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**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE BENEFICIARY
ACCESS TO SKILLED NURSING
FACILITIES: 2004**



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OBJECTIVE

To assess Medicare beneficiaries' access to skilled nursing facilities (SNFs) since the implementation of the prospective payment system.

BACKGROUND

This study is a followup to a series of earlier studies conducted by the Office of Inspector General (OIG) on access to skilled nursing for Medicare beneficiaries who are discharged from hospitals to SNFs. In 1997, the Centers for Medicare & Medicaid Services (CMS) began implementing a prospective payment system for SNFs. In 1999, CMS asked OIG to identify any early effects the new payment system may be having on Medicare beneficiaries' access to SNFs. This series is part of OIG's ongoing commitment to monitor beneficiaries' access to SNF care.

The Balanced Budget Act of 1997 required payments for skilled nursing care to be made on a prospective basis. The prospective payments rates are determined by Resource Utilization Groups (RUGs). SNFs are required to classify each beneficiary into 1 of 44 RUGs based on their care and resource needs. Each RUG represents a different Medicare payment rate.

This inspection is based on data from two sources: structured interviews with 256 hospital discharge planners who have firsthand experience placing Medicare beneficiaries in SNFs, and an analysis of 5 years of Medicare data on beneficiaries who were discharged from a hospital to a SNF.

FINDINGS

Most Medicare beneficiaries have access to skilled nursing facilities.

Eighty-four percent of discharge planners report that they are able to place all of their Medicare beneficiaries who need care in a SNF in a typical month. This is a statistically significant increase from our 2001 study, in which 73 percent of discharge planners reported being able to place all of their Medicare beneficiaries who need care in a SNF.

Further, Medicare data show no large changes that may indicate a decline in access for beneficiaries with certain medical conditions who were discharged from a hospital to a SNF in the past 5 years. We define a large change to be 1 percentage point or greater or 1 day or longer. A decrease in the proportion of Medicare beneficiaries with certain

medical conditions being placed in SNFs might indicate that beneficiaries are experiencing a decline in access to SNF care. We found no large decreases in the proportion of Medicare beneficiaries with 9 of the 10 most common Diagnosis Related Groups (DRG) and 8 of the 10 most common RUGs over the past 5 years. Similarly, an increase in the average length of stay in the hospital or an increase in the average length of time between hospital discharge and the start of SNF care might indicate a decline in access. We found no large increases in either of these measures for any of the 10 most common DRGs or for any of the 10 most common RUGs since the implementation of the prospective payment system.

However, beneficiaries with certain medical conditions or service needs may experience delays. Thirty-five percent of discharge planners report having Medicare beneficiaries who experience delays at least sometimes before being placed in a SNF. Discharge planners report that Medicare beneficiaries needing intravenous (IV) antibiotics and/or expensive drugs, wound care, a ventilator, or dialysis, as well as beneficiaries with behavior problems, are most often delayed before being placed in a SNF. Discharge planners who report delays placing Medicare beneficiaries in SNFs commonly explain that the cost of providing these services or Medicare reimbursement is the reason for placement delays.

Differences in placement rates and length of stay between beneficiaries in urban and rural areas and beneficiaries placed in nonprofit and for-profit facilities were detected. We analyzed the proportion of Medicare beneficiaries with certain medical conditions in SNFs in urban and rural areas to see if there were any large differences, compared to the proportion of all Medicare beneficiaries in SNFs in urban and rural areas. We found that beneficiaries with certain medical conditions are placed more frequently in SNFs in urban or rural areas as compared to the overall population. Specifically, for 3 of the 10 most common RUGs, a greater proportion of beneficiaries were in SNFs in urban areas. Conversely, for another 2 of the 10 RUGs, a greater proportion of beneficiaries were in SNFs in rural areas. Additionally, Medicare data show that beneficiaries with certain medical conditions in urban areas have longer average lengths of stay in the hospital than beneficiaries with the same conditions in rural areas.

We also found that beneficiaries with certain medical conditions are more frequently placed in nonprofit or for-profit SNFs as compared to

the overall population. Specifically, for 2 of the 10 most common RUGs, a greater proportion of beneficiaries were in nonprofit facilities. For another 3 of the 10 RUGs, a greater proportion of beneficiaries were in for-profit facilities.

CONCLUSION

We continue to find that Medicare beneficiaries discharged from hospitals have access to SNFs, as evidenced by a significant increase in the proportion of discharge planners who report that they are able to place all their beneficiaries in SNFs. Additionally, we find that Medicare data show no large changes that may indicate a decline in access to care for beneficiaries with the most common medical conditions and/or service needs discharged to SNFs in the past 5 years. At the same time, we find that discharge planners report that beneficiaries with certain medical conditions or service needs may experience placement delays.

These findings are similar to the findings in our prior three reports, suggesting that, overall, the prospective payment system has not resulted in reduced access to care. We encourage CMS to continue to monitor access to SNF care. In particular, CMS might closely monitor beneficiaries who experience delays in accessing care, including those who need IV antibiotics and/or expensive drugs, complex wound care, a ventilator, or dialysis, and those who have behavior problems.

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OBJECTIVE

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BACKGROUND

This study is a followup to a series of earlier studies conducted by the Office of Inspector General (OIG). In 1997, the Centers for Medicare & Medicaid Services (CMS) began implementing a prospective payment system for SNFs. In 1999, CMS asked OIG to identify any early effects the new payment system might be having on Medicare beneficiaries' access to SNFs.

In response, OIG conducted a series of studies on access to SNFs for Medicare beneficiaries who are discharged from hospitals. This series is part of OIG's ongoing commitment to monitor beneficiaries' access to SNFs. The Medicare Payment Advisory Commission has also emphasized the importance of these reports and of continuing to monitor access to care for Medicare beneficiaries following hospitalization.¹

Medicare Skilled Nursing Facilities

A SNF provides skilled nursing care and related services to residents who require medical or nursing care, or to injured, disabled, or sick persons who require rehabilitation services.² Care includes services of skilled medical personnel, such as registered nurses and professional therapists. This care is available 24 hours a day, is ordered by a doctor, and requires a treatment plan. A SNF may be freestanding or it may be a distinct part of a hospital.

Medicare Part A covers SNF care under certain conditions. These conditions include a requirement of daily skilled nursing or rehabilitation services, a prior 3-consecutive-day stay in a hospital, which is determined to have been medically necessary, admission to the SNF within a 30-day period after leaving the hospital, and treatment for the same condition that was treated in the hospital. SNF care provided under Medicare is limited to a benefit period of 100 days, with

¹ Medicare Payment Advisory Commission (MedPAC), "Report to Congress: Medicare Payment Policy March 2004," 2004.

² 42 U.S.C. § 1395i-3(a).

a copayment required for days 21 through 100.³ After the Medicare 100-day SNF Part A benefit runs out, the Medicare Part B benefit continues to pay for Part B-covered services furnished by a SNF.

SNF Prospective Payment System

The Balanced Budget Act of 1997 (BBA) requires payments for skilled nursing care to be made on a prospective basis. Accordingly, SNFs are now paid through prospective, case-mix adjusted per diem payments that cover routine, ancillary, and capital-related costs, including most items and services for which payment was previously made under Medicare Part B.

Under the prospective payment system, SNFs are required to classify residents into 1 of 44 Resource Utilization Groups (RUGs), which determine payment rates. The RUGs are divided into seven major categories: special rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical function.⁴ Appendix A provides a more detailed description of the RUGs.

Changes in the SNF Prospective Payment System

Congress has made several temporary adjustments to the prospective payment system since its inception. In accordance with the Balanced Budget and Refinement Act⁵ and the Benefits Improvement and Protection Act,⁶ the following payment changes were applied to selected RUGs and remained in effect until January 1, 2006:

- an increase of 20 percent in the payment rate for 15 RUGs, including those for extensive services, special care, clinically complex care, as well as 3 RUGs in the special rehabilitation category; and

³ A benefit period is a period of time for measuring the use of insurance benefits. It is a period of consecutive days during which covered services furnished to a patient may be paid for by the hospital insurance plan. The term “benefit period” is synonymous with spell of illness.

⁴ To determine the RUG to which a resident belongs, SNFs must complete the Minimum Data Set 2.0 assessment, which includes a standardized set of clinical and functioning status measures. SNFs complete this assessment for all patients at scheduled intervals during their stay.

⁵ Medicare, Medicaid, and SCHIP Balanced Budget and Refinement Act of 1999, Pub. L. No. 106-113, 113 Stat. 1501.

⁶ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, 114 Stat. 2763.

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- an increase of 6.7 percent in the payment rate for 14 rehabilitation RUGs. The other RUGs increased in the BBA maintained the 20-percent increase.

Both increases expired when CMS adopted the RUG-53 classification system on January 1, 2006.⁷

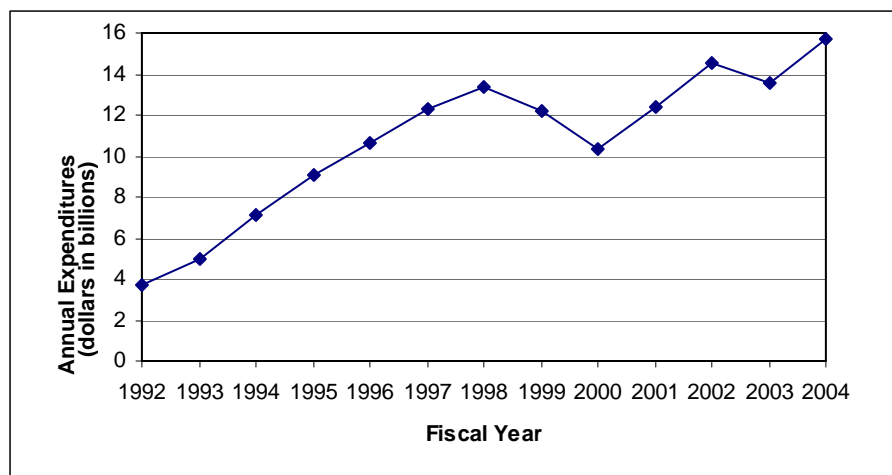
In accordance with the Balanced Budget and Refinement Act and the Benefits Improvement and Protection Act, the following two changes applied to all Medicare SNF beneficiaries and remained in effect until October 1, 2002:

- an increase of 4 percent in the per diem payment rate for all RUGs for fiscal years 2001 and 2002, and
- an increase of 16.66 percent in the nursing home component of the payment rate for all RUGs for April 2001 through September 2002.

Recent Trends in SNF Care

Between fiscal years 1992 and 2002, expenditures for Medicare SNF payments increased at an average rate of 15 percent annually, with a substantial dip in spending occurring in fiscal years 1999 and 2000. See Chart 1 below. Total Medicare spending for SNFs in fiscal year 2004 was estimated at \$15.7 billion.⁸

CHART 1
Medicare Spending for
Skilled Nursing
Facilities 1992-2004



Source: CMS Statistics Publications, Office of Research, Development and Information.

⁷ 70 FR 45026, 45031 (August 4, 2005).

⁸ CMS. Office of Financial Management, Office of the Actuary. Available online at www.cms.hhs.gov. Accessed December 28, 2005.

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Medicare data further show large increases in the total number of Medicare SNF beds since 2000. In 2000, there were a total of 939,356 Medicare SNF beds, which increased by 53 percent to 1,437,400 in 2004. See Table 1 below.

Table 1: Number of SNF Beds, 2000 2004						
	2000	2001	2002	2003	2004	Percentage change
Medicare Beds	939,356	1,105,503	1,260,685	1,372,010	1,437,400	53.0%
Total Beds*	1,658,032	1,653,997	1,666,051	1,672,034	1,677,614	1.2%

*Includes both certified and noncertified.

Source: Health Care Information System.

Finally, Medicare data show that more than 1,763,000 beneficiaries received SNF care in 2004—a 20-percent increase from 2000, when more than 1,468,000 beneficiaries received SNF care.

Discharge Planners

Federal regulations require all hospitals to offer discharge planning services.⁹ These services are developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel. In most hospitals, the social work, case management, or utilization review department has primary responsibility for discharge planning. Discharge planners conduct a patient assessment and meet with utilization review staff, the patient's nurses and physicians, and other relevant interdisciplinary team members to identify patients who are likely to suffer adverse health consequences in the absence of adequate discharge planning. Discharge planners then evaluate these patients' likely need for posthospital services and the availability of these services.

⁹ 42 CFR § 482.43.

Prior Work on Access to Skilled Nursing Facilities

OIG released three reports from 1999 to 2001 on access to SNFs for Medicare beneficiaries who were discharged from hospitals.¹⁰ The most recent report found that most Medicare beneficiaries generally did not have problems obtaining SNF care. However, discharge planners commonly reported that beneficiaries requiring intravenous (IV) antibiotics and/or expensive drugs and those with medically complex conditions experienced delays being placed in a SNF. These findings were consistent with those from the earlier studies.

SCOPE AND METHODOLOGY

We based this study on data from two sources: structured interviews with hospital discharge planners who have firsthand experience placing Medicare beneficiaries in SNFs, and an analysis of Medicare data for beneficiaries who were discharged from the hospital to a SNF.

Structured Interviews

We selected a random sample of 300 acute care hospitals with 30 or more beds from the 50 States and the District of Columbia. We found that 15 of these hospitals were in fact not acute care hospitals; were pediatric, psychiatric, or cancer care centers; or hospitals that were bankrupt or no longer qualified to meet the minimum bed standard.

Of the remaining 285 hospitals, we received responses from 256, a 90-percent response rate. We conducted structured interviews with the discharge planner or his or her designee from each hospital. We asked discharge planners about their experiences with placing Medicare beneficiaries in SNFs and about the medical conditions and/or service needs of beneficiaries they are unable to place or who experience delays. We conducted these interviews between December 2004 and March 2005. Note that this is the same sample of hospitals used in the OIG study “Medicare Beneficiary Access to Home Health Agencies: 2004” (OEI-02-04-00260). Appendix B provides confidence intervals for key findings.

For relevant questions, we determined whether there were any statistical differences between responses to our current interviews and

¹⁰ OIG. “Early Effects of the Prospective Payment System on Access to SNFs,” OEI-02-99-00400, August 1999; “Medicare Beneficiary Access to SNF: 2000,” OEI-02-00-00330, September 2000; and “Medicare Beneficiary Access to SNF: 2001,” OEI-02-01-00160, July 2001.

responses to similar questions from our 2001 study. Additionally, we compared key characteristics of the hospitals in our current sample with those in our 2001 sample. Specifically, we compared the number and type of beds, facility ownership, and whether the hospital was in an urban or rural area. The differences between the samples are within statistical sampling variation.

Analysis of Medicare Data

We used the most up-to-date Medicare data from CMS's National Claims History File that were available at the start of the study. We identified all beneficiaries who: (1) had a paid SNF claim between April 1, 2003, and March 31, 2004; and (2) had a hospital discharge within 30 days prior to their SNF claim.¹¹ We identified all beneficiaries who met these criteria for each year starting with April 1, 1999.

Based on these data, we analyzed several measures to determine whether there have been any large changes in beneficiaries' access to SNFs since the implementation of the prospective payment system. We define a large change to be 1 percentage point or greater or 1 day or longer in these analyses. We analyzed the following measures for the 5-year period:

1. the proportion of Medicare beneficiaries who were discharged from a hospital to a SNF for the 10 most common Diagnosis Related Groups (DRG)¹² and the 10 most common RUGs to assess whether beneficiaries with certain medical conditions are being placed in SNFs since the implementation of the prospective payment system,¹³
2. beneficiaries' average length of stay in the hospital for the 10 most common DRGs and the 10 most common RUGs to assess whether certain beneficiaries are experiencing longer delays before being

¹¹ Note that we refer to this year of data as 2004 and that each year starts with April 1 of the prior year and ends with March 31 of that year. The timeframe used in this study (April 1 to March 31) differs from the timeframe used in previous OIG studies on access to SNFs. These studies were based on data from the first quarter of each year, whereas this study is based on an entire year of data.

¹² Most hospitals are paid a fixed amount for each beneficiary depending upon the DRG to which the beneficiary is assigned. A DRG is assigned based on a beneficiary's diagnosis, surgery, age, discharge destination, and sex. Each DRG has a weight that reflects the relative cost, across all hospitals, of treating cases classified in that DRG.

¹³ We found little change in the 10 most common DRGs and RUGs in each year. The 10 most common DRGs represent approximately 35 percent of all beneficiaries each year and the 10 most common RUGs represent approximately 84 percent of all beneficiaries each year.

discharged to a SNF since the implementation of the prospective payment system, and

3. beneficiaries' average length of time in days between hospital discharge and the start of SNF care for the 10 most common DRGs and the 10 most common RUGs to assess whether certain beneficiaries are experiencing longer average times between discharge from a hospital and being placed in a SNF since the implementation of the prospective payment system.

We then analyzed these measures to determine whether there are large differences between beneficiaries in urban and rural areas and between beneficiaries who were placed in nonprofit and for-profit SNFs. Using the Urban Influence Codes developed by the U.S. Department of Agriculture, we divided the facilities, based on their addresses, into urban and rural areas. Appendix C provides a more detailed description of the Urban Influence Codes. Using data from CMS's Online Survey Certification and Reporting system, we determined which beneficiaries were placed in nonprofit and for-profit SNFs.

Specifically, we analyzed the proportion of Medicare beneficiaries with certain medical conditions receiving SNF care in urban and rural areas to see if there were any large differences compared to the proportion of all Medicare beneficiaries in SNFs in urban and rural areas. If the proportion of beneficiaries with a certain DRG or RUG differed from the proportion of all beneficiaries in urban and rural areas by 5 or more percentage points, we considered it to be a large difference. We conducted a similar analysis of the proportion of Medicare beneficiaries who were placed in nonprofit and for-profit SNFs. We conducted these analyses for 2004.

Standards

Our review was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

► FINDINGS

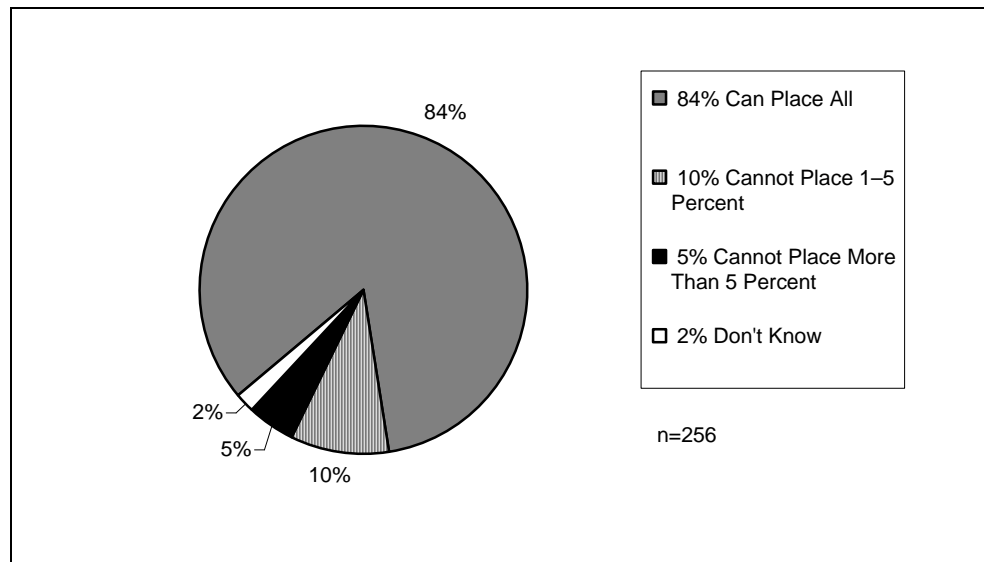
Most Medicare beneficiaries have access to skilled nursing facilities

Eighty-four percent of discharge planners report that all beneficiaries can be placed

As shown in Chart 2, 84 percent of discharge planners report that they are able to place all of their Medicare beneficiaries who need care in a SNF in a typical month. This is a statistically significant increase from our 2001 study, in which 73 percent of discharge planners reported being able to place all of their Medicare beneficiaries who needed care in a SNF.¹⁴

Additionally, 10 percent of discharge planners report not being able to place up to 5 percent of their Medicare beneficiaries, while another 5 percent report not being able to place more than 5 percent of their Medicare beneficiaries in a typical month. In total, discharge planners in our sample are not able to place about 0.5 percent of all their Medicare beneficiaries (108 of 21,323) who need skilled care in a typical month. Discharge planners most commonly explain that these beneficiaries typically stay in the hospital, go home, or enter home health or hospice care.

CHART 2:
Proportion of
Discharge
Planners Placing
Medicare
Beneficiaries in
SNFs



Note: Total does not equal 100 percent due to rounding.

Source: OIG analysis of discharge planner interviews, 2005.

¹⁴ In a 2-tailed t-test, this difference was significant at the 95-percent confidence level.

F I N D I N G S

Discharge planners also generally report that the supply of SNF beds in their area is adequate. Specifically, 73 percent of discharge planners report that there are enough SNF beds (including hospital swing beds) in their area for Medicare beneficiaries. Twenty-three percent of discharge planners report that, on average, they have to contact 1 facility to place a Medicare beneficiary in a SNF. An additional 35 percent report they have to contact an average of 2 facilities, 19 percent report they have to contact 3 facilities, and 23 percent report they have to contact 4 or more facilities.

Medicare data show no large changes that may indicate a decline in access
Medicare data show no large changes that may indicate a decline in access for beneficiaries with certain medical conditions who were discharged to SNF care in the past 5 years. Again, we define a large change in these analyses to be 1 percentage point or greater or 1 day or longer.

Diagnosis Related Groups. A decrease in the proportion of Medicare beneficiaries with a specific DRG who are discharged from the hospital to SNF care might indicate that beneficiaries with certain medical conditions are experiencing a decline in access to SNF care. However, we found no large decreases in the proportion of Medicare beneficiaries who were discharged from the hospital to a SNF for 9 of the 10 most common DRGs over the past 5 years. See Table 2 on the following page. One exception was DRG 014 (intracranial hemorrhage or cerebral infarction), which has decreased by more than 1 percentage point since 2000. This decrease may be explained by a change in the definition of DRG 014, or possible miscoding of this particular DRG.¹⁵

¹⁵ DRG 014 was designated a postacute transfer DRG in 2001. The purpose of the transfer policy is to avoid providing an incentive for a hospital to transfer a beneficiary to another hospital early in the beneficiary's stay in order to minimize costs while still receiving the full DRG payment. A recent OIG audit report (A-04-04-03000) found that hospitals did not always comply with Medicare's postacute transfer policy and improperly coded transfers to postacute care as discharges to home. Additionally, DRG 014 was redefined in October 2000, when the diagnosis for transient ischemia was removed from the DRG.

Table 2: Proportion of Medicare Beneficiaries Discharged to SNFs for the 10 Most Common DRGs (2000–2004)*

Initial Hospital DRG	2000	2001	2002	2003	2004	Difference 2000–2004
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	8.6%	8.6%	8.4%	8.3%	8.1%	-0.5
DRG 089—Simple Pneumonia and Pleurisy	5.6	5.0	5.5	5.1	5.6	0.0
DRG 127—Heart Failure and Shock	4.6	4.7	4.5	4.6	4.6	0.0
DRG 210—Hip and Femur Procedures Except Major Joint Procedures	4.8	4.7	4.4	4.3	4.2	-0.6
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	5.9	5.6	5.2	4.3	3.4	-2.5
DRG 320—Kidney and Urinary Tract Infections	2.3	2.4	2.5	2.5	2.8	0.5
DRG 296—Nutrition and Miscellaneous Metabolic Disorders	2.8	2.9	3.1	3.1	2.7	-0.1
DRG 462—Rehabilitation	2.4	2.5	2.4	2.4	2.4	0.0
DRG 416—Septicemia	2.2	2.1	2.1	2.2	2.4	0.2
DRG 088—Chronic Obstructive Pulmonary Disease	2.4	2.3	2.3	2.2	2.3	-0.1

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Resource Utilization Groupings. Similar to our analysis of DRGs, a decrease in the proportion of Medicare beneficiaries in a RUG might indicate that beneficiaries with certain service needs are experiencing a decline in access to SNF care. Again, we found no substantial decreases in the proportion of Medicare beneficiaries who were discharged from a hospital to a SNF for 8 of the 10 most common RUGs over the past 5 years. Two exceptions were RHB (Special Rehab, High 8–12) and RMB (Special Rehab, Medium 8–14), which decreased by 1.2 and 1.7 percentage points, respectively. See Table 3 on the following page.

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Table 3: Proportion of Medicare Beneficiaries Discharged to SNFs for the 10 Most Common RUGs (2000–2004)*

RUG	2000	2001	2002	2003	2004	Difference 2000–2004
RHC (Special Rehab, High 13–18)	16.0%	17.4%	18.5%	18.8%	19.1%	3.1
RHB (Special Rehab, High 8–12)	17.9	18.5	18.2	17.7	16.7	-1.2
RVB (Special Rehab, Very High 9–15)	9.6	7.7	8.9	9.8	11.3	1.7
SE2 (Extensive Care 2–3)	6.6	6.4	7.2	7.4	7.0	0.4
RMB (Special Rehab, Medium 8–14)	8.4	9.0	8.4	7.4	6.7	-1.7
SE3 (Extensive Care 4–5)	5.1	4.9	5.5	6.1	6.3	1.2
RHA (Special Rehab, High 4–7)	6.6	7.2	6.3	6.1	5.7	-0.9
RMC (Special Rehab, Medium 5–18)	4.8	4.8	4.9	4.6	4.3	-0.5
RUB (Special Rehab, Ultra High 9–15)	3.1	2.7	2.5	2.9	3.8	0.7
RVA (Special Rehab, Very High 4–8)	3.6	3.3	3.0	3.1	3.4	-0.2

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS’s National Claims History File, 2005.

Average length of stay in the hospital. An increase in the average length of stay in the hospital might indicate that beneficiaries with certain medical conditions or service needs are experiencing a decline in access to SNF care. However, we found no large increases in average length of stay in the hospital for any of the 10 most common DRGs or for any of the 10 most common RUGs. In fact, the average length of stay for all

but 2 of the 10 most common DRGs and all of the 10 most common RUGs either decreased or stayed the same since the implementation of the prospective payment system. See Appendix D, Tables 7 and 8.¹⁶

Average length of time between hospital discharge and the start of SNF care. Similarly, an increase in the average length of time between hospital discharge and the start of SNF care might indicate that beneficiaries with certain medical conditions or service needs are experiencing a decline in access. Again, we found no large increases in the average length of time between hospital discharge and the start of SNF care for any of the 10 most common DRGs or for any of the 10 most common RUGs. The average length of time between hospital discharge and the start of SNF care for all DRGs and all but two RUGs either decreased or stayed the same since the implementation of the prospective payment system. See Appendix D, Tables 9 and 10.

However, beneficiaries with certain medical conditions or service needs may experience delays

Discharge planners report delays placing certain beneficiaries

Thirty-five percent of discharge planners report having Medicare

beneficiaries who experience delays at least sometimes before being placed in a SNF. This is not a statistically significant decrease from the 2001 estimate, when 36 percent of discharge planners reported having Medicare beneficiaries who experienced delays at least sometimes.

Ninety-one percent (234 of 256) of discharge planners report ever having Medicare beneficiaries who experience delays. Of those, most (160 of 234) say that delays are associated with certain medical conditions or service needs. See Table 4 on the following page. Specifically, discharge planners report that Medicare beneficiaries needing IV antibiotics and/or expensive drugs, wound care, a ventilator, or dialysis, as well as beneficiaries with behavior problems, are most often delayed before being placed in a SNF. These medical conditions and service needs are similar to the ones that discharge planners report are associated with Medicare beneficiaries they can never place in a SNF.

¹⁶ Not all tables in the appendixes are referenced in the report; some are provided for informational purposes only.

Table 4: Medical Conditions/Service Needs Associated With Placement Delays

Medical Condition/Service Need	n=160
IV Antibiotics/Infusion/Drug Needs	67
Wound Care/Decubitus Ulcer	50
Behavior Problems	47
Ventilator	46
Renal Failure/Dialysis	43
Methicillin-Resistant Staphylococcus Aureus (MRSA)/Vancomycin-Resistant Enterococcus (VRE)/Tuberculosis	36

Note: Responses are not mutually exclusive.

Source: OIG analysis of discharge planner interviews, 2005.

Discharge planners who report delays placing Medicare beneficiaries in SNFs commonly explain that the cost of providing these services or Medicare reimbursement is the reason for placement delays (73 of 160). Specifically, they report that costs exceed reimbursements for treatments such as IV antibiotics and/or expensive drugs or dialysis, and that having too many patients who need high levels of care strains the facility. Discharge planners also explain that special equipment needs, such as specialty beds or prostheses (63 of 160), and shortage of qualified staff (36 of 160), such as registered nurses or nurses trained to work with psychiatric patients, may cause delays placing beneficiaries. They explain that it may be more difficult to find a SNF that can provide the appropriate level and/or type of care.

The medical conditions and service needs that discharge planners associate with beneficiaries whose placement is delayed, as well as the reasons for delays, are similar to the ones that discharge planners reported in previous studies. In 2001, discharge planners reported that Medicare beneficiaries who needed IV antibiotics and/or expensive drugs, required a ventilator, required dialysis, had behavior problems, and/or had wound care needs most often experienced placement delays.

Differences in placement rates and length of stay between beneficiaries in urban and rural areas and between beneficiaries in nonprofit and for-profit facilities were detected

Beneficiaries with certain medical conditions are placed more frequently in SNFs in urban or rural areas

We analyzed the proportion of Medicare beneficiaries with certain medical conditions in urban and rural areas to see if there were any large differences (i.e., 5 or more percentage points), compared to the proportion of all Medicare beneficiaries in SNFs in urban and rural areas. In 2004, 75 percent of all beneficiaries in SNFs were in urban areas and 25 percent were in rural areas.

We found that beneficiaries with certain medical conditions are placed more frequently in SNFs in urban or rural areas. Specifically, for 3 of the 10 most common RUGs, the proportion of beneficiaries in SNFs in urban areas was greater compared to all beneficiaries in SNFs in urban areas. Conversely, for another 2 of the 10 RUGs, the proportion of beneficiaries in SNFs in rural areas was greater compared to all beneficiaries in rural areas.¹⁷ See Appendix D, Table 12.

Additionally, Medicare data show that beneficiaries with certain medical conditions in urban areas have longer average lengths of stay in the hospital than beneficiaries with the same conditions in rural areas. In 2004, beneficiaries in urban areas with 6 of the 10 most common DRGs and those with 7 of the 10 most common RUGs had an average length of stay in the hospital that was greater by at least 1 day than beneficiaries with these same conditions in rural areas. See Appendix D, Tables 13 and 14.

In our interviews, 54 percent of discharge planners report no difference between placing Medicare beneficiaries in urban and rural areas, whereas 30 percent of discharge planners report some differences.¹⁸ Those who say that placing Medicare beneficiaries in urban areas is easier commonly explain that the capacity is greater in urban areas—there are more facilities, more beds, more qualified staff, and easier access to equipment. Those who report that placing Medicare

¹⁷ In addition, the proportion of beneficiaries in urban areas with DRG 462 was at least 5 percentage points greater than all beneficiaries in urban areas, whereas the proportion of beneficiaries in rural areas with DRG 089 was at least 5 percentage points greater than all beneficiaries in rural areas. See Appendix D, Table 11.

¹⁸ The remaining 16 percent of discharge planners report having no experience placing Medicare beneficiaries in both urban and rural areas or report that they “don’t know.”

F I N D I N G S

beneficiaries in rural areas is easier say that they often have better relationships with rural facilities.

Beneficiaries with certain medical conditions are more frequently placed in nonprofit or for-profit SNFs

We conducted a similar analysis of Medicare beneficiaries with certain medical conditions who are in nonprofit and for-profit SNFs to see if there were any large differences (i.e., 5 or more percentage points) compared to the proportion of all Medicare beneficiaries in nonprofit and for-profit SNFs. In 2004, 33 percent of all Medicare beneficiaries were in nonprofit facilities and 63 percent were in for-profit facilities.¹⁹

We found that beneficiaries with certain RUGs are placed more frequently in nonprofit or for-profit facilities, compared to all beneficiaries. Specifically, for 2 of the 10 most common RUGs, the proportion of beneficiaries in nonprofit facilities was greater compared to all beneficiaries in nonprofit facilities. For another 3 of the 10 RUGs, the proportion of beneficiaries in for-profit facilities was greater compared to all beneficiaries in for-profit facilities.²⁰ See Appendix D, Table 18. In addition, beneficiaries with 3 of the 10 most common RUGs in for-profit facilities have average lengths of stay in the hospital that were longer by at least 1 day than beneficiaries with these same conditions in nonprofit facilities. See Appendix D, Table 20.

¹⁹ The remaining 4 percent of beneficiaries were placed in Government facilities.

²⁰ In addition, the proportion of beneficiaries with DRG 209 in nonprofit facilities was at least 5 percentage points greater than all beneficiaries in nonprofit facilities, whereas the proportion of beneficiaries with DRG 320 and DRG 462 in for-profit facilities was at least 5 percentage points greater than all beneficiaries in for-profit facilities. See Appendix D, Table 17.

► C O N C L U S I O N

We continue to find that Medicare beneficiaries discharged from hospitals have access to SNFs, as evidenced by a significant increase in the proportion of discharge planners who report that they are able to place all their beneficiaries in SNFs. Additionally, we find that Medicare data show no large changes that may indicate a decline in access to care for beneficiaries with the most common medical conditions and/or service needs discharged to SNFs in the past 5 years. At the same time, we find that discharge planners report that beneficiaries with certain medical conditions or service needs may experience placement delays.

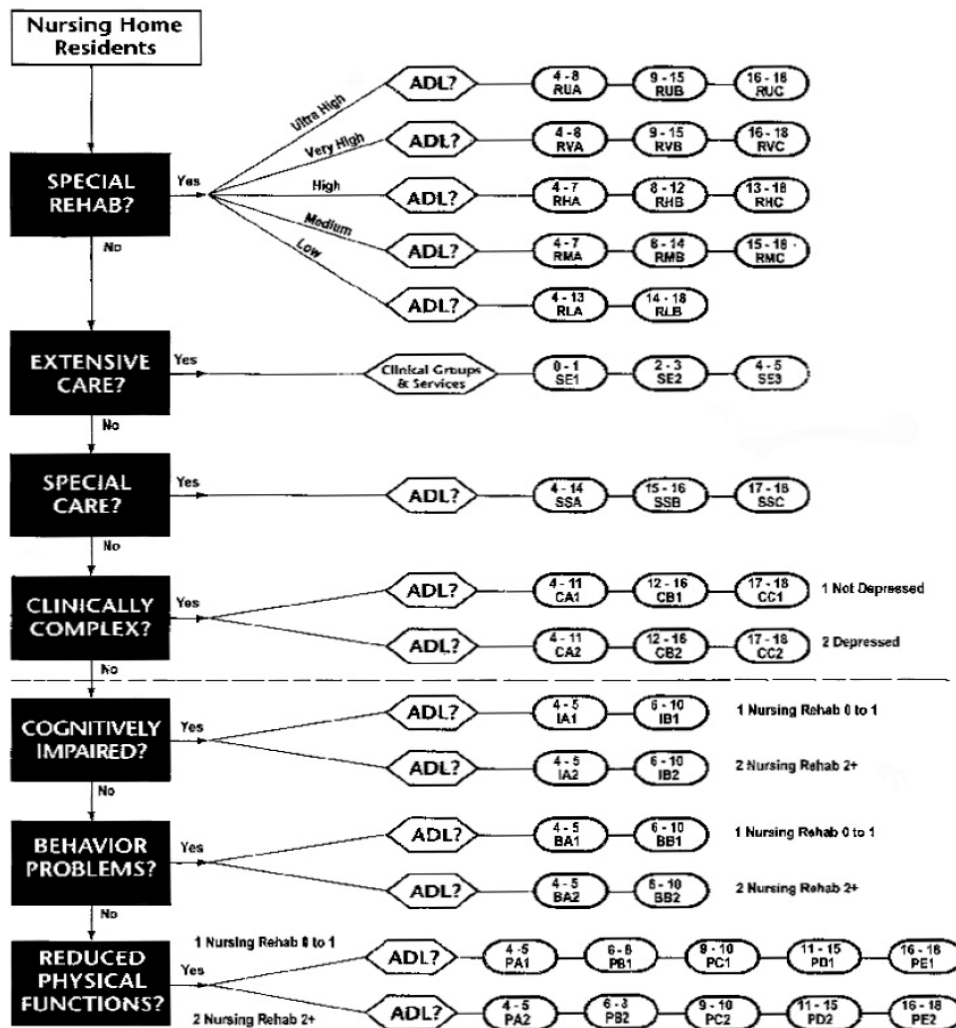
These findings are similar to the findings in our prior three reports, suggesting that, overall, the prospective payment system has not resulted in reduced access to SNF care. We encourage CMS to continue to monitor access to care. In particular, CMS might closely monitor beneficiaries who continue to experience delays in accessing care, including those who need IV antibiotics and/or expensive drugs, complex wound care, a ventilator, or dialysis, and those who have behavior problems.

▶ APPENDIX - A

Resource Utilization Group Classification System

SNFs are required to classify residents into 1 of 44 Resource Utilization Groups (RUGs), which determine payment rates. The RUGs are divided into seven major categories. To determine each resident's RUG, SNFs must complete the Minimum Data Set 2.0 assessment, which includes a standardized set of clinical and functioning status measures. SNFs complete this assessment for every patient at scheduled intervals during his or her stay.

RUG-III Classification System



1997 Version, 44-Group Model based on work of Brant E. Fries, PhD

Reformatted by JSC, Inc., 1998

Confidence Intervals for Key Findings

Table 5: Point Estimates and Confidence Intervals for Key Findings			
Key Findings	n	Point Estimate	Confidence Interval*
Eighty-four percent of discharge planners report that they are able to place all of their Medicare beneficiaries who need care in a SNF in a typical month.	256	84%	+/-4.49
Seventy-three percent of discharge planners report that there are enough SNF beds (including hospital swing beds) in their area for Medicare beneficiaries.	256	73%	+/- 5.44
Twenty-three percent of discharge planners report that, on average, they have to contact one facility to place a Medicare beneficiary in a SNF.	256	23%	+/-5.16
Thirty-five percent of discharge planners report having Medicare beneficiaries who experience delays at least sometimes before being placed in a SNF.	256	35%	+/- 6.10
Most of the discharge planners who report ever having Medicare beneficiaries who experience delays (160 of 234)** say that delays are associated with certain medical conditions or service needs.	234	68%	+/-5.98
Fifty-four percent of discharge planners report no difference between placing Medicare beneficiaries in urban and rural areas.	256	54%	+/-6.11

*95 Percent confidence interval.

** The denominator (i.e., 234) includes discharge planners who report having Medicare beneficiaries who experience delays at least sometimes and discharge planners who report rarely having Medicare beneficiaries who experience delays.

Source: OIG analysis of discharge planner interviews, 2005.

Department of Agriculture’s Urban Influence Codes

The Urban Influence Codes were developed by the Department of Agriculture Economic Research Service to take into account the geographic relationship of rural areas to larger urban economies. The Urban Influence Codes divide U.S. counties, county equivalents, and independent cities into 12 categories as described in the table below. In our analysis, we considered the first 2 categories as urban areas and the remaining 10 categories as rural areas. This is similar to the method used by the Medicare Payment Advisory Commission in its June 2001 “Report to Congress: Medicare in Rural America.”

Table 6: Urban Influence Codes		
Code	2003 Description	Designation
1	In large metro area of 1+ million residents	Urban
2	In small metro area of less than 1 million residents	Urban
3	Micropolitan adjacent to large metro	Rural
4	Noncore adjacent to large metro	Rural
5	Micropolitan adjacent to small metro	Rural
6	Noncore adjacent to small metro with own town	Rural
7	Noncore adjacent to small metro no own town	Rural
8	Micropolitan not adjacent to a metro area	Rural
9	Noncore adjacent to micro with own town	Rural
10	Noncore adjacent to micro with no own town	Rural
11	Noncore not adjacent to metro or micro with own town	Rural
12	Noncore not adjacent to metro or micro with no own town	Rural

Source: Economic Research Service, U.S. Department of Agriculture.

Analyses of Most Common DRGs and RUGs

Table 7: Average Length of Hospital Stay in Days for the 10 Most Common DRGs (2000–2004)*

DRG	2000	2001	2002	2003	2004	Difference 2000–2004
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	5.4	5.4	5.4	5.3	5.2	-0.2
DRG 089—Simple Pneumonia and Pleurisy, Age Greater Than 17, With Complications and Comorbidities	7.6	7.4	7.4	7.2	7.2	-0.4
DRG 127—Heart Failure and Shock	8.0	7.9	7.8	7.7	7.5	-0.5
DRG 210—Hip and Femur Procedures Except Major Joint Procedures, Age Greater Than 17, With Complications and Comorbidities	6.8	6.9	6.9	6.9	6.8	0
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	8.1	8.1	8.1	8.5	8.4	0.3
DRG 320—Kidney and Urinary Tract Infections, Age Greater Than 17, With Complications and Comorbidities	6.7	6.6	6.6	6.4	6.3	-0.4
DRG 296—Nutrition and Miscellaneous Metabolic Disorders, Age Greater Than 17, With Complications and Comorbidities	7.1	7.1	7.0	6.8	6.6	-0.5
DRG 462—Rehabilitation	16.5	16.1	16.0	16.5	16.5	0
DRG 416—Septicemia, Age Greater Than 17	9.5	9.5	9.5	9.5	9.6	0.1
DRG 088—Chronic Obstructive Pulmonary Disease	7.3	7.3	7.2	7.2	7.2	-0.1

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 8: Average Length of Hospital Stay in Days for the 10 Most Common RUGs (2000–2004)*

RUG	2000	2001	2002	2003	2004	Difference 2000–2004
RHC (Special Rehab, High 13–18)	10.0	10.1	9.9	9.9	9.9	-0.1
RHB (Special Rehab, High 8–12)	8.5	8.5	8.5	8.4	8.3	-0.2
RVB (Special Rehab, Very High 9–15)	8.6	8.5	8.6	8.6	8.6	0
SE2 (Extensive Care 2–3)	9.3	9.3	9.1	8.8	8.7	-0.6
RMB (Special Rehab, Medium 8–14)	9.0	8.9	8.9	8.8	8.6	-0.4
SE3 (Extensive Care 4–5)	10.3	10.3	10.1	9.9	9.8	-0.5
RHA (Special Rehab, High 4–7)	8.2	8.2	8.2	8.1	8.0	-0.2
RMC (Special Rehab, Medium 15–18)	10.7	10.7	10.6	10.5	10.4	-0.3
RUB (Special Rehab, Ultra High 9–15)	9.2	9.3	9.1	9.2	9.2	0
RVA (Special Rehab, Very High 4–8)	8.1	8.1	8.1	8.1	8.1	0

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 9: Average Length of Time Between Hospital Discharge and the Start of SNF Care in Days, for the 10 Most Common DRGs (2000–2004)*

DRG	2000	2001	2002	2003	2004	Difference 2000–2004
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	0.1	0.1	0.1	0.1	0.1	0
DRG 089—Simple Pneumonia and Pleurisy, Age Greater Than 17, With Complications and Comorbidities	0.4	0.4	0.4	0.4	0.3	-0.1
DRG 127—Heart Failure and Shock	0.6	0.6	0.6	0.6	0.6	0
DRG 210—Hip and Femur Procedures Except Major Joint Procedures, Age Greater Than 17, With Complications and Comorbidities	0.2	0.2	0.2	0.1	0.2	0
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	0.4	0.4	0.4	0.4	0.4	0
DRG 320—Kidney and Urinary Tract Infections, Age Greater Than 17, With Complications and Comorbidities	0.4	0.4	0.4	0.4	0.3	-0.1
DRG 296—Nutrition and Miscellaneous Metabolic Disorders, Age Greater Than 17, With Complications and Comorbidities	0.5	0.5	0.4	0.4	0.4	-0.1
DRG 462—Rehabilitation	0.8	0.9	0.8	0.8	0.8	0
DRG 416—Septicemia, Age Greater Than 17	0.3	0.3	0.3	0.3	0.3	0
DRG 088—Chronic Obstructive Pulmonary Disease	0.6	0.7	0.7	0.7	0.6	0

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 10: Average Length of Time Between Hospital Discharge and the Start of SNF Care in Days, for the 10 Most Common RUGs (2000–2004)*

RUG	2000	2001	2002	2003	2004	Difference 2000–2004
RHC (Special Rehab, High 13–18)	0.4	0.4	0.4	0.4	0.4	0
RHB (Special Rehab, High 8–12)	0.4	0.4	0.4	0.4	0.4	0
RVB (Special Rehab, Very High 9–15)	0.4	0.5	0.4	0.4	0.4	0
SE2 (Extensive Care 2–3)	0.3	0.3	0.3	0.3	0.3	0
RMB (Special Rehab, Medium 8–14)	0.4	0.5	0.4	0.4	0.4	0
SE3 (Extensive Care 4–5)	0.3	0.3	0.3	0.2	0.2	-0.1
RHA (Special Rehab, High 4–7)	0.5	0.5	0.5	0.5	0.6	0.1
RMC (Special Rehab, Medium 15–18)	0.4	0.4	0.4	0.4	0.4	0
RUB (Special Rehab, Ultra High 9–15)	0.5	0.5	0.5	0.5	0.5	0
RVA (Special Rehab, Very High 4–8)	0.5	0.5	0.5	0.6	0.6	0.1

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 11: Beneficiaries in Urban and Rural Areas for the 10 Most Common DRGs, Compared to All Beneficiaries, 2004*

DRG	Urban	Rural
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	71.9%	28.2%
DRG 089—Simple Pneumonia and Pleurisy, Age Greater Than 17, With Complications and Comorbidities	68.4%†	31.6%†
DRG 127—Heart Failure and Shock	73.7%	26.3%
DRG 210—Hip and Femur Procedures Except Major Joint Procedures, Age Greater Than 17, With Complications and Comorbidities	74.7%	25.3%
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	75.2%	24.8%
DRG 320—Kidney and Urinary Tract Infections, Age Greater Than 17, With Complications and Comorbidities	76.3%	23.7%
DRG 296—Nutrition and Miscellaneous Metabolic Disorders, Age Greater Than 17, With Complications and Comorbidities	74.0%	26.0%
DRG 462—Rehabilitation	80.0%†	20.1%†
DRG 416—Septicemia, Age Greater Than 17	75.6%	24.4%
DRG 088—Chronic Obstructive Pulmonary Disease	70.2%	29.8%
All Beneficiaries**	75.0%	25.1%

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

**Total does not equal 100 percent due to rounding.

†The proportion of beneficiaries with this DRG differed from the proportion of all beneficiaries by at least 5 percentage points, which we considered to be a large difference.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 12: Beneficiaries in Urban and Rural Areas for the 10 Most Common RUGs, Compared to All Beneficiaries, 2004*

RUG	Urban	Rural
RHC (Special Rehab, High 13–18)	77.7%	22.3%
RHB (Special Rehab, High 8–12)	77.1%	22.9%
RVB (Special Rehab, Very High 9–15)	86.4% [†]	13.6% [†]
SE2 (Extensive Care 2–3)	69.5% [†]	30.5% [†]
RMB (Special Rehab, Medium 8–14)	70.0% [†]	30.0%
SE3 (Extensive Care 4–5)	72.5%	27.5%
RHA (Special Rehab, High 4–7)	75.8%	24.2%
RMC (Special Rehab, Medium 15–18)	68.4% [†]	31.6% [†]
RUB (Special Rehab, Ultra High 9–15)	86.6% [†]	13.4% [†]
RVA (Special Rehab, Very High 4–8)	82.8% [†]	17.3% [†]
All Beneficiaries**	75.0%	25.1%

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

**Total does not equal 100 percent due to rounding.

[†]The proportion of beneficiaries with this DRG differed from the proportion of all beneficiaries by at least 5 percentage points, which we considered to be a large difference.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 13: Urban and Rural Differences in the Average Length of Hospital Stay in Days for the 10 Most Common DRGs, 2004*

DRG	Urban	Rural
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	5.3	5.1
DRG 089—Simple Pneumonia and Pleurisy, Age Greater Than 17, With Complications and Comorbidities	7.6 [†]	6.4 [†]
DRG 127—Heart Failure and Shock	7.9 [†]	6.5 [†]
DRG 210—Hip and Femur Procedures Except Major Joint Procedures, Age Greater Than 17, With Complications and Comorbidities	6.9	6.6
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	8.8 [†]	7.4 [†]
DRG 320—Kidney and Urinary Tract Infections, Age Greater Than 17, With Complications and Comorbidities	6.5	5.7
DRG 296—Nutrition and Miscellaneous Metabolic Disorders, Age Greater Than 17, With Complications and Comorbidities	6.8 [†]	5.8 [†]
DRG 462—Rehabilitation	16.6	16.5
DRG 416—Septicemia, Age Greater Than 17	10.0 [†]	8.1 [†]
DRG 088—Chronic Obstructive Pulmonary Disease	7.6 [†]	6.1 [†]

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

[†]Note that these DRGs differed by 1 day or more.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 14: Urban and Rural Differences in the Average Length of Hospital Stay in Days for the 10 Most Common RUGs, 2004*

RUG	Urban	Rural
RHC (Special Rehab, High 13–18)	10.2 [†]	8.9 [†]
RHB (Special Rehab, High 8–12)	8.6 [†]	7.5 [†]
RVB (Special Rehab, Very High 9–15)	8.7	8.0
SE2 (Extensive Care 2–3)	9.3 [†]	7.2 [†]
RMB (Special Rehab, Medium 8–14)	9.0 [†]	7.6 [†]
SE3 (Extensive Care 4–5)	10.5 [†]	8.1 [†]
RHA (Special Rehab, High 4–7)	8.2 [†]	7.2 [†]
RMC (Special Rehab, Medium 15–18)	11.1 [†]	8.8 [†]
RUB (Special Rehab, Ultra High 9–15)	9.2	8.7
RVA (Special Rehab, Very High 4–8)	8.2	7.5

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

[†]Note that these DRGs differed by 1 day or more.

Source: OIG analysis of CMS's National Claims History File, 2005.

Note that this table is for informational purposes only. It is not referenced in the report.

Table 15: Urban and Rural Differences in the Average Length of Time Between Hospital Discharge and the Start of SNF Care in Days, for the 10 Most Common DRGs, 2004*		
DRG	Urban	Rural
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	0.1	0.1
DRG 089—Simple Pneumonia and Pleurisy, Age Greater Than 17, With Complications and Comorbidities	0.3	0.4
DRG 127—Heart Failure and Shock	0.5	0.7
DRG 210—Hip and Femur Procedures Except Major Joint Procedures, Age Greater Than 17, With Complications and Comorbidities	0.2	0.2
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	0.4	0.4
DRG 320—Kidney and Urinary Tract Infections, Age Greater Than 17, With Complications and Comorbidities	0.3	0.4
DRG 296—Nutrition and Miscellaneous Metabolic Disorders, Age Greater Than 17, With Complications and Comorbidities	0.4	0.5
DRG 462—Rehabilitation	0.8	1.0
DRG 416—Septicemia, Age Greater Than 17	0.3	0.3
DRG 088—Chronic Obstructive Pulmonary Disease	0.6	0.6

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Note that this table is for informational purposes only. It is not referenced in the report.

Table 16: Urban and Rural Differences in the Average Length of Time Between Hospital Discharge and the Start of SNF Care in Days, for the 10 Most Common RUGs, 2004*		
RUG	Urban	Rural
RHC (Special Rehab, High 13–18)	0.4	0.4
RHB (Special Rehab, High 8–12)	0.4	0.5
RVB (Special Rehab, Very High 9–15)	0.4	0.5
SE2 (Extensive Care 2–3)	0.2	0.3
RMB (Special Rehab, Medium 8–14)	0.4	0.5
SE3 (Extensive Care 4–5)	0.2	0.2
RHA (Special Rehab, High 4–7)	0.5	0.7
RMC (Special Rehab, Medium 15–18)	0.4	0.4
RUB (Special Rehab, Ultra High 9–15)	0.4	0.6
RVA (Special Rehab, Very High 4–8)	0.5	0.7

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 17: Beneficiaries in Nonprofit and For-Profit SNFs for the 10 Most Common DRGs, Compared to All Beneficiaries, 2004*

DRG	Nonprofit	For-Profit
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	44.7%†	50.3%†
DRG 089—Simple Pneumonia and Pleurisy, Age Greater Than 17, With Complications and Comorbidities	31.3%	64.0%
DRG 127—Heart Failure and Shock	33.2%	62.5%
DRG 210—Hip and Femur Procedures Except Major Joint Procedures, Age Greater Than 17, With Complications and Comorbidities	35.0%	60.4%
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	32.7%	62.8%
DRG 320—Kidney and Urinary Tract Infections, Age Greater Than 17, With Complications and Comorbidities	26.7%†	69.2%†
DRG 296—Nutrition and Miscellaneous Metabolic Disorders, Age Greater Than 17, With Complications and Comorbidities	29.3%	66.6%
DRG 462—Rehabilitation	28.9%	68.7%†
DRG 416—Septicemia, Age Greater Than 17	30.3%	65.9%
DRG 088—Chronic Obstructive Pulmonary Disease	32.7%	62.9%
All Beneficiaries**	33.1%	62.7%

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

**Note that 4.2 percent of beneficiaries were placed in government SNFs.

†The proportion of beneficiaries with this DRG differed from the proportion of all beneficiaries by at least 5 percentage points, which we considered to be a large difference.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 18: Beneficiaries in Nonprofit and For-Profit SNFs for the 10 Most Common RUGs, Compared to All Beneficiaries, 2004*

RUG	Nonprofit	For-Profit
RHC (Special Rehab, High 13–18)	32.5%	63.7%
RHB (Special Rehab, High 8–12)	39.5%†	56.4%†
RVB (Special Rehab, Very High 9–15)	25.1%†	73.0%†
SE2 (Extensive Care 2–3)	32.3%	61.8%
RMB (Special Rehab, Medium 8–14)	43.8%†	49.4%†
SE3 (Extensive Care 4–5)	33.0%	62.0%
RHA (Special Rehab, High 4–7)	36.7%	58.9%
RMC (Special Rehab, Medium 15–18)	35.8%	58.1%
RUB (Special Rehab, Ultra High 9–15)	20.2%†	78.6%†
RVA (Special Rehab, Very High 4–8)	27.1%†	70.0%†
All Beneficiaries**	33.1%	62.7%

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

**Note that 4.2 percent of beneficiaries were placed in government SNFs.

†The proportion of beneficiaries with this RUG differed from the proportion of all beneficiaries by at least 5 percentage points, which we considered to be a large difference.

Source: OIG analysis of CMS's National Claims History File, 2005.

Note that this table is for informational purposes only. It is not referenced in the report.

Table 19: Nonprofit and For-Profit Differences in the Average Length of Hospital Stay in Days for the 10 Most Common DRGs, 2004*		
DRG	Nonprofit	For-Profit
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	5.0	5.6
DRG 089—Simple Pneumonia and Pleurisy, Age Greater Than 17, With Complications and Comorbidities	7.3	7.6
DRG 127—Heart Failure and Shock	7.6	7.8
DRG 210—Hip and Femur Procedures Except Major Joint Procedures, Age Greater Than 17, With Complications and Comorbidities	6.7	6.9
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	8.0	8.9
DRG 320—Kidney and Urinary Tract Infections, Age Greater Than 17, With Complications and Comorbidities	6.3	6.4
DRG 296—Nutrition and Miscellaneous Metabolic Disorders, Age Greater Than 17, With Complications and Comorbidities	6.6	6.7
DRG 462—Rehabilitation	16.2	16.7
DRG 416—Septicemia, Age Greater Than 17	9.3	10.0
DRG 088—Chronic Obstructive Pulmonary Disease	7.4	7.5

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Table 20: Nonprofit and For-Profit Differences in the Average Length of Hospital Stay in Days for the 10 Most Common RUGs, 2004*

RUG	Nonprofit	For-Profit
RHC (Special Rehab, High 13–18)	9.4	10.3
RHB (Special Rehab, High 8–12)	8.0	8.7
RVB (Special Rehab, Very High 9–15)	7.6†	8.9†
SE2 (Extensive Care 2–3)	8.7	9.0
RMB (Special Rehab, Medium 8–14)	8.6	8.9
SE3 (Extensive Care 4–5)	9.6†	10.6†
RHA (Special Rehab, High 4–7)	7.6	8.3
RMC (Special Rehab, Medium 15–18)	10.4	10.8
RUB (Special Rehab, Ultra High 9–15)	8.3†	9.5†
RVA (Special Rehab, Very High 4–8)	7.5	8.3

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

†Note that these DRGs differed by one day or more.

Source: OIG analysis of CMS's National Claims History File, 2005.

Note that this table is for informational purposes only. It is not referenced in the report.

Table 21: Nonprofit and For-Profit Differences in the Average Length of Time Between Hospital Discharge and the Start of SNF Care in Days, for the 10 Most Common DRGs, 2004*		
DRG	Nonprofit	For-Profit
DRG 209—Major Joint and Limb Reattachment Procedures of Lower Extremity	0.1	0.1
DRG 089—Simple Pneumonia and Pleurisy, Age Greater Than 17, With Complications and Comorbidities	0.3	0.4
DRG 127—Heart Failure and Shock	0.5	0.6
DRG 210—Hip and Femur Procedures Except Major Joint Procedures, Age Greater Than 17, With Complications and Comorbidities	0.1	0.2
DRG 014—Intracranial Hemorrhage or Cerebral Infarction	0.4	0.5
DRG 320—Kidney and Urinary Tract Infections, Age Greater Than 17, With Complications and Comorbidities	0.3	0.4
DRG 296—Nutrition and Miscellaneous Metabolic Disorders, Age Greater Than 17, With Complications and Comorbidities	0.4	0.4
DRG 462—Rehabilitation	0.7	0.8
DRG 416—Septicemia, Age Greater Than 17	0.3	0.4
DRG 088—Chronic Obstructive Pulmonary Disease	0.6	0.7

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.

Note that this table is for informational purposes only. It is not referenced in the report.

Table 22: Nonprofit and For-Profit Differences in the Average Length of Time Between Hospital Discharge and the Start of SNF Care in Days, for the 10 Most Common RUGs, 2004*

RUG	Nonprofit	For-Profit
RHC (Special Rehab, High 13–18)	0.3	0.4
RHB (Special Rehab, High 8–12)	0.3	0.5
RVB (Special Rehab, Very High 9–15)	0.3	0.5
SE2 (Extensive Care 2–3)	0.2	0.3
RMB (Special Rehab, Medium 8–14)	0.3	0.5
SE3 (Extensive Care 4–5)	0.2	0.3
RHA (Special Rehab, High 4–7)	0.4	0.7
RMC (Special Rehab, Medium 15–18)	0.3	0.4
RUB (Special Rehab, Ultra High 9–15)	0.4	0.5
RVA (Special Rehab, Very High 4–8)	0.4	0.6

*Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Source: OIG analysis of CMS's National Claims History File, 2005.



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