SECTION 2D

Skilled nursing facility services

RECOMMENDATION

The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2010.

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

SECTION 2D

Skilled nursing facility services

Section summary

Our indicators of the adequacy of Medicare payments to cover the costs of skilled nursing facility (SNF) services to beneficiaries are generally positive. These indicators include a stable supply of providers, a slight increase in service volume, and growth in Medicare margins. Quality indicators were mixed. Access to capital is tight, reflecting general uncertainty in the financial markets, not the adequacy of Medicare payments.

Supply and access to care—The supply of SNFs has remained essentially the same over the past four years, at about 15,000 providers. There were five fewer facilities in 2008 than in 2007. Most SNFs are freestanding and two-thirds are for profit. The shares of stays treated in for-profit facilities and freestanding facilities continue to increase.

The number of beneficiaries who used SNF services increased slightly between 2006 and 2007. Most beneficiaries continue to have good access to services, especially rehabilitation services. However, patients needing medically complex care (those in the clinically complex and

In this section

special care case-mix groups) may experience delays in placement. In 2006, fewer facilities admitted medically complex patients than admitted rehabilitation patients. Since 2002, admissions of medically complex patients have been increasingly concentrated in fewer facilities. This trend reflects distortions in the current payment system and the Commission has previously made recommendations to correct them (MedPAC 2008b).

Volume of services—Between 2006 and 2007, covered days for fee-for-service enrollees increased slightly (1.7 percent) while admissions remained flat. Days continued to shift to rehabilitation case-mix groups and within them to those groups with higher payments. Industry reports indicate that days in these case-mix groups are highly desirable, suggesting that the days are relatively more profitable than days in other case-mix groups.

Quality of care—Two quality measures for SNFs continued to show mixed trends. Between 2005 and 2006, rates of discharge to the community increased (indicating improved quality), while rates of potentially avoidable rehospitalizations also increased (indicating worse quality).

Access to capital—Access to capital is tight, reflecting broader lending conditions in the U.S. economy rather than the adequacy of Medicare's payments. Medicare continues to be a preferred payer because its payments exceed those of other payers. Industry reports describe strategies providers pursue to expand their Medicare revenues, particularly through rehabilitation care, suggesting that Medicare payments are adequate.

Payments and costs—Between 2006 and 2007, Medicare costs for freestanding SNFs grew faster than in the period between the two previous years. However, Medicare payments continued to outpace SNF costs, in part because of the increase in the days classified into the highest payment case-mix groups. As a result, the aggregate Medicare margin for freestanding SNFs was 14.5 percent in 2007, making it the seventh consecutive year

that the aggregate Medicare margin exceeded 10 percent. We project the aggregate margin for 2009 will be 12.6 percent.

Because indicators are generally positive and SNF payments are more than adequate to accommodate anticipated cost growth, we recommend a zero update for 2010. Together with this recommendation about the level of payments, we reiterate our previous recommendations that would affect the distribution of payments: to revise the SNF payment system and adopt a pay-for-performance program. The increasing concentration of medically complex cases in fewer SNFs, the continued growth and intensification of rehabilitation days (which are more profitable than other days), and the wide variation in Medicare margins underscore the inequities and poor incentives of the current design. The recommended prospective payment system redesign would shift payments from rehabilitation patients to patients with medically complex care needs and to those requiring high-cost nontherapy ancillary services. These revisions would more accurately reflect providers' costs to treat different types of cases, reduce the incentives to select certain patients over others, and narrow the range of Medicare margins across facilities. A pay-for-performance program would redirect payments to high-quality facilities and away from facilities with poor quality, thereby increasing the value of the program's purchases. ■

Recommendation 2D

The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2010.

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

Background

Fee-for-service (FFS) beneficiaries who need short-term skilled nursing or rehabilitation services on an inpatient basis are eligible to receive covered services in skilled nursing facilities (SNFs). For each spell of illness, Medicare covers up to 100 days of SNF care after a medically necessary hospital stay of at least three days.[1] Covered SNF services include skilled nursing care, rehabilitation services (physical and occupational therapy and speech–language pathology services), and other ancillary services, such as respiratory therapy and medications.[2] For services to be covered, the SNF must meet Medicare's conditions of participation and agree to accept Medicare's payment rates.[3] For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment rate for the first 20 days of care; after that point, beneficiaries are responsible for copayments (in 2009 the copayment is $133.50 per day). Nearly 5 percent of FFS beneficiaries used SNF services at least once in 2007.

The most common diagnosis for a SNF admission in 2006 was a major joint and limb reattachment procedure of the lower extremity, typically a hip or knee replacement (Table 2D-1). The 10 most frequent conditions accounted for more than one-third of all SNF admissions. Freestanding, hospital-based, for-profit, and nonprofit facilities each had the same top 10 diagnoses, with the same top 6 rank orderings of the conditions. Hospital-based facilities had more than double the share of major joint procedures (making up 14 percent of admissions compared with 6 percent for freestanding facilities).

Medicare spending on SNF services

In fiscal year 2007, spending for SNF services was $22.1 billion, up more than 12 percent from 2006 (Figure 2D-1, p. 164). Spending increases averaged more than 11 percent annually between 2000 and 2007.

Medicare actuaries projected that SNF spending in 2008 was $22.8 billion, a 3.4 percent increase from 2007. Compared with previous spending increases, the lower growth rate was due to a slowdown in the case-mix increases that have occurred since 2006 (discussed on p. 168).

Another factor in the slowing of spending growth is the decline in the number of FFS enrollees as more beneficiaries have enrolled in Medicare Advantage (MA) plans. MA spending on SNFs is not included in the spending totals.[4] Growth in SNF spending per FFS enrollee is projected to outpace growth in overall spending in 2008. Between 2007 and 2008, spending per FFS enrollee increased 4 percent (from $636 to $661), or 0.6 percentage point higher than the growth in overall SNF

TABLE 2D–1

Ten most common diagnoses accounted for more than a third of SNF Medicare admissions in 2006

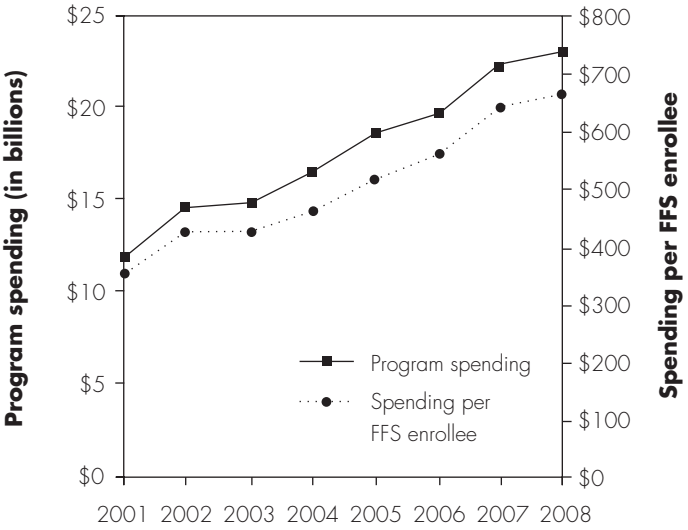
DRG code from hospital stay	DRG	Share of SNF admissions
544	Major joint and limb reattachment of lower extremity	6.9%
127	Heart failure and shock	4.8
089	Simple pneumonia and pleurisy, age >17, with CC	4.5
210	Hip and femur procedures except major joint, age >17, with CC	3.7
014	Intracranial hemorrhage and stroke with infarction	3.3
320	Kidney and urinary tract infection, age > 17, with CC	3.3
416	Septicemia, age >17	2.9
316	Renal failure	2.5
296	Nutritional and miscellaneous metabolic disorders, age > 17, with CC	2.3
079	Respiratory infections and inflammations, age > 17, with CC	2.3
	Total	36.5

Note: SNF (skilled nursing facility), DRG (diagnosis related group), CC (complication or comorbidity). The DRG code from the hospital stay is the discharge diagnosis.

Source: MedPAC analysis of DataPRO file from CMS, 2006.

FIGURE 2D–1

Medicare's payments to skilled nursing facilities continue to grow



Note: FFS (fee-for-service). Years are fiscal years. The 2008 spending is projected.

Source: CMS, Office of the Actuary, 2008.

spending. While a decline in FFS enrollees explains some of the spending slowdown, it is not the driving factor.

Mechanics of Medicare payments for SNF services

Under a prospective payment system (PPS), Medicare pays SNFs to cover the per day costs of nursing, ancillary services, and capital.[5] The base rates are updated annually for inflation based on the projected increase in the SNF market basket index, a measure of the national average price for the goods and services SNFs purchase to provide care.[6] Each daily payment has three components that are summed:

- a nursing component intended to reflect the intensity of nursing care and nontherapy ancillary (NTA) services that patients are expected to require;
- a therapy component to reflect the physical and occupational therapy and speech–language pathology services provided or expected to be provided; and
- a component to cover room and board, administrative, and other capital-related costs.

Information gathered from the standardized patient assessment instrument—the Minimum Data Set (MDS)—is used to classify patients into 53 resource utilization groups (RUGs).[7] RUGs differ by the services furnished to a patient (e.g., the amount and type of therapy furnished and the use of specialized feeding), patient characteristics (e.g., pneumonia or dehydration), a patient's need for assistance to perform activities of daily living (e.g., eating or toileting), and in some cases the signs of depression. The nursing and therapy components of each RUG have case-mix weights that adjust the daily payments up or down from the base rate; the other component is a uniform amount per day for all case-mix groups.

The nursing and therapy weights have not been recalibrated with new data since the SNF PPS was first implemented in 1998. CMS is in the process of analyzing recently collected data on staff time and other resources used to provide care from a sample of freestanding and hospital-based facilities that treat Medicare and Medicaid patients. The agency plans to incorporate at least some of the findings into the SNF PPS proposed rule expected to be issued in spring 2009.

The Commission has discussed two key problems with the SNF PPS (MedPAC 2008a, MedPAC 2008b, MedPAC 2007a, MedPAC 2007b, MedPAC 2006). First, the RUG classification system does not adequately adjust payments to reflect the variation in providers' costs for NTA services (e.g., respiratory therapy and medications, which make up an average 16 percent of daily costs).[8] As a result, payments are too low for many beneficiaries who use these services and too high for those who do not. Hospital discharge planners and hospital administrators have reported problems placing patients who need intravenous antibiotics, expensive drugs, or ventilator care into SNFs (Liu and Jones 2007, OIG 2006).

The second key problem with the PPS is that payments vary with the amount of therapy delivered, creating a financial incentive to furnish therapy services. Facilities are paid for providing therapy even when a patient's need for and benefit from it has not been demonstrated.[9] Over time, the number of beneficiaries receiving therapy and the amount they receive have increased (MedPAC 2008a). In 2001, 77 percent of days were classified into rehabilitation RUGs; by 2007, this share had risen to 88 percent. Days grouped into the most intensive rehabilitation RUGs (the ultra high and very high groups) grew from 32 percent in 2001 to 60 percent in 2007. For days grouped into

TABLE 2D–2

A growing share of Medicare stays and payments go to freestanding SNFs and for-profit SNFs

	Facilities		Medicare-covered stays		Medicare payments	
Type of SNF	**2005**	**2007**	**2005**	**2007**	**2005**	**2007**
Freestanding	92%	93%	87%	90%	93%	95%
Hospital based	8	7	13	10	7	5
Urban	67	67	79	79	81	81
Rural	33	33	21	21	19	19
For profit	68	68	66	68	72	74
Nonprofit	28	27	30	28	25	23
Government	5	5	4	4	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files.

rehabilitation case-mix groups (those patients receiving at least 45 minutes of therapy a week), the therapy payment comprises between 16 percent and 60 percent of the total daily payments, depending on the RUG.

In our June 2008 report, the Commission recommended that the PPS be redesigned to establish separate payments for NTA services, base its payments for therapy services on a patient's predicted care needs (not on the services the facility provides), and adopt an outlier policy (MedPAC 2008b). We showed that a revised PPS would better target payments for NTA services, more accurately calibrate therapy payments to therapy costs, and offer modest financial protection for patients with high ancillary costs and the SNFs treating them. Later in the chapter (p. 177), we describe two additional refinements to the proposed design that consider accounting for a long outlier stay's declining costs and countering incentives under prospective payment for facilities to underprovide services.

Providers of SNF care

SNF services may be furnished by hospital-based or freestanding facilities. In 2007, 93 percent of facilities were freestanding. A growing share of Medicare-covered stays and payments went to freestanding SNFs and for-profit SNFs (Table 2D-2). Freestanding facilities treated 90 percent of Medicare stays (up 3 percentage points since 2005) and accounted for an even larger share of spending. For-profit SNFs' shares of Medicare-covered stays and payments each increased 2 percentage points between 2005 and 2007.

Most SNFs (90 percent) are parts of nursing homes that also care for long-stay patients, which Medicare does not cover. Within SNFs, Medicare-covered SNF patients are typically a small share of the SNF's total patient population. At the median, Medicare-covered SNF days in 2007 made up just over 12 percent of total patient days in freestanding facilities; only 1 in 10 freestanding SNFs had 29 percent or more total patient days that were covered by Medicare. In contrast, the median share of Medicare-covered days in hospital-based facilities, which treat few long-term care residents, was 62 percent and 1 in 10 hospital-based SNFs had 91 percent or more total patient days that were covered by Medicare.[10]

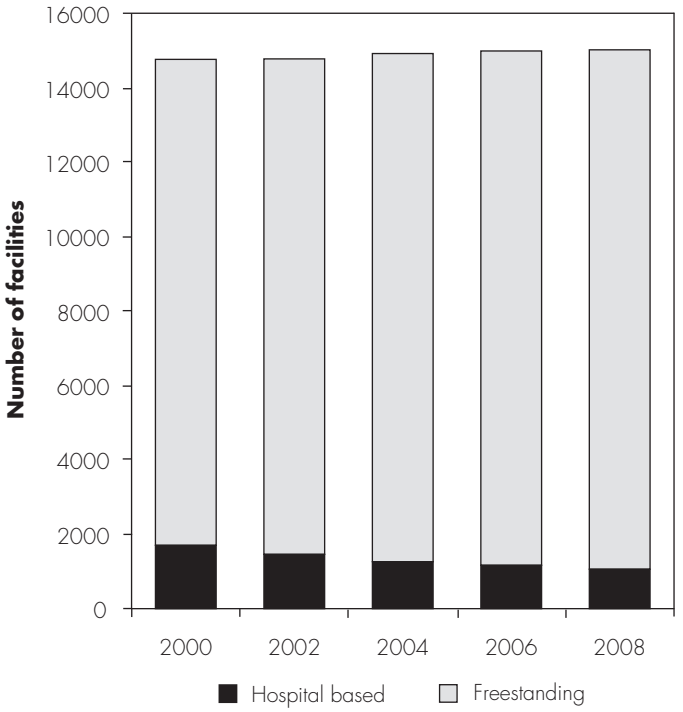
Are Medicare payments adequate in 2009 and how should they change in 2010?

Indicators of payment adequacy are generally positive for SNFs. To make this assessment, we analyzed the supply of providers, beneficiary access to care, volume of services, quality of care, provider access to capital, Medicare payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. As required by statute, we based our update assessments on the performance of efficient providers.

Generally, beneficiaries have good access to services, although those who need specific services may experience

FIGURE 2D–2

The number of Medicare-certified skilled nursing facilities has remained stable, with a declining share of hospital-based providers



Note: Counts do not include swing beds.

Source: MedPAC analysis of data from the Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system for 2000–2008.

delays while awaiting placement in a SNF. The number of SNFs has remained about the same for several years, but the number of SNFs willing or able to treat beneficiaries classified into the clinically complex and special service case-mix groups has declined, further concentrating where these patients are admitted. The refinements the Commission recommended in June 2008 would help correct the payment inaccuracies that can result in patient selection. Volume—as measured by SNF days per 1,000 FFS enrollees—increased between 2006 and 2007, while admissions remained the same. For the third year in a row, the two quality measures that the Commission analyzes show mixed results: Risk-adjusted rates of discharge to the community increased (indicating improved quality), while rates of potentially avoidable rehospitalizations increased (indicating poorer quality). As with all health care sectors, SNFs' access to capital was poor in the second half of 2008, reflecting turmoil in the financial markets rather than the adequacy of Medicare payments. All signs indicate that Medicare continues to be a preferred payer. Medicare margins increased from 2006 and exceeded 10 percent for the seventh year in a row.

Supply of providers has remained stable

Since 2000, the number of SNFs participating in the Medicare program has remained relatively stable at about 15,000 facilities (Figure 2D-2). Between 2007 and 2008, more than 100 facilities began participating in Medicare and about as many terminated so that, on balance, there were 5 fewer SNFs than in 2007.[11] Although 10 hospital-based units began participating in the Medicare program during 2008, more units stopped, and the number of hospital-based units declined during the year. Across all SNFs, less than 1 percent stopped participating and most of them were voluntary (e.g., due to a closure or merger).

State policies play a large role in the ability of this sector to expand. Certificate-of-need programs regulate the expansion of long-term care facilities in more than half the states. Two-thirds of the SNFs that started participating in the Medicare program were located in states without certificate-of-need programs for these services. The perceived adequacy of a state's Medicaid payment rates—the dominant payer in most facilities—is also a key factor in a facility's decision to enter or expand in this sector.

Slight increase in use of SNF services though fewer SNFs treat medically complex patients

The number of beneficiaries who used SNF services increased slightly between 2006 and 2007 (0.1 percent). Most Medicare beneficiaries appear to experience little or no delay in accessing SNF services, especially if they need rehabilitation services. Many SNFs have shifted their mix toward patients requiring rehabilitation care.

While access is generally good, placement of some patients who need complex care can be difficult and can result in longer hospital stays as discharge planners seek willing or able SNF providers to take them. Interviews with hospitals in spring 2007 indicated that medically complex patients could be hard to place because many (especially freestanding) SNFs are not staffed with the requisite nursing or respiratory specialists such patients need, or the patients require intensive intravenous antibiotics (Liu and Jones 2007). Patients who are difficult to place include patients with semipermanent or mainline access (for drug administration), patients with tracheostomies that require suctioning, ventilator-dependent patients who are not candidates for weaning,

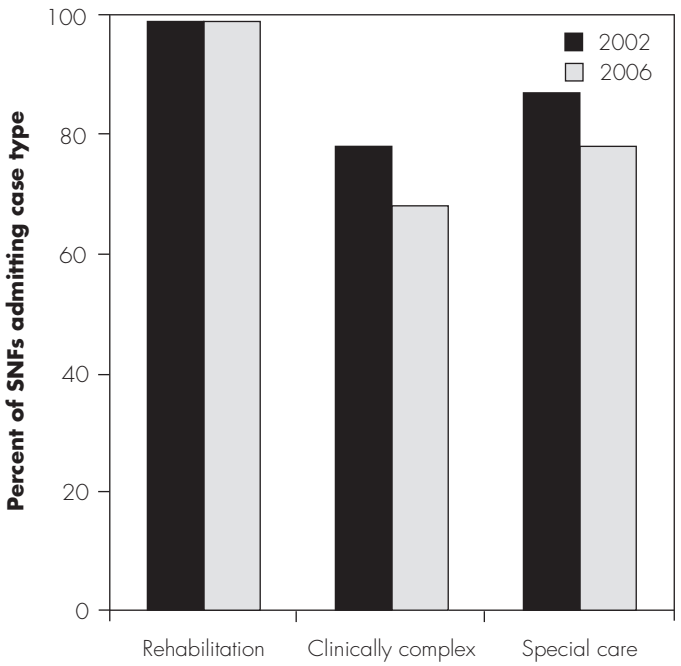
patients with wound vacuum-assisted closures, patients with psychiatric and behavioral problems, and bariatric patients who require special equipment (e.g., oversized beds, wheelchairs, and lifts). Some hospital administrators said that placement of these patients could improve if the SNF PPS were revised to more accurately pay for their care needs.

In 2006, fewer SNFs admitted patients classified into the special care and clinically complex RUGs (grouped together and referred to as medically complex patients) than rehabilitation patients, and the share has declined over time.[12] The Commission found that only 68 percent of SNFs admitted clinically complex patients (based on the admitting RUG assignment) and 78 percent admitted special care patients, compared with 99 percent of SNFs that admitted rehabilitation patients (Figure 2D-3). Between 2002 and 2006, the number of facilities admitting special care and clinically complex patients decreased (almost 9 percent and 12 percent, respectively), even though the number of SNFs remained about the same. As a result, the distributions of medically complex admissions were more concentrated in fewer SNFs than rehabilitation admissions.[13]

With fewer SNFs treating them, medically complex admissions were more concentrated in 2006 than in 2002. In 2002, SNFs with the highest shares of clinically complex cases (the top 25th percentile in terms of share of admissions) admitted 53 percent of these cases; by 2006, this share had grown to 59 percent. Similarly, in 2002, SNFs with the highest shares of special care cases admitted 49 percent of these cases; by 2006, this share had grown to 56 percent. In contrast, SNFs with the highest shares of rehabilitation admissions admitted a smaller share of these cases in 2006 than in 2002. With fewer SNFs willing or able to treat medically complex patients, more of these patients could experience delays in placement. By better targeting payments for NTA services, the Commission's recommended revisions to the SNF PPS would raise payments for patients grouped into the extensive service RUGs (e.g., patients who received intravenous medications or ventilator care), special care patients (e.g., patients treated for surgical wounds or skin ulcers), and clinically complex patients (e.g., patients who had pneumonia or received dialysis services). With a better match between payments and costs for all types of patients, SNFs would have less incentive to selectively admit certain types of patients over others and fewer medically complex patients would experience delays in their placements.

FIGURE 2D–3

The share of SNFs that admitted clinically complex and special care cases decreased between 2002 and 2006



Note: SNF (skilled nursing facility). Admission category based on admitting case-mix group assignment. The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or those who are aphasic or tube fed.

Source: MedPAC analysis of 2006 DataPro data from CMS.

Volume of services rose slightly and therapy provision continued to intensify

On a per FFS enrollee basis, SNF volume increased slightly between 2006 and 2007 (Table 2D-3, p. 168). Covered days rose 1.7 percent and admissions remained unchanged, resulting in a small increase in covered days per admission. We report these measures on a per FFS enrollee basis because the counts of days and admissions do not include the utilization of beneficiaries enrolled in MA plans. Because MA enrollment continues to increase, changes in utilization could reflect a smaller pool of users rather than changes in service use by the beneficiaries captured by the data.

TABLE 2D–3

Small increase in SNF days resulted in longer average stays

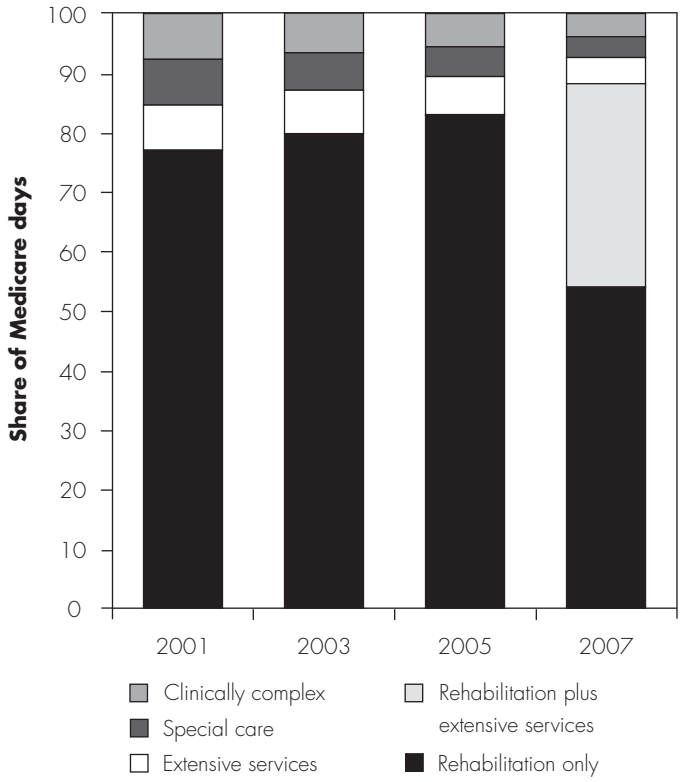
	2005	2006	2007	Percent change 2006–2007
Volume per 1,000 fee-for-service enrollees				
Covered admissions	70	72	72	0.0%
Covered days	1,817	1,892	1,925	1.7
Covered days per admission	26.0	26.3	26.7	1.5

Note: SNF (skilled nursing facility). Data include 50 states and the District of Columbia. Data for 2007 are preliminary.

Source: Calendar year data from CMS, Office of Research, Development, and Information.

FIGURE 2D–4

Case mix in freestanding SNFs shifted toward rehabilitation plus extensive services RUGs and away from other broad RUG categories



Note: SNF (skilled nursing facility), RUG (resource utilization group). The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or those who are aphasic or tube fed. The extensive services category includes patients who have received intravenous medications or suctioning in the past 14 days, have required a ventilator or respiratory or tracheostomy care, or have received intravenous feeding within the past 7 days. Days are for freestanding skilled nursing facilities with valid cost report data.

Source: MedPAC analysis of freestanding SNF cost reports.

Growth in the number and intensity of rehabilitation days

Rehabilitation days continued to grow as a share of all Medicare days. In 2007, rehabilitation days accounted for 88 percent of Medicare days, up 5 percentage points from 2005 (Figure 2D-4). In January 2006, CMS implemented nine new rehabilitation case-mix groups for patients who qualify for both rehabilitation and extensive services, adding them at the top of the classification hierarchy and assigning them the highest payments.[14] In 2007, these new RUG categories accounted for 34 percent of days, while days classified into the rehabilitation-only RUGs declined between 2005 and 2007, from 83 percent to 54 percent.[15]

Some of the growth in total rehabilitation days may be explained by a shift in the site of care from inpatient rehabilitation facilities (IRFs) to SNFs, as IRFs comply with the 75 percent rule for IRFs.[16] Between 2004 and 2007, the share of beneficiaries who had a major joint replacement or revision and were discharged from a hospital to a SNF increased 3 percentage points (from 33 percent to 36 percent), while the share discharged to an IRF declined 12 percentage points (from 28 percent to 16 percent).[17]

As we have reported in previous years, the distribution of rehabilitation days continued to shift toward the highest paying therapy groups (Figure 2D-5). Between 2006 and 2007, the number of ultra high rehabilitation days increased 30 percent, making up just under one-third of all rehabilitation days in 2007. During this period, the share of days in the very high, high, and low rehabilitation groups declined.

The share of medium rehabilitation days increased between 2006 and 2007, suggesting that the mix of

rehabilitation days is sensitive to payment rates. After implementation of the new case-mix groups in 2006, the payment rates for the medium rehabilitation plus extensive service groups were set higher than the rates for high rehabilitation plus extensive services case-mix groups.[18] Between 2006 and 2007, the volume of all medium days increased almost 5 percent, while the volume of all high days declined by 21 percent.

Growth in the rehabilitation plus extensive services days

Between 2006 and 2007, rehabilitation plus extensive services days increased more than 33 percent, while rehabilitation-only days declined almost 9 percent. The large number of days classified into the rehabilitation plus extensive services case-mix groups may reflect providers' coding improvements to record extensive services provided by the SNF or during the previous hospital stay. The MDS requires SNFs to report extensive services (e.g., NTA services) provided during a look-back period of 14 days, which can cover days during the prior hospitalization. Days early in a SNF stay can be classified into the highest paying case-mix groups based solely on services furnished during the preceding hospital stay. For these days, SNFs receive higher payments associated with the rehabilitation plus extensive services case-mix groups without incurring the cost of providing the extensive service.

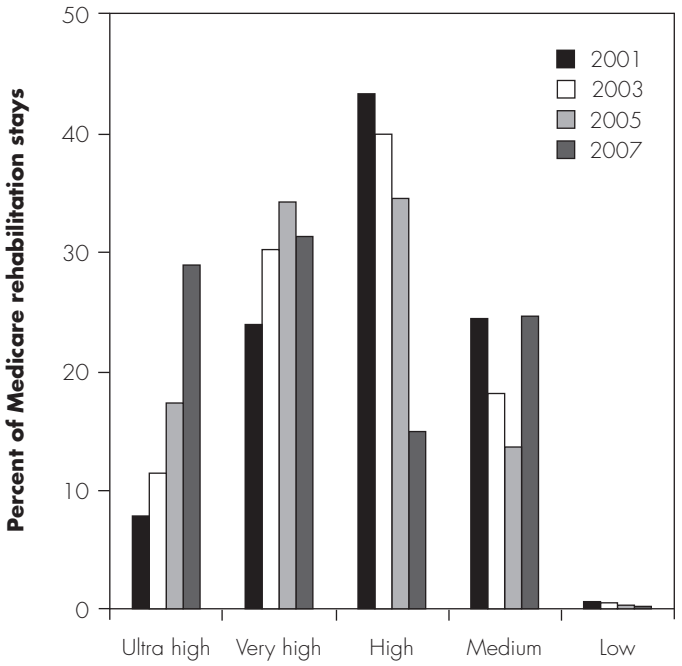
It is possible that patients who received extensive services during their hospitalization may continue to be more costly to treat in a SNF than other patients. CMS recently gathered staff time and service use data from nursing homes that allow them to compare the resources used by patients who did and did not receive extensive services during their hospital and SNF stays. CMS plans to evaluate this information and, based on its finding, make appropriate modifications to the SNF PPS. The Commission has recommended that CMS routinely gather the information required to distinguish between services furnished by the SNF and the hospital. This delineation will prevent Medicare from paying twice for the same service—once in the hospital and again in the SNF (MedPAC 2008a).

Providers of high-intensity therapy varied by facility type and ownership

The facilities with high and low shares of the most intensive rehabilitation days (defined as ultra high and very high rehabilitation RUG days) varied considerably by facility type and ownership. Freestanding SNFs and for-profit SNFs were underrepresented among facilities with low shares (defined as SNFs in the bottom 25th percentile of shares) of the most intense rehabilitation days (those in the ultra high and very high case-mix groups) and, to differing degrees, were overrepresented among facilities with high shares (defined as SNFs in the top 25th percentile of shares) of these days (Figure 2D-6, p. 170).[19] For example, freestanding SNFs made up 78 percent of facilities with low shares of the most intensive rehabilitation days even though they make up a much larger share of facilities and stays (93 percent and 90 percent, respectively). Their proportion of the facilities with high shares of the most intense rehabilitation days was slightly above their proportion of facilities or stays. Hospital-based facilities were relatively overrepresented among facilities with low shares of the most intense rehabilitation days and underrepresented among facilities with high shares. Turning to ownership, for-profit facilities

FIGURE 2D–5

Rehabilitation case mix in freestanding SNFs continues to shift toward higher paying rehabilitation RUGs

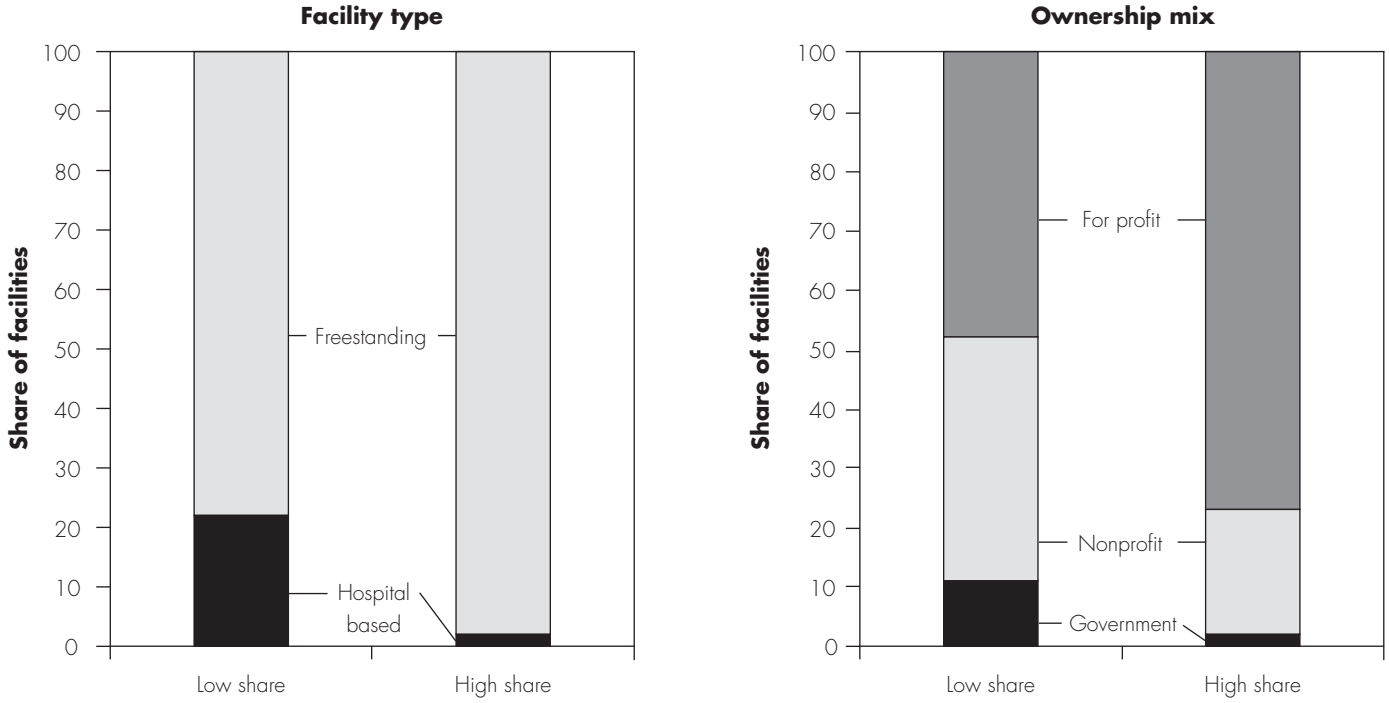


Note: SNF (skilled nursing facility), RUGs (resource utilization groups). Rehabilitation days include days in the rehabilitation case-mix groups and the rehabilitation plus extensive services case-mix groups. Days are for freestanding skilled nursing facilities with valid cost report data.

Source: MedPAC analysis of freestanding SNF cost reports.

FIGURE 2D–6

SNFs with low and high shares of the most intensive rehabilitation days differ by type and ownership



Note: SNF (skilled nursing facility). Intensive rehabilitation is defined as days in the ultra high and very high rehabilitation resource utilization groups (RUGs). Low share is defined as SNFs in the bottom 25th percentile of shares of rehabilitation days in the intensive rehabilitation RUGs. High share is defined as the SNFs in the top 25th percentile of shares of rehabilitation days in the intensive rehabilitation RUGs.

Source: MedPAC analysis of 2006 DataPro and Provider of Service files from CMS.

made up a larger proportion of the SNFs with high shares of the most intense rehabilitation days (77 percent) and a smaller share of facilities with low shares (48 percent) than of facilities and stays (68 percent).

Given the payment incentive to furnish therapy services, some publicly traded nursing home companies report strategies to grow their Medicare revenues by increasing their focus on rehabilitation patients and, within them, on the rehabilitation plus extensive services patients (Extendicare 2007, Kindred 2007, Sun Healthcare Group 2008). To shift patient mix, some SNFs developed specialized units for short-stay, post-acute patients recovering from joint replacement, cardiac, and respiratory ailments. They have also implemented specific strategies to handle a more intensive rehabilitation case mix, including different staffing levels, the selective use of nurse practitioners, and clinical case managers as ways to extend physician oversight of patients; one company added a therapist recruitment and retention program. Companies also report expanded marketing strategies to target short-term rehabilitation patients. We do not have data to compare the patient outcomes and costs of specialized units with those of traditional SNFs.

Patient condition at admission unlikely to explain growth in therapy provision

During this period of rapid growth in the provision of rehabilitation therapy, patients admitted to SNFs were slightly more impaired but not so much as to fully account for the large increases. Assessments conducted at or near admission (on or about day five of the stay) indicate that the share of patients requiring extensive assistance or who were considered totally dependent to transfer or walk increased from 51 percent to 60 percent between 2002 and 2006. At the same time, there were minimal reductions in patients' ability to conduct activities of daily living at admission (as measured by the Barthel score) and in their cognitive function.[20] Over three of these years (2004 through 2006), the average patient risk score

(the hierarchical coexisting condition) increased a small amount (2 percent), indicating that these patients were likely to be slightly more costly to treat. Yet, between 2002 and 2006, rehabilitation days grew 42 percent, while admissions grew at only one-third of this rate (14 percent). Because patient assessments are not required at discharge, we do not know whether, or by how much, patients benefited from the rehabilitation therapy they received.

Service use trends highlight need to make changes to PPS

These trends in SNF service use—the concentration of special care and clinically complex admissions in fewer SNFs, the growing share and intensity of rehabilitation days, and the shift of days into the rehabilitation plus extensive services—underscore recommendations previously made by the Commission. First, the SNF PPS needs to be revised to provide more targeted payments for NTA services and so that financial considerations do not drive service provision. In June 2008, the Commission recommended that the PPS pay for therapy services based on patient care needs, not on the services furnished, and that it include separate payments for NTA services (MedPAC 2008b). We noted that these changes would redistribute payments across different types of cases and the SNFs that treat them (see discussion on p. 175). In aggregate, payments would increase to SNFs treating large shares of patients with extensive service and special care needs and low shares of patients who require only rehabilitation services. By more closely matching payments to costs, SNFs would have less financial incentive to select certain types of patients over others and to furnish therapy services for financial gain.

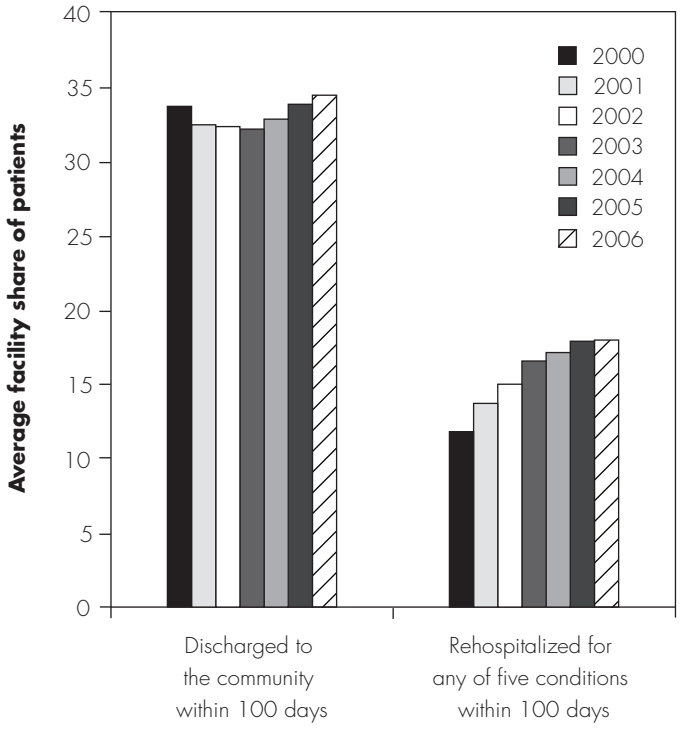
Second, the Commission recommended that the Secretary require SNFs to separately report information about services delivered to patients after admission. This action would enable CMS to distinguish between services furnished by the SNF from those provided during the prior hospital stay.

SNFs show mixed performance in the quality of care provided

Risk-adjusted measures of the quality of care furnished to patients during a Medicare-covered SNF stay show mixed performance regarding quality of care.[21] In 2006, the rates at which SNFs discharged patients to the community within 100 days were the highest they had been since 2000, indicating improved quality. The mean risk-adjusted rate of community discharge declined between 2000 and 2003 and has slowly increased since then. In 2006, the most recent year available, it was 34.4 percent (Figure 2D-7).

FIGURE 2D–7

Mixed quality results for SNFs between 2000 and 2006



Note: SNF (skilled nursing facility). The five conditions include congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance. Increases in rates of discharge to community indicate improved quality; increases in rehospitalization rates for the five conditions indicate worsening quality. Rates are calculated for all facilities with more than 25 stays.

Source: Analysis of DataPro data conducted by University of Colorado Health Sciences Center for MedPAC.

In contrast, the risk-adjusted rates of potentially avoidable rehospitalization within 100 days for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) have steadily increased throughout the period, indicating worsening quality. Although the rate increase between 2005 and 2006 was the smallest since 2000, the measure continued to worsen slightly. In 2006, the mean risk-adjusted facility rate for those five potentially avoidable rehospitalizations was 18.0 percent, compared with 11.8 percent in 2000.

Because of serious limitations with measures currently reported on CMS's Nursing Home Compare website, we used rates of community discharge and potentially

avoidable rehospitalization to assess the quality of care provided by SNFs to short-stay patients (MedPAC 2008a).[22] The discharge and rehospitalization measures target two important goals for SNF patients. Recovering prior function and being discharged to the community are fundamental goals of a patient's SNF stay, particularly for patients receiving rehabilitation therapy. Avoiding rehospitalization is also important, particularly for patients recovering from prior medical or surgical problems that prompted their SNF stay.

Risk-adjusted results for the two quality measures continue to differ by facility type and ownership. Hospital-based facilities performed comparatively well, with community discharge rates more than 14 percentage points higher and potentially avoidable rehospitalization rates more than 4 percentage points lower than those for freestanding facilities, after controlling for differences in case mix, ownership, and location. Hospital-based SNFs may have lower rehospitalization rates in part because they have higher staffing levels and skill mix, and their proximity to the hospital facilitates physician visits. The performance of for-profit facilities was mixed, with higher community discharge rates (0.8 percentage point) but also higher potentially avoidable rehospitalization rates (1.4 percentage points) compared with nonprofit SNFs. The slightly higher community discharge rates achieved by for-profit facilities may reflect their larger shares of high-intensity rehabilitation days compared with nonprofit facilities. Unmeasured differences in case mix and other factors that were not accounted for (e.g., staffing turnover and experience and facility practice patterns) could also explain some of the differences in quality measures by facility type and ownership.

In work examining the quality of care in nursing homes, the Office of Inspector General (OIG) found that almost 74 percent of nursing homes surveyed in 2007 were cited for deficiencies in quality of care—a 3 percentage point increase since 2005 (OIG 2008).[23] The share of homes cited for substandard quality of care (one or more deficiencies at the more serious scope and severity levels within certain categories) was small (3.6 percent) but had also increased over the study period. The deficiencies at the majority of nursing homes cited for actual harm deficiencies were considered to be isolated rather than widespread or exhibiting a pattern. The OIG noted that deficiency rates were affected by increased enforcement, additional guidance and training, and variations in survey practices.

Credit market turmoil has limited access to capital

In reaction to the credit market turmoil, there has been considerable pulling back of lending to nursing homes in the last quarter of 2008, as lenders themselves cannot access capital.[24] This slowdown is not a reflection of the adequacy of Medicare payments—the program continues to be a highly valued payer. In fact, Medicare share is one indicator lenders use to gauge the creditworthiness of a potential borrower.

In mid-2008, there were more than a dozen national lenders to nursing facilities, but this count fell to a small handful by late 2008 (Pomeranz 2008). Analysts with whom we spoke said that lending for large projects was at a standstill while the financial markets stabilize. One analyst told us that bonds for nursing homes have not been issued in months. With many nursing homes highly dependent on Medicaid revenues, lenders are also hesitant because the slowdown in the housing market has lowered state revenues that may, in turn, result in frozen or lower Medicaid payment rates.

Even before the crisis in the financial markets in 2008, lending to nursing homes had slowed. Last year, we reported that investment had slowed since August 2007, reflecting general lending conditions and real estate trends, not the adequacy of Medicare's payments. The number of publicly announced mergers and acquisitions of long-term care providers (nursing homes and assisted living facilities) declined 13 percent between 2006 and 2007, with the value of these deals taking a larger drop (Irvin Levin Associates 2008). In early 2008, several deals that began the previous year closed, but by midyear the number of mergers and acquisitions was down. Lending by the Department of Housing and Urban Development (HUD) for federally insured mortgages for nursing homes under Section 232/222 was also down in 2007 from 2006, financing fewer and smaller projects.[25] Although the number of financed new beds or units that HUD financed declined 18 percent from 2006, HUD dollars declined a smaller 8 percent (HUD 2008b). In 2007, the average price paid per nursing home bed continued to rise, reflecting the sector's steady cash and growth potential (Irvin Levin Associates 2008, Irvin Levin Associates 2007).[26] However, by late 2008 analysts thought the values had remained the same or declined.

Analysts with whom we spoke noted that while lending from large lenders was virtually frozen in late 2008, small and regional lenders were still financing small-scale

Medicaid payment effects on nursing facility margins

The Commission considers the Medicare margin to guide its update recommendation for skilled nursing facilities (SNFs) because our primary responsibility is to advise the Congress on Medicare payment policy. Because it focuses on the comparison of Medicare's payments with the costs to treat beneficiaries, the Medicare margin is an appropriate measure of the adequacy of the program's payments. A total margin reflects the financial performance of the entire facility across all lines of business (e.g., ancillary and therapy services, hospice, and home health care) and all payers.

Industry representatives contend that Medicare payments should cross-subsidize payments from other payers, in large part Medicaid. However, such cross-subsidization is not advisable for several reasons. First, a cross-subsidization policy would use a minority share of Medicare payments to underwrite a majority share of states' Medicaid payments. On average, Medicare payments account for less than a quarter of revenues to freestanding SNFs. Second, raising Medicare rates to supplement low Medicaid payments would result in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from the higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies. Third, increased Medicare payments could encourage states to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates still higher. In addition, a Medicare subsidy would have an uneven impact on payments, given the variation across states in the level and method of paying for nursing home care. In states where Medicaid payments were adequate, the subsidy would have no positive impact. Last, a higher Medicare rate could further encourage providers to select patients based on payer source or to rehospitalize dual-eligible patients so that they qualified for a Medicare-covered, higher payment stay. ■

projects (under $10 million). Currently, capital is more expensive than before and the terms and conditions are more restrictive.[27] Federally insured loans continue to be an option, especially for single providers and small multi-facility entities. Lenders look more favorably on facilities with a "good" payer mix (relatively high Medicare and private shares), high rehabilitation mix, high occupancy rates, good performance on quality measures, and those with whom the lender has a prior banking relationship. Although Medicare payments make up a small share of most nursing homes' revenues, the program's relatively generous payments are key to how attractive a nursing home is to investors (see text box on Medicaid payment effects on nursing facility margins). Entities that own facilities in multiple states are viewed favorably as a way to spread financial risk.

Experts do not expect the availability of capital to improve dramatically in 2009. Analysts predicted a continued divergence between strong and weak institutions based on payer mix, operational effectiveness, size and breadth of services, and steady cash flows that insulate facilities from adverse market conditions (Fitch Ratings 2008, Pomeranz 2008). Some analysts thought there could be an increase in the number of small operators that partner with financially strong providers, close, or file for bankruptcy protection.

One bright spot in nursing homes' access to capital is HUD's program for its federally insured mortgages. Implemented nationally in July 2008, the "lean" program streamlined and standardized its loan application process, which significantly reduced the time to loan closing—from 220 days to 30 days for simple refinancing and from 300–400 days for capital and reconstruction projects to 60–90 days (HUD 2008a). HUD officials report that, although the projected volume of nursing homes and assisted living facilities was down last year, the number of loan applications in 2008 was up considerably, including applications from larger operators. In the past, their lending had been mostly to single site and small multi-site facilities. HUD estimates that it may have funded about 300 projects in 2008 (up from 191 in 2007), with one investor newsletter noting that HUD is fast becoming a lender of choice (*SeniorCare Investor* 2008).

TABLE 2D–4 **Average Medicare margins for freestanding SNFs remain strong**

	2001	2002	2003	2004	2005	2006	2007
Number of SNFs	10,811	11,026	10,851	11,161	11,196	11,274	11,389
Margin, by type of SNF							
All	17.6%	17.4%	10.8%	13.7%	12.9%	13.3%	14.5%
Urban	17.4	16.8	10.0	13.0	12.4	13.0	14.2
Rural	18.4	20.0	14.1	16.5	15.3	14.5	16.0
For profit	19.9	19.9	13.9	16.6	15.6	16.2	17.5
Nonprofit	10.3	9.1	1.5	4.2	4.4	4.0	4.5
Government*	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: SNF (skilled nursing facility), N/A (not available).
* Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of freestanding SNF cost reports.

Medicare margins rose in 2007

Although aggregate Medicare margins for freestanding SNFs have varied some over the past seven years, they have exceeded 10 percent each year (Table 2D-4). In 2007, the aggregate Medicare margin for freestanding SNFs was 14.5 percent. This margin was a slight increase from 2006 (13.3 percent), as aggregate Medicare costs per day during this period grew more slowly than aggregate payments per day (4.7 percent compared with 6.2 percent). The growth in payments reflects the increased share of days in the highest paying rehabilitation RUGs.

Financial performance of freestanding SNFs continued to vary widely. In 2007, the aggregate Medicare margin for for-profit SNFs was 17.5 percent, compared with 4.5 percent for nonprofit facilities. One-half of freestanding SNFs had Medicare margins of 16.1 percent or more, while one-quarter of them had Medicare margins at or below 5.2 percent and one-quarter had Medicare margins of at least 24.8 percent. About 18 percent of the freestanding facilities reported negative Medicare margins. In addition, rural facilities in aggregate continued to have higher Medicare margins than their urban counterparts.

Lower daily costs, rather than higher payments, drove the differences in financial performance between freestanding SNFs with the lowest and highest Medicare margins (those in the bottom and top 25th percentiles of Medicare margins). Low-margin SNFs had case-mix-adjusted costs per day that were 45 percent higher than high-margin SNFs ($308 versus $212) and ancillary costs per day that were one-third higher (Table 2D-5). The low-margin SNFs' higher daily costs are explained partly by their lower average daily census (with poorer economies of scale) and shorter stays (over which to spread their fixed costs) compared with high-margin SNFs. Unmeasured differences in patient mix could also explain some of the cost differences.

On the revenue side, high-margin SNFs had Medicare payments that were 7 percent higher than low-margin SNFs. High-margin SNFs had lower shares of days in the less profitable case-mix groups (the clinically complex and special care groups) and higher shares of days in the rehabilitation plus extensive services groups compared with SNFs in the bottom margin quartile.

Hospital-based facilities continued to have very negative margins (–80 percent), in large part reflecting their higher daily costs and shorter stays (averaging less than half the length of stays in freestanding facilities). Per day costs for hospital-based SNFs were about double those of freestanding facilities. Their higher routine costs were a function of their higher staffing levels, their larger mix of professional staff, and their generally higher wage rates (hospital-based SNFs typically pay SNF staff the same rates as their hospital employees) (MedPAC 2007b). Hospital-based SNFs also have higher NTA costs that may capture unmeasured differences in case mix and in how physicians order tests, select drugs, and use other services when managing SNF care. Finally, hospital-

based SNFs have higher overhead costs than freestanding SNFs. Because hospital-based facilities are small, their administrative costs are spread over fewer patients; furthermore, they carry some overhead from their host hospital. These factors contribute to the higher costs relative to those of freestanding facilities.

The Commission continues to be concerned about the differences in financial performance between hospital-based and freestanding facilities and between for-profit and nonprofit facilities. In June 2008, we reported the impact of a proposed PPS design on payments that would shift payments from therapy stays to medically complex stays and stays with high NTA service costs. We estimated that payments for SNFs with low shares of rehabilitation-only patients would increase 17 percent, while payments to SNFs with high shares of these patients would decline 6 percent. Payments to SNFs with high shares of special care patients, high NTA costs per day, and high ancillary costs per day would increase (7 percent, 23 percent, and 21 percent, respectively). Because of the mix of patients and treatment patterns, payments to hospital-based SNFs and nonprofit SNFs would increase 20 percent and 7 percent, respectively. Payments to freestanding SNFs and for-profit SNFs would decline slightly (–2 percent and –3 percent, respectively), again based on their mix of patients and treatment patterns.

TABLE 2D–5

Freestanding SNFs in top quartile of Medicare margins in 2007 had much lower costs

Characteristic	Top margin quartile	Bottom margin quartile
Case-mix adjusted total costs per day		
Total	$212	$308
Ancillary	$89	$123
Average daily census (patients)	86	75
Length of stay (in days)	45	38
Medicare payment per day	$377	$352
Share of days, by broad case-mix group		
Rehabilitation plus extensive services	30%	27%
Clinically complex and special care	4%	6%
Share of SNFs, by type		
For profit	87%	53%
Urban	66%	71%

Note: SNF (skilled nursing facility). Values shown are medians for the quartile. Top margin quartile SNFs were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for case mix using the facility's nursing case-mix index.

Source: MedPAC analysis of freestanding cost reports.

The aggregate total margin for freestanding SNFs in 2007 was 2.4 percent. This margin is considerably lower than the aggregate Medicare margin and reflects the lower Medicaid payments that drive many SNFs' total financial performance. State policies regarding the level of Medicaid payments and the ease of entry into the market play key roles in shaping this industry's overall financial health. In addition, the share of revenues made up from private payers (generally considered favorable) and other lines of business (e.g., ancillary, home health, and hospice services) also contribute to the total financial performance. The Commission has a longstanding position that cross-subsidizing Medicaid payment levels is inadvisable for many reasons and that the Medicare margin is the appropriate measure of the adequacy of the program's payments (see text box on p. 173).

Payments and costs for 2009

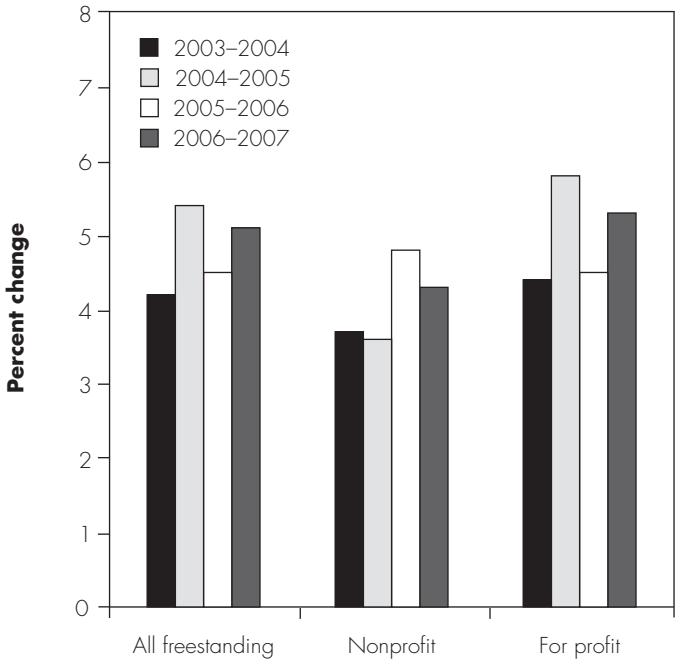
To estimate 2009 payments and costs with 2007 data, the Commission considers policy changes that went into effect in 2008 and 2009. There were no policy changes to consider for these years. SNFs received the full market basket updates each year. The SNF market basket, which measures the price inflation for the goods and services SNFs use to produce a day of care, increased Medicare payments by 3.3 percent in 2008 and 3.4 percent in 2009.

Our modeling of future year costs also considered recent cost growth for freestanding SNFs. Between 2006 and 2007, cost per day (unadjusted for case mix) grew faster than it did between 2005 and 2006 (Figure 2D-8, p. 176).[28] Although freestanding for-profit facilities experienced higher average cost growth than nonprofits between 2006 and 2007, they continued to have lower per day costs. In 2007, the per day costs at freestanding nonprofit SNFs were about 10 percent higher than the daily costs at for-profit SNFs, which could be due to differences in case mix, staffing levels, and general and administrative expenses.

In assessing payment adequacy, the Commission considers the estimated relationship between Medicare payments and SNF costs in the current fiscal year (2009). We project the SNF margin to be 12.6 percent in 2009. This estimate assumes that costs will increase at the actual average cost growth over the past five years (4.5 percent) and not at the

FIGURE 2D–8

Growth in freestanding SNF costs per day varies by ownership



Note: SNF (skilled nursing facility). Growth is in aggregate costs per day between two years for a cohort of facilities. Costs per day are unadjusted for case mix.

Source: MedPAC analysis of freestanding SNF cost reports.

rate of the market basket, which is lower. We also do not assume any behavioral offset, such as changes in coding that may increase payments.

How should Medicare payments change for 2010?

The update in current law for fiscal year 2010 is the forecasted change in input prices as measured by the SNF market basket. The market basket for SNFs in 2010 is projected to be 2.9 percent but CMS will update this forecast before using it to update payments for 2010.

Update recommendation

RECOMMENDATION 2D

The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2010.

RATIONALE 2D

The evidence indicates that most Medicare beneficiaries continue to have access to SNF services. Under policies in current law for 2008 and 2009, we project the Medicare margin for freestanding SNFs to be more than 12 percent in 2009. SNF payments appear more than adequate to accommodate cost growth without an update.

IMPLICATIONS 2D

Spending

- This recommendation would lower program spending relative to current law by between $250 million and $750 million for fiscal year 2010 and by between $1 billion and $5 billion over five years.

Beneficiary and provider

- We do not expect an adverse impact on beneficiary access, nor do we expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries.

The Commission considers the update recommendation to be only one tool to help improve the accuracy and equity of the SNF PPS (see text box on previous Commission recommendations). Of particular relevance to the update discussion are two recommendations previously made by the Commission that would redistribute payments across facilities: to revise the PPS and establish a pay-for-performance program (MedPAC 2008a, MedPAC 2008b). Although updates can help control overall spending, fundamental changes to the PPS are required to redistribute payments from therapy care to medically complex care. As previously noted, if the revisions to the PPS were implemented, payments would increase for facilities that treat large shares of patients with high NTA service costs, high ancillary costs, and medically complex care needs. Payments would be lower for facilities that treat high shares of patients who require only rehabilitation services.

The Commission has also recommended that payments be tied to the quality of the care facilities furnish. A quality incentive payment policy would redistribute payments toward facilities that provide good quality (or are improving) and away from facilities with poor quality.

The Commission urges the Congress to implement all three recommendations so that spending increases are limited and payments are distributed equitably across all types of cases and the facilities that treat them.

Previous Commission skilled nursing facility recommendations

Over the past year, the Commission has made several recommendations aimed at improving the accuracy of Medicare's payments, linking the program's payments to beneficiary outcomes, and increasing our ability to assess the value of Medicare's purchases (MedPAC 2008a, MedPAC 2008b).

The Congress should require the Secretary to revise the skilled nursing facility (SNF) prospective payment system (PPS) by:

- **adding a separate nontherapy ancillary (NTA) component,**
- **replacing the therapy component with one that establishes payments based on predicted patient care needs, and**
- **adopting an outlier policy.**

Compared with the existing PPS, the revised design would better target payments to stays with high NTA costs, more accurately calibrate therapy payments to therapy costs, and offer some financial protection to SNFs that treat stays with exceptionally high ancillary costs.

The Congress should establish a quality incentive payment policy for SNFs in Medicare.

Linking payments to beneficiary outcomes could help improve SNF quality and redistribute payments from low-quality to high-quality providers. Measures, such as rehospitalization rates, would encourage providers to improve their coordination of care across sites.

To improve quality measurement for SNFs, the Secretary should:

- **add the risk-adjusted rates of potentially avoidable rehospitalizations and community discharge to its publicly reported post-acute care quality measures;**
- **revise the pain, pressure ulcer, and delirium measures currently reported on CMS's Nursing Home Compare website; and**
- **require SNFs to conduct patient assessments at admission and discharge.**

These changes would improve accuracy of the public reporting of SNF quality and ensure that the measures reflect the care provided to all SNF patients. Gathering assessment information at discharge will allow the program to evaluate changes in patient conditions and tie them to the services furnished to beneficiaries.

The Secretary should direct SNFs to report more accurate diagnostic and service-use information by requiring that:

- **claims include detailed diagnosis information and dates of service,**
- **services furnished since admission to the SNF be recorded separately in the patient assessment, and**
- **SNFs report their nursing costs in the Medicare cost report.**

Better information would improve payment accuracy and enable policymakers to assess the value of SNF care. ■

Revising the PPS

Although Medicare payments for SNF care are more than adequate in aggregate, they continue to be distributed poorly. Without evidence that some categories of SNFs are less efficient than others, the wide variation in Medicare margins by facility type, ownership, and patient mix suggests that current payments are not targeted accurately. In addition, consistent with the payment incentives under current policy, many SNFs have substantially increased the amount of therapy furnished to beneficiaries, although the extent to which it has contributed to improved patient outcomes is unknown. Finally, medically complex and—under the current payment system—less profitable patients are increasingly concentrated at a smaller number of SNFs able and willing to treat them.

In June 2008, the Commission recommended that the Congress revise the SNF PPS to include:

- separate payments for NTA services,
- an outlier policy for stays with exceptionally high NTA costs, and
- therapy payments based on predicted patient care needs (not on the services the facility provides).

Our analysis demonstrated that a revised PPS would better target payments to stays with high NTA costs, afford some financial protection to SNFs that treat patients with exceptionally high ancillary care needs, and more accurately calibrate payments for therapy costs.

The Commission also noted that two refinements might improve the proposed SNF PPS design. First, an outlier policy that accounts for the declining costs of longer stays would help ensure that providers did not extend stays for financial gain. Second, a policy to help prevent the underprovision of therapy services would counter providers' incentives under any prospectively set payment to lower their costs. Staff, working with researchers at the Urban Institute, evaluated these refinements.

Refining the design of an outlier policy

An outlier policy offers modest financial protection for providers that treat exceptionally costly stays. By design, outlier payments are intended to apply to only a small share of stays. Outlier payments do not go into effect until the cost of a case exceeds the usual payment rate plus a predetermined loss amount (the fixed-loss amount). Consequently, outlier payments cover only a portion of the loss so a provider retains an incentive to be efficient. For each extremely costly case, a provider must cover the entire fixed-loss amount plus the share of the loss beyond the fixed-loss amount not covered by the outlier payment.

The outlier policy we proposed last summer as part of the revised PPS focused on losses attributable to ancillary costs because these costs are highly variable and fluctuate due to differences among patients. The design considered ancillary losses over the entire stay, as providers are at financial risk for the losses incurred over the stay, not on a per day basis. Specifically, we evaluated a policy that would make extra payments only after the ancillary loss for a stay exceeds $3,000; outlier payments would equal 80 percent of the loss above that amount. The fixed-loss amount of $3,000 requires SNFs to incur a loss equal to the average ancillary cost per stay. Under this design, we found that outlier payments would be made for fewer than 3 percent of all stays, and they would be broadly distributed across the majority of SNFs. This result is consistent with the narrow purpose of outlier payments and the random nature of extraordinary costs. With outlier payments financed by an equal offsetting reduction in regular prospective payments, about one-fifth of facilities would benefit, on net, from the outlier policy we modeled.

To more accurately reflect the lower daily costs of longer stays, we evaluated a loss-sharing ratio (the percentage of losses paid above the fixed-loss amount) that would decline for days beyond the median length of stay. Losses over the stay would still determine whether a stay qualifies for an outlier payment, but the daily payments would be lower for days beyond the median length of stay. As an example, we modeled a policy that would pay 80 percent of the loss (beyond the fixed-loss amount) for days up to the median length of stay and 60 percent of the loss for days beyond the median length of stay. Because the median lengths of stay are different for hospital-based and freestanding facilities, we compared a stay's length with the median for its facility type.

The effects of the outlier policy with and without the length-of-stay refinement were similar. The same share of stays would receive outlier payments and the same mix of facilities would benefit, on net, from the outlier policy. The distributional impacts on outlier payments would also be similar. However, an outlier policy with a length-of-stay refinement may offer more accurate payment because outlier payments would mirror the lower daily costs of later days of a stay.

Countering the incentive to underprovide therapy service

Under the recommended revisions to the PPS, providers would be paid for the predicted amount of therapy a patient needs, even if they provided fewer services. Like other providers facing prospectively determined payment rates, SNFs would have a financial incentive to underfurnish care—in this case, therapy services. To discourage underprovision, the Commission discussed the possibility of devising a policy whereby SNFs would be paid on a cost basis for stays with therapy care that was considerably below predicted levels.[29] CMS would identify unusually low utilization over the course of a stay, as therapy may not be provided on any given day for legitimate reasons.

To implement a low utilization payment adjustment (LUPA), CMS would have to make two design decisions. First, would the policy attempt to identify underprovision for individual stays or those facilities with a pattern of underprovision? A case-level LUPA policy would identify individual cases with unusually low therapy utilization and pay for them on a cost basis. A facility-level policy would identify facilities with patterns of low utilization across all patients' stays in one year and discount their payments in a subsequent year. A facility-level LUPA

policy could identify facilities that, across all Medicare stays, consistently furnished less therapy than predicted. A facility-level policy places less demand on the precision of the predictive model for individual stays, which may be appropriate as even good models accurately predict therapy use for only a portion of stays. For example, the Commission's alternative design for therapy payments explained one-third of the variation in therapy costs across stays and facilities.

Second, what level of underprovision would trigger cost-based or discounted payments? For example, would LUPA payments apply to stays in which the amount of therapy provided was less than 10 percent of the predicted amount, less than 20 percent of the predicted amount, or less than 30 percent? CMS would need to consider the accuracy of the therapy payment model in deciding which level to consider "low" utilization. Our preliminary modeling indicates that the share of stays that would be paid at cost would not increase proportionally with higher minimum thresholds. More stays would be identified for cost-based payments if the LUPA payments applied to stays with therapy amounts that were 30 percent of the predicted amounts than if the LUPA payments applied to stays with therapy amounts that were 10 percent of the predicted amount, but not three times as many. Higher thresholds (e.g., stays with actual therapy amounts equal to 20 percent or 30 percent of the predicted amounts) would result in larger program savings, since a larger share of stays would have their therapy payments based on costs rather than on the higher predicted amounts. CMS may also want to consider exempting essentially nontherapy stays from LUPA payments as a way to target the policy to higher use rehabilitation stays. As an example, a LUPA might apply only to those stays with a minimum amount of therapy, such as therapy payments of at least $250 over the stay.

To implement a LUPA policy, CMS needs to consider whether to measure underprovision using time (therapy minutes) or therapy costs. Both measures have limitations. Minutes are potentially a more accurate measure of service use than costs but may not be recorded accurately or consistently on SNF claims. The units recorded on the claim represent 15-minute blocks of therapy time, not actual minutes, and facilities could vary in how they count these blocks. CMS has not evaluated the accuracy of these claims data. Facilities also report therapy minutes in patient assessments regarding care furnished in the past seven days. However, this instrument does not capture the total amount of therapy furnished throughout the stay. Cost measures are more readily available but may be inaccurate for some facilities because of the limitations associated with the ratios used to convert charges to costs.[30]

To assess the feasibility and impact of adding a LUPA policy to the Commission's alternative PPS design, we developed preliminary case-level models using minutes and costs. One model compared actual costs (estimated from charges) with modeled base payments to assess differences between what therapy payments would have been under a revised PPS and the therapy costs for the stay. A second model compared estimated minutes (from patient assessments) with predicted minutes (using predictors from the payment model).[31] The estimates of the percent of stays that would be paid on a cost basis if a LUPA policy had been in place varied considerably depending on the percentage of predicted amounts that would trigger cost-based payments (e.g., whether actual provision was 10 percent or 20 percent of predicted amounts) and if the policy excluded essentially nontherapy stays (e.g., stays with predicted therapy amounts less than $250).

Although current service patterns (with the incentive to furnish therapy) are unlikely to reflect the extent of underprovision that might occur if the PPS established therapy payments based on predicted care needs, the exercise led us to conclude that a LUPA policy could be developed. In the short term, a cost-based measure of underprovision could be used until CMS has evaluated the quality of the minutes' information and, if necessary, taken steps to improve the data quality. In addition to identifying potential underprovision, accurate therapy minute data are key to linking service use to patient outcomes.

The Commission urges the Congress to take up the issue of revising the SNF PPS to better target payments and remove the incentive to furnish therapy services for financial rather than clinical reasons. Because payments would be more accurate, SNFs would have little financial incentive to select certain types of patients and access would improve for beneficiaries who require expensive NTA services. ■

Endnotes

1 A new spell of illness begins when a beneficiary has not had a hospital or SNF stay for 60 consecutive days.

2 The program pays separately for some services, including certain chemotherapy drugs, customized orthotics and prosthetics, ambulance services, dialysis, outpatient and emergency services furnished in a hospital, computed tomography, MRI, radiation therapy, and cardiac catheterizations.

3 Medicare's conditions of participation relate to many aspects of staffing and care delivery in the facility, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day, providing physical and occupational therapy services as delineated in each patient's plan of care, and providing or arranging for physician services 24 hours a day in case of an emergency.

4 MA plans do not submit claims to Medicare so their utilization is not captured in the volume or spending measures.

5 A more complete description of the SNF PPS is available at http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_SNF.pdf.

6 In 2008, the market basket index was 3.3 percent; in 2009, the market basket index is 3.4 percent.

7 When the PPS was first implemented, there were 44 case-mix groups and the nursing weights were calculated with data collected from time studies in volunteer facilities in six states in 1990, 1995, and 1997. When the RUGs were expanded to 53 groups, CMS regrouped the time-study observations into the 53 groups and recalibrated the nursing weights. For the therapy weights, the same weights for the 44 groups were used. For example, the two new "ultra high rehabilitation plus extensive services" groups have the same therapy weights as the three "ultra high rehabilitation" groups under the 44-group system, even though these groups used different amounts of therapy (MedPAC 2007a).

8 The PPS pays for NTA costs using the nursing component. As a result, it distributes payments based on the expected amount of nursing care, even though NTA costs are not necessarily associated with nursing costs and vary considerably more across patients. For example, payments are the same for patients who require equivalent nursing care even though some patients also require expensive drugs or respiratory therapy services.

9 Although the services were ordered and approved by a physician, the orders can be general and give providers latitude in the amount of therapy they furnish.

10 The median Medicare share was considerably lower (42 percent) when critical access hospitals were included in this measure.

11 A facility may begin to participate in the program but may not be "new." For example, a facility could have a change in ownership (and be assigned a new provider number) or in its certification status from Medicaid-only to dually certified for the Medicaid and Medicare programs. We use the number of SNFs that terminated their participation in the Medicare program as a proxy for the facilities that closed.

12 The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or those who are aphasic or tube fed.

13 The decline in the number of SNFs willing or able to treat special care and clinically complex patients reflects, in part, the relative attractiveness of the payments for rehabilitation case-mix groups. It may also be due to the expiration in October 2002 of the temporary add-on payments for the nursing components for all case-mix groups. Because nursing components make up a large share of the daily payment for clinically complex and special care cases (these case-mix groups do not have large therapy components to their daily rates), elimination of the additional payments made these case-mix groups even less financially attractive.

14 The extensive services category includes patients who have received intravenous medications or suctioning in the past 14 days or have required a ventilator or respiratory or tracheostomy care or have received intravenous feeding within the past 7 days.

15 In fiscal year 2007, daily payments for days classified into rehabilitation plus extensive services RUGs averaged 19 percent higher than payments for rehabilitation-only RUGs.

16 The 75 percent rule attempts to identify patients who need intensive rehabilitation services provided by IRFs. CMS established criteria (identifying 13 specific conditions) and required that at least 75 percent of the patients treated by IRFs have one of those conditions. In 2004, CMS revised its criteria, clarifying that only a subset of patients with major joint replacements, the largest category of IRF admission at the time, would count toward the threshold then in place. The Medicare, Medicaid, and SCHIP Extension Act of 2007 rolled back and permanently set the compliance threshold to 60 percent. It also put into law CMS's discretionary policy

allowing IRFs to count patients whose comorbidities (rather than primary diagnoses) were among the 13 conditions toward the compliance threshold.

17 The share of beneficiaries treated in home health care increased 8 percentage points (from 21 percent to 29 percent).

18 For example, payments for days in the medium group RMX are 14 percent higher than those for the high group RHX, even though more therapy minutes are required for days to be grouped into RHX.

19 Low share is defined as those SNFs in the bottom 25th percentile of shares of rehabilitation days in the ultra high and very high rehabilitation case-mix groups. High share is defined as those SNFs in the top 25th percentile of shares of rehabilitation days in the ultra high and very high rehabilitation case-mix groups.

20 The average Barthel score (a measure of functional independence) declined 5 percent and the cognitive performance score declined 2 percent. In both scales, lower scores indicate worse status.

21 The community discharge and potentially avoidable rehospitalization rates have been risk adjusted using many resident-level factors, including the presence of advance directives, the Barthel index (a measure of functional independence), the cognitive performance scale (a measure of cognitive impairment), select patient assessment items (e.g., bowel incontinence, indwelling catheter, feeding tube, parenteral or intravenous feeding), a weighted comorbidity index, select comorbid conditions (from the qualifying hospital stay), and length of stay of the qualifying hospitalization. Data for this risk adjustment methodology come from Medicare SNF and hospital claims, the MDS, and the Online Survey Certification and Reporting System (Kramer et al. 2008).

22 CMS's quality measures for short-stay patients include the percentage of patients with delirium, the percentage of patients with pain, the percentage of patients who develop a skin ulcer or had one worsen, flu vaccination rates, and pneumonia vaccination rates. In addition to definitional problems with each measure, there is considerable sample bias inherent in the way the data are collected (MedPAC 2008a). About half of Medicare patients do not stay long enough for a second assessment to be conducted, thereby biasing the data that are collected. The Commission recommended that CMS revise the pain, pressure ulcer, and delirium measures; require SNFs to conduct patient assessments at admission and discharge; and require SNFs to add risk-adjusted rates of community discharge and potentially avoidable rehospitalizations to its publicly reported post-acute care quality measures.

23 To participate in the Medicare and Medicaid programs, all nursing homes and stand-alone SNFs must be surveyed at least once every 15 months. Surveys assess the quality of care, nursing and rehabilitation services, infection control, physical environment, and several other aspects of patient care. The most common deficiencies in quality of care involved accident hazards; providing care for residents' highest practicable physical, mental, and psychosocial well-being; and urinary incontinence (OIG 2008).

24 Because the vast majority of SNFs are parts of larger nursing homes, we assess the access to capital for nursing homes.

25 The HUD Section 232 program finances new or substantial reconstruction of nursing homes. The Section 232/223(f) program finances the refinancing or purchase of existing facilities.

26 Between 2005 and 2007, the share of facilities that sold for more than $50,000 per bed increased substantially (from 28 percent to 43 percent), while the share that sold for less than $30,000 per bed decreased.

27 Interest expense is a small share of the SNF market basket (about 3 percent), so even a large increase in interest cost would change the overall market basket index by less than 1 percent.

28 The cost growth shown in Figure 2D-8 differs from the rate reported on p. 174 because it uses a consistent cohort of SNFs in each two-year period for the calculation.

29 This policy would be similar to the low utilization payment adjustment in the home health PPS that pays on a per visit cost basis for episodes with exceptionally few home health care visits.

30 These cost estimates will be more accurate if charge-to-cost ratios can be calculated specific to therapy services rather than as a ratio for all ancillary services or for the total facility.

31 We estimated minutes from the patient assessment by averaging the minutes reported on the assessment over the days covered by the assessment.

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