

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**EFFECT OF THE HOME HEALTH
PROSPECTIVE PAYMENT SYSTEM
ON THE QUALITY OF HOME
HEALTH CARE**



Daniel R. Levinson
Inspector General

January 2006
OEI-01-04-00160

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid Fraud Control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.



OBJECTIVE

To determine how hospital readmission and emergency department visit rates for Medicare beneficiaries discharged from hospitals to home health care have changed since implementation of the home health prospective payment system (PPS).

BACKGROUND

As a result of the Balanced Budget Act of 1997, the Centers for Medicare & Medicaid Services (CMS) implemented the PPS for Medicare home health care services in 2000. PPS was mandated in response to rapidly growing home health spending that had resulted from financial incentives under the previous cost-based system. Under the PPS, home health agencies receive a unit of payment that reflects a national 60-day episode rate with applicable adjustments. That payment is designed to reflect the clinical and functional severity of a beneficiary's condition.

The payment for an episode of care under the PPS can create a financial incentive to limit visits to patients, thus raising questions about how often home health agency staff check the health conditions of their patients. CMS, the Government Accountability Office, and the Medicare Payment Advisory Commission have all stressed the need to monitor outcomes of care following the implementation of the PPS because of this incentive. Increases in the rates of hospital readmission and emergency department visits are indicators of poor quality of care.

We used Medicare claims data and data on beneficiaries' clinical and functional characteristics to measure the rate of readmissions to hospitals and the rate of visits to hospital emergency departments. We analyzed these data for a consistent 3-month period (April–June) for 2000 (which served as the baseline), 2001, 2002, and 2003.

FINDINGS

Hospital readmission rates remain unchanged. Overall hospital readmission rates for Medicare home health beneficiaries discharged from hospitals remained at 47 percent from 2000 through 2003. Our analysis showed no consistent trend in hospital readmission rates for beneficiaries with at-risk diagnoses, although there were small increases in readmission rates for beneficiaries with renal failure,

multiple sclerosis, and pulmonary disease. Readmission rates due to preventable adverse events remained low.

Minimal changes in emergency department visits. The overall rate of emergency department visits for Medicare home health beneficiaries discharged from hospitals increased slightly, from 29 to 30 percent, from 2000 through 2003. Our analysis showed a slight increase in rates of emergency department visits for beneficiaries with at-risk diagnoses, including renal failure and heart failure. The rates of emergency department visits due to preventable adverse events remained low, at less than 1 percent.

CONCLUSION

Our analysis showed little overall change in hospital readmission rates and emergency department visit rates following the implementation of the home health PPS. This result suggests that the change in payment systems has not led to increased use of hospital and emergency department services.

At the same time, however, our analysis shows that beneficiaries with certain diagnoses, such as renal failure, pulmonary disease, and multiple sclerosis, had higher hospital readmission rates and more visits to emergency departments than other beneficiaries.

Consequently, it would be prudent to continue to monitor indicators of quality in home health care.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments to the draft report, CMS agreed with our findings of little change in hospital readmission and emergency department visit rates following the implementation of PPS. The agency also agreed with our observation that it would be prudent to continue monitoring indicators of quality in home health care. CMS stated that the results presented in the report will assist it in measuring and reporting on the performance of home health care.

We clarified the report background based on technical comments that CMS provided. The full text of CMS's comments is included as Appendix A.

▶ T A B L E O F C O N T E N T S

EXECUTIVE SUMMARY i

INTRODUCTION 1

FINDINGS 5

 Hospital readmission rates unchanged 5

 Minimal changes in emergency department visit rates..... 7

CONCLUSION 9

ENDNOTES 10

APPENDIX A: AGENCY COMMENTS..... 12

ACKNOWLEDGMENTS 15

OBJECTIVE

To determine how hospital readmission and emergency department visit rates for Medicare beneficiaries discharged from hospitals to home health care have changed since implementation of the home health prospective payment system (PPS).

BACKGROUND

The Home Health Prospective Payment System

Prior to 1997, Medicare paid for home health services under a cost-based system. That payment system created an incentive for home health agencies (HHA) to increase their Medicare revenues by delivering more services than necessary. From 1990 to 1997, Medicare's spending on home health services rose from \$3.7 billion to \$16.7 billion, and the number of HHAs increased from 5,730 to 10,807. In 1997, almost 3.6 million beneficiaries received home health services.¹

In response to this rapidly growing home health spending, Congress enacted the Balanced Budget Act of 1997 (BBA),² which required the Centers for Medicare & Medicaid Services (CMS) to implement a PPS for home health services by October 1, 1999. In 1999, Congress passed the Omnibus Consolidated and Emergency Supplemental Appropriations Act, delaying the implementation of home health PPS until October 1, 2000. The BBA also called for the implementation of an interim payment system (IPS), which revised the payment limits on home health services as a transition step to the new PPS. Beginning in October 1997, the IPS subjected Medicare HHAs to a new payment limit that was based on an aggregate per-beneficiary amount. This cap applied to an agency's total Medicare payments and did not limit payments for specific beneficiaries.

After implementation of the IPS, Medicare's spending on home health services fell to \$7.9 billion in 1999.³ By that same year, the number of HHAs decreased to about 7,830,⁴ and the number of beneficiaries receiving these services fell to 2.7 million.⁵

The home health PPS replaced the IPS on October 1, 2000. Under the PPS, agencies receive a payment for each 60-day episode of care. For calendar year 2005, the base payment for each episode is \$2,264.28. That base payment is adjusted by placing the beneficiary into 1 of 80 Home Health Resource Groups (HHRG), which reflect the clinical and functional severity of a beneficiary's condition and recent use of other

health services. In addition, the base rate is affected by wage adjustment factors (wage index) to account for area wage differences.

The Outcome and Assessment Information Set

The Outcome and Assessment Information Set (OASIS) is a clinical assessment tool that evaluates patients and measures outcomes through the use of 79 demographic, clinical, and functional data items. A registered nurse or rehabilitation therapy skilled professional conducts a comprehensive assessment of a beneficiary receiving home health services when specific events occur and at the end of each 60-day cycle of home health services. This assessment includes collection of OASIS data.^{6,7}

The OASIS serves two major purposes. First, the PPS uses the OASIS data to determine into which HHRG a beneficiary falls. Second, the OASIS provides a mechanism to monitor quality.

The OASIS captures information regarding hospital readmissions, visits to emergency departments, and adverse events that could cause a hospital readmission or emergency department visit. Adverse events include: (1) improper medication administration or side effects, toxicity, and anaphylaxis; (2) injury caused by a fall or accident at home; (3) wound infection, deteriorating wound status, and new lesion/ulcer; and (4) hypo/hyperglycemia or diabetes out of control.

Earlier Reports on the Effect of Home Health Payments on the Quality of Care

In 1999, OIG assessed how the IPS affected beneficiaries' access to home health care following discharge from hospitals. In that report, discharge planners volunteered concerns that some beneficiaries may not have received the care they needed under the IPS.⁸

In response to those concerns, OIG assessed the impact of the IPS on readmissions and emergency department visits. That report, released in 2000, found that these rates had decreased since implementation of the IPS in 1999.⁹

Concerns About Implementation of the Home Health PPS and Quality of Care

On its Home Health Compare Web site, CMS states that even with good home health care, beneficiaries may require readmission or an emergency department visit.¹⁰ Home Health Compare also advises beneficiaries that "some inpatient hospital care [and emergency care]

may be avoided if the home health staff is doing a good job at checking your health condition at each visit to detect problems early.”

The home health PPS creates a financial incentive to limit visits, thus raising questions about how often HHA staff check the health conditions of their patients. Increases in readmission rates or emergency department visits could indicate poor quality care. The incentive created by the PPS calls for a system to ensure that beneficiaries receive adequate visits.

CMS, the Government Accountability Office, and the Medicare Payment Advisory Commission (MedPAC) have stated that monitoring outcomes of care following implementation of the PPS is important because of incentives in the payment system to lower the level of services delivered.¹¹ MedPAC has also cautioned that the ambiguous definition of the home health benefit, along with the 60-day episode of care and broad range of services offered, can lead to greater opportunities for restricting care in home health than in other care settings.

METHODOLOGY

We based our analysis on a database created from the OASIS and the National Claims History (NCH) file. The NCH file incorporates 100 percent of home health claims, 100 percent of inpatient hospital claims, and 100 percent of outpatient hospital claims.

We identified all beneficiaries who began a new home health episode during a consistent 3-month period (April 1 through June 30) for each year (2000 through 2003). The 2000 data serve as our pre-PPS baseline. To qualify as a new home health episode, beneficiaries must have had no home health services billed to Medicare in the 60 days prior to the episode start date. After we identified these episodes, we used inpatient claims to limit the dataset to beneficiaries who had been discharged from hospitals within the 30 days prior to starting home health care.

For each episode, we used claims data to determine if the beneficiary had a readmission or an emergency department visit. We considered a readmission or emergency department visit to be associated with the episode if (1) it occurred during the initial 60-day home health episode of care, or (2) it occurred within 30 days after the initial episode. We extended the length of time to capture any beneficiary whose hospital readmission or emergency department visit occurred in the month immediately following the conclusion of his or her home health services.

We analyzed only the first readmission and/or emergency department visit for each home health episode. However, we calculated the readmission rate separately from the emergency department visit rate. Thus, if a beneficiary had both a readmission and an emergency department visit, we included each in the rate calculations.

For each year, we calculated hospital readmission and emergency department rates by dividing the number of beneficiaries who were discharged from the hospital and received home health services and who were readmitted to hospitals or visited emergency departments by the total number of beneficiaries receiving home health services.

We identified the primary diagnosis associated with each readmission and emergency department visit. We then calculated the percentage of those beneficiaries who had at-risk diagnoses¹² and the percentage who were readmitted and/or visited an emergency department due to preventable adverse events. To enable us to compare over time, we used the same International Classification of Diseases (ICD-9) and Diagnosis Related Groups (DRG) codes used in the 2000 OIG inspection. That report looked at numerous studies that analyzed the effects of the IPS and the adequacy of home health care to identify diagnoses and patient types that could have been at risk of receiving inadequate care.¹³

To parallel our previous inspection, we limited our analysis to Medicare beneficiaries who received home health services following hospitalization. During the period of our analysis, this population ranged from 64 to 66 percent of the universe of beneficiaries receiving home health services.¹⁴ Medicare has no prior hospitalization requirement for home health services, and beneficiaries come from nursing homes and the community as well as from hospitals.

We also limited our analysis to describing how the rates of hospital readmission and emergency department visits for Medicare beneficiaries who received home health services changed since implementation of the PPS. Our analysis does not address the cause of any changes.

We conducted this review 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

Hospital Readmission Rates Remained Unchanged

Overall hospital readmission rates for Medicare beneficiaries discharged from hospitals who received home health services remained unchanged from 2000 to 2003. In 2000, hospital readmission rates under IPS were about 47 percent. The readmission rates held steady from 2001 to 2003 after PPS replaced IPS. (See Table 1.)

Table 1					
Hospital Readmission Rates for Medicare Home Health Beneficiaries					
	2000	2001	2002	2003	Difference 2000–2003
Percentage of Medicare home health beneficiaries readmitted to the hospital	47%	47%	47%	47%	0%

Source: OIG analysis of National Claims History file data, 2005.

No consistent trend in hospital readmission rates by beneficiary diagnosis

Based on a previous OIG report that examined the effects of IPS and the adequacy of home health care,¹⁵ we included Medicare beneficiaries with the eight initial hospital diagnoses listed in Table 2 as at risk for receiving inadequate care. Our analysis showed no consistent trend in hospital readmission rates for beneficiaries with at-risk diagnoses from 2000 through 2003.¹⁶ While multiple sclerosis and pulmonary disease each showed 5 percentage point increases, diabetes and Alzheimer’s remained the same and dementia decreased by 1 percentage point.

Table 2					
Percentage of At-Risk Medicare Home Health Beneficiaries Readmitted to the Hospital					
Diagnosis and ICD-9 Code	2000	2001	2002	2003	Difference 2000–2003
Dementia – 294	19%	18%	17%	18%	-1%
Renal failure – 586	41%	46%	45%	45%	+4%
Diabetes – 250	27%	28%	28%	27%	0%
Alzheimer’s – 331	16%	17%	16%	16%	0%
Heart failure – 428	38%	38%	38%	38%	0%
Multiple sclerosis – 340	7%	12%	11%	12%	+5%
Pulmonary disease – 494	31%	33%	35%	36%	+5%
Quadriplegia – 344	20%	19%	22%	18%	-2%

Source: OIG analysis of National Claims History file data, 2005.

F I N D I N G S

We examined the five most common DRGs associated with Medicare beneficiaries who were readmitted to the hospital. The ranking of the five most common initial hospital DRGs for Medicare home health beneficiaries remained the same from 2000 through 2003. (See Table 3.) In addition, the rates of readmission for beneficiaries with those diagnoses remained stable.

Table 3 Highest Volume Diagnosis Related Groups for Medicare Home Health Beneficiaries Readmitted to Hospitals					
Initial Hospital Diagnosis and DRG*	2000	2001	2002	2003	Difference 2000–2003
Heart failure and shock – 127	8%	8%	7%	7%	-1%
Rehabilitation – 462	6%	7%	7%	7%	+1%
Simple pneumonia and pleurisy – 089	4%	4%	4%	4%	0%
Chronic obstructive pulmonary disease – 088	4%	4%	4%	4%	0%
Major joint and limb reattachment – 209	4%	4%	4%	4%	0%

* Refers to DRG for the first hospital admission.
Source: OIG analysis of National Claims History file data, 2005.

Stability in readmission rates for preventable adverse events

The OASIS dataset captures information on whether beneficiaries readmitted to the hospital needed care because of one of four adverse events: (1) improper medication administration, medication side effects, toxicity, and anaphylaxis; (2) injury caused by fall or accident at home; (3) wound infection, deteriorating wound status, and new lesion/ulcer; and (4) hypo/hyperglycemia or diabetes out of control. The readmission rate for wound infection is about 2 percent, and the rate for the other three adverse events is less than 1 percent. Readmission rates for two of the four adverse events remained the same and the other two changed by less than 0.2 percent from 2000 to 2003.

Minimal Changes in Emergency Department Visit Rates

The rate of emergency department visits for Medicare home health beneficiaries discharged from

hospitals increased slightly from 2000 to 2003. When Medicare reimbursed home health agencies under IPS in 2000, 29 percent of home health beneficiaries had an emergency department visit. After the PPS took effect, the percentage stayed the same in 2001 and 2002, but increased to 30 percent in 2003. (See Table 4.)

Table 4 Emergency Department Visit Rates for Medicare Home Health Beneficiaries					
	2000	2001	2002	2003	Difference 2000–2003
Percentage of Medicare home health beneficiaries with visits to emergency department	29%	29%	29%	30%	+1%

Source: OIG analysis of National Claims History file data, 2005.

Little change in rates of emergency department visits by beneficiary diagnosis

The percentages of home health beneficiaries with at-risk diagnoses who had an emergency department visit increased slightly from 2000 to 2003. Table 5 shows that four of the eight diagnoses increased by as little as 1 percent. Beneficiaries with renal failure had the largest increase, from 22 percent to 26 percent.

Table 5 Percentage of At-Risk Medicare Home Health Beneficiaries Who Made Emergency Department Visits					
Diagnosis and ICD-9 Code	2000	2001	2002	2003	Difference 2000–2003
Dementia – 294	13%	14%	13%	14%	+1%
Renal failure – 586	22%	28%	28%	26%	+4%
Diabetes – 250	18%	19%	19%	20%	+2%
Alzheimer’s – 331	11%	13%	12%	12%	+1%
Heart failure – 428	19%	22%	22%	22%	+3%
Multiple sclerosis – 340	9%	10%	9%	10%	+1%
Pulmonary disease – 494	19%	19%	20%	20%	+1%
Quadriplegia – 344	13%	15%	15%	15%	+2%

Source: OIG analysis of National Claims History file data, 2005.

F I N D I N G S

We examined the five most common DRGs associated with Medicare beneficiaries who visited the emergency department. The ranking of the five most common initial hospital diagnoses for Medicare home health beneficiaries changed slightly before and after the implementation of the PPS. The top four diagnoses remained the same. Specific cerebrovascular disorders (DRG 014) had the fifth-highest volume in 2000, although it dropped to sixth by 2003. In addition, the rates of emergency department visits for beneficiaries in the five diagnoses listed remained stable. (See Table 6.)

Table 6 Highest Volume DRGs for Medicare Home Health Beneficiaries With Emergency Department Visits					
Initial Hospital Diagnosis and DRG*	2000	2001	2002	2003	Difference 2000–2003
Rehabilitation – 462	7%	7%	7%	8%	+1%
Heart failure and shock – 127	7%	6%	6%	6%	-1%
Major joint and limb reattachment – 209	4%	5%	5%	5%	+1%
Simple pneumonia and pleurisy – 089	4%	4%	4%	4%	0%
Chronic obstructive pulmonary disease – 088	3%	4%	3%	4%	+1%

* Refers to DRG for the first hospital admission
Source: OIG analysis of National Claims History file data, 2005.

Stability in emergency department visit rates for preventable adverse events

The rates for emergency department visits due to the four measured preventable adverse events for home health beneficiaries remained stable from 2000 to 2003. The emergency department visit rates for all four adverse events were less than 1 percent. Emergency department visit rates for home health beneficiaries for two of the adverse events (wound infection and hypo/hyperglycemia) increased 0.1 percent in 4 years, while emergency department visit rates for the other two (improper medication administration and injury caused by fall or accident at home) remained the same.

► C O N C L U S I O N

Our analysis shows little overall change in hospital readmission rates and emergency department visit rates following the implementation of the home health PPS for beneficiaries discharged from hospitals. This result suggests that the change in payment systems has not led to increased use of hospital and emergency services.

At the same time, however, our analysis shows that beneficiaries with certain diagnoses are being readmitted to hospitals and visiting emergency departments to a greater extent than prior to the PPS. Most notably, beneficiaries with a primary diagnosis of renal failure showed increases in readmission rates and use of emergency departments. Beneficiaries with a primary diagnosis of pulmonary disease or multiple sclerosis also showed increased hospital readmission rates and, to a lesser degree, increased rates of emergency department usage.

Consequently, it would be prudent to monitor indicators of quality in home health care, such as readmission rates and use of emergency departments, on an ongoing basis.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments to the draft report, CMS agreed with our findings that there has been little change in hospital readmission rates and emergency department visit rates following the implementation of PPS. The agency also agreed with our observation that it would be prudent to continue monitoring indicators of quality in home health care in light of our analysis that showed that beneficiaries with certain diagnoses had higher hospital readmission rates and more visits to emergency departments than other beneficiaries. CMS stated that the results presented in the report will assist it in measuring and reporting on the performance of home health care.

We clarified the report background based on technical comments that CMS provided. The full text of CMS's comments is included as Appendix A.

▶ E N D N O T E S

¹ Centers for Medicare & Medicaid Services, “Health Care Financing Review: Medicare and Medicaid Statistical Supplement: 2001.”

² P. L. 105-33.

³ Centers for Medicare & Medicaid Services, “Health Care Financing Review: Medicare and Medicaid Statistical Supplement: 2001.”

⁴ <http://www.nahc.org/NAHC/LegReg/Crisis/hhasbystate.html>.

⁵ Centers for Medicare & Medicaid Services, “Health Care Financing Review: Medicare and Medicaid Statistical Supplement: 2001.”

⁶ 42 CFR 484.55(a)(1) and (2) Condition of Participation: Comprehensive assessment of patients.

⁷ These events and intervals are the start of care, end of each 60-day home health episode, time of a transfer to an inpatient facility, resumption of home health services after a hospitalization, hospital discharge, and death at home.

⁸ Department of Health and Human Services, Office of Inspector General, Final Report, “Medicare Beneficiary Access to Home Health Agencies,” OEI-02-99-00530, October 1999.

⁹ Department of Health and Human Services, Office of Inspector General, Final Report, “Adequacy of Home Health Services: Hospital Re-Admissions and Emergency Room Visits,” OEI-02-99-00531, September 2000.

¹⁰ www.medicare.gov/HHCompare/Home.asp, accessed August 1, 2005.

¹¹ Centers for Medicare & Medicaid Services’ PPS concerns found in the agency’s comments to the Department of Health and Human Services, Office of Inspector General’s Final Report, “Adequacy of Home Health Services: Hospital Re-Admissions and Emergency Room Visits,” OEI-02-99-00531, September 2000, p. 19.

Government Accountability Office's PPS concerns found in "Medicare Home Health: Prospective Payment System Will Need Refinement as Data Become Available," No. HEHS-00-9, April 2000.

Medicare Prospective Payment Assessment Commission's PPS concerns found in "Report to the Congress: Medicare Payment Policy," March 2004.

¹² A previous OIG report identified eight initial hospital diagnoses as at risk for receiving inadequate care (dementia, renal failure, diabetes, Alzheimer's, heart failure, multiple sclerosis, pulmonary disease, quadriplegia).

¹³ Department of Health and Human Services, Office of Inspector General, Final Report, "Medicare Beneficiary Access to Home Health Agencies," OEI-02-99-00530, October 1999.

Government Accountability Office, "Interim Payment System for Home Health Agencies," No. HEHS-98-234, August 6, 1998.

Government Accountability Office, "Closures Continue, With Little Evidence Beneficiary Access Is Impaired," No. HEHS-99-120, May 1999.

Medicare Prospective Payment Assessment Commission, "Report to the Congress: Post-Acute Care Providers: Moving Toward Prospective Payment," March 1999.

¹⁴ Department of Health and Human Services, Office of Inspector General, analysis of National Claims History file data 2004. (2000: 64%, 2001: 66%, 2002: 65%, 2003: 64%)

¹⁵ Department of Health and Human Services, Office of Inspector General, Final Report, "Adequacy of Home Health Services: Hospital Re-Admissions and Emergency Room Visits," OEI-02-99-00531, September 2000.

¹⁶ The ICD-9 codes from many of the beneficiaries in our 2000 data were missing. These omissions may explain some of the immediate changes in the percentages from the IPS in 2000 to PPS in 2001.

▶ A P P E N D I X A



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC 13 2005

TO: Daniel R. Levinson
Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D. *MM*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General Draft Report: "Effect of the Home Health
Prospective Payment System on the Quality of Home Health Care"
(OEI-01-04-00160)

2005 DEC 15 11 09:58
OFFICE OF INSPECTOR
GENERAL

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled, "Effect of the Home Health Prospective Payment System on the Quality of Home Health Care."

We appreciate the OIG's interest in the impact of the home health prospective payment system (HH PPS) on the quality of home health (HH) benefits. The analysis in the report shows little overall change in hospital readmission rates and emergency department visit rates following the implementation of the HH PPS. Consequently, OIG concludes that the change in payment system for home health agencies (HHAs) from the interim payment system to the HH PPS has not led to increased use of hospital and emergency department services. Also, the analysis does show that beneficiaries with certain diagnoses, such as renal failure, pulmonary disease, and multiple sclerosis, had higher hospital readmission rates (4 – 5 percent increase) and beneficiaries experiencing renal failure had more visits to emergency departments (an increase of 4 percent) than did other beneficiaries. The OIG concludes that it would be prudent to continue to monitor indicators of quality in HH care. We agree with that observation.

Through the Centers for Medicare & Medicaid Services' (CMS) contracts with the University of Colorado, Center for Health Services Research, the Outcome Assessment and Information Set (OASIS) was developed and is maintained. The OASIS assessment data for HH patients whose care is reimbursed by Medicare are required to be submitted as a Condition of Participation by Medicare-certified HHAs. Home Health Compare on the Medicare.gov Web site is based on OASIS data.

Page 2 – Daniel R. Levinson

The CMS has been working to reduce the cost and quality impacts of HH patients' rate of hospitalization for a number of years. Use of hospital resources (measured by hospital admissions) and urgent care are collected by OASIS, are displayed as rates for each HHA in Home Health Compare, and are a focus of the Nation's quality improvement organizations (QIOs) in their work with HHAs. Of particular note for CMS staff working on OASIS and with the QIO program is the difference in hospitalization rates cited in the OIG Draft Report (national average = 47 percent) and the national average rate of 28 percent reflected by OASIS data. We speculate that the difference is based on the sources of (and methodology for collecting) hospitalization rates. Two differences are key:

- 1) The CMS rate results from using only OASIS data; whereas, the OIG report used a combination of OASIS and claims (billing) data.
- 2) The OASIS hospitalization rate includes re-admissions and hospitalization of HH patients who were not hospitalized prior to home care; whereas, the OIG data include only patients re-admitted to a hospital from HH care. We would be interested in additional information on your findings.

In the future, we plan to link data from claims to our OASIS data. We expect that project will tell us much about how complete and accurate OASIS data alone can be presumed to be. Because an episode of care, rather than the entire HH experience of a patient, is the unit of measure used within OASIS and hospitalization can mark the end of an HH episode of care, the rate of hospitalization by HH patients may be impacted by how these data are defined and collected by the OASIS data collection tool.

Also of note to CMS are the disease-specific breakdowns of rates of hospitalization by HH patients. We would be interested to know what portion of HH patients who were hospitalized with each (hospital-assigned) diagnosis were being cared for at home for the same diagnosis. As CMS studies how process measures may be used in profiling the quality of HHAs, our intent is to assign priority to actions HHAs can take to monitor and care for patients with chronic conditions that are known to be ambulatory-sensitive. It seems quite plausible that hospitalization and the need for urgent care would decline as patient health status and functioning would improve with systematic attention to chronic conditions (such as heart failure and diabetes) that may or may not be the reason for referral to HH care. We are aware of no reason for the 2003 increase over the pre-PPS rate of re-hospitalization of patients with specific conditions such as renal failure, pulmonary disease, and multiple sclerosis. While we are aware that the average number of HH visits per episode of care has decreased under the PPS and the mix of services offered by various types of providers has also changed, why some patients with some chronic conditions would be affected differently than others is something we would need to investigate. CMS' Quality Measurement and Health Assessment Group's staff are exploring incorporation of immunization measures, as CMS recently has done to improve nursing home quality.

Page 3 – Daniel R. Levinson

The OIG report confirms that numbers remain small and rates are stable for adverse events that require a higher level of care. CMS remains concerned about improving patient safety and preventing adverse events in the home. Increased focus on patient transitions and coordination of care between care settings are priorities for post-acute care as a whole.

Again, we believe this report is favorable in that it concludes that little overall change in hospital readmissions rates and emergency department visit rates have occurred following the implementation of the HH PPS. The results presented in this report will assist us in how we measure and report on performance within this sector of health care. It will also contribute to the overall goal of improving HH care services. We want to thank the OIG for their efforts, and we will be advised as to the findings as we continue to monitor activities both under and related to the HH PPS. We look forward to working together with the OIG in the future as we continue to work towards ensuring that Medicare beneficiaries obtain the high quality services they are entitled to receive.

Attachment



A C K N O W L E D G M E N T S

This report was prepared under the direction of Joyce M. Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office, and Russell W. Hereford, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

Danielle Fletcher, *Project Leader*

Sandy Khoury, *Program Specialist*

Tricia Davis, *Director, Medicare and Medicaid Branch*

Technical Assistance

Scott Horning, *Program Analyst*