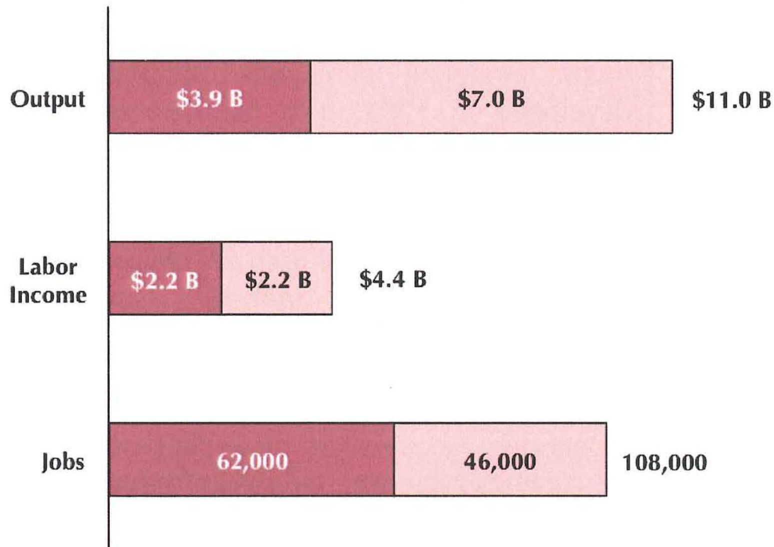
Economic Impact of Proposed Reductions in Medicare Spending for Skilled Nursing Facility (SNF) Services

July 2011

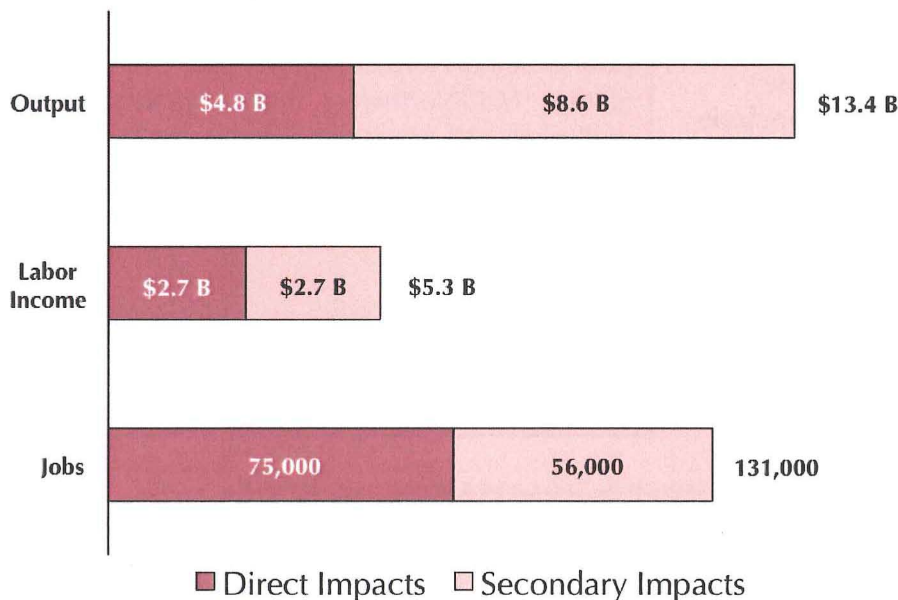
Recalibration of the Budget Neutrality Parity Adjustment ($3.94 billion)



A $3.94 billion cut in Medicare spending on SNF services in the proposed rule would produce a total $11.0 billion reduction in economic activity, including:

- $4.4 billion less in labor income
- 108,000 fewer full- and part-time jobs
- State and local tax and fee decreases of $548.5 million
- Federal tax and fee decreases of $863.6 million

Recalibration of the Budget Neutrality Parity Adjustment ($3.94 billion) + Plus Changes to Group Therapy ($850 million)



A combined $4.79 billion cut in Medicare spending on SNF services in the proposed rule would produce a total $13.4 billion reduction in economic activity, including:

- $5.3 billion less in labor income
- 131,000 fewer full- and part-time jobs
- State and local tax and fee decreases of $666.8 million
- Federal tax and fee decreases of $1.05 billion

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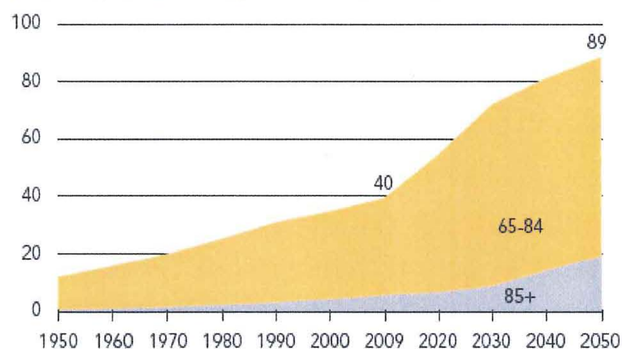
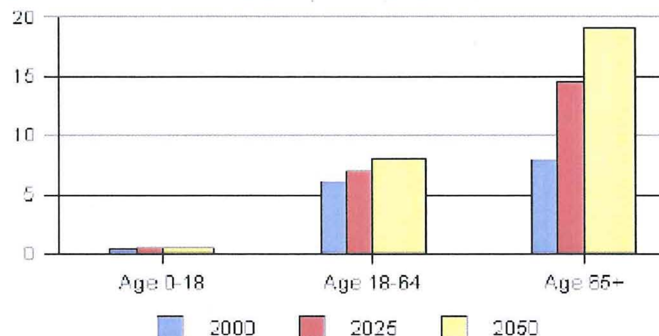
LONG-TERM CARE WORKFORCE AT A GLANCE

- The Long-Term Care (LTC) profession is the 10th largest employer in the United States, contributing **5.4 million** jobs
- Nursing facilities nationwide directly contribute **2 million** jobs
- According to the U.S. Department of Labor, nursing and residential care facilities alone added **63,000** new jobs in 2010
- 62 percent of total LTC employees are direct care workers (DCWs), including RNs, LPN, and CNAs
- Percentage increase of demands for DCWs between 2000 and 2020 : RNs – 41 percent, LPNs – 47 percent, CNAs – 50 percent
- More than 80 percent of nursing facilities employees work more than 30 hours a week
- More than 99 percent of nursing facilities and assisted living facilities provide health insurance to employees and their families

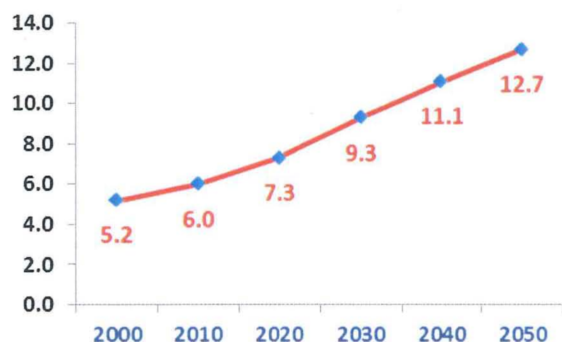
U.S. Population Ages 65 and plus, in million



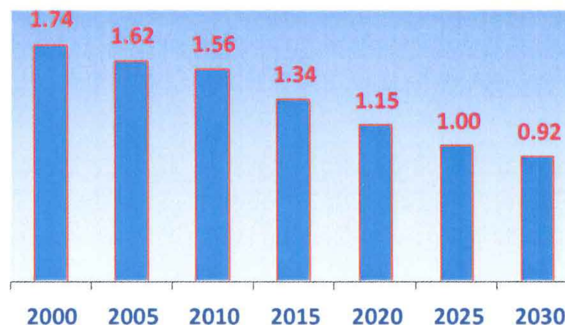
Estimates of Future Demand for LTC, in million



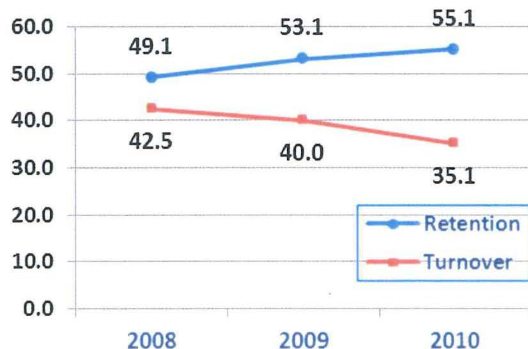
Estimated Population with ADL, in million



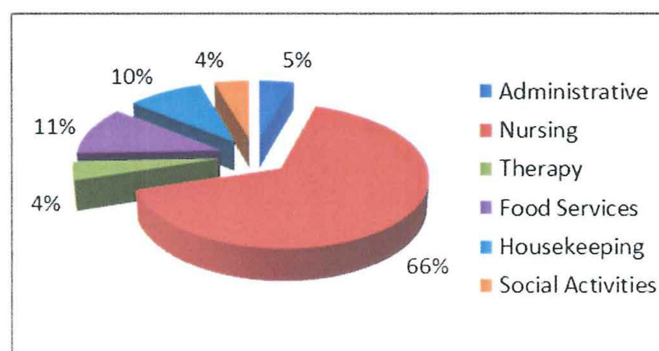
Decline in Supply of Caregiver, Ratio of Female aged 25-54 per individual aged 65 and older, 2000-2030



Nursing Facility Staff Retention & Turnover Rates, 2008 – 2010



Percentage Distribution of Nursing Facility Staff by Function, 2010



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Appendix C: Brief History of Phase-In of Changes to other Medicare Payment Systems

June 27, 2011

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Inpatient Hospital PPS	Implementing the new cost-based weight methodology in a 3-year transition, starting with FY 2007 as year 1	Three years for implementation of cost-based weights (FYs 2007-2009)	Year 1: 33% cost-based weight, 67% charge-based weight; Year 2: 67% cost-based weight, 33% charge-based weight; Year 3: 100% cost-based weight	Budget neutral; range of impact in first year was +0.7% to -2.2%	71 Fed. Reg. 47,870 (Aug. 18, 2006) – IPPS Final Rule 73 Fed. Reg. 48,434 (Aug. 19, 2008) – IPPS Final Rule 75 Fed. Reg. 50,042 (Aug. 16, 2010) – IPPS Final Rule 76 Fed. Reg. 25,788 (May 5, 2011) – IPPS Proposed Rule
	***********************	*****************	***********************	**********************	
	Conversion from DRGs to MS-DRGs over 2 years, starting in FY 2008	Two years for conversion to MS-DRGs (FYs 2008-2009) Two years for retrospective, non-cumulative payment adjustment (FYs 2011-2012)	0.6% reduction in FY 2008; 0.9% reduction in FY 2009 2.9% reduction in FY 2011 (recoupment); 2.9% reduction in FY 2012, off-set by a 2.9% restoration; 2.9% restoration expected in FY 2013	Industry projected that 4.8% reduction to hospital payments spread over three years (as originally proposed for FY 2007) would have equated to a $20-24 billion reduction over five years The difference between the 0.6% reduction and the	The TMA, Abstinence Education, and QI Programs Extension Act of 2007 mandated a payment reduction of 0.6% in FY 2008 and 0.9% in FY 2009, in lieu of the three-year prospective payment reduction finalized by CMS in the FY 2008 IPPS Final Rule. CMS originally planned a 1.2% reduction in FY 2008, a 1.8% reduction in FY 2009, and a 1.8% reduction in FY 2010 to maintain budget neutrality/ eliminate the estimated effects of nominal changes in coding

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
		Two years for a prospective payment adjustment (FY 2012 and an additional unspecified year).	3.15% proposed reduction for FY 2012 as a prospective adjustment. CMS estimates an additional 0.75% prospective adjustment is still needed in future years to return the payment system to budget neutrality	1.2% reduction in FY 2008 was approximately $665 million The 1.9 percentage point increase in FY 2008 resulted in an increase in aggregate payments of approximately $2.2 billion; the total 3.9 percentage point increase in FY 2009 will result in an aggregate payment of approximately $4 billion An aggregate 6.8% increase resulted in an increase in aggregate payments of approximately $6.9 billion	under the new MS-DRG system. The legislation also mandated further (unspecified) reductions in FYs 2010, 2011 and 2012, if necessary to return the payment system to budget neutrality. Congress mandated the smaller adjustments for FYs 2008 and 2009, superseding the CMS adjustments for those years. The legislation was enacted after the final rule was issued but before the reductions in the rule were implemented.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Home Health Agencies	New home health PPS implemented in CY 2001. In CY 2008, CMS found an estimated 11.75% increase in case-mix between CYs 2000 and 2003 that was attributable to nominal changes in case-mix. In CY 2011, further analysis of new case-mix data found that there was a 17.45% increase in case-mix between CYs 2000 and 2008 that was due to nominal changes in case-mix (this includes the 11.75% case-mix change found in CY 2008).	Four to five years (CYs 2008-2011). An additional adjustment is planned for CY 2012.	2.75% reduction in CY 2008 (recoupment); 2.75% reduction in CY 2009 (recoupment); 2.75% reduction in CY 2010 (recoupment); 3.79% reduction in CY 2011;[1] 3.79% reduction planned for CY 2012, with potential for modification based on new case-mix research	$410 million reduction in CY 2008 final rule $440 million reduction in CY 2009 final rule $480 million reduction in CY 2010 final rule $700 million reduction in CY 2011 final rule	72 Fed. Reg. 25,356 (May 4, 2007) – Home Health PPS Proposed Rule 72 Fed. Reg. 49,762 (Aug. 29, 2007) – Home Health PPS Final Rule 75 Fed. Reg. 70,372 (Nov. 17, 2010) – Home Health PPS Final Rule There was no legislative action (case-mix adjustments were done entirely by regulation).

[1] CMS increased the payment adjustment from 2.71% to 3.79% in 2011 to account for the additional increase identified in the 2011 analysis.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Long Term Care Hospitals	3-year phase-in of a payment policy adjusting the amount paid to co-located long-term care hospitals within a hospital (LTCH HwHs) if patients admitted from the host hospital are in excess of 25% or an applicable percentage threshold specified for special situations. Payment is based on the lesser of the LTCH PPS payment or an amount equivalent to what would have been paid under the otherwise unadjusted IPPS. ********************** Beginning in July 2007, CMS extended the 25% rule to apply to all freestanding LTCHs,	Three years for HwHs and satellites (FYs 2006-2008) **************** Three years for all freestanding LTCHs (RYs 2008-2010)	25% rule applied to HWHs and satellites: Threshold set at 75% for FY 2006; Threshold set at 50% for FY 2007; Threshold set at 25% for FY 2008 ********************** 25% rule applied to all freestanding LTCHs: Threshold set at 75% for RY 2008	$460 million projected reduction in estimated aggregate payments for 5 years due to the expansion of the 25% rule to freestanding LTCHs between RYs 2008 and 2012	69 Fed. Reg. 48,916 (Aug. 11, 2004) 72 Fed. Reg. 26,870 (May 11, 2007) 73 Fed. Reg. 24,871 (May 6, 2008) Payment adjustment related to co-location of a LTCH HwH or satellite and a host hospital was implemented in the IPPS final rule for FY 2005. The policy was expanded to all freestanding LTCHs in the LTCH PPS final rule for RY 2008. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) rolled back the phased-in implementation of the 25 percent rule for HWHs and satellites and prevented application of the rule to freestanding LTCHs for three years. The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
	limiting the proportion of patients who can be admitted to an LTCH from any one acute care hospital during a cost reporting period.				extended the roll-back for an additional two years, until 2012.
Inpatient Rehabilitation Facilities	Increase in payments following the implementation of the IRF PPS in FY 2002 based on nominal changes in coding.	Two years (FYs 2006-2007)	1.9% reduction in FY 2006; 2.6% reduction in FY 2007	$120 million reduction in FY 2006 $180 million reduction in FY 2007	70 Fed. Reg. 47,880 (Aug. 15, 2005) 71 Fed. Reg. 48,354 (Aug. 18, 2006) RAND estimated that between 1.9% and 5.9% of the change in case-mix under the new IRF PPS was attributable to nominal changes in provider coding practices. These percentages were used by CMS to make IRF PPS payment reductions.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Inpatient Rehabilitation Facilities	Extended phase-in of the Inpatient Rehabilitation Facility (IRF) Classification Criteria.	Five year phase-in from 50% to 75% threshold (FYs 2004-2008); thresholds modified during FYs 2006-2008; threshold capped at 60% retroactive to cost reporting periods beginning on or after July 1, 2007.	In 2007, the threshold was capped at 60%, retroactive to cost reporting periods beginning on or after July 1, 2007. *Prior to* the threshold being capped at 60%, the phase-in was scheduled as follows: 50% for cost reporting periods beginning on or after July 1, 2004, through June 30, 2005; 60% for cost reporting periods beginning on or after July 1, 2005, through June 30, 2006; 60% (originally 65%) for cost reporting periods beginning on or after July 1, 2006, through June 30, 2007; 65% (originally 75%)	Projected savings included in the FY 2004 Final Rule on Classification Criteria FY 2004: 3 months at 50%; $0 reduction FY 2005: 9 months at 50%, 3 months at 60%; $10 million reduction FY 2006: 9 months at 60%, 3 months at 65%; $30 million reduction FY 2007: 9 months at 65%, 3 months at 75%; $90 million reduction FY 2008: 12 months at 75%; $190 million reduction	69 Fed. Reg. 25,752 (May 7, 2004) Section 5005 of the Deficit Reduction Act of 2005 (DRA) modifies the phase-in established in the May 7, 2004 IRF final rule, which updated the classification criteria for IRFs under the Medicare program. The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) capped the classification criteria threshold at 60%, retroactive to cost reporting periods beginning on or after July 1, 2007.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
			for cost reporting periods beginning on or after July 1, 2007, through June 30, 2008; 75% for cost reporting periods beginning on or after July 1, 2008.		
Hospice Providers	Transition from the budget neutrality adjustment factor (BNAF), which was implemented in 1997 when CMS moved from an outdated wage index to a more current and accurate method for determining hospice payments. To minimize disruption to services during the transition, CMS applied a special budget neutrality adjustment.	Seven years (FY 2010-2016)	The BNAF is reduced by 10% in FY 2010, 15% in FY 2011, and successive 15% reductions from FY 2012 through FY 2016.	$50 million reduction for FY 2010 due to 10% reduction in the BNAF $80 million reduction for FY 2011 due to 25% reduction in the BNAF $90 million reduction estimated for FY 2012 due to 40% reduction in BNAF	74 Fed. Reg. 39,384 (Aug. 6, 2009) 75 Fed. Reg. 42,944 (Jul. 22, 2010) 76 Fed. Reg. 26,806 (May 9, 2011) CMS originally implemented the phase out of the BNAF over 3 years starting in FY 2007. The 3-year phase out was postponed by one year in the American Recovery and Reinvestment Act of 2009, and CMS was directed to reinstate the BNAF in the calculation of the hospice wage index retroactive to Oct. 1, 2008. In FY 2010, CMS adopted a schedule to phase out the BNAF over 7 years.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Outpatient PPS	Transition to community mental health center (CMHC) partial hospitalization program (PHP) ambulatory payment classification group (APC) per diem rates based on CMHC data only over 2 years.	Two years (CYs 2011-2012)	24.1% decrease in payments to CMHCs due to APC policy changes in CY 2011		75 Fed. Reg. 71,800, 71,992-93 (Nov. 24, 2010) CMHC advocates believed the policy would result in a 41% reduction in Medicare reimbursements, which would lead to center closures if implemented in one year. In response to comments to the proposed rule, CMS decided in the final rule to allow for a two-year transition to the new methodology. The 2011 transition year rates will be calculated by taking 50% of the difference between the medians of the 2010 methodology and the new methodology and adding that number to the new final 2011 CMHC medians. The new rates are expected to be fully implemented in 2012. There was no apparent legislative action driving this adjustment.