**Financing and Reimbursing**

**• Financing is the mechanism by which nursing home clients pay for the services. Payers determine the method and amount of reimbursement, except for private-pay rates that are established by the facility.**

**• Private financing includes out-of-pocket payment for services and coverage under private long-term care insurance. Several factors should be taken into account in establishing private-pay rates.**

**• Medicare is a federal program that is uniform across the United States. It covers three categories of people. Services for eligible people in a Medicare-certified skilled nursing facility (SNF) are covered under Part A on a postacute basis and are limited to a maximum of 100 days.**

**• Medicare Part B does not pay for skilled nursing care, but certain services are covered while the patient is in a long-term care facility. Beneficiaries enrolled in Part C obtain all health care services, including skilled nursing care, through a managed care plan.**

**• Medicare reimburses certified nursing homes according to a case-mix-based prospective payment system. Assessment plays a critical role in determining a facility’s case mix.**

**• Medicaid is a welfare program for the indigent. Those who have assets must spend down to the state-established threshold levels to qualify. Unlike Medicare, the program varies from state to state. Medicaid has no limit on the number of days a person may stay in a nursing facility.**

**• The PACE program aims to provide long-term care in community settings to those who risk being placed in a nursing home. Money is pooled from Medicare, Medicaid, and private sources to provide a capitated rate to the PACE organization.**

**• Managed care organizations are active players in Medicaid and Medicare. Reimbursement is based on capitation. The nursing facility must manage the cost of providing services within the capitation amount.**

**• The Affordable Care Act is driving changes within the health care system, which will require collaborations between hospitals and postacute providers. Contracting with the Veterans Health Administration (VHA) also provides opportunites to nursing homes.**

**• Fraud and abuse is prosecutable under the Health Insurance Portability and Accountability Act (HIPAA) and the False Claims Act. The Affordable Care Act has boosted the government’s**

**efforts to prosecute fraud. The False Claims Act includes the qui tam provision that encourages whistleblowers to confront fraud and abuse through the legal system.**

Financing and reimbursement are critical for sustaining internal facility operations. Research shows that reimbursement has ramifications for nursing home quality. For example, Mor and colleagues (2011) found that increases in Medicaid payment to nursing homes have achieved improvements in some measures of clinical quality. For the most part, health care financing is governed by external factors, notably politics, social changes, the economy, competition, and changes in the broader health care delivery system.

Much of the information covered in this chapter is of value to more than just nursing home corporations and administrators. Social workers and patient accounts managers should also have a clear understanding of financing so they can furnish advice and assistance to current and prospective patients, families, and the community. Department heads involved in quality of care must become familiar with the fraud and abuse laws, which are increasingly affecting nursing home finances when heavy penalties are imposed for delivering substandard quality of care.

Financing is the means by which patients receiving services in nursing facilities pay for those services. Institutional LTC is expensive. According to research by the Mature Market Institute of MetLife (2013), the national average cost for a private room in a nursing home in 2012 was $248 per day ($687 in Alaska); it was $222 for a semiprivate room ($682 in Alaska). The monthly base rate in an assisted living facility was $3,550 ($5,933 in Washington, DC and $5,800 in Alaska). Few patients or their families can afford such costs if they pay with their own funds. Although individual LTC insurance has grown, it is not widely popular. Hence, public financing, mainly Medicaid and Medicare, remains the predominant source of financing nursing home care. Sources of financing for nursing home care are illustrated in Figure 6–1.

Trends in nursing home financing show that people’s ability to pay for LTC from private sources has declined. In 1990, private sources of payment financed almost 50% of nursing home care nationwide. By 2000, the proportion of total private payments declined to 43%. Recently, private payments have accounted for roughly 37% of nursing home costs; the remainder is paid through public sources.

**Figure 6-1** Sources of Financing Nursing Home Care (Nonhospital-based facilities), 2010

**Medicaid** 31.5%

**Out of pocket**  28.3%

**Medicare** 22.3%

**Private insurance** 8.9%

**Other** 9%

Reimbursement covers two aspects of financing: (1) the method used by a payer to determine the amount of payment and (2) the amount that is actually paid to a facility on behalf of a patient. To restrain escalating expenditures, both state and federal governments have been trying to place some limitation on the amount of reimbursement to providers. Also, the government has escalated its efforts to prosecute long-term care providers and recover damages for fraud and abuse.

The Centers for Medicare and Medicaid Services (CMS) establishes Medicare reimbursement rates, whereas each state sets its own rates for Medicaid payment. The actual rate-setting methodologies are quite complex.

Private Financing

Of the two main types of private financing, direct out-of-pocket payment is the most common. The other type, presently much smaller in size, is private LTC insurance (see Figure 6–1).

Out-of-Pocket Financing

Out-of-pocket financing may come from cash savings, stocks, bonds, or annuities. For some people, such resources may provide adequate income to pay for nursing home care. In most instances, however, assets may have to be sold to generate cash.

A home is often the largest asset that most people have. In some situations, reverse mortgaging could provide cash against the built-up equity in a home without having to sell the property. But the owner has to continue to live in the home, which makes this option unavailable for nursing home care. Reverse mortgaging is more commonly used for in-home medical and assistive services. It can also be used to purchase private LTC insurance.

Private-Pay Rate Setting

Long-term care facilities are free to establish their own private-pay rates or prices. For noncertified beds, a facility may label its services as “skilled care,” “intermediate care,” “personal care,” or “residential care.” A facility can establish its own criteria for determining its different levels of services and how much it will charge for those services. Because of certification rules, however, when private-pay patients are placed in a section of the facility that is certified as SNF or NF, administrators must be careful when setting private-pay rates. They risk having the Medicare and Medicaid rates reduced if the all-inclusive private-pay rate happens to be lower than what the public programs are paying. Private-pay rates can be lower as long as the services are provided in noncertified beds.

Even though private-pay rates may be set at any level, they are governed by market forces and competition. Additional factors such as amenities that a facility offers should also be taken into account. Patients and their families who have sufficient private funds available are often willing to pay extra for a better living environment. A facility with a reputation for providing high-quality care can also charge its private-pay clients a premium.

When private-pay patients are admitted to Medicare/Medicaid certified beds, these patients cannot be provided better quantity or quality of services for clinical needs that are similar to those of patients on public assistance. For example, certified beds occupied by private-pay patients cannot have extra staffing or extra amenities such as a more exclusive menu because these extra services would be construed as discriminatory against patients on public assistance if they do not get these extra services. For these reasons, many facilities have a separate noncertified section to care for private-pay patients because the facility can then deliver extras and charge for them.

The general industry practice is to charge a basic room-and-board rate, which includes nursing care, meals, social services, activities, housekeeping, and maintenance services. Charges are then added for ancillaries such as pharmaceuticals; supplies such as catheters, dressings, and incontinence pads; and services such as oxygen therapy or rehabilitation therapy. The basic rates and the charges for ancillary products and services are spelled out in a contract between the facility and the patient.

Private Insurance

General health insurance plans sponsored by employers may have limited coverage for LTC services. Some retirees may also have similar limited coverage available under their company’s health insurance plan for retirees. In most instances, however, people have to buy their own LTC policies sold by various private insurance companies.

To be eligible for benefits, the insured person must meet the criteria for disability specified in the plan. Such criteria may include cognitive dysfunction or inability to perform certain activities of daily living (ADLs). Other criteria may be more loosely stated, such as medical necessity. In almost all instances, medical need for LTC must be certified by a physician.

When admitting patients with private insurance coverage, the facility’s business office manager should carefully review the coverage, such as the type of services covered by the insurance plan. Plans generally have restrictions on the length of coverage, amount the plan will pay each day, coverage for ancillaries such as supplies and therapies, and elimination period during which insurance does not pay.

Medicare

Medicare—also called Title 18 of the Social Security Act—is a federal program that is uniform across the United States. It finances medical care for three categories of people: (1) persons who are age 65 and over, (2) disabled individuals who are entitled to Social Security benefits, and (3) people who have end-stage renal disease. The program is operated under the administrative oversight of the CMS. Medicare has limited benefits for skilled nursing care. The Medicare program consists of Part A, Part B, Part C, and Part D.

Part A of Medicare

Part A—also called Hospital Insurance (HI)—includes hospital inpatient benefits as well as care in a facility certified as a SNF. Medicare does not pay for services provided in facilities that are not certified as SNFs, such as assisted living facilities. Part A also covers home health services for intermittent or part-time skilled nursing care and hospice care in a Medicare-certified hospice.

SNF Coverage in a Benefit Period

Medicare does not meet the needs of people who require care for a long period of time. The maximum coverage in a SNF-certified facility is for 100 days. Few people, however, qualify for the full 100 days of coverage. Medicare benefit for SNF is a postacute program; it requires prior hospitalization for at least 3 consecutive nights, not counting the day of discharge. The patient must be in need of skilled nursing care as certified by a physician and be admitted to a SNF within 30 days after discharge from the hospital. The 30-day period begins on the day following discharge from the hospital.

Inpatient benefits in a hospital or SNF fall within a benefit period. A benefit period begins when a patient is hospitalized for a particular spell of illness and ends when the beneficiary has not received care in a hospital or SNF for 60 consecutive days for that particular spell of illness. Four key criteria determine a benefit period:

• A spell of illness or principal condition for which a patient is hospitalized. Different spells of illness can trigger new benefit periods.

• If a spell of illness for which a patient is hospitalized subsequently requires skilled nursing care in a SNF, the benefit period continues.

• A benefit period associated with a given spell of illness ends when the patient remains out of the hospital or SNF for 60 consecutive days.

• Readmission to a hospital or SNF within the 60 days is considered the same benefit period.

The number of benefit periods a patient can have is unlimited.

At the time of admission, the facility’s business office manager should determine eligibility for Part A coverage by finding out whether the patient is enrolled in Part A, whether he or she had a hospital stay of at least 3 consecutive days, whether the patient is being admitted within 30 days of discharge from the hospital, and the number of SNF days that may already have been used up in the benefit period. Medicare rules on inpatient SNF care are quite complex. For details, refer to the Medicare Benefit Policy Manual (see Web link in For Further Learning section).

Part A Deductibles and Copayments

A deductible is the amount the patient must first pay when a benefit period begins. Medicare starts paying only after the patient has paid the required deductible ($1,216 per benefit period in 2014). In almost all instances, however, the deductible requirement is met during the 3-day hospitalization before a patient comes to the SNF.

A copayment is the amount an insured patient must pay out of pocket each time a particular type of service is used. Medicare fully pays for just the first 20 days of SNF care in a benefit period. From days 21 through 100, the patient must pay a copayment ($152 per day in 2014). Medicare pays nothing after 100 days, even if the patient’s condition may justify the need for ongoing services in a nursing facility. The copayments as well as payment for services that may be needed beyond the 100 days must be paid either privately or by Medicaid, provided the patient meets the eligibility criteria for Medicaid coverage (discussed later). It is illegal for nursing facilities to attempt to recover from patients any payments that exceed the applicable deductible and copayments for services covered under the public programs.

Part A Services: Skilled Nursing Care

The definition of skilled nursing care, as it applies to SNFs under the Medicare program, includes subacute care services. Hence, the same rules govern skilled nursing care and subacute care. According to Medicare law, skilled nursing care may include skilled nursing or skilled rehabilitation services. It has specific characteristics, summarized here:

• The services must be ordered by a physician.

• The care furnished must be for treating conditions for which the patient was hospitalized, or for conditions that arose while the patient was receiving care in a SNF but were related to the condition for which the patient was hospitalized.

• Skilled nursing services must be needed and must be provided 7 days a week, except for skilled rehabilitation, which must be needed and provided 5 days a week.

• The services must require the skills of, and must be furnished directly by or under the supervision of, registered nurses (RNs), licensed practical (or vocational) nurses (LPNs or LVNs), physical therapists, occupational therapists, or speech pathologists.

“Under the supervision of” means that some of the actual hands-on care can be provided by paraprofessionals, such as certified nursing assistants, physical therapy assistants, and occupational therapy assistants. Skilled services are inherently complex and are required for medical conditions that can be treated safely and effectively only by the personnel just mentioned.

Examples of complex nursing services include intravenous or intramuscular injections, enteral feeding (delivery of liquid feedings through a tube), nasopharyngeal aspiration (suctioning through the nose and pharynx), tracheostomy (direct opening into the windpipe for breathing), insertion and irrigation of urinary catheters, dressings for the treatment of infections, treatment of pressure ulcers or widespread skin disorders, heat treatments, start of oxygen therapy, and rehabilitation nursing. Examples of skilled rehabilitation include assessment of rehabilitation needs and restorative potential (probability of functional improvement), therapeutic exercises or activities, gait training, range-of-motion exercises, maintenance therapy that requires the skills of a professional therapist, ultrasound treatment, short-wave treatment, application of hot packs, infrared treatments, paraffin baths, whirlpool treatments, services needed for the restoration of speech or hearing, and therapy for swallowing disorders. The skilled care criteria do not require that a potential for restoration be present. Even if recovery or improvement is not possible, preventing further deterioration is a sufficient justification for providing skilled care. If a SNF contracts with a rehabilitation company to provide therapeutic services to its patients, the service company cannot bill Medicare directly for Part A services. The facility is responsible for paying that company.

A patient who requires only custodial care—such as assistance with ADLs—does not qualify for Part A coverage. Additional examples of custodial care include administration of routine oral medications, eye drops, or ointments; general maintenance of colostomy (attachment of colon to a stoma) and ileostomy (attachment of the small intestine to a stoma); routine maintenance of bladder catheters; dressings for noninfected conditions; care of minor skin problems; care for routine incontinence; periodic turning and positioning; and other routine and basic nursing services.

Part A Incidental Services Besides skilled nursing care and rehabilitation, postacute services provided in a SNF include certain incidental services that are part of a person’s nursing home stay:

• Lodging and meals in connection with the furnishing of nursing care. Medicare pays for semiprivate accommodations. However, Medicare will pay for a private room if the patient’s condition requires clinical isolation or if the SNF does not have semiprivate accommodations available.

• Medical social services, which include services such as assessment and treatment of social and emotional issues, adjustment to the facility, and discharge planning.

• Prescription drugs, biologics (medical preparations—serums, vaccines, etc.—made from living organisms), supplies, appliances, and equipment. Medicare pays for these items during the inpatient stay. To facilitate a patient’s discharge from the facility, Medicare pays for only a limited supply of the drugs and equipment that the patient must continue to use after leaving the facility.

Part A benefits in a nursing home do not cover services that only a hospital can provide. Also, Medicare does not pay for services of a private-duty nurse or attendant.

Part B of Medicare

Part B of Medicare—also called Supplementary Medical Insurance (SMI)—covers outpatient services. In general, these services include physician services, X-rays, laboratory tests, and other services listed in Exhibit 6–1. These services are generally delivered by providers other than SNFs, and the providers bill Medicare directly for the services.

Medicare Part B requires voluntary enrollment and payment of a monthly premium. Effective 2007, the premium became income based. The standard premium in 2014 was $104.90 per month. Premiums are higher for single people earning more than $85,000 and for married couples earning more than $170,000 and filing joint tax returns. Because Part B premiums are heavily subsidized by general taxes, 95% of the Medicare beneficiaries have chosen to purchase Part B coverage. At the price the elderly pay to purchase Part B coverage, they will not be able to buy a similar plan in the private insurance market. For those who also qualify for Medicaid, the state pays the Part B premiums.

Unlike Part A, Part B benefits are based on an annual basis, not on a benefit period basis. Hence, annual deductibles and copayments apply. The annual deductible for 2014 was $147. Copayments are paid according to an 80:20 coinsurance, meaning that after the deductible has been paid, Medicare pays 80% of the costs and the beneficiary pays the remaining 20%.

Part B Services

Although Part B does not include SNF services, certain services are paid under Part B while the patient is receiving SNF services under Part A. An example is physician services that are billed under Part B by the patient’s attending physician. Similarly, diagnostic services and outpatient mental health care are covered under Part B. Other services, such as therapies, can be covered under Part B even after a patient’s Part A benefits expire, and the patient may continue to stay in the nursing home as a private payer or as a Medicaid beneficiary. Preventive health screenings and immunizations are also included in Part B. Exhibit 6–1 summarizes Part B benefits.

Part C of Medicare

Medicare offers its beneficiaries the choice to either remain in the original Medicare fee-for-service program or enroll in Part C. Part C is also called Medicare Advantage. A beneficiary who chooses to enroll in Medicare Advantage must receive all Medicare benefits through a managed care plan that has contracted with Medicare. The managed care plan in turn contracts with various providers to deliver services to those enrolled in the plan.

Part D of Medicare

Part D, the prescription drug program, was added to the existing Medicare program under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and was fully implemented in January 2006. The program is available to anyone, regardless of income, who has coverage under Part A or Part B. Like Part B, the program is voluntary because it requires payment of a monthly premium, which varies from plan to plan. For 2014, the average premium was estimated to be $32.42 per month, plus an income-based adjustment (CMS, 2013). For Medicare beneficiaries receiving services in a SNF under Part A, Part D does not apply because prescription drugs are included in the reimbursement that nursing homes receive. Medicaid beneficiaries receive drugs under the state’s Medicaid program. Those who have both Medicare and Medicaid (dual eligible), however, must get their prescription drugs through Part D.

**Exhibit 6-1** Covered Benefits and Noncovered Services Under Medicare Part B

Main Covered Benefits

Physician services

Emergency department services

Outpatient surgery

Diagnostic tests and laboratory services

Outpatient physical therapy, occupational therapy, and speech therapy\*

Outpatient mental health services

Limited home health care under certain conditions

Ambulance

Renal dialysis

Artificial limbs and braces

Blood transfusions and blood components

Organ transplants

Medical equipment and supplies

Rural health clinic services

Annual physical exam

• Annual physical exam

• Preventive services (as medically needed): alcohol misuse screening and counseling, bone mass measurement, mammography, cardiovascular screening, Pap smears, colorectal cancer screening, depression screening, diabetes screening, glaucoma tests, HIV screening, nutritional counseling for diabetes and renal disease, obesity screening and counseling, prostate cancer screening, sexually transmitted infections screening, shots (flu, pneumococcal, Hepatitis B), and tobacco use cessation counseling.

Noncovered Services

Dental services

Hearing aids

Eyeglasses (except after cataract surgery)

Services not related to treatment or injury

\*As of September 1, 2003, Medicare placed limits on how much it would cover for outpatient physical (PT), occupational (OT), and speech (SLP) therapy. For 2014, the limits are $1,920 per calendar year for PT and SLP combined and $1,920 per calendar year for OT. After the patient has met the Part B deductible, Medicare pays 80% of the cost up to the maximum limits.

Data from Centers for Medicare and Medicaid Services.

Medicare Prospective Payment System

Section 4432(a) of the Balanced Budget Act of 1997 required Medicare to develop a prospective payment system (PPS) to reimburse SNFs. When it was implemented in 1998, the PPS replaced the retrospective cost-based reimbursement system. The new method provides for a per-diem rate based on a facility’s case mix. The rate is all inclusive, which means that it is a bundled rate that includes payment for all SNF services that a Medicare recipient is eligible to receive under the program.

The former retrospective, cost-based system reimbursed, with some limitations, the actual costs for routine services, ancillary service costs, and cost of capital. These same costs are now consolidated in the PPS rate.

There are three main steps involved in the reimbursement setting methodology:

 1. A base payment rate (base amount of reimbursement) was determined in 1998 using the mean costs of various SNFs. The base rates were computed separately for urban and rural facilities. These base rates have been adjusted annually for inflation according to a market-basket index, an index of input prices for SNFs. Beginning in 2012, the market basket update is offset by a productivity adjustment, as mandated by the Affordable Care Act. The inflation-adjusted base rates for 2014 are shown in Table 6–1.

 2. The base rates in Table 6–1 are further adjusted to account for geographic variations in wages.

 3. Finally, the nursing and therapy components are adjusted according to the facility’s case mix (described in the subsequent sections); the nonclinical component is not adjusted. The adjustment reflects the estimated resource costs of caring for each resident.

Rationale Behind Case-Mix Adjustment

The aggregate level of clinical severity (acuity level) of patients in a facility is referred to as its case mix. The case mix varies from facility to facility. The level of case mix rises as the number of seriously ill patients increases. For example, some residents require total assistance with their ADLs and have complex nursing care needs. Other residents may require less assistance with ADLs but may require skilled rehabilitation. Patients who are more seriously ill require more intensive use of resources and incur greater cost to the facility. Therefore, a higher case mix calls for greater reimbursement.

**Table 6–1** Inflation-Adjusted Base Rates for 2014

 **SNFs in urban areas SNFs in rural areas**

Nursing component base rate $165.81 $158.41

Therapy component base rate $124.90 $144.01

Nonclinical component $84.62 $86.19

(to cover the cost of room and board, linens, and administrative services)

Data from MedPAC. 2013. Skilled nursing facility services payment system. Revised October 2013. Available at: http://www.medpac.gov/documents/MedPAC\_Payment\_Basics\_13\_SNF.pdf. Accessed February 2014.

Use of Patient Assessment in Determining Case Mix

Patient assessment plays a critical role in prospective reimbursement because it is used to determine the case mix. A trained registered nurse in the facility oversees the assessment process for which a standardized Resident Assessment Instrument (RAI), called the minimum data set (MDS 3.0 is in current use, and is referenced in the For Further Learning section), must be used to conduct a comprehensive assessment of each patient’s needs. The MDS contains extensive information on the resident’s nursing care needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses. For example, Section G of MDS 3.0 is used for assessing functional status (see Appendix 6–1).

Subsequent to an assessment conducted on each patient, the facility’s case mix is derived from a patient classification system, called resource utilization groups (RUG–IV is in current use). Resource utilization groups (RUGs) provide a classification system that is designed to differentiate Medicare patients by their levels of resource use. The MDS information provides the input for classifying each patient in one of the 66 RUG classes, which are mutually exclusive; a resident can be classified in only one class. Of the 66 RUG classes, 52 pertain to skilled nursing care (see Figure 6–2); the other 14 are not Medicare reimbursable.

In simple terms, assignment of a patient to a RUG is based on the number of minutes of therapy the patient uses; the need for certain services (e.g., tracheostomy care or ventilator services); the presence of certain conditions (e.g., comatose, quadriplegia, or diabetes requiring daily injections); and an index based on the patient’s ability to perform four ADLs—eating, toileting, bed mobility, and transferring (MedPAC, 2012). The methodology for determining RUG categories is complex. Data transmission to the CMS is done electronically, such as by using the RAVEN software offered by the CMS.

Medicare Value-Based Purchasing

In the future, Medicare payments to SNFs will incorporate incentive payments for quality. Linking reimbursement to patient outcomes could help improve clinical quality and redistribute payments from low-quality to high-quality nursing facilities. This concept is referred to as value-based purchasing or pay for performance. The Affordable Care Act has directed Medicare to develop a plan to implement a value-based purchasing program. In response, the CMS has implemented demonstration projects in at least three states to test the pay-for-performance concept as it would apply to nursing homes. Domains represented in the quality measures include staffing, appropriateness of hospitalizations, outcome measures from the MDS, and inspection survey deficiencies. The Medicaid programs in some states have also started to incorporate quality measures as part of their reimbursement methodologies.

Note: RUG-IV (resource utilization group, version M.) Differences between RUGs are based on activity of daily living score, service use, and the presence of certain medical conditions. The extensive services category includes patients who receive tracheostomy care, ventilator or respirator services, or are in isolation for an active infectious disease while a resident. The special care-high category includes patients who are comatose; have quadriplegia, chronic obstructive pulmanary disease, septicemia, diabetes requiring daily injections, fever with specific other conditions; or require parenteral/intravenous feedings or respiratory therapy for 7 days. The special care-low indudes patients with cerebral palsy, multipie sclerosis, Parkinsan’s disease, respiratory failure, a feeding tube, pressure ulcers of specific sizes, fool infections, or who receive radiation therapy or dialysis while o resident. Clinically complex category includes patients who have burns, septicemia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a resident.

Reproduced from MedPAC 2013. Figure adapted from Government Accountability Office. 2002. Skilled nursing facilities: Providers have responded to Medicare payments systems by changing practices, no. GAO–02–841. Washington, DC: GAO.

Medicaid

Medicaid—also called Title 19 of the Social Security Act—is a jointly funded federal–state health insurance program. Medicaid is a welfare program for the indigent. People with very low incomes and those with few or no assets generally qualify. The eligibility criteria are set by the different states, so they vary from state to state. However, states are also required to follow federal guidelines. Under the guidelines, Medicaid must cover people receiving Supplemental Security Income (SSI). It includes many of the elderly, the blind, and the disabled. The Affordable Care Act had mandated the states to expand their Medicaid programs, but the Supreme Court, in its 2012 decision, struck down the mandate and left it up to each state to comply or not comply with the initial mandate.

People who have excess income or assets to qualify for Medicaid must spend down to Medicaid eligibility thresholds by incurring medical or remedial care expenses to offset their excess income and assets. The resource limits for spend down, meaning the amount of funds a person may keep in order to apply for Medicaid, generally vary between $2,000 and $3,000. This provision is particularly significant for nursing facilities because it allows middle-class elderly to qualify for Medicaid once they have exhausted their personal assets. An estimated one-fourth of the patients who are initially admitted to a nursing facility on a private-pay basis eventually switch over to the Medicaid program after their personal assets have been exhausted. If individuals who qualify for Medicaid receive income from any sources, they are required to apply most of that income toward nursing home expenses; Medicaid will then pay the rest. Under federal law, it is a felony to shelter or distribute personal assets with the intention of making oneself eligible for Medicaid coverage.

The spend-down provision of Medicaid was modified under the Medicare Catastrophic Coverage Act (MCCA) of 1988. Although much of the MCCA was repealed, the portions affecting Medicaid remain in effect. The law protects the assets of an institutionalized person’s spouse if the spouse must remain at home. The law was designed to prevent the impoverishment of the spouse remaining in the community. When one spouse enters a nursing home, there is a maximum amount of resources that the spouse at home is allowed to keep. This maximum amount, which varies from one state to another, is called Community Spouse Resource Allowance (CSRA). The community spouse is also allowed to keep a portion of the monthly income, an amount referred to as Community Spouse Monthly Income Allowance (MIA), which guarantees the spouse at home a basic monthly allowance for living expenses. Medicaid eligibility rules are complex. Specific details can be obtained from a local social/human services office.

Unlike Medicare, Medicaid has no limit on the number of days a person may stay in a nursing facility. Hence, Medicaid pays the largest share of national expenditures for nursing home services (see Figure 6–1). Many states also periodically (generally once a year) pay for eyeglasses, hearing aids, dental care, and other needed services. Also, states have been expanding coverage of community-based LTC services under the home- and community-based services (HCBS) waiver program. The waiver program allows those who may currently be in nursing homes or qualify for care in a nursing home to live in the community and received community-based LTC services.

Determination of reimbursement rates for nursing facilities is left up to each state. States employ diverse methods and policies to determine the per-diem rates, and the amount of the per-diem reimbursement can vary greatly from one state to another. Many states have adopted the case-mix method or a modified method similar to the Medicare prospective payment system discussed earlier.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) was authorized under the Balanced Budget Act of 1997. It is available in most states. PACE focuses on frail elderly who have already been certified for nursing home placement under Medicare or Medicaid. The main aim of the program is to provide LTC services in community settings to people who otherwise risk being placed in nursing homes. To reduce costs, PACE employs four major strategies (Eleazer & Fretwell, 1999):

• It exclusively targets the frail older adult. Those 55 years and older can qualify.

• It offers the full spectrum of acute care and long-term care services.

• Care is integrated by an interdisciplinary team of service providers.

• Financing is integrated through Medicare, Medicaid, and private funds. PACE organizations are paid a fixed monthly payment per enrollee (capitation). The reimbursement amount remains fixed during the contract year regardless of the services an enrollee may need.

The interdisciplinary team of professionals includes primary care physicians, nurses, rehabilitation therapists, social workers, personal care attendants, and dietitians. The team determines which services will best meet the enrollee’s needs; it ensures the delivery of services in accordance with a plan of care; and it coordinates the needed services. Services are available 24/7. The PACE service package must include all Medicare and Medicaid services. In addition, the PACE organization provides any service determined necessary by the interdisciplinary team. Basic services—such as primary care, social services, rehabilitation therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals services—are generally provided in an adult day care center setting. Other needed services are obtained through referral. These services include home health care, services from medical specialists, laboratory and other diagnostic services, hospitalization, and nursing home care.

PACE has no deductibles and copayments, which is an incentive for qualified individuals to participate. The program has been shown to result in reduced amount of hospitalizations and rehospitalizations (Meret-Hanke, 2011), and substantial cost savings over other alternatives of LTC delivery (Wieland et al., 2013).

Partnerships with Managed Care and Hospitals

The growing health care burden for an aging population will, by necessity, make public financing more stringent. It means that nursing home administrators will have to find innovative ways to increase revenues from private sources, something that will increasingly involve other organizations for financing and delivery of care.

Managed Care Financing

Managed care organizations (MCOs) are private organizations, but they contract with Medicare or Medicaid to deliver health care to beneficiaries covered by these public programs. The key to understanding the general concept of managed care financing is the delivery of all needed services to enrolled beneficiaries in exchange for a fixed monthly payment agreed to in advance. The fixed monthly payment that covers all services is called capitation. The nursing facility must manage the cost of providing the services within the capitation amount received. If the cost of services exceeds the capitated reimbursement, the nursing facility will lose money. Capitation is designed to control inappropriate use of services and to control the escalating costs of health care delivery.

A nursing facility could have contracts with several different MCOs to provide services to clients covered under private or public financial arrangements. Nursing facility administrators are faced with both an opportunity and a challenge to meet higher demands for subacute care. They must also develop contracting and negotiating skills to deal with MCOs, skills in costing and pricing skilled care and subacute services, and skills to manage clinical services that have become increasingly complex.

Partnerships with Hospitals and Accountable Care Organizations

Many hospitals have transitional care (or extended care) units or long-term care hospital (LTCH) units that deliver postacute services after a patient is discharged from acute care. This puts hospitals in the driver’s seat to steer patients away from nursing homes when these patients require postacute care in a skilled nursing facility. That means stiffer competition for freestanding community nursing facilities. On the other hand, not all hospitals have postacute care units. In either case, a nursing facility can establish partnerships with area hospitals to at least serve the overflow of patients that may require postacute care.

The Affordable Care Act may also create opportunities for hospital–nursing home partnerships. The law requires reduction in reimbursement to hospitals that incur excessive Medicare readmissions for selected conditions (MedPAC, 2012). One study found that 20% of Medicare patients were rehospitalized within 30 days, and the cost to Medicare from unplanned rehospitalizations was $17.4 billion in 2004 (Jencks et al., 2009). Hence, readmissions have become a quality issue for hospitals and a cost issue for Medicare. The CMS has set aside $128 million for organizations that collaborate with nursing homes to establish programs that prevent residents from going back to hospitals within a month (McKnight’s, 2012). Hence, there are new incentives that nursing homes can take advantage of by seeking partnerships with other health care organizations, but nursing homes will also have to revamp their infection control programs and further improve the overall quality of care.

In the evolving U.S. health care system, care coordination is receiving increased emphasis. For example, the Affordable Care Act has promoted coordinated care delivery through accountable care organizations (ACOs). In an ACO, a group of health care providers—such as physicians and hospitals—work together and take responsibility for improving the overall health status, care efficiency, and satisfaction with care for a defined population (DeVore & Champion, 2011). ACOs are still in their infancy. Nevertheless, care coordination has become the new mantra in health care delivery. Hence, it is conceivable that skilled nursing facilities would find opportunities to collaborate with both existing and emerging health delivery organizations. For nursing home administrators, the key will be to open dialogues with local hospitals and physicians in an effort to understand postacute needs of their patients. Under PPS and capitation reimbursement systems, coupled with decreased reimbursement from the government, hospitals will continue to have a need to keep patients for as few days as possible. The hospitals’ new worry is to minimize readmissions. While seeking postacute providers, hospitals are seeking a collaborative mindset. They are looking for providers who are easy to work with and open to changing care protocols (Slavik, 2013). Nursing home administrators can find collaborative ways with area hospitals to provide a level of services that would create a win–win opportunity for all parties involved. Hospitals across the nation are building collaborative relationships with SNFs. Nursing home administrators also need to take the initiative and reach out.

Veterans Health Administration Contracts

The VHA is responsible for providing nursing home care to any veteran in need of such care. The care may be provided directly in VHA’s own facilities, or the veterans needing care may be placed in community nursing homes because of capacity shortages within the VHA system. In 2012, the VHA contracted with approximately 2,500 community nursing homes to provide long-term care to veterans (Government Accountability Office, 2013). To participate in VHA’s nursing home program, community facilities must meet VHA standards and be certified to participate in Medicare and Medicaid. The VHA pays per-diem rates that are tiered according to intensity of resources required to provide care. The homes are prohibited from billing any other payer for services provided to veterans. In 2012, on an average day, 36,250 veterans resided in nursing homes. Of these, 19% received care in community nursing homes (Government Accountability Office, 2013).

Fraud and Abuse

Fraud and abuse by providers who participate in the Medicare and Medicaid programs have been a growing concern. Because fraud and abuse siphon off resources that could otherwise be used for providing legitimate services to needy people, the government has been cracking down on providers who abuse the system. Both criminal and civil laws can be enforced.

Federal Fraud and Abuse Law

The federal fraud and abuse law is a criminal statute. The legislation has evolved over time in the form of amendments to the Social Security Act. For example, the statute was expanded in the form of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The HIPAA legislation created the Health Care Fraud and Abuse Control Program, which gave the government expanded powers to investigate and prosecute fraud in the delivery of health care services.

These are the main provisions of the fraud and abuse statutes as they apply to nursing homes:

 1. It is a felony to make false statements or claims regarding services provided to Medicare or Medicaid patients. Violations are punishable with fines up to $25,000 or imprisonment of up to 5 years. Examples of violations include false billings or attempts to obtain payments for services not provided. Upcoding, that is, billing for services that procure a higher reimbursement than the services actually provided and that should have been billed at a lower rate of reimbursement, is also a felony. For example, manipulating the MDS to increase the case mix would be considered upcoding.

 2. It is a felony to induce referrals of Medicare or Medicaid patients by offering or receiving any kind of remuneration, kickback, or bribe, regardless of whether they are in cash or kind. Same penalties as in (1) apply. This category would include gifts to physicians or other referral agents. Antikickback provisions may also apply to situations in which the nursing home makes referrals to external providers (such as pharmacies, laboratories, and medical equipment suppliers) in exchange for benefits received. For example, a nursing facility may ask a clinical laboratory for free services such as chart review or infection control. These are services that nursing homes are required to provide, and they are included in the reimbursements nursing homes receive from Medicare and Medicaid. The clinical laboratory is in a position to financially gain from referral of clinical tests and other laboratory work from the facility. Under these circumstances, free services to the nursing home may be construed as inducement for referrals to the laboratory. Either offering or receiving any kind of remuneration to induce referrals violates the antikickback statute.

 3. Under HIPAA, any felony conviction for fraud, theft, embezzlement, or other financial misconduct by a health care provider must also result in the provider’s expulsion from Medicare and Medicaid programs.

The Affordable Care Act

The law increases federal sentencing guidelines for health care fraud exceeding $1 million in losses. Providers and suppliers who may pose a higher risk of fraud and abuse receive increased scrutiny. The CMS uses advanced predictive modeling technology to target highly suspect behaviors. The Affordable Care Act also provides an additional $350 million over 10 years to boost antifraud efforts.

False Claims Act

The civil False Claims Act (FCA) has become a major weapon to crack down on nursing facilities under the general legal theory of defrauding the government when claims are submitted for Medicare and Medicaid reimbursement and the services delivered are found to be substandard. The law was originally enacted in 1863 during the Civil War as a measure against fraud by companies furnishing supplies to the Union Army. It was amended in 1986, under the Reagan presidency, to curtail widespread reports of fraud in the defense industry. In the health care industry, the law makes it illegal to provide and bill for services that are medically unnecessary, to provide and bill for services that are not covered under a federal program or are of substandard quality, or to try to claim payment for unbundled services by submitting separate bills when in fact the services should be bundled.

Damages under the False Claims Act are severe. In 2009, Regency Nursing and Rehabilitation Center, Inc., a Texas-based nursing home chain, agreed to pay $4 million to settle allegations that it submitted false claims to the Texas Medicaid program by seeking reimbursement for services that the residents did not qualify for, were unnecessary, and were not supported by adequate documentation (U.S. Department of Justice, 2009).

Since 1996, prosecution based on a facility’s failure to deliver adequate care has become more common. In 1996, the U.S. Attorney’s Office for the Eastern District of Pennsylvania filed a civil complaint against the owner and former administrator of a nursing facility in Philadelphia. The government contended that the defendants had violated the FCA when they submitted claims for payment, despite the fact that the residents did not receive adequate care, because three residents in the facility had suffered from malnutrition and inadequate wound care. The case was settled for a $600,000 fine and consent by the facility to implement quality standards. Failure to hire adequate staff to provide sufficient care may be regarded as a deliberate intent to render substandard services and can fall under the provisions of the FCA.

More recently, the theory of “worthless services” has been applied under the FCA to recover damages for poor nursing home care and billing Medicare and Medicaid for those services. In 2013, a federal district court jury in Illinois found Momence Meadows Nursing Center, Inc. guilty of substandard care and resident abuse. The verdict imposed $28.1 million in civil penalties for providing services deemed “worthless” and retaliation against past employees who acted as whisleblowers (Cooper et al., 2013).

A unique feature of the FCA that has been widely credited for its success is the qui tam (informer or whistleblower) provision. Any individual who has knowledge that a person or an entity is submitting false claims or otherwise defrauding the federal government can bring a lawsuit on behalf of the government and can share in the damages recovered as a result of the lawsuit. The person who brings the case is referred to as a qui tam relator or whistleblower, who is often an employee or a former employee of a company. But a competitor, a subcontractor, a patient, or a family member can also be a relator if they have evidence of fraud against the government. As long as the information is not publicly disclosed and the government has not already sued the individual or company for the fraud, the relator may bring a qui tam lawsuit. Depending on various factors, the relators are entitled to between 15 and 30% of whatever amount the government recovers as a result of their qui tam lawsuits (Phillips & Cohen, 2003). A qui tam suit initially remains under seal, which allows the Department of Justice to review the case and decide whether to join the legal action.

The law provides certain protections to the relators. For example, the law prohibits an employer from harassing or retaliating against a relator. If retaliation occurs, the relator can recover damages including reinstatement, double the amount of back pay, and legal costs. In 2013, an employee, in the capacity of a relator, brought a lawsuit against Grace Healthcare, LLC and Grace Ancillary Services, LLC of Chattanooga, Tennessee, alleging violation of the FCA by submitting claims for therapy services in which therapists were pressured to increase the amount of therapy provided to patients without regard to patients’ individual therapy needs. The case was settled for $2.7 million of which the whistleblower received $405,000 (U.S. Department of Justice, 2013).