Medicare Prospective Payment in SNFs And Its Impact on Nursing Home Residents

Questions for Ombudsmen Considering The Care of Medicare Patients in Nursing Homes

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Introduction

Although Medicare pays for only 10 percent of nursing home expenditures, for over a decade the program's impact on nursing home care has greatly exceeded its relatively small proportion of nursing home costs. In the 1990s, many skilled nursing facilities (SNFs) began dumping residents who received Medicaid to make room for more lucrative Medicare patients who were being discharged from hospitals. Some began to call themselves "subacute care facilities," touting new, higher levels of rehabilitation services and skilled nursing care. Large chains reaped hundreds of millions of dollars (some of them illegal) by providing lucrative therapy services.

Most of the uncontrolled growth in Medicare spending was in these so-called "ancillary services" – physical, occupational and speech therapies – that were paid for under Part B of Medicare and had no cost limits. Between 1992 and 1995, ancillary costs increased 18.5 percent a year, compared to 6.4 percent in routine costs under Part A. The Department of Health and Human Services Office of Inspector General (OIG) and the U.S. General Accounting Office (GAO) reported that therapy costs were inflated and that unnecessary services were often provided.

This growth set the stage for Congress to pass legislation to control Medicare expenditures for post-acute care and to curb the abuses. The Balanced Budget Act of 1997 (BBA) implemented a prospective payment system (PPS) for SNFs and other post-acute care providers, including home care agencies. In 1998, SNFs began receiving a flat rate for people admitted as Medicare Part A patients, based on the resources the patients were expected to need (including nursing and therapy). Part B therapy costs were capped at $1,500 per resident.

Nursing homes, particularly the large, for-profit chains, charged that "Medicare cuts" had gone too far and caused massive bankruptcies in the industry. This debate is still continuing, although Congress has made adjustments in the law and payment amounts and several government reports convincingly refute claims that the cost controls themselves were responsible the industry's financial distress.

Medicare funding for SNFs increased dramatically in the 1990s. By the end of the decade, it had dropped significantly. Were patients and residents better off when nursing homes were reaping Medicare windfalls? Are they worse off now, when rates are fixed?

Unfortunately, government studies do not shed much light on the quality of care either before or after PPS. The OIG insists that most Medicare beneficiaries can find a SNF bed when they need it, even though many ombudsmen and hospital discharge workers in an OIG survey said placement became more

difficult after PPS was implemented. This paper reviews what is known about PPS's incentives for nursing homes to admit – or refuse – Medicare patients, and to provide too little – or too much – care. The National Long Term Care Ombudsman Resource Center hopes that this information will help ombudsmen understand the Prospective Payment System and its impact on Medicare beneficiaries' ability to get the services they need under Medicare.

I. PPS: The New Reimbursement System for SNFs

Medicare patients who have been in the hospital for at least three days may be eligible to continue their care in a skilled nursing facility for up to 100 days. Long-term nursing home residents can receive this coverage in their own nursing home if it is one of about 13,000 facilities that accept Medicare. Since hospitals have a prospective payment system that pays a flat rate for a patient's entire length of stay, they have a financial incentive to discharge patients as quickly as possible to another provider.

When patients or residents are admitted, or readmitted, to a SNF with Medicare coverage, they are assessed within five to eight days using the Minimum Data Set (MDS). MDS is the instrument required by the Nursing Home Reform Act to collect medical and psychosocial data on residents for care planning and quality assurance purposes. (Medicare assessments are repeated on the 14th, 30th, 60th and 90th days.) For Medicare purposes, the MDS data are used to classify the patient into a Resource Utilization Group (or RUG-III, for version three) based on the medical services and functional support the patient is expected to need. There are 44 RUG-III categories. Each category factors the average amount of staff time, supplies, and services used, on average, for patients classified in that group. The RUG determines the *daily* rate Medicare will pay for that patient. (Rates range from a high of almost $700 a day for high-end rehabilitation patients to a low of $130 a day.)

As noted in the introduction, in the years before PPS, nursing homes made huge profits on therapy services they provided under Medicare's Part B. RUG-III now includes these services in the flat Part A rate. While government experts and even many providers believe these rates are adequate and even generous for the care of all but the heaviest-need patients, any flat rate reimbursement system creates incentives for providers to cut corners on access or quality to enhance profits.

II. PPS' Impact on the Quality of Nursing Home Care

Are PPS Rates Adequate for All Patients?

Although Medicare pays only about 10 percent of all nursing home costs, the for-profit nursing home industry mounted a heated campaign to convince Congress and the public that Medicare cuts were responsible for nursing home bankruptcies that threatened the care of thousands of nursing home residents. The American Health Care Association maintained that Medicare reductions had turned out to be twice as large as Congress intended when it passed the Balanced Budget Act.

General Accounting Office (GAO) testimony at a Senate hearing in September 2000, contradicted the industry's claims that rates were inadequate. GAO called SNF payments "sufficient" and "in some cases, even generous." The agency said payments were currently about the same as the "excessive" rates in effect in 1996. At that time, Medicare SNF *payments* had been increasing at 12 percent a year while SNFs' *costs* were increasing at 3 percent a year.

Nevertheless, GAO said the system may not be adequately distributing payments to the highest-need patients, "which could result in access problems or inadequate care for some high-cost beneficiaries. At the same time, nursing homes treating patients with low service needs may be overpaid."[1]

In a report released in May 2000, HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE) said that both consumer groups and providers it interviewed were concerned that SNFs were cutting costs by using lower-paid staff to administer therapies; for example, both registered nurses and nursing assistants might be performing respiratory therapy for which they had had no specialized training.[2] However, the Inspector General found similar problems with use of unskilled workers when she looked back at Medicare expenditures in SNFs *before* PPS was implemented. (See more below.)

Does PPS Encourage Providers to Let Residents Decline?

Whenever government pays providers a higher rate for residents who need more care, consumer advocates worry that the reimbursement system gives providers incentives to let resident's decline. Under PPS, a SNF that allows a resident on Medicaid to develop a bedsore can actually increase the reimbursement it receives for her care. If she has to be hospitalized for treatment

[1] GAO, *Nursing Homes: Aggregate Medicare Payments Are Adequate Despite Bankruptcies*, Testimony Before the U.S. Senate Special Committee on Aging, September 5, 2000

[2] ASPE, *Post-Acute Care Issues for Medicare: Interviews with Provider and Consumer Groups, and Researchers and Policy Analysts*, May 2000

and is readmitted to the nursing home as a Part A Medicare patient, the nursing home will be paid a substantially higher rate while she is eligible for Medicare. The Center for Medicare Advocacy recommends including a mechanism in the reimbursement system to verify that a resident's decline was not caused by poor care. The center says the regulatory system for nursing homes "is too weak to counteract the payment incentives in the proposed reimbursement system."[3]

Does PPS Encourage Inappropriate Care?

Consumer advocates have been concerned for years that fixed, case-mix adjusted rates encourage poor care practices by paying higher rates for them.

PPS provides nursing homes financial incentives to provide high-cost services, such as tube feeding, that residents may not need and that may endanger their health and quality of life. The Health Care Financing Administration acknowledged that PPS can create "negative incentives" for facilities to make a profit on items or services that may be associated with poor care. In proposed modifications to PPS rates in April 2000, HCFA said it had decided not to include a higher rate for indwelling catheters because of reports associating increased reimbursement with greater use of catheters.

Can Providers Manipulate RUGs Classification for Higher Payment?

As noted above, nursing homes use the same data collection system – the Minimum Data Set, or MDS – to determine Medicare payment rates that they use for resident assessment and care planning. MDS information, collected and certified by a nurse, is used to determine the Resource Utilization Group, or RUG-III, the patient will belong to. The RUG-III determines the daily amount that will be paid for the resident or patient's care. Even the slightest change in the assessment of a resident's needs can shift him or her into a higher RUG-III category – increasing reimbursement without increasing the nursing home's costs.

The American Nurses Association (ANA) advised its members that PPS gives nurses "the opportunity to ensure quality of care and at the same time directly determine the payment for that care. Now that money is involved, the importance of assessments will be obvious to administrators." ANA urged nurses to reject "pressure to 'enhance' assessment to qualify for payment above that actually due for the resident."[4]

[3] Center for Medicare Advocacy, Inc., Comments on Proposed Rules for Prospective Payment of Skilled Nursing Facilities Under the Medicare Program, June 9, 2000

[4] ANA, Prospective Payment System for Long Term Care

Does PPS Encourage Excessive Care?

An OIG "probe" of physical and occupational therapy provided to Medicare Part A patients in California SNFs, just before PPS was implemented, found "alarming" incidents of frail SNF residents receiving levels of physical therapy usually associated with acute rehab.

"Most alarming," said the report, "were instances where exceptionally frail patients or people with Alzheimer's disease or advanced senility and dementia received 4 to 5 hours of therapy per day for several weeks."[5]

Although PPS was supposed to curb abusive uses of therapy to enhance reimbursement, it gives nursing homes incentives to provide medically questionable therapies to obtain higher payments.

An article in a professional journal in 1999 described how physical therapists could maximize the number of days and minutes they assessed patients for therapy to ensure that they qualified for the "ultra high" rehabilitation reimbursement category. The article acknowledged that this might require starting some patients on therapy immediately upon their discharge from the hospital, before they were medically stable. If a decision were made to postpone therapy until the patient was stronger, it suggested, therapists should be prepared to document the need for an intensified regimen to make up for the initial time lost.

The article said the ultra high reimbursement level could also be obtained by scheduling therapies on weekends and evenings, and increasing the number of days per week from five to seven. It noted, however, that residents might recover more quickly with this strategy, thus "diminishing [the] financial returns to the facility."[6]

III. PPS's Impact on Access to Nursing Homes

Is It More Difficult Now to Place Medicare Patients in Nursing Homes?

Since PPS rates are based on average costs of caring for certain types of patients, people whose needs are greater than average generate less profit. Therefore, they may have more trouble finding a SNF that will admit them.

- In a government survey of state ombudsmen in 2000, 18 ombudsmen reported there were no problems finding beds for Medicare patients in nursing

[5] OIG, *Medical Necessity of Physical and Occupational Therapy in Skilled Nursing Facilities: California Probe Sample Results*, April 1998

[6] Ciolek, Daniel, "Medicare in the Skilled Nursing Facility Under the Prospective Payment System; The New Managed Care: Implications and Strategies for Clinical Care Delivery," *Issues on Aging*, 1999,Vol.22

homes in their state. However, five state ombudsmen said access to nursing home care was a "large problem," and 26 answered that it was "somewhat of a problem."[7]

- In a separate survey of 202 hospital discharge planners in May and June 2000, 44 percent said they sometimes had difficulty placing Medicare patients, and 12 percent said they "always" or "usually" experienced delays. Sixty-nine percent of those who reported delays attributed them to PPS. They said the most difficult patients to place were those who required intravenous therapy or expensive drugs, or who were medically complex and required more staff time. Also cited as hard to place were ventilator patients; patients with infectious diseases; renal failure/dialysis patients; people with behavioral symptoms (dementia); and patients with feeding tubes. More than half of the discharge planners reported that since PPS, nursing homes were more likely to require additional information or conduct on-site visits to evaluate the patient. A few said nursing homes analyzed patients' reimbursement rates before accepting them.[8]

ASPE concluded after interviews with a large number of consumer and provider organizations in 2000 that SNFs "have incentives under the PPS to move toward providing more services to less costly, more traditional long-term care patients." That is because "nonancillary" therapy costs – such as ventilator care, prescription drugs, and prosthetic devices – were not incorporated into the PPS daily rate. Patients with high costs in those areas would thus be less attractive to providers.[9]

Did Spending Controls Cause Residents to Lose Access to Therapies?

Nursing home residents who are not receiving Part A benefits may be eligible to receive therapy under Medicare Part B. In the Balanced Budget Act (BBA), Congress capped Medicare Part B reimbursement for therapies at $1,500 to end abuses of the Part B program. Greeted with loud protests from the long term care industry (and concern from consumer advocates who felt the amount might not be adequate for some residents), Congress suspended the limits for two years (2000 and 2001). During 1999, the year the caps were in effect, OIG said there was a 14 percent drop in the number of SNF patients receiving Part B therapies. OIG concluded that during this period, residents received less therapy, received therapy that was not billed to Medicare, or "received maintenance therapy from nonskilled nursing home staff that previously would have been billed as skilled therapy." However, OIG concluded, "we should see a rebound in SNF Part B therapy charges in 2000 and 2001 [when the caps are lifted]."[10]

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[7] OIG, *The Effect of Financial Screening and Distinct Part Rules on Access to Nursing Facilities*, June 2000

[8] OIG, *Medicare Beneficiary Access to Skilled Nursing Facilities: 2000*; September 2000

[9] ASPE, *Post-Acute Care Issues for Medicare: Interviews with Provider and Consumer Groups, and Researchers and Policy Analysts*, May 2000

[10] OIG, *Monitoring Part B Therapy for SNF Patients*, November 2000

In the 2000 budget act, Congress extended the moratorium on caps through 2002.

Do Some Patients Have Better Access than Others?

By most accounts, people who require rehabilitation services experience fewer delays finding care because they are reimbursed under the highest RUG-III categories.

Did Residents Receive Better Care Before Congress Controlled Costs?

Although Medicare payments to nursing homes increased six-fold between 1990 and 1998, more money was concentrated on profitable physical, occupational and speech therapies under Part B, not on routine costs under Part A, such as nursing, where spending levels were controlled.

The nursing home industry now maintains it needs more money from Congress to provide adequate nurse staffing, but nursing levels in Medicare facilities did not improve significantly during the years when Medicare rates were increasing at 12 percent a year. OIG reported that during that time, SNFs received $145 million in overpayments for therapy provided by staff who did not have appropriate skills.

Did PPS Cause the Nursing Home Industry's Financial Problems?

At the September 2000, Senate Special Committee on Aging hearing on bankruptcies, GAO testified that the industry's troubles could "be traced to strategic business decisions made during a period when Medicare was exercising too little control over its payments." Senator Charles Grassley (R-IA), then chairman of the committee, expressed GAO's findings more brusquely: "Some corporate executives, their investors, and bankers gambled on a vision of ever-growing government largesse. They got hurt because this vision wasn't based on reality."

The committee summarized witnesses' testimony about factors that contributed to bankruptcies in nursing home chains:

- Business decisions based on a belief that Medicare payments would continue to increase without limit.
- The overuse of therapies and related services at inflated costs.
- Enormous debt burdens created by aggressive merger activity.
- Private payers (such as HMOs) negotiating tough contracts.

- Competition from assisted living and home care.

- Decreased revenues due to efforts to fight fraud, waste and abuse in the industry. [Several bankrupt chains had been charged with defrauding Medicare of hundreds of millions of dollars even as they complained about cost controls.]
- Litigation and related insurance costs.[11]

Since the aging committee hearing, the industry has turned its primary attention to the adequacy of Medicaid reimbursement, which pays 40 percent of nursing home costs.

IV. The Future of Prospective Payment

In spite of government reports showing that PPS rates are adequate for most patients and that nursing homes' financial woes are largely related to their previous abuses of the Medicare system, the nursing home industry has waged a successful campaign to get Congress to restore some of the funds lost when PPS was implemented. The 2000 budget act:

- Increased the inflation adjustment for Medicare rates.

- Extended the moratorium on implementing the $1,500 Part B therapy caps through 2002.

- Required GAO to study whether Medicare rates are adequate.

- Increased the Medicare daily payment rate for nursing services by 16.66 percent. The increase in the payment for nursing reflects the concern of some members of Congress – especially Senator Grassley, now chairman of the Senate Finance Committee – that federal funds are not being used to support basic quality of care. The $1 billion increase is accompanied by a requirement for GAO to conduct an audit to determine whether the additional funds make a difference.

The next concern for consumer advocates may be a new assault in the Congress against "paperwork." The minimum data set (MDS) has wide support as a resident assessment tool for care planning and also providing data to help states assess whether nursing facilities are providing appropriate care to individual residents. However, over time it also has generated complaints from

[11] U.S. Senate Special Committee on Aging Press Release, September 5, 2000

some nurses that conducting the assessment takes too much time away from hands-on care. The use of MDS as a critical tool for determining reimbursement rates has increased some providers' resistance to using it.

MedPAC, the Medicare Payment Advisory Commission, recently issued a report saying that the MDS had resulted in a "high rate of error" in Medicare SNF rates. The commission, headed by a prominent Republican and former HCFA Administrator, Gail Wilensky, called for developing a new classification system. Consumer advocates will be concerned about maintaining the MDS for resident assessment, care planning, and quality indicators if a new payment classification system is developed.

Proposed Medicare reforms and reorganization of the Health Care Financing Administration – also high on the current Administration and Congress's agenda – could also shape the Medicare system in skilled nursing facilities in ways that would not have been anticipated even a year ago.

About the Author

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