CHAPTER 6

Skilled nursing facility services

RECOMMENDATION

6 For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3 percent.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

CHAPTER 6

Skilled nursing facility services

In this chapter

- Are FFS Medicare payments adequate in 2024?
- How should FFS Medicare payments change in 2025?
- Medicaid trends

Chapter summary

Medicare covers short-term skilled nursing and rehabilitation services for beneficiaries in skilled nursing facilities (SNFs) after an inpatient hospital stay. Most SNFs also provide long-term care services not covered by Medicare. Medicare makes up a small share of the overall volume for the average SNF. In 2022, about 14,700 SNFs furnished about 1.8 million Medicare-covered stays to 1.3 million fee-for-service (FFS) beneficiaries. Medicare FFS spending on SNF services in SNFs and swing beds combined was $29 billion in 2022.

Assessment of payment adequacy

Overall, our indicators of payment adequacy were positive.

Beneficiaries' access to care—Changes in the indicators of access in 2022 were positive, with occupancy and utilization increasing from downturns in 2020 and 2021. But access to SNF care may be affected by ongoing workforce challenges.

- ***Capacity and supply of providers***—The supply of SNFs declined about 1 percent in 2023. In 2022, 88 percent of Medicare beneficiaries lived in a county with three or more SNFs or swing bed facilities—the same share as in 2021.

- ***Volume of services***—Between 2021 and 2022, Medicare-covered admissions and covered days per 1,000 FFS beneficiaries both increased more than 10 percent. Stays per FFS beneficiary in 2022 were lower than in 2019, but covered days per FFS beneficiary were higher.
- ***FFS Medicare marginal profit***—In 2022, the FFS Medicare marginal profit (an indicator of whether SNFs have an incentive to treat more Medicare beneficiaries) averaged 27 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 and 2022 period, the median facility risk-adjusted rate of discharge to the community from SNFs was 50.7 percent, which was one percentage point lower (worse) than the rate for the 2018 and 2019 period. The median facility risk-adjusted rate of potentially preventable readmissions was 10.4 percent and did not vary across provider types. (Due to a change in the measure calculation, we cannot compare this to a prior time period.) Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of SNF quality measures.

Providers' access to capital—In 2022, the number of nursing facilities acquired was higher than in 2021. The average price per SNF bed reached an all-time high. In 2022, the all-payer total margin—reflecting all payers and all lines of business—was –1.4 percent. Without pandemic-related funds, the all-payer total margin was –4 percent in 2022.

FFS Medicare payments and providers' costs—From 2021 through 2022, FFS Medicare payments per day to freestanding SNFs increased over 2.2 percent, while cost growth slowed to 1.7 percent. The FFS Medicare margin for freestanding SNFs was 18.4 percent in 2022. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth. We project a FFS Medicare margin for freestanding SNFs of 16 percent in 2024.

How should Medicare payment rates change in 2025?

Efficient purchasing of care for the Medicare program would require Medicare's payments to be reduced to more closely align aggregate payments with aggregate costs. The Commission recommends that, for fiscal year 2025, the Congress reduce the 2024 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–FFS Medicare margins. Medicaid finances most long-term care services provided in SNFs, 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 2022 and 2023, the number of Medicaid-certified facilities declined 1 percent, to about 14,500. FFS Medicaid spending (federal and state) was $40.2 billion in 2022, 4.8 percent more than in 2021. The average non–FFS Medicare margin (which includes all payers, funds related to the public health emergency, and all lines of business except FFS Medicare SNF services) was –6.5 percent, a decrease compared with 2021. The reduction in overall financial performance reflects lower reported pandemic-related relief funds, expiration of the sequestration suspension, and the expiration of temporary Medicaid payment increases in many states, but it does not reflect the adequacy of Medicare FFS payment rates. ■

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech–language pathology (SLP) services. SNF patients include those recovering from surgical procedures such as hip and knee replacements or from medical conditions such as infections, stroke, and pneumonia. In 2022, the program spent about $27 billion for 1.84 million FFS Medicare–covered SNF stays under the SNF prospective payment system (PPS). In addition, the program paid $2 billion for SNF care provided in swing beds, but most of those stays are not paid under the SNF PPS. (See the text box on skilled nursing facility care provided in swing beds.)

Medicare coverage and payment

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.[1] To qualify for Medicare coverage, a beneficiary must need daily skilled nursing or rehabilitation services.[2] Medicare's SNF PPS pays SNFs for each day of service.[3] For beneficiaries who qualify for SNF care, Medicare pays 100 percent of the daily amount for the first 20 days. Beginning with day 21, beneficiaries are responsible for copayments through day 100 of the covered stay.[4] In 2024, the copayment is $204 per day.

FFS Medicare's daily payments to SNFs are determined by adjusting base payment rates for geographic differences in labor costs and for case mix. CMS implemented a new SNF PPS case-mix system, the Patient-Driven Payment Model (PDPM), on October 1, 2019. The PDPM was intended to address two problems with the prior case-mix system. First, the PDPM considers more comorbidities and conditions than the prior case-mix system and recognizes and pays for the higher costs associated with medically complex patients. Second, under the prior case mix system, payments for therapy were based primarily on the minutes of therapy that a patient received, which encouraged providers to furnish more therapy services to receive higher payments. Under the PDPM, payments for therapy disciplines are based on patient characteristics and, for PT and OT, on function scores, which are determined from information on a standardized patient assessment instrument called the Minimum Data Set (MDS). As we reported last year, the share of FFS Medicare SNF stays receiving any PT or OT were similar pre- and post-PDPM implementation, but the number of PT and OT minutes per stay dropped

Skilled nursing facility care provided in swing beds

With approval from CMS, certain Medicare-certified hospitals, typically small, rural hospitals, and critical access hospitals (CAHs), may provide skilled nursing services in the hospital beds normally used to provide acute care services. These are called swing beds. In 2022, about 4 percent of SNF care was provided in swing beds. That year, the Medicare program paid nearly $2 billion for about 70,000 Medicare-covered swing bed stays. Skilled nursing facility (SNF)–level services of non-CAH swing bed facilities are paid under the SNF prospective payment system (PPS). The SNF-level services of CAHs with swing beds are exempt from the SNF PPS and are paid based on 101 percent of reasonable costs. In 2022, 88 percent of swing bed stays were in CAHs and 12 percent were in short-term acute care hospitals. Spending on CAH swing beds accounted for 97 percent of program spending on swing beds, owing to the much higher average daily rate (about $2,400 per day) for CAH swing bed days compared with the average SNF PPS daily rate (about $540 per day) paid for swing bed days provided in short-term acute care hospitals. Unless otherwise specified, analyses in this chapter do not include swing beds. ■

TABLE 6–1

Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, FFS Medicare stays, and FFS Medicare spending in 2022

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total number	14,691	1,842,676	$27 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	84	86
Rural	27	16	14
For profit	72	76	79
Nonprofit	22	21	18
Government	5	3	3

Note: SNF (skilled nursing facility), FFS (fee-for-service). Totals may not sum to 100 percent due to rounding and missing values. Table includes covered stays and program spending in SNFs and does not include swing beds. For swing bed information, see the text box on p. 167.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for calendar year 2022.

after the PDPM was implemented, consistent with the PDPM's elimination of incentives to provide more therapy to receive higher payments (Medicare Payment Advisory Commission 2023c).

SNF sector profile

A skilled nursing facility is a provider that meets Medicare's requirements of participation for Part A coverage of SNF care and agrees 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 PT, OT, and SLP 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.

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

Most SNFs (96 percent) are dually certified to provide Medicare Part A–covered SNF care and Medicaid-covered long-term care. 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. In freestanding facilities in 2022, FFS Medicare–covered days made up just 10 percent of facility days in the median facility compared with 63 percent of facility days paid by Medicaid. Given FFS Medicare's relatively high payment rates, the program made up a larger share of facility revenue (17 percent) on average, consistent with shares in 2021.

SNFs are overwhelmingly freestanding, and the majority are for profit

In 2022, 97 percent of facilities were freestanding, and they accounted for 98 percent of FFS Medicare SNF stays and 98 percent of spending (Table 6-1). Seventy-two percent of providers were for profit. Rural facilities make up the minority of SNFs, SNF stays, and SNF spending. (About 20 percent of FFS beneficiaries live in rural counties.) About 4 percent of SNF care was provided in swing bed facilities.

Freestanding SNFs vary in size. In 2022, the median SNF had 100 beds, while 10 percent of facilities had 176 or more beds and 10 percent of facilities had 50 beds or fewer. Nonprofit facilities and rural facilities are generally smaller than for-profit and urban facilities.

TABLE 6–2

Supply of SNFs continued to decline in 2023

	2019	2020	2021	2022	2023	Average annual change 2019–2023	Average annual change 2022–2023
Count of Medicare-participating SNFs	15,291	15,154	15,080	14,945	14,775	–3.4%	–1.1%
Count of certified beds (in millions)	1.62	1.61	1.61	1.60	1.58	–2.3	–0.8

Note: SNF (skilled nursing facility). Counts include active providers serving Medicare beneficiaries during the calendar year in Medicare-certified SNFs in the 50 states and the District of Columbia. Counts do not include nursing facilities that are not Medicare certified. Change was calculated using unrounded numbers.

Source: MedPAC analysis of active provider counts from CMS's Quality, Certification and Oversight Reports (QCOR), accessed on October 16, 2023.

However, the majority (58 percent) of small facilities (under 50 beds) in 2022 were in urban areas.

The SNF sector is fragmented and characterized by independent providers and regional chains. Complex ownership structures can make it difficult to identify common ownership of facilities and to determine the profitability of a SNF and its ancillary businesses and affiliated entities (Harrington et al. 2021). For example, SNFs may have separate operating companies and asset and property companies, which may have common ownership. In late 2022, to better identify common ownership of SNFs, CMS began publicly releasing detailed information on Medicare-certified nursing facilities—including direct and indirect facility owners, changes of ownership, and common ownership across affiliated entities. A recent study of the period from 2013 to 2022 found that investments by real estate investment trusts (REITs) in SNFs grew before leveling off with the start of the coronavirus pandemic and that private equity (PE) investment in SNFs peaked in 2015 and gradually decreased through 2022 (Stevenson et al. 2023).[5] Using CMS data supplemented with proprietary data sources, authors estimated that PE- and REIT-invested facilities were 5 percent and 9 percent, respectively, of U.S. SNFs in 2022 (Stevenson et al. 2023). This research as well as a report from the Government Accountability Office noted errors in the CMS ownership data (Government Accountability Office 2023, Stevenson et al. 2023). In November 2023, CMS issued a final rule defining PE and REIT ownership and requiring nursing facilities to disclose information about entities with operational, financial, or managerial control, including whether they are PE or REIT investors (Centers for Medicare & Medicaid Services 2023b).

Are FFS Medicare payments adequate in 2024?

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. Overall, our indicators of payment adequacy were positive.

Beneficiaries' access to care: SNF supply declined slightly, and occupancy and utilization increased

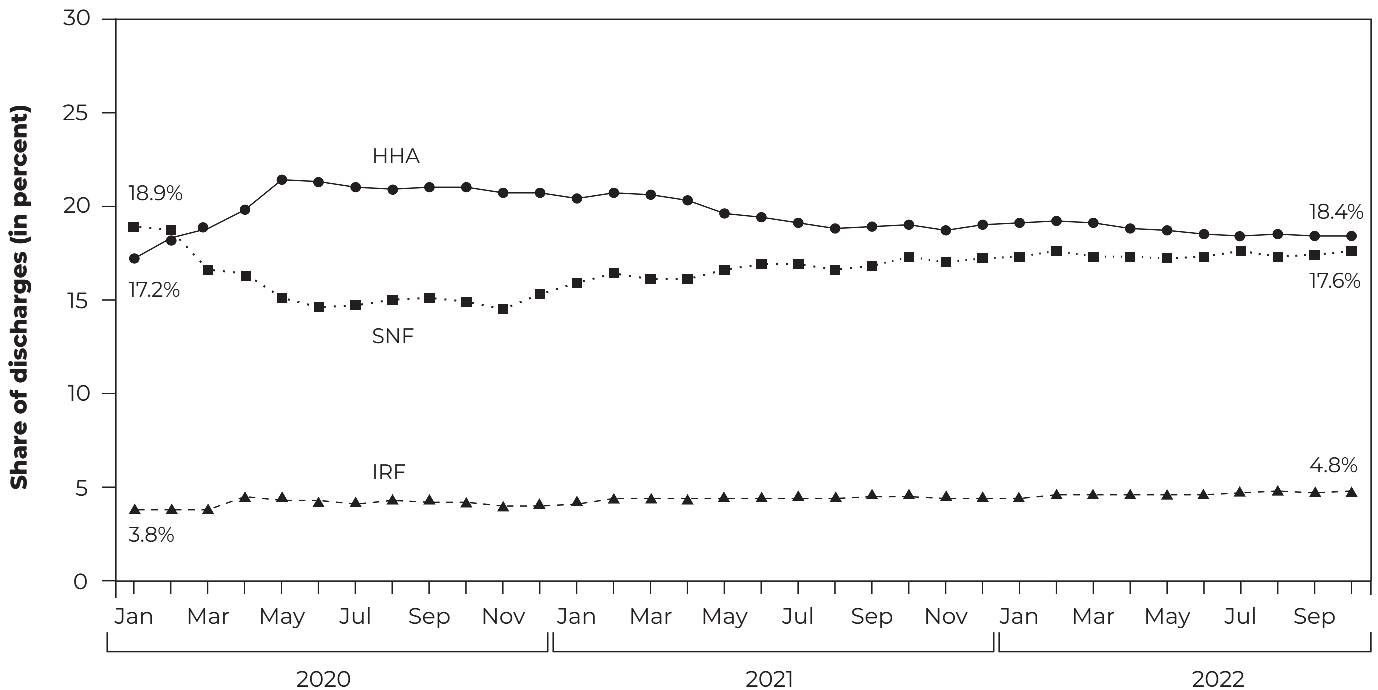
To assess access to SNF care, we consider the supply and capacity of providers and evaluate changes in service volume. We also assess whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve.

SNF supply declined slightly in 2023

In 2023, the number of SNFs participating in the Medicare program (through October) declined about 1 percent from 2022 to 14,775 (Table 6-2). The modest decline in the number of SNFs over time (less than

FIGURE 6–1

Monthly share of FFS Medicare inpatient discharges to SNFs, home health agencies, and IRFs, January 2020 to October 2022



Note: FFS (fee-for-service), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), HHA (home health agency). Figure includes discharges from acute care hospitals paid under the inpatient prospective payment system.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

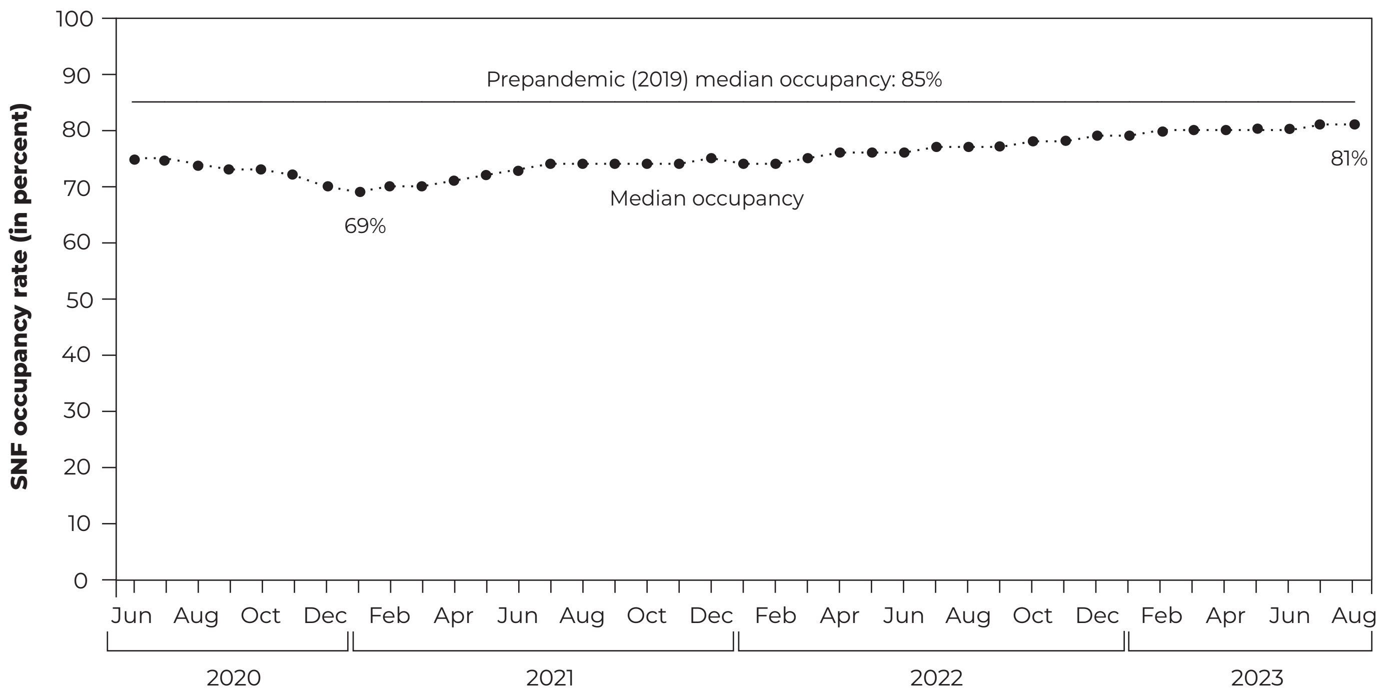
1 percent per year between 2017 and 2021 (Medicare Payment Advisory Commission 2023a)) is likely related to several factors affecting demand for nursing home care, such as states shifting to more home- and community-based long-term care, reportedly low Medicaid payment rates for long-term care, and patient preference for receiving care in non-SNF settings when possible.

In 2022, 88 percent of Medicare beneficiaries with Part A coverage lived in counties with three or more SNFs or swing bed facilities, and 5.8 percent of beneficiaries lived in counties with no or only one SNF or swing bed facility. These shares in 2022 are the same as in 2021. The presence of a facility alone does not ensure access because a facility may not have available capacity. For example, if a beneficiary lives in an area with very high occupancy, they may have a harder time accessing SNF care close to home. As of August 2023, about 6 percent of beneficiaries lived in a county where the average SNF occupancy rate was greater than 90 percent. About 45 percent lived in a county where the average SNF occupancy rate was between 80 percent and 90 percent, and about half lived in a county where the average SNF occupancy rate was lower than 80 percent. Even if a facility has an available bed, some beneficiaries may encounter access problems if they need specialized services or long-term care, as discussed below.

When a SNF terminates participation in the Medicare program, access could be affected if beneficiaries must travel long distances to another facility.[6] Among SNFs that terminated participation in Medicare between 2018 and 2023, the average travel distance to the next-closest SNF or swing bed facility (active in 2023) was greater for terminated SNFs in rural areas than for SNFs in metropolitan areas. For SNFs that closed in metropolitan areas, the median travel distance to the closest SNF or swing bed was less than two miles; for

FIGURE 6–2

SNF occupancy steadily climbed in 2022 and 2023, though not to prepandemic levels



Note: SNF (skilled nursing facility). Data include SNFs in the 50 states and the District of Columbia.

Source: MedPAC analysis of data from the Nursing Home COVID-19 Public File from CMS.

SNFs in rural areas, the median travel distance was about six miles.[7]

The rate of SNF use after an inpatient discharge increased in 2022 after pandemic-related declines

In January 2020, immediately prior to the pandemic, SNFs were the most common first post-acute care (PAC) destination after discharge from an inpatient hospital stay, accounting for 18.9 percent of FFS discharges (Figure 6-1). That same month, 17.2 percent of inpatient stays were discharged home with home health care. As the number of inpatient discharges dropped starting in March 2020, the share of beneficiaries discharged from a hospital to a SNF also declined. At the same time, the share discharged to home health care and inpatient rehabilitation facilities increased. Although by September 2022 SNFs had not regained their prepandemic share of FFS discharges, they had gradually recovered some of the share of discharge volume lost during the pandemic.

SNF occupancy and utilization increased in 2022

Before the public health emergency (PHE), between 2010 and 2019, median occupancy rates for freestanding SNFs were declining—from 88 percent to 85 percent, based on cost report data. Occupancy rates also varied by state. In 2019, median state occupancy rates ranged from 62 percent to 95 percent. Nationally, average occupancy fell during the coronavirus pandemic due to death, move-outs, and avoidance of the setting. SNF occupancy hit its lowest point in January 2021, when the median occupancy rate was 69 percent (Figure 6-2). After that point, occupancy steadily increased. By August 2023, the median national SNF occupancy rate was 81 percent, one-quarter of SNFs had higher than 90 percent occupancy, and one-quarter of SNFs had occupancy of 67 percent or less. By state, median occupancy rates ranged from 63 percent to 93 percent as of August 2023.

SNF employment remained below prepandemic levels but showed gains through July 2023

As occupancy declined in 2020 and 2021, the number of SNF employees also fell steeply. According to the Bureau of Labor Statistics, between March 2020 and the pandemic low in April 2022, the number of employees in the SNF sector declined nearly 18 percent (Bureau of Labor Statistics 2022).[8] Overall employment in the sector has been growing since the second quarter of 2022. By July 2023, employment in the SNF sector was 10 percent lower than in March 2020.

While we do not have empirical data on the extent to which staffing shortages may have constrained access to SNF care or how widespread the effects may have been, SNFs have reported limiting admissions, and hospitals have reported discharge delays and difficulty transitioning patients to SNFs, though delays are not exclusive to FFS Medicare patients (Stulick 2022b). In a report by the Massachusetts Hospital Association drawing on survey data from hospital case managers, the most commonly reported reason for discharge delays (of all patients) to PAC settings were "administrative delays and prior authorization decisions from commercial insurers, especially national Medicare Advantage plans" (Massachusetts Health & Hospital Association 2023). (FFS Medicare does not require prior authorization.) The report also cited discharge delays related to staffing shortages at PAC providers; patients' lack of guardianship or health care proxy designations that make it difficult to approve transfers; patients' needs for specialized services; and patients' needs for long-term care, particularly if a patient has a dementia diagnosis or behavioral health care needs (Massachusetts Health & Hospital Association 2023).

For all FFS Medicare cases discharged to a SNF, the average length of stay in an acute care hospital (ACH) paid under the inpatient prospective payment systems was about a third of a day longer in October 2023, the latest month for which we have complete data, compared with January 2020. During this same period, ACH length of stay also increased for FFS beneficiaries being discharged to other PAC settings and for beneficiaries who did not receive care in a PAC setting after an ACH discharge. The increasing length of stay nationally could be a function of several factors, including increased patient severity (as discussed in the chapter on payment adequacy for hospital services) and discharge delays, which could be more pronounced in some markets or for some patients who need specialized services or long-term care.

SNF admissions and days increased in 2022

SNF use among FFS Medicare beneficiaries was in decline for years prior to the pandemic. Between 2010 and 2019, covered admissions per FFS beneficiary fell 18.5 percent and covered days fell 25.2 percent (Medicare Payment Advisory Commission 2021c). Several factors likely contributed to this decline, including a contemporaneous reduction in inpatient hospital stays needed to qualify for SNF coverage. Although we cannot quantify the extent of this effect on overall FFS Medicare SNF use, the proliferation of alternative payment models may have also contributed, either directly or through spillover effects.[9]

During the first two years of the pandemic (2020 and 2021), SNF utilization per FFS beneficiary declined sharply. Between 2019 and 2021, admissions per FFS beneficiary fell 12 percent and days per FFS beneficiary fell 6 percent. Because hospital capacity was constrained during the pandemic, volume reductions might have been even steeper absent the PHE-related policy that waived the three-day-stay requirement for SNF coverage.

In 2022, the volume of FFS Medicare stays increased in SNFs. The number of SNF stays and covered days increased nearly 7 percent between 2021 and 2022 (not shown). Per FFS beneficiary, SNF admissions were up more than 10 percent between 2021 and 2022 to 54 per 1,000 FFS beneficiaries (Table 6-3). Compared with 2019, covered admissions per FFS beneficiary were 3.1 percent lower in 2022, but covered days were 7 percent higher, owing to longer lengths of stay. Because the SNF PPS pays on a per diem basis, longer lengths of stay result in increased revenue. Increased length of stay could have been driven by a number of factors, including changes in patient acuity and case mix during the pandemic. We will continue to monitor length of stay to see whether these changes persist or revert to lower prepandemic levels.

SNFs with available capacity continued to have a strong financial incentive to admit Medicare beneficiaries

Another measure of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. In considering

TABLE 6–3

SNF admissions and days increased in 2022

Volume measure	2019	2020	2021	2022	Change 2019–2022	Change 2021–2022
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	–3.1%	10.3%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,500	3.6	10.2
Covered days per admission	26.1	28.5	28.0	28.0	7.0	–0.1

Note: SNF (skilled nursing facility), FFS (fee-for-service). Data are for the calendar years and include SNFs in the 50 states and the District of Columbia. Data do not include swing bed stays. Results shown differ from those reported in prior years due to a change in the source. To be consistent with other sectors, we use our own analysis of claims data to assess utilization.

Source: MedPAC analysis of calendar year 2019–2022 Medicare Provider Analysis and Review and Common Medicare Environment data.

whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the FFS 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 FFS Medicare beneficiaries.[10]

In 2022, the FFS Medicare marginal profit among freestanding SNFs was 27 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. FFS Medicare is a preferred payer in this sector, although some SNFs that specialize in Medicare patients may avoid FFS Medicare beneficiaries who are likely to require long stays and exhaust their Medicare benefits.

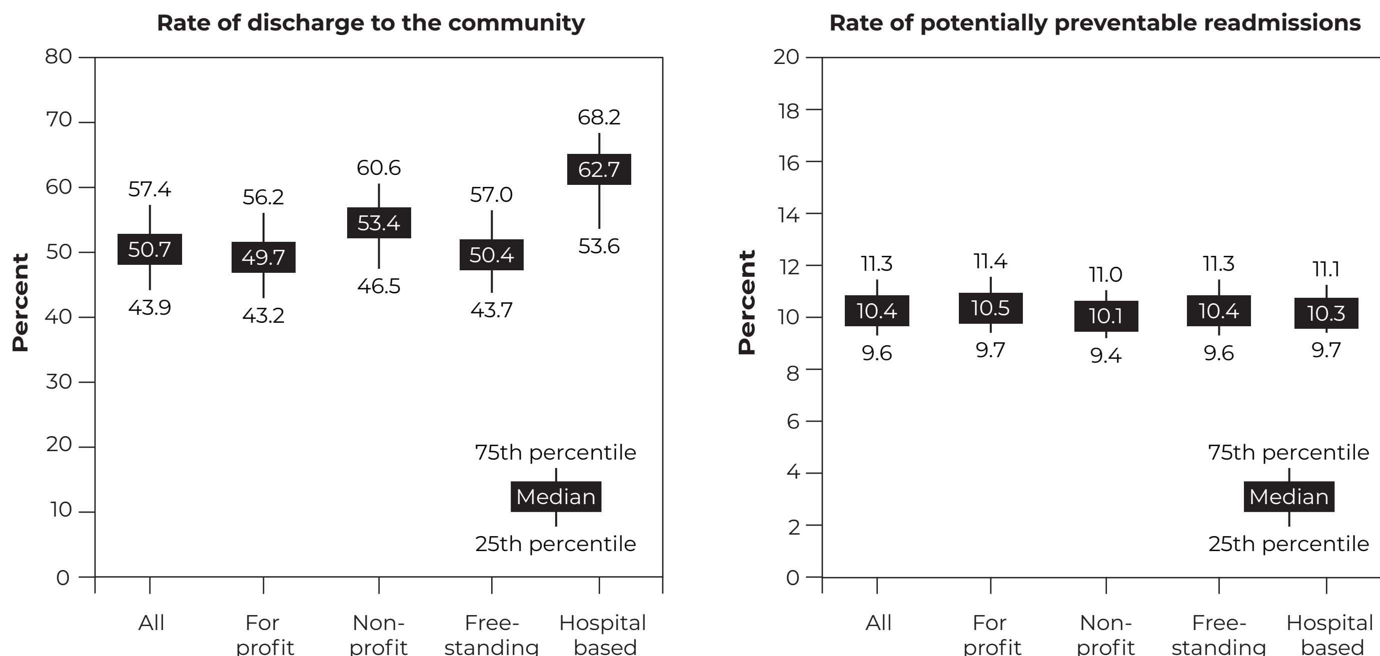
Quality of care: Discharge to the community and potentially preventable readmissions

The Commission prioritizes quality measures tied to clinical outcomes in our assessment of payment adequacy. This year, we report two outcome measures for SNFs: risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community. We are replacing prototype cross-sector measures developed by the Commission, which we have previously used in our analysis of payment adequacy, with these similar claims-based outcome measures developed by CMS. CMS outcome measures are the product of a transparent, expert-informed measure development process and have undergone public notice. They have been and will be refined over time to incorporate improvements. CMS publicly reports facility-level measures after providers have the opportunity to review the data. The measures are updated annually and cover a 24-month period. The most recent available data, released in October 2023, cover the period from the fourth quarter of 2020 through the third quarter of 2022 (fiscal year (FY) 2021 through FY 2022).

The measure of discharge to the community is a SNF's risk-standardized rate of FFS Medicare residents who are discharged to the community after a SNF stay, do not have an unplanned readmission to an acute care hospital or long-term care hospital in the 31 days following discharge to the community, and remain alive during those 31 days (higher rates are better) (RAND Corporation and RTI International 2019).[11] Baseline nursing facility residents—those who were nursing facility residents prior to their Part A–covered SNF stay—are excluded from the measure because discharge to the community may not be a safe or expected outcome for these patients (RAND Corporation and RTI International 2019). SNFs can improve their rate of discharge to the community by

FIGURE 6–3

Median and interquartile range of SNFs' risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2021 and FY 2022



Note: SNF (skilled nursing facility), FY (fiscal year). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (fiscal years 2021 and 2022 combined). The measure of discharge to the community is a SNF's risk-standardized rate of FFS Medicare residents who were discharged to the community after a SNF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of potentially preventable readmissions after discharge is calculated as the risk-adjusted percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Rates are computed from Medicare claims for eligible Medicare Part A–covered SNF stays and do not include swing bed stays.

Source: MedPAC analysis of claims-based outcome measures from CMS's Provider Data Catalog.

providing recuperative nursing care, rehabilitation to improve functional ability, discharge planning care and coordination, and patient and family education. In FY 2021 and FY 2022, the national average observed rate of discharge to the community was 49.7 percent (not shown) and the median facility risk-standardized rate of discharge to the community was 50.7 percent, which is a slight decline compared with the FY 2018 and FY 2019 rate of 51.7 percent (not shown). In FY 2021 and FY 2022, one-quarter of facilities had a risk-standardized rate below 43.9 percent and one-quarter had a rate above 57.4 percent (Figure 6-3).

Readmissions expose beneficiaries to hospital-acquired infections and increase the number of transitions between settings. They also unnecessarily increase Medicare spending. A SNF can reduce the number of potentially preventable hospital readmissions by preventing complications, providing clear discharge instructions to patients and families, and ensuring a safe discharge plan. Potentially preventable readmissions after discharge are calculated as the percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better) (RTI International 2016). During the FY 2021 and FY 2022 period, the national average observed rate (not shown) of potentially preventable readmissions was 10.5 percent. The median facility-level risk-adjusted rate of potentially preventable readmissions was 10.4 percent (Figure 6-3). This rate is not comparable with earlier periods

because CMS updated the list of diagnosis codes in diagnosis categories that are considered potentially preventable readmissions but which were excluded in the original development of this measure. This change makes the measure more comprehensive but incomparable with previous time periods.

Readmissions and discharge to the community measures assess key outcomes of SNF care, but they do not capture all aspects of quality in SNFs. Ideally, we could also measure other outcomes and the experience of SNF care for Medicare beneficiaries in a Part A stay. However, lack of data on patient experience and concerns about the validity of function data derived from the MDS limit our set of quality measures, as discussed below.

Patient experience data are not collected for SNF patients

The Medicare program does not collect data on beneficiaries' experience of their SNF care, nor on their informal primary caregivers' experiences. In 2021, the Commission recommended that the Secretary finalize development of and begin to report patient experience measures for SNFs. The Commission also noted that such measures should become part of the measure set for the SNF value incentive program (see text box on improving value-based payment to SNFs, p. 177) (Medicare Payment Advisory Commission 2021b). CMS proposed adopting a patient experience survey in the SNF proposed rule for 2024 but opted not to implement this provision in the final rule (Centers for Medicare & Medicaid Services 2023c).

Although not a direct measure of patient experience, the number and continuity of staff can impact quality of life and patient safety in a SNF (National Academies of Sciences 2022). In addition, the clearest evidence to emerge from research on the effects of SNF staffing is the positive correlation between registered nurse (RN) staffing levels and outcomes (Armijo-Olivo et al. 2020, Clemens et al. 2021, Jutkowitz et al. 2023) and turnover and outcomes (Gandhi et al. 2021, Loomer et al. 2022, Zheng et al. 2022). However, from the Commission's perspective, nursing facility staffing ratios and turnover are difficult to interpret as specific quality measures for Medicare-covered stays because they apply to the entire facility and not just to Medicare-covered stays.

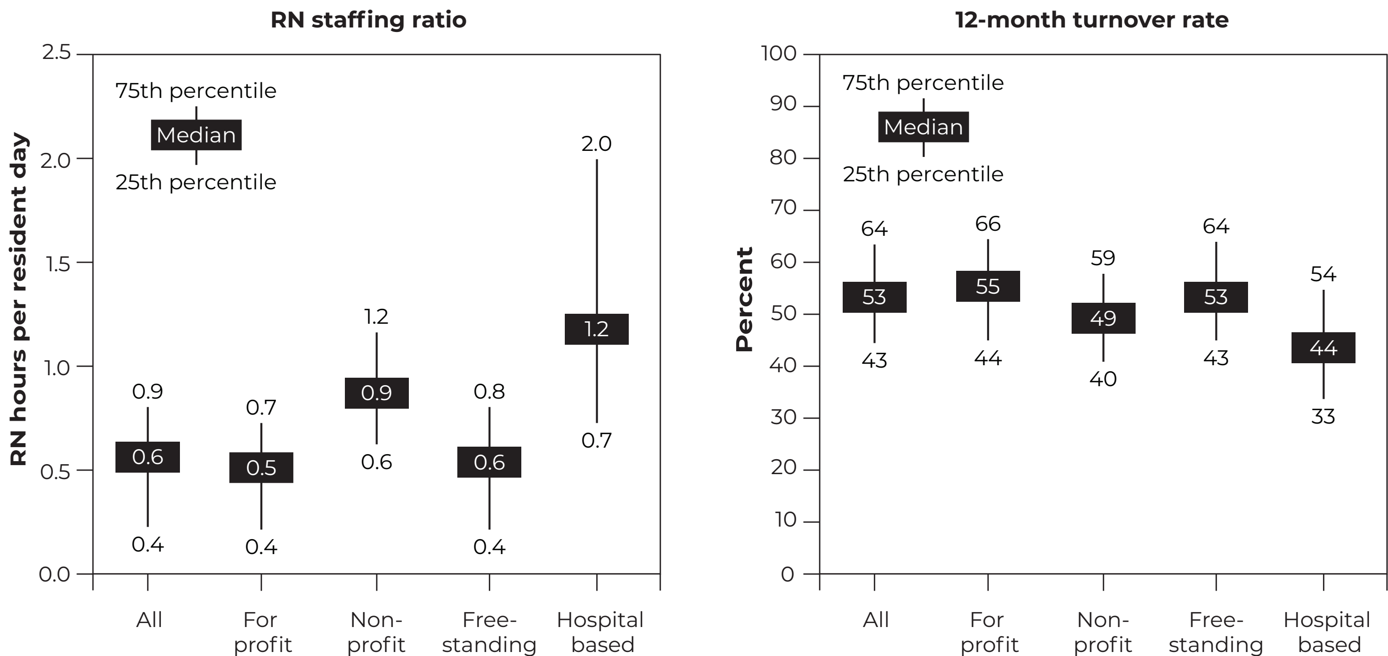
RN staffing ratios and staff turnover rates vary by facility and among categories of SNFs. In 2022, the median SNF provided 0.6 RN hours per resident day (HPRD), as shown in Figure 6-4 (p. 176). Freestanding SNFs had lower median case-mix-adjusted RN staffing (0.6 HPRD) than hospital-based SNFs (1.2 HPRD), and for-profit SNFs (0.5 HPRD) had lower median case-mix-adjusted RN staffing than nonprofit SNFs (0.9 HPRD) and government SNFs (0.7 HPRD). Although the staffing ratios are adjusted for acuity, some of the differences we observe could nevertheless reflect the mix of long-stay residents and short-stay PAC patients in a facility. The 12-month nursing staff turnover rate as of the fourth quarter of 2022 was 53 percent for the median SNF, as shown in Figure 6-4.[12] One-quarter of facilities had turnover rates greater than 64 percent—meaning nearly two-thirds of their nursing staff left the facility in a 12-month period.

Patient function is a key SNF outcome, but the Commission has questioned the accuracy of function information reported by PAC providers

Maintaining and improving patients' function is a key outcome of post-acute care. SNFs assess and record information on each beneficiary's level of function at admission to and discharge from a SNF using the MDS.[13] We analyzed SNFs' risk-adjusted share of short-stay patients who gained independence in function between admission to and discharge from the SNF and found that the mean facility share of patients who made improvements in function increased almost 9 percentage points between 2019 and 2023, even as the overall number of therapy minutes declined.[14] However, because provider-reported function data are used to assign patients to case-mix groups to adjust payment, the Commission has raised concerns about the validity of PAC function data. As we reported in our June 2019 report to the Congress, PAC providers' recording of functional assessment information, such as change in mobility, appears to be influenced by incentives in the applicable payment systems (Medicare Payment Advisory Commission 2019). Thus in our 2021 recommendations for an alternative quality incentive program—the SNF value-incentive program (see text box, p. 177)—the Commission noted that provider-reported patient assessment information (such as functional status) should not be included until CMS has a process in place to regularly validate these data (Medicare Payment Advisory Commission 2021b).

FIGURE 6–4

SNFs' median and interquartile range of acuity-adjusted RN staffing ratios and total nursing staff 12-month turnover rates, 2022



Note: SNF (skilled nursing facility), RN (registered nurse). Staffing ratios for the year are determined by averaging the quarterly values for each provider for the calendar year. All Medicare- and Medicare/Medicaid–certified SNFs with valid data are included.

Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's provider data catalog.

Because functional outcomes are critically important to patients receiving PAC, the Commission has discussed strategies to improve the assessment data, the importance of monitoring the reporting of these data, and the use of alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019). Beneficiaries and policymakers have a strong interest in objective information about SNFs' effectiveness in improving or maintaining their patients' functional abilities. The ability to monitor patient function is especially important given the reduction in therapy minutes that beneficiaries are provided since the implementation of the PDPM. (See the related discussion about decreased therapy minutes on pp. 167–168.)

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 the entire facility. Because Medicare makes up a minority share of most SNFs' revenue, access to capital generally reflects factors other than the adequacy of Medicare's payments, such as the adequacy of Medicaid payment rates.

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.

The SNF value-based purchasing program

As part of the Protecting Access to Medicare Act of 2014 (PAMA), the Congress enacted a skilled nursing facility (SNF) value-based purchasing (VBP) program that began adjusting payments to providers in October 2018. PAMA mandated the use of a single measure (30-day all-cause hospital readmissions) to gauge the quality of care that SNFs provide to fee-for-service (FFS) beneficiaries. Subsequently, in the Consolidated Appropriations Act, 2021, the Congress granted authority to the Secretary to add up to nine more measures to the SNF VBP program.

In June 2021, the Commission made two recommendations in a mandated report evaluating the SNF VBP program (Medicare Payment Advisory Commission 2021b). First, the Congress should eliminate Medicare's current SNF VBP program and establish a new SNF value incentive program that:

- scores a small set of performance measures,
- incorporates strategies to ensure reliable measure results,
- establishes a system that minimizes cliff effects in distributing rewards,
- accounts for differences in patient social risk factors using a peer-grouping mechanism, and
- completely distributes a provider-funded pool of dollars.

Second, the Commission recommended that the Secretary finalize patient experience measures for SNFs and begin to report the data.

Under its authority to expand the measure set, CMS adopted additional measures for the SNF VBP program in the SNF prospective payment system final rules for fiscal year (FY) 2023 and FY 2024 (Centers for Medicare & Medicaid Services 2022b). Three new measures will be added in fiscal year 2026, and an additional five new measures will be added in FY 2027 (Centers for Medicare & Medicaid Services 2022b). ■

Currently, 35 states and the District of Columbia maintain some form of CON program (National Conference of State Legislatures 2023). Similarly, at least 13 states have a moratorium, most commonly for long-term care providers, on certain activities and capital expenditures such as expanding the number of long-term care beds in a facility.

Each year, Irving Levin Associates produces data and commentary on the volume of SNF transactions and the price per bed. These indicators provide information on buyer interest and their willingness to invest in the sector. In 2022, the average price per SNF bed rose to a record high of $114,200, which was 17 percent higher than the 2021 average price of $98,000 (data not shown) (Irving Levin Associates LLC 2023a, Irving Levin Associates LLC 2022). The prices reported are based on arm's length transactions in which a willing buyer and a willing seller agree on a price with the property exposed to the market. Reported prices include the real estate and business operations, including any licenses.[15] In 2022, the number of SNF transactions was 104, compared with 139 in 2021. Although there were fewer transactions in 2022, the number of facilities and beds involved in these deals was higher in 2022 than in 2021 (Table 6-4, p. 178).

In 2022, buyers saw a favorable reimbursement environment that they could maximize in acquired facilities (Irving Levin Associates LLC 2023a). In

TABLE 6–4

The number of publicly announced SNF transactions, 2018–2022

	2018	2019	2020	2021	2022
Number of transactions	206	186	150	139	104
Number of facilities	351	365	265	258	381
Number of beds	43,550	42,043	31,900	31,300	43,500

Note: SNF (skilled nursing facility).

Source: Irving Levin and Associates Senior Care Acquisition Report 2019–2023.

addition, for buyers, "the ancillary businesses surrounding the SNF, from staffing agencies to therapy companies to food providers, all add revenue streams to the parent company and provide more opportunities for profit as they add more patients under their operational umbrellas" (Irving Levin Associates LLC 2023a). As debt became more expensive in 2023, the average price per bed dropped to $106,800 for the four quarters ending in mid-2023 (Irving Levin Associates LLC 2023b). While this price is still high by historical standards, analysts expect the average price to continue falling in 2024, "especially for struggling assets" (Irving Levin Associates LLC 2023b).

The Department of Housing and Urban Development (HUD) is an important lending source for this sector. Section 232 loans help finance SNFs by providing lenders with protection against losses if borrowers default on their mortgage loans. In 2023, HUD financed 196 projects, compared with 269 projects in 2022 (Department of Housing and Urban Development 2023, Department of Housing and Urban Development 2022). The total HUD-insured amount in 2023 was $2.9 billion, compared with $3 billion in 2022 (Department of Housing and Urban Development 2023, Department of Housing and Urban Development 2022). In addition to HUD and commercial bank loans, a minority of facilities access capital via private equity, as discussed above (ATI Advisory 2022).

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 in this sector.

All-payer total margins decreased in 2022

In 2022, the estimated all-payer total margin for freestanding SNFs (reflecting all lines of business, all payers, and investment income) was –1.4 percent, down from 3.4 percent in 2021. In 2022, 51 percent of SNFs had negative all-payer total margins, up from 40 percent in 2021. Higher all-payer total margins in 2020 and 2021 were due to the general and targeted funding that SNFs received during the PHE, the PHE-related changes in Medicare policies, and the increases in Medicaid rates made by many states, some of which were temporary. Provider relief funds were reported in 2022, though the amounts in aggregate were about half of what they were in 2020 and 2021, contributing to the reduced all-payer total margin. Without these additional funds, all-payer total margin in 2022 would have been about –4 percent.

Because the all-payer total margin includes Medicaid-funded long-term care, the overall financial performance of this setting is heavily influenced by state policies regarding the level of Medicaid payments, including base rates and supplemental payments. A 2023 Medicaid and CHIP Payment and Access Commission study found that nursing facility profitability under Medicaid varies by facility and across and within states, and it lacks transparency (see the text box on Medicaid nursing facility payments relative to costs, pp. 180–181).

While some have argued that Medicare SNF PPS rates should remain high to subsidize lower rates from other payers, particularly Medicaid, the Commission has long held that subsidizing Medicaid or other payers with Medicare payment rates that are far in excess of providers' costs is poor policy for several reasons, discussed below.

Higher Medicare payment rates could create undesirable incentives for providers that harm patient care and exacerbate inequities The differential between Medicare's payment rates and those of other payers such as Medicaid encourage providers to select patients based on payer source. It also encourages providers to rehospitalize dual-eligible facility residents (those enrolled in both Medicare and Medicaid) to qualify them for a Medicare-covered SNF stay at a higher payment rate, and to extend the length of a Medicare-covered SNF stay to receive additional payment. Higher FFS Medicare payment rates could further encourage providers to enter or leave certain markets to maximize utilization of the highly paid services, which could in turn limit access to non-Medicare-covered services for some patients, particularly dual-eligible beneficiaries.

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). Facilities that specialize in high-revenue Medicare-covered PAC services (as opposed to long-term care services) also care for fewer Black and Hispanic patients and patients on Medicaid, further limiting the reach of Medicare-funded subsidies (Werner et al. 2021). As some SNFs have increased their share of Medicare admissions, increased specialization in PAC may exacerbate existing racial and economic disparities in access to high-quality SNF care (Werner et al. 2021).

Medicare subsidization of other payers through Medicare's PPS payments results in poorly targeted subsidies Facilities with high Medicare volume currently receive the most in "subsidies" through higher Medicare payments, while facilities with low Medicare volume—potentially the facilities with the greatest financial need—receive the least. Thus, higher Medicare payments do not target assistance to those facilities with high Medicaid volumes.

Medicare's subsidization of Medicaid does not differentiate among states with relatively high or low Medicaid payments States establish Medicaid rates to nursing facilities, and those rates vary across and within states. Medicare's high payment levels encourage states to maintain low Medicaid payments or further reduce them. Lower Medicaid rates, in turn, increase a facility's reliance on the higher Medicare rates, creating pressure to raise Medicare rates even more—essentially creating a growing Medicare funding stream for long-term care, which is not a covered Medicare benefit.

Maintaining or raising Medicare's payments to subsidize other payers exerts pressure on an already fiscally challenged Medicare program If policymakers wish to provide additional support to certain SNFs, they could do so through a separate, targeted policy. It is important for providers that treat large shares of Medicaid patients to be supported, but that cost should be Medicaid's responsibility and not be funded by the Medicare program.

Medicare payments and providers' costs: FFS Medicare margins remained high in 2022

In 2022, the aggregate FFS Medicare margin for freestanding SNFs was 18.4 percent, an increase of less than 1 percentage point compared with 2021. FFS Medicare margins for individual facilities varied considerably across providers, as they have in prior years.

Trends in FFS spending and cost growth

In 2022, FFS Medicare spending on care in SNFs was $27 billion, an increase of 8.4 percent compared with 2021. This increase in overall spending is a function of rebounding volume (see discussion on pp. 172–173). Program spending in 2022 also reflects continued excess payment resulting from the implementation of the PDPM case-mix system starting in 2020. 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 2022a). CMS identified this overpayment starting in FY 2020, but it opted not to make an adjustment for overpayments (totaling 4.6 percent) until FY 2023 and FY 2024 (Centers for Medicare & Medicaid Services 2022a).[16]

Medicaid nursing facility payments relative to costs vary widely and appear to fall short of the cost of care, but better data are needed

States have flexibility to determine Medicaid nursing facility (NF) payment policy, including setting Medicaid base payment rates.[17] Information about Medicaid rates and their relationship to costs has been limited. A 2023 Medicaid and CHIP Payment and Access Commission (MACPAC) study examined Medicaid NF payments at the facility level and estimated how those payments compare with facility-level, Medicaid-specific costs (Medicaid and CHIP Payment and Access Commission 2023b). MACPAC found a wide range, both within and across states,

(continued next page)

Between 2021 and 2022, the average payment per day in freestanding SNFs increased 2.2 percent, while costs per day increased 1.7 percent. Changes in payments per day in 2022 reflect the combined effect of the market basket increase to the base rate and an increase in case mix, as well as the reinstatement of the 2 percent sequester starting in April 2022.[18] The relatively lower growth in costs per day reflects more covered days over which to spread fixed costs. Routine costs per day increased in 2022, but the rate of growth moderated compared with 2021, when growth in costs per day increased 4 percent. Total cost growth in 2022 reflects both a higher-than-historical average growth in routine costs per day and partially offsetting reductions in ancillary costs per day. The growth in routine costs reflects increased labor costs in 2022, which may have been driven by higher wages, use of contract labor, and a greater decline in lower-paid nursing aide staff relative to higher-paid nursing staff. Wage data for the SNF sector from the Bureau of Labor Statistics show that hourly wages in the sector grew nearly 5 percent in 2022 (Bureau of Labor Statistics 2023). While still higher than historical rates of growth, 2022 wage growth was lower than in 2020 or 2021, when it was over 8 percent per year.

In contrast to routine costs per day, ancillary costs per day declined between 2021 and 2022. Under the PDPM, providers no longer receive additional payments for providing additional minutes of therapy. Between 2021 and 2022, minutes of therapy per discharge decreased about 11 percent in aggregate and a greater share of all therapy minutes were provided in a group setting or concurrently. The reduction in ancillary costs per day between 2021 and 2022 is consistent with the reduced amount of therapy minutes and increased group and concurrent therapy we observe.

Consistent with past years, cost growth and level of costs varied by ownership. In 2022, nonprofit providers reported larger increases in cost per day compared with for-profit providers (2.3 percent vs. 1.8 percent). In 2022, 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. Nonprofit SNFs also have higher average nurse hours per resident day than for-profit SNFs.

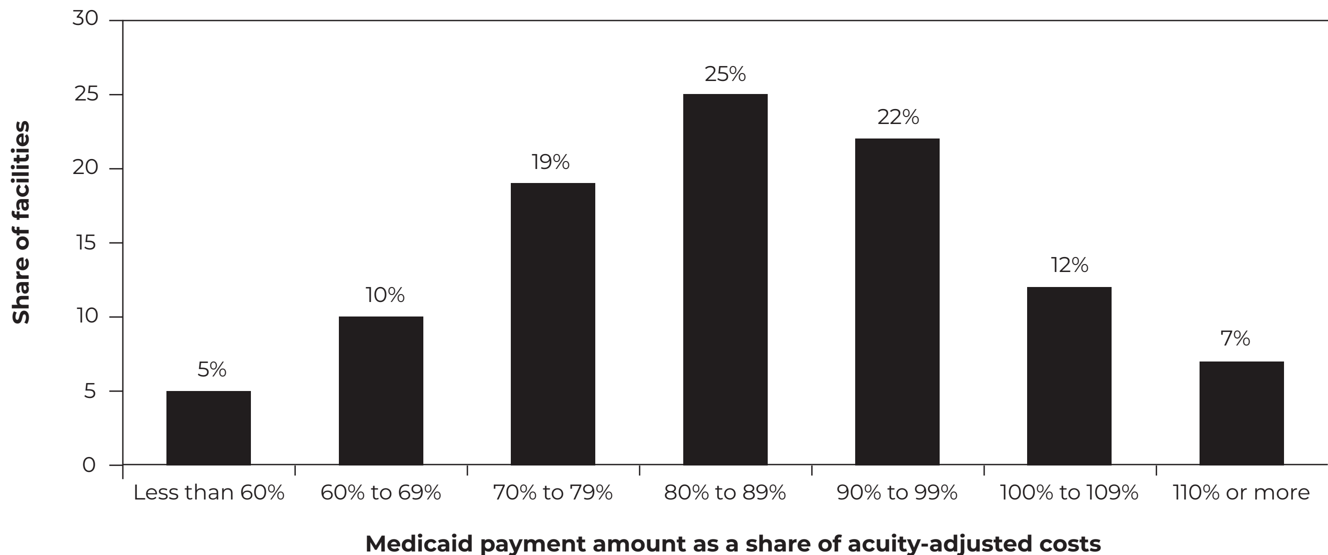
The FFS Medicare margin for freestanding SNFs remains high

The FFS Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's FFS payments with providers' costs to treat FFS beneficiaries. In 2022, the FFS Medicare margin for freestanding SNFs was 18.4 percent, not including federal relief funds.[19] For the 23rd consecutive year, the FFS Medicare margin for freestanding SNFs was 10 percent or higher (Figure 6-6, p. 182). While the PDPM better recognized medical complexity as it relates to resource use and reduced incentives to provide more therapy, it also

Medicaid nursing facility payments relative to costs vary widely and appear to fall short of the cost of care, but better data are needed (cont.)

FIGURE 6–5

Distribution of Medicaid base nursing facility payment amounts as a share of nursing facilities' acuity-adjusted costs, 2019



Note: Base payments include resident contributions to their share of costs. Analysis excludes Alaska, New Hampshire, and Idaho because of unreliable or missing data. Managed care–allowed amounts in California, Massachusetts, New Jersey, Rhode Island, and Virginia were not available, so only fee-for-service Medicaid spending is included for these states. Payment amounts do not include Medicaid supplemental payments.

Source: Abt Associates analysis for the Medicaid and CHIP Payment and Access Commission of the Transformed Medicaid Statistical Information System (T-MSIS), Medicare cost reports, and the Minimum Data Set Medicaid and CHIP Payment and Access Commission (2023b).

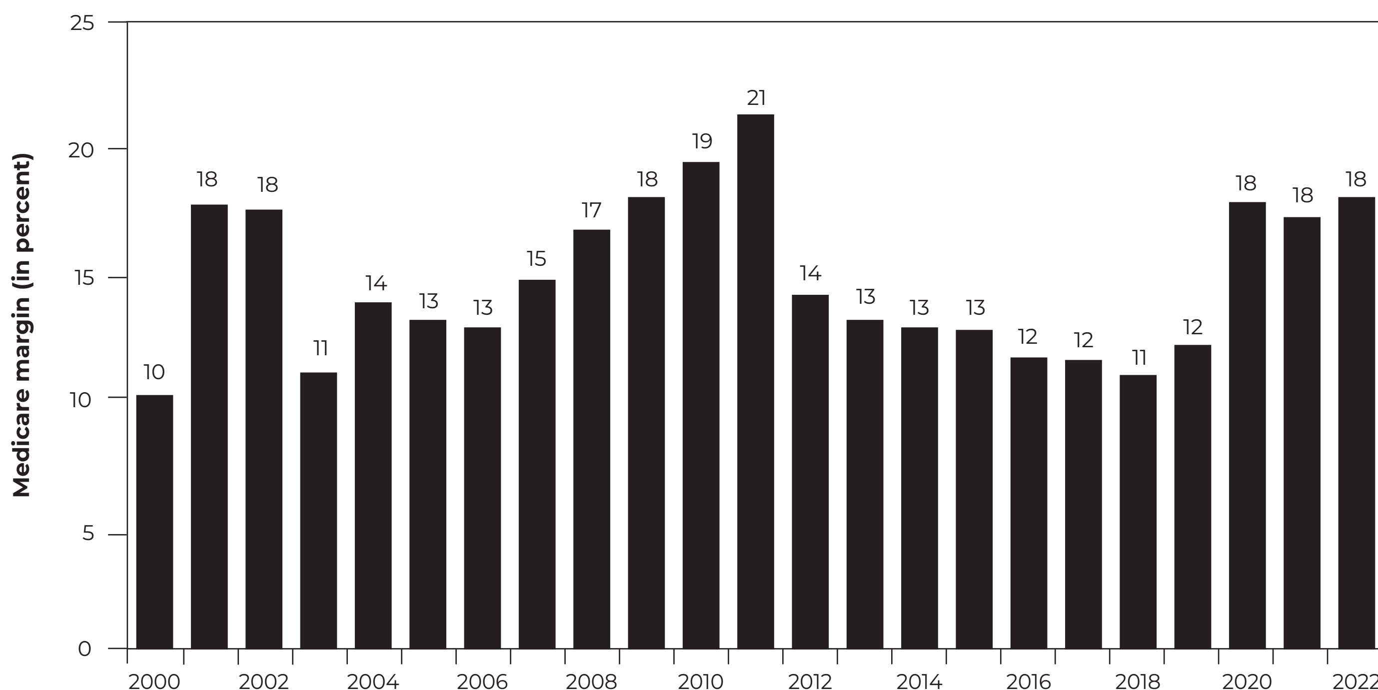
in base payments (not including supplemental payments) compared with acuity-adjusted costs in 2019. The median NF had base payment amounts that were 86 percent of costs. Fifteen percent of facilities had base payment amounts less than 70 percent of costs, while one-fifth of facilities had base payment amounts that covered at least 100 percent of costs (Figure 6-5).

Because NFs in 23 states also receive supplemental Medicaid payments in addition to base payment amounts, base payment amounts alone do not reflect total Medicaid payments to nursing facilities.[20] However, supplemental payments are not reflected in Figure 6-5 because facility-level supplemental payment data used in this study were not reliable for nearly all states. For two states with reliable supplemental payment data, MACPAC found that supplemental payments substantially increased payments, making Medicaid a profitable payer for more facilities in these states (Medicaid and CHIP Payment and Access Commission 2023a).

MACPAC's analysis showing the variability in Medicaid base payment rates and profitability of Medicaid at the facility level lends further support to the Commission's long-held principle that higher across-the-board Medicare fee-for-service payments would provide poorly targeted Medicare subsidies. ■

FIGURE 6–6

Freestanding SNFs' aggregate FFS Medicare margin has been 10 percent or higher since 2000



Note: SNF (skilled nursing facility), FFS (fee-for-service). FFS Medicare margin is calculated as aggregate FFS Medicare payments minus aggregate FFS Medicare costs, divided by aggregate FFS Medicare payments. The margins for 2020, 2021, and 2022 exclude pandemic-related federal relief funds.

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2022.

set payments too high. (As mentioned above, CMS estimates that payments were 4.6 percent higher than intended because of the PDPM.) Indeed, following implementation of the PDPM in 2019, the SNF FFS margin jumped from 12 percent to 18 percent and remained at about that level through 2022.

In 2022, hospital-based SNFs (which account for 2 percent of program spending on SNFs) continued to have substantial negative FFS Medicare margins (data not shown). The FFS Medicare margin for hospital-based SNFs was –56 percent (compared with –36 percent in 2021 and –48 percent in 2020). 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.

FFS Medicare margins varied widely in 2022

FFS Medicare margins for freestanding SNFs varied widely across SNFs: One-quarter of SNFs had FFS Medicare margins that were 28.9 percent or higher, and one-quarter had margins that were 4.4 percent or lower (Table 6-5). The differences in FFS 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 per day. Compared with for-profit facilities, nonprofit facilities were smaller (fewer beds and lower volume) and had lower payments per day, higher costs per day, and higher growth in costs per day between 2021 and 2022. The FFS Medicare margins for urban

SNFs were 1 percentage point higher than those for rural SNFs in 2022. 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 FFS Medicare margins partly reflect the economies of scale that larger SNFs achieve. Facilities with 20 to 50 beds had a lower average FFS Medicare margin compared with facilities with 100 to 199 beds. And low-volume facilities (bottom quintile of total facility days) had a lower average FFS Medicare margin 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 a FFS Medicare margin that was nearly 30 percentage points higher than SNFs with the highest (in the top 25th percentile) cost per day.

SNFs in the top quartile of the distribution of FFS Medicare margins appear to pursue cost and revenue strategies. Compared with SNFs in the lowest FFS Medicare margin quartile, high-margin SNFs have lower standardized costs per day and per discharge. High-margin SNFs also have lower total nursing and RN hours per resident day compared with low-margin SNFs, and this difference is reflected in their lower routine costs. High-margin SNFs are also more likely than low-margin SNFs to care for beneficiaries with low incomes: They had, on average, a higher share of Medicare-covered SNF stays attributable to beneficiaries receiving the Part D low-income subsidy and higher shares of total Medicaid-covered facility days. (For additional discussion about the relationship between LIS share and financial performance, see the text box on a Medicare safety-net index for SNFs, pp. 184–185.) Facilities with a higher Medicaid mix may keep their costs lower, in part through lower staffing, contributing to their higher FFS Medicare margins. High-margin SNFs also have longer lengths of stay, which yield additional revenue under the SNF per diem payment system, and higher nursing case-mix index. Economies of scale also affect the difference in financial performance. In 2022, high-margin SNFs had more beds and higher daily census on average.

TABLE 6–5

Variation in freestanding SNF FFS Medicare margins persisted in 2022

Provider group	FFS Medicare margin 2022
All providers	18.4%
25th percentile of FFS Medicare margins	4.4
75th percentile of FFS Medicare margins	28.9
For profit	22.0
Nonprofit	1.1
Urban	18.5
Rural	17.5
Frontier	13.3
Cost per day: High	3.2
Cost per day: Low	33.0
Small (20–50 beds)	–1.2
Large (100–199 beds)	20.6
Low facility volume	0.3
High facility volume	24.7
Low LIS share	3.3
High LIS share	29.1

Note: SNF (skilled nursing facility), FFS (fee-for-service), LIS (low-income [drug] subsidy). Except for the margins at the 25th percentile and 75th percentile, the FFS Medicare margins in the table are aggregates for the facilities included in the group. All margins exclude pandemic-related federal relief funds. "Frontier" refers to SNFs in counties with six or fewer people per square mile. "Facility volume" comprises all facility days. "High facility volume" is the top quintile of total facility days, and "low facility volume" is the bottom quintile of total facility days. "Low LIS share" is the bottom quartile of the LIS-beneficiary share of FFS Medicare stays, and "high LIS share" is the top quartile of the LIS-beneficiary share of FFS Medicare stays.

Source: MedPAC analysis of 2022 Medicare freestanding SNF cost reports and SNF Medicare Provider Analysis and Review and Common Medicare Environment data.

Information suggests Medicare Advantage rates are lower than FFS payments for SNF care, but better data on MA payments and use are needed

We do not have comprehensive information on Medicare Advantage (MA) enrollees' use of SNFs, MA plans' SNF payment rates, or SNFs' costs for MA-enrolled beneficiaries. Given the paucity of data, we instead compared Medicare FFS and MA payments reported from secondary sources. Two sources

Assessing the need for a Medicare safety-net index for SNFs

The Medicare program strives to ensure access to Medicare-covered services for all beneficiaries and to provide adequate payment to health care providers to ensure that access. Access to care for low-income Medicare beneficiaries is a particular concern because they often have the greatest health care needs and the fewest personal resources to address them. One way to support access to Medicare-covered services for low-income Medicare beneficiaries is to pay providers more to care for them if the cost to provide care for low-income beneficiaries is higher than the average payment rate.

The Commission developed a two-part framework to identify Medicare safety-net providers and evaluate whether new Medicare safety-net funding might be warranted in a given health care sector (Medicare Payment Advisory Commission 2022). According to the safety-net framework, additional Medicare payments to support safety-net providers serving low-income beneficiaries[21] may be appropriate if:

- low-income beneficiaries (beneficiaries receiving the Part D low-income subsidy (LIS)) are at risk of negative outcomes without additional funding;
- Medicare is not a materially profitable payer in the sector; and
- current payment adjustments cannot be redesigned to adequately support safety-net providers.

In our March 2023 report to the Congress, we applied our Medicare safety-net index framework to hospitals and clinicians, and we recommended additional payments to safeguard access for the vulnerable population (Medicare Payment Advisory Commission 2023c). Because these recommended safety-net payments are funded with Medicare dollars, the Commission's hospital and clinician safety-net policies target Medicare payments to ensure access to Medicare-covered services for Medicare beneficiaries. The Commission's method of gauging safety-net status is Medicare-centric by design; safety-net definitions used by Medicaid and other payers likely will differ.

In April 2023, we applied the Commission's Medicare safety-net index framework to skilled nursing facilities (SNFs) and home health agencies (Medicare Payment Advisory Commission 2023a). We showed that SNFs vary in the extent to which they care for low-income Medicare beneficiaries. For half of SNFs,

(continued next page)

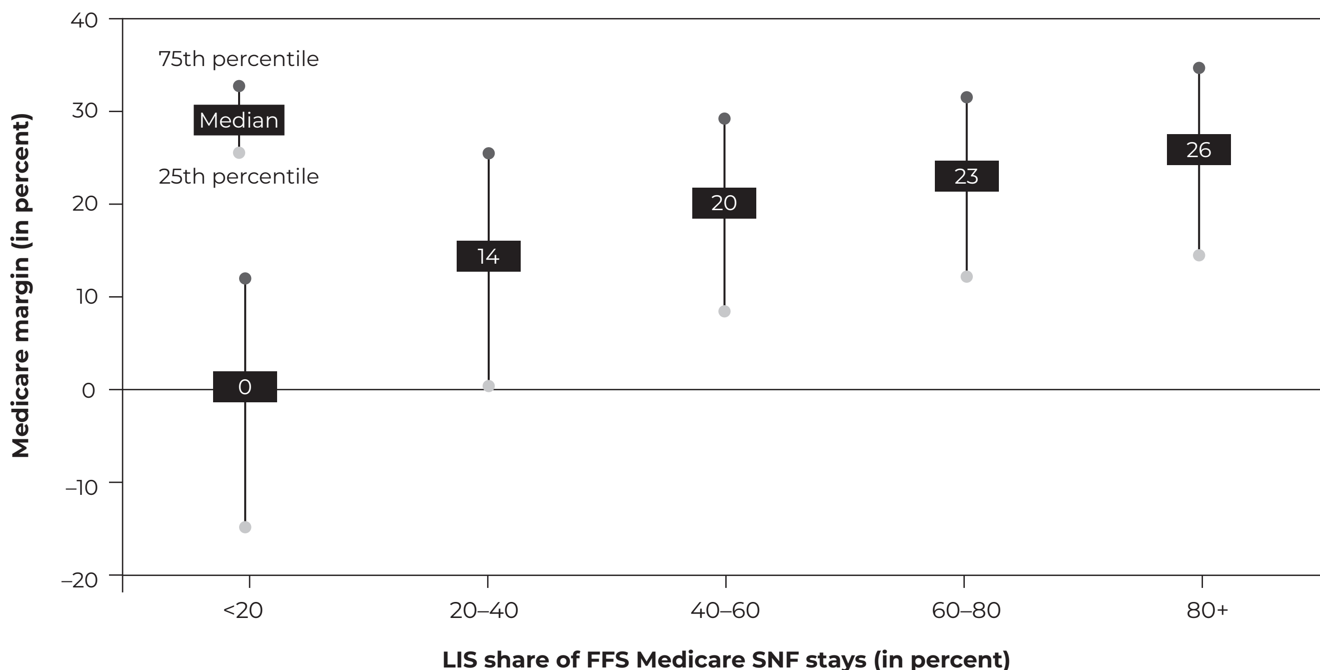
reported MA rates that are 21 percent to 26 percent lower than FFS rates (Ensign Group 2023, National Investment Center for Seniors' Housing and Care 2023). An analysis released by a PAC sector consulting firm using proprietary SNF claims data found that MA payments per day were below the FFS benchmark per day in 12 markets (Zimmit Healthcare Services Group LLC 2023). We do not know whether the lower average daily payment by MA plans relative to FFS rates, as reported in these data sources, reflects differences in service intensity, lower payments for the same service, or some combination. We also do not know how representative these sample rate differences are of the FFS-to-MA ratios for all SNFs. And finally, we do not know the extent of MA claims denials for SNF care.

For future update cycles, we will have finished an internal assessment of the completeness of PAC encounter and assessment data for MA enrollees. Once we determine the completeness of the encounter data, we will have more information about the feasibility of using them to analyze MA enrollees' use of SNFs, MA plans' SNF payment rates, SNFs' shares of patients with

Assessing the need for a Medicare safety-net index for SNFs (cont.)

FIGURE 6–7

Freestanding SNFs with higher shares of LIS Medicare volume had higher median FFS Medicare margins, 2021



Note: SNF (skilled nursing facility), LIS (low-income subsidy), FFS (fee-for-service).

Source: MedPAC analysis of Medicare freestanding SNF cost reports, SNF Medicare Provider Analysis and Review, Common Medicare Environment data.

LIS fee-for-service (FFS) beneficiaries comprised at least 49 percent of the Medicare-covered SNF stays in 2021. For the quarter of SNFs with the highest share of LIS FFS stays, LIS FFS beneficiaries made up 68 percent or more of Medicare-covered stays in 2021.

Using the framework, we grouped SNFs into cohorts based on the share of FFS Medicare-covered stays they provided to LIS beneficiaries and examined the FFS Medicare margins for these cohorts. Freestanding SNFs with greater shares of FFS Medicare stays attributable to LIS beneficiaries had higher median FFS Medicare margins than freestanding SNFs with lower LIS shares, on average (Figure 6-7).

The higher average FFS Medicare margins among SNFs with greater shares of LIS beneficiaries is driven in part by these SNFs' lower average standardized Medicare costs per day compared with providers that have lower LIS volume. These SNFs have greater total volume (measured as average daily census) than SNFs with smaller shares of LIS beneficiaries, so they may achieve economies of scale that could lower their costs per day. Based on these results, we concluded that, although some SNFs care for large shares of FFS LIS beneficiaries, their need for additional Medicare safety-net payments is not indicated by our finding that facilities with higher LIS shares also have higher average FFS Medicare margins than facilities with lower LIS shares. ■

TABLE 6–6

SNF updates and forecast errors for fiscal years 2022–2024

	2022	2023	2024
Updates based on forecasts			
Market basket	2.7%	3.9%	3.0%
Productivity	–0.7	–0.3	–0.2
Forecast error correction	–0.8	1.5	3.6
Parity adjustment	N/A	–2.3	–2.3
Total	1.2	2.7	4.0
Actual market basket			
Market basket	6.3	5.5*	3.2*
Forecast error	3.6	1.6*	TBD*

Note: SNF (skilled nursing facility), N/A (not applicable), TBD (to be determined). CMS makes forecast error corrections when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage points (either too high or too low). This correction is lagged two years.
*Actual market basket for 2023 and 2024 (and related forecast error) will be updated again prior to fiscal year 2025 (and fiscal year 2026) rulemaking.

Source: MedPAC analysis of SNF final rule for fiscal years 2022–2024 and CMS Office of the Actuary forecast from the third quarter of 2023 (with actual data through the second quarter of 2023).

MA-covered SNF stays, and how MA beneficiaries' use and payment compares with that of FFS beneficiaries.

Projecting payments and costs for 2024

To project the FY 2024 FFS Medicare margin for freestanding SNFs, the Commission considered the relationship between SNF costs and Medicare payments in 2022 as a starting point. To estimate costs, we used CMS's Office of the Actuary's (OACT's) estimates of the market baskets for 2023 and 2024 (based on a third-quarter 2023 forecast). The annual market basket indicates how SNFs' costs will change in those years (Table 6-6). OACT's estimate of the SNF market basket increase was 5.5 percent in FY 2023 and 3.2 percent in FY 2024. 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. CMS makes forecast error corrections to payment updates when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage points (either too high or too low).

To estimate payments in 2023 and 2024, we assumed the payment updates specified in the final rules for those years. The updates include the market basket with productivity adjustments and forecast error corrections. We also included the impact of a parity adjustment of –2.3 percent that CMS applied in 2023 and 2024 to correct for an estimated overpayment of 4.6 percent resulting from the implementation of the new case-mix system in 2020. We did not consider additional changes in payments for potential changes in patient acuity or the recording of patient characteristics that would raise or lower payments.

The projected FFS Medicare margin for 2024 for freestanding SNFs is 16 percent. We expect the margin to decline in 2024 relative to 2022 because projected cost growth will exceed payment changes—a combination of payment updates, reinstatement of the sequester, and adjustments CMS made to the case-mix indexes—in 2023 and 2024. Different assumptions about changes in costs, case mix, and revenues could raise or lower the projection.

How should FFS Medicare payments change in 2025?

In 2025, current law is expected to increase payment rates by 2.5 percent (an estimated market basket increase of 2.8 percent minus a productivity adjustment of 0.3 percent). CMS will revise its estimates before the publication of the FY 2025 final rule, expected before August 1, 2024. In addition to the market basket update, CMS corrects for overestimates and underestimates of the SNF market basket two years prior to the rule-making year (2023 in 2025 rulemaking). If it determines that it over- or underestimated the market basket by more than 0.5 percentage points in FY 2023, it will apply the correction in FY 2025. Currently, the correction would result in an increase to account for the 1.6 percentage point underestimate (5.5 percent minus 3.9 percent). On net, if all these changes are implemented, the update would be a 4 percent increase in 2025 relative to 2024.

The FFS Medicare margin in 2024 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, in general and in response to the resumption of the three-day-stay requirement that was waived during the coronavirus PHE. Because we project the margin in 2024 based on current law, our projection does not include any changes to staffing requirements.

The combination of excess payments under the PDPM, lower cost growth, and rebounding FFS Medicare volume in 2022 have contributed to improved financial performance for SNFs paid under FFS Medicare. FFS Medicare margins were high again in 2022, and FFS Medicare remains a preferred payer for SNFs. The FFS Medicare margin indicates that the SNF PPS exerts too little pressure on providers to control costs.

RECOMMENDATION 6

For fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3 percent.

RATIONALE 6

The level of Medicare's payments indicates that a reduction is needed to better align aggregate payments with aggregate costs. The freestanding SNF FFS Medicare margin was 18.4 percent in 2022. With the parity adjustment in 2023 and 2024 to correct for excess payments because of the new case-mix system, we project that the freestanding SNF FFS Medicare margin will be 16 percent in 2024. As such, FFS payments will remain more than adequate to ensure beneficiary access to SNF care even if payments are lowered. A 3 percent reduction to the base rate is needed, in part, to offset CMS's automatic forecast error correction to the payment update. We estimate that the correction will provide an additional 1.6 percent increase in 2025 due to underestimating the market basket in 2023.

Although the overall FFS Medicare financial performance of SNFs is good and projected to remain so, the share of providers that operated at a loss in 2022, as well as the large difference in FFS Medicare margins between nonprofit and for-profit SNFs, indicates that not all providers do well financially under the SNF PPS. 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 other approaches to redistribute FFS Medicare's payments. For example, as the Commission recommended in June 2021, the Congress should replace the value-based purchasing program with a value-incentive program that includes larger incentive payments, which would direct funds to facilities that perform well on quality and resource use measures (Medicare Payment Advisory Commission 2021b).

IMPLICATIONS 6

Spending

- Current law is expected to increase payment rates by 2.5 percent in 2025. This recommendation would lower program spending relative to current law by between $2 billion and $5 billion over one year and between $10 billion and $25 billion over 5 years.

TABLE 6–7

The number of active nursing facilities certified as Medicaid providers declined slightly from 2022 to 2023

	2019	2020	2021	2022	2023	Percent change 2022–2023
Number of facilities	14,965	14,840	14,756	14,630	14,463	–1.1%

Note: The figure for 2023 was calculated through October; it does not include data from the full calendar year. Counts include active providers serving Medicaid beneficiaries in the calendar year for Medicaid-certified facilities in the 50 states and the District of Columbia. Counts do not include SNFs that are not Medicaid certified.

Source: MedPAC analysis of active provider counts from CMS's Quality, Certification and Oversight Reports (QCOR) online reporting system.

Beneficiary and provider

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

Medicaid trends

Section 2801 of the Affordable Care Act of 2010 requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers with a significant portion of revenues or services associated with Medicaid. We report on nursing facility (the term we use for Medicaid-certified facilities that provide long-term care, also commonly called nursing homes) 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 and Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2022).

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

Count of Medicaid-certified nursing facilities

The number of Medicaid-certified nursing facilities has been declining steadily for years. Between 2016 and 2019, the number of active nursing facilities decreased 1.1 percent per year (data not shown). Historically, factors contributing to closures included 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. During the pandemic, the rate of nursing facility terminations slowed.

Between 2022 and October 2023, the number of active Medicaid-certified nursing facilities declined 1.1 percent from 14,630 to 14,463 (Table 6-7). 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 2023, 10 providers opened and 111 terminated (data not shown).

Spending

In 2022, Medicaid FFS spending on Medicaid-funded (combined state and federal funds) nursing facility services totaled $40.2 billion. This increase of 4.8 percent relative to 2021 likely reflects returning long-term care volume in 2022. Prior to the pandemic, FFS Medicaid spending on nursing facility services had

TABLE 6–8

Freestanding SNFs' all-payer total margins fell and were negative in 2022

Type of margin	2018	2019	2020	2021	2022
All-payer total margin	–0.3%	0.6%	3.1%	3.4%	–1.4%
Non-Medicare margin	–3.2	–2.2	–0.8	0.1	–6.5

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 pandemic-related relief funds reported in 2020–2022. The non-Medicare margins reflect the profitability of all lines of business and all payers, exclusive of FFS Medicare–covered SNF services.

Source: MedPAC analysis of Medicare freestanding skilled nursing facility cost reports for 2018 to 2022.

been in decline for years, in part due to a shift away from institutional long-term care and an increased use of managed care organizations, whose data are not reflected in these spending numbers. As of the second quarter of 2023, 24 states operated Medicaid managed care for long-term services and supports (ADvancing States 2023).

The Families First Coronavirus Response Act, 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.[22] Many states used at least a portion of this FMAP increase to raise nursing facility rates temporarily. A few states significantly and permanently (not tied to temporary enhanced FMAP or the PHE) increased Medicaid nursing facility funding in their state budgets for 2022 to 2023 (Gifford et al. 2021). Pennsylvania and Nebraska increased the base rate to nursing facilities by 17.5 percent and 15 percent, respectively (Stulick 2022c, Zorn 2022). Illinois increased funding by $700 million (Reiland 2022, Stulick 2022a). Maryland increased payment rates by 8 percent (Maryland Department of Health 2022). California increased Medicaid rates by 4 percent (California State Assembly 2022). Still more states, including Colorado, Kentucky, Montana, and North Carolina, increased nursing facility rates in their 2023 to 2024 budgets (Marselas 2023, North Carolina Department of Health and Human Services 2023, Patrick 2023, Towhey 2023). Texas increased its Medicaid funding for nursing facilities by $900 million, its first increase in funding in a decade (Grebbin 2023).

Some states have tied recent nursing facilities' rate increases to wages for direct care staffing. A report from November 2022 found that at least 19 states were implementing strategies to address wages for direct care workers through reporting, enforcement policies, or both (National Governors Association 2022). For example, Florida, Illinois, and North Carolina made 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 facility staff must be increased to $15 an hour as a condition of the rate increase. Massachusetts and North Carolina directed nursing facilities to dedicate most of their rate increase (75 percent to 80 percent) toward improving wages for direct care staff (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 facilities to increase federal matching funds (Gifford et al. 2021). The augmented federal funding may be split with the nursing facilities to increase their payments.[23]

Freestanding SNFs' all-payer and non-Medicare margins fell and were negative in 2022

All-payer total margins reflect all payers (including all FFS Medicare, MA Medicaid, and private insurers) and all lines of business plus investment income. In 2022, the all-payer margin for freestanding SNFs was –1.4 percent (Table 6-8). The reduction in overall financial performance reflects lower pandemic-related relief funds, the end of the sequestration suspension, and the

expiration of temporary Medicaid payment increases in many states.

In 2022, freestanding SNFs' all-payer total margins varied considerably. The median was –0.5 percent; 25 percent of SNFs had all-payer total margins of –9.5 percent or lower, and 25 percent of freestanding SNFs had all-payer total margins of 6.6 percent or higher; 51 percent of freestanding SNFs had negative all-payer total margins. Non-Medicare margins reflect the profitability of all lines of business and all payers, exclusive of FFS Medicare–covered SNF services. The non-Medicare margin for freestanding SNFs in 2022 was –6.5 percent. ■

Endnotes

1 A spell of illness ends when there has been a period of 60 consecutive days during which the beneficiary was not an inpatient in either a hospital or a SNF. Coverage for another 100 days does not begin until a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day hospital stay requirement. During the coronavirus public health emergency from January 2020 through May 2023, CMS waived the requirement for a three-day prior hospitalization for coverage of a SNF stay for fee-for-service beneficiaries whose care was affected by COVID-19. CMS also authorized renewed SNF coverage without having to start a new benefit period for certain beneficiaries who recently exhausted their SNF benefits. These waivers allowed facilities to "skill in place" beneficiaries who required skilled care without having to transfer them to a hospital for a three-day hospital stay, which helped retain hospital capacity for COVID-19 patients.

2 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.

3 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.

4 Throughout this chapter, "beneficiary" refers to an individual whose SNF stay is paid for by Medicare Part A. Except where specifically noted, this chapter examines FFS Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans.

5 REITs are corporate entities that own real estate that they lease back to the health care provider, who is responsible for rent, maintenance, insurance, and taxes.

6 Providers that terminated participation in the program may remain open but no longer accept Medicare patients, may have closed, may have been purchased by another entity, or may have been terminated by the program.

7 The travel distance is determined using ArcGIS software and is defined as the driving distance determined by the best path on the street network, rather than a straight-line distance.

8 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 nursing hours per resident day through 2022.

9 Many alternative payment models target the use of PAC to lower spending, either for an episode of care—such as a surgical procedure that is part of a bundled payment—or the total cost of care for assigned populations in a given year, as in the case of accountable care organizations (ACOs) (Haas et al. 2019, Schotland et al. 2023). Evidence from evaluations of the Comprehensive Care for Joint Replacement and the Bundled Payments for Care Improvement Initiative (Model 2), both of which included PAC spending in the episode of care, indicates that they reduced spending largely by reducing institutional PAC use (Barnett et al. 2019). Studies have found that ACOs reduced SNF stays and length of stay for assigned beneficiaries, resulting in modest program savings (Colla et al. 2019, McWilliams et al. 2017). Researchers have also found evidence of ACOs' spillover effects for all Medicare beneficiaries, including lower readmission rates, shorter SNF stays, and less Medicare spending on SNFs, both in hospitals and in SNFs participating in ACOs (Agarwal and Werner 2018).

10 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows: Marginal profit = (payments for FFS Medicare services – (total FFS Medicare costs – fixed building and equipment costs)) / FFS Medicare payments.

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

11 Community, for this measure, is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.

12 Calculation of the annual turnover measures requires six consecutive quarters of Payroll-Based Journal staffing data. Data from a baseline quarter (prior to the first quarter covered by the turnover measures) along with the first two quarters covered by the turnover measures are used for identifying employees who are eligible to be included in the turnover measure. For the total nurse turnover measures, the annual turnover percentage is calculated using this formula: Turnover = total number of employment spells that ended in turnover / total number of eligible employment

spells. An individual's employment spell is considered to end in turnover when they have a period of at least 60 consecutive days in which they do not work at all during the 12 months covered by the turnover measure (e.g., January to December 2022). For additional information, see Centers for Medicare & Medicaid Services (2023a).

13 The function items can be found in Section GG of the MDS. The MDS 3.0 Data Item Set and MDS 3.0 Resident Assessment Instrument Manual are available on the CMS website, https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual.

14 The facility-level risk-adjusted share of short-stay patients who gained independence in function between admission and discharge measure (CMS ID S023.02) is risk adjusted using patient-level covariates and is reported publicly on CMS's Care Compare site. The numerator includes short-stay SNF patients who have a change in function score between discharge and admission that is negative; the denominator includes all short-stay residents with a valid discharge and admission MDS. For each Part A short-stay patient who is included, function scores at admission and discharge are determined for multiple mobility items on the MDS related to transfer, locomotion, and walking, using a 6-point rating scale that ranges from 1 (dependent) to 6 (independent). Items are recoded to 1 (dependent) if they are skipped or missing. Total scores at admission and discharge can range from 15 to 90, with a higher score indicating greater independence. Patients who are independent on all items at admission are excluded. For additional exclusions and measure specifications, see Centers for Medicare & Medicaid Services (2023d), Centers for Medicare & Medicaid Services (2022c), Centers for Medicare & Medicaid Services (2019).

15 A sale by a provider to a REIT that then leases the property back to the same provider is not considered 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.

16 In the Commission's comment letter on Medicare's FY 2022 SNF payment update, the Commission supported a delayed implementation of the recalibration of the parity adjustment because of the impact of the PHE on SNF providers (Medicare Payment Advisory Commission 2021a). However, the Commission noted that a phased-in implementation may not be warranted given high payments in the sector. The Commission also noted that CMS should keep an account of the overpayments until the parity adjustment is made.

17 States are required to ensure that payment rates and methods are consistent with the statutory goals of efficiency, economy, quality, and access (Section 1902(a)(30)(A) of the Social Security Act).

18 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.

19 Allocating a portion of the relief funds reported on 2022 cost reports to payments based on Medicare's share of total facility days, we estimate that the FFS Medicare margin for freestanding SNFs was 20 percent, assuming these funds did not affect providers' costs. 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. SNFs 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, which were captured on the 2020 to 2022 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 FFS Medicare margin would be higher.

20 States can elect to make supplemental payments to providers under their Medicaid programs. Supplemental payments can take several forms, including upper payment limit (UPL) payments, disproportionate share hospital payments, and uncompensated care pool payments. UPL payments are based on the difference between (1) base fee-for-service payments to a class of providers in the aggregate for a fixed period and (2) a UPL specified in regulation. For NFs, the UPL is defined as a reasonable estimate of the amount that would have been paid for the same service under Medicare.

21 Our definition of low-income beneficiaries includes all those who receive full or partial Medicaid benefits (dual-eligible beneficiaries) and those who do not qualify for Medicaid benefits in their states but receive the Part D low-income subsidy (LIS) because they have limited assets and an income below 150 percent of the federal poverty level. Collectively, we refer to this population as "LIS beneficiaries"

because those who receive full or partial Medicaid benefits are automatically eligible to receive the LIS.

22 The Families First Coronavirus Response Act 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.

23 Under a provider tax, states tax all nursing facilities and use 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.

References

ADvancing States. 2023. State Medicaid Integration Tracker© Q1 and Q2 2023. http://www.advancingstates.org/sites/nasuad/files/u34188/CY2023%20Q2%20State%20Integration%20Tracker.pdf.

Agarwal, D., and R. M. Werner. 2018. Effect of hospital and post-acute care provider participation in accountable care organizations on patient outcomes and Medicare spending. *Health Services Research* 53, no. 6 (December): 5035–5056.

Armijo-Olivo, S., R. Craig, P. Corabian, et al. 2020. Nursing staff time and care quality in long-term care facilities: A systematic review. *Gerontologist* 60, no. 3 (April): e200–e217.

ATI Advisory. 2022. *Access to capital in the nursing home industry: A resource on the role of policy and implications for the future.* Washington, DC: ATI Advisory. https://content.nic.org/access-to-capital-in-the-nursing-home-industry.

Barnett, M., A. Wilcock, J. M. McWilliams, et al. 2019. Two-year evaluation of mandatory bundled payments for joint replacement. *New England Journal of Medicine* 380, no. 3 (January 17): 252–262.

Bureau of Labor Statistics, Department of Labor. 2023. Employment, hours, and earnings from the current employment statistics survey (national). https://beta.bls.gov/dataViewer/view/timeseries/CES6562160001.

Bureau of Labor Statistics, Department of Labor. 2022. Employment, hours, and earnings from the Current Employment Statistics survey (National) for NAICS 6321, all employees, thousands, nursing care facilities, seasonally adjusted. https://data.bls.gov/cgi-bin/srgate.

California State Assembly. 2022. California state budget 2022–23: Health and human services. https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023a. *Design for Care Compare nursing home five-star quality rating system: Technical users' guide.* Baltimore, MD: CMS. https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023b. Medicare and Medicaid programs; disclosures of ownership and additional disclosable parties information for skilled nursing facilities and nursing facilities; Medicare providers' and suppliers' disclosure of private equity companies and real estate investment trusts. Final rule. *Federal Register* 88, no. 221 (November 17): 80141–80169.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023c. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; updates to the quality reporting program and value-based purchasing program for federal fiscal year 2024. Final rule. *Federal Register* 88, no. 150 (August 7): 53200–53347.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023d. Skilled nursing facility quality reporting program measure calculations and reporting user's manual version 5.0. https://www.cms.gov/files/document/snf-qm-calculations-and-reporting-users-manual-v50.pdf-0.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022a. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; updates to the quality reporting program and value-based purchasing program for federal fiscal year 2023; changes to the requirements for the Director of Food and Nutrition Services and physical environment requirements in long-term care facilities. Final rule. *Federal Register* 87, no. 148 (August 3): 47502–47618.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022b. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; updates to the quality reporting program and value-based purchasing program for federal fiscal year 2024. Final rule. *Federal Register* 88, no. 150 (August 7): 53200–53347.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022c. Skilled nursing facility quality reporting program measure calculations and reporting user's manual version 4.0. https://www.cms.gov/files/document/snf-quality-measure-calculations-and-reporting-users-manual-v40.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2019. Skilled nursing facility quality reporting program measure calculations and reporting user's manual version 3.0. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf.

Clemens, S., W. Wodchis, K. McGilton, et al. 2021. The relationship between quality and staffing in long-term care: A systematic review of the literature 2008-2020. *International Journal of Nursing Studies* 122 (October): 104036.

Colla, C. H., V. A. Lewis, C. Stachowski, et al. 2019. Changes in use of postacute care associated with accountable care organizations in hip fracture, stroke, and pneumonia hospitalized cohorts. *Medical Care* 57, no. 6 (June): 444–452.

Department of Housing and Urban Development. 2023. FY 2023 summary statistics. https://www.hud.gov/federal_housing_administration/healthcare_facilities/residential_care.

Department of Housing and Urban Development. 2022. FY 2022 summary statistics. https://www.hud.gov/federal_housing_administration/healthcare_facilities/residential_care.

Ensign Group. 2023. Annual report (Form 10–K) for fiscal year ending December 31, 2022. Filing submitted to the Securities and Exchange Commission.

Gandhi, A., H. Yu, and D. C. Grabowski. 2021. High nursing staff turnover in nursing homes offers important quality information. *Health Affairs* 40, no. 3 (March): 384–391.

Gifford, K., A. Lashbrook, S. Barth, et al. 2021. *States respond to COVID-19 challenges but also take advantage of new opportunities to address long-standing issues: Results from a 50-state Medicaid budget survey for state fiscal years 2021 and 2022*. Washington, DC: Kaiser Family Foundation. https://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-provider-rates-and-taxes/.

Government Accountability Office. 2023. *Nursing homes: Limitations of using CMS data to identify private equity and other ownership*. GAO–23–106163. Washington, DC: GAO. September.

Grebbin, S. 2023. Texas legislators approve $900 million for Medicaid rate jump for nursing homes. *Skilled Nursing News*, May 31. https://skillednursingnews.com/2023/05/texas-legislators-approve-900-million-for-medicaid-rate-jump-for-nursing-homes/#:~:text=Texas%20skilled%20nursing%20providers%20may%20see%20a%20%24900,are%20signed%20into%20law%20by%20Governor%20Greg%20Abott.

Haas, D. A., X. Zhang, R. S. Kaplan, et al. 2019. Evaluation of economic and clinical outcomes under Centers for Medicare & Medicaid Services mandatory bundled payments for joint replacements. *JAMA Internal Medicine* 179, no. 7 (July 1): 924–931.

Harrington, C., A. Montgomery, and T. King. 2021. These administrative actions would improve nursing home ownership and financial transparency in the post COVID-19 period. *Health Affairs* blog, February 11. www.healthaffairs.org/do/10.1377/hblog20210208.597573/full/.

Irving Levin Associates LLC. 2023a. *The senior care acquisition report: 28th edition*. New Canaan, CT: Irving Levin Associates LLC.

Irving Levin Associates LLC. 2023b. *Values fall across the board in senior care*. New Canaan, CT: Irving Levin Associates LLC.

Irving Levin Associates LLC. 2022. *The senior care acquisition report*. New Canaan, CT: Irving Levin Associates LLC.

Jutkowitz, E., A. Landsteiner, E. Ratner, et al. 2023. Effects of nurse staffing on resident outcomes in nursing homes: A systematic review. *Journal of the American Medical Directors Association* 24, no. 1 (January): 75–81 e11.

Loomer, L., D. C. Grabowski, H. Yu, et al. 2022. Association between nursing home staff turnover and infection control citations. *Health Services Research* 57, no. 2 (April): 322–332.

Marselas, K. 2023. Panel advances proposal to remove cap, hike state's Medicaid pay by 10%. *McKnight's Long-Term Care News*, March 27. https://www.mcknights.com/news/state-panel-advances-proposal-to-remove-cap-hike-medicaid-pay-by-10/#:~:text=A%20Colorado%20House%20committee%20last%20week%20unanimously%20approved,year%2C%203%25%20in%202025%20and%201.5%25%20in%202026.

Maryland Department of Health. 2022. *Medicare claims processing manual—Chapter 8: Outpatient ESRD hospital, independent facility, and physician/supplier claims*. https://health.maryland.gov/mmcp/Documents/FY23%20Provider%20Rate%20Increases%20Public%20Notice.pdf.

Massachusetts Health & Hospital Association. 2023. *A clogged system: Keeping patients moving through their care journey*. Burlington, MA: Massachusetts Health & Hospital Association. June. https://mhalink.informz.net/mhalink/data/images/ACloggedSystemMHAReport.pdf.

McWilliams, J. M., L. G. Gilstrap, D. G. Stevenson, et al. 2017. Changes in postacute care in the Medicare Shared Savings Program. *JAMA Internal Medicine* 177, no. 4 (April 1): 518–526.

Medicaid and CHIP Payment and Access Commission. 2023a. *Estimates of Medicaid nursing facility payments relative to costs*. Issue brief. Washington, DC: MACPAC.

Medicaid and CHIP Payment and Access Commission. 2023b. *Report to the Congress on Medicaid and CHIP*. June. Washington, DC: MACPAC. https://www.macpac.gov/publication/march-2023-report-to-congress-on-medicaid-and-chip/.

Medicare Payment Advisory Commission. 2023a. Assessing the need for Medicare safety net payments for skilled nursing facilities and home health agencies. Presentation at the Commission's April public meeting. https://www.medpac.gov/wp-content/uploads/2022/07/Tab-G-SNF-HHA-SN-April-2023-SEC.pdf.

Medicare Payment Advisory Commission. 2023b. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf.

Medicare Payment Advisory Commission. 2023c. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2021a. Comment letter on the Centers for Medicare & Medicaid Services' proposed rule entitled "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022."

Medicare Payment Advisory Commission. 2021b. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2021c. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. 2022. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MedPAC/MACPAC.

Musumeci, M., E. Childress, and B. Harris. 2022. *State actions to address nursing home staffing during COVID-19*. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/state-actions-to-address-nursing-home-staffing-during-covid-19/.

National Academies of Sciences, Engineering, and Medicine. 2022. *The national imperative to improve nursing home quality*. Washington, DC: The National Academies Press. https://nap.nationalacademies.org/catalog/26526/the-national-imperative-to-improve-nursing-home-quality-honoring-our.

National Conference of State Legislatures. 2023. Certificate of need (CON) state laws. https://www.ncsl.org/health/certificate-of-need-state-laws.

National Governors Association. 2022. *Addressing wages of the direct care workforce through Medicaid policies*. Washington, DC: NGA. https://www.nga.org/wp-content/uploads/2022/11/DirectCareWorkforcePaper_Nov2022.pdf.

National Investment Center for Seniors' Housing and Care. 2023. *Skilled nursing monthly report: Data through February 2023*. Annapolis, MD: National Investment Center for Seniors' Housing and Care.

North Carolina Department of Health and Human Services. 2023. Legislated Medicaid provider rate increases: skilled nursing facilities (SNF), personal care services (PCS), and private-duty nursing (PDN). https://medicaid.ncdhhs.gov/blog/2023/10/19/legislated-medicaid-provider-rate-increases-skilled-nursing-facilities-snf-personal-care-services.

Patrick, M. 2023. Beshear increases Medicaid reimbursement rates for home and community-based services and long-term care facilities. *Kentucky Health News*, June 12. https://cidev.uky.edu/kentuckyhealthnews/2023/06/12/beshear-increases-medicaid-reimbursement-rates-for-home-and-community-based-services-and-long-term-care-facilities/#:~:text=The%20main%20lobbying%20group%20for%20nursing%20homes%20and,that%20it%20will%20vary%20from%20facility%20to%20facility.

RAND Corporation and RTI International. 2019. *Final specifications for SNF QRP quality measures and standardized patient assessment data elements (SPADEs)*. Report prepared by RAND Corporation and RTI International for the Center for Clinical Standards and Quality and the Office of Minority Health at the Centers for Medicare & Medicaid Services.

Reiland, J. 2022. Where states land on making nursing home Medicaid rate increases permanent. *Skilled Nursing News*, October 14. https://skillednursingnews.com/2022/10/where-states-land-on-making-nursing-home-medicaid-rate-increases-permanent/.

RTI International. 2016. *Measure specifications for measures adopted in the FY 2017 SNF QRP final rule*. Report prepared by RTI International for the Center for Clinical Standards and Quality at the Centers for Medicare & Medicaid Services.

Schotland, S., R. M. Werner, and J. Weiner. 2023. *Medicare payment policy for post-acute care in nursing homes: A review of current policies and utilization with recommendations for improving value*. Philadelphia, PA: University of Pennsylvania. September 14.

Sharma, H., M. C. Perraillon, R. M. Werner, et al. 2020. Medicaid and nursing home choice: Why do duals end up in low-quality facilities? *Journal of Applied Gerontology* 39, no. 9 (September): 981–990.

Stevenson, D., H. Peterson, R. Skinner, et al., Department of Health and Human Services. 2023. *Trends in ownership structures of U.S. nursing homes and the relationship with facility traits and quality of care (research brief)*. Washington, DC: Assistant Secretary for Planning and Evaluation.

Stulick, A. 2022a. $700M Medicaid boost tied to staffing levels greenlit for nursing homes. *Skilled Nursing News*, April 8. https://skillednursingnews.com/2022/04/700m-medicaid-boost-tied-to-staffing-levels-greenlit-for-nursing-homes/.

Stulick, A. 2022b. As labor crisis complicates care transitions, hospitals work to alleviate SNF referral backlog. *Skilled Nursing News*, October 4. https://skillednursingnews.com/2022/10/as-labor-crisis-complicates-care-transitions-hospitals-work-to-alleviate-snf-referral-backlog/.

Stulick, A. 2022c. Medicaid rate increases open doors for nursing homes to finally plan for future. *Skilled Nursing News*, August 25. https://skillednursingnews.com/2022/08/medicaid-rate-increases-open-doors-for-nursing-homes-to-finally-plan-for-future/.

Towhey, J. R. 2023. State's nursing homes to see 33% Medicaid rate increase, exec says. *McKnight's Long-Term Care News*, May 15. https://www.mcknights.com/news/oks-providers-about-to-get-a-not-ok-20-funding-loss/#:~:text=Montana%20nursing%20homes%20will%20see%20an%20approximate%2033%25,even%20that%20will%20be%20enough%20to%20stabilize%20facilities.

Werner, R. M., Z. Templeton, N. Apathy, et al. 2021. Trends in post-acute care in U.S. nursing homes: 2001-2017. *Journal of American Medical Directors Association* 22, no. 12 (December): 2491-2495 e2492.

Zheng, Q., C. Williams, E. T. Shulman, et al. 2022. Association between staff turnover and nursing home quality: Evidence from Payroll-Based Journal data. *Journal of American Geriatrics Society* (May): e222051.

Zimmit Healthcare Services Group LLC. 2023. *Zimmet Healthcare and eCapIntel analysis on Medicare Advantage reimbursement for SNF services, relative to FFS benchmarks.* Manalapan, NJ: Zimmet Healthcare Services Group, LLC.

Zorn, A. 2022. Nursing homes score win with 17.5% Medicaid increase in Pennsylvania for 2023. *Skilled Nursing News*, July 11. https://skillednursingnews.com/2022/07/nursing-homes-score-win-with-17-5-medicaid-increase-in-pennsylvania-for-2023/.

Zuckerman, R. B., S. Wu, L. M. Chen, et al. 2019. The five-star skilled nursing facility rating system and care of disadvantaged populations. *Journal of the American Geriatrics Society* 67, no. 1 (January): 108–114.