

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**Medicare Home Health Agency Survey  
and Certification Deficiencies**



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# EXECUTIVE SUMMARY

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## PURPOSE

To determine if the extent and nature of Medicare home health agency survey and certification deficiencies, particularly relating to adequacy of care, have changed since the implementation of the Interim Payment System in 1997.

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## BACKGROUND

This inspection follows an Office of Inspector General report issued in November 1999 entitled “Medicare Beneficiary Access to Home Health Care” (OEI-02-99-00530). In that study, most hospital discharge planners report generally being able to place Medicare beneficiaries with home health agencies; however, some volunteer concern that not all beneficiaries may be getting adequate care. This inspection follows up on those concerns. It is part of a series of inspections that the Office of Inspector General has conducted about home health care.

Home health services consist of skilled nursing, therapy (physical, occupational, and speech), home health aide and other related services furnished in a patient’s home. Medicare regulations require that each patient have a plan of care, established by a physician, that includes specific treatment information. All home health agencies participating in Medicare must be surveyed by the State in order to be certified as meeting Federal requirements.

We combined four methods for this inspection: an analysis of survey deficiency data; interviews with State and the Health Care Financing Administration survey and certification staff; a review of State survey deficiency reports; and a demographic data analysis. For the purpose of this study, we define adequate care to mean appropriate intensity and frequency of services. We assume the adequacy of care patients receive is indicated in part by the extent to which their plans of care are appropriately developed and implemented.

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## FINDINGS

**Overall, home health agency deficiencies have increased, but there is no single explanation for this growth**

### **Deficiencies increased from 1997 to 1999**

Nationally, both the rate and total number of all home health deficiencies have grown between the first 6 months of 1997 and the first 6 months of 1999. The deficiency rate

(deficiencies per survey) increased by 26 percent, from 3.1 to 3.9. At the same time, the total number of deficiencies grew by 53 percent, from 5,438 to 8,297.

During our study time frames, 12 so called “condition level” deficiencies with numerous standards within them could be cited if one or more of those standards were not met. Condition level deficiencies are therefore broader and more severe in scope. The rate for total condition level deficiencies went from .14 in 1997 to .23 in 1999, which is an increase of more than half.

## **Inconsistent survey processes may result in different deficiency rates among States**

States differ in their deficiency rates, number of surveys, and survey protocols. First, not all States have had an increase in their deficiency rates; about half have actually had a decrease. The sample States with a decrease attribute this to closures of poor care providers. Also, the number of surveys conducted between 1997 and 1999 varies among States; nearly all States with an increase in the number of surveys also had an increase in deficiencies, while those with fewer surveys had fewer deficiency citations. Lastly, inconsistent survey processes among the 10 sample States, including survey schedules and interpretations of deficiency tags, contribute to different deficiency rates.

## **Several reasons may account for the increase in deficiencies**

The State survey and certification and Health Care Financing Administration staff that we surveyed do not attribute the increase in deficiencies to any single factor. Instead they point to several factors, including the following four.

**Changes to the home health survey schedule.** Most State and Health Care Financing Administration respondents say the change to the home health survey schedule that increased the interval between standard surveys has allowed agencies to develop and maintain patterns of poor care.

**Increased Federal involvement.** State respondents cite increased Federal initiatives and training as having strengthened survey protocols to make them more stringent.

**Declining quality of home health care.** A few State respondents directly attribute the increase to a declining quality of home health care.

**Interim payment system.** While no State respondents volunteer the interim payment system as a direct cause for the increase in deficiencies, some note that it may be affecting the amount of care agencies provide.

## **Adequacy of care deficiencies are most common in both years**

Nationally, one fourth of all deficiencies in both 1997 and 1999 fall within what we call

the “plan of care” condition. The majority of standards within this condition pertain to whether the plan of care is appropriately developed, followed, reviewed, and updated. Also, four of the six most common standard deficiencies fall within the “plan of care” condition, including the top deficiency, G158. It is cited when patient care does not follow a written plan of care established and periodically reviewed by a physician.

Based on our review of 100 survey deficiency reports, we identified four main categories of “plan of care” deficiencies.

**Agencies are not providing all ordered visits.** The agency is not providing as many nursing visits, home health aide visits, or therapy visits as were ordered by the physician in the plan of care.

**Agencies are not providing all treatments.** The agency is not providing all appropriate treatments during visits, such as monitoring patients’ weight and pressure sores.

**Agencies are not contacting physicians when necessary.** Agency staff are not alerting physicians when patients’ conditions worsen or their prescribed treatment should be changed.

**Agencies are not developing comprehensive plans of care.** Agencies are failing to appropriately develop a comprehensive plan of care for all of their patients.

Less commonly, plan of care deficiencies also indicate that more care is provided than ordered.

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## CONCLUSION

Just as there is no single cause for the increase in home health agency deficiencies, there is no single course of action to be taken. Instead, a combination of approaches may be appropriate, including strengthened State survey protocols and continued close scrutiny of the care being provided to home health beneficiaries.

The nature of deficiencies being cited indicate that some beneficiaries may not be receiving all the care they need. The introduction of the Prospective Payment System should in part address this concern, since it allocates more money for the most severe patients and establishes new payments every 60 days for long term patients. At the same time, this new system could create or increase the incentive on the part of some home health agencies to shortchange Medicare home health beneficiaries in the amount and intensity of care provided. It will therefore become even more important that the Health Care Financing Administration and the States closely monitor the quality of home health care. We also intend to continue our own studies of all aspects of the implementation of the prospective payment system, including quality of care.

## Comments

The Health Care Financing Administration provided comments on this and two related draft reports. They concur with our conclusion that there appears to be no single cause for the increase in deficiencies. 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

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## PURPOSE

To determine if the extent and nature of Medicare home health agency survey and certification deficiencies, particularly relating to adequacy of care, have changed since the implementation of the Interim Payment System in 1997.

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## BACKGROUND

This inspection follows an Office of Inspector General (OIG) report issued in November 1999 entitled “Medicare Beneficiary Access to Home Health Care” (OEI-02-99-00530). In that study, most hospital discharge planners report that they are generally able to place Medicare beneficiaries with home health agencies; however, some discharge planners volunteer their concern that not all Medicare patients may be getting adequate care. By adequate care, we mean the appropriate duration and intensity of services. 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 1990's, Medicare spending for home health services increased substantially. From 1990 to 1997, Medicare 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, however, Medicare spending for home health services decreased to a total of approximately \$9.5 billion. Further, the average home health length of stay went from 98



days in 1997 to 58 days in 1999. The number of beneficiaries served also decreased, from 462,000 in 1997 to 358,000 in 1999.

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 (BBA).

## **Survey and certification process**

All home health agencies participating in Medicare must be certified and approved by meeting certain Federal requirements and conditions of participation. The certification process includes routine on-site surveys that HCFA contracts with State agencies to perform. As mandated by statute, agencies can go without a standard survey no longer than 36 months after the previous survey. If they are found to have serious deficiencies during a standard survey, the State will conduct an extended survey. During a home health survey, State surveyors select two case-mix stratified samples of patients based on a pre-existing formula, one sample for a medical record review only and a second for a medical record review and home visit. During the record review, surveyors assess the services that the HHA is providing by reviewing the plan of care, medical record, and agency chart. They visit the beneficiary's home to determine if the patient is in the condition that the HHA reports. Surveyors identify areas where the agency has failed to comply with Federal regulations. These deficiencies are cited and the agency is required to write a plan of correction.

During the time frames we examined, deficiencies were cited under any of 153 specific deficiency tags, which included 12 condition level deficiencies and 141 standard level deficiencies. The condition level deficiencies, based on the conditions of participation, are broader and more severe in scope, and they encompass more specific standards within them. For example, the condition level tag G156 - acceptance of patients, plan of care, and medical supervision - includes 12 standard level deficiencies for various aspects of care that fall into this category. Generally, an HHA will be cited with a condition level deficiency if one or more of the standards within it are not met. In June 1999, three additional conditions related to the incorporation of the Outcome Assessment and Information Set were established.

Several recent changes have occurred in the survey process. First, due to a moratorium on the formation of new Medicare home health agencies from September 1997 to January 1998, no new initial surveys were conducted during these time periods. Second, beginning in October 1996, the mandated survey schedule changed from every 9 to 15 months to a variable 36 month schedule. The HCFA developed comprehensive criteria to determine HHA survey frequency. Thus, if an agency is not cited with major deficiencies or has no change in ownership, it will typically be surveyed every 3 years. New agencies

must be surveyed annually for the first 3 years, and a new standard survey must also be conducted when a change of ownership occurs.

National data on home health agency survey and certification deficiencies is tracked by HCFA in the Online Survey Certification and Reporting System (OSCAR). The OSCAR tracks each agency's deficiencies for the past three survey periods as well as the current survey period.

In lieu of obtaining Medicare certification from the State, agencies can be deemed by a HCFA approved accreditation organization. The HCFA currently authorizes two deeming organizations: the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and the Community Health Accreditation Program (CHAP). The home health agencies are surveyed by the accrediting agency and the survey results are shared with HCFA. Approximately 200 home health agencies nationwide have deemed status.

## **Home health plans of care**

Medicare regulations require that each patient have a plan of care. This plan should include specific information such as all pertinent diagnoses, types of services and equipment required, frequency of visits, prognosis, medications, and instructions for timely discharge or referral. The plan of care must also contain the physician's orders for services and his or her signature. Currently, the physician is required to review the plan of care with agency staff at least every 62 days. As of October 1, 2000, the time period for review will be every 60 days.

A plan of care is generally developed through a collaborative process involving the physician, the home health agency, and the patient or family. If the patient is in the hospital when the referral for home health care is made, the home health agency may have its own nurse assess the patient in the hospital, talk to the patient and/or family, and discuss his or her treatment needs with the physician. At this time the agency nurse may develop a preliminary plan of care which can be reviewed by the physician. After the patient is released from the hospital, an agency nurse or therapist will be assigned to the patient's case and make a home visit. After assessing the home, talking to the patient and to the physician, the agency will modify the plan as needed. The physician may then sign the plan. If the patient is not in the hospital at the time of the home health referral, the same process is generally followed but does not begin until the agency's first visit to the home.

## **The Balanced Budget Act of 1997**

The Balanced Budget Act (BBA) of 1997 changed 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 implemented, however, home health agencies are reimbursed under an interim payment system (IPS) which imposes payment limits on their services. The IPS was implemented on October 1, 1997 and will continue to be in place until the 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 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. 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.

In the fall of 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget 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.

## **OASIS**

Home health agencies use a data collection system called the Outcome and Assessment Information Set (OASIS) as part of their conditions of participation. 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 readmissions and emergency room visits is also captured. The OASIS can be used by home health agencies to determine patients treatment needs, develop plans of care, and monitor quality of care.

## **Related home health studies**

In addition to our recent inspection report, "Medicare Beneficiary Access to Home Health Agencies," several other studies have been released recently that discuss access to and adequacy of home health care. A Medicare Payment Advisory Commission (MEDPAC) study on access to home health services found that some agencies are likely to discharge certain types of patients earlier because of the new payment system. Additionally, a George Washington University study reported that agencies are altering admissions standards and reducing clinical and administrative staff. It also found that chronically ill patients are experiencing greater fragmentation and disruption of care and that some patients were receiving insufficient intensity or duration of home health care services. Further, 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 payment 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 home health diagnoses. The report therefore concluded that a per-episode based home health PPS could reduce Medicare costs without harming quality of care.

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## **METHODOLOGY**

We combined four methods for this inspection: an analysis of OSCAR deficiency data; telephone or in-person interviews with State and HCFA survey and certification staff; a review of State survey deficiency reports; and a demographic data analysis.

### **Definition of “adequacy of care”**

For the purpose of this study, we are defining adequate care to mean appropriate intensity and frequency of services. In particular, we assume that the adequacy of care beneficiaries receive is indicated, in part, by the extent to which their plan of care is appropriately developed and implemented. We therefore focused our analysis on deficiency data pertaining to the plan of care. We note that adequacy of care can also be defined to include other facets of care, such as coordination of services and communication between care providers.

In this study, we also differentiate between adequacy of care and quality of care. For the former, we mean intensity and duration of services. For the latter, we mean the quality of services provided. For example, the quality of care being provided by a skilled physical therapist may be very high, but the number of times such care is provided may not be sufficient to meet a patient’s needs and, therefore, not adequate.

### **Analysis of OSCAR deficiency data**

As already discussed, national data on home health agency survey and certification deficiencies is tracked by HCFA in the Online Survey Certification and Reporting System (OSCAR). During the time frames we examined, deficiencies were cited under any of 153 specific deficiency tags, which included 12 condition level deficiencies and 141 standard level deficiencies. We analyzed OSCAR data for all home health agency surveys conducted in the first 6 months of 1997 and the first 6 months of 1999. This

enabled us to compare an analogous time frame before and after IPS was implemented. This time period is also the same one being used in the OIG study on hospital and emergency room re-admission rates.

For both years, we examined the following three levels of OSCAR data:

- overall deficiencies;
- the 12 condition level deficiencies, which are more severe in scope; and
- standard level deficiencies, particularly those relating to the plan of care.

From the first 6 months of 1997 to the first 6 months of 1999, we calculated the percentage change in the number of deficiencies and the percentage change in the deficiency rate (the number of deficiencies cited per survey). To determine the number of surveys conducted during each of our two time frames, we counted each unique provider number listed as one survey.

### **State and HCFA survey and certification staff interviews and discussions**

We selected a purposive sample of 10 States to include States with both increases and decreases in deficiency rates and States with geographical differences. These 10 States are Arizona, California, Connecticut, Florida, Idaho, Illinois, Louisiana, New York, Ohio, and Texas.

We conducted a total of 20 structured State interviews for this inspection. In each of the 10 States, we spoke with the survey and certification director or other manager and a home health surveyor. In two of the States, New York and Connecticut, we conducted these interviews in-person. For the remaining eight States, we conducted our interviews by telephone. During these interviews, we asked respondents questions about their State survey process, recent changes to the process, and for their perspectives on home health care trends.

We also had discussions with regional and headquarters HCFA staff. During these interviews, we asked respondents questions about HCFA policies on home health agency surveys, recent changes in survey policies and procedures, and for their perspectives on home health care trends.

### **Review of survey deficiency reports**

We asked each of our sample States to send us 10 survey deficiency reports (HCFA form 2567) from surveys conducted in 1999, mostly during the first 6 months, for a total of 100 reports. We asked for reports that specifically included any of 12 deficiency tags we identified as indicating adequacy of care. We then used structured review sheets to determine if the deficiencies cited related to documentation or adequacy of care issues. We also used this review to look for specific examples of inadequate care that illustrated typical problems found with deficient home health agencies.

## Demographic data analysis

Finally, we conducted a demographic analysis in order to determine if the Medicare home health population differed from the first 6 months of 1997 to the first 6 months of 1999. First, using a one percent sample of the National Claims History (NCH) File, we identified all beneficiaries who had a home health service from between January 1, 1997, and June 30, 1997, and between January 1, 1999, and June 30, 1999. We then merged this data with data from a one percent sample of inpatient claims to determine which beneficiaries had a hospital discharge within 30 days prior to the start of their home health services. This enabled us to determine the percentage of the home health population that had a prior hospitalization during both time periods.

We also merged our National Claims History File data with data from the Enrollment Database (EDB) to compare the variables of age, race, sex, and diagnosis for the home health population in our two time frames.

This analysis indicated no changes in the age, sex, and race of home health beneficiaries. It did, however, show an increase from 48 percent to 55 percent in prior hospitalization rates.

## Limitations

There are several limitations to our methodology. First, this inspection is not intended to attribute any change in deficiencies to a particular factor, since many reasons may contribute to increases in deficiency rates. Further, we note that States have not been consistent in their reporting of OSCAR survey data. Lastly, the structure of the OSCAR file does not permit a trend analysis over time, since data is maintained based on each home health agency's unique survey schedule.

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

# FINDINGS

## **Overall, home health agency deficiencies have increased, but there is no single explanation for this growth**

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### **Deficiencies increased from 1997 to 1999**

#### **Both the overall rate and the total number of all deficiencies have increased**

Nationally, both the rate and total number of all home health agency deficiencies have grown between the first 6 months of 1997 and the first 6 months of 1999. The deficiency rate increased by 26 percent, from 3.1 in 1997 to 3.9 in 1999. At the same time, the total number of deficiencies grew by 53 percent, from 5,438 in the first 6 months of 1997 to 8,297 in the first 6 months of 1999. The deficiency rate is defined as the number of deficiencies cited per survey. Since the total number of surveys conducted increased by 20 percent between 1997 and 1999, from 1763 to 2112, in order to control for this change we will report only deficiency rates for the remainder of the report.

During our study time frames, 12 so called “condition level” deficiencies with numerous standards within them could be cited if one or more of those standards were not met. Condition level deficiencies are therefore broader and more severe in scope. If a home health agency is found to have a condition level deficiency, it is considered to provide substandard care and must undergo an extended survey to determine if it meets the conditions of Medicare participation. The rate for total condition level deficiencies went from .14 in 1997 to .23 in 1999, which is an increase of more than half.

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### **Inconsistent survey processes may result in different deficiency rates among States**

#### **Some States increased while others decreased**

Not all States have had an increase in their deficiency rates between 1997 and 1999. About half have actually had a decrease. Survey and certification respondents from those sample States with a decrease in deficiency rates say that recent agency closures have resulted in fewer deficiencies being cited. In particular, they note that many of the agencies that closed did not provide good care. One survey director notes, “Many agencies with care problems went out of business.”

The numbers of surveys conducted between 1997 and 1999 also varies among States, with a few States having significant increases. In the State with the largest increase, respondents attribute the increase to changes in agency ownership and facility mergers,

which require that a new standard survey be conducted. While about half of all States have had some increase between 1997 and 1999, one third have had decreases, and the remaining have had no change. Nearly all of the States that have had an increase in the number of surveys conducted also saw an increase in the number of deficiencies cited. Similarly, most of the States with fewer surveys have fewer deficiency citations.

### **Different survey protocols are noted among the 10 sample States**

Our interviews with survey and certification staff in the 10 sample States, as well as our review of survey reports, reveal inconsistencies among State survey procedures in 1999 that may affect deficiency rates. First, not all States follow the same survey schedule; while most follow the HCFA variable 36 month schedule, within this schedule some States are surveying agencies more frequently than others. Further, States allocate their survey staff resources differently. In some, surveyors specialize in home health care only, while in others, survey staff are responsible for other types of providers as well, such as nursing homes and hospices. Additionally, some State respondents note that there is high staff turnover among surveyors.

Surveyors also do not appear to consistently interpret and cite deficiencies on their reports. In one State, survey respondents say that they had been citing few if any deficiencies at all in 1997. In reviewing different States' survey deficiency reports, we noticed that similar problems are cited under different deficiency tags. For example, a registered nurse may fail to alert a patient's physician of the need to alter his plan of care because it does not reflect his medical condition and needs; this deficiency can be cited under tag G164 (agency staff promptly alert the physician to any changes that suggest a need to alter the plan of care), tag G173 (duties of the registered nurse), or both. We also noticed that variation in surveyors' professional judgement and discretion may affect whether or not a condition level deficiency is cited. State respondents say they look at the scope and severity of the problem when determining whether to cite a deficiency. Typically, one report may cite a deficiency for a single occurrence, while another will cite the same deficiency for multiple occurrences.

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### **Several reasons may account for the increase in deficiencies**

The State survey and certification and HCFA staff we surveyed do not attribute the increase in deficiencies to any single factor. Instead, they point to several factors, including the following four.

#### **Change in survey schedule**

Most of the States we surveyed, as well as HCFA respondents, cite changes to the home health survey schedule as having had an impact on deficiency rates. As noted in the background, beginning in 1996, HCFA changed the survey schedule to require that agencies be surveyed up to every 36 months after a previous standard survey, or more



frequently if necessary. The schedule prior to this change was every 9 to 15 months. Both State and HCFA respondents believe that the decrease in survey frequency may be allowing home health agencies to develop and maintain patterns of poor care. One State respondent notes, "Agencies may become more lax if they know we're not in there every year." A HCFA respondent concurs, "Agencies that are on a 3 year cycle are getting into bad habits. Nobody is checking up on them."

A shift in survey and certification resources appears to have led to the change in the home health survey schedule. The HCFA respondents note that the majority of Federal oversight now goes towards nursing home providers. In half of the 10 sample States, respondents say that there were more home health surveyors in 1997 than there were in 1999. In one State, the director notes that funding for home health surveys has decreased due to funding increases for nursing home surveys.

### **Increased Federal initiatives and more stringent survey protocols**

Some State survey and certification respondents also cite increased Federal initiatives, including training they have received from HCFA and Operation Restore Trust (ORT) activities, as having strengthened their survey protocols to make them more stringent. In particular, they say that training provided to surveyors has increased their awareness of what to focus on during survey visits and how to appropriately interpret deficiency tags, thus resulting in more deficiencies being cited. In one State, HCFA re-trained the survey staff at the end of 1997 and beginning of 1998. Prior to this training, surveyors were only counting home health visits and looking at agency policies; they did not assess the care being provided or patient outcomes. A surveyor in another State notes, "Our training from HCFA has helped me to know what to look for. I am more likely to look a little deeper."

In addition to providing more training, ORT appears to have had other effects on the survey process. Beginning in October 1997, any agency that is part of a State, regional, or national fraud and abuse initiative must be surveyed at least every 12 months. In one State, the director says that both the volume and intensity of surveys increased as a result of ORT. The survey director in another State notes that since ORT, his staff has done a better job enforcing the homebound eligibility requirement.

### **Declining care**

A few State respondents directly attribute the increase in deficiencies to the declining care being provided by home health agencies. They say deficiencies have increased due to missed home health nursing, home health aide, and therapy visits as well as to poor documentation. One surveyor says that "corners are cut and mistakes are made." These respondents also mention that staffing shortages in home health agencies may be adversely affecting the care being provided.

## **Interim Payment System**

Finally, while no State survey and certification respondents volunteer IPS as a direct cause for the increase in deficiencies, some note that this reimbursement system may be affecting the amount of care that agencies provide. Several State respondents say that agencies are reducing the frequency of home health aide visits. One mentions that the intensity of physical therapy services being provided is not sufficient. Furthermore, some State respondents note that IPS has caused agencies to close or to be more selective of their case mix, being less inclined to accept patients with more intense or chronic care needs.

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## **Adequacy of care deficiencies are most common in both years**

### **One fourth of all deficiencies fall within the “plan of care” condition**

The “plan of care” condition (G156) is defined as “acceptance of patients, plans of care, and medical supervision.” The majority of standards within this condition pertain to whether the plan of care is appropriately developed, followed, reviewed, and updated. This condition has the most deficiency citations in the first 6 months of both 1997 and 1999. In both years, one fourth of all deficiencies were cited under this condition.

### **Four of the top six standard deficiencies fall within the “plan of care” condition**

Nationally, in both 1997 and 1999, four of the six most commonly cited standard deficiencies fall within the “plan of care” condition. In both years, the top deficiency standard is G158, which is cited when care does not follow a written plan of care established and periodically reviewed by a physician. The remaining three tags are G159 (the appropriate development of a plan of care), G165 (the appropriate administration of drugs and treatment as ordered by a physician), and G164 (the prompt notification of the physician when changes in a patient’s health status suggest the need to alter the plan of care).

### **Based on our review of survey reports, “plan of care” deficiencies fall into four major categories**

Based on our review of 100 survey deficiency reports, it appears that agencies cited with plan of care deficiencies are not providing all ordered services. More specifically, we found four main areas of deficiencies: the agency is not providing as many nursing visits, home health aide visits, or therapy visits as were ordered by the physician in the plan of care; the agency is not providing all appropriate treatments during visits; agency staff are not alerting physicians when patients’ conditions worsen or treatment needs change; and the agency is not appropriately developing a comprehensive plan of care. While in some instances deficiencies are being cited only due to poor documentation, in most cases these

deficiencies indicate that poor care is being provided. We provide the following examples of each of these types of deficiencies.

***Failure to provide all ordered visits:***

- ▶ One agency was cited for failing to provide home health aide services as frequently as ordered. For one patient, aide services were ordered for three to five times per week. The agency failed to provide any aide services at all during one week and provided only two visits during another.
- ▶ One agency was cited for failing to provide all ordered physical therapy and occupational therapy visits. For one patient, two physical therapy visits and two occupational therapy visits were ordered weekly, but the patient received only one of each type of visit in the weeks reviewed. Another patient at the same agency received no physical therapy services at all, despite physician orders for two such visits a month.
- ▶ Another agency was cited for failure to provide the intensity of skilled nursing visits as ordered by the physician for 7 of 10 sampled patients. Of these 7 patients, the skilled care provided was half of the ordered 16 hours per day throughout the 10 to 16 weeks when services were provided.

***Failure to provide all ordered treatments during visits:***

- ▶ In one agency, patient weights were not adequately monitored. In one case, a nurse failed to take a weekly weight as ordered for a patient with congestive heart failure during three of nine visits, despite documented symptoms of fluid retention, such as shortness of breath.
- ▶ Another agency was cited because the nurse failed to change the dressing of a patient's wound every three to four days, which was as often as called for in the patient's plan of care.
- ▶ One agency failed to provide all ordered treatments in seven of eight records reviewed. One patient with a head injury who was bed-bound and completely dependent on skilled services was not periodically re-positioned and turned every 1 ½ hours as ordered and was left on a prone position for as long as 7 hours at a time. This patient was also not provided with ordered tracheotomy and gastrostomy tube care and foley catheter care.

***Failure to alert physicians when patients' conditions worsen or treatment needs change:***

- ▶ One agency failed to notify the physician when a patient weighing only 120 pounds lost 9 pounds in less than 1 month.

- ▶ At another agency, the physician was not notified of two new open wounds on a patient's leg or of significant increase in edema of the leg. Consequently, the leg increased in size from 36 cm to 43 cm in just 1 week.
- ▶ In one extreme case, there was no communication by the skilled nurse to the physician or to the director of patient services and nurse supervisor about a patient's elevated temperature. According to the surveyor, a missed visit during this 3 day episode of elevated temperature compounded the problem. On the day following the missed visit, the patient was admitted to the hospital and died the evening of the next day.

***Failure to appropriately develop a comprehensive plan of care:***

- ▶ One agency failed to include all required information in the plans of care for 13 of 15 patient records reviewed by surveyors. These plans of care typically lacked instructions for the delivery of services, such as the frequency of visits. Other missing information pertained to the patients' prognoses and discharge plans.
- ▶ In another agency, a patient with multiple diagnoses had a plan of care that "lacked specific interventions and directives" related to blood glucose and nutritional monitoring, assessment and status of skin integrity, and psycho social issues. Despite clinical documentation of a worsening condition in all of these categories, including the development of stage II pressure sores, no further interventions or communications with the physician were made.

In most of the examples cited the agency did submit a plan of correction that addressed the problems found. These plans of corrections were subsequently approved by the State.

**Less commonly, plan of care deficiencies also indicate that more care was provided than ordered**

Our review also revealed cases where agencies provided more care than ordered by physicians in the plan of care. More specifically, they provided more visits or performed additional or different treatments than were ordered. Examples of this include:

- ▶ One agency provided an occupational therapy evaluation as well as six occupational therapy visits without the physician having ordered them.
- ▶ Another agency provided skilled nursing visits three times per week even though the physician ordered only one visit per week. The agency explained that after the registered nurse completed an initial assessment of the patient, she felt the patient needed more skilled nursing care than ordered. However, there was no documentation that the agency consulted the physician about this change.

# CONCLUSION

Just as there is no single cause for the increase in home health agency deficiencies, there is no single course of action to be taken. Instead, a combination of approaches may be appropriate, including strengthened State survey protocols and continued close scrutiny of the care being provided to home health beneficiaries.

The nature of deficiencies being cited indicate that some beneficiaries may not be receiving all the care they need. The introduction of the Prospective Payment System should in part address this concern, since it allocates more money for the most severe patients and establishes new payments every 60 days for long term patients. At the same time, this new system could create or increase the incentive on the part of some home health agencies to shortchange Medicare home health beneficiaries in the amount and intensity of care provided. It will therefore become even more important that HCFA and the States closely monitor the quality of home health care. We also intend to continue our own studies of all aspects of the implementation of the prospective payment system, including quality of care.

## Comments

The Health Care Financing Administration provided comments on this and two related draft reports. They concur with our conclusion that there appears to be no single cause for the increase in deficiencies. 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.

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

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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 Care: 2000,” OEI-02-00-00320, September 2000.

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

## **Agency Comments**

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



DATE: SEP - 1, 2000

TO: June Gibbs Brown  
Inspector General

FROM: Nancy-Ann Min DeParle  
Administrator

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EAIG	_____
PDIG	_____
DIG-AS	_____
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DIG-MP	_____
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Washington, D.C. 20201

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OFFICE OF INSPECTOR  
GENERAL

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).

*Nancy-Ann DeParle*

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.