CHAPTER 6

# Skilled nursing facility services

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

**6** For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rates for skilled nursing facilities by 3 percent.

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

CHAPTER 6

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## Chapter summary

Medicare covers short-term skilled nursing and rehabilitation services for beneficiaries in skilled nursing facilities (SNFs) after a recent inpatient hospital stay. Most SNFs also provide long-term care services not covered by Medicare. Medicare makes up a small share of the overall volume for the average SNF. In 2023, about 14,500 freestanding SNFs furnished about 1.6 million Medicare-covered stays to 1.2 million fee-for-service (FFS) beneficiaries. The FFS Medicare program and its beneficiaries spent $30 billion for SNF services.

### Assessment of payment adequacy

Overall, our indicators of payment adequacy were mostly positive. Although supply and utilization declined, these outcomes do not reflect the adequacy of Medicare's FFS payments.

***Beneficiaries' access to care*—**Changes in the indicators of access were mostly positive.

- ***Capacity and supply of providers*—**The number of SNFs declined by about 1 percent in 2024. Given that Medicare is a small share of most nursing homes' business and that its payment rates are high relative to costs, it is unlikely that the closures reflect the adequacy of Medicare's payments. In 2023, 88 percent of Medicare beneficiaries

## In this chapter

- Are FFS Medicare payments adequate in 2025?
- How should FFS Medicare payments change in 2026?
- Minimum staffing requirements set to begin in May 2026
- Medicaid trends

lived in a county with three or more SNFs or swing-bed facilities—the same share since 2018. However, beneficiaries who live in counties with high average occupancy rates or who require specialized services could face access problems.

- ***Volume of services***—Utilization decreased between 2022 and 2023 as inpatient hospital stays were again required for SNF admissions starting in May 2023 when the public health emergency (PHE) waivers expired. (During the PHE, the three-day inpatient stay prerequisite for Medicare-covered SNF admissions was suspended, allowing SNFs to admit beneficiaries and to "skill in place" nursing home residents who did not have a prior hospital stay.) Between 2022 and 2023, Medicare-covered SNF admissions per 1,000 FFS beneficiaries decreased by 12 percent, and Medicare-covered SNF days per 1,000 FFS beneficiaries decreased by 8 percent.
- ***Occupancy rate***—Occupancy rates continued to recover from the PHE period's lows, reaching 84 percent in October 2024. Many providers reported closing beds and denying admissions due to workforce challenges.
- ***FFS Medicare marginal profit***—In 2023, the FFS Medicare marginal profit (an indicator of whether SNFs with excess capacity have an incentive to treat more Medicare beneficiaries) was 31 percent for freestanding facilities.

***Quality of care***—Quality indicators were stable. In the two-year period from 2022 through 2023, the median facility risk-adjusted rate of discharge to the community from SNFs was 50.9 percent, similar to the rate for the 2021 and 2022 two-year period (50.7 percent). Also in the 2022 and 2023 two-year period, the median facility risk-adjusted rate of potentially preventable readmissions was 10.4 percent, similar to the rate in the 2021 and 2022 period. Staffing levels of registered nurses and nursing staff turnover rates were similarly unchanged. Lack of data on patient experience and concerns about the accuracy of provider-reported function data limit our set of SNF quality measures.

***Providers' access to capital***—The sector continues to be attractive to investors. In the first six months of 2024, there were 144 publicly announced merger and acquisition transactions, on pace for record transaction volume, indicating interest in the sector. In 2023, the all-payer total margin—the percentage of revenue from all payers and all lines of business that is left after accounting for all costs—improved from –1.3 percent in 2022 to 0.4 percent in 2023. Total

margins may be understated, given the complex arrangements many nursing homes have with third parties.

***FFS Medicare payments and providers' costs***—From 2022 through 2023, FFS Medicare payments per day to freestanding SNFs increased 2.4 percent, while cost per day increased 3.8 percent. The FFS Medicare margin for freestanding SNFs was 22 percent in 2023, a slight decline from 23 percent in 2022. These margins are higher than previously reported because we implemented a periodic update to our methodology to account for facility-level and payer-mix differences in the costs of treating Medicare patients. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth. We project a FFS Medicare margin for freestanding SNFs of 23 percent in 2025.

### How should Medicare payment rates change in 2026?

Based on our assessment of the payment-adequacy indicators listed above, Medicare's FFS payment rates need to be reduced to align aggregate payments more closely with aggregate costs. However, some uncertainty remains about the costs associated with new nurse staffing requirements that were recently finalized by CMS (see below). The Commission therefore proposes a modest reduction to the payment rates and recommends that, for fiscal year 2026, the Congress reduce the 2025 base payment rates for skilled nursing facilities by 3 percent.

### Minimum staffing requirement set to begin May 2026

Nurse staffing levels are key to patient outcomes and comprise a high share of SNF costs. In May 2024, CMS issued a final rule revising the staffing requirements for nursing homes that will be implemented in May 2026. We estimate that if the new staffing requirements had been fully implemented in 2024, 30 percent of nursing homes could be exempt from at least one of the staffing hour requirements and 12 percent could be exempt from all the staffing hour requirements. Of the nonexempt facilities, less than one-quarter would meet all the required minimums for hours per resident day under the full effect of the rule. However, the majority of facilities had staffing levels that were within 80 percent or 90 percent of the minimums. That said, those facilities would incur large expenses to meet the staffing requirements. Nonexempt facilities that did not meet applicable requirements tended to have higher FFS Medicare margins compared with other facilities.

## Medicaid trends

As required by the Affordable Care Act of 2010 (ACA), we report on Medicaid use and spending and non–FFS Medicare margins in nursing homes. Almost all SNFs are also long-term care nursing facilities, and Medicaid finances most long-term care services provided in SNFs. Some state programs also cover the SNF copayments for beneficiaries who are dually eligible for Medicare and Medicaid and who stay more than 20 days in a SNF. Between December 2023 and October 2024, the number of Medicaid-certified facilities declined 1.1 percent, to about 14,300 facilities. In 2023, FFS Medicaid spending (federal and state) was $42.5 billion, 5.6 percent more than in 2022. The average non–FFS Medicare margin (which includes all other payers, funds related to the public health emergency, and all lines of business except FFS Medicare SNF services) was –4.1 percent, an improvement from 2022. The improvement reflects the increases in base payment rates made by many states. ■

## Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech–language pathology (SLP) services. SNF patients include those recovering from surgical procedures such as hip and knee replacements or from medical conditions such as infections, stroke, and pneumonia. In 2023, the fee-for-service (FFS) Medicare program and its beneficiaries spent about $30 billion under the SNF prospective payment system (PPS) for 1.6 million FFS Medicare-covered SNF stays. Medicare also paid $2 billion for SNF care provided in hospital swing beds, but most of those stays are not paid under the SNF PPS. (See the text box on skilled nursing facility care provided in swing beds.)

### Medicare coverage and payment

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least three days.[1] To qualify for Medicare coverage, a beneficiary must need daily skilled nursing or rehabilitation services.[2,3] Medicare's SNF PPS pays SNFs for each day of service.[4] For beneficiaries who qualify for SNF care, Medicare pays 100 percent of the daily amount for the first 20 days. Beginning on Day 21, beneficiaries are responsible for copayments through Day 100 of the covered stay; in 2025, the copayment is $209.50 per day. This copayment structure impacts the use of SNF services. Our analysis of claims from 2023 found that the share of stays discharged on Day 20 (3.6 percent) is higher relative to the share discharged on Day 19 (2.5 percent) and Day 21 (2.6 percent). The evidence on whether shorter stays affect patient outcomes is mixed. One study found that stays that were one day shorter were associated with higher readmissions rates, while another found that shorter stays were not associated with worse mortality rates, rates of hospitalization for fall-related injuries, or all-cause hospitalization rates (McGarry et al. 2021, Werner et al. 2019).

FFS Medicare's daily payments to SNFs are determined by adjusting base payment rates for geographic differences in labor costs and for case mix. The case-mix system, the Patient-Driven Payment Model (PDPM), considers the clinical reason for treatment, comorbidities, and functional status at admission in setting payment rates so that providers are paid more to treat medically complex patients who are more costly to treat. Payments are no longer based on minutes of

### Skilled nursing facility care provided in swing beds

With approval from CMS, certain Medicare-certified hospitals may provide skilled nursing services in the hospital beds normally used to provide acute care services. These are called "swing beds," and they are typically located in small rural hospitals and critical access hospitals (CAHs). In 2023, about 4 percent of skilled nursing facility (SNF) care was provided in swing beds. That year, the fee-for-service (FFS) Medicare program paid $2 billion for about 67,000 Medicare-covered swing-bed stays. In 2023, 89 percent of swing-bed stays were in CAHs and 11 percent were in short-term acute care hospitals. SNF-level services of non-CAH swing-bed facilities are paid under the SNF prospective payment system (PPS). The SNF-level services of CAHs with swing beds are exempt from the SNF PPS and are paid based on 101 percent of reasonable costs. Spending on CAH swing beds accounted for 98 percent of program spending on swing beds, owing to the much higher average daily rate (about $2,600 per day) for CAH swing-bed days compared with the average SNF PPS daily rate (about $530 per day) paid for swing-bed days provided in short-term acute care hospitals. Unless otherwise specified, analyses in this chapter do not include swing beds. ■

**TABLE 6–1**

**Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, FFS Medicare stays, and FFS Medicare spending in 2023**

| Type of SNF | Facilities | Medicare-covered stays | Medicare spending |
|---|---|---|---|
| Total | 14,500 | 1,583,000 | $25 billion |
| Freestanding | 97% | 98% | 98% |
| Hospital based | 3 | 2 | 2 |
| Urban | 73 | 85 | 87 |
| Rural | 27 | 15 | 13 |
| For profit | 73 | 75 | 79 |
| Nonprofit | 22 | 22 | 18 |
| Government | 5 | 3 | 3 |

Note: SNF (skilled nursing facility). Components may not sum to 100 percent due to rounding and missing values. Table includes covered stays and program spending in SNFs and does not include swing beds. For swing-bed information, see the text box on p. 187. The facility count differs from the count in Table 6-2 (p. 190) because this table includes only SNFs that billed Medicare for services in 2023.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review file for calendar year 2023.

therapy provided and are calculated using information gathered from a standardized patient assessment instrument called the Minimum Data Set (MDS).

After a dramatic drop in the therapy minutes per stay immediately following the change in the case-mix system on October 1, 2019 (total minutes decreased 23 percent in the first three months), the provision of therapy continued to decrease 9 percent through 2022 (Medicare Payment Advisory Commission 2023). Between 2023 and 2024, therapy minutes per stay stabilized (increasing 0.3 percent). In addition to lowering the amount of therapy provided, providers have an incentive to lower their therapy costs by shifting therapy modalities to group or concurrent therapy (these types are lower cost because multiple patients receive therapy at the same time). These lower-cost modalities can comprise up to 25 percent of total therapy minutes. While the share of individual therapy has declined slightly, it remains the predominant form of provision, making up 93 percent of minutes.

## Skilled nursing facility sector profile

A SNF is a provider that meets Medicare's requirements of participation for Part A coverage of SNF care and agrees to accept Medicare's payment rates. Medicare's requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day; providing PT, OT, and SLP services as delineated in each patient's plan of care; and providing or arranging for physician services 24 hours a day in case of an emergency.

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

Most SNFs (96 percent) are dually certified to provide Medicare Part A–covered SNF care and Medicaid-covered long-term care. FFS Medicare–covered SNF days typically account for a small share of a facility's total patient days. Long-term care services, which are less intensive, typically make up the bulk of a facility's business. Medicaid pays for the majority of this care. In freestanding facilities in 2023, FFS Medicare–covered days made up just 8 percent of facility days in the median facility compared with 63 percent of facility days paid by Medicaid. The share of FFS Medicare-covered days in 2023 declined from 10 percent in 2022, in part due to the continued growth of Medicare Advantage (MA) enrollment and an increase in the share

of Medicaid days. As FFS Medicare's share of covered days declined, so did its share of facility revenue, which fell from 17 percent in 2022 to 14 percent in 2023. (Because of FFS Medicare's relatively high payment rates, the program makes up a larger share of facility revenue than covered days.)

#### SNFs are overwhelmingly freestanding, and the majority are for profit

In 2023, 97 percent of facilities were freestanding, and they accounted for 98 percent of FFS Medicare SNF stays and 98 percent of spending (Table 6-1). Seventy-three percent of providers were for profit. Rural facilities make up the minority of SNFs, SNF stays, and SNF spending. (About 16 percent of FFS SNF users saw a rural provider; data not shown.) About 4 percent of SNF care was provided in swing-bed facilities.

Freestanding SNFs vary in size. In 2023, the median SNF had 100 beds, while 10 percent of facilities had 176 or more beds and 10 percent of facilities had 51 beds or fewer. Nonprofit facilities and rural facilities are generally smaller than for-profit and urban facilities. However, the majority (59 percent) of small facilities (fewer than 50 beds) in 2023 were in urban areas.

The SNF sector is fragmented and characterized by independent providers and regional and local chains. Complex ownership structures can make it difficult to identify common ownership of facilities and to determine the profitability of a SNF and its ancillary businesses and affiliated entities (Harrington et al. 2021). For example, many SNFs have separate companies to operate the facility and to hold the property. This separation protects the nursing home from potential lawsuits and can infuse cash into the business. In late 2022, to better identify common ownership of SNFs, CMS began publicly releasing detailed information on Medicare-certified nursing facilities—including direct and indirect facility owners, changes of ownership, and common ownership across affiliated entities.

Private equity (PE) investment makes up about 5 percent of all facilities, and real estate investment trusts (REITs) make up another 9 percent (Stevenson et al. 2023).[5] This research, as well as work done by others, identified gaps and errors in the ownership data (Chen et al. 2024, Government Accountability Office 2023, Stevenson et al. 2023). In November 2023, CMS issued a final rule defining PE and REIT ownership and requiring nursing facilities to disclose information about entities with operational, financial, or managerial control, including whether they are PE or REIT investors (Centers for Medicare & Medicaid Services 2023b). Providers will be required to furnish this information when initially enrolling or revalidating their enrollment (required every five years) and when there are changes in their ownership information. To improve the accuracy of ownership and third-party information, CMS required all SNFs to revalidate this information by May 1, 2025 (Centers for Medicare & Medicaid Services 2024d).

## Are FFS Medicare payments adequate in 2025?

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, FFS Medicare payments in relation to costs to treat Medicare beneficiaries, and the relationship between Medicare's payments and SNFs' costs. Overall, our indicators of payment adequacy were positive.

### Beneficiaries' access to care: SNF supply and utilization declined while occupancy rates increased

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

#### SNF supply declined slightly in 2024 but reflected factors other than the adequacy of Medicare's payments

In the first nine months of 2024, the number of SNFs and swing beds participating in the Medicare program declined 1.2 percent from 2023 to 14,600 (Table 6-2, p. 190). Note that providers that stop participating in the program (either voluntarily or due to termination by Medicare) have not necessarily closed. No longer participating in the program could indicate that the facility was purchased by another entity and has a new provider number or that the facility remained open

**TABLE 6–2**

**Supply of SNFs continued to decline in 2024**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Count of Medicare-participating SNFs | 15,150 | 15,100 | 14,950 | 14,800 | 14,600 |
| Percent change from prior year | | –0.5% | –0.9% | –1.0 | –1.2 |

Note: SNF (skilled nursing facility). The figure for 2024 was calculated through October; it does not include data from the full calendar year. Counts include active providers serving Medicare beneficiaries in the calendar year for Medicare-certified SNFs in the 50 states and the District of Columbia. Counts do not include nursing facilities that are not Medicare certified. Percent changes were calculated on unrounded data.

Source: MedPAC analysis of active provider counts from CMS's Quality, Certification and Oversight Reports, accessed on October 3, 2024.

but stopped accepting Medicare patients (to become a nursing facility for long-stay residents only).

Since 2021, the year-to-year declines have been fairly consistent and are likely related to several factors that lowered utilization, such as states shifting to more home- and community-based long-term care, staffing difficulties that limit how many beds can remain open, reportedly low Medicaid payment rates for long-term care, and patient preference for receiving care in non-SNF settings when possible. Interestingly, the rate of closures during the pandemic did not increase, in part due to strategies that providers took to dampen the impact of staffing shortages (such as freezing admissions and closing beds) and additional government funds related to the public health emergency (such as the Provider Relief Fund) (Assistant Secretary for Planning and Evaluation 2024). Because Medicare constitutes a small share of most SNFs' businesses and its payment rates are high relative to the cost of care (see p. 201), the closures do not reflect the adequacy of Medicare's payments.

Of the 16 new facilities, one-third were nonprofit. Of 71 terminations as of October 2024, three-quarters were for-profit facilities, and all but 11 closed at their own initiative (i.e., they were not terminated by the program). The number of terminations decreased from 2023 to 2024.

In 2023, 88 percent of Medicare beneficiaries with Part A coverage lived in counties with three or more SNFs or swing-bed facilities and 5.9 percent of beneficiaries lived in counties with no or only one SNF or swing-bed facility, similar to the share in 2022 (5.8 percent). However, the presence of a facility alone does not ensure access. Beneficiaries who live in areas with very high occupancy rates may have a harder time accessing SNF care close to home. As of July 2024, about 9 percent of beneficiaries lived in a county where the average SNF occupancy rate was greater than 90 percent. About 48 percent lived in a county where the average SNF occupancy rate was between 80 percent and 90 percent, and 41 percent lived in a county where the average SNF occupancy rate was lower than 80 percent. Even if a facility has an available bed, some beneficiaries may encounter access problems if they need specialized services or long-term care, as discussed below.

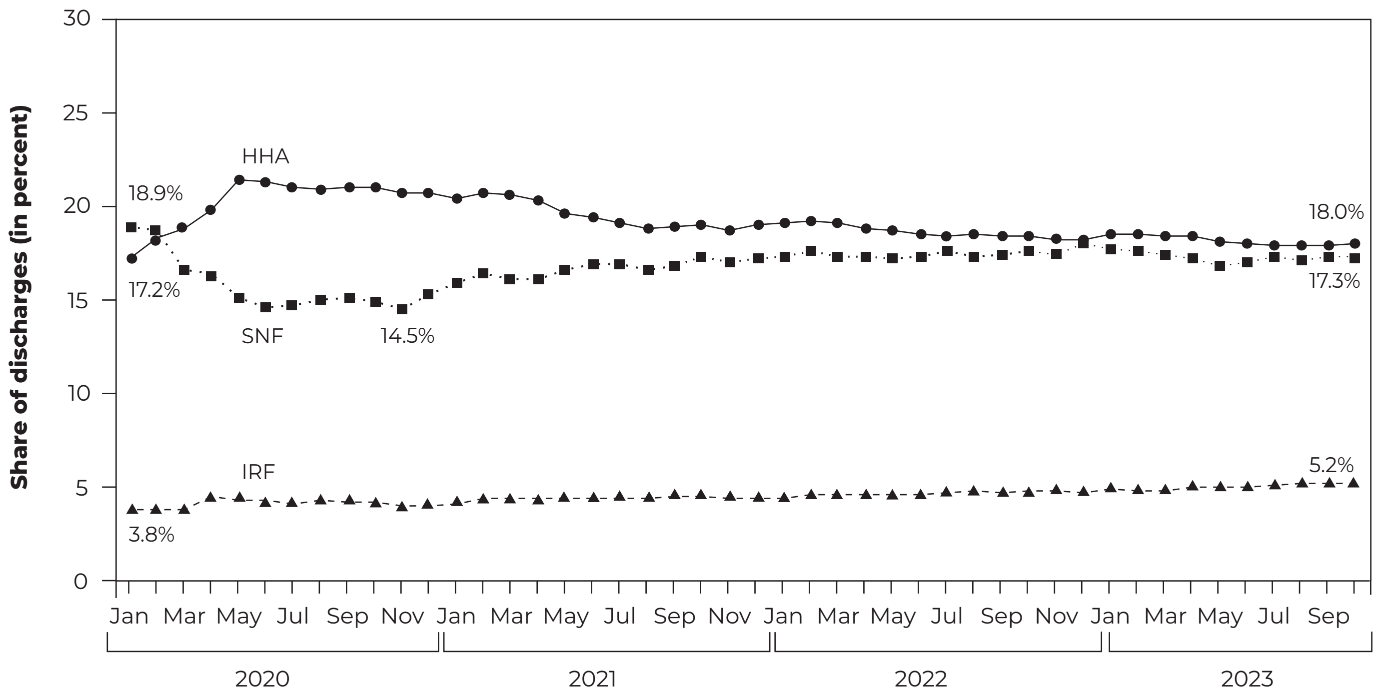
When a SNF terminates participation in the Medicare program, access could be affected if beneficiaries must travel long distances to another facility. As of November 2024, among SNFs that terminated participation in Medicare between 2019 and 2024, the median travel distance for facilities that closed in metropolitan areas (2.0 miles) was similar to the median distance for those that closed in rural areas (2.5 miles).[6] However, the mean travel distances varied more (less than three miles for urban closures compared with eight miles for rural closures), indicating long travel distances for some beneficiaries living in rural areas.

### The rate of SNF use after an inpatient discharge stabilized in 2023 at below prepandemic level

In January 2020, immediately before the pandemic, SNFs were the most common first post-acute care (PAC) destination after discharge from an inpatient

FIGURE 6–1

**Monthly share of IPPS discharges to SNFs, home health services, and IRFs, January 2020 to October 2023**




Note: HHA (home health agency), IPPS (inpatient prospective payment systems), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility).

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

hospital stay, accounting for 46 percent of all FFS discharges to a PAC destination (data not shown), or 18.9 percent of all FFS discharges (Figure 6-1). During the pandemic, the SNF share of all FFS discharges dropped to 14.5 percent as the number of inpatient discharges declined and beneficiaries avoided nursing homes. During 2021, SNFs slowly regained some of the lost volume, but since 2022, the share has remained fairly stable at around 17 percent—below the prepandemic level.

### SNF occupancy had mostly recovered to prepandemic levels as of October 2024

Before the public health emergency (PHE), between 2010 and 2019, median occupancy rates for freestanding SNFs were declining—from 88 percent to 85 percent (based on cost-report data). Occupancy rates also varied by state. Nationally, average occupancy fell during the coronavirus pandemic due to death, move-outs, and avoidance of the setting. SNF occupancy hit its lowest point in January 2021, when the median occupancy rate was 69 percent. Since then, occupancy rates have increased to about where they were before the PHE. In October 2024, the median national SNF occupancy rate was 84 percent; one-quarter of SNFs had greater than 92 percent occupancy, and one-quarter of SNFs had occupancy rates of 71 percent or less.

### SNF employment remained below prepandemic levels but showed gains through November 2024

As occupancy declined in 2020 and 2021, the number of SNF employees also fell steeply. According to the Bureau of Labor Statistics, between March 2020 and a PHE-low in March 2022, the number of employees in the SNF sector declined nearly 15 percent (Bureau of Labor Statistics 2024). Overall employment in the sector has been growing since the second quarter of

**TABLE 6–3**

**SNF admissions and days in 2023**

| Volume measure | 2019 | 2020 | 2021 | 2022 | 2023 | Change 2019–2023 | Change 2022–2023 |
|---|---|---|---|---|---|---|---|
| Covered admissions per 1,000 FFS beneficiaries | 55 | 50 | 49 | 54 | 47 | –14% | –12% |
| Covered days per 1,000 FFS beneficiaries | 1,447 | 1,429 | 1,361 | 1,500 | 1,385 | –4 | –8 |
| Covered days per admission | 26.1 | 28.5 | 28.0 | 28.0 | 29.0 | 12 | 5 |

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

Source: MedPAC analysis of 2019–2023 Medicare Provider Analysis and Review and Common Medicare Environment data.

2022, but in November 2024 it remained 7 percent lower than in March 2020.

While we do not have empirical data on the extent to which staffing shortages may have constrained access to SNF care, the industry reports that inadequate staffing levels have limited access for prospective residents. An industry-sponsored survey of 411 providers reported in March 2024 that about half of those surveyed had turned away potential residents and 19 percent had closed a unit, wing, or floor (American Health Care Association 2024). Hospitals have reported delays in transferring patients to SNFs, raising lengths of stays in acute care (Siddiqi 2024).

### SNF admissions and days decreased in 2023

SNF use among FFS Medicare beneficiaries was in decline for years prior to the pandemic. Between 2010 and 2019, covered admissions per FFS beneficiary fell 18.5 percent, and covered days fell 25.2 percent (Medicare Payment Advisory Commission 2021b). Several factors likely contributed to this decline, including a contemporaneous reduction in the inpatient hospital stays needed to qualify for SNF coverage. Although we did not quantify the extent of this effect on overall FFS Medicare SNF use, the proliferation of alternative payment models may have also contributed, either directly or through spillover effects.[7]

During the first two years of the pandemic (2020 and 2021), SNF use per FFS beneficiary declined sharply (Table 6-3). Between 2019 and 2021, admissions per FFS beneficiary fell 11 percent and days per FFS beneficiary fell 6 percent. Because hospital capacity was constrained during the pandemic, volume reductions might have been even steeper absent the PHE-related policy that waived the three-day-stay requirement for SNF coverage. (During the PHE, the three-day inpatient stay required for Medicare-covered SNF admissions was suspended, allowing SNFs to admit beneficiaries and to "skill in place" nursing home residents who did not have a prior hospital stay.) The following year (in 2022), SNF admissions and covered days per 1,000 FFS beneficiaries increased.

Between 2022 and 2023, FFS days and admissions dropped by over 10 percent. On a per FFS beneficiary basis, SNF admissions and days were down 12 percent and 8 percent, respectively (Table 6-3). Much of the decline is likely due to the expiration of the three-day hospital-stay waiver in May 2023. PHE-waiver admissions without a COVID-19 diagnosis accounted for approximately 15 percent of all SNF stays throughout the entire PHE (Avalere 2024). Because admissions per 1,000 FFS beneficiaries decreased more than the decline in days, the covered days per admission rose 5 percent. We will continue to monitor length of stay to see whether the lower levels of utilization persist.

We previously reported on differences across beneficiary subgroups in the use of SNFs. Black beneficiaries, Hispanic beneficiaries, and beneficiaries dually eligible for Medicare and Medicaid are less likely to use high-quality SNFs and facilities that specialize in

post-acute skilled care (as opposed to long-term care services) (Medicare Payment Advisory Commission 2024). Increased specialization in skilled care may exacerbate existing racial and economic disparities in access to high-quality SNF care (Werner et al. 2021). Clinical characteristics can also shape a beneficiary's access to specialized SNF care. One study found that facilities with higher shares of Medicare patients were more likely to have the resources needed to treat obese patients, indicating that access to these specialized services is uneven across facilities (Orewa et al. 2024). Another study found that short-stay beneficiaries with Alzheimer's disease and related dementias were less likely to be admitted to higher-quality SNFs compared with beneficiaries without these conditions (Kosar et al. 2023).

Over the coming year, we plan to examine SNF use by MA enrollees. Although we have not analyzed utilization management data from MA plans, interviews with hospital discharge planners and trade press articles suggest that MA plans use prior authorization and denials to manage admissions and length of stay.

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

Another component of access is whether providers have a financial incentive to expand the number of FFS Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to FFS Medicare patients. (Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., rent).) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional FFS beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional FFS beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

In 2023, the FFS Medicare marginal profit among freestanding SNFs was 31 percent, indicating that facilities with available beds had a strong incentive to admit Medicare patients. This high marginal profit is a strong positive indicator of beneficiary access to SNF care. FFS Medicare is a preferred payer in this sector, although some SNFs that specialize in Medicare patients may avoid FFS Medicare beneficiaries who are likely to require long stays and exhaust their Medicare benefits.

### Quality of care: All measures were stable but varied across facilities

We report two claims-based outcome measures for SNFs (risk-adjusted potentially preventable hospital readmissions after discharge and risk-adjusted discharge to the community) and two measures of staffing (risk-adjusted registered nurse hours per resident day and total nurse staffing turnover rates).

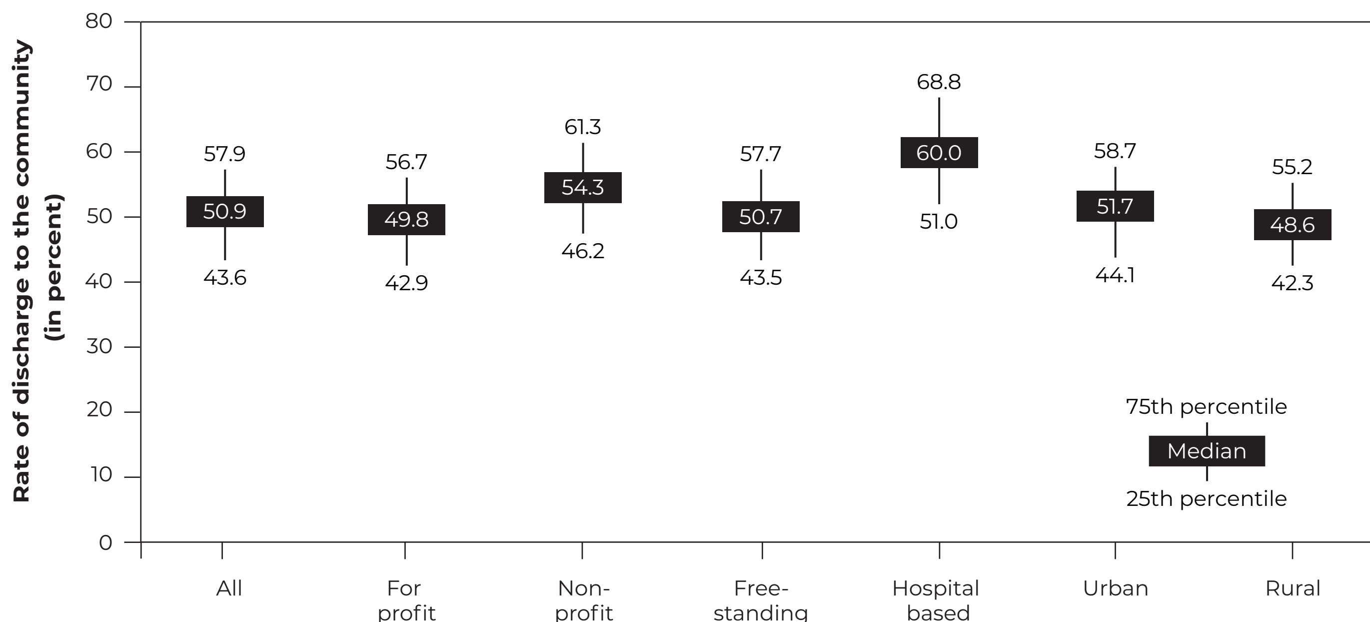
#### Discharge to the community

The measure of discharge to the community is a SNF's risk-adjusted rate of FFS Medicare residents who are discharged to the community after a SNF stay, do not have an unplanned readmission to an acute care hospital or long-term care hospital in the 31 days following discharge to the community, and remain alive during those 31 days (higher rates are better) (RAND Corporation and RTI International 2019).[8] Baseline nursing facility residents—those who were nursing facility residents before their Part A–covered SNF stay—are excluded from the measure because discharge to the community may not be a safe or expected outcome for these patients (RAND Corporation and RTI International 2019). SNFs can improve their rate of discharge to the community by providing recuperative nursing care, rehabilitation to improve functional ability, discharge planning care and coordination, and patient and family education.

In fiscal year (FY) 2022 and FY 2023 (combined), the national average observed rate of discharge to the community was 45 percent, and the median facility risk-adjusted rate of discharge to the community was 50.9 percent. The risk-adjusted rate has been fairly stable over time. The most recent result is similar to the FY 2021 and FY 2022 period (when it was 50.7 percent), but both rates are slightly worse than the rate for the FY 2018 and FY 2019 period, when it was 51.7 percent. In FY 2022 and FY 2023, one-quarter of facilities had a risk-adjusted rate below 43.6 percent and one-quarter had a rate above 57.9 percent (Figure 6-2, p. 194). Median rates varied considerably by

**FIGURE 6–2**

**Median and interquartile range of SNFs' risk-adjusted rates of discharge to the community in FY 2022 and FY 2023**




Note: SNF (skilled nursing facility), FY (fiscal year). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (FY 2022 and FY 2023 combined). The measure of "discharge to the community" is a SNF's risk-adjusted rate of FFS Medicare residents who were discharged to the community after a SNF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. Rates are computed from Medicare claims for eligible Medicare Part A–covered SNF stays and do not include swing-bed stays. Providers with fewer than 25 cases and missing data were excluded, and the analysis includes 12,063 providers.

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

ownership, facility type, location, and size. Nonprofit SNFs and hospital-based SNFs had higher (better) rates than for-profit SNFs and freestanding SNFs. Urban facilities had higher rates than rural facilities, and very rural SNFs (rural nonmicropolitan) had still lower rates (46.7 percent; data not shown). Smaller facilities had higher rates than larger facilities, reflecting their relatively large shares of hospital-based SNFs, urban SNFs, and nonprofit SNFs (data not shown). The within-group variation in rates was consistent across groups (about a 1.3-fold difference between the 25th percentile and 75th percentile).

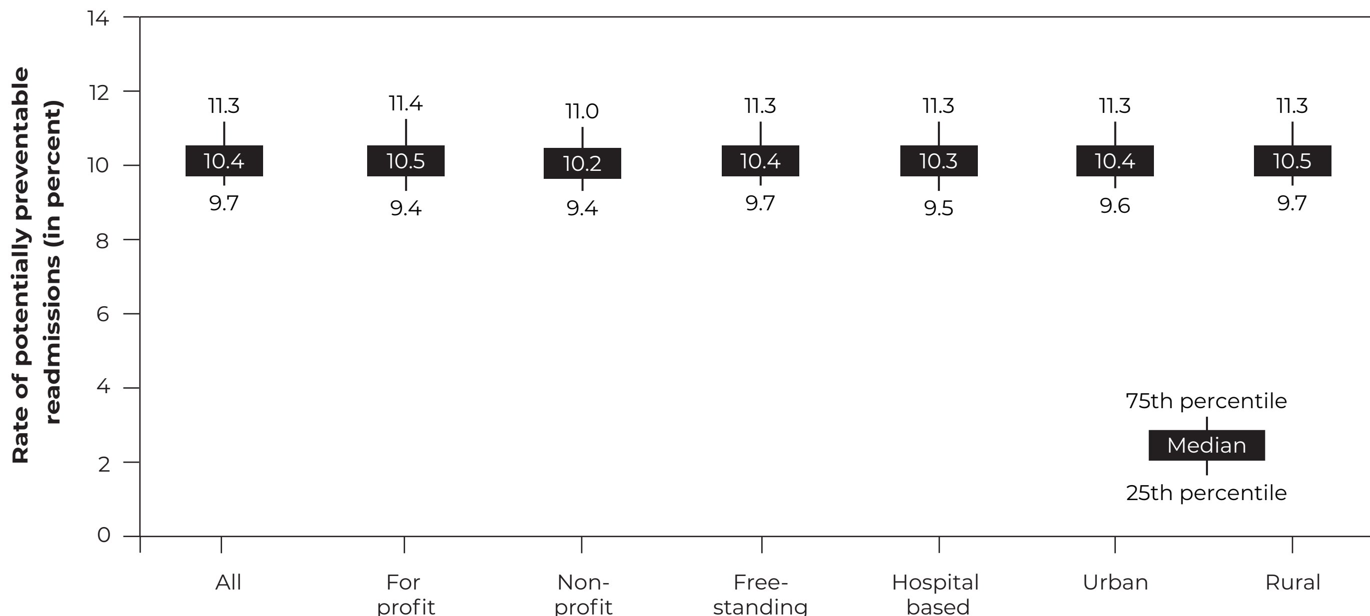
### Potentially preventable readmissions

Potentially preventable readmissions after discharge from the SNF are calculated as the percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented (lower percentages are better) (RTI International 2016). A SNF can reduce the number of potentially preventable hospital readmissions by preventing complications, providing clear discharge instructions to patients and families, and ensuring a safe discharge plan.

During the FY 2022 and FY 2023 period, the national average observed rate of potentially preventable readmissions was 10.3 percent, similar to the FY 2021 and FY 2022 period when it was 10.4 percent (data not shown). The median facility-level risk-adjusted rate of potentially preventable readmissions was 10.4 percent (Figure 6-3). One-quarter of facilities had rates below 9.7 percent and one-quarter had rates above 11.3 percent. This rate was the same as for the FY 2021 and FY 2022 period (data not shown).[9] The differences in

FIGURE 6–3

**Median and interquartile range of SNFs' risk-adjusted rates of potentially preventable readmissions in FY 2022 and FY 2023**




Note: SNF (skilled nursing facility), FY (fiscal year). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (FY 2022 and FY 2023 combined). The measure of "potentially preventable readmissions" after discharge from the SNF is calculated as the risk-adjusted percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Rates are computed from Medicare claims for eligible Medicare Part A–covered SNF stays and do not include swing-bed stays. Providers with fewer than 25 cases and missing data were excluded, and the analysis includes 12,063 providers.

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

the median rates were small across ownership, facility type, location, and SNF size (data on size is not shown). The across-group and the within-group variations were relatively small.

In addition to potentially preventable readmissions after the SNF stay, readmissions that occur during the stay are an important gauge of the care SNFs provide. In fiscal year 2028, CMS will include potentially preventable readmissions that occur any time within the entire SNF stay as a performance measure in the SNF value-based purchasing (VBP) program (see text box on the SNF VBP program, p. 198). This measure will replace the rate of all-cause readmissions within 30 days of admission to the SNF that is included in the current VBP. When these new data become available, we will report the rates of readmission during the entire SNF stay.[10]

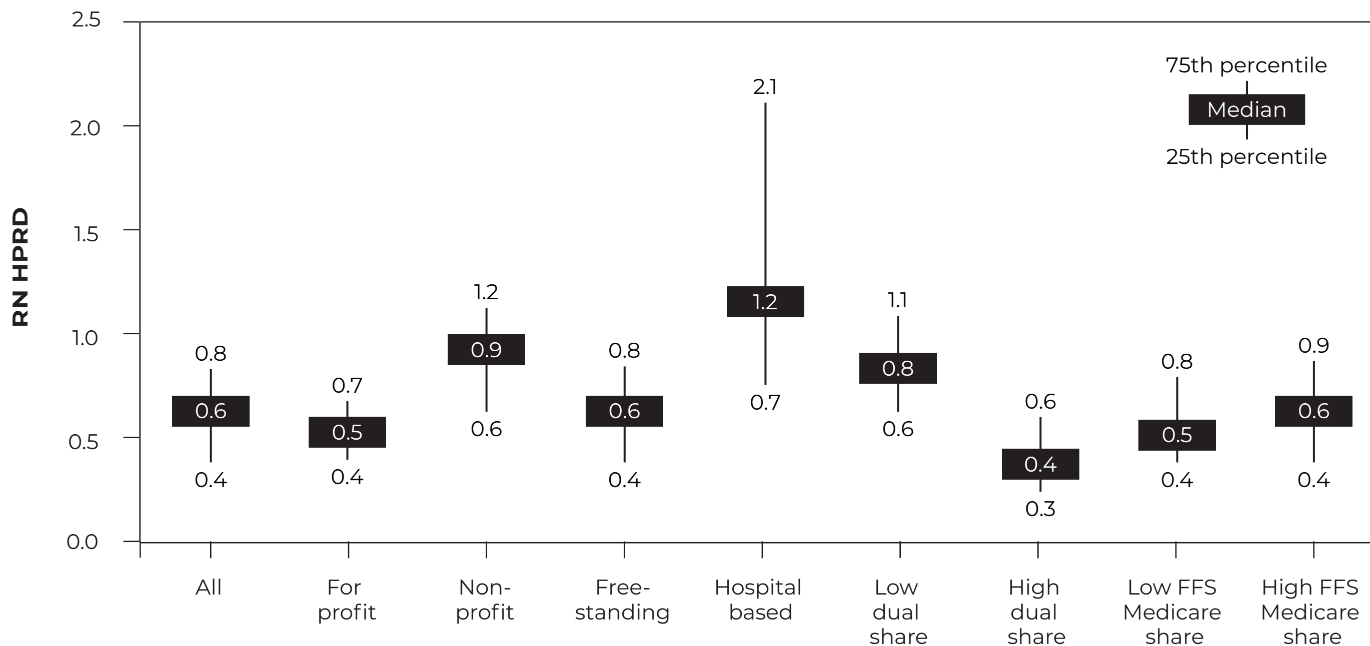
Readmissions and discharge to the community measures assess key outcomes of SNF care, but they do not capture all aspects of quality in SNFs. Ideally, we could also measure other outcomes and the experience of SNF care for Medicare beneficiaries in a Part A stay. However, lack of data on patient experience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

### Staffing measures

While the Commission has long tracked the quality of care using outcome measures, more recently it expanded its focus to include staffing measures because staffing plays a key role in shaping the quality of care in nursing homes and SNFs. The National Academies of Sciences concluded that the number and

FIGURE 6–4

**SNFs' median and interquartile range of acuity-adjusted RN hours per resident day by facility characteristics, 2023**




Note: SNF (skilled nursing facility), RN (registered nurse), HPRD (hours per resident day), FFS (fee-for-service). "Low dual share" is the bottom quartile of the fully and partially dual-eligible beneficiary share of FFS Medicare stays, and "high dual share" is the top quartile of the fully and partially dual-eligible beneficiary share of FFS Medicare days. "Low FFS Medicare share" is the bottom quartile of FFS Medicare beneficiary share of total facility days, and "high FFS Medicare share" is the top quartile of FFS Medicare beneficiary share of total facility days. Staffing ratios for the year are determined by averaging the quarterly values of the calendar year for each provider. All Medicare- and Medicare/Medicaid–certified SNFs with valid data are included.

Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's Provider Data Catalog, Medicare freestanding SNF cost reports, and CMS Common Medicare Environment.

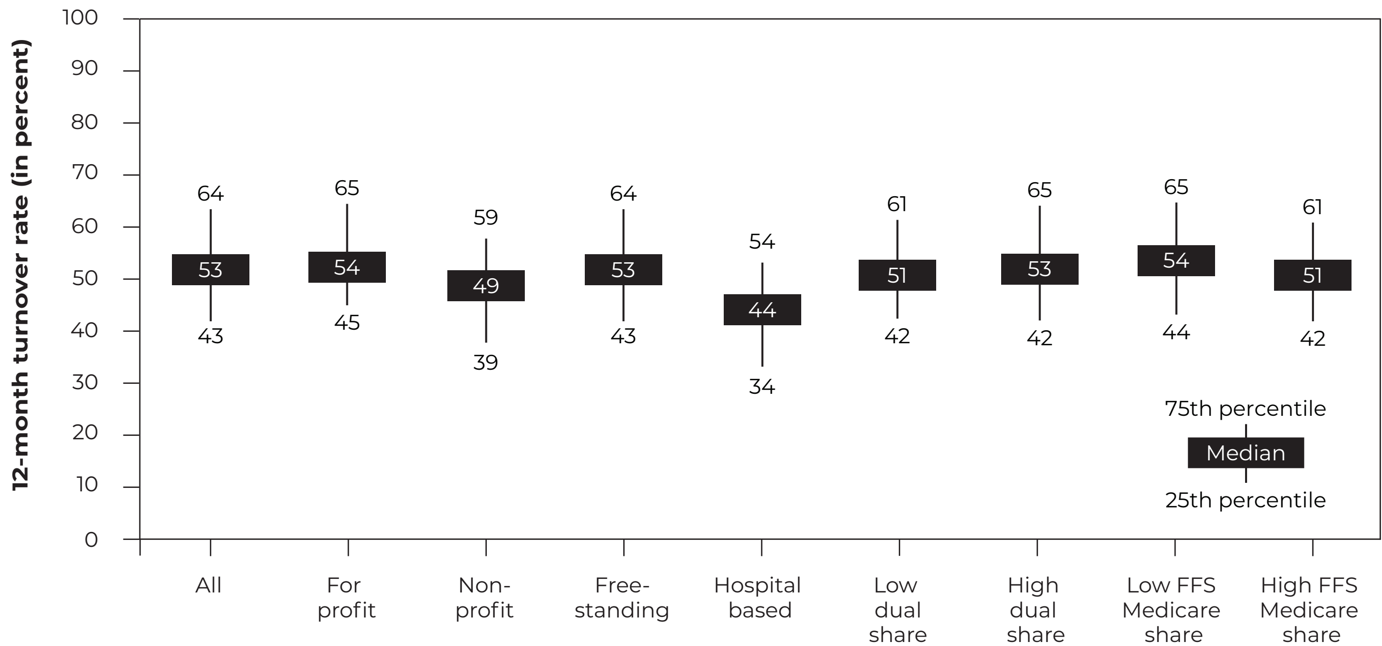
continuity of staff can impact quality of life and patient safety in a SNF (National Academies of Sciences 2022). We previously summarized the literature concluding that having more registered nurses (RNs) per resident day has been associated with better outcomes and lower staff turnover rates (Medicare Payment Advisory Commission 2024). In their review of the literature in a report to CMS, researchers at Abt Associates noted that the higher staffing levels were associated with fewer pressure ulcers, emergency department visits, and rehospitalizations (White and Olsho 2023).

We examined two staffing measures that researchers found are related to nursing home quality: the level of RN staffing and total staff turnover (Clemens et al. 2021, Gorges and Konetzka 2020, Kennedy et al. 2020, Mukamel et al. 2022). Although nursing facility staffing ratios and turnover rates refer to the entire facility (not just to Medicare-covered stays), these broad measures are likely to reflect the care beneficiaries receive during Medicare-covered stays. Many nursing homes (those with beds that are dually certified for Medicare and Medicaid) can use their beds interchangeably for long-stay residents and short-stay patients, and indeed, many beneficiaries switch between Medicare-covered PAC and long-term care covered by other payers.

In 2023, the median SNF provided 0.6 case-mix-adjusted RN hours per resident day (HPRD) (Figure 6-4). Freestanding SNFs had lower median case-mix-

FIGURE 6–5

**SNFs' median and interquartile range of acuity-adjusted total nursing staff 12-month turnover rates by facility characteristics, 2023**




Note: SNF (skilled nursing facility), RN (registered nurse), FFS (fee-for-service). "Low dual share" is the bottom quartile of the fully and partially dual-eligible beneficiary share of FFS Medicare stays, and "high dual share" is the top quartile of the fully and partially dual-eligible beneficiary share of FFS Medicare days. "Low FFS Medicare share" is the bottom quartile of FFS Medicare beneficiary share of total facility days, and "high FFS Medicare share" is the top quartile of FFS Medicare beneficiary share of total facility days. Staffing ratios for the year are determined by averaging the quarterly values of the calendar year for each provider. All Medicare- and Medicare/Medicaid–certified SNFs with valid data are included.

Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's Provider Data Catalog, Medicare freestanding SNF cost reports, and CMS Common Medicare Environment.

adjusted RN staffing (0.6 HPRD) than hospital-based SNFs (1.2 HPRD), and for-profit SNFs (0.5 HPRD) had lower median case-mix-adjusted RN staffing than nonprofit SNFs (0.9 HPRD) and government SNFs (0.7 HPRD). Metropolitan facilities (0.6 HPRD) had case-mix-adjusted RN staffing similar to that at very rural facilities (defined as "rural nonadjacent," 0.7 HPRD) (data not shown). The HPRD for facilities with low shares of dually eligible beneficiaries was double that for facilities with high shares (0.8 HPRD compared with 0.4 HPRD). Facilities with high Medicare shares had higher HPRD than facilities with low shares, but the differences were smaller. Although the staffing ratios are adjusted for acuity, some of the differences we observe could nevertheless reflect the mix of long-stay residents and short-stay PAC patients in a facility and unmeasured differences in case mix.

The 12-month nursing staff turnover rate as of 2023 was 53 percent for the median SNF, and one-quarter of facilities had turnover rates greater than 64 percent (Figure 6-5).[11] A facility can have a high turnover rate because it has very high turnover for select positions (but otherwise relatively stable staffing) or high turnover facility-wide. For-profit SNFs and freestanding SNFs had higher turnover rates compared with nonprofit SNFs and hospital-based SNFs. Urban facilities (53 percent) had turnover rates similar to rates at very rural facilities (51 percent), although RN-specific turnover was higher in urban facilities (51 percent) than in very rural facilities (44 percent) (data not shown).

## The SNF value-based purchasing program

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

In response to congressional action, CMS has made substantial revisions to the program. It expands the measure set from one (hospital readmissions) to a total of eight by fiscal year (FY) 2027 (Centers for Medicare & Medicaid Services 2024c). In FY 2026, the first three measures will be added: infections requiring hospitalization, total nurse staffing per resident day, and staff turnover rates. In FY 2027, four more measures will be added: discharge to community, the percentage of long-stay residents who have a fall with major injury, discharge function score for SNF patients, and hospitalizations per 1,000 long-stay residents. In FY 2028, CMS will replace the 30-day all-cause readmission rate with a within-stay potentially preventable readmission measure. To improve measure reliability, CMS established minimum case counts for a minimum number of measures. In FY 2026, when there will be four measures in the program, providers will be required to meet the minimum counts for two of them. In FY 2027, providers will have to meet the minimum counts for four of the eight measures. In addition, CMS extended the performance period to two years for two measures.

Beginning in FY 2027, the VBP program will include a health-equity adjustment that will increase VBP payments for SNFs that provide high-quality care and services for high proportions of dually eligible beneficiaries. The adjustment will vary depending on the number of measures for which the SNF has top performance and on its share of dually eligible beneficiaries.

The changes made to the program broadly address three of the concerns the Commission previously raised about the program—the program should score a small set of performance measures (not just one), incorporate strategies to ensure reliable measure results, and account for differences in patient social risk factors using a peer-grouping mechanism (Medicare Payment Advisory Commission 2021a). The Commission identified two other shortcomings: The design may not encourage all providers to improve, and the entire provider-funded incentive pool should be budget neutral and paid out each year. These provisions are in statute and require congressional action to change. ■

Differences were small between facilities with high and low shares of dually eligible beneficiaries and between high and low shares of FFS Medicare beneficiaries.

### CMS will implement new minimum staffing requirements beginning in May 2026

In May 2024, CMS finalized rules that revise the current staffing requirements for nursing homes, adding new minimums and making current RN requirements stricter (Centers for Medicare & Medicaid Services 2024b). The new requirements will be phased in over time, with urban facilities beginning in May 2026 and rural facilities beginning in 2027.[12] The Commission has not taken a position on the staffing rule. We examine current staffing levels relative to the staffing rule (p. 209).

#### Patient-experience data are not collected for SNF patients

The Medicare program does not collect data on beneficiaries' experience of their SNF care or their informal primary caregivers' experiences with SNFs. In 2021, the Commission recommended that the Secretary finalize patient-experience measures for SNFs and begin to report them. The Commission also noted that such measures should become part of the measure set for the SNF value incentive program (see text box on the SNF VBP program) (Medicare Payment Advisory Commission 2021a). In the SNF proposed rule for 2024, CMS proposed adopting a patient-experience survey but opted not to implement this provision (Centers for Medicare & Medicaid Services 2023c). In 2025, CMS requests information on patient-experience measures and stated it would consider the comments in future measure development (Centers for Medicare & Medicaid Services 2024c).

#### Patient function is a key SNF outcome, but the accuracy of the data needs to be validated

Maintaining and improving patients' function is a key outcome of post-acute care. SNFs assess and record information on each beneficiary's level of function at admission to and discharge from a SNF using the MDS. However, because provider-reported function data are used to assign patients to case-mix groups to adjust payment, the Commission has raised concerns about the validity of PAC function data. As we noted in our June 2019 report to the Congress, PAC providers' recording of functional-assessment information, such as change in mobility, appears to be influenced by incentives in the applicable payment systems (Medicare Payment Advisory Commission 2019). Thus, in our 2021 recommendations for an alternative quality incentive program, the Commission noted that provider-reported patient-assessment information (such as functional status) should not be included until CMS has a process in place to regularly validate these data (Medicare Payment Advisory Commission 2021a).

In FY 2024, CMS finalized its approach to validating the MDS information used in the value-based purchasing program: randomly selecting up to 1,500 SNFs on an annual basis and requesting up to 10 randomly selected medical records from each. In the FY 2025 final rule, CMS adopted the same approach to validate the MDS data used in the SNF Quality Reporting Program. To decrease the reporting burden on providers, the same records would be used for both purposes. The validation process will begin in FY 2027; for providers that do not submit the requested information within the specified timeframe, CMS will lower the market basket update by 2 percentage points.

### Providers' access to capital remains adequate

Access to capital allows SNFs to maintain, modernize, and expand their facilities. The vast majority of SNFs are part of nursing facilities. Therefore, in assessing SNFs' access to capital, we look at the availability of capital for the entire facility. Because Medicare makes up a minority share of most SNFs' revenue, access to capital generally reflects factors other than the adequacy of Medicare's payments, such as the adequacy of Medicaid payment rates.

Capital in this sector is less likely to finance new construction than to update facilities or finance purchases of existing facilities because of state certificate-of-need (CON) laws that limit bed supply. Currently, 35 states and the District of Columbia maintain some form of CON program (National Conference of State Legislatures 2024). At least 13 states have a moratorium, most commonly for long-term care providers, on certain activities and capital expenditures, such as expanding the number of long-term-care beds in a facility.

Each year, Irving Levin Associates produces data and commentary on the volume of SNF transactions and the price per bed. These indicators provide information on buyer interest and their willingness to invest in the sector. After a record-high average price per bed in 2022 ($114,200), prices dropped over 14 percent in 2023 to $97,700, though these were still higher than prepandemic levels (Irving Levin Associates LLC 2024c).[13] Prices dipped for three reasons: More distressed assets entered the market, there were fewer high-priced facilities for sale, and financing was more difficult (Irving Levin Associates LLC 2024c).

The first six months of 2024 saw a significant increase in the number of transactions (144 between January and June 2024, compared with 81 in all of 2023), indicating that the market is strong (Irving Levin Associates LLC 2024a, Irving Levin Associates LLC 2024c). This growth partly reflects smaller deals because financing

large transactions has become more difficult (Irving Levin Associates LLC 2024b). SNFs continue to offer attractive yields to investors, especially when considering the additional sources of revenue from other businesses (such as hospice) and incentives to grow one's patient population. Low-performing assets may offer even more opportunity because a new owner may be able to expand referrals and improve payer mix, efficiencies, and case-mix coding (Irving Levin Associates LLC 2024a). For example, in 2024 the Ensign Group, the PACS group, and CareTrust REIT continued to expand their portfolios (CareTrust REIT 2024, Ensign Group 2024, PACS Group Inc. 2024). The Ensign Group reported that it will continue to expand in new states and in states where it already has holdings. Also potentially affecting industry transactions are allegations of questionable practices, which could affect a company's performance and slow its expansion if investors shy away or penalties are levied (Business Wire 2024, Hindenburg Research 2024).

It remains to be seen how the staffing rule, if it is implemented, will affect SNFs' access to capital (see section on the staffing rule, p. 209). According to a poll of dealmakers conducted by Senior Care Investor, when asked how the staffing rule would impact lenders' ability to lend for SNFs, 64 percent said they would be "somewhat" impacted, 15 percent said "not at all," and 21 percent said "significantly" (Irving Levin Associates LLC 2024d).

The Department of Housing and Urban Development (HUD) is an important lending source for this sector. Section 232 loans help finance SNFs by providing lenders with protection against losses if borrowers default on their mortgage loans. In FY 2024, HUD financed 220 projects, an increase from 196 projects in 2023 (Department of Housing and Urban Development 2024, Department of Housing and Urban Development 2023). The total HUD-insured amount in 2024 was $3.2 billion, compared with $2.9 billion in 2023. Though the projects and insured amounts increased from last year, both are down about 30 percent since 2020. A minority of facilities access capital via private equity, as discussed above, in addition to HUD and commercial bank loans (ATI Advisory 2022).

The SNF sector remains attractive for investors because demand is expected to increase from an aging population and the setting's relatively low costs compared with other institutional PAC such as inpatient rehabilitation facilities. Recent increases in hiring have improved occupancy rates; many Medicaid programs have increased rates (see section on Medicaid, p. 213); and, for providers that borrowed or are considering borrowing, interest rates were lowered in September 2024. Any reluctance to invest in this setting does not reflect the adequacy of Medicare's FFS SNF payments: Medicare remains a preferred payer in this sector.

#### All-payer total margins rose in 2023

In 2023, the estimated all-payer total margin for freestanding SNFs (reflecting all lines of business, all payers, and investment income) was 0.4 percent, up from –1.3 percent in 2022. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) In 2023, 47 percent of SNFs had negative all-payer total margins, down from 51 percent in 2022. PHE-related provider relief funds were reported in 2022, though the amounts in aggregate were about half of what they were in 2020 and 2021, contributing to the reduced all-payer total margin. These relief funds continued through part of 2023, though the aggregate amount dropped by over 50 percent compared with 2022. Provider relief funds were about a quarter of their 2022 peak. Without these additional funds, the all-payer total margin would have been about –3.7 percent in 2022 and about –0.6 percent in 2023.

Because the all-payer total margin includes Medicaid-funded long-term care, state policies regarding the level of Medicaid payments, including base rates and supplemental payments, significantly affect the overall financial performance of this setting. A 2023 Medicaid and CHIP Payment and Access Commission study found that nursing facility profitability under Medicaid varies by facility and across and within states and that the 2019 median base payments (that exclude other supplemental payments from Medicaid) covered 86 percent of costs (Medicaid and CHIP Payment and Access Commission 2023). The continued expansion of enrollment in MA, with its lower payment rates, also factors into the total margin. One study of payments and costs from 2017 through 2019 found that as MA penetration in a county increased, the average total

margin of SNFs in the county decreased (Marr and Shen 2024).

The lack of transparency in reporting of third-party transactions and related entities makes it difficult to know if we are accurately assessing the finances of nursing facilities. Nationally, over three-quarters of nursing facilities reported payments to related third parties (including real estate companies, management companies, pharmacies, and medical supply companies) (Harrington et al. 2024). One study of nursing facilities in Illinois (a state that requires detailed financial reporting) examined costs before and after nursing facilities entered into a related-party agreement (Gandhi and Olenski 2024). The study found that facilities' costs increased due to inflated sales-leaseback agreements and costly management fees owed to the related-party entity. After reestimating nursing home profits based on what costs would have been without the inflated costs, it found that the reported profits were only 32 percent of actual industry profits—that is, 68 percent of the actual profits were "hidden" in inflated costs.

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

**Higher FFS Medicare payment rates could create undesirable incentives** The differential between Medicare's payment rates and those of other payers, such as Medicaid, encourages providers to select patients based on payer source. It also encourages providers to rehospitalize facility residents who are dually eligible (i.e., enrolled in both Medicare and Medicaid) to qualify them for a Medicare-covered SNF stay at a higher payment rate, and it encourages providers to extend the length of a Medicare-covered SNF stay to receive additional payment. Disparities in the use of SNFs could be exacerbated if Medicare rates were increased, thereby widening the differential between Medicare and Medicaid rates.

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

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

## Medicare payments and providers' costs: FFS Medicare margins remained high in 2023

In 2023, the FFS Medicare margin for freestanding SNFs was 22 percent, a slight drop from 23 percent in 2022 (see text box on the calculation of Medicare margins, pp. 202–205). FFS Medicare margins for individual facilities varied considerably across providers, as in prior years. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.)

### Trends in FFS spending and cost growth

In 2023, FFS Medicare spending on care in SNFs (excluding care in swing beds) was $25 billion, a decrease of 8 percent compared with 2022. This decrease in overall spending is a function of slowed volume and the payment reductions CMS made to adjust for the overpayments that had resulted from the implementation of the Patient-Driven Payment Model (PDPM) case-mix system. Though intended to be budget neutral, the new case-mix system raised payments by an estimated 4.6 percent compared with what would have been paid under the old case-mix

## Updated methodology to calculate FFS Medicare margins

To calculate freestanding skilled nursing facilities' (SNFs') fee-for-service (FFS) Medicare margins, we use the Medicare cost report. Beneficiaries in a Medicare-covered SNF stay are more costly to treat than the average nursing home resident; we recognize this difference by adjusting the apportioning of a facility's nursing labor costs between FFS Medicare stays and non–FFS Medicare stays. Using patient-assessment data, we estimate a nursing component case-mix index (CMI) for each case and, for each facility, aggregate these to two groups—FFS Medicare and non–FFS Medicare cases (such as Medicaid, Medicare Advantage, and other payers). Nursing CMIs can be reasonably compared across payers, but other case-mix-adjusted components cannot. We adjust each facility's nursing labor costs by its ratio of the FFS Medicare nursing CMI to non–FFS Medicare nursing CMI. Because the nursing CMI for FFS Medicare cases is higher than that for other cases, using this ratio as a multiplier raises the calculated nursing costs of treating beneficiaries in a Medicare-covered SNF stay.

SNFs are unique from many other facilities in that the same facility often provides vastly different care to its long-stay residents and short-stay patients (who are covered by separate payers), but the facility usually relies on the same labor to deliver both services; further, this labor represents an unusually high share of facility costs. Thus, in our SNF analyses, we adjust the labor allocations between payers when calculating the cost of labor.

In earlier work, researchers from Abt Associates found that in 2017, under the old case-mix system (Resource Utilization Groups, Version IV, or RUG–IV), the FFS Medicare to non–FFS Medicare ratio

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system (Centers for Medicare & Medicaid Services 2022). CMS responded to the overpayments by lowering payments 2.3 percent in FY 2023 and FY 2024 (Centers for Medicare & Medicaid Services 2022).

Between 2022 and 2023, the average payment per day in freestanding SNFs increased 2.4 percent while costs per day increased 3.8 percent. Changes in payments per day in 2023 reflect the combined effect of the market basket increase to the base rate and the adjustment for past overpayments under the PDPM (as discussed above). Payments also incorporate the forecast-error corrections made in both years (CMS makes these adjustments when its historical estimate of the market basket differs from the actual market basket by at least 0.5 percentage points—either too high or too low).

Cost growth outpaced the growth in payments in part due to the declines in volume, which would raise the fixed costs per day. Routine costs per day increased in 2023, but the growth rate continued to slow down. The growth in routine costs reflects labor cost trends in 2023. Wage data for the SNF sector from the Bureau of Labor Statistics show that hourly wages in the sector grew 3.3 percent in 2023, the smallest growth since 2018. Preliminary data for the first six months of 2024 indicate a similar trend, with wages growing 1.7 percent (Bureau of Labor Statistics 2024). Total cost growth in 2023 was partially driven by an increase in ancillary costs per day. Although these costs fell year over year from 2019 through 2022, ancillary costs per day rose by 4 percent from 2022 to 2023. For the first year since the implementation of the PDPM, ancillary costs grew in 2023. This change was largely driven by overall increases in per day physical therapy, occupational therapy, and drug costs, which grew for both the FFS Medicare portion and the entire facility. Administrative costs per day grew in line with previous years.

Consistent with past years, cost growth and the level of costs varied by ownership. In 2023, nonprofit providers

## Updated methodology to calculate FFS Medicare margins (cont.)

was roughly 1.41—meaning that in aggregate, facilities were estimated to require 41 percent more nursing labor in FFS Medicare than non–FFS Medicare. Applying this ratio raised FFS Medicare costs and lowered the FFS Medicare margin compared with what it would have been without the adjustment. In 2023, Abt reestimated the ratio for 2021 under the new case-mix system (the Patient-Driven Payment Model, or PDPM) for cases with the requisite patient-assessment information. This ratio for FFS Medicare to non–FFS Medicare cases dropped to 1.17, largely because the new case-mix system does not consider the provision of therapy in defining case-mix groups. Under RUG–IV, the majority of FFS Medicare cases were assigned to high-therapy case-mix groups, which had higher nursing CMI weights than other case-mix groups. Under the PDPM, most FFS Medicare cases were assigned to lower-weighted groups and, as a result, the difference between FFS Medicare and non–FFS Medicare cases shrank. Last year, we did not use this ratio in constructing margins because we could not assign all cases to PDPM case-mix groups (the patient-assessment items required to assign cases using the PDPM were not required of all cases until October 2023). Instead, we opted to continue using the higher RUG–IV ratio last year in reporting the 2022 FFS Medicare margins.

This year, Abt reestimated the FFS Medicare to non–FFS Medicare nursing ratios using the first two quarters of fiscal year 2024, when providers were required to record information needed to assign cases to the PDPM case-mix system for all cases. Abt again found the ratio of FFS Medicare to non–FFS Medicare nursing CMI to be 1.17. Given these consistent results, we believe that the updated

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reported larger increases in cost per day than for-profit providers did (4 percent vs. 2 percent). This difference was largely driven by ancillary costs. In 2023, nonprofit providers had 14 percent higher aggregate costs per day than for-profit providers, in part because they are smaller and have a lower average daily census, so they cannot achieve the same economies of scale as larger for-profit facilities. Nonprofit SNFs also have higher average nurse hours per resident day than for-profit SNFs.

### SNF FFS Medicare margins remain high

The FFS Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's FFS payments with providers' costs to treat FFS beneficiaries. In 2023, the FFS Medicare margin for freestanding SNFs was 22 percent, not including federal relief funds (see text box on updated methodology to calculate Medicare margins). For the 24th consecutive year, the FFS Medicare margin for freestanding SNFs was 10 percent or higher (data not shown). The margin was slightly lower than in 2022 (23 percent).

In 2023, hospital-based SNFs (which account for 2 percent of program spending on SNFs) continued to have substantial negative FFS Medicare margins. The FFS Medicare margin for hospital-based SNFs was −41 percent, similar to −43 percent in 2022. Hospital administrators consider their SNF units in the context of the hospital's overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their own SNF beds, thus making inpatient beds available to treat additional inpatients.

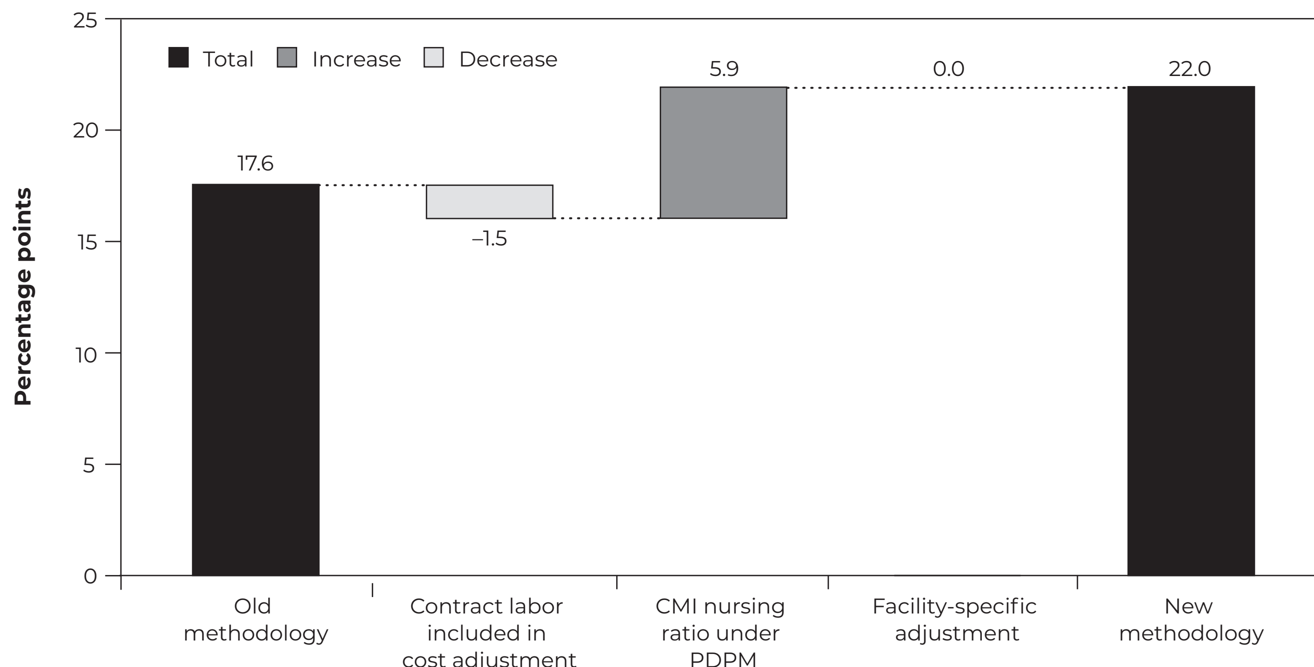
### FFS Medicare margins varied widely in 2023

FFS Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had FFS Medicare margins that were 32 percent or higher, and one-quarter had

## Updated methodology to calculate FFS Medicare margins (cont.)

FIGURE 6–6

**Effects of new margin methodology on 2023 SNF FFS Medicare margin, by change**




Note: SNF (skilled nursing facility), FFS (fee-for-service), CMI (case-mix index), PDPM (Patient-Driven Payment Model). The revised methodology includes contract-labor costs in the routine costs that are adjusted for differences between FFS Medicare and non–FFS Medicare stays. The revised CMI is based on the nursing component of the PDPM. The adjustments were calculated for each facility.

Source: MedPAC analysis of Medicare freestanding SNF cost reports and MDS data.

ratios better reflect the differences in nursing costs. Using the latest PDPM data results in a lower aggregate CMI ratio that lowers FFS Medicare costs and thus raises the FFS Medicare margins in aggregate by about 6 percentage points compared with previously reported margins (Figure 6-6).

We made two other refinements to the estimate. First, we also now adjust the costs of contract labor by the CMI ratio because of increasing use of contract labor in the past few years. This change has the effect of raising calculated FFS Medicare costs for facilities, thus lowering FFS Medicare margins by about 2 percentage points. Second, we calculate a facility-specific ratio and apply it to each facility's nursing costs. Ratios vary considerably across nursing homes; nonprofit facilities and small facilities have lower ratios compared with other facilities. Previously, we had calculated an aggregate ratio and applied it to all facilities. By itself, applying facility-specific ratios did not change the aggregate margin across all facilities, but because the ratios varied by provider, it affected the margins for individual SNFs. For example, although the overall aggregate ratio was 1.17, nonprofit facilities tended to have lower ratios. Calculating the FFS Medicare

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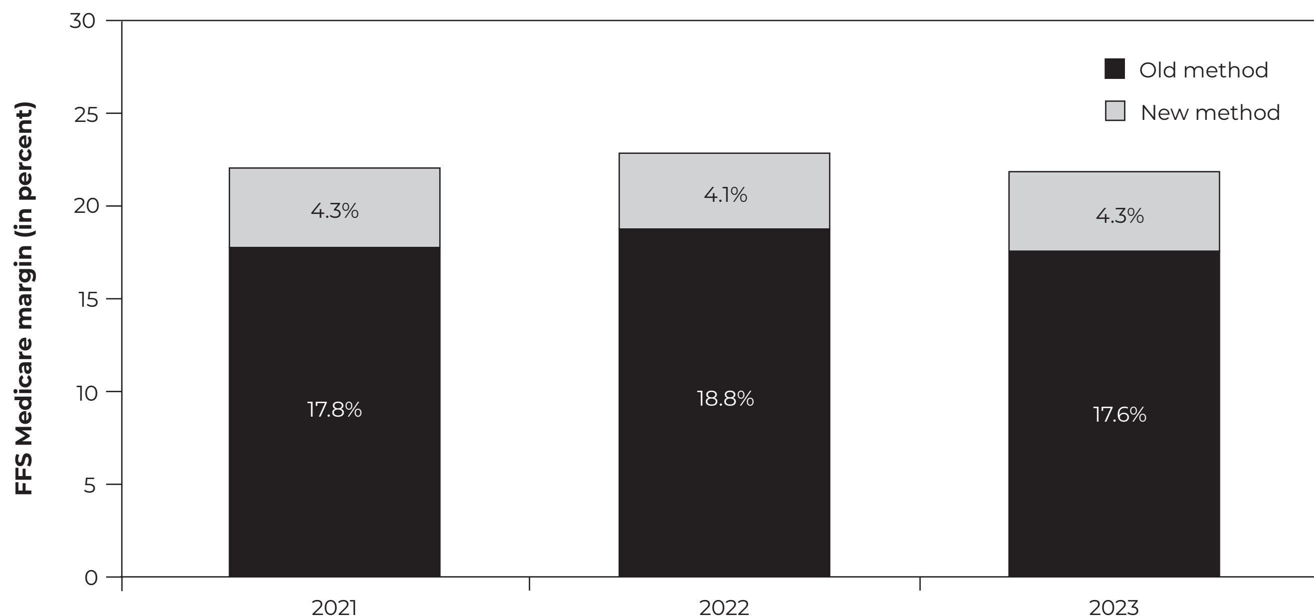
## Updated methodology to calculate FFS Medicare margins (cont.)

FIGURE 6–7

**SNF FFS Medicare margins under new and old methodology, 2021–2023**




Note: SNF (skilled nursing facility), FFS (fee-for-service).

Source: MedPAC analysis of Medicare freestanding SNF cost reports and MDS data.

margin for nonprofit facilities using a facility's specific ratio resulted in applying a ratio lower than 1.17 in many cases, thus lowering the calculated FFS Medicare nursing costs and raising their FFS Medicare margin compared with the margin we previously reported.

Factoring in all of the refinements, the 2022 FFS Medicare margin would have been 19 percent under the old methodology; under the new approach, that margin is 23 percent (Figure 6-7). Because certain groups of facilities have lower CMI ratios compared with the overall average, the aggregate margins of some groups (such as nonprofit facilities) have changed substantially.

As the methodology affects only the costs allocated to FFS Medicare (and not total costs), the overall all-payer total margins for facilities remain unaffected by this methodological change. The new calculations result in lowered margins for non–FFS Medicare payers that offset the increase in the FFS Medicare margin.

We also updated our hospital-based SNF inpatient margin methodology. Previously, our hospital-based inpatient margins reflected only SNFs in acute inpatient prospective payment system and critical access hospitals. This year, we include SNFs based in other types of hospitals, such as long-term care hospitals, inpatient rehabilitation facilities, and inpatient psychiatric facilities. Though this change added only about 50 hospital-based SNFs, the number of hospital-based SNFs is not large to begin with, and thus margins have shifted. ■

**TABLE 6–4**

**Variation in freestanding SNF FFS Medicare margins persisted in 2023**

| Provider group | FFS Medicare margin, 2023 |
|---|---|
| All providers | 21.9% |
| 25th percentile of FFS Medicare margins | 10.6 |
| 75th percentile of FFS Medicare margins | 32.0 |
| For profit | 25.1 |
| Nonprofit | 7.3 |
| Urban | 22.2 |
| Rural | 20.3 |
| Frontier | 15.8 |
| Cost per day: High | 11.8 |
| Cost per day: Low | 35.1 |
| Small (20–50 beds) | 4.0 |
| Large (100–199 beds) | 24.2 |
| Low-volume facility | 6.9 |
| High-volume facility | 26.8 |
| Low LIS share | 10.9 |
| High LIS share | 30.2 |

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

Source: MedPAC analysis of 2023 Medicare freestanding SNF cost reports and SNF Medicare Provider Analysis and Review data.

margins that were 10.6 percent or lower (Table 6-4). The differences in FFS Medicare margins between for-profit and nonprofit facilities have persisted for years. The disparity reflects differences in costs per day and, to a lesser extent, payments per day. Compared with for-profit facilities, nonprofit facilities were smaller (fewer beds and lower volume), and they had lower payments but higher costs per day (data not shown). The FFS Medicare margin for urban SNFs was about 2 percentage points higher than for rural SNFs in 2023. While rural SNFs are smaller on average than urban SNFs, the majority of facilities with fewer than 50 beds are urban, and small rural SNFs have, on average, higher margins than small urban SNFs. Differences in FFS Medicare margins partly reflect the economies of scale that larger SNFs achieve. Facilities with 20 to 50 beds had a lower FFS Medicare margin than facilities with 100 to 199 beds. And low-volume facilities (bottom quintile of total facility days) had a lower FFS Medicare margin than high-volume (top quintile of days) facilities. SNFs with the lowest cost per day (the bottom 25th percentile of the distribution of cost per day) had a FFS Medicare margin that was over 20 percentage points higher than SNFs with the highest (in the top 25th percentile) cost per day. SNFs with high shares of stays for patients receiving the low-income subsidy (LIS) (in the top quartile of the distribution of LIS shares) have much higher margins than facilities with low shares (30.2 percent compared with 10.9 percent). Facilities with a high LIS share of stays had lower costs per day (13 percent lower) and higher Medicare payments per day (11 percent higher) (data not shown).

SNFs in the top quartile of the distribution of FFS Medicare margins appear to pursue cost and revenue strategies. Compared with SNFs in the lowest FFS Medicare margin quartile, high-margin SNFs have lower standardized costs per day and per discharge (data not shown). High-margin SNFs also have lower total nursing and RN hours per resident day compared with low-margin SNFs, and this difference is reflected in their lower routine costs. High-margin SNFs may be more likely than low-margin SNFs to care for beneficiaries with low incomes: On average, high-margin SNFs had a higher share of Medicare-covered SNF stays attributable to beneficiaries receiving the Part D low-income subsidy and higher shares of total Medicaid-covered facility days. Facilities with a higher Medicaid mix may keep their costs lower, in part through lower staffing, contributing to their higher FFS Medicare margins. High-margin SNFs also have longer lengths of stay, which yield additional revenue under the SNF per diem payment system, and

a higher nursing CMI. Economies of scale also affect the difference in financial performance. In 2023, the median high-margin SNF had more beds and higher daily census than the median low-margin SNF.

**Projecting payments and costs for 2025**

To project the FY 2025 FFS Medicare margin for freestanding SNFs, the Commission considered the relationship between SNF costs and Medicare payments in 2023 as a starting point. The projection is especially sensitive to the uncertainties of estimating costs, whereas the payment updates have been set. To estimate 2025 costs, we used CMS's Office of the Actuary's November 2024 estimates of the market baskets for 2024 (3.7 percent) and 2025 (3.1 percent) (Centers for Medicare & Medicaid Services 2024a). The annual market basket indicates how SNFs' costs for a fixed basket of inputs will change, including estimates of the costs associated with higher wages and economy-wide inflation. The estimates of cost growth could be low or high depending on how actual costs differ from the projections. For FY 2025, we adjusted facilities' costs that are associated with complying with new policies that are likely to affect costs. For instance, CMS began to impose stronger civil monetary penalties for facilities that do not comply with federal requirements to participate in the Medicare and/or Medicaid program (estimated to increase costs). Our adjustments were based on CMS's estimates, prorated for our 2023 sample of providers (Centers for Medicare & Medicaid Services 2024c).[14]

In addition, we assumed that urban facilities would begin to incur higher nursing costs in 2025, in anticipation of new staffing requirements (see section on the staffing rule, p. 209). To approximate the added costs of compliance, we started with CMS's estimate for the first full year of the new rule ($1.4 billion), prorated this amount to the facilities included in the 2023 cost-report analysis, and inflated the figure to 2025 dollars (Centers for Medicare & Medicaid Services 2024b). We then apportioned a share to FFS Medicare based on FFS Medicare's share of payments, and we assumed urban facilities would begin to take on these costs during the last six months of FY 2025 as they add staff to meet the 2026 staffing requirements.

The actual costs of the staffing rule could differ from the estimate for many reasons. CMS assumed RN hours could be reallocated perfectly to meet the 24/7 (24 hours a day, 7 days a week) requirement, and that nursing-staff real wages would increase by an average 2.3 percent annually. Cost estimates would be higher or lower if the assumptions are not correct. CMS also did not model exemptions or possible cost savings and assumed that facilities would not replace nurses with lower-cost nursing aides to meet the total nursing requirement. Accounting for these factors could lower the cost estimate and would raise the projected 2025 Medicare margin.

Staffing costs could also increase if states raise Medicaid payment rates for nursing homes in response to the staffing minimums. Higher payment rates could enable facilities to hire more staff, thereby raising facilities' costs. Although states have not explicitly raised rates or supplemental payments in FY 2024 and FY 2025 as a direct response to the rule, several have increased Medicaid funding, coinciding with rising calls to address workforce concerns (see Medicaid section, p. 213).

To estimate payments in FY 2024 and FY 2025, we increased payment rates by the updates specified in the final rules for those years (Table 6-5, p. 208). The updates include the market basket with productivity adjustments and forecast-error corrections to market basket estimates made in earlier years. We did not consider additional changes in payments for potential changes in patient acuity or the recording of patient characteristics that would raise or lower payments.

The projected FFS Medicare margin for 2025 for freestanding SNFs is 23 percent. We expect the margin to increase in 2025 relative to 2023 because payment updates are projected to exceed cost growth in 2024 and 2025 due to the large forecast-error adjustments raising 2024 and 2025 payment rates. Different assumptions about changes in costs, case mix, and revenues could raise or lower the projection.

We project that the impact of the anticipated staffing rule will be small in FY 2025—a decline of less than half a percentage point. Medicare is a small share of nursing homes' revenues, and we projected that only urban providers affected by the rule in 2026 would increase their hiring. The impact will be larger if providers not affected by the rule in 2026 also hire new staff and incur higher labor costs. In future years, as the rule is

**TABLE 6–5**

**SNF payment updates for fiscal years 2023–2025**

| | 2023 | 2024 | 2025 |
|---|---|---|---|
| Updates based on forecasts | | | |
| Market basket | 3.9% | 3.0% | 3.0% |
| Productivity | –0.3 | –0.2 | –0.5 |
| Forecast-error correction | 1.5 | 3.6 | 1.7 |
| Parity adjustment | –2.3 | –2.3 | N/A |
| Total | 2.7 | 4.0 | 4.2 |

Note: SNF (skilled nursing facility), N/A (not applicable). CMS makes forecast-error corrections when its estimate of the market basket differs from the actual market basket by at least 0.5 percentage points (either too high or too low). This correction is lagged two years.

Source: CMS SNF final rules for fiscal years 2023–2025.

phased in, the cost to comply with the rule would grow and lower margins.

## How should FFS Medicare payments change in 2026?

In 2026, current law is expected to increase payment rates by 2.2 percent (an estimated market basket of 2.8 percent minus a productivity adjustment of 0.6 percent). CMS will revise its estimates before the publication of the FY 2026 final rule (which must be published before August 1, 2025). CMS also corrects for overestimates and underestimates of the SNF market basket two years prior to the rulemaking year (meaning the FY 2026 payment update will correct for under- or overestimates of the FY 2024 market basket). If CMS determines that it over- or underestimated the market basket by more than 0.5 percentage points in FY 2024, it will apply the correction in FY 2026. Currently, because the FY 2024 official market basket underestimated the actual FY 2024 market basket by 0.7 percentage points, the FY 2026 correction would result in an increase of 0.7 percentage points. On net, if all these changes are implemented, the update would be a 2.9 percent increase in 2026 (a projected market basket of 2.8 percent plus a 0.7 percent forecast-error correction minus a 0.6 percent productivity adjustment).

The FFS Medicare margin in 2025 will depend on many factors. The update to the payment rate may not accurately capture any real changes in patient acuity or the recording of patient characteristics that raise payments (with no effect on costs). Costs may increase more or less than the market basket estimates, in part depending on how staffing costs change as a result of the new staffing rule. Under any plausible scenario, Medicare margins are likely to remain high, indicating that the SNF PPS exerts too little pressure on providers to control costs. Not surprisingly, FFS Medicare remains a preferred payer for SNFs.

FFS Medicare margins were high again in 2023. Although the level of the Medicare margin might indicate that a larger reduction to the FFS payment rates is required to better align payments and costs, there is uncertainty about the costs associated with the staffing changes finalized in 2024 (discussed below). Therefore, the Commission has opted to recommend a more modest reduction to the payment rates.

**RECOMMENDATION 6**

**For fiscal year 2026, the Congress should reduce the 2025 Medicare base payment rates for skilled nursing facilities by 3 percent.**

RATIONALE 6

The level of Medicare's payments indicates that a reduction is needed to better align aggregate payments to aggregate costs. The freestanding SNF FFS Medicare margin was 22 percent in 2023. With the market basket updates and the likely forecast-error adjustments, we project that the freestanding SNF FFS Medicare margin will be 23 percent in 2025. Thus, FFS payments will remain more than adequate to ensure beneficiary access to SNF care even if payments are lowered. Last year, the Commission recommended a 3 percent reduction to the payment rates when the projected margin was considerably lower than what we estimate for 2025.

Although the overall FFS Medicare financial performance of SNFs is good and projected to remain so, the share of providers that operated at a loss in 2023—as well as the large difference in FFS Medicare margins between nonprofit and for-profit SNFs—indicates that not all providers do well financially under the SNF PPS. It is not sound policy to raise payments for all providers to address the poor financial performance of some. Nor does the Commission support differential updates for providers based on ownership status or geographic location. Instead, the Congress could consider other approaches to redistribute FFS Medicare's payments. For example, as the Commission recommended in June 2021, the Congress should replace the VBP program with a program that includes larger incentive payments, which would direct funds to facilities that perform well on quality and resource-use measures (Medicare Payment Advisory Commission 2021a).

IMPLICATIONS 6

**Spending**

- Current law is expected to increase payment rates by 2.9 percent in FY 2026. This recommendation would lower spending relative to current law by between $2 billion and $5 billion over one year and between $10 billion and $25 billion over five years.

**Beneficiary and provider**

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

## Minimum staffing requirements set to begin in May 2026

As noted above, nurse staffing levels have been shown to be key to patient outcomes. In May 2024, CMS issued a final rule revising its staffing requirements for nursing homes, with implementation beginning in May 2026 (Centers for Medicare & Medicaid Services 2024b). We compared current staffing levels to the revised requirements. Had all of the staffing requirements been in effect in 2024, we estimate that more than three-quarters of providers would not have met all the minimum requirements. However, we expect that many facilities could be exempted from at least one of the minimum requirements because they are in labor market shortage areas. In this section, for brevity, we refer to these potentially exempted facilities as "exempted," although it is possible a facility's application for exemption could be denied. We refer to facilities unable to apply for a labor shortage exemption as "nonexempted." We also found that the majority of facilities were within range of meeting each of the individual requirements: Their staffing levels were 80 percent or 90 percent of the minimums.

### The staffing requirements

CMS's final rule on staffing minimums requires all facilities (that is, all facilities that do not meet exemption criteria discussed below) to meet specific hours per resident day (HPRD) for three categories of caregivers and will be phased in over time (Centers for Medicare & Medicaid Services 2024b). Starting in May 2026, urban facilities must have a total nurse staffing (including RNs, licensed practical nurses, and nurse aides (NAs)) ratio of 3.48 HPRD and an RN on site 24/7.[15] The following year, they must have an RN ratio of 0.55 HPRD and an NA ratio of 2.45 HPRD. Rural facilities have longer to comply with the rules: The total nurse HPRD and 24/7 RN requirements will be in place starting in May 2027, and the RN and NA HPRD requirements will begin in May 2029.

The staffing ratios are not adjusted for a facility's mix of cases, though facilities will still be required to have "sufficient" staff to meet the care needs of their residents. That is, facilities treating complex cases would be expected to have higher staffing ratios to comply with the current requirement of "sufficient

nursing staff" to meet care needs and ensure residents' safety. CMS noted that it needed more time to consider facility-specific case-mix-adjusted HPRD requirements and that it may consider this approach in future rulemaking.

Facilities not meeting the requirements will be subject to standard enforcement actions by CMS, including termination of the provider agreement with CMS, denying Medicare and/or Medicaid payments for all services, or imposing civil monetary penalties. CMS will post a facility's noncompliance on its Care Compare website.

A facility can apply for a temporary exemption from some or all of the requirements if it is located in a workforce shortage area (the area's RN, NA, or total worker-to-population ratio is at least 20 percent below the national average), is making a good-faith effort to hire, and documents its financial commitment to staffing.[16] A facility that is exempted from the 24/7 RN requirement would be required to have an RN available 16 hours a day, 7 days a week. CMS's preliminary analyses found that the share of facilities that would be exempted varied considerably depending on the staffing requirement (Centers for Medicare & Medicaid Services 2024b).[17]

Industry representatives filed lawsuits against CMS and the Department of Health and Human Services (HHS) to dismiss the staffing rule, arguing that CMS exceeded its statutory authority; the Congress had already set staffing minimums (in the 1987 Nursing Home Reform Act); the one-size-fits-all approach does not consider a facility's circumstances; and that CMS failed to show that the Congress granted it the authority to impose new requirements or increase existing ones. Twenty-one states have challenged the rule (Marselas 2024).

### Impact of the staffing rule on facility costs

CMS estimated that the new requirements would raise nursing homes' costs by $1.43 billion for the first year that the minimum requirements are in place and an average of $4.3 billion per year over 10 years. Industry stakeholders' estimates of the average annual cost are higher, ranging from an estimate of $6.8 billion to $7.1 billion (Emerson et al. 2024, LeadingAge 2023). The estimates differ in the assumptions made about the hiring of employees, the year of the data used, and whether the estimate was in 2021 dollars (the year of the CMS estimate) (Centers for Medicare & Medicaid Services 2024b). None of the estimates considered the likelihood that many facilities would be exempt from specific provisions, although exempt facilities would still incur some cost in applying for exemptions and meeting exemption criteria (such as documenting efforts to hire and their financial commitment to staffing). The impact on Medicare costs would be much smaller given the small share that SNF days constitute for most facilities.

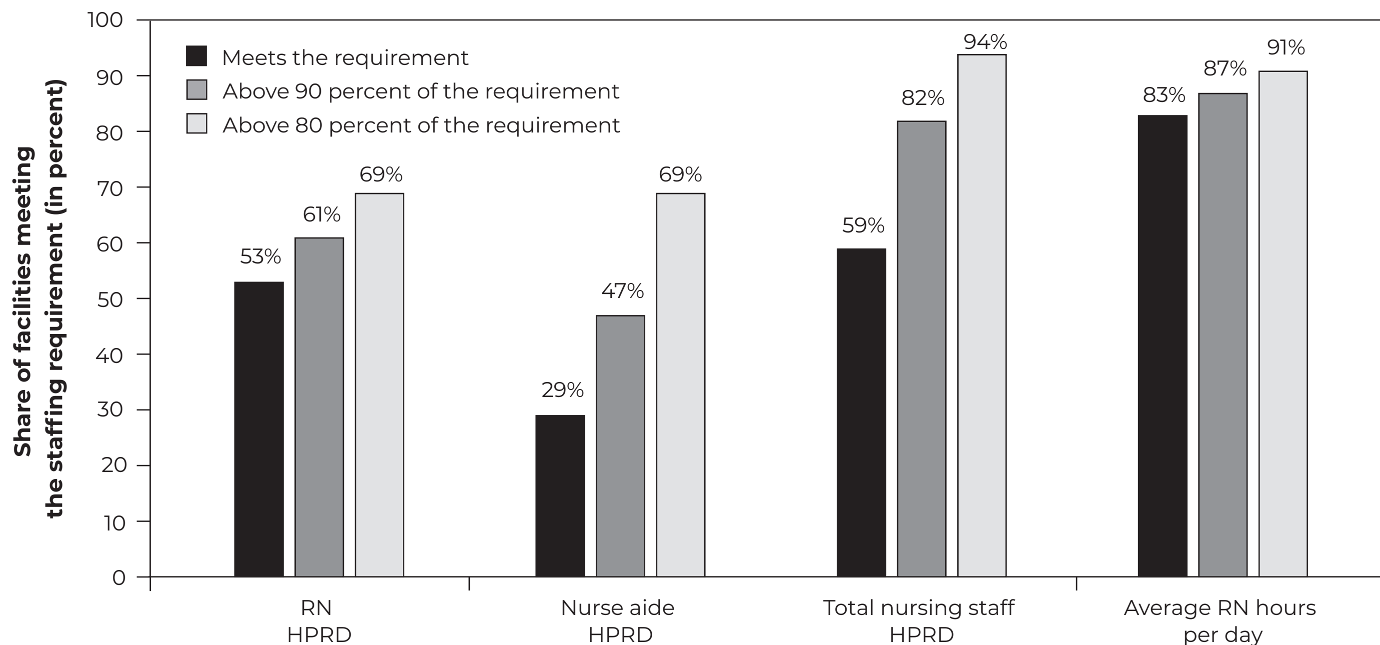
### The majority of facilities would currently not meet all minimums applicable to them, but many are close

We estimated that if the rule had been fully implemented in 2024, less than 22 percent of facilities that were nonexempt from at least one minimum would meet all the minimums required of them (a facility can be exempt from one or more requirements because of labor shortages in their area, as determined based on first-quarter 2024 Nursing Compare data). We also found that many facilities (30 percent) could be exempt from at least one of the minimum requirements, and 12 percent could be exempt from all the requirements.[18] (Facilities that would be exempt from the 24/7 RN requirement might still have to provide 16 hours of RN care a day.) A larger share of rural facilities could be exempt from at least one requirement compared with urban facilities (69 percent compared with 15 percent, respectively). Twenty-one percent of rural facilities could be exempt from all requirements compared with 9 percent of urban facilities.

We examined the share of nonexempt facilities that met each requirement and, if they did not, the shares that were close to meeting it. Only 23 percent of facilities met all the HPRD minimums required of them under the full effect of the rule (that is, considering only the HPRD categories each facility would not be exempted from). However, looking at individual requirements, a substantial number of facilities are operating reasonably close to the required hours. To define "reasonably close," we examined how many facilities' HPRD were 90 percent and 80 percent of the minimum (Figure 6-8). For example, we checked how many facilities had at least 3.132 total nursing staff HPRD (90 percent of the required 3.48 HPRD). We made this calculation for each minimum of the rule.

FIGURE 6–8

**Estimated shares of nonexempt facilities that meet each of the fully phased-in staffing requirements**




Note: RN (registered nurse), HPRD (hours per resident day). A nonexempt facility does not meet the definition of being located in a labor shortage area (the area's RN, nursing aide, or total worker-to-population ratio is at least 20 percent below the national average), seven days a week. "Total nursing staff" includes RNs, nursing aides, and licensed practical nurses. Average RN hours per day approximates whether a facility meets the requirement to have an RN on-site 24 hours a day. Estimates are based on circumstances in 2024.

Source: MedPAC analysis of Bureau of Labor Statistics, U.S. Census, and Nursing Home Compare Data, 2024.

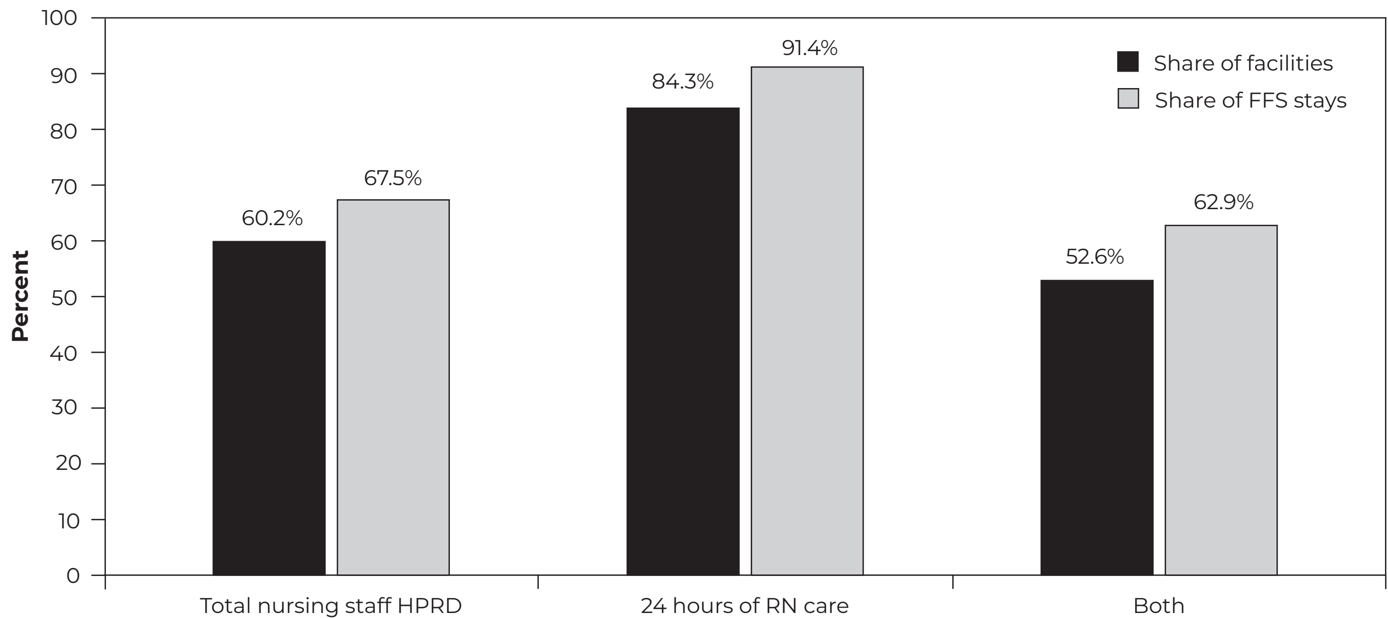
However, adding staff hours to fully meet the rule could still represent significant costs for these facilities, given the high share of facilities' costs that is labor.

Just over half (53 percent) of nonexempt facilities currently would meet the RN HPRD (0.55 HPRD), but 61 percent have HPRD above 90 percent of the requirement (0.495 HPRD), and 69 percent have ratios above 80 percent (0.44 HPRD). Just 29 percent of nonexempt facilities would meet the NA requirement (2.45 HPRD), but 69 percent had ratios above 80 percent of the requirement (1.96 HPRD). The majority (59 percent) of nonexempt facilities would meet the total nurse staffing requirement (3.48 HPRD), and most nonexempt facilities (94 percent) had ratios above 80 percent of the requirement (2.784 HPRD). Although data do not exist to model the 24/7 aspect of the 24/7 RN rule, we examined the number of facilities that averaged 24 hours per day of RN care. A facility could provide an average of 24 hours of RN care per day by staffing more than one RN during a shift and not have an RN on-site every hour of the day. Of the nonexempt facilities, 83 percent averaged 24 hours per day of RN care, though not necessarily 24/7.

Rural and frontier county facilities, which are generally smaller than urban facilities, may be less likely to have an RN present for an average of 24 hours per day, perhaps because the administrator determines that fewer RN hours are needed to adequately care for their smaller resident populations. However, these rural and frontier facilities were more likely to meet their HPRD minimums. Because HPRD minimums are a function of the number of residents, smaller and rural facilities are currently more likely to meet HPRD minimums due in part to staff hours being averaged over fewer residents.

FIGURE 6–9

Estimated share of urban nonexempt facilities meeting the May 2026 requirements




Note: HPRD (hours per resident day), RN (registered nurse), FFS (fee-for-service). A nonexempt facility does not meet the definition of being located in a labor shortage area (the area's RN, nurse aide, or total worker-to-population ratio is at least 20 percent below the national average), seven days a week. Total nursing staff includes RNs, nursing aides, and licensed practical nurses. Whether a facility meets the requirement to have an RN on-site 24 hours a day was estimated as the average RN hours per day. Unless exempt from a requirement, urban facilities must meet the total staffing HPRD and the 24-hours-per-day nursing requirements. Estimates are based on circumstances in 2024.

Source: MedPAC analysis of Bureau of Labor Statistics, U.S. Census Bureau, and Nursing Home Compare Data, 2024.

### Estimated shares of urban facilities not meeting the requirements in 2026

Urban facilities will be the first to come under the staffing rule. They will face minimum requirements in May 2026: the level of total nursing staff (3.48 HPRD) and 24/7 RN coverage. The majority (60 percent) of nonexempt urban facilities currently would meet the total nursing HPRD requirement (Figure 6-9). A larger share (84 percent) of facilities currently provide an average of 24 hours per day of RN care, though not necessarily 24/7. Of the urban facilities required to meet both May 2026 requirements (3.48 total nurse staffing minimum and 24 hours of RN care per day), only 53 percent currently meet them. For both measures, the facilities meeting the requirements account for larger shares of FFS days.

When fully implemented, the rule is likely to pose significant challenges for nursing homes, especially since they compete (often unsuccessfully) with hospitals and other providers that are also facing nursing workforce shortages. Recruitment and retention in the long-term care sector has always been difficult, and the problems were exacerbated by the coronavirus pandemic, when many health care workers left the field altogether. In a 2024 survey of 441 nursing homes, the American Health Care Association found that most facilities were actively trying to hire more staff and had raised wages as part of their recruitment and retention strategies (American Health Care Association 2024). The rule could place additional financial pressures on facilities that are already operating with thin total margins, especially those serving a higher proportion of Medicaid patients.

That said, we found that nonexempt facilities that did not meet applicable requirements tended to have higher FFS Medicare margins. For example, we examined facilities that would not be exempt from the total nurse staffing HPRD rule and therefore would have to hire more staff to meet the requirement. Among these facilities, the FFS Medicare margin was 29 percent for urban facilities and 25 percent for rural facilities. In contrast, nonexempt facilities that already meet this rule requirement had lower FFS Medicare margins of 20 percent in urban areas and 15 percent in rural.

### Possible unintended effects of the rule

The rule could have unintended effects. The mix of nursing staff could change because the rule does not set minimums for licensed practical nurses (LPNs) (CMS stated that the research did not find conclusive evidence of a relationship between LPN HPRD and outcomes). Facilities could lower their use of LPNs to meet the aide and RN requirements. The requirements could also have spillover effects on nonclinical staffing. One study of state minimum requirements found that indirect staffing (including dietary, housekeeping, and activities staff) decreased after nursing minimums were implemented (Bowblis 2011, Chen and Grabowski 2015). Another effect could be that facilities with staffing levels above the new requirements could reduce their staffing. Studies of states' experiences found that, in addition to raising HPRD for facilities with low staffing levels, state minimums lowered staffing at facilities that were already above the requirements (Chen and Grabowski 2015, Mueller et al. 2006, Park and Stearns 2009). If nursing homes successfully hire staff away from other settings, the rule could negatively affect the staffing levels for these other settings' providers. As it does every year, the Commission will continue to monitor staffing levels, facility closures, and beneficiary access.

## Medicaid trends

Section 2801 of the Affordable Care Act of 2010 (ACA) requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers that have a significant portion of revenues or services associated with Medicaid.

We report on nursing facility (the term we use for Medicaid-certified facilities that provide long-term care, also commonly called "nursing homes") spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported separately in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment and Access Commission, we report on characteristics, service use, and spending for dually eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2023, Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2022).

Medicaid covers long-term care and a portion of the skilled nursing care furnished to beneficiaries who are dually eligible for Medicaid and Medicare. Some state Medicaid programs pay dually eligible beneficiaries' Medicare copayments that begin on Day 21 of a SNF stay. Medicaid also pays for any skilled care for beneficiaries who exhaust their Part A coverage (that is, if their Part A stay exceeds 100 days). Medicaid also pays for long-term care services that Medicare does not cover. Similar to stays for non–dually eligible beneficiaries, discharges for dually eligible beneficiaries increased on Day 20. In addition, dually eligible beneficiaries were more likely to have stays past Day 20 or Day 100, possibly as a result of Medicaid coverage of cost sharing. For beneficiaries in long-term care stays who are enrolled in Part B or Part D, Medicare pays for covered Part B and Part D services.

### Count of Medicaid-certified nursing homes

The number of Medicaid-certified nursing facilities has been declining steadily for years. Between 2016 and 2019, the number of active nursing facilities decreased on average 0.3 percent per year. Historically, factors contributing to closures include shifts away from institutional care toward home- and community-based care, overexpansion of supply in states with no certificate-of-need laws (such as Texas), and low Medicaid rates. During the pandemic, the number of nursing facility terminations slowed. Between December 2023 and October 2024, the number of nursing facilities certified as Medicaid providers declined 1.1 percent from 14,500 to 14,300 (Table 6-6), but has since picked up. By comparison, the average annual percent change between 2019 and 2022 was –0.7 percent.

**TABLE 6–6**

**The number of active nursing facilities certified as Medicaid providers declined slightly from 2023 to 2024**

| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|
| Number of facilities | 15,000 | 14,800 | 14,800 | 14,600 | 14,500 | 14,300 |
| Change from prior year | | –0.8% | –0.6% | –0.9% | –1.0% | –1.1% |

Note: The figure for 2024 was calculated through October; it does not include data from the full calendar year. Counts include dually certified skilled nursing facilities/nursing facilities, distinct-part skilled nursing facilities/nursing facilities, and nursing facilities. Counts are for Medicaid-certified nursing facilities in the 50 states and the District of Columbia. Percentage changes were calculated on unrounded data.

Source: MedPAC analysis of active provider counts from CMS's Quality and Certification Oversight Reports (QCOR) online reporting system for 2019–2024.

Of all Medicaid nursing homes active in January 2024, 68 had terminated as of October, and the majority (58) of terminations were voluntary. Providers that terminated participation in the Medicaid program may have remained open but no longer accept Medicaid residents, may have closed, or may have been purchased by another entity and changed provider numbers. The share of facilities terminated varied by state. States with the highest termination rates during the period included Missouri (19 percent), Texas (9 percent), and Indiana (7 percent). This geographic variation in closure rates may result in differences in access to services across markets. During the same time period, 22 providers opened, and half of those were for profit.

## Spending

FFS spending on Medicaid-funded (combined state and federal funds) nursing home services totaled $42.5 billion in 2023. This spending excludes payments to nursing homes made by managed care organizations. Spending increased by 5.6 percent between 2022 and 2023, compared with an average decline of 0.9 percent per year between 2019 and 2022. As of June 2024, 24 states operated Medicaid managed care for long-term services and supports (ADvancing States 2024).

The Families First Coronavirus Response Act (FFCRA), enacted on March 18, 2020, provided a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), retroactive to January 1, 2020, through the end of 2023. Many states used at least a portion of this FMAP increase to raise payments to nursing facilities. A survey of Medicaid budget trends for FY 2024 and FY 2025 found that only five states reported decreases in base rates or supplemental payments (Hinton et al. 2024). Over three-quarters of the responding states (49) reported raising rates in both fiscal years 2024 and 2025 (Hinton et al. 2024). States with notable nursing facility rate increases included Iowa, Montana, Nevada, Ohio, Rhode Island, and Texas. Montana increased its base rates by 33 percent, phased in over FY 2024 and FY 2025 (Towhey 2023). Colorado will increase its Medicaid rates by a cumulative 14.5 percent through 2026 (Marselas 2023). Many states reported increasing base rates and supplemental payments in both years.

Some states have tied recent nursing facilities' rate increases to wages for direct-care staffing. A report from November 2022 found that at least 19 states were implementing strategies to address wages for direct-care workers through reporting, enforcement policies, or both (National Governors Association 2022). For example, Illinois, Massachusetts, and North Carolina made staff wage increases a condition of receiving increased Medicaid reimbursement rates (Musumeci et al. 2022, Reiland 2022). Massachusetts and North Carolina directed nursing facilities to dedicate most of their rate increase (75 percent to 80 percent) toward improving wages for direct-care staff (Musumeci et al. 2022).

States also continue to use nursing homes' provider taxes to raise federal matching funds. In FY 2024, 46 states levied provider taxes on nursing facilities to

**TABLE 6–7**

**Freestanding SNFs' all-payer total margin and non–FFS Medicare margins improved in 2023**

| Type of margin | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| All-payer total margin | 0.8% | 3.2% | 3.6% | –1.3% | 0.4% |
| Non–FFS Medicare margin | –3.1 | –1.8 | –0.9 | –7.6 | –4.1 |

Note: SNF (skilled nursing facility). "All-payer total margin" includes the revenues and costs associated with all payers and all lines of business and includes reported federal pandemic-related relief funds. "Non–FFS Medicare margin" includes the revenues and costs associated with Medicaid, Medicare Advantage, other private payers, and self-pay for all lines of business. Margins shown are aggregates.

Source: MedPAC analysis of Medicare freestanding skilled nursing facility cost reports for 2019 to 2023.

increase federal matching funds (Hinton et al. 2024). The augmented federal funding may be split with the nursing facilities to increase their payments.[19]

### Freestanding SNFs' all-payer total and non–FFS Medicare margins improved in 2023

An all-payer margin is the percentage of revenue from all payers (including all FFS Medicare, Medicare Advantage, Medicaid, and private insurers) and sources (including all lines of business plus investment income) after accounting for all costs. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) In 2023, the all-payer margin for freestanding SNFs was 0.4 percent, up from −1.3 percent in 2022 (Table 6-7). Forty-six percent of SNFs had negative total margins, a decrease from the 51 percent in 2022. The improvement reflects the increases in Medicaid base payment rates made by many states, as discussed above. The non–FFS Medicare margin for freestanding SNFs in 2023 was −4.1 percent. Non–FFS Medicare margins are the profitability of all lines of business and all payers exclusive of FFS Medicare–covered SNF services. The improvement in the non–FFS Medicare margin reflects the increases in payment rates made by 43 states in FY 2023 (Hinton et al. 2023).

In 2023, freestanding SNFs' all-payer total margins varied considerably. The median was 0.7 percent; 25 percent of SNFs had all-payer total margins of −6.6 percent or lower, and 25 percent of freestanding SNFs had all-payer total margins of 7.1 percent or higher; 46 percent of freestanding SNFs had negative all-payer total margins (data not shown). ■

## Endnotes

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

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

3 Skilled services must be ordered by a physician, require the skills of technical or professional personnel, and be furnished directly by or under supervision of such personnel. Coverage ends when a skilled service is no longer needed (e.g., maintenance services performed by the patient alone or with assistance from an unskilled caregiver).

4 The program pays separately for some services, including certain chemotherapy drugs, certain customized prosthetics, certain ambulance services, and radioisotope services. All physician services are paid separately under Part B.

5 Another study that made different assumptions in its estimates found higher shares of nursing homes with REITs and PE (16 percent and 13 percent, respectively (Williams et al. 2024)). Notably, these estimates do not consider divestments.

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

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

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

9 The rates for 2021 to 2022 and for 2022 to 2023 are not comparable with earlier periods because CMS updated the list of diagnosis codes in diagnosis categories that are considered potentially preventable readmissions but were excluded in the original development of this measure. This change makes the measure more comprehensive but incomparable with previous time periods.

10 We examined the all-cause readmissions within 30 days of admission to the SNF (referred to as the 30-day post-admission rate) and found that rates increased slightly between 2022 and 2023 and were more variable than post-discharge rates. Smaller hospital-based facilities, nonprofit facilities, and rural facilities tended to perform better than other SNFs. The 30-day post-admission and post-discharge rates were not strongly correlated. Because the 30-day post-admission measure could include a mix of days when the beneficiary is under the care of a facility and after discharge from the SNF, and includes only a portion of a stay if it is longer than 30 days, the Commission prefers a measure that gauges readmissions that occur only during the (entire) SNF stay (Medicare Payment Advisory Commission 2015).

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

end in turnover when they have a period of at least 60 consecutive days in which they do not work at all during the 12 months covered by the turnover measure (e.g., January to December 2023). Starting July 2024, a spell is considered to end in turnover when the individual has at least 90 consecutive days without working, instead of 60 days. (For additional information, see Centers for Medicare & Medicaid Services 2023a.)

12 The current staffing standards require nursing homes to have (1) an RN on duty 8 consecutive hours per day, seven days a week; (2) a licensed nurse—either an RN or a licensed practical nurse—on duty 24 hours per day, seven days a week; and (3) "sufficient" nursing staff with the appropriate competencies and skill sets to match patients' care needs and ensure resident safety (without specifying a minimum number of nurses per resident). The current standards translate to 0.3 hours of nursing time per resident day for a 100-bed facility (Medicaid and CHIP Payment and Access Commission 2022). As of 2023, many states (38 plus the District of Columbia) have additional staffing requirements, but their specifications vary.

13 The prices reported are based on arm's-length transactions in which a willing buyer and a willing seller agree on a price with the property exposed to the market. Reported prices include the real estate and business operations, including any licenses. A sale by a provider to an REIT that then leases the property back to the same provider is not considered arm's length. In contrast, a sale by a provider or owner to an REIT that then leases the property to an unrelated third party is considered an arm's-length sale.

14 In FY 2025, CMS estimated that changes to the civil monetary penalties on net would increase SNF costs. Currently, providers that do not comply with participation requirements are assessed either a per day or a per instance penalty based on the severity and scope of harm (or potential harm) to residents, and providers cannot be assessed for multiple instances (e.g., noncompliance on different days of the survey) for the same deficiency. Beginning in FY 2025, a facility that is out of compliance can be assessed for both types of penalties and for multiple instances for the same deficiency.

15 Nurse aides must meet minimum training standards but are not limited to certified nursing aides.

16 The exemption will remain in place until a facility's next recertification survey unless it becomes ineligible for an exemption. A facility is ineligible for an exemption if it is a special-focus facility, did not submit its payroll data to CMS (as required), or was cited within the past year for a pattern of or widespread insufficient staffing or it had an incident that caused or was likely to have caused serious harm or death.

17 It is estimated that 19 percent of rural facilities could be exempt from the aide requirement, 40 percent from the total nursing requirement, and 67 percent from the RN requirement. Estimates of the shares of total facilities that could be exempt from the staffing ratios are 23 percent from the aide requirement, 22 percent from the total nursing requirement, and 29 percent from the RN requirement (Centers for Medicare & Medicaid Service 2024b).

18 Our analyses assumed that facilities that met the "labor shortage" definition would apply for an exemption from the requirement.

19 Under a nursing home provider tax, states tax all facilities and use the collected amount to help finance the state's share of Medicaid funds. The provider tax increases the state's contribution, which in turn raises the federal matching funds. The augmented federal funds more than cover the cost of the provider-tax revenue, which is returned to providers. The provider tax is limited to 6 percent of net patient revenues.

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