SKILLED NURSING FACILITY SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2014

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities (SNFs). Medicare covers up to 100 days of SNF care per spell of illness.[1] Beginning on day 21 of a SNF stay, a beneficiary is responsible for a daily copayment. In 2014, the copayment is $152. SNFs are the most commonly used post-acute care setting. In 2013, Medicare estimates program spending to be almost $29 billion for SNF care.

Skilled nursing facilities can be hospital-based units or freestanding facilities. In 2012, 94 percent of stays were in freestanding facilities. With approval from CMS, certain Medicare-certified hospitals (typically small, rural hospitals and critical access hospitals) may also provide skilled nursing services in the hospital beds used to provide acute care services. These are called swing bed hospitals.

The SNF product and Medicare payment

The Medicare SNF benefit covers skilled nursing care, rehabilitation services and other goods and services and pays facilities a pre-determined daily rate for each day of care. The prospective payment system (PPS) rates are expected to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing most SNF services, with certain high-cost, low-probability ancillary services paid separately.[2] Medicare's PPS for SNF services started on July 1, 1998.[3] Prior to that, SNFs were paid on the basis of their costs, subject to limits on their per diem routine costs (room, board, and routine nursing care); no limits were applied for ancillary services (such as drugs and therapy).

Setting the payment rates

The initial payment rates were set in 1998 to reflect the projected amount that SNFs received in 1995, updated for inflation.[4] The base payment rates were computed separately for urban and rural areas and they are updated annually based on the projected increase in the SNF market basket index, a measure of the national average price level for the goods and services SNFs purchase to provide care. Beginning in 2012, the market basket update is offset by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010. In 2015, for SNFs located in urban areas, the nursing component base rate is $169.28, the therapy component base rate is $127.51, and the other component is a uniform $86.39 (regardless of the case-mix group). In rural facilities, the nursing component base rate is $161.72, the therapy component is $147.02, and the other component is $87.99.

Daily payments to SNFs are determined by adjusting the base payment rates for geographic differences in labor costs and case mix (Figure 1). To adjust for labor cost differences, the labor-related portion of the total daily rate—69 percent for fiscal year 2015—is multiplied by the hospital wage index in the SNF's location and the result is added to the nonlabor portion. The daily base rates are adjusted for case mix using a system known as resource utilization groups (RUGs). Each RUG has associated nursing and therapy weights that are applied to the base payment rates.

A patient's day of care is assigned to one of 66 RUGs based on patient characteristics and service use that are expected to require similar resources. The classification system includes: 14 rehabilitation groups; 9 groups for days with rehabilitation and extensive services (such as ventilator care); 3 groups for extensive services; 16 groups

This document does not reflect proposed legislation or regulatory actions.

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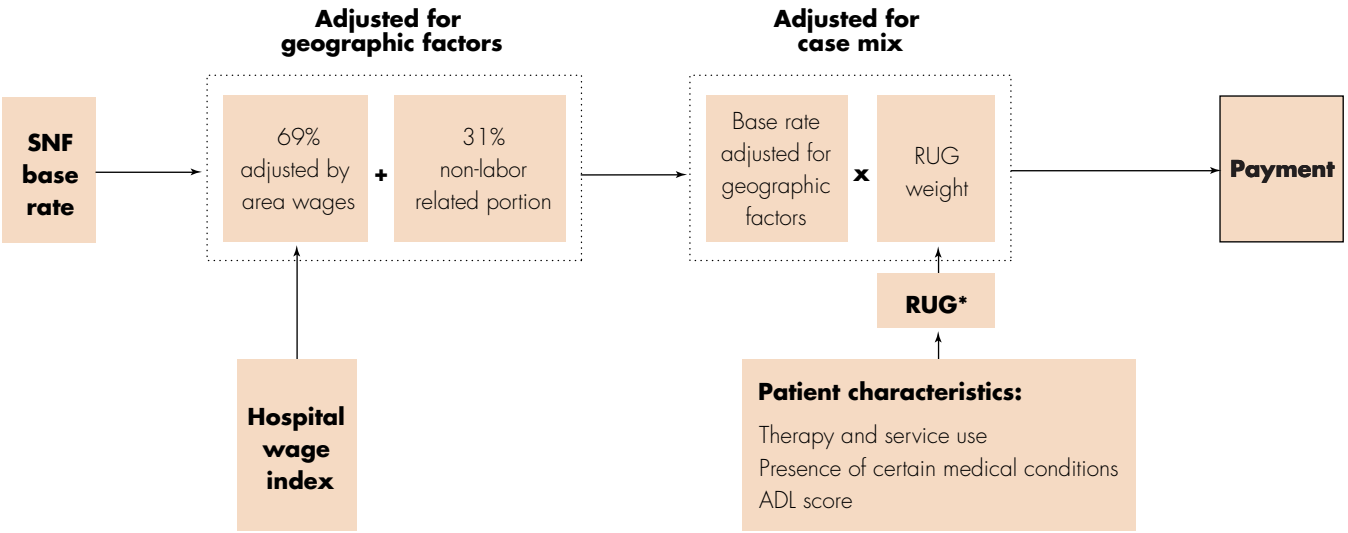
Figure 1 Skilled nursing facility services prospective payment system



Note: SNF (skilled nursing facility), RUG (resource utilization group), ADL (activity of daily living).
*See Figure 2 for more detail on case-mix adjustment.

for special care (such as patients who have chronic obstructive pulmonary disease); and 10 groups for clinically complex care (such as patients with pneumonia). Days classified into two broad groups—impaired cognition and reduced physical function, which account for 14 groups—are typically not covered by Medicare because the patient does not generally require skilled care. As shown in Figure 2, assignment of a beneficiary to one of the RUGs is based on the number of minutes of therapy (physical, occupational, or speech) that the patient has used or is expected to use; the need for certain services (e.g., respiratory therapy or specialized feeding); the presence of certain conditions (e.g., pneumonia or dehydration); and an index based on the patient's ability to perform independently four activities of daily living (eating, toileting, bed mobility, and transferring). Patients' characteristics and service use are determined by periodic assessments using the SNF patient assessment instrument, known as the Minimum Data Set.

The daily rate is the sum of three components:

- a nursing component, reflecting the intensity of nursing care patients are expected to require.

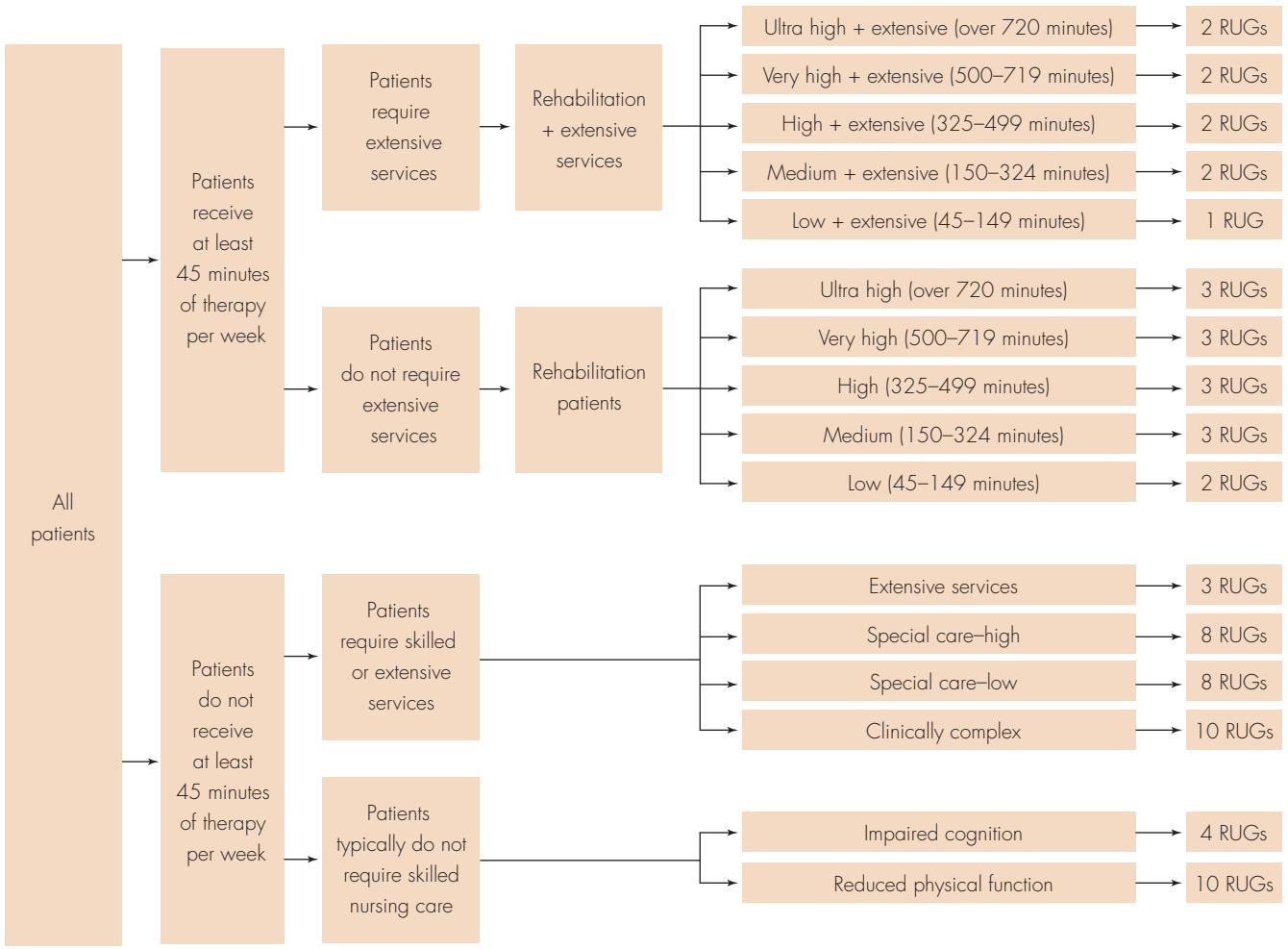
Table 1 Medicare daily base rates for fiscal year 2015

Rate component	Nursing	Therapy (for rehabilitation RUGs)	Therapy* (for nonrehabilitation RUGs)	Other*
Urban rate	$169.28	$127.51	$16.79	$86.39
Rural rate	161.72	147.02	17.94	87.99

Note: RUG (resource utilization group).
*Not case mix adjusted.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. CMS–1605–F. Medicare Program; Prospective payment systems and consolidated billing for skilled nursing facilities for fiscal year 2015. *Federal Register* 79, no. 150 (August 5): 45628–45659.

Figure 2 RUG–IV classification system



Note: RUG–IV (resource utilization group, version IV). Differences between RUGs are based on activity of daily living score, service use, and the presence of certain medical conditions. The extensive services category includes patients who receive tracheostomy care, ventilator or respirator services, or are in isolation for an active infectious disease while a resident. The special care–high category includes patients who are comatose; have quadriplegia, chronic obstructive pulmonary disease, septicemia, diabetes requiring daily injections, fever with specific other conditions; or require parenteral/intravenous feedings or respiratory therapy for 7 days. The special care–low includes patients with cerebral palsy, multiple sclerosis, Parkinson's disease, respiratory failure, a feeding tube, pressure ulcers of specific sizes, foot infections, or who receive radiation therapy or dialysis while a resident. Clinically complex category includes patients who have burns, septicemia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a resident.

Source: Figure adapted from Government Accountability Office. 2002. *Skilled nursing facilities: Providers have responded to Medicare payments systems by changing practices*, no. GAO–02–841. Washington, DC: GAO.

- a therapy component, reflecting the amount of therapy services provided or expected to be provided; and
- a non-case mix adjusted component reflecting the costs of room and board, linens, and administrative services.

The nursing component is case-mix adjusted for all RUGs. The therapy component is case-mix adjusted for rehabilitation RUGs and is a constant amount for nonrehabilitation RUGs. The payment for room and board is a constant amount for all RUGs. Medicare's daily base rates, unadjusted for case mix or wage differences, for fiscal year 2015 are shown in Table 1.

Starting October 1, 2004, SNFs receive a 128 percent increase in the Medicare PPS per diem payment for SNF patients with AIDS. This temporary add-on remains in effect until the Secretary certifies that the case-mix system makes appropriate adjustment for the costs of AIDS patients. ■

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

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

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

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