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Medicare Skilled Nursing Facility (SNF) Payments

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Summary

A Medicare skilled nursing facility (SNF) is an institution, or distinct part of an institution (e.g., building, floor, wing), that provides post-acute skilled nursing care and/or skilled rehabilitation services, has in effect a written agreement to transfer patients between one or more hospitals and the SNF, and is certified by Medicare. In general, *skilled* nursing and rehabilitative care are services ordered by a physician that require the skills of professional personnel (e.g., registered nurse, physical therapist) and are provided under the supervision of such personnel. Over 95% of SNFs are within long-term care facilities (or nursing homes).

A Medicare beneficiary is entitled to 100 days of SNF care for each Medicare-covered SNF stay. To be eligible for SNF coverage, a Medicare beneficiary must have been an inpatient of a hospital for at least 3 consecutive calendar days and transferred to a participating SNF usually within 30 days after discharge from the hospital. Beneficiaries must also receive treatment at the SNF for a condition they were receiving treatment for during their qualifying hospital stay (or for an additional condition that arose while in the SNF). For beneficiaries who meet these requirements, Medicare Part A may provide up to 100 days of coverage for the SNF stay.

Under Medicare Part A, SNFs are reimbursed under a prospective payment system (PPS), which began on July 1, 1998. The SNF PPS provides payment for bed and board, nursing care, therapy services, drugs, durable medical equipment, and certain ancillary services under a bundled per diem "per day" reimbursement amount, rather than Medicare paying for each item or service individually. For the first 20 days of SNF coverage, Medicare beneficiaries have no copayment. Medicare beneficiaries have a daily SNF copayment for the 21st through the 100th day indexed annually at one-eighth (12.5%) of the current Part A deductible. For 2016, the daily copayment is $161.

This report describes in further detail the Medicare SNF benefit and its resident population, covered SNF services and providers, and the SNF PPS. In addition, this report describes the Skilled Nursing Facility Value-Based Purchasing Program—a quality-based payment policy change included in the Protecting Access to Medicare Patients Act (PAMA; P.L. 113-93)—and other post-acute care reform efforts.

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Medicare provides coverage for certain post-acute care services—health care following an inpatient acute-care hospitalization.[1] Post-acute care can include services at other types of hospitals, such as long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), as well as home health care and outpatient care. Post-acute care also includes skilled nursing facility (SNF) care—the most common source of post-acute care for beneficiaries.[2] In 2014, Medicare fee-for-service (FFS) spending for SNF care totaled $28.6 billion.[3] SNF services include skilled nursing; bed and board; and physical, occupational, and speech and language therapies. The following sections provide greater detail on Medicare SNF eligibility, SNF services, and the SNF prospective payment system (PPS).

Eligibility for SNF Care

To be eligible to receive Medicare Part A SNF coverage, a beneficiary must have had an inpatient hospital stay of at least 3 consecutive calendar days (not including the day of discharge) and must be transferred to a participating SNF, usually within 30 days after discharge from the hospital.[4] In addition, Medicare requires SNFs to provide services for a condition the beneficiary was receiving treatment for during his or her qualifying hospital stay (or for an additional condition that arose while in the SNF).[5] The treatment must require reasonable and necessary skilled nursing care or skilled rehabilitation services on a daily basis. Additionally, a limited number of services (e.g., rehabilitation services) may be reimbursed under Medicare Part B for non-covered SNF stays, such as SNF stays of beneficiaries that have not met the three-day inpatient hospital stay requirement. For more information and recent developments on this requirement, see CRS Report R44512, *Medicare's Skilled Nursing Facility (SNF) Three-Day Inpatient Stay Requirement: In Brief*.

Overall, SNFs provide care to Medicare beneficiaries to treat a number of different diagnoses and conditions. Some of the more frequent hospital conditions of patients referred to SNFs for post-acute care are joint replacement, septicemia, kidney and urinary tract infections, hip and femur procedures not related to joint replacement, pneumonia, and heart failure.[6]

Covered SNF Services and Providers

A Medicare beneficiary who qualifies for SNF coverage is entitled to up to 100 days of covered SNF care per spell of illness.[7] Part A provides payment for daily skilled nursing, daily skilled rehabilitation, medical social services, drugs/biologicals, durable medical equipment, and bed and

[1] For more information on the Medicare program, see CRS Report R40425, *Medicare Primer*.

[2] Barbara Gage et al., *Examining Post Acute Care Relationships in an Integrated Hospital System*, RTI International, February 2009, pp. 3-37.

[3] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2016, p. 175, at http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf?sfvrsn=0.

[4] 42 U.S.C. §1395x(i).

[5] For more information, see Centers for Medicare & Medicaid Services (CMS), *Medicare Benefit Policy Manual*, October 16, 2015, §20.1, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf.

[6] Ibid., p. 180.

[7] A spell of illness, also referred to as the *benefit period*, begins when a beneficiary is admitted for inpatient hospital services and ends after 60 consecutive days when the beneficiary was neither an inpatient of a hospital nor a resident of an SNF. See §1861(a) of the Social Security Act.

board when receiving such services, among other benefits. In general, nursing and rehabilitation services can be labeled *skilled* if they (1) require the skills of a health professional (e.g., registered nurse, physical therapist) and (2) are provided by or under the supervision of such personnel.[8]

Two examples of services that are both skilled nursing and skilled rehabilitation services are

- management and evaluation of the patient's plan of care, and
- observation and assessment of the patient.

A few examples of skilled nursing services are

- intravenous injections,
- administration and replacement of catheters,
- administration of prescription medications, and
- supervision of bowel and bladder training programs.

Some examples of skilled rehabilitation services are

- continuing assessments of a patient's rehabilitation needs,
- therapeutic exercises, and
- range-of-motion exercises.

SNFs are more commonly found within urban areas and within long-term care nursing facilities (referred to as *freestanding SNFs*). Of the 15,005 SNFs that furnished covered SNF care in 2014, roughly 95% were freestanding.[9] The remaining 5% of SNFs were located in hospitals (referred to as *hospital-based SNFs*). Additionally, approximately 70% of SNFs are for-profit facilities, 24% are nonprofit facilities, and 5% are government-owned facilities.[10]

SNF Prospective Payment System

The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) required most SNFs to be reimbursed under a prospective payment system (PPS) beginning on July 1, 1998.[11] The SNF PPS reimburses providers a daily per diem amount after adjusting for urban or rural facility locale, case mix, and area wage differences (see **Figure 1**).[12] Beginning April 1, 2013, through March 31, 2026,

[8] For more information, see CMS, *Medicare Benefit Policy Manual*, October 16, 2015, §30.2.1, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf.

[9] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2016, p. 179, at http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf?sfvrsn=0.

[10] Ibid. Total may not sum to 100% due to rounding.

[11] The SNF PPS pricing method replaced the cost-based system for SNF services, which had been in use since the inception of SNF coverage in the Medicare program. The prior "reasonable cost reimbursement" method paid SNFs their actual costs of delivering care to Medicare beneficiaries subject to certain limitations. Under the reasonable cost method, SNFs had few incentives to control costs, which was one factor leading in the development of a new SNF payment system.

[12] For more information on FY2016 SNF PPS reimbursement rates, see CMS, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection," 80 *Federal Register* 46389, August 4, 2015.

Medicare payments to SNFs will be reduced by 2% as a result of automatic spending reductions (*sequestration*).[13]

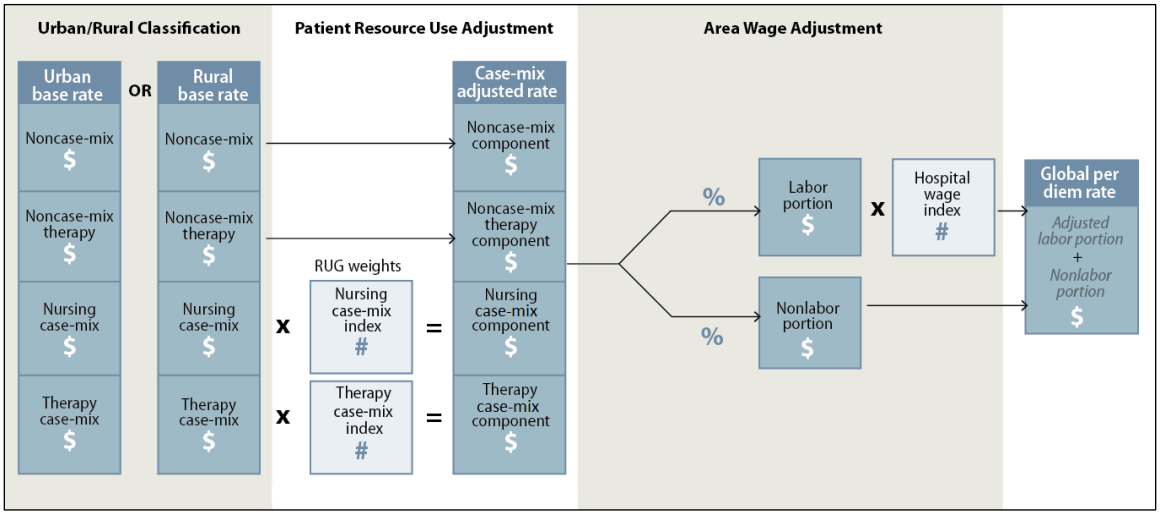
The SNF PPS covers most costs of furnishing SNF services to Medicare beneficiaries (routine, ancillary, and capital-related costs).[14] To be reimbursed under the SNF PPS, Medicare requires SNFs to use consolidated billing practices. Under consolidated billing, the SNF bills Part A for most of the SNF services the Medicare beneficiaries receive, regardless of whether the service was provided by an outside contractor (e.g., physical therapist contractor) or by SNF personnel.

In certain circumstances, consolidated billing does not apply and/or SNF services provided to the beneficiary are not billable to Part A. For instance, if an SNF resident were to exhaust his or her Part A benefits, coverage for some services, such as rehabilitation services, would still be provided under Part B for a beneficiary enrolled in Part B. Additionally, certain services are not reimbursed under the SNF PPS and may be separately billed to Part B.

For the first 20 days of a Medicare-covered SNF stay, no beneficiary copayment is required. For the 21st through the 100th day, a daily copayment, indexed annually at one-eighth (12.5%) of the current Part A inpatient hospital deductible, is required. The copayment is not adjusted geographically or based on the amount of Medicare SNF reimbursement. In 2016, the daily SNF copayment is $161.[15]

The following sections explain in greater detail the SNF PPS formula depicted in **Figure 1**, including the calculation of and update to (1) urban and rural base rates, (2) the case-mix classification system—Resource Utilization Groups (RUGs)—and (3) the wage index that is used to adjust payments for differences in area wages.

Figure 1. SNF Prospective Payment System Formula



Source: CRS graphic of the skilled nursing facility (SNF) prospective payment system (PPS) formula.

[13] The failure of the Joint Select Committee on Deficit Reduction to propose budget reduction legislation by its deadline, mandated by the Budget Control Act of 2011 (P.L. 112-25), triggered "sequestration." Most recently, the Bipartisan Budget Act of 2015 (P.L. 114-74) extended sequestration an additional year—through FY2025.

[14] For critical access hospitals (rural hospitals with no more than 25 inpatient beds) operating swing-bed SNFs (facility beds approved both for hospital and SNF patients), the SNF PPS does not apply, and the hospitals are instead reimbursed 101% of the reasonable costs for providing SNF care.

[15] For certain low-reimbursement SNF care in low-wage areas, Medicare may not contribute any payment because the required daily copayment exceeds the daily Medicare SNF reimbursement.

Note: The case-mix adjusted rate for each resource utilization group (RUG) is calculated as the sum of (1) a noncase-mix component, (2) a nursing case-mix component, and (3) either a noncase-mix therapy component or a therapy case-mix component.

Urban and Rural Base Rates

The urban and rural base rates are the daily SNF reimbursement rates before any adjustments. Determination between an urban or rural base rate depends on whether the SNF is located within a core-based statistical area (CBSA). For SNF billing purposes, providers within CBSAs are reimbursed at an urban rate, while providers outside of CBSAs are reimbursed at a statewide rural rate.[16]

As shown in the left portion of **Figure 1**, the urban and rural base rates are broken down into four separate components: noncase-mix, noncase-mix therapy, nursing case-mix, and therapy case-mix. The noncase-mix component reflects the administrative and room-and-board costs of providing SNF care, whereas the noncase-mix therapy component reflects the costs for minimal therapy use (e.g., rehabilitation evaluations). The base rate's nursing and therapy case-mix components respectively reflect the national average costs of nursing and more intensive therapy for a one-day stay in an SNF. Breaking down the base rate into four rate components allows the PPS to adjust the base rate by RUGs, which classify beneficiaries by varying levels of expected nursing and therapy intensity. Every RUG has a noncase-mix component and nursing case-mix component and either a noncase-mix therapy component or therapy case-mix component.

The base rates were developed from FY1995 SNF cost reports and are updated annually for inflation by the percentage change in the SNF market basket index.[17] The SNF market basket index is a composite of weighted price levels, based on FY2010 prices, which are estimated to capture an accurate picture of an average SNF provider's total costs. The change in the SNF market basket index from the prior year is referred to as the market basket update and is provided by IHS Global Insight, Inc. In the event actual cost report data shows the percentage change in SNF costs to be at least ½ percentage point greater than the market basket update, the base rate will receive an additional *forecast error correction* for the difference the following fiscal year.[18] In addition to any forecast error correction, as required by the Patient Protection and Affordable Care Act of 2010 (ACA, as amended; P.L. 111-148), the market basket update is offset by a productivity adjustment rate that is equal to an average of the previous 10-year productivity rates in the broader economy.[19] The SNF productivity adjustment began with the start of FY2012.

[16] The Office of Management and Budget (OMB) classifies CBSAs in either metropolitan or micropolitan areas. A *metropolitan* area is an urban cluster that consists of a county or counties that contain at least 50,000 people and has a high degree of social and economic integration to the surrounding counties. A *micropolitan* area is an urban cluster that consists of a county or counties that contain between 10,000 and 50,000 people and has a high degree of social and economic integration. For more information, see memorandum from Jeffrey Zients, *Revised Delineations of Metropolitan Statistical Areas Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas*, Office of Management and Budget, Bulletin No. 10-02, February 28, 2013, at https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.

[17] 42 C.F.R. §413.20 requires providers to submit cost reports on an annual basis. This information is collected in the Healthcare Cost Report Information System (HCRIS).

[18] The ½ percent difference threshold was administratively increased from ¼ percent difference beginning in FY2008.

[19] A productivity adjustment is intended to cancel out the price increases (i.e., wage increases) associated with productivity gains.

Resource Utilization Groups

The RUG classification system adjusts the urban or rural base rate for a beneficiary's expected SNF daily costs (i.e., nursing care, therapy care, bed and board, and drugs/biologicals). After admission to an SNF, a beneficiary is classified into a RUG, which can change over the course of his or her stay. The RUG is designed to be an accurate reflection of the beneficiary's SNF accommodation and service costs, given the beneficiary's medical conditions and current medical practices. The most recent version of the RUG classification system has 66 different groups within eight major categories: (1) Rehabilitation Extensive Services (Ultra High, Very High, High, Medium, Low); (2) Rehabilitation (Ultra High, Very High, High, Medium, Low); (3) Extensive Services; (4) Special Care High; (5) Special Care Low; (6) Clinically Complex; (7) Behavioral Symptoms and Cognitive Performance; and (8) Reduced Physical Function.

The information used to assign a beneficiary into a RUG is gathered from the Minimum Data Set 3.0 (MDS). The MDS is one of three parts of the Resident Assessment Instrument (RAI), which must be completed for all residents in Medicare- and Medicaid-certified nursing homes.[20] The additional two parts are the Care Area Assessment (CAA) and RAI Utilization Guidelines. The RAI is designed to help with "gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan."[21] The MDS portion of the RAI gathers data over 15 different criteria: (1) hearing, speech, and vision; (2) cognitive patterns; (3) mood; (4) behavior; (5) preference for customary routine activities; (6) functional status; (7) bladder and bowel; (8) active diagnoses; (9) health conditions; (10) nutritional status; (11) dental status; (12) skin conditions; (13) medications; (14) special treatments, procedures, and programs; and (15) restraints.

SNFs are required to complete the MDS for a beneficiary to receive reimbursement under Part A.[22] The MDS assessments for Medicare payment are required to be completed on or about the 5th day, 14th day, 30th day, 60th day, and 90th day of a patient's stay. For the most part, the MDS assessments' "look back" period, the time frame for gathering the patient's clinical information, is the seven days prior to the MDS payment assessment requirement dates. In addition to Medicare-required MDS assessments, federal law requires SNFs (as well as nursing homes) to complete the MDS and CAA for dual-eligible Medicare- and Medicaid-covered residents. These assessments must be completed near the beneficiaries' 92nd day of stay, 366th day of stay, and in the event of a significant change or correction in the beneficiary's status. Such assessments may be combined with the Medicare-required assessment dates when applicable.

The most recent version of the RUG classification system is RUG-IV, which replaced the RUG-53 system on October 1, 2010 (start of FY2011).[23] There are 66 RUGs; each RUG has a nursing case-mix index, and some RUGs have an additional therapy case-mix index, together known as RUG weights. The RUG weights are used to adjust the federal base rate for different levels of expected nursing and/or therapy intensity provided to the beneficiary. The federal base rate adjusted for a specific RUG is referred to as the case-mix adjusted rate.

[20] §4201 of The Omnibus Reconciliation Act of 1987 (OBRA; P.L. 100-203) required SNFs to, among other things, complete a standardized assessment for each resident.

[21] CMS, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, MDS 3.0, October 2015, p. 4.

[22] This requirement does not apply to swing-bed SNFs in CAHs. Swing bed-SNFs include CAHs and rural hospitals with less than 100 beds that have a swing bed agreement in effect.

[23] RUG-IV created an additional 13 possible groups for classifying beneficiaries, bringing the total from 53 groups under RUG-53 to 66 groups.

To create the case-mix adjusted rate, the relevant components of the urban or rural base rate must be added together. For each base rate, each RUG will have a noncase-mix component and a nursing component. The third and final component will be either a therapy case-mix component or a noncase-mix therapy component. The sum of all three components is the case-mix adjusted rate, which reflects the beneficiary's daily resource use before adjusting for area wage differences. The base rate's noncase-mix component is the same amount for every RUG. As shown in **Figure 1**, the nursing component is determined by multiplying the base rate's nursing case-mix by the RUG-specific nursing case-mix index. Depending on the RUG, the third component will either be the base rate's non-casemix therapy amount, which is the same across RUGs, or the base rate's therapy case-mix multiplied by the RUG-specific therapy case-mix index, if applicable.

Wage Index

After adjusting for a beneficiary's case-mix, a share of the case-mix adjusted rate is adjusted for area wage differences.[24] In order to calculate the area wage adjustment, the case-mix adjusted rate must be split into a labor-related share and a non-labor-related share. The labor-related share represents the amount of labor-related costs relative to total costs for providing SNF services to the average beneficiary. This labor-related share has historically been roughly 70% of the case-mix adjusted rate, with the remaining 30% allocated as the non-labor-related share.

As shown in **Figure 1**, the labor-related share of the case-mix adjusted rate is multiplied by a hospital wage index specific to the location of the SNF to account for differences in area wages. The SNF wage index is calculated from a survey of wages and wage-related costs from acute care hospitals (because specific SNF wage data does not exist). For areas with no hospitals and wage-related data available, adjacent areas are used as a proxy measure for the missing cost information. The wage index is updated every year but receives an adjustment so the updated wage index does not increase or decrease aggregate Medicare SNF payments.

After the wage index number has been determined and multiplied by the labor-related portion, the product is added back to the non-labor-related share. Finally, as shown in **Figure 1**, the global per diem rate is the sum of the labor-adjusted product and non-labor-related share.[25] The global per diem rate is the final reimbursement rate of daily SNF care reimbursed through Part A. For the most part, the global per diem rate and the beneficiary's length of stay in the SNF determine the total reimbursement amount to the SNF for the stay.

Medicare SNF Expenditures and Payment Adequacy

The following provides a brief summary of total Medicare SNF expenditures and the Medicare Payment Advisory Commission's (MedPAC's) analysis on the adequacy of these payments and the potential implications of using SNF payments to subsidize Medicaid nursing facility payments.

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[24] OMB revises delineations for the Nation's Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas based on Census Bureau data. On February 28, 2013, OMB released revised delineations based on 2010 Census Bureau data that created new statistical areas, revised existing statistical areas, and switched certain counties from urban to rural and rural to urban. The SNF PPS began to reflect these revised delineations through the wage index in FY2015.

[25] §511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) requires an additional 128% increase in the per diem payment for an SNF resident with acquired immune deficiency syndrome (AIDS).

In 2014, Medicare FFS spending on SNF care totaled $28.6 billion.[26] SNF payments have grown as an overall share of Medicare spending for the past two decades. In 1990, Medicare payments to SNFs represented 1.8% of total Medicare FFS spending, increasing to 8.0% of total Medicare FFS spending in recent years.[27]

In 2014, the for-profit Medicare margin and nonprofit Medicare margin were 14.9% and 3.9%, respectively, for freestanding SNFs.[28] The total Medicare margin for freestanding SNF care in 2014 was 12.5%. While MedPAC has found that Medicare reimbursements appear to be well above costs for SNFs in the aggregate, Medicare contributes 21% of the median nursing care facility's total revenue, with Medicaid payments comprising the largest share of revenue.[29] Therefore, MedPAC's analysis on the financial performance of Medicare payments for SNF care may capture only about a fifth of the financial picture of an average nursing facility.

However, Medicare margins are only one factor that MedPAC considers when assessing the adequacy of Medicare's payments and determining its annual payment update recommendation. MedPAC weighs other indicators, such as beneficiaries' access to care (the capacity and supply of providers and the volume of services rendered), quality of care, and providers' access to capital as well. After examining these factors, MedPAC recommended that Congress implement a 0% update to SNF payment rates for FY2017 and FY2018.[30] MedPAC has recommended a 0% update to SNFs since March 2002.[31]

Medicare SNF Rate-Setting Policy and Medicaid

The largest payer to all nursing facilities is the Medicaid program.[32] When stratifying freestanding SNFs by percentage of total Medicaid patient days, in the median nursing facility, roughly 61% of its patient days were covered by Medicaid in 2014.[33] Industry advocates insist that Medicaid does not cover the total costs of providing nursing facility services to its beneficiaries and that Medicare should subsidize Medicaid payments through its SNF reimbursements.[34] Evidence

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[26] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2016, pp. 179-200, at http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf?sfvrsn=0.

[27] CMS, *Health Care Financing Review 2013 Medicare and Medicaid Statistical Supplement*, Baltimore, MD, Table 6.1.

[28] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2016, p. 191, at http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf?sfvrsn=0.

[29] Ibid., p. 180.

[30] Ibid, p. 198.

[31] In their March 2002 Report to Congress, MedPAC recommended no update for freestanding SNFs and a 10% update for hospital-based SNFs. MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2002, p. 84, at http://www.medpac.gov/documents/reports/Mar02_Ch2D.pdf?sfvrsn=0.

[32] CMS, *National Health Expenditure Accounts Tables*, November 23, 2015, Table 4, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

[33] Medicaid is a means-tested entitlement program, financed jointly at the state and federal level, which finances the delivery of certain health care services. Nursing facility services under Medicaid include room and board, nursing care and related services, dietary services, physician services, specialized rehabilitation services (e.g., physical therapy), emergency dental care, and pharmacy services. MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2016, p. 196, at http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf?sfvrsn=0.

[34] Eljay, LLC & Hansen Hunter & Company, PC for the American Health Care Association, *A Report on Shortfalls in Medicaid Funding for Nursing Center Care*, March 2015, at https://www.ahcancal.org/research_data/funding/Documents/2014%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf.

suggests payments from non-Medicare payers do not cover the costs of their residents. In 2014, the non-Medicare margin (nursing facility payments from Medicaid, private, and other public payers less costs) was -1.5%.[35] When including Medicare, however, the nursing facility industry's total margin was 1.9%.[36]

MedPAC has examined potential implications of targeting Medicare SNF reimbursements to compensate for inadequate payments from other providers. According to MedPAC, this strategy results 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.[37] MedPAC also states that if Medicare raises or maintains its high payment levels, states could be encouraged to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates.[38]

SNF Value-Based Purchasing Program

Section 215 of the Protecting Access to Medicare Act (PAMA; P.L. 113-93) requires the Secretary of Health and Human Services (the Secretary) to establish a Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program beginning on or after October 1, 2018. In general, VBP refers to the Centers for Medicare & Medicaid Services (CMS) initiative that rewards health care providers with incentive payments for the quality of care provided to beneficiaries. The intent of such a system is to reward quality of care and not just quantity of care. Similar VBP programs are already established within other Medicare provider payment systems (e.g., Hospital Value-Based Purchasing Program, End-Stage Renal Disease Quality Incentive Program).

Under the SNF VBP Program, an SNF's current Medicare per diem reimbursement may be increased or reduced to reflect its SNF VBP performance score beginning on or after FY2019. The Secretary is required to develop a methodology for determining such total performance score based on performance standards. Performance standards will be established by the Secretary and reflect either the attainment of a certain level or improvement from the prior period (whichever scores better for the SNF) across a performance measure.

The performance measure will be each SNF's all-cause, all-condition hospital readmission rate for Medicare SNF patients. In general, the hospital readmission rate will be the number of SNF residents readmitted to the hospital during their SNF stay in a given year divided by the total number of SNF residents. This all-cause all-condition hospital readmission rate measure will be replaced, when practicable, by an all-condition, risk-adjusted *potentially preventable* hospital readmission rate, which is to be further specified by the Secretary no later than October 1, 2016. The law does not require that these measures be endorsed by the National Quality Forum (NQF).[39] Additionally, these measures do not have to be included in the pre-rule making selection process by NQF's Measure Application Partnership (MAP)—a multi-stakeholder group convened for the selection of quality measures pursuant to Section 1890A(a) of the Social Security Act.

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[35] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2016, p. 200, at http://www.medpac.gov/documents/reports/chapter-7-skilled-nursing-facility-services-(march-2016-report).pdf?sfvrsn=0.

[36] Ibid.

[37] Ibid, p. 196.

[38] Ibid.

[39] NQF is a voluntary consensus standards-setting organization with the mission of improving the quality of health care, specifically through setting national goals for improvement, through endorsing quality measures, and through education and outreach to facilitate the realization of the quality goals it has recommended. Currently, NQF is the only body that meets the criteria of a voluntary consensus standards-setting organization for health quality measures.

Further, beginning October 1, 2016, and every quarter thereafter, the Secretary will provide confidential feedback reports to SNFs on their all-cause hospital readmission performance and their risk-adjusted potentially preventable hospital readmission performance.

Under the SNF VBP Program, SNFs will be ranked based on the performance score from high to low. High-performing SNFs (that have attained relatively low hospital readmission rates or greatly improved [reduced] their hospital readmission rates) will receive a percentage add-on—a "value-based incentive payment"—in addition to their regular Medicare SNF per diem payments. SNFs ranked higher will receive a higher percentage add-on. Such percentage add-on may be zero, and SNFs ranked in the lowest 40% will receive a reduction in their Medicare SNF per diem payment rates. Payment adjustments for each SNF, either incentive payments or a reduction in the per diem for a fiscal year, will apply only to such fiscal year.

Value-based incentive payments awarded to high-performing SNFs will be funded through a portion of a 2% reduction in Medicare per diem payments applied to all Medicare-covered SNF days beginning in FY2019. Between 50% and 70% of the 2% reduction applied each fiscal year, subject to the Secretary's discretion, will be allocated for value-based incentive payments, while the remaining proportion will be retained as savings to the Medicare program. Information on the SNF VBP Program, including each SNF's performance score, which SNF was awarded incentive payments, and the total amount of incentive payments that had been provided, will be posted on the Medicare's Nursing Home Compare website.

Post-Acute Care Reform

Medicare SNF care has often been discussed in the context of other Medicare-covered post-acute care benefits. Observers have noted that there is wide geographic variation in Medicare payments and delivery of post-acute care (including SNF care).[40] In response to such concerns, Congress passed the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act; P.L. 113-185) on October 6, 2014, and the Center for Medicare & Medicaid Innovation (CMMI), established under the ACA, has tested alternative payment models for reimbursing post-acute care.

The IMPACT Act attempts to improve Medicare quality comparison and payment accuracy for post-acute care settings—LTCHs, IRFs, SNFs, and home health care—by gradually eliminating certain differences in post-acute care assessment instruments beginning on or after October 1, 2016. For SNFs, the IMPACT Act will result in changes to the MDS. The IMPACT Act will require the Secretary to provide feedback to post-acute care providers on quality measure and resource use measure performance beginning October 1, 2017. The Secretary will then create procedures for making quality measure performance and resource use measure performance publicly available beginning October 1, 2018. Following the public reporting stage, the Secretary will submit a report to Congress regarding alternative models for a post-acute care provider payment system that unifies payment across post-acute care settings including SNFs. This report will include recommendations on (1) a technical prototype of a post-acute care PPS, (2) methods to incorporate standardized patent assessment data, and (3) further clinical integration, among other recommendations. The report will be submitted no later than two years after the Secretary has collected two years of data on quality measures. Additionally, MedPAC is required to submit

[40] Thomas MaCurdy et al., *Geographic Variation in Spending, Utilization and Quality: Medicare and Medicaid Beneficiaries*, Acumen, LLC, May 2013; and Barbara Gage et al., *Post-Acute Care Payment Reform Demonstration: Final Report Volume 1 of 4*, RTI International, March 2012.

a report to Congress no later than June 30, 2016, that includes recommendations for a technical prototype for a post-acute care PPS that would satisfy the criteria submitted in the Secretary's report.[41]

The CMMI was created for the purpose of testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. Under some of the CMMI Medicare models that affect post-acute care, providers are allowed to construct gainsharing agreements—agreements among providers (e.g., hospitals, post-acute care providers) to share monies—from increased efficiencies in delivering health care following a hospitalization. Incentive payments under gainsharing agreements can be available for reducing Medicare FFS spending for certain beneficiaries below a Medicare episode spending benchmark. For example, Model 3 of the Bundled Payment for Care Improvement Initiative allows post-acute care providers and other providers to collaborate and choose certain episodes (e.g., post-acute care following a pneumonia hospitalization) and certain episode lengths (e.g., 90 days of Medicare FFS spending after hospital discharge) to achieve such incentive payments. A similar payment model being tested at CMMI—the Comprehensive Care Joint Replacement (CJR) Model—provides a 90-day Medicare episode spending benchmark to participants who provide a lower-extremity joint replacement procedure to beneficiaries. For more information on the CJR Model, see CRS In Focus IF10310, *The Comprehensive Care Joint Replacement Model*.

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[41] For more information on this MedPAC report and developing a unified payment system for post-acute care, see MedPAC, *Report to the Congress: Medicare Payment Policy*, June 2016, p. 57, at http://www.medpac.gov/documents/reports/chapter-3-mandated-report-developing-a-unified-payment-system-for-post-acute-care-(june-2016-report).pdf?sfvrsn=0.

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