

VALUE-BASED PAYMENT AND SKILLED NURSING FACILITIES:

Supporting SNFs During COVID-19 and Beyond

AUTHORS

Elizabeth Singletary
Rachel Roiland
Matthew Harker
Donald H. Taylor, Jr.
Robert Saunders

KEY THEMES

- While value-based payment (VBP) models are common in many health care settings, direct skilled nursing facility (SNF) participation in VBP is limited. Evidence is mixed on how SNF-focused VBP models have affected quality, outcomes, and value.
- SNFs indirectly benefitted from VBP during the pandemic, specifically through pre-pandemic relationships built between VBP providers and SNFs. During COVID-19, these relationships became avenues for obtaining resources and assistance with COVID-19 prevention, testing, and treatment activities.
- While many people sought to receive care outside of a SNF facility during COVID-19, and there's a broader trend to de-institutionalize and provide more home and community-based services, the COVID experience also highlights that a significant fraction of people will require facility-based care due to their health, functional needs, and limited caregiver resources. This highlights the continued need for VBP models that support improvement and flexibility in SNF settings.
- If VBP is to more directly benefit SNFs during future crises and facilitate effective changes in care patterns, new approaches to SNF-focused VBP models will need to account for the unique circumstances of SNFs (including their staffing, ownership structures, resident needs, financing, and other post-acute care sector challenges).

Skilled nursing facilities (SNFs) have been hit especially hard during the COVID-19 pandemic. The facilities have faced multiple structural factors that made COVID-19 challenging to manage—their residents are often frail, contagious respiratory diseases can spread quickly among congregate living facilities where people are cared for in close quarters, and, especially early in the pandemic, many new SNF residents were admitted directly from a hospital where they may have been exposed to the virus.¹⁻³ Further, SNFs struggled to access necessary resources for infection control and managing COVID care, such as personal protective equipment (PPE) to protect staff and residents as well as adequate staffing, given long-standing financial, workforce, and purchasing challenges.⁴ Many residents left or avoided SNFs if they had caregiving support in their home or otherwise in the community, which reduced SNF revenues at a time they needed financial resources to manage COVID-19 needs.^{5,6} The challenges exposed and

exacerbated by the COVID-19 pandemic highlight the need to continue to improve safety and quality in this setting.

In other health care settings, providers have found varying degrees of protection from the pandemic's impacts through participation in value-based payment (VBP) models.⁷ Because VBP models partially or fully decouple payment from service volume, health care delivery organizations were financially protected when services plunged during the early pandemic. In addition, many health care delivery organizations were able to re-deploy capabilities they had built to succeed under value-based payment, such as having care coordinators help with contact tracing or using telehealth or in-home care during stay-at-home orders. However, few VBP efforts have involved SNFs directly, and it is unclear whether participation in VBP models has been similarly helpful to SNFs as they respond to COVID-19.⁸

This brief provides a high-level overview of the VBP landscape for SNFs, including both their short-term, post-acute rehabilitation (i.e., skilled nursing care) and long-term care (sometimes referred to as nursing home care); describes ways in which VBP impacted SNFs' ability to respond to the COVID-19 pandemic; and provides recommendations for policymakers and regulators on designing effective VBP models for SNFs. The findings are the product of a literature review on payment and care delivery challenges in SNFs prior to and during the COVID-19 pandemic and interviews with SNF staff and leadership, professional societies representing SNFs and SNF providers, VBP providers working with SNFs, and post-acute and long-term care experts.

Different Types of Care Provided by SNFs

This issue brief captures payment models that can support both types of SNF care, including short-stay, post-acute rehabilitation (skilled nursing care) and long-term care (sometimes referred to as nursing home care). Of note, more than 90% of SNFs provide both long and short term care.⁹

Skilled nursing care is a high level of medical care often required after a hospitalization for injury or illness. The average length of stay for skilled nursing care is four weeks, and the primary payer for this type of care is Medicare. In 2019, 1.5 million Medicare FFS beneficiaries used short term skilled nursing care, totaling \$27.8 billion in Medicare expenditures.⁹

Nursing home care is long-term care primarily focused on assistance with activities of daily living. The average length of stay for nursing home care is 14 months, and the primary payer for this type of care is Medicaid. In 2019, there were approximately 1.3 million residents in long term nursing home care, totaling \$39 billion in Medicaid expenditures.^{9,10}

Limited Uptake of Value-Based Payment among SNFs

Across most health care settings during the past decade, there has been a major movement towards VBP models, driven by concerns over improving quality and reducing spending. In 2018, 25% of health care dollars flowed through pay for performance or similar models (category 2 in the Health Care Payment Learning and Action Network's [LAN's] framework), while 36% percent of health care payments flowed through more advanced alternative payment models (e.g., shared savings, bundled payments, population based payments; categories 3 and 4 of the LAN framework).¹¹

However, uptake of such models in SNFs has been slower, and SNF leaders noted in interviews that a very limited amount of their current revenue directly flows through a VBP model. This is partially a function of a limited number of payment models that are applicable to that setting, so facilities have few options even if they are interested in participating. While some VBP models touch or impact SNFs in various ways, few models have been specifically developed for SNFs or with the goal of specifically improving both quality and costs at facilities. The following sections will provide reasons why this is the case and detail some of the existing models that do impact SNFs.

SNF VBP Models Are Challenging to Operationalize Given Diversity in Services and Financing Streams

One of the reasons for the limited number of and participation in payment reforms for SNFs is the diversity of needs of the populations served in these facilities. SNFs generally provide two different types of care (see sidebar)—short-stay, post-acute rehabilitation and long-term care. The motivations, payment model structures, and payers differ between those types of care. Current VBP models tend to focus on short-stay, skilled nursing care and outcomes such as reducing hospital readmissions, while VBP models for long-stay, nursing home care are limited in number and scope, despite forecasts for a dramatic increase in the need for this type of care as the US population ages.¹²⁻¹⁴

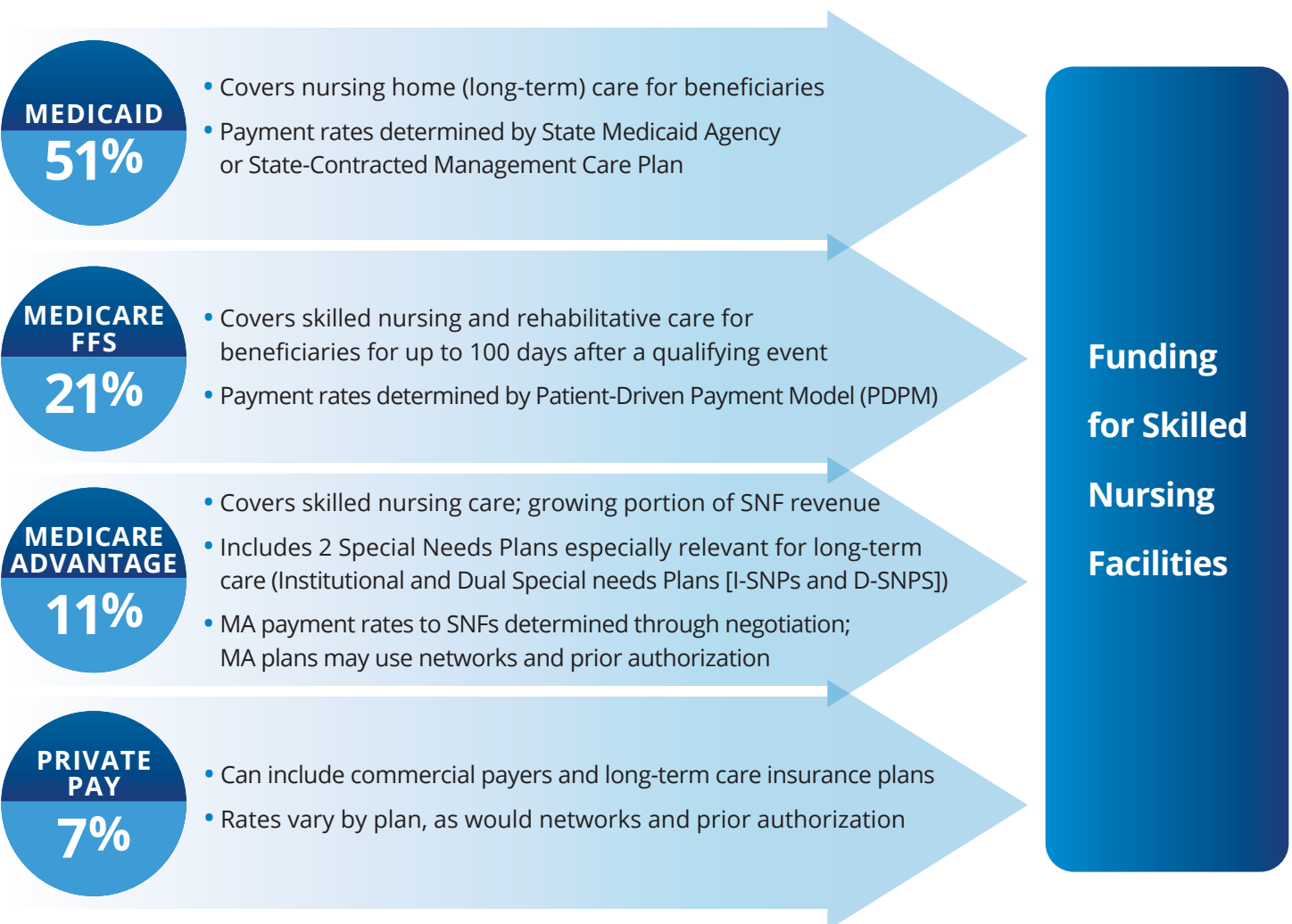
As shown in Figure 1, SNF payments come largely from public payers, with payments from Medicaid and Medicare (including Medicare Advantage) constituting over 90 percent of SNF revenue.¹⁵

Medicaid payments cover the majority of nursing home care, as Medicare does not pay for long-term care. Medicaid payment rates are set by state Medicaid agencies or state-contracted managed care plans and are often adjusted for factors such as resident acuity and facility location or bed size.^{16,17} On the other hand, Medicare payments to SNFs primarily cover skilled nursing and rehabilitative services for short-stay (i.e., up

to 100 days) residents admitted after a qualifying event, such as a hospitalization.^{18,19} Traditional Medicare rates are set by its Patient-Driven Payment Model (PDPM) rate setting model, which was implemented in 2019 and predicts a resident's care needs based on their initial diagnosis, functional and cognitive needs, and comorbidities.²⁰ Because payment rates from Medicare are higher than Medicaid rates, facilities frequently focus on maintaining an adequate census of short-stay, Medicare-covered residents in order to offset payments for the care delivered to the Medicaid-covered portion of their resident population.

FIGURE 1

SNF Payment Distribution, Highlighting Reliance on Public Payers.



Data Source: 2019 Annual Skilled Nursing Data Report. Key Occupancy and Revenue Trends. NIC MAP Data Service¹⁵
 Note: Remaining 10% is classified as "other", per the 2019 Annual Skilled Nursing Data Report.

While health care organizations in other settings receive payments from multiple payers, SNFs are unique in having strong differences between the types of care supported by each payer (short-stay vs. long-term care). The strong bifurcation of covered services by payer adds to the complexity in implementing value-based payment for SNFs.

Adding to payer complexity, Medicare Advantage (MA) has become a growing portion of SNF revenue. Medicare Advantage must cover at least the same basic services as supplied by traditional Medicare, and therefore pays for skilled nursing care (although its rates may differ from traditional Medicare as they are negotiated with the specific facility, the plan may have SNF networks, or the plan may require prior authorization)²¹⁻²³. The MA program also includes two Special Needs Plans that are especially relevant for long-term nursing home care. Institutional-Special Needs Plans (I-SNPs) provide coverage to MA beneficiaries requiring over 90 days of institutionalized care, and they are designed to provide resources for onsite care (such as nurse practitioners and physician assistants) and coordination to reduce unnecessary care (especially hospitalizations). I-SNPs are paid a per member per month (PMPM) premium that can be used to cover that onsite coordination and

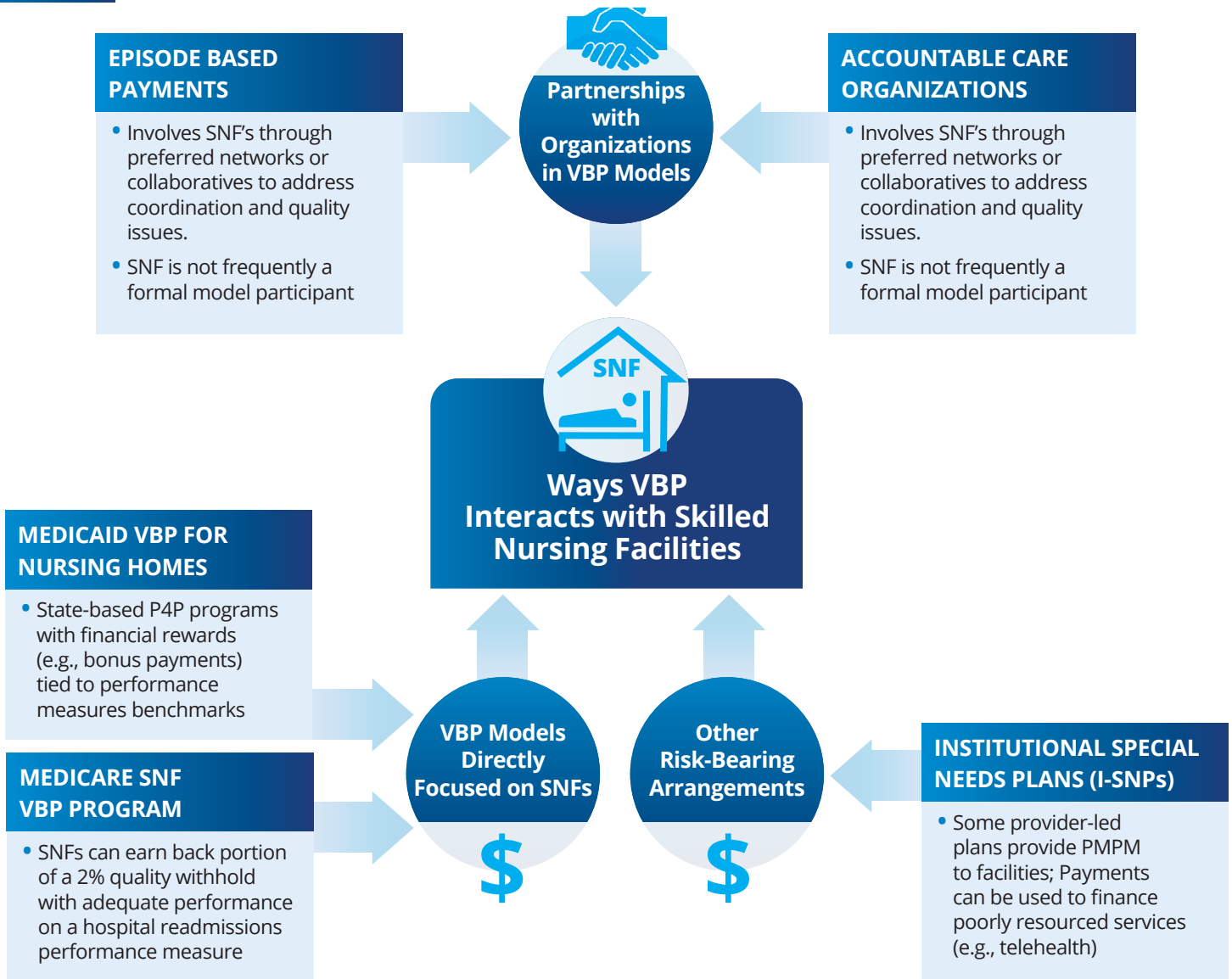
provide a risk-bearing arrangement that incentivizes the facility to reduce unnecessary hospitalizations.²⁴ The number of I-SNPs has increased significantly over the past 5 years, with both health plans and skilled nursing facilities starting these plans. Another important type of Special Needs Plan is the Dual Eligible-Special Needs Plans (D-SNPs) for MA beneficiaries dually eligible for Medicare and Medicaid, given that dual eligible beneficiaries are more likely to live in a nursing home than other Medicare beneficiaries.

KEY TAKEAWAYS

- Different payment streams for short-stay, skilled nursing care and long-term care can make it challenging to design and implement a SNF-focused VBP model, as current VBP models only focus on one portion of the SNF resident population (short-stay or long-term). The impact of current VBP models for SNFs are further limited by frequent cost shifting (such as facilities using higher Medicare rates to supplement lower Medicaid rates).
- Medicare Advantage is playing an increasingly important role in SNFs, especially through Special Needs Plans that focus on populations likely to use long-term care.

FIGURE 2

Payment Models with Incentives and Accountability for Skilled Nursing Facilities



VBP Models Focused on SNFs Are Mostly Pay for Performance Models

The most common forms of SNF-focused VBP to date have been pay-for-performance models where providers are paid for services through fee-for-service (FFS) methods but rewarded for their performance on specific performance measures.²⁵ For example, the Centers for Medicare and Medicaid Services' (CMS) Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program is a pay-for-performance model in which SNFs are assessed on a performance measure focused on hospital readmissions of Medicare-covered, short-stay residents. SNFs are eligible to earn back a portion of the two percent withhold Medicare takes from SNF's FFS Medicare Part A payments.

The Consolidated Appropriations Act of 2021 revises the CMS SNF-VBP program to allow CMS to expand the quality measures that can be tied to reimbursement.²⁶ Prior to this program, Medicare tested the Nursing Home Value-Based Purchasing Demonstration in 3 states, where improvements in care for Medicare beneficiaries warranted bonuses based on a risk pool funded by withheld payments from all participating nursing homes.²⁷

An example of a Medicaid VBP program for SNFs is the Texas Nursing Home Quality Incentive Payment Program (QIPP).²⁸ Implemented in 2017 through state-contracted managed care plans, facilities are eligible to receive direct payments based on achieving quality of care goals for the facility's Medicaid-covered, long-stay residents.

Quality is assessed through a set of performance measures related to pressure ulcers, residents' ability to move independently, staffing levels, and infection control.

While pay-for-performance programs can be a step toward more advanced changes, the evidence to date suggests they have not brought meaningful change to SNF care practices or quality. For example, Medicare's Nursing Home Value-Based Purchasing Demonstration found little impact on nursing home performance and limited savings.²⁷ While the CMS SNF VBP Program is ongoing, the number of SNFs eligible for bonus payments has declined from 26% in 2019 to 19% in 2020.²⁹ Further, a study of SNF pay-for-performance programs across multiple state Medicaid agencies also found that quality improvements were inconsistent, and sometimes worsened.³⁰ A 2020 report from US Department of Health and Human Services Office of the Inspector General found the Texas Nursing Home QIPP program provides some incentives for improvement, but operational challenges limited the program's ability to improve care quality.³¹

Based on feedback from formal evaluations, interviews, and other stakeholder reports, these programs may have limited impact because:

- Many facilities viewed existing models as not appropriately designed for the SNF setting;
- Several existing VBP models used a single performance measure to assess quality while facilities emphasize quality is multi-dimensional;
- Some VBP models relied on performance measures that facilities felt did not capture key elements of quality care for the SNF population;
- Measured performance could change substantially between years potentially because of a small number of beneficiaries included in quality measure calculations;
- Some models showed poor performance for those facilities that served large numbers of dually eligible or low socioeconomic status beneficiaries, indicating a need for better risk adjustment to outcomes; and
- The small size of the financial reward attached to performance may not be enough to justify changes in care delivery practices.³²

Overall, few SNFs were formal participants in a VBP model, beyond the mandatory pay-for-performance models.

VBP Models Involving Other Settings Have Led to Several Partnerships with SNFs

In addition to SNF-focused VBP models, SNFs can be involved and affected by VBP models that involve other sectors, such as accountable care organizations (ACOs) and episode-based payment models. Interviews noted there are various ways SNFs are engaged in these VBP models—they may sometimes be formal participants that receive financial incentives for quality and value, or they may be affected by the VBP participants through new referral patterns, care coordination support, learning networks, or partnerships with staffing and other supports. The frequency of partnerships has increased as health care organizations work with local SNFs to achieve their value-based goals. According to a survey published in August 2020, prior to the pandemic 10% of responding health systems were exploring partnerships with SNFs, 38% had partnerships without financial risk, 8% partnerships with financial risk and 23% owned SNFs.³³

ACOs have increased substantially over the past decade, with over 1000 ACOs serving 40 million people in 2019.³⁴ While ACOs are most frequently led by physician groups or large health systems, some ACOs may be led by post-acute care organizations involving SNFs or involve SNFs through partnerships. For example, Genesis Healthcare, one of the largest post-acute care organizations in the US, runs an ACO of nearly 200 affiliated facilities.³⁵ However, interviews with SNFs and SNF associations emphasized that overall SNFs are not formal ACO participants that receive shared savings.

Health care delivery organizations participating in an ACO may partner with SNFs to create preferred provider networks. The SNF benefits from increased referrals of ACO patients who require some level of SNF-level care after a hospitalization, and the ACO benefits in ensuring its patients receive a certain quality of care during their SNF stays. For an example of a formal network, Medicare Shared Savings Program (MSSP) ACOs can take advantage of a waiver that allows the ACO to refer a patient to a SNF without a preceding 3-day inpatient stay by identifying a network of SNF affiliates. In 2021, approximately 118 ACOs (out of 477 MSSP ACOs in 2021) involve SNFs as affiliates with an average of 15 SNF affiliates per ACO.^{36,37} Other ACOs use more informal networks that providers can use when making referrals for skilled nursing care. Regardless of the formality of the network, ACOs may invest in resources and staffing to improve care further, especially to reduce

unnecessary readmissions, which may include working with SNFs in activities such as care coordination during transitions to a SNF; providing staffing for SNFs such as NPs and medical directors, and creating avenues for peer-to-peer learning for facilities.³⁸⁻⁴⁰

Episode-based payment models, are designed to hold providers accountable for quality, costs, and outcomes of a given care episode (e.g., knee replacement). Procedure-focused episode-based payment models often capture a sufficient time frame after an inpatient episode where a patient may be using post-acute care (including SNFs), thereby encouraging organizations to focus on SNF care and utilization. For example, hospitals participating in procedure-focused models (e.g., knee replacements) in Medicare's Bundled Payments for Care Improvement (BCPI) Initiative and Comprehensive Care for Joint Replacement Model (CJR) have reduced SNF referrals for their patients, often opting instead for home health services.^{41,42} Like ACOs, some hospitals and health care delivery organizations involved in these models have created SNF networks to help improve care and coordination with SNFs. Actions taken through these partnerships include sharing data and access to electronic health records, telehealth access at the SNF to reduce ED and inpatient admissions, embedding hospital or health system staff (e.g., NPs) across facilities to help with care management, and hiring care coordination staff.^{41,43,44} While bolstering partnerships with SNFs has been given

some attention by organizations participating in episode-based models, interviews suggest it has been less so than ACOs, which may be driven by an ACO's accountability for a population over a longer period of time.

One consideration is that interviewed SNFs viewed VBP with hesitancy given that VBP savings often were achieved through reductions in SNF care and other post-acute care spending. In both ACOs and episode-based models, providers have focused on decreased SNF utilization and lengths of stay as a key cost-reduction strategy.⁴⁵⁻⁴⁷ As noted above, there are other ways that health care delivery organizations work with SNFs, such as providing staff or helping with care coordination, but this perception challenge can make it difficult to engage SNFs in VBP models.

Other Risk-Sharing Arrangements in the Value-Based Continuum Include Provider-Led Special Needs Plans

Another risk-sharing arrangement similar to formal value-based payment models, and also part of the value-based continuum, is MA Institutional Special Needs Plans (I-SNPs) led by SNF providers. Provider-led I-SNPs approximate VBP in that the providers share risk and have accountability for total health care costs and quality.^{24,48} The number of I-SNPs overall has been

KEY TAKEAWAYS

- Current SNF-focused VBP models are primarily pay-for-performance models, which had a limited impact on changing SNF care practices or improving quality of care.
- Institutional Special Needs Plans (I-SNPs) are a new type of Medicare Advantage plan focused on SNF care, and the number of such plans has grown rapidly. The plans provide flexibility to invest in resources (e.g., nurse practitioners, telehealth technologies) that may improve outcomes for SNF residents, and provider-led I-SNPs offer similar types of risk-sharing as other value-based payment models.
- VBP models developed for other health care settings or for multiple health care settings (e.g., ACOs, procedure-focused episode-based payment models) have often generated savings through lower post-acute care utilization (e.g., SNF admissions and lengths of stay). SNFs reported hesitancy with VBP as a result.
- SNFs have been indirectly affected by VBP as several health care providers participating in VBP have developed SNF preferred networks or partnerships to promote better coordination, quality of care, and outcomes.

increasing. Between 2019 and 2020, the number of I-SNPs increased from 125 to 147, with much of that growth driven by provider-led plans. With the plan's financial flexibility, I-SNPs have employed a provider, such as a nurse practitioner or physician assistant, who regularly visits covered residents on site to manage care to prevent unnecessary hospitalizations or other poor outcomes. Other I-SNPs have invested in telehealth to provide on-site care to avoid transporting patients or to avoid hospitalizations.⁴⁹

While some research has been done examining payer-led I-SNPs, which have been associated with lower ED use and fewer hospital admissions and readmissions. However, the impact of provider-led I-SNPs on these and other outcomes still needs to be investigated.⁵⁰

The Impact of Value-Based Payment on Skilled Nursing Facilities' Response to COVID-19

During the pandemic, many SNFs had to manage local COVID outbreaks, and SNFs also experienced significant drops in Medicare revenue as occupancy rates for short-stay, Medicare covered residents declined precipitously.⁵¹ Relief funding from the CARES Act, some of which was distributed based on performance on COVID-19 infection and mortality metrics, provided some relief but many facility operators continued to worry about their ability to keep their facilities open.^{52,53} At the same time, SNFs experienced an increased need for additional resources to respond to the pandemic (e.g., personal protective equipment [PPE], facility modifications to reduce transmission, additional staff).⁵⁴

The overall effect of VBP on SNFs during the pandemic was nuanced, with much greater impact on care delivery than SNF finances. Several SNFs we interviewed highlighted benefits from pre-pandemic relationships developed with VBP participants from other settings, such as help accessing PPE, staffing, treatments, and developing protocols for testing and treatment. On the other hand, our interviews suggested that VBP provided less financial protection for SNFs during the pandemic, largely due to the limited penetration of VBP among SNFs (whether through SNF-focused models, ACOs, episode-based models, or others). The limited exception to this finding was for I-SNPs, although they experienced some enrollment challenges.

VBP Models Offered Little Financial Protection to SNFs During the Pandemic

During interviews with SNF leadership and staff, they did not cite direct participation in VBP models as having a role in a facility's ability to withstand the financial impact of the pandemic. This differs from the experiences of providers in other sectors where VBP participation provided access to financial resources (e.g., shared savings, capitated payments) that could protect against financial losses when in-person visits and procedures dropped precipitously during the pandemic.⁷ The interviews noted two challenges—few SNFs participated in many VBP models, and those models in which they did participate, like Medicare's SNF-VBP program, had smaller bonus payments than the scale of their revenue losses during the pandemic.

A limited exception to this was the modest financial protection some I-SNPs may have offered to facilities. One interviewee noted that while many I-SNPs pay SNFs through FFS mechanisms, some plans may pass along the PMPM payment directly to facilities. This was more likely in smaller, provider-led I-SNPs where the provider also owns the facility caring for the I-SNP's beneficiaries. Such an arrangement could have provided the facility with a more reliable source of Medicare revenue during the pandemic. However, I-SNP enrollment often declined during the pandemic due to higher than expected beneficiary deaths, which blunted the financial protection an I-SNP was able to offer the facility.

Pre-Pandemic Relationships with VBP Providers Helped SNFs Meet Care Delivery Needs During the Pandemic

Interviews did emphasize that SNFs benefited from pre-pandemic partnerships with VBP participants in other settings through provider networks or collaboratives. While these partnerships did not usually involve formal financial arrangements, they proved valuable as avenues for communication and the sharing of resources and supports (e.g., PPE, assistance with infection control and COVID-19 treatment activities) that could bolster SNFs' responses to COVID-19. Providers, particularly hospital-based providers, were interested in ensuring SNFs' adequate response because an insufficient response could lead to spikes in hospital admissions from SNF residents and place additional pressure on hospitals' already strained capacities.

With little known about how to best prevent and treat COVID-19, frequent changes to guidance, and case surges in various parts of the country, SNFs needed a way to communicate their capacity issues and need for resources. The Henry Ford Health System—a participant in CMS’s Next Gen ACO model—in Michigan held daily morning calls with SNF partners to review capacity limitations, staffing issues, PPE needs, and any other issues impeding SNFs’ ability to respond to the pandemic. ChristianaCare’s eBrightHealth ACO in Delaware leveraged its pre-pandemic weekly care coordination calls and monthly meetings with SNF leadership across the state that were established through the eBrightHealth ACO to answer questions, facilitate communication, and coordinate access to needed resources as the pandemic evolved. As a part of these calls, the eBrightHealth ACO also created a statewide PAC/SNF task force that included public health officials, hospital/health system leaders, and SNF clinicians and administrators that met regularly to discuss challenges with the pandemic response and to collaborate and develop solutions to those challenges.

After communication channels were established, VBP providers and SNFs often focused on sharing resources. Many of the VBP providers we spoke with mentioned working to distribute supplies, particularly PPE, to their SNF partners. The Henry Ford Health System distributed nearly 800,000 gloves, gowns, masks, and other PPE to SNFs and other providers. Assistance, particularly with PPE, was not limited to SNFs with established relationships with VBP providers, but the existence of those relationships facilitated the identification of needs and distribution of resources to address those needs, if possible.

Beyond securing supplies, VBP providers worked with SNFs to develop pathways and protocols for managing COVID-19 among SNF residents. For example, Pioneer

Valley ACO in Massachusetts helped develop rapid protocols and testing supplies for COVID-19 surveillance and diagnosis so potential cases could be identified among SNF residents and appropriate precautions could be taken to prevent transmission.⁵⁵ Pioneer Valley ACO also worked with their SNF partners to repurpose an existing building into a COVID-19 only facility that could care for COVID-19 positive SNF residents and assisted with staffing the facility. This assistance with managing residents with COVID-19 was helpful since many SNFs were facing staffing issues and difficulties with adequately isolating residents who tested positive for the virus. For facilities with I-SNP covered beneficiaries, interviews noted the I-SNP care model involving an NP or other provider to help monitor and manage residents was particularly valuable during the pandemic. The NP could manage beneficiaries experiencing exacerbations of a non-COVID-19 condition (e.g., congestive heart failure) and proactively monitor beneficiaries for COVID-19 symptoms and flag residents for early testing, isolation, and/or treatment.

The eBrightHealth ACO also worked with its partner SNFs to address facilities’ testing and treatment needs. They worked collaboratively with public health officials to optimize and standardize the use of diagnostic testing, particularly in the period of transition between hospitals and post-acute care (PAC) facilities. Hospitals in the network also helped with SNF access to COVID-19 treatments, specifically monoclonal antibody therapies. Given limited access among PAC facilities, and the challenges of transporting vulnerable patients to infusion sites, several hospitals worked with the facilities to prepare and package monoclonal antibody treatment for SNFs to pick up and infuse at the facility for residents who met the criteria for the therapy. In addition to preparing and packing the therapy, the hospitals also agreed to report the necessary data to the US Department of Health and Human Services and the Food and Drug Administration.

KEY TAKEAWAYS

- Pre-pandemic relationships between VBP participants and SNFs became avenues for obtaining resources and assistance with COVID-19 screening, testing, and treatment activities.
- For SNFs that had relationships with VBP participants in other settings, the SNFs received significant help in securing PPE, developing testing and treatment protocols, and facilitating access to treatments and other needed resources.
- As few SNFs formally participated in extensive VBP models, VBP offered limited protection for SNFs against the financial impacts of the COVID-19 pandemic.

Policy Implications for How to Better Position SNFs for the Future

This brief has summarized the current state of VBP for SNFs, finding positive impacts (especially in encouraging partnerships that were leveraged during COVID for better care) and opportunities for improvement (such as in their reach and ability to provide financial resilience during emergencies). This section identifies potential policy opportunities to better tailor VBP models to account for unique SNF needs, provide more opportunities for SNFs to participate in VBP models, and improve long-standing workforce and financing issues that may limit SNF ability to succeed under VBP (and improve care overall).

The current time presents a unique opportunity for improving SNF care and payment. First, given the impact of COVID-19 on SNFs, and the vulnerabilities exposed by the pandemic, there are likely to be SNF-related policies enacted during the post-COVID period, whether by the federal government, states, and private payers. In addition, the new Administration, and new leadership at CMS, are currently articulating their health care vision, which will likely include payment and regulatory changes to improve equity, recover from the pandemic, and increase community-based caregiving.

Providing More Opportunities for SNFs to Participate in VBP

The precarious financial state of SNFs also indicates SNFs need more reliable and resilient payment models if they are to be better positioned for future crises and to meet the care needs of the aging U.S. population. VBP models have potential to supply more reliable revenue and support high-quality care, but more opportunities for SNFs to participate in VBP are needed if that potential is to be realized.

Several opportunities exist through Center for Medicare and Medicaid Innovation (CMMI) as its new leadership reviews its existing model portfolio and launches new or modified models. For example, CMMI could encourage greater SNF participation in existing ACO or episode-based payment models by streamlining the SNF 3-day waiver process, which would encourage more VBP participants to form the partnerships that were helpful during the pandemic. Another opportunity would be through the Direct Contracting model, which included a

track for Medicaid managed care organizations (MCOs). While CMMI is currently reviewing this track, it would involve the MCO taking on financial risk for dually-eligible beneficiaries' Medicare costs. Therefore, the MCO could establish a VBP arrangement with a SNF for the beneficiaries Medicare-covered services and embed performance measures into the arrangement that not only address utilization (e.g., hospitalizations), but other key areas of quality as well.^{56,57} The Direct Contracting Model's High Needs Population track may involve entities that have successfully taken risk for dual-eligible beneficiaries or complex Medicare Advantage patients, who could then adapt their model to SNF care. For 2021, 6 of the 53 Direct Contracting Entities are participating in the High Needs Population track, and CMS will not accept new applications for the 2022 cohort, which means it will take some time until evidence exists on how this track affects SNF care.

States may also be interested in building new VBP, building off prior Medicaid-focused VBP efforts (as described in the appendix and prior research)²⁵. Most prior SNF-focused payment reforms have been pay-for-performance models, which have had modest results. There may be opportunities for more advanced VBP models, such as identifying how SNFs can be part of Medicaid ACO models. Any Medicaid VBP model has to be carefully designed so as to attract SNF participation given the expressed concern about Medicaid rates for long-stay residents.

Delivery Model Changes

SNF care models are likely to change based on experiences from the pandemic and policies proposed by the new Administration. The pandemic has given renewed energy to efforts to move away from existing SNF models of care and toward smaller, more resident-centered facilities (e.g., Green House models) or facilities focused on a specific sub-set of the SNF population (e.g., memory centers caring for those with advanced dementia).⁵⁸ In addition, the new Administration has supported home- and community-based services, with the recently passed American Rescue Plan increasing Medicaid funding for home- and community-based services and the Biden infrastructure plan proposes adding \$400 billion for such services and their workforce. The motivation is that more people may be able to remain in their community if they have additional supportive services

and sufficient caregiving support. However, another lesson from the pandemic was that there is a significant group of patients with health or functional needs and limited caregiving support who will continue to need SNF care. The combination of these trends might be that SNFs serve smaller, but more complex, populations in the future. These delivery model changes will have significant implications for value-based payment for SNFs, such as reasonable financial benchmarks, appropriate measures of quality for this population, and challenges risk adjusting to capture a person's needs.

For VBP models to support better care models, it will need to be coupled with technical assistance, upfront capital, and support for organizational competencies to support larger care delivery changes.⁵⁹ One approach to meeting this upfront capital need was the ACO Investment Model, which provided small and rural providers with upfront capital to establish their ACOs.⁶⁰ Another is a per-member, per-month payment, similar to that used for D-SNPs and I-SNPs, although this would be appropriate for organizations ready to take on significant financial risk. Additionally, a portion of any additional COVID-19 related provider relief funding could be set aside for similar infrastructure investments and SNFs could be required to agree to transitioning into VBP models in exchange for the additional funds.

A further delivery model challenge in SNFs is inadequate staffing, which has challenged many facilities' ability to deliver high-quality care to their residents and, left unaddressed, will limit the impact of other reforms.^{54,61-63} SNF positions (e.g., nurses, certified nursing assistants, therapy aides) tend to be low-wage, high-stress positions with little opportunity for advancement and extremely high turnover rates.⁶⁴ Between 2009 and 2016, facilities' staffing hours per resident day were consistently below recommended levels.¹⁴ There are multiple existing state regulations requiring minimum staffing, and the federal Nursing Home Compare and associated SNF Quality Reporting Program collect staffing data. Future VBP models could include staffing as a quality measure to encourage greater staffing, but those models would likely need to provide upfront capital to help with hiring and effective monitoring strategies to ensure long-term change. Additional options that have been discussed include enhancing the SNF environment's appeal as a workplace, raising wages and benefits, and increasing the supply of trained workers.⁶⁵⁻⁶⁸

Tailoring VBP Models to the Unique Circumstances of SNFs and Their Residents

VBP models depend on measures to focus attention on what areas of care need to be improved. Current measures in SNF-focused VBP models tend to focus on utilization, such as the CMS SNF-VBP program consisting of one measure on hospital readmissions (although Congress has recently allowed CMS to expand the number of quality measures in that program). While utilization measures are important, they do not reflect the whole picture of quality care in SNFs. Quality measures can build on the substantial effort involved in implementing the Improving Medicare-Post Acute Care Transformation (IMPACT) Act of 2014, which advanced the collection of standardized data and quality measures more specific to SNFs (e.g., functional status, cognitive function, medication reconciliation) and other post-acute and long-term care settings. While important, the use of IMPACT Act-related measures in VBP models appears to be limited.⁶⁹ Functional status, advance care planning, quality of life (particularly for long-stay residents), resident-reported satisfaction or experience with care, and now COVID-19 testing and vaccination are also areas where more measurement is needed.

Quality measures and VBP can also help advance the Administration's equity goals. For example, SNFs serving greater numbers of racial and ethnic minorities often had higher COVID mortality among its residents.⁷⁰ One option for reducing disparities and improving equity would be to require that SNFs report measures stratified by race and ethnicity.⁷¹

Finally, another key challenge is the complicated relationship between facility owners and facility operators, which makes it difficult for the financial incentives in VBP models to have their desired effect.

The SNF owner increasingly does not operate the SNF, but rather leases the SNF buildings to an operator who handles the day-to-day operations of the SNF. A VBP model affects payments to the SNF operator, but the SNF owner receives a consistent level of rent regardless. This arrangement can be further challenging to SNF care as the rent paid to facility owners can take up a substantial portion of the operators' revenue and limit their access to capital that may be used in times of emergency (e.g., a pandemic) or to invest in facility infrastructure.⁷² The

growing proportion of owner investment by private equity companies has the potential to exacerbate this owner-operator disconnect even further, which could lead to poorer outcomes and higher costs.⁷³ One potential way to align incentives would be to publicly report quality data aggregated by owner, which would both increase public visibility of quality at various owner's facilities and provide a financial incentive for owners as poor quality could lead

to limited resident volume.⁷⁴ This approach could be strengthened by regulations stipulating minimum quality standards that must be met to maintain eligibility to be a SNF owner and greater transparency about SNF owners' other business holdings.^{74,75}

KEY TAKEAWAYS

- Existing SNF-focused VBP programs could be expanded and new SNF-focused VBP models could be developed and implemented to provide SNFs with more opportunities to participate in VBP.
- New care delivery models are likely after the pandemic and given proposed policies, such as greater use of home- and community-based services. This may require care and VBP models targeted at smaller, but more complex, resident populations in SNFs.
- VBP models can be better tailored to the unique circumstances of SNFs, such as through new quality measures, opportunities to reduce disparities within SNF care, and aligning incentives between owners and operators.

Conclusion

Skilled nursing facilities provide care to some of the most vulnerable individuals, and they faced substantial challenges in caring for that population during the COVID-19 pandemic. VBP models showed promise in helping SNFs during the pandemic by encouraging partnerships, but the models were generally not able to help with financial resilience. For VBP models to help SNFs be resilient during the next public health emergency, VBP models must be designed and implemented to account for the unique needs and populations of this setting. Addressing other long-standing issues facing the SNF industry is also required if SNFs are to be better positioned to deliver high-quality care to SNF residents in times of normalcy as well as in times of crisis.

Acknowledgments

We would like to thank the following individuals and organizations for speaking with us during the information gathering stage for this issue brief. They provided crucial insights and answered key questions we had, and we greatly appreciate their time and contributions to this work. The viewpoints expressed in this brief do not necessarily reflect the viewpoints of the individuals below nor their organizations.

- Alex Bardakh, AMDA – The Society for Post-Acute & Long-Term Care Medicine
- Christopher Laxton, AMDA – The Society for Post-Acute & Long-Term Care Medicine
- Adam Wolk, Alignment Healthcare
- Adam Sholar, North Carolina Health Care Facilities Association
- Michael Wasserman, Geriatrician
- Tim Engelhardt, CMS Medicare-Medicaid Coordination Office
- Sara Vitolo, CMS Medicare-Medicaid Coordination Office
- Andrew Brecher, CMS Medicare-Medicaid Coordination Office
- Terry Fulmer, The John A. Hartford Foundation
- JP Sharp, Care Solutions Strategy, Optum
- John Birkmeyer, Sound Physicians
- Amy Herr, West Health Policy Center
- Daniel Elliot, Christiana Care Health System, eBrightHealth ACO
- Adrienne Seiler, Baycare Health Partners, Pioneer Valley Accountable Care
- Ronald Chaffin, Seniors Select
- Clare Hays, Seniors Select
- Heather Bruemmer, Wisconsin Ombudsman Office
- Fran Rainer, Pruitt Health
- Angela Tolbert, Pruitt Health
- Cheryl Phillips, SNP Alliance
- Susan Craft, Henry Ford Health System
- Gloria Rey, Henry Ford Health System

We would like to thank members of the HOPE Collaborative at the Duke University Health System and the American Hospital Association's Post-Acute Care Committee for providing their insight. We would also like to thank the broader research team at Duke University's Robert J. Margolis for strategic guidance and input, including Patricia Green, Hemi Tewarson, Courtney Van Houtven, and Mark McClellan.

Support for this brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation. We would like to acknowledge specific support and interest from Katherine Hempstead, PhD.

About the Robert Wood Johnson Foundation

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

About the Duke Margolis Center for Health Policy

The mission of the Robert J. Margolis, MD, Center for Health Policy at Duke University is to improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions. For more information, visit healthpolicy.duke.edu. For more information about this brief, please contact: Robert Saunders at robert.saunders@duke.edu.

| | Payer | SNF Population Impacted | Model Structure |
|--|------------------------------------|----------------------------|---|
| Performance Payments | | | |
| CMS SNF VBP Program | Traditional Medicare | Short-Stay | SNFs are eligible to earn back a portion of the 2% withhold Medicare takes from SNF's FFS Medicare Part A payments (based on performance on hospital readmission measure) |
| CMS Nursing Home VBP Demonstration (inactive: 2009-2012) | Traditional Medicare | Short-Stay | Nursing homes with quality scores in the top 20% or in the top 20% in terms of improvement eligible for a share of that State's savings pool (quality based on staffing, appropriate hospitalizations, minimum data set (MDS) outcomes, and survey deficiencies) |
| Texas Nursing Home Quality Incentive Payment Program (QIPP) | Medicaid Managed Care | Long-Term Care | Facilities eligible to receive directs payments based on achieving quality of care (e.g., measures related to pressure ulcers, residents' ability to move independently, staffing levels, and infection control.) |
| Health Plan of San Mateo Nursing Facility Quality Payment | Medicaid Managed Care | Short-Stay, Long-Term Care | Facilities that meet quality benchmarks receive quality score points that are used to determine the amount of bonus payments (for measures related to skilled care and custodial care) |
| Partnerships | | | |
| Accountable Care Organizations (e.g. Pioneer Valley ACO, Henry Ford ACO) | Medicare, Medicaid, private payers | Short-Stay, Long-Term Care | ACOs are accountable for costs and outcomes of attributed beneficiaries. SNFs are infrequently financial partners in ACOs (and therefore are unable to share in available savings), but more frequently participate in ACO's post-acute care networks formed in response to ACO formation. |
| Long Term Care Accountable Care Organization (Genesis HealthCare's LTC ACO) | Medicare | Long-Term Care | The first LTC ACO, Genesis' ACO differs from most ACOs in that SNFs are formal partners. |
| Bundled Payments (e.g. Bundled Payments for Care Improvement Initiative, Comprehensive Care for Joint Replacement Model) | Traditional Medicare | Short-Stay | Participants must cover costs that go above the target price for an episode of and share in savings if they keep costs below the target price while maintaining quality standards. SNFs are rarely financial partners in models and consequently do not share in savings, but may participate in networks, in a similar manner to ACOs. |
| Other Risk-Sharing Approaches | | | |
| Institutional-Special Needs Plan (can be provider-led, such as PruittHealth or insurer-led, such as United Healthcare) | Medicare Advantage | Long-Term Care | Medicare pays a commercial plan administering the I-SNP a per member per month (PMPM) premium for each beneficiary. The plan then uses that PMPM to pay for the services required by their beneficiaries, sometimes paying the facility through PMPMs, sometimes through FFS. |

References

1. Houtven CHV, Boucher NA, Dawson WD. Impact of the COVID-19 Outbreak on Long-Term Care in the United States. *Int Long-Term Care Policy Netw CPECLSE*. Published online April 24, 2020:25.
2. Why Nursing Homes Become COVID-19 Hot Spots. California Health Care Foundation. Published July 13, 2020. Accessed March 1, 2021. <https://www.chcf.org/blog/why-nursing-homes-become-covid-19-hot-spots/>
3. Grabowski DC, Mor V. Nursing Home Care in Crisis in the Wake of COVID-19. *JAMA*. Published online May 22, 2020. doi:10.1001/jama.2020.8524
4. Boucher NA, Van Houtven CH. A Day in the Life during COVID-19: Long-term Care Providers in Durham, North Carolina. *Perm J*. 2020;24. doi:10.7812/TPP/20.165
5. Flynn M. 48 States Saw Nursing Home Occupancy of 80% or Worse as 2021 Dawned — With Census as Low as 56%. *Skilled Nursing News*. Published January 25, 2021. Accessed February 1, 2021. <https://skillednursingnews.com/2021/01/48-states-saw-nursing-home-occupancy-of-80-or-worse-as-2021-dawned-with-census-as-low-as-56/>
6. Continued Low Occupancy at Many U.S. Skilled Nursing Facilities Threatens Their Long-Term Survival. National Investment Center. Published December 2, 2020. Accessed February 5, 2021. <https://www.nic.org/news-press/year/2020/>
7. Roiland R, Japinga M, Singletary E, et al. Value-Based Care in the COVID-19 Era: Enabling Health Care Response and Resilience. :10.
8. The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program | CMS. Accessed February 16, 2021. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page>
9. MedPAC. Report to the Congress: Medicare Payment Policy. Published online March 2021. http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf
10. Total Number of Residents in Certified Nursing Facilities. KFF. Published August 3, 2020. Accessed April 7, 2021. <https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/>
11. Health Care Payment Learning & Action Network. APM Measurement Progress of Alternative Payment Models: 2019 Methodology and Results Report. Published online 2019. Accessed November 19, 2019. <http://hcp-lan.org/workproducts/apm-methodology-2019.pdf>
12. Medpac. Report to the Congress: Medicare Payment Policy. http://www.medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf?sfvrsn=0
13. MacPAC. MACStats Medicaid and CHIP Data Book December 2020. Published online December 2020. <https://www.macpac.gov/wp-content/uploads/2020/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2020.pdf>
14. Harrington C, Carrillo H, Garfield R, Squires E. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009-2015. Published online April 2018. <http://files.kff.org/attachment/REPORT-Nursing-Facilities-Staffing-Residents-and-Facility-Deficiencies-2009-2015>
15. National Investment Center. NIC MAP | Annual Skilled Nursing Data Report. Accessed February 1, 2021. <https://info.nic.org/nic-map-skilled-nursing-data-annual-report>
16. Holgash K, Nelb R. Payment Methods and Recent Developments in Nursing Facility Payment Policy. Published online September 2019. <https://www.macpac.gov/publication/nursing-facility-payment-policy-payment-methods-and-recent-developments/>
17. States' Medicaid Fee-for-Service Nursing Facility Payment Policies. MACPAC. Accessed February 2, 2021. <https://www.macpac.gov/publication/nursing-facility-payment-policies/>
18. Nursing Facilities | Medicaid. Accessed February 16, 2021. <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html>
19. SNF Care Coverage. Accessed February 2, 2021. <https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care>
20. Patient Driven Payment Model | CMS. Accessed February 3, 2021. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/PDPM>
21. Meyers DJ, Mor V, Rahman M. Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees. *Health Aff (Millwood)*. 2018;37(1):78-85. doi:10.1377/hlthaff.2017.0714
22. Chang E, Ruder T, Setodji C, et al. Differences in Nursing Home Quality Between Medicare Advantage and Traditional Medicare Patients. *J Am Med Dir Assoc*. 2016;17(10):960.e9-960.e14. doi:10.1016/j.jamda.2016.07.017
23. Medpac. Skilled Nursing Facility Services. http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch8_sec.pdf
24. Allen K. Preliminary Insights on 2020 Medicare Advantage and Part D Plan Offerings. Health Management Associates. Published September 26, 2019. Accessed February 5, 2021. <https://www.healthmanagement.com/blog/preliminary-insights-on-2020-medicare-advantage-and-part-d-plan-offerings/>
25. Libersky J, Stone J, Smith L, Verdier J, Lipson D. Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans. https://www.integratedcareresourcecenter.com/pdfs/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf
26. We need to reform America's elder-care system | Opinion. *Newsweek*. Published January 8, 2021. Accessed February 15, 2021. <https://www.newsweek.com/we-need-reform-americas-elder-care-system-opinion-1559800>
27. L&M Policy Research. Evaluation of the Nursing Home Value-Based Purchasing Demonstration. Published online 2013. https://innovation.cms.gov/files/reports/nursinghomevbp_evalreport.pdf
28. Quality Incentive Payment Program for Nursing Homes | Texas Health and Human Services. Accessed February 5, 2021. <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes>

29. Daras LC, Vadnais A, Pogue YZ, et al. Nearly One In Five Skilled Nursing Facilities Awarded Positive Incentives Under Value-Based Purchasing. *Health Aff (Millwood)*. 2021;40(1):146-155. doi:10.1377/hlthaff.2019.01244
30. Werner RM, Konetzka RT, Polsky D. The Effect of Pay-for-Performance in Nursing Homes: Evidence from State Medicaid Programs. *Health Serv Res*. 2013;48(4):1393-1414. doi:https://doi.org/10.1111/1475-6773.12035
31. Aspects of Texas' Quality Incentive Payment Program Raise Questions About Its Ability To Promote Economy and Efficiency in the Medicaid Program. Accessed February 5, 2021. <https://oig.hhs.gov/oas/reports/region6/61807001.asp>
32. Mandated Report: Skilled nursing facility value-based purchasing program. Published online September 3, 2020. http://www.medpac.gov/docs/default-source/meeting-materials/medpac_snf_vbp_sept_2020.pdf?sfvrsn=0
33. Nai Consulting. The State of Population Health: Fifth Annual Numerof of Survey Report. Published online 2020. <https://nai-consulting.com/numerof-state-of-population-health-survey/>
34. Spread of ACOs And Value-Based Payment Models In 2019: Gauging the Impact of Pathways to Success | Health Affairs Blog. Accessed April 15, 2021. <https://www.healthaffairs.org/doi/10.1377/hblog20191020.962600/full/>
35. Genesis, Signature Raise "Going Concern" Doubts with Omega, Prompting \$140M Write-Down. *Skilled Nursing News*. Published September 24, 2020. Accessed January 18, 2021. <https://skillednursingnews.com/2020/09/genesis-signature-raise-going-concern-doubts-with-omega-prompting-140m-write-down/>
36. Performance Year 2021 Medicare Shared Savings Program Accountable Care Organizations – SNF Affiliates | Data.CMS.gov. Accessed March 11, 2021. <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/Performance-Year-2021-Medicare-Shared-Savings-Prog/fk5t-aip7>
37. Performance Year 2021 Medicare Shared Savings Program Accountable Care Organizations | Data.CMS.gov. Accessed March 11, 2021. <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/Performance-Year-2021-Medicare-Shared-Savings-Prog/uq55-vjb2>
38. Partners Population Health Management. My CMS. Accessed April 1, 2021. https://populationhealth.partners.org/news_posts/a-clinical-collaboration-for-better-care/
39. RevCycleIntelligence. 5 Care Coordination Strategies for Medicare ACO Success. *RevCycleIntelligence*. Published April 16, 2019. Accessed April 1, 2021. <https://revcycleintelligence.com/news/5-care-coordination-strategies-for-medicare-aco-success>
40. Kennedy G, Lewis V, Kundu S, Mousqués J, Colla C. Accountable Care Organizations Are Transforming the Management of Post-Acute Care through Preferred SNF Networks. *Med Care Res Rev MCRR*. 2020;77(4):312-323. doi:10.1177/1077558718781117
41. Zhu JM, Patel V, Shea JA, Neuman MD, Werner RM. Hospitals Using Bundled Payment Report Reducing Skilled Nursing Facility Use And Improving Care Integration. *Health Aff (Millwood)*. 2018;37(8):1282-1289. doi:10.1377/hlthaff.2018.0257
42. Barnett ML, Joynt Maddox KE, Orav EJ, Grabowski DC, Epstein AM. Association of Skilled Nursing Facility Participation in a Bundled Payment Model With Institutional Spending for Joint Replacement Surgery. *JAMA*. 2020;324(18):1869-1877. doi:10.1001/jama.2020.19181
43. Transitioning to Value-Based Hospital Medicine: A Sound Investment? | NEJM Catalyst. Accessed April 15, 2021. <https://catalyst-nejm-org.proxy.lib.duke.edu/doi/full/10.1056/CAT.19.1135>
44. Daly R. Where Providers Are Finding Value-Based Profit. *hfma*. Accessed April 15, 2021. <https://www.hfma.org/topics/hfm/2018/october/61892.html>
45. McWilliams JM, Gilstrap LG, Stevenson DG, Chernew ME, Huskamp HA, Grabowski DC. Changes in Postacute Care in the Medicare Shared Savings Program. *JAMA Intern Med*. 2017;177(4):518-526. doi:10.1001/jamainternmed.2016.9115
46. Without Incentive to Share Savings, ACOs Add to SNFs' Financial Headaches. *Skilled Nursing News*. Published January 6, 2019. Accessed February 5, 2021. <https://skillednursingnews.com/2019/01/without-incentive-to-share-savings-acos-add-to-snfs-financial-headaches/>
47. Barnett ML, Mehrotra A, Grabowski DC. Postacute Care — The Piggy Bank for Savings in Alternative Payment Models? *N Engl J Med*. 2019;381(4):302-303. doi:10.1056/NEJMp1901896
48. Spanko A. Provider-Led I-SNPs Grow 28% in 2021, Outpacing Traditional Medicare Advantage Insurers. *Skilled Nursing News*. Published November 12, 2020. Accessed March 4, 2021. <https://skillednursingnews.com/2020/11/provider-led-i-snps-grow-28-in-2021-outpacing-traditional-medicare-advantage-insurers/>
49. Spanko A. I-SNP Case Studies Show Promise in Era Where Fee-for-Service Medicare Looks Unsustainable. *Skilled Nursing News*. Published October 28, 2019. Accessed February 5, 2021. <https://skillednursingnews.com/2019/10/i-snp-case-studies-show-promise-in-era-where-fee-for-service-medicare-looks-unsustainable/>
50. Managed Care for Long-Stay Nursing Home Residents: An Evaluation of Institutional Special Needs Plans. *AJMC*. Accessed February 10, 2021. <https://www.ajmc.com/view/managed-care-for-long-stay-nursing-home-residents-an-evaluation-of-institutional-special-needs-plans>
51. Decline in Skilled Nursing Occupancy Continues Due to COVID-19 Pandemic. *National Investment Center*. Accessed February 5, 2021. <https://www.nic.org/news-press/decline-in-skilled-nursing-occupancy-continues-due-to-covid-19-pandemic/>
52. Survey: Nursing Homes Incurring Significant Costs and Financial Hardship in Response to COVID-19. August 8-10, 2020. Published online August 2020. Accessed February 5, 2020. <https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/Survey-SNF-COVID-Costs.pdf>
53. CARES Act Provider Relief Fund: General Information. *HHS.gov*. Published May 27, 2020. Accessed March 1, 2021. <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html>
54. McGarry BE, Grabowski DC, Barnett ML. Severe Staffing And Personal Protective Equipment Shortages Faced By Nursing Homes During The COVID-19 Pandemic. *Health Aff (Millwood)*. Published online August 20, 2020;10.1377/hlthaff.2020.01269. doi:10.1377/hlthaff.2020.01269

55. NextGen ACO Coalition. ACO Resilience: Responding to the COVID-19 Pandemic. <https://nextgencoalition.org/wp-content/uploads/2020/10/ACOResilienceProject-PioneerValleyACO.pdf>
56. Direct Contracting Model: Professional and Global Options Medicaid Managed Care Organization (MCO)-based Direct Contracting Entity (DCE) Fact Sheet | CMS. Accessed February 15, 2021. <https://www.cms.gov/newsroom/fact-sheets/direct-contracting-model-professional-and-global-options-medicare-managed-care-organization-mco>
57. Johnson N, Shellabarger S, Hallum A. Direct Contracting Duals Model. Published online 2021. Accessed April 1, 2021. https://www.milliman.com/-/media/milliman/pdfs/2021-articles/2-8-21-direct_contracting_duals-v1.ashx
58. Fulmer TT, Koller CF, Rowe JW. Reimagining Nursing Homes in the Wake of COVID-19. *NAM Perspect*. Published online September 21, 2020. doi:10.31478/202009a
59. Zimmerman S, Bowers BJ, Cohen LW, et al. New Evidence on the Green House Model of Nursing Home Care: Synthesis of Findings and Implications for Policy, Practice, and Research. *Health Serv Res*. 2016;51(Suppl 1):475-496. doi:10.1111/1475-6773.12430
60. ACO Investment Model | CMS Innovation Center. Accessed February 17, 2021. <https://innovation.cms.gov/innovation-models/aco-investment-model>
61. Harrington C, Ross L, Chapman S, Halifax E, Spurlock B, Bakerjian D. Nurse Staffing and Coronavirus Infections in California Nursing Homes. *Policy Polit Nurs Pract*. 2020;21(3):174-186. doi:10.1177/1527154420938707
62. The Importance Of Nursing Home Transparency And Oversight, Even In The Midst Of A Pandemic | Health Affairs Blog. Accessed December 14, 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20200511.431267/full/>
63. Avila AWM Andrea Fuller and Joseph De. WSJ News Exclusive | Thinly Staffed Nursing Homes Face Challenges in Pandemic. *Wall Street Journal*. <https://www.wsj.com/articles/thinly-staffed-nursing-homes-face-challenges-in-pandemic-11588343407>. Published May 1, 2020. Accessed December 14, 2020.
64. Gandhi A, Yu H, Grabowski DC. High Nursing Staff Turnover In Nursing Homes Offers Important Quality Information. *Health Aff (Millwood)*. 2021;40(3):384-391. doi:10.1377/hlthaff.2020.00957
65. Raise the Floor: Quality Nursing Home Care Depends on Quality Jobs. Paraprofessional Healthcare Institute; 2016. Accessed February 15, 2021. <https://phinational.org/wp-content/uploads/legacy/research-report/phi-raisethefloor-201604012.pdf>
66. Impacts of Minimum Wage Increases on Nursing Homes: Final Report. ASPE. Published June 30, 2020. Accessed February 15, 2021. <https://aspe.hhs.gov/basic-report/impacts-minimum-wage-increases-nursing-homes-final-report>
67. Strengthening Nursing Home Policy for the Postpandemic World: How Can We Improve Residents' Health Outcomes and Experiences? doi:<https://doi.org/10.26099/b19s-cb53>
68. Famakinwa J. 'A Monumental Advance': Newly Unveiled American Jobs Plan Would Invest \$400B into Home-Based Care. *Home Health Care News*. Published March 31, 2021. Accessed April 1, 2021. <https://homehealthcarenews.com/2021/03/a-monumental-advance-newly-unveiled-american-jobs-plan-would-invest-400b-into-home-based-care/>
69. IMPACT Act of 2014 Data Standardization & Cross Setting Measures | CMS. Accessed February 15, 2021. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures>
70. Gorges RJ, Konetzka RT. Factors Associated With Racial Differences in Deaths Among Nursing Home Residents With COVID-19 Infection in the US. *JAMA Netw Open*. 2021;4(2):e2037431-e2037431. doi:10.1001/jamanetworkopen.2020.37431
71. Hefele JG, Ritter GA, Bishop CE, et al. Examining Racial and Ethnic Differences in Nursing Home Quality. *Jt Comm J Qual Patient Saf*. 2017;43(11):554-564. doi:10.1016/j.jcjq.2017.06.003
72. Spanko A. To Fix Nursing Homes, Landlords and Payers Must Change Broken Incentives — for Both Owners and Operators. *Skilled Nursing News*. Published February 2, 2021. Accessed March 4, 2021. <https://skillednursingnews.com/2021/02/to-fix-nursing-homes-landlords-and-payers-must-change-broken-incentives-for-both-owners-and-operators/>
73. Gupta A, Howell ST, Yannelis C, Gupta A. Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes. *Social Science Research Network*; 2020. doi:10.2139/ssrn.3537612
74. These Administrative Actions Would Improve Nursing Home Ownership And Financial Transparency In The Post COVID-19 Period | Health Affairs Blog. Accessed February 12, 2021. <http://www.healthaffairs.org/doi/10.1377/hblog20210208.597573/full/>
75. Harrington C, Wiener JM, Ross L, 2017. Key Issues in Long-Term Services and Supports Quality. KFF. Published October 27, 2017. Accessed December 14, 2020. <https://www.kff.org/medicaid/issue-brief/key-issues-in-long-term-services-and-supports-quality/>