

GAO

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

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SKILLED NURSING FACILITIES

Medicare Payment Changes Require Provider Adjustments But Maintain Access



**Health, Education, and
Human Services Division**

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The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Charles E. Grassley
Chairman
Special Committee on Aging
United States Senate

Since the mid-1980s, Medicare spending for skilled nursing facility (SNF) services has risen dramatically. Between 1986 and 1998, spending increased, on average, 30 percent annually, climbing from \$578 million to \$13.6 billion. This spending growth is due to a number of factors. SNF care, which once comprised relatively low-intensity nursing care and therapy, has in recent years included a growing number of services that previously were provided only in hospital settings. Changes in the nature of the services delivered and in the facilities that furnish SNF care, as well as the incentives of Medicare's payment method for acute hospital services, have expanded the range of services offered. At the same time, the former cost-based payment method for SNF services and a lack of appropriate program oversight encouraged SNFs to provide excessive ancillary services to SNF patients. As a result, the number of Medicare beneficiaries using SNF care and the number of services furnished to each patient have surged, making the Medicare SNF benefit one of the fastest growing components of Medicare spending.

In an effort to control spending growth, the Congress directed the Health Care Financing Administration (HCFA) in the Balanced Budget Act of 1997 (BBA) to develop a prospective payment system (PPS) for skilled nursing facility services provided to Medicare beneficiaries.¹ In July 1998, Medicare began the transition to a PPS, paying fixed, predetermined rates for each day of care—a major change from the former system of cost-based reimbursement. Previously, facilities benefited from furnishing more ancillary services to Medicare patients, without regard for their services' price or necessity. The PPS attempts to create incentives for providers to control their daily costs and deliver care more efficiently.

¹P.L. 105-33, section 4432(a).

Since implementation of the PPS began, concerns have been raised that weaknesses in the payment system's design may threaten access to SNF care for some high-cost beneficiaries. At the same time, some nursing home chains have claimed that their eroding financial performance is a result of the PPS. These concerns have prompted Congressional debates on modifications to the SNF PPS. You asked us to assess (1) the initial effect of the SNF PPS on Medicare beneficiaries' access to care, (2) the initial effect of the SNF PPS on providers, and (3) the role the SNF PPS has played in the poor financial performance of large nursing home chains. To do this, we conducted a nationwide survey of hospital discharge planners, interviewed industry analysts as well as representatives from several nursing home chains, and reviewed financial information from two chains, Sun Healthcare Group, Inc., and Vencor, Inc., which were experiencing large losses and recently filed for bankruptcy. Our work was performed in accordance with generally accepted government auditing standards between June and October 1999. (For a detailed discussion of our scope and methodology, see appendix I.)

Results in Brief

Medicare beneficiaries' ability to obtain needed care does not appear to have decreased since the implementation of the SNF PPS, although some patients may stay longer in the hospital before being admitted to a nursing home or may receive care from other post-acute-care providers. The PPS does appear, however, to have affected the willingness or ability of some nursing homes to accept certain types of Medicare patients. Hospital discharge planners reported that facilities are reluctant to admit patients requiring certain high-cost services, including some expensive drug treatments and infusion therapy, indicating that the payments for some types of SNF patients may be too low. We also found that Medicare patients needing short-term rehabilitation are preferred by nursing homes, raising concerns that payments for these patients may be too high. These findings are confirmed in recent surveys of hospital discharge planners and nursing home administrators by the Office of Inspector General of the Department of Health and Human Services (OIG).

Although the new payment system results in major changes in financial incentives, it is likely that aggregate SNF payments to providers are adequate, given that inflated costs were used to establish the per diem payment rates. However, the case-mix classification system used to adjust payments to reflect the needs of patients may not appropriately allocate payments across patients and providers. Payments, therefore, may be too low for certain types of patients and too high for others. Congress' recent

modifications to the PPS will temporarily increase payments for certain types of patients and thus may alleviate any current disincentives to admit patients. But even without these modifications, the generally low proportion of patient-days covered by Medicare at most nursing homes dampens the initial effects of PPS on providers, and the transition to the full PPS rates was intended to give them time to adjust. Some facilities will have to make bigger changes in their treatment patterns, particularly facilities with a large proportion of patient-days covered by Medicare, those with inefficient practices, and those that historically furnished excessive services to patients to maximize revenues. Other facilities, such as those that care for patients with extensive resource needs and those that have changed their mix of patients since 1995 (the year upon which payments were based), may be more selective in their admission policies, at least in the short term, until refinements in the classification system fully account for differences across patients.

The SNF PPS is only one of many factors contributing to the poor financial performance of Sun Healthcare Group, Inc., and Vencor, Inc., two corporations that operate a large number of nursing homes. The large total losses reported by the corporations stem from high capital-related costs that have shrunk SNF margins; reduced demand for ancillary services, related to several BBA provisions; and substantial nonrecurring expenses and write-offs, reflecting reductions in future anticipated earnings.

Background

The Medicare SNF benefit consists of inpatient skilled nursing and rehabilitative services furnished by a nursing home that is Medicare-certified.² To qualify for SNF services, a Medicare beneficiary must need daily skilled nursing or rehabilitative therapy services, generally within 30 days of a hospital stay of at least 3 days in length, and must be admitted to the nursing home for a condition related to the hospitalization. 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, for up to 100 days of care per benefit period.³ Beginning on the 21st day of care, the beneficiary is responsible for a daily coinsurance payment, which equals \$96 in 1999. Medicare beneficiaries residing in nursing homes who are not

²Such facilities are referred to as SNFs.

³A benefit period begins on the first day of an inpatient hospital stay and ends 60 days after the beneficiary is discharged from the hospital or from skilled care in a SNF or other inpatient facility providing skilled nursing or rehabilitative services. There is no limit to the number of benefit periods a beneficiary may have.

eligible for part A coverage of the inpatient stay⁴ may continue to receive coverage for some ancillary services, subject to limitations on the coverage for rehabilitation therapy services under part B.⁵

Skilled nursing services are provided by both hospital-based and freestanding facilities. In addition, rural hospitals designated as swing-bed facilities can use acute-care beds to provide SNF services.⁶ The number of Medicare-certified SNFs has grown, on average, about 6 percent per year throughout the 1990s, reaching 14,860 in 1998. About three-quarters are freestanding facilities. A majority (66 percent) of nursing homes are for-profit entities, and about half are owned or operated by corporations operating multiple facilities, known as chains. Most patients in nursing homes have their care paid for through the Medicaid program. Medicare-covered SNF days account for about 9 percent of total nursing home days. Prior to implementation of the PPS, Medicare revenues accounted for about 10 percent of nursing home revenues, on average.

The range of services furnished by nursing homes varies substantially. Some facilities provide traditional, low-intensity nursing care and therapy. Others furnish higher-intensity rehabilitative therapies and complex medical services, such as parenteral feeding and ventilator care, that previously were provided only in hospital settings.

Growth in Medicare Spending for SNF Services

The Medicare SNF benefit has been one of the fastest-growing components of Medicare spending. Since 1990, Medicare expenditures for SNF services have increased, on average, 25 percent annually, reaching \$13.6 billion in 1998. This growth is due primarily to a rise in the number of beneficiaries using SNF services and an increase in the number and type of services provided to SNF patients. Between 1990 and 1997, the number of beneficiaries receiving SNF care more than doubled, rising from 638,000 to

⁴Medicare part A (or hospital insurance) covers inpatient hospital, skilled nursing facility, hospice, and certain home health care services. Medicare part B (or supplementary medical insurance) covers physician and hospital outpatient services, outpatient rehabilitation services, home health services under certain conditions, diagnostic tests, and ambulance and other medical services and supplies.

⁵BBA required a \$1,500 per-beneficiary cap on payments for part B-covered physical and speech therapy services and a separate \$1,500 cap on part B-covered occupational therapy. See 42 U.S.C. § 1395l(g)(2). Recent changes in the law delay implementation of the spending caps until fiscal year 2002.

⁶Hospitals participating in the Medicare swing-bed program may use their beds for either acute care or post-acute care. To be certified as a swing-bed provider, a hospital must have 100 beds or fewer and be located in a rural area. Payments for routine SNF services provided in swing-bed hospitals continue to be based on Medicare's average routine payment for freestanding SNFs within each region. Capital and ancillary costs continue to be reimbursed on a facility-specific cost basis. Beginning in July 2001, swing-bed hospitals will receive prospective payments comparable to those to other SNFs.

1.6 million; Medicare's average payment per SNF day also more than doubled, from \$98 in 1990 to \$262 in 1998. At the same time, the number of days of care per SNF patient served dropped from 37 to 32. Much of the growth in Medicare per diem expenditures was due to increases in payments for ancillary services. Those payments increased 17 to 20 percent annually between 1992 and 1995, compared with 5 to 7 percent for routine services.

Medicare's cost-based reimbursement method, combined with a lack of appropriate program oversight, provided few checks on the growth in Medicare spending for SNF services. Ancillary cost growth, in particular, is considered to have been excessive.⁷ Before implementation of the BBA, nursing homes were paid the reasonable costs they incurred in providing Medicare-covered services. Routine costs, which include general nursing, room and board, and administrative overhead, were subject to cost limits,⁸ but payments for ancillary services and capital-related costs were virtually unlimited. Indeed, as a facility's costs of ancillary services rose, more of its overhead costs could be assigned to the program.⁹ Because higher ancillary service costs triggered higher payments, Medicare's payment method offered providers no financial incentive to furnish only clinically necessary services or to deliver them efficiently. Indeed, high ancillary costs could be used to justify a request for exceptions payments for routine costs over and above the cost limits.¹⁰ As a result, a provider's mix of services did not necessarily reflect the complexity of its cases or the true needs of its patients.

⁷See Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms (GAO/T-HEHS-99-192, Sept. 15, 1999); Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare (OEI-09-97-00122, Aug. 1999); Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 1995).

⁸For cost reporting periods beginning on or after October 1, 1997, the cost limits (before applicable wage index adjustments) were \$110.82 for urban freestanding facilities, \$108.28 for rural freestanding facilities, \$155.96 for urban hospital-based facilities, and \$137.52 for rural hospital-based facilities.

⁹Contract arrangements with ancillary service providers were found to result in markups of 800 percent or more over the direct cost of the therapy service. See Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 1995), p. 13.

¹⁰Under cost-based reimbursement, providers with reasonable costs that exceeded the routine cost limits could be granted exceptions from the limits if they provided information indicating that they served patients requiring more services than average. Those providers were paid an amount equal to the applicable cost limit plus an adjustment to reflect their higher costs.

Balanced Budget Act Provisions Aim to Better Control Costs

On July 1, 1998, HCFA began phasing in a Medicare PPS for SNF care, as required by the BBA. Under the new system, facilities receive a fixed payment for each day of care provided to a Medicare-eligible beneficiary.¹¹ During a 3-year transition period, each facility's per diem payment is a blend of a facility-specific (cost-based) rate and a federal per diem rate.¹² The facility-specific rate is based on the facility's 1995 average allowable costs for SNF services, updated to the current year.¹³ The federal portion of the rate is based on the average daily cost of providing all Medicare-covered SNF services in fiscal year 1995. Total costs were updated for inflation between the 1995 base year and 1999 by the SNF market-basket index minus 1 percentage point, as required by the BBA.¹⁴ Because not all patients require the same amount of care, the federal per diem rate paid for each patient is case-mix adjusted. Patients are classified into 44 case-mix groups based on their clinical condition, functional status, and expected use of certain services (particularly physical, occupational, and speech therapy).¹⁵ Each case-mix group has an associated relative weight that reflects the costliness of providing services to patients in that group relative to the average costliness of patients across all groups. The relative weight adjusts the per diem rate up or down. A facility then receives the same daily payment for all its patients in each group. By establishing fixed payments and including all services under the per diem payment, the PPS attempts to provide incentives for nursing homes to deliver care more efficiently. Facilities that can care for beneficiaries for less than the case-mix adjusted per diem payment can retain the difference as profit. Those with average costs higher than the per diem payments they receive will suffer a loss.

In addition to calling for a SNF PPS, the BBA requires nursing homes to submit to Medicare all bills for Medicare-covered services furnished to

¹¹The per diem payments are adjusted to account for differences in area wages.

¹²In the first year of the transition, the blended rate is 75 percent facility-specific, dropping to 50 percent in the second year and 25 percent in the third year. Subsequently, payments will be based on the federal rate only.

¹³Base-year costs are updated to the current year by applying an annual update factor for each intervening year equal to the increase in the SNF market-basket index minus 1 percentage point, as required by the BBA. See 42 U.S.C. § 1395yy(e)(3)(B)(i). The 1-percentage-point reduction reflects congressional concern that the base year included inappropriate costs.

¹⁴The market-basket index measures the annual change in the prices of goods and services providers use in producing SNF services.

¹⁵The groups are defined by a classification system developed by HCFA contractors. The categories of this system are known as Resource Utilization Groups, or RUGs. For the Medicare SNF PPS, version III of the classification system is being used.

their residents, regardless of who provides the services.¹⁶ Previously, when facilities had agreements with external providers to furnish ancillary services, Medicare allowed those external providers to bill directly for services covered under part B, even for patients in a Medicare-covered (part A) SNF stay. Requiring consolidated billing for all services furnished during a Medicare-covered SNF stay in conjunction with the PPS was necessary so that facilities could not reduce their costs simply by shifting the provision of ancillary services to part B providers, thereby stymieing Medicare's efforts to control total expenditures.¹⁷

The BBA also includes a per-beneficiary payment cap of \$1,500 for part B-covered physical and speech therapy and a \$1,500 cap for part B-covered occupational therapy.¹⁸ These limits do not pertain to Medicare beneficiaries during a Medicare-covered SNF stay, but can affect Medicare beneficiaries if their nursing home stay is not covered by Medicare. The provision likely will limit the revenues nursing homes and other providers earn from furnishing therapy services to nursing home patients under part B. Recent changes in the law delay implementation of the spending caps until fiscal year 2002.

PPS May Slow SNF Placements for Certain Medicare Beneficiaries

Our nationwide survey of 153 randomly selected hospital discharge planners suggests that nursing home behavior is changing with regard to admission practices. Nursing homes have become more cautious in accepting patients, favoring some types of patients over others when making admission determinations. Forty-three percent of our survey respondents mentioned that facilities prefer to admit patients needing short-term rehabilitation treatment, while nearly two-thirds reported a recent increase in difficulty placing Medicare beneficiaries needing certain types of treatment, including some costly nontherapy ancillary services. Yet, despite slower placements for some Medicare beneficiaries, few beneficiaries are experiencing barriers to appropriate care.

According to the discharge planners, facilities have become more cautious. Before accepting any patient, most facilities now appear to be assessing the beneficiary's condition more closely, requesting medical records, reviewing drug administration charts, and even sending staff to the hospital for in-person assessments. This behavior is confirmed in a

¹⁶See 42 U.S.C. § 1395y(a)(18).

¹⁷Implementation of the consolidated billing requirement has been delayed for residents of SNFs who are not covered by Medicare (that is, patients who have exhausted their part A SNF benefit or who were not eligible for part A coverage).

¹⁸The caps are not applicable to services furnished through hospital outpatient departments.

recent survey of nursing home administrators conducted by the OIG in which most administrators stated that they now scrutinize patients' medical status to a greater extent than they did prior to implementation of the PPS.¹⁹ In so doing, the nursing home may delay the hospital discharge process and extend the beneficiary's hospital stay.

Hospital discharge planners indicated that nursing homes favor some types of patients over others when making admission determinations. About 43 percent of those surveyed indicated that, under the PPS, nursing homes prefer to admit patients needing short-term rehabilitation for conditions such as stroke and hip replacement. In fact, 31 percent of respondents reported that facilities are actively recruiting such patients. A recent survey of hospital discharge planners conducted by OIG also found that patients with some conditions (including orthopedic and stroke patients and those requiring physical, rehabilitative, speech, and occupational therapies) are easier to place than before the payment change.²⁰ OIG's survey of nursing home administrators supports this finding as well: 46 percent of administrators in that survey reported that under PPS they were more likely to admit patients requiring special rehabilitation services, such as physical, occupational, or speech therapy.

By contrast, nearly two-thirds of the discharge planners we surveyed reported a recent increase in difficulty placing certain Medicare beneficiaries for a Medicare-covered SNF stay. Urban and rural hospitals reported difficulty placing patients at nearly an identical rate. The most frequently mentioned difficult placements were those patients requiring expensive drug treatment or infusion therapy (see table 1). Intravenous antibiotics, which fall into both of these categories, were cited most frequently of all specific medical treatments. Other treatments mentioned repeatedly included chemotherapy and total parenteral nutrition.²¹ A few medical needs were cited as problems, not because of the treatments themselves, but because of the transportation costs involved in providing

¹⁹Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators' Perspective (OEI-02-99-00401), Oct. 1999.

²⁰Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities (OEI-02-99-00400, Aug. 1999).

²¹This form of intravenous feeding supplies all of a person's nutritional requirements. It is a skilled service, requiring an intravenous tube or catheter placed in a large vein to administer the feeding solution.

the treatment.²² This appeared to be the problem for the respondents who cited difficulty placing dialysis patients. Our findings are consistent with those of OIG; 58 percent of the hospital discharge planners surveyed by OIG reported that Medicare patients requiring extensive services such as intravenous feedings, intravenous medications, or ventilator/respirator care have become more difficult to place in nursing homes in the past year. Similarly, 53 percent of the nursing home administrators surveyed by OIG reported that they were less likely under PPS to admit patients requiring expensive services and supplies.

Table 1: Discharge Planners Reporting Slowed SNF Placements, by Type of Medical Need

Medical need ^a	Percentage reporting
Expensive drugs	48
Infusion therapy	4
Ventilator care	29
Dialysis	28
Wound care	26
Care for decubitus ulcers	24
Tube feeding	22

^aCategories are not mutually exclusive.

Source: GAO Survey of hospital discharge planners, Aug. 1999.

While citing a recent increase in SNF placement delays among Medicare beneficiaries, several discharge planners noted that patients requiring certain types of complex services (such as ventilator care) have always been more difficult to place, particularly in areas not served by specialty facilities. Despite this, the reports of difficulty finding SNF beds for some patients needing certain costly nontherapy ancillary services are consistent with our previous work, suggesting that the case-mix classification system may not adequately account for some high-cost groups.²³

²²Once a beneficiary has been admitted to a SNF, it may be necessary to transport the beneficiary to a hospital or other site for specialized care. In this instance, the specialized services are furnished under arrangements made by the SNF. Following the treatment, the beneficiary is returned to the SNF to complete the inpatient stay. This movement of the beneficiary, considered patient transportation, is covered as a SNF service under part A and is included in the per diem rate.

²³Nontherapy ancillary services include drugs, laboratory tests, radiology procedures, respiratory therapy, medical supplies, intravenous therapy, and other nonroutine services. See *Skilled Nursing Facilities: Medicare Payments Need to Better Account for Nontherapy Ancillary Cost Variation* (GAO/HEHS-99-185, Sept. 1999).

At present, few Medicare beneficiaries are experiencing barriers to care. Nearly all (98 percent) of the discharge planners in our survey indicated that other arrangements are being made for patients who are difficult to place. Eighty-five percent of respondents reported that difficulty in placing patients results in longer hospital stays. Seventy-three percent reported finding alternative types of post-acute care, such as home health care and long-term care hospitals, for patients they could not place in nursing homes.

Longer hospital stays are probably not detrimental to most patients because they receive the care they need during their extended stay. Those Medicare patients who do stay in the hospital longer may subsequently require fewer days of care once they are admitted to a nursing home or may no longer need SNF care at all. To the extent that additional days in the hospital replace some SNF days, longer hospital stays generally reduce Medicare spending for the entire episode of illness.²⁴

Aggregate Payments to SNFs Are Likely Adequate, but Some Providers Must Make Adjustments

In aggregate, PPS payments are probably adequate and may, in fact, be excessive given that insufficient oversight allowed base-year costs associated with inefficient service delivery, unnecessary care, and improper billings to be included in both the facility-specific and the federal rates. But the rates established for individual patients may not appropriately reflect differing resource needs, and hence payments may not be adequate for certain types of patients, especially those with more extensive needs. Some facilities will need to modify their treatment patterns in response to the PPS. The adjustment to PPS may be eased, however, by two factors. First, Medicare patients generally constitute a small share of most nursing homes' patients; and second, a transition period, during which rates are based in part on each facility's own historical costs, is intended to give providers more time to make necessary changes.

Facilities that furnished excessive ancillary services or purchased services inefficiently will need to make the most modifications under PPS. Facilities that changed their mix of patients since the base year may make temporary adjustments, such as applying more selective admission policies, during the transition period. In addition, chains that deliver ancillary services to SNFs may need to make substantial changes in response to other BBA requirements that limit the provision of therapy

²⁴This is because Medicare's per-case payment to the hospital for a patient with a given condition is the same, regardless of the length of stay. Longer hospital stays can increase hospital operating costs, but not Medicare operating payments, unless the patient reaches the threshold for cost outlier payments.

under part B and require SNFs to bill for all services provided to their patients.

Aggregate Payments to SNFs Adequate, but Refinements Needed to Help Match Payments to Patients' Service Needs

HCFA used 1995 reported SNF costs as the basis for the federal per diem rates under PPS. We believe these base-year costs are likely to be too high as a result of inefficient service provision, unnecessary care, and improper billing for services, which went undetected due to minimal program oversight.²⁵ From 1992 to 1995, payments for ancillary services grew at triple the rate of routine services, which despite cost limits still increased 20 percent over the period. The low level of utilization review makes it difficult to know how much of the increase in ancillary service use was legitimate (because patient needs had also grown), and how much was due to excessive provision of services to generate additional revenues. GAO and the OIG also identified inappropriate billing practices and inclusion of unreasonable costs as contributors to the rise in SNF costs. For example, a recent OIG report found that, during the 12-month period ending June 30, 1998, Medicare reimbursed nursing homes almost \$1 billion for improperly billed physical and occupational therapy.²⁶ Limited audits of cost reports meant that HCFA had little ability to identify whether facilities were paying unreasonable amounts for services or were charging Medicare for costs unrelated to patient care or other unallowable costs.

OIG recently noted in its review of the SNF PPS that the rate-setting process did not adequately exclude improper SNF payments or the costs for medically unnecessary care.²⁷ The level of overpayments is not known, but it is likely that the PPS payment rates developed from the 1995 costs are high enough to cover appropriate care.

Though the total dollars in the payment system are at least adequate, two weaknesses in the case-mix classification system used in the PPS may hamper the proper allocation of payments across patients and facilities. First, the classification system does not directly account for variation in the costs of nontherapy ancillary services across patients. To the extent that payments do not adequately reflect nontherapy ancillary costs, some

²⁵Balanced Budget Act: Any Proposed Fee-for-Service Payment Modifications Need Thorough Evaluation (GAO/T-HEHS-99-139, June 10, 1999).

²⁶Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, Physical and Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare (OEI-09-97-00122), Aug. 1999.

²⁷Department of Health and Human Services, Office of Inspector General, Review of the Health Care Financing Administration's Development of a Prospective Payment System for Skilled Nursing Facilities, A-14-98-00350 (July 1998).

SNFs could be overpaid, while others could be underpaid. Facilities treating many patients with high nontherapy ancillary costs may be disadvantaged and might respond by declining to admit certain types of patients.²⁸ Second, the classification system may not adequately differentiate among patients and may classify them into too few groups to accurately reflect their expected resource variation. Because the same payment is made for all patients in each case-mix group, patients assigned to a group should be relatively homogeneous in terms of their resource use. There is some concern, however, that this is not the case, particularly for patients needing extensive medical ancillaries (including medication therapy and other nontherapy ancillary services) and rehabilitative therapy.²⁹ Again, there may be significant overpayment or underpayment for patients within the case-mix groups, benefiting some facilities and putting others at a disadvantage. Recent changes in the law will temporarily increase payments for certain types of patients, thereby alleviating this concern. In addition, certain costly nontherapy ancillary services, such as ambulance services for patients needing regular dialysis at a facility outside of the SNF, will be excluded from the PPS and paid for separately.

Adjustments Required by PPS Larger for Some Providers

The BBA provides for a 3-year transition period to allow facilities time to adjust to the new payment system. Under this transition plan, a majority of nursing homes currently receive per diem payments from Medicare that are based largely on their own historical costs.³⁰ For most facilities, the adjustments required should be modest because Medicare payments represent a small share of revenues (about 10 percent, on average). HCFA estimates that Medicare payments under the fully implemented SNF PPS would decline, on average, 17 percent, which would reduce total nursing home revenues by an average of 1.7 percent.³¹ For individual facilities, reductions in revenues under the PPS will be larger or smaller; for some facilities, Medicare revenues will increase. Facilities that historically have served a higher proportion of Medicare patients may experience bigger changes in their revenues, either positive or negative, and may need to modify their treatment patterns more than other facilities.

²⁸Skilled Nursing Facilities: Medicare Payments Need to Better Account for Non-Therapy Ancillary Cost Variation (GAO/HEHS-99-185, Sept. 1999).

²⁹Research currently under way by HCFA indicates that potential refinements to the case-mix model may include the division of the current 44 groups or the addition of new ones. See Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, 64 Fed. Reg. 41,644, 41,648 (1999) (to be codified at 42 C.F.R. pts. 409, 411, 413, and 489).

³⁰There is no transition period for facilities that were not participating in the Medicare program in 1995. Those facilities began to receive the federal rate immediately.

³¹See Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, 64 Fed. Reg. 41,644, 41,678 (1999) (to be codified at 42 C.F.R. pts. 409, 411, 413, and 489).

PPS requires larger adjustments for providers that were inefficient or that furnished a large number of ancillary services. Facilities that overprovided services in the past will have to permanently modify their treatment patterns by furnishing fewer services. Those that were not cost-conscious in purchasing ancillary services and supplies will now need to seek better prices from ancillary providers. Neither of these changes should adversely affect patient care.

For some facilities, the payment rates under the fully implemented PPS may be higher than they are during the transition. Among these facilities are those that, since the base year of 1995, have changed the mix of patients served to include more with intensive needs. The facility-specific portion of the rates reflects their costs of serving patients in 1995 who had fewer needs. Only the federal portion of their rates will be adjusted to reflect the needs of current patients. During the transition period, these facilities may adjust to the payment system by declining to admit certain patients with greater needs. Due to recent changes in the law, beginning on December 15, 1999, facilities may opt to make the transition to the federal rate immediately for cost-reporting periods beginning on or after January 1, 2000.

Financial Condition of Sun and Vencor Related to Factors Other Than SNF PPS

The troubled financial positions of two corporations that operate a large number of SNFs, Sun Healthcare Group, Inc., and Vencor, Inc., have received much public attention in recent months. Both corporations reported significant losses in fiscal year 1998—\$700 million and \$573 million, respectively. Sun expects a similar loss for fiscal year 1999 (\$612 million), while Vencor's estimated loss is much smaller (\$90 million). Industry reports have blamed Medicare payment policies for these losses and for the companies' recent filings for bankruptcy protection. Our analysis, however, suggests that the financial difficulties of Sun and Vencor are the result of several factors beyond the SNF PPS. In fact, the SNF operations of Vencor have remained profitable after the implementation of the PPS, and those of Sun would have as well, had that company's capital costs been in line with the industry average. The losses reported by the companies stem in large part from high capital-related costs; the reduced demand for ancillary services, related to several BBA provisions; and substantial nonrecurring expenses and write-offs.

SNF Operations Not Major Contributor to Financial Losses

In annual reports to the U.S. Securities and Exchange Commission and in public statements, both Sun and Vencor attribute their poor financial position primarily to Medicare's new SNF reimbursement method. Sun's SNF

operating revenues are expected to drop 14 percent in FY 1999, while Vencor's SNF operating revenues will decline about 6 percent. Nevertheless, Sun's SNF operating shortfalls represent only 13 percent of total losses in fiscal year 1998 and 37 percent of estimated total losses in fiscal year 1999. Vencor posted gains in its SNF operations in fiscal year 1998 and expects positive SNF operating income in fiscal year 1999 as well. Thus, factors other than PPS have affected their financial performance.

Sun's focus on serving a patient population with higher service needs is one factor affecting its performance. The corporation invested in the equipment and staff needed to provide complex medical and rehabilitative care during a time when doing so meant getting higher payments from Medicare. Thus, it may be affected more than other facilities by any shortcomings in the PPS case-mix classification system.

The losses experienced by the SNF business operations of Sun and Vencor are primarily due to increasing capital-related costs rather than operating shortfalls. In fact, both companies have cut their SNF operating expenses, such as the costs of labor and supplies, consistent with their declines in revenues, to improve their operating performance. Sun also indicates it has modified its admission policies. As a result, although Sun estimates a 14 percent drop in operating revenue in fiscal year 1999, it projects that its net SNF operating income (excluding capital) will decline only 9 percent. Likewise, Vencor estimates its net SNF operating income (excluding capital) will increase 5 percent in fiscal year 1999, despite a 6 percent decrease in operating revenue.

Table 2: SNF Operating Revenues and Expenses for Sun Healthcare Group, Inc., and Vencor, Inc., Fiscal Years 1997-99

Dollars in millions			
	FY 1997	FY 1998	FY 1999 (annualized)
Sun Healthcare Group, Inc.			
Net operating revenues ^a	\$1,156	\$1,913	\$1,652
Operating expenses ^b	\$950	\$1,633	\$1,398
Capital-related expenses	\$211	\$368	\$481
Net operating income (loss)	(\$5)	(\$87)	(\$227)
Vencor, Inc.			
Net operating revenues ^a	\$1,721	\$1,621	\$1,529
Operating expenses ^b	\$1,454	\$1,370	\$1,267
Capital-related expenses	\$121	\$193	\$218
Net operating income (loss)	\$147	\$57	\$45

Note: Columns may not sum to total due to rounding.

^aNet operating revenues are gross charges minus contractual and other adjustments.

^bOperating expenses do not include capital-related expenses.

Source: Sun and Vencor data provided to GAO.

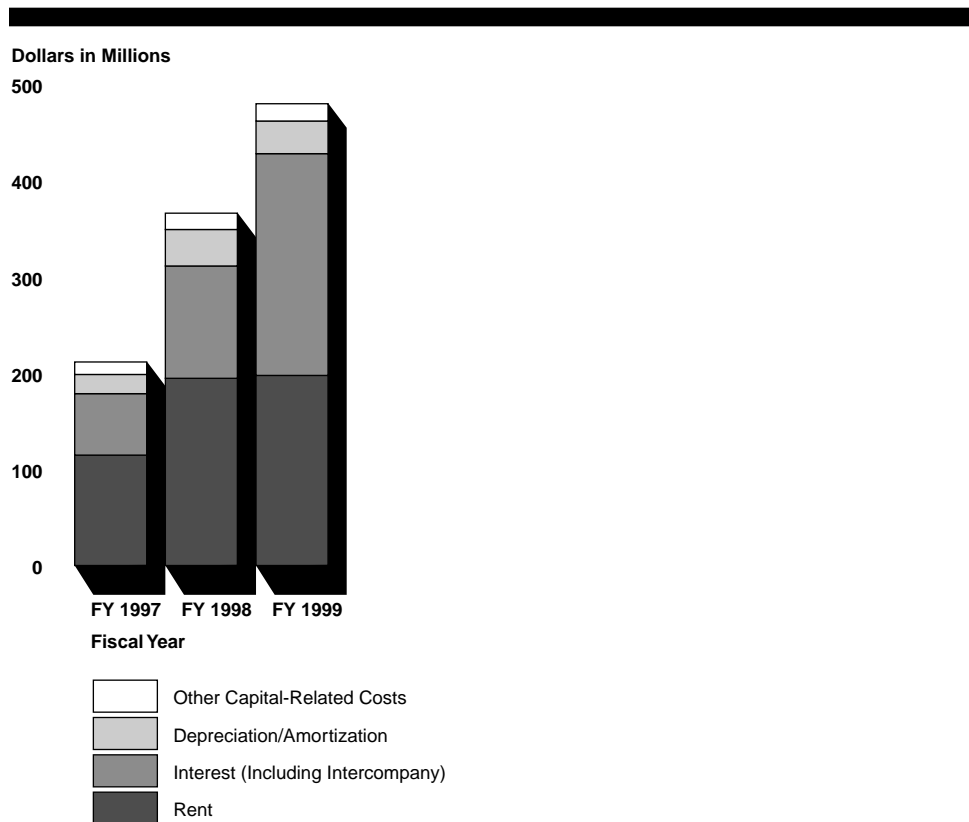
But capital-related costs for both Sun and Vencor have substantially increased. Sun's capital costs, already a larger share of total costs than the industry average, are expected to grow 30 percent in FY 1999 as its interest expenses double³² (see fig. 1). Similarly, Vencor's SNF capital-related costs are expected to rise nearly 80 percent between fiscal year 1997 and fiscal year 1999, driven by a four-fold increase in rental expenses (see fig. 2). During that period, Vencor reorganized into two separate, publicly held corporations, divesting the real property side of its business from the operating side. Ventas, a real estate investment trust, now leases formerly owned real estate holdings, including nursing homes, to the operating company, Vencor. Under the new structure, Vencor's rental expenses rose from \$42 million in fiscal year 1997 to nearly \$170 million in FY 1999.

SNFs operated by Sun and Vencor will likely be more affected by the SNF PPS than will typical facilities because a larger share of their revenues comes from Medicare. Although Medicare patients constitute about 10 percent of total SNF patient days for both Sun and Vencor (similar to the

³²While capital costs for nursing homes average about 12 percent of total costs, Sun's and Vencor's capital costs are estimated to be 26 and 15 percent, respectively, for fiscal year 1999.

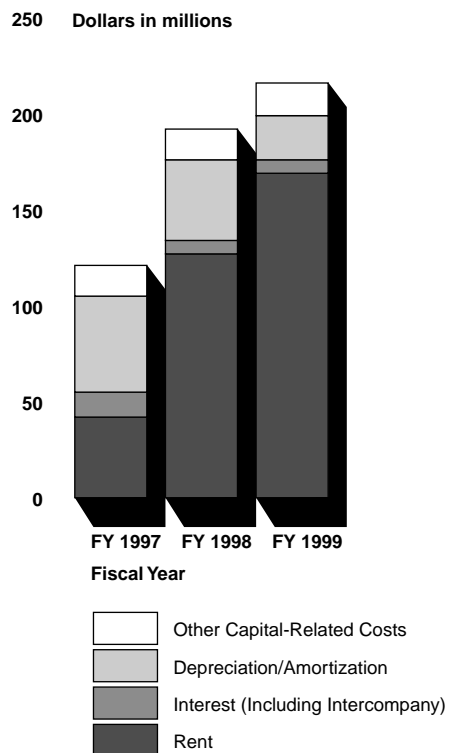
industry average), the corporations report that Medicare revenues are at least 25 percent of their SNF businesses.

Figure 1: SNF Capital-Related Expenses for Sun Healthcare Group, Inc., Fiscal Years 1997-99



Source: Sun data provided to GAO.

Figure 2: SNF Capital-Related Expenses for Vencor, Inc., Fiscal Years 1997-99



Declining Ancillary Revenues Reflect Multiple BBA Provisions

Ancillary revenues from the sale of therapy and other services to their own nursing homes and to others have represented a substantial share of both Sun's and Vencor's total revenues. Prior to BBA (fiscal year 1997), Sun reported net income for its ancillary services business of \$165 million while Vencor had net income of nearly \$104 million.

Several BBA provisions have affected the market for ancillary services. First, the SNF PPS has made SNFs more cost-conscious in purchasing contracted services—reducing both the demand for these services and the prices SNFs are willing to pay for them. Second, the BBA prohibits billing Medicare part B for services furnished to nursing home patients covered under part A. Third, it has revised the payments for therapy services under part B, establishing a fee schedule instead of cost-based reimbursement and thus limiting payments for many services. Finally, it has imposed a per-beneficiary cap of \$1,500 for part B-covered physical and speech therapy services and a per-beneficiary cap of \$1,500 for part B-covered occupational therapy services. These caps primarily affect therapy services for nursing home patients and are therefore likely to affect ancillary providers like Sun and Vencor that furnish services to nursing homes. Following implementation of these provisions, Vencor's reported net operating income for its ancillary operations fell from \$104 million to \$59 million in fiscal year 1998 and is expected to decline further to \$44 million in fiscal year 1999. Sun's net operating income is expected to plummet from \$230 million in fiscal year 1998 to \$9 million in fiscal year 1999.

Table 3: Net Operating Revenues From Ancillary Businesses of Sun Healthcare Group, Inc., and Vencor, Inc., Fiscal Years 1997-99

Dollars in millions			
	FY 1997	FY 1998	FY 1999 (annualized)
Sun Healthcare Group, Inc.			
Net operating revenues ^a	\$775	\$1,185	\$732
Net expenses	\$611	\$995	\$724
Net operating income (loss)	\$165	\$230	\$7
Vencor, Inc.			
Net operating revenues ^a	\$641	\$581	\$440
Net expenses	\$538	\$522	\$396
Net operating income (loss)	\$104	\$59	\$44

Note: Columns may not sum to total due to rounding.

^aNet operating revenues are gross charges minus contractual and other adjustments.

Source: Sun and Vencor data provided to GAO.

Unusual Transactions Account for Bulk of Corporate Losses

Most of the fiscal year 1998 and 1999 losses reported by Sun and Vencor relate to unusual transactions, or nonrecurring charges, such as asset impairment losses and restructuring costs (see table 4). Vencor reported unusual transactions of \$439 million in fiscal year 1998 and estimates another \$35 million to be posted in fiscal year 1999. These entries account for more than 75 percent of Vencor's losses for fiscal year 1998 and almost 40 percent of those for fiscal year 1999. Similarly, nearly \$394 million of Sun's total fiscal year 1998 losses and \$425 million of its total fiscal year 1999 losses are unusual transactions.

The bulk of these unusual transactions for both companies are the result of asset impairment losses. Accounting principles require corporations to calculate and recognize asset impairment losses on their balance sheets when it is determined that future expected revenue streams will be lower than anticipated.³³ This is necessary to inform investors of the performance of the company. The loss appearing on the income statement reflects the difference between an asset's original value and its revised value, based on the revenue the asset is expected to generate in the future. These values do not reflect the patient-care costs that are recognized by the Medicare program. The losses posted by Sun and Vencor may reflect a combination of inflated purchase prices as well as reduced future expected revenues from their assets. For example, approximately \$200 million of Vencor's impairment loss is attributable to an anticipated reduction in the value of its goodwill. Goodwill is an intangible asset—such as name recognition, good customer relations, or high employee morale—that represents the amount paid for an asset in excess of fair market value. These unusual transactions reflect business and accounting practices rather than losses from current operations. It is not known what share of these companies' lower projected value reflects changes due to the implementation of the SNF PPS or other BBA provisions.

³³The American Institute of Certified Public Accountants' Statement of Financial Accounting Standards No. 121 (SFAS No. 121), entitled Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of, requires such impairment losses to be recognized.

Table 4: Net Operating Income, Nonoperating Expenses, and Total Income for Sun Healthcare Group, Inc., and Vencor, Inc., for FYs 1997, 1998, and 1999

Dollars in millions			
	FY 1997	FY 1998	FY 1999 (annualized)
Sun Healthcare Group, Inc.			
Net operating income (loss)	\$116	\$29	(\$72)
Nonoperating revenues	\$12	\$22	\$16
Nonoperating expenses:			
Unusual transactions	\$20	\$394	\$425
Other nonoperating expenses ^a	\$22	\$302	\$125
Nonoperating expenses	\$42	\$696	\$550
Net nonoperating income (loss)	(\$30)	(\$674)	(\$534)
Income tax	\$43	\$56	\$0.8
Total post-tax income (loss)	\$43	(\$701)	(\$606)
Vencor, Inc.			
Net operating income (loss)	\$320	\$116	\$82
Nonoperating revenues	\$0	\$0	\$0
Nonoperating expenses:			
Unusual transactions	(\$14)	\$439	\$35
Corporate overhead	\$80	\$123	\$113
Nonoperating expenses	\$95	\$613	\$172
Net nonoperating income (loss)	(\$96)	(\$613)	(\$171)
Income tax	\$89	\$76	\$0.2
Total post-tax income (loss)	\$135	(\$573)	(\$90)

Note: Columns may not sum to total due to rounding.

^aSun's other nonoperating expenses include bad debt/losses on accounts receivable, gain (loss) on sale of assets, dividends on convertible preferred securities.

Source: Sun and Vencor data provided to GAO.

Conclusions

The BBA mandated a Medicare PPS for SNF services to replace the cost-based reimbursement system, with the goal of fostering more efficient provision and use of services to lower spending growth rates. We found little evidence that this change in payment method has reduced access to appropriate care, although facilities are assessing patients' conditions and projected costs of treatment more closely, even reportedly denying admission to patients needing certain types of services. As a result, some beneficiaries may stay longer in the hospital before being admitted to a nursing home for SNF care or may receive care from other post-acute-care providers. Monitoring of hospital and SNF lengths of stay and admissions is

required to ensure that Medicare beneficiaries continue to have access to medically necessary services. The PPS represents a major change to the previous incentives of cost-based reimbursement and, as a result, facilities may need to modify treatment practices and business strategies that were advantageous under the previous payment method if they are to operate profitably.

Agency and Other Comments

In written comments on a draft of this report, HCFA emphasized its commitment to ensuring that Medicare beneficiaries retain access to quality skilled nursing care. HCFA acknowledged concerns that the payment system may not fully reflect the costs of treating certain types of patients and stated its intent to continue monitoring access to care under the SNF PPS and to refine and improve the payment system. HCFA also noted that, in light of the recent reports of financial troubles in some nursing home chains, it has taken steps to ensure that states develop contingency plans for protecting nursing home patients. In addition, it has provided guidance to help states monitor conditions in nursing homes that are experiencing financial difficulties. HCFA also provided technical comments, which we incorporated where appropriate. The agency letter is reproduced in appendix II.

In their comments on portions of the draft related to them, both Sun and Vencor agreed that their financial situations were accurately represented. Both corporations acknowledged that their financial difficulties are the result of many factors, not just of the PPS. Both expressed general concerns that the effect of the BBA is only beginning to be felt and predicted that there will be more bankruptcy filings among nursing home chains and perhaps among independent nursing homes as well.

Vencor also submitted updated financial information, consistent with data shown in the report, illustrating that their SNF operations remain profitable and that a substantial portion of the corporation's overall losses pertains to other lines of business. (We did not include this updated information in the report because it did not change our conclusions. In addition, its format was different from that of the original data submitted and therefore was difficult to compare with information from previous years.)

Sun pointed out that part of the company's financial difficulties stems from having higher-than-average costs. Sun noted that such costs were not excessive under cost-based reimbursement. PPS, however, a system based on national averages, will not fully cover these costs. Sun also said that we

did not appropriately attribute the reductions in the demand and pricing for ancillary services to the implementation of PPS. In fact, the report clearly states that PPS is a factor in the reduced demand for ancillary services. Finally, Sun noted that its impairment losses are an accounting recognition of the economic reality that PPS has materially devalued Sun's nursing home assets. At the same time, Sun acknowledged that the company may have paid too much for the assets it acquired. Representatives of the corporation went on to express concern that any reduction in the value of nursing home assets would discourage the construction of new nursing facilities and thus adversely affect access to care. At the present time, however, our evidence indicates that beneficiaries continue to receive needed care.

Sun also expressed concern that their views about the PPS, obtained in interviews with GAO staff, were not included in the portions of the report Sun reviewed. Although not attributed directly to any individuals, the views of representatives from Sun and Vencor, as well as from other industry participants and analysts, were an important source of information and were incorporated into the report.

We are sending copies of this report to Michael Hash, Acting Administrator of HCFA, interested congressional committees, Sun Healthcare Group, Inc., Vencor, Inc., and other interested parties. We will also make copies available to others upon request.

If you have any questions, please call me or Laura Dummit, Associate Director, at (202) 512-7119. Major contributors to this report are listed in appendix II.



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

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Abbreviations

BBA	Budget Balance Act of 1997
HCFA	Health Care Financing Administration
OIG	Office of Inspector General
PPS	prospective payment system
SNF	skilled nursing facility

Scope and Methodology

To assess the effect of the prospective payment system (PPS) on access to skilled nursing facility (SNF) care, we interviewed hospital discharge planners about their recent experiences placing Medicare beneficiaries needing SNF care in nursing homes. Because SNF reimbursement under Medicare is dependent on a minimum 3-day hospital stay, nearly all Medicare beneficiaries receiving SNF services are first evaluated by a member of the hospital discharge staff. Discharge planners offer valuable information because they are professionals who help Medicare patients leaving the hospital find nursing homes that will provide them with appropriate care. We used structured interviews to elicit their opinions on whether changes in reimbursement policies have affected beneficiary access to care.

We identified and categorized hospitals using the Medicare Cost Reports for calendar year 1997. Only general short-term hospitals were included for study.³⁴ Swing-bed hospitals and hospitals with an affiliated SNF were eliminated from the pool to focus the study on those hospitals where patients would be most at risk of experiencing access problems. A simple random sample was used to choose the hospitals from the remaining population. We contacted discharge planners by telephone in 200 of these hospitals and completed interviews with 153. Urban hospitals represented two-thirds of the respondents, although they make up only 55 percent of hospitals nationwide. All 50 states (and the District of Columbia) were eligible for participation in the study; 43 were represented by the completed surveys.

We obtained testimony from Wall Street industry analysts to gain an understanding of the financial incentives driving the SNF industry before and after implementation of the Balanced Budget Act of 1997, as well as insight into the operational history of specific nursing home chains.

In addition, we interviewed the presidents and, in some cases, other senior management representatives of Sun, Vencor, and Beverly Enterprises, Inc. (Beverly). Sun and Vencor were chosen for examination because of their highly publicized financial problems and the distinct possibility that they would petition for bankruptcy protection under Chapter 11 of the U.S. Bankruptcy Code. As a national nursing home chain not in danger of filing for bankruptcy, Beverly offered perspective on the circumstances of Sun and Vencor.

³⁴Psychiatric hospitals, rehabilitation hospitals, cancer hospitals, childrens' hospitals, and long-term-care hospitals (those with an average length of stay exceeding 25 days) were excluded from the analysis.

Appendix I
Scope and Methodology

Documentary evidence used in analyzing the effect of PPS included both financial information provided by Sun and Vencor, and their corporate filings from the United States Securities and Exchange Commission. The filings are available under the 1934 Exchange Act and contain material financial and business information on publicly traded companies. Under the act, companies are obliged to keep such public information current by filing periodic reports on Forms 10-Q and 10-K, and on current event Form 8-K, as applicable.

Comments From the Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: NOV 22 1999

TO: Laura Dummit, Associate Director
Health Financing and Public Health Issues
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator
Health Care Financing Administration

SUBJECT: GAO Draft Report, "Skilled Nursing Facilities: Access to Care Maintained Under Prospective Payment System But Adjustments by Providers Needed," (GAO/HEHS-00-23R)

Thank you for the opportunity to review and comment on your draft report to Congress concerning the effects of the skilled nursing facility (SNF) prospective payment system (PPS). We appreciate GAO's continuing work to assess the impact of the changes in Medicare's payment system for nursing homes on the access to care for beneficiaries. We share a commitment to ensuring beneficiaries retain access to quality skilled nursing care. Given the difficulty in assessing the impact of this new payment system in its early stages of implementation, the report provides valuable insight into the effects of the SNF PPS on access to care for Medicare beneficiaries. In addition, its discussion of the various factors contributing to the present financial difficulties of certain SNF operators is insightful. We believe the report makes a significant contribution to the Health Care Financing Administration's (HCFA) ongoing efforts to aggressively monitor the impact of the Balanced Budget Act of 1997 (BBA).

HCFA worked actively with the Congress this year as it considered refinements to the SNF PPS to support access to quality care for the neediest of beneficiaries. We suggest that GAO may wish to consider the potentially mitigating effect of certain proposed BBA refinements that will likely be enacted by the time the final report is issued. For example, Congress is currently considering legislation to exclude from the SNF PPS two services that the report specifically cites as being problematic: chemotherapy services, and ambulance transportation associated with dialysis services. We will move quickly in the coming months to implement any changes that are enacted. A fundamental premise of the Medicare program is that Medicare beneficiaries deserve access to quality nursing home

**Appendix II
Comments From the Health Care Financing
Administration**

Ms. Laura Dummit – Page 2

care, and HCFA looks forward to working with the GAO and others to ensure that program policy supports this goal.

We know that there are concerns that, for some high-acuity patients, the payment system may not fully reflect the costs of non-therapy ancillary services and that patients requiring these services are having difficulty getting the care they need. Although we are gratified to learn of your finding that few beneficiaries are experiencing barriers to needed care, we are continuing to monitor the situation and are taking steps to refine and improve the system. We are currently conducting research that will assist us in making refinements to the system, if appropriate, next year. In addition, we are interested in your finding that SNFs express a preference for admitting patients in need of short-term rehabilitation. This, taken with a similar finding by the Inspector General, suggests that Medicare payments for these patients are adequate to meet their needs.

In 1998, HCFA embarked on an aggressive new initiative to strengthen federal and state nursing-home standards and to promote quality care for the 1.6 million Americans living in nursing homes. Since then, we have strengthened the inspection process to increase its focus on preventing bedsores, malnutrition and abuse, and required states to crack down on homes that repeatedly violate health and safety requirements.

In light of recent public reports of financial troubles at some nursing-home chains, HCFA has been working with the Office of the Inspector General, the Department of Justice, and the states since this spring to ensure that residents continue to get the kind of care that they deserve and that is required by federal and state regulations. We have also taken steps to ensure states develop and refine contingency plans for safeguarding residents. In addition, we have provided guidance to help states monitor conditions in nursing homes experiencing financial difficulties. States are already successfully monitoring nursing homes that are under financial distress, and the reports that we have received to date suggest that residents remain safe. **We are confident that the states will be able to move quickly to protect residents if such steps ever become necessary.**

We appreciate the effort that went into this report and the opportunity to review and comment on the issues raised. We look forward to working with GAO on this and other issues.

Attachment

GAO Contacts and Staff Acknowledgments

GAO Contact

Laura Dummit, (202) 512-7119

Staff Acknowledgments

Carol Carter, Dana Kelley, Erin Kuhls, and Carolyn Manuel-Barkin made key contributions to this report.

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