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# NURSING HOMES

# Aggregate Medicare Payments Are Adequate Despite Bankruptcies

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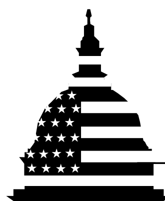



GAO/T-HEHS-00-192

# Nursing Homes: Aggregate Medicare Payments Are Adequate Despite Bankruptcies

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the causes of the bankruptcies of large corporations owning nursing homes, particularly whether recent Medicare payment reforms affected the bankruptcies, and implications for nursing home residents. Those payment reforms, set forth in the Balanced Budget Act of 1997 (BBA), were enacted to control rapid spending growth for Medicare-covered services furnished in nursing homes—spending growth that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. The reforms altered the financial incentives inherent in the former cost-based payment system to reward providers for delivering care efficiently.

Since the BBA provisions were implemented, five large nursing home chains—comprising almost 1,800 of the nation's 17,000 nursing homes—have filed for bankruptcy protection under Chapter 11 of the U.S. Bankruptcy Code. These bankruptcies and the large reported losses of these companies have received much public attention because of the number of homes involved and because of the fear that residents will be displaced if nursing homes close. Because the distribution of these facilities is concentrated, the potential threat of closure looms much larger for some states than for others. Almost half of the nursing homes in New Mexico and Nevada, for example, are operating in bankruptcy, compared with the national average of about 12 percent. Twelve other states have more than 20 percent of their homes operating in bankruptcy.

Many providers have blamed Medicare policies and the BBA for their financial difficulties and have pressured the Congress to undo some of the act's payment reforms. In response, the Congress has monitored the results of these reforms and made certain modifications in the Balanced Budget Refinement Act of 1999 (BBRA). But many in the industry argue that more changes are needed and are calling for higher payments.

Calls for increased payments come at a time when federal budget surpluses and reduced Medicare outlays could make it easier to consider increases in Medicare payment rates. However, in view of the coming surge in the Medicare-eligible population, the Comptroller General has cautioned repeatedly that projected Medicare spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Without meaningful reform, demographic trends alone will drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers.[1] It is therefore critical to the program's long-

[1] *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead* (GAO/T-HEHS/AIMD-00-103, Feb. 24, 2000).

term solvency and sustainability that we continue to evaluate provider payments and monitor beneficiary service use to ensure that beneficiaries receive needed services at the same time Medicare receives the best value for its money.

My comments today focus on the adequacy of Medicare's payment rates for skilled nursing services furnished in nursing homes, the relationship between the changes wrought by the BBA and recent nursing home bankruptcies, and what exists to protect patients. My remarks are based on our extensive published and ongoing work for this committee.[2]

In brief, our analysis indicates that aggregate Medicare payments for covered nursing home services likely cover the cost of care needed by beneficiaries, although some refinements to the payment system are needed. But Medicare policy changes have required many nursing homes to adjust their operations. The adjustments have been particularly disruptive for homes that took advantage of Medicare's previous payment policies to finance inefficient and unnecessary care delivery and for those companies that invested heavily in the provision of ancillary services (such as rehabilitation therapies) to nursing homes. The problems experienced by some providers of nursing home and ancillary services are therefore the result of business decisions made during a period when Medicare exercised too little control over its payments. Filing for bankruptcy protection under Chapter 11 allows these providers time to restructure their debts and streamline their operations while continuing to care for their nursing home residents. Should any of these providers not emerge from bankruptcy, however, the nursing homes will be sold or the residents may have to find alternative care arrangements.

## Background

Nursing homes in the United States—numbering about 17,000 nationwide—play an essential role in our health care system. They provide care for 1.6 million elderly and disabled persons who are temporarily or permanently unable to care for themselves but who do not require the level of care furnished in an acute care hospital. Nursing homes furnish a variety of services to residents, including nursing and custodial care; physical, occupational, respiratory, and speech therapy; and medical social services. Medicaid is the largest single source of nursing home revenue. In 1998, Medicaid accounted for 46 percent of total nursing home expenditures, while Medicare, out-of-pocket, and private insurance payments accounted for 12 percent, 33 percent, and 5 percent,

[2] *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access* (GAO/HEHS-00-23, Dec. 1999).

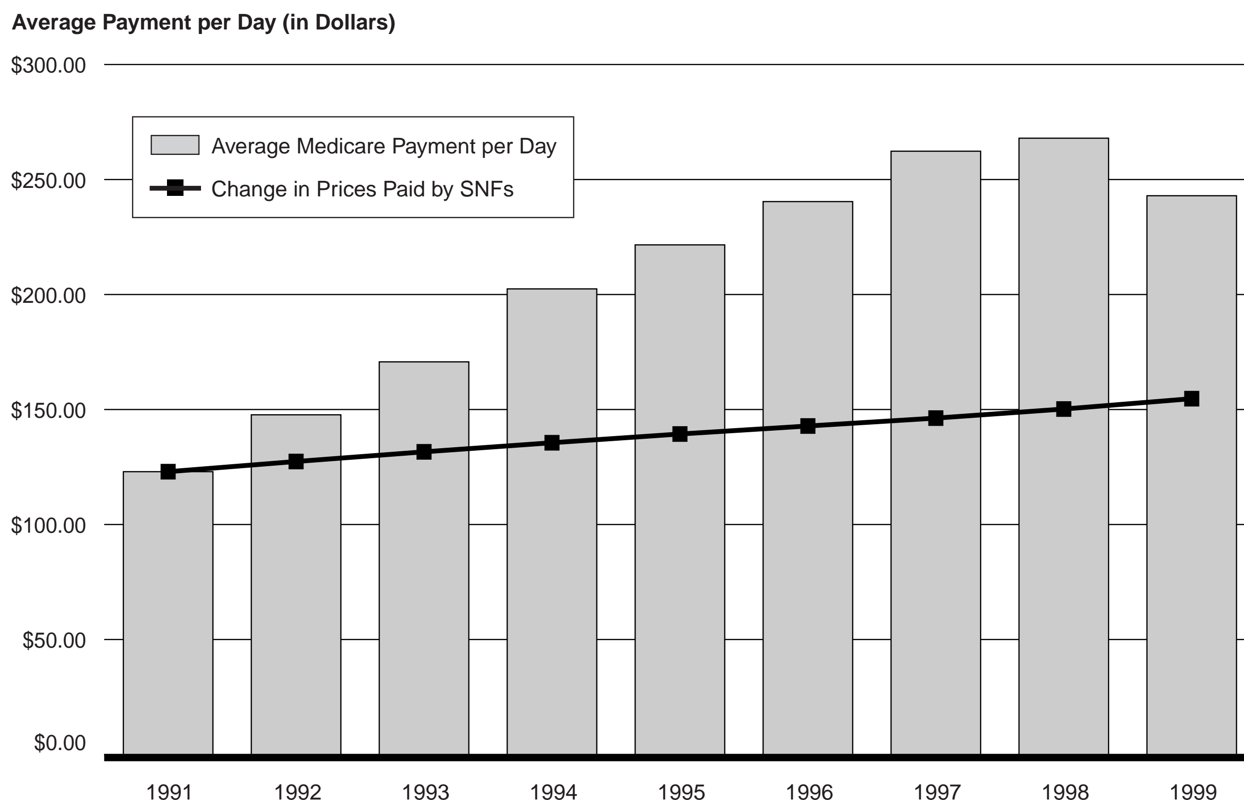
respectively. Two-thirds of nursing homes are for-profit entities; and about half are owned or operated by corporations operating multiple facilities known as chains. Many of these chains also operate other lines of business in addition to nursing homes, such as long-term care hospitals, assisted living facilities, pharmacies, and companies that furnish therapy.

Medicare covers nursing home care for beneficiaries who need skilled nursing or rehabilitative therapy services for conditions related to a hospital stay of at least 3 days occurring within 30 days before admission to a nursing home. All necessary services—including room and board, nursing care, and ancillary services such as drugs, laboratory tests, and physical therapy—are covered for up to 100 days of care per spell of illness. Beginning on the 21st day of care, the beneficiary is responsible for a daily coinsurance payment, which currently is $97.

Spending for skilled nursing services furnished in Medicare-certified nursing homes represents a growing share of total Medicare expenditures.[3] Between 1990 and 1998, Medicare expenditures for skilled nursing facility (SNF) services increased, on average, 25 percent annually, reaching $13.6 billion in 1998. This growth was due primarily to a rise in the number of beneficiaries using SNF services and to an increase in the provision of services to each SNF patient. Between 1991 and 1998, the number of beneficiaries receiving SNF care more than doubled, rising from 671,000 to 1.5 million. Over that period, Medicare's average payment per day increased, on average, 12 percent annually, reaching $268 in 1998, although the SNF market basket index, which measures yearly changes in the prices of goods and services purchased by nursing homes, rose only an average of 3 percent per year (see figure 1).

[3]Such facilities are referred to as skilled nursing facilities or SNFs.

**Figure 1. Average Medicare SNF Payments per Day Compared With Changes in Prices Paid by SNFs, 1991-1999**




Source: GAO analysis of data from the Health Care Financing Administration, Office of the Actuary, and DRI/McGraw-Hill, Inc.

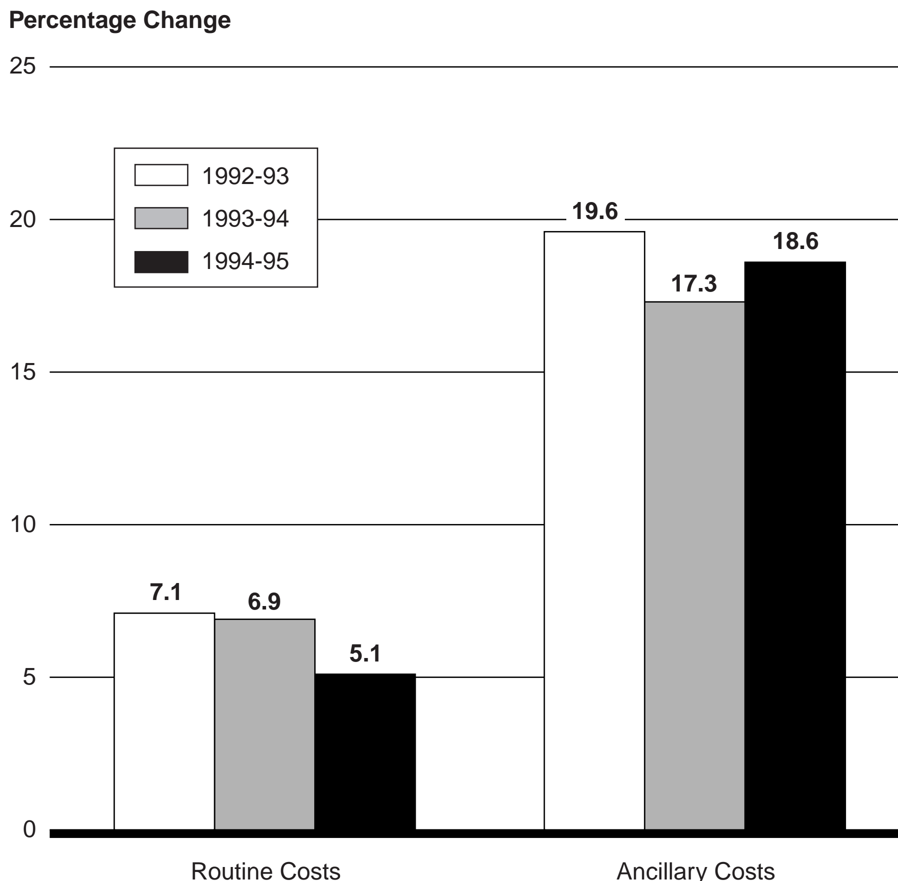
Medicare's cost-based reimbursement method, combined with a lack of appropriate program oversight, provided few checks on the growth in Medicare spending for SNF services. We believe, and the Department of Health and Human Services' Office of Inspector General (OIG) agrees, that the growth in costs for ancillary services, such as rehabilitation therapies,

was excessive.[4] Before implementation of the BBA, Medicare paid nursing homes the reasonable costs they incurred in providing Medicare-covered services. Routine services (which include general nursing, room and board, and administrative overhead) were subject to cost limits, but payments for ancillary services and capital-related costs were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no financial incentive to furnish only clinically necessary services and little incentive to deliver them efficiently. Further, high ancillary costs could be used to justify a request for exceptions payments for routine costs over and above the cost limits.[5] Indeed, the growth in Medicare per day expenditures was driven largely by increases in payments for ancillary services. An analysis of SNF costs from 1992 through 1995 found that reported ancillary costs per day rose 19 percent per year, on average, compared to 6 percent per year for routine costs (see fig. 2). This rapid cost growth is not explained by a commensurate increase in Medicare beneficiaries' needs.

[4]See *Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* (GAO/T-HEHS-99-192, Sept. 15, 1999); Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, *Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare* (OEI-09-97-00122, Aug. 1999); *Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes* (GAO/HEHS-95-23, Mar. 1995).

[5]Under cost-based reimbursement, providers with reasonable costs that exceeded the routine cost limits could be granted exceptions from the limits if they provided information indicating that they served patients requiring more services than the average.

**Figure 2: Percentage Growth in SNF Routine and Ancillary Costs per Day, 1992-1995**




Source: Prospective Payment Assessment Commission

This was the situation facing the Congress when it mandated in the BBA the implementation of a prospective payment system (PPS) for Medicare-covered SNF care. As required, the Health Care Financing Administration (HCFA) began phasing in the PPS on July 1, 1998. Under the new system, facilities receive a fixed payment for each day of care provided to an eligible Medicare beneficiary. Because not all patients require the same amount of care, payments are adjusted to reflect differences in patient characteristics and service needs. In fiscal year 2001, the payment for those patients expected to be the most costly will be more than three times greater than the payment for those with the lowest expected costs. By establishing fixed payments and including most services under the per

diem payment, the PPS attempts to provide incentives for nursing homes to furnish only necessary services and to deliver those services more efficiently. Facilities that can care for beneficiaries for less than the adjusted per diem payment can retain the difference as profit. Those with average costs higher than the per diem payments they receive will incur a loss.

## SNF PPS Rates Cover Medicare-Related Costs

Nursing home companies that recently have filed for bankruptcy and reported large losses have blamed Medicare payment policies, charging, among other things, that payment rates under the PPS are too low. Before we turn to the causes of the bankruptcies, let us address this issue. We believe that Medicare SNF payments are likely to provide sufficient—and in some cases, even generous—compensation for services furnished to Medicare beneficiaries. The average Medicare payment per day declined about $25 or 9 percent between FY 1998 and FY 1999, reaching about the same average rate as in FY 1996. This is noteworthy, because payments per day in 1996 were thought to be excessive, given that they reflected 6 years of growth of more than 12 percent per year at a time when prices for goods and services purchased by SNFs were rising about 3 percent each year.

Even with the reduction in average payments per day under PPS, we see no evidence that beneficiary access to SNF care has been compromised. Surveys of hospital discharge planners and nursing home administrators conducted by us and the OIG indicate that beneficiaries needing SNF care continue to receive it, even though some patients may have more difficulty finding a nursing home that can care for them. However, hospital lengths of stay for admissions likely to lead to a SNF stay continue to decline, providing no evidence that patients are “backing up” in hospitals.

Although aggregate Medicare payments are adequate to cover the costs of caring for Medicare patients, constraining payments to nursing homes may have created financial difficulties for some providers. Nursing homes with average daily costs that are higher than their payments must modify their treatment patterns and business strategies if they are to operate profitably. In addition, homes that used historically generous Medicare payments to make up for the uncovered costs of other residents may find that their Medicare revenues no longer stretch this far. Some industry representatives and analysts argue that Medicaid payments were often inadequate to cover the costs of Medicaid residents, so Medicare profits were used to make up the difference. But Medicare payments were never intended to finance the costs of these or other non-Medicare residents.

At the same time, the new incentives for efficiency created by the PPS have come at a time when providers are facing other external cost pressures. For example, in our healthy economy, nursing homes may be experiencing increased competition for staff. Competition for workers may have forced nursing homes to increase wages and expand benefits to attract and retain qualified personnel. Nursing homes have also been experiencing slight but steady reductions in occupancy rates over the last few years. Industry representatives contend that competition from assisted living facilities and other residential alternatives has spurred this decline. Still, the median nursing home occupancy rate is 88 percent.

We believe that aggregate payments are adequate, but we are concerned that the system may not adequately identify the most costly patients and distribute payments accordingly. Facilities treating a disproportionate number of high-cost cases may not receive adequate payments for those patients, which could result in access problems or inadequate care for some high-cost beneficiaries. At the same time, nursing homes treating patients with low service needs may be overpaid.[6] HCFA is aware of these distributional problems and is working to refine the system so that payments more accurately reflect differences in patient needs.

In the meantime, the BBRA, which modified some elements of the BBA, included a provision that temporarily boosts payments for certain cases by 20 percent.[7] At the same time, the Act increased payment rates across-the-board by 4 percent for fiscal years 2001 and 2002. These changes will add an estimated $200 million to Medicare SNF spending in fiscal year 2000 and, if allowed to remain in effect for 5 years, will increase total spending by $1.4 billion. To the extent that shortcomings in the payment system created access problems for some patients, the BBRA increase will ease concerns about the distribution of payments across patients. But fiscal prudence and the need for accurate payments to ensure appropriate service provision argues for implementing research-based improvements to the rates as soon as practicable. Such improvements aim to distribute existing payments more appropriately, avoiding the unwarranted expenditure of an additional hundreds of millions of dollars each year.

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[6] *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access* (GAO/HEHS-00-23, Dec. 1999).

[7] This BBRA provision is scheduled to expire on October 1, 2000, or when HCFA implements refinements to the payment system, whichever comes later. No refinements are planned for fiscal year 2001.

## Nursing Home Performance Under PPS is Primarily a Function of Previous Business Practices

The nursing home chains that have filed for bankruptcy in recent months have blamed the Medicare PPS for their financial difficulties. Yet our work indicates that the problems experienced by these corporations can be traced to strategic business decisions made during a period when Medicare was exercising too little control over its payments. The former SNF payment system encouraged nursing homes to increase their ancillary and capital costs, because doing so increased their payments. It also created opportunities for other organizations to supply services such as therapy at inflated prices to nursing homes, which then passed the costs onto the Medicare program. The PPS replaced these incentives with ones that are more closely aligned with Medicare's goals of encouraging provider efficiency and ensuring that payments are adequate for efficient providers to furnish needed services to Medicare beneficiaries. Not surprisingly, providers that most aggressively responded to the incentives in the old payment system have had to make the most adjustments under the new system.

To better understand the issues surrounding the nursing home bankruptcies seen in the past year, we examined financial information submitted to us by seven of the largest nursing home chains, including four of the five corporations that have filed for bankruptcy.[8] We found a number of common elements among the bankrupt corporations. First, most of the chains in bankruptcy reported higher than average nursing home costs, which is detrimental under a payment system based on national average costs. Although Medicare's 1998 average payment per day (which was based on facility costs) was $268, some of the chains reported pre-PPS payments exceeding $300 per day. It is not clear why their costs and resulting payments were higher than average. Their nursing homes may have served patients who needed more intensive care than the average Medicare SNF patient, in which case their PPS payments will likely also be higher than average. Higher costs might also, however, reflect provider inefficiencies, inflated prices, or over-provision of ancillary services.

[8]The companies included in our analysis were: Beverly Enterprises, Inc., Extendicare Health Services, Inc., HCR-Manor Care, Inc., Integrated Health Services, Inc., Mariner Post-Acute Care Network, Inc., Sun Healthcare Group, Inc., and Vencor, Inc. Documentary evidence used in analyzing the effect of the BBA included both financial information provided by the companies and their corporate filings from the United States Security and Exchange Commission, which contain material financial and business information on publicly traded companies.

Since implementation of the PPS, most of the companies we analyzed have cut costs to improve overall performance in their nursing home businesses. Several chains, for example, report that they have decreased costs by reducing the number of ancillary services provided to their nursing home patients and purchasing ancillary services and supplies at lower prices. Some also are opting not to purchase ancillary services from contractors and instead are hiring their own staff to furnish necessary services. At least one chain reports seeking to reduce its costs by admitting patients needing fewer ancillary services.

Some costs, however, are more difficult to reduce in the short term. For two of the bankrupt companies we examined, reported capital-related costs such as depreciation, interest on debt, and rent are substantially higher than the industry average. These companies invested heavily in the nursing home and ancillary service businesses in the years immediately preceding the PPS, both expanding their acquisitions and upgrading facilities to provide more intensive services. Under constrained payments, these debt-laden enterprises are particularly challenged.

A third company now operating in bankruptcy reported a four-fold increase in its rental costs between 1997 and 1999. This increase was due to a business decision to separate the property side of the business from the operating side, with the new real estate company leasing the nursing homes back to the operating company. Under this new structure, the operating company reported its nursing home rental expenses rose from $42 million in 1997 to $171 million in 1999, without a commensurate decline in other capital costs. As might be expected, this business decision greatly affected the operating company's bottom line. In fact, had the company's capital costs remained at the 1997 level, profits from their nursing home operations would have fallen 9 percent between 1997 and 1999, due primarily to reductions in nursing home revenues. Instead, the company's profits from their nursing home operations fell 78 percent.

The pattern with regard to nursing home revenues is less clear. Almost all of the companies we analyzed, including those not operating in bankruptcy, reported reductions in the proportion of their total nursing home revenues attributable to Medicare. In 1998, the companies we examined had an average Medicare revenue share of 26 percent. In 1999, that average fell to 22 percent.

Declining Medicare revenues resulted in reductions in total nursing home revenues for most of the chains we examined (although one of the companies now operating in bankruptcy saw its total nursing home revenues climb 13 percent between 1998 and 1999). Most of the

companies expect total nursing home revenues to be higher in 2000 than in 1999. Moreover, three of the four companies operating in bankruptcy have continued to generate profits in their nursing home operations throughout the transition to the PPS. The remaining company had been operating its nursing homes at a loss even before the implementation of the PPS.

That companies can generate profits in their nursing home operations and at the same time file for bankruptcy can be explained in large part by losses from their ancillary service lines of business. Most corporations that have filed for bankruptcy had invested heavily in the business of furnishing ancillary services to their own nursing homes and others. Two companies attributed about 25 percent of their total corporate revenues in 1998 to their ancillary service lines of business, while one company attributed almost half. But the PPS has made nursing homes, those belonging to these chains as well as others, more cost-conscious in purchasing contracted services, which had the effect of reducing both the demand for and the price of ancillary services. As a result, revenues from ancillary service lines of business have plummeted.

Without the prospect of overly generous, rapidly rising Medicare revenues, these publicly owned corporations were forced to post asset impairment losses on their balance sheets. Accounting principles dictate that such losses be calculated and recognized to inform investors that future expected revenue streams will be lower than anticipated.[9] Companies also have downsized their businesses by selling nursing homes and ancillary service providers, often at a loss. Losses from asset impairment and sales account for much of the bankrupt corporations' reported total shortfalls but reflect business and accounting practices rather than losses from current operations. They are, in effect, paper losses that do not contribute to the companies' bankruptcy filings, although they do affect calculations of the companies' worth.

[9]The losses appearing on their income statements reflect the difference between the original value of assets and the revised value, based on the revenue the asset is expected to generate in the future. The American Institute of Certified Public Accountants' Statement of Financial Accounting Standards No. 121 (SFAS No. 121), entitled *Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of*, requires such impairment losses to be recognized.

## Operations Continue While Companies Restructure, but Some Facilities May Be Closed

Given the protections and benefits available under the U.S. Bankruptcy Code (Code), it is unlikely that the bankruptcy filings of the five large nursing home chains will affect the short-term operations of their nursing homes. The five chains have filed for bankruptcy under Chapter 11 of the Code. Filing for bankruptcy protection under this chapter offers a number of benefits to companies. First, Chapter 11 bankruptcy proceedings focus on restructuring a company's debt and reorganizing its business operations with the goal of achieving future profitability and some debt repayment. Protection under Chapter 11 allows a company to cease making debt payments while it renegotiates the terms of those debts, including loan amounts and payment schedules.

A company in Chapter 11 usually retains control of its assets as the "debtor in possession," while a creditor committee is appointed to protect the interests of the creditors. Because Chapter 11 allows the companies to continue to operate as they establish a payment schedule with their creditors, the bankruptcy proceedings should not affect the chains' short-term ability to provide services to their residents. In fact, the Code allows a business to obtain special financing while in bankruptcy to help ensure that it has the funding necessary to operate. All five nursing home chains that have filed petitions under Chapter 11 have obtained such funding. With access to this cash, operations of the nursing homes run by the chains should continue.

Bankruptcy protection under Chapter 11 is designed to allow a company to continue operating, so a nursing home in bankruptcy can continue to care for its residents. However, a nursing home chain that does not emerge from a Chapter 11 proceeding will convert to a proceeding under Chapter 7, in which case residents of the chain's nursing homes would not be protected under federal law, because there are no provisions to do so. In a Chapter 7 bankruptcy, a company is dissolved and its assets are sold to pay its debts. Assets are put under the control of a court-appointed trustee, whose responsibility is primarily to the creditors. Many states have trusteeship (or receivership) laws that allow the state to intercede in a Chapter 7 bankruptcy proceeding involving a health care provider, delaying asset liquidation to protect patients. In such a case, a state court-appointed trustee continues to operate the facility until a buyer is found or until alternative care arrangements can be made for residents. Trusteeship statutes are not present in every state, however, and even if they do exist, implementing them may not be easy. Finding qualified and interested individuals to act as trustees may be problematic, particularly if many are needed, as might be the case in some states if a major nursing home chain files for Chapter 7 bankruptcy. Neither is it clear who would finance the costs of continued operations or the costs of transferring patients to alternative care settings. In some cases, states have argued to the court, generally with little success, that these costs should be charged

to the bankrupt company and should receive priority over other debts. Such an arrangement would not be in the interest of other creditors, since the company's remaining assets may not be enough to retire its debts.

Although industry analysts and government officials expect that most public chains currently operating in bankruptcy will recover, it is important for states to be prepared to address nursing home closures, particularly in states where large numbers of nursing homes are operating in bankruptcy. HCFA has been involved on a limited scale in states' contingency planning processes, by providing guidance to state agencies for the enhanced monitoring of bankrupt facilities and surveying states' contingency planning efforts. Unfortunately, our discussions with HCFA suggest that, in the unlikely event of substantial nursing home closures, some states may not be adequately prepared.

Even if nursing home chains emerge from bankruptcy, some of their facilities may be sold. Given the current climate, corporations may reevaluate their cost structures and decide to get rid of certain facilities based on their profitability or other factors. If no buyers can be found, some facilities may be closed.

The recent bankruptcy filings and the resulting recapitalization or reorganization of nursing homes' debt structures also has had consequences for the industry as a whole. According to market analysts and industry representatives, lenders are now more hesitant to provide capital to nursing homes. Nursing homes that do not have established relationships with lenders may have difficulty obtaining funds for expansions or upgrades to current facilities. This may be problematic for businesses that want to expand or for homes that need improvements. However, prospects for raising capital may improve with recognition of the fact that our aging population will dramatically increase demand for long-term care services.

## Conclusions

As anticipated, BBA reforms have had significant effects on the delivery, cost, and use of SNF services. The changes wrought by the BBA have required providers to adjust both their patterns of care and their business strategies. These adjustments have not been easy for some, and those who have experienced the most difficulty have been quick to attribute their problems to inadequate Medicare payments and call for additional federal dollars. However, our analysis indicates that the nursing homes' responses are adaptations to appropriately tightened Medicare payments following a period of unchecked growth.

The SNF PPS needs some refinements, which are under development. In assessing the merits of these refinements, prudence suggests that beneficiary needs and the program's prospects for long-term financial sustainability should be of paramount concern. We will continue to monitor the effects of the BBA to help the Congress ensure that beneficiary access is protected, providers are fairly compensated, and taxpayers do not shoulder the burden of funding unnecessary or inefficient spending by nursing homes.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee may have.

## GAO Contact And Acknowledgments

For future contacts regarding this testimony, please call Laura A. Dummit at (202) 512-7118. Individuals who made key contributions to this testimony include Carol L. Carter, Jennifer DuLac, Dana K. Kelley, and Erin M. Kuhls.

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