CHAPTER 7

Skilled nursing facility services

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

7 For fiscal year 2024, the Congress should reduce the 2023 Medicare base payment rates for skilled nursing facilities by 3 percent.

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

CHAPTER 7

Skilled nursing facility services

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Chapter summary

Medicare covers short-term skilled nursing and rehabilitation services for beneficiaries in skilled nursing facilities (SNFs) after an inpatient hospital stay. In 2021, about 14,700 SNFs furnished about 1.7 million Medicare-covered stays to 1.2 million fee-for-service (FFS) beneficiaries (3.4 percent of Medicare's FFS beneficiaries). In that year, Medicare FFS spending on SNF services was $28.5 billion. Most SNFs are also certified as nursing homes, which furnish long-term care services not covered by Medicare. Owing to federal policies to support SNFs during the coronavirus public health emergency (PHE) and the implementation of Medicare's new case-mix system, SNFs' aggregate financial performance under Medicare was robust in 2021, despite occupancy that has been slow to rebound and ongoing staffing pressures.

Assessment of payment adequacy

Overall, our indicators of payment adequacy were positive; where indicators were mixed, it was generally due to the coronavirus pandemic rather than the adequacy of Medicare's payment rates.

Beneficiaries' access to care—Changes in the indicators of access in 2021 were mixed and reflect the impact of the coronavirus pandemic, not the

adequacy of Medicare's payments. FFS Medicare remains a preferred payer for SNFs.

- ***Capacity and supply of providers***—In 2021, 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). Nationally, occupancy has not returned to prepandemic levels, which suggests there is excess capacity, but staffing shortages may constrain capacity for some facilities. Continued reduced occupancy also reflects the impact of the coronavirus pandemic rather than the adequacy of Medicare's payments.
- ***Volume of services***—Between 2020 and 2021, Medicare-covered admissions per 1,000 FFS beneficiaries dropped 2.4 percent. Covered days per 1,000 FFS beneficiaries fell 3.7 percent because of a decrease in length of stay during the same period. Continued waiver of coverage rules during the PHE tempered the reductions in Medicare volume beginning in March 2020. Volume, too, declined because of the impact of the coronavirus pandemic, not the adequacy of Medicare payments.
- ***Medicare marginal profit***—In 2021, Medicare marginal profit (an indicator of whether SNFs have an incentive to treat more Medicare beneficiaries) averaged 26 percent for freestanding facilities. This profit is a strong positive indicator of beneficiary access to SNF care, though factors other than the level of payment (such as bed availability or staffing shortages) could challenge access.

Quality of care—In 2021, the mean facility risk-adjusted rate of successful discharge to the community from SNFs was 43.5 percent, and the mean facility risk-adjusted rate of hospitalizations was 13.1 percent. The pandemic and PHE-related policies confound our measurement and assessment of trends in our quality measures.

Providers' access to capital—The number of nursing facility transactions in 2021 was lower than it was before the pandemic, reflecting a lack of sellers rather than a lack of investor interest. In 2021, the average price per bed increased to a near record level. In 2021, 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 3.4 percent, which was higher than recent, prepandemic averages. The all-payer margin increased during the pandemic because of funding that nursing homes received during the PHE and

changes in Medicare and Medicaid payments. Without pandemic-related funds, the all-payer margin was –1.5 percent.

Medicare payments and providers' costs—Between 2020 and 2021, Medicare's aggregate FFS spending on SNF services increased 0.5 percent to $28.5 billion, despite a reduction in covered SNF days. Payments per day increased over 3 percent, while costs per day grew 4 percent. The Medicare margin for freestanding SNFs was 17.2 percent in 2021. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth. The 2021 Medicare margin for relatively efficient SNFs was 22 percent. We project an aggregate SNF margin of 10 percent for 2023.

How should Medicare payment rates change in 2024?

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. Medicare's payments need to be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2024, the Congress reduce the 2023 Medicare base payment rates for skilled nursing facilities by 3 percent.

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 beneficiaries who are dually eligible for Medicare and Medicaid and 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 about 14,600. Spending was $38.4 billion in 2021, 3.5 percent less than in 2020. The average non-Medicare margin (which includes all payers, PHE-related funds, and all lines of business except FFS Medicare SNF services) was 0.1 percent, an increase over 2020.■

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.[1] In 2021, 1.2 million Medicare fee-for-service (FFS) beneficiaries (3.4 percent of Medicare Part A FFS beneficiaries) used SNF services at least once for a total of about 1.7 million stays.[2] The Medicare program spent $28.5 billion on SNF services in 2021 (about 14 percent of FFS Part A spending) (Boards of Trustees 2022, Office of the Actuary 2022b).[3] Medicare's median payment per day was $556, and its median payment per stay was $23,797.

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 three days.[4] (CMS temporarily waived the three-day hospital-stay requirement and other payment policies during the coronavirus public health emergency (PHE), as discussed below.)[5] For beneficiaries who qualify for SNF care, 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 2023, the copayment is $200 per day. To qualify for Medicare coverage, a beneficiary must require daily skilled nursing or rehabilitation services.[6] In October 2019, CMS implemented a new case-mix system, the Patient-Driven Payment Model (PDPM), discussed in the text box, pp. 210–211.

FFS Medicare accounts for a small share of most nursing facilities' total patient days

FFS Medicare–covered SNF days typically account for a small share of a facility's total patient days. Long-term care services, which are less intensive, typically make up the bulk of a facility's business; Medicaid pays for most of this care.[7] In freestanding facilities in 2021, 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 (16 percent) on average. Medicare's shares of days and revenues were consistent between 2020 and 2021 and higher than in 2019, in part due to the temporary waiver of the three-day hospital stay requirement that increased Medicare coverage for stays that otherwise would have been covered by other payers and in part due to Medicare's payment increases, as discussed below.

SNFs are overwhelmingly freestanding, and the majority are for profit (Table 7-1, p. 208). In 2021, 97 percent of facilities were freestanding, and they accounted for 97 percent of Medicare stays and 98 percent of spending. Seventy-two percent of providers were for profit. Rural facilities make up the minority of providers, stays, and spending.

Freestanding SNFs vary by size. In 2021, the median SNF had 100 beds, while 10 percent of facilities had 175 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. The majority of small facilities (under 50 beds) are in metropolitan areas (Medicare Payment Advisory Commission 2021b).[8]

The SNF sector is fragmented and characterized by independent providers and regional chains. Of the largest 50 operators, most are privately held. The 10 largest chains accounted for about 11 percent of SNFs in 2022. However, common ownership can be difficult to identify among this largely privately owned sector. Nursing facilities may have complex organizational structures with multiple investor owners. They may also have separate operating companies and asset and property companies, which may have common ownership. A recent paper estimated that about 12 percent of nursing facilities are owned by real estate investment trusts (REITs), which are corporate entities that own real estate and lease it back to the health care provider, who is responsible for rent, maintenance, insurance, and taxes (Bruch et al. 2022). Though they are not unique to this sector, complex ownership structures in the nursing facility sector can obscure common ownership of facilities and the profitability of a nursing home across all owners and related parties (Harrington et al. 2021).

The second year of the coronavirus pandemic saw vaccine rollout and continuation of Medicare's PHE-related payment policies

Our analysis of Medicare beneficiaries' SNF utilization, quality of care, and providers' costs and payments in this chapter relies largely on data from 2021, the second year of the coronavirus pandemic and PHE-related policies. That year saw the rollout of vaccinations, and

TABLE 7–1

Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, Medicare stays, and Medicare spending in 2021

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total number	14,720	1,689,000	$24.3 billion
Freestanding	97%	97%	98%
Hospital based	3	3	2
Urban	73	84	85
Rural	27	16	14
For profit	72	74	77
Nonprofit	23	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 the Certification and Survey Provider Enhanced Reporting data from CMS's Survey and Certification QCOR online reporting system. Facilities, stays, and spending reported for 2020 in our March 2022 Report to the Congress were undercounts because an error in the Provider of Services file led to their exclusion. These exclusions of observations in 2020 did not materially affect the proportions of facilities, stays, or spending by SNF type reported in the table.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2021.

nursing facility residents and staff were among the first to be vaccinated in the winter of 2020 to 2021. As of the week ending January 1, 2023, an average of 86 percent of nursing facility residents and staff per facility had received their primary vaccination; 51 percent of residents and 22.4 percent of staff were up to date with vaccines (i.e., had received the bivalent booster) (Centers for Medicare & Medicaid Services 2022a).[9] Up-to-date vaccination rates, particularly among staff, vary widely by state. Among facilities reporting vaccination data for the week ending January 1, 2023, the average percentage of current staff up to date with the coronavirus disease 2019 (COVID-19) vaccine ranged from a low of 11 percent to a high of 46 percent (Centers for Medicare & Medicaid Services 2022a).

The effects of the pandemic have been devastating to nursing facility residents and staff. As of the week ending January 1, 2023, about 1.46 million resident COVID-19 cases and more than 162,000 COVID-19-related deaths had been confirmed (Centers for Medicare & Medicaid Services 2022a).[10] Among staff, 1.49 million cases and more than 2,900 COVID-19-related deaths were confirmed (Centers for Medicare & Medicaid Services 2022a). After the rollout of vaccines in early 2021, COVID-19 mortality rates among nursing facility residents and staff declined sharply, but facility occupancy and staffing continued to be affected.

Facility volume and employment in the sector began to increase in 2022 but remained below prepandemic levels nationally, although rebounds in occupancy have varied (see pp. 210–211). Slow-to-return demand is likely due to several pandemic-related factors, including continued avoidance of the setting, mortality due to COVID-19 among the aged and disabled populations that would otherwise be receiving care in a nursing facility, and remote work increasing the availability of informal caregivers. Nevertheless, industry analysts point to the aging U.S. population in coming years as a reason to expect that demand for nursing facilities will increase, though perhaps not to prepandemic levels (Ensign Group 2021, Kauffman 2022).

Federal policies implemented in 2020 to help SNFs manage during the pandemic PHE remained in place in 2021 and 2022. The waived three-day hospital-stay requirement 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 if beneficiaries met the other coverage requirements. CMS also allowed a one-time extension of the benefit period (for an additional 100 days) for certain beneficiaries.[11] In fiscal year 2021, 27 percent of stays were admitted with a PHE-related waiver, compared with 17 percent in 2020 (Centers for Medicare & Medicaid Services 2022b). In both years, the majority of waiver stays were the result of the hospital-stay waiver (Centers for Medicare & Medicaid Services 2022b). The temporary policies are scheduled to end when the coronavirus PHE expires (currently slated for May 11, 2023).

Are Medicare payments adequate in 2023?

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. Overall, our indicators of payment adequacy were positive; where indicators were mixed, it was generally due to the coronavirus pandemic rather than the adequacy of Medicare's payment rates.

Beneficiaries' access to care: Indicators were consistent with secular trends and were not related to the adequacy of Medicare payments

We 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. 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 declined slightly in 2021

The number of SNFs participating in the Medicare program in 2022 declined less than 1 percent to 14,923. In calendar year 2021, 175 SNFs terminated participation in the Medicare program, up from 136 in 2020 but below the 212 SNFs that terminated participation in 2019. In 2022, 74 SNFs stopped participating in Medicare between January and October. Of those, all but 10 closed at their own initiative (i.e., their participation was not terminated by the program). During the same period, 14 new facilities opened, 12 of which were for profit. While the PHE may have contributed, other factors also contributed to the decline in the number of SNFs, such as patients' preference for receiving care in non-SNF settings when possible, low Medicaid payment rates, the lower (than FFS Medicare) use of SNFs by Medicare Advantage (MA) plans and alternative payment models (APMs), and overexpansion of the SNF supply (in states that do not have certificate-of-need laws). In 2021, nonprofit facilities comprised a disproportionate number of the terminations. Terminations can create opportunities for future industry consolidation. In the SNF industry, consolidations more commonly occur at the regional or state level than at the national level because information about potential referring hospitals, state regulations, and Medicaid policies are essential elements for successful nursing home operations. A recent analysis of detailed SNF ownership data as of September 2022 found that most geographic markets (defined as hospital referral regions) for SNF services have had low levels of concentration as measured by the Herfindahl-Hirschman Index (Welch et al. 2022).

In 2021, 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 hospital beds). In 2021, 5.7 percent of beneficiaries lived in counties with no or only one SNF or swing bed facility, a slight increase from 2020, when it was 5 percent. If a closure occurs in these counties, beneficiaries who live there might find it more difficult to obtain SNF care. In any county, SNF conversions from multiple-occupancy 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

Before the PHE, between 2010 and 2019, median occupancy rates for freestanding SNFs were high, though declining (from 88 percent to 85 percent, based on cost report data), and varied by state and facility. National average occupancy fell dramatically early in the pandemic and continued to fall throughout 2020. In early January 2021, national average occupancy hit a pandemic-period low of about 67 percent (National

Effects of the new case-mix system

Medicare uses a prospective payment system (PPS) to pay skilled nursing facilities (SNFs) for each day of service.[12] CMS implemented a new SNF PPS case-mix system, the Patient-Driven Payment Model (PDPM), on October 1, 2019.[13] The PDPM was intended to address two problems with the prior case-mix system. First, therapy payments under the prior case-mix system were based primarily on the amount of therapy provided to a patient. The PDPM does not determine therapy payments based on the amount of therapy provided but instead uses patient characteristics. Second, the PDPM was designed to better target payments for nontherapy ancillary items such as drugs. Because it considers more comorbidities and other measures of medical complexity than the prior case-mix system, the new system is able to recognize and pay for the higher costs associated with medically complex patients.

The PDPM adjusts payments for patient characteristics, including the primary reason for treatment, prior surgery, comorbidities, functional status, cognitive status, swallowing and nutritional status, depression, and receipt of special treatments (such as ventilator care). Payments for therapy are determined separately for each therapy discipline—physical therapy (PT), occupational therapy (OT), and speech–language pathology (SLP) services—and are based on patient characteristics and, for PT and OT, on function scores. 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.

Less than four months into the implementation of the PDPM, the coronavirus public health emergency (PHE) was declared. To examine changes in coded clinical characteristics and therapy provision under the PDPM, we analyzed claims by month of admission for the period 2019 through March 2022. Results were analyzed separately for the populations with coronavirus disease 2019 (COVID-19) at admission or those admitted under the PHE-related waiver policies and the populations without these characteristics.

Data from monthly claims for SNF cases show how the PDPM and COVID-19 affected characteristics of SNF users and service delivery. For example, coding of depression, swallowing disorder, and mechanically altered diet increased in October 2019 when the PDPM was implemented. This change is consistent with the incentives under the PDPM: These conditions were explicitly recognized in the PDPM as factors that increase payment. Around April 2020 (the first peak of COVID-19 cases), December 2020 (the second peak), and January 2022 (the third peak of COVID-19 cases, driven by the Omicron variant), we observed increases in ventilator, respirator, and tracheostomy cases and coding of isolation or quarantine for active infectious disease, likely due to increased prevalence of COVID-19 infections.

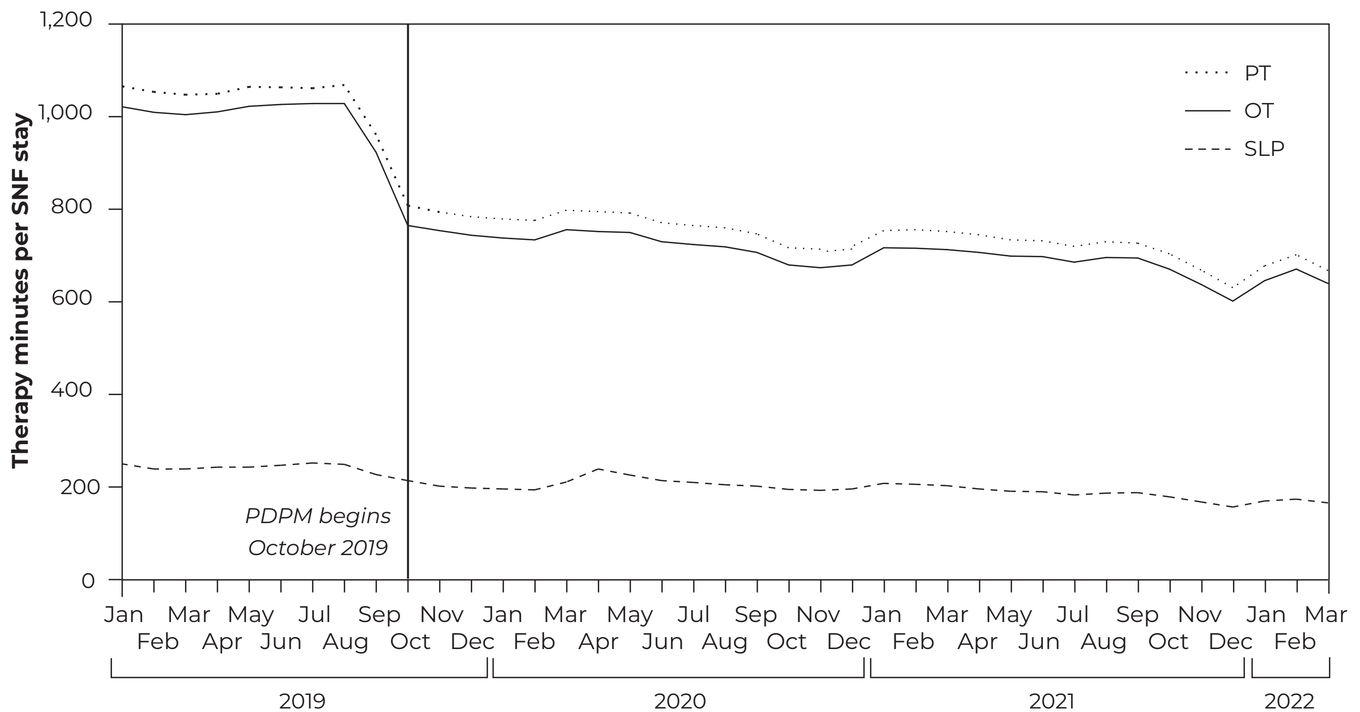
Changes in patterns of therapy use reflected the PDPM incentives and COVID-19 surges. Under the prior case-mix system, payments were based primarily on the amount of therapy provided to a patient. Under the PDPM, the share of stays receiving OT and PT declined around the PDPM

(continued next page)

Investment Center for Seniors Housing & Care 2022).[14] Since that nadir, national average occupancy rates have slowly increased—reaching nearly 75 percent in September 2022—but have remained below prepandemic levels (National Investment Center for Seniors Housing & Care 2022). Occupancy rates and patterns of decline and recovery during the pandemic vary widely across states—reflecting both baseline supply differences and geographic differences in the timing of outbreaks. While occupancy remains below prepandemic levels nationally, it varies by facility: 25 percent of SNFs had occupancy of 88 percent or

Effects of the new case-mix system (cont.)

FIGURE 7–1 **Number of therapy minutes per stay, January 2019–March 2022**



Note: SNF (skilled nursing facility), PT (physical therapy), OT (occupational therapy), SLP (speech–language pathology). Cases exclude those with a COVID-19 diagnosis at admission and those admitted under a public health emergency waiver. The number of therapy minutes is the average therapy minutes per stay for all therapy modes combined (individual, concurrent, and group therapy).

Source: Acumen LLC analysis for MedPAC of data from Medicare SNF claims and the Minimum Data Set for 2019 through March 2022.

implementation, while the share of cases receiving SLP services increased, likely due to explicit payment for SLP services under the PDPM. The shares of cases receiving PT or OT rebounded quickly to pre-PDPM levels, though with dips in months coinciding with COVID-19 surges (April 2020, December 2020, and January 2022). While the share of stays receiving any PT or OT were similar pre-PDPM and post-PDPM implementation, the number of PT and OT minutes per stay dropped as the incentives to provide more therapy in order to receive higher payments were eliminated under the PDPM, as shown in Figure 7-1. We found that after the PDPM's implementation, the share of stays with improved function between admission and discharge and the magnitude of that change was fairly consistent (data not shown). ■

higher as of August 2022. A bed may not be available in a facility with a high occupancy rate, particularly if a patient requires special services.

SNFs have faced staffing shortages during the pandemic that could affect access. While we do not have data on the extent to which workforce shortages may have affected access to SNF care, SNFs have

TABLE 7–2

SNF admissions and days declined during the pandemic but less than in the immediate prepandemic period

	Prepandemic			Pandemic		Average annual change	
Volume measure	**2017**	**2018**	**2019**	**2020**	**2021**	**2017–2019**	**2020–2021**
Covered admissions per 1,000 FFS beneficiaries	64.6	62.5	59.5	54.8	53.5	–4.0%	–2.4%
Covered days per 1,000 FFS beneficiaries	1,623	1,559	1,475	1,453	1,399	–4.7	–3.7
Covered days per admission	25.1	25.0	24.8	26.5	26.2	–0.6	–1.3

Note: SNF (skilled nursing facility), FFS (fee-for-service). Data are for the calendar year and include 50 states and the District of Columbia. Average annual changes are calculated using unrounded values and then rounded to the nearest tenth.

Source: Centers for Medicare & Medicaid Services 2022c.

reported limiting admissions and hospitals have reported discharge delays and difficulty transitioning patients to SNFs (Stulick 2022b). The peak of reported SNF staffing shortages coincided with the outbreak of the Omicron variant in early 2022. In January 2022, about 28 percent of SNFs reported a shortage of nursing staff (NIC Map Vision 2022b). As of mid-October 2022, about 20 percent of SNFs reported such shortages (National Investment Center for Seniors Housing & Care 2022). One analysis of staffing and occupancy found that cohorts of SNFs with higher occupancy have lower shares of properties experiencing shortages of nursing staff (NIC Map Vision 2022b).

The coronavirus pandemic has exacerbated long-standing staffing issues for SNFs. Economy-wide wage pressure and ongoing labor market shortages mean that SNFs are competing with other sectors and industries for scarce labor (NIC Map Vision 2022b). Despite proportionally large wage increases relative to other sectors (e.g., hospitals, physician offices), SNF employment saw larger declines during the first two years of the pandemic than other sectors. SNF employment has also been slower to rebound and remains below prepandemic levels (Cantor et al. 2022). Rates of employment changes varied geographically, with one study finding that employment declines among SNFs were more severe in counties with high COVID-19 burdens (Cantor et al. 2022). (See discussion of Bureau of Labor Statistics (BLS) data on nursing facility wages and employment in 2021 and 2022, p. 218.)

Between 2020 and 2021, SNF admissions and days decreased but by less than the annual changes between 2017 and 2019

SNF use for Medicare beneficiaries has been declining for years. Expanded enrollment in MA has contributed to lower SNF use because MA enrollees tend to have shorter SNF stays or avoid the setting altogether. Similarly, alternative payment models create financial incentives for at-risk entities to lower spending for post-acute care (PAC) services. This could result in less FFS SNF use if providers participating in at-risk entities encourage beneficiaries to use lower-cost settings or shorten SNF stays. Lower FFS use is not a symptom of inadequate Medicare payment rates for SNF care. Medicare's rates are high relative to those of other payers and Medicare is a preferred payer, although some providers may avoid Medicare beneficiaries who are likely to require long stays and exhaust their Medicare benefits.

The coronavirus pandemic compounded secular trends in declining FFS SNF use. In 2020, as the number of hospital discharges dropped due to the pandemic, the share of beneficiaries discharged from a hospital to a SNF also declined, while the share going to home health agencies increased. In 2021, the share of discharges going to SNFs recovered somewhat but did not reach prepandemic levels. In January and February 2020, immediately prior to the initial coronavirus outbreak, the share of hospital discharges going to SNFs was 19 percent; in October 2021, the share was 17

percent. Meanwhile, the overall share of discharges to any PAC setting remained consistent during 2020 and 2021. It remains to be seen whether SNFs will recover their prepandemic share of discharges or whether some of the apparent postdischarge substitution of home health for SNF care will be permanent.

To control for the change in FFS enrollment, we examine service use per 1,000 FFS beneficiaries. Between 2020 and 2021, SNF admissions per 1,000 FFS beneficiaries dropped 2.4 percent (Table 7-2). Because stays were slightly shorter in 2021 than 2020 (data not shown), covered days declined more (3.7 percent). However, the decline in admissions and days per 1,000 FFS beneficiaries between 2020 and 2021 was less than the annual decline between 2017 and 2019.

In 2021, among SNF stays following an inpatient hospital stay, the top five most common diagnosis related groups (DRGs) accounted for nearly a quarter of stays. The top DRG in 2021 (9.5 percent of stays)—septicemia or severe sepsis without mechanical ventilation for more than 96 hours with major complication or comorbidity—was the same as in 2020 and 2019. Respiratory infection and inflammation with major complication or comorbidity was the only DRG in the top five with an increase in the absolute number of cases in 2021, consistent with the ongoing effects of the coronavirus pandemic. This DRG became the second most common (5.8 percent of stays). The share of orthopedic DRGs continued to decline in 2021, with major hip and knee joint replacement or reattachment of lower extremity without major complication or comorbidity falling out of the top five most common DRGs.

Compared with their shares of all FFS enrollees, White and Black beneficiaries were more likely to use SNF services, while Hispanic and Asian/Pacific Islander beneficiaries were less likely. Beneficiaries who received the Part D low-income subsidy, which includes dual-eligible beneficiaries, were more likely to use SNFs relative to their share of all FFS enrollees. Other researchers have found that, compared with other SNF users, Black, Hispanic, and dual-eligible beneficiaries are more likely to use lower-quality facilities (Sharma et al. 2020, 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.[15]

In 2021, the Medicare marginal profit was 26 percent, indicating that facilities with available beds had a strong incentive to admit Medicare patients. This high marginal profit is a strong positive indicator of beneficiary access to SNF care. However, despite providers' favorable 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 or long-term care hospital, or if they are able to receive home health care or outpatient services at home).

Quality of care is difficult to assess during the pandemic

We evaluate quality of care in post-acute settings, including SNFs, using two measures: average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a stay. Both measures are uniformly defined and risk adjusted across all PAC settings.[16] A successful discharge to the community is a SNF stay that ends in a discharge to home with or without home health and does not experience an unplanned hospitalization or death in the next 30 days.[17] 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.

In 2021, the mean facility risk-adjusted rate of successful discharge to the community from SNFs was 43.5 percent and the mean facility risk-adjusted rate of hospitalizations was 13.1 percent (Table 7-3, p. 214). We present these rates with the caveat that the pandemic

TABLE 7–3

SNFs' mean risk-adjusted rates of successful discharge to the community and all-cause hospitalizations between 2017 and 2021

		Prepandemic			Pandemic	
Measure	**Provider subgroup**	**2017**	**2018**	**2019**	**2020**	**2021**
Successful discharge to the community	**All SNFs**	44.4%	44.3%	44.8%	38.6%	43.5%
	For profit	43.6	43.5	43.7	37.6	42.7
	Nonprofit	47.6	47.4	48.0	42.5	46.6
	Freestanding	44.0	44.0	44.4	38.2	43.1
	Hospital based	53.8	52.8	53.6	48.2	53.0
All-cause hospitalizations	**All SNFs**	14.4%	14.1%	13.7%	14.2%	13.1%
	For profit	14.9	14.6	14.2	14.7	13.5
	Nonprofit	12.9	12.7	12.3	12.6	11.7
	Freestanding	14.6	14.3	13.8	14.3	13.2
	Hospital based	10.2	10.6	10.0	10.4	9.8

Note: SNF (skilled nursing facility). "Successful discharge to the community" includes beneficiaries discharged to the community (home with or without home health care) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions, readmissions, and outpatient observation stays that occur during the SNF stay. Providers with at least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate. The "All SNFs" category includes the performance of government-owned SNFs, which are not displayed separately in the table.

Source: MedPAC analysis of SNF claims and linked inpatient hospital stays from 2017 through 2021 for fee-for-service beneficiaries.

and PHE-related policies confound our measurement and assessment of trends in our quality measures for several reasons. First, capacity constraints of acute care hospitals or PAC providers, increased mortality due to COVID-19 infections, and increased or earlier discharges to avoid the setting could affect the measures during the pandemic. Second, the PHE-related waiver of the three-day hospital stay could result in long-stay patients making up a greater share of SNF cases, which could affect the rates of both measures. Third, risk adjustment for these measures does not include COVID-19, so our models may not adequately adjust for the acuity and mix of patients receiving care during the pandemic.

Unrelated to the pandemic, the implementation of the interrupted stay policy in 2020 could also affect our quality measures. Under the interrupted stay policy, if a beneficiary under a Medicare-covered SNF stay leaves the facility (say, for a hospitalization) and returns to that same SNF no later than the third calendar day after they left, that entire period is considered a single SNF stay. Prior to this policy change, this would have been considered two SNF stays. Decreasing the size of the denominator could affect a facility's rate of successful discharge to the community and hospitalization.

Providers' access to capital remains adequate

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

TABLE 7–4

The number of publicly announced SNF transactions fell during the pandemic

	Prepandemic		Pandemic	
	2018	**2019**	**2020**	**2021**
Number of transactions	206	186	150	139
Number of facilities	351	365	265	258
Number of beds	43,550	42,043	31,900	31,300

Note: SNF (skilled nursing facility).

Source: Irving Levin and Associates *Senior Care Acquisition Report*, 2019–2022.

Capital in this sector is less likely to finance new construction than to update facilities or finance purchases of existing facilities because of state certificate-of-need (CON) laws that limit bed supply. Most states (35 states plus the District of Columbia) have CON laws, though 22 states suspended these laws during the PHE (National Conference of State Legislatures 2021).

In 2021, the number of SNF transactions dropped to 139, compared with 150 in 2020, but the number of facilities and beds involved in these deals were similar in both years (Table 7-4) (Irving Levin Associates Inc. 2022).[18] The average price per bed rose to $98,000, which was 23 percent higher than the 2020 average price and just below the record high set in 2016 (data not shown) (Irving Levin Associates Inc. 2022). Many potential acquirers competing for fewer sales pushed prices up relative to 2020. Although there were clear differences in the SNF prices by occupancy rate, as well as by age of the facility, prices were up across all types of SNFs in 2021. There was a 15 percent increase in the median price per bed ($83,700) in 2021 compared to 2020, although this median price was below several prepandemic years (Irving Levin Associates Inc. 2022). Increases in the average price paid for SNFs for each facility age group and the narrowing of the price per bed differential between low- and high-occupancy SNFs show the willingness of buyers to enter the sector or increase their scale (Irving Levin Associates Inc. 2022). In 2022, high per bed values could have enticed more owners to sell, but distressed assets entering the market could have depressed average prices (Irving Levin Associates Inc. 2022). During the first 10 months of 2022, the number of transactions was up (168) compared to 2021 (2022 data not shown).

In 2022, despite lingering low occupancy rates, labor challenges, chronically low payments from Medicaid, and recent beneficiary reluctance to use SNFs, there continues to be buyer interest in the setting (Bush 2022b). Buyer demand is fueled by an aging population, many of whom have complex care needs that cannot be treated at home; improved Medicaid funding; and opportunities created by underperforming facilities. Improved Medicaid funding (see a more detailed discussion, pp. 227–228) will enable some operators to make capital improvements to convert rooms to single occupancy and to add specialty services (such as dialysis services) (Stulick 2022c, Zorn 2022). Omega Health Investors and LTC Properties reported active asset management in 2022, buying and selling facilities to fit their market strategies (Seeking Alpha 2022a, Seeking Alpha 2022b). After its busiest acquisition quarter in years (third quarter of 2022), the Ensign Group indicated that it planned to slow down its growth in the fourth quarter of 2022 and continue to grow in 2023 to take advantage of the "attractive" acquisition market (Ensign Group 2022). One analyst noted that nonprofit owners are more likely to adjust their size (for example, by converting multiple-occupancy rooms to single-occupancy rooms) rather

than exit the market entirely (Bush 2022a). 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.

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 down in 2022 compared with 2021. In 2022, HUD financed 269 projects (compared with 328 in 2021), with the aggregate insured amount totaling $3.0 billion (compared with $3.9 billion in 2021) (Department of Housing and Urban Development 2022). In addition to HUD and commercial bank loans, a minority of facilities access capital via private equity (ATI Advisory 2022). The extensive regulations (which vary by state) and the housing dimension of SNF care can influence which investors enter the lending space (ATI Advisory 2022).

Although the total all-payer margins are slim (as discussed below) and occupancy rates may never fully rebound to prepandemic levels, the SNF sector remains attractive for investors because of demand stemming from the aging population and the setting's relatively lower costs compared with other institutional PAC such as inpatient rehabilitation facilities. Any reluctance to invest in this setting does not reflect the adequacy of Medicare's FFS SNF payments: Medicare remains a preferred payer.

All-payer total margins increased in 2021

In 2021, the estimated all-payer total margin for nursing homes (reflecting all lines of business and all payers) was 3.4 percent, up from 3.1 percent in 2020. All-payer total margins in 2020 and 2021 were higher than in 2019, when the margin was 0.6 percent. In 2021, 40 percent of SNFs had negative total margins, up from 34 percent in 2020 but fewer than in 2019 (45 percent). Higher all-payer total margins during the pandemic were largely due to the general and targeted funding that nursing homes received during the PHE, the changes in Medicare policies, and the increases in Medicaid rates made by many states, though some of these are temporary.

Facilities are required to report the coronavirus PHE funds in Medicare cost reports, and some of these funds are included in the 2021 total margin.[19] Federal funds improved providers' bottom lines and may have averted the closing of some financially distressed providers. In aggregate, without these additional funds, total margins in 2021 would have been about –1.5 percent.

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 Medicare payments should not subsidize payments from Medicaid or other payers (see text box on subsidizing other payers' payments).

Medicare payments and providers' costs: Medicare margins remained high in 2021

In 2021, Medicare FFS spending on SNF services increased 0.5 percent despite a decline in volume. The aggregate Medicare margin for freestanding SNFs was 17.2 percent, a slight decline compared with 2020. Medicare margins for individual facilities varied considerably across providers, as they have in prior years. SNFs reported that payment rates from MA plans 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 2021, CMS estimates that Medicare FFS spending for SNF services was $28.5 billion, a 0.5 percent increase from 2020 (Figure 7-2, p. 218) (Office of the Actuary 2022b). Aggregate spending increased slightly despite 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.

Program spending in 2021 reflects the PHE-related policies that were first implemented in 2020 to give SNFs flexibility to care for patients during the pandemic. The Congress temporarily (from May 2020 to March 2022) suspended the 2 percent sequester

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

Almost all skilled nursing facilities (SNFs) are also certified as nursing facilities, which typically provide long-term care services that are not covered by the Medicare program. These long-term care services, commonly provided to Medicare beneficiaries but not covered by the Medicare program, typically make up the bulk of a nursing facility's business. Although Medicare pays for a relatively small share of nursing facility care on average, Medicare payments to SNFs, financed by taxpayer contributions to the Part A Trust Fund, subsidize payments from other payers, most notably Medicaid. High Medicare payments also likely subsidize payments from private payers. The Commission has long held that such cross-subsidization via Medicare's prospective payment system (PPS) rates is poor policy for several reasons (listed below).

Medicare subsidization of other payers through Medicare's PPS payments 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—potentially the facilities with the greatest financial need—receive the least. One recent study found that nursing facilities that concentrate on Medicare-covered post-acute care serve fewer Black and Hispanic patients and patients on Medicaid than facilities that do not concentrate on Medicare-covered services (Werner et al. 2021). This disparity demonstrates the poor targeting of Medicare-funded subsidies through PPS payments.

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.

Higher Medicare payment rates could create undesirable incentives for providers. Medicare's higher payment rates could encourage providers to select patients based on payer source or to rehospitalize patients who are dually eligible for Medicare and Medicaid coverage to qualify them for a Medicare-covered stay at a higher payment rate. Higher Medicare payment rates could also encourage providers to differentially provide Medicare-covered services or to enter certain markets to maximize utilization of the highly paid services, which could in turn limit access to non-Medicare-covered services for some patients.

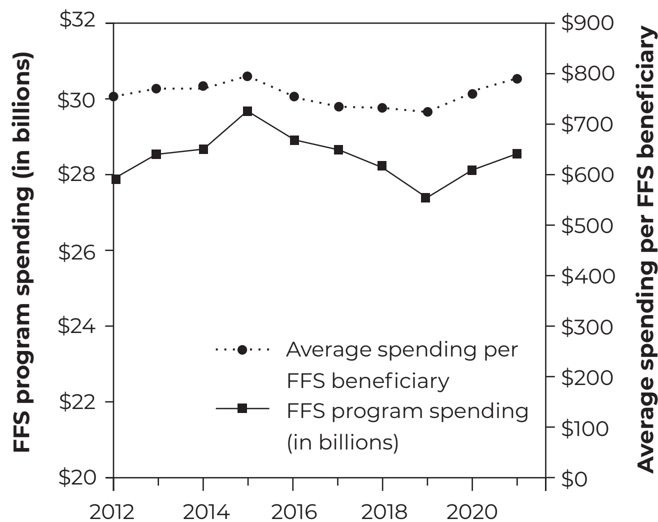
Maintaining or raising Medicare's payments to subsidize other payers exerts pressure on the already fiscally challenged Medicare program. If policymakers wish to provide additional support to certain nursing facilities, they could do so more effectively through a separate, targeted policy.■

that otherwise would have lowered payment rates. The temporary suspension of the sequestration increased Medicare payments by about 1.8 percent.[20] In addition, the PHE-related policies (waiver of the three-day hospital-stay requirement and the effective extension of the benefit period) continued to shift spending onto Medicare for beneficiaries whose SNF care would normally not have been covered by the program.

Program spending in 2021 also reflects unintended increases in payment resulting from the implementation of the PDPM case-mix system starting in October 2019. CMS estimated that the new case-mix system, though intended to be budget neutral, increased payments compared with what would have been paid under the old case-mix system (Centers for Medicare & Medicaid Services 2022b). While CMS identified this overpayment in its rulemaking for fiscal

FIGURE 7–2

After steadily declining since 2015, total FFS program spending on SNF services increased during the coronavirus pandemic



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

Source: Office of the Actuary 2022b and Boards of Trustees 2022.

year 2022, it opted not to make an adjustment to fiscal year 2022 payments. In rulemaking for fiscal year 2023, CMS estimated that PDPM implementation caused an unintentional 4.6 percent increase in payments in 2020 and announced in the final rule that PDPM parity adjustment would be achieved over two years with a payment reduction of 2.3 percent in fiscal years 2023 and 2024 (Centers for Medicare & Medicaid Services 2022b).

Between 2020 and 2021, the average payment per day increased 3 percent, while costs per day increased 4 percent. The relatively high cost growth reflects fewer covered days over which to spread fixed costs, an increase in routine costs per day, and a small decline in ancillary costs per day compared with 2020, consistent with declining therapy minutes under the PDPM. Higher routine costs per day reflect an increase in labor costs that may be driven by signing bonuses, use of contract labor, and a greater decline in lower-paid nursing aide staff relative to higher-paid nursing staff. Data from BLS show a 7 percent increase in weekly wages for the nursing facility sector between January and December of 2021 (Bureau of Labor Statistics 2022b, Bureau of Labor Statistics 2022c).[21] However, during this same period, BLS data show a 5 percent decline in the number of employees in the sector (Bureau of Labor Statistics 2022a). Data for the first seven months of 2022 show that the sector added employees (Bureau of Labor Statistics 2022a). While the reduction in employment in the sector has been dramatic since the start of the pandemic, it had been declining for several years prepandemic as volume declined.

Consistent with past years, cost growth and level of costs varied by ownership. In 2021, nonprofit providers reported larger increases in cost per day compared with for-profit providers (4.7 percent compared with 3.7 percent). Nonprofit providers had 17 percent higher costs per day than for-profit providers, in part because they are smaller and have a lower average daily census, so they cannot achieve the same economies of scale as larger for-profit facilities.

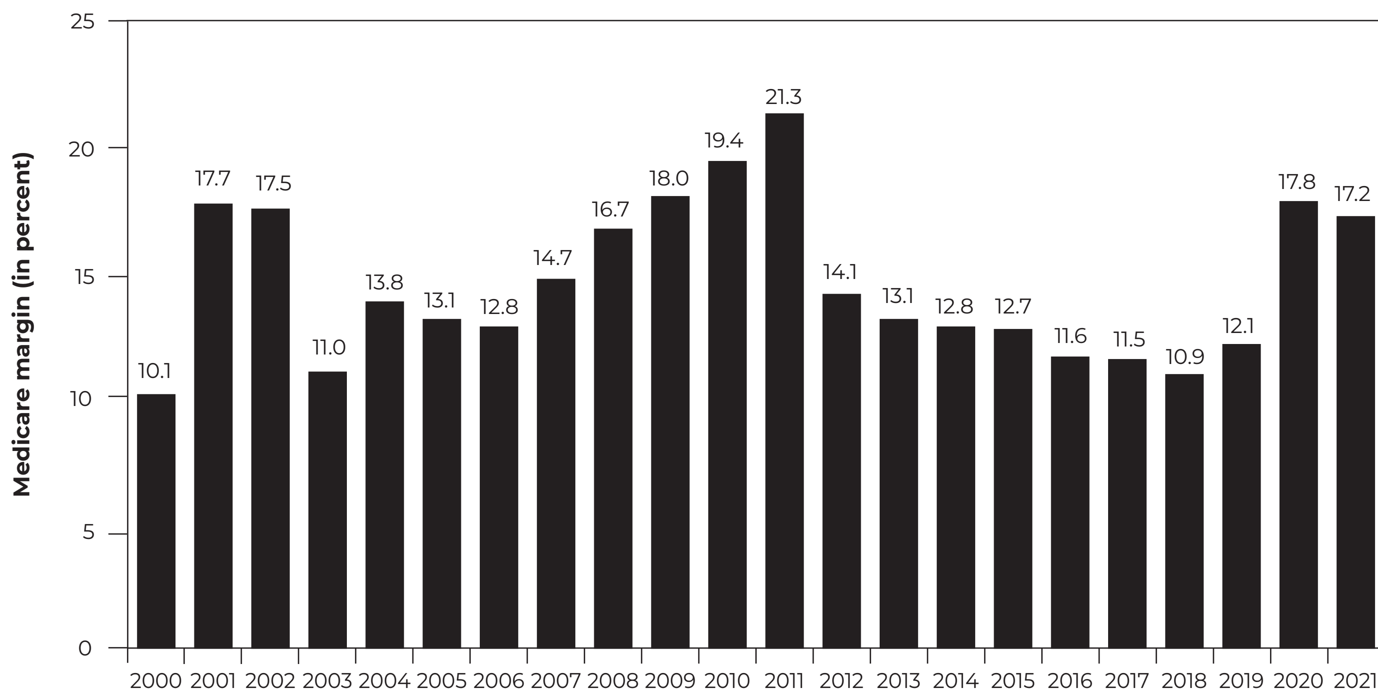
SNF aggregate Medicare margins remain high

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. Policy changes tied to the PHE that affected SNFs' costs, volume, and revenue in 2020 persisted into 2021. In addition, the implementation of the new case-mix system starting in October 2019 has also affected providers' payments and changed incentives to provide therapy services.

In 2021, the aggregate Medicare margin for freestanding SNFs, not including federal relief funds, was 17.2 percent (Figure 7-3). In our March 2022 report to the Congress, we reported an aggregate Medicare margin for freestanding SNFs in 2020 of 16.5 percent (Medicare Payment Advisory Commission 2022). Using a more complete sample of 2020 cost reports available this year, we calculated a higher 2020 Medicare margin of 17.8 percent. We do not typically update prior years' estimates, but we report this recalculation here because it affects the direction of the change between 2020 and 2021. Compared with the Medicare margin using a more complete sample of SNF cost reports for

FIGURE 7–3

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 margins for 2020 and 2021 exclude pandemic-related federal relief funds.

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2021.

2020, the 2021 Medicare margin for freestanding SNFs represents a small decline, consistent with the changes we observe in costs and payments per day between 2020 and 2021.

For the 22nd consecutive year, the Medicare margin for freestanding SNFs was above 10 percent. Medicare margins have increased for the two years of the pandemic for which we have data. Allocating a portion of the relief funds reported on 2021 cost reports to payments based on Medicare's share of total facility days, we estimate that the Medicare margin for freestanding SNFs was 19.6 percent, assuming these funds did not affect providers' costs.[22]

Hospital-based SNFs (which account for 3 percent of program spending on SNFs) continued to have substantial negative Medicare margins. In 2021, the Medicare margin for hospital-based SNFs was −40 percent (compared with −50 percent in 2020 and −68 percent in 2019). 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 own SNF beds, thus making inpatient beds available to treat additional inpatients.

Aggregate Medicare margins varied widely in 2021

Aggregate Medicare margins for freestanding SNFs varied widely across SNFs: One-quarter of SNFs had Medicare margins that were 27.9 percent or higher, and one-quarter had margins that were 3.8 percent or lower (Table 7-5, p. 220). The differences in aggregate Medicare margins between for-profit and nonprofit facilities have persisted for years. The disparity reflects differences in costs per day and, to a lesser extent, payments. Compared with for-profit facilities,

TABLE 7–5

Variation in freestanding SNF aggregate Medicare margins reflects differences in economies of scale, 2021

Provider group	Medicare margin
All providers	17.2%
25th percentile of Medicare margins	3.8
75th percentile of Medicare margins	27.9
For profit	20.6
Nonprofit	2.8
Rural	17.3
Urban	16.8
Frontier	15.7
Cost per day: High	1.1
Cost per day: Low	32.0
Small (20–50 beds)	–2.4
Large (100–199 beds)	19
High facility volume (highest 20%)	22.9
Low facility volume (lowest 20%)	0.9

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 and 2021 freestanding SNF Medicare cost reports.

nonprofit facilities were smaller (fewer beds and lower volume) and they had lower payments per day, higher costs per day, and higher growth in costs per day between 2020 and 2021. Consistent with several years before the pandemic, urban SNFs had higher aggregate Medicare margins than rural or frontier SNFs in 2021. The difference between urban and rural SNFs is a result of lower cost growth and, to a lesser extent, higher payment growth for urban SNFs between 2020 and 2021. While rural SNFs are smaller on average than urban SNFs, the majority of facilities with fewer than 50 beds are urban, and small rural SNFs have, on average, higher margins than small urban SNFs. Differences in aggregate Medicare margins partly reflect the economies of scale that larger SNFs achieve. Facilities with 20 to 50 beds had lower average Medicare margins compared with facilities with 100 to 199 beds. And low-volume facilities (bottom quintile of total facility days) had lower average Medicare margins than high-volume (top quintile of days) facilities. 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.

As we have reported in previous years, SNFs in the top quartile of the distribution of Medicare margins appear to pursue cost and revenue strategies (Medicare Payment Advisory Commission 2020). Compared with SNFs in the lowest Medicare margin quartile, high-margin SNFs have lower standardized daily total, routine, and ancillary costs and lower costs per discharge. Further, high-margin SNFs have, on average, fewer nursing hours per resident day, adjusted for facility case mix. Economies of scale also affect the difference in financial performance. In 2021, high-margin SNFs had higher daily census on average and higher occupancy rates. High-margin SNFs also had, on average, a higher share of Medicare-covered SNF days attributable to beneficiaries receiving the Part D low-income subsidy and higher shares of total Medicaid-covered facility days. Facilities with a higher Medicaid mix may keep their costs lower, in part through lower staffing, contributing to their higher Medicare margins.

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. 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). The Commission's approach is to examine those providers that meet a pre-established set of criteria. It does not establish a

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. 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).[23]

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. ■

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, 2021), 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 geographically) that it may be hard to draw meaningful conclusions from the analysis. We report our findings with the broad caveat that performance in 2021 may have little to do with relative efficiency. To avoid using data from 2020, we defined efficient providers using prepandemic data.

Our analysis included 4,317 SNFs that had quality and cost report information for the 2017 to 2019 baseline and the 2021 performance 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 2021, relatively efficient SNFs had community discharge rates that were 14 percent higher and hospitalization rates that were 14 percent lower (Table 7-6, p. 222). The median standardized cost per day for efficient SNFs was 7 percent lower than the median for other SNFs. The Medicare margin (excluding the federal relief funds) for these SNFs was 22 percent, indicating that although these providers were relatively efficient, the Medicare program could get better value for its purchases if its payments were lower. The high margin for these providers underscores the need for the program to lower its payments to more closely align with the costs of care. Measures of economies of

TABLE 7–6

Financial performance of relatively efficient SNFs was a combination of lower cost per day and higher revenue per day, 2021

Performance measure / subgroup	Type of SNF: Relatively efficient	Type of SNF: Other SNFs	Ratio of relatively efficient to other SNFs
Rate of successful discharge to the community	51%	44%	1.14
Hospitalization rate	11%	13%	0.86
Standardized cost per day	$473	$510	0.93
Medicare revenue per day	$634	$579	1.10
Medicare margin	22.0%	15.5%	N/A
All-payer total margin	4.4%	3.0%	N/A
Facility case-mix index	1.64	1.65	0.99
Medicare average length of stay	30 days	35 days	0.85
Occupancy rate	76%	75%	1.01
Average daily census	85	86	0.98
Medicaid share of facility days	57%	58%	0.99
Share urban	90%	86%	N/A
Share for profit	77%	70%	N/A
Share nonprofit	18%	26%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). To be included in the analysis, the SNF had to have quality and cost report information for 2017 to 2019 and 2021 and a minimum of 60 stays a year. The number of freestanding facilities included in the analysis was 4,317, of which 403 (or 9.3 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 2017–2019 and 2021.

scale (average daily census and occupancy) were similar for the relatively efficient 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 found in 38 states. Despite the effects of the pandemic, these results are consistent with findings from prepandemic years.

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 publicly available information on their revenues per day.[24] We also included the average payments per day reported by the National Investment Center (NIC) for Seniors Housing & Care for 1,226 SNFs in 2021 (NIC Map Vision 2022a). For the admittedly limited snapshot in the NIC survey, Medicare's FFS per day payments were 25 percent higher than MA rates (Table 7-7). We do not know whether the lower average daily payment by MA

TABLE 7–7 **Comparison of SNFs' Medicare fee-for-service and managed care daily payments, 2021**

	Medicare payment		
Company	FFS	Managed care (MA)	Ratio of FFS to MA payment
Diversicare	$500	$414	1.21
Ensign Group	687	498	1.38
National Investment Center for Seniors Housing & Care	567	453	1.25

Note: SNF (skilled nursing facility), FFS (fee-for-service), MA (Medicare Advantage). MA makes up the majority of managed care payments. Data for Diversicare are from the first nine months of 2021. Data for the Ensign Group and from the National Investment Center for Seniors Housing & Care are for calendar year 2021. Diversicare had 61 facilities. The Ensign Group had 245 facilities. The information for the National Investment Center for Seniors Housing & Care shows the average rates for a survey of 1,226 SNFs.

Source: Diversicare 10-Q for the third quarter of 2021 is available from the SEC website (DiversiCare 2021). The Ensign Group annual report for 2021 is available from the company's website (Ensign Group 2021). National Investment Center for Seniors Housing & Care data are from the Annual 2021 NIC Map Vision Skilled Nursing Data Report (NIC Map Vision 2022a).

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) for beneficiaries enrolled in FFS and MA plans who used SNFs and concluded 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, 10 months younger and had similar risk scores. FFS Medicare beneficiaries may want a broader selection of providers if they have underlying health conditions. The payment differential between MA and FFS SNF rates indicates that facilities accept lower payments to treat MA enrollees who are not much different from FFS beneficiaries. Some publicly traded PAC firms with SNF holdings report seeking managed care patients as a business strategy, indicating that the MA rates are attractive.

Projected aggregate Medicare margin for 2023

To project the aggregate fiscal year 2023 Medicare margin for freestanding SNFs, the Commission considered the relationship between SNF costs and Medicare payments in 2021 as a starting point. The potential impact of the coronavirus pandemic and PHE-related policies on providers' volume, costs, and revenues makes projections during the pandemic 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.

To estimate costs, we used CMS's Office of the Actuary's (OACT's) estimates of the market baskets for 2022 and 2023 (based on a September 2022 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 was 6.2 percent in fiscal year 2022 and will be 4.2 percent in fiscal year 2023. The market basket estimates reflect the costs associated with higher wages and economy-wide inflation. The estimates of cost growth could be low or high depending on how actual costs differ from the projections.

To estimate payments in 2022 and 2023, we assumed that payment rates each year would increase by the updates specified in the final rules for those years, 1.2 percent and 2.7 percent, respectively (Table 7-8).[25] The updates for 2022 and 2023 reflect an adjustment for forecast error.[26] In 2022, CMS applied a forecast error correction of −0.8 percent to correct for an overestimate of the market basket used in the 2020 final rule. In 2023, CMS applied a forecast error correction of 1.5 percent to correct for an underestimate of the market basket used in the 2021 final rule. Finally, we included the impact of a parity adjustment of −2.3 percent that CMS applied in 2023 to correct for overpayment resulting from the implementation of the new case-mix system in 2020. 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.

The projected aggregate Medicare margin for 2023 for freestanding SNFs is 10 percent. We expect the margin to drop in 2023 because cost growth is likely to exceed the payment updates, the sequester was reinstated in April 2022, and CMS will adjust the case-mix indices to reduce half of the unintended increase in payments resulting from the implementation of the new case-mix system starting in 2023. Different assumptions about costs, case mix, and revenues will raise or lower the projection.

How should Medicare payments change in 2024?

In considering how payments should change for 2024, we note that current law is expected to increase payment rates by 2.6 percent in 2024 (an estimated market basket increase of 2.7 percent minus a productivity adjustment of 0.1 percent). CMS will revise its estimates before the publication of the final rule, expected before August 1, 2023. CMS has also announced in the 2023 final rule that it intends to reduce payments in 2024 by 2.3 percent to correct for unintentional increases in payment resulting from the implementation of the PDPM payment system. In addition, while it is not required by law, CMS corrects for overestimates and underestimates of the SNF market basket. If CMS determines that it underestimated the market basket by more or less than 0.5 percentage point in fiscal year 2022, it will apply the correction in fiscal year 2024. Currently, the correction would result in an increase to account for the 3.5 percentage point underestimate. On net, if all of these changes are implemented, the update would be a 3.8 percent increase in 2024 relative to 2023.

The Medicare margin in 2023 will depend on many factors. On the payment side, the update to the payment rate may not accurately capture any real changes in patient acuity or the recording of patient characteristics that 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.

The combination of the new case-mix system, provider relief funds, and the temporary federal policies resulted in robust financial performance in 2021. Medicare margins were high, and total margins increased. 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. FFS Medicare is a preferred payer for SNFs. The Medicare margin indicates that the SNF PPS exerts too little pressure on providers to control costs. Indicators of access to care and quality continue to reflect the impact of the pandemic in 2021. Furthermore, transaction activity in the industry suggests that buyers see continued financial opportunities in this setting.

RECOMMENDATION 7

For fiscal year 2024, the Congress should reduce the 2023 Medicare base payment rates for skilled nursing facilities by 3 percent.

RATIONALE 7

The level of Medicare's payments indicates that a reduction is needed to better align aggregate payments to aggregate costs. The financial performance of SNFs has not deteriorated during the pandemic. Quite the opposite: Despite reduced volume, and staffing and wage pressure, the aggregate SNF Medicare margins were higher during the pandemic than before, due in part to a new case-

TABLE 7–8

SNF updates and forecast errors

	2021	2022	2023
Updates based on forecasts			
Market basket	2.2%	2.7%	3.9%
Productivity	0.0	–0.7	–0.3
Forecast error correction	–	–0.8	1.5
Parity adjustment	–	–	–2.3
Total	2.2	1.2	2.7
Actual market basket			
Market basket	3.7	6.2*	4.2*
Forecast error	1.5	3.5*	0.3*

Note: SNF (skilled nursing facility), TBD (to be determined). CMS makes a forecast error correction when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage point (either too high or too low). This correction is lagged two years.
*Actual market basket for 2022 and 2023 (and related forecast error) will be updated again prior to fiscal year 2024 and 2025 rulemaking.

Source: MedPAC analysis of SNF final rule for fiscal year 2021–2023 and CMS Office of the Actuary forecast from September 2022.

mix system that inadvertently raised payments and the suspension of the sequester. Though a slight decline compared with 2020, the 17.2 percent margin in 2021 was robust. With a projected aggregate Medicare margin in 2023 of 10 percent, payments will remain more than adequate to ensure beneficiary access to SNF care even if payments are lowered.

Although the overall Medicare financial performance of SNFs is good and projected to remain so, the share of providers that operated at a loss in 2021, as well as the large difference in performances between nonprofit and for-profit SNFs, indicate 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 Medicare 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. Second, as the Commission recommended in June 2021, the Congress should revamp the value-based purchasing program, including larger incentive payments, which would direct funds to facilities that perform well on quality and resource use measures (Medicare Payment Advisory Commission 2021a).

IMPLICATIONS 7

Spending

- Current law is expected to increase payment rates by 2.6 percent in 2024. 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.

TABLE 7–9

The number of active nursing homes certified as Medicaid providers declined slightly from 2021 to 2022

	2018	2019	2020	2021	2022
Number of facilities	15,040	14,965	14,840	14,756	14,611

Note: The 2022 number is through October; 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 data from CMS's Survey and Certification Quality, Certification and Oversight Reports (QCOR) online reporting system.

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 2022).

Medicaid covers nursing home care, which Medicare does not, and Medicaid pays 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 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

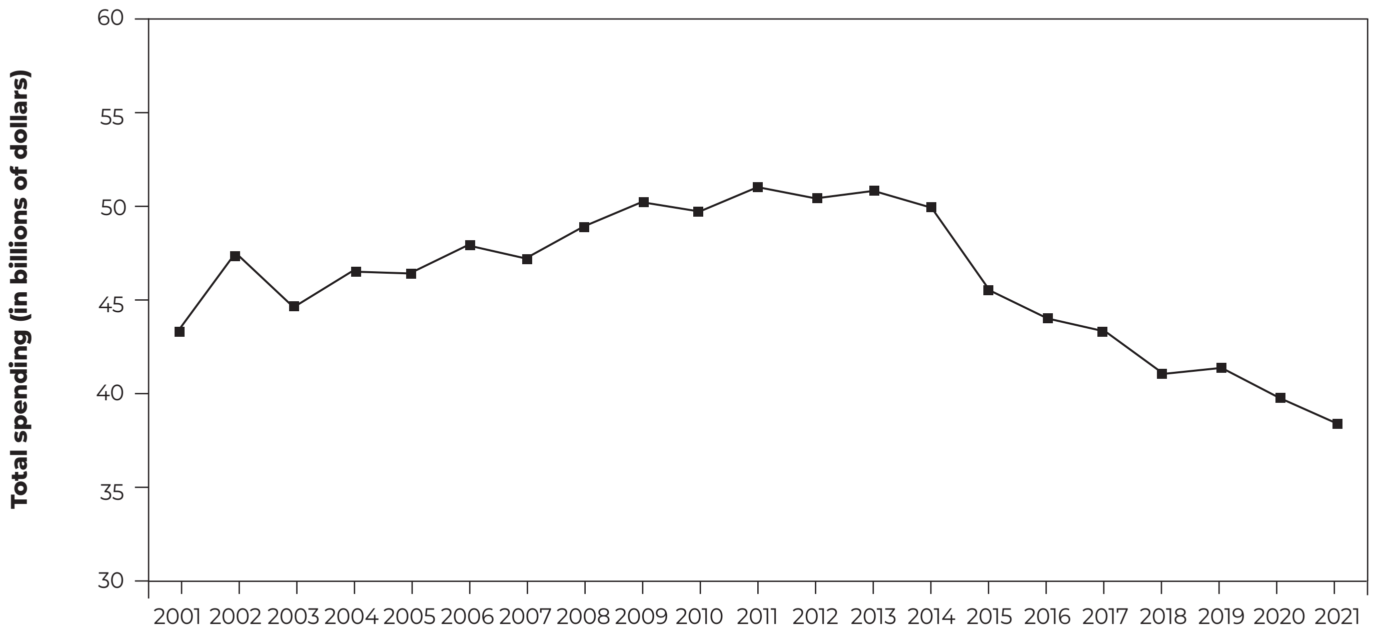
In 2022, 14,611 Medicaid nursing homes were active through October, down from 14,756 in 2021 (Table 7-9). We do not know whether the providers that terminated participation in the Medicaid program remained open but no longer accepted Medicaid patients, closed, or were purchased by another entity and remained open. Between January and October 2022, 14 providers opened and 70 terminated (data not shown). The share of facilities that stopped participating in Medicaid varied by state. States accounting for the highest share of terminations during the period included Minnesota (9 percent); Texas (7 percent); and Iowa, Massachusetts, Ohio, and Wisconsin (6 percent each). Historically, factors contributing to these facilities' fiscal pressures include the lower use of these facilities by beneficiaries in MA plans and alternative payment models, shifts away from institutional care toward home- and community-based care, overexpansion of supply in states with no certificate-of-need laws (such as Texas), and low Medicaid rates. For example, media reports highlighting recent nursing home closures in Montana and South Dakota have cited the role that low Medicaid rates and their impact on hiring and retaining staff have played in facility closures (Hall 2022a, Hall 2022b).

Spending

In 2021, Medicaid FFS spending on Medicaid-funded (combined state and federal funds) nursing home services totaled $38.4 billion, as shown in Figure 7-4 (Office of the Actuary 2022a). This spending dropped an average of 1.5 percent per year between 2018 and 2020 and 3.5 percent between 2020 and 2021. The larger decline in spending in 2021 could reflect Medicaid spending shifting to Medicare due to the waiver of the three-day stay requirement. As of 2021, 24 states operated Medicaid managed care for long-term

FIGURE 7–4

Total Medicaid fee-for-service spending on nursing home services, 2001–2021



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

Source: Office of the Actuary 2022a.

services and supports (Medicaid and CHIP Payment and Access Commission 2021).

In 2021, states increased their Medicaid rates to nursing homes; in 2022, some states significantly raised rates and tied them to staffing improvements

An analysis of Medicaid rate-setting trends in fiscal year 2021 in the 50 states and the District of Columbia found that 8 states froze or reduced rates paid to nursing homes while 39 states increased nursing facility rates, and 4 states did not report data (Gifford et al. 2021). In 2020, this analysis found that 37 states increased their rates. The Families First Coronavirus Response Act (FFCRA), enacted on March 18, 2020, provided a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), retroactive to January 1, 2020, through the end of 2022.[27] Many states spent at least a portion of this FMAP increase to raise nursing home rates.

A few states have significantly and permanently (not tied to temporary enhanced FMAP or the PHE) increased Medicaid nursing home funding in their 2022–2023 state budgets. Pennsylvania and Nebraska increased the base rate to nursing homes by 17.5 percent and 15 percent respectively (Stulick 2022a, Zorn 2022). Illinois increased funding by $700 million (Reiland 2022, Stulick 2022a). Maryland increased reimbursement rates by 8 percent (Maryland Department of Health 2022). California increased Medicaid rates by 4 percent (California State Assembly 2022).

Some states have tied recent nursing facility rate increases to improving direct care staffing. A report from November 2022 found that at least 19 states were implementing strategies to address direct care worker wages through reporting, enforcement policies, or both (National Governors Association 2022). For example, Florida, Illinois, and North Carolina made

TABLE 7–10

All-payer total and non-Medicare SNF margins increased in 2021

Type of margin	2017	2018	2019	2020	2021
All-payer total margin	0.6%	–0.3%	0.6%	3.0%	3.4%
Non-Medicare margin	–2.4	–3.2	–2.2	–0.3	0.1

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 2021. "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 2017 to 2021.

staff wage increases a condition of receiving increased Medicaid reimbursement rates (Musumeci et al. 2022, Reiland 2022). Florida and North Carolina specified that the minimum wage of nursing home staff must be increased to $15 an hour as a condition of the rate increase. Massachusetts and North Carolina directed nursing homes to dedicate most of their rate increase (75 percent to 80 percent) toward improving direct care staff wages (Musumeci et al. 2022).

States also continue to use provider taxes to raise federal matching funds. In 2022, 45 states and the District of Columbia levied provider taxes on nursing homes to increase federal matching funds (Gifford et al. 2021). The augmented federal funding may be split with the nursing homes to increase their payments.[28]

All-payer total and non-Medicare margins in nursing homes in 2021

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, such as nursing home care, hospice care, ancillary services, home health care, and investment income). In 2021, the all-payer total margin for freestanding providers was 3.4 percent (Table 7-10). The improvement in overall performance reflects the remaining pandemic-related relief funds, PHE-related policy changes, temporary pandemic-related increases in Medicaid payment rates in many states, and higher payments under Medicare's new case-mix system. Since 2000, except for 2018 (when the total margin was negative), the all-payer total margin has ranged from 0.4 percent to 3.8 percent (not all years shown).

In 2021, all-payer total margins varied considerably. The median was 3 percent; 25 percent of nursing homes had total margins of –5.7 percent or lower, and 25 percent of nursing homes had total margins of 10.6 percent or higher; 40 percent of SNFs had negative total margins. While sizable and greater than in 2020, the share of SNFs with negative margins was smaller than in 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 0.1 percent. ■

Endnotes

1 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.

2 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 may 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.

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

4 A spell of illness ends when there has been a period of 60 consecutive days during which the beneficiary was neither a hospital nor a SNF inpatient. 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.

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 coronavirus disease 2019 (COVID-19) in the United States, on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed most recently on January 11, 2023.

6 Skilled services must be ordered by a physician, require the skills of technical or professional personnel, and be furnished directly by or under supervision of such personnel.

7 Almost all SNFs certified for Medicare patients, nearly 96 percent, are dually certified as nursing homes that provide long-term care services.

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 CMS mandated vaccines for health care workers, but the mandate does not include booster shots for nursing facilities and other providers that participate in Medicare or Medicaid. Although some states sued to challenge this rule, the Supreme Court allowed the mandate to take effect while those cases are resolved by the lower courts (Chidambaram and Musumeci 2022).

10 This value is an undercount because it does not include deaths and cases prior to May 2020.

11 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; that is, 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.

12 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.

13 Urban and rural facilities have separate base rates under the SNF PPS. Rural base rates are higher for physical therapy, occupational therapy, speech–language pathology services, 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 https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_SNF_FINAL_SEC.pdf.

14 Data published by the National Investment Center for Seniors Housing & Care is derived from the Nursing Home COVID-19 Public File, as captured by the Centers for Disease Control and Prevention (CDC) and reported by CMS. Results include facilities that submitted data for the reporting week and passed the CDC's quality assurance checks. Results were calculated using a "same-store" methodology, which includes only facilities that reported in both comparison time periods (week over week). Facilities that did not provide total number of beds or occupied beds or where the occupied number of beds was greater than the total number of beds were

excluded (National Investment Center for Seniors Housing & Care 2022).

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

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

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

16 The risk adjustment for the measure of successful discharge to the community includes age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for entitlement, principal diagnosis, comorbidities, length 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.

17 In prior reports we characterized the successful discharge to community measure as inclusive of stays that end in a return to the nursing facility from which a beneficiary was admitted. However, Medicare-covered SNF stays that end in a discharge to a nursing home are not considered a discharge to the community in our measure. Consistent with our principle that measures should assess the quality of care provided to all Medicare SNF patients, we will consider ways to modify our measure to include nursing home residents who were successfully discharged to the nursing facility from which they were admitted.

18 Data are from the Senior Care Acquisition Report by Irving Levin and Associates (Irving Levin Associates Inc. 2022). The prices reported are based on arm's length transactions where a willing buyer and a willing seller agree on price with the property exposed to the market. Reported prices include the real estate and the business operations, including any licenses. A sale by a provider to a REIT that then leases the property back to the same provider is not considered to be arm's length. In contrast, a sale by a provider or owner to a REIT that then leases the property to an unrelated third party is considered an arm's length sale.

19 Reporting PHE funds should include the Provider Relief Fund payments and Paycheck Protection Program loans that were booked as revenue and not returned.

20 Because the sequestration is not applied to beneficiary copayments, the reduction to SNF payments is slightly lower than 2 percent. Suspension of the full sequester amount was in effect from May 1, 2020, through March 31, 2022. Between April 1, 2022, and June 30, 2022, half of the full sequester amount was suspended. The full reinstatement of the sequester began on July 1, 2022.

21 BLS data capture changes in hours for employed staff and counts of employed staff. Those data do not account for wages or counts of contract labor. Using Payroll-Based Journal data, we found increased use of contract labor hours per resident day, although it is still a small share of overall labor in the sector.

22 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 for creating and maintaining a safe environment, and $2.25 billion was slated for quality incentive payments (apart from the value-based purchasing program). The incentive funds were disbursed in multiple phases, some of which were captured on the 2021 cost reports. Using Medicare's share of revenues allocates a larger share of the PHE funds to Medicare than using Medicare's share of total days because Medicare's payments are substantially higher than payments from other payers. In this case, the estimate of the Medicare margin would be higher.

23 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.

24 As of November 2021, Diversicare was no longer publicly traded. After being acquired by DAC Acquisition LLC in November 2021, it is privately held (Business Wire 2021).

25 The market basket estimate (2.7 percent) used to establish the 2022 update to payment rates was based on a June 2021 forecast. Since then, the estimate has been revised. The most recent estimate from a September 2022 forecast of the 2022 market basket is 6.2 percent. Consistent with policy precedent in this sector, any correction for under- or overestimate of the market basket by at least 0.5 percentage point in 2022 would be added to the update for fiscal year 2024.

26 CMS makes forecast error corrections when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage point (either too high or too low).

27 FFCRA was enacted on March 18, 2020 (Pub. L. 116–127). Section 6008 provided a temporary 6.2 percentage point increase to each qualifying state's or territory's FMAP ("temporary FMAP increase") under Section 1905(b) of the Social Security Act. States must meet certain conditions to receive the temporary FMAP increase.

28 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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