Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

JUNE GIBBS BROWN
Inspector General

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

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

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 their 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 adequacy of the payments and the effect of the new system on patients and on nursing homes.

To address these concerns, we contacted a random sample of hospital discharge planners who are responsible for coordinating nursing home care for patients being discharged from hospitals. We asked them about their ability to place Medicare patients in nursing homes and about changes in nursing home admissions practices. Our analysis is primarily based on patients who are likely to leave the nursing home when their Medicare Part A coverage ends. We also examined Medicare data related to SNF discharges and hospital length of stay.

FINDINGS

So far, no serious problems in placing Medicare patients in nursing homes are apparent. However, nursing homes are changing their admissions practices in response to the prospective payment system.

Generally, discharge planners report that they can place Medicare patients.

Most discharge planners (66 percent) report that it is "not at all difficult" to place patients in nursing homes when their stay will be paid under the Medicare prospective payment system. Another 32 percent say that it is "somewhat difficult," while 1 percent report that it is "very difficult." Discharge planners do not indicate that they are unable to place these patients. They commonly explain that nursing homes generally want Medicare patients because they are short-

term or because nursing homes are reimbursed at a higher rate for these patients than for Medicaid patients. At the same time, about a fifth believe that it has become more difficult to place Medicare patients in the past year because of the new prospective payment system. Also, 44 percent of discharge planners report that it has become more difficult to place patients whose Medicare Part A coverage will likely end before they are discharged and who will then become Medicaid residents. However, discharge planners do not generally attribute this to the prospective payment system.

Medicare data show no changes in nursing home placements.

Medicare data confirm that Medicare patients are still being placed in nursing homes. Specifically, these data do not show any change in where patients are being placed and in the types of Medicare patients who are being placed in nursing homes. In addition, Medicare data indicate an increase in the total number of Medicare beds, which is a key factor in nursing home access.

Nursing homes are changing their admissions practices in response to the prospective payment system.

About half of all discharge planners report that nursing homes have changed their admissions practices as a result of the new prospective payment system. Discharge planners explain that nursing homes request more detailed clinical information about the patient and are more consistently coming to the hospital to directly assess the patient before making admissions decisions.

The patients who have become harder to place are those who need extensive services.

When asked which types of patients have become more difficult to place, the majority of discharge planners (58 percent) identify patients who require extensive services. They specifically mention patients who require intravenous feedings, intravenous medications, tracheostomy care, or ventilator/respirator care. Discharge planners report that some types of special care and clinically complex patients have also become more difficult to place in the past year.

On the other hand, the patients who have become easier to place are those who need rehabilitation services.

Most discharge planners (69 percent) report that Medicare patients who need special rehabilitation have become easier to place in nursing homes in the past year. They most commonly state that orthopedic patients, who have had a hip or knee fracture or joint replacement, and stroke patients, who require intensive short-term rehabilitation, have become easier to place. It is important to note that special rehabilitation is reimbursed at the highest rate under the prospective payment system.

CONCLUSION

It appears that in an early response to the prospective payment system, some nursing homes have modified their admission practices. However, despite this practice change, there is no direct evidence that Medicare patients are not receiving the SNF care they require. This is partly due to an overall increase in the number of Medicare beds and to the fact that Medicare continues to reimburse at a higher rate than Medicaid, which is the primary payer of nursing home care.

We stress that this is an early assessment of the effects of the prospective payment system on access. We believe that the Department must remain vigilant to potential problems for Medicare patients and for nursing homes. As part of this effort, we will periodically replicate this study of discharge planners and analysis of Medicare data. We will particularly focus on the types of patients who were identified as being more difficult to place. Additionally, we suggest that the Administration on Aging (AoA) alert long-term care ombudsmen to potential admissions problems in their areas. The AoA also needs to monitor related National Ombudsmen Reporting System data for patterns of abuse.

COMMENTS

We received comments on the draft report from the Health Care Financing Administration. They generally agree with our findings and our conclusion and note that our report is consistent with the early findings of their ongoing monitoring efforts. A copy of their comments is provided in Appendix B.

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INTRODUCTION

PURPOSE

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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 adequacy of the payments and the effect of the new system on patients and on 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 100 days per benefit period, with a co-payment required for days 21 through 100.

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 5.9 percent of the Medicare budget.

Medicare Payments to Nursing Homes

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. 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.

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 any early 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. They place patients 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.

Nursing Home Concerns

The nursing home industry has raised several concerns about the new reimbursement system. The industry believes that the system is causing considerable pressure on SNFs and that it will reduce payments to these facilities. In media reports, industry representatives have expressed concern that the new system may cause some SNFs to go out of business.

METHODOLOGY

We conducted this inspection in two stages. First, we conducted a survey of hospital discharge planners. To do this, we randomly selected a total of 200 hospitals in eight States. We contacted each hospital and sought to interview the discharge planning supervisor or the staff person who

was most familiar with the study issues. We were able to interview a total of 180 discharge planners between June 16, 1999 and June 25, 1999. We specifically asked respondents about their ability to place different types of patients in nursing homes and about changes in nursing home admissions practices in the past year. In order to isolate the effect of the new payment system, our analysis is primarily based on patients who are likely to leave the nursing home when their Medicare Part A coverage ends. However, we also asked questions about patients who are likely to outstay their Medicare Part A coverage.

Second, we reviewed Medicare data from two sources. Specifically, we analyzed trends in the number of nursing home beds using data from the Provider of Services (POS) File which is based on the Online Survey Certification and Reporting System (OSCAR). We also analyzed post-hospital services from a one percent sample of Medicare beneficiaries from the Medicare National Claims History File.

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 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 25 hospitals within each of these States. This State sample is the same as the one used for two related studies being conducted by the Office of Inspector General. These forthcoming studies are: *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, this report is limited to identifying only early effects of the new reimbursement system. The majority of SNFs started shifting to the prospective payment system as of January 1, 1999. In addition, the most recent Medicare data that were available for this report include the first five months of 1999. Note that time lags may occur and that these data may not be complete.

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

FINDINGS

So far, no serious problems in placing Medicare patients in nursing homes are apparent. However, nursing homes are changing their admissions practices in response to the prospective payment system.

The following findings present a more detailed discussion of Medicare beneficiaries' access to nursing home care. They also describe early effects on access due to changes in nursing home admissions practices.

Generally, discharge planners report that they can place Medicare patients.

Most discharge planners (66 percent) report that it is "not at all difficult" to place patients in nursing homes when their stay will be paid under the Medicare prospective payment system. Another 32 percent say that it is "somewhat difficult," while 1 percent report that it is "very difficult." Discharge planners do not indicate that they are unable to place these patients. They commonly explain that nursing homes generally want Medicare patients because they are short-term or because nursing homes are reimbursed at a higher rate for these patients than for Medicaid patients. Some discharge planners also note that there is an adequate number of beds available in their area and therefore it is not difficult to place these patients. Further, most discharge planners (60 percent) report that nursing homes never or rarely refuse Medicare patients because they do not have a Medicare certified bed available.

At the same time, about a fifth of all discharge planners believe that it has become more difficult to place Medicare patients in the past year because of the new prospective payment system. Also, 44 percent of discharge planners report that it has become more difficult to place patients whose Medicare Part A coverage will likely end before they are discharged and who will then become Medicaid residents. However, discharge planners do not generally attribute this to the prospective payment system.

Medicare data show no changes in nursing home placements.

Medicare data generally support discharge planners' views. The data indicate that Medicare patients are still being placed in nursing homes. Specifically, the data show no change in where Medicare patients are being placed. As shown in Table 1, the proportion of all Medicare hospital discharges that went to SNFs does not differ between the first five months in 1998, which is prior to the implementation of the prospective payment system and the same five months in 1999, which is after the implementation of the new system.

Table 1
Distribution of Medicare Discharges to Post Hospital Services, First Five Months of 1998 and 1999

Post Hospital Service	January to May 1998 Percent of Total Discharges	January to May 1999 Percent of Total Discharges	Difference 1998-1999
Home	58.7	57.2	-1.5
SNF	15.6	15.4	-0.2
Home Health	9.8	10.8	1.0
Intermediate Care	2.5	3.1	0.6
Other	13.5	13.5	0.0

Source: Medicare National Claims History File

The data also do not show any large changes in the types of Medicare patients who are being placed in nursing homes. As shown in Table 2, there are no substantial differences in the diagnoses of patients who were discharged to SNFs in the first five months of 1998 compared to the same time period in 1999. The ten most common diagnoses discharged to SNFs are the same in both years.

There are small differences in the proportion of discharges to SNFs for a few of the individual diagnoses. The largest difference is the proportion of discharges to SNFs for stroke patients. This proportion decreased by 1.4 percentage points from the first five months of 1998 to the same period in 1999.

Table 2
Distribution of Medicare Discharges by Diagnosis Related Groups, First Five Months of 1998 and 1999

DRG	Description	January to May 1998 Percent of Discharges to SNFs	January to May 1999 Percent of Discharges to SNFs	Difference 1998-1999
209	Major joint limb reattachment	7.2	6.6	-0.5
089	Simple pneumonia and pleurisy	6.9	7.2	0.4
014	Specific cerebrovascular disorders	6.0	4.5	-1.4**
127	Heart failure and shock	5.1	5.0	-0.0
079	Respiratory infections and inflammation	3.7	3.9	0.2
210	Hip and femur procedures	3.5	4.0	0.5
416	Septicemia	3.0	3.1	0.1
296	Nutritional/misc. metabolic disorders	2.9	3.3	0.4
088	Chronic obstructive pulmonary disease	2.6	2.5	-0.2
320	Kidney and urinary tract infections	2.5	2.9	0.4

**Statistically significant at the .01 level.

Source: Medicare National Claims History File
Note: Differences may be due to rounding.

Further, it is important to note that the most recent available data show that at the time that the prospective payment was implemented, the total number of discharges to SNFs was increasing. As shown in Table 3, in 1996, there were about 1.7 million discharges to SNFs, which amounted to about 13.6 percent of all Medicare hospital discharges. In 1998, the number of discharges to SNFs increased to approximately 1.8 million, which was about 15.3 percent of all Medicare hospital discharges. (Similar data are not available for 1999.)

Table 3
Distribution of Medicare Discharges to Post Hospital Services, 1996 to 1998

Post Hospital Service	1996 Percent of Total Discharges	1997 Percent of Total Discharges	1998 Percent of Total Discharges	Difference 1996-1998
Home	60.1	59.0	58.9	-1.2
SNF	13.6	14.5	15.3	1.6
Home Health	10.8	10.7	9.8	-1.0
Intermediate Care	2.4	2.4	2.6	0.2
Other	13.1	13.4	13.4	0.3

Source: Medicare National Claims History File
Note: Differences may be due to rounding.

Two-thirds of discharge planners also report that the total number of Medicare patients they discharge to nursing homes has increased over the past two years. Most of these respondents suggest that this increase is due to a greater number of patients who are elderly and who need skilled care. They also note that patients are staying in the hospital for shorter periods of time and that some are leaving sicker and therefore more likely to need skilled care. Few discharge planners (7 percent) mention that changes in the number of Medicare patients discharged to nursing homes are the result of the new prospective payment system.

In addition, annual Medicare data show an increase in the total number of Medicare beds, which is a key factor in nursing home access. As shown in Table 4, in 1998, there were approximately 17,300 nursing facilities with about 1.86 million nursing home beds nationwide. About 722,000 of these beds, or nearly 40 percent, were Medicare certified. Since 1996, the total number of Medicare certified beds has increased by 7 percent. Thus, an increase in capacity was occurring just as the new perspective payment system was coming on-line.

Table 4
Total Number of Nursing Home Beds, 1996 to 1998

Nursing	1996	1998	Percent Change 1996-1998
Total Beds	1,848,335	1,861,281	0.7%
Total Medicare Beds	672,329	722,278	7.4%

Source: Provider of Services File

Discharge planners generally confirm these national trends. The majority (93 percent) state that the total number of nursing home beds in their area has remained the same or has increased over the past two years. Further, more discharge planners report an increase in the number of Medicare certified beds than those who report an increase in all nursing home beds. Less than 10 percent of discharge planners attribute changes in the supply of nursing home beds in their area to the new prospective payment system.

In addition, about eight percent of discharge planners report that they are aware of a nursing home closing in their area in the past year. One percent report that a nursing home has closed as the result of the prospective payment system. Others believe that these closures are due to poor management or fraud. Note that we did not independently verify these reports.

Nursing homes are changing their admissions practices in response to the prospective payment system.

About half of all discharge planners report that nursing homes have changed their admissions practices as a result of the new prospective payment system. Nearly two-thirds state that the new system has had some effect on their ability to place Medicare patients in nursing homes. Discharge planners explain that in the past year nursing homes have requested more detailed clinical information about patients. They note that nursing homes are increasingly looking at the cost of care and of services before making admissions decisions. In some cases, nursing homes review the cost of patients' medications. Discharge planners also observe that nursing home staff are more consistently coming to the hospital to directly assess the patient. About 20 percent of all discharge planners specifically note that nursing homes are less willing to accept patients

with certain medical conditions because of the prospective payment system. A similar proportion also say that nursing homes will only take patients for whom they will be reimbursed at a high rate.

The patients who have become harder to place are those who need extensive services.

When asked which types of Medicare patients have become more difficult to place in nursing homes, the majority of discharge planners (58 percent) identify patients who require extensive services. (See Table 5.) These types of patients typically require complex direct nursing care and expensive medications. They include patients who require intravenous feedings, intravenous medications, tracheostomy care, or ventilator/respirator care.

Discharge planners report that some types of special care and clinically complex patients have also become more difficult to place in the past year. Specifically, they mention patients who need dialysis and patients who have surgical wounds or open lesions that require substantial direct nursing care time and special supplies and medications.

Additionally, discharge planners comment that in the past year some other types of patients have become harder to place. These include patients who require isolation, especially those with antibiotic resistant infections, patients who have multiple diagnoses, and patients with behavior problems.

Several discharge planners suggest that some of these patients may be harder to place because the cost of their care may be higher than the amount that nursing homes are reimbursed under the prospective payment system. A few discharge planners note that nursing homes have told them that some of the supplies and equipment required by extensive services patients, such as IV medications and ventilators, are too costly for them to provide under the new reimbursement system. Several also observe that nursing homes are reluctant to accept patients with high transportation costs, especially dialysis patients, because the cost of transporting these patients may exceed the amount that nursing homes are reimbursed for these patients under the prospective payment system.

Table 5
Clinical Conditions That Have Become Harder to Place in the Past Year

Clinical Condition*	Percent of Discharge Planners
Dialysis	33.8
IV Medications	31.5
Ventilator/Respirator	28.8
Surgical Wounds or Open Lesions	17.7
Isolation/Antibiotic Resistant Infection	15.2
IV Feedings	15.0
Multiple Conditions	10.6
Behavior Problems	10.5
Alzheimer's	6.7
Tracheostomy Care	5.9
Radiation Treatment	5.6
Chemotherapy	4.7
Septemia	4.6
Dementia	4.0
Diabetes	3.4

* Categories are not mutually exclusive

Source: OEI Discharge Planning Survey, June 1999

The patients who have become easier to place are those who need rehabilitation services.

Most discharge planners (69 percent) report that Medicare patients who need special rehabilitation have become easier to place in nursing homes in the past year. (See Table 6.) They most commonly report that orthopedic patients, who have had a hip or knee fracture or joint replacement, and stroke patients, who require intensive short-term rehabilitation, have become easier to place. At the same time, some discharge planners do not cite specific diagnoses, but rather comment that patients who require rehabilitation therapy such as physical, occupational, or

speech therapy have become easier to place. Several discharge planners explain that patients needing rehabilitation generally have short stays in nursing homes and become independent in activities of daily living quickly. Further, it is important to note that special rehabilitation is reimbursed at the highest rate under the prospective payment system.

Table 6
Clinical Conditions that Have Become Easier to Place in the Past Year

Clinical Condition*	Percent of Discharge Planners
Orthopedics	54.7
Stroke/CVA	34.5
Physical Therapy	16.2
Rehabilitation Therapy (general)	13.9
Occupational Therapy	3.0
Speech Therapy	2.0

* Categories are not mutually exclusive Source: OEI Discharge Planning Survey, June 1999

Evidence that Medicare patients are staying in hospitals longer is mixed.

About half of discharge planners believe that the number of Medicare patients who have extended lengths of stay has increased in the past year. One-third report that this increase is due to the new prospective payment system. They explain that nursing homes are focusing on the cost of medical supplies and services and that they are being more selective about which types of patients they accept. Others attribute the increase in extended stays to fewer beds being available in their area or to a general increase in the number of patients who need skilled care.

Discharge planners explain that patients who are difficult to place generally remain in the hospital until they can be placed in a nursing home. Some discharge planners attempt to place these patients farther away or in alternate forms of care such as home health. In some cases, patients who are the most difficult to place stay in hospitals until they are able to go home.

Medicare data, however, do not show any substantial increases in the average lengths of stay for the ten most common diagnoses discharged to SNFs. As shown in Table 7, the average lengths of stay of these diagnoses are similar for the first five months of 1998 and the first five months of 1999. Note that the average lengths of stay also do not increase for any of the three diagnoses that are affected by the transfer policy, which we would expect to increase the average length of stay.

Table 7
Average Length of Stay by Diagnosis Related Groups,
First Five Months of 1998 and 1999

DRG	Description	January to May 1998 Average Length of Stay	January to May 1999 Average Length of Stay	Difference 1998-1999
014	Specific cerebrovascular disorders [1]	9.6	8.2	-1.4
079	Respiratory infections and inflammation	9.3	9.1	-0.2
088	Chronic obstructive pulmonary disease	6.7	6.8	0.1
089	Simple pneumonia and pleurisy	7.2	7.3	0.1
127	Heart failure and shock	7.8	7.7	-0.1
209	Major joint limb reattachment [1]	5.4	5.3	-0.1
210	Hip and femur procedures [1]	6.8	6.7	-0.1
296	Nutritional/misc. metabolic disorders	7.3	7.1	-0.2
320	Kidney and urinary tract infections	5.9	6.6	0.7
416	Septicemia	9.8	8.6	-1.2

[1] Included in the transfer policy Source: Medicare National Claims History File

Differences were not statistically significant at the .05 level

CONCLUSION

It appears that in an early response to the prospective payment system, some nursing homes have modified their admission practices. However, despite this practice change, there is no direct evidence that Medicare patients are not receiving the SNF care they require. This is partly due to an overall increase in the number of Medicare beds and to the fact that Medicare continues to reimburse at a higher rate than Medicaid, which is the primary payer of nursing home care.

We stress that this is an early assessment of the effects of the prospective payment system on access. We believe that the Department must remain vigilant to potential problems for Medicare patients and for nursing homes. As part of this effort, we will periodically replicate this study of discharge planners and analysis of Medicare data. We will particularly focus on the types of patients who were identified as being more difficult to place. Additionally, we suggest that the Administration on Aging (AoA) alert long-term care ombudsmen to potential admissions problems in their areas. The AoA also needs to monitor related National Ombudsmen Reporting System data for patterns of abuse.

COMMENTS

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APPENDIX A

CONFIDENCE INTERVALS FOR KEY FINDINGS

We calculated confidence intervals for 7 key findings. The point estimate and 95% confidence interval are given for each of the following:

KEY FINDINGS	POINT ESTIMATE	
It is not difficult to place Medicare patients in nursing homes.	65%	61 - 69%
It has become more difficult to place Medicare patients in the past year because of the new prospective payment system.	19%	6 - 32%
Nursing homes have changed their admissions practices as a result of the new prospective payment system.	53%	47 - 59%
The new system has had an effect on discharge planners' ability to place Medicare patients in nursing homes.	65%	60 - 70%
Patients requiring extensive services have become more difficult to place in nursing homes in the past year.	58%	54 - 62%
The number of Medicare patients who have extended hospital stays has increased in the past year because of the new prospective payment system.	32%	20 - 44%
Medicare patients who need special rehabilitation have become easier to place in nursing homes in the past year.	69%	59 - 79%

APPENDIX B

Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 20 1999

TO: June Gibbs Brown
Inspector General, Department of Health and Human Services

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Early Effects of the Prospective Payment System for Skilled Nursing Facilities," (OEI-02-99-00400)

We appreciate the Inspector General's work to assess the impact of the changes in Medicare's payment system for nursing homes on the access to care for beneficiaries. Protecting beneficiaries' access to quality skilled nursing care is an essential goal for all of us.

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 1990 to $12.1 billion in Fiscal Year 1997.

The Balanced Budget Act of 1997 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.

Your report concludes that, despite some changes in admissions practices at skilled nursing facilities, Medicare beneficiaries who require post-acute care are getting placed into appropriate facilities. This is consistent with the early conclusions of our own on-going monitoring efforts.

We know that there are concerns that, for some high-acuity patients, the payment system might not fully reflect the costs of non-therapy ancillary services. We are conducting research to evaluate the adequacy of payments under the new PPS, and will implement refinements to the payment system next year if the research indicates that changes are warranted.

We also agree that we must 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, which will help us assess and guide policies to better serve our beneficiaries. We will continue to evaluate additional evidence 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 Balanced Budget Act that may adversely affect beneficiaries' access to quality services. We will 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 critical program to meet their health-care needs.