MEDPAC

Advising the Congress on Medicare issues

Medicare beneficiaries in nursing homes

Eric Rollins and Carol Carter

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Introduction

- At our April meeting, commissioners expressed interest in taking a closer look at Medicare beneficiaries who live in nursing homes (NHs)
- NH population has significant care needs and high medical costs
- Longstanding concerns about the quality of care in NHs
- Payment models that promote value-based care have not prioritized this population

Presentation overview

1. The long-stay nursing home population
2. The nursing home industry
3. Major challenges to improving care for beneficiaries living in nursing homes
4. Next steps
5. Discussion

What do nursing homes do for their residents?

- Provide 24-hour medical and skilled nursing care, rehabilitation services, and assistance with activities of daily living
- Nearly all NHs operate as both:
  - Nursing facilities (NFs) providing custodial care for individuals with physical and/or cognitive impairments
  - Skilled nursing facilities (SNFs) providing short-term skilled care after a hospitalization
- Annual cost of custodial care is $104,000 (for a semi-private room)
- Medicare's coverage of nursing home care is limited to 100 days of SNF care following a prior hospital stay of 3+ days

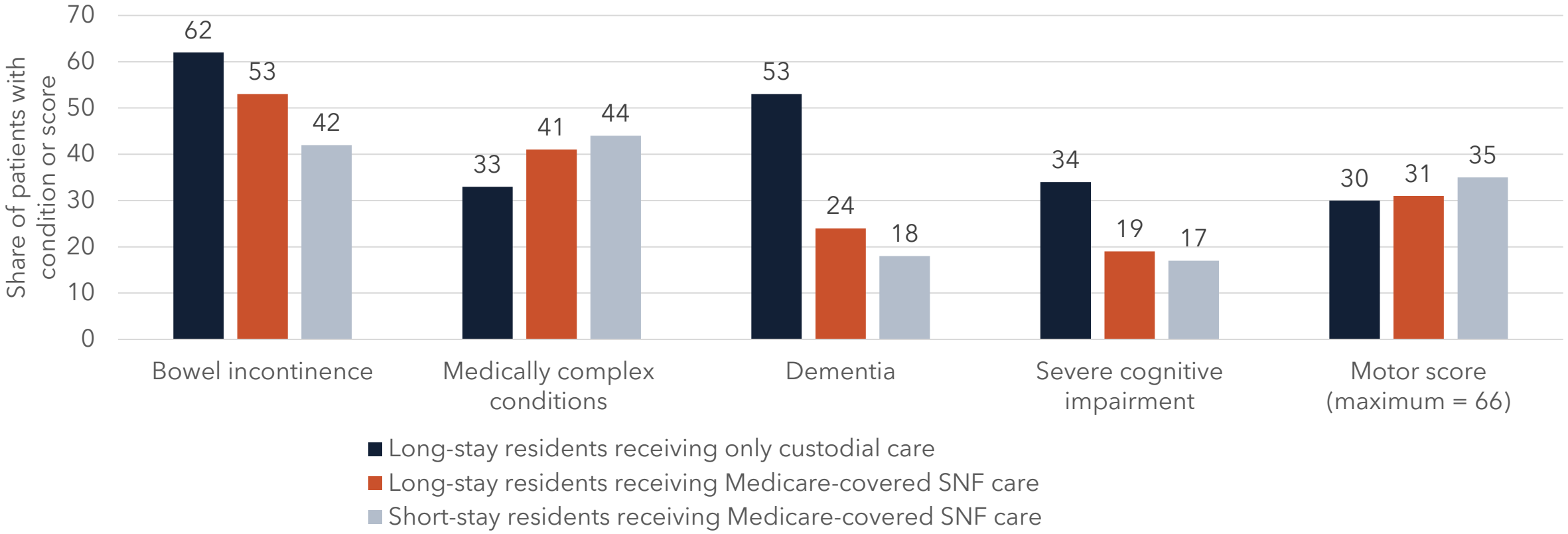
Long-stay nursing home residents differ from other beneficiaries in several respects

Characteristic (2022)	Long-stay residents	Other beneficiaries
Number (millions)	1.2	65.7
Median age (years)	81	72
Age 90 and older	24%	5%
Female	63%	54%
Eligible for Medicaid	82%	13%
Rural	24%	18%
Died during the year	25%	4%
Average CMS-HCC risk score	2.12	1.01

Note: HCC (hierarchical condition category). We classified beneficiaries as long-stay residents if they had at least one month during the year where they had been in a nursing home for more than 90 days.
Source: MedPAC analysis of 2022 Medicare administrative and risk score data.

- Long-stay residents make up a small share of the Medicare population (1.7% in 2022)
- Part A & B spending per capita for long-stay residents was about two times higher than spending for other beneficiaries
- Median NH length of stay was 27 months

Beneficiaries receiving long-term custodial care differ from those receiving short-term SNF care

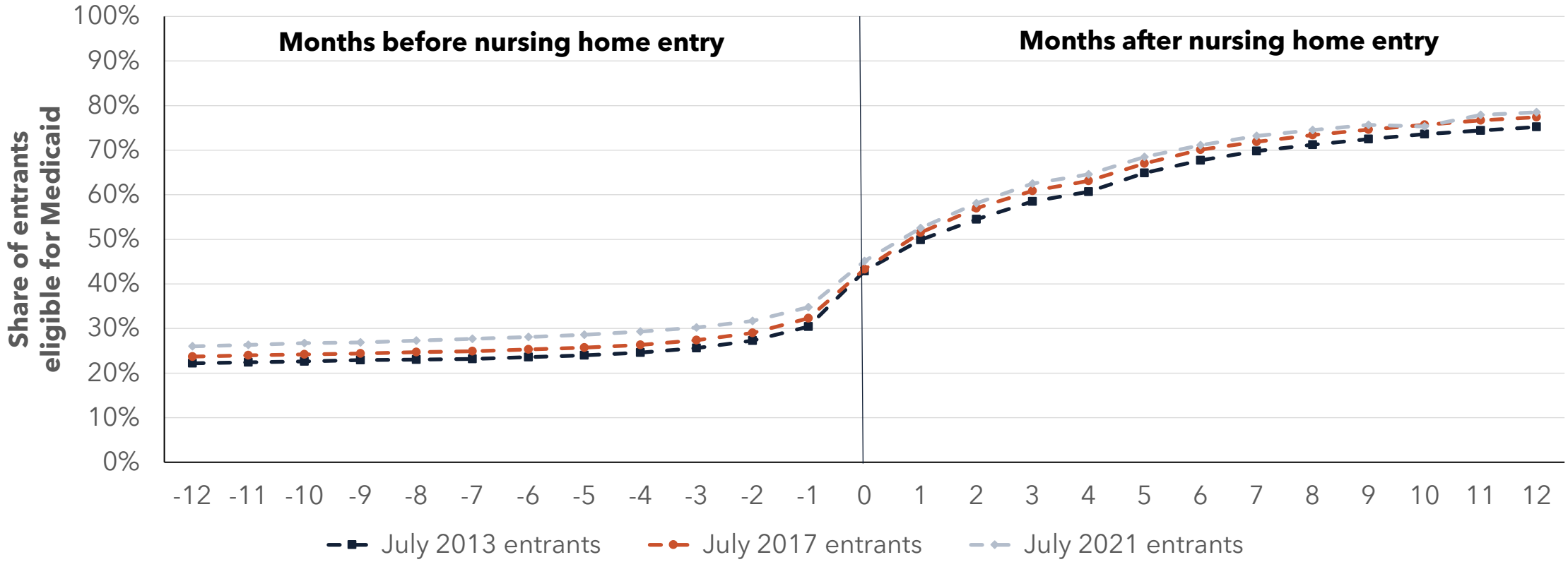


Note: We classified beneficiaries as long-stay residents if they had been in a nursing home for 90+ days. Figures are based on each beneficiary's most recent assessment. Medically complex conditions are defined in the instructions to the patient assessment tool and include conditions such as diabetes and chronic kidney disease. Beneficiaries were classified as having severe cognitive impairment if they had a score of 0 to 7 on the Brief Interview for Mental Status test. The motor score is a composite of 11 self-care and mobility items.
Source: MedPAC analysis of Minimum Data Set patient assessments for nursing home stays between October 1, 2023, and March 30, 2024.

Medicaid plays a key role for long-stay residents

- States are required to cover NH care
- All states have at least one eligibility pathway for higher-income individuals who need NH care
  - Many beneficiaries must "spend down" assets on NH care to qualify
  - Beneficiaries contribute nearly all of their income towards their care
- Medicaid covers the difference between its payment rate for NH care and the beneficiary's contribution

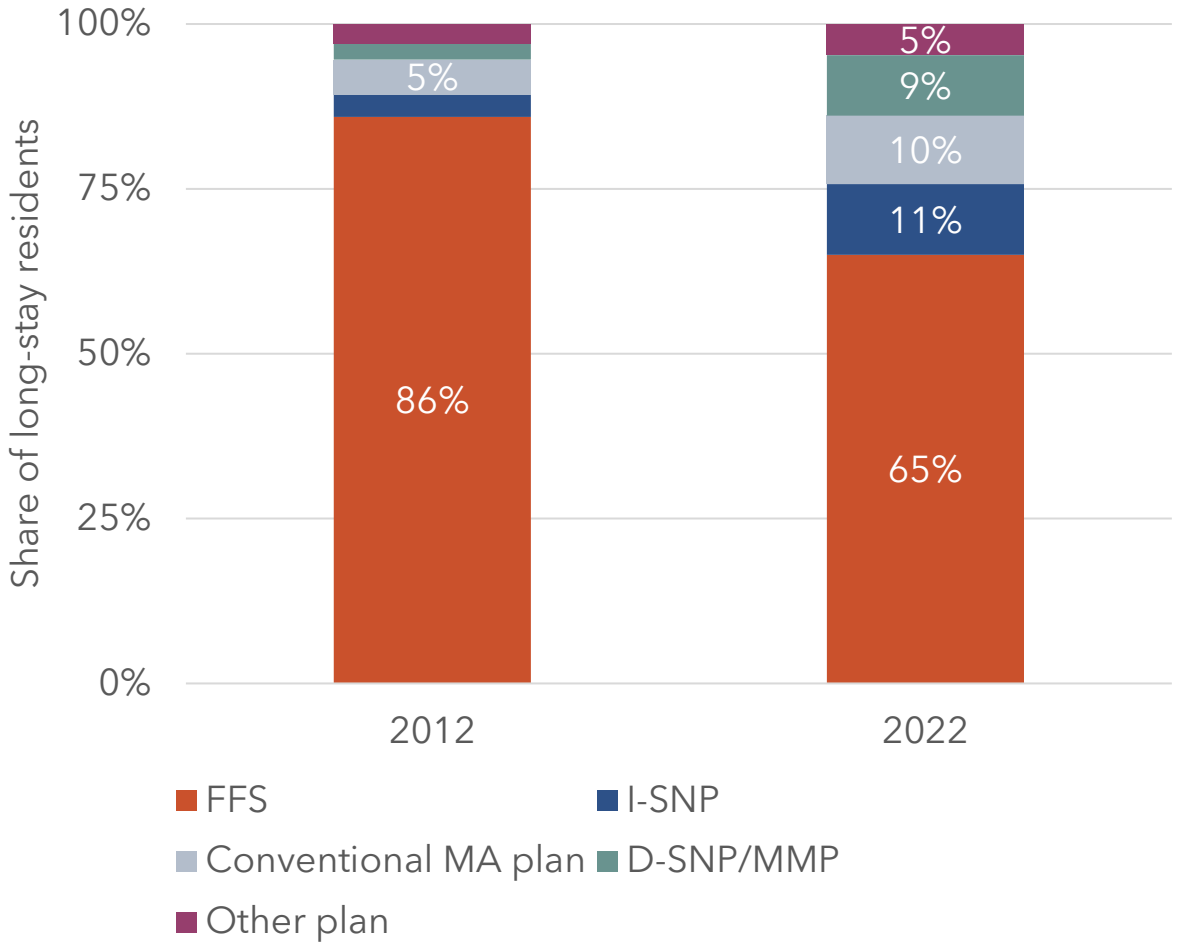
Most Medicare beneficiaries qualify for Medicaid within a few months of entering a nursing home



Note: Figure is based on beneficiaries with a nursing home stay that lasted for more than 90 days. "Eligible for Medicaid" means eligibility for full Medicaid benefits including nursing home care. Figure does not include beneficiaries who had a previous long nursing home stay or entered a nursing home less than 12 months after becoming eligible for Medicare.

Source: MedPAC analysis of Medicare enrollment data and Minimum Data Set assessment data.

Most long-stay NH residents have FFS Medicare, but MA enrollment has been growing



- I-SNPs target beneficiaries who need a NH level of care
- D-SNPs target beneficiaries with both Medicare & Medicaid
- Medicare allows NH residents to change plans monthly

Note: FFS (fee-for-service), I-SNP (institutional special needs plans), MA (Medicare Advantage), D-SNP (dual-eligible special needs plan), MMP (Medicare-Medicaid Plan).

Source: MedPAC analysis of Medicare enrollment data and Minimum Data Set assessment data.

Assisted living facilities are another important source of residential care

Industry overview

- Serve people who had been living independently but now need support as their functioning declines
- About 30,000 ALFs
- Not health facilities
- Regulated by states

Services offered

- Housing
- Help with ADLs, housekeeping, meals, taking medications, etc.
- Coordination with health care providers
- Do not directly provide medical services

Financing

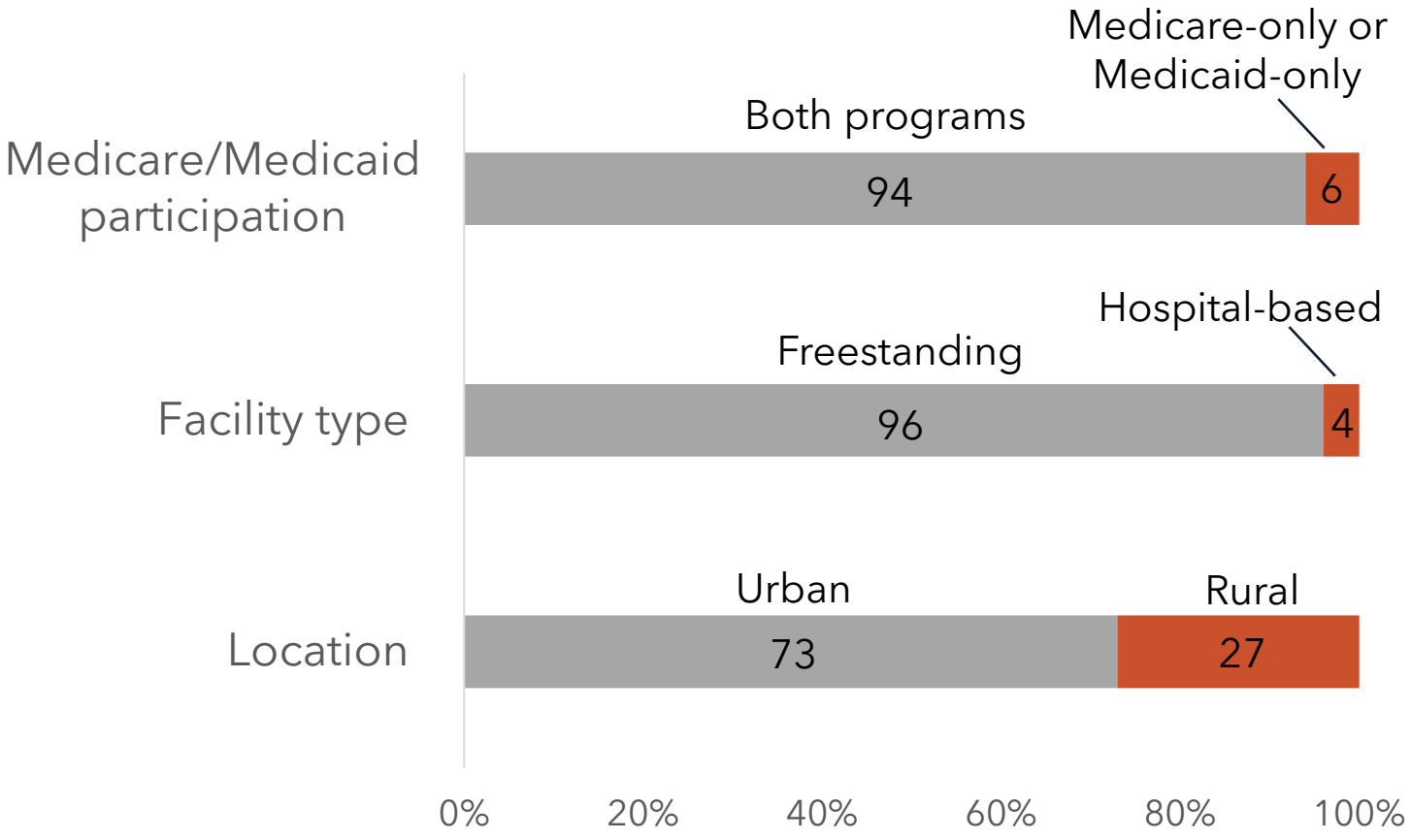
- Annual cost of care is about $64,000
- Care generally financed with personal or family funds
- Medicare and Medicaid do not cover housing but may cover some other services

ALF population

- About 800,000 residents; most are age 65 and older
- Generally less impaired than NH residents
- Residents live in ALFs for 22 months on average
- 60% of residents later move to a nursing home

Note: ALF (assisted living facility), ADL (activity of daily living).

Characteristics of the nursing home industry



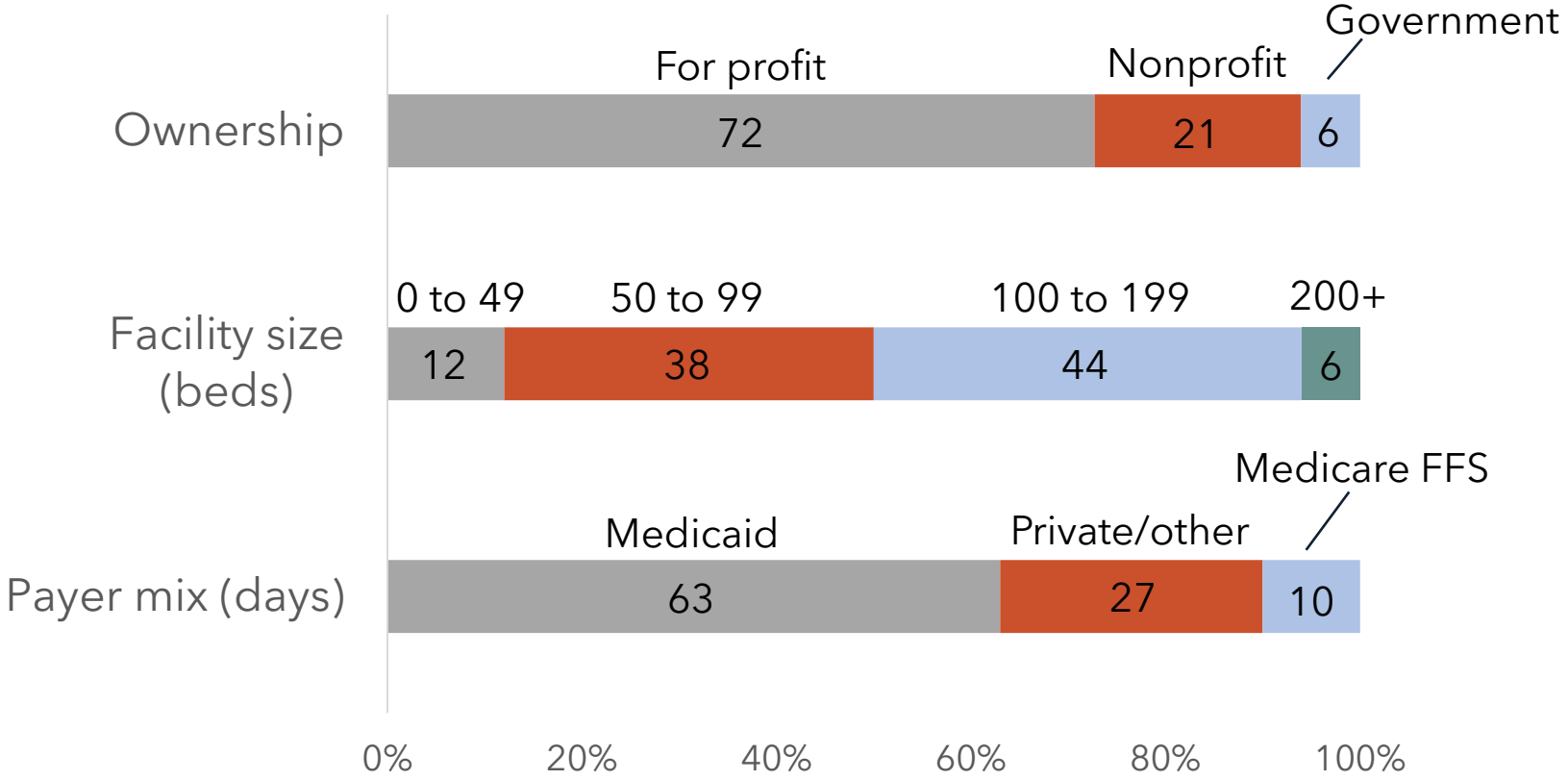
There are about 15,000 NHs in the US.

The majority of NHs are:

- Certified to participate in both Medicare and Medicaid
- Freestanding
- Located in urban areas

Source: Program participation and facility type are based on QCOR.CMS.gov/main.jsp for 2023. Location is based on data from the 2022 CMS Provider of Service file.

Characteristics of the nursing home industry (continued)



The majority of NHs are for profit entities.

About half of NHs have <100 beds; 12 percent have < 50 beds.

Medicaid is the largest payer for NH days.

Medicare FFS accounts for a relatively small share of days.

Note: FFS (fee for service). For payer mix, the "Private/other" category includes days covered by MA plans, out-of-pocket spending, and private long-term care insurance. Components may not sum to 100% due to rounding.
Source: Facility size and ownership are based on QCOR.CMS.gov/main.jsp for 2023. Payer mix data are from 2022 Medicare cost reports and exclude the Medicaid-only facilities.

Private long-term care insurance plays a limited role in financing nursing home care

Long-term care insurance policies

- 7.5 million people (including people under 65) had policies in 2020
- Policies vary in services covered, daily benefit amounts, inflation protection, duration of coverage, and waiting periods
- Coverage begins with documented need for help with ADLs

Factors limiting supply of policies

- Hard to project costs, mortality, and morbidity
- Adverse selection
- Moral hazard with policies that cover home-based care
- Consumer preferences for comprehensive policies that are more costly

Factors limiting demand for policies

- Many beneficiaries prefer to self-insure if they can afford it
- Premiums are out of reach for lower-income beneficiaries
- Presence of Medicaid coverage discourages purchase of policies
- Many beneficiaries wrongly believe Medicare covers LTC
- Limits on coverage for older, sicker, cognitively impaired beneficiaries
- Women face higher premiums

Note: ADL (activity of daily living), LTC (long-term care).

Differences between urban and rural NHs

Characteristic	Urban	Rural
Share of:		
Providers	73%	27%
All days	80%	20%
Total revenues	84%	16%
Utilization		
Average daily census	85	59
Average occupancy rate	78%	70%
Average length of stay (days)	100	148
Financial		
Costs per day	$417	$323
Payments per day	$409	$325
Total margin	-1.8%	0.6%

Source: MedPAC analysis of 2022 Medicare cost reports; does not include Medicaid-only facilities.

- Rural NHs make up 27% of facilities but smaller shares of days and revenues
- Compared with urban NHs, rural NHs are smaller, have lower occupancy rates, and have longer lengths of stay
- Urban NHs have higher payments but they do not cover their higher costs, resulting in a negative total margin
- Rural NHs have lower payments but also lower costs, resulting in a positive total margin

Major challenges to improving care for beneficiaries in nursing homes

- NHs have a financial incentive to hospitalize long-stay residents
- Medicaid payment rates are often low
  - MACPAC: 81% of NHs had base payment amounts that did not cover their acuity-adjusted costs (2019)
  - Low rates affect staffing levels, staff turnover, and quality of care
- Racial/ethnic minority groups are more likely to reside in areas with NHs that have lower staffing and lower quality

Note: MACPAC (Medicaid and CHIP Payment and Access Commission).

Major challenges to improving care for beneficiaries in nursing homes (continued)

- High rates of potentially avoidable hospitalizations
- The Commission has raised concerns about NH quality reporting
  - Many measures are based on assessment data, which may not be accurate because that data is also used to establish payments (2019, 2023)
  - No measures of quality of life, resident satisfaction, end-of-life care; the Commission has recommended that CMS finalize development of patient experience measures and begin reporting them (2021)
- Efforts to improve quality have had limited success

Sources: Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*
Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*
Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*

Next steps: Examine Medicare's efforts to improve care for long-stay nursing home residents

- Managed care-based approaches (with a focus on I–SNPs)
- FFS-based approaches (such as value-based purchasing, ACOs, CMMI demonstration to reduce hospitalizations) and other quality improvement efforts (star ratings, inspections)
- Informational chapter in our June 2025 report to the Congress

→ We will monitor the recent nursing home staffing rule as part of our payment adequacy work (December/January)

Note: I–SNP (institutional special needs plan), FFS (fee-for-service), ACO (accountable care organization), CMMI (Center for Medicare & Medicaid Innovation).

Discussion

- Questions
- Additional issues related to beneficiaries in NHs that you would like us to explore during this meeting cycle
- Potential policies related to beneficiaries in NHs that you might be interested in exploring in the future

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