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Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

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SKILLED NURSING FACILITIES

Medicare Payments Need to Better Account for Nontherapy Ancillary Cost Variation

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GAO

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Health, Education, and
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The Honorable William M. Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

Over the last decade, Medicare payments for skilled nursing facility (SNF) services have increased dramatically, with spending rising on average over 23 percent per year between 1990 and 1996. To curb this growth, the Balanced Budget Act of 1997 (BBA) replaced Medicare's existing cost-based payment methodology with a prospective payment system (PPS).[1] PPS payments for SNFs—which provides facilities an all-inclusive daily payment, adjusted for the complexity and expected care needs of each patient—began being phased in on July 1, 1998.[2]

Concerns have been raised about whether the rates under the new payment system account for disparate patient costs, particularly high or low nontherapy ancillary service costs, which include drugs, laboratory tests, radiology procedures, respiratory therapy, medical supplies, intravenous therapy, and other nonroutine services. These concerns have prompted legislative proposals to raise SNF PPS payments for all or some types of patients. In this context, you asked us to (1) assess whether the SNF payment rates incorporate the costs of nontherapy ancillary services and (2) analyze the PPS design and nontherapy ancillary cost variation to assess whether payments are distributed appropriately.

To complete this study, we reviewed the provisions of BBA and the Health Care Financing Administration's (HCFA) interim rule and final rule on the prospective payment system and consolidated billing for SNFs, which took effect on July 1, 1998, to determine the extent to which nontherapy ancillary cost variation was accounted for in the payment rates. We also analyzed provider cost reports from fiscal year 1995 (the most recent available data) to estimate the average costs per day, the components of

[1]P.L. 105-33, section 4432(a).

[2]There is a 3-year transition to the new payment system during which payments are a blend of facility-specific and national average per diem rates. In the first year, payments are 75-percent facility-specific; 50-percent facility-specific in the second year; and 25-percent facility-specific in the third. The facility-specific portion is based on each facility's updated 1995 costs. SNFs are being phased in according to the start of their fiscal year.

daily costs, and the variations in costs across Medicare-certified SNFs. We conducted our work between December 1998 and August 1999 in accordance with generally accepted government auditing standards. (For a detailed discussion of our scope and methodology, see app. I.)

Results in Brief

SNF PPS rates were calculated using the full historical costs of nontherapy ancillary services, updated for inflation. Costs associated with unnecessary care and improperly billed services may have boosted these historical costs above what was warranted, resulting in generous PPS payment rates. However, BBA explicitly reduced payments by not accounting for total cost increases, raising concerns about whether the adjustment process adequately accounts for cost increases that occurred between the base-year and the first PPS payment year. Although the case-mix adjustments to payments for each patient under PPS are intended to account for changes in costs due to shifts in the mix of treatments, evidence indicates that for some types of patients, these adjustments may not be adequate. A full audit of SNF base-year and current costs and medical reviews of service provision would be needed to establish the actual relationship between the current costs of medically appropriate care and payments.

Nontherapy ancillary costs were not used to develop the payment adjusters that raise or lower the average payment to account for resource need differences across patients. As a result, per diem payments may not be adequate for types of patients who are likely to incur high nontherapy ancillary costs or may be excessive for those groups of patients with low expected nontherapy ancillary costs. In 1995, nontherapy ancillary service costs comprised 16 percent of total daily SNF costs, indicating that failure to adequately account for nontherapy ancillary cost variation could result in substantial under- or overpayments. This potential misallocation could contribute to beneficiary access problems if certain patients are identified prior to SNF admission as requiring nontherapy ancillary costs higher than the PPS rate.

HCFA is investigating possible refinements to PPS that could address these problems. In the meantime, increasing SNF payments will not improve the allocation of the payments but will only increase program outlays and possible overpayments to certain facilities.

Background

Medicare covers up to 100 days of care in a SNF for beneficiaries who need skilled nursing or rehabilitative care on a daily basis following a hospital stay of at least 3 days. Medicare pays for routine services, such as room and board, skilled nursing care, social services, and supplies and equipment. It also pays for ancillary services, including physical, occupational, respiratory, and speech therapies; laboratory services; radiology procedures; and drugs.

Cost-Based Reimbursement Had Few Incentives to Constrain Costs

Prior to the implementation of PPS, Medicare paid SNFs on a reasonable cost basis. Routine nursing and room and board costs were paid up to specified limits, with higher limits applied to hospital-based SNFs than to freestanding ones. New providers were exempt from the cost limits for up to their first 4 years of operation. In addition, providers that demonstrated higher than average costs as a consequence of atypical patients or patterns of care could be granted exceptions to the routine cost limits.

Unlike payments for routine costs, payments for ancillary (therapy and nontherapy) costs were not subject to limits. Services had to meet medical necessity criteria, but there was little Medicare review of their use. As a result, facilities had few incentives to constrain costs or to restrict ancillary service provision to only necessary services—increases in ancillary service costs increased payments. In fact, payments for ancillary services increased 17 to 20 percent annually between 1992 and 1995, compared with 5 to 7 percent for routine services.

Despite the growth in Medicare expenditures, funding for program safeguards decreased by 50 percent between 1989 and 1995. Limited auditing of cost reports and medical review of claims raised concerns that ancillary cost growth was not entirely due to increases in the service needs of Medicare beneficiaries.

PPS Implemented to Control Spending

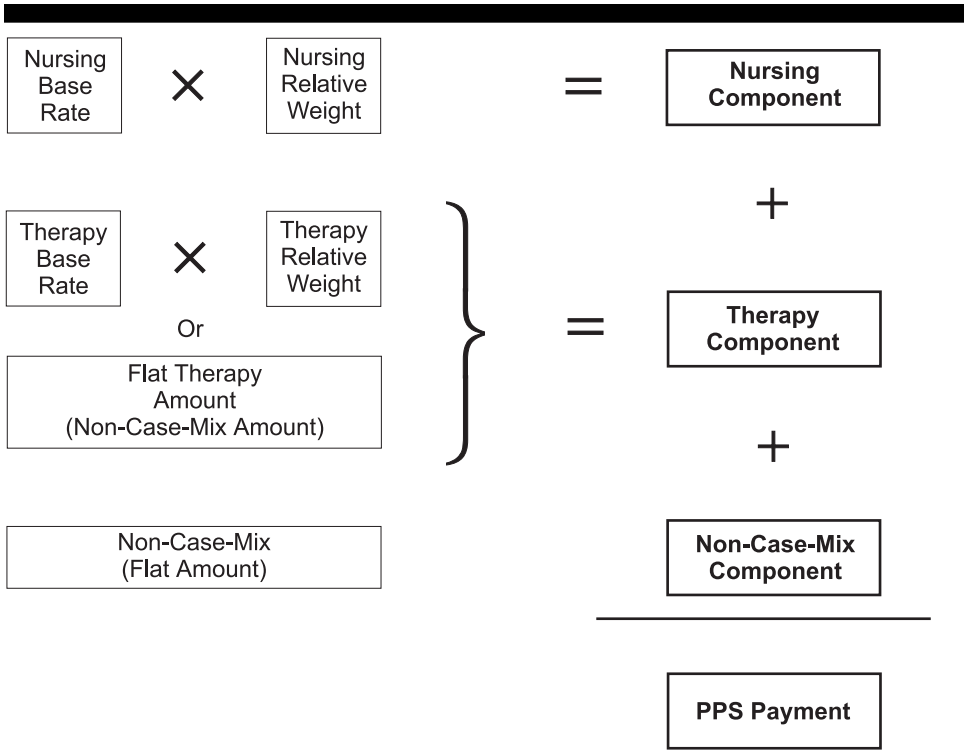
To curb the rise in Medicare SNF spending, BBA required HCFA to implement a PPS for SNFs. HCFA designed an all-inclusive per diem payment approach to replace the cost-based reimbursement methodology (see app. II). The per diem payment, which is adjusted for differences in the resource needs of patients and for geographic differences in labor costs, covers all routine, ancillary, and capital costs incurred in treating a SNF patient.

The per diem rate has three components—one for nursing (nursing care, social services, and nontherapy ancillary services), one for therapies

(physical, occupational, and speech), and a non-case-mix services component (for example, capital, maintenance, dietary)—that are totaled to determine the overall payment. The nursing and therapy components are adjusted upward for patients who are expected to be more resource-intensive—and thus more costly to care for—or downward for patients who are expected to be less resource intensive than average. The non-case-mix component covers costs that are assumed to be uniform across all patients and, therefore, is not adjusted.

The adjustments of nursing and therapy payments are based on a case-mix classification system—Resource Utilization Group, version III, or RUG-III—developed by HCFA contractors. The system comprises 44 distinct patient groups distinguished by patient clinical condition, functional status, and expected use of certain types of services. Each case-mix group has a corresponding "nursing relative weight" that reflects the costliness of providing services to patients in that group relative to the average costliness of patients across all groups. Of the 44 RUG-III groups, 14 describe patients who require substantial therapy services and have an associated "therapy relative weight." The remaining case-mix groups are assumed to require a minimal amount of therapy services and are paid a fixed non-case-mix therapy payment. The payment for each day of care for a patient is the sum of three parts—the nursing component (the product of the nursing base rate and the nursing relative weight for the appropriate RUG-III group), the therapy component (the product of the therapy base rate and the appropriate relative weight or a flat amount, depending on the RUG-III category), and the non-case-mix amount (see fig. 1). (App. II contains a more complete discussion of the payment amount calculation.)

Figure 1: Overview of SNF PPS Rate Calculation



Average SNF Payments Include Historical Nontherapy Ancillary Costs

HCFA used 1995-reported SNF costs, including those for nontherapy ancillary services, as the basis for the 1999 base payments under PPS. Given the lack of incentives under the prior payment approach to control ancillary costs, the 1995 costs may be higher than warranted due to inefficient service provision, the costs of unnecessary care, and improper billings. On the other hand, some contend that the method for updating the 1995 costs to 1999 levels underestimated appropriate cost increases over that period. Without a systematic review of SNF costs, service provision, and payments, it is not possible to determine the appropriateness of the resulting 1999 base rates.

The base PPS payment amounts include (1) the per diem routine, ancillary, and capital costs reported by SNFs in fiscal year 1995 and (2) an estimate of the per diem average amount paid during that year for ancillary services furnished to SNF patients by external providers (such as outside laboratories.) The 1995 nontherapy ancillary costs were thus fully included in the calculation of the base rates. Total costs were updated for inflation

between the 1995 base year and 1999 by the SNF market-basket index minus 1 percent, as required by BBA.[3]

There is evidence that base year spending was higher than it should have been due to unwarranted growth in ancillary expenditures and unnecessary costs or inappropriate billing for services, which was undetected because of minimal program oversight. We have reported that it is likely that the base year costs include too many services and that the costs per service were inappropriately high.[4] Likewise, in its review of the SNF PPS, the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) noted that the rate-setting process did not adequately exclude costs for medically unnecessary care or the amount of improper SNF payments.[5] Due to these factors, the level of overpayments is not known.

The adequacy of the method of updating the 1995 costs to 1999 costs has been called into question. Some contend that actual SNF costs rose faster than the inflation adjuster because SNFs were treating more complex patients and providing more intensive treatments. Some of this increase, however, will be accounted for by the case-mix adjustment to the payments. To the extent that higher costs are due to a different mix of patients than is measured by the case-mix adjustment method, the national portion of the payments will be higher.[6] Reflecting congressional concerns about excessive cost increases due to inefficient or inappropriate service provision under cost-based payments, BBA explicitly reduces SNF per diem payments by requiring the use of an inflation adjuster that is less than the expected increase in SNF costs, as measured by the market-basket index.

Additional information is required to determine the adequacy and appropriateness of payments. Thoroughly audited Medicare cost reports, patient assessment data, and beneficiary claims are needed to establish the appropriateness of facility costs, and medical reviews of services provided to Medicare beneficiaries would determine if any unnecessary care had been provided. Together, this information would provide a

[3]The market-basket index measures the annual change in the prices of goods and services providers use in producing health care services.

[4]Balanced Budget Act: Any Proposed Fee-for-Service Payment Modifications Need Thorough Evaluation (GAO/T-HEHS-99-139, June 10, 1999).

[5]OIG, Review of the Health Care Financing Administration's Development of a Prospective Payment System for Skilled Nursing Facilities, A-14-98-00350 (Washington, D.C.: HHS).

[6]During the transition, the facility portion of the payment is not case-mix adjusted because it already includes facility-specific costs.

clearer picture of what Medicare should be paying for services and could be used to identify and assess the appropriateness of any cost growth that remains unaccounted for by the inflation adjuster or the case-mix adjustment to payments.

PPS Case-Mix Adjustments May Not Appropriately Distribute SNF Payments

The SNF case-mix-adjustment system does not directly account for the variation in nontherapy ancillary costs across patients because only variations in nursing time were used to establish the relative weights for the case-mix groups. As a result, SNF payments may not vary consistently with the expected variation in patient costs. This could disadvantage those facilities that treat many patients with high nontherapy ancillary costs and may create access problems for patients who are identified as having high nontherapy ancillary needs prior to admission. The dollars at stake are substantial. In 1995, Medicare nontherapy ancillary costs accounted for 16 percent ($45) of the daily costs of care. To the extent that payments do not adequately reflect nontherapy ancillary costs, some SNFs could receive substantial overpayments relative to the expected costs of their mix of patients, while others could be underpaid.

In order to assess the adequacy of the payments for nontherapy ancillary costs across the different case-mix categories, average patient-level costs and average payments would need to be compared. These data are not yet available.[7] However, facility-level data indicate that there is a ninefold variation in average nontherapy ancillary costs per day. By comparison, the relative weights used to adjust payments for these costs only allow payments to vary by about two and a half times—suggesting that PPS could be overpaying some facilities and underpaying others. Further, by comparing the range in potential payments for nontherapy ancillary costs to facilities' costs, we found that two-thirds of the SNFs had reported costs either below or above that range. This also indicates that there could be substantial over- or underpayments under PPS to certain facilities.

[7]Until data are available, many elements required to classify patients into the 44 RUG-III groups—such as the frequency and duration of therapies, the number of physician visits or order changes, and activities of daily living—cannot be reproduced using existing claims information.

Classification System's Relative Weights Not Likely to Adequately Account for Patient Cost Variation

The RUG-III classification system groups similar types of patients based on their expected level of resource use.[8] To adjust payments, each group is assigned two weights: one based on the average cost of providing nursing services to the patients in the group relative to overall patient averages and the other based on relative therapy costs. Although total nontherapy ancillary costs were included in the base nursing rate, these costs were not considered in the calculation of the nursing relative weights. Rather, nursing time was used to develop the relative weights. If nontherapy ancillary costs are correlated with nursing time, the nursing weights will appropriately distribute payments according to patients' nontherapy ancillary resource needs. If this is not the case, the payments for some groups of patients will be too high and for others, too low.

According to HCFA, it incorporated nontherapy ancillary costs into the nursing base rate because its analysis showed that patients in the RUG-III categories with high nursing relative weights tend to have high nontherapy ancillary charges. However, this does not necessarily mean that weights based only on nursing time are adequate to distribute payments for nontherapy ancillary services. At the time the classification system was developed, nontherapy ancillary costs did not comprise a substantial share of SNF costs[9]—they now do, averaging approximately 16 percent of SNF per diem costs in 1995.[10] Thus, if the relative weights do not adequately account for these costs, the total per diem payment may not be appropriate. For example, some patients requiring relatively limited nursing time might have costly nontherapy ancillary needs, such as the administration of expensive drugs. Without other service needs that would place these patients in higher weighted groups, they would get assigned to case-mix groups with lower relative weights that may not fully reflect their high nontherapy ancillary costs. If nursing homes identify these patients and choose not to admit them, the patients may need to stay in a hospital longer to receive the care they need. Our work and work conducted by HHS' OIG found that some patients who require extensive services are more

[8]The need for certain nontherapy ancillary services, such as chemotherapy, radiation therapy, and parenteral feeding, are used to classify patients into some case-mix groups. The costs of these nontherapy ancillary services, however, are not used in calculating the relative weights for these case-mix groups.

[9]For example, pharmacy costs, the largest, was 5 percent of nursing costs. See Brant E. Fries, Don P. Schneider, and others, "Refining a Case-Mix Measure for Nursing Homes: Resource Utilization Groups (RUG-III)," Medical Care, Vol. 32, No. 7 (1994), pp. 668-85.

[10]PPS provides incentives for SNFs to lower their provision of nontherapy ancillary services and to negotiate lower prices paid for them. As a result, the share of total costs that are attributable to nontherapy services may have declined since 1995.

difficult to place.[11] Conversely, payments may be too high for patients with relatively low nontherapy ancillary use. For example, an unstable patient may require significant amounts of nursing time for monitoring but may not be receiving treatments involving many nontherapy ancillary resources.

HCFA has acknowledged concerns about whether the case-mix adjustment method appropriately accounts for nontherapy ancillary cost variation and is sponsoring research to determine if the accuracy of the rates could be improved by refining the RUG-III system to explicitly incorporate nontherapy ancillary services. HCFA also is investigating whether relative weights based on ancillary charges, rather than the current weights based on nursing time, would be more appropriate for adjusting the nontherapy ancillary component of the payment amount. It anticipates completing these research projects by January 1, 2000. Any payment system refinements resulting from these projects would be implemented starting October 1, 2000, before the transition to the full PPS is complete.

Nontherapy Ancillary Cost Variation Wider Than Range in PPS Payments

Measuring the effect of omitting nontherapy ancillary costs in computing the RUG-III relative weights on patients and facilities requires data on patient characteristics not currently available.[12] However, our analysis of facility-level information revealed that two-thirds of facilities have average nontherapy ancillary costs that are outside of the range of potential PPS payments. This means that many facilities could be over- or underpaid.

According to our analysis, nontherapy ancillary costs averaged about $45 per day in 1995 (see table 1).[13] Although for the majority of SNFs, these costs averaged below $40, the most expensive providers of these services (the top 10 percent) had daily costs of $95 or more, while the least expensive providers (the bottom 10 percent) had costs below $11. (See app. III for a more complete presentation of facility cost variation.) Thus, facilities with the highest nontherapy ancillary costs were nine times more expensive than the bottom 10 percent of facilities. Patient-level costs could vary considerably more than these facility averages.

[11]OIG, Office of Evaluation and Inspections, Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities, OEI-02-99-00400 (Washington, D.C.: HHS, Aug. 1999).

[12]In developing the payment rates and the relative weights, HCFA did not have a national sample of patient-level data to classify patients into the RUG-III groupings. Instead, it used available claims data and decision rules to group patients into 10 broad categories, using a model known as the MedPAR analog.

[13]App. III shows the average costs and the distribution of costs for the major nontherapy ancillary services.

Table 1: Average Daily SNF Reported Costs for Medicare Patients, 1995

Cost category	Average per-day costs	Percent of total
Nontherapy ancillary services	$45	16%
Therapy services[a]	78	28
Routine[b]	153	56
Total	**$276**	**100%**

[a]Therapy costs include speech, occupational, and physical therapy.

[b]Routine costs include room and board, nursing, and other costs.

Source: GAO analysis of 1995 SNF Medicare cost reports.

By contrast, PPS payments for nontherapy ancillary services will range from about $35 to almost $80 per day, depending on the RUG-III category of the patient.[14] A comparison of reported costs to the possible range in payments indicates that two-thirds of the SNFs had average daily nontherapy ancillary costs either below or above the range of potential payments established in PPS (see table 2). This may be an underestimate of the proportion of patient days that would be under- or overpaid because each facility treats patients across a range of the RUG-III categories. Therefore, these facility averages may mask the extreme payment and cost variation across patient days.

Table 2: Facility-Level Nontherapy Ancillary Reported Costs Compared to Estimated PPS Payment Range, 1995

Nontherapy ancillary costs	Number of facilities	Percent
Costs less than estimated payment range	5,291	53%
Costs within payment range	3,185	32
Costs above estimated payment range	1,539	15
Total	**10,015**	**100%**

Source: GAO analysis of 1995 SNF Medicare cost reports.

Conclusions

Total Medicare payments for all SNFs are likely to be adequate, if not generous, to cover the costs of nontherapy ancillary services. However, the PPS case-mix adjustment method may not appropriately account for the variation in the nontherapy ancillary costs and thus may not correctly

[14]Nontherapy ancillary costs account for approximately 43 percent of the nursing base rate. Therefore, the nontherapy ancillary portion of the nursing rate is $47 for urban facilities (43 percent of $109.48) and $45 for rural facilities (43 percent of $104.88.) The range in the weights for urban facilities is ($47 x .75) to ($47 x 1.7); the range for rural facilities is ($45 x .75) to ($45 x 1.7). We examined this variation only for the 26 RUG-III patient groups that account for most Medicare-covered stays.

raise or lower payments across the patient groups to reflect expected differences in nontherapy ancillary needs. Therefore, Medicare payments for certain patient groups may be too high or too low, relative to the average. Any assessment of the adequacy of total Medicare payments to any SNF, however, would need to consider total Medicare costs and payments over the entire year.

HCFA is aware of the concern about this issue. It has commissioned research to assess the extent of any payment distributional problem and evaluate the possibility of refining the RUG-III classification system and weights to explicitly account for nontherapy ancillary cost variation. These refinements will become even more important as the 3-year transition to fully prospective rates proceeds.

In the meantime, increasing SNF payments for all or some RUG-III groups will not address the allocation problem. It would simply add costs to the program and increase overpayments without improving the distribution of payments across patient categories and SNFs. Rather, as a first step, the extent of any maldistribution of SNF payments across case-mix groups needs to be assessed. If any distributional problems are identified, the RUG-III relative weights would have to be recalculated to better target payments to the case-mix groups that contain patients with high expected nontherapy ancillary needs.

Agency Comments

In written comments on a draft of this report, HCFA shared GAO's concerns for PPS' potential effects on medically complex patients under the SNF PPS. HCFA noted that it is expediting research that will allow it to refine the payment system for nontherapy ancillary services and affirmed its commitment to assessing potential changes that could affect quality of care and access to skilled nursing care for Medicare beneficiaries.

HCFA also provided technical comments, which we incorporated where appropriate. Among these, HCFA stressed two important advantages of a PPS. First, under PPS, SNFs receive an all-inclusive per diem payment, which is fungible among the various services provided to SNF patients. SNFs do not receive separate payments for nontherapy ancillary services. Second, because of the all-inclusive nature of the payment, SNFs are encouraged to provide services in an efficient manner. Providers may choose to provide fewer nontherapy ancillary services and to negotiate lower prices paid for them. Because our sample was based on 1995 costs, any reductions in

ancillary pricing or utilization will not be reflected in these data. HCFA's letter is reprinted as appendix IV.

We are sending copies of this report to Nancy-Ann Min DeParle, Administrator of HCFA; appropriate congressional committees; and other interested parties. We will also make copies available to others upon request.

If you or your staff have any questions, please call me or Laura Dummit, Associate Director, at (202) 512-7114. Other major contributors include Carol Carter, Jennifer DuLac, Daniel Lee, and Dana Kelley.

Sincerely yours,

William J. Scanlon
Director, Health Financing and
Public Health Issues

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Abbreviations

BBA	Balanced Budget Act of 1997
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MDS	Minimum Data Set
OIG	Office of the Inspector General
PPS	prospective payment system
RUG	Resource Utilization Group
SNF	skilled nursing facility

Scope and Methodology

To determine how HCFA incorporated nontherapy ancillary costs into the SNF PPS, we reviewed (1) the provisions of the Balanced Budget Act of 1997 that mandated the new SNF PPS; (2) the SNF PPS interim rule, which took effect on July 1, 1998; (3) the SNF PPS final rule, which took effect September 30, 1999; and (4) associated research concerning SNF payment policies. We also discussed HCFA's implementation of the SNF PPS with officials at its Division of Inpatient Post Acute Care.

To determine the variation in SNF costs, we analyzed the 1995 SNF Minimum Data Set (MDS), which contains cost, financial, and other statistical information for Medicare-certified SNFs from the Medicare cost report. We used fiscal year 1995 data because they were the most complete data available at the time of our analysis. Based on input from HCFA officials, we calculated per diem ancillary (therapy and nontherapy), routine, and total costs for each facility.[15] To control for regional wage differences, we adjusted costs for wage differences across geographic areas according to the methodology prescribed in the regulations.[16] Finally, based on input from HCFA officials, examinations of the regulations, and our own determinations, we excluded SNFs that met any of the following conditions: (1) cost report periods less then 10 months or greater than 13 months, (2) low or no Medicare utilization, (3) extremely high or low routine or ancillary costs,[17] or (4) no identifiable wage index. These conditions reduced the analytic file from 12,276 to 10,015 facilities.

Due to data limitations, we could not examine SNF costs by case-mix group. The RUG-III classification system uses variables that were not in the 1995 cost report or claims files. Therefore, we focused our analysis on average per diem costs at the facility level. Although this limited our ability to examine the impact of the payment system under the new provisions, comparisons were adequate to establish a potential problem with the distribution of payments under PPS.

[15]Ancillary costs are costs for specialized services that are directly identifiable to individual patients. Therapy-ancillary costs include speech, occupational, and physical therapy costs. Nontherapy ancillary costs are all other ancillary cost categories, including drugs, medical supplies, labs, and X rays. Routine costs include regular room, dietary, nursing, and other services for which a separate charge is not made. All costs are after the allocation of overhead expenses.

[16]64 Fed. Reg. 41, 643-41, 683 (1999) (to be codified at 52 C.F.R. 409, 411, 413, 489).

[17]We excluded SNFs with no ancillary or routine costs and excluded SNFs whose routine or ancillary costs were within the top or bottom 0.25 percent for each group of hospital-based and freestanding SNFs. We chose this approach over HCFA's typical approach of excluding values equal to the mean plus three standard deviations or minus three standard deviations since it would have eliminated many of the high-cost providers without eliminating any of the extremely low-cost providers. Because many of the high-cost providers were hospital based, HCFA's approach would have eliminated a disproportionate number of hospital-based SNFs.

Medicare's Prospective Payment System Rate Calculation

Under PPS, SNFs are paid for their Medicare patients on a per diem basis. Each patient is grouped into 1 of 44 RUG-III categories based on their clinical condition, functional status, and expected use of certain services (see table II.1). A base payment is adjusted for each RUG-III category to account for the nursing and therapy costs associated with treating the average patient in that group.

Table II.1: RUG-III Groups

Service	Clinical condition/need	Number of groups
Rehabilitation	Patients who require rehabilitation in one of five groups based on the number of therapy minutes per week: — Ultra: 720 or more therapy minutes per week — Very high: 500 to 719 therapy minutes per week — High: 325 to 499 therapy minutes per week — Medium: 150 to 324 therapy minutes per week — Low: 45 to 149 therapy minutes per week	14
Extensive services	Patients who require intravenous feeding or medications, suctioning, tracheostomy care, or are on a ventilator/respirator	3
Special care	Patients with cerebral palsy; quadraplegia; multiple sclerosis; pressure ulcers; fever with vomiting, weight loss, or dehydration; tube feeding and aphrasia; or receiving radiation therapy.	3
Clinically complex	Patients with burns, coma, septicemia, pneumonia, internal bleeding, chemotherapy, wounds, kidney failure, urinary tract infections, oxygen, or transfusions	6
Impaired cognition	Patients with poor cognitive performance	4
Behavior problems	Patients with behavior symptoms such as wandering, hallucinations, or physical or verbal abuse of others (unless other condition would place patient in other category)	4
Reduced physical function	No special clinical conditions; RUG groups based solely on patient ability to perform activities of daily living	10

Each payment has three components to cover different types of costs: nursing, therapy, and other services.[18] The nursing component is calculated by multiplying the nursing weight assigned to each RUG-III category by the nursing base rate ($109.48 for urban facilities in 1998). The nursing weight reflects nursing, social services, and nontherapy ancillary resources necessary for providing care to the average patient within the associated RUG-III category. For the 26 RUG-III groups that will cover the

[18]The labor-related portion of the rate is adjusted by the hospital wage index to reflect the wage level in each SNF's market area.

majority of Medicare patients, the nursing weight ranges from 0.75 to 1.7.[19]

The costs of nontherapy ancillary services are included in the nursing component of the payment amount. Consequently, the nursing weights determine the payment range for nontherapy ancillary services. The nursing payment component, which covers nursing, social service, and nontherapy ancillary costs, ranges from $82.11 to $186.12 for urban facilities, depending on the RUG-III category, and $78.66 to $178.30 for rural facilities.

The therapy component consists of either a therapy case-mix amount or a therapy non-case-mix amount, depending on the RUG-III category and the amount of therapy resources required. For high-therapy-use groups, the therapy case-mix amount is calculated by multiplying the therapy weight by the therapy base amount ($82.67 for urban facilities in 1998). The therapy weight reflects resources necessary to provide physical therapy, speech therapy, or occupational therapy to the average patient within the associated RUG-III group. Patients who require minimal therapy services receive the therapy non-case-mix amount. This fixed amount reflects costs incurred to provide lower levels of therapy services.

The non-case-mix component is a fixed amount assigned to all RUG-III groups. This amount covers administrative, overhead, and other general patient care costs.

Table II.2 shows the PPS rate calculations for urban SNFs for the upper 26 case-mix groups.

[19]Patients classified into 1 of the upper 26 RUG-III categories are deemed to be eligible for Medicare coverage. Patients classified into 1 of the lower 18 RUG-III categories are reviewed on a case-by-case basis to determine Medicare eligibility.

Table II.2: PPS Rate Calculations for Urban SNFs for the Upper 26 Case-Mix Groups

	Nursing component[a]		Therapy component[b]			Non-case-mix	Total
RUG-III category (code)	Relative weight	Weight x base rate (A)	Relative weight	Weight x base rate (B)	Non-case-mix (C)	(D)	(A+B+C+D)
Rehabilitation							
Ultra C (RUC)	1.30	$142.32	2.25	$186.01		$55.88	$384.21
Ultra B (RUB)	0.95	104.01	2.25	186.01		55.88	345.90
Ultra A (RUA)	0.78	85.39	2.25	186.01		55.88	327.28
Very high C (RVC)	1.13	123.71	1.41	116.56		55.88	296.15
Very high B (RVB)	1.04	113.86	1.41	116.56		55.88	286.30
Very high A (RVA)	0.81	88.68	1.41	116.56		55.88	261.12
High C (RHC)	1.26	137.94	0.94	77.71		55.88	271.53
High B (RHB)	1.06	116.05	0.94	77.71		55.88	249.64
High A (RHA)	0.87	95.25	0.94	77.71		55.88	228.84
Medium C (RMC)	1.35	147.80	0.77	63.66		55.88	267.34
Medium B (RMB)	1.09	119.33	0.77	63.66		55.88	238.87
Medium A (RMA)	0.96	105.10	0.77	63.66		55.88	224.64
Low B (RLB)	1.11	121.52	0.43	35.55		55.88	212.95
Low A (RLA)	0.80	87.58	0.43	35.55		55.88	179.01
Extensive services							
Level 3 (SE3)	1.70	186.12			$10.91	55.88	252.91
Level 2 (SE2)	1.39	152.18			10.91	55.88	218.97
Level 1 (SE1)	1.17	128.09			10.91	55.88	194.88
Special care							
Level C (SSC)	1.13	123.71			10.91	55.88	190.50
Level B (SSB)	1.05	114.95			10.91	55.88	181.74
Level A (SSA)	1.01	110.57			10.91	55.88	177.36
Clinically complex							
ADL high, with depression (CC2)	1.12	122.62			10.91	55.88	189.41
ADL high, without depression (CC1)	0.99	108.39			10.91	55.88	175.18
ADL medium, with depression (CB2)	0.91	99.63			10.91	55.88	166.42
ADL medium, without depression (CB1)	0.84	91.96			10.91	55.88	158.75
ADL low, with depression (CA2)	0.83	90.87			10.91	55.88	157.66
ADL low, without depression (CA1)	0.75	82.11			10.91	55.88	148.90

[a]The urban SNF base rate for nursing is $109.48; the rural SNF nursing base rate is $104.88.

[b]The urban SNF base rate for therapy is $82.67; the rural SNF base rate for therapy is $95.51.

Types of and Variation in Nontherapy Ancillary Service Costs, 1995

Drug and medical supply costs accounted for the highest shares of nontherapy ancillary service spending in 1995 (see table III.1). Drugs were the most commonly provided service and were also the most expensive service on average. Virtually all (99 percent) of the SNFs in 1995 had reported drug costs, averaging almost $20 per day, and making up over half (58 percent) of all nontherapy ancillary costs. Ten percent of facilities had drug costs of $37 per day or more. Medical supplies were the next most common service (supplied in 90 percent of the SNFs) and made up about 18 percent of total nontherapy ancillary costs, or $9 per day. Again, the top 10 percent of facilities had costs well above that, at $22 or more per day.

Table III.1: Distribution of Daily Nontherapy Ancillary Costs by Cost Center, 1995

	Range of costs			
Nontherapy ancillary service	**10th percentile**	**Mean**	**90th percentile**	**Percent of SNFs reporting costs**
Drugs	$7	$20	$37	99%
Medical supplies	0	9	22	90
Oxygen therapy	0	8	26	54
Labs	0	2	10	26
All other cost centers[a]	0	2	7	42
Intravenous therapy	0	2	4	22
Radiology	0	1	5	32

[a]Electrocardiology, dental, and other nontherapy ancillary cost centers.

Source: GAO analysis of 1995 SNF Medicare cost reports.

Facility-level nontherapy ancillary costs ranged from less than $11 at the 10th percentile to $95 or greater at the 90th percentile (see table III.2). Although most of the facilities in our sample had average daily nontherapy ancillary costs below $40, 8 percent of facilities had costs that exceeded $101 per day. The type of institution may explain some of the variation in daily nontherapy ancillary costs, as seen in table III.3. For 67 percent of freestanding SNFs, these costs were $40 or less. However, only 25 percent of hospital-based SNFs had daily nontherapy ancillary costs of $40 or less.

Table III.2: Per Diem Nontherapy Ancillary Costs, by Percentile, 1995

Percentile	Daily cost
1st	$2
5th	7
10th	10
25th	18
50th (median)	33
75th	60
90th	95
95th	123
99th	181

Source: GAO Analysis of 1995 SNF Medicare cost reports.

Table III.3: Daily Nontherapy Ancillary Costs, Range Across Facilities, 1995

Average daily nontherapy ancillary cost	Number of facilities, by type			Percent of facilities	Cumulative percent of facilities
	Freestanding	Hospital-based	Total		
$0-10	1,012	104	1,116	11%	11%
11-20	1,888	123	2,011	20	31
21-30	1,558	94	1,652	16	48
31-40	1,147	105	1,252	13	60
41-50	781	100	881	9	69
51-60	548	110	658	7	76
61-70	399	150	549	5	81
71-80	290	140	430	4	85
81-90	203	141	344	3	89
91-100	148	128	276	3	92
101+	349	497	846	8	100
Total	**8,323**	**1,692**	**10,015**	**100%**	**100%**

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

SEP 2 3

DATE:

TO: William J. Scanlon
Director, Health Financing and Public Health Issues
General Accounting Office

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report: "Skilled Nursing Facilities: Medicare Payments Need to Better Account for Non-Therapy Ancillary Cost Variation," (GAO-HEHS-99-185).

We appreciate the General Accounting Office's work to assess the impact of the changes in Medicare's payment system for skilled nursing facilities. We are committed to paying nursing homes appropriately while ensuring beneficiaries retain access to quality skilled nursing care. This report provides useful analysis as we evaluate the payment changes.

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 total Medicare payments to nursing homes under prospective payment are likely to be adequate for non-therapy ancillary services, though nursing homes may be overpaid or underpaid for certain patient groups. We share the concerns involving medically complex patients, and we are working to ensure that the system provides for the most accurate payments possible. As the report notes, we are expediting research that will allow us to refine the payment system for non-therapy ancillary services if appropriate next year.

So far, the early evidence, including several reports by the HHS Inspector General, has shown that beneficiaries are continuing to get placed into appropriate skilled nursing facilities to meet their needs. The Inspector General also noted that nursing homes are changing their admission practices in response to PPS, and even though medically complex patients may be more difficult to place, they continue to get placed appropriately. We will 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 to help us assess and guide policy to serve our beneficiaries, and we will continue to evaluate any additional evidence and research about quality and access to care.

Decisions about the overall adequacy of the prospective payment rates should take place in the context of the larger discussion taking place between Congress and the Administration. As part of the Clinton Administration's plan to modernize and strengthen Medicare, the President has proposed setting aside $7.5 billion over 10 years to smooth out any provisions in the Balanced Budget Act that may 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 protect Medicare for the nearly 40 million elderly and disabled Americans who rely on this essential program.

I again thank you for the opportunity to review this report. Our technical comments are attached.

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