United States General Accounting Office

GAO

Report to the Honorable
Howard M. Metzenbaum, U.S. Senate

September 1990

NURSING HOMES

Admission Problems for Medicaid Recipients and Attempts to Solve Them

GAO/HRD-90-135

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-232993

September 5, 1990

The Honorable Howard M. Metzenbaum
United States Senate

Dear Senator Metzenbaum:

This report, prepared at your request, discusses problems Medicaid recipients face when trying to gain admission to nursing homes. It includes information on the types of reforms that have been implemented in various states and factors that influence states' willingness to improve access for Medicaid recipients.

We are sending copies of this report to interested congressional committees, the Director of the Office of Management and Budget, and the Secretary of Health and Human Services, and are making copies available to others on request.

Please contact me on (202) 275-5451 if you or your staff have any questions concerning the report. Other major contributors are listed in appendix I.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

Executive Summary

Purpose

To control Medicaid spending for nursing home care, states can limit their payment rates and restrict the supply of nursing home beds. Restricting bed supply can create an excess demand for nursing home care. When this occurs, nursing homes that participate in Medicaid have an incentive to select the most profitable applicants—such as higher paying private payers or Medicaid recipients needing relatively limited care. Medicaid recipients with greater care needs may have trouble gaining access to nursing homes.

Responding to a request from Senator Howard Metzenbaum, GAO identified the types of people having problems getting into nursing homes, factors contributing to those problems, the effects those problems have on health care costs, and state actions to improve access.

Background

Medicaid is a federally aided, state-administered medical assistance program enacted to provide the poor with access to health care. Intended initially as an acute-care program for the poor, Medicaid has become the principal public program financing long-term care for the elderly and disabled.

Nursing home care is one of the largest components of Medicaid spending and is likely to grow as our population ages. Federal and state Medicaid spending for 1988 was $49 billion; over $14 billion of it went to nursing home care.

GAO reviewed research and reports on nursing home access issues, interviewed long-term care experts, and visited nine states to obtain information on the types of elderly having access problems and state actions to improve access.

Results in Brief

Medicaid recipients have more problems getting into nursing homes than higher paying private payers. Equalizing payment rates for the two groups, or reducing the difference between their payment rates, can improve access for Medicaid recipients. Establishing rates that are scaled to the severity of Medicaid recipient care needs can also improve access for those needing more care, that is those with "heavy" care needs. Increasing Medicaid rates, however, obviously would cost more money, and some states believe they cannot afford to pay more due to limited financial resources and competing demands for those resources. In order to avoid higher Medicaid spending, some states have restricted the supply of nursing home beds, and, thereby, created a shortage.

Faced with these shortages, some states have tried regulatory reforms, with uncertain effectiveness, to allocate existing beds so that Medicaid recipients and private payers have an equal chance of getting an available bed.

Principal Findings

Wide Variation in Types and Severity of Access Problems

Although consistent, quantitative state data on the extent and severity of access problems and their effects on health care spending are lacking, the predominant views of those GAO visited were that certain types of Medicaid recipients in the nine states have more problems getting into nursing homes than comparable private payers. In Minnesota and Ohio, for example, only Medicaid recipients with the heaviest care needs have more problems than comparable private payers, but those with light and heavy care needs have more problems in California, Massachusetts, and South Carolina.

There are no generally accepted measures of access, but nursing home access problems are described in some states by the length of time it takes to be placed in a nursing home. A Massachusetts state office found, for example, that a Medicaid recipient waited an average of 101 days for admission to a nursing home compared to an average 56-day wait for private payers. (See pp. 14-19.)

Nursing Home Access Problems Can Result in Increased Health Care Costs

When Medicaid recipients unnecessarily stay in a hospital because a nursing home bed is not available, the care they receive is much more costly than that provided in a nursing home. In California, for example, the days that patients spent in a hospital waiting for an available Medicare or Medicaid nursing home bed increased 55 percent in 1 year, raising the cost of care for these days from $5.7 million to $10.5 million. (See pp. 19-22.)

Payment Reforms to Improve Access

Minnesota required that Medicaid and private-pay rates be equal, thereby improving access for Medicaid recipients by removing the financial incentive nursing homes had to select private payers. Reducing differences between Medicaid and private-pay rates or changing the payment system from one where the same payment is made for all Medicaid recipients to one based on the level of care needed also improved

access for Medicaid recipients in a number of states. For example, Ohio and Florida reported significant improvement in access to nursing homes for Medicaid recipients after implementation of Medicaid rate increases. Likewise, New York reported that implementation of a payment system based on care needs improved access for Medicaid recipients with heavy care needs. (See pp. 23-28.)

States May Not Be Willing to Improve Access

For financial reasons, states may not be willing to voluntarily improve Medicaid recipients' access to nursing homes through payment reforms or other measures, such as expanding the supply of nursing home beds. In an environment of tight budgets and competing priorities for expanded services, some states have acted in ways that do not promote improved access. South Carolina, for example, placed a moratorium on new Medicaid nursing home beds in 1981, resulting in a decline in the percentage of Medicaid residents from over 80 percent to about 71 percent in 1988. California and Mississippi have imposed limits on the amount of Medicaid spending, effectively restricting their ability to expand the number of Medicaid nursing home beds or implement payment reforms. (See pp. 29-33.)

Regulatory Reforms to Improve Access

Regulatory reforms that remove the source of payment as a criterion for admission can improve access for Medicaid recipients. Connecticut and Ohio established so called wait list laws essentially requiring nursing homes to admit applicants on a first-come, first-served basis. Four states (Massachusetts, New York, Ohio, and South Carolina) established census requirements—admissions must be on a first-come, first-served basis until a specified census of Medicaid recipients is achieved.

Some officials, however, considered such regulatory reforms inappropriate and ineffective. Some questioned the appropriateness of regulatory reforms because they remove nursing home flexibility to select private payers over Medicaid recipients. They maintain that this flexibility is essential for financial viability; if states want equity of access, they must also provide equity of payment. Others felt census requirements institutionalized discrimination in the Medicaid program by allowing nursing homes to openly discriminate against Medicaid recipients after the home has reached a predetermined population of Medicaid recipients. Little data was available to evaluate the effectiveness of regulatory reforms. (See pp. 33-36.)

Recommendations

This report contains no recommendations.

Agency Comments

GAO did not obtain written comments on this report. GAO discussed the issues addressed in this report with HCFA officials. Their comments are included where appropriate.

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children
AND	administratively necessary day
DRG	diagnosis related group
GAO	General Accounting Office
HCFA	Health Care Financing Administration
ICF	intermediate care facility
SNF	skilled nursing facility
SSI	Supplemental Security Income

Introduction

People whose health care is paid through Medicaid—Medicaid recipients—generally have more trouble getting into a nursing home than those who pay for their own care—private payers. State long-term care ombudsmen (state advocates for the elderly who resolve complaints about nursing homes) have consistently identified Medicaid recipients' access to nursing homes as a significant problem. Moreover, we reported in 1988 that Medicaid recipients are among those most likely to wait for nursing home admission.[1]

Responding to a request from Senator Howard Metzenbaum, we identified the types of Medicaid recipients and other elderly, including those thought to be suffering from Alzheimer's disease,[2] who have problems getting into nursing homes, factors contributing to those problems, the effects of those problems on health care costs, and state actions to improve access.

Medicaid

Medicaid is a federally aided, state-administered medical assistance program intended, among other things, to provide the poor with access to mainstream health care. It became effective on January 1, 1966, under authority of title XIX of the Social Security Act (42 U.S.C. 1396).

Each state designs and manages its Medicaid program within broad federal guidelines administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services. Title XIX requires states to provide certain basic services to the majority of Medicaid recipients; these services include inpatient and outpatient hospital, home health, physician, and skilled nursing facility (SNF) services.[3] States may also provide other "optional" services, including home and

[1]Long-Term Care for the Elderly: Issues of Need, Access, and Cost (GAO/HRD-89-4, Nov. 28, 1988). Other groups likely to wait for nursing home admission include those with mental/behavioral problems and those whose condition requires extra nursing care.

[2]Alzheimer's is a cause of dementia. It is a degenerative disease of the central nervous system characterized by a gradual decline in intellectual functioning (memory, thought, and language) and behavioral problems, such as disruptiveness and wandering. Its diagnosis is exceedingly difficult and is usually made after other causes of dementia, such as alcohol intoxication, brain tumor, stroke, and depression have been excluded. The definitive diagnosis of Alzheimer's disease is made based on the examination of brain tissue taken at autopsy.

[3]SNFs care for people whose need for daily professional nursing services is demonstrated and documented.

community based long-term care services and services in intermediate care facilities (ICFs).[4]

The federal and state government shares of Medicaid spending are determined by a statutory formula that provides a minimum federal share of 50 percent and a higher share to states with low per capita incomes. During 1989, the maximum federal share was about 79 percent.

Medicaid eligibility criteria are among the most complex of any assistance programs. At a minimum, states must provide Medicaid coverage to all people receiving cash assistance under the federal Aid to Families With Dependent Children (AFDC) program and to almost all people covered by the Supplemental Security Income (SSI) program.[5] However, people in or attempting to gain admission to nursing homes can obtain coverage in other ways. Thirty-one states and the District of Columbia extend coverage to those whose financial resources, after deducting for medical expenses, meet Medicaid income and asset limits. The other 19 states extend coverage to those whose income is below 300 percent of the SSI payment level and assets are below state established limits. A substantial portion of a Medicaid recipient's income is applied to the cost of care and Medicaid pays the remaining amount.

Many Elderly Rely on Medicaid for Help in Paying for Nursing Home Care

The high cost of nursing home care—approximately $25,000 or more per year—and the limited coverage available under Medicare and private insurance force many elderly to rely on Medicaid's assistance in paying for nursing home care.[6] Many elderly apply for Medicaid coverage when trying to gain admission to a nursing home. Nursing homes are generally reluctant to admit anyone without a guaranteed source of

[4]ICFs care for people who do not require the degree of care and treatment a hospital or SNF provides but, because of a physical or mental condition, require supervision, protection, or assistance. Beginning October 1, 1990, the distinction between SNFs and ICFs will be eliminated and all nursing facilities participating in Medicaid will have to meet a single set of quality standards for services, residents' rights, and administration.

[5]States can choose to limit Medicaid coverage of SSI recipients by requiring them to meet more restrictive eligibility standards that were in effect on January 1, 1972, before implementation of SSI. States choosing this option, however, must allow applicants to deduct SSI, optional state supplements, and medical expenses from income to establish eligibility. Fourteen states use the more restrictive standards option: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Utah, and Virginia. These states are commonly referred to as 209(b) states.

[6]Medicare is a federal health insurance program that covers most Americans 65 years of age or older and certain people under 65 years of age who are disabled or have chronic kidney disease. Only limited SNF services and no ICF services are covered by Medicare.

payment and, consequently, access to nursing homes can be limited while a state determines an applicant's eligibility.

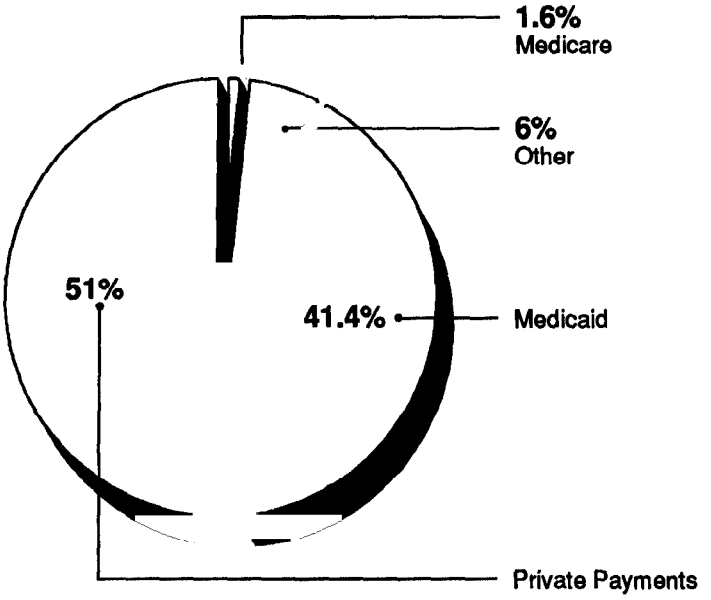
Historically, about 40 percent of elderly nursing home residents enter as Medicaid recipients, about 50 percent as private payers, and the remaining 10 percent under private insurance, Medicare, or other public programs. Some of those who enter a nursing home as private payers, however, subsequently become Medicaid-eligible. One recent study found that about 11 percent of those entering as private payers spent down to Medicaid-eligibility levels during their stay.[7] Overall, about two-thirds of nursing home residents are receiving Medicaid assistance at any point.

Medicaid Is an Important Source of Revenues for Nursing Homes

Private payments from individuals and their families is the primary source of revenue for nursing homes, followed by Medicaid payments, the primary public funding source. As shown in figure 1.1, these two sources accounted for more than 92 percent of total national nursing home revenues in calendar year 1986. Medicare financed less than 2 percent, with other sources, such as public agencies and private long-term care insurers, financing the remaining 6 percent.

[7]Korbin Liu, Pamela Doty, and Kenneth Manton, "Medicaid Spenddown in Nursing Homes," The Gerontologist, Vol. 30, No. 1, 1990, pp. 7-15.

Figure 1.1: Source of Nursing Home Revenues (Calendar Year 1986)



Source: Congressional Research Service.

Nursing Home Spending Strains State and Federal Medicaid Budgets

Medicaid spending for nursing home care is likely to grow as the population ages,[8] further straining federal and state Medicaid budgets. Intended initially as an acute-care program for the poor, Medicaid has become the principal public program financing long-term nursing home care for the elderly and disabled. Although not foreseen when Medicaid was enacted in 1965, spending for nursing home care is one of the largest components of Medicaid spending. Approximately $14.3 billion of the total $48.7 billion in federal and state Medicaid spending went for nursing home care in fiscal year 1988.

Two ways that states can control increased Medicaid nursing home spending are restricting the supply of nursing home beds and limiting Medicaid payment rates for nursing home care. States can restrict the bed supply by limiting construction of nursing homes or by limiting the number of beds the states will certify for Medicaid payments. Restricting the supply of beds, in turn, can create a situation in which demand for nursing home care exceeds the supply of available beds.

[8]Between 1987 and 2020, the Bureau of the Census estimates that the 65 and over age group will grow from 1 in 8 to 1 in 5 of the American population. People 85 and older, who are at the greatest risk of needing nursing home care, represent the fastest growing segment of the elderly population.

When this occurs, nursing homes choosing to participate in the Medicaid program have more of an incentive to select those applicants who are most profitable—such as higher paying private payers or those Medicaid recipients who need relatively limited care.[9] Other Medicaid recipients with greater care needs may have trouble gaining access to a nursing home.

Objectives, Scope, and Methodology

Our objectives were to identify (1) the types of Medicaid recipients and other elderly who have problems getting into nursing homes, (2) the factors contributing to those problems, (3) the effects of those problems on health care costs, and (4) state actions to improve access to nursing homes for Medicaid recipients and other elderly.

To meet these objectives, we

- reviewed, synthesized, and analyzed information from research and reports on nursing home access issues;
- discussed factors that affect Medicaid recipients' access to nursing homes with long-term care experts, including officials from nursing home industry associations, advocacy groups for the elderly, health policy organizations, and federal agencies; and
- conducted structured interviews in nine states to gather and analyze information on (1) the types of elderly having problems getting into nursing homes, (2) the severity of access problems, (3) factors contributing to the access problems and affecting the ability of the state to improve access, and (4) state actions to improve access.[10]

In each state we interviewed Medicaid and health department officials, long-term care ombudsmen, representatives from nursing home industry associations, advocates for the elderly, and a judgmental sample of hospital discharge planners and nursing home officials.

We did not attempt to quantify the severity of Medicaid recipients' problems in gaining access to nursing homes because of the lack of (1) generally accepted measures of access and (2) consistent quantitative

[9]Seventy-five percent of all nursing homes voluntarily participate in the Medicaid program.

[10]The nine states (California, Connecticut, Florida, Massachusetts, Minnesota, Mississippi, New York, Ohio, and South Carolina) were selected to provide diversity in (1) geographic location, (2) per capita income (which affects states' ability to provide Medicaid services), (3) the number of nursing home beds per 1,000 elderly over age 65, and (4) the Medicaid payments to nursing homes.

data on access problems. Where available, however, we did obtain and analyze studies attempting to quantify the severity of access problems.

We performed our work between September 1988 and May 1989 in accordance with generally accepted government auditing standards.

The Nature and Effects of Problems in Getting Into Nursing Homes Vary

There are no generally accepted measures of access. Frequently cited data used to describe nursing home access include such measures as the number of beds per 1,000 elderly over age 65, occupancy rates, waiting times, and the percentage of nursing homes participating in Medicaid. But evaluating access based on these measures can be misleading. Further, consistent quantifiable data on the extent and severity of access problems are limited.

During our visits to nine states, we found a wide variation in the types of Medicaid recipients having access problems. Other than Medicaid recipients, those having problems gaining access to nursing homes were individuals awaiting approval of Medicaid eligibility and those with Alzheimer's disease or behavioral problems.

In some states, time spent waiting for a nursing home bed to become available is used as a measure of the severity of access problems. When the elderly spend that time in a hospital, health care costs increase. In some cases, these increased costs, however, are absorbed by the hospital or the Medicare program, giving the state little incentive to see that Medicaid recipients are placed in nursing homes because the state Medicaid program does not assume liability until residents enter the nursing home.

Little Data Available on Extent and Severity of Access Problems

Although it is generally conceded that Medicaid recipients have more trouble getting into nursing homes than private payers, there are little data available, either at the national or state level, on the extent and severity of access problems. Further, while there is a common understanding of what is meant by the concept of "access to care" (that is, do those who need health care gain entry into the system?), there are no generally accepted measures of access.

Without any generally accepted measures, nursing home access problems are frequently described by such measures as

- how many nursing home beds there are per 1,000 elderly over age 65,
- how long is the waiting period to get into a nursing home,
- whether the nursing home of choice or in the desired location is available,
- how many nursing homes accept Medicaid recipients,
- how many nursing home beds are full (occupancy rates),
- how many elderly are going without needed services that are provided in nursing homes, and

- how many patients remain in the hospital because they cannot get into a nursing home.

Consistent quantitative data on the extent and severity of access problems that would permit comparisons among states are limited. Frequently cited data relate nursing home access to bed supply, comparing beds per 1,000 elderly and occupancy rates.

Evaluating access based solely on such measures can be misleading. Referring to data in table 2.1, for example, Medicaid recipients would appear to have significant access problems in Florida based on the low number of beds per 1,000 elderly. The relatively low occupancy rates of Florida nursing homes suggests, however, that beds are available. A lower ratio of beds per 1,000 elderly may be adequate if the state provides a wide range of alternative care services to allow them to remain in the community. Most of the officials we spoke with in Florida thought that the supply of nursing home beds was adequate.

Table 2.1: Bed Supply-Related Measures of Access in Selected States

State	Beds per 1,000 elderly[a]	Occupancy rates[b]
California	41.7	93
Connecticut	64.3	94–97
Florida	26.7	90
Massachusetts	59.4	98
Minnesota	89.6	94
Mississippi	45.8	98
New York	43.4	98
Ohio	63.7	88–90
South Carolina	36.5	98

[a]HCFA, 1986 data.

[b]As reported during visit.

A bed supply that appears adequate based on a high ratio of beds per 1,000 elderly may not be adequate if available beds are occupied by patients who do not really need to be in a nursing home or if the beds are not Medicaid-certified or not made available to Medicaid recipients. An ample bed supply may go unfilled if Medicaid payment rates are too low to make it profitable to admit most Medicaid recipients. Finally, measuring access based on the number of facilities participating in Medicaid can be misleading in assessing access for Medicaid recipients because participating facilities may seek Medicaid certification for only

part of the facility's beds or may limit the number of Medicaid recipients admitted or both.

Because of the limitations in the current measures of access, we visited nine states to obtain a better understanding of the nature and severity of access problems.

Wide Variation in Types and Severity of Access Problems

Interviews with Medicaid officials, long-term care ombudsmen, hospital discharge planners, nursing home operators, and industry association representatives in each of the nine states visited revealed wide variation in the types and severity of access problems for Medicaid recipients. In addition to Medicaid recipients, they frequently reported access problems for those with (1) no guaranteed source of payment (including those with Medicaid applications pending) and (2) Alzheimer's or other behavioral problems. As shown in table 2.2, state official's comments indicated variation among states in the predominant types of Medicaid recipients with access problems.

Table 2.2: Predominant Types of Medicaid Recipients Having Access Problems

	Care needs[a]	
State	**Light**	**Heavy**
California	Yes	Yes
Connecticut	No	Yes
Florida	No	Yes
Massachusetts	Yes	Yes
Minnesota	No	No[b]
Mississippi	No	Yes
New York	Yes	No[b]
Ohio	No	No[b]
South Carolina	Yes	Yes

[a]Nursing home residents, including Medicaid beneficiaries, are usually categorized according to their care needs, ranging from light to heavy care. Contrasted with light care patients, heavy care patients are those needing more assistance in activities of daily living (eating, bathing, dressing, using the toilet, getting in or out of a chair or bed, and continence—i.e., bowel or bladder control) and also includes those who may need special nursing services.

[b]Although heavy care patients in general did not have trouble getting into nursing homes, those with the heaviest care needs were still experiencing some access problems.

In two states (Ohio and Minnesota) Medicaid recipients were said to experience few problems getting into nursing homes. Only those with the heaviest care needs, such as ventilator dependent residents, were said to be having trouble finding nursing home beds. The Ohio long-term care ombudsman said that in 1988 he received only 11 complaints

relating specifically to nursing home admission practices. He said that in the late 1970s he was receiving about 250 complaints a year. Hospital discharge planners in Minnesota cited their ability to place a Medicaid recipient in a nursing home within 72 hours or even directly from the emergency room, if necessary, as evidence that Medicaid recipients generally do not have access problems.

In contrast to Ohio and Minnesota, the severity of access problems was expressed in terms of waiting times by officials from five states:

- The Massachusetts Executive Office of Elder Affairs found that Medicaid recipients waited an average of 101 days for nursing home placement compared to 56 days for private payers. A study conducted by the University of Massachusetts also found longer average waiting times for Medicaid recipients.
- Hospital discharge planners in Connecticut said that the severity of access problems varies across the state. In some areas, Medicaid recipients can be placed as quickly as private payers, while in other areas placement takes an average of 4 weeks for Medicaid recipients but only 5 days for private payers.
- Hospital discharge planners in New York told us that placement takes significantly longer for Medicaid recipients. One said it takes 88 days to place Medicaid recipients, 45 days to place private payers. Another said the difference at his hospital was 171 days for Medicaid recipients compared to 71 for private payers. Likewise, the New York Public Health Council reported that it took Medicaid recipients an average of about 41 days to find an available bed in 1984 compared to about 29 days for private payers.
- A 1987 report by the Florida Statewide Health Council reported longer placement times for Medicaid recipients, particularly those with heavy care needs. Hospital discharge planners and the long-term care ombudsman also said that Medicaid patients must wait longer for placement but did not estimate how much longer.
- Discharge planners in California reported average placement times for private payers of 1 or 2 days and about 7 days for Medicaid recipients. Placement times for heavy care Medicaid recipients were said to average 4 to 6 weeks, with some remaining in the hospital 6 to 8 months awaiting a nursing home bed. A study by California's auditor general concluded that from 8 to 12 percent of the Medicaid population have care needs so extensive that they have trouble getting into nursing homes.

Several officials described access problems in terms of the recipients' ability to get into the nursing home of choice. For example, in New York,

a representative from Friends and Relatives of the Institutionalized Aged said that Medicaid patients can eventually find a nursing home bed but generally cannot get into the nursing home of their choice. Further, many nursing homes were, he said, segregating Medicaid and private-pay residents within the nursing home. Advocates for the elderly in Connecticut similarly said that Medicaid recipients generally have fewer choices of nursing homes but, other than heavy care patients, do not have trouble getting into nursing homes.

Elderly with behavioral problems thought to be caused by Alzheimer's disease or other conditions may have trouble getting into nursing homes whether they are Medicaid recipients or not. Officials in all nine states indicated that access problems probably exist for these people, but none could estimate the extent of the problems. Residents with Alzheimer's disease often disrupt other nursing home residents. In addition, some Alzheimer's residents have a tendency to wander, making them difficult to manage in nursing homes not specifically designed to allow wandering in a controlled environment. Nursing homes specifically consider behavior during the admissions process, one California advocate explained, and determine how well the individual would fit in with the overall environment of the home. Discharge planners from the Ohio State University Hospital told us that they have trouble placing Alzheimer's patients who are combative or wander. In Mississippi, Alzheimer's residents are considered heavy care residents in a nursing home market oriented toward light care. Only one or two nursing homes in the state currently have special Alzheimer's units.

Other elderly identified as having problems getting into nursing homes are those who have too much income and assets to immediately qualify for Medicaid but too little to pay for care as a private payer for more than a few months. In states, such as South Carolina and Florida, that do not allow the elderly to spend down "excess" income to Medicaid eligibility levels, nursing homes may be reluctant to admit such patients

because once their assets are gone they will have no guaranteed source of payment.[1]

Elderly in Hospitals Awaiting Nursing Home Placement Increase Health Care Costs

When Medicaid recipients in need of nursing home care remain unnecessarily in the hospital because a nursing home bed is not available, health care costs increase. Although data on the number of days and costs associated with such unnecessary hospital stays are limited, significant problems appeared to exist in several of the states visited. Many of the costs of such stays are, however, shifted from Medicaid to Medicare or the hospital.[2]

[1]While most states allow the elderly whose income and/or assets exceed Medicaid eligibility limits to qualify for Medicaid after spending those "excess" resources on health care, there are 19 states, including 3 we visited (Florida, South Carolina, and Mississippi), that do not allow the elderly to establish eligibility for nursing home care through spend down. In such states, the elderly with income slightly above the Medicaid-eligibility level may have trouble getting into nursing homes unless a family member is willing to guarantee payment.

South Carolina, for example, uses the 300-percent rule to establish Medicaid eligibility for nursing home care. This means that the elderly with income above 300 percent of the SSI payment level cannot become Medicaid-eligible regardless of how much of their income they spend on their own care. For example, a person with a $1,065 per month pension during 1989 would have too much income to qualify for Medicaid but too little to pay higher monthly private-pay charges for nursing home care in South Carolina. Such people "fall through the cracks" unless they have a family member or other person willing to guarantee payment of the difference between charges and what the person can afford to pay. Included in this group, state officials said, are a number of retired teachers, state employees, and civil service retirees.

[2]Other problems can also result. Medicaid recipients could be forced to remain in the community without getting all the care they need; the availability of home- and community-based long-term care was generally viewed as inadequate in each of the nine states visited. The recipients also are likely to become an excessive burden on family caregivers.

Many Patients Stay in the Hospital Waiting for Nursing Home Placement

Some patients cannot be discharged from acute-care hospitals as soon as a physician indicates their readiness because a nursing home bed is not available or their Medicaid eligibility has not been established.[3] The days that patients spend in the hospital waiting for a Medicare or Medicaid nursing home bed are commonly referred to as "administratively necessary days" (ANDs).

National data on the number of patients waiting in hospitals for nursing home placement and the time spent waiting are very limited. We previously reported, however, that ANDs are a serious problem in some states and can significantly increase health care costs.[4] Similarly, the Congressional Research Service reported that Massachusetts hospitals provided about 260,000 ANDs in 1985. ANDs continue to be a problem in some states. For example:

- ANDs increased 55 percent in California from fiscal year 1985-86 (80,340 days at a cost of $5.7 million) to fiscal year 1986-87 (124,903 days at a cost of $10.5 million), the state's auditor general reported. Good data on the specific nature of ANDs were not available, but the auditor general reported most appear to be because placement cannot be arranged.
- 412 Medicaid recipients were in Massachusetts hospitals awaiting placement in a SNF on the day surveyed by the Massachusetts Hospital Association (April 27, 1989). In total, they had been waiting over 100,000 days on AND status, an average of 8 months per Medicaid recipient.
- Mississippi patients are in a medically unnecessary status for an average of 91 days awaiting nursing home placement, a survey by the Mississippi Society for Hospital Social Work Directors found.

[3]Because they have no guaranteed source of payment, elderly who meet Medicaid income and asset limits and have applied for Medicaid find it difficult to get into a nursing home until their application is processed and eligibility established. Although almost all applications are eventually approved and Medicaid payments made retroactive to the date of the application, nursing homes can experience cash flow problems if they admit applicants who have not yet been approved for Medicaid.

Therefore, elderly people awaiting Medicaid eligibility may remain unnecessarily in the hospital because nursing homes are reluctant to admit them. For example, Connecticut officials said that the elderly with pending Medicaid applications frequently remain in hospitals for as long as 90 days awaiting placement in nursing homes; the cost of such care is paid by Medicare and the hospital. Hospital social workers in South Carolina made similar statements. A nursing home administrator in South Carolina said that, in her opinion, patients whose Medicaid applications are pending are the most difficult to place. A consumer advocate in New York said that nursing homes that admit patients with pending Medicaid applications are "courting financial disaster" because of the cash flow problem. He said that the application process in New York, while typically taking 45 to 60 days, can take as long as 3 years.

[4]Ohio's Medicaid Program: Problems Identified Can Have National Importance (GAO/HRD-78-98A, Oct. 23, 1978).

Effect of ANDs on Health Care Costs

The net effect of ANDs on health care costs is difficult to estimate because the costs may be paid by Medicare or Medicaid, absorbed by the hospital, or a combination of both. In addition, the alternative cost of caring for these patients in nursing homes, had they not been in hospitals, must be considered as well. It is clear, however, that they increase overall health care costs.

Medicare Payments for ANDs

Medicare covers most hospital stays for the elderly, including the stays of those who also qualify for Medicaid. Medicare pays hospitals for each beneficiary at a preestablished (diagnosis related group (DRG)) rate, regardless of the costs actually incurred for the beneficiary. The payment system, however, does have a mechanism to recognize longer hospital stays. When a beneficiary has an extraordinarily long length of stay compared to other beneficiaries in the DRG, a hospital can qualify for an additional "outlier" payment. For each DRG, Medicare regulations establish the extent to which the hospital stay must exceed the average to qualify for payment as an outlier.

The additional payment for a day outlier is a per diem amount based on 60 percent of the average Medicare per diem rate under the DRG. The payment is intended to approximate the marginal cost of care beyond the outlier cut-off criteria. The hospital must absorb the costs of any ANDs until the criteria for outlier payments are met.

The number of days of outlier care can provide an approximate estimate of the number and cost of ANDs. It provides, however, only an estimate because (1) some patients qualifying for outlier payments still require hospital care, and (2) patients with ANDs will not have outlier payments associated with those days if they are discharged before reaching a stay long enough to qualify as an outlier.

Medicaid Payments for ANDs

While still in a hospital, some elderly lose their Medicare coverage because they (1) exhaust their Medicare benefit or (2) no longer require acute care or Medicare skilled care. When this happens, and the person is Medicaid eligible and needs a nursing home bed that is not available, the cost of ANDs is covered by Medicaid in some states. As shown by table 2.3, five states we visited pay for ANDs at rates ranging from $0 to $444 higher than the rates paid for skilled nursing home care. The other four states do not pay for ANDs under their Medicaid program, thus forcing hospitals to absorb the costs of ANDs not covered by Medicare.

Table 2.3: Comparison of Average Medicaid Payment Rates for SNFs and ANDs

State	Does Medicaid cover ANDs?	Average SNF rate	Average and rate
California	Yes	$60	$184[a]
Connecticut	Yes	97	[b]
Florida	No	[c]	[c]
Massachusetts	Yes	100	235–270
Minnesota	No	[c]	[c]
Mississippi	Yes[d]	50	402–494[e]
New York	Yes	89[f]	89[f]
Ohio	No	[c]	[c]
South Carolina	No	[c]	[c]

[a]Maximum; average not available.

[b]Not available.

[c]Not applicable.

[d]Limited to 30 days per hospital stay.

[e]Rate depends on hospital size.

[f]In New York City, $114.

Those states that do not pay for ANDs do not always have incentive to reduce ANDs by seeing that elderly patients who have exhausted regular Medicare benefits are placed in nursing homes. By allowing patients to remain in hospitals in an AND status, many of the costs may be absorbed by Medicare or the hospital or both. For example, South Carolina, which does not pay for ANDs under its Medicaid program, allows patients to become an uncompensated care burden on the hospital unless they qualify for day outlier payments under Medicare. Once they are placed in a nursing home, however, the South Carolina Medicaid program begins to incur a liability. In South Carolina, ANDs thus reduce state spending for Medicaid but increase overall health care spending.

Payment Reforms Can Improve Access to Nursing Homes

States can improve access to nursing homes for Medicaid recipients by establishing payment reforms. States have considerable flexibility in setting Medicaid-payment rates and systems. They have used that flexibility to establish systems where rates are set in advance. States that have a wide difference between Medicaid and private-payment rates have more access problems than states with a smaller difference between rates. Reducing the differences between rates by increasing the Medicaid rate decreases the financial incentive nursing homes have to select private payers over Medicaid recipients, resulting in fewer access problems. However, unless payments are also adjusted for patient care needs, nursing homes have an incentive to select those Medicaid patients needing lighter care. Thus, reducing the difference between Medicaid and private payers may not help Medicaid patients needing heavy care. Conversely, basing Medicaid payments on care needs can improve access for heavy care Medicaid recipients, sometimes at the expense of light care recipients.

States Have Considerable Flexibility in Setting Medicaid-Payment Rates

Within broad federal guidelines, states have considerable flexibility to design their Medicaid nursing home payment systems and set payment rates. Under provisions enacted in the Omnibus Reconciliation Act of 1980, states must provide for payment for nursing home care through the use of rates that the state finds are reasonable and adequate to meet costs. These are costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. States must make satisfactory assurances to the Secretary of HHS that rates meet these criteria.[1]

Most states have used the flexibility provided by the 1980 act to establish or modify prospective payment systems. Under these systems, per diem rates are set in advance and the nursing home may be permitted to keep all or part of the difference between the rate and actual costs. If

[1]We concluded in Medicaid: Methods for Setting Nursing Home Rates Should Be Improved (GAO/HRD-86-26, May 9, 1986), that, due to a lack of HCFA guidance and oversight, HCFA and the states do not know whether payment rates are reasonable and adequate. HCFA disagreed with our recommendation to establish guidelines for states to use in making assurances that rates are reasonable and adequate. Since 1980, lawsuits have been brought in numerous states challenging Medicaid nursing home rates on the basis that rates are not reasonable and adequate as required under Medicaid law. The Supreme Court recently held, in Wilder v. Virginia Hospital Association that such suits are proper, and expectations are that they will continue to proliferate.

the home's costs are more than the prospective payment rate, it suffers a loss.[2]

Reducing Rate Difference May Improve Access for Those Needing Light Care

States that have a small difference between Medicaid and private-pay rates generally reported fewer access problems for light care Medicaid recipients. Reducing the difference can improve access by decreasing the financial incentive to select private payers over Medicaid recipients. State actions to reduce the rate difference could include increasing Medicaid rates, setting equal rates for Medicaid recipients and private payers or setting a limit on private-pay rates.

Relationship Between Access Problems and Payment Rates and Methods

As shown in table 3.1, the types of Medicaid recipients having the most trouble getting into nursing homes depends on the difference between Medicaid and private-payment rates and the extent to which Medicaid rates are adjusted based on care needs.

Table 3.1: Relationship Between Access Problems and Medicaid Payments

	Types of recipients having problems		Medicaid payments	
State	Light care	Heavy care	Much lower than private pay?	Based on care needs?
California	Yes	Yes	Yes	No
Connecticut	No	Yes	No	No
Florida	No	Yes	No	No
Massachusetts	Yes	Yes	Yes	No
Minnesota	No	No	No	Yes
Mississippi	No	Yes	No	No
New York	Yes	No	Yes	Yes
Ohio	No	No	No	Yes
South Carolina	Yes	Yes	Yes	No

In each of the three states where Medicaid recipients with light and heavy care needs had problems getting into nursing homes, the state did

[2]Although specific methods used to establish prospective payment rates vary, states generally (1) establish allowable nursing home costs for some specified base period using actual cost data submitted by nursing homes on annual cost reports, (2) assign the state's nursing homes to various subgroups (such as urban vs. rural, SNF vs. ICF) to reflect differences in their operating costs, (3) establish a maximum or "cap" on costs to be reimbursed so that inefficient or uneconomical nursing homes will not be "rewarded" for their high costs, and (4) apply indices to the base-year costs to account for economic inflation since that year.

not have a payment system based on care needs, and the Medicaid payment was much lower than the private-pay rate. States where Medicaid recipients with light care needs did not have problems getting into nursing homes, the Medicaid payment was not much lower than the private-pay rate.

Equal Rates Removes Financial Incentive to Select Private Payers

Requiring that Medicaid and private-pay rates be the same removes a nursing home's financial incentive to select private payers over Medicaid recipients. Advocates for the elderly generally support equal rates as a way to eliminate access problems for Medicaid recipients, asserting that the financial incentive to select private payers must be eliminated before access problems can be eliminated. Industry representatives, on the other hand, usually do not support equal rates because nursing home revenues would then be controlled by the states because they would set the payment rates nursing homes could charge for private payers and Medicaid residents.

Minnesota equalized Medicaid and private-pay rates in 1978 at the impetus of private payers, who argued that the difference between the Medicaid and private payments was a form of taxation on them or their families because the higher private payments were subsidizing the Medicaid-payment rates. In addition, advocates favored equal rates because they realized it would improve access for Medicaid recipients. Most of the nursing home industry did not oppose the law primarily because the difference between the Medicaid and private payments was small, and the Medicaid payment was based on costs incurred. With Medicaid and private-payment rates being equal, Medicaid recipients in Minnesota generally do not have problems getting into nursing homes. Access problems for Medicaid recipients in Minnesota, however, were not significant before the adoption of equal rates.

Increasing Medicaid Rates Can Improve Access

Two of the states included in our review (Ohio and Florida) increased their Medicaid-payment rates in an attempt to improve access to nursing homes for Medicaid recipients. Both states reported significant improvement following the increases.

Ohio increased its Medicaid payment, providing a financial incentive to nursing homes to admit more Medicaid recipients. The difference between the Medicaid and private-pay rates was decreased from $10 to $15 per day in the mid-1970s to $5 per day in 1989. The state's long-term care ombudsman said that nursing homes often chose to keep

nursing home beds empty rather than admit Medicaid recipients before the rate increase. State officials report that since the state increased the Medicaid rate, the statewide Medicaid census in nursing homes has increased from 50 to 65 percent without displacing private payers; beds once kept empty are now occupied by Medicaid recipients.

Florida, like Ohio, significantly increased Medicaid nursing home rates, decreasing access problems. Before 1983, Florida had one of the lowest Medicaid-payment rates in the country. As a result, Medicaid recipients were having significant problems in getting into nursing homes. The state increased Medicaid nursing home rates after the settlement of a nursing home association lawsuit claiming that Medicaid-payment rates were too low to allow nursing homes to recover the costs of caring for Medicaid residents. At the time of our review, Florida's Medicaid rate was in the top 50 percent. Most state and industry officials and advocates agree that the higher rates have improved access to the point where problems are limited primarily to heavy care Medicaid patients.

Connecticut Sets Limit on Rate Difference

Rather than increasing Medicaid rates, Connecticut, in 1980, placed a cap on private-pay rates that limits the difference between Medicaid and private-pay rates. Private-pay rates can be no more than 12 percent higher than the Medicaid rate for a triple occupancy room; 25 percent higher for a double occupancy room; and 50 percent higher for a private room. State and industry officials, advocates, and hospital discharge planners generally agreed that the Medicaid rates were adequate overall. They said that the payment system, however, made it difficult for heavy care patients and patients with behavioral problems, such as some Alzheimer's patients, to get into nursing homes. Problems for light care patients appear to be limited to difficulties or delays in getting into the nursing home of choice.

Basing Medicaid Payments on Care Needs Can Improve Access for Those Needing Heavy Care

Frequently, the Medicaid recipients having the most trouble getting into nursing homes are those with the heaviest care needs. Basing Medicaid payments on the care needs of the individual can improve access to nursing homes for those needing heavy care. Nursing homes are not likely to admit a patient if the cost of caring for the patient is likely to exceed the payment received. For example, Connecticut and Florida improved access for light care Medicaid recipients by decreasing the difference between Medicaid and private-pay rates; heavy care patients, however, continued to have trouble getting into nursing homes. Minnesota, New York, and Ohio, on the other hand, minimized this problem by

setting Medicaid payments based on the individual Medicaid recipient's care needs.

Minnesota implemented a needs-based payment system in 1985. Under the system, individuals are classified into 11 levels of care based on their dependencies in the activities of daily living,[3] special nursing needs (for example, tube feeding, intravenous therapy), and behavioral problems (for example, wandering, physically or verbally abusive).

Although the needs-based payment system has, officials told us, improved access for most heavy care recipients in Minnesota, those with the heaviest care needs still have trouble getting into nursing homes; this is because the upper limit of the case mix payment is too low to cover the cost of caring for these recipients. Likewise, discharge planners from the Ohio State University Hospital told us that, although under the state's needs-based payment system most Medicaid recipients going from acute-care hospitals to nursing homes have few problems gaining admission, those with the heaviest care needs may still have trouble getting into a nursing home. Again, this is because the upper rate level under the payment system is too low to cover the cost of caring for these types of Medicaid recipients. Similar views were expressed by state and industry officials in Ohio.

New York's needs-based payment system was implemented in 1986 to improve access for those with heavy care needs. Its goal was to address access for both private payers and Medicaid recipients needing such care, not to improve access for other Medicaid recipients. Under this system, a nursing home's Medicaid payment is based on the average case mix of all the nursing home's residents. Therefore, admitting private payers or Medicaid recipients needing heavy care increases a nursing home's Medicaid-payment rate.

State officials told us that nursing homes are admitting more people with heavy care needs since the needs-based system was implemented. A New York State Public Health Council study reported that the number of Medicaid recipients (expressed as a percentage of all nursing home applicants) being admitted to nursing homes has remained the same, 50 percent. However, the Medicaid recipients now being admitted to nursing homes are recipients needing heavier care. Like Minnesota and Ohio, however, those needing the heaviest care were still having

[3]Getting in and out of bed, dressing, getting around inside the house, bathing, eating, and using the toilet.

problems getting into nursing homes in New York. Reasons cited were lack of equipment and staff to care for these types of residents.

Factors Influencing States' Willingness to Improve Access to Nursing Homes Through Payment or Regulatory Reforms

States' willingness to voluntarily improve access to nursing homes for Medicaid recipients through changes in Medicaid-payment rates and systems can be influenced by financial conditions within a state and competing demands for limited funds. Some states have

- set controls over Medicaid spending that prevent states from supporting an expanded bed supply or higher Medicaid payments;
- budget deficits that strain their ability to meet current Medicaid program costs; or
- placed a higher priority on other programs, such as education, or on other Medicaid services, such as those for pregnant women.

One of the primary methods states have used to contain Medicaid spending is to control the supply of nursing home beds. Faced with the resulting shortage of nursing home beds, severely limited financial resources and competing priorities for those resources, some states have attempted to improve access for Medicaid recipients through regulatory reforms that are intended to give Medicaid recipients and private payers an equal chance of obtaining a nursing home bed.

Medicaid Spending for the Aged Varies by State

As shown in table 4.1, per capita state spending, including spending for long-term care, for aged Medicaid recipients varied from $2,014 in Mississippi to $11,303 in New York in 1986. Even though Mississippi had the lowest payment per aged recipient of the nine states visited, nearly 40 percent of its Medicaid payments were for aged recipients. Each of the states' Medicaid payments per aged recipient was disproportionately large compared to the percentage of aged Medicaid recipients.

Table 4.1: Variation in State Medicaid Spending for Aged Recipients

	Aged recipient as a percent of all recipients	Medicaid payments for aged recipients as a percent of all payments	Payment per aged recipient
California	13.6	23.7	$2,221
Connecticut	16.4	49.3	9,366
Florida	19.6	43.5	3,790
Massachusetts	19.6	41.3	6,649
Minnesota	16.5	43.2	7,923
Mississippi	19.6	39.8	2,014
New York	15.2	48.6	11,303
Ohio	8.8	29.2	6,331
South Carolina	17.4	30.6	2,638

Source: HCFA data for fiscal year 1986.

Legislatively Imposed Controls Over Medicaid Spending

Legislatively imposed controls over Medicaid spending can be taken as one indication of the willingness of a state legislature to improve access. These controls effectively prevent states from supporting an expanded bed supply or increased Medicaid rates. A constitutional amendment limits state spending in California. Referred to as "Gann limits," spending authority, including that for the Medicaid program, can only be increased beyond adjustments for inflation and total population growth by voter approval. State officials said that because of the spending limit, no initiative could be taken that would increase Medicaid spending. Others generally shared this view, stating that the highest priorities in California are currently education, law enforcement, and transportation.

California's auditor general reported that California ranked 38th out of 50 states in Medicaid expenditures for nursing home care per elderly resident in 1980. A comparison completed in 1987 showed similar results; California's Medicaid expenditures on nursing home care for the elderly averaged $423 per recipient compared to $851 in Massachusetts, $1,128 in Minnesota, and $1,653 in New York in 1985.

Mississippi, at the time of our visit, had a limit on its Medicaid budget of $95 million. Individual components of the program, such as nursing home care, could not increase without a corresponding decrease in another component. For example, an increase in Medicaid coverage for pregnant women and infants was accomplished by cutbacks in other services.

Industry representatives cited Mississippi's spending limits and tax base (the lowest per capita income in the nation) as the primary causes of the low Medicaid nursing home payment rates and the limited bed supply, but recognized that there were many other programs competing for the state's available tax revenues.

State Financial Condition May Influence Willingness to Improve Access

A state's financial condition may influence its willingness to support actions that would improve Medicaid recipients' access to nursing homes. Connecticut and Massachusetts have among the highest per capita incomes in the nation and long-standing commitments to long-term care. Their current financial condition, however, may influence their willingness to improve access to nursing homes for Medicaid recipients.

Connecticut's commitment to long-term care may be waning because of large budget deficits. There has been little legislative interest in expanding long-term care services. Industry representatives, advocates for the elderly, nursing home officials, and hospital discharge planners said that at present the state's overriding objective is cost containment.

Massachusetts' budget problems affect not only its willingness to improve access but also to meet existing commitments. If no new taxes are imposed, the state budget for fiscal year 1991 may have to be cut by $1.3 billion, with the Governor proposing that about 60 percent of the cuts ($735 million) come from Medicaid. Massachusetts has also delayed making Medicaid payments to nursing homes.[1] The delay, industry representatives, advocates for the elderly, and state officials agree, has caused cash flow problems for nursing homes, making them more reluctant to admit Medicaid applicants. The cash flow problems have made banks reluctant to approve loans for nursing homes that want to maintain or expand their bed supply, industry sources said.

[1]Massachusetts makes nursing home payments based on an interim rate established at the start of the rate year; it adjusts those payments at the end of the year to compensate for cost increases during the year. The state has fallen behind in making these payment adjustments, and, according to industry officials, owes nursing homes $250 million in final rate settlements. Although it disagrees with the amount it owes (the state maintains it owes $200 million), the state agrees that it has fallen behind in making payments.

Competing Priorities May Influence Willingness to Improve Access

Competing priorities, both within the Medicaid program and from other state programs, such as education, can also influence a state's willingness to improve access for Medicaid recipients. For example, officials in Ohio and California said that education was a higher priority in their states.

Competing priorities within the Medicaid program can also affect a state's willingness to improve access by expanding long-term care services. South Carolina Medicaid officials reported that the state's budget was being stressed by federally mandated expansions of Medicaid eligibility. The Medicare Catastrophic Coverage Act of 1988 made mandatory a previous Medicaid option that states cover pregnant women and infants with family incomes at or below the federal poverty level.[2] The National Governors' Association recently called for a moratorium on further expansions of Medicaid, saying that the expansions have forced states to make tradeoffs within the program.

State Actions to Control Bed Supply Have Mixed Effects on Access

Even though, as discussed in chapter 3, increased payment rates can help improve access, state efforts to control Medicaid spending by restricting the supply of nursing home beds could exacerbate access problems. Each of the states visited has either directly (through moratoria on construction of new nursing home beds) or indirectly (through the certificate-of-need programs[3] or other requirements) controlled the growth of nursing home beds. While excess bed supply can encourage overuse of nursing homes, controls that are too strict may limit access to nursing homes, especially for Medicaid recipients. Concerns were expressed by some of those interviewed in South Carolina, Mississippi, California, Massachusetts, Connecticut, and New York that the controls over bed supply were budget driven, not based on demand, and were adversely affecting Medicaid recipients' access to nursing homes.

For example, South Carolina placed a moratorium on the approval of certificates-of-need for new Medicaid nursing home beds in 1981 due to a concern about the growth in state spending for nursing home care under Medicaid. The nursing home population of Medicaid residents declined from over 80 percent before the moratorium went into effect to

[2]This provision was not repealed by the Medicare Catastrophic Coverage Repeal Act of 1989.

[3]State regulatory mechanisms for reviewing and approving or disapproving hospital-related or other capital expenditures (e.g., for nursing home beds) or the provision of certain new services. In a state with this program, a health care provider cannot initiate construction unless a certificate-of-need is obtained from the state. Review of each project is based on certain preestablished planning criteria, and approval requires a finding of community need.

about 71 percent in 1988. Also, data provided by the state showed that the number of beds per 1,000 elderly underwent a similar decline during this time. South Carolina Medicaid officials told us that the moratorium was a major factor in the declines.[4]

State officials in New York and Connecticut said that they use the certificate-of-need program to restrict the development of nursing homes and to encourage the development of alternative care services. Industry representatives and advocates, however, felt that the states were using the certificate-of-need program as a cost-containment tool. At the time of our review, New York was projecting a shortage of over 11,000 nursing home beds by 1993 (based on its certificate-of-need program).

Although California no longer has a certificate-of-need program, California Association of Health Facilities officials said that little new construction is taking place because Medicaid-payment rates are considered inadequate, capital investment costs are high, and administrative requirements for the approval of new beds are expensive. An association official said that most of the newly constructed nursing homes are exclusively private pay. A study by California's Attorney General found that the number of beds per 1,000 elderly declined from 53 to 40 between 1976 and 1986.

Regulatory Reforms to Improve Access Under Medicaid

In an environment of severely limited financial resources and competing priorities for those resources, some states have attempted to improve access to nursing homes for Medicaid recipients through regulatory reforms. These reforms include (1) wait list laws that require nursing homes to admit applicants on a first-come, first-served basis or (2) census requirements that require admissions on a first-come, first-served basis until a specified census of Medicaid residents is achieved. By removing the source of payment as a criterion for admission, these reforms are intended to give Medicaid recipients and private payers an equal chance of obtaining a nursing home bed. There is disagreement, however, over the appropriateness and effectiveness of such reforms. Of the nine states visited, two (Connecticut and Ohio) had established wait list laws. Four states (Massachusetts, New York, Ohio, and South Carolina) had established census requirements.

[4]Although South Carolina lifted the moratorium in 1986, no new Medicaid-certified beds had been completed at the time of our visit; 300 had been approved for construction.

Appropriateness of Wait List and Census Requirements Disputed

There was considerable disagreement concerning the appropriateness of wait list and census requirements. The American Health Care Association stated that wait list laws and census requirements do not allow nursing homes the flexibility to select private payers over Medicaid recipients, which they maintain is essential for financial viability. Association officials believe that if states want equity of access, they must also provide equity of payment; the Medicaid rate should be comparable to the private-pay rate.

The National Senior Citizens Law Center, an advocacy group, supports wait list laws because, in their opinion, they promote equity of access. Advocacy groups for the elderly do not, however, support census requirements because, in their view, these laws institutionalize discrimination in the Medicaid program; that is, they legitimize open discrimination against Medicaid recipients after the home has reached a predetermined population of Medicaid residents. Further, nursing homes can easily meet census requirements when, as often happens, private payers convert to Medicaid and are counted as part of the Medicaid census the nursing home must maintain.

Effectiveness of Wait List and Census Requirements Questioned

In those states that had established wait list or census requirements, there were little data on the effectiveness of the requirements. Some of those we spoke with, however, questioned their effectiveness as the following examples illustrate.

Connecticut

A first-come, first-served wait list law was implemented in 1980, state officials told us, after the state had capped private-pay rates to control spending. By capping these rates, the state could effectively control the time it takes private payers to spend down to Medicaid eligibility. Still, the difference between the Medicaid and the capped private payment provided a financial incentive for nursing homes to select private payers over Medicaid recipients. To overcome that incentive, the state enacted its wait list law.

The effect of Connecticut's law on access is unclear. We were unable to obtain data on the extent of access problems either before or after the law was implemented. State officials assert that the law has been effective, citing the 17 nursing homes fined for violation of the law between 1984 and 1988. In the state's view, these fines sent a message to the industry that the law will be enforced. The state's long-term care ombudsman also stated that the wait list law has improved access for

Medicaid recipients, citing a reduced number of complaints concerning nursing home admission practices for these recipients.

The nursing home industry, however, stated that Connecticut's wait list law has had little effect on access for Medicaid recipients. The percentage of nursing home residents with care paid by Medicaid has not changed since implementation of the law, according to the Connecticut Association of Health Care Facilities. In addition, the association maintained that nursing homes continue to attract residents from the same geographic area: nursing homes in poor areas predominantly admit Medicaid recipients. The association's representative noted, however, that the law may have improved access for Medicaid recipients seeking admission to nursing homes located in middle-income areas.

Hospital discharge planners and a Connecticut nursing home director of admissions said that nursing homes may be circumventing the intent of the wait list law. Nursing homes are (1) refusing to admit Medicaid recipients because, as they claim, they cannot provide the level of care needed and (2) offering assistance in completing lengthy and complex applications to private payers but not to Medicaid recipients. Applicants are not placed on the wait list until they have a substantially complete application.

Ohio

Ohio's wait list law differs from Connecticut's in that it also includes a census requirement; facilities with a Medicaid census of less than 80 percent must admit all applicants on a first-come, first-served basis. Once a nursing home's Medicaid census is 80 percent, it can select private payers while refusing admission to Medicaid recipients. With a statewide average Medicaid census of 67 percent, the wait list provisions apply to the majority of nursing homes in Ohio. Because the state increased the Medicaid-payment rate and established a needs-based payment system at the same time the wait list law was established, its effect on access to nursing homes is unknown. Medicaid access problems decreased significantly, but the improvement has been attributed primarily to the higher Medicaid-payment rates. (See p. 25.)

Massachusetts

A census requirement was established in 1981 as part of the certificate-of-need program; new facilities and facilities adding more than 12 beds must have a 60-percent Medicaid recipient admittance during the first year of operation. In subsequent years, the nursing home must maintain a Medicaid census equal to the average Medicaid census for nursing homes in the community in which it is located.

The census requirement may have had limited effect on Medicaid recipients' access to nursing homes because it applies only to new or expanded facilities (50 of 522 Medicaid-certified nursing homes at the time of our review). The effect is difficult to determine because, as state officials told us, the requirement is difficult to monitor. Finally, as long as there is a shortage of beds, to the extent the requirement improves access for Medicaid recipients, it merely shifts access problems to other elderly.

Although industry officials said that the census requirement was not effective, they differed on why. Representatives for the for-profit industry said that the census requirement is a disincentive to developers because nursing homes cannot survive financially on Medicaid payments in urban areas with a high ratio of Medicaid recipients. Representatives for the nonprofit industry, said, however, that the census requirement does not affect access because most of the existing nursing homes already have a high Medicaid census; as long as the new or expanded nursing homes meet the census requirement, they are free to refuse access to additional Medicaid recipients.

New York

Like Massachusetts, New York requires that new nursing homes admit a given percentage of Medicaid recipients in the first year of operation and maintain a specific Medicaid census after that. Because this requirement was recently implemented (Nov. 1988), its effect on Medicaid access is unclear. However, state officials, industry representatives, and advocates predicted that the requirement will have little effect on access because it only applies to new nursing homes, lacks enforcement provisions, and does not address the underlying causes of the access problems, namely a shortage of nursing home beds and a difference in the payment rates between private payers and Medicaid.

South Carolina

A census requirement was implemented in 1988. Under the program, nursing homes must declare at the beginning of the year how many Medicaid patient days they expect to provide in the coming year. Nursing homes can be penalized for exceeding or coming in under their approved estimates by more than 10 percent. Although the program was established to improve access to nursing homes by allowing the state to better plan for future funding needs and encouraging nursing homes to accept Medicaid patients, concerns have been raised by HCFA and others that the penalties for exceeding the anticipated Medicaid ceiling could have a negative effect on access.

Concluding Observations

Medicaid recipients have more trouble getting into nursing homes than private payers. For the most part, the reasons are financial; nursing homes prefer private payers because they pay more. Although there are little quantitative data on the extent or severity of access problems for Medicaid recipients, our visits to nine states revealed a wide variation in the types and severity of access problems for these recipients. Individuals awaiting approval of Medicaid eligibility and those with Alzheimer's disease also had problems getting into nursing homes.

If a Medicaid recipient remains in the hospital awaiting a nursing home bed, health care costs are likely to be higher than if the individual had been discharged to the nursing home at the appropriate time. In those states that do not pay for ANDs through their Medicaid program, the higher costs are likely to be absorbed by the hospital or the Medicare program, leaving the state little incentive to see that Medicaid recipients get into nursing homes.

There are no easy solutions to the access problems Medicaid recipients face. Many factors come into play, including the Medicaid-payment rate, the system used to make payments, the bed supply, and the state's willingness or ability to increase Medicaid spending.

Actions in some states to narrow or eliminate the difference between the Medicaid and private-pay rates or basing the Medicaid rate on the care needs of nursing home residents appear to have improved access for Medicaid recipients. Requiring equal rates for Medicaid recipients and private payers eliminates the financial incentive for nursing homes to select private payers. Increasing the Medicaid rate, without adjusting for patient care needs reduces the incentive to select private payers but leaves nursing homes with an incentive to select Medicaid recipients who are less expensive to care for (that is, those needing lighter care). Basing Medicaid nursing home payments on care needs improves access for those with heavier care needs but, unless the needs-based rate is sufficient to cover the cost of all needed care, those with the heaviest care needs continue to experience access problems.

Although improving access for Medicaid recipients, payment reforms, such as changing the Medicaid-payment rate or system, will also increase Medicaid nursing home spending. A state's financial condition, coupled with competing demands for services that increase costs, may influence the state's willingness to voluntarily improve access through payment reforms. Some states impose controls over Medicaid spending

that effectively limit the state's ability to improve access through payment reforms.

In an environment of limited financial resources and heavy competition for those resources, state regulatory reforms, such as wait list laws or census requirements, have been adopted as options to improve access for Medicaid recipients. Where these types of reforms have been implemented, however, there are little data on their effectiveness, which has been questioned by some. In the case of wait list laws, some of those we spoke to noted that some nursing homes may be taking actions to circumvent their intent. Census requirements appear to shift access problems to other elderly in states with a shortage of nursing home beds.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Jane L. Ross, Senior Assistant Director, (202) 275-6195 James R. Linz, Assistant Director Donald J. Walthall, Assignment Manager Jacquelyn Reid, Evaluator Eric Anderson, Social Science Analyst
Boston Regional Office	Donald B. Hunter, Regional Management Representative Vincent J. Forte, Evaluator-in-Charge Melissa P. Read, Evaluator

Ordering Information

The first five copies of each GAO report are free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20877

Orders may also be placed by calling (202) 275-6241.

United States
General Accounting Office
Washington, D.C. 20548

Official Business
Penalty for Private Use $300

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100