SECTION 2C

Assessing payment adequacy and updating payments for skilled nursing facility services

RECOMMENDATIONS

2C-1 The Secretary should continue a series of nationally representative studies on access to skilled nursing facility services (similar to studies previously conducted by the Department of Health and Human Services' Office of Inspector General).

***YES: 16 • NO: 0 • NOT VOTING: 0 • ABSENT: 1**

2C-2 The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2004.

YES: 16 • NO: 0 • NOT VOTING: 0 • ABSENT: 1

2C-3A Consistent with previous MedPAC recommendations, the Secretary should develop a new classification system for care in skilled nursing facilities.

Because it may take time to develop this system, the Secretary should draw on new and existing research to reallocate payments to achieve a better balance of available resources between the rehabilitation and nonrehabilitation groups.

To allow for immediate reallocation of resources, the Congress should give the Secretary the authority to:

- remove some or all of the 6.7 percent payment add-on currently applied to the rehabilitation RUG–III groups.
- reallocate money to the nonrehabilitation RUG–III groups to achieve a better balance of resources among all of the RUG–III groups.

2C-3B If necessary action does not occur within a timely manner, the Congress should provide for a market basket update, less an adjustment for productivity growth of 0.9 percent, for hospital-based skilled nursing facilities to be effective October 1, 2003.

YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

***COMMISSIONERS' VOTING RESULTS**

SECTION 2C

Section 2C: Assessing payment adequacy and updating payments for skilled nursing facility services

In this section

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

Based on the available evidence, we conclude that aggregate Medicare payments for skilled nursing facilities (SNFs) are adequate as of fiscal year 2003, but that payments are not distributed appropriately to account for the expected resource needs of different types of Medicare beneficiaries. Our estimate of the overall Medicare margin for SNF services across all providers in fiscal year 2003 is about 5 percent, with the Medicare margin for freestanding SNFs (90 percent of all facilities) about 11 percent and the Medicare margin for hospital-based facilities about –36 percent. After high cost growth prior to the implementation of the prospective payment system for SNFs, we have seen a decline in costs for free-standing facilities in recent years in response to incentives in the SNF prospective payment system. We expect this trend to continue into fiscal year 2004. This decline in costs does not appear to have resulted in a lower quality of care. Continued entry of for-profit freestanding providers, increases in the volume of services provided, continued access to services for most Medicare beneficiaries, and lack of systematic problems with SNFs' access to capital that would pose problems for beneficiaries' access to services suggest that Medicare payments are at least adequate to cover the costs of caring for Medicare beneficiaries. We believe it is important to continue monitoring beneficiaries' access to SNF services.

Background

Medicare 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).[1] These services may be provided either in freestanding or hospital-based facilities, with freestanding facilities representing about 90 percent of all SNFs. A freestanding SNF is typically part of a nursing facility that also provides residential long-term care, which is not covered by Medicare.

Skilled nursing facility payment system

In July 1998, Medicare adopted a prospective payment system for SNF services. This system pays SNFs a case mix adjusted amount for each day of care.[2]

The per diem payment rates under this system are intended to provide full payment for all facility services, except for the costs of approved medical education programs. The rates cover all routine, ancillary, and capital costs, as well as those for most ancillary items and services for which payment previously was made under Medicare Part B.[3]

Patients are assigned to 1 of 44 groups, called resource utilization groups, version III (RUG–III). Each RUG–III group includes patients with similar service needs who are expected to require similar amounts of resources. Patients' expected resource needs are determined by periodic assessments of their condition, including their need 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 and using the toilet). The daily rate for each RUG–III group 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 and ancillary services patients are expected to require, and
- a variable amount for the expected intensity of therapy services (physical, occupational, and speech therapies).

Payment rates for SNF services are computed separately for urban and rural areas, and the labor portion of the total rate is adjusted to reflect the wage market conditions within the SNF's geographic location. Furthermore, rates are updated annually on the basis of 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 (see Appendix A for more information on the SNF payment system).

Shortly after the SNF prospective payment system was implemented, the Congress responded to providers' concerns about payment rates and the distribution of payments by granting a series of temporary payment rate increases:

- The Balanced Budget Refinement Act of 1999 (BBRA) increased rates for all 44 RUG–III groups by 4 percent for care furnished between April 2000 and 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.
- BBRA and BIPA increased payment rates for 14 rehabilitation groups by 6.7 percent and rates for 12 complex care groups by 20 percent. These increases were intended to give CMS time to refine the RUG–III classification system and are scheduled to expire when CMS adopts that refinement.

Trends in Medicare payments for skilled nursing facility services

Total spending for SNF services on behalf of Medicare beneficiaries was $15.3 billion in fiscal year 2001. This amount includes benefit payments by the Medicare program and beneficiaries' payments for cost-sharing obligations. Medicare spending on SNF services grew an average of 13 percent from fiscal years 1992 through 2002, with a noticeable dip in spending occurring in fiscal years 1999 and 2000 (Figure 2C-1). The Congressional Budget Office (CBO) projects that expenditures for this sector will grow by about 8 percent per year from fiscal years 2002 to 2007.[4] Medicare spending for SNF services represents

1 Medicare covers 100 SNF days in a spell of illness. Medicare pays 100 percent of the rate for the first 20 days of a SNF stay. From the 21st to the 100th day, beneficiaries are responsible for a copayment equal to one-eighth of the hospital deductible, or $105 per day in fiscal year 2003.

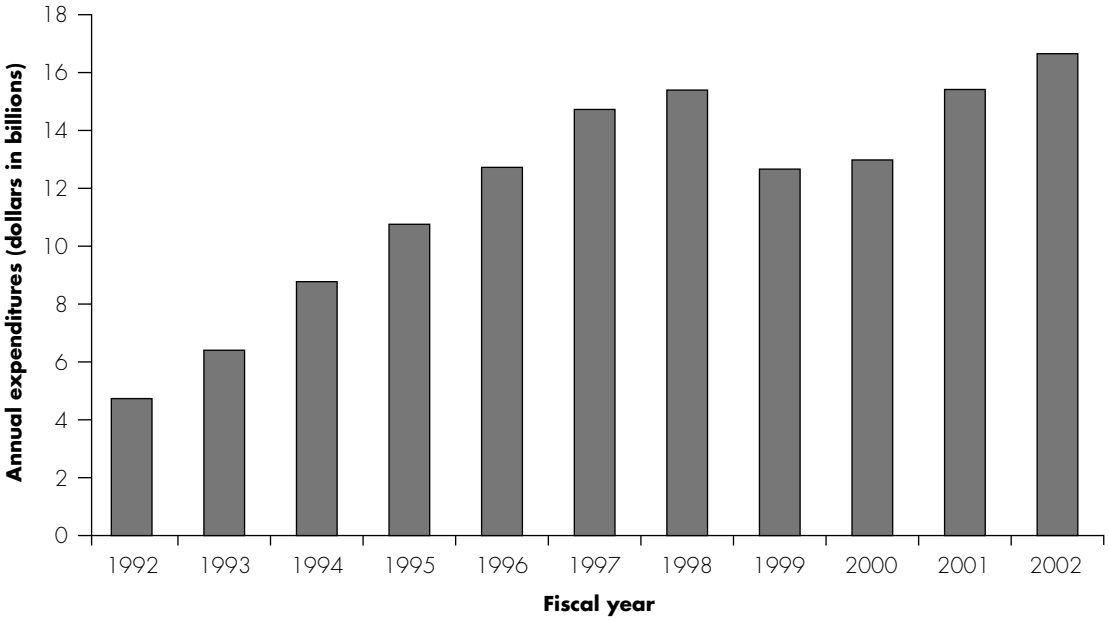
2 The prospective payment system differs substantially from the payment system in effect throughout most of the 1980s and 1990s, when SNFs were paid on the basis of their costs subject to limits on their per diem routine costs (room, board, and routine nursing care). No limits were applied for ancillary services (such as drugs and therapy).

3 The per diem rates exclude amounts for services furnished by physicians and certain other practitioners, such as qualified psychologists, and for dialysis services and supplies. These services continue to be paid for under Part B. Certain high cost, low probability ancillary services have also been excluded from the SNF per diem rate to limit SNFs' liability for services typically outside the scope of SNF care. These services include emergency room care, outpatient hospital CAT scans, MRIs and surgeries, and certain high cost chemotherapy agents and prosthetic devices. Costs for physical, occupational, and speech therapy services are included in the per diem rate even if they are furnished by or under the supervision of a physician.

4 CBO plans to revise its projections of Medicare spending for SNF services downward after conducting an updated analysis of the relationship between the use of SNF services and the incidence of disabilities and hospitalizations among Medicare beneficiaries. CBO's updated projections for SNF services were not available before our report went to press.

FIGURE 2C-1

Medicare spending for skilled nursing facility services, 1992–2002



Note: Spending is for Part A services only.

Source: CMS, Office of the Actuary, 2002.

about 6.5 percent of total Medicare spending for all services. Although about 1.4 million beneficiaries (about 3.5 percent of all beneficiaries) use SNF services each year, Medicare's payments for these services account for only about 10 to 12 percent of freestanding nursing facilities' revenues and less than 2 percent of total revenues for hospitals. Other payments for these services come from Medicaid and private sources.

Assessing payment adequacy

Each year, MedPAC makes payment update recommendations for the coming fiscal year for SNF services. To inform our recommendations, we consider multiple factors, including the relationship of payments to costs and the appropriateness of current costs, providers' entry and exit from the program, changes in the volume of services, beneficiaries' access to care, and SNFs' access to capital.

After assessing all of these factors, we conclude that fiscal year 2003 payments to SNFs overall are adequate to cover the costs of caring for the beneficiaries that use these services. We estimate the Medicare margin—a measure of the relationship between Medicare payments and costs—for all SNFs to be about 5 percent, with the Medicare margin for freestanding SNFs (90 percent of all SNFs) about 11 percent (Table 2C-1). The costs of providing SNF services appear to be decreasing, while we find no evidence of declines in the quality of care. In addition, the most recent available data suggest no declines in the overall number of SNFs participating in the Medicare program between 1998 and 2002—with increases in freestanding providers balancing decreases in hospital-based providers—or in the volume of services provided. We find no evidence of substantial declines in beneficiaries' ability to access SNF services or in SNFs' access to capital.

However, while Medicare payments to SNFs appear adequate overall, the SNF classification system appears to do a poor job of tracking the expected resource needs of different types of beneficiaries who use SNF services. This causes some types of beneficiaries to be more profitable for SNFs than others. Studies

TABLE 2C-1

Medicare margins for skilled nursing facilities, 2000 and estimated 2003

	Reported 2000	Estimated 2003
Freestanding	17	11
Hospital-based	–57	–36
All facility types	7	5

Source: MedPAC analysis of Medicare cost report data from CMS.

have repeatedly shown that hospital-based SNFs tend to treat a much larger proportion of the less-profitable types of patients—those with multiple complex needs that do not include rehabilitation therapy—than freestanding facilities (Dalton 2002, Liu and Black 2002, MedPAC 2001). The Medicare margin for hospital-based facilities also tends to be lower (–36 percent in fiscal year 2003) than the Medicare margin for freestanding facilities.[5] This may be one of many reasons why some hospital-based facilities—about 26 percent between 1998 and 2002—have exited the Medicare program. The decline in hospital-based facilities does not appear to have led to a decline in beneficiaries' access to care, though, because beneficiaries who otherwise would have been treated in these facilities either remain in the acute care hospital setting longer or receive care in a freestanding facility. However, the substantial declines in the number of hospital-based facilities participating in Medicare may indicate an imbalance in the distribution of payments across different types of patients in the SNF payment system.

Current payments and costs

One of the many factors we use to inform our update recommendation for fiscal year 2004 is the estimated relationship between SNF payments and costs (margin) for fiscal year 2003.[6] To produce this estimate, we modeled fiscal year 2003 SNF payments and costs using methods similar to those we use for all settings for which we make update recommendations:

- We used the latest cost report data available (fiscal year 2000) as the cost and payment base.
- We increased costs by the actual SNF market basket index for fiscal years 2001 and 2002 and used CMS's forecast of the SNF market basket index for fiscal year 2003.
- We increased payments by the update factor that applied for each year starting after fiscal year 2000.

In modeling fiscal year 2003 payments and costs, we incorporated any policy changes scheduled in current law for fiscal year 2004. We excluded the 16.66 percent increase in the nursing component of the base rate from our estimate because it was implemented after fiscal year 2000 (our base year) and expired before fiscal year 2003 (the year we modeled). We deducted the 4 percent increase to all payment rates from the fiscal year 2000 payments before estimating fiscal year 2003 payments because this add-on is not scheduled to be in effect for fiscal year 2004. We included the 20 percent add-on for certain RUG–III groups in our projections because we anticipate that this increase will still be in effect in fiscal year 2004.[7]

We estimate that the overall Medicare margin for all SNFs will be about 5 percent in fiscal year 2003. This is about the same as the overall Medicare margin for all SNFs we estimated for fiscal year 2002. However, the lack of a difference is due largely to our approach to estimating the Medicare margin for hospital-based SNFs—it is more conservative than last year's approach.[8] If we had used the same method as last year, we would likely have seen an increase in the Medicare margin for all SNFs in fiscal year 2003 both because the Medicare margin for freestanding SNFs increased substantially and the proportion of all SNFs that are freestanding increased between 1998 and 2002.

On average, we estimate that the Medicare margin for the 90 percent of all SNFs that are freestanding will be 11 percent in fiscal year 2003, an increase of less than 2 percentage points over the 9.4 percent we estimated for fiscal year 2002.[9] The increase is due largely to substantial increases in freestanding SNFs' reported margins between fiscal years 1999 and 2000. The reported margin for freestanding facilities was about 9 percent in fiscal year 1999 and just under 17 percent in fiscal year 2000 (see text box next page).

In contrast to the increase in the margin seen for freestanding facilities, the Medicare margin for hospital-based facilities does not appear to have changed much between fiscal year 1999 and fiscal year 2000 (–56 to –57 percent). However, the fiscal year 2003 Medicare margin for hospital-based facilities is different from that which we estimated for fiscal

5 Hospital-based SNFs' higher case mix is only one factor that may explain the lower Medicare margin for these facilities. Recent research indicates that much of the difference between freestanding and hospital-based SNF margins is due to hospital-based SNFs having higher fixed costs (Pizer et al. 2002). To some extent, these higher fixed costs result from hospital cost allocation methods. Hospital-based SNFs may also offer a different product than freestanding SNFs, with more licensed staff and a much shorter average length of stay (MedPAC 2001).

6 A margin is calculated as payments less costs, divided by payments.

7 The 20 percent add-on for certain RUG–III groups that became effective in April 2000 was intended to give CMS time to refine the SNF classification system. BIPA changed this add-on, effective April 2001, by applying the 20 percent add-on only to nonrehabilitation RUG–III groups and applying a 6.7 percent add-on to all of the rehabilitation RUG–III groups. However, the 20 percent add-on as originally mandated in BBRA only applies in fiscal year 2000.

8 To estimate the fiscal year 2002 Medicare margin for hospital-based SNFs last year, we used the costs for freestanding SNFs and inflated them by 30 percent (our best estimate of the difference in costs attributable to a different case mix and product between the two types of facilities). In computing the fiscal year 2003 Medicare margin for hospital-based SNFs, we took a more conservative approach; we used the costs for hospital-based SNFs and deducted 17.5 percent (our best estimate of the amount attributable to hospital cost accounting based on a study sponsored by the Health Care Financing Administration [HCFA, now CMS] that estimated the range to be between 15 and 20 percent) (CHPS Consulting 1994).

9 The 9.4 percent estimate for fiscal year 2002 was modeled assuming that the 20 percent add-on to payments for 12 complex care groups and the 6.7 percent add-on to payments for 14 rehabilitation groups would remain in current law in fiscal year 2003. Because CMS has yet to announce a refinement of the SNF classification system, this add-on remains in effect.

Adjustment to freestanding skilled nursing facility costs (margin)

Prior to implementation of Medicare's prospective payment system for skilled nursing facilities (SNFs) in 1998, many nursing facilities designated separate and distinct units as Medicare SNF units. Nursing facilities would generally use the beds in these SNF units exclusively to care for patients during their Medicare coverage for SNF services; the rest of the nursing facility would generally care for other types of patients, such as long-term care patients paid for under Medicaid or with private resources. Nursing facilities that maintained separate units for Medicare and non-Medicare patients were required to report the costs of caring for their Medicare patients to the Medicare program each year, and Medicare payments were based on these reported costs for Medicare patients.

Under the SNF prospective payment system, Medicare no longer pays nursing facilities based on their reported costs; instead, facilities receive a fixed, case-mix adjusted per diem amount for each Medicare SNF patient. Consequently, many nursing facilities have abandoned their practice of maintaining a separate unit for Medicare SNF patients, now interspersing them with non-Medicare patients throughout their facilities. The nursing facilities that made this change now report the average costs of caring for all patients in the facility to Medicare each year, instead of reporting separate costs for Medicare SNF patients only. Facilities may have chosen to make this change for a number of reasons: It allows them to keep patients in the same beds when the Medicare SNF coverage ends and patients must transition to other sources of coverage, and it allows facilities flexibility to accept more Medicare SNF patients.

Averaging Medicare and non-Medicare costs results in understated costs for Medicare patients. Medicare SNF patients generally require a higher level of nursing care than other patients. So, Medicare payment-to-cost ratios appear higher than they would if the SNFs' reported costs were only based on their Medicare patients. Independent analysis by the General Accounting Office using a different method reaches a similar conclusion—that the use of freestanding SNFs' unadjusted average costs in computing the Medicare margin overstates SNFs' actual Medicare margin (GAO 2002b).

To account for this understatement of the actual costs of caring for Medicare SNF patients, we adjusted fiscal year 2000 costs. We estimated the cost differential between Medicare and non-Medicare patients in the 54 percent of SNF facilities that reported separate costs for each patient group in fiscal year 2000 and applied this adjustment to the Medicare costs for facilities that reported average costs across all patients. It should be noted that this adjustment relies on the accuracy of facilities' reported costs of caring for Medicare patients in the distinct part units, which are determined using cost-allocation methods. To the extent that these costs are overallocated, our adjustment would underestimate the true margin.

Prior to the adjustment, we estimate a fiscal year 2000 Medicare margin for freestanding SNFs of almost 20 percent. The adjustment brings the Medicare margin for fiscal year 2000 down to just under 17 percent. ■

year 2002, primarily because we changed the method to estimate the margin (see footnote 6). We estimate the hospital-based facilities' Medicare margin to be about –36 percent in fiscal year 2003. Differences in measured margins between hospital-based and freestanding facilities are difficult to interpret, because they result from both the artifact of hospitals' allocation of costs to their SNFs and differences in case mix and product between the two types of facilities.

Appropriateness of current costs

Under the cost-based Medicare payment system in effect for SNFs throughout most of the 1980s and 1990s, SNFs were paid based on their reported costs. Both the General Accounting Office (GAO) and the Office of Inspector General (OIG) found that these costs were excessively high (GAO 1998, OIG 1999b). According to 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. Separate limits applied based on location (urban or rural) and whether facilities were hospital-based or freestanding, with hospital-based facilities having higher limits than freestanding facilities. In addition, new SNFs were exempt from the routine cost limits for up to their first four years of operation.

Because Medicare's payments were based on SNFs' costs and SNFs had little incentive to contain costs, Medicare spending grew rapidly during this period.

Between 1990 and 1996, for example, SNF spending grew at an average of about 23 percent per year (MedPAC 2002). Much of this growth in spending was due to increased provision of ancillary services.[10]

Under the prospective payment system, SNFs have financial incentives to decrease their costs, and evidence indicates that freestanding SNFs have responded accordingly.[11] Freestanding SNFs have lowered costs in a number of ways, including negotiating lower prices for contract therapy (physical, occupational, and speech therapists) and pharmaceuticals, substituting lower-cost labor for higher-cost labor (Liu et al. 2000), and decreasing the number of therapy staff (White 2001).

In addition, preliminary research suggests that the average number of minutes of therapy provided in freestanding SNFs may have declined (Gifford and Angelelli 2002) and that rehabilitation charges per patient per SNF day declined substantially in freestanding SNFs—in some cases, by as much as 47 percent—from 1997 to 2000 (White 2002c).

Freestanding SNFs appear to have responded to incentives in the prospective payment system by reducing the average number of minutes of physical, occupational, and speech therapy they provide per week to patients in each of the rehabilitation RUG–III groups. In contrast to prospective payment systems for most other providers, payment rates under the SNF prospective payment system for patients requiring rehabilitation therapy are determined based on the number of minutes per week SNFs actually provide—or estimate they will provide—rather than on the patients' characteristics. So, to a certain extent, SNFs can determine the amount they are paid by controlling the number of therapy minutes they provide per week. Prospective payments to SNFs increase at certain threshold amounts of therapy provided, meaning that SNFs are paid one rate for providing between 45 and 149 minutes of therapy to a given patient and a higher rate for providing between 150 and 324 minutes for that same patient, all else being equal. Thus, under the SNF prospective payment system, facilities have strong incentives to provide levels of therapy that correspond to the lower end of each range, unless they can provide enough therapy to move the patient into the next highest RUG–III group (Figure 2C–2).

The way the RUG–III payment rates are structured provides greater incentives for SNFs to treat patients needing moderate to high levels of therapy than patients in other groups because these types of patients tend to be more profitable for SNFs than patients in other groups. Studies have generally found that, since the SNF prospective payment system was implemented, SNFs increased the proportion of patients they care for in RUG–III groups requiring moderate to high levels of therapy and reduced the proportion of patients in the groups requiring either extremely high levels of therapy or no therapy (GAO 2002c, White 2002c).

Despite substantial evidence that the costs of caring for Medicare patients in freestanding SNFs have decreased, we can find no evidence of decreases in the quality of care delivered to beneficiaries in SNFs. This may be because SNFs' costs were so high before the SNF prospective payment system that they had room to reduce their costs without reducing quality. Preliminary research examining national data from 1997 to 2000 has found no change in crude measures of quality—such as activity of daily living (ADL) scores, walking scores, rates of rehospitalizations, or incidence of mortality (White 2002b). In addition, preliminary evidence from a study of 84,000 Medicare SNF patients in Ohio between 1997 and 2000 indicates that quality of care either remained the same or improved slightly over the period (Gifford and Angelelli 2002). Researchers found that rehospitalization rates improved among beneficiaries in certain Ohio SNFs, walking scores improved slightly, and other measures of quality remained relatively constant. They concluded that these findings were not attributable to changes in the case mix of patients.

Furthermore, studies point to a positive relationship between increased nursing staff times and nursing home quality of care (Abt 2001, HCFA 2000), and we find no evidence of declines in the overall amount of nursing staff time provided to beneficiaries since the SNF prospective payment system began. Studies by GAO and by the American Health Care Association (AHCA) both indicate that slight increases in nursing staff time may have occurred in SNFs between 2000 and 2002 (AHCA 2002, GAO 2002a). GAO reported that nursing staff time per patient per day increased by about 1.9 minutes; AHCA reported an increase of 4.8 minutes per patient day in freestanding facilities, with no change in hospital-based facilities. However, both studies indicate a shift in the mix of nursing staff time provided, with the proportion of time delivered by registered nurses declining and the proportion of time delivered by licensed nurse practitioners and nurse aides both increasing. Because we do not know what implications these changes might have for quality, it will be important to continue to monitor the quality of care in SNFs over time to ensure that changes in staff mix do not lead to decreases in quality in the future.

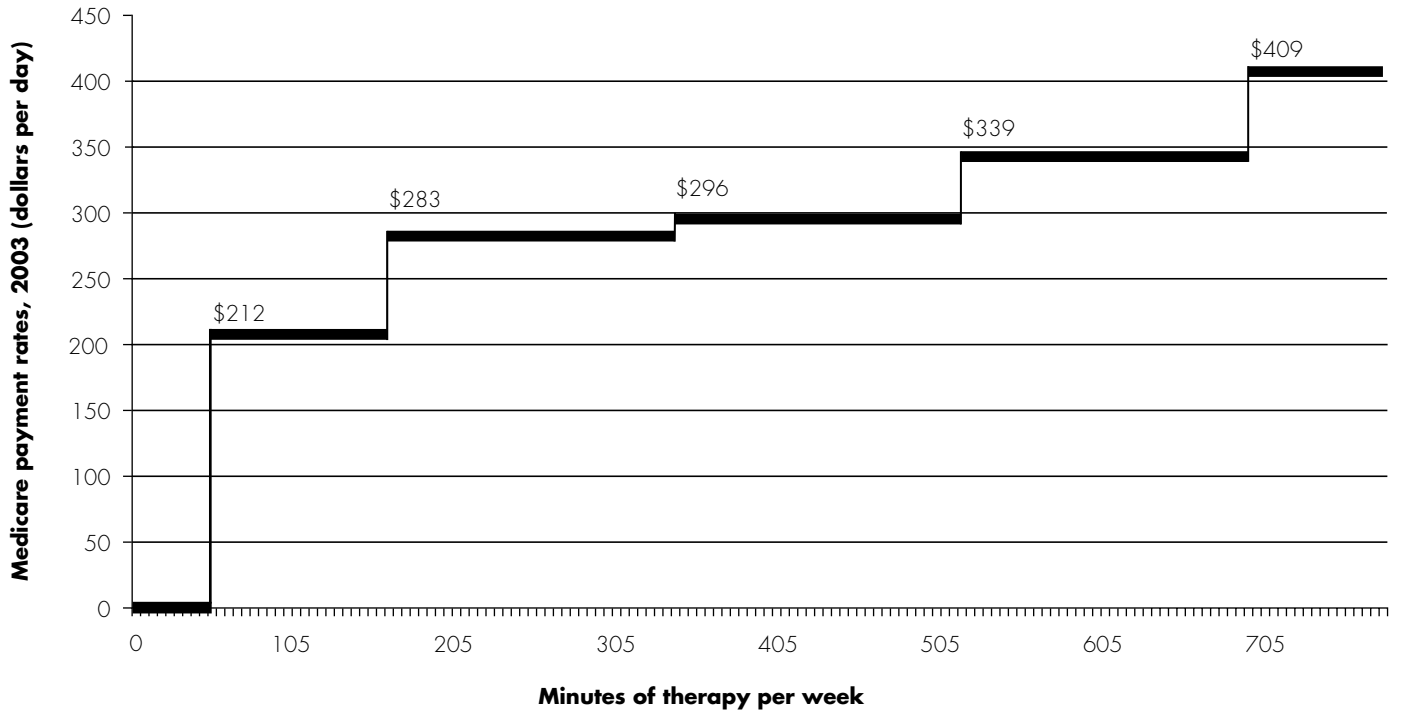
SNFs may have additional incentives to improve quality regardless of cost

10 In addition, during the 1990s, the OIG found that some SNFs were billing Medicare for therapy that was not medically necessary, that was provided by staff without the proper skill level to perform the therapy, and that may not have been provided at all. They also found that, in some cases, Medicare may have been paying SNFs as much as 86 percent more than the SNFs actually paid their contractors to provide the therapy. These improper billing practices likely contributed to Medicare's spending increases for SNFs over the period (OIG 1999b).

11 Although freestanding SNFs appear to have lowered their costs significantly since the implementation of the SNF prospective payment system, evidence indicates that costs for hospital-based SNFs actually increased from 1997 to 1999. In fact, GAO reported that hospital-based SNF costs increased by $29 per day from 1997 to 1999, while freestanding facilities' costs decreased by $49 per day over the same period (GAO 2002a).

FIGURE 2C-2

Skilled nursing facility payments and minutes of therapy for rehabilitation patients, 2003



Note: Payment rates are based on 2003 urban payment rates for a Medicare skilled nursing facility patient with Activities of Daily Living score of 9. The 6.7 percent payment add-on is included.

Source: CMS. Medicare program: prospective payment system and consolidated billing for skilled nursing facilities—update. Federal Register. July 31, 2002, Vol. 67, No. 147, p. 49802.

pressures because CMS has recently begun to publish nationwide reports with quality measures at the individual nursing facility level. CMS is also devoting resources to help nursing facilities that wish to improve their scores on these nationally reported measures. Nursing facilities generally indicate that they are aware of the public reporting of the quality measures and that they would like to improve their scores on future reports. Thus, this public reporting may serve as a countervailing force to maintain quality in nursing facilities even as the incentives of the prospective payment system encourage facilities to reduce costs.

We therefore conclude that SNFs have lowered the costs of inputs to providing care to Medicare beneficiaries. At the same time, we find no reductions in the quality of care. Together, this points to an improvement in productivity in the SNF sector because SNFs appear to have been able to reduce the resources needed to produce SNF services while maintaining service quality.

Relationship of payments to costs

Although our estimate of the Medicare margin for SNFs provides one important piece of information regarding the adequacy of Medicare's payments for SNF services, we look to other available evidence from market factors to ensure that Medicare payments are generally adequate to meet the needs of providers and beneficiaries. From this analysis, we can find no indications of overall problems with Medicare payments to SNFs.

Entry and exit of providers

The total number of SNFs participating in Medicare remained relatively stable between 1998 and 2002, declining by less than 1 percent in each of the first three years of the period and increasing by less than 1 percent between 2001 and 2002 (Table 2C-2). The patterns of entry and exit vary among different types of SNFs, however. From 1998 to 2002, the number of freestanding SNFs participating in Medicare increased by about 3 percent, while 26 percent of hospital-based SNFs have exited the program over the same period.

Recent research examining the entry and exit of SNF providers using average daily census measures and inflows and outflows of providers finds similar patterns in entry and exit (White 2002a). This research also

TABLE 2C-2

Change in the number of certified skilled nursing facilities, by type, 1998–2002

	1998	2001	2002	Percent change 1998–2002	Percent change 2001–2002
Hospital-based	2,173	1,762	1,611	–26%	–9%
Freestanding	12,862	12,993	13,204	3	2
All facility types	15,035	14,755	14,815	–1	<1

Source: MedPAC analysis of Online Survey, Certification, and Reporting (OSCAR) system data from CMS.

indicates that post-prospective payment system changes in SNF payment rates may be one of many factors determining whether facilities remained in the program or exited, though perhaps not the most important factor. Freestanding SNFs were more likely to close if they were new to the market, nonprofit, and smaller, with a smaller fraction of Medicare beds. They were less likely to exit if they had more patients needing high levels of rehabilitation therapy (more profitable under the prospective payment system) or fewer patients requiring expensive pharmaceutical services (which are not reimbursed outside of the per diem payment). Similarly, hospital-based SNFs were more likely to exit if they were new to the market, if they were for profit (especially members of chains), or if a greater proportion of their patients had high inhalation therapy costs. For the most part, only facilities experiencing more than a 40 percent decline in payments after the implementation of the SNF prospective payment system had a higher than average exit rate from the program between 1998 and 2000.

The continuing entry of freestanding SNF providers—particularly for-profit freestanding providers—to the Medicare program may indicate that these providers find the flow of revenues from Medicare to be at least adequate. However, hospital-based SNF providers continue to leave the program. Analysis by MedPAC and others shows that hospital-based SNFs have a substantially higher case mix of patients than freestanding SNFs and may treat a disproportionate number of patients with expensive, nonrehabilitation therapy needs (Dalton and Howard 2002, Liu and Black 2002, MedPAC 2001). Because the SNF classification system appears to do a poor job of allocating resources according to the expected resource needs of rehabilitation and nonrehabilitation patients, hospital-based SNFs may have more difficulty making a profit under the SNF prospective payment system than freestanding SNFs.

In addition, hospital administrators may be responding to increased demand for acute care services. Acute care hospital occupancy rates have increased in recent years at the same time that the nation is experiencing a shortage of nurses. Some hospital administrators report an increase in demand for hospital beds and nurses on the acute care side and may have shifted beds and nurses from the SNF to the acute care units. In some cases, this may have meant closing the SNF unit altogether.

Other possible reasons for hospital-based SNFs to exit may include large changes in Medicare reimbursements before and after the SNF prospective payment system and state and federal regulatory burden issues.

Changes in the volume of services

Changes in the volume of services delivered by a particular set of Medicare providers may indicate whether payments to those providers are too high or too low relative to providers' costs. If we see increases in the volume of services, this likely indicates that payments are at least adequate. Large increases may signal that payments are too high relative to costs.

The most recent available data from 2000 suggest that the volume of SNF services has increased overall (Table 2C-3).

TABLE 2C-3

Payment and use of skilled nursing facilities, 1996–2000

	1996	1997	1998	1999	2000	Percent change, 1999–2000
Payment (billions)	$ 9.3	$ 11.0	$ 11.3	$ 9.5	$ 10.4	10%
Average payment/day	208	233	250	223	236	6
Discharges (1,000s)	1,318	1,582	1,588	1,450	1,439	–1
Covered days (1,000s)	44,639	47,295	45,240	42,535	44,103	4
Average days/discharge	33.9	29.9	28.5	29.3	30.7	5

Note: Data include facilities in Puerto Rico, Virgin Islands, and "unknown." Data do not include swing bed units.

Source: CMS.

The total number of discharges from SNFs remained essentially stable between 1999 and 2000, decreasing by less than 1 percent. Over this same period, the average length of stay in SNFs increased by more than one day. Hence, total Medicare covered days increased by about 4 percent from 1999 to 2000. Total Medicare payments to SNFs and average payments per day also increased, by 10 and 6 percent respectively, from 1999 to 2000. These payment increases reflect, at least in part, the payment add-ons that took effect in April 2000 (a 4 percent increase in payments for all RUG groups and a 20 percent increase in payments for 12 complex care groups).

Beneficiaries' access to care

In 2001, the OIG reported that beneficiaries generally did not have problems obtaining SNF care. However, the findings suggested that patients requiring costly services might have experienced delays in accessing SNF care (OIG 2001). These findings were consistent with those from a similar study in 2000 (OIG 2000).

In October 2002, MedPAC convened a focus group of 15 hospital discharge planners to continue to monitor patients' access to SNF care. These discharge planners told us that beneficiaries needing rehabilitation therapy services generally had no problem accessing SNF services. Certain beneficiaries needing expensive, nonrehabilitation services might remain in the acute care hospital longer than before the SNF prospective payment system. Hospitals are concerned about this because they do not receive additional Medicare reimbursement for the additional time these patients spend in the hospital (decreasing the profit hospitals can make on these patients). However, it is not clear that the additional time in the hospital is an inappropriate outcome for these patients. Overall, we did not find evidence of widespread access problems.

Because beneficiaries' access to care is such an important indicator of the adequacy of Medicare payments, it is imperative that we continue to monitor this market factor using the most current and reliable information possible. From 1999 to 2001, the Department of Health and Human Services' Office of Inspector General conducted an annual series of studies assessing beneficiaries' access to SNF services (OIG 1999a, OIG 2000, OIG 2001). The OIG did not issue a report on SNF access in 2002, and has indicated that it does not plan to continue these reports in the future. We believe these studies are an important and relevant addition to the policy process.

RECOMMENDATION 2C-1

The Secretary should continue a series of nationally representative studies on access to skilled nursing facility services (similar to studies previously conducted by the Department of Health and Human Services' Office of Inspector General).

IMPLICATIONS 2C-1

Spending

- This recommendation should not affect Medicare benefit spending.

Beneficiary and provider

- To the extent that future OIG studies allow us to monitor beneficiaries' access to SNF services closely and to react quickly if problems develop, they contribute to preserving beneficiaries' access to care. We believe this recommendation represents a minimal burden to providers.

In MedPAC's report to the Congress in March 2000, we recommended that the Secretary conduct annual studies to identify potential problems in beneficiaries' access to care that may arise in the evolving Medicare program, particularly from the implementation of new payment systems in the various sectors (MedPAC 2000). The SNF payment system continues to evolve, indicating a need for continued monitoring of beneficiaries' access to SNF services.

Future reports do not need to be done on an annual basis; they may be necessary only every few years as long as no adverse trends in access are observed and as long as Medicare payments to SNFs remain relatively stable over the course of a few years. Primarily, it is important that a consistent knowledge base be built up over time in this area. We expect that the length of time between studies would generally be left to the discretion of the Secretary, as would the best operating division to conduct these studies (for example, OIG or CMS).

SNFs' access to capital

Overall, SNFs' access to capital may have been affected by recent bankruptcies, payment uncertainties, and the costs of liability insurance and lawsuits. However, the evidence does not suggest systematic problems with SNFs' access to capital that would pose problems for beneficiaries' overall access to SNF services.

Whereas Medicare payments for inpatient hospitalizations, for example, represent a relatively large share of hospitals' revenues, Medicare payments for SNF care represent a small share of both hospitals' and nursing facilities' revenues.[12] Thus, Medicare payments to SNFs have a less important role in determining whether SNFs are able to access capital than other factors, such as whether SNFs are associated with acute care hospitals or nursing facilities and the amount of funding SNFs receive from

12 Medicare payments, on average, comprise about 10 to 12 percent of revenue for nursing facilities and about 2 percent for hospitals. Large for-profit nursing facility companies derive the largest share of revenues from Medicare, about 25 percent.

other sources. Given that Medicaid payments generally comprise the largest share of nursing home revenues, investors' views of the nursing home industry may be driven largely by perceptions of the adequacy of Medicaid payments. Current fiscal pressures and state budget cuts may be leading to decreases in Medicaid payments, which would tend to make investors more wary of investing in this sector than they have been in the past. However, to the extent that this may be happening, all indications are that this is more a reflection of the adequacy of Medicaid payments than Medicare payments to nursing homes (see text box below).

As mentioned earlier, hospital-based SNFs represent about 10 percent of all SNFs. They generally have access to capital through their parent hospital organizations; the extent to which they are able to access capital depends on the financial condition of the hospital as a whole. (Hospitals' access to capital is discussed in more detail in Chapter 2A.)

About 90 percent of all SNFs are located within nursing facilities. The nursing facility industry consists of many small companies, with the top 10 nursing facility companies (as measured by the number of beds) controlling only about 18 percent of the market. Nursing facilities' access to capital may have been affected by recent bankruptcies, uncertainties about government revenues, and the cost of liability lawsuits and insurance.

Five of the 10 biggest for-profit publicly-held companies are either restructuring under Chapter 11 or have recently emerged from bankruptcy. Both GAO and CMS found that these bankruptcies resulted from extensive investment in ancillary service lines of business and high capital-related costs (such as depreciation, interest, and rent) (CMS 2002, GAO 2000). Some of these companies appear to be regaining competitive ground as they emerge from bankruptcy (CMS 2002).

Most smaller- and mid-sized for-profit companies appear to have been able to respond to lower Medicare revenues under the prospective payment system by lowering their costs (Fitch 2001). If this fact is recognized by lenders, those facilities may have reasonable access to capital.

Uncertainty about government revenues and liability insurance rates and lawsuits continues to be a concern for the nursing facility sector. Uncertainty about whether or not the Congress intends to reinstate two temporary payment add-ons that expired on October 1, 2002 has caused investors to be generally cautious. In addition, nursing facilities have had a number of recently publicized problems with liability and lawsuits. One for-profit nursing facility chain sold 49 Florida nursing facilities last January in part because of liability concerns; another large nursing facility chain's stock price fell by over 16 points, to $11.36, when it announced it was recording about $55 million in additional costs for professional liability claims (Charles Schwab 2002, Standard & Poor's 2002).

Nonprofit SNFs had difficulty getting investment grade ratings both before and after the SNF prospective payment system.

The evidence regarding demand for capital in this sector is mixed. Some evidence indicates that the demand for capital to finance new construction may be low because of large capital investments in the late 1990s and nursing facility occupancy rates that average about 81 percent (National Investment Center 2001). On the other hand, we should be mindful of the need to replace old buildings and equipment, which may require additional capital to finance renovations and improvements to the existing capital stock.

Medicaid payments to nursing facilities

Many are concerned about potential inadequacies in Medicaid payments to nursing facilities. For this reason, many representatives of the nursing facility industry and others have suggested that Medicare should maintain higher payments—that far exceed the costs of caring for Medicare beneficiaries—in order to compensate for the lower Medicaid payments and maintain the financial stability of the industry.

However, MedPAC believes that using high Medicare payments to compensate for any inadequacies that may exist in Medicaid payments is an inefficient way of improving the financial situation of this industry for three reasons. First, Medicare payments represent about 10 to 12 percent of total revenues for the average nursing facility; with such a small base of revenues, Medicare cannot be expected to assume responsibility for the financial welfare of the whole industry. Second, if Medicare does assume this responsibility, states may be encouraged to reduce their Medicaid funding even further. Finally, using high Medicare payments to compensate for low Medicaid payments targets the money to the wrong facilities (i.e., more money would go to facilities with fewer Medicaid patients, instead of those facilities that presumably would need additional funding the most—those with a high proportion of Medicaid patients). ■

Accounting for cost changes in the coming year

MedPAC's update recommendations depend on two assessments: the adequacy of current payments for care in SNFs and expected changes in the costs of providing care in the coming year. As in other settings, when considering changes in costs in the coming year, we start with a forecast of the market basket index. The SNF market basket index, currently projected to be 2.9 percent for fiscal year 2004, provides a measure of how prices change for a fixed set of inputs to provide SNF care.

In predicting expected changes in costs for the coming year, we look for evidence of the adoption of quality-enhancing new technologies that put substantial upward pressure on the costs of care. We do not find evidence of quality-enhancing technological advances in the SNF sector that would significantly increase costs. The largest component of SNF costs is labor. The SNF market basket index is designed to account for any cost increases for labor and other inputs to the provision of services in SNFs.[13]

Similarly, we look for evidence of productivity growth that typically lowers the cost of providing care. Evidence shows that SNFs have lowered the costs of caring for Medicare beneficiaries in SNFs substantially since the SNF prospective payment system was implemented. This appears to have occurred without a reduction in the quality of care provided, indicating an overall improvement in productivity in the SNF sector. We expect this trend to continue into fiscal year 2004, with SNF productivity at least matching the economy-wide growth in multifactor productivity—about 0.9 percent per year—over the coming year.

Because we do not anticipate quality-enhancing advances in new technology that will significantly increase costs in this sector, our update recommendation is based primarily on our assessment of the adequacy of current payments to SNFs and our assumption that growth in productivity will continue over the next year.

Update recommendations

We estimate that overall Medicare payments to SNFs are adequate to cover the costs of caring for Medicare SNF patients, but the evidence indicates that the distribution of payments in the system may make it more difficult for facilities to profit from treating a higher proportion of patients with expensive, nonrehabilitation therapy needs. MedPAC therefore recommends two changes: one affecting the base payment amount and the other one affecting payments for SNF patients with expensive, nonrehabilitation therapy needs.

In our March 2002 recommendations, we recommended differential updates to freestanding and hospital-based SNFs because we believed that the development and implementation of a new SNF patient classification system would take too much time. We recommended differential updates as an interim measure. This year, we recommend more immediate measures to balance the distribution of payments in the system so they better track the expected resource needs of SNF patients. Differential updates are no longer necessary, unless the recommended changes do not occur rapidly enough.

RECOMMENDATION 2C-2

The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2004.

IMPLICATIONS 2C-2

Spending

- Because this recommendation provides no update to payments for skilled nursing facility services, whereas current law updates payments for these services by the SNF market basket index, this provision is expected to reduce Medicare spending relative to current law by between $200 million and $600 million for fiscal year 2004 and between $1 billion and $5 billion over 5 years.

Beneficiary and provider

- Because we estimate current Medicare payments to be substantially above the costs of caring for Medicare beneficiaries in SNFs, we expect little if any effect of this provision on beneficiaries' access to care. Similarly, we do not anticipate major problems for providers of SNF services, particularly in combination with Recommendation 2C-3.

Given that the overall Medicare margin for all SNFs is about 5 percent and that market factor evidence indicates no major problems in this sector, the base rate for all SNFs appears to be adequate and no update to payment rates is necessary at this time.

However, while we find overall Medicare payments to SNFs to be adequate, we remain concerned about the distribution of expenditures resulting from a SNF patient classification system that makes certain types of Medicare beneficiaries more profitable for SNFs to treat than others. For this reason, we combine this recommendation with a recommendation designed to improve the allocation of resources in the SNF payment system so that it will recognize and better balance the resource needs of SNF patients with respect to rehabilitation therapy and nonrehabilitation therapy needs.

13 In the years since the SNF prospective payment system was implemented, the projected SNF market basket index used to determine SNF payment rate updates has understated the actual SNF market basket index. Had CMS been able to go back and correct for this error in forecasting the market basket index, fiscal year 2003 Medicare payments to SNFs would exceed the costs of caring for Medicare SNF patients by more than the 5 percent we estimate.

RECOMMENDATION 2C-3A

Consistent with previous MedPAC recommendations, the Secretary should develop a new classification system for care in skilled nursing facilities.

Because it may take time to develop this system, the Secretary should draw on new and existing research to reallocate payments to achieve a better balance of available resources between the rehabilitation and nonrehabilitation groups.

To allow for immediate reallocation of resources, the Congress should give the Secretary the authority to:

- **remove some or all of the 6.7 percent payment add-on currently applied to the rehabilitation RUG–III groups.**
- **reallocate money to the nonrehabilitation RUG–III groups to achieve a better balance of resources among all of the RUG–III groups.**

RECOMMENDATION 2C-3B

If necessary action does not occur within a timely manner, the Congress should provide for a market basket update, less an adjustment for productivity growth of 0.9 percent, for hospital-based skilled nursing facilities to be effective October 1, 2003.

IMPLICATIONS 2C-3

Spending

- Because part A of this recommendation suggests a redistribution of resources already in the system, this provision is expected to be spending neutral.
- Part B of this recommendation would increase spending relative to the combination of Recommendation 2C-2 and Recommendation 2C-3A. However, it would not change the expectation of a reduction in spending for Recommendation 2C-2 of between $200 million and $600 million over 1 year and between $1 billion and $5 billion over 5 years, relative to current law.

Beneficiary and provider

- To the extent that payments track more closely the expected resource needs of different types of SNF patients and increase the incentives for providers to accept patients with high nontherapy ancillary service needs, beneficiaries' access to care is expanded.
- To the extent that this provision redistributes payments to providers that care for a disproportionate number of SNF patients with high nontherapy ancillary service needs, Medicare payments may be more equitably distributed among SNF providers according to the costs of the patients they treat. To the extent that hospital-based SNFs treat more of these types of patients, this redistribution should provide them with more resources.

The Commission remains concerned that the current SNF patient classification system does not appropriately distribute resources among patients with different types of resource needs. SNFs who care for more patients with expensive, nonrehabilitation therapy needs may not be able to operate as profitably under the SNF prospective payment system as SNFs that care for a higher proportion of patients with short-term rehabilitation needs. In addition, patients with expensive, nonrehabilitation therapy needs may experience longer delays in accessing SNF services than other types of patients. The Commission recommends a series of long-, intermediate-, and short-term steps to address these problems and better balance the available resources among patients with different types of resource needs.

History of skilled nursing facility payment add-on

In the Balanced Budget Refinement Act of 1999 (BBRA), the Congress mandated a 20 percent increase to the payment rates for 12 RUG–III groups covering medically complex cases in the extensive services, special care, and clinically complex groups, as well as 3 select rehabilitation RUGs. This payment increase began on April 1, 2000, and was designed to remain in effect until CMS announced a revised skilled nursing facility (SNF) classification system. MedPAC indicated at the time that this add-on was not a perfect solution, although it might help offset some provider expenses for these patients. MedPAC continued to be concerned, however, that Medicare's reimbursement rates for the rehabilitation RUGs were too high.

The following year in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the Congress altered the payment increase mandated by BBRA such that all 14 rehabilitation RUG–III groups, including those previously receiving the 20 percent add-on, would receive a 6.7 percent payment add-on until CMS announced a refinement to the classification system. BIPA left in place the 20 percent add-on to payment rates for the nonrehabilitation RUG–III groups. The revised payment add-ons became effective April 1, 2001.

The 6.7 percent payment rate add-on to the rehabilitation RUGs and the 20 percent payment add-on to the nonrehabilitation RUGs both remain in effect until CMS announces a refinement to the SNF classification system. At the moment, it is unclear when CMS might announce such a refinement, although they are required by law to report to the Congress on alternatives to the existing RUG–III payment system by January 1, 2005. ■

In the long term, the problems described here cannot be fully addressed with the current SNF patient classification system. The best solution, therefore, is to develop a new system that distributes resources more appropriately among patients with different expected service needs.

However, a new payment system will almost surely take time to develop and implement. Therefore, as an intermediate step, we feel it is important to look to all currently available sources of information for ways to improve payments until a new classification system can be adopted.

Two key conditions must be met before the Secretary significantly restructures the current SNF patient classification system or implements any new SNF patient classification system:

1. Any changes must be demonstrated to be effective on a nationally representative sample of Medicare beneficiaries.

2. The new system must be more effective than the current system, in that it must explain more of the variation in SNF patients' expected resource needs.

Substantial improvements may still be years away, so a more immediate redistribution of resources is needed within the current payment system. Such redistribution involves adjusting the payment add-on that the Congress implemented in BBRA (and revised in BIPA) to give CMS time to refine the RUG–III payment system (see text box previous page).

Accordingly, the Congress should give the Secretary the authority to redistribute some or all of the 6.7 percent payment increase from the rehabilitation RUG–III groups to the nonrehabilitation groups. This has no effect on the 20 percent add-on to payment rates for the nonrehabilitation RUGs in current law. Payments to SNFs for rehabilitation patients appeared more than adequate even before the Congress implemented the 6.7 percent payment add-on to the rehabilitation RUGs, and payments to SNFs for nonrehabilitation patients appear not to be adequate even with the 20 percent add-on currently in effect. ■

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