

CHAPTER

8

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**Skilled nursing facility services**

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

- 8** For fiscal year 2021, the Congress should eliminate the update to the fiscal year 2020 Medicare base payment rates for skilled nursing facilities.

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

# Skilled nursing facility services

## Chapter summary

In skilled nursing facilities (SNFs), Medicare covers short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2018, about 15,000 SNFs furnished 2.2 million Medicare-covered stays to 1.5 million fee-for-service (FFS) beneficiaries (4 percent of Medicare’s FFS beneficiaries). Medicare FFS spending on SNF services was \$28.5 billion in 2018, 1 percent less than in 2017.

## Assessment of payment adequacy

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

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

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program has been stable. The vast majority (88 percent) of beneficiaries live in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds), and less than 1 percent live in a county without one.

## In this chapter

- Are Medicare payments adequate in 2020?
- How should Medicare payments change in 2021?
- Medicaid trends

Between 2017 and 2018, the median occupancy rate declined slightly but remained high (about 84 percent).

- ***Volume of services***—Medicare-covered admissions per FFS beneficiary decreased 3 percent between 2017 and 2018, consistent with a decrease in the number of admissions for hospital stays that last at least three days (required for Medicare coverage). Lengths of stay also declined slightly. Both contributed to fewer covered days in 2018 compared with 2017.
- ***Marginal profit***—An indicator of whether freestanding SNFs have an incentive to treat more Medicare beneficiaries—marginal profit—averaged about 18 percent for freestanding facilities in 2018.

***Quality of care***—Between 2017 and 2018, discharge to community and readmission rates improved. However, over a longer period, SNF quality measures have shown mixed performance. Since 2012, the average rates of discharge to the community and hospital readmission during the SNF stay improved, while the rate of readmissions after the SNF stay worsened.

***Providers' access to capital***—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. For the first year since 2000, the total margin (a measure of the total financial performance across all payers and lines of business) was slightly negative in 2018 (–0.3 percent). Access to capital was adequate in 2019 and is expected to remain so in 2020. Any lending wariness reflects broad changes in post-acute care, not the adequacy of Medicare's payments. Medicare is regarded as a preferred payer of SNF services.

***Medicare payments and providers' costs***—Medicare's FFS spending in 2018 decreased 1 percent to \$28.5 billion. In 2018, the average Medicare margin for freestanding SNFs was 10.3 percent—the 19th year in a row that the average was above 10 percent. Margins varied greatly across facilities, reflecting differences in costs and shortcomings in the SNF prospective payment system (PPS) that favored treating rehabilitation patients over medically complex patients.

In October 2019, CMS substantially revised the SNF PPS, removing therapy as a payment adjuster and adding components and factors that better reflect differences in the clinical care needs of patients. The redesign is estimated to increase payments for medically complex patients and patients with high costs for nontherapy ancillary items (such as drugs). The redesign is consistent with the Commission's previously recommended designs for the SNF PPS and a unified post-acute care PPS. The changes are likely to alter the mix of cases treated in SNFs, providers' cost structures, and the relative costs of different types of stays.

In 2018, the level of FFS payments continued to be well above the cost to treat Medicare beneficiaries. Several factors indicate that the aggregate level of Medicare’s FFS payments remains too high. First, since 2000, the average Medicare margin has been above 10 percent; the marginal profit in 2018 was even higher, suggesting that facilities with available beds have an incentive to admit Medicare patients. Second, Medicare Advantage (managed care) payment rates to SNFs, considered attractive by many SNFs, are much lower than the program’s FFS payments. The differences between beneficiaries enrolled in Medicare Advantage and FFS who used SNF services in 2018 would not explain the large difference in payments. Costs varied widely for reasons unrelated to case mix and wages. Finally, the very high Medicare margin (16.9 percent) for efficient SNFs—those providers with relatively low costs and high quality—is further evidence that Medicare continues to overpay for SNF care.

Considering these factors, the recommendation states that the Congress should eliminate the update to the fiscal year 2020 Medicare base payment rates for SNFs. While the level of payments indicates a reduction to payments is needed to more closely align aggregate payments and costs, the SNF industry is likely to undergo considerable changes as it adjusts to the redesigned PPS. Given the impending changes, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with costs while exerting pressure on providers to keep their cost growth low.

## **Medicaid trends**

As required by the Affordable Care Act of 2010, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins. Medicaid finances most long-term care services provided in nursing homes but also covers the copayments on SNF care for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. Between 2018 and 2019, the number of Medicaid-certified facilities declined almost 1 percent, to 14,889. CMS projects that total FFS spending on nursing home services declined between 2018 and 2019 but will increase slightly between 2019 and 2020.

In 2018, the average total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as skilled and long-term care, hospice, ancillary services, home health care, and investment income)—was –0.3 percent, down from 2017 (0.6 percent). The average non-Medicare margin (which includes all payers and all lines of business except Medicare FFS SNF services) was –3.0 percent, down from –2.4 percent in 2017. ■



## Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include beneficiaries recovering from surgical procedures such as hip and knee replacements or from medical conditions such as stroke and pneumonia.<sup>1</sup> In 2018, almost 1.5 million Medicare fee-for-service (FFS) beneficiaries (4 percent of Medicare Part A FFS beneficiaries) used SNF services at least once; program spending on SNF services was \$28.5 billion (about 7 percent of FFS spending) (Boards of Trustees 2019, Office of the Actuary 2019b). Medicare’s median payment per day was \$487, and its median payment per stay was \$18,247. In 2018, one-fifth 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.<sup>2</sup> For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of the spell of illness. Beginning with day 21, beneficiaries are responsible for copayments through day 100 of the covered stay. For fiscal year 2020, the copayment is \$176 per day.

The term *skilled nursing facility* refers to a provider that meets Medicare requirements for Part A coverage.<sup>3</sup> Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes (which typically provide less intensive, long-term care services). Thus, a facility that provides skilled care often also provides long-term care services that Medicare does not cover. The less intensive long-term care services typically make up the bulk of a facility’s business, and Medicaid pays for the majority of this care.

The mix of facilities where beneficiaries receive skilled nursing care has shifted over time toward freestanding and for-profit facilities. In 2018, almost all facilities were freestanding (96 percent), and they accounted for an even larger share of revenue (97 percent) than other types of facilities (Table 8-1). Hospital-based SNFs made up a small share of facilities, stays, and spending (4 percent or less). For-profit facilities accounted for 71 percent of all SNFs and 74 percent of revenues.

Freestanding SNFs vary by size. In 2018, while the median SNF had 100 beds, the largest facilities (those at the 90th percentile or higher) had least 174 beds and the smallest facilities (those at or below the 10th percentile) had 50 beds or fewer. The typical nonprofit facility and rural facility were smaller (the median sizes were 87 beds and 85 beds, respectively) than for-profit facilities and urban facilities (the median sizes were 102 beds and 110 beds, respectively). In 2018, the majority (61 percent) of small

**TABLE  
8-1**

**Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, Medicare stays, and Medicare spending, 2018**

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total number	15,042	2,191,246	\$25.4 billion
Freestanding	96%	96%	97%
Hospital based	4	4	3
Urban	73	84	85
Rural	27	16	15
For profit	71	71	74
Nonprofit	23	25	22
Government	6	4	4

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

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2018.

SNFs (50 or fewer beds) were located in metropolitan areas and 39 percent were located in nonmetropolitan areas. Four percent were located in the most rural counties (not in or adjacent to metropolitan or micropolitan areas, Urban Influence Codes 11 and 12). A small share (less than 4 percent) of the small facilities were located in frontier areas (counties with six or fewer persons per square mile).

Medicare FFS–covered SNF days typically account for a small share of a facility’s total patient days but a disproportionately larger share of the facility’s revenues. In freestanding facilities in 2018, Medicare’s median share of facility days was 10 percent but 18 percent of facility revenue, a decline from 2010 when FFS Medicare accounted for 23 percent of facility revenue (data not shown). The decrease in the FFS Medicare share of revenues reflects the growth in Medicare Advantage (MA) enrollment. Between 2017 and 2018, MA enrollment increased almost 8 percent while FFS Part A enrollment decreased slightly (–0.3 percent).

The five most common hospital conditions of patients referred to SNFs for post-acute care are septicemia, joint replacement, heart failure and shock, hip and femur procedures (except major joint replacement), and pneumonia. Compared with other beneficiaries, SNF users are older; more frail; and disproportionately female, disabled, living in an institution, and dually eligible for Medicare and Medicaid (Medicare Payment Advisory Commission 2013). In 2019, CMS implemented a final rule requiring hospitals to provide beneficiaries at discharge with information about the quality of SNFs that may help them make more informed decisions about where to get this care (Centers for Medicare & Medicaid Services 2019a).

### **Revised SNF prospective payment system implemented October 1, 2019**

Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.<sup>4</sup> Information gathered from a standardized patient assessment instrument—the Minimum Data Set—is used to classify patients into case-mix categories. By statute, the payment system makes payments for each day of care (not the entire stay), thus undermining the prospective nature of the design and allowing providers to have some control over how much Medicare will pay them for their services.

Until October 2019, the original SNF PPS design was criticized for encouraging the provision of excessive

rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) items such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002). The payment system resulted in providers having a financial incentive to select which patients they would admit and furnishing therapy services of questionable value. Since 2013, the Justice Department has settled about 20 cases involving allegations of improperly billing for intensive therapy services that were not reasonably or medically necessary.<sup>5</sup> The Commission and the Office of Inspector General called for a redesign that would vary payments based on patient characteristics rather than the amount of therapy furnished (Medicare Payment Advisory Commission 2008, Office of Inspector General 2015).

On October 1, 2019, CMS implemented the Patient-Driven Payment Model (PDPM), which makes substantial changes to the payment system that consider many aspects of a patient’s condition in establishing payments. Six components—nursing, physical therapy, occupational therapy, speech–language pathology, NTA items, and room and board—are summed to establish a daily payment.<sup>6</sup> Except for the room and board component (which is uniform for every day of care), each component has its own case-mix factors that capture the key patient characteristics driving that component’s costs. For example, the primary reason for treatment and functional status are used to adjust payments for physical and occupational therapy, while a patient’s comorbidities and special treatments adjust the payments for NTA services. Depending on the component, the following information from the patient assessments is used to adjust payments: the primary reason for treatment, prior surgery, comorbidities, functional status, cognitive status, swallowing and nutritional status, depression, and special treatments (such as ventilator care). To reflect the declining costs incurred for physical and occupational therapies and NTA services over the course of a stay, the payments for these components are lower for days later in the stay. Group and concurrent therapies together are limited to 25 percent of total therapy minutes so that individual therapy remains the dominant modality.

CMS estimates that the PDPM will redistribute payments from patients assigned to the highest rehabilitation case-mix groups to medical patients, patients with high NTA costs, and patients requiring tracheostomy or ventilator services (Centers for Medicare & Medicaid Services 2018). CMS noted that the redesigned SNF PPS will



align the payment system closer to an eventual transition to a unified post-acute care (PAC) PPS. The revisions are expected to change provider behavior. Without therapy incentives in place, providers may be more willing to admit a broader mix of patients. After one month, one market analyst reported that SNFs were already taking higher acuity patients who otherwise may have gone to inpatient rehabilitation facilities or long-term care hospitals (Valiquette et al. 2019b). Leading up to the implementation of the PDPM, many providers increased the clinical training of their staffs and educated themselves about the case-mix factors that affect payments so that their coding and assessments were complete and accurate.

Under the PDPM, facilities' case mix, service provision, and cost structures are likely to change. To keep payments aligned with the cost of care, CMS may need to recalibrate the relative weights of the case-mix groups. In addition, though intended to be budget neutral, the new payment system may result in higher aggregate payments, depending on provider behavior, in which case CMS may make an across-the-board reduction to the level of payments. CMS plans to monitor numerous provider responses to the new payment system, including the coding of the primary reasons for treatment, comorbidities, and cognitive function; the minutes of therapy furnished (and the mixes of modalities); and changes in quality measures.

The changes to the SNF PPS could have a broader impact beyond Medicare-covered stays. Similar to current practice, some managed care plans will adopt the revised case-mix system, while others will not (Spanko 2019). In states that adopt the new case-mix system for their Medicaid payments, the PDPM could affect the upper payment limit calculations and their case-mix determinations. To facilitate those states using some version of the now-retired payment system, CMS will continue to report the older case-mix groups and develop an optional assessment that some states will need to calculate their Medicaid payments. These transitional accommodations will be available for fiscal year 2020.

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## **Are Medicare payments adequate in 2020?**

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To examine the adequacy of Medicare's FFS payments, we analyze beneficiaries' access to care (including the

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

### **Beneficiaries' access to care: Access is stable for most beneficiaries**

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

The SNF industry is highly fragmented and characterized by independent providers and local and regional chains. Of the 50 largest operators, most are privately held. In 2018, the 25 largest nursing home chains in the country operated about 19 percent of all facilities (IQVIA Institute for Human Data Science 2018). One study of chains found that new entrants tended to locate in the same state but not in the same markets in which the chains already have holdings (Hirth et al. 2019). Single operators make up about 40 percent of the industry, small (often regional or religious) operators make up about one-quarter of facilities, and the remaining third is run by large chains (Ritchie and Johnson 2017).

The number of SNFs participating in the Medicare program in 2019 was fairly stable at 15,249. Of the 46 new facilities, the majority were for profit, and of the 113 terminations as of November 2019 (less than 1 percent of SNFs), most closed at their own initiative. The count of terminations is greater than the count at the same point in 2018. According to trade press, facilities have closed as the result of several factors: the reportedly low Medicaid rates, lower payment rates paid by MA plans and their lower use of SNFs, and the overexpansion of the SNF supply (in states that do not have certificate-of-need laws). Terminations will affect access to SNF care for those beneficiaries who live in a county with few options, further limited by a closure. In 2018, 88 percent of beneficiaries lived in counties with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds). Another 11 percent lived in counties with one or two SNFs or swing bed facilities.

**TABLE  
8-2**

**SNF admissions and days continued to decline in 2018**

Volume measure	2010	2013	2016	2017	2018	Percent change 2010-2018	Percent change 2017-2018
Covered admissions per 1,000 FFS beneficiaries	73.0	69.3	65.9	64.6	62.5	-14.4%	-3.3%
Covered days per 1,000 FFS beneficiaries	1,972	1,872	1,693	1,623	1,559	-20.9	-3.9
Covered days per admission	27.1	27.0	25.7	25.1	25.0	-7.7	-0.4

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

Source: Centers for Medicare & Medicaid Services 2019b.

Median occupancy rates for freestanding SNFs declined between 2017 and 2018 but remained high (84 percent) in 2018. The median occupancy rate in 2018 for rural facilities was lower than that of urban facilities (80 percent compared with 85 percent), while the median occupancy rate for nonprofit facilities was higher than that of for-profit facilities (87 percent compared with 84 percent). There is wide variation in occupancy rates. One-quarter of freestanding facilities had occupancy rates at or below 72 percent, while another quarter had rates 91 percent or higher. Occupancy rates were high for one-quarter of small facilities (20 to 50 beds) and large facilities (100 to 199 beds), and for the most rural and the most urban facilities (defined using Urban Influence Codes).<sup>7</sup> Among the most rural facilities, one-quarter of small facilities had occupancy rates of at least 89 percent, while one-quarter of large facilities had occupancy rates of at least 94 percent. Among the most urban facilities, large and small facilities had occupancy rates of at least 91 percent. By state, median occupancy rates ranged from 64 percent (Utah) to 94 percent (New York and West Virginia). Of the nine states with median occupancy rates at or above 90 percent, seven of them have certificate-of-need laws limiting industry expansion. Given the relatively high occupancy rates in many facilities, a bed may not be available in the market when a beneficiary is seeking placement, particularly if he or she requires special services.

**Between 2017 and 2018, SNF admissions decreased and stays shortened**

In 2018, 4.0 percent of FFS beneficiaries used SNF services, a small decline from 2017 (when it was 4.2

percent). Between 2017 and 2018, SNF admissions per 1,000 FFS beneficiaries decreased over 3 percent (Table 8-2) (Centers for Medicare & Medicaid Services 2019b). We examine service use for only FFS beneficiaries because the CMS data on users, days, and admissions do not include service use by beneficiaries enrolled in MA plans. Covered days per admission also declined slightly to 25 days. The combination of fewer admissions and shorter stays resulted in 3.9 percent fewer days per 1,000 beneficiaries. Since 2010, admissions of FFS beneficiaries have declined over 14 percent, and covered days per admission dropped almost 21 percent.

The decline in SNF admissions is tied to the decline (-2.3 percent) in per capita FFS inpatient hospital stays that were three days or longer—one of the factors needed to qualify beneficiaries for Medicare coverage of SNF care. The use of observation stays (during which a patient is observed and treated but not admitted to the hospital) by hospitals is another contributing factor to lower SNF use. Because a three-day hospital stay is required for Medicare coverage, some beneficiaries not meeting this requirement may continue to receive care that is not covered by Medicare or be discharged home.

To a smaller extent, the declines in FFS SNF use also reflect a growing presence of alternative payment models, such as accountable care organizations (ACOs) and bundled payment demonstrations that create financial incentives for entities to lower their spending and use of services. ACOs have had a small impact on slowing the growth in Medicare spending, in part by referring fewer beneficiaries to institutional PAC and shortening stays

in SNFs (McWilliams et al. 2017, Medicare Payment Advisory Commission 2019a). Studies of CMS's mandatory Comprehensive Care Joint Replacement bundling initiative and the voluntary Bundled Payments for Care Improvement (BPCI) demonstrations found that participants referred a smaller share of beneficiaries discharged from hospitals to institutional PAC and shortened those PAC (predominantly SNF) stays (Barnett et al. 2019, Dummit et al. 2018a, Dummit et al. 2018b, Finkelstein et al. 2018). Somewhat surprisingly, BPCI participants do not appear to have changed their referral patterns by narrowing their networks or increasing their referrals to high-quality SNFs (Joynt Maddox et al. 2019, Zhu et al. 2019).

Some SNFs report negative experiences with managed care organizations and ACOs. A survey of 184 chief financial officers found that two-thirds reported moderate or significant negative impacts from managed care plans, including reduced volume, higher administrative burden, denied claims following initial approval, and difficulty collecting payments (Ziegler 2019). Although there was initial enthusiasm for ACOs, some SNFs now acknowledge that the volume has not materialized, they are expected to meet length-of-stay goals that are not tailored to the patient, and the SNFs do not share in the savings ACOs achieve (Flynn 2019).

### **Service mix underscores a key reason the SNF PPS design was changed**

Since the PPS was implemented, providers responded to the incentives to furnish enough therapy to classify days into rehabilitation case-mix groups and, within those groups, into the highest payment groups. For example, between 2002 and 2018, the share of days classified into rehabilitation case-mix groups in freestanding facilities increased from 78 percent to 95 percent; days assigned to special care, clinically complex, and extensive services made up the other 5 percent of days. During the same period, the share of intensive therapy days (days assigned to the ultra-high and very high groups) as a share of total days rose from 27 percent to 84 percent. Differences across facilities in the amount of therapy they provided narrowed over time as all providers assigned an increasing share of days to intensive rehabilitation case-mix groups.

More recently, growth in therapy intensification has slowed (or perhaps topped out). Between 2014 and 2018, the amount of intensive therapy furnished to beneficiaries increased 4 percent. During this period, though the

average SNF user was slightly younger (by a year), the average risk score increased 15 percent (indicating more comorbidities), and patients were less able to perform activities of daily living (ADLs). The average Barthel index, a composite measure of a person's ability to perform ADLs, decreased 2 percent, indicating less ability to perform ADLs. For the 10 ADLs we examined, the changes in the shares of SNF users requiring the most help were mixed: 4 measures showed more disability, and 6 showed less disability.<sup>8</sup>

Though access does not appear to be an issue in general, industry representatives and patient advocates report that some providers were reluctant to admit patients with high NTA costs (such as those who need expensive antibiotics, complex wound care, or ventilator and hemodialysis care). Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex admissions. While making up 4 percent of facilities, hospital-based SNFs made up 7.4 percent of the SNFs with the highest shares (the top quartile) of medically complex admissions. The new payment system design should improve access for these patients because payments will increase for patients with high NTA care needs by an estimated 27 percent (Centers for Medicare & Medicaid Services 2018). Still, providers may continue to avoid patients who are likely to require long stays and exhaust their Medicare benefits because a facility's daily payments decline if the patient becomes eligible for Medicaid or the stay results in bad debt.

### **Marginal profit: A measure of the attractiveness of Medicare patients**

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.<sup>9</sup> Among providers with available data, the marginal profit in 2018 was about 18 percent. Because Medicare payments far exceed facilities' marginal costs, facilities with available beds have an

incentive to admit Medicare patients, also signifying a positive indicator of patient access.

### **Quality of care: Measures indicate general improvement**

The Commission tracks three broad categories of SNF quality indicators: risk-adjusted rates of discharge to the community, hospital readmission, and change in functional status during the SNF stay (the methodology for calculating the measures is fully described in the Commission's March 2019 report to the Congress (Medicare Payment Advisory Commission 2019c)). We use these measures because they reflect the goals of most beneficiaries: to return home, avoid a readmission, and improve or maintain function. The readmission rate during the SNF stay measures how well the SNF detects, monitors, and furnishes adequate care to prevent readmissions. The postdischarge measure indicates how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home). Given the evidence that the function information is inconsistently reported by providers, the Commission has less confidence that the function measures reflect actual differences in maintaining or improving patient function (Medicare Payment Advisory Commission 2019b).

Between 2017 and 2018, the rates of discharge to community and readmissions show improvement. However, over a longer period, SNF performance was more mixed. Since 2012, the average rates of discharge to the community and readmissions during SNF stays improved, but the rate of readmissions during the 30 days after discharge got worse, while the two measures of change in function were essentially the same over this period.

### **Recent performance shows improvement in rates of community discharge and readmissions, but longer term trends are more mixed**

The average risk-adjusted rates of discharge to the community have steadily improved since 2012 and reached 41.4 percent in 2018, up from 35.7 percent in 2012 (Table 8-3).<sup>10</sup>

We separately measure potentially avoidable readmissions that occur during the SNF stay and those that occur within 30 days of discharge from the SNF because they measure different aspects of care—care furnished by the SNF and the SNF handoff to the next setting (or home).<sup>11</sup>

Between 2012 and 2018, the average risk-adjusted rate of potentially avoidable readmissions during the SNF stay improved, declining from 11.4 percent in 2012 to 10.6 percent in 2018 (Table 8-3). However, the rates of potentially avoidable readmissions during the 30 days after discharge from the SNF have varied more. Between 2012 and 2017, this postdischarge rate worsened (it increased from 5.7 percent to 6.1 percent) but more recently (between 2017 and 2018) has improved (it declined to 5.9 percent).

There is a low correlation between the during-stay readmission rates and the readmission rates during the 30 days after discharge from the SNF (0.14, which was statistically significant given the sample sizes), confirming that the measures capture different dimensions of quality. Since 2012, SNF outcome-based measures show mixed results.

As part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing (VBP) policy that uses one measure—readmissions for any cause within 30 days of discharge from the preceding hospital stay.<sup>12</sup> The VBP program began adjusting payments to providers in October 2018. The VBP program withholds 2 percent of payments; of the withheld amount, 60 percent will be returned to providers as incentive payments and 40 percent will be retained as program savings. In the second year, among the SNFs that had sufficient data to calculate performance scores, the program lowered payments to the majority (77 percent). These SNFs did not earn some portion of the amount withheld, and 39 percent of all SNFs did not earn back any portion of the 2 percent withheld. The remaining 23 percent of SNFs saw their payments increase; that is, they earned back at least the amount withheld. Two percent of facilities earned the maximum incentive payment (3.1 percent). Many facilities (16 percent) did not have sufficient case counts (at least 25) to have performance scores calculated. The second-year results indicate slightly worse performance compared with year 1 results, when 73 percent of facilities experienced payment reductions and about one-fifth did not earn back any portion of the amount withheld. However, among facilities that gained, those with the best performance in year 2 saw increases of 3.1 percent compared with 1.6 percent in year 1.

In addition to the single VBP measure, the SNF quality reporting program includes 11 other measures. The



**TABLE  
8-3**

**Mean risk-adjusted rates of community discharge and potentially avoidable readmissions, 2012-2018**

Measure	2012	2014	2016	2017	2018
Discharged to the community	35.7%	37.7%	39.6%	39.9%	41.4%
Potentially avoidable readmissions:					
During SNF stay	11.4	10.8	10.8	10.8	10.6
During 30 days after discharge from SNF	5.7	5.7	5.8	6.1	5.9

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 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 2012 through fiscal year 2018 Minimum Data Set and inpatient acute hospital claims data for fee-for-service beneficiaries.

following are the eight assessment-based measures: the share of patients who experienced one or more falls with major injury during their stay, the share of patients with assessments and a care plan that addresses function, drug regimen review with follow-up, changes in skin integrity, changes in self-care, changes in mobility, discharge scores for self-care, and discharge scores for mobility. The three claims-based measures are the rate of successful discharges to the community (i.e., discharged to the community without deaths or unplanned readmissions within the 30 days after discharge), the rate of potentially preventable readmissions in the 30 days after discharge from the SNF, and Medicare spending per beneficiary. Since October 2018, providers that do not submit the necessary data to calculate the assessment-based measures on at least 80 percent of assessments will have their update for that year reduced by 2 percentage points.

**Measures of changes in functional status were essentially unchanged**

Most SNF 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 (such as those with chronic and degenerative diseases) may expect, at best, to maintain their function. We measure SNF performance on both aspects of patient function—improvement and no decline. The risk-adjusted rates consider the likelihood that a

patient’s functionality will change, given the functional ability at admission.

In the aggregate, the functional assessment data can capture trends in quality. In its June 2019 report to the Congress, the Commission reported that broad function levels were associated with other patient characteristics (such as age and patient complexity), giving some reassurance that in aggregate the measures are reasonable. However, when assessments for individual patients were compared, the work raised serious questions about the accuracy of the provider-reported functional assessments. For beneficiaries transferred from one PAC setting and admitted to another, the functional status recorded at discharge from one setting and at admission to the next were often different, and the differences favored reporting that would raise payments. Further, for the same beneficiaries, a disproportionate share of the levels reported for quality were reported higher than those reported for payment purposes. The Commission concluded that the accuracy of this information needs to be improved before it is used as a risk adjuster in establishing payment, used to gauge provider quality, and tied to quality payment (such as value incentive payments).

That said, 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 2012 and 2018 (Table 8-4, p. 230). So, even though the program paid for more therapy over

**TABLE  
8-4**

**Mean risk-adjusted functional outcomes in SNFs were essentially unchanged between 2012 and 2018**

Composite measure	2012	2014	2016	2017	2018
Rate of improvement in one or more mobility ADLs	43.6%	43.5%	43.6%	44.0%	43.9%
Rate of no decline in mobility	87.2	87.1	87.1	87.1	87.2

Note: SNF (skilled nursing facility), ADL (activity of daily living). The three mobility ADLs include bed mobility, transfer, and ambulation. The rate of mobility improvement refers to 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 of these ADLs are counted in the improvement measure. The rate of stays with no decline in mobility is the share of stays with no decline in any of the three mobility ADLs. Rates are the mean of facility rates and are calculated for all facilities with 25 or more stays.

Source: Analysis of fiscal year 2012 through fiscal year 2018 Minimum Data Set data.

this period (the share of days assigned to the highest rehabilitation case-mix groups increased), the therapy did not translate into notably different functional outcomes.

**Large variation in rates of community discharge and readmissions indicates considerable room for improvement**

Considerable variation exists across the industry in performance on the quality measures we track. We found one-quarter of facilities in 2018 had risk-adjusted community discharge rates at or below 33.0 percent, whereas the best performing quarter of facilities had rates of 50.7 percent or higher (higher rates are better) (Table 8-5). Similar variation was seen in readmissions during the SNF stay: The worst performing quartile had rates at or above 13.2 percent, whereas the best quartile had rates at or below 7.5 percent (lower readmission rates are better). 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.

Consistent with prior years, there were differences in discharge and readmission rates by ownership and provider type. In 2018, nonprofit SNFs had higher average rates of community discharges and fewer readmissions (that is, better rates) during the SNF stay and after discharge compared with for-profit facilities. The nonprofit SNFs had community discharge rates that were 9 percent higher (44.4 percent compared with 40.7 percent for for-profit facilities), during-stay readmission rates that were 15 percent lower (9.3 percent compared with 11.0 for for-profit facilities), and after-stay readmission rates that were 9 percent lower

(5.5 percent compared with 6.0 percent for for-profit facilities). By provider type, compared with freestanding facilities, hospital-based SNFs had, on average, higher rates of discharge to the community (12 percent higher), lower during-stay readmission rates (29 percent lower), and lower after-stay readmission rates (15 percent lower).

Medicare is increasingly focused on measuring the value of the care it purchases. In addition to implementing a VBP program in October 2018, CMS has a Nursing Home Compare website that displays comparative information about SNFs and nursing homes to help beneficiaries select a provider. As part of its star ratings, CMS now separately calculates one of the three component ratings (the quality rating) for short stays. The short-stay measures include improvement in function, use of antipsychotic medications, new or worse pressure ulcers, readmissions, emergency room visits, and successful discharge home. The quality rating is part of a facility’s overall star rating, which incorporates the facility’s performance on its health inspection, its staffing ratios, and quality measures for the short and long stays. As a result, the star rating does not entirely reflect the quality of care furnished to Medicare-covered short-stay patients. Separate overall star ratings for short- and long-stay care and an improved search function on the website would enable consumers to get more meaningful information on the care that is being sought.

**Providers’ access to capital was adequate in 2019**

The vast majority of SNFs are part of a larger nursing facility entity. Therefore, in assessing SNFs’ access to capital, we look at the availability of capital for nursing

**TABLE  
8-5**

**SNF quality measures varied considerably across SNFs, 2018**

**Risk-adjusted rates**

Quality measure	Risk-adjusted rates			Ratio of 75th to 25th percentile
	Mean	25th percentile	75th percentile	
Discharged to the community	41.4%	33.0%	50.7%	1.5
Potentially avoidable readmissions during SNF stay	10.6	7.5	13.2	1.8
Potentially avoidable readmissions within 30 days after discharge from SNF	5.9	3.7	7.7	2.1

Note: SNF (skilled nursing facility). Higher rates of discharge to community indicate better quality. Higher readmission rates indicate worse quality. Rates are the average of facility rates and are 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 2018 Minimum Data Set and inpatient acute hospital data.

homes. Medicare makes up a minority share of most nursing homes’ revenues. With restrictions placed on bed supply in many states (35 states plus the District of Columbia have certificate-of-need laws that regulate nursing home bed supply), capital is most often used to update facilities rather than expand capacity.

Access to capital was “robust” in 2019 (Connole 2019). In 2019, of all health care sectors, long-term care had the most mergers and acquisitions (Herschman et al. 2019). In the second quarter of 2019, long-term care deals made up 41 percent of the health care activity and 28 percent of the dollars associated with them (PricewaterhouseCoopers 2019). Despite the overall sector’s declining volume, investors are “positive” on the sector (Valiquette et al. 2019a). With sufficient buyer interest, the price per bed has remained stable (Irving Levin Associates Inc. 2019).

Activity in the capital markets reflects several factors. First, some national companies continued to exit markets to focus their holdings in select states. Given the state-specific regulatory and reimbursement requirements and the hospital referrals needed, regional knowledge is seen as key to a successful business. Assets sold by larger chains were picked up by smaller regional or local operators. At least one company shed its assets in states where it had few homes and then expanded its holdings in core states with significant volume. At the other end of the scale, small chains and single-property operators were purchased

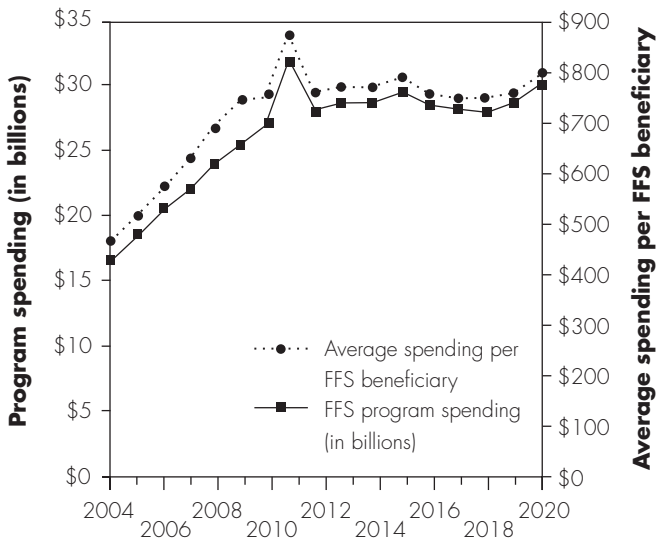
by larger regional chains with economies of scale and organizational backing to face a more complex operating environment. Real estate investment trusts continued to right-size their holdings that created opportunities for other investors (Wilson et al. 2019). Transactions (sales, receiverships, and foreclosures) reflected a variety of struggles, including low Medicaid payment rates and updates, costly contractual rent obligations, and the decline in the much-needed high-payment Medicare FFS volume to remain financially viable.

The aggregate total margin for nursing homes (reflecting all lines of business and all patients) was slightly negative (–0.3 percent), after having been modestly positive (ranging from 0.6 percent and 3.8 percent) since 2001. Because a “total margin” includes the Medicaid-funded long-term care (the nursing home portion of the business), the overall financial performance of this setting is heavily influenced by state policies regarding the level of Medicaid payments and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need).

Some investors eye the slim total margins, declining occupancy rates, and increasing share of revenues from payers with lower rates and opt to pare back their investments or avoid the sector altogether. Other investors view the industry as remarkably stable, having the advantage of demographic trends and being a lower cost

**FIGURE 8-1**

**After declining since 2015, FFS program spending on SNF services is expected to increase in 2019 and 2020**



Note: FFS (fee-for-service), SNF (skilled nursing facility). Fiscal year spending is shown. Data for 2019 and 2020 are estimates.

Source: Office of the Actuary 2019b.

alternative to other institutional PAC. Any reluctance to invest in this setting does not reflect the adequacy of Medicare's FFS SNF payments; Medicare remains a preferred payer.

The Department of Housing and Urban Development (HUD) continues to be an important lending source for this sector. Section 232 loans help finance nursing homes by providing lenders with protection against losses if borrowers default on their mortgage loans. In fiscal year 2019, HUD financed 288 projects, with the insured amount totaling \$3.7 billion (Department of Housing and Urban Development 2019). Though fewer projects were financed in 2019 compared with 2018, the average mortgage amount increased. In 2019, defaults by some homes guaranteed by HUD prompted critics to underscore the importance of adequate oversight of the homes it insures (Goldstein and Geleloff 2019).

The nursing home industry is increasingly dividing into providers that can treat posthospital and medically complex patients and providers that cannot. The transition from FFS to alternative payment models (including ACOs

and bundled payments) and VBP requires SNFs to achieve good outcomes and communicate that performance to potential partners (hospitals and health systems) to secure volume. While some facilities had already started to develop and market their "niche" clinical capabilities to hospitals, the revised SNF payment system is likely to reinforce the divide between facilities that are able to adapt to the changes required and the facilities that are not. Some small solo operators may opt to stop participating in the Medicare program or to sell rather than transition to a more complex model of care. If providers stop participating in the Medicare program, beneficiaries, particularly those in rural areas, may have to go to a facility that is not their first choice or to one that is farther away from their residence. Decisions about exiting the Medicare program do not reflect the adequacy of Medicare's payments; Medicare's payments are well above providers' costs and higher than those made by other payers.

Investors are generally cautiously optimistic about the overall ability of the sector to respond to the revised SNF payment system (Valiquette et al. 2019a, Wilson et al. 2019). The new payment system may spark mergers and acquisitions because providers that cannot adjust to the new design and its requirements will create opportunities for buyers (Wilson et al. 2019).

Because Medicaid payments are lower than Medicare FFS payments, some representatives in the industry argue that high Medicare payments are needed to subsidize losses on Medicaid. The Commission does not support this policy for several reasons (see text box on not subsidizing other payments). It should be noted that while Medicare's payments are higher than Medicaid's, the programs pay for different levels of care. Medicare pays for skilled services posthospitalization; Medicaid generally covers long-term care. (For dually eligible beneficiaries, Medicaid also pays for the copayments that begin on day 21 of a SNF stay and for any skilled care for beneficiaries who have exhausted their Part A coverage.) While some long-term care residents have complex care needs, the average resident does not. The average differences in the level of care are captured by the relative weights for the average Medicare beneficiary and Medicaid resident. The average therapy relative weight for a Medicare-covered beneficiary was nine times higher than the relative weight for a Medicaid-covered resident (White and Zheng 2018). The average nursing relative weight was 40 percent higher for a Medicare-covered beneficiary compared with a Medicaid-covered resident.



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

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

In addition, Medicare's subsidization does not differentiate among states with relatively high and low

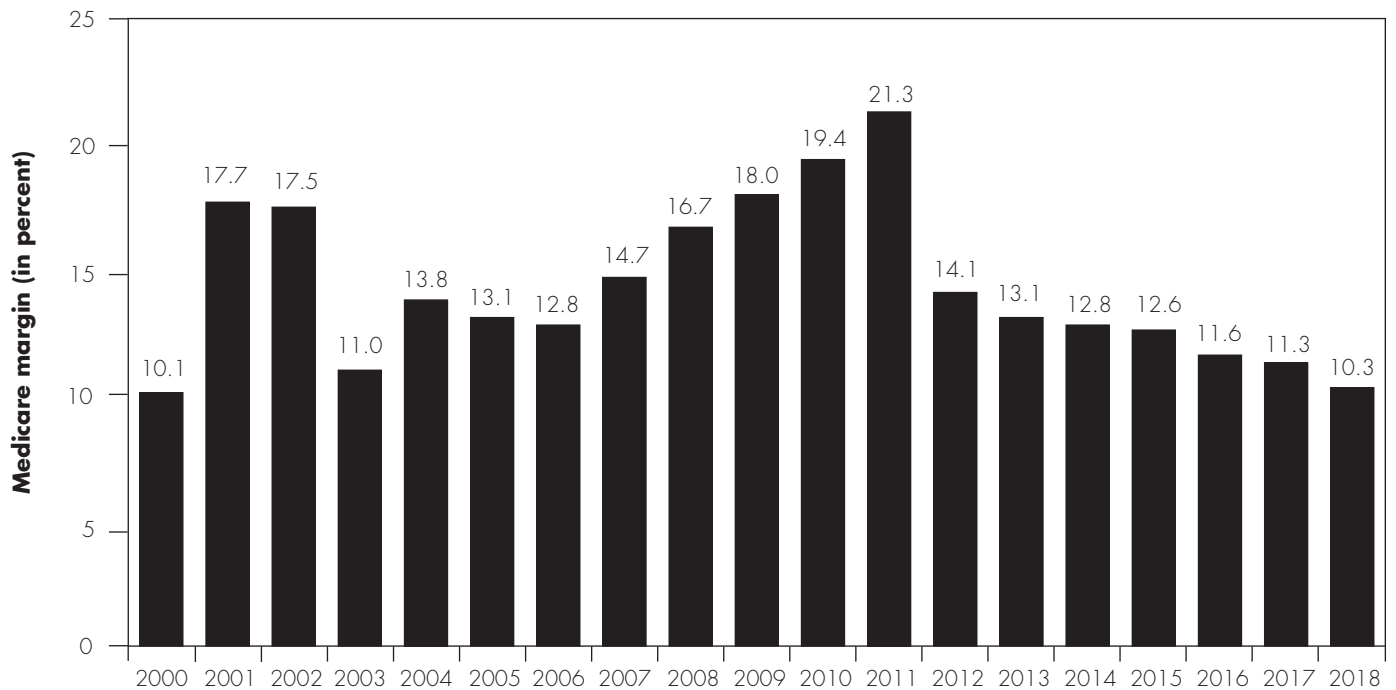
Medicaid payments. If Medicare raises or maintains its high payment levels, states could be encouraged to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates even more. Further, these higher Medicare payments could also further encourage providers to select patients based on payer source or rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay. Finally, Medicare's high payments represent a subsidy from trust fund dollars (and taxpayer support) of the low payments made by states and private payers. Moreover, maintaining or raising Medicare's payments would exert additional fiscal pressure on the already fiscally strapped program. If the Congress wishes to financially support certain nursing facilities (such as those with high Medicaid shares) efficiently, it could do so through a separate, targeted policy. ■

### Medicare payments and providers' costs: Medicare margins remained high in 2018

In 2018, the aggregate Medicare margin for freestanding SNFs was 10.3 percent. Margins for individual facilities continue to vary depending on the facility's share of intensive therapy days, size, and cost per day. High-margin SNFs had higher shares of intensive therapy days and lower average costs per day compared with low-margin SNFs. Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. The 959 (or 8 percent) freestanding facilities defined as relatively efficient—providers with consistently low costs and higher quality care, in relative terms—had Medicare margins of 16.9 percent, indicating Medicare overpays freestanding facilities for this care. Some MA plans' payment rates were considerably lower than Medicare's FFS payment rates, and the disparity is unlikely to be explained by differences in patient mix.

### Trends in FFS spending and cost growth

In fiscal year 2018, Medicare FFS spending for SNF services was \$28.5 billion, about 1 percent lower than in 2017 (Figure 8-1) (Office of the Actuary 2019b). Between 2004 and 2010, program spending increased an average of almost 8 percent a year. In 2011, program spending was unusually high because rates for the new case-mix classification system included an adjustment that was too large for the mix of therapy modalities (i.e., individual versus group or concurrent) assumed in setting the rates. The industry took advantage of the new policies by quickly shifting its mix of modalities, and spending increased by over 19 percent in 2011. To correct for the excessive payment, CMS revised the adjustment downward in 2012, and total payments declined over 12 percent in 2012. Since 2013, program spending has changed little. The Office of the Actuary estimates that FFS spending will increase in 2019 and 2020 (Figure 8-1). On a per FFS beneficiary basis, spending in 2018 was \$745, a small decrease from 2017 (\$752).

**FIGURE  
8-2****Aggregate freestanding SNF Medicare margins have been above 10 percent since 2000**

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

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2018.

Between 2017 and 2018, aggregate costs per day grew 2.7 percent, slightly higher than the market basket (2.6 percent). Costs increased more quickly for nonprofit SNFs compared with for-profit SNFs (3.6 percent compared with 2.4 percent, respectively). Cumulatively since 2013, the industry kept the growth in the average cost per day below the market basket (11.5 percent compared with the market basket of 12.4 percent). Over the same period, nonprofit SNFs had higher cost growth (for total, routine, ancillary, and administrative costs) compared with for-profit SNFs (for example, total costs increased 15.7 percent for nonprofit facilities compared with 10.2 percent for for-profit SNFs). In addition to higher cost growth, nonprofit facilities had higher average costs per day in 2018 for all broad cost categories (total, routine, ancillary, and administration)—the average cost per day was 11 percent higher—than the cost per day in for-profit facilities. Differences in the level of cost per day by ownership have

grown over time. The higher costs for nonprofit facilities partly reflect their smaller size, so they generally cannot achieve the same economies of scale. In 2018, compared with for-profit facilities, the median nonprofit facility was smaller (87 beds compared with 102 beds) and had a lower average daily census (71 compared with 81).

**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 FFS payments with providers' costs to treat FFS beneficiaries. In 2018, the aggregate Medicare margin for freestanding SNFs was 10.3 percent, down from 11.3 percent in 2017. Even with this decline, it was the 19th consecutive year of Medicare margins above 10 percent (Figure 8-2). Medicare margins declined because costs per day increased 2.7 percent, while payment rates were increased by 1.0 as required by the Medicare Access and

CHIP Reauthorization Act of 2015. With changes in case mix, payments per day increased 1.5 percent.

In 2018, hospital-based facilities (3 percent of program spending on SNFs) continued to have extremely negative Medicare margins (–63 percent), in part because of the higher cost per day reported by hospitals. However, hospital administrators consider their SNF units in the context of the hospital’s overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their SNF beds, thus making inpatient beds available to treat additional inpatient admissions.

### Widely varying SNF Medicare margins illustrate why a revised PPS was needed

The wide variation in Medicare margins illustrates why a revised PPS design was needed. In 2018, one-quarter of freestanding SNFs had Medicare margins of 19.7 percent or higher, while another quarter of freestanding SNFs had margins of –0.7 percent or lower (Table 8-6). Providers’ case mix played a key role in shaping Medicare margins. In 2018, facilities with high shares of intensive therapy days had Medicare margins that averaged 9 percentage points higher than facilities with low shares of these days (12.3 percent compared with 3.1 percent). Facilities that treated low shares of medically complex days had higher margins than those with high shares (11.9 percent compared with 8.0 percent).

Medicare margins also reflect the economies of scale that larger SNFs are able to achieve. Small (20 to 50 beds) and low-volume facilities (bottom quintile of total facility days) had low average Medicare margins (–2.1 percent and –0.8 percent, respectively) compared with large and high-volume facilities (11.7 percent and 12.8 percent, respectively). SNFs with the lowest cost per day (SNFs in the bottom 25th percentile) had Medicare margins that were more than 20 percentage points higher than SNFs with the highest cost per day (SNFs in the top 25th percentile).

Since 2006, for-profit facilities’ Medicare margins have averaged about 10 percentage points higher than nonprofit facilities’ margins. In 2018, the difference was 12.5 points. The disparity reflects differences in facilities’ mix of patients, costs, size, and service provision. Nonprofit facilities on average have higher costs per day (about 11 percent higher), in part because they are smaller and had higher cost growth compared with for-profit facilities. As

**TABLE  
8-6**

### Variation in freestanding SNF Medicare margins reflects the mix of cases, cost per day, and economies of scale, 2018

Provider group	Medicare margin
All providers	10.3%
For profit	13.0
Nonprofit	0.5
Rural	8.2
Urban	10.7
Frontier	2.9
25th percentile of Medicare margins	–0.7
75th percentile of Medicare margins	19.7
Intensive therapy: High share of days	12.3
Intensive therapy: Low share of days	3.1
Medically complex: High share of days	8.0
Medically complex: Low share of days	11.9
Small (20–50 beds)	–2.1
Large (100–199 beds)	11.7
Cost per day: High	–1.4
Cost per day: Low	22.1
Cost per discharge: High	8.6
Cost per discharge: Low	11.5
Facility volume: Highest fifth	12.8
Facility volume: Lowest fifth	–0.8

Note: SNF (skilled nursing facility). The margins are aggregates for the facilities included in the group. “Intensive therapy” days are those classified in the ultra-high and very high rehabilitation case-mix groups. “Low” is defined as facilities in the lowest 25th percentile; “high” is defined as facilities in the highest 25th percentile. “Frontier” refers to SNFs located in counties with six or fewer people per square mile. Facility volume includes all facility days.

Source: MedPAC analysis of 2018 freestanding SNF Medicare cost reports.

for revenues, nonprofits had somewhat lower shares of the more profitable ultra-high and very high therapy days compared with for-profit facilities (84 percent compared with 85 percent, respectively) and shorter stays, both lowering revenue (data not shown).

**TABLE  
8-7**

**Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2018**

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
<b>Cost measures</b>			
Standardized cost per day	\$278	\$410	0.68
Standardized ancillary cost per day	\$118	\$167	0.70
Standardized routine cost per day	\$157	\$230	0.68
Standardized cost per discharge	\$11,392	\$14,506	0.79
Average daily census (patients)	88	65	1.34
Occupancy rate (in percent)	86%	83%	1.04
<b>Revenue measures</b>			
Medicare payment per day	\$530	\$458	1.16
Medicare payment per discharge	\$22,554	\$15,730	1.43
Medicare length of stay (days)	41	34	1.20
Share of days in intensive therapy	89%	81%	1.10
Share of medically complex days	3%	3%	1.00
Medicare share of facility revenue	22%	12%	1.83
Medicaid share of days	66%	57%	1.16
<b>Patient characteristics</b>			
Case-mix index	1.42	1.32	1.08
Share dual-eligible beneficiaries	51%	36%	1.42
Share minority beneficiaries	15%	5%	3.00
Share very old beneficiaries	26%	33%	0.79
<b>Facility mix</b>			
Share for profit	85%	55%	N/A
Share urban	81%	70%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Top margin quartile SNFs (n=3,318) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n=3,318) were in the bottom 25 percent of the distribution of Medicare margins. "Standardized cost" refers to 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 in 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 and older. Figures in the first two columns are rounded, but ratios were calculated on unrounded data.

Source: MedPAC analysis of freestanding 2018 SNF cost reports and claims.

The highest margin freestanding SNFs (those in the top quartile of the distribution of Medicare margins) appear to pursue both cost and revenue strategies (Table 8-7). Compared with lower margin SNFs (those in the bottom quartile), high-margin SNFs had considerably lower standardized daily total, routine, and ancillary costs and lower cost per discharge. Economies of scale play a role; high-margin SNFs had higher daily censuses on average

and had higher occupancy rates than lower margin facilities. Somewhat surprisingly, high-margin facilities had larger shares of dual-eligible beneficiaries, minority beneficiaries, and Medicaid days. It is possible that, given their larger Medicaid mix (and the lower payments typically made by Medicaid), these facilities keep their costs lower, which contributes to their higher Medicare margins.

## Identifying relatively efficient skilled nursing facilities

**W**e defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and good quality of care for three years in a row, 2015 through 2017. The cost per day was calculated using cost report data and was adjusted for differences in case mix (using the nursing component relative weights) and area wages. To assess quality, we examined risk-adjusted rates of community discharge and potentially avoidable readmissions that occurred during the SNF stay. Only facilities with at least 25 stays were included in the quality measures. To be included in the relatively efficient group, a SNF had to be in the best third of the distribution of at least one measure and not in the bottom third of any measure for three consecutive years. Another criterion was that SNFs not be part of CMS’s Special Focus Facility Initiative for any portion of time covered by the definition (2015 through 2017), which excluded five facilities from the pool of efficient providers.<sup>13</sup>

We found that 8 percent (959 of the 11,551 facilities that had all of the data items required for this analysis) provided relatively low-cost, high-quality

care. Relatively efficient facilities were more likely to be urban and for profit. Efficient SNFs were geographically dispersed (located in 44 states), though the states without an efficient SNF tended to be predominantly rural (Alaska, Maine, Montana, North Dakota, South Dakota, and West Virginia, plus the District of Columbia).

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

### Relatively efficient SNFs illustrate Medicare’s payments are too high

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

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

To identify efficient SNFs, we examined the performance of freestanding SNFs with consistent cost and quality performance. To measure costs, we looked at costs per day that were adjusted for differences in area wages and case mix. The quality measures were risk-adjusted rates of community discharge and potentially avoidable readmissions during the SNF stay.

Our analyses found that many SNFs (959, or 8 percent of the 11,551 facilities included in this analysis) had relatively low costs and provided relatively good quality care. Compared with other SNFs in 2018, relatively



**TABLE  
8-8****Financial performance of relatively efficient freestanding SNFs is a combination of lower cost per day and higher revenues per day**

Performance in 2018	Type of SNF		Ratio of relatively efficient to other SNFs
	Relatively efficient	Other SNFs	
Community discharge rate	52%	41%	1.27
Readmission rate	9%	10%	0.85
Standardized cost per day	\$304	\$331	0.92
Standardized cost per discharge	\$9,042	\$12,444	0.73
Medicare revenue per day	\$530	\$482	1.10
Medicare margin	16.9%	9.9%	
Total margin	2.0%	0.26%	
Facility case-mix index	1.44	1.36	1.06
Medicare average length of stay	30 days	37 days	0.80
Occupancy rate	88%	84%	1.04
Average daily census	98	78	1.26
Share ultra-high therapy days	69%	56%	1.22
Share medically complex days	4%	4%	1.00
Medicaid share of facility days	58%	63%	0.93
Share urban	85%	68%	N/A
Share for profit	79%	67%	N/A
Share nonprofit	16%	21%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). The number of freestanding facilities included in the analysis was 11,551, of which 959 (or 8 percent) of SNFs were identified as “relatively efficient” based on their cost per day and two quality measures (community discharge and readmission rates) between 2015 and 2017. Relatively efficient SNFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of three years and were not a facility under “special focus” by CMS. Costs per day and per discharge were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted 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 therapy days” include days assigned to ultra-high case-mix groups. “Medically complex days” includes days assigned to clinically complex and special care case-mix groups. The table shows the medians for the measure. The median total margins for relatively efficient and other SNFs were positive, although the aggregate total margin for all freestanding SNFs was -0.3 percent. Figures in the first two columns are rounded, but ratios were calculated on unrounded data.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2015–2018.

efficient SNFs had community discharge rates that were 27 percent higher and readmission rates that were 15 percent lower (Table 8-8). Standardized costs per day were 8 percent lower than for other SNFs. The aggregate Medicare margin for relatively efficient SNFs was high (16.9 percent), indicating that although these providers were relatively low cost and achieved relatively high quality, the Medicare program could get better value for its purchase if its payments were lower. The high margin for these providers underscores the need for the program

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

Similar to high-margin SNFs, relatively efficient SNFs appear to pursue cost and revenue strategies. On the cost side, relatively efficient SNFs achieved greater economies of scale, with a higher daily census compared with other facilities (98 compared with 78, respectively) and higher occupancy rates (88 percent versus 84 percent). Because the relatively efficient providers were also higher quality, their volume could reflect their success in attracting

**TABLE  
8-9**

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

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	Managed care (MA)	
Diversicare	\$458	\$394	1.16
Ensign Group	616	466	1.32
Genesis HealthCare	526	456	1.15

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

Source: Third quarter 10-Q 2019 reports available at each company’s website.

admissions. On the revenue side, relatively efficient providers had higher shares of the most intensive therapy days, which raised their daily Medicare payments relative to all SNFs. They also had lower Medicaid shares, which improved their total financial performance; efficient providers’ total margin was 2.0 percent compared with 0.26 percent for other SNFs. Relatively efficient facilities had more complex case mixes (driven in part by higher therapy intensity) and shorter stays.

**FFS payments for SNF care are considerably higher than MA payments for three publicly traded nursing home companies**

Another indicator that Medicare’s payments under the SNF PPS are too high is the comparison of Medicare FFS and MA payments. (We use “MA” as shorthand for all managed care payments since MA makes up the majority of rates reported as “managed care payments.”) We compared Medicare FFS and MA payments for three companies with SNF holdings for which such information was publicly available. For these companies, Medicare’s FFS payments averaged 21 percent higher than MA rates (Table 8-9). We do not know whether the lower average daily payment by MA plans reflects differences in service intensity (for example, fewer intensive therapy days), lower payments for the same service, or some combination. We also do not know how these rates compare with rates paid to other SNF chains and independent facilities. It is possible that companies with SNF holdings differ in their ability to negotiate high payment rates from MA plans. However, similar differences in payments were reported by the National

Investment Center for Seniors Housing & Care, a nonprofit organization that supports access and choice for seniors’ housing and care, including nursing homes and assisted living. It found that for the 1,389 SNF properties included in its sample, FFS payments per day were 22 percent higher than MA rates (National Investment Center for Seniors Housing & Care 2019).

We compared the patient characteristics of beneficiaries enrolled in FFS and MA plans in 2018 and found the differences are unlikely to explain the magnitude of the differences between FFS payments and payments typically made by MA plans.<sup>14</sup> Compared with FFS beneficiaries, MA enrollees were slightly older (by a year) and had slightly higher Barthel scores (about two points, indicating slightly more independence), and lower risk scores (4 percent lower, indicating fewer comorbidities). The considerably lower MA payments indicate that some facilities accept much lower payments to treat MA enrollees who may not be much different in terms of case mix from FFS beneficiaries. Some publicly traded post-acute care firms with SNF holdings report seeking managed care patients as a business strategy, indicating that the MA rates are attractive.

**Payments and costs for 2020**

To project the aggregate fiscal year 2020 Medicare margin for freestanding SNFs, the Commission considers the relationship between SNF costs and Medicare payments in 2018 as a starting point. To estimate costs for 2019 and 2020, we assumed a cost growth for freestanding

SNFs equal to the average for the past five years (which was slightly below the average market basket) and no behavioral changes. While the cost growth between 2017 and 2018 was slightly higher than the market basket, we have no reason to assume this pace of growth will continue. Over the past five years, SNFs held their cost growth below market basket for three years and exceeded it in two. Taking a five-year average is a reasonable approach to projecting costs in fiscal years 2019 and 2020. For 2020, we lowered costs by CMS's estimate of the net savings to providers associated with the implementation of the new payment system. Providers are required to conduct fewer patient assessments (that lowers providers' costs) but collect more assessment items to comply with the quality reporting requirements (that slightly increases providers' costs).

To estimate 2019 payments, we assumed payments in 2018 would increase in 2019 by 2.4 percent, as required by the Balanced Budget Act of 2018. We also reduced 2019 payments by the portion of the VBP withhold that was retained as program savings. For 2020, we assumed payments would also increase by 2.4 percent, the market minus productivity, as required by law.

We expect margins to decrease slightly in 2019 due to the program savings from the SNF VBP that will lower providers' revenues in 2019, but to increase slightly in 2020 because the update (2.4 percent) will be higher than estimated cost growth. The projected Medicare margin for 2020 is 10 percent.

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## How should Medicare payments change in 2021?

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In considering how payments should change for 2021, we note that costs are estimated to increase 3.0 percent that year. The update to payments in 2021 is estimated to be lower because the productivity adjustment will lower the market basket update by an estimated 0.4 percent, for a net update of 2.6 percent. The change in Medicare margins will depend, in part, on whether cost growth exceeds the growth in payments on a case-mix-adjusted basis.

In fiscal year 2020, CMS implemented substantial changes to the SNF PPS. While CMS estimated the redesign to be budget neutral, provider responses to the new PPS may alter total program spending and facilities' cost structures,

the mix of cases, and the relative costs of different types of stays. Thus, behavioral responses will dictate whether CMS will need to take future action to rebase and recalibrate payments to keep them aligned with the cost of care.

Regarding the level of payments, indicators of the adequacy of Medicare's payments are positive. The aggregate Medicare margin for SNFs has been above 10 percent since 2000 and is expected to remain above 10 percent in 2020. In 2018, the marginal profit was 18.7 percent, indicating facilities with an available bed have an incentive to admit Medicare patients. Relatively efficient SNFs had a median Medicare margin of 16.9 percent, further evidence that the level of payments is too high relative to the cost of care. Furthermore, FFS payments were considerably higher than the MA payments made to some SNFs, suggesting that some facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries. These findings show that the PPS continues to exert too little pressure on providers to keep their costs low.

### RECOMMENDATION 8

**For fiscal year 2021, the Congress should eliminate the update to the fiscal year 2020 Medicare base payment rates for skilled nursing facilities.**

### RATIONALE 8

The aggregate Medicare margin in 2018 was 10.3 percent and is expected to remain above 10 percent in 2020, indicating that the current level of Medicare's payment rates is more than adequate to accommodate cost growth and provide care to Medicare beneficiaries without an update to the base rate. Current law will increase base payments by a projected 2.6 percent (the market basket net of productivity) in fiscal year 2021.

While the level of Medicare's payments indicates that a reduction to payments (i.e., not simply maintaining payment rates at current levels) is needed to align aggregate payments to aggregate costs, we expect the SNF industry to undergo considerable changes as it adjusts to the redesigned PPS. Given the potential changes, the Commission will proceed cautiously in considering recommendations to lower payments to more closely align them to costs. A zero update would begin to align payments with costs while exerting pressure on providers to keep their cost growth low. The Commission



**TABLE  
8-10**

**The number of nursing homes treating Medicaid enrollees declined slightly from 2018 to 2019**

	2014	2016	2018	2019	Average annual percent change	
					2016-2018	2018-2019
Number of facilities	15,084	15,057	15,007	14,889	-0.33%	-0.79%

Note: The 2019 number is through mid-October of that year; it does not include data from the full calendar year. Counts include dually certified skilled nursing facilities/nursing facilities, distinct-part skilled nursing facilities/nursing facilities, and nursing facilities.

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2014-2019.

will monitor beneficiary access, quality of care, and providers' financial performance and will consider future recommendations based on the sector's responses to the new payment system.

**IMPLICATIONS 8**

**Spending**

- Relative to current law, this recommendation would lower program spending by between \$750 million and \$2 billion for fiscal year 2021 and by between \$5 billion and \$10 billion over five years. Program savings would occur because current law requires market basket increases for 2021 that would raise program spending relative to spending that would occur if payment rates remained at the 2020 levels.

**Beneficiary and provider**

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

**Medicaid trends**

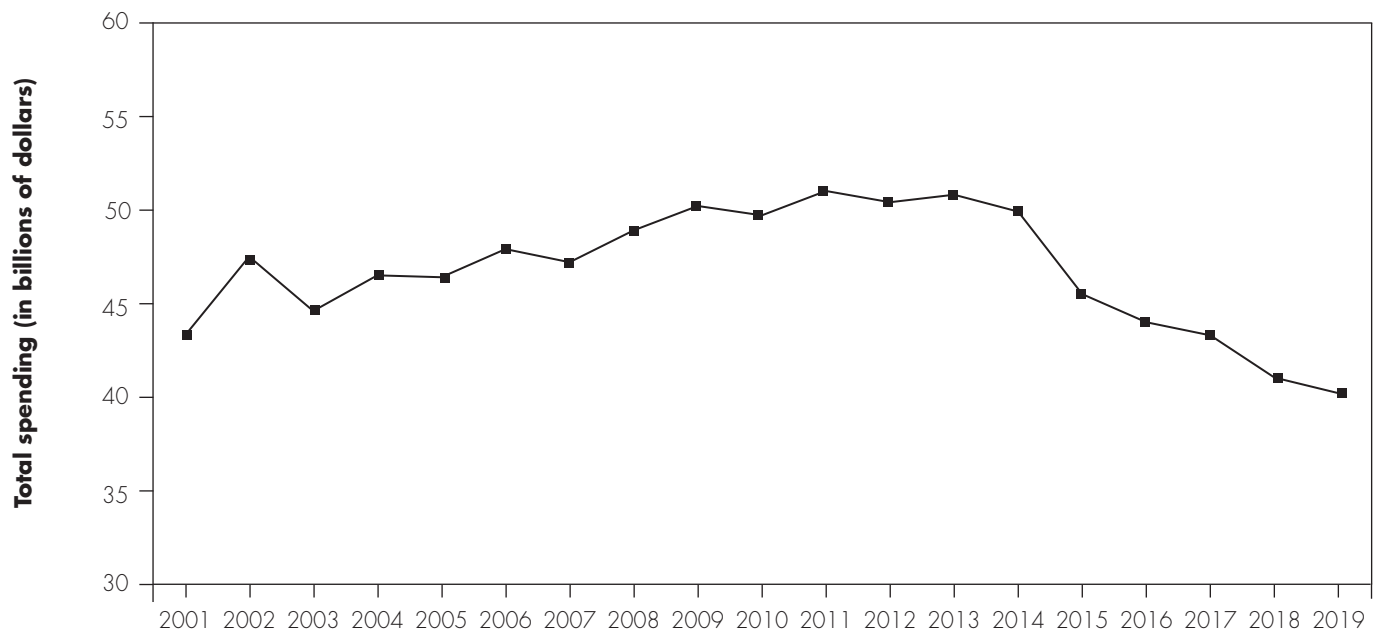
Section 2801 of the Affordable Care Act of 2010 requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers with a significant portion of revenues or services associated with Medicaid. We report on nursing home

spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2018).

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

**Count of Medicaid-certified nursing homes**

Between 2018 and 2019, the number of nursing facilities certified as Medicaid providers declined almost 1 percent to 14,889, similar to the decline of Medicare providers (Table 8-10). The number of nursing homes certified as Medicaid providers that terminated their participation in the Medicaid program varied by state. (We do not know whether the providers that terminated participation in the Medicaid program remained open but no longer accepted Medicaid patients, closed, or were purchased by another entity and remained open.) Of the 14,845 Medicaid nursing homes active in January 2019, about 1 percent of providers had terminated as of mid-October 2019,

**FIGURE  
8-3****Total Medicaid fee-for-service spending on nursing home services, 2001-2019**

Note: Spending does not include any managed care organization spending on nursing homes. Data for 2019 are projected.

Source: Office of the Actuary 2019a.

while many providers opened during the same period (data not shown). Several states had above-average shares of their facilities terminate. During this period, about 5 percent of providers in Massachusetts terminated; about 4 percent terminated in South Dakota and Wisconsin; about 2 percent terminated in Texas; and about 1.5 percent terminated in Nebraska. According to trade press, facilities in these states closed primarily due to the reportedly low Medicaid rates. The lower payment rates paid by MA plans and their lower use of these facilities and the overexpansion of the supply of post-acute care providers (in Texas, which has no certificate-of-need laws) also contributed to their fiscal pressures.

The decline may also reflect the expansion in some states of home- and community-based services (HCBS), which allow beneficiaries to remain in their homes rather than an institution. State HCBS waivers and federal initiatives have accelerated the trend toward HCBS. In fiscal year

2019, 48 states expanded the number of beneficiaries served by HCBS, an increase from 46 states in fiscal year 2018 (Gifford et al. 2018).

### Spending

FFS spending on Medicaid-funded nursing home services (combined state and federal funds) totaled \$41.0 billion in 2018 (Figure 8-3) (Office of the Actuary 2019a). CMS estimates that FFS Medicaid spending on nursing home services decreased by 2.1 percent between 2018 and 2019 but that spending will increase by 0.98 percent in 2020. This trend of lower spending is in part due to an increased use of managed care organizations, whose spending is not included in these data. As of June 2019, 24 states operated Medicaid managed care for long-term services and supports (Medicaid and CHIP Payment and Access Commission 2019). This figure represents a 50 percent increase from 2012, when only 16 states had such

**TABLE  
8-11**

**Total margins continued to decline and were slightly negative in 2018**

Type of margin	2013	2014	2015	2016	2017	2018
Total margin	1.9%	1.9%	1.6%	0.7%	0.6%	-0.3%
Non-Medicare margin	-1.8	-1.5	-2.1	-2.4	-2.4	-3.0

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

Source: MedPAC analysis of Medicare freestanding SNF cost reports for 2013 to 2018.

programs (Lewis et al. 2018). Year-to-year changes in spending have been variable, increasing in some years and decreasing in others, with overall spending in 2019 below what it was in 2001. The large decreases in FFS Medicaid spending beginning in 2015 reflect increased enrollment in Medicaid managed care.

Analysis of Medicaid rate-setting trends found that 10 states restricted (froze or reduced) rates paid to nursing homes in 2019, while 40 states and the District of Columbia increased rates (Gifford et al. 2019). More states increased rates to nursing homes than in 2018 (only 34 states raised rates in 2018, while 17 states restricted rates) (Gifford et al. 2018). Furthermore, the National Investment Center for Seniors Housing & Care reported that Medicaid revenue per day has been increasing steadily since 2011 (National Investment Center for Seniors Housing & Care 2019). Rates will likely stay the same in 2020; 40 states and the District of Columbia have indicated that they will increase nursing home rates. Eight states plan to restrict rates in 2020 (Gifford et al. 2019).

States continue to use provider taxes to raise federal matching funds. In fiscal year 2019, 44 states and the District of Columbia levied provider taxes on nursing homes to increase federal matching funds (Gifford et al. 2019).<sup>15</sup> The augmented federal funding may be split with the nursing homes.

The majority of states (33 plus the District of Columbia) have expanded their Medicaid programs since the passage of the Affordable Care Act of 2010. Three more states (Idaho, Nebraska, and Utah) passed initiatives to expand their Medicaid programs in November 2018; however, these have not been approved by CMS thus far.

**Total and non-Medicare margins in nursing homes**

Total margins reflect all payers (including all fee-for-service and managed care funds from Medicare, Medicaid, and private insurers across all lines of business (for example, nursing home care, hospice care, ancillary services, home health care, and investment income). In 2018, the aggregate total margin was -0.3 percent, the first year since 2000 that the total margin was negative (Table 8-11; only most recent years shown). In the past 19 years, the total margin has ranged from 0.6 percent to 3.8 percent (not all data shown).

Total margins in 2018 varied considerably: The median was 0.3 percent, while the total margins at the 25th and 75th percentiles were -5.9 percent and 5.0 percent, respectively (data not shown). Total margins have declined since 2013, reflecting several factors: the impact of reductions to Medicare payments mandated by congressional action, the growing share of facilities' payments by MA plans (whose payments are lower than Medicare's FFS payments), the lower volume of high-payment Medicare FFS patients, and lower average occupancy rates (thus raising the average cost per day). Beneficiaries receiving skilled nursing services were increasingly enrolled in alternative payment models (including bundled payments and ACOs) and MA plans, which have shorter stays or avoid this setting entirely.

Non-Medicare margins reflect the profitability of all services except FFS Medicare-covered SNF services. The aggregate non-Medicare margin in 2018 was -3.0 percent, lower than in 2017 (Table 8-11). Non-Medicare margins also varied considerably: 25 percent of facilities had non-Medicare margins of -10.8 percent or lower

and 25 percent of facilities had non-Medicare margins of 3.4 percent or higher. This variation reflects, in large part, differences in states' Medicaid payment rates. The National Investment Center for Seniors Housing & Care

reported that Medicaid revenue per patient day increased 2.7 percent in 2019 but that rates may not cover the cost of care in some states (National Investment Center for Seniors Housing & Care 2019). ■

## Endnotes

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- 1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay coverage is paid for by Medicare (Part A). Some beneficiaries who no longer qualify for SNF Medicare coverage remain in the facility to receive long-term care services, which are not covered by Medicare. During long-term care stays, beneficiaries may receive care such as physician services, outpatient therapy services, and prescription drugs that 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 prospective payment system and are not considered in this chapter. Except where specifically noted, this chapter examines FFS Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans. Some beneficiaries also qualify for Medicaid and are referred to as “dual-eligible beneficiaries.”
- 2 A spell of illness ends when there has been a period of 60 consecutive days during which the beneficiary was an inpatient of neither a hospital nor a SNF. Coverage for another 100 days does not begin until a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day hospital stay requirement.
- 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, and radioisotope services.
- 5 The Justice Department’s cases alleged that the defendants engaged in one or more of the following strategies: falsely reporting the minutes of therapy delivered, furnishing services that were medically unnecessary given the patient’s clinical care needs, discouraging therapists from providing services beyond the minimum threshold minutes for a given case-mix group, pressuring therapists and patients to complete planned minutes of care even when patients were sick or declined to participate in therapy, or presumptively assigning patients to the highest rehabilitation case-mix group regardless of each patient’s individual care needs.
- 6 The *SNF Payment Basics* is available at <http://medpac.gov/documents/-payment-basics>.
- 7 The most rural facilities and the most urban facilities were defined using the Urban Influence Codes developed by the Department of Agriculture. The most rural facilities are those located in counties that are noncore, nonadjacent to a metropolitan or micropolitan area and do not contain a town of at least 2,500 residents (Urban Influence Code 12). The most urban facilities are those located in counties with a large metropolitan areas of at least one million residents (Urban Influence Code 1).
- 8 The shares of SNF users requiring the most assistance decreased for transferring, eating, performing personal hygiene, toileting, dressing, and bed mobility; the shares of patients requiring the most assistance increased for patients with bowel incontinence and urinary incontinence and requiring help walking in the corridor and bathing.
- 9 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:  
$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 10 The Commission’s measure of discharge to community captures a key goal of many beneficiaries: to go home. It measures the share of beneficiaries discharged home from a SNF. In contrast, CMS’s quality reporting measure gauges the share of beneficiaries who were discharged home, did not have an unplanned readmission within 31 days of discharge, and remained alive. We include beneficiaries who reside in a nursing home because the nursing home is effectively their “community.”
- 11 The readmission measures count patients whose primary diagnosis for readmission was considered potentially avoidable; that is, the development of the conditions leading to the hospital admission typically could have been managed with appropriate care to avoid the hospitalization. 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. We do not use CMS's measure (readmissions that occur within 30 days of discharge from the hospital) because it can include readmissions that occur while the patient is in the SNF and those that occur after discharge. By conflating the two dimensions of care, the measure is less actionable.

- 12 CMS's VBP readmission measure differs from the Commission's measures that separately track readmissions during the SNF stay and readmissions that occur within 30 days after discharge. By including readmissions that occur within 30 days of discharge from the hospital, CMS's measure can include readmissions that occur during the SNF stay and after discharge, depending on the length of the SNF stay. For short SNF stays, CMS's measure includes readmissions after discharge from the SNF but still within 30 days of discharge from the hospital stay. For long SNF stays, the measure includes only readmissions that occur within the first 30 days of the SNF stay (assuming an immediate transfer from the hospital) and misses readmissions that occur later in the SNF stay.
- 13 The Special Focus Facility Initiative is a program to stimulate improvements in the quality of care at nursing homes with a history of serious quality problems. The initiative targets homes with a pattern over three years of more frequent and more serious problems (including harm or injury to residents) detected in their annual facility surveys. Facilities that improve and maintain those improvements can "graduate" from the program. Providers that do not improve face civil monetary penalties (fines) and eventual termination from Medicare and Medicaid.
- 14 We compared the assessments conducted at the beginning of stays (the "day 5" assessment). MA plans are not required to submit these assessments, and we cannot determine what share of plans submits them or the possible bias in the assessments that are submitted.
- 15 A provider tax works as follows: A state taxes all nursing homes and uses the collected amount to help finance the state's share of Medicaid funds. The provider tax increases the state's contribution, which, in turn, raises the federal matching funds. The augmented federal funds more than cover the cost of the provider tax revenue, which is returned to providers. The provider tax is limited to 6 percent of net patient revenues.



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