CHAPTER 8

Skilled nursing facility services

RECOMMENDATION

8 The Congress should:

- eliminate the market basket update for skilled nursing facilities for fiscal years 2019 and 2020;
- direct the Secretary to implement a redesigned prospective payment system (PPS) in fiscal year 2019 for skilled nursing facilities; and
- direct the Secretary to report to the Congress on the impacts of the revised PPS and make any additional adjustments to payments needed to more closely align payments with costs in fiscal year 2021.

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

CHAPTER 8

Skilled nursing facility services

Chapter summary

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2016, about 15,000 SNFs furnished 2.3 million Medicare-covered stays to 1.6 million fee-for-service (FFS) beneficiaries. Medicare FFS spending on SNF services was $29.1 billion in 2016, about 1 percent less than in 2015. Just over 4 percent of beneficiaries used SNF services.

Assessment of payment adequacy

To examine the adequacy of Medicare's payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, provider access to capital, and Medicare payments in relation to providers' costs to treat Medicare FFS beneficiaries. Key measures indicate Medicare payments to SNFs are adequate.

***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 (89 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

Between 2015 and 2016, the median occupancy declined slightly but remained high (85 percent).

- ***Volume of services*—**Medicare-covered admissions per FFS beneficiary decreased between 2015 and 2016, consistent with decreases in inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services under FFS). Lengths of stay also declined. Both contributed to fewer covered days in 2016 compared with 2015.

***Quality of care*—**Between 2015 and 2016, SNF quality measures had mixed performance. The community discharge rate increased (improved), while the rates of hospital readmissions (during a SNF stay and within 30 days after discharge) increased slightly (got worse). However, since 2011, both readmission rates have improved. Measures of changes in patients' functional status have remained essentially constant.

***Providers' access to capital*—**Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Access to capital was adequate in 2017 and is expected to remain so in 2018. 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*—**In 2016, the average Medicare margin for freestanding SNFs was 11.4 percent—the 17th 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 favor treating rehabilitation patients over medically complex patients. The marginal profit, a measure of the relative attractiveness of treating Medicare beneficiaries, was at least 19.6 percent for freestanding facilities.

Last year, the Commission recommended that payment rates remain the same for two years while the Secretary undertakes revising the payment system. For the year following, it recommended that the Secretary evaluate the need to make additional adjustments to payments to align them with providers' costs. The circumstances of the SNF PPS remain unchanged: The system still needs to be revised to base payments on patient characteristics, while the level of Medicare's payments remains high relative to the cost of treating FFS beneficiaries. In 2017, CMS proposed changes to the SNF PPS that it plans to implement in fiscal year 2019. These changes are consistent with the Commission's recommended SNF redesign: It bases payments on patient characteristics and better targets payments for nontherapy ancillary services (such as drugs). Several factors indicate that the aggregate level of Medicare's payments remains too high. First, Medicare margins have historically

been above 10 percent; the marginal profit in 2016 was high, suggesting that facilities with available beds have an incentive to admit Medicare patients. Medicare Advantage (managed care) payment rates to SNFs are considerably lower than the program's FFS payments, even though the differences between beneficiaries enrolled in Medicare Advantage and FFS who used SNF services were small. Costs varied widely for reasons unrelated to case mix and wages. Many SNFs (970, or 8 percent of the facilities included in the analysis) were able to keep their costs relatively low while maintaining relatively high quality.

On the basis of these factors, the Commission recommends that the Congress (1) eliminate the update for SNFs in 2019 and 2020, (2) direct the Secretary to implement a revised PPS in 2019, and (3) direct the Secretary, in 2021, to evaluate the need to make further adjustments to payments to bring them in alignment with costs. The recommendation regarding the level of payments to SNFs is made in the context of the Commission's recommendation (discussed in the post-acute care (PAC) chapter (Chapter 7)) to establish SNF payments using a blend of the unified PAC PPS and current SNF PPS relative weights beginning in fiscal year 2019. A blend of the relative weights would redistribute payments within the SNF setting by increasing payments for medically complex patients and lowering payments for patients who receive rehabilitation therapy unrelated to their care needs. The recommendation would narrow the differences in financial performance across providers based on their mix of patients and would enable the Commission to recommend, and policymakers to implement, an aggregate level of payments that would better align payments with the cost of care.

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid use, spending, and non-Medicare (private-payer and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes, but also covers copayments for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities has declined slightly since 2015, less than 0.5 percent, but remains close to 15,000. CMS reports total FFS spending on nursing home services declined 3.2 percent between 2015 and 2016 and estimates a smaller decline (–1.6 percent) between 2016 and 2017. In 2016, the average total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as hospice, ancillary services, home health care, and investment income)—was 0.7 percent, down from 2015 (1.6 percent). The average non-Medicare margin (which includes all payers and all lines of business except Medicare FFS SNF services) was –2.3 percent, also lower than in 2015 (–2.1 percent). ■

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services, such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include those recovering from surgical procedures such as hip and knee replacements or from medical conditions such as stroke and pneumonia. In 2016, almost 1.6 million fee-for-service (FFS) beneficiaries (4.3 percent of Part A FFS users) used SNF services at least once; program spending on SNF services was $29.1 billion (about 8 percent of FFS spending) (Boards of Trustees 2017, Office of the Actuary 2017b). Medicare's median payment per day was $470 and its median payment per stay was $18,321.[1] In 2015, about one-fifth of hospitalized beneficiaries were discharged to SNFs.

Medicare covers up to 100 days of SNF care after a medically necessary inpatient hospital stay of at least 3 days.[2] For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of care. Beginning with day 21, beneficiaries are responsible for copayments. For 2018, the copayment is $167.50 per day.

The term *skilled nursing facility* refers to a provider that meets Medicare requirements for Part A coverage.[3] Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes (which typically provide less intensive, long-term care services). Thus, a facility that provides skilled care often also provides long-term care services that Medicare does not cover. Medicaid pays for the majority of nursing facility days. In 2016, CMS finalized rules overhauling the requirements nursing homes must meet to participate in the Medicare and Medicaid programs (Centers for Medicare & Medicaid Services 2016). The rules included changes to infection control, patient's rights, staff training and competencies, care planning, arbitration agreements, and order writing by dieticians and therapists. The required changes will be phased in over three years, with the first phase implemented on November 28, 2016. The second phase was implemented in late November 2017.[4]

Like all post-acute care (PAC) providers (e.g., home health agencies, rehabilitation facilities), the SNF industry is under increasing pressure to improve care coordination and patient outcomes. Medicare's hospital readmission policy and value-based purchasing program, bundled payments, and accountable care organizations (ACOs) encourage SNFs to avoid readmissions so they are attractive partners with referring hospitals. Managed care organizations and private insurers are also looking for high-quality, low-cost SNFs to include in their referral networks. In addition, in fiscal year 2019, SNFs will face their own financial incentive to lower readmissions when the SNF value-based purchasing policy begins to affect program payments to SNFs.

The mix of facilities where beneficiaries receive skilled nursing care has shifted over time toward freestanding and for-profit facilities. In 2016, almost all facilities (96 percent) were freestanding and accounted for almost all revenue (97 percent, Table 8-1, p. 210). Hospital-based SNFs made up a small share of facilities, stays, and spending (5 percent or less). For-profit facilities accounted for 70 percent of SNFs and 74 percent of revenues.

Medicare-covered FFS 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 2016, Medicare FFS beneficiary stays constituted 11 percent of total facility days but accounted for 20 percent of facility revenue, a decline from 2010 when FFS Medicare accounted for 23 percent of facility revenue (data not shown).

The 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), kidney and urinary tract infections, renal failure, 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).

SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.[5] Information gathered from a standardized patient assessment instrument—the Minimum Data Set—is used to classify patients into case-mix categories, called resource utilization groups (RUGs). RUGs differ depending on the services SNFs provide to a patient (such as the amount and type of rehabilitation therapy and the use of respiratory therapy and specialized feeding); the patient's clinical condition (such as whether

TABLE 8–1

Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, Medicare stays, and Medicare spending, 2016

Type of SNF	Facilities	Medicare-covered stays	Medicare spending
Total number	15,080	2,310,753	$26.4 billion
Freestanding	96%	95%	97%
Hospital based	4	5	3
Urban	72	83	85
Rural	28	17	15
For profit	70	71	74
Nonprofit	23	24	21
Government	6	4	4

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding and missing values. The spending amount included here is slightly 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 2016.

the patient has pneumonia); and the patient's need for assistance in performing activities of daily living (ADLs). Medicare's payment system for SNF services is described in the Commission's *Payment Basics*, available on the Commission's website.[6] Although the payment system is referred to as "prospective," two features undermine how prospective it is: The system makes payments for each day of care (rather than a set payment for the entire stay), and it bases payments partly on the minutes of rehabilitation therapy furnished to a patient. Both features result in providers having some control over how much Medicare will pay them for their services.

Almost since its inception, the SNF PPS has been criticized for encouraging the provision of excessive rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) services such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002). Over time, the accuracy of Medicare's payments has steadily eroded: Payments for NTA services are unrelated to the cost of SNF care, and therapy payments have become less and less proportional to the costs of therapy services.[7] As a result, the PPS continues to advantage providers that furnish therapy services unrelated to a patient's condition and avoid patients with high NTA costs (Medicare Payment Advisory Commission and The Urban Institute 2015). The Office of Inspector General (OIG) of the Department of Health and Human Services also found that the difference between payments for and costs of therapy services increased as the amount of therapy provided per day increased (Office of Inspector General 2015).

In 2008, the Commission recommended revising the PPS to base therapy payments on patient characteristics (not service provision), remove payments for NTA services from the nursing component, establish a separate component within the PPS that adjusts payments for NTA services, and implement an outlier payment policy (Medicare Payment Advisory Commission 2008). Each year since then, the Commission has urged CMS to move forward with the much-needed reform. Beginning in 2012, the Commission has recommended revising and rebasing the SNF PPS to address both the distribution and level of payments (Medicare Payment Advisory Commission 2012). The Commission's recommended revisions to the PPS would more closely align payments with patient characteristics and result in considerable redistribution of payments (Medicare Payment Advisory Commission and The Urban Institute 2015).

Under the recommended design, payments would increase substantially for facilities with relatively low shares of intensive therapy, facilities with relatively high NTA costs per day, and facilities with high shares of clinically complex

and special care days (we refer to these days collectively as "medically complex").[8] Payments would decrease for facilities with high shares of intensive therapy and facilities with low NTA costs per day.[9] Based on the mix of patients and therapy practices, payments would increase for hospital-based facilities and nonprofit facilities and would decrease for freestanding facilities and for-profit facilities. The effects on individual facilities would depend on their mix of patients and current therapy practices.

Based on its work examining SNFs' billing practices and its analysis of therapy costs and payments, OIG has recommended that CMS evaluate the extent to which therapy payments should be reduced; change the method for paying for therapy; adjust Medicare payments based on patient characteristics (not the amount of therapy furnished); and strengthen the oversight of SNF billing (Office of Inspector General 2015). CMS has concurred with these recommendations and proposed an alternative to the current PPS design (Centers for Medicare & Medicaid Services 2017b). OIG has work under way to examine the documentation at selected SNFs to see whether, for each day, patients are assigned to the appropriate case-mix group (Office of Inspector General 2016).

CMS's revisions of the SNF PPS

CMS's work on alternative designs for the SNF PPS began 13 years ago in response to a legislative requirement (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) to conduct research on potential refinements of the SNF PPS (Liu et al. 2007, Maxwell et al. 2003, Urban Institute 2004). In the spring of 2017, CMS issued an advance notice of proposed rulemaking (ANPRM) and sought comments on a redesign of the SNF PPS (Centers for Medicare & Medicaid Services 2017b). Based on work conducted since 2014, CMS has proposed basing payments for therapy services on patient characteristics (function and cognitive impairment) and establishing separate components for NTA services (such as drugs) and for speech–language pathology services. Payments for routine services (mostly nursing care) would be based on a patient's ability to perform ADLs, the use of extensive services (such as ventilator or tracheostomy care), and the presence of specific clinical conditions. CMS also proposed adjusting payments for physical and occupational therapy and NTA services by day of the stay (such that payments decline throughout the stay). To gather stakeholder input, CMS held four expert panels and extended the comment period on the ANPRM.[10] The ANPRM states that CMS plans to implement the changes in fiscal year 2019.

The design is consistent with the design recommended by the Commission in 2008, and the estimated impacts would be similar. The design would redistribute payments from rehabilitation patients (especially those assigned to the highest rehabilitation case-mix groups) to medical patients, patients with high NTA costs, and patients requiring extensive services or wound care. Reflecting the mix of patients, payments would shift from freestanding to hospital-based providers and from for-profit to nonprofit providers (Centers for Medicare & Medicaid Services 2017b).

Are Medicare payments adequate in 2018?

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 and low Medicare margins and 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, in part because the need for SNF care, as opposed to 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.

Capacity and supply of providers: Supply remains stable

The number of SNFs participating in the Medicare program in 2017 was stable at 15,348. There was a handful of new facilities (83, the majority of which were for profit) and a smaller number of terminations (51, most of which were at their own initiative) (Centers for Medicare & Medicaid Services 2017a). 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. Single operators make up about 40 percent of the industry, small (often regional or religious)

TABLE 8–2

SNF admissions and days declined in 2016

Volume measure	2012	2014	2015	2016	Percent change 2015–2016
Covered admissions per 1,000 FFS beneficiaries	69.0	68.6	68.9	66.4	–3.6%
Covered days per 1,000 FFS beneficiaries	1,893	1,849	1,824	1,706	–6.5
Covered days per admission	27.4	27.0	26.5	25.7	–3.0

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 2017d.

operators make up about one-quarter of facilities, with the remaining third run by large chains (Ritchie and Johnson 2017). The share of hospitals with financial links to SNFs has slowly increased as alternative payment models encourage hospitals to lower spending and improve clinical outcomes for services furnished in post-acute care. In 2015, 18 percent of hospitals had a financial link to a SNF, up from 11 percent in 2005 (Fowler et al. 2017). One study found that the integration of hospitals and SNFs increases Medicare payments (by extending the lengths of the SNF stays and, at the same time, lowering the hospital length of stay) but also lowers rehospitalization rates (Konetzka et al. 2016).

In 2016, 89 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). Less than 1 percent of beneficiaries lived in a county without a SNF or swing bed facility, and another 11 percent lived in counties with one or two SNFs or swing bed facilities.

Between 2015 and 2016, median occupancy rates for freestanding SNFs declined slightly (from 86 percent to 85 percent) but remained high. The lower occupancy rates reflect the shorter stays and lower admissions. Occupancy rates at hospital-based facilities were slightly lower but remained steady at 81 percent. There is wide variation in occupancy rates: One-quarter of freestanding facilities had occupancy rates at or below 74 percent while another quarter had rates 92 percent or higher. This variation indicates that some markets have the capacity to accommodate more admissions while other markets do not. The median occupancy rate for freestanding SNFs in rural areas was lower than average (81 percent), and facilities located in areas with small populations (fewer than 2,500 people) had lower median occupancy rates (78 percent).

Between 2015 and 2016, SNF admissions decreased and stays shortened

In 2016, 4.2 percent of FFS beneficiaries used SNF services, a slight decline from 2015 (4.4 percent of beneficiaries). Between 2015 and 2016, SNF admissions per FFS beneficiary decreased 3.6 percent (Table 8-2) (Centers for Medicare & Medicaid Services 2017d). 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 Medicare Advantage (MA) plans. Covered days per 1,000 FFS beneficiaries declined even more (–6.5 percent). The combination of decreased SNF admissions and even larger declines in days resulted in shorter stays on average (25.7 days in 2016). The decline in SNF admissions per capita is consistent with the 2.8 percent decrease in hospital admissions (see Chapter 3) per capita (a hospital admission within the past 30 days is required for Medicare coverage of a SNF stay under FFS).

The change in SNF use reflects several trends, including a growing presence of alternative payment models such as ACOs and bundled payments. To lower spending and financial risk, these models may have lowered the number of beneficiaries referred to SNF care and the amount of care beneficiaries receive, which could reflect more appropriate use for beneficiaries with lower care needs. There is some evidence that providers participating in alternative payment models refer fewer patients to PAC (including SNF) and that their SNF use includes shorter and less therapy-intensive stays (Colla et al. 2016, Dummit et al. 2016, McWilliams et al. 2017). Likewise, as SNFs expand their

MA business, there are similar pressures to lower SNF use (both users and days). One study of differences in PAC use between MA and FFS enrollees reported that MA enrollees had shorter stays for beneficiaries recovering from joint replacement, stroke, or heart failure—between 1.7 and 3.5 days, depending on the condition, after adjusting for severity (Huckfeldt et al. 2017).[11]

Service mix reflects biases in PPS design

Between 2002 and 2016, the share of days classified into rehabilitation case-mix groups in freestanding facilities increased from 78 percent to 94 percent; medically complex days make up the other 6 percent of days.[12] 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 83 percent. The share of days assigned to the highest rehabilitation case-mix groups (the ultra-high group) increased from 7 percent to 58 percent.

Facilities differed in the amount of intensive therapy they provided, though the differences by provider type and ownership have narrowed over time. In 2016, there was an 18 percentage point difference between freestanding and hospital-based facilities in intensive therapy days (83 percent in freestanding facilities, 65 percent in hospital-based facilities) compared with a 34 percentage point difference between the two in 2010 (71 percent in freestanding, 37 percent in hospital-based SNFs). Differences by ownership exhibit similar but less remarkable trends. In 2016, a 3 percentage point difference in intensive therapy days existed between for-profit and nonprofit facilities (84 percent in for-profits, 81 percent in nonprofits), compared with an 11 percentage point difference between the two in 2010 (72 percent in for profit SNFs, 61 percent in nonprofits). We analyzed what effect, if any, inpatient rehabilitation facilities (IRFs) in the same county had on the share of intensive therapy days, but our findings were inclusive. Counties with more IRF beds per 1,000 FFS enrollees had smaller shares of intensive therapy days (suggesting a relationship), but counties without an IRF had the smallest share. Citing work showing that intensive therapy is associated with more functional improvement for certain beneficiaries, CMS concluded that the variation in the amount of therapy provided warranted the monitoring of patient outcomes (Centers for Medicare & Medicaid Services 2017c).

Changes in the frailty of beneficiaries at admission to a SNF do not explain the increases in therapy. The average SNF user in 2016 had slightly less ability to perform ADLs (a 4 percent lower modified Barthel score), had a slightly higher (2 percent) risk score (indicating more comorbidities), and was the same age (78 years old) as the average SNF user in 2012.[13] Over the same period, for the 10 individual ADLs we examined, the shares of SNF users requiring the most help decreased for 7 activities, remained the same for 2 activities, and increased for 1 activity.[14] Similarly, OIG found that SNFs had increased their billing for the highest levels of therapy even though beneficiary characteristics—including age and reasons for and severity levels of the preceding hospital stay—remained unchanged (Office of Inspector General 2015). A study examining whether additional therapy improved patient outcomes (in this case, the likelihood of being discharged home) focused on beneficiaries, between 2000 and 2009, who were recovering from hip fracture (Jung et al. 2016). It found that patients with more therapy were more likely to be discharged home, but the benefit of additional therapy decreased as the amount of therapy increased, and there was no additional benefit for patients in the highest case-mix groups. Since the study period, among the rehabilitation case-mix groups, the highest therapy group (the ultra-high group) has grown the most (while the share of days assigned to other therapy groups has declined), raising the question of the value of these additional therapy services.

In 2017, the Department of Justice continued its enforcement of the False Claims Act, investigating fraud and abuse in SNFs' therapy billings (Department of Justice 2017). Since 2013, there have been 12 settlements of cases involving the provision of medically unnecessary therapy services and other issues related to billing and documentation requirements to maximize reimbursement (Department of Justice 2017, Department of Justice 2016a, Department of Justice 2016b, Department of Justice 2016c, Rolf Gottman Lang 2017).

The share of medically complex days (those assigned to the clinically complex or special care case-mix groups) continues to be low (6 percent). Because rehabilitation days remain highly profitable, the PPS encourages providers to furnish enough therapy to convert medically complex days to rehabilitation days. That said, our analysis found that most SNFs (96 percent) admit patients assigned to medically complex case-mix groups, and the presence of a long-term care hospital (LTCH) in the county had no clear effect on the share of medically complex days in SNFs. Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex

Measures of skilled nursing facility quality

To assess skilled nursing facility (SNF) quality, the Commission examines risk-adjusted rates of readmission to the hospital, discharge back to the community, and change in functional status during the SNF stay.[15]

The community discharge measure counts (in the numerator) beneficiaries discharged to a community setting (including assisted living). The numerator and denominator exclude beneficiaries discharged to an inpatient setting (e.g., an acute care hospital or nursing home) within 1 day of the SNF discharge, beneficiaries who die within 1 day of the SNF discharge, and beneficiaries who are readmitted to an acute care hospital within 30 days of admission to the SNF (Kramer et al. 2015). Nursing home residents who are beneficiaries admitted to a hospital and discharged to the community are included in the numerator, though this is an unlikely trajectory for them. Although the risk of hospital admission is high for nursing home residents, the risk adjustment accounts for differences in patient health status. Residents admitted to the hospital and discharged back to a nursing home are not counted as community discharges. The risk adjustment method (and the comorbidities included) is sufficiently robust that including an indicator for whether the beneficiary is discharged to a nursing home does not improve the accuracy of the models.[16]

The readmission measures count patients whose primary diagnosis for rehospitalization was considered potentially avoidable—that is, the condition typically can be managed in the SNF setting. The potentially avoidable conditions include congestive heart failure, electrolyte imbalance/dehydration, respiratory infection, septicemia, urinary tract or kidney infection, hypoglycemia and diabetic complications, anticoagulant complications, fractures and musculoskeletal injuries, acute delirium, adverse drug reactions, cellulitis/wound infection, pressure ulcers, and blood pressure management. The count of readmissions excludes those that were likely to have been planned (e.g., inpatient chemotherapy or radiation therapy) and readmissions that signal a premature discharge from the hospital. The denominator includes beneficiaries who were readmitted for other causes or not readmitted. We separately measure readmissions that occur during the Medicare-covered SNF stay and those that occur within 30 days of discharge from the SNF.

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

(continued next page)

admissions. While making up 4 percent of facilities, hospital-based SNFs made up 9 percent of the SNFs with the highest shares (the top quartile) of medically complex admissions. Had the provision of therapy been ignored in making case-mix group assignments, the share of medically complex cases would have declined slightly between 2013 and 2016.[17]

Though access does not appear to be an issue in general, industry representatives and patient advocates report that some providers are reluctant to admit patients with high NTA costs (such as the need for expensive antibiotics). The Commission's recommended design would increase payments for medically complex patients and improve the targeting of payments for patients who require high-cost NTA services. Likewise, the design proposed by CMS would increase payments for nonrehabilitation patients (by an estimated 45 percent) and for patients with high NTA costs (by an estimated 19 percent) (Centers for Medicare & Medicaid Services 2017b). In addition, providers may 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 if the stay results in bad debt.

Measures of skilled nursing facility quality (cont.)

controlling for beneficiaries' comorbidities, mental illness, and functional status (Kramer et al. 2014).

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

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

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

Quality of care: Some measures improved while others remained the same

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 (see text box on measures of SNF quality). We use these measures because they reflect the goals of most beneficiaries: to return home, avoid a rehospitalization, and improve or maintain function. The readmission rate during the SNF stay measures how well the SNF detects, monitors, and furnishes care to prevent rehospitalizations. 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). While quality has improved since 2011, the changes between 2015 and 2016 showed mixed progress. The average rate of discharge to the community improved, the average rates of readmission were slightly worse, and the two measures of functional change were essentially unchanged.

Rates of community discharge rate and readmissions show mixed progress

Over the past six years, SNF outcome-based measures (risk-adjusted rates of community discharge and readmissions to hospitals) have generally improved, but with mixed progress (Table 8-3, p. 216). The risk-adjusted rates of discharge to the community steadily improved. In 2016, the average rate was 39.5 percent, up from 33.2 percent in 2011. The risk-adjusted rates of potentially avoidable readmissions during the SNF stay have improved since 2011, declining from 12.4 percent to 10.8 percent in 2016, but the rate increased slightly from 2015. The increase may be a by-product of fewer readmissions being spread over an even smaller number of SNF stays (hence the slight uptick in the rate).

The risk-adjusted rates of potentially avoidable readmissions during the 30 days after discharge from the SNF exhibited the same trend—overall improvement since 2011 but a slight worsening between 2015 and 2016.[18] In 2016, 5.8 percent of discharges from the SNF

TABLE 8–3

Mean risk-adjusted rates of community discharge and potentially avoidable readmissions, 2011–2016

Measure	2011	2013	2015	2016
Discharged to the community	33.2%	37.5%	38.7%	39.5%
Potentially avoidable readmissions:				
During SNF stay	12.4	11.1	10.4	10.8
During 30 days after discharge from SNF	5.9	5.5	5.0	5.8

Note: SNF (skilled nursing facility). Higher rates of discharge to the community indicate better quality. Higher readmission rates indicate worse quality. Rates are the mean 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 2011 through fiscal year 2016 Minimum Data Set and hospital claims data.

were readmitted to a hospital within 30 days. The low correlation between the 30-day postdischarge and during-stay readmission rates (0.15, which was statistically significant given the sample sizes) confirms that the readmission measures capture different dimensions of quality.

The general trend of lower readmission rates during the SNF stay since 2011 in part reflects the increased attention from hospitals to avoid readmission penalties by partnering with SNFs that have low readmission rates. Some hospitals have established preferred provider networks with higher quality SNFs, hoping to lower their own readmission rates in exchange for increased referrals to SNFs. One study found that hospitals with a network of preferred SNFs had lower readmission rates from their partnering SNFs (McHugh et al. 2017). Another study found that, while all hospitals had lowered their readmission rates between 2007 and 2013, those affiliated with ACOs were quicker to lower them (Winblad et al. 2017). Because the ACO-affiliated hospitals were at greater financial risk, they may have had more effective discharge planning and information sharing with the SNFs they used. In addition to partnering with hospitals, many SNFs want to secure volume from MA plans and ACOs by demonstrating improvements in their readmission rates.

The American Health Care Association (AHCA) has a goal for its member SNFs to lower their 30-day all-cause, all-patient readmission rate. The association claims that, as of March 2017, 22 percent of members had achieved a 30 percent reduction in readmissions or achieved a rehospitalization rate below 10 percent (across all patients, not just Medicare) (American Health Care Association 2017). With these improvements, their members' average readmission rate in early 2017 was almost at the national average (17.0 percent compared with 16.8 percent for nonmembers nationally). In addition to lowering readmissions, the AHCA Quality Initiative aims to improve staff turnover rates, customer satisfaction, unintended health care outcomes, functional outcomes, and discharges to the community.

As part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing policy that uses one measure—readmissions. Public reporting of readmission rates began in October 2017. A value-based purchasing program will adjust a facility's payments based on its readmission rate starting in October 2018, beginning with an all-cause rate and moving to a potentially preventable rate as soon as practicable. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) established a SNF quality reporting program that requires SNFs to report several quality measures.[19] Providers that do not submit the necessary data to calculate the required quality measures will have their market basket update reduced by 2 percentage points.

No improvement in managing patients' functional status

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 with chronic and degenerative diseases may expect, at best, to maintain their function. We measure SNF performance on both aspects of patient

TABLE 8–4

Mean risk-adjusted functional outcomes in SNFs showed little change between 2011 and 2016

Composite measure	2011	2013	2015	2016
Rate of improvement in one or more mobility ADLs	43.6%	43.8%	43.6%	43.6%
Rate of no decline in mobility	87.2	87.2	87.1	87.1

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 2011 through fiscal year 2016 Minimum Data Set data.

function on a risk-adjusted basis (see text box on SNF quality measures, pp. 214–215).

The average risk-adjusted rates of functional change—rate of improvement in one, two, or three mobility ADLs (bed mobility, transfer, and ambulation) and the rate of no decline in mobility—were essentially unchanged between 2011 and 2016 (Table 8-4). These risk-adjusted rates consider the likelihood that a patient's functionality will change, given the functional ability at admission. So even though the amount of therapy furnished over this time period increased, the average functional status of beneficiaries did not improve. However, functional levels were maintained despite shorter SNF stays.

Large variation in quality measures indicates considerable room for improvement

Considerable variation exists across the industry in the quality measures we track. We found one-quarter of facilities in 2016 had risk-adjusted community discharge rates at or below 31.4 percent, whereas the best performing quarter of facilities had rates of 48.5 percent or higher (Table 8-5, p. 218). Some of this variation will reflect differences in the mix of short-stay patients and long-term residents. Some facilities have large shares of short-stay SNF patients who would expect to be discharged back to the community, while others have large shares of long-stay residents who are not expected to be discharged back to the community. Similar variation was seen in readmissions during the SNF stay: The worst performing quartile had rates at or above 13.5 percent, whereas the best quartile had rates at or below 7.7 percent. Finally, rates of readmission in the 30 days after discharge from the SNF varied most—a twofold difference between the 25th percentile and the 75th percentile. The amount of variation across and within the groups suggests considerable room for improvement, all else being equal. There was less variation in the mobility measures, particularly the measure detecting no decline in mobility. The relatively high and fairly uniform rates indicate that most SNFs are able to prevent declines for most beneficiaries. Comparing the best and worst (the 10th and 90th percentiles), there is a 24 percent difference in rates (77.5 percent compared with 95.8 percent, respectively), indicating room for improvement (data not shown).

Over the past six years, nonprofit SNFs and hospital-based SNFs have had higher rates of community discharges and fewer readmissions (that is, better rates) during the SNF stay. The readmission rates for hospital-based SNFs and freestanding SNFs during the 30 days after discharge from the SNF were similar, with hospital-based facilities having higher rates in some years and lower rates in others.

Medicare is increasingly focused on measuring the value of the care it purchases. In 2018, CMS will implement a value-based purchasing program that will affect payments, beginning with an all-cause all-condition readmission measure, and using 2017 as the performance period. In addition, last year, CMS expanded the number of short-stay quality measures reported in Nursing Home Compare, a Medicare website that displays comparative information about SNFs and nursing homes to help beneficiaries select a provider. Until recently, 8 of the 11 quality measures focused on long-stay care. Of the three short-stay measures (the share of residents with pressure sores that are new or worsened, the share of residents who self-report moderate or severe pain, and the share of residents who newly received antipsychotic medication), none captures the main goals of SNF care. To correct this shortcoming,

TABLE 8–5

SNF quality measures varied considerably across SNFs, 2016

Quality measure	Risk-adjusted rates			
	Mean	25th percentile	75th percentile	Ratio of 75th to 25th percentile
Discharged to the community	39.5%	31.4%	48.5%	1.5
Average mobility improvement across the three mobility ADLs during SNF stay	43.6	36.0	51.5	1.4
No decline in mobility during SNF stay	87.1	82.7	92.5	1.1
Potentially avoidable readmissions during SNF stay	10.8	7.7	13.5	1.8
Potentially avoidable readmissions within 30 days after discharge from SNF	5.8	3.7	7.6	2.1

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

Source: Analysis of fiscal year 2016 Minimum Data Set and hospital claims data.

CMS added four measures to the Nursing Home Compare website and to its star rating methodology: rates of discharge to the community, emergency room visits, rehospitalization within the first 30 days of admission to a SNF, and improvement in function. Though the measure definitions differ from those used by the Commission, they capture key dimensions of care for short-stay patients.[20]

Providers' access to capital in 2017

The vast majority of SNFs operate within nursing homes; therefore, in assessing SNFs' access to capital, we look at the availability of capital for nursing homes. Although Medicare makes up the minority share of almost all facilities' revenues, many operators see Medicare as their best payer.

Access to capital was adequate in 2017 and is expected to remain so in 2018. Some lending wariness reflects broad changes in post-acute care—the uncertainty accompanying the transition away from utilization-driven FFS and toward value-based care—not the adequacy of Medicare's payments. Medicare is regarded as a preferred payer of SNF services.

Market analysts report that capital in 2017 has been generally available, but some lenders may be cautious for several reasons. First, there is downward pressure on SNF volume as bundled payments, increased MA enrollment, and ACOs shorten stays or eliminate them entirely (with beneficiaries discharged home, with or without home health care). Analysts note that the transition from FFS to alternative payment models (including ACOs, bundled payment, and value-based purchasing) will require many SNFs to change their practices and enhance their capabilities to achieve and report good outcomes. Another factor is the lower revenues they receive per day for MA enrollees. Some uncertainty has also been raised by CMS as it considers whether to remove certain procedures (including total knee replacements and total and partial hip replacements) from the inpatient-only list (a list of procedures that must be performed in an inpatient setting), which would lower the demand for SNF services (Fitch Ratings 2017). Finally, the Department of Justice's investigations into therapy billing practices will require some providers to change their current therapy practices. As evidence of this sector's wariness, some real estate investment trusts (REITs) with large SNF holdings have moved those holdings into separate REITs or have sold a portion of their SNF assets (Ritchie and Johnson 2017). In 2017, Kindred Healthcare completed the sale of its SNFs and now relies on preferred provider relationships with SNFs in each of its integrated markets (Kindred Healthcare 2017). In late 2017, Genesis sought relief from its creditors while it restructured its businesses (Brubaker 2017).

Despite these reservations, buyer demand for SNFs remains strong. During 2017, some companies (including REITs) added SNFs to their portfolios, knowing that the aging demographics and relatively lower price position (compared with IRFs and LTCHs) will continue to fuel demand for these services (Irving Levin Associates Inc. 2017a, Monroe 2017). One analyst noted that a smaller, regional strategy was more likely to be successful than a national one because these operators have a better understanding of the markets and referral patterns that enable them to be more adaptive to local conditions (Berklan 2017). Yet, uncertainty for some small operators has resulted in some market consolidation (Connole 2017). Some companies see the fragmentation of the industry as an opportunity to acquire underperforming properties (Ensign Group 2017, Genesis HealthCare 2017).

Reflecting the demand for SNF properties, the average price per bed has steadily increased for five consecutive years, increasing 15 percent in 2016 (on top of a 12 percent increase the prior year). In 2016, over one-quarter (29 percent) of facilities sold for $125,000 or more per bed, compared with 19 percent in 2015 (Irving Levin Associates Inc. 2017b). Some properties sold for more than $150,000 per bed, underscoring the prospect that a facility in the right market with the right patient mix can be successful. One analyst noted that, as competition for Medicare business increases, buyers are less interested in the lower end of the market (Irving Levin Associates Inc. 2017a).

As the nursing home industry becomes increasingly bifurcated—into providers with the capabilities to furnish skilled nursing care and successfully participate in alternative payment models versus providers without those capabilities—buyers will seek SNFs that already treat the high-acuity Medicare patients or facilities that can be renovated to meet this demand. In conducting their due diligence on potential borrowers, lenders review the quality of the potential borrower's management team; cash flow and amount of debt; operating trends (volume, occupancy, payer mix, and patient mix); quality of care; ability to carry out strategic plans to shift payer or service mix; and the specificity of the facility's plans to meet performance goals. Lenders continue to focus on facilities with high Medicare and private-payer mixes, facilities furnishing PAC as opposed to long-term care, and those with the potential to expand their share of PAC patients.

The Department of Housing and Urban Development (HUD) continues to be an important lending source. In fiscal year 2017, HUD financed 310 projects, with the insured amount totaling $3.4 billion, a 20 percent increase from 2016 (Department of Housing and Urban Development 2017). Lending increased because both the number and size of the loans increased. Refinancing, rather than new construction or renovation, continues to make up most of HUD loans. Despite this growth, HUD plays a smaller lending role than it has previously because low-cost borrowing and widely available capital sources have made it only one of many alternative lenders (Swett 2015).

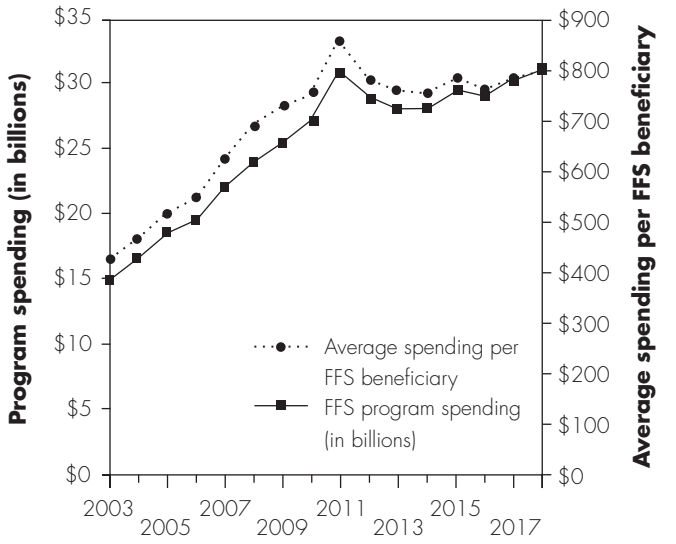
As payment reforms shift risk from payer to provider, providers use a variety of strategies to increase their revenue and improve their value. Revenue strategies include developing specialty services (such as rehabilitation centers) to attract Medicare patients, expanding service lines (such as home health and hospice), increasing their managed care business (including MA), aligning with ACOs and hospitals for referrals, and diversifying geographically. To increase their quality, some SNFs have increased staff training, improved their physical plants, increased physician presence, and developed cardiac and pulmonary capabilities (DiversiCare 2017, Genesis HealthCare 2017). Many SNFs have developed the data and analytics necessary to participate in alternative payment models and be successful partners with referring hospitals.

Medicare payments and providers' costs: Medicare margins remained high in 2016

In 2016, the aggregate Medicare margin for freestanding SNFs was 11.4 percent. Margins for individual facilities continue to be highly variable, depending on the facility's share of intensive therapy days, size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics: High-margin facilities had higher case-mix indexes and higher shares of dual-eligible and minority beneficiaries. Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. The 970 freestanding facilities defined as relatively efficient consistently had relatively low costs while furnishing higher quality 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. These facts strongly suggest that SNFs can provide high-quality care at lower payment rates.

FIGURE 8–1

After declining in 2016, program spending on SNF services is estimated to increase in 2017 and 2018



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year spending is shown. Data for 2017 and 2018 are estimates.

Source: Office of the Actuary 2017b.

Trends in FFS spending and cost growth

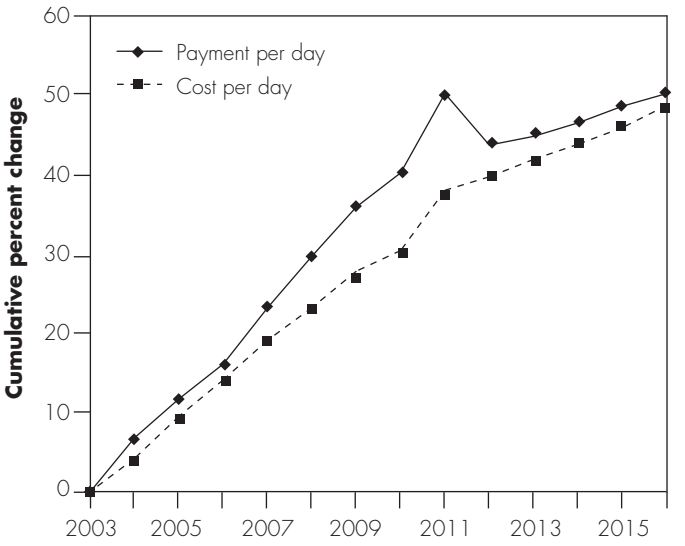
In fiscal year 2016, Medicare FFS spending for SNF services was $29.1 billion, about 1 percent lower than in 2015 (Figure 8-1) (Office of the Actuary 2017b). Before 2012, the average increase in program spending was over 9 percent a year. In 2011, program spending was unusually high because the rates for the new case-mix classification system included an adjustment that was too large for the mix of therapy modalities assumed in setting the rates. The industry took advantage of the new policies by quickly shifting its mix of modalities, and spending increased by over 13 percent in 2011. To correct for the excessive payment, CMS revised the adjustment downward in 2012, and total payments declined between 2012 and 2014. Since 2014, the growth in spending has averaged almost 3 percent a year. The Office of the Actuary estimates FFS spending increased over 3 percent in fiscal year 2017 and expects spending to increase at a faster rate (over 4 percent) in fiscal year 2018, to $31.4 billion. On a per FFS beneficiary basis, average spending in 2016 ($765) was about 2 percent lower than in 2015.

From 2003 to 2016, the cumulative increase in payments per day was slightly higher than the cumulative increase in cost per day (Figure 8-2). Payments per day incorporate both annual updates to the per diem rates and changes in case mix. During this period, costs per day rose 49 percent while payments grew 50 percent. Every year since 2004, costs have increased faster than the year's update except for 2012. That year, Medicare lowered its rates by 11 percent to correct for the previous year's overpayments, and providers kept their cost growth low. Between 2003 and 2011, the increases in Medicare payments per day were much higher than the updates, followed by two years of modest growth in payments per day and one year (between 2011 and 2012) in which they declined. Since 2014, Medicare payments per day have again been higher than the updates.

Since 2012, costs have grown more quickly for nonprofit SNFs than for-profit SNFs. Cumulatively, costs grew 13.7 percent for nonprofit facilities compared with 9.5 percent for for-profit SNFs. The differences in growth were larger for routine and administrative costs compared with ancillary costs. During this same period, routine costs increased 13.6 percent for nonprofit SNFs, but almost half that (7.7 percent) of for-profit SNFs. In addition to higher cost growth, nonprofit facilities also had standardized cost per day (adjusted for differences in wages and case mix)

FIGURE 8–2

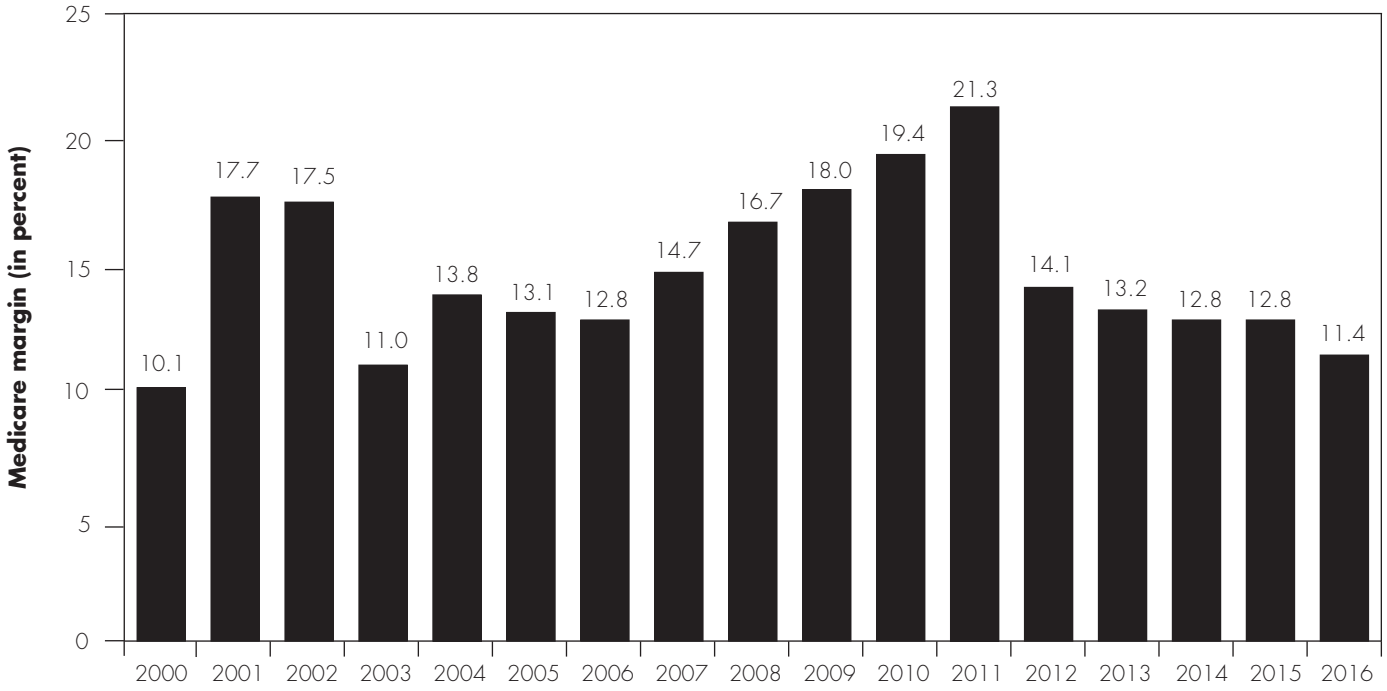
Cumulative growth in Medicare cost and payments per SNF day, 2003–2016



Note: SNF (skilled nursing facility). Data reported are for freestanding SNFs. Changes in payments reflect annual updates and changes in case mix.

Source: MedPAC analysis of freestanding SNF Medicare cost reports from 2003–2016.

FIGURE 8–3 **Aggregate freestanding SNF Medicare margins have been above 10 percent since 2000**



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

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2016.

that was about 10 percent higher than the cost per day in for-profit facilities.

SNF Medicare margins remain high

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

In 2016, the aggregate Medicare margin for freestanding SNFs was 11.4 percent, the 17th consecutive year of Medicare margins above 10 percent (Figure 8-3). In aggregate, SNFs maintained their substantial margins despite productivity adjustments that lower market basket updates and despite the federal budget sequester that began lowering payments in April 2013 by 2 percent per year. The Medicare margin declined 1.4 percentage points from 2015 because CMS made a forecast error correction in 2016 (–0.6 percent), and cost growth outpaced the increase in payments. Between 2015 and 2016, payments per day increased 1.6 percent compared with a 2.8 percent increase in costs per day. Shorter lengths of stay may have also contributed to the decrease in the Medicare margin since the days at the end of the stay are likely to be lower cost compared with days early in the stay. As stays shorten, early days make up a larger share of total days. A small increase (from 82 percent to 83 percent) in the share of days assigned to the highest payment case-mix groups (the ultra-high and very high groups) contributed to the increase in payments per day that grew faster than the update for 2016 (1.2 percent).

In 2016, hospital-based facilities (3 percent of program spending on SNFs) continued to have extremely negative Medicare margins (–67 percent), in part because of

TABLE 8–6

Variation in freestanding SNF Medicare margins reflects the mix of cases and cost per day, 2016

Provider group	Medicare margin
All providers	11.4%
For profit	14.0
Nonprofit	2.3
Rural	9.8
Urban	11.7
Frontier	1.4
25th percentile of Medicare margins	0.7
75th percentile of Medicare margins	20.2
Intensive therapy: High share of days	13.2
Intensive therapy: Low share of days	4.3
Medically complex: High share of days	9.6
Medically complex: Low share of days	12.4
Small (20–50 beds)	–0.9
Large (100–199 beds)	12.9
Standardized cost per day: High	0.7
Standardized cost per day: Low	24.1
Standardized cost per discharge: High	9.3
Standardized cost per discharge: Low	13.3
Facility volume: High	13.7
Facility volume: Low	1.0

Note: SNF (skilled nursing facility). The margins are aggregates for the facilities included in the group. "Low" is defined as facilities in the lowest 25th percentile; "high" is defined as facilities in the highest 25th percentile. "Frontier" refers to SNFs located in counties with six or fewer people per square mile. "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. Facility volume includes all facility days.

Source: MedPAC analysis of 2016 freestanding SNF Medicare cost reports.

the higher cost per day reported by hospitals. Previous analysis by the Commission found that routine costs in hospital-based SNFs were higher, reflecting more staffing, higher skilled staffing, and shorter stays (over which to allocate costs) (Medicare Payment Advisory Commission 2007). However, hospital administrators consider their SNF units in the context of the hospital's overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their SNF beds, thus making inpatient beds available to treat additional inpatient admissions. As a result, hospital-based SNFs can contribute to the bottom-line financial performance of hospitals: In fact, hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs.

Marginal profit: A measure of the attractiveness of Medicare patients

Another factor we consider when evaluating the adequacy of payments is whether providers have any 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. If we approximate marginal cost as total Medicare cost minus fixed building and equipment cost, then marginal profit is:

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

This comparison is a lower bound on the marginal profit because we ignore any potential labor costs that are fixed. For providers with available data, the marginal profit in 2016 was at least 19.6 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.

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

The persistently high Medicare margins and their wide variation indicate that the PPS needs to be revised and rebased so that payments more closely match patient characteristics, not the services provided to them. In 2016, one-quarter of freestanding SNFs had Medicare margins of 20.2 percent or higher, while another quarter of freestanding SNFs had margins of 0.7 percent or lower

(Table 8-6). One-quarter of SNFs (slightly more than last year) had negative Medicare margins (data not shown).

Over the past 10 years, for-profit facilities' Medicare margins have averaged about 10 percentage points higher than nonprofit facilities' margins, which continued to be true in 2016 (Table 8-6). Nonprofit facilities had an average Medicare margin of 2.3 percent, while the average for-profit margin was 14.0 percent. The disparity reflects differences in facilities' mix of patients, costs, size, and service provision. Nonprofit facilities tend to have higher costs per day (about 10 percent higher) and, since 2011, have had higher cost growth compared with for-profit facilities. The higher costs for nonprofit facilities are partly due to their smaller size. In 2015, the median nonprofit facility had 85 beds compared with 103 beds for the median for-profit facility (data not shown); therefore, the nonprofits may not be able to achieve the same economies of scale as larger facilities. As for revenues, nonprofits had somewhat lower shares of the more profitable ultra-high and very high therapy days compared with for-profit facilities (81 percent compared with 84 percent, respectively) and shorter stays, both lowering revenue.

The mix of days played a key role in shaping Medicare margins. In 2016, facilities with high shares of intensive-therapy days had Medicare margins that averaged almost 9 percentage points higher than facilities with low shares of these days (13.2 percent compared with 4.3 percent, respectively; Table 8-6). Despite the payment increases for medically complex cases in October 2010, facilities with high shares of medically complex patients had Medicare margins that were almost 3 percentage points lower than facilities with low shares of medically complex days.

Lower cost SNFs and larger and higher volume SNFs had higher Medicare margins than higher cost and smaller SNFs.[21] The Medicare margin for facilities with the lowest cost per day (the bottom quartile of cost per day) was 24.1 percent, while the margin for facilities with the highest cost per day (the top quartile of cost per day) was 0.7 percent (Table 8-6). The differences in Medicare margins for these various reporting groups increased slightly from 2015.

High-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, p. 224). Compared with lower margin SNFs (those in the bottom quartile), high-margin SNFs had considerably lower daily total, routine, and ancillary costs. Economies of scale play a role; high-margin SNFs were larger on average than lower margin facilities. Compared with lower margin SNFs, 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.

On the revenue side, high-margin SNFs had revenues per day that were 16 percent higher, driven in part by having larger shares of intensive therapy days, and, to a lesser extent, smaller shares of medically complex days. The differences in financial performance based on a provider's case mix illustrate the need to revise the PPS. Under a revised payment system based on patient and stay characteristics, relative profitability would be more uniform across different types of cases, so providers would be much less financially advantaged by their mix of cases and therapy practices.

Even after CMS expanded the number of medically complex case-mix groups and shifted spending away from therapy care, the PPS continues to result in higher Medicare margins for facilities providing higher amounts of intensive therapy. A PPS design based on patient characteristics (such as the one recommended by the Commission and the design proposed by CMS) would redistribute Medicare spending to SNFs according to their mix of patients, not the amount of therapy provided.

Ownership of low-margin and high-margin facilities did not mirror the industry mix. Although for-profit facilities made up almost three-quarters of all freestanding SNFs in 2016, they constituted a smaller share (57 percent) of the low-margin facilities and a higher share (88 percent) of the high-margin group. Similarly, high-margin SNFs were disproportionately urban, accounting for 80 percent of this group (Table 8-7, p. 224).

Many SNFs had relatively low costs and achieved relatively high quality

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on both cost and quality metrics. Second, the 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

TABLE 8–7

Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2016

Characteristic	SNFs in the top margin quartile	SNFs in the bottom margin quartile	Ratio of SNFs in the top margin quartile to SNFs in the bottom margin quartile
Cost measures			
Standardized cost per day	$266	$387	0.69
Standardized ancillary cost per day	$117	$162	0.72
Standardized routine cost per day	$151	$217	0.70
Standardized cost per discharge	$11,190	$14,246	0.79
Average daily census (patients)	88	66	1.33
Average length of stay (days)	42	36	1.17
Revenue measures			
Medicare payment per day	$510	$441	1.16
Medicare payment per discharge	$22,472	$15,940	1.41
Share of days in intensive therapy	87%	79%	1.10
Share of medically complex days	3%	4%	0.75
Medicare share of facility revenue	24%	14%	1.71
Patient characteristics			
Case-mix index	1.41	1.32	1.07
Share dual-eligible beneficiaries	39%	27%	1.44
Share minority beneficiaries	14%	5%	2.8
Share very old beneficiaries	28%	33%	0.85
Medicaid share of days	65%	56%	1.16
Facility mix			
Share for profit	88%	57%	N/A
Share urban	80%	69%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Top margin quartile SNFs (n=3,263) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n=3,262) 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.

Source: MedPAC analysis of freestanding 2016 SNF cost reports.

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 financial performance of freestanding SNFs with consistent cost and quality performance on two measures (see text box on identifying efficient providers). To measure costs, we looked at costs per day that were adjusted for differences in area wages and case mix. To assess quality, we examined risk-adjusted rates of community discharge and potentially avoidable readmissions that occurred during the SNF stay. To be included in the relatively efficient group, a SNF had to be in the best third of the distribution of at least one measure and not in the bottom third on any measure for three consecutive years. We also required that SNFs not be part of CMS's Special Focus Facility Initiative for any portion of time covered by the definition (2013 through 2015).[22] This criterion excluded seven

Identifying relatively efficient skilled nursing facilities

We defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and good quality care for three years in a row, 2013 through 2015. The cost per day was calculated using cost report data and was adjusted for differences in case mix (using the nursing component relative weights) and wages. Quality measures were risk-adjusted rates of community discharge and potentially avoidable readmissions during the SNF stay. Only facilities with at least 25 stays were included in the quality measures.

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

facilities from the pool of efficient providers. Having applied the cost, quality, and special-focus exclusions, we found that 8 percent (970 of the 11,545 facilities that had all of the data items required for this analysis) provided relatively low-cost, high-quality care—37 fewer facilities than last year. Of the 970, two-thirds were identified as efficient last year.

Our analyses found that SNFs can have relatively low costs and provide relatively good quality care (Table 8-8, p. 226). Compared with other SNFs in 2016, relatively efficient SNFs had community discharge rates that were 26 percent higher and readmission rates that were 17 percent lower. Standardized costs per day were 8 percent lower than for other SNFs.

We did not find significant differences between relatively efficient and other SNFs in terms of occupancy rates, but efficient SNFs had a higher daily census (99 compared with 80, respectively). Efficient facilities had more complex case mixes (driven in part by higher therapy intensity) but shorter stays. In terms of case-mix, efficient providers had higher shares of the most intensive therapy days but the same shares of medically complex days. The higher therapy intensity raised their daily Medicare payments relative to all SNFs, indicating that, in addition to controlling their costs, efficient providers pursued revenue strategies to maximize their Medicare payments. The median Medicare margin for efficient SNFs was 18.2 percent, and their total margin (for all payers and all lines of business) was 2.5 percent. Relatively efficient facilities were more likely to be urban and for profit. Efficient SNFs were located in 45 states plus the District of Columbia and included one in a frontier location.

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 FFS and MA payments, which are per person rather than per service 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 at three nursing home companies where such information was publicly available. For these companies, Medicare's FFS payments averaged 21 percent higher than MA rates (Table 8-9, p. 227). We do not know whether the lower average daily payment 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 those paid to smaller chains and independent facilities. It is possible that smaller companies

TABLE 8–8

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

	Type of SNF		
Performance in 2016	**Relatively efficient**	**Other SNFs**	**Ratio of relatively efficient to other SNFs**
Community discharge rate	49.1%	39.1%	1.26
Readmission rate	8.9%	10.7%	0.83
Standardized cost per day	$291	$315	0.92
Standardized cost per discharge	$9,187	$12,211	0.75
Medicare revenue per day	$512	$466	1.10
Medicare margin	18.2%	10.6%	1.71
Total margin	2.5%	1.1%	2.40
Facility case-mix index	1.43	1.36	1.05
Medicare average length of stay	32 days	39 days	0.82
Occupancy rate	87%	85%	1.03
Average daily census	99	80	1.24
Share ultra-high therapy days	65%	54%	1.19
Share medically complex days	4%	4%	1.0
Medicaid share of facility days	56%	61%	0.91
Share urban	83%	68%	N/A
Share for profit	79%	69%	N/A
Share nonprofit	14%	21%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). The number of freestanding facilities included in the analysis was 11,545. SNFs were identified as "relatively efficient" based on their cost per day and two quality measures (community discharge and readmission rates) between 2013 and 2015. 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. Table shows the medians for the measure.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2013–2016.

have less leverage and do not negotiate similarly low rates. However, similar differences in payments were reported by the National Investment Center for Seniors Housing & Care. It found that, for 1,433 SNF properties included in its sample, MA daily payments were 15 percent lower than Medicare FFS payments and that the MA revenue per day was at its lowest rate since July 2012 (National Investment Center for Seniors Housing & Care 2017a).

We compared the patient characteristics of beneficiaries enrolled in FFS and MA plans in 2016 and found small differences that are unlikely to explain the lower payments typically made by MA plans.[23] Compared with FFS beneficiaries, MA enrollees were slightly older (less than a year), had slightly higher Barthel scores (less than two points, indicating slightly more independence), and had slightly lower (5 percent lower) risk scores (indicating fewer comorbidities). The considerably lower MA payments indicate that some facilities accept much lower payments to treat MA enrollees who are not much different in terms of case mix from FFS beneficiaries. Some publicly traded firms report seeking managed care patients as a business strategy, indicating that the MA rates are attractive.

TABLE 8–9

Comparison of Medicare fee-for-service and managed care daily payments in 2017 to three companies

	Medicare payment		
Company	**FFS**	**Managed care (MA)**	**Ratio of FFS to MA payment**
Diversicare	$453	$392	1.16
Ensign Group	597	449	1.33
Genesis HealthCare	531	463	1.15

Note: MA (Medicare Advantage), FFS (fee-for-service). 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 2017 reports available at each company's website.

Total margins remained the same in 2016 as in 2013

The average total margin for freestanding SNFs in 2016 remained positive (0.7 percent) but lower than the total margin in 2015 (1.6 percent). A total margin reflects the costs and payments for services to all patients (public and private, including managed care) across all lines of business (for example, long-term care, hospice, home health care, and ancillary services) and nonpatient sources of revenue sources (such as investment income). Total margins reflect state policies regarding the level of Medicaid payments, managed care payments (including Medicare Advantage), and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need). As enrollment in MA increases, the lower revenues from MA will lower total margins.

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 residents. Such a policy is ill advised for several reasons (see text box on not subsidizing other payments, p. 228).

Payments and costs for 2018

In assessing the payment update for 2018, the Commission considers the relationship between SNF costs and Medicare payments in 2016. To estimate costs for 2017 and 2018, we assumed cost growth equal to the market basket and no behavioral changes. We included Medicare's share (based on the Medicare share of nursing facility revenues) of the estimated cost of the nursing home regulation included in the final rule for these regulations (Centers for Medicare & Medicaid Services 2016). To estimate 2018 payments, we began with reported 2016 payments and increased them by the market basket net of the productivity adjustment for 2017 (as required by the Patient Protection and Affordable Care Act of 2010). We assumed payments in 2018 would increase by 1.0 percent, as required the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We also reduced 2018 payments by the portion of the value-based purchasing (VBP) withhold that will be retained as program savings.[24] The projected Medicare margin for 2018 is 9 percent. The level is expected to be lower than the margin in 2016 due to the market basket update being offset by the productivity adjustment in 2017, the MACRA-mandated update in 2018, and the program savings from VBP.

How should Medicare payments change in 2019?

In considering how payments should change for 2019, we note that financial circumstances of SNFs remain largely the same since the Commission made its recommendation last year to eliminate the market basket increases for 2018 and 2019 while the Secretary revises the SNF PPS. The recommendation also stated that, in 2020, the Secretary should evaluate the need for additional adjustments to more closely align payments and costs.

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

Medicare payments, which are financed by taxpayer contributions to the Part A Trust Fund, effectively subsidize payments from other payers, most notably Medicaid. High Medicare payments may also subsidize payments from private payers. Industry representatives contend that this supplementation should continue. The Commission believes such cross-subsidization is not advisable for several reasons. First, this strategy results in poorly targeted subsidies. Facilities with high shares of Medicare beneficiary days would 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—would receive the smallest subsidies. Shares of Medicare and Medicaid days vary widely across facilities (Table 8-10). As a result, the impact of the Medicare subsidy would vary considerably across facilities, putting more dollars into facilities with high Medicare use (and low Medicaid use), which are likely to have higher Medicare margins than other facilities.

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

TABLE 8–10

Medicare and Medicaid shares vary widely across freestanding skilled nursing facilities, 2016

	Percentile of facility days				
Payer	**10th**	**25th**	**Median**	**75th**	**90th**
Medicare share	5%	7%	11%	17%	26%
Medicaid share	0	40	61	73	81

Source: MedPAC analysis of skilled nursing facility Medicare cost reports, 2016.

Since last year, CMS has proposed revising the SNF PPS in fiscal year 2019 in a way that is generally consistent with the Commission's recommended design. The revisions will redistribute payments toward medically complex patients (and away from stays that receive rehabilitation therapy unrelated to their characteristics) and better target payments for NTA services. The Commission supports the implementation of a revised PPS in fiscal year 2019 to correct the distortions and inequities of the current design.

Regarding the level of payments, aggregate Medicare margins for SNFs have been above 10 percent since 2000. In 2016, the marginal profit was 19.6 percent, indicating facilities with an available bed have an incentive to admit Medicare patients. Further, the variation in

Medicare margins is not related to differences in patient characteristics and location since cost differences remain after adjusting for differences in wages, case mix, and beneficiary demographics. Rather, differences in financial performance reflect, in part, the amount of therapy furnished to patients, differences in costs per day, and cost control. Relatively efficient SNFs, with relatively low costs and high quality, have Medicare margins of 18 percent. FFS payments were considerably higher than the MA payments made to some SNFs, suggesting some facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries. These factors show that the PPS continues to exert too little pressure on providers. The industry has shown it is nimble at responding to the level of Medicare's payments. Even in years when CMS lowered payments, providers tempered their practices so that aggregate payments increased.

RECOMMENDATION 8

The Congress should:

- **eliminate the market basket update for skilled nursing facilities for fiscal years 2019 and 2020;**
- **direct the Secretary to implement a redesigned prospective payment system (PPS) in fiscal year 2019 for skilled nursing facilities; and**
- **direct the Secretary to report to the Congress on the impacts of the revised PPS and make any additional adjustments to payments needed to more closely align payments with costs in fiscal year 2021.**

RATIONALE 8

This recommendation calls for the Congress to lower the level of payments and for the Secretary to proceed with the revisions to the SNF PPS. To lower the level of payments, rates would not be increased for 2019 and 2020 while CMS implements its plans for a revised PPS. By comparison, current law calls for market basket increases net of productivity adjustments each year (a 2.0 percent increase in fiscal year 2019 and a 2.1 percent increase in fiscal year 2020). With the current Medicare margin at over 11 percent and the projected Medicare margin in 2018 at 9 percent, Medicare payments appear more than adequate to accommodate SNF cost growth without updates.

As discussed in Chapter 7, before implementing a unified PAC PPS in 2021, the Commission recommends that the Congress direct the Secretary to establish SNF payments using a blend of the unified PAC PPS and current SNF PPS relative weights. The recommendation to blend relative weights does not affect the *level* of payments to a setting but the *distribution* of those payments across conditions. A blend of the relative weights would redistribute payments within the SNF setting by increasing payments for medically complex patients and lowering payments for patients who receive rehabilitation therapy unrelated to their care needs. Based on their mix of patients and current therapy practices, the blend would have the effect of raising payments to nonprofit and hospital-based SNFs and lowering payments to for-profit and freestanding SNFs. The blended weights would narrow the relative profitability across types of stays, which would improve access for medically complex patients. Narrower differences in profitability would also mean there would be fewer financial incentives for providers to engage in patient selection. The redistribution across providers enables the Commission to recommend, and policymakers to implement, a level of payments that would better align payments with the cost of care.

The SNF update recommendation also would require the Secretary to proceed with plans to revise the SNF PPS. Like a unified PAC PPS, revisions to the SNF PPS will increase the equity in payments for different types of stays, increasing payments for medically complex stays and decreasing payments for stays that include intensive therapy unrelated to a patient's care needs. While the redesign would narrow the disparities in financial performance that result from the mix of cases facilities treat and therapy practices, it would not, and should not, address disparities that result from providers' inefficiencies. The Commission first recommended a revised design in 2008 and since then has continued to develop and communicate alternative design features that redirect payments toward medically complex care. The Commission has grown increasingly frustrated with the lack of statutory and regulatory actions to lower the level of payments and implement a revised payment system.

The recommendation to blend the relative weights of the unified PAC PPS with the relative weights of each PAC setting's current PPS (discussed in Chapter 7) does not diminish the need for the Secretary to proceed with plans to revise the SNF PPS. Until action is taken to blend the relative weights and implement the unified PAC PPS, CMS must proceed with its plans to revise the SNF PPS to correct the current distortions that encourage providers to furnish therapy service for financial gain and to selectively admit certain patients and avoid medically

TABLE 8–11

The number of nursing homes treating Medicaid enrollees declined slightly from 2016 to 2017

							Percent change	
	2010	2012	2014	2015	2016	2017	2015–2016	2016–2017
Number of facilities	15,127	15,083	15,062	15,052	15,039	14,978	–0.001%	–0.4%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2010–2017.

complex patients. Because the PAC PPS is on a longer implementation timetable, CMS should continue to improve the accuracy and the equity of SNF payments. When CMS implements the revised SNF PPS, those new relative weights would be used in the blending with the PAC PPS weights to establish payments to SNFs.

Because the directional impacts of the PAC PPS and the setting-specific redesigns are the same, revising the SNF PPS would complement the implementation of the PAC PPS by beginning to redistribute payments across conditions. Further, the redesigned SNF PPS and the unified PAC PPS establish similar incentives for providers, so the blending of the relative weights would give providers more time to adjust their practices and gain valuable experience with the types of changes necessary to succeed under a unified PAC PPS. Because the SNF redesign is estimated to redistribute payments in ways directionally similar to a unified PAC PPS, the impacts of the blended relative weights on payments by clinical condition would be less since the "starting point" for payments would already include some redistribution achieved by the redesigned SNF PPS.

The Commission is focused on ensuring beneficiaries' access to SNF care. The recommendations to revise the SNF PPS and blend the unified PAC PPS weights with the SNF relative weights are aimed at increasing the equity of Medicare's payments so that beneficiaries have equal access to SNF services regardless of their care needs. The Commission will continue to monitor beneficiary access, quality of care, and financial performance and may consider future recommendations based on industry performance.

IMPLICATIONS 8

Spending

- Relative to current law, this recommendation would lower program spending by between $750 million and $2 billion for fiscal year 2019 and by greater than $10 billion over five years. Savings occur because current law requires market basket increases for 2019 and 2020. (These spending implications do not reflect changes in SNF policy mandated by the Bipartisan Budget Act of 2018.)

Beneficiary and provider

- The recommended changes will increase access to services for beneficiaries who are disadvantaged by the design of the current payment system, such as medically complex patients. By raising payments for medically complex cases, providers will be more likely to admit and treat beneficiaries with such care needs compared with the selective admissions that some providers currently engage in.

- Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries. Aggregate provider payments would be lower than under current law, but the recommendation would reduce the disparities in Medicare margins across providers. The recommendation has the effect of increasing payments to hospital-based and nonprofit SNFs and lowering them to for-profit and freestanding SNFs based on their mix of patients. Effects on individual providers would be a function of their mix of patients, current practices, and cost structures. The recommendation would not eliminate all differences in Medicare margins across providers because cost differences could remain.

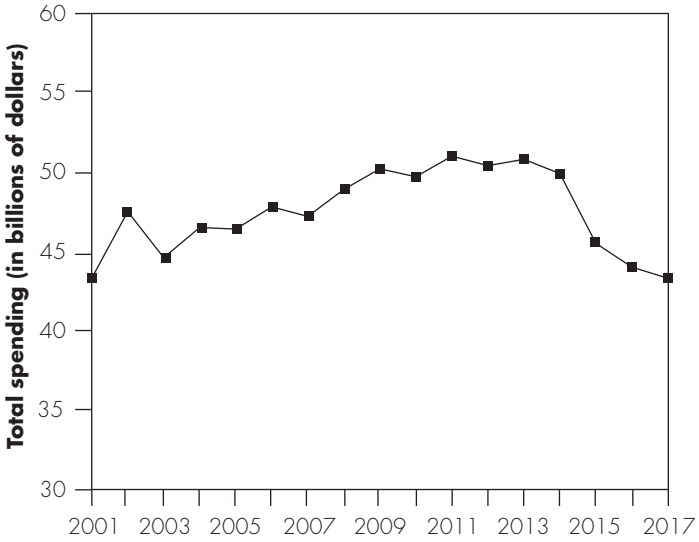
Medicaid trends

Section 2801 of the Patient Protection and 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 the Medicaid program. We report nursing home spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2018).

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

FIGURE 8–4

Total Medicaid fee-for-service spending on nursing home services, 2001–2017



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

Source: Total spending data are from CMS, Office of the Actuary (2017a).

Count of Medicaid-certified nursing homes

The number of nursing facilities certified as Medicaid providers has stayed relatively stable, with a small decline between 2016 and 2017 (Table 8-11). The decline may 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 2017, 47 states expanded the number of beneficiaries served by HCBS, an increase from 46 states in fiscal years 2015 and 2016 and 42 states in fiscal year 2014 (Gifford et al. 2017). This number will continue to increase in 2018, with all 50 states and the District of Columbia expanding the number of beneficiaries served by HCBS.

Spending

Spending on Medicaid-funded nursing home services (combined state and federal funds) totaled $44 billion in 2016 (Office of the Actuary 2017a) (Figure 8-4). CMS estimates that FFS Medicaid spending on nursing home services decreased by 1.6 percent between 2016 and 2017 and that spending will increase by 0.69 percent in 2018. 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. Year-to-year changes in spending have been variable, increasing in some years and decreasing in others, with overall spending in 2017 down to the same level that it was in 2001. The large decreases in spending beginning in 2015 reflect increased enrollment in managed care.

Analysis of Medicaid rate-setting trends found that 15 states restricted (froze or reduced) rates paid to nursing homes in 2017, while 36 states and the District of Columbia increased rates (Gifford et al. 2017). More states increased rates to nursing homes than in 2016 (only 32 states raised rates in 2016), and only 1 of the 15 states restricting rates reduced rates paid to providers. Furthermore, the National Investment Center for Seniors Housing & Care reported that Medicaid revenue per day reached its highest point in five years (National Investment Center for Seniors Housing & Care 2017b). Rates will likely shift in 2018; however, only 28 states and the District of Columbia have indicated that they will increase nursing home rates. Twenty-two states plan to restrict

TABLE 8–12

Over the past nine years, non-Medicare margins have been negative, but total margins remained positive in freestanding SNFs

Type of margin	2008	2010	2012	2013	2014	2015	2016
Total margin	2.2%	3.6%	1.8%	1.9%	1.9%	1.6%	0.7%
Non-Medicare margin	–2.4	–1.5	–2.0	–1.9	–1.5	–2.1	–2.3

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 2008 to 2016.

rates, and two of these states plan to cut them. One state was undecided as to whether it would restrict or reduce rates.

States continue to use provider taxes to raise federal matching funds. In fiscal year 2017, 44 states and the District of Columbia levied provider taxes on nursing homes to increase federal matching funds, and all plan to continue to do so in fiscal year 2018.[25] The augmented federal funding may be split with the nursing homes.

Non-Medicare and total margins in nursing homes

Total margins reflect all payers (including Medicare, Medicaid, private insurers, and managed care) across all lines of business (for example, nursing home care, hospice care, ancillary services, home health care, and investment income). In 2016, total margins were positive (0.7 percent) (Table 8-12). The median total margin was 1.0 percent, with margins at the 25th and 75th percentiles ranging from –4.9 percent to 5.9 percent, respectively (data not shown). Total margins have declined since 2012, reflecting the impact of reductions to Medicare payments mandated by the Patient Protection and Affordable Care Act of 2010 and the growing share of managed care payments that are lower than Medicare's FFS payments. Non-Medicare margins reflect the profitability of all services except Medicare FFS SNF services. The aggregate non-Medicare margin in 2016 was –2.3 percent, a decline from 2015 (Table 8-12). ■

Endnotes

1 Throughout this chapter, "beneficiary" refers to an individual whose SNF stay coverage (Part A) is paid for by Medicare. Some beneficiaries who no longer qualify for Medicare coverage remain in the facility to receive long-term care services, which are not covered by Medicare. During long-term care stays, beneficiaries may receive 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 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 CMS estimated that the regulations will raise the average provider's costs by $62,900 in the first year and by $55,000 in subsequent years. Some industry representatives contend these are underestimates.

5 The program pays separately for some services, including certain chemotherapy drugs; certain customized prosthetics; certain ambulance services; Part B dialysis; emergency services; and certain outpatient services provided in a hospital (such as computed tomography, MRI, radiation therapy, and cardiac catheterizations).

6 The *SNF Payment Basics* is available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_17_snf_finalb4a411adfa9c665e80adff00009edf9c.pdf?sfvrsn=0.

7 Payments for NTA services are included in the nursing component, even though NTA costs vary much more than nursing care costs and are not correlated with them.

8 There are two broad categories of medically complex case-mix groups: clinically complex and special care. Clinically complex groups are used to classify patients who have burns, surgical wounds, hemiplegia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while in a SNF. Special care groups include patients who are comatose; have quadriplegia, chronic obstructive pulmonary disease, septicemia, diabetes requiring daily injections, fever with specific other conditions, cerebral palsy, multiple sclerosis, Parkinson's disease, respiratory failure, a feeding tube, pressure ulcers of specific sizes, or foot infections; receive radiation therapy or dialysis while a resident; or require parenteral or intravenous feedings or respiratory therapy for seven days.

9 Intensive therapy days are those classified in the ultra-high and very high rehabilitation case-mix groups. Rehabilitation groups are based on minutes of rehabilitation provided per week. "Ultra-high rehabilitation" includes patients who receive more than 720 minutes per week; "very high rehabilitation" includes patients who receive 500–719 minutes per week.

10 Summaries of the technical expert panels are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

11 It can be hard to draw conclusions about differences in service use among beneficiaries enrolled in FFS and MA because MA plans are required to submit patient assessment data at day 15 of a beneficiary stay, but beneficiaries may have been discharged before then. In contrast, assessments are submitted for all FFS users on or about day 5 of the stay. It is not possible to determine the possible bias in the information submitted given the differences in the reporting requirements. In addition, there could be differences in the beneficiaries who elect to enroll in MA.

12 See endnote 8 for the definition of *medically complex.*

13 A modified Barthel score is a composite measure of a person's ability to perform nine activities of daily living, including bladder and urinary incontinence, transfer, walk in the facility corridor, self-feed, toilet, bathe, perform oral hygiene, and dress.

14 The share of SNF users requiring the most assistance dropped for bladder control, transfer, self-feeding, toileting, dressing,

performing personal hygiene, and bed mobility; remained the same for walking in the corridor and always being incontinent; and increased for help with bathing.

15 CMS reports similar measures in Nursing Home Compare, but the measures are defined and calculated differently, and therefore the rates are not directly comparable to those reported by the Commission.

16 Separate models (with their own covariates) are used to estimate expected community discharge rates for different discharge destinations (e.g., discharged home with home health care, discharged home without home health care, and discharged to a nursing home).

17 The SNF PPS case-mix classification system considers the number of therapy minutes furnished during a week. We examined the case-mix assignments when all rehabilitation therapy is ignored. Cases were assigned to the nontherapy case-mix groups, including extensive services, special care, clinically complex, behavior and cognitive performance, and reduced physical function.

18 The readmission rates of patients during their SNF stay and in the period after discharge cannot simply be added to get a combined rate because, in the combined measure, a stay is counted only once, even if the patient was readmitted during the SNF stay and in the post-stay period. In contrast, each relevant stay is counted separately in each measure.

19 The quality measures include the following: the share of patients with pressure ulcers that worsened; the share of patients experiencing one or more falls with major injury; the share of patients with an admission and discharge functional assessment and a care plan that addresses function; the rate of discharge to community (including no deaths or unplanned rehospitalizations within the 30 days after discharge); the rate of potentially preventable hospital readmissions following discharge from the SNF; and Medicare spending per beneficiary. SNFs must submit all data necessary to calculate quality measures on at least 80 percent of the patient assessments submitted. Such requirements are not needed for claims-based measures (community discharge, readmissions, and resource use).

20 The measure of improvement in function measures the share of short-stay patients whose independence in transfer, bed mobility, and ambulation increased. The readmission rate includes readmissions that occur within 30 days of admission (not during the entire SNF stay). The community discharge rate includes patients who were discharged home and were not readmitted to the SNF or to a hospital and did not die during the stay or within 30 days of discharge; it excludes long-stay residents of a nursing home before the SNF stay.

21 We use the nursing component (as opposed to the payment weight of the case-mix group) to avoid distorting the measure of patient complexity by the amount of therapy furnished, which could be unrelated to patient care needs. We used the indexes adjusted for CMS's policy decisions to shift payments toward certain case-mix groups and away from others (White 2012). Because the nursing weights for intensive therapy are relatively high, a facility can have both a high case-mix index and a moderate or low share of medically complex patients.

22 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.

23 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.

24 The VBP program will withhold 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.

25 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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