

## Skilled nursing facility services payment system

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities (SNFs). SNFs can be hospital-based units or freestanding facilities, with 90 percent of all SNFs located in freestanding facilities. About 1.4 million beneficiaries use SNF care in a year, but Medicare's payments for these services account for only about 12 percent of freestanding nursing facilities' revenues (25 percent of revenues in many large for-profit nursing home chains); they make up less than 2 percent of hospitals' revenues. Similarly, payments to SNFs (about \$17.3 billion in 2004) represent only about 5.2 percent of total Medicare spending.

With approval from CMS, certain Medicare-certified hospitals (typically small, rural hospitals and critical access hospitals) may also provide skilled nursing services in the same hospital beds they use to provide acute care services. These are called swing bed hospitals.

Medicare adopted a new prospective payment system (PPS) for SNF services starting on July 1, 1998. Prior to that, SNFs were paid on the basis of their costs, subject to limits on their per diem routine costs (room, board, and routine nursing care); no limits were applied for ancillary services (such as drugs and therapy). Under the PPS, SNFs are paid a predetermined rate for each day of care. The

per diem rates are based primarily on the patient's expected service needs and market conditions in the facility's location.

### The product that Medicare buys

Patients are assigned to one of 44 resource utilization groups, version III (RUG-III), each containing patients with similar service needs that are expected to require similar amounts of resources. Patients' expected service needs are determined by periodic assessments of their condition, including their needs for intensive physical, occupational, or speech therapy; special treatments (such as tube feeding); and their functional status (their ability to manage unassisted ordinary daily activities, such as eating, bathing, and dressing).

### Setting the payment rates

The PPS rates are expected to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing covered SNF services (with the exception of certain high-cost, low-probability ancillary services). The daily rate for each of the 44 RUG-III groups is the sum of three components:

- a fixed amount for routine services (such as room and board, linens, and administrative services);

- a variable amount reflecting the intensity of nursing care patients are expected to require; and
- a variable amount for the expected intensity of therapy services.

The rates are computed separately for urban and rural areas, and the rates are adjusted to account for differences in input prices among SNF markets. The labor-related portion of the daily payment rate—slightly over 76 percent for fiscal year 2004—is multiplied by the hospital wage index in the SNF’s location and the result is added to the nonlabor portion. Rates are updated annually, based on the projected increase in the SNF market basket index, a measure of the national average price level for the goods and services SNFs purchase to provide care.

The initial payment rates in 1998 were set to reflect the projected amount that SNFs received in 1995, updated for inflation.<sup>1</sup> Because of some perceived problems with the initial SNF payment rates, the Congress temporarily increased the rates in several ways:

- the Balanced Budget Refinement Act of 1999 (BBRA) increased rates for all 44 RUG-III groups by 4 percent for care furnished from April 2000 through September 2002,
- the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) increased the base rate for the nursing component by 16.66 percent for care furnished from April 2001 through September 2002,
- the BBRA and BIPA increased rates for 14 rehabilitation groups by 6.7 percent, and those for 12 complex care

groups by 20 percent. These increases were intended to give CMS time to refine the RUG-III classification system, and they expire when CMS adopts that refinement, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 increased the per diem RUG payment for a SNF resident with AIDS by 128 percent for services furnished on or after October 1, 2004. However, SNFs will not receive the 6.7 percent increase for 14 rehabilitation groups and the 20 percent increase for 12 complex care groups mandated by the BBRA and BIPA, if applicable, for a resident with AIDS.

The first of these temporary payment increases expired on October 1, 2002.

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<sup>1</sup> By law, this projection excluded costs of SNFs that were exempt from Medicare’s routine cost limits or that had so-called atypical exceptions in 1995 and included only 50 percent of the difference between the average costs of hospital-based and freestanding facilities.