FACT SHEET

DISCRIMINATION AGAINST THE POOR AND DISABLED IN NURSING HOMES

Problem:
A Special Committee on Aging investigation has discovered widespread nursing home practices which serve to restrict or deny access to services for Medicaid patients, particularly those with certain disabling conditions.

Forms of Discrimination:
- refusal to admit some or all Medicaid patients into vacant, certified beds; a violation of Congressional intent to provide Medicaid beneficiaries with services equal in amount, duration, scope and quality to those purchased by others.
- requiring large cash payments from the family of a patient as a precondition for admitting the patient for care, or as condition of retaining the patient in the facility; a felony under the Social Security Act when and if enforced once a patient becomes Medicaid eligible
- threats and evictions of residents who "spend down" and become Medicaid eligible; a violation of Patients' Rights under federal law
- refusal to admit patients with more severe conditions or disabilities, even when physician prescribes nursing home care; banned under the civil rights of the disabled protections of the Rehabilitation Act of 1973, (as Amended)

Discriminatory Practices are Widespread and Flagrant:
- nursing home Ombudsman programs in 21 States cited this as a "serious problem" in fiscal 1982, ranking 4th among all problems reported;
- numerous studies describe nursing homes' refusal to admit "heavy care" Medicaid patients when hospital discharge is medically appropriate;
- from 25 to 80 percent of nursing homes, depending on the region of the country, demand a fixed period of cash payments before they will admit a patient;
- many providers use written admissions contracts containing illegal provisions (described above), sometimes in bold print.

Discrimination by Nursing Homes Is Costly to Patients, their Families, Hospitals, and Medicare:
- Patients refused by local facilities often must be placed at a great distance from loved ones;
- Elderly children and families spend thousands of dollars on "contributions" for the care of a Medicaid eligible relative;
- Medicare pays large sums for hospital care, as unwanted "heavy care" Medicaid patients remain inappropriately hospitalized, in spite of the presence of a sufficient number of vacant nursing home beds in the community;
- Medicare's payments to hospitals for these patients don't begin until approx. 20 days after the average length of stay for the DRG, then cover only the hospital's fixed costs, not the marginal costs of caring for the patient, making these very unwelcome patients at the hospital.

The Federal Agencies Charged with Enforcement Have Done Little to Discourage Illegal Discriminatory Practices:
Despite widespread practice of discrimination, there has been only one criminal prosecution under the authority of Sec. 1909(d) of the Social Security Act, passed in 1977 to protect Medicaid patients; only a handful of legal actions based on Sec. 504 of the Rehabilitation Act of 1973 have been undertaken by the Department of HHS; a key enforcement regulation authorized by Congress in 1980 has been languishing in the Dep't of HHS; State Survey and Certification agencies have not been trained in ways to combat the most prevalent forms of discriminatory admissions practices.

Nursing Homes Claim that Inadequate Reimbursement Rates Justify Discriminatory Practices:

- they assert that profitability and quality cannot be maintained if they must accept heavy care patients within the level of care for which they are certified, if payments remain structured as they are at present.
- discrimination is not caused by poor reimbursement rates, occurring instead wherever occupancy rates are high enough to allow providers to pick and choose from candidates for admission;
- even facilities with very high Medicaid census make substantial profits (22-33% return on equity), and provide no worse care than facilities with fewer Medicaid patients;
- providers may challenge reimbursement rates in Court, as Federal law requires States to pay rates adequate for an efficient provider.