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Medicare's Skilled Nursing Facility Payments

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Summary

Medicare covers skilled nursing facility (SNF) care following a beneficiary's discharge from a hospitalization of at least three days. If the beneficiary needs skilled care, Medicare will pay for up to 100 days of SNF care per "spell of illness."

Medicare pays for a relatively small proportion of nursing home care in the United States. In 2005, Medicare payments accounted for 16% of total national spending on this care. Medicaid, by comparison, accounted for 43%, and out-of-pocket expenditures accounted for about 26%.

Between 1999 and 2004, Medicare spending on SNF care almost tripled, increasing from almost $5.9 billion to $17.2 billion. Spending on SNF care also grew as a share of total Medicare spending, from 4.7% to 6.7% during this period.

Medicare pays SNFs using a prospective payment system (PPS). Under SNF PPS, Medicare makes a daily payment that varies depending upon the therapy, nursing, and special care needs of the beneficiary as described by one of 53 different payment groups, known as resource utilization groups (RUGs). Payments are updated annually by the SNF "market basket" increase (the measure of inflation of goods and services used by SNFs). For FY2007, the SNF payment update is the full market basket of 3.1 percentage points. Add-on payments are also made for care provided to persons who are HIV-positive or have Acquired Immune Deficiency Syndrome (AIDS).

A refined payment system was implemented through regulation on January 1, 2006. The refinements updated and recalibrated the RUGs and added nine new Rehabilitation plus Extensive Services groups into the RUG classification system. It is still too soon to know whether the refined case mix system is adequate or will warrant additional refinements.

The Medicare Payment Advisory Commission (MedPAC) recommends the elimination of a market basket increase for SNFs for FY2008. The President's budget proposal would also freeze SNF payments for FY2008, and would increase payments annually starting in FY2009 and beyond by the SNF market basket minus 0.65 percentage points. HHS projects the President's proposal would save Medicare $1.01 billion in FY2008 and $9.21 billion over the five-year budget period between FY2008 and FY2012. The Congressional Budget Office's (CBO) estimate of the President's budget proposal projects savings of $400 million in FY2008 and $4.2 billion between FY2007 through FY2012.

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Introduction

Medicare covers nursing home services for beneficiaries who require skilled nursing care and/or rehabilitation services following a hospitalization of at least three consecutive days. The program does not cover nursing care if only custodial care is needed — for example, when a person needs assistance with bathing, walking, or transferring from a bed to a chair. To be eligible for Medicare-covered skilled nursing facility (SNF) care, a physician must certify that the beneficiary needs daily skilled nursing care or other skilled rehabilitation services that are related to the hospitalization,[1] and that these services, as a practical matter, can be provided only on an inpatient basis. For example, 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.

SNF services may be offered in a free-standing or hospital-based facility. A freestanding facility is generally part of a nursing home that covers Medicare SNF services as well as long-term care[2] services for people who pay out-of-pocket, through Medicaid, and/or through a long-term care insurance policy. Generally, Medicare SNF patients make up just a small portion of the total resident population of a free-standing nursing home.

Some hospitals also offer SNF services[3] in addition to a broad range of acute and emergency care services. The majority of hospital-based providers have dedicated beds that they use only for SNF beneficiaries. Some small rural hospitals, however, are permitted to use their beds for either SNF care or acute care services, as needed. These are referred to as swing-beds and are authorized under section 1883 of the Social Security Act. (See **Figure 1**).

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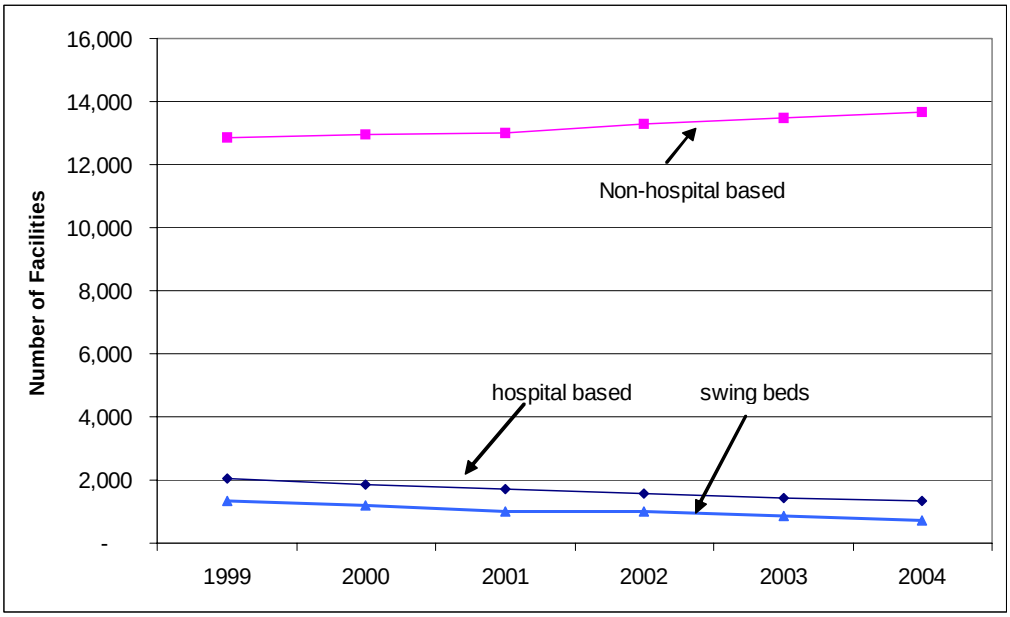
[1] Or that the condition started while the beneficiary was getting Medicare-covered SNF care.

[2] Long-term care refers to a wide range of supportive and health services for persons who have limited or no capacity for self-care due to illness, cognitive disorders, or a physically disabling condition. It differs from other types of care in that the goal of long-term care is not to cure an illness, but to allow an individual to attain or maintain an optimal level of functioning.

[3] The Medicare Payment Advisory Commission (MedPAC), "Skilled Nursing Facility Services," Section 4A, March 2006.

Figure 1. Number of SNF Providers by Type of Facility, 1999 to 2004



Source: Tables 43 of the *Annual Statistical Supplement* for years 2001, 2002, 2003, 2004, and 2005; and Table 6.7 of the *Annual Statistical Supplement* for 2006, Centers for Medicare and Medicaid Services.

In 2004, freestanding facilities covered 91% of SNF stays whereas hospital-based facilities covered 8.9% of SNF stays (4.78% of which were covered by swing bed facilities). In recent years, the number of freestanding nursing homes have increased slightly (from 12,868 facilities in 1999 to 13,648 facilities in 2004) while the number of hospital-based nursing homes (including swing bed facilities) have decreased slightly (from 3,336 facilities in 1999 to 2,055 in 2004). Also in 2004, 67% of SNF facilities were for-profits, 28% were nonprofit, and 5% were government run.[4]

Financed under Part A of Medicare, these "extended care services"[5] must be provided in a SNF that is certified to participate in Medicare. Medicare covers 100 days of SNF care in each "spell of illness."[6] Beneficiaries pay nothing for the first 20 days of care but are required to pay a daily copayment for days 21 through 100

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[4] MedPAC, *Report to Congress: Medicare Payment Policy*, Section 3A, March 2007.

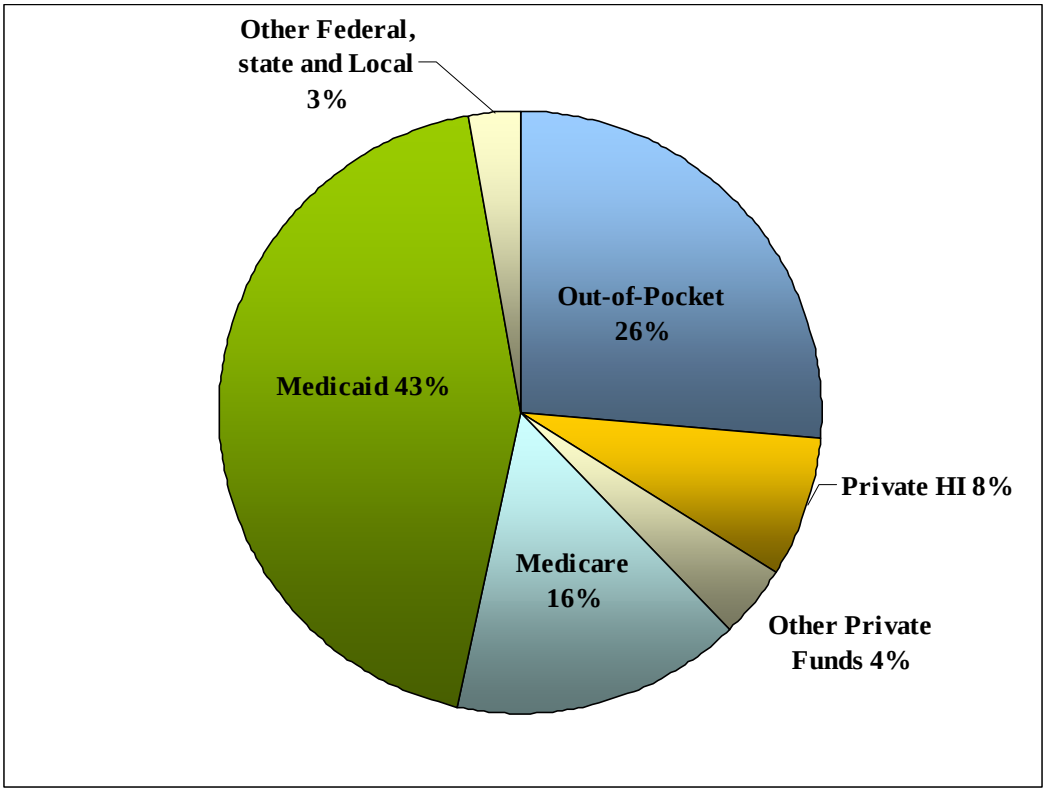
[5] Section 1812(a)(2)(A) of the Social Security Act defines the scope of the benefit, "post-hospital extended care services for up to 100 days during any spell of illness."

[6] A spell of illness begins when a beneficiary receives inpatient hospital or Part A covered SNF care and ends when the beneficiary has not been an inpatient of a hospital or in a covered SNF stay for 60 consecutive days (§ 1861(a) of the Social Security Act). A beneficiary may have more than one spell of illness per year.

($124 per day in 2007).[7] If a beneficiary exhausts his or her Medicare Part A SNF benefit, yet continues to need care in a nursing facility, Medicare pays for other covered medical services, such as physician visits or durable medical equipment, that may be provided in the nursing facility but cannot pay for the nursing facility care itself. Some of these Medicare beneficiaries may also be eligible for Medicaid which covers custodial nursing facility care for persons with long-term care needs, among other services. Some beneficiaries can be discharged to their homes and be eligible for Medicare-covered home health care or Medicaid-covered acute and/or long-term care services. Others may pay out-of-pocket for needed care not covered by Medicare.

Medicare pays for a relatively small proportion of nursing home care in the United States. In 2005, Medicare payments accounted for 16% of total national spending on this care. Medicaid, by comparison, accounted for 43%, and out-of-pocket expenditures accounted for about 26%[8] (see **Figure 2**).

Figure 2. National Nursing Home Expenditures, 2005



Source: CRS analysis of Centers for Medicare and Medicaid Services, Office of the Actuary.

[7] This co-payment is equivalent to one-eighth of inpatient hospital deductible amounts.

[8] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, U.S. Bureau of the Census.

Although SNF spending declined during the three-year transition period (1998-2000) between Medicare's cost-based reimbursement system and its prospective payment system (PPS), spending on SNF care across the longer period between 1994 and 2004 almost tripled, increasing from almost $5.9 billion in 1994 to $17.2 billion in 2004. Spending on SNF care also grew as a share of total Medicare spending ($255.3 billion in 2004), from 4.7% to 6.7% during this period.

Between 1994 and 1998, prior to the implementation of PPS, average annual spending increased by 17%. Between 2000 and 2004, after the transition to PPS, spending growth slowed to an average annual rate of 13%. The average annual growth rate of SNF care is greater than Medicare's average annual growth rate as a whole (13% versus 10% from 2000-2004). The number of days covered by SNF care also grew between 1994 and 2004 — from 36.1 million days to 62.3 million days. (Data are not available to show the amount of funds paid to SNFs for care provided for the managed care enrollees.[9]) See **Table 1** and **Figure 3** for more detail.

Table 1. Skilled Nursing Facility Payments, Days Covered by Medicare, Calendar Years 1994-2004

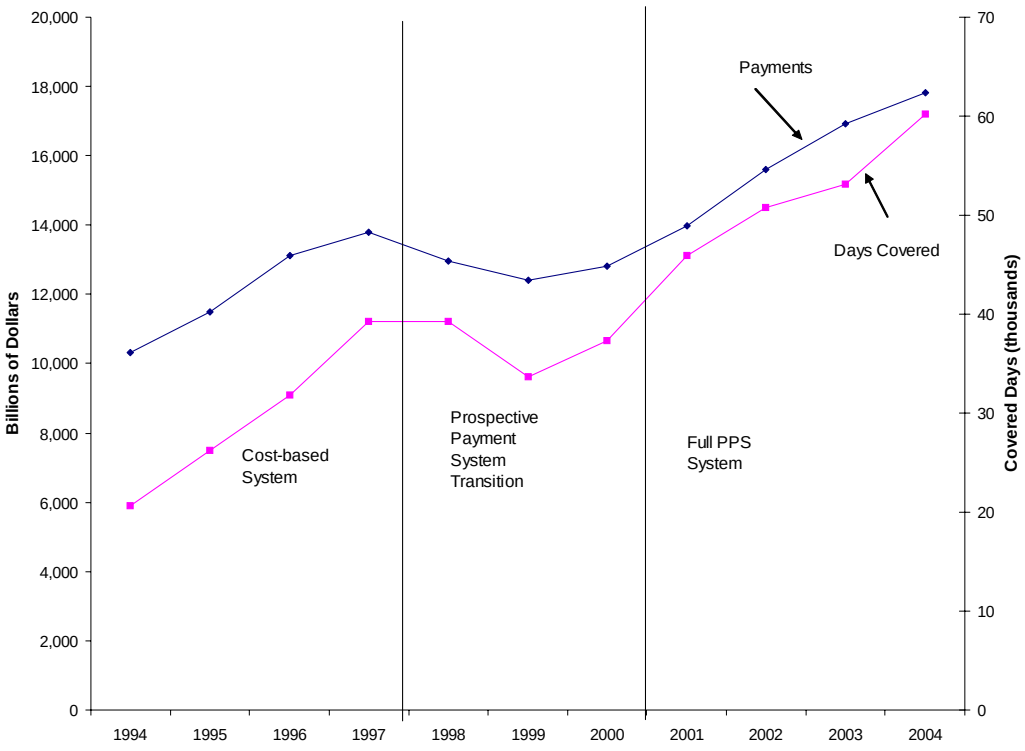
Year	Payments (millions)	Percent change	Covered days (thousands)	Percent change	Total Medicare payments (millions)	SNF as a % of Medicare payments
1994	5,904	—	36,091	—	147,106	—
1995	7,495	26.9%	40,182	11.3%	158,980	4.7%
1996	9,095	21.3%	45,883	14.2%	167,063	5.4%
1997	11,199	23.1%	48,239	5.1%	175,423	6.4%
1998	11,224	0.2%	45,429	-5.8%	168,164	6.7%
1999	9.617	-14.3%	43,397	-4.5%	166,687	5.8%
2000	10,651	10.8%	44,834	3.3%	174,261	6.1%
2001	13,105	23.0%	48,974	9.2%	197,505	6.6%
2002	14,503	10.7%	54,674	11.6%	215,411	6.7%
2003	15,172	4.6%	59,240	8.4%	232,821	6.5%
2004	17,213	13.5%	62,263	5.1%	255,325	6.7%
Average annual percent change:						
1994-1998 (pre-PPS)		17%		6%		
1998-2000 (PPS transition)		-3%		-1%		
2000-2004 (Post-PPS)		13%		9%		

Source: CRS analysis of Table 6.1 of Medicare and Medicaid *Annual Statistical Supplement* 2006.

Note: Payments represent fee-for-service only and exclude amounts paid for managed care services. Numbers have been rounded.

[9] Data only reflect spending for Medicare fee-for-service service and would not reflect spending on SNF services made by plans for managed care enrollees.

Figure 3. SNF Payments and Covered Days, 1994-2004



Source: CRS analysis of Table 6.1 of the Medicare and Medicaid *Annual Statistical Supplement* 2006.

In 2003, about 2.4 million Medicare beneficiaries used SNF care. Utilization of SNF care increased by 33% between 1999 and 2003, while days per admission remained relatively stable, growing by 5.5% between this period (average annual increase was 1%) (See **Table 2).**

Table 2. Utilization of SNF Benefit, 1999-2003

	1999	2000	2001	2002	2003
Number of admissions (thousands)	1,796	1,824	1,950	2,223	2,385
Days per admission	23.6	24	24.6	24.6	24.9

Source: SNF Medicare Provider Analysis and Review stay records from CMS, Office of Research, Development and Information.

SNF Payment

The rapid growth of Medicare payments to SNFs during the 1990s focused Congressional attention on the payment system. From the inception of the Medicare program in 1966, SNFs were paid using "reasonable cost reimbursement." In other words, Medicare paid SNFs their actual costs of delivering care to Medicare beneficiaries. Thus SNFs had few incentives to control costs — a system that many regarded as inherently inflationary. Although there were limits on "routine service costs"[10] there were no limits on "ancillary costs"[11] which the General Accountability Office (GAO) and others noted helped fuel the large increases in SNF costs in the early 1990s.[12]

In response to escalating SNF spending, Congress enacted a number of provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) to control growth in this benefit. Chief among these provisions was the requirement to implement a prospective payment system (PPS) for SNFs being paid through the fee-for-service delivery system. SNF payments made by Medicare Advantage for managed care enrollees are paid based on the terms negotiated between the Medicare advantage plan and the particular provider, and are not necessarily paid using the SNF PPS system.

SNF PPS

In the BBA 97, Congress required the Secretary of Health and Human Services to establish a PPS for SNF care beginning July 1, 1998. The new payment system was implemented on a staggered basis — beginning with the start of each SNF cost-reporting period[13] on or after July 1, 1998 — and phased in over three years.[14] Under the SNF PPS, a SNF receives a daily payment that covers all the services provided that day, including room and board, nursing, therapy, and drugs, as well as an estimate of capital-related costs.[15] Any profits are retained by the SNF, and any losses must be absorbed by the SNF, thereby providing an incentive to deliver services as efficiently as possible.

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[10] Routine service costs included costs of regular room, dietary, nursing services, minor medical supplies, medical social services, psychiatric social services, and use of certain facilities and equipment for which a separate charge is not made.

[11] Ancillary costs are costs for specialized services, such as therapy, drugs, and laboratory services, that are directly identifiable with individual patients.

[12] "Between 1992 and 1995, daily ancillary costs grew 18.5% a year, compared to 6.4% for routine service costs." Testimony of William J. Scanlon, Sept. 15, 1999, before the House Committee on Commerce, Subcommittee on Health and the Environment.

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

[14] Payments for care provided through Critical Access Hospital (CAHs) are made on a reasonable cost-basis and not through the SNF PPS system.

[15] Some care costs are paid separately under the statute such as physician visits and dialysis.

Base Payment

The daily base payment is based on 1995 costs that have been increased for inflation and vary by urban or rural location. This "federal per diem rate" is adjusted for treatment type and care needs of the beneficiary based on the resource utilization group (RUG) assignment of the beneficiary. The beneficiary is classified into one of 53 RUG categories. Each RUG represents a payment adjusted for case mix and is composed of three parts. For RUGs used to pay for the care of patients who require intensive therapy, the three parts include (a) a nursing component; (b) a variable therapy component; and (c) a non-case mix adjusted flat rate component. For RUGs used to pay for the care of patients who do not require intensive therapy, the three components are: (a) a nursing component; (b) a flat therapy component; and (c) a non-case mix adjusted flat rate component. For 2007, the per diem base amounts range from $583.10 to $157.60 for urban facilities, and from $609.24 to $156.70 for rural facilities. Patient assessments are done at various times during a patient's stay[16] and the RUG category in which a patient is placed can change with changes to the patient's condition.

Wage and Other Adjustments

A portion of these daily payments is further adjusted for variations in area wages, using the hospital wage index, to account for geographic variation in wages. Seventy-six percent of the per diem amount will be adjusted by a budget neutral wage index.

SNF per diem PPS payments are also adjusted to include a temporary 128% increase for any SNF resident who are HIV-positive or have Acquired Immune Deficiency Syndrome (AIDS; see later section of this report). Unlike other PPSs, the SNF PPS statute does not provide for an adjustment for extraordinarily costly cases (an "outlier" adjustment).

Payment Updates

Section 1888(e) of the Social Security Act requires that the base payments be adjusted each year by the SNF market basket update — that is the measure of inflation of goods and services used by SNFs. For FY2007, the SNF payment update is the full market basket increase of 3.1%. The update for future years, without changes to current law, is also the full market basket increase.

Each year, the update of the payment rate also includes, as appropriate, an adjustment to account for the market basket forecast error for previous years. This adjustment accounts for the most recently available fiscal year for which there are final data and applies whenever the difference between the forecasted and actual change in the market basket exceeds 0.25 percentage points. For FY2005 (the most recently available data), the estimated increase in the market basket was 2.8 percentage points, while the actual increase was 2.9 percentage points, resulting in

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[16] SNFs use an assessment tool, called the Minimum Data Set (MDS), to evaluate and record the health status and functional capabilities of residents in nursing homes.

only a 0.1 percentage point difference. As a result, the payment rates for FY2007 did not include a forecast error adjustment.

Legislative History

On several occasions, payment rates for SNFs have also been affected by specific legislative provisions. A summary of the more recent legislative changes follows.

In response to concerns raised by the nursing home industry regarding adequacy of SNF PPS payments, temporary payment increases were provided in the Balanced Budget Refinement Act of 1999 (BBRA 99, **P.L. 106-113**) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000, **P.L. 106-554**).

Two of the three temporary increases expired September 30, 2002. One, from BBRA 99, increased the SNF base rates 4% for FY2001 and FY2002. The second, from BIPA 2000, was a 16.6% increase in the nursing component of the payment rate from April 1, 2001 until September 30, 2002. The dollar value of these two temporary increases was $1.4 billion in 2002.[17] (The expiration of these add-ons has been dubbed by some in the industry as the SNF "cliffs.")

The third temporary increase, from BBRA 99 (as amended by BIPA 2000), increased payment rates by 6.7% for 14 RUG groups for persons needing rehabilitation therapies and by 20% for 12 RUG groups for certain patients needing complex care. These add-ons were intended to correct for a distortion in the payment system for rehabilitation therapy which had been paying by the number of minutes of therapy rather than by the patients' clinical characteristics, the costs of providing nontherapy ancillary services (e.g., prescription drugs), and the relative weights of basing payments on old data.[18] The add-ons expired with the implementation of the refinements to the case-mix classification system on January 1, 2006.[19]

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (**P.L. 108-173**) provided for a temporary 128% increase in the PPS per diem payment for any SNF resident who is HIV-positive or has Acquired Immune Deficiency Syndrome (AIDS), effective October 1, 2004, and intended to remain in effect only until the Secretary certified that there is an appropriate adjustment in the case mix to compensate for the increased costs associated with such residents. In the CMS Notice (71 FR 43158-43198, July 31, 2006), the Secretary did not address certification of the AIDS add-on with the implementation of the case-mix refinements, thus allowing the temporary add-on payments to continue through FY2007 and beyond.

Medicare pays the costs of certain items on a reasonable cost basis (outside of the applicable SNF PPS system), including unpaid debt for beneficiaries' coinsurance

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[17] 67 *Federal Register* 49817, July 31, 2002.

[18] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2004.

[19] Described in the Final Rule 70 FR 45028, Aug. 5, 2005.

and deductible amounts. Historically, CMS reimbursed certain providers for 100% of the debt. The Deficit Reduction Act of 2005 (**P.L. 109-171**) reduced Medicare payments to SNFs for allowable bad debts to 70% for beneficiaries who are not eligible for both Medicare and Medicaid. Medicare's payments for allowable bad debts attributed to dual eligible beneficiaries would remain at 100%.

MedPAC recommends the elimination of a market basket increase for SNFs for FY2008. The President's budget proposal would also freeze SNF payments for FY2008, and would increase payments annually starting in FY2009 and beyond by the SNF market basket minus 0.65 percentage points. HHS projects the President's proposal would save Medicare $1.01 billion in FY2008 and $9.21 billion over the five-year budget period between FY2008 and FY2012. The Congressional Budget Office's (CBO) estimate of the President's budget proposal projects savings of $400 million in FY2008 and $4.2 billion from FY2007 through FY20012.

Current Issues

RUGs Refinement

Since the inception of SNF PPS, the Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare within the Department of Health and Human Services, has been conducting research on refinements to the RUGs to ensure adequacy of payments. In April 2000 the Secretary proposed refining the RUGs by adding payment categories to better compensate SNFs for providing care to medically complex patients as well as to better account for the "non-therapy ancillary service" costs (such as prescription drugs and respiratory therapy). However, the proposal was withdrawn when, upon further analysis, CMS determined that the existing RUGs did a better job than the proposed ones in describing differences in patient resource use. Later that year, BIPA 2000 required the Secretary to study different systems for categorizing SNF patients and to report to Congress by January 1, 2005 with the results and any recommendations for changing the SNF PPS statute.

Reports published in 2002 and 2003 by the GAO and MedPAC further emphasized the importance of refining the PPS RUG system. Both reports raised concerns that payment rates for certain types of patients were not adequate because the patient classification system did not sufficiently account for the different care needs of patients. They also noted that the therapy RUGs were paid at levels that far exceed costs and were thus highly profitable for certain providers.[20] Refining the RUGs so that payments are better aligned with the actual resources used in caring for patients, they asserted, would eliminate incentives to care for one kind of patient over another.

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[20] U.S. General Accounting Office, *Skilled Nursing Facilities: Providers Have Responded to Medicare Payment System by Changing Practices*, GAO-02-841 (Washington, DC, August 2002); Medicare Payment Assessment Commission, *Report to the Congress: Medicare Payment Policy*, (Washington, DC, March 2003).

In May 19, 2005 (70 FR 29070), the Secretary issued a proposed rule which was finalized on August 4, 2005 (42 CFR Parts 409, 411, 424, and 489).This rule laid out refinements to the SNF PPS. The refinements updated and recalibrated the therapy and nursing case-mix indices associated with all of the RUGs and added nine new Rehabilitation plus Extensive Services groups into the RUG classification system (increasing the number of RUGs from 44 to 53). The final rule also authorized the incorporation of the Office of Management and Budget's revised definitions for Metropolitan Statistical Areas and Combined Statistical Areas used to distinguish payment adjustments for SNFs located in urban and rural areas. The refined RUG system became effective on January 1, 2006. It is still too soon to know whether the refined case mix system is adequate or will warrant additional refinements.

Spending

The PPS system was intended to help control spending on SNF care and since its application the spending growth rate has slowed (from a 17% average annual growth rate between 1994 and 1998, pre-PPS, to a 13% average annual growth rate between 2000 and 2004, post-PPS). However, spending on SNF care continues to increase.

Such expenditure growth may, in part, be attributable to growth in the number of SNF admissions as well as growth in number of SNF days. Between 1999 and 2003, the number of admissions increased from 1.8 million in 1999 to 2.4 million in 2003. This represents an average annual increase of 7%, exceeding the growth rate in the Medicare population during that period (i.e. 1.2% for Part A).[21]

Spending growth may also be attributable to recent changes in the the RUG classification system. Since the refinement of the payment system, MedPAC has seen a shift in the utilization of the higher rehabilitation case-mix groups, each of which is also attached to higher payment rate. As a result, the program is now paying for more therapy and less for nursing and other items, relative to prior years.[22]

Supply

One indicator of payment adequacy is provider supply. The number of SNF providers nationwide remained relatively steady between 1999 and 2004. MedPAC reports that freestanding SNFs grew an average of 3.7% annually between 2000 and 2004. It also reports that for-profit facilities had a lower average annual growth rate (3.5%) than non-profit providers (4.4 %).

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[21] edPAC, "A Data Book: Healthcare Spending and the Medicare Program: Section 9, Post-Acute Care," June 2006 and MedPAC, *Report to Congress: Medicare Payment Policy*, Section 3A, March 2007.

[22] This shift may be a result of a changing Medicare population. *MedPAC, Report to Congress: Medicare Payment Policy*, Section 3A, March 2007.

Medicare Margins

MedPAC also projects that the Medicare margins, a measure of the difference between estimated costs and SNF expenditures, for freestanding SNFs will be 11% in 2007, accounting for the full MB update scheduled in Medicare law. Significant variation exists across facilities, with one-quarter of all freestanding SNFs having margins at or below 4.7%, two-quarters (or half) having margins of at least 15.5%, and almost one quarter having margins of almost 25%.[23] MedPAC also explains that margins vary by facility type, with for-profit facilities earning much larger margins (18%), while non-profit facilities earn much smaller margins (9%). Further, margins are higher in rural facilities than they are in urban facilities.

Access

The Office of Inspector General (OIG) of the Department of Health and Human Services conducted a 2004 study to investigate whether Medicare beneficiaries have adequate access to needed SNF care upon discharge from a hospital, among other questions. Through interviews with discharge planners, persons responsible for conducting patient assessments prior to hospital discharge and assisting with post-hospital placement when necessary, the OIG found that 84% of discharge planners reported that they are able to place all of their Medicare beneficiaries who need care in a SNF (For a 2001 survey, 73% of discharge planners reported successful placements).

OIG also reported that it did not find a large (i.e., greater than 1%) change since its 2001 study in access to care among those beneficiaries in nine out of the 10 most common diagnostic groups and eight out of 10 of the most common RUG payment groups. However, ninety-one percent of responders reported that beneficiaries with certain conditions experienced more delays. These patients required intravenous antibiotics and/or expensive drugs, wound care, ventilator, or dialysis, or patients having behavioral problems. The survey responders suggested that among the explanations for these delays are the difficulties SNFs sometimes have in providing the appropriate level and/or type of care to certain patients. They also suggested that SNF reimbursement for intravenous antibiotics, and payment for expensive drugs or dialysis were inadequate, and that SNFs may not have the necessary equipment or appropriately trained staff to care for certain patients.[24]

Acute Care Versus Long-Term Care

Since the program's inception in 1965, Medicare has delivered acute care services to the elderly and certain persons under age 65 who have disabilities.[25] The

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[23] MedPAC, *Report to Congress: Medicare Payment Policy*, Section 3A, March 2007.

[24] Office of Inspector General, Department of Health and Human Services, "Medicare Beneficiary Access to Skilled Nursing Facilities: 2004," OEI-02-04-00270, July 2006.

[25] Medicare was enacted in 1965 (P.L. 89-97) in response to the concern that only about half of the nation's seniors had health insurance, and most of those only had coverage for inpatient hospital costs. The new program, which became effective July 1, 1966, included

(continued...)

program was established to respond to the need for assistance in paying for hospital and post-hospital care among the elderly and certain persons with disabilities. At that time, life expectancy among the elderly and persons with disabilities was lower than it is today and the demand for long-term care services on a widespread basis was far less pressing.

In the more than 40 years since the program was established, demographic changes and advances in medical technology are just some of the factors that have contributed to a longer life span for both populations and a greater demand for long-term care services, including custodial nursing home care.

As a post-hospitalization benefit, covering no greater than 100 days of skilled nursing home care, Medicare's SNF benefit does not cover long-term custodial care and is thus not considered a long-term care benefit. However, since long-term custodial stays in nursing home or in community-based settings are often triggered by acute care episodes and hospitalizations (e.g., strokes or falls), Medicare's SNF coverage does play a significant role on the continuum of care for persons transitioning between a higher level of independence and the need for assistance with self-care.

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[25] (...continued)
coverage for hospital and post-hospital services under Part A and doctors and other medical services under Part B.