

Medical Loss Ratios for Nursing Homes: Protecting Residents and Public Funds

Background. Substandard care and insufficient staffing are longstanding problems in too many nursing homes across the United States. The nursing home industry often blames lack of funds for the failure to ensure appropriate staffing. However, the nonpartisan Medicare Payment Advisory Commission (MedPAC) [reports](#) that nursing homes have experienced double-digit Medicare profits for the last 17 years. Additionally, in July 2018, the Centers for Medicare & Medicaid Services (CMS) finalized a new [payment system](#) that provides for \$820 million in increased payments to nursing homes and two billion dollars in savings over the next ten years. As one industry-oriented [news](#) outlet has noted, “historians may look back at 2018 as a kind of Golden Age for skilled care.”

Meanwhile, CMS has begun to [deregulate nursing homes](#) through a process of rolling back resident rights and protections. As a result of the lack of accountability, some states are even being forced to take over nursing homes due to the poor management of private operators, leaving residents in danger of not receiving essential care. How can these two realities be reconciled? How can the industry experience a “golden age” while residents are forced back into the Dark Age?

Part of the problem is that some nursing home operators are not properly utilizing payments from Medicare and Medicaid for the benefit of residents. Instead, they all too often disproportionately use public reimbursement to pay for salaries, administrative costs, and other non-direct care services. For instance, the NY State Attorney General recently filed a [complaint](#) against an operator, alleging that the operator diverted Medicaid funds away from residents and “paid such monies for their own benefit through companies they owned or controlled.” An [article](#) in *The New York Times* reports that related-party transactions have become a “common business arrangement, [as] owners of nursing homes outsource a wide variety of goods and services to companies in which they have a financial interest or that they control.” *The New York Times* confirms that nursing homes with related-party transactions have “fewer nurses and aides per patient, they have higher rates of patient injuries and unsafe practices, and they are the subject of complaints almost twice as often as independent homes.”

Solution. A medical loss ratio (MLR)—requiring providers to use designated percentages of reimbursement on resident care—serves as a check to the poor use of public and private money. Federal law already places an MLR on health insurance companies under the Affordable Care Act, requiring them to spend at least 80 to 85% of premium dollars on medical care. The nursing home industry itself has come out in support of MLRs, with one [industry group](#) stating that “[t]he ACA recognizes the value of minimum MLR standards as a health reform measure . . . in order to maximize that portion of premiums spent on health care rather than administration and profit.” A medical loss ratio for nursing homes would similarly work by placing an appropriate cap on the amount of money that a nursing home may use to pay for non-health care expenses, freeing money for hiring additional staff and improving resident care.

A medical loss ratio implements the mandate of the Nursing Home Reform Law—that every nursing home resident is entitled to services that attain or maintain his or her “highest practicable physical, mental, and psychosocial well-being.” Our organizations believe it is time for Congress to enact a medical loss ratio for nursing homes.