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Opinion: Nursing homes can't take more cuts

By VINCENT MOR and GAIL WILENSKY | 02/21/2012 05:37 AM EST

Recent reductions in Medicare reimbursements to U.S. nursing homes are already risking the well-being of frail, older Americans — both those admitted for short term stays following hospitalizations, and those residing in facilities for the long term.

Having studied these issues and observed the historical response of nursing homes under financial pressure, we are concerned further Medicare reductions as part of the upcoming FY 2013 budget deliberations will endanger this vulnerable population.

Historically, Medicare has been a more generous payer for nursing home services than Medicaid, which pays the majority of seniors' nursing home care. However, Medicare funding for nursing homes is scheduled to be reduced by more than $125 billion over the next decade. At the same time, Medicaid has restricted or frozen reimbursements in 29 states in the fiscal year that just ended.

These state budget shortfalls make it likely this trend will continue. If further reductions in Medicare are imposed — like those recommended by the Medicare Payment Advisory Commission — it will be difficult for facilities to continue using Medicare to help make up for the underpayment of Medicaid for long-stay patients.

Cuts will have to come from somewhere — forcing facilities to choose between reducing rehabilitation services, skilled nursing and amenities for short-stay Medicare patients, or essential direct care nursing aides for long stay Medicaid patients. Each scenario has negative implications for seniors' care.

Moreover, if there are more reductions in the combined funding of Medicare and Medicaid for nursing homes, they could not come at a worse time. Facilities are treating more short-term and clinically complex patients: The median length of stay for Medicare patients is less than one month. More than 80 percent have nine or more diagnoses, and a majority now enter facilities with major or extreme severity of illness as measured by a Medicare claims data base.

Nursing homes have recently made measurable improvements to residents' quality of care, health survey citations have been declining, and elderly residents and their families have been reporting high and stable satisfaction. Staffing has increased, and several important quality measures have improved.

Undoubtedly, quality improvements must continue. The difficulty, however, is that reducing Medicare and Medicaid reimbursements is not the way for this to occur.

Putting a still greater squeeze on nursing homes without changing the incentives they face will make it more difficult to continue hiring and retaining key staff such as nurse practitioners and skilled nurses, and make it harder for them to stop patients from having to re-enter hospitals.

Always a worry because of the disruptive nature these sudden transitions from setting to setting have on patients, hospitals will be particularly sensitive to readmissions beginning this year — when they will start being financially penalized by Medicare for certain rehospitalizations that occur within 30 days of discharge, for certain diagnoses.

Moving forward, it is more important than ever for policymakers to change the current disincentives built into the separate streams that fund nursing homes and hospitals. We need to incentivize hospitals and nursing homes to work together to treat a patient over the course of an entire episode of illness, and to share any savings that could result from joint efforts.

Pilot projects Medicare is scheduled to run in the near future may help point the way forward, and should be closely analyzed in the context of both cost-savings and patient benefit. Until then, however, further reductions in nursing home reimbursements — on top of those already put in place — run the risk of harming the very patients who can least afford it.

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