

CHAPTER

8

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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

*(The Commission reiterates its March 2012 recommendation on updating Medicare's payments to skilled nursing facilities. See text box, p. 203.)*

# 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 2013, almost 15,000 SNFs furnished 2.4 million Medicare-covered stays to 1.7 million fee-for-service (FFS) beneficiaries. Medicare FFS spending on SNF services was \$28.8 billion in 2013.

## 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 beneficiaries. Key measures indicate Medicare payments to SNFs are adequate. We also find that relatively efficient SNFs—facilities identified under our current definition as providing relatively high-quality care at relatively low costs—had very high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

**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 is stable, with a small increase in new providers in 2014. Three-quarters of beneficiaries live in a county with five or more

## In this chapter

- Are Medicare payments adequate in 2015?
- How should Medicare payments change in 2016?
- Medicaid trends

SNFs, and less than 1 percent live in a county without one. Available bed days increased slightly. The median occupancy rate was 86 percent, with one-quarter of SNFs having rates at or below 73 percent, indicating some capacity for additional admissions.

- **Volume of services**—Days and admissions per FFS beneficiary declined between 2012 and 2013, consistent with declines in inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services).

**Quality of care**—Quality measures show mixed performance. Between 2012 and 2013, the community discharge and readmission measures improved, and the functional change measures were essentially unchanged.

**Providers' access to capital**—Because most SNFs are part of larger nursing homes, we examine nursing homes' access to capital. Access to capital was adequate and is expected to remain so. Medicare is regarded as a preferred payer of SNF services.

**Medicare payments and providers' costs**—In 2013, the average Medicare margin was 13.1 percent—the 14th year in a row that the average was above 10 percent. This margin is lower than the 2012 average (14 percent) and reflects reduced revenues due to the implementation of the budget sequester in April 2013. Margins continued to vary greatly across facilities, depending on the share of intensive therapy days, facility size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics (such as share of very old, dual-eligible, and minority beneficiaries). Rather, in part they reflected shortcomings in the SNF prospective payment system (PPS), the resulting favorable selection of rehabilitation patients (over medically complex patients), and providers furnishing high levels of therapy. The disparity in margins between for-profit and nonprofit facilities was considerable and reflected differences in service provision and costs. In 2013, about 500 of the 7,800 freestanding facilities included in the analysis provided relatively low-cost and high-quality care over 3 consecutive years and had Medicare margins averaging more than 20 percent. The projected Medicare margin for 2015 is 10.5 percent.

In 2012, the Commission recommended restructuring and rebasing the SNF payment system. Specifically, the Commission recommended that the Congress direct the Secretary to first revise the SNF PPS to strike a better balance between paying for therapy and nontherapy ancillary (NTA) services (such as drugs). During this year of revision, payment rates would be held constant (no update). The Commission recommended three revisions to improve the accuracy of payments. First, base payments for therapy services on patient characteristics, not

on the amount of rehabilitation therapy provided. Second, remove payments for NTA services from the nursing component and establish a separate component specifically to adjust for differences in patients' needs for these services. Third, add an outlier policy to the PPS. In the year following these three changes, CMS would begin a process of rebasing payments, starting with a 4 percent reduction in payments.

This multiyear recommendation to revise the PPS in the first year and rebase payments the next year is based on several facts: (1) payments were well above costs, resulting in high and sustained Medicare margins; (2) costs varied widely, but variation was unrelated to case mix or wages; (3) more than 500 SNFs had consistently below-average costs and above-average quality of care, suggesting greater efficiency is possible; (4) the industry continued to maintain high margins despite changing policies; and (5) in many cases, Medicare Advantage payments to SNFs were considerably lower than the program's FFS payments, suggesting that some facilities are willing to accept rates much lower than FFS payments to treat beneficiaries.

The factors examined to assess payment adequacy indicate that the circumstances of the SNF industry have not changed materially during the past year, yet the urgency for change remains. Our work indicates that there is even more need for reform because payments for therapy and NTA services have grown more inaccurate over time. Further, the continued high level of payments essentially requires taxpayers to continue to finance the high margins of this industry.

Therefore, the Commission stands by its two-part recommendation to revise and rebase the SNF payment system. In the first year (2016), there would be no update to the base payment rate while the PPS was revised and, in year two (2017), payments would be lowered by an initial 4 percent. In subsequent years, the Commission would evaluate whether continued reductions were necessary to further align payments with costs.

In its deliberations, the Commission discussed the possibility of recommending an immediate, small rebasing of payments, followed by the implementation of a revised PPS and subsequent further rebasing. Although this sequence would change the Commission's long-standing position to revise the PPS before making payment reductions, it reflects a growing impatience with the lack of progress in improving the accuracy of Medicare's payments and lowering the level of the program's payments. An initial reduction could spark the industry's interest in revising the PPS so that reductions are made from a more equitable distribution of payments across providers. Over the coming year, the Commission will explore this alternative.

## **Medicaid trends**

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid use, spending, and non-Medicare (private payer and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes, but also covers copayments 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 remained essentially unchanged between 2013 and 2014. In 2013, the average total margin, reflecting all payers and all lines of business, was 1.9 percent. The average non-Medicare margin was –1.9 percent. ■

**TABLE  
8-1**

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

Type of SNF	Facilities		Medicare-covered stays		Medicare spending	
	2006	2013	2006	2013	2006	2013
Total number	15,178	14,978	2,454,263	2,365,743	\$19.5 billion	\$26.6 billion
Freestanding	92%	95%	89%	94%	94%	97%
Hospital based	8	5	11	6	6	3
Urban	67	72	79	83	81	85
Rural	33	28	21	17	19	15
For profit	68	70	67	71	73	75
Nonprofit	26	25	29	25	24	21
Government	5	5	4	3	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 and Medicare Provider Analysis and Review files for 2006 and 2013.

## 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. In 2013, almost 1.7 million fee-for-service (FFS) beneficiaries (4.5 percent) used SNF services at least once; program spending on SNF services was \$28.8 billion, or about 8 percent of FFS spending (Centers for Medicare & Medicaid Services 2014b, Office of the Actuary 2014b); 20 percent of hospitalized FFS beneficiaries were discharged to SNFs; Medicare’s average payment per day was \$411; and Medicare’s average payment per stay was \$11,357.<sup>1</sup>

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 care. Beginning with day 21, beneficiaries are responsible for copayments. For 2015, the copayment is \$157.50 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 accounts for the majority of nursing facility days (see discussion of Medicaid trends, p. 204).

The mix of facilities where beneficiaries seek skilled nursing care has shifted over time toward freestanding and for-profit facilities (Table 8-1). In 2013, freestanding facilities and for-profit facilities accounted for larger shares of Medicare stays and spending than in 2006. After a steady decline in the number of hospital-based facilities over a decade, that share has been stable since 2011. In 2013, 70 percent of SNFs were for profit; they accounted for a slightly higher share of stays (71 percent) and 75 percent of Medicare payments. Between 2011 and 2013, these shares were fairly stable.

Medicare-covered SNF patients typically comprise a small share of a facility’s total patient population but a disproportionately larger share of the facility’s revenues. In freestanding facilities in 2013, the median Medicare-

covered share of total facility days was 12 percent, but it was 22 percent of facility revenue.

The most frequent hospital conditions of patients referred to SNFs for post-acute care are joint replacement, septicemia, kidney and urinary tract infections, hip and femur procedures except major joint replacement, pneumonia, and heart failure and shock. Compared with other beneficiaries, SNF users are older, frailer, and disproportionately female, disabled, living in an institution, and dually eligible for both 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). RUGs differ by the services SNFs provide to a patient (such as the amount and type of rehabilitation therapy 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 in performing activities of daily living (ADLs). Medicare’s payment system for SNF services is described in the Commission’s *Payment Basics*, available on the Commission’s website (<http://www.medpac.gov/documents/payment-basics/skilled-nursing-facility-services-payment-system-14.pdf?sfvrsn=0>). Though 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 setting a 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 has been criticized for encouraging the provision of unnecessary rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) services such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002). Under current policy, therapy payments are not proportional to costs but, instead, rise faster than providers’ therapy costs increase (Medicare Payment Advisory Commission and The Urban Institute 2014).

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.

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. An outlier policy would offer some financial protection by partly compensating providers that treat exceptionally costly patients. An outlier case would be defined on a stay basis, not on a day basis, because the financial risk to a facility is determined by its losses over the stay, not a given day.

Since 2008, the Commission has periodically evaluated current policy relative to the alternative design (Carter et al. 2012, Wissoker and Garrett 2010, Wissoker and Zuckerman 2012). Our most recent analysis found that the accuracy of payments has deteriorated over time. Current payments are too high for therapy and are unrelated to the costs of NTA services. As a result, the PPS advantages facilities that predominantly admit patients with rehabilitation care needs and provide intensive therapy, and it discourages facilities from admitting patients who require costly NTA services.

The Commission’s recommended revisions to the PPS would greatly improve the accuracy of payments for therapy and NTA services (Medicare Payment Advisory Commission and The Urban Institute 2014). Assuming no other changes in patient mix or care delivery, aggregate payments would increase for hospital-based facilities (21 percent), nonprofit facilities (4 percent), facilities with relatively high NTA costs (12 percent), facilities with relatively high shares of medically complex days (5 percent for high shares of special care days and 7 percent for high shares of clinically complex days), facilities with relatively low shares of intensive therapy (16 percent), and rural facilities (4 percent). Payments would decrease slightly for for-profit facilities (–1 percent), but the impact would be greater for facilities with relatively high shares of intensive therapy (–7 percent) and low shares of clinically complex days (–3 percent) and special care days (–2 percent). The effects on individual facilities could vary substantially.

Based on its work examining SNFs’ billing practices between 2006 and 2008 and in 2009, the Department of



Health and Human Services (HHS) Office of Inspector General (OIG) recommended that CMS change the way Medicare pays for therapy, consistent with the Commission's recommendation. OIG found that SNFs had increasingly billed for higher payment RUGs, even though the ages and diagnoses of beneficiaries were largely unchanged, and upcoding was responsible for the majority of the billing errors (Office of Inspector General 2012, Office of Inspector General 2011). The Departments of Justice and HHS have increased their investigation of fraud and abuse under the False Claims Act and in 2014 settled three cases involving alleged billing for medically unnecessary therapy services (Department of Justice 2014a, Department of Justice 2014b, Department of Justice 2014c).

### **CMS's revisions of the SNF PPS**

Although CMS has taken steps to enhance payments for medically complex care, it has not revised the basic design of the PPS to pay for NTAs more accurately or to base payments for rehabilitation therapy services on patient care needs. In 2010, CMS changed the definitions of the existing case-mix groups and added 13 case-mix groups for medically complex days.<sup>5</sup> At the same time, CMS shifted program dollars away from therapy care and toward medically complex care (Centers for Medicare & Medicaid Services 2010). After these changes, the share of days classified into medically complex groups between 2010 and 2012 increased from 5 percent to 7 percent. In 2010 and 2011, CMS also lowered payments for therapy furnished to multiple beneficiaries at the same time rather than in one-on-one sessions, and it required providers to reassess patients when the provision of therapy changed or stopped (which would, in turn, change assignments in case-mix groups).<sup>6</sup> Despite these changes, we found that Medicare's payments for therapy services continue to exceed the cost of these services, and its payments for NTA services bear no relationship to the cost of these services (Medicare Payment Advisory Commission and The Urban Institute 2014).

CMS's work on alternative designs for the SNF PPS began 13 years ago in response to a legislative requirement (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) to conduct research on potential refinements of the SNF PPS (Liu 2007, Maxwell et al. 2003, Urban Institute 2004). Yet, to date, CMS continues to evaluate alternative ways to pay for NTA and therapy services and has not revised the basic PPS design. In 2014, CMS reviewed alternative ways

to pay for therapy and concluded that it would evaluate two approaches over the coming year. One would use patient characteristics to establish payments (such as the alternative design recommended by the Commission); the other would use a combination of resident characteristics and some measure of resource use (Acumen LLC 2014). This fall, CMS announced it was expanding the scope of its research to consider revisions of the entire PPS. We urge CMS to include its plans for revising the well-known shortcomings of the current PPS in its proposed rule for fiscal year 2016.

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## **Are Medicare payments adequate in 2015?**

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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, providers' access to capital, Medicare payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compare the performance of SNFs with relatively high and low Medicare margins and 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 other post-acute care (PAC) or no PAC, is not well defined. Instead, we consider the supply and capacity of providers and evaluate changes in service volume. We also examine the mix of SNF days to assess the shortcomings of the PPS that can result in delayed admission for certain types of patients.

### **Capacity and supply of providers: Supply remains stable**

The number of SNFs participating in the Medicare program is stable at just under 15,000. In 2014, there were 98 facilities new to the program, the majority of which were for profit (Centers for Medicare & Medicaid Services 2014a). In 2013, less than 1 percent of beneficiaries lived in a county without a SNF, 5 percent lived in counties with 1 SNF, 17 percent lived in counties with between 2 and 4 SNFs, more than three-quarters of beneficiaries lived in counties with 5 or more SNFs, and 60 percent of beneficiaries lived in counties with 10 or more SNFs. In that year, the median occupancy rate was 86 percent in freestanding facilities, down slightly from 2012 (87

**TABLE  
8-2**

**SNF service use declined between 2012 and 2013**

Volume measure	2006	2008	2010	2012	2013	Percent change 2012-2013
Covered admissions per 1,000 FFS beneficiaries	72	73	72	68	67	-2.2%
Covered days (in thousands)	1,892	1,977	1,938	1,861	1,835	-1.4
Covered days per admission	26.3	27.0	27.1	27.4	27.6	0.7

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

Source: Calendar year data from CMS, Office of Information Products and Data Analytics 2013.

percent), and 81 percent in hospital-based facilities. Nonprofit, freestanding, and urban facilities had higher occupancy rates compared with other SNFs. Although these averages are high, one-quarter of freestanding facilities had occupancy rates at or below 73 percent, indicating capacity for more admissions.

**SNF volume was slightly lower in 2013 than in 2012**

In 2013, 4.5 percent of FFS beneficiaries used SNF services, about the same share as in 2012. Between 2012 and 2013, SNF volume per FFS beneficiary declined. We examine service use for FFS beneficiaries because the CMS data on users, days, and admissions do not include service use by beneficiaries enrolled in Medicare Advantage (MA) plans. Admissions per 1,000 FFS beneficiaries declined 2.2 percent, while covered days declined less (-1.4 percent), resulting in a small increase in covered days per admission (Table 8-2). The reductions in per capita SNF admissions were consistent with the decline in per FFS admissions to acute care hospitals. (In general, declines in hospital use will lower SNF admissions because an acute care inpatient hospital stay of at least three days is a prerequisite for Medicare coverage of SNF services.) Declines in hospital admissions (and, to a lesser extent, readmissions) are the key driver of the decline in SNF stays. The increase in observation days, which do not qualify for an inpatient hospital admission, may be a small factor, but because the count of observation stays is low relative to the total number of SNF admissions, they cannot account for the more than 2 percent decline in admissions.

**Service mix reflects biases of the PPS**

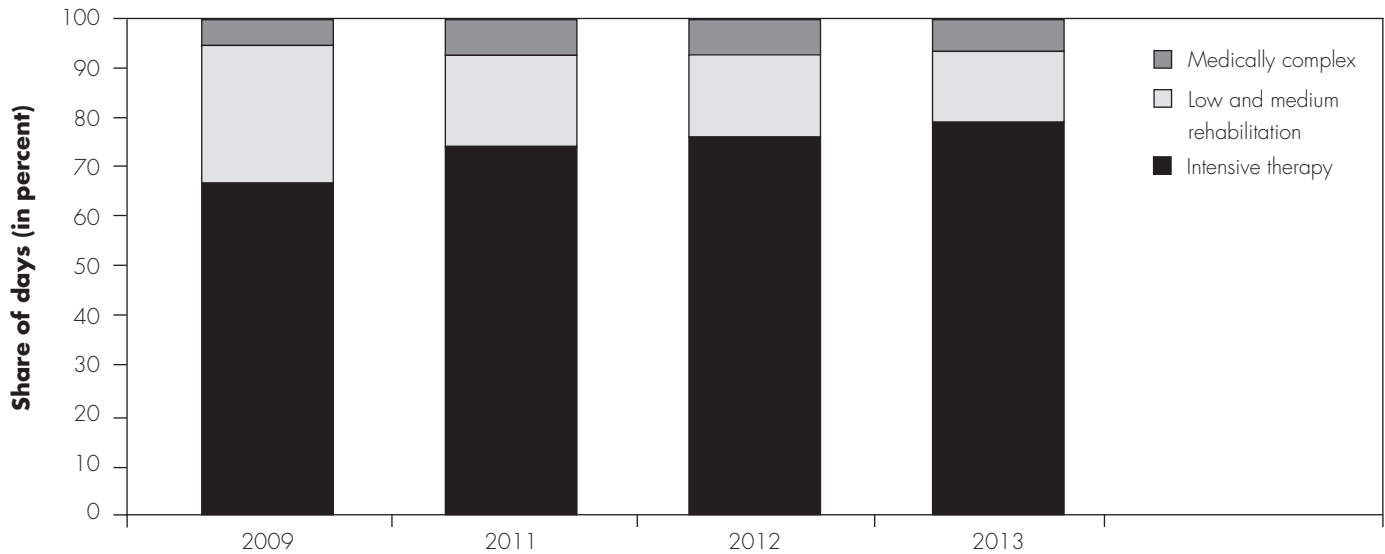
Between 2002 and 2013, the share of days classified into rehabilitation case-mix groups in freestanding facilities

increased from 78 percent to 93 percent.<sup>7</sup> During the same period, the share of intensive therapy days as a share of total days rose from 29 percent to 79 percent.<sup>8</sup> The most recent changes indicate the continued intensification of therapy provision (Figure 8-1). Between 2012 and 2013, the share of intensive therapy days increased from 76 percent to 79 percent, and the share of days assigned to the highest rehabilitation case-mix groups (the ultra-high groups) increased from 50 percent to 54 percent. Facilities differed in the amount of intensive therapy they provided. Among freestanding facilities, for-profit facilities and facilities located in urban areas had higher shares of intensive therapy (81 percent for each group) compared with nonprofit facilities (75 percent) and facilities in rural (72 percent) and frontier areas (49 percent). Hospital-based facilities had lower shares of intensive therapy days (54 percent) compared with freestanding facilities. Counties with low counts of inpatient rehabilitation facility (IRF) beds per 1,000 FFS beneficiaries had slightly higher shares of intensive therapy days, though counties with no IRF beds had the lowest share.

Changes in the frailty of beneficiaries at admission to a SNF do not explain the increases in therapy. Compared with the average SNF user in 2011, the average SNF user in 2013 had comparable abilities to perform activities of daily living (as measured by a modified Barthel score) and was the same age. Over the same period, the shares of SNF users requiring the most help with the 10 activities of daily living decreased or were comparable.<sup>9</sup> Despite these similar characteristics, the share of days assigned to an intensive therapy case-mix group between 2011 and 2013 increased 5 percentage points, from 74 percent to 79 percent. Shorter hospital stays could have shifted some therapy provision from the hospital to the SNF setting. For example, between 2009 and 2013, hospital lengths of stay

**FIGURE  
8-1**

**The share of intensive therapy days in SNFs continues to increase**



Note: SNF (skilled nursing facility). “Medically complex” includes two broad categories of case-mix groups: clinically complex and special care. “Intensive therapy” includes days assigned to ultra-high and very high rehabilitation case-mix groups.

Source: MedPAC analysis of freestanding cost reports 2009–2013.

decreased 7 percent on average for the five highest volume diagnosis related groups discharged to SNFs.

The share of medically complex days (those assigned to the clinically complex or special care case-mix groups) continued to be low (6 percent, down from 15 percent in 2000). Most SNFs admitted these cases: 80 percent of SNFs admitted clinically complex patients and 89 percent admitted special care patients, both up from 2009 when only 54 percent of SNFs admitted clinically complex patients and 64 percent admitted special care patients. Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex admissions. Although the payments for medically complex days were increased recently, which encouraged SNFs to admit these patients, rehabilitation days remained highly profitable, and the PPS continued to encourage providers to furnish enough therapy to convert medically complex days to rehabilitation days. The Commission’s recommended design would increase payments for medically complex patients; hospital-based facilities would benefit the most from this policy.

Industry representatives and patient advocates report that patients with high NTA costs (such as those requiring expensive antibiotics) can be hard to place. In addition,

patients who are more likely to require long stays and exhaust their Medicare benefits are also avoided by some facilities because the facility’s daily payments decline if the patient is eligible for Medicaid or the stay results in bad debt.

**Quality of care: Improvements in some measures and essentially no change in others**

The Commission tracks three broad categories of SNF quality indicators: risk-adjusted rates of readmission, discharge back to the community, and change in functional status during the SNF stay. Between 2012 and 2013, the rates of readmissions and discharge to the community improved, while the two measures of functional change were essentially unchanged.

**Rates of rehospitalization and community discharge rates show recent improvements**

Between 2000 and 2010, both the rate of rehospitalization for SNF patients with any of five potentially avoidable conditions (congestive heart failure, electrolyte imbalance/dehydration, respiratory infection, septicemia, urinary tract infection/kidney infection) and the rate of discharge to the community remained almost the same (see text box

## Measures of skilled nursing facility quality

The community discharge measure includes beneficiaries discharged to a community setting (including assisted living) and excludes those discharged to an inpatient setting (e.g., an acute care hospital or nursing home) within one day of the skilled nursing facility (SNF) discharge. It 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. This time frame was revised in 2014 (from excluding readmissions within 100 days) to align it with our readmission measure, which includes beneficiaries readmitted to the hospital within 30 days of discharge from the SNF (Kramer et al. 2015). As a result of the revision, the community discharge numbers for fiscal years 2011 and 2012 have increased from last year's report. Beneficiaries who are discharged to a nursing home are not counted as community discharges, although the risk adjustment method (and the comorbidities) will capture some of the differences in the risks between beneficiaries discharged home and those discharged to a nursing home. In addition, 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).

The readmission measures count rehospitalized patients whose primary diagnosis for readmission was considered potentially avoidable—that is, the condition should have been managed in the SNF setting. 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.

The observed rehospitalization 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 rehospitalization rates for all facilities with 25 or more admissions. Demographics (including race, gender, and age categories except younger than 65 years old) were not important in explaining differences in rehospitalization and community discharge rates after controlling for beneficiaries' comorbidities, mental illness, and functional status (Kramer et al. 2014).<sup>10</sup>

Two risk-adjusted measures of functional change gauge the percent of a facility's stays during which patients' conditions improve and the percent of stays during which patients' functioning does not decline, given the prognosis of the facility's patients. Change is measured by comparing the initial and discharge assessments. For stays that 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

*(continued next page)*

on measures of SNF quality). More recently, both rates have improved. Between 2011 and 2012, rehospitalization rates declined and community discharge rates increased. These trends repeated between 2012 and 2013, though the improvements were smaller (Table 8-3). Between 2012 and 2013, risk-adjusted community discharge rates increased from 35.6 percent to 37.5 percent, and potentially avoidable rehospitalizations for patients

during their SNF stays declined from 11.5 percent to 11.1 percent.

The rate of readmission for beneficiaries discharged from a SNF and readmitted to a hospital within 30 days reflects how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home). Between 2012 and 2013, the

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

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 recording functional status at a single point in time. Therefore, any 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 there are changes from year to year in when initial assessments are conducted.

Each stay's initial assessment 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. The scales of these two measures were revised this year because CMS no longer collects some of the information used.

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

risk-adjusted rehospitalization rate for beneficiaries during the 30 days after discharge from the SNF was essentially unchanged. The rate of rehospitalization during the SNF stay or within 30 days of SNF discharge declined from 15.5 percent to 15.1 percent, indicating opportunities for SNFs to improve the care they provide and the care provided by others after discharge.<sup>11</sup>

The lower rehospitalization rates reflect increased attention from hospitals to avoid readmission penalties

by partnering with SNFs with low readmission rates (Gerhardt 2014). In addition, many SNFs want to secure volume from MA plans and accountable care organizations by demonstrating improvements in their readmission rates. The American Health Care Association, which supports the SNF rehospitalization program, has a goal for its members to lower readmission rates 15 percent by 2015 and has reported that half of its members met this target (across all patients, not just Medicare) by June 2014 (American Healthcare Association 2015).

**TABLE  
8-3**

### Improvements in risk-adjusted rates of community discharge and potentially avoidable rehospitalizations

Measure	2011	2012	2013
Discharged to the community	33.2%	35.6%	37.5%
Potentially avoidable rehospitalizations:			
During SNF stay	12.4	11.5	11.1
During 30 days after discharge from SNF	5.8	5.6	5.5
During or 30 days after SNF stay	16.5	15.5	15.1

Note: SNF (skilled nursing facility). Higher rates of discharge to community indicate better quality. Higher rehospitalization rates indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 25 or more stays, except the rate of potentially avoidable rehospitalizations 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 2013 Minimum Data Set data by Kramer et al. 2015.

**TABLE  
8-4**

**Mean risk-adjusted functional outcomes in SNFs show little change between 2011 and 2013**

Composite measure	2011	2012	2013
Rate of improvement in one or more mobility ADLs	43.6%	43.6%	43.7%
Rate of no decline in mobility	87.2	87.2	87.2

Note: SNF (skilled nursing facility), ADL (activity of daily living). The three mobility activities of daily living include bed mobility, transfer, and ambulation. The rate of mobility improvement is 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 ADLs are counted in the improvement measure. The rate of stays with no decline in mobility is the percent of stays with no decline in any of the three ADLs. Rates are the average of facility rates and calculated for all facilities with 25 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2013 Minimum Data Set data by Kramer et al. 2015.

As part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF readmission policy, with facilities to begin publicly reporting in October 2017. The law requires the Secretary to develop an all-condition risk-adjusted potentially preventable readmission measure by October 2015. Beginning in October 2018, the Secretary must establish a value-based purchasing program that would adjust a facility’s payments based on its readmission rate.

**No improvement in managing patients’ functional status**

Most 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 with chronic and degenerative diseases may expect, at best, to maintain their function. We measure SNF performance on both aspects of patient function on a risk-adjusted basis (see text box on SNF quality measures, pp. 190–191).

The average risk-adjusted rates were essentially unchanged between 2011 and 2013, indicating that even though the program paid for more therapy during this period, the average functional status of beneficiaries did not improve. In 2013, across all facilities, the mean risk-adjusted facility rate of improvement in one or more mobility ADLs during the SNF stay was 43.7 percent, and the mean percent of facility stays with no decline in any of the three ADLs was 87.2 percent (Table 8-4). These risk-adjusted rates consider the likelihood that a patient will change, given the functional ability at admission.

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

Considerable variation exists across the industry in five quality measures we track. We found one-quarter of facilities had risk-adjusted community discharge rates lower than 29.2 percent, whereas the best performing quarter of facilities had rates of 46.6 percent or higher (Table 8-5). Similar variation was seen in the rehospitalization rates: The worst performing quartile had rates of potentially avoidable readmissions at or above 13.9 percent, whereas the best quarter had rates at or below 8 percent. Finally, rates of rehospitalization in the 30 days after discharge from the SNF varied most—more than twofold 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.

We controlled for facility and geographic characteristics (with multiple regression models) and found that, compared with freestanding facilities, hospital-based facilities had higher community discharge rates (by 6.6 percentage points) and lower readmission rates (by 2.1 percentage points). Nonprofit facilities had moderately higher community discharge rates (by 0.9 percentage point) and lower readmission rates (also by 0.9 percentage point) than for-profit facilities. Compared with urban facilities, rural SNFs had lower community discharge rates (1.5 percentage points), but not statistically different readmission rates. Differences in the rates between hospital-based and freestanding facilities were not statistically meaningful once we controlled for staffing levels. Another study found nonprofit facilities and

**TABLE  
8-5**

**SNF quality measures varied considerably across SNFs, 2013**

**Risk-adjusted rate**

Quality measure	Risk-adjusted rate			Ratio of 25th to 75th percentile
	Mean	25th percentile	75th percentile	
Discharged to the community	37.5%	29.2%	46.6%	1.6
Potentially avoidable rehospitalizations during SNF stay	11.1	8.0	13.9	1.7
Potentially avoidable rehospitalizations within 30 days after discharge from SNF	5.5	3.4	7.2	2.1
Average mobility improvement across the three mobility ADLs	43.6	35.6	52.5	1.5
No decline in mobility during SNF stay	87.2	82.7	92.9	1.1

Note: SNF (skilled nursing facility), ADL (activity of daily living). Higher rates of discharge to community indicate better quality. Higher rehospitalization 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 calculated for all facilities with 25 or more stays, except the rate of potentially avoidable rehospitalizations during the 30 days after discharge, which is reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2013 Minimum Data Set data by Kramer et al. 2015.

facilities that did better on their annual survey inspection had lower risk-adjusted readmission rates, but differences by facility type (hospital based versus freestanding) were not significant (Neuman et al. 2014).<sup>12</sup>

There was considerable geographic variation across states in the SNF quality measures. For example, after controlling for differences in the mix of facilities, rates of community discharge varied more than 25 percentage points (the average was 37.5 percent) among the states with the best and worst performing SNFs, and the rates of potentially avoidable rehospitalization (occurring during the SNF stay) varied more than 8 percentage points (the average was 11.1 percent).

**Providers’ access to capital: Lending in 2014**

A vast majority of SNFs operate within nursing homes; therefore, in assessing the SNFs’ access to capital, we look at the availability of capital for nursing homes. Though Medicare makes up the minority share of almost all facilities’ revenues, many operators see Medicare as the best payer.

Market analysts we spoke with reported that capital is generally available and expected to remain so. Lenders continue to focus on the quality of the potential borrower’s management team, its cash flow and amount of debt, operating trends (volume, occupancy, payer mix, and acuity mix), and its ability to carry out strategic plans to shift payer or service mix. For example, if a facility

is planning to increase the number of its short-term rehabilitation patients, shift its payer mix, or improve its quality, lenders want to know the operational changes the facility plans to make to achieve its goals. Lenders continue to focus on facilities with high Medicare and private payer mixes and high “acuity” (i.e., intensive therapy), and the potential to expand both.

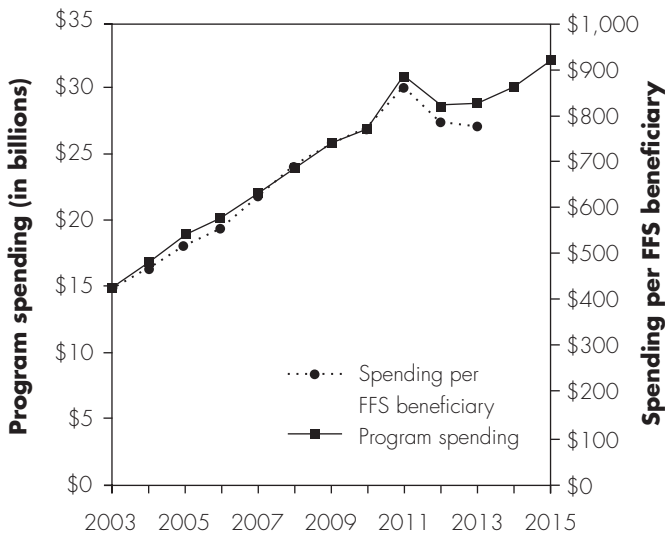
There is increased consolidation this year as health care companies seek more integration across the PAC continuum (Olivia 2014). Strategies include expanding holdings to include multiple PAC service lines (such as home health and hospice) and solidifying presence across the continuum within select markets. Lenders look favorably at a diversified earning stream as a way to spread risk.

The Department of Housing and Urban Development (HUD) continues to be an important lending source. In fiscal year 2014, HUD financed 484 projects, with the insured amount totaling \$4.2 billion. While this number represents a decline from fiscal year 2013, when the count of existing projects that were refinanced is excluded, the number of projects new to HUD increased (including the refinancing of facilities new to HUD, new construction, major renovation, or expansion) (Department of Housing and Urban Development 2014).

Analysts note that in addition to a long-standing wariness about potential budget cuts, lower volume has increased the hesitancy among some lenders. Lenders’ reluctance

**FIGURE 8-2**

**After temporary slowdown, SNF spending growth returns to prior pace**



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year spending is shown. Data for 2014 and 2015 are estimates.

Source: CMS, Office of the Actuary 2014.

patient mix. These points strongly suggest that SNFs can provide high-quality care at lower payment rates.

**Trends in spending and cost growth**

The Office of the Actuary projects program FFS spending for SNF services in fiscal year 2014 to be \$30.2 billion (Figure 8-2). In 2011, payments were unusually high because the rates for the new case-mix classification system included an adjustment that was too large for the mix of therapy modalities assumed in setting the rates. The industry responded to the payment incentive afforded by the new policies and quickly shifted its mix of modalities, and payments increased by 14 percent in 2011. To correct for the excessive payment, CMS revised the adjustment downward in 2012, and total payments were lower in 2012 and 2013. Since then, the growth in spending has risen in line with previous trends, projecting to have increased 4.6 percent in 2014. On a per FFS beneficiary basis, spending in 2013 (\$777) was about the same as in 2012. CMS projects spending in fiscal year 2015 to be \$31.5 billion.

From 2003 to 2013, the cumulative increase in payments per day outpaced the increase in cost per day (Figure 8-3). Costs per day rose 42 percent during this period, while payments grew 47 percent. The large increase in payments

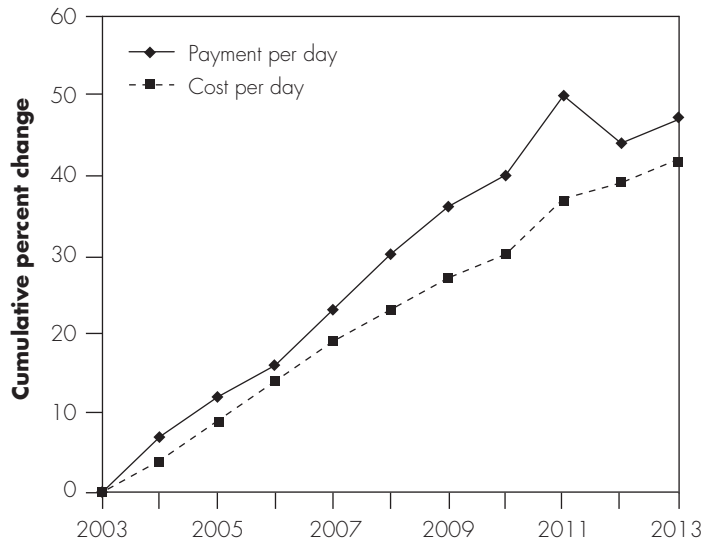
is not a statement about the adequacy of Medicare’s payments to SNFs. Medicare continues to be a preferred payer.

**Medicare payments and providers’ costs: Medicare margins remained high in 2013**

In 2013, the aggregate Medicare margin was 13.1 percent—the 14th consecutive year that Medicare margins were above 10 percent. Margins for individual facilities continue to be highly variable, depending on the facility’s share of intensive therapy days, size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics: High-margin facilities had higher case-mix indexes and higher shares of dual-eligible and minority beneficiaries. Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. More than 500 freestanding facilities (7 percent of the SNFs included in the analysis of 7,800 facilities) consistently furnished relatively low-cost, higher quality care and had substantial Medicare margins over three consecutive years. Some MA plans’ payments were considerably lower than Medicare’s FFS payments, and the disparity is unlikely to be explained by differences in

**FIGURE 8-3**

**Cumulative growth in Medicare cost and payments per SNF day, 2003–2013**



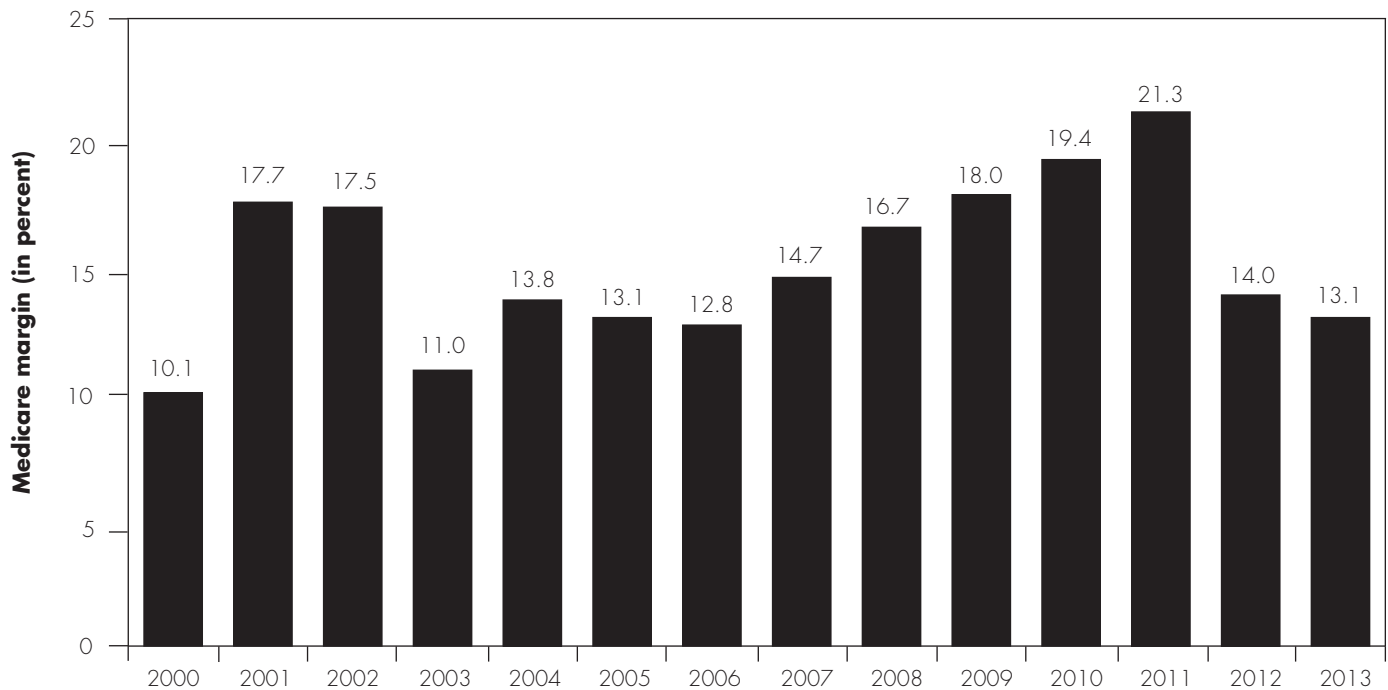
Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding skilled nursing facility Medicare cost reports from 2003–2013.



**FIGURE  
8-4**

**Freestanding SNF Medicare margins have been above 10 percent since 2000**



Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports from 2000 to 2013.

reflects the intensification of therapy treatment during this period. Between 2003 and 2011, cost increases were larger than the market basket updates, but because increases in payments exceeded them, SNFs have been highly profitable on average. When Medicare lowered its rates by 11 percent in 2011 to correct for the previous year's overpayments, providers kept their cost growth below the market basket increases. Between 2012 and 2013, cost per day increased at the market basket rate.

By ownership, since 2003, cumulative cost growth for nonprofits has been lower than that of for-profit SNFs. However, since 2011, nonprofits' cost growth has been higher than that of for-profit facilities. In 2013, nonprofit facilities had standardized cost per day (adjusted for differences in wages and case-mix) that was 10 percent higher than the cost per day in for-profit facilities.

### **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 payments with costs to treat beneficiaries. An all-payer

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, and is presented as context for the Commission's update recommendation.

In 2013, the aggregate Medicare margin was 13.1 percent, the 14th consecutive year of Medicare margins above 10 percent (Figure 8-4). The 2013 margin was lower than the 2012 margin for two reasons. First, current law requires market basket increases to be offset by a productivity adjustment. Second, the sequester began lowering payments in April 2013 by 2 percent on an annualized basis.<sup>13</sup> The combined impact of these policies would have been greater but was offset by the continued increase in the share of cases assigned to the highest payment case-mix groups, the ultra-high therapy groups. In 2011, the Medicare margin was 21.3 percent, reflecting the large increase in payments because of the implementation of the new case-mix groups and an incorrect adjustment factor. Despite reductions to correct SNF payments the following year, Medicare margins remained high in 2012 (14 percent).

**TABLE  
8-6**

**Variation in freestanding SNF Medicare margins reflects the mix of cases and cost per day, 2013**

Subgroup	Medicare margin
All	13.1%
For profit	15.3
Nonprofit	5.0
Rural	12.1
Urban	13.3
Frontier	2.9
25th percentile	3.7
75th percentile	21.7
Intensive therapy: High share of days	15.1
Intensive therapy: Low share of days	8.0
Medically complex: High share of days	11.0
Medically complex: Low share of days	13.9
Small (20-50 beds)	3.7
Large (100-199 beds)	14.4
Standardized cost per day: High	3.2
Standardized cost per day: Low	26.4
Standardized cost per discharge: High	10.6
Standardized cost per discharge: Low	15.1

Note: SNF (skilled nursing facility). "Low" is defined as facilities in the bottom 25th percentile; "high" is defined as facilities in the highest 25th percentile. "Standardized costs per day" are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries.

Source: MedPAC analysis of 2013 freestanding SNF Medicare cost reports.

In 2013, hospital-based facilities (3 percent of program spending on SNFs) continued to have extremely negative Medicare margins (-70 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, administrators consider their SNF units in the context of the hospital's overall financial performance. Hospitals with SNFs can lower their inpatient lengths of stay and make inpatient beds available to 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 reforms to the PPS are still needed**

The persistently high Medicare margins and the 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 2013, one-quarter of freestanding SNFs had Medicare margins of 21.7 percent or higher, while another quarter of freestanding SNFs had margins of 3.7 percent or lower (Table 8-6). The disparity between for-profit and nonprofit facilities is considerable and reflects differences in case mix, service provision, and costs. Facilities with the highest SNF margins had high shares of intensive rehabilitation therapy and low shares of medically complex days. Despite the payment increases for medically complex cases in October 2010, the relative financial performance for facilities with high shares of these cases did not on average improve. Lower cost SNFs and larger SNFs had higher Medicare margins than higher cost SNFs and smaller SNFs. The SNF Medicare margin for facilities with the lowest cost per day (the bottom quartile of cost per day) was 26.4 percent, while the margin for facilities with the highest cost per day (the top quartile) was 3.2 percent.

Differences in costs and revenues between freestanding facilities in the top and bottom quartiles of Medicare margins underscore the need to revise the PPS and more closely align payments with costs. The highest margin SNFs had lower daily costs (their costs were 70 percent of the costs of low-margin SNFs and their revenues were 1.1 times the revenues for low-margin SNFs), driven partly by having higher shares of intensive therapy days (Table 8-7). Treating higher shares of dually eligible or minority beneficiaries did not reduce the financial performance of the highest margin facilities. They had higher shares of these beneficiaries compared with the lowest margin facilities. Facilities with high margins also treated more complex patients (as measured by the relative weights associated with the nursing component of the case-mix groups) but had lower shares of patients classified into medically complex case-mix groups.<sup>14</sup>

These differences in financial performance illustrate why the PPS needs to be revised. Even after CMS expanded the number of medically complex case-mix groups and shifted spending away from therapy care, the

**TABLE  
8-7**

**Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2013**

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	\$250	\$359	0.7
Standardized cost per discharge	\$11,116	\$13,591	0.8
Standardized ancillary cost per day	\$113	\$154	0.7
Standardized routine cost per day	\$139	\$201	0.7
Average daily census (patients)	88	68	1.3
Average length of stay (days)	46	37	1.3
<b>Revenue measures</b>			
Medicare payment per day	\$474	\$424	1.1
Medicare payment per discharge	\$22,391	\$15,790	1.4
Share of days in intensive therapy	82%	73%	1.1
Share of medically complex days	4%	6%	0.7
Medicare share of facility revenue	26%	16%	1.6
<b>Patient characteristics</b>			
Case-mix index	1.39	1.30	1.1
Dual-eligible share of beneficiaries	40%	27%	1.5
Share minority beneficiaries	13%	4%	3.3
Share very old beneficiaries	30%	35%	0.9
Medicaid share of days	66%	58%	1.1
<b>Facility mix</b>			
Share for profit	90%	60%	N/A
Share urban	76%	68%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Top margin quartile SNFs (n=3,238) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n=3,238) were in the bottom 25 percent of the distribution of Medicare margins. "Standardized costs per day" are 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 into ultra-high and very high rehabilitation case-mix groups. "Very old beneficiaries" are 85 years or older.

Source: MedPAC analysis of freestanding 2013 SNF cost reports.

PPS continues to result in higher Medicare margins for facilities providing intensive therapy. A PPS design based on patient characteristics (such as the one recommended by the Commission) would redistribute Medicare spending to SNFs according to their mix of patients, not the amount of therapy provided.

Ownership of low-margin and high-margin facilities did not mirror the industry mix. Although for-profit facilities made up 70 percent of SNFs overall, they comprised a smaller share (60 percent) of the low-margin facilities and a higher share (90 percent) of the high-margin group.

**Variation in costs per day for freestanding SNFs not related to patient demographics or facility characteristics**

We also found that most of the variation in costs per day was not related to a SNF's location, case mix, ownership, or beneficiary demographics (a facility's share of very old, dual-eligible, and minority beneficiaries). Across the freestanding facility subgroups, median standardized cost per day varied 13 percent, from \$282 to \$319 per day after differences in wages and case mix were taken into account (Table 8-8, p. 198). However, there was more variation

**TABLE  
8-8**

**Freestanding SNFs' standardized costs per day vary within and across groups, 2013**

Subgroup of SNF	Median	Within-group variation (ratio of high-cost to low-cost SNFs)
All freestanding	\$296	1.23
Location		
Rural	295	1.22
Urban	296	1.24
Ownership		
Nonprofit	319	1.24
For profit	289	1.22
Share of dual-eligible beneficiaries		
Low share	317	1.25
High share	283	1.25
Share of minority beneficiaries		
Low share	302	1.24
High share	282	1.23
Share of very old beneficiaries (over 85 yrs old)		
Low share	288	1.23
High share	311	1.26

Note: SNF (skilled nursing facility). "High-cost SNFs" were in the top 25 percent of the distribution of Medicare cost per day. "Low-cost SNFs" were in the bottom 25 percent of the distribution of Medicare per day. "Standardized costs per day" are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries. "Low share" includes facilities in the bottom 25th percentile. "High share" includes facilities in the highest 25th percentile.

Source: MedPAC analysis of freestanding SNF Medicare cost reports 2013 and 2013 Medicare denominator file.

within each group (22 percent to 26 percent). This variation, even after controlling for key reasons why costs might differ, suggests that facilities can lower their costs to match those of other facilities.

**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 (see text box). 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 that occurred during the SNF stay. To be included in the relatively efficient group, 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. According to this definition, 524 SNFs (7 percent of the 7,800 facilities included in the analysis) provided relatively low-cost, high-quality care. Of these, more than half were identified as efficient last year.

Our analyses found that SNFs can have relatively low costs and provide relatively good quality of care while maintaining high margins (Table 8-9, p. 200). Compared with the national average in 2013, relatively efficient SNFs had community discharge rates that were 20 percent higher and rehospitalization rates that were 18 percent lower. Standardized costs per day were 7 percent lower than the average. We did not find significant differences between relatively efficient and other SNFs in terms of occupancy rates or size of facility. Efficient facilities had more complex case mixes (driven in part by higher therapy intensity) but shorter stays. In terms of case-mix days, efficient providers had higher shares of the most intensive therapy days and comparable shares of medically complex days. The higher therapy intensity raised their daily Medicare payments relative to all SNFs, indicating that in addition to controlling their costs, efficient providers pursue revenue strategies to maximize their Medicare payments. The median Medicare margin for efficient SNFs was 20.6 percent, and their total margin (for all payers and all lines of business) was 3.5 percent. Relatively efficient facilities were more likely to be urban and for profit.

We recognize that a SNF may appear to be efficient with respect to the care it provides but may not be when considering a patient's entire episode of care. For example, SNFs that discharge patients to other post-acute care services may keep their own costs low but shift costs to other settings, thus increasing total Medicare program spending. In the future, we may compare providers' costs for the episode of care.

**FFS payments for SNF care are considerably higher than MA payments**

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

## 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 care for three years in a row, 2010 through 2012. 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 wages. Quality measures were risk-adjusted rates of community discharge and potentially avoidable rehospitalizations during the SNF stay. Only facilities with at least 25 stays were included in the quality measures.

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, 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 affect the assessment of the group’s performance.

Fewer facilities this year were both relatively low cost and relatively high quality than last year. Fewer facilities were in the best two-thirds for each measure for three years and therefore could not qualify as being efficient. Among efficient providers, fewer were in the best third for the cost measure and one quality measure, and fewer were in the best third for all three measures. Because nonprofit facilities have a higher cost per day and have had higher recent cost growth, they are underrepresented in the efficient group. Efficient SNFs were located in 39 states, including 1 in a frontier location.

The most recent Commission discussions of the efficient provider analyses raised several questions about the existing methods for defining efficient providers and generated new ideas for consideration. The Commission staff will be undertaking a reexamination of the efficient provider analyses. ■

payments. We compared Medicare FFS and MA payments at five nursing home companies where such information was publicly available. Medicare’s FFS payments averaged 22 percent higher than MA rates (Table 8-10, p. 200).<sup>15</sup> It is possible that smaller MA companies have less leverage and do not negotiate similarly low rates.

We compared the patient characteristics of beneficiaries enrolled in FFS and MA plans in 2013 and found small differences that would not explain the payment differences between the two. Compared with FFS beneficiaries, MA enrollees were the same age, had slightly higher Barthel scores (less than two points, indicating slightly more independence), and had slightly lower (4 percent) risk scores, indicating fewer comorbidities. The considerably lower MA payments indicate some facilities accept much lower payments to treat MA enrollees who are not 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 rates are attractive.

### Total margins increased slightly in 2013

The average total margin for freestanding SNFs in 2013 was 1.9 percent, a small increase from 2012 (1.8 percent). A total margin reflects services to all patients (public and private) across all lines of business (for example, their long-term care, hospice, and other services) and revenue sources. Total margins are driven in large part 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 publicly traded companies we examined report several trends in revenues. Companies try to grow their high-acuity rehabilitation (including Medicare) days and spread their risk by expanding into other businesses, including home health care, hospice, and outpatient therapy (AdCare 2014, DiversiCare 2014, Ensign Group 2014a, Extencicare 2014a, Kindred Healthcare 2014a, Skilled Healthcare 2014a). In addition, companies try to increase their managed care and private payer business (Extencicare 2014a, Skilled Healthcare 2014a).

**TABLE  
8-9****Financial performance of relatively efficient SNFs is a combination of lower cost per day and higher revenues per day****Type of SNF****Performance in 2013**

	<b>Relatively efficient</b>	<b>All SNFs</b>
Community discharge rate	48%	40%
Rehospitalization rate	9%	11%
Standardized cost per day	\$272	\$293
Medicare revenue per day	\$487	\$458
Medicare margin	20.6%	14.5%
Total margin	3.5%	2.1%
Facility case-mix index	1.42	1.37
Medicare average length of stay	33 days	37 days
Occupancy rate	88%	87%
Number of beds	120	117
Share intensive therapy days	82%	80%
Share medically complex days	5%	5%
Medicaid share of facility days	58%	61%
Share urban	81%	74%
Share for profit	83%	75%

Note: SNF (skilled nursing facility). The number of freestanding facilities included in the analysis was 7,928. SNFs were identified as “relatively efficient” based on their cost per day and two quality measures (community discharge and rehospitalization rates) between 2010 and 2012. 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. 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 patients with potentially avoidable conditions within 100 days of hospital discharge. Quality measures were calculated for all facilities with at least 25 stays. “Intensive therapy days” includes days classified into the ultra-high and very high case-mix groups. Table shows the medians for the measure.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2010–2013.

**TABLE  
8-10****Comparison of Medicare fee-for-service and Medicare Advantage daily payments in 2014 for five companies****Medicare payment**

<b>Company</b>	<b>FFS</b>	<b>MA</b>	<b>Ratio of FFS to MA payment</b>
Diversicare	\$441	\$380	1.16
Ensign Group	561	412	1.36
Extendicare	474	454	1.04
Kindred	551	436	1.26
Skilled Healthcare	522	410	1.27

Note: FFS (fee-for-service), MA (Medicare Advantage). The rates are reported as “managed care payments,” of which MA would make up the majority. The Kindred rate is specific to MA payments.

Source: Third quarter 10-Q 2014 reports available at each company’s website.

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

Industry representatives contend that Medicare payments should continue to subsidize payments from other payers, most notably from Medicaid. However, high Medicare payments could also subsidize payments from private payers. The Commission believes such cross-subsidization is not advisable for several reasons. First, this strategy results in poorly targeted subsidies. Facilities with high shares of Medicare payments would receive the most in subsidies from higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies. Shares of Medicare and Medicaid patients vary widely across facilities (Table 8-11). As a result, the impact of the Medicare subsidy would vary considerably across facilities, putting more dollars into facilities with high Medicare use (and low Medicaid use), which are likely to have higher Medicare margins than other facilities.

In addition, Medicare's subsidy does not discriminate 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. 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. Finally, Medicare's high payments represent a subsidy of Trust Fund dollars (and its taxpayer support) to the low payments made by states and private payers. If the Congress wishes to help certain nursing facilities (such as those with high Medicaid shares), it would be more efficient to do so through a separate targeted policy. ■

**TABLE  
8-11**

**Medicare and Medicaid shares vary widely across freestanding skilled nursing facilities, 2013**

SNF type and payer	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicare share	5%	8%	12%	17%	26%
	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicaid share	0	43	62	74	81

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of SNF Medicare cost reports, 2013.

Even though these shifts may lower their revenues because these payment rates and lengths of stay are typically lower, they are preferred to Medicaid admissions. Furthermore, the average daily payments from Medicaid increased between 2013 and 2014 (DiversiCare 2014, Ensign Group 2014b, Extencicare 2014b, Kindred Healthcare 2014b, Skilled Healthcare 2014b).

Because Medicaid payments are lower than Medicare payments, some in the industry argue that high Medicare payments are needed to subsidize losses on Medicaid residents. This strategy is ill advised for several reasons (see text box). In addition to Medicare's share of facility revenues, other factors that shape a facility's total financial performance are its share of revenues from private payers (generally considered favorable), its other

lines of business (such as ancillary, home health, and hospice services), and nonpatient sources of income (such as investment income).

## Payments and costs for 2015

In assessing the payment update for 2016, the Commission considers the estimated relationship between SNF costs and Medicare payments in 2015. To estimate costs for 2014 and 2015, we assumed cost growth of the market basket. To estimate 2014 payments, we began with reported 2013 payments and increased payments by the market basket net of the productivity adjustment (as required by the Patient Protection and Affordable Care Act of 2010) and the forecast error correction in 2014. We also factored in the program's reduced payments for bad debt, as required by the Middle Class Tax Relief and Job Creation Act of 2012, and estimated the impact of the sequester for a full year. For 2015, estimated 2014 payments were increased by the market basket and offset by the productivity adjustment, reduced payments for the bad debts of dual-eligible beneficiaries, and the impact of the sequester. The projected 2015 Medicare margin is 10.5 percent.

## How should Medicare payments change in 2016?

In 2012, the Commission recommended to the Congress that it direct the Secretary first to revise the PPS and, in the subsequent year, rebase Medicare payments in stages, with an initial reduction of 4 percent (see text box on recommendation language). The recommendation begins with revising the PPS and not updating payments in the first year (now fiscal year 2016). The revision would be done in a budget-neutral fashion and would redistribute payments away from intensive therapy care that is unrelated to patient care needs and toward medically complex beneficiaries. Payments would increase for the following types of facilities: hospital based, nonprofit, rural, those with high NTA costs, and those treating high shares of medically complex patients. By improving the accuracy of payments, the revised design would narrow the disparities in financial performance that result from the facility's mix of cases treated and its therapy practices (see p. 186). On average, Medicare margins would rise for low-margin facilities and would fall for high-margin facilities. Because payments would be based on a patient's care needs, the design would allow for high payments if a patient required many services but would not (and should

not) address disparities across providers that result from their inefficiencies.

After the proposed revision, the recommendation outlines a strategy to bring payments closer to provider costs over subsequent years, making reductions in stages. This approach acknowledges the need to proceed cautiously but deliberately to help ensure there are no unintended disruptions caused by rebasing. The recommended changes are not expected to impair beneficiary access to care. In fact, they are expected to improve access to services for beneficiaries who might be disadvantaged by the design of the current payment system. Because payments would be reduced after the PPS was redesigned, the effects would be tempered for those facilities whose poor financial performance is based on their mix of cases.

The Commission based its 2012 recommendation on several pieces of evidence pointing to the need to revise and rebase the PPS:

- Aggregate Medicare margins for SNFs have been above 10 percent since 2000. Since the payment system was implemented in 1998, the industry has shifted its mix of days to increase its revenues.
- Variation in Medicare margins is not related to differences in patient characteristics but, rather, to the amount of therapy furnished to patients.
- Large cost differences remain after adjusting for differences in wages, case mix, and beneficiary demographics.
- Relatively efficient SNFs, with relatively low costs and high quality, indicate that payments could be lowered without adversely affecting the quality of care.
- FFS payments to some SNFs were considerably higher than some MA payments, suggesting some facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries.
- The industry has shown it is nimble at responding to the level of Medicare's payments. Even in years when CMS lowered payments, providers tempered the effects with longer stays and the assignment of days into higher payment case-mix groups. In 2010, when payments were recalibrated and lowered to reflect the implementation of new case-mix groups in 2006, program spending still increased. In 2012, when CMS lowered payments to correct its overpayment, facilities



## The Commission reiterates its March 2012 update recommendation for skilled nursing facilities

### Recommendation 7-1, March 2012 report

The Congress should eliminate the market basket update and direct the Secretary to revise the prospective payment system for skilled nursing facilities (SNFs) for [2016]. Rebasing payments should begin in [2017], with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare's payments are better aligned with providers' costs.

### Implications 7-1, March 2012 report

#### Spending

- When this recommendation was made in March 2012, the spending implications were that it would lower program spending relative to current law by between \$250 million and \$750 million for fiscal year 2013 and between \$5 billion and \$10 billion over five years. Savings occur because current law requires a market basket increase (offset by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010). Updated for implementation three years later, the direction of the savings is identical. The one-year

savings estimate ranges from \$750 million to \$2 billion and the five-year estimated savings is more than \$10 billion.

#### Beneficiary and provider

- We do not expect an adverse effect on beneficiary access. Most beneficiaries live in counties with multiple providers, so that even if a low-performing SNF were to close, most beneficiaries would continue to have a SNF in the county. Revising the prospective payment system will result in fairer payments across all types of care, making providers more likely to admit and treat beneficiaries with complex care needs. We do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries. Provider payments will be lower, but the differences in Medicare margins will be smaller. Effects on individual providers will be a function of their mix of patients and current practice patterns. The recommendation would not eliminate all of the differences in Medicare margins across providers because of their large cost differences. ■

kept their cost growth below the SNF market basket for the first year in more than a decade.

The factors examined to assess payment adequacy indicate that the circumstances of the SNF industry have not changed materially during the past year, yet the urgency for change remains. Our work indicates that there is even more need for reform because payments for therapy and NTA services have grown more inaccurate over time. Further, the continued high level of payments essentially requires taxpayers to continue to finance the high Medicare margins of this industry.

Therefore, the Commission stands by a two-part recommendation to revise and rebase the SNF payment system. In the first year (2016), there would be no update to the SNF PPS base rate while the PPS was revised and, in year two (2017), payments would be lowered by an initial 4 percent. In subsequent years, the Commission would evaluate whether continued reductions were necessary to further align payments with costs.

In its deliberations, the Commission discussed the possibility of recommending an immediate small rebasing of payments, followed by the implementation of a revised PPS and subsequent further rebasing. Although this sequence would diverge from the Commission's long-standing position to revise the PPS before payment reductions were made, it reflects a growing impatience with the lack of progress in improving the accuracy of Medicare's payments and lowering the level of the program's payments. The industry has not actively engaged in the Commission's recommended reforms of the SNF PPS. Further, we found that the multiple revisions CMS has made to the PPS have been inadequate to address the fundamental shortcomings and inaccuracies of the current design. An initial reduction could spark the SNF community's interest in revising the PPS so that subsequent reductions are taken from a more equitable distribution of payments across providers. Over the coming year, the Commission will explore this alternative.

**TABLE  
8-12**

**The number of nursing homes treating Medicaid enrollees stayed relatively stable in 2014**

	2004	2006	2008	2010	2012	2013	2014	Percent change 2013-2014
Number of facilities	15,682	15,319	15,201	15,082	15,056	15,035	15,011	-0.2%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2004-2014.

## Medicaid trends

Section 2801 of the Patient Protection and Affordable Care Act of 2010 (PPACA) requires the Commission to examine spending, use, and financial performance trends under the Medicaid program for providers with a significant portion of revenues or services associated with the Medicaid program. We report nursing home spending and use 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 2015).

Medicaid covers nursing home (long-term care) and skilled nursing care provided 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 the Medicare copayments required of beneficiaries beginning on day 21 of a SNF stay.

## Utilization

There were more than 1.62 million users of Medicaid-financed nursing home services in 2011, the most recent year of available data (Centers for Medicare & Medicaid Services 2013). This use represents a small increase from 2010 but a 4.9 percent decline from 2000. The number of nursing facilities certified as Medicaid providers also declined slightly between 2013 and 2014 (Table 8-12). The decline in facilities may reflect the expansion in some states of home- and community-based services (HCBS), which allow beneficiaries to remain in their homes rather than in an institution. State HCBS waivers and federal initiatives have accelerated the trend toward HCBS.

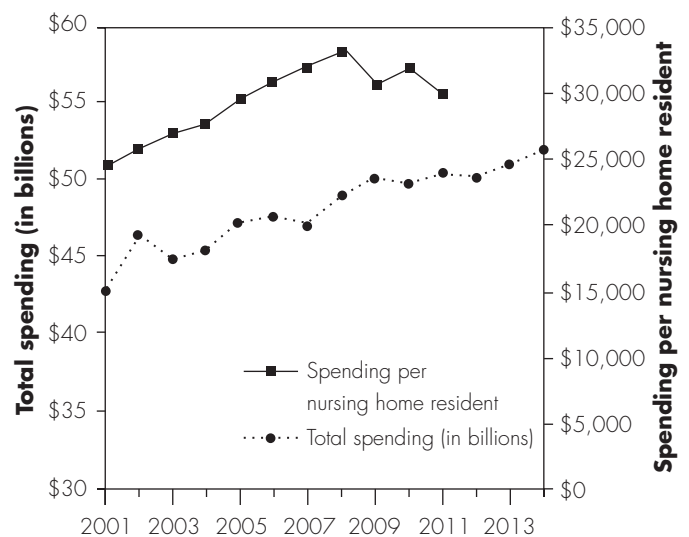
In fiscal years 2014 and 2015, 42 states and 47 states, respectively, expanded the number of beneficiaries served by HCBS, up from 33 states in fiscal year 2013 (Smith et al. 2014).

## Spending

CMS estimates that about \$52 billion (combined state and federal funds) was spent in 2014 on Medicaid-funded nursing home services (Office of the Actuary 2014a) (Figure 8-5). Between 2013 and 2014, Medicaid spending on nursing home services increased by almost 2

**FIGURE  
8-5**

**Total and per user Medicaid spending on nursing home services**



Note: Resident counts (and therefore per resident spending) are not available for 2012 through 2014.

Source: Total spending data come from CMS, Office of the Actuary. Per user spending data come from Health Care Financing Review 2013 Statistical Supplement available at <https://www.cms.gov/Medicare/MedicaidStatSupp>.

**TABLE  
8-13****Non-Medicare margins were negative, but total margins were positive**

Type of margin	2004	2006	2008	2010	2012	2013
Non-Medicare margin	-1.3%	-0.8%	-2.4%	-1.5%	-2.0%	-1.9%
Total margin	1.8	2.2	2.2	3.6	1.8	1.9

Note: "Non-Medicare margins" include the revenues and costs associated with Medicaid and private payers. "Total margins" include the revenues and costs associated with all payers and all lines of business.

Source: MedPAC analysis of freestanding 2004–2014 skilled nursing facility cost reports.

percent. CMS projects spending to grow by 2.3 percent in 2015. Spending increases averaged 1.6 percent annually between 2001 and 2014, for a total of almost 22 percent over the period. Year-to-year changes in spending were variable, increasing in some years and decreasing in others. On a per user basis, spending per nursing home resident averaged \$29,855 in 2011, the most recent year for resident counts. Between 2010 and 2011, spending per resident decreased by about 6.3 percent and represented a 32 percent increase from 2000 (Centers for Medicare & Medicaid Services 2013).

Analysis of Medicaid rate-setting trends found 12 states restricted (froze or lowered) rates paid to nursing homes in 2014, while 38 states and the District of Columbia increased rates (Smith et al. 2014). In 2015, 40 states plan to increase rates and 10 states plan to decrease them. This change represents a steady improvement in the Medicaid revenues for nursing homes. In 2012, 16 states froze rates and another 12 reduced them, while in 2013, 17 states restricted payments for nursing homes. States continue to use provider taxes to raise federal matching funds. In fiscal year 2014, 44 states levied provider taxes on nursing homes, and all of them intended to do so in fiscal year 2015 (Smith et al. 2014).

Medicare's higher payments are often pointed to as evidence that Medicaid rates are too low. However, the acuity of the average Medicare SNF patient is considerably higher than the acuity of the average Medicaid resident. Using data from 2011, we previously estimated that the differences in acuity between the average Medicaid nursing home resident and the average Medicare SNF patient translate to payments that would be 84 percent higher for Medicare patients (White 2012, White et al. 2002). So, while Medicare payments are higher, the vast majority of the difference is explained by differences in the acuity of the enrollees.

**Non-Medicare and total margins in nursing homes**

In 2013, total margins (reflecting services to all patients across all lines of business and including all revenue sources) were positive (1.9 percent) but lower than total margins in 2010. This decrease reflects the impact of PPACA reductions to Medicare payments since 2010, as well as a growing share of managed care payments that are lower than Medicare's payments. The aggregate non-Medicare margin in 2013 (i.e., for Medicaid and private payers) was -1.9 percent (Table 8-13). ■

## Endnotes

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- 1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay coverage (Part A) is paid for by Medicare. 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 services such as physician services, outpatient therapy, 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 PPS and are not considered in this chapter. Some beneficiaries also qualify for Medicaid and are referred to as dual-eligible beneficiaries.
- 2 A spell of illness begins when 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 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 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 dialysis, emergency services, and certain outpatient services provided in a hospital (such as computed tomography, MRI, radiation therapy, and cardiac catheterizations).
- 5 There are two broad categories of medically complex case-mix groups: clinically complex and special care. Clinically complex groups are used to classify patients who have burns, surgical wounds, hemiplegia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a SNF patient. Special care groups include patients who 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.
- 6 In 2010 (for fiscal year 2011), CMS revised how the therapy time for concurrent therapy (two patients engaged in different therapy activities at the same time) was to be allocated between the two patients treated, which effectively lowered the payment for this modality. It also required end-of-therapy assessments to prevent paying for therapy services after they have been discontinued. In 2011 (for fiscal year 2012), CMS revised how the time spent in group therapy (therapy provided in groups with up to four patients engaged in the same therapy activities at the same time) was to be allocated across the four patients in the group, again effectively lowering payments for this modality.
- 7 Medically complex days make up the other 7 percent of days. See endnote 5 for the definition of medically complex.
- 8 Intensive therapy days are those 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 received more than 720 minutes per week; *very high rehabilitation* includes patients who received 500–719 minutes per week.
- 9 The 10 activities of daily living include bowel control, bladder control, transfer, walk in the facility corridor, self-feed, toilet, bathe, dress, perform personal hygiene, and bed mobility.
- 10 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 rehospitalization during the 30 days postdischarge for community-residing beneficiaries younger than 65.
- 11 The readmission rates of patients during their SNF stay and in the period after discharge cannot simply be added to get a combined rate because, in the combined measure, a stay is counted only once, even if the patient was readmitted during the SNF stay and in the poststay period. In contrast, each relevant stay is counted separately in each measure.
- 12 The study also found differences in staffing were not related to readmission rates, but limitations of the staffing measure (it did not distinguish between staffing type, grouped all staffing hours into ranges rather than using the hours per patient day, and did not adjust for regional variation) may explain this unexpected finding.

- 13 Program payments were lowered by an estimated 1.3 percent, reflecting differences in the cost reporting periods of the freestanding SNFs included in the margin calculation. Almost three-quarters of freestanding SNFs (and the same share of Medicare payments) are on a calendar year cost reporting period; the sequester lowered payments to these SNFs for nine months.
- 14 We use the nursing component (as opposed to the payment weight of the case-mix group) to avoid distorting the measure of patient complexity by the amount of therapy furnished, which could be unrelated to patient care needs. We used the indexes adjusted for CMS's policy decisions to shift payments toward certain case-mix groups and away from others (White 2012). Because the nursing weights for intensive therapy are relatively high, a facility can have both a high case-mix index and a moderate or low share of medically complex patients.
- 15 The differences for Extencicare are smaller than for other companies because many of its contracts with managed care companies are based on the FFS system.

## References

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- Acumen LLC. 2014. *SNF therapy payment models. Base year final summary report*. Burlingame, CA: Acumen. [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Summary\\_Report\\_20140501.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Summary_Report_20140501.pdf).
- AdCare. 2014. Quarterly report (Form 10-Q). Filing submitted to the Securities and Exchange Commission. <http://www.adcarehealth.com/>.
- American Healthcare Association. 2015. Personal communication with David Gifford. January 30.
- Carter, C., A. B. Garrett, and D. Wissoker. 2012. Reforming Medicare payments to skilled nursing facilities to cut incentives for unneeded care and avoiding high-cost patients. *Health Affairs* 31, no. 6 (June): 1303–1313.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014a. Certification and Survey Provider Enhanced Reporting (CASPER) on CMS's survey and certification providing data quickly (PDQ) system.
- Centers for Medicare & Medicaid Services, Office of Information Products and Data Analytics, Department of Health and Human Services. 2014b. Personal communication with Maria Diacogiannis, November 5.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. *Medicare and Medicaid Research Review: 2013 statistical supplement*. Baltimore, MD: CMS. <http://www.cms.gov/Research-statistics-data-and-systems/statistics-trends-and-reports/MedicareMedicaidStatSupp/2013.html>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities for FY 2011; minimum data set, version 3.0 for skilled nursing facilities and Medicaid nursing facilities. Final rule. *Federal Register* 75, no. 140 (July 22): 42886–42942.
- Department of Housing and Urban Development. 2014. Personal communication with Jennifer Buhlman, November 14.
- Department of Justice. 2014a. Extendicare Health Services Inc. agrees to pay \$38 million to settle False Claims Act allegations relating to the provision of substandard nursing care and medically unnecessary rehabilitation services. News release. October 10.
- Department of Justice. 2014b. Maryland skilled nursing facility agrees to pay \$1.3 million to resolve allegations that it submitted false claims for rehabilitation therapy. News release. September 15. <http://www.justice.gov/usao/ma/news/2014/September/EMAPR.html>.
- Department of Justice. 2014c. Two companies to pay \$3.75 million for allegedly causing submission of claims for unreasonable or unnecessary rehabilitation rehabilitation therapy at skilled nursing facilities. News release. September 5. <http://www.justice.gov/usao/ma/news/2014/September/LCS-ParkVistasettlementPR.html>.
- DiversiCare. 2014. Quarterly report (Form 10-Q). Filing submitted to the Securities and Exchange Commission. <http://dvcr.com/>.
- Ensign Group. 2014a. *Annual report 2013*. [http://files.shareholder.com/downloads/ENSG/2802503367x0x657480/371A28E5-C0AB-48B0-AC30-3513C21CAC23/2012\\_Annual\\_Report.pdf](http://files.shareholder.com/downloads/ENSG/2802503367x0x657480/371A28E5-C0AB-48B0-AC30-3513C21CAC23/2012_Annual_Report.pdf).
- Ensign Group. 2014b. Quarterly report (Form 10-Q). Filing submitted to the Securities and Exchange Commission. <http://www.ensigngroup.net/>.
- Extendicare. 2014a. *Annual report 2013*. Markham, Ontario, Canada: Extendicare. <http://www.extendicare.com>.
- Extendicare. 2014b. Quarterly report (Form 10-Q). Filing submitted to the Securities and Exchange Commission. <http://www.extendicare.com>.
- Gerhardt, W. 2014. *Going vertical: Opportunities for hospitals to embrace post-acute care*. Washington, DC: Deloitte Center for Health Solutions.
- Government Accountability Office. 2002. *Skilled nursing facilities: Providers have responded to Medicare payment system by changing practices*. GAO-02-841. Washington, DC: GAO.
- Government Accountability Office. 1999. *Skilled nursing facilities: Medicare payments need to better account for nontherapy ancillary cost variation*. GAO/HEHS-99-185. Washington, DC: GAO.
- Kindred Healthcare. 2014a. *Annual report 2013*. Louisville, KY: Kindred Healthcare. <http://www.kindredhealthcare.com>.
- Kindred Healthcare. 2014b. Quarterly report (Form 10-Q). Filing submitted to the Securities and Exchange Commission. <http://www.kindredhealthcare.com>.

- Kramer, A., R. Fish, and M. Lin. 2014. *Potentially avoidable readmission and functional outcome quality measure development and 2012 rates for SNFs*. Report prepared for the Medicare Payment Advisory Commission. Washington, DC: MedPAC.
- Kramer, A., M. Lin, R. Fish, et al. 2015. *Refinement of community discharge, potentially avoidable readmission, and functional outcome SNF quality measures, for fiscal years 2011, 2012, and 2013*. Report prepared for the Medicare Payment Advisory Commission. Washington, DC: MedPAC.
- Liu, K., B. Garrett, S. Long, et al. 2007. *Final report to CMS: Options for improving Medicare payment for skilled nursing facilities*. Report submitted by the Urban Institute to the Centers for Medicare & Medicaid Services. Washington, DC: The Urban Institute.
- Maxwell, S., J. Wiener, and K. Liu. 2003. *A review of issues in the development and implementation of the skilled nursing facility prospective payment system*. Report to the Centers for Medicare & Medicaid Services. Contract no. 500-00-0025/TO#2. Baltimore, MD: CMS.
- Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. 2015. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MedPAC/MACPAC.
- Medicare Payment Advisory Commission and The Urban Institute. 2014. *The need to reform Medicare's payments to SNFs is as strong as ever*. Washington, DC: MedPAC/Urban Institute.
- Neuman, M. D., C. Wirtalla, and R. M. Werner. 2014. Association between skilled nursing facility quality indicators and hospital readmissions. *Journal of the American Medical Association* 312, no. 15 (October 15): 1542–1551.
- Office of Inspector General, Department of Health and Human Services. 2012. *Inappropriate payments to skilled nursing facilities cost Medicare more than a billion dollars in 2009*. Report no. OEI-02-09-00200. Washington, DC: OIG.
- Office of Inspector General, Department of Health and Human Services. 2011. *Early alert memorandum report: Changes in skilled nursing facilities billing in fiscal year 2011*. Report no. OEI-02-09-00204. Washington, DC: OIG.
- Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014a. Personal communication of author with John Klemm. October 15.
- Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014b. Personal communication with James Hardesty, November 18.
- Olivia, J. 2014. Healthcare industry executives expect massive consolidation ahead. *Senior Housing News*, August 10. <http://seniorhousingnews.com/2014/08/10>.
- Skilled Healthcare. 2014a. *Annual report 2013*. Foothill Ranch, CA: Skilled Healthcare Group. <http://www.skilledhealthcaregroup.com/>.
- Skilled Healthcare. 2014b. Quarterly report (Form 10-Q). Filing submitted to the Securities and Exchange Commission. <http://www.skilledhealthcaregroup.com/>.
- Smith, V. K., K. Gifford, E. Ellis, et al. 2014. *Medicaid in an era of health & delivery system reform: Results from a 50-state Medicaid budget survey for state fiscal years 2014 and 2015*. Menlo Park, CA: Kaiser Family Foundation.
- Urban Institute. 2004. *Classifying Medicare SNF patients: Initial findings from three approaches*. Report to the Centers for Medicare & Medicaid Services. Contract no. 500-00-0025. Baltimore, MD: CMS.
- White, A. 2012. *Differences in resident case-mix between Medicare and non-Medicare nursing home residents*. Report prepared by staff from Abt Associates for the Medicare Payment Advisory Commission. Washington, DC: MedPAC.
- White, C., S. D. Pizer, and A. J. White. 2002. Assessing the RUG-III resident classification system for skilled nursing facilities. *Health Care Financing Review* 24, no. 2 (Winter): 7–15.
- Wissoker, D., and B. Garrett. 2010. *Development of updated models of nontherapy ancillary costs*. Washington, DC: Urban Institute.
- Wissoker, D., and S. Zuckerman. 2012. *Impacts of a revised payment system for SNFs*. A memo prepared by staff from the Urban Institute for the Medicare Payment Advisory Commission. Washington, DC: MedPAC.

