

CHAPTER

8

Skilled nursing facility services

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

(The Commission reiterates its previous recommendation on updating Medicare's payments to skilled nursing facilities. See text box, p. 204.)

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 2012, almost 15,000 SNFs furnished Medicare-covered care to 1.7 million fee-for-service (FFS) beneficiaries during 2.4 million stays. Medicare FFS spending on SNF services was \$28.7 billion in 2012.

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 that provided relatively high-quality care at relatively low costs—had high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

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

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program was stable between 2011 and 2012. Three-quarters of beneficiaries live in a county with five or more SNFs, and less than 1 percent live in a county without one. Available bed days

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?
- Medicaid trends

increased slightly. The median occupancy rate was 87 percent, indicating some excess capacity for admissions.

- **Volume of services**—Days and admissions per FFS beneficiary declined between 2011 and 2012, consistent with declines in inpatient hospital admissions (a prerequisite for Medicare coverage).

Quality of care—The Commission tracks three indicators of SNF quality: risk-adjusted rates of community discharge, rehospitalizations for potentially avoidable conditions during a beneficiary’s SNF stay, and rehospitalizations within 30 days after discharge from the SNF. All three measures showed small improvement between 2011 and 2012. We also report on a measure of change in beneficiaries’ functional status during their SNF stay. In 2012, across facilities, the facility mean rate of improvement in one or more activities of daily living (ADLs) during the SNF stay was about 27 percent, and the mean percent of facility stays with no decline in any of the three ADLs was about 89 percent. The average risk-adjusted rates remained essentially unchanged between 2011 and 2012.

Providers’ access to capital—Because most SNFs are part of a larger nursing home, we examine nursing homes’ access to capital. Capital will continue to be available in 2014, though uncertainties surrounding the federal budget continue to make some lenders wary. This reluctance is not a statement about the adequacy of Medicare’s payments to SNFs.

Medicare payments and providers’ costs—In 2012, the Medicare margin was 13.8 percent, down from 21 percent in 2011, a year of exceptionally high Medicare margins. The 2011 margins were the result of unwarranted overpayments generated by the industry’s response to Medicare policy changes. For the 13th consecutive year, Medicare margins were above 10 percent. Margins continue 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, they reflect shortcomings in the SNF prospective payment system (PPS) that favor SNFs treating patients who receive high levels of rehabilitation therapy. The disparity in margins between for-profit and nonprofit facilities is considerable and reflects differences in patient mix, service provision, and costs. We found 11 percent of freestanding facilities furnished relatively low-cost and high-quality care and had substantial Medicare margins over three consecutive years.

The projected margin for freestanding SNFs in 2014 is 12 percent. This projection does not consider the impact of the sequester, which would lower the margin by about 2 percentage points.

In 2012, the Commission recommended first restructuring the SNF payment system and then rebasing payments. Specifically, the Commission recommended that the Congress direct the Secretary to revise the SNF PPS; during the year of revision, 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) should 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. 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 facts: (1) high and sustained Medicare margins; (2) widely varying costs unrelated to case mix and wages; (3) cost growth well above the market basket in all but one of the past 10 years, reflecting little fiscal pressure from the Medicare program; (4) the ability of many SNFs (almost 900) to have consistently below-average costs and above-average quality of care; (5) the continued ability of the industry to maintain high margins despite changing policies; and (6) in many 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 would materially affect these findings. Therefore, the Commission maintains its position with respect to the SNF PPS and urges the Congress to direct the Secretary, as soon as practicable, 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 2012 and 2013. In 2012, the average non-Medicare margin was -2 percent. The average total margin, reflecting all payers and all lines of business, was 1.8 percent. ■

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 2012, almost 1.7 million fee-for-service (FFS) beneficiaries (4.5 percent) used SNF services at least once. Program spending on SNF services was \$28.7 billion in 2012, or about 6 percent of FFS spending. Of all FFS beneficiaries hospitalized in 2012, 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 2014, the copayment is \$152 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 SNFs and as nursing homes (which typically furnish 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 accounts for the majority of nursing facility days (see p. 202).

The mix of facilities where beneficiaries seek skilled nursing care has shifted toward freestanding and for-profit facilities (Table 8-1). Between 2006 and 2012, freestanding facilities and for-profit facilities accounted for growing shares of Medicare stays and spending. In 2012, 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 2012, these shares were fairly stable.

Medicare-covered SNF patients typically comprise a small share of a facility’s total patient population but a larger share of the facility’s revenues. In freestanding facilities in 2012, the median Medicare-covered share of total facility days was 11 percent, but 22 percent of facility revenue.

The most frequent hospital conditions of patients referred to SNFs for post-acute care were 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 more likely to be female, disabled, living in an institution, and

**TABLE
8-1**

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

Type of SNF	Facilities		Medicare-covered stays		Medicare spending	
	2006	2012	2006	2012	2006	2012
Total number	15,178	14,938	2,454,263	2,396,548	\$19.5 billion	\$26.2 billion
Freestanding	92%	95%	89%	94%	94%	97%
Hospital based	8	5	11	6	6	3
Urban	67	70	79	82	81	84
Rural	33	30	21	18	19	16
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 2012.

dually eligible for both Medicare and Medicaid (Medicare Payment Advisory Commission 2013). 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, or ADLs (such as dressing, bathing, and eating), with 49 percent reporting this level of impairment. SNF users are much more likely to be living in an institution (33 percent of SNF users) compared with beneficiaries who have not used a SNF (4 percent). SNF users are more than twice as likely as other beneficiaries to be disabled.

SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay for each day of service.⁴ 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 in performing ADLs. Medicare’s payment system for SNF services is described in Medicare *Payment Basics*, available on the Commission’s website (http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_SNF.pdf). 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 total Medicare spending for SNF care. Although the daily rate is set prospectively, program spending depends on how long the beneficiary stays in the SNF and how much therapy is provided, making these aspects of the PPS similar to a fee schedule.

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. Under this PPS, payments are not proportional to costs. That is, Medicare’s therapy payments rise faster than providers’ therapy cost increases (Garrett and Wissoker 2008, Medicare Payment Advisory Commission 2008). 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 and establish a separate component within the PPS that adjusts payments for the need for NTA services, and implement an outlier payment policy. A revised PPS would raise providers’ payments for medically complex care and lower providers’ payments for high-intensity therapy (Carter et al. 2012, Wissoker and Garrett 2010, Wissoker and Zuckerman 2012). 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.

Based on its work examining the billing practices of SNFs, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) recommended that CMS change the way it 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).

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 more accurately pay for NTAs or 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.⁵ At the same time, CMS shifted program dollars away from therapy care 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 required providers to reassess patients when the provision of therapy changed or stopped (which would, in turn, change assignments to case-mix groups).⁶ Despite these changes, we found

that Medicare continues to overpay for therapy services and disadvantage facilities that treat medically complex patients (Carter et al. 2012).

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 to the SNF PPS (Liu et al. 2007, Maxwell et al. 2003, Urban Institute 2004). Yet, to date, CMS continues to evaluate alternative ways to pay for NTA and therapy services. CMS is expected to issue a report in 2014 reviewing the literature (including the Commission's work) on possible approaches to pay for therapy services. In the next phase, it will select a narrow set of options to further explore. CMS expects this development work to take about two years. Because 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, congressional action is required to make these changes.

SNFs continue to be adept at modifying their practices in response to changes in policy. By furnishing more intensive rehabilitation therapy (which is more profitable), freestanding facilities increased their payments per day by more than 5 percent despite payment reductions of 1.1 percent in 2010. In 2012, when rates were lowered by 11 percent to correct for an overpayment in 2011, average payments per day declined only 6.3 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. In 2012, individual therapy made up over 99 percent of therapy furnished, up from 74 percent in 2006 (Centers for Medicare & Medicaid Services 2012a).

Are Medicare payments adequate in 2014?

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. 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. Most SNFs are freestanding (95 percent), and for-profit facilities make up 70 percent of the industry.

Most beneficiaries live in counties with multiple SNFs. In 2012, over three-quarters of beneficiaries lived in counties with 5 or more SNFs, and the majority of beneficiaries lived in counties with 10 or more. Few beneficiaries (less than 1 percent) lived in a county without a SNF.

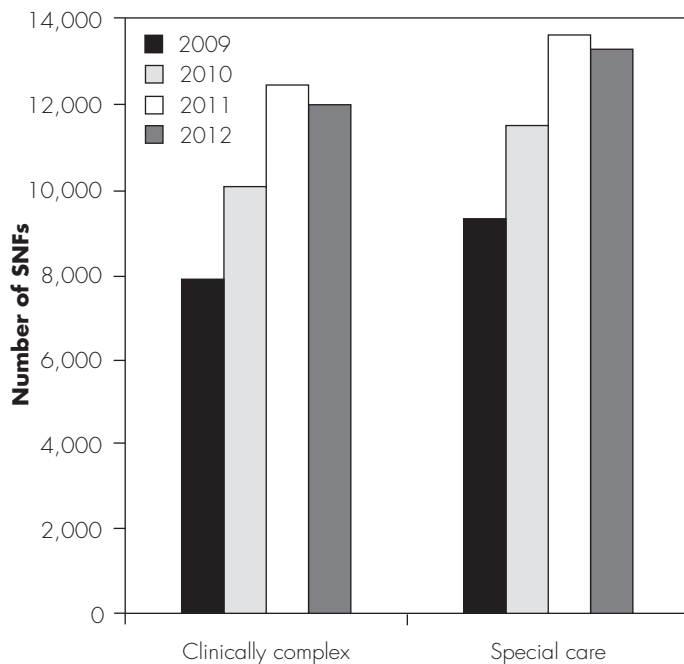
SNF bed days available (defined as days available for occupancy after adjusting for beds temporarily out of service due to, e.g., renovation or patient isolation) in freestanding facilities increased slightly (less than 1 percent) between 2011 and 2012. In 2012, the median occupancy rate was 87 percent in freestanding facilities, indicating some capacity to admit beneficiaries seeking SNF care. Nonprofit and urban facilities had higher occupancy rates than rural and for-profit facilities.

The number of SNFs admitting medically complex patients (those assigned to the clinically complex or special care case-mix groups) decreased slightly between 2011 and 2012 but remained above 2009 levels (Figure 8-1, p. 188). Most SNFs (84 percent) admitted clinically complex cases and almost all (92 percent) admitted special care cases. Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex patients. Because minority beneficiaries make up a disproportionate share of medically complex admissions to SNFs, they could face impaired access to SNF services.⁷

The larger number of SNFs since 2009 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 45 minutes a week) to qualify them for a higher paying therapy group. Although the higher payment rates may increase the willingness of SNFs to admit medically complex patients, the PPS

FIGURE 8-1

Number of SNFs with clinically complex and special care cases decreased slightly from 2011 to 2012 but remain above 2009 levels



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 have burns, surgical wounds, hemiplegia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a SNF patient. The special care category includes 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.

Source: MedPAC analysis of 2009–2012 Minimum Data Set data from CMS.

continues to disadvantage SNFs that admit high shares of medically complex cases (Wissoker and Zuckerman 2012). In addition, some facilities may avoid admitting medically complex patients if the patients are more likely to require long stays and exhaust their Medicare benefits. If facilities did so, daily payments could decline, depending on the payer.

SNF volume of services was slightly lower in 2012 than in 2011

In 2012, 4.5 percent of FFS beneficiaries used SNF services, a slightly lower share than in 2011. Between 2011 and 2012, 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. Because MA enrollment continues to increase, changes in utilization could reflect slower growth in the number of FFS beneficiaries rather than changes in service use. Admissions per 1,000 FFS beneficiaries declined 4.5 percent, while covered days declined less (–3.8 percent), resulting in a small increase in covered days per admission (Table 8-2). The reductions in per capita SNF admissions are identical to the declines in per FFS admissions to acute care hospitals. An acute care hospital stay of at least three days is a prerequisite for Medicare coverage of SNF services.

Intensity of rehabilitation services unexplained by health status factors

Between 2002 and 2012, the share of days classified into rehabilitation case-mix groups increased from 78 percent to 93 percent.⁸ During the same period, the share of intensive therapy days as a share of total days rose from 29 percent to 77 percent.⁹ Recent changes indicate the continued intensification of therapy provision. Between 2011 and 2012, the share of intensive therapy days increased from 75 percent to 77 percent, and the share of days assigned to the highest rehabilitation case-mix groups (the ultra-high groups) increased from 48 percent to 51 percent. 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 (78 percent for each group) than nonprofit facilities and facilities in rural and frontier areas (71 percent and 68 percent, respectively).

For the period 2005 to 2012, 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 2005, the average SNF user in 2012 had more independence (as measured by a higher modified Barthel score) and was younger (by two years). Over a more recent period (between 2008 and 2012), the shares of SNF users requiring the most help with the nine individual activities of daily living decreased (an average of 3 percentage points).¹⁰ Although more patients may be able to tolerate the highest levels of therapy, the increase in the most intensive therapy days (18 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 2012, hospital lengths of stay decreased 9 percent on average for the five highest volume diagnosis related groups discharged to SNFs.

**TABLE
8-2**

SNF service use declined between 2011 and 2012

Volume measure	2006	2008	2010	2011	2012	Percent change 2011-2012
Covered admissions per 1,000 FFS beneficiaries	72	73	71.5	71.2	68	-4.5%
Covered days (in thousands)	1,892	1,977	1,938	1,935	1,861	-3.8
Covered days per admission	26.3	27.0	27.1	27.2	27.4	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: Data from CMS, Office of Information Products and Data Analytics 2012.

Quality of care: Small improvements between 2011 and 2012

The Commission tracks three indicators of SNF quality: risk-adjusted rates of community discharge, rehospitalizations for potentially avoidable conditions during beneficiaries' SNF stay, and rehospitalizations within 30 days after discharge from the SNF. All three measures showed small improvement between 2011 and 2012. This year, we also report on the change in beneficiaries' functional status during their SNF stays. These risk-adjusted measures of functional change showed considerable variation across facilities and remained relatively stable between 2011 and 2012.

Rehospitalization and community discharge rates show small improvements after a decade of almost no change

Between 2000 and 2010, both the rate of rehospitalization for SNF patients with any of five potentially avoidable conditions and the rate of discharge to the community remained almost the same. Beginning with data for 2011, we revised the rehospitalization measure to better reflect potentially avoidable readmissions. In the past, the

measure included rehospitalized patients with any of five conditions (congestive heart failure, electrolyte imbalance/dehydration, respiratory infection, sepsis, urinary tract infection/kidney infection) listed among the patient's primary or secondary diagnoses. Upon further review, the principal reason for the hospital readmission may have been an unrelated or unavoidable condition, so we shifted to counting potentially avoidable readmissions using only the primary diagnosis for the hospital readmission. We also expanded the list of conditions that could result in a potentially avoidable readmission, though the original five conditions constitute the majority of the readmissions (see text box, p. 190). This expanded measure is consistent with the Commission's preference to track potentially preventable readmissions (not all-cause measures) across all admissions as a quality metric.

Between 2011 and 2012, SNF quality on average improved by a small amount (Table 8-3). Risk-adjusted community discharge rates increased from 28.8 percent to 30.6 percent and potentially avoidable rehospitalization rates (while the beneficiary was still a SNF patient) declined between 2011 and 2012 from 12.5 percent to 11.7 percent.

**TABLE
8-3**

Small improvements were made in risk-adjusted rates of community discharge and potentially avoidable rehospitalization

Measure	2011	2012
Discharged to the community	28.8%	30.6%
Potentially avoidable rehospitalizations during SNF stay	12.5	11.7
Potentially avoidable rehospitalizations during 30 days after discharge from SNF	5.9	5.8
Combined during and after SNF stay rehospitalization rate	15.6	14.9

Note: SNF (skilled nursing facility). High rates of discharge to community indicate better quality. High rehospitalization rates indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 25 or more stays. Hospital-based units exclude swing beds.

Source: Analysis of fiscal year 2011 and fiscal year 2012 Minimum Data Set data (Kramer et al. 2014).

Revised measure of rehospitalizations

The rehospitalization measure was revised in two ways to better demonstrate that the readmission was potentially avoidable. First, only the primary reason for the rehospitalization (as recorded by the hospital) is counted in calculating a facility's readmission rate. Second, the list of conditions was expanded after examining other definitions of readmissions for long-term nursing home residents, ambulatory care-sensitive conditions, and planned readmissions (Carter 2003, Halfon et al. 2006, Horwitz et al. 2011, Jencks et al. 2009, Spector et al. 2013, Walker et al. 2009). Conditions were included in the measure when the primary diagnosis for readmission could reasonably be expected to be managed in the skilled nursing facility (SNF) setting or when the SNF could be held accountable for poor care management—for instance, readmissions for a disease management error such as anticoagulation or diabetic complications. We excluded readmissions from the definition that are likely to be planned (e.g., inpatient chemotherapy or radiation therapy). While readmissions are potentially avoidable for long-stay nursing home residents with chronic conditions (such as anemia or angina), in the case of post-acute SNF admissions, these patients were likely to have been discharged too soon from the hospital for the condition to have been adequately stabilized. Hence, these were not included in the list attributable to the SNF.

The measure now includes the original five conditions (congestive heart failure, electrolyte imbalance/

dehydration, respiratory infection, sepsis, and urinary tract or kidney infection) plus eight new ones: hypoglycemia and diabetic complications, anticoagulant complications, fractures and musculoskeletal injuries, acute delirium, adverse drug reactions, cellulitis/wound infection, pressure ulcers, and blood pressure management (Kramer et al. 2014). The original five conditions account for three quartiles of potentially avoidable rehospitalizations included in the new measure. Using the principal reason for the hospitalization accounted for the majority of the difference between the old and revised measure. The readmission rate across all beneficiaries for any reason (i.e., all causes) in 2011 was 24.4 percent, and the potentially avoidable conditions accounted for almost half of them.

The observed facility rates were risk adjusted for medical comorbidity, cognitive comorbidity, mental health comorbidity, function, and clinical conditions (e.g., surgical wounds, shortness of breath). The rates reported are the average risk-adjusted rehospitalization rates for all facilities with 25 or more admissions. This risk adjustment relies on information contained in the Minimum Data Set. 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).¹¹ ■

Last year, the Commission began tracking the rate of readmission for beneficiaries discharged from a SNF and readmitted to a hospital within 30 days. This performance measure gives information about how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home). The risk-adjusted rehospitalization rate for beneficiaries during the 30 days after discharge from the SNF also declined slightly (from 5.9 percent to 5.8 percent). The rate of rehospitalization during the SNF stay or within 30 days of SNF discharge declined between 2011 and 2012 from 15.6 percent to 14.9 percent, largely due to declines in rehospitalization during the SNF stay.¹²

The lower rehospitalization rates may reflect several trends. First, hospitals are subject to readmission penalties and are seeking SNFs that can work with them to lower their own readmission rates. Some SNFs are also interested in securing volume from MA plans and accountable care organizations by positioning themselves as preferred post-acute care providers. To do that, SNFs need to demonstrate improvements in their readmission rates. One study found that hospitals with stronger relationships to SNFs (as measured by the concentration of a SNF's admissions from the hospital) had lower readmission rates, especially for readmissions shortly after discharge from the hospital (Rahman et al. 2013).

In addition, industry associations such as the American Health Care Association (AHCA) are emphasizing reduction of readmissions through quality initiatives, aiming to lower readmission rates 15 percent by 2015. Using a 30-day all-cause measure across all patients (not just Medicare), AHCA members reported lowering their average readmission rate between October 2011 and December 2012 from 18.2 percent to 17.9 percent (American Health Care Association 2013).

When the separate rehospitalization rates are considered together, they indicate that 15 percent of beneficiaries were rehospitalized for the 13 conditions that were considered potentially avoidable. This finding suggests there are opportunities for SNFs to improve the care they provide and the care furnished by others after discharge. Some rehospitalizations during the period after discharge will result from inadequate care provided by physicians and the patients' caregivers, but SNFs should make careful arrangements to minimize potentially avoidable rehospitalizations. Holding SNFs accountable for rehospitalizations during a period after discharge is identical to hospitals being held responsible for readmissions under the Hospital Readmissions Reduction Program. Considerable program spending is made for hospitalizations that could have been avoided.

Tracking facility performance in managing functional status changes

Most beneficiaries receive rehabilitation therapy, and the amount of therapy furnished to them has steadily increased over time. To see how facilities compare in their ability to improve or maintain the functional status of the beneficiaries they treat, we worked with a contractor to develop a risk-adjusted measure of functional change (Kramer et al. 2014). We wanted a measure that reflects whether patients improved or did not decline (i.e., at least maintained) in their functional status during the SNF stay, given their functional status at admission and how much improvement they would be expected to make. Some patients, such as relatively healthy 65-year-olds recovering from an elective knee replacement, are likely to improve across several ADLs during their SNF stay. Other patients, such as those who are 85 years old and suffering from a progressive neurological disease, may have poor prognoses (e.g., they are unlikely to walk without extensive assistance but could attain some independence and enhanced quality of life through improved bed mobility). In fact, for certain patients who are not expected to improve across several ADLs, maintaining their function may constitute a realistic outcome.

To develop risk-adjusted measures of functional change, our contractor designed a classification system to categorize patients into 22 groups defined by patients' functional ability at admission and rehabilitation prognoses during the SNF stay (see text box, pp.192–193). Functional ability at admission was defined using the support a patient required to perform three mobility-related ADLs at admission: bed mobility, transfer, and ambulation. Rehabilitation prognosis was based on self-performance of two other ADLs, the ability to eat and dress. These two ADLs affect the likelihood of improving mobility because they encompass cognitive functioning as well as other dimensions of physical functioning that facilitate rehabilitation. The classification system acts as the risk adjustment, differentiating patients based on their expected ability to independently perform the three mobility-related ADLs.

Two observed-change measures were created to gauge the change in functional status between the first and last assessments for each of the three mobility-related ADLs: the share of a facility's patient stays that improved and the share of patient stays with no decline in functional status.

We also defined a facility-level composite measure of mobility improvement calculated as the facility average of the three ADL improvement rates (weighted by the number of stays with the potential for improvement in each ADL). Across all stays (not the average facility rate), 43 percent of stays improved in one or more ADLs, 26 percent improved in two or more ADLs, and 14 percent improved in all three ADLs. About 48 percent of patients had no measureable change in mobility during the stay. The share of patients who declined was small for each of the three mobility measures (less than 5 percent in each ADL), so we developed a composite measure of no decline in mobility when all three ADLs were maintained or improved. Across all stays (not the facility average), about 91 percent of stays had no decline in mobility. Thus, across the three mobility measures, patients declined or had no measureable change in function during the majority (57 percent) of SNF stays. This finding supports the need for both an improvement measure and a measure of functional maintenance.

Risk-adjusted rates were calculated by comparing a facility's observed rates with its expected rates based on the mix of patients in the 22 functional outcome groups. For each of the 22 groups, an expected rate of achieving each outcome was based on national average rates. The facility's risk-adjusted rate for each outcome was calculated by adjusting the observed rates by the expected rates, using each facility's mix of patients.

Measuring change in functional status for beneficiaries treated in SNFs

The measures of functional change are based on patient assessment information collected on each patient admitted to a skilled nursing facility (SNF) or nursing facility and recorded periodically throughout the Medicare-covered stay. Each stay's initial assessment was used to assign the patient to one of 22 case-mix groups using three measures of mobility (bed mobility, transfer, and ambulation) and two additional measures (eating and dressing) to capture the patient's potential to change on each of the three focal mobility measures. Change in the amount of support needed in the three mobility measures was used to gauge each patient's functional performance across the SNF stay. For example, a patient's functional status improved if the patient went from needing a two-person support at admission to a one-person support at discharge. This scale was used instead of the self-performance information because it allows for more discrimination among patients' function and is less subjective. Although we could not evaluate the accuracy or subjectivity of the activities of daily living (ADLs), or the extent to which payment incentives influenced the recording of ADLs, the use of the more objective support scale helped counter the limitations of the functional measures in the Minimum Data Set (MDS). That said, the eating and dressing ADLs were gauged using the self-performance scale because the range in the amount of support needed to conduct these activities is limited (e.g., almost no one required two-person support for either activity).

To calculate facility-level risk-adjusted outcome measures for functional change, we calculated the observed rates of stays with improvement in each mobility measure (e.g., the share of stays with

improvement in bed mobility) and the observed rates of stays with no decline in each mobility measure between the first and last assessments (e.g., the share of stays with no decline in bed mobility). Patients at the highest functional ability were excluded from the improvement calculation because these patients could not improve—they were already at the top of the scale at admission. Conversely, if a patient was unable to move in bed, transfer, or ambulate at admission, they were excluded from the no-decline calculations.

We calculated two composite mobility measures. To calculate the stay-level composite measure of stays with no decline, each patient's changes in the three mobility-related functions were examined to assess whether the patient maintained or improved in all three mobility measures. The composite measure of stays with no decline is calculated by dividing the number of stays with no decline in any one of three measures by the number of all stays. To calculate a facility-level observed composite measure of mobility improvement, the share of stays with improvement in each of the three mobility ADLs (bed mobility, transfer, and ambulation) was computed and then averaged across the three ADLs, weighted by the number of stays included in each measure. The composite measure of improvement thus includes patients who improved in one or more of the three ADLs. The facility-expected rate for each outcome measure is calculated by averaging the expected outcomes, where the expected outcome for a stay is the national proportion of stays with the outcome for the patients' case-mix groups. The facility's observed rate was essentially divided by the facility's expected rate to calculate the facility's risk-adjusted rate.

(continued next page)

Across all eligible facilities, the mean facility rate of improvement in one or more mobility ADLs during the SNF stay in 2012 was 27.4 percent, and the mean percent of facility stays with no decline in any of the three ADLs was 88.9 percent of stays (Table 8-4). These risk-adjusted rates consider the likelihood that a patient will change given the functional ability at admission. Thus, a facility that admits patients with worse prognoses will have a

lower expected rate of achieving these outcomes, which will be reflected in the risk-adjusted rate. The average risk-adjusted rates remained essentially unchanged between 2011 and 2012, indicating that even if case mix changed, SNF performance did not. We will continue to track these measures to see if there are longer term trends over time.

These analyses uncovered two problems with the current collection of patient assessment information that

Measuring change in functional status for beneficiaries treated in SNFs (cont.)

The magnitude of the change was not calculated for two reasons. First, the MDS data do not collect highly disaggregated data on functional ability. Patients are assigned to one of five categories of functional ability ranging from independent (no set-up or physical help is needed) to the most dependent. Therefore, fine differentiation between patients is not possible. Second, most patients did not change more than one “step” (e.g., they required two-person assistance when they were first assessed and required one-person assistance—the next step in improvement—when they were last assessed). For bed mobility and transfer, less than 1 percent of SNF patients declined two or more

steps during the SNF stay, and only about 7 percent of SNF patients improved two or more steps during the SNF stay. At the facility level, the composite measures do, however, capture whether a facility has stays during which patients improve in more than one ADL. SNF stays with improvement in two ADLs will count in each ADL rate calculation; in contrast, a facility with improvement in a single ADL will have that improvement count in only one of the three rate calculations. Thus, facilities with more patients with improvements in two or more ADLs will have higher composite rates of improvement than facilities with improvement in only one ADL. ■

undermine measurement of changes in functional status. First, to compare providers’ performance in improving or maintaining their patients’ functional status, assessment information needs to be collected at admission and preferably on the same ordinal day of the stay. But current Medicare rules give providers discretion about when they conduct their first assessments (the 5-day assessments). Furthermore, the first assessment is most frequently done on day 8, well into the SNF stay and after some change in functional status may have occurred. Thus, depending on when assessments are done, facilities can look worse or better than other facilities even though they treat identical patients. The second problem is that a sizable share of stays (13.7 percent) did not have two assessments (even though an end or discharge assessment has been required since October 1, 2010). To accurately measure facilities’ performance, we need information about all patients’ functional status at admission (or close to it) and discharge

(including assessments for patients who remain in the facility but end their Medicare-covered stay). Without it, Medicare cannot assess the efficacy of its spending.

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-fourth of facilities had risk-adjusted community discharge rates lower than 23.3 percent, whereas the best performing fourth of facilities had rates of 38.4 percent or higher (Table 8-5, p. 194). Rehospitalization rates varied even more—the worst performing quartile had rates of potentially avoidable readmissions at or above 14.7 percent whereas the best quarter had rates at or below 8.4 percent. Finally, rates of rehospitalization in the 30 days after discharge from the SNF varied most—more than twofold between the 25th and 75th percentiles. The

**TABLE
8-4**

Mean risk-adjusted functional outcomes in SNFs were stable between 2011 and 2012

Composite measure	2011	2012
Rate of improvement in one or more mobility ADLs	27.1%	27.4%
Rate of no decline in mobility	88.7	88.9

Note: SNF (skilled nursing facility), ADL (activity of daily living). The rate of 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. Stays with improvement in one, two, or three ADLs are counted in the improvement measure. The rate of no decline in mobility is the share 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. Hospital-based facilities exclude swing bed units.

Source: Analysis of fiscal year 2011 and fiscal year 2012 Minimum Data Set data (Kramer et al. 2014).

**TABLE
8-5**

SNF quality measures varied considerably across SNFs, 2012

Risk-adjusted rate

Quality measure	Mean	Minimum	25th percentile	75th percentile	Maximum
Discharged to the community	30.6%	0.0%	23.3%	38.4%	70.8%
Potentially avoidable rehospitalizations during SNF stay	11.7	0.0	8.4	14.7	43.2
Potentially avoidable rehospitalizations within 30 days after discharge from SNF	5.8	0.0	3.7	7.7	28.3
Rate of mobility improvement in one or more mobility ADLs	27.4	0.0	19.9	33.9	100.0
Rate of no decline in mobility	88.9	31.9	84.7	94.3	100.0

Note: SNF (skilled nursing facility), ADL (activity of daily living). High rates of discharge to community indicate better quality. High rehospitalization rates indicate worse quality. The rate of 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. Stays with improvement in one, two, or three ADLs are counted in the improvement measure. The rate of no decline in mobility is the share 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. Hospital-based facilities exclude swing beds.

Source: Analysis of fiscal year 2012 Minimum Data Set data (Kramer et al. 2014).

amount of variation across and within the groups suggests considerable room for improvement, all else being equal. For the average mobility improvement measure, the rate at the 75th percentile was 33.9 percent compared with 19.9 percent at the 25th percentile. There was less variation across facilities in the no-decline measure.

We controlled for facility and geographic characteristics (with multiple regression models) and found that, compared with freestanding facilities, hospital-based facilities had community discharge rates that were higher by 4.8 percentage points and readmission rates that were lower by 2.8 percentage points. Nonprofit facilities had moderately higher community discharge rates (by 1.2 percentage points) and lower readmission rates (by 1.2 percentage points) than for-profit facilities. Compared with urban facilities, rural SNFs had lower community discharge rates (by 2.2 percentage points).

Across the quality measures, there were not consistent differences by facility type or location, but there were similar patterns across the measures by ownership. Compared with the average freestanding facility, the average hospital-based facility had higher rates of community discharge, lower rehospitalizations during SNF stays, and higher rates of stays with no decline in mobility, but they had lower rates of functional improvement. The average hospital-based facility's rate of rehospitalization after discharge from the SNF was comparable with the average freestanding facility's rate. The average rural facility had similarly uneven performance relative to the average urban facility: a better rate of rehospitalization

after discharge from the SNF and improvements in mobility but worse rates of community discharge and no decline in mobility. In contrast to these mixed performances, the average nonprofit facility had better rates for all five measures compared with the average for-profit facility.

Providers' access to capital: Lending in 2013

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. Though Medicare makes up the minority share of almost all facilities' revenues, many operators use their Medicare payments to subsidize low payments from other payers. Lenders increasingly focus on a facility's outcomes, the quality of the management team, and the stability of the company's cash flow and rely less on using Medicare patient mix as a metric of a facility's financial health. They want to see that a facility's management has depth, understands its operations, and can track and communicate its outcome measures with potential partners. For example, as Medicare's patient mix shifts from FFS to MA, lenders look at a facility's strategy to address the anticipated reductions in length of stay. The diversification of the borrower's risk is also considered, such as whether its operations span multiple states (some lenders avoid states with low Medicaid payments) and other businesses (such as hospice and home health care).

The Department of Housing and Urban Development (HUD) is a key 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(f).¹³ Between 2010 and 2013, the number of projects financed more than doubled (to 766), and the insured amounts increased 76 percent to \$5.8 billion in 2013 (Department of Housing and Urban Development 2013, Department of Housing and Urban Development 2012). The Federal Housing Administration plays an increasing role in securing bank loans, which lowers nursing homes' financing costs (Pruitt 2013a).

Analysts reported the sector's need for capital may increase as providers ready themselves for evolving health care delivery systems and the accompanying IT requirements to track outcomes. Yet they note the bifurcation of the industry into facilities concentrated on treating high rehabilitation-acuity patients and those that are not (Andrews 2013b, Monroe 2013). Operators that can adjust to changes in their financial environment and demonstrate their good outcomes are likely to succeed and have access to capital. Hospitals increasingly want to meet with facility operators to discuss readmission rates and ways to lower them. The providers needing capital to renovate space and adopt information technology may look less attractive to a lender than SNFs that already have taken these steps. Credit may be more expensive for borrowers without a solid performance record (both financial and quality of care), and overall diligence is more thorough than before the financial crisis of 2008 (Andrews 2013a).

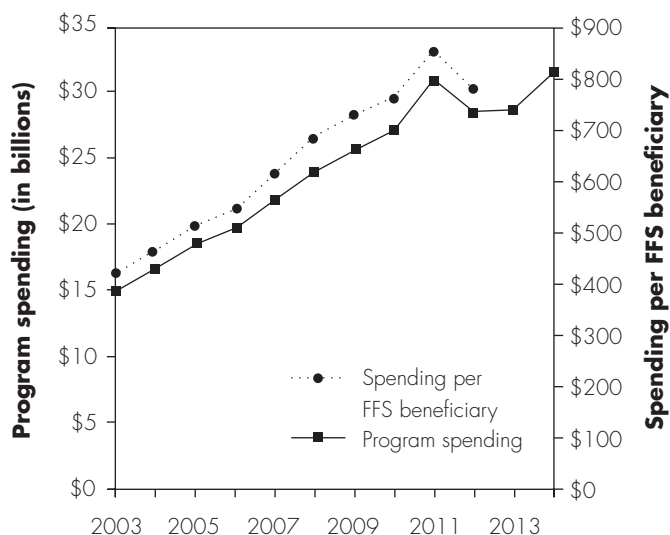
Market analysts and lenders we spoke with reported that capital is generally available and expected to continue, especially for borrowers with good financial, management, and quality performances. Analysts note that only a small number of lenders understand the risks of the "nursing home space." These lenders are highly selective about the facilities they lend to. Other lenders are more reluctant to enter this market, reflecting a general unease about across-the-board cuts in spending (from sequestration) or possible cuts to Medicare's payments to some sectors to pay for changes to the sustainable growth rate formula for paying physicians (Pruitt 2013b). This reluctance is not a statement about the adequacy of Medicare's payments to SNFs.

Medicare payments and providers' costs: Medicare margins remained high in 2012

In 2012, the Medicare margin was 13.8 percent, down from 21 percent in 2011, a year of exceptionally high Medicare margins. The 2011 margins were the result of unwarranted overpayments generated by the industry's response to Medicare policy changes. For the 13th

FIGURE 8-2

Program spending for SNF care slowed after overpayments taken back but estimated to return to previous growth rate



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year spending is shown. Data for 2013 and 2014 are estimates.

Source: Office of the Actuary 2013a.

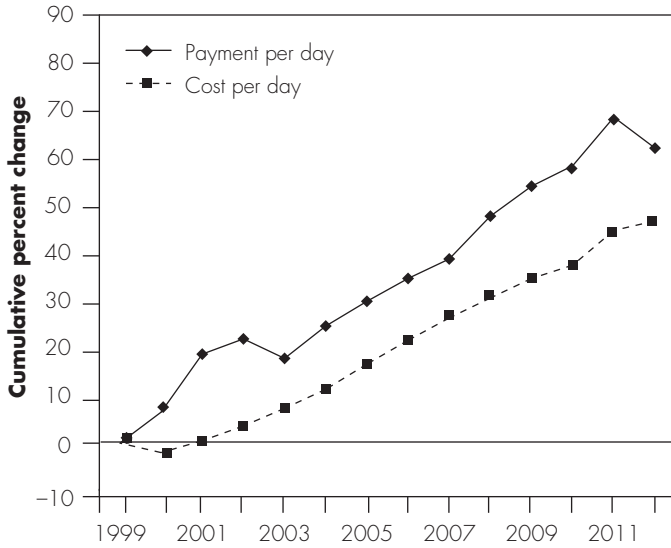
consecutive year, Medicare margins were above 10 percent. Margins continue to be highly variable, depending on the facilities' share of intensive therapy days, size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics (such as share of very old, dual-eligible, and minority beneficiaries). Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. We found about 11 percent of freestanding facilities furnished relatively low-cost, high-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 patient mix.

Trends in spending and cost growth

In 2013, the Office of the Actuary projects program FFS spending for SNF services to be almost \$29 billion, reflecting slower growth than in prior years (Figure 8-2). For fiscal year 2014, spending growth is estimated to regain its prior pace, with spending estimated to be \$31.4 billion. In 2011, payments were unusually high because the rates included an adjustment for implementation of the new case-mix classification system. Once 2011

FIGURE 8-3

Cumulative growth in Medicare cost and payments per SNF day, 1999-2012



Note: SNF (skilled nursing facility).

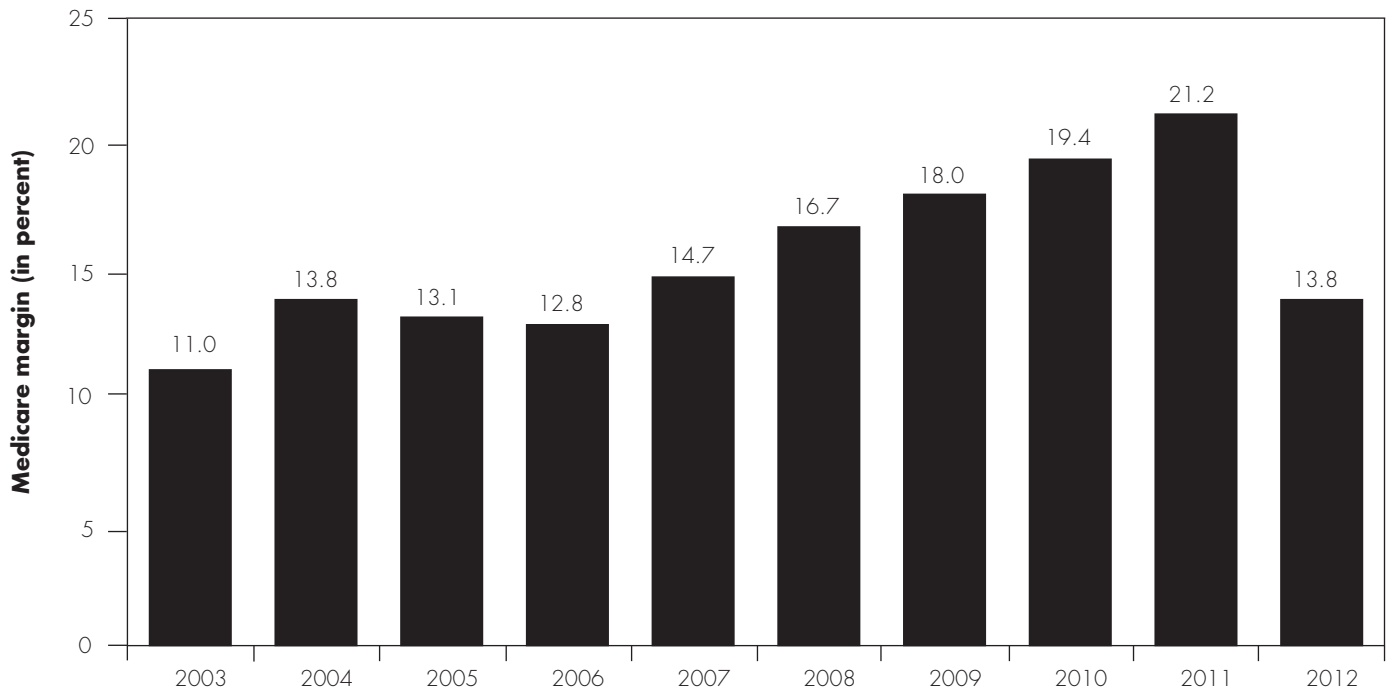
Source: MedPAC analysis of freestanding skilled nursing facility Medicare cost reports from 2000 to 2012.

data were available, it was clear the adjustment was too large and the resulting payment rates had been set too high. CMS revised the adjustment downward in 2012, lowering payments and putting spending back in line with previous trends. After the reductions, 2012 rates were 3.7 percent higher than those in 2010, and program spending increased 6 percent over this two-year period. On a per FFS beneficiary basis, spending in 2012 was \$782, a decline from the high spending in 2011 (\$856) but a 3 percent increase over 2010. Spending per Medicare SNF user increased slightly more over this two-year period (3.2 percent), reflecting the small increase in length of stay.

From 1999 to 2012, the cumulative increase in payments per day outpaced the increases in cost per day (Figure 8-3). Costs per day rose 47 percent during this period, while payments grew 62 percent. The large increase in payments reflects the intensification of the provision of therapy during this period. On the cost side, except for 2011 to 2012, cost increases were larger than the market basket updates. Between 2011 and 2012, when Medicare lowered its rates by 11 percent to correct for the previous year's overpayments, providers held their cost growth to 1.7 percent (below the market basket).

FIGURE 8-4

Freestanding SNF Medicare margins remain high despite reductions in payments



Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports from 2003 to 2012.

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. Total margins are presented as context for the Commission's update recommendation.

Despite recent reductions to SNF payments, Medicare margins remained high in 2012 (13.8 percent) (Figure 8-4). In 2011, the Medicare margin was 21.2 percent, reflecting the large increase in payments with the implementation of the new case-mix groups and an incorrect adjustment factor. Once this adjustment factor was corrected in October 2011, payments were reduced and margins were lower than in the previous year. The 2012 margin is lower than the 2009 margin in part because current law requires market basket increases to be offset by a productivity adjustment beginning in 2011. Though lower than in recent years, the 2012 margin is the 13th year of Medicare margins above 10 percent.

In 2012, hospital-based facilities (3 percent of facilities) continued to have extremely negative Medicare margins (-62 percent), in part due to their higher cost per day. Prior work found that routine costs in hospital-based SNFs were higher, reflecting more staffing, more 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 admissions. As a result, SNFs can contribute to the bottom line financial performance of the hospitals. Prior work found that hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs. Deciding to retain or close a hospital-based SNF reflects a hospital's larger strategy about how to best use its beds. Many hospitals closed their SNFs during the past decade, noting the large losses and figuring the beds and space could be better used in other ways (Medicare Payment Advisory Commission 2007). Other hospitals kept their units open, citing the savings on the acute care business, maintaining continuity of care, and, in areas with few alternatives, ensuring access to post-acute care.

**TABLE
8-6**

Variation in freestanding SNF Medicare margins reflect mix of cases and cost per day, 2012

Subgroup	Medicare margin
All	13.8%
For profit	16.1
Nonprofit	5.4
Rural	12.9
Urban	14
Frontier	7.3
25th percentile	4.8
75th percentile	23
Intensive therapy: High share of days	15.7
Intensive therapy: Low share of days	7.7
Medically complex: High share of days	11.1
Medically complex: Low share of days	14.6
Small (20-50 beds)	4.6
Large (100-199 beds)	15.3
Cost per day: High	3.5
Cost per day: Low	26.5
Cost per discharge: High	11.3
Cost per discharge: Low	15.4
Minority: High share of beneficiaries	18.4
Minority: Low share of beneficiaries	9.4
Dual eligible: High share of beneficiaries	9.0
Dual eligible: Low share of beneficiaries	16.5
Very old: High share of beneficiaries	19.7
Very old: Low share of beneficiaries	7.9

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. "Frontier" refers to SNFs located in counties with six or fewer people per square mile. "Very old" is defined as 85 years or older.

Source: MedPAC analysis of 2012 freestanding SNF Medicare cost reports.

High and widely varying SNF Medicare margins indicate reforms to the PPS are still 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. One-quarter of SNFs had Medicare margins of 23 percent or higher, while one-quarter of SNFs had margins of 4.8 percent or lower (Table 8-6). Facilities with the highest SNF margins

**TABLE
8-7****Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2012**

Characteristic	Top margin quartile	Bottom margin quartile	Ratio of top margin quartile to bottom margin quartile
Cost measures			
Standardized cost per day	\$247	\$355	0.7
Standardized cost per discharge	\$11,389	\$13,268	0.9
Standardized ancillary cost per day	\$112	\$152	0.7
Standardized routine cost per day	\$136	\$199	0.7
Average daily census (patients)	89	70	1.3
Average length of stay (days)	47	36	1.3
Revenue measures			
Medicare revenue per day	\$467	\$421	1.1
Medicare revenue per discharge	\$22,562	\$15,633	1.4
Share of days in intensive therapy	79%	70%	1.1
Share of medically complex days	4%	6%	0.7
Medicare share of facility revenue	26%	16%	1.6
Patient characteristics			
Case-mix index	1.37	1.28	1.1
Dual-eligible share of beneficiaries	40%	26%	1.5
Percent minority beneficiaries	12%	4%	3
Percent very old beneficiaries	30%	36%	0.8
Medicaid share of days	65%	59%	1.1
Facility mix			
Percent for profit	89%	59%	N/A
Percent urban	77%	68%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Top margin quartile SNFs ($n=3,136$) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs ($n=3,137$) were in the bottom 25 percent of the distribution of Medicare margins. "Standardized cost per day" is 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" is defined as 85 years or older. Values shown are medians for the quartile.

Source: MedPAC analysis of freestanding 2012 SNF cost reports.

had high shares of intensive rehabilitation therapy and low shares of medically complex days, were larger, and had lower cost per day. The SNF Medicare margin for facilities with the lowest cost per day was 26.5 percent, while the margin for facilities with the highest cost per day was 3.5 percent. The disparity between for-profit and nonprofit facilities is considerable and reflects differences in case mix, service provision, and costs. In aggregate, the Medicare margin was higher for facilities with higher shares of minority or very old beneficiaries but lower for facilities with higher shares of dual-eligible beneficiaries compared with facilities with low shares.

Comparing freestanding facilities with the highest and lowest Medicare margins (those in the top and bottom 25th percentiles of Medicare margins), we found cost and revenue 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 revenues (by 11 percent) associated with intensive therapy case-mix groups (Table 8-7). Facilities with the highest margins had higher shares of beneficiaries who were dually eligible and minority than facilities with lowest margins.¹⁴ 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.¹⁵

These differences in financial performance underscore the need to revise the PPS. Even after CMS expanded the number of medically complex case-mix groups and shifted spending 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 spending to SNFs according to their mix of patients, not the amount of therapy furnished (see discussion, p. 186).

Ownership of low-margin and high-margin facilities did not mirror the industry mix. Although for-profit facilities make up 70 percent of SNFs, they composed a smaller share (58 percent) of the low-margin facilities and a higher share (89 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 \$278 to \$314 per day after differences in wages and case mix were taken into account (Table 8-8). However, there was more variation 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, p. 201). 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. To be included in the relatively efficient

TABLE 8-8

Freestanding SNFs' standardized costs per day vary within and across groups, 2012

Subgroup of SNF	Median	Within-group variation (ratio of 75th to 25th percentile)
All freestanding	\$291	1.24
Location		
Rural	289	1.23
Urban	292	1.24
Ownership		
Nonprofit	314	1.25
For profit	285	1.22
Share of dual-eligible beneficiaries		
Low share	312	1.26
High share	279	1.24
Minority share		
Low share	298	1.26
High share	278	1.24
Very old beneficiaries (over 85 yrs old)		
Low share	284	1.22
High share	305	1.26

Note: SNF (skilled nursing facility). Low share includes facilities in the bottom 25th percentile. High share includes facilities in the highest 25th percentile. Standardized costs account for differences in wages and case mix.

Source: MedPAC analysis of freestanding SNF Medicare cost reports 2012 and Medicare denominator file.

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, 11 percent of SNFs provided relatively low-cost, high-quality care.

Our analyses found that SNFs can have relatively low costs and provide good quality of care while maintaining high margins (Table 8-9, p. 200). Compared with the national average, in 2011, relatively efficient SNFs had community discharge rates that were 18 percent higher and rehospitalization rates that were 12 percent lower. In 2011 and 2012, costs per day were 4 percent lower than the average. We did not find significant differences between relatively efficient and other SNFs in terms of

**TABLE
8-9**

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

Performance measure	Type of SNF	
	Relatively efficient	Other
Share of SNFs	11%	89%
Performance in 2011		
Relative:*		
Community discharge rate	1.18	0.97
Rehospitalization rate	0.88	1.02
Cost per day	0.96	1.01
Medicare margin	25.0%	22.7%
Performance in 2012		
Community discharge rate*	1.16	0.97
Rehospitalization rate*	0.89	1.02
Cost per day	\$280	\$292
Medicare margin	17.3%	15.0%
Facility case-mix index	1.36	1.35
Medicare revenue per day	\$463	\$453
Medicare average length of stay	33 days	39 days
Share intensive therapy days	76%	77%
Share medically complex days	0.6	0.6
Total margin	3.5%	2.3%
Medicaid share of facility days	58%	62%
Trends in cost and revenue growth 2005-2010		
Share of facilities with low growth in cost per day	17%	83%
Share of facilities with high growth in revenue per day	12%	88%

Note: SNF (skilled nursing facility). The number of freestanding facilities included in the analysis was 7,814. Efficient SNFs were defined by their cost per day (2008-2010) and two quality measures (community discharge and rehospitalization rates) for 2008 through September 2010. 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 include days classified into the ultra-high and very high case-mix groups. Table shows the medians for the measure.

*Measures are relative to the national average.

Source: MedPAC analysis of quality measures for 2008 to 2012 and Medicare cost report data for 2005 to 2012.

occupancy rates, size of facility, or case-mix complexity. Consistent with previous years' findings, efficient SNFs furnished less intensive therapy compared with other SNFs. Relatively efficient facilities were more likely to have experienced low cost growth: Efficient SNFs were 11 percent of all SNFs but made up 17 percent of SNFs with the lowest cost growth (bottom third of the distribution). They were slightly more likely to have had high revenue growth (were in the top third of the distribution of growth in revenue per day) relative to other facilities.

We recognize that a SNF may appear to be efficient in providing its own care 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 raising total Medicare program spending. In the future, we may compare providers' costs for the episode of care. Another refinement may be to consider changes in the functional status of the patients SNFs treat as a quality measure in defining efficient providers.

Identifying relatively efficient skilled nursing facilities

We defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and good quality care.

The cost per day was adjusted for differences in case mix (using the nursing component relative weights) and wages. Quality measures were risk-adjusted rates of community discharge and rehospitalization for patients with any of five conditions (congestive heart failure, respiratory infection, urinary tract and kidney infections, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Quality measures were calculated for all facilities with at least 25 stays. We used quality data from January 2008 through September 2010 to identify facilities with relatively high quality and identified facilities with relatively low cost using cost report data from 2008 through 2010.

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, we avoided having a facility’s poor data affect both its own categorization and the assessment of the group’s performance. We used quality and cost performance over three years to categorize SNFs into relatively efficient and other groups; once the groups were defined, we evaluated their performance in 2011 and 2012. 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.

The mix of efficient providers was comparable with the urban–rural mix of freestanding SNFs but not with a mix of profit status. Nonprofits were more likely to be in the efficient group relative to their share in the industry. ■

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 payments. We compared Medicare FFS and MA payments at four large nursing home companies where such information was publicly available. Medicare’s FFS payments averaged 25 percent higher than MA rates

(Table 8-10).¹⁶ We compared the patient characteristics of beneficiaries enrolled in FFS and managed care plans in 2013 and found small differences that would not explain the payment differences between the two. Compared with beneficiaries enrolled in FFS, MA beneficiaries were the same age, had slightly higher Barthel scores (2 points, indicating slightly more independence), and had risk scores in 2011 that were 4 percent lower (indicating fewer

**TABLE
8-10**

Comparison of Medicare fee-for-service and Medicare Advantage daily payments in 2013 for four companies

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	MA	
Ensign Group	\$565	\$393	1.4
Extendicare	476	439	1.1
Kindred	503	417	1.2
Skilled Healthcare	519	389	1.3

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

Source: Second quarter 10-Q 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—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. 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 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 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 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**

Distribution of Medicare and Medicaid shares of facility days in freestanding facilities, 2012

SNF type and payer	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicare share	5%	8%	12%	17%	25%
	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicaid share	0	44	62	74	82

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of SNF and hospital Medicare cost reports, 2012.

comorbidities). The considerably lower MA payments indicate some facilities accept much lower payments to treat MA enrollees who are not that different in some ways from FFS beneficiaries.

Total margins remained positive in 2012

The average total margin for freestanding SNFs in 2012 was 1.8 percent. A total margin reflects services to all patients (public and private) across all lines of business

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).

Publicly traded companies report several trends in revenues. First, declines in Medicare business (days and payments) have been partially offset by an increase in MA business (Ensign Group 2013, Extencicare 2013,

Skilled Healthcare 2013). Second, expansion of MA at the expense of FFS Medicare will lower facility revenues, given MA's shorter stays and lower payment rates. Third, companies try to grow their high-acuity rehabilitation days and spread their risk by expanding into other businesses, including home health care, hospice, and outpatient therapy (Ensign Group 2013, Extencare 2013, Kindred Healthcare 2013a, Skilled Healthcare 2013).

Publicly traded firms report higher average Medicaid rates for 2013 than for 2012 (Ensign Group 2013, Extencare 2013, Kindred Healthcare 2013b, Skilled Healthcare 2013). Higher Medicaid rates in 2013 reflect many states' improved economies, prompting 34 states to increase their nursing home payments in fiscal year 2013 and 38 states in fiscal year 2014 (Smith et al. 2013). More states also adopted provider taxes to bolster their Medicaid payments (see p. 206).

Because Medicaid payments are lower than those made by Medicare (case-mix differences aside, see discussion, p. 206), 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 2014

In assessing the payment update for 2015, the Commission considers the estimated relationship between SNF costs and Medicare payments in 2014. To estimate costs for 2013 and 2014, we assumed cost growth of the market basket. To estimate 2013 payments, we began with reported 2012 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. We also factored in the Medicare program's first year of a three-year phase-in of reduced payments for bad debt, as required by the Middle Class Tax Relief and Job Creation Act of 2012. For 2014, estimated 2013 payments were increased by the market basket and offset by the productivity adjustment and a forecast error correction. In addition, we considered the program's reduced payments for bad debt. For 2014, the projected Medicare margin is 12 percent. The margin is lower than the reported margin for 2012 because costs are likely to increase faster than

the payment updates that were lowered by the productivity adjustment and the other policy changes. If the sequester is in place, the projected margin would be about 2 percentage points lower.

How should Medicare payments change in 2015?

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, p. 204). 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, the 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' need for these services. Third, an outlier policy would be added to the PPS.

The recommendation begins with revising the PPS and not updating payments in the first year (now 2015). 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, 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 may be disadvantaged by the design of the current payment system.

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 January 2012, the spending implications of this recommendation 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 to \$10 billion over five years. Savings result from current law requiring a market basket increase (offset by a productivity adjustment, as required by the Patient Protection

and Affordable Care Act of 2010). Updated for implementation two 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 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. 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. ■

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.
- Variation in Medicare margins is 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, or 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 in two ways. First, even in years when CMS lowers payments, providers tempered the impacts with longer stays and the assignment of days into higher payment case-mix groups. For example, in 2010, when payments were recalibrated and lowered to reflect the implementation of new case-mix groups in 2006, program spending still increased. Second, Medicare's cost growth has consistently been above the SNF market basket since 2001, except between 2011 and 2012. In 2012, when CMS corrected the 2011 overpayments, providers responded to the lower payments by focusing on the efficiency of their operations, and cost growth was the lowest it had been in a decade.

These factors have not changed for the industry and illustrate 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

**TABLE
8-12**

Number of nursing homes treating Medicaid enrollees declined slightly in 2013

	2002	2004	2006	2008	2010	2012	2013	Percent change 2012-2013
Number of facilities	15,993	15,611	15,274	15,161	15,081	15,043	14,971	-0.5%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2002-2013.

with a high Medicaid payer mix, a better targeted and separately financed program could be established to do so.

Therefore, the Commission stands by its 2012 recommendation, believing that the PPS requires fundamental reforms to correct the known shortcomings and 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 the PPS revisions and subsequent staged rebasing of payment rates.

In 2015, there are no policy changes known at this time aside from the required update and productivity adjustment and the final year of the reductions to program payments for bad debt. 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 2015 is projected to be 2.4 percent, and the productivity adjustment is estimated to be 0.3 percent, but CMS will update both before establishing the payment rates for 2015.

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. In a joint publication with the Medicaid and CHIP Payment and 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 2013).

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

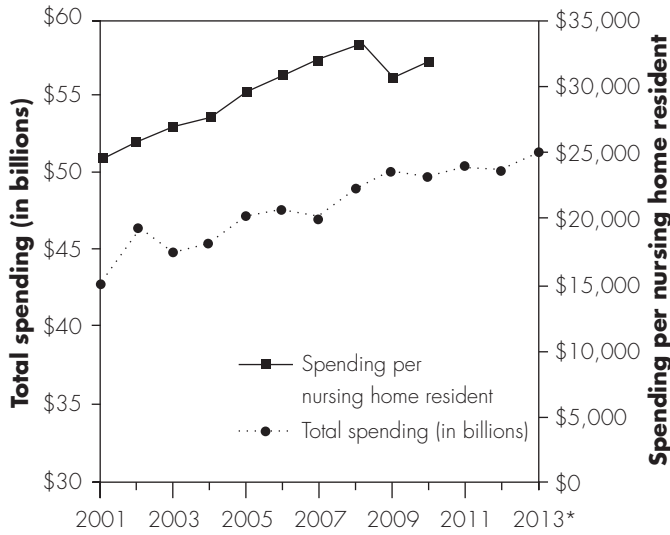
There were over 1.54 million users of Medicaid-financed nursing home services in 2010, the most recent year of data available (Centers for Medicare & Medicaid Services 2012b). This use represents a small decrease from 2009 and a 9 percent decline from 2000. The number of nursing facilities certified as Medicaid providers also declined slightly between 2012 and 2013 (Table 8-12). However, the vast majority of nursing home facilities are certified as Medicare and Medicaid providers. The decline in users and facilities reflects 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 year 2011, spending on HCBS services accounted for 45 percent of total Medicaid long-term care spending, up from 32 percent in 2002 (Smith et al. 2013).

Spending

In 2013, CMS estimates that about \$51 billion was spent on Medicaid-funded nursing home services (combined state and federal funds) (Figure 8-5, p. 206) (Office of the Actuary 2013b). Spending increases averaged 1.8 percent annually between 2001 and 2013, for a total of 24 percent over the period. Year-to-year changes in spending were variable, increasing in some years and decreasing in others. Between 2012 and 2013, CMS estimates that spending will increase by about 5 percent. On a per user basis, spending per nursing home resident averaged \$31,735 in 2010, the most recent year for resident counts. Between 2009 and 2010, spending per resident increased

FIGURE 8-5

Total and per user Medicaid spending



Note: Resident counts (and therefore per resident spending) are not available for 2011 through 2013.
*Spending in 2013 is estimated.

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/Medicare/MedicaidStatSupp>.

by about 7.5 percent and represented a 57 percent increase from 2000 (Centers for Medicare & Medicaid Services 2012b).

In 2013, Medicaid spending growth averaged 3.8 percent. This growth rate is expected to be lower compared with historical rates, but higher than in 2012 when Medicaid spending growth was at a historic low. Most states report slower enrollment growth and improvement in the economy as the primary factors contributing to the lower

rate of Medicaid spending in 2013. In 2013, 17 states restricted payments (14 states enacted freezes and 3 states enacted rate reductions) for nursing homes. For 2014, 12 states adopted rate restrictions, with 2 of the states adopting rate cuts. This decline marks a shift from 2012 when 16 states froze nursing home rates and 12 states reduced them (Smith et al. 2013).

States continue to use provider taxes to raise federal matching funds. In fiscal year 2014, 44 states had provider taxes on nursing homes (Smith et al. 2013). The President’s budget includes a proposal to slowly reduce provider taxes from a maximum 6 percent to 3.5 percent in 2017. In fiscal year 2014, four states increased provider tax rates on nursing facilities and two states decreased them.

Medicare’s payments are much higher than Medicaid’s, in part because the acuity of the average Medicare beneficiary is considerably higher, as reflected in the average nursing case-mix index for Medicaid and Medicare patients. Using data from 2011, we 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.

Non-Medicare and total margins in nursing homes

In 2012, total margins (reflecting services to all patients across all lines of business and including revenue sources) were positive (1.8 percent) but decreased from 2010. This decrease reflects the impact of Patient Protection and Affordable Care Act of 2010 reductions to Medicare payments since 2010 and a growing share of managed care payments that are often lower than Medicare’s payments. Non-Medicare margins (i.e., for Medicaid and private payers) were –2 percent (Table 8-13). ■

TABLE 8-13

Non-Medicare margins were negative but total margins were positive

Type of margin	2002	2004	2006	2008	2010	2012
Non-Medicare margin	-2.7%	-1.3%	-0.8%	-2.4%	-1.5%	-2.0%
Total margin	1.2	1.8	2.2	2.2	3.6	1.8

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.

Source: MedPAC analysis of freestanding 2002–2012 skilled nursing facility cost reports.

Endnotes

- 1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay (Part A) coverage is paid for by Medicare. Some beneficiaries remain in the facility to receive long-term care services, which is 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 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 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).
- 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 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 2011 (for fiscal year 2012), CMS lowered payments for therapy furnished in groups (multiple patients engaged in the same therapy activities at the same time).
- 7 Minority beneficiaries made up 20 percent of medically complex admissions in 2012 compared with only 16 percent of all SNF admissions.
- 8 Medically complex days make up the other 7 percent of days. See endnote 5 for the definition of *medically complex*.
- 9 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* includes patients who received over 720 minutes per week; *very high rehabilitation* includes patients who received 500–719 minutes per week.
- 10 A modified Barthel score is a composite measure of a patient’s ability to perform nine activities of daily living, including control bowel and urinary incontinence, transfer, walk in the facility corridor, feed themselves, toilet, bathe, perform personal hygiene, and dress.
- 11 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.
- 12 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, the separate measures count each relevant stay in its count of readmissions.
- 13 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.
- 14 The finding that high-margin SNFs have higher shares of dual-eligible beneficiaries appears to contradict the finding in Table 8-6 showing that the aggregate margin for SNFs with high shares of dual-eligible beneficiaries was lower than the margin for SNFs with low shares (9 percent vs. 16.5 percent). However, the difference is due to the statistic reported. Table 8-6 reports aggregate margins, effectively weighting the margin by facility size (their costs and revenues). Large SNFs

(those with high Medicare revenues) have lower shares of dual-eligible beneficiaries compared with the smallest SNFs. However, across SNFs of varying size, SNFs with more dual-eligible beneficiaries have higher margins than smaller SNFs. Table 8-7 shows the median share of dual-eligible beneficiaries for facilities in the top and bottom quartiles of Medicare margins. The shares of dual-eligible beneficiaries were consistently higher in high-margin (and larger) SNFs compared with low-margin SNFs.

- 15 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).
- 16 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.

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