BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Chairman, Subcommittee On Health And The Environment Of The Committee On Energy And Commerce

Preliminary Findings On Patient Characteristics And State Medicaid Expenditures For Nursing Home Care

In this report, GAO presents preliminary findings on the increasing disability and dependence of nursing home patients and the increasing difficulties States are experiencing in paying Medicaid nursing home expenditures. Because these trends are conflicting and because they are likely to continue over the next several years, the type of care provided to Medicaid patients is likely to change significantly. Adequate inspection and certification procedures should take these trends into account to insure that participating facilities meet the health and safety standards required by law.

GAO/IPE-82-4
July 15, 1982

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INSTITUTE FOR PROGRAM
EVALUATION

B-208217

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

Subject: Preliminary Findings on Patient Characteristics and State Medicaid Expenditures for Nursing Home Care (GAO/IPE-82-4)

On July 7, 1982, you requested our preliminary findings on State nursing home expenditures and the characteristics of patients in nursing homes because of their relevance to your review of proposed changes in procedures for the inspection and certification of nursing homes. The preliminary findings that we present here in response to your request are part of a larger study in which we examine Medicaid expenditures across 49 States (Arizona does not have a Medicaid program) and the District of Columbia, nursing home reimbursement rates, and the rate of change in the supply of beds in nursing homes across the Nation.

The current inspection (or survey) and certification procedures are designed to insure that Medicaid and Medicare nursing home residents are cared for in facilities that meet certain health and safety standards. On May 27, 1982, the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), proposed revisions to these procedures. One of these revisions would allow the surveying of homes every two years rather than annually. Another would delete the rule that an on-site inspection be conducted within 90 days of identifying deficiencies in a nursing home during a survey.

Our analysis of trends in the nursing home industry, particularly trends related to State nursing home expenditures and the characteristics of nursing home patients, reveals two important considerations in the issue of whether the proposed revisions in inspection and certification procedures should be adopted. These considerations are:

--survey data indicate that patients entering nursing homes over the past several years are increasingly dependent or disabled; this trend is likely to continue. A more-disabled nursing home population may imply a need for more extensive, and potentially more costly, care.

--at the same time, States are finding it difficult to pay the escalating cost of this care and are taking steps to reduce their nursing home expenditures. Since more than half of the increases in expenditures are a result of inflation, States are cutting reimbursement rates, freezing bed supply, and taking other actions that may change both the quality of nursing home care and patients' access to it.

Because these conflicting trends--increased patient needs for care versus State efforts to cut the cost of that care--are likely to continue over the next several years, the type of care provided to Medicaid patients is likely to change significantly. During a time of increasing demand for services, combined with efforts to reduce costs, adequate inspection and certification procedures for nursing homes are crucial to insure that facilities meet the health and safety requirements of the law. Information on trends in State expenditures for nursing homes and the characteristics of the patients in those homes is, therefore, important in assessing the adequacy of proposed changes to those procedures. In the rest of this report, we discuss these conflicting trends and how they might be relevant to the proposed regulation changes.

HOW THE CHARACTERISTICS OF PATIENTS IN NURSING HOMES HAVE CHANGED

Information from national surveys indicates that the nursing home population in the aggregate has become increasingly dependent in recent years. The data in table 1 show, for example, that the percentage of current nursing home residents who were rated independent with regard to 6 activities of daily living was notably lower in 1977, at 10 percent, than in 1973, at 24 percent. 1/* Accordingly, the percentage who were rated dependent in all 6 activities was higher in 1977, at 23 percent, than in 1973, at 14 percent. In addition, table 1 shows that the percentages of nursing home residents dependent in bathing, dressing, transferring, continence, and eating were higher in 1977 than 1973.

The increasing proportion of people who are dependent and institutionalized across the Nation is consistent with our findings from analyzing all institutionalized Medicaid recipients in Minnesota in 1976 through 1979. In this analysis, we examined

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*Our explanatory notes and bibliographic citations appear at the end of this report as a separate enclosure.

Table 1

Percentage Distribution of Nursing Home Residents in 1973-74 and 1977 Dependent in Activities of Daily Living

	1973-74	1977
Activity		
Bathing	70.7	86.3
Dressing	58.9	69.4
Toileting	52.7	52.5
Transferring	51.6	66.1
Continence	33.8	45.3
Eating	17.6	32.6
Dependency		
Not dependent	23.5	9.6
Dependent in one activity	12.7	12.4
Dependent in bathing and one other activity	8.4	12.2
Dependent in bathing, dressing, and one other activity	4.5	8.5
Dependent in bathing, dressing, toileting, and one other activity	14.3	9.6
Dependent in bathing, dressing, toileting, transferring, and one other activity	16.0	15.6
Dependent in all six activities	14.4	23.3
Other	6.2	8.9

Sources: U.S. Department of Health and Human Services, National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the U.S. (Washington, D.C.: July 1979), p. 45; Nursing Home Utilization in California, Illinois, Massachusetts, New York, and Texas: 1977 National Nursing Home Survey (Washington, D.C.: October 1980), p. 10; Nursing Home Costs--1972: U.S. National Nursing Home Survey, 1973-74 (Washington, D.C.: November 1978), p. 60.

Medicaid Quality Assurance Review data for all nursing home residents in Minnesota who were 65 and older and who had been assigned to skilled nursing facilities (SNF) or intermediate care facilities (ICF). 2/ We also examined the characteristics of new admissions in each of the four years. In the rest of this section, we summarize our findings from this analysis.

Our comparison of recent and early Medicaid admissions in Minnesota

New Medicaid admissions in Minnesota in 1976-79 were similar across the four years with regard to certain background characteristics. For example, the mean age of new residents (81 years) was fairly constant. One-fourth of the new admissions in each of the four years were admitted from home while a little more than half, or 56 percent, were admitted from a hospital. Another 17 percent were admitted from other long-term care facilities, and only 2 percent were admitted from State mental institutions or facilities for the mentally retarded.

With respect to dependence, however, we found a consistent pattern of increasing dependence from 1976 through 1979. In table 2, we show the percentage of new admissions in each year who were dependent in 14 areas of daily living. For most of these functional areas, the percentages were 4 to 7 points higher in 1979 than the corresponding figures in 1976, indicating that the percentages of dependent patients increased. This was most pronounced in the activities of walking, seeing, and toileting.

When we considered new patients' dependence in the six activities of toileting, eating, dressing, grooming, walking and bathing, we found that in 1979 the percentage of new residents who were independent was lowest, and that the percentage of new residents who were dependent was highest. In 1976, residents were dependent in 3.74 activities, on the average, and by 1979 this had risen to 4.04 activities. 3/

Trends in the characteristics of nursing home patients

As we noted earlier, information from national surveys and from Medicaid Quality Assurance Reviews in Minnesota indicates a trend toward increasing numbers of more dependent nursing home residents. In the future, the number of potential users of nursing home care will increase and so will their dependence. One factor in this trend of growing numbers is the simple fact of the increase in the size of the population who are old and have high rates of institutionalization. Trends in fertility and mortality rates (including reduced mortality associated with chronic disease and, hence, increased life expectancy) reveal a rapid growth over the past several years in the number of Americans who are 65 years old and older. 4/ This group has increased at a faster rate than the U.S. population in general. In addition, nationally

Table 2

Percentage Distribution of New Medicaid Residents in Minnesota Dependent in Fourteen Activities in 1976-79

	Year of entry into residence			
	1976	1977	1978	1979
Number of new residents	2,278	1,585	1,367	1,389
% of total residents	12.1	8.0	6.7	6.6
% dependent a/				
Dressing	67.6	69.6	71.1	71.6
Grooming	69.5	72.3	73.7	72.9
Bathing	91.1	94.7	96.4	96.8
Eating	34.2	34.6	36.5	38.5
Bed mobility	25.9	27.1	27.2	29.9
Transferring	42.4	43.0	43.5	46.1
Walking	62.6	66.5	66.6	70.1
Wheeling	82.6	83.9	85.6	86.2
Communicating	21.1	26.2	24.4	26.9
Hearing	28.4	30.9	29.1	28.3
Seeing	79.1	84.8	84.6	86.5
Toileting b/	48.8	50.7	51.3	55.4
Orientation c/	59.3	60.4	56.1	56.5
Behavior d/	45.3	49.3	48.5	45.5

a/All percentages exclude patients for whom the rating was not made.
b/Includes patients with catheter or ostomy.
c/Includes patients who show minor forgetfulness or intermittent or total disorientation or who are comatose.
d/Includes patients with potential behavior problems or who are uncooperative, withdrawn, wandering, disruptive, or assaultive.

and by State, the oldest age group (85 years and older) is growing the fastest. 5/

The elderly are the predominant users of nursing homes--in 1977, they constituted about 85 percent of the Nation's nursing home population. 6/ Increasing age is associated with a greater incidence of physical impairments, increased likelihood of living alone, and a decline in financial income and assets. These factors contribute to a greater probability of using nursing home care.

Another contributor to increasing dependence among residents in nursing homes is the development of Medicaid pre-admission screening programs. According to a HCFA State survey conducted early in 1981, 28 States and the District of Columbia have implemented some form of pre-admission screening. 7/ These programs are designed to help the less disabled applicants avoid institutionalization when appropriate services are available in their communities. If these programs are successful, only the more disabled will be admitted and the average disability levels of nursing home residents could rise.

STATE PROBLEMS IN PAYING FOR NURSING HOME EXPENDITURES

If the trend toward a more dependent nursing home population continues, it could indicate a need for more extensive and potentially more costly care. Meanwhile, State governments, which subsidize the majority of all nursing home residents (with Federal support), are already finding it difficult to pay for Medicaid and its nursing home coverage. 8/

The Medicaid program is the most rapidly increasing component of many State budgets and constitutes between 10 and 15 percent of many States' operating funds. In addition, Medicaid has been growing faster than the State budgets. For example, between 1978 and 1979 State budgets increased 9.3 percent while Medicaid expenditures grew 18 percent. Many States have had to enact substantial supplemental appropriations to prevent Medicaid program shortfalls. A survey conducted in May 1981 found 11 States with significant program deficits, 13 States that had passed supplemental appropriations bills. 9/

Nursing home services constitute a substantial proportion of Medicaid program expenditures, referred to as the "black hole of State budgets" by one State Medicaid director. Table 3 shows that in fiscal year 1980, 34 percent of all Medicaid program dollars (excluding Medicaid expenditures for intermediate care facilities for the mentally retarded) were spent on nursing home services. 10/ However, 21 States spent 40 percent or more of their Medicaid budgets on nursing home services, although the table also shows that the percentages across the States varied widely. For example, in fiscal year 1980, the District of Columbia spent 9 percent of its Medicaid program on nursing home care while New Hampshire spent 61 percent. Even the five States that together comprised more than 40 percent of national nursing home expenditures varied among themselves, with California and Illinois spending a relatively small percentage (22 and 27, respectively) and New York, Texas, and Wisconsin spending more than the national average (36, 44, and 53 percent, respectively).

While preliminary data (as of October 1981) indicate that Medicaid nursing home services cost approximately $8 billion in fiscal year 1980, projected expenditures range from $24.8 billion to $31.0 billion by 1990. 11/ In table 4, on page 9, we display

Table 3

Medicaid Nursing Home (SNF and ICF) Expenditures as a Percentage of Total Medicaid for Fiscal Years 1976-80 a/

State	1976	1977	1978	1979	1980	State	1976	1977	1978	1979	1980
United States	33.3	33.0	34.6	35.0	34.2						
Alabama	49	46	47	44	47	Massachusetts	37	31	29	27	27
Alaska	46	40	43	44	44	Michigan	31	31	29	27	28
Arkansas	53	55	56	55	41	Minnesota	40	44	46	48	47
California	21	20	23	24	22	Mississippi	33	37	38	35	37
Colorado	44	41	37	37	42	Missouri	26	25	30	32	35
Connecticut	45	45	51	50	46	Montana	45	44	45	47	48
Delaware	26	29	25	30	29	Nebraska	45	46	45	48	43
D.C.	13	6	6	6	9	Nevada	28	40	46	45	41
Florida	39	35	38	32	35	New Hampshire	57	56	62	58	61
Georgia	41	38	37	39	35	New Jersey	30	33	31	29	30
Hawaii	32	37	42	41	34	New Mexico	22	22	24	25	25
Idaho	43	41	40	41	44	New York	33	33	38	37	36
Illinois	28	27	27	29	27	North Carolina	28	35	30	31	32
Indiana	50	50	50	51	52	North Dakota	54	50	53	54	55
Iowa	50	45	43	41	41	Ohio	33	34	33	35	35
Kansas	31	27	31	38	34	Oklahoma	46	46	42	44	41
Kentucky	28	32	34	37	33	Oregon	34	30	30	32	32
Louisiana	32	37	35	37	36	Pennsylvania	28	28	26	31	27
Maine	40	45	49	49	54	Rhode Island	25	26	28	34	33
Maryland	25	27	34	35	33	South Carolina	36	36	36	41	34

(Table 3 continued)

State	1976	1977	1978	1979	1980	State	1976	1977	1978	1979	1980
South Dakota	56	53	48	49	49	Virginia	33	34	37	34	34
Tennessee	35	34	37	37	35	Washington	42	36	34	36	41
Texas	51	51	48	45	44	West Virginia	16	21	22	26	30
Utah	43	47	38	38	39	Wisconsin	45	45	57	55	53
Vermont	34	35	35	33	33	Wyoming	55	58	61	65	59

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research, Demonstrations, and Statistics, Medicaid State tables.

a/1980 data are preliminary (fall 1981). Expenditures for intermediate care facilities for the mentally retarded (ICF-MR) could not be disaggregated for the following States in the years indicated: Ala., Ark., Calif. (1976-79); Conn., Fla. (1976); Hawaii (1977-79); Ill., Maine, Md. (1976-80); Mo. (1976); Mont. (1980); Nev. (1976-77); N.H. (1976-78); N.J. (1977); Wash. (1976); W. Va. (1979).

Table 4

Medicaid Nursing Home (SNF and ICF) Expenditures and Average Annual Growth Rate in Expenditures by State for Fiscal Years 1976-80 (in thousands of dollars) a/

State	1976	1977	1978	1979	1980	Average annual growth rate 1976-80
United States	4,677,482	5,334,310	6,180,811	7,160,368	7,929,780	14.1
Alabama	76,501	84,749	86,801	105,438	123,796	12.8
Alaska b/	4,848	6,977	9,503	11,661	11,661	24.5
Arkansas	61,858	78,286	96,741	106,185	96,443	11.7
California	358,029	423,499	551,288	611,750	605,169	14.0
Colorado	46,636	44,799	57,223	60,754	76,020	13.0
Connecticut	86,571	96,611	129,600	149,471	162,087	17.0
Delaware	4,593	6,976	7,275	11,705	13,298	30.4
D.C.	13,425	7,478	6,645	8,925	15,918	4.4
Florida	68,607	79,363	94,213	109,532	136,076	18.7
Georgia	100,241	120,231	132,560	147,885	163,708	13.0
Hawaii	16,905	24,563	33,692	35,055	32,218	17.5
Idaho	13,080	13,213	15,184	18,600	22,985	15.1
Illinois	208,226	223,090	255,423	292,124	326,602	11.9
Indiana	103,746	116,767	133,638	159,362	184,703	15.5
Iowa	59,786	70,503	76,604	86,149	93,538	11.8
Kansas	38,531	44,604	50,830	61,674	68,396	15.4
Kentucky	40,487	55,640	68,628	90,986	98,635	24.9
Louisiana	61,326	80,773	98,455	125,792	148,697	24.8
Maine	28,703	38,692	49,383	56,016	67,175	23.7
Maryland	57,113	66,610	76,535	90,122	106,631	16.9
Massachusetts	195,008	215,212	204,423	246,717	269,138	8.4
Michigan	221,385	242,004	263,106	283,488	295,019	7.4
Minnesota	128,120	163,666	193,804	229,201	275,687	21.1
Mississippi	36,739	46,422	60,205	70,220	78,279	20.8
Missouri	31,633	42,449	59,226	76,529	104,013	34.7
Montana	13,990	18,301	22,603	24,781	29,898	20.9
Nebraska	26,012	31,650	37,871	45,046	46,910	15.9
Nevada	6,291	8,261	11,409	14,391	18,228	30.5
New Hampshire	18,365	24,304	31,371	35,113	43,950	24.4
New Jersey	122,453	149,716	160,988	192,724	225,954	16.6
New Mexico	8,014	10,067	11,533	14,785	17,270	21.2
New York	1,104,488	1,094,690	1,277,208	1,434,920	1,650,080	10.6
North Carolina	47,551	89,738	84,095	105,320	126,897	27.8
North Dakota	13,482	16,540	19,071	22,685	25,452	17.2
Ohio	146,737	176,426	199,044	235,249	282,394	17.8

(Table 4 continued)

State	1976	1977	1978	1979	1980	Average annual growth rate 1976-80
Oklahoma	74,862	88,640	84,012	111,270	107,522	9.5
Oregon	31,758	39,622	44,429	51,558	56,518	15.5
Pennsylvania	223,512	284,046	296,124	365,590	281,212	5.9
Rhode Island	22,435	28,228	33,213	47,257	53,546	24.3
South Carolina	36,961	50,588	59,846	78,783	89,099	24.6
South Dakota	13,951	16,528	19,269	24,094	27,023	18.0
Tennessee	61,501	69,301	97,029	119,471	132,840	21.2
Texas	297,709	313,682	351,963	393,597	430,717	9.7
Utah	14,787	22,383	23,916	29,739	30,663	20.0
Vermont	12,567	14,191	16,193	17,521	19,270	11.3
Virginia	59,791	79,037	96,587	106,886	123,363	19.8
Washington	74,290	78,337	84,078	104,712	133,842	15.9
West Virginia	9,872	12,822	16,694	23,738	30,913	33.0
Wisconsin	170,312	219,105	285,310	308,498	361,808	20.7
Wyoming	3,694	4,930	5,970	7,299	8,519	23.2

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research, Demonstrations, and Statistics, Medicaid State tables.

a/1980 data are preliminary (fall 1981) and include Federal, State, and local expenditures. Expenditures for intermediate care facilities for the mentally retarded (ICF-MR) could not be disaggregated for the following States in the years indicated: Ala., Ark., Calif. (1976-79); Conn., Fla. (1976); Hawaii (1977-79); Ill., Maine, Md. (1976-80); Mo. (1976); Mont. (1980); Nev. (1976-77); N.H. (1976-78); N.J. (1977); Wash. (1976); W. Va. (1979).

b/1980 data are missing, and 1979 data have been used instead.

Medicaid SNF and ICF expenditures for fiscal years 1976 through 1980 by State with their average annual growth rates. Since the 1980 data are preliminary, it is difficult to determine whether the apparent decline in 1980 expenditures in many States actually occurred. 12/ Despite this, there was a great deal of variation in the average annual growth rates of State expenditures between 1976 and 1980. Expenditure increases ranged from lows in the District of Columbia (4.4 percent), Pennsylvania (5.9 percent), and Michigan (7.4 percent) to highs in Missouri (34.7 percent), West Virginia (33.0 percent), Nevada (30.5 percent), and Delaware (30.4 percent).

Nursing home expenditures have also grown faster than the rest of the Medicaid program. Between 1976 and 1980, nursing home expenditures grew at an average annual rate of 14.1 percent, compared to 13.0 percent for non-nursing home expenditures. In addition, expenditure increases exceeded 14.1 percent in 32 States, and in 5 States the average growth rate was higher than 25 percent.

An analysis conducted by the Health Care Financing Administration indicates that the largest proportion of nursing home expenditure increases can be attributed to inflation. According to HCFA, 49 percent of the 16.7 percent average annual increase in all nursing home costs, from all sources, between 1969 and 1979, was the result of inflation. 13/ Since the Medicaid program is the largest single buyer of nursing home services, it can be assumed that inflation was also the primary contributor to the growth in its costs for nursing home services between 1976 and 1980.

Because much of the increase in nursing home costs is attributable to inflation, States are not able to control it directly. The increase in the elderly population is also uncontrollable and contributes to the increase in program costs. Therefore, slowing the rate of increase in expenditures can be achieved only by such means as reductions in eligibility, reimbursement, and supply of services and improvements in efficiency.

The Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35, sec. 2161) requires States to stay within a specified percentage cost increase to avoid a reduction in the Federal contribution. The recent 13.4 percent annual growth rate in the Medicaid program indicates that many States may exceed the permissible rate of increase. 14/ This could place additional stress on States' ability to finance nursing home services.

STATE ACTIONS TO REDUCE NURSING HOME EXPENDITURES

The States are actively seeking ways to reduce the rate of increase in their Medicaid programs. The dominance of nursing home expenditures in their budgets has made these expenditures a major target for reduction initiatives. The most notable

Medicaid changes, allowing States greater flexibility in achieving program cost savings, were passed in the 1980 Omnibus Reconciliation Act (Pub. L. No. 96-499) and the 1981 Omnibus Budget Reconciliation Act (Pub. L. No. 97-35). These Acts provide for such changes as simplifying the modification of nursing home reimbursement methods, reducing payments for hospitalized patients awaiting nursing home placement, and developing community-based long-term care services to reduce the rate of nursing home use (Pub. L. No. 96-499, sec. 962, and Pub. L. No. 97-35, sec. 2173 and sec. 2176). Information through April 1982 shows that States have been enacting legislation affecting nursing home reimbursement systems, financial and medical eligibility requirements, certificate-of-need regulations, and payments for administratively necessary hospital days (AND's). 15/

According to recent surveys on changes in State Medicaid programs, 24 States changed their nursing home reimbursement policies or methods in 1981 and 1982 in order to reduce costs. 16/ While most of these changes represent adjustments to their present systems, some States, among them Arkansas, Missouri, and Utah, have implemented uniform class rates (that is, flat rates or negotiated flat rate systems) that are similar to rate-setting methods currently used by a small number of States. Georgia changed its inflation factor for nursing home reimbursement rates from 12.6 percent in mid-1981 to 4.6 percent in November 1981. Minnesota and Wisconsin intend to hold nursing home cost increases to 10 percent and 7 percent, respectively, for fiscal year 1982. Wisconsin has also passed recent legislation that defers all rate increases for three months. Idaho has requested that nursing home providers accept a voluntary 5 percent reduction in reimbursement rates for the coming fiscal year. Colorado has passed legislation that shifts a portion of Medicaid nursing home costs to local governments.

In another recent survey asking State Medicaid directors to rank the importance of Medicaid amendments from the 1980 Omnibus Reconciliation Act and the 1981 Omnibus Budget Reconciliation Act, 22 directors, out of a total response from 41 directors, ranked changes in nursing home reimbursement among the top 3 of 15 amendments. Seventeen directors ranked nursing home reimbursement changes among the top 3 when the amendments were ranked for potential cost savings. 17/

States are also using certificate-of-need regulations to limit the supply of nursing home beds and, hence, program expenditures. Currently, five States have moratoriums on the construction of new nursing home beds. A sixth State, South Carolina, will not contract for new nursing home beds built after fiscal year 1982. In 1980 and 1981, two States, Kentucky and Mississippi, tried to limit the number of beds for which they would reimburse; however, we understand that this policy has been abandoned as being in violation of Federal Medicaid law.

Some States have applied more stringent financial and medical requirements for nursing home care. Eighteen States have revised financial eligibility in order to reduce costs. Many changes are intended to limit the transfer of assets for Medicaid eligibility purposes. Pre-admission screening programs have been implemented to insure that only Medicaid patients whose needs can best be met in nursing homes are admitted to them.

For Medicaid patients waiting in hospitals to be placed in nursing homes, six States have implemented a reduced rate for these days of care, as required by section 2173 of the 1981 Omnibus Budget Reconciliation Act. Eight States have also eliminated or reduced the number of days designated as "bed reserve days" in nursing homes. These days had been paid by the Medicaid program to reserve nursing home beds for residents who were temporarily hospitalized or otherwise absent from the nursing home.

SUMMARY

In summary, two recent trends may have an effect on care provided in nursing homes throughout the United States. For one, the data indicate that disability in the nursing home population is on the increase. This trend is likely to continue, partly because of the growing numbers of elderly people with chronic diseases (the predominant recipients of institutional care) and partly because of the expansion of nursing home pre-admission screening programs. An increase in the dependence of the nursing home population may mean that they will require more intensive care that is costly to provide.

At the same time that States may be subsidizing more residents who are dependent, they are also taking steps to reduce or slow the rates of growth in their nursing home expenditures. This is because increases in Medicaid expenditures exceed the growth in State revenues (largely as a result of spiraling nursing home costs) and because of other State economic conditions together with the potential reductions in the Federal Medicaid contribution. As the primary cause of nursing home expenditure increases is inflation, States may be forced to make changes in areas that may affect the care of patients or their access to care--reimbursement rates, bed supply, and eligibility.

Because these trends--increasing patient needs for care and increasing State efforts to cut the cost of care--conflict with one another and are likely to continue over the next several years, the type of care provided to Medicaid residents is likely to change significantly. Since the increased demand for potentially more costly services is occurring at the same time as expenditures for care are being reduced, it is crucial that inspection and certification procedures for nursing homes be adequate to insuring that facilities meet the health and safety requirements of the law. We hope this information on changes in State nursing home expenditures and the characteristics of patients in nursing

homes will assist you in assessing the adequacy of the proposed revisions of the regulations.

As we agreed with your office, we will release this report on July 19, 1982, for a hearing that your Subcommittee has scheduled on proposed revisions to nursing home inspection and certification regulations. At that time, we will forward copies of the report to the U.S. Department of Health and Human Services and to other people with an interest in it.

Sincerely yours,

Eleanor Chelimsky
Director

Enclosure

NOTES

1/These percentages were based on judgments made by nursing staff regarding assistance needed from other people and special equipment. Patients who were able to perform the activities without assistance were considered to be independent. Because such judgments are difficult to make, there may be errors in the dependency indexes. Nursing homes that provide minimal care--that is, personal care homes that do not provide nursing and domiciliary care homes--were included in the 1977 but not in the 1973 survey; therefore, the increasing proportion of dependent nursing home residents may be understated. The understatement is probably slight, however, since these homes represented only 1 percent of beds and residents in 1973. The National Nursing Home Survey, from which we took our 1977 figures, was the last national survey of nursing homes to be conducted; there are no current plans to conduct another one in the future.

2/A skilled nursing facility (SNF) is an institution offering services to people who require daily skilled nursing care or other skilled rehabilitation services that can be provided only to in-patients. At a lower level of care, an intermediate care facility (ICF) offers services to people who require regular health-related care and services above the level of room and board.

3/Scores for patients on the Lawton and Brody Physical Self-Maintenance Scale reflect the number of areas in which they are dependent. For the six activities of toileting, eating, dressing, grooming, walking, and bathing, scores range from zero (independence in all) to six (dependence in all).

4/K. Liu, K. Manton, and W. Alliston, "Demographic and Epidemiological Determinants of the Magnitude of Long-Term Care Expenditures," in vol. 2 of HCFA's July 1981 draft report entitled Long-Term Care: Some Perspectives from Research and Demonstration, ed. by R. J. Vogel and H. C. Palmer.

5/Limited census data are available on the elderly by age cohorts. However, one study by the U.S. Bureau of the Census found that the population aged 85 and older grew at an average annual rate of 4.5 percent between 1975 and 1979. (The sampling methodology may have resulted in a growth rate slightly different from the rate an actual census might have produced.) In contrast, the population aged 65 and older grew annually at an average rate of 2.7 percent between 1976 and 1980. See U.S. Bureau of the Census, Estimates of the Population by Age: July 1, 1971 to 1979 (Washington, D.C.: January 1980); Age, Sex, Race and Spanish Origin of Population by Regions, Divisions, and States 1980 (Washington, D.C.: May 1980); and the discussion of unpublished data in Methodology for Experimental Estimates of the Population of Counties, by Age and Sex: July 1, 1975 (Washington, D.C.: May 1980).

6/According to the 1977 National Nursing Home Survey, 86.4 percent of all nursing home residents were 65 or older in 1977. See NCHS, The National Nursing Home Survey: 1977 Summary for the U.S. (Washington, D.C.: July 1979), p. 29, table 19.

7/HCFA, A Report on Nursing Home Pre-admission Screening Programs (Washington, D.C.: August 1981), p. vii.

8/Medicaid does not pay the full cost (that is, the per diem rate) of care for most patients. People who receive Medicaid contribute all their resources minus a personal allowance to the cost of their care.

9/Intergovernmental Health Policy Project, State Health Notes (Washington, D.C.: George Washington University, February 1981).

10/This excludes expenditures for intermediate care facilities for the mentally retarded (ICF-MR) except in Illinois, Maine, Maryland, and Montana. (Expenditures are also excluded for Guam, Puerto Rico, the northern Mariana islands, and the Virgin Islands.) In fiscal year 1981, if ICF-MR and home health care expenditures are included, 44 percent of all Medicaid expenditures were for long-term care. (See Congressional Budget Office, Reducing the Federal Deficit: Strategies and Options (Washington, D.C.: February 1982, p. 145.) In this report, we include only expenditures for SNF and ICF unless we have noted otherwise.

11/For the 1990 projections, see "Formulation of an Actuarial Cost Model for Federal Long-Term Care Programs," ICF, Inc., HCFA contract 500-79-0053, September 1981, ch. 4, p. 8, and, with reference to unpublished HHS data, M. S. Freeland and C. E. Schendler, "National Health Expenditures: Short-Term Outlook and Long-Term Projections, Health Care Financing Review, Winter 1981, pp. 97-138.

12/For example, nursing home expenditures grew at an average rate of 15.3 percent between 1976 and 1979 compared to only 14.1 percent between 1976 and 1980; this appearance of decline may be largely a function of the fact that the data are only preliminary.

13/See Freeland and Schendler, p. 103.

14/Total Medicaid expenditures grew at an average annual rate of 13.4 percent between 1976 and 1980. Expenditures are excluded for Guam, Puerto Rico, the northern Mariana islands, and the Virgin Islands.

15/A more recent and controversial initiative is the requirement that families contribute financially to the care of parents eligible for Medicaid. Three States have passed laws containing requirements for family responsibility for relatives. A

fourth State, Mississippi, has applied for a Federal waiver under which families would supplement the support of relatives receiving Medicaid. (It submitted a section 1115 demonstration waiver to HHS in February 1982, which will make its decision in mid-July 1982.) In August 1981, Idaho established a voluntary fund for private contributions; donations to it can be deducted from the State income tax. Georgia's law requiring family financial responsibility is contingent upon the removal of Federal restrictions currently prohibiting family supplementation. Minnesota's law is similar to Georgia's but does not contain the clause concerning the removal of current Federal restrictions.

16/ Information through the end of this section has been taken from "Recent and Proposed Changes in State Medicaid Programs: A 50-State Survey," compiled by the Intergovernmental Health Policy Project of George Washington University and the State Medicaid Information Center of the National Governors' Association, April 1982, and "Medicaid Program Changes, State by State Profiles," compiled by the State Medicaid Information Center of the National Governors' Association, May 1982. Changes between May 1982 and early July 1982 are included for approximately half the States.

17/ There was a significant positive relationship between the rankings of importance and the rankings of potential cost savings; the Spearman correlation coefficient was .79. See Bartlett Associates, "Assessment of State Medicaid Agencies' Technical Assistance Needs Resulting from Passage of P.L. 97-35, The Omnibus Budget Reconciliation Act of 1981," January 18, 1982, pp. 9, 12-13.

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