SECTION 2C

# Skilled nursing facility services

## RECOMMENDATIONS

**2C-1** The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2006.

**COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2**

**2C-2** The Secretary should develop a new classification system for care in skilled nursing facilities. Until this happens, the Congress should authorize the Secretary to:

- remove some or all of the 6.7 percent payment add-on currently applied to the rehabilitation RUG–III groups, and
- reallocate the money to the nonrehabilitation RUG–III groups to achieve a better balance of resources among all of the RUG–III groups.

**COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2**

**2C-3** CMS should:

- develop and use more quality indicators specific to short-stay patients in skilled nursing facilities,
- put a high priority on developing appropriate quality measures for pay for performance, and
- collect information on activities of daily living at admission and discharge.

**COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2**

SECTION 2C

# Section 2C: Skilled nursing facility services

**In this section**

- Are Medicare payments adequate in 2005?
- How should Medicare payments change in 2006?
- Update and distributional recommendations
- Improving quality measurement for monitoring SNF care

Aggregate Medicare payments for skilled nursing facility (SNF) services are more than adequate. Most beneficiaries appear to have access to SNF care, although those who do not need rehabilitation therapy but need complex care or special services may experience delays in finding SNF care. The number of facilities providing SNF care to Medicare beneficiaries remained almost unchanged in the past year, but the volume of SNF services provided increased. Access to capital for for-profit SNFs that dominate the industry seems to have improved over recent years, but nonprofit SNFs continue to have limited access to capital. The aggregate Medicare margin for freestanding SNFs is 13 percent in fiscal year 2005. To address the concern that payments for patients needing nontherapy ancillary services may not be aligned with their resource use, the Commission again recommends that the Congress authorize the Secretary to reallocate Medicare payments from the rehabilitation to nonrehabilitation payment groups until the SNF payment system is refined. Evidence on the quality of SNF care shows small and mixed changes, with most measures indicating small reductions in quality of care provided to Medicare SNF patients. This chapter contains a recommendation to improve quality measurement for care provided to Medicare SNF patients.

## Background

Medicare beneficiaries who need short-term skilled nursing care or rehabilitation services on a daily basis in an inpatient setting after a medically necessary hospital stay of at least three days qualify for covered services in a skilled nursing facility (SNF).[1] Either freestanding or hospital-based SNFs can provide this care, with freestanding SNFs representing about 90 percent of all SNFs. A freestanding SNF is typically part of a nursing home that also provides residential long-term care, which Medicare does not cover.

Medicare pays SNFs a set amount for each day of care, adjusted for the case mix of the patients.[2] These per diem payment rates cover all routine, ancillary, and capital costs, as well as costs for many items and services previously reimbursed under Medicare Part B.[3] Case mix is determined by the SNF's assignment of each Medicare patient receiving care in its facility to 1 of 44 groups, called resource utilization groups, version III (RUG–III), that are intended to predict the patient's resource needs. The RUG–III classification system is hierarchical. The 44 groups are divided into seven categories: rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical function.[4] Medicare does not typically reimburse SNFs for the last three RUG–III categories because they do not usually require skilled care. CMS's decision to reimburse for these last three RUG categories is made on a case-by-case basis.

In the Medicare, Medicaid, and SCHIP Benefits Improvement & Protection Act of 2000 (BIPA), the Congress directed CMS to study alternative systems to the RUG–IIIs. In response, CMS sponsored research on RUG–III alternatives that categorize patients in a manner that accounts for the relative resource use of different patient types. A report on this study, including proposed alternatives to the RUG–IIIs, was due to the Congress no later than January 1, 2005. As of this report going to press, however, CMS has not released the results of this research.

## Are Medicare payments adequate in 2005?

We examine the following factors for changes that can be attributed to the adequacy of Medicare payments to SNFs:

- access to care
- supply
- volume of services
- quality
- access to capital
- payments and costs

Overall, our analysis finds no major changes in these factors that would indicate problems for beneficiaries who need SNF services. Most beneficiaries appear to have access to SNF care, although those who do not need rehabilitation therapy but need complex care or special services may experience delays in finding SNF care. The stabilization in the number of facilities providing SNF care to Medicare beneficiaries and the increase in the volume of SNF services provided are indicators that access to SNF care has not declined. Available evidence on changes in the quality of SNF care is mixed, with most measures indicating small reductions. Nonprofit SNFs continue to have relatively limited access to capital, but some large for-profit SNFs reported capital spending to construct or expand facilities. Our analysis of SNFs' Medicare payments and costs found that payments will cover SNFs' costs of caring for Medicare patients in 2005.

### Changes in access to care

Available evidence suggests that most beneficiaries have access to SNF care. Research on Medicare beneficiaries' use of post-acute care between 1996 (pre-PPS) and 2002 (post-PPS) found that the number of acute care hospital discharges to a SNF increased 36 percent during this period (Hogan 2004). In addition, the proportion of Medicare beneficiaries who were discharged from a hospital to a SNF increased from 10 percent in 1996 to 13 percent in 2002.[5]

Past reports by the Health and Human Services Office of Inspector General (OIG) found that beneficiaries had little difficulty accessing SNF services, especially if they needed physical, occupational, or speech rehabilitation therapies, which more than three-quarters of Medicare SNF patients receive. Some patients needing nontherapy ancillary services such as intravenous therapy, dialysis, expensive drugs, or specialized feeding, however, were

more likely to have experienced delays (OIG 1999a, 2000, 2001). These results were based on interviews with more than 200 discharge planners across the United States about their ability to place patients in SNFs. Subsequent work by MedPAC supports these conclusions (MedPAC 2004a).

Beneficiaries who do not need rehabilitation services but do need certain nontherapy ancillary services may experience delays in accessing SNF care in part because the Medicare payment rates for these services may not be aligned with their costs. MedPAC and the Government Accountability Office (GAO) have pointed out that the RUG–III classification system may not pay enough to cover the costs of patients who require nontherapy ancillary services, such as expensive drugs and ventilator care services (MedPAC 2004a, GAO 2002d, GAO 1999). As a result, SNFs may try to avoid patients who need these services. Similarly, ready access to SNF services for patients receiving rehabilitation therapies may also be related to Medicare payments for these services. Payment for rehabilitation RUG–IIIs reflects minutes of therapy provided or estimated to be provided and may encourage SNFs to provide unnecessary services in order to increase the amount of Medicare's payment (GAO 2002e).

As the Commission has recommended in the past, it is critical to continue monitoring the ability to place patients who need skilled nursing facility care in a SNF in order to detect access problems. Consistent with a previous MedPAC recommendation, the OIG is currently conducting a follow-up study on beneficiaries' most recent experiences accessing SNF and home health services (MedPAC 2003). Results are expected in spring 2005.

## Changes in supply of facilities and volume of services

The most recent data on the supply of SNFs serving Medicare beneficiaries and the volume of SNF services provided to Medicare show that the availability and use of SNF services have not declined. There was a very small net increase in the number of SNFs serving Medicare beneficiaries between 2003 and 2004. The overall supply of Medicare-participating SNFs nationwide has stabilized in recent years. The rate of hospital-based SNF closures appears to have slowed somewhat, while the number of freestanding SNFs continues to increase at a rate of about 1 percent per year (Table 2C-1). The total number of SNFs that participated in Medicare in 2004 is slightly greater than the number of SNFs that participated in 1999—the first full year of the prospective payment system for SNFs.

**TABLE 2C-1**

**The number of skilled nursing facilities serving Medicare beneficiaries has stabilized in recent years**

| | 1999 | 2003 | 2004 | Percent change 2003–2004 | Annual change 1999–2004 |
|---|---|---|---|---|---|
| All facility types | 14,933 | 14,918 | 14,941 | 0% | 0% |
| Freestanding | 12,859 | 13,455 | 13,568 | 1 | 1 |
| Hospital-based | 2,074 | 1,463 | 1,373 | –6 | –8 |

Note: Data do not include swing bed units.

Source: MedPAC analysis of CMS Online Survey, Certification, and Reporting system (OSCAR) data.

The volume of SNF services, as measured by payment and use, increased between 2001 and 2002 (Table 2C-2, p. 90). Specifically,

- payment increased by 10 percent,
- discharges increased by about 5 percent,
- covered days increased by 10 percent, and
- average length of stay increased by 6 percent.

Total payments to SNFs continued to rise between 2001 and 2002, even though the average payment per day declined slightly during this period; therefore, the 10 percent growth in total payments is explained entirely by a 10 percent increase in covered days of SNF care between those two years. Covered days increased because more patients were admitted to SNFs and because patients were staying longer.

The small decline in average payment per day between 2001 and 2002 followed steady increases since 1999 and a 13 percent increase between 2000 and 2001. The expiration of temporary payment add-ons lowered payments per day in the last quarter of 2002, but relatively steep increases in volume more than offset those reductions, resulting in an increase in total payments to SNFs. As of October 1, 2002, two payment increases ended: the 4 percent increase across all RUG–IIIs from the Balanced Budget Refinement Act of 1999 (BBRA) and the 16.66 percent increase for the nursing component of the base rate from the BIPA. Other payment add-ons—including a 6.7 percent increase for the 14 rehabilitation

**TABLE 2C-2**

**Total payments to and use of skilled nursing facilities are growing**

| Measure | 1998 | 1999 | 2000 | 2001 | 2002 | Percent change, 2001–2002 | Annual change, 1998–2002 |
|---|---|---|---|---|---|---|---|
| Payment (billions) | $11.3 | $9.5 | $10.4 | $12.7 | $14.0 | 10.3% | 5.5% |
| Average payment/day | 250 | 223 | 236 | 266 | 265 | –0.2 | 1.5 |
| Discharges (1,000s) | 1,588 | 1,450 | 1,439 | 1,520 | 1,601 | 5.3 | 0.2 |
| Covered days (1,000s) | 45,240 | 42,535 | 44,103 | 47,776 | 52,787 | 10.5 | 3.9 |
| Average days/discharge | 29 | 29 | 31 | 31 | 33 | 6.5 | 3.3 |

Note: Data include Puerto Rico, Virgin Islands, and unknown locations. Data do not include swing bed units. The prospective payment system for skilled nursing facilities was implemented for cost reporting periods beginning on or after July 1, 1998.

Source: Health Care Information System from CMS Office of Information Services.

RUG–IIIs; a 20 percent increase for the 12 extensive care, special care, and clinically complex RUG–IIIs; and a 128 percent increase for patients with AIDS—remain in effect until case-mix refinements to the SNF prospective payment system are implemented. Yet, the nature of such refinements and a timetable for their implementation have not been determined. In 2004, SNF payments were increased by the full market basket (3.0 percent) plus 3.26 percent. The added 3.26 percent was made to correct for cumulative market basket forecast error since the implementation of the PPS for SNFs.

## Changes in quality of care

Most short-term skilled nursing care is provided to Medicare patients in the same facilities that provide custodial long-term care. Nevertheless, experts we interviewed believe that quality measures should distinguish between the quality of care provided to short-stay and long-stay patients, because the goals of care for these two types of patients can be different (see text box, opposite). We examined two sets of SNF-specific quality indicators to determine quality trends across the industry.[6] Our analysis found positive and negative changes in quality since the SNF prospective payment system was implemented, but most indicators found small reductions in quality of care. We also examined the quality indicators for short-stay patients, which are part of CMS's Nursing Home Compare measure set for nursing facilities. We found improvement on one measure and no change on another. As we discuss in detail later in this chapter, these indicators may not accurately assess the quality of SNF care because they are limited by the focus of the Minimum Data Set (MDS), the questionable accuracy of the data, and the timing of data collection.

Rates of preventable readmission to an acute care hospital for five conditions—electrolyte imbalance, respiratory infection, congestive heart failure, sepsis, and urinary tract infection—all increased slightly between 1999 and 2002 (Table 2C-3). These five conditions were selected by researchers as short-stay quality indicators because they are affected by nurse staffing levels, are of a sufficiently high incidence to be stable, can be adjusted for risk, and have accurate data available to measure their incidence (Kramer and Fish 2001). These rates are calculated using all Medicare SNF stays, are controlled for diagnosis and functional severity of patients, and indicate when a short-stay patient may be receiving poor-quality care.[7]

A comparison of Medicare SNF patients' rates of death, hospital readmissions, and return to the community within 30 days in 2002 with those rates in 1996 shows mixed trends (Hogan 2004).[8] Specifically, SNF patients had lower than expected rates of mortality in 2002, but higher than expected rates of readmissions, and lower than expected rates of discharge to the community (Table 2C-4). Although this study calculated expected rates for 2002 using the rates for a given principal post-acute care diagnosis in 1996, the analysis cannot rule out that SNF patients with a given post-acute care diagnosis in 2002 were sicker than those with the same diagnosis in 1996.

## Care of short-term patients in nursing homes differs from care of long-term residents

Nursing facilities care for short-term patients in need of skilled nursing facility (SNF) care and long-term residents. Most long-term residents only require custodial care, although some may require skilled services. The components of care for these two groups differ. SNFs provide daily posthospital skilled care. If the task can be performed safely and effectively only by or under the general supervision of skilled nursing or rehabilitation personnel, then it is considered skilled.[9]

In contrast to SNFs, nursing homes—sometimes called nursing facilities—provide nonskilled or custodial services to most individuals residing there. These residents frequently live in a nursing facility for an extended period of time. Medicare does not pay for this type of care when it is the only care required, although some of this care is provided as a matter of course to SNF patients. Examples of custodial services are:

- administration of routine oral medications, eye drops, and ointments;
- general maintenance care;
- routine services or care;
- assistance in dressing, eating, and other activities of daily living;
- periodic turning and positioning in bed; and
- general supervision of exercises and performance of repetitive exercises that do not require help from skilled rehabilitation personnel.

In 2004 almost all facilities that treat SNF patients (94 percent) were nursing homes that were also certified to care for nursing facility residents paid for by Medicaid. Nevertheless, SNF patients make up only 8 percent of the residents in a nursing home.

Other differences between SNF patients and residents of nursing facilities are:

- The main goal of care for SNF patients is recovery to maximum level of functioning; more than three-quarters of SNF patients receive rehabilitation services (Liu et al. 2003). The main goal of care for most nursing facility residents is to maintain function to the extent possible. Estimates of SNF patients who remain in nursing homes to receive long-term care range from 58 percent (Datapro Team 2002a) to 30 percent (Kramer et al. 1999).
- Average length of stay for SNF patients is 25 days versus 24 months for nursing facility residents.[10] ■

**TABLE 2C-3**

### Adjusted readmission rates for five conditions increased between 1999 and 2002

| Condition | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|
| Electrolyte imbalance | 3.7% | 3.7% | 4.1% | 4.0% |
| Respiratory infection | 3.0 | 2.9 | 3.1 | 3.2 |
| Congestive heart failure | 3.2 | 3.3 | 3.7 | 3.7 |
| Sepsis | 1.2 | 1.2 | 1.3 | 1.3 |
| Urinary tract infection | 2.1 | 2.2 | 2.4 | 2.4 |

Note: Data for 2002 are based on stays beginning between January and May 2002; results from other years reflect a full year of data.

Source: MedPAC analysis of Medicare claims data.

**TABLE 2C-4**

### Measures of skilled nursing facility quality show mixed trends

| Endpoint | 1996 actual | 2002 actual | 2002 expected |
|---|---|---|---|
| Death | 21% | 18% | 21% |
| Readmission to hospital | 22 | 25 | 23 |
| Discharge to community | 56 | 54 | 55 |

Note: The 2002 actual values for each measure were statistically significantly different from the 1996 values at least $p<.05$, two-tailed test. Expected endpoint was based on principal diagnosis and type of post-acute care, using endpoint rates observed in 1996. Data are from claims and enrollment data for a 5 percent sample of fee-for-service enrollees.

Source: Hogan 2004.

We also analyzed data from 2002 through 2004 on the proportion of each facility's short-stay residents with delirium and pain, as reported on CMS's Nursing Home Compare public website. We found no change in reporting facilities' median proportions of short-stay residents with delirium and a slight decline in facilities' median proportion of short-stay residents with moderate to severe pain. Data on the proportion of residents with pressure sores were available only for 2004, so we could not analyze the trend for this indicator. As we discuss later in this chapter, however, some experts we consulted believe that these measures are limited in their ability to assess quality.

## Access to capital

SNFs' access to capital can be difficult to determine because SNFs are not typically independent financial entities. They are usually part of another facility—either a hospital or a nursing facility. About 90 percent of SNFs are part of a freestanding nursing facility, most of which provide long-term care, which Medicare does not cover. About 10 percent of facilities are part of a hospital and, therefore, access capital through their hospital organizations. In addition, Medicare payments account for only about 12 percent of all nursing home revenue and are less likely to have an impact on access to capital than other payers (Levit et al. 2003). Although providers currently regard Medicare payments favorably, they assert that potential refinements to the RUG–IIIs and the loss of current payment add-ons introduce uncertainty about their ability to continue to subsidize what they contend are inadequate Medicaid payments (see text box below). The remainder of this section focuses on freestanding SNFs' access to capital.

### For-profit SNFs

Determining the freestanding SNF industry's access to capital is further complicated by the paucity of measures that provide reliable information on total overall financial performance of all types of facilities. Information on the financial performance of the large for-profit chains that operate freestanding nursing facilities is relatively accessible, while similar information on other owners is not. While for-profit companies dominate the industry, the

## Medicare and Medicaid

The nursing facility industry and others are concerned about the level of Medicaid payments to nursing facilities. Although 31 states increased Medicaid payments to nursing facilities in 2005, the industry contends that these payments are still too low (Kaiser 2004). In addition, facilities may still face the prospect of rate cuts or freezes as states attempt to trim their budgets in the future. The industry regards Medicare payments favorably, but it has suggested that MedPAC consider total nursing facility margins when making payment update recommendations and that Medicare pay more than the cost of providing care for Medicare beneficiaries to compensate facilities for inadequate Medicaid payment rates.

It would be inefficient to use Medicare payments to compensate for any perceived inadequacies in Medicaid payments. If Medicare were to pay still higher rates to subsidize low Medicaid payments, states might be encouraged to reduce Medicaid payments even further. In addition, payments would be directed to the wrong facilities. Facilities with low Medicare shares and high Medicaid shares—presumably the facilities that need revenues the most—would receive the least if subsidies were provided in the form of higher Medicare payments.

Although one goal of Medicare is to maintain access to necessary covered services for Medicare beneficiaries, the Commission remains concerned about the coordination of care for Medicare beneficiaries who remain in nursing homes and receive long-term care even though Medicare does not cover it. Some of these beneficiaries are or become dually Medicare and Medicaid eligible and have their long-term care paid for by Medicaid. In our June 2004 report we presented information on the spending and care patterns, access to care, and the coverage and payment policies affecting dual eligibles (MedPAC 2004b). During the coming year, we plan to study the characteristics of Medicare beneficiaries who remain in a nursing facility, exhaust their Medicare skilled nursing facility benefit, and receive long-term care in a nursing facility. ■

10 largest nursing home chains account for only about 16 percent of nursing home beds. So although the majority of facilities are for profit, the financial experiences of the large for-profit chains do not necessarily apply to the population of SNFs serving Medicare beneficiaries.

The financial situation of companies that operate for-profit, chain nursing homes appears to have improved over recent years. In their annual Securities and Exchange Commission filings, several of these chains discuss the financial benefits of increasing the share of Medicare patients and the favorable effect this has on their bottom lines. One financial firm that analyzes SNF performance sees evidence that "the industry is improving, wants to renew ties to capital providers and that some smaller operators are searching for acquisitions" (Legg Mason Wood Walker 2004). Several large chains reported capital spending to construct or expand facilities in 2003. An index of seven publicly traded companies operating SNFs increased 12 percent between January and October 2004 compared with the broader Standard & Poor's 500 Index, which declined 0.47 percent during this period (Cain Brothers 2004).

### Nonprofit SNFs

FitchRatings, a firm that analyzes credit markets, reported that the overall outlook for nonprofit nursing facilities, which are about one-quarter of freestanding SNFs, remains negative in 2004. According to FitchRatings, this "negative outlook is due to the significant challenges in the industry, which will continue to pressure already weak financial performance" (FitchRatings 2004). These challenges are identified as "inadequate Medicaid reimbursement; rising insurance, labor, and benefits expense; and increased capital needs." The firm also notes that "[c]apital needs continue to increase due to deferred spending on plant[s]," which its analysts explain "is usually the result of weak financial performance and limited free cash flow."

This situation is no different from recent years. Access to capital for smaller nursing homes and for many nonprofit nursing homes has typically been limited compared with their larger, for-profit counterparts. From a peak of more than $2 billion in 1998, annual public debt issuance has declined to about half a billion dollars in 2002. Bond issuance for nursing homes dropped yet again in 2003 to $382 million. FitchRatings expects there will not be many investment-grade nursing homes and that the "credits that have obtained investment-grade ratings typically have additional support through an endowment or affiliation with a large health system" (FitchRatings 2004). Smaller organizations often have to issue unrated bonds, resulting in higher interest rates. Facilities that are part of a larger organization with assisted-living or continuing-care retirement communities may also have access to more sources of capital because of their affiliation with these larger entities. In addition, due to recent low interest rates, small nonprofit facilities may be able to access relatively cheap funds through mortgages and loans from banks. But the extent of this type of lending is unclear.

## Payments and costs for 2005

To assess the adequacy of Medicare payments, we calculate an aggregate Medicare margin for all SNFs. This margin is the difference between Medicare SNF payments and costs, as a percentage of Medicare payments to SNFs. Conceptually, this represents the percentage of revenues that the providers keep.

### Freestanding SNF payments and costs

Based on 2003 cost report data, we estimate that the 2005 aggregate Medicare margin for freestanding SNFs is 13 percent.[11] This margin represents a decrease of 2.3 percentage points from the 2004 margin (MedPAC 2004a). Our estimates do not reflect any changes to the payment system that may result from the report on proposed alternatives to the RUG–IIIs that was due to the Congress by January 1, 2005. As of this MedPAC report going to press, CMS has not released the report or disclosed any intentions to modify the payment system in response to the report. Because we do not yet know whether or when these proposals will be implemented, nor what their payment effects may be, including them in our margin calculations would require us to speculate about changes in law, the timing of those changes, and how changes would affect SNF payments.

An analysis of SNFs' Medicare margins from 2000 to 2003 found that 5 percent of SNFs had negative Medicare margins in all four years.[12] Sixty percent of facilities had positive margins in all four years, and 35 percent had both positive and negative margins during this period. The cohort of SNFs with a higher share of Medicare days were more likely to have consistently positive Medicare margins than those with the lowest share of Medicare days.

### Hospital-based SNF payments and costs

The aggregate Medicare margin for hospital-based SNFs was –87 percent in 2003. This margin represents a decrease from the 2001 Medicare margin of –62.7 percent that we reported last year (MedPAC 2004a). Interpreting the negative Medicare margin for hospital-based SNFs is complicated by the standard practice of allocating the hospital's overhead costs across all of the units in its facilities, including its SNF units. The effect of this practice may be that hospital-based SNF units likely record higher overhead and total costs than they otherwise would if they had recorded only the costs of providing services to SNF patients. Hospitals also may have higher cost structures than freestanding nursing homes.

## How should Medicare payments change in 2006?

When recommending appropriate Medicare payment changes for fiscal year 2006, MedPAC first considers whether payments appear adequate in 2005 and then examines how costs are likely to change in 2006. In this section we discuss recent cost growth in the SNF industry.

SNFs' costs of providing care have changed dramatically since the prospective payment system for SNFs was implemented. In the 1980s and 1990s, before the PPS, Medicare payments were based on incurred costs. During this period, Medicare imposed payment limits for routine services, such as room and board, but did not limit payments for capital and ancillary services, including therapy. The GAO and the OIG found that costs during this period were excessive (GAO 2002e, OIG 1999b). For example, cost growth for ancillary services averaged 19 percent per year between 1992 and 1995, while the cost of routine services increased an average of 6 percent annually (GAO 2002e). According to the GAO, Medicare spending growth on SNF services also was high, averaging 30 percent per year between 1986 and 1996. Much of this growth was due to an increase in the provision of ancillary services, such as therapy (GAO 2002d).

Under the PPS, SNFs have incentives to decrease the costs of providing each day of care. Research suggests that SNFs have reduced their costs in response to these incentives (MedPAC 2004a). MedPAC's analysis of SNFs' reported costs also found that cost growth has slowed since the PPS was implemented. Freestanding SNFs' average annual per-day cost growth for Medicare beneficiaries was 3.6 percent between 2000 and 2003.[13] At the 25th percentile of the distribution, average annual SNF per-day cost growth was 0.4 percent; at the 75th percentile it was 7.9 percent.

## Update and distributional recommendations

SNFs should be able to accommodate cost changes in 2006 with the Medicare margin they have in 2005; therefore, we recommend:

**RECOMMENDATION 2C-1**

**The Congress should eliminate the update to payment rates for skilled nursing facility services for fiscal year 2006.**

**RATIONALE 2C-1**

The evidence generally indicates that Medicare beneficiaries continue to have access to skilled nursing facility services. We project the Medicare margin for freestanding SNFs will be 13 percent in fiscal year 2005, and we expect prior cost trends to continue. Our analysis of cost growth finds that average per-day Medicare cost growth was 3.6 percent between 2000 and 2003. Given these circumstances, SNF payments appear adequate to accommodate cost growth; thus no update is needed.

**IMPLICATIONS 2C-1**

#### Spending

- This recommendation reduces Medicare spending relative to current law by $200 million to $600 million for fiscal year 2006 and by $1 billion to $5 billion over five years.

#### Beneficiary and provider

- No adverse impact on beneficiary access is expected. This recommendation is not expected to affect providers' willingness and ability to provide care to Medicare beneficiaries.

## Recommendation to improve the distribution of payments

We reiterate our recommendations from the past two years to distribute payments more equitably across SNF services.

**RECOMMENDATION 2C-2**

**The Secretary should develop a new classification system for care in skilled nursing facilities. Until this happens, the Congress should authorize the Secretary to:**

- **remove some or all of the 6.7 percent payment add-on currently applied to the rehabilitation RUG–III groups, and**
- **reallocate the money to the nonrehabilitation RUG–III groups to achieve a better balance of resources among all of the RUG–III groups.**

**RATIONALE 2C-2**

The Commission remains concerned that the current SNF patient classification system does not appropriately distribute resources among patients with different resource needs. This is due to the following:

- Payments for rehabilitation services are based on the actual or estimated number of minutes of therapy, rather than on a patient's clinical characteristics.
- The RUG–III classification system does not directly capture differences in patient costs that arise from nontherapy ancillary services, such as prescription drugs and respiratory therapy.
- Payment rates for the RUG–IIIs are based on relative weights derived from old data that are expensive and time-consuming to update.

SNFs that care for more patients with expensive nonrehabilitation therapy needs may not be able to operate as profitably under the prospective payment system for SNFs as those that care for a higher proportion of patients with short-term rehabilitation needs. This disparity could explain why patients with expensive nonrehabilitation therapy ancillary service needs may experience longer delays in accessing SNF services than other patients. This recommendation would provide a more equitable distribution of resources among patients with different resource needs within the SNF payment system.

**IMPLICATIONS 2C-2**

### Spending

- This recommendation would not affect federal program spending relative to current law.

### Beneficiary and provider

- This recommendation is expected to improve beneficiary access and could have redistributive effects on providers.

## Improving quality measurement for monitoring SNF care

Medicare is responsible for monitoring the quality of care provided to skilled nursing facility patients. MedPAC also uses quality measures in determining whether Medicare payments for SNFs are adequate. MedPAC relies on data collected by CMS to assess quality in other sectors (e.g., hospitals and home health care). Although CMS collects quality information on nursing facilities, few of these indicators address the short-stay, skilled care provided to SNF patients as distinct from those for nursing home residents. In addition, the quality indicators CMS reports for short-stay patients have shortcomings.

To better understand both the importance of quality measures specific to the care of short-stay patients and the information CMS currently collects to monitor quality, as well as to identify ways to improve the SNF-specific information available to assess quality, we interviewed representatives of CMS, researchers, clinicians, nursing home quality improvement experts, the National Quality Forum (NQF), quality improvement organizations (QIOs), and the nursing home industry. We also reviewed the literature.

In this section, we synthesize what we learned from our interviews and literature review and examine ways to improve Medicare's and MedPAC's ability to monitor quality for SNF patients. Our focus here is on measuring quality for SNF patients exclusively for the purposes of quality monitoring and assessing payment adequacy, as distinct from paying for performance. Further work is needed to determine whether these measures or other measures are appropriate for paying facilities based on the quality of care they provide.

### Why SNF-specific information is important

CMS has always been responsible for monitoring the quality of care provided to SNF patients as part of its responsibilities for the Medicare program. Monitoring the

quality of care is especially important when providers are paid prospectively for a fixed unit of care, such as the per diem payment made to SNFs. The concern under PPS is whether providers have incentives to reduce or improve quality of care under a payment system adjusted for case mix (Grabowski 2002).

The experts we interviewed agreed that the quality of SNF care and nursing home care are not necessarily related even though SNF care is frequently provided in nursing homes. They pointed out that the goals and type of care provided to short- and long-term patients are very different (see text box on p. 91). Nevertheless, few researchers study SNFs separately from nursing homes, and some explicitly exclude short-term patients from their analysis. One reason short-term patients are excluded might be the small number of these patients in a nursing home at any one time—half of nursing homes have five or fewer Medicare patients per day (Liu et al. 2003). The lack of independent research on SNF-specific quality issues makes it even more imperative for Medicare to monitor SNF quality and to explicitly distinguish between the quality of short- and long-term care in nursing homes.

## The SNF-specific information CMS currently collects is too limited

CMS has only three quality indicators focused specifically on measuring the quality of SNF patient care—delirium, pain, and pressure ulcers—derived from questions on the MDS.[14] The MDS is a standardized assessment filled out for every patient in a nursing home and every patient with skilled nursing facility care needs in a hospital (see text box on MDS opposite). Information on these three indicators is posted on CMS's Nursing Home Compare public website, although CMS reports no information on these indicators for about one-third of SNFs because they have too few SNF patients or 14-day assessments to report. CMS currently has no other way of monitoring SNF quality.[15]

The quality measures for short-term patients that CMS creates from the MDS information are:

- percentage of patients with symptoms of delirium that represent a departure from usual functioning on a 14-day assessment,
- percentage of patients at 14-day assessment with moderate pain at least daily or horrible/excruciating pain at any frequency, and
- percentage of patients who develop a pressure ulcer between 5-day and 14-day assessment or percentage of patients who had any stage pressure ulcer at the 5-day assessment that worsened by the 14-day assessment.

Based on our interviews with experts, the indicators do not reflect whether beneficiaries benefit from the care they receive in SNFs. Most experts suggested that instead of identifying the major concerns about quality in SNFs and what one needs to know to assess quality in those areas, CMS created quality indicators from available MDS data. In effect, the three SNF-specific quality indicators are limited by the focus of the MDS, the questionable accuracy of the data, and the timing of data collection.

### Focus of the indicators

The experts we interviewed are concerned about the indicators' lack of focus on the SNF stay. The MDS was developed to assess patients with long-term care needs. Although some short-term patients may experience a care trajectory that leads to a long stay or to death, many are in skilled care to recover from surgery or other acute events and are expected to improve their functioning. Because most short-term patients are expected to improve, our experts suggested that important measures of quality of care should assess whether patients benefited from the care provided and whether the care resulted in patients achieving the goals of the care plan. For example, more than three-quarters of Medicare SNF patients receive rehabilitation services. CMS could assess whether these rehabilitation services improved patients' functioning. In addition, most Medicare beneficiaries want to return to the community after their SNF stay. Yet estimates, from two sources, of SNF patients being discharged to the community range from 42 percent to 70 percent.[16] Comparisons of expected and actual discharge destination could provide information on whether patients' goal of returning home is achieved.

### Accuracy of the data

The GAO has questioned the accuracy of information from the MDS (GAO 2002a, 2002b). It found that when some states began to monitor MDS accuracy, as many as 85 percent of MDS assessments had errors (GAO 2002a). The GAO attributed these errors to high turnover in the nursing home staff who complete the MDS and misunderstandings of the MDS definitions. The GAO also expressed concerns about the MDS data because two studies of MDS error rates by the same CMS contractor

## What is the minimum data set?

The minimum data set (MDS) is a tool of 300-plus items (more than 500 data points) used to assess individuals who receive services in nursing facilities. It began in 1987, when the Congress directed the Secretary of Health and Human Services to identify a core set of elements for nursing homes to use in assessing residents' care needs. By the early 1990s nursing homes that served either Medicare or Medicaid patients were collecting MDS data on all residents. The MDS is now the basis for measuring quality for long- and short-term patients and for determining the level of Medicare payment for short-term patients and Medicaid payments in some states. The MDS also is used to identify nursing homes that may need special attention during the survey and certification process.

During the 1990s the percentage of short-term nursing home residents was very low (less than 5 percent). Thus, the MDS was primarily aimed at residents who did not require skilled care and were not expected to improve. Over time, the percentage of nursing home patients who are considered in need of skilled care but who are expected to stay for a shorter time period has increased to 8 percent (Liu et al. 2003).

The nursing home is required to complete the MDS on skilled nursing facility (SNF) patients by the 5th, 14th, and 30th day of their stays and every 30 days thereafter. For short-term patients, a nursing home is expected to fill out the MDS by reviewing patient information for the past 14 days. The assessment includes questions that require observing the patient, asking the patient questions, and retrieving information from the medical record. Unlike home health agencies, nursing homes are not required to assess a patient on discharge. Because the first assessment is not required in the first 24 hours, technically SNFs are not required to use the MDS to assess a patient at admission. ■

produced different results. In one study, the contractor found high rates of error for the MDS items at the individual facility level, especially for the items that make up the quality indicators (Abt 2001b). In a later but similar study, the contractor reported that the three SNF-specific quality indicators reflected actual quality of care the facility provides, given the patients it served (Abt 2003). In comments on the GAO's findings, CMS attributed these different results to actual improvement in MDS coding accuracy, but the GAO claimed there was little evidence of efforts that would have led to improvements in MDS data accuracy. The GAO also questioned the representativeness of the data used in the later study because the sample of SNFs was drawn from six states and because 50 percent of the facilities that were asked to participate declined (GAO 2002b). Given the concerns raised by the GAO about the MDS data and the studies that evaluated MDS data, we believe that the data collected using the MDS have not been conclusively found to be accurate. Quality measures based on these data, therefore, may not adequately reflect the quality of care provided in a SNF.

### Timing of the assessment

Although SNF patients are assessed frequently—on the 5th, 14th, 30th, 60th, and 90th day of their stay—they are not assessed upon admission or discharge. Because our interviewees support the concept of assessing progress over time, they suggested two changes in timing to expand and improve the MDS for quality indicators. These changes would not necessarily increase the number of times the MDS is completed. Assessment upon discharge and admission could be done using an abbreviated instrument or could possibly substitute for one of the other routine assessments.

- Assessment on discharge. Our experts uniformly agreed that an assessment on discharge would provide missing information for several measures of quality, in particular functional improvement. An assessment strategy focusing on the change between the initial assessment and the discharge would help answer many of the quality concerns raised by experts, including whether the goals of care were achieved and whether pressure sores or delirium were appropriately

managed. They did not believe a full MDS assessment is necessary; rather it could focus on quality indicators for short-term patients, activities of daily living (ADLs), or even be done using a different instrument.

- Assessment on admission. Currently, the facility has to fill out the initial MDS assessment by the fifth day, and the nurse looks back two weeks into the patient's history to better understand his or her condition. Some experts told us that this two-week look back and the time allotted for filling out the MDS are important for care management but questioned whether they improved quality measurement. They suggested that it might be more appropriate to use a few items (e.g., ADLs) measured at admission to measure quality.

## Improving Medicare's ability to monitor SNF quality

The experts we interviewed identified several indicators that CMS does not use to monitor quality of SNF care—rehospitalization, discharge of patients to the community, and improvement in functioning. They pointed out that these indicators would provide better information on whether beneficiaries benefit from SNF care and whether the goals of the care plan are achieved.

Two of the three indicators suggested by experts—rehospitalization and disharge to the community—are readily available from existing administrative data, although not from the MDS.

### Rehospitalization

The experts we interviewed unanimously suggested that rehospitalization be used as an indicator of SNF quality of care. NQF also suggested that rehospitalization be used as a quality indicator for SNF patients (GAO 2002b). Recent evidence points to an increase in rehospitalizations, with Hogan finding that SNF patients were rehospitalized more than was expected in 2002 (Hogan 2004).

There are several ways to consider rehospitalization by analyzing SNF and hospital claims. To examine trends in the quality of SNF care, CMS could examine a range of measures from all rehospitalizations to only those that SNFs can prevent. A set of avoidable rehospitalizations for five conditions that are risk-adjusted have been developed by a CMS contractor specifically as a measure of SNF quality (Abt 2001a). We have adopted these measures as part of our examination of changes in quality in assessing payment adequacy for SNFs (see page 90).

### Discharge to the community

Most beneficiaries prefer to return home from SNFs, rather than stay in a nursing home. Hogan found that the share of beneficiaries discharged home from SNFs in 2002 was lower than expected based on pre-PPS discharge patterns (Hogan 2004).

The MDS is collected on all nursing home residents, which allows CMS and researchers to determine from data already collected whether patients discharged from the SNF remained in a nursing home. SNF claims combined with hospital claims and dates of death enable researchers to determine the discharge destination for SNF patients. In addition, the Colorado QIO and researchers at the University of Colorado (and others) have developed and tested a method to predict discharge home that would allow the actual and expected outcomes to be compared (Datapro Team 2002b).

### Improvement in functional ability

More than one-half of SNF patients—51 percent—do not have a second MDS assessment (Liu et al. 2003). As a result, improvement in functional status cannot be assessed for most SNF patients.

Although Medicare pays for rehabilitation services for more than three-quarters of SNF patients, CMS currently has no way to determine if beneficiaries' functional abilities improve during their SNF stay. An indicator of ADL improvement for all SNF patients could be constructed if ADLs were assessed and reported at admission (without a look-back period) and at discharge. Because SNFs have to establish a care plan for a patient within 24 hours of admission, ADLs could be available at admission. Several of our experts suggested that SNFs could report the discharge ADLs on a revised tracking form.

To improve Medicare's monitoring of the quality of care SNFs provide, we recommend:

**RECOMMENDATION 2C-3**

**CMS should:**

- **develop and use more quality indicators specific to short-stay patients in skilled nursing facilities,**
- **put a high priority on developing appropriate quality measures for pay for performance, and**
- **collect information on activities of daily living at admission and discharge.**

## RATIONALE 2C-3

Currently, CMS has only three quality indicators for SNF patient care, all of them limited. Most important, these indicators—delirium, pain, and pressure ulcers—do not focus on determining whether Medicare patients benefit from SNF care or whether the goals for a SNF patient's care are achieved. The experts we interviewed suggested three quality indicators—rehospitalization, discharge to the community, and ADL improvement—that would change the focus of SNF quality. Medicare urgently needs quality indicators that allow the program to assess whether patients benefit from SNF care. Rehospitalization and discharge to the community are currently available from administrative data.

## IMPLICATIONS 2C-3

### Spending

- This recommendation would not affect federal program spending relative to current law.

### Beneficiary and provider

- This recommendation is expected to improve quality for beneficiaries. It also would minimally increase the administrative burden on providers if the assessment of ADLs at admission could be substituted for the first assessment and only a few items were assessed for quality purposes at discharge. ■

## Endnotes

1 Medicare covers 100 SNF days in a spell of illness. Medicare pays 100 percent of the payment rate for the first 20 days of a SNF stay. From the 21st to the 100th day, beneficiaries are responsible for a copayment equal to one-eighth of the hospital deductible, or $115 per day in fiscal year 2005.

2 With approval from CMS, certain Medicare-certified hospitals—typically small, rural hospitals and critical access hospitals—may also provide extended care skilled nursing services in the same hospital beds they use to provide acute care services. These are called swing bed hospitals. We do not include an analysis of swing beds in this report. On July 1, 2002, Medicare began paying swing bed hospitals that are not critical access hospitals according to the SNF prospective payment system for SNF services provided to Medicare beneficiaries. Critical access hospitals continue to be paid for their swing beds based on their costs of providing care.

3 The SNF per diem payment rates do not cover the costs of physician services or services of certain other practitioners (such as qualified psychologists). Medicare Part B still covers these services. In addition, to limit SNFs' liability for services typically outside the scope of SNF care, the Congress excluded payments for certain high-cost, low-probability ancillary services from the SNF per diem rates. Thus, Medicare pays separately when SNF patients receive emergency room care, outpatient hospital scans, imaging and surgeries, and certain high-cost chemotherapy agents and prosthetic devices. But the per diem rates do cover the costs of physical, occupational, and speech therapies, even if a physician supervises.

4 The rehabilitation category includes patients who would qualify for one of the other RUG–III skilled care categories if they were not receiving or expected to receive at least 45 minutes of rehabilitation therapy each week. The extensive services category includes patients who have received intravenous medications or tracheostomy care or required a ventilator/respirator or suctioning in the past 14 days or have received intravenous feeding in the past seven days. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory therapy seven days per week, or are aphasic and tube-fed. The clinically complex category includes patients who are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy.

5 Data are for SNF as the sole post-acute care modality and exclude deaths and transfers.

6 Quality indicator is a generic term in this chapter.

7 MedPAC used a program developed by Andrew M. Kramer, M.D., and Ron Fish, M.B.A. at the Center on Aging, University of Colorado Health Sciences Center.

8 The episode endpoint was determined by events occurring within 31 days of the last bill in the episode. Only episodes that were not truncated by the end of the year were used in the analysis. For this analysis, episode terminations were made mutually exclusive by creating a hierarchy of the possible end points. For example, all deaths within a month of episode termination were counted as a single category even if death occurred after a readmission to the hospital. To make results comparable, 2002 rates were adjusted for case mix using the principal post-acute care diagnosis. Expected rates in 2002 were determined by first calculating the 1996 average rates of episode end points by principal post-acute care diagnosis. Next, the average episode endpoint rate for each post-acute care diagnosis in 1996 was applied to the 2002 data to determine the 2002 expected episode endpoint.

9 SNF services, covered by Medicare under Part A, must be furnished within 31 days of a 3-day hospital stay, pursuant to a physician's orders, be reasonable and necessary for the treatment of the patient's injury or illness, and must be reasonable in length and quantity.

10 The average length of stay (ALOS) for SNF patients is from MedPAC 2004a; ALOS for nursing facility residents is from Bates-Jensen et al. 2003. The ALOSs are mutually exclusive.

11 When calculating SNFs' aggregate costs in the base year, we increase the estimated nursing share of the average routine costs reported on the SNFs' cost reports by the additional nursing costs of caring for Medicare patients. This adjustment reduces the Medicare margin as it increases SNFs' routine costs.

12,13 This analysis included freestanding SNFs with complete cost report data in each year between 2000 and 2003.

14 NQF endorsed these indicators.

15 The Nursing Home Compare also lists staffing levels and complaints and deficiencies reported by nursing homes through the Online Survey, Certification and Reporting (OSCAR) system. The information, however, is facility specific and is not broken down by whether the individual is a short-term patient or a long-term resident. CMS, GAO, and the OIG all have reported concerns about the reliability of OSCAR data (GAO 2002b, HCFA 2000, OIG 2004).

16 The 42 percent is from Datapro Team 2002a; the 70 percent is from Kramer et al. 1999.

# References


Abt Associates, Inc. 2003. *Validation of long-term and post-acute care quality indicators.* Final report prepared for CMS. Cambridge, MA: Abt. June.

Abt Associates, Inc. 2001a. *Appropriateness of minimum nurse staffing ratios in nursing homes: Phase II final report*. Cambridge, MA: Abt. Winter.

Abt Associates, Inc. 2001b. *Development and testing of a minimum data set accuracy verification protocol.* Final report prepared for HCFA. Cambridge, MA: Abt. February.

Bates-Jensen, B., M. M. Cadogan, J. Jorge, et al. 2003. Standardized quality-assessment system to evaluate pressure ulcer care in the nursing home. *Journal of American Geriatrics Society* 51, no. 9: 1195–1321.

Cain Brothers. 2004. Cain Brothers' indices: assisted living and skilled nursing indices compared to the S&P 500 Index. October. http://www.cainbrothers.com.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2003. *CMS health care industry market update: Nursing facilities*. Baltimore: CMS.

Datapro Team. 2002a. Skilled nursing facilities prospective payment system findings from analysis of residents discharged to the community. Unpublished report to CMS.

Datapro Team. 2002b. Skilled nursing facilities prospective payment system: Rehabilitation data flag analysis. Unpublished report to CMS.

Deutsche Bank. 2004. *High yield health care: 3Q04 outlook and 2Q04 review*. New York: Deutsche Bank.

FitchRatings. 2004. 2004 industry outlook for nonprofit continuing care retirement communities and nursing homes. http://www.fitchratings.com.

Government Accountability Office. 2002a. *Nursing homes: Federal efforts to monitor resident assessment data should complement state activities*, no. GAO-02-279. Washington, DC: GAO. February.

Government Accountability Office. 2002b. *Nursing homes: Public reporting of quality indicators has merit, but national implementation is premature*, no. GAO-03-187. Washington, DC: GAO. October.

Government Accountability Office. 2002c. *Nursing homes: Quality of care more related to staffing than spending*, no. GAO-02-431R. Washington, DC: GAO. June.

Government Accountability Office. 2002d. *Skilled nursing facilities: Medicare payments exceed costs for most but not all facilities*, no. GAO-03-183. Washington, DC: GAO. December.

Government Accountability Office. 2002e. *Skilled nursing facilities: Providers have responded to Medicare payment system by changing practices*, no. GAO-02-841. Washington, DC: GAO. August.

Government Accountability Office. 1999. *Skilled nursing facilities: Medicare payment changes require adjustment but maintain access,* no. GAO-HEHS-00-23. Washington, DC: GAO. December.

Grabowski, D. C. 2002. The economic implications of case-mix Medicaid reimbursement for nursing home care. *Inquiry* 39: 258–278.

Health Care Financing Administration. 2000. *Report to Congress: Appropriateness of minimum nurse staffing ratios in nursing homes, phase 1*. Baltimore: HCFA.

Hogan, Christopher. 2004. Medicare beneficiaries' use of post-acute care trends, 1996 to 2002. Draft working paper being developed under MedPAC contract. Direct Research, LLC, Vienna, VA.

Kaiser Commission on Medicaid and the Uninsured. 2004. The continuing Medicaid budget challenge: State Medicaid spending growth and cost containment in fiscal years 2004 and 2005: Results from a 50-state survey. Kaiser Commission on Medicaid and the Uninsured. October. www.kff.org/Medicaid.

Kramer, Andrew M. MD, and Ron Fish MBA. 2001. The relationship between nurse staffing levels and the quality of nursing home care. In *Appropriateness of minimum nurse staff ratios in nursing homes*, phase II final report, vol. 1 of 3. Cambridge, MA: Abt Associates, Inc.

Kramer, A. M., T. B. Eilertsen, M. K. Ecord, et al. 1999. A prospective study of new case-mix indices for subacute care. Report to the National Subacute Care Association and the American Health Care Association.

Legg Mason Wood Walker, Inc. 2004. *Health care—specialty providers: Positive outlook for nursing homes and assisted living at NIC*. Baltimore: Legg Mason Wood Walker, Inc.

Levit, Katharine, Cynthia Smith, Cathy Cowan, et al. 2003. Trends in U.S. health care spending, 2001. *Health Affairs* 22, no. 1 (January/February): 154–164.

Liu, K., and K. Black, The Urban Institute. 2002. Hospital-based and freestanding skilled nursing facilities: Any cause for differential Medicare payments? Working paper, The Urban Institute, Washington, DC.

Liu, K., K. Black, S. Maxwell, et al. 2003. Information presented to 2003 technical expert panel, The Urban Institute, Washington, DC.

Medicare Payment Advisory Commission. 2004a. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2004b. *Report to the Congress: New approaches in Medicare.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2003. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2002. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Office of Inspector General, Department of Health and Human Services. 2004. *Inspection results on Nursing Home Compare: Completeness and accuracy*, no. OEI–01–03–00120. Washington, DC: OIG. June.

Office of Inspector General, Department of Health and Human Services. 2001. *Medicare beneficiary access to skilled nursing facilities*, no. OEI–02–01–00160. Washington, DC: OIG. July.

Office of Inspector General, Department of Health and Human Services. 2000. *Medicare beneficiary access to skilled nursing facilities*, no. OEI–02–00–00330. Washington, DC: OIG. September.

Office of Inspector General, Department of Health and Human Services. 1999a. *Early effects of the prospective payment system on access to skilled nursing facilities,* no. OEI–02–99–00400. Washington, DC: OIG. August.

Office of Inspector General, Department of Health and Human Services. 1999b. *Physical and occupational therapy in nursing homes: Costs of improper billing to Medicare*, no. OEI–09–97–00122. Washington, DC: OIG. August.