

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Early Effects of the
Prospective Payment System
on Access to Skilled Nursing Facilities**

Nursing Home Administrators' Perspective



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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To identify any early effects of the prospective payment system on Medicare beneficiaries' access to skilled nursing facilities based on the perspective of nursing home administrators.

BACKGROUND

The Health Care Financing Administration (HCFA) asked the Office of Inspector General to assess whether the new prospective payment system for skilled nursing facilities (SNFs) is causing access problems for Medicare beneficiaries. The Balanced Budget Act of 1997 changed SNF reimbursement to a prospective payment system. 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. Concerns have been raised about the effect of the new system on patients and on nursing homes.

To address these concerns, the OIG issued a study entitled, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities* OEI-02-99-00400 in August 1999 which is based on interviews with hospital discharge planners and on an analysis of Medicare data. This inspection found that, so far, no serious problems in placing Medicare patients in nursing homes are apparent. However, nursing homes are changing their admission practices in response to the prospective payment system. As a supplement to this study, we conducted a study based on interviews with a random sample of 57 nursing home administrators and personnel responsible for assessing residents' needs.

FINDINGS

Few nursing home administrators believe that access to nursing home care has become a problem because of the prospective payment system

Seventy percent of nursing home administrators report that access to nursing home care is "not at all" a problem for Medicare patients *in their area*. They most commonly explain that access is not a problem because there are beds available in their area. Only 8 percent of all nursing home administrators attribute access problems to the prospective payment system. They more frequently attribute such problems to a shortage of beds in their area.

Seventy-four percent of administrators report that *their own* facility “never” or “not often” refuses Medicare patients because it does not have a Medicare-certified bed available.

Individuals in nursing homes who are responsible for assessing patients’ needs, the “MDS coordinators,” also believe that the prospective payment system is not preventing access to nursing home care. Ninety-four percent of them believe that their facility has not refused residents because of the new reimbursement system.

Nursing homes have changed their admissions practices

Seventy percent of nursing home administrators report that their admission practices have changed as a result of the prospective payment system. Most administrators state that they scrutinize patients’ medical status to a greater extent than they did prior to the implementation of the prospective payment system.

Medical condition has become more important in nursing home admissions decisions

Seventy-four percent of nursing home administrators report that a patient’s medical condition has become a more important factor in admissions decisions under the new reimbursement system. When asked specifically, 53 percent of administrators report that they are *less* likely to admit patients who require expensive supplies or services such as expensive intravenous medications, ventilators, feeding tubes, wound care or dialysis. At the same time, 46 percent of administrators report that they are *more* likely to admit patients who require special rehabilitation services, such as physical, occupational, or speech therapy. It is important to note that while administrators say that they prefer to admit certain types of patients, Medicare data show no changes in nursing home placements, as noted in our companion report.

Most support the concept of prospective payment

Over 80 percent of nursing home administrators support the overall concept of the prospective payment system. They agree that matching reimbursement with services rendered is generally a fair method of payment. Despite their overall support, many administrators also stress the need to revise some of the current reimbursement rates.

CONCLUSION

The findings in this report support those in our companion report. Together, the two reports show that nursing homes are changing their admissions practices in response to the prospective payment system but that, so far, access to skilled nursing care is not a problem, most likely because beds are available. These early assessments note, however, that these practice changes may affect beneficiaries with certain medical conditions and may also affect nursing homes' reimbursement. Accordingly, we believe that the Department must remain vigilant to potential problems for Medicare patients and for nursing homes.

COMMENTS

We received comments on the draft report from the Health Care Financing Administration. They generally agree with our findings and our conclusion and will remain vigilant in their efforts to assess potential changes that could affect quality and access to skilled nursing care for Medicare beneficiaries. A copy of their comments is provided in Appendix C.

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INTRODUCTION

PURPOSE

To identify any early effects of the prospective payment system on Medicare beneficiaries' access to skilled nursing facilities based on the perspective of nursing home administrators.

BACKGROUND

The Health Care Financing Administration (HCFA) asked the Office of Inspector General to assess whether the new prospective payment system for skilled nursing facilities (SNFs) is causing access problems for Medicare beneficiaries. Concerns have been raised about the effect of the new system on patients and on nursing homes. To address these concerns, the OIG conducted this study and a companion inspection. This study is primarily based on interviews with nursing home administrators.

The companion inspection entitled, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities* OEI-02-99-00400, which was issued in August 1999, is based on interviews with hospital discharge planners and on an analysis of Medicare data. This inspection found that, so far, there are no serious problems in placing Medicare patients in nursing homes. More specifically, most discharge planners report that they can place Medicare patients in nursing homes. Further, Medicare data show no changes in nursing home placements for Medicare patients. Discharge planners, however, also report that nursing homes are changing their admissions practices in response to the new prospective payment system. They note that patients who need extensive services have become more difficult to place, whereas patients who need rehabilitation services have become easier to place.

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 three 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 7100 days per benefit period, with a co-payment required for days 21 through 100. A patient must be in a bed certified by Medicare for a facility to be reimbursed by Medicare.

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. 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. 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 1 of 44 Resource Utilization Groups (RUGS-III). This new payment system is being phased in over a 3 year transition period.

Under the prospective payment system, SNFs are required to classify residents into one of the RUGs based on assessment data from the Minimum Data Set (MDS). This data set contains a standardized set of clinical and functional status measures for each resident which are collected at specific intervals during a resident's nursing home stay. The MDS coordinators work with others to complete these assessments that also determine how much the facility will be reimbursed under the prospective payment system.

Nursing Home Concerns

The nursing home industry has raised several concerns about the new reimbursement system. The industry believes that the system will reduce payments to SNFs and may cause access problems for Medicare beneficiaries. In media reports, industry representatives have expressed concern that the new system may cause some SNFs to go out of business.

METHODOLOGY

This inspection is based on interviews with a random sample of nursing home administrators and MDS coordinators. To do this, we selected a total of 64 nursing homes in eight States. We contacted the nursing home administrator by telephone and an MDS coordinator by mail in each of these facilities. We asked each respondent about changes in both their admissions practices and in access to nursing home care that have resulted from the new prospective payment system. Seven nursing facilities in our sample do not accept Medicare Part A patients. Our analysis, therefore, is based on the responses

of the 57 administrators from nursing homes that accept Medicare Part A patients. We conducted these interviews in July 1999.

Sample Selection

We selected a two-stage stratified cluster sample for this inspection. The first stage of sampling was a stratified sample of eight States:

- the four States with the most SNF beds (CA, NY, IL, TX);
- two of the four States currently using a Medicaid demonstration prospective payment system (MS, ME);
- two States randomly selected from the remaining 40 contiguous States (VA, CT).

At the second stage, we selected a simple random sample of eight nursing homes that had greater than 60 beds within each of these States. The State sample is the same as the one used for three related studies being conducted by the Office of Inspector General. These studies are: *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities*, OEI-02-99-00400; *Nursing Home Financial Screening and Distinct Part Rules*, OEI-02-99-00340; and *Nursing Home Resident Assessment*, OEI-02-99-00040.

Limitations

The findings in this report are primarily based on self-reported data that were not independently verified. Further, the precision of the estimates is limited by the small sample size. Appendix A provides the confidence intervals for the key estimates used in the report. Results are best interpreted when compared to findings in the main report, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities*, OEI-02-99-00400.

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

FINDINGS

Few nursing home administrators believe that access to nursing home care has become a problem because of the prospective payment system

Seventy percent of nursing home administrators report that access to nursing home care is “not at all” a problem for Medicare patients *in their area*. They most commonly explain that access is not a problem because there are beds available in their area for Medicare patients. On the other hand, 24 percent report that access is “somewhat” of a problem, and 6 percent report that access is a “large” problem *in their area*. Only 8 percent of all nursing home administrators attribute access problems to the prospective payment system. They more frequently attribute such problems to a shortage of beds in their area. Some also point to the lack of beds available in facilities that have good reputations or in facilities that are patients’ first choice.

Seventy-four percent of administrators report that *their own* facility “never” or “not often” refuses Medicare patients because it does not have a Medicare-certified bed available, however, some nursing homes do have difficulty accepting patients. Twenty-five percent report that *their own* facility does not have a Medicare-certified bed available “somewhat often,” while less than 1 percent report not having a bed available “very often.”

Those individuals in the nursing home who are responsible for assessing patients’ needs, the “minimum data set” coordinators also believe that the prospective payment system is not preventing access to nursing home care. Ninety-four percent of them believe that their facility has not refused residents because of the new reimbursement system.

Nursing homes have changed their admissions practices

Seventy percent of nursing home administrators report that their admission practices have changed as a result of the prospective payment system. Most administrators state that they scrutinize patients’ medical status to a greater extent than they did prior to the implementation of the prospective payment system. They typically require more medical information about the patient and conduct more thorough reviews of the services and the types of care the patient needs before making admissions decisions. In many situations, nursing home staff now go to the hospital to review the patient’s chart or to directly assess his or her condition prior to admission. A few say that in their review, they particularly focus on whether a patient requires costly intravenous medication, lab work, or ambulance transportation.

Nursing home administrators seem to use this information in two ways. Some state that it helps them determine whether their facility can meet the patient's needs. Others state that the information helps them determine how much it will cost to take care of the patient. Some report that they then compare this estimate to the amount they will be reimbursed for that patient under the prospective payment system. In general, administrators comment that they have become more cost-conscious about which types of patients they accept and about how they deliver services.

Medical condition has become more important in nursing home admissions decisions

Seventy-four percent of nursing home administrators report that a patient's medical condition has become a more important factor in admissions decisions under the new reimbursement system. When asked specifically about which types of medical conditions they are more or less likely to admit as a result of the prospective payment system, most administrators identify at least one type. The types of conditions they mention are similar to those noted by discharge planners.

More specifically, 53 percent of all nursing home administrators say that there are some types of patients that they are *less* likely to admit. They most commonly cite patients who require expensive supplies or services such as those who require expensive intravenous medications, ventilators, feeding tubes or wound care. Twelve percent of administrators also mention that they are less likely to admit dialysis patients, because they have high transportation costs that they are not reimbursed for separately under the prospective payment system.

At the same time, 46 percent of all nursing home administrators say that there are some types of patients that they are *more* likely to admit. They most commonly point to patients requiring special rehabilitation services, such as physical, occupational, or speech therapy. In particular they mention orthopedic patients, who have had fractures or joint replacements, and stroke patients.

It is important to note that while administrators say that they prefer to admit certain types of patients, Medicare data show no changes in nursing home placements, as noted in our earlier report entitled *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities* OEI-02-99-00400. Specifically in that report, we found no difference in where Medicare patients are being placed and in the types of Medicare patients that are being placed in skilled nursing facilities between the first five months of 1998, which is prior to the implementation of the prospective payment system and the same five months of 1999, which is after the implementation of the new system.

Most support the concept of prospective payment

Over 80 percent of nursing home administrators support the overall concept of the prospective payment system. They agree that matching reimbursement with services rendered is generally a fair method of payment. Some administrators recognize that there were abuses under the cost-based system and support the need for a new system that aims to control costs. Despite their overall support, many administrators also stress the need to revise some of the current reimbursement rates. Some believe that the resource utilization groups are not appropriate for all patients and that the current reimbursement levels do not cover costs they incur to take care of some patients.

CONCLUSION

The findings in this report support those in our companion report. Together, the two reports show that nursing homes are changing their admissions practices in response to the prospective payment system but that, so far, access to skilled nursing care is not a problem, most likely because beds are available. These early assessments note, however, that these practice changes may affect beneficiaries with certain medical conditions and may also affect nursing homes' reimbursement. Accordingly, we believe that the Department must remain vigilant to potential problems for Medicare patients and for nursing homes.

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CONFIDENCE INTERVALS FOR KEY FINDINGS FOR NURSING HOME ADMINISTRATORS

KEY FINDINGS	POINT ESTIMATE	
Access to nursing homes care is not a problem for Medicare patients in your area.	70%	43 - 97
Facilities rarely or never refuse Medicare patients because they do not have a Medicare-certified bed available.	74%	65 - 83
Access to nursing home care is a problem as a result of the prospective payment system.	8%	0 - 18
Admissions practices have changed as a result of the prospective payment system.	70%	52 - 88
A patient's medical condition has become a more important factor in admissions decisions.	74%	55 - 92
Nursing home administrators say that there are some types of patients that they are <i>more</i> likely to admit.	46%	36-57
Nursing home administrators say that there are some types of patients that they are <i>less</i> likely to admit.	53%	45-61
Nursing home administrators support the concept of the prospective payment system.	87%	84 - 91

**CONFIDENCE INTERVALS FOR KEY FINDINGS FOR
MINIMUM DATA SET (MDS) COORDINATORS**

We calculated confidence intervals for the key findings. The point estimate and 95 percent confidence interval are given for each of the following findings. The point estimates and confidence intervals for each finding vary based on the standard error for each individual finding.

KEY FINDINGS	POINT ESTIMATE	
Facilities do not refuse Medicare patients based on PPS reimbursement.	94%	84-100
The number of Medicare certified beds has remained the same as a result of PPS.	76%	46-100

COMMENTS

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

**DATE:****TO:** June Gibbs Brown
Inspector General**FROM:** Michael M. Hash *Michael M. Hash*
Deputy Administrator**SUBJECT:** Office of Inspector General (OIG) Working Draft Report: "Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities--Nursing Home Administrators' Perspective," (OEI-02-99-00401)

We appreciate the Inspector General's continuing work to assess the impact of the changes in Medicare's payment system for nursing homes on the access to care for beneficiaries. We share a commitment to ensuring beneficiaries retain access to quality skilled nursing care. This report and your earlier research provides helpful data and evidence as we evaluate the payment system.

The Administration and Congress have worked together to protect Medicare's skilled nursing care benefit, which grew at an unsustainable rate under Medicare's old cost-based payment system -- from \$2.8 billion in Fiscal Year (FY) 1990 to \$12.1 billion in FY 1997.

The Balanced Budget Act of 1997 (BBA) required Medicare to implement the prospective payment system, which covers the daily costs of providing post-acute care in skilled nursing facilities based on a beneficiary's expected medical needs. Under the system, Medicare pays nursing homes at higher rates to treat more resource-intensive patients than to treat relatively healthier ones. The payment rates were designed to pay facilities fairly while encouraging efficient, quality care.

The report concludes that although nursing homes are changing their admission practices in response to the new payment system, Medicare beneficiaries so far continue to have access to skilled nursing care. This is consistent with your other research and with the early findings of our own on-going monitoring efforts.

Medicare's skilled nursing facility benefit has evolved in recent years from more 'traditional' post acute care (nursing and therapy) to include care for more medically complex patients as well. While changes in nursing-home admission practices are not necessarily inappropriate, by law, nursing homes cannot treat Medicare beneficiaries differently than they do other patients. States can and do investigate such complaints and

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would recommend penalties against nursing homes found to discriminate against Medicare beneficiaries.

We know that there are concerns that, for some high-acuity patients, the payment system does not fully reflect the costs of non-therapy ancillary services. We share these concerns and are conducting research that will allow us to refine the payment system if appropriate next year.

We will remain vigilant in our efforts to assess potential changes that could affect quality and access to skilled nursing care for Medicare beneficiaries. We look forward to further studies to help us assess and guide policy to serve our beneficiaries, and we will continue to evaluate any additional evidence and research about quality and access to care.

As you know, the President has proposed setting aside \$7.5 billion over 10 years to smooth out any provisions in the BBA that may affect beneficiaries' access to quality services. We continue to work with Congress and others to identify any such problems and develop appropriate solutions to strengthen Medicare for the nearly 40 million elderly and disabled Americans who rely on this essential program.