Order Code RS20386
Updated April 16, 2001

Medicare's Skilled Nursing Facility Benefit

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Summary

During much of the 1990s, skilled nursing facility (SNF) care under Medicare had been one of the program's fastest growing benefits, increasing from $2.5 billion in 1990 to $13.5 billion in 1998. In an effort to control this growth, Congress, in the Balanced Budget Act of 1997 (P.L. 105-33, BBA 97), established a prospective payment system (PPS) for SNF benefits. BBA 97 also enacted a consolidated billing system under which SNFs bill Medicare for *all* services provided to beneficiaries. As a result of several factors, including BBA 97 program changes, Medicare spending for SNF care dropped by an unexpected 12.6% in 1999. Some observers expressed concern that these reduced payment levels would lessen beneficiaries' access to care and suggested changes to the new payment system to assure access for certain patients with complex clinical problems requiring extensive services. The 1999 Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) included in the Consolidated Appropriations Act for 2000 (P.L. 106-113) increased payments under the SNF PPS for certain "high acuity" patients. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA, a part of the Consolidated Appropriations Act 2001, P.L. 106-554), enacted in December 2000 included additional payment liberalizations. This report provides background information on the Medicare SNF benefit. It will be updated as events and legislation warrant.

Background

Medicare covers nursing home services for beneficiaries who require additional skilled nursing care and rehabilitation services following a hospitalization. Financed under Part A of the program, these "extended care services," commonly known as skilled nursing facility (SNF) benefits, must be provided in a SNF certified to participate in Medicare. Coverage is provided for up to 100 days per spell of illness.[1] Beneficiaries pay nothing for

[1] A spell of illness is that period which begins when a beneficiary is furnished inpatient hospital or covered SNF care and ends when the beneficiary has not been an inpatient of a hospital or in a Part A covered SNF stay for 60 consecutive days. A beneficiary may have more than one spell of (continued...)

the first 20 days of care and are required to pay a daily copayment for days 21-100 ($99 in 2001).

To be eligible for Medicare coverage of SNF care, a beneficiary must have been an inpatient of a hospital for at least three consecutive days prior to being transferred to a SNF. Further, a physician must certify that the beneficiary needs daily skilled nursing care or other skilled rehabilitation services that are related to the hospitalization, and that these services, as a practical matter, can only be provided on an inpatient basis. A beneficiary released from the hospital after a stroke and in need of physical therapy or a beneficiary in need of skilled nursing care for wound treatment following a surgical procedure might be eligible for Medicare-covered SNF care.

Covered SNF services include the following: skilled nursing care provided by or under the supervision of a registered nurse; physical, occupational, or speech therapy; medical social services; drugs, biologicals, supplies, appliances, and other services ordinarily furnished by a SNF; and room and board.

Medicare spending for SNFs, which totaled less than $1 billion in 1988, increased dramatically beginning in 1989,[2] rising at an average annual rate of 21%, and reaching $13.0 billion in 1997. Spending in 1998 was $13.5 billion, an 3.8% increase over 1997. In 1999, spending fell to $11.8 billion, a decrease of 12.6%. In addition, the number of beneficiaries receiving SNF care increased to more than 400%, rising from 384,000 in 1988 to 1,630,000 in 1998.

Some factors contributing to growth in SNF spending and utilization include declining lengths of stay in hospitals, leading to increased admissions to SNFs, a higher level of care being provided by SNFs, and an increase in the number of participating facilities. Between 1989 and 1997, the number of SNFs participating in the program increased from 8,638 to 14,619.

Payment Issues

Concern over growth in SNF payments focused attention on the methods used by Medicare to pay for SNF care. Before passage of the Balanced Budget Act of 1997 (P.L. 105-33, BBA 97), Medicare reimbursed most SNF care on a retrospective, cost-based basis. This meant that SNFs billed Medicare *after services were delivered*, and Medicare reimbursed them for costs that were defined as reasonable by the program. Many argued that providers had few incentives to maximize efficiency and minimize their costs and little inducement to control either the amount or number of services they provided. As a result, SNF care became one of Medicare's fastest growing benefits.

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[1] (...continued)
illness per year.

[2] This rise in spending was due, in large part, to two events. First, in 1989 HCFA issued new coverage guidelines which standardized and clarified SNF eligibility criteria, eliminating regional inconsistencies in coverage. Second, the Medicare Catastrophic Coverage Act (MCCA, P.L. 100-360) eliminated the 3-day hospital stay requirement for SNF coverage. Although this requirement was reinstated the next year with the repeal of MCCA, studies suggest that the temporary expansion induced SNFs to accept more Medicare patients.

Balanced Budget Act of 1997.

Prospective Payment System. In BBA 97, Congress required the Health Care Financing Administration (HCFA) to establish a prospective payment system (PPS) for SNF care. This new system began with SNF's first cost-reporting period[3] starting on or after July 1, 1998. Prospective payment involves setting a rate or set of rates for a specific amount of services *before the services are provided.* Like other PPSs that pay health care providers on the basis of predetermined, fixed amounts, payments to SNFs are intended to reimburse the provider for its Medicare beneficiary costs *on average*. That is, although the payment is fixed, a facility's actual costs may be above or below that amount for an individual patient. The goal for the facility is to incur costs that, on average, over time, do not exceed the PPS average amounts.

Under the SNF PPS, a SNF receives a fixed payment for each Medicare-covered day a beneficiary spends in the facility. The amount of this federal per diem payment is based on the cost of SNF resources the patient is likely to use per day. Patients are classified into one of the 44 Resource Utilization Groups (RUGs). These RUGs account for the type and level of care needed by SNF patients and the relative amount of resources needed to provide a patient's care. For example, patients needing physical therapy use different kinds and amounts of resources from those needing skilled nursing care or intravenous feeding. The RUG system distinguishes these patients and payments for their care by assigning them to one of the 44 categories after an assessment of their condition and needs. These amounts are adjusted by a wage index to account for geographic variations in wages among urban and rural areas. The rates are updated annually using a SNF market basket index. For FY2001 and FY2002, the federal per diem rates were to be updated by the SNF market basket index, minus one percentage point. HCFA issued a final rule implementing the PPS on July 30, 1999 (64 *Federal Register* 41644-701).

Transition Period. BBA 97 provided that the federal per diem rate would apply immediately to all SNFs that received their first Medicare payment on or after October 1, 1995. For those that received their first Medicare payment *before* that date, a 3-year transition period (July 1998 to July 2001) was established. During the transition period, the PPS has two components: a federal PPS component under the RUG system and a "facility-specific" component computed separately for each SNF to reflect the facility's own average costs under the pre-PPS system. In the first year of the PPS, SNFs received a blend of 75% facility-specific rate and 25% federal rate. This proportion shifted by 25 percentage points each year of the transition until, beginning July 2001, the federal rate is the full payment.

Balanced Budget Refinement Act of 1999.

Payments to SNFs prior to passage of BBA 97 had been rising rapidly. For example, payment levels in 1996 were 20.2% higher than in 1995; in 1997 they were 17.1% higher than in 1996. However, in 1998, payment levels rose only 3.8%. The Congressional Budget Office (CBO) projected that payments would drop by 12.5% in 1999. A number of factors contributed to the reductions in Medicare spending for SNFs. These included improvements in the economy which led to lower inflation, resulting in lower payments to

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[3] A cost-reporting period is the equivalent of a fiscal year for the facility.

providers; and HCFA's heightened efforts to combat fraud and abuse, resulting in a reduction in incorrect payments.[4] Many in the SNF industry, however, said that the reductions indicated that changes made to Medicare's reimbursement policies were too drastic, causing financial problems for SNFs, and that they should be reexamined.

In addition, industry representatives and others (including the Medicare Payment Advisory Commission, MedPAC) were concerned that the PPS might not adequately reflect the costs of treating patients with clinically complex problems requiring skilled nursing care (high acuity patients), and those needing extensive ancillary *non-therapy* services, such as lab tests, drugs and biologicals, imaging services, and transportation. As required by BBA 97, ancillary services are included in the PPS reimbursement rate.

In response to these concerns, Congress enacted temporary payment increases for SNFs in the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) (a part of the Consolidated Appropriations Act for 2000, P.L. 106-113). The per diem payments to SNFs were temporarily[5] increased by 20% for 15 RUGs for patients categorized as needing extensive services, special care, clinically complex care, and certain high level and medium level rehabilitation services. BBRA also provided for a 4% increase in the federal per diem rate for SNF services for FY2001 and FY2002. This increase was not to be considered in the base amount used to compute updates to the federal per diem rate. BBRA also allowed SNFs to elect to opt out of the transition payment schedule and to receive Medicare payments based 100% on the federal per diem rate if it were more advantageous.

For certain hospital-based SNFs serving a large number of patients (at least 60%) who are immuno-compromised, a temporary (November 29, 1999, to September 30, 2001) payment adjustment was made. These facilities are computed as 50% on the facility-specific component and 50% of the federal per diem rate.

Benefits Improvement and Protection Act of 2000.

After enactment of BBRA, industry representatives continued to express concerns regarding Medicare payments. They said the daily rates were inadequate for items and services for certain high-cost patients. In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), part of the Consolidated Appropriations Act 2001 (P.L. 106-554), Congress included further refinements to the payment rates.

For FY2001 the law established a formula to update the payment rates by the full increase in the SNF market basket index. The update for FY2002 and FY2003 was set at the market basket index increase minus 0.5 percentage point. The General Accounting Office (GAO) is to submit a report by July 2002 on the adequacy of the SNF PPS, and the Secretary of Health and Human Services (HHS) is to study the current system for

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[4] For a complete discussion of this issue, see CRS Report RS20238, *Trends in Medicare Spending After the Balanced Budget Act*, by Hinda Ripps Chaikind.

[5] The increases are for services furnished from April 1, 2000, to the *later* of October 1, 2000, or the date the Secretary of Health and Human Services issues a revised RUG payment system. As of April 2001, the revisions have not be issued.

classifying SNF patients and to make any recommendations for alternatives by January 2005.

BIPA also made other adjustments to the PPS. Each RUG has components reflecting nursing care, therapy services, and other cost items. BIPA increased the nursing component of each RUG by 16.66% for SNF care furnished between April 1, 2001 and October 1, 2002. Certain RUG rates for SNF residents with "ultra high" and "high" rehabilitation therapy needs were increased by 6.7%. GAO is to conduct an audit of nurse staffing ratios in SNFs and recommend whether the 16.66% increase be continued.

Administrative Issues

In addition to issues with RUG payment levels, policymakers were also concerned about the ways the program paid providers of Part B-covered supplies and services for SNF patients. Part B services and supplies include physician services, therapy services performed by outside providers, outpatient hospital services, and durable medical equipment. Beneficiaries in a Part A-covered SNF stay and those whose stays do not qualify for Part A coverage[6] are entitled to the full range of services and supplies covered under Part B. Prior to BBA 97, Part B providers in many instances billed Medicare separately from the SNF for the services they administered to Medicare beneficiaries. This practice created opportunities for duplicate billing for the same services by both the SNF and the Part B provider.[7] Concern was also raised about the possibilities for billing fraud.

Consolidated Billing.

To address these concerns, Congress included a consolidated billing provision in BBA 97. Under this provision, the SNF is responsible for billing Medicare for *all* services (with certain exceptions) provided to its residents under both Parts A and B of the program. Although the SNF might provide these services under arrangements with outside providers, the outside provider must get its payment through the SNF rather than by billing Medicare directly. The provision covered all SNF residents regardless of whether their stay was covered under Part A.

BBA 97 excluded some services from the SNF consolidated billing requirement, including those provided by physicians and certain non-physician practitioners, and certain dialysis-related supplies. Regulations issued in 1999 listed additional exempted services, including hospice care related to a beneficiary's terminal illness. In addition, certain ambulance trips to and from SNFs were exempted. Providers of these services may directly bill their Medicare Part B carriers.

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[6] Most elderly residents in nursing homes do not qualify for Part A coverage. These include persons who have exhausted their Part A benefits, those who did not enter the SNF after a minimum three-day hospital stay, and those whose level of care needs do not qualify for Part A coverage. Many of these beneficiaries have chronic conditions that require long-term stays in nursing homes.

[7] For example, SNFs can contract with an outside agency to provide physical therapy services to residents. In some cases, both the SNF and the agency billed Medicare for the same provided services.

After passage of BBA 97, HCFA implemented regulations applying consolidated billing to patients in Part A- covered stays, but never issued them for patients whose stays were not covered by Part A. BIPA formally limited the provision to only those residents in Part A-covered stays and to therapy services for those whose stays are not covered by Part A.

Pass-through Payments.

SNF industry representatives expressed concern that some patients require unusually high-cost services that were not adequately compensated under PPS. In BBRA, Congress addressed these concerns by exempting from PPS certain costly items and services that are provided infrequently to SNF residents. These are certain chemotherapy drugs and services, ambulance transportation to and from a renal dialysis center, the use of certain radioisotope products, and certain customized prosthetic devices delivered to a SNF resident for use during and after the SNF stay. These items and services will be paid in amounts determined under Part B, but from Part A funds.

Swing Beds.

Certain rural hospitals with fewer than 100 beds may enter into "swing bed" agreements with HHS to use their beds to provide either acute inpatient hospital care or extended skilled nursing facility services. A certificate of need for providing long term care granted by the state health planning and development agency is required. For hospitals with more than 49 beds but fewer than 100, no more than 15% of the hospital's beds could be designated as swing beds. These hospitals were also required to transfer swing bed patients to beds in free-standing SNFs within their geographic region within 5 working days of such a bed's becoming available.

BBRA eliminated the certificate of need requirement, the limitation on the number of beds being designated as swing beds, and the transfer requirement.

Another category of small rural hospital is the critical access hospital (CAH). These are hospitals that have no more than 15 acute care inpatient beds and have a 96-hour length of stay limitation. These hospitals can also have swing beds. BIPA clarified that swing beds in CAHs are exempted from the SNF PPS and required that their SNF-covered services be paid on a reasonable cost basis.