CHAPTER 7

Skilled nursing facility services

RECOMMENDATION

7 For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for skilled nursing facilities.

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

CHAPTER 7

Skilled nursing facility services

Chapter summary

In skilled nursing facilities (SNFs), Medicare covers short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2019, about 15,000 SNFs furnished about 2 million Medicare-covered stays to 1.5 million fee-for-service (FFS) beneficiaries (4 percent of Medicare's FFS beneficiaries). FFS Medicare spending on SNF services was $27.8 billion in 2019. Most SNFs are also certified as nursing homes that furnish long-term care services, which Medicare does not cover.

Nursing homes have been particularly hard hit by the coronavirus pandemic and the associated public health emergency (PHE). As devastating as the pandemic's effects have been—on staff and residents and their families and friends, and on providers' costs and volume—we expect the industry to eventually rebound, though its recovery may be sluggish and will vary by provider and market. To recommend a payment rate update for 2022, we review the adequacy of Medicare's payments using the most recent complete data we have available and make our best effort to consider how Medicare's payments will compare with the costs of Medicare-covered stays in 2021, noting that the future is highly uncertain. Where relevant, we have considered the effects of the coronavirus PHE on our payment adequacy indicators and whether those effects are likely to be temporary or permanent. To the extent the effects of the PHE are temporary or vary significantly across SNFs,

In this chapter

they are best addressed through targeted temporary funding policies rather than a permanent change to SNF payment rates in 2022 and future years. Based on information available at the time of publication, we expect certain long-term PHE-related effects that warrant inclusion in the annual update to SNF payments in 2022, including additional costs for testing and infection control.

Assessment of payment adequacy

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

Beneficiaries' access to care—Before the PHE, access to SNF services was adequate for most beneficiaries.

- ***Capacity and supply of providers—***The number of SNFs participating in the Medicare program has been stable for many years. In 2019, the vast majority (90 percent) of beneficiaries lived in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds). Between 2018 and 2019, the median occupancy rate declined slightly but remained high (about 85 percent). During the PHE, occupancy slid more than 10 percentage points and has not recovered as of the time of this writing. This decline is unrelated to the adequacy of Medicare's payments.
- ***Volume of services—***Between 2018 and 2019, Medicare-covered admissions per capita decreased 4.8 percent, consistent with a decrease in the number of hospital stays that last at least three days (required for Medicare coverage). The length of SNF stays also declined slightly, resulting in more than a 5 percent decrease in days per capita. During the PHE, temporary changes in coverage rules tempered the reductions in Medicare volume beginning in March 2020.
- ***Marginal profit—***An indicator of whether SNFs have an incentive to treat more Medicare beneficiaries, the marginal profit, in aggregate was almost 20 percent for freestanding facilities in 2019. This high level of marginal profit is a strong, positive indicator of beneficiary access to SNF care.

Quality of care—Between 2018 and 2019, consistent with the trend since 2015, rates of successful discharge to the community have increased and hospitalizations have decreased.

Providers' access to capital—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Before the PHE, access to capital was

adequate, and though lending activity has stalled during the PHE, it is expected to be good in 2021. In 2019, the total margin (a measure of the total financial performance across all payers and lines of business for the facility) was 0.6 percent. Any lending wariness reflects broad changes in post-acute care, not the adequacy of Medicare's payments. Medicare is regarded as a preferred payer of SNF services.

Medicare payments and providers' costs—In 2019, Medicare's FFS spending on SNF care decreased 2 percent to $27.8 billion. The aggregate Medicare margin for freestanding SNFs was 11.3 percent. Margins varied greatly across facilities, reflecting economies of scale and the share of days assigned to the most profitable rehabilitation case-mix group.

The level of Medicare's FFS payments remains well above the cost of Medicare-covered stays. Since 2000, the average Medicare margin has been above 10 percent, and the very high Medicare margin (19.2 percent) for efficient SNFs—those providers with relatively low costs and high quality—is further evidence that Medicare continues to overpay for SNF care. Medicare Advantage (MA) plans' payment rates, considered attractive by many SNFs, are much lower than the program's FFS payments and are unlikely to be explained by the differences in patient characteristics between SNF users enrolled in MA and FFS.

In 2021, providers are likely to incur higher costs associated with post-PHE changes in practices (e.g., higher expenditures for personal protective equipment and testing). We also expect Medicare volume to not fully recover to pre-PHE levels, at least in the near term. Providers will continue to adjust their practices to the new case-mix system that was implemented on October 1, 2019. Acknowledging the many uncertainties regarding the costs and payments after the PHE, we estimate the the aggregate Medicare margin in 2021 will be about 10 percent.

How should Medicare payment rates change in 2022?

Considering these factors, the Commission recommends that, for fiscal year 2022, the Congress eliminate the update to the fiscal year 2021 Medicare base payment rates for SNFs. While the projected level of payments indicates that payments need to be reduced to more closely align aggregate payments and costs, the lasting impacts of COVID-19 on SNFs and the effects of the new case-mix system are uncertain. Because the SNF industry is likely to undergo considerable changes as it adjusts to both, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with costs while exerting pressure on providers to keep their cost growth low.

Medicaid trends

As required by the Affordable Care Act, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins for nursing homes. Medicaid finances most long-term care services provided in nursing homes, but it also covers the copayments on SNF care for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. Between 2019 and 2020, the number of Medicaid-certified facilities declined less than 1 percent, to about 15,000. Medicaid spending was $39 billion in 2019, about 5 percent less than in 2018.

In 2019, the aggregate total margin—reflecting all payers and all lines of business—was 0.6 percent, an increase from 2018. The average non-Medicare margin (which includes all payers and all lines of business except Medicare FFS SNF services) was –2 percent, also an improvement from 2018. ■

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include beneficiaries recovering from surgical procedures such as hip and knee replacements or from medical conditions such as heart failure.[1] In 2019, almost 1.5 million Medicare fee-for-service (FFS) beneficiaries (4 percent of FFS Medicare Part A beneficiaries) used SNF services at least once; program spending on SNF services was $27.8 billion (about 7 percent of FFS spending) (Boards of Trustees 2020, Office of the Actuary 2020b).[2] Medicare's median payment per day was $498, and its median payment per stay was $18,559. In 2019, one-fifth of hospitalized beneficiaries were discharged to SNFs.

Medicare coverage

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least 3 days.[3] For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of the spell of illness. Beginning with day 21, beneficiaries are responsible for copayments through day 100 of the covered stay. For fiscal year 2021, the copayment is $185.50 per day.

To qualify for Medicare coverage, all SNF users have a preceding hospital stay of at least three days. In 2019, the five most common hospital conditions of patients referred to SNFs for post-acute care were septicemia; joint replacement; heart failure and shock; hip and femur procedures (except major joint replacement); and kidney and urinary tract infections. In 2019, CMS implemented a final rule requiring hospitals to provide beneficiaries at discharge with information about the quality of SNFs that may help them make more informed decisions about where to get this care (Centers for Medicare & Medicaid Services 2019).

During the public health emergency (PHE) declared by the Secretary of Health and Human Services, to help reserve hospital capacity for treating COVID-19 patients, CMS temporarily waived the three-day prior hospital stay requirement beginning in March 2020.[4] This change allowed facilities to bill Medicare for long-stay residents requiring skilled care without a preceding hospitalization, referred to as "skilling in place." The discharge information requirements for hospitals were also waived during the PHE. The temporary policies are scheduled to end in April 2021.

Composition of the industry

The term *skilled nursing facility* refers to a provider that meets Medicare requirements for Part A coverage.[5] Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes (which typically provide less intensive, long-term care services). Thus, a facility that provides skilled care often also provides long-term care services that Medicare does not cover. The less intensive long-term care services typically make up the bulk of a facility's business, and Medicaid pays for the majority of this care.

The SNF industry is made up almost entirely of freestanding facilities, and the majority are for profit (Table 7-1, p. 202). In 2019, 96 percent of facilities were freestanding, and they accounted for an even larger share of Medicare spending (97 percent). For-profit facilities accounted for 71 percent of providers and Medicare-covered stays and 75 percent of Medicare spending.

Freestanding SNFs vary by size. In 2019, the median SNF had 100 beds, but 10 percent of facilities had 173 or more beds and 10 percent of facilities had 50 beds or fewer. Nonprofit facilities and rural facilities are generally smaller than for-profit and urban facilities. Small facilities (under 50 beds) are not limited to rural locations. The majority are located in metropolitan areas, and less than 10 percent are located in the most rural counties or in frontier areas (counties with six or fewer persons per square mile) (Medicare Payment Advisory Commission 2020).[6]

Medicare FFS–covered SNF days typically account for a small share of a facility's total patient days but a disproportionately larger share of a facility's revenues. In freestanding facilities in 2019, Medicare's median share of facility days was 9 percent but 16 percent of facility revenue. FFS Medicare's share of SNF revenue has steadily declined as an increasing share of beneficiaries are enrolled in Medicare Advantage (MA) plans, whose days and revenue are not included in these figures.

CMS implemented a new case-mix system on October 1, 2019

By statute, Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.[7] By controlling length of stay, providers can influence how much Medicare will pay them for their services. Information

TABLE 7–1

Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, Medicare stays, and program spending, 2019

Type of SNF	Facilities	Medicare-covered stays	Program spending
Total number	14,923	2,069,107	$24.9 billion
Freestanding	96%	96%	97%
Hospital based	4	4	3
Urban	73	84	85
Rural	27	16	15
For profit	71	71	75
Nonprofit	23	25	22
Government	6	4	3

Note: SNF (skilled nursing facility). The spending amount included here is lower than that reported by the Office of the Actuary, and the count of SNFs is slightly lower than what is reported in CMS's Survey and Certification Providing Data Quickly system.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2019.

gathered from a standardized patient assessment instrument—the Minimum Data Set—is used to classify patients into case-mix categories. How complete and accurate the patient assessment information is can also influence payments.

Before October 1, 2019, the PPS had two fundamental shortcomings: It encouraged the provision of excessive rehabilitation therapy services and did not accurately target payments for nontherapy ancillary (NTA) items such as drugs. As a result, providers preferred to admit patients requiring rehabilitation care and avoided medically complex patients. Spending between January and September 2019 reflected these incentives.

Beginning on October 1, 2019, CMS implemented a new case-mix system, the Patient-Driven Payment Model (PDPM), which shifted providers' incentives.[8] The PDPM was expected to redistribute payments from rehabilitation care to medically complex care (Centers for Medicare & Medicaid Services 2018). Six components—nursing, physical therapy, occupational therapy, speech–language pathology, NTA, and room and board—are summed to establish a daily payment.[9] Depending on the component, the following information is used to adjust payments: the primary reason for treatment, prior surgery, comorbidities, functional status, cognitive status, swallowing and nutritional status, depression, and special treatments (such as ventilator care). Group and concurrent therapies together are limited to 25 percent of total therapy minutes—per stay and per therapy discipline—so that individual therapy remains the dominant modality.

With the profitable therapy services no longer encouraged, differences in financial performance across providers hinge on the recording of medical conditions and functional status rather than the provision of therapy. The trade press reports that the best performers under the PDPM had higher shares of "special care high" nursing days (e.g., patients with septicemia or chronic obstructive pulmonary disease who also had low functional ability) and patients recorded as having depression, but their therapy mixes did not differ (Spanko 2020c). Providers are likely to continue to improve the recording of patient information as they gain experience with the new case-mix system and understand the importance of certain patient assessment items for payment. The trade press has reported that the recording of depression and the need for respiratory therapy represent such opportunities (Flynn 2020a, Flynn 2020d).

Though intended to be budget neutral, the new case-mix system appears to have increased payments. Our analysis of claims from the first quarter of the PDPM (October

through December 2019) found that average payments per day were 7 percent higher than the average daily payments for the nine months of 2019 under the old case-mix system, and the increase was seen beginning in October. In addition to the update (2.4 percent), the increase reflects a combination of higher payments for the same cases and, if SNFs admitted a different mix of cases, higher case complexity. Before the PHE, publicly traded nursing home companies reported positive effects of the PDPM on payments (Genesis Healthcare 2020, Omega HealthCare Investors 2020, SABRA Health Care REIT 2020).

In the fiscal year 2021 final rule, CMS stated that an across-the-board adjustment may be needed to retain budget neutrality, but it did not have sufficient information to determine the adjustment (Centers for Medicare & Medicaid Services 2020c). The changes in costs, case-mix, and policy changes as a result of the PHE will further complicate and delay this assessment. By shifting providers' focus away from intensive therapy to clinical models of care, the industry reported that the new case-mix system enabled them to capture more of the comorbidities and costs associated with treating COVID-19 patients (American Health Care Association 2020).

Are Medicare payments adequate in 2021?

To examine the adequacy of Medicare's FFS payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, providers' access to capital, Medicare FFS payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compare the characteristics of relatively efficient SNFs with other SNFs. Throughout the section, we note the effects of the coronavirus pandemic, starting with the text box on the impact on nursing homes (p. 204).

Beneficiaries' access to care: Access was adequate for most beneficiaries and volume is expected to slowly recover from PHE declines

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

SNF supply is stable

The SNF industry is highly fragmented and characterized by independent providers and local and regional chains. Of the 50 largest operators, most are privately held. In 2018, the 25 largest nursing home chains in the country operated about 19 percent of all facilities (IQVIA Institute for Human Data Science 2018). One study of chains found that new entrants tended to locate in the same state but not in the same markets in which the chains already have holdings (Hirth et al. 2019).

The number of SNFs participating in the Medicare program in 2020 was fairly stable at 15,127. Of the 43 new facilities, the majority were for profit, and of the 93 terminations as of November 2020 (less than 1 percent of SNFs), most closed at their own initiative (i.e., they were not terminated by the program). There were fewer terminations in 2020 than at the same point in 2019, indicating that, to date, the PHE has not resulted in an increase in the number of closures. In 2019 and 2020, the rates of closure were comparable between for-profit and nonprofit facilities, consistent with a study of nursing home closures since 2015 (Flinn 2020a). Typically, facilities close as the result of several factors: the reportedly low Medicaid rates, lower payment rates paid by MA plans and their lower use of SNFs, and the overexpansion of the SNF supply (in states that do not have certificate-of-need laws). Terminations will affect access to SNF care for those beneficiaries who live in a county with few options, further limited by a closure. In 2019, 90 percent of beneficiaries lived in counties with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds). If closures occur in counties with only one SNF or swing bed facility, beneficiaries who live in these areas (3.3 percent of beneficiaries) might have more difficulty obtaining SNF care.

Pre-PHE, median occupancy rates for freestanding SNFs were high, though they have slowly declined over time, from 88 percent in 2010 to 85 percent in 2019. Occupancy rates vary widely: In 2019, one-quarter of freestanding facilities had occupancy rates at or below 72 percent, while another quarter had rates 91 percent or higher. Median occupancy rates for rural facilities and for-profit facilities

The impact of COVID-19 on nursing homes

The coronavirus pandemic and associated public health emergency (PHE) has had tragic effects on beneficiaries' health. It also has had material effects on providers' patient volume, revenues, and costs. The effects of COVID-19 have varied considerably both geographically and over time, and it is not clear when the full effects of the pandemic will end. Though weekly cases and deaths decreased through the summer of 2020, both steadily increased after mid-September 2020, with spikes occurring late in the year due to holiday-related community outbreaks and new variants of the COVID-19 virus.

Nursing home residents and staff have been particularly hard hit by the PHE. For months, infection and mortality rates were high and facilities were often unable to access testing and affordable personal protective equipment (PPE). To help control infections, facilities were required to be closed to visitors and barred from conducting communal activities. Residents have borne the emotional and physical health effects of isolation, while frontline workers face challenging work conditions. By late summer, as nursing homes were able to access PPE and testing, homes were allowed to reopen to outside visitors and conduct limited communal activities. But as local infection rates flared, CMS guidance resulted in the re-imposition of restrictions on visits.

Nursing homes have benefited from federal grants and loans and temporary policy changes that eased the impact of PHE-related lower volume (and associated reductions in revenue) and higher costs for staffing, PPE, and testing. The temporary suspension of the sequestration increased Medicare payments. The federal grants and loans will affect total facility margins, but not Medicare margins, in 2020. Facility volume remains below prepandemic levels due to a combination of deaths, move-outs, restrictions on hospital transfers, fewer hospital referrals, and delayed or averted admissions. Eventually, the sector is likely to mostly recover, but the effects of the pandemic on patterns of care, volume, and financial performance in 2020 and 2021 are still unclear. The short-term effects of COVID-19 have been highly variable and, as discussed below, are best considered in temporary and targeted payments to individual providers. Volume may remain depressed for even longer as beneficiaries seeking long-term care or post-acute care avoid this setting.

In this chapter, we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have are generally from 2019. The coronavirus PHE created additional data lags, most notably for cost reports because the deadlines for their submission were extended. As always, we use the best available data and changes in payment policy to project margins for 2021 and make payment recommendations for 2022. To the extent the effects of COVID-19 are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2022 that will also affect payments in future years. For each payment adequacy indicator in this chapter, we discuss whether the effects of COVID-19 on those indicators will most likely be temporary or permanent. Only permanent effects of the pandemic are factored into recommended permanent changes in Medicare payment rates. (For an overview of how our payment adequacy analysis takes account of the PHE, see Chapter 2). ■

were lower than for urban facilities and nonprofit facilities. By state, median occupancy rates ranged from 62 percent (Montana) to 95 percent (Alaska). Of the 12 states plus the District of Columbia with median occupancy rates at or above 90 percent, 10 have certificate-of-need laws limiting industry expansion (though 8 states suspended these laws during the PHE). Given the relatively high occupancy rates in many facilities, a bed may not be available in the market when a beneficiary is seeking placement, particularly if he or she requires special services.

Between 2018 and 2019, SNF admissions decreased and stays shortened

In 2019, 3.9 percent of FFS beneficiaries used SNF services, nearly equal to the share in 2018. Between 2018 and 2019, SNF admissions per 1,000 FFS beneficiaries

TABLE 7–2 **SNF admissions and days continued to decline in 2019**

Volume measure	2010	2012	2014	2016	2018	2019	Percent change 2018–2019	Percent change 2010–2019
Covered admissions per 1,000 FFS beneficiaries	73.0	69.0	68.3	65.9	62.5	59.5	–4.8%	–18.5%
Covered days per 1,000 FFS beneficiaries	1,972	1,893	1,843	1,693	1,559	1,475	–5.4	–25.2
Covered days per admission	27.1	27.4	27.0	25.7	25.0	24.8	–0.8	–8.5

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

Source: Centers for Medicare & Medicaid Services 2020d.

decreased 4.8 percent (Table 7-2) (Centers for Medicare & Medicaid Services 2020d). We examine service use for only FFS beneficiaries because the CMS data on users, days, and admissions do not include service use by beneficiaries enrolled in MA plans. Covered days per admission also declined, to 24.8 days. The combination of fewer admissions and shorter stays resulted in 5.4 percent fewer days per 1,000 beneficiaries. Since 2010, admissions per capita have declined about 18 percent, and covered days per admission have dropped over 8 percent.

Several factors contributed to the decline in SNF admissions between 2018 and 2019. First, given coverage rules, the rate of SNF use parallels inpatient hospital use. During this period, per capita FFS inpatient hospital stays that were three days or longer declined 2.5 percent. The increased use of observation stays is another factor. Because patients who are treated in observation units are not technically admitted, their observation stays, even if three days or longer, do not qualify them for Medicare coverage of subsequent SNF use. Declines in service use also reflect a growing presence of alternative payment models (APMs), such as accountable care organizations and bundled payment demonstrations. These APMs create financial incentives for entities to lower their spending and use of services by avoiding PAC altogether (for example, referring beneficiaries to outpatient therapy instead), shortening SNF stays, and using lower cost home health care when possible.

Before the PHE, access to SNF care for beneficiaries was generally good. Medicare's high payment rates ensured that short-stay beneficiaries were preferable to other patients. Some providers may have avoided beneficiaries who were likely to require long stays and exhaust their Medicare benefits. In such cases, a facility's daily payments could decline if the patient became eligible for Medicaid or the stay resulted in bad debt.

During the PHE, access may be impaired depending on local-market COVID-19 conditions, hospital referral patterns, and an individual facility's admitting policies (see text box on service use during the PHE, p. 206). CMS's waiver of the required three-day hospital stay tempered what might have otherwise been larger volume declines.

Marginal profit: A measure of the attractiveness of Medicare patients

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.[10] The aggregate marginal profit in 2019 was 19.7 percent, indicating that facilities

Service use during the public health emergency

During the public health emergency (PHE), skilled nursing facilities (SNFs) have had varying admission practices. Some states required nursing homes to admit COVID-19–positive cases; other SNFs restricted their capacity so they could isolate infected individuals; and a small number of facilities converted to treating only COVID-19–positive individuals. We have not assessed whether Medicare's payments for COVID-19 patients cover the costs of care, which would be one indicator of whether Medicare beneficiaries would be attractive to admit.

The demand for SNF services declined when referring hospitals stopped performing elective surgery in mid-March 2020. Of the beneficiaries who were discharged from the hospital, many opted to bypass SNFs and go directly home when possible. The declines in occupancy rates varied considerably by local market and timing of COVID-19 case rates. After hospital volume started to return in May, SNF occupancy rates have been slow to recover and remain, as of mid-December 2020, more than 10 percentage points below their levels in February. However, Medicare's share of days and revenues increased between March and August, indicating that the "skilling in place" (which shifts financial responsibility for some care from Medicaid to Medicare) had a positive effect on facilities' financial position (National Investment Center for Seniors Housing & Care 2020). When the temporary waiver expires, some Medicare utilization will revert to being covered by Medicaid. As a result, Medicare volume may decline and may not recover until staff and residents can be readily tested and vaccinated. We will have more information next year when we conduct our analyses of the adequacy of 2020 payments to support our update recommendation for fiscal year 2023. ■

with available beds had an incentive to admit Medicare patients. This high level of marginal profit is a strong positive indicator of beneficiary access to SNF care.

Quality of care: Measures indicate small improvements

We evaluate quality of care using two measures: average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a stay. Successful discharge to the community includes beneficiaries discharged to the community (including those discharged to the same nursing home where the beneficiary was before the hospitalization) who did not have an unplanned hospitalization and did not die in the next 30 days. The hospitalization measure captures all unplanned hospitalizations (admissions and readmissions) and outpatient observation stays that occur during the stay. Each measure is uniformly defined and risk adjusted across home health agencies, SNFs, inpatient rehabilitation facilities, and long-term care hospitals—thus taking another step toward achieving a unified payment system and evaluation of outcomes across PAC settings.[11]

Between 2015 and 2019, both quality measures—risk-adjusted rates of successful discharge to the community and hospitalization—improved. During that period, the average rate of successful discharge to the community rose from 43.9 percent to 45.8 percent (higher rates are better), while the average hospitalization rate dropped from 15.1 percent to 13.7 percent (lower rates are better) (Table 7-3). Nonprofit facilities and hospital-based facilities had better performance than their for-profit and freestanding counterparts: They had higher rates of discharge to the community and lower hospitalization rates.

TABLE 7–3

SNFs' quality measures improved slightly between 2015 and 2019

Measure/subgroup	2015	2016	2017	2018	2019	Average annual change 2018–2019	Average annual change 2015–2019
Successful discharge to the community							
All SNFs	43.9%	44.5%	44.4%	44.3%	45.8%	3.2%	1.1%
For profit	43.0	43.7	43.6	43.5	44.8	3.0	1.0
Nonprofit	47.2	47.7	47.6	47.4	48.7	2.7	0.8
Freestanding	43.4	44.1	44.0	44.0	45.4	3.3	1.1
Hospital based	52.9	53.3	53.8	52.8	53.8	2.0	0.4
Hospitalizations							
All SNFs	15.1	14.5	14.4	14.1	13.7	–3.1	–2.4
For profit	15.7	15.0	14.9	14.6	14.2	–2.6	–2.4
Nonprofit	13.3	12.8	12.9	12.7	12.3	–2.9	–2.0
Freestanding	15.3	14.7	14.6	14.3	13.8	–3.0	–2.5
Hospital based	10.6	10.1	10.2	10.6	10.0	–5.4	–1.5

Note: SNF (skilled nursing facility). "Successful discharge to the community" includes beneficiaries discharged to the community (including those discharged to the same nursing home they were in before) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions, readmissions, and outpatient observation stays that occur during the SNF stay. Providers with at least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate. The "All SNFs" category includes the performance of government-owned SNFs, which are not displayed separately in the table. The average annual changes were calculated using unrounded annual rates.

Source: MedPAC analysis of SNF claims and linked inpatient hospital stays 2015 through 2019 for fee-for-service beneficiaries.

Considerable variation exists across the industry in performance on the quality measures we track. The lowest performing quarter of facilities in 2019 had risk-adjusted rates of successful discharge to the community at or below 39.5 percent, whereas the best performing quarter of facilities had rates of 53.5 percent or higher (Table 7-4, p. 208). Even larger variation was seen in the hospitalization rates. The worst performing quartile had rates at or above 16.4 percent, whereas the best quartile had rates at or below 10.6 percent. The amount of variation across providers suggests considerable room for improvement, all else being equal.

We no longer include measures of functional improvement in our assessment of quality. While the Commission contends that maintaining and improving functional status is a key goal of PAC, the Commission has raised serious questions about the integrity of this information (Medicare Payment Advisory Commission 2019). Because functional assessments are used in the case-mix system to establish payments, it is unlikely that this information can be divorced from payment incentives. Yet, because functional outcomes are critically important to patients, improving the reporting of assessment data such that these outcomes can be adequately assessed is desirable. In its June 2019 report to the Congress, the Commission discussed possible strategies to improve the assessment data, the importance of monitoring the reporting of these data, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019).

TABLE 7–4

Quality measures vary considerably across SNFs, 2019

Quality measure	Risk-adjusted rates		
	Mean	25th percentile	75th percentile
Successful discharge to the community	45.8%	39.5%	53.5%
Hospitalizations during the stay	13.7	10.6	16.4

Note: SNF (skilled nursing facility). Higher rates of discharge to community indicate better quality. Higher readmission rates indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 60 or more stays.

Source: MedPAC analysis of 2019 SNF claims and linked inpatient hospital stays for fee-for-service beneficiaries.

A high-level summary of the effects of COVID-19 on nursing home quality and safety is discussed in the text box.

SNF value-based purchasing program

As part of the Protecting Access to Medicare Act of 2014 (PAMA), the Congress enacted a SNF value-based purchasing (VBP) program that began adjusting payments to providers in October 2018. The program uses one measure of performance—readmissions for any cause within 30 days of discharge from the preceding hospital stay. The VBP program withholds 2 percent of payments from providers meeting the minimum case count to participate in the program. Of the withheld amount, 60 percent is returned to providers as incentive payments and 40 percent is retained as program savings. In each of the first two years of the program, the majority of providers earned back some portion of the 2 percent of payments withheld, but, on net, their payments remained below what they would have been without the program. During the PHE, CMS announced that it would exclude claims from January 1, 2020, through June 30, 2020, from the VBP calculations but reserved the right to extend the exclusion period depending on the PHE.

The Consolidated Appropriations Act, 2021, made three changes to the SNF VBP. First, it gave the Secretary of Health and Human Services the authority to expand the measure set. An expanded measure set can affect payments beginning in fiscal year 2024. Second, the program cannot apply to providers that do not have a minimum number of cases for each measure. Third, the measures and data submitted to calculate the measures must be validated.

PAMA required the Commission to report on the status of the VBP program and make recommendations as appropriate. In September 2020, the Commission discussed several shortcomings of the program's design; in October 2020, it considered an alternative design that corrects them. Those discussions highlighted the lack of claims-based quality measures and a measure of patient experience for all PAC providers, including SNFs. Regarding the incentives established by the program, the trade press has noted that the size of the program's payments may be too small to change behavior (Spanko 2018). Quality improvement might be accelerated if the program's incentive payments were larger—either by fully paying out the amounts withheld from payments as incentive payments (rather than retaining a portion as program savings) or increasing the amount withheld. The Commission will include its review of the program and any recommendations in its June 2021 report to the Congress.

Providers' access to capital remains adequate

Access to capital allows SNFs to maintain, modernize, and expand their facilities. The vast majority of SNFs are part of a nursing facility. Therefore, in assessing SNFs' access to capital, we look at the availability of capital for nursing homes. With restrictions placed on bed supply in many states (35 states plus the District of Columbia have

Impact of COVID-19 on nursing home quality and safety

Nursing homes were hit especially hard by the public health emergency (PHE). Between late May (when facilities began reporting COVID-19–related information to CMS) and December 13, 2020, facilities reported 441,473 confirmed cases among residents and 86,775 COVID-19 resident deaths (Centers for Medicare & Medicaid Services 2020b). Case rates and deaths per 1,000 residents varied widely by state and over time, as the virus peaked and waned by local market. Researchers found that outbreaks were tied to facility location, prevalence of COVID-19 in the community, and facility size—and not quality ratings or ownership (Abrams et al. 2020, Gorges and Konetzka 2020). Nursing homes with relatively high shares of Black or Hispanic residents were more likely to have had at least one COVID-19 case (and their outbreaks were larger) and at least one death compared with other nursing homes (Chidambaram et al. 2020).

For months into the PHE, operators reported an inability to procure personal protective equipment (PPE) and testing, and they lacked adequate infection control practices to curb the virus's spread. To increase the availability of COVID-19 testing, the federal government sent testing equipment and tests directly to nursing homes. Signaling improvement, the president of the largest nursing home trade association reported in October that testing and PPE were more widely available and that operators had a better understanding of how to handle outbreaks (Flynn 2020b). Still, in mid-December, 10 percent of the facilities submitting data reported not having a week's supply of masks, eye protection, gowns, gloves, and hand sanitizer (Centers for Medicare & Medicaid Services 2020b).

CMS and the Centers for Disease Control and Prevention undertook many actions aimed at mitigating the impact of COVID-19. They issued guidance on the use of telehealth, visitation and communal activities, infection control, isolation of suspected or confirmed cases, and the frequency of testing of staff and residents. To increase transparency during the PHE, they required nursing homes to report COVID-19–related metrics, including infection and mortality rates among residents and staff, facility capacity, staffing shortages, testing capacity and turnaround times, and the availability of PPE and ventilator capacity. A CMS-convened commission issued recommendations regarding testing and screening, equipment and PPE, visitation and cohorting of infected individuals, workforce, sharing of best practices, and the Nursing Home Compare website (Coronavirus Commission for Safety and Quality in Nursing Homes 2020). ■

certificate-of-need laws that regulate nursing home bed supply), capital is less likely to finance new construction than to update facilities or finance purchases of existing facilities (National Conference of State Legislatures 2019). Because Medicare makes up a minority share of most nursing homes' revenues, access to capital generally reflects factors other than the adequacy of Medicare's payments.

In 2020, access to capital slowed during the early months of the PHE but then started to open up and is reported to be widely available in many markets (Cain Brothers 2020). Valuations have been complicated by uncertainty about the impact of COVID-19 on operations and how to consider the federal funds and policies in assessing an operator's assets. Compared with other sectors, there were more deals involving long-term care, and those deals totaled over $4 billion (PricewaterhouseCoopers 2020). The merger and acquisition activity was partly the result of real estate investment trusts (REITs) scaling back their holdings and private equity firms expanding theirs. The interest of private equity firms in the SNF setting is expected to continue (Flynn 2020c). Further sparking interest are low lending rates. Other activity was generated by national companies shedding assets that did

not fit into a more geographically focused portfolio. Some poor-performing SNFs were sold to investors looking for turnaround opportunities. Acquisitions and consolidations could accelerate in 2021 as SNFs with poor financial performance exit the market. In 2021, nursing homes may have increased demand for capital for renovations if facilities opt to create single-occupancy rooms and negative-pressure rooms and to improve their ventilation systems.

The Department of Housing and Urban Development (HUD) continues to be an important lending source for this sector. Section 232 loans help finance nursing homes by providing lenders with protection against losses if borrowers default on their mortgage loans. In fiscal year 2020, HUD financed 323 projects, with the aggregate insured amount totaling $4.8 billion (Department of Housing and Urban Development 2020). Both the number of projects and amounts insured were substantial increases over 2019 (12 percent and 17 percent, respectively).

Total margins were positive in 2019

The estimated aggregate total margin for nursing homes (reflecting all lines of business and all payers) in 2019 was slightly positive (0.6 percent). Except for fiscal year 2018 (when the total margin was slightly negative, –0.3 percent), total margins have been slightly positive (ranging from 0.6 percent to 3.8 percent) since 2001. Because a "total margin" includes Medicaid-funded long-term care (the nursing home portion of the business), the overall financial performance of this setting is heavily influenced by state policies regarding the level of Medicaid payments and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need). The industry has long argued that high Medicare margins are needed to subsidize its reported losses from Medicaid. The Commission contends that this cross-subsidization is poor policy for several reasons (see text box on not subsidizing other payments).

Access to federal and other coronavirus PHE–related funding helped maintain operations in 2020

During 2020, federal funds and programs greatly helped this sector maintain its operations. Provider relief funds, amounting to about 2 percent of total revenues, were slated to help prevent, prepare for, and respond to the COVID-19 outbreak and for reimbursing providers for lost revenues and health care–related expenses attributable to COVID-19. Other programs included the Medicare accelerated and advance payments program, employer payroll tax deferral, paycheck protection program, and temporary elimination of the sequester.[12] SNFs varied in whether they participated in the optional paycheck protection and advanced payment programs.[13] An additional $11.2 billion was targeted to nursing homes. The industry reports that the federal funds were essential to offset the increased costs and decreased revenue that has accompanied the PHE. The Commission estimated that these funds would have underwritten the expected reductions to net revenues and increased costs for 8 to 10 months from the beginning of the PHE, though the impact would vary considerably across individual facilities. Evidence from two large nursing home companies illustrates the uneven and uncertain effects of COVID-19 on nursing home providers' finances, with one company unsure it will survive through 2021 and another returning federal funds after recording record profits (Ensign Group 2020, Genesis Healthcare 2020).

In addition to federal assistance, many states temporarily raised Medicaid rates (Flinn 2020b). Some REITs offered rent reductions to offset the financial difficulties some operators faced; these reductions are likely to be offered in 2021 as well (Spanko 2020b). In mid-December 2020, LTC Properties, a publicly traded REIT, announced that it would lower the rent escalators for its operating partners (LTC REIT 2020).

Although the PHE has had a profound impact on the industry, analysts remain optimistic about the sector (Cain Brothers 2020, Fitch Ratings 2020). The total margins are slim and occupancy rates will be slow to fully rebound, but the industry has the advantages of demographic trends and of being a lower cost alternative to other institutional PAC. Further, investors consider the setting a relatively "safe bet" given its reliance on government funds (Spanko 2020a). Any reluctance to invest in this setting does not reflect the adequacy of Medicare's FFS SNF payments: Medicare remains a preferred payer.

Medicare payments and providers' costs: Medicare margins remained high in 2019

In 2019, the aggregate Medicare margin for freestanding SNFs was 11.3 percent. Margins for individual facilities varied considerably across providers. Large SNFs, SNFs with lower average daily costs, and for-profit facilities had

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

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

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

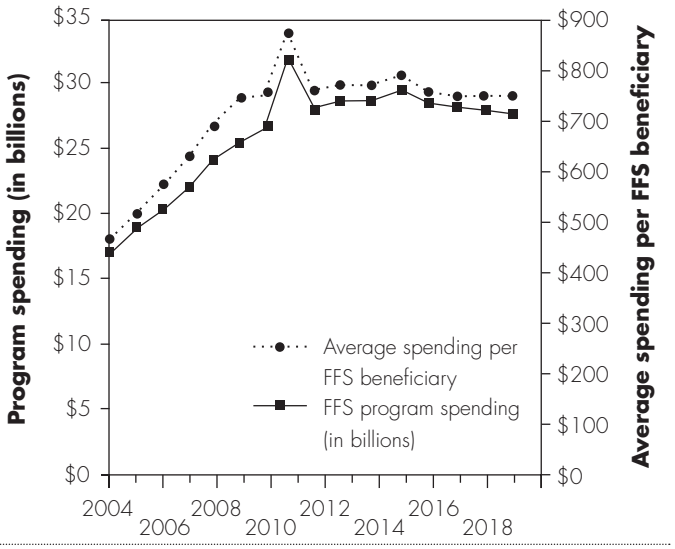
much higher margins compared with other facilities. The 9 percent of freestanding facilities defined as relatively efficient—providers with consistently low costs and higher quality care, in relative terms—had a median Medicare margins of over 19 percent, indicating Medicare overpays freestanding facilities for this care. Some MA plans' payment rates were considerably lower than Medicare's FFS payment rates, and the disparity is unlikely to be explained by differences in patient acuity.

Trends in FFS spending and cost growth

In fiscal year 2019, CMS estimates that Medicare FFS spending for SNF services was $27.8 billion, almost 2 percent less than in 2018 (Figure 7-1, p. 212) (Office of the Actuary 2020b). Between 2004 and 2010, program spending increased an average of almost 8 percent a year. In 2011, program spending was unusually high because rates for a new case-mix classification system included an adjustment that was too large for the mix of rehabilitation therapy modalities (i.e., individual versus group or concurrent) assumed in setting the rates. The industry took advantage of the new policies by quickly shifting its mix of modalities, and in 2011, spending increased by over 19 percent. To correct for the excessive payment, CMS revised the adjustment downward in 2012; as a result, total payments declined that year over 12 percent. Since 2013, program spending and spending per FFS beneficiary have declined by 3 percent and 5 percent, respectively. These declines reflect growing beneficiary enrollment in MA (whose spending on SNF care is not included in FFS spending data) and greater provider participation in APMs, which create incentives for participating entities to lower SNF use. Lower hospitalization rates are also a contributing factor.

Between 2018 and 2019, adjusted costs per day for freestanding facilities grew 1.5 percent. The low growth rate is likely due in part to lower therapy costs that accompanied the implementation of the new case-mix

FIGURE 7–1 **Since 2015, FFS program spending on SNF services has declined**



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year–incurred spending (that excludes cost sharing) is shown.

Source: Office of the Actuary 2020b.

system. Between 2018 and 2019, average ancillary costs per day decreased 0.8 percent.

Consistent with past years, there were differences by ownership in the growth rates and level of costs. For example, between 2018 and 2019, nonprofit facilities' costs grew 2.1 percent compared with 1.3 percent growth at for-profit facilities. In 2019, nonprofit facilities also had higher average costs per day (12 percent higher) than did for-profit facilities in part because they are smaller and have lower average daily census, so they cannot achieve the same economies of scale as larger for-profit facilities.

SNF Medicare margin remains high

The Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's FFS payments with providers' costs to treat FFS beneficiaries. In 2019, the aggregate Medicare margin for freestanding SNFs was 11.3 percent. The Medicare margin increased from 2018 because SNFs kept their cost growth below the average increase in per day payments (2.5 percent). This marks the 20th consecutive year that SNFs' aggregate Medicare margin was over 10 percent (Figure 7-2).

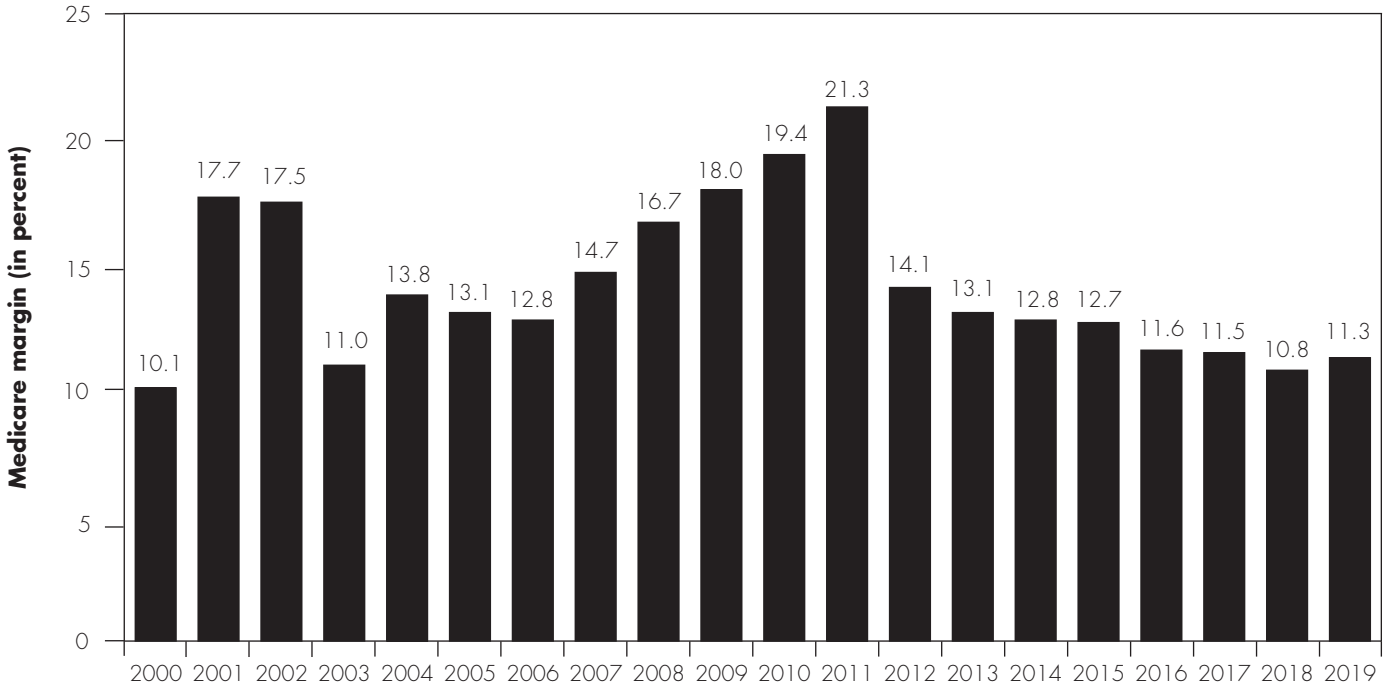
In 2019, hospital-based facilities (3 percent of program spending on SNFs) continued to have an extremely negative Medicare margin (–64 percent; data not shown), in part because of the higher cost per day reported by hospital-based SNFs. However, hospital administrators consider their SNF units in the context of the hospital's overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their SNF beds, thus making inpatient beds available to treat additional inpatients.

SNF Medicare margins varied widely in 2019

Medicare margins varied widely across freestanding SNFs (Table 7-5, p. 214). One-quarter of SNFs had Medicare margins that were 21.3 percent or higher; one-quarter had margins that were –0.9 percent or lower. Medicare margins reflect the economies of scale that larger SNFs are able to achieve. Small (20 to 50 beds) and low-volume facilities (bottom quintile of total facility days) had low aggregate Medicare margins (–3.7 percent and –0.8 percent, respectively) compared with large and high-volume facilities (12.8 percent and 14.4 percent, respectively). SNFs with the lowest cost per day (SNFs in the bottom 25th percentile of the distribution of cost per day) had an aggregate Medicare margin that was more than 20 percentage points higher than SNFs with the highest cost per day (SNFs in the top 25th percentile).

High-margin SNFs also pursued revenue strategies by having longer stays and larger shares of intensive therapy days (data not shown). SNFs with the highest Medicare margin (those in the top quartile of the distribution of Medicare margins) had 89 percent of their days assigned to the highest rehabilitation case-mix groups (the ultra-high and very high groups) compared with 81 percent of days for SNFs with the lowest margins (those in the bottom 25th percentile). Previous analysis found these days were more profitable than other types of care and that as therapy provision increased, the increases in costs were outpaced by increases in payments (Medicare Payment Advisory Commission and The Urban Institute 2015, Office of Inspector General 2015). Differences in Medicare margins across providers are likely to change under the new case-mix system.

FIGURE 7–2 **Freestanding SNFs' aggregate Medicare margins have been above 10 percent since 2000**



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

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2019.

Compared with low-margin SNFs, high-margin SNFs had larger shares of Medicaid days and dual-eligible beneficiaries (those who qualify for both Medicare and Medicaid). It is possible that given their large Medicaid mix (and the lower payments typically made by Medicaid), these facilities keep their costs lower, which contributes to their higher Medicare margins.

Since 2006, each year the aggregate Medicare margin for freestanding for-profit facilities has been about 10 percentage points higher than nonprofit facilities' margins, and this trend continued in 2019. The disparity reflects differences in costs and payments. Nonprofit facilities are smaller and have higher per day costs compared with for-profit facilities. They also have lower average payments per day (4 percent lower), in part reflecting their lower share of the high-payment intensive therapy days.

Relatively efficient SNFs further illustrate that Medicare's payments are too high

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The analysis informs the Commission's update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures.

The Commission follows two principles when selecting a set of relatively efficient providers. First, the providers must do relatively well on both cost and quality metrics (see text box on identifying relatively efficient SNFs, p. 215). Second, performance must be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission's approach is to

TABLE 7–5

Variation in freestanding SNF Medicare margins reflects differences in economies of scale, 2019

Provider group	Medicare margin
All providers	11.3%
For profit	14.3
Nonprofit	0.9
Rural	9.6
Urban	11.6
Frontier	6.0
25th percentile of Medicare margins	–0.9
75th percentile of Medicare margins	21.3
Cost per day: High	–0.3
Cost per day: Low	23.3
Small (20–50 beds)	–3.7
Large (100–199 beds)	12.8
Facility volume: Highest fifth	14.4
Facility volume: Lowest fifth	–0.8

Note: SNF (skilled nursing facility). Except for the margins reported for the 25th and 75th percentiles, the margins are aggregates for the facilities included in the group and were adjusted to account for the mix of facilities that had filed cost reports at the time of the analysis. "Frontier" refers to SNFs located in counties with six or fewer people per square mile. "Facility volume" includes all facility days. "Low" is defined as facilities in the lowest 25th percentile; "high" is defined as facilities in the highest 25th percentile.

Source: MedPAC analysis of 2019 freestanding SNF Medicare cost reports.

examine how many providers meet a preestablished set of criteria. It does not establish a set share (for example, 10 percent) of providers to be considered relatively efficient and then define criteria to meet that pool size.

To identify relatively efficient SNFs, we examined the performance of freestanding SNFs with consistent cost and quality performance. To measure costs, we examined costs per day that were adjusted for differences in area wages and case mix. The quality measures were risk-adjusted rates of successful discharge to the community and hospitalizations during the SNF stay (these measures are defined on p. 206). Our analysis included 5,174 SNFs that had quality and cost report information for the 2016 to 2019 period and a minimum of 60 stays a year.

Nine percent of the SNFs met the criteria we use to define relatively efficient providers. Compared with other SNFs in 2019, relatively efficient SNFs had community discharge rates that were 15 percent higher and hospitalization rates that were 21 percent lower (Table 7-6, p. 216). Standardized costs per day were 7 percent lower than other SNFs'. Compared with other SNFs, they had higher shares of ultra-high therapy days, which raises payments per day. The aggregate Medicare margin for these SNFs was high (19.2 percent), indicating that although these providers were relatively efficient, the Medicare program could get better value for its purchases if its payments were lower. The high margin for these providers underscores the need to more closely align its payments with the costs of care.

In contrast to last year's analysis, the measures of economies of scale (average daily census and occupancy) had smaller or no differences between relatively efficient and other SNFs. This is most likely due to the higher minimum stay requirements for the quality measures that exclude small providers from the analysis.

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 Medicare FFS and MA payments. (We use "MA" as shorthand for all managed care payments since MA makes up the majority of rates reported as "managed care payments.") We compared Medicare FFS and MA payments for three companies with SNF holdings for which such information was publicly available (Table 7-7, p. 217). For these companies, Medicare's FFS per day payments were, on average, more than 24 percent higher than MA rates (data not shown).

We do not know whether the lower average daily payment by MA plans reflects differences in service intensity (for example, fewer intensive therapy days), lower payments for the same service, or some combination. It is possible that companies with SNF holdings differ in their ability to negotiate high payment rates from MA plans. We also do not know how these rates compare with rates paid to other SNF chains and independent facilities. However, similar payment disparities were reported by the National Investment Center for Seniors Housing & Care, a nonprofit organization that supports access and choice for

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 of care for three years in a row, 2016 through 2018. The cost per day was calculated using cost report data and was adjusted for differences in case mix (using the nursing component relative weights) and area wages. To assess quality, we examined risk-adjusted rates of successful discharge to the community and hospitalizations during the SNF stay (for definitions of the measures, see p. 206.) To meet a reliability standard of 0.7, only facilities with at least 60 stays were included in the quality measures. To be included in the relatively efficient group, a SNF had to be in the best third of the distribution of at least one measure and not in the bottom third of any measure for three consecutive years. Another criterion was that SNFs not be part of CMS's Special Focus Facility Initiative for any portion of time covered by the definition (2016 through 2018), which excluded one facility from the pool of efficient providers.[14]

We found that 9 percent (or 489 facilities of the 5,174 facilities that met the data requirements for this analysis) of SNFs were relatively efficient. They were more likely to be urban and for profit and were geographically dispersed (located in 40 states plus the District of Columbia).

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

seniors' housing and care, including nursing homes and assisted living. It found that for the 1,537 SNF properties included in its sample, FFS payments per day were 22 percent higher than MA rates (National Investment Center for Seniors Housing & Care 2020).

We compared broad patient characteristics of beneficiaries enrolled in FFS and MA plans and found those differences are unlikely to explain the magnitude of the differences between FFS payments and payments typically made by MA plans. Compared with FFS beneficiaries, MA enrollees were, on average, the same age but had lower risk scores (8 percent lower, indicating fewer comorbidities). Previous analyses have found that MA enrollees were slightly more independent (Medicare Payment Advisory Commission 2020). The considerably lower MA payments indicate that some facilities accept much lower payments to treat MA enrollees who are not that different from FFS beneficiaries. Some publicly traded post-acute care firms with SNF holdings report seeking managed care patients as a business strategy, indicating that the MA rates are attractive.

Payments and costs for 2021

To project the aggregate fiscal year 2021 Medicare margin for freestanding SNFs, the Commission considers the relationship between SNF costs and Medicare payments in 2019 as a starting point. The impact of the coronavirus PHE on providers' volume, costs, and revenues makes this year's projection more uncertain than those made in previous years. Delays in the availability of data have further complicated this estimate. To project the 2021 margin, we made many assumptions about how costs and payments will change and note how better and worse scenarios would affect it.

TABLE 7–6

Financial performance of relatively efficient SNFs is a combination of lower cost per day and higher revenues per day, 2019

Performance in 2019	Type of SNF		Ratio of relatively efficient to other SNFs
	Relatively efficient	Other SNFs	
Rate of successful discharge to the community	53%	46%	1.15
Hospitalization rate	11%	14%	0.79
Standardized cost per day	$312	$335	0.93
Standardized cost per discharge	$8,373	$10,755	0.78
Medicare revenue per day	$547	$517	1.06
Medicare margin	19.2%	11.9%	N/A
Total margin	2.6%	1.0%	N/A
Facility case-mix index	1.41	1.39	1.01
Medicare average length of stay	27 days	31 days	0.87
Occupancy rate	88%	88%	1.00
Average daily census	99	97	1.02
Share ultra-high therapy days	69%	64%	1.08
Share medically complex days	4%	3%	1.33
Medicaid share of facility days	56%	58%	0.97
Share urban	89%	82%	N/A
Share for profit	79%	70%	N/A
Share nonprofit	18%	26%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). To be included in the analysis, the SNF had to have quality and cost report information for 2016 to 2019 and a minimum of 60 days a year. The number of freestanding facilities included in the analysis was 5,174, of which 489 (or 9 percent) were identified as "relatively efficient" based on their cost per day and two quality measures (community discharge and readmission rates) between 2016 and 2018. Relatively efficient SNFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of three years and were not a facility under "special focus" by CMS. Costs per day and per discharge were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted successful discharge to the community (higher rates are better) and hospitalization during the SNF stay (lower rates are better). "Ultra-high therapy days" include days assigned to ultra-high case-mix groups. "Medically complex days" includes days assigned to clinically complex and special care case-mix groups. Table shows the medians for the measure.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2016–2019.

Our projections include assumptions about COVID-19–related costs that we expect to remain for the foreseeable future and therefore should be incorporated into the update. Compared with 2019, we expect higher PPE and testing costs to continue to be a part of SNFs' operating costs. While we expect the pricing of PPE to return to prepandemic levels, its use is likely to remain high. Regarding testing, we expect vaccines will become widely available in the first half of 2021. Clearly, a vaccine will affect case rates and the frequency of testing. However, even with a vaccine, we expect facilities will continue to test staff at regular intervals and to test residents suspected of having the virus. Further, vaccine hesitancy will contribute to lingering case rates. But as county-level infection rates subside, we expect testing frequency to abate.

To estimate costs for 2020 and 2021, we assumed that all costs would increase at a rate equal to the average of the annual changes between 2016 and 2019 (2 percent), with additional cost increases for PPE and testing as discussed below. Between 2016 and 2019, cost growth was below the market basket, in part due to declining volume each year. During this period, annual volume reductions

TABLE 7–7

Comparison of Medicare fee-for-service and managed care daily payments to three companies, 2019

	Medicare payment		
Company	**FFS**	**Managed care (MA)**	**Ratio of FFS to MA payment**
Diversicare	$491	$407	1.21
Ensign Group	671	498	1.35
Genesis HealthCare	565	480	1.18

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

Source: Second quarter 10–Q 2020 reports available at each company's website.

ranged from 3.6 percent to 5.0 percent, yet costs per day increased between 1.5 percent and 2.5 percent. If volume reductions were larger than estimated, cost growth might be lower, which would increase the projected margin (and conversely, higher-than-expected cost growth would lower the projected margin). However, a major component of SNF costs, labor, appears to be relatively slow to respond to declines in volume. For the 2016 to 2019 period, data from the Bureau of Labor Statistics indicate that decreases in employees were much smaller than the reductions in volume. Between January and September 2020, increases in weekly earnings (that reflect overtime and pandemic premium pay) offset much of the decline in number of employees.

We do not have accurate data on the increased costs for PPE, cleaning supplies, and testing during the PHE or afterwards, so we estimated them as follows:

- PPE and cleaning costs—We calculated the nonlabor share of facility costs in 2019 for four supply cost centers in the Medicare cost report, including central supplies, laundry and linen, medical supplies charged to patients, and housekeeping. These supply costs account for 2.3 percent of total facility costs. After increasing Medicare costs by 2 percent, we took 2.3 percent of costs and increased it by 25 percent to account for increased use and prices. Although there was considerable surge pricing early in the PHE, by late summer of 2020 prices had begun to moderate, and we expect them to become more normal in 2021. We expect PPE use to remain high for the foreseeable future. Higher PPE costs would increase cost growth and lower the projected margin.
- Testing costs—To date, the Department of Health and Human Services (HHS) has provided most SNFs with testing machines so facilities can conduct timely, point-of-care testing of their employees and residents. We assumed that, by 2021, all facilities would be able to conduct in-house testing at an estimated cost of $5 per test. We assumed that SNFs would make arrangements to retest all residents and staff who had positive or suspicious results (estimated at 10 percent of the in-house tests conducted) at an estimated cost of $87.50 per test (more accurate tests are generally more costly).
  - We assumed facilities would test all employees monthly and that providers would assume these costs. We apportioned this cost to Medicare based on its share of facility costs.
  - Regarding residents, current HHS guidance is to not conduct routine testing of asymptomatic residents. We assumed that as of 2021, the rate of point-of-care testing would be half of the rate reported by facilities for the week of December 13, and we apportioned this cost based on Medicare's share of facility residents.
  - The combined cost of testing staff and residents added over $54 million (or 0.2 percent) to Medicare's estimated costs for 2021. Higher

testing rates (such as weekly testing) or higher cost per test would increase cost growth and lower the projected margin.

To estimate payments in 2020 and 2021, we assumed that payments each year would increase by the required updates, 2.4 percent and 2.2 percent, respectively. We also factored in the suspension of the 2 percent sequestration reduction to payments from May 1, 2020, through March 31, 2021.

We estimated that volume declines would lower aggregate revenues in 2020 and 2021. We assumed that before the PHE, volume would continue to decline at the same rate as the decline between 2018 and 2019. During the PHE, the industry reports that the skilling-in-place policy tempered what would have otherwise been larger declines in Medicare revenue. After the PHE, we expect that volume will be slow to recover as some beneficiaries remain reluctant to use SNFs. Therefore, for the period after the PHE, we assumed a larger decline in volume than the recent (2018 to 2019) decline. To estimate aggregate revenue, we calculated a weighted average of the volume declines during the months pre-PHE, the duration of the PHE, and the months post-PHE. If volume declines are larger than projected, without commensurate reductions in costs, the Medicare margin will be lower than estimated. Conversely, if volume rebounds more than projected, without commensurate increases in costs, the estimated margin would increase.

We also factored in higher payments under the new case-mix system in 2020 and 2021. Based on industry reports that providers have not coded certain patient characteristics, we assumed that providers would continue to improve their coding in 2021. Larger or smaller increases in payments as a result of the new case-mix system will raise or lower the projected margin.

We expect the aggregate Medicare margin to decrease in 2021 due to cost growth that will exceed the payment updates. Although the elevated COVID-19–related costs of 2020 will subside, the costs for PPE and testing in 2021 will remain high relative to 2019 because the industry will have incorporated infection control and COVID-19 monitoring into its standard operating practice. Given the many uncertainties regarding costs and volume post-PHE and the impact of the new case-mix system, the Medicare margin projected for 2021 is highly uncertain. We estimate that the aggregate Medicare margin for freestanding SNFs will be 10 percent, though different assumptions about costs, volume, and revenues will raise or lower the projection.

How should Medicare payment rates change in 2022?

In considering how payments should change for 2022, we note that current law is expected to increase payment rates by 2 percent in 2022 (a market basket increase of 2.3 percent less a 0.3 percent productivity adjustment). As discussed above, SNFs' Medicare margin will depend on many factors that are unknown, including how much the elevated COVID-19–related costs remain a part of facilities' operations, the degree to which one or more vaccines reduce the frequency of testing, whether SNF volume reverts to pre-PHE trends, and the degree to which facilities adjust their costs to changes in volume.

Further complicating this picture is the impact of the new case-mix system. Although CMS estimated the redesign to be budget neutral, initial evidence suggests that it has raised payments. The PHE may delay any CMS action to revise payments so they are aligned with the cost of care.

Pre-PHE, indicators of the adequacy of Medicare's payments are positive. Supply has been relatively stable for years, and access has been good. Although service use declined, it is not a reflection of Medicare's payments: Medicare is a preferred payer. In 2019, the marginal profit for freestanding SNFs was high (19.7 percent), indicating facilities with an available bed have an incentive to admit Medicare patients. Pre-PHE, access to capital was good and is expected to remain so in 2022. Quality of care has improved slightly over time. The aggregate Medicare margin for freestanding SNFs has been above 10 percent since 2000. Relatively efficient SNFs had a median Medicare margin of 19.2 percent in 2019, further evidence that the level of payments is too high relative to the cost of care. Furthermore, FFS payments were considerably higher than the MA payments made to some SNFs, suggesting that many facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries. These factors show that the PPS continues to exert too little pressure on providers.

RECOMMENDATION 7

For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for skilled nursing facilities.

RATIONALE 7

Indicators of the adequacy of Medicare's payments are positive and are expected to remain so, despite the devasting impact of COVID-19 on nursing home staff and residents. There are many uncertainties about the pandemic's long-term effects on nursing homes, but Medicare payments are expected to be more than adequate to accommodate the elevated costs and the sluggish volume returns that we have factored into our estimates of projected Medicare margin. The aggregate Medicare margin in 2019 for freestanding SNFs was 11.3 percent and is expected to be about 10 percent in 2021, indicating that payments will remain more than adequate to ensure beneficiary access to SNF care without an update to the base rate.

The level of Medicare's payments indicates that a reduction to payments (i.e., not simply maintaining payment rates at current levels) is needed to align aggregate payments to aggregate costs. However, given the uncertainty over how long the PHE will last and what its long-term effects will be, the Commission will proceed cautiously in considering recommendations to lower SNF payments to more closely align them to costs. A zero update would begin to align payments with costs while exerting pressure on providers to keep their cost growth low. The Commission will monitor beneficiary access, quality of care, and providers' financial performance and will consider future recommendations regarding the level of payments.

While Medicare's payments are more than adequate to cover the costs to treat beneficiaries during their SNF stays, nursing homes may need additional financial support in 2021. However, an update to Medicare's per day payments in fiscal year 2022 would be a poor approach to providing this support because assistance would not begin until October 2021. Instead, if additional financial support is required, it should be separate from the annual update and targeted to facilities that have been especially affected by the PHE.

IMPLICATIONS 7

Spending

- Relative to current law, this recommendation would lower program spending by between $750 million and $2 billion for fiscal year 2022 and between $1 billion and $5 billion over five years. Program savings would occur because current law requires market basket increases for 2022 that would raise program spending relative to spending that would occur if payment rates remained at the 2021 levels.

Beneficiary and provider

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

Medicaid trends

Section 2801 of the Affordable Care Act requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers with a significant portion of revenues or services associated with Medicaid. We report on nursing home spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2018).

Medicaid covers nursing home (long-term) care and a portion of the skilled nursing care furnished to beneficiaries who are dually eligible for Medicaid and Medicare. Medicaid pays the dual-eligible beneficiaries' Medicare copayments that begin on day 21 of a SNF stay and for any skilled care for beneficiaries who exhaust their Part A coverage (that is, if their Part A stay exceeds 100 days). Medicaid also pays for long-term care services that Medicare does not cover.

Count of Medicaid-certified nursing homes

Between 2019 and 2020, the number of nursing facilities certified as Medicaid providers declined approximately 0.7 percent to 14,784, similar to the decline of Medicare providers (Table 7-8, p. 220). We do not know whether the providers that terminated participation in the Medicaid program remained open but no longer accepted Medicaid patients, closed, or were purchased by another entity and remained open.

TABLE 7–8

The number of nursing homes treating Medicaid enrollees declined slightly from 2019 to 2020

					Average annual percent change	
	2016	2018	2019	2020	2016–2019	2019–2020
Number of facilities	15,057	15,007	14,889	14,784	–1.11%	–0.71%

Note: The 2020 number is through November of that year; it does not include data from the full calendar year. Counts include dually certified skilled nursing facilities/nursing facilities, distinct-part skilled nursing facilities/nursing facilities, and nursing facilities.

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2016–2020.

In 2020, of the 14,744 Medicaid nursing homes active in January, approximately 0.7 percent of providers had terminated as of November, while many providers opened during the same period (data not shown). The share of facilities that terminated varied by state. States with the highest termination rates during this period included Washington (3 percent) and Florida, Massachusetts, Texas, and Wisconsin (1 percent each). Historically, the lower payment rates paid by MA plans and their lower use of these facilities, as well as the overexpansion of supply in states with no certificate-of-need laws (such as Texas) contributed to these facilities' fiscal pressures.

The decline in the count of Medicaid-certified nursing homes may also reflect the expansion in some states of home- and community-based services (HCBS), which allow beneficiaries to remain in their homes rather than in an institution. State HCBS waivers and federal initiatives have accelerated the trend toward HCBS. In September 2020, CMS announced $165 million in supplemental funding to help certain state Medicaid programs transition individuals with disabilities and older adults from nursing facilities to home and community-based settings (Centers for Medicare & Medicaid Services 2020a). In fiscal year 2020, 47 states expanded the number of beneficiaries served by HCBS, a decrease from 48 states in fiscal year 2019 (Gifford et al. 2019, Gifford et al. 2018).

Spending

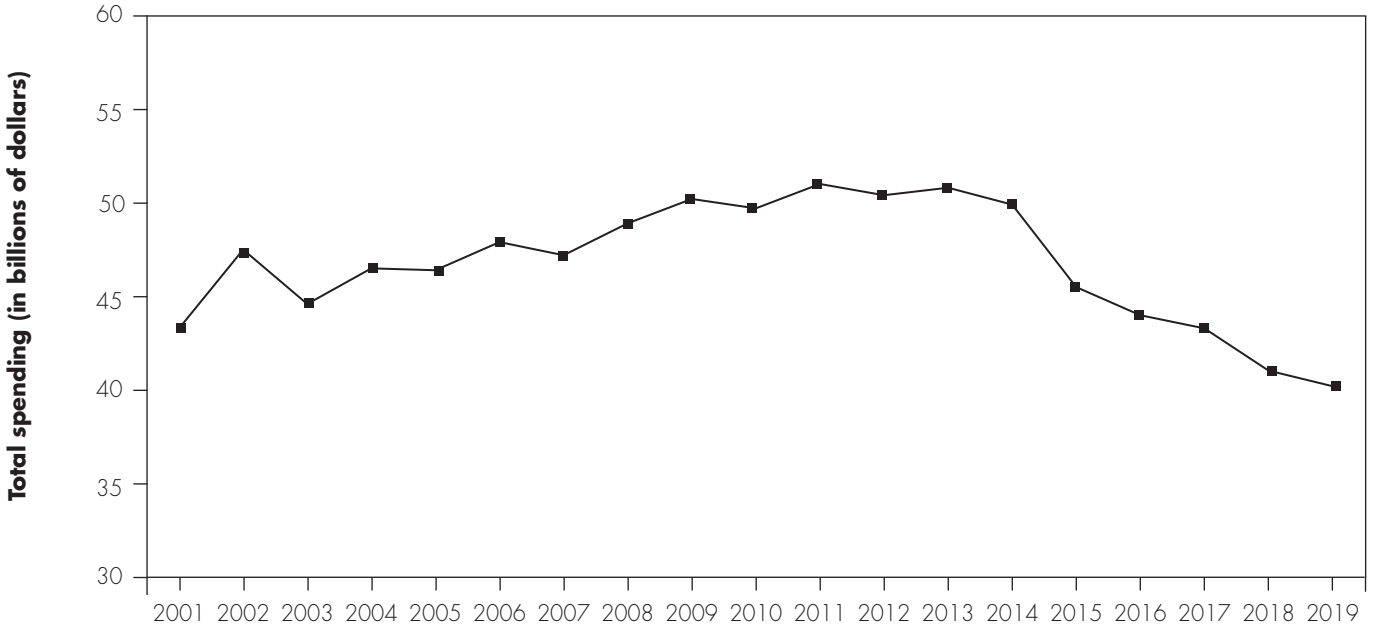
FFS spending on Medicaid-funded nursing home services (combined state and federal funds) totaled $39 billion in 2019 (Figure 7-3) (Office of the Actuary 2020a). CMS estimates that FFS Medicaid spending on nursing home services between 2017 and 2019 decreased 5 percent each year. The trend of lower spending is in part due to an increased use of managed care organizations, whose spending is not included in these data. As of July 2019, 25 states operated Medicaid managed care for long-term services and supports (Gifford et al. 2019). This figure represents a 56 percent increase from 2012, when only 16 states had such programs (Lewis et al. 2018). Year-to-year changes in spending have been variable, increasing in some years and decreasing in others, with overall spending in 2020 below what it was in 2001. The large decreases in FFS Medicaid spending beginning in 2015 reflect increased enrollment in Medicaid managed care.

Analysis of Medicaid rate-setting trends before the PHE found that 8 states restricted (froze or reduced) rates paid to nursing homes in 2020, while 40 states plus the District of Columbia increased nursing facility rates, with two states not reporting data (Gifford et al. 2019). In 2019, 10 states restricted rates to nursing homes and the same number of states increased rates (40 states plus the District of Columbia) (Gifford et al. 2018).

States continue to use provider taxes to raise federal matching funds. In fiscal year 2020, 44 states and the District of Columbia levied provider taxes on nursing homes to increase federal matching funds (Gifford et al. 2019).[15] New Mexico has implemented a provider tax on nursing facilities, bringing the total number of states with taxes on nursing facilities to 45 states and the District of Columbia. The augmented federal funding may be split with the nursing homes.

FIGURE 7–3

Medicaid fee-for-service spending on nursing home services, 2001–2019



Note: Spending does not include any managed care organization spending on nursing homes.

Source: Office of the Actuary 2020a.

The majority of states (36 plus the District of Columbia) have expanded their Medicaid programs since the passage of the Affordable Care Act. More states (Missouri, Oklahoma, Utah) have passed initiatives to expand their Medicaid programs as of November 2020; however, some of these initiatives have not yet received CMS approval (National Academy for State Health Policy 2020).

The coronavirus pandemic is likely to have mixed effects on FFS Medicaid spending on nursing home services in 2020 and 2021. Spending will decrease because the industry overall has faced volume declines caused by potential residents avoiding this setting, some residents moving out, resident mortality, and the temporary skilling-in-place policy which shifted the financial responsibility for some care from Medicaid to Medicare. Countering these downward trends are the temporary increases in FFS Medicaid nursing home rates in 37 states (Kaiser Family Foundation 2020). We do not know whether these higher payment rates will cover the increased costs associated with more medically complex COVID-19 patients and the higher costs of PPE and testing.

Total and non-Medicare margins in nursing homes in 2019

Nursing homes' total margin reflects all payers (including all FFS and managed care funds from Medicare, Medicaid, and private insurers) across all lines of business (for example, nursing home care, hospice care, ancillary services, home health care, and investment income). In 2019, the aggregate total margin was 0.6 percent (Table 7-9, p. 222). Since 2000, except for 2018 (when the total margin was slightly negative), the total margin has ranged from 0.4 percent to 3.8 percent (data not shown).

Total margins in 2019 varied considerably: The median was 0.7 percent; 25 percent of nursing homes had total margins of –5 percent or lower and 25 percent of homes had total margins of 5.5 percent or higher (data not shown).

Nursing homes' total margins have declined since 2013, reflecting factors previously discussed: the impact of Medicare payment reductions mandated by the Congress,

TABLE 7–9 **Total and non-Medicare margins improved in 2019**

Type of margin	2015	2016	2017	2018	2019
Total margin	1.6%	0.7%	0.6%	–0.3%	0.6%
Non-Medicare margin	–2.1	–2.4	–2.4	–3.2	–2.0

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

Source: MedPAC analysis of Medicare freestanding SNF cost reports for 2015 to 2019.

the growing share of facilities' revenues attributed to MA plans (whose payments are lower than Medicare's FFS payments), fewer high-payment Medicare FFS patients, and lower average occupancy rates (which raise the average cost per day).

Nursing homes' non-Medicare margins reflect the profitability of all services except FFS Medicare–covered SNF services. The aggregate non-Medicare margin in 2019 was –2 percent, an improvement from 2018. ■

Endnotes

1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay is paid for by Medicare (Part A). Some beneficiaries who no longer qualify for SNF Medicare coverage remain in the facility to receive long-term care services, which are not covered by Medicare. During long-term care stays, beneficiaries may receive care, such as physician services, outpatient therapy services, and prescription drugs, that is paid for separately under the Part B and Part D benefits. Services furnished outside the Part A–covered stay are not paid under the SNF prospective payment system and are not considered in this chapter. Except where specifically noted, this chapter examines fee-for-service (FFS) Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans. Some beneficiaries also qualify for Medicaid and are referred to as "dual-eligible beneficiaries."

2 Throughout this chapter, we use the term "FFS Medicare" as equivalent to the CMS term "Original Medicare."

3 A spell of illness ends when there has been a period of 60 consecutive days during which the beneficiary was an inpatient of neither a hospital nor a SNF. Coverage for another 100 days does not begin until a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day hospital stay requirement. In 2015, the Commission recommended that the time spent in observation care count toward the three-day requirement as long as the patient was formally admitted and had at least one day as an inpatient (Medicare Payment Advisory Commission 2015). The requisite prior three-day hospital stay was temporarily waived during the coronavirus public health emergency.

4 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021, for an additional 90 days.

5 For services to be covered, the SNF must meet Medicare's requirements of participation and agree to accept Medicare's payment rates. Medicare's requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day, providing physical and occupational therapy services and speech–language pathology services as delineated in each patient's plan of care, and providing or arranging for physician services 24 hours a day in case of an emergency.

6 Rural counties are those that are not in or adjacent to metropolitan or micropolitan areas and are defined using Urban Influence Codes 11 and 12.

7 The program pays separately for some services, including certain chemotherapy drugs, certain customized prosthetics, certain ambulance services, and radioisotope services. All physician services are paid separately under Part B.

8 The Commission and the Office of Inspector General called for a redesign that would vary payments based on patient characteristics rather than the amount of therapy furnished (Medicare Payment Advisory Commission 2008, Office of Inspector General 2015).

9 A description of the SNF PPS is found in *SNF Payment Basics*, available at http://medpac.gov/-documents-/payment-basics.

10 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:

Marginal profit = (payments for Medicare services – (total Medicare costs – fixed building and equipment costs)) / Medicare payments

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.

11 The risk adjustment for the successful discharge to the community measure includes age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for entitlement, principal diagnosis, comorbidities, the length of stay of the preceding hospital stay (if there was one), and a count of the hospitalizations during the preceding year. Risk adjusters for the hospitalization measure include primary diagnosis, comorbidities and severity of illness, special conditions (severe wounds, difficulty swallowing, and bowel incontinence), age and sex, disability and ESRD status, hospitalization in the previous month, days in the intensive care unit during a preceding hospitalization (if there was one), a count of the hospitalizations during the preceding year, and the provision of ventilator care during the PAC stay. Providers with at least 60 stays in the year, the minimum count to meet

a reliability of 0.7, were included in calculating the average facility rate.

12 Because the sequestration is not applied to beneficiary copayments, the reduction to SNF payments is slightly lower than 2 percent.

13 Affiliates of chains with more than 500 employees were not eligible for the paycheck protection program, even if individual nursing homes had fewer than 500 employees.

14 The Special Focus Facility Initiative is a program to stimulate improvements in the quality of care at nursing homes with a history of serious quality problems. The initiative targets homes with a pattern over three years of more frequent and more serious problems (including harm or injury to residents) detected in their annual facility surveys. Facilities that improve and maintain those improvements can "graduate" from the program. Providers that do not improve face civil monetary penalties (fines) and eventual termination from Medicare and Medicaid.

15 A provider tax works as follows: A state taxes all nursing homes and uses the collected amount to help finance the state's share of Medicaid funds. The provider tax increases the state's contribution, which, in turn, raises the federal matching funds. The augmented federal funds more than cover the cost of the provider tax revenue, which is returned to providers. The provider tax is limited to 6 percent of net patient revenues.

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