Research Report: An Analysis of Skilled Nursing Facility (SNF) Payer Mix in the United States, 2024-2025 with Wound Complexity Analysis

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Executive Summary

This report provides a comprehensive analysis of the Skilled Nursing Facility (SNF) payer mix in the United States for the 2024-2025 period. The research definitively establishes the composition of patient populations and revenue streams from key payers—Medicare, Medicaid, and Private/Other sources—and clarifies the critical distinctions in how payer mix is measured and interpreted. The findings are based on an extensive synthesis of the most recent data from authoritative sources, primarily the Medicare Payment Advisory Commission (MedPAC), the Centers for Medicare & Medicaid Services (CMS), and leading industry organizations [1, 3, 9, 15].

Payer mix is a fundamental concept in the SNF industry, representing the distribution of a facility's business across different payment sources. It is measured in two primary ways: by **patient days**, which reflects the volume of care and operational focus, and by **revenue**, which illustrates the financial drivers and profitability [1]. The disparity between these two metrics is the central financial dynamic of the SNF sector; payers that account for a high volume of days do not necessarily contribute a proportional share of revenue, and vice versa [1].

Based on the most recent comprehensive national data from 2023, which serves as the baseline for the 2024-2025 period, the national payer mix for a typical freestanding SNF is as follows [1]:

By Patient Days: * **Medicaid:** 63% [1] * **Medicare Fee-for-Service (FFS):** 8% [1] * **Private/Other (including Medicare Advantage):** 29% [1]

By Revenue: * **Medicare Fee-for-Service (FFS):** 14% [1] * **Medicaid, Private/Other (including Medicare Advantage):** 86% [1]

These figures reveal a stark reality: Medicaid is the dominant payer in terms of patient volume, accounting for the vast majority of care days, which are typically for long-term custodial care [1, 12]. However, Medicare FFS, despite covering a small fraction of patient days for short-term, post-acute care, contributes a disproportionately large share of revenue due to its significantly higher reimbursement rates [1].

A new analysis integrated into this report examines the profound impact of complex clinical conditions, specifically **pressure ulcers and diabetic ulcers**, on SNF operations and payer dynamics. These conditions are highly prevalent in the SNF population and serve as a powerful driver of patient acuity [19, 21]. The presence of severe or non-healing wounds often qualifies a patient for a Medicare-covered post-acute stay, making them a key component of the high-margin Medicare census. Under Medicare's Patient-Driven Payment Model (PDPM), these conditions trigger higher reimbursement rates to cover the intensive skilled nursing care required [10, 25]. However, this increased revenue is offset by substantial treatment costs, significant litigation risk (particularly for pressure ulcers, which can indicate neglect), and intense scrutiny under CMS quality programs [3, 23, 27]. Poor outcomes in wound care can lead to direct financial penalties, further complicating the financial model for facilities [27].

The report further clarifies the distinction between "Medicare-certified SNFs" and "all nursing homes." In practice, these terms are nearly interchangeable from a facility standpoint, as approximately 96% of nursing homes are dually certified to provide both Medicare-funded skilled care and Medicaid-funded long-term care [1]. The critical difference lies not in the facility type but in the *type of stay*. The national payer mix estimates reflect the blended reality of these dually-certified facilities, which manage both a high-volume, low-margin long-term care business (primarily Medicaid) and a low-volume, high-margin short-term rehabilitation business (primarily Medicare) [1, 3].

The analysis concludes that the SNF sector is navigating a period of profound challenge and transition. Key trends shaping the 2024-2025 landscape include the steady erosion of the high-margin Medicare FFS population due to the rapid growth of Medicare Advantage (MA), persistent financial pressure from low Medicaid reimbursement rates, a severe workforce crisis, and an impending federal staffing mandate that will significantly increase operating costs [1, 15]. While CMS has finalized a modest payment increase for Medicare services in 2025, these pressures, combined with MedPAC's recommendation to reduce Medicare base rates in the future, create a volatile and uncertain outlook for the industry [1, 9].

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1. Introduction

The financial viability and operational strategy of Skilled Nursing Facilities (SNFs) in the United States are intrinsically linked to their **payer mix**. This term, which describes the proportional representation of different payment sources within a facility's patient population, is the single most important determinant of its economic health. Understanding the nuances of payer mix is essential for a wide range of stakeholders, including healthcare providers, facility operators, policymakers, investors, and patients and their families. It dictates revenue streams, influences care decisions, and shapes the overall stability of the long-term care sector.

This report aims to provide a definitive and comprehensive analysis of the SNF payer mix for the 2024-2025 period. The primary objective is to answer four fundamental questions: 1. What is 'payer mix' for SNFs and how is it measured by patient days versus revenue? 2. What are the best-supported national estimates for payer mix by patient days? 3. What are the best-supported national estimates for payer mix by revenue? 4. How do these estimates differ when considering Medicare-certified SNFs versus all nursing homes?

The American healthcare landscape is supported by a complex web of payers. For SNFs, the principal sources of payment are Medicare, for short-term, post-acute skilled nursing and rehabilitation services; Medicaid, the primary funder of long-term custodial care for financially eligible individuals; and a diverse category of "Private and Other" payers, which includes private insurance, out-of-pocket payments from residents, and, increasingly, managed care plans under Medicare Advantage (MA) [1, 4, 12]. Each of these payers operates under different rules, covers different types of services, and reimburses at vastly different rates, creating a complex financial environment that facilities must navigate to remain solvent. This report will dissect the role of each payer and analyze the critical trends, such as the growth of MA, that are reshaping the financial future of the SNF industry [1, 11].

2. Methodology

This research report is a comprehensive synthesis and analysis of data and findings from highly credible, authoritative sources in the healthcare policy and data landscape. The methodology was designed to consolidate the most current and reliable information to construct a definitive picture of the SNF payer mix for 2024-2025.

The analysis primarily relies on quantitative data and expert commentary from the **Medicare Payment Advisory Commission (MedPAC)**, an independent congressional agency that advises the U.S. Congress on the Medicare program. Specifically, this report draws heavily from MedPAC's March 2025 and June 2025 Reports to Congress, which provide detailed 2023 data—the most recent complete dataset available for comprehensive analysis—on SNF payment adequacy, utilization, and payer distribution [1, 3]. These reports

use Medicare cost report data, claims data, and other sources to generate national estimates for the median freestanding facility [1].

Additional context and supporting information were derived from publications and data releases from the **Centers for Medicare & Medicaid Services (CMS)**, including the Fiscal Year 2025 SNF Prospective Payment System (PPS) final rule, quality program documentation, and information on its cost reporting systems [8, 9, 27]. Research and analysis from the **Kaiser Family Foundation (KFF)** were incorporated to provide deeper insight into the roles of Medicaid and Medicare Advantage [11, 12]. Finally, reports and surveys from the **American Health Care Association (AHCA)**, a major industry trade group, were used to understand the on-the-ground operational and financial challenges facing SNF providers, such as workforce shortages and facility closures, which provide critical context for the payer mix data [15].

This report, dated February 5, 2026, analyzes data primarily from calendar and fiscal years 2023 and 2024 to establish a robust baseline for understanding the market dynamics of the 2024-2025 period. New research on the impact of pressure ulcers and diabetic ulcers has been integrated using recent studies and CMS policy documents to provide a more granular view of how clinical complexity affects payer mix and facility finances [19, 21, 23, 24, 25, 27]. All claims and figures presented are directly supported by the cited source materials. The report acknowledges and discusses the inherent limitations of the available data, such as the aggregation of Medicare Advantage into broader categories, to provide a transparent and accurate analysis [1].

3. Defining and Measuring SNF Payer Mix

A clear understanding of what payer mix is and how it is measured is foundational to any analysis of the Skilled Nursing Facility sector. The concept is not monolithic; its interpretation depends entirely on the metric used—patient days or revenue. The significant divergence between these two measurements reveals the core financial architecture and challenges of the modern nursing home [1].

3.1. What is Payer Mix?

For a Skilled Nursing Facility, **payer mix** refers to the distribution of its patient population and corresponding revenue across the various entities that pay for care. It is, in essence, a portfolio of funding sources. A facility's specific payer mix is the result of its geographic location, market competition, clinical specializations, relationships with local hospitals, and strategic decisions regarding which types of patients to admit. The three primary payer categories that constitute this mix are Medicare, Medicaid, and Private/Other sources [1, 4]. Each payer covers different services for different populations under distinct payment structures, creating a bifurcated system within most facilities. Medicare typically covers short-term, intensive rehabilitation stays following a hospitalization, while Medicaid is the default payer for long-term, custodial care for individuals who have exhausted their personal financial resources [1, 12].

3.2. Measurement by Patient Days vs. Revenue

Payer mix is quantified using two distinct but equally important metrics: patient days and revenue. Analyzing both is necessary to gain a complete picture of a facility's operational and financial reality [1].

Measurement by Patient Days Measuring payer mix by **patient days** quantifies the volume of care provided. This metric reflects the proportion of total occupied bed-days attributable to residents covered by each payer source over a given period. For example, if Medicaid patients occupy 60% of a facility's beds on an average day, then Medicaid constitutes 60% of the payer mix by patient days. This measurement is an indicator of a facility's operational focus and census composition. It answers the question: "Who are our residents, and how much of our capacity is dedicated to each payer group?" As will be detailed, this metric shows that the overwhelming majority of care delivered in nursing homes, in terms of sheer volume and time, is long-term care funded by Medicaid [1, 12].

Measurement by Revenue Measuring payer mix by **revenue** quantifies the financial contribution of each payer to the facility's top line. This metric reflects the proportion of total patient service revenue

generated by each payer source. It is a direct indicator of a facility's financial drivers and profitability. This measurement answers the question: "Where does our money come from?" Due to vast differences in reimbursement rates, the payer mix by revenue looks dramatically different from the payer mix by days [1]. Medicare's daily payment rates for post-acute care are substantially higher than Medicaid's rates for long-term care [1]. Consequently, Medicare's share of revenue is far greater than its share of patient days [1]. This disparity is the central economic principle of the SNF industry: a small number of high-acuity, short-stay Medicare patients often generate the profit margin necessary to offset losses or low margins incurred from caring for a large population of long-stay Medicaid residents [1].

The tension between these two measurement frameworks defines the strategic challenge for SNF operators. They must manage a high volume of low-reimbursement Medicaid residents to maintain census and cover fixed costs, while simultaneously attracting a sufficient number of high-reimbursement Medicare patients to ensure overall financial viability.

4. National Payer Mix Estimates: Detailed Findings (2024-2025 Baseline)

The most reliable national estimates for SNF payer mix are derived from the Medicare Payment Advisory Commission's (MedPAC) analysis of Medicare cost report data [1]. The following figures, based on 2023 data for the median freestanding Skilled Nursing Facility, provide the definitive baseline for the 2024-2025 period [1].

4.1. National Payer Mix by Patient Days

When measured by the volume of care provided, Medicaid is unequivocally the dominant payer in the nursing home sector [1, 12]. These figures illustrate the operational reality for a typical facility, where the majority of beds are occupied by long-term care residents.

Table 1: National Payer Mix by Patient Days (Freestanding SNFs, 2023)

Payer Category

Percentage of Total Patient Days

Primary Role

Medicaid

63%

Primary payer for long-term, custodial care.

Private & Other Payers

29%

Includes Medicare Advantage, private insurance, and out-of-pocket payments.

Medicare Fee-for-Service (FFS)

8%

Payer for short-term, post-acute skilled care.

Total

100%

Source: MedPAC March 2025 Report to Congress. The "Private & Other" category is calculated as the remainder after accounting for Medicaid and Medicare FFS [1].

The data clearly show that nearly two-thirds of all patient days in a typical SNF are financed by Medicaid [1]. This underscores the sector's profound reliance on this government program for its core, long-term

care mission [12]. The Medicare FFS portion, at just 8%, represents the small but critical segment of post-hospitalization rehabilitation stays [1]. The "Private & Other" category, at 29%, is a significant and complex segment. It includes residents paying out-of-pocket (often before "spending down" to Medicaid eligibility), individuals with private long-term care insurance, and the rapidly growing population of beneficiaries enrolled in Medicare Advantage plans [1, 3].

4.2. National Payer Mix by Revenue

When the payer mix is viewed through the lens of revenue, the financial importance of Medicare becomes immediately apparent. Despite accounting for a small fraction of patient days, Medicare's high reimbursement rates for clinically complex, short-term care give it an outsized role in a facility's financial health [1].

Table 2: National Payer Mix by Revenue (Freestanding SNFs, 2023)

Payer Category

Percentage of Total Facility Revenue

Analysis

Medicare Fee-for-Service (FFS)

14%

Disproportionately high share of revenue relative to its 8% share of days.

Medicaid, Private & Other Payers

86%

This combined category generates the bulk of revenue, but at lower per-day rates.

Total

100%

Source: MedPAC March 2025 Report to Congress. A specific revenue breakdown for Medicaid vs. Private/Other is not provided in the source data [1].

The contrast between Table 1 and Table 2 is striking. Medicare FFS, with only 8% of patient days, generates 14% of total facility revenue [1]. This highlights its status as a premium payer. The MedPAC data does not provide a separate revenue percentage for Medicaid and the "Private & Other" category [1]. However, it is well-established that Medicaid's revenue share is significantly lower than its 63% share of days due to its low payment rates [1]. Conversely, the revenue share from private pay and some Medicare Advantage plans is generally higher than their share of days, as their rates, while variable, typically exceed those of Medicaid. This financial structure creates a powerful incentive for facilities to maximize their Medicare census, as this small patient population is essential for subsidizing the costs of caring for the much larger Medicaid population [1].

5. Analysis of Payer Mix Dynamics and Trends

The national payer mix is not a static picture but a dynamic system influenced by demographic shifts, policy changes, and evolving market forces. The 2024-2025 period is characterized by several powerful trends that are actively reshaping the financial landscape for Skilled Nursing Facilities.

5.1. The Evolving Role of Medicare

Medicare has traditionally been the most coveted payer for SNFs due to its high reimbursement rates for post-acute care. However, the nature of the Medicare population is undergoing a fundamental transformation.

Medicare Fee-for-Service (FFS): The FFS program remains a critical, high-margin business line. MedPAC data from 2023 shows a robust aggregate FFS Medicare margin of 22% for freestanding SNFs, with a

projected margin of 23% for 2025 [1]. The marginal profit on each additional Medicare patient was 31% in 2023, creating a strong financial incentive for facilities with available capacity to admit these beneficiaries [1]. However, the pool of FFS beneficiaries is shrinking. MedPAC reports that the FFS share of facility days dropped from 10% in 2022 to 8% in 2023, with a corresponding revenue decline from 17% to 14% [1]. This erosion is a direct consequence of the growth of Medicare Advantage [1].

Medicare Advantage (MA): The rapid expansion of Medicare Advantage is the most significant trend affecting SNF payer mix. In 2023, MA plans covered 48% of all Medicare beneficiaries, and this share continues to grow [1]. As more beneficiaries choose MA plans over traditional FFS, SNFs are increasingly contracting with these private insurers. This shift has profound implications. While MA plans also cover post-acute care, their payment rates are typically lower than FFS Medicare rates, and they often employ more aggressive utilization management, leading to shorter lengths of stay [1]. A growing subset of MA plans are Institutional Special Needs Plans (I-SNPs), which are specifically designed for nursing home residents. KFF and MedPAC note the substantial growth in I-SNP enrollment, which now covers about 12% of Medicare nursing home residents [3, 11]. These plans aim to provide more coordinated care within the facility to reduce costly hospitalizations, but they further move the payment model away from the traditional FFS structure [3].

5.2. The Enduring Dominance of Medicaid

Medicaid remains the bedrock of the nursing home industry from a volume perspective. As the primary payer for long-term care, it covers 63% of all patient days [1]. This makes nearly every SNF operator heavily dependent on state Medicaid programs. This dependence creates significant financial strain.

Medicaid payment rates are notoriously low and, in many states, fail to cover the actual cost of care [1]. This is reflected in MedPAC's calculation of the "non-FFS Medicare margin," which includes Medicaid and other payers. In 2023, this margin was negative at -4.1% [1]. While this was an improvement from 2022, due to some states increasing their base rates, it still indicates that, on average, facilities lose money on their non-FFS Medicare business, which is predominantly composed of Medicaid residents [1]. This structural deficit forces facilities to rely on profits from their Medicare and private pay business to remain solvent. Furthermore, as detailed in the MedPAC June 2025 report, the pathway to Medicaid coverage often involves residents "spending down" their personal assets to meet strict eligibility limits [3]. This means a resident who enters as a higher-paying private pay patient will often transition to the lower-paying Medicaid category over time, adding another layer of financial pressure.

5.3. The Ambiguous "Private and Other" Category

This category, which accounts for 29% of patient days, is a diverse mix of payers including private long-term care insurance, direct out-of-pocket payments, and Medicare Advantage [1]. The lack of granular data, particularly for MA, is a significant limitation in public datasets. Cost reports do not require facilities to separate MA days and revenue from other private payers, making it difficult to precisely quantify MA's true share of the payer mix [1, 8]. However, given that MA enrollment is approaching 50% of the Medicare population, it is clear that MA constitutes a large and growing portion of this 29% of patient days and the corresponding 86% of non-FFS revenue [1]. The profitability of this category is highly variable, with private pay rates being the highest and MA rates falling somewhere between FFS Medicare and Medicaid.

6. Comparison: Medicare-Certified SNFs vs. All Nursing Homes

A key objective of this report is to clarify the payer mix for "Medicare-certified SNFs" versus "all nursing homes." The analysis reveals that the distinction is more conceptual than practical, as the vast majority of facilities function as both.

6.1. Defining the Facilities

A **Medicare-Certified Skilled Nursing Facility (SNF)** is a provider that has met Medicare's stringent requirements of participation to furnish Part A-covered, short-term skilled nursing and rehabilitation services

[4]. These services are typically for patients recovering from a hospital stay.

An **All Nursing Homes** designation is a broader term that encompasses facilities providing long-term custodial care, which includes assistance with activities of daily living, room and board, and less intensive nursing services. This type of care is primarily funded by Medicaid and private funds [12].

The critical point, as noted by MedPAC, is that these are not typically separate types of buildings. Approximately 96% of SNFs are **dually certified**, meaning they are equipped and approved to provide both Medicare-funded post-acute care and Medicaid-funded long-term care [1]. Therefore, the national payer mix data provided by MedPAC for a "freestanding SNF" is, in effect, the payer mix for a typical dually-certified nursing home that serves both populations simultaneously under one roof [1, 3].

6.2. Payer Mix by Stay Type vs. Facility Type

The most accurate way to understand the difference is not by facility type, but by the **type of stay**. Within a single dually-certified nursing home, the payer mix for a short-term, post-acute stay is vastly different from the payer mix for a long-term residential stay.

Table 3: Conceptual Payer Mix by Stay Type within a Dually-Certified Nursing Home

Stay Type

Primary Payers

Secondary Payers

Description

Post-Acute Skilled Stay

Medicare (FFS & MA)

Private Insurance

Short-term (up to 100 days), intensive rehabilitation and skilled nursing care following a qualifying hospital stay. High reimbursement rates [4].

Long-Term Custodial Stay

Medicaid

Private Pay (Out-of-Pocket)

Long-term residential care for individuals with chronic conditions or functional limitations. Lower reimbursement rates [12].

This conceptual table illustrates that the term "SNF" is often used to refer to the post-acute care *service*, while "nursing home" refers to the long-term care *service*. Since most facilities provide both, the national payer mix estimates represent a blend of these two distinct business lines [1, 3].

6.3. Comparative Payer Mix Tables

Because nearly all facilities are dually certified, the national payer mix estimates are functionally identical for both "Medicare-certified SNFs" and "all nursing homes." The tables below present the same data under both headings to definitively answer the user's query, while emphasizing that they describe the same blended operational reality for the vast majority of the industry.

Table 4: Payer Mix by Days vs. Revenue (Medicare-Certified SNFs, All Stays)

Payer Category

Share of Patient Days

Share of Revenue

Medicare FFS

8%

14%

Medicaid

63%

Not Specified

Private/Other (incl. MA)

29%

Not Specified

Total

100%

100%

Note: The 86% of revenue not from Medicare FFS is generated by the Medicaid and Private/Other categories combined [1].

Table 5: Payer Mix by Days vs. Revenue (All Nursing Homes, All Stays)

Payer Category

Share of Patient Days

Share of Revenue

Medicare FFS

8%

14%

Medicaid

63%

Not Specified

Private/Other (incl. MA)

29%

Not Specified

Total

100%

100%

Note: The 86% of revenue not from Medicare FFS is generated by the Medicaid and Private/Other categories combined [1].

In conclusion, the best-supported national estimates for payer mix apply to the typical dually-certified facility that constitutes the overwhelming majority of the U.S. nursing home market. The distinction is not between different facilities, but between the different payer-supported services offered within them.

7. Discussion of Data Sources and Limitations

The findings in this report are built upon the most authoritative data available. However, it is crucial to acknowledge the inherent limitations of these sources to ensure a complete and transparent understanding of the SNF payer mix.

Primary Data Source: The quantitative estimates for national payer mix are drawn primarily from the Medicare Payment Advisory Commission (MedPAC) [1]. MedPAC's analysis of Medicare cost reports is the gold standard for this type of research, providing a comprehensive view based on data submitted by nearly all providers nationwide [1, 8]. The authority and rigor of MedPAC's work lend significant weight to the findings presented.

Key Limitations:

1. **Data Timeliness:** The most recent comprehensive payer mix data available from MedPAC is for the 2023 calendar year [1]. While this serves as an excellent and stable baseline for the 2024-2025 period, it is not real-time data. The market is dynamic, and trends such as the growth of Medicare Advantage have continued to evolve since this data was collected.
2. **Lack of Granularity for Medicare Advantage (MA):** This is the most significant data limitation. In the Medicare cost reports that form the basis of MedPAC's analysis, facilities are not required to separately report patient days and revenue for Medicare Advantage plans [1, 8]. Instead, MA data is aggregated within the "Private and Other Payers" category [1]. This makes it impossible to precisely isolate and quantify the true share of MA in the national payer mix. As MA's influence grows, this data gap becomes increasingly problematic for policymakers and researchers seeking to understand its full impact on SNF finances [1].
3. **Incomplete Revenue Breakdown:** While MedPAC provides a clear revenue percentage for Medicare FFS (14%), it does not offer a further breakdown of the remaining 86% between Medicaid and the "Private/Other" category [1]. This prevents a direct comparison of the revenue contributions of these payers, though it is widely understood that Medicaid's revenue share is substantially smaller than its share of patient days.
4. **Use of Median Data:** The national estimates represent the payer mix for the *median* freestanding facility [1]. This provides a valuable national benchmark but masks the immense variation that exists across the country. An individual facility's payer mix can differ dramatically from the national median based on its location (urban vs. rural), ownership (for-profit vs. nonprofit), clinical specialization, and local market dynamics. The figures in this report should be understood as a national average, not a reflection of every facility's specific situation.

8. The Impact of Complex Clinical Conditions on Payer Mix: Pressure Ulcers and Diabetic Ulcers

Beyond the broad categories of payers, the clinical complexity of the resident population has a profound effect on a facility's operational and financial dynamics. Chronic, non-healing wounds, particularly pressure ulcers and diabetic ulcers, are highly prevalent conditions in SNFs that directly influence payer mix, reimbursement, costs, and quality ratings. These conditions serve as a clear example of how patient acuity shapes a facility's reliance on the high-reimbursement Medicare payer.

8.1. Prevalence and Clinical Significance in SNFs

Pressure ulcers and diabetic ulcers are a major clinical challenge in the long-term care setting. * **Pressure Ulcers:** Also known as pressure injuries, these are localized damages to the skin and underlying tissue caused by prolonged pressure, typically over bony prominences. They are a significant concern in SNFs due to the high number of residents with limited mobility, advanced age, and chronic conditions. A systematic review found a pooled pressure injury prevalence of 8.5% among older adults in nursing homes [20]. A large 2024 cohort study analyzing over 126,000 SNF stays found that over 42,000 patients developed a pressure injury during their stay, underscoring the high incidence within this setting [19]. * **Diabetic Ulcers:** These

ulcers, most commonly diabetic foot ulcers (DFUs), are a complication of diabetes resulting from neuropathy and poor circulation. While specific prevalence data for the SNF population is not readily available, the broader context is alarming. The global prevalence of DFUs among adults with diabetes is 6.3%, but in North America, the rate is more than double at 13.0% [21]. Given the high rates of diabetes in the elderly population, DFUs represent a substantial and growing burden for SNFs. These ulcers are associated with high rates of infection, lower-extremity amputation, and a five-year mortality rate that can exceed 70% for patients who undergo a major amputation [21, 22].

8.2. Correlation with Payer Mix and Patient Acuity

The presence of a severe pressure ulcer or a complex diabetic ulcer is a strong indicator of high patient acuity. This clinical complexity directly correlates with the payer mix, as these patients are more likely to require a level of care covered by Medicare Part A. A patient admitted from a hospital with a Stage 3 or 4 pressure ulcer, or a non-healing DFU requiring skilled wound care, meets the criteria for a Medicare-covered post-acute stay.

Consequently, a facility's ability to manage complex wound care is directly linked to its ability to attract and serve high-acuity Medicare patients. These patients, while representing a small portion of total patient days, are critical to the facility's financial health. This creates a dynamic where clinical specialization in areas like wound care becomes a strategic tool for optimizing payer mix.

However, this dynamic is complicated by liability concerns. Pressure ulcers are often considered a preventable condition and a strong indicator of potential nursing neglect. Research indicates that facilities may have a "vested interest" in diagnosing a wound as a diabetic ulcer (a complication of a disease) rather than a pressure ulcer to avoid legal risk and regulatory scrutiny [23]. This potential for misdiagnosis highlights the intense pressure facilities face at the intersection of clinical care, reimbursement, and liability.

8.3. Reimbursement Under the Patient-Driven Payment Model (PDPM)

Medicare's reimbursement system for SNFs, the Patient-Driven Payment Model (PDPM), is designed to align payment with patient characteristics and clinical needs [10]. Complex wounds are a key factor in this model. The presence of unhealed, surgical, or worsening pressure ulcers (Stage 2, 3, or 4) or other complex skin conditions can significantly increase a patient's case-mix index. This adjustment primarily impacts the **Nursing** and **Non-Therapy Ancillary (NTA)** components of the daily Medicare rate, resulting in higher reimbursement to cover the costs of increased nursing time, specialized dressings, and other treatments [25].

For example, treating a Stage 4 pressure ulcer requires intensive resources that are recognized and compensated under PDPM. Similarly, advanced treatments for DFUs, such as skin substitute grafts, are high-cost interventions. While CMS has recently focused on standardizing and limiting coverage for these grafts to ensure cost-effectiveness, their use is concentrated within the Medicare-covered population, further cementing the link between high clinical complexity, high cost, and high reimbursement [24].

8.4. Cost, Revenue, and Liability Implications

The management of complex wounds creates a challenging balance of costs, revenues, and risks.

- **High Costs:** Treating these wounds is resource-intensive and expensive. The cost to treat a single Stage 4 pressure ulcer can be as high as $19,000 [3]. These costs include specialized mattresses, frequent repositioning, advanced wound dressings, nutritional support, and potentially surgical debridement or high-cost skin substitutes.
- **High Revenue:** As noted, these high costs are offset by higher Medicare payments under PDPM. For a facility, a patient with a complex wound represents a higher-revenue case compared to a patient with lower acuity needs. This reinforces the fundamental SNF business model of using high-margin Medicare revenue to subsidize other payers.
- **High Liability:** The risk associated with pressure ulcers is substantial. They are a leading cause of litigation against nursing homes, with allegations of neglect often leading to significant financial

settlements and damage to a facility's reputation [23]. This legal risk represents a major indirect cost that facilities must manage.

The following table provides an analytical framework illustrating these interconnected dynamics.

Table 6: Analytical Framework: Impact of Complex Wounds on SNF Operations and Payer Dynamics

Factor

Pressure Ulcer (Stage 3-4)

Diabetic Foot Ulcer (Non-Healing)

Likely Primary Payer

Medicare Part A (Post-Acute)

Medicare Part A (Post-Acute)

Reimbursement Driver

High PDPM case-mix (Nursing & NTA components) [10, 25]

High PDPM case-mix (Nursing & NTA components) [10, 25]

Associated Direct Costs

High: Skilled nursing, advanced dressings, nutritional support, specialized equipment [3].

High: Skilled nursing, debridement, off-loading devices, potential for high-cost grafts [24].

Associated Indirect Costs

Very High: Litigation risk, regulatory fines, reputational damage [23].

Moderate: Costs associated with managing comorbidities (diabetes, vascular disease).

Quality/Financial Risk

High: Directly measured in SNF QRP; poor performance impacts payments and public ratings [27].

Moderate: Contributes to overall patient outcomes but less directly measured than pressure ulcers.

8.5. Impact on Quality Measures and Financial Penalties

CMS explicitly ties wound care outcomes to a facility's financial performance through its quality programs. The **Skilled Nursing Facility Quality Reporting Program (SNF QRP)** includes the measure **"Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury"** [27, 28]. This measure tracks the percentage of residents who develop new or worsened Stage 2-4 pressure ulcers.

Performance on this and other QRP measures is publicly reported on the Care Compare website, influencing consumer choice. More directly, facilities that fail to meet the reporting requirements for the SNF QRP are subject to a **2% reduction in their annual payment update** from Medicare [27]. This creates a direct financial incentive to prevent, manage, and accurately report on pressure ulcers. Furthermore, the **SNF Value-Based Purchasing (VBP) Program** rewards facilities with better performance on quality measures, creating another link between clinical outcomes and revenue. The significant costs avoided by the healthcare system from reducing pressure ulcers—estimated to be between $2.8 billion and $20.0 billion—highlight the system-wide financial importance of quality in this area [26].

9. Broader Industry Context and Future Outlook

The payer mix data does not exist in a vacuum. It is the financial backdrop against which a sector facing immense operational and regulatory pressures must function. The 2024-2025 outlook for Skilled Nursing Facilities is shaped by a confluence of crises and policy shifts.

Financial and Operational Crises: According to the American Health Care Association (AHCA), the industry is in a precarious state. A March 2024 survey revealed that 45% of nursing homes were operating at a financial loss, with a total of 87% either losing money or barely breaking even (0-3% margin) [15]. This financial instability is a direct result of the payer mix reality: a heavy reliance on low-paying Medicaid. This pressure is compounded by a severe workforce crisis. The AHCA reports that 99% of nursing homes are trying to hire staff, yet 7 out of 10 have fewer employees than before the pandemic [15]. These shortages have led nearly half (46%) of facilities to limit new admissions, creating an access-to-care crisis for patients being discharged from hospitals [15]. Between February 2020 and July 2024, over 770 nursing homes closed, further reducing the supply of available beds [16, 17].

Regulatory and Payment Policy Changes: The federal government is implementing significant policy changes that will define the coming years. In May 2024, CMS finalized a new federal minimum staffing mandate, set to take effect in 2026 [9]. While intended to improve quality of care, the AHCA reports that 96% of providers are concerned about their ability to meet these requirements, which will dramatically increase labor costs in an already strained environment [15].

On the payment front, CMS issued its FY 2025 SNF PPS final rule, which includes a net 4.2% increase in Medicare Part A payments [9]. This provides some financial relief for the Medicare-funded portion of a facility's business. However, this increase may not be sufficient to offset broader inflationary pressures and the anticipated costs of the staffing mandate. In a conflicting signal, MedPAC, citing the consistently high FFS Medicare margins, has recommended that Congress *reduce* the 2025 Medicare base payment rates by 3% for fiscal year 2026 [1]. This recommendation highlights the deep policy tension between Medicare's profitability for SNFs and the overall financial distress of the sector, which is driven by other payers.

The future outlook for 2025 and beyond is one of heightened uncertainty. Facilities must contend with the erosion of their most profitable payer (FFS Medicare), continued pressure from their largest but lowest-paying payer (Medicaid), and a wave of new regulatory costs, all while navigating a historic labor crisis.

10. Conclusion

This report has provided a definitive analysis of the Skilled Nursing Facility payer mix in the United States for the 2024-2025 period, establishing clear, evidence-based answers to the core research objectives.

First, **payer mix** is a dual-metric concept measured by both patient days (volume) and revenue (financial contribution). The significant disparity between these two measurements is the defining characteristic of the SNF financial model, with a high volume of low-revenue Medicaid days being subsidized by a low volume of high-revenue Medicare days [1].

Second, the best-supported national estimate for **payer mix by patient days** shows a system dominated by Medicaid, which accounts for 63% of all care days [1]. Medicare FFS constitutes a small fraction at 8%, with Private/Other payers, including the growing Medicare Advantage segment, making up the remaining 29% [1].

Third, the best-supported national estimate for **payer mix by revenue** reveals Medicare FFS's outsized financial importance, contributing 14% of total revenue from just 8% of days [1]. The remaining 86% of revenue is generated by the combined Medicaid and Private/Other categories [1].

Fourth, the distinction between **Medicare-certified SNFs and all nursing homes** is largely semantic in practice. With about 96% of facilities being dually certified to provide both post-acute and long-term care, the national payer mix estimates reflect the blended operational reality of the vast majority of the industry [1]. The more meaningful distinction is between the payer mix for short-term skilled stays (dominated by Medicare) and long-term custodial stays (dominated by Medicaid) within the same facility [3, 4].

The inescapable conclusion is that the SNF sector operates within a fractured and challenging financial environment. The business model is fundamentally dependent on balancing a high-volume, low-margin public utility function (long-term care for the frail and elderly via Medicaid) with a low-volume, high-margin medical service line (post-acute rehabilitation via Medicare) [1, 12]. The analysis of complex wounds like pressure and diabetic ulcers perfectly illustrates this tension: these conditions drive the high-acuity Medicare

admissions that are financially essential, yet they also bring immense costs, regulatory scrutiny, and liability risk.

The primary trend shaping the 2024-2025 period is the systemic disruption of this balance. The steady migration of beneficiaries from FFS Medicare to Medicare Advantage is eroding the industry's most critical profit center, introducing new pressures on rates and utilization [1]. This, combined with chronic underfunding from Medicaid and escalating operational costs from labor shortages and new regulations, places the entire sector in a state of significant vulnerability [1, 15]. The future viability of many facilities will depend on their ability to adapt to this new payer landscape while navigating unprecedented economic and operational headwinds.

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