Vol. VI, No. 2
March 2003

Changes in
HEALTH CARE
FINANCING &
ORGANIZATION

findings brief

New Payment System Has Little Effect on Access and Quality

The skilled nursing facility prospective payment system led to concern among the nursing home industry that beneficiaries' access to nursing home services would be limited. Data from Gifford and Angelelli's study indicate that that does not seem to be the case.

Despite fears to the contrary, Medicare's prospective payment system (PPS) for skilled nursing facilities (SNF) has not had a significant adverse effect on nursing-home residents in Ohio, according to findings from a study by David Gifford, M.D., and Joseph Angelelli, Ph.D., at Brown University's Center for Gerontology and Health Care Research. There are indications, however, that the new system is affecting facility behavior in ways that might affect access and quality in the long term, including facilities' willingness to admit high-cost patients, their ability to remain financially stable, and changes in the level of care provided to their residents.

The researchers conducted a two-year study of the effects of the SNF PPS on access to and quality of care in Ohio. They used various measures to compare access and outcomes during the 18 months before and after the new payment system was implemented on January 1, 1999.

"We looked at broad questions of access to and quality of nursing home care," Dr. Gifford says. "Are patients being transferred from hospitals to skilled nursing facilities? What kind of care are they receiving once they get there?" By creating a longitudinal database that links Medicare claims data with the nursing homes' minimum data sets over time, the researchers could track patients and changes through the system.

Access to Care

Created as part of the Balanced Budget Act of 1997 to encourage cost-efficient care,[1] the SNF PPS led to concern among the nursing home industry that beneficiaries' access to nursing home services would be limited. Data from Gifford and Angelelli's study indicate that that does not seem to be the case, although the prospective payment system had a small negative effect on highest-cost patients' access to freestanding nursing facilities.

Drs. Gifford and Angelelli found that the facilities that would lose the most revenue by accepting high-cost patients are admitting fewer of them, indicating that SNFs are inclined to limit their risk under a prospective payment system. For example, after increasing over the three years preceding implementation, the percentage of costliest patients discharged to freestanding facilities

AcademyHealth
Advancing Research, Policy and Practice

AcademyHealth is the national program office for HCFO, an initiative of The Robert Wood Johnson Foundation.

decreased from 14.2 percent in the first six months of 1998 to 12.9 percent in the first six months of 1999 (see Figure 1).[2] Instead, more patients are being discharged to other settings (e.g., home, assisted living, or acute rehabilitation centers) or are dying in the hospital. This pattern was consistent for all patients, but was more pronounced among the highest-cost patients.

The researchers also found an increase in nursing home closures following the implementation of PPS. Nationwide, the percentage of facilities closing voluntarily was relatively stable for both freestanding and hospital-based facilities from 1992 through 1997, but in the late 1990s, the percentage of hospital-based closures increased substantially (from 1.6 percent in 1997 to 4.4 percent in 1998 and peaking at 7.9 percent in 1999).[3] The closure of hospital-based facilities may have placed added strain on access to care, especially if concentrated in certain markets.

Despite these findings, the researchers did not find that diminished access to SNFs was widespread. "The anecdotal stories of access problems are true but do not represent a large population of patients," says Gifford. "Although a subpopulation of very vulnerable people is having some trouble accessing nursing home care, the initial fears of access problems are not supported by the data."

Quality

The prospective payment system is designed to encourage appropriate and efficient care; however, it has the potential to negatively affect outcomes if facilities choose to maximize revenue by scaling back costs through providing less or lower-quality care.

In this study, concerns about quality did not materialize, although there are indications that facilities might be providing fewer rehabilitative services. "We detected a response to the incentives created by prospective payment evidenced by a reduction in the number of therapy-minutes provided," says Angelelli. "Many facilities went from providing 25 percent of their Medicare patients at least 700 minutes of rehab in a preceding seven-day period to providing half of that."

Although the changes in rehabilitative services were concentrated in larger, for-profit facilities that may have been overutilizing services in the years before the PPS, policymakers should track carefully the change in behavior to ensure that quality of care is not compromised.

"Overall, we did not find adverse effects on aggregate outcomes after PPS implementation," says Angelelli. Rehospitalization

What is the SNF PPS?

The Balanced Budget Act of 1997 established the SNF PPS. Under the PPS, facilities are paid a per diem rate, adjusted for its case mix, for each Medicare resident that is designed to cover the costs of all patients' needs, including medications, supplies, rehabilitation therapies, and emergency room use. Prior to implementation of the prospective payment system, skilled nursing facilities were reimbursed based on the actual costs each patient incurred.

Why was it created?

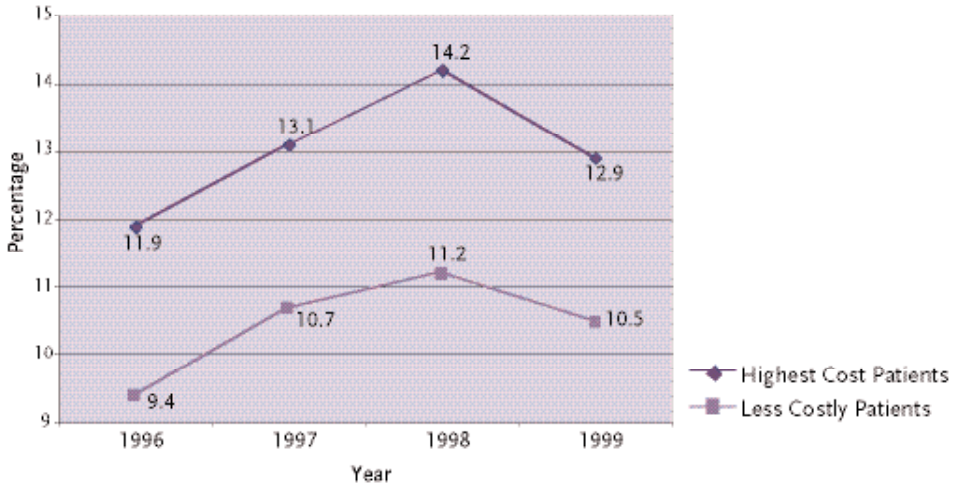
The goal of the PPS in skilled nursing facilities is to encourage more efficient care. Increased utilization, especially of ancillary services (e.g., rehabilitative therapy, prescription drugs, etc.), led to rapid growth in the services Medicare beneficiaries receive after hospitalization. With the earlier reimbursement system, facilities that used more ancillary services received more money. According to the General Accounting Office, because the PPS includes ancillary services in the per diem payment, the financial incentives associated with these services disappears.

How has it been implemented?

The PPS was phased in over time beginning in 1999. In the transition period from 1999 to 2002, the per diem rate facilities received was based partially on the new federal rate and partially on a facility-specific amount derived from the facility's FY 1995 cost report.

Year	Percent of Payment Based on New Federal Rate	Percent of Payment Based on 1995 Cost Report
1999	25%	75%
2000	50%	50%
2001	75%	25%
2002	100%	0%

Figure 1:
Percentage of Patients Discharged to Freestanding Nursing Homes (1996-1999)



rates—a measure of how often a patient returns to the hospital for further treatment of their condition at the time of discharge—remained stable over time before and after implementation of the SNF PPS.[4]

Future Effects of PPS

Because the PPS was phased in over time and this study did not cover the years in which the PPS was in effect completely, the full effects of the new payment system have yet to be determined. In the transition period (1999-2001), the per diem rate facilities received were based partially on the new federal rate and partially on a facility-specific amount derived from the facility's FY 1995 cost report. In 2002, each facility's per diem rates were computed based on national averages. (See box on page 2.)

The Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000 may have mitigated some initial effects of the SNF PPS on access and quality. BBRA increased payments to nursing homes by 4 percent for all groups, and BIPA increased the base rate of the nursing component of the PPS by almost 17 percent.[5] Both provisions ended October 1, 2002, however, reducing expected Medicare payments to nursing homes by $1 billion annually.

"The expiration of the Medicare 'giveback' provisions from BBRA and BIPA increases the risk of future access and quality problems, especially in light of the problems confronting Medicaid financing at the state level," according to Angelelli.

The researchers note that a final determination of the overall effects of the SNF PPS on access to and quality of skilled nursing facility care remains unknown. Although their analysis revealed only slight effects of the SNF PPS, it suggests that future problems could occur as facilities now begin to experience the full effects of the payment change.

"Wholesale changes based on current anecdotal evidence would not be appropriate, but small tinkering may be needed to address the access problems of the highest cost patients," says Angelelli. "Continued monitoring of the prospective payment system is essential for informed policy making."

For more information contact David Gifford, M.D., at 401.528.3261, or david_gifford@brown.edu.

About the Author

Kathryn Martin is a senior associate working primarily on The Robert Wood Johnson Foundation's HCFO program, which supports investigator-initiated research and policy analysis, evaluation, and demonstration projects examining major changes in health care financing and their effects on cost, access, and quality. AcademyHealth (www.academyhealth.org) serves as the national program office for HCFO. Ms. Martin can be reached at 202.292.6700 or kathryn.martin@academyhealth.org.

Endnotes

1 General Accounting Office. Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms. (GAO/TT-HEHS-99-192, September 15, 1999)

2 Angelelli, J. et al. "Access to Postacute Nursing Home Care Before and After the BBA," *Health Affairs*, Sept/Oct 2002. Vol. 21, No. 5, pp. 254-64.

3 Angelelli, J. et al. "Oversight of Nursing Homes: Pruning the Tree or Just Spotting Bad Apples?" *The Gerontologist* (in press).

4 Angelelli, J. et al. "Access to Postacute Nursing Home Care Before and After the BBA," *Health Affairs*, Sept/Oct 2002. Vol. 21, No. 5, pp. 254-64.

5 Ibid.