United States General Accounting Office 132243

GAO Testimony

For Release
on Delivery
Expected at
10:00 a.m. EST
Thursday
February 26, 1987

REPORTED PROBLEMS IN ACCESS TO POSTHOSPITAL CARE FOR MEDICARE BENEFICIARIES

Statement of
Eleanor Chelimsky, Director
Program Evaluation and
Methodology Division

Before the
Subcommittee on Health
Committee on Ways and Means
House of Representatives

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

It is a pleasure to be here today to share with the committee some of the information we have developed over the past few years regarding the Medicare Prospective Payment System and posthospital care. Other panelists today have noted some of the ways in which hospitals have responded to the incentives of PPS--primarily through operational efficiencies and reduced lengths-of-stay. Granted, there is some disagreement about the precision and significance of estimated hospital profit margins.[1] However, PPS has other effects about which there can be little disagreement. I am referring to the effects of shorter hospital lengths-of-stay on Medicare beneficiaries and on their need for and access to posthospital care.

The results I present here come primarily from our recently released study of access to posthospital care for Medicare beneficiaries.[2] Because of the lack of nationally representative information on direct measures of access to posthospital care, we

---

[1]Early last year because of the numerous problems we had identified with the databases used to calculate PPS payment rates, we recommended that the Secretary of the Department of Health and Human Services revise prospective payment rates and base the revision on data that reflect hospital circumstances under prospective payment. See Medicare: Past Overuse of Intensive Care Services Inflates Hospital Payments, GAO/HRD-86-25 (Washington, D.C.: March 7, 1986), p. 4.

[2]GAO, Posthospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients, GAO/PEMD-87-5BR (Washington, D.C.: January 1987).

surveyed discharge planners working in a nationally representative sample of 985 hospitals. We received responses from 93 percent of these hospitals. We surveyed discharge planners because of their direct responsibility for assisting hospital patients in finding posthospital care. We asked the discharge planners about the problems they have encountered in attempting to arrange placements for Medicare patients in posthospital settings, primarily skilled nursing facilities (SNFs) and home health care. As such, our work represents the first national study of access to posthospital care for Medicare patients whose need for such care has been ascertained by hospital professionals. Of course, arranging placements for this particular subpopulation of discharged Medicare inpatients is only one aspect of the broader issue of access to nursing homes and home health care.

It is important to note that Medicare posthospital benefits were intentionally designed to cover short-term skilled nursing and rehabilitative care for patients recuperating from acute illnesses. The types and amounts of services covered are strictly limited, and there is substantial beneficiary cost-sharing in the case of the SNF benefit.[3]

---

[3]Under current rules, Medicare SNF benefits are limited to individuals who need skilled nursing or rehabilitative services on a daily basis following a period of 3 or more days of hospitalization. Rehabilitative services are limited to persons who are expected to be "rehabilitated" and to return to independent living. For covered SNF stays, Medicare requires no beneficiary deductible, but after the 20th day, beneficiaries pay a large daily copayment (currently $65) for the next 80 days of care, and Medicare pays nothing at all after 100 days of SNF care (except for

My remarks today focus on the size and direction of problems reported nationwide in placing Medicare patients in appropriate posthospital care, on changes over time in these problems, and on the underlying reasons discharge planners cite for these problems. In addition to learning whether discharge planners have difficulty placing patients nationally, and not just in individual sites, we were interested in understanding the impediments to arranging posthospital placements. Therefore, most of our questions were accompanied by a list of potentially important barriers to placements for the respondents to consider. The list was developed from our prior work and included

-- Medicare program rules and regulations[4];

-- Medicaid program rules and regulations;

-- the availability of services;

---

covered ancillary services).

There is currently no copayment for home health services covered by Medicare (except for durable medical equipment furnished by the home health agency), but coverage is limited to persons who are confined to their homes under the care of a physician and in need of part-time or intermittent skilled nursing services or physical or speech therapy. Home health aides, occupational therapy, medical supplies, and medical equipment may also be covered for patients who require skilled nursing services.

[4]I will clarify what is meant by Medicare program rules and regulations when I present some details of discharge planners' open-ended comments later.

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

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

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

-- other problems.

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

THE PROBLEMS REPORTED BY DISCHARGE PLANNERS

Across the nation, 97 percent of the discharge planners across the nation reported at least some problems in placing Medicare patients in skilled nursing facilities.[5] 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 came the availability of

---

[5]Information on sampling error and tests of significance for the statistics cited in this testimony can be found in GAO/PEMD-87-5BR.

beds and the need for complex skilled services, cited by 63 percent. Of the problems listed in the questionnaire, the only one selected by less than 50 percent of the discharge planners was the presence of chronic care needs.

To the discharge planners nationally, home health care placement is slightly less a problem than SNF placement. Eighty-six percent reported having had at least some problems arranging home health care for Medicare patients. Of those who reported specific barriers to home health placement for Medicare patients, 68 percent identified Medicare program rules and regulations as an important barrier. Chronic care problems were identified by 40 percent. But the availability of home health care was identified as a problem by only 29 percent of the discharge planners.

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 ACCESS VARIES

Some regional differences in the discharge planners' views of access to posthospital care are apparent when we compare the results from the seven regions in our survey: Northeast, South, East North Central, West North Central, West South Central, Mountain, and Pacific. Problems with Medicare rules and regulations were identified most frequently as a barrier to SNF placement by discharge planners in the Pacific region. Discharge planners in the Northeast and South mentioned the supply of nursing home beds more frequently. With respect to home health care, a single pattern holds for each of these regions: a relatively large percentage of the discharge planners selected Medicare program rules and regulations as a problem.

The reported change in access between 1982 and 1985 varied considerably by region. 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.

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 barrier. Thirty-three percent 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 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, 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. The availability of nursing home beds was identified by a

larger percentage in the Northeast and the South. 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.

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 helped to clarify some of the issues implied by the selection of Medicare 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 focused on perceptions that there have been cuts in coverage, a tightening of eligibility determinations, changes in criteria for coverage and eligibility, and an increasingly restrictive definition of skilled

care, making it more difficult to place Medicare patients in SNFs. Other discharge planners commented that some patients are very difficult to place in SNFs because their needs are either too great for SNFs 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 cutting off 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 was cited as a problem.

THESE PROBLEMS WERE PREDICTABLE

Prior to PPS, when hospitals were reimbursed for the cost of individual services and days of hospital care, their financial interests could lead them to err on the side of providing too much health care. At times this could have negative consequences to quality, given the danger of complications and infection that accompany all medical interventions, but the prime objection to this reimbursement method was its cost. Medicare was seen as paying for too much unnecessary and inappropriate care.

In shifting to a system of prospective payment based on diagnoses, Medicare removed the financial incentive to provide more health care services than needed. Instead, hospitals now stand to gain the most by curtailing both services and days of hospital care wherever possible. Hospitals can profit financially from cutting back on medically appropriate as well as inappropriate services. Thus, the extent to which patients are discharged while still in need of acute hospital care was seen as a potential problem when PPS was enacted and has, in fact, become a primary concern.

Another concern relates to the ability of hospitals to respond to PPS incentives by arranging for the provision of subacute care in appropriate posthospital settings. Patients who no longer require acute care should be discharged from the hospital. But some of these patients are still not sufficiently recovered to care for themselves at home, requiring appropriate and competent posthospital care.

Even prior to PPS, there were problems in obtaining access to skilled nursing facilities for some patients. As a result, some of these patients remained in hospitals longer than medically necessary.[6] This is less likely to occur under PPS because such extensions of hospital stays have changed from being generally

---

[6]GAO, Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly, GAO/IPE-84-1 (Washington, D.C.: October 21, 1983), pp. 110-15; GAO, Ohio's Medicaid Program: Problems Identified Can Have National Importance, GAO/HRD-78-98A (Washington D.C.: October 23, 1978), p. 7.

profitable to being relatively unprofitable. Pressure to discharge patients combined with problems in nursing home access could mean that some patients end up with less than optimal placements.

Similarly, with the regard to home health care, we found that problems of unmet need existed prior to the introduction of the Prospective Payment System. In 1982, an estimated 168,000 of the chronically-ill elderly lacked needed assistance with such basic activities of daily living as bathing, dressing, eating, etc.[7] These unmet needs reflect some of the same gaps in coverage for unskilled care that discharge planners cited in our current study as a barrier to appropriate home care placements.

The information that is available indicates that hospitals have responded as expected in terms of these incentives: average lengths of stay are down and the number of patients discharged to posthospital care, including nursing homes and home health care, has increased sharply.[8] Evidence of some problems of quality stemming from these incentives has also emerged. There have been numerous reports of cases in which people have been discharged from hospitals in unstable medical condition or without adequate provision for posthospital care, or to inappropriate types of posthospital care.

---

[7]GAO, Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs, GAO/HRD-87-9 (Washington, D.C.: December, 1987), pp. 4-5.

[8]HHS, Report to Congress: The Impact of the Medicare Prospective Payment System, 1984 Annual Report (Washington, D.C.: November 1985), p. 6-13 and 8-6 to 8-12.

We reported to the Senate Special Committee on Aging in February 1984, that the hospital, nursing home, and home health care administrators, discharge planners and patients' advocates with whom we met in six communities across the country agreed substantially that patients were being discharged sooner and in poorer health than before PPS.[9] We were told that there was an increased demand for posthospital care and that patients in the post-PPS period required more intensive services after hospital discharge. The results of our recent survey of hospital discharge planners indicates clearly that the problem of obtaining appropriate subacute care for some patients is national in scope and not limited to individual communities.

SOME CHANGES DESIGNED TO ADDRESS PROBLEMS IN ACCESS TO POSTHOSPITAL CARE HAVE BEEN MADE BUT QUESTIONS REMAIN

Some changes have been made in the Medicare program since the problems associated with the introduction of Prospective Payment have surfaced. The scope of work assigned to Peer Review Organizations has been expanded to include review of the appropriateness of discharge planning as one element of a broader set of quality-of-care screens, more emphasis on indicators of

---

[9]GAO, Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-term Care Services: Preliminary Report, GAO/PEMD-85-8 (Washington, D.C.: February 21, 1985), pp. 4-8.

underutilization, and more specific requirements to examine patient readmissions that may have been caused by premature or inappropriate discharge.

The Omnibus Budget Reconciliation Act of 1986 requires each Peer Review Organization to devote a reasonable proportion of its activities to reviewing the quality of services in a variety of settings including posthospital care settings. The Act also requires HHS to develop a uniform needs assessment instrument that evaluates functional capacity to be used in establishing the need for posthospital care services, and requires hospitals to have a discharge planning program as a condition for their participation in the Medicare program.

Important questions remain, however, about HCFA's ability to identify and correct problems related to access, quality and costs of posthospital care.[10] We have recommended that the Secretary of HHS do studies to evaluate factors contributing to unmet need for home care assistance and options for meeting the future home care needs of the elderly.[11] At your request, GAO is currently examining the systems in place to measure and monitor quality of care over the entire range of Medicare-covered services. We will be presenting to you this spring our preliminary analyses regarding strategies for assessing the quality of care that Medicare

---

[10]GAO, Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payment Effects Are Insufficient, GAO/PEMD-86-10 (Washington, D.C.: June 2, 1986).

[11]GAO/HRD-87-9, p. 58.

beneficiaries receive and for using that information to make systematic improvements in quality of care.

CONCLUSIONS

The incentives associated with the Medicare Prospective Payment System made a variety of potential outcomes likely: positive outcomes in terms of reductions in hospital costs and unnecessary services; negative outcomes in terms of quality of and access to care in general, and access to appropriate posthospital care in particular. Our survey shows that, in fact, access to posthospital care is a national concern. Problems are encountered by the vast majority of discharge planners in placing Medicare patients in appropriate posthospital settings. It is clear also that the situation has deteriorated: discharge planners report that the problems associated with placing Medicare patients in posthospital care are greater now than before Prospective Payment. Overall, discharge planners are telling us, first, that Prospective Payment is associated with increased pressure to use posthospital care and, second, that certain aspects of the Medicare program itself impede access to and use of appropriate posthospital care.

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