THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT

# IMPROVING THE FINANCIAL ACCOUNTABILITY OF NURSING FACILITIES

June 2013

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**The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.**

# Executive Summary

Expenditures for nursing facility services have increased over time, and nursing facilities' profit margins have grown over the past decade. Primarily paid by government sources, nursing facility profit margins that come at the expense of direct care services could adversely affect quality of care. Nursing facilities continue to struggle to meet federal quality standards, with low nurse staffing levels associated with many quality problems. This report provides a short background on nursing facility financing, expenditures and profit margins and an in-depth look at California. The brief then explores two financial policy options designed to control nursing facility costs and improve financial accountability while promoting expenditures on services likely to improve care quality: (1) reimbursement by cost category and (2) a standard medical loss ratio (MLR).

**The analysis shows that the percent of California nursing facility revenues allocated to administrative costs and profits has been increasing and ranged from 19 to 22 percent of total expenditures between 2007 and 2010**. At the same time, the share of nursing facility revenues allocated to direct and indirect resident care has been decreasing, with nursing services experiencing the largest decline. Of the total California nursing facilities studied, 54 percent had administrative costs and profits above 20 percent, and nursing facility profits as a percent of total revenues grew by 88 percent from 2007 to 2010.

**One policy option to improve nursing facility financial accountability is for the Medicare and Medicaid programs to set per diem rates for specific cost categories (rather than the current practice of one overall per diem rate) and to prevent nursing facilities from shifting funds across cost categories.** Payments allocated for nursing, ancillary, support, and capital costs would have to be spent within those cost categories or returned to the payers; they could not be used for administration and profits. Since Medicare profit levels for U.S. nursing facilities equaled 18.5 percent in 2010, a ceiling of 20 percent for total Medicare administration and profits could result in considerable savings to the Medicare program.

**A second policy option is to establish a ceiling on nursing facility administration and profits similar to the concept of a MLR standard for health insurers**. An MLR refers to the proportion of health insurance premium dollars that insurers can spend on health care services, excluding administrative costs and profits. Administrative expenses and profits accounted for 22 percent of California nursing facilities' revenue in 2010, suggesting that an MLR of 80 percent would be reasonable. If an 80 percent MLR applied in California, total savings would have been $139 million in 2010. An analysis of Medicare cost reports for all nursing homes would determine the accuracy of the savings potential nationally.

Improving financial accountability among nursing facilities could result in government savings, increased transparency, and improved care quality for residents. The feasibility of these policy options warrants further exploration and discussion by policy makers at the federal and state levels.

# Introduction

Nursing facility service expenditures in the U.S., primarily paid by Medicaid and Medicare, have increased over the last decade. In 2010, the U.S. had about 15,600 nursing facilities with 1.4 million residents. Of that total, 68 percent of nursing facilities were owned by for-profit companies, while non-profit organizations owned 26 percent and government owned six percent.[1] Over half of nursing facilities are part of a chain that owns two or more facilities.

This report examines nursing facility expenditures by cost category to assess relative spending increases in areas such as nursing services, administrative costs, and profits. The report first provides a short background on nursing facility financing, expenditures and profit margins. It then analyzes California nursing home expenditure data by cost category from 2007 to 2010 and profit margins from 2003 to 2010 as a case study to describe nursing facility expenditure patterns. Finally, the report explores two financial policy options designed to improve nursing home financial accountability and care quality: (1) reimbursement by cost category and (2) a standard medical loss ratio (MLR) option. The analysis of California nursing home profits, administrative costs, and other service costs is used to illustrate the feasibility of both options. Nursing home quality and nurse staffing issues that also may be impacted by the implementation of either of these two policy options are briefly described in the Appendix.

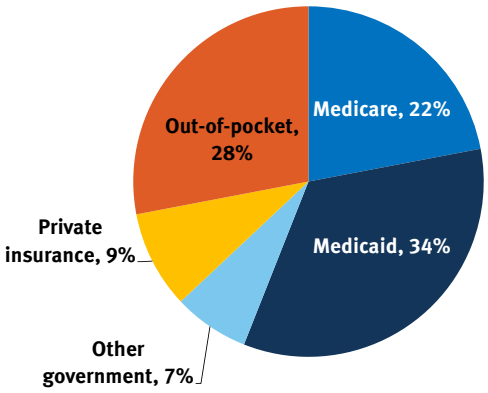
## PART I: NURSING FACILITY PAYMENT AND SPENDING PATTERNS OVER TIME

### *Medicare and Medicaid's Roles as Nursing Facility Payers*

**Nursing facility services are primarily paid by government sources (63% in 2010).** Of total nursing facility expenditures in 2010, Medicaid paid 34 percent, out-of-pocket payments were 28 percent, Medicare paid 22 percent, private health insurance paid nine percent, and other government sources paid seven percent (Figure 1).[2]

Figure 1

**Medicare and Medicaid Finance Over Half of U.S. Nursing Facility Expenditures, 2010**




Total Expenditures, 2010: $143 Billion

SOURCE: CMS National Health Expenditure Data, 2012.

**Consequently, most nursing facilities are certified to provide services to individuals who are eligible for either or both Medicare and Medicaid.** Medicare pays for short-term, post-acute nursing facility care, which includes skilled nursing and rehabilitation services. It covers up to 100 days of nursing facility services per episode of illness after a medically necessary inpatient hospital stay of at least three days. Almost 1.7 million beneficiaries in the traditional fee-for-service Medicare program (or 4.3% of all Medicare beneficiaries) used Medicare-funded nursing facility services at least once in 2010.[3]

**The Medicare program uses a prospective payment system (PPS) to pay daily rates to nursing facilities.** The Centers for Medicare and Medicaid Services (CMS) establishes and periodically adjusts Medicare nursing facility payment rates to take into account cost increases. The Medicare rates also are adjusted for each facility's relative case-mix of resident care needs, or acuity, based on information gathered from a standardized resident assessment instrument called the Minimum Data Set (MDS).[4] MDS data are used to classify residents into one of 66 case-mix categories, known as resource utilization groups (RUGs), based on expected costs for the amount and type of nursing and therapy services that each resident needs. Payment rates are established for each RUG.[5] The Medicare per diem rate also is adjusted for urban and rural wage differences for nursing and therapy case-mix, therapy non-case-mix, and non-case-mix components.[6] The non-case-mix components include administrative and capital costs.

**Recent data show a significant increase in nursing facility case-mix, indicating that residents have high needs for nursing and therapy services and raising questions about low nurse staffing levels and unmet resident need in nursing facilities.** The Medicare Payment Advisory Commission (MedPAC) documented that the share of resident days classified in rehabilitation case-mix groups with the highest Medicare payment rates has increased since 2001.[7] (Additional background about nursing facility care quality and nurse staffing levels is provided in the Appendix.)

**MedPAC has observed that the Medicare PPS incentivizes nursing facilities to furnish therapy services and therefore qualify residents in case-mix groups with higher payment rates to increase their Medicare revenues.**[8] In 2011, Medicare program spending for skilled nursing facility (SNF) services increased to almost $32 billion, up more than 17 percent from 2010. This spike in Medicare spending was reported by MedPAC to reflect overpayments from CMS's implementation of new case-mix groups (an increase from 53 to 66 groups) in 2011.[9] Although the new case-mix system was expected to be budget neutral, the change resulted in $4.5 billion in increased payments. Because Medicare pays nursing facilities prospectively and does not recoup payments for missed services, the Medicare rules allow nursing facilities to bill for nursing and therapy visits that are not provided.[10] MedPAC also noted an OIG report finding that nursing facility resident characteristics do not explain patterns of case-mix reports that reflect an increase in higher service intensity groups.[11]

**Medicare rates are generally much higher than Medicaid nursing facility rates, which are established by states**. Medicaid, jointly funded by the federal and state governments and administered by states, covers many people with low incomes who need nursing facility care.[12] It also covers Medicare cost-sharing for those who are eligible for both Medicare and Medicaid (so called "dual eligible beneficiaries"), and it covers nursing facility services for some dual eligible beneficiaries who have exhausted their Medicare coverage.

**Most state Medicaid programs pay nursing facilities on a prospective per diem basis, and some take into account the case-mix level of residents.**[13] States are given wide flexibility in establishing their Medicaid nursing facility payment methods and rates, with little federal involvement. The Medicaid and CHIP Payment and Access Commission (MACPAC), which is charged with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to Congress, the Secretary of Health and Human Services (HHS), and the states, has not yet focused on Medicaid nursing facility payment policies.[14]

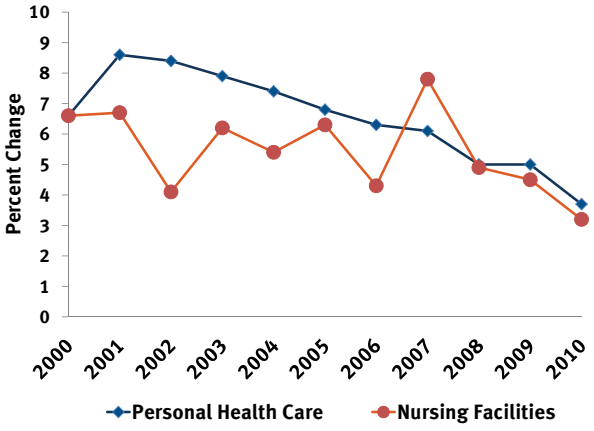
## *Increasing Nursing Facility Expenditures*

Across all payers, spending on nursing facilities has been increasing during the last decade. Expenditures increased from $85 billion in 2000 to $143 billion in 2010 (or by 68%). The average annual increase in nursing facility expenditures was 5.4 percent over that period compared to 6.6 percent for personal health care expenditures (excluding costs for administration of government programs and public health).[15]

However, the rate of growth in nursing facility and personal health care expenditures has declined since 2007, probably related to the economic recession (Figure 2). Total nursing facility expenditures were estimated to be $155.2 billion in 2012, and they are projected to increase to $255 billion in 2021 (over 6% annually).[16] Expenditures have increased even though the number of nursing facilities and occupancy rates (defined as the share of total beds that are vacant) have declined gradually since 2001.[17]

Figure 2

**Rate of Change in U.S. Total Nursing Facility and Personal Health Care Expenditures, 2000-2010**




SOURCE: CMS National Health Expenditure Data, 2012.

## *Nursing Facility Profit Margins*

**From 1999 to 2010, the cumulative increase in Medicare payments (75%) far exceeded increases in costs for nursing facility services, resulting in a large growth in Medicare nursing facility profits**. Medicare nursing facility profit margins are the difference between Medicare's payments to nursing facilities and their expenditures for resident care.[18]

**In 2010, the average Medicare profit margin for non-hospital based nursing facilities was 18.5 percent, marking the tenth consecutive year with average margins above 10 percent**.[19] For-profit nursing facility margins were 20.7 percent while non-profit facility margins were 9.5 percent. Medicare profit margins also have become less variable over time. The large profit margins led MedPAC to recommend a rate cut for Medicare SNFs that was adopted in 2011.[20] Because of the high profit margins in the Medicare program, MedPAC also recommended that Congress eliminate adjustments for inflation in the Medicare payment rate in 2012. While a report from the nursing home industry argued that the MedPAC methodology overstates profit margins,[21] MedPAC also recommended that HHS revise its Medicare PPS for nursing facilities beginning with an initial reduction of four percent with subsequent reductions over an appropriate transition period until Medicare's payments are better aligned with providers' costs.[22]

**Although Medicare profit margins were high relative to service costs, U.S. aggregate total nursing facility profit margins for all payers including Medicare, Medicaid, and other payers were 3.6 percent, and one-quarter of nursing facilities had total profit margins at or below –1.3 percent in 2010**. One-quarter of nursing facilities had total margins that were equal to or greater than 8.2 percent.[23] Total profit margins were lower because state Medicaid nursing facility payment rates were historically lower than Medicare. However, total nursing facility profit margins

have grown during the last decade.[24] Nationally, the nursing facility industry maintains that state Medicaid funding for nursing facilities is inadequate (average state rates were $172 per day in 2010) and that the shortfall between Medicaid payments and costs was expected to be $17 per Medicaid day (or a total of $5.6 billion) in 2010.[25]

## PART II: ANALYSIS OF CALIFORNIA NURSING FACILITY EXPENDITURE DATA BY COST CATEGORY

Against this background of increasing nursing facility expenditures and increasing Medicare profit margins, we examined nursing facility expenditure patterns by cost category. California nursing facilities were selected for this analysis because of the availability of the state's annual financial cost reports and complete nursing facility data for all payers (Medicare, Medicaid, and other payers). California financial cost reports are similar to Medicare cost reports with information about revenues and expenditures by cost category. Additional information about the study sample is described in Table 1, and the cost categories studied are detailed in Table 2.

### Table 1: Description of California Nursing Facilities Included in Study Sample

| Study sample includes: | Total number of nursing facilities in study sample, by year: | | Tax status of nursing facilities in study sample: | |
|---|---|---|---|---|
| | Year | Sample Size | Non-profit | For-profit |
| All California nursing facilities, except those that were<br>(1) government-owned;<br>(2) hospital-based;<br>(3) intermediate care facilities;<br>(4) hospice programs;<br>(5) assisted and congregate living facilities;<br>(6) combination assisted living facilities-nursing facilities; and<br>(7) facilities licensed to serve individuals with mental health disabilities and/or developmental disabilities. | 2007 | 881 | 37 | 835 |
| | 2008 | 879 | | |
| | 2009 | 876 | | |
| | 2010 | 872 | | |

SOURCE: California Office of Statewide Health Planning and Development, "Long-Term Care Facility Annual Financial Data, January 2007-December 2010," accessed March 21, 2013, http://www.oshpd.ca.gov/HID/Products/LTC/AnnFinanclData/FinancialTrends/default.asp.

### Table 2: Cost Categories Accounting for Total California Nursing Facility Costs Analyzed

| Cost Category | Description |
|---|---|
| Nursing services | Includes labor costs for nursing managers and nursing personnel |
| Ancillary services | Includes therapy services, supplies, pharmacy, laboratory, and other health care services |
| Support services | Includes plant operations and maintenance, laundry and linen, dietary, social services, and in-service education |
| Capital costs | Includes depreciation, leases and rentals, interest, property taxes, insurance, interest payments, other interest and provisions for bad debts |
| Other expenditures | Includes quality assurance fees and licensing fees; since these items are not separately reported within the administrative cost center in California, they were estimated using data from the California Department of Health Services;* quality assurance fees were calculated based on the average fees per resident day, and licensing fees were calculated based on the annual established fee per facility bed |
| Administrative costs | Includes all nursing facility administration-related costs, e.g., management and executive wages and benefits, home office expenses for parent companies, and other costs; excludes Medicaid quality assurance fees and licensing fees |
| Profits | Includes net income from health and other operations minus health care expenditures |

SOURCE: California Office of Statewide Health Planning and Development, "Long-Term Care Facility Annual Financial Data, January 2007-December 2010," accessed March 21, 2013, http://www.oshpd.ca.gov/HID/Products/LTC/AnnFinanclData/FinancialTrends/default.asp.

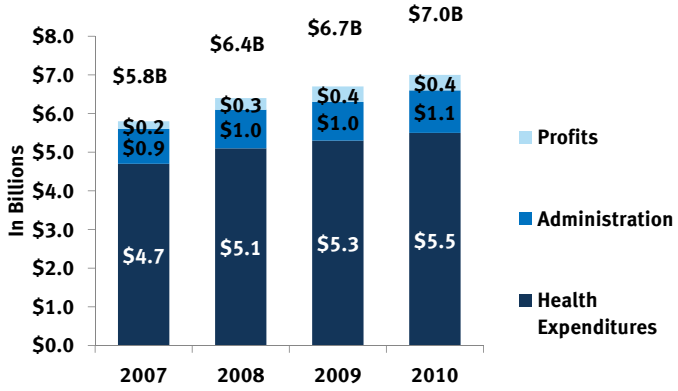
NOTE: *California Department of Health Services, "SNF Quality Workgroup Peer Groups," accessed June 1, 2013, http://www.dhcs.ca.gov/services/medi-cal/Documents/SNF Quality Workgroup/Item III PEER GROUP KEY_FINAL.xls

## *California Nursing Facility Expenditures*

**California nursing facility profits and administrative expenses ranged from 19 to 22 percent of total expenditures between 2007 and 2010.** California nursing facility revenues were $7 billion in 2010, having increased by almost 20 percent between 2007 and 2010.[26] Nursing facility expenditures for nursing, ancillary, support, capital, and other costs were 81 percent of total health care revenues in 2007, 80 percent in 2008, 79 percent in 2009, and 78 percent of total revenues in 2010 (Figure 3). The remainder of nursing home expenditures was for administration and profits.

Figure 3

**California Nursing Facility Profits and Administrative Expenses Ranged from 19 to 22% of Total Expenditures, 2007 - 2010**



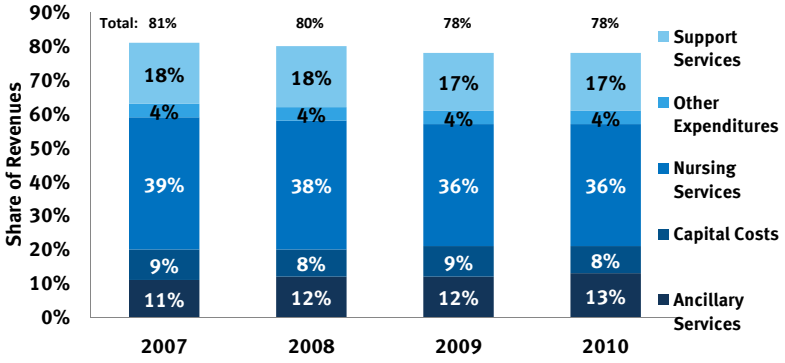

SOURCE: California Office of Statewide Health Planning and Development Financial Data, 2007 – 2010.

## *California Expenditures for Nursing, Ancillary Services, Support, Capital, and Other Expenses*

Expenditures for nursing services in California declined steadily as a percent of revenues (from 39% in 2007 to 36% in 2010) (Figure 4).[27] Ancillary expenditures increased (from 11 to 13%) while support services declined during the study period. Capital and other expenses remained fairly stable at eight to nine percent and four percent, respectively. The decline in California nursing service expenditures at a time when Medicare resident case-mix and Medicare payments have been increasing, as observed by MedPAC,[28] is notable. Nursing services expenditures varied widely among facilities, from 18 to 74 percent of facility revenues in 2010.

Figure 4

**California Nursing Facility Expenditures for Nursing Services Declined as a Percent of Total Annual Revenues, 2007-2010**




SOURCE: California Office of Statewide Health Planning and Development Financial Data, 2007 – 2010.

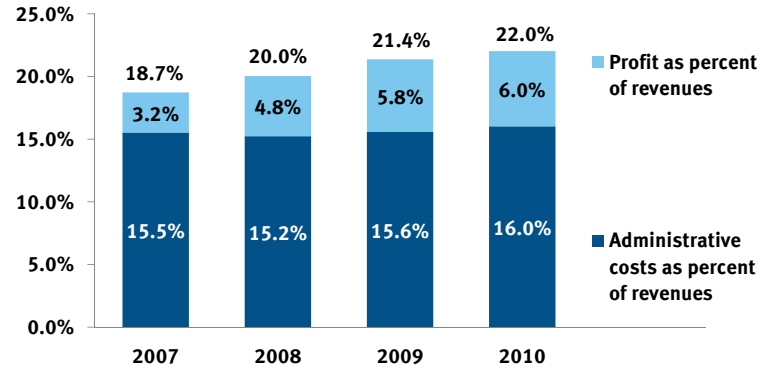
Expenditures for nursing services averaged 36 percent of revenues in for-profit nursing facilities and 41 percent in non-profit facilities from 2007 to 2010. Nonprofit facilities had lower ancillary and capital expenditures and higher support service expenditures than for-profit facilities. Overall, 20 percent of all California nursing facilities in this analysis spent 31 percent or less of their revenues on nursing services.

## *California Nursing Facility Expenditures for Administration and Profits*

California nursing facility administrative expenses as a percent of total revenues grew slightly (3%), while profits grew by 88 percent from 2007 to 2010 (Figure 5). Administrative expenses averaged 16.0 percent of revenues (the median was also 16%) and varied widely across nursing facilities and ownership types. Ten percent of nursing facilities had over 20 percent administrative costs and one percent had over 28 percent. Some nursing facility chains have high administrative costs attributable to their parent companies. For example, one California-based nursing facility chain with 22 facilities had administrative costs of 19 percent of total expenditures, of which 60 percent was allocated to the parent company in 2010.[29]

Figure 5

**California Nursing Facility Profits Increased as a Percent of Total Revenues, 2007- 2010**




SOURCE: California Office of Statewide Health Planning and Development Financial Data, 2007-2010.

Although administrative expenditures are necessary to operate nursing facilities, excessively high administrative expenditures can result in less funding available for direct care services and could adversely affect quality of care. For example, if nursing facilities pay high salaries to executives and corporate officers, there could be fewer resources available for resident care. However, as nursing facilities grow more complex in operation and administration, their administrative costs may increase.[30] It is noteworthy that the recent California trends in the share of administrative expenses and profits out of total revenue have been different. While the share of administrative expenses has basically been stable, growing at a rate of less than one percent per year, the share of profits has been growing at a very fast rate of about 20 percent per year as shown in Figure 5.

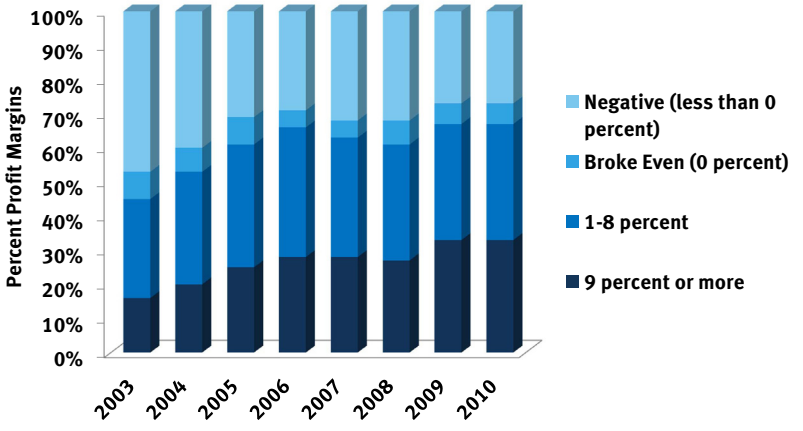
**Although profit margins for California-based nursing facilities averaged six percent of revenues, margins varied from a loss of 55 percent to a profit of 72 percent in 2010.** It should be noted that these self-reported profit margins do not include profits for related-party services (other companies owned by the nursing facility company). For example, some nursing facilities have established separate companies to manage the facility and companies that hold the assets such as buildings and property.[31] Leases and rent and management contracts with related-parties may include profits that are not reported on the cost reports.

**Of the total California nursing facilities studied, 54 percent had administrative costs and profits above 20 percent.**[32] For-profit nursing facilities (96% of total study population) had higher combined administrative costs and profits than non-profit nursing facilities (23% compared to 21% for non-profit facilities) in 2010.[33] We note, however, that California has very few non-profit nursing facilities, and their financial structure, in addition to reflecting different organizational missions and structures, may also reflect other operational or market differences and advantages not shared by most for-profit nursing facilities in California and nationwide.

**Total nursing facility profit margins in California have grown since 2003.** For example, the percent of California nursing facilities with profits in the highest profit margin category has increased steadily since 2003 (Figure 6). At the same time, almost a third of California nursing facilities showed financial losses during this period.

Figure 6

**California Nursing Facility Profit Margins Have Increased, 2003-2010**




SOURCE: California Office of Statewide Health Planning and Development Financial Data, 2003-2010.

## Part III: Policy Options to Improve Financial Accountability of Nursing Facilities

The data presented above show that in recent years: (1) Medicare rates of return for nursing facilities nationally have been high relative to service costs; and (2) in California, the percent of nursing facility revenues allocated to administrative costs and profits has been increasing, while the share of nursing facility expenditures allocated to direct and indirect resident care has been decreasing, with nursing services experiencing the largest decline. This raises questions about the ability of nursing facilities to maintain or improve care quality to the levels considered adequate by federal regulatory standards. Some nursing facilities may respond to future Medicare rate cuts by further reducing nursing, ancillary, and support services and expenditures to maintain their profit margins, which could create additional quality problems.

Given the above trends, this brief examines two alternative policy options that could control nursing facility costs and improve financial accountability while promoting expenditures on services likely to improve care quality.

### *Policy Option 1: A Cost Category Reimbursement Method*

**One policy option to improve nursing facility financial accountability is for Medicare and Medicaid payers to set prospective per diem rates for specific cost categories and to require nursing facilities to spend their allocated funds within each cost category.** Rates would be set for nursing and therapy, ancillary, support, capital, other expenses, and administration and profits, rather than one overall per diem rate, and nursing facilities would not be permitted to shift funds to other cost categories such as administration and profits. Payments would have to be spent within the cost category to which they were allocated or returned to the payer. In such a system, Medicare could continue to adjust its nursing and therapy rates based on resident case-mix and make adjustments for cost of living changes and geographic variations.

**The current Medicare and Medicaid rate setting methods take into account nursing facility costs, but nursing facility providers are given latitude in how the funds are used and may shift funds allocated for various other categories into administration and profits.** In the current Medicare PPS, nursing facilities must submit an annual cost report that shows expenditures by cost center, but after Medicare payments are made, facilities may use the funds without regard to the allocations in the payment formula, which allows them to decrease the amount spent for

resident care services and instead increase the funds devoted to administrative costs and profits.[34] As noted above, Medicare sets a prospective payment rate per day using a complex formula with a consolidated bill for almost all services except for some physicians, nurse practitioners, and other related professional services.[35]

**In California, nursing facilities had increasing profits margins over the last four years, and some had high administrative costs.** In the California Medicaid program, nursing facilities do not have to spend Medicaid funds within established cost categories, although they have an incentive to do so because actual facility expenditures in each category determine future rates. State Medicaid nursing facility payment methods and rates vary widely. California has a complex prospective rate setting system where each facility receives its own rate based on its expenditure pattern, as documented in its audited Medicaid cost report.[36] Medicaid rates are calculated for five cost categories: (1) labor costs; (2) non-labor costs; (3) administrative costs; (4) capital costs; and (5) other costs.[37] The first three categories are reimbursed based on past self-reported costs per day trended forward (using a category specific cost-index) and are subject to caps (i.e., ceilings). The caps are based on peer facility expenditures set at the 90$^{th}$ percentile for labor costs, 75$^{th}$ percentile for non-labor costs, and 50$^{th}$ percentile for administrative costs. Capital costs are reimbursed based on a fair market value formula. Each facility also receives an additional eight percent rate increase for every dollar spent on labor thereby incentivizing increases in labor expenditures.[38] Thus, the overall California Medicaid facility-specific per diem rate is based the calculations for the five cost categories. For rate setting purposes, California's Medicaid program has an audit system to determine actual past expenditures, excluding certain costs that are not allowable and costs over the cost caps.

**The major change from the current Medicare PPS to a cost category reimbursement model would be in accountability for the payments, where nursing facilities would be required to either demonstrate that the Medicare funds were spent for specific cost categories or return funds to CMS rather than to allocate funds to other categories**. Nursing facilities would continue to submit audited financial cost reports, but Medicare would need to establish auditing and reimbursement systems for unused funds by cost category.

**A modified, and possibly simpler, cost category approach would establish a cost ceiling on total administrative expenses and profits and require a return payment for expenditures that exceed the Medicare and Medicaid cost ceilings**. This approach might be more advantageous because it preserves the freedom of nursing facilities to manage their operations as they see fit, within government guidelines, in those areas related to resident care. Since Medicare profit levels for U.S. nursing facilities equaled 18.5 percent (about three times higher than the overall average profit in California of six percent) in 2010, a ceiling of 20 percent for total Medicare administration and profits would result in a considerable savings to the Medicare program.

**Many state Medicaid programs use prospective rate setting methods similar to Medicare, so it is possible that a change in Medicare's rate setting approach would encourage a change in state Medicaid methods**. Under this proposed option, states would continue to have some flexibility in their Medicaid rate setting methodologies but by adopting a cost category reimbursement method, they could increase nursing facility accountability for the funds allocated in the same way that adoption of this policy by the Medicare program would encourage financial accountability.

**Establishing allocations for cost categories with limits on administrative costs and profits could result in substantial savings to both the Medicare and Medicaid programs, while protecting funds for resident services**. Quality could improve if allocated funds are used for resident services. A disadvantage of this policy

option is that changes in Medicare and Medicaid policies may not protect other payers such as private insurers and individuals who self-pay. The cost category policy option would not require major changes in the rate setting process for either Medicare or Medicaid, but it would require more resources for the auditing process to ensure financial accountability.

### *Policy Option 2: A Medical Loss Ratio (MLR) for Nursing Facilities*

**A second policy option to increase nursing home financial accountability would establish a ceiling on nursing facility administration and profits similar to the concept of an MLR, which was established in the ACA for health insurers**. An MLR refers to the proportion of health insurance premium dollars that are spent on health care services, excluding administrative costs and profits. Historically, an MLR was used by financiers to assess the investment quality of an insurance company. Expenditures for care services are considered a "loss" to an insurance company.[39] Previously, some insurance companies spent as little as 60 percent on patient care with the remainder spent on dividends, profits, marketing, sales expenses, CEO salaries, overhead, and administrative costs.[40]

**The ACA sought to curtail this practice by setting a ceiling on administration and profits for insurers at 20 percent**.[41] This was considered feasible because prior to the ACA, some large insurers and Medicare had already achieved MLRs ranging from 95 to 98 percent.[42] A standard MLR increases financial transparency by making expenditure and revenue information publicly available to consumers and employers, and it gives insurers incentives to reduce administrative costs to assure that "consumers get fair value for their healthcare dollars."[43]

**Under the ACA, the MLR for health insurers is defined as the sum of total health care claims and quality improvement expenses divided by the total premiums for health insurance minus taxes, licensing, and regulatory fees**. In addition, health insurers are allowed to make adjustments based on enrollment levels and other factors.[44] Insurance companies that fail to meet the national MLR standard of 80 percent of revenues for the prior year must issue rebates to consumers proportionate to the amount of premiums paid. Nationwide, rebates of about $150 per household were issued for a total of about $1.1 billion in 2012.[45]

### *Is an MLR Appropriate for Nursing Facilities?*

**It is not immediately obvious whether an MLR is reasonable for nursing facilities because nursing facilities, unlike insurers, are direct providers of care and may have a different cost and profit structure**. As noted above in Figure 5, administrative expenses and profits accounted for 22 percent of revenues for California-based nursing facilities in 2010, suggesting that an MLR threshold of 80 percent would be a reasonable level for nursing facilities to meet while ensuring adequate funding for administrative costs.

**Implementation of an MLR threshold for nursing facilities should be accompanied by ongoing monitoring of the administrative performance of the industry to allow for adjustments to the policy and the MLR threshold if need be**. This is necessary because under an MLR standard, if nursing homes reduce administrative expenditures to increase profits, then resident care could be adversely affected.

**An advantage of an MLR standard for nursing facilities is that it would apply to all payers rather than only government payers**. One disadvantage is that nursing facilities have more complex organizational structures than insurance companies, and as a result, may be able to develop ways to allocate profits and administrative costs in leases and services agreements with related-party organizations.

### *MLR and Potential Savings*

**If California nursing facilities had an MLR of 80 percent, total savings would have been $139 million in 2010, or a savings of about $159,000 per facility**. As stated above, in 2010, average administrative costs and profits were 22 percent in California. We also calculated the potential savings if all nursing homes met the 80 percent MLR threshold. Although the California nursing facilities included in the study are not necessarily representative of the 15,600 nursing facilities across the country because there is a higher percentage of for-profit facilities in California,[46] the savings potential as a result of establishing a minimum MLR could be large. (An estimated $2.5 billion a year nationally in 2010 dollars could possibly be achieved, calculated by multiplying the average California savings per facility by 15,600 facilities in the U.S. However, the savings potential in California may be greater than in other states due to the greater prevalence of for-profit facilities in California.) An analysis of Medicare cost reports for all nursing homes would determine the accuracy of the savings potential nationally.

**Similar to the penalty for failing to meet the MLR standard for health insurance companies, nursing facilities that failed to meet the applicable MLR standard for the prior year could be required to issue rebates to Medicare, Medicaid, other government payers, private insurers, and consumers who paid out of pocket**. The rebates could be distributed proportionately to the payers based on the share of the total funds that were not in compliance with the MLR standard. Similar to the rules set forth for health insurers in the ACA, if the rebate amount is so small such that the administrative expenditures that would be incurred to process the rebate exceed the value of the rebate, nursing facilities would not be required to process the rebate. Instead, the rebates could be put in a pool of funds which would be used for quality improvement initiatives.

### *Discussion of Policy Issues*

The above analysis of nursing facility expenditures in California illustrates two alternative policy options to improve nursing facility financial accountability. California nursing facility expenditures on resident care have gradually declined from 81 percent in 2007 to 78 percent in 2010. Although the profit margins for Medicare are substantially higher than total nursing facility profit margins, the total nursing facility profit margins in California were six percent in 2010, having grown substantially since 2007. Non-profit facilities spent a greater proportion of their revenues on resident care (79 %) than for-profit facilities (77 %) did, with wide variations across facilities.

**In California, administrative expenditures averaged 16 percent in 2010, but with a wide range in total administrative expenses, suggesting that some facilities may have excessive administrative expenditures**. Administrative expenditures, of course, are necessary to manage nursing facilities. The optimal percent of administrative expenditures of total revenues is unknown and undoubtedly varies by facility size (number of beds), ownership, location, and many other factors. Since 16 percent is the industry's national average for administrative expenditures as a share of total revenues, that level could be set as a target for all U.S. nursing homes to encourage greater administrative efficiency.

**These findings suggest that establishing cost categories or an MLR for financial accountability in nursing facility spending could yield potential savings for government payers**. Establishing a minimum MLR for nursing facilities could result in savings for all payers including Medicare, Medicaid, other government payers, private health insurance, and private-pay residents. If a nursing facility-specific MLR was set at 80 percent, there could be a large potential savings nationally based on the analysis of California expenditures in 2010. An analysis of Medicare cost reports for all US nursing homes would determine the accuracy of the savings potential nationally.

**One benefit of establishing either cost categories for spending accountability or an MLR is that it could be useful for public reporting and transparency**. The Medicare *Nursing Home Compare* website provides detailed information on nursing homes and rates the quality of care on various dimensions including facility deficiencies, staffing levels, and quality measures.[47] Providing information on spending may be helpful to policymakers, payers, and consumers who are selecting or contracting with providers.

**If either of these policy options was developed for nursing facilities, a system for auditing financial reports and recovery of excess payments would be needed to ensure financial accountability**. Moreover, some consideration would be needed to address potential profits that may be attached to facility lease or other service arrangements with parent companies or related-party companies.

**The feasibility of these policy options needs further exploration and discussion by policy makers at the federal and state levels**. It is expected that these options would improve financial accountability among nursing facilities. These options could incentivize nursing facilities to improve administrative efficiency and reduce profits and could result in reduction of unmet need and improved care quality for residents.

## Appendix: Nursing Facility Care Quality and Nurse Staffing Levels

Poor care quality in nursing facilities is a problem that Congress and the Centers for Medicare and Medicaid Services have tried to address at various points over the years. For nursing facilities to receive federal funding from Medicare and Medicaid (which about 98 percent of facilities do), they must meet minimum federal quality and life-safety standards.[48]

In 1986, many serious problems with federal oversight of nursing facilities were identified by the Institute of Medicine which led Congress to pass the Omnibus Budget Reconciliation Act (OBRA) of 1987.[49] OBRA established a system of intermediate sanctions, such as civil monetary penalties and holds on admissions, for serious quality violations as well as facility decertification from the Medicare and Medicaid programs.[50]

After implementation of the 1987 legislation, over 20 studies by the federal Government Accountability Office have documented continued nursing facility quality problems and ineffective federal and state survey and enforcement procedures.[51] The federal Office of the Inspector General (OIG) also has written many reports about poor nursing facility quality and the federal oversight system.[52] In 2010, over 94 percent of the 15,600 nursing facilities were cited, receiving a total of about 150,000 deficiencies for failure to meet federal regulations and violations of quality standards.[53] Overall, state survey systems found that nursing facilities failed to: provide adequate infection control (43%); ensure a safe environment and prevent accidents (43%); provide adequate food sanitation (39%); and meet care quality standards (34%), along with many other serious violations. State regulatory agencies reported that 23 percent of nursing facilities were cited for causing "actual harm" or "immediate jeopardy" to their residents in 2010.[54]

Low nurse staffing levels have been associated with many of these quality problems. The positive outcomes for residents in nursing facilities with high nurse-to-patient staffing levels, especially registered nurse (RN) staffing levels, include: lower mortality rates; improved physical functioning; less antibiotic use; fewer pressure ulcers, catheterizations, and urinary tract infections; lower hospitalization rates; and less unplanned weight loss and dehydration.[55] The change from the Medicare retrospective (which sets rates based on actual expenditures) to prospective payment system (which sets rates per day before services are delivered) for nursing facilities in 1987

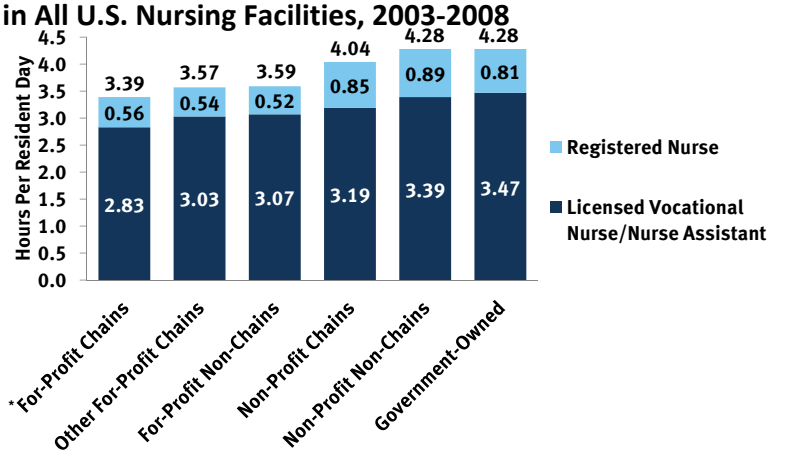
resulted in a decline in RN staffing and quality. Because nursing facilities are not required to actually provide the nursing and therapy services that are prospectively paid by Medicare, after prospective payment was adopted the ratio of RN staff to nursing facility residents declined, and the number of deficiencies increased significantly.[56]

A 2001 CMS-sponsored study showed that nurse staffing levels below a total of 4.1 nursing hours per resident day, including 0.75 RN hours and 0.55 LVN hours per resident, can result in harm or jeopardy to residents.[57] Nationwide, the average nursing facility reported 4.05 total nursing hours per resident day, including 0.78 RN hours and 0.83 LVN hours per resident day in 2012.[58] Although average nurse staffing levels have improved over time, many nursing facilities continue to have very low staffing levels.

Staffing levels vary widely across nursing facilities and are associated with type of ownership (Figure 7). The lowest staffing levels can be found among the for-profit facilities, all averaging around 3.5 nursing hours per resident day, with somewhat lower staffing levels among the 10 largest for-profit chains in terms of the number of facilities. In contrast, non-profit and government-owned nursing facilities average four or more nursing hours per resident day, providing on average roughly 15 percent more staffing than for-profit facilities.[59]

Figure 7

**Nurse Staffing Hours Per Resident Day, by Ownership Type, in All U.S. Nursing Facilities, 2003-2008**




NOTE: * Includes only on the 10 largest for-profit chains.
SOURCE: Charlene Harrington et al., "Nurse Staffing and Deficiencies in the Largest for-Profit Chains and Chains Owned by Private Equity Companies," *Health Services Research* 47, no. 1 (2012):106-128

Furthermore, the extent of residents' care needs was actually higher among the 10 largest for-profit chains compared with non-profit nursing facilities, thus raising additional concerns about the adequacy of the care that for-profit nursing home staff is able to provide. The staffing level at non-profit and government-owned nursing homes was similar to the levels recommended in the 2001 CMS study (i.e., 4.1 nursing hours per resident day).[60] Thus, the data suggest that the majority of nursing facilities (the 68 percent that are for-profit) are understaffed relative to the CMS study recommendations.

The ACA addresses some of these problems through provisions to improve nursing facility transparency, care quality, and resident abuse prevention, which CMS is in the process of implementing.[61] However, the ACA did not change the nurse staffing standard or the Medicare and Medicaid payment systems applicable to nursing homes. Consequently, other policy options, such as those explored in this brief, could not only improve nursing facility financial accountability but also address care quality by limiting nursing facility profit margins that come at the expense of direct care services and nurse staffing levels.

# Endnotes

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