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SKILLED NURSING FACILITIES

Services Excluded From Medicare's Daily Rate Need to be Reevaluated



Contents

Letter	1
Results in Brief	2
Background	3
Certain Services Appropriately Excluded from SNF PPS, but Revisions to the Exclusions May Be Needed	8
Current Exclusion Policies May Have Unintended Consequences	11
Conclusions	14
Matter for Congressional Consideration	15
Recommendations for Executive Action	15
Agency Comments	15

Appendix I	Comments From Centers for Medicare and Medicaid Services	19
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Tables		
	Table 1: Services Excluded from the SNF PPS Rate, Regulatory or Legislative Source, and Effective Dates	7
	Table 2: Examples of Services Considered for Exclusion from the SNF PPS and HCFA's Reasons for Not Excluding Them	10

Abbreviations

BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
CT	Computerized axial tomography
CMS	Centers for Medicare and Medicaid Services
HCFA	Health Care Financing Administration
MRI	Magnetic resonance imaging
PPS	Prospective payment system
RUG	Resource utilization group
SNF	Skilled nursing facility



August 22, 2001

Congressional Committees

The Health Care Financing Administration (HCFA) replaced its cost-based reimbursement method for skilled nursing facility (SNF) services with a prospective payment system (PPS) in 1998.¹ Mandated in the Balanced Budget Act of 1997 (BBA),² the PPS was intended to slow Medicare SNF spending growth by paying a daily amount based on the historical national average costs of care. This rate covers all health care services provided to a beneficiary during each day of a Medicare-covered SNF stay. Under this new payment approach, SNFs have strong financial incentives to control the cost of providing a day of care. They can do this by reducing the number of services delivered, changing to a less costly mix of services, or minimizing the cost of each service. However, facilities could also keep their costs down by stinting on needed services, especially expensive ones, or avoiding patients who are likely to need particular types of care. Facilities that cannot keep their average daily costs below their payments will be financially disadvantaged.

To counter the possible undesirable consequences of the PPS, certain services provided to Medicare beneficiaries during a SNF stay were excluded from the SNF daily rate. Some of the exclusions were identified in statute and HCFA exercised its administrative rule-making authority to exclude others. Excluded from the rates are expensive services that generally are not provided in SNFs—such as cardiac catheterization, magnetic resonance imaging (MRI), radiation therapy, and selected chemotherapy services. Separate payments are made for these excluded services so that SNFs are not financially disadvantaged by making these services available. This is intended to protect beneficiary access to these services and the SNFs that care for these beneficiaries. However, if too many services are excluded from the daily rate, the cost-control potential of the PPS could be undermined.

¹On June 14, 2001, the Secretary of Health and Human Services (HHS) changed the name of the Health Care Financing Administration to the Centers for Medicare and Medicaid Services (CMS). We continue to refer to HCFA where our findings apply to the organizational decisions and operations associated with that name.

²P.L. 105-33, sec. 4432(a), 111 Stat. 251, 414 (codified at 42 U.S.C. 1395yy(e)).

Because of concerns about beneficiary access to SNF care under the PPS and the financial condition of facilities that provide high-cost services, the conference report accompanying the Balanced Budget Refinement Act of 1999 (BBRA) directed us to examine the services excluded from the PPS.³ We were directed to: (1) analyze the appropriateness of the services excluded from the PPS and the process for determining the exclusions, and (2) identify any potential problems with the exclusions as implemented. To do so, we examined HCFA program memoranda, the BBA, and the BBRA, and interviewed agency officials. Service cost and volume data on all services provided to SNF residents were not available so we could not systematically evaluate the excluded services and the services that remained in the daily rate. Therefore, we conducted structured interviews with 10 nationally recognized clinical experts on nursing home care about the criteria and the excluded services. They included university-based health services researchers, clinical department chairs at nationally recognized health care facilities, the medical directors of nursing homes in health care systems, and board members of national medical organizations. We performed our work from July 2000 through August 2001 in accordance with generally accepted government auditing standards.

Results in Brief

Although the service-exclusion criteria and the services removed from the daily payment rate appear reasonable, questions remain about whether certain other services should also be excluded and how to modify the exclusions over time. HCFA generally relied on three criteria in choosing services to exclude. Excluded services must be high cost, infrequently provided during a SNF stay, and not likely to be overprovided. Because SNFs have an incentive under the PPS to minimize costs that are covered under the daily payment, these criteria are intended to identify services that may be inappropriately foregone, while maintaining the PPS incentives to control service use and cost. However, raising concerns about beneficiary access to services that remain in the daily rate, many of the clinical experts we interviewed questioned whether additional services should have been excluded from the PPS. Because information on the frequency and cost of all services provided to beneficiaries is not available, it is difficult to confirm that the criteria have been applied consistently and that all of the services that meet these criteria were excluded from the PPS. CMS does not intend to collect data on all services

³H.R. Conf. Rep. No. 106-479, at 854 (1999).

provided to beneficiaries receiving SNF care, or to develop a process for systematically reviewing the services included and excluded from the PPS rate.

Current exclusion policies have three unintended consequences. First, because of the way HCFA defined coverage for excluded facility services, beneficiary liability is increased and beneficiaries may lose coverage for certain services if they are excluded from the PPS. Second, some services are excluded only if they are provided in a hospital outpatient department, creating incentives for SNFs to refer patients to this setting, even though there may be alternative medically appropriate sites of care that would be less expensive for beneficiaries and the program. Finally, to ensure prompt medical attention in emergency situations, HCFA excluded emergency room services from the PPS rate, but the broad definition of emergency services may result in SNFs classifying care as “emergency” to gain separate payments.

Congress may wish to clarify Medicare’s coverage for facility services excluded from the SNF PPS. We are also recommending that the Administrator of CMS exclude any service that meets the criteria, regardless of where it is provided. To refine the SNF PPS and ensure adequate beneficiary access to appropriate medical services, we are also recommending that CMS develop a strategy to collect and analyze cost and utilization data on all services provided to beneficiaries during SNF stays. In commenting on a draft of this report, CMS stated that it can not disregard the site of service delivery in excluding certain services because it believes it does not have the administrative authority to do so and because these services can not be provided safely in nonhospital settings. It acknowledged the need for service-level data, but noted that collecting these data could meet with considerable industry opposition.

Background

Medicare covers skilled nursing and rehabilitative therapy for beneficiaries being treated in SNFs for conditions related to a hospital stay. The hospital stay must have been for at least 3 days and have occurred within 30 days before admission to the SNF. For beneficiaries who qualify, Medicare will pay for all necessary services, including room and board, nursing care, and ancillary services such as drugs, laboratory tests, and physical therapy, for up to 100 days under Medicare part A, the hospital insurance portion of Medicare. In 2001, beneficiaries are responsible for a \$99 daily copayment after the 20th day of SNF care, regardless of the cost of services received. If the beneficiary stay is not covered under part A, Medicare will pay for covered services, provided the

beneficiary has purchased part-B supplemental insurance. Part-B covered services include physician, hospital outpatient, and ancillary services (such as laboratory tests and physical therapy). For most part-B services, coinsurance is 20 percent of Medicare payments, but for services and procedures provided in hospital outpatient departments the coinsurance is higher.

For over a decade beginning in 1986, Medicare part-A SNF spending rose dramatically—averaging 30 percent annually. This high growth was due to a number of factors. Implementation of a PPS for inpatient hospital care in 1983 created an incentive to discharge patients from the hospital sooner, which may have resulted in more beneficiaries needing SNF care. Indeed, the number of Medicare beneficiaries receiving SNF services more than doubled between 1983 and 1990. Technological advances also contributed to a change in the mix of services provided by some SNFs, allowing some SNFs to offer more complex services that had previously been delivered only in hospitals. For example, SNFs now admit beneficiaries who require ventilator support, specialized wound care, or intravenous medications following their hospital stay.

Medicare's cost-based reimbursement method for SNFs, which provided few checks on spending, combined with minimal program oversight, contributed to SNF expenditure growth. Medicare's payment method controlled spending for routine costs, such as room and board, but spending for ancillary services and capital costs was not constrained. In most cases, ancillary services such as therapies were provided by outside suppliers that billed the SNFs.⁴ The outside suppliers' charges, in turn, became the SNFs' costs to provide these services. These costs were reimbursed by Medicare, so that the more SNFs spent, the more they were paid. Under this payment approach, SNFs had no financial incentive to furnish only clinically necessary ancillary services or to control their costs. As a result, SNFs provided more services and higher cost services to Medicare beneficiaries, making the SNF benefit one of the fastest growing components of Medicare.

⁴In some cases, outside suppliers billed Medicare part B directly for ancillary services, with no direct involvement by the SNF. Under this arrangement, beneficiaries were responsible for the 20 percent coinsurance.

Prospective Payment for SNFs

In response to rising SNF spending, the BBA required a PPS for SNF services, which HCFA began to phase-in on July 1, 1998. SNFs now receive a fixed daily payment to cover the cost of most services provided to beneficiaries during a part-A covered stay. Because not all patients require the same amount of care, per diem rates are adjusted to reflect differences in patient characteristics that affect the cost of care, as measured by the Resource Utilization Group (RUG) system. The RUG system uses clinical and other factors to assign each patient to 1 of 44 different RUG categories. These categories group patients who receive similar services and therefore have similar costs. The daily payment rate is based on the national average cost of treating beneficiaries in that RUG category.

The PPS creates the incentive for SNFs to control their costs because they financially benefit if their costs are below their payments, but are liable if their costs exceed their payments. SNFs can control their costs by reducing the number of services delivered, changing to a less costly mix of services, or controlling the cost of each service. However, the PPS may encourage undesirable provider responses. SNFs may lower their costs by withholding medically necessary services, substituting lower quality services, or avoiding higher cost beneficiaries.

In conjunction with the PPS, the BBA made each SNF financially responsible for almost all services provided during a part-A stay, including services rendered by an outside supplier.⁵ This “consolidated billing” provision minimizes the potential for duplicate billing and prevents facilities from reducing their costs by having outside providers furnish ancillary services for additional Medicare payment. Consolidated billing results in these services being covered under part A.

Providers have been concerned that SNF payments are too low, but our previous work on the SNF PPS indicated that in aggregate, SNF payments are likely to cover the costs of care needed by beneficiaries. However, we have noted that refinements to the payment system are needed to better

⁵P.L. 105-33, Sec. 4432(b), 111 Stat. 251, 420 (codified at 42 U.S.C. 1395u(b)(6), 1395y(a)(18), and 1395yy(e)(9)).

match payments with patient needs.⁶ These refinements would be similar to those routinely implemented in Medicare’s inpatient hospital PPS.⁷

Services Excluded From the PPS Rate

The costs of certain services provided during a SNF stay were excluded from the calculation of the daily PPS payment and separate payments are made for these services under part B. Because additional payments are made for these services, SNFs do not have to cover the costs of these services under the daily payment rate. This removes any financial disincentive to the SNF for providing these services or admitting beneficiaries who require these services.

Services were excluded from the PPS at three different junctures (see table 1). In mandating the implementation of a PPS, the BBA was explicit that payments to practitioners (such as physicians) not be included under the PPS, continuing the distinct payments Medicare generally makes for facility and for professional services.⁸ Next, in a 1998 interim final rule to implement the PPS, HCFA identified a set of facility services to exclude from the PPS rate. HCFA characterized these services—such as cardiac catheterization, magnetic resonance imaging (MRI), ambulatory surgery performed in an operating room, and emergency services—as beyond the scope of SNF care if they were provided in a hospital outpatient department.⁹

⁶*Nursing Homes: Aggregate Medicare payments are Adequate Despite Bankruptcies* (GAO/T-HEHS-00-192, Sept. 12, 2000); *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access* (GAO/HEHS-00-23, Dec. 14, 1999); and *Skilled Nursing Facilities: Medicare Payments Need to Better Account for Nontherapy Ancillary Cost Variation* (GAO/HEHS-99-185, Sept. 30, 1999).

⁷The Secretary of HHS is required to adjust the patient classifications for the inpatient hospital PPS at least annually. See Sec 1886 (d)(4)(C) of the Social Security Act. Since 1983, over 40 patient categories have been added to the original 467 groupings. Detailed data on service use and patient characteristics are used to improve this patient classification system.

⁸See 42 U.S.C. § 1395yy(e)(2)(A)(ii).

⁹If these services are provided in a critical access hospital (a special designation of small, rural hospitals defined by Medicare), they would also be excluded from the PPS rate.

Table 1: Services Excluded from the SNF PPS Rate, Regulatory or Legislative Source, and Effective Dates

Excluded services	Exclusion source (effective date)
Services provided by physicians, midwives, psychologists, nurse anesthetists Certain dialysis-related services and drugs	BBA (July 1998)
Certain outpatient services when provided in a hospital (including associated medically indicated ambulance transport): Cardiac catheterization Computerized axial tomography (CT) scans and MRI Ambulatory surgery performed in operating rooms Emergency services Radiation therapy ^a Angiography ^a Lymphatic and venous procedures ^a	HCFA Interim Final Rule (July 1998) and HCFA Program Memorandum (November 1998)
Specified chemotherapy items and services Radioisotope services Customized prosthetic devices Ambulance transportation for dialysis	BBRA (April 2000)

^aThe Interim Final Rule identified broad service categories of services to exclude. The subsequent Program Memorandum issued by HCFA identified specific billing codes within these broad categories.

Source: GAO analysis.

Because HCFA lacked statutory authority to exclude services provided during a part-A stay from the PPS, it used its administrative rule-making authority to redefine “residency status” so that beneficiaries are temporarily not SNF residents while they receive certain services in hospital outpatient departments.¹⁰ This site-of-service distinction enabled HCFA to exclude these services if they were provided in a hospital outpatient department. These facility services are then covered by

¹⁰63 Fed. Reg. 26,252, 26,308 (1998) (codified at 42 C.F.R. 411.15(p) (3) (iii)). HCFA defined SNF resident in such a way as to exclude those who are receiving “a small number of exceptionally intensive services that lie well beyond the scope of care that SNFs would ordinarily furnish.” HCFA Program Memorandum, Transmittal No. A-98-37 (Nov. 1998). HCFA subsequently finalized and amended this regulation. 64 Fed. Reg. 41, 644 (1999) and 65 Fed. Reg. 46,769 (2000).

Medicare under part B, even though they are being provided during a part-A eligible stay.¹¹ Following the implementation of the PPS, HCFA added radiation therapy, angiography, and lymphatic and venous procedures to the list of services that are excluded when provided in a hospital outpatient department. All of these facility services are excluded from the SNF rate and are paid for separately under part B.

Based on HCFA recommendations, in the BBRA Congress excluded another set of services from the daily rate.¹² The BBRA excluded specific services within three broad categories (chemotherapy, radioisotopes, and customized prosthetic devices) and it excluded ambulance transportation for dialysis.¹³ The BBRA also granted the Secretary of HHS the authority to modify the list of excluded services within these three broad categories and specified that Medicare payments for these services would be determined in the same way as when these services are paid for under part B.

Certain Services Appropriately Excluded from SNF PPS, but Revisions to the Exclusions May Be Needed

HCFA generally relied on three criteria to guide the selection of services to be excluded from the PPS rate. To be excluded, services had to be high cost, infrequently needed by SNF beneficiaries, and not likely to be overprovided. The first two criteria identify services that a SNF might inappropriately avoid delivering or that could financially compromise a facility that did provide them. The third criterion minimizes the opportunities for facilities to boost Medicare revenues by providing services for separate payment. Almost all of the clinical experts we consulted agreed with the criteria and with the specific services excluded from the PPS. The majority raised concerns, however, about the adequacy of beneficiary access to certain services that were not excluded from the PPS. Without systematic review of cost and use data for all services provided to SNF residents, it is not possible to determine if all services that meet the criteria were excluded. The agency does not have, nor does

¹¹However, if the listed service is delivered in another setting (such as an ambulatory surgery center or imaging center) or if another (not excluded) service is provided in a hospital outpatient department (such as an x-ray), the beneficiary is still considered a SNF resident—and the service, and payment for it, is included in the part-A stay.

¹²P.L. 106-113, div. B, sec. 1000(a)(6) [H.R. 3426, title I, sec. 103(a)], 113 Stat. 1501, 1536 and 1501A-325 (codified at 42 U.S.C. 1395yy(e)(2)(A)(iii)).

¹³Ambulance transportation for dialysis is excluded only when provided in conjunction with part-B covered dialysis, which is generally limited to beneficiaries with end-stage renal disease (ESRD).

it plan to develop, the data necessary to conduct a systematic evaluation, nor is it developing a strategy to periodically review the excluded services to ensure that services that meet the exclusion criteria are excluded and paid for separately from the PPS rate.

Criteria Help Ensure Access and Protect SNFs, Without Encouraging Unnecessary Service Use

In establishing its three criteria, HCFA excluded services that cost substantially more than the daily SNF payment rate because the SNF would have strong financial incentives to avoid providing them or admitting the beneficiaries who would be likely to need them. If the high-cost services were provided infrequently, the daily payment rate, which is based on average costs of care for a typical patient in a payment category, could be much lower than the actual costs of treating a patient needing some of these high-cost services. Facilities treating a disproportionate number of beneficiaries requiring these services could be disadvantaged compared to facilities that did not. Frequently provided high-cost services would boost average daily costs, so they would be reflected in the PPS rate.

The third criterion, that the service not be easily overprovided, helps ensure that the PPS minimizes overall costs by reducing the opportunity for providers to seek additional reimbursements outside of the PPS rate. Facilities have an incentive to ensure that they provide only medically needed care for services that are included in the PPS rate. However, they may be less concerned about evaluating the need for a service when the service is paid for separately.

Clinical consultants we interviewed generally agreed that the three criteria used to select services for exclusion are reasonable.

Concerns Remain About Additional Services To Exclude From PPS

When deciding on the service exclusions, HCFA lacked detailed service cost and use data to examine which services met the criteria. Instead, HCFA relied on its staff's clinical and institutional expertise to identify services that appeared to meet the exclusion criteria. It also consulted with the medical directors of the contractors responsible for processing SNF claims and with providers.¹⁴ To elicit public input in developing its recommendations to Congress for services to exclude in the BBRA, HCFA held a public meeting to receive comments on the proposed rules and to

¹⁴The agency contracts with fiscal intermediaries (part A) and carriers (part B) to review submitted claims and to make payments to providers.

gather suggestions for service exclusions. HCFA considered these suggestions and some—for example, related to ambulance transport for beneficiaries with ESRD—were adopted. But several services that were proposed for exclusion were kept in the rate because, according to agency officials, they did not appear to meet all three criteria (see table 2.)

Table 2: Examples of Services Considered for Exclusion from the SNF PPS and HCFA’s Reasons for Not Excluding Them

Selected services considered for exclusion	Exclusion criterion not met^a
Ambulance transport not already excluded	Cost
Clinical social work services	Frequency
Doppler flow studies ^b	Cost; frequency
Hyperbaric oxygen therapy ^c	Possible overprovision
Modified barium swallow studies ^d	Frequency
Nuclear medicine services	Cost; possible overprovision
Orthotics	Frequency; possible overprovision
Stress tests	Frequency

^aTo be considered for exclusion from the PPS, a service must be high cost, infrequently provided, and not likely to be overprovided.

^bA doppler flow study is an ultrasound procedure measuring blood flow through veins and arteries performed to detect blockages, injury, or blood clots.

^cHyperbaric oxygen therapy is a medical treatment in which oxygen is administered at greater than normal pressure to a patient to treat conditions such as burns and peripheral vascular disease.

^dA modified barium swallow is a procedure done to evaluate the swallowing process for people who are having problems speaking or swallowing food without aspirating it into the windpipe.

Source: Interviews with HCFA officials.

The clinical experts we consulted told us additional services should have been excluded from the PPS, though they agreed the current exclusions were reasonable. For example, all of the clinical experts we interviewed disagreed with the agency’s policy regarding ambulance transportation.¹⁵ They argued that without additional payment for ambulance transport associated with excluded services beneficiary access to certain services

¹⁵Medicare pays for ambulance transport only in those circumstances where other means, such as taxicab service, would be medically contraindicated. Medically necessary ambulance transport is excluded from the PPS and paid for separately when associated with dialysis and the following services if provided in a hospital—cardiac catheterization, MRI, CT scan, certain ambulatory surgery procedures, emergency services, radiation therapy, angiography, and lymphatic and venous procedures.

could be impaired. Most experts we interviewed also thought that ambulatory surgery for many beneficiaries, CT scans, and MRIs performed in nonhospital settings should be excluded from the PPS regardless of where they are provided. These services are excluded, however, only if they are provided in a hospital outpatient setting.

There was less agreement about whether other services currently included in the daily rate should be excluded. Some thought that excluding services would lead to overprovision of certain services, such as modified barium swallows, orthotics, and hyperbaric oxygen therapy. However, more often we were told that beneficiaries who are likely to need services included in the daily rate may face barriers to SNF admission, or as residents, may not receive the care that they need. One expert noted that the current exclusions may encourage the substitution of a more expensive service for a less expensive alternative that remained in the daily rate.

With medical advances and as providers respond to payment incentives, the services meeting the exclusion criteria are likely to shift. Certain services that are currently excluded may not warrant exemption in the future and, conversely, services that have not been excluded may at some time meet the exclusion criteria. Agency officials stated that they consider modifying which services are excluded in response to public comments they receive on proposed PPS regulations. However, objective and systematic evaluation of the excluded services is not possible without data on all services provided to beneficiaries in a SNF and the costs of these services. HCFA did not have these data available in developing the PPS and agency officials told us they do not plan to require SNFs to include on billing records the specific services provided during a part-A stay. These officials told us that complete data on all services would require considerable changes to provider billing requirements and to the computer systems that process the claims.

Current Exclusion Policies May Have Unintended Consequences

CMS's current exclusion policies have three unintended consequences. First, coverage has been shifted from part A to part B for excluded facility services that otherwise would have been covered in the daily rate, thereby increasing beneficiary liability. As a result of this shift in coverage and because certain services (primarily self-administered prescription drugs) are not covered under part B, beneficiaries would lose their coverage under Medicare if these services were excluded from the PPS. Therefore, HCFA did not consider excluding these services from the PPS. Second, excluding services based on where they are provided may encourage SNFs to refer beneficiaries to hospital outpatient departments, when other,

often less costly ambulatory settings could be appropriate. This site-of-service incentive is likely to increase beneficiary liability and program spending. Finally, SNFs may have an incentive to classify certain services as emergencies so that they are excluded from the PPS and can be paid for separately.

HCFA's Interpretation of BBRA Exclusion Language Increases Beneficiary Liability and Limits Coverage

The BBRA provided that the amounts paid for excluded services are to be determined in the same way as when the services are paid for under part-B payment rules and that the funds for the services are to come from the part-A program.¹⁶ The law is silent on whether coverage for these services is to be determined under part A or part B. In its interpretation of the BBRA language, HCFA applied part-B coverage rules to the excluded services delivered during a part-A covered stay. In shifting coverage from part A to part B, excluded services are subject to part-B cost-sharing requirements. As a result, beneficiaries are responsible for the coinsurance for the excluded services, even though they would have had no additional cost-sharing obligations had the services remained in the PPS rate.¹⁷

The application of part-B coverage rules also restricts the services that HCFA considered excluding from the PPS to those covered under part B. Since the agency has no authority to pay for non-covered services, excluding them from the PPS and shifting their coverage to part B would eliminate any reimbursement for them. For example, no expensive medications were excluded from the rate because most self-administered prescription drugs are not covered under part B. Agency officials have noted that by keeping these services in the PPS rate, providers at least receive a higher daily payment rate than if these services were excluded. Yet the higher daily rate is unlikely to cover the costs of these services for any given patient, so that SNFs would have a financial incentive to avoid admitting anyone who is on expensive drug regimens.

¹⁶P.L. 106-113, div. B, sec. 1000(a)(6) [H.R. 3426, title I, sec. 103(a)(3)], 113 Stat. 1501, 1536 and 1501A-325 (codified at 42 U.S.C. 1395yy(e)(9)).

¹⁷Most beneficiaries have supplemental coverage, which usually pays for part-B coinsurance. Those without supplemental coverage would be responsible for these liabilities.

Exclusions Based on Site of Service May Raise Costs to Beneficiaries and Program

CMS's policy of excluding certain services only when provided in hospital settings creates an incentive for SNFs to send beneficiaries to hospitals rather than other ambulatory settings to receive those services.¹⁸ The site-of-service policy raises concerns that SNFs will make decisions about where services will be provided based solely on financial considerations, even though other settings may be clinically appropriate. Almost all of the clinical experts we consulted disagreed with current policy to exclude ambulatory surgery procedures and imaging services (CT scans and MRIs) only when provided in hospital outpatient departments. The majority argued that nonhospital settings provide similar services and therefore should be treated the same as hospital outpatient departments, though several cautioned that hospitals may be a more appropriate treatment site for certain services provided to high-risk beneficiaries. Some of the clinicians commented that many nonhospital settings are much better than hospitals at handling frail elderly patients, for example, in terms of facilitating their transportation, admission, and discharge.

This site-of-service policy also has important cost implications. Because Medicare's payments are often higher for services provided in hospital outpatient settings compared with other ambulatory settings, Medicare expenditures may be higher as well. For example, in 2001, Medicare pays about \$50 more for a CT scan of the head when furnished in an outpatient department of a hospital compared to one furnished in a freestanding imaging center in the same area. Likewise, beneficiary cost sharing is likely to be substantially higher when services are provided in hospital settings compared with other ambulatory settings.

Furthermore, ambulance transport is paid for separately only in conjunction with the provision of the services excluded when provided in a hospital outpatient department.¹⁹ Most of the clinical experts we consulted disagreed with CMS's current policy, saying that patients receiving some of the other excluded services, such as chemotherapy, are equally likely to need ambulance transport.

¹⁸Services excluded only when provided in hospital outpatient departments include cardiac catheterization, CT scans, MRIs, ambulatory surgery procedures performed in an operating room, emergency services, radiation therapy, angiography, and lymphatic and venous procedures.

¹⁹Ambulance transport is also paid for separately in conjunction with dialysis.

Incentive Exists to Classify Certain Hospital Outpatient Services as Emergencies To Gain Separate Payments

Payments for medical emergencies are made outside of the PPS rate to help ensure appropriate treatment and protect SNFs that arrange for prompt medical care. Medicare’s definition of what services constitute “emergency” care is broad to provide important protection for beneficiaries.²⁰ However, the exclusion for emergency services, combined with the broad definition of emergency, could invite abuse and increase Medicare expenditures.²¹ SNFs have a financial incentive to send beneficiaries to emergency departments for nonemergent care to receive separate payments for services that otherwise would be included in the PPS rate. The clinical experts we consulted uniformly agreed that the provision was open to overuse by SNFs. They gave examples of patients sent by SNFs to emergency rooms because they needed expensive drugs or time-consuming nursing services. While CMS is reviewing claims to make sure it is not paying twice for the same service, it is not analyzing whether the services should have been provided in the emergency room, nor is it identifying if particular providers appear to be overusing the emergency room exclusion.

Conclusions

Congress and HCFA recognized that certain services needed to be excluded from the SNF PPS rate to help ensure beneficiary access to appropriate care and to financially protect the SNFs that take care of high-cost patients. The criteria used to identify services— high cost, infrequently provided during a SNF stay, and not likely to be overprovided—and the services currently excluded appear reasonable. Although the criteria and current exclusions appear reasonable, questions remain about whether beneficiaries have appropriate access to services that are covered in the rate or whether additional services should have been excluded. A second concern is that Medicare coverage for excluded facility services has been shifted from part A to part B, which will increase beneficiary liability and limit the services considered for exclusion. In addition, beneficiary liability and program spending may increase because

²⁰In HCFA’s Program Memorandum A-98-37, HCFA defines emergency services as “those necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services” (as defined under regulation at 42 C.F.R. sec. 424.101).

²¹One study examining transfers to emergency rooms and hospitals in California found that over a third of SNF transfers to emergency rooms were inappropriate and could have been treated in a lower level of care. See Debra Saliba, et al, “Appropriateness of the Decision to Transfer Nursing Facility Residents to the Hospital,” *Journal of the American Geriatrics Society* 48: pp. 154-163, 2000.

certain services are excluded only when provided in hospital settings, thus discouraging the use of less expensive, clinically appropriate sites of service. Finally, though providing important broad protection for beneficiaries, excluding services from the PPS rate when they are provided in emergency rooms may lead to overuse of this setting and could unnecessarily increase Medicare spending.

CMS does not plan to collect data on all services provided to beneficiaries during their SNF stays. Without these data, CMS will be hampered in its efforts to update the exclusions over time. The lack of information about services provided to beneficiaries during their SNF stays will also severely limit efforts to refine the payment system. An analysis of which settings (for example, SNF, hospital outpatient department, ambulatory care, and emergency department) are used to deliver services to SNF patients is also important to ensure that services are provided at the most efficient and appropriate site.

Matter for Congressional Consideration

Because coverage under part B increases beneficiary liability and limits the services that are considered for exclusion from the SNF PPS, Congress may wish to clarify whether Medicare coverage of facility services excluded from the SNF PPS rate should be provided under part B or under part A.

Recommendations for Executive Action

To help ensure that services are provided in the most appropriate setting, we recommend that the Administrator of CMS exclude services from the PPS if they meet the exclusion criteria, regardless of where they are provided.

To refine and adjust the SNF PPS and to ensure adequate beneficiary access to appropriate medical services, we recommend that the Administrator of CMS develop a strategy to collect and analyze cost and utilization data on all services provided to Medicare beneficiaries during a SNF stay.

Agency Comments

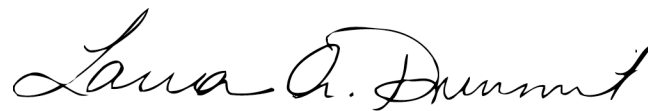
In its comments on a draft of this report (see app. I), CMS stated that in excluding services from the SNF PPS, it was concerned about maintaining the integrity of the PPS and the intent of the consolidated billing requirement that SNFs be responsible for essentially all residents' services

provided during a Medicare part-A covered stay. It disagreed with our recommendation to eliminate the site-of-service restriction on certain excluded services, stating that it has used its administrative authority to modify the BBRA provisions to the fullest extent possible and noted in its technical comments that this recommendation needed to be directed to Congress. It stated that these services require the intensity of hospital outpatient settings to be provided safely and effectively but added that it would consider reincorporating these services back into the SNF PPS rate once they could be provided safely elsewhere. In addition, CMS agreed with our analysis that excluding services from the PPS increases beneficiary liability. Further, CMS acknowledged the need for cost and utilization data but indicated that its previous efforts to collect such information met with intense industry opposition. Finally, in its technical comments it acknowledged that monitoring the use of emergency room services is important and may be a focus for program safeguard contractor activities.

We agree with CMS that additional service exclusions must balance the need to protect SNFs and beneficiaries with the need to maintain the cost-control potential of the PPS and be mindful of the effect exclusions have on beneficiary liability. However, we disagree with CMS's rationale regarding the site-of-service exclusions. Medicare currently covers these services in other settings for other beneficiaries. Although CMS used its broad administrative authority to redefine SNF residency status to exclude patients receiving certain services in hospital outpatient departments, it gave no reason as to why it could not use this same authority to redefine the residency status of beneficiaries receiving the same services in other settings. We believe that services should be provided in the most appropriate setting and that this site-of-service distinction will effectively limit the choice of where services are provided for beneficiaries in SNFs. Except to acknowledge that shifts in coverage increase beneficiary liability for these services, CMS did not address the shift in coverage from part A to part B that results from its policies. We believe part-B payment rules could be applied to excluded services while maintaining part-A coverage. In our Matters for Congressional Consideration, we state that Congress should clarify if coverage for facility services excluded from the PPS should be provided under part A or part B. Finally, while recognizing the importance of cost and utilization data, CMS raised concerns about the administrative burden this collection might impose. We believe that CMS should explore less burdensome ways to collect adequate data to evaluate the current service exclusions or additional exclusions proposed by the industry. Without a data collection strategy, it will be difficult to make informed decisions about refinements to the PPS over time.

We are sending copies of this report to the Administrator of CMS and interested congressional committees. We will also make copies available to others upon request.

If you have any other questions about this report, please call me at (202) 512-7119 or Carol Carter, Assistant Director, at (312) 220-7711. Cristina Boccuti and Dan Lee also contributed to this report.

A handwritten signature in black ink that reads "Laura A. Dummit". The signature is written in a cursive style with a large initial 'L' and a distinct 'A'.

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

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House of Representatives

Appendix I: Comments From the Centers for Medicare and Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

AUG -6 2001

DATE:

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

FROM: Ruben J. King-Shaw, Jr.
Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, *SKILLED NURSING FACILITIES: Services Excluded from Medicare's Daily Rate Need to be Reevaluated* (GAO-01-816)

We have reviewed the above-subject report, and offer the following comments.

Accordingly, in any examination of possible revisions to the consolidated billing requirement, the foremost concern is maintaining the continued integrity of the comprehensive package of care for which the skilled nursing facility (SNF) prospective payment system (PPS) makes payment. As we noted in the July 31, 2000, final rule (65 FR 46791), we do not view the identification of new service categories for exclusion from consolidated billing in terms of a process of continual expansion to encompass an ever-broadening array of excluded services. Rather, the fundamental purpose of this provision is to make the SNF itself responsible for billing Medicare for essentially all of its residents' services, other than those identified in a small number of narrow and specifically delineated exclusions.

A principal concern raised in the report relates to the site of service restrictions for certain consolidated billing exclusions under the regulations at 42 CFR 441.15(p)(3)(iii). Specifically, the report suggests that the restriction of these exclusions to the outpatient hospital setting may:

1. create "... incentives for SNFs to refer patients to this setting, even though there may be alternative, medically appropriate sites of care that would be less expensive for beneficiaries and the program; and
2. have "unintended consequences" such as the underutilization of alternative, medically appropriate sites of care.

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS).
We are exercising fiscal restraint by exhausting our stock of stationery.

Page 2 – Laura A. Dummit

In crafting the site of service restriction, the Centers for Medicare and Medicaid Services (CMS) used its authority to modify the Balanced Budget Refinement Act of 1999 (BBRA) provisions in the broadest manner open to the Agency. Further, the exclusions from consolidated billing under the regulations at section 411.15(p)(3)(iii) pertain exclusively to outpatient hospital services, because they are targeted specifically at those services that are so far and above the normal range of SNF care (e.g., cardiac catheterization), as to require the intensity of the hospital setting, in order to be furnished safely and effectively for the beneficiary.

There may already be certain exceptional instances where such services are available in less intensive, non-hospital settings, and that advances in medical practice over time might eventually make it feasible to perform these services more widely in such settings. However, we do not believe this argues in favor of expanding the exclusion to encompass the non-hospital performance of these services. Rather, as we indicated in the July 31, 2000 final rule (65 FR 46791), to the extent that such services ceases to require the intensity of the hospital setting for its safe and effective performance, this would warrant consideration of whether the service should be rebundled entirely back to the SNF, even when, or if, it is actually performed in the hospital outpatient setting.

We note that the Conference Report accompanying the BBRA directed to GAO “. . . to review the codes of the excluded items and make recommendations on whether the criteria for their exclusion are appropriate . . .” (H.R. Conf. Rep. No. 106-479, at 854).

To the extent that beneficiaries are currently required to pay the Part B deductible and copays, we agree with GAO’s observation that creating additional exclusions from consolidated billing would have the effect of increasing beneficiary liability. In fact, we note that one of the original reasons for establishing the consolidated billing requirement was to spare beneficiaries from unnecessary out-of-pocket liability under Part B, by ensuring that the SNF would include its residents’ services, to the maximum extent possible, on its Part A bill.

Thus, any consideration of creating additional exclusions from consolidated billing must balance the need to protect not only the SNF, but also the beneficiary, from excessive financial liability.

The GAO recommends that that the Administrator of CMS develop a strategy to collect and analyze cost and utilization data on all services provided to Medicare beneficiaries during a SNF stay. When the SNF PPS was being implemented, CMS proposed a change to SNF billing that would require line item, date-of-service billing for all Part A claims. Under this proposed billing system, we would have been able to identify the type and charge for each ancillary service provided for Part A beneficiaries. This proposal did not go forward due to intense opposition from the nursing home industry and concerns about the burden of requiring this type of detailed billing. However, in the absence of detailed

Page 3 – Laura A. Dummit

billing, we know of no way to collect accurately the utilization data needed to implement this recommendation.

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