

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicare Beneficiary Access
to Skilled Nursing Facilities
2001**



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EXECUTIVE SUMMARY

PURPOSE

To assess the effects of the prospective payment system on access to skilled nursing facilities for Medicare beneficiaries.

BACKGROUND

The Balanced Budget Act (BBA) of 1997 changed reimbursement for skilled nursing care from a cost-based method to a prospective payment system (PPS) of fixed, predetermined rates. The prospective payment system was implemented in January 1999.

In addition, the Balanced Budget Refinement Act increased certain payment rates under PPS that went into effect October 1, 2000.

This report is a follow-up to two previous Office of Inspector General inspections, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities*, OEI-02-99-00400 and *Medicare Beneficiary Access to Skilled Nursing Facilities: 2000*, OEI-02-00-00330. Both reports found that most discharge planners are able to place Medicare patients in SNFs. However, about half of discharge planners believe that nursing homes are changing their admissions practices in response to PPS.

We used several methods to address the inspection issues. We conducted a survey of a random sample of 208 hospital discharge planners that focused on beneficiary access to skilled nursing care. We also analyzed the Centers for Medicare and Medicaid Services' Provider of Services File and the National Claims History File.

FINDINGS

Most Medicare beneficiaries continue to have access to skilled nursing facilities

Little change in placing beneficiaries since increases to payment rates. About 73 percent of discharge planners report that they are able to place all of their Medicare patients who need care in skilled nursing facilities. Another 20 percent are able to place all but 1 to 5 percent, and 7 percent are not able to place more than 5 percent. Discharge planners report that they have to contact an average of three facilities to place a Medicare patient. They explain that patients whom they are not able to place in a skilled

nursing facility often remain in the hospital or go home either with or without home health care.

Sufficient number of Medicare nursing home beds seems to be available. Seventy-five percent of discharge planners report that there are enough skilled nursing facility beds in their area for Medicare patients. Those who say there are not enough beds note that facilities are often full or that the bed supply in their area has not kept pace with the needs of a growing elderly population. Medicare data indicate that the number of skilled nursing facility beds nationwide increased by nearly 38 percent from 1997 to 2000.

Patients with certain service needs experience delays

Some discharge planners report delays in placing Medicare patients in skilled nursing facilities. Thirty-six percent say they experience delays sometimes, while 16 percent say they usually or always experience delays when placing beneficiaries in skilled nursing facilities. Seventy-six percent of discharge planners who report delays say that they are associated with certain medical conditions or service needs. They most commonly cite delays associated with patients who need IV antibiotics and/or expensive drugs, ventilator-dependent patients, and those who require dialysis.

Over half of the discharge planners who report delays associated with medical conditions or service needs attribute these delays to PPS. Some explain IV therapy often requires expensive medications that are not adequately reimbursed for under PPS. In addition, some dialysis patients experience delays when transportation costs are not covered by Medicare. Lastly, ventilator and wound care patients are delayed because their needs are often labor intensive and require expensive medical supplies.

CONCLUSION

Similar to the findings of our two previous inspections, most Medicare beneficiaries continue to have access to skilled nursing facilities. At the same time, access to care does not appear to have changed as a result of increases to certain payment rates under the Balanced Budget Refinement Act of 1999. We encourage the Centers for Medicare and Medicaid Services to continue to monitor access to care and skilled nursing facilities' responses to the payment system.

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INTRODUCTION

PURPOSE

To assess the effects of the prospective payment system on access to skilled nursing facilities for Medicare beneficiaries.

BACKGROUND

This inspection re-examines the effects of the prospective payment system (PPS) on Medicare beneficiary access to skilled nursing facilities (SNFs). It is part of the Office of Inspector General's (OIG) continuing commitment to safeguard skilled nursing care and to respond to ongoing concerns that the new payment system may adversely affect beneficiary access to SNFs.

In 1999, the Centers for Medicare and Medicaid Services (CMS) asked the OIG to assess the effects of the prospective payment system for SNFs on access to care for Medicare beneficiaries. In response, the OIG completed two reports, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities*, OEI-02-99-00400 and *Medicare Beneficiary Access to Skilled Nursing Facilities: 2000*, OEI-02-00-00330. Both reports found that most discharge planners are able to place Medicare patients in SNFs. However, about half of discharge planners believe that nursing homes are changing their admissions practices in response to PPS.

In another report entitled *Trends in the Assignment of Resource Utilization Groups by Skilled Nursing Facilities*, OEI-02-01-00280, we examined the proportion of Medicare beneficiaries assigned to each of the Resource Utilization Groups (RUGs) in light of recent legislative changes to PPS. (See Appendix A.)

Medicare Payments to SNFs

Medicare Part A helps to pay for SNF care when a beneficiary meets certain conditions. These conditions include a requirement of daily skilled nursing or rehabilitation services, a prior three consecutive days stay in a hospital, admission to an SNF within a short period of time after leaving the hospital, treatment for the same condition that was treated in the hospital, and a medical professional certifying the need for daily skilled nursing or rehabilitation care. The number of SNF days provided under Medicare is limited to 100 days per benefit period, with a co-payment required for days 21 through 100. After the Medicare 100 day SNF Part A benefit runs out, the Medicare Part B benefit continues to pay for physician services and other Part B-covered services.

Between 1990 and 1998, expenditures for Medicare SNF services have increased, on average, 25 percent annually, reaching \$13.6 billion in 1998. Between 1990 and 1997, the number of beneficiaries receiving SNF care more than doubled, rising from 638,000 to 1.6 million. Medicare's average payment per SNF day also more than doubled, from \$98 in 1990 to \$262 in 1998. At the same time, the number of days of care per SNF patient served dropped from 37 to 32.¹ The latest data available show that SNF expenditures have decreased slightly to \$12.2 billion in Fiscal Year 1999.

SNF Prospective Payment

In order to control escalating nursing home costs, Congress passed the Balanced Budget Act of 1997 that changed SNF reimbursement from a cost-based to a prospective payment system. Beginning with the first cost reporting period after July 1, 1998, SNFs are 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. The per diem payment is based on Fiscal Year 1995 Part A & B costs adjusted using the SNF market basket index, the case-mix from resident assessments, and geographical wage variations. The market basket index represents an inflation factor. The case-mix index takes into account that SNF residents require different levels of care.

To determine the case-mix, SNFs are required to assign residents into 1 of 44 Resource Utilization Groups (RUGs). The RUGs are divided into seven major categories: special rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical function. To determine the RUG, SNFs must fill out the Minimum Data Set 2.0 (MDS) assessment which is a standardized set of clinical and functioning status measures. Facilities must complete an assessment for each patient at scheduled intervals during his or her stay.

In the Fall of 1999, Congress enacted the Balanced Budget Refinement Act (BBRA) in response to providers' concerns that reductions in payments were too severe. The BBRA included a 4 percent across-the-board increase in payments to SNFs for Fiscal Years 2001 and 2002 and a temporary 20 percent increase for 15 RUGs for patient conditions considered medically complex. These include all the RUGs in the clinically complex, special care, and extensive care categories as well as three RUGs in the special rehabilitation category. In addition, several costly non-therapy ancillary services, including certain ambulance services, prostheses, and chemotherapy drugs, were excluded from the prospective payment system and paid for separately. The BBRA changes went into effect on October 1, 2000.

¹ General Accounting Office, *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access*, 1999.

In 2000, Congress further adjusted the payment rates under the Benefits Improvement and Protection Act (BIPA). The BIPA increased the inflation update to the full market basket in Fiscal Year 2001 and raised the nursing component of the RUGs by 16.6 percent in an effort to improve PPS nursing staff ratios. Additionally, the BBRA 20 percent increase to the three rehabilitation RUGs was spread across all 14 special rehabilitation RUGs as a 6.7 percent increase. The other RUGs increased in the BBRA maintained the 20 percent increase. These changes went into effect on April 1, 2001.

Discharge Planners

By definition, all Medicare Part A beneficiaries in SNFs are discharged from hospitals. Hospital discharge planners are responsible for coordinating the discharge of patients to SNF care and are therefore in a unique position to assess the effects of the prospective payment system on access to nursing home care.

Federal regulations require all hospitals to offer discharge planning services. The goal of these services is to identify a patient's post-hospital needs and ensure that he or she is discharged to a safe environment with the appropriate level of services. In most hospitals, the social work, case management, or utilization review department has primary responsibility for discharge planning. Patients can be placed in a variety of settings including SNFs, home health care, hospices, or intermediate care.

Discharge planning staff generally follow a standard process. In a typical scenario, staff screen patients' records within 24 hours of admission. They attempt to identify patients who will require discharge planning services, such as those who are 65 years and older and living alone or those with possibly life-threatening illnesses. They then conduct a psycho-social assessment and discuss the patient's care plan with his or her nurses and physicians as well as utilization review staff, and other relevant interdisciplinary team members. Discharge planners also solicit the patient's preferences and contact family members or other potential caregivers to get their input and cooperation. Based on this information, they attempt to place the patient in the most appropriate setting.

Other Work on Access to Skilled Nursing Facilities

In 1999, the General Accounting Office (GAO) released *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access*. The report generally concurs with the OIG reports discussed earlier. It found that Medicare beneficiaries' ability to obtain care does not appear to have decreased since the implementation of PPS. However, about two-thirds of discharge planners reported that SNFs have become more reluctant to admit higher-cost patients, such as those requiring expensive drug treatment or infusion therapy. Many discharge planners further noted that facilities prefer to admit patients needing short-term rehabilitation.

METHODOLOGY

We used several methods to address the inspection issues. These methods replicate the approach used in the two prior OIG inspections on access to SNFs.

Discharge Planner Survey

We conducted a survey of hospital discharge planners that focused on beneficiary access to home health care. To do this, we selected a random sample of 225 acute care hospitals with 30 or more beds from the 50 States and the District of Columbia. We conducted interviews with 208 discharge planners or their designees within a 3 week period from April 2, 2001 to April 20, 2001. We achieved a 92 percent response rate. Note that this sample is the same sample of hospitals used in the OIG inspection, *Medicare Beneficiary Access to Home Health Care: 2001, OEI-02-01-00180*.

Analysis of Medicare Data

In addition, we analyzed Medicare data for beneficiaries who were discharged from a hospital to a SNF. Specifically, we analyzed the proportion of Medicare beneficiaries discharged to SNFs by key diagnosis related groups (DRGs) to determine the extent to which SNFs are admitting different types of patients. We also analyzed the length of hospital stays by key DRGs to examine whether patients are experiencing longer delays before entering SNFs.

These analyses are based on data from the National Claims History File. We identified all beneficiaries who: 1) were discharged from a hospital between January 1, 2001 through March 31, 2001, and; 2) had a SNF stay that started within 30 days of their hospital discharge. We then compared these data to the same data for the first quarters of 1997, 1998, 1999, and 2000. In addition, we examined trends in the number of SNFs and the number of nursing home beds certified for Medicare based on data from the Provider of Services (POS) File.

Limitations

The data for the most recent quarter, January to March 2001, are not as complete as the other quarters of data. Additional and adjusted claims will be collected for this quarter that may alter these data.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

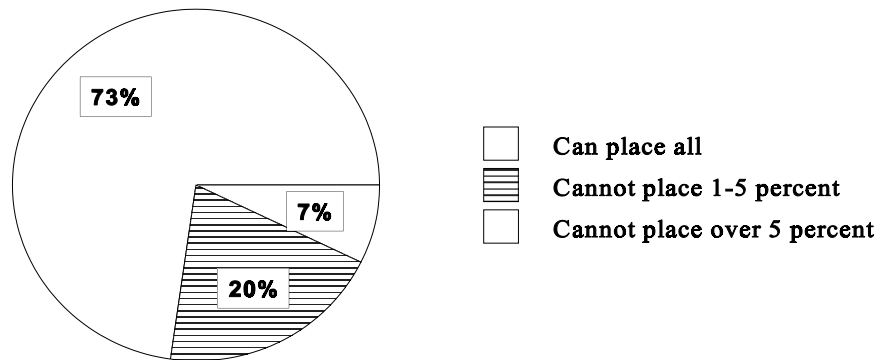
FINDINGS

Most Medicare beneficiaries continue to have access to skilled nursing facilities

Little change in placing beneficiaries since increases to payment rates

About 73 percent of discharge planners report that they are able to place all of their Medicare patients who need care in skilled nursing facilities. Another 20 percent are able to place all but 1 to 5 percent. Seven percent are not able to place more than 5 percent. (See Figure 1). About 80 percent of discharge planners were able to place all of their Medicare patients last year. The differences between the estimates for this year and last year, however, are not statistically significant. Most discharge planners (86 percent) also report no difference in the number of patients whom they cannot place since last year when increases were made to certain payment rates under PPS.

Figure 1
Proportion of Discharge Planners Placing Patients in SNFs



Source: Discharge Planner Survey, 2001

Discharge planners report that they have to contact an average of three facilities to place a Medicare patient. They explain that patients whom they are not able to place in a SNF often remain in the hospital or go home either with or without home health care.

Medicare data support discharge planners' experiences. The data show that there are no large changes in the types of Medicare beneficiaries being discharged to SNFs in the last 5 years. A decrease in a diagnosis related group (DRG) may indicate that patients with that condition are experiencing problems with access to care. However, there are no large decreases in the proportion of Medicare beneficiaries for the 10 most common

DRGs discharged to SNFs in any of the years between 1997 and 2001. The 10 most common DRGs are the same in each of the last 5 years and represent about 44 percent of all Medicare beneficiaries discharged to SNFs. (See Appendix C.)

Two of these DRGs experienced small decreases that are greater than one percentage point. Specifically, respiratory infections and inflammations (DRG 79) and specific cerebrovascular disorders (DRG 14) decreased by 1.5 percentage points and 1.2 percentage points, respectively, between 1997 and 2001.

Another report issued by the OIG, *Trends in the Assignment of Resource Utilization Groups by Skilled Nursing Facilities, OEI-02-01-00280*, also found no large changes in the types of patients being admitted to SNFs in the last 2 years. Specifically, the report shows that the proportion of Medicare beneficiaries assigned to each of the Resource Utilization Groups (RUGs) at admission has remained about the same from 1999 to 2001.

Sufficient number of Medicare nursing home beds seems to be available

Seventy-five percent of discharge planners report that there are enough SNF beds in their area for Medicare patients. Those who say there are not enough beds explain that facilities are often full or that the bed supply in their area has not kept pace with the needs of a growing elderly population. A similar proportion of discharge planners in urban and rural hospitals report that the bed supply for Medicare patients is sufficient in their area. In addition, most (86 percent) report that the number of Medicare beds in their area has stayed the same or increased since last year.

Medicare data indicate that the number of Medicare SNF beds continues to increase. As shown in Figure 2, the number of Medicare beds nationwide increased by nearly 38 percent between 1997 and 2000. This increase was largely due to a rise in the number of dually certified beds that are available for either Medicare or Medicaid patients. The total number of certified nursing home beds and the number of SNFs nationwide increased only slightly during this time period.

Figure 2
Total Number of SNFs and Nursing Home Beds

	1997	1998	1999	2000	Percent Change 1997-2000
Number of SNFs	14,772	15,025	14,911	14,839	0.5%
Total Medicare Beds	681,456	722,278	836,701	939,356	37.8%
Total Certified Beds*	1,528,061	1,556,495	1,556,569	1,560,661	2.1%

* Medicare and Medicaid beds

Source: Provider of Services File

Patients with certain service needs experience delays

Some discharge planners report delays in placing Medicare patients in SNFs.² Thirty-six percent say they experience delays sometimes, while 16 percent say they usually or always experience delays when placing beneficiaries in SNFs. A similar proportion of discharge planners reported placement delays last year.

Most discharge planners (76 percent) who report delays say that they are associated with certain medical conditions or service needs. They most commonly cite delays associated with patients who need IV antibiotics and/or expensive drugs, ventilator-dependent patients, and those who require dialysis. (See Figure 3.) Discharge planners reported similar conditions associated with delays last year. These are also the same medical conditions and service needs discharge planners describe for beneficiaries whom they cannot place.

Figure 3
Responses of Discharge Planners who Report that Delays are Associated with Medical Conditions/ Service Needs

Medical Condition/ Service Need	Percent (n=142)
IV Antibiotics/ Expensive Drugs	36%
Ventilator	28%
ESRD/ Dialysis	25%
Behavior Problems/ Alzheimer's	23%
Wound Care/ Decubitus Ulcers	22%
Infectious Disease/ Isolation Needs	22%

Note: Categories are not mutually exclusive.

Source: Discharge Planner Survey, 2001

A few discharge planners also note delays that are associated with other types of patients. Some mention delays placing patients with tracheotomies or respiratory failure and patients requiring parenteral or enteral feedings. Others cite patients with specialized equipment needs such as those with weight problems. A few cite delays associated with patients who have mental health issues, chemotherapy needs, and HIV/AIDS. They explain that these patients may be delayed because they require expensive medications or more supervision than other patients.

² Delays in placement occur when a patient has been cleared for discharge by the physician but no SNF bed has been secured.

Medicare data, however, show no increases in the average hospital length of stay for Medicare beneficiaries discharged to SNFs. In fact, the average length of stay slightly decreased for all but 1 of the 10 most common DRGs between 1997 and 2001. Specifically, the average length of stay for each of these DRGs decreased by less than one day. (See Appendix D.)

Over half of discharge planners who report that delays are associated with medical conditions or service needs attribute these delays to PPS. They comment that delays are due to low reimbursement and to staffing issues under PPS. Some explain IV therapy often requires expensive medications that are not adequately reimbursed for under PPS. In addition, some dialysis patients experience delays when transportation costs are not covered by Medicare.³ Lastly, ventilator and wound care patients also experience delays because their needs are often labor intensive and require expensive medical supplies.

Discharge planners mention several other factors that affect the placement process. About half of all discharge planners report that SNFs have changed their admissions practices since last year. They most commonly say that SNFs request more information about patients and more frequently conduct on-site visits prior to admission. Some discharge planners also cite family issues. They mention that family members or caregivers sometimes delay the process to consider different placement options or because they want to wait for a bed in a particular nursing home. Others cite issues that are related to physicians. A few note that physicians may prefer to wait for a bed in a hospital-based SNF so that they can track the patient more closely.

³ The BBRA allows ambulance transport to be paid for under Part B, although some discharge planners suggest that transportation remains a problem.

CONCLUSION

Similar to the findings of our two previous inspections, most Medicare beneficiaries continue to have access to skilled nursing facilities. At the same time, access to care does not appear to have changed as a result of increases to certain payment rates under the Balanced Budget Refinement Act of 1999. We encourage the Centers for Medicare and Medicaid Services to continue to monitor access to care and skilled nursing facilities' responses to the payment system.

Recent Office of Inspector General Skilled Nursing Facility Inspections

Office of Inspector General, U.S. Department of Health and Human Services, “Trends in the Assignment of Resource Utilization Groups by Skilled Nursing Facilities,” OEI-02-01-00280, July 2001.

Office of Inspector General, U.S. Department of Health and Human Services, “Nursing Home Resident Assessment Resource Utilization Groups,” OEI-02-99-00041, January 2001.

Office of Inspector General, U.S. Department of Health and Human Services, “Medicare Beneficiary Access to Skilled Nursing Facilities: 2000,” OEI-02-00-00330, September 2000.

Office of Inspector General, U.S. Department of Health and Human Services “Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrator’s Perspective,” OEI-02-99-00401, October 1999.

Office of Inspector General, U.S. Department of Health and Human Services “Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities,” OEI-02-99-00400, August 1999.

Confidence Intervals for Key Findings

We calculated confidence intervals for key findings for discharge planners. The point estimate and 95% confidence intervals are given for each of the following:

KEY FINDINGS	n	POINT ESTIMATE	CONFIDENCE INTERVAL
Seventy-three percent of discharge planners report that under PPS they are able to place their Medicare patients in skilled nursing facilities.	208	73%	±6.1%
Most discharge planners (86 percent) also report no difference in the number of patients who they cannot place since last year when several changes were made to increase payments to PPS.	195	86%	±4.8%
Seventy-five percent of discharge planners report that there are enough SNF beds in their area for Medicare patients.	208	75%	±5.9%
Thirty-six percent say they experience delays sometimes.	208	36%	±5.9%
Most discharge planners (76 percent) who report delays say that they are associated with certain medical conditions or service needs.	186	76%	±6.1%
Over half of the discharge planners who report delays associated with medical conditions or service needs attribute these delays to PPS.	142	59%	±8.1%
About half of discharge planners report that SNFs have changed their admissions practices since last year.	208	53%	±6.8%

**Proportion of Beneficiaries Discharged to SNFs
by Top Diagnosis Related Groups (DRGs)***

Initial Hospital DRG	1997	1998	1999	2000	2001	1997-2001 Difference
DRG 079- Respiratory infections and inflammations	4.2%	3.4%	3.1%	2.8%	2.7%	-1.5
DRG 014- Specific cerebrovascular disorders	6.7	6.0	6.0	5.6	5.5	-1.2
DRG 210- Hip and femur procedures except major joint	5.2	4.6	4.7	4.5	4.3	-0.9
DRG 416- Septicemia	2.7	2.5	2.3	2.2	2.2	-0.5
DRG 209- Major joint and limb reattachment procedures	8.5	8.2	8.4	8.0	8.5	0.0
DRG 088- Chronic obstructive pulmonary disease	2.7	3.2	3.3	3.1	2.8	0.0
DRG 089- Simple pneumonia and pleurisy	6.5	8.0	8.0	8.2	6.6	0.1
DRG 127- Heart failure and shock	4.8	5.0	4.9	4.9	5.1	0.2
DRG 296- Nutritional and misc. metabolic disorders	2.6	2.6	2.7	2.8	2.9	0.3
DRG 320- Kidney and urinary tract infections	2.1	2.2	2.2	2.3	2.5	0.5

Source: National Claims History File

*Note: Differences may be due to rounding.

**Average Hospital Lengths of Stay For Beneficiaries
Discharged to SNFs by Top Diagnosis Related Groups
(DRGs)***

Initial Hospital DRG	1997 Days	1998 Days	1999 Days	2000 Days	2001 Days	1997-2001 Difference
DRG 014- Specific cerebrovascular disorders	9.7	9.4	9.2	9.2	9.1	-0.6
DRG 089- Simple pneumonia and pleurisy	9.0	8.7	8.6	8.7	8.4	-0.6
DRG 296- Nutritional and misc. metabolic disorders	8.6	8.3	8.2	8.1	8.0	-0.5
DRG 320- Kidney and urinary tract infections	8.2	7.8	7.8	7.8	7.7	-0.5
DRG 127- Heart failure and shock	9.2	8.8	8.8	8.8	8.7	-0.4
DRG 088- Chronic obstructive pulmonary disease	8.8	8.5	8.4	8.5	8.4	-0.4
DRG 209- Major joint and limb reattachment procedures	6.7	6.4	6.4	6.5	6.3	-0.3
DRG 210- Hip and femur procedures except major joint	8.1	7.8	7.8	7.8	7.8	-0.2
DRG 079- Respiratory infections and inflammations	11.2	11.1	11.1	11.3	11.1	0.0
DRG 416- Septicemia	10.5	10.3	10.4	10.9	10.7	0.2

Source: National Claims History File

*Note: Differences may be due to rounding.