CHAPTER 8

Skilled nursing facility services

RECOMMENDATIONS

(The Commission reiterates its previous recommendation on updating Medicare's payments to skilled nursing facilities. See text box, p. 178.)

CHAPTER 8

Skilled nursing facility services

Chapter summary

Skilled nursing facilities (SNFs) furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2011, almost 15,000 SNFs furnished Medicare-covered care to 1.7 million fee-for-service (FFS) beneficiaries during 2.4 million stays. The Office of the Actuary estimates that Medicare spending for 2011 was $31.3 billion and comprised about 6 percent of Medicare's spending.

Assessment of payment adequacy

To examine the adequacy of Medicare's payments, we analyze 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. Indicators of payment adequacy for SNFs were positive. With regard to our assessment of efficient providers, we base our findings on data from each of the past three years, as cost report data for 2011 were not available at the time of our analysis. We were able to identify facilities that furnished relatively high quality and had relatively low costs compared with other SNFs and had high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies without losing Medicare revenue.

Beneficiaries' access to care—Access to SNF services remains stable for most beneficiaries.

In this chapter

- ***Capacity and supply of providers***—The number of SNFs participating in the Medicare program increased slightly between 2010 and 2011. Three-quarters of beneficiaries live in a county with five or more SNFs, and less than 1 percent live in a county without one. Bed days available did not change between 2009 and 2010, the most recent years with available data. The median occupancy rate was 88 percent, indicating some excess capacity for admissions.
- ***Volume of services***—Days and admissions on a per FFS beneficiary basis were essentially unchanged between 2010 and 2011.

Quality of care—SNF quality of care, as measured by risk-adjusted rates of community discharge and rates of rehospitalization for patients with five avoidable conditions, has changed little over the past decade. This year, the Commission reports a third measure—rehospitalizations within 30 days of discharge from the SNF. The three measures show considerable variation across the industry.

Providers' access to capital—Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Lending in 2013 is expected to be similar to that in 2012. Uncertainties surrounding the federal budget continue to make borrowers and lenders wary, but this lending environment reflects the economy in general, not the adequacy of Medicare payments. Medicare remains a preferred payer.

Medicare payments and providers' costs—Increases in payments between 2010 and 2011 outpaced increases in providers' costs, reflecting the continued concentration of days in the highest payment case-mix groups. In addition, payments in 2011 were unusually high because of overpayments resulting from an adjustment made to implement the new case-mix groups. Because Medicare cost reports were not available in time for this report, we estimated a range for the 2011 margins: from 22 percent to 24 percent. This year is the 11th year in a row with Medicare margins above 10 percent. We project that the 2013 margin will range from 12 percent to 14 percent.

Last year, the Commission made a recommendation to first restructure the SNF payment system and then rebase payments. Specifically, the Commission recommended that the Congress direct the Secretary to revise the SNF prospective payment system (PPS) in 2012; during the year of revision, the payment rates were to be held constant (no update). The Commission discussed three revisions to improve the accuracy of payments. First, payments for therapy services should be based on patient characteristics (not services provided). Second, payments for nontherapy ancillary services (such as drugs) need to be removed from the nursing component and made through a separate component established specifically to

adjust for differences in patients' needs for these services. Third, an outlier policy would be added to the PPS. After the PPS is revised, in the following year, 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 was based on several factors:

- high and sustained Medicare margins,
- widely varying costs unrelated to case mix and wages,
- cost growth well above the market basket that reflects little fiscal pressure from the Medicare program,
- the ability of many SNFs (more than 900) to have consistently below-average costs and above-average quality of care,
- the continued ability of the industry to maintain high margins despite changing policies, and
- the fact that in some cases Medicare Advantage payments to SNFs are 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.

No policy changes have been made that will materially affect the trajectory of these findings going forward. Therefore, the Commission maintains its position with respect to the SNF PPS and urges the Congress as soon as practicable to direct the Secretary to revise the PPS and begin a process of rebasing payments.

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid utilization, spending, and non-Medicare (private pay 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 decreased slightly between 2011 and 2012. In 2011, estimates of non-Medicare margins and total margins indicate that both improved over 2010. Non-Medicare margins ranged from an estimated –1 percent to –3 percent, and total margins ranged from 4 percent to 6 percent for all payers and all lines of business. ■

TABLE 8–1

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

	Facilities		Medicare-covered stays		Medicare payments	
Type of SNF	**2006**	**2011**	**2006**	**2011**	**2006**	**2011**
Total number	15,178	14,935	2,454,263	2,455,730	$19.5 billion	$28.8 billion
Freestanding	92%	95%	89%	93%	94%	97%
Hospital based	8	5	11	7	6	3
Urban	67	71	79	81	81	84
Rural	33	29	21	19	19	16
For profit	68	70	67	72	73	76
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 2011.

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 2011, almost 1.7 million fee-for-service (FFS) beneficiaries (4.7 percent) used SNF services at least once (there were over 2.4 million stays). The Office of the Actuary estimates program spending on SNF services was $31.3 billion in 2011. Of all beneficiaries hospitalized in 2011, about 20 percent were discharged to SNFs.[1]

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least three days.[2] For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment rate for the first 20 days of care. Beginning with day 21, beneficiaries are responsible for copayments. For 2013, the copayment is $148 per day.

The term "skilled nursing facility" refers to a provider that meets Medicare requirements for Part A coverage.[3] Most SNFs (more than 90 percent) are dually certified as a SNF and as a nursing home (which typically furnishes less intensive, long-term care services). Thus, a facility that provides skilled care often also furnishes long-term care services that Medicare does not cover. Medicaid is the predominant payer in nursing homes, accounting for the majority of days and dollars.

The mix of facilities and the facility type where beneficiaries seek care has shifted toward freestanding and for-profit facilities (Table 8-1). Between 2006 and 2011, freestanding facilities and for-profit facilities accounted for growing shares of Medicare stays and spending. In 2011, 70 percent of SNFs were for profit; they provided about 72 percent of stays and accounted for 76 percent of Medicare payments.

Medicare-covered SNF patients typically comprise a small share of a facility's total patient population but a larger share of the facility's payments. In 2010, in freestanding facilities the median Medicare-covered share of total facility days was 12 percent, but it accounted for 23 percent of facility revenue. These shares represent increases from 2000, when Medicare's share of facility days was 7 percent and its share of revenues was 14 percent.

The most frequent hospital conditions referred to SNFs for post-acute care were joint replacement, septicemia, kidney and urinary tract infections, hip and femur procedures except major joint replacement, and heart failure and shock. Compared with other beneficiaries, SNF users are older, frailer, and more likely to be female, disabled, living in an institution, and dual eligible (see text box, pp. 162–163).

Description of beneficiaries who use skilled nursing facility services

Compared with other Medicare beneficiaries who have not used a skilled nursing facility (SNF), SNF users are more likely to be female, older, and White (Table 8-2). SNF users are two times more likely than other beneficiaries to report poor health status and four times more likely to have three to six limitations in their activities of daily living (such as dressing, bathing, and eating), with 49 percent reporting this level of impairment. Further, only 13 percent of SNF users report being in excellent or very good health compared with 43 percent of other beneficiaries. Compared with other beneficiaries,

TABLE 8–2

Users of skilled nursing facilities are older, frailer, and more likely to report poor health status compared with other beneficiaries, 2010

	Percent of:	
Characteristic	**Beneficiaries who use SNF services**	**Other beneficiaries**
Sex		
Female	59%	54%
Male	41	46
Race/ethnicity		
White, non-Hispanic	85	79
African American	10	9
Hispanic	2	6
Other	2	5
Age (in years)		
Less than 65	8	18
65–74	20	45
75–84	34	25
85 or older	39	12
Self-reported health status		
Excellent or very good	13	43
Good or fair	68	48
Poor	19	8
Limitations in ADLs		
No ADLs	26	69
1–2 ADLs	25	19
3–6 ADLs	49	12
Education		
No high school diploma	32	23
Completed high school	29	30
Beyond high school	36	46
Living arrangement		
In an institution	33	4
Alone	28	29
With a spouse	23	49
Other	15	18

Note: SNF (skilled nursing facility), ADL (activity of daily living).

Source: MedPAC analysis of Medicare Current Beneficiary Survey 2010 cost and use files.

(continued next page)

Description of beneficiaries who use skilled nursing facility services (cont.)

SNF users are less educated—more likely to have not completed high school and less likely to have education beyond that level.

SNF users are much more likely to be living in an institution, with 33 percent living in one compared with 4 percent of beneficiaries who have not used a SNF. Almost equal shares of SNF users and other beneficiaries live alone. However, 23 percent of SNF users live with a spouse compared with 49 percent of other beneficiaries who live with a spouse. SNF users are more than twice as likely as other beneficiaries to be disabled.

Comparing SNF users who were dually eligible for Medicare and Medicaid and SNF users who were not, in 2010, dual-eligible beneficiaries accounted for 17 percent of Medicare beneficiaries but 37 percent of SNF users. Compared with other SNF users, dual-eligible SNF users were younger, more likely to be a minority, less likely to be married, and more dependent in function as indicated by a lower average Barthel activity of daily living score (a score of 34 vs. 41 out of a possible score of 90).[4] They also had a higher rate of most chronic medical conditions (e.g., falls, heart failure, diabetes mellitus), mental illnesses, and cognitive impairments (Table 8-3). Dual-eligible SNF users were more than twice as likely to be discharged to long-term nursing home care rather than to a community setting compared with other SNF users (50 percent vs. 22 percent). This substantially higher rate of long-term nursing home placement was only partially explained by differences in patient characteristics, indicating that dual-eligible SNF users are substantially more likely to be placed in long-term nursing home care than other SNF users, independent of risk (Kramer et al. 2013). ■

TABLE 8–3

Dual-eligible users of SNFs are younger, more likely to be minority, and more likely to have mental illness or cognitive impairment compared with other SNF users, 2010

	Percent of:	
Characteristic	**Dual-eligible SNF users**	**Other SNF users**
Race/ethnicity		
White, non-Hispanic	72%	92%
African American	18	6
Hispanic	8	1
Other	3	1
Age (in years)		
Less than 65	19	4
85 or older	28	39
Married	20	39
Falls since admission or prior assessment	23	16
Mental illness		
Alzheimer's disease	9	5
Dementia	33	21
Depression	46	33
Psychosis	9	3
Schizophrenia	5	1

Note: SNF (skilled nursing facility).

Source: Analysis of patient assessment data for fiscal year 2011 (Kramer et al. 2013).

SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay for each day of service.[5] 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 furnish to a patient (such as the amount and type of 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 to perform activities of daily living (such as eating and toileting). Medicare's payments for SNF services are described in Medicare *Payment Basics*, available on the Commission's website (http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_SNF.pdf). Though the payment system is referred to as "prospective," two features undermine its prospectivity: Payments are made for each day of care (rather than establishing a payment for the entire stay) and payments are partly based on the amount of service furnished to a patient. Both features result in providers having some control over their payments.

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. The PPS encourages the provision of therapy because payments are based in part on the amount of service furnished to beneficiaries, rather than being set prospectively, and payments are not proportional to costs. That is, as therapy costs increase, therapy payments rise even faster (Garrett and Wissoker 2008, Medicare Payment Advisory Commission 2008). The problem with payments for NTA services is that they 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 that the PPS be revised to base therapy payments on patient characteristics (not service provision), remove the payments for NTA services from the nursing component and establish a separate component within the PPS that adjusts payments for the need for NTA services, and implement an outlier policy (Medicare Payment Advisory Commission 2008). A revised PPS would raise payments for medically complex care (and the SNFs that provide it) and lower payments for high-intensity therapy (and the SNFs that provide it) (Wissoker and Garrett 2010).

Since 2008, the Commission has updated its PPS design work in three ways. First, the Commission compared an alternative PPS design with current (2012) policy that incorporates changes to the case-mix system and the balance of payments between therapy and nontherapy care. We found that a revised design is still needed to improve the predicted costs per day and redistribute payments from SNFs with high shares of therapy stays to SNFs with high shares of medically complex stays (Carter et al. 2012, Wissoker and Zuckerman 2012). The effects of a revised payment design would vary considerably across SNFs by type and ownership, reflecting differences in patient mixes and therapy practices. Assuming no other changes in patient mix or care delivery, aggregate payments would increase for hospital-based facilities (27 percent) and nonprofit facilities (8 percent) and decrease slightly for freestanding facilities (1 percent) and for-profit facilities (2 percent), but the effects on individual facilities could vary substantially. Given the mix of patients facilities treat, Medicare margins would increase for nonprofit facilities and hospital-based facilities (facilities with the lowest Medicare margins) and decline slightly for for-profit facilities and freestanding facilities (facilities with the highest Medicare margins).

Second, a 2009 update to this work explored designs for the NTA component that met the criteria CMS laid out for this component (Centers for Medicare & Medicaid Services 2009). These designs retained most of their ability to predict NTA costs and considerably improved the accuracy of payments for NTA services (Wissoker and Garrett 2010).

Third, the Commission examined designs that paid for therapy on a per stay basis as a way to dampen the incentive to extend stays or furnish unnecessary therapy. We found that stay-based designs would be less accurate, though not remarkably so. One stay-based design explained between 18 percent and 21 percent of the variation in therapy costs per stay. The better designs included features of the case-mix system used to pay inpatient rehabilitation facilities or the predictive model developed by CMS's Post-Acute Care Payment Reform Demonstration to explain the direct patient care costs of therapy. One of the better day-based designs, using CMS's predictive therapy cost model, explained 26 percent of the variation (Wissoker 2012). Designs that included measures of length of stay had more than double the explanatory power but, like current policy, would most likely result in unnecessary services.

CMS's revisions to 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 more accurately pay for NTAs 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.[6] 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, between 2010 and 2011, the share of days classified into medically complex groups increased from 5 percent to 7 percent. In addition, in 2010 and 2011, CMS made important changes to more accurately pay for rehabilitation therapy—including lower payments for therapy furnished to multiple beneficiaries treated at the same time rather than in one-on-one sessions and requiring providers to reassess patients when the provision of therapy changed or stopped (that would, in turn, change the assignments to case-mix groups).[7]

SNFs continue to be adept at modifying their practices in response to changes in policy—varying the amount of therapy provided and deciding whether they furnish therapy individually or in groups—and they will most likely continue to do so. For example, in 2010, when Medicare payments were lowered by 1.1 percent, total spending increased almost 5 percent from 2009. SNFs achieved this increase in part by providing more intensive rehabilitation that resulted in more days being classified into the higher intensity case-mix groups, from 65 percent to 69 percent. When CMS lowered its payments for therapy provided to groups of beneficiaries, SNFs shifted their mix of modalities to furnish therapy in one-on-one sessions almost exclusively. Individual therapy now makes up over 99 percent of therapy furnished, up from 74 percent in 2006 (Centers for Medicare & Medicaid Services 2012).

Provider adjustments to rate reductions in 2012 have included both cost reduction and revenue enhancement strategies. Cost reductions have focused on nonpatient care areas, such as corporate overhead, administration, and outsourcing of dietary, laundry, and housekeeping services. Some providers have improved the efficiency of therapists with the use of hand-held devices. This technology has reduced the time needed to complete paperwork and allowed therapists to bill more hours per shift (Kindred Healthcare 2012b). Increasing occupancy is another strategy (Ensign Group 2012). Revenue enhancements have targeted improving payer mix (i.e., lowering Medicaid days by expanding commercial days) and continuing to seek short-term, high-rehabilitation Medicare patients (Ensign Group 2012, Extendicare 2012, Kindred Healthcare 2012c, Skilled Healthcare 2012, Sun Healthcare Group 2012).

With respect to the Commission's recommendations to reform the PPS, CMS continues to evaluate a possible NTA component and in 2012 began a multiyear study to consider alternative PPS designs for therapy services. To establish a separate NTA component, CMS will need to complete its research before deciding whether to pursue this option. CMS is likely to exclude services that are especially discretionary (e.g., oxygen therapy) and is updating its analysis to reflect more recent practice patterns. In fall 2012, CMS engaged a contractor to study possible reforms to therapy payments within the PPS, including (but not limited to) episode-based payments and payments for therapy services based on patient characteristics (as the Commission recommended). CMS does not have the authority to establish an outlier policy, rebase payment rates, or update the SNF rates using alternatives to the market basket, and it therefore has not aggressively pursued these options. Congressional action is required to make these changes to the SNF PPS.

Are Medicare payments adequate in 2013?

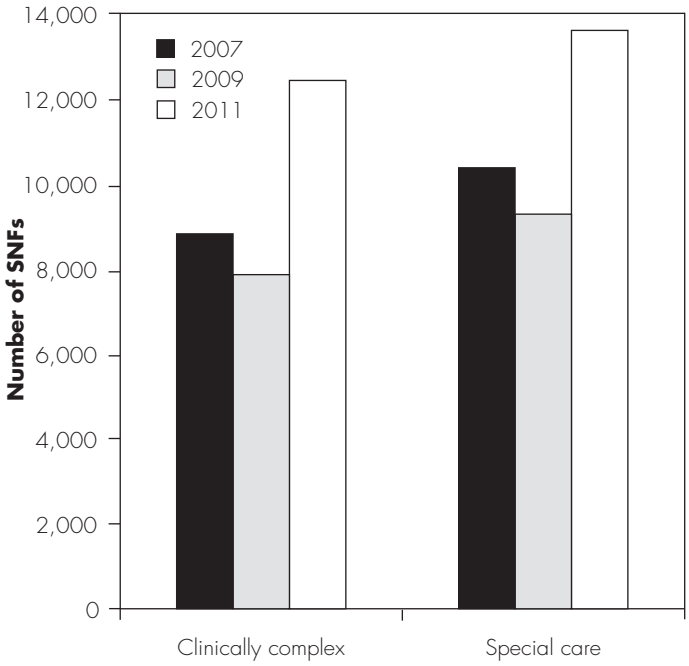
To examine the adequacy of Medicare's payments, we analyzed access to care (including the supply of providers and volume of services), quality of care, providers' access to capital, Medicare payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compared the performance of SNFs with relatively high and low Medicare margins and efficient SNFs with other SNFs.

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

We do not have direct measures of access. Instead, we consider the supply and capacity of providers and evaluate changes in volume. 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.

FIGURE 8–1

Number of SNFs with clinically complex and special care cases increased after case-mix groups were expanded in 2010



Note: SNF (skilled nursing facility). Category based on the case-mix group assignment of the day-5 assessment. The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or those who are aphasic or tube-fed.

Source: MedPAC analysis of 2007, 2009, and 2011 Minimum Data Set data from CMS.

Capacity and supply of providers: Supply remains stable

Since 2006, the number of SNFs participating in the Medicare program decreased slightly to 14,935 in 2011. However, between 2010 and 2011, 24 more SNFs were treating Medicare beneficiaries. Most new participants are for profit and freestanding.[8] Most SNFs are also freestanding (96 percent) and for-profit facilities make up 70 percent of the industry.

Most beneficiaries live in counties with multiple SNFs. Over three-quarters of beneficiaries live in counties with 5 or more SNFs and the majority of beneficiaries live in counties with 10 or more. Few beneficiaries (less than 1 percent) live in a county without a SNF.

Although more recent data were not available, our prior work found that SNF bed days available (defined as days available for occupancy after adjusting for beds temporarily out of service due to, e.g., renovation or patient isolation) in freestanding facilities were unchanged between 2009 and 2010. Between 2001 and 2010, the increase in bed days available averaged 6 percent a year. In 2010, the median occupancy rates were 88 percent in freestanding facilities and 81 percent in hospital-based units, indicating capacity to admit beneficiaries seeking SNF care.

The number of SNFs admitting medically complex patients increased between 2009 and 2011, reversing a steady decline from 2005 (Figure 8-1, early years not shown). Medically complex admissions continued to be more concentrated in fewer SNFs compared with rehabilitation admissions, though less so than in previous years.[9] Nonprofit SNFs and hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top 10th percentile) of medically complex patients. The concentration of medically complex cases in certain SNFs may have implications for minorities because minority beneficiaries made up a disproportionate share of medically complex admissions to SNFs in 2011.[10]

The expansion of the number of SNFs treating medically complex patients reflects the increased rates paid for this care. In the past, many of these patients would have received enough therapy (at least 75 minutes a week) to qualify them for a higher payment therapy group. Although CMS's changes may increase the willingness of SNFs to admit medically complex patients, the PPS continues to disadvantage SNFs that admit high shares of medically complex cases (Wissoker and Zuckerman 2012). Some facilities may be discouraged from admitting these patients if they have a higher likelihood of exhausting their 100-day benefits, which may put financial pressure on the provider.

Volume of services: Essentially unchanged between 2010 and 2011

In 2011, just under 5 percent of FFS beneficiaries used SNF services. We examine per person utilization for FFS beneficiaries, as the CMS data on counts of users, days, and admissions do not include service use by beneficiaries enrolled in Medicare Advantage (MA) plans. Because MA enrollment continues to increase, changes in utilization could reflect a declining number of FFS beneficiaries rather than reductions in service use.

TABLE 8–4 **Volume essentially unchanged between 2010 and 2011**

Volume measure	2006	2008	2009	2010	2011	Percent change 2010–2011
Covered admissions per 1,000 FFS beneficiaries	72	73	72	71.5	71.2	–0.3%
Covered days (in thousands)	1,892	1,977	1,963	1,938	1,935	–0.2
Covered days per admission	26.3	27.0	27.3	27.1	27.2	0.4

Note: FFS (fee-for-service). Data include 50 states and the District of Columbia.

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

SNF volume per FFS beneficiary was essentially unchanged between 2010 and 2011. Admissions per 1,000 FFS beneficiaries were essentially constant (they declined 0.3 percent), while covered days declined slightly less, resulting in a very small increase in covered days per admission (Table 8-4).[11] Although the decline in inpatient cases was larger (about 1.5 percent) than the decline in SNF admissions, the decline in hospital cases that go on to use post-acute care may have been smaller than the overall average. Hospital stays of at least three days (which qualify a beneficiary for Medicare coverage of a SNF stay) declined only 0.6 percent.

Intensity of rehabilitation services unexplained by health status factors

Between 2001 and 2011, the share of days classified into rehabilitation case-mix groups increased from 75 percent to 92 percent.[12] In the rehabilitation case-mix groups, intensive therapy days made up three-quarters of the days in 2011.[13] Even after all policy and payment changes CMS made to therapy care, the levels of therapy remained high. Payments are determined by the amount of therapy furnished, and even though costs increase when more therapy is furnished, payments rise even faster. Facilities differed in the amount of intensive therapy they furnished. For-profit facilities and facilities located in urban areas had higher shares of intensive therapy than nonprofit facilities and facilities in rural and frontier areas.

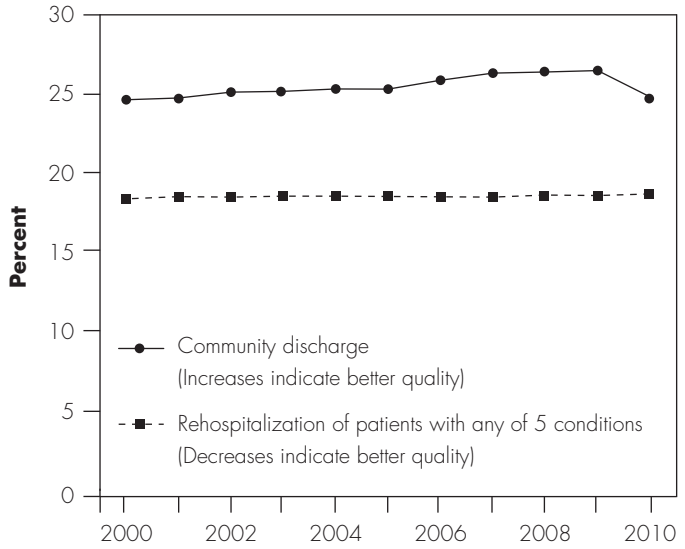
Between 2008 and 2011, changes in the frailty of patients at admission to a SNF do not explain the increases in therapy. During this period, the average modified Barthel score was about the same (it increased one point, indicating slightly more independence). We also looked at the nine individual measures (see endnote 4) and found that the shares of patients requiring the most help (and possibly less able to tolerate high levels of therapy) decreased an average of 3 percent. Although more patients may be able to tolerate the highest levels of therapy, the increase in the most intensive therapy days (16 percent) far outpaces the changes in patient characteristics. Shorter hospital stays could have shifted some therapy provision from the hospital to the SNF sector. For example, between 2008 and 2011, hospital lengths of stay decreased less than 7 percent on average for the five highest volume diagnosis related groups discharged to SNFs.

The Office of Inspector General has continued to investigate the billing practices of SNFs. Earlier work found that between 2006 and 2008, SNFs increasingly billed for higher payment RUGs, even though the ages and diagnoses of beneficiaries were largely unchanged (Office of Inspector General 2011). Recently, it found that one-quarter of Medicare claims in 2009 were billed in error, with upcoding making up the majority of errors (Office of Inspector General 2012). In about half of these cases, SNFs billed for the highest rehabilitation case-mix groups when they should have billed for lower levels of care. In addition to recommending that CMS expand its review of claims and increase monitoring of industry practices, the Office of Inspector General recommended that CMS change the way it pays for therapy, consistent with the Commission's recommendation.

In the past, we reported that the intensification of therapy could partly reflect some of the shift in cases from inpatient rehabilitation facilities to SNFs. This trend appears to have stabilized between 2010 and 2011. Of the top 10 diagnosis related groups discharged to inpatient rehabilitation facilities, there was almost no change in the shares of cases going to SNFs. For example, among patients recovering from major joint replacement, 33

FIGURE 8–2

SNF quality shows little improvement over 10 years



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

Source: Risk-adjusted rates for years 2003 to 2010 calculated by MedPAC based on a risk-adjustment model developed by the Division of Health Care Policy and Research, University of Colorado at Denver and Health Sciences Center (Fish et al. 2011).

percent were discharged to SNFs in 2004; this share increased to 38 percent in 2010 and remained at that share in 2011.

Quality of care: A decade with little improvement

The Commission tracks two indicators of SNF quality: risk-adjusted rates of community discharge and rehospitalization of patients with five potentially avoidable conditions during the SNF stay.[14] Between 2000 and 2010, the rates showed little change. This year, the Commission developed a risk-adjustment measure of rehospitalization of beneficiaries within 30 days of discharge from the SNF. This performance measure would encourage facilities to ensure safe and appropriate transitions to the next health care setting (or home). Between 2010 and 2011, performance for all three measures varied considerably across facilities.

Rehospitalization and community discharge rates are essentially unchanged from 2000

Between 2000 and 2010, rates of rehospitalization for patients with any of five potentially avoidable conditions and discharge to the community remained almost the same (Figure 8-2). These rates differ slightly in level but not in the trends previously reported by the Commission. The levels differ because the Commission adopted a new base year for the measures (2011) so that the rates are more directly comparable over time to the rates reported for 2011, as discussed below.

The persistent lack of improvement in rehospitalization rates likely reflects the financial incentive to transfer patients back to the hospital when they require expensive ancillary services, poor communication (among staff and between staff and physicians), and a lack of adequate staffing at facilities (especially at night and on weekends). Although all SNFs face the same incentives, there are facilities with consistently low and high rehospitalization rates. Last year, we found over 1,200 SNFs with rehospitalization rates in the lowest (the best) quartile of the distribution of rates for 3 years in a row; of them, over 300 were in the best 10th percentile each of the 3 years. Conversely, over 900 facilities had rates in the top quartile (the worst) 3 years in a row; of them, almost 200 were in the worst 10th percentile each year.

In October 2010, CMS implemented a new patient assessment tool for use by nursing homes and SNFs (Minimum Data Set version 3.0). The change in assessment tools required us to revise the methods we use to risk adjust the quality measures the Commission tracks. The revised Minimum Data Set has improved patient tracking and provides more complete data than the previous assessment data. The risk-adjustment methods continue to include patient comorbidities and measures of functional status but exclude service-use measures, such as the provision of therapy or the patient's use of a feeding tube or catheter—conditions that providers could influence.[15] Because the comorbidity index includes indicators for several mental illnesses, a separate measure of cognitive status was not statistically significant and was excluded from the final risk-adjustment model.[16] While the risk-adjusted rates for 2011 are close to those for 2010, some discrepancies exist that partly reflect differences in methods. Thus, changes between 2010 and 2011 need to be interpreted with caution. However, going forward, the new and more current methodology will be used and will be comparable to that used for 2011. In that year, the community discharge rate was 27.8 percent and the

TABLE 8–5

SNF quality measures vary within and across ownership and facility type, 2011

Quality measure	Mean	Group mean relative to industry mean	25th percentile	Median	75th percentile	Ratio of 75th to 25th percentile
Discharged to the community						
All	27.8%		21.7%	28.8%	34.7%	1.6
Freestanding	27.9	1.00	21.8	28.7	34.6	1.6
For profit	27.9	1.00	21.8	28.7	34.6	1.6
Nonprofit	28.8	1.04	22.8	29.4	35.0	1.5
Government	23.4	0.84	16.8	24.3	30.2	1.8
Hospital based	32.5	1.17	27.9	33.1	38.1	1.4
For profit	32.2	1.16	27.3	32.5	38.6	1.4
Nonprofit	33.0	1.19	28.5	33.3	38.1	1.3
Government	30.2	1.09	25.2	31.8	37.3	1.5
Readmission for patients with any of 5 potentially avoidable conditions						
All	19.2		14.8	19.1	23.4	1.6
Freestanding	19.8	1.03	15.5	19.5	23.7	1.5
For profit	20.3	1.06	16.0	19.9	24.1	1.5
Nonprofit	18.7	0.97	14.3	18.4	22.5	1.6
Government	17.5	0.91	13.0	17.3	22.2	1.7
Hospital based	12.7	0.66	8.4	11.7	16.4	2.0
For profit	12.7	0.66	7.7	11.1	17.1	2.2
Nonprofit	12.9	0.67	8.6	11.9	16.3	1.9
Government	11.9	0.62	7.4	11.6	16.2	2.2

Note: SNF (skilled nursing facility). Increases in rates of discharge to community indicate improved quality. The five conditions include congestive heart failure, respiratory infection, urinary tract infection, septicemia, and electrolyte imbalance. Increases in rehospitalization rates for the five conditions indicate worsening quality. Rates are facility averages and calculated for all facilities with 25 or more stays. Rehospitalizations are for beneficiaries during SNF stay. Facility counts do not sum to the total because ownership or facility type was unknown.

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

rehospitalization rate was 19.2 percent (Kramer et al. 2013).

There is considerable variation in the performance of quality measures across the industry. One-quarter of facilities had rates 60 percent higher than facilities in the lowest quartile (Table 8-5). Hospital-based facilities had higher risk-adjusted community discharge rates and lower rehospitalization rates than freestanding SNFs, indicating better quality at hospital-based facilities. Compared with nonprofit facilities, freestanding for-profit SNFs had lower rates of discharge to the community and higher rates of rehospitalization. Within groups (ownership and facility type), there was also considerable variation in rehospitalization rates. For example, among freestanding for-profit facilities, community discharge rates were 60 percent higher and rehospitalization rates were 50 percent higher for facilities in the worst quartile than for those in the best quartile. Between 2000 and 2010, the variation in rates remained about the same.

Demographics (including race, gender, and age categories except those less 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. 2013). Differences in observed rehospitalization rates between dual-eligible

and other SNF users were essentially eliminated with risk adjustment. However, differences in rates of community discharge between dual-eligible and other SNF users remained after risk adjustment, reflecting the more limited options dual-eligible beneficiaries have in being placed in affordable community settings with adequate support services.

These data predate industry initiatives to lower rehospitalizations. In September 2012, the American Health Care Association announced a quality initiative to lower readmission rates 15 percent by 2015. Some providers are hoping to position themselves as preferred post-acute care providers for patients being discharged from hospitals, which are now subject to readmission penalties. Industry efforts include identifying patients at high risk of readmission, carefully monitoring changes in patients' conditions and communicating those changes among staff, and educating hospital discharge planners about facility capabilities.

Rates of rehospitalization after discharge from the SNF

Last year, to align the incentives of hospitals and SNFs to lower unnecessary rehospitalizations, the Commission recommended that the Congress direct the Secretary to reduce payments to SNFs with relatively high risk-adjusted rates of rehospitalization during Medicare-covered stays. The Commission stated that the measure should consider a time period after discharge from the facility once a risk-adjusted measure was developed, similar to the hospital readmission policy that holds hospitals accountable for admissions that occur within 30 days of discharge. Because the processes and actors are likely to differ for the period when a patient is in the SNF versus the period after discharge, separate measures would give the SNF more actionable information. For example, a high rehospitalization rate for patients after discharge from the SNF could point out shortcomings in community-based care, poor patient (and family) education before discharge from the SNF, or a patient's limited ability to manage at home. Financial incentives may also play a role in when patients are discharged. A beneficiary may go home when copayments begin on day 21 of a stay even though she could benefit from additional days of care. If facilities faced rehospitalization penalties, they would be more inclined to ensure that patients were physically ready, to see that their families were adequately educated (e.g., about medication management, advance directives, and hospice care), and to partner with high-quality community services to avoid readmission to the hospital.

A high rate of rehospitalization of patients still in the SNF would point to the care processes in the facility. To lower rehospitalization rates, facilities could focus efforts on improving staff competencies (such as their ability to detect and manage small changes in a patient's condition); staff mix and level; communication among staff about the current medical status of each patient; medication management; and medical staff backup on weekends and at night. Staff could also be educated about appropriate and inappropriate hospitalizations and best practices for potentially avoidable conditions.

This year, Commission staff worked with a contractor to develop a risk-adjusted measure of rehospitalization during the 30 days after discharge from the SNF. Consistent with the other SNF risk-adjustment methods, the method for the 30-day measure considers a patient's comorbidities, ability to perform activities of daily living, whether the patient had a surgical procedure during a prior hospital stay, and the number of times physicians' orders were changed (reflecting patient instability). SNF discharges, excluding direct hospitalizations and deaths, were to long-term nursing home care 31 percent of the time, home health care 45 percent of the time, and the community with no services or some other type of care (e.g., hospice) 24 percent of the time. Because the characteristics of patients discharged to these three settings are different, the readmission risk models for patients discharged to each type of setting were tailored to each patient setting.[17] As with the other measures, to estimate the rehospitalization rate for each SNF during the 30-day period after SNF discharge, the readmission risk for all SNF beneficiaries was aggregated to calculate the risk-adjusted readmission rate for the facility.

The average risk-adjusted rate of rehospitalization after discharge from the SNF for the five potentially avoidable conditions was 10 percent. Compared with the rates while the beneficiaries were in the SNF, there was more variation across facilities. One-quarter of facilities had rates of 7 percent or lower, while one-quarter had rates of 12.5 percent or higher.

When the separate rehospitalization rates are considered together, they indicate that over 28 percent of beneficiaries were rehospitalized (for any one of the five conditions) either during or after a SNF stay. This finding suggests considerable opportunities for SNFs to improve the

care they provide and the arrangements they make for beneficiaries after discharge. It also represents considerable program spending for those hospitalizations that could have been avoided.

Providers' access to capital: Lending in 2012

A vast majority of SNFs operate within nursing homes; therefore, in assessing SNFs' access to capital, we look at the availability of capital for nursing homes. Most operators make their bottom line using Medicare profits; lenders and owners use Medicare patient mix as one metric of a facility's financial health. Even after Medicare's reduction in payments in fiscal year 2012, the industry continues to seek Medicare patients, particularly those who could receive intensive rehabilitation.

The Department of Housing and Urban Development (HUD) is an important source of lending for nursing homes. Since 2008, HUD's lending dramatically increased as a result of an overhaul of its federally insured mortgage program for nursing homes under Section 232/222.[18] Between 2011 and 2012, the number of HUD-financed projects increased 68 percent (to 706 projects), with insured amounts totaling $5.5 billion in 2011 (Department of Housing and Urban Development 2012). HUD is expected to maintain the same level of activity for 2013, particularly as providers seek to refinance existing loans with lower interest rates. To evaluate loan applications, HUD's underwriting considers a facility's Medicare share of revenues, quality ratings, and performance on state surveys. In addition to these indicators, other lenders report looking at the diversification of the potential borrower's risk (whether the company spans multiple states or other businesses), the quality of the management team, and the stability of the company's cash flow.

Non-HUD lending began slowly in early 2012, reflecting uncertainty over how the industry would react to lower Medicare rates. As lenders realized that providers were adjusting to lower rates, borrowing picked up and lending for 2012 will be higher than for the previous year. Analysts report companies being adept at mitigating the effects of Medicare's lower payments by carefully examining the cost of their operations, including lowering overhead and corporate expenses, renegotiating the terms of contracts, and increasing the efficiency of their therapists.

Some companies report a decline in Medicare business (days and payments) but an increase in MA business. Capital market analysts report that expansion of MA at the expense of FFS Medicare will lower facility revenues given MA's shorter stays and lower payment rates. However, because MA plans often contract with specific providers for post-acute care, high-quality SNFs that partner with plans may be able to offset some of the revenue reductions with volume (Stifel Nicolaus 2012). Companies continue to seek to grow their high-acuity rehabilitation days. Publicly traded firms report higher average Medicaid rates for 2012 than for 2011 (Ensign Group 2012 , Extendicare 2012, Kindred Healthcare 2012c, Skilled Healthcare 2012, Sun Healthcare Group 2012). Higher Medicaid rates in 2012 reflect many states' improved economies (fewer states lowered or froze their payments to nursing homes compared with 2011) and the expanded use of provider taxes to bolster their Medicaid payments. In 2012, 42 states had provider taxes for nursing homes, up from 39 in 2011 (Smith et al. 2012, Smith et al. 2011).

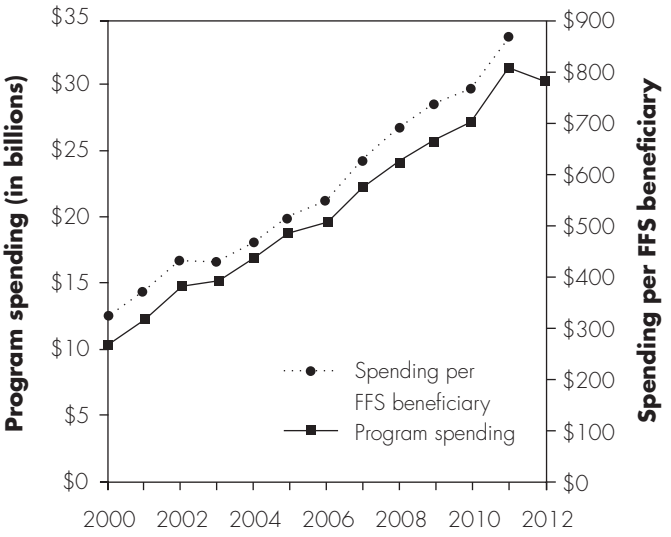
Market analysts and lenders we spoke with thought borrowing in 2013 would continue at about the same pace as in 2012. On the risk side, credit may tighten for some borrowers due to uncertainties over possible rate reductions through sequestration or as part of a broad fiscal package and state budget discussions. Some companies have spread their risk by expanding their other high-margin businesses, including home health care, hospice, and outpatient therapy (Flavelle 2012, Kindred Healthcare 2012a, Sun Healthcare Group 2012). At the same time, lenders see the sector as having long-term viability. High-quality SNFs can position themselves as the lower cost option for post-acute care relative to inpatient rehabilitation facilities and long-term care hospitals.

Estimated Medicare payments and providers' costs: Medicare margins continue to increase in 2011

Between 2010 and 2011, Medicare payments increased faster than Medicare costs, especially given the overpayments that occurred with initial implementation of the new case-mix groups. The estimated aggregate 2011 Medicare margin ranges from 22 percent to 24 percent, depending on the assumptions used to model growth in days and costs.[19] Last year, we reported that high-margin SNFs had considerably lower costs and, to a smaller extent, higher payments (from providing more intensive therapy) than low-margin SNFs. The variations in Medicare margins and costs per day were not attributable to differences in patient mix. We also found that about

FIGURE 8–3

Overpayments in 2011 sparked spike in program spending on SNFs



Note: SNF (skilled nursing facility), FFS (fee-for-service). Data for 2012 are estimates.

Source: CMS, Office of the Actuary, 2012.

10 percent of freestanding facilities furnished relatively low-cost, high-quality care and had substantial Medicare margins over three consecutive years.[20] Compared with the average, relatively efficient SNFs had costs per day that were 10 percent lower (adjusted for differences in wages and case mix), quality measures that were considerably better (17 percent lower rehospitalization rates and 38 percent higher community discharge rates), and Medicare margins of 22 percent (Medicare Payment Advisory Commission 2012). MA plans' payments, which were considerably lower than Medicare's FFS payments, are unlikely to be explained by differences in patient mix.

Trends in spending and cost growth

In 2012, the Office of the Actuary projects program FFS spending for SNF services to be $30.4 billion (Figure 8-3). In 2011, payments were unusually high because the rates included an adjustment for implementation of the new case-mix classification system. Once 2011 data were available, it became clear the adjustment was too large and the resulting payment rates had been set too high. Thus, CMS revised the adjustment downward in 2012, putting spending back in line with previous trends. After the reductions, 2012 rates were 3.7 percent higher than those in 2010. Even though rates were lowered, total spending in 2012 was projected to be 12 percent higher than it was in 2010. On a per FFS beneficiary basis, spending in 2011 was $871.

Between 1999 and 2011, the cumulative increase in cost per day (49 percent) outpaced the market basket updates. Payments rose far faster than either of these (84 percent), reflecting changes in the provision of therapy that resulted in more days classified as higher payment case-mix groups (Figure 8-4).

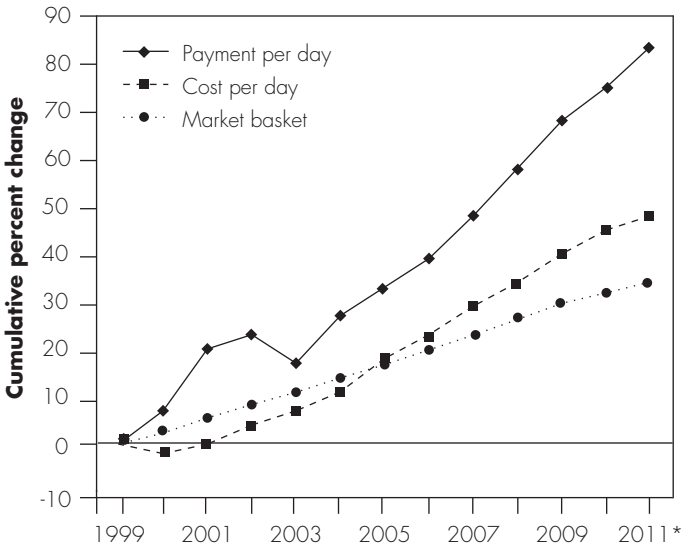
SNF Medicare margins continue to grow

The Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's payments with 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. Total margins are presented as context for the Commission's update recommendation.

Because Medicare cost reports were not available to conduct our margin analysis for 2011, we estimated a range of margins for that year. We modeled revenues for

FIGURE 8–4

Cumulative change in payments per day, costs per day, and market basket update since 1999

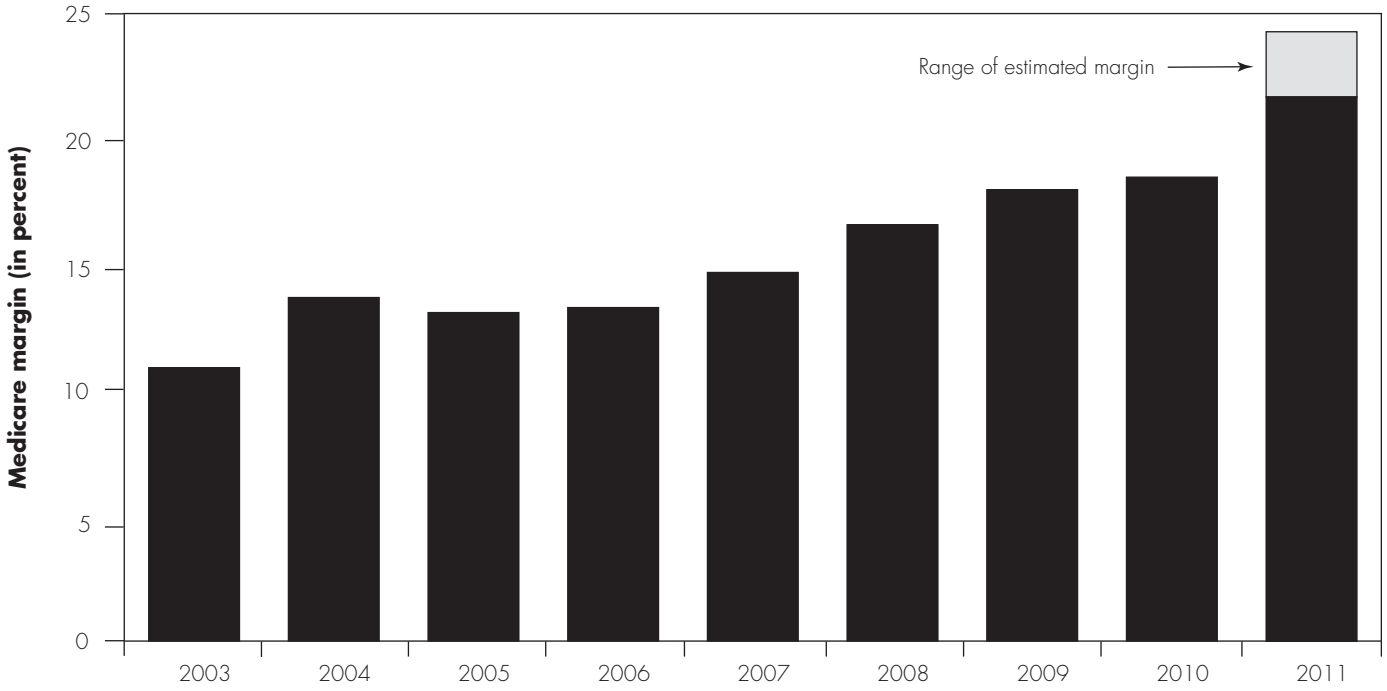


Note: *Estimated.

Source: MedPAC analysis of freestanding skilled nursing facility Medicare cost reports from 1999 to 2010, estimates of 2011 revenues and costs, and *Federal Register* final rules for skilled nursing facility services for fiscal years 1999 to 2011.

FIGURE 8–5

Freestanding SNF Medicare margins continue to increase



Note: SNF (skilled nursing facility). Range of estimates for 2011 incorporate different assumptions about days, revenues, and costs.

Source: MedPAC analysis of freestanding SNF cost reports from 2003 to 2011.

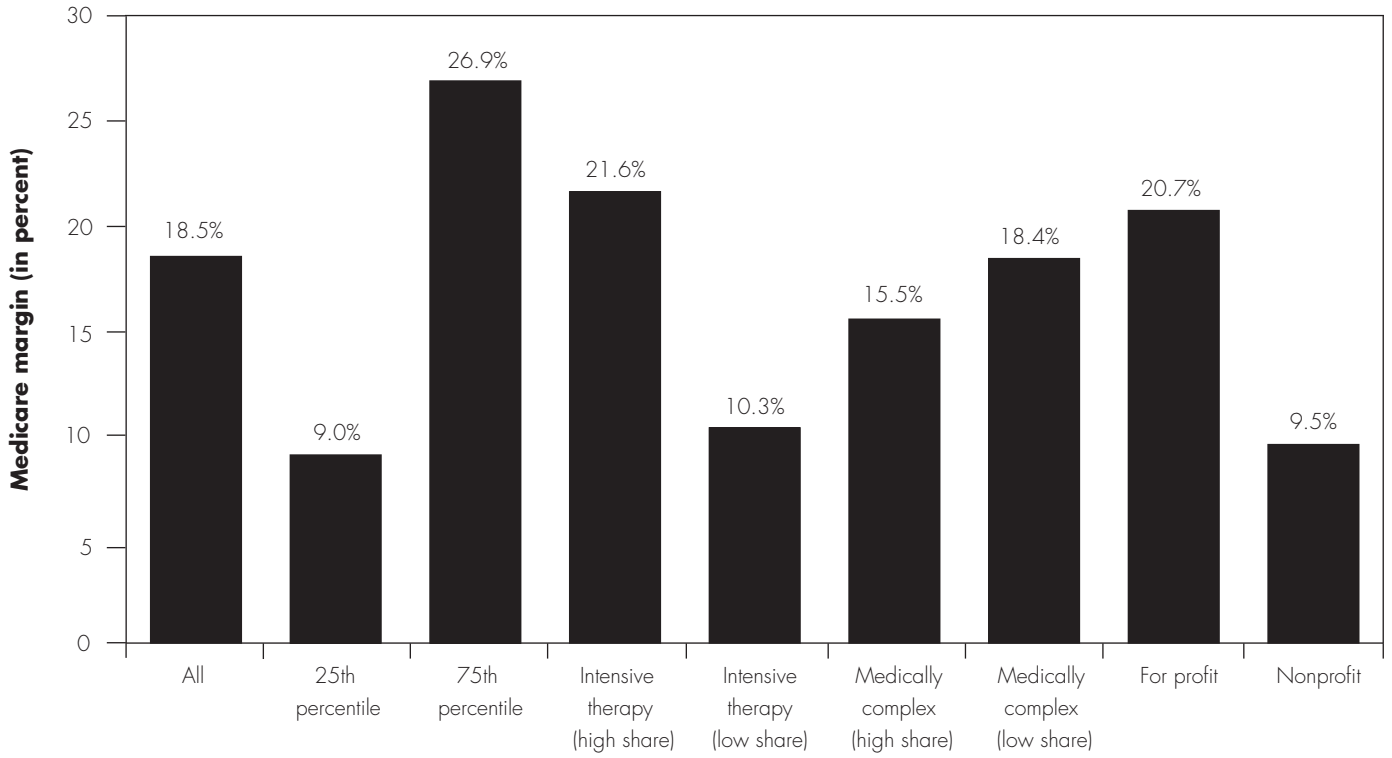
2011 using 2011 claims matched to freestanding facilities' cost reporting periods and we adjusted the revenues for differences between claims and cost reports. To estimate 2011 costs, we calculated cost per day in 2010 and modeled three cost growth assumptions: the market basket for 2011, the most recent cost increase between 2009 and 2010, and the middle point between the two. We used claims to estimate the days in 2011 but adjusted the count for historical differences between the day counts in the claims and cost reports. We did not estimate margins by ownership or location.

SNF aggregate Medicare margins have steadily increased since 2005 (Figure 8-5). The revised case-mix groups implemented in 2006 led to even higher Medicare margins, reflecting the continued concentration of days in the highest paying case-mix groups. Estimates of the Medicare margin for freestanding SNFs in 2011 range from 22 percent to 24 percent. This year is the 11th consecutive year that the average SNF margin exceeded 10 percent and the 4th year in a row it was above 15 percent. Margins spiked in 2011 because of Medicare's overpayments in implementing the new case-mix groups. This spike aside, Medicare payments per day have increased faster than costs per day since 2006, resulting in growing SNF margins.

In 2011, hospital-based facilities (3 percent of facilities) continued to have negative Medicare margins (–60 percent). However, administrators consider the SNF units in the context of the hospital's overall financial performance. Hospitals with SNFs can lower their inpatient length of stay and make inpatient beds available to treat additional admissions. As a result, SNFs contribute to the bottom line financial performance of the hospitals. Hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs. Given the mix of patients that hospital-based facilities treat and their therapy practices, the Commission's changes to the SNF PPS would increase

FIGURE 8–6

Freestanding SNF Medicare margins are highly variable, 2010



Note: SNF (skilled nursing facility). High share is defined as facilities in the top 25th percentile of shares; low share is defined as facilities in the bottom 25th percentile.

Source: MedPAC analysis of 2010 freestanding SNF Medicare cost reports.

payments to hospital-based facilities by an estimated 27 percent.

Level and variation in SNF Medicare margins indicate reforms to the PPS are needed

The persistently high Medicare margins and the wide variation by mix of patients indicate that the PPS needs to be revised so that payments match patient characteristics, not the services furnished to them. Last year we found one-quarter of SNFs had Medicare margins of 26.9 percent or higher in 2010, while one-quarter of SNFs had margins of 9 percent or lower (Figure 8-6). Facilities with the highest SNF margins had high shares of intensive rehabilitation therapy and low shares of medically complex days and dual-eligible days. The disparity between for-profit and nonprofit facilities is considerable and reflects differences in patient mix, service provision, and costs.

Comparing freestanding facilities with the highest and lowest Medicare margins (those in the bottom and top 25th percentiles of Medicare margins), we found cost and payment differences that underscore the need to revise the PPS and more closely align payments with costs. High-margin SNFs had lower daily costs (by 30 percent, after adjusting for differences in wages and case mix) and higher payments (by 10 percent) associated with the high-therapy case-mix groups. Differences in patient characteristics (shares of beneficiaries who are dual eligible, minority, or very old) did not explain the cost differences across facilities. Facilities with high margins had identical case-mix indexes—as measured by the relative weights associated with the nursing component of the case-mix groups.[21] Even after CMS expanded the number of medically complex case-mix groups and shifted payments away from therapy care, the PPS continues to result in higher Medicare margins for facilities furnishing intensive therapy and treating few medically complex patients (Carter et al. 2012). A PPS design based on patient characteristics (such as the one recommended by the Commission) would redistribute Medicare payments to

TABLE 8–6

Comparison of Medicare fee-for-service and Medicare Advantage daily payments in 2012 for five companies

	Medicare payment		
Company	**FFS**	**MA**	**Ratio of FFS to MA payment**
Ensign Group	$561	$372	1.51
Extendicare	459	430	1.07
Kindred	490	409	1.20
Skilled Healthcare Group	509	383	1.33
Sun Healthcare	464	380	1.22
Average ratio			1.27

Note: FFS (fee-for-service), MA (Medicare Advantage). The MA payments are listed for Kindred and Sun Healthcare. In the other reports, the rates are reported as "managed care payments," of which MA would make up the majority.

Source: Third quarter 2012 results available at each company's website.

SNFs according to their mix of patients, not the amount of therapy furnished (see discussion on p. 164).

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). Costs per day varied by more than 60 percent across all freestanding providers after differences in wages and case mix were taken into account. Within each subgroup (e.g., nonprofit SNFs), standardized costs varied consistently by 20 percent to 30 percent between the 25th and 75th percentiles and by 60 percent to 70 percent between the 10th and 90th percentiles. 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.

For the past three years, we have examined efficient SNFs (those furnishing relatively high-quality care and having low costs per day) and compared them with other SNFs. In 2011, we found that 10 percent of facilities had relatively low costs and provided good quality care while maintaining high margins. Compared with the other SNFs, relatively efficient SNFs had community discharge rates that were 38 percent higher, rehospitalization rates that were 17 percent lower, and costs per day that were 10 percent lower. The efficient SNFs achieved these costs and quality metrics even though their patients were more complex (as measured by their nursing component case-mix index) and more days were classified in the medically complex case-mix groups.

Another indicator that Medicare's payments are too high is the comparison of FFS and MA payments. We compared Medicare FFS and MA payments at five large nursing home companies where such information was publicly available. These companies, which report managed care payments, note that MA is the majority of their business. Medicare's FFS payments averaged 27 percent higher than MA rates (Table 8-6).[22] Last year, we reported even larger differences because of the FFS overpayments associated with implementation of the new case-mix groups. It is unlikely that these large differences in payments are due solely to the comorbidities of the enrollees in FFS and MA. However, until encounter-level data are available, we cannot compare the patient severity of FFS and MA enrollees who use SNFs. That said, the considerably lower MA payments suggest that some facilities accept considerably lower payments to treat beneficiaries.

Total margins estimated to increase in 2011

The aggregate total margin for freestanding SNFs in 2011 is estimated to be 5 percent. A total margin reflects services to all patients (public and private) across all lines of business and revenue sources. This estimate represents an improvement in the financial performance over 2010, when the total margin was 3.6 percent. 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). In fiscal year 2011, 19 states reported increasing payments to nursing homes (Government Accountability Office 2012). The five publicly traded nursing home companies report higher average Medicaid payments for 2012 than for 2011 (Ensign Group 2012, Extendicare 2012, Kindred Healthcare 2012c, Skilled Healthcare 2012, Sun Healthcare Group 2012).

Using Medicare payments to subsidize Medicaid payments is ill advised for several reasons (see text box). In addition to Medicare's share of payments, 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 2013

In assessing the payment update for 2014, the Commission considers the estimated relationship between SNF costs and Medicare payments in 2013. Because cost reports for 2011 are not yet available, we used a range of estimated 2011 revenues and costs as a starting point for estimating a range for the Medicare margin for 2013.

To estimate costs for 2012 and 2013, we used the middle point cost estimate for 2011 costs and modeled 2012 and 2013 costs using two growth assumptions: the market basket and a middle point between the market basket for each year and the most recent cost increase between 2009 and 2010.

To estimate 2013 payments, we began with 2011 payments from claims and modeled the impacts of the policy changes that went into effect in 2012 and 2013 (as estimated by CMS). These policy changes included the following:

- 2012 payments were estimated by factoring in the impact of the lowered payments for 2012 and the market basket offset by the productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010. CMS estimated that 2012 payments would be 11.1 percent lower than payments in 2011, which included the overpayments. Despite the reductions taken in 2011, payment rates in 2012 were 3.7 percent higher than they were in 2010.
- 2013 payments were estimated by increasing estimated 2012 payments by the market basket and offset by the productivity adjustment.

For 2013, the projected Medicare margin ranges from 12 percent to 14 percent. Ignoring the high margin for 2011, which reflects temporary overpayments, the margin is lower than the 2010 margin because costs may increase faster than the market basket in 2011, and each year the payment updates are lowered by the productivity adjustments.

How should Medicare payments change in 2014?

Last year, the Commission recommended to the Congress that it direct the Secretary to first revise the PPS and then, in the following year, to rebase Medicare payments in stages, with an initial reduction of 4 percent (see text box, p. 178). The Commission discussed three revisions needed to improve the accuracy of payments. First, payments for therapy services should be based on patient characteristics (not services provided). Second, payments for nontherapy ancillary services (such as drugs) need to be removed from the nursing component and made through a separate component established specifically to adjust for differences in patients' needs for these services. Third, an outlier policy should be added to the PPS.

The Commission stands by its recommendation, believing that the PPS requires fundamental reforms to correct the known shortcomings and to more closely align payments with costs. With no action taken this past year, the Congress needs to act as soon as practicable to direct CMS to implement both parts of the recommendation.

The recommendation began with revising the PPS and with no update in the first year (2013). 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 care. 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. 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 narrow payments closer to provider costs over subsequent years, taking reductions in stages. This

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, the strategy of using Medicare rates to supplement low payments from other payers results in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies. Medicare and Medicaid shares vary widely across facilities (Table 8-7). As a result, the impact of the Medicare subsidy would vary considerably across facilities, putting more dollars into those 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 payments. In 2009, Medicaid payments to nursing homes varied twofold, yet Medicare's high payments subsidize facilities even in states with relatively high Medicaid rates. 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 rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay. Finally, Medicare's current overpayments 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 8–7

Distribution of Medicare and Medicaid share of facility days in freestanding facilities, 2010

	Percentile of facility days				
Payer	**10th**	**25th**	**Median**	**75th**	**90th**
Medicare share	5%	8%	12%	17%	25%
	Percentile of facility days				
	10th	**25th**	**Median**	**75th**	**90th**
Medicaid share	0	45	63	74	82

Note: Medicare share includes fee-for-service and Medicare Advantage days.

Source: MedPAC analysis of skilled nursing facility Medicare cost reports, 2010.

approach acknowledges the need to proceed cautiously but deliberately to help ensure there are no unintended disruptions caused by rebasing. The recommended changes should not impair beneficiary access to care; in fact, they should improve access to services for beneficiaries who are disadvantaged by the design of the current payment system.

The Commission based its 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.

The Commission's 2012 update recommendation for skilled nursing facility services

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 for 2013. Rebasing payments should begin in 2014, 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

Spending

- When this recommendation was made in March 2012, its 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 a year later, the direction of the savings is identical. The one-year savings estimate remains the same, while the five-year estimated savings grew slightly and are over $10 billion.

Beneficiary and provider

- We do not expect an adverse impact on beneficiary access. 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. Impacts on individual providers will be a function of their mix of patients and current practice patterns. The recommendation will not eliminate all the differences in Medicare margins among providers due to their large cost differences. ■

- Variations in Medicare margins are not related to differences in patient characteristics but rather to the amount of therapy furnished to patients.
- Cost differences are unrelated to wage levels, 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 that some facilities are willing to accept much lower rates than FFS payments to treat beneficiaries.
- The industry has shown it is nimble at responding to the level of Medicare's payments in two ways: Medicare's cost growth has consistently been above the SNF market basket since 2001 and revenues increased even when payment rates were lowered in 2010. In reaction to the lower payments in 2012, SNFs focused on the efficiency of their therapists so they could continue to furnish high levels of therapy.

These factors show that the PPS has exerted too little fiscal pressure on providers. Moreover, Medicare payments, which are financed by taxpayer contributions to the trust fund, currently subsidize payments by Medicaid and private payers. If the Congress wishes to help nursing facilities with a high Medicaid payer mix, a better targeted and separately financed program could be established to do so.

For 2014, there are no policy changes known at this time aside from the required update and productivity adjustment. The payment update in current law is the forecasted change in input prices as measured by the SNF market basket minus a productivity factor. The market basket for SNFs in 2014 is projected to be 2.8 percent and the productivity adjustment is estimated to be 0.4 percent, but CMS will update both before establishing payment rates for 2014.

TABLE 8–8

Number of nursing homes treating Medicaid enrollees declined slightly in 2012

	2002	2004	2006	2008	2010	2011	2012	Percent change 2011–2012
Number of facilities	15,992	15,609	15,273	15,162	15,083	15,058	15,007	–0.3%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2002–2012.

Medicaid trends

Section 2801 of the Patient Protection and Affordable Care Act of 2010 requires the Commission to examine spending, utilization, 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 utilization trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports.

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

Utilization

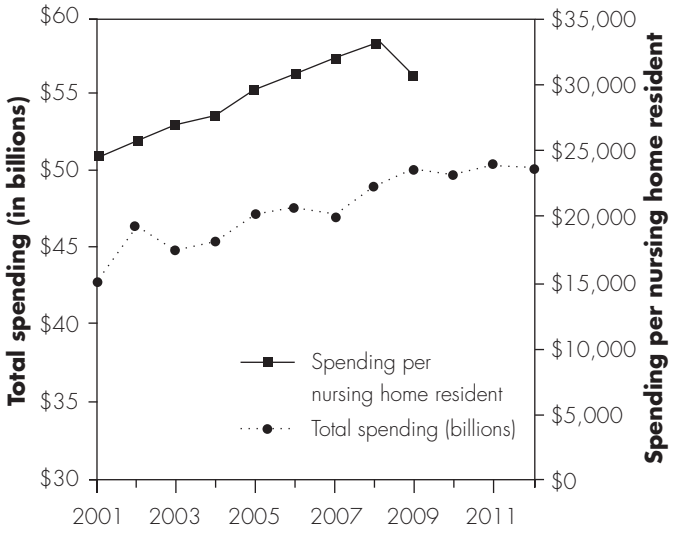
There were over 1.64 million users of Medicaid-financed nursing home services in 2009, the most recent year of data (Centers for Medicare & Medicaid Services 2011). This use represents a small increase over 2008 but a 5 percent decline from 2001. The number of nursing facilities certified as Medicaid providers declined slightly between 2011 and 2012 (Table 8-8). In a recent Government Accountability Office survey, two states reported challenges to ensuring adequate numbers of nursing home providers for Medicaid recipients (Government Accountability Office 2012). The decline in users and facilities reflects the expansion in some states of home- and community-based services that allow some residents to remain in their homes. A vast majority of nursing home facilities are certified as Medicare and Medicaid providers.

Spending

In 2012, CMS estimates just over $50 billion was spent on Medicaid-funded nursing home services (combined state and federal funds) (Figure 8-7). Spending increases averaged 1.5 percent annually between 2001 and 2012, for a total of 17 percent over the period (Office of the Actuary 2012). Year-to-year changes in spending were variable, increasing in some years and decreasing in others. Between 2011 and 2012, CMS estimates that spending will decrease slightly. On a per user basis, spending per nursing home resident averaged $29,551 in 2009, the most recent year for resident counts. Between 2008 and

FIGURE 8–7

Total and per user Medicaid spending



Note: Total spending for 2012 is an estimate. Resident counts (and therefore per resident spending) are not available for 2010 through 2012.

Source: Total spending data come from CMS, Office of the Actuary. Per user spending data come from Health Care Financing Review 2011 Statistical Supplement. Available at https://www.cms.gov/MedicareMedicaidStatSupp.

TABLE 8–9 **Non-Medicare margins were negative but total margins were positive, 2001–2011**

Type of margin	2001	2003	2005	2007	2009	2011*
Non-Medicare margin	–2.6%	–1.7%	–0.8%	–1.2%	–1.2%	–1 to –3%
Total margin	1.0	1.7	2.2	2.5	3.4	4 to 6

Note: Non-Medicare margins include the revenues and costs associated with non-Medicare payers (Medicaid and private payers). Total margins include the revenues and costs associated with all payers and all lines of business.
*Margins for 2011 are estimates, and the range is based on varying assumptions about growth in days and costs.

Source: MedPAC analysis of freestanding 2000–2010 skilled nursing facility cost reports. Margins for 2011 are based on 2010 data trended forward.

2009, spending per resident declined 8 percent but still represented a 25 percent increase from 2001 (Centers for Medicare & Medicaid Services 2011).

In fiscal year 2012, Medicaid spending growth slowed to 2 percent, one of the slowest rates of growth in the past 15 years. This slowdown in spending is largely attributable to lower growth in enrollment, as the economy improved relative to 2010, as well as expiration of federal matching funds for the Medicaid program in June 2011. For the state fiscal year 2012, 28 states restricted payments (16 states enacted freezes and 12 states enacted rate reductions) for nursing homes (Alliance for Quality Nursing Home Care 2012). For fiscal year 2013, 20 states restricted rates and, of them, three states lowered nursing home rates (Smith et al. 2012). States expect enrollment to continue to increase but at a slower pace than in 2012.

States continue to use provider taxes to raise federal matching funds. In fiscal year 2013, 44 states had provider taxes on nursing homes, up from 42 states in fiscal year 2012 (Smith et al. 2012). The President's budget includes a proposal to slowly reduce provider taxes from a maximum 6 percent to 3.5 percent in 2017.

The differences between Medicaid's and Medicare's payments are sometimes compared. Although Medicare's payments are much higher than Medicaid's, the acuity of the average Medicare beneficiary is considerably higher, as reflected in the average nursing case-mix index for Medicaid and Medicare patients. In 2011, the average Medicare nursing case-mix index was 45 percent higher than that for Medicaid residents (after adjusting the nursing indexes of all case-mix groups for overstatement of the parity adjustment) (White 2012). Differences in the therapy case-mix indexes were even larger. The therapy case-mix index for Medicare beneficiaries was almost 13 times that for Medicaid patients. In 2011, Medicare's payments for the average Medicaid resident would be $235, compared with $433 for the average Medicare patient. That is, the differences in acuity between the average Medicaid resident and the average Medicare patient translate to payments that would be 84 percent higher for Medicare patients.

Non-Medicare and total margins in nursing homes

In 2011, we estimate non-Medicare margins (i.e., for Medicaid and private payers) to range from –1 percent to –3 percent. Total margins (reflecting services to all patients across all lines of business and including revenue sources) were positive and increased in 2011, reflecting the increased payments from Medicare (Table 8-9). Total margins have steadily increased since 2000 and are estimated to be between 4 percent and 6 percent in 2011.

In 2012, we reported that non-Medicare margins were slightly more variable than total margins (Medicare Payment Advisory Commission 2012). Given the delay in the availability of cost reports this year, we cannot verify this pattern for 2011. ■

Endnotes

1 Throughout this chapter, "beneficiary" refers to individuals whose SNF stay (Part A) coverage is paid for by Medicare. 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 conditions of participation (COPs) and agree to accept Medicare's payment rates. Medicare's COPs relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day; providing physical and occupational therapy services as delineated in each patient's plan of care; and providing or arranging for physician services 24 hours a day in case of an emergency.

4 The Barthel score is a composite measure of nine functional abilities: bowel and urinary incontinence and patients' ability to transfer, walk in the facility corridor, feed themselves, toilet, bathe, perform personal hygiene, and dress.

5 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 furnished in a hospital (such as computed tomography, MRI, radiation therapy, and cardiac catheterizations).

6 There are two broad categories of medically complex days: clinically complex and special care case-mix groups. Clinically complex groups are used to classify patients who have burns, septicemia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a 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.

7 In fiscal year 2011, CMS lowered payments for therapy furnished concurrently (multiple patients engaged in different therapy activities at the same time) and required end-of-therapy assessments to prevent paying for therapy services after they have been discontinued. In fiscal year 2012, CMS lowered payments for therapy furnished in groups (multiple patients engaged in the same therapy activities at the same time).

8 A facility may begin to participate in the program but may not be "new." For example, a facility could have a change in ownership (and be assigned a new provider number) or in its certification status from Medicaid only to be dually certified for the Medicaid and Medicare programs.

9 In 2011, SNFs with the highest shares of medically complex admissions (the top quartile) treated 41 percent of all these patients. By contrast, SNFs with the highest rehabilitation shares (the top quartile) treated 31 percent of all rehabilitation admissions. In 2009, the comparable shares were 57 percent (for medically complex admissions) and 32 percent (for rehabilitation admissions).

10 Minority beneficiaries made up 20 percent of medically complex admissions in 2011, even though they made up only16 percent of all SNF admissions.

11 A recent court case between the Department of Health and Human Services and the Center for Medicare Advocacy (*Jimmo v. Sebelius* 2011) will require the program to clarify the language in its benefit manual regarding the coverage of services needed to maintain or prevent deterioration of a patient's current condition. Coverage will hinge on existing requirements that the beneficiary needs daily skilled care furnished by skilled personnel and has had a hospital stay of at least three days preceding admission to the SNF. Until CMS revises the benefit manuals, specifies instructions, and trains claims contractors and providers, it is hard to estimate the impact this change will have on utilization. If these changes broaden access to care, then expenditures could increase.

12 Medically complex days make up the other 8 percent of days. See endnote 6 for the definition of medically complex.

13 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 furnished per week. Ultra-high rehabilitation is for those patients who received over 720 minutes per week; very-high rehabilitation includes patients who received 500–719 minutes per week.

14 The five conditions are congestive heart failure, respiratory infection, urinary tract infections, septicemia, and electrolyte imbalance.

15 The models include 19 diagnostic and 4 mental illness categories and other elements from the Minimum Data Set

found to be associated with one or both quality measures: whether the patient uses a walker, shortness of breath when sitting, presence of a fever, whether the patient had a fall since admission or the prior assessment, and average number of times physicians' orders were changed. One factor important in the prior models (whether the patient had do-not-resuscitate orders) is no longer reported in the assessment. The models explain a fair amount of the variation in rates across facilities, with C-statistics of 0.76 and 0.75. A C-statistic measures the probability that the prediction is better than chance, and a model with a value greater than 0.7 is considered reasonable.

16 The comorbidity index includes indicators for the following mental illnesses: Alzheimer's disease, dementia, depression, psychotic disorders, and schizophrenia.

17 Separate models were developed for patients discharged to a nursing home, home health care, or the community or other (such as receiving hospice). The models included the same variables, but the importance of each factor (the coefficients) varied.

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

19 SNF cost reports were not available for fiscal year 2011. Providers were given more time to complete the reports because they include new schedules. We estimated margins using 2010 data and various assumptions about growth in costs and days.

20 To measure costs, we look at costs per day that were adjusted for differences in wages and case mix. To measure quality, we examined risk-adjusted rates of community discharge and potentially avoidable rehospitalizations. To be in the group of relatively efficient providers, a SNF had to be in the best third of one measure and not in the bottom third on any measure for three consecutive years (2006–2008).

21 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.

22 The differences for Extendicare are smaller than for other companies because almost half of its contracts with managed care companies are based on the FFS system.

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