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Study of Profit/Loss Margins For Not-for-profit Skilled Nursing Facilities

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For Not-for-profit
Skilled Nursing Facilities

Effective October 1, 2002, skilled nursing facilities (SNFs) will receive approximately 10 percent less in Medicare reimbursement payments. Recent government studies and reports have circulated this year that suggest nursing facilities have high profit margins resulting from several temporarily enhanced Medicare payments, and do not need continuation of these provisions. The American Association of Homes and Services for the Aging (AAHSA) represents 5,600 mission-driven, not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations. Since the results of the government studies seem to contradict the experience of not-for-profit nursing facility members, AAHSA undertook a study of the profit/loss margins in not-for-profit skilled nursing facilities.

Background

The Balanced Budget Act of 1997 (BBA) contained sweeping changes to the Medicare program for SNFs including tremendous cuts in funding and a change to a prospective payment system (PPS). Effective with cost reporting periods on or after July 1, 1998, Medicare reimbursed SNFs a fixed payment rate based on the Resource Utilization Groups version three (RUGs-III) case mix classification system. Recognizing that cuts to nursing facilities were too much and that payments for medically complex residents were inadequate, Congress passed temporary rate enhancements under the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA).

The 1999 BBRA contained two major provisions impacting the reimbursement rates to SNFs under the PPS. First was a temporary 20 percent increase to 15 RUGs effective April 1, 2000 and continuing until the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration - HCFA) could develop and apply refinements to the RUG-III classification that would account for utilization of non-therapy ancillary services. Medically complex cases were not adequately reimbursed for expensive non-therapy ancillary services such as prescription drugs, radiology and other Medicare Part B services that were bundled into the PPS rates. At the time of BBRA, it was anticipated that CMS would implement refinements by October 1, 2000. However, CMS found that its proposed refinements accounted for only three percent of the variation in nursing home costs. As a result, CMS rightfully concluded that it could not implement the refinements, therefore the 20 percent add-on to the 15 RUGs continued. The second provision was a four percent add-on to the federal RUG rates during fiscal years 2001 and 2002.

In 2000, BIPA included two provisions impacting temporary enhancements to SNF PPS payments. For eighteen months starting with care provided on or after April 1, 2001, BIPA increased the nursing component of the SNF PPS methodology by 16.66 percent. In addition, BIPA implemented a budget neutral modification that reallocated the BBRA

20 percent increase for three rehabilitation RUG-III groups to increase all 14 rehabilitation groups by 6.7 percent each. As with the 20 percent add-on from BBRA, the 6.7 percent increase for all rehabilitation RUG-III ends when CMS refines the RUG-III classification system.

Summary of Add-on Provisions that Provided Temporary Medicare Enhanced Rates

Legislation	SNF Provision	Description	Ends
BBRA	20% Add-on	Increased RUG-III rate by 20% for 15 selected RUGs	When CMS modifies RUGs
BIPA	Modify 20% add-on for rehabilitation RUGs	Reallocate 20% add-on to 3 rehabilitation RUGs to increase all 14 rehabilitation RUG groups by 6.7%	When CMS modifies RUGs
BBRA	4% Add-on - all RUGs	Increase all RUG groups by 4%	September 30, 2002
BIPA	16.66% Increase to Nursing Component	Increase the nursing component of all RUG rates by 16.66 % and evaluate whether the increase should continue.	September 30, 2002 unless recommended to continue

The Medicare "cliffs", so-called because of the drastic reduction of the Medicare Rates effective October 1, 2002, means that SNFs will receive substantially less to provide care to residents funded by Medicare Part A. Initially when CMS was expected to propose refinements to RUGs, SNFs were expecting on average $56.25 less per resident day effective October 1, 2002. For an average facility of 100 residents, with 10 percent of those residents covered by Medicare Part A, this meant approximately $200,000 less per year. In April 2002, CMS announced that it was not planning to revise the RUG case mix system. This decision effectively continues the add-on of 6.7 percent for 14 rehabilitation RUGs and 20 percent for 12 selected medical RUGs. The pending cliff effect was thereby reduced to $35.42 per day or slightly more than $100,000 per year for the average SNF.

This scale of deficit in a not-for-profit facility is not easily managed with increased fund raising, drawing down of endowment principal and simple cost cutting measures. The situation is even worse for facilities that serve medically complex residents who require expensive non-therapy ancillary services. For example, whereas the average cliff loss is $35 per resident day, the loss for residents who are categorized into the Extensive Care RUG category has a cliff loss of $50 a day. Nursing facilities were already losing money on medically complex residents before the cliff, and many facilities may have to limit the number of medically complex residents admitted to their facility if forced to reduce staffing because of lower reimbursement. Medically complex beneficiaries, therefore, may have to remain in the hospital because they will not have adequate access to post acute care.

In addition to the pending cuts from Medicare, the budget cuts from Medicaid have an even more drastic impact on nursing facilities. Medicaid is the single largest public source of funding for long-term care in general and nursing homes in particular. Many state legislatures have restricted Medicaid reimbursement rates for nursing home

services, resulting in Medicaid not paying adequately for nursing homes to provide quality care. According to a Kaiser Commission report[1], for FY 2002 ten states reduced or froze reimbursement rates to nursing homes; for FY 2003 almost 30 states will restrict provider reimbursement.

Studies have shown that Medicaid rates for routine room and board are often less than a night's stay in Motel 6. In Wisconsin, a study quantified that the Medicaid rates are on average $11 per day less than the minimum cost to provide services. A review of state Medicaid rates conducted by AAHSA in 2001 found that not-for-profit facilities are paid on average almost $14 less per day than the cost to provide care. Analysis of state Medicaid cost reports have found that not-for-profit facilities tend to staff at higher levels, pay staff more, and provide better benefits, which increases the cost to provide services. Medicaid rate setting systems often do not pay adequately for all direct care costs. According to the Kaiser Commission report, in 2002 36 states face Medicaid budget shortfalls. For FY 2003, 41 states will have shortfalls, forcing states to further restrict reimbursement rates to providers, especially nursing homes.

The Medicare cliff will impact all residents in Medicare certified nursing homes. Nursing facilities determine staffing needs based on the acuity of the entire resident population. Low payment rates from one revenue source require budget constraints throughout the facility. The 10 percent reduction from Medicare on top of already extremely low reimbursement rates from Medicaid will be a challenge for not-for-profit nursing facilities that rely on charitable contributions to provide benevolent care and do not have the profit margins to withstand these reductions in payment rates without drastic cuts in staffing or other areas.

Analysis of Profit Margins in Nursing Facilities

The obvious need for adequate reimbursement from Medicare and Medicaid seems to have fallen on deaf ears, primarily because of reports in 2002 that Medicare profit margins in nursing facilities are high. In February, CMS released a Health Care Industry Market Update[2] for Nursing Facilities that reviewed financial information available to Wall Street. Believing that Medicare provides adequate profit margins in nursing facilities, CMS recommends that the two remaining add-on provisions are unnecessary. The Medicare Payment Advisory Commission (MedPAC) analyzed the adequacy of Medicare payment for SNFs for its March 2002 Report to Congress[3] and recommended that some of the enhancement provisions were not needed because of adequate profit margins in freestanding nursing facilities. In October the General Accounting office (GAO) is expected to release its analysis of whether the 16.66 percent add-on to the nursing component of PPS should be continued based on increased staffing and profit margins for nursing facilities. It is expected that GAO will recommend to Congress that the add-on should not be continued because GAO could not find evidence that facilities increased staffing and found that profit margins were high. AAHSA conducted analysis of the profit margins of not-for-profit nursing facilities to assess whether the three government studies reflected accurately the experience of the not-for-profit facilities.

Methodology

In an effort to quantify the need for increases to Medicare and Medicaid payment rates to nursing facilities, AAHSA conducted a study of the profit margins for not-for-profit facilities. According to the 2001 Nursing Home Statistical Yearbook[4], the 4,765 not-for-profit nursing facilities represent 28.6 percent of all Medicare/Medicaid certified nursing facilities that report information to CMS through the Online Survey Certification and Reporting (OSCAR) database. Government-owned facilities account for an additional 1,065 (6.4 percent) facilities. Facilities that are not certified for Medicare or Medicaid are excluded from the national database. Almost 82 percent of the facilities are dually certified for both Medicare and Medicare, 1,930 facilities (11.6 percent) are certified by Medicaid only and 1,085 (6.5 percent) are certified by Medicare only. Of the 14,755 dual or Medicare only certified facilities, MedPAC, in its March 2002 report to Congress, stated that hospital-based SNFs represented 12 percent of Medicare certified SNFs with the remaining being freestanding.

Since a major reason for this study is to quantify the profit margins of not-for-profit SNFs under the Medicare payment system, the study included facilities that are certified for both Medicare and Medicaid, referred to as dual certified, and facilities that are Medicare only certified. Facilities that have neither a Medicare nor Medicaid certification or were certified only for Medicaid were excluded. In addition, the study excluded hospital-based and government-owned nursing facilities for two reasons. First, other studies have shown that hospital-based and government-owned facilities have negative margins. Both the MedPAC study and the GAO study demonstrated that hospital-based SNFs have negative profit margins for Medicare payments. Furthermore, MedPAC recommended an additional 10 percent higher Medicare payment rates for hospital-based facilities. The as yet unreleased GAO report indicated that government-owned facilities also have negative margins. The second reason for not including them is that financial statements do not readily identify separate financial operations for hospital-based and government-owned facilities.

The study identified 3,716 not-for-profit, Medicare-certified, freestanding nursing facilities. Some freestanding nursing facilities are within continuing care retirement communities (CCRC) for the exclusive use of residents of the community. CCRC nursing facilities often have a small percentage of beds available for Medicare and the finances are blended within the community's finances. Therefore, the study excluded not-for-profit nursing facilities that identified themselves as primarily CCRC. A sample of 476 facilities was selected from the resulting not-for-profit database for inclusion in the study.

AAHSA decided to review the most recent 990 federal tax forms for each facility in the sample. The GAO used the Medicare cost report that all Medicare certified facilities are required to submit to CMS. Although AAHSA considered using the Medicare cost report information, the accuracy, level of detail and timeliness of the data was a concern. Because all not-for-profit organizations with annual revenues exceeding $25,000 are

required to submit annual 990 tax returns to the Internal Revenue Service (IRS), AAHSA felt that the IRS tax information would be more suitable than the Medicare cost reports for not-for-profit facilities. Financial information for the study came from the IRS Business Master File of 501(c) not-for-profit organization database.

The BBRA provision to enhance Medicare payment rates started with services on or after April 1, 2000. When available, the 990 financial information for the 2001 tax year was reviewed. If the 2000 tax year was the latest that financial information was available, AAHSA reviewed financial records for tax reporting years ending on or after September 30, 2000. For those with 2000 tax year financial information included in the study, the vast majority of the facilities had fiscal years ending December 31, thereby including a minimum of 9 months of enhanced Medicare payments in the financial information.

Researchers accessed publicly available 990 tax forms on-line for the 476 SNFs that were randomly selected to be part of the study. Tax information was not found for all facilities for several reasons. Freestanding nursing facilities that are owned by a hospital or medical center may not have 990 tax information submitted separately from the hospital. A facility that is part of a retirement community may not have separate 990 tax information for the freestanding nursing facility. Tax information was not available for facilities that closed. Some tax information was for tax reporting period prior to September 30, 2000. Occasionally, the 990 tax form contained financial information for multiple nursing facilities. The final database included financial information from 272 facilities for the study.

The 990 tax form provides complete revenues and expenses and balance sheet information for the organization. The first page provides a summary with documentation of details found in subsequent pages. The 990 tax form provides revenues, expenses and changes in net assets or fund balances. Revenue categories show the amount of revenue from program services including government payments, and lists non-program revenues such as public support from contributions, interest and dividends from investments and endowments, and sale of assets. Expenses include direct program service expenses, management and general expenses, fund raising expenses and payments to affiliates.

Based on the revenues and expenses provided, an operating margin and a total margin were computed. Operating margins were computed by subtracting the sum of program and management expenses from the program service revenues, then dividing the results by the program/management expenses. Total margins were computed by subtracting the total expenses from the total revenues, then dividing the results by the total expenses.

Results

The study found that the operating margins for the sample of not-for-profit, freestanding SNFs were a negative 4.28 percent. Facilities used resources from public contributions, interest and dividends from investments or endowments, and the proceeds from the sale of assets or drawing down of endowment to cover the loss from operating margins. As a result, total margins for not-for-profit, freestanding SNFs were a positive 1.82 percent.

Expenses for management, general operations and fund raising accounted for 13.17 percent of total expenses. The impact on a facility from 10 percent drop in Medicare payments will depend on the proportion of program revenue that come form Medicare. For most not-for-profit freestanding nursing facilities experiencing both Medicare cliff and reduced Medicaid payments, total margins will be negative without substantial increases in non-program revenues from public fund raising support and drawing down of endowment funds.

Discussion

AAHSA's assertion that the Medicare cliff will have devastating impact on not-for-profit, freestanding nursing facilities is supported by research contained in the three government studies referenced earlier. In the long run, all organizations, both not-for-profit and for-profit, must have positive margins in order to survive. Not-for-profits use funds in excess of expenses to further the mission of the organization. For not-for-profit nursing facilities, any excess is used for resident care, thereby increasing the quality of care and quality of life for residents. Reduction in reimbursement rates will worsen the negative operating margins for program services and will require more dependence on non-program service revenues, including drawing down of endowments that are meant for future services. und raising and endowments are not a stable revenue source in these difficult economic and political times.

In January 2002 the CMS released its Health Care Industry Market Update for SNFs. This was the second in a series of reports that reviews and summarizes financial information from major investment firms. Most of the report concentrates on the financial information of for-profit facilities, primarily those of the eight major national chains, many of which filed for Chapter 11 bankruptcy after the severe cuts from BBA. For not-for-profits, the study reviewed information from financial services organizations dealing with bond ratings. Moody's Investors Services cautioned about the financial pressures facing not-for-profits. Salomon Smith Barney emphasized that not-for-profits did not optimize Medicare revenues prior to PPS, have smaller Medicare populations and smaller debt, and never own Medicare ancillary business that led many of the for-profits chains into bankruptcy. Salomon stated that freestanding not-for-profit nursing facilities do not have access to bond markets. CMS cites Salomon Smith Barney as saying that "One of the greatest credit challenges for long-term care facilities is developing adequate endowments. It is very challenging for them to build significant reserves because, in general, the business does not have high margins and subsequently does not throw off much cash flow." The findings from AAHSA's study of not-for-profit, freestanding nursing facilities reached very similar conclusions. Without public support through contributions, interest and dividends from investments and endowments, and, when necessary, the selling of assets or drawing down of endowments, not-for-profits have negative operating margins.

In MedPAC's study of the adequacy of Medicare payments released in its March 2002 report to Congress, it considered several factors such as entry and exit of providers, access to SNF care, and access to capital. Assessment of the adequacy of Medicare rates

included the review of the Medicare margins with and without the enhanced payments for two segments of the nursing facility field, freestanding and hospital-based. MedPAC did not consider the separate margins for not-for-profit facilities other than those that were hospital-based. MedPAC concluded that hospital-based facilities have negative margins even with all the add-on provisions. MedPAC further noted that the majority of nursing facilities that closed were hospital-based facilities. MedPAC attributed the negative margins to allocation of administrative costs, a higher proportion of registered nurse (RN) positions and a higher case-mix. While the allocation of administrative cost of a hospital may be somewhat responsible for negative margins, it is not the reason for a hospital to close its SNF unit. Closures are primarily due to the higher case mix and the resulting need for more RNs. Not-for-profit, freestanding SNFs also tend to serve more medically complex residents, which will increase as hospital-based SNFs continue to close. Although the MedPAC did not report the margins of not-for-profit SNFs, the assessment of the higher case mix causing the negative margins for hospital-based SNFs sheds light on why not-for-profit, freestanding SNFs experience negative operating margins.

In September 2002, AAHSA previewed two GAO reports that are expected to be released in October. The first study was on the profit margins of nursing facilities under Medicare's enhanced payments. The second study was an analysis of whether SNFs used the 16.66 percent increase to the nursing component to hire more staff, and made a recommendation to Congress regarding the continuation of the provision. AAHSA staff read both studies prior to releasing to the public. At the time of completion of this study, neither study has been officially released by GAO. Comparisons to these studies are based on AAHSA's best recollection of both studies.

Based on Medicare cost report information, the GAO reported the operating and total margins of for-profit and not-for-profit SNFs, both hospital-based and freestanding. The study reports high profit margins for for-profit facilities, especially the national chains. However, the GAO reports that profit margins for not-for-profit were considerably lower, which supports the conclusion of this study.

In the second study, GAO attempted to measure whether SNF increased direct care staff in the six months after the 16.66 percent increase was applied to the nursing components of the PPS reimbursement rates April 1, 2001. GAO found that facilities with high staffing ratios actually decrease staffing and that facilities with very low staffing ratios increased slightly. Finding no evidence that SNFs increased staffing as a result of the enhanced payment, GAO recommended that the 16.66 percent add-on should not be continued. The study is flawed not in what it attempted to do, but in what it did not consider as factors in the analysis. The 16.66 percent add-on started April 1, 2001 for 18 months. In the six months time period that GAO studied, major economic and social changes affected every way of life. In second quarter 2001, the United States economy was slowing down and had negative growth by the summer. Then came terrorist attacks on September 11 that changed outlooks on life for everyone and further sent our economy reeling downward. Today we are on the brink of war and the stock market has fallen drastically wiping out investments that not-for-profit facilities rely on to support patient care. Nursing facilities do not staff based on reimbursement levels of any one revenue

source. Rather, facilities base staffing on acuity of residents and the overall budget. No responsible organization would increase staffing in a time of severe economic uncertainty knowing that they may have lay people off later. The enhanced payments were scheduled for only 18 months, furthering the uncertainty of the funding for new positions. Certainly, enhanced payments from Medicare were needed to pay existing staff as states reduced or froze Medicaid payments. In addition, as not-for-profit facilities already provide more staff hours per resident day than the average nursing facility, not-for-profit providers could have spent enhanced payments on improving benefits, increasing wages of direct care workers and sponsoring training and other staff enhancements. GAO did not consider the environment for the time period of the study and did not consider any other uses of the enhancements other than more staff. As required in BIPA, the study was due to Congress by August 1. That as of mid October, GAO has not officially released the study is testimony to the difficulty GAO had in conducting the study. More time is needed to conduct the study.

Conclusion

Negative operating margins of over 4 percent and slim total margins of less than 2 percent will not enable not-for-profit, freestanding nursing facilities that are Medicare certified to withstand a reduction of Medicare reimbursement on top of already severely low Medicaid reimbursement. Staffing shortages are a major problem facing nursing facilities. Adequate reimbursement is essential for nursing facilities to attract and retain staff, especially direct care staff. Not-for-profit providers tend to serve more medically complex residents and have higher staffing levels, especially registered nurses to care for the diverse and expensive medical needs of the frail elderly. According to the 2001 Nursing Home Statistical Yearbook, not-for-profit nursing facilities provided 61 percent more total registered nurse hours per resident day than for-profit facilities and 85 percent more registered nursing hours for direct care. In general, not-for-profit facilities staff higher. Not-for-profit facilities provide 16 percent more licensed practical nursing hours per resident day and 15 percent more certified nursing aides. Not-for-profit facilities also provide more therapy hours per resident days than for-profit facilities. They provide 56 percent more occupational therapy hours per resident days, 58 percent more physical therapy and 11 percent more speech, language pathology services.

In addition, not-for-profit facilities tend to pay higher salaries and benefits to direct care workers and have lower administrative costs than other nursing facilities. Many not-for-profits have incorporated child care, career ladders, training opportunities, and staff empowerment programs to maintain employee satisfaction and enhance the quality of care to residents. In addition, not-for-profits hire other direct care staff, such a pastoral staff, which enhances the quality of life of residents.

Maintaining higher staffing levels takes money and without adequate reimbursement to maintain reasonable positive margins, the service to frail elderly will suffer. Across the country nursing facilities are closing. In a competitive economic model, providers leave the market when profit margins are low. From 2000 to 2001, over 200 nursing facilities closed. Many of these facilities are hospital-based SNF that MedPAC and other have

found to experience extremely high negative margins. However, not-for-profit, freestanding facilities have also closed. For-profit corporations have the option to file for Chapter 11 bankruptcy, which many for-profit chains choose before Congress provided the enhanced Medicare payments. Although not-for-profit organizations have the option to file Chapter 11 bankruptcy, most not-for-profits simply choose to close operation, thus depriving a community of quality nursing services. In a survey of states, more than 20 percent of the states indicated that not-for-profit nursing facilities have closed. In Indiana, 13 not-for-profit facilities closed. Not-for-profit facilities can expect lower revenues caused by the continued hemorrhaging of state budgets that will force Medicaid offices to further reduce payments to nursing homes and the 10 percent reduction in Medicare reimbursement effective October 1. This will force not-for-profit facilities to rely more heavily on non-program revenues at a time when non-program revenues will not be available to make up for loss of Medicare and Medicaid reimbursement. Fundraising is more difficult after 9-11 and continued terrorist threats. The lower economic forecast and the fall of the stock market mean lower returns on investments that not-for-profit facilities use to provide benevolent care and to make up for negative operating margins. Negative total profit margins for not-for-profit nursing facilities will become more common and may force more facilities to close.

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[2] Van der Walde, Lambert, *Health Care Industry Market Update Nursing Facilities*, Centers for Medicare and Medicaid Services, February 6, 2002.
[3] *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, March 2002.
[4] Cowles, C McKeen, *2001 Nursing Home Statistical Yearbook*, Cowles Research Group, 2002.