

**Case-Mix Comparison Between
Hospital-Based and Freestanding Nursing Facilities:
A Preliminary Research Note**

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Executive Summary

The two most recent Medicare Payment Advisory Commission annual reports have highlighted differences in the patient mix of freestanding and hospital-based skilled nursing facilities (SNF) as the basis for recommending differential Medicare payment adjustments across these facility types. The Commission seems concerned that, without some differential adjustment to the rates, hospital-based facilities will close at a disproportionately higher rate than freestanding facilities and those closures will create a problem of access to care for Medicare SNF patients. This report examines case-mix differences by type of facility using calendar year 2000 claims data for all Medicare-covered SNF patient days included in the Centers for Medicare and Medicaid Services Standard Analytical File. Case mix was measured using the Resource Utilization Group classification system that is used as the basis for Medicare SNF prospective payment.

Hospital-based facilities accounted for 15.4 percent of Medicare SNF patients and 12.8 percent of facilities in calendar year 2000. Results presented in this report suggest that the overall case mix, as measured by the relative resource use underlying Medicare payments, was similar across freestanding and hospital-based facilities. Generally, hospital-based facilities had a slightly higher nursing resource weight and freestanding facilities had a higher therapy weight. While those differences tended to offset each other when combined, freestanding facilities had a slightly higher case mix overall. The higher nursing weight for hospital-based facilities was primarily the result of a disproportionately greater number of Extensive Services patients – those requiring 1 or more high-resource services such as IV medication or a ventilator – being treated in those facilities.

A subset of freestanding facilities with a relatively high number of Extensive Services patients was identified to examine the extent to which freestanding facilities as a whole already serve populations that are as comparable as possible to hospital-based facilities. That subset included more than the number of hospital-based facilities and the distribution of patients across RUG categories was generally comparable across facility types. There are regional differences that suggest Extensive Services patients are more concentrated in hospital-based facilities in isolated areas, such as states in the Central West. It is also useful to note that there is now (in 2003) a lower percentage of hospital-based facilities overall (closer to 11 percent according to more recent CMS data) than is reflected in this report as a result of the most recent terminations among facilities. Those closures are likely to have reduced the limited differences across types of facilities shown in this report.

The last section of this report presents a preliminary simulation of fiscal year 2003 Medicare payments using the distribution of patients in calendar year 2000. Those results suggest that, under the Commission recommendation to shift add-on payments from Rehabilitation to other RUG categories, while payments for Rehabilitation RUG services would be reduced for both types of facilities at roughly the same rate, re-directed funds would go disproportionately to one or the other type of facility depending on what RUG categories are involved.

Case-Mix Comparison Between Hospital-Based and Freestanding Nursing Facilities

The two most recent Medicare Payment Advisory Commission (MedPAC) annual reports have highlighted differences in the patient mix and cost structure of freestanding and hospital-based skilled nursing facilities (SNF) as the basis for recommending differential Medicare payment adjustments across these facility types. In making this recommendation, the Commission assumes that hospital-based facilities serve a distinctly different patient population than do freestanding facilities. Moreover, in comparing the positive Medicare profit margins for freestanding facilities to the negative Medicare margins for hospital-based facilities, the Commission suggests that hospital-based facilities receive a disproportionately lesser share of Medicare SNF payments than is appropriate. The Commission acknowledges that the negative margins in hospital-based facilities are partly related to inflated costs at hospital-based facilities compared to freestanding facilities. At the same time, the Commission seems concerned that, without some differential adjustment to the rates, hospital-based facilities will continue to close at a disproportionately higher rate than freestanding facilities (as they have in recent years) and these closures will create a problem of access to care for Medicare SNF patients. The Commission's concern follows from the notion that hospital-based facilities serve a patient group that requires high clinical resources, but whom freestanding facilities do not serve.

In this paper we examine MedPAC's assumptions about the differences between hospital-based and freestanding facilities and its suggestion that closures among hospital-based facilities would restrict access to care. We looked at case-mix using calendar year 2000 SNF claims data made available for public use by the Centers for Medicare and Medicaid Services (CMS). In this analysis, case-mix was measured using the Resource Utilization Groups (RUG) patient classification system, which is used in the SNF prospective payment system (PPS), and claims for calendar year 2000. Results we have found to date are presented in this report.¹

For this analysis we compared the aggregate case-mix of freestanding and hospital-based facilities overall, as well as for rural and urban areas and across regions. We also examined the distribution of patient days, and those days weighted by the RUG case-mix index, across RUG levels (i.e., groupings of RUG categories) and individual RUG categories by type of facility.

In order to address the potential issue of access to care, we also examined the distribution of case-mix at the facility level. One guiding hypothesis for this analysis was that there are a substantial number of freestanding facilities with case-mix and patient distributions similar to most hospital-based facilities. If a number of freestanding facilities serve populations that are similar to those in hospital-based facilities, then one cannot assume that closures of hospital-based facilities will necessarily lead to a restriction in access. It is important to note that recent terminations among hospital-based providers that are not represented in the data available for this analysis may moderate some differences shown in the results below.

Finally, the SNF claims data can also be used to simulate Medicare PPS payments. Preliminary simulation results are presented in the context of the overall case-mix analysis which suggest how payments would shift across different RUG categories given MedPAC's recommendations.

¹ Issues related to cost reporting, which are otherwise key to understanding the nature of differences in profit margins across types of SNF facilities are not discussed in this report.

Case-Mix Analysis

Data Sources and Methods

The primary data source for this analysis is the public-use version of Medicare SNF claims included in the CMS Standard Analytical File (SAF). We used the 2000 data in the analysis reported here. Briefly, the SAF SNF file includes line-item information on payments (including coinsurance), covered days, clinical data (e.g., diagnoses, procedures, related conditions, etc.), and revenue codes, as well as RUG assignments for each Medicare SNF claim. The file includes a record for all claims with “through dates” in the respective calendar year.² Only adjudicated claims related to PPS SNF payment were used for this analysis.³

Data Elements. The primary information needed to assess case-mix across facilities is reported in revenue line-item data. Multiple revenue lines are reported, one for each standard revenue code line and one for each MDS assessment related to a given claim.⁴ The federal provider number used in standard CMS data reporting is included on each claim. It was used in this analysis to aggregate data across claims and to link records to other related data.⁵ The initial analytical file for this analysis included the provider numbers, RUG assignments, associated days of care, and additional provider-level information drawn from other sources (e.g., OSCAR files). The additional information included type of facility (hospital-based versus freestanding), state, county, region, a metropolitan statistical area (MSA) code if applicable, and a variable indicating urban or rural location.

Case Mix Weights. Case mix was assessed using the relative resource weights that underlie the Medicare PPS system. Three sets of weights were applied that reflect nursing-only, rehabilitation therapy, and the combined nursing and rehabilitation therapy resource weights. Some of the results reported below include all three sets of relative weights in the comparison of hospital-based and freestanding facilities. At this stage of our analysis, the RUG-based case-mix index is the best readily-available measure of resource use. Despite otherwise well-documented misgivings about how good (or robust) of a measure the RUG system is of resource intensity, it does provide one classification of types of patients for comparing patients served at different facilities. The analysis includes the distribution of patient days by RUG categories (e.g., type of patients), as well as summary case-mix scores.

² In practice this means that a limited number of days of care in the previous calendar year are included in the file and a roughly comparable amount of days during a given calendar year, but reported in claims with through dates in the following year, are not included in the file. On the whole, however, the file reflects a good approximation of comprehensive data on a full year period.

³ CMS SAF files contain final adjudicated claims. Thus, for example, some records are flagged as being a replacement for a previously submitted claim. In such a case, the previously submitted claim has been removed and is not in the SAF file. The file includes “no-pay” claims as well as those related to primary payers other than Medicare that are not associated with payment on behalf of the Medicare program. Claims associated with no payment were screen from this analysis. In the calendar year 2000 SAF SNF file, there were 112,154 (or 3.4%) of 3,166,429 claims screened/removed because they were not associated with payment.

⁴ RUG assignments and associated days are reported on revenue records that contain the revenue code “0022” for PPS payment.

⁵ While there is an encrypted identification key sufficient to link claims at the beneficiary level, the data as a whole are not sufficient to create stay-level records. Dates reported on the file only reflect the year and quarter associated with a give date field, such as admission and through dates. Without the month, day, and year, records clearly associated with a specific stay cannot be defined and combined.

It is important to note a few aspects of the RUG weighting system that help shape this analysis. As it is applied under Medicare, the RUG system includes 44 categories, each of which falls within one of a hierarchy of seven levels of care⁶. All RUG categories are assigned a nursing-only relative weight but only the 14 Rehabilitation categories are assigned a separate case-mix weight for therapy. A table of the relative resource weights associated with each RUG is presented in Appendix A. The general method applied in this analysis involves attaching a RUG weight to each record. Each record includes one RUG assignment and an associated number of days of care. The total relative weight associated with any given record is the RUG weight times the number of days. Records are then aggregated at various levels, such as type of facility and the provider. The mean case-mix per patient day is calculated by dividing the total weighted case-mix across records by the total patient days.

Initial Case-Mix Results

The SAF SNF claim files include records reflecting 44 million SNF patient days reported for calendar year (CY) 2000 (see Table 1). Roughly 15% and 85% of those days were in hospital-based and freestanding facilities, respectively. Rural facilities, as a whole, accounted for 22.3% of SNF patient days. The distribution of days across hospital-based and freestanding facilities was similar to the national pattern within urban versus rural areas, although there was a slightly higher proportion of hospital-based facilities in rural areas.

Table 1 shows mean relative resource weights, for the three indexes described above, across freestanding and hospital-based facilities for the nation as a whole and by rural and urban locations. Generally, hospital-based facilities have a higher mean nursing-only weight (1.134 vs. 1.078) and a lower therapy-only weight (.753 vs. .840) than do freestanding facilities. The combined nursing and therapy weights tend to moderate those differences, although freestanding facilities have a higher mean weight overall (1.918 vs. 1.887). The pattern of differences between freestanding and hospital-based facilities in urban and rural areas is much the same as the overall pattern (i.e., higher nursing weights and lower therapy weights for hospital-based facilities and higher combined weights overall for freestanding facilities), with the modest exception of a greater difference in mean therapy weights across types of facilities in rural areas.⁷

Table 2 compares the case-mix of freestanding and hospital-based facilities by geographic region. There are a few noticeable differences across regions from the general overall pattern of relative weights described above. There are marked differences in the overall percentages of patient days by type of facility across regions, with fewer hospital-based days in the northeast and relatively more in lower central and western regions. As at the national level, hospital-based

⁶ The 7 levels of RUG categories in descending hierarchical orders (and the number of RUG categories at each level) include: Rehabilitation (14); Extensive Services (3); Special Care (3); Clinically Complex(6); Impaired Cognition (4); Behavior Problems (4); and, Reduced Physical Function (10). A 45th category is used as a default assignment when an MDS assessment is incomplete or otherwise unavailable. The lowest nursing-only weight is used for the default category.

⁷ It is worth noting that while the distinction between urban and rural areas doesn't appear to shed much light on the differences between hospital-based and freestanding facilities at this level, PPS payments based on the weighting applied here are further affected by the use of a geographic wage index. Thus, the results shown here are not fully representative of case-mix adjusted payment differences across urban and rural areas.

Table 1: SNF Days and Mean Relative Resource Weights (CY 2000)
By Urban/Rural Status and Type of Facility

	# Facilities	Day Count	% of area Day Count	% National Day Count	Relative Resource Weights		
					Nursing Only	Therapy Only	Nursing & Therapy
National							
1 <i>All Facilities</i>	14,759	44,066,042	100%		1.087	0.827	1.913
2 Freestanding	12,870	37,276,574	84.6%		1.078	0.840	1.918
3 Hospital-Based	1,889	6,789,468	15.4%		1.134	0.753	1.887
Rural							
4 <i>Rural</i>	4,643	9,828,698	100%	22.3%	1.097	0.784	1.881
5 Freestanding	3,956	8,252,721	84.0%	22.1%	1.089	0.803	1.891
6 Hospital-Based	687	1,575,977	16.0%	23.2%	1.143	0.683	1.826
Urban							
7 <i>Urban</i>	10,116	34,237,344	100%	77.7%	1.084	0.839	1.923
8 Freestanding	8,914	29,023,853	84.8%	77.9%	1.075	0.851	1.926
9 Hospital-Based	1,202	5,213,491	15.2%	76.8%	1.132	0.774	1.905

Note: Based on 100% of SAF SNF claims data related to PPS payment in CY 2000, and PPS RUG weighting.

facilities tend to have higher mean nursing weights across regions, although by varying degrees and not consistently. Except for New England states, freestanding facilities have the same or higher mean therapy weights, with markedly higher results in the South Central states.

RUG Resource Levels. We looked at the distribution of Medicare SNF days across RUG levels and categories to further examine the differences across types of facilities shown in Table 1. The distribution of patient days and case-mix weighted days by RUG hierarchy level are shown in Table 3 and Table 4, respectively: for all patients and separately for freestanding and hospital-based facilities. As shown in Table 3, nearly three quarters of all patient days fall within the highest resource RUG level (Rehabilitation) and 95% fall within the 4 highest levels, for both freestanding and hospital-based facilities. Overall, the distribution of patient days is much the same across types of facilities with the noticeable exception of a higher percentage of Extensive Services (ES) days and a lower percentage of Clinically Complex days for hospital-based as opposed to freestanding facilities. The higher ES-related days, in particular, is consistent with, and may largely explain, the higher nursing-only weight for hospital-based facilities reported in Table 1 given the high nursing weight of ES-related care (see Appendix A).

Table 4 shows the distribution of case-mix-weighted patient days. The weighted patient days reported in this table reflect the unweighted patient days (in Table 3) multiplied by their respective RUG case-mix weight. In this case, the RUG weights for combined nursing and therapy resources were used. Said another way, Table 3 shows the distribution of types of patients and Table 4 shows the distribution of resource need as reflected in the RUG system. A comparison of those tables suggest, for example, that while essentially the same proportion of individuals fall within the Rehab RUG categories across types of facilities (~ 75% in Table 3),

**Table 2: SNF Days and Mean Relative Resource Weights (CY 2000)
By Region and Type of Facility**

	# Facilities	Day Count	% of area Day Count	% National Day Count	Relative Resource Weights		
					Nursing Only	Therapy Only	Nursing & Therapy
Regions							
1 <i>New England</i>	1,089	3,536,130	100%	8.0%	1.058	0.750	1.808
2 Freestanding	1,026	3,280,901	92.8%	8.8%	1.057	0.743	1.800
3 Hospital-Based	63	255,229	7.2%	3.8%	1.080	0.844	1.923
(CT, MA, ME, NH, RI, VT)							
4 <i>NY/NJ</i>	1,007	5,146,997	100%	11.7%	1.088	0.692	1.781
5 Freestanding	911	4,728,772	91.9%	12.7%	1.089	0.700	1.788
6 Hospital-Based	96	418,225	8.1%	6.2%	1.083	0.608	1.691
(NY, NJ)							
7 <i>Mid Atlantic</i>	1,387	4,977,446	100%	11.3%	1.110	0.832	1.941
8 Freestanding	1,189	4,149,337	83.4%	11.1%	1.108	0.831	1.939
9 Hospital-Based	198	828,109	16.6%	12.2%	1.120	0.833	1.953
(DC, DE, MD, PA, VA, WV)							
10 <i>Southeast</i>	2,555	9,396,720	100%	21.3%	1.082	0.852	1.934
11 Freestanding	2,201	8,099,918	86.2%	21.7%	1.076	0.863	1.938
12 Hospital-Based	354	1,296,802	13.8%	19.1%	1.120	0.789	1.909
(AL, FL, GA, KY, MS, NC, SC, TN)							
13 <i>North Central</i>	3,246	9,621,550	100%	21.8%	1.084	0.871	1.956
14 Freestanding	2,897	8,256,598	85.8%	22.1%	1.078	0.882	1.960
15 Hospital-Based	349	1,364,952	14.2%	20.1%	1.123	0.809	1.932
(IL, IN, MI, MN, OH, WI)							
16 <i>South Central</i>	1,741	3,766,350	100%	8.5%	1.096	0.855	1.951
17 Freestanding	1,504	2,896,257	76.9%	7.8%	1.065	0.930	1.995
18 Hospital-Based	237	870,093	23.1%	12.8%	1.201	0.607	1.808
(AR, LA, NM, OK, TX)							
19 <i>Central West</i>	1,190	1,963,133	100%	4.5%	1.102	0.834	1.936
20 Freestanding	1,042	1,376,665	70.1%	3.7%	1.072	0.888	1.960
21 Hospital-Based	148	586,468	29.9%	8.6%	1.172	0.706	1.879
(IA, KS, MO, NE)							
22 <i>Mountain</i>	585	1,098,067	100%	2.5%	1.069	0.846	1.915
23 Freestanding	464	877,384	79.9%	2.4%	1.062	0.866	1.929
24 Hospital-Based	121	220,683	20.1%	3.3%	1.097	0.764	1.861
(CO, MT, ND, SD, UT, WY)							
25 <i>Southwest</i>	1,477	3,437,154	100%	7.8%	1.088	0.857	1.944
26 Freestanding	1,216	2,630,100	76.5%	7.1%	1.067	0.895	1.962
27 Hospital-Based	261	807,054	23.5%	11.9%	1.155	0.732	1.886
(AZ, CA, HI, NV)							
28 <i>Northwest</i>	482	1,122,495	100%	2.5%	1.079	0.850	1.929
29 Freestanding	420	980,642	87.4%	2.6%	1.078	0.850	1.928
30 Hospital-Based	62	141,853	12.6%	2.1%	1.086	0.854	1.940
(AK, ID, OR, WA)							

Note: Based on 100% of SAF SNF claims data related to PPS payment in CY 2000, and PPS RUG weighting.

Table 3: Medicare SNF Days by RUG Level (CY 2000)
By Type of Facility

Rug Level	Total		Freestanding		Hospital-Based	
	Day Count	% of Column	Day Count	% of Column	Day Count	% of Column
1 All	44,066,042	100%	37,276,574	100%	6,789,468	100%
2 1: Rehabilitation	32,890,903	74.64%	27,852,881	74.72%	5,038,022	74.20%
3 2: Extensive Services	3,584,235	8.13%	2,631,400	7.06%	952,835	14.03%
4 3: Special Care	3,341,521	7.58%	2,869,455	7.70%	472,066	6.95%
5 4: Clinically Complex	3,110,847	7.06%	2,868,582	7.70%	242,265	3.57%
6 5: Impaired Cognition	224,808	0.51%	219,109	0.59%	5,699	0.08%
7 6: Behavioral	23,176	0.05%	22,466	0.06%	710	0.01%
8 7: Reduced Physical	690,876	1.57%	651,744	1.75%	39,132	0.58%
9 Default	199,676	0.45%	160,937	0.43%	38,739	0.57%

Note: Based on 100% of SAF SNF claims data related to PPS payment in CY 2000.

Table 4: Case-Mix Weighted Medicare SNF Days* by RUG Level (CY 2000)
By Type of Facility

Rug Level	Total		Freestanding		Hospital-Based	
	Day Count	% of Column	Day Count	% of Column	Day Count	% of Column
1 All	84,255,464	100%	71,507,723	100%	12,811,802	100%
2 1: Rehabilitation	72,100,352	85.57%	61,486,982	85.99%	10,613,370	82.84%
3 2: Extensive Services	5,430,604	6.45%	3,960,417	5.54%	1,470,187	11.48%
4 3: Special Care	3,502,621	4.16%	3,017,794	4.22%	484,828	3.78%
5 4: Clinically Complex	2,597,975	3.08%	2,400,602	3.36%	197,373	1.54%
6 5: Impaired Cognition	139,981	0.17%	136,405	0.19%	3,577	0.03%
7 6: Behavioral	12,842	0.02%	12,424	0.02%	418	0.00%
8 7: Reduced Physical	443,299	0.53%	419,068	0.59%	24,231	0.19%
9 Default	27,790	0.03%	74,031	0.10%	17,820	0.14%

Note: Based on 100% of SAF SNF claims data related to PPS payment in CY 2000, using combined PPS RUG nursing & therapy weights.

* A weighted day is the reported day (unweighted) times the respective case-mix weight for the associated RUG category. As such, the weighted day reflects resource intensity rather than the calendar 24-hour patient day.

hospital-based facilities tend to draw (or report) a slightly lower resource distribution of cases than freestanding facilities within that RUG level (82.84% vs. 84.99%, respectively, in Table 4).

Table 5 presents case-mix-weighted days distributed across specific RUG categories.⁸ RUG categories are listed in descending hierarchical order. For this table, the 19 lowest resource-use RUG categories (including the default) are aggregated to one category in order to focus on the higher resource-use groups. As a general rule, the distribution of patient days across RUG categories within freestanding facilities is the same as that for the population as a whole, although that is largely because freestanding facilities account for 85 percent of patient days. At the same time, there are some differences in the distribution of patient days across the two types of facilities.

As the percentage of case-mix-weighted days at the Rehabilitation level shown in Table 4 suggests, hospital-based facilities tend to have a lower percentage of weighted days in the highest resource-intensive Rehabilitation categories. The greatest differences in the distribution of patient days within the Rehabilitation level across types of facilities tend to be in medium sub-level categories, such as RVB (freestanding facilities are higher), and RHB and RMB (hospital-based facilities are higher).

The disproportionately more case-mix-weighted hospital-based patient days at the Extensive Services level tend to fall within the two highest resource-intensive Extensive Service categories (SE3 and SE2).⁹ Case-mix-weighted patient days at the Special Care level are roughly 4 percent across both types of facilities (see table 4) but hospital-based facilities have disproportionately more days in the lowest Special Care RUG (SSA).

Taken together, the most that can be said at this point in the analysis is that the patient population admitted to hospital-based facilities as a whole tends to have a higher percentage of Extensive Services patient days: roughly twice as many in relative terms as freestanding facilities. The net effect of case-mix differences between types of facilities that is attributable at the ES level is close to 6 percent (11.48-5.54, see Table 4). The slightly greater emphasis on Extensive Services days for hospital-based facilities tends to be offset by a slightly lower distribution of case-mix-weighted days in other categories. Except for the patterns associated with ES patients, which involve a limited number of patients, there are few significant differences in patient populations across types of facilities.

Provider-Level Measures. Although the results so far show distinct but modest differences in the patient populations across freestanding and hospital-based facilities, they do not show how those effects are distributed across facilities. As noted earlier, MedPAC has implied that patient populations that are commonly admitted to hospital-based facilities might have problems with access to care if freestanding facilities are not prepared to accept them. Are there, for example, freestanding facilities that serve patient populations comparable to those in hospital-based

⁸ The unweighted version of Table 5 is not shown here but can be calculated for specific RUG categories by dividing the weighted day count by the category's PPS weight – see Appendix A.

⁹ The Extensive Services level of care includes patients who have an ADL score of at least 7 and require at least 1 of 5 specific services: parenteral / IV; IV medication; suctioning; tracheostomy care; and, ventilator or respirator. Assignment to a specific Extensive Services RUG is based on the number of those services required.

**Table 5: Case-Mix Weighted Medicare SNF Days* by Selected RUG (CY 2000)
By Type of Facility**

RUG Level	RUG	Total		Freestanding		Hospital-Based	
		Day Count	% of Total	Day Count	% of Total	Day Count	% of Total
1	Total	84,255,464	100%	71,507,723	100%	12,811,802	100%
2	1 RUC	1,508,615	1.79%	1,374,290	1.92%	134,325	1.05%
3	1 RUB	5,320,525	6.31%	4,872,550	6.81%	447,974	3.50%
4	1 RUA	1,412,516	1.68%	1,310,263	1.83%	102,253	0.80%
5	1 RVC	2,427,554	2.88%	2,184,372	3.05%	243,182	1.90%
6	1 RVB	12,120,050	14.38%	10,858,020	15.18%	1,262,029	9.85%
7	1 RVA	4,109,502	4.88%	3,728,861	5.21%	380,641	2.97%
8	1 RHC	13,738,591	16.31%	11,579,440	16.19%	2,159,150	16.85%
9	1 RHB	12,149,542	14.42%	9,783,252	13.68%	2,366,290	18.47%
10	1 RHA	3,758,637	4.46%	3,098,141	4.33%	660,496	5.16%
11	1 RMC	5,085,153	6.04%	4,286,973	6.00%	798,180	6.23%
12	1 RMB	7,774,729	9.23%	6,263,543	8.76%	1,511,187	11.80%
13	1 RMA	2,374,920	2.82%	1,880,013	2.63%	494,906	3.86%
14	1 RLB	149,571	0.18%	129,462	0.18%	20,109	0.16%
15	1 RLA	170,447	0.20%	137,802	0.19%	32,645	0.25%
16	2 SE3	2,589,207	3.07%	1,768,869	2.47%	820,338	6.40%
17	2 SE2	2,715,717	3.22%	2,086,318	2.92%	629,399	4.91%
18	2 SE1	125,680	0.15%	105,231	0.15%	20,449	0.16%
19	3 SSC	796,603	0.95%	745,599	1.04%	51,004	0.40%
20	3 SSB	1,131,116	1.34%	1,062,222	1.49%	68,894	0.54%
21	3 SSA	1,574,903	1.87%	1,209,973	1.69%	364,930	2.85%
22	4 CC2	96,211	0.11%	90,890	0.13%	5,321	0.04%
23	4 CC1	312,811	0.37%	293,130	0.41%	19,681	0.15%
24	4 CB2	238,308	0.28%	226,295	0.32%	12,013	0.09%
25	4 CB1	863,915	1.03%	810,449	1.13%	53,466	0.42%
26	4 CA2	236,136	0.28%	222,600	0.31%	13,536	0.11%
27	4 CA1	850,594	1.01%	757,238	1.06%	93,356	0.73%
28	All other RUGs	623,911	0.74%	641,928	0.90%	46,045	0.36%

Note: Based on 100% of SAF SNF claims data related to PPS payment in CY 2000, using combined PPS RUG nursing & therapy weights.

* A weighted day is the reported day (unweighted) times the respective case-mix weight for the associated RUG category. As such, the weighted day reflects resource intensity rather than the calendar 24-hour patient day.

facilities? As a practical matter, the primary difference that is at issue is the distribution of Extensive Services patients. In order to examine this issue, patient days and resource weights were aggregated to the provider level. The mean case-mix weight was calculated for each provider and the distribution of the mean provider weight across providers was examined.

Tables 6a and 6b show two perspectives on the distribution of provider-level measures that are related to the signature differences across freestanding and hospital-based providers: high nursing-only case-mix weights and higher numbers of ES patients in hospital-based facilities. As noted earlier, these differences appear to be related in that the Extensive Services category is associated with high nursing weights. Table 6a shows the distribution of the facility-average nursing-only case-mix weight, as well as the median and quartiles, for freestanding and hospital-based facilities. Table 6b shows the distribution of the facility-level day count of the most resource intensive of the Extensive Services RUG categories (SE3). In each of these tables, results are shown for all providers and then separately for those that provided more or fewer than 1,500 patient days of total Medicare SNF care. The screen on total patient days of care is used as a proxy for the size of the facility.

As indicated throughout these results, nursing-only case-mix weights are higher on average for hospital-based facilities. Mean provider-level nursing weights were 1.086 and 1.131 for freestanding and hospital-based facilities, respectively (see Table 6a). There was the same level of difference between types of facilities overall on all the measures in this table (~ 4%). The medians shown in this table are close enough to the mean to suggest that the distribution of this measure is generally normal. The upper quartile measure indicates the lowest mean nursing weight for the 25 percent of facilities with the highest mean weights. The upper quartile measure for freestanding facilities is close to the mean for hospital-based facilities. This suggests that – with respect to overall nursing burden – the 25 percent highest freestanding facilities on this measure (~ 3,200 facilities) are comparable to the average hospital-based facility. There was slightly less difference between types of facilities on these measures among those that provided fewer than 1,500 patient days of care.

Measures based on the count of SE3 patient days shown in Table 6b suggest a more skewed distribution and more variable differences between types of facilities. The mean is markedly higher than the median indicating that most facilities have fewer SE3 patient days relative to the mean. Moreover, a relatively limited number of facilities have a disproportionately large number of SE3 patient days, regardless of type of facility. The upper quartile count for freestanding facilities (102 in Table 6b) is closer to (but smaller than) the median for hospital-based facilities rather than the mean. Facilities with fewer than 1,500 total SNF patient days of care were more comparable by type of facility than larger facilities.

In order to address the underlying question of the extent to which freestanding facilities are comparable to hospital-based facilities, the next step in this analysis was to identify a set of freestanding facilities that serve a similar patient population based on criteria relevant to the composition of hospital-based facilities. Because Extensive Services patients appear to be key to hospital-based facilities, the population of freestanding facilities was limited to those with the upper quartile count of SE3 patient days for freestanding facilities with at least 1,500 total patient days (142, see Table 6b). This number was chosen because it was greater than the median for all hospital-based facilities and served as an indirect screen for small facilities with more limited experience with Extensive Services patients.¹⁰ Measures of the distribution of the count of SE3 patient days for this reduced set of freestanding facilities are shown in line 7 of Table 6b.

¹⁰ To meet the screen of 142 SE3 patient days, smaller facilities would have to have nearly 10% of their patient population assigned to the Extensive Services category.

**TABLE 6a: Distribution of Facility-Average Nursing Case-Mix Weights (CY 2000)
By Type and Size of Facility**

	Facility Type	Facility Count	%	Lower Quartile	Mean	Median	Upper Quartile	Maximum
<i>All</i>								
1	Freestanding	12,870	87.2%	1.040	1.086	1.084	1.129	1.700
2	Hospital-Based	1,889	12.8%	1.071	1.131	1.123	1.186	1.700
<i>>= 1500 Days</i>								
3	Freestanding	8,392	85.7%	1.039	1.081	1.079	1.122	1.406
4	Hospital-Based	1,404	14.3%	1.076	1.135	1.126	1.188	1.453
<i>< 1500 Days</i>								
5	Freestanding	4,478	90.2%	1.041	1.094	1.094	1.145	1.700
6	Hospital-Based	485	9.8%	1.047	1.121	1.117	1.180	1.700

Note: Based on 100% of SAF SNF claims data related to PPS payment in CY 2000, and PPS RUG weighting.

**TABLE 6b: Distribution of Facility-Level Day Counts of RUG SE3 (CY 2000)
By Type and Size of Facility**

	Facility Type	Facility Count	%	Lower Quartile	Mean	Median	Upper Quartile	Maximum
<i>All</i>								
1	Freestanding	12,870	87.2%	9	81	39	102	1,727
2	Hospital-Based	1,889	12.8%	26	255	113	328	2,872
<i>>= 1500 Days</i>								
3	Freestanding	8,392	85.7%	24	110	65	142	1,727
4	Hospital-Based	1,404	14.3%	64	329	187	427	2,872
<i>< 1500 Days</i>								
5	Freestanding	4,478	90.2%	0	27	11	34	642
6	Hospital-Based	485	9.8%	0	43	18	60	429

Freestanding with at least 142 SE3 Patient days

7	Freestanding	2,227		174	284	224	325	1,727
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Note: Based on 100% of SAF SNF claims data related to PPS payment in CY 2000, and PPS RUG weighting.

Table 7 shows the distribution of SNF days and mean relative weights, comparable to Table 1, but limited to include freestanding facilities with relatively high counts of SE3 patients. While hospital-based facilities still have slightly higher nursing-only weights than do freestanding facilities, the overall pattern across types of facilities is much closer than when looking at all freestanding facilities. Table 8, which is comparable to Table 2 showing the regional distribution of measures, also shows that freestanding facilities with a higher proportion of SE3 patients tend to be closer to hospital-based facilities on these measures than freestanding facilities as a whole. Regions with the biggest disparity in nursing weights across types of facilities, such as the Central West, do tend to have disproportionately fewer freestanding facilities with high SE3 patient day counts.

Table 9 and Table 10 show case-mix-weighted patient days by RUG categories using the SE3 screen on freestanding facilities. Those results also show that existing freestanding facilities with high SE3 day counts are comparable in this respect to hospital-based facilities as a whole. While there is less difference in the resource impact of Extensive Services care across types of facility, freestanding facilities that are included using the high SE3 day screen do have a higher proportion of both Special Care and Clinically Complex patient days.

Table 7: SNF Days and Mean Relative Resource Weights (CY 2000)
All Hospital-Based vs. Freestanding Facilities w/ HIGH Counts of SE Patients

	# Facilities	Day Count	% of area Day Count	% National Day Count	Relative Resource Weights		
					Nursing Only	Therapy Only	Nursing & Therapy
National							
1 <i>All Facilities</i>	4,116	18,310,303	100%		1.119	0.743	1.862
2 Freestanding	2,227	11,520,835	62.9%		1.110	0.737	1.847
3 Hospital-Based	1,889	6,789,468	37.1%		1.134	0.753	1.887
4 <i>Rural</i>	1,148	3,353,355	100%	18.3%	1.134	0.686	1.820
5 Freestanding	461	1,777,378	53.0%	15.4%	1.126	0.688	1.814
6 Hospital-Based	687	1,575,977	47.0%	23.2%	1.143	0.683	1.826
7 <i>Urban</i>	2,968	14,956,948	100%	81.7%	1.116	0.756	1.871
8 Freestanding	1,766	9,743,457	65.1%	84.6%	1.107	0.746	1.853
9 Hospital-Based	1,202	5,213,491	34.9%	76.8%	1.132	0.774	1.905

Note: Freestanding facilities limited to those with at least 142 SE3 patient days during CY 2000.

Table 8: SNF Days and Mean Relative Resource Weights (CY 2000 - by Region)

All Hospital-Based vs. Freestanding Facilities w/ HIGH Counts of SE Patients

	# Facilities	Day Count	% of area Day Count	% National Day Count	Relative Resource Weights		
					Nursing Only	Therapy Only	Nursing & Therapy
Regions							
1 <i>New England</i>	241	1,191,408	100%	6.5%	1.082	0.700	1.782
2 Freestanding	178	936,179	78.6%	8.1%	1.082	0.661	1.743
3 Hospital-Based (CT, MA, ME, NH, RI, VT)	63	255,229	21.4%	3.8%	1.080	0.844	1.923
4 <i>NY/NJ</i>	424	2,794,021	100%	15.3%	1.102	0.642	1.744
5 Freestanding	328	2,375,796	85.0%	20.6%	1.105	0.648	1.753
6 Hospital-Based (NY, NJ)	96	418,225	15.0%	6.2%	1.083	0.608	1.691
7 <i>Mid Atlantic</i>	526	2,624,951	100%	14.3%	1.124	0.789	1.913
8 Freestanding	328	1,796,842	68.5%	15.6%	1.125	0.769	1.894
9 Hospital-Based (DC, DE, MD, PA, VA, WV)	198	828,109	31.5%	12.2%	1.120	0.833	1.953
10 <i>Southeast</i>	925	4,249,038	100%	23.2%	1.110	0.781	1.891
11 Freestanding	571	2,952,236	69.5%	25.6%	1.106	0.777	1.883
12 Hospital-Based (AL, FL, GA, KY, MS, NC, SC, TN)	354	1,296,802	30.5%	19.1%	1.120	0.789	1.909
13 <i>North Central</i>	777	3,335,489	100%	18.2%	1.121	0.789	1.910
14 Freestanding	428	1,970,537	59.1%	17.1%	1.119	0.776	1.895
15 Hospital-Based (IL, IN, MI, MN, OH, WI)	349	1,364,952	40.9%	20.1%	1.123	0.809	1.932
16 <i>South Central</i>	383	1,331,040	100%	7.3%	1.177	0.651	1.828
17 Freestanding	146	460,947	34.6%	4.0%	1.133	0.733	1.866
18 Hospital-Based (AR, LA, NM, OK, TX)	237	870,093	65.4%	12.8%	1.201	0.607	1.808
19 <i>Central West</i>	163	654,650	100%	3.6%	1.166	0.710	1.876
20 Freestanding	15	68,182	10.4%	0.6%	1.114	0.741	1.855
21 Hospital-Based (IA, KS, MO, NE)	148	586,468	89.6%	8.6%	1.172	0.706	1.879
22 <i>Mountain</i>	141	306,718	100%	1.7%	1.101	0.743	1.844
23 Freestanding	20	86,035	28.1%	0.7%	1.111	0.690	1.801
24 Hospital-Based (CO, MT, ND, SD, UT, WY)	121	220,683	71.9%	3.3%	1.097	0.764	1.861
25 <i>Southwest</i>	427	1,477,134	100%	8.1%	1.132	0.761	1.893
26 Freestanding	166	670,080	45.4%	5.8%	1.104	0.796	1.900
27 Hospital-Based (AZ, CA, HI, NV)	261	807,054	54.6%	11.9%	1.155	0.732	1.886
28 <i>Northwest</i>	109	345,854	100%	1.9%	1.099	0.774	1.873
29 Freestanding	47	204,001	59.0%	1.8%	1.108	0.718	1.826
30 Hospital-Based (AK, ID, OR, WA)	62	141,853	41.0%	2.1%	1.086	0.854	1.940

Note: Freestanding facilities limited to those with at least 142 SE3 patient days during CY 2000.

Table 9: Case-Mix Weighted Medicare SNF Days* by RUG Level (CY 2000)
All Hospital-Based Facilities vs. Freestanding w/ High SE Patient Count

Rug Level	Total		Freestanding		Hospital-Based	
	Day Count	% of Column	Day Count	% of Column	Day Count	% of Column
1 All	34,066,343	100%	21,279,559	100%	12,811,802	100%
2 1: Rehabilitation	27,717,950	81.36%	17,104,580	80.38%	10,613,370	82.84%
3 2: Extensive Services	3,498,501	10.27%	2,028,315	9.53%	1,470,187	11.48%
4 3: Special Care	1,641,356	4.82%	1,156,529	5.43%	484,828	3.78%
5 4: Clinically Complex	1,019,010	2.99%	821,637	3.86%	197,373	1.54%
6 5: Impaired Cognition	40,520	0.05%	36,944	0.05%	3,577	0.03%
7 6: Behavioral	3,540	0.00%	3,123	0.00%	418	0.00%
8 7: Reduced Physical	137,470	0.16%	113,239	0.16%	24,231	0.19%
9 Default	7,994	0.01%	15,193	0.02%	17,820	0.14%

Note: Freestanding facilities limited to those with at least 142 SE3 patient days during CY 2000, using combined PPS RUG nursing & therapy weights.

* A weighted day is the reported day (unweighted) times the respective case-mix weight for the associated RUG category. As such, the weighted day reflects resource intensity rather than the calendar 24-hour patient day.

Table 10: Case-Mix Weighted Medicare SNF Days* by Selected RUG (CY 2000)
All Hospital-Based Facilities vs. Freestanding w/ High SE Patient Count

RUG Level	RUG	Total		Freestanding		Hospital-Based	
		Day Count	% of Total	Day Count	% of Total	Day Count	% of Total
1	Total	34,066,343	100%	21,279,559	100%	12,811,802	100%
2	1 RUC	475,405	1.40%	341,080	1.60%	134,325	1.05%
3	1 RUB	1,595,850	4.68%	1,147,875	5.39%	447,974	3.50%
4	1 RUA	375,017	1.10%	272,764	1.28%	102,253	0.80%
5	1 RVC	804,065	2.36%	560,883	2.64%	243,182	1.90%
6	1 RVB	3,949,755	11.59%	2,687,726	12.63%	1,262,029	9.85%
7	1 RVA	1,178,784	3.46%	798,143	3.75%	380,641	2.97%
8	1 RHC	5,729,508	16.82%	3,570,358	16.78%	2,159,150	16.85%
9	1 RHB	5,186,482	15.22%	2,820,192	13.25%	2,366,290	18.47%
10	1 RHA	1,441,086	4.23%	780,590	3.67%	660,496	5.16%
11	1 RMC	2,243,897	6.59%	1,445,717	6.79%	798,180	6.23%
12	1 RMB	3,583,813	10.52%	2,072,626	9.74%	1,511,187	11.80%
13	1 RMA	1,020,774	3.00%	525,868	2.47%	494,906	3.86%
14	1 RLB	60,102	0.18%	39,992	0.19%	20,109	0.16%
15	1 RLA	73,411	0.22%	40,766	0.19%	32,645	0.25%
16	2 SE3	1,895,772	5.56%	1,075,434	5.05%	820,338	6.40%
17	2 SE2	1,545,947	4.54%	916,548	4.31%	629,399	4.91%
18	2 SE1	56,782	0.17%	36,333	0.17%	20,449	0.16%
19	3 SSC	330,988	0.97%	279,985	1.32%	51,004	0.40%
20	3 SSB	487,412	1.43%	418,518	1.97%	68,894	0.54%
21	3 SSA	822,956	2.42%	458,026	2.15%	364,930	2.85%
22	4 CC2	36,852	0.11%	31,531	0.15%	5,321	0.04%
23	4 CC1	116,488	0.34%	96,807	0.45%	19,681	0.15%
24	4 CB2	90,808	0.27%	78,795	0.37%	12,013	0.09%
25	4 CB1	342,192	1.00%	288,726	1.36%	53,466	0.42%
26	4 CA2	87,455	0.26%	73,920	0.35%	13,536	0.11%
27	4 CA1	345,215	1.01%	251,858	1.18%	93,356	0.73%
28	All other RUGs	189,525	0.56%	168,498	0.79%	46,045	0.36%

Note: Freestanding facilities limited to those with at least 142 SE3 patient days during CY 2000, using combined PPS RUG nursing & therapy weights.

* A weighted day is the reported day (unweighted) times the respective case-mix weight for the associated RUG category. As such, the weighted day reflects resource intensity rather than the calendar 24-hour patient day.

Modeling Medicare SNF Prospective Payment

As an extension of the analysis presented above, we have also begun to use the SAF SNF files to model PPS payments. In brief, Medicare PPS SNF rates are composed of four distinct components, two of which are case-mix adjusted using the weights that underlie the previous analysis, with separate sets of components defined for urban and rural settings. The basic rate calculation also includes an adjustment for geographic wage differences that is applied to the portion of the full rate that is determined to be labor-related.¹¹ In addition, certain add-on payments may be included in the final calculation of the rate.

Table 11 presents the unadjusted federal rate components for fiscal year (FY) 2003 and the percentage of the final rate that is adjusted for differences in wage rates. There are two distinct add-on payments included in the calculation of FY2003 final rates: 20% is added to the Extensive Services, Special Services, and Clinically Complex RUG categories; and, 6.7% is added to the Rehabilitation RUG categories.¹²

In order to model the payment system as a whole, we applied FY2003 PPS SNF reimbursement rates to the distribution of patient days in the SAF files for CY2000 described in the previous sections of this report. The modeling included all aspects of the calculation of the rate including the adjustment to the labor portion and add-on payment amounts. It is important to note that this is not the same as estimating FY2003 payments but, more properly, an introduction to the concept of simulating payments using the historical data we have on hand. In order to estimate actual payments using these data, some additional steps would need to be taken, such as adjusting the total number of patient days and, possibly, the distribution of RUG assignments. The overall number of days could be adjusted, for example, using a growth factor based on enrollment trends. The distribution of RUG assignments could be adjusted using trends drawn from MDS data. Adjustments could also be made to account for changes in market share across types of facility if that is an important factor for further analysis. As it is, however, this analysis does suggest the general relative volume and distribution of payments across types of patients and facilities.

Table 11: PPS SNF Unadjusted Federal Per Diem Rates (FY2003)

	<u>Nursing case-mix</u>	<u>Therapy case-mix</u>	<u>Therapy non-case-mix</u>	<u>Other non-case-mix</u>	<u>Labor Portion</u>
Urban	\$121.59	\$91.58	\$12.06	\$62.05	76.128%
Rural	\$116.17	\$105.61	\$12.88	\$63.20	76.128%

Source: Federal Register, Vol. 67, No. 147 - July 21, 2002

¹¹ The CMS hospital wage index, which includes an index value for each MSA and a separate value for the rural portion of each state, is currently used for this adjustment.

¹² The Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA) included provisions to add 20% and 6.7%, respectively, to rates for selected RUG categories. These provisions are to remain in effect until CMS introduces mandated refinements to the RUG case-mix system.

Table 12 shows what would be the distribution of payments if the current FY2003 payment rates and add-on amounts were applied to the distribution of patient days from CY2000. The table shows, for example, that close to \$1.1 Billion dollars are added as a result of the two existing add-ons. Three-fifths of the total add-on payments are associated with the Rehab RUG categories. Based on the CY2000 distribution of SNF patients, freestanding facilities would receive a very slightly higher proportion of the 6.7% add-on and hospital-based facilities would receive more of the 20% add-on. Less than half of the 20% add-on is currently associated with Extensive Services patient days, although this add-on is disproportionately associated with hospital-based facilities. The add-on associated with Rehabilitation RUG categories is distributed at very nearly the same rate as the distribution of payments overall (85% and 15% for freestanding and hospital-based facilities, respectively). The add-on associated with Special Care and the Clinically Complex are disproportionately associated with freestanding facilities.

This type of information is directly relevant to AHCA's consideration of payment policy and the impact of potential changes to that policy. For example, MedPAC has suggested that, in the absence of a refined RUG system and in lieu of differential adjustments for freestanding and hospital-based facilities, some portion of the 6.7% BIPA add-on be re-directed to some or all of the non-Rehabilitation RUG categories. Table 12 suggests that, while the reduction in payments for Rehabilitation RUG services overall would affect both types of facilities at about the same rate, re-directed funds would go disproportionately to one or the other type of facility depending on what RUG categories are involved.

As noted in the introduction to this report, hospital-based facilities have closed at a higher rate than freestanding facilities between the calendar period represented in this analysis and fiscal year 2003. The net effect is likely to reduce the differences shown here, and in the analysis above, although the extent (and the true direction) of any changes are not yet known. AHCA's Health Services Research and Evaluation team will be refining this analysis as appropriate on an on-going basis.

Table 12: Simulation of Medicare SNF PPS Payments - by RUG Level and Type of Facility

Based on CY2000 SAF SNF Claims and FY2003 Medicare PPS SNF Payment Rates

RUG level	HB/FS	Total w/add-ons	%	BIPA (6.7%)	%	BBRA (20%)	%	Patient Days	%
all	Total	\$13,070,961,911	100%	\$649,758,979	5.0%	\$425,823,500	3.3%	44,066,042	
	FS	\$11,094,029,709	84.9%	\$554,447,961	5.0%	\$351,262,154	3.2%	37,276,574	84.6%
	HB	\$1,976,932,202	15.1%	\$95,311,019	4.8%	\$74,561,347	3.8%	6,789,468	15.4%
1: Rehabilitation	Total	10,347,654,195	100%	649,758,979		0		32,890,903	
	FS	8,829,790,658	85.3%	554,447,961	85.3%	0		27,852,881	84.7%
	HB	1,517,863,537	14.7%	95,311,019	14.7%	0		5,038,022	15.3%
2: Extensive Services	Total	1,090,219,954	100%	0		181,703,326		3,584,235	
	FS	802,770,262	73.6%	0		133,795,044	73.6%	2,631,400	73.4%
	HB	287,449,692	26.4%	0		47,908,282	26.4%	952,835	26.6%
3: Special Care	Total	806,345,557	100%	0		134,390,926		3,341,521	
	FS	696,201,859	86.3%	0		116,033,643	86.3%	2,869,455	85.9%
	HB	110,143,697	13.7%	0		18,357,283	13.7%	472,066	14.1%
4: Clinically Complex	Total	658,375,491	100%	0		109,729,249		3,110,847	
	FS	608,600,801	92.4%	0		101,433,467	92.4%	2,868,582	92.2%
	HB	49,774,690	7.6%	0		8,295,782	7.6%	242,265	7.8%
5: Impaired Cognition	Total	33,926,855	100%	0		0		224,808	
	FS	33,074,880	97.5%	0		0		219,109	97.5%
	HB	851,975	2.5%	0		0		5,699	2.5%
6: Behavioral	Total	3,317,998	100%	0		0		23,176	
	FS	3,213,137	96.8%	0		0		22,466	96.9%
	HB	104,860	3.2%	0		0		710	3.1%
7: Reduced Physical	Total	131,121,862	100%	0		0		890,552	
	FS	120,378,112	91.8%	0		0		812,681	91.3%
	HB	10,743,750	8.2%	0		0		77,871	8.7%

Note: HB (Hospital-Based); FS(Freestanding)

Appendix A

Table A1: Medicare PPS Relative Resource-use Weights by RUG

RUG			Nursing	Therapy	Combined
Level	RUG	short label	Index	Index	Nursing & Therapy
1	1	RUC Rehab / Ultra High / 16 - 18 ADLs	1.30	2.25	3.55
2	1	RUB Rehab / Ultra High / 9 - 15 ADLs	0.95	2.25	3.20
3	1	RUA Rehab / Ultra High / 4 - 8 ADLs	0.78	2.25	3.03
4	1	RVC Rehab / Very High / 16 - 18 ADLs	1.13	1.41	2.54
5	1	RVB Rehab / Very High / 9 - 15 ADLs	1.04	1.41	2.45
6	1	RVA Rehab / Very High / 4 - 8 ADLs	0.81	1.41	2.22
7	1	RHC Rehab / High / 13 - 18 ADLs	1.26	0.94	2.20
8	1	RHB Rehab / High / 8 - 12 ADLs	1.06	0.94	2.00
9	1	RHA Rehab / High / 4 - 7 ADLs	0.87	0.94	1.81
10	1	RMC Rehab / Medium / 15 - 18 ADLs	1.35	0.77	2.12
11	1	RMB Rehab / Medium / 8 - 14 ADLs	1.09	0.77	1.86
12	1	RMA Rehab / Medium / 4 - 7 ADLs	0.96	0.77	1.73
13	1	RLB Rehab / Low / 14 - 18 ADLs	1.11	0.43	1.54
14	1	RLA Rehab / Low / 4 - 13 ADLs	0.80	0.43	1.23
15	2	SE3 Extensive Services / 7+ ADLs / 4 or 5 ES services	1.70		1.70
16	2	SE2 Extensive Services / 7+ ADLs / 2 or 3 ES services	1.39		1.39
17	2	SE1 Extensive Services / 7+ ADLs / 1 ES service	1.17		1.17
18	3	SSC Special Care / 17 - 18 ADLs	1.13		1.13
19	3	SSB Special Care / 15 - 16 ADLs	1.05		1.05
20	3	SSA Special Care / 7 - 14 ADLs*	1.01		1.01
21	4	CC2 Clinically Complex / 17 - 18 ADLs / Depression	1.12		1.12
22	4	CC1 Clinically Complex / 17 - 18 ADLs	0.99		0.99
23	4	CB2 Clinically Complex / 12 - 16 ADLs / Depression	0.91		0.91
24	4	CB1 Clinically Complex / 12 - 16 ADLs	0.84		0.84
25	4	CA2 Clinically Complex / 4 - 11 ADLs / Depression*	0.83		0.83
26	4	CA1 Clinically Complex / 4 - 11 ADLs*	0.75		0.75
27	5	IB2 Impaired Cognition / 6 - 10 ADLs / Nursing Rehab	0.69		0.69
28	5	IB1 Impaired Cognition / 6 - 10 ADLs	0.67		0.67
29	5	IA2 Impaired Cognition / 4 - 5 ADLs / Nursing Rehab	0.57		0.57
30	5	IA1 Impaired Cognition / 4 - 5 ADLs	0.53		0.53
31	6	BB2 Behavior Only / 6 - 10 ADLs / Nursing Rehab	0.68		0.68
32	6	BB1 Behavior Only / 6 - 10 ADLs	0.65		0.65
33	6	BA2 Behavior Only / 4 - 5 ADLs / Nursing Rehab	0.56		0.56
34	6	BA1 Behavior Only / 4 - 5 ADLs	0.48		0.48
35	7	PE2 Physical Function / 16 - 18 ADLs / Nursing Rehab	0.79		0.79
36	7	PE1 Physical Function / 16 - 18 ADLs	0.77		0.77
37	7	PD2 Physical Function / 11 - 15 ADLs / Nursing Rehab	0.72		0.72
38	7	PD1 Physical Function / 11 - 15 ADLs	0.70		0.70
39	7	PC2 Physical Function / 9 - 10 ADLs / Nursing Rehab	0.65		0.65
40	7	PC1 Physical Function / 9 - 10 ADLs	0.64		0.64
41	7	PB2 Physical Function / 6 - 8 ADLs / Nursing Rehab	0.51		0.51
42	7	PB1 Physical Function / 6 - 8 ADLs	0.50		0.50
43	7	PA2 Physical Function / 4 - 5 ADLs / Nursing Rehab	0.49		0.49
44	7	PA1 Physical Function / 4 - 5 ADLs	0.46		0.46
45		AAA Default, if missing key data	0.46		0.46

* Includes cases otherwise eligible for the next higher hierarchical level but fewer than 7 ADLs