

CHAPTER

7

Skilled nursing facility services

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

- 7** For fiscal year 2023, the Congress should reduce the 2022 Medicare base payment rates for skilled nursing facilities by 5 percent.

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

Skilled nursing facility services

Chapter summary

In skilled nursing facilities (SNFs), Medicare covers short-term skilled nursing and rehabilitation services to beneficiaries after an inpatient hospital stay. In 2020, about 15,000 SNFs furnished 1.7 million Medicare-covered stays to 1.2 million fee-for-service (FFS) beneficiaries (3.3 percent of Medicare's FFS beneficiaries). In that year, Medicare FFS spending on SNF services was \$28.1 billion. Most SNFs are also certified as nursing homes that furnish long-term care services that the program does not cover.

The effects of the coronavirus pandemic on beneficiaries and nursing home staff have been devastating. However, the combination of federal policies and the implementation of Medicare's new case-mix system resulted in considerably improved financial performance for SNFs in 2020. Some of the changes in our indicators likely reflect the unusual circumstances of 2020 rather than the adequacy of Medicare's payments. In presenting our analyses, we caution against drawing conclusions from certain findings.

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

In this chapter

- Are Medicare payments adequate in 2022?
- How should Medicare payments change in 2023?
- Medicaid trends

of services), quality of care, provider access to capital, and Medicare payments in relation to providers' costs to treat Medicare FFS beneficiaries.

Beneficiaries' access to care—Changes in the indicators of access in 2020 were mixed and reflect the impact of the pandemic, not the adequacy of Medicare's payments.

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program has been fairly stable at about 15,000 for many years. In 2020, the vast majority (88 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). The median occupancy rate declined from 85 percent before the start of the pandemic to 74 percent in September 2021. This decline reflects the impact of the pandemic and is unrelated to the adequacy of Medicare's payments.
- **Volume of services**—Between 2019 and 2020, Medicare-covered admissions per 1,000 FFS beneficiaries dropped 7.9 percent, consistent with the lower number in the early days of the pandemic of admissions for hospital stays lasting at least three days, which is normally required for Medicare coverage. This requirement has been waived during the public health emergency (PHE). Covered days per 1,000 FFS beneficiaries also declined, though not as much (–1.5 percent), since lengths of stay increased. Temporary changes in coverage rules during the coronavirus PHE tempered the reductions in Medicare volume beginning in March 2020. The decline in volume was due to the impact of the coronavirus pandemic, not the adequacy of Medicare payments.
- **Medicare marginal profit**—Medicare marginal profit (an indicator of whether SNFs have an incentive to treat more Medicare beneficiaries) averaged 25 percent for freestanding facilities in 2020. This high level is a strong positive indicator of beneficiary access to SNF care, though factors other than the level of reimbursement (such as the availability of a bed) could challenge access.

Quality of care—Between 2019 and 2020, rates of successful discharge to the community fell and the rates of hospitalization rose. Given the effects of the pandemic, we do not draw conclusions about whether the changes reflect the adequacy of Medicare's payments.

Providers' access to capital—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Though lending activity stalled in 2020, transactions picked up in 2021, indicating investor interest in this sector.

In 2020, the all-payer total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as skilled and long-term care, hospice, ancillary services, home health care, and investment income)—was 3.0 percent, an increase from 2019. This improvement is due to the general and targeted funding nursing homes received during the PHE, changes in Medicare payments, and the temporary increases in Medicaid rates made by many states.

Medicare payments and providers' costs—Despite the decline in volume, Medicare's aggregate FFS spending between 2019 and 2020 rose 2.7 percent to \$28.1 billion, reflecting the effects of the new case-mix system and PHE-related policies. On a per day basis, payments increased over 8 percent, while costs grew 2.1 percent. The aggregate Medicare margin for freestanding SNFs was 16.5 percent. If we allocate a portion of the reported federal relief funds to Medicare payments, we estimate that the aggregate Medicare margin was 19.2 percent. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth.

The level of Medicare's FFS payments remains well above the cost of Medicare-covered stays. Since 2000, the aggregate Medicare margin has been above 10 percent. The 2020 Medicare margin for efficient SNFs was very high (22.8 percent), though we are reluctant to place much weight on this indicator, given the impact of the pandemic on costs and quality measures. Medicare Advantage plans' payment rates, considered attractive by many SNFs, are much lower than the program's FFS payments, which is unlikely to be explained by the differences in patient characteristics.

How should Medicare payment rates change in 2023?

Considering these factors, the Commission recommends that, for fiscal year 2023, the Congress should reduce the 2022 Medicare base payment rates for skilled nursing facilities by 5 percent. While the effects of the pandemic on beneficiaries and nursing home staff have been devastating, the combination of federal policies and the implementation of the new case-mix system resulted in improved financial performance for SNFs. The high level of Medicare's payments indicates that a reduction to payments is needed to more closely align aggregate payments to aggregate costs.

Medicaid trends

As required by the Affordable Care Act of 2010, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins. Medicaid

finances the majority of long-term care services provided in nursing homes, and some state programs also cover 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 2020 and 2021, the number of Medicaid-certified facilities declined less than 1 percent, to 14,720. Spending was \$39.8 billion in 2020, 3.8 percent less than in 2019. The average non-Medicare margin (which includes all payers and all lines of business except FFS Medicare SNF services) was -0.3 percent, an improvement from 2019. ■

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. The five most common conditions of beneficiaries referred to SNFs for post-acute care from hospital—septicemia, heart failure and shock, joint replacement, respiratory infections, and hip and femur procedures (except major joint replacement)—accounted for 24 percent of cases.¹ In 2020, 1.2 million Medicare fee-for-service (FFS) beneficiaries (3.3 percent of Medicare Part A FFS beneficiaries) used SNF services at least once; program spending on SNF services was \$28.1 billion (about 14 percent of FFS Part A spending) (Boards of Trustees 2021, Office of the Actuary 2021b).² Medicare’s median payment per day was \$539, and its median payment per stay was \$23,494.

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. Beginning with day 21, beneficiaries are responsible for copayments through day 100 of the covered stay. In 2022, the copayment is \$194.50 per day.

To qualify for Medicare coverage, a beneficiary must require daily skilled nursing or rehabilitation services and have had a preceding hospital stay of at least three days.⁴ On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) to help reserve hospital capacity for treating COVID-19 patients. During the PHE, CMS has temporarily waived the three-day prior hospital-stay requirement beginning on March 1, 2020.⁵ This waiver has allowed facilities to treat long-stay residents who required skilled care without a preceding hospitalization, referred to as “skilling in place,” and allowed admissions directly from the community as long as beneficiaries met the other coverage requirements. CMS is also allowing for a one-time extension of the benefit period (for an additional 100 days) for certain beneficiaries.⁶ In fiscal year 2020, about 16 percent of stays were admitted with a PHE-related waiver, the majority of which were the result of

the prior hospital-stay waiver (Centers for Medicare & Medicaid Services 2021b). The temporary policies are scheduled to end when the coronavirus PHE expires (currently slated for mid-April 2022).

Composition of the industry

The term *skilled nursing facility* refers to a provider that meets Medicare requirements for Part A coverage.⁷ Almost all SNFs (more than 94 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 fragmented and characterized by independent providers and local and regional chains. In 2021, the largest nursing home company (Genesis) operated 357 facilities (2.4 percent of all facilities), and the largest 10 companies operated 1,708 facilities (11 percent of all facilities) (Connole 2021). 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).

Most SNFs are freestanding and the majority are for profit (Table 7-1, p. 238). In 2020, 96 percent of facilities were freestanding, and they accounted for a slightly larger share of Medicare stays and spending (97 percent). For-profit facilities accounted for 71 percent of providers, 74 percent of Medicare-covered stays, and 78 percent of Medicare spending. About 11 percent of nursing facilities nationwide are owned by private equity firms (Harrington et al. 2021). Rural facilities make up the minority of providers, stays, and spending.

Freestanding SNFs vary by size. In 2020, the median SNF had 100 beds, but 10 percent of facilities had 176 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).⁸

**TABLE
7-1**

Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, Medicare stays, and Medicare spending, 2020

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total number	13,884	1,722,212	\$24.7 billion
Freestanding	96%	97%	97%
Hospital based	4	3	3
Urban	73	83	84
Rural	27	17	16
For profit	71	74	78
Nonprofit	24	23	20
Government	5	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding and missing values. 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 2020.

FFS Medicare-covered SNF days typically account for a small share of a facility's total patient days (Figure 7-1). In freestanding facilities in 2020, Medicare made up 10 percent of facility days compared with 63 percent for Medicaid. Given Medicare's relatively high payment rates, the program made up a larger share of facility revenue (17 percent). Medicare's shares of days and revenues increased from 2019, in part due to the temporary PHE policies that increased Medicare coverage for stays that otherwise would have been paid by other payers (or out of pocket) and in part due to increases in Medicare's payments.

Effects of the new case-mix system

By statute, Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.⁹ By controlling length of stay, providers can influence how much Medicare will pay them for their services. Information 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.

Beginning on October 1, 2019, CMS implemented a new case-mix system, the Patient-Driven Payment Model (PDPM), which shifted providers' incentives. Six components—nursing, physical therapy, occupational therapy, speech-language pathology, NTA, and room and board—are summed to establish a daily payment.¹⁰ The following patient information is used to adjust payments: the primary reason for treatment, prior surgery, comorbidities, functional status, cognitive status, swallowing and nutritional status, depression, and whether the patient received special treatments (such as ventilator care). By considering more comorbidities and other measures of medical complexity than its predecessor did, the new case-mix system is better able to recognize the higher costs associated with treating patients with COVID-19. To ensure that individual therapy remains the dominant modality, group and concurrent therapies together are limited to 25 percent of total therapy minutes per discipline.

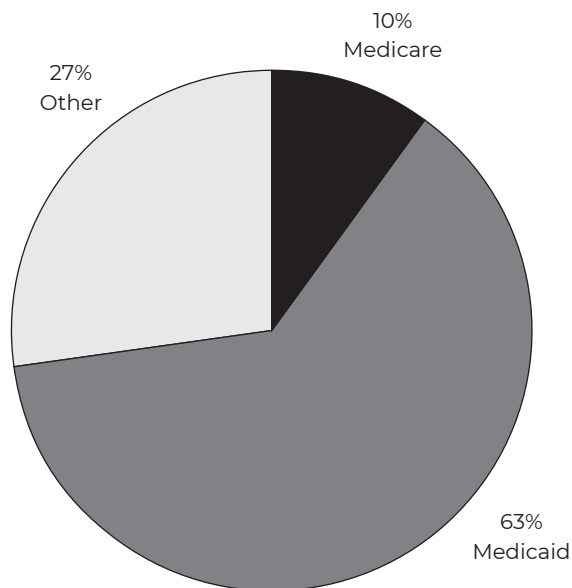
Though intended to be budget neutral, the new case-mix system increased payments in 2020 by 5.3 percent compared with what would have been paid under the old case-mix system (Centers for Medicare & Medicaid Services 2021b). The case-mix indexes (CMIs) for the nursing, speech–language pathology services, and NTA components were higher in 2020 than what CMS had estimated (Centers for Medicare & Medicaid Services 2021b). After comparing the changes in the CMIs with and without the PHE/COVID-19 cases, CMS stated that it believed that the increases in CMIs and payments were largely unrelated to the PHE waivers and COVID-19 diagnoses.

Responding to the incentives of the new case-mix system, providers changed the amounts of therapy furnished and the modalities used. Compared with 2019, therapy minutes per day declined 32 percent prior to the declaration of the PHE in 2020, and the mix of therapy shifted away from individual therapy to the lower-cost group and concurrent modalities (Centers for Medicare & Medicaid Services 2021b). CMS also found that following the implementation of the new case-mix system but before the PHE, there were no changes in the share of stays reporting falls, the share of stays with serious pressure ulcers, or hospital readmissions during the 30 days after discharge from the SNF. After the PHE was declared in January 2020 and facilities limited patient interactions, the use of group and concurrent therapy decreased and individual therapy increased. Other analysis found that the reduction in the provision of therapy was not associated with changes in hospitalizations, lengths of stays, or functional scores at discharge (Rahman et al. 2022).

In the proposed rule updating payments for fiscal year 2022, CMS sought stakeholder input on an approach that, if adopted, would lower payments by 5 percent and on options to ease the transition (delaying or phasing in the reduction). In the final rule, CMS did not lower the level of payments for fiscal year 2022 but instead stated that it would consider the input gathered from stakeholders to develop the best approach to establish budget neutrality, which the agency plans to publish in the fiscal year 2023 proposed rule. CMS also stated that it would continue to monitor all available data and take that into account in its proposed rule.

FIGURE 7-1

FFS Medicare made up a minority of nursing facility days, 2020



Note: FFS (fee-for-service). Data shown are medians. "Other" includes managed care, commercial insurance, and private pay.

Source: Medicare skilled nursing facility cost reports 2020.

Are Medicare payments adequate in 2022?

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 pandemic, starting with the text box on the impact on nursing homes (pp. 240–241).

The impact of the coronavirus pandemic on nursing homes

The coronavirus pandemic and associated public health emergency (PHE) have had tragic effects on beneficiaries' health. (For details on the effects of COVID-19 on beneficiaries' health and access to care, see Chapter 1.) They have had material effects on providers' patient volume, revenues, and costs. The effects of the pandemic have varied considerably both geographically and over time, and it is not clear when or if the full effects will end.

Nursing home residents and staff were hit especially hard by the PHE. Between late May 2020 (when facilities began reporting COVID-19-related information to CMS) and early November 2021, facilities reported almost 1.4 million confirmed cases among residents and staff and 139,729 COVID-19 deaths among residents (Centers for Medicare & Medicaid Services 2021a). The counts for 2020 do not include cases or deaths prior to May 2020, when reporting began, so the totals are actually higher (Shen et al. 2021). After declining in the spring and early summer of 2021, cases and deaths started to increase again due to the Delta variant (Kaiser Family Foundation 2021). Case rates and deaths per 1,000 residents varied widely and were related to the

prevalence of COVID-19 in the community, staffing levels, and facility size—not to quality star ratings or type of ownership (Abrams et al. 2020, Gorges and Konetzka 2021, Gorges and Konetzka 2020). Early in the pandemic, nursing homes with low shares of White residents had higher death rates compared with homes with high shares of White residents, but by April 2021, the two groups had comparable rates (Gilman and Bassett 2021).

Frontline nursing home staff treating COVID-19 cases have faced burnout and risks to their health and safety. Data from the Bureau of Labor statistics indicate a 15 percent drop in employees between February 2020 and September 2021 (Bureau of Labor Statistics 2021). However, the Commission's analysis of Payroll Based Journal data for 2019 and 2020 found that after adjusting for changes in the number of patient days, nursing hours per resident actually increased, thus confirming another study's findings (Werner and Coe 2021). The increases were larger for licensed practical nurses and registered nurses (RNs) compared with certified nursing assistants and aides in training, perhaps because Medicare has staffing requirements that would maintain RN staffing.¹¹ In an analysis of CMS's nursing home

(continued next page)

Beneficiaries' access to care: Decline in volume was due to the impact of the pandemic, not the adequacy of Medicare payments

Although we do not have direct measures of access, we typically examine the supply of providers, changes in service use, and whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. Complicating the assessment is the lack of clear guidelines about when beneficiaries need SNF care as opposed to a different post-acute care (PAC) service or the use of outpatient services (and no PAC). During the PHE, beneficiary access has been especially affected by the local markets' COVID-19

conditions, hospital referral patterns, staffing shortages, and SNF admitting policies.

SNF supply is stable

The number of SNFs participating in the Medicare program in 2021 was fairly stable at 15,064. A majority of the 39 new facilities entering the program in 2021 were for profit. Of the 102 terminations as of October 2021 (less than 1 percent of all SNFs), all but 3 terminated at their own initiative (i.e., they were not terminated by the program).¹² The number of terminations increased from 2020 to 2021, but in both years, there were fewer terminations than at the same point in 2019. Thus, while the PHE may have accelerated terminations

The impact of the coronavirus pandemic on nursing homes (cont.)

COVID-19 data, the National Investment Center for Senior Housing and Care reported that nursing home staff shortages in the wake of the coronavirus pandemic reached a peak in late September 2021, when 23 percent of skilled nursing facilities (SNFs) reported shortages of aides and 20 percent reported shortages of nursing staff (Zahraoui and Kaufman 2021). The study found that nursing homes reporting staff shortages had lower occupancy rates and higher rates of COVID-19 infections.

Nursing homes have benefited from federal grants and loans and temporary policy changes that eased the effect of the decline in volume (and associated revenue) due to the pandemic, as well as COVID-19-related increased costs for staffing, personal protective equipment, infection control, and testing. Our calculations of 2020 Medicare margins do not include the impact of federal relief funds because of the way they are reported on cost reports, though they are included in our calculations of total facility margins. However, these funds were intended to help cover lost revenue and additional costs to treat patients—including Medicare beneficiaries. Therefore, we allocated a portion of these funds to Medicare to estimate their impact on Medicare margins (see discussion, p. 251).

In this chapter, we use available data and changes in payment policy to project SNF margins for 2022 and recommend payment rate updates for 2023. However, significant uncertainty remains about how long the pandemic will last and whether the changes in volume and providers' costs will persist after the PHE. Therefore, while analyzing 2020 data is important, our "usual" indicators of payment adequacy (beneficiary access, quality of care, providers' access to capital, and Medicare costs and payments) are more difficult to interpret this year.

To the extent that the pandemic's effects are temporary—even if over multiple years—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 2023, which also affects payments in future years. For each payment adequacy indicator in this chapter, we discuss whether the effects of the pandemic 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.) ■

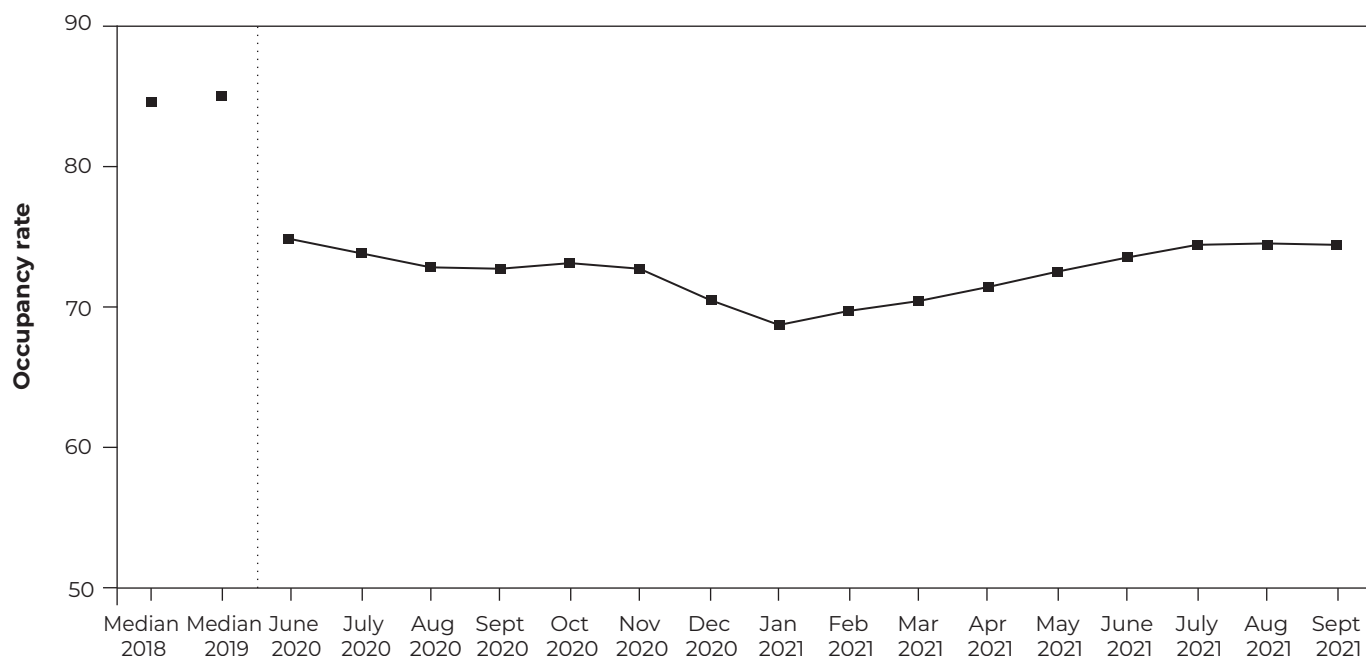
for some facilities, there are other factors in play, such as relatively low Medicaid payment rates, lower payment rates paid by Medicare Advantage (MA) plans, the lower use of SNFs by MA plans and alternative payment models (APMs), and the overexpansion of the SNF supply (in states that do not have certificate-of-need laws). We found that in 2020 and 2021, the rates of termination were comparable between for-profit and nonprofit facilities, consistent with a recent study of nursing home closures since 2015 (Flinn 2020). Terminations may create opportunities for increased industry consolidation. In the SNF industry, consolidations are more likely to occur at the regional or state level because information about potential

referring hospitals, state regulations, and Medicaid policies are essential elements to successful nursing home operations.

In 2020, 88 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). However, 5 percent of beneficiaries lived in counties with no or only one SNF or swing bed facility, up from 3.3 percent of beneficiaries in 2019. If a closure occurs in these counties, beneficiaries who live there might have more difficulty obtaining SNF care. In any county, SNF conversions from multiple-occupancy

FIGURE 7-2

SNF occupancy has slowly recovered from low in January 2021 but remains well below pre-COVID-19 levels



Note: SNF (skilled nursing facility). The values for 2018 and 2019 are medians for a consistent sample of 10,979 SNFs.

Source: MedPAC analysis of COVID-19 nursing home database (2020 and 2021 data); Medicare Provider Analysis and Review data for 2018 and 2019.

to single-occupancy rooms for infection control can also reduce capacity (Stulick 2021).

Lower occupancy rates indicate bed availability for most beneficiaries, but staffing shortages may limit access

Pre-PHE, median occupancy rates for freestanding SNFs were high, though declining over time (from 88 percent in 2010 to 85 percent in 2019). Early in the coronavirus pandemic, hospital admissions were restricted and, as a result, referrals to SNFs waned (Figure 7-2). By June 2020, occupancy rates had fallen 10 percentage points, averaging 75 percent. Even after hospital inpatient volume started to rebound, beneficiaries avoided SNFs when they could be safely discharged home; as a result, admissions remained low, and occupancy rates continued to decline, reaching 69 percent in January 2021.¹³ Since then, occupancy rates

have slowly improved (though they declined slightly in September) but remained 10 points (74 percent) below their prepandemic levels.

Occupancy rates vary widely across facilities. In September 2021, one-quarter of freestanding facilities had occupancy rates at or below 63 percent, while another quarter had rates 85 percent or higher. Given the relatively high occupancy rates in many facilities, a bed may not be available when a beneficiary is seeking placement, particularly if they require special services or are seeking admission to a specific facility.¹⁴

Staffing shortages reported by SNFs also affect access (see text box on the impact of the pandemic, pp. 240–241). The American Health Care Association reported that of the 1,038 nursing facilities surveyed, 58 percent reported having limited new admissions due to staffing shortages (American Health Care Association/National

**TABLE
7-2**

SNF admissions and days continued to decline in 2020

Volume measure	Prepandemic						Average annual change	
	2012	2014	2016	2018	2019	2020	2012–2019	2019–2020
Covered admissions per 1,000 FFS beneficiaries	69.0	68.3	65.9	62.5	59.5	54.8	-2.1%	-7.9%
Covered days per 1,000 FFS beneficiaries	1,893	1,843	1,693	1,559	1,475	1,453	-3.5	-1.5
Covered days per admission	27.4	27.0	25.7	25.0	24.8	26.5	-1.4	6.9

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 2021c.

Center for Assisted Living 2021). Though perhaps more acute this year, staffing shortages are not new to this sector and reflect the low pay, high turnover, and limited benefits common to the industry (Lee 2021).

Between 2019 and 2020, SNF admissions and days decreased

SNF use for all Medicare beneficiaries has been declining for years. The expanded enrollment in MA has lowered SNF use because MA enrollees tend to have shorter SNF stays or avoid the setting altogether. Similarly, more FFS beneficiaries are in entities participating in APMs, such as accountable care organizations and bundled payment demonstrations. APMs create financial incentives for entities to lower their spending and use of services by avoiding PAC altogether (for example, by referring beneficiaries to outpatient therapy instead), shortening SNF stays, and using lower-cost home health care when possible. The declining use is not a symptom of inadequate Medicare payment rates for SNF care. Rather, Medicare's payment rates are high relative to those for other patients, and Medicare is a preferred payer, though 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.

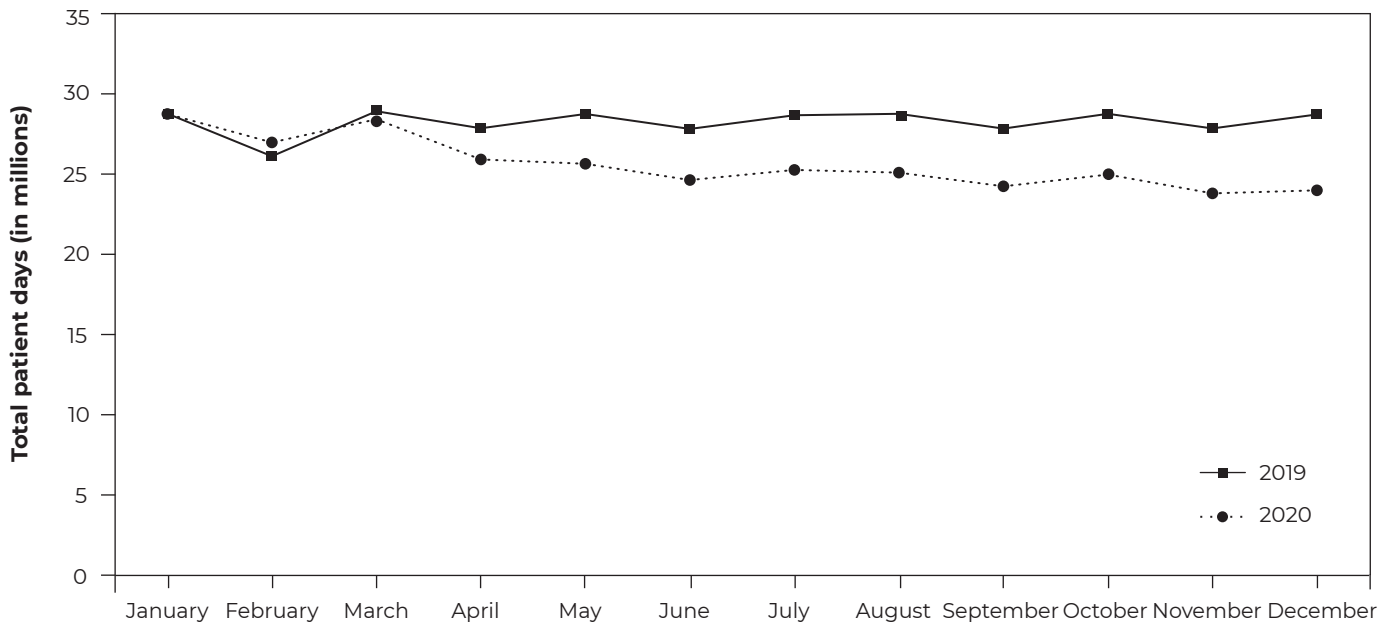
The PHE compounded these secular trends, as hospital referrals shrank in spring 2020 and many beneficiaries who required PAC avoided SNFs if possible. Between January 2020 and December 2020, the share of beneficiaries discharged from a hospital to a SNF declined from 18.9 percent to 13.6 percent. Conversely, during the stay period, the share of beneficiaries going to home health agencies (HHAs) increased from 16 percent to 21 percent. Some observers contend that at least some of the substitution will be permanent (Brown 2021).

Between 2019 and 2020, total FFS discharges and days (i.e., not adjusted for the number of FFS enrollees) decreased 13 percent and 5 percent, respectively. To control for the steady expansion of enrollment in MA, we examine service use per 1,000 FFS enrollees. Between 2019 and 2020, SNF admissions per 1,000 FFS beneficiaries decreased 7.9 percent (Table 7-2) (Centers for Medicare & Medicaid Services 2021c). Because stays were longer, covered days declined at a slower 1.5 percent. Since 2012, admissions per 1,000 FFS beneficiaries have declined over 20 percent and days have decreased over 23 percent.

The decline in SNF use paralleled the large decline (-11.4 percent) between 2019 and 2020 in per capita FFS inpatient hospital stays that were three days or longer.¹⁵ However, even after hospital admissions began to rebound in May 2020, SNF use did not recover

**FIGURE
7-3**

Fewer SNF patient days in 2020 than 2019



Note: SNF (skilled nursing facility).

Source: MedPAC analysis of Payroll Based Journal data, 2019 and 2020.

(Figure 7-3). CMS’s waiver of the required three-day hospital stay tempered what might have otherwise been even larger volume declines as beneficiaries continued to avoid SNF care.

Among SNF patients, the mix of the top diagnosis-related groups (DRGs), which are assigned to the preceding hospital stay, shifted slightly between 2019 and 2020. The share of respiratory and sepsis DRGs increased, while the share of hip and knee procedures decreased. The changes are consistent with the impact of COVID-19: Many COVID-19 cases are assigned to respiratory DRGs (there is not a specific COVID-19 DRG), while the hospital referrals for PAC care after orthopedic procedures shrank in 2020.

Compared with their shares of all FFS enrollees, Black beneficiaries were more likely to use SNF services, while Hispanic and Asian beneficiaries were less likely to use SNF services. Compared with other users, Black, Hispanic, and dual-eligible beneficiaries are more likely to use lower-quality facilities (Zuckerman et al. 2019).

Medicare 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.¹⁶

The Medicare marginal profit in 2020 was 25 percent, indicating that facilities with available beds would have had a strong incentive to admit Medicare patients. This high marginal profit is a very positive indicator

of beneficiary access to SNF care. However, even though providers may have an incentive to treat Medicare beneficiaries, beneficiaries may continue to be reluctant to use SNF services if alternative sources of care are an option (e.g., if they qualify for care at an inpatient rehabilitation facility (IRF) or long-term care hospital (LTCH), or if they are able to receive home health care or outpatient services at home).

Quality of care is difficult to assess

Maintaining high-quality care in the midst of a pandemic challenged many providers (see a discussion of COVID-19 cases and deaths in nursing homes in the text box, pp. 240–241). While we report 2020 results for quality measures we track, these data reflect conditions unique to the PHE that confound our measurement and assessment of trends in 2020. For example, increased mortality due to COVID-19 infection and capacity constraints of acute care hospitals could affect the measures. In addition, the Commission's quality metrics rely on risk-adjustment models that use performance from previous years to predict beneficiary risk; COVID-19, a new diagnosis, is not included in the current models. As a result, our models may not adequately represent the acuity and mix of patients receiving care in 2020. Therefore, we report the changes we have observed in the quality measures but do not draw conclusions about whether quality improved, worsened, or stayed the same in 2020.

We evaluate quality of SNF 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 (beneficiaries who died during the SNF stay are excluded from the measure). Discharges to hospice and beneficiaries with the hospice benefit are excluded from the calculation of both measures. Both measures are uniformly defined and risk adjusted across HHAs, SNFs, IRFs, and LTCHs—thus taking another step

toward achieving a unified payment system and evaluation of patient outcomes across PAC settings.¹⁷

Compared with 2019, the 2020 risk-adjusted rate of successful discharge to the community was lower and the rate of hospitalization was higher (Table 7-3, p. 246); a smaller share of beneficiaries was successfully discharged home (38.6 percent vs. 44.8 percent). Compared with 2019, the 2020 rate of hospitalizations rose from 13.7 percent to 14.2 percent. The differences by ownership and facility type have been consistent for years. We expect quality trends to return to pre-pandemic levels once the PHE is over.

We no longer include measures of patient functional improvement in our assessment of quality. While the Commission contends that maintaining and improving functional status is a key PAC goal, 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).

With a few exceptions, SNFs must participate in a value-based purchasing program (summarized in the text box, p. 247).¹⁸ This program was put on hold during the PHE. Payments to providers continue to be lowered by the requisite 2 percent withhold, and the program retains 40 percent of the withheld amount. However, performance does not influence the amount that is returned to each provider (each receives 60 percent of the 2 percent withheld).

Providers' access to capital remains adequate

Access to capital allows SNFs to maintain, modernize, and expand their facilities. The vast majority of SNFs

**TABLE
7-3**

Changes in SNFs' mean risk-adjusted rates of successful discharge to the community and all-cause hospitalizations between 2015 and 2020

Measure/subgroup	Prepandemic				Average annual change	
	2015	2017	2019	2020	2015–2019	2019–2020
Rate of successful discharge to the community						
All SNFs	43.9%	44.4%	44.8%	38.6%	0.5%	-13.8%
For profit	43.0	43.6	43.7	42.5	0.4	-2.7
Nonprofit	47.2	47.6	48.0	37.6	0.4	-21.7
Freestanding	43.4	44.0	44.4	38.2	0.6	-14.0
Hospital based	52.9	53.8	53.6	48.2	0.3	-10.1
Rate of hospitalization						
All SNFs	15.1	14.4	13.7	14.2	-2.4	3.6
For profit	15.7	14.9	14.2	14.7	-2.5	3.5
Nonprofit	13.3	12.9	12.3	12.6	-1.9	2.4
Freestanding	15.3	14.6	13.8	14.3	-2.5	3.6
Hospital based	10.6	10.2	10.0	10.4	-1.4	4.0

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. Both measures are risk adjusted. 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 reported separately in the table.

Source: MedPAC analysis of SNF claims and linked inpatient hospital stays from 2015 through 2020 for fee-for-service beneficiaries.

are part of a nursing facility. Therefore, in assessing SNFs' access to capital, we look at the availability of capital for nursing homes. 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 nursing homes, capital is less likely to finance new construction than to update facilities or finance purchases of existing facilities due to state certificate-of-need (CON) laws that limit bed supply. The majority of states (35 states plus the District of Columbia) have

CON laws, though 22 states suspended these laws during the PHE.

In 2020, there were fewer mergers and acquisitions (151) compared with 2019 (186) (Irving Levin Associates Inc. 2021). The low level of activity reflected several factors, including the scaling back of real estate investment trusts (REITs) in this setting, uncertainty about the impacts of the pandemic on operations, and questions of how to consider the PHE-related federal funds and policies in assessing an operator's assets. Medicare is a preferred payer, and a high Medicare

Skilled nursing facility value-based purchasing program

As part of the Protecting Access to Medicare Act of 2014 (PAMA), the Congress enacted a skilled nursing facility (SNF) value-based purchasing (VBP) policy that began adjusting payments to providers in October 2018.¹⁹ 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 three 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 public health emergency (PHE), payments are lowered by 1.2 percent (the 2 percent withhold minus the 40 percent retained by the program) for all providers meeting the minimum stay count.

PAMA required the Commission to report on the status of the VBP program and make recommendations as appropriate. In June 2021, the Commission identified five shortcomings of the design that warrant correction: (1) performance is measured with a single measure; (2) the minimum

stay counts do not ensure that the results capture actual performance rather than random variation; (3) the performance scoring includes “cliffs,” or perfunctory cut points, that do not provide enough encouragement for improvement; (4) the design does not address the variation across SNFs in the social risks of their patient populations; and (5) the VBP program does not distribute the entire pool of incentive payments but instead retains a portion as program savings (Medicare Payment Advisory Commission 2021). Although the Consolidated Appropriations Act, 2021, made changes that could improve the program (depending on how they are implemented), the Commission concluded that fundamental flaws remain.

Based on its analysis of an alternative design that would correct the program’s current shortcomings, the Commission recommended that the Congress eliminate the current VBP program and replace it with an alternative design. Because there is not a measure of patient experience, the Commission also recommended that the Secretary finalize development of and begin to report patient experience measures (Medicare Payment Advisory Commission 2021). ■

volume continues to enhance the attractiveness of a potential transaction.

In keeping with previous trends, there is an increasing bifurcation between SNFs that are highly valued (e.g., younger facilities with high shares of Medicare and private-pay patients and high occupancy rates) and those that are not (e.g., older facilities with high shares of Medicaid patients and lower occupancy rates). At the high end, compared with 2019, a larger share of the industry’s transactions in 2020 had average sales prices per bed of \$125,000 or more (17 percent of transactions in 2020 compared with 10 percent in 2019)

(Irving Levin Associates Inc. 2021). SNFs at the low end (under \$50,000 per bed) made up a growing share of transactions (38 percent in 2020, up from 19 percent in 2019) and may represent turnaround opportunities.

In 2021, despite the low occupancy rates and uncertainty about continued federal funding, the industry is reportedly “on fire” with increased mergers and acquisitions (Zorn 2021a). Compared with the first quarter of 2020, the average price per bed in the first quarter of 2021 increased 22 percent (JLL 2021). Historically, buyers tend to be regional, given the premium on knowing the market, potential hospital

and health system partners, and a state's regulatory environment. SNFs that offer specialized care and focus on value will be particularly attractive (Zorn 2021b). Poor-performing SNFs are expected to sell to investors looking for turnaround opportunities. Some nursing homes may have increased demand for capital if they opt to create single-occupancy rooms and negative-pressure rooms and to improve their ventilation and infection control systems.

The Department of Housing and Urban Development (HUD) remains 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. Activity was high in 2021. HUD financed 328 projects, with the aggregate insured amount totaling \$3.9 billion (Department of Housing and Urban Development 2021). The dollar amount was about 10 percent lower than the previous year's, but the number of projects was about the same.

Although the total margins are slim (as discussed below) and occupancy rates may never fully rebound, the SNF sector remains attractive for investors. The aging of the population will maintain demand for SNF and nursing facility services, and the setting has relatively lower costs compared with other institutional PAC. Further, investors consider the setting a relatively "safe bet," given its reliance on government funds (Spanko 2020). Any reluctance to invest in this setting does not reflect the adequacy of Medicare's FFS SNF payments: Medicare remains a preferred payer.

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

During 2020, federal funds and programs greatly assisted this sector in maintaining its operations. General distribution of Provider Relief Fund payments, amounting to 2 percent of total revenues, aimed to help prevent, prepare for, and respond to the coronavirus outbreak and reimburse providers for lost revenues and health care-related expenses attributable to COVID-19. Nursing homes received these general distribution funds and an additional \$10 billion in targeted funds. About half of the targeted funds were earmarked for infection control and creating and maintaining a safe environment, and

\$2.25 billion was slated for quality incentive payments (apart from the VBP program). The incentive funds were disbursed in multiple phases, not all of which are fully captured in the 2020 cost reports. The temporary suspension of the sequestration began on May 1, 2020, and increased Medicare payments by about 1.8 percent.²⁰ Other policies and programs offered additional financial support to providers, including the Medicare accelerated and advance payments program, employer payroll tax deferral, and the Paycheck Protection Program.²¹

The industry trade press and earnings reports for the publicly traded companies confirm 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 reductions to net revenues and providers' higher costs for 11 to 14 months from the beginning of the PHE, though the impact would vary considerably across individual facilities. The experiences of two large nursing home companies illustrate the widely differing effects of COVID-19 on nursing home providers' finances. Facing dire financial circumstances, Genesis Healthcare undertook a strategic restructuring and opted to delist itself from the New York Stock Exchange. Conversely, the Ensign Group has recorded record profits throughout the PHE and returned all federal funds.

In addition to federal assistance, 37 states plus the District of Columbia increased their Medicaid nursing home payment rates in fiscal year 2020, 8 did not, and 5 states did not respond to the survey conducted by the Kaiser Family Fund (Gifford et al. 2020). The survey also reported that in 2021, 30 states planned to increase their rates.

All-payer total margins increased in 2020

The estimated all-payer total margin for nursing homes (reflecting all lines of business and all payers) in 2020 was 3 percent, a considerable improvement from 2019 (when it was 0.6 percent). Between 2019 and 2020, the share of nursing homes with negative margins declined substantially, from 45 percent to 34 percent. These improvements were largely due to the general and targeted funding nursing homes received during the PHE, the changes in Medicare policies, and the temporary increases in Medicaid rates made by many

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

Medicare payments (which are financed by taxpayer contributions to the Part A Trust Fund) to skilled nursing facilities (SNFs) 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 least.

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 to 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 Part A Trust Fund dollars (and taxpayer support) of the low payments made by states and private payers. Moreover, maintaining or raising Medicare's payments would exert additional fiscal pressure on the already fiscally challenged program. If the Congress wishes to financially support certain nursing facilities efficiently, it could do so through a separate, targeted policy. ■

states. The improvement in financial performance is consistent with a recent study of 8 publicly traded REITs and 3 nursing home chains: It found that 9 of the 11 companies reported higher net income in 2020 compared with 2019 (Kingsley and Harrington 2021).²²

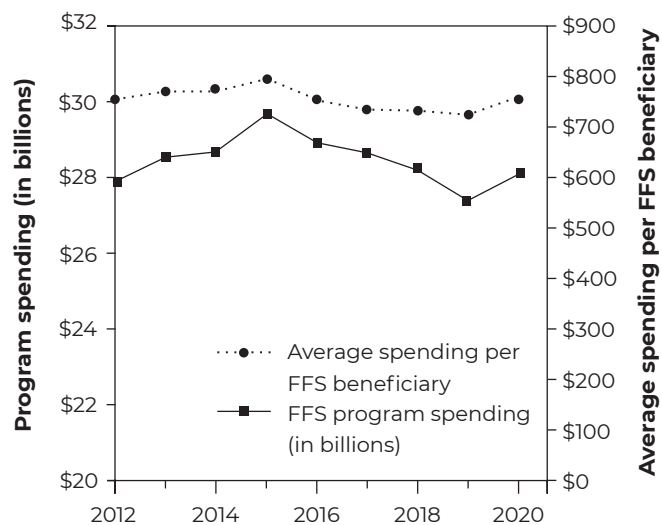
Facilities are required to report the COVID-19 PHE funds in their 2020 Medicare cost reports, and these funds are included in the 2020 total margin.²³ However, the reporting of these funds appears to be incomplete and likely understates total margins. That said, we can use the reported funds to estimate a lower bound on the impact of these funds on total margins. In aggregate, without these additional funds, total margins would have been about -1.8 percent. Clearly, these funds helped compensate providers for the added costs associated with the pandemic. So, while the pandemic has been a tragedy for beneficiaries and

nursing home staff, in aggregate it has not had negative financial impacts on providers. Indeed, the federal funds improved providers' bottom lines and may have averted the closing of some financially distressed providers.

Because the all-payer 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 a certificate of need is required). The industry has long argued that high Medicare margins are needed to subsidize the low payments from Medicaid. The Commission contends that this cross-subsidization is poor policy (see text box on subsidizing payments from other payers).

FIGURE 7-4

After steadily declining since 2015, total FFS program spending on SNF services increased between 2019 and 2020



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

Source: Office of the Actuary 2021b.

SNFs are expected to continue to pursue multiple strategies to enhance their financial performance. These include expanded relationships with accountable care organizations, investments in specialty care (such as dialysis and ventilator care), growth of ancillary businesses (home health care, hospice, pharmacy), and the development of special needs plans (Spanko 2021).

Medicare payments and providers' costs: Medicare margins remained high in 2020

In 2020, Medicare FFS spending on SNF services increased 2.7 percent despite the large decline in volume. Higher payments resulted from the new case-mix system and pandemic-related policy changes. Facilities kept the growth in their costs per day below the update made to payment rates. As a result, between 2019 and 2020, the aggregate Medicare margin for freestanding SNFs rose almost 5 percentage points, climbing from 11.9 percent to 16.5 percent. Medicare margins for individual facilities varied considerably

across providers. Large SNFs, SNFs with lower average daily costs, and for-profit facilities had much higher margins compared with other facilities. Some MA plans' payment rates were considerably lower than Medicare's FFS rates, suggesting that many SNFs are willing to accept these rates to treat beneficiaries.

Trends in FFS spending and cost growth

For fiscal year 2020, CMS estimates that Medicare FFS spending for SNF services was \$28.1 billion, a 2.7 percent increase from 2019 (Figure 7-4) (Office of the Actuary 2021b). Aggregate spending increased despite large volume declines during the PHE and the secular downward trends that reflect expanded enrollment in MA (whose spending on SNF care is not included in FFS spending data) and participation in APMs, which create incentives for entities to lower SNF use. Lower hospitalization rates are also a contributing factor.

Several factors contributed to the increase in program spending. First, the new case-mix system raised payments by over 5 percent compared with what payments would have been under the old case-mix system. Second, the Congress temporarily suspended the sequester that otherwise would have lowered payment rates. Third, the PHE-related policies (the "skilling in place" and the effective extension of the benefit period) shifted spending onto Medicare for beneficiaries whose care would normally not have been covered by the program. Finally, the complexity of patients admitted may have increased because some lower-complexity beneficiaries avoided the setting and SNFs received fewer referrals for care after elective surgery during the spring of 2020. A higher average case mix would increase the average payment per day.

On a per day basis, between 2019 and 2020, the average payment increased 8.6 percent. Per day costs increased 2.1 percent over the same period, considerably higher than the 1.4 percent increase between 2018 and 2019. The relatively high cost growth reflects fewer days over which to spread fixed costs and higher unit costs for labor and PHE-related expenses (e.g., cleaning and personal protective equipment). Between February and December 2020, data from the Bureau of Labor Statistics (BLS) show an 8.2 percent rise in weekly wages, capturing the higher use of more-costly contract labor, overtime, and pandemic premium pay. Countering this relatively high cost growth was

the decline in employment in nursing homes. During the same time period, BLS data show a 9.6 percent decline in the number of employees. One factor was the new case-mix system, which decreased the need for therapy staff. A study found that therapy staffing minutes per day declined 5.5 percent in the week immediately following the PDPM implementation and continued to decline for the next six months (Prusynski et al. 2021). Between 2019 and 2020, ancillary costs per day decreased almost 14 percent.

Consistent with past years, there were differences in cost growth and level of costs by ownership. Nonprofit providers reported larger increases in cost per day compared with for-profit providers (3.8 percent compared with 1.1 percent). Nonprofit providers had 13 percent higher costs per day than for-profit providers, 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 aggregate Medicare margins remain high

The aggregate 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. This year, it is especially hard to assess how much "weight" to give this indicator of payment adequacy, given the unusual circumstances of 2020—the effects of the pandemic on costs, volume, and revenues; the varying impacts of the pandemic over time and by geography; differences in the mix of patients admitted to SNFs during the PHE; and the changes in policies made in response to the PHE. Adding to the mix was the implementation of the new case-mix system in October 2019. Some of the pandemic-related changes will be temporary (such as the policy changes tied to the PHE), while others are expected to be permanent.

Further complicating the picture are differences in the cost reporting periods across providers. The cost reporting periods for SNFs vary, with the midpoint of their reporting period falling in fiscal year 2020. While always true, the differences are more relevant in 2020 because the cost reports include varying numbers of months after the declaration of the PHE, the elimination of the sequester, and the new PDPM case-mix system. About three-quarters of freestanding SNFs are on a calendar reporting year, so their cost reports

include 8 months of relief from the sequester and 12 months of the PDPM. Most of the remaining facilities have July 1 or October 1 reporting period start dates, so their cost reports will reflect pandemic circumstances for different lengths of time. Given the duration of the PHE and related policies and the timing of cost reports, we expect to see effects of these policies on payments and costs in future years' analyses.

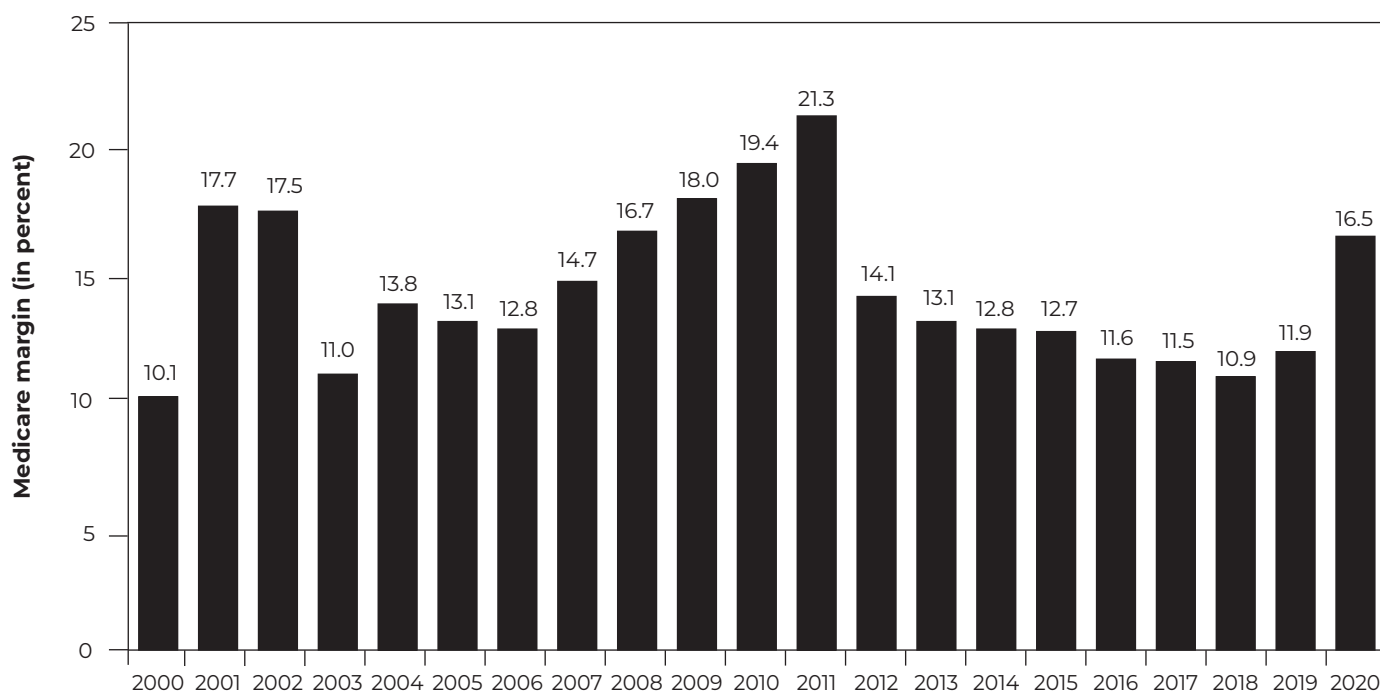
With these caveats in mind, we report the aggregate Medicare margin for all providers and for various subgroups of providers to give a sense of the variation in performance. In 2020, the aggregate Medicare margin for freestanding SNFs was 16.5 percent, a sizable increase from 2019 (Figure 7-5, p. 252). For the 21st consecutive year, the aggregate Medicare margin was above 10 percent. The aggregate Medicare margin increased in 2020 because SNFs kept their cost growth below the payment rate increase and, on the payment side, providers received augmented payments from the new case-mix system and the elimination of the sequester.

The aggregate Medicare margin does not consider the additional federal relief funds providers received. These funds were intended to help cover lost revenue and additional costs to treat patients—including Medicare beneficiaries. Therefore, we allocated a portion of the relief funds based on Medicare's share of total facility days.²⁴ With these additional funds, we estimate that the aggregate Medicare margin was 19.2 percent, assuming these funds did not affect providers' costs. The reporting of these funds appears to be incomplete, in part because some of the funds were disbursed in 2021.²⁵ As a result, the margin that considers these funds may be understated.

Hospital-based facilities (3 percent of program spending on SNFs) continued to have very low negative Medicare margins (the aggregate Medicare margin was -50 percent in 2020 compared with -68 percent in 2019), in part because of the higher costs per day reported by hospitals. 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.

**FIGURE
7-5**

Aggregate freestanding SNF Medicare margins have been above 10 percent since 2000



Note: SNF (skilled nursing facility). Medicare margin is calculated as the sum of Medicare payments minus the sum of Medicare costs, divided by Medicare payments. The margin for 2020 excludes the federal relief funds.

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2020.

Aggregate Medicare margins varied widely in 2020

Aggregate Medicare margins (excluding the federal relief funds) varied widely across freestanding SNFs (Table 7-4). One-quarter of SNFs had Medicare margins that were 28.7 percent or higher; one-quarter had margins that were 4 percent or lower. Twenty percent of providers had negative Medicare margins, a decrease from 2019 (when the share was 24 percent) (data not shown). Compared with urban SNFs, rural SNFs and SNFs located in frontier counties had higher aggregate Medicare margins.

The differences in Medicare margins between for-profit and nonprofit facilities have steadily increased, reaching over 19 percentage points in 2020. The disparity reflects differences in costs per day and, to

a lesser extent, payments. Compared with for-profit facilities, nonprofit facilities are smaller (fewer beds and lower volume), have higher costs per day, and had much higher growth in costs per day between 2019 and 2020. Nonprofit SNFs also had lower payments per day (1.8 percent lower; data not shown).

Differences in aggregate Medicare margins partly 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 average Medicare margins (–0.5 percent and 2.1 percent, respectively) compared with large (100 to 199 beds) and high-volume (top quintile of days) facilities (18.2 percent and 19.9 percent, respectively). SNFs with the lowest cost per day (the bottom 25th percentile of the distribution of cost per day) had Medicare margins

that were more than 30 percentage points higher than SNFs with the highest (in the top 25th percentile) cost per day.

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 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 and their performances must be consistent (see text box for details on identifying relatively efficient SNFs, p. 255). The Commission’s approach is to examine those providers that 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. Then the Commission reports performance of SNFs during the year of performance (this year, 2020), comparing efficient providers with other providers.

In a typical year, the Commission informs its update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures. However, this year the cost and quality measures are sufficiently affected by the pandemic (and its variations over time and by geography) that it may be hard to draw meaningful conclusions from the analysis. We report our findings with the broad caveat that performance in 2020 may have little to do with relative efficiency.

Our analysis included 4,256 SNFs that had quality and cost report information for the 2017 to 2020 period and at least 60 stays each year. Nine percent of the SNFs met the criteria we use to define relatively efficient providers.

Compared with other SNFs in 2020, relatively efficient SNFs had community discharge rates that were 15 percent higher and hospitalization rates that were 21 percent lower (Table 7-5, p. 254). The median standardized cost per day for efficient SNFs was 7 percent lower than the median for other SNFs. The aggregate Medicare margin (excluding the federal relief funds) for these SNFs was high (22.8 percent),

**TABLE
7-4**

Variation in freestanding SNF aggregate Medicare margins reflects differences in economies of scale, 2020

Provider group	Medicare margin
All providers	16.5%
For profit	20.0
Nonprofit	0.6
Rural	18.4
Urban	16.1
Frontier	19.1
25th percentile of Medicare margins	4.0
75th percentile of Medicare margins	28.7
Cost per day: High	0.2
Cost per day: Low	31.7
Small (20–50 beds)	–0.5
Large (100–199 beds)	18.2
High facility volume (highest 20%)	19.9
Low facility volume (lowest 20%)	2.1

Note: SNF (skilled nursing facility). Except for the margins at the 25th and 75th percentiles, the margins in the table are aggregates for the facilities included in the group. All margins exclude the federal relief funds. “Frontier” refers to SNFs located in counties with six or fewer people per square mile. “Facility volume” includes all facility days.

Source: MedPAC analysis of 2020 freestanding SNF Medicare cost reports.

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 for the program to lower its payments to more closely align with the costs of care.

Measures of economies of scale (average daily census and occupancy) were similar for the relatively efficient

**TABLE
7-5**

Financial performance of relatively efficient SNFs was a combination of lower cost per day and higher revenues per day, 2020

Performance measure / subgroup	Type of SNF		Ratio of relatively efficient to other SNFs
	Relatively efficient	Other SNFs	
Rate of successful discharge to the community	46%	40%	1.15
Hospitalization rate	11%	14%	0.79
Standardized cost per day	\$445	\$479	0.93
Medicare revenue per day	\$578	\$557	1.04
Medicare margin	22.8%	15.5%	N/A
All-payer total margin	4.6%	3.2%	N/A
Facility case-mix index	1.64	1.67	0.98
Medicare average length of stay	30 days	35 days	0.86
Occupancy rate	79%	79%	1.00
Average daily census	92	90	1.02
Medicaid share of facility days	59%	58%	1.02
Share urban	87%	85%	N/A
Share for profit	82%	72%	N/A
Share nonprofit	15%	24%	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 2017 to 2020 and a minimum of 60 stays a year. The number of freestanding facilities included in the analysis was 4,256, of which 383 (or 9 percent) were identified as “relatively efficient” based on their cost per day and two quality measures (community discharge and readmission rates) between 2017 and 2019. 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). Table shows the medians for the measure. The federal relief funds are included in the all-payer total margin but excluded from the aggregate Medicare margin.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2017–2020.

and other SNFs, most likely because the higher minimum-stay requirements for the quality measures exclude small providers from the analysis. Relatively efficient SNFs were more likely to be for profit and were geographically dispersed (located in 41 states). Of the 383 SNFs that were relatively efficient in this year’s analysis, 211 (55 percent) were also relatively efficient last year.

Although these results are consistent with findings from prior years when the pandemic was not a factor, we are reluctant to place much weight on this analysis. The cost and quality measures are both heavily

influenced by the impact of the pandemic and thus may distort the performances in 2020.

FFS payments for SNF care are considerably higher than MA payments

The comparison of Medicare FFS and MA payments also indicates that Medicare’s payments under the SNF PPS are too high. (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 two companies (Diversicare and the Ensign Group) with

Identifying relatively efficient skilled nursing facilities

We defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and relatively good quality of care for three years in a row, from 2017 through 2019, for this report. 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. 245). 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 (2017 through 2019).²⁶

The method we use 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 the “relatively efficient” group or the “other” 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. ■

publicly available information on their revenues per day. We also included the average payments per day reported by the National Investment Center for Senior Housing and Care for 1,289 SNFs. For the admittedly limited snapshot, Medicare’s FFS per day payments were more than 27 percent higher than MA rates (Table 7-6, p. 256).

We do not know whether the lower average daily payment by MA plans reflects differences in service intensity, 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.

We compared broad patient characteristics (average age and risk scores) of beneficiaries enrolled in FFS and MA plans and conclude that 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 and had slightly lower risk scores (3 percent lower, indicating fewer comorbidities). (The risk scores for MA enrollees may be lower because some SNFs might encourage enrollees whose health is in decline to switch to FFS.²⁷ Also, some MA plans waive the three-day prior hospital-stay requirement, so their SNF users could be less medically complex.) 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

**TABLE
7-6**

Comparison of SNFs' Medicare fee-for-service and managed care daily payments, 2021

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	Managed care (MA)	
Diversicare	\$489	\$416	1.18
Ensign Group	688	504	1.37
National Investment Center for Seniors Housing & Care	560	447	1.25

Note: SNF (skilled nursing facility), FFS (fee-for-service), MA (Medicare Advantage). MA makes up the majority of managed care payments. In 2021, Diversicare had 62 facilities; the Ensign Group had 219 facilities. The information for the National Investment Center for Seniors Housing & Care shows the average rates for a survey of 1,289 SNFs.

Source: Diversicare and Ensign Group 10-Q 2021 reports available at each company's website; National Investment Center for Seniors Housing & Care 2021.

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 2022

To project the aggregate fiscal year 2022 Medicare margin for freestanding SNFs, the Commission considered the relationship between SNF costs and Medicare payments in 2020 as a starting point. We made assumptions about how costs and payments will change and noted how better and worse circumstances would affect the projection. The extent to which the pandemic will continue to affect providers' volume, costs, and revenues makes this year's projection especially uncertain.

Our projections include assumptions about pandemic-related costs that we expect to remain for the foreseeable future and therefore should be incorporated into the update. The cost reports for 2020 capture some of the incurred additional expenses associated with personal protective equipment, cleaning, testing, labor (due to overtime, premium pandemic pay, and the expanded use of contract labor), and higher patient complexity. However, due to timing differences in the cost reporting periods, some providers' cost reports will miss some portion of PHE-

related costs in fiscal year 2020, and these costs will be captured in future years' cost reports.

To estimate costs, we used CMS's Office of the Actuary's (OACT's) estimates of the market baskets for 2021 and 2022 (based on a June 2021 forecast). These market baskets indicate how SNFs' costs will change in those years, including the costs of labor. OACT estimates that the market basket increase will be 3.3 percent in fiscal year 2021 and 3.2 percent in fiscal year 2022. The market basket estimates are much higher than the estimate for 2020 (2 percent) and reflect the lingering higher costs associated with paying higher wages to attract workers to this setting, the higher costs of personal protective equipment and cleaning, and higher economy-wide inflation. The estimates of cost growth could be low or high depending on how actual costs differ from the projections. For example, nursing homes' labor costs could be higher than projected if facilities have to offer even higher wages than what was assumed.

To estimate payments in 2021 and 2022, we assumed that payment rates each year would increase by the updates specified in the final rules for those years, 2.2 percent and 1.2 percent, respectively.²⁸ The update for 2022 is relatively low because CMS made a forecast

error correction (–0.8 percent) to the 2020 market basket (its estimate was 2.8 percent, but the actual update was 2.0 percent).²⁹ We also factored in the suspension of the sequester from May 1, 2020, through March 31, 2022, the reintroduction of a small reduction (1 percent) between April 1, 2022, and June 30, 2022, and the full reinstatement of the sequester (2 percent reduction to payments) beginning on July 1, 2022.

We did not consider additional changes in payments due to potential changes in patient acuity or the recording of patient characteristics that would raise payments. Patient acuity might have increased if, for example, COVID-19 diagnoses were not fully reported in 2020. Cases may have been undercounted in 2020 because, early in the pandemic, the code in the International Classification of Diseases, 10th Revision, Clinical Modification was not yet available for documentation and testing was not yet widely available to confirm cases. Even if patient acuity increased, we do not know if the case-mix system fully accounts for the higher costs.³⁰ Payments might also have increased if providers changed their coding of patient characteristics (e.g., depression, difficulty swallowing, and comorbidities), which may more accurately reflect patient characteristics or raise payments with no commensurate change in costs.

The projected aggregate Medicare margin for 2022 for freestanding SNFs is 14 percent. We expect the margin to drop in 2022 because cost growth is likely to exceed the payment updates and the sequester will begin to be reapplied on April 1, 2022. Different assumptions about costs, case-mix, and revenues will raise or lower the projection.

How should Medicare payments change in 2023?

In considering how payments should change for 2023, we note that current law is expected to increase payment rates by 1.8 percent in 2023 (an estimated market basket increase of 2.4 percent minus a productivity adjustment of 0.6 percent). CMS will revise its estimates before the publication of the final rule, expected before August 1, 2022. The Medicare margin will depend on many factors. On the payment side, the

update to the payment rate may or may not accurately capture any changes in patient acuity or the recording of patient characteristics to raise payments (with no effect on costs). Costs may increase more or less than the market basket estimates, in part depending on the extent to which providers adjust their costs based on changes in volume.

Further complicating the context for 2023 are potential adjustments CMS may make to fiscal year 2023 payment rates to reestablish budget neutrality in the case-mix system. As discussed earlier, the PDPM raised payments in 2020 by 5.3 percent; in this year’s final rule, CMS noted that it intends to adjust the case-mix indexes in future years to remove the unintended increases in payments. CMS will consider the stakeholder suggestions the agency received for the methodology it will use to estimate the recalibration needed to maintain budget neutrality and the time line for implementing any changes. Its final decision about the payment rates for fiscal year 2023 will not be known until the final rule is published later in 2022.

While the pandemic has had devastating effects on beneficiaries and nursing home staff, the combination of the new case-mix system, the provider relief funds, and the temporary federal policies resulted in improved financial performance for SNFs in 2020. Medicare and total margins increased, and there were fewer SNFs with negative Medicare margins and all-payer total margins. The high FFS payments relative to rates paid by at least some MA plans suggest that many facilities are willing to accept much lower rates to treat Medicare beneficiaries. The Medicare margin indicates that the SNF PPS exerts too little pressure on providers. The other indicators—access to care and quality—may not signal anything about the adequacy of Medicare payments in 2020 but instead reflect the broad impact of the pandemic on service use and our measures of quality. Furthermore, transaction activity in the industry suggests that buyers think there will continue to be financial opportunities in this setting.

RECOMMENDATION 7

For fiscal year 2023, the Congress should reduce the 2022 Medicare base payment rates for skilled nursing facilities by 5 percent.

RATIONALE 7

Despite the severe effects of the pandemic on beneficiaries and nursing home staff, the financial performance of SNFs did not deteriorate. Quite the opposite: Due to a new case-mix system that inadvertently raised payments and the suspension of the sequester, the aggregate Medicare margin climbed to a nine-year high (16.5 percent). With a projected aggregate Medicare margin in 2022 of 14 percent, payments will remain more than adequate to ensure beneficiary access to SNF care even if payments are lowered.

The level of Medicare's payments indicates that a reduction (i.e., not simply maintaining payment rates at current levels) is needed to better align aggregate payments to aggregate costs. Last year, the Commission recommended a zero update, opting to proceed cautiously as the effects of the pandemic and the case-mix system played out. We now know that the financial performance of SNFs is the most robust it has been since 2011. And while CMS may opt to apply a downward adjustment to payment rates for fiscal year 2023 to restore budget neutrality following implementation of the new case-mix system, we cannot base our recommendation on actions that have not yet been determined. Those actions could include a smaller reduction and an approach that phases in the reduction over multiple years.

Although the overall financial performance of SNFs is good and projected to remain so, the share of providers that operated at a loss in 2020, as well as the large difference in performances between nonprofit and for-profit SNFs, indicates that not all providers do well financially. However, poor performances reflect, in part, an inability to control cost growth or achieve economies of scale, or both. In the interest of responsible fiscal stewardship of the program, it is not sound policy to raise payments for all providers to address the poor performance of some. Nor does the Commission support differential updates for providers based on ownership status or geographic location. Instead, the Congress could consider two approaches that would redistribute Medicare's payments. First, the Congress could direct Medicare to redistribute payments to support select facilities that are necessary for beneficiaries' access to care. Over the coming year,

the Commission plans to analyze the characteristics of providers with consistently poor financial performance. Second, the Congress should revamp the value-based purchasing program (including larger incentive payments) that would direct funds to facilities that perform well on quality and resource use measures, as the Commission recommended in June 2021 (Medicare Payment Advisory Commission 2021).

IMPLICATIONS 7

Spending

- Current law is expected to increase payment rates by 1.8 percent in 2023. This recommendation would lower program spending relative to current law by over \$2 billion in one year and over \$10 billion over five years.

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 of 2010 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 reported 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 (which Medicare does not cover) and a portion of the skilled nursing care furnished to beneficiaries who are dually eligible for Medicaid and Medicare. Some Medicaid programs pay dual-eligible beneficiaries' Medicare

**TABLE
7-7**

The number of nursing homes treating Medicaid enrollees declined slightly from 2020 to 2021

	2017	2019	2020	2021	Average annual percent change	
					2017-2020	2020-2021
Number of facilities	15,069	14,954	14,827	14,720	-0.6%	-0.7%

Note: The 2021 number is through October 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, 2017-2021.

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).

Count of Medicaid-certified nursing homes

Between 2020 and 2021, the number of nursing facilities certified as Medicaid providers declined approximately 0.7 percent to 14,720 (Table 7-7), similar to the small decline of Medicare providers. 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.

In 2021, of the 14,685 Medicaid nursing homes active in January, approximately 0.3 percent of providers had terminated as of October, while 41 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 the District of Columbia (11 percent); Idaho and Rhode Island (3 percent each); and Washington and Delaware (1 percent each). Historically, the lower payment rates paid by Medicaid, the lower use of these facilities by MA plans and alternative payment models, and the overexpansion of supply in states with no certificate-of-need laws (such as Texas) contributed to these facilities' fiscal pressures.

Spending

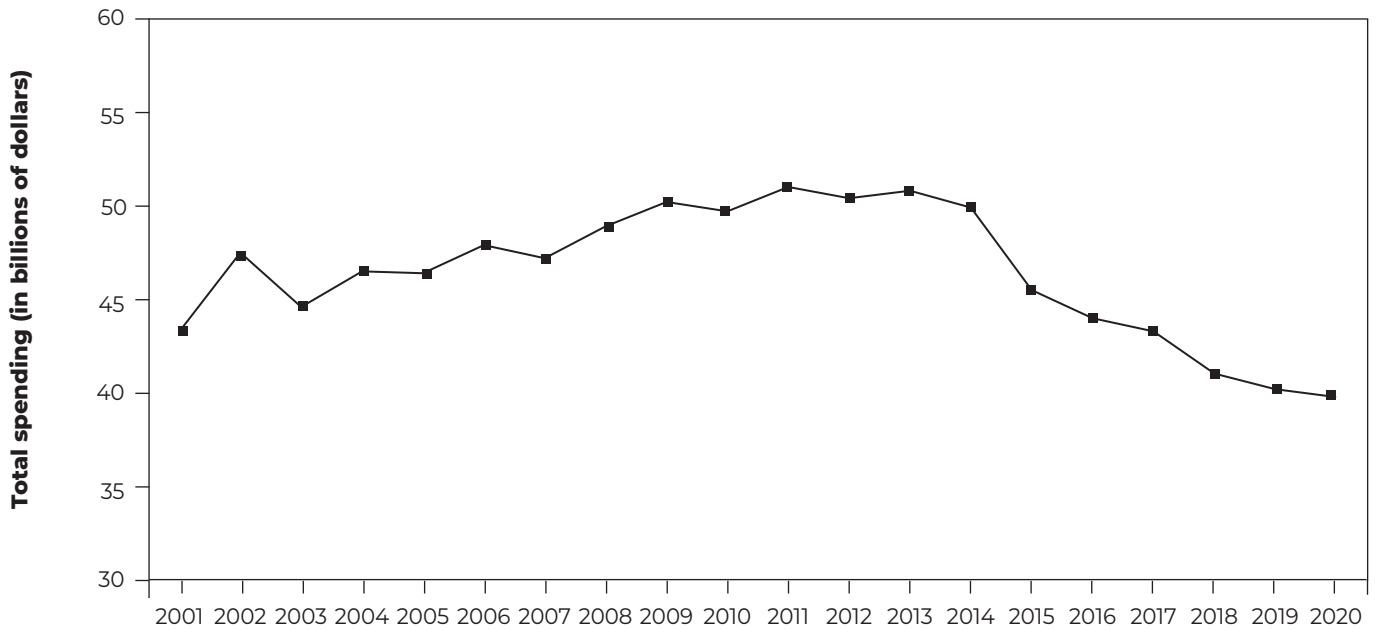
FFS spending on Medicaid-funded (combined state and federal funds) nursing home services totaled \$39.8 billion in 2020 (Figure 7-6, p. 260) (Office of the Actuary 2021a). This spending dropped an average 2.3 percent per year between 2017 and 2019 and 3.8 percent between 2019 and 2020. The trend of lower spending is in part due to increased enrollment in managed care organizations, whose spending is not included in these data. As of November 2020, 25 states operated Medicaid managed care for long-term services and supports (Medicaid and CHIP Payment and Access Commission 2021). Year-to-year changes in spending have been variable, rising in some years and falling in others, with overall spending in 2020 below what it was in 2001.

Analysis of Medicaid rate-setting trends in fiscal year 2020 found that 6 states restricted (froze or reduced) rates paid to nursing homes, while 37 states increased nursing facility rates and 7 states did not report data (Gifford et al. 2020). The study also noted that 30 states planned to increase their rates in 2021.

States continue to use provider taxes to raise federal matching funds. In fiscal year 2021, 41 states and the District of Columbia levied provider taxes on nursing homes to increase federal matching funds (Gifford et al. 2020).³¹ The augmented federal funding may be split with the nursing homes.

FIGURE 7-6

Total Medicaid fee-for-service spending on nursing home services, 2001-2020



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

Source: Office of the Actuary 2021a.

All-payer total and non-Medicare margins in nursing homes in 2020

All-payer total margins reflect 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 2020, the all-payer total margin for freestanding providers was 3.0 percent (Table 7-8). The improvement in overall performance reflects the infusion of general distribution and targeted relief funds, the PHE-related policy changes, the temporary pandemic-related

TABLE 7-8

All-payer total and non-Medicare SNF margins improved in 2020

Type of margin	2016	2017	2018	2019	2020
All-payer total margin	0.7%	0.6%	-0.3%	0.6%	3.0%
Non-Medicare margin	-2.4	-2.4	-3.2	-2.2	-0.3

Note: SNF (skilled nursing facility). "All-payer total margin" includes the revenues and costs associated with all payers and all lines of business and includes the federal relief funds disbursed in 2020. "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 skilled nursing facility cost reports for 2016 to 2020.

increases in Medicaid payment rates in many states, and the higher payments under Medicare's new case-mix system. Since 2000, except for 2018 (when the total margin was slightly negative), the all-payer total margin has been positive and ranged from 0.4 percent to 3.8 percent (not all data shown).

The all-payer total margins in 2020 varied considerably. The median was 3.7 percent; 25 percent of nursing homes had total margins of -2.6 percent or lower and 25 percent of homes had total margins of 10 percent or

higher (data not shown). In 2020, 34 percent of SNFs had negative margins. While sizable, the share is an improvement from 2019, when 45 percent of SNFs had negative margins.

Non-Medicare margins reflect the profitability of all services except FFS Medicare-covered SNF services. The aggregate non-Medicare margin in 2020 was -0.3 percent, an improvement from 2019, when it was -2.2 percent. ■

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 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 has been temporarily waived during the COVID-19 public health emergency.
- 4 Skilled services are defined as ordered by a physician, requiring the skills of technical or professional personnel, and furnished directly by or under supervision of such personnel.
- 5 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 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 United States, on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed multiple times, most recently on January 14, 2022.
- 6 The extended benefit applies only to beneficiaries who were delayed or prevented by the PHE from starting or completing the end of the current benefit period—i.e., renewing the SNF benefit would have occurred under normal circumstances. Beneficiaries with continued need for skilled care unrelated to the PHE cannot renew their benefit.
- 7 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.
- 8 Rural counties are those not in or adjacent to metropolitan or micropolitan areas and are defined using Urban Influence Codes 11 and 12.
- 9 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.
- 10 There are separate base rates for urban and rural facilities. Rural base rates are higher for the physical therapy, occupational therapy, speech language-pathology, and the non-case-mix (room and board) components; the urban base rates are higher for the nursing and nontherapy ancillary components. A description of the SNF PPS is found in *SNF Payment Basics*, available at <http://medpac.gov/-documents-/payment-basics>.
- 11 Medicare’s staffing requirement that SNFs have a registered nurse on duty for at least eight consecutive hours a day, seven days a week, may have been a factor in the increase in the nursing hours per resident day.
- 12 We do not know whether providers that terminated from the program actually closed, were purchased by another entity and remained open (but under a new provider number), or remained open but stopped participating in the Medicare program.
- 13 The occupancy rates are based on the Commission’s analysis of the COVID-19 data for a cohort of 10,979 SNFs that reported valid data for 66 weeks (during the period from June 2020 to September 2021).

- 14 Of the 7 states plus the District of Columbia with median occupancy rates at or above 85 percent, 6 have certificate-of-need laws limiting industry expansion (though one state suspended these laws during the PHE).
- 15 Although the required prior hospital stay was suspended during the PHE, the majority of SNF use in 2020 was preceded by one.
- 16 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:
- $$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$
- This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 17 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.
- 18 Rural critical access hospitals with swing beds are excluded from the program. Providers with fewer than 25 stays per year are effectively held harmless under the program.
- 19 In the Consolidated Appropriations Act, 2021, the Congress made three changes to the SNF VBP that could affect payments beginning in fiscal year 2024. First, it gave the Secretary of Health and Human Services the authority to expand the measure set. 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.
- 20 Because the sequestration is not applied to beneficiary copayments, the reduction to SNF payments is slightly lower than 2 percent.
- 21 SNFs varied in whether they participated in the optional Paycheck Protection Program (PPP). Data from the Health Resources and Services Administration show that “nursing home” businesses received about \$6.8 billion in PPP loans, about half of which was forgiven. However, a cursory examination of the recipients revealed that the category includes many health care entities that do not appear to be nursing homes.
- 22 Two other companies, Genesis Healthcare and Five Star Senior Living, had different experiences that suggest underlying financial weaknesses predating the pandemic. Genesis Healthcare left the New York Stock Exchange to restructure its financial arrangements, and Five Star continued its shift away from SNFs and toward senior living.
- 23 The reporting of the public health emergency funds should include the Provider Relief Fund payments and Paycheck Protection Program loans that were booked as revenue and not returned.
- 24 Had we allocated PHE funds based on Medicare’s share of revenues, a larger share of the PHE would have been allocated to Medicare because Medicare’s payments are substantially higher than payments from other payers. In this case, the estimate of the Medicare margin would be higher.
- 25 Of targeted funds, \$2.25 billion in nursing home quality incentive payments (apart from the VBP) were disbursed in four waves between October 2020 and February 2021.
- 26 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.
- 27 One study of switching between MA and FFS after the onset of functional disability found that, compared with beneficiaries with lower levels of disability, beneficiaries with greater levels of disability were more likely to switch from MA to FFS (Ankuda 2020).
- 28 The market basket estimate used to establish the 2021 update to payment rates was based on a June 2020 forecast. Since then, the estimate has been revised multiple times, most recently using a June 2022 forecast. The more recent estimate of the 2021 market basket is 3.1 percent, compared with the earlier estimate of 2.2 percent.

- 29 CMS makes forecast error corrections when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage points (either too high or too low).
- 30 For example, while the case-mix system does not use the COVID-19 diagnosis in assigning cases to case-mix groups, it considers ventilator care, pulmonary diagnoses, and patient isolation in its assignments.
- 31 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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