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ACCESS TO POSTHOSPITAL CARE FOR MEDICARE BENEFICIARIES

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Subcommittee on Health and Long-term Care
Special Committee on Aging
House of Representatives

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MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

It is a pleasure to be here today to report to you on our study of access to posthospital care for Medicare beneficiaries. More details may be found in our report entitled Posthospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients (GAO/PEMD-87-5BR). As you know, approximately 11.5 million elderly individuals who are hospitalized each year receive benefits under the Medicare program. Upon discharge, some of these individuals need access to nursing homes and home health care to aid in their recovery. In our study, we looked at the problems discharge planners face in placing Medicare patients in appropriate posthospital settings and whether the problems have changed since the advent of Medicare's Prospective Payment System.

The fundamental restructuring of Medicare's hospital payment methods brought about by its Prospective Payment System, authorized in 1983, provides hospitals with incentives to limit the inpatient costs associated with each admission of a Medicare patient. One way to contain costs is to shorten a patient's length of stay and substitute posthospital care. Average lengths of stay have clearly shortened since the implementation of the Prospective Payment System, and discharges to home health agencies and skilled nursing facilities have increased. When we began our study, reports that some Medicare beneficiaries experienced difficulties in obtaining needed posthospital services had raised concerns about general

access to appropriate posthospital care by the patients who need it.

Unfortunately, there was, and still is, no nationally representative information on the number of patients who need care after they leave the hospital and there are no studies of the percentage of patients who receive the care they need. Such data are not routinely collected at the national level. Most of the available studies of access to posthospital care have relied on indirect, or proxy, measures such as the supply and use of posthospital services. Lower supply and less use are understood as indicating more difficult access. Proxy measures, however, cannot speak to the issue of appropriate access -- that is, to what extent appropriate services are or are not available to the patients who need them.

Because of the lack of nationally representative information on direct measures of access to posthospital care, we surveyed discharge planners working in a nationally representative sample of 985 hospitals. Of these hospitals, 93 percent responded. We chose discharge planners because of their direct responsibility for assisting hospital patients in finding posthospital care. We asked about the problems they have encountered in attempting to place discharged hospital patients who need further medical attention in skilled nursing facilities (SNF's) and through home health care. Our work, therefore, represents the first national study of

Medicare patients whose need for posthospital care has been ascertained by hospital professionals. Of course, arranging placements for discharged Medicare inpatients is only one aspect of the more general issue of access to nursing homes and home health care.

My remarks today will focus on the extent of reported problems, changes over time in these problems; regional and urban/rural variation; and the reasons underlying posthospital placement difficulties. In addition to learning whether discharge planners are experiencing difficulty in placing discharged patients nationally, and not just with particular cases, we were interested in understanding better the factors that might act as barriers in arranging posthospital placements. Therefore, most of our questions were accompanied by a list of potentially important factors that we developed from our prior work and from pretesting the questionnaire. The list of factors on our list included

-- Medicare program rules and regulations;

-- Medicaid program rules and regulations;

-- the availability of services;

-- social or legal situations such as living conditions, family situations, guardianship, and conservatorship;

-- the need for complex or skilled services such as feeding problems, IV's, respirators, and the like;

-- the chronic care problems such as Alzheimer's disease, pulmonary disease, incontinence;

-- other problems.

I will allude to these factors throughout my remarks in order to provide a clearer context for understanding access problems as perceived by discharge planners.

THE DISCHARGE PLANNERS REPORTED PROBLEMS

Ninety-seven percent of the discharge planners across the nation reported at least some problems in placing Medicare patients in skilled nursing facilities. The problem they identified most frequently as a barrier to SNF placement was Medicare program rules and regulations. This was noted by 71 percent of the discharge planners. Next were the availability of beds and the need for complex skilled services, cited by 63 percent. Of the problems listed on the questionnaire, the only one less than 50 percent of the discharge planners selected was the presence of chronic care needs.

Discharge planners across the nation reported that the availability of skilled nursing and intermediate care beds is between inadequate and marginal. "Marginal" indicated a neutral position on our rating scale. The availability of rehabilitation centers was reported as almost marginal.

According to the discharge planners, home health care placement is somewhat less of a problem than SNF placement. Nationally, 86 percent of the discharge planners reported having had at least some problems arranging home health care for Medicare patients. This is contrasted with 97 percent reporting problems with SNF placement. Of those who reported specific barriers to home health placement for Medicare patients, 68 percent nationally identified Medicare program rules and regulations as an important barrier. Chronic care problems were identified by 40 percent. But the supply of home health care was identified as a problem by only 29 percent of the discharge planners.

Indeed, the availability of home health care is generally regarded as adequate nationally. However, the discharge planners' perceptions of the supply of homemaker, hospice, and adult congregate living services ranged between inadequate and marginal nationally, "marginal" again indicating a neutral position.

ACCESS PROBLEMS HAVE REPORTEDLY WORSENED

More than half the discharge planners across the nation reported that access problems were greater in 1985 than in 1982. Discharge planners saw the introduction of Medicare or state-sponsored prospective payment systems for hospital services as contributing greatly to access difficulties, but they reported several other factors as also making it somewhat more difficult to place Medicare patients in posthospital care. These factors include increased numbers of Medicare patients, increased use of complex medical equipment and other "high-tech" services in posthospital care, the state regulation of nursing home beds through certificates of need, and changes in the number of certified SNF beds. An exception to this pattern was the growth in the number of home health agencies, which was seen as making the placement of patients somewhat less difficult.

REGIONAL AND URBAN/RURAL ACCESS VARIES

Some regional differences in the discharge planners' views of access to SNFs are apparent when we compare the results from our seven regions: the Northeast, South, East North Central, West North Central, West South Central, Mountain, and Pacific. Problems with Medicare program rules and regulations were identified most frequently by discharge planners in the Pacific region. However, discharge planners in the Northeast and South mentioned the supply

of nursing home beds as a problem more frequently. Discharge planners in the Pacific, Northeast and South regions indicated problems associated with patients' needing complex skilled care or lacking appropriate social or legal arrangements more frequently than discharge planners indicated them in the other regions. Discharge planners were more likely in the Northeast and Pacific regions than in the West North Central and Mountain regions to view chronic care problems as SNF placement barriers.

With respect to home health, a single pattern holds for each of the regions: a comparatively large percentage of the discharge planners selected Medicare program rules and regulations as a problem. Only in the Northeast did more than half the discharge planners identify any factor other than this as a barrier to home health care. In that region, each of the factors listed earlier was identified by at least 49 percent of the discharge planners, with the exception of Medicaid program rules and regulations.

The reported change in access between 1982 and 1985 varied considerably. In the Northeast, South, and East North Central regions, 59 percent or more of the discharge planners reported that the percentage of patients who had to remain in the hospital waiting for posthospital placement was greater in 1985 than in 1982. In two regions, West North Central and Pacific, the majority of the discharge planners reported no difference or a decrease in the percentage of patients waiting.

With regard to urban/rural differences, discharge planners in large SMSAs -- that is Standard Metropolitan Statistical Areas with more than 1 million population -- reported each problem on our list as an important barrier to placement in posthospital care more frequently than discharge planners in rural areas, with only a few exceptions. The responses of discharge planners in small SMSAs -- those with populations up to 1 million -- were usually closer to those of their rural counterparts than to those in large SMSAs, but the differences were not statistically significant. However, population density did not appear to be related to the generally reported change in access problems.

MEDICARE PROGRAM RULES AND REGULATIONS ARE SEEN AS THE MOST IMPORTANT BARRIER TO ARRANGING POSTHOSPITAL CARE

In addition to asking the discharge planners which of several factors contributed to difficulties in placing patients, we asked them to identify the most important barrier. With regard to SNF placements, roughly equivalent numbers of discharge planners viewed Medicare program rules and regulations and the availability of beds as the most important barriers. Thirty-three percent of the discharge planners cited Medicare program rules and regulations. Almost as many, 30 percent, thought the availability of beds was the most important problem. However, with regard to home health

placement, 52 percent chose Medicare program rules and regulations as the most important barrier. No other factor was selected by more than 15 percent of the discharge planners.

In terms of regional variation on this factor, the percentage of discharge planners who identified Medicare program rules and regulations as the most important barrier to SNF placement was larger in the Mountain and West North Central regions than in the Northeast and South. In the latter regions, the availability of nursing home beds was identified by a larger percentage than in the other regions, except West North Central. Approximately equal percentages of discharge planners in the West South Central region identified this factor and the need for complex skilled care as the most important factors.

Discharge planners in each region reported Medicare program rules and regulations as the most important barrier to home health care. In general, population density did not seem to be systematically related to the selection of this problem as the most important barrier to either SNF or home health placements.

Finally, we encouraged the respondents to provide us with "any other comments" they had on posthospital care for Medicare patients. Fifty-four percent chose to do so. The responses were particularly enlightening in clarifying some of the issues implied

by the selection of Medicare program rules and regulations as a placement barrier. The comments addressed two major issues:

-- a perception that the Medicare program has changed the way in which individual eligibility and coverage determinations are made and

-- a sense that posthospital benefits do not cover all the types of services the elderly need.

With respect to SNF services, the respondents' perceptions about Medicare program rules and regulations focused on several specific factors including cuts in coverage, the tightening of eligibility determinations, changes in criteria, restrictive definitions of skilled care, and similar factors. As one discharge planner explained,

> "Very few patients qualify for skilled level care under Medicare regulations. The few that do qualify are not accepted by ECFs (another term for SNFs) because they require 'too much care,' and 'are cost prohibitive.' For example, it is impossible to find ECF placement for respirator patients unless they are private pay at $300.00 daily."

Other discharge planners commented that some patients are very difficult to place in SNFs because their needs are either too great

for the SNF to handle or too costly, given Medicare reimbursement. Such patients include those on respirators, those with multiple decubitus ulcers, and those requiring extensive observation.

With respect to home health services, the respondents noted the lack of coverage for nonskilled services in the absence of skilled care needs (or the cutoff of nonskilled services before patients are ready to function without them). The types of nonskilled services mentioned most often included homemaker, chore, extended observation, and "custodial" and "chronic" care services. In addition, the supply of related community-based services such as meals on wheels and home visitation are a problem. For example, one discharge planner wrote,

> "Home care services are available to the elderly through the . . . County Area Agency on Aging. However, there are long waiting lists for services, and it is almost impossible to arrange for service to commence immediately upon discharge, a time when home services such as home delivered meals are crucial. Often, by the time services are given, due to lengthy waiting lists, the patient's need is less urgent. Services which are lacking in [the] County are affordable personal care homes, foster care and respite care/companionship type services."

DISCHARGE PLANNERS' PERCEPTIONS COMPARED TO OTHER AVAILABLE INFORMATION

It might have been preferable to enumerate actual incidents of access problems, but this approach was not feasible because of the limitations in hospital information systems and the resources available for our study. The information we did obtain represents the perceptions and opinions of professionals who are directly responsible for helping patients gain access to posthospital care and who know most about why their patients have problems gaining it. Some of our results are corroborated by other sources of information. For example, the perceptions of the discharge planners about the availability of nursing home beds in their regions generally agree with the data available from the Health Care Financing Administration on regional nursing home bed/population ratios.

On the issue of access, this Committee and others have heard testimony describing some of the same types of difficulties Medicare patients face in obtaining posthospital care. In February 1985, we reported access problems based on meetings with small, local surveys of providers and community agencies (GAO/PEMD-85-8). The issues we have raised about Medicare coverage of posthospital care have been raised in other forums by health services researchers, consumer groups, and health care providers involved with the Medicare program.

As we reported this year, we have estimated that over 1.1 million elderly who are chronically ill lacked assistance with essential day-to-day activities such as grocery shopping, managing money, and getting transportation (GAO/HRD-87-9). Another 168,000 of the elderly who are chronically ill lack needed assistance with such activities of daily living as bathing, dressing, getting around inside the house, getting in and out of bed, using the toilet, and eating.

CONCLUSION

Our study confirms the existence, on a national level, of the problems of gaining access to posthospital care that have been suggested previously by local studies. It is clear that the reported problems are widespread: 97 percent of the discharge planners across the nation have problems in placing Medicare patients in skilled nursing facilities. Somewhat fewer discharge planners, 86 percent, have problems helping patients who need home health care. It is clear also that the situation has deteriorated: the discharge planners feel that the problems associated with placing Medicare patients in posthospital care are greater now than in the past.

Some types of problems the discharge planners face are not new. For example, patients requiring complex skilled services continue to present difficulties for arranging skilled nursing home

placements. Patients who need nonskilled care in their homes also present problems for the discharge planners.

But the discharge planners clearly feel that specific aspects of the Medicare program contribute to their difficulties. Some of these have to do with changes in the administration of the Medicare program. For example, they believe that eligibility and coverage criteria are being applied more restrictively now than in the past. However, the chief problem with home health care is not new: it is that the Medicare home health benefit does not cover the types of nonskilled services many elderly need in order to stay at home.

In summary, we sought to address two questions--do discharge planners face problems in placing Medicare patients in appropriate posthospital settings and, if so, do they believe these problems have become greater since the advent of Medicare's Prospective Payment System? To both questions, the answer must be yes.

This concludes my prepared statement. I will be happy to answer any questions you or other members of the committee have.