SECTION 2D

Skilled nursing facility services

RECOMMENDATIONS

2D-1 The Secretary should develop a new classification system for care in skilled nursing facilities.

***YES: 13 • NO: 0 • NOT VOTING: 0 • ABSENT: 4**

2D-2 If the Centers for Medicare & Medicaid Services refines the classification system for care in skilled nursing facilities, the temporary payment increase, previously implemented to allow time for refinement, will end. The Congress should retain this money in the base payment rate for skilled nursing facilities.

YES: 13 • NO: 0 • NOT VOTING: 0 • ABSENT: 4

2D-3 For fiscal year 2003, the Congress should update payments to skilled nursing facilities as follows. For freestanding facilities, no update is necessary. For hospital-based facilities, update payments by market basket and increase payments by 10 percent until a new classification system is developed.

YES: 12 • NO: 1 • NOT VOTING: 0 • ABSENT: 4

***COMMISSIONERS' VOTING RESULTS**

SECTION

2D

In this section

- Assessing payment adequacy
- Accounting for cost changes in the coming year
- Update recommendation

Section 2D: Skilled nursing facility services

Medicare spending for care in skilled nursing facilities grew rapidly in the early 1990s—23 percent annually from 1990 to 1996. To control growth, the Congress required the Centers for Medicare & Medicaid Services to implement a prospective payment system for care in skilled nursing facilities. From its beginning in July 1998, the payment system has had problems classifying patients and paying appropriately for their care. To mitigate shortcomings in the prospective payment system, the Congress enacted a series of temporary rate increases. In this section of Chapter 2, we recommend that a new classification system for skilled nursing facility care be developed because the existing system is fundamentally flawed. We also examine whether the payments are adequate to ensure beneficiaries' access to skilled nursing facility care, and we conclude that the overall base payment is adequate but that payments are maldistributed between freestanding and hospital-based facilities. Therefore, for fiscal year 2003, we recommend different updates to payments for the two types of skilled nursing facilities.

Under the prospective payment system (PPS), skilled nursing facilities (SNFs) are paid a case-mix adjusted, per diem amount intended to cover the routine, ancillary, and capital-related costs of furnishing SNF services (see Chapter 1, p. 22, for additional information on the payment method).

Patients are assigned to one of 44 groups by a case-mix classification system, the resource utilization group, version III (RUG-III). The RUG-III measures patients' relative resource use on the basis of staff time to provide nursing care and rehabilitation. It does not adequately measure the resource needs of patients who require multiple types of services (such as extensive medical services and rehabilitation) or nontherapy ancillary services (such as pharmaceuticals or laboratory tests) (MedPAC 2001).[1]

In response to providers' concerns about the SNF PPS, the Congress instituted a series of temporary rate increases through two pieces of legislation—the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. These laws provided for:

- a 4 percent increase for all rates for care furnished from April 2000 through September 2002, which in the following discussion we call add-on X;
- a 16.66 percent increase in the base rate for the nursing component for care furnished from April 2001 through September 2002, which we call add-on Y; and
- a 20 percent increase for 12 case-mix groups of medically complex patients and a 6.7 percent increase for 14 groups of patients receiving rehabilitation; these latter two rate increases were intended to give the Centers for Medicare & Medicaid Services (CMS) time to refine the RUG-III and will expire when CMS declares the case-mix system refined. We call these temporary increases add-on Z.

Assessing payment adequacy

The Medicare Payment Advisory Commission's (MedPAC's) assessment of payment adequacy for SNFs is made in the context of enormous uncertainty because of the age and poor quality of the underlying data available to inform the evaluation. Because we know that the data are imperfect, our assessment process attempts to consider multiple factors, including providers' entry into and exit from the program, beneficiaries' access to SNF care, and SNFs' access to capital. Our assessment is also complicated by the fact that SNF care is furnished in two settings—freestanding facilities that generally are part of nursing homes and skilled nursing units that are part of hospitals.

Two issues lie at the heart of assessing payment adequacy: whether the base rate is adequate and whether the distribution of payments is appropriate. According to our best estimate, the base rate for SNFs overall appears to be adequate if add-on Z remains in effect. Without this add-on, however, the base rate would probably be less than adequate.

Based on Medicare margins, the distribution of payments between freestanding and hospital-based SNFs appears inappropriate, with or without add-on Z. Freestanding SNFs have high Medicare margins while hospital-based facilities appear to have large negative margins. Differences in measured margins are difficult to interpret, although they result partly from the artifact of hospitals' allocation of costs to their SNFs and partly from differences in case mix and product between the two types of facilities. From 1998 to 2001, almost 20 percent of hospital-based facilities have left the Medicare program, but there has been a 1 percent increase in freestanding SNFs. Exits of hospital-based SNFs without comparable exits of freestanding facilities reinforce margin data that suggest the distribution of payments is inappropriate.

In the next sections, we discuss the evidence supporting these conclusions.

Appropriateness of current costs

SNF costs were extremely high under cost-based payment. Under that system, SNFs had limits for routine operating costs (for example, room and board) but no limits on costs for ancillary services, such as physical therapy. Most of the rapid growth in SNF spending—23 percent annually from 1990 to 1996—was due to increased provision of ancillary services. Both the General Accounting Office (GAO) and Office of Inspector General (OIG) maintain that SNF costs were overstated under the cost-based payment system (GAO 1998, OIG 1999).

Under prospective payment, SNFs have financial incentives to decrease their costs and have responded accordingly—costs per day for freestanding SNFs dropped from $305 in 1997 (pre-PPS) to $240 in 1999. Anecdotal evidence suggests that after the implementation of the PPS, SNFs were able to cut costs substantially by negotiating lower prices for contract therapy (physical, occupational, and speech therapists) and pharmaceuticals. SNFs also cut costs by substituting lower-cost labor for higher-cost labor (Liu et al. 2000); for example, using therapy assistants instead of therapists to provide therapy services or using licensed nurses instead of respiratory therapists to provide respiratory therapy. In addition, SNFs cut the number of therapy staff under the PPS (White 2001). We do not know how these cost-cutting measures affect the quality of care furnished to beneficiaries in SNFs because studies have not yet been completed.

Hospital-based SNF costs ($470 per day in 1998, compared with $305 for freestanding facilities) are difficult to interpret because hospitals have historically allocated administrative costs

1 Nontherapy ancillary is the term used to describe an ancillary service that is not physical, occupational, or speech therapy.

to units paid on a cost basis—including SNFs and outpatient departments (OPDs). For hospital OPDs, this cost allocation has increased reported costs by an estimated 15 to 20 percent. We do not know the extent that costs are allocated to SNFs, but reported costs for hospital-based SNFs appear inappropriately high, even after we take their higher case-mix index and staffing into consideration.

Hospital-based SNFs have had a substantially higher case mix than freestanding SNFs, as shown by MedPAC's analysis using all-patient refined diagnosis related groups (MedPAC 2001). Hospital-based SNFs also have more licensed staff than freestanding SNFs (HCFA 2000). How much of the different staff mix is a result of a higher case mix is not known. However, a shorter average length of stay—13 days, compared with 26 days for freestanding SNFs—combined with differences in staffing and case mix suggests that hospital-based SNFs furnish a different product.

Relationship of payments to costs

Every year MedPAC recommends to the Congress a payment update for the coming fiscal year for skilled nursing facilities. To inform our recommendation, we estimated margins for 2002, including policy changes that will be in effect for 2003 under current law.

To estimate the relationship between payments and costs, we modeled fiscal year 2002 SNF payments and costs using methods like those we use for all settings paid prospectively. For each PPS, we:

- used the latest cost report data available (fiscal year 1999) as the cost and payment base,
- increased costs by market basket for 2000 and 2001 and used CMS's forecast of market basket increase for 2002,
- increased payments by the update factor for each year starting after 1999.

We modeled 2002 payments and costs to reflect policy changes that will be in effect in 2003:

- SNFs will be paid at 100 percent of the federal rate because the phase-in of the PPS will be complete.
- Because of uncertainty of whether CMS will refine the RUG-III classification system and the effect of these changes on payments, we modeled 2002 payments and costs with and without add-on Z (the 20 percent increase for medically complex patients and 6.7 percent increase for rehabilitation patients).

We did not include add-ons X and Y, the two temporary rate increases that were in effect after fiscal year 1999 but expire in fiscal year 2003.

We also adjusted costs for hospital-based SNFs to reflect our best estimate of reasonable costs. We began with costs for freestanding SNFs because these facilities are able to deliver SNF care under the PPS. We then added 30 percent to costs for freestanding facilities to account for differences in case mix and product between the two types of facilities.

The estimate of current costs MedPAC used to calculate 2002 margins may be overstated for two reasons. First, we used fiscal year 1999, the first year that most SNFs were subject to the PPS, as the cost base for our modeling.[2] Second, we assumed that costs increased by the full market basket increase for each year after 1999. Our method did not allow us to take into account SNFs' behavioral adjustment to the PPS after the first year. SNFs likely cut costs as they gained experience with the PPS and as knowledge of ways to cut costs diffused within the industry. For example, SNFs substituted some licensed practical nurse and nurse aide time for registered nurse time after some experience with the PPS (Hodlewsky et al. 2001).

Overall margins for 2002 suggest that with add-on Z in effect, Medicare's payments are adequate. The Medicare margin for all facilities is almost 5 percent, including the adjustment for hospital-based SNFs costs discussed above (Table 2D-1). Without add-on Z, however, the Medicare margin for all facilities drops to almost –5 percent.

The factors we examined in addition to the Medicare margin also suggest that the base rate is adequate. Freestanding SNFs have stayed in the Medicare program (although more than 400 hospital-based SNFs have closed). In addition, the OIG found that beneficiaries have had stable access to SNF care in 2000 and 2001 (OIG 2001). Finally, most SNFs appear to have adequate access to capital.

Entry and exit of providers

A significant number of hospital-based SNFs (almost 20 percent) have exited the Medicare program since the PPS began

TABLE 2D-1

Medicare margins for skilled nursing facilities, 1999 and estimated 2002

SNF group	Reported 1999 (No add-ons)	Estimated 2002 With add-on Z	Estimated 2002 Without add-on Z
Freestanding	9.0	9.4	0.4
Hospital-based	−55.6	−21.0	−33.0
All SNFs	−4.2	4.8	−4.6

Note: For 2002, we modeled costs for hospital-based skilled nursing facilities (SNFs) as equal to costs for freestanding facilities plus 30 percent. Add-on Z increases rates by 20 percent for medically complex patients and 6.7 percent for rehabilitation patients.

Source: MedPAC analysis of CMS cost reports.

2 SNFs became subject to the PPS according to their cost reporting year as of July 1998; more than 60 percent of SNFs had cost reporting years beginning January 1999.

TABLE 2D-2

Change in number of certified skilled nursing facilities by type, 1998–2001

	1998	2001	Percent change 1998–2001
Medicare only			
Hospital-based	1,032	705	–32%
Freestanding	428	401	–6
Medicare/Medicaid			
Hospital-based	1,141	1,057	–7
Freestanding	12,434	12,592	1
Totals			
Hospital-based	2,173	1,762	–19
Freestanding	12,862	12,993	1
All facility types	15,035	14,755	–2

Source: MedPAC analysis of CMS On-line Survey, Certification, and Recording System (OSCAR) data.

(Table 2D-2). At the same time, the number of freestanding SNFs has increased modestly (1 percent). Particularly notable is the 32 percent decrease in Medicare-only hospital-based SNFs, compared with a 6 percent decrease in Medicare-only freestanding SNFs.

Beneficiaries' access to care

According to a recent OIG study of access, beneficiaries have generally not had problems obtaining SNF care. Almost three-fourths of hospital discharge planners reported in 2001 that they were able to place all patients who needed SNF care; one-fifth reported being able to place all but 1 to 5 percent and the rest had problems placing more than 5 percent of patients. Patients requiring costly services had the most difficulty accessing SNF care (OIG 2001). These findings are consistent with those from a 2000 study (OIG 2000).

Access to capital

More than 90 percent of SNFs are part of either a hospital or a nursing home. Medicare-covered SNF care represents a small share of both hospitals' and nursing homes' business.[3]

Hospitals generally have good access to capital (see Section 2B). However, hospitals may not continue to allocate capital to SNFs if that line of business continues to lose money.

Most nursing homes also have access to capital. Under the PPS, many independent freestanding SNFs and small to medium-sized regional chains, which represent 47 percent of the nursing home market, have had increases in net income and debt coverage, before any payment add-ons (PricewaterhouseCoopers 2001). Generally, researchers have found that net operating income margins and the ability to service debt for these facilities were about the same under PPS as under cost-based payment.

As widely reported, five of the seven largest publicly traded nursing home chains declared bankruptcy in 1999. GAO (2000) found that these bankruptcies resulted from heavy investment in ancillary service lines of business and high capital-related costs (such as depreciation, interest and rent). Two chains emerged from Chapter 11 bankruptcy in 2001 and another is expected to emerge in early 2002.

Different updates for freestanding and hospital-based SNFs

Assuming the continuation of add-on Z, payments appear to be more than adequate for freestanding SNFs. For hospital-based SNFs, departures from the Medicare program and negative margins beyond what we would expect after adjusting for case mix and cost allocation together suggest payments are not adequate.

This difference in payment adequacy is partly the result of the RUG-III classification system's inability to adequately classify patients and partly due to differences in product between hospital-based and freestanding SNFs. The RUG-III classification system is based on a patient assessment instrument that does not collect certain information needed to account for the resource use of more medically complex patients who need SNF care (MedPAC 2001). In addition, the system does not appropriately account for all the costs of providing SNF care, especially costly ancillaries such as drugs.

Ideally, an inappropriate distribution of payments that results from the classification system would be addressed by fixing that system. However, CMS faces substantial obstacles in refining the RUG-III successfully to provide an acceptable case-mix classification system for SNF patients.

RECOMMENDATION 2D-1

The Secretary should develop a new classification system for care in skilled nursing facilities.

The Commission believes that the RUG-III cannot be refined to provide an acceptable classification system. The RUG-III has four fundamental problems, three of which refinement cannot remedy. First, it is based on a patient assessment instrument that does not collect the information needed to account for the needs of patients who require SNF care. Second, the system is subject to a high rate of error in classifying patients. Third,

3 SNFs make up 2 percent of hospitals' Medicare payments and 3 percent of their Medicare costs. Medicare SNF payments make up about 10 percent of nursing homes' revenue (AHCA 2001).

classification of rehabilitation patients is based on services provided rather than patient characteristics and because payment rates are higher for these patients, the system gives SNFs incentives to provide therapies when they may not be beneficial. Finally, the system allocates expected resource use inappropriately because costs of nontherapy ancillary services are included only to the extent that these costs are correlated with nursing staff time. Even if CMS were able to refine the RUG-III to better account for the resources needed to care for SNF patients, the problems of inadequate information, classification errors, and provider manipulation of the system would remain.

We anticipate that a new classification system will be available no sooner than fiscal year 2006.[4] Therefore, we recommend a less than optimal fix—different updates for freestanding and hospital-based SNFs—to temporarily address existing distributional problems.

Accounting for cost changes in the coming year

MedPAC's update recommendation depends on two things: the adequacy of current payments for care in skilled nursing facilities and expected changes in the cost of providing care in the coming year. As in the other PPS settings, when considering changes in costs in the coming year we start with a market basket forecast. The SNF market basket provides a measure of how prices change for a fixed set of inputs to provide SNF care (see Section 2A); however, we expect SNFs to continue adjusting to the PPS in fiscal year 2003, finding more efficient ways to use inputs and reduce costs. The phase-in of the prospective payment system was intended to allow facilities to adjust gradually to prospective payment, and we anticipate that SNFs will continue to do so. Using MedPAC's framework for making update recommendations and taking into account our expectation that SNFs will reduce costs, we recommend that overall SNF payments be increased by about market basket minus 1 percent.

Update recommendation

To implement this overall increase, MedPAC recommends several specific changes: one affecting the base payment amount and two affecting payments for care in hospital-based SNFs.

RECOMMENDATION 2D-2

If the Centers for Medicare & Medicaid Services refines the classification system for care in skilled nursing facilities, the temporary payment increase, previously implemented to allow time for refinement, will end. The Congress should retain this money in the base payment rate for skilled nursing facilities.

To protect beneficiaries' access to SNF care, we recommend that if CMS refines the RUG-III classification system and add-on Z expires, the money should be incorporated in the base payment rate. Without add-on Z, the estimated Medicare margin for all SNFs would be –5 percent, which appears to be inadequate.

RECOMMENDATION 2D-3

For fiscal year 2003, the Congress should update payments to skilled nursing facilities as follows. For freestanding facilities, no update is necessary. For hospital-based facilities, update payments by market basket and increase payments by 10 percent until a new classification system is developed.

Contingent on the money from add-on Z being retained in the base rate, we recommend different updates for freestanding and hospital-based SNFs. We believe, based on an estimated 9 percent Medicare margin and other indicators, that no update for freestanding SNFs is appropriate. In contrast, we believe that the Medicare margins of hospital-based SNFs, as well as other indicators, suggest that a market basket update is needed for fiscal year 2003 to account for changes in input prices between 2002 and 2003. In addition, to recognize differences in case mix and product, we recommend that the base rate for hospital-based SNFs be increased temporarily by 10 percent until a new and effective classification system is implemented. Together, these updates for hospital-based SNFs would cost about the same as updating payments for all SNFs by market basket minus 1 percent. ■

4 The Congress required CMS to report on alternative SNF classification systems in January 2005. We estimate that implementation will take an additional nine months.

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