126291
30548

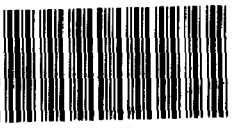
UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

PROGRAM EVALUATION
AND
METHODOLOGY DIVISION

B-217732

FEBRUARY 21, 1985

The Honorable John Heinz
Chairman, Special Committee
on Aging
United States Senate


126291

Dear Mr. Chairman:

Subject: Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report (GAO/PEMD-85-8)

On February 12, 1985, you asked us to provide a preliminary report on our study of the information needed to assess the impacts of the Medicare prospective payment system (PPS) on post-hospital long-term care. You expressed a particular interest in a statement and explanation of the key issues. We have identified four key issues:

1. Have patients' post-hospital care needs changed?
2. How are patients' needs being met?
3. Are patients having access problems?
4. How have long-term-care costs been affected?

In addition to these key issues, we found that the long-term-care community is concerned about whether Medicare is adequately apprising beneficiaries of the changes brought on by PPS and whether Medicare is appropriately administering coverage determinations.

PPS was intended to control Medicare hospital costs. This reimbursement system, which is based on fixed payments for diagnosis-related groups, provides hospitals with incentives to limit costs incurred for each Medicare patient by carefully controlling the amount of services provided or limiting length of stay or both. Although there is concern that these actions could adversely affect the quality of care, experts have argued that some reduction in hospital services or length of stay and costs is possible without sacrificing quality. Shorter hospital stays might also, in some cases, reduce patients' risk of infection and provide them with additional positive benefits.

However, experts have also expressed a variety of concerns about the possible effects of PPS on the quality of care. Among the most important are that some discharges from the hospital may be premature, the availability and affordability of the appropriate follow-up care may not be guaranteed, and the medical needs of patients referred to nursing homes, home health care, and other forms of care provided in the community could be greater than providers are equipped to handle. In addition, it has been argued that increases in Medicare patients' use of long-term-care services could partially or fully offset the savings in hospital costs and thereby affect total Medicare costs. Changes brought on by PPS might also increase the costs of other public programs, particularly Medicaid, and the costs incurred by individual Medicare beneficiaries and their families.

OBJECTIVES, SCOPE, AND METHODOLOGY

In 1984, we initiated a study designed to identify the information that is necessary for addressing the key post-hospital issues associated with PPS. The objectives of this study are to

1. identify and develop the key issues related to the post-hospital care of Medicare patients given currently available information and the experiences of individuals with firsthand knowledge of prospective payment systems and

2. review the data collection and analysis under way or planned by the U.S. Department of Health and Human Services (HHS) to address the key issues and to determine whether additional work or refinement to ongoing work is needed to insure that the information the Congress needs to address the key issues will be available, valid, and timely.

Our work on the first objective, the development of the key issues, is complete. Our work on the second objective, reviewing the activities of HHS in data collection and analysis, is nearing completion. This preliminary report focuses on our assessment of the most important issues that HHS should address in evaluating the impacts of PPS on post-hospital care.

We identified potential issues from four broad sources of information. First, a review of the literature and research, including our earlier reports, helped us define the potential issues. In addition, we met with HHS officials and other experts on health care financing and health services research. Second, group discussions with representatives of national associations of hospitals, nursing homes, home health care agencies, and advocates for the elderly helped us better understand their

perspectives on the issues. Third, short visits were made to six communities in July 1984 (Adrian, Michigan; Corpus Christi, Texas; Orlando, Florida; Pittsburgh, Pennsylvania; Richmond, Virginia; and Seattle, Washington). These visits allowed us to talk to local providers of care (representing hospitals, home health agencies, and skilled nursing facilities) as well as representatives of advocate groups, health-planning agencies, and peer-review organizations. We asked them to tell us, from their experience, how they expected PPS to affect long-term care. Fourth, we conducted telephone interviews with program officials and health industry experts in Maryland, Massachusetts, New Jersey, and New York, the states that have been granted waivers from PPS because they have implemented alternative prospective payment systems.

The site visits were important in helping us develop the issues. Of course, our discussions at any one site were not necessarily representative of the views of the entire community or of its specific providers or consumers. However, we selected our sites carefully in order to achieve a wide coverage of the issues that are believed to be important. The criteria we used for selecting the sites were average length of stay in acute-care hospitals, the availability of nursing home beds, certificate-of-need regulations for establishing home health agencies, and population size.

The representatives of hospitals, nursing homes, and home health agencies and the discharge-planners and consumer advocates we met with had had as much as 9 months and as little as a few weeks of experience with PPS. We also talked with local health planners and representatives of peer-review organizations. Much of our information derives from the expectations that these people have based on their personal experience. In some instances, providers and local Medicare peer-review organizations were also able to provide us with data on changes in the use of long-term-care services after the introduction of PPS.

THE KEY ISSUES

Our key issues thus represent a distillation of the views of people working in different parts of the health care system at the federal, state, and local levels. Many of the same issues were raised in different forums by people representing different interests among providers and consumers living and working in different regions of the country. This reinforces our view that these issues are important.

1. Have Medicare patients' post-hospital needs changed? PPS creates strong incentives for hospitals to shorten patients' lengths of stay. In a December 1982 report to the Congress proposing a prospective payment system for Medicare, several

potential problems were discussed by HHS, including incentives in the system that could lead to the premature discharge of patients. We at GAO have raised similar concerns.[1]

Recent data on the use of hospitals under Medicare appear to show that hospitals have in fact responded by reducing lengths of stay. The average length of stay per PPS discharge in fiscal year 1984 was 7.5 days. The average length of stay per discharge in fiscal year 1983 (pre-PPS) was 9.5 days.[2] While reducing the length of a hospital stay may not affect a patient's need for follow-up care, it is also possible that some patients may be discharged at a time in their illness when they have substantial needs for care.

At each site we visited, the view was expressed in at least three groups among hospitals, nursing homes, and home health providers of care and advocates and discharge-planners that patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health than prior to PPS. In five of the sites, the issue of Medicare patients entering the various levels of post-hospital care (skilled nursing facilities, intermediate-care facilities, and home health) with more extensive service needs was raised in one or more of the meetings. Individuals in the four states with their own prospective payment systems also expressed the opinion that prospective payment may be associated with patients being discharged sooner and in poorer health. We were provided data by home health representatives in several communities showing more visits per case, more cases requiring multiple visits per week, and more need for specialized services such as I.V. therapy and catheters and ventilator care after the introduction of PPS.

2. How are patients' needs being met? To the extent that Medicare patients are discharged from hospitals sooner and with greater needs for care, PPS may increase the effective demand for the post-hospital nursing home and home health services covered by Medicare. HHS has predicted that the number of persons qualifying for the Medicare skilled nursing home benefit will increase. However, the Department's analyses indicate that a

---

[1]GAO Staff Views on the President's Fiscal Year 1984 Budget Proposals, GAO/OPP-83-1 (Washington, D.C.: March 4, 1983), pp. 69-72.

[2]The data for fiscal year 1984 are based on monthly billing data that have not been adjusted to reflect the geographic distribution of hospitals that began to implement PPS during the year or the slow reporting of complex hospital stay records. See "Report on PPS Monitoring Activities," Health Care Financing Administration memorandum, January 20, 1985, p. 4.

marked increase in the use of skilled nursing facilities may be precluded by such factors as the shortage of nursing home beds and the importance that state Medicaid reimbursement policies have in determining nursing homes' willingness to accept Medicare patients requiring skilled care.[3]

What we were told at our site visits was consistent with this HHS analysis. In meetings at the three sites where the beds in skilled nursing facilities are very scarce, the view was expressed that any increase in Medicare skilled nursing home placements may be effectively precluded. However, in the one site with a relatively large supply of unoccupied nursing home beds, we were told that some increase in Medicare skilled nursing home placements was anticipated.

Attributing increases in home health placements to PPS may be difficult. Medicare is the major buyer of home health services, and the program's expenditures for home health services were increasing rapidly before the introduction of PPS. Between 1969 and 1980, Medicare home health expenditures grew at an average annual rate of 21.4 percent.[4] The Congressional Budget Office has projected 20-percent annual increases in Medicare home health costs for 1985-89.[5] Determining the incremental effects of PPS on an already rapidly expanding service will involve fairly complex analysis.

We were told in meetings of home health care providers at five of the six sites that discharges of hospital patients to home health services covered by Medicare had increased, both as a result of a trend toward greater use of home health services that began before the introduction of PPS and because of incentives created by PPS to discharge patients from the hospital more quickly. In the sixth site, where average length of stay has been traditionally lower than in most of the rest of the nation, we were told in meetings with representatives of both hospitals and home health care agencies that there do not appear to be increased discharges to home health care.

---

[3]HHS, Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare (Washington, D.C.: January, 1985).

[4]Health Care Financing Administration, The Medicare and Medicaid Data Book, 1983 (Baltimore, Md.: 1983), p. 38.

[5]Congressional Budget Office, Reducing the Deficit: Spending and Revenue Options, part 3 (Washington, D.C.: February 1984), p. 73.

However, evidence of a trend toward increased use of home health services may not be showing up on early reports of the use of Medicare home health services that are based on hospitals' discharge data. At two sites, we compared hospital discharge data from peer-review organization files with data provided to us by hospital discharge-planners. A large proportion (in one hospital, 89 percent) of monthly hospital referrals to home health care were not showing up as discharges to home health care on the hospital discharge abstracts processed by the peer-review organizations.

3. Are patients having access problems? Medicare's skilled nursing facility benefit covers only skilled care and provides full payment for only the first 20 days of care. A $50 per day copayment applies from the 21st day to the 100th day, after which coverage ends. GAO has found that some nursing homes may prefer to avoid accepting Medicare patients who might become eligible for Medicaid after exhausting their Medicare benefits. This is because Medicaid reimbursement rates for skilled care are not always sufficient to cover the costs of skilled care for Medicaid patients.[6] GAO has also documented similar problems of access to nursing homes for patients whose service needs are extensive, the so-called "heavy care" patients. PPS may unintentionally increase the problems of Medicaid patients who are waiting in hospitals for nursing home beds.[7]

At each site we visited, problems of access were raised in meetings with health care providers or advocates for the elderly. Problems associated with arranging placements for patients who depend on Medicaid for reimbursement and those who require "heavy care" or the use of sophisticated "high-technology" services were mentioned. However, at two sites we were told in meetings with nursing home administrators that patients who need extensive care and can afford to pay private skilled nursing facility rates do not necessarily have the problem of finding nursing home beds that patients eligible for Medicaid do.

The combination of PPS incentives for hospitals to discharge Medicare patients as soon as possible and weak incentives for

---

[6] Improved Administration Could Reduce the Costs of Ohio's Medicaid Program, GAO/HRD-79-98 (Washington, D.C.: October 23, 1979), pp. 129-37.

[7] 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. 107-27.

nursing homes to admit some of them leads to the possibility of some inappropriate placements. Before the introduction of PPS, some patients who could not be placed in appropriate skilled-level beds remained in hospitals for considerable periods of time as so-called "back-up" patients. PPS provides stronger incentives for hospitals to discharge these patients. At several sites, we heard considerable speculation about what is going to happen to hospitalized Medicare patients who are difficult to place in appropriate long-term-care settings.

4. How have long-term-care costs been affected? If the introduction of PPS leads directly to a greater use of the nonhospital services that Medicare covers, including those provided by skilled nursing facilities and home health care agencies, the costs of these services will increase and thereby affect overall Medicare costs. There may be other effects on costs as well. For example, GAO has found that the use of home health care services may not be cost-effective for certain types of patients, compared to either nursing home care or hospital care.[8] Increases in the number of skilled staff employed by nursing homes and home health agencies to care for sicker patients may also mean increased costs for Medicare services.

If Medicare beneficiaries make greater use of various post-hospital services, the costs of other federally funded programs, particularly Medicaid, and of state-supported programs, insurers, and private payers may increase. Any increased use of Medicaid skilled-care or intermediate-care beds by post-hospital Medicare beneficiaries could increase the costs of the Medicaid program. In meetings with advocates for the care of the elderly and discharge-planners in four sites, the possibility was also raised that out-of-pocket expenses for post-hospital care for beneficiaries and their families will increase.

LONG-TERM-CARE COMMUNITY CONCERNS

We were told in site meetings with providers and advocates that beneficiaries are upset and confused about their Medicare benefits and how PPS has affected them. We heard reports that some patients are being told, improperly, that they have to leave the hospital because their Medicare coverage has run out. We also heard that they sometimes do not understand why they are denied coverage for home health care or skilled nursing facility care. If problems such as these are in fact widespread, better education is needed for beneficiaries and providers.

---

[8] The Elderly Should Benefit from Expanded Home Health Care but Increasing These Services Will Not Insure Cost Reductions, GAO/IPE-83-1 (Washington, D.C.: December 7, 1982), pp. 26-28.

In many of our site meetings with nursing home and home health providers, the view was expressed that Medicare was not making appropriate adjustments to coverage rules or reimbursement amounts in response to the perceived changes in the needs of the patients. In meetings with nursing home representatives at five of the six sites, we heard that Medicare and Medicaid reimbursement for skilled nursing home care does not meet the needs of some post-hospital patients. In all six sites, the view was expressed in meetings with home health representatives that either the restrictions of the rules on coverage or variations in fiscal-intermediary determinations of coverage created problems for discharged Medicare patients.

As we have reported in the past, some problems with coverage and eligibility determinations, particularly for home health services, reflect a lack of clarity in the Medicare regulations. We have found that under consistent application of those regulations, a fairly high proportion (27 percent in a 1981 study) of home health claims paid by Medicare do not meet program requirements for coverage.[9] More consistent enforcement of Medicare requirements may lead to more claims being denied, since changes in the administration of the home health benefit have been made to address the problems identified in our earlier report.

CONCLUDING OBSERVATIONS

We believe that the issues discussed in this report are sufficiently important to warrant HHS studies that will assess problems in access to and quality of post-hospital services supported by Medicare. In addition, we believe that studies should be done to analyze changes in long-term care and the total health care costs that are associated with PPS.

Because of variation in regional and local conditions, we believe that the extent to which the issues we have raised become serious problems may vary considerably. Differences in state and local long-term-care policy and in market conditions that shape demand and supply and the cost of post-hospital long-term care should be specifically addressed in the design of planned studies of PPS impacts.

As we indicated earlier, we are currently completing our work on our second objective, which is to review the data collection and analysis under way or planned at HHS for

---

[9] Medicare Home Health Services: A Difficult Program to Control, GAO/HRD-81-155 (Washington, D.C.: September 25, 1981), pp. 10-17.

addressing the key issues and determining whether additional work needs to be done to insure that valid information will be available in a timely manner.

As stated in your request, your urgent need for this preliminary report precluded us from obtaining agency comments. We will obtain advance review and ask for comments from HHS on our final report. Unless you publicly announce its contents earlier, we will make no further distribution of this report for 7 days. At that time, we will send copies to those who are interested and will make copies available to others on request.

Sincerely yours,

Eleanor Chelimsky
Director