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Overview of Federally Certified Long-Term Care Facilities

Long-term care facilities (LTCFs), commonly referred to as nursing homes, provide services to those who require skilled nursing care over a short period of time for recuperation or rehabilitation after an acute illness or injury, often referred to as *post-acute care*. LTCFs also provide continuous care for an extended period, including around-the-clock supervision of, and assistance with, basic personal care activities, which is referred to as *long-term care* (LTC) or *long-term services and supports* (LTSS).

Individuals may qualify for LTCF coverage through the federal Medicare program—which covers health care for elderly and certain disabled individuals—or through the state-federal Medicaid program, a means-tested entitlement that finances primary and acute medical services and LTSS. The programs differ in regard to the type and scope of services covered. Specifically, both programs cover post-acute care, but only Medicaid covers LTSS for eligible beneficiaries. Medicare does not cover LTSS in nursing homes.

In the United States, 15,436 LTCFs, with 1.6 million total beds, participated in Medicare and/or Medicaid as of April 2020. The overwhelming majority of these facilities (94%) were dually certified *by state survey agencies* (SAs), under federal guidelines, to participate in both Medicare and Medicaid—4% were certified as Medicare only, and 2% were certified as Medicaid only. Medicare facilities are designated as *skilled nursing facilities* (SNFs); Medicaid facilities are known as *nursing facilities* (NFs).

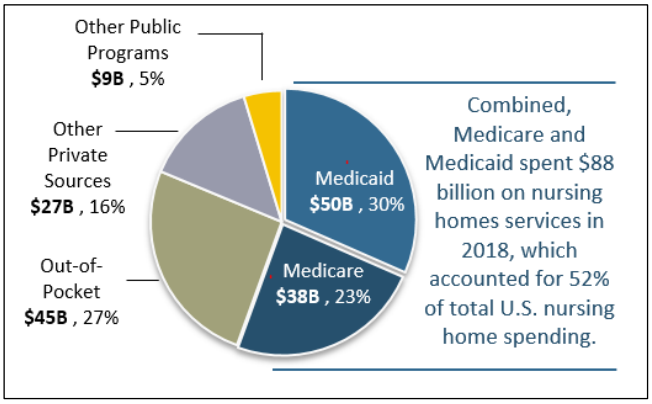
Financing

Nursing homes receive payment for services from private and public sources. Medicaid is the primary payment source for most certified nursing home residents. In 2016, Medicaid was the primary payer for nearly 62% of residents, just over 25% of residents paid privately or with another payment source (e.g., private insurance), and Medicare was the primary payer for just over 14% of residents. A nursing home resident's primary payment source may change over time. For example, once residents have reached Medicare coverage limits and have spent down personal assets on their care, they may use Medicaid as their primary payer, assuming the residents are dually eligible for Medicare and Medicaid.

In the United States, $168.5 billion was spent on nursing home services across all payers in 2018. **Figure 1** shows the major sources of nursing home care expenditures and the proportion of monies spent, by payer. Combined, Medicare and Medicaid (state and federal) spent $88 billion on nursing home services in 2018, which accounted for 52% of total U.S. nursing home spending.

Medicare pays for nursing home services under a prospective payment system (PPS). The PPS pays SNFs a daily per diem amount after adjusting for urban or rural facility locale, resident case mix, and area wage differences.

Figure 1. 2018 U.S. Spending on Nursing Home Care



Source: CRS analysis of National Health Expenditure data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared November 2019. Data include freestanding and hospital-based nursing care facility expenditures for both Medicare and Medicaid.

Notes: Sum of values may exceed totals due to rounding. "Other Public Sources" include sources such as the Veterans Health Administration and state and local programs.

Under Medicaid, states establish their own payment rates for nursing home services. Federal statute requires that these rates be consistent with efficiency, economy, and quality-of-care standards, as well as sufficient to enlist enough providers so covered benefits are available to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area. In some cases, states make supplemental payments to Medicaid providers that are separate from, and in addition to, the standard payment rates for services to Medicaid enrollees.

Medicare-Covered Skilled Nursing Facility Services

SNFs provide post-acute care to qualifying Medicare beneficiaries, on a limited basis, for treatment of different diagnoses and conditions. Medicare pays SNFs for daily skilled nursing, daily skilled rehabilitation, drugs/biologicals, durable medical equipment, and bed and board provided with such services, among other benefits.

To be eligible for Medicare SNF coverage, a beneficiary must have had an inpatient hospital stay of at least three consecutive calendar days (not including the day of discharge) and must be transferred to a participating SNF,

usually within 30 days after discharge from a hospital. The participating SNF must provide services for a condition that was treated during the beneficiary's qualifying hospital stay (or an additional condition arising in the SNF).

A Medicare beneficiary who qualifies for SNF coverage is entitled to up to 100 days of covered care per spell of illness. For most Medicare beneficiaries, SNF cost sharing is as follows: for the first 20 days of a Medicare-covered SNF stay, no beneficiary cost sharing is required; for the 21st through the 100th day, daily coinsurance, indexed annually at one-eighth (12.5%) of the current Part A inpatient hospital deductible, is required. In 2020, the daily SNF coinsurance amount is $176.

Medicaid-Covered Nursing Facility Services

NFs provide post-acute care to Medicaid beneficiaries who require skilled nursing care and rehabilitation due to an injury, disability, or illness. NFs also provide LTSS to eligible Medicaid beneficiaries who meet state-defined nursing home eligibility criteria, referred to as *level-of-care criteria*. State Medicaid programs are required to cover NF services for beneficiaries aged 21 and older. States have the option to cover NF services for beneficiaries under the age of 21. All states provide this optional service.

To define level-of-care criteria, states may use *functional* criteria, such as an individual's ability to perform certain activities of daily living (e.g., eating, bathing, dressing, and walking) or to perform certain instrumental activities of daily living (e.g., shopping, housework, and meal preparation) that allow an individual to live independently in the community. States also may use *clinical* criteria, which include diagnosis of an illness, injury, disability, or other medical condition; treatment and medications; and cognitive status, among other information. Most states use a combination of functional and clinical criteria in defining the need for institutional long-term care.

NF services include nursing care and related services, dietary services, specialized rehabilitation services (e.g., physical and occupational therapy, speech pathology and audiology services, and mental health rehabilitative services), dental care, pharmacy services, medically related social services, and a program of activities. Medicaid coverage of NF services also includes room and board.

Minimum Federal Requirements

Nursing homes must meet certain Requirements of Participation (RoPs) to receive federal payment for services provided to qualifying beneficiaries under Medicare and Medicaid. Included in the RoPs, among other requirements, are the specific rights granted to residents and the scope of services that must be provided to those eligible for residency. Consolidated implementing regulations for Medicare and Medicaid nursing homes are established in 42 C.F.R. Part 483, Subpart B.

Nursing homes also are subject to state licensing requirements and state regulations. A state may set minimum requirements for staffing, quality of care, or the physical environment in its nursing homes that are more stringent than federal requirements.

Home- and Community-Based Settings vs. Institutional Settings

Other types of residential settings that provide housing and services (e.g., assisted living facilities) generally do not provide the type of skilled nursing or continuous care offered in nursing homes. These settings are considered community-based, not institutional. As such, they are not subject to federal Medicare and Medicaid Requirements of Participation (RoPs) for long-term care facilities.

Community-based residential settings are licensed and regulated by states. However, some residential settings may qualify to provide Medicare skilled nursing facility (SNF) care or Medicaid nursing facility (NF) care as part of a continuum of services in, for example, Continuing Care Retirement Communities. To take part in the federal programs and receive payment, the institutional care associated with these settings would have to meet Medicare SNF or Medicaid NF RoPs. In addition, Medicare- and Medicaid-covered services such as home health or personal care may be provided in community-based residential settings, similar to services provided in a participant's private residence. Home health agencies must meet federal requirements to participate in the Medicare and/or Medicaid programs. For more information, see CRS In Focus IF11544, *Overview of Assisted Living Facilities*.

Survey and Certification

Federal law requires a survey and certification process for determining whether nursing home providers meet the RoPs and qualify for federal payments. Federal certification to participate in Medicare and/or Medicaid is not the same as state licensure. A state license permits a provider to operate as a nursing home in a particular state. Generally, a nursing home must be licensed by a state before it is operational, whereas federal certification is determined after a facility has been licensed and has been in operation for a short period of time.

States carry out the processes of initially certifying nursing homes and determining continued compliance with the RoPs through agreements with the Secretary of Health and Human Services (HHS). SAs conduct the survey process, which includes unannounced, on-site inspections of nursing homes. Certain survey metrics and quality ratings for nursing homes can be found on the CMS website "Nursing Home Compare."

The HHS Secretary is statutorily authorized to impose certain "remedies" for deficiencies found during surveys. For example, the HHS Secretary may impose fines on nursing homes, which are referred to as *civil monetary penalties*. Additionally, the HHS Secretary is required to maintain a program of increased surveys for nursing homes identified as being significantly out of compliance with the RoPs. The program is known as the Special Focus Facility (SFF) program; as of April 2020, the SFF program included 85 nursing homes.

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