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[Review of Complaints Which Caused Three Nursing Homes to Withdraw from the Medicare Program]. HRD-77-137; B-164031(4). September 9, 1977. Released September 12, 1977. 7 pp.

Report to Sen. Strom Thurmond; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs: Compliance With Financing Laws and Regulations (1207).
Contact: Human Resources Div.
Budget Function: Health: Health Care Services (551).
Organization Concerned: Blue Cross of South Carolina; Blue Shield of South Carolina; Department of Health, Education, and Welfare; Social Security Administration.
Congressional Relevance: Sen. Strom Thurmond.
Authority: Social Security Act.

Complaints made by three nursing homes in South Carolina involved many of the same issues which have caused other nursing homes to withdraw from the Medicare program in the past. The most important criticism of the program is that Medicare's payment of services already provided may be denied if the intermediary determines that the services were not medically necessary. This problem can only be eliminated by liberalizing Medicare's law and regulations. Findings/Conclusions: The Honorage Nursing Center and the Commander Nursing Home in Florence, South Carolina, and the Hampton Nursing Center in Sumter, South Carolina, all complained of the large amount of paperwork required by the Medicare program. A cursory review of the forms and documents required showed the paperwork to be voluminous and frequent, but necessary to control of the program. The nursing homes also complained that the Medicare guidelines do not allow for adequate compensation of the owner-administrator of the homes. The amount of money not allowed due to limitations on compensating the owner-administrator does not seem significant, since the administrator's salaries are a small part of the nursing homes' total cost. All three of the homes complained of the uncertainty of the intermediary's decisions with regard to the necessity of the medical services and the level of care provided and of the possible financial losses which could result from losing their waivers of liability. (SC)

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

SEP 9 1977

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B-164031(4)

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The Honorable Strom Thurmond
United States Senate

Dear Senator Thurmond:

We visited the three nursing homes in South Carolina mentioned in your October 8, 1976, letter, and discussed with management their complaints which led to their withdrawal from the Medicare program. We also talked to Blue Cross and Blue Shield of South Carolina officials who were responsible for reimbursing these nursing homes.

These complaints involve many of the same issues that caused other homes to withdraw from the program in the past. We believe that the major reason for withdrawing from Medicare is the risk of financial loss if it is determined that the health care provided a beneficiary was unnecessary. This risk can only be eliminated by changing the Medicare law and regulations.

Although these three nursing homes withdrew from the Medicare program, the total number of homes participating in the program, nationwide, has remained about the same.

BACKGROUND

The primary purpose of a skilled nursing facility is to provide skilled nursing care for inpatients or rehabilitation services for the injured, sick, or disabled.

The Social Security Act provides for Medicare payments to skilled nursing facilities based on the reasonable "cost" of services. Payments based on this method can not include profits, although proprietary institutions are allowed a return on equity. The act authorized the Secretary of Health, Education, and Welfare to prescribe regulations establishing the methods to be used in determining reasonable costs.

Medicare payments are made either directly by the Government or by an intermediary selected by the provider of services. The homes we visited had selected Blue Cross and Blue Shield of South Carolina as their intermediary.

To qualify for skilled nursing care, a patient must have stayed for medical reasons in a hospital for at least 3 consecutive days and must be admitted to the skilled nursing facility within 14 days of discharge from the hospital. The patient must need and receive a skilled level of nursing care; custodial care is not covered.

The facility is responsible for deciding the level of necessary care on admission and this decision must be certified by a doctor. For continued coverage, a doctor is required to recertify the necessity of skilled nursing services within 14 days after admission. Subsequent recertifications must be made at least every 30 days.

The intermediary is responsible for reviewing if, and for how long, the patient needs skilled nursing care and may determine that some or all of the care should not be covered by Medicare.

Under Medicare regulations, a skilled nursing facility may be reimbursed for noncovered services if it makes at least 90 percent of its covered care decisions correctly and meets other conditions, such as timely submittal of admission notices. In this situation, Medicare will accept liability for an incorrect decision and pay the facility. If the error rate is greater than 10 percent the facility loses its "waiver of liability" and must bear the cost of noncovered services for at least the following 60 days, with no right to reimbursement from the patient. It may regain its waiver status if the intermediary determines that at least 90 percent of the facility's covered care decisions are correct during the 60 days following the date it lost its waiver.

As of February 1977, there were about 4,000 skilled nursing facilities participating in Medicare. Payments to skilled nursing facilities for fiscal year 1976 amounted to about $264 million.

COMPLAINTS MADE BY THREE NURSING HOMES IN SOUTH CAROLINA

We discussed the complaints made by Honorage Nursing Center and Commander Nursing Home in Florence, South Carolina, and Hampton Nursing Center in Sumter, South Carolina with the owner-administrator or manager.

All three complained of the large amount of paperwork required by the Medicare program. A cursory review of the forms and documents required showed the paperwork to be voluminous and frequent.

Although the requirements are time consuming, we believe they are necessary to control the program. We discussed this problem with intermediary officials, and they said that they considered either reducing the number of required forms or combining some of them, but determined that no changes can be made.

The nursing homes also complained that the Medicare guidelines do not allow for adequate compensation of the owner-administrator. In 1976, two were allowed $16,500, and one was allowed $18,000. According to a Medicare Bureau official, these amounts were based on the intermediary's recent studies of salaries paid to nonowner-administrators in the Bureau's Atlanta region in accordance with Medicare regulations. Bureau officials said that these salaries were in the upper range for this region and are liberal for the area of South Carolina where the homes are located.

Since the administrators' salaries are a small part of the nursing homes' total cost, and an average of only about 4 percent of the homes' patient days were for Medicare beneficiaries, the amount of money not allowed due to limitations on compensating the owner-administrator does not seem significant.

The nursing homes complained that their patients' use of Medicare was too low to justify the time needed to prepare the required paperwork. The intermediary said that the nursing homes discourage Medicare usage by their patients because they are afraid of making

incorrect level-of-care decisions which could cost them money. The homes also said that they receive less reimbursement for their services from Medicare than they receive from Medicaid or private patients. Officials of all three facilities said they believed the Medicare law was too restrictive in its reimbursement for services because profit was not allowed. They also stated that they discouraged the use of Medicare coverage by prospective patients if the individual also qualified for Medicaid. None of the three had difficulty filling their facilities with Medicaid and private patients. Therefore, there was little incentive to secure Medicare patients.

The nursing home officials said that nursing review teams sent by the intermediary sometimes overrule the medical-necessity determinations of doctors. This upsets the nursing homes because it affects their error rates and upsets the doctors because it offends their professional pride. The intermediary officials said that physicians' decisions are overruled, not because of professional judgment, but because the physicians do not understand Medicare program criteria. They added that their nursing review teams' decisions were reviewed by intermediary physicians.

Complaints by two of the nursing homes that the intermediary was consistently late in paying them or processing case information were not substantiated by case files we reviewed.

Officials of two nursing homes stated that the Medicare program provides little benefit to beneficiaries regarding skilled nursing coverage. They said that when skilled care is no longer needed by Medicare standards, Medicare coverage ceases because the program does not reimburse for custodial services. They feel the beneficiaries do not receive enough coverage to pay for their full recovery at the facility, even though the physician recommends continued service. In addition, there are Medicare patients whose doctors recommend nursing care following hospitalization, but whose conditions do not meet the program criteria for skilled care. In these cases, either the beneficiary or another program must pay for the services.

All three homes complained of the uncertainty of the intermediary's decisions and possible financial losses which could result from losing their waivers of liability. This appears to be the major reason why they left the program. Two of the homes had lost their waiver status because they did not meet the 10-percent error rate criteria. Although the losses involved for their last fiscal year were less than $1,000, the fear of not being reimbursed for services provided was of great concern.

The Social Security Administration's statistics show that as of July 1, 1976, 82 percent of the skilled nursing facilities in South Carolina were on waiver, as compared to 79 percent nationwide. Although the major reason for the loss of waiver in the Medicare Bureau's Atlanta region was that program data was submitted late, the error rate was the major reason in South Carolina.

Blue Cross and Blue Shield of South Carolina officials said that they were beginning to review cases at an earlier stage in the beneficiaries' stay than they had in the past. This should reduce the possible losses of the facilities for incorrect length-of-stay decisions. Also, they are sponsoring Medicare workshops to further educate skilled nursing facilities regarding Medicare coverage criteria to try to improve the accuracy of the facilities' decisions.

PREVIOUS GAO REPORT INVOLVING NURSING HOMES

Our report, "Sizable Amounts Due the Government by Institutions that Terminated Their Participation in the Medicare Program" (B-164031(4), Aug. 4, 1972), discussed the reasons why many skilled nursing facilities withdrew from Medicare. We listed the nine most prevalent reasons of nursing homes for ending their participation between July 1966 and April 1970. The complaints made by the three nursing homes in South Carolina are generally the same as those reasons.

We were concerned in 1972 that facilities continuing to withdraw from Medicare could reduce the elderly's access to needed health care. However, as shown below, this trend seems to have leveled off.

Skilled Nursing Facilities Participating in Medicare

Fiscal year	Number of facilities	Available beds
1976	3,928	309,800
1975	3,932	287,500
1974	3,952	294,000
1973	3,977	287,600
1972	4,041	291,600
1971	4,287	307,500
1970	4,656	333,600
1969	4,849	341,700
1968	4,702	329,600

The number of participating facilities has remained about the same since 1973, while the corresponding number of available beds has increased slightly. Statistics for 1976 show that about the same number of skilled nursing facilities joined the Medicare program as those which left.

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The complaints made by the three nursing homes we visited involve many of the same issues that caused other nursing homes to withdraw from Medicare in the past. We believe that the most important criticism of the program is that Medicare's payment of services already provided may be denied if the intermediary determines the services were not medically necessary. As with most of the complaints, the problem can only be eliminated by liberalizing Medicare's law and regulations.

Blue Cross and Blue Shield of South Carolina officials have tried recently to reduce the effects of retroactive denials and increase the facilities' understanding of the Medicare program by (1) writing simplified covered-care guidelines, (2) holding Medicare workshops, and (3) implementing prepayment audits and reducing postpayment audits to once a year. We believe that these steps should help improve some of the problem areas mentioned above.

As your office requested, agency comments were not obtained on this report. We will send copies to interested parties and make copies available upon request.

Sincerely yours,

Comptroller General
of the United States