CARE CONTEXT
THE ALLIANCE FOR QUALITY NURSING HOME CARE SEPTEMBER 2009

Trends in Post-Acute and Long-Term Care

ON ANY GIVEN DAY, there are 1.5 million Americans being cared for in 16,000 nursing facilities nationwide.[1] These facilities provide complex medical, therapeutic, and rehabilitative care to a diverse, clinically complicated population. Nursing facilities serve a crucial role in the post-acute and long-term care continuum, serving as the primary provider of Medicare post-acute care while simultaneously caring for a functionally impaired and clinically complex longer-stay population.[2]

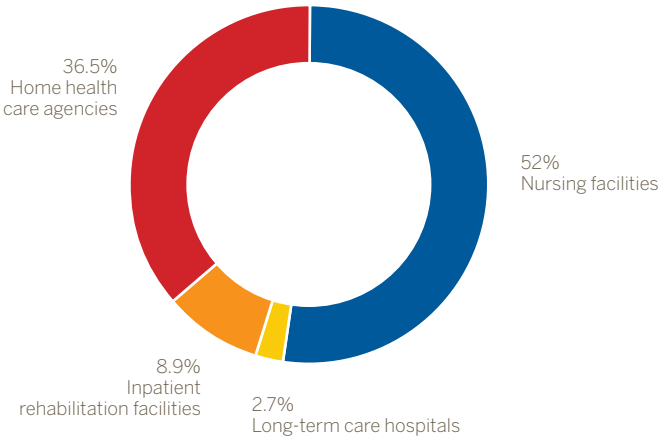
Nursing Facilities Serve Two Distinct Populations[3,4]

NURSING FACILITIES provide intense medical, rehabilitative, and therapeutic care to patients following a hospitalization. Many patients treated in nursing facilities after an acute hospital admission ("post-acute" care) are covered by Medicare and have relatively short lengths of stay. Nursing facilities are, in fact, the dominant provider of Medicare post-acute care services, treating more than 50 percent of all Medicare beneficiary hospital discharges that require post-acute care.[5]

Nursing facilities simultaneously care for a longer-stay population, most of whom are medically complex, functionally limited, and, in some cases, also cognitively impaired.[6] These residents are more likely to be paid for by the individual, their family, or Medicaid.[7] The average length of stay for Medicaid residents in FY 2007, for example, was 386 days.[8]

Nursing facilities are the dominant Medicare post-acute care provider.

Figure 1: Share of Medicare Hospital Post-Acute Discharges by Provider, 2006



Source: Avalere analysis of 2006 Medicare 100 Percent Standard Analytic File (SAF) claims data base from the Centers for Medicare & Medicaid Services (CMS).

The Alliance For Quality Nursing Home Care

Nursing Facilities' Role Is Evolving to Serve a More Clinically Complex, Functionally Impaired Population

SEVERAL STUDIES have documented the rise in nursing facility acuity and level of functional limitation over the past 30 years, with some suggesting this change could be due to the increase in short-stay Medicare patients.[9] In the mid and late 1990s, for example, studies reported acuity increases of 1.3 to 2.5 percent per year.[10]

Nursing facility residents today are also more functionally impaired. Activities of daily living (ADLs) measure the level of an individual's functional limitation by counting difficulties in performing self-care activities, such as bathing and eating. National survey data suggest that in 2004, 65.1 percent of residents in nursing facilities had limitations in 5 or more ADLs versus 50.2 percent of residents in 1985.[11] Given recent changes in acuity, level of functional limitation today may be even greater.

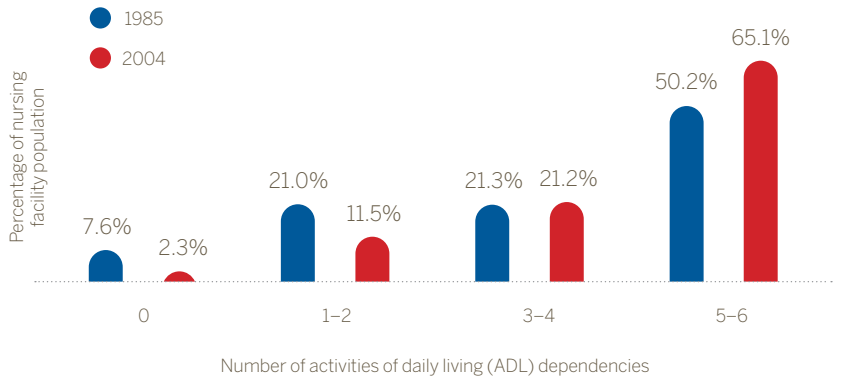
People served in nursing facilities today are more likely to have shorter lengths of stay and return to the community. The average length of stay for all nursing facility discharges was 398 days in 1985, decreasing 32 percent to 272 days in 1999.[12] More recent data suggest current length of stay may be considerably lower.[13] The discharge rate has increased dramatically from 77.4 discharges per 100 nursing facility beds in 1985 to 134 discharges per 100 nursing facility beds in 1999.[14] For short-stay Medicare patients, the rate is considerably higher with 39 percent of patients discharged to the community after an average stay of about 25 days.[15]

CONSIDER

Nursing facilities treat 52% of all Medicare hospital beneficiary discharges requiring post-acute care

Average patient acuity is increasing in nursing facilities.

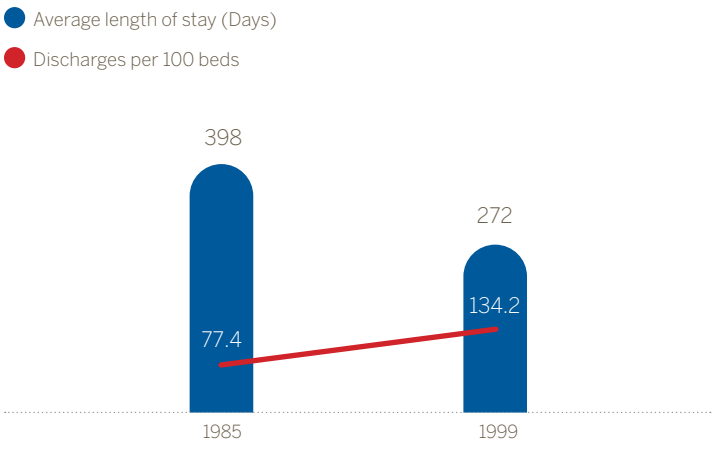
Figure 2: Percentage of Nursing Facility Patients with Activities of Daily Living Limitations, 1985 Versus 2004



Source: Lisa Alecxih. Nursing Home Use by the "Oldest Old" Sharply Declines. The Lewin Group. 21 November 2006.

Nursing facility length of stay is decreasing as the rate of discharge increases.

Figure 3: Nursing Facility Discharges per 100 Beds by Length of Stay, 1985 Versus 1999



Source: Frederick H. Decker. Nursing Homes 1977-1999: What Has Changed, What Has Not? National Center for Health Statistics. 2005.

Policy Changes Coupled with Greater Home and Community-Based Care Alternatives May Have Contributed to Increased Nursing Facility Complexity

SEVERAL IMPORTANT POLICY changes coupled with market forces, which drove growth in assisted living, contributed to the increased complexity of the nursing facility population.[16] These policy changes include the Centers for Medicare & Medicaid Services' (CMS) implementation of a Medicare prospective payment system (PPS) for hospitals in 1983, which resulted in dramatic decreases in hospital length of stay and increases in Medicare post-acute care utilization.[17] The nursing facility PPS, implemented in 1998, allowed for higher payments for more clinically complex patients. Nursing facility complexity increased and length of stay decreased.[18] CMS also tightened patient criteria for certain post-acute care providers, for example, inpatient rehabilitation facilities in 2004, resulting in nursing facilities caring for an even greater share of certain rehabilitation patients.[19]

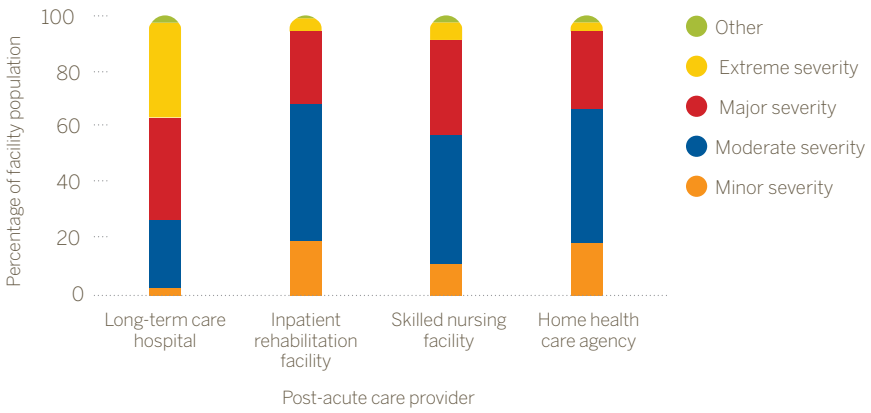
Other trends, such as growth in Medicaid home- and community-based service programs (HCBS) and privately financed assisted living, may also have spurred migration among less impaired nursing home residents to other care settings. The number of Medicaid beneficiaries using HCBS grew from approximately 935,000 in 1999 to more than 1.3 million in 2004.[20] Assisted living grew independent of government policy in response to market demand. The number of assisted living facility units increased from 160,000 in 1995 to 360,000 in 2008.[21]

Nursing Facilities Represent a Cost-Effective and Critical Component of the Care Continuum

MEDICARE COVERS post-acute care in multiple settings – in long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), nursing facilities, and at home through home health care agencies. Medicare has facility-specific and patient requirements for coverage, but the care follows, in most cases, an acute hospitalization. Among post-acute providers, only long-term care hospitals care for a larger share of high-severity patients.[22] In 2006, nearly 40 percent of the nursing facility patient population was classified as having major or extreme severity of illness.[23] In comparison, about 31 percent and 33 percent of the patient population in home health care agencies and inpatient rehabilitation facilities, respectively, fell into this group.[24]

In 2006, only long-term care hospitals cared for a larger share of high-severity post-acute patients than nursing facilities.

Figure 4: Post-Acute Health Care Settings by Condition Severity, 2006



Source: Barbara Gage, et al. Examining Post Acute Care Relationships in an Integrated Hospital System. RTI International. Prepared for Assistant Secretary for Planning and Evaluation, DHHS, February 2009.

IN CONTEXT **Nursing facilities** are a cost-effective setting, treating some patients at a lower cost than other post-acute providers. Medicare payments for hip and knee replacement patients, for example, were $4,400 higher in inpatient rehabilitation facilities than in nursing facilities.

Nursing facilities are treating an increasing number and share of patients requiring rehabilitation services. Of the top 10 hospital diagnoses most likely to require post-acute rehabilitation care, nursing facilities' share of total patients increased from 2003 to 2006.[25]

Nursing facilities are able to treat some patients with similar diagnoses at a lower cost than other post-acute care settings. A study commissioned by the Medicare Payment Advisory Commission, for example, found that Medicare payments for hip and knee replacement patients were $4,400 higher in inpatient rehabilitation facilities than in nursing facilities.[26]

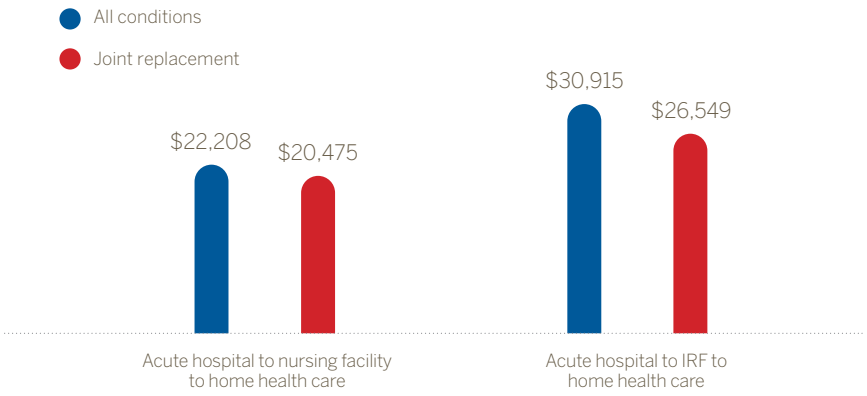
Medicare payments for the entire episode are also lower when the patient is treated in a nursing facility. A joint replacement patient who is treated in an acute hospital, transfers to an inpatient rehabilitation facility, and then receives home health care generates Medicare payments of, on average, $26,549.[27] Medicare payments for a patient treated in a hospital and then transferred to a nursing facility and, finally, to home health care are, on average, $20,475, about $6,000 or 22.9 percent less.[28]

With respect to quality, promising new research suggests that the place of service (inpatient rehabilitation facility versus nursing facility) has less effect on patient outcomes than other variables, such as patient volume, patient age, and functional status.[29]

In addition to being a lower-cost provider, nursing facilities play a crucial and interconnected role along the post-acute and long-term care continuum. The increasing functional limitations of nursing facility residents suggest people may receive long-term care in the community until their health needs become too complex to be addressed in a non-institutional setting.[30]

Average episode payments for patients treated in nursing facilities are lower than those in inpatient rehabilitation facilities.

Figure 5: Medicare Costs Across Care Patterns and Conditions, 2006



Source: Barbara Gage, et al. Examining Post Acute Care Relationships in an Integrated Hospital System. RTI International. Prepared for Assistant Secretary for Planning and Evaluation, DHHS, February 2009.

Nursing Facilities Face Unique Financial Challenges

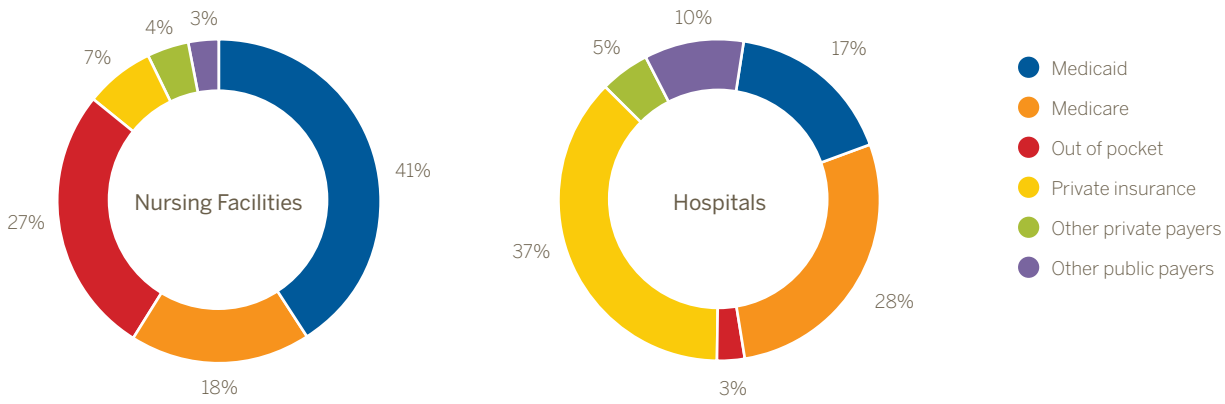
UNLIKE NEARLY every other type of health care provider, nursing facilities receive very little private insurance revenue, relying instead on Medicare and Medicaid reimbursements and direct out-of-pocket payments from residents. In 2007, Medicaid was the single largest payer for nursing facility services, representing, on average, 41 percent of facilities' total revenue. Individual and family sources accounted for 27 percent of payments and Medicare 18 percent. Private health insurance represented only 7 percent of nursing facility funding.[31] The remaining 7 percent represented a combination of other private payments (4 percent) and other public payments (3 percent).[32,33]

In contrast, hospitals receive 37 percent of their revenue from commercial payers. Private payer reimbursement levels are often more generous and can subsidize low payments from other sources.[34] Since commercial insurance represents such a small portion of total nursing facility revenue, nursing facilities have less ability to cross-subsidize any Medicare or Medicaid shortfalls.

Though Medicaid is a major payer of nursing facility care, the program does not fully reimburse facilities for the cost of treating residents. For example, the Medicaid margin, the difference between total revenue and costs as a percentage of total revenue, was negative 9.2 percent in 2007,[35] and the average shortfall in Medicaid funding per person per day

Compared to hospitals, nursing facilities are highly reliant on Medicare and Medicaid.

Figure 6: Nursing Facility and Hospital Revenue, by Payer, 2007



Source: The National Health Expenditure Accounts (NHEA), National Health Expenditures by type of services and source of funds, CY 2007, Nursing Home Care, Centers for Medicare & Medicaid Services.

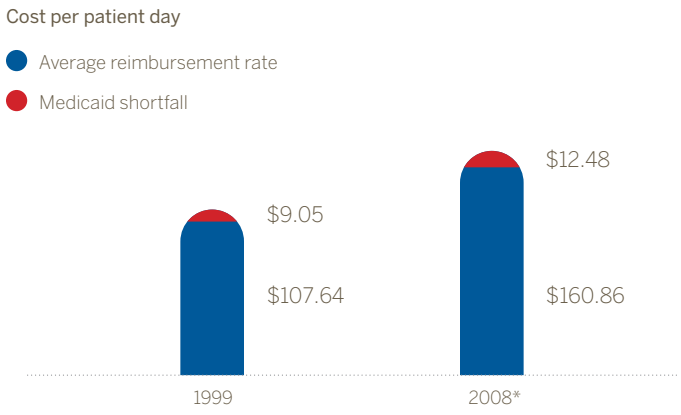
was projected to be $12.48 in 2008.[36] Notably, this estimate is based on Medicaid-allowed costs, which generally exclude costs related to marketing, taxes, professional fees, and bad debt. If these costs were included, they would be equivalent to additional unreimbursed cost of approximately $3.47 per day.[37]

Without a private insurance revenue stream, Medicare revenue is crucial in helping to offset a portion of Medicaid losses. The average Medicare margin for nursing facilities was 13.1 percent in 2006.[38] The Medicare margin, however, is not sufficient to cover the financial losses associated with treating Medicaid beneficiaries. In 2006, the weighted average margin for the two programs was negative 1.8 percent.[39]

In the near future, long-term care insurance is unlikely to represent a robust funding source for nursing facility care. Long-term care insurance only covers about 10 percent of all seniors now[40] and largely pays for care that is not provided

The Medicaid reimbursement shortfall for nursing facilities has increased over the last 10 years.

Figure 7: Medicaid Reimbursement Shortfall for Nursing Facilities, 1999 Versus 2008



*Projected
**Medicaid reimbursement shortfall is defined as the difference between cost and payment.

Source: Eljay, LLC. A Report on Shortfalls in Medicaid Funding for Nursing Home Care. 2008.

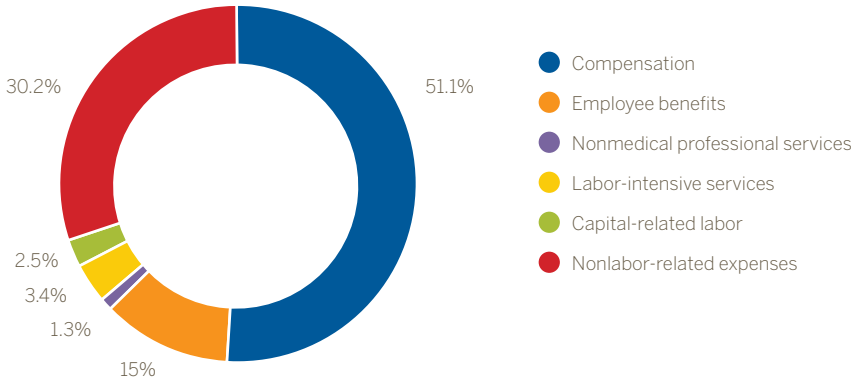
in the nursing facility setting. Individual market long-term care insurance sales have declined or been stagnant for much of this decade.[41] Individuals with this coverage use it more frequently to cover home health care aides (67 percent of claimants), while far fewer (7 percent) use it on nursing home care.[42]

Nursing facilities' ability to decrease expenses is complicated by their cost structure. Labor constitutes nearly 70 percent of all nursing facility input price expenses.[43]

In addition to operating costs, nursing facilities are likely to need to make capital improvements to their physical plants. Nursing facilities tend to be relatively old, with a median age of 29 years.[44] Facilities will face challenges in the current environment funding these capital improvements, which include updates to better meet the rising acuity needs of nursing facility residents.

Nursing facilities' ability to cut costs is constrained by their labor-dominated expense structure.

Figure 8: Projected Relative Importance of Labor-related Cost Categories in the Input Price Index, FY 2010



Centers for Medicare & Medicaid Services. Prospective Payment System and Consolidated Billing for Skilled Nursing Facility for FY 2010 Final Rule. July 2009.

Nursing Facilities Face Future Financial Challenges

STATES CONTINUE to feel budgetary pressure due to the recession with 48 states having addressed or still reporting budget shortfalls for 2010.[45] State budget gaps have placed increased pressure on Medicaid rates, which already are insufficient to cover the cost of nursing facility care.[46] Though the American Recovery and Reinvestment Act (ARRA) temporarily increased federal Medicaid matching funds to help close state budget shortfalls, this funding was not earmarked for payment increases to providers, including nursing facilities. A majority of nursing facilities are expecting frozen or reduced 2009 payment rates relative to 2008.[47]

The ARRA requires states to maintain eligibility standards as a condition of receiving the enhanced funding. States trying to close budget gaps through reduced Medicaid spending, therefore, have only two options: cut Medicaid payment rates or reduce benefits. For example, New York expects to receive $12.6 billion in stimulus funding yet plans to cut Medicaid reimbursements to nursing facilities by $225 million.[48]

Nursing facilities will also face decreased Medicare payments in FY 2010 as CMS reduces payments by 1.1 percent

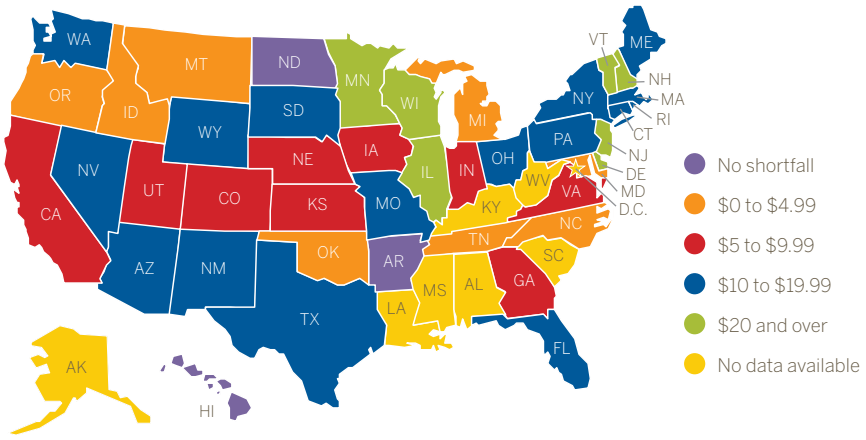
IN CONTEXT **Nursing facilities in most states** lose money treating Medicaid beneficiaries. In 2008, for example, the average Medicaid nursing facility shortfall is estimated to be $12.48 per person per day.

($360 million).[49] Facilities may experience larger reimbursement shifts next year (FY 2011) as CMS transitions to a new payment system, which will redistribute payments from rehabilitation to medically complex cases. Although intended to be budget neutral across all nursing facilities, it may cause substantial disruption as it redistributes payments among facilities.

In addition to these CMS changes, Congress is considering several nursing facility policy proposals as part of health reform legislation. The Congressional Budget Office estimates that the market basket cut and the productivity adjustment as included in the House legislation will decrease Medicare payments to nursing facilities by $32 billion over 10 years.[50] Other proposals, such as post-acute care bundling and reductions in payments for readmissions, could further reduce Medicare payments to nursing facilities.

Nursing facilities in a majority of states face Medicaid reimbursement shortfalls.

Figure 9: Medicaid Reimbursement Shortfall for Nursing Facilities, by State, 2008*



*Projected
**Medicaid reimbursement shortfall is defined as the difference between cost and payment.
Source: Eljay, LLC. A Report on Shortfalls in Medicaid Funding for Nursing Home Care. 2008.

Key Considerations

NURSING FACILITIES play a crucial role in the care continuum, providing complex medical, therapeutic, and rehabilitative care to post-acute and longer-stay populations. Nursing facilities serve as the primary provider of Medicare post-acute care while at the same time providing long-term care for the most functionally limited individuals. They serve these functions in a unique reimbursement environment in which private insurance plays a very limited role. The ongoing imposition of additional payment constraints in Medicare and Medicaid raises important considerations for policymakers. These include:

- Policymakers should evaluate total operating margins from all payer sources, including Medicare and Medicaid, to understand the impact of specific policies and payment reforms on nursing facilities' ability to hire and retain staff, maintain and improve physical plants, and enhance the quality of care.
- Policymakers should evaluate the direct and indirect effects of post-acute policies to ensure that Medicare beneficiaries have access to the most cost-effective post-acute setting. For example, to what extent will payment reductions for nursing facilities result in patients requiring intensive rehabilitative and/or medically complex care being admitted to higher cost settings?
- Policymakers should advance efforts to develop a set of common post-acute quality measures that transcend sites of care so that comparative effectiveness research can be conducted across settings to evaluate cost and quality outcomes.

CONSIDER

39 percent of short-stay Medicare patients are discharged to the community after an average nursing facility stay of about 25 days

ENDNOTES

1 AL Jones, et al. The National Nursing Home Survey: 2004 Overview. National Center for Health Statistics 13(167). 2009.

2 Nursing facilities serve two distinct patient populations. Nursing facilities treat short stay patients, who require medical and rehabilitative care following an acute hospitalization, as well as long-stay residents who have chronic conditions that require extended care.

3 Lisa Alecxih. Nursing Home Use by the "Oldest Old" Sharply Declines. The Lewin Group. 21 November 2006.

4 Frederick H. Decker. Nursing Homes 1977-1999: What Has Changed, What Has Not? National Center for Health Statistics. 2005.

5 Avalere analysis of 2006 Medicare 100 Percent Standard Analytic File (SAF) claims data base from the Centers for Medicare & Medicaid Services (CMS). Post-acute refers to settings of care that admit patients for restorative and recuperative services following a hospitalization for an acute episode.

6 Lisa Alecxih. Nursing Home Use by the "Oldest Old" Sharply Declines. The Lewin Group. 21 November 2006; Avalere analysis of 2004 National Nursing Home Survey on long-stay patients with a diagnosis of Alzheimer's or dementia, or are in a special program for individuals with behavioral problems or dementia.

7 Ibid.

8 Avalere analysis of Medicare skilled nursing facility cost report data.

9 Frederick H. Decker. Nursing Homes 1977-1999: What Has Changed, What Has Not? National Center for Health Statistics. 2005; Zhanlian Feng, et al. The Effect of State Medicaid Case-Mix Payment on Nursing Home Resident Acuity. Health Services, 41(4), Part 1. August 2006.

10 Zhanlian Feng, et al. The Effect of State Medicaid Case-Mix Payment on Nursing Home Resident Acuity. Health Services, 41(4), Part 1. August 2006; David Grabowski. The Economic Implications of Case-Mix Medicaid Reimbursement for Nursing Home Care, Inquiry-Excellus Health Plan, 39(3). Fall 2002.

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13 Vincent Mor, et al. Prospects for Transferring Nursing Home Residents to the Community, *Health Affairs*, November/December 2007.

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15 Avalere Health. Nursing and Rehabilitation Facilities of the 21st Century. 2009. Short-stay defined as a length of stay of less than 100 days.

16 Christine E. Bishop. Where are the Missing Elders? The Decline in Nursing Home Use, 1985 to 1995. *Health Affairs*, 18(4). July/August 1999.

17 Michael Morrisey, et al. Shifting Medicare Patients out of the Hospital. *Health Affairs*, Winter 1988; K Liu et al. Medicare's Post-Acute Care Benefit: Background, Trends, and Issues to Be Faced, U.S. Department of Health and Human Services, January 1999.

18 Lisa Alecxih. Nursing Home Use by the "Oldest Old" Sharply Declines. The Lewin Group. 21 November 2006.

19 Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. March 2008.

20 Kassner, Enid, et al. "A Balancing Act: State Long-Term Care Reform." AARP Public Policy Institute. July 2008.

21 National Investment Center for the Seniors Housing and Care Industry, MAP Data & Analysis Service.

22 Barbara Gage, et al. Examining Post Acute Care Relationships in an Integrated Hospital System. RTI International. Prepared for Assistant Secretary for Planning and Evaluation, DHHS, February 2009.

23 Ibid.

24 Ibid.

25 Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. March 2008.

26 Ibid. This analysis did not adjust for patient severity, but a 2009 RTI study found that, on average, a higher percentage of SNF cases fall into the higher severity of illness categories as compared to IRFs.

27 Barbara Gage, et al. Examining Post Acute Care Relationships in an Integrated Hospital System. RTI International. Prepared for Assistant Secretary for Planning and Evaluation, DHHS, February 2009.

28 Ibid.

29 Margaret Stineman and Leighton Chan. Commentary on the Comparative Effectiveness of Alternative Settings for Joint Replacement Rehabilitation. Archives of Physical Medicine and Rehabilitation, (90). August 2009; Gerben DeJong, et al, Joint Replacement Rehabilitation Outcomes on Discharge from Skilled Nursing Facilities and Inpatient Rehabilitation Facilities, Archives of Physical Medicine and Rehabilitation, (90). August 2009.

30 Bishop, Christine E. Where are the Missing Elders? The Decline in Nursing Home Use, 1985 to 1995. *Health Affairs*, 18(4). July/August 1999.

31 Most likely only a small percentage of this amount is private LTC insurance, the remainder being health insurance copayments for Medicare covered days.

32 The National Health Expenditure Accounts (NHEA), National Health Expenditures by type of service and source of funds, CY 2007, Nursing Home Care, Centers for Medicare & Medicaid Services.

33 More research should be done to help policymakers better understand current nursing facility payment sources. Industry data suggests that Medicare represent a more important funding source than federal surveys may suggest. For example, Kindred in their 2007 10-K filing with the Securities and Exchange Commission (SEC), show that Medicare represents 34 percent of their revenue, with Medicaid contributing 44 percent and other (including private) accounting for the remaining 22 percent. Additional research can help policymakers understand why these national datasets may understate Medicare revenue contributions.

34 The National Health Expenditure Accounts (NHEA), National Health Expenditures by type of service and source of funds, CY 2007, Nursing Home Care, Centers for Medicare & Medicaid Services.

35 Eljay, LLC. A Report on Shortfalls in Medicaid Funding for Nursing Home Care. October 2008.

36 Ibid.

37 Ibid.

38 Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy, March 2008.

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40 Anne Tumlinson and Christine Aguiar. Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance. The Kaiser Commission on Medicaid and the Uninsured. June 2009.

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42 LifePlans, Inc and the Center for Health and Long-Term Care Research. A Descriptive Analysis of Patterns of Informal and Formal Caregiving Among Privately Insured and Non-Privately Insured Disabled Elders Living in the Community. April 1999.

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47 American Health Care Alliance. Cuts in Governmental Reimbursement: Nursing Facilities. August 2009.

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50 Douglas Elmendorf, Congressional Budget Office, Letter to Honorable Charles B. Rangel, Chairman, Ways and Means, U.S. House of Representatives. 17 July 2009.

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The Alliance For Quality Nursing Home Care

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

Avalere®

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