

3 SECTION A

Skilled nursing facility services

R E C O M M E N D A T I O N S

3A The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2011.

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

.....

(For additional recommendations on improving the skilled nursing facility payment system, see text box on p. 191.)

SECTION 3 A

Skilled nursing facility services

Section summary

Skilled nursing facilities (SNFs) furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. Most SNFs are part of nursing homes that furnish long-term care, which Medicare does not cover. In 2008, 15,053 SNFs furnished covered care to 1.6 million beneficiaries. In fiscal year 2009, Medicare spent \$25.5 billion on SNF care.

Assessment of payment adequacy

Most indicators of payment adequacy for SNFs are positive.

Beneficiaries' access to care—Access to SNF services remains good for most beneficiaries, but certain subgroups of beneficiaries—those with medically complex care needs and members of racial minorities—warrant further analysis.

- **Capacity and supply of providers**—The number of SNFs has increased slowly since 2001. SNF bed days available have steadily risen at an average annual increase of 7 percent since 2001. SNF occupancy (84 percent) has been stable for several years. Since 2003, the share of SNFs admitting medically complex patients decreased, indicating that access for these beneficiaries may be delayed.
- **Volume of services**—Days and admissions on a per fee-for-service beneficiary basis increased slightly between 2007 and 2008, suggesting

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that access was maintained. However, admission rates for African American beneficiaries were lower than for white beneficiaries, and the differences have grown over time. SNF days were increasingly concentrated in the rehabilitation case-mix groups and, within those, in the highest intensity categories.

Quality of care—SNF quality of care continues to be mixed. Two indicators of quality in SNFs are the rates at which patients are discharged to the community within 100 days of admission and rates at which patients are rehospitalized for conditions that potentially could have been avoided. Between 2006 and 2007, the risk-adjusted rates of community discharge increased to reach the highest level since 2000 (indicating higher quality), while potentially avoidable rehospitalizations steadily increased (indicating poorer quality), though the 2007 rate was almost the same as that for the prior year. Risk-adjusted quality outcomes did not vary by race.

Providers' access to capital—Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Access to capital improved over the last year but the lending terms are stricter and owners and operators are more carefully screened than in the past. Uncertainties in lending do not center on the adequacy of Medicare payments; from all accounts, Medicare remains a sought-after payer.

Medicare payments and providers' costs—Increases in payments between 2007 and 2008 outpaced increases in provider costs, reflecting the continued concentration of days in the highest payment case-mix groups. In 2008, the average Medicare margin for freestanding SNFs was 16.5 percent. Financial performance continued to differ substantially across the industry—a function of distortions in the prospective payment system (PPS) and cost differences among providers. SNFs with the highest margins had higher shares of days in intensive rehabilitation case-mix groups and lower shares of days in the medically complex groups than SNFs with relatively low margins. We found that freestanding SNFs with low Medicare margins had standardized costs per day (adjusted for differences in wages and case mix) 42 percent higher than SNFs with high Medicare margins. Our previously recommended changes to the PPS design—adding a new component to pay separately for nontherapy ancillary services and basing therapy payments on patient care needs—would, if implemented, result in narrowing the differences in financial performance across the industry. The projected Medicare margin for 2010 is 10.3 percent. We believe this margin is sufficient to accommodate cost increases in 2011.

On the basis of these analyses, the Commission recommends eliminating the update for fiscal year 2011. ■

**TABLE
3A-1**

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

Type of SNF	Facilities		Medicare-covered stays		Medicare payments	
	2005	2008	2005	2008	2005	2008
Total number	14,955	14,819	2,444,796	2,411,296	\$18.2 billion	\$22.9 billion
Freestanding	92%	93%	87%	91%	93%	95%
Hospital based	8	7	13	9	7	5
Urban	67	70	79	81	81	83
Rural	33	30	21	19	19	17
For profit	68	68	66	69	72	74
Nonprofit	28	26	30	27	25	22
Government	5	5	4	3	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.

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services, such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include those recovering from surgical procedures such as hip and knee replacements or from medical conditions such as stroke and pneumonia (see the online appendix to this chapter, available at <http://www.medpac.gov>). About 5 percent of fee-for-service (FFS) beneficiaries used SNF services at least once in 2008 and program spending totaled \$25.5 billion in fiscal year 2009.

Medicare covers up to 100 days of SNF care after a medically necessary hospital stay of at least 3 days. For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment rate for the first 20 days of care. Beginning with day 21, beneficiaries are responsible for copayments. In 2010, the copayment is \$137.50 per day.

The term “skilled nursing facility” refers to a provider that meets Medicare requirements for Part A coverage.¹ The vast majority (more than 90 percent) of SNFs are dually certified as a SNF and as a nursing home. Thus, a facility that provides skilled care often also furnishes long-term care services that Medicare does not cover. SNFs are

either hospital based or freestanding. In 2008, 93 percent of SNFs were freestanding and accounted for a growing share of Medicare stays and spending (Table 3A-1). In 2008, about two-thirds of SNFs were for profit and treated about the same share of stays but accounted for almost three-quarters of Medicare payments to SNFs.

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 2008 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.

Medicare uses a prospective payment system (PPS) to pay for each day of service.² Information gathered from a standardized patient assessment instrument—the Minimum Data Set (MDS)—is used to classify patients into 53 case-mix categories, called resource utilization groups (RUGs). RUGs differ by the services furnished to a patient (such as the amount and type of therapy furnished and the use of respiratory therapy and specialized feeding), the patient’s clinical condition (such as whether the patient has pneumonia), and the patient’s need for assistance to perform activities of daily living (such as eating and toileting). In 2011, CMS plans to revise the case-mix groups to more accurately reflect relative differences in resource use, as measured by staff times associated with caring for different types of patients (see discussion on p. 176).

**TABLE
3A-2**

Broad case-mix groups in the skilled nursing facility prospective payment system

Patient group	Types of patients included in group
Broad resource utilization groups	
Clinically complex	Patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy.
Special care	Patients with multiple sclerosis, surgical wounds, skin ulcers, or cerebral palsy; those who receive respiratory services seven days per week; or those who are aphasic or tube fed.
Extensive services	Patients who have received intravenous medications or suctioning in the past 14 days, required a ventilator/respirator or tracheostomy care, or received intravenous feeding within the past 7 days.
Rehabilitation	Groups based on minutes of therapy per week: Ultra high: patients received over 720 minutes Very high: patients received 500–719 minutes High: patients received 325–499 minutes Medium: patients received 150–324 minutes Low: patients received 45–149 minutes
Rehabilitation plus extensive services	Patients received enough to qualify them for a rehabilitation case-mix group and they received one or more extensive services
Subgroups used in MedPAC analyses	
Medically complex	Clinically complex and special care cases. Extensive service groups are excluded from this definition because days can be assigned to them based on services furnished before admission to the skilled nursing facility. CMS found that services provided during the prior hospital stay were not an accurate proxy for medical complexity (Centers for Medicare & Medicaid Services 2009).
Intensive rehabilitation	Ultra high rehabilitation, ultra high rehabilitation plus extensive services, very high rehabilitation, and very high rehabilitation plus extensive services cases

The Commission previously described and made recommendations related to two key shortcomings of the SNF PPS (Medicare Payment Advisory Commission 2008a, Medicare Payment Advisory Commission 2008b) First, the PPS does not adequately adjust payments to reflect the variation in providers' costs for nontherapy ancillary (NTA) services (for most patients, these services are predominantly drugs). Payments for NTA services are tied to the nursing component, even though NTA costs do not necessarily vary with, and are much more variable than, staff time. The Commission recommended that a separate payment component be established to pay for NTA services so that payments are targeted to patients with high NTA care needs.

Second, payments increase with the provision of therapy, creating a financial incentive to furnish these services. Moreover, therapy payments are not well calibrated to therapy costs so that, as the cost of these services increases, payments to cover them rise even faster. The Commission recommended replacing the existing therapy component with one that bases payments on patient characteristics so that payments vary with care needs.

CMS has acknowledged and taken several steps to enhance payments for medically complex care and to control therapy provision. CMS plans to implement a new case-mix system in 2011 that expands the number of case-mix groups for special care and clinically complex

case-mix groups and more narrowly tailors the extensive services groups (eliminating the provision of intravenous (IV) medications from the definition; see Table 3A-2 for definitions). CMS also directed program dollars away from therapy care and toward medically complex care by raising nursing component payments by an estimated 21 percent and lowering therapy component payments by 41 percent (Centers for Medicare & Medicaid Services 2009).³ As payments for the nursing component increase, payments for NTA services also rise. However, because payments for NTA services will continue to be tied to the nursing component, they may not match individual patients' care needs. As a result, the PPS may continue to encourage SNFs to avoid patients with above-average NTA care needs. To that end, CMS intends to implement a payment adjustment for NTA services but has not yet proposed a design.

In 2011, CMS plans two other changes that will affect the assignment of patient days into case-mix groups. The patient assessment tool used to classify patients into the groupings will no longer consider services (such as IV medications) furnished before admission to the SNF. This change will lower the number of patients who qualify for the rehabilitation-plus-extensive-services case-mix groups. In addition, CMS will modify the way it counts therapy services furnished concurrently (when a therapist supervises multiple patients at the same time, and patients are engaged in different therapy activities). Patients who receive therapy services concurrently will be more likely to qualify for less intensive rehabilitation case-mix groups than under current rules.

The planned changes to the therapy component—the shifting of program dollars away from the therapy component and the counting of concurrent therapy minutes—will make rehabilitation care less financially attractive for providers. They may not, however, remove the basic incentive to furnish more therapy in order to be paid more. The Commission supports basing payments on care needs and not on service provision.

Are Medicare payments adequate in 2010?

Indicators of payment adequacy are positive for SNFs. To make this assessment, we analyzed access to care (including the supply of providers and 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. We also compared the performance of SNFs with relatively high and low Medicare margins.

Beneficiaries' access to care: Access is good for most beneficiaries but certain subgroups warrant closer examination

In 2009, most beneficiaries had good access to services, but the Commission is concerned about two subgroups of beneficiaries—those with medically complex care needs and minorities. The number of SNFs has remained about the same for several years and volume—as measured by SNF days and covered admissions per 1,000 FFS enrollees—increased between 2007 and 2008. The share of days assigned to rehabilitation case-mix groups and, within those, to high-intensity case-mix groups, continued to increase.

Capacity and supply of providers: Supply remains stable

The number of SNFs participating in the Medicare program slowly increased from 14,778 in 2001 to 15,053 in 2009 (Figure 3A-1, p. 178). Between 2008 and 2009, there were 108 new facilities but during the same period 83 facilities closed.⁴ Although 6 hospital-based units began participating in the Medicare program during 2008, many more hospital-based units stopped, so there were 41 fewer hospital-based facilities by the end of 2009. Fewer than 1 percent of SNFs stopped participating in the Medicare program last year and most of them did so voluntarily.

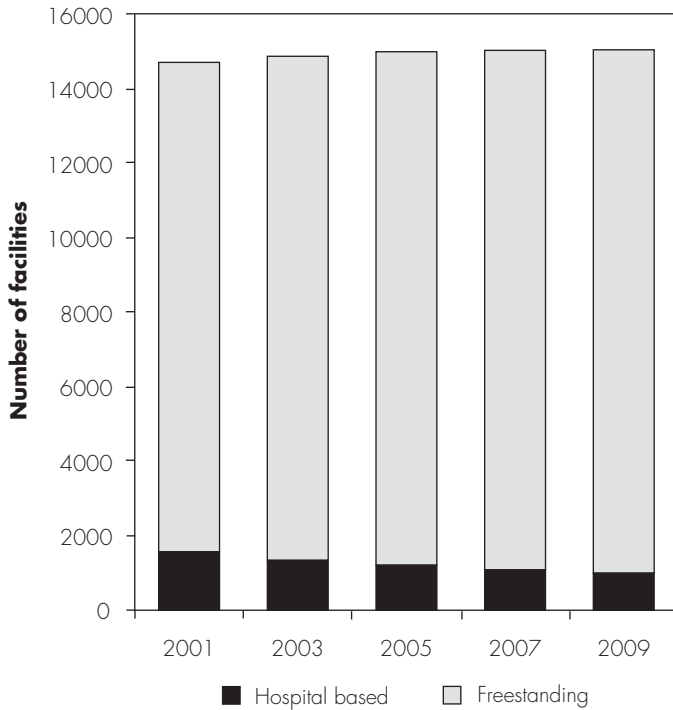
The mix of ownership and facility type remained constant between 2007 and 2009. After a steady decline since 2000, the share of hospital-based facilities remained at 7 percent for the third year in a row. The share of for-profit SNFs remained at 69 percent, having increased slightly from 67 percent in 2000.

Other measures of capacity include the number of SNF beds available during the year and occupancy rates. SNF bed days available (the days available for occupancy after adjusting for beds temporarily out of service due to, for example, renovation or patient isolation) increased 7 percent between 2007 and 2008, consistent with the average annual increase since 2001. The average occupancy rate was 84 percent, consistent with occupancy rates since 2002.

State policies play a large role in the ability of this sector to expand. Certificate-of-need programs regulate the

FIGURE 3A-1

The number of SNFs grew slightly since 2001 but the mix has shifted to freestanding facilities



Note: SNF (skilled nursing facility). 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 2000-2009.

expansion of long-term care facilities in more than half the states. Yet, more than half of the new SNFs in 2009 (those that began participating in the Medicare program) were located in states with 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 the market or to expand.

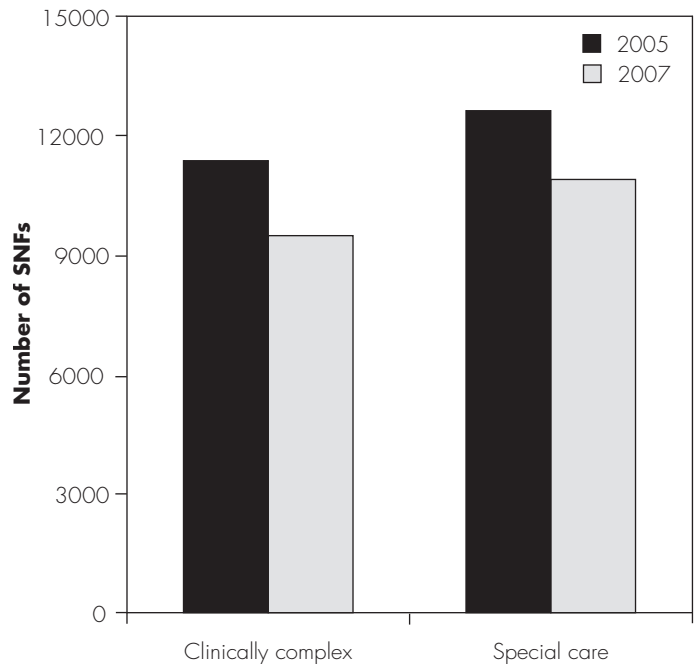
While supply remains stable, the number of SNFs that treat medically complex patients continues to decline. Patients grouped into the clinically complex and special care case-mix groups account for about 6 percent of Medicare days (see Table 3A-2, p. 176, for definitions). Between 2005 and 2007, the number of facilities admitting clinically complex and special care patients decreased (almost 9 percent and 7 percent, respectively), even though the number of SNFs remained about the same (Figure

3A-2). As a result, the distributions of medically complex admissions were more concentrated in fewer SNFs than rehabilitation admissions.⁵ Because minorities make up a larger share of medically complex admissions than rehabilitation admissions, some minority beneficiaries may experience delays in being transferred to a SNF or may be placed in SNFs further from their homes.⁶ 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. Some SNFs may furnish enough therapy services to medically complex patients to qualify them for higher payment rehabilitation case-mix groups.

The changes to the PPS that CMS plans to implement in 2011 are likely to increase access for medically complex patients because they raise payments for medically

FIGURE 3A-2

The number of SNFs that admitted clinically complex and special care cases decreased between 2005 and 2007



Note: SNF (skilled nursing facility). 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.

**TABLE
3A-3**

SNF volume increased in 2008

	2005	2006	2007	2008	Percent change 2007-2008
Volume per 1,000 fee-for-service enrollees					
Covered admissions	70	71	72	74	2.3%
Covered days (in thousands)	1,811	1,874	1,925	1,991	3.4
Covered days per admission	25.9	26.4	26.7	27.0	1.1
Total SNF volume					
Covered admissions	2,546,408	2,543,133	2,533,016	2,561,073	1.1
Covered days (in thousands)	66,002	67,143	67,663	69,157	2.2
Covered days per admission	25.9	26.4	26.7	27.0	1.1

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

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

complex patients. The Commission will continue to monitor the distribution of where medically complex patients are treated to assess whether the new classification system has improved access for them. However, patients who require high-cost NTA services may still experience delays in SNF placement because the changes do not specifically target payments to patients with high NTA care needs. The Commission’s recommended changes to the PPS—adding a separate NTA component and revising the existing therapy component—would redistribute payments across different types of cases and the SNFs that treat them. We estimated that aggregate payments to SNFs with the highest NTA costs would increase 23 percent (Medicare Payment Advisory Commission 2008b).

Volume of services: Increased volume suggests access is adequate

Between 2007 and 2008, the share of FFS beneficiaries who used SNF services remained at just under 5 percent. We examine utilization on a FFS enrollee basis because the counts of users, days, and admissions do not include service use by beneficiaries enrolled in Medicare Advantage (MA) plans. Because MA enrollment continues to increase, changes in reported utilization could reflect a declining number of FFS beneficiaries rather than reductions in service use.

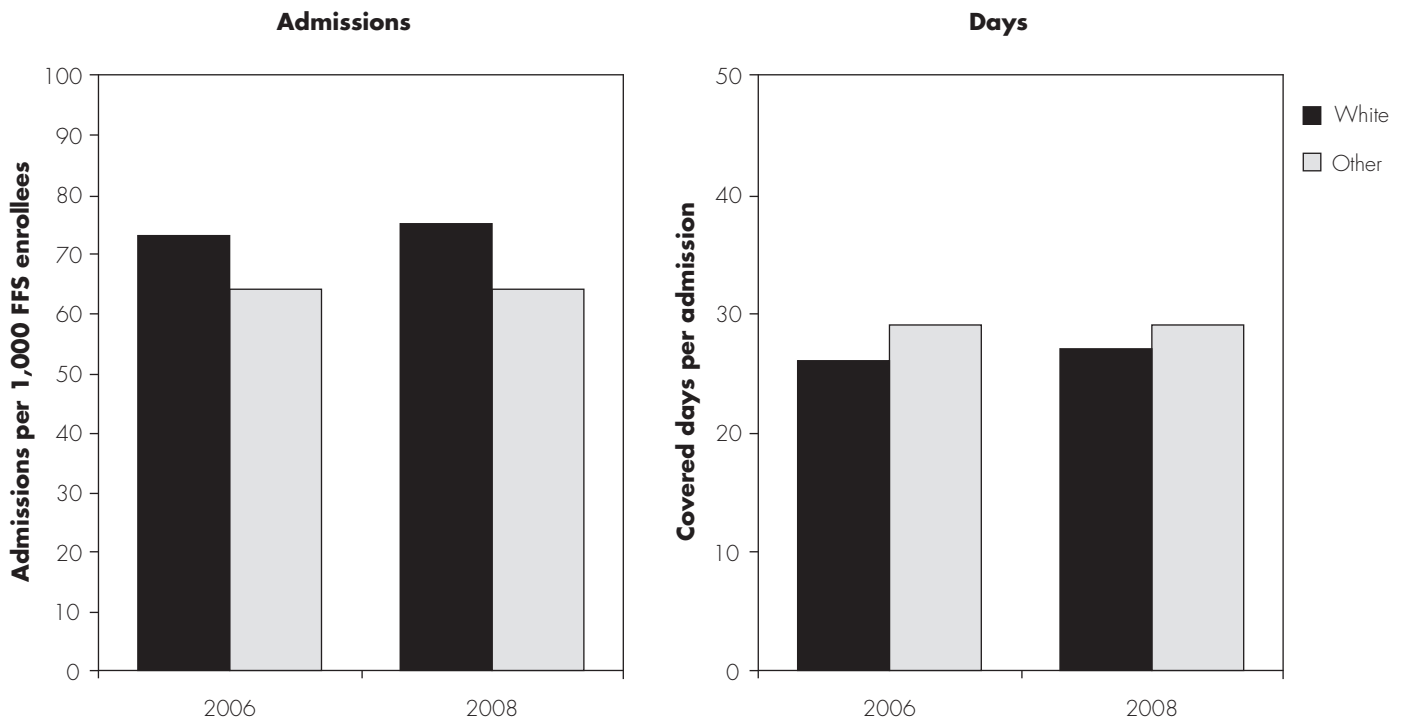
On a per FFS enrollee basis, SNF volume grew between 2007 and 2008. Admissions rose 2.3 percent, while covered days increased 3.4 percent, translating into longer covered stays (Table 3A-3). Despite increased enrollment

in MA, for which volume is not included in the data, unadjusted volume measures also grew during this period. Between 2007 and 2008, admissions increased by more than 1 percent and days increased by more than 2 percent.

SNF use is uneven among beneficiaries of different races, raising concerns about minorities’ access to care (Figure 3A-3, p. 180). In 2008, admissions per 1,000 FFS enrollees were 17 percent higher for whites than for beneficiaries of other races and these differences have grown over time. Although admission rates were lower, lengths of stay for beneficiaries of other races were longer than those for white beneficiaries, perhaps reflecting differences in case mix. As lengths of stay for whites have increased, differences among the races have gotten smaller. We have not examined these racial differences to know, for example, if minority beneficiaries use other post-acute services instead of SNF care or whether minority beneficiaries are less likely to be hospitalized for conditions that typically are followed by SNF care.

Growth in the number and intensity of rehabilitation days

Rehabilitation days continued to grow as a share of all Medicare SNF days. In 2008, rehabilitation days accounted for 90 percent of Medicare SNF days, up from 82 percent in 2004 (Figure 3A-4, p. 181). In January 2006, CMS implemented nine new rehabilitation case-mix groups for patients who qualify for both rehabilitation and extensive services (see Table 3A-2, p. 176, for definitions). The new case-mix groups were added to the top of the

**FIGURE
3A-3****Admission rates and covered days per admission vary by race**

Note: FFS (fee-for-service). Data include 50 states and the District of Columbia.

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

classification hierarchy and assigned the highest payments. In 2008, these new RUG categories accounted for 37 percent of days, while days classified in the rehabilitation-only RUGs continued to decline. The large number of rehabilitation plus extensive services days may reflect providers' coding improvements to record extensive services provided by the SNF or during the previous hospital stay to obtain higher payments associated with these case-mix groups.⁷ In 2011, CMS plans to change the extensive services that qualify for the extensive services' case-mix groups, which is likely to reduce the days that are assigned to them.

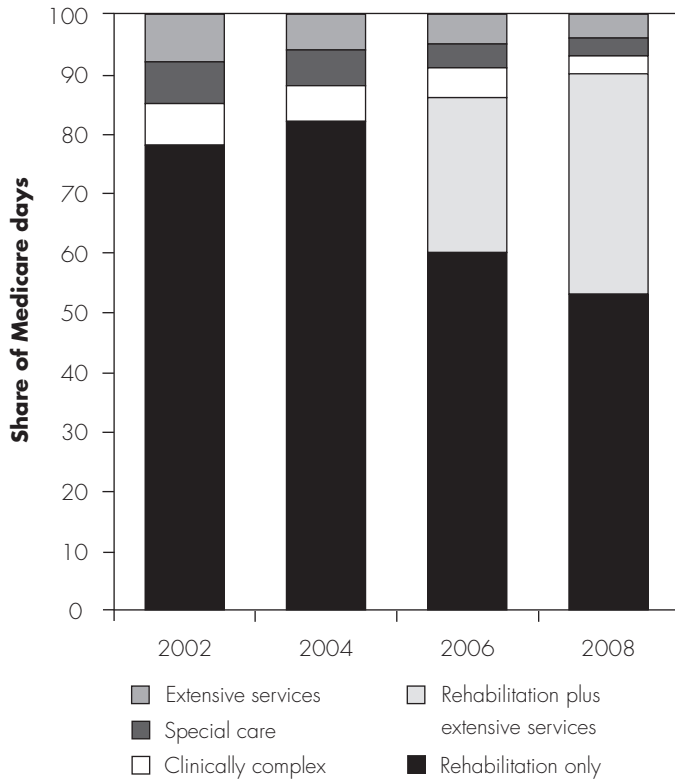
Within the rehabilitation case-mix groups, the distribution of days continued to shift toward the highest intensity (and payment) therapy groups (Figure 3A-5). Between 2006 and 2008, the share of ultra-high and very high rehabilitation days increased 35 percent, making up almost two-thirds of all rehabilitation days in 2008. During this period, the share of rehabilitation days in the high, medium, and low rehabilitation groups declined 10 percent.

In addition to the payment incentives, some of the growth in rehabilitation days may also be explained by a shift in the site of care from inpatient rehabilitation facilities (IRFs) to SNFs, as IRFs comply with the 60 percent rule, stipulating that at least 60 percent of patients treated by IRFs have 1 of 13 specified conditions.⁸ Between 2004 and 2008, the share of beneficiaries who had a major joint replacement or revision (not among the IRF-specified conditions) 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 14 percentage points (from 28 percent to 14 percent).

It is unlikely that changes in the care needs of the patients admitted between 2005 and 2007 fully account for the growth in rehabilitation days. Assessments conducted at or near admission (on or about day five of the stay) indicate that reductions between 2005 and 2007 were small in the patients' ability to conduct activities of daily living at admission (as measured by the Barthel score) and in their cognitive function.⁹ During the same period, the average

FIGURE 3A-4

Case mix in freestanding SNFs continued to shift 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 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/respirator or tracheostomy care, or have received intravenous feeding within the past 7 days. Days are for freestanding SNFs with valid cost report data.

Source: MedPAC analysis of freestanding SNF cost reports.

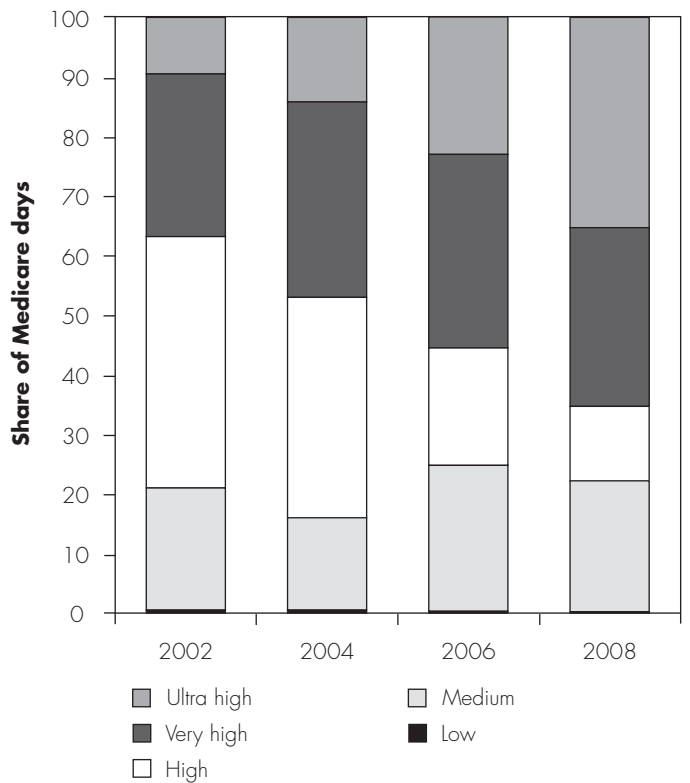
MA risk score for Medicare beneficiaries who used SNF services decreased slightly (-1.6 percent), indicating that Medicare beneficiaries would be less, rather than more, costly to treat.¹⁰

SNFs vary considerably in their provision of intensive rehabilitation services (see Table 3A-2, p. 176, for definition). Annual reports filed by publicly traded companies state that attracting Medicare patients and furnishing intensive therapy are business strategies

they pursue (Extencicare 2008, Extencicare 2009, Sun Healthcare Group 2009). Our analysis of the providers of intensive therapy found that hospital-based facilities were overrepresented in the group of SNFs with the lowest shares (the bottom 10th percentile) of the intensive rehabilitation days. They made up 19 percent of this group, even though hospital-based facilities make up only 7 percent of SNFs. For-profit facilities were underrepresented, making up 55 percent of this lowest percentile group compared with their two-thirds share of facilities. One industry analysis reported that some freestanding SNFs specializing in short-term rehabilitation use narrow patient selection criteria to admit the highest payment patients, leaving lower payment, harder-to-place patients to be treated in hospital-based facilities (Cain Brothers 2009).

FIGURE 3A-5

Rehabilitation days in freestanding SNFs continue to shift toward higher intensity case-mix groups

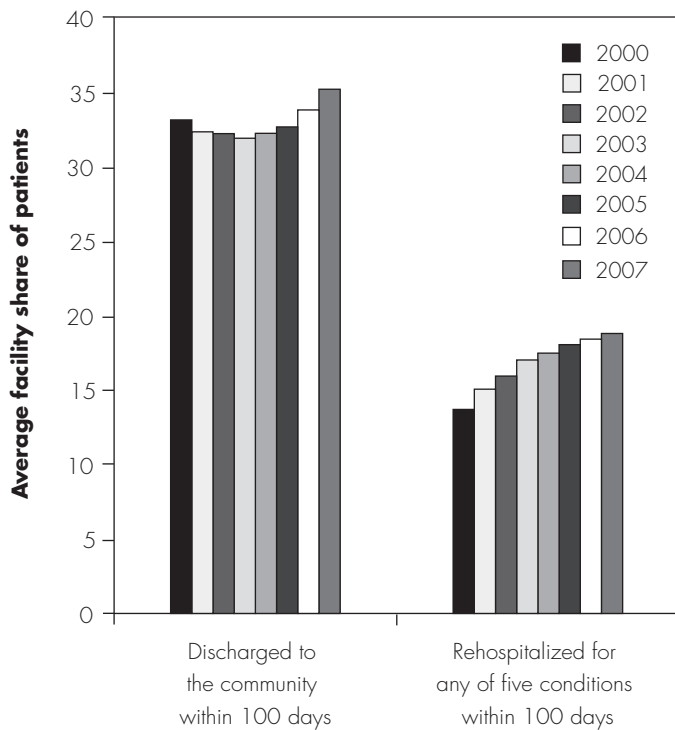


Note: SNF (skilled nursing facility). Days are for freestanding SNFs with valid cost report data. Rehabilitation days include days in the rehabilitation case-mix groups and the rehabilitation plus extensive services case-mix groups.

Source: MedPAC analysis of freestanding SNF cost reports.

**FIGURE
3A-6**

**Quality results for SNFs
between 2000 and 2007**



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 risk adjusted and calculated for all facilities with more than 25 stays.

Source: Rates calculated for MedPAC by A. Kramer et al. 2009.

Service use trends highlight need to make changes to PPS

The concentration of special care and clinically complex admissions in fewer SNFs and the growing share and intensity of rehabilitation days underscore the need to change the PPS. The changes recommended by the Commission would raise payments for medically complex patients and lower them for rehabilitation case-mix groups. Payments would be redirected across facilities, depending on their mix of patients—for example, payments to hospital-based facilities and nonprofit facilities would increase 20 percent and 7 percent, respectively (Medicare Payment Advisory Commission 2008b). These distributional impacts are important in considering the package of SNF recommendations (see p. 191).

The revisions planned by CMS—the restructuring of the case-mix system and the shifting of program spending away from the therapy component and toward the nursing component—also redistribute payments, though their impacts on various groups of SNFs are smaller.¹¹ While the changes represent important building blocks to shift payments, the Commission believes that additional reforms for NTA and therapy services are still needed. Payments need to target NTA services so that patients with these high care needs do not face delays in placement. CMS intends to establish a payment adjustment for NTA services but has not yet proposed a design. Therapy payments need to be based on patients’ care needs and not on the services furnished. Otherwise, providers may still have an incentive to furnish therapy for financial rather than for clinical reasons.

Quality of care: SNF quality mixed

The quality of rehabilitation care furnished to patients during a Medicare-covered SNF stay continued to show mixed results over time—with one indicator showing improved quality and the other showing poorer quality, though the rate of deterioration has slowed. In 2007, the most recent data available, the risk-adjusted rate at which SNFs discharged patients to the community within 100 days was the highest it had been since 2000, indicating improved rehabilitation quality (Figure 3A-6).¹² The mean risk-adjusted rate of community discharge declined between 2000 and 2003 and since then has slowly increased, with the most recent data indicating the largest improvement. In 2007, the rate was 35.2 percent compared with 33.1 percent in 2000.

The rate at which Medicare-covered SNF patients were returned to the hospital for potentially avoidable causes remained essentially the same between 2006 and 2007. The risk-adjusted rates of potentially avoidable rehospitalization within 100 days for 5 conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) have been increasing since 2000, indicating declining quality. The increases have been less each year (i.e., the upward trend has leveled off) with the rates in 2006 and 2007 being comparable. In 2007, the mean risk-adjusted facility rate for the five potentially avoidable rehospitalization conditions was 18.5 percent, compared with 13.7 percent in 2000.

Risk-adjusted results for the two quality measures continue to differ by facility type and ownership. Compared

with freestanding facilities, hospital-based facilities had community discharge rates that were 7.4 percentage points higher and potentially avoidable rehospitalization rates 3.1 percentage points lower, 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. In addition, patients in hospital-based facilities have relatively easy access to physician and ancillary services that could otherwise require a hospital readmission for patients in freestanding SNFs. Previous Commission analysis found that about half of hospital-based facilities operate rehabilitation models of SNF care and are selective in the patients they admit (Medicare Payment Advisory Commission 2007). The performance of for-profit facilities differed from nonprofits, with higher community discharge rates (by 0.5 percentage point) but also higher potentially avoidable rehospitalization rates (by 1.3 percentage points) compared with nonprofit SNFs. Additional unmeasured differences in case mix and other factors that were not accounted for (such as staffing turnover and level of experience) could also explain some of the differences in quality measures by facility type and ownership.

We also examined outcome measures by race and found differences by racial group that were not significant when other factors, such as patient condition, were considered. In 2007, whites had community discharge rates that were 1.4 times those of African Americans, who had the lowest rates of all racial groups examined. This difference was consistent over time (since 2000). African Americans had potentially avoidable rehospitalization rates that were 1.4 times higher than those for whites (and the highest of all racial groups), though the differences have declined since 2000. However, once beneficiaries' characteristics—such as their ability to perform activities of daily living, their cognitive function, and their comorbidities—were accounted for, the outcome differences by racial group were not statistically significant.

With an increasing share of beneficiaries classified into rehabilitation case-mix groups, changes in a beneficiary's functional status between admission and discharge could help assess whether these services were beneficial. Unfortunately, providers are not required to conduct patient assessments at discharge, so we do not have this information. However, beginning in 2011, providers will be required to conduct assessments at discharge, and we will be able to assess whether service provision is related to improvement (or no deterioration) in functional status.

Providers' access to capital: Available but uncertainties persist

Because the vast majority of SNFs operate within nursing homes, we assess the access to capital for nursing homes. Capital is more available than last year, but lending is constrained by uncertainties in this sector. The restrained lending is not a reflection of the adequacy of Medicare payments—the program continues to be a highly valued payer. Market analysts we spoke with indicated that, because most operators make their bottom line by using Medicare profits, lenders use Medicare payer mix as one metric of a facility's financial health (see text box, p. 184, on Medicaid payment effects on nursing facility margins).

Some market analysts noted that, while capital is available, at least two uncertainties have slowed lending and raised its price. First is the downturn in many states' economies that analysts report could threaten the level of Medicaid payments, the dominant payer for most facilities. Delays in states' payments have also increased facilities' need for working capital. Second, with so few projects being financed, lenders face uncertainty in establishing the conditions for borrowers because they lack comparables. Analysts did not think lending would ease considerably during 2010.

The number and scale of the projects continue to be small. Between 2006 and 2008, the number and value of publicly announced mergers and acquisitions of long-term care providers (nursing homes and assisted living facilities) declined considerably (Irvin Levin Associates 2009). For nursing homes that sold, the average price paid per nursing home bed declined 18 percent between 2007 and 2008 (Irvin Levin Associates 2009). This year, a survey of lenders to long-term care operators found that the number of lenders had declined considerably from two years ago (Andrews 2009). For the first six months of 2009, the volume of lending transactions was down 77 percent from 2007 (Ambrose 2009).

Market analysts indicate that nursing homes can get loans for the right project, but the loan process can be more demanding than before the credit crisis. Borrowers may need to canvass 15 to 30 lenders before getting a loan. Lending criteria have become stricter, with more information required about the owner and operator. Facilities are examined for their cash flow, their accounts receivable, and financial operating history. In addition, more attention is being paid to the quality of care and operations; both will help ensure a facility's financial viability. Local and regional banks continue to do smaller

Medicaid payment effects on nursing facility margins

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

Industry representatives contend that Medicare payments should subsidize payments from other payers, in large part Medicaid. However, the Commission believes 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 payment rates could encourage states to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates. 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 add to excessive payments. Last, higher Medicare payments 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. ■

deals and increasingly require that a borrower use them for their working capital loans. Ideal borrowers were described as those with multiple facilities (10 to 15), located in multiple states, and with ancillary businesses—all ways to spread risk.

Lending by the Department of Housing and Urban Development (HUD) has tempered an otherwise sluggish lending environment. In 2009, HUD's lending dramatically increased as a result of an overhaul of its federally insured mortgages program for nursing homes under Section 232/223.¹³ Last year, we reported on the streamlined and simplified loan application process aimed at standardizing and speeding up the process. Between 2008 and 2009, the number of HUD-financed projects increased 35 percent (to 255 projects) and HUD's insured mortgage amounts increased 61 percent, totaling more than \$2 billion in 2009 (Department of Housing and Urban Development 2009). HUD reports 600 to 700 projects in its queue as of November 2009, making it the sector's

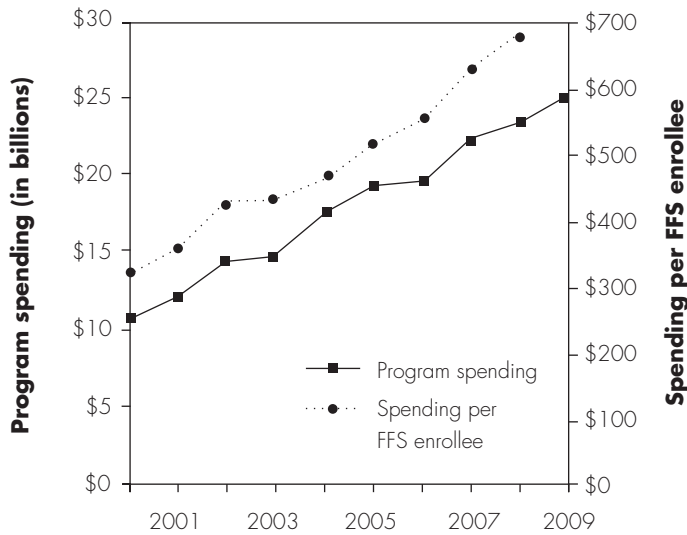
busiest lender. The high demand for the program has resulted in extended delays until the agency can begin to process an application, though the agency plans to more than double the number of underwriters it employs to keep pace with the number of applications. The government will continue to be a major lender in 2010 (Ambrose 2009).

Medicare payments and providers' costs: Medicare margins continue to increase

Between 2007 and 2008, Medicare payments increased faster than Medicare costs, resulting in an aggregate 2008 Medicare margin of 16.5 percent. Medicare margins continued to vary more than twofold by ownership group. Examining the range in financial performance, we found that high-margin SNFs had considerably lower costs and, to a smaller extent, higher payments than low-margin SNFs. We also found that some SNFs consistently furnished relatively low-cost, high-quality care and had substantial Medicare margins.

**FIGURE
3A-7**

Medicare's payments to skilled nursing facilities continue to grow



Note: FFS (fee-for-service). Years are fiscal years. FFS enrollee count for 2009 is not available.

Source: CMS, Office of the Actuary, 2009.

Program spending in 2009 topped \$25 billion

In fiscal year 2009, spending for SNF services was \$25.5 billion, up more than 6 percent from 2008 (Figure 3A-7). This rate of increase was slower than for the previous two years, yet spending increases still averaged 10.6 percent annually between 2000 and 2009. The slower growth rate was due, in part, to the slowdown in the shift in case-mix groups from rehabilitation-only to rehabilitation plus extensive services groups, the highest payment groups. Between 2006 and 2007, the number of days classified into rehabilitation plus extensive services groups grew 31 percent; between 2008 and 2009, this growth slowed to about 9 percent. Another factor in the constrained spending growth rate was the decline in the number of FFS enrollees as more beneficiaries enrolled in MA plans. Spending by MA plans on SNFs is not included in the SNF spending totals. Even with declining FFS enrollment, however, spending increases averaged more than 10 percent a year since 2000.

SNF margins continue to grow

SNF aggregate margins continued to increase, making 2008 the eighth consecutive year with margins above 10 percent (the 2001 margin—17.6 percent—is not shown) (Table 3A-4). In 2008, the aggregate Medicare margin

**TABLE
3A-4**

Freestanding SNF Medicare margins continue to increase

	2002	2003	2004	2005	2006	2007	2008 ^a
Number of freestanding SNFs	11,015	10,854	11,161	11,190	11,284	11,567	12,401 ^b
Margin, by type of SNF							
All	17.4%	10.8%	13.7%	12.9%	13.3%	14.7%	16.5%
Urban	16.8	10.2	13.1	12.4	13.1	14.5	16.1
Rural	20.4	14.0	16.3	15.4	14.6	15.7	18.3
For profit	19.6	13.4	16.2	15.2	15.8	17.4	19.0
Nonprofit	8.7	1.3	3.5	4.2	3.3	4.0	7.0
Government ^c	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: SNF (skilled nursing facility), N/A (not available).

^a In 2009, we updated our method of calculating Medicare margins using more recent data on the cost differences between Medicare and other patients. This update accounted for one-third of the difference in the margins between 2007 and 2008.

^b CMS reports that an increased number of SNFs filed cost reports in 2008. This increase is attributed to the consolidation of audit operations at Medicare contractors that resulted in a change in the number of "low utilization" cost reports filed by providers. As a result, more SNFs met MedPAC's data screens to be included in the analysis. The expanded number of SNFs did not affect the 2008 margin. Using the same 2007 cohort of SNFs, the 2008 margin is also 16.5 percent.

^c 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.

**TABLE
3A-5**

Freestanding SNF margins and costs vary considerably in 2008

Measure	Percentile				
	10th	25th	50th	75th	90th
Medicare margin	-6.6%	7.4%	17.9%	26.2%	33.1%
Standardized Medicare cost per day	\$334	\$293	\$259	\$229	\$203

Note: SNF (skilled nursing facility). Costs were standardized for differences in wages and case mix (using the nursing case-mix index).

Source: MedPAC analysis of freestanding SNF cost reports for 2008.

for freestanding SNFs was 16.5 percent, 1.8 percentage points higher than the margin in 2007. From 2007 to 2008, Medicare costs per day grew more slowly than payments per day (3.4 percent compared with 5.6 percent). The high growth in payments reflects the increased share of days in the highest payment rehabilitation RUGs.

A factor contributing to the large increase in the Medicare margin between 2007 and 2008 is an update to the method we use to account for the higher nursing costs of treating Medicare patients compared with non-Medicare patients.¹⁴ Using more recent patient assessment information, we found that our former adjustment method was overstating the cost difference between Medicare and non-Medicare patients and would, in turn, understate Medicare margins. Had the prior years' adjustment been used, Medicare margins for 2008 would have been 15.9 percent.¹⁵ With more recent information, we believe the revised adjustment more accurately represents Medicare margins.

Like other sectors, the financial performance of freestanding SNFs continued to vary widely. Consistent with previous years, rural SNFs had higher Medicare margins than their urban counterparts and the disparity between for-profit and nonprofit facilities was large. The Medicare margin for for-profit SNFs was 19.0 percent, compared with 7.0 percent for nonprofit facilities. One-half of freestanding SNFs had Medicare margins of 17.9 percent or more, while one-quarter of them had Medicare margins at or below 7.4 percent and one-quarter had Medicare margins of 26.2 percent or higher (Table 3A-5). About 16 percent of the freestanding facilities reported negative Medicare margins, a small decrease from 2007.

A key factor in the difference in Medicare margins across facilities is cost per day. One-quarter of SNFs had costs

(adjusted for differences in case mix and wages) at or below \$229 per day, while one-quarter had costs that equaled or exceeded \$293 a day—a 28 percent difference. There were also differences by ownership. At the median, nonprofit SNFs had costs per day (adjusted for differences in case mix) that were 8 percent higher than in for-profit SNFs. Additional analysis of the differences between SNFs with high and low margins is described on p. 187.

The aggregate total margin for freestanding SNFs in 2008 was 1.9 percent, reflecting lower Medicaid payments that drive many facilities' total financial performance. This industry's overall financial health is shaped by state policies on the level of Medicaid payments and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need). The Commission has a long-standing position that 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, p. 184). An additional factor in a facility's total financial performance is the share of revenues from private payers (generally considered favorable) and other lines of business (such as ancillary, home health, and hospice services) that contribute to a facility's total financial performance. Annual reports from publicly traded companies indicate that expanding private payer shares and hospice services are strategies actively pursued by some facilities (Extendicare 2009, Kindred 2008, Sun Healthcare Group 2009).

Hospital-based facilities continued to have very negative margins (-74 percent), in large part reflecting their higher daily costs and shorter stays (averaging less than half the length of stay in freestanding facilities). Their higher costs are a function of their higher staffing levels, larger mix of professional staff, and generally higher wage rates

(hospital-based SNFs typically pay SNF staff the same rates as their hospital employees). The higher NTA costs in hospitals may indicate that physicians view SNF stays as an extension of the inpatient stay, with their practices not fully adjusting to the fact that the patient has moved into a lower intensity, post-acute setting. In addition, hospital-based SNFs have higher overhead costs per day than freestanding SNFs, in part because they are smaller and their administrative costs are spread over fewer patients. Finally, the higher NTA costs of hospital-based SNFs may capture differences in case mix. Because patients requiring high-cost NTA services can be hard to place, they may remain in some hospital-based facilities. Our recommended changes to the SNF PPS would increase payments to hospital-based facilities by an estimated 20 percent, given the mix of patients they treat.

The Commission has examined hospital-based SNFs and their impact on hospitals' financial performance. We interviewed hospital administrators to understand their decisions to keep their SNF units open despite their low SNF margins (Medicare Payment Advisory Commission 2007). We learned that the decision to stay open or to close was multifaceted. Administrators considered the SNF units in the context of the hospital's overall business model and the SNF's impact on the inpatient margin, the inpatient length of stay, and freeing up inpatient capacity to treat additional acute care patients. Our analysis of 2008 hospital cost reports found that SNF services contributed to the bottom line financial performance of the hospitals. Hospitals with SNFs had higher inpatient Medicare margins and higher overall Medicare margins (a margin that considers all lines of business) than hospitals without SNFs.

Comparing SNFs with high and low margins

To help evaluate the range in SNF margins, we compared the characteristics of freestanding facilities with high and low Medicare margins. We found that lower daily costs and higher payments contributed to the differences in financial performance between 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 42 percent higher (\$312 vs. \$219) and ancillary costs per day that were 40 percent higher (\$126 vs. \$96) than high-margin SNFs (Table 3A-6). The higher daily costs of the low-margin SNFs are explained partly by their lower average daily census (with fewer economies of scale) and shorter stays (over which to spread their fixed costs)

**TABLE
3A-6**

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

Characteristic	High-margin quartile	Low-margin quartile
Medicare margin	31.6%	-3.0%
Costs per day		
Total	\$219	\$312
Ancillary	\$96	\$126
Administration and general cost (overhead)	\$27	\$38
Average daily census (patients)	86	73
Length of stay (days)	43	38
Medicare payment per day	\$402	\$373
Share of days, by case-mix group		
Ultra-high and very high rehabilitation	62%	45%
Clinically complex and special care	4%	6%
Medicare share of days	12.7%	11.0%
Share of SNFs, by type		
Percent for profit	89%	58%
Percent urban	70%	73%

Note: SNF (skilled nursing facility). Values shown are medians for the quartile. High-margin quartile SNFs were in the top 25 percent of the distribution of Medicare margins. Low-margin quartile SNFs were in the bottom 25 percent of the distribution of Medicare margins. Total and ancillary costs per day have been adjusted for differences in area wages and case mix (using the nursing component's relative weights).

Source: MedPAC analysis of freestanding cost reports.

than high-margin SNFs. The median SNF occupancy rates of facilities with high and low margins did not vary. 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 8 percent higher than low-margin SNFs. High-margin SNFs had much higher shares of days in the ultra-high and very high rehabilitation case-mix groups (62 percent compared with 45 percent) and lower shares of days in the less profitable case-mix groups (the clinically complex and special care groups) compared with SNFs in the low-margin quartile. These differences in revenue may also reflect the current distortions in the PPS. Our previous work found that as therapy costs increase,

Identifying skilled nursing facilities that furnish relatively low-cost, high-quality care

To be included in the group of skilled nursing facilities (SNFs) that furnished relatively low-cost, high-quality care, a SNF had to be in the lowest third of the distribution of costs per day, in the top third on one quality measure, and not in the bottom third for the other quality measure for three consecutive years (2004 through 2006). The cost per day was adjusted for differences in case mix (using the nursing component relative weights) and wages. Quality measures were risk-adjusted rates of community discharge and rehospitalization for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Quality measures were calculated for all facilities with more than 25 stays.

The method we used to assess performance attempts to limit drawing incorrect conclusions about performance

based on poor data. Using three years to categorize SNFs as efficient (rather than just one year) avoids categorizing providers based on random variation or one “bad” year. In addition, we separated a SNF’s assignment to a group from examination of the group’s performance to avoid having poor data for a facility affect both its categorization and assessment of the group’s performance. Performance over three years (2004 through 2006) was used to categorize SNFs into relatively efficient and other groups, and once the groups were defined, we evaluated their performances in 2007 and 2008. Thus, a SNF’s erroneous data could result in inaccurately assigning it to a group, but because the group’s performance is assessed with data from later years, these “bad” data would not affect assessment of the group’s performance. Using this definition, we found 6 percent of SNFs provided relatively low-cost, high-quality care. ■

payments rise faster (Medicare Payment Advisory Commission 2008b). Conversely, medically complex days are relatively underpaid because of the poor targeting of payments for NTA services. High-margin SNFs had a higher average Medicare share of days than low-margin SNFs.

The ownership mixes varied considerably for high-margin and low-margin facilities. Although for-profit facilities made up two-thirds of SNFs, they made up 89 percent of the high-margin facilities. Conversely, they were underrepresented in the low-margin group. Urban facilities were slightly overrepresented in the high-margin group, making up 73 percent of this group but only 70 percent of facilities (though they made up 83 percent of payments).

The Commission has expressed concern about the differences in financial performance across facilities due to shortcomings in the PPS design. In 2008, SNFs with high Medicare margins had much higher shares of intensive therapy days and lower shares of special care and clinically complex days than SNFs with low Medicare margins. Changes to the PPS that the Commission recommended in 2008 would raise payments to hospital-

based SNFs and nonprofit SNFs and would lower payments to freestanding SNFs and for-profit SNFs.

High margins achieved by relatively low-cost SNFs furnishing high-quality care

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with an efficient provider. This year, we begin the analysis by examining the financial performance of freestanding SNFs with consistently low costs per day and high quality (see text box on definitions). To measure costs, we looked at costs per day that were adjusted for differences in area wages and case mix. To assess quality, we examined risk-adjusted rates of community discharge and potentially avoidable rehospitalizations.

Our analyses found that SNFs can have relatively low costs and provide good quality of care while maintaining high margins. Relatively efficient SNFs were less likely to be located in urban areas and more likely to be nonprofit than other freestanding SNFs. Compared with other SNFs, the relatively efficient ones had community discharge

rates that were 39 percent higher, rehospitalization rates that were 21 percent lower, and costs per day that were 17 percent lower (Table 3A-7). They also had shorter stays than other SNFs. Yet, these SNFs had margins of 24.9 percent compared with a median margin of 17.7 percent for the other SNFs. Clearly, their financial performance did not jeopardize their relatively good patient outcomes.

We recognize that a SNF may appear to be efficient in providing its own care but not when considering a patient's entire episode of care. For example, SNFs that discharge patients to other post-acute services may be efficient in their own practice but raise total program spending. Although the rehospitalization quality measure will prevent those SNFs that routinely discharge their patients back to the hospital from being considered efficient, SNFs will differ in their use of hospital services. In the future, we plan to examine the total costs of the episode of care to assess SNFs' practice patterns in a broader context.

Payments and costs for 2010

To estimate 2010 payments, the Commission considers policy changes that went into effect in 2009 and 2010, including the legislated SNF market increases. The SNF market basket, which measures price inflation for the goods and services SNFs use to produce a day of care, increased Medicare payments by 3.4 percent in 2009 and 2.2 percent in 2010. In 2009, there were no other policy changes to consider besides the projected market basket increase.

For fiscal year (FY) 2010, CMS lowered payments to account for overpayments that had resulted from implementation of new case-mix groups in 2006. As background, whenever changes to a classification system are introduced, CMS uses the best available data to make an across-the-board adjustment so that payments under the "new" case-mix groups are the same as payments would have been under the "old" case-mix groups. This year, CMS's analysis of 2006 case-mix data found that it had substantially underestimated the impact of the new groups and that the new groups had resulted in 3.3 percent overpayments, or about \$1 billion (Centers for Medicare & Medicaid Services 2009). To ensure parity between the "old" and "new" case-mix groups, CMS lowered payments to account for the overpayment. The reduction is partly offset by the market basket increase for 2010, so that payments on net were lowered by 1.1 percent, or \$360 million. We factored this reduction in payments into our estimate of 2010 payments.

**TABLE
3A-7**

SNFs with relatively low costs and high quality maintained high margins

Measure	SNFs with relatively low costs and good quality	Other
Percent of SNFs	6%	94%
Performance in 2007		
Relative*:		
Community discharge rate	1.39	1.0
Rehospitalization rate	0.79	1.0
Cost per day	0.83	1.0
Median:		
Length of stay (in days)	35	41
Medicare margin	24.6%	16.0%
Performance in 2008		
Relative* cost per day	0.85	1.00
Median:		
Length of stay (in days)	37	40
Medicare margin	24.9%	17.7%
Percent urban, 2008	64	75
Percent nonprofit, 2008	24	21
Median number of beds, 2008	99	109

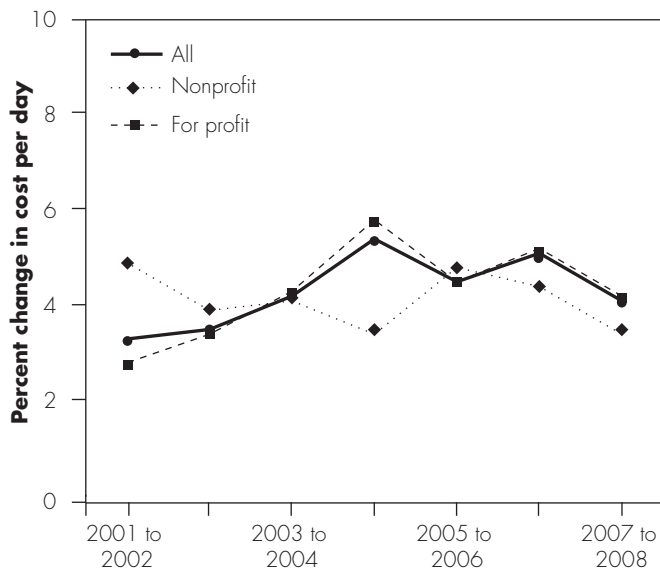
Note: SNF (skilled nursing facility). SNFs with relatively low costs and good quality were those in the lowest third of the distribution of cost per day, in the top third for one quality measure, and not in the bottom third for the other quality measure. Costs per day were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and rehospitalization for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Increases in rates of discharge to community indicate improved quality; increases in rehospitalization rates for the five conditions indicate worsening quality. Quality measures were calculated for all facilities with more than 25 stays.
*Measures are relative to the national average.

Source: MedPAC analysis of quality measures for 2004–2007 and Medicare cost report data for 2004–2008.

Our modeling of future year costs also considers recent observed cost growth for freestanding SNFs. Between 2007 and 2008, costs per day (unadjusted for case mix) grew more slowly (4.1 percent) than between 2006 and 2007 (Figure 3A-8, p. 190).¹⁶ Although freestanding for-profit facilities experienced higher average cost growth than nonprofit facilities, they continued to have lower costs per day. In 2008, the average per day cost at

**FIGURE
3A-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.

Source: MedPAC analysis of freestanding SNF cost reports.

freestanding nonprofit SNFs was 10 percent higher than the average daily cost at for-profit SNFs. Compared with for-profit facilities, nonprofit facilities' routine costs (that reflect staffing levels and mix) were 16 percent higher and their administration and general expenses were 9 percent higher, both unadjusted for differences in case mix. Differences in the mix of patients treated may explain some of these observed cost differences.

In assessing payment adequacy, the Commission considers the estimated relationship between Medicare payments and SNF costs in FY 2010. We project the SNF margin to be 10.3 percent in 2010. This estimate may be conservative for two reasons. First, it assumes that costs will increase at the actual average cost growth over the past five years (4.8 percent) and not at the market basket rate, which is lower. However, it is possible that costs may grow more slowly than the recent average rate because of the condition of the economy. Second, we have not assumed any changes in the mix of the case-mix groups that may result from revisions to the payment system. In 2011, CMS plans to implement a new classification system and other rules for counting therapy times. In aggregate, CMS will make these changes in a budget-neutral manner. Their projection does not, however, assume any behavioral offset, such

as shifts in the mix of group, concurrent, and individual therapy in reaction to the new rules.

How should Medicare payments change in 2011?

The update in current law for fiscal year 2011 is the forecasted change in input prices as measured by the SNF market basket. The market basket for SNFs in 2011 is projected to be 2.2 percent, but CMS will update this forecast before establishing payments for 2011. SNFs should be able to accommodate cost changes in fiscal year 2011 with payments held at 2010 levels.

Update recommendation

RECOMMENDATION 3A

The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2011.

RATIONALE 3A

The evidence indicates that Medicare beneficiaries continue to have access to SNF services. Under policies in current law for 2009 and 2010, we project the Medicare margin for freestanding SNFs to be 10.3 percent in 2010. SNF payments appear more than adequate to accommodate cost growth without an update.

IMPLICATIONS 3A

Spending

- This recommendation would lower program spending relative to current law by between \$250 million and \$750 million for fiscal year 2011 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 part of the package of its SNF recommendations that together consider the level and distribution of payments. The Commission's previous recommendations regarding SNF services are listed in the text box. Of

Previous Commission skilled nursing facility recommendations

The Commission made several recommendations aimed at improving the accuracy of Medicare's payments, linking the program's payments to beneficiary outcomes, and increasing the ability to assess the value of Medicare's purchases (Medicare Payment Advisory Commission 2008a, Medicare Payment Advisory Commission 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. The Commission has also discussed the need to synchronize the payment policies for hospitals and SNFs with high readmission rates. To make these policies parallel, SNFs would be penalized for having high readmission rates (without budget neutrality assumed in a quality incentive payment policy). If aligned, hospitals and SNFs would both have incentives to prevent premature discharge from hospitals, ensure good care transitions to SNFs, and furnish appropriate care in the SNF to prevent potentially avoidable rehospitalizations.

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.**

Revisions to the patient assessment instrument CMS plans to implement in fiscal year 2011 will require SNFs to separately record services furnished since admission to the SNF. Better information would improve payment accuracy and enable policymakers to assess the value of SNF care. ■

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 (Medicare Payment Advisory Commission 2008a). Although updates can help control overall spending, changes beyond those already planned by CMS are required to more accurately pay for NTA services and medically complex care. The Commission has also

recommended that payments be tied to the quality of 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. ■

Endnotes

- 1 For services to be covered, the SNF must meet Medicare's conditions of participation (COPs) and agree to accept Medicare's payment rates. Medicare's COPs relate to many aspects of staffing and care delivery, 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.
- 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, magnetic resonance imaging, radiation therapy, and cardiac catheterizations. A more complete description of the SNF PPS is available at: http://www.medpac.gov/documents/MedPAC_Payment_Basics_09_SNF.pdf.
- 3 For example, the nursing component for patients in the highest extensive services case-mix groups will increase more than 90 percent and payments for patients in the highest special care case-mix group (such as patients with chronic obstructive pulmonary disease) will increase almost 80 percent.
- 4 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.
- 5 In 2007, SNFs with the highest shares of clinically complex admissions (the top quartile) treated 61 percent of these patients compared with SNFs with the highest rehabilitation shares (they treated 33 percent of rehabilitation admissions).
- 6 In 2007, African American beneficiaries made up 16 percent of medically complex admissions and 10 percent of all SNF admissions.
- 7 In its analysis of staff resources associated with caring for different types of patients, CMS found that services furnished during the prior hospital stay were not an accurate proxy for medical complexity (Centers for Medicare & Medicaid Services 2009). As a result, beginning with implementation of the new case-mix groups in 2011, services furnished during the prior hospital stay will no longer be considered when classifying patients in case-mix groups. Furthermore, CMS will revise the definition of extensive services, eliminating IV medications from the list. CMS found that the staff time associated with IV medications was consistent with clinically complex patients but not with patients in the extensive services category.
- 8 The 60 percent rule attempts to identify patients who need intensive rehabilitation services provided by IRFs. CMS established criteria (identifying 13 specific conditions) and requires that at least 60 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.
- 9 The average Barthel score (a measure of functional independence) and the cognitive performance score each declined 2 percent. In both scales, lower scores indicate worse status.
- 10 Every beneficiary is assessed a risk score each year to predict a beneficiary's spending in the next year based on diagnostic and demographic information in the current year. The risk score considers hospital and physician diagnoses, the beneficiary's age and sex, institutional status, Medicaid enrollment (a poverty indicator), and an indicator of original disabled status (Pope et al. 2004).
- 11 For example, CMS estimated that payments to hospital-based facilities will decrease slightly (-1.4 percent for urban hospital-based facilities and -0.8 percent for rural hospital-based facilities) and payments to nonprofit SNFs will increase 0.2 percent.
- 12 The community discharge and potentially avoidable rehospitalization rates have been risk adjusted by using many resident-level factors. Both models include a derived comorbidity index, a Barthel score (a measure of functional independence), the cognitive performance scale (a measure of cognitive impairment), and the presence of advance directives. The community discharge model also includes the rehabilitation case-mix hierarchy (e.g., very high or medium), selected clinical conditions associated with community discharge (depression, schizophrenia), and whether the patient was married. The rehospitalization model also includes select patient needs and characteristics associated with hospitalization (e.g., indwelling catheter, feeding tube,

and pressure ulcers). This risk-adjustment methodology was updated in 2009 to better reflect the relative importance of comorbid conditions, among other improvements (Kramer et al. 2009). Data for this risk-adjustment methodology come from Medicare SNF and hospital claims, the MDS, and the Online Survey Certification and Reporting System.

- 13 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.
- 14 Medicare patients require more nursing resources than non-Medicare patients. However, the Medicare cost report does not require facilities to report their nursing costs or the routine costs (which include nursing costs) attributable to Medicare beneficiaries. To estimate how much higher Medicare nursing costs are relative to other patients, we compared the nursing relative weights of the case-mix groups that Medicare and non-Medicare patients were assigned during 2007 and 2008 (Plotzke and White 2009) We found that the average nursing component's relative weight was 34.5 percent (in 2007) and

34.6 percent (in 2008) higher for Medicare patients than for non-Medicare patients. The previous difference (based on 2001 and 2002 patient assessments) was 38 percent. We then adjusted an estimate of nursing costs by the difference in nursing weights to reflect the higher costs to care for Medicare patients. Because the difference between Medicare and non-Medicare patients is smaller than it had been, Medicare costs were lower, which increased the Medicare margin.

- 15 The patient assessments for 2007 also indicated that the adjustment was overstating the difference in nursing costs between Medicare and non-Medicare patients. Had the more accurate adjustment been applied in 2007, the Medicare margin would have been 15.3 and not the reported 14.7 percent.
- 16 The cost growth in Figure 3A-8 differs from the rate reported on page 186 because the figure uses a consistent cohort for each two-year period for the calculation.

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