Study Measures Impact of Cuts

The American Health Care Association (AHCA) has released a new independent analysis detailing the state-by-state impact of unintended Medicare cuts resulting from implementation of the 1997 Balanced Budget Act (BBA) and the 1999 Balanced Budget Refinement Act (BBRA).

In releasing the report, Charles H. Roadman II, MD, president and CEO of AHCA, said, “The analysis brings the skilled nursing care funding crisis home to Americans in every state.” The fifty-state analysis was prepared by The Lewin Group, an independent public policy research firm based in Falls Church, VA.

The fifty-state study stems from an original national study, conducted in May by the Lewin Group, that showed that Medicare reforms in the 1997 BBA were intended by Congress to reduce skilled nursing facility spending over the following seven years by one out of every six dollars. Yet, subsequent Congressional Budget Office (CBO) projections have forecast reductions nearly twice as large, cutting one out of every three dollars. Looked at in the aggregate, between the years 1998 and 2004, federal spending for skilled nursing facility care is now projected by the CBO to be $15.8 billion less than Congress anticipated and intended, based on the scoring of its 1997 BBA reforms.

Using both “claim payment” and “covered day” methodological criteria, which provide the broadest depth of insight into the state-by-state analysis, the states of California, Florida, Texas, New York, Pennsylvania, Ohio, Illinois, Missouri, Michigan, and New Jersey have suffered the steepest level of cuts. However, every state, as well as the District of Columbia, has suffered skilled nursing Medicare cuts.

The Clinton/Gore Administration recently proposed a $2 billion restoration of funding specifically for skilled nursing care through the year 2010, a move Roadman characterized as, “a good first start.” He concludes: “Every demographic analyst you talk to will tell you that the baby boom generation will begin retiring in huge numbers in approximately 2010, and we believe it makes simple common-sense – and good public policy – to bolster the skilled nursing system to meet the current and future needs of our nation’s frail and elderly.” (AHCA)

Staffing Levels Come Under Scrutiny

A new government report on nursing homes may further complicate the use of personnel in these facilities. According to an article in the New York Times that appeared last summer before the report was released, the Department of Health and Human Services (HHS) is planning to call for new rules governing staffing levels in nursing homes.

Specifically, HHS will propose that all nursing homes be staffed to provide patients with an average of two hours of care each day from nurse’s aides and an average of 12 “Staffing Levels” continued on page 2
Higher Payments In, Refinements Out (for Now)

Beginning October 1, skilled nursing facilities started receiving new and increased payment rates under the prospective payment system. The final rule including the new rates was published in the July 31 Federal Register.

According to Health Care Financing Administration (HCFA) Administrator Nancy-Ann DeParle, "Nursing home residents deserve and expect access to safe, quality care, especially our country’s frailest and sickest beneficiaries. These changes will help to ensure that Medicare pays nursing homes fairly and appropriately when caring for the 39 million Medicare beneficiaries."

In fiscal year 2001, Medicare payments to nursing homes are projected to increase more than 20% over the current year’s projections. The updates are based on increases in the cost of covered care and provisions of the Balanced Budget Act of 1997 (BBA), along with those of the Balanced Budget Refinement Act of 1999 (BBRA), which provided a 4% increase and also temporarily boosted payments for certain patients by 20%.

Proposed refinements to create additional Resource Utilization Group payment categories for skilled nursing care patients with complex medical needs, however, have been postponed because additional research conducted by HCFA has not supported those refinements. As a result, HCFA will continue the temporary payment increases provided by the BBRA. “We will continue our research to make sure that Medicare is paying appropriately for the skilled nursing care provided to beneficiaries, including those with serious health problems that require complex care and treatment,” says DeParle. “Changes could be made as early as next year.”

Under the final rule, Medicare will continue to pay higher rates for beneficiaries with more complex medical needs. Payments will also reflect geographic wage differences and a facility’s historical costs, as well as the BBRA adjustments. (HCFA)
Federal Report Gathers Data on Older Americans

Older Americans are living longer and better than ever before, but many of those age 65 and older face disability, chronic health conditions, or economic stress, according to a new report from the Federal Interagency Forum on Aging-Related Statistics, a consortium of U.S. government agencies working together to improve the quality and usefulness of data on older Americans.

The 128-page report, “Older Americans 2000: Key Indicators of Well-Being,” covers 31 key indicators and is divided into five subject areas: population, economics, health status, health risks and behaviors, and health care. Highlights include:

Population

- The number of older people in the U.S. has increased ten-fold since 1900. Today, an estimated 35 million people, 13% of the population, are age 65 and older. By 2050, 20% of Americans, about 70 million, will have passed their 65th birthday.
- The population age 85 and above is currently the fastest growing segment of the older population; its growth is particularly important for anticipating health care and assistance needs, because these individuals tend to be in poorer health and require more services than people below age 85.
- In 2000, an estimated 84% of the population age 65 and older is non-Hispanic white; 8% non-Hispanic black; 6% Hispanic; 2% non-Hispanic Asian and Pacific Islander, and less than 1% non-Hispanic American Indian and Alaska Native. By 2050, those proportions are projected to be substantially different: 64% of the older population is expected to be non-Hispanic white, 16% Hispanic, 12% non-Hispanic black, and 7% non-Hispanic Asian and Pacific Islander, with the non-Hispanic American Indian and Alaska Native populations remaining at less than 1%.

Economics

- In 1998, 11% of older Americans had incomes below the poverty threshold, compared to 35% in 1959. The proportions of the older population in poverty vary, however, by age, gender, and race and ethnicity. For example, the poverty rate is highest at older ages – 14% for people age 85 and older, compared with 9% for people ages 65 through 74. It is higher among older women (13%) than older men (7%). And it is higher for minorities than non-Hispanic whites; for example, divorced black women ages 65 through 74 had a poverty rate of 47% in 1998, among the highest for any subset of older people. On the other end of the income spectrum, almost two-thirds of the older population experienced medium and high incomes in 1998, compared with about half in 1974.

Health status

- Americans born at the beginning of the 21st century are expected to live almost 30 years longer than those born at the turn of the 20th century. In 1997, a newborn baby girl could expect to live 79 years and a boy 74 years, compared to 51 years for a girl and 48 years for a boy born in 1900. Life expectancy varies by race, however. The average life expectancy for a white baby born in 1997 was 6 years higher than for a black baby born in the same year.
- Chronic disease, memory impairment, and depressive symptoms affect large numbers of older people, and the risk of such problems often increases with age. In 1995, almost 60% of people age 70 and older reported having arthritis, up from 56% in 1984.
Web Site Assists Seniors, Families

A new web site called TotalLivingChoices.com offers free assistance to senior citizens and their families faced with researching, identifying, and securing viable options for seniors facing health or lifestyle challenges that require a change in their current living situation. Visitors to the site can find in-depth information on the facilities that best match the senior’s needs, including 360-degree “virtual tours” and toll-free telephone numbers to call for additional information. The site can even arrange tours of facilities and can make reservations to hold a place at a chosen facility. In addition to these features, the site has a “staying at home” function that offers a range of services, from personal care and home deliveries to customized remodeling for seniors who want to remain in their current living situation. Other features include a glossary of terms, answers to frequently asked questions, and advice from eldercare and medical experts. (TotalLivingChoices.com)

Subacute Care Bulletin

“Older Americans” continued from page 3

slightly from the proportion reporting arthritis in 1984. The prevalence of arthritis and other chronic diseases, such as hypertension, heart disease, cancer, diabetes, and stroke also vary by race and ethnicity. Increases in memory impairment and depressive symptoms occur with advancing age. One-third or more of men and women age 85 and older have moderate or severe memory impairment, and 23% of this group experience severe depressive symptoms.

• Despite the prevalence of illness or chronic conditions, the proportion of Medicare beneficiaries age 65 and older with a chronic disability was 21% in 1994, down from 24% in 1982. During this time period, the older population grew significantly, and the number of older people estimated to have functional limitations increased by 608,000. This was considerably fewer, however, than the 1.5 million increase projected had disability rates not declined.

Health risks and behaviors

• A large majority of older people report social contacts with friends, neighbors, and relatives or say that they engage in activities such as going out to restaurants. The proportion of older Americans engaged in physical activity is increasing: between 1985 and 1995 the percentage who were sedentary decreased from 34% to 28% for men and 44% to 39% for women.

• From 1989 through 1995, the proportion of older people who were vaccinated against influenza and pneumonia increased, but reached the 60% coverage target set by Healthy People 2000 for only one group, non-Hispanic whites. An increasing trend also holds true for older women getting mammograms: 55% of older women in 1994 reported having had a mammogram in the previous two years, compared with 23% in 1987.

Health care

• Between 1992 and 1996, there was a slight increase in average inflation-adjusted annual health care expenditures (both public and private) for older Americans. In 1996, the average annual expenditure was $5,664 for people age 65 through 69, rising to $16,465 at age 85 and older. In 1996, 69% of noninstitutionalized Medicare beneficiaries had some type of private or public coverage for prescription drugs, while 31% did not. Out-of-pocket expenditures for prescription drugs were 83% higher for those not covered than for those with coverage.

• People age 85 and older are the most likely Americans to live in nursing homes. In 1997, only 11 people per 1,000 age 65 through 74 lived in a nursing home, compared with 192 people per 1,000 among those age 85 and older. About three-fourths of nursing home residents are women, roughly equal to their representation in the population age 85 and older. People in nursing homes today are more functionally impaired than their counterparts in previous years. The percentage of nursing home residents who were incontinent, who needed help with eating, or who were dependent on others for mobility increased slightly between 1985 and 1997.

• For those who receive home care, the nature of assistance may be changing. Most home care is provided informally by family, friends, and the community, as it has been for quite some time. But since the 1980s, the use of informal support as an exclusive means of help appears to be declining. The percentage of older people receiving only informal care dropped from 74% in 1982 to 64% in 1994, while the use of combined formal and informal care increased from 21% to 28% during the same time period. (Administration on Aging)
JCAHO Accreditation Report

The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the Bulletin.

Accreditation visit you are reporting (choose one):
- Home Care
- Hospital
- Long Term Care
- Pathology & Clinical Laboratory Services

Inspection Date: ____________________________________________________________
Facility Name: _____________________________________________________________
Contact: ________________________________________________________________
(Please provide name and email address.)

1. What was the surveyors’ focus during your site visit?__________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

2. What areas were cited as being exemplary?__________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

3. What suggestions were made by the surveyors?________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

4. What changes have you made to improve compliance with the guidelines?__________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

Additional comments:

Mail or fax your form to:
William Dubbs, RRT
AARC Associate Executive Director
11030 Ables Lane
Dallas, TX 75229
FAX (972) 484-2720