

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicare Beneficiary Access
to Home Health Agencies: 2000**



**JUNE GIBBS BROWN
Inspector General**

**SEPTEMBER 2000
OEI-02-00-00320**

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To assess the effects of the interim payment system on access to home health agencies for Medicare beneficiaries discharged from the hospital.

BACKGROUND

The Health Care Financing Administration asked the Office of Inspector General to assess the effects of the interim payment system for home health services on beneficiaries' access to care. The interim payment system changed the method and level of payment to home health agencies and is intended to control home health spending until a prospective payment system is developed. Concerns have been raised that the payment limits under the interim payment system may adversely affect beneficiary access to home health care. As the implementation of the prospective payment system proceeds, continued monitoring of agencies' responses to these changes is important to ensure that beneficiary access is not compromised.

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

For this study we interviewed a random sample of 202 hospital discharge planners, as well as analyzed data from the Health Care Financing Administration related to discharges to home health agencies and hospital lengths of stay.

FINDINGS

Almost All Medicare Beneficiaries Can be Placed With Home Health Care

Most Medicare beneficiaries can be placed. Eighty-seven percent of discharge planners report they can place all of their patients. Another 6 percent estimate between 1 and 5 percent of patients cannot be placed, while the remaining discharge planners put the estimate above 5 percent. Patients who cannot be placed reportedly remain in the

hospital, go to a nursing facility, or are cared for by family or friends at home.

Among those Medicare patients whom discharge planners say they cannot place are some who are no longer eligible due to recent changes in eligibility. When discharge planners responded to our question on the percentage they could not place, some may have included beneficiaries whose need for venipuncture alone no longer qualifies them for home care.

In a separate effort to assess patient access to home health care under the interim payment system, we compared pre- and post-interim payment system data for patients in the 12 diagnosis related groups most commonly discharged to home health agencies. With the exception of one diagnosis related group (106- coronary bypass), we found no substantial decreases. This seems to indicate that, in general, patients with these medical conditions are not being denied access to home health care.

Some experience delays. Seventy-eight percent of discharge planners report that they rarely or never experience delays in placing Medicare patients. Nineteen percent report they sometimes do. When we asked discharge planners whether delays are more common now than before the interim payment system, 74 percent report there has been no change, while 20 percent report that they are more common under the interim payment system.

However, in a separate analysis based on data from the Health Care Financing Administration, we found that for the 12 diagnosis related groups most commonly discharged to a home health agency, there were no substantial increases in the average hospital length of stay. In fact, for all but one diagnosis related group, there was a decrease.

Changes in The Medicare Home Care Environment Have Affected The Placement Process

Stricter enforcement. Discharge planners report that during the placement process, home health agencies are now looking more carefully at whether patients meet Medicare homebound and skilled need eligibility requirements. This may be a result of recent enforcement activities by the Health Care Financing Administration and the Office of Inspector General.

Focus on medical conditions. Some discharge planners suggest agencies are using information on medical condition and service needs to screen certain patients. On the occasions when there are placement delays, discharge planners most commonly cite problems with patients needing IV antibiotics or expensive drugs. They also cite delays in placing patients who have decubitus ulcers or who need other wound care, as well as those who need rehabilitation. On average, about a third who cite delays due to medical conditions attribute these delays directly to the interim payment system.

Fewer home health agencies. Forty-two percent of discharge planners report that the availability of home care for Medicare patients in their area has decreased since the implementation of the interim payment system. Analysis of data from the Health Care Financing Administration show a 25 percent decrease in home health agencies from 1997 to 1999. A small number of discharge planners we spoke with volunteered that home health agency closures in their area were making the process of placement more difficult. Some of them attribute these closures to the interim payment system.

Staffing shortages. There appears to be a drop in home health care staffing in some areas. About one quarter of discharge planners report home health staffing shortages in their area have contributed to delays in placement. Those who volunteered this information most commonly attribute the shortage to payments under the interim payment system.

CONCLUSION

The findings of this follow-up study are consistent with those in original study “Medicare Beneficiary Access to Home Health Agencies, OEI-02-99-00530.” There appear to be no major disruptions in placing Medicare hospital patients with home health agencies. To the extent that there are some disruptions, they appear to be localized.

Agency Comments

The Health Care Financing Administration provided comments on this and two related draft reports. They concur with our conclusion that qualified Medicare beneficiaries are receiving the home health care they need. They also note that on October 1, 2000, the new prospective payment system for home health care will go into effect. They, like we, will monitor that new system to assure that beneficiaries continue to have access to home care. The Health Care Financing Administration comments are in Appendix E.

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INTRODUCTION

PURPOSE

To assess the effects of the interim payment system (IPS) on access to home health agencies for Medicare beneficiaries discharged from the hospital.

BACKGROUND

The Health Care Financing Administration (HCFA) asked the Office of Inspector General (OIG) to assess the effects of the interim payment system (IPS) for home health services on beneficiaries' access to care. The IPS changed the method and level of payment to home health agencies (HHAs) and is intended to control home health spending until a prospective payment system is developed. Concerns have been raised that the payment limits under IPS may adversely affect beneficiary access to home health care. As the implementation of the prospective payment system proceeds, continued monitoring of agencies' responses to these changes is important to ensure that beneficiary access is not compromised.

This inspection follows an earlier study completed by the OIG in October 1999 entitled, *Medicare Beneficiary Access to Home Health Agencies OEI-02-99-00530*. In that study, most hospital discharge planners report generally being able to place Medicare beneficiaries with home health agencies; however, some volunteer concern that not all beneficiaries may be getting adequate care. Most discharge planners further note that patients with chronic health care needs, and those who need IV care, high cost care, or intensive care have become more difficult to place in home health care and that home health agencies have changed their admissions practices. This study follows up on those concerns and is part of a series of inspections that the OIG has conducted on home health care. (See Appendix A.)

Medicare Home Health Care

Home health care services consist of skilled nursing; therapy (physical, occupational and speech), and certain related services, including aide services, all furnished in a patient's home. Services are typically provided by registered nurses, therapists, social workers, or home health aides employed by or under contract with a HHA. These agencies can be free-standing or provider-based and be classified as not-for-profit, proprietary, or governmental.

Medicare will pay for home health care only if it is reasonable and necessary for the treatment of the patient's illness or injury. In order to be eligible for services, a beneficiary must be homebound, be under the care of a physician who has established a

plan of care, and need physical therapy, speech therapy, continued occupational therapy, or skilled nursing on an intermittent basis. There are no limits on the number of visits or length of coverage and no co-payments or deductibles apply.

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

Several initiatives were implemented in response to concerns about Medicare home health spending and fraud and abuse. An anti-fraud campaign known as Operation Restore Trust employed a number of approaches and is at least partially responsible for helping to slow Medicare home health spending. The Health Insurance Portability and Accountability Act also included measures to control fraud and abuse by HHAs. Changes to Medicare participation rules designed to screen out problem providers as well as payment limits which are discussed below were also initiated.

Two recent coverage rule changes are noteworthy. The first relates to IV antibiotic therapy. The HCFA issued a rule, effective September 1, 1996, that there was insufficient evidence to support the necessity of an external infusion pump to administer vancomycin, a popular broad spectrum antibiotic. Medicare covers IV drugs only when there is a medical necessity for them to be administered by an infusion pump. Therefore, Medicare no longer covers vancomycin for home care patients as it does not require a pump. The second change that is generally thought to have had a measurable impact on the number of Medicare beneficiaries eligible for home care relates to the provision of venipuncture services as a qualifying skilled need. Beginning on February 5, 1998, a patient's need for venipuncture no longer constitutes a qualifying skilled need. Prior to this change, some patients, for whom this was their only skilled need, qualified for home care.

The Balanced Budget Act of 1997

The Balanced Budget Act (BBA) of 1997 changed the way Medicare pays for home health care. The BBA required that the existing cost-based payment system be replaced with a prospective payment system (PPS) of fixed, predetermined rates for home health services. To allow time for HCFA to develop this prospective payment system, the BBA mandated an interim payment system (IPS) to limit payments. The IPS became effective for cost-reporting periods beginning October 1, 1997, and will continue until PPS begins on October 1, 2000.

The IPS is intended to control the aggregate costs of services provided to beneficiaries in two ways. First, it subjects Medicare HHAs to a new payment limit that is based on an aggregate per-beneficiary amount. This limit is based on a blend of historical per-user costs for the agency and agencies in the region. It is applied to an agency's total Medicare payments and not to specific beneficiaries. Second, it decreases the per-visit

limits from 112 percent of the national mean cost per visit to 105 percent of the national median. Medicare then pays HHAs the lower of their actual costs, the aggregate per-beneficiary limit, or the aggregate per-visit limit.

The Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 moderated the restrictiveness of IPS. This legislation made several changes to the payment limits, including increasing the per-visit limits for all agencies and increasing the aggregate beneficiary limit for certain agencies. In that same year, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, which delayed a 15 percent payment reduction to be imposed with the implementation of PPS and increased payments under IPS to certain agencies. The changes stemmed from a concern that access to care was being adversely affected and that providers were overburdened.

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

Prior Work on Access to Home Health Care

Several past studies have examined access to home health care for Medicare beneficiaries. A recent report by the General Accounting Office found that although about 14 percent of HHAs have closed since 1997, there is little evidence that appropriate access to care has been impaired. The study found that closures occurred most frequently in areas that had experienced considerable growth. Additionally, interviews with 130 stakeholders in 34 counties that had significant closures indicated few access problems. The interviews suggested, however, that as HHAs change their operations in response to IPS, beneficiaries who are likely to be costlier than average to treat may have increased difficulty obtaining home health care.

A two-part study released by George Washington University (GWU) entitled, *An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care*, found that the majority of HHAs participating in the study in eight States altered their case mix and/or practice patterns to conform utilization to IPS reimbursement. It also found that diabetics and other beneficiaries with more intensive care needs as well as chronically ill beneficiaries appeared to be most affected by IPS.

The second phase of the GWU study focused on the experiences of discharge planners in eight States. It found that most hospital discharge planners reported increased difficulty in obtaining home health services for Medicare beneficiaries. Most attributed these increases to changes in admitting and practice patterns by HHAs, changes in staffing patterns, or the effects of agency closures in their service area. Additionally, respondents reported that beneficiaries most affected by these changes were those with short-term high intensity needs or chronic diseases, and those needing complex wound care or two

visits per day.

Similarly, a recent study sponsored by the Medicare Payment Advisory Commission that surveyed HHAs and held a panel discussion with individuals familiar with access problems found that many HHAs have adopted new admission and discharge practices since IPS was implemented. Agencies reported that they are avoiding high-cost patients and most frequently identified long-term or chronic care patients as those they no longer admitted or have discharged as a result of IPS.

Finally, two reports based on early data from HCFA's Per-Episode Home Health Prospective Payment Demonstration suggest that prospective payment can lower Medicare home health costs without harming quality of care. Specifically, the first report found no evidence that quality of care as measured by patient outcomes was adversely affected. A second report found that although the per-episode prospective payment demonstration substantially reduced home visits, it did not affect the use of or reimbursement for other Medicare-covered services, suggesting that prospective payment does not adversely affect quality of care. Case studies conducted early in the demonstration found that agencies did not change their behavior in ways that threatened access or quality of care. Specifically, there was no evidence that agencies changed their referral or admission practices to avoid costly patients or recruit lower-care ones as a result of per-episode PPS.

METHODOLOGY

Discharge Planner Interviews

We used a combination of methods to analyze information for this inspection. We chose a random sample of 225 acute care hospitals with 30 beds or more. The sample was drawn from the 50 states in addition to the District of Columbia. We conducted interviews with 202 directors of discharge planning or their designees within a three week period from May 22 until June 23, 2000. Twelve of the remaining 23 hospitals did not discharge Medicare patients to HHAs. We were unable to reach a discharge planner to schedule an interview at the other 11 hospitals.

Analysis of Medicare Data

Secondly, we analyzed Medicare data. Using HCFA's National Claims History data, we identified all Medicare beneficiaries who: 1) were discharged from a hospital between January 1, 1996, and March 31, 1996; and, 2) had a home health episode that started within 30 days of their hospital discharge. We then identified patients who met this criteria for an analogous period in 1997, 1998, 1999, and 2000. We analyzed beneficiaries in the diagnosis related groups (DRGs) that are most commonly discharged to HHAs for these five time periods. As part of this analysis we assessed whether HHAs are admitting different types of beneficiaries since the implementation of IPS. We also

analyzed hospital length of stay for beneficiaries discharged to home health care by these DRGs to examine whether certain patients are experiencing longer delays before being admitted to HHAs since IPS. Lastly, using HCFA's Provider of Services File, we analyzed trends in the number of HHAs.

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

FINDINGS

Almost all Medicare beneficiaries can be placed with home health care

Most Medicare beneficiaries can be placed

Eighty-seven percent of discharge planners report they can place all of their patients. Another 6 percent estimate between 1 and 5 percent of patients cannot be placed, while the remaining discharge planners put the estimate above 5 percent. Patients who cannot be placed reportedly remain in the hospital, go to a nursing facility, or are cared for by family or friends at home.

Additionally, when we asked whether the number of patients they are never able to place with home care has increased, decreased, or stayed the same since the implementation of the interim payment system (IPS), 79 percent say it has remained the same.

It should be noted that recent changes in eligibility have had an impact on discharge planners' ability to place Medicare beneficiaries. As indicated in the background of this report, a patient's need for venipuncture alone no longer constitutes a qualifying skilled need. Prior to HCFA's rule change, a significant number of patients who required venipuncture qualified for home care. When discharge planners responded to our question on the percentage they could not place, some may have included beneficiaries who are no longer eligible.

In another effort to assess patient access to home health care under IPS, we compared pre- and post-IPS data for patients in the 12 diagnosis related groups (DRGs) most commonly discharged to HHAs. We did this in order to evaluate whether certain patient types were experiencing a reduction in access to HHAs. With the exception of one diagnosis related group (DRG 106 coronary bypass), we found no substantial decreases. (See Appendix C.)

Some experience delays

Seventy-eight percent of discharge planners report that they rarely or never experience delays in placing Medicare patients. Nineteen percent report they sometimes experience delays. When we asked discharge planners whether delays are more common now than before IPS, 74 percent report there has been no change, while 20 percent report that they are more common under IPS.

In an effort to determine whether patients with certain diagnoses are being delayed to the point that their hospital stays are longer, we compared pre- and post-IPS hospital lengths of stay for patients in the 12 DRGs most commonly discharged to HHAs. Overall, we

found no substantial increases in the average hospital length of stay prior to discharge to an HHA. In fact, for all but one DRG, there was a decrease. (See Appendix D.)

Finally, we asked discharge planners if the number of HHAs they need to contact in order to place a Medicare patient increased, decreased, or remained the same since the implementation of IPS. Eighty-one percent say the number of HHAs they need to contact has remained the same since the implementation of IPS. They contact, on average, between one and two agencies both before and since the implementation of IPS. Twelve percent say they had to contact fewer agencies before IPS. Four percent say they had to contact more agencies before IPS. The remaining 4 percent say they do not know.

Changes in the Medicare home care environment have affected the placement process

Although most discharge planners do not attribute any significant increases in access problems to IPS, just over 40 percent indicate they have noticed changes in the placement process. These changes reflect recent changes within the Medicare home care environment.

Stricter enforcement

Discharge planners report that during the placement process, home health agencies are now looking more carefully at whether patients meet Medicare homebound and skilled need eligibility requirements. This may be a result of recent HCFA and OIG enforcement activities.¹

Focus on medical conditions

Some discharge planners observe that the admissions process is taking longer because agencies are asking for more medical information from prospective patients. They suggest agencies are using information on medical condition and service needs to screen certain patients.

On the occasions when there are placement delays, discharge planners most commonly cite problems with patients needing IV antibiotics or expensive drugs. As mentioned in the background, vancomycin, a broad spectrum antibiotic, is no longer covered under Medicare. Discharge planners report that some patients tend to stay in the hospital longer to continue receiving IV antibiotics or are placed instead into skilled nursing facilities where IV antibiotic coverage is still available. Additionally, we have heard of incidents

¹ 1995 legislation established Operation Restore Trust which allocated funds to reduce fraud, waste, and abuse in the Medicare program. The home health benefit was one of the primary areas of focus. In addition, the Health Insurance Portability and Accountability Act of 1996 included measures to control fraud and abuse by HHAs.

where discharge planners have asked hospitals to pay for IV antibiotics in order for the patient to receive home health care.

Discharge planners also cite delays in placing patients who have decubitus ulcers or who need other wound care, as well as those needing rehabilitation. It appears that it takes longer to place these patients primarily because of staffing issues. Wound care patients often require frequent dressing changes, which may entail multiple visits per day. Rehabilitation patients require the assistance of physical, speech, or occupational therapists that some discharge planners tell us are in short supply.

On average, only about a third of the discharge planners who cite delays in getting home care for patients with the previously mentioned medical conditions attribute these delays directly to IPS. The majority of discharge planners who say delays are associated with certain medical conditions or service needs attribute these delays to a wide range of factors. These include: HHAs not able to afford enough qualified staff to care for certain medical conditions; finding family members capable of providing enough care at home; and, rural area travel distances.

Fewer home health agencies

Forty-two percent of discharge planners report that the availability of home care for Medicare patients in their area has decreased since the implementation of IPS. Analysis of HCFA data shows a 25 percent decrease in HHAs from 1997 to 1999. A small number of discharge planners we spoke with volunteered that HHA closures in their area were making the process of placement more difficult. Some of them attribute these closures to IPS.

Staffing shortages

In addition, there appears to be a drop in home health care staffing in some areas. About one quarter of discharge planners report home health staffing shortages in their area have contributed to delays in placement. Discharge planners who volunteered this information most commonly attribute the shortage to IPS. They explain that because of low reimbursement, they believe that HHAs have cut back on staffing or have closed. These discharge planners say that the remaining staff have been unable to provide care for everyone who needs home care in their area. Other discharge planners cite labor market forces when asked about the cause of staff shortages. These discharge planners say that, in some areas, nurses and home health aides are simply in short supply.

CONCLUSION

The findings of this follow-up study are consistent with those in original study “Medicare Beneficiary Access to Home Health Agencies, OEI-02-99-00530.” There appear to be no major disruptions in placing Medicare hospital patients with home health agencies. To the extent that there are some disruptions, they appear to be localized.

AGENCY COMMENTS

The Health Care Financing Administration provided comments on this and two related draft reports. They concur with our conclusion that qualified Medicare beneficiaries are receiving the home health care they need. They also note that on October 1, 2000, the new prospective payment system for home health care will go into effect. They, like we, will monitor that new system to assure that beneficiaries continue to have access to home care. The Health Care Financing Administration comments are in Appendix E.

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

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

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

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

Confidence Intervals for Key Findings

We calculated confidence intervals for key findings for discharge planners. The point estimate and 95% confidence interval are given for each of the following:

KEY FINDINGS	POINT ESTIMATE	
Eighty-seven percent of discharge planners report they can place all of their patients.	87%	+/- 4.6
Seventy-nine percent of discharge planners say the number of Medicare patients they cannot place with home care has remained the same since IPS.	79%	+/- 7.3
Seventy-eight percent of discharge planners report that they rarely or never experience delays in placing Medicare patients.	78%	+/- 5.7
Seventy-four percent report no change in the percentage of Medicare patients who experience a delay since IPS.	74%	+/- 6.1
Nineteen percent of discharge planners report they sometimes experience delays in placing Medicare patients.	19%	+/- 5.4
Eighty-one percent of discharge planners report that the number of HHAs they need to contact has remained the same since IPS.	81%	+/- 5.5
Just over 40 percent indicate they have noticed changes in the placement process.	44%	+/- 6.9
On the occasions when there are placement delays, discharge planners most commonly cite problems with patients needing IV antibiotics or expensive drugs.	47%	+/- 11.0
Forty-two percent of discharge planners report that the availability of home care for Medicare patients in their area has decreased since IPS.	42%	+/- 6.8

Proportion of Discharges to HHAs by Top Diagnosis Related Groups (DRGs)

Initial Hospital DRG	Percent 1996	Percent 1997	Percent 1998	Percent 1999	Percent 2000	Difference 1996-2000
DRG 106- Coronary bypass with PTCA	2.2	2.2	2.1	0.1	0.1	-2.1
DRG 014- Specific cerebrovascular disorders	4.0	3.9	3.4	3.3	3.1	-0.9
DRG 079- Respiratory infections and inflammations	1.6	1.7	1.3	1.2	1.1	-0.5
DRG 209- Major joint and limb reattachment	8.1	8.0	8.3	8.0	7.7	-0.4
DRG 148- Major small and large bowel procedures	2.1	2.0	1.9	1.8	1.7	-0.3
DRG 127- Heart failure and shock	6.2	6.0	6.1	5.9	6.0	-0.3
DRG 121- Circulatory disorders w/acute myocardial infarction	1.7	1.6	1.6	1.7	1.7	0.0
DRG 174- GI hemorrhage w/CC	1.2	1.2	1.2	1.2	1.2	0.0
DRG 296- Nutritional and misc. metabolic disorders	1.5	1.5	1.5	1.6	1.6	+0.2
DRG 088- Chronic obstructive pulmonary disease	3.2	3.7	4.3	4.5	4.1	+0.9
DRG 462- Rehabilitation	5.2	5.3	5.1	5.7	6.1	+0.9
DRG 089- Simple pneumonia and pleurisy	3.9	4.6	5.7	6.0	5.9	+2.0

Source: National Claims History File

Average Hospital Lengths of Stay For Top Diagnosis Related Groups (DRGs) Discharged to HHAs

Initial Hospital DRG	Days 1996	Days 1997	Days 1998	Days 1999	Days 2000	Difference 1996-2000
DRG 462- Rehabilitation	16.5	15.5	14.2	14.3	14.0	-2.5
DRG 079- Respiratory infections and inflammations	10.0	9.9	9.8	9.9	7.9	-2.1
DRG 014- Specific cerebrovascular disorders	8.8	8.1	7.6	7.5	7.5	-1.3
DRG 210- Hip and femur procedures except major joint	7.5	6.8	6.5	6.4	6.4	-1.1
DRG 209- Major joint and limb reattachment	5.7	5.2	4.8	4.8	4.7	-1.0
DRG 121- Circulatory disorders w/acute myocardial infarction	9.2	8.7	8.5	8.4	8.3	-0.9
DRG 296- Nutritional and misc. metabolic disorders	6.7	6.3	6.0	6.1	5.9	-0.8
DRG 148- Major small and large bowel procedures	13.8	13.5	12.9	13.2	13.1	-0.7
DRG 127- Heart failure and shock	7.2	6.8	6.6	6.6	6.5	-0.7
DRG 089- Simple pneumonia and pleurisy	7.9	7.6	7.3	7.2	7.2	-0.7
DRG 088- Chronic obstructive pulmonary disease	7.4	7.1	6.7	6.8	7.0	-0.4
DRG 106- Coronary bypass with PTCA	11.9	11.3	10.9	11.7	12.0	+0.1

Source: National Claims History File

Agency Comments

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



DATE: SEP - 1, 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

IG	✓
EAIG	_____
PDIG	_____
DIG-AS	_____
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ExecSec	_____
Date Sent	9-5

Office of the Administrator
Washington, D.C. 20201

2000 SEP -5 AM 9:44

OFFICE OF INSPECTOR
GENERAL

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

Nancy-Ann DeParle

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

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

Background

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

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

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

Development of the PPS

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

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

Response to the OIG Reports

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

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

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

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