Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Beneficiary Access to Skilled Nursing Facilities: 2000

JUNE GIBBS BROWN
Inspector General

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EXECUTIVE SUMMARY

PURPOSE

To assess the effects of the nursing home prospective payment system (PPS) on Medicare beneficiaries' access to skilled nursing facilities.

BACKGROUND

The Health Care Financing Administration (HCFA) asked the Office of Inspector General (OIG) to assess the effects of the new prospective payment system for skilled nursing facilities (SNFs) on access to care for Medicare beneficiaries. Concerns have been raised that the new payment system may change nursing facilities' willingness and ability to serve Medicare beneficiaries and may adversely affect beneficiary access to SNFs. This inspection is part of an on-going look at access to skilled nursing facilities. Previous inspections entitled, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities, OEI-02-99-00400,* and *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators' Perspective, OEI-02-99-00401* also examined the effects of PPS on quality of care.

For this study, we interviewed a random sample of 202 hospital discharge planners, as well as analyzed HCFA data related to SNF discharges and hospital lengths of stay.

FINDINGS

Almost all Medicare beneficiaries can be placed in skilled nursing facilities

Almost all discharge planners report that they are able to place Medicare beneficiaries in skilled nursing facilities (SNFs). In fact, about 80 percent of discharge planners state that they could place all of the Medicare patients. Another 14 percent estimate that between 1 and 5 percent of patients cannot be placed, while the remaining 5 percent of discharge planners put the estimate at over 5 percent. Most discharge planners indicate that there are enough beds available in their particular area, and HCFA data indicate an increasing bed supply.

Discharge planners also indicate that patients whom they are unable to place remain in the hospital or eventually go home with or without home health care. Our analysis of HCFA data indicate that the medical profile of patients discharged to nursing homes remains

largely unchanged after introduction of the new prospective payment system.

Some Medicare beneficiaries experience delays

When specifically asked how often they experience delays in placing Medicare patients in SNFs, 43 percent rarely or never experience delays while 44 percent of discharge planners report that they sometimes experience delays. Twelve percent of discharge planners say they always or usually confront delays in placing patients.

Despite concerns about delays, Medicare data from the first three months of 1996 through 2000 show a decrease in the average length of hospital stays for Medicare patients prior to a SNF admission. These data suggest that Medicare patients do not have extended lengths of stay while waiting for a bed in a nursing home.

Multiple factors affect the placement process

Medical Needs: Eighty percent of hospital discharge planners who report delays in placing Medicare patients in SNFs state that patients with particular medical conditions or service needs are more likely to experience delays before being placed in skilled nursing facilities. Discharge planners most often note that patients requiring intravenous or expensive drugs experience delays. They say that medically complex patients are also more likely to experience delays.

Prospective Payment System: Sixty-nine percent of discharge planners who mention delays in placement for medical conditions or service needs attribute these delays to PPS while the remainder note that they experienced these delays prior to the implementation of PPS. About 54 percent of discharge planners volunteer that nursing homes have altered their admission practices for Medicare patients since the implementation of PPS. A few discharge planners add that nursing homes analyze the reimbursement rates of the individual patients before they accept patients and that the routine screening and admission process takes longer.

Other Reasons: In addition to medical conditions and PPS, discharge planners most often mention the decision making process by patients and their family members as a source of delay. In addition, discharge planners also note that secondary payor issues cause delays. They point specifically to the Medicaid application process.

Access improves for dialysis patients

In a September 1999 we found that discharge planners most often listed end stage renal disease (ESRD) as the clinical condition that had become the hardest to place since the implementation of PPS. The Balanced Budget Reform Act of 1999 extended pass-

through payments to ambulance services for renal dialysis so that nursing homes no longer have to absorb these costs. Although discharge planners continue to report delays for dialysis patients, dialysis patient delays dropped to the fifth most commonly cited delay.

CONCLUSION

The findings in this follow-up study are consistent with those in the original "Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities, OEI-02-99-00400." While it reveals some practice adjustments, there do not appear to be any major disruptions as a result of implementing the prospective payment system. To the extent that there are some disruptions, they appear to be localized.

Agency Comments

The Health Care Financing Administration provided comments on the draft report. They concurred with our conclusion that there do not appear to be any major disruptions as a result of implementing PPS. Furthermore, HCFA notes that they will continue to aggressively monitor access to SNFs and the quality of SNF care. The OIG will also continue our work in this area, being sensitive to any localized access issues.

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INTRODUCTION

PURPOSE

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BACKGROUND

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This inspection is part of an on-going look at access to skilled nursing facilities. A previous study entitled, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities, OEI-02-99-00400* was based on a survey of discharge planners and an analysis of Medicare data. We found that at the time there were no serious problems placing Medicare patients in nursing homes. However, nursing homes were changing their admissions practices in response to the prospective payment system. As a result, we concluded that the Department must remain vigilant to potential problems and that as part of this effort, the OIG would periodically replicate this study.

Another study conducted by the OIG entitled, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators' Perspective, OEI-02-99-00401* found similar results. Based on a survey of nursing home administrators, we found that few administrators believe that access to nursing home care had become a problem because of the prospective payment system. However, many administrators noted that they had changed their admissions practices, and that medical condition has become more important in making admissions decisions.

Medicare Payments to Nursing Homes

Skilled nursing facility care is covered by Medicare Part A under certain conditions. Specifically, the patient must have been hospitalized for 3 or more days within the last 30 days for the condition that will be treated in the SNF. The SNF stay must also be certified as medically necessary and the patient must require daily skilled nursing or skilled rehabilitation services. The number of SNF days provided under Medicare is

limited to 100 days per benefit period, with a co-payment required for days 21 through 100.

Medicare Part A payments for SNF care cover routine costs such as the room, dietary service, nursing service, minor medical supplies, and social service. Payments also cover capital costs for the building and equipment, and ancillary care for specialized services such as therapy, laboratory tests, and transportation. Until recently, SNFs were reimbursed on a retrospective, reasonable cost basis.

The Balanced Budget Act of 1997 changed SNF reimbursement to a prospective payment system in order to control Medicare Part A program costs. Beginning with the SNF's first cost reporting period after July 1, 1998, SNFs are paid through "per diem, prospective, case-mix adjusted" payments which cover routine, ancillary, and capital-related costs, including most items and services for which payment was previously made under Medicare Part B. The per diem payment is based on fiscal year 1995 Part A & B costs adjusted using the SNF market basket index (minus 1 percent), case-mix from resident assessments, and geographical wage variations. The market basket index represents an inflation factor. The case-mix index recognizes that SNF residents require different levels of care and is based on an assessment that assigns each resident to one of 44 Resource Utilization Groups (RUGS-III). This new payment system is being phased in over a three year transition period.

In the Fall of 1999, Congress enacted the Balanced Budget Refinement Act (BBRA) in response to providers' concerns that reductions were too severe. The BBRA included a 4 percent across-the-board increase in payments to SNFs for FY2001 and 2002 and a temporary 20 percent increase for 15 payment categories of patients considered medically complex. In addition, several costly non-therapy ancillary services, including certain ambulance services, prostheses, and chemotherapy drugs, were excluded from the prospective payment system and are now paid for separately. These changes addressed concerns that payments were too low for patients who need relatively high levels of non-therapy ancillary services.

In 1989, Medicare paid $2.8 billion to nursing homes, or about 4.7 percent of the Medicare budget. In 1997, this amount increased to $12.2 billion, which was about 5.9 percent of the Medicare budget. In general, Medicare payments represent a relatively small share of nursing homes' revenues, about 10 percent on average.

Discharge Planners

By definition, all Medicare Part A beneficiaries in SNFs are discharged from hospitals. Hospital discharge planners who are responsible for coordinating SNF care are therefore in a unique position to assess the effects of the prospective payment system on access to nursing home care.

Federal regulations require all hospitals to offer discharge planning services. The goal of these services is to identify a patient's post-hospital needs and ensure that he or she is discharged to a safe environment with the appropriate level of services. In most hospitals, the social work, case management, or utilization review department has primary responsibility for discharge planning. Patients can be placed in a variety of settings including SNFs, home health care, hospices, or intermediate care.

Discharge planning staff generally follow a standard process. In a typical scenario, staff screen patients' records within 24 hours of admission. They attempt to identify patients who will require discharge planning services, such as those who are 65 years and older and living alone or those with possibly life-threatening illnesses. They then conduct a psycho-social assessment and discuss the patient's care plan with his or her nurses and physicians, as well as utilization review staff, and other relevant interdisciplinary team members. Discharge planners also solicit the patient's preferences and contact family members or other potential caregivers to get their input and cooperation. Based on this information, they attempt to place the patient in the most appropriate setting.

METHODOLOGY

Discharge Planner Interviews

We used a combination of methods to analyze information for this inspection. We chose a random sample of 225 acute care hospitals with 30 beds or more. The sample was drawn from the 50 states in addition to the District of Columbia. We conducted interviews with 202 directors of discharge planning or their designees within a 3 week period from May 22 until June 23, 2000. Twelve of the remaining 23 hospitals did not discharge Medicare patients to SNFs. We were unable to reach a discharge planner to schedule an interview at the other 11 hospitals.

Analysis of Medicare Data

Secondly, we analyzed Medicare data. Using HCFA's National Claims History data, we identified all Medicare beneficiaries who were discharged from a hospital between January 1, 1996, and March 31, 1996. We then identified patients who met this criteria for an analogous period in 1997, 1998, 1999, and 2000. We analyzed beneficiaries in the diagnosis related groups (DRGs) that are most commonly discharged to SNFs for these four time periods. As part of this analysis we assessed whether SNFs are admitting different types of beneficiaries since the implementation of PPS. We also analyzed hospital length of stay for beneficiaries discharged to SNFs care by these DRGs to examine whether certain patients are experiencing longer delays before being admitted to SNFs since PPS. Lastly, using HCFA's Provider of Services File, we analyzed trends in the number of SNFs.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Almost all Medicare beneficiaries can be placed in skilled nursing facilities

Most Medicare beneficiaries can be placed

Almost all discharge planners report that they are able to place Medicare beneficiaries in skilled nursing facilities (SNFs). In fact, about 80 percent of discharge planners state that they could place all of the Medicare patients. Another 14 percent estimate that between 1 and 5 percent of patients cannot be placed, while the remaining 5 percent of discharge planners put the estimate at over 5 percent. Most discharge planners indicate that there are enough beds available in their particular area to accommodate Medicare patients. Many volunteer that they have flexibility because their own hospital beds are certified by the Medicare program to be used as SNF beds when needed. Discharge planners also indicate that patients whom they are unable to place remain in the hospital or eventually go home with or without home health care.

More Medicare beds are available

Medicare data support the response of discharge planners that there are adequate skilled nursing home beds available for Medicare patients. As shown in Table 1, Medicare SNFs have increased 0.9 percent from 1997 to 1999. The number of Medicare certified beds has seen a substantial increase at 22.8 percent. This increase is largely due to the increase in dual certified beds which are available for either a Medicare or Medicaid patient. Similarly, the total number of certified nursing home beds also increased 1.9 percent. Total nursing home beds includes Medicare only, dual certified, and Medicaid only beds. Currently, about 54 percent of the total nursing home beds are Medicare certified.

Table 1
Total Number of SNFs and Nursing Home Beds, 1997 to 1999

	1997	1998	1999	Percent Change 1997-1999
SNF Facilities	14,772	15,025	14,911	0.9%
Total Medicare Beds	681,456	722,278	836,701	22.8%
Total Certified Beds	1,528,061	1,556,495	1,556,569	1.9%

Source: Provider of Services File

Medical profile remains unchanged

We also looked at pre- and post-PPS data for patients with diagnostic related groups (DRGs) from the first 3 months of years 1996 to 2000 to see if the proportion of patients with certain medical conditions is decreasing which would possibly indicate that certain patient types are experiencing a reduction in access to SNFs. We did not find any large decreases. Three DRGs had decreases over 1 percent: specific cerebrovascular disorder (-1.6 percent), respiratory infections and inflammations (-1.1 percent), and hip and femur procedures except major joint (-1.0 percent). Four DRGs had decreases of less than 1 percentage point. Three DRGs showed an increase of less than 1 percent in the proportion of patients being discharged to SNFs. The largest increase was for simple pneumonia at 2 percent. (See Appendix B)

Some Medicare beneficiaries experience delays

Some discharge planners experience delays in placing patients. For purposes of discharge planning, a delay occurs when a patient is medically cleared by a doctor for discharge, however, no SNF bed has been secured. When specifically asked how often they experience delays in placing Medicare patients in SNFs, 43 percent rarely or never experience delays while 44 percent of discharge planners report that they sometimes experience delays. Twelve percent of discharge planners say they always or usually confront delays in placing patients. While 62 percent of discharge planners experience the same percentage of delays as prior to PPS implementation, 28 percent state that they have a higher percentage of delays since PPS implementation.

On average, discharge planners state that they have to contact about three nursing homes to place a Medicare patient in a SNF. Sixty-six percent of discharge planners had to contact approximately the same number of nursing homes prior to the implementation of PPS. Twenty-three percent respond that they had to contact fewer nursing homes since PPS implementation, and 9 percent respond that they contact more nursing homes.

However, hospital length of stays are shorter

Despite concerns about delays, Medicare data from the first 3 months of 1996 through 2000 show a decrease in the average length of hospital stays for Medicare patients prior to a SNF admission. These data suggest that Medicare patients do not have extended lengths of stay while waiting for a bed in a nursing home. As can be seen in Appendix C, the average lengths of stay for the top 10 DRGs of patients discharged to SNFs show that the length of hospital stays decreased ranging from 1.8 days (specific cerebrovascular disorders) to .2 days (septicemia).

Multiple factors affect the placement process

Medical Needs: Eighty percent of hospital discharge planners who report delays in placing Medicare patients in SNFs state that patients with particular medical conditions or service needs are more likely to experience delays before being placed in skilled nursing facilities. Discharge planners most often note that patients requiring intravenous or expensive drugs experience delays. They say that medically complex patients are also more likely to experience delays. These patients typically require extensive services by the nursing home staff to adequately care for their medical needs. See Table 2. Discharge planners point to similar medical conditions or service needs when asked which patients they are never able to place in nursing homes.

Table 2
Medical Conditions or Service Needs Associated with Delays

Medical Condition/Service Need	Percent of Discharge Planners Reporting Delays
IV antibiotics or expensive drugs	44%
Medically complex patients	34%
Ventilator patients	32%
Infectious diseases/isolation patients	27%
Renal failure/dialysis patients	25%
Behavior Problems (Alzheimers/Dementia)	20%
Total parenteral feedings	20%

* Categories are not mutually exclusive Source: OEI Discharge Planning Survey, June 2000

Prospective Payment System: Sixty-nine percent of discharge planners who acknowledge delays in placement for medical conditions or service needs attribute these delays to PPS. The remaining discharge planners note that they experienced delays for these particular medical conditions or services prior to the implementation of PPS. About 54 percent of discharge planners volunteer that nursing homes have altered their admission process for Medicare patients since the implementation of PPS. For example, discharge planners report that nursing homes request additional patient information and on-site visits to evaluate the patient. A few discharge planners add that nursing homes analyze the reimbursement rates of the individual patients before they accept patients and

that the routine screening and admission process takes longer. Most discharge planners respond that the reimbursement levels for these patients are too low to cover the expenses of the nursing homes. About a third of discharge planners also state that patients requiring rehabilitation services (physical, speech, or occupational therapy) are experiencing fewer delays because of PPS. They indicate that higher reimbursement levels for these patients makes it advantageous for nursing homes to accept these patients. They also mention that rehabilitation patients are often short-term with foreseeable discharge dates and that their service needs are easily administered.

Other Reasons: In addition to medical conditions and PPS, discharge planners note other reasons that Medicare beneficiaries experience delays before being placed in a SNF. The decision making process by patients and their family members is mentioned most often as a source of delays. The patient and the family may be considering placement options or waiting for a bed to become available in their nursing home of choice. Lack of nursing home beds is also mentioned by the discharge planners in some areas. In addition, discharge planners also note that secondary payor issues cause delays. They explain that Medicare patients applying for Medicaid may experience delays waiting for approval.

Access improves for dialysis patients

In a September 1999 OIG report, *Early Effects of PPS on Access to SNFs, OEI-02-99-00400,* we found that discharge planners most often listed end stage renal disease (ESRD) as the clinical condition that had become the hardest to place since the implementation of PPS. Discharge planners noted that the transportation to dialysis facilities for ESRD residents was not covered in the per diem rate. The Balanced Budget Refinement Act of 1999, which became effective April 1, 2000, extended pass-through payments to ambulance services for renal dialysis so that nursing homes no longer have to absorb these costs. Although discharge planners continue to report delays for dialysis patients, dialysis patient delays dropped to the fifth most commonly cited delay. About a third of the discharge planners who say that ESRD patients experience delays state that transportation costs are a factor in the delay despite the changes in the regulations. It is important to note that the regulation had only been effective for approximately 2 months at the time we surveyed discharge planners.

CONCLUSION

The findings in this follow-up study are consistent with those in the original "Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities, OEI-02-99-00400." While it reveals some practice adjustments, there do not appear to be any major disruptions as a result of implementing the prospective payment system. To the extent that there are some disruptions, they appear to be localized.

AGENCY COMMENTS

The Health Care Financing Administration provided comments on the draft report. They concurred with our conclusion that there do not appear to be any major disruptions as a result of implementing PPS. Furthermore, HCFA notes that they will continue to aggressively monitor access to SNFs and the quality of SNF care. The OIG will also continue our work in this area, being sensitive to any localized access issues.

APPENDIX A

Confidence Intervals for Key Findings

We calculated confidence intervals for key findings for discharge planners. The point estimate and 95% confidence interval are given for each of the following:

KEY FINDINGS	POINT ESTIMATE	
Eighty percent of discharge planners report they can place all of their patients.	80%	+/- 5.5
Most discharge planners indicate that there are enough available beds in their particular area to accommodate Medicare patients.	79%	+/- 5.6
When specifically asked how often they experience delays in placing Medicare patients in SNFs, 43 percent report they rarely or never experience delays.	43%	+/- 6.8
When specifically asked how often they experience delays in placing Medicare patients in SNFs, 44 percent of discharge planners report that they sometimes experience delays.	44%	+/- 6.9
Twenty-three percent of discharge planners responded they had to contact fewer nursing homes to place a Medicare patient in a SNF since the implementation of PPS.	23%	+/- 5.8
Eighty percent of discharge planners who report delays state that patients with particular medical conditions are more likely to experience delays.	80%	+/- 5.9
Discharge planners most often note that patients requiring intravenous drugs or expensive drugs are associated with delays.	44%	+/- 8.1

About 54 percent of discharge planners volunteer that nursing homes have altered the process of placing Medicare patients in SNFs.	54%	+/- 6.9
About a third of discharge planners also state that patients requiring rehabilitation services are experiencing fewer delays because of PPS.	39%	+/- 8.0
In addition to medical conditions, discharge planners note other reasons that Medicare beneficiaries experience delays before being placed in a SNF. The decision making by patients and their family members is mentioned most often as a source of delays.	23%	+/- 6.2

APPENDIX B

Proportion of Discharges to SNFs by DRG

Initial Hospital DRG	Percent 1996	Percent 1997	Percent 1998	Percent 1999	Percent 2000	Difference 1996-2000
DRG 014- Specific cerebrovascular disorders	7.1	6.5	5.9	5.7	5.5	-1.6
DRG 079- Respiratory infections and inflammations	3.5	3.8	3.2	2.9	2.4	-1.1
DRG 210- Hip and femur procedures except major joint	5.3	4.8	4.3	4.4	4.3	-1.0
DRG 209- Major joint and limb reattachment procedures	8.1	7.9	7.6	7.7	7.6	-0.5
DRG 416- Septicemia	2.4	2.5	2.3	2.1	1.9	-0.5
DRG 127- Heart failure and shock	4.8	4.8	4.9	4.9	4.7	-0.2
DRG 296- Nutritional and misc. metabolic disorders	2.8	2.7	2.7	2.8	2.7	-0.1
DRG 320- Kidney and urinary tract infections	2.0	1.9	2.0	2.1	2.1	+0.1
DRG 462- Rehabilitation	2.1	2.1	2.0	2.1	2.4	+0.3
DRG 088- Chronic obstructive pulmonary disease	2.4	2.8	3.2	3.3	3.0	+0.6
DRG 089- Simple pneumonia and pleurisy	5.1	5.9	7.4	7.5	7.2	+2.0

Source: National Claims History File

APPENDIX C

Average Hospital Lengths of Stay for Top DRGs Discharged to SNFs

Initial Hospital DRG	Days 1996	Days 1997	Days 1998	Days 1999	Days 2000	Difference 1996-2000
DRG 014- Specific cerebrovascular disorders	10.7	9.8	9.4	9.0	8.9	-1.8
DRG 296- Nutritional and misc. metabolic disorders	8.7	7.7	7.4	7.4	7.2	-1.5
DRG 210- Hip and femur procedures except major joint	8.0	7.2	6.9	6.9	6.9	-1.1
DRG 209- Major joint and limb reattachment procedures	6.7	6.1	5.8	5.8	5.7	-1.0
DRG 320- Kidney and urinary tract infections	7.8	7.5	7.0	7.0	6.9	-0.9
DRG 127- Heart failure and shock	8.7	8.2	8.0	8.0	7.9	-0.8
DRG 088- Chronic obstructive pulmonary disease	8.6	8.1	7.8	7.7	7.8	-0.8
DRG 089- Simple pneumonia and pleurisy	8.6	8.3	8.0	7.8	8.0	-0.6
DRG 079- Respiratory infections and inflammations	10.6	10.3	10.2	10.2	10.3	-0.3
DRG 416- Septicemia	10.2	9.7	9.6	9.7	10.0	-0.2

Source: National Claims History File

APPENDIX D

Comments on the Draft Report

In this appendix, we present in full the comments from the Health Care Financing Administration.

DATE: AUG 31 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of the Inspector General (OIG) Working Draft Report: "Medicare Beneficiary Access to Skilled Nursing Facilities: 2000" (OEI-02-00-00330)

We appreciate the Inspector General's work to assess Medicare beneficiaries' access to quality skilled nursing care under the skilled nursing facility (SNF) prospective payment system (PPS). This is a critical issue for the Health Care Financing Administration and we are pleased to see that, under SNF PPS, there do not appear to be any major disruptions in access to SNF care for Medicare beneficiaries and that Medicare patients requiring various levels of skilled care are being admitted to nursing homes.

We believe that the information contained in this report demonstrates that the PPS system has had positive effects on the operations of SNFs and on the marketplace in which their services are provided. For example, the number of Medicare certified beds has increased, evidence that there has been a decrease in Medicare distinct parts and a corresponding increase in beds accessible to Medicare beneficiaries. We also noted increased access for end stage renal disease (ESRD) patients, which we believe may have occurred in part as a result of the Medicare, Medicaid, and States Children's Health Insurance Program Balanced Budget Refinement Act of 1999 changes.

Although a few discharge planners have been quoted that some SNFs analyze the reimbursement rates before they accept prospective patients, we believe that overall the PPS system has led SNFs to conduct a more careful assessment of potential patients and pay more attention to care planning. We believe, as does OIG, that the fact that the medical profile of SNF patients has remained roughly the same since 1996 and that hospital stays before SNF admissions are actually decreasing in length are further signs that Medicare beneficiaries continue to have access to SNF care. Finally, we note that the areas where the OIG found some

delays in admission to SNFs may, in fact, represent a positive result of the new payment system. Prior to the implementation of the SNF PPS, significant concerns had been raised about the premature discharge of patients with complex conditions to SNFs that were not prepared to address their intensive needs.

As you know, we are continuing to aggressively monitor access to SNFs and the quality of SNF care through our Nursing Home Initiative, medical review process, development of quality indicators, survey and certification process, and special studies conducted by Peer Review Organizations.

Technical Comments

Page 8, under the section "Other Reasons", change the fourth sentence to read: "Lack of nursing homes beds in the area is also mentioned by discharge planners in some areas."