Challenges and Consequences of Reduced Skilled Nursing Facility Lengths of Stay

Denise A. Tyler , John P. McHugh, Renée R. Shield, Ulrika Winblad, Emily A. Gadbois , and Vincent Mor

Objective. To identify the challenges that reductions in length of stay (LOS) pose for skilled nursing facilities (SNFs) and their postacute care (PAC) patients.

Data Sources/Setting. Seventy interviews with staff in 25 SNFs in eight U.S. cities, LOS data for patients in those SNFs.

Study Design. Data were qualitatively analyzed, and key themes were identified. Interview data from SNFs with and without reductions in median risk-adjusted LOS were compared and contrasted.

Data Collection/Extraction Methods. We conducted 70 semistructured interviews. LOS data were derived from minimum dataset (MDS) admission records available for all patients in all U.S. SNFs from 2012 to 2014.

Principal Findings. Challenges reported regardless of reductions in LOS included frequent and more complicated re-authorization processes, patients becoming responsible for costs, and discharging patients whom staff felt were unsafe at home. Challenges related to reduced LOS included SNFs being pressured to discharge patients within certain time limits. Some SNFs reported instituting programs and processes for following up with patients after discharge. These programs helped alleviate concerns about patients, but they resulted in nonreimbursable costs for facilities.

Conclusions. The push for shorter LOS has resulted in unexpected challenges and costs for SNFs and possible unintended consequences for PAC patients.

Key Words. Nursing facilities, postacute care, length of stay

Length of stay (LOS) among postacute care patients in skilled nursing facilities (SNFs) has been steadily decreasing for the past several years. Empirical studies on overall SNF LOS are scant because most studies focus on LOS for certain conditions or procedures (e.g., Haghverdian, Wright, and Schwarzkopf 2017). However, analysis of LOS data available at Brown University's LTCFocus website (www.ltcfocus.org) illustrates that SNF LOS has been dropping in

recent years. These reductions have been due, in part, to Medicare policy changes and market based pressures, including the emergence of accountable care organizations (ACOs) and bundled payment and shared savings programs, as well as the growth of Medicare Advantage. However, little is known about how shorter LOS is affecting SNFs or their postacute care patients.

Implementation of the Affordable Care Act (ACA) included several programs to improve care quality, increase efficiency, and reduce costs through value-based payment models. In these programs, participating providers, including doctors, hospitals, and other health care organizations, join together voluntarily to provide coordinated care to their Medicare patients. These groups are reimbursed for episodes of care, payments are capitated and risk-adjusted, and participating organizations share savings they achieve from their Medicare population (Centers for Medicare and Medicaid Services 2017). Because over 20% of Medicare patients who are hospitalized each year are discharged to postacute care (PAC; Tian 2016), many of the patients covered by these programs are cared for in SNFs. However, research has shown that a minority of ACOs, for example, actually include SNFs as full participants (Colla et al. 2016). This means that ACOs are relying on SNFs to provide better care at lower costs without including those SNFs in the shared savings or through contractual or other formal relationships.

In the last several years, there has also been extraordinary growth in the Medicare Advantage program, which now covers one-third of all Medicare beneficiaries (Jacobson et al. 2017). Medicare Advantage is the managed care version of Medicare where private insurers are paid by Medicare on a per beneficiary per month basis for the care of all their enrolled beneficiaries. Unlike traditional Medicare where patients have choice among all available providers, Medicare Advantage managed care organizations (MCOs) are free to form networks of preferred providers. This affords MCOs some control over the care delivered by providers in their networks, including increased control over LOS.

Address correspondence to Denise A. Tyler, Ph.D., RTI International, 307 Waverley Oaks Rd, Waltham, MA 02453-8413; e-mail: dtyler@rti.org. John P. McHugh, Ph.D., M.B.A., is with the Department of Health Policy and Management, Columbia University Mailman School of Public Health, New York, NY. Renée R. Shield, Ph.D., Emily A. Gadbois, Ph.D., and Vincent Mor, Ph.D., are with the Center for Gerontology & Health Care Research, Brown University School of Public Health, Providence, RI. Ulrika Winblad, Ph.D., is with the Department of Public Health and Caring Sciences, Uppsala University, Uppsala, Sweden.

Decreases in LOS due to these market and policy pressures are likely having an effect on SNFs. Therefore, the purpose of this research was to identify the key challenges that reductions in LOS pose for SNFs, the unintended consequences of reduced LOS for SNFs and SNF patients, SNF responses to these, and suggestions for modifications to current policy.

METHODS

We used a multiple case study methodology that included site visits to eight U.S. markets between April and November 2015. Our site visits were conducted as part of a larger study examining the role of Medicare Advantage in PAC, the effect of readmission penalties on hospitals and PAC providers, and the care of frail nursing home residents during hospitalizations. We selected markets across the United States based on Medicare Advantage penetration rates, including four markets with a high rate ($>40\%$) and four markets with a lower rate ($<30\%$). For the study reported herein, in each market, we recruited approximately three SNFs. However, in one large market, we included five SNFs, and in one small market, we included two.

At each SNF, we interviewed the administrator, an admissions coordinator, and the director of nursing. Interview protocols were pilot tested in a large city in the Northeast. Our interview topics were wide ranging, but the topics most salient to the study reported here were SNF relationships with hospitals, including those participating in ACOs, how hospitals influence PAC services, SNF relationships with MCOs, how MCOs influence PAC services, efforts to reduce re-hospitalizations, and the facility's experience with LOS. Sample questions are shown in Table 1. All interviews were recorded, with the participant's consent, and transcribed for data analysis. Interviews averaged 40 minutes in length.

Data analysis involved a rigorous process to code the transcripts and identify emerging patterns and themes across transcripts (Crabtree and Miller 1999; Padgett 2012). We began by developing a preliminary coding scheme based on the questions we asked in our interview guides; we then modified and refined the scheme in an iterative fashion to add codes and refine code definitions. Additional codes resulted when unanticipated material emerged from interviews (Weston et al. 2001). Therefore, the resulting coding scheme reflected both a priori areas of interest from the interview questions as well as unanticipated findings that emerged from the data.

Table 1: Sample Interview Questions by Respondent Type

<i>Respondent Type</i>	<i>Sample Questions</i>
SNF Administrator	<p>Can you describe your contracting experience with Medicare managed care plans? Can you walk me through how Medicare managed care plans influence the use of post-acute services provided to your patients? What oversight do they provide? Please share any additional perspectives you may have about your relationships with Medicare managed care plans</p> <p>Does your facility serve as a “preferred provider” for any hospital or hospital system in the sense that you receive many of their discharges or a specific type of patient (e.g., high risk)? If so, please tell me how this was established? Do you have formal or informal agreements regarding the number and type of discharges received from hospitals/systems?</p> <p>Is your facility involved with any ACOs? In what way are you involved with the ACO? Are you part of the network in that you share in savings? How was this relationship established? Please describe any quality metrics you have to meet to remain in their network?</p>
Director of Nursing	<p>What has been your facility’s experience with length of stay? What would you attribute that to? How has changing length of stay affected the facility or how you provide care?</p> <p>Is your facility involved with any ACOs? How has this changed how you care for patients? Do ACO staff visit the SNF to check on patients? Tell me about any joint activities, such as education, training, or service provision.</p>
Admissions Coordinator	<p>Do you have any contracts with managed care companies for post-acute care services? About how many managed care patients are admitted every week? Since you have a managed care contract, do you know what factors went in to selecting you as provider for that managed care organization?</p> <p>Is there a hospital that provides the majority of your referrals? What kinds of patients does the hospital send you (e.g., types of diagnoses, etc.)? What do you think influences their decision to refer to you? Can you describe how new hospital policies or procedures may have affected your work?</p>

To begin data analysis, all research team members read all interviews from the first two sites multiple times and individually made notations to code the material line by line using the constant comparative method (Glaser 1965). After analysis of interviews from the first two sites was completed, coding became more standardized as familiarity with the coding scheme increased with practice. Each of the remaining interviews was then coded by subteams of two team members in which each team member coded the transcripts independently and the two subsequently met to agree on final coding and reconcile coding decisions when there were disagreements. Members of these subteams rotated and the entire team convened biweekly to discuss and resolve any remaining discrepancies.

Throughout analysis, the full team meetings were also used to note potential emerging themes, that is, patterns of ideas and concepts expressed across interviews. An audit trail was used to keep track of these themes and decisions related to codes and code definitions. Once coding was completed, the entire team discussed the potential themes to determine how prevalent they were across the interviews. By the same token, outliers were identified along with disconfirming evidence to indicate expressed variance of experience. All coded data were entered into NVivo 11 qualitative software for data management and organization.

After all qualitative data were coded and themes related to LOS were identified, we used data on median risk-adjusted LOS for 2012 through 2014 to identify the SNFs with reductions in LOS and those with no reductions (or increases) in LOS to compare findings between these types of facilities. Data from these years were used because they are from the year of implementation of the ACA and a later year. Changes in LOS were expected due to ACA programs, such as creation of ACOs and bundled payment programs. National data were used for each year. A facility's observed median LOS was calculated for all new admissions from hospitals to the facility using the date of facility admission and date of facility discharge found on minimum dataset (MDS) assessments completed for all patients regardless of payer (see Appendix SA2). Individuals with an LOS greater than 120 days were assigned an LOS of 120 days. The facility median risk-adjusted LOS was then calculated by first estimating the expected LOS for each individual using quantile regression based on about 50 variables from the individual's MDS assessment. These expected LOS were then used to determine the facility's median expected LOS. The median risk-adjusted LOS for each facility was then calculated by dividing the observed median by the expected median and multiplying by the national median, which was derived based on all admissions to all facilities in the United States each year. Data from interviews with staff in nursing homes with no reduction in (or increased) median risk-adjusted LOS were then compared and contrasted with data from interviews with staff in nursing homes with reductions in median risk-adjusted LOS.

RESULTS

We interviewed 70 staff members in 25 SNFs. In five cases, the staff member was unavailable or the position in the facility was vacant at the time

Table 2: Change in LOS 2012 to 2014 among Participating SNFs

<i>Region</i>	<i>Adjusted LOS 2012</i>	<i>Adjusted LOS 2014</i>	<i>Change in LOS</i>
S	50.0	25.1	-24.9
MW	23.5	18.0	-5.5
W	21.7	18.9	-2.8
MW	22.7	20.2	-2.5
NW	22.0	19.5	-2.5
S	22.2	20.0	-2.2
NE	20.1	18.0	-2.1
NW	20.8	19.3	-1.5
S	22.1	20.9	-1.2
NE	17.9	17.0	-0.9
W	12.3	11.5	-0.8
MW	22.7	21.9	-0.8
S	15.1	15.0	-0.1
MW	17.6	17.8	+0.2
MW	16.1	16.7	+0.6
MW	16.3	17.8	+1.5
S	18.2	21.0	+2.8
W	42.6	45.6	+3.0
S	21.3	24.5	+3.2
NE	15.8	19.3	+3.5
S	20.5	24.6	+4.1
NW	22.0	26.3	+4.3
S	17.5	23.1	+5.6
S	20.8	30.5	+9.7

of our visit. Thirteen of the 25 SNFs where we interviewed staff had experienced reductions in their median risk-adjusted LOS between 2012 and 2014. Among these, the average reduction in LOS was 3.7 days and the median reduction was 2.1 days (see Table 2). In 2014, postacute care admissions to these SNFs had an average LOS of 18.8 days and a median LOS of 19.3 days. In the 12 facilities where LOS did not drop between 2012 and 2014, mean LOS in 2014 was 22.6 days and median LOS was 21.0 days.

Challenges Regardless of Reductions in LOS

Regardless of whether SNFs experienced reductions in their LOS, increased burdens in dealing with MCOs were reported as they pushed for reduced LOS. For example, SNF staff reported increased paperwork and re-authorization processes. One administrator in a facility in the southern United States

that had not reduced its LOS noted avoiding managed care patients due to this additional work:

We have to fax records and that's time consuming, so we don't like to have a lot of managed care patients because I don't have the dedicated staff person just to do that. So nursing notes, therapy notes, and then they're reviewed by the plan who will say "yes, we'll continue benefits" or "no we won't continue benefits" and for how long. So, I mean, if we can easily get five days to a week extra, we consider that pretty good, and when they start going into the two and three day approvals, then, you know, you're nearing the end, but it's also burdensome every two and three days to have to fax more records. (S8 N2 I1)

SNF staff also reported incidents where patients were becoming unexpectedly responsible for the costs of part of their stay and having to work with patients through the appeals process. As one admissions coordinator in a facility with reduced LOS in the Midwest explained, patients are now paying privately when their MCO limits their stay:

We have a big amount of private pay in here. There is a total dynamic change in the census that we have. We used to have a lot of Medicare before, and then now it's turning out to be more private because . . . Medicare [Advantage] is getting more stricter in terms of the reimbursements . . . The [Medicare Advantage] replacement plans, which is now their insurance, which is more stricter. Instead of giving you the traditional 20 days, they'll give you seven days first, then later on I'll give you another seven days. Unlike the traditional Medicare, they give you 20 and then . . . it can go to the hundred. However, that's where the corporate policy comes in and they'll say "we just have to limit the patient's stay in here." (S4 N3 I3)

An administrator of a different facility in the same city that had also reduced its LOS described family members deciding to pay to keep patients in the SNF when the MCO would not:

People are using their own money, too, let me tell you, staying here privately because they don't feel comfortable taking mom home. (S4 N2 I1)

A west coast administrator whose facility's LOS was unchanged explained that patients will also try to appeal to stay in the facility longer:

The resident has the right to appeal and we'll assist with that. Sometimes the appeals do go through and most of the time they don't. (S5 N2 I1)

Finally, participants reported they had to discharge patients who they felt were unsafe at home due to MCO refusal to continue coverage of the SNF stay. As one admissions coordinator in the western United States stated:

My difficulties with managed care is they want the person out and they don't want them better. You know what I mean, so even if we say, like this person, like we need more time. We need another five days, they're pushing, pushing, pushing to get them out, because they're getting reimbursed from Medicare, so they want them out as fast as possible. And I understand that. But I also understand that if we send them home too early, they're going to fail and end up back in the hospital and it's going to cost that company more money. (S1 N2 I3)

Challenges Reported by SNFs with Reductions in LOS

Staff in the facilities with reductions in LOS reported similar pressure from MCOs and, in addition, reported pressure from hospitals participating in ACOs and bundled payment programs. Staff in these facilities noted specific limits on LOS imposed by these hospitals. For example, a director of nursing in the Midwest reported on the pressure being placed on her facility to reduce its LOS to 17 days by a hospital participating in an ACO program:

It's a situation that you don't feel like you want to lose your connection with them [the hospital] and you want to make sure that you reach the goal, the expectation, so all we gotta do is just speed up and do things. You see? And to me I'm not very happy with that 17 days. I'm not. Because some patients come and you see they are really sick and they sometimes need extra days, but then because it's like cutoff time for you, you gotta do whatever sometimes. (S4 N2 I2)

This director of nursing continued and stated that the issue has been worsening recently:

So I put my feet down and most of the time I fight for this, but I don't always win so it's been kind of very challenging. It wasn't like that before, but now it's kind of . . . the length of stay is being cut off slowly. (S4 N2 I2)

Interestingly, an administrator in a different nursing facility in the same city described a situation where once ACO hospitals started limiting LOS, MCOs in the region began following suit:

What we've seen more recently is a definite "we're not listening to your recommendation that the patient needs another 10 days" and "we don't care that there's

necessarily a caregiver that needs to get trained” and “we’re not quite sure why you’re so worried that the patient’s unsafe to go home” and so we’ve seen a little bit more of a heavy hand, I would say, in the last I would say the last six months, specifically, we’ve felt it . . . I think there’s an increased pressure in the industry. It starts at the hospital, it comes to us because where the hospital looks at us to help manage that readmission, and the insurance company says “well look, the hospital’s not admitting the person, well we’re gonna start behaving the same way.” (S4 N1 I1)

Similar to what staff reported about MCOs and having to discharge patients home that they felt were unsafe, an admissions coordinator in the South said the following about an ACO hospital her facility was working with:

So our focus is getting them safely home. Their focus is getting them home as quickly as possible without home health. (S8 N1 I3)

Positive Responses to Pressure to Reduce LOS

SNFs with and without actual reductions in LOS also reported on how they were dealing with the challenges related to the push for reduced LOS. Some described developing programs or processes for following up with patients postdischarge. For example, one program described by an admissions coordinator in a facility that had reduced its LOS utilized the LACE¹ score for identifying patients at risk of readmission:

Then we have the care transition coach that follows them outside when they discharge from us. If your LACE score is high [indicating a high risk of readmission], they call them, talk to them, go visit with them, make sure they’re getting to their doctor’s appointments. If they need help making doctor’s appointments or getting transportation, what are the barriers that they’re not taking care of their health at home to prevent hospitalization. And so, the care transition coaches are following them once they get home. (S5 N4 I3)

Another director of nursing in a facility with reduced LOS described a similar program in use for all discharged patients:

So when the person goes home, in the next 24 hours, we have a dedicated staff who calls, and asks the person how he’s doing, and everything, you know, just to make sure he’s okay, if there’s any problem that we can help with. And we continue to follow them as much as we can until we know that they are very, you know, they are okay. (S8 N1 I2)

And, an administrator in a facility whose LOS had not changed said:

And so our discharge planner does 2-day, 14-day, 30-day, and then 60-day follow-ups with that patient to make sure they are taking their medication, to see if they have questions and to see how they're doing. (S3 N2 I1)

While another facility in the same city that had not reduced its LOS was doing something similar, they actually hired a full-time staff member to handle patient follow-up. As their administrator noted, the cost of this new staff person was borne by the facility:

Two-day follow-up, 10-days, 30, 60, 90-day follow-up. So we have a staff member specifically hired full-time to do that. (S3 N3 I3)

Possibly Negative Responses to Pressure to Reduce LOS

While several facilities reported programs or processes they developed to follow up with patients they felt were unsafe at home or at risk for re-hospitalization, some facilities looked for ways to game the system. Again, these were both facilities with and without actual reductions in LOS. For example, one facility that had reduced its LOS learned how to remove patients from ACO participation:

If you're gonna hit over 17 [days] they're gonna say okay, well then discharge them. . . . They can't afford to pay privately and they have this benefit that they again can't use and we're then put in this position where we're the patient advocate yet at the same time we're discharging you . . . you're now paying privately or you're doing whatever it is that you have to do. . . . And the only way to get out of the [ACO] is if you don't have an [ACO participating] doctor. So . . . we have a very tricky game we play. If we know a family really deserves that 100 days [Medicare SNF benefit] and we know they're not safe and they don't have the money, we secretly get them to switch to a non [ACO] doctor and then they're automatically out of the [ACO] and they can use their 100 days, but if that [ACO] finds out like they did once, you're in trouble. (S4 N2 I1)

Other SNFs reported avoiding patients who had the chance of becoming long-stay and driving up their average LOS. As one admissions coordinator in a facility in the Northeast that had not reduced LOS stated:

So I do the screen and I find out that she does need some rehab, but her rehab potential is very poor. She's not participating very well and she lives alone in her apartment and the likelihood of her, it's a risk for the subacute bed. So then I have to factor in what kind of insurance does she have, how long, how many benefit days does she have. (S6 N1 I3)

Another administrator similarly noted the discretion they take in placing some patients into long-term care who are, indeed, eligible for rehabilitation:

I mean we are very selective in who we admit. And we send then, therefore, 91% go home again. But some people that other people would take, then we were putting in long-term care. . . . They fit the [rehab unit] criteria, but we put them in long-term care. (S3 N1 I3)

DISCUSSION

Our findings suggest that the pressure for shorter LOS in SNF by MCOs, ACOs, and other bundling programs may have resulted in several important consequences for SNFs and their patients. This is regardless of whether SNFs have actually reduced LOS. Some SNFs have responded to these pressures in both positive and negative ways. While more efficient and effective SNF care is an important policy goal, this push for shorter SNF LOS appears to have resulted in challenges for SNFs and possible unintended consequences for patients and the overall healthcare system. Our interviews with SNF staff indicate that the pressure from MCOs and ACOs is causing SNFs to discharge patients home who they feel are unsafe. This was evidenced by reports of appeals that patients are filing and the willingness of families to pay out of pocket for the care they believe is necessary to ensure a safe return to the community. While another recent study (McWilliams et al. 2017) showed no increases in mortality or re-hospitalization rates due to reduced LOS in SNFs that are part of ACOs, our interviews highlight the increased stress felt by SNF staff and possibly by patients and family members.

On a positive note, some SNFs reported accommodating to the pressure for shorter LOS by introducing programs or processes to both coordinate discharge into the community and to follow patients postdischarge. These initiatives may reduce re-hospitalizations and improve other patient outcomes. Under current reimbursement models, the costs of these types of programs are absorbed by the SNF as they are not reimbursable under Medicare FFS nor did we hear of examples of MCOs or ACOs incorporating the costs of such programs into their contracts. Without some acknowledgment of these costs, it is unlikely that these practices would be widely adopted. Of course, in the future, the value of these efforts may become recognized by hospitals participating in ACOs and bundles as they may be benefitting most from these

efforts. This could cause these groups to give more consideration to the need to include SNFs as participating partners in their programs (Winblad et al. 2017).

The fact that MCOs and ACO hospitals do not appear to be working collaboratively with SNFs may represent a lost opportunity; SNFs might be more willing to invest in programs to further reduce LOS and facilitate coordinated transitions to the community were they more tightly integrated contractually. As it is, by not including SNFs as partners, ACOs could run the risk of SNFs seeking to remove patients from the ACO, as one of our SNFs reported doing.

Our study is consistent with the results of a recent quantitative study showing greater disenrollment from Medicare Advantage plans by beneficiaries following SNF use (Goldberg et al. 2016). Our SNF interviews indicate that managed care patients were discharged earlier than SNF staff felt to be appropriate and patients sometimes appealed Medicare Advantage plans' decision that they did not need to remain in the SNF longer. These experiences might lead beneficiaries to switch from Medicare Advantage to traditional Medicare at the next open enrollment period.

Finally, while previous research has found that SNFs are sometimes selective about whom they admit (Mukamel et al. 2009), our study suggests that some SNFs may now avoid patients who have the potential to become long-stay, especially as it relates to the incentives of ACOs and bundles. It seems that LOS has been identified as the simplest mechanism to control costs and this could be sending the message to SNFs that those patients are not wanted in the facility. Therefore, if potentially long-stay patients are avoided by SNFs, those in need of long-term care might receive substandard care if they are relegated to less desirable facilities (i.e., those not deemed by hospitals to be high enough quality to receive ACO or other bundled payment patients). Past studies have found that the long-term care system in the United States is tiered in that many facilities catering to poorer patients, especially those that rely heavily on the Medicaid program, provide substandard care (Mor et al. 2004). A further division of facilities into those that provide primarily short-term SNF care, funded by Medicare, and those that provide long-term care, funded by Medicaid, could greatly exacerbate these inequities.

In addition to working to ensure efficient and effective postacute care, policymakers should also work to ensure patients receive the care they need, are not left responsible for unexpected costs, and are not discharged unsafely to home or a location that cannot provide the care they may need. Any

policies that unintentionally discourage SNFs from admitting patients likely to become long-stay should be carefully examined.

Although our study was quite robust in terms of qualitative standards, our results may not be generalizable and should be considered exploratory. The 25 SNFs that participated and 70 SNF staff that we interviewed may not be representative of all SNFs in that those willing to participate may have been different from SNFs generally. In addition, our study is limited by the fact that we spoke only to SNF staff about LOS and its challenges. We also did not speak to SNF patients. Therefore, additional research is needed to determine if the challenges and unintended consequences identified by our study are widespread. Additional research could also explore the appropriate length and intensity of postacute care for various conditions or develop clinical guidelines for determining when care is “finished.” Moreover, future research should be conducted among ACO and Medicare Advantage managers and clinicians to elicit their views on these topics. Research could also explore whether Medicare Advantage or ACO-affiliated patients were more likely to become long-stay or determine the proportion of these patients or their families who are choosing to pay out of pocket.

CONCLUSIONS

This study finds that the push for shorter LOS due to various market and policy pressures may be resulting in challenges and unintended consequences for SNFs and their patients regardless of whether the SNF actually reduced LOS. Some facilities have established positive ways of dealing with these pressures, such as developing programs to follow up with patients after discharge. However, some negative responses also seem to have emerged, such as avoiding patients who may become long-stay. More attention should be paid by policy-makers to such negative consequences, especially those that could affect patient access to quality care.

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NOTE

1. LACE score is calculated using “Length of stay of the hospital index admission,” “Acuity,” “Co-morbidities, and “number of Emergency Department visits in the last 6 months.”

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SUPPORTING INFORMATION

Additional supporting information may be found online in the supporting information section at the end of the article.

Appendix SA1: Author Matrix.

Appendix SA2: Methods for Calculating Median Risk-Adjusted LOS.