Skilled Nursing Facilities: Execution, Effectiveness and Size

Skilled nursing facilities (SNF) have benefitted from the rapid growth of Medicare FFS (Part A) admissions during the past ten years. Part A payment per day is more than double that of Medicaid, and represents the primary driver of profitable growth.

Health system and hospital consolidation, combined with the growth of Accountable Care Organizations, Medicare Advantage enrollment and bundled (episode of care) payments, has raised concerns with SNF costs and quality. Medicare Advantage discounts vary widely among providers, as does potentially avoidable hospitalizations.

In this article, we highlight the importance of Medicare, wide variation in Medicare FFS operating margins and quality, and longer-term demographics favorable to the growth of Medicare short-term stays.

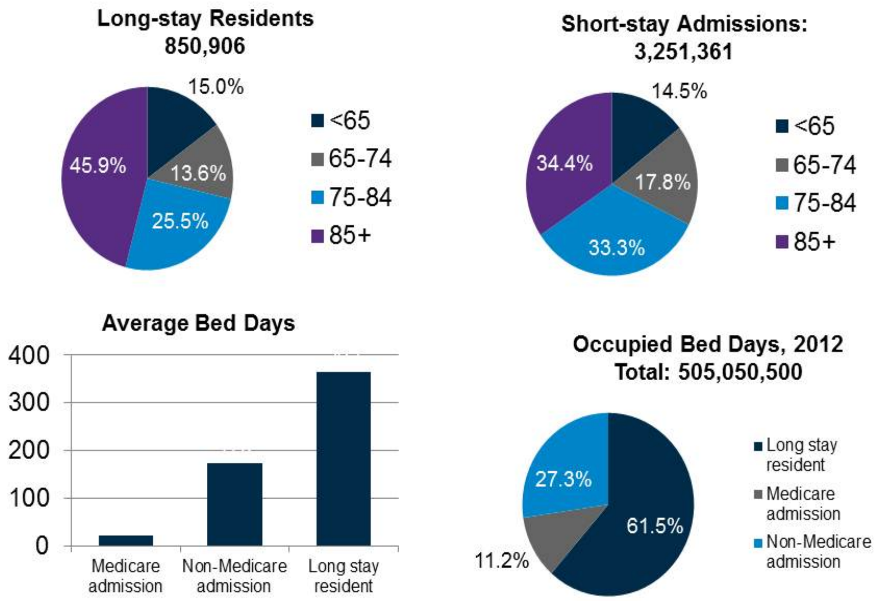
Medicaid Drives Resident Stays, but Not Revenues

In 2012, there were 15,643 skilled nursing facilities with 1.67 million beds. The vast majority of facilities, 80.9%, were between 50-199 beds, 13.0% are fewer than 50 beds and 6.1% are greater than 199 beds.[1] For-profit institutions account for 69% of the total, whereas non-for-profit (25%) and government (6%) entities account for the remainder.

Users of skilled nursing facilities users tend to be elderly; >85 years: 43%, 75-84: 27%, 65-74: 15% and <65 years: 15%. Moderate to severe cognitive impairment is found in 63% of patients; many are highly dependent for supportive care with four (38.6%) or five (23.3%) impairments in Activities of Daily Living (ADLs). Non-Hispanic whites and African Americans are over-represented, whereas are Hispanics under-represented relative to the U.S. population mix.

Medicaid accounts for 63% of residents and 42% of revenues, whereas Medicare accounts for 14% of residents and 25% of revenues. Private pay (commercial, out-of-pocket) remains an under-recognized driver, as it accounts for 22% of residents and 33% of revenue.[2]

The dynamics of payer mix are complex. Occupied bed days represent the best approach to understanding the relationship between payer mix and length of stay. A SNF occupancy rate of 83.0% implies 1.38 million occupied beds (residents) each day. Residents may be long stay (Medicaid or “Spend Down”) or short stay (Medicare Part A, commercial). On any given day, on average, long stay (institutional) residents account for 61.5% of occupied beds and short-stay residents account for the remaining 38.5%. The average bed days for long-stay patients exceeds one year, implying limited turnover whereas short stay admissions of 3.3 million imply a far higher turnover of 6:1 for each available bed.



Medicaid Payment Rates Vary by State

Payment rates for institutional Medicaid residents are below that of other payers, and can vary considerably by state based on funding allocation decisions among competing needs including: acute inpatient, post-acute and institutional; and children, adults, the disabled and aged. A wide range of spending per aged Medicaid enrollee exists, with New York ($28,336), Ohio ($27,494) and Massachusetts ($27,205) among the highest spending states and Illinois ($11,431), California ($12,019) and Florida ($14,253) among the lowest.[3] Flat SNF Medicaid spending growth reflects a growing preference for aging at-home and supportive personal care services.

Post-Acute Payments Affected by Medicare Advantage Penetration

The average base payment rate for Medicare, $388 per day is 2.2x the payment rate for Medicaid, $179. The actual rate is usually higher by $50-150/day (as per the Resource Utilization Groups) to better reflect the patient's clinical complexity, functional status (e.g., activity of daily living score), therapy utilization (e.g., number of minutes of speech, occupational or physical) and need for extensive services (e.g., specialized feedings).[4]

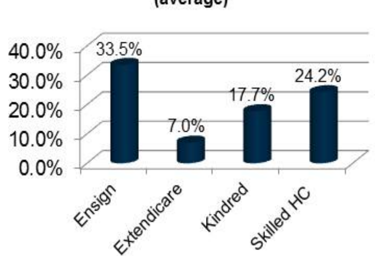
The number of Medicare Advantage (MA) beneficiaries has increased from 5.6 million in 2005 to 16.8 million in 2015; the penetration rate has increased from 19% to 31% of all Medicare recipients.[5]

Data compiled from publicly-traded SEC filings (10Q) suggest a broad range of (per day) price discounting relative to Medicare fee-for-service (FFS) reimbursement. Price discount compression seems to be occurring in 2010-14, driven by a higher rate of reimbursement growth in MA plans relative to FFS reimbursement.

MEDICARE ADVANTAGE DISCOUNTS TO FFS RANGE FROM 7-34%

	FFS 3Q10	FFS 3Q12	FFS 3Q14	MA 3Q10	MA 3Q12	MA 3Q14
Ensign Group	$578	$561	$561	$345	$372	$412
Extendicare	$471	$459	$474	$422	$430	$454
Kindred	$485	$490	$551	$409	$409	$436
Skilled Healthcare Group	$515	$509	$522	$379	$383	$410
Sun Healthcare Group	$476	$464		$374	$380	

% MA discount to FFS	3Q10	3Q12	3Q14
Ensign Group	40.3%	33.7%	26.6%
Extendicare	10.4%	6.3%	4.2%
Kindred	15.7%	16.5%	20.9%
Skilled Healthcare Group	26.4%	24.8%	21.5%
Sun Healthcare	21.4%	18.1%	



Source: MedPAC 2011, 2013, 2015 accessing 10-Qs

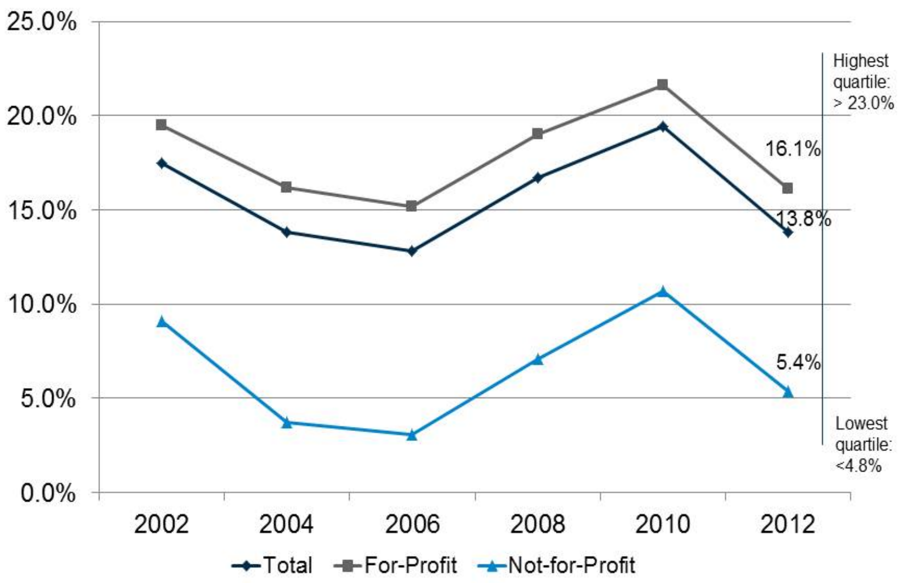
Profitability Driven by Medicare (and Commercial Payers, Out-of-Pocket)

According to MEDPAC, total SNF operating margins across all payers and service lines was 1.8% in 2012.[6] The Moran Group, in a study commissioned by the American Health Care Association, estimated SNF industry margins of 0.75% in 2009.[7] Given an average 2012 Medicare operating margin of 13.8% implies a net loss on the Medicaid (institutional) service offerings.[8] Non-Medicare margins of -0.8% to -2.6% were reported for 2001-2009.[9]

Wide Variation in Medicare FFS Operating Margins

For-profit nursing homes have higher Medicare FFS operating margins than non-for-profit facilities. A broad range of performance is evident with operating margins spanning from <4.8% in the lowest quartile to >23.0% in the highest quartile. *Higher profit skilled nursing facilities tend to have lower cost per day (discharge) and higher reimbursement based on the Case-Mix Index (CMI) and the intensity of services.*

SNF MEDICARE OPERATING MARGINS



Source: MedPAC Data Book: Health care spending and the Medicare program, June 2014; Chart 8.5. 2013 Medicare margin" 13.1%
http://medpac.gov/documents/reports/chapter-8-skilled-nursing-facility-services-(march-2015-report).pdf

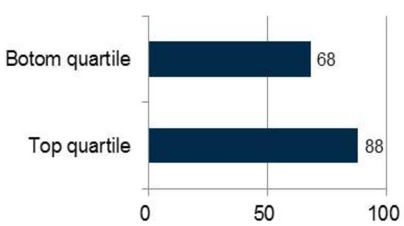
Primary Drivers of Operating Margins: Payer Mix, Size and Costs

Medpac analysis of cost report data suggests that SNFs in the top quartile of operating margins have a higher average daily census (+33%), higher acuity patients requiring more intensive therapy days, higher payments per day (+10%) and lower costs per day (-30%). Both, routine (-32%) and ancillary costs (-20%) were significantly lower for high performers.

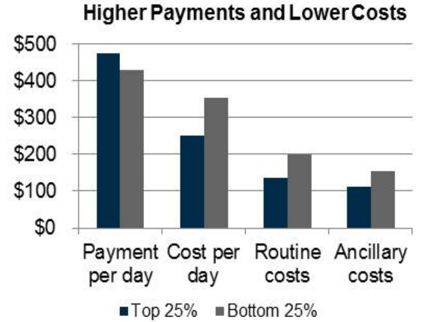
MEDICARE FFS DRIVERS OF OPERATING MARGINS: COSTS AND REVENUE MIX, 2012

- Higher case-mix index (Top: 1.39; Bottom: 1.30)
- Share of medically complex days (Top: 4%; Bottom: 6%)
- Higher intensive therapy days (Top:82%; Bottom: 73%)
- Ultra-high rehabilitation is for those patients who received over 720 minutes (12 hours) per week
- Very-high rehabilitation includes patients who received 500–719 minutes (8.3 – 12 hours) per week.

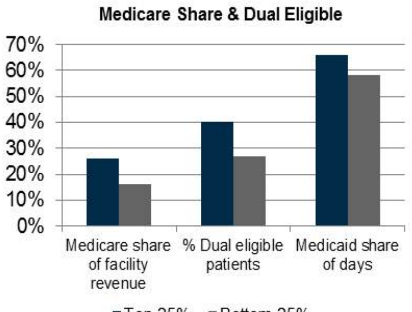
Higher Average Daily Census



Higher Payments and Lower Costs



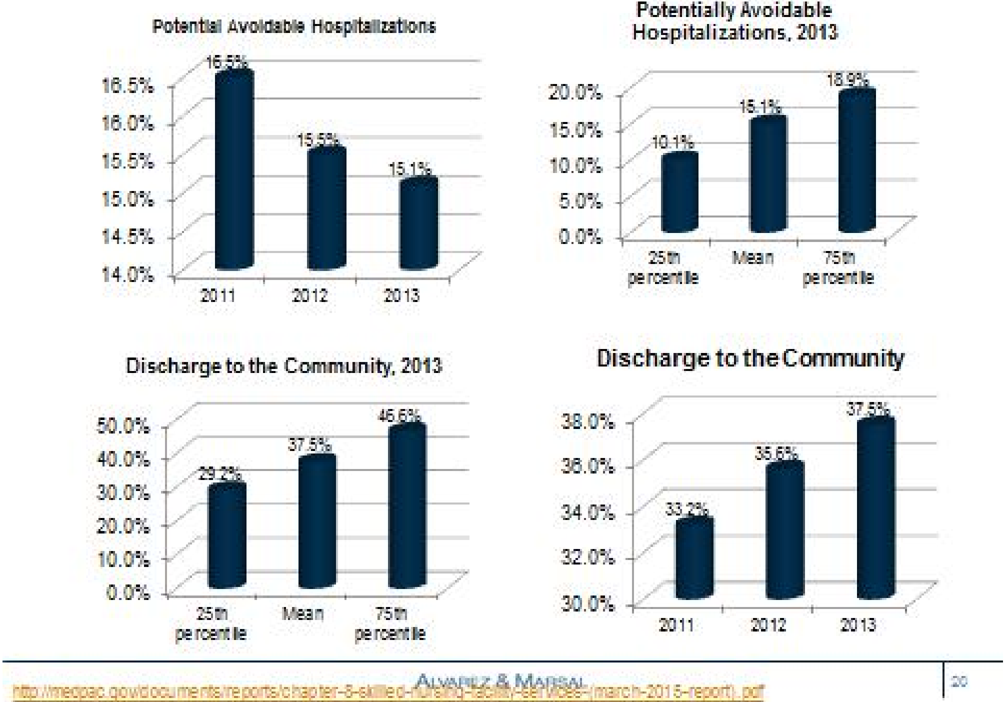
Medicare Share & Dual Eligible



Source: Table 8-7 http://medpac.gov/documents/reports/chapter-8-skilled-nursing-facility-services-(march-2015-report).pdf

Wide Variation in Quality; Validity of Self-Reported and Inspection Data Questionable

The quality of skilled nursing facility care is measured in a multitude of manner including hospital re-admissions, self-reported quality and staffing metrics and inspection results. In 2013, CMS reported a potentially avoidable hospitalization rate of 15.1%, with the 25th quartile at 10.1% and the 75th quartile at 18.9%.[10]



A March 2014 OIG report highlighted 33% of nursing home Medicare beneficiaries experienced an adverse event (22%) or temporary-harm event (11%), with 59% of the total preventable and resulting from substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.[11] *Re-hospitalization rates and adverse events will gain increasing importance to hospital and health system providers participating in bundled payment programs and Accountable Care Organizations.*

CMS uses a 5-star quality rating based on staffing, quality measures and health inspections; an overall score is also generated. Quality measures and staffing levels, self-reported by the nursing home, are a source of major concern to the Center for Public Integrity.[12]

Major concerns also apply to the variability of state survey inspection citations, as highlighted by the OIG. Citations are generated by state survey inspectors (based on Federal and state-specific standards) without a consistent measurement technique and/or approach; i.e., are not necessarily reproducible. An OIG report from 2003 identified four factors contributing to the variation: "an inconsistent survey focus; unclear guidelines; the lack of a common review process for draft survey reports; and high surveyor staff turnover."[13] A more recent study published in the Journal from Healthcare Quality, the official publication of the National Association for Healthcare Quality stated: "the high degree of variation limits the usefulness of deficiency citations not only for CMS but also for consumers and providers".[14]

Elements of the Nursing Home Compare data may actually be invalid!

High Employee Turnover Affects Quality

Nursing home quality is labor intensive and is worsened by high rates of employee turnover. High turnover interferes with care continuity, may stress patients, results in inexperienced and less productive workers, weakens standards of care, increases the workload of experienced workers and raises operating costs (e.g., recruitment, training and temporary staff). A 2012 study highlights a median SNF employee turnover rate of 43.9% (RNs: 50.0%, LPNs/LVNs: 36.4%, certified nursing assistants: 51.5%).[15]

Of concern is data suggesting lower quality outcomes with employee turnover above a specified threshold of greater than 30% for RN's (already exceeded), greater than 50% for LPNs/LVNs and greater than >40% certified nurse assistants.[14]

2015-25 Demographics Suggest a Favorable Payment Mix Upgrade to Medicare

Demographics are favorable, particularly as applied to Medicare Part A admissions. The population >85 years – the source of 45.9% of institutional residents - is forecast to increase from 5.9 million in 2012 to 7.2 million, +23.0% in 2025. The rate of institutionalization increases with age: <65 years: 0.05%; 65-74: 0.5%; 75-84: 1.6% and >85: 6.5%. Applying these (constant) rates to the forecast population growth results in an increase in the long-term institutional population from 851k

in 2012 to 1.0 million in 2020 and 1.1 million, 20.3% in 2025.

In terms of SNF Medicare Part A admissions, the population >65 years – the source of 85.5% of admissions - is forecast to increase from 43.1 million in 2012 to 63.9 million, +48.3% in 2025. The rate of admission (per thousand population) increases with age, though not as significantly as the slope for institutional residents: <65 years: 0.2%; 65-74: 2.4%; 75-84: 8.2% and >85: 18.7%. Applying these (constant) rates to the forecast population growth results in an increase in the number of SNF admissions from 3.3 million in 2012 to 3.8 million in 2020 and 4.4 million, 35.2% in 2025. In summary, the future demand for short-term beds will exceed that of long-term stays, potentially leading to a more favorable payer mix and higher operating margins.

Conclusion

Aging demographics are favorable to SNFs, with the growth of potential Medicare Part A patients exceeding that of Medicaid (institutional) patients during the next ten years. SNFs will also benefit from the "downstream" effect of the IMPACT ACT of 2014 on inpatient rehabilitation facilities (IRFs) and long-term acute care hospitals (LTCHs).

The SNF sector will, however, be increasingly challenged by consolidating healthcare providers and payers interested in efficiency and effectiveness. A wide range of operating costs highlights major differences in management execution capabilities. Stand-alone SNFs with less than 50-100 beds will increasingly be challenged by the need for regulatory, IT and other infrastructure investments. Quality metrics, and in particular re-hospitalization rates require increased attention. Referrals remain a strategic imperative as major providers narrow their post-acute networks.

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[1]CMS Nursing Home Data Compendium, 2013 Edition.

[2]NIC Investment Guide, Section 6.4: Nursing Care Reimbursement. Private pay includes LTC and other health insurance (11%) as well as out-of-pocket (22%). O'Shaughnessy CV. The Basics: National Spending for Long-Term Services and Supports, 2012 in the Scan Foundation Fact Sheet 2013; and Kaiser Family Foundation. OSCAR data, 2011

[3]Kaiser Family Foundation: State Health Facts. Medicaid Spending by Service
http://kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/

[4]Payment basics: Skilled nursing facility services; October 2014
http://www.medpac.gov/documents/payment-basics/skilled-nursing-facility-services-payment-system-14.pdf?sfvrsn=0

[5]Medicare Advantage 2014 Spotlight: Enrollment Market Update kff.org/report-section/medicare-advantage-2014-spotlight-enrollment-market-update-overall-trends; and
http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/

[6]MEDPAC data book: Health care spending and the Medicare program, June 2014

[7]Assessing the Implications of Alternative Reimbursement Policies for Nursing Facilities; December 2011

[8]MEDPAC Data Book: Health care spending and the Medicare program, June 2014

[9]MEDPAC Report to Congress, March 2013. Table 8-9 http://www.medpac.gov/documents/reports/mar13_ch08.pdf?sfvrsn=0

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[11]OIG Compendium of Priority Recommendations; March 2014
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[12]The Center for Public Integrity. Analysis shows widespread discrepancies in staffing levels reported by nursing homes; November 12, 2015

[13]Office of the Inspector General. Nursing Home Deficiency Trends and Survey and Certification Process Consistency; March 2003 www.oig.hhs.gov/oei/reports/oei-02-01-00600.pdf
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[14]Castle N, Engberg J, Men A. Variation in the use of nursing home deficiency citations. Healthcare Quality; Volume 29(6), 2007 Nov-Dec www.ncbi.nlm.nih.gov/pubmed/18232603

[15]American Health Care Association 2012 Staffing Report

www.ahcancal.org/research_data/staffing/Documents/2012_Staffing_Report.pdf

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