Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Adequacy of Home Health Services: Hospital Re-Admissions and Emergency Room Visits

JUNE GIBBS BROWN
Inspector General

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OFFICE OF INSPECTOR GENERAL

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OEI's New York regional office prepared this report under the direction of John I. Molnar, Regional Inspector General, and Renee C. Dunn, Deputy Regional Inspector General. Principal OEI staff included:

REGION

Ellen Vinkey, *Project Leader*
Judy Lin

HEADQUARTERS

Brian Ritchie, *Director, Technical Support Staff*
Tricia Davis, *Program Specialist*
Barbara Tedesco, *Mathematical Statistician*

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EXECUTIVE SUMMARY

PURPOSE

To determine if hospital re-admission and emergency room visit rates for Medicare patients discharged from the hospital to home health care have increased since the implementation of the home health interim payment system.

BACKGROUND

The Health Care Financing Administration has asked the Office of Inspector General to assess whether hospital re-admission rates and emergency room visits for Medicare home health patients have increased since the implementation of the interim payment system. The Health Care Financing Administration made this request in response to a recent Office of Inspector General study entitled *"Medicare Beneficiary Access to Home Health Agencies"* (OEI-02-99-00530). In that study, most hospital discharge planners reported that they were generally able to place Medicare beneficiaries with home health agencies; however, some discharge planners volunteered their concern that some of their patients may not be getting the care they need once they are placed. Two of the changes that hospital discharge planners cite as indications that patients may not be getting the home health care they need are higher hospital re-admission rates and increasing use of hospital emergency rooms. This inspection follows up on those concerns. It is part of a series of inspections that the Office of Inspector General has conducted on home health care.

For this study, we analyze Health Care Financing Administration claims data for all Medicare beneficiaries discharged from a hospital to home health care in early 1997 and for an analogous period in 1999.

FINDINGS

Hospital Re-Admissions and Emergency Room Visits for Home Health Patients Have Decreased

Comparing the first 2 months of 1997 and 1999, we found that the percentage of Medicare patients who were re-admitted to the hospital or visited an emergency room has not increased since the implementation of the interim payment system.

Hospital Re-admission and Emergency Room Visit Rates For Home Health Patients Before and After Interim Payment System

	1997	1999
Hospital Re-admission Rate	41.2%	37.8%
Emergency Room Visit Rate	21.9%	19.0%

Source: National Claims History File

In fact, the percentage has decreased. We looked for other changes for this population. We found that the average length of home health episodes for Medicare patients discharged to home health care has decreased by 41 percent since the implementation of the interim payment system. We also found that the number of Medicare patients discharged to home health care declined by 23 percent. However, many other characteristics of this population have not changed. We found home health patients do not differ pre- and post- interim payment system in terms of age, sex, race, and hospital length of stay.

We also compared these patients to the general Medicare population. We found that re-admission rate changes pre- and post- interim payment system for home health patients are consistent with those for the general population.

Re-Admission Rates Do Not Vary By Diagnoses

The re-admission rates for both high volume and frequently re-admitted diagnoses have not increased since the implementation of the interim payment system. The re-admission ranking for the five most common diagnoses associated with patients who get re-admitted to the hospital has remained relatively constant pre- and post- interim payment system. Not surprisingly, in both 1997 and 1999, these high volume re-admission diagnoses are very similar to those of patients most likely to get home health care upon discharge from the hospital. They include heart failure, stroke, and pneumonia. Patients with cancer-related diagnoses are the most likely to be re-admitted to the hospital both pre- and post-interim payment system. We also compared hospital re-admission rates for patients in diagnoses that a number of recent studies identified as patient types which may be at-risk of receiving inadequate care. We found no significant increases in the percentage of patients re-admitted in at-risk diagnoses.

Emergency Room Visit Rates Do Not Vary By Diagnoses

For the majority of high volume and frequent emergency room visit diagnoses, the emergency room visit rates have not increased since the implementation of the interim payment system. The ranking for the five most common diagnoses associated with patients who visit the emergency room has remained relatively constant pre- and post-interim payment system. Home health patients most likely to visit the emergency room covered a broader range of diagnoses than those likely to be re-admitted to the hospital. However, patients with respiratory illnesses and those with kidney and urinary tract diagnoses show up at the top of this list in both 1997 and 1999. We also found no significant increase in the rate at which patients in at-risk diagnoses visited the emergency room pre- and post- interim payment system. Seven of the eight at-risk diagnoses we looked at show no increase in emergency room visits rates between 1997 and 1999.

Agency Comments

The Health Care Financing Administration provided comments on this and two related draft reports. They note that our finding that re-admissions and ER visits have declined is an indicator of stability in home care under the interim payment system. They also note that on October 1, 2000, the new prospective payment system for home health care will go into effect. They, like we, will monitor care under the new system. The Health Care Financing Administration's comments are in Appendix B.

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INTRODUCTION

PURPOSE

To determine if hospital re-admission and emergency room visit rates for Medicare patients discharged from the hospital to home health care have increased since the implementation of the home health interim payment system (IPS).

BACKGROUND

The Health Care Financing Administration (HCFA) has asked the Office of Inspector General (OIG) to assess whether hospital re-admission rates and emergency room visits for Medicare home health patients have increased since the implementation of the interim payment system (IPS). The HCFA made this request in response to a recent OIG study entitled *"Medicare Beneficiary Access to Home Health Agencies"* (OEI-02-99-00530). In that study, most hospital discharge planners reported that they were generally able to place Medicare beneficiaries with home health agencies; however, some discharge planners volunteered their concern that some of their patients may not be getting the care they need once they are placed. Two of the changes that hospital discharge planners cite as indications that patients may not be getting the home health care they need are higher hospital re-admission rates and increasing use of hospital emergency rooms. This inspection follows up on those concerns. It is part of a series of inspections that the OIG has conducted about home health care. (See Appendix A.)

Medicare Home Health Care

Home health care services consist of skilled nursing, therapy (physical, occupational, and speech) and certain related services, including 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 with a home health agency (HHA). These agencies can be free-standing or provider-based and 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 for a beneficiary to qualify for Medicare coverage of home health services, he/she must be confined to home, require at least one skilled service, and be under the care of a physician who has established a plan of care. Skilled services are defined as intermittent skilled nursing services, physical therapy, speech therapy, and a continued need for occupational therapy.

During much of the 1990s, Medicare spending for home health services increased

substantially. From 1990 to 1997, expenditures rose from $3.7 billion to $17.8 billion. This resulted from both an increase in the number of beneficiaries who received home health services and an increase in the number of visits they received. In 1999, Medicare spending for home health services was about $9.5 billion.

Beginning in 1995, several initiatives were implemented to address concerns about fraud and abuse, and to control the costs of Medicare home health. These included the creation of an anti-fraud campaign entitled Operation Restore Trust, changes to Medicare participation rules designed to screen out problem providers, and, most recently, payment limits created by the Balanced Budget Act of 1997.

The Balanced Budget Act of 1997

The Balanced Budget Act of 1997 changes the way Medicare pays for home health care. The law requires a payment change from a cost-based method to a prospective payment system (PPS) of fixed, predetermined rates for home health services. The HCFA has proposed a national 60-day episode payment which will be case-mix adjusted based on the patient's medical assessment and the projected number of therapy hours needed in the 60-day episode.

Until this PPS is developed, however, home health agencies are reimbursed under an interim payment system which imposes payment limits on their services. The IPS was implemented on October 1, 1997 and will continue to be in place until PPS begins on October 1, 2000. The IPS is intended to control the aggregate costs of services provided to beneficiaries. In addition to reducing the per-visit limit, it subjects Medicare HHAs to a new payment limit that is based on an aggregate per-beneficiary amount; this cap is applied to an agency's total Medicare payments and does not limit payments for specific beneficiaries. The Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 moderated the restrictiveness of IPS. This legislation made several changes to the payment limits, including increasing the per-visit limits for all agencies and increasing the aggregate beneficiary limit for certain agencies. In that same year, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, which delayed a 15 percent payment reduction to be imposed with the implementation of PPS and increased payments under IPS to certain agencies.

Under IPS, agencies can use several methods to keep costs below their payment limits, including balancing their mix of low and high cost patients, reducing their costs overall, and increasing their proportion of low-cost patients.

As part of the conditions of participation, home health agencies must use a new home health agency data collection system called the Outcome and Assessment Information Set (OASIS). All HHAs have been required to collect OASIS data on all patients receiving skilled care, regardless of payment source, since July 1999. The OASIS data elements focus primarily on the patient's medical status and include socio-demographic, environmental, support systems, health status, and functional status information on each patient. Information on hospital re-admissions and emergency room visits is also

captured. The OASIS can be used by home health agencies to determine patients treatment needs, develop the plan of care, and monitor quality of care.

Related Studies

As a follow-up to our recent OIG inspection, "Medicare Beneficiary Access to Home Health Agencies," we contacted a number of the discharge planners who had expressed concerns about the adequacy of home health services. We asked them to elaborate on their concerns regarding hospital re-admissions and emergency room visits. Most of the discharge planners we spoke to indicated that between 5 and 35 percent of their Medicare patients are not getting the amount of home care they need or the duration of services needed. A few discharge planners indicated that they were particularly concerned about diabetic patients and those who had suffered a stroke. These discharge planners told us that when they see HHA patients re-admitted to the hospital it is usually during their home health services or within one month of their discharge from the HHA.

In addition to our recent inspection report, "Medicare Beneficiary Access to Home Health Agencies," several other studies have been released recently that discuss adequacy and access to home health care. A General Accounting Office report found that overall beneficiary access has not been affected by recent agency closures but did suggest that, as agencies change their operations in response to IPS, beneficiaries whose treatment costs are higher than average may have increasing difficulty obtaining home health care.

Also, the Medicare Payment Advisory Commission (MedPAC) reported the following: a decline in the number of home health agencies; concerns about impaired access; and, abrupt home health discharges for patients with expensive care needs. MedPAC notes, however, that IPS is only one factor of many that may be affecting access to care.

A George Washington University study reported that agencies are altering admissions standards, reducing clinical and administrative staff, and chronically ill patients are experiencing greater fragmentation and disruption of care. Over 40 percent of discharge planners surveyed reported an increase in hospital readmission rates for Medicare patients within 30 days of discharge to an HHA. They attributed this trend to "insufficient intensity or duration of home health care services either resulting from direct efforts by home health agencies to control individual patient costs or the indirect results of general staffing cuts to reduce costs."

A study by the Institute for Health Care Research and Policy at Georgetown University found that similar patients with greater use of home care services are more likely to experience health improvements than those with low home care utilization.

Finally, HCFA has completed two PPS demonstration projects. The latest, which looks at per-episode payments, found no evidence that quality of care, as measured by patient outcomes, had been adversely affected by the per-episode PPS demonstration. It also found that the per-episode PPS demonstration substantially reduced the number of home visits without increasing the use of other Medicare services. Based on an analysis of

claims data, HCFA found lower usage of emergency rooms by per-episode PPS patients and no significant differences in institutional admissions for a diagnosis related to the home health diagnosis. The report therefore concluded that a per-episode based home health prospective payment system could reduce Medicare costs without harming quality of care.

METHODOLOGY

Using HCFA's National Claims History data, we identified **all** Medicare beneficiaries who: 1) were discharged to home health care from a hospital between January 1, 1997, and February 28, 1997; and, 2) had a home health episode that started within 30 days of their hospital discharge. We also identified patients who met this criteria for an analogous period in 1999, allowing us to evaluate two comparable time periods pre- and post-IPS. For both years, we summarized beneficiary claims data from the National Claims History file to establish home health service begin and end dates for each beneficiary. When a gap of greater than 30 days existed between a home health claim "service thru date" and the "begin date" on the following claim for a given beneficiary, we considered this to be the end of the beneficiary's home health episode.

Hospital Re-admit And Emergency Room Analysis

For beneficiaries in each of these two groups we analyzed beneficiary claims history data for the period that they received home health care, as well as the 30 days following their HHA discharge. For beneficiaries whose home health episode continued beyond August 31st, we analyzed claim history data through August 31st[1]. In cases where a beneficiary had multiple hospital discharges, re-admissions or emergency room visits, during our sampling time frame, only the first hospital discharge and "post-hospital event" were included in our analysis. We compared hospital re-admission and emergency room visit rates pre- and post-IPS. In this comparison, we calculated the overall re-admission and emergency visit rates for sample Medicare beneficiaries and looked for any differences. In addition, we calculated these rates for a number of sub-groups including, for example, different patient diagnosis and beneficiaries by State.

Patient Profile Analysis

In order to gain a better understanding of any pre- and post-IPS rate differences, we looked at a number of different variables to develop a profile of the two groups. For example, we looked at whether the pre- and post-IPS groups differed significantly in terms of their diagnoses or hospital length of stay prior to their discharge. Using information from HCFA's Enrollment database, we also compared beneficiary variables

[1] In 1997 17% of beneficiaries in our sample had home health episodes that continued past our Aug. 31st cut off. In 1999 6% had home health episodes that continued past Aug. 31st.

including the following: age; race; sex; and, State of residence.

HHA Beneficiary And General Medicare Population Rate Analysis

We also compared HHA patient pre- and post-IPS re-admission and emergency visit rates to those associated with the general population of Medicare beneficiaries discharged from the hospital during the same time frame. For this comparison, we tracked the general population beneficiaries, as well as the HHA beneficiaries for 60 days after their hospital discharge**.**

Limitations

A limitation to our methodology is that our analysis reports only on changes in hospital re-admission and emergency room visit rates. This inspection is not intended to attribute any change to a particular factor, since many reasons, including IPS, may contribute to changes in readmission and emergency room visit rates. In addition, we do not make pre- and post- IPS comparisons by geographical region or by urban/ rural designation. Therefore, our analysis does not address the possibility of increased re-admission or emergency room visit rates within smaller geographical areas or in primarily urban or rural areas.

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

FINDINGS

Hospital re-admissions and emergency room visits for home health patients have decreased

Despite significantly shorter home health episodes[2], the percentage of Medicare patients who are re-admitted to the hospital or visit the emergency room has not increased since the implementation of the interim payment system (IPS). In fact, the percentage has decreased. Forty-one percent of all Medicare patients who were discharged from the hospital to home health in January and February 1997 (pre-IPS) were re-admitted to the hospital within 30 days of the end of their home health services. The re-admission rate for those discharged during an analogous period in 1999 (post-IPS) was 38 percent. Emergency room visit rates did not increase between 1997 and 1999 either. In 1997, 22 percent of patients discharged from the hospital to home health had emergency room visits. In 1999, 19 percent had emergency room visits. (See Table 1 below.)

Our analysis of these data was prompted by concerns expressed on the part of some hospital discharge planners that shorter home health episodes are resulting in increased re-admissions and emergency room visits, usually within one month of the end of patients' home health care. As indicated above, although we follow patients for the length of their home health episode plus 30 days[3], we do not find evidence to support this theory. An analysis by State shows that hospital re-admission rates for home health patients did not increase in any State between 1997 and 1999. Finally, we found virtually no increase in any State in the rate at which home health patients visited emergency rooms pre- and post-IPS.

Table 1
Hospital Re-admission and Emergency Room Visit Rates For Home Health Patients

	1997	1999	Difference 1997-1999
Hospital Re-admission Rate	**41.2%**	**37.8%**	**-3.4**
Emergency Room Visit Rate	**21.9%**	**19.0%**	**-2.9**

Source: National Claims History File

[2] A home health episode is the length of time a patient receives home care.

[3] We analyzed beneficiary claims history data for the period that beneficiaries received home health care, as well as the 30 days following their HHA discharge. For beneficiaries whose home health episode continued beyond August 31st, we analyzed claim history data through August 31st.

We also calculated re-admission and emergency room visit rates for the first 60 days of patients' home health episodes. We did this in order to control for the difference in length of home health episodes pre- and post-IPS. As would be expected, the re-admission and emergency room visit rates for this shorter time frame are lower, however, the data still do not show an increase in either of these rates. In both 1997 and 1999, 30 percent of home health patients were re-admitted to the hospital within the first 60 days of their home health services. In 1997, 13 percent of home health patients had emergency room visits within the first 60 days of their home health services. In 1999, 14 percent visited the emergency room within 60 days.

Home health lengths of stay are significantly shorter

We found significantly shorter home health care episodes after the implementation of IPS. Our data, which are consistent with other research, show a 41 percent decrease in the average home health stay for Medicare patients between 1997 and 1999. On average, Medicare patients received home health care for 98 days in 1997. The average was 58 days in 1999. A closer look at these data shows that this decrease is not across the board. The percentage of patients who have stays of 60 days or less increased by 29 percent, while the percentage of patients with stays 300 days or longer decreased by a 90 percent.

Number of home health patients has declined

The number of patients discharged from the hospital with home health care declined 23 percent between 1997 and 1999. In the first two months of 1997, approximately 462,000 hospital patients received home health services upon their return home. During the first two months of 1999, this number was down to about 358,000.

Demographic profile of patients discharged to home health unchanged

As indicated earlier, although the average length of home health episodes for Medicare patients discharged from the hospital to home health has decreased significantly since the implementation of IPS, many other characteristics of this population have not changed between 1997 and 1999. We found only minimal change in the diagnoses of patients who get re-admitted or visit the emergency room pre- and post- IPS. We also found that home health patients do not differ pre- and post- IPS in terms of age, sex, race, and hospital length of stay. In both 1997 and 1999, the average age of Medicare patients discharged to home health was 77. Sixty-three percent were women, while 37 percent were men in both 1997 and 1999. In addition, the distribution across race categories was similar. For example, in both 1997 and 1999, 85 percent of Medicare patients discharged to home health were white and 11 percent were black. Finally, the average hospital stay for these patients pre- and post- IPS was also very similar, 7.9 and 7.6 days, respectively.

Re-admission rates do not vary by diagnoses

Little change in diagnoses of high volume re-admissions

The re-admission ranking for the five most common diagnoses[4] associated with patients who get re-admitted to the hospital has remained relatively constant pre- and post-IPS. Table 2 shows the most common hospital diagnoses for re-admitted patients based on total volume. Not surprisingly, in both 1997 and 1999, these diagnoses are very similar to the diagnoses of patients most likely to get home health care upon discharge from the hospital. The re-admission rates for patients in these high volume diagnoses have not increased since the implementation of the interim payment system.

Table 2
Ranking of Highest Volume Diagnoses For Re-Admitted Patients, Pre- and Post-IPS

Initial Hospital Diagnosis	Total Volume Rank 1997	Total Volume Rank 1999
DRG 127- Heart failure and shock	**1**	**1**
DRG 088- Chronic obstructive pulmonary disease	**2**	**3**
DRG 089- Simple pneumonia and pleuresy	**3**	**2**
DRG 014- Specific cerebrovascular disorders	**4**	**4**
DRG 079- Respiratory infections and inflammations	**5**	*9*
DRG 296- Nutritional and misc. metabolic disorders	*6*	**5**

Source: National Claims History File

Re-admission rates have not increased for most frequently re-admitted diagnoses

We found that patients with cancer-related diagnoses are the most likely to be re-admitted to the hospital. As Table 3 on the next page shows, the rates at which home health patients in these diagnoses were re-admitted to the hospital do not increase pre- and post-IPS.

[4] Based on diagnosis related group code (DRG) assigned to patient during their initial hospital stay.

Table 3
Pre- and Post- IPS Highest Re-admission Rates for Home Health Patients By Diagnoses

Initial Hospital Diagnosis	Percent 1997	Percent 1999	Difference 1997-1999
DRG 473- Acute leukemia w/o major OR procedure	75.3	66.5	-8.8
DRG 202- Cirrhosis and alcoholic hepatitis	64.2	59.1	-5.1
DRG 489- HIV w/ major related condition	62.3	58.6	-3.7
DRG 403- Lymphoma and nonacute leukemia w/ CC	67.9	65.1	-2.8
DRG 410- Chemotherapy w/o acute leukemia	85.2	83.0	-2.2
DRG 172- Digestive malignancy w/ CC	63.6	63.3	-0.3

($N \geq 200$) Source: National Claims History File

No increase is found in re-admissions of patients in at-risk diagnoses

The data in Table 4 on the next page, show no significant increases in the percentage of patients re-admitted in at-risk diagnoses. A number of recent studies[5] that look at the effects of IPS and the adequacy of home health care identify diagnoses and patient types which may be at-risk of receiving inadequate care. We compared pre- and post-IPS re-admission rates for these patient types where a Medicare diagnosis code[6] match could be established. For example, we are able to examine re-admission rates for congestive heart failure home health patients because they can be designated as such under ICD9 code 428. However, our analysis does not include two other groups of patients which some researchers raise concerns about--chronic care patients and those requiring intensive services--because they cannot be identified by diagnosis code.

[5] The sources of the studies we reviewed include: GAO; MedPAC; George Washington University; and, DHHS OIG.

[6] For this analysis we used the ICD9 diagnosis code assigned at the start of the patient's home health care episode.

Table 4
Pre- and Post- IPS Percentage of Re-admitted Patients In At-Risk Diagnoses

Home Health ICD9 Diagnosis Code	Percent 1997	Percent 1999	Difference 1997-1999
ICD9 294- Dementia	39.8	35.5	-4.3
ICD9 586- Renal Failure	61.8	57.6	-4.2
ICD9 250- Diabetes	47.8	43.7	-4.1
ICD9 331- Alzheimer's	38.9	35.5	-3.4
ICD9 428- Heart Failure	52.3	49.0	-3.3
ICD9 340- Multiple Sclerosis	39.4	36.9	-2.5
ICD9 494- Bronchiectasis (Pulmonary Disease)	43.6	41.8	-1.8
ICD9 344- Quadriplegia	45.0	45.5	+0.5

Source: National Claims History File

Emergency room visit rates do not vary by diagnoses

Little change in diagnoses of high volume emergency room users

As Table 5 on the following page indicates, the ranking for the five most common diagnoses associated with patients who visit the emergency room has remained relatively constant. Similar to the case with re-admissions, the rate at which patients in these high volume diagnoses visit the emergency room has not increased since the implementation of the interim payment system.

Table 5
Ranking of Highest Volume Diagnoses For Emergency Room Visit Patients, Pre- and Post-IPS

Initial Hospital Diagnosis	Total Volume Rank 1997	Total Volume Rank 1999
DRG 127- Heart failure and shock	1	1
DRG 089- Simple pneumonia and pleuresy	2	2
DRG 088- Chronic obstructive pulmonary disease	3	3
DRG 014- Specific cerebrovascular disorders	4	4
DRG 079- Respiratory infections and inflammations	5	*10*
DRG 209- Major joint and limb reattachment procedures	*6*	5

Source: National Claims History File

Emergency room visit rates have not increased for patients that frequently visit the emergency room

In both 1997 and 1999, the diagnoses of home health patients most likely to visit the emergency room covered a broader range of diagnoses than those most likely to be re-admitted to the hospital. However, patients with respiratory illnesses and those with kidney and urinary tract diagnoses show up in the list of frequent emergency room visitors in both 1997 and 1999. As Table 6 on the next page shows, we found the rates at which patients in the majority of these diagnoses visit the emergency room does not increase pre- and post- IPS.

Table 6

Pre- and Post- IPS Emergency Room Visit Rates for Home Health Patients By Diagnoses

Initial Hospital Diagnosis	Percent 1997	Percent 1999	Difference 1997-1999
DRG 132- Artherosclerosis w/ CC	34.1	27.9	-6.2
DRG 315- Other kidney and urinary tract OR procedures	34.6	29.7	-4.9
DRG 099- Respiratory signs and symptoms w/ CC	35.4	30.6	-4.8
DRG 140- Angina pectoris	31.2	29.5	-1.7
DRG 143- Chest pain	34.1	32.6	-1.5
DRG 482- Tracheostomy for face, mouth and neck diagnoses	28.9	32.3	+3.4
DRG 425- Acute adjustment reactions/psychosocial dysfunction	26.3	30.1	+3.8

($N \geq 200$) Source: National Claims History File

No increase is found in emergency room visit rates for at-risk diagnoses

Finally, we found no significant increase in the rate at which patients in at-risk diagnoses visited the emergency room pre- and post-IPS. As Table 7 on the next page indicates, seven of the eight diagnoses we looked at show no increase in emergency room visits rates between 1997 and 1999.

Table 7

Pre- and Post- IPS Percentage of Emergency Room Visits in At-Risk Diagnoses

Home Health ICD9 Diagnosis	Percent 1997	Percent 1999	Difference 1997-1999
ICD9 250- Diabetes	26.6	22.8	-3.8
ICD9 428- Heart Failure	26.2	22.5	-3.7
ICD9 331- Alzheimer's	24.2	20.7	-3.5
ICD9 340- Multiple Sclerosis	22.6	19.6	-3.0
ICD9 294- Dementia	23.4	21.1	-2.3
ICD9 586- Renal Failure	31.1	29.8	-1.3
ICD9 344- Quadriplegia	27.6	26.6	-1.0
ICD9 494- Bronchiectasis (Pulmonary Disease)	14.7	18.3	+3.6

Source: National Claims History File

Change in re-admission and emergency room visit rate for home health patients is consistent with general Medicare population

Re-admission rate changes pre- and post-IPS for home health patients are consistent with those for the general population. The same percentage of home health patients are re-admitted to the hospital within 60 days of their hospital discharge in 1997 and 1999 (30 percent). The rate at which **all** patients are re-admitted, within this time frame, does not change between 1997 and 1999 either (25 percent). This trend holds up for emergency room visit patients as well. In both 1997 and 1999, 14 percent of home health patients visit the emergency room within 60 days of their discharge. Twelve percent of **all** patients discharged visit the emergency room, within this time frame, in both 1997 and 1999.

AGENCY COMMENTS

The Health Care Financing Administration provided comments on this and two related draft reports. They note that our finding that re-admissions and ER visits have declined is an indicator of stability in home care under the interim payment system. They also note that on October 1, 2000 the new prospective payment system for home health care will go into effect. They, like we, will monitor care under the new system. The HCFA's comments are in Appendix B.

APPENDIX A

Selected List of Other Recent Office of Inspector General Home Health Inspections

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

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

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

APPENDIX B

Agency Comments

In this appendix, we present the comments from the Health Care Financing Administration.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

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Washington, D.C. 20201

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TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Adequacy of Home Health Services: Hospital Re-Admission and Emergency Room Visits," (OEI-02-99-00531), "Medicare Home Health Agency Survey and Certification Deficiencies," (OEI-02-99-00532), and "Medicare Beneficiary Access to Home Health Agencies," (OEI-02-00-00320).

Thank you for the opportunity to review the above-mentioned draft reports. As you know, these reports are critical steps in our ongoing efforts to monitor the impact of the Balanced Budget Act of 1997 (BBA) on home health agencies (HHAs).

Home health care is an important benefit that enables Medicare beneficiaries to receive many services in their homes as covered under Medicare. HCFA is committed to protecting this critical benefit for those who qualify for it. The home health prospective payment system (PPS) will help strengthen this benefit for Medicare beneficiaries by appropriately paying HHAs according to the health condition and care needs of each beneficiary.

Background

In the Balanced Budget Act of 1997 (BBA), Congress significantly reformed the payment system and other rules for HHAs. The BBA eliminated cost-based reimbursement that encouraged agencies to provide more visits and to increase costs up to set limits. As a first step toward giving HHAs incentives to refocus their efforts on providing care efficiently, this older system was replaced by the Congressionally-mandated interim payment system (IPS). This interim system is to operate until the PPS is effective.

Since the enactment of the BBA, there has been a significant decline in actual home health spending. The recent drop in home health spending came after a period of rapid growth. Between 1990 and 1997, home health expenditures grew at an average annual rate of 25 percent – three times the growth rate for the program overall. Since then, the Administration and Congress have worked together to protect Medicare's home health benefit while slowing the rapid rise in its costs. As required by the BBA, we have taken a number of steps to protect and strengthen the home health benefit, and we are seeing the successful results. In November, the Department of Health and Human Services' Office of Inspector General (OIG) issued a report showing that we had cut the home health improper payment rate by more than half – from 40 percent to 19 percent – since a similar study in 1997.

While some of the reduction in spending reflects elimination of overpayments, waste and fraud, it may be causing isolated access problems in some limited situations. To assure a smooth transition to the PPS, the President, as part of his Mid-Session review budget, has proposed to dedicate $2 billion over 5 years ($3 billion over 10 years) to ensure adequate payment to HHAs during the transition to PPS.

Development of the PPS

The home health PPS is the product of over ten years of research on case mix and HHA payment issues. Even prior to the passage of the BBA, HCFA used numerous demonstration projects and worked with outside research organizations, such as Mathematica Policy Research, to help lay the groundwork for PPS. Although work on home health PPS has intensified since the passage of BBA, HCFA will continue to conduct research on the PPS. That is why HCFA will closely monitor and refine the PPS based on experience and the findings of future research. This is critical for protecting beneficiaries, HHAs, and the Medicare Trust Fund. HCFA has taken, and will continue to take, actions to ensure that beneficiaries have access to the quality home health care guaranteed to them under Medicare.

HCFA is continuing to build on these earlier research activities. In fact, HCFA has developed plans to pursue on-going research and refinements to the home health PPS. This will include intensive monitoring of PPS claims, payments, cost report data, and quality/outcome data from the Outcome and Assessment and Information Set (OASIS) system. HCFA will also conduct additional research, both internally and with Abt Associates, on case mix. This aggressive monitoring effort, coupled with the research effort, will serve as the basis for future improvements that HCFA will make to the PPS. HCFA has also taken steps to ensure that beneficiaries are protected from the major risk inherent in all PPS systems --underutilization-- and to ensure that all HHAs are paid appropriately for the services provided.

Response to the OIG Reports

The conclusions in your reports reinforce earlier findings by OIG, the General Accounting Office (GAO), and other independent sources that Medicare beneficiaries who qualify for the home health benefit continue to have access to quality services, even as the BBA has taken effect. We agree with your conclusion that, "there appear to be no widespread problems with placing Medicare patients with home health agencies." Although we are pleased that the evidence shows there has been continued access to home health services under the IPS, we will continue to monitor beneficiaries' access to care and the quality of that care as we move to the PPS. We are committed to making adjustments as needed, including consideration of a range of options and proposals by outside sources, such as the GAO. We specifically designed the PPS to ensure that Medicare pays appropriately for quality care based on the individual needs of each beneficiary who qualifies for these important services.

Since the implementation of the BBA, your evaluation also found a slight drop in hospital re-admissions and emergency room visits for home health patients. Moreover, your report found that there has not been an increase in re-admissions of patients in at- risk diagnoses and that there has been little change in diagnoses of high-volume emergency room users. Both of these are indications of stability in the care being delivered to the home health patient population.

Your reports also note a modest increase in survey and certification deficiencies for home health agencies between 1997 and 1999. As indicated in your findings, it is difficult to determine the precise reasons for this increase. In the late 1990s, States generally began conducting more intense, but less frequent, inspections of these facilities, and these trends could account for the changes identified in the report. We will continue to monitor these trends to ensure agencies meet Medicare's requirements for providing quality care to patients. Further, HCFA continues to work with State survey agencies and our central and regional offices to strengthen the survey process and address the concerns raised in the report. This work will include potential changes to survey frequency and continued statewide training of surveyors in an effort to strive for consistency among States. In addition, we expect to create a web page that would include answers to frequently asked questions and provide additional timely information about home health policy HCFA's efforts to date represent our continued commitment to review and monitor the quality of care and adequacy of services provided to Medicare beneficiaries.

We are pleased that the GAO, MedPAC and the OIG agree that there do not appear to be system-wide access problems for beneficiaries to home health services. We appreciate the OIG's efforts to monitor the impact of the BBA on HHAs, and we look forward to working with you in the future on this important issue.