tax (Kaiser Commission on Medicaid and the Uninsured 2009). In early years, states used the funds to raise payments; now, states often use the funds to minimize rate reductions or freezes or to lower budget deficits (Eljay 2010). However, the opportunity to use this mechanism to raise payment levels is shrinking. Most states with provider taxes are taxing providers at or near the maximum allowed (5.5 percent), leaving states fewer opportunities for raising funds (Eljay 2010).

Non-Medicare margins

The Medicare cost reports do not include the information required to estimate the costs or payments associated with Medicaid patients or a margin for the nursing facility. They

TABLE 7–12 **Medicaid-covered nursing facility days increased, 2001–2009**

	2001	2003	2005	2007	2009	Percent change, 2001–2009
Number of days	214,355	216,803	222,243	225,663	242,057	12.9%

Note: Nursing facility days include skilled and nursing facility levels of care.

Source: Medicare skilled nursing facility cost reports.

TABLE 7–13 **Total and per user Medicaid spending**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2001–2009
Total spending										
In billions	$42.7	$46.4	$44.8	$45.3	$47.2	$47.5	$46.9	$48.9	$50.1	
Percent change	N/A	8.7%	–3.4%	1.1%	4.2%	0.6%	–1.3%	4.3%	2.5%	17%
Spending per nursing home resident	$25,103	$26,364	$26,493	$26,507	$27,716	$27,827	$28,511	N/A	N/A	

Note: N/A (not available).

Source: Centers for Medicare & Medicaid Services 2010 and CMS, Office of the Actuary.

do, however, allow us to estimate margins for treating non-Medicare patients and all patients across all lines of business (including hospice and rehabilitation therapy). In 2009, the aggregate non-Medicare margin was –1.2 percent (Table 7-14). Since 2001, aggregate non-Medicare margins have been below 0, ranging from –2.6 percent in 2001 to –0.8 percent in 2005. However, total margins have remained positive throughout this period, ranging from 0.8 percent in 2003 to 3.5 percent in 2009.

State-by-state analysis did not reveal a consistent pattern in the change in non-Medicare margins in 2007, 2008, and 2009. Comparing 2007 and 2008 non-Medicare margins, although 32 states (including the District of Columbia) had lower aggregate margins in 2008 than in 2007, there were 19 states with improved non-Medicare financial performance, including 11 that went from negative to positive margins. Of the nine states with large declines (more than 3 percentage points) between 2007 and 2008, three experienced large increases (more than 3 percentage points) in performance between 2008 and 2009.

In 2009, non-Medicare margins were slightly more variable than total margins and centered around a much lower median (–1.6 percent compared with the median total margin of 3.5 percent). About one-quarter of facilities had non-Medicare margins equal to or less than –8.3 percent, while one-quarter had non-Medicare margins that equaled or exceeded 4.2 percent (Table 7-15, p. 168) One-quarter of facilities had total margins at or below –1.2 percent, while one-quarter of facilities had margins at or above 8.3 percent.

Should Medicare's skilled nursing facility payments subsidize payments from other payers?

Industry representatives have consistently stated that Medicare payments are needed to cross-subsidize payments from Medicaid. However, the Commission

TABLE 7–14 **Non-Medicare margins were negative but total margins were positive**

Type of margin	2001	2003	2005	2007	2009
Non-Medicare margin	–2.6%	–17%	–0.8%	–1.2%	–1.2%
Total margin	1.0	0.8	2.2	2.5	3.5

Note: Non-Medicare and total margins include revenues and costs associated with non-Medicare payers and all lines of business (including nursing facility, hospice, and rehabilitation therapy services).

Source: MedPAC analysis of freestanding 2001–2009 skilled nursing facility cost reports

TABLE 7–15

Freestanding SNF margins vary considerably in 2009

	Percentile				
Type of margin	**10th**	**25th**	**50th**	**75th**	**90th**
Non-Medicare	–17.0%	–8.3%	–1.6%	4.2%	10.2%
Total	–7.9	–1.2	3.5	8.3	13.3

Note: SNF (skilled nursing facility). Non-Medicare and total margins include revenues and costs associated with non-Medicare payers and all lines of business (including nursing facility, hospice, and rehabilitation therapy services).

Source: MedPAC analysis of freestanding 2009 skilled nursing facility cost reports

believes such cross-subsidization is not advisable for several reasons. First, on average, Medicare payments account for less than a quarter of revenues to freestanding SNFs. A cross-subsidization policy would use a minority share of Medicare payments to underwrite a majority share of states' Medicaid payments. Second, raising Medicare rates to supplement low Medicaid payments would result in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from the higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies. Third, increased Medicare payment rates could encourage states to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates. In addition, a Medicare subsidy would have an uneven impact on payments, given the variation across states in the level and method of paying for nursing home care. In states where Medicaid payments were adequate, the subsidy would add to excessive payments. Last, higher Medicare payments could further encourage providers to select patients based on payer source or to rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay. ■

Endnotes

1 For services to be covered, the SNF must meet Medicare's conditions of participation (COPs) and agree to accept Medicare's payment rates. Medicare's COPs 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 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.

2 The program pays separately for some services, including certain chemotherapy drugs, customized orthotics and prosthetics, ambulance services, dialysis, outpatient and emergency services furnished in a hospital, computed tomography, MRI, radiation therapy, and cardiac catheterizations. A more complete description of the SNF PPS is available at http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_SNF.pdf.

3 The original model did not meet two of the criteria CMS laid out in the 2009 SNF PPS final rule (Centers for Medicare & Medicaid Services 2009). One criterion indicated that the payment method should use data from the patient assessment or claims; the original model included diagnostic information from the hospital stay. A second criterion was that the design should result in a minimal number of payment groups to limit complexity of the PPS. The original model used 70 variables and did not result in discrete case-mix groups for these services. Rather, payments varied for every patient based on his or her characteristics.

4 In 2010, CMS raised nursing component payments by an estimated 21 percent and lowered therapy component payments by 41 percent. As a result of this shift, the nursing component for patients in the highest extensive services case-mix groups will increase by more than 90 percent and payments for patients in the highest special care case-mix group (such as patients with chronic obstructive pulmonary disease) will increase almost by 80 percent.

5 A facility may begin to participate in the program but may not be "new." For example, a facility could have a change in ownership (and be assigned a new provider number) or in its certification status from Medicaid-only to dually certified for the Medicaid and Medicare programs. We use the number of SNFs that terminated their participation in the Medicare program as a proxy for the facilities that closed.

6 In 2008, SNFs with the highest shares of clinically complex admissions (the top quartile) treated 55 percent of all these patients compared with SNFs with the highest rehabilitation shares (which treated 33 percent of all rehabilitation admissions).

7 The share of medically complex admissions was 31 percent at the 99th percentile of the distribution of medically complex shares of Medicare admissions.

8 In 2008, African American beneficiaries made up 10 percent of all SNF admissions but 16 percent of special care admissions and 17 percent of clinically complex admissions.

9 In its analysis of staff resources associated with caring for different types of patients, CMS found that services furnished during the prior hospital stay were not an accurate proxy for medical complexity (Centers for Medicare & Medicaid Services 2009). As a result, beginning with implementation of the new case-mix groups, services furnished during the prior hospital stay are no longer considered in classifying patients in case-mix groups. Furthermore, the definition of extensive services no longer includes furnishing intravenous (IV) medications. CMS found that the staff time associated with IV medications was consistent with clinically complex patients, not with patients in the extensive services category.

10 The community discharge and potentially avoidable rehospitalization rates have been risk-adjusted using many resident-level factors. Both models include a derived comorbidity index, the Barthel index (a measure of functional independence), a cognitive performance scale (a measure of cognitive impairment), and the presence of do-not-resuscitate orders. The community discharge model also includes the rehabilitation case-mix hierarchy (ranging from ultra high to low), selected clinical conditions associated with community discharge (depression, schizophrenia), and whether the patient was married. The rehospitalization model also includes select patient needs and characteristics associated with hospitalization (indwelling catheter, feeding tube, and pressure ulcers) and select clinical conditions (congestive heart failure, respiratory disease, and electrolyte imbalance). This risk-adjustment methodology was updated in 2009 to better reflect the relative importance of comorbid conditions, among other improvements (Kramer et al. 2009). Observed rates for both measures were adjusted by using each facility's predicted-to-observed odds ratio applied to a constant national rate for the year 2000. These measures gauge how well each facility performed at discharging patients back to the community or avoiding rehospitalizations, compared with other facilities, and track nationwide trends in outcome performance. Data for this risk-adjustment methodology come from Medicare SNF and hospital claims; the Minimum Data Set; and the Online Survey, Certification, and Reporting system.

11 The risk-adjusted rates were calculated differently this year to more accurately reflect the changes in case-mix over time. In prior analyses, we adjusted each year's measures for the mix of cases treated by SNFs in that year but did not account for the changes in the mix of cases over time. We have adopted a methodology that adjusts for the mix of cases each year as well as the change in the mix of cases over time. This refinement provides a more accurate comparison of outcome measure performance over time.

12 The HUD Section 232 program finances new or substantial reconstruction of nursing homes. The Section 232/222(f) program finances the refinancing or purchase of existing facilities.

13 The method we used to assess performance attempts to limit drawing 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 one "bad" year. In addition, we separated a SNF's assignment to a group from the examination of the group's performance to avoid having poor data for a facility affect both its own categorization and the assessment of the group's performance. Performance over three years (2005 through 2007) was used to categorize SNFs into relatively efficient and other groups; once the groups were defined, we evaluated their performances in 2008 and 2009. Thus, a SNF's erroneous data could result in the inaccurate assignment of the SNF to a group, but because the group's performance is assessed with data from later years, these "bad" data would not affect the assessment of the group's performance.

References

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2009. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities for FY 2010; minimum data set, version 3.0 for skilled nursing facilities and Medicaid nursing facilities. Final rule. *Federal Register* 74, no. 153 (August 11): 40288–40395.

Centers for Medicare & Medicaid Services, Office of Research and Demonstrations Information, Department of Health and Human Services. 2010. Health Care Financing Review. Medicaid statistical supplement, Table 13.15.

Department of Housing and Urban Development. 2010. Personal communication with William Lammers, acting director of the Section 232 Program.

Eljay. 2010. *A report on shortfalls in Medicaid funding for nursing home care.* Prepared for the American Health Care Association. Washington, DC: American Health Care Association.

Extendicare. 2008. *Annual report 2008.* Markham, Ontario, Canada: Extendicare. http://www.extendicare.com.

Extendicare. 2009. Extendicare REIT announces 2009 third quarter results: Increased profitability through higher rates and cost controls. Press release. November 4. http://www.extendicare.com.

Extendicare Real Estate Investment Trust. 2009. *Annual report 2009.* Markham, Ontario, Canada: Extendicare. http://www.extendicare.com.

Fish, R., D. Hittle, and S. Min. 2011. *Risk-adjusted quality measures for skilled nursing facilities.* A study conducted by staff from the Division of Health Care Policy and Research University of Colorado at Denver and Health Sciences Center for MedPAC. Washington, DC: MedPAC.

Grabowski, D. C., Z. Feng, O. Intrator, et al. 2008. Medicaid nursing home payment and the role of provider taxes. *Medical Care Research and Review* 65, no. 4 (August): 514–527.

Irving Levin Associates Inc.. 2009. *The senior care acquisition report, 14th ed.* Norwalk, CT: Irving Levin Associates Inc.

Irving Levin Associates Inc. 2010. *The senior care acquisition report: 15th ed.* Norwalk, CT: Irving Levin Associates Inc.

Kaiser Commission on Medicaid and the Uninsured. 2009. *The crunch continues: Medicaid spending, coverage and policy in the midst of a recession*. Washington, DC: KCMU. http://www.kff.org/medicaid/upload/7985.pdf.

Kindred Healthcare. 2010. *Annual report 2009.* Louisville, KY: Kindred Healthcare. http://www.kindredhealthcare.com.

Konetzka, R. T., and R. M. Werner. 2009. Disparities in long-term care: Building equity into market-based reforms. *Medical Care Research and Review* 66, no. 5 (October): 491–521.

Kramer, A., S. Min, R. Fish, et al. 2009. *Changes in SNF rates of community discharge and rehospitalization 2000–2007.* A study conducted by staff from the Division of Health Care Policy and Research University of Colorado at Denver and Health Sciences Center for MedPAC. Washington, DC: MedPAC. http://www.medpac.gov/documents/Mar08_SNF_contractor_CC.pdf.

Medicare Payment Advisory Commission. 2008a. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2008b. *Report to the Congress: Reforming the delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2010. Comment letter to CMS on the proposed rule entitled: Medicare program; prospective payment system and consolidated billing for skilled nursing facilities for FY 2011. July 29.

Plotzke, M., and A. White. 2009. *Differences in resident case-mix between Medicare and non-Medicare nursing home residents.* Cambridge, MA: Abt Associates.

Skilled Healthcare Group. 2010. *Form 10-K, FY 2009*. Filing submitted to the Securities and Exchange Commission. http://ir.skilledhealthcaregroup.com.

Sun Healthcare Group. 2009. Sun HealthCare Group, Inc. reports third-quarter earnings and normalized EPS of $0.25. Press release. October 27. http://ir.sunh.com/phoenix.zhtml?c=70364&p=irol-IRHome.

Sun Healthcare Group. 2010. *Form 10-K, FY 2009.* Filing submitted to the Securities and Exchange Commission. http://ir.sunh.com.

Wells Fargo Securities. 2010. *Equity research: Sun Healthcare Group, Inc.* San Francisco: Wells Fargo. October 28.

Williamson, J. 2010. Proving your worth: Finding capital in tight times. *McKnight's Long Term Care News.* http://www.mcknights.com.

Wissoker, D., and B. Garrett. 2010. *Development of updated models of nontherapy ancillary costs.* Washington, DC: Urban Institute.