CARE CONTEXT
THE ALLIANCE FOR QUALITY NURSING HOME CARE SPRING 2012

Impact of Payment Reductions on Nursing Facilities

Payment Cuts Leading to Nursing Facility Layoffs and Cancellation of New Jobs

AS PART OF THE "Middle Class Tax Relief and Job Creation Act of 2012" passed in February, Congress cut Medicare payments to nursing facilities by reducing reimbursement for so-called Medicare "bad debt" – Medicare co-payments not made by beneficiaries or state Medicaid programs. Facilities have no legal avenue to collect bad debt from state Medicaid agencies.

This cut comes on the heels of an 11.1 percent reduction to Medicare nursing facility payment rates, which was imposed by the Centers for Medicare and Medicaid Services (CMS) in August 2011.[1] In addition, many states have reduced or frozen their Medicaid rates for nursing facilities (NFs).[2] The results of a recent survey suggest that, in response to the CMS cut, facilities will lay off over 20,000 staff and cancel projects that would have created 20,000 - 25,000 new jobs. Sufficient levels of skilled staffing are essential to providing high quality care and reducing unnecessary readmissions, a systemic Medicare cost driver.

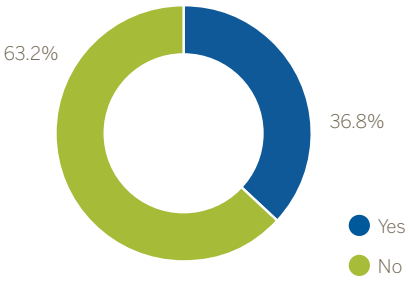
As post-acute care providers, nursing facilities play a key role in the health care system, allowing high-acuity patients to be discharged from hospitals sooner. They are a highly cost-effective site of post-acute care for patients with complex clinical needs and functional limitations. In recent years, the acuity of nursing facility patients has increased as providers have simultaneously faced reduced government funding – state Medicaid payment cuts, the 11.1 percent reduction in rates imposed by CMS, additional reductions in Medicare payments as a result of the health reform legislation, the February 2012 reduction in reimbursement for Medicare bad debt (most of it effectively uncollectible), and yet more Medicare cuts through sequestration, slated for January 2013.

The Alliance for Quality Nursing Home Care recently commissioned Avalere Health to conduct an industry survey regarding NF operators' planned responses to the 11.1 percent Medicare payment cut.[3] The survey responses indicate that the Medicare payment reductions could result in at least 20,000 layoffs industry-wide and cancellation of approximately 400 nursing facility expansions or renovations that would have generated approximately 20,000-25,000 new jobs. Research demonstrates a correlation between funding cuts to nursing facilities, patient care quality, and the ability of the nation's third largest health care employer to sustain local job growth.

Over one-third of the survey respondents planned to lay off direct service staff such as registered nurses, licensed practical nurses, certified nursing assistants, therapists and other staff. Over one-third of respondents also planned to indefinitely postpone or cancel new hiring of direct service staff and corporate or other non-direct service staff.

Over One-Third of NF Operators Surveyed Expect to Lay Off Direct Service Staff

Figure 1: In response to the rule, do you expect to lay off direct service staff (including staff at any facilities that will be closed)?



Source: Avalere Survey of Nursing Facilities (234 respondents)

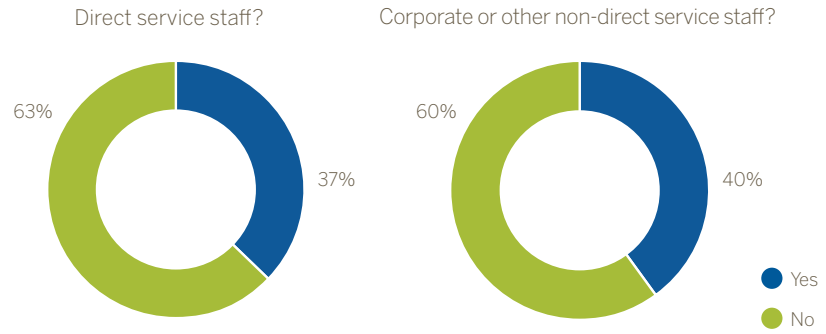
The Alliance For Quality Nursing Home Care

About three-quarters of respondents planned to make changes in wage rates, with over half of respondents expecting to implement a wage freeze or a reduction in annual increases. Almost half of respondents also planned to make changes to employee benefits such as eliminating paid holidays, increasing cost sharing for employee health insurance plans, reducing or freezing contributions to health insurance premiums, or reducing or eliminating 401(k) matching contributions.

Over one-fifth of respondents planned to delay or cancel facility expansions or renovation projects, which would have generated jobs. The respondents indicated that they would delay or cancel a total of 80-85 facility expansions or renovation projects that would have generated 4,500-5,000 jobs. Extrapolating from that figure suggests that approximately 20,000-25,000 jobs will be lost industry-wide (survey respondents represent one-fifth of all nursing facilities).

Over One-Third of NF Operators Surveyed Expect to Postpone or Cancel New Hiring

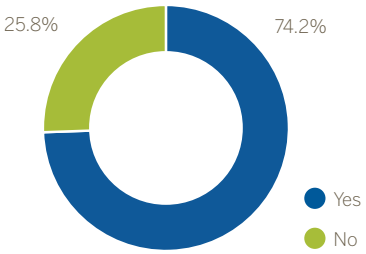
Figure 2: In response to the rule, do you expect to indefinitely postpone or cancel hiring of:



Source: Avalere Survey of Nursing Facilities (227 respondents for the question regarding direct service staff and 210 respondents for the question regarding corporate or other non-direct service staff)

About Three-Quarters of NF Operators Surveyed Plan to Change Wage Rates

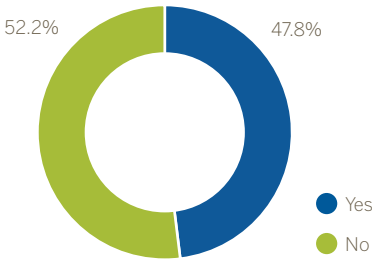
Figure 3: In response to the rule, do you plan to make any changes in wage rates (e.g., smaller raises, a wage freeze)?



Source: Avalere Survey of Nursing Facilities (213 respondents)

Almost Half of NF Operators Surveyed Plan to Change Benefits

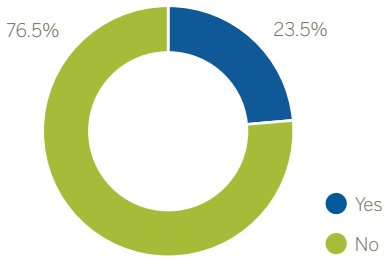
Figure 4: In response to the rule, do you plan to make any changes in benefits (e.g., an increase in cost-sharing and/or a reduction in the employer contribution, restrictions in benefits covered)?



Source: Avalere Survey of Nursing Facilities (209 respondents)

Over One-Fifth of NF Operators Surveyed Plan to Delay or Cancel Opening New Facilities or Expanding Existing Facilities

Figure 5: In response to the rule, do you plan to significantly delay or cancel the opening of new facilities and/or expansion of existing facilities?



Source: Avalere Survey of Nursing Facilities (238 respondents)

Nursing Facilities Have Experienced Several Consecutive Years of Medicare and Medicaid Payment Reductions

In recent years, nursing facilities have absorbed a number of Medicare cuts. Often, nursing facilities have little more than two to three months to prepare for these cuts (i.e., from the issuance of the final rule to the start of the new fiscal year). This unpredictability in funding makes it very difficult for nursing facilities to adequately plan from year to year.

First, in the fiscal year (FY) 2010 rule, CMS reduced skilled nursing facility (SNF) Medicare payments by a 3.3 percent forecast error adjustment – i.e., an adjustment in response to case-mix change that, in the CMS view, did not reflect changes in patient characteristics. Second, the Affordable Care Act (ACA) requires the SNF market basket update to be reduced by a productivity adjustment beginning in FY 2012 (the FY 2012 productivity adjustment was 1 percent).

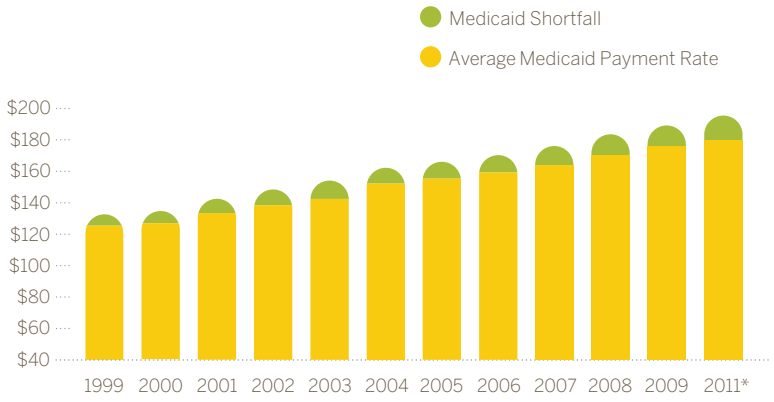
The third (and largest) Medicare payment reduction was imposed by the FY 2012 SNF final rule, which cut nursing facility rates by 11.1 percent. The final rule reduced rates for therapy Resource Utilization Groups (RUGs), in response to larger-than-expected payments to SNFs during FY 2011.[4] In FY 2011, CMS made the transition between Versions III and IV of the RUG system (the SNF Prospective Payment System), adding new RUG categories and increasing payment rates for existing categories. CMS intended for this system change to be budget neutral (i.e., CMS did not intend to pay more under RUG-IV than it would have under RUG-III), but as it turned out payments under RUG-IV were significantly higher. CMS responded by reducing SNF payment rates by 11.1 percent beginning October 1, 2011 (FY 2012) – a 12.6 percent cut in rates, offset by the annual market basket update.

Fourth, in February 2012 Congress passed the "Middle Class Tax Relief and Job Creation Act of 2012," which includes a reduction in Medicare bad debt payments, as an offset for the "doc fix" – deferring a scheduled cut in Medicare physician payment rates. Medicare bad debt payments are payments made to nursing facilities and hospitals as reimbursement for unpaid deductibles and co-payments owed by beneficiaries or state Medicaid programs. Dual Medicare-Medicaid eligibles are exempt from Medicare co-payments and deductibles. Medicaid programs are generally required to make co-payments on behalf of dual eligibles, but federal law effectively allows Medicaid programs to opt out of making these co-payments much of the time. Currently, Medicare reimburses nursing facilities for 100 percent of bad debt (i.e., unpaid co-payments) for dual-eligible beneficiaries and 70 percent for other Medicare bad debt. The new legislation reduces the reimbursement rate for all Medicare bad debt to 65 percent. This cut has a disproportionate impact on nursing facilities, relative to hospitals, because approximately 90 percent of nursing facility bad debt is related to dual-eligible beneficiaries (as compared to 55 percent for hospitals).[5,6]

Additional payment reductions are looming. On August 2, 2011, Congress passed the "Budget Control Act of 2011"

The Shortfall in Medicaid Payments Is Increasing

Figure 6: Aggregate Medicaid Payments Compared to Cost of Care, 1999 to 2011



Source: Eljay, LLC. A Report on Shortfalls in Medicaid Funding for Nursing Home Care. American Health Care Association. 2011.

*Notes: 2011 data are projected. These data show the shortfall between Medicaid reimbursement and allowable Medicaid costs.

(BCA) to address federal spending and the deficit. The law combines the authority for the President to raise the debt ceiling with a requirement that the deficit be reduced through either: 1) enactment of measures recommended by a Joint Select Committee of Congress; or 2) automatic reductions in spending by means of a process known as sequestration. The Joint Select Committee on Deficit Reduction failed to make recommendations for deficit-cutting measures. As a result, SNF payment rates may be reduced by an additional 2 percent as of January 1, 2013, through sequestration.[7]

While Medicaid is exempt from the sequestration process, the environment for nursing facility Medicaid reimbursement is nonetheless bleak. Medicaid is a federal-state program that covers, among other services, (long-term) nursing home care for low-income individuals. Medicaid payment rates are set at the state level. In virtually all states, these rates are not adequate to cover the cost of nursing home care.[8] Nursing facilities have faced Medicaid funding shortfalls for more than ten consecutive years and the shortfall continues to increase.[9]

In state fiscal year (SFY) 2011, given budgetary pressures from the recession and the phase-out of the enhanced federal Medicaid match rate provided through the American Recovery and Reinvestment Act (ARRA), few states increased nursing home rates from the previous year. In fact, at least 22 states froze rates and 10 states cut rates for that year. For SFY 2012, at least 16 states enacted or proposed rate freezes and 16 states enacted or proposed rate cuts.[10] These reductions will exacerbate existing Medicaid shortfalls.

The Number of States Cutting Medicaid Payments Continues to Increase

Figure 7: Summary of Reductions and Freezes in State Medicaid Nursing Facility Payment Rates

	SFY 2010	SFY 2011	SFY 2012	SFY 2010-2012*
Number of States Freezing Payments	15	22	16	17
Number of States Cutting Payments	7	10	16	23

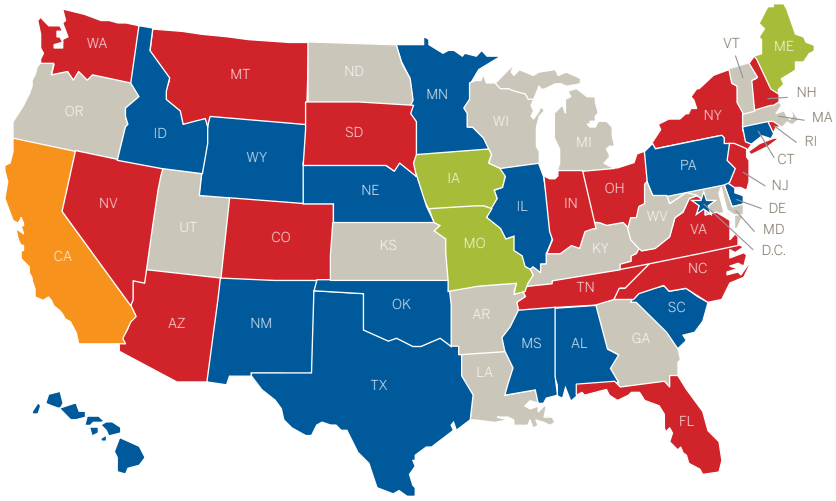
*For purposes of this column, a state that reduced payments in any of the three years counts as a "cut" state and a state that froze rates in any of the three years but did not cut rates in any of the three years counts as a "freeze" state.

Note: The survey does not consider the impact of provider taxes, fees, and other policies apart from direct changes to payment rates.

Sources: News sources, interviews with state affiliates of the American Health Care Association and interviews with state Medicaid departments.

In 2012, Thirty-Two States Enacted or Proposed Nursing Facility Rate Cuts or Payment Freezes

Figure 8: States Imposing Freezes or Cuts to Medicaid Nursing Facility Provider Reimbursement Rates, SFY 2012



States labeled as undecided had all proposed rate increases to CMS, but had not finalized them as of 1/19/2012. Note: The survey does not consider the impact of provider taxes, fees, and other policies apart from direct changes to payment rates.

Source: News sources, interviews with state affiliates of the American Health Care Association and interviews with state Medicaid departments.

Medicare Reimbursement Plays a Disproportionately Important Role for Nursing Facilities

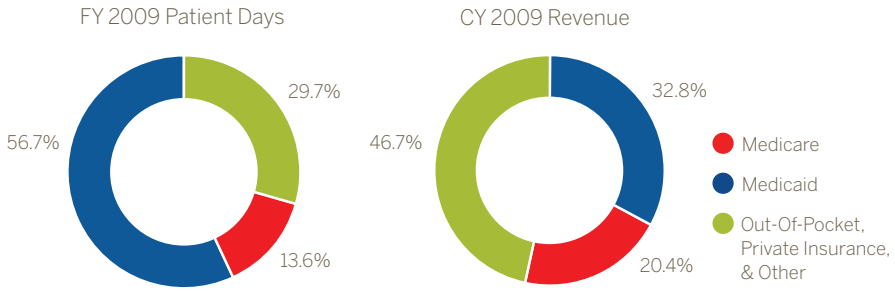
Medicare payment levels are disproportionately important for nursing facilities, because while Medicare patients are a minority of nursing facility residents at any point in time[11], data suggest that most facilities use Medicare payments to help cover the costs of care for Medicaid-funded residents. As previously discussed, Medicaid rates do not cover these costs, nor are the rates moving in that direction. Medicaid patients make up 57 percent of NF patient days, but Medicaid payments comprise only 33 percent of NF revenues.[12]

The reliance on Medicare payments to cross-subsidize Medicaid residents is pervasive throughout the industry – only about 13 percent of nursing facilities have too few Medicare patients (and too many Medicaid residents) to effectively cross-subsidize.[13] In the case of Medicare-Medicaid dual eligibles, these Medicare and Medicaid-funded residents can be the same people, but at different times.

Nursing facilities have the lowest overall margins of any publicly-traded health care company, as illustrated in figure 10. This is due in large part to the high number of under-funded Medicaid residents.[14] Accordingly, Medicare payments are critical to maintaining the financial stability of nursing facilities.

Nursing Facilities Rely on Medicare Payments to Subsidize Medicaid Patient Days

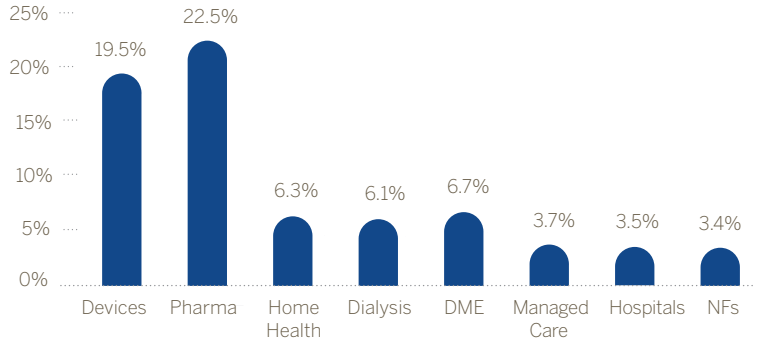
Figure 9: Nursing Facilities' Patient Days and Revenues by Payer



Source: Patient revenues: 2009 National Health Expenditures data; Patient days: Analysis of 2009 Skilled Nursing Facility Centers for Medicare and Medicaid Services Cost Report Data

Nursing Facilities Have the Lowest Overall Margins of Publically Traded Health Care Companies

Figure 10: Net Margins by Provider, Q4, CY2010



Source: Avalere analysis of company financials and Factset data.
*Results are normalized to remove one-time gains or losses

Reductions to Medicare and Medicaid Payment Rates Adversely Affect Quality of Care

Nursing facility quality, access, and employment are adversely affected by decreases in Medicare and Medicaid funding. In the not-too-distant past, a reduction comparable in magnitude to the FY 2012 cut in Medicare payments to nursing facilities resulted in serious unintended consequences. The reduction in question was part of the Balanced Budget Act (BBA) of 1997, which required nursing facilities to transition from cost-based reimbursement to a per diem prospective payment system (PPS) under Medicare.[15] In the first year of SNF PPS implementation,

payments to nursing facilities declined from $13.2 billion in 1998 to $11.2 billion in 1999.[16] Academic research has found that this dramatic reduction in Medicare payments had a significant negative impact on quality and access to care for both Medicare-funded post-acute care patients and long-stay residents funded by Medicaid, private insurance or out-of-pocket spending.

For example, facilities cut nursing hours per resident day by 17 to 33 percent after implementation of the SNF PPS.[17] Nursing facilities' mean number of survey deficiencies increased by about 12 percent (post-BBA).[18] The staffing reductions caused by the BBA payment cuts could have led to as many as 20,000 additional adverse events per year, industry-wide (e.g., urinary tract infections and pressure sores).[19]

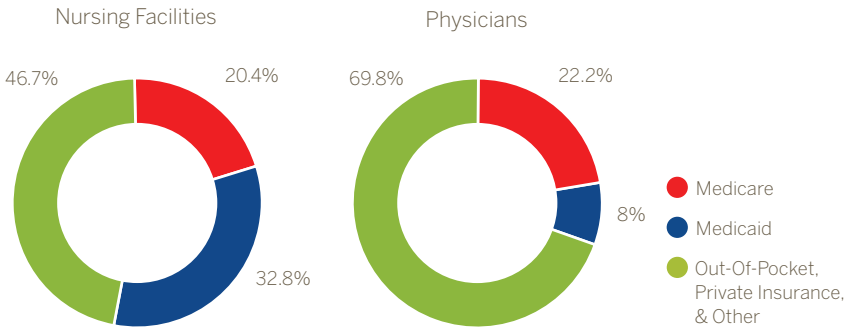
Furthermore, reimbursement cuts can have the effect of limiting access to NF care. In 1997, there were 17,388 nursing facilities. By 2002, this number had dropped almost 5 percent to 16,559 nursing facilities, which some researchers attribute to the decreased Medicare revenues.[20]

Nursing facilities are more reliant on government funding than physicians, for example, because the facilities receive 53 percent of their total revenue from these two programs, compared to just 30 percent for physicians.[21]

Labor constitutes 70 percent of NF costs. When Medicare[22] and/or Medicaid reduce payment rates[23], nursing facilities can be forced to reduce staffing levels, as well as staff compensation. These cuts can trigger quality and access problems for both short- and long-stay residents.[24]

Nursing Facilities Are More Reliant on Government Funding than Physicians

Figure 11: Nursing Facilities' and Physicians' Revenues by Payer



Source: Avalere analysis of National Health Expenditures data, 2009.

Key Policy Considerations

The Medicare Payment Advisory Commission (MedPAC) makes recommendations to the Congress about Medicare payment policies. MedPAC's longstanding position has been that Medicare payments should not cross-subsidize Medicaid shortfalls. MedPAC has previously argued that because facilities vary significantly in their shares of Medicare and Medicaid patients, Medicare payments serve as a poorly targeted subsidy for Medicaid-funded care.[25]

Section 2810 of the Affordable Care Act, however, requires MedPAC to analyze NF revenue, utilization and financial performance associated with Medicaid.[26]

Policymakers should consider how both Medicare and Medicaid payments affect NFs. A silo-ed approach to payment policy can have a negative effect on the quality of patient care by jeopardizing the financial stability of facilities. Key considerations for policymakers include:

1. Are Medicare and Medicaid payments to nursing facilities sufficient in combination?
2. How do Medicare reimbursement changes affect the quality of care for Medicaid-funded residents?
3. What impact does Medicare reimbursement have on facilities' financial viability?
4. How can payment systems be structured to reduce readmissions?
5. How can payment reforms focusing post-acute care payments on patient needs, rather than setting of care, stimulate efficiency in the post-acute care sector?

ENDNOTES

1 Centers for Medicare and Medicaid Services. "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012." August, 2011. http://www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf

2 Avalere Health, LLC. Analysis of reports from news sources, state affiliates of the American Health Care Association and state Medicaid departments.

3 Avalere fielded a survey among members of the Alliance for Quality Nursing Home Care and other nursing home providers between October 3 and October 17, 2011. There were 292 non-duplicated responses, representing 2,932 facilities in almost all states. Providers with over 1,000 beds represented 19 percent of respondents, and providers with fewer than 100 beds represented 37 percent of respondents. Not all survey respondents answered each individual question above; percentages are calculated with the number of respondents answering the question as the denominator. However, all 292 respondents answered the majority of the questions

4 Centers for Medicare and Medicaid Services. "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012." August, 2011. http://www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf

5 Avalere Health, LLC. Analysis of FY 2009 Medicare SNF Cost Reports

6 American Hospital Association. "Medicare Bad Debt Reimbursement." http://www.aha.org/content/11/110909-baddebt.pdf.

7 Budget Control Act of 2011.

8 Eljay, LLC. "A Report on Shortfalls in Medicaid Funding for Nursing Home Care." American Health Care Association, December 2011. http://www.ahcancal.org/research_data/funding/Documents/Eljay%20Medicaid%20Shortfalls%20Report%202011.pdf

9 Ibid.

10 Avalere Health, LLC. Analysis of reports from news sources, state affiliates of the American Health Care Association and state Medicaid departments.

11 Avalere Health, L.L.C. Analysis of FY 2009 Medicare SNF Cost Reports.

12 Avalere Health, LLC. Analysis of National Health Expenditures data, 2009 and SNF Cost Reports, 2009.

13 Mor, Vince. "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care." *Milbank Quarterly* 82(2) (2004): 227-256.

14 Eljay, LLC. "A Report on Shortfalls in Medicaid Funding for Nursing Home Care." American Health Care Association, December 2011. http://www.ahcancal.org/research_data/funding/Documents/Eljay%20Medicaid%20Shortfalls%20Report%202011.pdf

15 Konetzka, Tamara, Deokhee Yi, Edward Norton and Kerry Kilpatrick. "Effects of Medicare Payment Changes on Nursing Home Staffing and Deficiencies." *Health Services Research* 39(3) (2004): 463-488.

16 Office of the Actuary, Medicare and Medicaid Cost Estimates Group. "Medicare: Estimated Hospital Insurance Disbursements. Fiscal Years 1967-2008." January, 2009.

17 Konetzka, Tamara, Deokhee Yi, Edward Norton and Kerry Kilpatrick. "Effects of Medicare Payment Changes on Nursing Home Staffing and Deficiencies." *Health Services Research* 39 (3) (2004): 463-488.

18 Ibid.

19 Konetzka, Tamara, Edward Norton and Sally Stearns. "Medicare Payment Changes and Nursing Home Quality: Effects on Long-Stay Residents." *International Journal of Health Care Economics*, 6 (2006): 173-189.

20 Ibid.

21 Avalere Health, LLC. Analysis of National Health Expenditures data, 2009

22 Konetzka, Tamara, Edward Norton and Sally Stearns. "Medicare Payment Changes and Nursing Home Quality: Effects on Long-Stay Residents." *International Journal of Health Care Economics*, 6 (2006): 173-189.

23 Harrington, Charlene, James Swan and Helen Carrillo. "Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities." *Health Services Research*, 42(3) (2007): 1105-1129.

24 Konetzka, Tamara, Edward Norton and Sally Stearns. "Medicare Payment Changes and Nursing Home Quality: Effects on Long-Stay Residents." *International Journal of Health Care Economics*, 6 (2006): 173-189.

25 Medicare Payment Advisory Commission, "Chapter 7: Skilled Nursing Facility Services," in Report to the Congress: Medicare Payment Policy: March 2011.

26 Ibid.

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Alliance for Quality Nursing Home Care
1101 Pennsylvania Ave. NW, Sixth Floor
Washington, DC 20004
202.742.6740
www.aqnhc.org

Avalere Health LLC
1350 Connecticut Avenue, NW
Washington, DC 20036
202.207.1300
www.avalerehealth.net