SKILLED NURSING FACILITY SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2020

Payment system changes during the COVID-19 public health emergency

The three-day hospital stay requirement for Medicare coverage is waived during the public health emergency.

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). Medicare covers up to 100 days of SNF care per spell of illness.[1] Beginning on day 21 of a SNF stay, a beneficiary is responsible for a daily copayment. In 2020, the copayment is $176. In 2019, Medicare estimates program spending was $29.3 billion for SNF care.

Skilled nursing facilities can be hospital-based units or freestanding facilities. In 2018, 96 percent of stays were in freestanding facilities. With approval from CMS, certain Medicare-certified hospitals (typically small, rural hospitals and critical access hospitals) may also provide skilled nursing services in the hospital beds used to provide acute care services. These are called swing bed hospitals.

Defining the care Medicare buys

The Medicare SNF benefit covers skilled nursing care, rehabilitation services, and other goods and services. Medicare's prospective payment system (PPS) for SNF services began on July 1, 1998.[2] Under the PPS, facilities are paid a pre-determined daily rate for each day of SNF care. The PPS rates are expected to cover all per diem operating and capital costs that efficient facilities would be expected to incur in furnishing most SNF services, with certain high-cost, low-probability ancillary services paid separately.[3]

Setting the payment rates

Payments to SNFs are determined by adjusting base payment rates for geographic differences in labor costs and for case mix. The initial payment rates were set in 1998 based on the average facility costs in 1995, updated for inflation.[4] The base rates are computed separately for urban and rural areas. Beginning on October 1, 2019, daily payments to SNFs are determined by summing payment rates for six components of care—nursing, physical therapy, occupational therapy, speech–language pathology services, nontherapy ancillary services and supplies, and non–case mix (room and board services) (Table 1).

For each component of care, the base payment is adjusted for geographic differences in labor costs by multiplying the labor-related portion of the daily rate—71.3 percent for fiscal year 2021—by the hospital wage index in the SNF's location; the result is added to the nonlabor portion (Figure 1). The wage-adjusted base rates for five of the components are adjusted for case mix, with each component having its own set of factors that have been found to affect the cost of care (Table 2).

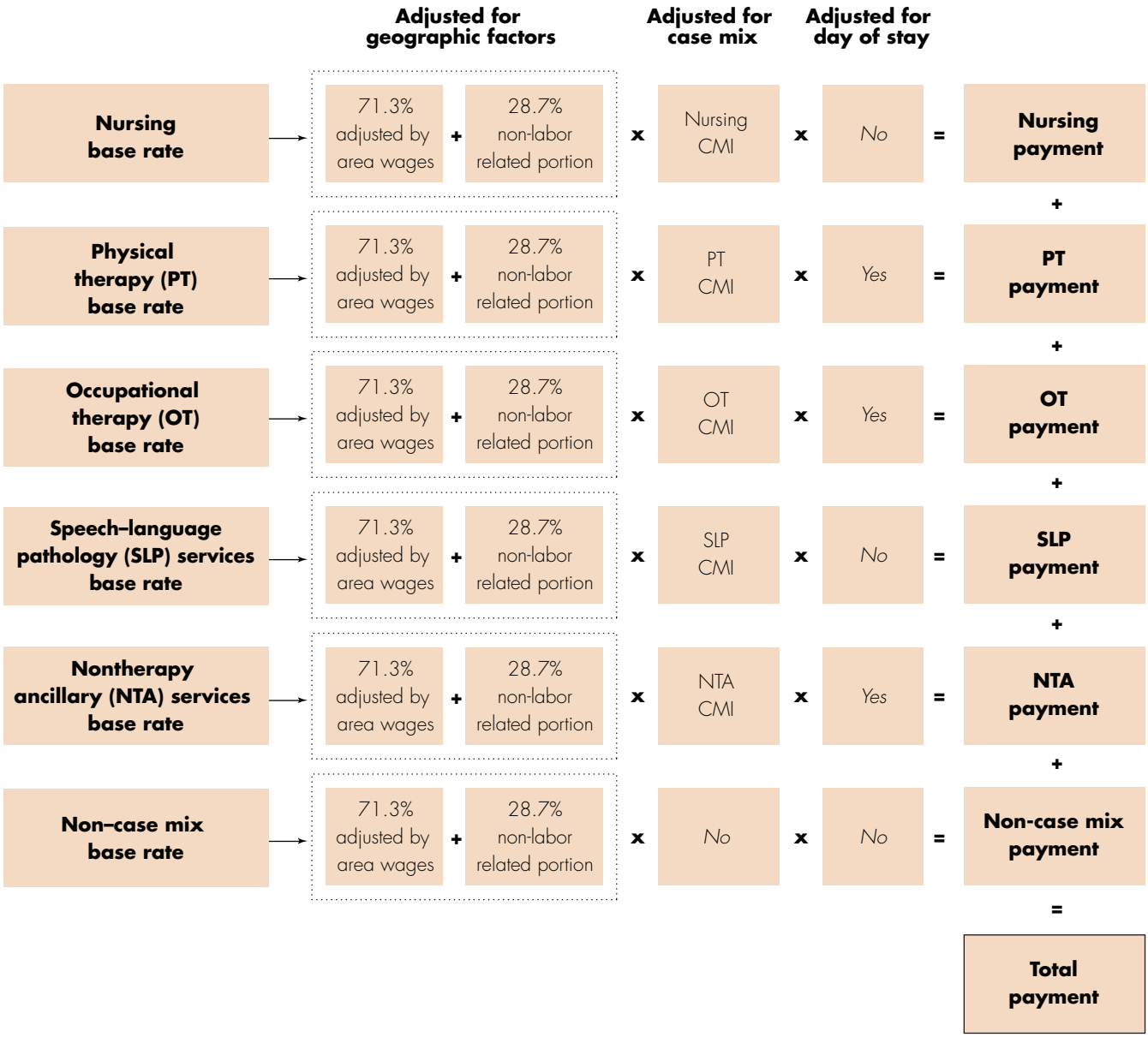
In addition, payments for three components (PT, OT, and NTA) are adjusted for the day of the stay, with higher payments for care furnished during earlier days in a stay. Payments for NTA services during first three days are three times those for NTA services during later days. Payments for PT and OT

The policies discussed in this document were current as of September 15, 2020, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

MEDPAC

425 I Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Skilled nursing facility services prospective payment system



Note: CMI (case-mix index).

Source: Adapted from Acumen LLC. 2018. *Skilled nursing facilities patient-driven payment model technical report.* Burlingame, CA: Acumen, LLC.

services are the same for the first 20 days of a stay and slowly decrease for later days.

Payment updates

The base rates are updated annually based on the projected increase in the SNF market basket, a measure of the national average price level for the goods and services SNFs purchase to provide care. Beginning in 2012, the market basket update is offset by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010. ■

Table 1 Medicare daily base rates for fiscal year 2021

Rate component	Nursing	Physical therapy	Occupational therapy	Speech–language pathology services	Nontherapy ancillary services	Non–case mix
Urban rate	$108.16	$62.04	$57.75	$23.16	$81.60	$96.85
Rural rate	103.34	70.72	64.95	29.18	77.96	98.64

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020. CMS–1737–F. Medicare program: Prospective payment system and consolidated billing for skilled nursing facilities; Updates to the value-based purchasing program for federal fiscal year 2021. *Federal Register* 85, no. 151 (August 5): 47594–47633.

1 A spell of illness begins with the first day of a hospital or SNF stay and ends when there has been 60 consecutive days during which a patient was not in a hospital or a SNF.

2 On July 1, 2002, Medicare began paying swing bed hospitals that are not critical access hospitals according to the SNF prospective payment system. Critical access hospitals continue to be paid for their swing beds based on their costs of providing care.

3 The following services are excluded from the SNF PPS when furnished on an outpatient basis by a hospital or critical access hospital: cardiac catheterization, computed axial tomography, magnetic resonance imaging, radiation therapy, ambulatory surgery involving the use of a hospital operating room, emergency services, angiography services, lymphatic and venous procedures, and ambulance services used to transport a beneficiary to a facility to receive any of these services. In addition, the following services must be billed separately: physician, dialysis, and other services billed under the physician fee schedule; erythropoietin for certain dialysis patients; dialysis-related ambulance transportation; hospice care related to a terminal illness; radioisotope services; certain chemotherapy services; and certain customized prosthetic devices.

4 By law, the 1995 costs used to set the initial payment rates excluded costs of SNFs that were exempt from Medicare's routine cost limits and costs related to payments for exceptions to the routine cost limits. In addition, the costs used to set the initial payment rates included only 50 percent of the difference between the average costs of hospital-based and freestanding facilities.

Table 2 Case mix factors in the skilled nursing facility prospective payment system

Nursing*	Physical therapy	Occupational therapy	Speech–language pathology services	Nontherapy ancillary services
• Broad clinical condition or special care • Extensive services • Functional status • Depression • Number of restorative nursing services	• Primary reason for SNF care • Functional status	• Primary reason for SNF care • Functional status	• Neurology/non-neurology case mix groups • SLP-specific comorbidities • Cognitive status • Difficulty swallowing or requiring mechanically altered diet	• Comorbidities • Special treatments

Note: SNF (skilled nursing facility), SLP (speech–language pathology). The numbers of case-mix groups for each category are: nursing, 25; physical therapy, 16; occupational therapy, 16; speech–language pathology services, 12; and nontherapy ancillary services, 6. "Special care" includes daily insulin injections; parenteral or IV feeding; daily respiratory therapy; respiratory failure and oxygen therapy while a patient; stage 2+ skin ulcers and selected skin treatments; foot wounds with application of dressings; and IV medications, transfusions, radiation, chemotherapy, or dialysis treatment while a patient. "Extensive services" include tracheostomy or ventilator care while a patient, or the need for isolation for an active infectious disease while a patient. "Special treatments" include tube or parenteral IV feeding, or intravenous medications, tracheostomy care, ventilator or respirator care, transfusion, radiation, suctioning, or isolation post admission.
*Days classified into the nursing groups for behavioral or cognitive symptoms and assistance with daily living and general supervision (8 groups) are typically not covered by Medicare because the patient does not generally need skilled care.

Source: Adapted from Acumen LLC. 2018. *Skilled nursing facilities patient-driven payment model technical report.* Burlingame, CA: Acumen, LLC.