Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Access to Home Health Care After Hospital Discharge 2001

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EXECUTIVE SUMMARY

PURPOSE

To assess the effects of the prospective payment system on access to home health care for Medicare beneficiaries who are discharged from the hospital.

BACKGROUND

The Balanced Budget Act of 1997 (BBA) changed the way Medicare pays for home health care. The law changed reimbursement for home health services from a cost-based method to a prospective payment system of fixed, predetermined rates. To allow time for the Centers for Medicare and Medicaid Services to develop this system, the law mandated an interim payment system. On October 1, 2000, the prospective payment system replaced the interim payment system. This is the first report that looks at access to care under the prospective payment system.

This report is a follow-up to two previous Office of Inspector General inspections, *Medicare Beneficiary Access to Home Health Agencies, OEI-02-99-00530* and *Medicare Beneficiary Access to Home Health Agencies: 2000*, *OEI-02-00-00320.* Both reports found that hospital discharge planners can place most Medicare beneficiaries in home health care. In the most recent report, some discharge planners also noted that the placement process has changed and that some HHAs are asking for additional medical information about prospective patients.

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 home health care. We also analyzed the Provider of Services File and the National Claims History File.

FINDINGS

Medicare beneficiaries discharged from hospitals maintain access to home health care

The prospective payment system does not appear to limit access to home health care. Eighty-nine percent of discharge planners report that under the prospective payment system they can place all of their Medicare patients who need care in home

health agencies. Another 7 percent estimate they are able to place all but 1 to 5 percent of patients, and 4 percent put the estimate above 5 percent. Discharge planners gave similar responses last year. Discharge planners most commonly explain that patients whom they cannot place go to a nursing home, are sent home to be cared for by a family member, or stay in the hospital.

Medicare data support discharge planners' experiences. The data show that there are no large changes in the types of Medicare beneficiaries being discharged to HHAs in the last five years. Specifically, there are no substantial decreases in the 13 most common DRGs discharged to home health care between 1997 and 2001.

Availability of home health services seems to be sufficient, even though the number of agencies has decreased. The majority of discharge planners (83 percent) report that there are sufficient home health services available in their area for Medicare patients. Medicare data show that the number of agencies dropped by 32 percent, from 10,556 in 1997 to 7,175 in 2000.

Some patients experience delays associated with certain service needs

About one quarter of discharge planners reports that they experience delays at least sometimes when placing Medicare patients in home health agencies. Many discharge planners (61 percent) who report delays say that they are associated with medical conditions or service needs. Some explain that patients who need IV therapy may require expensive drugs that are not usually reimbursed under Medicare. These patients may also need frequent or continuous monitoring of their IV which may require multiple or long visits. Patients with wound care needs may also be delayed because they require many expensive supplies and frequent visits by home health staff.

Medicare data, however, show no large increases in the average hospital length of stay for Medicare beneficiaries discharged to HHAs. In fact, the average length of stay decreased for all but 2 of the 13 most common DRGs between 1997 and 2001.

CONCLUSION

The results this year are similar to the findings in our prior two inspections on access to home health care. We continue to find that Medicare beneficiaries discharged from hospitals have access to home health care. In addition, we find little evidence that the new prospective payment system that replaced the interim payment system limits beneficiaries' access to care. We encourage the Centers for Medicare and Medicaid Services to continue to monitor access to care and home health agencies' responses to the payment system.

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INTRODUCTION

PURPOSE

To assess the effects of the prospective payment system on access to home health care for Medicare beneficiaries who are discharged from the hospital.

BACKGROUND

This inspection is part of the Office of Inspector General's (OIG) continuing effort to monitor home health care. It examines the effects of the prospective payment system (PPS) on Medicare beneficiary access to care in response to concerns that changes to the payment system may affect the ability of home health agencies (HHAs) to serve Medicare beneficiaries. The OIG monitors HHAs' implementation of these payment changes to ensure that beneficiary access is not compromised. This is the first report that looks at access to care under the prospective payment system.

This report is a follow-up to two previous OIG inspections. In 1999, the Centers for Medicare and Medicaid Services (CMS) asked the OIG to assess the effects of the interim payment system (IPS) on access to home health care. In response, we completed two reports entitled, *Medicare Beneficiary Access to Home Health Agencies, OEI-02-99-00530* and *Medicare Beneficiary Access to Home Health Agencies: 2000*, *OEI-02-00-00320.* Both reports found that hospital discharge planners can place most Medicare beneficiaries in home health care. In the most recent report, some discharge planners also noted that the placement process has changed and that some HHAs are asking for additional medical information about prospective patients.

This inspection is part of a current series of four Office of Inspector General inspections about Medicare home health care. *Medicare Home Health Care- Beneficiaries from the Community, OEI -02-01-00070,* looks at access to home health care for Medicare beneficiaries who have not recently been in the hospital. *Medicare Beneficiary Experiences with Home Health Care, OEI-02-00-00560,* describes the experiences of Medicare beneficiaries who obtain and receive home health care. We are also conducting a study that examines physician practices in prescribing, certifying, and monitoring Medicare home health services. See Appendix A for a list of recent OIG reports relating to home health care.

Medicare Home Health Care

Home health services consist of part-time or intermittent skilled nursing, physical, occupational, and speech therapy, and certain related services, including social work and home health aide services, all furnished in a patient's home. Services are typically provided by registered nurses, therapists, social workers, or home health aides employed by or under contract to a home health agency. These agencies can be freestanding or hospital-based and are classified as not-for-profit, proprietary, or governmental.

Medicare will pay for home health care only if it is reasonable and necessary for the treatment of the patient's illness or injury. In order to be eligible for services, a beneficiary must be homebound, under the care of a physician who has established a plan of care, **and** need at least one of the following intermittent and not full time skilled services: skilled nursing care, physical therapy, speech language pathology or continued occupational therapy at the start of care. Occupational therapy alone does not constitute a skilled need. However, after care has begun and other skilled services are discontinued, continued occupational therapy is a skilled need. There are no specific limits on the number of visits or length of coverage and no co-payments or deductibles.

The Prospective Payment System

The Balanced Budget Act of 1997 (BBA) changed the way Medicare pays for home health care. The law changed reimbursement for home health services from a cost-based method to a prospective payment system of fixed, predetermined rates.

To allow time for the CMS to develop PPS, the BBA mandated an interim payment system (IPS) that was in effect from October 1997 to October 2000. The IPS intended to control aggregate costs of services provided to beneficiaries. It decreased the per-visit limits and subjected HHAs to a new payment limit based on an aggregate per-beneficiary amount. Medicare then paid HHAs the lower of either their actual costs, the aggregate per-beneficiary limit, or the aggregate per-visit limit.

Beginning October 1, 2000, PPS replaced IPS. Under PPS, home health agency payments are based on a 60-day episode, and are case-mix and wage adjusted. The case mix is based on data elements from a patient's medical assessment that incorporates the Outcomes and Assessment Information Set (OASIS), and the projected number of therapy hours. Upon receiving a referral, the home health agency performs an initial assessment using OASIS that converts the patient's condition into a numeric score for three areas: clinical severity, functional status, and service utilization. These scores are totaled and assigned a value, which correlates to a patient's home health resource group (HHRG), which are used to determine payment rates. There are 80 HHRGs representing the range of complexity of a patient's condition.

In general, HHAs are paid for a full 60-day episode even if the actual services are provided during a fewer number of days. HHAs typically receive two payments for each 60-day episode. At the beginning of an episode, HHAs submit a Request for Advanced Payment (RAP) that includes the HHRG. Upon receipt of the RAP, the home health agency receives 60 percent of the estimated base payment for the initial 60-day episode. At the end of the episode, the agency submits a "clean" claim that accurately details the services provided and receives the residual 40 percent of the payment. If a beneficiary is still eligible for care at the end of the first episode, the agency can begin a second 60-day episode. There is no limit to number of episodes that an eligible beneficiary can receive.

There are two types of outlier payments, a Partial Episode Payment and a Significant Change In Condition payment, that are made in addition to 60-day payments for episodes that incur unusually large costs. There is also a Low Utilization Payment Adjustment for episodes that include four or fewer visits. These are described in more detail below.

The Partial Episode Payment (PEP). The PEP adjustment occurs when 1) a beneficiary elects to transfer to another HHA, or 2) a beneficiary is discharged and returns to the same HHA. The original episode payment is proportionally adjusted to reflect the length of time the beneficiary remains under the agency's care before the intervening event.

Significant Change In Condition (SCIC). The SCIC is the proportional payment adjustment that occurs when a patient experiences a significant change in condition that was not envisioned in the original plan of care. In order to receive a new case-mix assignment for purposes of SCIC payment, the HHA must complete an OASIS assessment and obtain the necessary physician orders reflecting the significant change in treatment approach.

Low Utilization Payment Adjustment (LUPA). The HHAs receive less than the full 60-day episode rate if they provide four or fewer visits to a beneficiary. For these episodes, HHAs are paid the standardized, service-specific per-visit amount multiplied by the number of visits actually provided during the episode.

Trends in Medicare Home Health Care

After a history of increases, Medicare home health expenditures have decreased since 1998. Between Fiscal Years 1991 and 1997, home health care annual expenditures rose from $4.7 billion to $17.6 billion. This was due to an increase in both number of beneficiaries receiving home health services and the number of visits they received. In 1998, however, spending for home health services began to drop and in Fiscal Year 1999 was $8.7 billion.

A number of factors have contributed to the recent decrease in Medicare home health spending. These include the prospective payment limits created by the Balanced Budget Act of 1997 as well as several initiatives that were implemented in response to concerns about fraud and abuse. Specifically, the Health Insurance Portability and Accountability Act substantially increased financial support to the OIG's fraud control efforts.

Other Changes to Medicare Home Health Care

Medicare home health care has experienced a number of other changes in recent years. One significant change is in the coverage rules for vancomycin and venipuncture. As of September 1996, Medicare discontinued payment for infusion pump delivery of vancomycin, a popular broad spectrum antibiotic used in IV therapy. Medicare covers IV drugs only when there is a medical necessity for them to be administered by an external infusion pump, and there was insufficient evidence to support the necessity of a pump to administer this antibiotic. Additionally, as of February 1998, a patient's need for venipuncture no longer constituted a qualifying skilled need. Prior to this change, patients whose only skilled need was venipuncture qualified for home care.

The clarification of the definition of homebound is another recent change to Medicare home health rules. There were some concerns about the ambiguity of the definition and the potential to deny benefits to eligible beneficiaries who are able to leave their home occasionally. In response, the Benefits Improvement and Protection Act of 2000 (BIPA) clarified the definition, stating that a person can leave his or her home for certain purposes such as attending adult day care activities or religious services and still qualify for Medicare home health services.

Finally, a January 1999 special OIG fraud alert that addressed the role of physicians in certifying services also affected Medicare home health. Physicians were cautioned in the fraud alert not to: 1) prescribe services and items as a courtesy to a patient or service provider, nor prescribe medical equipment, without first making a determination of medical necessity; 2) knowingly or recklessly sign false or misleading medical certifications; and 3) accept kickbacks in return for their signature.

Related Work

Three recent reports focus on the effects of IPS on Medicare beneficiary access to home health care. In 1999, the GAO released a report entitled *Medicare Home Health Agencies; Closures Continue, With Little Evidence Beneficiary Access is Impaired*. The GAO found that although about 14 percent of HHAs closed since 1997, there is little evidence that appropriate access to care has been impaired. Additionally, interviews with stakeholders in counties that had significant closures indicate few access problems. The interviews suggested, however, that as HHAs change their operations in response to IPS,

beneficiaries who are likely to be costlier than average to treat may have increased difficulty obtaining home health care.

A two-phase study conducted by George Washington University Medical Center in 1999 also examined the effects of IPS on access to care. The first phase found that the majority of HHAs participating in a study in eight States altered their case mix and/or practice based on IPS reimbursement. Diabetics, beneficiaries with intensive care needs, and chronically ill beneficiaries appeared to be most affected by IPS.

The second phase of the study interviewed hospital discharge planners in eight States and found that most of them reported increased difficulty in obtaining home health services for Medicare beneficiaries. Most attributed these difficulties to changes in admitting patterns by HHAs, changes in staffing patterns, or the effects of agency closures in their service area. Respondents reported that beneficiaries most affected by these changes were those with short-term, high-intensity needs or chronic diseases, and/or those needing complex wound care or two visits a day.

A third report, *Access to Home Health Services* conducted by the Medicare Payment Advisory Commission (MedPAC) analyzed health claims data, surveyed home health agencies, and convened a panel discussion with individuals familiar with access problems. The report found that many HHAs have adopted new admission and discharge practices since IPS was implemented. The HHAs reported that they are avoiding high-cost patients. They most frequently identified long-term or chronic-care patients as those they no longer admit or have discharged as a result of IPS.

In 2000, the GAO released two studies on PPS. *PPS Could Reverse Recent Declines in Spending* found that program controls may be inadequate and lead to overpayments and increased program spending. The other, *Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available*, found that although the CMS's research and demonstration projects have proven useful in designing PPS, information gaps remain that could lead Medicare to overpay for unnecessary services or underpay for required care. The report suggests that these consequences may result in beneficiaries facing access problems or receiving poor quality of care.

METHODOLOGY

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

Discharge Planner Interviews

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 directors of discharge planning or their designees within a 3 week period between April 2, 2001 and April 20, 2001. We achieved a 92 percent response rate. This sample of hospitals is the same as the one used in the OIG inspection, *Medicare Beneficiary Access to Skilled Nursing Facilities: 2001*, *OEI-02-01-00160.*

Analysis of Medicare Data

We also conducted several analyses of Medicare data. First, we reviewed trends in the number of HHAs using the Provider of Services (POS) File. Second, we analyzed Medicare data for beneficiaries who were discharged from a hospital to home health care. Specifically, we analyzed the proportion of Medicare beneficiaries discharged to home health care by key diagnosis related group (DRG) to determine the extent to which HHAs 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 being admitted to HHAs.

These analyses are based on data from the National Claims History File. We identified all beneficiaries who: 1) had a home health claim in the first quarter of 2001, and; 2) had a hospital discharge within 15 days prior to their home health claim. We then compared these data to the same data for beneficiaries who met these criteria for the first quarter of 1997, 1998, 1999, and 2000. Note that this definition is the same as the one used in the inspection, *Medicare Home Health Care - Beneficiaries from the Community, OEI-02-01-00070*.[1]

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.

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[1] This definition differs from the one used in the prior two OIG inspections on access to home health. These studies were based on data for all beneficiaries who were discharged from a hospital in the first quarter of each year and who had a home health claim within 30 days of discharge.

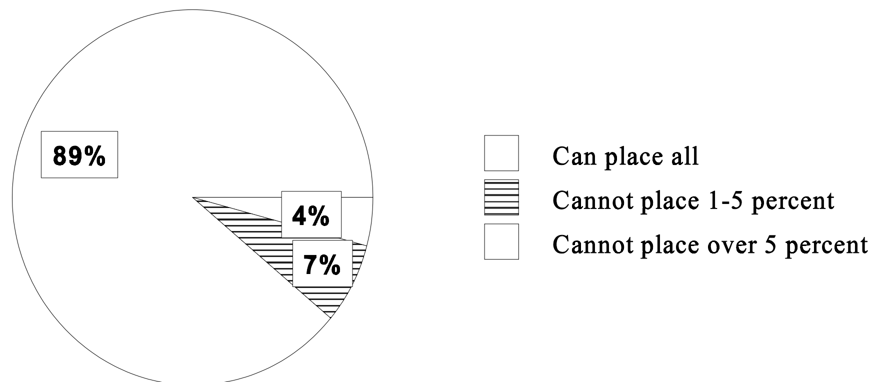
FINDINGS

Medicare beneficiaries discharged from hospitals maintain access to home health care

PPS does not appear to limit access to home health care

Eighty-nine percent of discharge planners report that under PPS they can place all of their Medicare patients who need care in home health agencies. Another 7 percent estimate they are able to place all but 1 to 5 percent of patients, and 4 percent put the estimate above 5 percent. (See Figure 1). Most discharge planners (90 percent) also report no change in the number of patients whom they cannot place since last October when PPS was implemented. Discharge planners most commonly explain that patients whom they cannot place go to a nursing home, are sent home to be cared for by a family member, or stay in the hospital.

Figure 1
Proportion of Discharge Planners Placing Patients in HHAs



Source: Discharge Planner Survey, 2001

We looked at several factors that may affect access to care and found no large differences. Specifically, discharge planners in urban and rural hospitals are able to place Medicare beneficiaries in home health care at similar rates. There are also no differences in the proportion of discharge planners from hospitals with affiliated HHAs and those without affiliations who can place all of their Medicare patients. Further, discharge planners' ability to place Medicare beneficiaries under PPS is similar to that of discharge planners last year under the interim payment system.

Medicare data support discharge planners' experiences. The data show that there are no large changes in the types of Medicare beneficiaries being discharged to HHAs 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. With one exception, there are no substantial decreases in the 13 most common DRGs discharged to HHAs between 1997 and 2001.[2] These 13 DRGs represent about 43 percent of all beneficiaries discharged to home health care. (See Appendix C.)

Medicare data also suggest that beneficiaries who are discharged from hospitals have access to care. The data show that beneficiaries receiving home health care are increasingly coming from the hospital as opposed to the community. In 2000, almost half of Medicare beneficiaries in home health care came from a hospital within 15 days of their discharge. Another 14 percent came from a SNF, while the remaining 38 percent came from the community. Between 1998 and 2000, the number of beneficiaries coming from the hospital increased by 3 percent, whereas those coming from the community decreased by 10 percent.

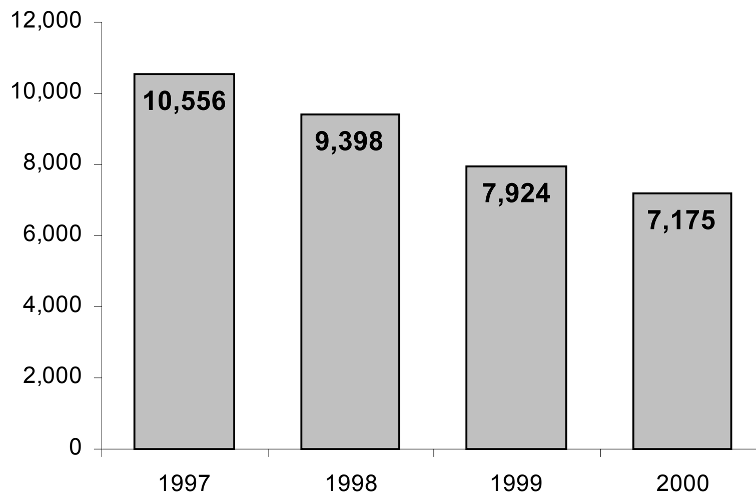
Availability of home health services seems to be sufficient, even though the number of agencies has decreased

The majority of discharge planners (83 percent) report that there are sufficient home health services available in their area for Medicare patients. About 63 percent note that the availability of services is about the same as last year under the interim payment system. Discharge planners also report that they need to contact an average of 1 to 2 agencies to place a patient, about the same number discharge planners reported last year.

At the same time, there continues to be a decline in the number of home health agencies in some areas. About one third of discharge planners say that there is a decrease in the availability of home health services since last year. Medicare data support these observations and show that the number of HHAs nationwide has decreased. As shown in Figure 2, the number of agencies dropped by 32 percent, from 10,556 in 1997 to 7,175 in 2000.

[2] The proportion of beneficiaries in DRG 106 decreased by 2.4 percentage points due to a change in the definition of that DRG that occurred in 1998.

Figure 2
Number of Home Health Agencies, 1997-2000



Source: Provider of Services File

Some patients experience delays associated with certain service needs

About one quarter of discharge planners report that they experience delays at least sometimes when placing Medicare patients in home health agencies.[3] About 22 percent also note that the number of delays have increased since last October when PPS was implemented. These responses are similar to those given by discharge planners last year under the interim payment system.

Many discharge planners (61 percent) who report delays say that they are associated with certain medical conditions or service needs. They most frequently note that patients who need IV antibiotics and/or expensive drugs and those who require wound care are delayed. Several also report that delays are associated with conditions requiring multiple visits per day. These are the same medical conditions and service needs discharge planners describe for beneficiaries who they cannot place.

[3] A placement delay occurs when a patient is medically cleared by a doctor but no home health services have been arranged.

Medicare data, however, show no large increases in the average hospital length of stay for Medicare beneficiaries discharged to HHAs. In fact, the average length of stay decreased for all but 2 of the 13 most common DRGs between 1997 and 2001.[4] Specifically, the average length of stay decreased by 2.2 days and 1.1 days for rehabilitation and specific cerebrovascular disorders, respectively and by less than one day for all the other DRGs. (See Appendix D.)

About half of discharge planners who report that delays are associated with medical conditions or service needs attribute these delays to PPS. Some explain that patients who need IV therapy may require expensive drugs that are not usually reimbursed under Medicare. These patients may also need frequent or continuous monitoring of their IV which may require multiple or long visits. Patients with wound care needs may also be delayed because they require many expensive supplies and frequent visits by home health staff.

Some discharge planners also attribute delays to staffing issues. They observe that HHAs do not have enough skilled nurses or home health aides to provide necessary services. A few discharge planners note that staffing shortages are a problem in rural areas where staff have to travel long distances to reach beneficiaries. Additionally, a few explain that some patients experience delays because HHAs cannot afford to pay staff under PPS to provide care for patients with certain conditions.

Finally, discharge planners mention several other factors that affect the placement process. About 40 percent report that HHAs have changed their admissions practices since PPS was implemented last October. Many explain that HHAs are requesting more information about patients and screening patients before making admission decisions. Some also note that HHAs are conducting more thorough evaluations in order to assess whether a patient has a skilled need and is eligible for Medicare. In addition, some discharge planners mention that HHAs are putting more emphasis on teaching family members and others to provide care and that finding individuals willing to be trained is often difficult.

[4] The average length of stay for beneficiaries in DRG 106 and 107 increased but this may be due to a change in the definition of these DRGs that occurred in 1998.

CONCLUSION

The results this year are similar to the findings in our prior two inspections on access to home health care. We continue to find that Medicare beneficiaries discharged from hospitals have access to home health care. In addition, we find little evidence that the new prospective payment system that replaced the interim payment system limits beneficiaries' access to care. We encourage the Centers for Medicare and Medicaid Services to continue to monitor access to care and home health agencies' responses to the payment system.

APPENDIX A

Recent Office of Inspector General Home Health Inspections

Office of Inspector General, U.S. Department of Health and Human Services, "Medicare Beneficiary Experiences with Home Health Care," OEI-02-00-00560, July 2001.

Office of Inspector General, U.S. Department of Health and Human Services, "Medicare Beneficiary Access to Home Health Agencies: 2000," OEI-02-00-00320, September 2000.

Office of Inspector General, U.S. Department of Health and Human Services, "Adequacy of Home Health Services: Hospital Readmission and Emergency Room Visits," OEI-02-99-00531, September 2000.

Office of Inspector General, U.S. Department of Health and Human Services, "Medicare Home Health Agency Survey and Certification Deficiencies," OEI-02-99-00532, September 2000.

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

APPENDIX B

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	
89 percent report they can place all of their Medicare patients with home health care under PPS.	208	89%	±4.4%
90 percent report no change in the number of patients whom they cannot place since last October when PPS was implemented.	206	90%	±4.1%
The majority of discharge planners (83 percent) report that there are sufficient home health services available in their area for Medicare patients.	208	83%	±5.1%
About 63 percent note that the availability of services is about the same as last year under the interim payment system.	208	63%	±6.6%
About one quarter of discharge planners (23%) report that they experience delays at least sometimes in placing Medicare patients in home health care.	208	23%	±5.7%
22 percent note that delays have increased since last October when PPS was implemented.	206	22%	±5.7%
Many discharge planner (61 percent) who report delays say that they are associated with certain medical conditions or service needs.	135	61%	±8.2%
About half of discharge planners who report that delays are associated with service needs attribute these delays are because of PPS.	83	57%	±10.7%
About 40 percent of discharge planners report that HHAs have changed their admissions practices since PPS was implemented last October.	208	40%	±6.6%

APPENDIX C

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

Initial Hospital DRG	1997	1998	1999	2000	2001	1997-2001 Difference
DRG 106-Coronary bypass with PTCA*	2.5%	2.3%	0.1%	0.1%	0.1%	-2.4
DRG 079- Respiratory infections and inflammations	1.7	1.3	1.2	1.1	1.0	-0.8
DRG 014- Specific cerebrovascular disorders	3.3	2.9	2.8	2.7	2.7	-0.6
DRG 148- Major small and large bowel procedures	2.1	2.0	1.8	1.8	1.8	-0.3
DRG 088- Chronic obstructive pulmonary disease	4.2	4.9	5.1	4.6	4.1	-0.1
DRG 121- Circulatory disorders w/acute myocardial infarction & major complications	1.8	1.7	1.8	1.7	1.7	-0.1
DRG 089- Simple pneumonia and pleurisy	4.9	6.1	6.5	6.2	4.9	0.0
DRG 127- Heart failure and shock	6.7	6.9	6.8	6.7	6.8	0.1
DRG 296- Nutritional and misc. metabolic disorders	1.5	1.5	1.6	1.7	1.6	0.1
DRG 107- Coronary bypass with cardiac catheterization*	1.6	1.5	2.1	2.1	2.1	0.5
DRG 209- Major joint and limb reattachment procedures of lower extremity	4.5	4.5	4.4	4.4	5.2	0.7
DRG 116-Other permanent cardiac pacemaker implant or PTCA with coronary artery stent implant*	0.8	1.6	1.6	1.7	1.7	1.0
DRG 462- Rehabilitation	7.1	6.9	7.8	8.5	9.1	2.0

Source: National Claims History File

*Note: In 1998, the CMS reclassified DRG 107 as DRG 106, coronary bypass with cardiac catheterization. DRG 109 was classified as coronary bypass without catheterization, formerly DRG 107. DRG 106 was classified as coronary bypass with PTCA. Under DRG 116, PTCA with coronary artery stent implant replaced AICD lead or generator procedure.

**Note: Differences may be due to rounding.

APPENDIX D

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

Initial Hospital DRG	1997 Days	1998 Days	1999 Days	2000 Days	2001 Days	1997-2001 Difference
DRG 462- Rehabilitation	16.6	15.4	15.4	15.1	14.4	-2.2
DRG 014- Specific cerebrovascular disorders	10.3	9.6	9.4	9.5	9.1	-1.1
DRG 209- Major joint and limb reattachment procedures	6.5	6.1	6.0	5.9	5.7	-0.8
DRG 121- Circulatory disorders w/acute myocardial infarction & major complications	9.6	9.4	9.2	9.1	8.8	-0.8
DRG 148- Major small and large bowel procedures	14.2	13.6	13.8	13.9	13.6	-0.6
DRG 089- Simple pneumonia and pleurisy	8.6	8.3	8.2	8.2	8.1	-0.5
DRG 296- Nutritional and misc. metabolic disorders	7.3	7.1	7.1	7.0	7.0	-0.3
DRG 127- Heart failure and shock	7.8	7.6	7.6	7.5	7.5	-0.3
DRG 088- Chronic obstructive pulmonary disease	8.3	7.8	7.9	8.0	8.0	-0.3
DRG 116-Other permanent cardiac pacemaker implant or PTCA w/coronary artery stent implant*	7.6	7.4	7.4	7.4	7.4	-0.3
DRG 079- Respiratory infections and inflammations	11.1	11.0	11.1	11.5	11.0	-0.1
DRG 106-Coronary bypass with PTCA*	11.7	11.4	12.2	12.1	12.2	0.4
DRG 107- Coronary bypass with cardiac catheterization*	9.1	8.6	11.2	11.1	11.2	2.1

Source: National Claims History File

*Note: In 1998, the CMS reclassified DRG 107 as DRG 106, coronary bypass with cardiac catheterization. DRG 109 was classified as coronary bypass without catheterization, formerly DRG 107. DRG 106 was classified as coronary bypass with PTCA. Under DRG 116, PTCA with coronary artery stent implant replaced AICD lead or generator procedure.

**Note: Differences may be due to rounding.