The Underused Benefit: Medicare's Coverage of Nursing Home Care

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MEDICARE COVERS NURSING HOME CARE AS A lower cost alternative to extended hospital stays. Because Medicare policies impede beneficiaries' access to covered services, however, patients often cannot substitute nursing home for hospital care and the program forgoes intended savings.

Medicare's benefits for nursing home care differ from all its other benefits. Limited by law to short-term postacute care, Medicare-covered services account for only a small portion of the care nursing homes provide. Hence Medicare depends on service for a nursing home industry oriented toward long-term non-Medicare patients. Medicare has never recognized its limited purchasing power. On the contrary, Medicare's payment, certification, and claims processing rules depart from predominant industry practices. Medicare's payment methods acknowledge neither the costs of the more intensive care its patients sometimes require nor the costs of satisfying its particular rules. Consequently, many nursing homes (about a third) that could participate in Medicare do not, and many participating nursing homes limit their Medicare service.

Nursing homes' willingness to provide Medicare-covered service has declined in recent years. Medicare-covered days per beneficiary dropped

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17 percent between 1977 and 1979, with no change in coverage rules or perceived decline in the demand for service (Health Care Financing Administration, 1981). The consequences have been extended hospital stays, as patients try to find a nursing home willing to take them. Estimates of these so-called "back-up days" range from 1 million to 9.2 million per year (Feder and Scanlon, 1981). Medicare pays for most of these days in the hospital, where routine costs are about four times what a nursing home would cost. Limited access to nursing homes also imposes costs on beneficiaries and state Medicare programs. When admitted to a nursing home, patients (or Medicaid, for patients who qualify) pay for services that Medicare could cover.

The severity of this access problem is not uniform across all areas. Medicare-covered days per enrollee vary tenfold across states (Health Care Financing Administration, 1981). In some areas, transfers of Medicare beneficiaries from hospitals to nursing homes occur smoothly and quickly. In others, such transfers are impossible.

This article explores the policies that limit the availability of Medicare-covered service and the reasons why availability varies from place to place. Basically, we will demonstrate that Medicare is dependent for service on a market dominated by the state-run Medicaid program. Medicaid policies of the states determine whether facilities exist to serve Medicare patients and whether nursing homes will find Medicare patients attractive. We describe the reasons for Medicare's dependence on Medicaid policies, the kinds of policy differences that inhibit access to Medicare-covered service, and the consequences of policy differences for Medicare beneficiaries, states, and the federal government.

Findings are based on analysis of available secondary data and interviews with central and regional officials in the Health Care Financing Administration, representatives of Medicare intermediaries, state Medicaid officials, nursing home operators and association representatives, hospital discharge planners, and nursing home ombudsmen.

Medicare's Role in the Nursing Home Market

Medicare is a minor actor in the nursing home market. The program provides only 2 percent of total industry revenues, and over half the facilities certified for Medicare (two-thirds of all skilled facilities)

reported less than 5 percent Medicare days in 1977. In contrast, Medicaid provides half the industry's revenues and supports, at least partially, 60 percent of nursing home residents (National Center for Health Statistics, 1977).

The difference in the two programs' importance results from differences in their definitions of covered care. First, Medicare covers skilled care; Medicaid, skilled and intermediate care. Second, Medicare defines skilled care far more narrowly than do many state Medicaid programs. According to the law, both Medicare and Medicaid are to limit coverage for skilled care to persons needing:

> . . . on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis . . . (P.L. 92-603, 1972, Section 247)

In practice, the two programs define skilled coverage differently and finance different types of skilled-level nursing home care. Designed by law as an alternative to extended hospital stays, the Medicare skilled nursing home benefit offers elderly and disabled beneficiaries a maximum of 100 days of intensive nursing or rehabilitation care following a hospital stay. Most Medicare patients obtain short-term coverage for nursing or rehabilitation services delivered on a daily basis.

In contrast, Medicaid, which covers health care for the poor, finances relatively long nursing home stays in skilled as well as intermediate care facilities. Medicaid skilled benefits are not limited to 100 days and do not require a prior hospital stay. More important in explaining longer stays is the fact that in many states Medicaid-covered patients are receiving general rather than specific skilled nursing services (including supervision of aide-delivered assistance in activities of daily living) or have mental or physical problems that make them difficult for nursing homes to manage.

Medicare Benefits

Medicare limits its coverage and liabilities for nursing homes in several ways. Medicare is prohibited by law from covering custodial care. To

assure that care is "skilled," in ambiguous cases program rules tie coverage to changes in patients' conditions. Medicare also limits its liabilities by determining coverage *after* care has been delivered and by putting nursing homes at financial risk for submitting claims that Medicare's fiscal agents (intermediaries) reject.

Unless patients are receiving specific treatments (like intravenous or intramuscular injections, tube feedings, or aspiration of air passages), Medicare coverage for skilled nursing care is difficult to obtain. The law authorizes coverage for nursing observation or supervision of unskilled services, but regulations restrict coverage for observation to patients whose condition is "unstable" and supervision to cases with a "high probability" of complications. It is the nursing home's responsibility to document "instability" or "risk," typically by providing evidence of actual changes in a patient's condition. A patient whose only needs are for assistance in activities of daily living or whose deterioration reflects the aging process and not a specific medical condition would not be covered.

Coverage for skilled rehabilitation services is similarly dependent upon changes in patients' conditions and their documentation. Regulations define care as skilled only when patients have "rehabilitation potential"—a potential for "significant" improvement in the condition being treated within a "reasonable" (and generally predictable) period. Patients who have reached their "rehabilitation potential" are judged to need only "maintenance therapy," which is not considered a skilled service once a professional has developed a plan of care.

Coverage is determined after care has been delivered, when the nursing home submits a claim. A nursing home will be liable for claims denied if more than 5 percent of the days the home claimed as covered in the previous quarter were denied by the intermediary. Although most homes do not exceed this ceiling, this performance often reflects a conservative interpretation of Medicare rules. Determination that a patient was "unstable," at "risk," or lacking "rehabilitation potential" is considerably more precise ex post than ex ante. Skilled practitioners often differ considerably in making prognoses, particularly short-term ones, about individual patients. To assure certainty of payment, minimize burdens of documentation, and avoid financial risk, homes are likely to inform patients not receiving treatments clearly labeled skilled that they are ineligible for Medicare coverage.

Although there is considerable variation in intermediaries' interpretation of coverage rules (Smits et al., 1982), the rules and the coverage process have effectively limited Medicare benefits to the short-term nursing home care specified in the Medicare statute. The effectiveness of these criteria is demonstrated by the fact that 1977 Medicare-covered stays averaged 28.1 days, as compared with a 227-day average stay for all patients in skilled nursing homes (Helbing, 1980; National Center for Health Statistics, 1977).

Medicaid Benefits

Since 1972, federal law has required Medicare and Medicaid to apply the same criteria for skilled-level coverage. Some states (e.g., Oklahoma, Iowa, Texas, and Oregon) do apply coverage criteria equivalent to or more restrictive than those of Medicare and, as a result, finance very little skilled care. But other states interpret coverage criteria more broadly than Medicare. The breadth of these criteria is apparent from Medicaid patients' extensive use of skilled nursing facilities. In fiscal year 1979, Medicaid programs paid for more than 80 million days in skilled nursing facilities (Health Care Financing Administration, 1980); Medicare paid for only 8 million days (Health Care Financing Administration, 1981). Almost 80 percent of the Medicaid-covered days went to elderly Medicaid recipients who were potentially eligible for Medicare-covered days (Health Care Financing Administration, 1980). Although Medicaid does not require a hospital stay prior to nursing home coverage, it is unlikely that the absence of this requirement explains the high volume of Medicaid coverage. Preliminary evidence from Health Care Financing Administration (HCFA) demonstrations eliminating the 3-day hospital stay requirement for Medicare indicates that Medicare's definition of covered care—not the prerequisite hospital stay—is the primary factor limiting Medicare use (Schwartz et al., 1980).

States with broader interpretations of skilled coverage than Medicare define coverage in different ways. While Medicare tends to tie coverage to changes in patients' conditions, some states award benefits for maintenance therapy and supervision of an aggregate of unskilled services based on a patient's current status. Massachusetts, for example, allows skilled coverage for maintenance therapy to patients with advanced Parkinson's disease. In contrast, Medicare intermediaries indicate that such coverage would be inappropriate if patients have

reached their "restoration potential" and do not require skilled nursing care.

Functional limitations are sometimes explicit criteria for coverage, as in Massachusetts. Until recently, Connecticut offered an extreme example of this approach, classifying as "skilled" all patients who are incapable of leaving the facility independently in the case of an emergency. Medicare intermediaries emphasize that a person whose needs for institutional care rest solely on functional incapacities is not eligible for Medicare coverage.

Some states have made "skilled" care synonymous with higher cost care. When a patient needs more services than can be purchased at rates paid to intermediate facilities, the care is classified as skilled. This policy may explain states' willingness to cover supervision of patients needing extensive assistance. Skilled classification, with its higher rates, may also be necessary to assure access to care for other patients likely to impose extra costs on nursing home operators (patients with psychiatric problems, special dietary needs, etc.).

Differences between Medicare and Medicaid skilled coverage also result from differences in the programs' procedures for determining coverage. Medicare coverage is determined retroactively (although some intermediaries give informal indications of coverage in advance). Medicaid coverage is guaranteed prospectively by program officials. Nursing homes have little or no responsibility for patient classification. Furthermore, Medicaid coverage is approved for relatively long periods—30, 60, or 90 days—in cases for which Medicare coverage would depend on changes in a patient's condition. Medicare makes its decisions on the basis of actual experience, denying coverage to patients whose conditions stabilize or who prove lacking in restoration potential. These procedural differences make coverage for general nursing "observation" and for therapy services both more likely and more extensive under Medicaid than under Medicare.

Determinants of Access to Medicare Benefits

Medicare access problems stem in some areas from the simple absence of skilled nursing facilities. Basically, Medicare-covered care is too limited to sustain reasonable-sized nursing homes. With use at average 1977 levels of 395 days per 1,000 elderly, only a community of

500,000 people could fully utilize a 60-bed facility. As a result, the presence of skilled facilities in an area depends on whether there are sufficient Medicaid or private patients to support them. Where skilled-level facilities exist, service to Medicare patients will depend on nursing homes' willingness to participate in Medicare and on the willingness of participating nursing homes to provide Medicare-covered care.

Existence of Skilled Facilities

Medicaid demand for skilled care is probably more important than demand from private patients in determining the existence of skilled nursing facility (SNF) beds. Generally, few skilled-level beds exist in states where Medicaid supports only a small number of skilled days.

Virtually half of the nonmetropolitan counties and 17 percent of the metropolitan counties lack any certified skilled facilities. Those counties contain one-third of the elderly residing in nonmetropolitan areas and about 5 percent of the elderly from metropolitan areas. Overall, 13 percent of the elderly reside in counties without skilled facilities (Feder and Scanlon, 1981).

These statistics overstate the problem. Health facilities often are designed to serve the populations of adjacent counties. Facilities in neighboring counties may be as close or as accessible to noncounty residents as they are to county residents.

Nevertheless, the absence of skilled facilities in some states is quite severe. Over half the elderly population in 5 states (Iowa, Louisiana, Nebraska, New Mexico, and Oklahoma) live in counties without SNFs; in another 8 states (Kansas, Maine, Missouri, South Dakota, Tennessee, Texas, Virginia, and West Virginia), more than a quarter of the elderly are in similar circumstances. The problem is more severe for the elderly in rural areas. More than 50 percent of the rural elderly in 11 states live in areas without SNFs and in 4 (Iowa, Louisiana, New Mexico, and Oklahoma), the proportion is 80 percent.

Skilled Facilities' Willingness to Participate in Medicare

When skilled facilities exist, Medicare depends for service on nursing homes whose primary orientation is toward Medicaid or private pa-

tients. Over 50 percent of Medicare-certified facilities had less than 5 percent of their days paid by Medicare in 1977, with 8 percent of them having no Medicare days at all. Only 4.8 percent of Medicare-certified SNFs provided more than a quarter of their days to Medicare patients (National Center for Health Statistics, 1977). In Hawaii, the state with the highest Medicare utilization in 1979, Medicare days amounted to only 8 percent of certified capacity (Health Care Financing Administration, 1981).

Service to Medicare beneficiaries requires, first, that these skilled facilities be willing to participate in Medicare, and, second, that participating facilities be willing to accept Medicare patients. Nationally, a full third of Medicaid-certified facilities, with one third of skilled-level beds, do not seek Medicare certification (See Table 1). These national rates mask the substantial variation among states. Participation rates vary from only 3.6 percent in Arkansas to full participation in 16 states (Table 1). (In 13 of the 16 states with full participation in 1980, state law required that facilities certified for Medicaid be certified for Medicare as well.)

TABLE 1
Percentage of Skilled Nursing Facility Beds Certified for Medicare, 1980

State	Percent of Certified Skilled Beds That Are Certified for Medicare
Arizona	100.0
District of Columbia	100.0
Hawaii	100.0
Kentucky	100.0
Louisiana	100.0
Maine	100.0
Maryland	100.0
Nevada	100.0
New Hampshire	100.0
New Mexico	100.0
North Dakota	100.0
Oklahoma	100.0
South Carolina	100.0
Tennessee	100.0
Virginia	100.0
West Virginia	100.0

TABLE 1 (*cont'd*)

New York	99.7
Alabama	99.3
Rhode Island	98.4
Delaware	97.8
Iowa	97.7
North Carolina	94.8
Connecticut	92.0
Oregon	91.7
Michigan	91.6
Vermont	90.4
California	86.0
Indiana	85.7
Montana	85.3
Ohio	78.6
Pennsylvania	74.0
Idaho	72.6
Utah	68.7
Florida	68.7
Alaska	62.4
New Jersey	61.9
Missouri	53.3
Nebraska	50.9
Colorado	50.7
Massachusetts	45.9
Kansas	42.4
Washington	39.7
Illinois	30.0
Georgia	28.6
Wisconsin	21.1
Minnesota	17.6
Texas	16.1
South Dakota	12.6
Wyoming	12.1
Mississippi	5.4
Arkansas	3.6
United States	67.1

Source: Derived from Medicare-Medicaid Automated Certification System data, Health Standards and Quality Bureau, Health Care Financing Administration.

Varying participation combined with the absence of any skilled facilities in some areas produces great differences in the number of Medicare-certified beds per elderly person, as seen in Table 2. The number ranges from 51 beds per 1,000 elderly in Connecticut to 1 bed per 1,000 in Arkansas. Whether nursing homes in a given state will participate in Medicare depends on the characteristics of a state's homes and the similarity between Medicare policies and the Medicaid policies in that state.

TABLE 2
Current Medicare Certified Beds Per Thousand Persons Age 65 and Over, 1978, by State

Arkansas	1.04
Oklahoma	1.13
Texas	1.78
Iowa	1.83
Mississippi	1.97
New Mexico	1.99
Maine	2.68
Arizona	2.82
Virginia	3.28
Louisiana	4.07
Kansas	4.20
Wyoming	4.41
District of Columbia	4.48
South Dakota	5.18
Nebraska	5.36
Tennessee	6.00
Illinois	6.64
Missouri	7.19
New Hampshire	8.22
Minnesota	8.23
Massachusetts	9.11
Oregon	9.80
Kentucky	10.56
Indiana	11.19
West Virginia	11.63
Vermont	11.90
Georgia	11.99
Florida	13.28
North Carolina	13.30
Utah	14.29
Rhode Island	14.99

TABLE 2 (*cont'd*)

Wisconsin	15.70
Delaware	16.79
New Jersey	18.57
Washington	22.85
Maryland	22.92
Colorado	23.49
Hawaii	23.72
Michigan	23.93
South Carolina	25.20
Pennsylvania	25.66
Ohio	27.16
Alaska	28.52
Alabama	30.20
Nevada	30.27
New York	31.97
Montana	33.61
Idaho	35.19
California	38.33
North Dakota	44.99
Connecticut	50.99
United States	17.87

Source: Beds—Derived from Medicare-Medicaid Automated Certification System data, Health Standards and Quality Bureau, Health Care Financing Administration.
Population Age 65 and Over—U.S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 796, Illustrative Projections of State Populations by Age, Race, and Sex: 1975 to 2000. Washington, D.C.: U.S. Government Printing Office, 1979, Table 6, Series IIb.

Advantages of Medicare Participation

Attraction of Private Patients. Nursing homes' interest in Medicare participation depends on the advantages or disadvantages of serving Medicare patients relative to the homes' primary market—Medicaid and private pay. Nursing homes oriented toward the private market have substantially larger proportions of Medicare patients than other homes. In nursing homes that participate in Medicare but not Medicaid, 13 percent of patient days are covered by Medicare, as compared with 7 percent in homes participating in Medicare and Medicaid

(National Center for Health Statistics, 1977). Nursing homes report that a primary advantage to (and reason for) Medicare participation is its value in attracting private-pay patients. This attraction works in two ways. First, patients who obtain Medicare coverage on admission may remain in nursing homes as private-pay patients after Medicare coverage ends. No data are available to measure the frequency of this occurrence, but the fact that patients receiving some Medicare benefits stayed an average of 58 days in 1977—twice the average number of Medicare-covered days per stay—suggests that such shifts are common (National Center for Health Statistics, 1977). In interviews conducted for this study, nursing homes indicated that as many as half their Medicare patients may shift to private-pay status.

Medicare participation may also attract private patients by providing nursing homes with a "seal of approval." Although many homes interviewed found any such "seal" unnecessary, given the demand for their services, other homes reported that they could not operate successfully in their community without it.

Higher Reimbursements. Another reason that private-oriented homes tend to participate in Medicare has to do with their higher costs. To attract private-pay patients, nursing homes may maintain more staff than adequate patient care requires. If these homes cannot occupy all their beds with private patients and if the staff are not fully utilized, homes can serve patients with more extensive-care needs at little or no extra cost. In these circumstances, differences in Medicare and Medicaid reimbursement policies can make Medicare participation attractive.

Medicaid nursing home reimbursement systems have many provisions that limit what accounting costs are recognized for setting reimbursement rates. For example, they may include a percentile ceiling on individual cost centers or total operations, recognition of only actual construction or original purchase cost for capital instead of book value, limits on allowable interest rates, etc. Medicare only recently imposed ceilings on routine costs and these ceilings are likely to be less restrictive than most state Medicaid programs. The result is that homes whose costs significantly exceed the Medicaid ceiling in their state may receive considerably more from Medicare than Medicaid.

Medicare will also pay a proportionate share of the costs of maintaining empty beds; many Medicaid programs will not. Homes with

low occupancy and/or high costs may find Medicare reimbursement attractive or may need the extra revenues Medicare provides to support their operations. Not surprisingly then, facilities participating in Medicare have higher costs ($34.53 versus $22.21) per patient day and lower occupancy rates (87.3 percent versus 92.1 percent) than comparable facilities that do not participate (National Center for Health Statistics, 1977).

Disadvantages of Medicare Participation

Medicare participation can impose costs as well as benefits, however. A Medicaid-oriented home that is experiencing neither low occupancy nor high costs may find that these costs outweigh Medicare's potential benefits. As described below, Medicare may require more rigorous health and safety standards and greater staffing than Medicaid and may impose different and burdensome accounting and reporting requirements. Neither of these costs is likely to be fully reimbursed, as Medicare reimbursements are based on the averaging of costs for both Medicare and non-Medicare patients. Where Medicare and Medicaid practices are similar, dual participation may be a matter of course. Where they are different, Medicaid-oriented homes may not participate in Medicare.

Certification Standards. Since the 1972 amendments to Medicare and Medicaid, federal law has required both programs to impose a single set of health and safety standards on participating skilled nursing facilities. Surveys to assess compliance with these standards are, in fact, conducted by state employees. Certification of compliance with the standards, however, proceeds through different channels depending on whether homes are participating in Medicaid only or in both Medicare and Medicaid. State Medicaid agencies have made the final determination of compliance for Medicaid-only homes; and HCFA regional offices, for Medicare-Medicaid homes. In practice, regional offices have reportedly been more rigorous in enforcing standards than have some states. HCFA regional offices have pressed states to decertify some Medicaid nursing homes identified as out of compliance with certification requirements.

Comments from HCFA regional officials and nursing homes suggest that discrepancies in enforcement arise both with respect to overall health and safety standards and to the specific issue of nursing staff.

State Medicaid programs pay for the bulk of publicly supported nursing home care. Aggressive enforcement of health and safety standards may put pressure on states to raise Medicaid reimbursement rates. Furthermore, where beds are in short supply, states report reluctance to terminate agreements with homes serving large numbers of Medicaid patients. Closing these homes would leave patients with no place to go. Pressures of this sort have reportedly led Medicaid agencies to certify homes, despite surveyors' negative findings and a negative decision on Medicare certification by the regional office.

Until recently, the federal government's ability to assure states' enforcement of standards has been limited. Although some regional offices effectively pressed states in some cases, in others the authority was challenged. The Omnibus Reconciliation Act of 1980 (P.L. 96-499) attempted to alter this situation by clearly establishing the federal government as the final authority in determining compliance.

Where its authority has been clear (i.e., for Medicare-Medicaid homes), the federal government's quality enforcement has not been influenced by cost or access concerns. Medicare has not experienced these pressures to the extent that Medicaid programs have. Given the small number of Medicare patients, the program pays only a small share of the additional costs that rigorous quality enforcement may impose. Furthermore, Medicare offers nursing home coverage as a short-term substitute for hospital care, not the long-term residence that Medicaid provides. Because the Medicare benefit is not as critical to individuals, the Medicare program has paid less attention to access than has the Medicaid program.

The federal government—at least in some regional offices—appears to be particularly rigorous (relative to the states) in interpreting and enforcing nurse staffing requirements. The Medicare and Medicaid conditions for participation require skilled nursing homes to have 24-hour nursing service "sufficient to meet nursing needs." Nursing homes and regional office personnel indicate that, in interpreting these provisions, states may make allowances for limited availability of nurses in local areas. Hence the formal listing of a nurse on staff may be considered adequate, regardless of absenteeism, illness, or other conditions that may, in practice, reduce staffing below the 24 hours required. Furthermore, states may not require that staffing reflect a home's particular mix of patients, as long as minimal staffing needs are met. Regional offices, on the other hand, reportedly pay greater

attention to homes' actual staffing and require that nursing staff equal what surveyors believe necessary to serve a given set of patients. The result is reportedly higher staffing requirements for Medicare-participating homes.

While Medicare requirements may improve patient care, higher standards and/or operating requirements may also impose higher costs for Medicare than for Medicaid participation. Where these costs are incurred as a natural part of doing business, i.e., in homes staffing heavily to attract private patients, they represent no deterrent to Medicare participation. Conversely, where homes can earn acceptable profits (or net revenues) from Medicaid with minimal staff, they may be uninterested in participating in the Medicare program.

Reimbursement Practices. Even if a nursing home is adequately staffed to serve Medicare patients, Medicare's reimbursement practices may deter its participation. Medicare bases reimbursement on reasonable costs incurred in delivering care to Medicare beneficiaries. Costs are determined retroactively, according to detailed program rules for "allowable" or "nonallowable" costs. For routine services (including all nursing and nursing aide services and routine supplies), Medicare pays the average cost per day times the number of days attributed to Medicare beneficiaries. For ancillary services and special supplies that are directly attributable to specific patients, Medicare pays a share of the home's costs equal to the proportion of charges attributed to Medicare beneficiaries. Nursing homes report three major problems with this system: the detailed accounting it requires, its retroactive application, and the actual rates it produces.

To determine reimbursable costs, the Medicare system requires nursing homes, like hospitals, to keep track of their expenses on a departmental or cost-center basis. Separate cost centers exist for various support functions (administration, maintenance, laundry, dietary, housekeeping, etc.) routine inpatient services, ancillary service departments, outpatient services, and miscellaneous reimbursable and nonreimbursable costs. To calculate Medicare's share of a home's cost, the costs of each general-support costs center must be allocated among the revenue-generating cost centers. Allocation is based on different types of statistics—square feet for maintenance, pounds of laundry and hours of service for housekeeping, staff time spent for medical records or social services, requisitions from central supply, patient volume for administration, etc. Nursing homes that certify only some

of their beds for Medicare must also keep statistics to distinguish routine service and support costs for Medicare and non-Medicare beds.

Although nursing homes may keep track of costs in this fashion for purposes of efficient management, many homes reportedly do not. A concern for efficiency might lead homes to make occasional assessments of support costs associated with specific types of patients or particular cost centers. But efficiency would not demand the detailed and continuous record keeping Medicare requires. Similarly, many Medicaid programs do not require such detailed cost finding. When they do, they may require different types of statistics and calculations than Medicare.

Nursing homes interviewed for this study were asked to estimate accounting costs associated with Medicare. Since these estimates reflect the homes' perceptions of Medicare-specific costs, rather than direct measurement, they must be treated with caution. Estimates for preparing Medicare's cost report ranged from a low of $250 to as high as $10,000. Several homes indicated the need to assign full- or part-time staff specifically to bookkeeping for Medicare purposes and the need to rely on certified public accountants, preferably with Medicare experience, to complete the cost report. The variation clearly reflected differences in the accounting system employed by the home for its own purposes. But it also appeared to reflect differences in investment to maximize Medicare reimbursement. A nursing home operator who spent $5,000 on his cost report said that without that investment in expertise he would have lost $10,000. Homes with low Medicare volume or less aggressive collection practices may not incur these expenses.

The nursing homes' interest in protective or creative accounting raises another aspect of Medicare payment that causes them concern. In determining what it will pay, Medicare distinguishes between costs that are and are not allowable, and assesses these costs, on audit, after costs are actually incurred. Nursing homes object strenuously to Medicare's retroactive disallowances. Medicaid programs in most states do not pose this problem because the systems determine payment in advance, rather than retrospectively. Although some so-called "prospective" systems may include retrospective audits, these systems tend to be simpler than Medicare's, involving less detailed accounting and, therefore, a less intensive audit.

Predictable Medicare disallowances, based on readily understandable

regulations, are not the homes' primary concern. The major issue is disallowances that result from retroactive interpretation of imprecise rules—in other words, intermediary judgments that reduce nursing home reimbursements below expected levels. Such disallowances may result from interpretation of specific costs as allowable or not allowable (e.g., determining whether advertising expenses went to maintain "a good public image"—allowable—or to "increase patient utilization"—not allowable; deciding whether employee profit-related bonuses are fringe benefits—allowable—or profits—not fully allowable) or from decisions on how to allocate certain costs to Medicare patients (assessing the adequacy of homes' statistical support for its nursing allocation; allowing adjustments when statistics are lacking). Homes report not only uncertainty as to how intermediaries will handle certain items but also inconsistent decisions on the same items from year to year. As one nursing home administrator put it: "Dealing with Medicare is like dealing with a cloud."

The problems created by unpredictable disallowances obviously depend on the amounts disallowed. Settlements can occur two to three years after costs have been incurred. At a minimum, the prospect of disallowances impedes homes' investment or distribution of revenues during that period. At a maximum, actual disallowances mean that homes are paid less than the costs they incurred in treating Medicare beneficiaries. Both of these burdens, however, may be mitigated by Medicare's reported willingness to negotiate settlements allowing nursing homes to keep a portion of the disallowed costs.

Whether the revenues Medicare provides are equal to or greater than the costs associated with service to Medicare patients is probably the most important issue raised regarding Medicare reimbursement methods. As noted earlier, for most services (including administration), Medicare pays a daily rate calculated as the nursing home's average cost per day for all its patients. Medicare patients would cost more than the average to the extent that Medicare service is more intensive than average, that extra staff time is required for documentation of covered care, or that special bookkeeping and accounting are necessary to maintain Medicare records and complete cost reports. If any or all of these costs are considerable, a home would lose money treating Medicare patients. The degree to which these costs are likely to be small or large will depend upon the similarity between Medicare requirements and a home's practices for its non-Medicare patients (private-pay and Medicaid).

Some nursing homes can mitigate losses (or reap benefits) even where Medicare requires some departure from their predominant mode of operation. This can occur if a home identifies a "distinct part" of its facility to serve Medicare patients. Where a home designates only some of its beds as Medicare beds, Medicare will pay the nursing, housekeeping, and other costs that are directly attributable to those beds—i.e., not average across the entire facility. Thus, if patients in the distinct part require more nursing than the rest of the home's patients, more staff can be legitimately assigned to that unit and Medicare will pay a larger share of staff costs.

Use of the distinct part allows homes to obtain Medicare reimbursement commensurate with the nursing care Medicare patients require. In practice, staff allocation to the distinct part may exceed Medicare patients' needs. Medicare then supports staff that are not fully utilized. Creative management and accounting will also allow nursing homes to allocate a larger proportion of other costs—overhead and capital—to the distinct part, essentially shifting some of these costs to the Medicare program, increasing profits from private or Medicaid patients.

To use the distinct part in this way, however, requires a degree of accounting sophistication not present in many homes. Allocation of staff and other costs to the Medicare distinct part is audited carefully by intermediaries and must be supported with detailed records of actual staff time spent in the distinct part.

Even for homes unable to use a distinct part, Medicare's average cost reimbursement may provide a home adequate revenue if not all of its Medicare patients require intensive care. Homes report that Medicare patients who require rehabilitation rather than skilled nursing services require relatively little staff time and incur less than average costs. Gains on these patients can offset losses on other patients, if the home has a mix. Overall, most of the participating homes contacted for this study indicated that they "break even" on Medicare reimbursement, despite their complaints about the program. Homes that do not expect such a sanguine result are apparently unlikely to participate in the first place.

Distrust of the Medicare Program. Although economic issues are clearly critical to nursing homes' participation decisions, other aspects of Medicare policy appear to influence borderline homes. Nursing home administrators in some states appear reluctant to deal with Medicare, due to their own or their associates' experience with the

program in its early years. In response to dramatic and unanticipated expenditure increases, the Medicare program began imposing rigorous claims reviews in 1969. The result was a 60 percent drop in Medicare-covered days between 1969 and 1972 (Helbing, 1980). Much of the drop reflected retroactive denial of claims after care had been delivered.

Medicare's restriction of coverage in 1969 has apparently left a lasting impression that the program can easily change rules that are critical to participating homes. Without a strong financial incentive, some nursing homes are unwilling to "risk" participation.

Participating SNFs' Admission Practices

Medicare beneficiaries may encounter access problems even when an ample number of homes participate. Participating facilities may be unable or unwilling to serve more or particular Medicare patients. Evidence of this phenomenon is the weak relationship between nursing home use and nursing home participation. A simple regression showed that an increase of 10 percent in Medicare-certified beds per elderly person is accompanied by less than a 5 percent increase in covered days per elderly person, on average. Experience differs considerably among states. As seen in Figure 1, utilization rates vary substantially for states with similar certified bed supplies.

A portion of this phenomenon stems from the very tight supply of nursing home beds. There is such great demand that occupancy rates are uniformly very high. They averaged 89 percent in 1977 for skilled facilities. At that time, 81 percent of those facilities reported they had a waiting list. The mean number of patients on those lists was 25.3. Given the discharge rates in skilled facilities, a patient on the bottom could expect to wait approximately 75 days for a bed in a particular home (National Center for Health Statistics, 1977). Patients probably wait much less time as they may seek admission to several homes, and some patients (especially private-pay patients) probably move up the list faster than others.

Even though the waiting time may be considerably less than 75 days, a wait of even 2 to 3 weeks can seriously affect Medicare use. With the emphasis on intensive short-term care, many persons may recover sufficiently while remaining in the hospital to become ineligible for Medicare coverage. Also, by law, even patients who do not

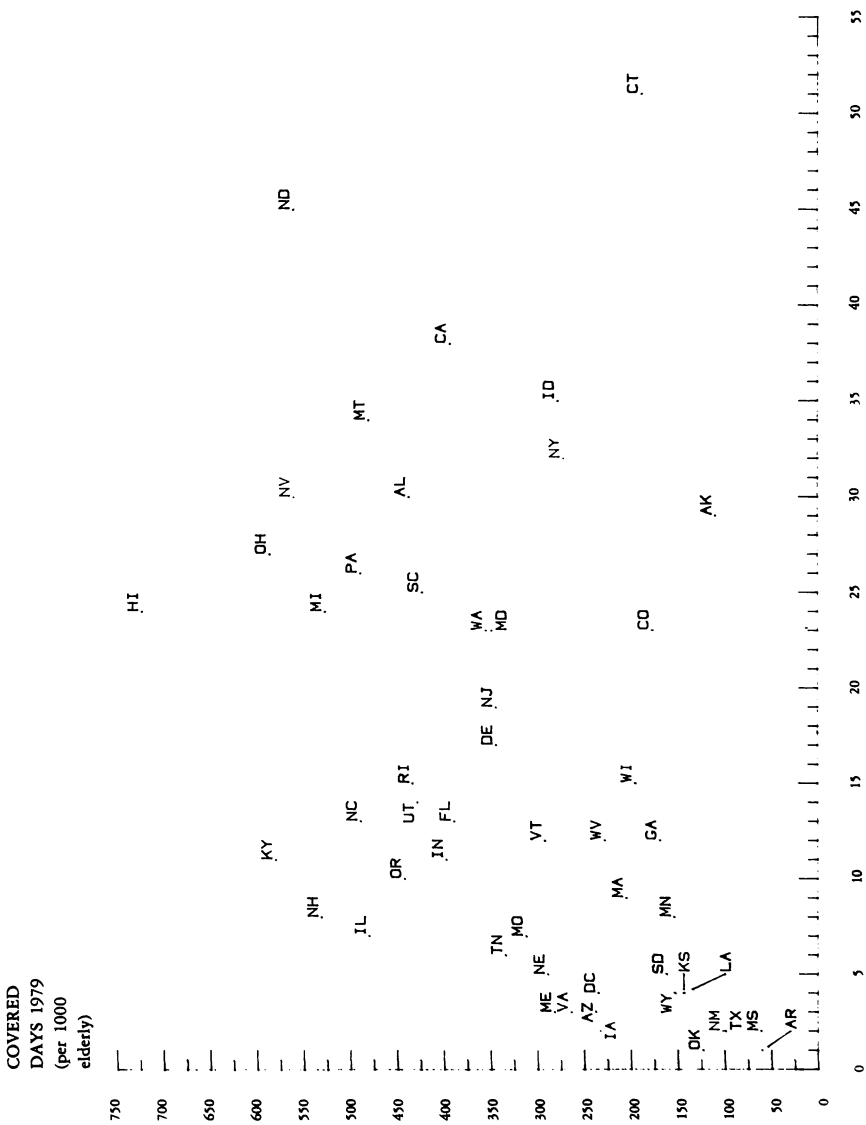

FIG. 1. Medicare-covered days by Medicare-certified SNF beds.

recover may lose access to Medicare benefits if they are not admitted to a nursing home within 30 days of their hospital discharge.

The tight supply also gives homes the ability to select patients on other than a first-come, first-served basis. Homes may not have sufficient staff to care adequately for patients requiring extensive or complex care. Homes can choose to have smaller staffs, knowing that market conditions guarantee they can fill their beds with patients needing less care.

Ethical concerns may lead homes to refuse patients requiring more than existing staff. Nursing homes themselves may feel that they are not equipped to handle difficult cases properly. Medicare's certification enforcement also discourages admission of difficult cases, by requiring more staff for a more complicated case mix.

Medicare patients' short stay relative to Medicaid patients also creates demands on staff time that may make patients unattractive. Eighty-six percent of Medicare patients stayed in nursing homes for fewer than 60 days (including noncovered as well as covered time), while more than half the Medicaid skilled patients in skilled facilities stayed longer than 180 days. New admissions require patient assessments and development of treatment plans; discharges also require planning and training. Rather than invest this time in short-stay patient after short-stay patient, nursing homes may prefer to accept patients who will stay in the home for some time.

Interviews with hospital discharge personnel indicate the extent to which nursing homes carefully distinguish among potential patients. When informed that a patient needs a bed, nursing homes reportedly obtain detailed information on the patient's source of payment (private resources, Medicare, or Medicaid) and on the patient's overall condition. Homes question not only the amount of skilled and personal care a patient requires, but also request information on specific management problems a patient may pose (psychological problems, excessive weight, loudness, belligerence, special dietary needs, etc.).

Most hospital discharge personnel reported that payment source makes an important difference in the placement process. Private patients are typically admitted to nursing homes without difficulty, regardless of their care needs. To protect their revenues, homes sometimes require patients admitted as private-pay to sign a contract to remain private-pay for a specified period of time. Periods of 6 months to 2 years have been reported.

Nursing homes' preferences for Medicare over Medicaid patients (or vice versa) vary considerably from place to place. In some cases, discharge personnel said that homes openly discuss their preferences and maintain separate waiting lists for different types of patients. In other cases homes reportedly keep their preferences to themselves.

For Medicare and Medicaid patients, unlike private patients, specific patient characteristics or care needs appear to affect access to beds. Preferences for different types of Medicare patients differed across areas. Some hospitals indicated that nursing homes willing to take Medicare patients preferred patients who needed clearly identifiable skilled procedures. More commonly, homes favored patients with recognizable "restoration potential" and need for therapies (e.g., patients recovering from strokes or fractured hips). Nursing homes appeared particularly reluctant to accept Medicare patients who needed oxygen, care for extensive decubitus ulcers, or tube feedings.

Nursing homes' preferences can be interpreted as responses to the incentives associated with the Medicare payment systems. Patients receiving skilled procedures are clearly covered. Patients needing therapy may cost less to care for and patients needing oxygen, skin care, or tube feedings are costly to care for. Homes clearly stand to gain or lose from particular types of patients, depending on care needs relative to payment rates. To paraphrase one home's explanation: "We don't discriminate by source of payment, we discriminate by *amount* of payment." In some cases this leads to outright rejection of Medicare patients; in others, to careful patient selection.

Even if nursing homes are willing to provide Medicare-covered care, they may be unwilling to bill Medicare for their services, billing patients directly or billing Medicaid instead. Nursing homes and intermediaries agree that obtaining Medicare coverage is an art and is heavily dependent on detailed knowledge of coverage requirements and documentation of patients' conditions, plans of care, and services provided. Homes with frequent turnover in personnel or with very few Medicare patients may be unwilling to invest in the effort coverage requires.

The burdens and uncertainties of Medicare payment may lead homes to avoid taking patients for whom coverage is questionable or to admit these patients as private or Medicaid—not Medicare—patients. Since private charges are higher than Medicare payments, homes always have an incentive to treat patients on a private-pay basis. Where the

probability of Medicare coverage is questionable or the need for such coverage is particularly difficult to document (e.g., for observation or supervision), homes may identify care as "noncovered" by Medicare, both to avoid an error for which they could be liable and to gain private rates. Unless beneficiaries appeal the homes' judgments, they lose Medicare benefits to which they are entitled.

Homes might also prefer billing Medicaid rather than Medicare in some cases, even though Medicaid rates are rarely higher than Medicare's. As described at the outset, Medicaid programs make coverage decisions in advance of treatment, award longer periods of coverage than Medicare for similar cases, do not make coverage for observation or supervision contingent upon changes in patients' conditions, and do not require detailed documentation of patients' conditions or service delivery. Given the greater probability of coverage for longer periods under Medicaid than under Medicare, homes may find it simpler and less costly to bill Medicaid rather than Medicare for some patients.

Consequences of Limited Medicare Service

To summarize, the availability of Medicare nursing home benefits depends on: 1) the existence of skilled-level facilities—a function of Medicaid coverage and payment policies; 2) the willingness of nursing homes participating in Medicaid to participate in Medicare—a function of the similarity between Medicare and Medicaid patients, certification rules, and reimbursement policies; and 3) participating nursing homes' interest in providing Medicare-covered service—a function of Medicare patients' attractiveness relative to alternative patients. These conditions vary from place to place. In some areas, Medicare beneficiaries have no access to covered care; in others, access is limited; and in some, access is not a problem. Limited access has consequences for beneficiaries, states, and the federal government.

Effects on Medicare Beneficiaries

Limited nursing home benefits do more to affect Medicare beneficiaries' financial liabilities than their access to needed care. The occurrence of hospital back-ups means that hospitals do serve Medicare beneficiaries who cannot find nursing home beds.

Hospitals compensate both for the absence of skilled facilities and for limited access to existing facilities. There are few areas which do not have either hospitals or skilled facilities. Furthermore, many hospitals presently have excess capacity. Counting only hospitals that had less than 90 percent occupancy in 1979, only 6 percent of the elderly live in a county without available hospital beds (Feder and Scanlon, 1981). This represents less than one-half the number that reside in counties without skilled facilities.

The use of hospitals as substitutes for skilled facilities under Medicare should not strain hospital capacity in most areas. If all Medicare-covered SNF days in 1979 had been supplied by hospitals, they would amount to one-sixth of the excess capacity in hospitals. Furthermore, serving patients who could not gain admission to a skilled facility would probably use little of the hospitals' excess capacity. Most of these patients remain hospitalized rather than being discharged anyway and, therefore, are already counted in current hospital utilization.

As long as beneficiaries remain in hospitals, they are likely to receive the skilled care they require. Medicare will pay in full for that care, for all but the tiny proportion of Medicare beneficiaries who exhaust their covered hospital days. In contrast, patients who enter nursing homes (perhaps under pressure from a fully occupied hospital) may be denied the Medicare benefits to which they are legally entitled. Obviously no benefits will be available in homes that do not participate in Medicare—a fact that a beneficiary can readily comprehend. But beneficiaries are less likely to perceive the denial of benefits that results from participating homes' reluctance to submit claims for which Medicare coverage is uncertain or hard to obtain.

Nursing homes' judgments on coverage tend to be conservative, since nursing homes gain more from private than from public payment and since homes bear a financial risk for submitting inappropriate Medicare claims. Homes' reluctance to submit claims would undoubtedly increase if Congress enacted the administration's proposal to make nursing homes liable for all erroneous claims, not just the excess over 5 percent.

Beneficiaries can appeal a nursing home's judgment that Medicare coverage is inappropriate, requesting that the claim be submitted anyway. But most beneficiaries are likely to accept the home's judgment, unaware of the benefits they forgo. In these circumstances, beneficiaries will pay the full cost of their nursing home stay.

Effect on State Medicaid Programs

States are similarly likely to bear the costs of limited nursing home participation and reluctance to bill Medicare. Some homes value the certainty and simplicity of Medicaid payment, even if rates are lower than Medicare's. To the extent that homes prefer to bill Medicaid, states finance what should be a fully federal expense.

Some states have tried to minimize this occurrence by pressing homes to collect from Medicare first. A 1981 survey by the George Washington University Intergovernmental Health Policy Project identified 15 states requiring nursing homes that participate in Medicaid to participate in Medicare. As described above, participation by itself may not affect admission or billing practices. Recognizing this fact, some states require nursing homes to bill Medicare for all potentially covered patients before billing Medicaid. "Medicare-maximization" policies, which require nursing homes to present Medicare denials when submitting Medicaid claims for skilled care, have been used in California (in lieu of mandatory participation); in states that also mandate participation (e.g., New York and Michigan); and in other states for homes that voluntarily participate in both programs (e.g., Connecticut and New Jersey). New York has been particularly aggressive in pursuing this policy, requiring homes not only to submit all potential Medicaid-skilled claims to Medicare but also to resubmit for reconsideration any claims that Medicare denies. Michigan has taken a similar approach but has required fewer reconsiderations. In the summer of 1981, however, Michigan was considering requiring not only reconsiderations by intermediaries but administrative appeals.

The success of a state's Medicare maximization policy in increasing billings to Medicare appears to depend heavily on certain features of mandatory participation and Medicare administration. Michigan allows homes to certify only some of their Medicaid-certified beds for Medicare, permitting homes to admit patients whose Medicare coverage is questionable to noncertified beds. This may help to explain why Michigan experienced no increase in Medicare use as a result of its policies. New York, which does not allow homes this approach, attributed a huge increase in Medicare use (from 700,000 days in 1975 to 1.1 million days in 1977) to their Medicare-maximization policies. But after the initial spurt, Medicare days declined 48 percent—to below the 1975 level.

The short duration of New York's Medicare boom appears to reflect intermediaries' initial inability to handle the enormous increase in claims. Before the state required billings to Medicare, Medicare intermediaries in New York performed medical review on only a sample of claims. In response to New York's initiative, the regional office required intermediaries to review 100 percent of claims and to determine coverage prospectively. With new procedures and an expanded staff, Medicare reduced its coverage below the levels that prevailed before Medicare-maximization began.

This experience suggests that Medicaid financial liabilities depend heavily on Medicare claims review procedures. The administration has constrained intermediaries' budgets, raising the probability that intermediaries would have difficulty coping with the onslaught of claims a Medicare-maximation policy could induce. If so, states would gain heavily from pursuing such a policy.

Effects on the Federal Government

Medicare finances only a narrowly defined portion of nursing home care. Its beneficiaries are therefore dependent for access on an industry oriented toward other patients. Current federal policies fail to make maximum use of the Medicaid-oriented industry and cost the government money.

Hospitals' retention of patients who could be placed in nursing homes means that Medicare pays about four times as much as necessary for patient care. Estimates of back-up days ranging from 1 million to 9.2 million imply an annual cost to the federal government of $100 million to $900 million.

Policy Options

Because Medicare is a federal program, solutions to availability problems require changes in federal policy. These policy changes need not sacrifice Medicare's current limitation to short-term, post-acute nursing home care. Given its current benefit structure, the program has two options: 1) the program could address only the federal cost problem, accepting limited access but reducing the price it pays for patients

backed up in hospitals, or 2) the program could address all parties' problems, improving access for Medicare beneficiaries by adapting many of its policies to general practice in the nursing home market.

Congress supported the first option with 1980 legislation that authorized payment for back-up days at average Medicaid-skilled nursing home rates. Lower rates would apply only to hospitals with occupancy rates below 80 percent. Before this provision was implemented, Congress amended it to eliminate the 80 percent occupancy condition, requiring payment at the lower rate to all hospitals and areas with "excess beds."

The Department of Health and Human Services has been slow to implement this provision, apparently for two reasons. First, identification of excess beds involves values, not science, and is fraught with political difficulties. Second, and perhaps more importantly, restricting payment for some hospital days does not eliminate the fixed costs associated with those days. Someone has to bear those costs, and their allocation among hospital payers is highly controversial.

Medicare could reduce the cost it bears for limited access by paying the nursing home rate in as many places as possible and by adjusting its rules to eliminate or minimize its share of fixed costs above the rate. Because lower rates would reduce the likelihood that hospitals would identify patients awaiting placement, Medicare would have to accompany this policy with a rigorous claims review.

This strategy would solve the federal government's financial problems, but without a commensurate reduction in social costs. Lower rates for back-up days would eliminate any incentive hospitals have to retain patients inappropriately. But lower rates will do nothing to eliminate back-ups that reflect placement problems and not hospitals' incentives. To the extent hospitals cannot or do not reduce the costs of these days, hospital payers other than Medicare will bear costs that Medicare will not pay.

An alternative strategy would have Medicare reduce costs by reducing barriers to access for Medicare patients. As a small purchaser in a large market, Medicare cannot change the nursing home industry. But the program could get more service from that industry by *acting* as a small buyer, accommodating its policies to industry practice.

More homes would probably participate in Medicare if the program allowed homes to accept payment at Medicaid rates or developed its own prospective payment system. These homes and homes already

participating in Medicare would probably serve more Medicare patients if Medicare payment recognized the above-average costs of more intensive service or shorter-than-average stays for some of its patients. These reforms would probably do far more to eliminate back-up days than reducing hospital payment.

The federal government's concern with Medicare administration should go beyond fiscal issues to assurance that beneficiaries receive the benefits to which they are entitled. Policies that put nursing homes at risk for all incorrect claims submissions run counter to this objective. Far more appropriate would be prospective review of claims that informs both homes and beneficiaries of the payments they can expect. Prospective review would make formal and uniform the informal review on admission now used by several intermediaries and would be equivalent to the approach taken by state Medicaid programs. Authorized periods of coverage need not be long; they could vary with diagnosis and a patient's condition on admission. The purpose of the new approach would be to make coverage predictable, not to extend covered stays.

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