CHAPTER 5

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Chapter summary

About 40 percent of Medicare acute inpatient hospital discharges result in use of post-acute care (PAC), which includes four provider types: skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities, and long-term care hospitals. Ensuring that the patient is served by the appropriate type of PAC provider is critical, but the selection of a provider *within* a PAC category can be crucial because the quality of care varies widely among providers. Increasing the use of higher quality PAC providers is particularly important as CMS implements value-based payment reforms, such as the Hospital Readmissions Reduction Program (HRRP), hospital value-based purchasing programs, and accountable care organizations (ACOs), which hold providers accountable for the expenditures related to readmissions during a PAC stay.

Beneficiaries report that they value quality of care and that they prefer PAC providers that are close to their home or family. Medicare discharge planning regulations place responsibility with hospitals for connecting inpatient acute care hospital patients with their options for PAC, including educating beneficiaries about their choices and facilitating access to PAC when necessary. Medicare regulations also require that hospitals consider patient preferences and guarantee beneficiary freedom of choice in selecting PAC providers, but hospitals are limited in the assistance they can provide. Though they are required to provide beneficiaries who need PAC with a list of nearby

In this chapter

SNFs and HHAs, Medicare regulations prohibit hospitals from recommending specific PAC providers. The Improving Medicare Post-Acute Care Transformation Act of 2014 requires hospitals to include quality data when informing beneficiaries about their options, but CMS has yet to finalize the regulations implementing this requirement. CMS has developed consumer-oriented websites that provide information on the quality of SNFs and HHAs, but many studies have concluded that these efforts have not significantly increased the use of higher quality PAC providers, possibly because beneficiaries are not always made aware of the data.

The Commission's analysis of referral patterns of Medicare beneficiaries who were sent to SNFs and HHAs indicates that, for many beneficiaries, another nearby provider offered better quality care, though not all of the higher quality providers may have had available capacity. For example, over 94 percent of beneficiaries who used HHA or SNF services had at least one provider within a 15-mile radius that had higher performance on a composite quality indicator than the provider they selected. About 70 percent of beneficiaries who received HHA services had 5 or more other HHAs within a 15-mile radius that offered better quality than their original provider, while almost half of SNF users had 5 or more options with better quality.

Helping beneficiaries to identify better quality PAC providers should be a goal in a reformed discharge planning process, and authorizing hospital discharge planners to recommend specific higher quality PAC providers would further this goal. However, several design decisions would need to be resolved. First, a consistent approach to identifying better quality PAC providers would be needed, and quality standards would need to be transparent for PAC providers and beneficiaries. Second, policies would be needed to safeguard against potential conflicts of interest that could ensue from the authority to recommend specific providers. Finally, the criteria to determine what defines a quality provider would need to account for variations in quality across markets since the number of higher quality providers available in any market will depend on how quality is defined.

Regardless of the approach selected to encourage the use of higher quality PAC providers, beneficiaries should retain freedom of choice. Beneficiaries may have important concerns that are not necessarily reflected in standard quality measures, such as language competency or proximity to family members. These preferences may lead them to select a PAC provider that has lower performance on some quality measures, but additional quality information would allow them to better understand the nature of their options and any trade-offs.

Medicare's options for expanding the authority of discharge planners to recommend higher quality PAC providers could include prescriptive approaches that provide specific metrics or definitions that hospitals must use or more flexible approaches that leave key decisions to discharge planners. A hybrid approach could specify certain selection criteria hospitals would need to use while granting hospitals discretion in the application of these criteria.

In a flexible approach, hospitals would be responsible for defining the criteria they would use for identifying higher quality PAC providers. Hospitals would select quality measures, collect data from PAC providers or other sources of information, and set the performance levels that PAC providers have to meet. CMS could require that hospitals establish formal vetting processes for setting the criteria and reviewing PAC provider performance to provide some degree of transparency for beneficiaries and PAC providers. This option would allow hospitals to use criteria they believe best meet the needs of their patient populations and reflect the availability of PAC providers in their local markets. However, it could be confusing for beneficiaries and PAC providers in a market area to have different hospitals use different quality definitions. In addition, this option could be administratively complex for CMS to oversee.

In a prescriptive approach, CMS would select the quality measures, set the performance levels, identify and notify hospitals and PAC providers, and update the measures as new data became available. Hospitals would be required to notify beneficiaries of the PAC providers that are designated as higher quality. This option would ensure consistent standards of quality and would be less burdensome for hospitals. However, the number of PAC providers designated as high quality would vary across markets. Beneficiaries could find it difficult to select a higher quality provider in areas with limited supply.

In a variation of the prescriptive approach, CMS could rate providers on a composite measure that captures various aspects of PAC quality. In each market, discharge planners could highlight the PAC providers that are higher rated and have available capacity. This approach would account for the variation in quality across markets and provide more flexibility to discharge planners. ■

Introduction

While many delivery system reform options highlight the importance of placing patients in the appropriate type of post-acute care (PAC)—skilled nursing facility (SNF), home health agency (HHA), inpatient rehabilitation facility (IRF), or long-term care hospital (LTCH)—the selection of a *particular* PAC provider from among several of any given type can also be crucial for the clinical outcome and expenditures of an episode of care. Beneficiaries seeking posthospital care, particularly those patients referred to SNFs and HHAs, frequently have many agencies or nursing facilities operating in their markets. CMS has implemented some initiatives to help beneficiaries identify better PAC providers, but these efforts may not be adequate.

Encouraging beneficiaries to use higher quality providers is also important because PAC services are costly and frequently used in traditional fee-for-service (FFS) Medicare. In 2015, about 40 percent of hospital discharges resulted in the use of PAC services, and Medicare spending on PAC totaled about 10 percent of all FFS expenditures—over $60 billion. PAC providers vary in the quality of care they provide, as we have reported annually in our analyses of Medicare payment adequacy (Medicare Payment Advisory Commission 2018). Lower quality providers have higher rates of complications such as rehospitalizations and emergency services use, resulting in worse health outcomes for beneficiaries and further driving up Medicare spending. Policies that encourage the selection of higher quality providers could yield better quality of care and lower Medicare spending and beneficiary cost sharing.

Medicare discharge planning regulations place responsibility with hospitals for connecting inpatient acute hospital patients with their options for PAC, including educating beneficiaries about their choices and providing referrals when necessary. These regulations are designed not only to ease the burden for arranging posthospital care for beneficiaries but also to guarantee beneficiary freedom of choice in selecting PAC providers. In fact, current regulations do not permit discharge planners to recommend specific PAC providers to beneficiaries.

Increasing the use of higher quality PAC providers is particularly important as CMS implements value-based payment reforms that hold hospitals accountable for the expenditures and outcomes related to PAC (Table 5-1, p. 116). For example, under the Hospital Readmissions Reduction Program (HRRP), the quality of the PAC providers selected by a hospital's patients could affect whether the hospital receives a reward or penalty. Other models, such as accountable care organizations (ACOs) and payment bundles that include inpatient hospital care and PAC, can create even more explicit links between hospitals' financial incentives and the use of higher quality PAC providers. Because Medicare's current discharge planning regulations have not been substantially revised in over 20 years, opportunities exist to update them to better serve beneficiaries and advance delivery system reform.

Beneficiaries seeking PAC often have many PAC options that vary substantially in quality

Though the supply of PAC providers varies widely across the country, most beneficiaries have a number of PAC providers in their local area. Most areas have at least one, if not many, SNFs and HHAs participating in Medicare. For example, 86 percent of beneficiaries had five or more HHAs operating in their zip code of residence in 2016 (Medicare Payment Advisory Commission 2018). The supply of IRFs and LTCHs is more concentrated. In practice, most hospitals refer to many SNF and HHA providers. For example, one study found that, in 2008, the average hospital referred patients needing PAC services to 23 HHAs and 34 SNFs (Lau et al. 2014). Two recent studies have found that readmission rates generally decrease when a hospital's PAC discharges are concentrated with a select number of providers, so referring to a wider range of providers than necessary may increase readmission rates (Rahman et al. 2013, Schoenfeld et al. 2016). While factors in addition to supply, such as distance from a beneficiary's residence, bed availability, and any special clinical needs, can constrain a beneficiary's options, the substantial supply of providers in many areas indicates that beneficiaries usually have a number of nearby options in selecting a PAC provider.

Selecting among providers in markets with a robust supply is complicated by the variation in quality among PAC providers. For example, the Commission found the following in analyses of PAC providers:

- Among SNFs, potentially avoidable rehospitalization rates for the first 30 days of a stay averaged 20.2 percent for the lowest performing quartile of facilities

TABLE 5–1 **Medicare initiatives that place hospitals at financial risk for readmissions from PAC**

	Initiative	Participation	Financial incentive to prevent readmissions
Inpatient hospital value-based purchasing program	VBP incentive that pays hospitals bonuses or imposes penalties based on their performance	Mandatory for all PPS hospitals	Payment determination is in part based on a measure of spending in the 30-day postdischarge period.
Hospital Readmissions Reduction Program	Penalty for hospitals that exceed expected rate of readmission for six conditions	Mandatory for all PPS hospitals	The program includes a financial penalty for hospitals with higher than expected readmissions.
Comprehensive Care for Joint Replacement	Creates an incentive that holds hospitals accountable for cost and quality of the inpatient acute care services and 90 days of postdischarge care for joint replacement patients	Mandatory for all hospitals in 67 selected urban areas (CMS intends to reduce to 34 areas in 2018)	Hospitals in the CCJR program can receive a bonus or penalty depending on their aggregate spending in the payment bundle. Lowering readmissions from PAC helps keep spending below target.
Bundled Payments for Care Improvement	Includes a model that allows hospitals to select a bundle that includes the inpatient stay plus PAC and all related services up to 90 days after discharge; the beneficiary's condition must be 1 or more of 48 diagnostic groups	Voluntary	Participants in the BPCI initiative can receive bonus payments if they keep spending below a target based on prior utilization.
Accountable care organizations (Next Generation or Medicare Shared Savings Program)	Hospitals can participate in ACOs with other stakeholders to share financial risk and collaborate to improve care; not all ACOs include a hospital	Voluntary	Incentives vary depending on the program. Hospitals that lower readmissions relative to their target will have lower spending and better quality, which will influence whether they receive penalties or bonuses.

Note: PAC (post-acute care), VBP (value-based purchasing), PPS (prospective payment system), CCJR (Comprehensive Care for Joint Replacement), BPCI (Bundled Payments for Care Improvement), ACO (accountable care organization).

Source: MedPAC analysis.

compared with 8.4 percent for the highest performing quartile in 2015 (Medicare Payment Advisory Commission 2017).

- Among HHAs, rates of hospitalization during or within the 30 days after home health care in 2014 varied from 17.5 percent for the agency at the 25th percentile compared with 30.1 percent for the agency at the 75th percentile.
- Among IRFs, the share of patients discharged to a SNF in 2015 almost doubled between the providers at the 25th percentile and the 75th percentile of the range of performance (Medicare Payment Advisory Commission 2017).

These examples illustrate the importance of selecting a quality provider since the choice of provider can have implications for the quality of care received. Beneficiaries served by lower quality providers could experience additional hospital stays, have more difficulty recovering from the acute condition that required their hospitalization, and may have adverse long-term health outcomes (e.g., not recovering to a premorbid level of walking or other form of physical function).

Patients referred to PAC need assistance to identify better quality providers

Patients selecting an HHA or SNF after a hospitalization report that they value quality and a provider that is close to the beneficiary's residence, but several factors complicate the challenge for beneficiaries to make informed choices (BearingPoint 2003, Sefcik et al. 2016, Shugarman and Brown 2006). Reports of patient experience suggest that many beneficiaries who need PAC do not understand the basic nature of the services, particularly those who have no prior experience with posthospital care (BearingPoint 2003, Coleman et al. 2005, Shugarman and Brown 2006). Some patients report being unaware they have a choice of provider, despite Medicare's requirements for making them aware of their options (Baier et al. 2015).

The hospital stay can be a confusing period when beneficiaries and their families are focused on the patient's acute health problem that led to admission, and they may not recognize, or may be slow to realize, that the beneficiary will require posthospital care. While provider-level quality information is available for beneficiaries, some studies suggest that patients are not always aware of it and can find the information difficult to understand (Castle et al. 2009, Harris and Beeuwkes-Buntin 2008). In addition, the decision to discharge a beneficiary can come suddenly. In one study, 30 percent of patients reported being discharged with less than a day's notice (Horwitz et al. 2013). The selection of a PAC provider may need to happen swiftly. With these pressures, it can be challenging, without significant assistance, for many beneficiaries to identify the highest quality provider available.

Medicare's discharge planning policies are intended to facilitate choice and access to PAC

Under Medicare's conditions of participation (COPs), hospitals are responsible for evaluating their patients' postdischarge needs, educating beneficiaries about those needs, and, if necessary, arranging transfers to the selected postdischarge provider. The hospital discharge planner is required to solicit patient preferences for postdischarge care and consider the practicability of the patient returning to home when presenting PAC options.

Medicare statute and the hospital discharge planning COPs are intended to protect beneficiary choice in the selection of PAC providers. As they have with other Medicare providers, beneficiaries have a "basic freedom of choice" to select any PAC provider participating in the program (though PAC providers do not have an obligation to accept any patient that is referred). In addition, the Medicare statute defining discharge planning indicates that a hospital "may not specify or otherwise limit" the PAC providers made available to beneficiaries. (Medicare Advantage allows plans to establish their own networks; these plans' enrollees must select a provider that is in their plan's network.) The Balanced Budget Act of 1997 also requires that hospitals provide a list of HHAs or SNFs that are near the beneficiary's residence for patients identified as needing these services. The list is not required to include quality or performance information. In practice, many discharge planners are cautious about providing advice to beneficiaries because they do not want to be seen as limiting patient choice (Baier et al. 2015, Tyler et al. 2017).

Providing PAC quality information has had limited success in shifting volume to higher quality providers

Medicare has made provider-level PAC quality measures available for PAC providers through components of the Medicare.gov website.[1] For each of the four settings, consumers may search for providers by zip code, and the website provides a list of participating providers, quality measures, and other information describing the provider. The website includes 23 quality measures for SNFs and 21 quality measures for HHAs. The information is updated quarterly. Consumers search the SNF data about 158,000 times a month; the HHA data, about 33,000 times a month.

The information provided through Medicare.gov—such as staffing ratios, quality measures for short-stay patients, compliance survey results, and services offered—can be useful to beneficiaries but also has some limitations for patients seeking PAC. The measures generally cover broad categories of patients, so there is no ability to examine quality for specific conditions, such as outcomes for a facility's poststroke or other rehabilitation patients. The site also does not identify facilities that provide specialized treatments such as ventilator care.

In recent years, Medicare has added a star rating system to make the quality reports under Nursing Home Compare and Home Health Compare easier to interpret. Under this system, Medicare computes a composite measure for SNFs and HHAs that summarizes performance on several

individual quality measures. The value of the composite measure is used to rate providers: The highest scoring providers receive 5 stars, and the lowest receive 1 star. The quality measures in the SNF and HHA star rating systems include patients receiving PAC, but many of the measures also pertain to long-term care or community-admitted patients. Because the rating's measures are not specific to the PAC population, their utility for posthospital patients may be limited.

The evidence suggests that Medicare's Nursing Home Compare and Home Health Compare data have minimal impact in motivating beneficiaries to choose higher quality providers. Studies have assessed whether patient selection of HHAs and SNFs changed after Medicare.gov data were made available to consumers. One study found that most SNF patients did not appear to select higher quality providers after the Medicare.gov data were released to consumers, while another found that the data had a small impact (an increase of less than 1 percent of a facility's volume) when there was a large difference in the quality of available providers (Werner et al. 2012, Werner et al. 2011). A review of the impact of the HHA data available through Medicare.gov also found minimal impact: On average, the best performing agencies might have increased their market share by less than 1 percent (Jung et al. 2016). The lack of impact is consistent with studies of the use of information about quality for consumers in other settings. Reviews of the health services literature have found that, while provider quality information can be useful for consumers, it has had limited or minimal success in getting beneficiaries to select higher quality providers (Goncalves-Bradley et al. 2016, Harris and Beeuwkes-Buntin 2008, Hussey et al. 2014). The limited impact of these data may indicate that patients are often unaware of this information or that they have limited or no access to online services when hospitalized. Patients who are hospitalized may be too distracted or sick to conduct detailed research about their PAC provider options, and a beneficiary's family member or other caregiver may also have difficulty finding and using this information.

Beneficiaries seek assistance from trusted intermediaries for selection of a PAC provider

In practice, beneficiaries report soliciting the views of physicians, family members, or other associates to recommend a PAC provider (Advisory Board Company 2016, Harris and Beeuwkes-Buntin 2008, Shugarman and Brown 2006). Beneficiaries generally view this information as more valuable than comparative quality data available through sources like Medicare.gov (Advisory Board Company 2016, Harris and Beeuwkes-Buntin 2008, Sefcik et al. 2016). However, some patients find that physicians vary in their knowledge of the quality of posthospital care (Burke et al. 2017, Colwell 2017).

Hospital discharge planners might be a natural source of recommendations since their principal responsibilities should make them familiar with the PAC options in an area. However, Medicare discharge planning rules do not permit them to recommend specific PAC providers. In addition, a lack of knowledge about PAC quality may limit their ability to provide useful information to beneficiaries. A 2004 survey of discharge planners found that, while 63 percent of planners were aware of the PAC quality data that Medicare makes available, only 38 percent reported using it (Castle 2009). A more recent analysis found that discharge planners are not always aware of comparative quality data on PAC providers or do not believe that PAC providers differ significantly in quality (Baier et al. 2015). Discharge planners' awareness may have increased since 2004, but the survey suggests that a significant share may not use quality data even if they are aware of it.

Concern about protecting patient choice reportedly also makes some discharge planners cautious in the assistance they provide, even when patients ask for their opinions (Baier et al. 2015). Hospital and health system representatives have been concerned that COPs do not adequately define permissible educational activities that respect the beneficiary's freedom to select a PAC provider (Kahn 2015, Thompson 2016). In practice, this lack of definition means that some discharge planners see providing more tailored information, such as highlighting PAC providers that have agreed to collaborate with the hospital, as part of their assistance responsibilities. In contrast, others report being unwilling because they believe it violates Medicare's freedom of choice requirements (Baier et al. 2015, Tyler et al. 2017). For many patients, especially those who lack family contacts or a physician prepared to advise on PAC, the hesitancy of a discharge planner to provide additional assistance could be problematic since there may not be other medical professionals in a better position to help beneficiaries consider their options.

IMPACT mandates hospitals' use of quality information, but implementation status is unclear

In 2014, the Improving Medicare Post-Acute Care Transformation Act (IMPACT) required changes to the

discharge planning COPs to mandate that hospitals "take into account quality, resource use, and other measures . . . in the discharge planning process." CMS proposed regulations in 2015 to put this mandate into effect but never finalized the regulation. The proposed rule also would have required that beneficiaries referred to IRFs or LTCHs be given a list of nearby providers, similar to the current requirement for SNFs and HHAs. These policies had the potential to strengthen patient choice by explicitly permitting hospitals to provide and explain quality data to beneficiaries during the discharge planning process. However, the expanded use of quality information did not address some concerns about current discharge planning regulations. Hospital representatives wanted the rule to be more explicit that a discharge planner could recommend a PAC provider to a beneficiary (Kahn 2015, Thompson 2016).

The proposed regulation would have required hospitals to share with beneficiaries the cross-sector PAC measures of quality that CMS was required to develop under IMPACT.[2] Since the measures were not expected to be ready before the regulation's expected implementation, the rule suggested that hospitals use other sources of quality information such as the data on SNFs and HHAs found on Medicare.gov. The regulations implementing IMPACT requirements were never finalized, and CMS has offered no information about future actions on the proposed rule.

While CMS has made data available to beneficiaries through Medicare.gov, there is no regulatory requirement that hospitals inform patients about these data. If discharge planners do not inform beneficiaries, beneficiaries would have to know about publicly reported measures from their own research. Finding and understanding this information may be challenging for beneficiaries who have been recently hospitalized or who are unfamiliar with online information.

Patient choice under Medicare's delivery system reform efforts

CMS has also had to consider how to address beneficiary choice of PAC in some of its delivery system reform models. Many of these initiatives are intended to encourage partnerships or collaboration among providers to improve care, such as encouraging PAC providers and hospitals to coordinate transitional care or quality improvement efforts. The high cost of readmissions from posthospital care in many episodes suggests that the quality of PAC providers significantly affects the success of these models. Participant hospitals and ACOs have an incentive to encourage the use of better PAC providers.

In most reform models, CMS has not changed or waived any existing discharge planning requirements, and hospitals continue to be subject to the current regulations. Hospitals and health systems participating in these efforts have indicated that they seek to encourage the use of preferred PAC providers by educating beneficiaries about PAC choices and highlighting the supplemental services available in their reform model. For example, in the Bundled Payments for Care Improvement (BPCI) initiative, hospitals can indicate that they have identified preferred PAC providers with which they collaborate; beneficiaries selecting one of these providers can receive additional services, such as a transitional care nurse that will follow the patient across settings. While some hospitals report success with encouraging beneficiaries to use preferred providers, no studies have directly assessed the impact of these efforts (Hargrave et al. 2014).

Another approach to the PAC selection issue is found in the Comprehensive Care for Joint Replacement (CCJR) program. CMS provides hospitals participating in the CCJR program with the authority to recommend preferred PAC providers but leaves the beneficiary's right to select the PAC provider unchanged. In effect, hospitals can recommend a provider, but beneficiaries are not obligated to use it. While the CCJR program has been active since 2016, no studies of the impact on patient choice of PAC provider have been released.

Hospitals have developed preferred PAC provider networks to lower readmission rates

The changes in payment policy resulting from the Patient Protection and Affordable Care of 2010 (PPACA) led many hospitals to establish partnerships with PAC providers to perform well under the new policies regarding hospital readmission rates. In recognition of these new incentives, hospitals established PAC networks with select providers to strengthen their connections with posthospital care. While some hospitals created these networks because of their participation in programs like BPCI or ACOs, all prospective payment system hospitals had an incentive to scrutinize PAC quality because patients readmitted from these settings could affect their payments under the HRRP and hospital value-based purchasing programs. Initial efforts were reportedly focused on SNF networks, though some organizations reported developing networks for the

other provider types. These networks are widespread and likely to increase in number. A 2016 survey of Premier Health hospitals found that 56 percent had established a formal or informal PAC network and that 32 percent were developing a network (Compton-Phillips and Mohta 2016).

To establish a network, hospitals generally release a solicitation for PAC providers to indicate interest and to collect information about PAC providers' ability to meet criteria on a variety of metrics. Hospitals are free to establish their metrics, which can include quality measures, clinical capabilities, performance on licensing and accreditation surveys, compliance history, physician staff affiliation, and geographic coverage in the hospital's service area. Frequently, a major consideration is the volume of patients a PAC provider currently receives from a hospital. Focusing the network on higher volume PAC providers ensures that any quality improvement efforts are targeted to the PAC providers that serve a significant share of a hospital's patients. These networks are arrangements between the hospital and the PAC providers, and beneficiaries are not required to select a PAC provider in the hospital's network. Once the networks are established, the hospital and PAC providers can collaborate on quality improvement activities such as establishing new clinical protocols and case reviews.

Hospitals with preferred networks use voluntary approaches to promote preferred PAC providers to beneficiaries, such as beneficiary education about the quality of preferred providers or the offer of transitional care nurses that follow patients through their episode of care (Hargrave et al. 2014). For example, one provider established an online tool that allowed beneficiaries to search the preferred providers by geographic location and quality performance. Though some hospitals reported success in encouraging beneficiaries to select preferred PAC providers, they also reported that discharge planners could be reluctant to highlight network providers because they were concerned about violating patient choice requirements or disrupting current referral patterns (Hargrave et al. 2014). Hospital representatives indicated that changing the practices of hospital discharge planners continued to be a challenge.

Beneficiaries who use PAC often have a higher quality provider nearby

A review of the referral patterns of Medicare beneficiaries that were sent to SNFs and HHAs provides an illustration of current policies and practices. In 2015, about 1.8 million beneficiaries were referred to a SNF and about 2.2 million beneficiaries were referred to an HHA after a hospitalization. To understand the options available to these beneficiaries, the Commission compared the quality of the 5 closest providers within a 15-mile radius of a beneficiary's home zip code with the quality of the provider from which the beneficiary received service.[3] Each provider within the radius was rated using a composite score that included two quality measures: one for adverse events such as hospitalization and a second for improvement in functional ability such as walking.[4] Over 94 percent of beneficiaries who used HHA services had at least one provider within a 15-mile radius that had a higher quality score than the provider from which they received services (Table 5-2).[5] Similarly, about 84 percent of beneficiaries who used SNF services had at least one better provider within a 15-mile radius of their residence. Many beneficiaries lived in an area with multiple options, though they were disproportionately located in urban areas. About 70 percent of beneficiaries who received HHA services had five or more other HHAs that offered better quality than their selected provider, while almost half of SNF users had five or more options with better quality. Beneficiaries who used SNF services and resided in rural areas typically had fewer options: Only 9.9 percent had 5 or more SNFs in the 15-mile radius.

The magnitude of the quality difference between the higher performing nearby providers and the provider selected was substantial in many cases. For example, for beneficiaries with one better provider nearby, the geographically closest better SNF had a rate of rehospitalization 3 percentage points lower on average. The average difference between the selected provider and the higher quality providers nearby increased with market size. For example, for beneficiaries with five nearby providers with better quality, the average rehospitalization rate for the better nearby SNFs was 15 percentage points lower than the selected hospital's rate.

There are some limitations to this analysis. First, the analysis does not measure whether SNFs had available capacity at the time a beneficiary was discharged from the hospital. Second, CMS does not report data on quality for smaller providers. The absence of data for small providers may be acute for the rates observed in rural areas because these providers tend to have lower patient volume than urban providers. In addition, the rural rates for the availability of SNFs could be affected because critical access hospitals are not required to report quality data for the swing beds they operate.

TABLE 5–2 **Many beneficiaries had higher quality PAC options nearby, 2015**

	Number of higher quality providers available within 15-mile radius						
	0 (No better options)	1	2	3	4	5 or more	Total
Share of beneficiaries with higher quality options nearby:							
Skilled nursing facility patients	14.7%	12.2%	9.8%	8.3%	8.2%	46.8%	100%
Home health patients	5.5	5.7	6.0	5.9	7.4	69.5	100

Note: PAC (post-acute care). Beneficiary and provider locations were measured using zip code centroids. A provider's location had to be within 15 miles of the beneficiary's zip code.

Source: Medicare Provider and Review skilled nursing facility file 2015, home health standard analytic file 2015, and Medicare Beneficiary Summary File 2015.

These results suggest that a significant share of beneficiaries had a nearby HHA or SNF that offered better quality. While several factors such as available capacity, clinical needs, or patient preference could affect where a beneficiary is served, it is also clear that the current hospital discharge planning process can limit efforts to refer patients to better performing PAC providers.

Principles for improving hospital discharge planning

Helping beneficiaries to identify better quality PAC providers should be a goal in a reformed discharge planning process, and authorizing hospital discharge planners to recommend specific PAC providers would further this goal. However, several design decisions would need to be resolved. First, a clear approach to identifying better quality PAC providers would be needed, and quality standards would need to be transparent for PAC providers and beneficiaries. Second, policies would be needed to safeguard against potential conflicts of interest that could ensue from the authority to recommend specific providers. Finally, the criteria to determine what defined a quality provider would need to account for variations in quality across markets because the number of a market's higher quality providers will depend on how quality is defined.

CMS would need to consider whether it should limit the PAC providers a hospital can recommend to those that meet specific quality levels (e.g., top third nationwide) or give hospitals the authority to flag the best of the PAC providers in their local markets available at discharge. A more prescriptive approach would focus attention on PAC providers that are higher overall performers. However, if these providers were not available or unable to take a patient, the advice a discharge planner could provide would be limited. Setting a less restrictive policy that allows hospital discharge planners to recommend the higher performing of available providers could address this issue, but the quality of recommended providers could be more variable.

CMS has developed a significant quantity of measures for its various quality reporting programs (Table 5-3, p. 122). The selection of a subset of these measures that were of shared importance to beneficiaries and the program could serve as criteria for identifying better PAC providers. These measures would need to minimize bias due to shortcomings in risk adjustment or industry coding practices. Outcome measures that focused on high-cost events would be appropriate, as would more easily verifiable quality measures such as claims-based measures of rehospitalization or emergency department use. Other outcomes such as functional gain are important but are more difficult to verify because they rely solely on provider assessment practices. In identifying higher quality providers, CMS should avoid selecting measures that could be vulnerable to manipulation. Finally, a revised policy could allow hospitals to supplement Medicare's core measures with other information. Beneficiaries would

TABLE 5–3 **Selected PAC quality measures available through Medicare quality programs**

Setting	Examples of measures available
Skilled nursing facilities	Share of short-stay residents who: • were rehospitalized after a nursing home admission • had an outpatient emergency department visit • were successfully discharged to the community • received antipsychotic medication for the first time
Home health agencies	Share of patients experiencing: • acute care hospitalizations • emergency department use without hospitalization • rehospitalization during the first 30 days of home health care • emergency department use without hospital readmission during the first 30 days of home health
Inpatient rehabilitation facilities	All-cause unplanned 30-day post-IRF discharge readmission measure
Cross-sector measures *(not yet implemented in all sectors)*	Discharge to community Medicare spending per beneficiary Potentially preventable 30-day postdischarge readmission measure

Note: PAC (post-acute care), IRF (inpatient rehabilitation facility). Includes certain measures from Skilled Nursing Home Compare and Home Health Compare websites. IRF and long-term care hospital measures are from Medicare's quality reporting programs for these settings.

Source: Information on Nursing Home Compare, IRF quality reporting measures, and LTCH quality reporting measures from CMS.

be free, but not obligated, to weigh both the core measures and any supplemental information when selecting their PAC provider.

Medicare's five-star rating systems for SNFs and HHAs reflect its current approach to a composite measure of quality for PAC providers, but it would likely need some modifications to serve as a measure in a revised discharge planning policy. Both systems use a number of process measures, which may give providers a better rating for measures that do not necessarily improve outcomes. The five-star measures do not focus solely on Medicare PAC patients. Both systems also include measures of functional improvement that can be sensitive to provider coding practices. A revised star-rating system that focuses on post-acute services and claims-based outcomes measures would address these shortcomings.

Beneficiaries must retain their freedom to choose a PAC provider under a revised discharge planning process. Beneficiary preferences would be incorporated in the options a discharge planner presented, as current requirements encourage (Center for Medicare Advocacy 2016, Coalition to Preserve Rehabilitation 2016). Beneficiaries could have concerns that are not necessarily reflected in standard quality measures, such as language competency or proximity to family members. Their preferences could lead them to select a PAC provider that has lower performance on some quality measures, but additional quality information would allow them to understand the nature of their options and any trade-offs.

PAC provider capacity, in addition to patient decision-making, will also affect the ability of any quality information to shift beneficiaries to higher quality PAC providers. The supply of higher quality PAC capacity is finite. Facilities vary in the services they offer, and, consequently, beneficiaries requiring specialized or higher cost services may have even fewer options. These factors can limit the ability to shift beneficiaries to PAC providers with higher quality. Optimally, any additional authority for hospital discharge planners would allow them to identify, when possible, the higher performing PAC providers among those with available capacity at discharge.

Additional assistance selecting providers could be even more important if CMS implements a unified payment system for PAC. Under such a system, providers could have the option to consolidate separate PAC operations into a single PAC facility. Quality metrics could be used to explain the clinical services and goals of care a patient can expect from particular PAC providers. Improved quality information about the new category of providers, along with the discharge planner's ability to highlight the better performing ones, would make it easier for beneficiaries to choose among the options in a PAC PPS.

Improving discharge planning should also complement other efforts to improve value in Medicare. Hospitals have a financial incentive to encourage beneficiaries to use the PAC providers with which they collaborate under payment reforms such as ACOs and bundling programs. However, if the new authority limited the PAC provider options to only those that met the Medicare-selected quality metrics, hospitals could find that some of their referral partners were not highly rated under these terms. In these instances, hospitals would have to weigh how to respond. They could encourage these providers to improve quality, provide supplemental information to beneficiaries that emphasizes these providers' other merits (such as meeting other facets of quality not measured by Medicare or providing supplemental services like transitional care nurses), or opt to collaborate with different PAC providers.

Developing quality measures that capture the full gamut of beneficiaries' preferences could be challenging. Medicare already has many clinical quality measures, but beneficiaries may have other preferences such as facility condition, staff cultural or linguistic competencies, and facility amenities such as dining and recreation options. Developing these additional indicators would dilute a focus on clinical outcomes, and, in some cases, it could be impractical or impossible to develop useful measures for preferences that are more subjective (e.g., facility décor or staff demeanor). A more practical approach could be for CMS to focus on a core set of measures that focus on outcomes that matter for the beneficiary and the program and allow hospitals to supplement these measures with other information when they deem it relevant to beneficiary preferences. As mentioned earlier, many beneficiaries want hospital discharge planners or other clinicians to recommend a facility. Such a recommendation should respect patient preferences, and a revised discharge planning policy should not overload beneficiaries with more information than they can process during an acute health crisis.

Approaches for identifying higher quality PAC providers

Medicare's options for helping hospitals select appropriate PAC providers at the point of patient discharge range from flexible (leaving key decisions about selecting beneficiaries' PAC providers to hospital discharge planners) to prescriptive (setting specific metrics or other criteria that define a PAC provider as high quality and limiting a hospital's selection of PAC providers to those meeting this definition) (Table 5-4, p. 124). A hybrid approach could specify certain quality criteria hospitals must use while granting hospitals discretion in the use of these criteria. Table 5-4 illustrates two hypothetical policy options, one more flexible, the other more prescriptive.

Illustrative example of a flexible approach

Under a flexible approach, hospitals would be responsible for defining the criteria they would use to identify higher quality PAC providers. A hospital would be responsible for selecting quality measures, collecting data from PAC providers, and setting the performance levels that PAC providers would have to meet to be recommended by the hospital. CMS could require that hospitals establish formal vetting processes for setting the criteria and reviewing PAC provider performance to provide some degree of transparency for beneficiaries and PAC providers. Hospitals could be required to make their criteria and selection process available for public review.

The advantage of this approach is that it provides hospitals with the freedom to establish the criteria that they believe best reflect the needs of their patients and to tailor those criteria to the available supply of providers. Some hospitals have conducted similar processes to identify PAC referral partners for ACOs and bundled payment initiatives, for instance. Metrics could be set to identify the best of the local PAC providers, regardless of how they compared with national levels. As many programs make hospitals accountable for readmissions, hospitals would have a significant incentive to work with higher quality providers.

Flexibility would permit hospitals to select the quality measures they deem appropriate and could include compliance history and selected quality measures. If some measures did not adequately control for differences in patient mix, hospitals could also opt to use judgments of a PAC provider's clinical reputation among hospital medical staff. On the one hand, flexibility could permit

TABLE 5–4 **Illustrative examples of policies for revising discharge planning**

	Option 1: Hospitals have flexibility to write own standards	Option 2: Medicare sets standards to define higher quality PAC providers
Medicare's role	• Medicare COPs require hospitals to define criteria.	• Medicare designates providers that can be recommended (e.g., must be at least three or four stars, better CAHPS® score).
Use of quality measures	• Hospitals select measures, allowing for innovation and experimentation.	• Medicare sets hospitals' selection criteria.
Regulatory safeguards	There would need to be: • safeguards to prevent financial conflicts of interest; • disclosure of conflict of interest/ownership/ collaboration; and • CMS approval of individual hospitals' criteria and monitoring of proper application.	• Likely, the same safeguards stated in Option 1 would be needed, but standards for recommending PAC providers would be clearer.
Beneficiary implications	• Beneficiaries would receive recommendations that reflect quality of PAC care in the market. • It could be confusing to have multiple definitions across hospitals.	• A single set of standards across hospitals would make reasoning behind selected PAC providers more transparent to beneficiaries. • The quality of PAC providers selected would be more consistent.
PAC provider implications	• Providers would have to consider multiple definitions if working with many hospitals, potentially with different measures for each setting. • Designation as a higher quality provider could vary among hospitals and across geographic markets.	• A single set of standards would result in consistent designation. • There would be consistency across markets as to which providers qualify as higher quality.
Advantages	• Flexibility in the definition of quality would allow hospitals to develop patient-centered definitions and require them to scrutinize referral partners. • Approaches could reflect local PAC markets' capacity and scope of offerings.	• A single definition of "quality" would provide clear standards for PAC providers, consistent treatment under policy. • The implementation burden on hospitals would be lighter. • Enforcement would be less complex. CMS would need to ensure that hospitals observe sanctioned criteria when recommending PAC providers.
Disadvantages	• There would be a greater burden on hospitals to implement and maintain standards and on CMS to verify and audit standards and their application. • Multiple definitions of higher quality providers could be confusing for beneficiaries and PAC providers.	• If there were a single standard, the number of designated providers would vary across areas.

Note: PAC (post-acute care), COP (condition of participation), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®).

Source: MedPAC analysis.

the development of more patient-centered standards based on a hospital's clinical expertise. On the other hand, the quality of PAC providers selected and recommended to beneficiaries could vary as a result. In addition, hospitals would have the burden of developing criteria for identifying higher quality PAC providers.

Both beneficiaries and PAC providers could find this policy confusing since there would be no consistent

standards for designating a provider as higher quality. PAC providers would be subject to different definitions of quality among hospitals and could find it difficult to satisfy the multiple and potentially conflicting definitions. A single PAC provider could have different quality designations among the hospitals in the PAC provider's market, qualifying as a higher quality provider with some hospitals but not others. Medicare has been moving in the opposite direction, toward efforts to develop standardized cross-sector measures of PAC quality that facilitate comparisons; the use of unique measures by hospitals could increase the reporting burden on PAC providers.

Another disadvantage of this more flexible approach is that it would be more challenging for CMS to oversee. Ensuring that hospitals were not creating inappropriate business or financial relationships that encouraged undue favoritism or inappropriate PAC volume would require some oversight by CMS. Ensuring that collaboration among hospitals and PAC providers is aimed at improving outcomes and not cooperating in ways that inefficiently increase Medicare spending would be important. A broad range of permissible policies would make it challenging to identify when a hospital's practices created unacceptable risk for fraud, waste, and abuse. CMS might find it difficult to conduct a uniform and efficient review process if each hospital followed a unique approach.

Illustrative example of a prescriptive approach

Under a more prescriptive approach, CMS could establish quality metrics for designating PAC providers as higher quality. Under this approach, CMS would select the measures, set the performance levels, identify and notify hospitals and PAC providers, and update the measures as new data became available. Hospitals would be required to notify beneficiaries of the PAC providers designated as higher quality.

Establishing a single standard would make the program easier for beneficiaries and PAC providers to understand. Beneficiaries would likely better understand why the recommended providers were selected, which might make them more inclined to use higher quality PAC providers. There would be more consistency in the quality of care available to beneficiaries from designated providers because the standards applied by Medicare would be identical across markets. The administrative burden on hospitals would be lower relative to the more flexible option, though CMS would have more responsibility. Since the standards are set by CMS, this approach does not have the same vulnerabilities to fraud, waste, and abuse that are present in the flexible approach.

The quality measures available vary among PAC settings, but CMS could, in most cases, start with measures of efficiency and quality that are used in the pay-for-reporting and value-based purchasing programs for PAC providers. CMS might focus on hospital readmissions, discharge to community, and other measures that reflect high-cost and high-consequence events. CMS is developing cross-sector measures of PAC quality, including readmissions, and these measures could be used when they become available.

CMS would have to consider how to set the performance levels to qualify as a higher quality PAC provider, such as setting a benchmark for rehospitalization from a SNF or HHA to be specified as higher performing. Setting a single national benchmark would have the advantage of simplicity and consistency, but because the quality of PAC providers varies across regions, some regions would have more providers that qualified for selection and other regions would have fewer.

For example, a national benchmark could be set defining higher quality SNFs as those in the bottom third (lowest) on rehospitalization rates. With this benchmark, 114 core-based statistical areas (CBSAs) would have only 1 or 2 SNFs that qualified as higher quality, while 39 CBSAs would have 20 or more SNFs that qualified. A lower performance benchmark (i.e., a higher rate of readmissions as the criteria) could be specified that would increase supply in some markets, but doing so would degrade the acceptable level of quality in all markets nationwide, even in areas that did not need more providers.

Alternatively, a prescriptive approach could establish a definition that uses both national and local standards. For example, the definition could be a two-step test: the first would designate providers that are in the lowest third of the nationwide distribution for readmission rates, and the second would qualify any providers in the lowest third relative to other providers in their local market area. This combination approach could result in a more even supply of designated higher quality providers across markets but would result in designations that varied from region to region. For example, across urban areas, the average rate of readmissions for SNFs varied in 2014 from 11 percent to 21 percent.[6] Even if beneficiaries used only providers deemed "high quality" in their areas, the quality of care received would vary across markets. Further, PAC providers with the same level of performance could receive different designations depending on their market.

In a variation of this option, CMS could rate providers on a composite measure that captured different aspects of PAC quality. Within each market, discharge planners could highlight the PAC providers that are more highly rated and have available capacity. This approach would account for the variation in quality across markets and provide more flexibility to discharge planners.

Another approach would be for CMS to create a core set of metrics but permit hospitals to supplement this information with their own measures. Medicare's measures could reflect outcomes important to patients and the program, such as rates of readmission and discharge to the community, and CMS could require that this information be reported to beneficiaries. Hospitals could have the option to include additional information they also deem important, and discharge planners could be charged with helping beneficiaries understand the different indicators.

Hybrid approaches combining elements of flexible and prescriptive frameworks

Policymakers could combine elements of the two approaches to balance or mitigate the disadvantages of each approach. For example, policymakers could begin with the flexible framework but require hospitals to select quality measures that meet certain standards or are already in use in the program. Alternatively, Medicare could leave the exact measures open for determination but require that PAC providers achieve certain performance levels (e.g., top third of providers) on selected measures to be designated as a higher quality PAC provider. If policymakers favored the more prescriptive approach, CMS could provide a standardized definition that includes a quality rating of PAC in a market. The hospital could observe how the supplemental data revised the rating of PAC providers, with the better PAC providers receiving the designation as higher performing. Determining the appropriate balance would benefit from experimentation, and CMS could pilot policies that varied the degree of flexibility and regulatory specificity—for example, by geographic region.

Conclusion

Medicare policy currently places a premium on protecting beneficiary choice of PAC provider, but it does not encourage beneficiaries to use higher quality PAC providers. Any new policy should seek to ease or simplify the burden on beneficiaries, many of whom already report that discharge planning can be a difficult and confusing period. Efforts to provide additional information should not overwhelm beneficiaries and should ensure that patient preferences for PAC are recognized. ■

Endnotes

1 Medicare provides information through Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility Compare, and the Long-Term Care Hospital Compare websites available at Medicare.gov.

2 IMPACT requires CMS to develop quality measures for resource use, hospital readmission, and discharge to community for PAC providers.

3 The measure of distance was based on zip codes. For each beneficiary, we identified the zip codes with a geographic center within 15 miles of the center of the beneficiary's residential zip code. The five closest providers were identified and rated based on the quality measures.

4 The measures for skilled nursing facilities included all-cause readmissions during the SNF stay and improvement in mobility; the HHA measures included hospitalization during the HHA stay and improvement in walking at discharge. Providers within a 15-mile radius of the beneficiary were rated from high to low on these measures, with the two measures weighted evenly.

5 We included only providers with a complete set of quality measures data in this analysis.

6 This finding pertains to core-based statistical areas with 10 or more SNFs that had adequate data for computation of the readmission rate.

References

Advisory Board Company. 2016. What consumers want: Understanding post-acute patients and families. Infographic. https://www.advisory.com/research/post-acute-care-collaborative/members/multimedia/infographics/2016/what-consumers-want-from-post-acute-care.

Baier, R. R., A. Wysocki, S. Gravenstein, et al. 2015. A qualitative study of choosing home health care after hospitalization: The unintended consequences of 'patient choice' requirements. *Journal of General Internal Medicine* 30, no. 5 (May): 634–640.

BearingPoint. 2003. *Consumer testing of Home Health Compare website prototype.* Report prepared for the Centers for Medicare & Medicaid Services by BearingPoint. McLean, VA: BearingPoint.

Burke, R. E., E. Cumbler, E. A. Coleman, et al. 2017. Post-acute care reform: Implications and opportunities for hospitalists. *Journal of Hospital Medicine* 12, no. 1 (January): 46–51.

Castle, N. G. 2009. The Nursing Home Compare report card: Consumers' use and understanding. *Journal of Aging & Social Policy* 21, no. 2 (April–June): 187–208.

Castle, N. G., J. Engberg, J. Lave, et al. 2009. Factors associated with increasing nursing home closures. *Health Services Research* 44, no. 3 (June): 1088–1109.

Center for Medicare Advocacy. 2016. Letter to CMS regarding the proposed rule entitled, "Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies," January 4.

Coalition to Preserve Rehabilitation. 2016. Letter to CMS regarding the proposed rule entitled, "Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies," January 4.

Coleman, E. A., E. Mahoney, and C. Parry. 2005. Assessing the quality of preparation for posthospital care from the patient's perspective: The care transitions measure. *Medical Care* 43, no. 3 (March): 246–255.

Colwell, J. 2017. Perfecting post-acute care. *ACP Hospitalist*, April. https://acphospitalist.org/archives/2016/04/post-acute-care.htm.

Compton-Phillips, A., and N. Mohta. 2016. Strengthening the Post-Acute Care Connection. *NEJM Catalyst*. http://catalyst.nejm.org/strengthening-post-acute-care-connection/.

Goncalves-Bradley, D. C., N. A. Lannin, L. M. Clemson, et al. 2016. Discharge planning from hospital. *Cochrane Database Systematic Review*, no. 1 (Jan 27): CD000313.

Hargrave, E., K. Quirk, and D. Weinstein. 2014. *Private sector approaches to managing post-acute care*. A study conducted by staff from NORC at the University of Chicago and Georgetown University for the Medicare Payment Advisory Commission. Washington, DC: MedPAC.

Harris, K., and M. Beeuwkes-Buntin. 2008. *Choosing a health care provider*. Synthesis report. Princeton, NJ: Robert Wood Johnson Foundation.

Horwitz, L. I., J. P. Moriarty, C. Chen, et al. 2013. Quality of discharge practices and patient understanding at an academic medical center. *JAMA Internal Medicine* 173, no. 18 (October 14): 1715–1722.

Hussey, P. S., H. S. Luft, and P. McNamara. 2014. Public reporting of provider performance at a crossroads in the United States: Summary of current barriers and recommendations on how to move forward. *Medical Care Research and Review* 71, no. 5 supplement (October): 5S–16S.

Jung, J. K., B. Wu, H. Kim, et al. 2016. The effect of publicized quality information on home health agency choice. *Medical Care Research and Review* 73, no. 6 (December): 703–723.

Kahn, C. 2015. Comment letter by the Federation of American Hospitals on CMS's proposed rule entitled, "Medicare Program; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies" (CMS 3317–P). December 21.

Lau, C., A. Alpert, P. Huckfeldt, et al. 2014. Post-acute referral patterns for hospitals and implications for bundled payment initiatives. *Healthcare* 2, no. 3 (September): 190–195.

Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Rahman, M., A. D. Foster, D. C. Grabowski, et al. 2013. Effect of hospital-SNF referral linkages on rehospitalization. *Health Services Research* (October 17): 1–22.

Schoenfeld, A. J., X. Zhang, D. C. Grabowski, et al. 2016. Hospital-skilled nursing facility referral linkage reduces readmission rates among Medicare patients receiving major surgery. *Surgery* 159, no. 5 (May): 1461–1468.

Sefcik, J. S., R. H. Nock, E. J. Flores, et al. 2016. Patient preferences for information on post-acute care services. *Research in Gerontological Nursing* 9, no. 4 (July 1): 175–182.

Shugarman, L., and J. Brown. 2006. *Nursing home selection: How do consumers choose? Volume I: Findings from focus groups of consumers and information intermediaries*. Report prepared for the Department of Health and Human Services by the RAND Corporation. Washington, DC: Department of Health and Human Services.

Thompson, A. 2016. Comment letter by the American Hospital Association on CMS's proposed rule entitled, "Medicare Program; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies" (CMS 3317–P). December 21.

Tyler, D. A., E. A. Gadbois, J. P. McHugh, et al. 2017. Patients are not given quality-of-care data about skilled nursing facilities when discharged from hospitals. *Health Affairs* 36, no. 8 (August 1): 1385–1391.

Werner, R. M., R. T. Konetzka, E. A. Stuart, et al. 2011. Changes in patient sorting to nursing homes under public reporting: Improved patient matching or provider gaming? *Health Services Research* 46, no. 2 (April): 555–571.

Werner, R. M., E. C. Norton, R. T. Konetzka, et al. 2012. Do consumers respond to publicly reported quality information? Evidence from nursing homes. *Journal of Health Economics* 31, no. 1 (January): 50–61.