

Memorandum

DATE: August 3, 2011

TO: State Directors

SUBJECT: Nursing Home Reimbursement Changes

On July 29, the Centers for Medicare & Medicaid Services (CMS) announced a final rule reducing Medicare skilled nursing facility (SNF) Prospective Payment System (PPS) payments in FY 2012 by \$3.87 billion, or 11.1 percent lower than payments for FY 2011. CMS' actions are intended to "correct for an unintended spike in payment levels and better align Medicare payments with costs." On August 2, CMS also released a final rule indicating that Medicare payments to Long Term Care Hospitals (LTCHs) in FY 2012 are projected to increase by \$126 million or 2.5 percent. Both final rules are available at www.ofr.gov/inspection.aspx. At the same time, driven by budget crises, many states have frozen or reduced Medicaid payments to SNFs and LTCHs.

Of interest to state aging and disability agencies is that historically SNFs have relied upon Medicare payments to offset any possible shortfalls in Medicaid lines of business. While nursing home providers were bracing for a Medicare reduction, trade association officials indicated that most were not anticipating a reduction on the scale of 11 percent. One trade association indicated that CMS' SNF rule "makes reductions beyond what is necessary for budget neutrality. This will threaten our ability to provide quality care to America's seniors. Coupled with changes in group therapy definitions, this drastic reduction will be especially challenging for skilled nursing facilities to manage."

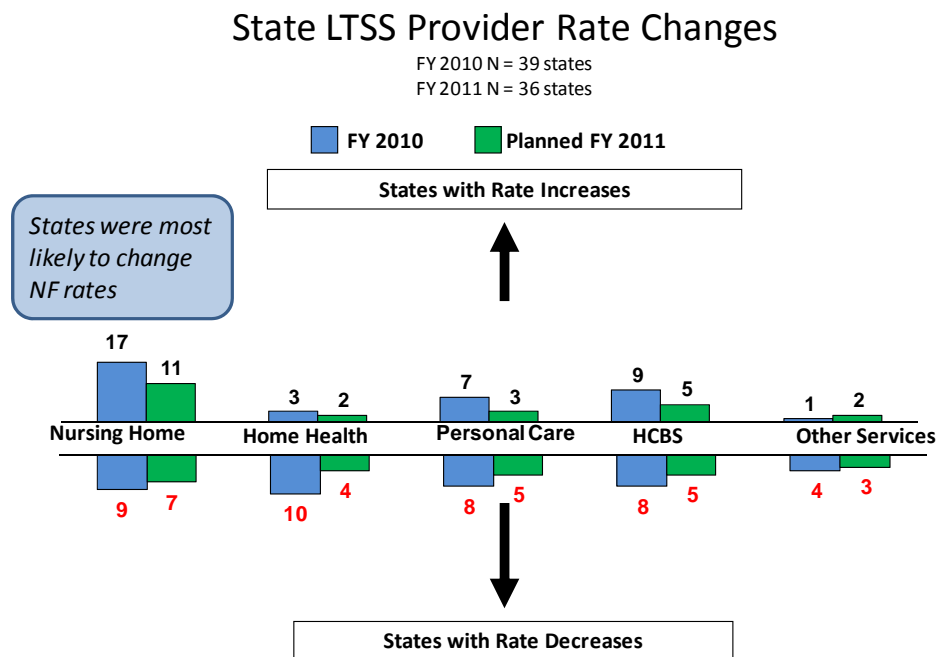
Such possible impacts on nursing facility quality of care could have implications for State Long-Term Care Ombudsman and State Aging and Disabilities Agencies with other nursing home roles and responsibilities.

Background

The nursing home provider marketplace relies on a “Medicare – Medicaid hydrolic.” Specifically, nursing home providers use Medicare reimbursement for post-acute care stays to offset any possible losses from lower Medicaid reimbursement.¹ However, nursing facility providers are reporting reductions in both Medicare and Medicaid reimbursements and that such reductions could impact quality of care.

In terms of Medicaid reimbursement, a June 2010 study found that states were slight more likely to reduce nursing home rates than Medicaid-financed home and community-based services (HCBS) rates (see *Figure 1*, below).²

Figure 1. Projected NH Rate Reductions Compared to HCBS Reductions



¹ Grabowski, D.C. (2010) Post-Acute and Long-Term Care: A Primer on Services, Expenditures and Payment Methods. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

² Walls, O'Rourke, Fox-Grange, et al. (2010) Weathering the Storm: Impact of the Great Recession on Long-Term Services and Supports

While states may have provided increases in the service components of nursing reimbursement methodologies, they were, and are, far less likely to provide adjustments in the capital cost components.³ An annual trade association report indicates that the average shortfall in Medicaid nursing home reimbursement was about \$17.33 per Medicaid patient day in 2010. The report goes on to state that “un-reimbursed nursing home Medicaid allowable costs were estimated at over \$5.6 billion in 2010.”⁴ Industry trade association officials have indicated that the Medicaid reimbursement outlook for 2012 could present further industry challenges.

For Federal fiscal year (FY) 2012, MedPAC recommended that Congress eliminate the FY 2012 Medicare market basket or Medicare payment update.⁵ MedPAC’s recommendations were, in part, realized in CMS’ FY 2012 final rule. Additionally, the Affordable Care Act (ACA) includes a productivity adjustment in the market basket calculations that could result in negative adjustments over a ten year period.

Adjustments in Medicare managed care payments also may have nursing facility implications. In April 2011, CMS released its Medicare Advantage (MA) final rate and call letter indicating that the plans will receive an average payment increase of 0.4 percent, a decrease from the agency’s earlier estimate of 1.6 percent.⁶ To date, approximately, one in four Medicare beneficiaries is enrolled in a MA plan. The resulting impact on nursing homes is financial volatility in Medicaid as well as both the Medicare fee-for-service and managed care arenas.

Implications

While the adequacy of SNF payment levels is a point of debate, reductions in both Medicare and Medicaid SNF payments raises concern about the stability of the marketplace and, potentially, some nursing facility providers. Quality of care also may come into question. Such potential SNF facility operational impacts could produce additional work load pressures for state and local long-term care ombudsman and state aging and disabilities agencies with other nursing facility roles and responsibilities.

³ Grabowski, D.C. (2010) Post-Acute and Long-Term Care: A Primer on Services, Expenditures and Payment Methods. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

⁴ American Health Care Association (AHCA) (December 2010) A Report on Shortfalls in Medicaid Funding for Nursing Home Care

⁵ MedPAC Fact Sheet (March 2011) Report to Congress.

⁶ *The rate announcement and Call Letter are available*

at <http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf>.

A similar dynamic was identified in the 2010 *Weathering the Storm: Impact of the Great Recession on Long-Term Services and Supports* report. In the report, researchers noted that reductions in home and community-based services correlated with increased calls to and demand for Adult Protective Services (APS).

If you have questions, suggestions or concerns, please contact Mike Cheek, Senior Director for State Services, at mcheek@nasuad.org.