Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOSPITAL DISCHARGE PLANNING

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Inspector General

DECEMBER 1997
OEI-02-94-00320

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To determine how and to what extent hospital ownership of home health agencies or nursing homes impacts hospital discharge planning for Medicare beneficiaries.

BACKGROUND

Hospital discharge planning is a process where a plan is developed for a patient to receive appropriate post-hospital placement and services.

A significant reduction in the average length of stay for acute care hospital patients created a greater need for post-hospital services such as home health and nursing home care. These reductions are widely believed to be associated with advances in medical technology as well as the implementation of the Medicare prospective payment system. As the average hospital stay decreases, the role of the hospital discharge planning process has become more critical.

This study focuses on discharge planning for patients who are referred to home health agencies or nursing homes owned by their discharging hospitals. We based our results on: utilization data for the hospital and post-hospital stays for a stratified random sample of Medicare beneficiaries who had been discharged from a hospital and went to either a home health agency or a nursing home; mail questionnaires sent these Medicare beneficiaries; mail questionnaires sent to discharge planners from the beneficiaries' discharging hospitals; and a review of materials related to the discharge planning process that were submitted to us by the discharge planners.

FINDINGS

Hospital ownership seems to have little influence on which nursing homes patients are referred to

We analyzed the discharge process experienced by beneficiaries in our sample who went to a nursing home. Regardless of whether the nursing home was owned by the discharging hospital, nursing home beneficiaries report having input in the referral process. Only 13 percent of them say, "the hospital just told me where to go." Only a quarter of beneficiaries report "no say" in the decision about which nursing home to choose. Many beneficiaries report that the decision to go to a particular nursing home was made by a relative. Of nursing home patients who were discharged from a hospital that owned a nursing home, only 40 percent went to the one owned by the discharging hospital.

However, it does influence the length of stay in both the hospital and the nursing home

There has been concern and some evidence that hospitals which own nursing homes discharge patients sooner to their own facilities and those patients stay in the facilities longer.

This raises the question of whether hospitals are lowering their costs for patients for whom they are receiving a lump sum prospective payment from Medicare and discharging those same patients to post-hospital services for which they are being paid on a cost basis. This cost shifting would result in increased Medicare reimbursement for the hospital.

When we analyzed relevant data for beneficiaries who got services from hospital-owned nursing homes, we found additional evidence supporting this concern. We found a statistically significant difference in the length of hospital stays; beneficiaries discharged to the hospital-owned nursing homes had average hospital stays of 6.8 days, as compared to 8.9 days for those beneficiaries who went to a nursing home independent of their hospital. In addition, we found a statistically significant difference in the length of nursing home stays; beneficiaries who went to the hospital owned nursing home averaged a 37 day nursing home stay while those who went to a nursing home independent of their hospital averaged a 29 day nursing home stay. This supports the concern that hospitals are shifting patients from acute care, reimbursed under a lump sum prospective payment, to post-acute care in nursing homes, which is reimbursed on a cost basis, thus maximizing Medicare reimbursement.

Hospital ownership does seem to have influence on which home health agencies patients are referred to

Many beneficiaries report not having full choice in selecting a home health agency. In contrast to nursing home beneficiaries, 38 percent of home health agency beneficiaries who went to hospital-owned agencies report that the hospital "just sent home care people to them." Again, in contrast to nursing home beneficiaries, focusing only on home health patients who were discharged from a hospital that owned a home health agency, we found that fully 62 percent of them went to the agency owned by the discharging hospital.

Discharge planners from hospitals which own home health agencies report that hospital ownership is a factor in their referral process to home health agencies: 19 percent report that, unless patients or families object, they refer all patients to their hospital-owned agency and almost 10 percent believe that someone from the hospital puts pressure on patients to choose a particular home health agency. Finally, hospitals owning home health agencies are more likely to have referral procedures than those which do not own agencies.

Hospital ownership also influences the duration of home health agency services

There was a statistically significant difference with regard to the length of home health agency services; those beneficiaries that received services from a home health agency owned by the hospital they were discharged from averaged 49 days of service while those receiving care from a home health agency independent of their hospital averaged 37 days of service. However, no statistically significant difference in the length of the hospital stay was found when comparing hospital stays for beneficiaries who received care from a home health agency owned by their discharging hospital to stays for those beneficiaries who received care from an agency independent of their discharging hospital.

Beneficiaries who go to hospital-owned nursing homes and home health agencies report better continuity of care

One goal of the discharge planning process is to promote a strong connection between the care provided in the hospital and the care given by the home health agency or nursing home. It is generally assumed that if discussions are held with patients regarding their post-hospital needs and how they can be addressed, the likelihood that these needs will be met is improved. It is also assumed that the earlier discussions are held and the more comfortable beneficiaries are with the timing of their hospital discharge, the better the continuity of their care will be.

Beneficiaries who went to hospital-owned home health agencies are more likely than those who got independent services to report: having been discharged at the right time (89 versus 77 percent); knowing what healthcare services they are supposed to get after leaving the hospital (92 versus 83 percent); and, that the connection between their care providers was very good (88 versus 43 percent). Those who went to hospital-owned nursing homes were more likely to report: having been talked to early; having been talked to about the post-hospital services they thought they would need (95 versus 61 percent); having been discharged at the right time; and, that their overall health improved (77 versus 43 percent).

Hospital ownership does not impact beneficiaries' level of satisfaction

Both home health agency and nursing home beneficiaries report high levels of satisfaction with the discharge planning process. Their satisfaction does not differ based on ownership.

RECOMMENDATIONS

Our findings suggest that hospital ownership of nursing homes plays a significant role with regard to the nursing home beneficiary utilization patterns. The hospital stay is shorter and the nursing home stay longer thus the hospital may be shifting cost from a prospective payment system to a cost-based system, maximizing Medicare reimbursement. Therefore, we recommend the following:

- The HCFA should develop statistical methods to target for special review providers who may be maximizing their Medicare reimbursement in this way. The records of these providers should be reviewed by the Peer Review Organizations, as in the past, or through some other suitable mechanism. Providers who are found to be inappropriately discharging beneficiaries to their own nursing homes should be subject to payment adjustments and appropriate fines or penalties.

Our findings also suggest that hospital ownership plays a significant role in home health agency referral discussions and some role, albeit a lesser one, in nursing home referral discussions. In addition, we found that many Medicare beneficiaries do not have full choice in selecting a home health agency or nursing home. Therefore, we recommend the following:

- The HCFA should assure that hospitals disclose ownership of home health agencies and nursing homes in a systematic way.

    - Hospitals which own home health agencies and nursing homes should be required to disclose the names of the home health agencies and nursing homes which they own to all beneficiaries who are possible candidates for these post-hospital services.

    - Hospitals which own home health agencies and nursing homes should be required to disclose this information to HCFA.

- The HCFA should take additional measures to assure that when beneficiaries are being discharged from the hospital they are given a choice in selecting a home health agency or nursing home from which to receive care.

    - Hospitals should be required to inform patients (or their families) that they are free to choose among home health agency providers and nursing homes. This information should be provided as early as possible.

    - Hospitals should maintain a file of Medicare participating home health agencies and nursing homes in the area and provide beneficiaries (or their families) with a list of alternatives which are appropriate for the level of care they need.

- Since our findings support the need for additional Medicare beneficiary information related to post-hospital services and choice, we recommend that HCFA prepare information for beneficiaries addressing this issue and circulate it widely.

1997 BALANCED BUDGET ACT

The 1997 Balanced Budget Act includes a provision which addresses the concern that some hospitals are shifting costs from a prospective payment system to a cost-based system, thus maximizing Medicare reimbursement. Section 4407 of this recently enacted law redefines beneficiaries with certain diagnoses who are discharged from hospitals to nursing homes and home health agencies (as well as other prospective payment exempt settings) as "transfers." This law limits payments to hospitals for these cases.

This recently enacted law addresses the concern disclosing hospital ownership information and Medicare that beneficiaries are informed of their freedom to choose the home health agency or nursing home to which they will be referred. Section 4321 of the 1997 Balance Budget Act requires hospitals referring patients to home health agencies (HHA) and other post-hospital providers to:

- not specify or otherwise limit beneficiaries in terms of which post-hospital service provider they receive services from;

- provide beneficiaries with information on HHAs and other post-hospital providers which serve the area;

- disclose to the beneficiary any financial interest which the hospital may have in an HHA or other post-hospital provider to which they are referred; and,

- disclose to HCFA the nature of any financial interest which the hospital has in a home health agency or other post-hospital service provider, as well as related referral rate information.

The HCFA is in the process of implementing both of these new provisions.

COMMENTS

We received comments on the draft report from the Health Care Financing Administration, the Assistant Secretary for Planning and Evaluation (ASPE) and the Assistant Secretary for Management and Budget. They generally concur with our recommendations. The actual comments received are in Appendix E.

The HCFA stated it hopes to use experience gained in implementing the new transfer policy authorized by the Balanced Budget Act to develop techniques that can be applied to a broader set of DRGs. The HCFA also expressed concern that the publication referenced in a draft report recommendation does not target the intended audience. To accommodate this concern we have modified our recommendation.

The ASPE provided suggestions for changes in wording and clarifications of the text which we have for the most part incorporated into the final report. They suggest that the report provide additional detail to the discussion about Federal requirements for discharge planning and the referral processes used by hospitals when discharging patients to nursing homes and home health agencies. Specifically, the ASPE recommended including a discussion of the criteria used by hospitals in selecting the post-acute provider type to which beneficiaries were referred. In an effort to better understand what factors are considered in making these post-hospital placement decisions, we asked discharge planners "When you determine that Medicare patients need post-hospital services, how do you decide whether they need home health agency services or they need to go to a nursing home?" Most respondents indicated that the following criteria were among the factors used to make this determination: the patients's medical needs, the degree of support available to the patient in their home, the preference of the patient and family, and the patient's ability to function safely at home. No one criterium was cited as being more important than the others.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To determine how and to what extent hospital ownership of home health agencies or nursing homes impacts hospital discharge planning for Medicare beneficiaries.

BACKGROUND

Post Hospital Care

A significant reduction in the average length of stay for acute care hospital patients created a greater need for post-hospital services such as home health and nursing home care. These reductions are widely believed to be associated with medical technology advances as well as the implementation of the Medicare prospective payment system. As the average hospital stay decreases, the role of the hospital discharge planning process has become more critical. Rapid growth of managed care organizations, with their emphasis on cost containment and efficiency, has also promoted discharging patients from hospitals as quickly as possible, and arranging for lower cost post-acute services.

According to the Prospective Payment Assessment Commission, the average length of a hospital stay for Medicare patients fell 13 percent between 1991 and 1994. During a similar period, the Commission found that, of all Medicare facility payments, the share going to post-hospital care providers increased from 6.9 percent to 22.4 percent. Facility payments include those made by the Medicare program and co-insurance companies, as well as beneficiary co-payments. As one example, while Medicare payments for home health care totalled an estimated $14.4 billion in 1995, home care spending is projected by the Congressional Budget Office to grow to $26 billion by the year 2000. As the average hospital stay decreases, the role of the hospital discharge planning process has become more critical.

Hospital Discharge Planning

There appears to be no single recommended model for a hospital discharge planning process. Definitions of what discharge planning involves and the organizational structures of the departments and professional credentials of the discharge planning staff vary from hospital to hospital. The social work or nursing department often has the primary responsibility for discharge planning, generally with input from other healthcare team members. The responsibility is sometimes in the case management or utilization review department.

Effective discharge planning identifies the patient's post-hospital needs early to ensure discharge to a safe environment with the appropriate level of services. A typical scenario might look like this: within 24 hours of entering the hospital, the admission record would be screened to identify a high risk patient who requires discharge planning. Typical high risk criteria might include: age 65 and older, living alone with no immediate social supports;

stroke, heart attack, chronic obstructive pulmonary disease, congestive heart failure, emphysema, dementia, Alzheimers, AIDS, or other possibly life threatening illnesses; admission from a residential care home; homelessness; and no insurance.

Once a determination has been made that a patient needs discharge planning, the discharge planner conducts a psycho-social assessment and meets with utilization review staff, the patient's nurses and physicians, or other relevant interdisciplinary team members, to discuss the patient's care plan. Early on, the discharge planner solicits the patient's preferences and concerns, and reaches out to the family or other potential care givers to get their input and cooperation. As the discharge planner gains a clearer understanding of the level of care that the patient needs after discharge, he/she analyzes the patient's insurance coverage in an effort to match the patient's needs for services with those for which they are eligible.

Patients may be discharged to a variety of settings. These include a patient's home with or without services from a home health agency or a nursing home. One recent national study on post-acute care[1] found that two-thirds of discharged patients received post-acute care services, with 29 percent going to nursing homes and 25 percent going home with care from home health agencies (another 8 percent were discharged to rehabilitative homes).

Regulations Affecting Hospital Discharge Planning

Each hospital is required to have a discharge planning process in place. These requirements are addressed in a number of places, including Federal laws and regulations, State licensing requirements, and the Joint Commission on Accreditation of Healthcare Organizations' accreditation standards. Federal policies related to financial arrangements between hospitals and post-hospital services can be found in the Federal anti-kickback regulations.

Medicare Conditions of Participation

Federal regulations[2] require that hospitals have in place a discharge planning process. This process must apply not only to Medicare and Medicaid patients but to all patients served by the hospital who need discharge planning. The rules include requirements that:

(1) Patients in need of evaluation be identified on a timely basis;

(2) a discharge planning evaluation be completed for patients identified during the initial screening, including an evaluation of the patient's capacity for self-care and the possibility of this patient being cared for in the environment from which he/she entered the hospital;

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[1]Kane, R.L., M.D., Principal Investigator. A Study of Post-Acute Care. Institute For Health Services Research (HCFA #17-C98891) May 1994.

[2] 42 CFR Section 482.43, effective January 12, 1995

(3) discharge plans be developed by qualified personnel, patients be counseled as needed to prepare them for post-hospital care and the initial implementation of the patient's discharge plan be done by the hospital;

(4) the hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities for follow-up care; and

(5) the hospital must reassess its discharge planning process on an on-going basis to ensure that it is responsive to the discharge needs of their patients.

JCAHO Requirements

When hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations, HCFA does not independently review the hospital. The JCAHO's continuum of care standards address discharge planning. They specifically address the hospital's need to provide for: referral, transfer, or discharge of the patient to another level of care based on the patient's assessed needs; a discharge process which results in continuing care which is appropriate; exchange of patient care and clinical information when patients are discharged; and the establishment of a procedure to resolve denial-of-care conflicts over care, services, or payment in the hospital.

Utilization Review

Federal regulations[3] discuss utilization review, a process which seeks to assure that each patient is discharged from the hospital at the appropriate time. These regulations state that the hospital must have in effect a utilization review plan that provides for review of services furnished by the institution and members of their medical staff to patients entitled to Medicare and Medicaid.

Patient Freedom to Choose

Section 1802 of the Social Security Act seeks to ensure that free choice is guaranteed to all Medicare patients. It states: "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services." This gives patients freedom to choose who they want as their provider of post-hospital services. Some within the home health industry interpret it even further to say that patients must be provided with choices whenever a discharge planner refers them for post-hospital services[4].

Additionally, Medicare requires all hospitals that participate in the Medicare program to

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[3] 42 CFR Section 482.30 Conditions of Participation

[4] See 1997 Balanced Budget Act section on page x.

provide patients with "An Important Message From Medicare" at the time of admission. This message provides information on discharge from the hospital, including a description of the patient's right to appeal to the Peer Review Organization if they think they are being asked to leave the hospital too soon.

Anti-Kickback Laws

The Federal anti-kickback statute[5] is also pertinent to the discharge planning process. Aimed at stemming fraud and abuse, this statute places some limitations on the referral of Medicare and Medicaid patients to services. It makes it illegal to offer or pay anything of value to induce a person to order any item for which payment may be made under the Medicare or Medicaid programs.

A separate statute[6] prohibits a physician with "a significant ownership interest in or a significant financial or contractual relationship with a home health agency" from preparing plans for care or certifying or recertifying to the need for care. Finally, another statute[7] generally prohibits Medicare or Medicaid payment where physicians refer patients to 11 kinds of healthcare facilities or services, such as home health agencies, in which they have an ownership interest.

State Licensing

Depending on the State, the State hospital licensing requirements may or may not have discharge planning criteria. In New York State, these requirements are considered by discharge planners to be more stringent than Federal or JCAHO rules. However, it should be noted that New York is not necessarily representative of the country.

Home Health Fraud Alert

In June 1995, the Office of Inspector General issued a Home Health Fraud Alert which included information pertinent to the hospital discharge planning process. It discussed providers paying or receiving kickbacks in exchange for Medicare or Medicaid referrals. Specifically, providers were warned that, "Providing hospitals with discharge planners, home health coordinators, or home care liaisons in order to induce referrals can constitute a kickback."

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[5] Section 1128B [42 U.S.C. Section 1320a-76(b)]

[6] Section 1814(a)

[7] Section 1877

Health Care Financing Administration Activities

Oversight of Home Health Agency Reimbursement

As the number of hospitals with on-site home care coordinators grows, so does the potential for inappropriate solicitation and increased reimbursement. The HCFA continues to oversee the process by which the intermediaries audit home health agencies' reimbursement claims for home health agency coordination costs. The Health Insurance Manual[8] specifies which home health agency coordination costs are allowable. While specifying that some costs for activities performed at the hospital are reimbursable, it emphasizes that a careful evaluation is needed to ensure that no payment is made for: patient solicitation; activities duplicative of the hospital's discharge planning; and/or visits by home health agency staff to patients not yet referred.

The manual also addresses reimbursement rules for home health coordination in hospital-based home health agencies. In these instances, reasonable costs of hospital discharge planning services performed by personnel assigned to the home health agency are allowable, provided that the costs are classified as costs of the hospital and do not represent a duplication of costs performed by other personnel.

Uniform Needs Assessment Instrument

As the result of a legislative mandate, HCFA developed and has begun testing a Uniform Needs Assessment Instrument to evaluate a patient's requirements for post-acute care.

Recent Studies

An Office of Inspector General report entitled "Financial Arrangements Between Physicians and Health Care Businesses," mandated by Congress in June of 1988 and published May 1989, analyzed the extent and impact of financial arrangements between physicians and other service providers. The major finding was that many physicians had financial relationships with health care businesses to which they referred patients. A September 1993 report entitled "Medicare Home Infusion Therapy" found that physician ownership of home infusion companies (and other financial arrangements) were common.

A recent study, "Understanding Hospital Referrals to Home Health Agencies," by Kathryn H. Dansky, RN, PhD et al. studied 1990 discharge data from 61 Pennsylvania hospitals. They found that patients who were discharged from hospitals that own a home health agency are 21 percent more likely to receive a referral for home care services than those who are discharged from hospitals that do not own an agency. This increased referral rate was greater for urban than it was for rural hospitals.

The previously referenced HCFA funded research project, "A Study of Post-Acute Care,"

[8] (HIM) #2113

included an analysis of whether hospital ownership of a post-acute facility was a good predictor of the place to which patients would be discharged. The fact that a hospital owned a post-acute facility was not found to be a consistent predictor of whether or not a patient received post-acute services, or of whether the post-acute provider was hospital-owned.

Other relevant work includes research done by the Prospective Payment Assessment Commission which sought, among other things, to analyze whether hospital ownership of a post-acute unit affected the average length of stay in the hospital. The Commission found that the average length of hospital stay was lower in hospitals which owned post-acute care units than in hospitals which did not own such a unit. In their view, this finding is significant because it raises the question of whether hospitals are lowering their costs for patients for whom they are receiving a lump sum payment from Medicare and discharging those same patients to post-acute care for which they are being paid on a cost basis.

Operation Restore Trust

This inspection is being conducted as part of the Department of Health and Human Services anti-fraud initiative called Operation Restore Trust (ORT). This is a joint effort by the Office of Inspector General, HCFA, and the Administration on Aging designed to coordinate Federal and State resources to combat fraud, waste, and abuse related to home health agencies, nursing homes, and medical equipment and supplies. This initiative is focused on 5 States (California, Florida, Illinois, New York, and Texas) which together account for 40 percent of Medicare beneficiaries and expenditures.

METHODOLOGY

Sample Selection

A stratified random sample of 1,000 Medicare beneficiaries was selected from the 1 percent 1995 inpatient Common Working File. We used this file even though it contained only 89 percent of 1995 claims because we needed the most up-to-date information we could get to survey Medicare beneficiaries about their hospital and post-hospital experience. We selected all claims where the discharge date was between September 1, 1995 and December 31, 1995 and the discharge indicator showed the patient was sent to a skilled nursing home, intermediate care nursing home or home health agency. For purposes of this report, we grouped skilled and intermediate care facilities together and refer to them as nursing homes. The result of this extract was 6,915 claims for 6,136 beneficiaries. The Medicare numbers for these 6,136 beneficiaries were matched to the Enrollment Database to find out which beneficiaries were alive. A total of 1,316 beneficiaries had died, leaving 4,820 claims.

These 4,820 claims were divided into two strata: the five Operation Restore Trust States and all other States. There were 1,572 inpatient claims for the five ORT States and 3,248 for all others. We then randomly selected a total of 1,000 beneficiaries; 750 from the ORT strata and 250 from all others. Unless otherwise noted, there were no significant differences in respondents' answers based on whether they were in the ORT or non-ORT strata. Since managed care data is not included in the Common Working File and there is no itemization

of services, managed care beneficiaries were not included in our sample for this study.

The hospital provider number was then selected from each beneficiary inpatient claim. This number was subsequently found in the Online Survey and Certification Reports data, as well as in the Hospital Cost Report Information System and used to identify which hospitals owned nursing homes or home health agencies. The hospital-based designation was utilized as a surrogate for ownership. These files were also used to identify the nursing home or home health agency (HHA) provider number.

The Common Working File was divided between the nursing home and home health agency stay records for sample beneficiaries. The provider numbers were compared to the hospital-owned provider numbers to determine hospital ownership. This enabled us to identify those beneficiaries in our sample who were discharged from hospitals to a post-hospital service owned by their discharging hospital, as well as those discharged to services that were not owned by their hospital.

For the purposes of this study, we use the term "post-hospital services" to refer to care by either a nursing home or a home health agency. Post-hospital services which are not owned by the discharging hospital are referred to as "independent."

Utilization Data

We obtained data for each beneficiary in the sample for the period during hospitalization and the 6 months subsequent to discharge from the hospital. This data included: the beneficiary's diagnosis related group; the hospital length of stay; the hospital charges; the type and duration of the post-hospital service; the post-hospital diagnoses; the post-hospital charges and, whether and how often the beneficiary was re-admitted to the hospital during the 6 month period following discharge from the hospital. This information was analyzed to compare those beneficiaries who went to their hospital-owned post-hospital facilities with those who did not.

Beneficiary Questionnaire

Since previous Office of Inspector General studies have demonstrated the value of data obtained from beneficiaries in understanding important issues, we used a mail survey to contact beneficiaries about their hospital discharge planning experience and determine their level of satisfaction with the process and its outcome.

From the sample, we identified the name and address of the beneficiary, and sent a mail questionnaire to each of the 1,000 beneficiaries in our sample to be answered by either the beneficiary or his/her surrogate. We asked questions about: the hospital discharge planning that was done for them; how they thought nursing homes or home health agencies were chosen; whether they were given choices for their post-hospital care; how satisfied they were with the post-hospital service selection process, as well as with the service itself; changes in their activities of daily living and in their overall health; and, whether or not the post-hospital service they received helped in their recovery. We received responses from 650 (65

percent) of the 1,000 surveys. After excluding beneficiaries whose data records were incomplete, 561 beneficiaries remained--362 who received home health services and 199 who went to nursing homes upon discharge. We then compared the answers of those beneficiaries who received services from providers owned by their discharging hospital to those who received services from providers not owned by their discharging hospital.

Hospital Discharge Planner Questionnaire

We sent mail questionnaires to the discharge planning departments of our sample beneficiaries' discharging hospitals. We asked discharge planners questions about: their experiences as a hospital discharge planner; directives their hospital had given them regarding their responsibility in the discharge planning process; how the choice of post-hospital service for our sample beneficiary was made; any concerns they have in the area of discharge planning; and other questions about the discharge planning process when patients go to home health agencies and nursing homes. The discharge planners were also asked to send copies of relevant documents including: the screening criteria they use to determine which patients receive discharge planning services; a checklist of discharge-related discussion points to cover with patients and their families; and, written procedures on determining which home health agency or nursing home to which Medicare patients will be referred. We then compared the answers of those discharge planners from hospitals that owned a nursing home or home health agency to those that did not.

Since our unit of analysis was a beneficiary and there were instances where multiple beneficiaries went to a particular hospital, we duplicated pertinent records and counted those discharge planners' responses more than once. Discharge planner questionnaires were received for 630 (63 percent) of the sample beneficiaries; the number of unique discharge planner responses received was 466.

All differences reported between subgroups are statistically significant at the 90 percent level unless otherwise noted.

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

FINDINGS

HOSPITAL OWNERSHIP SEEMS TO HAVE LITTLE INFLUENCE ON WHICH NURSING HOME PATIENTS ARE REFERRED TO

Regardless of whether the nursing home was owned by the discharging hospital, nursing home beneficiaries report having input in the referral process

We analyzed the discharge process experienced by beneficiaries in our sample who went to nursing homes. Regardless of whether the nursing home was owned by the discharging hospital, only 13 percent of beneficiaries say, "the hospital just told me where to go." Only a quarter of them report "no say" in the decision about which nursing home to choose. Beneficiaries who went to hospital-owned nursing homes are likely to report that someone from the hospital talked to them about which nursing home they wished to be referred to (73 percent).

Seventy-nine percent of all beneficiaries who were referred to a nursing home report that they felt "no pressure" in their choice of a particular nursing home. There was no significant difference in the responses of those who did and those who did not go to the hospital-owned nursing home. In addition, many beneficiaries report that the decision to go to a particular nursing home was made by a relative.

There appears to be a correlation between the amount of input a beneficiary believes he/she has in the referral process and his/her satisfaction with the process and its outcome. With regard to nursing homes, those who indicate that they had no say in their referral to a particular nursing home were less likely (47 percent) than beneficiaries who had all of the say (93 percent) to report that they were satisfied with how the referral to the nursing home was made.

The majority of Medicare patients who were in a nursing home prior to admission to the hospital returned to the same service provider after hospitalization. The beneficiaries that went to a different nursing home generally attribute the switch to a change in their health care needs after discharge.

Regardless of ownership, discharge planners report that hospital ownership is not a major factor in the nursing home referral process

Just 5 percent of the discharge planners from hospitals that own nursing homes report that they refer patients to the hospital-owned nursing home unless patients and families object. None of the discharge planners from hospitals that own nursing homes report that it is generally understood that they should send all their patients to the hospital-owned nursing home.

Fourteen percent of discharge planners, when asked which things were important in choosing the nursing home that a Medicare patient would go to, answered, "the nursing home is

owned by the hospital." None of those discharge planners cited it as the main reason.

Hospitals are not likely to have procedures for referral to nursing homes

Two-thirds of discharge planners from hospitals which own nursing homes report not having instructions on nursing home referral.

Forty-three discharge planners submitted attachments regarding their nursing home referral policies. The policies outlined in these attachments were generally dictated by bed availability. The typical procedure was that a patient would select three to five nursing homes in a 50 mile radius. The beneficiary would go to the first nursing home to accept them.

In the attachments we received on this issue, hospital ownership of a nursing home did not seem to have a strong affect on the discharge policy. Of the 23 attachments received from hospitals which owned a nursing home, only four mentioned their nursing home. An example is that patients would be sent to the hospital-owned nursing home only if the patient, his or her family and doctor had no preference. All of the attachments seemed to indicate that the patient was to be given input into the process of choosing their nursing home.

Forty percent of patients discharged from hospitals that owned nursing homes were referred to the nursing home owned by their discharging hospital

Focusing only on nursing home patients who were discharged from a hospital that owned a nursing home, we found that only 40 percent of them went to the hospital-owned nursing home. The nursing home referral process is a complex one with many factors at work. These include limited service and bed availability, as well as the proximity of the nursing home to relatives or friends.

HOSPITAL OWNERSHIP DOES INFLUENCE THE LENGTH OF STAY IN BOTH THE HOSPITAL AND THE NURSING HOME

Hospital ownership results in both shorter hospital stays and nursing home use of longer duration

As discussed in the background section, there has been concern and some evidence that hospitals which own nursing homes discharge patients sooner to their own facilities and those patients stay in the facilities longer and are readmitted to the hospital more frequently. This raises the question of whether hospitals are lowering their costs for patients for whom they are receiving a lump sum prospective payment from Medicare and discharging those same patients to post-hospital services for which they are being paid on a cost basis. This cost shifting would result in increased Medicare reimbursement for the hospital. When we analyzed relevant data for beneficiaries who got services from hospital-owned nursing homes, we found additional evidence supporting this concern.

We found that the patients discharged to the hospital-owned nursing homes had significantly

shorter hospital stays. The average number of days that beneficiaries were in the hospital prior to going to a nursing home owned by their discharging hospital was 6.8, as compared to 8.9 days for those beneficiaries who went to a nursing home independent of their hospital. This result is statistically significant. (See Appendix B.)

Those beneficiaries who went to a nursing home owned by the hospital they were discharged from also averaged a longer stay in the nursing home. Beneficiaries who went to the owned facility averaged a 37 day nursing home stay while those who went to a nursing home independent of their hospital averaged a 29 day nursing home stay. This is also a statistically significant difference. (See Appendix B.) This supports the concern that hospitals are shifting patients from acute care, reimbursed under a lump sum prospective payment, to post-acute care in nursing homes, which is reimbursed on a cost basis, thus maximizing Medicare reimbursement.

There was, however, no significant difference in the number or hospital readmissions based on ownership. Also, our sample selection did not allow for analysis of specific diagnosis related groups or sub-components of care providers such as skilled nursing facility distinct units.

HOSPITAL OWNERSHIP INFLUENCES REFERRALS TO HOME HEALTH AGENCIES MORE THAN IT DOES FOR NURSING HOMES

Many beneficiaries do not have full choice in selecting a home health agency

In contrast to nursing home beneficiaries, beneficiaries who went to hospital-owned home health agencies were more likely than those who went to agencies not owned by their hospital to report that the hospital "just sent home care people to them." Thirty-eight percent of beneficiaries who went to hospital-owned home health agencies report that "the hospital just sent home care people" to them. In contrast, only 24 percent of the recipients of home health services which were independent of their discharging hospital reported this. Additionally, recipients of hospital-owned services were less likely to indicate that they had some form of input into the choice of a home care agency. These recipients were **less** likely to report one of the following:

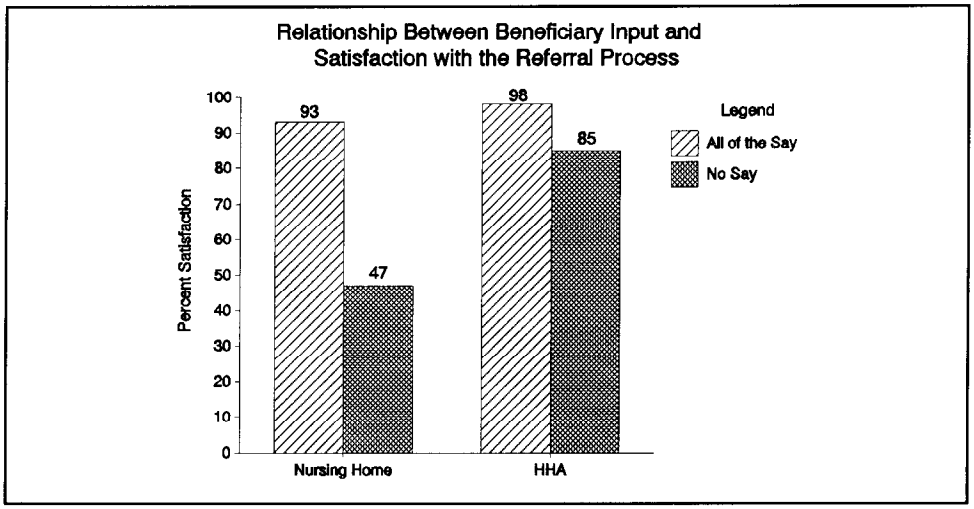
- "the hospital advised me but I made my own decision;"
- "I made the decision on my own without any advice from the hospital;"
- "I asked for advice, and took the hospital's recommendation;"
- "the hospital gave me a list of home care agencies and I picked one."

Because of the relatively small sample size, we cannot demonstrate that the differences discussed above are statistically significant. However, the trend they point to is consistent with a number of other related survey respondent trends.

When Medicare beneficiaries were asked whether someone from their discharging hospital suggested the name of a home health agency or they thought of the agency themselves, beneficiaries who got HHA services from providers which were owned by their discharging

hospital were less likely to report that they thought of the home care agency themselves.

While a quarter of nursing home beneficiaries report "no say" in the decision about which nursing home to go to, more beneficiaries who got home health services (one-third) report having "no say," regardless of ownership. There appears to be a correlation between the amount of input a beneficiary believed he/she had in the referral process and his/her satisfaction with the process. Those who indicate that they had no say in their referral to a particular home health agency were less likely (85 percent) than beneficiaries who had all of the say (98 percent) to report that they were satisfied with how the referral to the home care agency was made.



The majority of Medicare patients who had home health agency services before entering the hospital, used the same service provider after their hospitalization. This is true regardless of whether or not a patient was in a hospital which owns an HHA. When patients who report not using the same home care agency after their hospitalization were asked why they switched home care agencies after their hospitalization, most of them say that they did not like their original agency. No beneficiaries report changing agencies because the hospital indicated they should use the hospital-owned agency.

Sixty-two percent of patients discharged from hospitals that owned a home health agency were referred to an agency owned by the hospital

In contrast to nursing home beneficiaries, focusing only on home health patients who were discharged from a hospital that owned a home health agency, we found that fully 62 percent of them went to agency owned by the discharging hospital.

Discharge planners report that hospital ownership is a factor in their referral process to home health agencies

Nineteen percent of discharge planners from hospitals that own home health agencies report that it is generally understood that they refer all their patients who need home health care to their hospital-owned agency or that, unless patients or families object, they refer all patients to their hospital-owned agency.

When discharge planners were asked which things were important in choosing a home health agency for a Medicare beneficiary, 25 percent of those from hospitals that own a home health agency responded, "the home health agency is owned" by the hospital. Seven percent of them give it as the main reason.

Almost 10 percent of the discharge planners from hospitals that own home health agencies believe that someone from the hospital puts pressure on patients to choose a particular home health agency compared to 6 percent when there is no ownership. Because of the relatively small sample size, we cannot demonstrate that this last difference is statistically significant. However, this trend is consistent with other related survey responses.

Hospitals owning home health agencies are somewhat more likely to have written or verbal referral procedures than those without ownership

Fifty-three percent of discharge planners from hospitals that own home health agencies reported having written procedures or verbal instructions for determining to which home health agency a patient is to be referred. Forty-one percent of discharge planners from hospitals that do not own agencies report having similar instructions.

Of the 121 discharge planners that reported having written procedures, almost half (58) of them submitted attachments in response to our request for procedural information on the home health care referral process. Of these, the majority (33) cited patient choice as the dominant factor in their discharge process. When patient choice is cited, the patient is usually presented with a list of options from which to choose.

Fourteen of the planners who submitted attachments indicated that patients without a preference were directed to their hospital-owned home health agency. A typical example of this policy would be that "It is the policy of the case management department to refer patients to X home health agency if the patient lives in the area and does not express a preference for another care provider." Seven of the discharge planners submitted attachments which cited the discharge planning team or physician's preference as the deciding factor in referring patients to a particular home health agency. In this case, a policy would not mention patient choice but would state that "the physician may recommend that a specific vendor be used."

Only four attachments contained language which strongly encouraged the promotion of hospital-owned HHAs in the discharge process. One of these even included a hospital policy that says, "Referrals leaving the [hospital-owned] system = $$$ leaving the system."

Discharge planners report giving adequate choice

Almost all discharge planners say that there is meaningful beneficiary involvement in the discharge planning process. Regardless of ownership, 84 percent of all discharge planners report that beneficiaries have all of the say or quite a bit of say in the choice of a home health agency or nursing home to go to and less than 10 percent report that beneficiaries have no say or just a little say.

Discharge planners rank a patient's diagnosis and home support as the most important factors in determining the patient's need for post-hospital services. Similarly, in deciding whether to refer a patient to a home health agency or a nursing home, discharge planners cite the patient's medical needs, the need for 24 hour supervision and home support as the dominant considerations.

Most discharge planners list lack of patient/family commitment and availability of appropriate services as the greatest obstacles to effective discharge planning (81 percent and 67 percent, respectively). Five percent of the respondents cite hospital pressure to discharge patients to inappropriate post-hospital services as a problem in discharge planning.

While 72 percent of the discharge planners report having no checklist of discharge related discussion points, the majority of those without a checklist believe that one would be helpful to them. See Appendix A for a sample checklist based on common factors from selected checklists submitted by the discharge planners.

HOSPITAL OWNERSHIP INFLUENCES THE DURATION OF HOME HEALTH AGENCY SERVICES

Hospital ownership results in home health agency use of longer duration

As with nursing homes, there has been some evidence that hospitals which own home health agencies discharge patients sooner to their own facilities and those patients stay in the facilities longer. We found some evidence supporting this concern.

Those beneficiaries that received services from a home health agency owned by the hospital they were discharged from averaged 49 days of service while those receiving care from a home health agency independent of their hospital averaged 37 days of service. This is a statistically significant difference. (See Appendix B.)

The average number of days that beneficiaries were in the hospital prior to receiving care from a home health agency owned by their discharging hospital was 7.3 days. For those beneficiaries who received care from an agency independent of their discharging hospital the average was 8.3 days. This one day difference was not satistically significant.

The number of hospital readmissions during the 6 month period after hospital discharge to a home health agency showed no significant differences based on ownership.

BENEFICIARIES WHO GO TO HOSPITAL-OWNED NURSING HOMES AND HOME HEALTH AGENCIES REPORT BETTER CONTINUITY OF CARE

One goal of the discharge planning process is to promote a strong connection between the care provided in the hospital and the care given by the home health agency or nursing home. It is generally assumed that if discussions are held with patients regarding their post-hospital needs and how they can be addressed, the likelihood that these needs will be met is improved. It is also assumed that the earlier discussions are held and the more comfortable beneficiaries feel with the timing of their hospital discharge, the better the continuity of their care will be.

Beneficiaries who went to hospital-owned nursing homes are more likely to report having been talked to early and having been discharged at the right time

Beneficiaries who received services from hospital-owned nursing homes are much more likely to report having been consulted in the beginning or middle of their stay about the services they might need after their discharge. Those who received services from a nursing home which was not owned by their hospital are more likely to report having been talked to just before they left the hospital or not at all.

Ninety-five percent of the beneficiaries who went to a hospital-owned nursing home say that someone from the hospital spoke to them (or their families) about the services they thought they would need after discharge. In contrast, only 61 percent of those beneficiaries who did not go to a hospital-owned nursing home reported having a similar conversation. Furthermore, the beneficiaries who went to the hospital-owned nursing home were twice as likely to report that the information hospital staff gave them about the post-discharge services they would need was helpful. Finally, beneficiaries who received services from hospital-owned nursing homes are more likely to report believing that they were discharged from the hospital at the right time rather than too soon.

Beneficiaries who went to the nursing home owned by their hospital are more likely to report that the connection between their care providers is very good

Beneficiaries who received services from the hospital-owned nursing home are also more likely to report that they received the services they were told they would get (100 percent versus 64 percent). In addition, a greater proportion of this group said that the connection between the care they got in the hospital and the care they received from the nursing home was very good (88 percent versus 43 percent).

In addition, a higher percentage of beneficiaries who went to their hospital-owned nursing home report that their overall health improved in the nursing home (77 percent versus 43 percent).

Beneficiaries who went to hospital-owned home health agencies are more likely to report having been discharged at the right time

Beneficiaries who received services from hospital-owned agencies are more likely to report believing that they had been discharged from the hospital at the right time (89 percent versus 77 percent) rather than too soon (8 percent versus 15 percent). In addition, beneficiaries who got services from the hospital-owned home health agency are more likely than those who received independent services to know what health care services they were supposed to get after leaving the hospital.

Beneficiaries who went to hospital-owned home health agencies are more likely to report that the connection between their care providers was very good

Beneficiaries who received services from the hospital-owned home health agency are also more likely to report that they received the home health agency services they were told they would get (92 percent versus 83 percent). In addition, a greater proportion of this group said that the connection between the care they got in the hospital and the care they received from the home health agency was very good. Because of the relatively small sample size, we cannot demonstrate that the difference reported with regard to the connection between care providers was statistically significant. However, the trend which the responses point to is consistent with a number of other related survey responses.

HOSPITAL OWNERSHIP DOES NOT IMPACT BENEFICIARIES' REPORTED LEVEL OF SATISFACTION

Beneficiaries report high levels of satisfaction with the discharge planning process

Over 80 percent of beneficiaries report being satisfied with: how much of a say they had in the kind of services they would get after leaving the hospital; how well the hospital planned for their post-hospital services; as well as, how the home health referral decision was made. This was true regardless of whether or not the Medicare patient went to a home health agency owned by their discharging hospital.

Beneficiary satisfaction with nursing home or home health agency services does not differ based on hospital ownership

We asked beneficiaries about their level of satisfaction with: the care they got in the nursing home; how long each visit by a nursing home person lasted; how well the nursing home people worked together; and how well the nursing home people responded to their needs. Over 85 percent of beneficiaries reported being satisfied in all of these areas. This pattern held true when beneficiaries were asked about their overall level of satisfaction as well. We asked beneficiaries about their level of satisfaction with: the number of home health agency visits; how long each visit was; how well the staff worked together; and, how well staff responded to their needs. Almost all (90 percent) beneficiaries reported being satisfied in all of these areas. This pattern held true when beneficiaries were asked about their overall level of satisfaction as well.

RECOMMENDATIONS

Our findings suggest that hospital ownership of nursing homes plays a significant role with regard to the nursing home beneficiary utilization patterns. The hospital stay is shorter and the nursing home stay longer thus the hospital may be shifting cost from a prospective payment system to a cost-based system, maximizing Medicare reimbursement. Therefore, we recommend the following:

- The HCFA should develop statistical methods to target for special review providers who may be maximizing their Medicare reimbursement in this way. The records of these providers should be reviewed by the Peer Review Organizations, as in the past, or through some other suitable mechanism. Providers who are found to be inappropriately discharging beneficiaries to their own nursing homes should be subject to payment adjustments and appropriate fines or penalties.

Our findings also suggest that hospital ownership plays a significant role in home health agency referral discussions and some role, albeit a lesser one, in nursing home referral discussions. In addition, we found that many Medicare beneficiaries do not have full choice in selecting a home health agency or nursing home. Therefore, we recommend the following:

- The HCFA should assure that hospitals disclose ownership of home health agencies and nursing homes in a systematic way.

    - Hospitals which own home health agencies and nursing homes should be required to disclose the names of the home health agencies and nursing homes which they own to all beneficiaries who are possible candidates for these post-hospital services.

    - Hospitals which own home health agencies and nursing homes should be required to disclose this information to HCFA.

- The HCFA should take additional measures to assure that when beneficiaries are being discharged from the hospital they are given a choice in selecting a home health agency or nursing home from which to receive care.

    - Hospitals should be required to inform patients (or their families) that they are free to choose among home health agency providers and nursing homes. This information should be provided as early as possible.

    - Hospitals should maintain a file of Medicare participating home health agencies and nursing homes in the area and provide beneficiaries (or their families) with a list of alternatives which are appropriate for the level of care they need.

- Since our findings support the need for additional Medicare beneficiary information related to post-hospital services and choice, we recommend that HCFA prepare information for beneficiaries addressing this issue and circulate it widely.

1997 BALANCED BUDGET ACT

The 1997 Balanced Budget Act includes a provision which addresses the concern that some hospitals are shifting costs from a prospective payment system to a cost-based system, thus maximizing Medicare reimbursement. Section 4407 of this recently enacted law redefines beneficiaries with certain diagnoses who are discharged from hospitals to nursing homes and home health agencies (as well as other prospective payment exempt settings) as "transfers." This limits payments to hospitals for these cases.

This recently enacted law also addresses the concern that hospitals disclose ownership information and that Medicare beneficiaries are informed of their freedom to choose the home health agency or nursing home to which they will be referred. Section 4321 of the 1997 Balance Budget Act requires hospitals referring patients to home health agencies (HHA) and other post-hospital providers to:

- not specify or otherwise limit beneficiaries in terms of which post-hospital service provider they receive services from;

- provide beneficiaries with information on HHAs and other post-hospital providers which serve the area;

- disclose to the beneficiary any financial interest which the hospital may have in an HHA or other post-hospital provider to which they are referred; and,

- disclose to HCFA the nature of any financial interest which the hospital has in a home health agency or other post-hospital service provider, as well as related referral rate information.

The HCFA is in the process of implementing both of these new provisions.

COMMENTS

We received comments on the draft report from the Health Care Financing Administration, the Assistant Secretary for Planning and Evaluation (ASPE) and the Assistant Secretary for Management and Budget. They generally concur with our recommendations. The actual comments received are in Appendix E.

The HCFA stated it hopes to use experience gained in implementing the new transfer policy authorized by the Balanced Budget Act to develop techniques that can be applied to a broader set of DRGs. The HCFA also expressed concern that the publication referenced in a draft

report recommendation does not target the intended audience. To accommodate this concern we have modified our recommendation.

The ASPE provided suggestions for changes in wording and clarifications of the text which we have for the most part incorporated into the final report. They suggest that the report provide additional detail to the discussion about Federal requirements for discharge planning and the referral processes used by hospitals when discharging patients to nursing homes and home health agencies. Specifically, the ASPE recommended including a discussion of the criteria used by hospitals in selecting the post-acute provider type to which beneficiaries were referred. In an effort to better understand what factors are considered in making these post-hospital placement decisions, we asked discharge planners "When you determine that Medicare patients need post-hospital services, how do you decide whether they need home health agency services or they need to go to a nursing home?" Most respondents indicated that the following criteria were among the factors used to make this determination: the patients's medical needs, the degree of support available to the patient in their home, the preference of the patient and family, and the patient's ability to function safely at home. No one criterium was cited as being more important than the others.

APPENDIX A

PROPOSED DISCHARGE PLANNING CHECKLIST

Of the 121 discharge planners that report having checklists, 53 submitted them for our review.

The documents submitted varied greatly in length and content. We identified a number of check lists which had a relatively simple, clear and user-friendly format and analyzed them. They also had a relatively comprehensive set of items. Our working definition of comprehensive was that the checklist included at least some items which fell into each of the following three types: pre-admission factors; pre-discharge factors; and patient and family involvement in discharge planning.

On the basis of our analysis of the documents and discharge related discussions with patients and families we developed the sample checklist below:

Hospital Discharge Planning Checklist
(A Proposed Model)

Patient ID_____ Admission Date_____
Admitting Dx_____ Planned Rx_____

I. PRE-ADMISSION STATUS

1. Living arrangements ____
7. Special Circumstances ____
2. Physical (ADL) function ____
3. Mental function ____
4. Social supports ____
5. DME used ____
6. Services received ____

(DESCRIBE EACH BELOW):

II. PRE-DISCHARGE FACTORS

1. Understanding of medical condition by patient ____
2. Understanding of medical condition by family/SO ____
3. Physical (ADL) function ____
4. Mental function ____
5. Financial resources ____
6. Social supports available after discharge ____
7. Special circumstances ____

(DESCRIBE EACH BELOW):

III. DISCHARGE PLAN

1. Services needed after discharge ____
2. Type of Placement preferred by patient ____
3. Type of Placement preferred by family/SO ____
4. Type of Placement recommended by hospital ____
5. Type of Placement agreed to by patient/family ____
6. Specific agency/home recommended by hospital ____
7. Specific agency/home agreed to by patient/family ____
8. Pre-discharge counseling recommended ____
9. Special circumstances ____

(DESCRIBE EACH BELOW):

IV. SUMMARY

1. Nature and outcome of patient and family involvement in discharge planning process:

2. Anticipated problems in implementing post discharge plans:

3. Further hospital action contemplated:

APPENDIX B

ANALYSIS OF BENEFICIARY UTILIZATION DATA

Two separate files were created (one for nursing homes and one for HHAs) since it was hypothesized that these two types of discharges might be different. The analysis involved comparisons of the following data: (1) beneficiaries who went to a HHA (or nursing home) **owned by their discharging hospital**, (2) beneficiaries who went to a HHA (or nursing home) **not owned by their discharging hospital even though their discharging hospital did own** a HHA (or nursing home), and (3) beneficiaries who where discharged from a **hospital which did not own** a HHA (or nursing home) and went to an HHA (or nursing home) which was independent of their hospital. Categories 2 and 3 were combined for this analysis.

The analysis was a series of t-tests or chi-square tests depending on whether the variable was continuous or categorical. A separate analysis was performed for the HHA and nursing home files. The continuous variables analyzed included the following:

1) the number of days of the original hospitalization;
2) the number of HHA or nursing home covered days; and,

The categorical variables analyzed were:

1) the DRG of the original hospitalization (coded for the top 35% of the DRGs);
2) the primary diagnosis for the HHA (or nursing home) service (coded for the top 35% of diagnoses); and,
3) the number of hospital readmissions during a six month period after the original hospital discharge.

Continuous Variables-nursing home file

Of the continuous variables analyzed by the two categories of ownership described above within the nursing home file, both the DAYS variable and the HOSPCOVD variable showed a significant difference by type of ownership as a result of the weighted analysis. The DAYS variable refers to the number of nursing home covered days and the HOSPCOVD variable refers to the number of days of the original hospitalization. The difference appeared in each of the two strata, ORT vs. non-ORT States, individually and when the strata were combined. The table below shows the difference combined.

Comparison of Number of nursing home covered days-Overall Sample

Type of Ownership	Average Days	Standard Error of Mean
1	37.41	3.32
2	29.54	2.17

*t=1.98- significant at the 95% confidence level

Comparison of Number of Days of Original Hospitalization

Type of Ownership	Average Days	Standard Error of Mean
1	6.83	.55
2	8.89	.45

*t= -2.89- significant at the 99% confidence level

Continuous Variables-HHA File

Of the continuous variables analyzed by the two categories of ownership described above within the HHA file, the only one which showed up significant as a result of the t-test was the number of HHA covered days. It showed up higher for the cases where the beneficiary was discharged to a home health agency owned by the beneficiary's discharging hospital. The difference appeared in each of the two strata, ORT vs. non-ORT States, individually and when the strata were combined. The table below shows the difference combined.

Comparison of Number of HHA covered days- Overall Sample

Type of Ownership	Average Days	Standard Error of Mean
hospital-owned	49.33	3.23
independent	37.25	2.13

*t=3.12 - significant at the 99% confidence level

Categorical Variables-HHA and nursing home File

Of the three categorical variables analyzed within the HHA and nursing home file, no relationships were significant when the chi-square test was performed by the two types of ownership for the overall sample. There was a problem with the analysis of the two variables dealing with DRG and diagnosis code. Due to the many codes that exist for DRGs, categories of the DRGs and diagnoses were very small when the sample was analyzed. Since the sample was not designed for the specific purpose of comparing DRGs or diagnoses, this

made a significant difference less likely to appear. The sample size for the number of readmissions was not a problem, however, the value of the chi-square statistic (1.359) was not significant.

CONFIDENCE INTERVALS FOR PERCENTAGE OF PATIENTS DISCHARGED TO A HOME HEALTH AGENCY OR NURSING HOME OWNED BY THEIR DISCHARGING HOSPITAL

The computation of confidence intervals for the percentage of nursing home or home health agency patients who were discharged from a hospital which owned a nursing home or a home health agency is as follows:

Nursing Home

Forty percent (rounded from 39.8 percent) of patients were referred to the nursing home owned by the discharging hospital when the hospital owned a nursing home. The 95 percent confidence interval for the estimate is:

40% +/- 8.9%

Home Health Agency

Sixty-two percent (rounded from 61.6 percent) of patients were referred to the home health agency owned by the discharging hospital when the hospital owned a home health agency. The 95 percent confidence interval for the estimate is:

62% +/- 8.33%

APPENDIX C

CHI-SQUARE VALUES

We computed Chi-square values for survey response differences based on whether or not the hospital owned a home health agency or nursing home. These values were computed for a number of key questions for which such differences are reported in our findings. Differences reported in the text of the report are significant at the 90% confidence level unless otherwise noted.

Table C

CHI-SQUARE Values for Testing Significance of Differences Based on Ownership for Key Survey Questions

Survey Question	DF *	Chi-Square Value	P Value	Confidence Level @ Which Difference Is Significant
Do you believe the hospital ever puts pressure on Medicare patients to choose a particular home health agency?	1	1.66	.20	80%
Were you given written procedures or verbal instructions from your hospital on how to determine which home health agency to refer Medicare patients to?	1	3.06	.08	92%
Which of the following best describes how the decision was made about which home care agency you would get care from after leaving the hospital?	1	2.09	.14	86%
Which of the following best describes the amount of say you had about which home care agency to use? How satisfied you were with how the decision was made on which home care agency you would get services from?	1	4.08	.04	96%

Which of the following best describes the amount of say you had about which nursing home to go to? How satisfied you were with how the decision was made on which nursing home you would go to after leaving the hospital?	1	3.35	.07	93%
Did you feel that you were discharged at the right time, too soon or later than necessary? (HHA patients)	1	2.53	.11	89%
How good was the connection between the care you got in the hospital and the care you got at home?	1	1.20	.27	73%
About how soon after you were admitted to the hospital did someone from the hospital first talk to you or your family about health care services you might need after you left the hospital?	1	2.91	.09	91%
Did you feel that you were discharged at the right time, too soon or later than necessary? (NH patients)	1	3.43	.06	94%
How good was the connection between the care you got in the hospital and the care you got in the nursing home?	1	3.77	.05	95%

* Degrees of Freedom

APPENDIX D

NON-RESPONDENT ANALYSIS

When surveys are used to collect data, the results may be biased if non-respondents differ from respondents. For this inspection, a beneficiary for whom a beneficiary survey was not received is a non-respondent. Additionally, a discharge planner for whom a discharge planner survey was not received is a non-respondent. To test for the presence of any bias, we first obtained information from HCFA's 1995 1 percent Common Working File for all 1000 beneficiaries who were sent a mail questionnaire. Information was also obtained on the hospitals from which sample beneficiaries were discharged. (These were the hospitals to which discharge planner surveys were sent.)

Beneficiary Non-Respondent Analysis

A total of 651 beneficiary surveys were returned, for a response rate of 65 percent. To test for the presence of any non-response bias, we analyzed the variables which might influence whether an individual would respond to the survey or that might affect his or her responses. For the 1000 beneficiaries in our survey we looked at: whether the beneficiary went to a home health agency owned by their discharging hospital; whether the beneficiary went to a nursing home owned by their discharging hospital; sex; and, whether the beneficiary resided in a ORT or non-ORT State. These categorical variables were tested using Chi-square with the appropriate degrees of freedom.

The results of this analysis are presented in tables D(1-4). The Chi-square values given in the tables provide a test of the difference between the distribution of the respondents and that of the non-respondents for the variable of interest. Also provided in the tables are the response rates by the different values of the variables. The differences between the response rates for the variables tested are not statistically significant.

Table D (1 - 4)

CHI-SQUARE Values for Testing Significance of Differences Between Respondents and Non-Respondents For (1) Hospital Ownership of HHA (2) Hospital Ownership of Nursing Home (3) Sex and (4) ORT or non-ORT State

(1) HOME HEALTH AGENCY OWNERSHIP

	Respondents	Non-respondents	Total	Percent
Beneficiary went to the **HHA owned** by the discharging hospital	100 (28%)	41 (28%)	141	71%
Beneficiary **did not go to the HHA owned** by the discharging hospital	262 (72%)	105 (72%)	367	72%
Total	362	146	508	71%
CHI-SQ=.011 Degrees of Freedom = 1				

(2) NURSING HOME OWNERSHIP

	Respondents	Non-respondents	Total	Percent
Beneficiary went to the **nursing home owned** by the discharging hospital	13 (6%)	21 (11%)	34	38%
Beneficiary **did not go to the nursing home owned** by the discharging hospital	187 (94%)	179 (89%)	366	51%
Total	200	200	400	50%
CHI-SQ=2.057 Degrees of Freedom = 1				

(3) SEX

	Respondents	Non-respondents	Total	Percent
Male	221 (34%)	105 (30%)	326	68%
Female	430 (66%)	244 (70%)	674	64%
Total	651	349	1000	65%

CHI-SQ=1.542
Degrees of Freedom = 1

(4) ORT or non-ORT STATE

	Respondents	Non-respondents	Total	Percent
ORT State	497 (76%)	253 (72%)	750	66%
Non-ORT State	154 (24%)	96 (28%)	250	62%
Total	651	349	1000	65%

CHI-SQ=1.797
Degrees of Freedom = 1

Discharge Planner Non-Respondent Analysis

A total of 625 discharge planner surveys were returned, for a response rate of 63 percent. Because there was no data for 74 of the 1000 hospital records obtained, this analysis is based on 926 records rather than the full sample size.

To test for the presence of any non-response bias, we analyzed the variables that might influence whether a hospital discharge planner would respond to the survey or that might affect his or her responses. For the 926 discharge planners in our sample, we looked at: whether or not their hospital owned a home health agency; whether or not their hospital owned a nursing home; and, whether their hospital was in an ORT or non-ORT State. These categorical variables were tested using Chi-square with the appropriate degrees of freedom.

Tables D-5 and D-6 show no statistically significant differences between respondents and non-respondents for the variables tested.

Table D-7 shows a statistically significant difference between respondents and non-respondents with respect to whether or not the discharge planner's hospital was in an ORT or non-ORT State. In order to test whether this difference introduced any bias, we analyzed answers to a couple of key survey questions given by discharge planners from ORT and non-ORT States. The two questions we looked at were: whether any home health agencies ever help make decisions about whether patients are in need of home health services and what the main reason was to send patients to the home health agency which the hospital owns. In both instances, the distribution of answers provided by ORT and non-ORT respondents were within 5 percentage points of each other. This difference was not statistically significant.

Given the results of this analysis, we believe that the inspection findings fairly represent the experience and opinions of beneficiaries and discharge planners to whom the questionnaires were sent. We therefore believe that our survey results can be generalized to the universe of Medicare beneficiaries who were discharged to a home health agency or nursing home during the last four months of 1995, as well as the discharge planners who assisted them.

Tables D(5-7)

CHI-SQUARE Values for Testing Significance of Differences Between Respondents and Non-Respondents For (5) Hospital Ownership of HHA (6) Hospital Ownership of Nursing Home and (7) ORT or non-ORT State

(5) HOSPITAL OWNERSHIP OF HOME HEALTH AGENCY

	Respondents	Non-respondents	Total	Response Rate
Hospital **Owns HHA**	298 (48%)	130 (43%)	428	70%
Hospital **Does Not Own HHA**	327 (52%)	171 (57%)	498	66%
Total	625	301	926	67%
CHI-SQ=1.648 Degrees of Freedom = 1				

(6) HOSPITAL OWNERSHIP OF NURSING HOME

	Respondents	Non-respondents	Total	Response Rate
Hospital **Owns NH**	252 (40%)	122 (40%)	374	67%
Hospital **Does Not Own NH**	373 (60%)	179 (59%)	552	68%
Total	625	301	926	67%
CHI-SQ=0.004 Degrees of Freedom = 1				

(7) ORT OR non-ORT STATE

	Respondents	Non-respondents	Total	Response Rate
ORT State	446 (71%)	247 (82%)	693	64%
non-ORT State	179 (29%)	54 (18%)	233	77%
Total	625	301	926	67%

CHI-SQ=12.352
Degrees of Freedom = 1

APPENDIX E

COMMENTS ON THE DRAFT REPORT

In this appendix, we present in full the comments from the Health Care Financing Administration, the Assistant Secretary for Planning and Evaluation and Assistant Secretary for Management and Budget.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

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Date Sent 11-21

DATE:

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle NMD
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Hospital Discharge Planning," (OEI-02-94-00320)

We reviewed the above-referenced report that examines how and to what extent hospital ownership of home health agencies (HHAs) or nursing homes impacts hospital discharge planning for Medicare beneficiaries.

A significant reduction in the average length of stay for acute care hospital patients created a greater need for post-hospital services such as home health and nursing home care. These reductions are widely believed to be associated with advances in medical technology as well as the implementation of the Medicare prospective payment system. As the average hospital stay decreases, the role of the hospital discharge planning process becomes more critical.

The report raises concerns of whether hospitals are lowering their costs for patients for whom they are receiving a lump sum prospective payment from Medicare and discharging those same patients to post-hospital services for which they are being paid on a cost basis. This cost shifting would result in increased Medicare reimbursement for the hospital.

The Health Care Financing Administration (HCFA) concurs with OIG recommendations one through five. We do not concur with recommendation six. Our detailed comments are as follows:

OIG Recommendation #1

HCFA should develop statistical methods to target special review providers who may be maximizing their Medicare reimbursement in this way. The records of these providers should be reviewed by the peer review organizations (PROs), as in the past, or through

some other suitable mechanism. Providers that are found to be inappropriately discharging beneficiaries to their own nursing homes should be subject to payment adjustments and appropriate fines or penalties.

HCFA Response

We concur with the intent of the recommendation that inappropriate discharges should be eliminated. However, we do not believe these discharge patterns only occur in the context of hospitals discharging to their own post-acute facilities. Rather, the recent increases in system integration and coordination between hospitals and post-acute facilities have changed discharge patterns across a wide range of hospitals. We are currently evaluating projects to be undertaken by the PROs concerning hospital admissions and discharges.

We believe a more positive approach to these changes is the post-acute transfer policy that was recently enacted in the Balanced Budget Act of 1997 (BBA). Beginning in fiscal year 1999, the Secretary will be allowed to implement a limited, post-acute transfer policy. Under this policy, if a hospital transfers a patient under 1 of 10 diagnosis-related groups (DRGs) designated by the Secretary to a post-acute facility, the case will be paid as a transfer, not as a discharge. The transfer payment is based on a per diem methodology, capped at the level of the full DRG payment. In fiscal year 2001, the Secretary has the option of expanding this policy to other DRGs. We believe this incremental approach will give us the time and experience to create a post-acute transfer policy that addresses the concerns of this report. We are currently working with the PROs to identify pilot projects to address these issues.

OIG Recommendation #2

HCFA should ensure that hospitals disclose ownership of HHAs and nursing homes in a systematic way.

Hospitals should inform beneficiaries who are possible candidates for these post-hospital services of the names of the HHAs and nursing homes they own.

HCFA Response

We concur. This issue is addressed by section 4321(a) of BBA that HCFA will implement by issuing regulations and, as needed, instructions.

OIG Recommendation #3

Hospitals should be required to disclose to HCFA the names of HHAs and nursing homes that they own.

HCFA Response

We concur. Fiscal intermediaries process cost reports for all entities owned by the hospital so they do know ownership information. This issue is addressed by section 4321(b) of BBA that HCFA will implement by issuing regulations and, as needed, instructions.

OIG Recommendation #4

HCFA should take additional measures to ensure that when beneficiaries are being discharged from the hospital they are given a choice in selecting a HHA or nursing home from which to receive care.

Hospitals should be required to inform patients (or their families) that they are free to choose between home health agency providers and nursing homes. This information should be provided as early as possible.

HCFA Response

We concur. This issue is addressed by section 4321(a) of BBA that HCFA will implement by issuing regulations and, as needed, instructions.

OIG Recommendation #5

Hospitals should maintain a file of Medicare participating HHAs and nursing homes in the area and provide beneficiaries (or their families) with a list of alternatives appropriate for the level of care they need.

HCFA Response

We concur. This issue is addressed by section 4321(a) of BBA that HCFA will implement by issuing regulations and, as needed, instructions.

OIG Recommendation #6

The report findings support the need for additional Medicare beneficiary information related to post-hospital services and choice. Therefore, a wide circulation of the next released HCFA publication entitled "Healthcare Choice--A Consumer Guide for Planning Ahead" is recommended.

HCFA Response

While we recognize the need identified in this recommendation, we do not concur at this time because there is no publication that is soon to be released. The draft publication referenced in your recommendation does not target the intended audience. Also, the information in the draft does not meet the needs described in the recommendation. With the recent reorganization within HCFA, we are currently undertaking, through a contract, an extensive examination of the way we distribute all Medicare informational materials, and options for changing the way we provide printed and audiovisual materials. HCFA recently received the draft report that details the number and types of informational materials produced in its central and regional offices and by HCFA's partners. A survey revealed a large number of publications by partners, many of which appear to be duplicative, have inaccuracies, and are without HCFA-wide coordination. The survey demonstrates the opportunity for improved customer service through consolidation of current information dissemination functions.

The next publications report will include a set of design options for accomplishing consolidation, including a centralized electronic publications clearinghouse. Any of the suggested designs is expected to incorporate principles of efficient dissemination, be tailored to individual beneficiary needs, eliminate duplication, and use a consistent message. The target date for the final report is December 22. Once we have the survey results as well as other needs assessment information, we will determine the need for the referenced publication.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

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Date Sent 8-26

TO: June Gibbs Brown
Inspector General

FROM: David F. Garrison Jeff Merkowitz for
Principal Deputy Assistant Secretary
for Planning and Evaluation

SUBJECT: OIG Draft Report: "Medicare Hospital Discharge Planning" -- **Conditional Concurrence** OEI-02-94-00320

The OIG proposes to issue a report on hospital discharge planning for Medicare beneficiaries discharged to nursing homes (NHs) or home health agencies (HHAs). The OIG was particularly interested in understanding the impact of hospital ownership on patterns of care and discharge processes for beneficiaries discharged to NHs and HHAs. I concur on the condition that the report be rewritten to reflect the enactment of the Balanced Budget Act of 1997, and more completely reflect ProPac's discussion about possible explanations for observed differences in hospital and nursing home lengths of stays for persons referred to hospital-owned facilities. In addition, I have made other minor and technical comments on the report, including areas that the OIG may want to consider for further study.

OIG Recommendations and the Balanced Budget Act. Several recommendations proposed by the OIG were recently enacted in the Balanced Budget Act (BBA) of 1997. Specifically:

- The OIG recommends, due to concerns about cost shifting between the hospital and NH, that HCFA conduct targeted provider reviews by organizations such as the PROs and recommends that hospitals found to inappropriately discharge beneficiaries to their own NHs be subject to payment adjustments and fines.

  Section 4407 of the BBA limits payment to acute care hospitals for cases defined as "transfer cases," i.e., beneficiaries with certain diagnoses who are discharged from acute care hospitals to PPS-exempt settings (including home health and skilled nursing facilities). The law limits payments to hospitals for these cases.

- The OIG recommends that hospitals inform beneficiaries of their freedom of choice of providers, maintain a list of NHs and HHAs in the area, and that hospital-ownership of NHs and HHAs be disclosed to HCFA and beneficiaries who may use these services.

Section 4321 of the BBA requires that hospitals disclose to the Secretary the financial relationships between the hospital and post-hospital providers to which beneficiaries are referred and the percentage of patients referred to post-hospital settings in which the hospital has a financial interest. The BBA requires the Secretary to disclose this information to the public. In addition, the law also prohibits hospitals from limiting the home health providers that may provide post-hospital services.

I recommend that the report and the recommendations be rewritten to reflect the enactment of these provisions in the BBA.

Impact of Ownership on Hospital and Nursing Home Length of Stay. The OIG reported finding that beneficiaries referred to hospital-owned NHs had shorter lengths of hospital stays and longer NH stays compared with beneficiaries referred to NHs not owned by the hospital. As the OIG notes, this finding is consistent with earlier work by ProPac. However, the OIG states that this finding may indicate cost shifting from a prospective payment system to a cost-based reimbursement system. While I do not disagree that this could simply be an effort to maximize Medicare reimbursement, I also believe that this could reflect efforts by hospitals and hospital-based facilities to more effectively coordinate care across settings for certain types of beneficiaries. I note that ProPac also suggested that the observed impact on hospital and nursing home lengths of stays could be due to coordination and case mix. I recommend the OIG report be more balanced when attributing causes to differences in length of stay and more completely discuss the ProPac findings.

Other Issues

The OIG report references should work on the Uniform Needs Assessment Instrument. This discussion should be strengthened to include information on the purpose and potential use of this instrument.

The report should indicate how the sampled nursing homes and home health agencies were divided into hospital-owned and not hospital-owned providers.

The report should clarify the source of supporting evidence that beneficiaries who are discharged to hospital-owned home health agencies have more frequent hospital readmissions (i.e., p. 14 -- first paragraph under the heading, "*Hospital ownership results in home health use of longer duration*"). In addition, I recommend that the second sentence of this paragraph clarify that while the OIG found some evidence supporting this finding, this evidence was not statistically significant.

The OIG recommends wide circulation of a publication entitled, "Health care Choices -- A Consumer Guide for Planning Ahead." I recommend the report provide the reader with more information about this guide.

Next Steps

The OIG report includes a discussion about Federal requirements for discharge planning and the referral processes used by hospitals when discharging patients to nursing homes and home health agencies. The report does not discuss the criteria used by hospitals in selecting the post-acute provider type to which beneficiaries were referred. Given that there is at least some overlap in the types of patients served by the various post-acute care providers, I believe it is important to understand what factors are considered in making post-hospital placement recommendations and decisions. If possible, I recommend the OIG include a discussion about the criteria used by hospitals in referring patients to home health agencies or nursing home providers. If the OIG did not gather this information as part of this study, the OIG may wish to identify this as an area in which further study is needed.

On a related note, the OIG points out that there is no single model of hospital discharge planning (e.g., definitions of discharge planning, organizational structures, and staff qualifications vary across hospitals). An additional area that would benefit from further work is the development of a typology of discharge planning. I recommend that the OIG consider identifying this as area in need of development.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

AUG 29 1997

MEMORANDUM TO: June Gibbs Brown
Inspector General

FROM : John J. Callahan
Assistant Secretary for Management and Budget

SUBJECT : **Concur with Comment** -- OIG Draft Report: "Medicare Hospital Discharge Planning" OEI-02-94-00320

The Balanced Budget Act of 1997 includes a provision that will change hospital discharge policy in certain situations. Under the new policy, certain hospital DRGs selected by the Secretary will be treated as "transfers" rather than "discharges." The change addresses to some extent the problem of hospitals discharging patients quicker in order to maximize their Medicare reimbursement.

As this policy change will likely affect discharge planning procedures in some hospitals, we recommend that OIG include a paragraph in the introduction section explaining the new law.

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