



Medicare's Skilled Nursing Facility Primer: Benefit Basics and Issues

Scott R. Talaga
Analyst in Health Care Financing

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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.

The Medicare SNF benefit has drawn attention due to the rapid increase in SNF expenditures. In 2010, Medicare Parts A and B payments to SNF providers totaled \$27.4 billion, having grown at an average annual rate of 9.9% since 2000. SNF payment reductions have been recommended by various deficit reduction groups. Some of the recommendations have included reducing the SNF reimbursement rate and reducing or eliminating Medicare bad debt reimbursement.

Given the beneficiary has met certain requirements, 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 the first 20 days of SNF coverage, Medicare beneficiaries have no copayment. Medicare beneficiaries have a daily SNF copayment for the 21st through the 100th day indexed annually at one-eighth (12.5 percent) of the current Part A deductible. For 2012, the daily copayment is \$144.50.

SNFs are reimbursed under a prospective payment system (PPS), which began on July 1, 1998. The PPS reimbursement is a per diem “per day” amount that covers most costs of furnishing SNF services to Medicare beneficiaries. With the exception of certain high-cost ancillary services, the SNF PPS bundles covered-SNF services into a single per diem reimbursement rather than Medicare paying for each service individually.

This report describes the Medicare SNF benefit and the reimbursement system for SNF services. In addition, this report describes recent issues, as well as congressional and other proposals 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) care. For the most part, SNF services include skilled nursing; bed and board; and physical, occupational, and speech and language therapies. In 2010, total Medicare fee-for-service payments on SNF services were \$27.4 billion, about 8.3% of Medicare Parts A and B spending.¹ Medicare expenditures to SNFs grew at an average annual rate of 9.9% from 2000 to 2010,² compared with 8.9% for all of Medicare spending.³ The following sections provide greater detail to the SNF beneficiary population, SNF eligibility requirements, SNF services, and differences in SNF utilization across states.

SNF Beneficiaries and Eligibility

Overall, SNFs provide services for Medicare beneficiaries across a number of different diseases and conditions. A disease of the circulatory system (e.g., heart failure) was the most prominent disease for admitted Medicare beneficiaries, with 13.4% of all diagnoses in 2010.⁴ Other common conditions are pneumonia, bone fractures, muscular calcification, and hypertension. In 2010, the average number of Medicare-covered SNF days for a beneficiary was 27.1.⁵

To be eligible for residence in an SNF, a beneficiary must have 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 their qualifying hospital stay (or for an additional condition that arose while in the SNF). The treatment must require services to be furnished on a daily basis that can only be provided by an SNF. In addition, some services may be reimbursed under Medicare Part B for noncovered SNF stays. For instance, if the beneficiary did not have a qualifying three-day inpatient stay, and does not have Medicare Part A, some or all the services provided by the SNF can be covered under Medicare Part B.

¹ Centers for Medicare & Medicaid Services, *Health Care Financing Review 2011 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, November 2011, Table 6.1.

² Ibid.

³ 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table V.B1, p. 203, <http://www.cms.hhs.gov/reportstrustfunds/>.

⁴ Centers for Medicare & Medicaid Services, *Health Care Financing Review 2011 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, November 2011, Table 6.6.

⁵ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, p. 179, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

Three-Day Inpatient Requirement and Hospital Outpatient Status

One of the requirements for Medicare SNF coverage is an 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 began providing separate payments for observation services starting in 2002. Medicare beneficiaries are receiving longer observation services as hospital outpatients on an increasing basis. Between 2006 and 2008, the average length of observation time increased from 26 to 28 hours and the number of claims with observation services of more than 48 hours increased by 70%. The increase in observation services may be attributed to regulatory changes and pressures for shorter inpatient stays from private insurers.⁶

According to patient advocates, the beneficiary may not realize that the care received in the hospital may not qualify as an inpatient stay, especially when that care extends over several days and "looks like" an inpatient stay. In the 112th Congress, companion bills in the House (H.R. 1543) and Senate (S. 818) were introduced in April 2011 to amend the Social Security Act to include days spent in outpatient observation status toward satisfying the three-day prior inpatient hospitalization requirement for Medicare coverage of SNF services. The bills were referred to their respective committees, and there has been no further congressional activity as of the cover date of this report.

SNF Services

A Medicare beneficiary who qualifies for SNF services is entitled to up to 100 days of skilled nursing and skilled rehabilitation services per spell of illness.⁷ For beneficiaries who meet these requirements, no copayment is required for the first 20 days, but a daily copayment is required for the 21st through the 100th day. The daily copayment is indexed annually at one-eighth (12.5%) of the current Part A deductible. For 2012, the daily copayment is \$144.50.

For beneficiaries who qualify for SNF coverage, Medicare will provide payment for skilled nursing, skilled rehabilitation, medical social services, drugs/biologicals, 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 professional personnel (i.e., registered nurse, physical therapist), and (3) are provided by or under the supervision of such personnel.

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.

⁶ Zach Gaumer and Dan Zabinski, *Recent Growth in Hospital Observation Care*, MedPAC, meeting transcript, Washington, DC, September 13, 2010, <http://www.medpac.gov/transcripts/observation%20sept%202010.pdf>.

⁷ 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 an SNF.

Some examples of skilled rehabilitation services are

- continuing assessments of a patient's rehabilitation needs,
- therapeutic exercises, and
- range-of-motion exercises.

SNF Providers

SNFs are more commonly found within long-term care nursing facilities (referred to as *freestanding*). Of the 15,084 SNFs that furnished care in 2010, roughly 94% of SNFs were freestanding. The remaining 6% of SNFs were located in hospitals (referred to as hospital-based).⁸ While the number of hospital-based SNFs has fallen by 54% since 1999 (from 2,046 facilities in 1999 to 934 facilities in 2010), the number of freestanding SNFs has increased by roughly 10% (from 12,868 facilities in 1999 to 14,150 facilities in 2010), leaving the total supply of SNFs relatively unchanged.⁹

The supply of SNFs and the utilization of SNF services appear to be relatively greater in states within the Midwest and North Atlantic regions (see **Figure 1**). In 2010, the number of Medicare-covered SNF admissions per 1,000 Medicare Part A enrollees was highest in Connecticut (105), followed by New Jersey (100) and Minnesota (98). The three states with the lowest rates of SNF utilization were Alaska (19), Hawaii (28), and New Mexico (40). 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). States with a high SNF utilization pattern may also have a greater supply of SNFs located near referring acute care providers.¹⁰

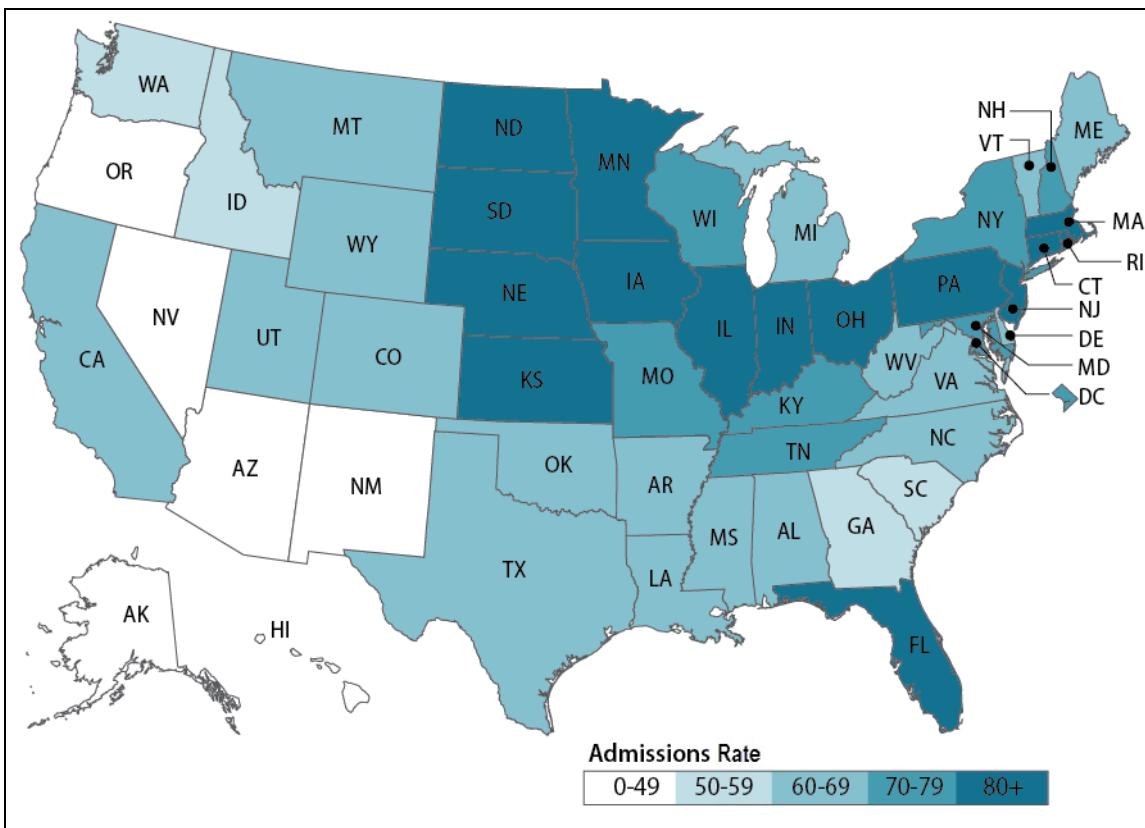
⁸ Centers for Medicare & Medicaid Services, *Health Care Financing Review 2011 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, November 2011, Table 6.7.

⁹ Centers for Medicare & Medicaid Services, *Health Care Financing Review 2001 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, April 2003, Table 43.

¹⁰ Melina Beeuwkes Buntin, Anita Datar Garten, and Susan Paddock et al., "How Much is Postacute Care Use Affected By Its Availability," *Health Services Research*, vol. 40, no. 2 (April 2005).

Figure 1. SNF Utilization

Number of SNF Covered-Admissions per 1,000 Medicare Part A Enrollees, 2010



Source: CRS analysis of data from the Centers for Medicare & Medicaid Services, *Health Care Financing Review 2011 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, November 2011, Table 6.3.

Medicare's SNF Prospective Payment System

The Balanced Budget Act of 1997 required SNFs to be reimbursed under a prospective payment system (PPS) beginning on July 1, 1998.¹¹ 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**). The SNF PPS covers most costs of furnishing SNF services to Medicare beneficiaries (routine, ancillary, and capital-related costs).

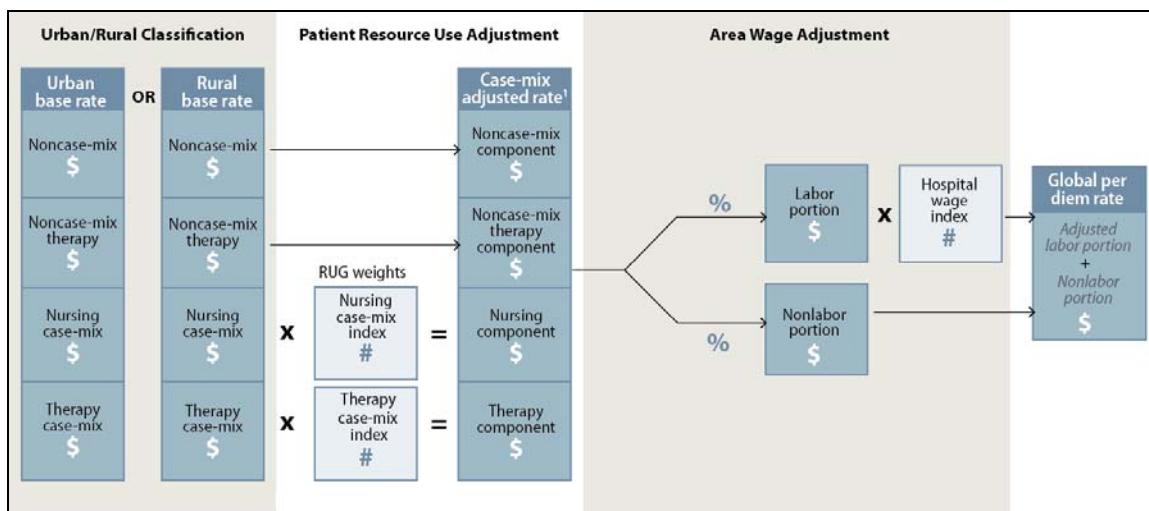
To be reimbursed under the SNF PPS, Medicare uses consolidated billing practices, which makes the SNF responsible to bill Medicare Part A for most of the SNF services the Medicare beneficiaries receive, regardless if the service was provided by an outside supplier. Rather than Medicare paying for each service individually, the consolidated billing practice “bundles” the beneficiary’s SNF care into a single predetermined daily payment.

¹¹ 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 to the development of a new SNF payment system.

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

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, this report includes 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 rural rate. 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.¹²

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 an 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, but not every RUG will have 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 composition of weighted price levels that 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.¹³ In addition to any forecast error correction, 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.¹⁴ 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 an 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). The MDS is one of three parts of the Resident Assessment Instrument (RAI), which must be completed for all residents in Medicare- and Medicaid-certified nursing homes. The additional two parts are the Care Area Assessment (CAA) and RAI Utilization Guidelines. The

¹² Peter Orszag, *Update of Statistical Area 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>.

¹³ The $\frac{1}{2}$ percent difference threshold was increased from $\frac{1}{4}$ percent difference beginning in FY2008.

¹⁴ A productivity adjustment is intended to cancel out the price increases (i.e., wage increases) associated with productivity gains.

RAI is designed to help “gather definitive information on a resident’s strengths and needs, which must be addressed in an individualized care plan.”¹⁵ 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.

With the exception of swing-bed SNFs,¹⁶ Medicare requires nursing homes and SNFs to complete the MDS and CAA for a beneficiary’s 92nd day of stay, 366th day of stay, and in the event of a significant change or correction in the beneficiary’s status.¹⁷ In addition, 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 5th day, 14th day, 30th day, 60th day, and 90th 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.

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 an additional therapy case-mix index, together known as RUG weights. The RUG weights 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.

Wage Index

After adjusting for a beneficiary’s case-mix, a share of the case-mix adjusted rate is adjusted for area wage differences. 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.

¹⁵ Centers for Medicare & Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User’s Manual*, MDS 3.0, October 2011, p. 4.

¹⁶ A swing-bed SNF is a small rural hospital approved to allocate facility beds between hospital care and SNF care.

¹⁷ The Omnibus Reconciliation Act of 1987 (OBRA, P.L. 100-203) implemented this provision.

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, **Figure 2** shows that the global per diem rate is the sum of the labor-adjusted product and nonlabor related share.¹⁸ 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.

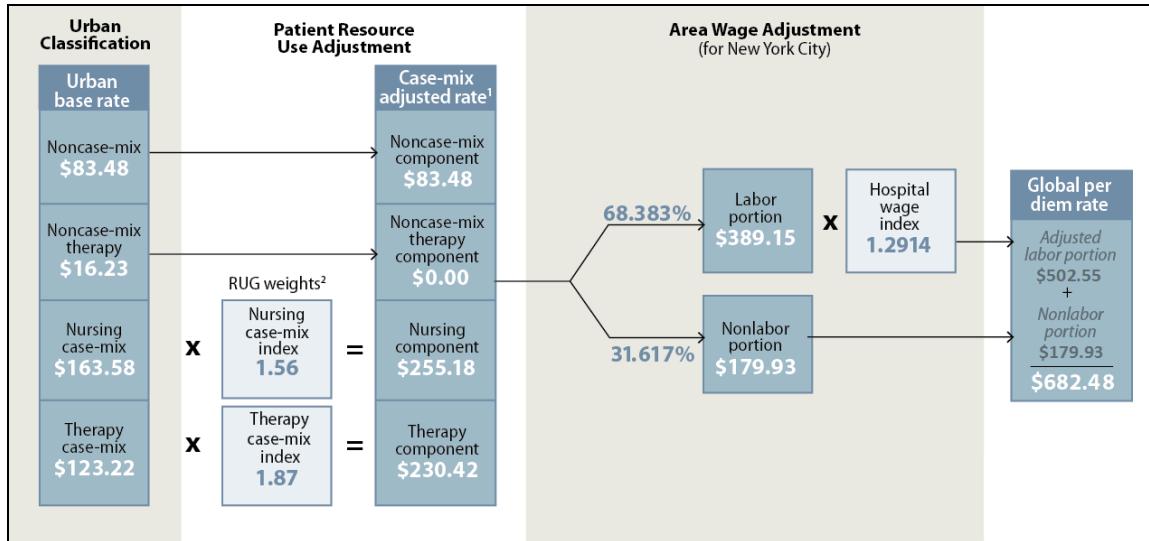
Examples of a Per Diem SNF Reimbursement

To better understand this complex payment system, the following are a few hypothetical reimbursement calculations. **Figure 3** provides an example of how much an 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).¹⁹ For comparison, **Figure 4** provides an additional example of how much an 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).

¹⁸ 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 an SNF resident with acquired immune deficiency syndrome (AIDS).

¹⁹ 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.

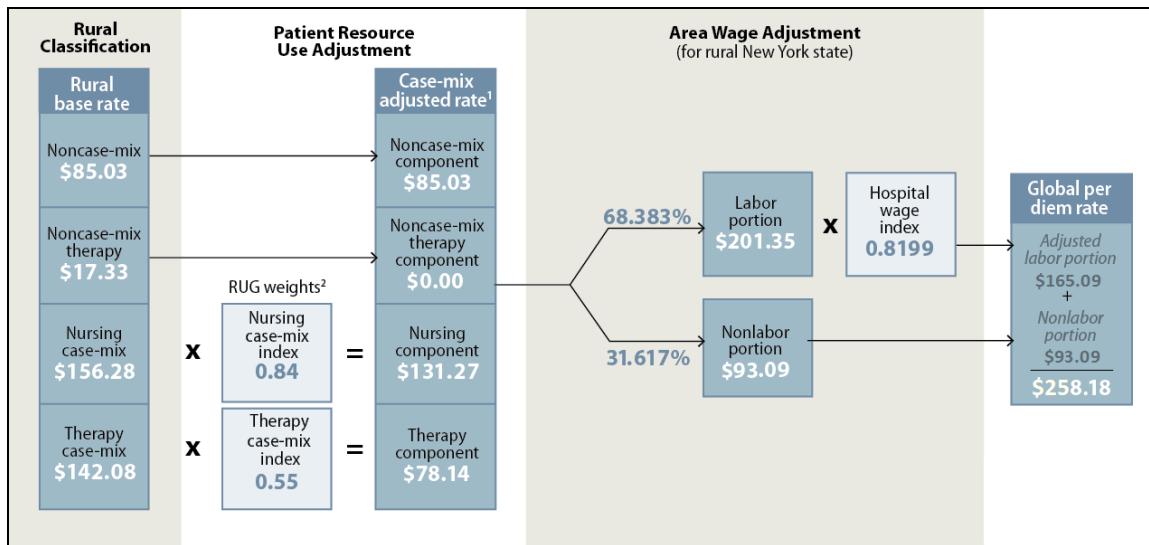
Figure 3. FY2013 SNF Prospective Payment System
Urban Example



Source: CRS analysis of Centers for Medicare & Medicaid Services, "Prospective Payment and Consolidated Billing for Skilled Nursing Facilities for FY 2013," 77 Federal Register, August 2, 2012.

Notes: 1. Not all groups will have a noncase-mix therapy component or therapy component. 2. RUG weights are for group Rehabilitation Ultra, B (RUB)—beneficiaries receiving at least 720 minutes of therapy over the seven-day look-back period and an activities of daily living (ADL) index score between 6 and 10 (B).

Figure 4. FY2013 SNF Prospective Payment System
Rural Example



Source: CRS analysis of Centers for Medicare & Medicaid Services, "Prospective Payment and Consolidated Billing for Skilled Nursing Facilities for FY 2013," 77 Federal Register, August 2, 2012.

Notes: 1. Not all groups will have a noncase-mix therapy component or therapy component. 2. 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

Total Medicare Parts A and B expenditures on SNF services were \$27.4 billion in 2010. 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 Parts A and B payments, increasing to 8.3% of total Medicare Parts A and B payments in 2010.²⁰

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, which comprise 94% of all SNFs, have had positive Medicare margins.²¹ Between 2003 and 2010, Medicare margins have been increasing across all types of freestanding providers (i.e., urban, rural, for profit, nonprofit). In 2003, aggregate freestanding for-profit SNF margins and aggregate freestanding nonprofit SNF margins were 13.4% and 1.3%, respectively (see **Table 1**). In 2010, aggregate freestanding for-profit SNF margins increased to 20.7%, while freestanding nonprofit SNF margins decreased slightly to 9.5%. In 2010, aggregate freestanding SNF had a Medicare margin of 18.5%, with at least 75% of freestanding SNFs operating with a Medicare margin greater than 9%.²² While Medicare reimbursements appear to be well above costs for SNFs in the aggregate, Medicare contributes to roughly 23% of a nursing care facility's total revenue, with Medicaid payments for custodial care and skilled care comprising the largest share of revenue.²³ 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
All	10.9%	13.7%	13.1%	13.3%	14.7%	16.6%	18.0%	18.5%
Urban	10.3	13.2	12.6	13.1	14.5	16.3	17.9	18.5
Rural	13.8	16.1	15.2	14.3	15.5	18.0	18.7	18.4
For profit	13.8	16.1	15.2	15.7	17.2	19.1	20.2	20.7
Nonprofit	1.4	3.5	4.5	3.5	4.1	6.9	9.6	9.5

Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, p. 184, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

Note: A Medicare margin is the percentage of total Medicare SNF payments that exceed total costs for all SNF providers.

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

²⁰ Centers for Medicare & Medicaid Services, *Health Care Financing Review 2011 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, November 2011, Table 6.1.

²¹ MedPAC determines the financial performance of providers by calculating the Medicare margin, measured by the percentage difference in Medicare revenue paid to a facility 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.

²² Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, p. 183, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

²³ Ibid., p. 175.

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 FY2012. 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.²⁴

Medicare SNF Rate-Setting Policy and Medicaid

The largest payer to all nursing facilities is the Medicaid program, which covers 63% of days in a nursing facility.²⁵ 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.²⁶ 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 beneficiaries. In 2010, the non-Medicare margin (nursing facility payments from non-Medicare payers less costs) was -1.2%.²⁷ When including Medicare, however, the nursing facility industry's total gross margin is 3.6%.²⁸

MedPAC has examined potential implications of targeting Medicare SNF reimbursements to compensate for inadequate payments from other providers. According to MedPAC, "Raising Medicare rates to supplement low Medicaid payments would result 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."²⁹ MedPAC also states that "increased Medicare payment rates could encourage states to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates."³⁰

Recent Developments

Since the implementation of the SNF PPS, the mix of SNF providers and SNF services has changed. The most notable changes have been the decline in SNFs located within hospitals, the

²⁴ 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.

²⁵ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, p. 175, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

²⁶ 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.

²⁷ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, p. 203, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

²⁸ *Ibid.*

²⁹ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2011, p. 168, http://www.medpac.gov/documents/Mar11_EntireReport.pdf.

³⁰ *Ibid.*

increase in rehabilitative therapy provided to beneficiaries, and an 11.1% reduction in Medicare payments to SNFs.

Decline in Hospital-Based SNF Providers

While most SNFs are nursing facilities (freestanding) that provide custodial care in addition to skilled nursing and rehabilitation care, SNFs are also located as distinct parts of a hospital (hospital-based). To qualify as an SNF within a hospital, the distinct part must be physically separated from the rest of the institution (e.g., building, floor, wing).

Prior to the SNF PPS, the number of hospital-based facilities furnishing SNF care was 2,165 in 1998, a 62% increase from the early 1990s.³¹ Since 1999, the number of hospitals operating an SNF declined by 54%, to 934 hospitals.³² A number of factors are thought to have contributed to the decline in hospital-based SNFs. The major reason is thought to be inadequate payments relative to the costs for operating an SNF in the distinct part of a hospital.³³ The SNF PPS was designed to make no payment distinction between hospital-based and freestanding SNFs. According to MedPAC's calculations, between 2003 and 2010, Medicare margins for hospital-based SNFs yielded substantially negative results.³⁴ In 2010, the aggregate Medicare margin for hospital-based SNFs was -67%. These negative margins are thought to be attributed to higher hospital overhead costs and a greater number of skilled personnel per SNF bed in hospital-based SNFs.

Additional reasons for the decline in hospital-based SNFs are thought to be the opportunity cost of using hospital beds to provide post-acute care relative to acute care, SNF regulations, and difficulties with providing a staff of nurses for the SNF from other parts of the hospital.³⁵ In spite of negative Medicare margins, some hospitals continue to operate their SNF, reporting that the SNF fosters savings for the acute care side of the hospital and provides an important continuity of care for the patient.

Shift in SNF Classification

At the time the SNF PPS was implemented, beneficiaries primarily receiving therapy services (classified in rehabilitation groups) consisted of 71% of Medicare-covered SNF stays. By 2009, beneficiaries classified in rehabilitation resource utilization groups (RUGs) consisted of 90.4% of Medicare-covered SNF stays. In addition to the distribution shift toward beneficiaries primarily

³¹ Centers for Medicare & Medicaid Services, *Health Care Financing Review 1994 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, February 1995, Table 42. Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare*, June 2007, p. 203, http://www.medpac.gov/chapters/Jun07_Ch08.pdf.

³² Centers for Medicare & Medicaid Services, *Health Care Financing Review 2001 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, April 2003, Table 43. Centers for Medicare & Medicaid Services, *Health Care Financing Review 2011 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, November 2011, Table 6.7.

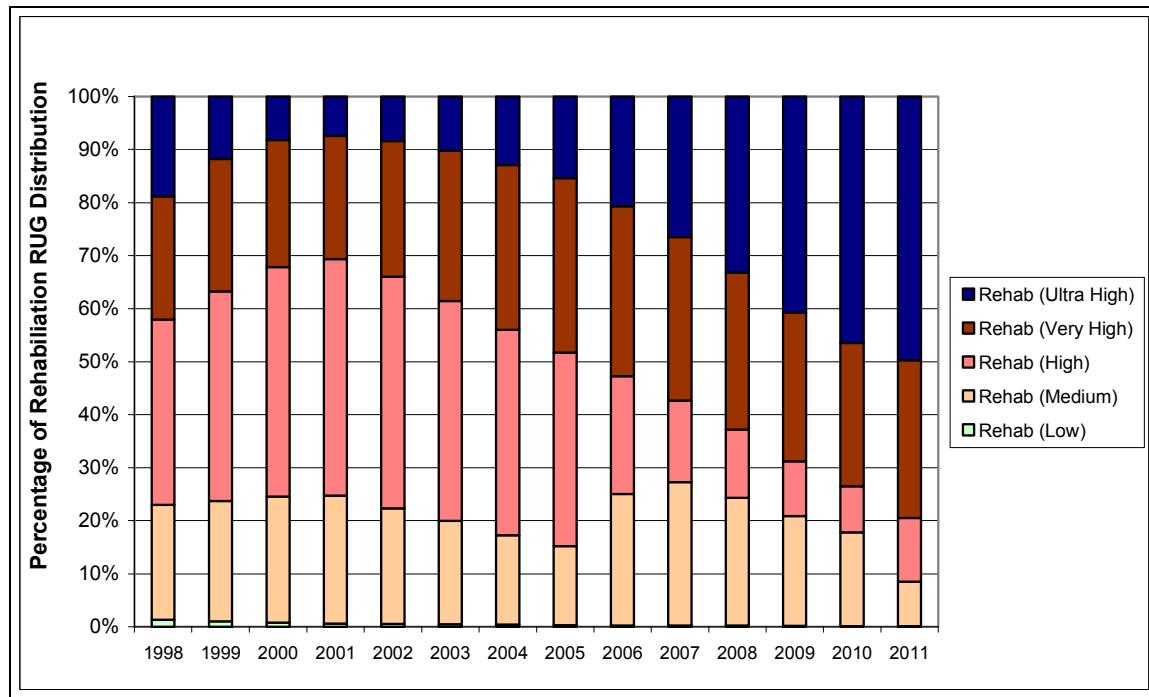
³³ Korbin Liu and Emily Jones, *Closures of Hospital-Based SNF Units: Insights from Interviews with Administrators, Discharge Planners and Referring Physicians*, Urban Institute, No. 07-1, Washington, DC, March 2007, p. 20, http://www.medpac.gov/documents/Mar07_Hospitalbased_SNFs_CONTRACTOR.pdf.

³⁴ CRS analysis of MedPAC's annual Medicare Payment Policy reports (2005 – 2012).

³⁵ Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare*, June 2007, p. 208, http://www.medpac.gov/chapters/Jun07_Ch08.pdf.

receiving therapy, a shift of covered SNF days within rehabilitation RUGs occurred, moving toward therapy-intensive groups.³⁶ Between 2001 and 2011, the share of Medicare-covered stays in SNFs for beneficiaries classified in Ultra-high Rehabilitation RUGs has increased substantially, from 7.4% to 49.7% of all Medicare rehabilitation groups (see Error! Reference source not found.). These trends could be attributed to the recent decline in cases at inpatient rehabilitation facilities or payment incentives within the SNF PPS.³⁷ 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.

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



Source: CRS analysis of Resource Utilization Group data obtained from the Centers for Medicare & Medicaid Services, prepared August 1, 2012.

Medicare SNF Overpayments in FY2011

The HHS Office of Inspector General estimated that CMS overpaid SNFs by \$4 billion in FY2011.³⁸ The overpayment occurred when CMS implemented the new case-mix classification system (RUG-IV) and the accompanying beneficiary assessment (MDS 3.0) at the start of FY2011. The RUG-IV classification system introduced 13 new groups that SNF beneficiaries could be assigned to in addition to the existing 53 groups, for a new total of 66 RUGs. The

³⁶ 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.

³⁷ 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>.

³⁸ Stuart Wright, *Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011*, Health & Human Services Office of Inspector General, OEI-02-09-00204, Washington, DC, July 8, 2011.

updated classification system is intended to be more accurate at assigning Medicare payments to actual SNF beneficiary costs than its predecessor.

The companion MDS 3.0 also introduced a change to the number of concurrent therapy minutes that could be allocated to a beneficiary. Under the previous MDS 2.0 assessment, a provider counted the total minutes of therapy provided to a beneficiary, usually over a seven-day window, regardless if the therapy was provided individually, concurrently (a therapist providing different therapy to two patients at the same time), or in a group (a therapist providing the same therapy to three or four patients at the same time). With the implementation of MDS 3.0, CMS changed this policy: in a concurrent therapy session *half of the session minutes* are allocated to the beneficiary. For example, a therapist providing 60 minutes of occupational therapy to one beneficiary and physical therapy to another beneficiary at the same time would allocate 30 minutes in the MDS 3.0 to each beneficiary for that particular session.

Because total therapy minutes partly determine a beneficiary's RUG assignment, CMS expected that some beneficiaries would "receive" a smaller amount of total therapy minutes because of the new classification and be assigned to a less therapy-intensive and lower-paying RUG with MDS 3.0. CMS intended the transition to RUG-IV to be budget-neutral, so to address the expected shift into less therapy-intensive RUGs and the subsequent Medicare SNF expenditure decline, CMS increased the reimbursement rate for particular RUGs.

The expected decline in therapy minutes and shift of beneficiaries into different RUGs did not occur, and as a result the HHS Office of Inspector General estimated that CMS overpaid SNFs by \$4 billion in FY2011. In order to make Medicare SNF expenditures equal to what would have occurred in the absence of introducing RUG-IV, CMS recalibrated the RUG-IV classification system in FY2012 to account for the change in provider behavior. The recalibration of RUG-IV is expected to reduce Medicare SNF expenditures in FY2012 by 11.1% from FY2011 spending levels.

Issues for Congress

Deficit Reduction Options from Medicare SNF Payments

Reducing 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 FY2013, the market basket update is 2.5%.³⁹ A provision in the Patient Protection and Affordable Care Act (ACA, as amended, P.L.

³⁹ Centers for Medicare & Medicaid Services, "Prospective Payment and Consolidated Billing for Skilled Nursing Facilities for FY 2013," 77 *Federal Register*, August 2, 2012.

111-148) requires a productivity adjustment—a decrease of the market basket update based on a measure of the economy-wide change in productivity. For FY2013, the productivity adjustment is 0.7%, making the net update to Medicare SNF rates a 1.8% increase. The Obama Administration's Plan for Economic Growth and Deficit Reduction included a proposal of adjusting the SNF market basket updates between 2014 and 2021.⁴⁰ Constraining the growth in the market basket would lower SNF spending relative to current law, resulting in lower Medicare SNF expenditures.

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.

As established by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), SNFs are now reimbursed at 70% of the beneficiary's bad debt if the beneficiary does not have Medicaid as a secondary payer. For bad debt that has arisen from services rendered to dual-eligible beneficiaries (beneficiaries with both Medicare and Medicaid), the SNF is reimbursed at 100% of the bad debt. In general, Medicaid will not pay a dual-eligible's cost-sharing amount because the Medicare provider payment is higher than what Medicaid would have paid for that same service. In addition, providers are generally prohibited from collecting Medicare copayments or deductibles from dual-eligible beneficiaries if Medicaid has denied payment.

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 is reduced to 65% in FY2013 and subsequent fiscal years. Reimbursement on bad debt for SNF services provided to a dual-eligible is reduced 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 Obama Administration has suggested the percentage be reduced to 25%.⁴¹ Similarly, a bill sponsored by House Republican Dave Camp and supported by the House Republican Policy Committee Chairman, Tom Price, proposed reducing the amount of

⁴⁰ Office of Management and Budget, *The President's Plan for Economic Growth and Deficit Reduction*, September 2011, p. 36, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf>.

⁴¹ The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, p. 38, http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.
Office of Management and Budget, *Fiscal Year 2013 Budget of the U.S. Government*, February 2012, p. 33, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf>.

Medicare SNF bad debt reimbursement to 55% for FY2015 and subsequent fiscal years.⁴² In 2011, Medicare paid an estimated \$600 million for Medicare beneficiaries' SNF bad debt. Of that amount, approximately \$260 million was for dual-eligible beneficiaries' SNF bad debt.

Concluding Observations

Since 2003, SNF aggregate Medicare margins have been steadily increasing (reaching 18.5% for freestanding SNFs in 2010). Nursing facilities, where 94% of SNFs are located, however, had an overall total margin of 3.6% in 2010 for all services, including both SNF care and custodial care. These nursing facilities primarily provide custodial care with the Medicaid program providing the largest source of revenue. 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. 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.

Author Contact Information

Scott R. Talaga
Analyst in Health Care Financing
stalaga@crs.loc.gov, 7-5956

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⁴² House Republican Policy Committee, "Price Votes to Protect Seniors, Taxpayers, and Promote a Stronger Energy Future," press release, December 13, 2011, <http://policy.house.gov/press-release/price-votes-protect-seniors-taxpayers-and-promote-stronger-energy-future>.