Skilled Nursing Facilities and Inpatient Surgery Analysis

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Skilled nursing facilities and inpatient surgical hospitals occupy different positions within the U.S. healthcare continuum. Inpatient surgery provides acute hospital treatment when a patient requires operative care, anesthesia, monitoring, and hospital-level recovery. A skilled nursing facility (SNF) provides post-acute nursing and rehabilitation for patients who no longer need acute hospital care but still require skilled services that cannot be delivered safely through ordinary home care alone. The two settings are therefore linked by transitions of care, but they differ in clinical intensity, payment systems, staffing, regulation, and expected length of stay.

The original analysis correctly recognized Medicare as an important influence on both sectors, but several details were outdated. Modern SNF payment is no longer based primarily on rehabilitation minutes, and inpatient surgery is not governed by the Ambulatory Surgery Center Association. Medicare SNFs are paid under the Skilled Nursing Facility Prospective Payment System using the Patient-Driven Payment Model (PDPM), while most Medicare acute inpatient hospital stays are paid through the Hospital Inpatient Prospective Payment System using diagnosis-related groups and related adjustments (CMS, 2025a, 2025b).

Care Settings

An SNF provides skilled nursing, therapy, and related services for patients who need continued clinical care after hospitalization or another qualifying episode. Typical needs can include wound care, medication management, intravenous therapy, rehabilitation after surgery or stroke, monitoring of chronic disease, and assistance with functional recovery. SNFs should not be confused with ordinary long-term custodial care. Medicare Part A coverage depends on whether the patient requires skilled services under program rules, not simply whether the person needs help with daily activities.

Inpatient surgical care operates at a different level of intensity. Patients undergoing procedures that require admission may need operating-room services, anesthesia, postoperative monitoring, diagnostic testing, pharmacy services, nursing, respiratory care, rehabilitation consultation, and management of complications. Many operations that historically required hospitalization have moved to ambulatory settings as anesthesia, minimally invasive techniques, and recovery protocols have improved. Inpatient surgery is now increasingly concentrated among patients and procedures requiring greater complexity or medical monitoring.

These changes make site-of-care selection important. Performing a procedure as an inpatient merely

because it was historically done that way can expose patients to unnecessary hospital stays and increase cost. Conversely, moving a high-risk patient to an outpatient setting simply to reduce expense can compromise safety. Appropriate site selection depends on procedure complexity, comorbidities, functional status, social support, expected recovery, and the availability of emergency resources.

Post-acute planning should begin before hospital discharge. Patients who are likely to need skilled nursing should be assessed for mobility, cognition, wound care, medication complexity, rehabilitation potential, caregiver support, and home environment. Poor discharge planning can result in delayed transfers, medication discrepancies, avoidable readmission, or placement in a facility that cannot meet the patient's needs.

SNF Operations

Medicare SNF payment changed substantially with implementation of PDPM in fiscal year 2020. Rather than paying according to the volume of therapy minutes, PDPM classifies patients using clinical characteristics and resource needs across components including physical therapy, occupational therapy, speech-language pathology, nursing, and non-therapy ancillary services. CMS continues to update PDPM mappings and payment rates annually (CMS, 2026b). For FY 2026, CMS finalized a 3.2 percent increase in SNF PPS payments before considering certain value-based purchasing adjustments (CMS, 2025a).

Medicare coverage also continues to include the traditional three-day qualifying inpatient hospital stay for many beneficiaries. Medicare states that a qualifying stay generally means at least three consecutive inpatient days, excluding the discharge day; time spent under observation before formal inpatient admission does not count. However, some beneficiaries can qualify through approved waivers, including certain Accountable Care Organization arrangements (Medicare, 2026). This distinction matters because patients and families may assume that several nights physically spent in a hospital automatically satisfy the rule.

Quality measurement has become an increasingly important part of SNF governance. The SNF Quality Reporting Program requires standardized patient-assessment and quality data, while the Value-Based Purchasing program links part of payment to performance. CMS publicly reports SNF quality information through Medicare's comparison tools. Facilities that fail QRP reporting requirements can receive reductions in their annual payment update (CMS, 2026a).

Ownership and governance are also more transparent than in the earlier analysis. CMS now publishes detailed ownership data for Medicare-enrolled SNFs and requires reporting of additional ownership and management information, including certain private-equity and real-estate relationships. Ownership structure does not by itself establish quality, but transparency helps regulators, researchers, patients, and families evaluate how facilities are organized.

SNF performance should be judged through outcomes rather than simple occupancy. Relevant measures include functional improvement, preventable readmissions, falls, pressure injuries, infections, medication safety, discharge to the community, staffing stability, patient experience, and successful transition to follow-up care. Staffing levels matter because post-acute residents may have complex needs even when they no longer require hospital care.

Telehealth can supplement SNF care by improving access to specialists and allowing earlier assessment of clinical deterioration (Driessen et al., 2018). It is most useful when incorporated into a clear workflow with nurses who can assess the patient locally and clinicians who can respond to findings. Technology cannot compensate for inadequate staffing or the absence of necessary bedside care.

Inpatient Surgery

Medicare payment for acute inpatient hospital care is generally organized through the Inpatient Prospective Payment System. Cases are assigned to Medicare Severity Diagnosis Related Groups (MS-DRGs) based on diagnoses, procedures, complications, and other factors. Hospitals receive prospectively determined payment subject to adjustments for wages, teaching status, disproportionate-share responsibilities, high-cost outliers, quality programs, and other policies. CMS updates the system every fiscal year; the FY 2026 rule included revised MS-DRG classifications and hospital quality-payment adjustments (CMS, 2025b).

This means inpatient surgical reimbursement is not one flat payment based simply on the number of services provided. The DRG system creates incentives for hospitals to manage resources efficiently because the payment is largely prospective for the episode. At the same time, case severity and major complications can alter classification and payment. Cost accounting remains important because the payment amount does not guarantee that a particular procedure or patient is profitable (Grenda et al., 2016).

Clinical outcomes have also become part of financial accountability. Hospital readmission reductions, value-based purchasing, infection reporting, and other quality programs can affect payment and public reputation. Surgical quality therefore depends on more than the technical act in the operating room. Preoperative optimization, antibiotic timing, venous-thromboembolism prevention, anesthesia, nursing, postoperative mobilization, pain control, nutrition, discharge planning, and communication all influence results.

Enhanced recovery pathways illustrate this broader model. These programs coordinate evidence-based practices before, during, and after surgery to reduce avoidable physiological stress and support earlier recovery. Their purpose is not simply to discharge patients faster. A safe program reduces unnecessary variation while monitoring pain, mobility, nutrition, complications, and readmission.

Ownership of inpatient surgery also requires correction from the older paper. Surgery is not “owned

solely by the hospital" in a professional sense. Hospitals provide the licensed facility and many resources, but surgeons, anesthesiologists, nurses, advanced practice clinicians, pharmacists, rehabilitation teams, and other professionals share responsibility. Governance comes through hospital medical staff structures, state licensing, federal conditions of participation, accreditation where applicable, professional licensing boards, and payer requirements.

The Ambulatory Surgery Center Association is an industry organization representing ambulatory surgery centers, not the federal regulator of inpatient hospital surgery. Acute hospitals participating in Medicare are primarily governed through CMS conditions, state regulation, and other applicable laws and accreditation frameworks.

Transitions and Quality

The connection between inpatient surgery and skilled nursing care becomes most visible at discharge. Older adults and patients with limited mobility may leave the hospital medically stable but unable to return home safely. The SNF may then provide rehabilitation, wound care, medication management, and nursing monitoring until the patient can transition to the community or another level of care.

Transitions create risk because responsibility shifts between organizations. Medication lists can be inconsistent, wound instructions incomplete, follow-up appointments unclear, and functional changes poorly communicated. Standardized discharge summaries, medication reconciliation, direct handoff, clear weight-bearing or activity instructions, pending test results, and contingency plans can reduce these failures.

Payment incentives do not always align automatically. Hospitals may wish to reduce length of stay, while SNFs may receive patients with increasing complexity. SNFs may also face incentives created by PDPM and quality programs. The safest transition therefore requires clinical criteria rather than simply moving the patient to the least expensive available setting.

Quality comparison should also adjust for patient differences. A facility treating highly complex postoperative patients may experience more readmissions than one treating lower-risk patients even when care quality is similar. Risk adjustment is therefore essential, but it cannot capture every difference. Publicly reported measures should be combined with staffing, inspection history, ownership information, clinical capabilities, and patient-specific needs.

The most important change since the older reimbursement model is the movement away from paying primarily for volume. PDPM in SNFs attempts to reflect patient characteristics, while hospital DRGs pay prospectively for inpatient episodes and quality programs increasingly influence payment. Both systems are imperfect, but they are designed to encourage more efficient care than open-ended fee-for-service reimbursement.

Skilled nursing facilities and inpatient surgery should therefore be analyzed as connected but distinct

parts of healthcare. Inpatient hospitals manage acute surgical episodes; SNFs provide skilled post-acute recovery when hospital-level care is no longer needed. Their effectiveness depends on appropriate patient selection, adequate staffing, accurate assessment, evidence-based care, transparent quality measurement, and well-managed transitions. Modern Medicare policy reinforces this connection by linking payment increasingly to patient characteristics, quality reporting, and outcomes rather than only the quantity of services delivered.

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