

# A Call for Federal Action to Improve Nursing Facilities

By Kate McEvoy and Charles Milligan

## Policy Points

- > To address longstanding quality concerns and disparities in nursing facilities, CMS should link federal funding to quality improvement and promote value-based payment
- > To spur improvement in nursing facilities, CMS should expand its nursing facility guidance and include structural measures like staff turnover in its Medicare and Medicaid certification requirements

## ABSTRACT

Nursing facility (NF) residents' high infection rates and poor overall care experiences during the COVID-19 public health emergency have reinforced and amplified long-standing concerns about the quality and cost-effectiveness of NF care. In light of documented disparities in access, experience of care, and outcomes, these concerns are especially urgent for residents of color. While the Centers for Medicare and Medicaid Services (CMS) has taken some actions to promote a focus on quality, much more should be done to articulate federal policy and to inspire and incentivize improvement. Specifically, CMS should:

- Endorse linkage of any further public health emergency–related funding or other federal financial reimbursement to quality improvement.
- Align Medicare and Medicaid efforts to promote payment policies that are based on risk adjustment for complex care and incorporate value-based payment principles, eliminate unintended consequences of federal policies such as routine approval of nursing home bed taxes, and adopt a common foundation of quality measures.
- Expand existing guidance on rebalancing long-term services and supports.
- Enhance conditions of participation for nursing homes and hospitals by including structural measures such as census and staff turnover.
- Build out existing mechanisms like Care Compare to enhance public transparency, availability, and usability of cost report and ownership information and to provide timely and complete information on NF citations.

## THE CURRENT STATE OF NURSING FACILITIES

Medicare and Medicaid are the main payers of institutional long-term services and supports (LTSS), which are usually delivered in NFs. While rebalancing LTSS in favor of community-based options has been a high priority of the Center for Medicaid and CHIP (Children's Health Insurance Program) Services (CMCS), both the federal and state governments acknowledge the necessity of nursing facilities as a component of a meaningful and high-quality continuum of care.

That said, the Olmstead decision<sup>2</sup> and associated calls for action from stakeholders have led to broad agreement among policymakers and stakeholders that NFs most suitably serve individuals with complex medical, personal care, and psychosocial needs, whereas people with other conditions and disabilities (e.g., behavioral health needs) can effectively be supported in integrated community settings. This approach calls for a focus on improving the availability and quality of skilled services, which require nursing or rehabilitation staff to manage observe or evaluate care, rather than custodial services

designed to help with activities of daily living like bathing, dressing, eating, or getting in or out of a bed or chair.

While the NF experience during the public health emergency – which included high infection and mortality rates, deficits of care, isolation, and a resulting negative psychosocial impact – deserves serious scrutiny and remedial action, other historical phenomena, including reduced consumer demand and a lack of federal guidance, must also be examined and addressed.

**Consumer demand continues to trend down.** Consumer demand for NFs services has been contracting over the last decade as people increasingly choose home- and community-based care options. AARP's 2018 *Across the States* report showed that between 2011 and 2016, 46 states experienced decreases in the number of people served by NFs, reflecting a 4% overall reduction in occupancy nationwide.<sup>3</sup> Leading Age found that from June 2015 to June 2019, 39 states experienced a decrease in average occupancy, and 13 states had reductions in occupancy of 3 percentage points or more.<sup>4</sup>

Relatedly, a large number of Medicare- and Medicaid-certified facilities have closed in recent years. A key takeaway here is that closure of facilities did not keep

the national average occupancy rate from decreasing. The rate dropped despite demographic trends that show an increase in incidence of older adults and people with disabilities who meet a NF level of care.

Demand has been further suppressed during the public health emergency, leaving average NF occupancy rates well below the 95% occupancy level that CMS has identified as associated with high-quality care and economic efficiency. (See Figure 1.) While rates have rebounded somewhat since their lowest point during the public health emergency, they still fall far short of historically typical levels.

**Residents of color experience serious disparities.** Historical factors that have disfavored equitable experience and outcomes for NF residents of color have

### US NURSING FACILITIES AT A GLANCE



15,327

Number of certified nursing facilities in the United States, serving 1,290,177 residents.



94%

The percentage of facilities dually certified by Medicare and Medicaid.



70%

The percentage of facilities owned by for-profits, 23% are owned by non-profits, and 6% are government-owned.



78%

The national average occupancy rate, ranging from 62% in Indiana and Montana to 89% in Maine.



67.9%

The percentage of facilities with deficiencies, with an average incidence of 10 per facility.

Source: Kaiser Family Foundation. State health facts. <https://www.kff.org/state-category/providers-service-use/nursing-facilities/>. 2020. Accessed January 10, 2022.

been starkly illuminated during the public health emergency. Before the onset of the COVID-19 pandemic, as compared with white individuals, Black individuals were more likely to:

- be admitted to the lowest-quality nursing homes;
- live in homes that are terminated from participation in the Medicaid program; and
- live in facilities that are for profit, large, substantially Medicaid funded, and cited for deficiencies in care.<sup>5</sup>

In addition, recent research has shown that Black individuals have disparate experiences in assessment and treatment in nursing facilities, as compared with white individuals. Examples include a higher incidence of pressure ulcers and more frequent use of feeding tubes,<sup>6</sup> and, for individuals diagnosed with Alzheimer’s disease or related dementia, a greater likelihood of being diagnosed as schizophrenic on Minimum Data Set assessments, which are used to justify continued use of antipsychotic medications.<sup>7</sup>

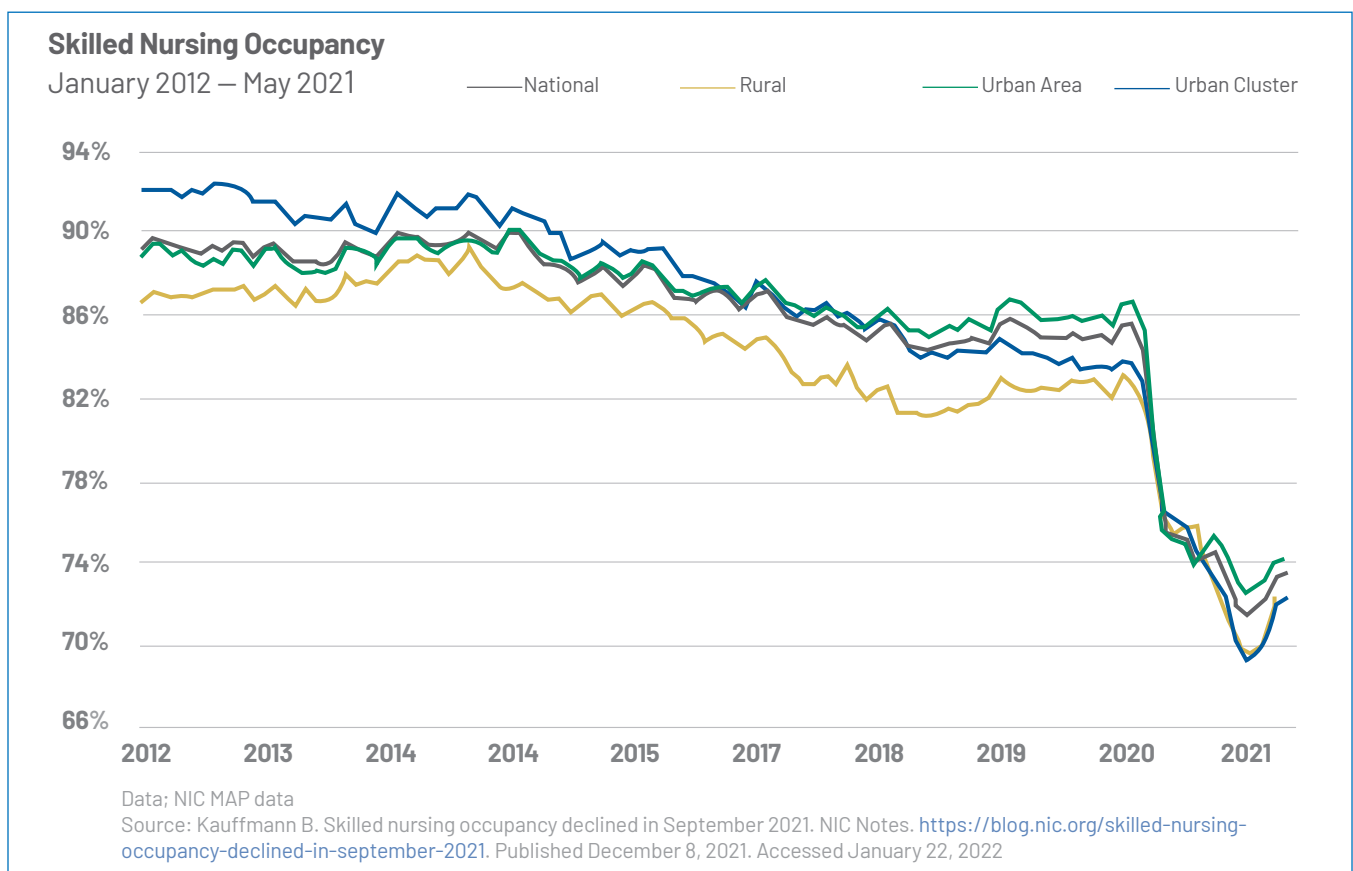
Black NF residents have also suffered disproportionately during the COVID-19 pandemic. Nursing homes

in which more than 40% of residents were people of color experienced COVID-19 case and death counts that were 3.3 times higher than those of nursing homes with low proportions of residents who were people of color. Differences in COVID-19 resident deaths by race were associated with nursing home size (as measured by the number of certified beds) and community-level outbreak severity.<sup>5</sup>

These factors, as well as compelling differences in report of experience of care by race and ethnicity, demand immediate use of a race equity lens in selecting, tracking, and evaluating the efficacy of care delivery and reimbursement reforms on access, treatment, and outcomes for residents of color.

**Quality is not where it should be.** A significant proportion of NFs have survey-identified deficiencies in quality of care. Quality also varies significantly across the country, as captured by the few measures currently in use nationally.<sup>3</sup> AARP’s *Across the States* detailed broad state variation in indicators of nursing home quality.<sup>3</sup>

Figure 1: Skilled Nursing Occupancy Declined Dramatically during the COVID-19 Pandemic



For example:

- The percentage of long-stay residents with a hospital admission in 2014 ranged from 5% (Hawaii) to 28% (Mississippi).
- The percentage of long-stay residents without a psychiatric diagnosis receiving an antipsychotic medication in 2017 ranged from 7% (Hawaii) to 20% (Oklahoma).
- The percentage of high-risk residents with pressure sores in 2017 ranged from 3% (Hawaii) to 10% (District of Columbia).

While both Medicare and Medicaid are using a few NF quality measures, there is little alignment in areas of quality focus between Medicare and Medicaid. Medicare has focused its NF agenda on indicators related to discharge to the community, potentially preventable readmissions, spending per beneficiary, falls, skin integrity, drug regimen review, and a number of functional outcome measures.<sup>8</sup> And the CMCS Medicaid and CHIP Scorecard<sup>9</sup> includes measures related to number of hospitalizations and incidence of use of antipsychotic medications for long-stay residents, with reported results published on an aggregate, state-by-state basis.

With respect to linking payment to quality, Medicare has solely focused on a single claims-based all-cause all-condition hospital readmission measure in its NF [Value-Based Purchasing initiative](#). By contrast, Medicaid has not specifically endorsed acuity-based nursing home reimbursement, with or without a value-based component.

**Current payment models do not incentivize high-quality care.** Current NF reimbursement models are generally not value-based and continue to incentivize facilities to select residents with less complex needs, including but not limited to people with behavioral health conditions who could otherwise be served in the community. Medicare has adopted the [Patient Driven Payment Model \(PDPM\)](#), and 30 states have transitioned to some form of Medicaid risk-adjustment-based nursing home payment. Yet, the remainder of states (using both capitated managed care and managed fee-for-service models) are still relying on cost-based reimbursement that is not risk-adjusted or value-based. The use of a cost-based model for NFs stands in stark contrast to the great majority of

Medicaid reimbursable services, which are neither cost-based nor routinely adjusted for inflation.

Other policies may also be perpetuating referrals to and reliance on NF care, even as demand contracts. Both acuity-based rate enhancements received by Medicare Advantage plans and states' dependence on the additional federal revenue generated by nursing home provider taxes contribute to nursing home placements.

**Federal public health emergency financial assistance to NF has not been meaningfully linked to quality.** Over the course of the public health emergency, nursing facilities have reported significant revenue losses associated with (1) reduction in the incidence of elective surgeries and associated short-term, Medicare-funded rehabilitative stays; and (2) a downward trend in demand for nursing home beds among people with Medicaid. Further, NFs have historically reported, and continue to report, that Medicaid reimbursement does not cover their costs.

To support NFs during the public health emergency, the federal government has provided in-kind assistance (testing equipment, personal protective equipment [PPE]), Paycheck Protection Program assistance, and four distinct distributions of CARES Act Provider Relief Fund funding to NFs nationwide, reflecting tens of millions of dollars of direct support. Many states have also provided significant support to nursing homes through financial assistance via Medicaid rate increases, in-kind support for testing of residents and staff, and in-kind direct distribution of PPE.

Federal public health emergency-related financial and in-kind assistance to NFs has, with the exception of requirements related to COVID-19 infection control, not been contingent on improved quality of care or cost-efficiency. While the public health emergency-related needs to which the funding has been applied (e.g., contingency staffing, PPE, other operational needs) are real, further federal support should not exist in a vacuum separate from quality and efficiency improvement. If nursing facilities' payments are based on the complexity of their residents' health needs, they will be incentivized to meet the needs of those who require extensive support.

**Incompleteness and inaccessibility of data remain obstacles to informed decision-making.** Access to and use of Medicare and Medicaid quality and cost report data on NFs remain challenging, despite the progress

Medicare has made by making data on nursing home quality and ownership type publicly available through Care Compare.

Medicare participating providers must complete and submit Minimum Data Set data as well as report on select quality measures to CMS. Providers that participate in Medicare and Medicaid are also required to disclose ownership and controlling financial interests and affiliations, as defined by federal regulations.<sup>10</sup>

Relatedly, Medicare-certified NFs are required to submit annual cost reports (including facility characteristics, utilization data, cost and charges by cost center, settlement data, and financial statement data), and this information is centrally maintained in the Healthcare Provider Cost Reporting Information System. Medicaid programs typically require NFs to submit annual cost reports. Some, but not all, states make these publicly available.

The federal Care Compare site<sup>11</sup> has enabled public access to and use of the following data points:

- General detail including name, location, certification, affiliation, ownership status (proprietary or non-profit)
- Star ratings
- Health inspections by state survey agencies
- Fire safety inspections
- Staffing hours per resident day
- Results on quality measures for both short- and long-stay residents
- Penalties for homes with serious health or fire safety citations or failure to correct citations over time

That said, ownership information is limited to descriptors relating to tax status. It does not include information about sometimes complex ownership structures, for example, and cost information is not featured.

Further, as a recent article<sup>12</sup> in the *New York Times* revealed, citations against nursing homes are not included in Care Compare data during the informal dispute resolution process, during the formal appeal process, or even thereafter. Given that nursing homes are cited when they fail to meet standards of care, the exclusion of citations requires immediate attention and remedy.

Finally, CMS has not established standards or an approval process for changes in nursing home ownership. Lack of standards for those scenarios leaves residents at risk of new ownership that does not have the motivation, expertise, acumen, or financial wherewithal to adequately protect health and safety and promote positive outcomes.

**CMCS has not issued recent guidance on NFs.** While CMCS has issued an excellent and comprehensive resource on Medicaid LTSS rebalancing, this resource focused on the home- and community-based components of the LTSS continuum and provided only a few examples of state actions taken to transform institutional models.<sup>13</sup> Further, CMCS has historically relied on general reimbursement principles and has not issued subregulatory guidance for states on cost-effectiveness, reasonable and allowable costs, and idle space considerations of nursing home reimbursement. These issues have become much more urgent over time as the number of residents in many homes drops but physical plant obligations remain unchanged, effectively leaving Medicaid programs to pay for unused space without revised reimbursement guidance.

## Five Recommendations for Federal Action

To address these needs, CMS should take action in each of the following areas:

### **CMS should endorse linkage of federal financial reimbursement to NF performance on quality improvement measures.**

This linkage should transcend the current focus on infection control by incorporating specific outcome and care experience measures selected from the Minimum Data Set and survey reports.

### **CMS and CMCS should address the lack of alignment between Medicare and Medicaid guidance, regulation, and reimbursement policies by endorsing risk-adjusted and value-based payment, as well as adopting a foundation of common, equity-focused quality measures. CMS should also examine unintended consequences of its current policies.**

- Medicare's PDPM could usefully serve as a foundation for CMCS to endorse migration from cost-based reimbursement to risk-adjustment-based

reimbursement by the approximately 17 state Medicaid programs (both capitated managed care and managed fee-for-service models) that have not already done so.

- CMS and CMCS could partner to develop Section 1115 research and demonstration waiver authority for modernization and improvement of the quality and cost-efficiency of NF services.
- CMCS could collaborate with CMS to use survey data to identify and endorse a suite of Medicaid-specific, equity-focused quality measures from which states could choose, with the goals of supporting quality improvement and value-based payment arrangements with NFs. Disparate outcomes and experiences of people of color should be a primary driver in selection of these measures.
- CMCS should provide more specific interpretive guidance to states on nursing home reimbursement as it relates to reduction of licensed beds and idle space.
- CMS should examine processes associated with nursing home placement of individuals served by Medicare Advantage plans to determine whether home- and community-based services could more regularly be utilized.
- CMCS should examine whether nursing home provider taxes have the unintended consequence of perpetuating a larger-than-needed number of NF beds at the state level, related to reliance on the additional revenue that is generated. Approval of these taxes should be conditioned on improvement in quality.

**CMCS should augment its existing guidance around LTSS rebalancing to address NF modernization and diversification.**

- CMCS should issue companion guidance to the [Home and Community Based Settings toolkit](#), focusing on the following:
  - reinforcement that nursing home services remain a critical element of the LTSS continuum of care;
  - an overview of the benefits of acuity-based payment, along with methods and Medicaid

authority pathways for such payment, with and without value-based components;

- a suite of Medicare-aligned quality measure options;
- expanded subregulatory guidance on reasonable and allowable costs, as well as idle space;
- examples of innovative care models as well as diversification of NF services (e.g., continua of care, micro-housing);
- reference to companion initiatives such as Money Follows the Person, supportive housing services, and substance use disorder waivers, all of which can enable community care or community reintegration of individuals whose leading reason for institutionalization relates to behavioral health; and
- promotion of policy levers at the state level (e.g., moratoria on new beds, development of municipality-specific needs projections, state-wide benchmark occupancy rates, strengthened certificate-of-need processes, and removal of rate subsidies such as stop-loss provisions).

**CMS should enhance conditions of participation for nursing homes and hospitals by including structural measures.**

- CMS could meaningfully enhance its conditions of participation for nursing homes and hospitals by including structural measures such as the following:
  - occupancy rate as compared with a national standard, with the caveat that the current informal standard of 95% may need to be reassessed given the reality of current rates;
  - staffing continuity, as reflected by trends in staff turnover; and
  - measures of care transition that would be instrumental for continued LTSS rebalancing, such as the settings to which hospital discharges occur.

**CMS and CMCS should enhance the Care Compare platform to improve the public transparency, availability, and usability of cost report and ownership information for nursing facilities and to provide more detail on citations, as well as adopt formal standards and processes around changes in ownership.**

- CMS and CMCS could usefully collaborate on these enhancements:
  - develop and implement consistent, expanded standards for nursing home institutional-level data collection, including cost reporting, ownership structure, and related party transactions;<sup>14</sup>
  - ensure timely and complete publication of information on citations against nursing facilities within Care Compare;
  - ensure that the data are published in a format that is readily usable by interested stakeholders, including residents and their families, as has been done with the quality data and limited ownership information currently available through Care Compare; and
  - create public education campaigns, with a focus on families of color, to promote the use and application of Care Compare data.
- As proposed in the Build Back Better legislation,<sup>15</sup> CMS could be required to conduct audits that would meaningfully improve the accuracy and completeness of cost report data.
- CMS could also create requisites (e.g., related to minimum staffing levels and types, compliance with conditions of participation, and/or financial status) and an approval process for NF ownership transitions.

## CONCLUSION

The challenges faced by NF residents are multifaceted and require a comprehensive and integrated federal response. Such a response will necessarily involve steps by CMS that prioritize quality and care experience, with a focus on health equity, by aligning Medicare and Medicaid in value-based NF payment and adoption of common performance measures related to quality and experience of care. In relation to that focus, states will need more federal guidance to successfully improve NF quality and reduce disparities. In addition, CMS should expand its current standards to define and clarify requirements around occupancy rates, staff continuity, and measures of transition. Finally, CMS should collect additional data points and publish those along with currently available citation data, to improve individuals' and families' capacity to make informed choices among NFs. Such improvements can help ensure that those who need skilled nursing care are receiving it in safe, high-quality environments.



## NOTES

- <sup>1</sup> Kaiser Family Foundation. State health facts. <https://www.kff.org/state-category/providers-service-use/nursing-facilities/>. Accessed January 10, 2022.
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- <sup>9</sup> Centers for Medicare and Medicaid Services. Medicaid and CHIP Scorecard. <https://www.medicaid.gov/state-overviews/scorecard/index.html>. Published December 2021. Accessed January 10, 2022.
- <sup>10</sup> 42 CFR 420.206 and 455.104.
- <sup>11</sup> Centers for Medicare and Medicaid Services. Care Compare. <https://www.medicare.gov/care-compare/>. Accessed January 10, 2022.
- <sup>12</sup> Gebeloff R, Thomas K, Silver-Greenberg J. How nursing homes' worst offenses are hidden from the public. *New York Times*. <https://www.nytimes.com/2021/12/09/business/nursing-home-abuse-inspection.html>. Published December 9, 2021. Accessed January 10, 2022.
- <sup>13</sup> Centers for Medicare and Medicaid Services. Long-term services and supports rebalancing toolkit. <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf>. Published November 2020. Accessed January 10, 2022.
- <sup>14</sup> For compelling, detailed recommendations on this topic, see Harrington C, Montgomery A, King T, Grabowski DC, Wasserman M. These administrative actions would improve nursing home ownership and financial transparency in the post COVID-19 period. *Health Affairs*. <https://www.healthaffairs.org/doi/10.1377/hblog20210208.597573/full/>. Published February 11, 2021. Accessed January 21, 2022.
- <sup>15</sup> Section 30718: Ensuring Accurate Information on Cost Reports. This section appropriates \$250 million to the Secretary of HHS in fiscal year (FY) 2022 for the purposes of auditing the Medicare cost reports that skilled nursing facilities are required to submit, beginning in FY 2023 and ending in FY 2031.

## ABOUT THE AUTHORS

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She is a former president and vice president of the National Association of Medicaid Directors Board of Directors and served on the steering committee of the Reforming States Group, the predecessor to the Milbank State Leadership Network. She also contributed to state health reform initiatives as assistant comptroller for the State of Connecticut.

An elder law attorney by training, Ms. McEvoy spent her early career working for a regional Agency on Aging and as a legislative liaison for the Connecticut Association of Area Agencies on Aging. She is a past chair of the Elder Law Section of the Connecticut Bar Association, is the author of a treatise on elder law, and led several major coalition-based projects around advance directives. She has a JD from the University of Connecticut School of Law and a BA in English and economics from Oberlin College.

**Charles Milligan**, JD, MPH, began a health care consulting practice in April 2020. Before that, he served as CEO of UnitedHealthcare's Community Plan of New Mexico from 2015 to 2020. Prior to joining United, Mr. Milligan was the state Medicaid director in Maryland from 2011 to 2014. His role included starting the Affordable Care Act health insurance exchange and implementing the Medicaid expansion, and in New Mexico from 1996 to 2000, where the governor asked him to convert Medicaid from fee-for-service to managed care and launch the Children's Health Insurance Program (CHIP).

Mr. Milligan has been an appointed commissioner on the federal Medicaid and CHIP Payment and Access Commission (MACPAC) since 2015 and is the current vice chair of MACPAC. He holds a JD from Harvard Law School and an MPH from UC Berkeley.

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