

August 2002

SKILLED NURSING FACILITIES

Providers Have Responded to Medicare Payment System By Changing Practices



Contents

| | | |
|---------------------|--|----|
| Letter | | 1 |
| | Results in Brief | 3 |
| | Background | 4 |
| | Distribution of Patients Across Payment Categories Has Changed Since PPS, SNFs Provide Fewer Minutes of Therapy | 11 |
| | Concluding Observations | 15 |
| | Agency Comments | 16 |
| Appendix I | Scope and Methodology | 17 |
| Appendix II | Therapy Minutes, Activities of Daily Living, and Medicare Payment Rates to SNFs | 20 |
| Appendix III | Comments from the Centers for Medicare & Medicaid Services | 22 |
| Tables | | |
| | Table 1: Share of Medicare Patients at Initial Assessment By Category and Percent Change, First Quarters 1999, 2000, and 2001 | 13 |
| | Table 2: Share of Medicare Patients at Initial Assessment in Rehabilitation RUGs and Percent Change, Before and After BBRA Payment Increases | 14 |
| | Table 3: Median Therapy Minutes Per Week Provided on or Before the Initial Medicare Assessment By Rehabilitation Category, 1999 and 2001 | 16 |
| | Table 4: Therapy Minutes, Activities of Daily Living, and Medicare Payment Rates to SNFs in Fiscal Year 2002 ^a | 20 |
| Figure | | |
| | Figure 1: Resource Utilization Group (RUG) Classification Scheme | 6 |



G A O

Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

August 23, 2002

The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Larry Craig
Ranking Minority Member
Special Committee on Aging
United States Senate

In 1998, the Health Care Financing Administration (HCFA) implemented a prospective payment system (PPS) for skilled nursing facility (SNF) services provided to Medicare beneficiaries.¹ Mandated in the Balanced Budget Act of 1997 (BBA), PPS is intended to control the growth in Medicare spending for skilled nursing and rehabilitative services that SNFs provide.² Medicare pays SNFs a daily rate to cover most services provided to a patient during each day of a covered SNF stay. Because each patient differs in the amount of care required, the rate is adjusted for the patient's expected care needs and therapy based on information gathered by SNFs using a uniform clinical assessment instrument known as the nursing home minimum data set (MDS). Information from the MDS—such as a patient's diagnoses, the amount of rehabilitative therapy,³ and ability to perform activities of daily living (ADL)—is used by SNFs to assign each patient to a Medicare payment group.

Patients assigned to the same Medicare payment group exhibit similar care needs, so Medicare's daily payment rate is the same for each patient within a group. The payment rate is based on the national average cost of

¹On July 1, 2001, the Secretary of Health and Human Services changed the name of the Health Care Financing Administration (HCFA) to the Centers for Medicare & Medicaid Services (CMS). In this report, we will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

²Pub. L. No. 105-33, § 4432(a), 111 Stat. 251, 414 (codified as amended at 42 U.S.C. § 1395yy(e) (2000)).

³This report uses therapy to refer to rehabilitation therapy, which includes physical, speech, and occupational therapies.

providing care to patients in each group, not the actual costs for any given patient. As a result, a SNF profits when its costs are below the payment rate and loses if its costs are above it. A SNF can control its costs by treating less expensive patients within a group, providing care more efficiently, or providing fewer or a less expensive mix of services compared to the national average. A SNF can maximize its payments by admitting patients who are likely to be classified into particular payment groups or by modifying its patient assessment and documentation practices to support higher payment group assignments.

The implementation of PPS raised providers' concerns about whether payments would cover their costs.⁴ Our work and the work of others indicated that the payment groups may not adequately identify high-cost patients and distribute payments accordingly. The Congress addressed these concerns by increasing Medicare payments across all payment groups. At the same time, the Congress mandated additional increases for selected payment groups in response to concerns that payments for some types of patients were too low. Payments were increased for some of the payment groups for patients receiving primarily rehabilitation therapy and all payment groups for patients requiring extensive or special care and for clinically complex patients.

Given possible provider responses to PPS, you asked us to analyze (1) shifts in the mix of Medicare beneficiaries across payment groups and (2) the amount of therapy services provided to patients within payment groups. To do so, we examined MDS data to determine the mix of patients treated and the services that Medicare beneficiaries received across and within payment groups for three points in time—early in PPS (January through March 1999), 1 year later and 2 years later. (For more details, see app. I, Scope and Methodology). We also interviewed staff from the Centers for Medicare & Medicaid Services (CMS) responsible for SNF payment policy and we reviewed regulations, literature, and other documents relating to SNF PPS and MDS. We performed our work from March 2000 through June 2002 in accordance with generally accepted government auditing standards.

⁴U.S. General Accounting Office, *Nursing Homes: Aggregate Medicare Payments are Adequate Despite Bankruptcies*, [GAO/T-HEHS-00-192](#) (Washington, DC: Sept. 5, 2000), U.S. General Accounting Office, *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access*, [GAO/HEHS-00-23](#) (Washington, DC: December 14, 1999), and Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington, DC: March 2001).

Results in Brief

Two years after the implementation of PPS, the mix of patients across the categories of payment groups has shifted, as determined by the patients' initial MDS assessments. Although the overall share of patients classified into rehabilitation payment group categories based on their initial assessments remained about the same, more patients were classified into the high and medium rehabilitation payment group categories, and fewer were initially classified into the most intensive (highest paying) and least intensive (lowest paying) rehabilitation payment group categories. This shift is consistent with industry assertions that payments in relation to the cost of caring for patients in the high and medium rehabilitation payment group categories were more favorable than those for other categories of payment groups. Further, the share of patients initially assigned to the selected rehabilitation payment groups for which the Congress gave additional payment increases grew, while the share of patients assigned to almost all of the other rehabilitation payment groups remained the same or declined. Among patients who were not in rehabilitation payment groups, the share that was initially classified into categories requiring more extensive services increased almost 12 percent. SNFs changed two patient assessment practices that could have contributed to the shift in patients, at admission, across payment groups. First, SNFs increasingly used estimates of therapy needed, rather than actual therapy delivered, to assign patients to payment group categories. Second, SNFs conducted their initial patient assessments later in the stays of patients needing therapy, expanding the period of time over which they could receive therapy and increasing the likelihood that they would be classified into categories with the highest possible payments.

Two years after PPS was implemented the majority of patients in rehabilitation payment groups received less therapy than was provided in 1999. This was true even for patients within the same rehabilitation payment group categories. The patients categorized into the two most common (high and medium) rehabilitation payment group categories typically received 30 minutes less therapy during their first week of care, a 22 percent decline. Across all rehabilitation payment group categories, fewer patients received the highest amounts of therapy associated with each payment group.

In its written comments on a draft of this report, CMS agreed with our findings and noted that they were generally consistent with its analyses of provider responses to the PPS.

Background

Generally, Medicare covers SNF stays for patients needing skilled nursing and therapy for conditions related to a hospital stay of at least 3 consecutive calendar days, if the hospital discharge occurred no more than 30 days prior to admission to the SNF. For qualified beneficiaries, Medicare will pay for medically necessary services, including room and board, nursing care, and ancillary services such as drugs, laboratory tests, and physical therapy, for up to 100 days per spell of illness.⁵

SNF PPS

For more than a decade beginning in 1986, Medicare SNF spending rose dramatically—averaging 30 percent annually. During this period, Medicare payments to each SNF were based on the costs incurred by the SNF in serving its Medicare patients. There was minimal program oversight, providing few checks on spending growth. Although Medicare imposed payment limits for routine services, such as room and board, it did not limit payments for capital and ancillary services, such as therapy. Cost increases for ancillary services averaged 19 percent per year from 1992 through 1995, compared to a 6 percent average increase for routine service costs.

To curb the rise in Medicare SNF spending, BBA required a change in Medicare's payment method. HCFA began phasing in the SNF PPS on July 1, 1998.⁶ Under PPS, SNFs are paid a prospectively determined rate intended to cover most services provided to a patient during each day of a Medicare-covered SNF stay.⁷ The SNF payment rate is based on the 1995 national average cost per day, updated for inflation. Because the costs of treating patients vary with their clinical conditions and treatments, daily payments for each patient are adjusted for the patient's expected care needs depending on the patient's assignment into one of 44 different payment groups, also called resource utilization groups (RUG). A RUG

⁵A spell of illness is a period that begins when a Medicare beneficiary is admitted to a hospital or a SNF and ends when a beneficiary has not been an inpatient of a hospital or a SNF for 60 consecutive days. A beneficiary may have more than one spell of illness per year and maintain Medicare coverage.

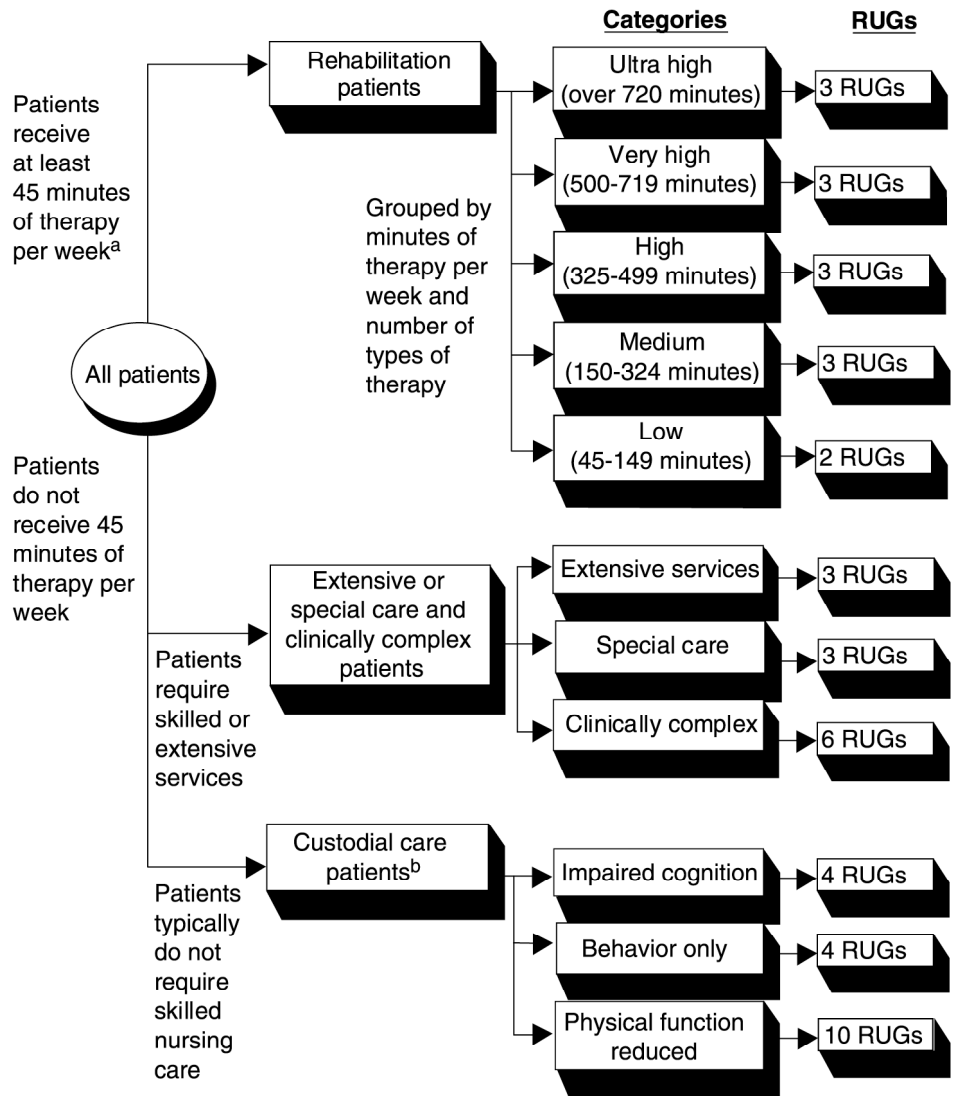
⁶SNFs came under PPS beginning with their new fiscal year. Over 90 percent of SNFs came under PPS before or during January 1999. The remainder came under PPS later in 1999.

⁷Payments are adjusted for the local variation in wages. Certain high-cost, infrequently provided services, such as cardiac catheterizations and radiation therapy, are paid for separately outside the daily SNF rate. See U.S. General Accounting Office, *Skilled Nursing Facilities: Services Excluded From Medicare's Daily Rate Need to be Reevaluated*, [GAO-01-816](#) (Washington, DC: Aug. 22, 2001).

describes patients with similar therapy, nursing, and special care needs and has a corresponding payment rate.

The RUG classification system is hierarchical. The first distinction made is whether the patient has received (or is expected to receive) at least 45 minutes a week of therapy (see fig. 1). For these rehabilitation patients, further divisions—into ultra high, very high, high, medium, and low therapy categories—are made based on the total minutes and type of physical, occupational, and speech therapy provided over 7 days. Each of these categories is defined by a range of therapy minutes and the type of therapy provided. For example, patients in the very high category receive between 500 and 719 minutes of therapy over 7 days. Each category is further subdivided into RUGs, based on a patient's dependency in performing ADLs, such as eating, transferring from a bed to a chair, or using the toilet. There are 14 rehabilitation RUGs, which account for three-fourths of Medicare-covered stays.

Figure 1: Resource Utilization Group (RUG) Classification Scheme



^aFor patients classified based on estimates of care needs, patients are expected to receive at least 45 minutes of therapy a week.

^bCare generally not paid by Medicare because patient does not require skilled nursing care.

Source: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, *64 Federal Register* 41,644 (July 30, 1999) and Department of Health and Human Services, Health Care Financing Administration, *Payment Safeguard Review of Skilled Nursing Facility Prospective Payment Bills*, Program Memorandum Transmittal A-99-20 (Baltimore, MD: May 1999).

Among patients who have not received (or are not expected to receive) 45 minutes a week of therapy, the system distinguishes between patients requiring extensive or special care or who are clinically complex (12 RUGs) and those receiving custodial care (18 RUGs).⁸ The classification system uses specific medical conditions (such as having multiple sclerosis or being comatose) and special care needs (such as requiring tracheostomy care or ventilator support) within the past 14 days to group patients into extensive services, special care, and clinically complex categories. Patient characteristics such as the ability to perform ADLs, signs of depression, and conditions requiring more technical clinical knowledge and skills are used to assign patients into RUGs within these categories.

MDS Patient Assessments

Since 1991, SNFs have carried out a requirement to periodically assess and plan for residents' care using the MDS,⁹ which documents 17 aspects of a patient's clinical condition, including the amount of therapy provided or planned, diagnoses, certain care needs, and the ability to perform ADLs at the patient's most dependent state. In addition to determining Medicare payments, these data are used to measure patient needs, develop a plan of care, and monitor the quality of care.

To gather the MDS, an in-house interdisciplinary team assesses each patient's clinical condition at established intervals throughout the patient's stay. The Medicare assessment schedule requires that the initial assessment be performed during days 1 through 5 of a patient's stay, but may be performed as late as days 6 through 8, termed "grace days," which give staff additional flexibility in conducting the assessments. The initial assessment is used to assign patients to a RUG that establishes payments for the first 14 days of care. For patients staying longer than 14 days, a second assessment must be conducted during days 11 through 14 that determines the RUG assignment and payment rate for days 15 through 30 of the patient's stay. An additional assessment is performed prior to the 30th day of care and every 30 days thereafter; each of these assessments establishes the payment for the next 30 days up to the 100th day.

⁸Patients in the custodial RUGs are divided into three broad categories—impaired cognition, behavior only, and physical function reduced—based on the need for nursing services and the patient's ability to perform ADLs. Patients classified into a custodial care RUG typically do not meet the skilled nursing care requirements for Medicare coverage.

⁹42 U.S.C. §§ 1395i-3(b)(3)(A) and 1396r(b)(3)(A) (2000).

SNFs can classify patients primarily needing therapy into the high, medium, or low rehabilitation payment group categories for the initial assessment using either actual minutes of therapy provided or an estimate of the amount that will be provided over the 2 weeks covered by the initial assessment. If a patient is classified into one of these rehabilitation categories using an estimate, but actually receives less than the amount of therapy to qualify into that category, payments to the SNF for the initial assessment period are not reduced. To classify patients into the very high or ultra high payment group categories on the initial assessment, SNFs must have already provided the minimum amount of therapy that defines these categories when the assessment is done.¹⁰

Possible SNF Responses to PPS Incentives

The accuracy and completeness of the patient assessment information are critical to ensure appropriate categorization of patients into payment groups. For example, to distinguish between different levels of assistance required in performing ADLs, a SNF needs to document how often and how much assistance was provided to a patient during the past 7 days. For a patient receiving over 720 minutes of therapy a week (the ultra high rehabilitation category), the difference between assessing a patient as needing “extensive” versus “limited” assistance in performing one ADL, such as eating, may result in an additional payment of up to \$48 per day to the SNF. (See app. II for a comparison of ADLs and payment rates for each RUG.) Thus, a SNF might respond to the PPS by increasing the resources devoted to completing the MDS.

This possible SNF response to the new payment system may be similar to how hospitals responded to the inpatient hospital PPS. Under the inpatient PPS, hospitals are paid a prospectively determined rate per patient stay, which is adjusted for expected resource needs based on factors such as patient diagnoses and treatment. After the implementation of the inpatient PPS in 1983, hospitals expanded the number of diagnoses they reported to describe patients. These changes in documentation resulted in some patients being classified into higher payment categories, which increased hospital payments.

¹⁰For the second and all subsequent assessments, a SNF must have provided the minimum amount of therapy in the range to classify a patient into any of the therapy categories. This categorization establishes payment for the next period.

A SNF also has an incentive to change the amount of care provided to minimize its costs and maximize its payments. Because the amount of therapy provided is key to classifying the majority of patients into RUGs, a SNF benefits when it provides an amount of therapy on the low end of the range of therapy minutes associated with that RUG. For example, furnishing 1 additional minute of therapy a week could move a patient from the very high to the ultra high category. The SNF would receive an additional \$63 or \$99 more per day, depending on the patient's ADL needs, but there may not have been a proportionate increase in costs.

To ensure that its patients are grouped into the highest possible payment groups, a SNF may adjust the timing of its initial patient assessments. Grace days are intended to give SNFs the flexibility to delay care until patients are ready to receive therapy, while ensuring that payments reflect the treatment levels that are provided to the patient. SNFs may opt to use grace days when conducting the initial assessment of patients who may be grouped into the payment group categories that require actual minutes of therapy (ultra and very high rehabilitation). Otherwise, if initial assessments are done before the grace days, patients may not have received enough therapy to reach the weekly threshold for placement into one of these categories.

Refinements to the SNF PPS

Since the implementation of the SNF PPS, some nursing home chains have claimed that payments are inadequate and that this has caused their financial condition to erode. We have reported that total SNF PPS payments are likely to be adequate and may be excessive given that the payment rates include the costs of inefficient delivery, unnecessary care, and improper billings.¹¹ But the Medicare Payment Advisory Commission and we have raised concerns that the payment rates for certain types of patients may be inadequate because the patient classification system may not appropriately reflect the differing needs of patients who require multiple kinds of health care services, such as extensive or special care, rehabilitative therapy, and ancillary services.¹² We have also expressed

¹¹GAO/T-HEHS-00-192 and GAO/HEHS-00-23.

¹²See Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington, DC: March 2001) and U.S. General Accounting Office, *Skilled Nursing Facilities: Medicare Payments Need to Better Account for Nontherapy Ancillary Cost Variation*, GAO/HEHS-99-185 (Washington, DC: Sept. 30, 1999).

concern that the use of therapy minutes provided to patients as a way to classify patients might encourage the provision of unnecessary services.¹³

In response to concerns about the overall adequacy of Medicare payments and their distribution across different types of patients, the Congress has raised payments twice since the PPS implementation. These actions increased payments across-the-board for all RUGs and, in addition, for certain RUGs. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) temporarily increased Medicare's payments for all RUGs by 4 percent, beginning in fiscal year 2001 through the end of fiscal year 2002.¹⁴ In addition, BBRA increased payments for 15 RUGs (3 rehabilitation RUGs and all extensive services, special care, and clinically complex RUGs) by 20 percent beginning in April 2000.¹⁵ The Congress intended this increase to be temporary—until refinements to the RUGs patient classification system were implemented. However, refinements have not been implemented and the Congress again revised the payment rates.¹⁶ The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) temporarily increased the portion of the payment related to nursing costs by 16.66 percent for all payment groups,¹⁷ which raised the overall payment rates from 4 to 12 percent, depending on the RUG, beginning April 1, 2001, through September 30, 2002. In addition, BIPA replaced the 20 percent BBRA increase that applied to 3 out of the 14 rehabilitation RUGs with a 6.7 percent increase for all rehabilitation RUGs.¹⁸

CMS has also responded to concerns about PPS. In July 2001, CMS awarded a contract to determine the feasibility of refinements to PPS, including alternatives to the RUGs patient classification system. To date, this contract has not resulted in proposed refinements to the RUGs system and the contractor's preliminary report is not due until fall 2004. CMS has

¹³U.S. General Accounting Office, *Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms*, [GAO/T-HEHS-99-192](#) (Washington, DC: Sept. 15, 1999).

¹⁴Pub. L. No. 106-113, App. F, § 101(d), 113 Stat. 1501, 1501A-325.

¹⁵BBRA § 101(a) and (b). This 20 percent increase is calculated separately from the 4 percent increase.

¹⁶65 *Fed. Reg.* 46,770 (July 31, 2000).

¹⁷Pub. L. No. 106-554, App. F, § 312(a), 114 Stat. 2763, 2763A-498.

¹⁸The remaining 12 RUGs—extensive services, special care, and clinically complex—retained the 20 percent increase. BIPA § 314.

also supported work to assess and verify the MDS data that underlie PPS. However, we recently reported that CMS's proposed on-site and off-site review of MDS assessments may not be sufficient to ensure the accuracy of MDS assessments in most nursing homes or to systematically evaluate the performance of state efforts to do so.¹⁹ In September 2001, CMS awarded a contract to determine if there are differences between the documentation of patient care needs and actual patient care needs and to detect irregularities in MDS assessments. The contractor began these data monitoring activities in the spring of 2002, which include checking that the RUGs reported on the Medicare claims match those on the MDS assessments and examining the distribution of patients across the payment groups.

Distribution of Patients Across Payment Categories Has Changed

Among patients primarily receiving rehabilitation care, more were classified at their initial assessment into moderate rehabilitation payment group categories and fewer into the intensive and low rehabilitation categories since the implementation of PPS. Providers reported that the payments for the moderate rehabilitation payment groups were more favorable, relative to their costs, than other payment groups. Further, the share of patients initially classified into the rehabilitation RUGs whose payments were increased by BBRA provisions grew, while the share of patients initially classified into most of the other payment groups declined or stayed the same. Across patients initially assigned to the extensive, special care, or clinically complex categories, more were classified as requiring extensive services—the highest paying category—and fewer into the special care or clinically complex categories. SNFs changed two patient assessment practices that could have contributed to these shifts in patients' initial payment group assignments. First, SNFs increased their use of estimated—rather than actual—therapy minutes to assign patients to rehabilitation categories. Second, SNFs assessed patients later in their stays, making it more likely that they received more therapy and therefore would be classified into categories with higher payments.

¹⁹For more information on CMS and state efforts to monitor the accuracy of the MDS data see U.S. General Accounting Office, *Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities*, [GAO-02-279](#) (Washington, DC: Feb. 15, 2002).

More Patients Initially Categorized into Payment Groups with Payment Increases

Although the proportion of SNF Medicare patients initially classified into rehabilitation payment group categories remained the same overall, the distribution of patients within these categories changed considerably from first quarter 1999 to first quarter 2001 (see table 1).²⁰ By 2001, more Medicare patients receiving therapy were initially classified into the two moderate rehabilitation categories—medium (16 percent more) and high (17 percent more), which made up about two-thirds of Medicare SNF admissions.²¹ The share of patients initially classified into ultra high—the most intensive rehabilitation category—decreased to comprise just 3 percent of all Medicare SNF patients at their initial assessment in 2001. This shift is consistent with the industry’s assertions that the high and medium categories have more favorable payments, relative to their costs, than other categories. We do not know if this shift reflects a change in the care needs of patients from 1999 to 2001.

²⁰Over three-quarters of Medicare SNF patients were classified into rehabilitation categories, while a little less than one quarter were classified into extensive services, special care, or clinically complex categories.

²¹Our findings about the share of rehabilitation versus extensive, special care, and clinically complex patients and the distribution of patients across rehabilitation categories are consistent with other analyses of claims data. See Department of Health and Human Services, Office of the Inspector General, *Trends in the Assignment of Resource Utilization Groups by Skilled Nursing Facilities*, OEI-02-01-00280 (Washington, DC: HHS, July 2001).

Table 1: Share of Medicare Patients at Initial Assessment By Category and Percent Change, First Quarters 1999, 2000, and 2001

| Predominant type of care | Category | January-March 1999 (percent) | January-March 2000 (percent) | January-March 2001 (percent) | Percent change 1999-2001 |
|---|--------------------|------------------------------|------------------------------|------------------------------|--------------------------|
| Rehabilitation therapy | Ultra high | 6.6 | 3.8 | 3.2 | -51.5 |
| | Very high | 15.6 | 14.1 | 11.8 | -24.4 |
| | High | 37.1 | 42.1 | 43.5 | 17.3 |
| | Medium | 15.9 | 16.9 | 18.5 | 16.4 |
| | Low | 0.5 | 0.3 | 0.2 | -60.0 |
| Extensive, special care, and clinically complex | Extensive services | 11.9 | 13.1 | 13.3 | 11.8 |
| | Special care | 5.8 | 5.1 | 4.9 | -15.5 |
| | Clinically complex | 4.1 | 3.1 | 2.9 | -29.3 |
| Custodial care | Other | 2.6 | 1.6 | 1.5 | -42.2 |
| Total | | 100 | 100 | 100 | - |

Note: Percentages do not add to 100 due to rounding.

Source: GAO analysis of the nursing home MDS, Medicare initial assessments, first quarters of 1999, 2000, and 2001.

Some of the shifts in the distribution across individual rehabilitation RUGs paralleled changes in payment rates made by the Congress. Within the high and medium rehabilitation payment group categories, the shares of patients initially classified into RUGs that received congressionally mandated payment increases in 2000 grew substantially more than the shares of patients classified into rehabilitation RUGs that did not (see table 2). For 8 of the 11 rehabilitation RUGs without this special increase, the shares of patients at their initial assessment declined and only one experienced an increase.

Table 2: Share of Medicare Patients at Initial Assessment in Rehabilitation RUGs and Percent Change, Before and After BBRA Payment Increases

| Rehabilitation RUG | Share January-March 2000 (percent) | Share January-March 2001 (percent) | Percent change 2000-2001 |
|---|------------------------------------|------------------------------------|--------------------------|
| RUGs with payments increased 20 percent by BBRA | | | |
| RHC | 17.4 | 19.3 | 11 |
| RMC | 5.2 | 5.6 | 8 |
| RMB | 8.4 | 9.5 | 13 |
| RUGs with payments not increased 20 percent by BBRA | | | |
| RUC | 0.6 | 0.5 | -17 |
| RUB | 2.5 | 2.2 | -12 |
| RUA | 0.6 | 0.5 | -17 |
| RVC | 1.8 | 1.3 | -28 |
| RVB | 9.2 | 7.8 | -15 |
| RVA | 3.2 | 2.7 | -16 |
| RHB | 18.2 | 18.1 | -1 |
| RHA | 6.4 | 6.2 | -3 |
| RMA | 3.4 | 3.5 | 3 |
| RLB | 0.1 | 0.1 | 0 |
| RLA | 0.2 | 0.2 | 0 |

Note: The payment increases mandated by BBRA applied to services furnished on or after April 1, 2000. Beginning April 1, 2001, BIPA replaced the 20 percent BBRA increase with a 6.7 percent increase for all rehabilitation RUGs.

Source: GAO analysis of the nursing home MDS, Medicare initial assessments, first quarters of 2000 and 2001.

Among the patients initially classified into the extensive and special care or clinically complex categories (all of which were increased 20 percent by BBRA), the share of patients initially assessed as requiring the most intensive care—those in the extensive services category—increased to become about two-thirds of patients in these categories, while the share of patients in the special care and clinically complex categories decreased.

Since the introduction of PPS, changes in SNF patient assessment practices have made it easier to classify patients into some categories with higher payments. When performing their initial patient assessments, SNFs have increasingly opted to use estimates of the amount of therapy they expect to provide (rather than actual therapy given during the first week of care) to categorize patients into the high, medium, and low therapy categories for the first 14 days of care. Because payments are based on these estimates, payments for some patients were higher than they would

Changes in Assessment Practices May Contribute to Different Classifications and Higher Payments

have been if the payments were based on actual therapy provision. Comparing the first quarters of 1999 and 2001, the practice of using estimated therapy minutes, rather than actual therapy provided, to classify patients into therapy categories increased more than 35 percent, becoming the mechanism for classifying nearly two-thirds of all patients in high, medium, and low rehabilitation categories. Of the patients who could be evaluated,²² one quarter of the patients classified using estimated minutes of therapy did not receive the amount of therapy they were assessed as needing, while three-quarters eventually did.²³

SNFs increasingly performed initial patient assessments later in patient stays, during the grace days, for patients in the highest paying therapy categories—ultra high and very high. Because classification into these categories is based on the actual amount of care provided, conducting the patient assessments during the grace days allows additional time for more therapy services to be provided, making it likelier that patients would be classified into the ultra high and very high categories. To classify patients into these categories, the use of grace days increased more than 40 percent from the first quarter of 1999 to the first quarter of 2001.

Since PPS, SNFs Provide Fewer Minutes of Therapy

In the 2 years following the implementation of PPS, SNFs provided less therapy to almost two-thirds of all Medicare SNF patients—those in the medium and high rehabilitation payment group categories. The typical patient in these categories received 22 percent less therapy, at least 30 fewer minutes, per week during the initial assessment period between the first quarters of 1999 and 2001. Indeed, in 2001 half of the patients initially categorized in these two groups did not actually receive the amount of therapy required to be classified into those groups, due in part to the use of estimated therapy minutes for classification (see table 3). Further, during their initial assessment period, fewer patients received therapy near the higher end of the range that defines each category. For example, to be assigned to the high rehabilitation category, patients are assessed as needing between 325 and 499 minutes of therapy a week. In

²²Only patients who stay long enough to have a second assessment done (where the actual minutes of therapy provided in the past 7 days are recorded) could be evaluated. For the largest share of patients, however, we do not know if they received the projected services because these patients did not stay in the facilities long enough for a second assessment.

²³It is possible that between the initial assessment and the end of the second assessment period the care needs of some patients changed and they no longer required the amount of therapy that had been originally estimated.

1999, 20 percent of patients in the high rehabilitation payment group category received 390 minutes or more of therapy per week during their initial assessment period. Two years later, less than 13 percent received this much therapy. In 1999, 5 percent of patients initially assessed in the high rehabilitation payment group category received 480 minutes or more of therapy per week. Two years later, only 2 percent of patients received this level of therapy.

Table 3: Median Therapy Minutes Per Week Provided on or Before the Initial Medicare Assessment By Rehabilitation Category, 1999 and 2001

| Rehabilitation category (required therapy minutes per week) | Minutes per week provided in | | Percent change 1999-2001 |
|---|------------------------------|------|-----------------------------|
| | 1999 | 2001 | |
| Ultra high (720 or more) | 735 | 737 | 0 |
| Very high (500-719) | 525 | 525 | 0 |
| High (325-499) | 325 | 255 | -22 |
| Medium (150-324) | 150 | 117 | -22 |
| Low (45-149) | 80 | 77 | -4 |

Source: GAO analysis of the nursing home MDS, Medicare initial assessments, first quarters of 1999 and 2001.

Across all therapy patients, the median amount of therapy provided during the initial assessment period also declined from 1999 through 2001. The declines in therapy service use and resultant reductions in costs were not uniform across the rehabilitation payment group categories. Consequently, payments for some categories of RUGs are likely to be higher than their service costs, compared to other categories of RUGs. For patients in the more intensive rehabilitation payment group categories, where estimated minutes cannot be used to classify patients, median therapy minutes did not decline.

Concluding Observations

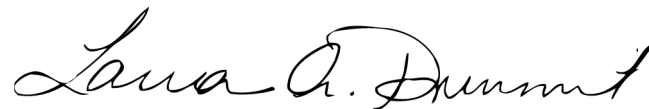
Our work indicates that SNFs have responded to PPS in two ways that may have affected how payments compare to SNF costs. SNFs have (1) changed their patient assessment practices and (2) reduced the amount of therapy services provided to Medicare beneficiaries. The first change can increase Medicare's payments and the second can reduce a SNF's costs. CMS's ongoing efforts to refine the payment system are particularly important in light of these provider responses to the PPS.

Agency Comments

In its written comments on a draft of the report, CMS agreed that ongoing evaluations of PPS are important. CMS stated that our findings are generally consistent with its analyses and with its expectations regarding provider responses to the incentives of the PPS. CMS noted that it intends to examine whether therapy provided is consistent with payment levels and ADL coding accuracy through its program safeguard contractor project. CMS stated that reporting the percentage change of relatively small shares of patients across payment categories may overemphasize the changes and is somewhat misleading. However, the percentage changes reported in table 1 demonstrate that the shifts in shares of patients across payment categories are consistent with the industry's assertions that high and medium categories have the most favorable payments, relative to costs. In addition, the percentage changes reported in table 2 demonstrate that the shifts among RUGs parallel the congressionally mandated payment increases. CMS also provided technical comments, which we incorporated as appropriate. CMS's comments are in appendix III.

We are sending copies of this report to the Administrator of CMS, appropriate congressional committees, and other interested parties. We will also provide copies to others upon request. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff has any questions, please call me at (202) 512-7114. Laura Sutton Elsberg, Leslie Gordon, and Walter Ochinko prepared this report under the direction of Carol Carter.



Laura A. Dummit
Director, Health Care—Medicare Payment Issues

Appendix I: Scope and Methodology

We used data from the 1998 Medicare cost reports to identify SNFs that began participating in PPS on or before January 1, 1999. Facility ownership and other characteristics were taken from HCFA's end-of-year Provider of Services file for 1999. We included in our analysis only those SNFs that had transitioned to PPS before or during January 1999, were active in 1999, and submitted Medicare MDS assessments in the three periods used in this study. This cohort comprised approximately 80 percent of all SNFs that filed a 1998 cost report and was representative of the universe of SNFs in terms of bed size, location (rural and urban), and ownership characteristics.

For the SNFs in our sample, we analyzed data from the nursing home MDS national repository to compare differences in patient classification and therapy services across three points in time—early in PPS (January-March 1999), 1 year later (January-March 2000), and 2 years later (January-March 2001).¹ Data to examine the distribution of Medicare patients after the implementation of BIPA-mandated changes (applied to services on or after April 1, 2001) were not available in time for this analysis. Our sample included over 350,000 MDS assessments for Medicare beneficiaries for each time period. To examine the differences in patient classification, we grouped patient assessments into 11 major categories—the 5 major rehabilitation categories (ultra high, very high, high, medium, and low), 3 categories for patients requiring extensive or special care or who are clinically complex, and 3 categories for patients requiring custodial care, based on the RUG reported on the initial assessment.

To examine the differences in the provision of therapy services, we aggregated the reported physical, occupational, and speech therapy minutes for each assessment. We calculated the number of initial assessments that had used estimated minutes to qualify patients into a rehabilitation category by counting the number of first assessments that reported actual therapy minutes below the minimum number of minutes required in the three rehabilitation categories (high, medium, and low). To determine the extent to which patients received the estimated therapies, we calculated, for the patients who had a second assessment, the percent who had received less than the minimum number of therapy minutes required for the RUG reported on the initial assessment. We also

¹The national repository contains resident assessment information for every resident of a Medicare- or Medicaid-certified long-term care facility.

interviewed CMS staff responsible for SNF policy and we reviewed regulations, literature, and other documents relating to SNF PPS and MDS.

Appendix II: Therapy Minutes, Activities of Daily Living, and Medicare Payment Rates to SNFs

Table 4: Therapy Minutes, Activities of Daily Living, and Medicare Payment Rates to SNFs in Fiscal Year 2002^a

| Predominant type of care | Category | Therapy minutes per week | ADLs ^b | Resource utilization group | Medicare daily payment rate |
|---|--|--------------------------|-------------------|----------------------------|-----------------------------|
| Rehabilitation therapy | Ultra high | 720+ | 16-18 | RUC | \$441.18 |
| | | | 9-15 | RUB | \$392.78 |
| | | | 4-8 | RUA | \$369.27 |
| | Very high | 500-719 | 16-18 | RVC | \$342.67 |
| | | | 9-15 | RVB | \$330.22 |
| | | | 4-8 | RVA | \$298.41 |
| | High | 325-499 | 13-18 | RHC | \$318.68 |
| | | | 8-12 | RHB | \$291.02 |
| | | | 4-7 | RHA | \$264.74 |
| | Medium | 150-324 | 15-18 | RMC | \$315.94 |
| | | | 8-14 | RMB | \$279.99 |
| | | | 4-7 | RMA | \$262.01 |
| Low ^c | 45-149 | 14-18 | RLB | \$252.39 | |
| | | 4-13 | RLA | \$209.52 | |
| | | 7-18 | 3 RUGs | \$234.06-\$307.35 | |
| Extensive or special care or clinically complex | Extensive services ^d | N/A | 7-18 | 3 RUGs | \$211.93-\$228.53 |
| | Special care ^e | N/A | 7-18 | 3 RUGs | \$175.98-\$227.14 |
| | Clinically complex ^f | N/A | 4-18 | 6 RUGs | \$145.55-\$167.68 |
| Custodial ^g | Impaired cognition ^c | N/A | 4-10 | 4 RUGs | \$138.64-\$166.30 |
| | Behavior only ^c | N/A | 4-10 | 4 RUGs | \$135.87-\$181.51 |
| | Physical function reduced ^c | N/A | 4-18 | 10 RUGs | |

^aThe payment rates in the table became effective October 1, 2001, for SNFs located in urban areas and include the 16.66 percent increase for the nursing component as required by BIPA, but do not include the add-on payments for individual RUGs. There are separate payment rates for facilities located in rural areas.

^bADL scores range from 4 (least dependent) to 18 (most dependent).

^cThe low rehabilitation RUG and some of the custodial RUGs require at least two nursing rehabilitation activities, 6 days a week. Some examples include: passive or active range of motion, amputation care, and splint or brace assistance.

^dThe extensive services category includes patients who have had the following specific medical or skilled nursing care needs in the past 14 days—intravenous medications, tracheostomy care, ventilator/respirator support, suctioning, or intravenous feeding in the last 7 days.

^eThe special care category includes patients who have any of the following clinical conditions: multiple sclerosis, cerebral palsy, quadriplegia with high ADL dependency, surgical wounds or open lesions, pressure or stasis ulcers on two or more body sites or have a fever in combination with dehydration, pneumonia, vomiting, weight loss, or tube feeding. It also includes patients who require specific medical and skilled nursing care, such as radiation therapy and respiratory therapy.

^fThe clinically complex category includes patients who have any of the following clinical conditions: comatose, burns, systemic infection (septicemia), pneumonia, internal bleeding, dehydration, dialysis, or paralysis on one side (hemiplegia) in combination with a high ADL dependency. It also includes patients receiving chemotherapy, tube feeding of at least 26 percent of daily calorie intake and 501 milliliters of fluid, being treated for foot wounds or transfusions, receiving injections 7 days per week for diabetes while their condition is somewhat unstable, or those who have received oxygen therapy in the last 14 days. The group also includes patients with unstable conditions.

Appendix II: Therapy Minutes, Activities of Daily Living, and Medicare Payment Rates to SNFs

^aPatients are classified into the custodial categories according to their need for nursing services and assistance with ADLs. These patients typically do not meet the criteria for Medicare coverage because they generally do not require skilled nursing care.

Sources: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, 63 *Federal Register* 26,252 (May 12, 1998), table 2C and Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, 66 *Federal Register* 39,562 (July 31, 2001), table 3.

Appendix III: Comments from the Centers for Medicare & Medicaid Services



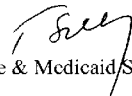
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG - 1 2002

TO: Laura Dummit
Director, Health Care—Medicare Payment Issues
General Accounting Office

FROM: Thomas A. Scully 
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, "Skilled Nursing Facilities: Providers Have Responded to New Payment System By Changing Practices" (GAO-02-841)

Thank you for the opportunity to review and comment on the above-referenced report regarding the Medicare skilled nursing facility (SNF) prospective payment system (PPS). The Centers for Medicare & Medicaid Services (CMS) recognizes the importance of continuing to monitor and evaluate this and other new payment systems implemented pursuant to the Balanced Budget Act of 1997. The CMS appreciates GAO's efforts in this regard.

The findings of the report are generally consistent with those of our own analysis. As noted in the report, providers appear to have identified the cost-effective levels for provision of therapy services, and the majority of beneficiaries are treated within the High and Medium resource utilization group (RUG)-III categories. This trend in the classification meets our expectations, given the relatively high levels of rehabilitation associated with the top two case-mix categories.

We do not see any evidence to suggest that beneficiaries are not receiving needed rehabilitation services. In fact, prior to implementation of the SNF PPS, there was concern among policy-makers regarding the widespread provision of unnecessary rehabilitation therapy to Medicare beneficiaries. We believe the incentives built into the SNF PPS have likely worked to diminish inappropriate provision of therapy services, which often subjected beneficiaries to arduous, but ineffective, therapy regimens.

With regard to the report's finding that the Medicare program may be paying for therapy services that are predicted but not delivered, we will be focusing on this area as part of our monitoring activities. This is an aspect of the payment system that we have identified for review and analysis through our program safeguard contractor project, Data Accuracy and Assessment Verification (DAVE). The results of this report's analysis certainly indicate that this is an area of potential program vulnerability that we should examine. The CMS policy and program integrity staffs will work together in addressing this issue.

Page 2 – Laura Dummit

The movement noted in patient classification among the clinical RUG-III categories is also similar to CMS's own findings. We have found little change across RUG-III groups between 1999 and 2001. Our analysis of claims data shows a slight increase in the percent of days paid at the Extensive Services level (less than 1 percent between 1999 and 2000, and 1 percent between 2000 and 2001); with equally slight decreases in paid days for the two other RUG-III clinical categories (i.e., special care and clinically complex). However, we believe that the percentage increases presented in the report (Table 1 and elsewhere) are somewhat misleading. For example, the 60 percent decrease reported in beneficiaries' classifications into the Rehabilitation Low groups represents a shift of 0.5 percent to 0.3 percent. This is a mere shift of two-tenths of one percentage point. The approach used in the report to present this and other changes tends to amplify somewhat insignificant changes.

GAO's Mission

The General Accounting Office, the investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through the Internet. GAO's Web site (www.gao.gov) contains abstracts and full-text files of current reports and testimony and an expanding archive of older products. The Web site features a search engine to help you locate documents using key words and phrases. You can print these documents in their entirety, including charts and other graphics.

Each day, GAO issues a list of newly released reports, testimony, and correspondence. GAO posts this list, known as "Today's Reports," on its Web site daily. The list contains links to the full-text document files. To have GAO e-mail this list to you every afternoon, go to www.gao.gov and select "Subscribe to daily E-mail alert for newly released products" under the GAO Reports heading.

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. General Accounting Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
 TDD: (202) 512-2537
 Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Public Affairs

Jeff Nelligan, managing director, NelliganJ@gao.gov (202) 512-4800
U.S. General Accounting Office, 441 G Street NW, Room 7149
Washington, D.C. 20548