

CHAPTER

7

Skilled nursing facility services

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

- 7** The Congress should eliminate the market basket update for 2017 and 2018 and direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities. In 2019, the Secretary should report to the Congress on the effects of the reformed PPS and make any additional adjustments to payments needed to more closely align payments with costs.

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

Skilled nursing facility services

Chapter summary

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2014, about 15,000 SNFs furnished 2.4 million Medicare-covered stays to 1.7 million fee-for-service (FFS) beneficiaries. Medicare FFS spending on SNF services was \$28.6 billion in 2014.

Assessment of payment adequacy

To examine the adequacy of Medicare’s payments, we analyze beneficiaries’ access to care (including the supply of providers and volume of services), quality of care, provider access to capital, and Medicare payments in relation to providers’ costs to treat Medicare beneficiaries. Key measures indicate Medicare payments to SNFs are more than adequate. We also find that relatively efficient SNFs—facilities identified as providing relatively high-quality care at relatively low costs—had very high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

Beneficiaries’ access to care—Access to SNF services remains adequate for most beneficiaries.

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program is stable. Over 90 percent of beneficiaries live in a county with three or more SNFs, and less than 1 percent live in a county without one. Available bed days increased slightly between 2013 and

In this chapter

- Are Medicare payments adequate in 2016?
- How should Medicare payments change in 2017?
- Medicaid trends

2014. In 2014, the median occupancy rate remained at 86 percent, with one-quarter of SNFs having rates at or below 76 percent.

- **Volume of services**—Days and admissions per FFS beneficiary declined between 2013 and 2014, consistent with declines in inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services).

Quality of care—Quality measures show mixed performance. Between 2013 and 2014, the community discharge rate and the rate of hospital readmissions occurring during SNF stays improved slightly. The rate of readmissions that occurred in the 30-day period after discharge from the SNF increased slightly (got worse), and the functional change measures were essentially unchanged.

Providers' access to capital—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Access to capital was adequate and is expected to remain so. Medicare is regarded as a preferred payer of SNF services.

Medicare payments and providers' costs—In 2014, the average Medicare margin was 12.5 percent—the 15th year in a row that the average was above 10 percent. Margins continued to vary greatly across facilities and reflect shortcomings in the SNF prospective payment system (PPS), the resulting favorable selection of rehabilitation patients (over medically complex patients), differences in costs per day, and the cost control exhibited by some providers. The marginal profit (a comparison of Medicare payments to the marginal costs of Medicare patients) was 20.4 percent. The projected Medicare margin for 2016 is 10.7 percent.

Several pieces of evidence indicate that Medicare needs to revise the PPS. Over time, Medicare's payments have grown more inaccurate despite the many changes made to the payment system. The overpayments for therapy services have gotten larger, strengthening the existing incentive to furnish therapy services, regardless of clinical value. At the same time, the payments for nontherapy ancillary services are unrelated to these services' costs, making payments even more poorly targeted than they had been. As broad payment reforms (such as bundled payments and accountable care organizations) are implemented, SNF use may increase because it is a lower cost alternative to inpatient rehabilitation facilities and long-term care hospitals for some patients. Therefore, the importance of the accuracy of FFS payments to SNFs has increased.

Regarding the need to rebase payments, the Commission has found:

- Medicare margins above 10 percent for 15 years;
- marginal profits in 2014 of 20 percent;

- widely varying costs unrelated to case mix and wages;
- cost growth above the market basket that reflects little fiscal pressure from the Medicare program;
- the ability of many SNFs (almost 900, or 8 percent of the facilities included in the analysis) to have consistently relatively low costs and relative high quality;
- the continued ability of the industry to maintain high margins despite changing policies; and
- in some cases, Medicare Advantage (managed care) payments to SNFs that are considerably lower than the program's FFS payments.

Given the continued need to revise the SNF PPS and rebase Medicare's level of payments, the Commission recommends that the Congress freeze Medicare's payments for 2017 and 2018, direct the Secretary to revise the payment system, and require the Secretary to report to the Congress on whether any additional adjustments are needed to align payments with costs.

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid use, spending, and non-Medicare (private payer and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes, but also covers copayments for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities remained essentially unchanged between 2014 and 2015. In 2014, the average total margin, reflecting all payers (including managed care, Medicaid, and private insurers) and all lines of business (such as hospice, ancillary services, home health care, and investment income) was 1.9 percent, the same total margin as in 2013. The average non-Medicare margin (that reflects all services except SNF services for Medicare beneficiaries) was -1.5 percent, a slight improvement from 2013. ■

**TABLE
7-1**

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

Type of SNF	Facilities		Medicare-covered stays		Medicare spending	
	2006	2014	2006	2014	2006	2014
Total number	15,178	15,005	2,454,263	2,344,173	\$19.5 billion	\$27.0 billion
Freestanding	92%	95%	89%	95%	94%	97%
Hospital based	8	5	11	5	6	3
Urban	67	72	79	83	81	85
Rural	33	28	21	17	19	15
For profit	68	70	67	72	73	76
Nonprofit	26	24	29	24	24	21
Government	5	5	4	3	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding and missing values. The spending numbers included here are slightly lower than those reported by the Office of the Actuary. The count of SNFs is slightly lower than what is reported in CMS's Survey and Certification Providing Data Quickly system.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2006 and 2014.

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include those recovering from surgical procedures such as hip and knee replacements or from medical conditions such as stroke and pneumonia. In 2014, almost 1.7 million fee-for-service (FFS) beneficiaries (4.5 percent) used SNF services at least once; program spending on SNF services was \$28.6 billion, or about 8 percent of FFS spending (Boards of Trustees 2015, Office of the Actuary 2015b).¹ Medicare's median payment per day was \$454, and Medicare's median payment per stay was \$18,499. Typically about 20 percent of hospitalized beneficiaries were discharged to SNFs.

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least 3 days.² For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of care. Beginning with day 21, beneficiaries are responsible for copayments. For 2017, the copayment is \$161 per day.

A skilled nursing facility must meet Medicare requirements for Part A coverage.³ Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes (which typically provide less intensive, long-term care services). Thus, a facility that provides skilled care often also provides long-term care services that Medicare does not cover. Medicaid pays for the majority of nursing facility days.

The mix of facilities where beneficiaries seek skilled nursing care has shifted over time toward freestanding and for-profit facilities (Table 7-1). In 2014, freestanding facilities and for-profit facilities accounted for larger shares of Medicare stays and spending than in 2006. After a steady decline in the number of hospital-based facilities over a decade, that share has been stable since 2011. In 2014, 70 percent of SNFs were for profit; they accounted for a slightly higher share of stays (72 percent) and Medicare payments (76 percent), both small increases from 2013.

Medicare-covered SNF days typically comprise a small share of a facility's total patient days but a disproportionately larger share of the facility's revenues. In freestanding facilities in 2014, the median Medicare

share of total facility days was 12 percent, but Medicare accounted for 21 percent of facility revenue.

The most frequent hospital conditions of patients referred to SNFs for post-acute care are joint replacement, septicemia, kidney and urinary tract infections, hip and femur procedures (except major joint replacement), pneumonia, and heart failure and shock. Compared with other beneficiaries, SNF users are older, frailer, and disproportionately female, disabled, living in an institution, and dually eligible for both Medicare and Medicaid (Medicare Payment Advisory Commission 2013).

SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.⁴ Information gathered from a standardized patient assessment instrument—the Minimum Data Set—is used to classify patients into case-mix categories, called resource utilization groups (RUGs). RUGs differ depending on the services SNFs provide to a patient (such as the amount and type of rehabilitation therapy and the use of respiratory therapy and specialized feeding), the patient’s clinical condition (such as whether the patient has pneumonia), and the patient’s need for assistance in performing activities of daily living (ADLs). Medicare’s payment system for SNF services is described in the Commission’s *Payment Basics*, available on the Commission’s website (<http://medpac.gov/documents/payment-basics/skilled-nursing-facility-services-payment-system-15.pdf?sfvrsn=0>). Although the payment system is referred to as “prospective,” two features undermine how prospective it is: The system makes payments for each day of care (rather than set a payment for the entire stay), and it bases payments partly on the minutes of rehabilitation therapy furnished to a patient. Both features result in providers having some control over how much Medicare will pay them for their services.

Almost since its inception, the SNF PPS has been criticized for encouraging the provision of unnecessary rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) services such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002). Under current policy, therapy payments are not proportional to costs but, instead, rise faster than providers’ therapy costs increase (Medicare Payment Advisory Commission and the Urban Institute 2014). The Office of Inspector General (OIG) of the

Department of Health and Human Services also found that the difference between the payments for and the costs of therapy services increased as the amount of therapy provided per day increased (Office of Inspector General 2015b). Payments for NTA services are included in the nursing component, even though NTA costs vary much more than nursing care costs and are not correlated with them.

In 2008, the Commission recommended revising the PPS to base therapy payments on patient characteristics (not service provision), remove payments for NTA services from the nursing component, establish a separate component within the PPS that adjusts payments for NTA services, and implement an outlier payment policy. An outlier policy would offer some financial protection by partly compensating providers that treat exceptionally costly patients. An outlier case would be defined on a stay basis, not on a day basis, because the financial risk to a facility is determined by its losses over the stay, not a given day. In 2012, the Commission recommended revising and rebasing the SNF PPS to address both the distribution and level of payments (Medicare Payment Advisory Commission 2012).

The Commission’s recommended revisions to the PPS would greatly improve the accuracy of payments for therapy and NTA services (Medicare Payment Advisory Commission and the Urban Institute 2014). Assuming no other changes in patient mix or care delivery, the recommendations would not change payments in aggregate but would result in considerable redistribution of payments. In 2014, payments would have increased 32 percent for facilities with relatively low shares of intensive therapy and 12 percent for facilities with relatively high NTA costs per day; payments would have decreased 7 percent for facilities with high shares of intensive therapy and 2 percent for facilities with low NTA costs per day.⁵ Based on the mix of patients and therapy practices, payments would have increased 21 percent for hospital-based facilities, 4 percent for nonprofit facilities, and 4 percent for rural facilities and would have decreased only 1 percent for for-profit facilities. The effects on individual facilities could have varied substantially depending on their mix of patients and current therapy practices.

The American Health Care Association (AHCA), an organization representing long-term care and post-acute care (PAC) providers, has also developed a proposal to revise the SNF PPS, basing payments on a SNF stay (Moran Company 2015). The proposal’s design uses

broadly defined clinical groups based on the patient's condition and reason for SNF care, but not the amount of therapy furnished to a patient. Payments would be adjusted for factors that increase the costs of care, such as having dementia or being over the age of 85 years. The clinical groups and adjusters would be determined by the Secretary of Health and Human Services. The proposal would replace the current rural adjusters (separate base rates for the components) with a 10 percent add-on for geographically isolated facilities and would include short-stay and high-cost outlier policies. Consistent with the Commission's recommended changes to the SNF PPS, AHCA's proposal would lower payments to for-profit facilities (because they furnish more intensive therapy and their stays are longer) and would raise payments to nonprofit facilities (because they furnish less intensive therapy and their stays are shorter).

Based on its work examining SNFs' billing practices and analysis of therapy costs and payments, OIG recommended that CMS evaluate the extent to which therapy payments should be reduced, change the method for paying for therapy, adjust Medicare payments to eliminate any increases unrelated to patient characteristics, and strengthen the oversight of SNF billing (Office of Inspector General 2015b). CMS concurred with these recommendations and stated it was working on an alternative to the current PPS design. In its 2016 work plan, OIG outlined new work to review compliance with documentation requirements to support claims that SNF care is reasonable and necessary (Office of Inspector General 2015a).

In 2015, the Department of Justice continued its enforcement of the False Claims Act, investigating fraud and abuse of therapy billings in SNFs (Noller and Rubin 2015). The inquiries focus on providers that assign large shares of days to case-mix groups with the most intense levels of therapy, the practice of furnishing the minimum number of minutes to assign days to a case-mix group, billing for more minutes than actually provided, billing group therapy as individual therapy, and other issues related to billing and documentation requirements that can maximize reimbursement.

CMS's revisions of the SNF PPS

Although CMS has taken steps to enhance payments for medically complex care, it has not revised the basic design of the PPS to pay more accurately for NTAs or to base payments for rehabilitation therapy services on

patient care needs. In 2010, CMS changed the definitions of the existing case-mix groups and added 13 case-mix groups for medically complex days.⁶ At the same time, CMS shifted program dollars from therapy care toward medically complex care (Centers for Medicare & Medicaid Services 2010). After these changes, the share of days classified into medically complex groups between 2010 and 2011 increased from 5 percent to 7 percent. However, by 2013, the share had decreased to 6 percent, where it remained in 2014. In 2010 and 2011, CMS also lowered payments for therapy furnished to multiple beneficiaries at the same time rather than in one-on-one sessions, and it required providers to reassess patients when the provision of therapy changed or stopped (which would, in turn, change assignments in case-mix groups).⁷ Despite these changes, we found that Medicare's payments for therapy services continue to exceed the cost of these services, and its payments for NTA services bear no relationship to the cost of these services (Medicare Payment Advisory Commission and the Urban Institute 2014).

CMS's work on alternative designs for the SNF PPS began 15 years ago in response to a legislative requirement (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) to conduct research on potential refinements of the SNF PPS (Liu et al. 2007, Maxwell et al. 2003, Urban Institute 2004). Yet, to date, CMS continues to evaluate alternative ways to pay for NTA and therapy services and has not revised the basic PPS design. In 2014, CMS reviewed alternative ways to pay for therapy and later that year announced it was expanding the scope of its research to consider revisions of the entire PPS. In 2015, it held two expert panels to discuss various aspects of alternative designs. It plans additional outreach activities, including another panel in 2016, before it proposes an alternative design.

Are Medicare payments adequate in 2016?

To examine the adequacy of Medicare's payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, providers' access to capital, Medicare payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compare the performance of SNFs that have relatively high and low Medicare margins and compare relatively efficient SNFs with other SNFs.

**TABLE
7-2**

SNF service use declined between 2013 and 2014

Volume measure	2008	2010	2012	2013	2014	Percent change 2013-2014
Covered admissions per 1,000 FFS beneficiaries	73	72	68	67	66	-1.4%
Covered days per 1,000 FFS beneficiaries	1,977	1,938	1,861	1,835	1,808	-1.5
Covered days per admission	27.0	27.1	27.4	27.6	27.6	0.0

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

Source: Centers for Medicare & Medicaid Services 2015b.

Beneficiaries’ access to care: Access is stable for most beneficiaries

We do not have direct measures of access, in part because the need for SNF care, as opposed to other PAC or no PAC, is not well defined. Instead, we consider the supply and capacity of providers and evaluate changes in service volume. We also examine the mix of SNF days to assess PPS shortcomings that can result in delayed admission for certain types of patients.

Capacity and supply of providers: Supply remains stable

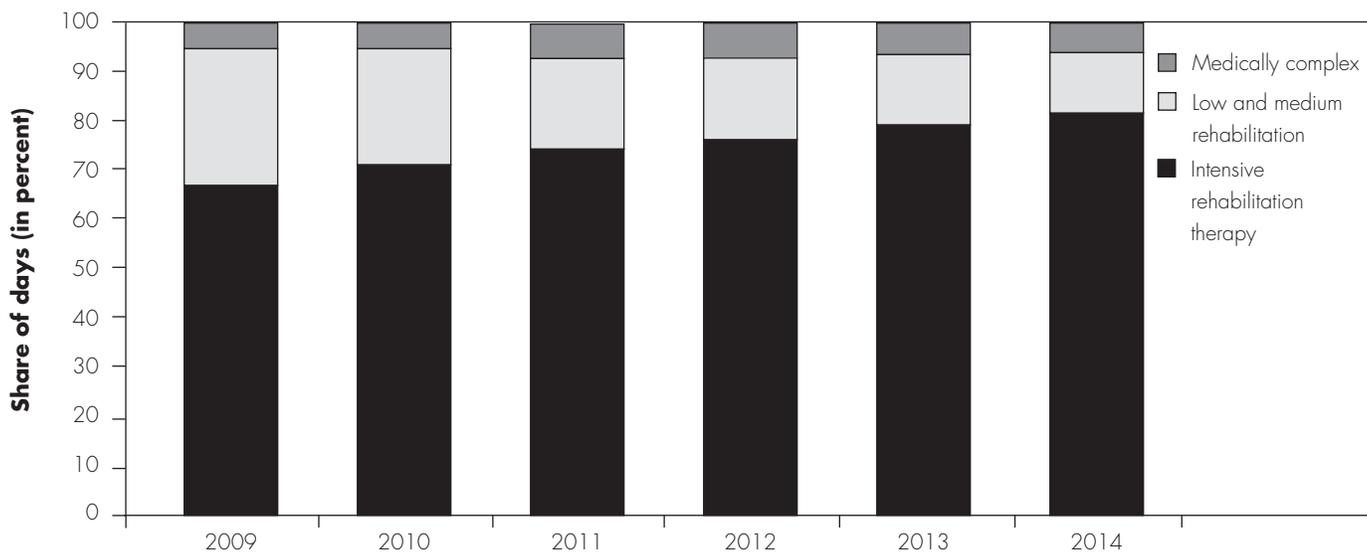
The number of SNFs participating in the Medicare program has been stable for the past 10 years, with just over 15,000 providers. In 2014, there were 92 facilities new to the program, the majority of which were for profit (Centers for Medicare & Medicaid Services 2015a). In 2014, over 90 percent of beneficiaries lived in counties with three or more SNFs or swing bed facilities (a rural hospital with beds that can serve as SNF or acute care beds). Less than 1 percent of beneficiaries lived in a county without a SNF or a swing bed facility, and another 8 percent lived in counties with one or two skilled nursing or swing bed facilities. Between 2013 and 2014, median occupancy rates for freestanding SNFs remained the same (86 percent) and increased slightly for hospital-based facilities (from 81 percent to 82 percent). Although these averages are high, one-quarter of freestanding facilities had occupancy rates at or below 76 percent, indicating capacity for more admissions. The median occupancy rate for freestanding SNFs in rural areas was lower than average (83 percent), and facilities located in areas with small populations (fewer than 2,500 people) had lower median occupancy rates (81 percent).

SNF volume was slightly lower in 2014 than in 2013

In 2013, 4.5 percent of FFS beneficiaries used SNF services, the same share as in 2013. Between 2013 and 2014, SNF volume per FFS beneficiary declined slightly. We examine service use for FFS beneficiaries because the CMS data on users, days, and admissions do not include service use by beneficiaries enrolled in Medicare Advantage (MA) plans. Admissions and days per 1,000 FFS beneficiaries both declined slightly, but there was no change in the average covered length of stay (27.6 days, Table 7-2). Declines in hospital admissions (and, to a lesser extent, readmissions) are the key driver of the decline in SNF stays. As hospital admissions declined, the average patient complexity increased and these patients continued to require PAC. The share of hospital discharges going to SNFs, home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs) increased between 2013 and 2014. As a result, the decline in SNF use was smaller than the decline in inpatient hospital use. The increase in observation days, which do not count toward qualifying as an inpatient admission, may be a small factor, but because the count of observations stays is low relative to the total number of SNF admissions, observation days do not account for a large share of the decline in admissions.

Service mix reflects biases in PPS design

Between 2002 and 2014, the share of days classified into rehabilitation case-mix groups in freestanding facilities increased from 78 percent to 93 percent.⁸ During the same period, the share of intensive therapy days as a share of total days rose from 29 percent to 81 percent. The most recent changes indicate the continued intensification of

**FIGURE
7-1****The share of intensive therapy days in SNFs continues to increase**

Note: SNF (skilled nursing facility). “Medically complex” includes days assigned to clinically complex and special care case-mix groups. “Intensive rehabilitation therapy” includes days assigned to ultra-high and very high rehabilitation case-mix groups.

Source: MedPAC analysis of freestanding cost reports 2009–2014.

therapy provision (Figure 7-1). Between 2011 and 2014, the share of intensive therapy days increased from 74 percent to 81 percent, and the share of days assigned to the highest rehabilitation case-mix groups (the ultra-high groups) increased from 47 percent to 56 percent. Facilities differed in the amount of intensive therapy they provided. In 2014, for-profit facilities and facilities located in urban areas had higher shares of intensive therapy (83 percent for each group) compared with nonprofit facilities (78 percent) and facilities in rural and frontier areas (75 percent and 53 percent, respectively). Hospital-based facilities had lower shares of intensive therapy days (59 percent) compared with freestanding facilities (82 percent). The presence of IRFs in the county did not appear to influence the share of intensive therapy days at SNFs.

Changes in the frailty of beneficiaries at admission to a SNF do not explain the increases in therapy. Compared with the average SNF user in 2011, the average SNF user in 2014 had slightly less ability (5 percent lower score) to perform ADLs (as measured by a modified Barthel score), a 5 percent lower risk score (which measures a patient’s comorbidities), and was the same age. Over the

same period, for the 10 ADLs we examined, the shares of SNF users requiring the most help decreased for 9 activities.⁹ OIG also concluded that SNFs had increased their billing for the highest levels of therapy even though beneficiary characteristics—including age and reasons for and the severity levels of the prior hospital stay—remained unchanged (Office of Inspector General 2015b). Shorter hospital stays could have shifted some therapy provision from the hospital to the SNF setting. However, OIG found that the lengths of stay of the preceding hospitalizations had changed very little between 2011 and 2013 (Office of Inspector General 2015b).

The share of medically complex days (those assigned to the clinically complex or special care case-mix groups) continued to be low (6 percent). Most SNFs admitted medically complex and special care cases: 84 percent of SNFs admitted clinically complex patients and 91 percent admitted special care patients, both up slightly from 2013. Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex admissions. Although the payment rates for medically complex

Measures of skilled nursing facility quality

The measures the Commission examines regarding skilled nursing facility (SNF) quality are risk-adjusted rates of readmission, discharge back to the community, and change in functional status during the SNF stay.

The community discharge measure includes beneficiaries discharged to a community setting (including assisted living) and excludes those discharged to an inpatient setting (e.g., an acute care hospital or nursing home) within one day of the SNF discharge. The measure also excludes beneficiaries who die within 1 day of the SNF discharge and beneficiaries who are readmitted to an acute care hospital within 30 days of admission to the SNF (Kramer et al. 2015). Beneficiaries who are discharged to a nursing home are not counted as community discharges, although the risk adjustment method (and the comorbidities) captures some of the differences in patient health status between beneficiaries discharged home and those discharged to a nursing home.

The readmission measures count patients whose primary diagnosis for rehospitalization was considered potentially avoidable; that is, the condition should have been managed in the SNF setting. The potentially avoidable conditions include congestive

heart failure, electrolyte imbalance/dehydration, respiratory infection, septicemia, urinary tract or kidney infection, hypoglycemia and diabetic complications, anticoagulant complications, fractures and musculoskeletal injuries, acute delirium, adverse drug reactions, cellulitis/wound infection, pressure ulcers, and blood pressure management. The count excludes readmissions that were likely to have been planned (e.g., inpatient chemotherapy or radiation therapy) and readmissions that signal a premature discharge from the hospital. We separately measure readmissions that occur during the SNF stay and those that occur within 30 days of discharge from the SNF.

The observed readmission and community discharge rates were risk adjusted for medical comorbidity, cognitive comorbidity, mental health comorbidity, function, and clinical conditions (e.g., surgical wounds and shortness of breath). The rates reported are the average risk-adjusted readmission rates for all facilities with 25 or more stays (20 stays for the postdischarge readmission measure). Demographics (including race, gender, and age categories except younger than age 65 years) were not important in explaining differences in readmission and community discharge rates after controlling for beneficiaries' comorbidities, mental illness, and functional status (Kramer et al. 2014).¹⁰

(continued next page)

days were increased recently, rehabilitation days remain highly profitable, and the PPS continues to encourage providers to furnish enough therapy to convert medically complex days to rehabilitation days. The presence of a long-term care hospital in the county does not appear to influence the share of medically complex days in SNFs. The Commission's recommended design would increase payments for medically complex patients.

Though access does not appear to be an issue in general, industry representatives and patient advocates report that patients with high NTA costs (such as those requiring expensive antibiotics) can be hard to place. In addition, patients who are more likely to require long stays and exhaust their Medicare benefits are also avoided by some

facilities because either a facility's daily payments decline if the patient is eligible for Medicaid or the stay results in bad debt.

Quality of care: Mixed performance

The Commission tracks three broad categories of SNF quality indicators: risk-adjusted rates of readmission, discharge back to the community, and change in functional status during the SNF stay.¹¹ Between 2013 and 2014, these quality measures showed mixed performance: The rates of readmissions and discharge to the community improved slightly, the readmission rate during the 30 days after discharge from SNFs increased (got worse), and the two measures of functional change were essentially unchanged.

Measures of skilled nursing facility quality (cont.)

Two risk-adjusted measures of functional change gauge the percentage of a facility's stays during which patients' function improves (the rate of improvement in one, two, or three mobility measures—bed mobility, transfer, and ambulation) and the percentage of stays during which patients' functioning does not decline (including stays with improvement and stays with no change), given the prognosis of the facility's patients. Change is measured by comparing initial and discharge assessments. For stays that go on to use long-term nursing home care, the assessment closest to the end of Medicare coverage is used, as long as it is within 30 days of the end of the SNF stay. Although the initial assessment often occurs toward the end of the first week of the stay, the Minimum Data Set information pertains to the number of times over the past week that assistance was provided, rather than the recorded functional status at a single point in time. Therefore, any measurement error due to the reliance on an assessment conducted at the end of the first week of the stay is unlikely and would not affect our ability

to examine quality trends over time, unless changes occur from year to year when initial assessments are conducted.

Each stay's initial assessment is used to assign the patient to 1 of 22 case-mix groups using 3 measures of mobility—bed mobility, transfer, and ambulation (Kramer et al. 2014). This classification system acts as a form of risk adjustment, differentiating patients based on their expected ability to perform the three mobility-related activities of daily living (ADLs). A patient's prognosis is measured using the patient's ability to eat and dress because these two ADLs encompass cognitive functioning and other dimensions of physical functioning that facilitate rehabilitation.

Each risk-adjusted rate compares a facility's observed rate with its expected rate ((actual rate/expected rate) × the national average rate) based on the mix of patients across functional outcome groups. Each facility-level measure combines the functional status information for the three mobility measures. ■

Between 2013 and 2014, the rate of readmissions during the SNF stay and the community discharge rate improved slightly, but the rate of readmissions after discharge from the SNF worsened slightly

After about 10 years of almost no improvement, both the rate of potentially avoidable readmission for SNF patients and the rate of discharge to the community have started to improve (see text box on measures of SNF quality). Between 2011 and 2014, readmission rates during the SNF stay declined (consistent with declines in the hospital readmission rate) and community discharge rates increased (Table 7-3, p. 186).¹² The improvements in both measures between 2013 and 2014 were small. However, between 2013 and 2014, readmissions during the 30 days after discharge from the SNF increased slightly (from 5.5 percent to 5.6 percent). The post-period measure indicates how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home). So while SNFs have improved the quality they furnished, the post-period

measure indicates opportunities for SNFs to improve the handoffs to the next setting and, when subsequent PAC providers are involved, to partner with higher quality providers. Across the three measures, the trends over four years are encouraging. Readmission rates have declined, and rates of discharge to the community have increased.

The lower readmission rates during the SNF stay reflect increased attention from hospitals to avoid readmission penalties by partnering with SNFs with low readmission rates. Hospitals are increasingly establishing preferred provider networks with higher quality SNFs, hoping to lower their own readmission rates in exchange for increased referrals from SNFs (Evans 2015). In addition, many SNFs want to secure volume from MA plans and accountable care organizations by demonstrating improvements in their readmission rates. The AHCA had a goal for its members to lower their 30-day all-cause, all-patient readmission rate 15 percent by 2015. AHCA reported that, between the last quarter of 2011 and the first quarter of 2015, its members lowered readmissions

**TABLE
7-3****Changes in risk-adjusted rates of community discharge and potentially avoidable readmissions, 2011–2014**

Measure	2011	2012	2013	2014
Discharged to the community	33.1%	35.6%	37.5%	37.6%
Potentially avoidable readmissions:				
During SNF stay	12.4	11.5	11.2	10.9
During 30 days after discharge from SNF	5.9	5.7	5.5	5.6

Note: SNF (skilled nursing facility). Higher rates of discharge to the community indicate better quality. Higher readmission rates indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 25 or more stays, except the rate of potentially avoidable readmissions during the 30 days after discharge, which is reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2014 Minimum Data Set and hospital claims data.

by 4.9 percent in the aggregate (from 18.2 percent to 17.3 percent) and that over one-third of its members met the 15 percent target (across all patients, not just Medicare) (American Healthcare Association 2015).

As part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF readmission policy, with facilities to begin publicly reporting in October 2017. The law requires the Secretary to develop an all-condition, risk-adjusted, potentially preventable readmission measure by October 2016. A value-based purchasing program will adjust a facility's payments based on its readmission rate beginning in October 2018.

No improvement in managing patients' functional status

Most beneficiaries receive rehabilitation therapy, and the amount of therapy furnished to them has steadily increased over time. Yet patients vary considerably in their expected

improvement during the SNF stay. Some patients are likely to improve in several ADLs during their SNF stay, while others with chronic and degenerative diseases may expect, at best, to maintain their function. We measure SNF performance on both aspects of patient function on a risk-adjusted basis (see text box on SNF quality measures, p. 184–185).

The average risk-adjusted rates of functional change—rate of improvement in one, two, or three mobility ADLs (bed mobility, transfer, and ambulation) and the rate of no decline in mobility—were essentially unchanged between 2011 and 2014 (Table 7-4). These risk-adjusted rates consider the likelihood that a patient's functionality will change, given the functional ability at admission. Even though the program paid for more therapy during this period, the average functional status of beneficiaries did not improve.

**TABLE
7-4****Mean risk-adjusted functional outcomes in SNFs show little change between 2011 and 2014**

Composite measure	2011	2012	2013	2014
Rate of improvement in one or more mobility ADLs	43.6%	43.5%	43.7%	43.5%
Rate of no decline in mobility	87.3	87.2	87.2	87.1

Note: SNF (skilled nursing facility), ADL (activity of daily living). The three ADLs include bed mobility, transfer, and ambulation. The rate of mobility improvement is the average rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. Stays with improvement in one, two, or three ADLs are counted in the improvement measure. The rate of stays with no decline in mobility is the percentage of stays with no decline in any of the three ADLs. Rates are the average of facility rates and calculated for all facilities with 25 or more stays.

Source: Analysis of fiscal year 2011 through fiscal year 2014 Minimum Data Set data.

**TABLE
7-5**

SNF quality measures varied considerably across SNFs, 2014

Quality measure	Risk-adjusted rate			
	Mean	25th percentile	75th percentile	Ratio of 75th to 25th percentile
Discharged to the community	37.6%	29.4%	46.5%	1.6
Potentially avoidable readmissions during SNF stay	10.9	7.8	13.6	1.7
Potentially avoidable readmissions within 30 days after discharge from SNF	5.6	3.6	7.3	2.0
Average mobility improvement across the three mobility ADLs	43.5	35.5	52.1	1.5
No decline in mobility during SNF stay	87.1	82.7	92.7	1.1

Note: SNF (skilled nursing facility), ADL (activity of daily living). Higher rates of discharge to community indicate better quality. Higher readmission rates indicate worse quality. "Mobility improvement" is the average of the rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. "No decline in mobility" is the share of stays with no decline in any of the three ADLs. Rates are the average of facility rates and calculated for all facilities with 25 or more stays, except the rates of potentially avoidable readmissions during the 30 days after discharge, which are reported for all facilities with 20 or more stays.

Source: Analysis of fiscal year 2014 Minimum Data Set and hospital claims data.

Large variation in quality measures indicates considerable room for improvement

Considerable variation exists across the industry in the five quality measures we track. We found one-quarter of facilities in 2014 had risk-adjusted community discharge rates lower than 29.4 percent, whereas the best-performing quarter of facilities had rates of 46.5 percent or higher (Table 7-5). Similar variation was seen in the readmission rates: The worst-performing quartile had rates of potentially avoidable readmissions at or above 13.6 percent, whereas the best quartile had rates at or below 7.8 percent. Finally, rates of readmission in the 30 days after discharge from the SNF varied most—a twofold difference between the 25th percentile and the 75th percentile. The amount of variation across and within the groups suggests considerable room for improvement, all else being equal. There was less variation in the mobility measures.

Medicare is increasingly focused on measuring the value of the care it purchases and, in the future, may establish a unified payment system for all PAC. To facilitate both, the program is developing cross-setting outcome measures. The Commission also has work under way to develop uniformly defined readmission measures that will facilitate the comparison of rates across settings.

Providers' access to capital: Lending in 2015

A vast majority of SNFs operate within nursing homes; therefore, in assessing SNFs' access to capital, we look

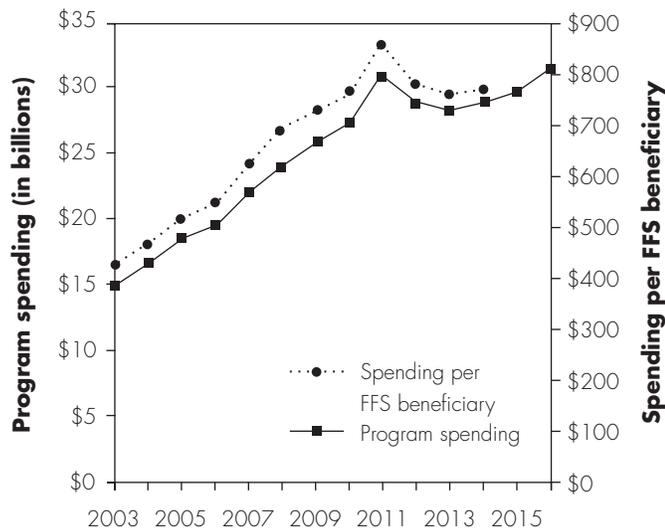
at the availability of capital for nursing homes. Although Medicare makes up the minority share of almost all facilities' revenues, many operators see Medicare as their best payer.

Market analysts we spoke with reported that capital is generally available and expected to remain so. Over time, lenders have gotten more selective about the facilities they lend to and have increased the due diligence conducted on potential borrowers. Lenders review the quality of the potential borrower's management team, its cash flow and amount of debt, operating trends (volume, occupancy, payer mix, and patient mix), quality of care, its ability to carry out strategic plans to shift payer or service mix, and the specificity of the facility's plans to meet performance goals. Lenders continue to focus on facilities with high Medicare and private-payer mixes and the potential to expand both. For the last several years, we have heard about the bifurcation of this industry into providers seeking the high acuity-subacute patients and other nursing facilities maintaining their focus on the long-term care population. One analyst opined that while the future of SNFs is to be the low-cost operator of PAC, not all providers are interested in or capable of playing that role.

Consolidation continued in 2015 as health care companies sought more integration across the PAC continuum (Ensign Group 2015, Genesis HealthCare 2015b, Kindred Healthcare 2015b). Strategies include expanding holdings to include multiple PAC service lines (such as home health

FIGURE 7-2

After a temporary slowdown, SNF spending growth returns to prior pace, 2003–2016



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year spending is shown. Program spending data for 2015 and 2016 are estimates.

Source: Spending data are from Office of the Actuary 2015b; FFS counts are from the 2015 annual report of the Boards of Trustees of the Medicare trust funds.

and hospice) and solidifying presence across the continuum within select markets. For example, Kindred purchased Gentiva, a home health care company, and Centerre, a small chain of IRFs, in 2015. Lenders look favorably at a diversified earning stream as a way to spread risk.

The SNF industry set a record number of merger and acquisition transactions in 2014, with 165 publicly recorded sales and a 4 percent increase from 2013 in the price per bed, following a 21 percent increase the year before (Irving Levin Associates Inc. 2015). Some market analysts note that the fragmented SNF industry represents an opportunity for consolidation. Two publicly traded for-profit chains report an acquisition strategy to purchase underperforming SNFs and turn around their quality and financial performance (DiversiCare 2015, Ensign Group 2015). Other chains seek out high-performing facilities, with high-acuity and high-revenue stays (Irving Levin Associates Inc. 2015). Reflecting the continued viability of the SNF market, Genesis purchased another SNF chain (Skilled HealthCare) in 2015.

The Department of Housing and Urban Development (HUD) continues to be an important lending source. In

fiscal year 2015, HUD financed 291 projects, with the insured amount totaling \$2.7 billion (Department of Housing and Urban Development 2015). Both the number of projects and the total amount of lending declined substantially from 2014, in large part because low-cost borrowing and widely available capital sources have made HUD only one of many alternative lenders (Swett 2015). Refinancing makes up the majority of loans, while new and major construction comprise the minority of projects.

Analysts note that, in addition to a long-standing wariness about potential budget cuts, increased scrutiny by OIG, lower volume, and concerns about the increased expectations for providers to assume risk (through accountable care organizations, bundling, and value-based purchasing) have increased the hesitancy among some lenders. That said, lenders' reluctance is not a statement about the adequacy of Medicare's payments to SNFs. Medicare continues to be a preferred payer.

Medicare payments and providers' costs: Medicare margins remained high in 2014

In 2014, the aggregate Medicare margin was 12.5 percent—the 15th consecutive year that Medicare margins were above 10 percent. Margins for individual facilities continue to be highly variable, depending on the facility's share of intensive therapy days, size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics: High-margin facilities had higher case-mix indexes and higher shares of dual-eligible and minority beneficiaries. Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. Eight percent of freestanding facilities defined as relatively efficient consistently furnished relatively low-cost, higher quality care and had substantial Medicare margins over three consecutive years. Some MA plans' payments were considerably lower than Medicare's FFS payments, and the disparity is unlikely to be explained by differences in patient mix. These points strongly suggest that SNFs can provide high-quality care at lower payment rates.

Trends in spending and cost growth

In 2014, Medicare spending was \$28.6 billion, a slight increase over 2013 (\$28.4 billion). The CMS Office of the Actuary projects program FFS spending for SNF services in fiscal year 2015 to be \$30 billion (Figure 7-2) (Office of the Actuary 2015b). In 2011, payments were unusually high because the rates for the new case-mix classification

system included an adjustment that was too large for the mix of therapy modalities assumed in setting the rates. The industry responded to the payment incentive afforded by the new policies and quickly shifted its mix of modalities, and payments increased by 14 percent in 2011. To correct for the excessive payment, CMS revised the adjustment downward, and total payments were lower in 2012. Since then, the growth in spending has risen in line with previous trends and is projected to increase 3.9 percent in 2015. On a per FFS beneficiary basis, spending in 2014 (\$767) was about the same as in 2013. CMS projects spending in fiscal year 2016 to be \$31.5 billion.

From 2003 to 2014, the cumulative increase in payments per day outpaced the increase in cost per day (Figure 7-3). During this period, costs per day rose 44 percent while payments grew 46 percent. The cost increases were larger than the market basket updates in every year except one (2012), but payments rose even more. As a result, SNFs remained highly profitable on average. When Medicare lowered its rates by 11 percent in 2012 to correct for the previous year's overpayments, providers kept their cost growth in that year below the market basket increases.

Since 2011, costs have grown more quickly for nonprofit SNFs compared with for-profit SNFs. Cumulatively, costs grew 7.7 percent for nonprofit facilities compared with 5.2 percent for for-profit SNFs. Nonprofit facilities also had a standardized cost per day (adjusted for differences in wages and case mix) that was about 10 percent higher than the cost per day in for-profit facilities.

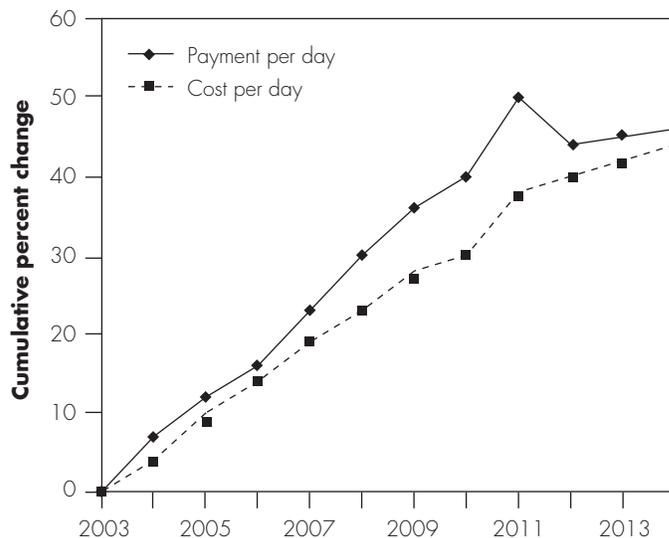
SNF Medicare margins remain high

The Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's payments with providers' costs to treat beneficiaries. An all-payer total margin, in contrast, reflects the financial performance of the entire facility across all lines of business (such as ancillary and therapy services, hospice, and home health care) and all payers (including Medicaid, private insurers, and managed care) and is presented as context for the Commission's update recommendation.

In 2014, the aggregate Medicare margin for freestanding SNFs was 12.5 percent, the 15th consecutive year of Medicare margins above 10 percent (Figure 7-4, p. 190). The 2014 margin was lower than the 2013 margin for two reasons. First, current law requires market basket increases to be offset by a productivity adjustment. Second, the federal budget sequester began lowering payments in

FIGURE 7-3

Cumulative growth in Medicare cost and payments per SNF day, 2003-2014

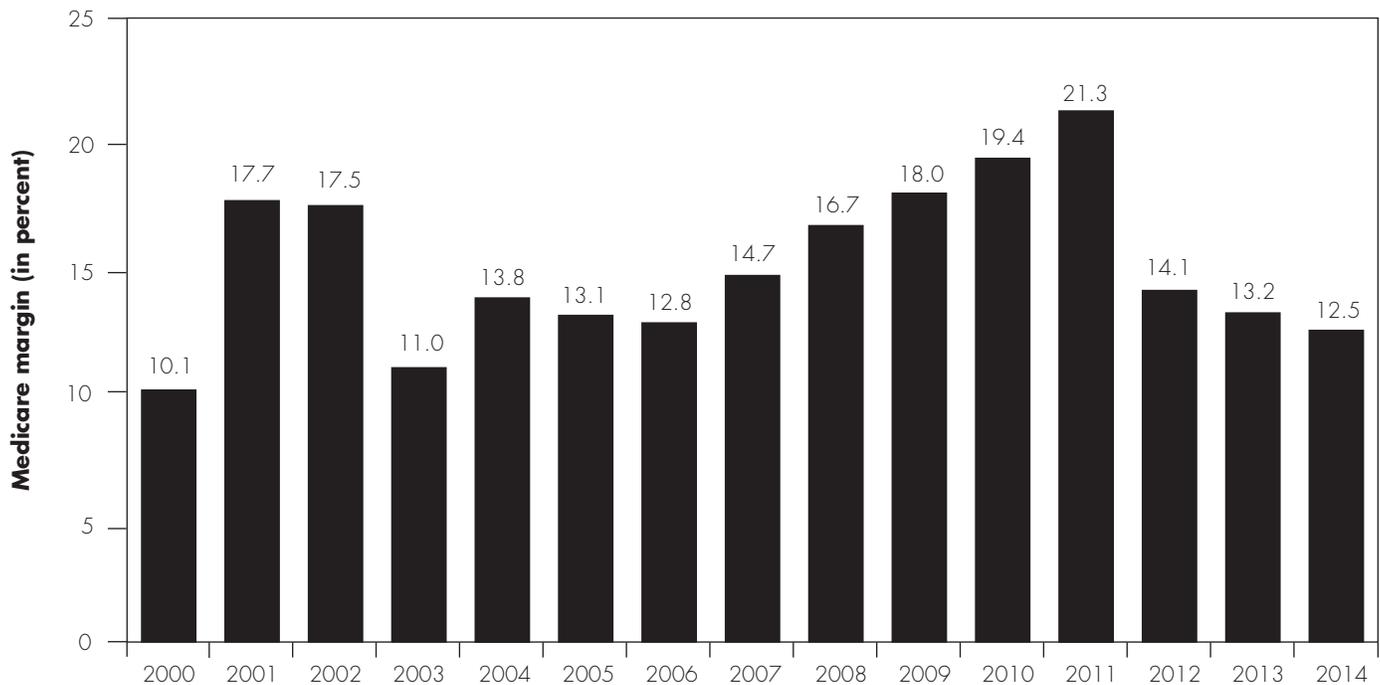


Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF Medicare cost reports from 2003-2014.

April 2013 by 2 percent on an annualized basis so that the year's data reflected its impact for only part of the year.¹³ The combined impact of these policies would have been greater but was offset by the continued increase in the share of cases assigned to the highest payment case-mix groups, the ultra-high therapy groups. In 2011, the Medicare margin was 21.3 percent, reflecting the large increase in payments because of the implementation of the new case-mix groups and an incorrect adjustment factor. Despite reductions to correct SNF payments the following year, Medicare margins remained high in 2012 (14.1 percent).

In 2014, hospital-based facilities (3 percent of program spending on SNFs) continued to have extremely negative Medicare margins (-70 percent), in part because of the higher cost per day reported by hospitals. Previous analysis by the Commission found that routine costs in hospital-based SNFs were higher, reflecting more staffing, higher skilled staffing, and shorter stays (over which to allocate costs) (Medicare Payment Advisory Commission 2007). However, hospital administrators consider their SNF units in the context of the hospital's overall financial

**FIGURE
7-4****Aggregate freestanding SNF Medicare margins have been above 10 percent since 2000**

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2014.

performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their SNF beds, thus making inpatient beds available to treat additional inpatient admissions. As a result, hospital-based SNFs can contribute to the bottom-line financial performance of hospitals: Hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs.

Marginal profit: A measure of the attractiveness of Medicare patients

Another consideration in evaluating the adequacy of Medicare payments is the assessment of whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, the provider compares the marginal revenue it will receive for treating one additional patient (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume, in this case, to treat one additional patient. If Medicare payments do

not cover a facility's marginal costs, the provider could have a disincentive to admit Medicare beneficiaries. To operationalize this concept, we compare payments for Medicare services to marginal costs, approximated as:

$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$

This comparison is a lower bound on the marginal profit because we ignore any potential labor costs that are fixed. For providers with available data, the marginal profit in 2014 was 20.4 percent; Medicare payments far exceed the marginal costs, which suggests that facilities with available beds have an incentive to admit Medicare patients and represents a positive indicator of patient access.

High and widely varying SNF Medicare margins indicate reforms to the PPS are still needed

The persistently high Medicare margins and their wide variation indicate that the PPS needs to be revised and rebased so that payments more closely match patient characteristics, not the services provided to them. In 2014, one-quarter of freestanding SNFs had Medicare margins of 21.2 percent or higher, while another quarter of freestanding SNFs had margins of 2.4 percent or lower (Table 7-6). One-fifth (about the same share as last year) of SNFs had negative Medicare margins (not shown).

Over the past 10 years, Medicare margins for for-profit facilities have ranged from 9 percentage points to almost 13 percentage points higher than the margins for nonprofit facilities. In 2014, the disparity continued; nonprofit facilities had an average Medicare margin of 3.9 percent, while the average for-profit margin was 14.9 percent. The disparity reflects differences in facilities' costs, size, and service provision. Nonprofit facilities have higher costs per day and since 2012 have had higher cost growth compared with for-profit facilities. The higher costs for nonprofit facilities are partly due to their smaller size. In 2014, the median nonprofit facility had 85 beds compared with 104 beds for the median for-profit facility; therefore, the nonprofits may not be able to achieve the same economies of scale as larger facilities. On the revenue side, in 2014, nonprofits had lower shares of the more profitable ultra-high and very high therapy days compared with for-profit facilities (78 percent compared with 83 percent, respectively).

Facilities with the highest SNF margins had high shares of intensive rehabilitation therapy and low shares of medically complex days. Despite the payment increases for medically complex cases in October 2010, the relative financial performance in 2014 of facilities with high shares of these cases did not improve, and there was almost a 3 percentage point difference in the Medicare margins between facilities with high and low shares. Lower cost SNFs and larger SNFs had higher Medicare margins than higher cost SNFs and smaller SNFs. The SNF Medicare margin for facilities with the lowest cost per day (the bottom quartile of cost per day) was 26.3 percent, while the margin for facilities with the highest cost per day (the top quartile of cost per day) was 2.1 percent.

Differences in costs and revenues between freestanding facilities in the top and bottom quartiles of Medicare margins underscore the need to revise the PPS and more closely align payments with costs. The highest margin

**TABLE
7-6**

Variation in freestanding SNF Medicare margins reflects the mix of cases and cost per day, 2014

Subgroup	Medicare margin
All	12.5%
For profit	14.9
Nonprofit	3.9
Rural	10.6
Urban	12.9
Frontier	5.2
25th percentile of Medicare margins	2.4
75th percentile of Medicare margins	21.2
Intensive therapy: High share of days	14.5
Intensive therapy: Low share of days	7.3
Medically complex: High share of days	10.8
Medically complex: Low share of days	13.7
Small (20–50 beds)	2.8
Large (100–199 beds)	13.8
Standardized cost per day: High	2.1
Standardized cost per day: Low	26.3
Standardized cost per discharge: High	9.2
Standardized cost per discharge: Low	14.6

Note: SNF (skilled nursing facility). The margins are aggregates for the facilities included in the group. "Low" is defined as facilities in the lowest 25th percentile; "high" is defined as facilities in the highest 25th percentile. "Standardized costs per day" are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries.

Source: MedPAC analysis of 2014 freestanding SNF Medicare cost reports.

SNFs had lower daily costs (their costs were 70 percent of the costs of low-margin SNFs) and their revenues were 10 percent higher, driven partly by having higher shares of intensive therapy days (Table 7-7, p. 192). Compared with lower margin SNFs, higher margin SNFs had higher shares of dually eligible beneficiaries, minority beneficiaries, and Medicaid days. It is possible that given their higher Medicaid shares, these facilities keep their costs low and consequently have higher margins. Facilities with higher margins also treated more complex patients (as measured by the relative weights associated with the

**TABLE
7-7**

Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2014

Characteristic	SNFs in the top margin quartile	SNFs in the bottom margin quartile	Ratio of SNFs in the top margin quartile to SNFs in the bottom margin quartile
Cost measures			
Standardized cost per day	\$254	\$369	0.7
Standardized ancillary cost per day	\$115	\$158	0.7
Standardized routine cost per day	\$142	\$204	0.7
Average daily census (patients)	89	67	1.3
Average length of stay (days)	45	37	1.2
Revenue measures			
Medicare payment per day	\$489	\$428	1.1
Share of days in intensive therapy	85%	77%	1.1
Share of medically complex days	4%	5%	0.8
Medicare share of facility revenue	25%	15%	1.7
Patient characteristics			
Case-mix index	1.40	1.31	1.1
Share dual-eligible beneficiaries	39%	27%	1.4
Share minority beneficiaries	13%	5%	2.6
Share very old beneficiaries	29%	34%	0.9
Medicaid share of days	65%	58%	1.1
Facility mix			
Share for profit	90%	58%	N/A
Share urban	78%	67%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Top margin quartile SNFs (n=3,186) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n=3,186) were in the bottom 25 percent of the distribution of Medicare margins. "Standardized costs per day" are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries. "Intensive therapy" days are days classified into ultra-high and very high rehabilitation case-mix groups. "Medically complex" includes days assigned to clinically complex and special care case-mix groups. "Very old beneficiaries" are 85 years or older.

Source: MedPAC analysis of freestanding 2014 SNF cost reports.

nursing component of the case-mix groups) and had lower shares of patients classified into medically complex case-mix groups.¹⁴ (Because the nursing weights for intensive therapy are relatively high, a facility can have both a high case-mix index and a moderate or low share of medically complex patients.)

These differences in financial performance illustrate why the PPS needs to be revised. Even after CMS expanded the number of medically complex case-mix groups and shifted spending away from therapy care, the PPS continues to result in higher Medicare margins for facilities providing

higher amounts of intensive therapy. A PPS design based on patient characteristics (such as the one recommended by the Commission) would redistribute Medicare spending to SNFs according to their mix of patients, not the amount of therapy provided.

Ownership of low-margin and high-margin facilities did not mirror the industry mix. Although for-profit facilities made up 70 percent of SNFs overall, they comprised a smaller share (58 percent) of the low-margin facilities and a higher share (90 percent) of the high-margin group.

Identifying relatively efficient skilled nursing facilities

We defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and good quality care for three years in a row, 2011 through 2013. The cost per day was calculated using cost report data and was adjusted for differences in case mix (using the nursing component relative weights) and wages. Quality measures were risk-adjusted rates of community discharge and potentially avoidable readmissions during the SNF stay. Only facilities with at least 25 stays were included in the quality measures.

The method we used to assess performance attempts to limit drawing incorrect conclusions about performance based on poor data. Using three years to categorize SNFs as efficient (rather than just one year) avoids categorizing providers based on random variation or on

one “bad” year. In addition, by first assigning a SNF to a group and then examining the group’s performance in the next year, we avoided having a facility’s poor data affect both its own categorization and the assessment of the group’s performance. Thus, a SNF’s erroneous data could result in its inaccurate assignment to a group, but because the group’s performance is assessed with data from later years, these “bad” data would not affect the assessment of the group’s performance.

Of the 892 facilities identified as efficient in 2014, three-quarters of SNFs were not in the best third for both a quality measure and the cost measure. Over half (52 percent) met only one best quality measure and another 23 percent were in the best third for only the cost measure. Only 4 percent of SNFs were in the best third on all three measures. ■

High margins achieved by relatively efficient SNFs

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well both on cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over the previous three years. The Commission’s approach is to develop a set of criteria and then examine how many providers meet them. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

Periodically, we review the set of criteria used to define efficient providers and evaluate the potential for improvements in our methodology. This year, we tested the effect of using different selection criteria such as adjusting the threshold of minimum acceptable quality or relaxing the consistency requirement. The Commission concluded that, while the alternative methods could change the number efficient providers by varying degrees, those methods did not result in greater distinction between the efficient and average providers, and in some cases the differences were reduced. Most fundamentally, the

clarity of the information obtained in assessing payment adequacy would not improve significantly with any of the new methods tested. Therefore, the Commission will continue to use its previous definition of an efficient provider in this year’s report. In the future, we will continue to look for improvements in our methods, including using new quality metrics as better indicators of patient outcomes are developed.

To identify efficient SNFs, we examined the financial performance of freestanding SNFs with consistent cost and quality performance on two measures (see text box on identifying efficient providers). To measure costs, we looked at costs per day that were adjusted for differences in area wages and case mix. To assess quality, we examined risk-adjusted rates of community discharge and potentially avoidable readmissions that occurred during the SNF stay. To be included in the relatively efficient group, a SNF had to be in the best third of the distribution of at least one measure and not in the bottom third on any measure for three consecutive years. According to this definition, 8 percent (892 of the 11,637 facilities included in the analysis for 2014) provided relatively low-cost, high-quality care, an increase from the 7 percent in 2013. Of those identified as efficient in 2014, 42 percent were also identified as efficient in 2013.

**TABLE
7-8**

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

Performance in 2014	Type of SNF		Ratio of relatively efficient to other SNFs
	Relatively efficient	Other SNFs	
Community discharge rate	47.3%	37.3%	1.27
Readmission rate	9.2%	10.9%	0.84
Standardized cost per day	\$277	\$303	0.92
Medicare revenue per day	\$492	\$450	1.09
Medicare margin	20.0%	11.8%	1.69
Total margin	3.5%	1.7%	2.01
Facility case-mix index	1.43	1.35	1.06
Medicare average length of stay	35 days	40 days	0.86
Occupancy rate	89%	87%	1.02
Number of beds	120	100	1.20
Share ultra-high days	63%	52%	1.22
Share medically complex days	4.7%	4.6%	1.04
Medicaid share of facility days	58%	61%	0.94
Share urban	78%	66%	N/A
Share for profit	83%	70%	N/A
Share nonprofit	11%	20%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). The number of freestanding facilities included in the analysis was 11,637. SNFs were identified as “relatively efficient” based on their cost per day and two quality measures (community discharge and readmission rates) between 2011 and 2013. Relatively efficient SNFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of three years. Costs per day were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and readmission during the SNF stay for patients with potentially avoidable conditions. Quality measures were calculated for all facilities with at least 25 stays. “Ultra-high days” include days assigned to ultra-high case-mix groups. “Medically complex” includes days assigned to clinically complex and special care case-mix groups. Table shows the medians for the measure.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2011–2014.

Our analyses found that SNFs can have relatively low costs and provide relatively good quality of care while maintaining high margins (Table 7-8). Compared with other SNFs in 2014, relatively efficient SNFs had community discharge rates that were 27 percent higher and readmission rates that were 16 percent lower. Standardized costs per day were 8 percent lower than other SNFs’. We did not find significant differences between relatively efficient and other SNFs in terms of occupancy rates, but efficient SNFs were larger (120 beds compared with 100 beds). Efficient facilities had more complex case mixes (driven in part by higher therapy intensity) but shorter stays. In terms of case-mix days, efficient providers had higher shares of the most intensive therapy days and comparable shares of medically complex days.

The higher therapy intensity raised their daily Medicare payments relative to all SNFs, indicating that, in addition to controlling their costs, efficient providers pursued revenue strategies to maximize their Medicare payments. The median Medicare margin for efficient SNFs was 20.0 percent, and their total margin (for all payers and all lines of business) was 3.5 percent. The median marginal profit for efficient providers was 26.1 percent. Relatively efficient facilities were more likely to be urban and for profit. Efficient SNFs were located in 43 states, including 2 SNFs in frontier locations.

We recognize that a SNF may appear to be efficient with respect to the care it provides but may not be when considering a patient’s entire episode of care. For example,

**TABLE
7-9**

Comparison of Medicare fee-for-service and managed care/MA daily payments in 2015 for four companies

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	MA	
Diversicare	\$452	\$383	1.18
Ensign Group	566	418	1.35
Kindred	570	450	1.27
Genesis	502	448	1.12

Note: FFS (fee-for-service), MA (Medicare Advantage). In the companies' 10-Q reports, Diversicare and Ensign Group report "managed care payments." Genesis reports "insurance rates," which includes managed care and commercial insurance but excludes Medicaid managed care. Kindred separately reports MA rates.

Source: Third quarter 10-Q 2015 reports available at each company's website.

SNFs that discharge patients to other post-acute care providers may keep their own costs low but shift costs to other settings, thus increasing total Medicare program spending. In the future, we may compare providers' costs for an episode of care.

FFS payments for SNF care are considerably higher than managed care/MA payments for four publicly traded nursing home companies

Another indicator that Medicare's payments under the SNF PPS are too high is the comparison of FFS and managed care/MA payments that exclude Medicaid managed care. (We created a combined term to indicate that MA and managed care rates are often combined in the reporting of payment rates. However, Medicare Advantage plans typically cover the majority of SNF service use among managed care plans.) We compared Medicare FFS and managed care/MA payments at four nursing home companies where such information was publicly available. Medicare's FFS payments averaged 23 percent higher than MA rates (Table 7-9). MA makes up the majority of the managed care business at most SNFs. It is possible that smaller MA companies have less leverage and do not negotiate similarly low rates. We also do not know how these rates compare to those paid to smaller chains and independent facilities.

We compared the patient characteristics of beneficiaries enrolled in FFS and MA plans in 2014 and found small differences that do not explain the payment differences between the two. Compared with FFS beneficiaries, MA enrollees were the same age, had slightly higher Barthel scores (less than two points, indicating slightly more independence), and had slightly lower (5 percent) risk

scores (indicating fewer comorbidities). The considerably lower MA payments indicate some facilities accept much lower payments to treat MA enrollees who are not much different in terms of case-mix from FFS beneficiaries. Some publicly traded firms report seeking managed care patients as a business strategy, indicating that the rates are attractive.

Total margins remained the same in 2014 as in 2013 despite sequester reductions

The average total margin for freestanding SNFs in 2014 was 1.9 percent, the same as in 2013 even though the sequester reductions were in place for a full year. A total margin reflects services to all patients (public and private, including managed care) across all lines of business (for example, long-term care, hospice, home health care, and ancillary services) and revenue sources (for example, including investment income). Total margins are driven in large part by state policies regarding the level of Medicaid payments and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need).

The publicly traded companies we examined report several trends in revenues. Companies try to grow their high-acuity business because they report it to be more profitable. They also spread their risk by expanding into other businesses, including home health care, hospice, home care, and outpatient therapy (DiversiCare 2015, Ensign Group 2015, Genesis HealthCare 2015b, Kindred Healthcare 2015a). Geographic diversification also spreads their risk. In addition, companies try to increase their managed care and private-payer business (DiversiCare 2015, Ensign Group 2015). Even though these shifts may lower their revenues because these payment rates and lengths of stay are typically lower, they are preferred to

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

Industry representatives contend that Medicare payments should continue to subsidize payments from other payers, most notably from Medicaid. However, high Medicare payments could also subsidize payments from private payers. The Commission believes such cross-subsidization is not advisable for several reasons. First, this strategy results in poorly targeted subsidies. Facilities with high shares of Medicare payments would receive the most in subsidies from higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies. Shares of Medicare and Medicaid patients vary widely across facilities (Table 7-10). As a result, the impact of the Medicare subsidy would vary considerably across facilities, putting more dollars into facilities with high Medicare use (and low Medicaid use), which are likely to have higher Medicare margins than other facilities.

In addition, Medicare's subsidy does not discriminate among states with relatively high and low Medicaid payments. If Medicare raises or maintains its high payment levels, states could be encouraged to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates. Higher Medicare payments could further encourage providers to select patients based on payer source or to rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay. Finally, Medicare's high payments represent a subsidy of Trust Fund dollars (and its taxpayer support) to the low payments made by states and private payers. If the Congress wishes to help certain nursing facilities (such as those with high Medicaid shares), it would be more efficient to do so through a separate, targeted policy. ■

**TABLE
7-10**

Medicare and Medicaid shares vary widely across freestanding skilled nursing facilities, 2014

Payer	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicare share	5%	8%	11%	17%	26%
Medicaid share	0	42	61	74	82

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of SNF Medicare cost reports, 2014.

Medicaid admissions. Further, the average daily payments from Medicaid increased between 2014 and 2015 (third quarter 2015 10-Q filings from DiversiCare, The Ensign Group, Genesis, and Kindred; second quarter filing from AdCare).

Companies also report several strategies to attract the higher paying (and more profitable) stays (Medicare, private pay, and managed care). Some SNFs are increasing

their quality (and their performance) to secure referrals (DiversiCare 2015, Ensign Group 2015, Genesis HealthCare 2015a). Some SNFs report increasing the skill mix and competencies of their staff (such as the ability to manage intravenous medications and pain) to care for a higher acuity mix of patients (DiversiCare 2015, Genesis HealthCare 2015b). One company reported increasing their internal operating efficiencies by lowering staff turnover and using contract labor (Ensign Group 2015).

Because Medicaid payments are lower than Medicare payments, some in the industry argue that high Medicare payments are needed to subsidize losses on Medicaid residents. This strategy is ill advised for several reasons (see text box on not subsidizing Medicaid payments). In addition to Medicare's share of facility revenues, other factors that shape a facility's total financial performance are its share of revenues from private payers (generally considered favorable), its other lines of business (such as ancillary, home health, and hospice services), and nonpatient sources of income (such as investment income).

Payments and costs for 2016

In assessing the payment update for 2016, the Commission considers the estimated relationship between SNF costs and Medicare payments in 2015. To estimate costs for 2015 and 2016, we assumed cost growth of the market basket. To estimate 2015 payments, we began with reported 2014 payments and increased payments by the market basket net of the productivity adjustment (as required by the Patient Protection and Affordable Care Act of 2010). We also factored in the program's reduced payments for bad debt, as required by the Middle Class Tax Relief and Job Creation Act of 2012. For 2016, estimated 2015 payments were increased by the market basket and offset by the productivity adjustment and the forecast error correction. Projected payments for 2015 and 2016 fully reflect the impact of the sequester. The projected 2016 Medicare margin is 10.7 percent.

How should Medicare payments change in 2017?

In considering how payments should change for 2017, we note that the broad circumstances of SNFs have not changed since the Commission made its recommendation in 2012 to revise the SNF PPS and rebase the level of payments. In terms of the need to revise the PPS, our analysis of the payment system has found that, over time, its payments are increasingly inaccurate despite the many changes made to the payment system. The overpayments for therapy services have gotten larger, strengthening the existing incentive to furnish therapy services. At the same time, the payments for NTA services are unrelated to these services' costs, making payments even more poorly targeted than they had been. As broad payment reforms (such as bundled payments, accountable care organizations, and a unified PAC PPS) are implemented,

SNF use may increase because it is a lower cost alternative to IRFs and long-term care hospitals for some patients. Therefore, the importance of the accuracy of FFS payments to SNFs has increased.

Regarding the need to rebase payments, the Commission has found:

- Aggregate Medicare margins for SNFs have been above 10 percent since 2000. In 2014, the marginal profit was 20 percent, indicating facilities with an available bed have an incentive to admit Medicare patients.
- Variation in Medicare margins is not related to differences in patient characteristics but rather, in part, reflect the amount of therapy furnished to patients, differences in costs per day, and cost control.
- Cost differences remain after adjusting for differences in wages, case mix, and beneficiary demographics.
- Relatively efficient SNFs, with relatively low costs and high quality, have Medicare margins of 20 percent.
- FFS payments were considerably higher than some MA payments, suggesting some facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries.
- The industry has shown it is nimble at responding to the level of Medicare's payments. Even in years when CMS lowered payments, providers tempered the effects with longer stays, better cost control, and the assignment of days into higher payment case-mix groups.

These factors show that the PPS continues to exert too little pressure on providers. Moreover, Medicare payments, which are financed by taxpayer contributions to the Trust Fund, currently subsidize payments from other payers, most notably Medicaid. If the Congress wishes to help nursing homes with high Medicaid payer mix, a better targeted and separately financed program could be established to do so.

For 2017, there are no policy changes known at this time, aside from the required update offset by the productivity adjustment. The payment update in current law for fiscal year 2017 is the forecasted change in input prices, as measured by the SNF market basket minus the productivity factor. The market basket in 2017 is projected

to rise 2.7 percent, and the productivity adjustment is estimated to be 0.5 percent, but CMS will update both before establishing the payment rates for 2017.

The evidence for the continued need to revise and rebase the SNF PPS is compelling, yet there has been little movement from CMS and the Congress to implement changes. Last year, the Commission expressed its growing impatience with the lack of progress in redesigning and rebasing SNF payment. The structure of the Commission's recommendation may have contributed to the delay because it called for the PPS to be revised *before* the rebasing (a 4 percent reduction) would begin. This order was made to protect low-margin, typically nonprofit SNFs. The large disparities in Medicare margins (e.g., over the past seven years, the Medicare margin for nonprofit SNFs has averaged 8 percentage points lower than the average for all SNFs) made the Commission reluctant to recommend large reductions in payments without *first* revising the PPS to redirect payments to the low-margin SNFs.

An alternative approach is to set much smaller rebasing steps in motion while the PPS is revised. This approach would begin the process of lowering payments at the same time that the PPS was being revised, but because the steps are small, most SNFs would be able to adjust their practices. Beginning the rebasing process before the implementation of a revised PPS is intended to accomplish three objectives: begin the alignment of payments and costs sooner than would otherwise occur, move cautiously in the short-term to protect low-margin SNFs, and exert pressure on the industry and CMS to make essential changes to the payment system that are long overdue. (Freezing rates for two years effectively lowers the update because rates would otherwise be updated by the market basket minus productivity.) The Commission underscores the importance of restructuring the payment system away from rewarding the provision of therapy services and toward basing payments on the care needs of beneficiaries.

The revised design would have the effect of moving payments from SNFs with high Medicare margins to those with lower Medicare margins—nonprofit SNFs, rural SNFs, and hospital-based SNFs. Although there would continue to be disparities in Medicare financial performance, the differences would be smaller. For example, nonprofit SNFs would continue to have lower margins than for-profit SNFs because nonprofit SNFs have higher costs per day and recently have had higher cost growth.

RECOMMENDATION 7

The Congress should eliminate the market basket update for 2017 and 2018 and direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities. In 2019, the Secretary should report to the Congress on the effects of the reformed PPS and make any additional adjustments to payments needed to more closely align payments with costs.

RATIONALE 7

Under this recommendation, payments would not be updated for 2017 and 2018. The evidence indicates that Medicare beneficiaries continue to have access to SNF services, and Medicare payments are well above Medicare costs. Under current law policies for 2015 and 2016, we project the Medicare margin to be 10.7 percent in 2016. SNF payments appear to be more than adequate to accommodate cost growth without updates in 2017 and 2018. The Commission recognizes the need to proceed cautiously but deliberately to help ensure there are no unintended disruptions caused by rebasing. Therefore, a final adjustment to the level of payments would not be considered until initial effects can be assessed.

The recommendation considers the distribution of payments and variability in financial performance that results from shortcomings in the current PPS. It requires the Secretary to revise the PPS, and we believe that 2018 is a feasible implementation date. The Commission first proposed an alternative design in 2008 and has continued to work on possible refinements since then. Further, CMS has work under way to consider alternative PPS designs. A revised design would direct payments away from intensive therapy that is unrelated to patient care needs while continuing high payments for patients with high care needs and directing payments toward medically complex care. A needs-based design would improve the accuracy of payments and narrow the disparities in financial performance that result from the mix of cases facilities treat and their therapy practices. The design would not, and should not, address disparities that result from inefficiencies.

The Commission is focused on ensuring beneficiaries' access to SNF care. Some variation in financial performance reflects patient selection and the provision of services that are unrelated to patients' characteristics. The recommended changes should not impair beneficiary access; in fact, they should improve access to services for beneficiaries who are disadvantaged by the design of the current payment system. At the same time, the

**TABLE
7-11**

The number of nursing homes treating Medicaid enrollees stayed relatively stable in 2015

	2005	2007	2009	2011	2013	2014	2015	Percent change 2014-2015
Number of facilities	15,484	15,254	15,118	15,074	15,043	15,031	14,985	-0.3%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2005-2015.

industry should be able to furnish services while having positive Medicare margins, including facilities with higher concentrations of medically complex patients. The Commission will continue to monitor beneficiary access, quality of care, and financial performance and may consider future recommendations based on industry performance.

IMPLICATIONS 7

Spending

- Relative to current law, this recommendation would lower program spending by between \$750 million and \$2 billion for fiscal year 2017 and between \$5 billion and \$10 billion over five years. Savings occur because current law requires market basket increases for 2017 and 2018 (offset by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010).

Beneficiary and provider

- We do not expect an adverse effect on beneficiary access. Revising the prospective payment system would raise payments for medically complex cases, making providers more likely to admit and treat beneficiaries with such care needs. Even if a low-performing SNF were to close, most beneficiaries live in counties with multiple providers and therefore would continue to have a SNF in the county. We do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries. Provider payments would be lower, but the recommendation would reduce the disparities in Medicare margins across providers. Effects on individual providers would be a function of their mix of patients and current practice patterns. The recommendation would not eliminate all of the differences in Medicare margins across providers because of their large cost differences.

Medicaid trends

Section 2801 of the Patient Protection and Affordable Care Act of 2010 (PPACA) 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 the Medicaid program. We do not have more updated information on Medicaid utilization than was reported last year and therefore have not included that information in this year's report. We report nursing home spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2016).

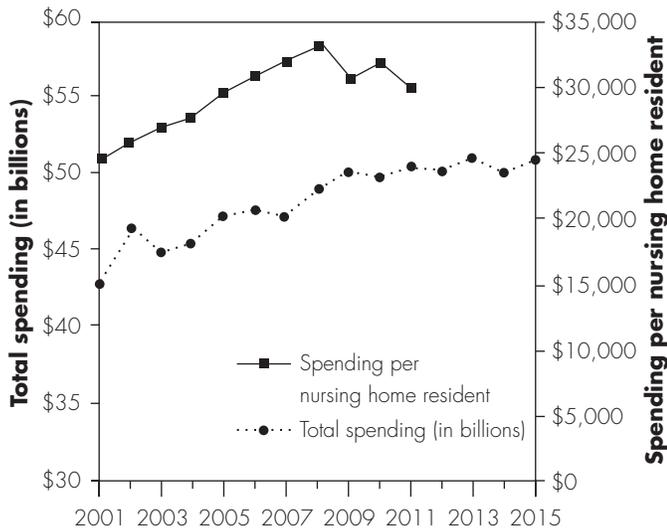
Medicaid covers nursing home (long-term care) and skilled nursing care provided in nursing facilities. Medicaid pays for long-term care services that Medicare does not cover. For beneficiaries who are dually eligible for Medicaid and Medicare, Medicaid pays the Medicare copayments required of beneficiaries beginning on day 21 of a SNF stay.

Count of Medicaid-certified nursing homes

The number of nursing facilities certified as Medicaid providers has stayed relatively stable, with a small decline between 2014 and 2015 (Table 7-11). The decline in facilities may reflect the expansion in some states of home- and community-based services (HCBS), which allow beneficiaries to remain in their homes rather than in an institution. State HCBS waivers and federal initiatives have accelerated the trend toward HCBS. In fiscal years 2015 and 2016, 46 states expanded the number of

FIGURE 7-5

Total and per user Medicaid spending on nursing home services



Note: Resident counts (and therefore per resident spending) are not available for 2012 through 2015.

Source: Office of the Actuary 2015a.

beneficiaries served by HCBS, an increase from 42 states in fiscal year 2014 and 33 states in fiscal year 2013 (Smith et al. 2015).

The data source for the counts of users of Medicaid-financed nursing home services was not updated this year, so we do not have more current information than was reported last year.

Spending

CMS estimates that about \$51 billion was spent in 2015 on Medicaid-funded nursing home services (combined

state and federal funds) (Office of the Actuary 2015a) (Figure 7-5). Between 2014 and 2015, Medicaid spending on nursing home services increased by 1.5 percent. CMS projects that spending will grow by 1.7 percent in 2016. Spending increases averaged 1.3 percent annually between 2001 and 2015, for a total of 17.9 percent over the period. Year-to-year changes in spending were variable, increasing in some years and decreasing in others. On a per user basis, spending per nursing home resident averaged \$29,855 in 2011, the most recent year for resident counts. Although spending per resident decreased between 2009 and 2010, the level in 2011 was 32 percent higher than it was in 2000 (Centers for Medicare & Medicaid Services 2013).

Analysis of Medicaid rate-setting trends found that 14 states restricted (froze or reduced) rates paid to nursing homes in 2015, while 36 states and the District of Columbia increased rates (Smith et al. 2015). In 2016, 28 states and the District of Columbia plan to increase rates, and 21 states plan to restrict them (Illinois was not determined at the time the article was published). This trend represents a steady improvement in the Medicaid revenues for nursing homes. In 2014, 12 states restricted payments for nursing homes and 38 states and the District of Columbia increased payments. States continue to use provider taxes to raise federal matching funds. In fiscal year 2015, 44 states levied provider taxes on nursing homes, and all plan to continue to do so in fiscal year 2016.

Because the care needs of the average Medicare beneficiary are considerably higher than those of the average Medicaid resident, the average daily Medicare payment is higher than the average Medicaid payment. Using data from 2011, we previously estimated that the differences in the care needs (as measured by the average

TABLE 7-12

In the past eight years, non-Medicare margins have been negative, but total margins were positive in freestanding SNFs

Type of margin	2007	2009	2010	2011	2012	2013	2014
Non-Medicare margin	-1.2%	-1.2%	-1.5%	-2.6%	-2.0%	-1.9%	-1.5%
Total margin	2.5	3.5	3.5	3.8	1.8	1.9	1.9

Note: SNF (skilled nursing facility). "Non-Medicare margin" reflects the profitability of all services and all payers except Medicare-funded SNF services. "Total margins" reflects the profitability of all services and all payers, including Medicare.

Source: MedPAC analysis of freestanding 2007–2014 SNF cost reports.

nursing case-mix index) between the average Medicaid nursing home resident and the average Medicare SNF patient would translate to payments that would be 84 percent higher for Medicare patients, thus explaining most of the difference between Medicare and Medicaid payments.

Non-Medicare and total margins in nursing homes

Total margins reflect all payers (including Medicaid, private insurers, and managed care) across all lines of business (for example, nursing home care, hospice care, ancillary services, home health care, and investment income). In 2014, total margins were positive (1.9 percent). The median total margin was 1.8 percent, with

margins at the 25th and 75th percentiles ranging from –3.2 percent to 6.5 percent. Total margins have declined since 2011, reflecting the impact of PPACA reductions to Medicare payments and the growing share of managed care payments that are lower than Medicare’s FFS payments.

Non-Medicare margins reflect the profitability of all services and all payers except Medicare-funded SNF services. The aggregate non-Medicare margin in 2014 was –1.5 percent (Table 7-12). Non-Medicare margins improved from 2013, mostly reflecting increases in state Medicaid payment rates. ■

Endnotes

- 1 Throughout this section, *beneficiary* refers to an individual whose SNF stay coverage (Part A) is paid for by Medicare. Some beneficiaries who no longer qualify for Medicare coverage remain in the facility to receive long-term care services, which are not covered by Medicare. During long-term care stays, beneficiaries may receive services such as physician services, outpatient therapy, and prescription drugs that are paid for separately under the Part B and Part D benefits. Services furnished outside the Part A–covered stay are not paid under the SNF PPS and are not considered in this section. Except where specifically noted, the chapter examines FFS Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans. Some beneficiaries also qualify for Medicaid and are referred to as dual-eligible beneficiaries.
- 2 A spell of illness begins when a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day requirement.
- 3 For services to be covered, the SNF must meet Medicare’s requirements of participation and agree to accept Medicare’s payment rates. Medicare’s requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day, providing physical and occupational therapy services and speech–language pathology services as delineated in each patient’s plan of care, and providing or arranging for physician services 24 hours a day in case of an emergency.
- 4 The program pays separately for some services, including certain chemotherapy drugs, certain customized prosthetics, certain ambulance services, Part B dialysis, emergency services, and certain outpatient services provided in a hospital (such as computed tomography, MRI, radiation therapy, and cardiac catheterizations).
- 5 Intensive therapy days are those classified in the ultra-high and very high rehabilitation case-mix groups. Rehabilitation groups are based on minutes of rehabilitation provided per week. *Ultra-high rehabilitation* includes patients who receive more than 720 minutes per week; *very high rehabilitation* includes patients who receive 500–719 minutes per week.
- 6 There are two broad categories of medically complex case-mix groups: clinically complex and special care. Clinically complex groups include patients who have burns, surgical wounds, hemiplegia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a SNF patient. Special care groups include patients who are comatose; have quadriplegia, chronic obstructive pulmonary disease, septicemia, diabetes requiring daily injections, fever with specific other conditions, cerebral palsy, multiple sclerosis, Parkinson’s disease, respiratory failure, a feeding tube, pressure ulcers of specific sizes, or foot infections; receive radiation therapy or dialysis while a resident; or require parenteral or intravenous feedings or respiratory therapy for seven days.
- 7 In 2010 (for fiscal year 2011), CMS revised how the therapy time for concurrent therapy (two patients engaged in different therapy activities at the same time) was to be allocated between the two patients treated, which effectively lowered the payment for this modality. It also required end-of-therapy assessments to prevent paying for therapy services after they have been discontinued. In 2011 (for fiscal year 2012), CMS revised how the time spent in group therapy (therapy provided in groups with up to four patients engaged in the same therapy activities at the same time) was to be allocated across the four patients in the group, again effectively lowering payments for this modality.
- 8 Medically complex days make up the other 7 percent of days. See endnote 6 for the definition of *medically complex*.
- 9 The nine ADLs include bowel control, bladder control, transfer, walk in the facility corridor, self-feeding, toileting, dressing, performing personal hygiene, and bed mobility. The share of the most dependent increased for bathing.
- 10 With inclusion of the other covariates, age categories were not found to be significant in explaining variation in outcomes and were dropped from the models, except for the model explaining differences in readmission during the 30 days postdischarge for community-residing beneficiaries younger than 65.
- 11 We use these measures because they reflect the goals of post-acute care: to return home, avoid a rehospitalization, and improve or maintain function. The Commission does not use CMS’s nursing home 5-star rating system for two reasons. First, until it was recently overhauled in response to criticism, the rating system reflected self-reported data that was hard to verify. Second, 8 of the 11 quality measures focus on long-stay care, and of the 3 short-stay measures (the share of residents with pressure sores that are new or worsened, the share of residents who self-report moderate or severe pain, and the share of residents who newly received antipsychotic medication), none capture the main goals of SNF care.

- 12 Readmission rates of patients during their SNF stay and in the period after discharge cannot simply be added to get a combined rate because, in the combined measure, a stay is counted only once, even if the patient was readmitted during the SNF stay and in the post-stay period. In contrast, each relevant stay is counted separately in each measure.
- 13 Almost three-quarters of freestanding SNFs (and the same share of Medicare payments) are on a calendar year cost reporting period. In 2013, the sequester lowered payments to these SNFs for nine months.
- 14 We use the nursing component (as opposed to the payment weight of the case-mix group) to avoid distorting the measure of patient complexity by the amount of therapy furnished, which could be unrelated to patient care needs. We used the indexes adjusted for CMS's policy decisions to shift payments toward certain case-mix groups and away from others (White 2012). Because the nursing weights for intensive therapy are relatively high, a facility can have both a high case-mix index and a moderate or low share of medically complex patients.

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