

# Medicare Skilled Nursing Facility Primer: Benefit Basics and Issues

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## Summary

A Medicare skilled nursing facility (SNF) is an institution, or distinct part of an institution (e.g., building, floor, wing), that provides post-acute skilled nursing care and/or skilled rehabilitation services, has in effect a written agreement to transfer patients between one or more hospitals and the SNF, and is certified by Medicare. In general, “skilled” nursing and rehabilitative care are services ordered by a physician that require the skills of professional personnel (i.e., registered nurse, physical therapist) and are provided under the supervision of such personnel. Over 95% of SNFs are within long-term care facilities (or nursing homes).

A Medicare beneficiary is entitled to 100 days of SNF care for each Medicare-covered SNF stay. To be eligible for SNF coverage, a Medicare beneficiary must have been an inpatient of a hospital for at least 3 consecutive calendar days and transferred to a participating SNF usually within 30 days after discharge from the hospital. Beneficiaries must also receive treatment at the SNF for a condition they were receiving treatment for during their qualifying hospital stay (or for an additional condition that arose while in the SNF). For beneficiaries who meet these requirements, Medicare Part A may provide up to 100 days of coverage for the SNF stay.

Under Medicare Part A, SNFs are reimbursed under a prospective payment system (PPS), which began on July 1, 1998. The SNF PPS provides payment for bed and board, nursing care, therapy services, drugs, durable medical equipment, and certain ancillary services under a bundled per diem “per day” reimbursement amount, rather than Medicare paying for each item or service individually. For the first 20 days of SNF coverage, Medicare beneficiaries have no copayment. Medicare beneficiaries have a daily SNF copayment for the 21<sup>st</sup> through the 100<sup>th</sup> day indexed annually at one-eighth (12.5%) of the current Part A deductible. For 2015, the daily copayment is \$157.50.

The Medicare SNF benefit has drawn attention due to the rapid increase in SNF expenditures. Medicare fee-for-service (FFS) spending on SNFs totaled \$27.6 billion, or roughly 8.0% of total Medicare FFS spending in 2012, and grew at an average annual rate of 8.3% between 2000 and 2012. SNF payment reductions have been recommended by various deficit reduction advocacy groups. Some of the recommendations have included reducing the SNF reimbursement rate and reducing or eliminating Medicare’s reimbursement of bad debt from SNF care.

This report describes in further detail the Medicare SNF benefit and its resident population, SNF services, and the SNF PPS. In addition, this report describes recent developments in Medicare SNF payments, such as the Skilled Nursing Facility Value-Based Purchasing Program—a quality-based payment policy change included in the Protecting Access to Medicare Patients Act (PAMA, P.L. 113-93)—as well as congressional and other issues designed to slow the growth of Medicare SNF expenditures.

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Medicare provides limited coverage for some post-acute care services, one of which is skilled nursing facility (SNF, pronounced “sniff”) care. For the most part, SNF services include skilled nursing; bed and board; and physical, occupational, and speech and language therapies. In 2012, Medicare fee-for-service (FFS) spending for SNF care totaled \$27.6 billion, which consisted of 8.0% of total Medicare FFS spending.<sup>1</sup> Medicare SNF expenditures grew at an average annual rate of 8.3% from 2000 to 2012, compared with 5.9% for total Medicare FFS spending.<sup>2</sup> The following sections provide greater detail on the SNF beneficiary population, SNF eligibility requirements, SNF services, and differences in SNF utilization across states.

## SNF Beneficiaries and Eligibility

Overall, SNFs provide services to Medicare beneficiaries across a number of different diseases and conditions. Some of the more frequent hospital conditions of patients referred to SNFs for post-acute care were joint replacement, septicemia, kidney and urinary tract infections, hip and femur procedures not related to joint replacement, pneumonia, and heart failure.<sup>3</sup>

To be eligible to receive Medicare Part A SNF coverage, a beneficiary must have had an inpatient hospital stay of at least 3 consecutive calendar days and be transferred to a participating SNF usually within 30 days after discharge from the hospital. In addition, Medicare requires SNFs to provide services for a condition the beneficiary was receiving treatment for during his or her qualifying hospital stay (or for an additional condition that arose while in the SNF). The treatment must require reasonable and necessary skilled nursing care or skilled rehabilitation services on a daily basis. Additionally, some a limited number of services (e.g., rehabilitation services) may be reimbursed under Medicare Part B for noncovered SNF stays, such as beneficiaries that have not met the three-day inpatient hospital stay requirement.

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<sup>1</sup> Centers for Medicare & Medicaid Services, *Health Care Financing Review 2013 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, Table 6.1.

<sup>2</sup> Ibid.

<sup>3</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 185, [http://www.medpac.gov/documents/reports/mar14\\_ch08.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/mar14_ch08.pdf?sfvrsn=0).

### Three-Day Inpatient Requirement and Hospital Outpatient Observation Status

One of the requirements for Medicare SNF coverage is a prior inpatient hospital stay of at least three consecutive calendar days. Outpatient observation services, which can occur within a hospital and extend over several days, are not considered to be an inpatient hospital stay and therefore do not count toward a beneficiary's three-day qualifying hospital stay. Medicare beneficiaries are receiving longer observation services as hospital outpatients on an increasing basis. The number of outpatient observation stays per 1,000 Medicare Part B beneficiaries increased from 28 in 2006 to 53 in 2012.<sup>4</sup>

According to patient advocates, the beneficiary may not realize that the hospital care, which included multiple overnight stays, was not provided on an inpatient status but rather on an outpatient basis in the hospital. Since Medicare regulations do not require hospitals to provide discharge planning to hospital outpatients, beneficiaries under outpatient observation status may be unaware that the following SNF care ordered by the hospital is not covered under Medicare. Additionally, in cases when the beneficiary did not have a prior three-day inpatient hospital stay, SNFs are not required by federal law to notify the beneficiary before SNF care is delivered that Medicare will not pay for their stay.

## SNF Services and Providers

A Medicare beneficiary who qualifies for SNF coverage is entitled to up to 100 days of covered SNF care per spell of illness.<sup>5</sup> For beneficiaries who qualify, Medicare Part A will provide payment for skilled nursing, skilled rehabilitation, medical social services, drugs/biologicals, durable medical equipment, and bed and board when receiving such services, among others. In general, nursing and rehabilitation services can be labeled “skilled” if they are (1) ordered by a physician, (2) require the skills of a health professional (i.e., registered nurse, physical therapist), and (3) are provided by or under the supervision of such personnel.<sup>6</sup>

Two examples of services that are both skilled nursing and skilled rehabilitation services are

- management and evaluation of the patient's plan of care, and
- observation and assessment of the patient.

A few examples of skilled nursing services are

- intravenous injections,
- administration and replacement of catheters,
- administration of prescription medications, and
- supervision of bowel and bladder training programs.

Some examples of skilled rehabilitation services are

- continuing assessments of a patient's rehabilitation needs,

<sup>4</sup> Zach Gaumer, Kim Neuman, and Craig Lisk, “Hospital short stay policy issues,” MedPAC Public Meeting, Washington, DC, September 12, 2014, <http://www.medpac.gov/documents/september-2014-meeting-presentation-hospital-short-stay-policy-issues.pdf?sfvrsn=0>.

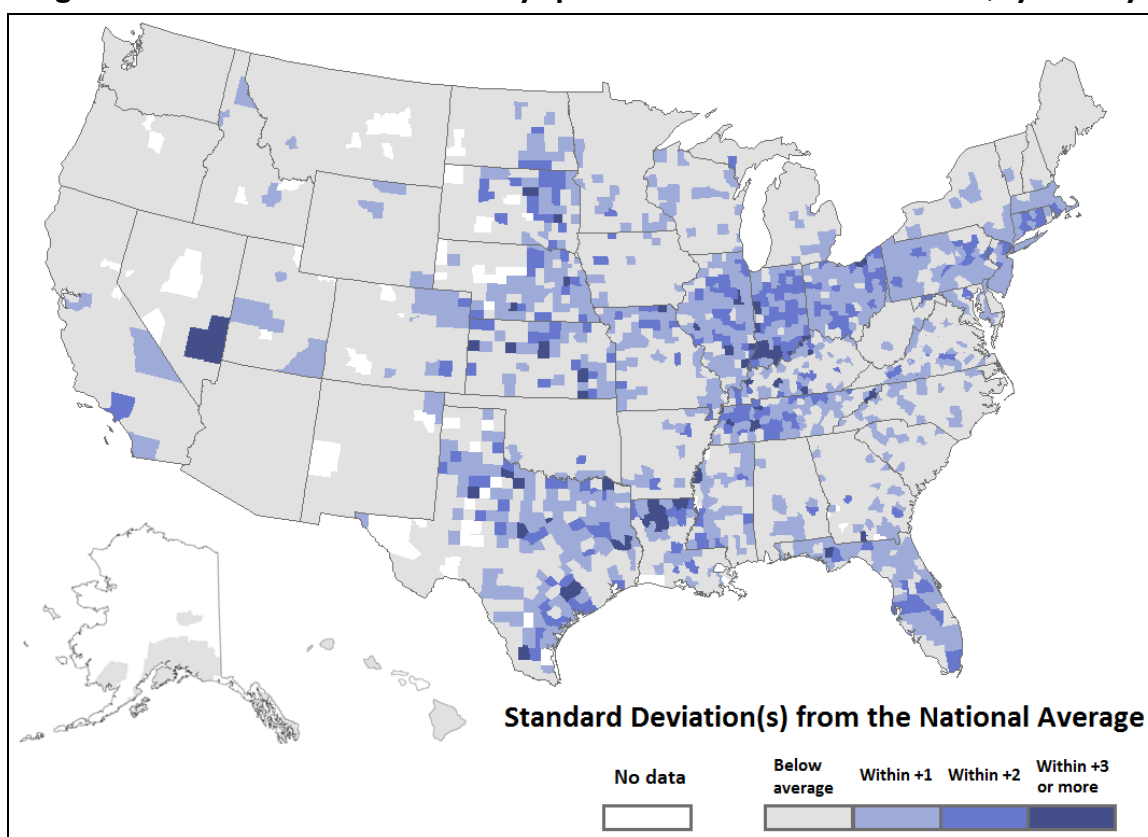
<sup>5</sup> A spell of illness, also referred to as the “benefit period,” begins when a beneficiary is admitted for inpatient hospital services and ends after 60 consecutive days when the beneficiary was neither an inpatient of a hospital nor a resident of a SNF. See section 1861(a) of the Social Security Act.

<sup>6</sup> For more information, see Chapter 8 of the Medicare Benefit Policy Manual.

- therapeutic exercises, and
- range-of-motion exercises.

The utilization of SNF services, as measured by the number of Medicare-covered SNF days per 1,000 Part A beneficiaries, is relatively greater in Connecticut, Indiana, and Ohio (as shown in **Figure 1**). In 2012, the national county average of Medicare-covered SNF days per 1,000 Part A beneficiaries was 1,917 days or roughly 1.92 days per beneficiary. Across all counties in Connecticut, Indiana, and Ohio, the ratio of SNF days to Medicare beneficiaries was 2.63 days, 2.59 days, and 2.54 days, respectively. One explanation for the disparity in utilization across states is the supply of SNFs compared with other similar post-acute care providers (e.g., inpatient rehabilitation facilities and home health agencies). In addition, states with a high SNF utilization pattern may also have a greater supply of SNFs located near referring acute care providers.<sup>7</sup>

**Figure 1. Medicare-Covered SNF Days per Part A Beneficiaries in 2012, by County**



**Source:** CRS analysis of CMS's Medicare geographic variation public use file, available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV\\_PUF.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html).

**Notes:** Data excludes beneficiaries only enrolled in Part A or Part B. Counties are categorized by standard deviations from the national average of Medicare-covered SNF days per 1,000 Part A beneficiaries per county. Data may be unavailable for certain low-population counties.

<sup>7</sup> Melina Beeuwkes Buntin, Anita Datar Garten, Susan Paddock, et al., "How Much is Postacute Care Use Affected By Its Availability," *Health Services Research*, vol. 40, no. 2 (April 2005).

SNFs are more commonly found within urban areas and long-term care nursing facilities (referred to as *freestanding SNFs*). Of the 15,143 SNFs that furnished care in 2012, roughly 94% of SNFs were freestanding.<sup>8</sup> The remaining 6% of SNFs were located in hospitals (referred to as hospital-based). While the number of hospital-based SNFs has fallen by 58% since 1999 (from 2,046 facilities in 1999 to 850 facilities in 2012), the number of freestanding SNFs has increased by roughly 11% (from 12,868 facilities in 1999 to 14,293 facilities in 2012), leaving the total supply of SNFs relatively unchanged.<sup>9</sup> Additionally, 70% of SNFs were for profit facilities, 25% of SNFs were nonprofit facilities, and the remaining 5% of SNFs were government-owned facilities in 2012.<sup>10</sup>

## Medicare's SNF Prospective Payment System

The Balanced Budget Act of 1997 required most SNFs to be reimbursed under a prospective payment system (PPS) beginning on July 1, 1998.<sup>11</sup> The SNF PPS reimburses providers a daily amount after adjusting for urban or rural facility locale, case-mix, and area wage differences (see **Figure 2**). Beginning April 1, 2013, through March 31, 2024, Medicare payments to SNFs will be reduced by 2% as a result of automatic spending reductions (“sequestration”).<sup>12</sup>

The SNF PPS covers most costs of furnishing SNF services to Medicare beneficiaries (routine, ancillary, and capital-related costs).<sup>13</sup> To be reimbursed under the SNF PPS, Medicare requires SNFs to use consolidated billing practices. Under consolidated billing, the SNF bills Medicare Part A for most of the SNF services the Medicare beneficiaries receive, regardless of whether the service was provided by an outside contractor (e.g., physical therapist contractor) or by SNF personnel.

In certain circumstances, consolidated billing does not apply and/or SNF services provided to the beneficiary are not billable to Part A. For instance, if a SNF resident were to exhaust his or her Part A benefits, coverage for some services is still provided under Part B for a beneficiary enrolled in Medicare Part B. For example, certain non-therapy services and high-cost ancillary services, such as diagnostic x-ray tests, diagnostic laboratory tests, and prosthetic devices, are not reimbursed under the SNF PPS and may be separately billed to Medicare Part B.

<sup>8</sup> Centers for Medicare & Medicaid Services, *Health Care Financing Review 2013 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, Table 6.7.

<sup>9</sup> Centers for Medicare & Medicaid Services, *Health Care Financing Review 2001 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, Table 43.

<sup>10</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 185, [http://www.medpac.gov/documents/Mar14\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar14_EntireReport.pdf).

<sup>11</sup> The SNF PPS pricing method replaced the cost-based system for SNF services, which had been in use since the inception of SNF coverage in the Medicare program. The prior “reasonable cost reimbursement” method paid SNFs their actual costs of delivering care to Medicare beneficiaries subject to certain limitations. Under the reasonable cost method, SNFs had few incentives to control costs, which was one factor leading in the development of a new SNF payment system.

<sup>12</sup> The failure of the Joint Select Committee on Deficit Reduction to propose budget reduction legislation by its deadline, mandated by the Budget Control Act of 2011 (P.L. 112-25), triggered “sequestration.” The Bipartisan Budget Act of 2013 (P.L. 113-67) and subsequent legislation extended sequestration an additional three years—through 2024.

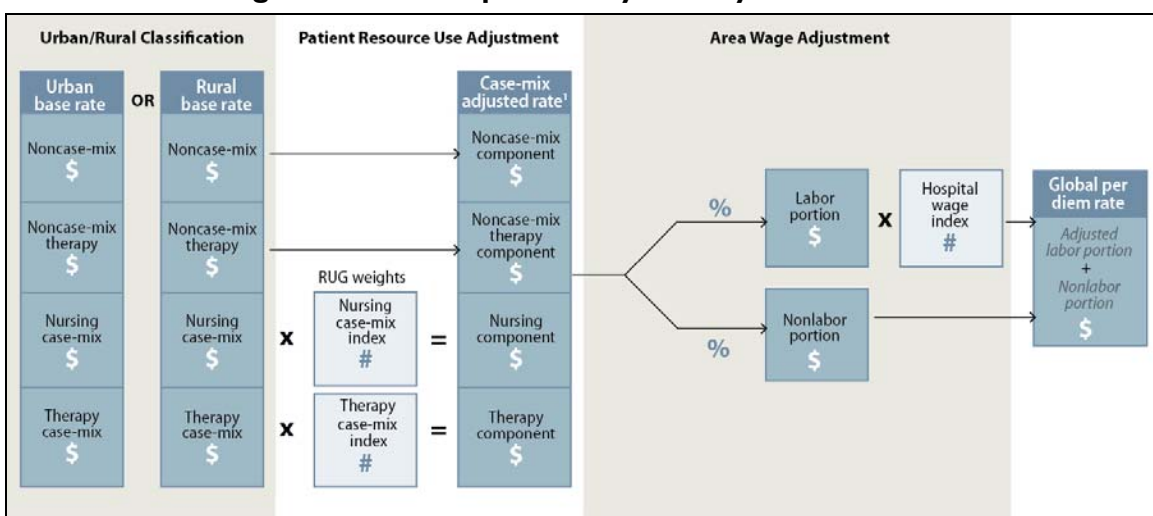
<sup>13</sup> Physician services are not covered under the SNF PPS and are separately reimbursed under Medicare Part B. For critical access hospitals operating swing-bed SNFs (facility beds approved to be both for hospital and SNF patients), the SNF PPS does not apply, and the hospitals are instead reimbursed 101% of the reasonable costs for providing SNF care.<sup>13</sup>



For the first 20 days no beneficiary copayment is required for Medicare-covered SNF stays. For the 21<sup>st</sup> through the 100<sup>th</sup> day, a daily copayment, indexed annually at one-eighth (12.5%) of the current Part A inpatient hospital deductible, is required. The copayment is not adjusted geographically or based on the amount of Medicare SNF reimbursement. In 2015, the daily SNF copayment is \$157.50. For certain low-reimbursement SNF care instances in low-wage areas, Medicare may not contribute any payment because the required daily copayment exceeds the daily Medicare SNF reimbursement.

The following sections explain in greater detail the urban and rural base rates, the case-mix classification system—resource utilization group (RUG)—and the wage index that is used to adjust payments for differences in area wages. In addition, the following provides mathematical examples of SNF PPS reimbursement and a brief summary of total Medicare SNF expenditures and the Medicare Payment Advisory Commission’s (MedPAC) analysis on the adequacy of these payments.

**Figure 2. SNF Prospective Payment System Formula**



**Source:** CRS graphic of the SNF PPS formula.

**Note:** Not all resource utilization groups (RUGs) will have a noncase-mix therapy component or therapy component.

## Urban and Rural Base Rates

The urban and rural base rates are the daily SNF reimbursement rates before any adjustments. Determination between an urban or rural base rate depends on whether the SNF is located within a core-based statistical area (CBSA). For SNF billing purposes, providers within CBSAs are reimbursed at an urban rate, while providers outside of CBSAs are reimbursed at a statewide rural rate.<sup>14</sup>

<sup>14</sup> The Office of Management and Budget classifies CBSAs in either metropolitan or micropolitan areas. A metropolitan area is an urban cluster that consists of a county or counties that contain at least 50,000 people and has a high degree of social and economic integration to the surrounding counties. Similarly, a micropolitan area is an urban cluster that consists of a county or counties that contain between 10,000 to 50,000 people and has a high degree of social and economic integration. For more information, see memorandum from Peter Orszag, *Update of Statistical Area* (continued...)



As shown in **Figure 2**, the urban and rural base rates are broken down into four separate components: noncase-mix, noncase-mix therapy, nursing case-mix, and therapy case-mix. The two noncase-mix components reflect the administrative and room-and-board costs of providing SNF care. The base rate's nursing and therapy case-mix components respectively reflect the national average costs of nursing and therapy for a one-day stay in a SNF. Breaking down the base rate into four rate components allows the PPS to later adjust the base rate by varying levels of expected nursing and therapy intensity to classify beneficiaries within resource utilization groups (RUGs). Every RUG will have a noncase-mix component and nursing component and either a noncase-mix therapy component or therapy component.

The base rates were developed from FY1995 cost reports and are updated annually for inflation by the percentage change in the SNF market basket index. The SNF market basket index is a composite of weighted price levels, based on FY2010 prices, which are estimated to capture an accurate picture of an average SNF provider's total costs. The change in the SNF market basket index from the prior year is referred to as the market basket update and is provided by IHS Global Insight, Inc. In the event actual cost report data shows the percentage change in SNF costs to be at least  $\frac{1}{2}$  percentage point greater than the market basket update, the base rate will receive an additional "forecast error correction" for the difference the following fiscal year.<sup>15</sup> In addition to any forecast error correction, as required by the Patient Protection and Affordable Care Act of 2010 (ACA, as amended, P.L. 111-148), the market basket update is offset by a productivity adjustment rate that is equal to an average of the previous 10-year productivity rates in the broader economy.<sup>16</sup> The SNF productivity adjustment began with the start of FY2012.

## Resource Utilization Group

The RUG classification system adjusts the base rate for a beneficiary's expected SNF daily costs (i.e., nursing care, therapy care, bed and board, and drugs/biologicals). After admission to a SNF, a beneficiary is classified into a RUG, which can change over the course of his or her stay. The RUG is designed to be an accurate reflection of the beneficiary's SNF accommodation and service costs, given the beneficiary's medical conditions and current medical practices. The most recent version of the RUG classification system has 66 different groups within eight major categories: (1) Rehabilitation Extensive Services (Ultra High, Very High, High, Medium, Low); (2) Rehabilitation (Ultra High, Very High, High, Medium, Low); (3) Extensive Services; (4) Special Care High; (5) Special Care Low; (6) Clinically Complex; (7) Behavioral Symptoms and Cognitive Performance; and (8) Reduced Physical Function.

The information used to assign a beneficiary into a RUG is gathered from the Minimum Data Set 3.0 (MDS).<sup>17</sup> The MDS is one of three parts of the Resident Assessment Instrument (RAI), which

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(...continued)

*Definitions and Guidance on Their Uses*, Office of Management and Budget, Bulletin No. 10-02, December 1, 2009, p. 2, <http://www.whitehouse.gov/sites/default/files/omb/assets/bulletins/b10-02.pdf>.

<sup>15</sup> The  $\frac{1}{2}$  percent difference threshold was administratively increased from  $\frac{1}{4}$  percent difference beginning in FY2008.

<sup>16</sup> A productivity adjustment is intended to cancel out the price increases (i.e., wage increases) associated with productivity gains.

<sup>17</sup> The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT, P.L. 113-185) requires, among other things, SNFs to begin reporting patient assessment data in a format that is standardized and interoperable with other post-acute care settings no later than October 1, 2018. This requirement may alter the current MDS and assessment process.

must be completed for all residents in Medicare- and Medicaid-certified nursing homes.<sup>18</sup> The additional two parts are the Care Area Assessment (CAA) and RAI Utilization Guidelines. The RAI is designed to help “gather definitive information on a resident’s strengths and needs, which must be addressed in an individualized care plan.”<sup>19</sup> The MDS portion of the RAI gathers clinical data over 14 different criteria: (1) hearing, speech, and vision; (2) cognitive patterns; (3) behavior; (4) preference for customary routine activities; (5) functional status; (6) bladder and bowel; (7) active diagnoses; (8) health conditions; (9) nutritional status; (10) dental status; (11) skin conditions; (12) medications; (13) special treatments, procedures, and programs; and (14) restraints.

SNFs are required to complete the MDS for a beneficiary to receive reimbursement under Part A Medicare. The MDS assessments for Medicare payment are required to be completed on or about the 5<sup>th</sup> day, 14<sup>th</sup> day, 30<sup>th</sup> day, 60<sup>th</sup> day, and 90<sup>th</sup> day. For the most part, the MDS assessments’ “look back” period, the time frame for gathering the patient’s clinical information, are the seven days prior to the MDS payment assessment requirement dates. In addition to Medicare-required MDS assessments, federal law requires SNFs (as well as nursing homes) to complete the MDS and CAA for Medicare- and Medicaid-covered residents. These assessments must be completed near the beneficiaries’ 92<sup>nd</sup> day of stay, 366<sup>th</sup> day of stay, and in the event of a significant change or correction in the beneficiary’s status.<sup>20</sup> Such assessments may be combined with the Medicare-required assessment dates when applicable.

The most recent version of the RUG classification system is RUG-IV, which replaced the RUG-53 system on October 1, 2010 (start of FY2011). RUG-IV created an additional 13 possible groups for classifying beneficiaries, bringing the total from 53 groups under RUG-53 to 66 groups. These 66 groups each have a nursing case-mix index, and some groups have an additional therapy case-mix index, together known as RUG weights. The RUG weights are used to adjust the federal base rate for different levels of expected nursing and/or therapy intensity provided to the beneficiary. The federal base rate adjusted for a specific RUG is referred to as the case-mix adjusted rate.

To create the case-mix adjusted rate, the relevant components must be added together. As shown in **Figure 2**, the nursing component and therapy component are created by multiplying the base rate’s nursing case-mix by the nursing case-mix index and the base rate’s therapy case-mix by the therapy case-mix index. Each RUG will have a nursing component and a noncase-mix component. The final third component will be either a therapy component or a noncase-mix therapy component. The sum of all relevant components is the case-mix adjusted rate, which reflects the beneficiary’s daily resource use before adjusting for area wage differences.

<sup>18</sup> Section 4201 of The Omnibus Reconciliation Act of 1987 (OBRA, P.L. 100-203) required SNFs to, among other things, complete a standardized assessment for each resident.

<sup>19</sup> Centers for Medicare & Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User’s Manual*, MDS 3.0, October 2011, p. 4.

<sup>20</sup> This requirement does not apply to swing-bed SNFs. Swing-bed SNFs operate in small rural hospitals that contain facility beds approved to treat both hospital and SNF patients.

## Wage Index

After adjusting for a beneficiary's case-mix, a share of the case-mix adjusted rate is adjusted for area wage differences.<sup>21</sup> In order to calculate the area wage adjustment, the case-mix adjusted rate must be split into a labor-related share and a non-labor-related share. The labor-related share represents the amount of labor-related costs relative to total costs for providing SNF services to the average beneficiary. This labor-related share has historically been roughly 70% of the case-mix adjusted rate, with the remaining 30% allocated as the non-labor-related share.

As shown in **Figure 2**, the labor-related share of the case-mix adjusted rate is multiplied by a hospital wage index specific to the location of the SNF to account for differences in area wages. The SNF wage index is calculated from a survey of wages and wage-related costs from acute care hospitals (because specific SNF wage data does not exist). For areas with no hospitals and wage-related data available, adjacent areas are used as a proxy measure for the missing cost information. The wage index is updated every year but receives an adjustment so the updated wage index does not increase or decrease aggregate Medicare SNF payments.

After the wage index number has been determined and multiplied by the labor-related portion, the product is added back to the non-labor-related share. Finally, as shown in **Figure 2**, the global per diem rate is the sum of the labor-adjusted product and non-labor-related share.<sup>22</sup> The global per diem rate is the final reimbursement rate of daily SNF care reimbursed through Medicare Part A. For the most part, the global per diem rate and the beneficiary's length of stay in the SNF determine the reimbursement amount for the SNF.

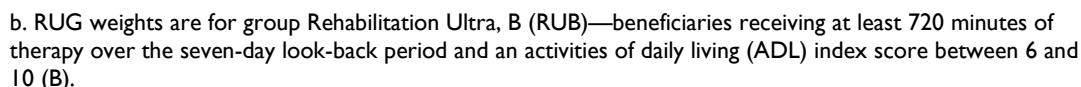
## Examples of a Per Diem SNF Reimbursement

To better understand this complex payment system, two hypothetical reimbursement calculations are presented. **Figure 3** provides an example of how much a SNF in New York City would be reimbursed for providing one day's care to a beneficiary classified under the Rehabilitation Ultra High group with a high activities of daily living (ADL) index score (there is no noncase-mix therapy component for this particular RUG).<sup>23</sup> For comparison, **Figure 4** provides an additional example of how much a SNF in a rural New York town would be reimbursed for providing one day's care to a beneficiary classified under the Rehabilitation Medium group with a low ADL index score (there is no noncase-mix therapy component for this particular RUG). For days 21 to 100, the per diem reimbursement would be reduced by the beneficiary's copayment—\$157.50 in 2015.

<sup>21</sup> The Office of Management and Budget (OMB) revises delineations for the Nation's Metropolitan Statistical Areas, Metropolitan Statistical Areas, and Combined Statistical Areas based on Census Bureau data. On February 28, 2013, OMB released revised delineations based on 2010 Census Bureau data that created new statistical areas, revised existing statistical areas, and switched certain counties from urban to rural and rural to urban. The SNF PPS will begin to reflect these revised delineations through the wage index beginning FY2015.

<sup>22</sup> Section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) requires an additional 128% increase in the per diem payment for a SNF resident with acquired immune deficiency syndrome (AIDS).

<sup>23</sup> The ADL index measures the patient's function capability to perform routine daily activities independently. A higher ADL index score represents less capability than a lower ADL index score.



b. RUG weights are for group Rehabilitation Medium, A (RMA)—beneficiaries receiving at least 150 minutes of therapy over the seven-day look-back period and an activities of daily living (ADL) index score between 0 and 5 (A).

## Medicare SNF Expenditures and Financial Performance

In 2012, Medicare FFS spending on SNF care totaled \$27.6 billion.<sup>24</sup> SNF payments have grown as an overall share of Medicare spending for the past two decades. In 1990, Medicare payments to SNFs represented 1.8% of total Medicare FFS spending, increasing to 8.0% of total Medicare FFS spending in 2012.<sup>25</sup>

Since the implementation of the SNF PPS, the majority of hospital-based SNFs have had large negative Medicare margins, while at the same time the majority of freestanding SNFs have had positive Medicare margins.<sup>26</sup> Between 2003 and 2012, Medicare margins have been consistently high for freestanding SNF providers. Between 2003 and 2011, Medicare margins steadily increased, reaching a peak of 21% in 2011 before a recent decline in margins in 2012. The large increase in SNF margins in 2011 may be attributable to industry-wide increase in therapy services as well as administrative changes to the SNF PPS.<sup>27</sup>

In 2012, aggregate for profit freestanding SNF margin and aggregate nonprofit freestanding SNF margin were 16.1% and 5.4%, respectively (see **Table 1**). The total Medicare margin for freestanding SNF care in 2012 was 13.8%. While Medicare reimbursements appear to be well above costs for SNFs in the aggregate, Medicare contributes to roughly 22% of a nursing care facility's total revenue, with Medicaid payments for custodial care and skilled care comprising the largest share of revenue.<sup>28</sup> Therefore, MedPAC's analysis on the financial performance of Medicare payments for SNF care may capture only about a quarter of the financial picture of an average nursing facility.

**Table 1. Aggregate Freestanding SNF Medicare Margins**

Type of SNF	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
All	10.9%	13.7%	13.1%	13.3%	14.7%	16.6%	18.0%	18.5%	21.2%	13.8%
Urban	10.3	13.2	12.6	13.1	14.5	16.3	17.9	18.5	n.a.	14.0
Rural	13.8	16.1	15.2	14.3	15.5	18.0	18.7	18.4	n.a.	12.9
For profit	13.8	16.1	15.2	15.7	17.2	19.1	20.2	20.7	n.a.	16.1
Nonprofit	1.4	3.5	4.5	3.5	4.1	6.9	9.6	9.5	n.a.	5.4

**Source:** Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, March 2013, and March 2014, <http://www.medpac.gov>.

<sup>24</sup> Centers for Medicare & Medicaid Services, *Health Care Financing Review 2013 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, Table 6.1.

<sup>25</sup> Ibid.

<sup>26</sup> MedPAC determines the financial performance of providers by calculating the Medicare margin, measured by the percentage difference in Medicare revenue compared to the costs of providing care to Medicare beneficiaries. A positive margin may indicate a profit, whereas a negative margin may indicate a loss.

<sup>27</sup> For more information on the administrative changes, see HHS Office of Inspector General, *Changes in Skilled Nursing Facilities Billing in FY 2011*, July 2011, <https://oig.hhs.gov/oei/reports/oei-02-09-00204.pdf>.

<sup>28</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 185, [http://www.medpac.gov/documents/reports/mar14\\_ch08.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/mar14_ch08.pdf?sfvrsn=0).

**Notes:** N.a. = not available. A Medicare margin is the percentage of total Medicare SNF payments that exceed total costs for all SNF providers. MedPAC's March 2013 *Report to the Congress* did not provide a Medicare margin breakdown by type of SNF in 2011.

However, Medicare margins are only one factor that MedPAC considers when assessing the adequacy of Medicare's payments and determining its annual payment update recommendation. MedPAC weighs other indicators, such as beneficiaries' access to care (the capacity and supply of providers and the volume of services rendered), quality of care, and providers' access to capital as well. After examining these factors, MedPAC recommended that Congress implement a 0% update to SNF payment rates for FY2015.<sup>29</sup> While Congress has not enacted legislation to eliminate a market basket update over the past decade, MedPAC has made such an update recommendation for each of the past 10 years.<sup>30</sup>

## Medicare SNF Rate-Setting Policy and Medicaid

The largest payer to all nursing facilities is the Medicaid program, which covers roughly 62% of days in a nursing facility.<sup>31</sup> Medicaid is a means-tested entitlement program, financed jointly at the state and federal level, that provides health insurance for the delivery of certain health care services. According to the National Nursing Home Survey, in 2004, 88.3% of Medicaid beneficiaries in a nursing facility were also eligible for Medicare; however, while Medicaid covers both custodial care and skilled care in a nursing facility, custodial care is not a covered benefit under Medicare.<sup>32</sup> Industry advocates insist that Medicaid does not cover the total costs of providing services to its beneficiaries and that Medicare should subsidize Medicaid payments through SNF reimbursements. Evidence suggests payments from non-Medicare payers do not cover the costs of their residents. In 2012, the non-Medicare margin (nursing facility payments from non-Medicare payers less costs) was -2.0%.<sup>33</sup> When including Medicare, however, the nursing facility industry's total gross margin is 1.8%.

MedPAC has examined potential implications of targeting Medicare SNF reimbursements to compensate for inadequate payments from other providers. According to MedPAC, "this strategy results in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from the higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies."<sup>34</sup> MedPAC also states

<sup>29</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 204, [http://www.medpac.gov/documents/reports/mar14\\_ch08.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/mar14_ch08.pdf?sfvrsn=0).

<sup>30</sup> The Centers for Medicare & Medicaid Services (CMS) is required by statute to implement an annual update to the SNF payment rates equal to the changes in the SNF market basket index. MedPAC's payment recommendations can be found in their annual *Report to the Congress: Medicare Payment Policy* released in March.

<sup>31</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, Table 8-9, [http://www.medpac.gov/documents/reports/mar14\\_ch08.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/mar14_ch08.pdf?sfvrsn=0).

<sup>32</sup> James M. Verdier, *Coordinating and Improving Care for Dual Eligibles in Nursing Facilities: Current Obstacles and Pathways to Improvement*, Mathematica Policy Research, Inc., Policy Brief, Princeton, NJ, March 2010, p. 10, [http://www.mathematica-mpr.com/publications/pdfs/health/nursing\\_facility\\_dualeligibles.pdf](http://www.mathematica-mpr.com/publications/pdfs/health/nursing_facility_dualeligibles.pdf).

<sup>33</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, Table 8-13, [http://www.medpac.gov/documents/reports/mar14\\_ch08.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/mar14_ch08.pdf?sfvrsn=0).

<sup>34</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 202, [http://www.medpac.gov/documents/reports/mar14\\_ch08.pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/mar14_ch08.pdf?sfvrsn=0).



that “states could further encourage providers to reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates.”<sup>35</sup>

## Recent Developments

Since the implementation of the SNF PPS, the mix of SNF services has shifted toward greater levels of rehabilitation services. Additionally, the Protecting Access to Medicare Act (PAMA, P.L. 113-93) altered how Medicare will provide payments for SNF care by establishing a value-based purchasing (VBP) program. Under the VBP program, beginning FY2019, SNF PPS payments will be adjusted based on the SNF’s hospital readmission rate.

### Increase in Intensive Rehabilitation SNF Care

At the time the SNF PPS was implemented, beneficiaries primarily receiving therapy services (classified in rehabilitation resource utilization groups, or RUGs) represented 71% of Medicare-covered SNF stays. By 2012, beneficiaries classified in rehabilitation RUGs represented 90.4% of Medicare-covered SNF stays. In addition to the distribution shift toward beneficiaries primarily receiving therapy, a shift of covered SNF days within rehabilitation RUGs occurred, moving toward therapy-intensive groups.<sup>36</sup> Between 2001 and 2012, the share of Medicare-covered SNF stays for Ultra-high Rehabilitation RUGs, a classification for beneficiaries who generally receive 12 hours of therapy over a week, increased substantially, from 7.4% of all Medicare rehabilitation groups to 53.6% of all Medicare rehabilitation groups (see **Figure 5**). These trends could be attributed to an increase in patients that require more intensive rehabilitation care needs as well as payment incentives within the SNF PPS.<sup>37</sup> Since the Ultra-high Rehabilitation RUGs are one of the more higher-paying case-mix groups, this shift has in part contributed to the strong growth in Medicare SNF expenditures.

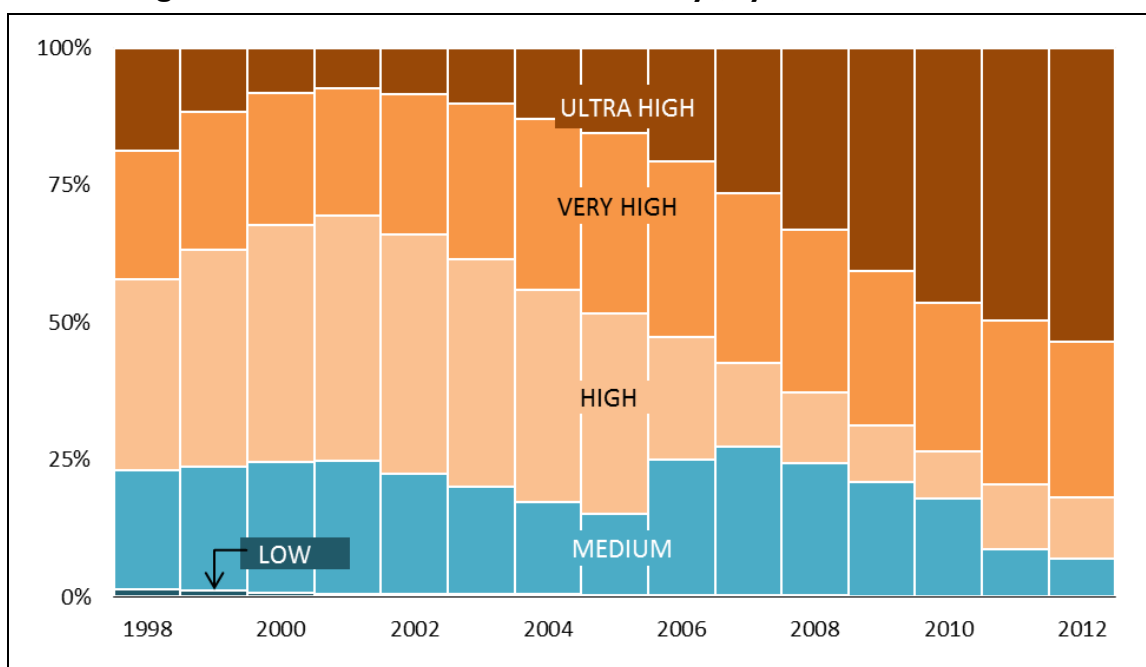
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<sup>35</sup> Ibid.

<sup>36</sup> There are five different classifications for rehabilitation groups: low, medium, high, very high, and ultra high. The amount of therapy minutes provided to a beneficiary separates the five different classifications.

<sup>37</sup> Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2011, p. 125, <http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf>.



**Figure 5. Distribution of Covered SNF Days, by Rehabilitation RUG**

**Source:** CRS analysis of Resource Utilization Group data for FY1998 to FY2009 obtained from the Centers for Medicare & Medicaid Services, prepared August 1, 2012, and FY2010, FY2011, and FY2012 data publicly available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/Spotlight.html>.

### SNF Value-Based Purchasing Program

Section 215 of the Protecting Access to Medicare Act (PAMA, P.L. 113-93) requires the Secretary to establish a Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program beginning on or after October 1, 2018. In general, VBP refers to a CMS initiative that rewards health care providers with incentive payments for the quality of care provided to beneficiaries. The intent of such a system is to reward quality of care and not just quantity of care. Similar VBP programs are already established within other Medicare provider payment systems (e.g., Hospital Value-Based Purchasing Program, End-Stage Renal Disease Quality Incentive Program).

Under the SNF VBP Program, a SNF's current Medicare per diem reimbursement may be increased or reduced to reflect its SNF VBP performance score beginning on or after FY2019. The Secretary is required to develop a methodology for determining such total performance score and will be based on performance standards. Performance standards will be established by the Secretary and reflect either the attainment or improvement (whichever is higher for each SNF) across a performance measure.

The performance measure will be each SNF's all-cause all-condition hospital readmission rate, which is to be further specified by the Secretary no later than October 1, 2016. In general, the hospital readmission rate will be the number of SNF residents readmitted to the hospital during their SNF stay in a given year divided by the total number of SNF residents. This all-cause all-condition hospital readmission rate measure will be replaced, when practicable, by an all-condition risk-adjusted *potentially preventable* hospital readmission rate, which is to be further

specified by the Secretary no later than October 1, 2016. The law does not require that these measures be endorsed by the National Quality Forum (NQF).<sup>38</sup> Additionally, these measures do not have to be included in the pre-rule making selection process by NQF’s Measure Application Partnership (MAP)—a multi-stakeholder group convened for the selection of quality measures pursuant to Section 1890A(a) of the Social Security Act. Further, beginning October 1, 2016, and every quarter thereafter, the Secretary will provide confidential feedback reports to SNFs on their all-cause hospital readmission performance and their risk-adjusted potentially preventable hospital readmission performance.

Under the SNF VBP Program, SNFs will be ranked based on such performance score from high to low. High-performing SNFs (that have relatively low hospital readmission rates) will receive a percentage add-on—a “value-based incentive payment”—in addition to their regular Medicare SNF per diem payments. SNFs ranked higher will receive a higher percentage add-on. Such percentage add-on may be zero, and SNFs ranked in the lowest 40% will receive a reduction in their Medicare SNF per diem payment rates. Payment adjustments for each SNF, either incentive payments or a reduction in the per diem for a fiscal year, will apply only to such fiscal year.

Value-based incentive payments awarded to high-performing SNFs will be funded through a portion of a 2% reduction in Medicare per diem payments applied to all Medicare-covered SNF days beginning in FY2019. Between 50% and 70% of the 2% reduction applied each fiscal year, subject to the Secretary’s discretion, will be allocated for value-based incentive payments, while the remaining proportion will be retained as savings to the Medicare program. Information on the SNF VBP Program, including each SNF’s performance score, which SNF was awarded incentive payments, and the total amount of incentive payments that had been provided, will be posted on the Nursing Home Compare website.

## Issues for Congress

### Deficit Reduction Options from Medicare SNF Payments

Reducing Medicare payments to SNFs has been proposed as one option to help reduce overall federal spending and to restrain growth in Medicare spending. Different methods to reduce the deficit through Medicare SNF payments include freezing the market basket update and reducing or eliminating reimbursement to providers for a Medicare beneficiary’s bad debt.

#### SNF Market Basket Update

As noted earlier, the SNF urban and rural base rates are updated for inflation by the percentage change in the SNF market basket index. The change in the SNF market basket index from the prior year is referred to as the *market basket update*. For FY2015, the market basket update is 2.0%.<sup>39</sup> A provision in the ACA requires a productivity adjustment—a decrease of the market

<sup>38</sup> NQF is a voluntary consensus standards-setting organization with the mission of improving the quality of health care, specifically through setting national goals for improvement, through endorsing quality measures, and through education and outreach to facilitate the realization of the quality goals it has recommended. Currently, NQF is the only body that meets the criteria of a voluntary consensus standards-setting organization for health quality measures.

<sup>39</sup> Centers for Medicare & Medicaid Services, “Prospective Payment and Consolidated Billing for Skilled Nursing (continued...) ”

basket update based on a measure of the economy-wide change in productivity. For FY2015, the productivity adjustment is a 0.5 percentage point reduction making the net update to Medicare SNF rates a 2.0% increase. The President's FY2015 Budget included a proposal of adjusting the SNF market basket updates between 2015 and 2022 as well as for other providers.<sup>40</sup> CBO scored this proposal as a savings of \$77 billion between 2015 and 2024.<sup>41</sup>

## Medicare Reimbursement of Bad Debt for SNF Services

Historically, Medicare has reimbursed SNFs 100% of the unpaid and uncollectable deductible or copayment amounts (bad debt) that occurred from Part A services rendered to Medicare beneficiaries. Bad debt related to Medicare Part B services are generally not reimbursed under the Medicare program. This payment policy applies to Part B services (physicians' services, durable medical equipment) that are separately billable and Part B services that are bundled into the per diem SNF reimbursement. To be reimbursed for bad debt, the outstanding amount must meet four fundamental requirements: (1) the debt was related to the beneficiary's deductible and/or copayment amounts of a covered service; (2) a reasonable collection effort was made; (3) the debt was uncollectible when declared "worthless"; and (4) sound business judgment established that there was no likelihood of recovering the debt at any time in the future.<sup>42</sup>

With the enactment of The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96), reimbursement on bad debt for SNF services provided to Medicare beneficiaries was reduced from 70% to 65% in FY2013 and subsequent fiscal years.<sup>43</sup> Reimbursement on bad debt for SNF services provided to a dual-eligible was reduced from 100% to 88% in FY2013, 76% in FY2014, and 65% in FY2015 and subsequent fiscal years.

Reducing the amount that Medicare reimburses SNFs for bad debt has been discussed in deficit-reduction strategies. The Simpson-Bowles Commission put forth a proposal eliminating any bad debt reimbursement, whereas the President's budget included a proposal that reduced bad debt reimbursement to 25%.<sup>44</sup> CBO scored the Administration's proposal as a reduction of \$28.8 billion between 2015 and 2024. Similarly, a bill sponsored by Senate Republican Bob Corker proposed gradually reducing Medicare SNF bad debt reimbursement to 0% for FY2018 and subsequent fiscal years.<sup>45</sup>

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(...continued)

Facilities for FY 2015," 79 *Federal Register*, August 5, 2014.

<sup>40</sup> For more information, see CRS Report R43446, *Centers for Medicare & Medicaid Services: President's FY2015 Budget*, coordinated by (name redacted).

<sup>41</sup> Congressional Budget Office, *Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's 2015 Budget*, April 2014, [http://www.cbo.gov/sites/default/files/cbofiles/attachments/45250-Health\\_Programs\\_Proposals.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/45250-Health_Programs_Proposals.pdf).

<sup>42</sup> 42 C.F.R. §413.89(e).

<sup>43</sup> The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) reduced SNF reimbursement on Medicare bad debt from 100% to 70% of the beneficiary's bad debt if the beneficiary does not have Medicaid as a secondary payer.

<sup>44</sup> For more information see CRS Report R43446, *Centers for Medicare & Medicaid Services: President's FY2015 Budget*, coordinated by (name redacted).

<sup>45</sup> For more information see S. 11, the Fiscal Sustainability Act of 2013.

## Concluding Observations

Between 2003 and 2012, aggregate freestanding SNF Medicare margins have been consistently high (reaching 21.2% for freestanding SNFs in 2011). Because Medicare SNF payments have been, in the aggregate, well over costs, reducing these reimbursements to SNFs has been discussed in the context of deficit reduction efforts. While the Medicare SNF margin was 13.8% in 2012, nursing facilities, where 94% of SNFs are located, however, had an overall total margin of 1.8% in 2012 for all services, including both Medicare-covered SNF care and non-Medicare-covered long-term care. These nursing facilities primarily provide custodial care with the Medicaid program providing the largest source of revenue. Current reductions in SNF reimbursements as well as any future payment reductions will receive close attention from nursing care industry advocates, who are likely to contend that Medicare provides necessary subsidies to help cover the losses associated with other residents living in the nursing care facility. However, under its established rate-setting policy, CMS only addresses the adequacy of Medicare's SNF payments relative to Medicare's SNF recipients and does not subsidize other payers and other non-Medicare covered services.

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