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EXTENDED CARE FACILITIES—SKILLED NURSING FACILITIES

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UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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EXTENDED CARE FACILITIES—SKILLED NURSING FACILITIES

Serious problems have arisen with respect to the skilled nursing home benefit under medicaid and the extended care benefit under medicare.

In the case of medicare, the definition of eligibility has been extremely difficult to apply objectively and, consequently, has led to great dissatisfaction on the part of patients, providers and practitioners, resulting in many facilities' refusal to participate in medicare and widespread retroactive denial of benefits. These retroactive denials have worked particular hardships on patients and extended care facilities. The entire matter of coverage of extended care beneficiaries has given rise to the greatest amount of day-in-day out complaint concerning medicare. The benefit is not proving out as intended, namely, as an extension of necessary care which would otherwise have to be provided in the hospital. Of course, the above findings do not excuse the efforts of some facilities to manipulate the program so as to increase reimbursement through attempts to make otherwise ineligible beneficiaries appear eligible.

Medicaid has its own set of problems with respect to skilled nursing home care. These include, according to G.A.O. and the H.E.W. Audit Agency, widespread inappropriate placement of patients in skilled nursing homes who more properly belong in other institutional settings—such as intermediate care facilities—and widespread noncompliance with required standards. It appears difficult to insist that a skilled nursing facility meet all necessary standards without, at the same time, assuring that reimbursement is equitable for necessary care in the peoper setting. In general, that is not the case today. The Comptroller General and others have reported on the often irrational payment mechanisms developed and utilized by most States in reimbursing for nursing home care. On an aggregate basis, it appears that nursing homes are not underpaid. However, because of the arbitrary payment structures in many States, in all probability, many facilities are being overpaid for the care they provide while others are being underpaid.

With a view toward solving some of these problems, the staff and the Department have developed a series of suggestions for the Committee's consideration which we believe would, in large part, resolve these issues, if properly implemented.

The recommendations discussed below relate to:

I. Conditions of facility participation.
II. Levels of care requirements.
III. ECF 14-day transfer requirement.
IV. Reimbursement rates.
V. Basic standards and certification procedures.

I. Conditions of Facility Participation

The Committee, both in 1970 in connection with H.R. 17550 and again recently during consideration of H.R. 1, approved provisions conforming basic standards for extended care facilities under medicare and skilled nursing facilities under medicaid. These standards relate to health, safety, environmental conditions and staffing. The rationale for the provision was stated in the following material in the 1970 Committee report:

Conform Medicare and Medicaid Standards for Nursing Facilities

(Sec. 240 of the bill)

At the present time, the conditions of participation for extended care facilities under medicare and the standards required of skilled nursing homes under medicaid are identical in some respects and similar in others. In large part, medicaid skilled nursing homes were substantially upgraded as a consequence of the specific statutory requirements applicable to such homes which were included in the Social Security Amendments of 1967.

While the emphasis of the care under the two programs may differ somewhat—medicare focusing on the short-term care patient and medicaid on the long-term patient—patients under both plans require the availability of essentially the same types of services and are often in the same institution. Indeed, not infrequently, after expiration of medicare benefits, the patient may remain in the same facility—even in the same room—continuing on as a medicaid recipient.

Because of the substantial similarities in the services required of skilled nursing facilities under the two programs, the existence of separate requirements (which may differ only slightly) and separate certification processes for determining institutional eligibility to participate in either program, is both administratively cumbersome and unnecessarily expensive. The same facility is more often than not approved to provide care under both medicare and medicaid.

The Committee believes it would be desirable to apply a single set of standards relative to health, safety, environmental conditions, and staffing, with respect to skilled nursing facilities under both medicare and medicaid. As provided in the House bill, States would also be expected to consolidate certification activities for both programs in a single State agency. The Committee intends that the single State agency carry out its responsibilities to the greatest extent possible through means of a single consolidated survey to determine a facility's qualifications for medicare and medicaid.

The Committee amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities.

Recommendation:

While the amendment was adopted by the Committee, the staff and the Department suggest that, in order to remove the remaining deficiencies in interpretation and conflicting policy, there be a single definition and single set of standards for the skilled nursing home and the extended care facility. The definition would incorporate the best features of the medicaid and medicare requirements.

Conditions of facility participation

While the SNF and ECF regulations are virtually identical in concept, they are susceptible to different interpretations and application from State to State. As a result, there are varying degrees of difference within a State between the rules governing participation in the two programs. The Department and the staff believe that ECF's and SNF's should be subject to the same basic minimum standards and that facilities found eligible under one program should be recognized by the other.

The definition of facilities should be the same under medicare and medicaid. Medicaid staff indicates that this will impose no additional burden on that program.

The proposed change could be accomplished by (1) substituting the medicaid term "skilled nursing facility" for the medicare term, (2) providing that facilities which satisfy the new definition of "skilled nursing facility" under one program shall be eligible to participate in the other and (3) by adding to the present medicare definition of the facility in section 1861(j) the following four medicaid requirements as paragraphs (10), (11), (12) and (13):

"(10) supplies full and complete information as to the identity (i) of each person having (directly or indirectly) an ownership interest of 10 per centum or more in such nursing home, (ii) in case a nursing home is organized as a corporation, of each officer and director of the corporation, and (iii) in case a nursing home is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied;

"(11) participates in an effective program pursuant to section 1902(a)(26) of this Act, which provides for (A) a regular program of medical review (including medical evaluation of each patient's need for skilled nursing facility care); (B) for periodic inspections to be made in skilled nursing facilities of the care provided for purposes of determining (i) the adequacy of services available to meet the current health needs of each patient; (ii) the necessity and desirability of continued placement of such patients in such nursing facilities; and (iii) the feasibility of meeting their health needs through alternative institutional and noninstitutional services; and

"(12) meets such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; and

"(13) operates under the supervision of an administrator licensed under a State program which meets the requirements set forth in section 1908 for licensing of administrators of nursing homes; and"

II. Levels of Care Requirement

To be eligible for ECF benefits, the patient is required to be admitted to an ECF as an inpatient in order to receive skilled nursing care on a continuing basis. The staff proposes that this "level of care" requirement be modified in a way that would make the ECF benefit more effective in promoting early discharges from the hospital. The Department's reservations on this recommendation are based solely on the fact that the proposal would increase medicare costs somewhat. It is proposed that this medicare requirement also be made a requirement under the medicaid program.

A change in the level-of-care requirement which would be consistent with both the role ECF's and SNF's are structured to play would be to redefine the level-of-care requirement so that patients could qualify for benefits on the basis of the daily need for either skilled nursing and/or other skilled services. Such a modification could be carried out by amending section 1814(a)(2)(C) by deleting the phrase "because the individual needs or needed skilled nursing care on a continuing basis" and inserting in lieu thereof: "because the individual needs or needed skilled nursing care and/or skilled rehabilitation services on a daily basis in a skilled nursing facility which it is practical to provide only on an inpatient basis." In the case of medicare the care must be for the condition for which the beneficiary was hospitalized.

Committee report language could indicate that both the availability of alternative facilities and services and the patient's condition would be taken into account in determining whether his need for daily skilled care justifies the utilization of a skilled nursing facility rather than a more economical alternative. In addition, the language could indicate the Committee's intent to cover under both programs skilled services which prevent deterioration of the patient's condition and sustain the patient's current capacities even when medical improvement or recovery is not possible.

Under the proposed approach, nonambulatory stroke victims whose needs are for regular skilled rehabilitative services but not necessarily skilled nursing services could qualify if such services can, as a practical matter, be provided them only in the skilled facility setting. The simplified benefit approach could very well result in increased ECF benefit costs. The Department estimates such costs at $65 million during the first full year of operation. However, to some extent those costs should be offset by reduced expenditures for hospital care and reduced medicaid costs. Medicare staff indicates no administrative difficulties flowing from such a change and medicaid staff indicates no added problem from the more precise spelling out of coverage requirements that are more strict than at least some States now apply.

In some cases patients will be placed in a skilled nursing facility who require intermediate care, not skilled care (skilled care defined as a service required to be provided by or under the supervision of skilled personnel). During the period when these patients do not require skilled care, medicare would generally make no payment.

Under medicaid, however, the care would be paid for at an amount commensurate with the intermediate level of service required, not at the amount paid for skilled care. Of course, during a stay in which skilled services were normally required and provided, if there was a day or two on which no skilled services were provided but discharge from the skilled facility for that brief period was not practical, medicare would pay for the services provided.

The Professional Standards Review Organizations could provide assurances that appropriate patient placement was being made and the inspector-general would also observe the operation of the provision.

III. 14-day Transfer Provision

It is also suggested that it might be appropriate to amend the medicare ECF benefit requirement that the patient's transfer to the ECF take place within 14 days of his discharge from a hospital. Under the proposal, intervals of more than 14 days would be permitted when immediately following discharge from the hospital, the patient's condition did not permit immediate provision of skilled services, or the nonavailability of appropriate bed space in facilities ordinarily utilized in the geographic area, prevented admission for not longer than 2 weeks beyond the 14 days. The 14-day limitation is intended to help provide assurance that the ECF benefit is limited to cases where the care received is a continuation of hospital care.

For example, a patient with a fractured hip may require little in the way of skilled care for several weeks after his discharge from the hospital because the fracture will not have mended to the point where physical therapy and restorative nursing can be utilized. In such a case, it would be reasonable to begin payment of ECF benefits when the patient begins an active program of skilled care even though more than 14 days will have elapsed since his transfer from the hospital because the rendition of the skilled care would be clearly related to his hospitalization. The cost of this change would not be significant.

IV. Reimbursement Rates

Under the medicare program ECF's are paid on the basis of a formula which provides for the reimbursement of the reasonable costs they incur in providing covered services plus, in the case of proprietary institutions, an allowance related to the owner's net capital equity. The medicaid statute leaves the States free to develop their own bases for reimbursement to SNF's. Concern has been expressed that some SNF's are being overpaid by medicaid while others are being paid too little to support the quality of care that medicaid patients are expected to receive. Since medicaid's enactment, the Federal Government has enacted additional requirements intended to assure that federally-aided patients receive proper care in a proper setting.

It is proposed that the medicaid law be amended to require States to pay SNF's and intermediate care facilities by July 1, 1974, on a reasonable cost-related basis, using acceptable cost-finding techniques to determine what is reasonable cost and applying to the results appropriate methodologies for determining payment. The methods would have to be approved and verified by the Secretary. Methodologies which the Secretary might authorize States to use might

include: a reasonable cost formula similar to that established for the medicare program; prospective-rate reimbursement under which the payment to the facility would be related to the cost a reasonably efficient SNF could be expected to incur; and similar innovative, cost-based methods. Any methodology should include adequate procedures for auditing, as necessary, the financial records of an institution. The Secretary would be expected to validate, on site, a State's methodology through sample audits. Cost reimbursement methods which the Secretary would find acceptable for a State's medicaid program would be adopted, with appropriate adjustments, in the State for purposes of medicare reimbursement in accordance with the amendment, described below, which the Committee approved in 1970 as part of H.R. 17550.

The reasonable cost reimbursement approach of the medicare program has created difficulties for extended care facilities. The detailed and expensive cost-finding requirements have proved extremely cumbersome, and the lack of advance knowledge of actual payments impedes effective budgeting and planning. Further, the extended care facility has no incentive to contain costs or control delivery of services since virtually all costs are reimbursable.

Under medicaid, however, institutions generally know in advance how much income can be expected as well as the types of services which are expected to be furnished to their patients. The skilled nursing home has an economic incentive to contain costs and deliver its services economically and efficiently.

The 1970 provision approved as part of H.R. 17550 would authorize the Secretary of Health, Education, and Welfare to adopt (and adjust as specified), as reasonable-cost payments for extended care facilities in any State, the rates developed in that State under medicaid for reimbursement of skilled nursing care, if the Secretary finds that they are based upon reasonable analyses of costs of care in comparable facilities.

The Department and the staff suggest reapproval of that amendment. Thus, in the event the committee approves the prior suggestion with respect to rational reimbursement of skilled facilities under medicaid, by July 1, 1974, medicare reimbursement for extended care would be made on a simplified and predictable basis related to medicaid payment to a facility.

V. Basic Standards and Certification Procedures

It is suggested that the final decision as to whether a facility is qualified to participate as a "skilled nursing facility" in both the medicare and medicaid programs be made by the Secretary. As is now the case under the medicare program, the appropriate State health agency would survey a facility that wishes to participate in these programs and report to the Secretary its findings. The President has recommended and the staff suggests approval of 100% Federal financing of the survey and inspection costs attributable to the medicare and medicaid programs. The Secretary would make a determination as to eligibility and advise the State if a facility

meets the basic requirements for a "skilled nursing facility." A State could for good cause decline to accept as a participant in the medicaid program a facility certified by the Secretary. However, a State could not overrule the Secretary and receive Federal medicaid matching funds for any facility not approved by the Secretary.

Authority for Demonstration Projects Concerning the Most Suitable Types of Care for Beneficiaries Ready for Discharge From a Hospital or Skilled Facility

Present medicare policy

Under present law, when a medicare beneficiary who has recovered from a condition for which he was hospitalized still requires medical care for that condition, there are only two alternative levels of covered care available to him which are furnished by providers of services: (1) the beneficiary may be transferred to a participating extended care facility (ECF) where he may receive up to 100 days of covered care in a benefit period; or (2) he may receive up to 100 covered home health visits in a calendar year following discharge from the hospital under part A and an additional 100 home health visits under part B.

Problem

It is not unusual, however, for a previously hospitalized medicare beneficiary to need services other than those described above and sometimes these services are not covered under the program. A beneficiary who is discharged from a hospital may need further institutional care for a condition for which he was hospitalized, but the care required is not skilled care.

Proposal

The staff and the Department recommend that the provision in H.R. 1 authorizing the Secretary to conduct experiments and demonstration projects be expanded. The authority could also include experiments and projects designed to determine the most suitable level of care for medicare beneficiaries who are ready for discharge from a hospital, or who are unable to maintain themselves at home without assistance.

The experiments and demonstration projects could include (1) making medicare payment for each day of care provided in an ICF, count as one covered day of ECF care, if that care was for the condition for which the person was hospitalized, (2) covering the services of homemakers (not exceeding 3 weeks), where institutional services are not needed, (3) determining whether such coverage would effectively lower long-range costs by postponing or precluding the need for higher cost institutional care or by shortening such care, and (4) ascertaining what eligibility rules may pe appropriate and the resultant costs of application of various eligibility requirements, if the project suggests extension of coverage would be desirable.

These experiments and projects would be conducted only in areas where there is effective professional control precluding inappropriate utilization, as determined by the Secretary.

Waiver of Registered Nurse in Rural Skilled Nursing Facility

On March 7, the Committee considered the provision in the House bill which would authorize a waiver of the requirement for a full-time registered nurse in rural skilled nursing homes. The Committee passed over this provision and asked the staff to study alternative proposals which would recognize the difficulty some of these skilled nursing homes encounter in trying to find enough registered nurses to staff the nursing home 7 days a week.

Discussion

Under Federal law, payments under medicaid are made to skilled nursing homes only for patients who are in need of regular skilled nursing services. Examples of skilled nursing services (as defined by the State health officers) are:

The administration of potent and dangerous injectable and intravenous medications on a regular basis;

Maintenance of tracheotomies and gastrotomies; (these are surgical openings directly into the airway or stomach necessary for a patient's unobstructed respiration or feeding);

Administration of tube feedings; and

Administration of medicinal gases on a regular basis.

There are a large number of patients who need these services on a daily basis.

Problem

There are some rural nursing homes which can obtain a registered nurse to work one shift 5 days a week, but which are unable to obtain the services of an additional registered nurse to work on the other 2 days, generally the weekend. The House bill would allow a complete waiver of the requirement for a registered nurse in a rural nursing home, if there is no other skilled nursing home in the area to meet patient needs. Under the bill a skilled nursing home could function without any skilled nurse at all.

Proposal

(1) A solution along the lines of the committee's discussion would allow such a rural skilled nursing home, which has one full-time registered nurse and is making good faith efforts to obtain another, a special waiver of the nursing requirement with respect to not more than 2-day shifts. This special waiver could be authorized if the facility had only patients whose physicians indicated that each such patient could go without a registered nurse's services for a 48-hour period. The physicians orders and admission note should reflect this fact.

(2) Alternatively, if the facility had any patients for whom physicians had indicated a need for daily skilled nursing services, the facility would have to make arrangements for a registered nurse or a physician to spend such time as was necessary at the facility on the uncovered day to provide the skilled services needed.