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Report to the Ranking Minority Member, Special Committee on Aging, U.S. Senate

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SKILLED NURSING FACILITIES

Approval Process for Certain Services May Result in Higher Medicare Costs

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The Honorable David H. Pryor
Ranking Minority Member
Special Committee on Aging
United States Senate

Dear Senator Pryor:

In response to your request, we conducted a study of (1) the growth of skilled nursing facility (SNF) costs and SNF use in relation to hospital use; (2) the characteristics of Medicare SNF patients and the types of services they receive in SNFs being paid higher than normal amounts compared to other SNFs, as well as whether patients in such facilities receive appropriate care; and (3) whether the Health Care Financing Administration's (HCFA) process for assessing requests for higher payments ensures that only SNFs furnishing atypical services are granted exceptions, and what information HCFA gathers to assess such requests. This process does not adequately distinguish between SNFs that provide atypical services (and thus qualify for additional payments under the regulations) and SNFs that have higher than normal costs for other reasons, such as inefficiency.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to appropriate congressional committees and other interested parties. We will also make copies available to others upon request.

This report was prepared under the direction of David P. Baine, Veterans' Affairs and Military Health Care Issues, who can be reached on (202) 512-7101. You may also call Thomas Dowdal at (202) 512-6588 or Sandra K. Isaacson at (202) 512-7174. Other GAO contacts and staff acknowledgments are listed in appendix VII.

Sincerely yours,

Janet L. Shikles
Assistant Comptroller General

Executive Summary

Purpose

Skilled nursing facilities (SNF) provide posthospital care for people who need a level of care higher than what could be provided in the home. Medicare payments to SNFs have been growing rapidly, increasing from $456 million in fiscal year 1983 to an estimated $10.8 billion in 1996. The number of SNFs that have sought and been granted payments higher than those normally allowed by Medicare has also grown, from a total of 80 during fiscal years 1979 through 1992 to 552 in fiscal year 1995 alone. The SNF industry maintains that a major reason for cost growth and increased requests for higher payments is that SNFs care for more complex and costly patients than they did in the past.

Concerned over the increase in Medicare SNF costs and the number of SNFs granted higher than normal payments, the Ranking Minority Member, Senate Special Committee on Aging, requested that GAO report on (1) the growth of SNF costs and SNF use in relation to hospital use; (2) the characteristics of Medicare SNF patients and the types of services they receive in SNFs being paid higher than normal amounts compared to other SNFs, as well as whether patients in such facilities receive appropriate care; and (3) whether the Health Care Financing Administration's (HCFA) process for assessing requests for higher payments ensures that only SNFs furnishing atypical services are granted exceptions, and what information HCFA gathers to assess such requests.

Background

After a hospitalization, Medicare covers in full the allowable costs of SNF care received by beneficiaries for up to 20 days and costs above a daily coinsurance amount for the 21st through the 100th day. In 1979, HCFA established limits on the amount of routine costs (room, board, and general nursing care) that Medicare would recognize as reasonable. These limits are known as routine cost limits (RCL). Medicare pays SNFs for routine costs on a per-patient-day basis, up to the RCL. However, if a SNF incurs high costs as a result of providing atypical services to some or all of its Medicare patients, it may request an exception from the RCL. For example, patients with complex care needs, such as ventilator care or treatment for severe bedsores, might require nursing care beyond what would typically be provided, causing the SNF providing such care to incur higher than normal nursing costs. If the SNF seeks and is granted an RCL exception, it would be reimbursed for all or part of its routine costs above its RCL.

Results in Brief

SNF use has increased since 1983 when the Medicare hospital prospective payment system (PPS), which pays a predetermined amount per hospital discharge, was introduced and gave hospitals a financial incentive to shorten lengths of stay. Higher SNF use means higher total costs for SNF care. The average length of hospital stay for Medicare patients has decreased from 10 days in 1983 to 7.1 days in 1995, indicating that, as expected, some substitution of SNF care for hospital care has occurred. Furthermore, the average length of hospital stay decreased more for those Medicare patients whose diagnoses were more likely to lead to a SNF admission, such as hip fractures, than for Medicare patients as a whole. In addition, considering patients with these types of diagnoses, hospitals with SNF units saw larger decreases in the average patient length of stay than did hospitals without SNF units. Another factor leading to increased SNF use was that coverage rules were liberalized in 1988 in response to a court decision. Finally, the increasing number of SNFs granted RCL exceptions and the resulting additional payments—almost $100 million in fiscal year 1995—has contributed to the growth in Medicare SNF costs.

To gain an exception to RCL, a SNF is supposed to show that it furnishes atypical services to Medicare beneficiaries. Therefore, it is reasonable to expect the SNFs with exceptions would be caring for patients with more complex care needs. However, contrary to expectation, GAO did not find that SNFs with exceptions had a higher proportion of patients requiring complex care than SNFs without exceptions. For example, in the four states' data GAO analyzed, it found no substantive difference in Medicare patients' ability to perform activities of daily living (such as eating) regardless of whether the SNF had received an exception. Furthermore, considering therapy that might be indicative of complex care needs, GAO found no substantive differences in the amount and type of therapy provided. When reviewing the medical records of patients identified as requiring complex care and who reside in SNFs granted exceptions, GAO found that appropriate care was generally provided.

The number of SNFs granted exceptions to RCL has risen from 62 in fiscal year 1992 to 552 in 1995. However, HCFA's review process for RCL exception requests does not ensure that SNFs actually provide atypical services to their Medicare patients. HCFA's exception screening benchmarks basically take into account only whether requesting SNFs treat a higher than average proportion of Medicare patients. Moreover, the patient-specific information obtained from requesting SNFs is generally not used to assess whether the Medicare beneficiaries need or receive atypical services. In effect, to gain approval for an exception, a SNF that treats a higher than

average percentage of Medicare patients only has to show average routine costs that exceed RCLs, which could be due to inefficiency rather than the provision of atypical services.

Principal Findings

SNF Use Has Increased as Hospital Length of Stay Has Decreased

Medicare's switch in 1983 to PPS for inpatient hospital care with its incentive to discharge patients as soon as possible combined with a 1988 liberalization of Medicare's SNF coverage criteria both contributed to the substantial growth in SNF use. With increased use, Medicare costs for SNF reimbursement also grew. In 1984, Medicare beneficiaries had 333,000 covered SNF stays at a total cost of about $465 million (or $1,397 per admission), but by 1995, there were over 1.5 million stays at a cost of about $7.5 billion (or $4,902 per admission). Over this same period, the average length of hospital stay decreased from 10 days to 7 days, indicating that some substitution of SNF care for what would in the past have been the last few days of hospital care occurred.

Hospital lengths of stay declined more for Medicare patients whose diagnoses suggested that they might need posthospital care, such as patients treated for hip or pelvic fractures, than for Medicare patients as a whole. GAO examined 12 such diagnoses and each showed this trend. Furthermore, for 11 of these 12 diagnoses, the average length of stay for Medicare patients was shorter in hospitals with SNFs than for hospitals without SNFs.

SNFs With and Without Exceptions Care for Similar Medicare Patients and Provide Similar Services

Because SNFs with exceptions are reimbursed higher amounts than SNFs without exceptions, they could be expected to take care of patients who are sicker or who otherwise require more services than patients in SNFs without exceptions. However, in the four states GAO studied, it found no substantive differences between the characteristics of, and services received by, Medicare patients residing in SNFs granted exceptions and those in SNFs that did not receive exceptions. For example, GAO found no substantive difference in Medicare patients' ability to perform various activities of daily living, or in the frequency with which certain types of treatments and therapies were furnished to these patients. Furthermore, according to peer review organization reviewers who studied the medical records of 100 Medicare patients in five SNFs with exceptions, who were

identified as requiring or likely requiring complex care by SNF staff, patients in three of the SNFs did not demonstrate a need for intense or complex care. The reviewers did find in the other two SNFs, however, that about half of the patients reviewed required more complex care than would typically be expected.

The physician reviewers also found, after reviewing the 100 medical records, that the patients generally received appropriate care. However, in several of these SNFs, the reviewers did find some cases in which inappropriate care had been furnished. Of the 100 cases reviewed, physician reviewers found, among other problems, 5 instances of medication errors and 3 instances of delays in contacting physicians about patient problems. Reviewers identified one patient who required outpatient hospital treatment as a result of a SNF staff member's failure to carry out a procedure properly.

HCFA's Exception Review Process Is Inadequate

To be granted an exception, a SNF must demonstrate for all its patients, both Medicare and others in Medicare-certified beds, that it meets one of three HCFA benchmarks by having (1) a shorter average length of stay; (2) a higher than average amount of ancillary services, such as drugs or therapy;[1] or (3) a higher than average proportion of Medicare patients. However, Medicare patients generally have much shorter lengths of stay and receive many more ancillary services than other patients. As a result, for many facilities the three criteria really boil down to one—Medicare's portion of SNF patients. For example, urban hospital-based SNFs have overall average lengths of stay of 132 days and average ancillary costs of $63 per day while these averages for Medicare patients are just 17 days and over $142 per day. Thus, as the proportion of Medicare patients increases, average length of stay should decrease and ancillary costs per day should increase. But a higher percentage of Medicare patients itself does not necessarily mean that these patients receive atypical routine services.

In addition to demonstrating that they meet one of the HCFA benchmarks, SNFs must submit data summarizing patients' diagnoses, ability to perform activities of daily living, and destination upon discharge. HCFA has not, however, developed guidance on how these data are to be used in determining whether a SNF provided atypical services, and only 3 of the 10 fiscal intermediaries GAO visited used any of these data when reviewing exception requests. Thus, a SNF that meets a benchmark in effect only has

[1]HCFA uses ancillary services costs as an indicator of atypical services even though these services are not considered routine and are paid without regard to HCFA's routine cost limit.

to show that its costs are higher than its RCL to gain an exception, even though the higher costs could be the result of inefficiency rather than the Medicare patients' need for atypical services.

Recommendation

GAO recommends that the Secretary of Health and Human Services direct the HCFA Administrator to revise the SNF exception to the RCL review process so that it can differentiate between SNFs that furnish atypical services to Medicare patients and SNFs that merely have higher than normal costs.

Agency Comments

The Department of Health and Human Services (HHS) generally agreed with GAO's recommendation to improve the exception process. HHS believes that data being developed under a current SNF payment method demonstration will prove adequate for this purpose.

Contents

Tables

Figures

Abbreviations

ADL	activity of daily living
DRG	diagnosis-related group
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
MDS	Minimum Data Set
MDS+	Minimum Data Set Plus
MEDPAR	Medicare provider analysis and review
NPR	Notice of Program Reimbursement
PPS	prospective payment system
PRO	peer review organization
RCL	routine cost limit
RUG-III	Resource Utilization Group, version III
SNF	skilled nursing facility
TIA	transient ischemic attack

Introduction

Skilled nursing facilities (SNF) provide care for people who no longer require a hospital level of care but need a higher level of medical services than what could be provided in the home. Medicare's payments for SNF services have grown from $456 million in fiscal year 1983 to an estimated $10.8 billion in fiscal year 1996. During this same period, the number of SNFs requesting and being granted payments for routine services higher than those normally allowed has also grown. The main reason cited by the SNF industry for the requests for higher rates is that some SNFs are caring for more complex and costly patients and, therefore, higher payments are justified.

Medicare and SNFs

Medicare, authorized by title XVIII of the Social Security Act, is a federal health insurance program that covers almost all citizens 65 years of age or older and certain disabled people. About 38 million individuals are covered. The program has two parts. Part A, financed by payroll taxes, covers inpatient services in hospitals and SNFs as well as home health and hospice care. Part B, a voluntary program financed by enrollee premiums and general revenues, covers physician services and a wide range of other services such as laboratory tests and medical equipment used in the home. Medicare is administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS).

To qualify for SNF services, a Medicare beneficiary must have been hospitalized for 3 or more days, be admitted to the SNF on a medical professional's order for a condition related to the hospitalization, and need daily skilled nursing or therapy services. When the beneficiary meets these conditions, Medicare covers all necessary services, including room and board, nursing care, and ancillary services such as drugs, laboratory tests, and physical therapy. Medicare pays the full amount for the first 20 days. For the 21st through the 100th day of covered care, the beneficiary pays coinsurance of up to $92 per day (in 1996), and Medicare pays the remainder. Medicare coverage ends after the 100th day.

To be eligible to receive payment under the Medicare program, SNFs must meet a set of 15 requirements, each of which consists of a number of elements. These requirements are designed to ensure that the SNF is capable of providing quality care to patients in a safe environment and cover such areas as fire safety, cleanliness, nursing staff, and medical records. HCFA contracts with state health agencies to survey nonstate-owned SNFs to determine whether they meet the requirements, a process known as survey and certification. A team of health and safety

professionals annually inspects the facility and reviews the care furnished to patients. The state team recommends to HCFA whether to certify the facility for participation, and HCFA makes the final decision.

Medicare SNF Payment Method

Medicare pays SNFs on the basis of reasonable costs, which Medicare defines as those costs that are appropriate, necessary, and related to patient care. The program has a set of cost reimbursement principles that are used to determine whether claimed costs meet the definition of reasonable costs. SNFs submit cost reports to Medicare annually that are the basis for determining the facilities' reasonable costs.

HCFA contracts with insurance companies such as Blue Cross and Blue Shield plans and Mutual of Omaha to process part A claims. These contractors are called intermediaries, and their functions for SNFs include paying claims, reviewing the necessity of care, and auditing cost reports. The intermediaries pay SNFs during the year on the basis of interim rates, which are designed to closely approximate reasonable costs. After reviewing, and perhaps auditing, a SNF's cost report, the intermediary makes a final settlement, either paying any underpayment or recovering any overpayment.

Under authority granted by section 223 of the Social Security Amendments of 1972, HCFA has established a limit on the amount of costs for routine services (room, board, general nursing, and administration costs) Medicare will recognize as reasonable. This routine cost limit (RCL) is set separately for freestanding urban, freestanding rural, hospital-based urban, and hospital-based rural SNFs. For freestanding SNFs the RCL is set at 112 percent of mean routine costs. Cost limits for hospital-based SNFs are set at the limit for freestanding SNFs plus 50 percent of the difference between the freestanding limit and 112 percent of mean routine costs of hospital-based SNFs. In 1996, this resulted in the RCL for urban hospital-based SNFs being about $39 per day higher than that for urban freestanding SNFs and about $26 per day higher for rural hospital-based versus rural freestanding SNFs. The RCL is adjusted for differences in wage rates across geographic areas.

Exemptions and Exceptions to RCL

During SNFs' first 3 years of operation, they can receive new provider exemptions from RCLs. The exemptions can last as long as 3 years and 11 months depending on when during the SNF's cost-reporting year the exemption becomes effective. The reason for the exemption is that new providers often have higher than usual costs as they hire staff and

gradually increase their occupancy rates. During the exemption period, SNFs are paid their full reasonable costs whether or not those costs exceed their RCLs.

Any SNF that is not exempt from the RCL can request an exception if its routine costs exceed its limit.[2] While there are five circumstances for exceptions,[3] about 98 percent of exception requests are for the atypical services criterion. As defined by regulation (42 C.F.R. 413.30), atypical services are items or services furnished because of the special needs of the Medicare patients treated and necessary in the efficient delivery of needed health care. For example, a common claim by SNFs seeking exceptions for atypical services is that they have high nursing care costs.

Regulations governing exemptions and exceptions were in existence when RCLs were first established in 1979. In 1994, HCFA issued Transmittal 378, the agency's first written guidelines on the exception process. Transmittal 378 established comparative data for the four groups of SNFs for which RCLs are established, required SNFs to submit patient-specific data such as patient diagnosis, and imposed time deadlines on the intermediary and HCFA to handle exception requests.

To obtain an exception, a SNF must submit a written request to the intermediary responsible for paying the SNF's claims. The intermediary reviews the request using Transmittal 378 guidelines and sends the exception request and its recommendation to HCFA. The intermediary's recommendation can be to approve the requested rate, approve at a lower rate, or deny the request. HCFA reviews the request and the intermediary's recommendation and makes the final decision.[4] (See app. I for a detailed description of the exception process).

Objectives, Scope, and Methodology

The Ranking Minority Member of the Senate Special Committee on Aging asked us to describe how Medicare's SNF costs and usage have grown in relation to hospital use and to assess whether Medicare's process for deciding whether SNFs warrant higher rates discriminates between SNFs

[2]SNFs with a low volume of Medicare patients can elect to be paid the average amount per day for Medicare patients in the state. SNFs choosing this option are not eligible for exceptions.

[3]RCL exceptions are permitted for atypical services, extraordinary circumstances, providers in areas with fluctuating populations, medical and paramedical education, and unusual labor costs.

[4]Under a pilot project initiated in August 1995 and currently authorized to continue until August 1997, HCFA delegated final decision authority for exception request approvals to six intermediaries for the SNFs served by those intermediaries.

that treat more complex cases and those that have high costs but do not treat more complex cases. He also asked us to ascertain whether there were differences between the Medicare patients treated by facilities that received higher rates and those that did not. To respond to this request, we addressed the following questions:

- How have SNF costs and use grown in relation to hospital use?
- How do Medicare patients in SNFs granted exceptions compare with Medicare patients in SNFs that have not received exceptions, including whether patients in SNFs granted exceptions need more intense or complex care?
- How do services provided by SNFs granted exceptions compare with services provided by SNFs that have not received exceptions (for example, nurse staffing levels, physician coverage, and therapy services)?
- Do patients in SNFs granted exceptions receive appropriate care?
- What information does HCFA gather to assess RCL exception requests, and does its process ensure that SNFs are furnishing atypical services before granting RCL exceptions?

To identify growth in SNF use and its relation to hospital use, we obtained and analyzed HCFA data on Medicare beneficiary use of services in both settings. We also reviewed a number of studies and reports related to this area. To assess whether hospital length of stay was different when hospitals have SNF units, we examined changes in length of stay between fiscal years 1991 and 1994 for all Medicare patients and for 12 diagnoses that are likely to result in posthospital care. (See app. II for a description of the 12 diagnosis-related groups.)

To address whether HCFA's RCL exception process ensures that SNFs granted exceptions actually furnish atypical services, we reviewed HCFA's statutory authority and responsibilities for establishing and administering Medicare's SNF RCL exception process and HCFA's regulations and guidance to intermediaries for reviewing exception requests filed by SNFs. In particular, we reviewed the current SNF exception request review process that was set out in HCFA's Transmittal 378 instructions issued in July 1994. We also discussed the SNF exception process with HCFA officials in the Bureau of Policy Development.

We visited 10 intermediaries[5] to determine the SNF exception request review process employed by each and verify that their reviews complied with the guidance laid out in Transmittal 378 and subsequent written correspondence. In November 1995, HCFA provided us with a database that contained information on 1,379 approved exception requests.[6] The 10 intermediaries processed 789, or 57 percent, of these exceptions. The intermediaries we visited included five that processed more than 50 exception requests, two that processed fewer than 20 requests, and three participating in HCFA's experiment giving final approval authority to intermediaries. Two of the five selected high volume intermediaries also participated in the pilot project.

To answer the questions about SNF patient characteristics and facility services, we analyzed (1) a compilation of HCFA-required resident assessment data (known as the Minimum Data Set (MDS)) about each nursing home resident in Maine, Missouri, Ohio, and Washington for calendar year 1994 and (2) Medicare claims file data for 1992 and 1994. In addition, for Maine and Ohio, we applied a HCFA method for classifying nursing home patients into homogenous groups according to common health characteristics and the amount and type of resources they use. To provide additional information on patient and facility characteristics, we visited five SNFs that had received exceptions in the past and continue to apply for exceptions. We chose these SNFs, located in California, Illinois, Indiana, Massachusetts, and Washington, with input from state officials and local nursing home ombudsmen.

To assess whether the care Medicare beneficiaries received in SNFs granted exceptions was appropriate, we asked officials in the SNFs we visited to identify a universe of their Medicare patients who they believed needed or likely needed more intense or complex care. We then randomly selected 20 of these patients' records from each facility that were sent to the peer review organization (PRO) located in the SNF's state, where they were reviewed by registered nurses and physicians using HCFA evaluation

[5]These were Aetna Life Insurance Co. offices in South Windsor, Connecticut; Aetna Life Insurance Co. offices in North Hollywood, California; Aetna Life Insurance offices in Fort Washington, Pennsylvania; Associated Hospital Service of Maine (Maine Blue Cross); Blue Cross of California; Blue Cross and Blue Shield of Mississippi; Community Mutual Insurance Corp., Ohio; IASD Health Services Corporation (Blue Cross of Western Iowa); Mutual of Omaha Insurance Co.; and Veritus Inc. (Blue Cross of Western Pennsylvania).

[6]HCFA provided revised and updated information in June 1996. Those data are the source for the 1,759 approved exceptions discussed in ch. 4 of this report.

guidelines for quality and appropriateness of care.[7] We also asked the reviewers to judge the intensity and complexity of care needed by the patients.

We did not independently examine the internal and automated data processing controls for automated systems from which we obtained data used in our analyses. HCFA subjects its data to periodic reviews and examinations and relies on the data obtained from these systems as evidence of Medicare-covered services and expenditures and to support its management and budgetary decisions. We did however, assess the reliability of the data by testing multiple data elements to confirm their expected relationships to one another, and individual data elements for specific attributes. The state-specific data we analyzed and the information from the site visits cannot be projected to the nation as a whole. (See app. III for a more detailed discussion of the methodology for analyzing patient characteristics, services provided, and appropriateness of care.)

With this exception, we conducted our review from July 1995 to September 1996 in accordance with generally accepted government auditing standards.

[7]PROs are organizations that contract with HCFA to review the necessity, appropriateness, and quality of inpatient hospital services, health maintenance organization (HMO) services, and some outpatient surgical services received by Medicare beneficiaries. PROs are also responsible for reviewing Medicare beneficiary complaints, including those about care in SNFs.

SNF Use Increased as Hospital Length of Stay Decreased

The average length of hospital stay for Medicare patients has gone down since the prospective payment system (PPS) was introduced in 1983. At the same time, SNF use has gone up, indicating that some substitution of SNF care for hospital care has occurred under PPS. Average length of hospital stay has decreased more for those patients whose diagnoses are more likely to lead to a SNF admission. Moreover, for patients with these diagnoses, hospitals with a SNF unit saw even larger decreases in average length of stay than hospitals without a SNF unit.

Changes in Hospital and SNF Use

Before Medicare introduced its hospital PPS in fiscal year 1984, hospitals could maximize their Medicare revenues by keeping beneficiaries in the hospital as long as possible. Each additional day of hospital stay meant more reimbursement. PPS changed financial incentives for hospitals by paying them a fixed amount per discharge that differs on the basis of the patient's diagnosis. This encouraged hospitals to be more efficient and to control costs. One way for hospitals to control costs is to reduce the average length of patient stay, and one way to reduce the length of stay is to transfer patients to SNFs as soon as medically appropriate. As a result, it was expected that SNF use would increase after PPS.

Table 2.1 shows for fiscal years 1983 through 1995 the number of discharges from hospitals and admissions to SNFs along with the average length of stay in each setting. Hospital average length of stay decreased by about 29 percent, and discharges per 1,000 beneficiaries also decreased by about 24 percent. The reduction in discharges per 1,000 beneficiaries can be explained in large part by the substitution of ambulatory and outpatient surgery for inpatient surgery. For example, in 1981, the base year for PPS, about 332,000 Medicare discharges were for cataract surgery, accounting for over 1 million days of care. Today, almost all cataract surgery is done on an outpatient basis.

Table 2.1: Medicare Inpatient Hospital and SNF Use, 1983-95

	Hospitals			SNFs	
Fiscal year	Discharges (in thousands)	Average length of stay	Calendar year	Admissions (in thousands)	Average length of stay
1983	11,700	10.0	1983	309	29.2
1984	11,500	9.2	1984	333	26.6
1985	10,500	8.7	1985	353	23.4
1986	10,600	8.7	1986	347	22.4
1987	10,400	8.9	1987	327	21.5
1988	10,400	9.0	1988	446	26.5
1989	10,300	9.0	1989	805	35.5
1990	10,500	9.0	1990	738	28.8
1991	10,700	8.7	1991	[a]	[a]
1992	11,100	8.5	1992	919	27.5
1993	11,100	8.2	1993	1,105	28.1
1994	11,500	7.6	1994	1,319	27.4
1995[b]	11,100	7.1	1995	1,543	26.0

[a]Data not available.

[b]Hospital and SNF data for 1995 are preliminary.

Even though the complexity of hospital cases, as measured by the mean hospital case mix index, has increased on average by almost 28 percent since PPS began, average length of stay has gone down. Some of the decrease can probably be explained by the substitution of SNF care for what would in the past have been the last few days of hospital care. Beneficiary use of SNF services has increased from 10 admissions per 1,000 beneficiaries in 1983 to 42 per 1,000 based on preliminary data for 1995, and the percentage of hospital discharges resulting in SNF admissions has increased from 2.7 percent to 13.3 percent.

PPS' effect on SNF use was initially smaller than expected and sometimes contrary to expectations. Medicare SNF admissions increased from 309,000 in 1983 to 353,000 in 1985. During the same period, Medicare SNF payments increased 5 percent, from $456 million to $480 million. However, between 1985 and 1987, this trend reversed. Medicare SNF admissions fell to 327,000, a 7 percent decline. Any PPS effect on Medicare SNF utilization was offset by intensified utilization review by Medicare intermediaries.

Several events occurred in the late 1980s that resulted in increased SNF usage. In 1988, HCFA implemented revised SNF coverage guidelines in response to a lawsuit (Fox v. Bowen, 1987). The intent of these new guidelines was to make it easier for beneficiaries to obtain SNF coverage and to increase the consistency of coverage determinations. Enactment of the Medicare Catastrophic Coverage Act in 1988 also had a major effect by increasing coverage and reducing beneficiary cost sharing. These changes provided a strong incentive for providers to become certified as Medicare SNFs. Over 1,600 new SNFs and nearly 75,000 new beds were certified between December 1988 and December 1990.

The combined effects of increased coverage and increased provider resources produced rapid growth in the use of the Medicare SNF benefit during calendar year 1989, the only year the catastrophic coverage provisions were fully in effect. Covered days of care more than doubled over the previous year, from 11.8 million to 28.6 million, while program payments increased from about $1 billion to $2.8 billion.

With the repeal of the Medicare Catastrophic Coverage Act in 1989, the SNF benefit structure returned to that in effect in 1988 after settlement of the lawsuit. This, as expected, produced a drop in utilization and payments for Medicare SNF services in 1990. However, SNF utilization and payments remained well above pre-1989 levels, and by 1992 had surpassed the 1989 level.

Length of Stay Declines Were Larger for Diagnoses Often Requiring Postacute Care

In 1991 the average length of stay for Medicare patients in PPS hospitals was 7.9 days. It fell to 6.9 days in 1994, a decrease of 12.9 percent. However, we found that for 12 diagnosis-related groups (DRG)[1] that are likely to require posthospital-care services, the declines in length of stay were larger. As shown in table 2.2, the change in length of stay between 1991 and 1994 for these 12 DRGs ranged from 16.7 percent to over 27 percent.

[1]Each DRG includes one or more diagnoses that are expected to require about the same level of hospital resources to treat. A hospital receives the same payment amount for all cases that fall into an individual DRG.

Table 2.2: Change in Average Length of Stay for Selected DRGs From 1991 to 1994

	Average length of stay		Decline in length of stay	
DRG[a]	1991	1994	Days	Percent
001	13.4	10.6	2.8	20.9
014	9.0	7.5	1.5	16.7
113	15.4	12.8	2.6	16.9
209/491[b]	10.1	7.3	2.8	27.7
210	12.0	9.1	2.9	24.2
211	9.2	7.0	2.2	23.9
217	15.7	12.5	3.2	20.4
218	8.6	6.4	2.2	25.6
236	8.9	7.3	1.6	18.0
253	7.7	6.0	1.7	22.1
263	16.2	12.5	3.7	22.8
271	10.2	8.4	1.8	17.6

Note: Discharges from Maryland were not included because that state has a different hospital payment system.

[a]The DRGs are described in app. II.

[b]In 1991, DRG 209 contained procedures involving both the lower and upper extremities. In 1992, DRG 491 was added, and procedures involving the upper extremities were removed from 209 and assigned this DRG. In order to compare them with 1991, discharges for both of these DRGs were combined for 1994.

As shown in table 2.3, the average length of stay in PPS hospitals with SNFs was shorter than the average length of stay in PPS hospitals that did not have a SNF unit for all but 1 of the 12 DRGs included in our analysis. Lengths of stay ranged from 4 percent to almost 14 percent shorter in hospitals with SNF units.

Table 2.3: Average Length of Stay for Selected DRGs, for PPS Hospitals With and Without SNF Units, 1994

	Average length of stay		Shorter length of stay in hospitals with SNFs	
DRG[a]	Hospitals without SNF units	Hospitals with SNF units	Days	Percent
001	10.7	10.3	0.4	3.7
014	7.7	7.2	0.5	6.5
113	13.3	12.0	1.3	9.8
209/491[b]	7.6	7.0	0.6	7.9
210	9.5	8.5	1.0	10.5
211	7.3	6.5	0.8	11.0
217	13.1	11.6	1.5	11.5
218	6.6	6.0	0.6	9.1
236	7.0	7.7	(0.7)	(10.0)
253	6.2	5.7	0.5	8.1
263	13.3	11.5	1.8	13.5
271	8.9	7.9	1.0	11.2

Note: Discharges from Maryland were not included because that state has a different hospital payment system.

[a]The DRGs are described in app. II.

[b]In 1991, DRG 209 contained procedures involving both the lower and upper extremities. In 1992, DRG 491 was added, and procedures involving the upper extremities were removed from 209 and assigned this DRG. In order to compare them with 1991, discharges for both of these DRGs were combined from 1994.

For the 12 DRGs analyzed, about 248,000 Medicare beneficiaries were discharged to a SNF from a PPS hospital during fiscal year 1994. This represented about 23 percent of discharges from PPS hospitals for these DRGs. As shown in table 2.4, for beneficiaries discharged to a SNF, the average length of stay for hospitals with SNFs was less than that for hospitals without SNFs for each of the 12 DRGs. The differences ranged from 0.3 to 2.7 days.

Table 2.4: Average Length of Stay for Patients Discharged to a SNF for 12 DRGs, for Hospitals With and Without SNF Units, 1994

	Average length of stay		Shorter length of stay in hospitals with SNFs	
DRG[a]	Hospitals without SNF units	Hospitals with SNF units	Days	Percent
001	15.3	13.7	1.6	10.5
014	10.0	8.5	1.5	15.0
113	12.3	11.7	0.6	4.9
209/491[b]	8.4	6.6	1.8	21.4
210	9.2	7.9	1.3	14.1
211	7.2	6.0	1.2	16.7
217	15.4	12.7	2.7	17.5
218	8.3	6.8	1.5	18.1
236	7.0	6.7	0.3	4.3
253	6.7	5.8	0.9	13.4
263	14.1	11.4	2.7	19.1
271	9.8	7.8	2.0	20.4

Note: Discharges from Maryland were not included because that state has a different hospital payment system.

[a]The DRGs are described in app. II.

[b]In 1991, DRG 209 contained procedures involving both the lower and upper extremities. In 1992, DRG 491 was added, and procedures involving the upper extremities were removed from 209 and assigned this DRG. In order to compare them with 1991, discharges for both of these DRGs were combined for 1994.

Patients and Services Appear Similar in SNFs With and Without Exceptions

Because SNFs with exceptions are supposed to be furnishing atypical services, they might be expected to have a higher proportion of patients requiring more nursing assistance or more complex care than SNFs without exceptions. However, in the four states we studied, we found no substantive differences between the characteristics of, and services received by, Medicare patients residing in SNFs granted exceptions and those in SNFs that did not receive exceptions. For example, we found no substantive differences in patients' ability to perform activities of daily living (ADL), the types of patient diagnoses, or the frequency with which certain types of treatments and therapies were administered.

PRO reviewers found that patients in the five SNFs with exceptions that we visited generally received appropriate care—that is, the right care at the right time. They did find instances in which inappropriate care had been furnished in several of the SNFs granted exceptions. However, except for one case, no adverse outcomes resulted.

Despite Different SNF Payment Rates, Patient Characteristics Appear Similar Between the Two Groups

Although HCFA intends that exceptions be granted only to SNFs that care for patients requiring atypical services, when comparing SNFs with exceptions and those without, we found little difference in either the Medicare patients themselves or the services they were provided.[8] For example, we found no substantive difference between the two groups of SNFs in terms of (1) patients' ability to perform activities of daily living, (2) patients' diagnoses, (3) patients' cognitive status, or (4) patients' prior nursing home stays.

Patients in Both Groups Were Similar in Several Characteristics We Examined

When comparing data about the characteristics of residents in SNFs that received exceptions and SNFs that did not, we found that facilities in both groups care for some Medicare patients who required complex care. However, we found no substantive differences between these groups of facilities in a number of areas that may reflect the overall complexity of patient care needs. (See app. IV for the results of certain patient characteristics we analyzed.) Furthermore, during their review of medical records of a sample of patients in the five SNFs with exceptions we visited, PRO reviewers found that a majority of patients in three SNFs sampled did not need complex or intense care, while half of the patients sampled in the other two SNFs did require more complex or intense care.

[8]HCFA considers costs associated with providing care to non-Medicare patients in Medicare-certified beds as well as those associated with caring for Medicare patients when evaluating the SNF's application for an exception. However, we limited our analysis to only Medicare patients.

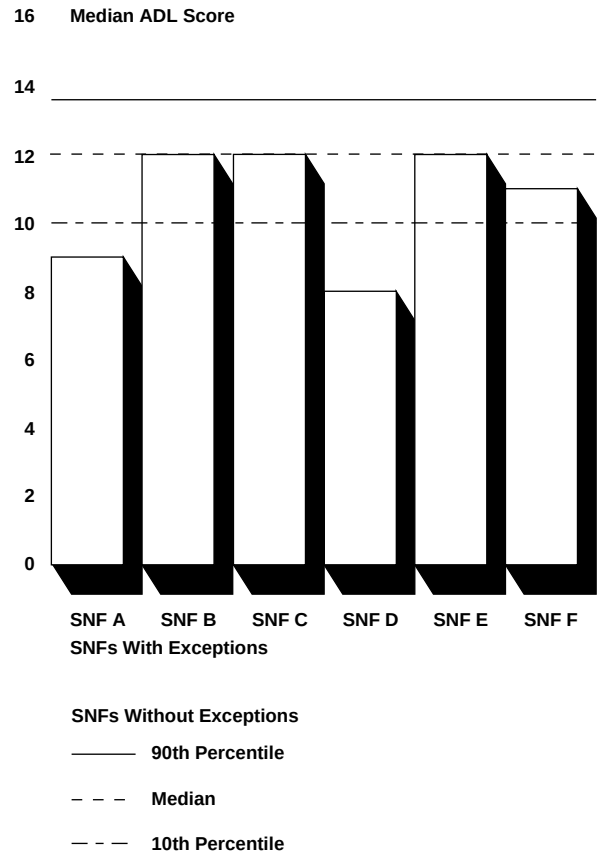
Activities of Daily Living

We analyzed ADLs because they are a measure of patient need and the facility resources required to meet those needs.[9] Lower ADL scores indicate patients with relatively fewer needs for assistance compared with patients with higher ADL scores. In each of the states we studied, according to the MDS data, patients in SNFs with exceptions and those in SNFs without exceptions had, on average, similar abilities to perform ADLs. For example, as figure 3.1 shows, patients in both groups of SNFs in Missouri had ADL scores of about 12, on average.[10] Missouri SNFs with exceptions' individual facility ADL scores ranged from 8 to 12. Missouri SNFs without exceptions had a median ADL score of 12, with 10 percent of the SNFs with exceptions having ADL scores of 10 or lower and 10 percent having ADL scores of 14 and higher. (See app. IV for information about patient ADLs in the other three states we analyzed.)

[9]For the collection of resident assessment data, the Minimum Data Set (MDS) instrument directs the rater to measure the patient's ability to perform various activities using a numerical scale, which increases with the patient's need for assistance. We analyzed the sum of patient ADL scores for four types of activities: bed mobility (the patient's ability to reposition himself or herself in bed), transfer (the patient's ability to move from a wheelchair to a bed, for example, or into and out of an armchair), toilet use, and eating.

[10]Patients in two of the six Missouri SNFs with exceptions had lower average ADL scores than those of patients in most Missouri SNFs without exceptions.

Figure 3.1: Median Patient ADL Scores in Missouri SNFs, 1994



Diagnosis-Related Groups

To obtain information about diagnoses, we analyzed 1992 and 1994 data from HCFA's Medicare provider analysis and review (MEDPAR) database, classifying the SNF patients into DRGs using software developed for HCFA for hospital prospective payment.[11] We found few differences between the two groups of SNFs.[12] For example, in 1994 the most common DRG for patients in both groups of Ohio SNFs was fractures of the hip and pelvis. Table 3.1 shows, for each group of Ohio SNFs, the five most common DRGs. (DRG information for the other three states, and for the nation as a whole, is in app. IV.)

[11]The DRG software was developed for hospital patients rather than SNF patients. However, applying this classification scheme to the SNF MEDPAR data provided an understanding of the types of diseases and related needs of patients that the two groups of SNFs are caring for—SNF patients have to have received hospital care and be admitted to the SNF for a condition related to that care.

[12]Diagnosis information alone often does not indicate the severity of a patient's condition.

Table 3.1: Five Most Common DRGs of Ohio SNF Patients, 1994

Rank, measured by frequency of DRG occurrence	DRG name (percentage of total Medicare patients)	
	SNFs with exceptions	SNFs without exceptions
1	Fractures of the hip and pelvis (10.0%)	Fractures of the hip and pelvis (9.8%)
2	Specific cerebrovascular disorders other than transient ischemic attack (TIA)[a] (8.8%)	Specific cerebrovascular disorders other than TIA (8.2%)
3	Diabetes, over age 35 (5.8%)	Rehabilitation (6.0%)
4	Heart failure and shock (4.5%)	Heart failure and shock (5.0%)
5	Chronic obstructive pulmonary disease (4.2%)	Diabetes, over age 35 (4.9%)

[a]Temporary interference with the blood supply to the brain that causes neurological symptoms lasting only a few moments or several hours.

Resource Utilization Groups

Higher nursing costs as a result of providing atypical services are the foremost reason HCFA cites in granting exceptions. As a result, it might be expected that patients in SNFs granted an exception would need—and the SNF would provide—more nursing care. To obtain additional information about patients' need for nursing care in SNFs with and without RCL exceptions in Maine and Ohio, we estimated the nursing resources patients require.

We used HCFA's Resource Utilization Group, version III (RUG-III) model, a model for sorting nursing home residents into like groups according to common health characteristics and the amount and type of resources they use, to evaluate each patient's nursing resource need.[13] RUG-III considers patient characteristics, such as whether the patient is in a coma or has pneumonia, as well as services provided to the patient, such as kidney dialysis or physical therapy, and assigns the patient to 1 of 44 categories depending on the nursing resources that patient requires.[14] Each category

[13]We selected the version of RUG-III that measures and classifies data by overall nursing resources associated with each RUG category. Another version of RUG-III measures and classifies data by overall nursing and therapy resources. However, exceptions are not granted for therapy and, therefore, this version was not relevant. The RUG-III model that we used requires data that are collected only through the Minimum Data Set Plus (MDS+) instrument, an enhanced MDS version that includes information not contained in the MDS. Consequently, we could only apply it to data from Maine and Ohio, the two states in our analysis using the MDS+.

[14]HCFA currently is conducting a demonstration in which it uses RUG-III data to determine prospective Medicare and Medicaid payments for certain nursing homes in states participating in the demonstration.

has a number, or score, associated with it, providing a relative measure of resource use compared with other categories. For example, a patient who has complex health problems requiring more nursing care would be placed in a higher category, and given a higher score, signifying more resources required, than a patient who has simpler health problems and requires less nursing care.

When we analyzed the results of the RUG-III estimates, we observed that in Ohio, the distribution of Medicare patients among the categories was similar in SNFs with exceptions and in SNFs without.[15] And, unexpectedly, in Maine the SNFs with exceptions had patients requiring fewer nursing resources when compared with patients in SNFs without exceptions. (See app. IV for additional information regarding the results of the RUG-III analysis.)

In addition to calculating RUG-III scores for each patient, we used the results of the RUG-III patient analysis to calculate each facility's case-mix index score—the average amount of nursing resources required to care for the facility's overall patient population. In both Maine and Ohio, we found the case-mix scores to be similar when comparing each state's SNFs with exceptions with its SNFs without exceptions.[16] For example, as figure 3.2 shows, the two groups of SNFs in Maine had case-mix scores of approximately 1.3, indicating that the SNFs' patients had generally similar nursing resource needs. Similarly, figure 3.3 shows that the two groups of Ohio SNFs had case-mix scores of about 1.4, indicating similar nursing resource needs among their patients.

[15]Because the RUG-III model considers both patient characteristics and the facility resources involved in caring for them when sorting the patients into the various categories, this might be considered both a measure of patient characteristics and services provided.

[16]This amount, represented by the facility's case-mix index score, is determined by calculating the average RUG-III score for patients in that facility. A facility caring for sicker patients—those with higher RUG-III scores—will have a higher case-mix index score than a facility caring for less sick patients, signifying more nursing resources required.

Figure 3.2: Mean Case-Mix Scores of Maine SNFs, 1994

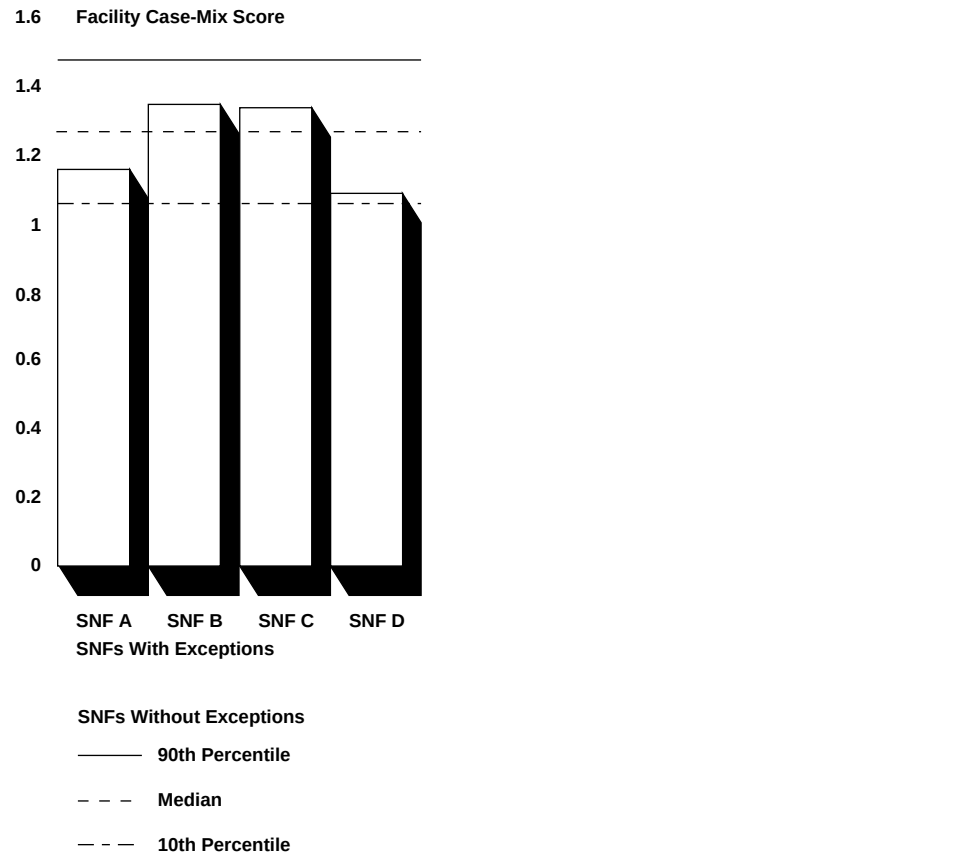
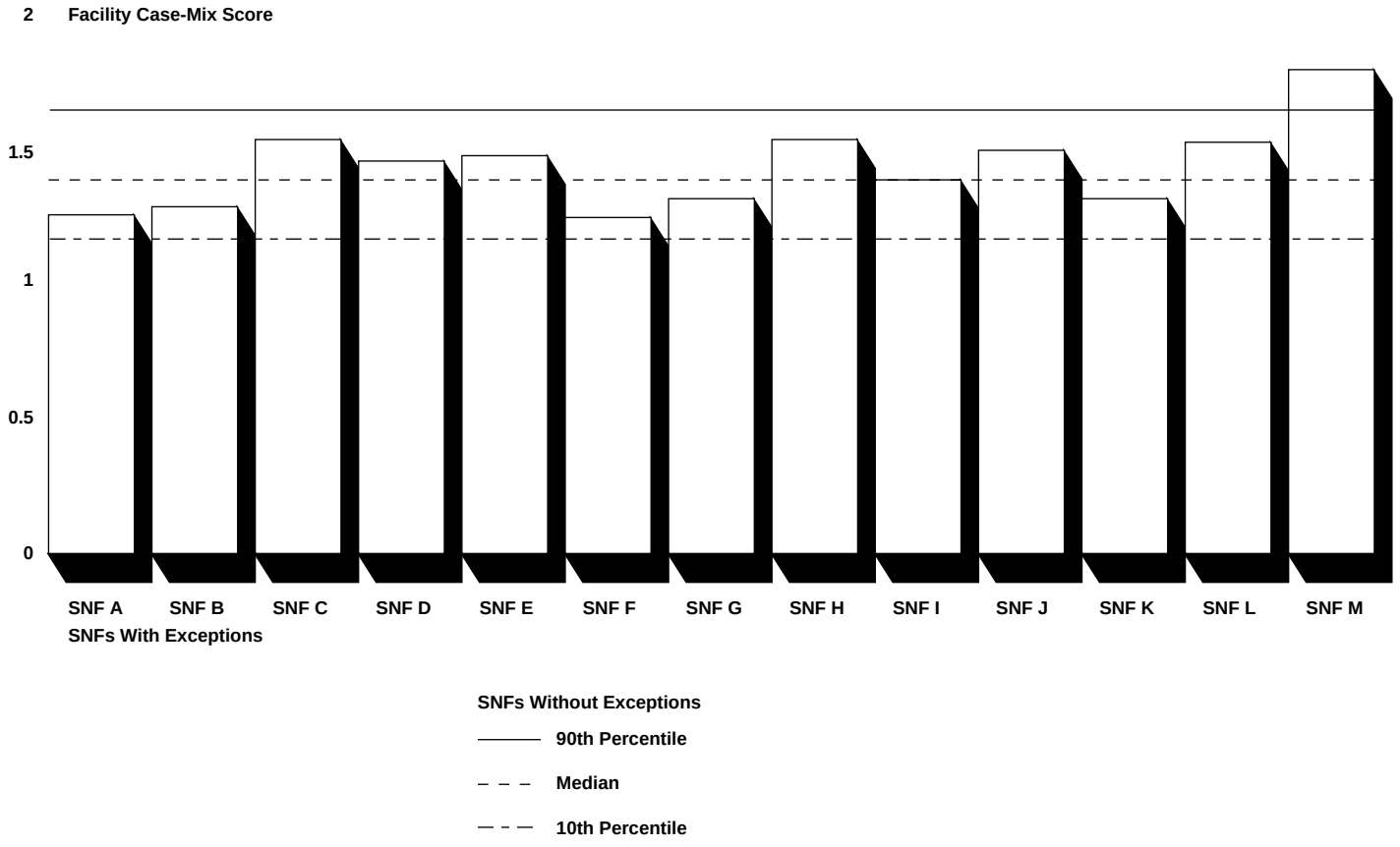


Figure 3.3: Mean Case-Mix Scores of Ohio SNFs, 1994



Both the RUG-III individual patient analysis and case-mix index scores indicate that there were patients in both SNFs with exceptions and SNFs without exceptions that required intense or complex care. For example, in Ohio, 1.1 percent of patients in SNFs with exceptions and 1.4 percent of patients in SNFs without exceptions were determined to need the highest category of nursing resource use. And, also in Ohio, there were a few SNFs in both groups—one SNF with an exception and several SNFs without exceptions—with overall case-mix index scores of 1.6 and higher, indicating a relatively larger proportion of patients with high nursing resource needs in these SNFs.

Other Patient Characteristics

MDS data also showed no substantive differences in patients' cognitive status, a measure of the patients' ability to make decisions about the tasks or activities of daily living, such as choosing items of clothing or determining mealtimes. Nor did the data show any substantive difference between SNFs with and without exceptions in the number of patients with a prior stay in a nursing home or other residential facility, a measure that may indicate those patients with a history of poor health. In each of the four states we studied, patients in both groups of SNFs were similar when measured across both of these elements.[17] (See app. IV for additional information regarding these and other patient characteristics we analyzed.)

PRO Reviews

We asked the PROs, as part of their medical record review, to evaluate the health care needs of a sample of 20 patients identified as having or likely having complex care needs by SNF staff in each of the five SNFs with exceptions we visited. The PRO evaluations were based on a five-point scale, with one representing the needs of a typical skilled nursing facility patient and five being the needs of a typical acute-care hospital patient. In three SNFs, all or almost all of the patients reviewed were judged to have the health care needs of a typical SNF patient, and, in fact, several patients in two of these SNFs were judged not to require SNF care at all. In the two remaining SNFs, half the patients reviewed were judged to have needs greater than those of a typical SNF patient.

Services Provided to Patients Appear Similar Between the Two Groups

SNFs with exceptions receive that status because they have documented to HCFA's satisfaction that they furnish patients atypical services. However, in the four states we studied, we found that the percentage of patients receiving certain special treatments, such as ventilator care, and certain therapies, such as physical therapy, was generally similar in SNFs with exceptions and SNFs without. Furthermore, the typical amount of therapy given to the patients in each group of SNFs was generally similar.[18] During our five site visits to SNFs with exceptions, we found that staffing of nursing and therapy services as well as physician coverage varied.

[17]We did observe a small difference between the two groups of SNFs when we compared patient ages. In analyzing 1992 national MEDPAR data and 1994 MEDPAR data for the four states whose MDS data we analyzed, we found that patients in SNFs with exceptions were younger than patients in SNFs without exceptions. However, the difference was slight—1 to 2 years. App. IV contains further information on patient ages for the SNFs we reviewed nationwide in 1992 and for SNFs in four states in 1994.

[18]Although the costs of ancillary services—which include therapy charges—are not considered routine costs and are excluded from HCFA's routine cost limit. HCFA uses these costs as an indicator of atypical services.

Facilities in Both Groups Provided Similar Services

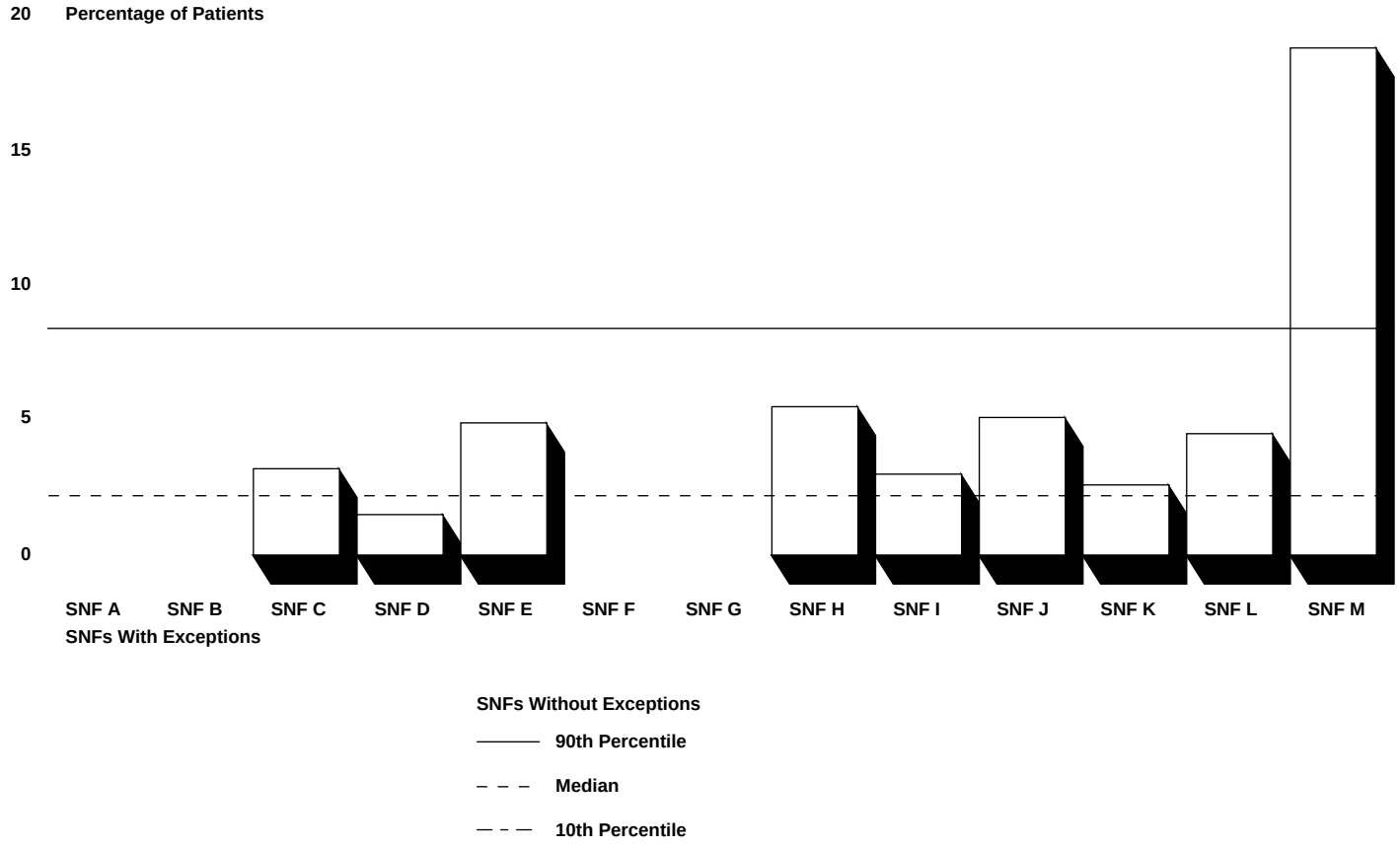
We analyzed MDS data about special treatments and therapies, items that could be indicative of different levels of SNF resource use. Generally, we found no substantive differences in the type and intensity of these services in SNFs with exceptions and in those without. (See app. IV for the results of certain facility service characteristics we analyzed.)

Special Treatments

The percentage of patients receiving certain treatments and procedures, such as suctioning[19] and ventilator care, appeared similar in both groups of facilities. For example, as figure 3.4 shows, generally less than 5 percent of patients in each group of Ohio SNFs received suctioning. (See app. IV for additional information regarding special treatments.)

[19]Suctioning is the removal of fluids from the throat or lungs by mechanical means.

Figure 3.4: Percentage of Ohio SNF Patients Receiving Suctioning, 1994



Note: When no bar is displayed for a SNF with an exception, then the value was zero. The 10th percentile value for SNFs without exceptions was zero.

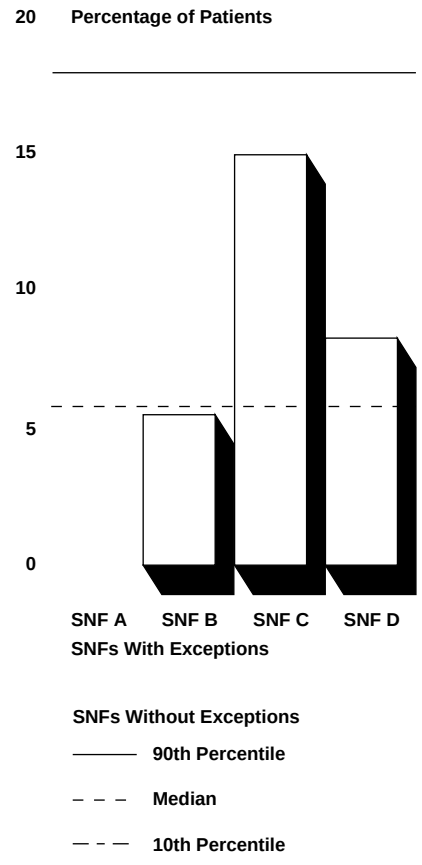
Therapies

The percentage of patients receiving therapies, such as speech, occupational, and physical therapy, appeared similar in both groups of facilities in all four states. For example, as figure 3.5 shows, generally less than 20 percent of patients in each group of Maine SNFs received speech therapy. Likewise, the number of days of therapy patients received appeared similar. As shown in figure 3.6, patients in each group of Washington SNFs received about 10 days of therapy, on average.[20] We also analyzed Maine and Ohio data regarding minutes of therapy provided and

[20]Figure 3.6 aggregates all types of therapy—speech, occupational, physical, psychological, and respiratory—given in 1 week. Thus, the sum of therapy days may be greater than 7.

generally found no differences between the two groups.[21] (See app. IV for additional information regarding therapies. Also, see app. IV for a listing of other variables analyzed.)

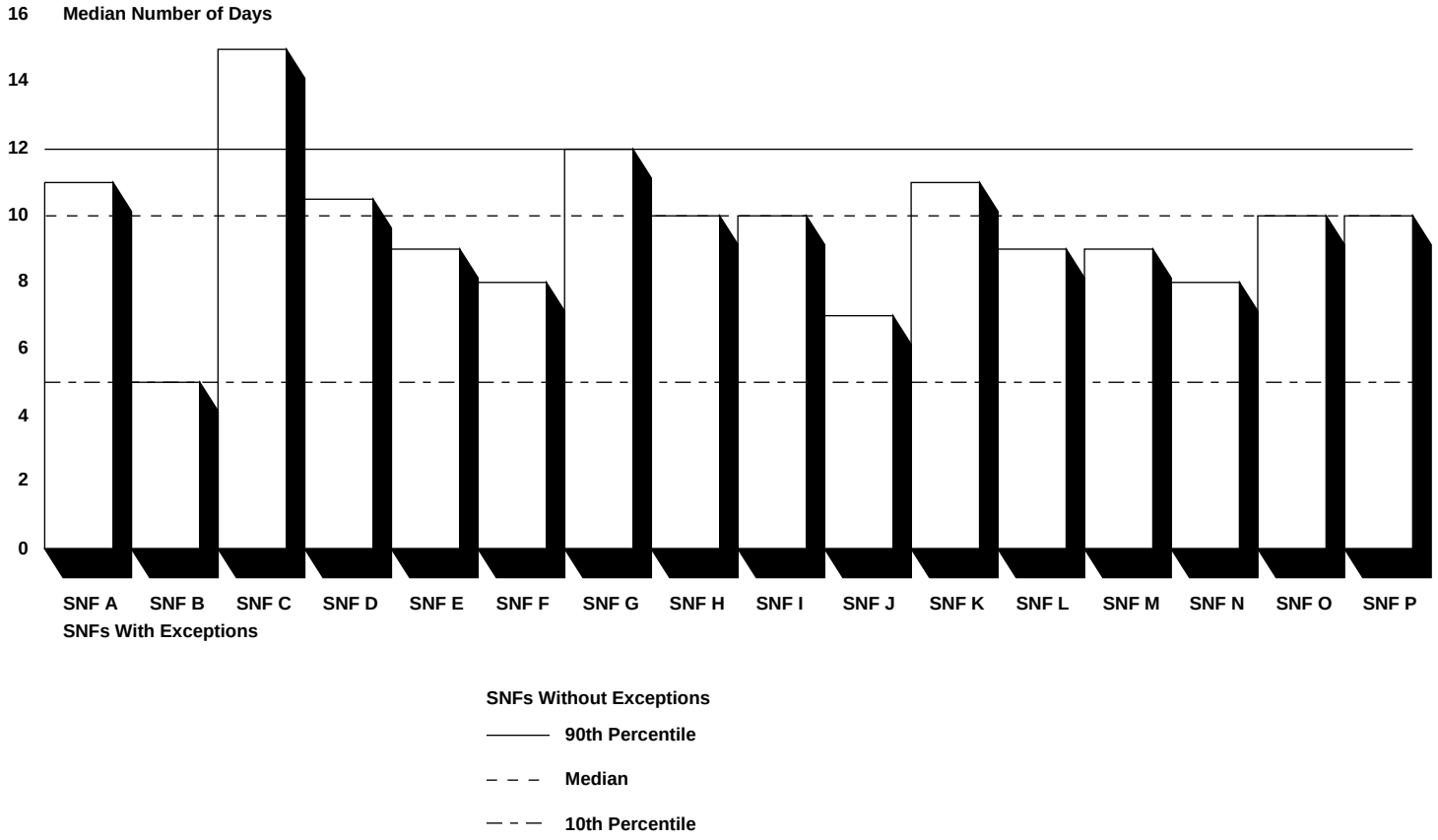
Figure 3.5: Percentage of Maine SNF Patients Receiving Speech Therapy, 1994



Note: When no bar is displayed for a SNF with an exception, then the value was zero. The 10th percentile value for SNFs without exceptions was zero.

[21]Of the states whose data we examined, only Maine and Ohio collected information on minutes of therapy provided.

Figure 3.6: Median Number of Days of Therapy Received by Washington SNF Patients, 1994



Note: Types of therapies include speech, occupational, physical, psychological, and respiratory.

Other Characteristics

MDS, MEDPAR, and other nationally available databases did not contain information about staffing, training, and other areas you were interested in, such as nursing care, therapy services, and physician coverage. Therefore, to provide information about these issues, we can only describe our observations during our site visits to five SNFs with exceptions. These observations cannot be assumed to be representative of SNFs in general.

Nursing Care

According to officials at the SNFs we visited, SNFs attempt to staff according to the complexity or intensity of the patients' needs. For example, patients with more complex needs require more licensed nursing

care; thus, a higher licensed-nurse-to-patient ratio is desirable.[22] Patients with less complex needs might allow SNFs to staff with more certified nurse assistants and fewer licensed nurses. However, other factors, such as financial constraints or inability to recruit qualified personnel, may influence staffing ratios. Licensed-nurse-to-patient staffing ratios reported by SNF officials varied considerably among the five SNFs we visited. For example, daytime licensed-nurse-to-patient ratios ranged from 1:6 to 1:15; nighttime licensed nursing ratios ranged from 1:18 to 1:31. (See app. IV for information on nurse staffing levels.) The SNF with the lowest daytime licensed-nurse-to-patient staffing ratio, according to officials at the SNF, had adopted a system under which registered nurses performed most patient care tasks because the SNF had difficulty finding and retaining qualified nurse aides.

Officials at most of the SNFs we visited said they preferred to have nurses with hospital experience on their staff to care for patients with complex medical needs. Hospital acute-care experience—as opposed to only long-term care experience—gives nurses the requisite skill and training to provide appropriate care to patients with complex needs, according to these officials. We did not determine the number of nurses with acute-care experience at each SNF we visited. However, many of the nursing staff at one SNF—which had a predominantly orthopedic patient population—had acute-care experience, and several of the nursing staff at this SNF were in the process of securing recognition as certified registered rehabilitation nurses. We also found that most of the SNFs had established on-the-job training programs for their nursing staffs to maintain and increase their skills.

Therapy Staff

All the SNFs we visited provided physical, occupational, and speech therapies, and three of them also performed respiratory therapy. As estimated by SNF officials, the percentage of Medicare patients in each SNF receiving therapy varied widely, from a low of 40 percent in one SNF to almost 90 percent in another.

SNFs attempt to provide the number and type of therapists—such as physical or occupational therapists—appropriate to their patients' needs. The SNFs we visited predominantly contracted with outside vendors for therapists and therapy aides, with only one facility using mostly in-house staff.

[22]Licensed nurses include registered nurses as well as licensed practical nurses.

Following is an example of how one SNF uses therapy services to meet its patients' needs. Therapy services in this SNF are available 7 days a week, but not all patients receive therapy on weekends. Most patients receive at least 1 hour of physical therapy and 1 hour of occupational therapy each day, as well as participate in an exercise group. On average, complex care patients receive about 2-1/2 hours of total therapy per day. All patients are screened for speech therapy.[23]

Physician Coverage

According to experts, aside from physicians acting in administrative capacities as medical directors, SNFs generally do not have physicians on staff. As in hospitals, SNF patients have their own attending physicians who direct their care. However, unlike hospital patients, most SNF patients' conditions generally do not require a daily physician visit. As a result, physicians often rely on SNFs' nursing staffs to keep them informed of the patients' conditions. One SNF we visited arranged for more physician coverage through an agreement with nearby hospitals under which the hospitals provided physicians to follow up on SNF patients, seeing them two or three times a week.

In three of the five SNFs we visited, some staff expressed concern that physicians did not visit their patients as frequently as they should, particularly the sicker patients. One SNF medical director expressed concern that physicians were relying on nurses to notify them of their patients' conditions rather than visiting the patient, which she believed may be inappropriate for sicker patients. At another SNF we visited, a staff person indicated that some attending physicians failed to visit their SNF patients in person or oversee their care at the facility.

PRO Review Found Care to Be Generally Appropriate

PRO physician reviewers found that the services provided at the five SNFs with exceptions we visited were almost always appropriate to the patients' needs for those cases reviewed. However, several problems with quality of care, such as errors in administering medication and delays in contacting physicians when problems arose, were identified during the review of medical records collected at the SNFs we visited. Except for one patient who required hospital outpatient treatment as a result of a quality problem the PROs identified, no other adverse outcomes resulted from the problems noted.

[23]Additional resources this SNF has in place to support higher-level care include a full-time dietician on staff to support fluid stabilization and wound care programs, and a multidisciplinary wound care team that does weekly rounds.

In reviewing the medical records of 100 SNF patients (20 patients at each facility) identified by SNF staff as needing complex care, the PROs found the following quality problems:[24]

- five instances of medication errors;
- three instances of delays in contacting a physician upon change in patient's condition;
- two instances of not notifying a physician upon a change in a patient's condition;
- two instances of falls, indicating a failure to develop a system to assess patients with an increased risk of falling and to implement preventive measures; and
- one instance of failure to provide necessary treatment.

Furthermore, the PROs noted 55 instances in which documentation of the patient's condition or progress was inadequate or inconsistent. Generally, reviewers assume that care not documented was not furnished.

Following are some specific examples of problems identified by the PROs. For one SNF, failure to follow medically prescribed procedures resulted in a complication. Physician orders instructed SNF staff to irrigate on a weekly basis a patient's central venous catheter. The PRO reviewers found that this procedure was not followed. As a result, problems with the catheter developed, and the patient was sent to the hospital for outpatient care.

At another facility a patient was given twice the ordered dosage of medication for at least a week before the error was noticed and the physician notified. In yet another facility, the issue of physician notification was raised after abnormal laboratory test results were returned but the physician was not informed until 3 days later.

[24]PRO reviewers used the HCFA generic quality screens for SNFs to identify quality problems. (See app. V for a copy of the screening instrument.) Problems were identified at four of the five SNFs we visited. More than one problem might have been identified for each patient. We did not perform a similar review of the appropriateness of care provided to patients in SNFs without exceptions.

Standards for Evaluating Requests for RCL Exceptions Are Inadequate

The number of SNFs granted exceptions to routine cost limits (RCL) is growing rapidly, with exception approvals increasing from 184 to 552 from fiscal year 1993 to fiscal year 1995. The extra payments associated with these approvals also increased from $35 million in fiscal year 1993 to $98 million in fiscal year 1995. However, HCFA's exception review process is not adequate for discerning SNFs that have higher costs because they furnish atypical services, and thereby qualify for an exception, from SNFs that have higher costs for other reasons, such as inefficiency. The primary reasons for this situation are that benchmarks used to screen for exception eligibility rely almost entirely on a SNF's proportion of Medicare patients, and patient-specific information submitted by SNFs on Medicare patients is not used. In effect, if a nursing home can demonstrate it has a higher than average proportion of Medicare patients and high costs, it can receive an exception to the RCL, which in turn defeats the cost-control incentives of RCLs.

Number of SNFs With Exceptions Is Growing

From the time RCLs were first established in 1979 through fiscal year 1992, a total of only 80 exceptions were granted. More than twice as many were granted in fiscal year 1993 alone, and more than 550 were granted in fiscal year 1995 (see table 4.1). Moreover, HCFA and industry officials expect that the number of exception requests and approvals is likely to continue to grow, and data in table 4.1 covering part of fiscal year 1996 suggest this will happen.

Table 4.1: Number of Exceptions Approved, by Fiscal Year

	Number of exceptions approved		
Fiscal year	**Hospital-based**	**Freestanding**	**Total**
Before 1993[a]	25	55	80
1993[a]	96	88	184
1994	188	148	336
1995	302	250	552
1996[b]	177	430	607
Total	**788**	**971**	**1,759**

[a]Because HCFA's data are incomplete for these years, the number of approved exceptions may be somewhat understated.

[b]As of late July 1996, HCFA had recorded approvals of 417 exceptions during fiscal year 1996. As of June 30, 1996, the six intermediaries with final approval authority had approved another 190 exceptions during fiscal year 1996.

Although data for fiscal year 1996 are based on part of the year, these data indicate a continued increase in approvals. During approximately the first 10 months of fiscal year 1996, HCFA approved 417 exceptions, which would be worth about $70 million to the SNFs. In addition, the six intermediaries with final approval authority approved 190 exceptions during the first 9 months of fiscal year 1996, which were worth about $29 million to the SNFs. If these trends continue, approved exceptions by all intermediaries during fiscal year 1996 could total about 750 and cost the Medicare program about $120 million.

Besides the fact that SNFs that receive exceptions in one year are likely to continue receiving exceptions, another factor that could continue the trend to more exceptions in the future is the number of exemptions to RCLs currently in effect. Historically, over 20 percent of SNFs with new provider exemptions received exceptions after their exemption period ended. As of September 30, 1995, 2,422 SNFs had obtained exemptions from RCLs since 1979. More than 80 percent of the 2,422 exemptions were approved after fiscal year 1989, with 35 percent of the exemptions (846) approved during fiscal years 1994 and 1995. Thus, over the next few years, a substantial number of SNFs will be completing their RCL exemption periods and likely will be requesting exceptions.

Exception Benchmarks Not Related to Atypical Services

The first step a SNF must take to gain an exception to the RCL is to demonstrate that it meets at least one of three benchmarks established by HCFA. The benchmarks are as follows:

- The SNF has a shorter length of stay than the average of its peer group. Shorter lengths of stay can indicate, for example, that services are furnished more intensively so patients can be released sooner.
- The SNF has higher average ancillary costs per day than its peer group. Higher ancillary costs can indicate, for example, that the SNF treats a higher proportion of patients needing rehabilitation services or drug infusion therapy.
- The SNF treats a higher proportion of Medicare patients than its peer group. As the ratio of Medicare to total patients rises, SNF costs can grow because Medicare patients generally have more acute conditions in need of more health services than other patients, who often need more long-term and custodial care.

Benchmarks are set on the basis of the average value of four peer groups—rural and urban groups for both hospital-based and freestanding

facilities. In establishing the peer group averages, HCFA officials told us they used data on all patients (in Medicare-certified units) in the SNFs, not just Medicare patients, because Medicare's cost reimbursement method is designed to pay on the basis of average costs of all patients in a SNF for routine services, up to the RCL.

However, Medicare patients are different from other nursing home patients. Medicare patients are admitted because they have been discharged from a hospital but need continued care because of the acute condition that resulted in the hospitalization. Other patients need long-term care for chronic conditions, which involves more custodial-type care. In effect, for most SNFs, the three benchmarks all depend on the same factor—the percentage of a SNF's patients who are Medicare beneficiaries. Therefore, treating a higher proportion of Medicare patients will usually get a SNF past the benchmarks, but this does not mean the patients require atypical services. The next and final stage of the process as it operates only requires a SNF to demonstrate that its costs are higher than its peer group. The process does not require a SNF to demonstrate that its costs are high because atypical services are needed and furnished. Therefore, SNFs that are simply inefficient in their operations can gain RCL exceptions.

Tables 4.2, 4.3, and 4.4 give the benchmarks and actual Medicare averages for length of stay, ancillary costs, and portion of Medicare-covered days, respectively.

Table 4.2 contains the peer group benchmarks for average length of stay and the actual average for Medicare-covered SNF patients in fiscal year 1994. The average length of stay of Medicare patients is so much less than the benchmark that it is unlikely this benchmark can distinguish facilities that provide atypical services to Medicare beneficiaries from facilities that do not. Furthermore, each of the four peer group benchmark values exceed the maximum Medicare benefit of 100 days.

Table 4.2: Peer Group Benchmark and Actual Medicare-Covered Patient Average Length of Stay, Fiscal Year 1994

Number of days

	Hospital-based		Freestanding	
	Urban	Rural	Urban	Rural
Benchmark	132.3	223.5	236.7	251.5
Actual for Medicare-covered patients	17.0	19.6	48.7	48.0

Table 4.3 presents a similar comparison for ancillary costs.

Table 4.3: Peer Group Benchmark and Actual Medicare-Covered Patient Ancillary Costs Per Day, Fiscal Year 1994

	Hospital-based		Freestanding	
	Urban	Rural	Urban	Rural
Benchmark	$62.73	$24.31	$32.71	$21.31
Actual for Medicare-covered patients	$142.67	$106.89	$108.41	$92.54

The actual peer group ancillary costs are so much larger than the benchmarks that ancillary costs also are unlikely to be a good indicator of whether a SNF provides atypical services to Medicare patients. The actual average costs range from 2.3 to 4.4 times the benchmarks. A primary reason for these differences in costs is that Medicare patients are different from most other patients in nursing homes. Medicare patients typically have been recently discharged from hospitals after treatment for acute conditions. The majority of non-Medicare patients in nursing homes are Medicaid patients with chronic conditions and long-term and custodial care needs. Thus, basing a benchmark on the ancillary costs for all patients produces a benchmark that does not adequately distinguish facilities that do provide atypical services to Medicare patients from those that do not.

A comparison based on the third benchmark, proportion of Medicare patients, is shown in table 4.4.

Table 4.4: Peer Group Benchmark and Actual Percentage of Medicare-Covered Patients, Fiscal Year 1994

Numbers in percent

	Hospital-based		Freestanding	
	Urban	Rural	Urban	Rural
Benchmark	52.4	32.7	25.7	23.7
Actual for Medicare-covered patients	36.1	18.2	17.5	19.2

This benchmark is of little or no value in identifying facilities that provide atypical services. For example, in fiscal year 1994, Medicare patients made up about 36 percent of the patients in hospital-based urban nursing homes. If a nursing home had a Medicare population of, say, 60 percent (above the benchmark), this merely indicates that the nursing home had an atypical population mix, not that it was providing atypical services. A nursing home could have a low proportion of Medicare patients and provide atypical services to every one of its Medicare patients.

Furthermore, the benchmarks are out of date. The benchmarks were computed from data spanning the periods October 31, 1988, through September 30, 1989, for hospital-based facilities and June 30, 1989, through May 31, 1990, for freestanding facilities. For each type of facility, the base data included substantial time under the Medicare Catastrophic Coverage Act of 1988 coverage criteria, which, as discussed, substantially liberalized Medicare coverage criteria for SNFs. The benchmarks, then, were computed on data representing an atypical year in the number and type of Medicare patients who were admitted to SNFs.

Patient-Specific Information Not Used

Data describing patient characteristics submitted as part of an exception request generally are not used in the exception review process. Transmittal 378 requires SNFs to submit patient data, showing patients' diagnoses and ability to perform ADLs, for a random sample of all patients treated at their facilities. Although Transmittal 378 requires a random sample, HCFA officials told us that they have verbally communicated to various intermediary and SNF officials that they expect the SNF to submit clinical data for all patients treated during the year for which an exception is requested. None of the intermediaries we visited knew of HCFA's expectation.

Transmittal 378 says the intermediary should use the patient-specific data to determine whether the nursing staff level of a SNF is excessive, and if so, the intermediary should adjust the SNF's costs before comparing the costs to the peer group. A HCFA official told us that HCFA expects the intermediaries to follow the instructions in Transmittal 378 and evaluate whether the nursing staff level of a SNF is excessive. He told us that HCFA expected the intermediaries' professional health staff to make decisions on excessive staffing levels, although HCFA has provided no specific criteria to judge whether nursing staff levels are excessive. Although 3 of the 10 intermediaries visited told us that they used patient-specific data in their review of exception requests, none of the 10 had ever referred a request to its professional health staff for an opinion on the appropriateness of nursing staff levels.

Officials at two of the three intermediaries using patient-specific data told us that HCFA had verbally told them to verify that the ADL scores of the applicant's patients are higher than the ADL scores presented in a 1985 national survey of nursing home populations. An intermediary official told us that higher ADL scores indicate a need for additional nursing personnel. An official at a third intermediary we visited told us that, although the

intermediary received no guidance from HCFA, it requires a SNF applying for exception to clarify its ADL data by interpreting in writing how its ADL data demonstrate that the SNF is providing atypical services.

HCFA's Transmittal 378 also requires SNFs to submit a listing of the discharge destination for all patients. Officials for all 10 intermediaries we visited told us they verify that this information is submitted, but because HCFA has not provided any criteria to determine its significance, they do not use this information when reviewing an exception request. HCFA officials told us the discharge data should show a large number of patients going home if the SNF is atypical. However, they told us that there are no plans to establish a benchmark for discharge data because setting such a benchmark for the number or percentage of patients discharged to their homes would be difficult.

Conclusions, Recommendation, and Agency Comments

The use of SNF services by Medicare beneficiaries and Medicare's payments for these services have grown dramatically during the 1990s. One reason for this growth is that Medicare guidelines for when SNF services are covered were liberalized in 1988 in response to a court decision. Another reason is that some substitution of SNF care has occurred for what in the past would have been the last few days of hospital care. This was an expected result of Medicare's hospital PPS.

The number of SNFs requesting exceptions to the RCL has grown rapidly and is expected to continue to grow. Over 500 requests were processed and approved in 1995, and as many as 750 may be processed in 1996. Almost all exception requests claim that routine costs are higher than the RCL because the SNF provides atypical services. However, HCFA's current screening benchmarks for exception requests are unlikely to differentiate between SNFs that provide atypical services and those that do not. Moreover, the patient-specific information submitted with exception requests is not used to evaluate them. Thus, if a SNF can show that its costs are higher than the RCL, it will receive an exception without demonstrating that it does, in fact, furnish atypical services.

Our analysis of four states' Medicare patients in SNFs with and without exceptions found

- virtually the same ADL scores for patients in both groups of SNFs;
- no substantive differences in the patients' diagnoses;
- RUG-III scores that indicated a need for the same level of nursing resources to treat both groups of patients; and
- similar amounts of therapy and special treatments.

Moreover, despite the fact that SNFs with exceptions were expected to have sicker patients, PRO review of 100 patients identified as requiring complex care by staff in the SNFs we visited showed that all or almost all patients in three of five SNFs were typical SNF patients. Only half of the selected patients in the other two SNFs needed complex care. PRO review did find that services furnished to the selected patients were almost always appropriate to patients' needs.

Weaknesses in HCFA's exception request review process make it unlikely that it limits exception approvals to SNFs furnishing atypical routine services and likely that SNFs will receive approval for merely showing higher than normal costs. Our analyses of SNF patient characteristics also showed no significant difference between patients in SNFs with and

without RCL exceptions, giving further evidence that HCFA's review process is not working as intended.

Recommendation

The Secretary of HHS should direct the Administrator of HCFA to revise the SNF exception to the RCL review process so that it can differentiate between SNFs that furnish atypical routine services to Medicare patients and SNFs that merely have higher than normal costs. Looking at factors that reflect Medicare patients rather than all SNF patients occupying Medicare-certified beds might be one way to do so. Using patient-specific data, some of which are currently submitted but not used, might be another way.

Agency Comments and Our Evaluation

In commenting on a draft of this report, HHS generally agreed with our recommendation to revise the exception review process to enable HCFA to better differentiate between SNFs that furnish atypical services and those that merely have higher costs. Specifically, HHS concurred with our suggestion to expand the use of patient-specific data in the review process. HHS said that HCFA's ongoing SNF payment method demonstration project using the RUG-III classification system will provide the data necessary to cost-out atypical services and items and begin to integrate patient-specific data into the exception process.

However, HHS disagreed with our suggestion that looking at factors that pertain to Medicare patients rather than all SNF patients might be one way to enhance the exception review process. HHS said this suggestion failed to take into account the fact that Medicare patients are often the most resource-intensive patients a SNF treats and that the proportion of Medicare patients in a SNF is a valid indicator of case mix. HHS added that the RCLs are based on the average cost of all patients and that use of data on only Medicare patients would be inappropriate.

We discuss in the report the differences between Medicare and other SNF patients and the rationale for using data on all patients in establishing the benchmarks used in evaluating exception requests. We did not recommend that HCFA substitute data on only Medicare patients for the current benchmark. Rather, we recommended that HCFA look at such data as one way to revise the process and give exception request reviewers additional data upon which to base decisions. We envision that the data could be a useful supplement to the existing process to help differentiate between SNFs furnishing atypical services and those that merely have

higher costs. For this reason, we do not believe that our suggestion would be inconsistent with Medicare's principles of cost reimbursement.

HHS also disagreed with our suggestion to look at data on only Medicare patients because the suggestion was derived from what HHS considers to be a methodological flaw in our analysis of SNF patients. HHS considers the methodology flawed because it compared only Medicare patients in SNFs with exceptions with Medicare patients in SNFs without exceptions, which does not consider HCFA's proxy for case mix—the facility's percentage of Medicare patients. First, our suggestion was based primarily on our review of HCFA's exception process discussed in chapter 4. We found that in general the only factor that affected a determination of whether a facility met the atypical services criterion was its proportion of Medicare patients, but a higher than average proportion in itself does not mean a SNF furnishes atypical services. Thus, we recommended that the review process be revised and suggested several types of information that might be useful to differentiate SNFs that furnish atypical services from those that merely have higher than normal costs. Second, as stated in chapter 1's scope and methodology section, our analysis of SNF patients was designed to answer questions about the characteristics of and services received by Medicare patients in facilities with and without RCL exceptions. The analysis is valid for these purposes. Moreover, we would expect that at least some differences between patients in the two SNF groups would be shown by such an analysis, and the fact that no differences emerged lends additional support to our suggestion to look at using Medicare-only data during the exception review process.

HHS also noted that, in concert with the Congress, it is working on development of a PPS for SNFs that is expected to be sensitive to a facility's case mix. HHS believes that such a payment method would eliminate the need for an exception process. A SNF PPS that is sensitive to case mix might lessen the need for an exception process, but we suspect that some exception-type process would remain either for individual cases or facilities. Prospective payment methods generally retain such features. For example, Medicare's inpatient hospital PPS provides for paying sole community hospitals differently because of their special circumstances and provides a way for hospitals to receive additional payments for outlier cases that are extremely costly.

The Skilled Nursing Facility Exception Process

This appendix details the process SNFs must follow to request exceptions to the routine cost limits (RCL) Medicare has established for providers. Included is information on the authorizing and subsequent legislation and description of the process itself, including the responsibilities of SNFs, intermediaries, and the Health Care Financing Administration (HCFA).

Background

Section 223 of the Social Security Amendments of 1972 (P. L. 92-603, Oct. 30, 1972) authorized Medicare to establish limits on the amount of costs it would recognize as reasonable in the efficient delivery of health services. The purpose of cost limits is to give providers a financial incentive to contain their costs because they will not be reimbursed for costs above the limit. Effective for cost-reporting periods beginning on or after October 1, 1979, HCFA established such limits for the routine operating costs of SNFs, which are known as RCL. Routine operating costs include those for room, board, and general nursing and the general and administrative costs associated with those three cost categories. Routine costs do not include costs for capital, ancillary services, outpatient services, and research at the SNF.

Section 1888(a) of the Social Security Act, which was added by section 2319 of the Deficit Reduction Act of 1984 (P. L. 98-369, July 18, 1984), specifies that SNF RCLs shall be based on the mean per diem costs for four groups—hospital-based and freestanding SNFs each located in urban and rural areas. Section 4008 of the Omnibus Budget Reconciliation Act of 1990 (P. L. 101-508, Nov. 5, 1990) provided that the RCLs be updated for cost-reporting periods on or after October 1, 1992, and every 2 years thereafter. The RCLs were updated in 1992, but subsequent legislation delayed the update schedule.

Since RCLs were first established in 1979, the regulations governing them have provided for granting RCL exceptions (42 C.F.R. 413.30), and section 1888(c) of the Social Security Act, as added in 1984, also authorizes exceptions. A SNF can apply for an exception on any of five bases,[1] but 98 percent of requests are for atypical services.[2] The atypical services criterion is met when the SNF's actual costs exceed its RCL during a

[1]HCFA allows exceptions to its RCLs for five circumstances: atypical services, extraordinary circumstances, providers in areas with fluctuating populations, medical and paramedical education, and unusual labor costs.

[2]Under regulations at 42 C.F.R. 413.30, atypical services are items or services furnished because of the special needs of the Medicare patients treated and that are necessary in the efficient delivery of needed health care. For example, a common claim by SNFs seeking exceptions is that they have high nursing care costs.

cost-reporting period because the SNF's Medicare patients needed atypical services. SNFs requesting exceptions generally claim that they are treating sicker patients and providing more services and that as a result their costs are higher than the RCLs.

HCFA established an exception request process through which SNFs must demonstrate that their costs are associated with atypical services and exceed the RCLs. Initially, HCFA did not have detailed instructions for the exception request process. In July 1994, HCFA published Transmittal 378 to assist SNFs in preparing and submitting exception requests and defining intermediaries' responsibilities.

The exception request process is a complicated procedure including much documentation, complicated cost allocations and justifications, peer group cost comparisons, deadlines, interim or final exception requests, resubmission rights, and appeal processes. An overview of the process a SNF must follow to get a final exception approved follows. This overview is not intended to represent the entire process but to provide a sense of what is required of the SNFs, the intermediaries, and HCFA before a final exception is granted.

General Requirements and Procedures

- The SNF must submit its exception request in writing with supporting documentation to the intermediary no later than 180 days after the date of the intermediary's Notice of Program Reimbursement (NPR)[3] (the date that the SNF's cost report for the period is settled by the intermediary).
- The intermediary has 90 days from the day it receives the SNF's request for an exception to review it and forward a recommendation and supporting documentation to HCFA. The intermediary can recommend approval of the full request, approval of the request at a lower level, or denial of the request.
- If the intermediary determines that more information is needed from the SNF, the SNF has 45 days to respond. Upon receipt of the additional information, a new 90-day intermediary review period starts.
- HCFA has 90 days to review the request after receiving it, the related documentation, and recommendation from the intermediary. HCFA can request additional information, approve the request, approve the request at a lower level, or deny the request. If additional information is requested, the particular time frames cited above would begin again.

[3]Prior to issuance of an NPR, a SNF may request an interim exception. Once the cost report has been settled and an NPR has been issued, the intermediary revises the interim exception to reflect any settlement adjustments, and a final recommended exception amount is sent to HCFA for approval.

The SNF Exception Process

Specific Information SNFs Are Required to Submit

SNFs are required to submit the following information when requesting an exception:

- Data for HCFA's three benchmarks: average length of stay for patients, costs of ancillary services furnished to patients, and Medicare utilization.[4]
- A cost report for the period for which an exception has been requested and for the prior period.
- A comparison of per diem costs between the cost-reporting period for which an exception is requested and the prior cost-reporting period (any changes in excess of 20 percent must be documented and explained; changes in excess of 20 percent and over $2 per patient day are handled as initial requests, not as continuing or repeat requests).
- An allocation of costs into the 12 routine cost centers that compose HCFA's Uniform National Peer Group (a SNF must explain, by cost center, all per diem costs that exceed its peer group). (The 12 cost centers are listed in the next section.)
- A complete breakdown of direct costs, including nursing salary costs of registered nurses, licensed practical nurses, and nurses' aides.
- A list of productive and nonproductive nursing personnel hours.
- The percentage of discharges, by reason (for example, patient went home, entered hospital, or died).
- Diagnoses and scores on activities of daily living (ADL) for a sample of patients.
- If a SNF's occupancy rate is below 75 percent, a list of per diem costs, which vary with occupancy (these costs must be excluded from the low-occupancy adjustment).
- An explanation of the nature and scope of the services provided and how the services relate to costs requested in the exception request.

Allowable Atypical Services or Items, by Cost Centers

Exceptions to the RCLs are allowed if the SNF's actual costs exceed its peer group because of items or services atypical for the peer group that it must furnish because of the special needs of a patient. Listed here is the cost center information that SNFs must report to demonstrate that their high costs are the result of the atypical services provided. Also included is a

[4]Although Transmittal 378 indicates that submitting benchmark data is optional, HCFA officials told us that SNFs are required to submit these data and that a SNF that receives an exception normally exceeds at least one of these three benchmarks.

brief description of what the SNF must demonstrate in its comparison with the peer group. The total allowable exception reimbursement would be the net amount of the atypical costs for these cost centers.

- Direct cost, including nurses, nurses' aides, routine supplies and drugs. Total direct nursing hours, including nurses and aides, cannot exceed 9.6 hours per patient day.
- Employee health and welfare cost. An exception is granted for that portion of employee health and welfare associated with direct salary per diem considered atypical.
- Nursing administration cost. An exception may be granted on the basis of the amount of atypical nursing hours.
- Plant/maintenance cost. An exception may be granted for demonstrated atypical special equipment needs, such as ventilators.
- Housekeeping. An exception may be granted for demonstrating a lower than average length of stay and/or higher than average proportion of incontinent patients (HCFA considers the latter to be 40 to 50 percent or more of the patient population).
- Laundry cost. An exception may be granted for demonstrating a higher than average proportion of incontinent patients or rendering rehabilitation care that results in a high percentage of patients discharged to their homes, which results in the provider cleaning the patient's clothes.
- Dietary cost. An exception may be granted for demonstrating kosher food costs in excess of nonkosher food costs or higher costs associated with foods with higher nutrition, pureed foods, or tube-feeding mixtures.
- Cafeteria cost. An exception may be granted on the basis of the amount of atypical direct nursing costs and is based on calculating the percentage of nursing costs that are atypical multiplied by the cafeteria costs or the provider's per diem cost in excess of the peer group, whichever is less.
- Routine central service/supply and routine pharmacy cost. An exception may be granted if the provider demonstrates atypical direct nursing costs.
- Medical records cost. An exception may be granted for demonstrating lower than average length of stay and/or higher than average Medicare utilization.
- Social services. An exception may be granted for demonstrating lower than average length of stay and/or higher than average Medicare utilization.
- Administration and general cost. A percentage of this may be granted on the basis of the portion of atypical direct and employee health and welfare per diem costs related to atypical nursing services.

Fiscal Intermediary Responsibilities

- Ensure that the exception request is in writing, the type of exception requested is designated, the request was submitted within the required time frame, and cost reports for the exception request year and the previous year accompany the request. Then send a notice to the SNF acknowledging receipt of the exception request.
- Ensure that the SNF has submitted the cost information discussed, in the proper form, and that the SNF's analysis is complete.
- Notify the SNF in writing of any problems with or questions about the information supplied with the request.
- Determine the SNF's exception amount using the following procedure: (1) Verify that the SNF's actual per diem costs exclude any capital-related cost. (2) Verify that the SNF's direct patient care hours (nursing hours) per patient day do not exceed 9.6 hours. If the nursing hours exceed 9.6 per day, the excess nursing costs are removed from the routine cost. (3) Verify that the SNF's occupancy rate is 75 percent or higher. If the occupancy rate is below 75 percent, all fixed per diem costs, by cost centers, are adjusted to reflect the per diem equivalent at the 75-percent occupancy level. (4) After any adjustments, compare, by cost center, the SNF's costs with those of its peer group. Freestanding rural and urban SNF costs are compared with their peer group's RCL. Hospital-based rural and urban SNFs' costs are compared with 112 percent of their peer group's mean per diem cost. Peer group mean per diem costs are adjusted by the wage index and cost-reporting-year adjustment for the applicable reporting year.
- Within 90 days of receiving the request, recommend approval,[5] partial approval, or denial of the request, and forward supporting documents to HCFA. The recommendation is submitted along with the following: (1) a peer group comparison, (2) the nursing hours per patient day for each classification of nursing service personnel, and (3) the per diem amount of each type of exception recommended and the total dollar amount of all exceptions.

HCFA Responsibility

HCFA must notify the intermediary when it receives the exception request. HCFA then has 90 days to review the submitted information and recommendation and return the request if it finds problems or needs more information to make a final determination. If HCFA does not respond within 90 days, the recommendation of the intermediary becomes final.

[5]Six intermediaries—Aetna Life Insurance Co., Clearwater, Florida; Aetna Life Insurance Co., Fort Washington, Pennsylvania; Associated Hospital Service of Maine, South Portland, Maine; Blue Cross of California, Woodland Hills, California; IASD Health Services Corporation, Des Moines, Iowa; and Veritus Inc., Pittsburgh, Pennsylvania—currently have the authority to make final decisions on exception requests. HCFA delegated this authority to evaluate the feasibility of having intermediaries make final decisions. It was effective August 1995 and is scheduled to expire in August 1997.

Description of 12 Diagnosis-Related Groups for Length-of-Stay Analysis

To assess whether hospital length of stay was different when hospitals had SNF units, we examined the average length of stay for the following 12 selected diagnosis-related groups (DRG).

Table II.1: Number and Description of 12 DRGs Selected for Analysis

DRG number	DRG description
001	Cerebral—Craniotomy, age > 17, except for trauma
014	Cerebral—Specific cerebrovascular disorders except transient ischemic attack (TIA)[a]
113	Orthopedic—Amputation for circulatory system disorders except upper limb and toe
209 and 491	Orthopedic—Major joint and limb reattachment procedures for upper and lower extremities
210	Orthopedic—Hip and femur procedures except major joint, age > 17, with complications
211	Orthopedic—Hip and femur procedures except major joint, age > 17, without complications
217	Skin—Wound debridement and skin graft except hand, for musculoskeletal and connective tissue disorders
218	Orthopedic—Lower extremity and humor procedures except hip, foot, and femur, age > 17, with complications
236	Orthopedic—Fractures of hip and pelvis
253	Orthopedic—Fracture, sprain, strain, and dislocation of upper arm or lower leg except foot, age > 17, with complications
263	Skin—Skin graft and/or debridement for skin ulcer or cellulitis with complications
271	Skin—Skin ulcers

[a]Temporary interference with the blood supply to the brain that causes neurological symptoms lasting only a few moments or several hours.

We focused on these 12 high-volume DRGs because they are likely to result in posthospital care. From a list of 27 DRGs identified by HCFA's Office of Research and Demonstrations as the most likely to result in SNF or rehabilitation facility admission, we selected the 12 DRGs with the highest volume of prospective payment system (PPS) discharges. These 12 DRGs in 1994 accounted for 10 percent of all PPS discharges and are predominantly orthopedic procedures, particularly hip replacements and fractures, and stroke and skin conditions. These same 12 DRGs were also used by the Prospective Payment Assessment Commission in recent analyses regarding changes in PPS hospital length of stay for posthospital DRGs and in comparing differences in length of stay between facilities with and without posthospital-care units.

Analyzing Patient Characteristics, Services Provided, and Appropriateness of Care

To determine patient characteristics in SNFs granted exceptions and SNFs that did not receive exceptions and to describe the services these two groups of SNFs provide, we analyzed (1) calendar year 1992 and 1994 data from HCFA's Medicare provider analysis and review (MEDPAR) database, which is a Medicare claims file; and (2) calendar year 1994 data collected from Maine, Missouri, Ohio, and Washington Minimum Data Set (MDS) databases, a state-maintained compilation of HCFA-required resident assessments about each nursing home resident.[6] We also used the Resource Utilization Group, version III (RUG-III), a model for sorting nursing home residents into homogenous groups according to common health characteristics and the amount and type of resources they use, to evaluate patients' nursing resource use in Maine and Ohio SNFs.[7] We analyzed 1992 MEDPAR data because 1992 was the most recent year for which complete national information was available about SNFs that had received exceptions. We analyzed 1994 MDS data because that was the most recent year reliable databases were available on patient characteristics and services provided. We sent a sample of medical records from the SNFs we visited to peer review organizations (PRO) for an evaluation of the appropriateness of care the patients received.

MEDPAR and MDS Databases

The MDS and MEDPAR databases cover calendar years; however, HCFA bases its exceptions for atypical services on a SNF's fiscal year, a time period that may not coincide with the calendar year. Furthermore, the state MDS databases included information about all nursing home residents, regardless of payer and the patient's need for skilled care. Therefore, we undertook the following processes to develop comparable information for our analysis.

Identifying SNFs With Exceptions

HCFA's Bureau of Policy Development provided us with a list of SNFs that had received an exception for calendar year 1992. To identify SNFs granted an exception for the full 1992 calendar year, we included in our analysis (1) SNFs receiving exceptions for fiscal year 1992 whose fiscal year 1992 coincided with calendar year 1992 and (2) SNFs receiving exceptions for fiscal years 1992 and 1993 when those years spanned January 1 through December 31, 1992.

[6]Maine and Ohio use the Minimum Data Set Plus (MDS+) database, an enhanced MDS version that includes information not contained in the MDS.

[7]The RUG-III model may only be used with data collected through the MDS+ instrument. Consequently, we could only use it with data from Maine and Ohio.

We used information provided to us by Medicare intermediaries to identify SNFs granted exceptions for calendar year 1994 in Maine, Missouri, Ohio, and Washington. To identify SNFs granted exceptions for calendar year 1994, we used the same process we used for 1992 data. However, at the time of our study, few SNFs that had applied for an exception had received a final notification granting the exception for 1994. Because in previous years almost all the SNFs applying for exceptions ultimately received them, we assumed that those SNFs applying for or receiving interim exceptions would likely receive final approval of their exception requests. Therefore, in addition to considering SNFs that had received final notification that an exception had been granted for 1994, we considered as a SNF with an exception any SNF that had (1) requested an exception but had not yet received an interim or final exception or (2) received an interim exception from the intermediary.

MDS Databases

The MDS databases are state-maintained compilations of SNF staff responses to selected items from the resident assessment instrument mandated by the Congress under the Omnibus Budget Reconciliation Act of 1987. The primary purpose of collecting the assessment information is to help nursing home staff plan and evaluate the care they provide to residents. The assessment incorporates over 300 items, including information about a resident's functional status, health conditions, services received, and demographics. HCFA has instructed all Medicare-certified and Medicaid-certified nursing facilities to complete this assessment on all residents upon admission, whenever a significant change occurs in the patient's condition, and at least annually after admission or any significant change. HCFA does not require that the assessment results be submitted to it or to any other entity. However, 13 states currently require nursing facilities to submit all or some of the assessment information to them, and each of these states has created an MDS database. We analyzed MDS data from 4 of the 13 states—Maine, Missouri, Ohio, and Washington—after we determined that they were states with accessible MDS databases containing data covering all of 1994 and that they also had adequate numbers of SNFs granted exceptions.

The states did not collect assessment data from nursing homes that care for Medicare patients only. Therefore, information about these providers and their patients is excluded from our MDS analysis. As a result, 4 Medicare-only Maine facilities; 55 Medicare-only Missouri facilities; 82

Medicare-only Ohio facilities, and 7 Medicare-only Washington facilities are excluded from our MDS analysis.[8]

All remaining assessments included in the 1994 MDS from Maine, Missouri, and Washington are included in our analysis. But states collect their MDS data using different criteria for when the data are collected and which patients are included in the database. Because Ohio collects data from facilities on the last day of each quarter, obtaining assessments performed only for patients who are in the facility on that date, our analysis does not include assessments performed for Ohio patients who were admitted and discharged within the quarter.

Analyzing the MDS Information

So we could adhere to the requester's questions about differences among Medicare patients and the services they received in SNFs with and without exceptions, we eliminated from the MDS those assessments that were not performed for Medicare patients in SNF-designated beds. To accomplish this, we first eliminated from the database all assessments from facilities reimbursed only by Medicaid; the remaining MDS data were assessments from facilities that had both Medicare- and Medicaid-designated beds. We then sorted assessments according to the MDS "current payment sources" field to eliminate assessments in which Medicare did not appear to be the primary payer for routine care. In Maine and Ohio, only those assessments that indicated Medicare-paid per diem costs were included in our analysis because Medicare-paid per diem costs should identify those patients receiving skilled, rather than nonskilled, nursing care.

Our method for selecting Medicare skilled nursing patients in Missouri and Washington was different because the MDS databases in these states do not clearly identify when Medicare is paying for per diem costs. In these states, more than one payer field, such as Medicare, Medicaid, or a private insurer, can be checked. As a result, when more than one field was checked, we were unable to discern when Medicare was responsible for routine costs.[9] Therefore, we included in our analysis only those assessments for which Medicare was the only payer field checked.

To further ensure that we analyzed assessment information from Medicare patients only, we eliminated all assessments for patients under the age of

[8]These data were obtained from HCFA's Online Survey Certification and Reporting database.

[9]Medicare sometimes pays for ancillary services when another insurer, such as Medicaid, is paying the per diem costs. However, ancillary services are not incorporated in routine costs and are not considered by HCFA when making exception decisions.

18; for example, Medicare only covers patients under that age if they have end-stage renal disease. We also eliminated all assessments indicating that the time between nursing home admission and assessment was greater than 100 days because Medicare only pays for 100 or fewer days of skilled care.

We limited our analysis to those SNFs with 30 or more assessments within the calendar year and aggregated the assessments according to the facility providing the care. We computed summary measures, comparing the distributions of these measures between the two groups. Also, to ensure consistency between states, we restricted our analysis to initial assessments only.

Rug-III Analysis

Because high nursing resource utilization is a primary reason for SNFs to request an exception, we were interested in identifying each facility's overall nursing resource use. To do so, we applied the RUG-III model to Maine's and Ohio's MDS data. We selected the version of RUG-III that measures and classifies the MDS+ data by overall nursing resources associated with each RUG-III category. One of the other RUG-III versions considers therapy resources used in addition to nursing, but therapy costs are not included under the RCLs; thus, this version was not relevant for our study. Another version is one used by states for Medicaid reimbursement, but this version also was not relevant.

MEDPAR Data

We analyzed MEDPAR demographic and diagnostic information contained in 1992 data for all states and in 1994 data for Maine, Missouri, Ohio, and Washington only. We also limited this analysis to those SNFs with 30 or more completed stays during the calendar year and grouped the remaining SNFs into those with exceptions and those without exceptions. Then, similar to our analysis of MDS data, we computed summary measures for each facility on certain data elements, comparing the distributions of these measures between the two groups.

Limitations of the MDS and MEDPAR Data

Our analysis of MDS and MEDPAR data cannot be generalized to all SNFs. Although the MDS and MEDPAR data we used are the most complete databases available about SNF patients, the data may not include information on certain patient characteristics that, if analyzed, would show differences between the two groups of SNFs. In addition, when HCFA considers whether to grant an exception to a SNF, it compares that SNF only

with those SNFs in its peer group: urban freestanding, urban hospital-based, rural freestanding, and rural hospital-based. We did not similarly subdivide the SNFs into peer groups. Instead, we compared all SNFs within a state that were granted exceptions with all SNFs within that state that did not receive exceptions, to ensure we had an adequate number of facililties for analysis purposes.

Appropriateness of Care

To provide information about the appropriateness of the care SNFs furnish their patients, we visited five freestanding SNFs that had received exceptions in the past and continued to apply. The sites—located in California, Illinois, Indiana, Massachusetts, and Washington—were chosen with input from state officials and local nursing home ombudsmen. At each site, we collected the medical records of 20 patients who had received SNF care. At four SNFs, the sample was taken from patients who were identified by SNF personnel as having required or likely having required atypical SNF care. One SNF was unable to identify its atypical SNF population; therefore, we randomly selected 20 files from all the Medicare patient medical records. Many SNF staff members said that HCFA has not adequately defined atypical SNF care, so they did not believe objective criteria were available for them to use to make their selection. As a result, the selection criteria used by the SNF staff may have differed at each facility we visited.

The selected medical records from each SNF were sent to the PRO located in that SNF's state and reviewed by PRO staff. Using the HCFA generic screens for SNFs to evaluate the adequacy of care, a PRO nurse reviewed the medical record to identify any quality-of-care issues. If a potential quality-of-care problem was identified, a physician who practices in the same or similar specialty reviewed the medical record. If the PRO physician upheld the nurse reviewer's finding of a potential quality-of-care concern, the PRO contacted the SNF with the results of the physician review and offered the facility an opportunity to explain or give additional information not contained in the medical record. Only after the facility responded did the PRO physician reviewer make a final determination about whether a quality-of-care problem existed.[10]

We also asked the PRO reviewers to evaluate the health care needs of the sample of 20 patients in each of the five SNFs with exceptions we visited. The PRO evaluations were based on a five-point scale, with one being the

[10]In one case, the facility did not respond; therefore, the PRO upheld its original determination that a problem existed.

needs of a typical skilled nursing home patient and five being the needs of a typical acute-care hospital patient. We did not ask the SNFs that we visited to review the PRO reviewers' judgments on the complexity of their patients' needs.

Results of Analyses of Patient and Service Characteristics

Activities of Daily Living

The MDS instrument directs the rater to measure the patient's ability to perform various activities of daily living (ADL) using a numerical scale that increases with the patient's need for assistance. We analyzed patient ADL scores for four types of activities: bed mobility (the patient's ability to reposition himself or herself in bed), transfer (the patient's ability to move from a wheelchair to a bed, for example, or into and out of an armchair), toilet use, and eating. Figures IV.1 through IV.3 show, for Maine, Ohio, and Washington, the median total ADL scores (the sum of the scores for each of the four activities analyzed) for patients in each group of SNFs.

Figure IV.1: Median Patient ADL Scores in Maine SNFs, 1994

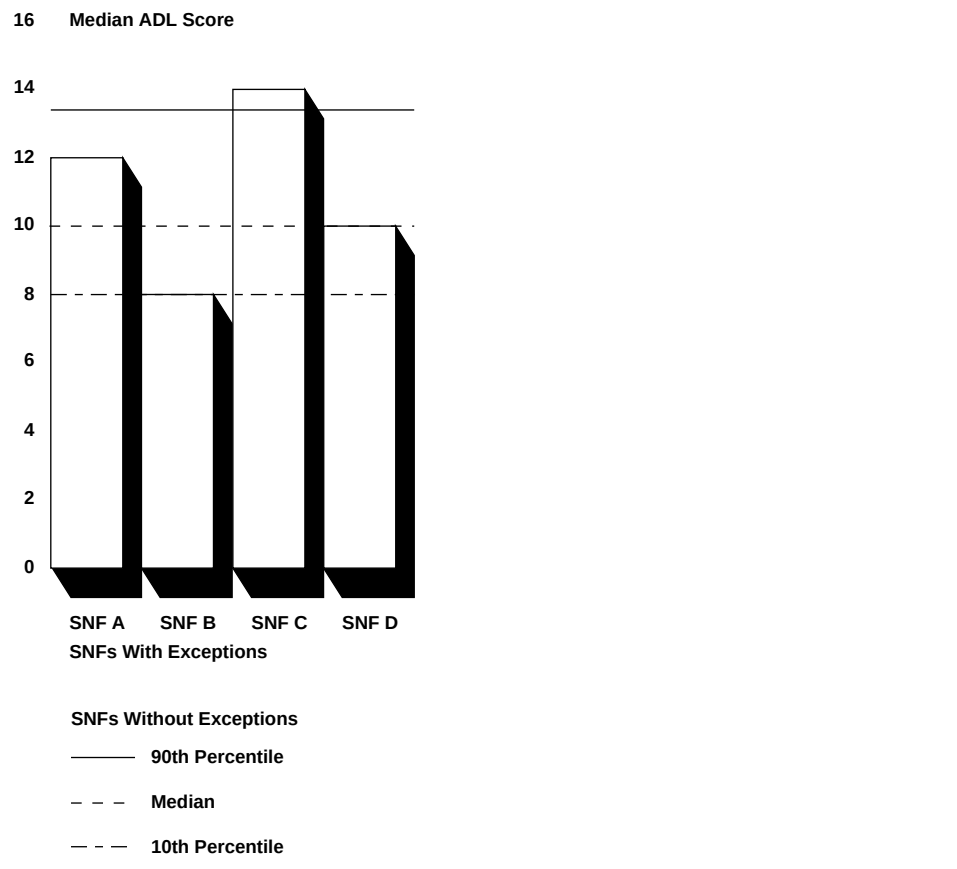


Figure IV.2: Median Patient ADL Scores in Ohio SNFs, 1994

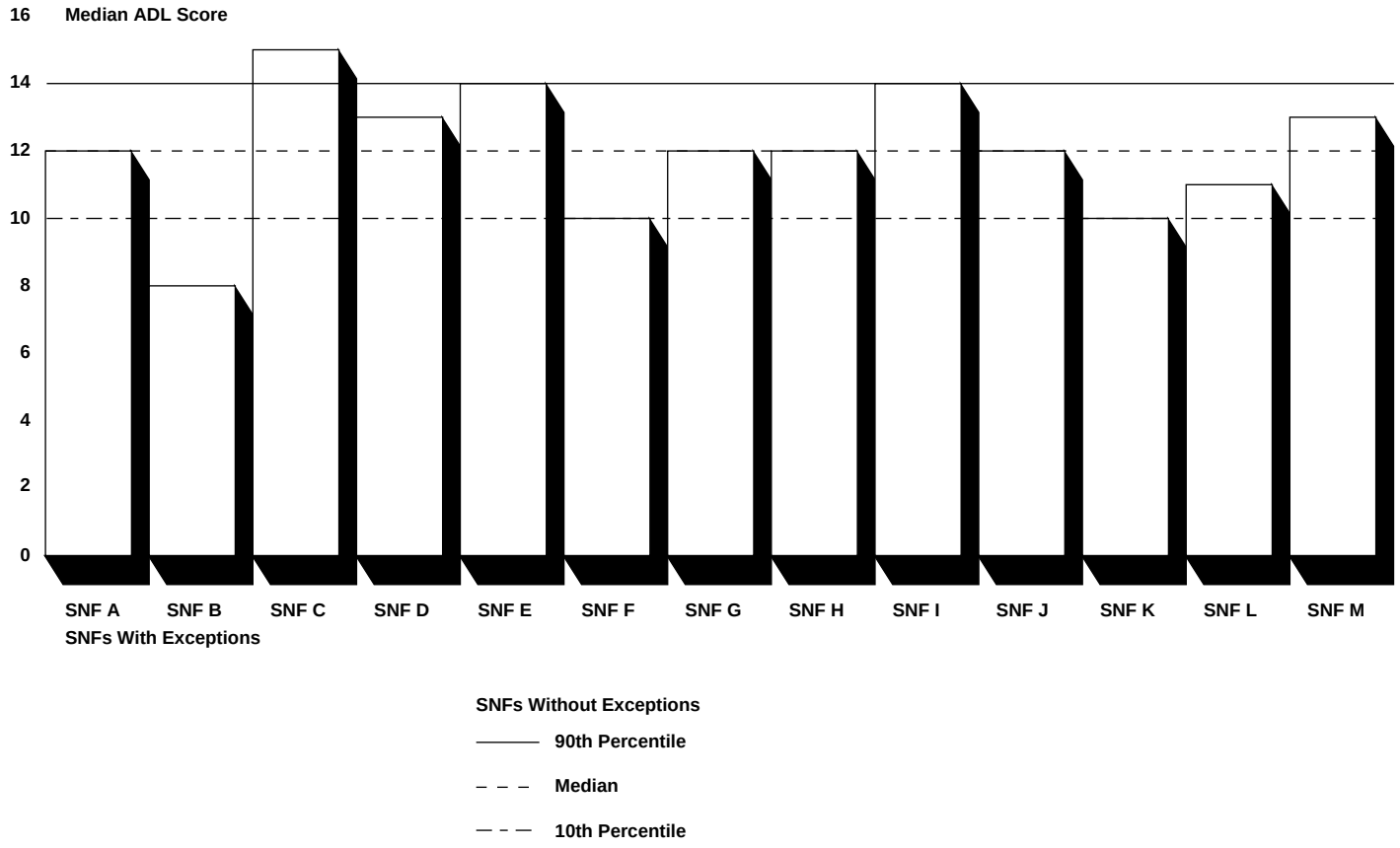
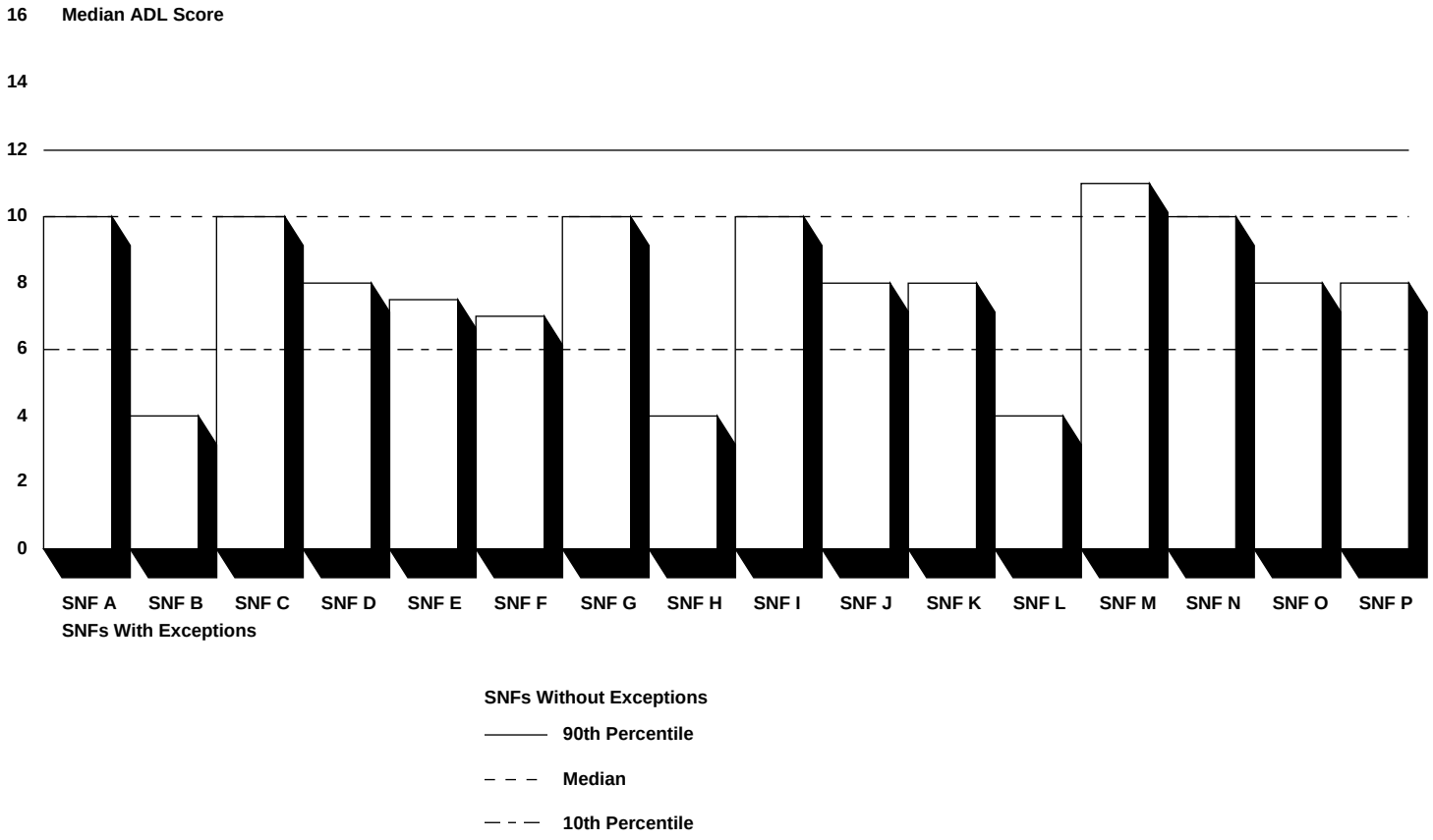


Figure IV.3: Median Patient ADL Scores in Washington SNFs, 1994



Diagnosis-Related Groups

DRGs provide a means of classifying patients into groups by relating the diagnoses of patients to the resources used. Tables IV.1 through IV.7 show the national and four states' rankings of the most frequently cited DRGs for patients in SNFs with exceptions and in SNFs without exceptions.

Table IV.1: Ranking of Most Frequently Cited DRGs for Patients in SNFs Nationwide With and Without Exceptions, 1992 MEDPAR

DRG number	DRG	SNFs with exceptions	SNFs without exceptions
012	Degenerative nervous system disorders	9	6
014	Specific cerebrovascular disorders except TIA	3	2
088	Chronic obstructive pulmonary disease	8	8
089	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	6	7
127	Heart failure and shock	5	4
236	Fractures of hip and pelvis	2	1
245	Bone diseases and specific arthropathies without complication and/or comorbidity	7	
294	Diabetes, age > 35	10	5
462	Rehabilitation	1	3
466	Aftercare without history of malignancy as secondary diagnosis	4	9
467	Other factors influencing health status	9	8
470	Ungroupable		10

Note: A blank indicates that no ranking was given.

Table IV.2: Ranking of Most Frequently Cited DRGs for Patients in Four States' SNFs With and Without Exceptions, 1994 MEDPAR

		Maine	
DRG number	DRG	SNFs with exceptions	SNFs without exceptions
012	Degenerative nervous system disorders	6	5
014	Specific cerebrovascular disorders except TIA	3	2
082	Respiratory neoplasms	8	
088	Chronic obstructive pulmonary disease	7	6
089	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity		9
090	Simple pneumonia and pleurisy, age > 17, without complication and/or comorbidity	6	
127	Heart failure and shock	4	3
130	Peripheral vascular disorders with complication and/or comorbidity		
173	Digestive malignancy without complication and/or comorbidity	9	
183	Esophagitis, gastroenteritis and miscellaneous digestive disorders, age > 17, without complication and/or comorbidity	5	
236	Fractures of hip and pelvis	2	1
239	Pathological fractures and musculoskeletal and connective tissue malignancy		
243	Medical back problems		10
245	Bone diseases and specific arthropathies without complication and/or comorbidity		
249	Aftercare, musculoskeletal system and connective tissue		
294	Diabetes, age > 35		8
297	Nutritional and miscellaneous metabolic disorders, age > 17, without complication and/or comorbidity	10	
316	Renal failure	9	
462	Rehabilitation	1	7
466	Aftercare without history of malignancy as secondary diagnosis		
467	Other factors influencing health status		
470	Ungroupable		4

Missouri		Ohio		Washington	
SNFs with exceptions	SNFs without exceptions	SNFs with exceptions	SNFs without exceptions	SNFs with exceptions	SNFs without exceptions
	9	8	6	8	5
3	3	2	2	2	2
8	7	5	7	6	7
6	6	6	6	3	6
		9			
5	5	4	4	4	4
7					
1	2	1	1	1	1
9					
10	10	10	10		10
			8		
				10	
	8	3	5	7	
2	1		3	5	
4	4				3
			9	9	9
		7			8

Note: A blank indicates that no ranking was given.

Table IV.3: Ten Most Frequently Cited DRGs for Patients in SNFs Nationwide With and Without Exceptions, 1992 MEDPAR

Ranking	DRG	DRG number	Percentage of patients
SNFs with exceptions			
1	Rehabilitation	462	10.04
2	Fractures of hip and pelvis	236	8.99
3	Specific cerebrovascular disorders except TIA	014	7.81
4	Aftercare without a history of malignancy as secondary diagnosis	466	5.68
5	Heart failure and shock	127	3.85
6	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	2.97
7	Bone diseases and specific arthropathies without complication and/or comorbidity	245	2.26
8	Chronic obstructive pulmonary disease	088	2.17
9	Degenerative nervous system disorders	012	1.84
9	Other factors influencing health status	467	1.84
10	Diabetes, age > 35	294	1.74
SNFs without exceptions			
1	Fractures of hip and pelvis	236	10.04
2	Specific cerebrovascular disorders except TIA	014	9.58
3	Rehabilitation	462	5.18
4	Heart failure and shock	127	4.36
5	Diabetes, age > 35	294	3.01
6	Degenerative nervous system disorders	012	3.00
7	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	2.65
8	Chronic obstructive pulmonary disease	088	2.37
8	Other factors influencing health status	467	2.37
9	Aftercare without a history of malignancy as secondary diagnosis	466	2.36
10	Ungroupable	470	2.08

Table IV.4: Ten Most Frequently Cited DRGs for Patients in Maine SNFs With and Without Exceptions, 1994 MEDPAR

Ranking	DRG	DRG number	Percentage of patients
SNFs with exceptions			
1	Rehabilitation	462	35.67
2	Fractures of hip and pelvis	236	6.00
3	Specific cerebrovascular disorders except TIA	014	5.33
4	Heart failure and shock	127	3.67
5	Esophagitis, gastroenteritis, and miscellaneous digestive disorders, age > 17, without complication and/or comorbidity	183	2.50
6	Degenerative nervous system disorders	012	2.33
6	Simple pneumonia and pleurisy, age > 17, without complication and/or comorbidity	090	2.33
7	Chronic obstructive pulmonary disease	088	2.17
8	Respiratory neoplasms	082	1.83
9	Digestive malignancy without complication and/or comorbidity	173	1.67
9	Renal failure	316	1.67
10	Nutritional and miscellaneous metabolic disorders, age > 17, without complication and/or comorbidity	297	1.50
SNFs without exceptions			
1	Fractures of hip and pelvis	236	12.69
2	Specific cerebrovascular disorders except TIA	014	6.49
3	Heart failure and shock	127	4.20
4	Ungroupable	470	3.62
5	Degenerative nervous system disorders	012	3.45
6	Chronic obstructive pulmonary disease	088	3.36
7	Rehabilitation	462	3.19
8	Diabetes, age > 35	294	2.38
9	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	2.23
10	Medical back problems	243	2.14

Table IV.5: Ten Most Frequently Cited DRGs for Patients in Missouri SNFs With and Without Exceptions, 1994 MEDPAR

Ranking	DRG	DRG number	Percentage of patients
SNFs with exceptions			
1	Fractures of hip and pelvis	236	8.47
2	Rehabilitation	462	6.69
3	Specific cerebrovascular disorders except TIA	014	6.13
4	Aftercare without a history of malignancy as secondary diagnosis	466	4.75
5	Heart failure and shock	127	4.73
6	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	4.36
7	Peripheral vascular disorders with complication and/or comorbidity	130	2.65
8	Chronic obstructive pulmonary disease	088	2.28
9	Pathological fractures and musculoskeletal and connective tissue malignancy	239	2.00
10	Medical back problems	243	1.83
SNFs without exceptions			
1	Rehabilitation	462	9.53
2	Fractures of hip and pelvis	236	8.65
3	Specific cerebrovascular disorders except TIA	014	7.18
4	Aftercare without a history of malignancy as secondary diagnosis	466	6.68
5	Heart failure and shock	127	4.87
6	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	3.66
7	Chronic obstructive pulmonary disease	088	2.60
8	Diabetes, age > 35	294	2.34
9	Degenerative nervous system disorders	012	2.30
10	Medical back problems	243	1.53

Table IV.6: Ten Most Frequently Cited DRGs for Patients in Ohio SNFs With and Without Exceptions, 1994 MEDPAR

Ranking	DRG	DRG number	Percentage of patients
SNFs with exceptions			
1	Fractures of hip and pelvis	236	10.04
2	Specific cerebrovascular disorders except TIA	014	8.80
3	Diabetes, age > 35	294	5.80
4	Heart failure and shock	127	4.54
5	Chronic obstructive pulmonary disease	088	4.18
6	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	3.40
7	Ungroupable	470	2.79
8	Degenerative nervous system disorders	012	2.53
9	Simple pneumonia and pleurisy, age > 17, without complication and/or comorbidity	090	1.93
10	Medical back problems	243	1.85
SNFs without exceptions			
1	Fractures of hip and pelvis	236	9.75
2	Specific cerebrovascular disorders except TIA	014	8.21
3	Rehabilitation	462	5.95
4	Heart failure and shock	127	4.97
5	Diabetes, age > 35	294	4.89
6	Degenerative nervous system disorders	012	3.02
6	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	3.02
7	Chronic obstructive pulmonary disease	088	2.87
8	Bone diseases and specific arthropathies without complication and/or comorbidity	245	2.29
9	Other factors influencing health status	467	2.18
10	Medical back problems	243	1.77

Table IV.7: Ten Most Frequently Cited DRGs for Patients in Washington SNFs With and Without Exceptions, 1994 MEDPAR

Ranking	DRG	DRG number	Percentage of patients
SNFs with exceptions			
1	Fractures of hip and pelvis	236	9.86
2	Specific cerebrovascular disorders except TIA	014	8.32
3	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	4.22
4	Heart failure and shock	127	4.13
5	Rehabilitation	462	3.88
6	Chronic obstructive pulmonary disease	088	2.79
7	Diabetes, age > 35	294	2.34
8	Degenerative nervous system disorders	012	2.09
9	Other factors influencing health status	467	1.97
10	Aftercare, musculoskeletal system and connective tissue	249	1.91
SNFs without exceptions			
1	Fractures of hip and pelvis	236	9.96
2	Specific cerebrovascular disorders except TIA	014	6.72
3	Aftercare without history of malignancy as secondary diagnosis	466	5.14
4	Heart failure and shock	127	4.37
5	Degenerative nervous system disorders	012	3.55
6	Simple pneumonia and pleurisy, age > 17, with complication and/or comorbidity	089	3.47
7	Chronic obstructive pulmonary disease	088	3.03
8	Ungroupable	470	2.52
9	Other factors influencing health status	467	2.07
10	Medical back problems	243	2.05

Rug-III Ranking of Patients According to Nursing Resource Use

The RUG-III model uses MDS data to apportion patients into one of 44 categories according to the amount of nursing resources they use. Table IV.8 shows the distribution of Maine SNF patients into each of the 44 categories; table IV.9 shows similar information for Ohio SNF patients. In each state, we combined all patients in SNFs with exceptions and compared them, in the aggregate, to all patients in SNFs without exceptions (considering only SNFs with 30 or more MDS assessments).

Because the category names used in RUG-III are not self-explanatory, we did not use these names. Instead, we placed in rank order the categories according to the amount of nursing resources used: Rank 1 indicates that patients in this RUG-III category use the most resources, rank 2 indicates the second-highest use, and so on.

Table IV.8: Distribution of Maine SNF Patients, by Ranking of Nursing Resource Use as Measured by RUG-III, 1994

	Percentage of patients[a]			
Ranking	SNFs with exceptions	SNFs without exceptions	SNFs with exceptions (cumulative)	SNFs without exceptions (cumulative)
1	0.0	0.1	0.0	0.1
2	0.2	0.5	0.2	0.6
3	0.6	3.3	0.8	3.9
4	2.5	1.6	3.3	5.5
5	2.7	4.6	6.1	10.1
6	1.9	1.8	7.9	11.9
7	2.1	2.1	10.0	13.9
8	1.3	6.3	11.3	20.2
9	2.7	1.6	14.0	21.8
10	6.3	4.7	20.3	26.5
11	0.2	2.2	20.5	28.7
12	20.9	19.4	41.4	48.1
13	3.3	2.2	44.8	50.3
14	2.9	2.2	47.7	52.5
15	2.5	3.4	50.2	55.8
16	6.3	7.5	56.5	63.4
17	0.8	0.7	57.3	64.1
18	1.9	1.0	59.2	65.1
19	5.2	2.2	64.4	67.3
20	4.6	4.0	69.0	71.3
21	1.9	2.5	70.9	73.8
22	0.8	0.4	71.8	74.2

(continued)

	Percentage of patients[a]			
Ranking	SNFs with exceptions	SNFs without exceptions	SNFs with exceptions (cumulative)	SNFs without exceptions (cumulative)
23	9.6	5.9	81.4	80.1
24	1.9	1.3	83.3	81.4
25	0.4	0.6	83.7	82.0
26	0.2	0.6	83.9	82.6
27	0.6	0.7	84.5	83.3
28	0.0	0.0	84.5	83.3
29	1.5	1.6	86.0	85.0
30	3.6	5.1	89.5	90.0
31	0.8	0.8	90.4	90.8
32	0.8	0.9	91.2	91.7
33	0.2	0.1	91.4	91.8
34	0.0	0.0	91.4	91.8
35	1.0	0.4	92.5	92.2
36	4.2	4.2	96.7	96.5
37	0.0	0.5	96.7	96.9
38	0.0	0.1	96.7	97.0
39	0.0	0.0	96.7	97.0
40	1.3	0.9	97.9	97.9
41	0.2	0.5	98.1	98.5
42	0.4	0.2	98.5	98.7
43	0.2	0.1	98.7	98.8
44	1.3	1.2	100.0	100.0

[a]Numbers may not add to totals because of rounding.

Table IV.9: Distribution of Ohio SNF Patients, by Ranking of Nursing Resource Use as Measured by RUG-III, 1994

	Percentage of patients[a]			
Ranking	SNFs with exceptions	SNFs without exceptions	SNFs with exceptions (cumulative)	SNFs without exceptions (cumulative)
1	1.1	1.4	1.1	1.4
2	2.2	1.7	3.3	3.0
3	12.4	9.2	15.7	12.2
4	2.2	2.4	17.9	14.6
5	2.4	3.9	20.2	18.5
6	1.6	2.1	21.9	20.6
7	2.6	3.0	24.4	23.6
8	17.3	16.4	41.7	40.0
9	1.6	1.5	43.4	41.5
10	3.8	3.3	47.2	44.8
11	1.8	2.4	49.0	47.2
12	11.3	14.2	60.3	61.5
13	2.6	2.4	62.8	63.9
14	2.6	1.5	65.4	65.4
15	0.4	0.5	65.8	65.9
16	1.6	1.9	67.4	67.7
17	0.0	0.3	67.4	68.0
18	2.4	1.8	69.8	69.7
19	2.2	2.5	71.9	72.2
20	0.2	0.5	72.1	72.7
21	1.6	2.0	73.8	74.6
22	0.0	0.2	73.8	74.9

(continued)

	Percentage of patients[a]			
Ranking	SNFs with exceptions	SNFs without exceptions	SNFs with exceptions (cumulative)	SNFs without exceptions (cumulative)
23	9.1	8.3	82.9	83.1
24	0.7	0.9	83.6	84.0
25	0.4	0.6	84.0	84.6
26	0.0	0.1	84.0	84.6
27	0.0	0.1	84.0	84.7
28	0.0	0.1	84.0	84.8
29	1.6	1.5	85.6	86.3
30	6.9	5.6	92.5	92.0
31	0.5	0.5	93.1	92.5
32	0.2	0.3	93.3	92.8
33	0.2	0.0	93.4	92.8
34	0.5	0.2	94.0	93.0
35	1.1	0.6	95.1	93.6
36	3.5	3.3	98.5	96.9
37	0.0	0.0	98.5	96.9
38	0.0	0.0	98.5	96.9
39	0.0	0.0	98.5	96.9
40	0.4	1.1	98.9	98.0
41	0.0	0.2	98.9	98.2
42	0.0	0.0	98.9	98.2
43	0.0	0.3	98.9	98.5
44	1.1	1.5	100.0	100.0

[a]Numbers may not add to totals because of rounding.

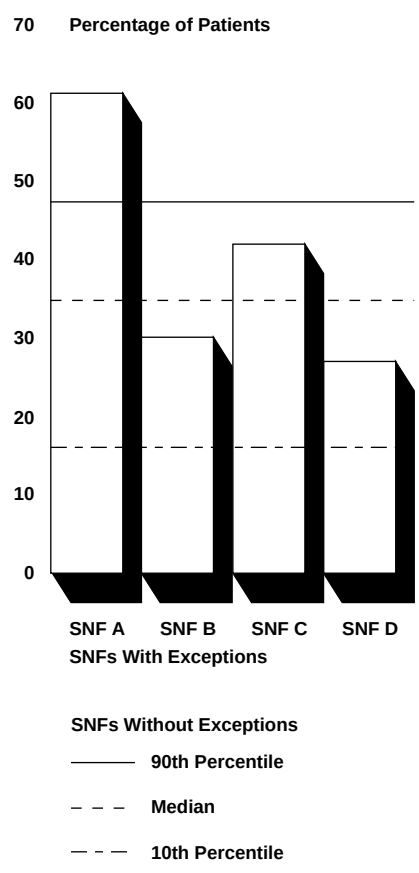
Other Patient Characteristics

Cognitive Status

The MDS directs the rater to select, from four possible choices, the patient's ability to make decisions regarding the tasks of daily life (for example, selecting clothing or determining mealtimes). The four possible levels are (1) independent (decisions are consistent and reasonable), (2) moderately

independent[11] (some difficulty in new situations only), (3) moderately impaired (decisions are poor, and cues or supervision are required), or (4) severely impaired (rarely or never makes decisions). Figures IV.4 through IV.7 show, for each of the four states we analyzed, the percentage of patients in each group of SNFs with moderate or severe cognitive impairment.

Figure IV.4: Percentage of Maine SNF Patients With Moderate or Severe Cognitive Impairment, 1994



[11]The MDS characterizes this level as "modified independence."

Figure IV.5: Percentage of Missouri SNF Patients With Moderate or Severe Cognitive Impairment, 1994

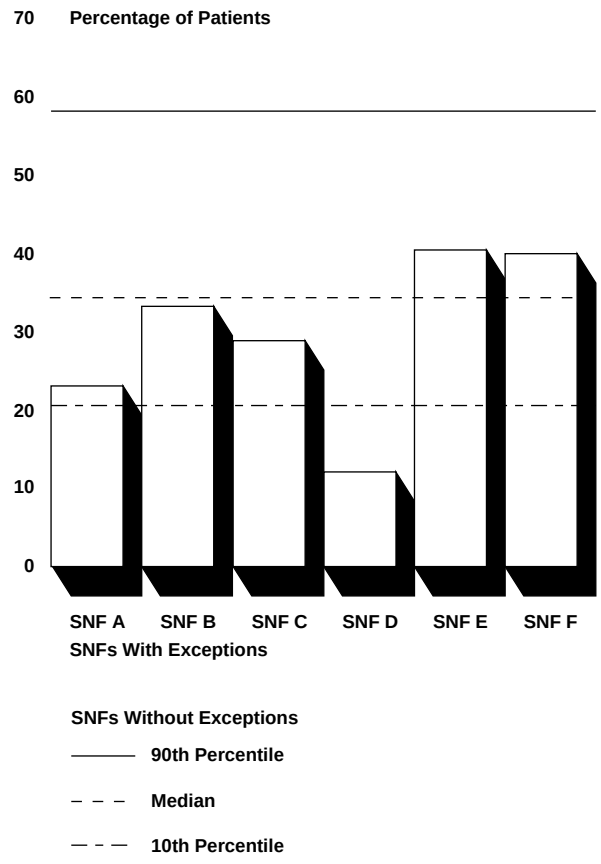


Figure IV.6: Percentage of Ohio SNF Patients With Moderate or Severe Cognitive Impairment, 1994

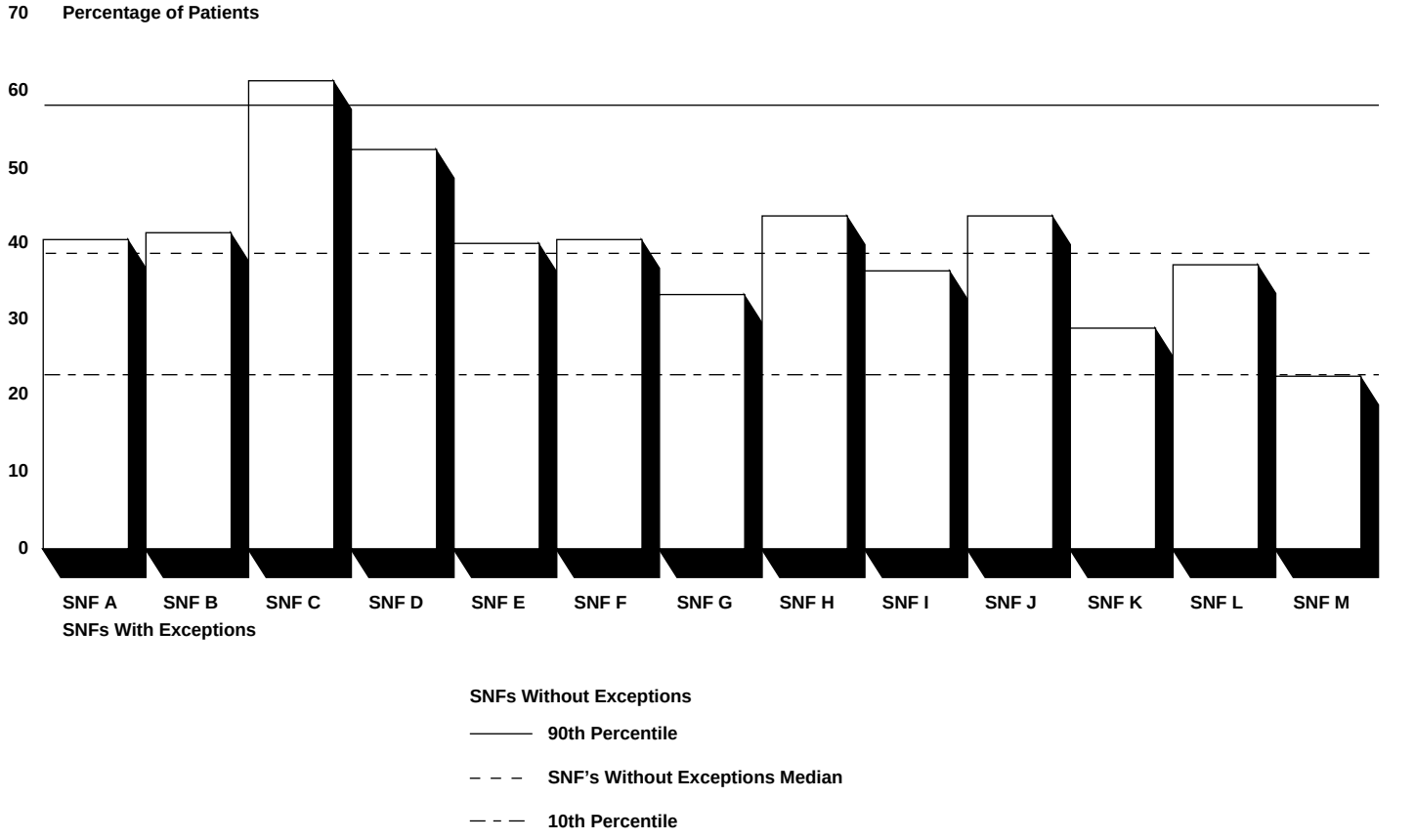
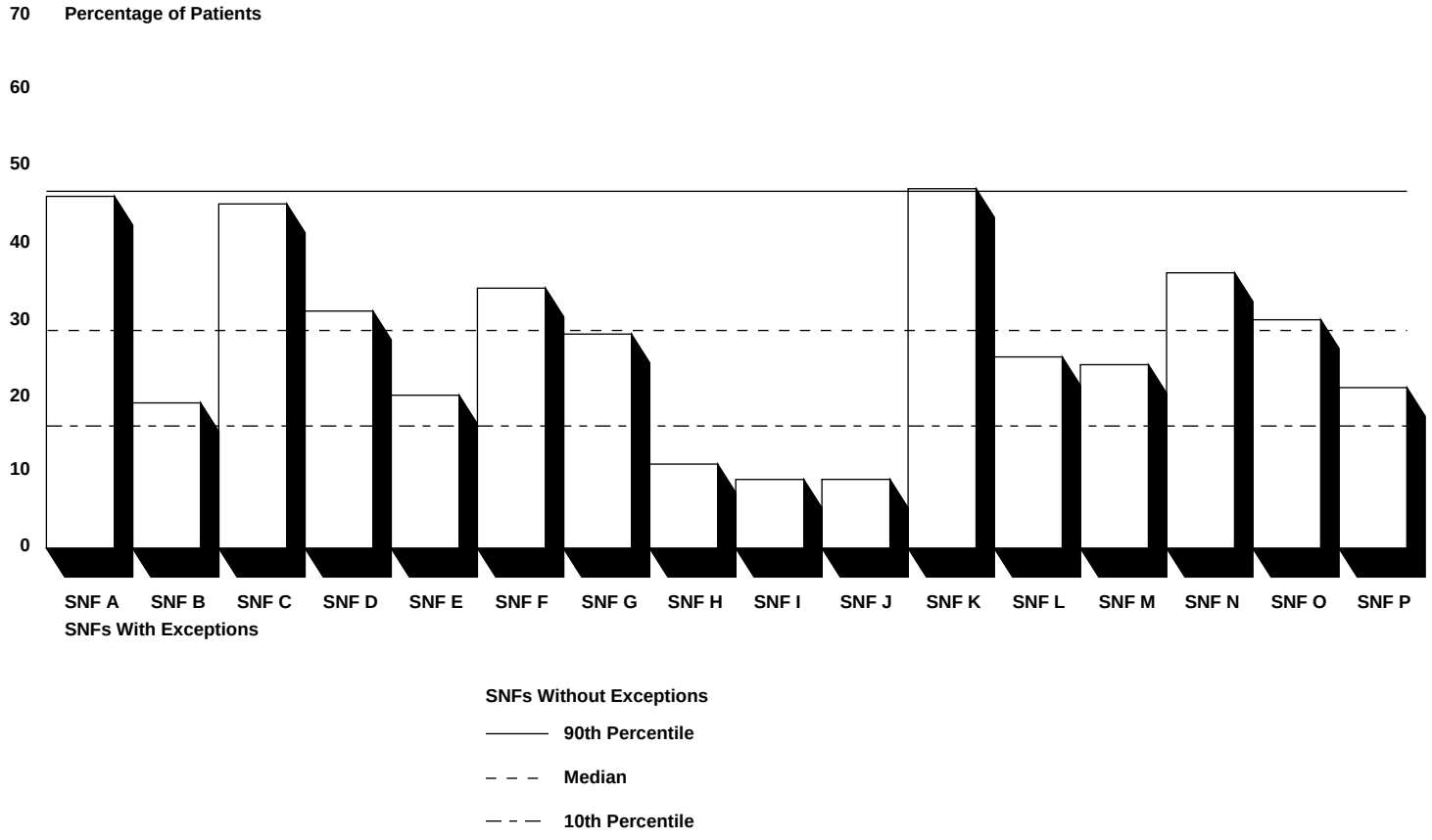


Figure IV.7: Percentage of Washington SNF Patients With Moderate or Severe Cognitive Impairment, 1994



Prior Nursing Home Stay

The MDS directs the rater to indicate, from the following list of settings, all settings the patient lived in during the 5 years prior to admission: (1) this nursing home, (2) another nursing home or residential facility, (3) mental health or psychiatric setting, and (4) mental retardation or developmentally disabled setting. Figures IV.8 through IV.11 show, for each of the four states we analyzed, the percentage of patients in each group of SNFs who had a prior stay at the current facility or at another nursing home or residential facility.

Figure IV.8: Percentage of Maine SNF Patients With a Prior Stay in This or Another Nursing Home or Residential Facility, 1994

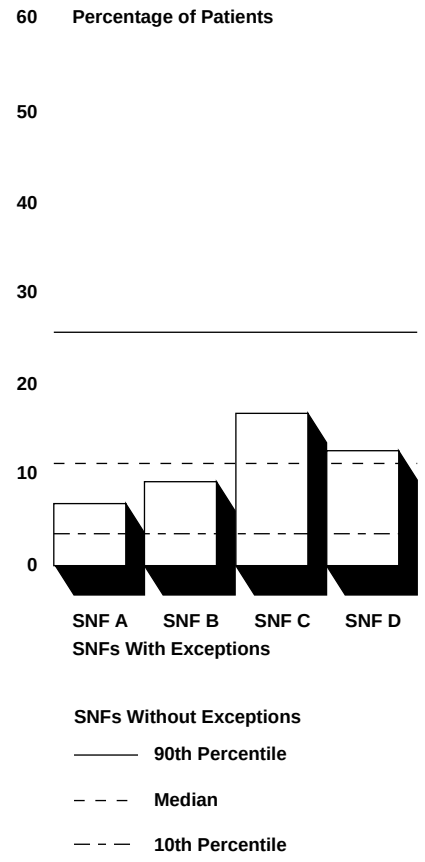


Figure IV.9: Percentage of Missouri SNF Patients With a Prior Stay in This or Another Nursing Home or Residential Facility, 1994

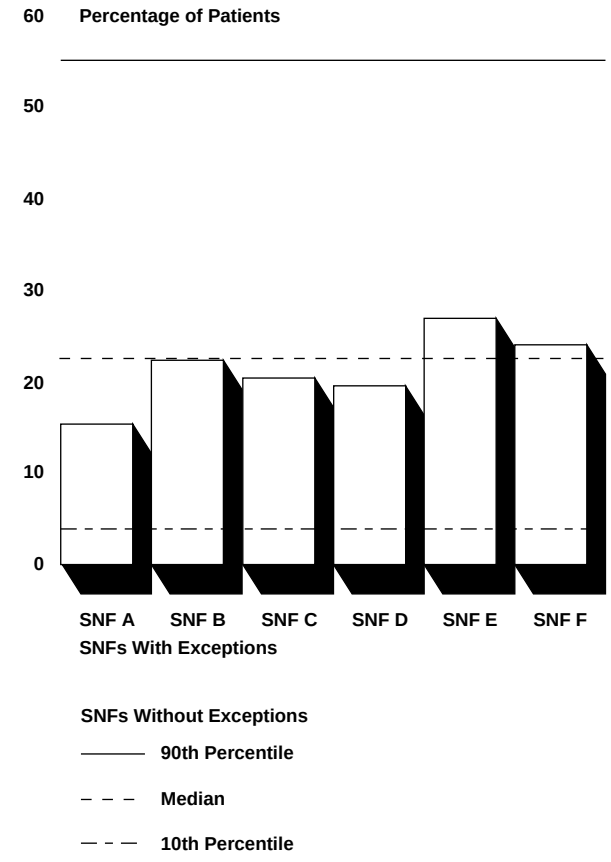


Figure IV.10: Percentage of Ohio SNF Patients With a Prior Stay in This or Another Nursing Home or Residential Facility, 1994

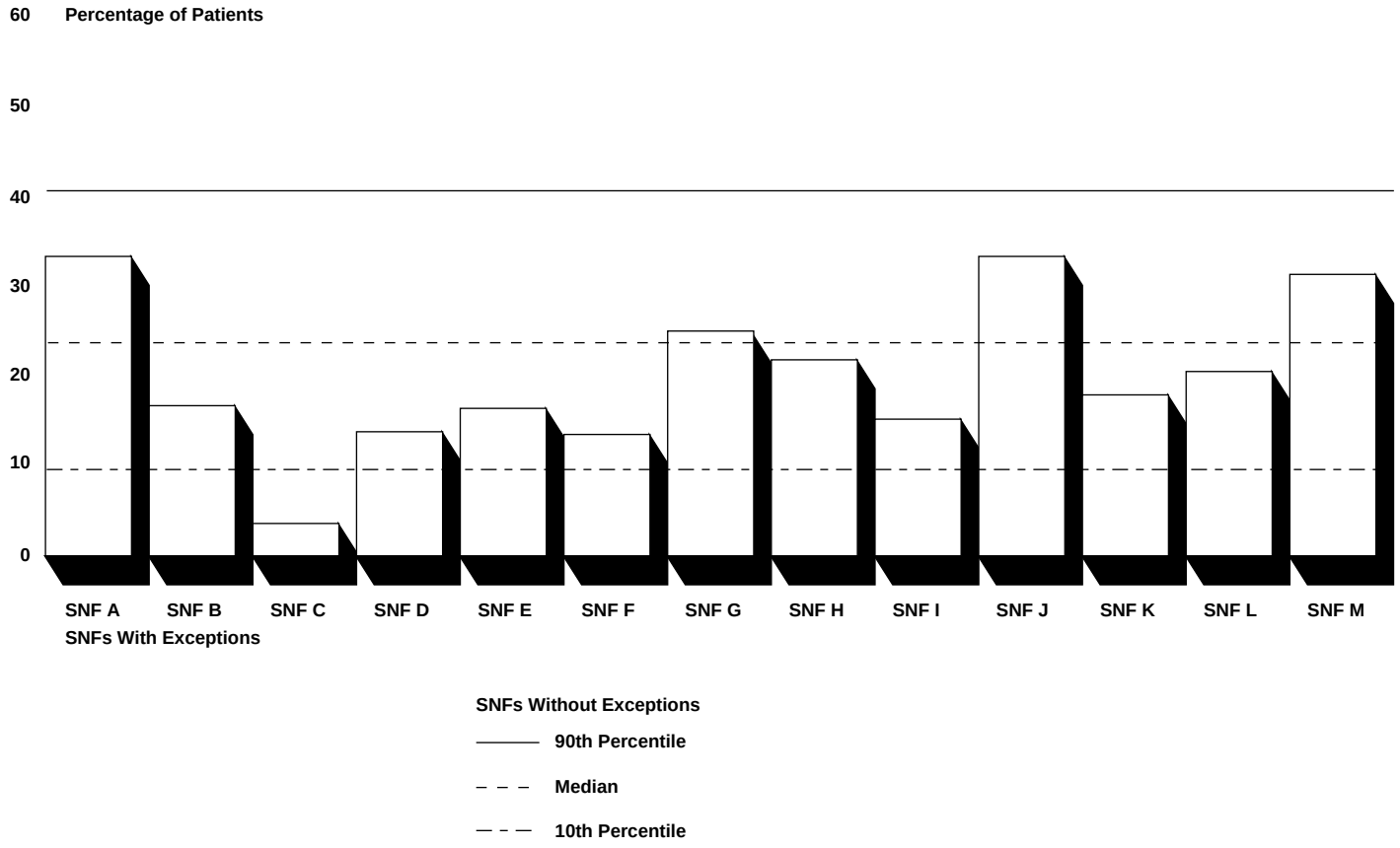
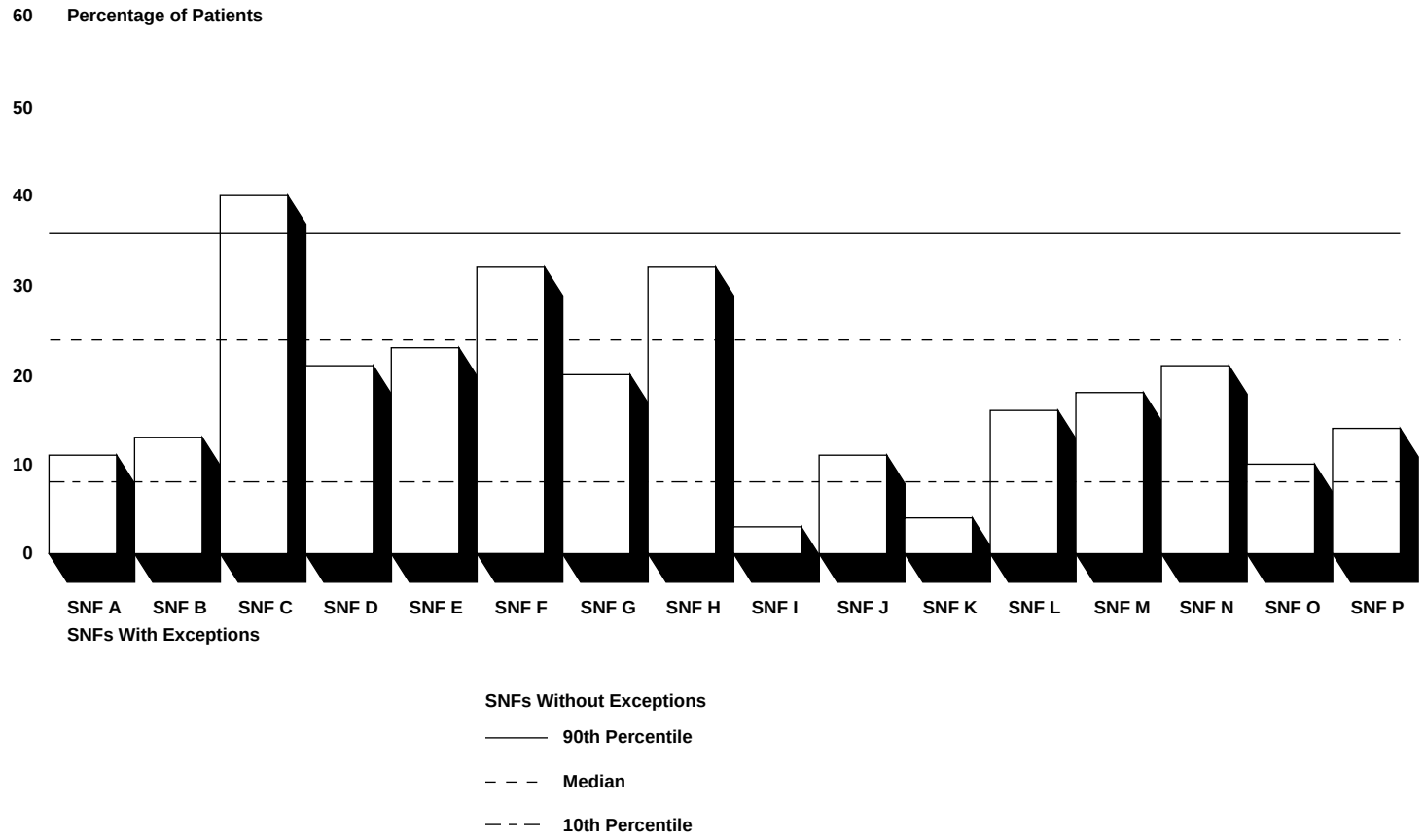


Figure IV.11: Percentage of Washington SNF Patients With a Prior Stay in This or Another Nursing Home or Residential Facility, 1994



Age

MEDPAR contains information about patient age. Figures IV.12 through IV.14 show, respectively, the median ages of patients in both groups of SNFs nationwide in 1992; the median ages of patients in both groups of SNFs in Missouri, Ohio, and Washington in 1994; and the median ages of patients in both groups of SNFs in Maine in 1994.

Figure IV.12: Median Age of SNF Patients Nationwide, 1992

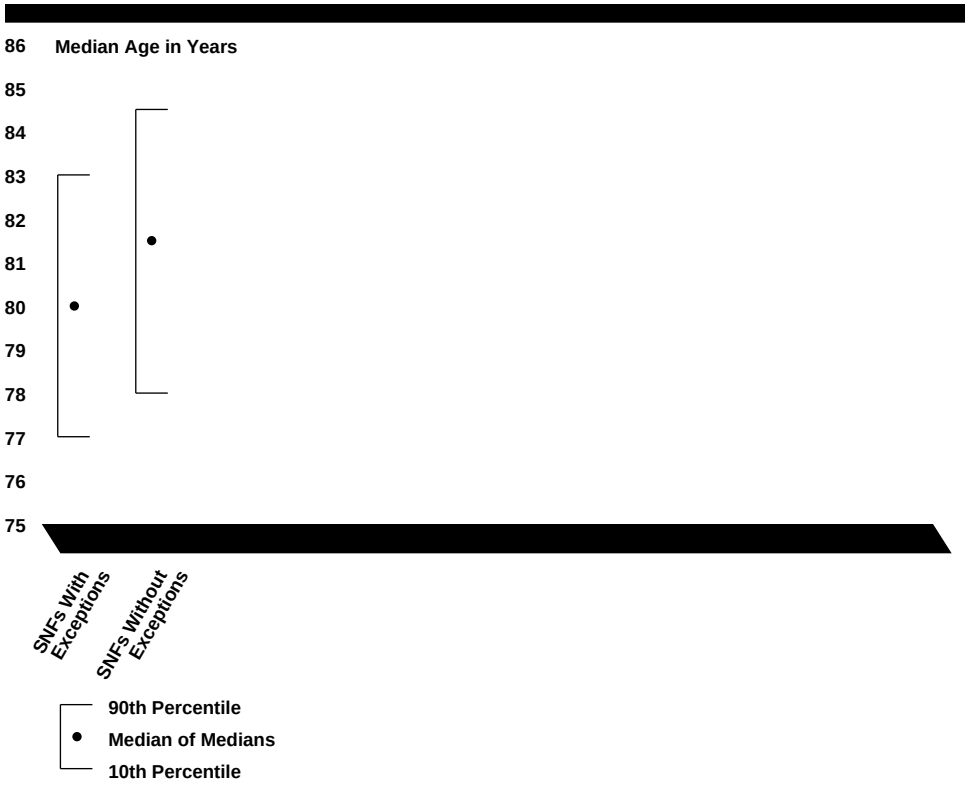


Figure IV.13: Median Age of SNF Patients in Three of the Four States GAO Analyzed, 1994

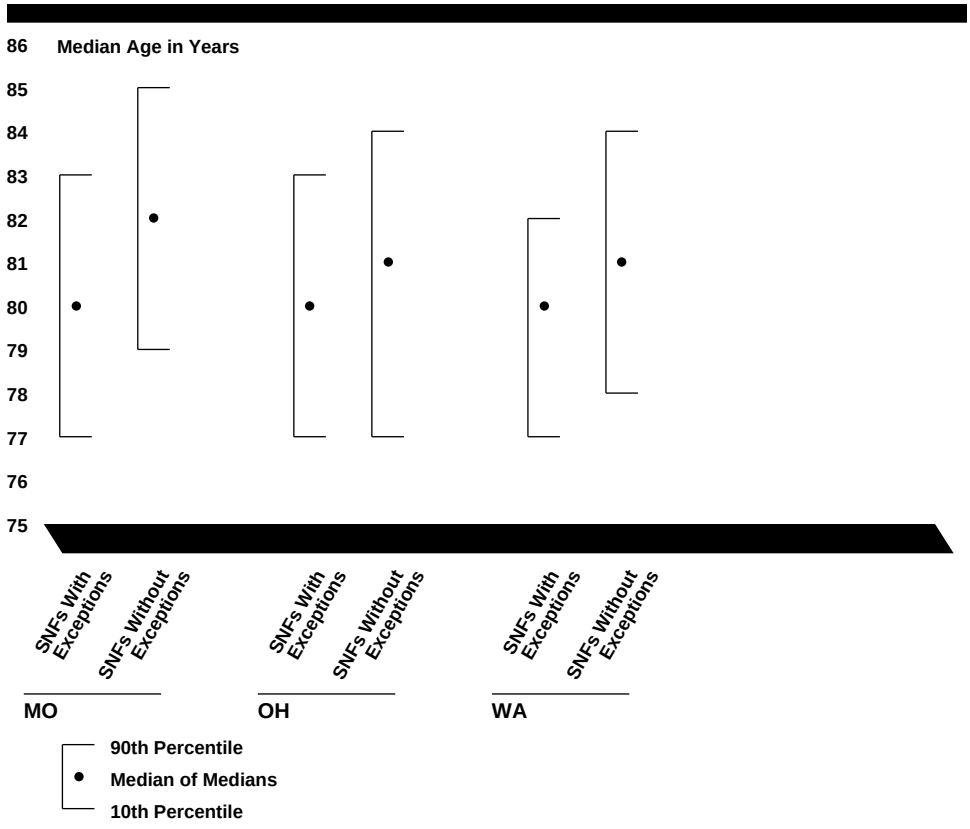
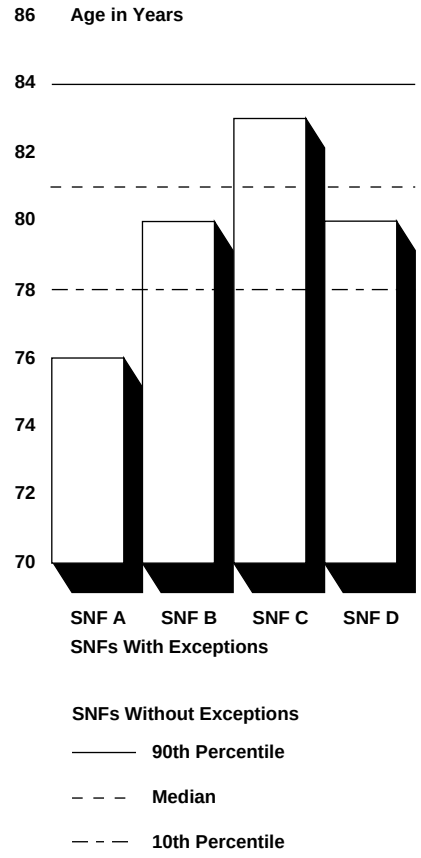


Figure IV.14: Median Age of Maine SNF Patients, 1994



Special Treatments

The MDS directs the rater to indicate, from a list of special treatments and procedures, all treatments received by the patient in the prior 14 days. Following is a list of the treatments and procedures. Figures IV.15 through IV.30 show, for each of the four states we studied, the median number of all treatments and procedures each patient received as well as the percentage of patients in each group of SNFs receiving suctioning, intravenous medication, and oxygen.

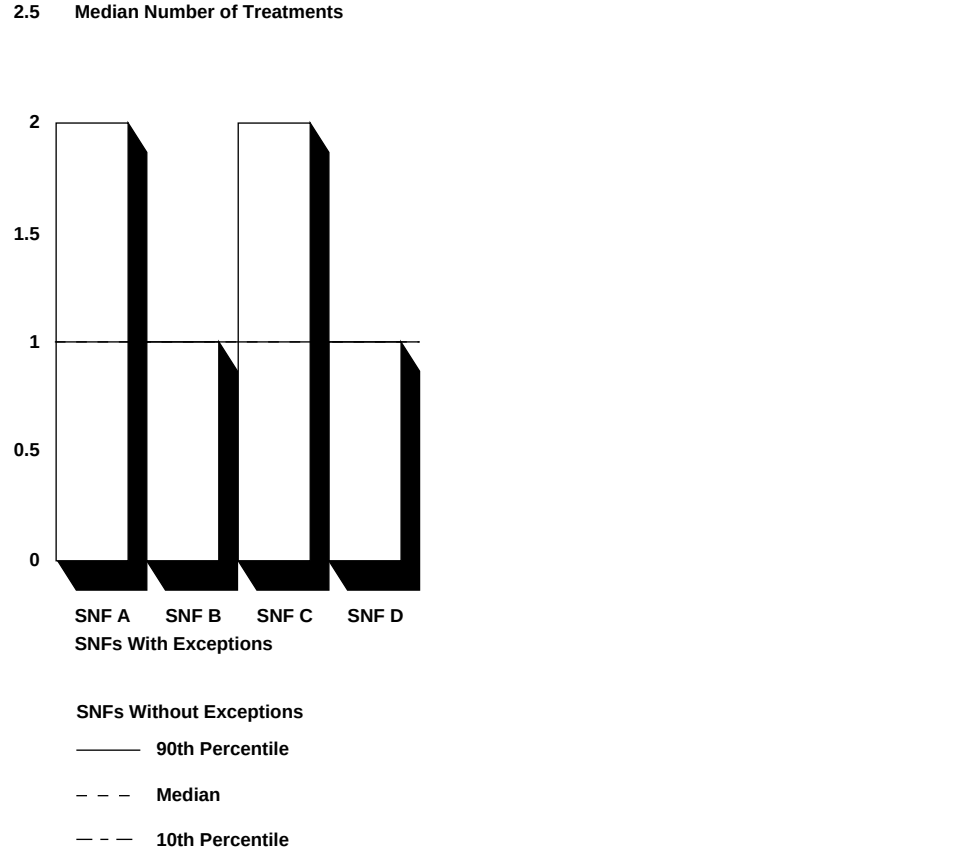
Special Treatments and Procedures Included in the MDS

- Chemotherapy
- Radiation
- Dialysis
- Suctioning
- Tracheostomy care

- Intravenous medications
- Transfusions
- Oxygen
- Intake/output measurement (MDS+ only)
- Ventilator/respirator care (MDS+ only)
- Other

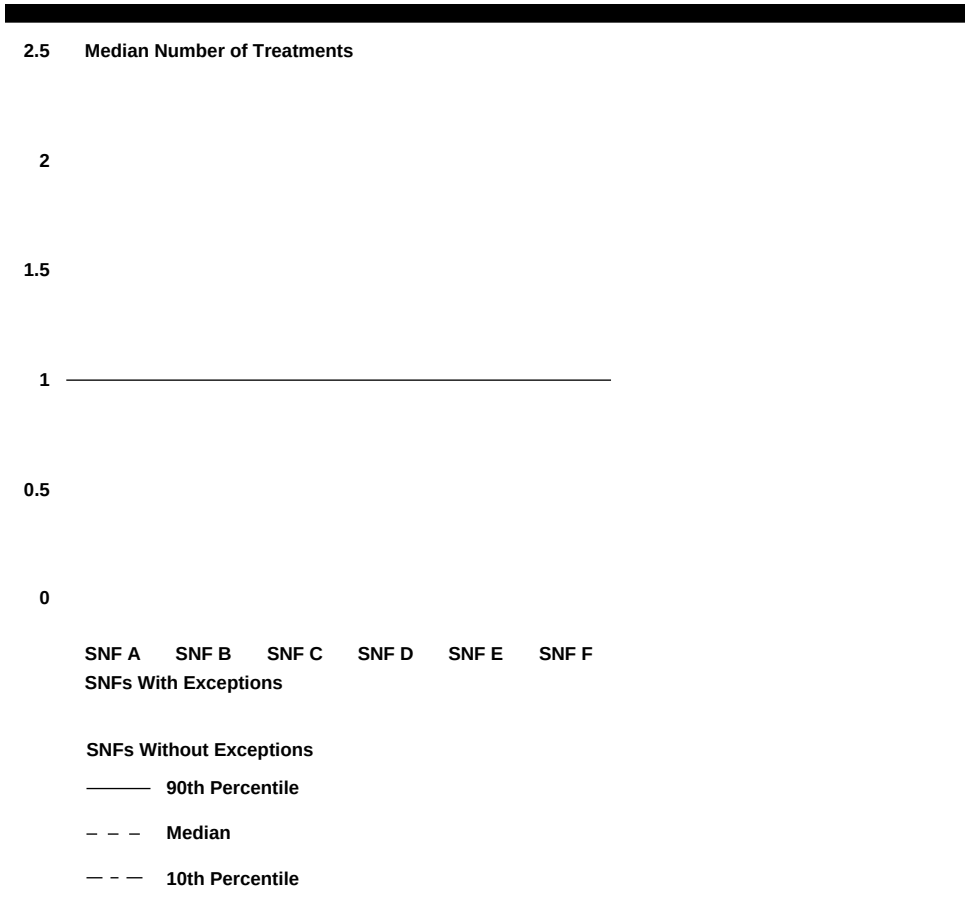
Most of these treatments are defined in the glossary at the end of this report.

Figure IV.15: Median Number of Special Treatments Received by Maine SNF Patients, 1994



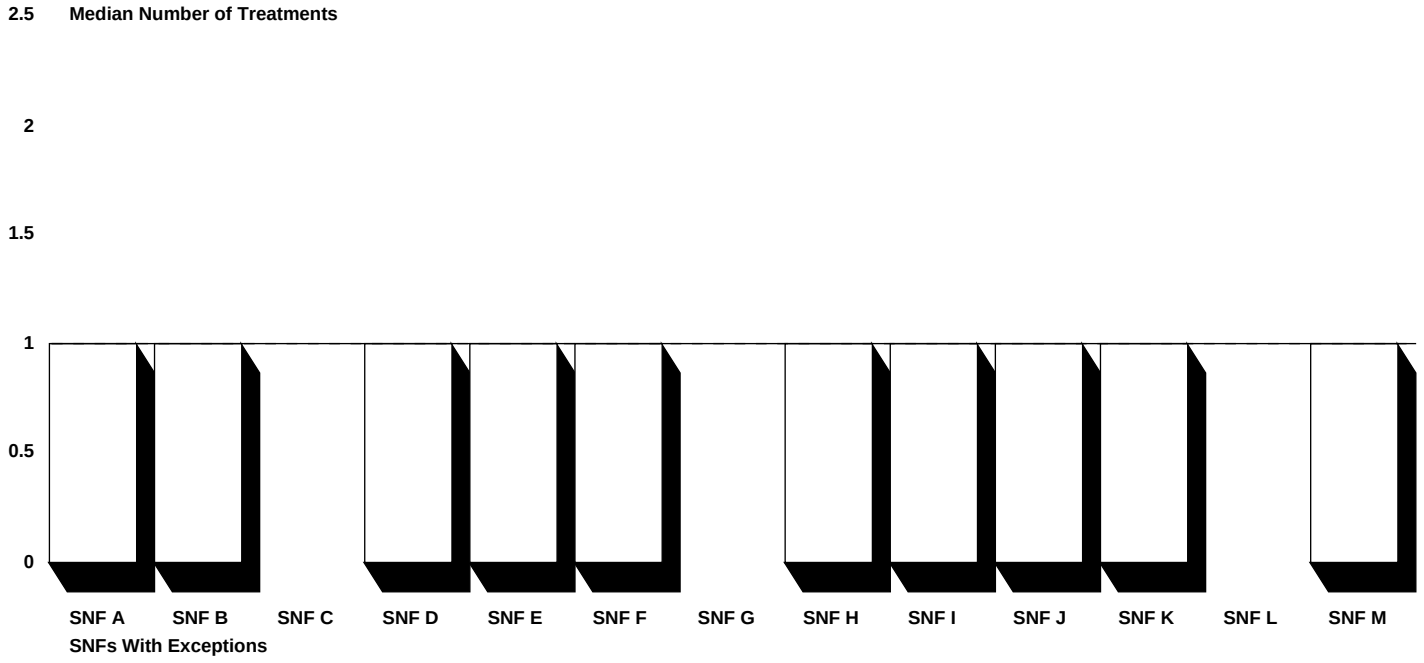
Note: The 90th percentile and median values for SNFs without exceptions were one; the 10th percentile value for SNFs without exceptions was zero.

Figure IV.16: Median Number of Special Treatments Received by Missouri SNF Patients, 1994



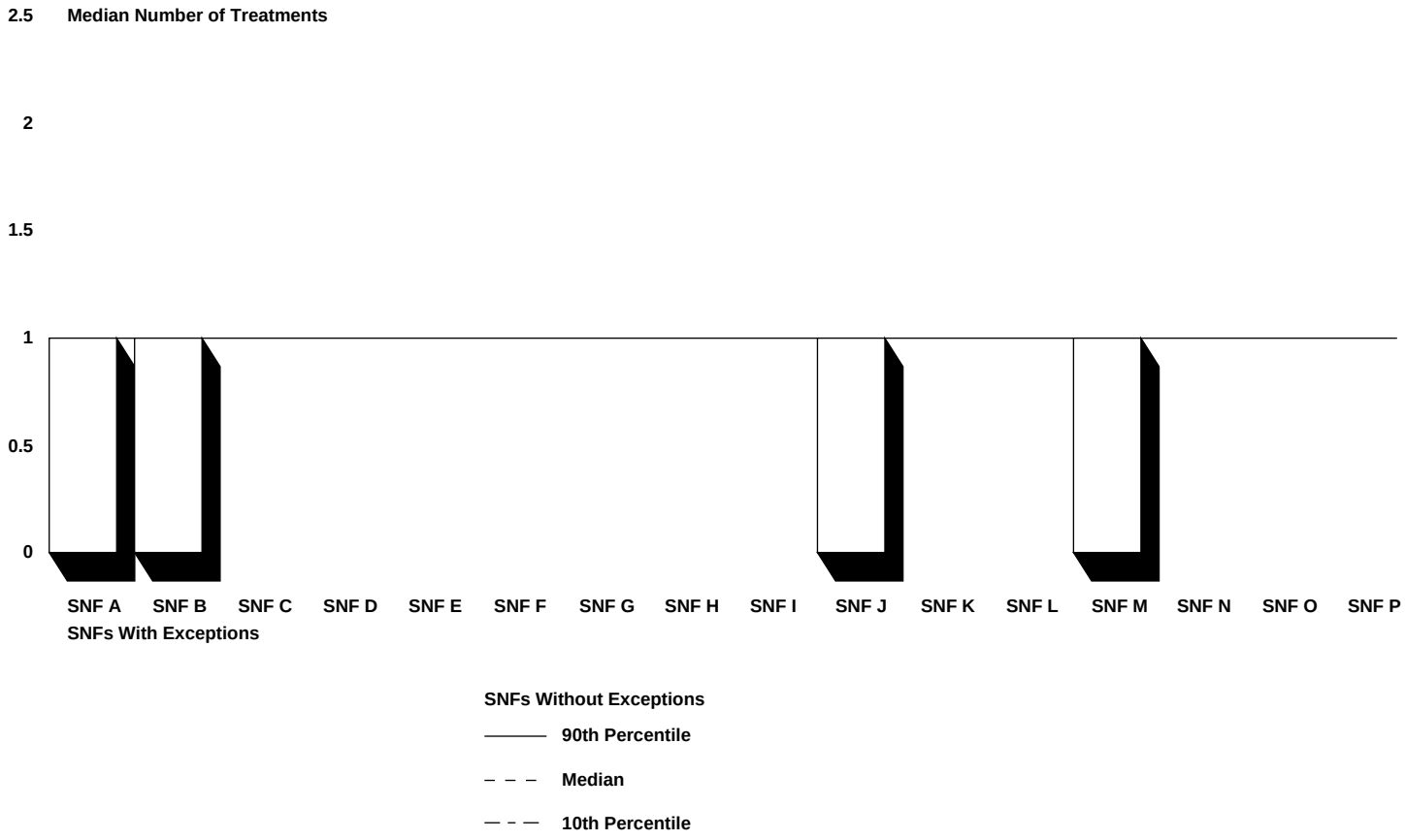
Note: When no bar is displayed for a SNF with an exception, then the value was zero. The median and 10th percentile values for SNFs without exceptions were zero.

Figure IV.17: Median Number of Special Treatments Received by Ohio SNF Patients, 1994



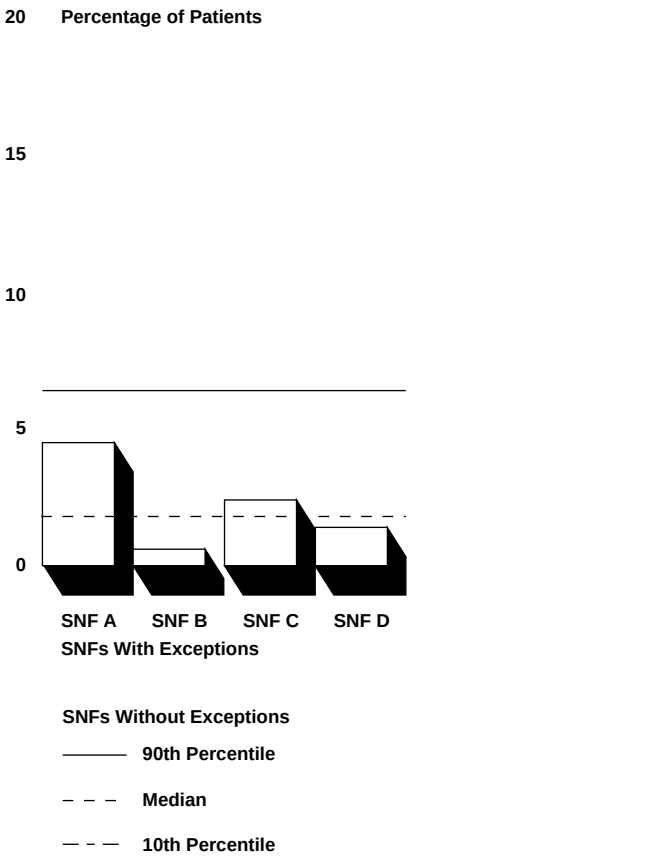
Note: When no bar is displayed for a SNF with an exception, then the value was zero. The 90th percentile and median values for SNFs without exceptions were one; the 10th percentile value for SNFs without exceptions was zero.

Figure IV.18: Median Number of Special Treatments Received by Washington SNF Patients, 1994



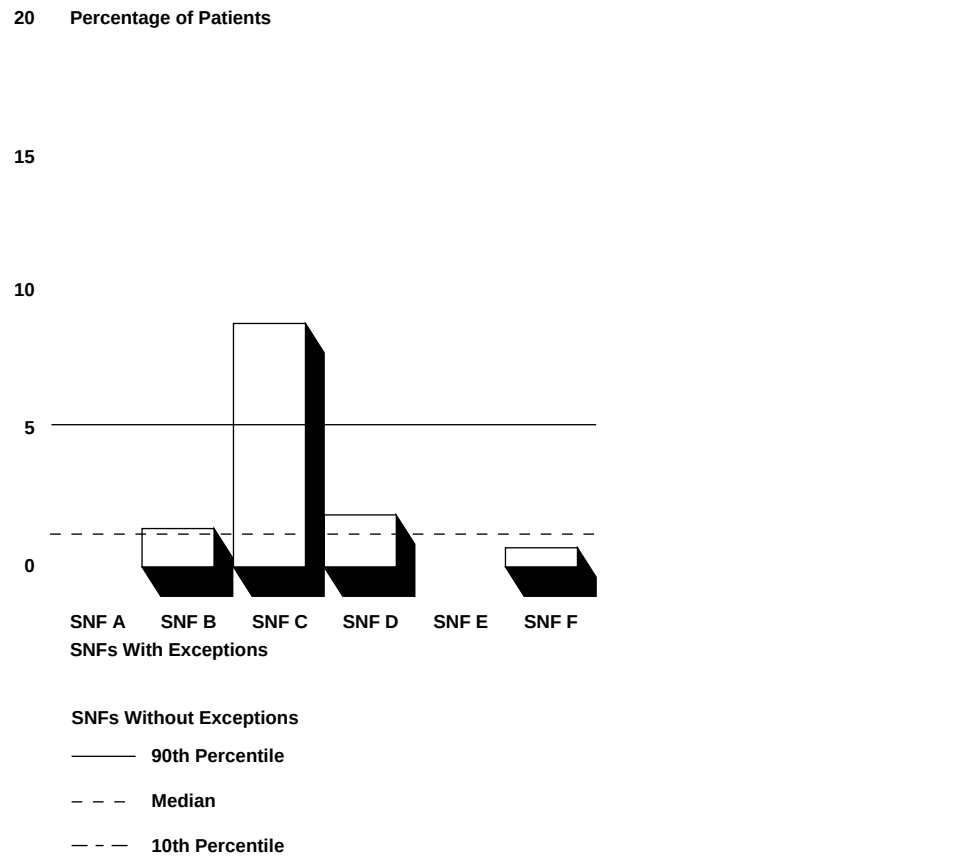
Note: When no bar is displayed for a SNF with an exception, then the value was zero. The median and 10th percentile values for SNFs without exceptions were zero.

Figure IV.19: Percentage of Maine SNF Patients Receiving Suctioning, 1994



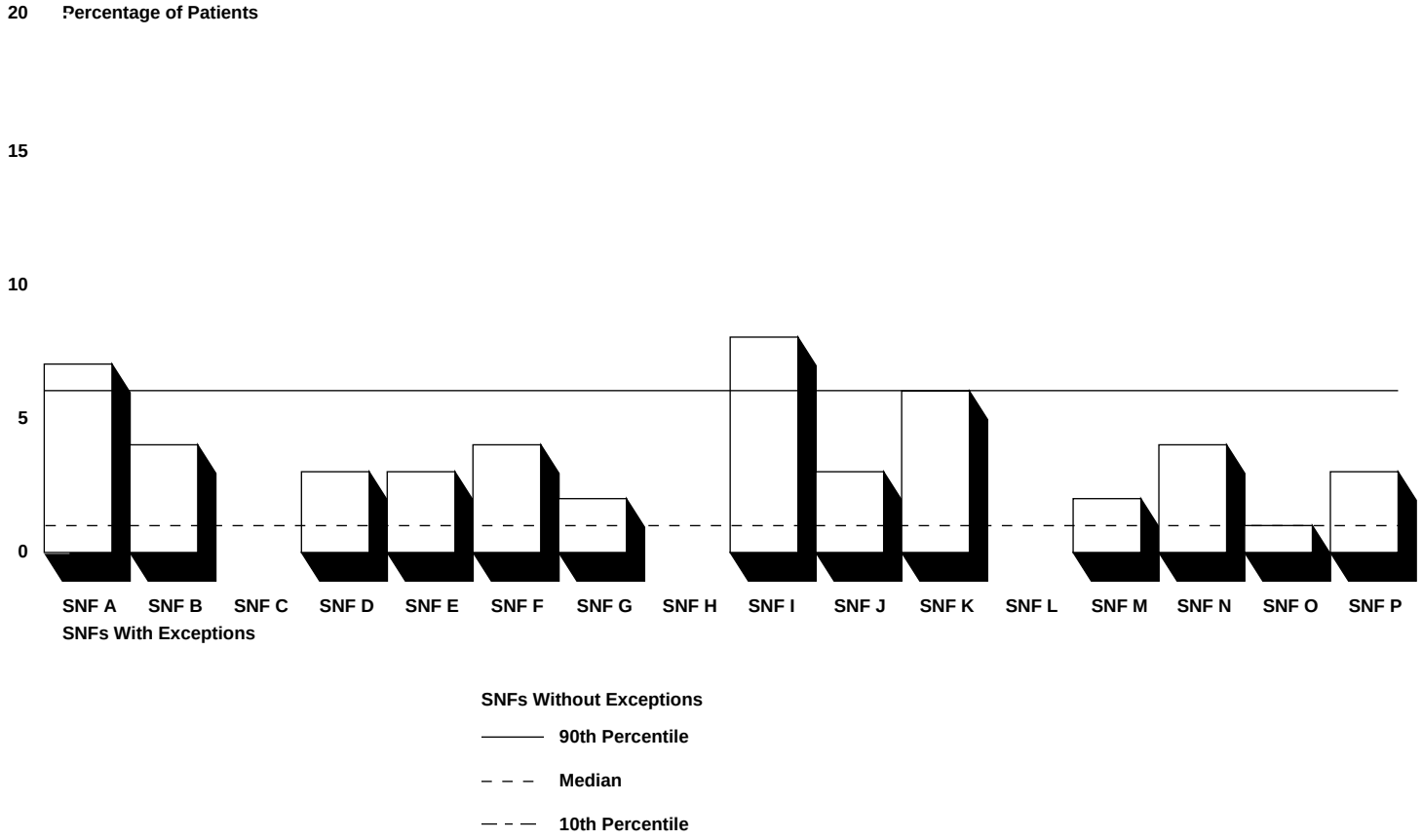
Note: The 10th percentile value for SNFs without exceptions was zero.

Figure IV.20: Percentage of Missouri SNF Patients Receiving Suctioning, 1994



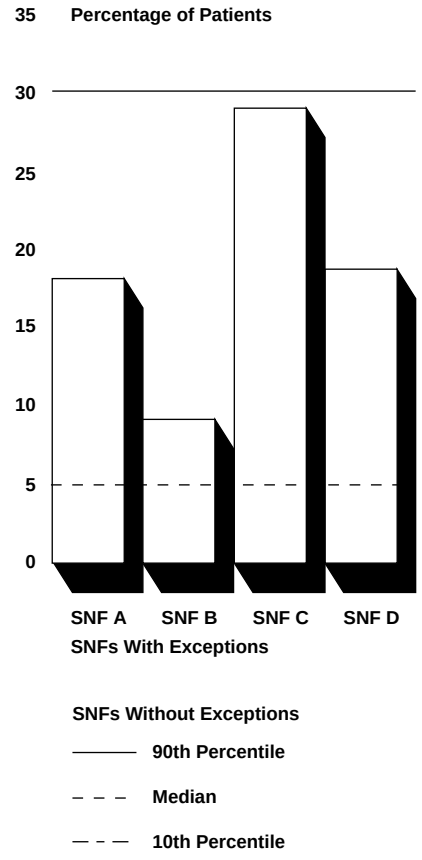
Note: When no bar is displayed for a SNF with an exception, then the value was zero. The 10th percentile value for SNFs without exceptions was zero.

Figure IV.21: Percentage of Washington SNF Patients Receiving Suctioning, 1994



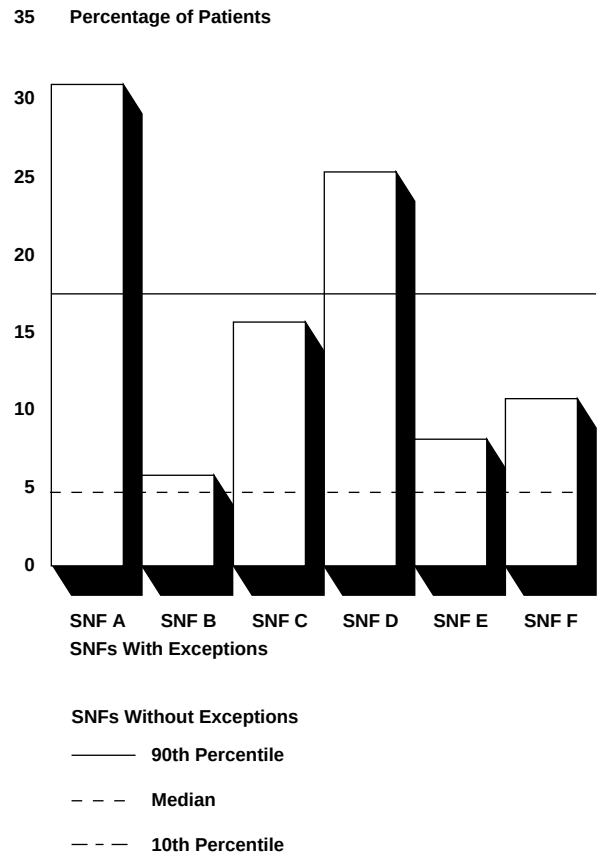
Note: When no bar is displayed for a SNF with an exception, then the value was zero. The 10th percentile value for SNFs without exceptions was zero.

Figure IV.22: Percentage of Maine SNF Patients Receiving Intravenous Medications, 1994



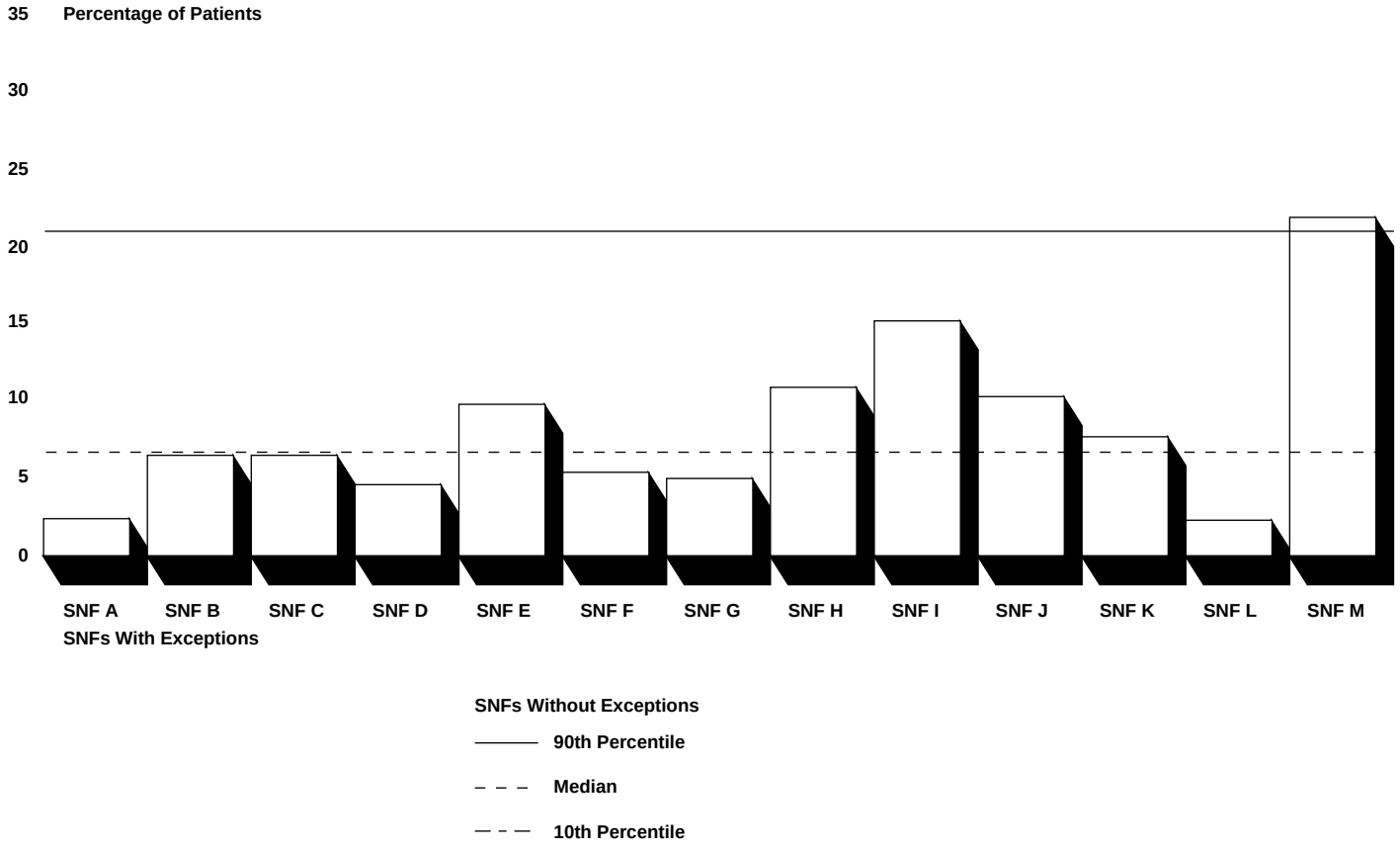
Note: The 10th percentile value for SNFs without exceptions was zero.

Figure IV.23: Percentage of Missouri SNF Patients Receiving Intravenous Medications, 1994



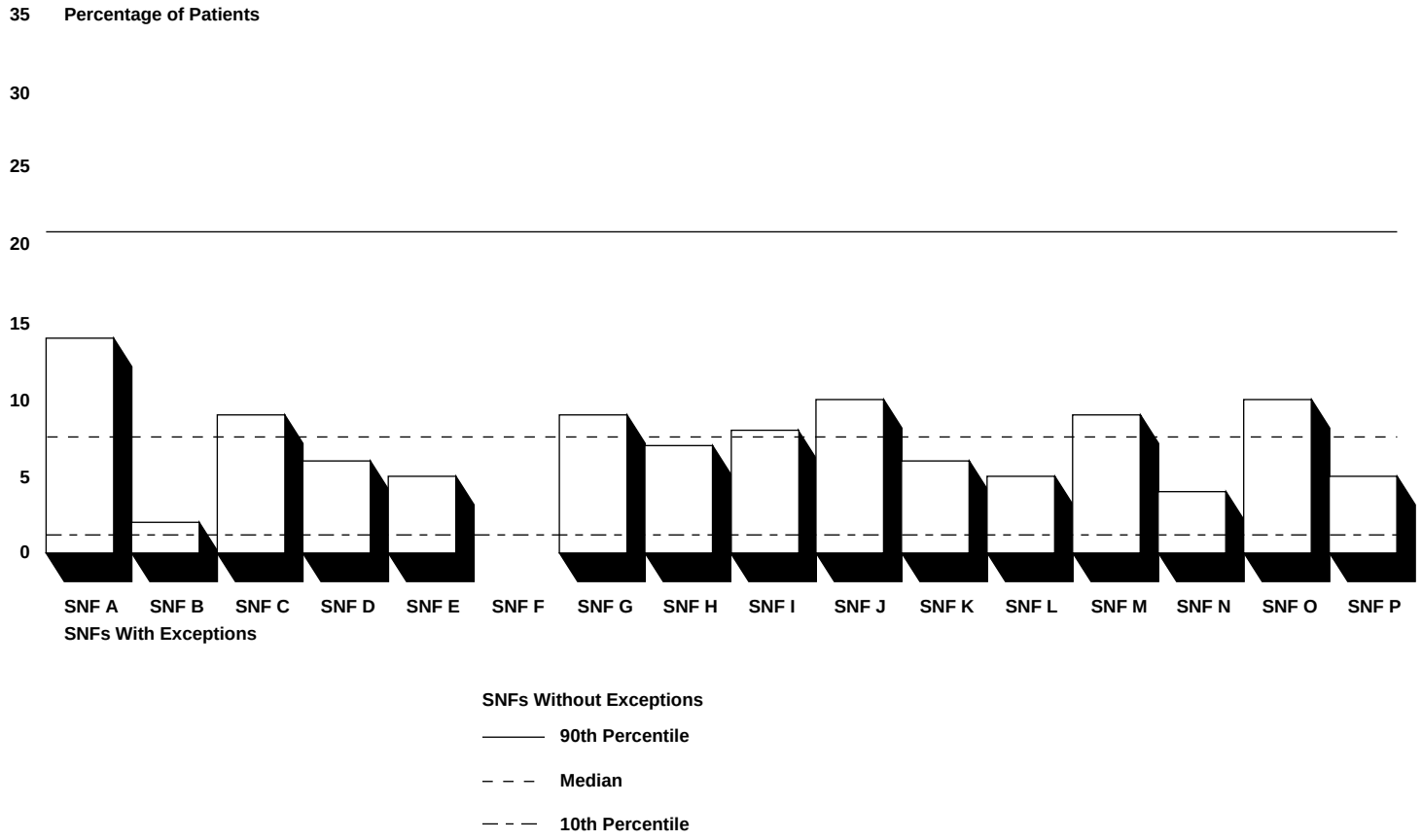
Note: The 10th percentile value for SNFs without exceptions was zero.

Figure IV.24: Percentage of Ohio SNF Patients Receiving Intravenous Medications, 1994



Note: The 10th percentile value for SNFs without exceptions was zero.

Figure IV.25: Percentage of Washington SNF Patients Receiving Intravenous Medications, 1994



Note: When no bar is displayed for a SNF with an exception, then the value was zero.

Figure IV.26: Percentage of Maine SNF Patients Receiving Oxygen Therapy, 1994

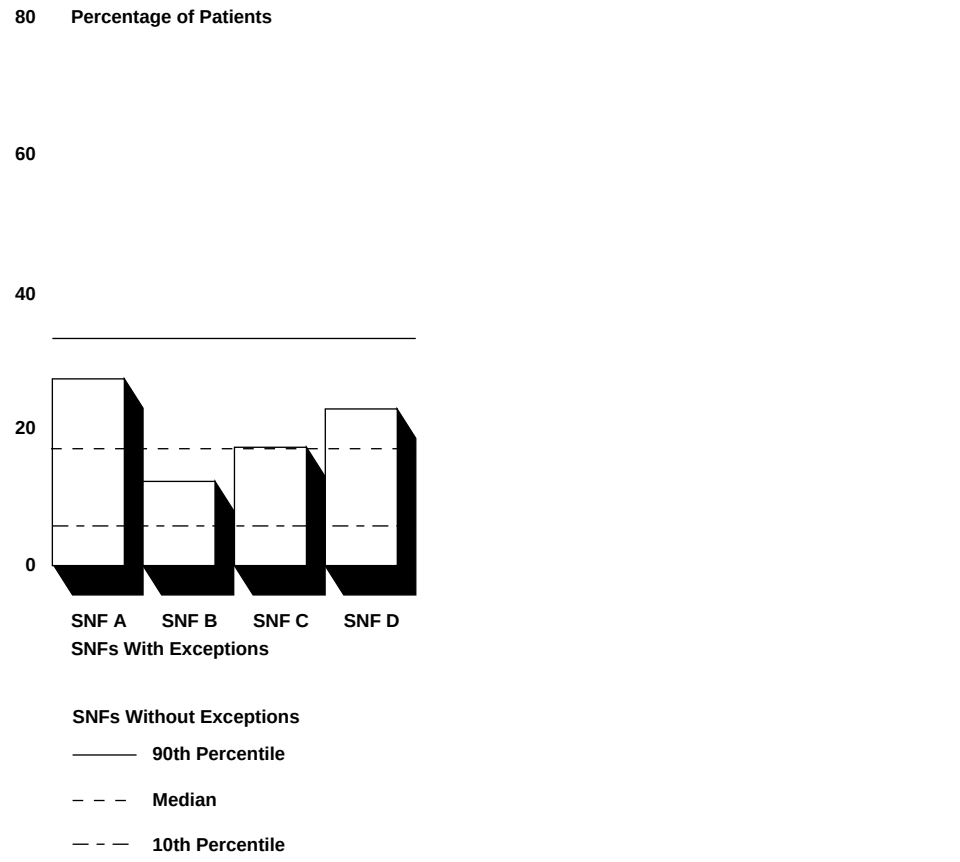


Figure IV.27: Percentage of Missouri SNF Patients Receiving Oxygen Therapy, 1994

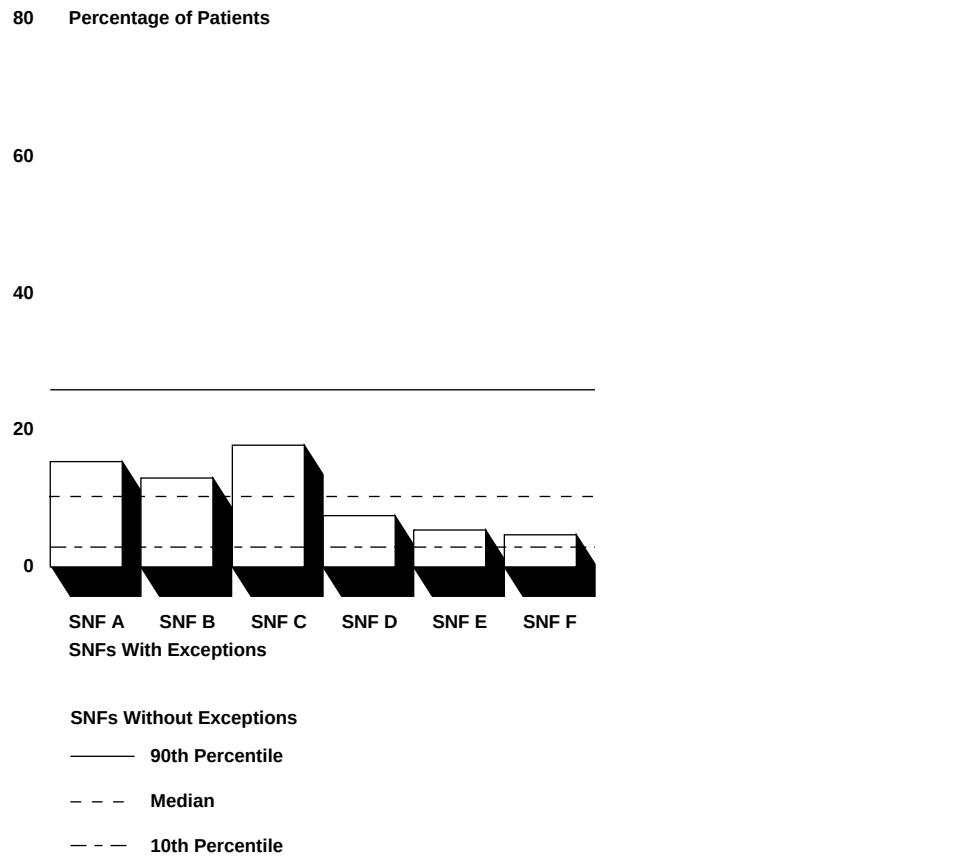


Figure IV.28: Percentage of Ohio SNF Patients Receiving Oxygen Therapy, 1994

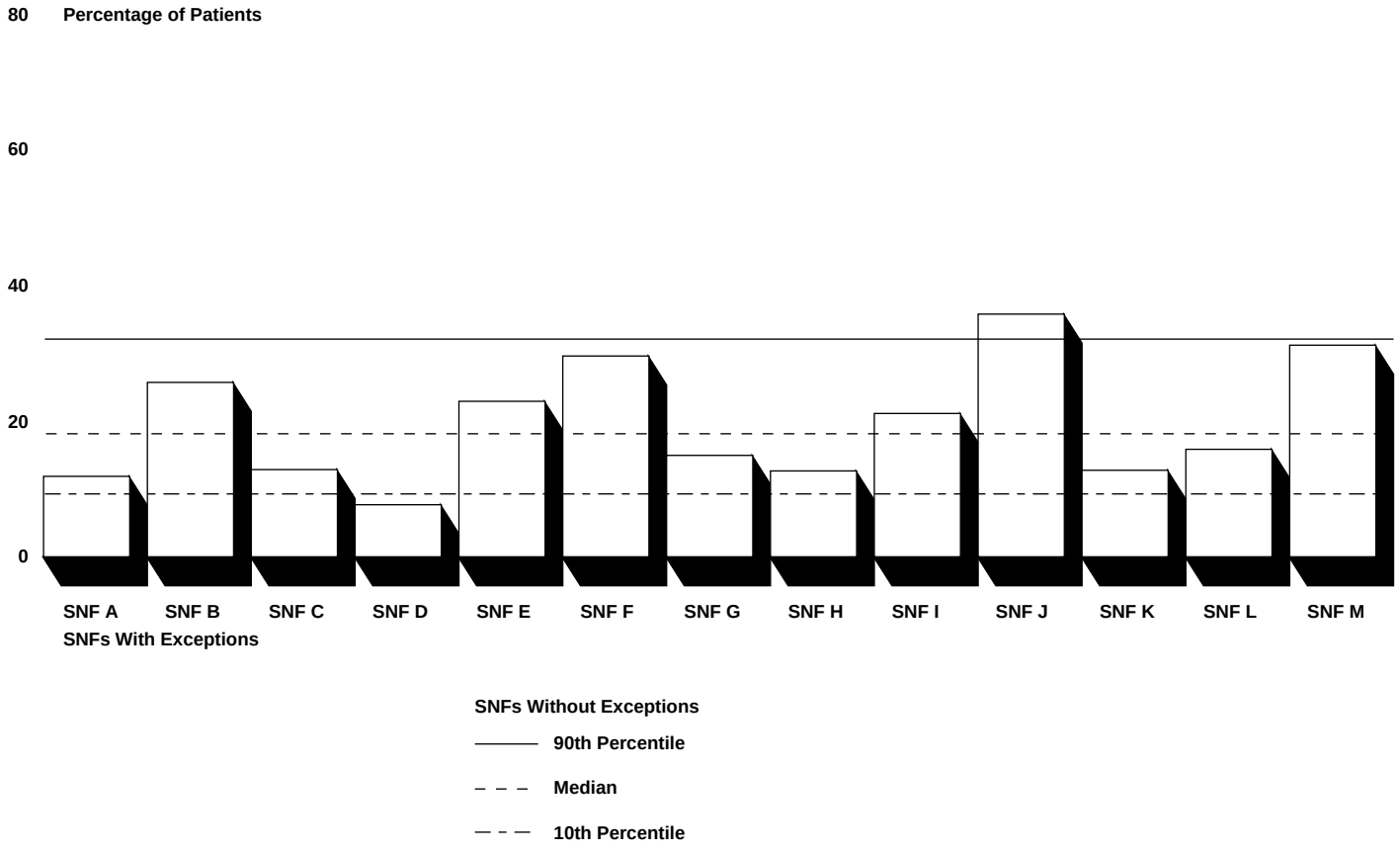
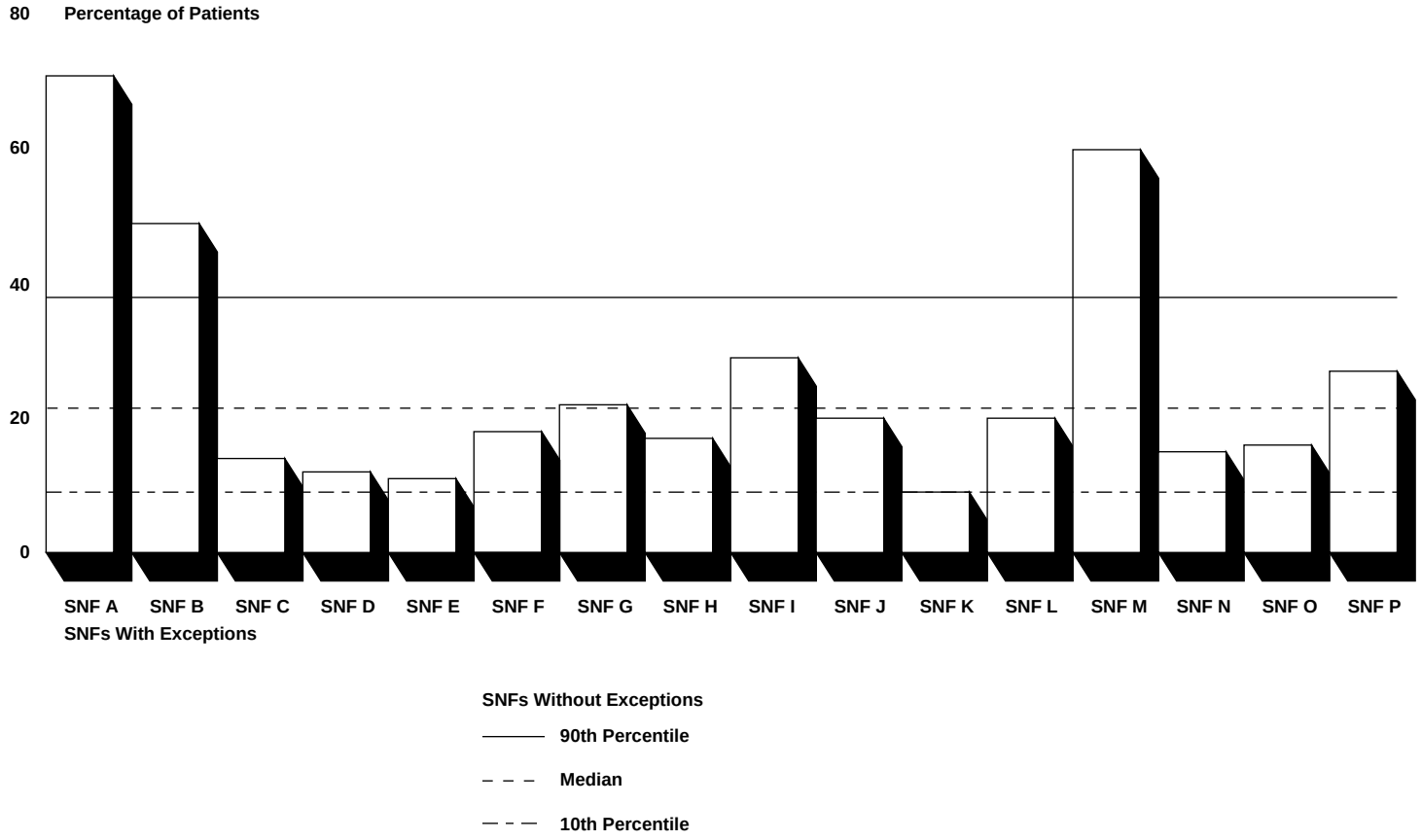


Figure IV.29: Percentage of Washington SNF Patients Receiving Oxygen Therapy, 1994

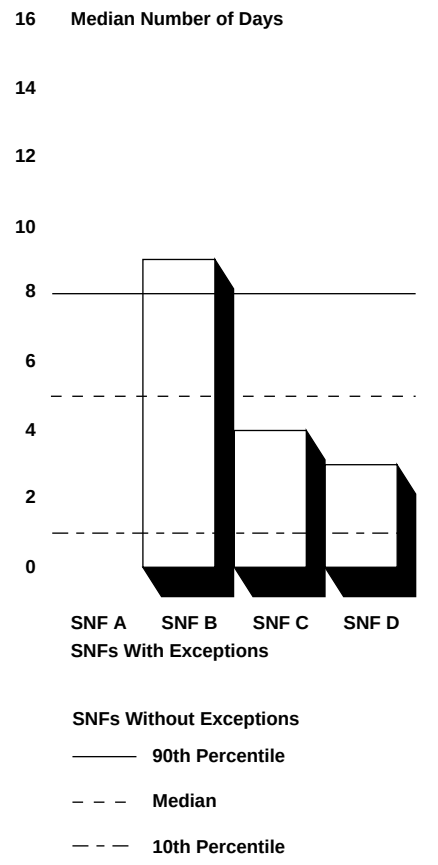


Therapies

The MDS directs the rater to note the number of days in the prior week that each of the following types of therapy was administered (for at least 10 minutes during a day): speech, occupational, physical, psychological, and respiratory therapy. The MDS+ directs the rater to gather information on these five types of therapy as well as on a sixth type, recreation therapy. Figures IV.30 through IV.32 show, for Maine, Missouri, and Ohio, the median number of days patients in each group of SNFs received any type of therapy. (Because we included all types of therapy in our analysis, the sum of days may exceed 7. For example, a Missouri patient receiving 2 days of each of the five types of therapy would be recorded as receiving 10 days of therapy in the prior week.) Figures IV.33 through IV.47 show the

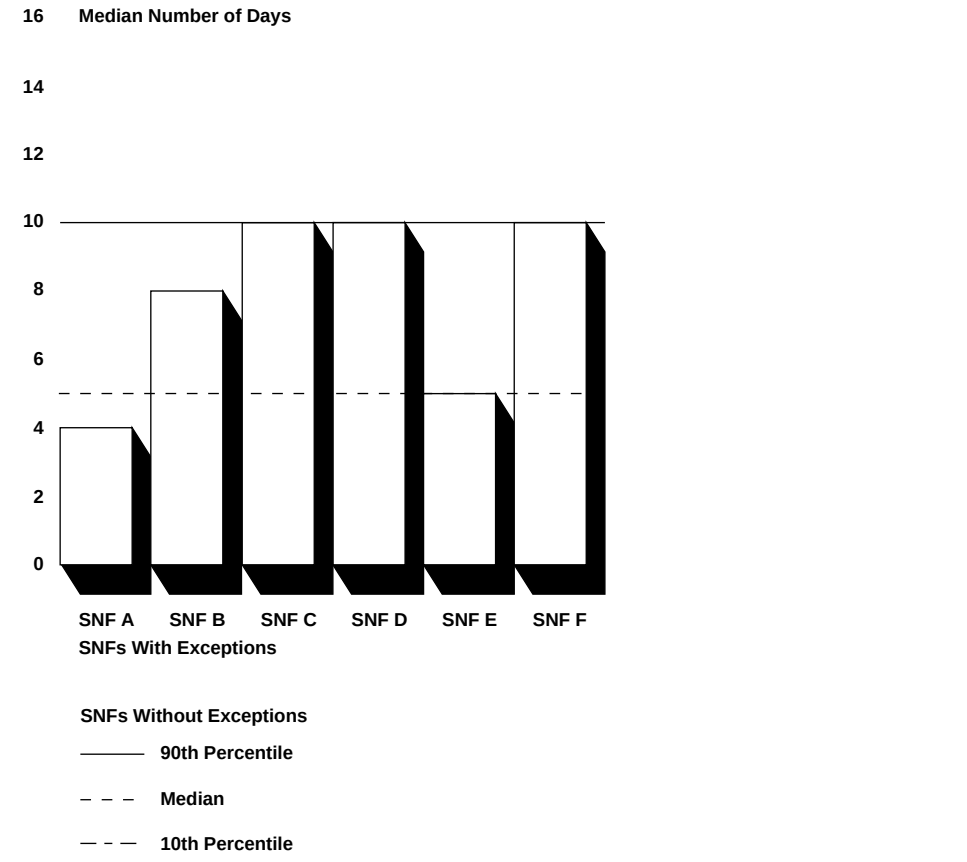
percentage of patients receiving occupational, physical, respiratory, and speech therapy.

Figure IV.30: Median Number of Days of Therapy Received by Maine SNF Patients, 1994



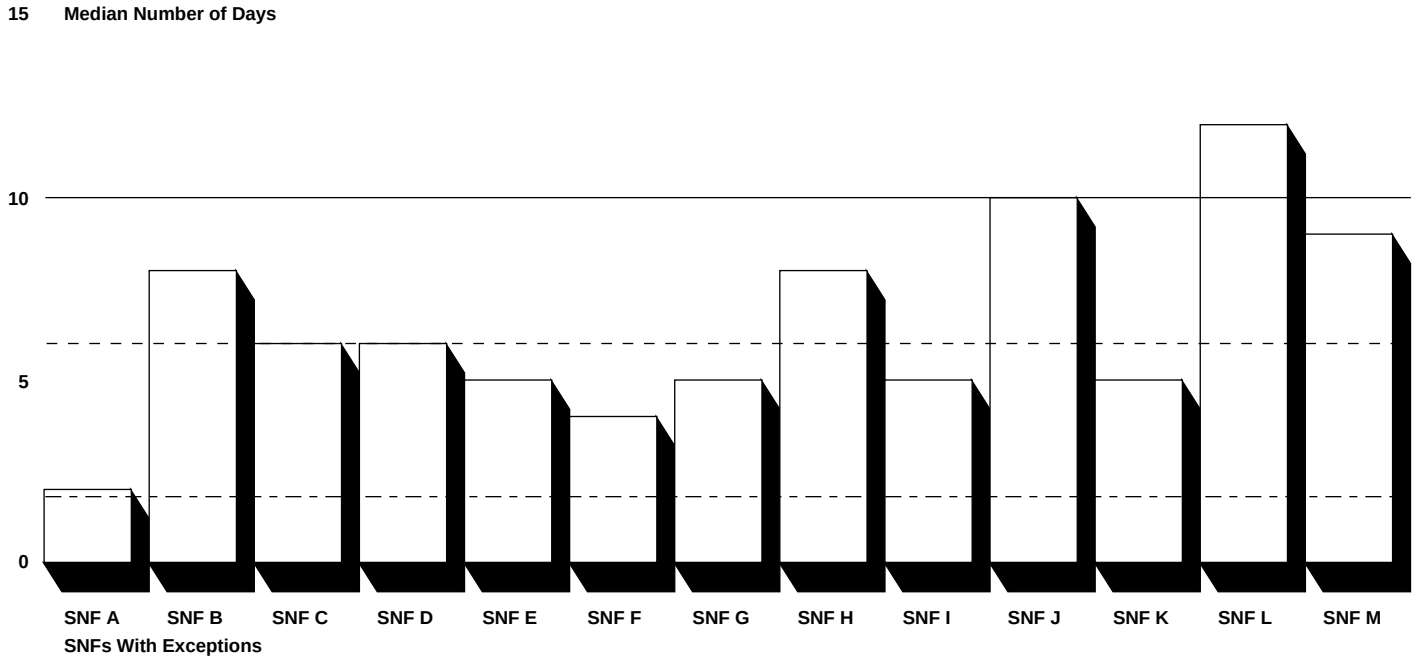
Note: When no bar is displayed for a SNF with an exception, then the value was zero. Types of therapies include speech, occupational, physical, psychological, respiratory, and recreation.

Figure IV.31: Median Number of Days of Therapy Received by Missouri SNF Patients, 1994



Note: The 10th percentile value for SNFs without exceptions was zero. Types of therapies include speech, occupational, physical, psychological, and respiratory.

Figure IV.32: Median Number of Days of Therapy Received by Ohio SNF Patients, 1994



Note: Types of therapies include speech, occupational, physical, psychological, respiratory, and recreation.

Figure IV.33: Percentage of Maine SNF Patients Receiving Occupational Therapy, 1994

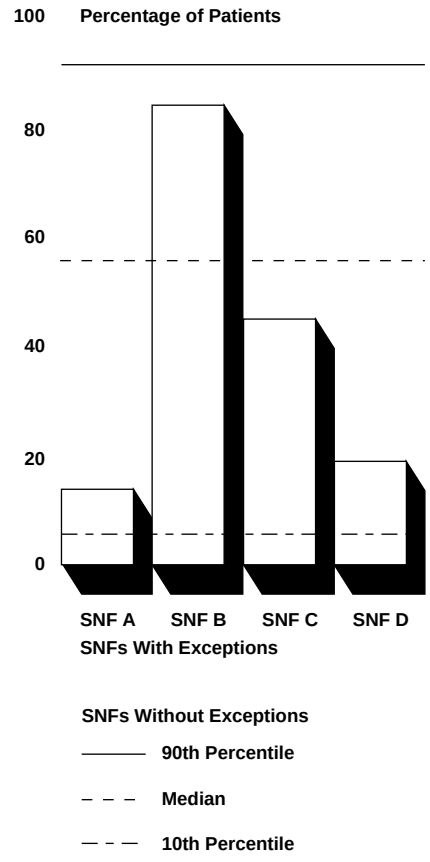


Figure IV.34: Percentage of Missouri SNF Patients Receiving Occupational Therapy, 1994

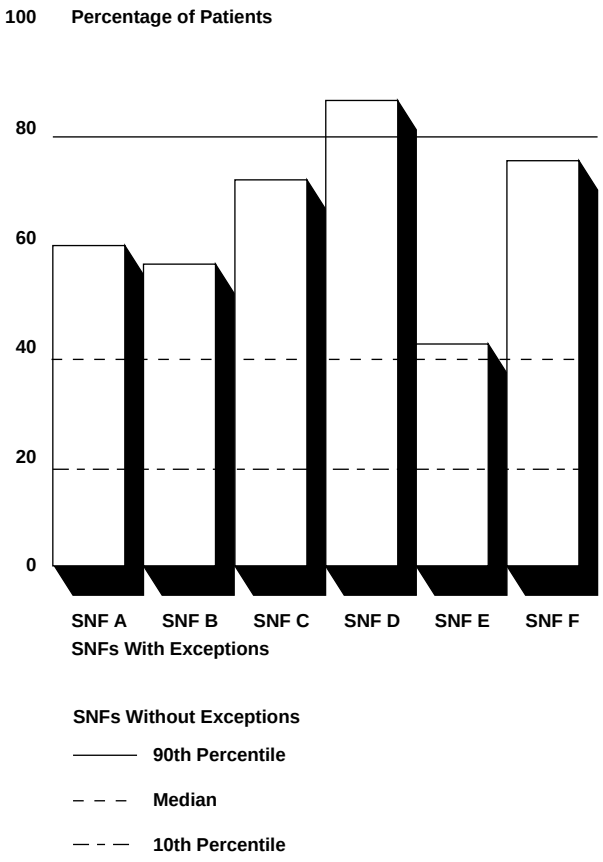


Figure IV.35: Percentage of Ohio SNF Patients Receiving Occupational Therapy, 1994

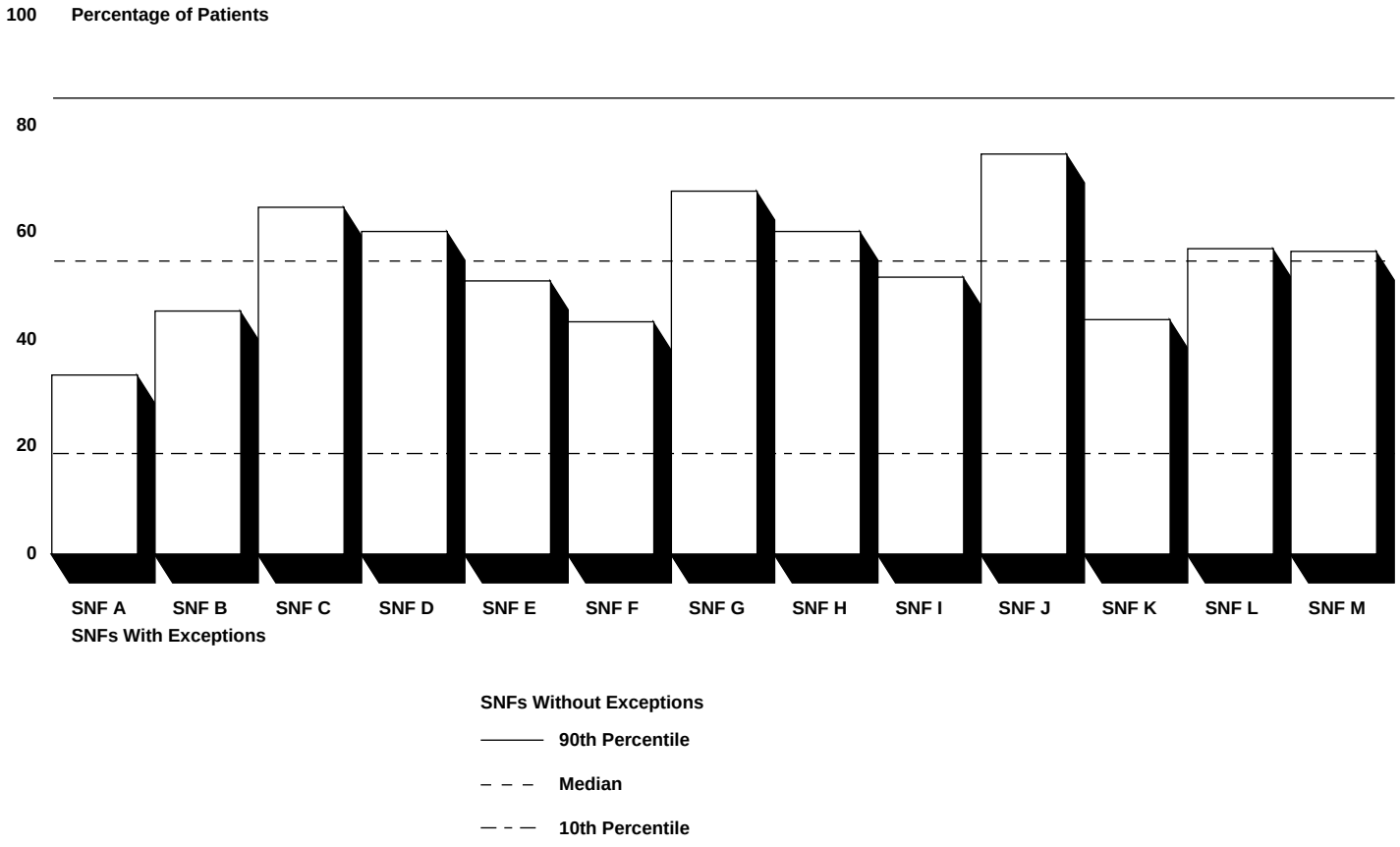


Figure IV.36: Percentage of Washington SNF Patients Receiving Occupational Therapy, 1994

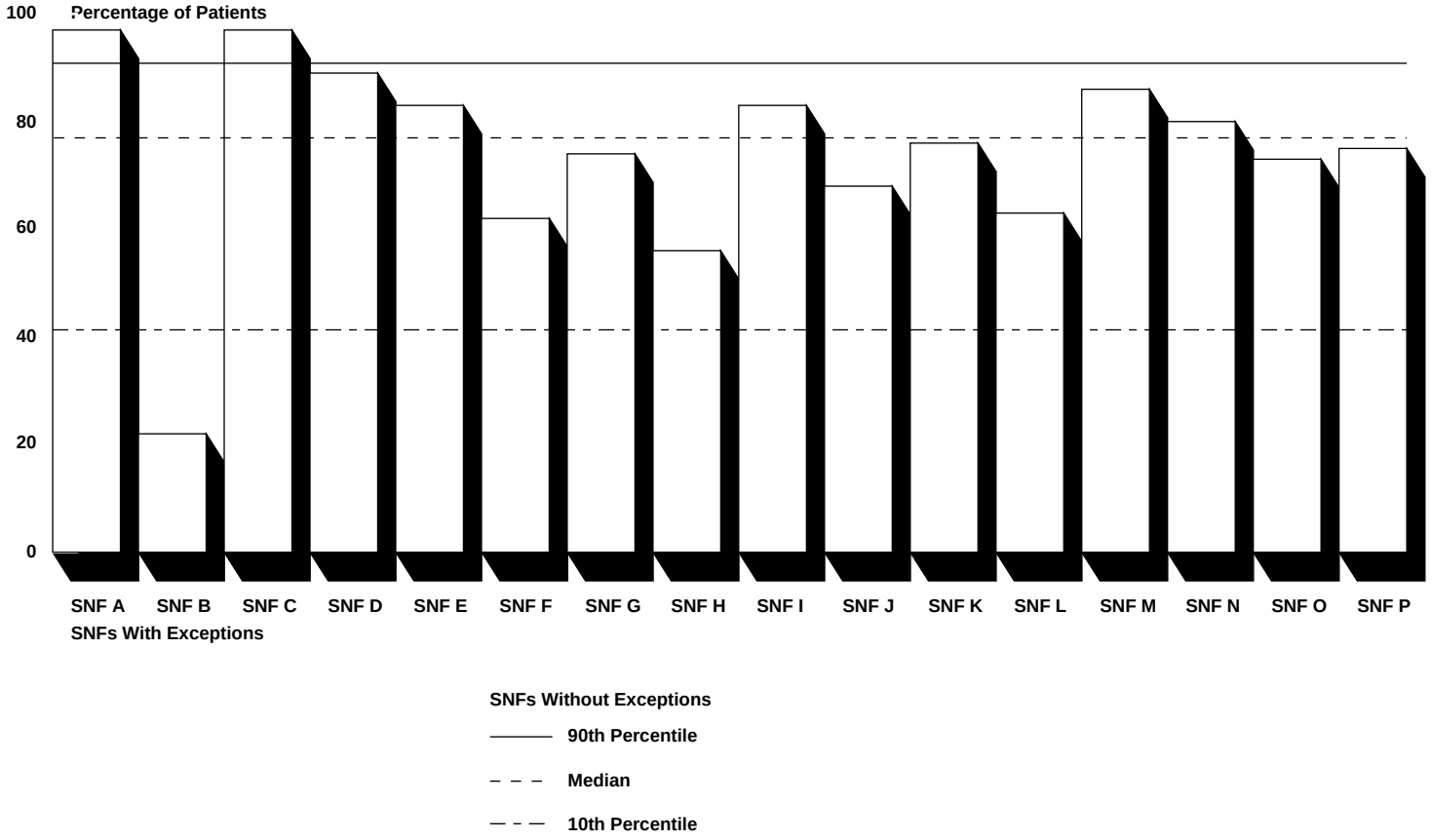


Figure IV.37: Percentage of Maine SNF Patients Receiving Physical Therapy, 1994

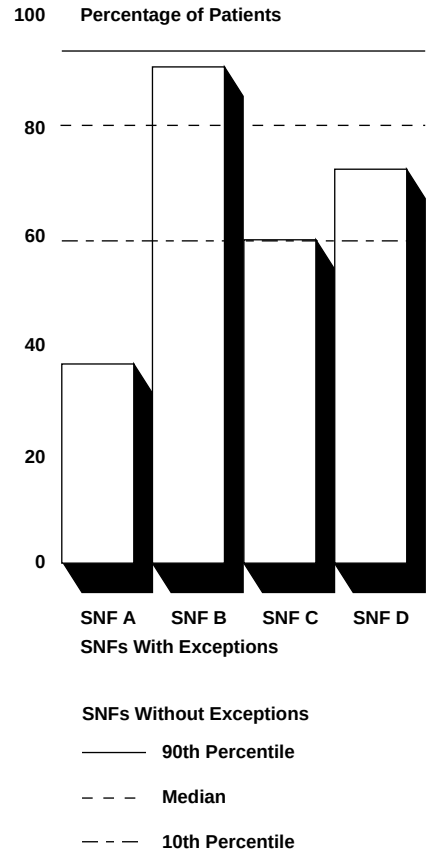


Figure IV.38: Percentage of Missouri SNF Patients Receiving Physical Therapy, 1994

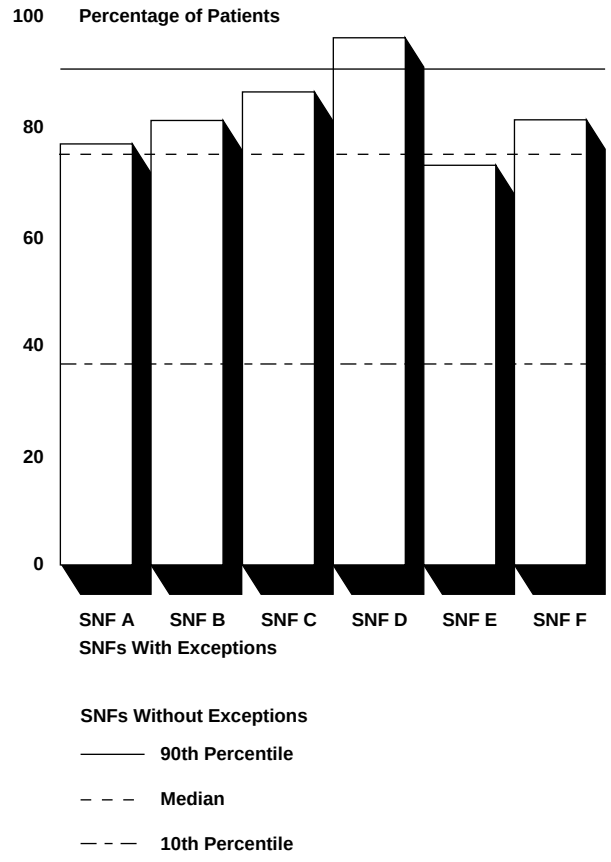


Figure IV.39: Percentage of Ohio SNF Patients Receiving Physical Therapy, 1994

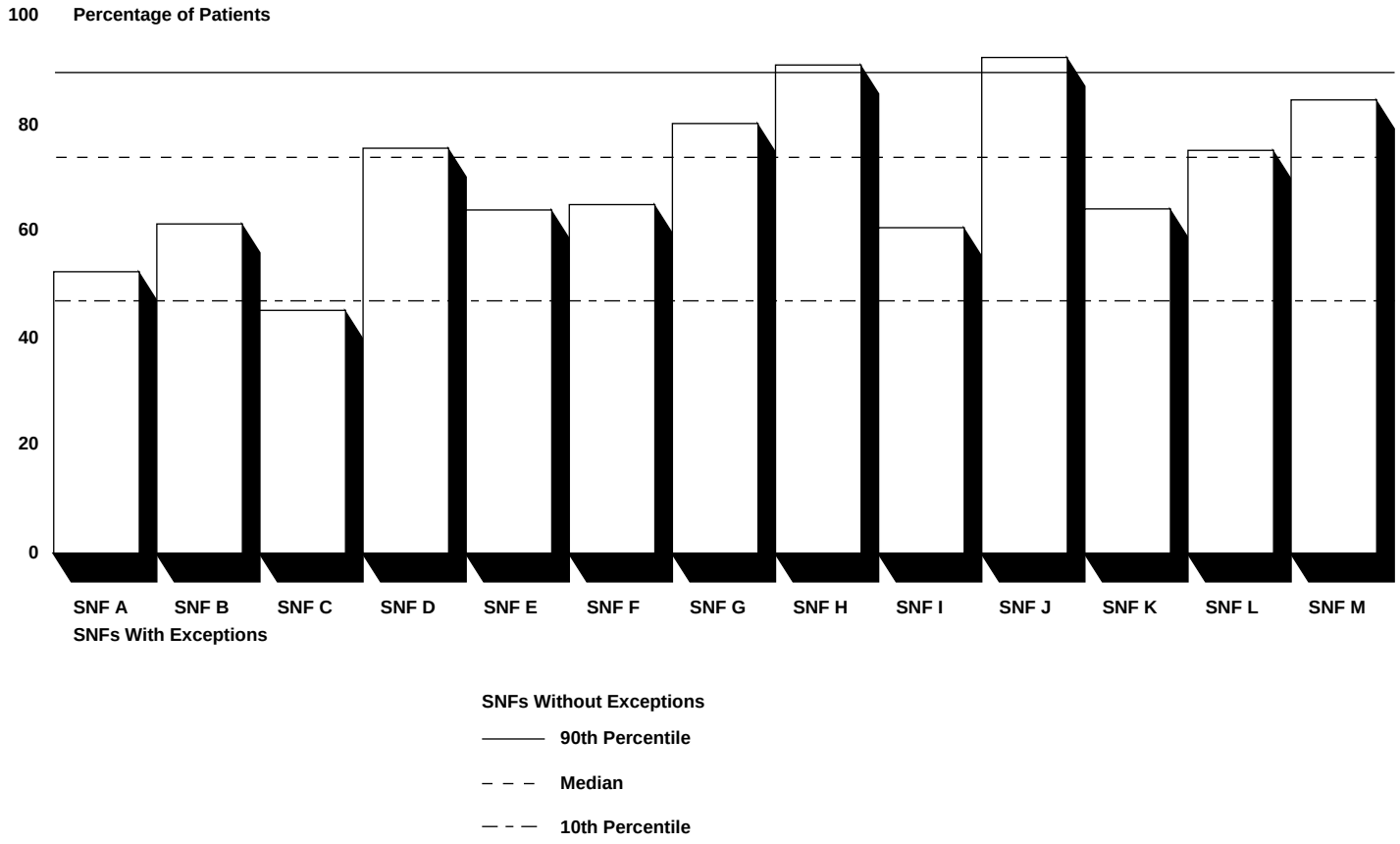


Figure IV.40: Percentage of Washington SNF Patients Receiving Physical Therapy, 1994

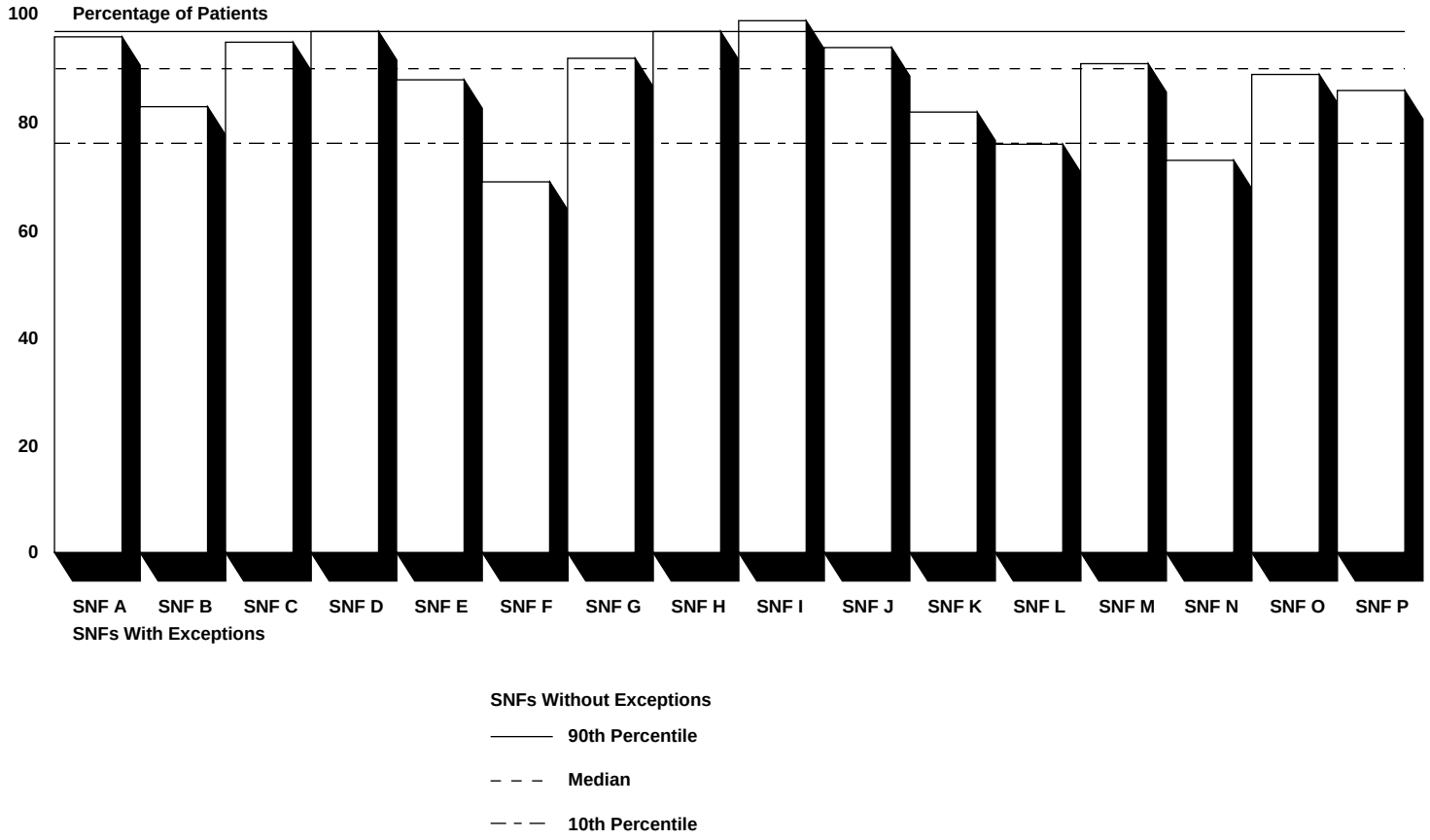
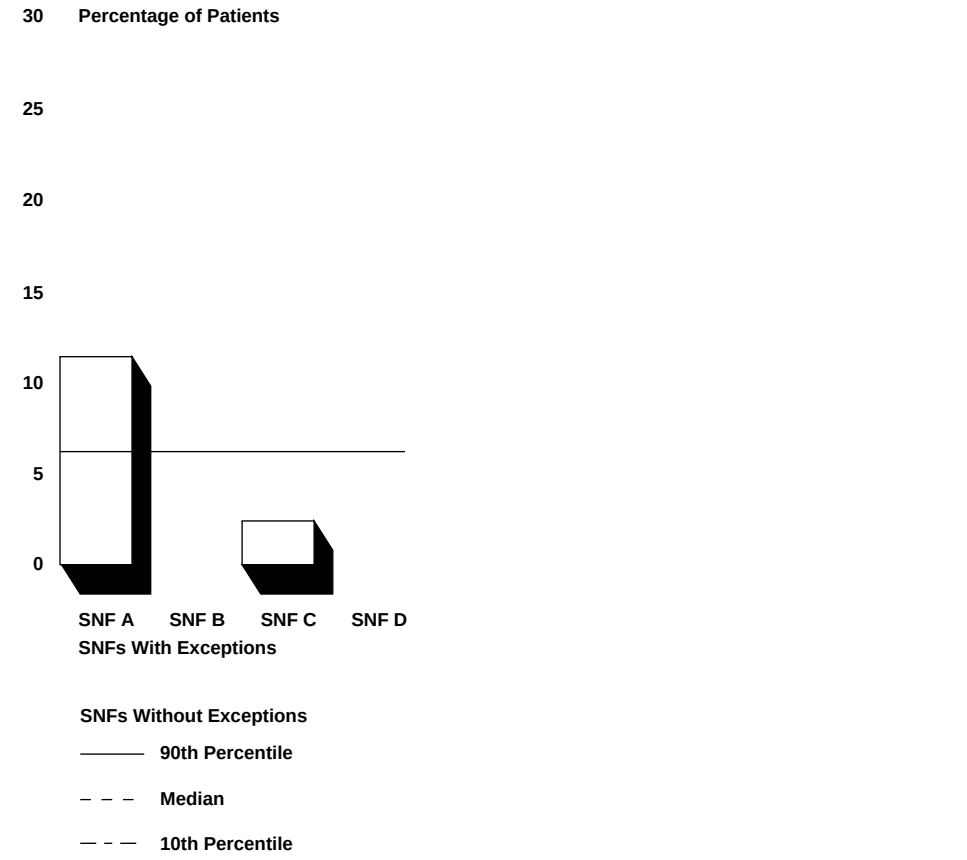
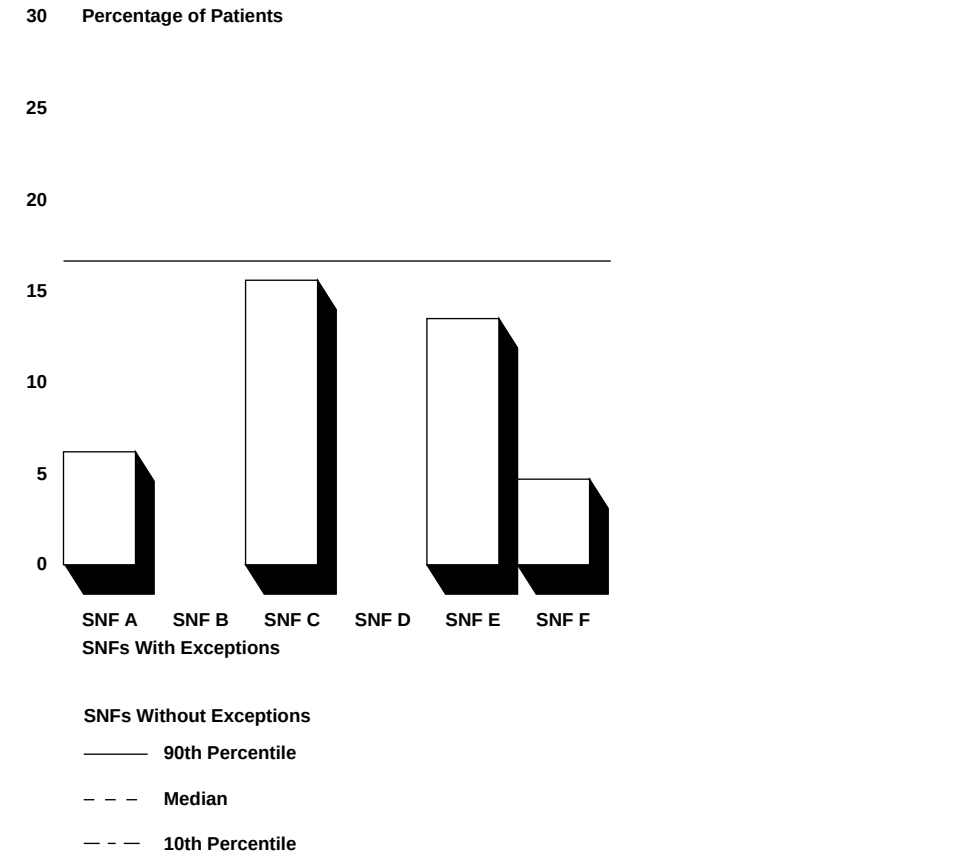


Figure IV.41: Percentage of Maine SNF Patients Receiving Respiratory Therapy, 1994



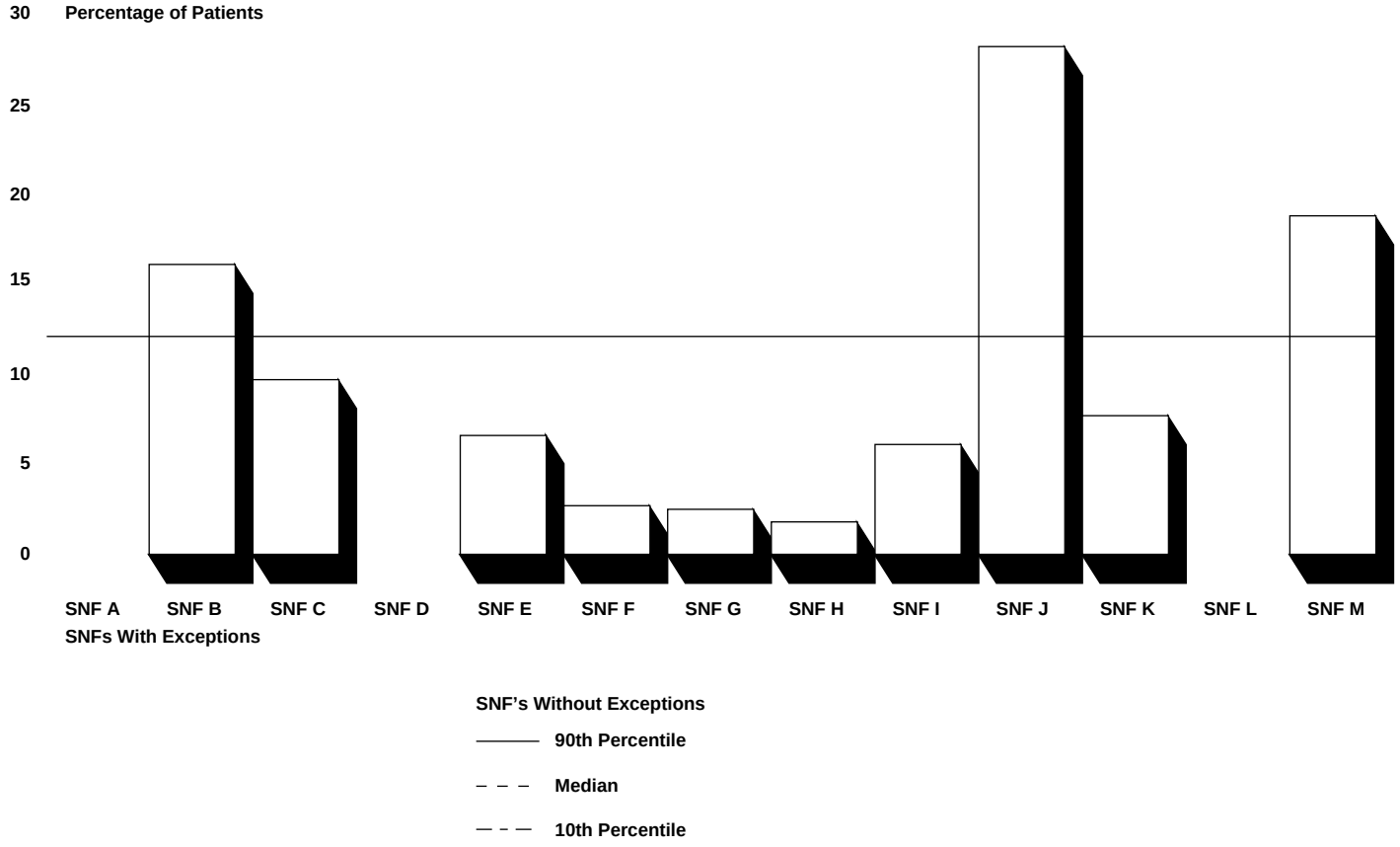
Note: When no bar is displayed for a SNF with an exception, then the value was zero. The median and 10th percentile values for SNFs without exceptions were zero.

Figure IV.42: Percentage of Missouri SNF Patients Receiving Respiratory Therapy, 1994



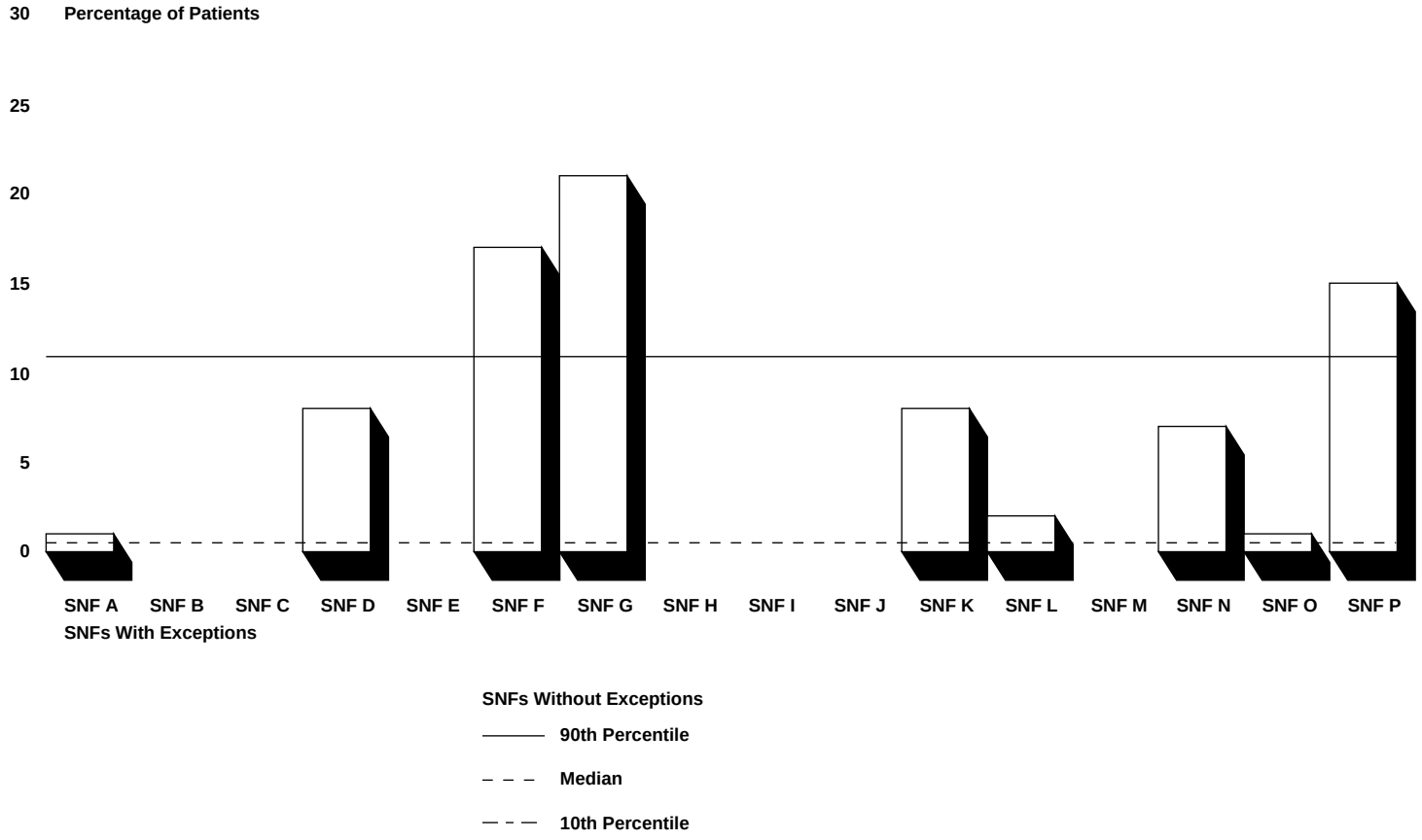
Note: When no bar is displayed for a SNF with an exception, then the value was zero. The median and 10th percentile values for SNFs without exceptions were zero.

Figure IV.43: Percentage of Ohio SNF Patients Receiving Respiratory Therapy, 1994



Note: When no bar is displayed for a SNF with an exception, then the value was zero. The median and 10th percentile values for SNFs without exceptions were zero.

Figure IV.44: Percentage of Washington SNF Patients Receiving Respiratory Therapy, 1994



Note: When no bar is displayed for a SNF with an exception, then the value was zero. The 10th percentile value for SNFs without exceptions was zero.

Figure IV.45: Percentage of Missouri SNF Patients Receiving Speech Therapy, 1994

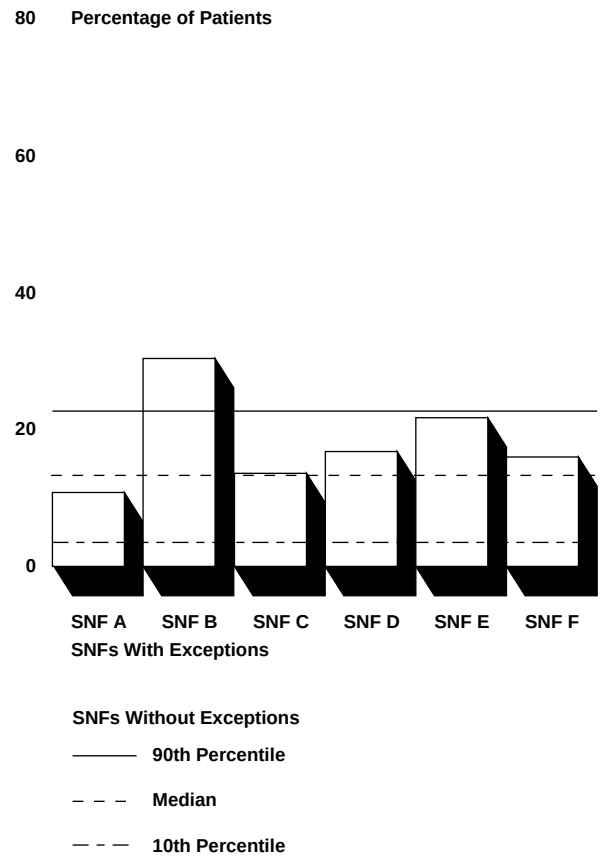


Figure IV.46: Percentage of Ohio SNF Patients Receiving Speech Therapy, 1994

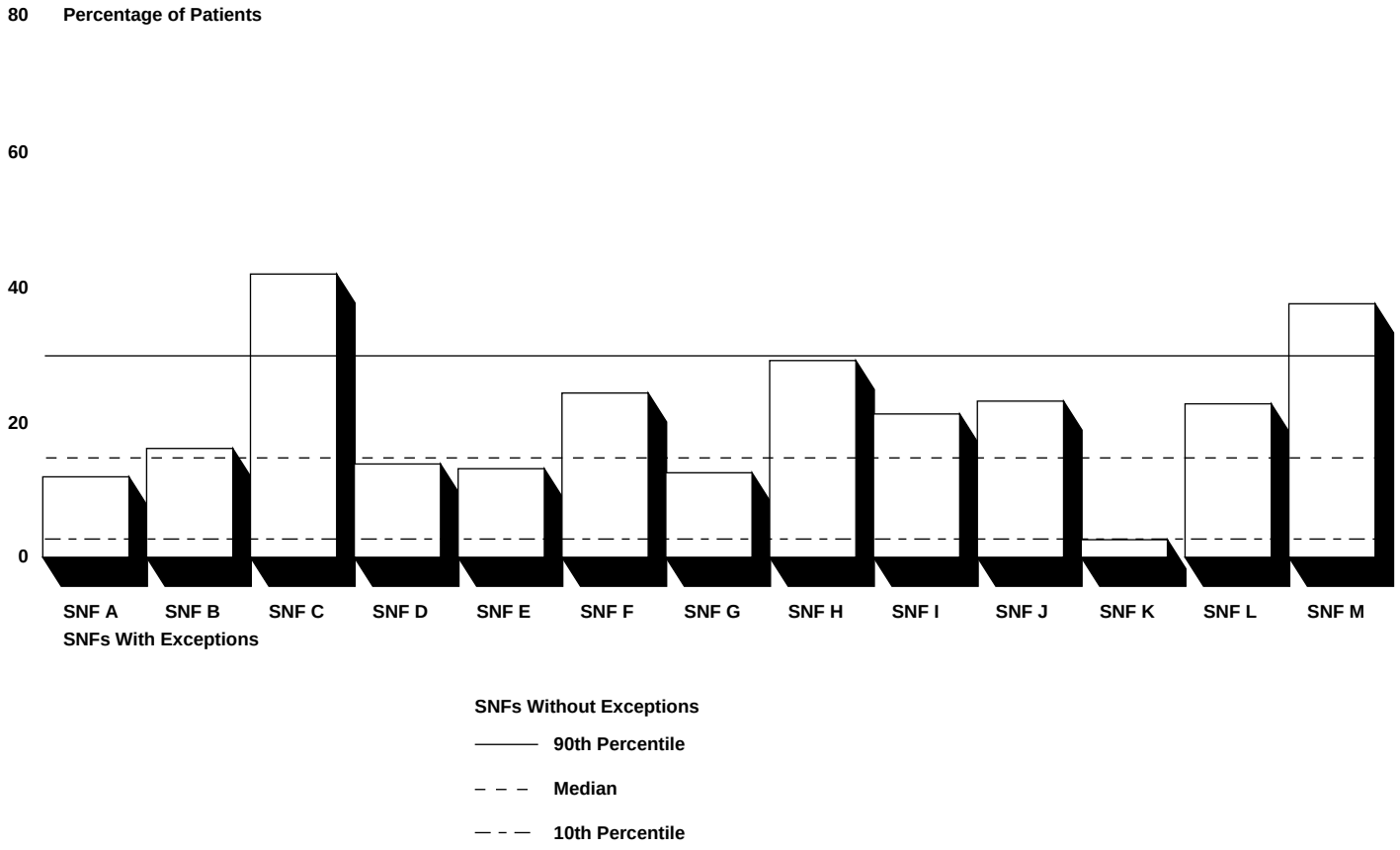
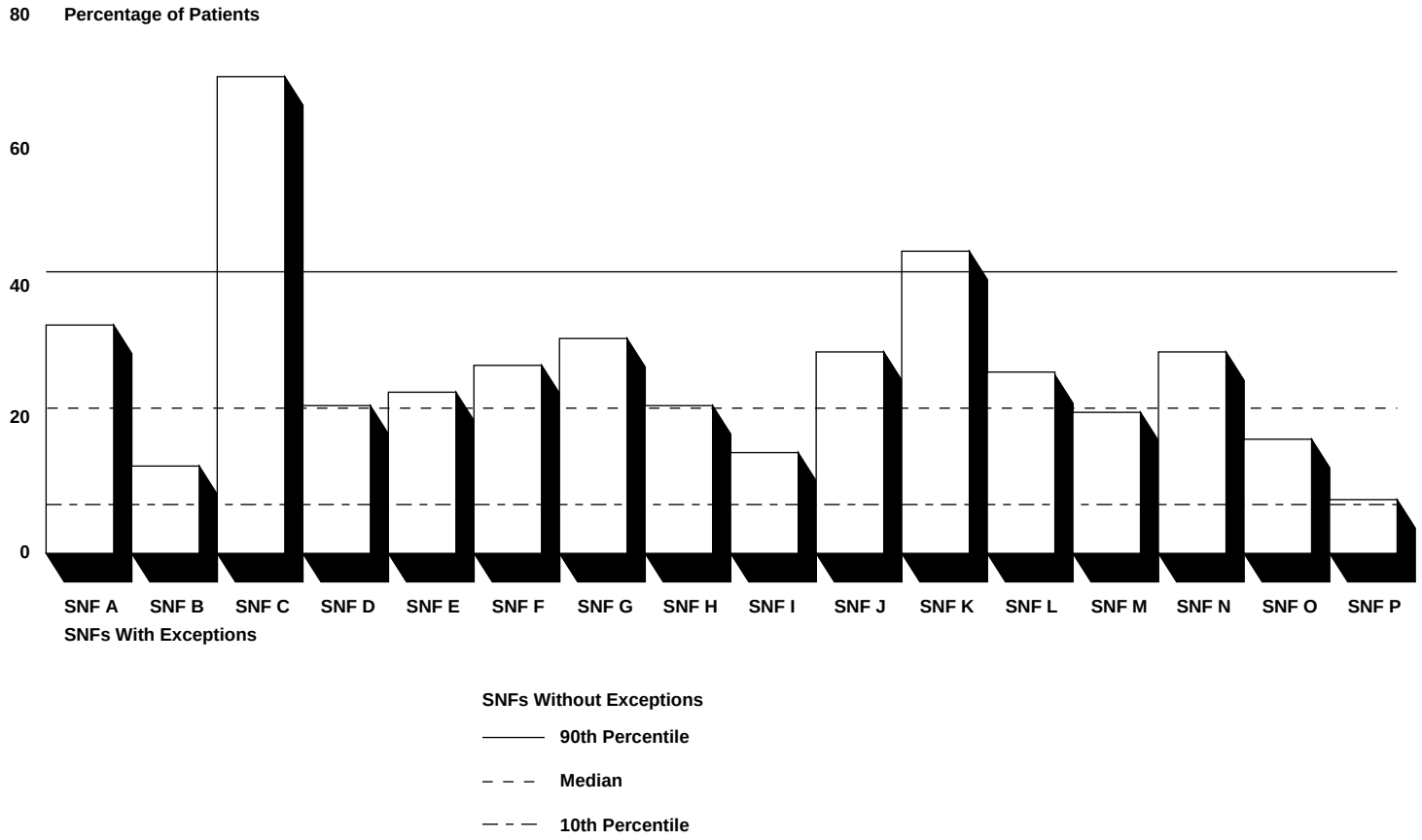
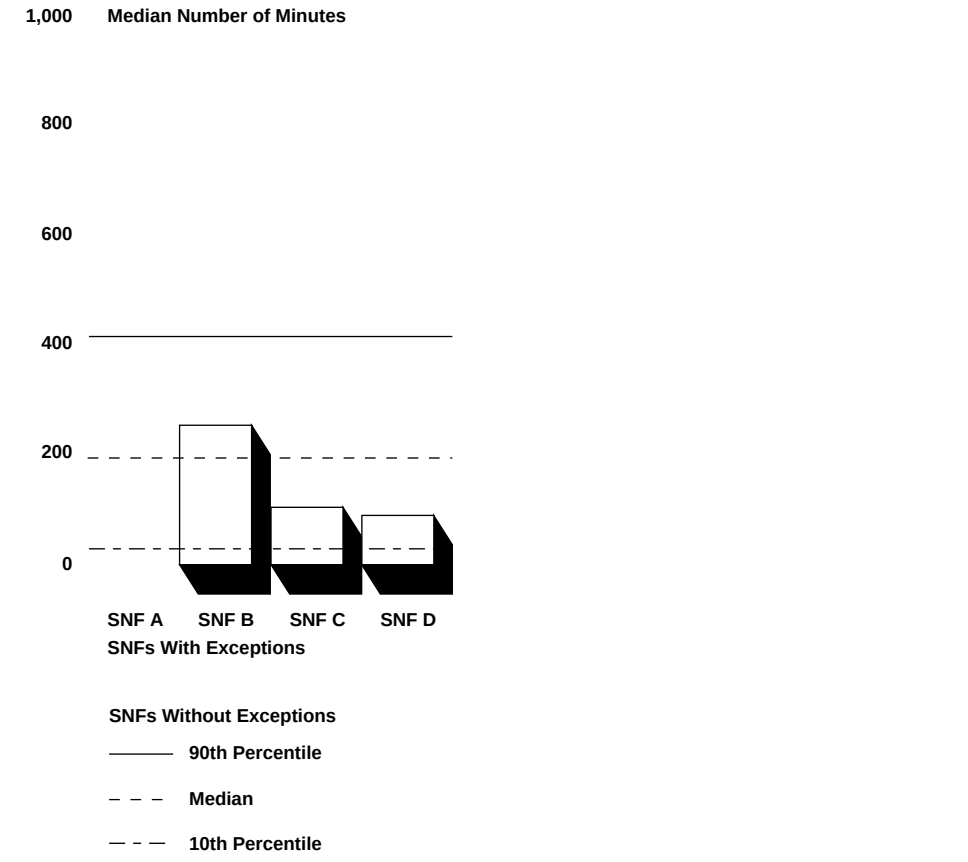


Figure IV.47: Percentage of Washington SNF Patients Receiving Speech Therapy, 1994



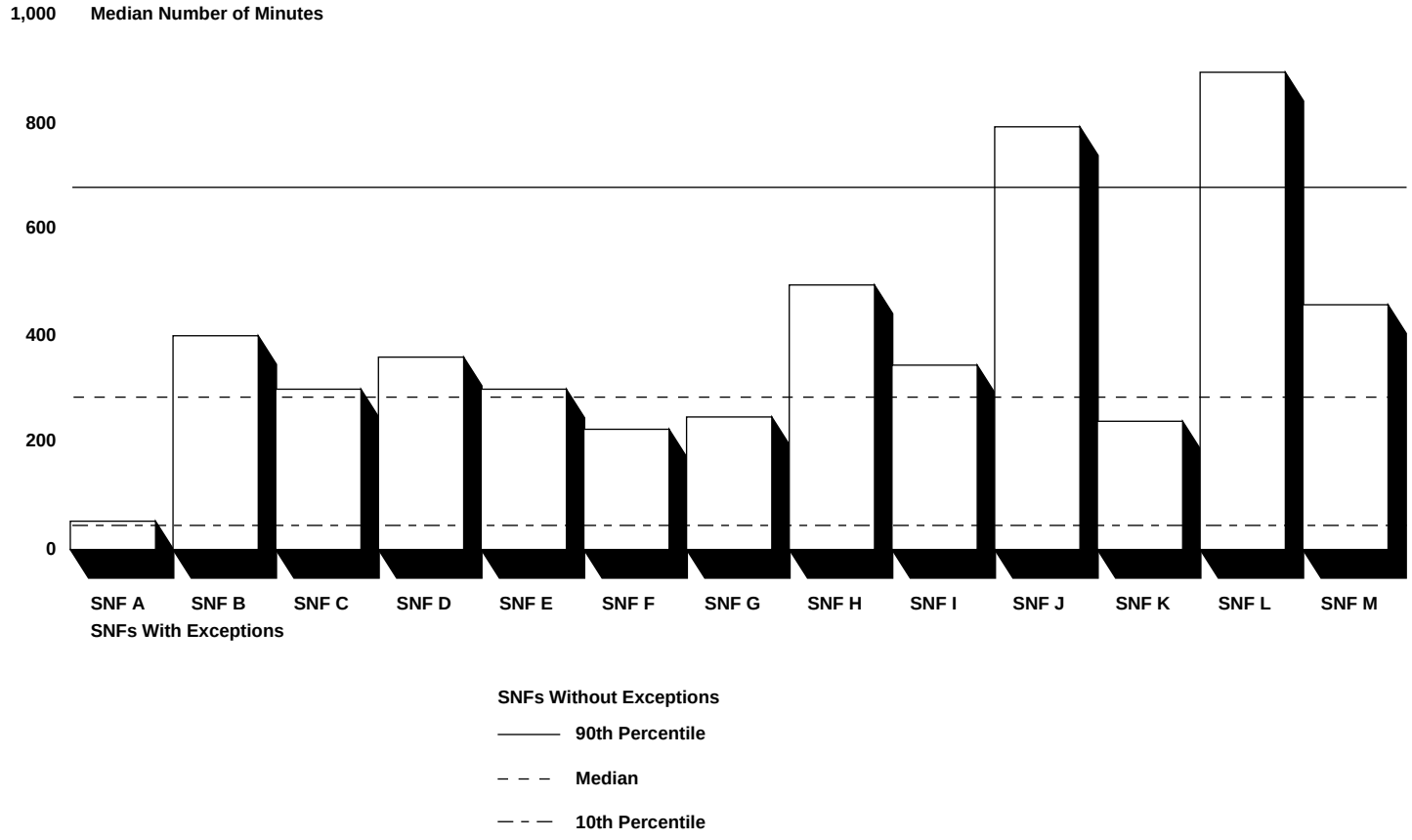
The MDS+ also directs the rater to record, for each patient, the total number of minutes each type of therapy was received during the prior 7 days. Figures IV.48 and IV.49 show, for Maine and Ohio (the two states in our analysis using the MDS+), the median number of minutes of all types of therapy received by patients in each group of SNFs.

Figure IV.48: Median Number of Minutes of Therapy Received by Maine SNF Patients, 1994



Note: When no bar is displayed for a SNF with an exception, then the value was zero.

Figure IV.49: Median Number of Minutes of Therapy Received by Ohio SNF Patients, 1994



Other Variables

In addition to those items previously discussed, we analyzed MDS information, when available, pertaining to (1) special treatments, including chemotherapy, radiation, dialysis, tracheostomy care, transfusions, intake and output monitoring, ventilator/respirator care, and other treatments; and (2) psychological and recreation therapies. As with the previous items, no substantive differences between SNFs with exceptions and SNFs without exceptions were found.

Site Visit Nursing Staff Ratios

These ratios are based on estimated average patient census and staffing levels at the time of our visits. Most of the directors of nursing we interviewed indicated that they will adjust the staff levels and mix of

professional and aide staff according to the number of patients and the complexity of patient needs.

Table IV.10: Estimated Ratios, by Shift, of Professional Nurses and Aides to Patients in Five SNFs GAO Visited, as Reported by SNF Staff

	Professional nurses			Nurses' aides		
SNF	Day	Evening	Night	Day	Evening	Night
1	1:10	1:12	1:19	1:10	1:10	1:19
2	1:7	1:12	1:18	1:8	1:11	1:14
3	1:15	1:15	1:30	1:8	1:8	1:8
4[a]	1:6	1:6	1:31	1:31	1:31	1:21
5	1:10	1:24	1:24	1:12	1:10	1:24

[a]Staff at this SNF told us that, because of their difficulty finding and retaining qualified nurses' aides, they have implemented a system of nursing under which registered nurses perform most patient care tasks.

HCFA Generic Quality Screens for SNFs

Generic Quality Screens - Skilled Nursing Facility

1. Appropriateness of Admission

Compare hospital discharge summary and admission assessment to SNF to determine appropriateness of discharge to SNF, and appropriateness of admission to and continued stay in that SNF. If SNF was unable to provide the care determined to be appropriate, was there documentation to initiate and provide safe, appropriate care within 24 hours?

2. Patient Assessment

In assessing the following elements, judge whether there was an appropriate notification, response and further evaluation process initiated within 4 hours for A-D, and 24 hours for E-J.

a. Medication.

- o Polypharmacy (more than 7 drugs).
- o Drug regime review.
- o Drug renewal.
- o Prescribed administration.
- o Errors.

b. Vital signs.

- o Temperature of 101°F oral (102°F rectal).
- o B.P. < 85 or > 180 systolic or < 50 or > 110 diastolic.
- o Pulse < 50 (45 if the patient is on a beta blocker), or > 120.

c. Fall with injury or untoward effect.

d. Indication of an infection following an invasive procedure.

e. Hydration and nutrition.

f. Sudden onset of confusion or change of mental status.

g. Mobility.

- o Decrease in activities of daily living.
- o New contractures.
- o Ability to transfer.

h. Pressure sores.

i. Appropriate use of restraints.

Rev. 10

j. Elimination.

- o Change in continence.
- o Change in urinary output.
- o Diarrhea or constipation.

3. Diagnostic Tests

Abnormal results of diagnostic services are addressed and resolved, or the record explains why they are unresolved.

4. Plan of Care

If appropriate, were the following disciplines addressed by an assessment, plan of care, ongoing evaluation and discharge plan?

- o Occupational therapy.
- o Physical therapy.
- o Speech therapy.
- o Social service.
- o Physician.
- o Nursing.
- o Dietary care.

5. Deaths

Deaths following transfer to hospital as ascertained from the hospital record.

6. Adequacy of Care

In the judgment of the professional reviewer, are there any other events/patterns of care that resulted in adverse outcomes that should be evaluated?

No_____ Yes_____ Explain

Rev. 10

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

NOV 18 1996

Mr. David P. Baine
Director, Veterans' Affairs
and Military Health Care
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Baine:

The Department has carefully reviewed your draft report entitled, "Skilled Nursing Facilities: Inadequate Exception Standards Can Result in Higher Medicare Costs." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano
for June Gibbs Brown
Inspector General

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services (HHS) on the General Accounting Office (GAO) Draft Report," Skilled Nursing Facilities: Inadequate Exception Standards Can Result in Higher Medicare Costs"

GAO performed a review of the process established by the Health Care Financing Administration (HCFA) to grant exceptions of the routine cost limits (RCL) for skilled nursing facilities (SNF) that claim to have higher costs due to serving atypical residents. In summary, GAO found that the process used by HCFA which uses the percentage of Medicare to total residents in a SNF unit as a proxy for identifying high need residents is inadequate. GAO recommends that HCFA utilize other resident-specific information to determine the need for higher (atypical) levels of service.

The current HCFA exception process utilizes case-mix proxies in evaluating a facility's eligibility for an atypical services exception. Higher than average percentage of Medicare utilization and lower than average length of stays for all SNF patients were identified as proxy case-mix measurements in the 1984 Report to Congress on the Study of the Skilled Nursing Facility Benefit under Medicare. At the time the exception process was instituted, these were the best available, readily obtained measures of case-mix.

GAO Recommendation

The Secretary of HHS should direct the Administrator of HCFA to revise the SNF exception to the RCL review process so that it can differentiate SNFs that furnish atypical routine services to Medicare patients from those SNFs that merely have higher than normal costs. Looking at factors that reflect Medicare patients rather than all SNF patients occupying Medicare-certified beds might be one way to do so. Using patient-specific data, some of which are currently submitted but not used, might be another way.

Department Comment

We are in general agreement with this recommendation to the extent that HCFA should revise the exceptions review process so that HCFA can better differentiate SNFs that furnish atypical services from those SNFs that merely have higher costs. We also feel compelled to make a number of comments.

The report suggests two solutions that could be used to revise the exceptions determinations process.

We do not concur with the suggestion that HCFA, in making exceptions determinations, should look at factors that reflect Medicare patients rather than all SNF patients occupying Medicare-certified beds. This suggestion does not take account of the fact that Medicare patients are often the most resource-intensive patients whom facilities serve, and the proportion of Medicare patients in a facility is an important and valid indicator of case mix (atypical services and resource use). The current statutory and regulatory provisions pertaining to the principles of cost reimbursement prohibit the separation of Medicare patients from non-Medicare patients to determine a facility's payment for routine (or other) services. Specifically, the statute, at 1861(v)(1)(A) of the Social Security Act (the Act), which authorizes the Secretary to base a facility's payment on the reasonable cost of services, also mandates that the necessary cost of efficiently delivering such services to individuals covered by the Medicare program not be borne by individuals not so covered and vice versa. The Medicare routine service cost per day computed on the Medicare cost report--the instrument used to determine the cost of inpatient services and the apportionment of routine service costs to the various insurance programs, including Medicare--is based on the average routine per diem costs of all patients. In addition, the Medicare routine costs are then subject to cost limits that are statutorily mandated to reflect the mean routine service costs of all patients as reported on the Medicare cost report. In reviewing exceptions to the cost limits, the statistics and costs of services and items for all patients in the SNF are used in determining the eligibility for, and the quantification of an atypical services exception. Accordingly, HCFA believes that the analysis used in the report to suggest that the exceptions process be revised to reflect Medicare patients rather than all SNF patients is inappropriate unless the report suggests changes to the statutory provision on determining reasonable cost of services or items. Such a statutory change would have to encompass payment to SNFs based on the cost of treating only Medicare patients. This would have an substantial adverse impact not only on the Medicare Trust Fund but on Medicare beneficiaries whose coinsurance payments would increase substantially.

The GAO recommendation is derived from what we believe is a methodological flaw in the study. By comparing Medicare patients and costs in facilities with exceptions to Medicare patients in facilities without exceptions, rather than to all SNF patients, GAO failed to consider a facility's percentage of Medicare utilization as a proxy for case mix.

We do concur with the second suggestion to expand the use of patient-specific data in evaluating atypical routine services under the exceptions process and will achieve this as follows: HCFA is currently conducting a Nursing Home Case-Mix and Quality Demonstration (NHCMQ) which has lead to the development of a patient

classification system which utilizes resident-specific information from the Minimum Data Set to classify all of the residents in a facility into 44 case-mix categories based on predicted use of nursing staff time. This classification system, Resource Utilization Group (RUG-III), which GAO used as part of its review, is being tested in six states as part of a SNF prospective payment and quality assurance demonstration. The goals of this demonstration are to: 1) develop a patient classification system, 2) develop a payment rate based on the patient classification, and 3) evaluate the adequacy of facility payments under the demonstration. A time measurement study relating patient classification data to nursing staff resource use has only recently become available as part of the aforementioned demonstration. HCFA believes that these data will prove to be adequate in costing atypical services and items and will begin to integrate patient data from the resident assessment instruments and staff time data into the exceptions process.

In addition, we believe that the report speaks loudly to the need for the development of a prospective payment system (PPS) for SNFs that embraces a valid and reliable case-mix adjustment system. A PPS that is sensitive to a facility's case-mix would eliminate the need for an exceptions process.

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Glossary

Activities of Daily Living	Activities performed as part of a person's daily routine of self-care, such as bathing, dressing, toileting, and eating.
Assessment	An evaluation of nursing home patients using a standard set of items mandated by HCFA to measure a resident's physical, mental, and psychosocial status.
Chemotherapy	The treatment of disease, usually certain types of cancer, by chemical agents.
Dialysis	The mechanical process of purifying the blood of patients with kidney disease.
Intermediary	An entity, usually an insurance company such as Blue Cross and Blue Shield, Travelers, and Aetna, under contract to HCFA to process Medicare claims and perform payment safeguard or payment control activities.
Input/Output Monitoring	Measuring the volume of fluids consumed and eliminated by a patient over a determined time period.
Intravenous Medication	A method of administering medicine and other fluids through a vein.
Occupational Therapy	The use of self-care, work, and play activities to increase patient function, enhance development, and prevent disability.
Physical Therapy	Treatment by physical means, such as stretching and walking, as opposed to medical, surgical, or radiologic measures, to ameliorate physical disability.
Peer Review Organization	A group mandated by the Tax Equity and Fiscal Responsibility Act of 1982 to review quality of care and appropriateness of admissions for Medicare and Medicaid beneficiaries.

Oxygen	The administration of oxygen by inhalation, often to treat or assist patients with lung and heart problems.
Radiation	The treatment of disease, usually certain types of cancer, using radioactive material.
Recreation Therapy	Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility.
Respiratory Therapy	Exercises to improve breathing, which may include such techniques as coughing, deep breathing, aerosol treatments, and mechanical ventilation.
Speech Therapy	The use of special techniques used to correct speech and language disorders.
Suctioning	The removal of fluids, often from the lungs, by mechanical means.
Tracheostomy	The surgical creation of an opening into the trachea through the neck for the purpose of inserting a tube to relieve airway obstruction and assist in breathing.
Transfusions	The introduction of whole blood or a blood component, such as platelets, directly into the bloodstream through a vein or artery.
Ventilator/Respirator	A mechanical device to maintain an exchange of air in patients unable to breathe on their own.

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