

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Hospital Stays For Medicare
Beneficiaries Who Are Discharged To
Home Health Agencies**



**JUNE GIBBS BROWN
Inspector General**

**AUGUST 1998
OEI-02-94-00321**

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EXECUTIVE SUMMARY

PURPOSE

To determine if hospital ownership of a home health agency has an effect on the inpatient length of stay.

BACKGROUND

This section follows up on the OIG report, “Medicare Hospital Discharge Planning,” OEI 02-94-00320, that found hospital ownership plays a significant role in the referral process to home health agencies. There is an on-going concern that hospitals owning home health agencies are discharging patients sooner to these services and increasing their Medicare reimbursement. The Balanced Budget Act of 1997 includes a provision addressing this cost shifting practice, as well as a provision that spells out requirements for hospitals that own post-hospital services, including home health agencies. We based this study on an analysis of Medicare data for all Medicare patients in 6 diagnosis related groups (DRGs) in 120 hospitals.

FINDINGS

Hospital Ownership of a Home Health Agency Affects Hospital Length of Stay

Patients discharged to any HHA from hospitals owning HHAs had a shorter length of stay than similar patients discharged from hospitals not owning HHAs. The average hospital stay for patients discharged from a hospital that owns a home health agency was 6.0 days compared to a 7.0 day stay for patients discharged from hospitals that do not own home health agencies. This difference is statistically significant.

This Difference Occurs Regardless of Whether the Patient is Discharged to the Hospital’s Own Home Health Agency

Among hospitals that own a home health agency, the patients’ average length of stay does not change if the patient is discharged to a home health agency owned by the discharging hospital. The average stay for patients discharged to a home health agency owned by their discharging hospital is 6.1 days. The hospital stay for patients discharged to a home health agency not owned by their discharging hospital is 6.0 days.

The Effect of Hospital Ownership Varies by Diagnosis Related Group

When we analyzed patients in different diagnosis related groups separately, we found that patients who had bowel procedures (DRG 148), joint replacements (DRG 209) and those with chronic obstructive pulmonary disease (DRG 88) and were discharged to a HHA from a hospital that

owned one had shorter hospital stays. The differences were 4 days for bowel procedures and 1 day for joint replacement and pulmonary disease. We found no statistically significant differences in the length of hospital stay based on hospital ownership of a home health agency for patients with heart failure and shock (DRG 127), vascular procedures (DRG 478), and heart procedures (DRGs 105, 106, and 107).

CONCLUSION

As part of the 1997 Balanced Budget Act, Congress changed the payment formula for Medicare inpatient stays for patients in certain diagnosis related groups who are discharged early to post-hospital settings, including home health agencies. Such cases will now be considered “transfers” rather than “discharges” and reimbursement for the inpatient stay will therefore be reduced. Our finding that hospital ownership of home health agencies is associated with shorter hospital lengths of stay for certain diagnosis related groups provides additional analytical support for this provision.

In light of our findings, we suggest that the Health Care Financing Administration consider hospital ownership as an additional factor when selecting future diagnosis related groups to be covered under this new “transfer reimbursement provision.”

COMMENTS

We received comments on the draft report from the Health Care Financing Administration and the Assistant Secretary for Management and Budget (ASMB). The ASMB agree with our conclusion and suggested a technical change in the background which we have made.

The HCFA agree that they should continue to monitor the data to understand the effect of hospital ownership on post-acute patient referral patterns, but they are not prepared to use hospital ownership as a factor when selecting DRGs to be covered under the new transfer provision. We agree that hospital ownership is only one variable among others and that HCFA should continue to monitor data to better understand the effect of hospital ownership on post-acute referral patterns. We certainly did not intend to imply that hospital ownership should be a deciding factor in making these decisions.

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INTRODUCTION

PURPOSE

To determine if hospital ownership of a home health agency has an effect on the inpatient length of stay.

BACKGROUND

This inspection follows up on the Office of Inspector General report, "Medicare Hospital Discharge Planning", OEI 02-94-00320. We found that hospital ownership plays a significant role in the referral process to home health agencies (HHAs). Sixty-two percent of patients discharged from hospitals that owned a home health agency were referred to an agency owned by the hospital. We also found that ownership affected the duration of hospital stay. The hospital stay was 1 day shorter for Medicare patients discharged to the hospital's HHA than for patients discharged to an HHA not owned by the discharging hospital. Although this 1 day difference was not statistically significant, when combined with our other findings it warranted further study.

Concerns About Hospital Ownership

There is an on-going concern that hospitals owning post-hospital services are discharging patients sooner to these services. Post-hospital services include: home health agencies, nursing homes and rehabilitation and other specialty hospitals. By following this pattern, hospitals can lower their costs for patients for whom they are receiving a lump sum prospective payment from Medicare and discharge these same patients to post-hospital services for which they are being paid on a cost basis. This cost shifting results in increased Medicare reimbursement for the hospital.

Early Hospital Discharges

In 1983, Medicare implemented the prospective payment system (PPS) in response to concerns that patients were remaining in the hospital longer than necessary. This system pays a lump sum for patient hospital stays based on diagnosis. Subsequent to implementation of the PPS there has been a significant reduction in the average length of stay for Medicare hospital patients. There are growing concerns as to whether patients are being discharged prematurely and post-hospital services, like home health, are being over utilized.

According to the Prospective Payment 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, the share of Medicare facility payments going to post-hospital care providers increased 15.5 percent. As one example, Medicare payments for home health care

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totaled an estimated \$16.9 billion¹ in FY 1996, and are projected by the Congressional Budget Office to grow to \$26 billion by the year 2000.

Discharge Planning Referrals

Medicare requires hospitals to have a discharge planning process that identifies patients' post-hospital needs soon after admission and puts in place a plan that will ensure a safe discharge from the hospital. Section 1802 of the Social Security Act seeks to ensure that free choice is guaranteed to all Medicare patients in choosing a post-hospital provider, such as a home health agency. When there is hospital ownership of post-hospital services, it raises concerns about the discharge planning process. First, will patients be given the freedom to choose a post-hospital provider in an environment where the hospital discharge planner works for an organization which also owns post-hospital services? And secondly, in an effort to maximize Medicare reimbursement, will hospitals use the discharge planning process inappropriately to shorten patient hospital stays and transfer patients to post-hospital services they own?

1997 Balanced Budget Act

The Balanced Budget Act of 1997 included a provision that changes the Prospective Payment System Diagnosis Related Group (DRG) payment formula for Medicare patients in certain DRGs discharged to post-hospital care, including home health agencies. Medicare patients in these yet to be determined DRGs will be considered "transfer" cases instead of "discharges" if the patient is referred to a home health agency. In a proposed rule published on May 8, 1998 HCFA identified 10 DRGs that they recommend as "transfer" cases, if the patient is transferred to an HHA within three days of a hospital admission. In instances where a patient in one of these DRGs stays in the hospital for a period shorter than the average stay and is then transferred to post-hospital care in a prospective payment system (PPS) exempt setting, reimbursement will be reduced. The hospital will be reimbursed on a per-day basis with double payment for the first day of the stay. Where a large portion of the costs are incurred during the first days of the stay, the law allows for payment based on 50 percent of the full DRG plus 50 percent of the transfer payment.

Other provisions of the Balanced Budget Act require hospitals referring patients to home health agencies (HHA) and other post-hospital providers to:

- ! not specify or otherwise limit Medicare patients in terms of which post-hospital service provider they receive services from;
- ! provide Medicare patients with information on HHAs and other post-hospital providers which serve the area;
- ! disclose to the Medicare patient any financial interest which the hospital may have in a HHA or other post-hospital provider to which they are referred; and,

¹1997 HCFA Statistics. HCFA Pub. No. 03403, October 1997.

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! 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.

Ownership Studies

A number of studies indicate that hospital ownership of post-hospital care facilities may affect patient length of stay. Findings related to the relationship between hospital ownership of post-acute services and patient referrals have been varied. For this reason, we have continued our work in this area.

Work by Kathryn H. Dansky et al entitled "Understanding Hospital Referrals to Home Health Agencies" analyzed 1990 discharge data from 61 Pennsylvania hospitals. Results showed that HHA ownership was a significant predictor of home health referrals for both rural and urban hospitals, with the effect being greater for urban hospitals. The results also suggested that home health referrals for heart failure (DRG 127) and bowel procedures (DRG 148) are especially sensitive to hospital ownership of a home health agency.

The HCFA funded research project, "A Study of Post-Acute Care," included an analysis of whether hospital ownership of a post-acute facility (including a home health agency) was a predictor of discharge placement. Hospital ownership of a post-acute facility was not found to be a consistent predictor of whether or not a patient received post-acute services, nor whether the post-acute provider was hospital-owned.

The Prospective Payment Assessment Commission (ProPAC) has done a number of analyses relevant to this study. For example, they found that patients discharged from hospitals with a skilled nursing facility (SNF) were 24 percent more likely to use a SNF than patients whose hospitalization was in a facility without a SNF. They did not find a significant difference in use of home health care when the hospital owned a HHA.

There are a number of other factors that may affect the hospital length of stay and subsequent discharge to a home health agency such as the availability of post-hospital services, the severity of the patient's illness, hospital ownership of other post-hospital services, hospital location, and other hospital characteristics. The purpose of this study is to determine if hospital ownership of a home health agency affects the hospital length of stay.

METHODOLOGY

Using Hospital Cost Report Information System (HCRIS) data for the most recent year available (PPS 12), we selected a random sample of 240 hospitals. Specialty hospitals, hospitals that are not paid under the prospective payment system, were excluded from our sample. Hospitals were stratified by size (less than 100 beds, 100 to 299 beds, and more than 299 beds) and grouped by whether or not a hospital owns a HHA (ownership status). Six cells were created for our analysis. We then verified size and ownership status with a mail survey; we had a 98 percent response rate.

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We based our sample on the first 20 hospitals selected for each cell. If one of those hospitals' HCRIS data was inaccurate, that hospital was dropped and replaced by the next hospital for that cell with accurate HCRIS data. This process resulted in a sample of 120 hospitals with 20 in each cell.

All Medicare patient hospital claims for 1996 associated with the sample hospitals for 6 DRG groups were selected using the Medicare Provider Analysis and Review Hospital Record database (MEDPAR). To determine that patients were discharged to a HHA, we used the hospital discharge indicator and matched it to their HHA records to select only those patients who actually received HHA services.

We analyzed lengths of stay for the following DRG groups:

- ! 148- Bowel Procedures with Co-morbidities (bowel procedures);
- ! 127- Heart Failure and Shock;
- ! 209- Joint Re-attachment of the Lower Extremity (joint replacement);
- ! 88- Chronic Obstructive Pulmonary Disease;
- ! 478- Vascular Procedures with Co-morbidities (vascular procedures); and,
- ! 105, 106, and 107- Cardiac Valve Procedures without Cardiac Catheter; Coronary Bypass with Cardiac Catheter and Coronary Bypass without Cardiac Catheter (heart procedures).

The first five of these DRG groups were chosen based upon two criteria: 1) they had the highest volume of patients discharged from hospitals to HHAs; and 2) the number of patients in each of these DRGs constituted at least 1 percent of all patients discharged from hospitals, regardless of post-hospital care. Because we also wanted to include DRGs with higher weights, that is DRGs associated with higher resource consumption and larger payments, we grouped patients in DRGs 105, 106 and 107 together.

We then grouped all the patients who were discharged to a HHA in their respective hospitals according to ownership and compared the overall average length of stay across hospitals and within each strata. For further detail, see Appendix A. This analysis was also performed for each DRG group. Within the group that owned an HHA, we also compared the length of hospital stay for those beneficiaries that went to the hospital's own HHA to those that went to another HHA.

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

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FINDINGS

Hospital Ownership of a Home Health Agency Affects Hospital Length of Stay

Patients discharged to any HHA from hospitals owning HHAs had a shorter length of stay than similar patients discharged from hospitals not owning HHAs. The average hospital stay for patients discharged from a hospital that owns a home health agency was 6.0 days compared to a 7.0 day stay for patients discharged from hospitals that do not own home health agencies. (See Figure I). This difference is statistically significant.

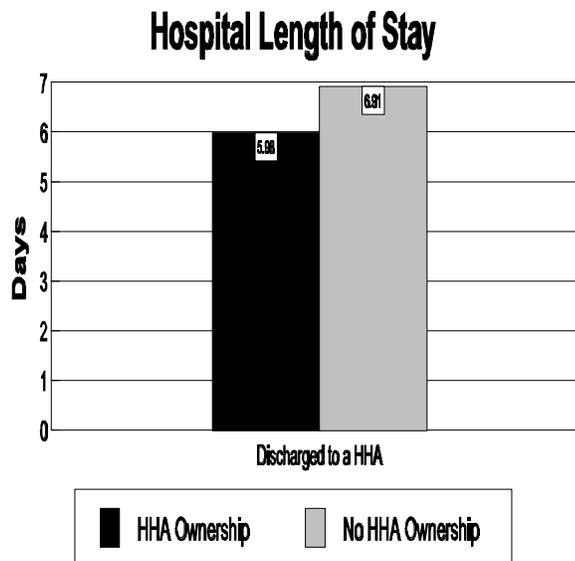


Figure I

This Difference Occurs Regardless of Whether the Patient is Discharged to the Hospital's Own Home Health Agency

Among hospitals that own a home health agency, the patients' average length of stay does not change if the patient is discharged to a home health agency owned by the discharging hospital. The average stay for patients discharged to a home health agency owned by their discharging hospital is 6.1 days. The hospital stay for patients discharged to a home health agency not owned by their discharging hospital is 6.0 days.

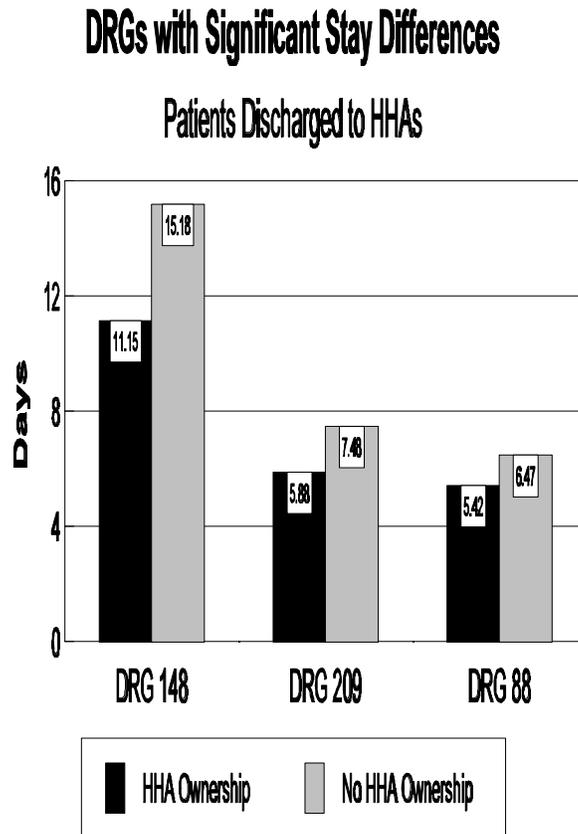
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The Effect of Hospital Ownership Varies By Diagnosis Related Group

Ownership Effects Hospital Length of Stay For Diagnosis Related Groups 148, 209, and 88

Patients in DRGs 148, 209 and 88 discharged to any HHA from a hospital that owned one had statistically shorter inpatient stays than those who were discharged to a HHA from a hospital that did not own one. For patients who had bowel procedures (DRG 148) the difference in the length of the hospital stay was 4 days. Similarly, patients that had joint replacements (DRG 209) and chronic obstructive pulmonary disease (DRG 88) had hospital stays that were 1 day shorter (See Figure II).

Figure II

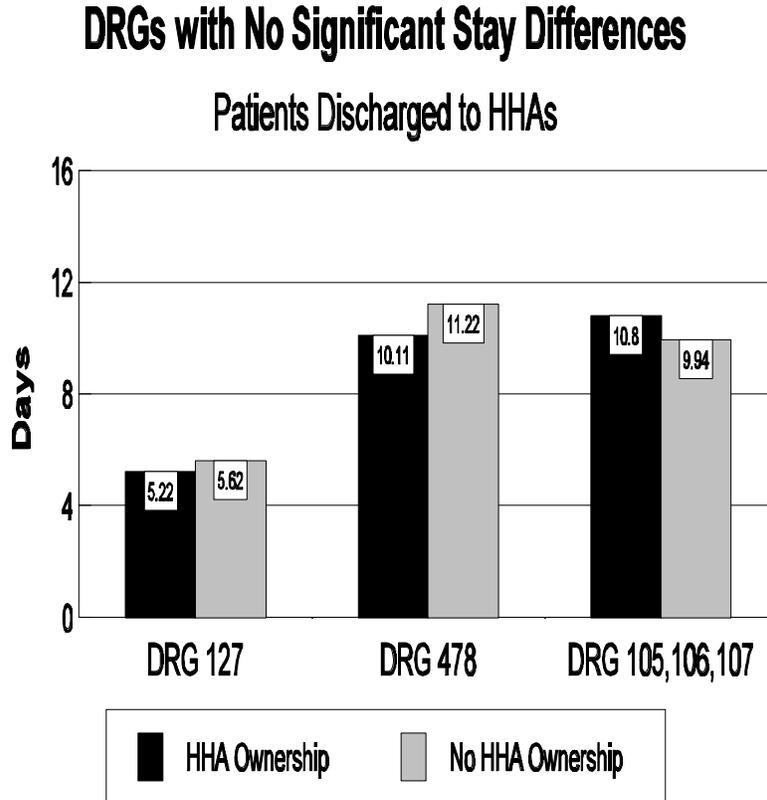


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Hospital Ownership Does Not Effect Length of Stay For Diagnosis Related Groups 127, 478, 105, 106 , and 107

We found no differences in the length of the hospital stay for the remaining three DRGs. These included the following: heart failure and shock (DRG 127), vascular procedures (DRG 478), and heart procedures (DRGs 105, 106 and 107). Although there is a 1 day difference for vascular procedures, it was not statistically significant. We might hypothesize that patients in these DRGs are less likely to be safely discharged early than patients in the other DRGs. (See Figure III).

Figure III



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CONCLUSION

As part of the 1997 Balanced Budget Act, Congress changed the payment formula for Medicare inpatient stays for patients in certain diagnosis related groups who are discharged early to post-hospital settings, including home health agencies. Such cases will now be considered “transfers” rather than “discharges” and reimbursement for the inpatient stay will therefore be reduced. Our finding that hospital ownership of home health agencies is associated with shorter hospital lengths of stay for certain diagnosis related groups provides additional analytical support for this provision.

In light of our findings, we suggest that the Health Care Financing Administration consider hospital ownership as an additional factor when selecting future diagnosis related groups to be covered under this new “transfer reimbursement provision.”

COMMENTS

We received comments on the draft report from the Health Care Financing Administration and the Assistant Secretary for Management and Budget (ASMB). The ASMB agree with our conclusion and suggested a technical change in the background which we have made.

The HCFA agree that they should continue to monitor the data to understand the effect of hospital ownership on post-acute patient referral patterns, but they are not prepared to use hospital ownership as a factor when selecting DRGs to be covered under the new transfer provision. We agree that hospital ownership is only one variable among others and that HCFA should continue to monitor data to better understand the effect of hospital ownership on post-acute referral patterns. We certainly did not intend to imply that hospital ownership should be a deciding factor in making these decisions.

We received comments on the draft report from the Health Care Financing Administration and the Assistant Secretary for Management and Budget (ASMB). They generally agree with our conclusion. The actual comments received are in Appendix B.

The HCFA agrees that they should continue to monitor the data to understand the effect of hospital ownership on post-acute patient referral patterns, but they are not prepared to use hospital ownership as a factor when selecting DRGs to be covered under the new transfer provision. We agree that hospital ownership is only one variable among others that HCFA should continue to monitor to better understand the effect of hospital ownership on post-acute referral patterns. In a prior OIG report, “Medicare Hospital Discharge Planning,” OEI-02-94-00320, we looked at many different variables and found that hospital ownership plays a significant role in the referral process to home health agencies. We also found that ownership affected the duration of hospital stay, but the difference was not statistically significant. Because of these other findings we studied the issue further in this inspection, and found the shorter hospital length of stay to be

statistically significant. These findings support the need for continued monitoring of this data.

The ASMB suggested a technical change in the background which we have made.

APPENDIX A

ANALYSIS OF HOSPITAL LENGTH OF STAY DATA

All beneficiaries in our sample hospitals who were discharged to a home health agency were grouped according to hospital provider number. Overall hospital average lengths of stay were calculated for each hospital. Information regarding the number of days spent in the hospital by each patient, as well as their DRG, came from the MEDPAR database. The analysis involved comparisons of the following data: (1) overall hospital average lengths of stay between hospitals owning HHAs and hospitals not owning HHAs and (2) overall hospital average lengths of stay in DRGs 148, 127, 209, 88, 478, and 105,106, and 107 between hospitals owning HHAs and hospitals not owning HHAs.

In order to test for statistical significance, p-values were calculated for the average lengths of stay at the 90 percent level of confidence. The overall length of stay demonstrated a significant differences at the 90% level of confidence (see Table I). The length of stay difference for DRGs 148, 209, and 88 was also significant at the 90% level of confidence (see Table II).

Table I

**Average Lengths of Stay for Hospitals When
Beneficiaries Were Discharged to HHAs**

	Mean: HHA Ownership	Standard Error	Mean: No HHA Ownership	Standard Error	t-test	p-value	Degrees of Freedom
Discharged to a HHA	5.98	0.25	6.91	0.33	2.271	0.02859	40

Table II

**Average Lengths of Stay for Hospitals When Beneficiaries
Were Discharged to HHAs in Certain DRGs**

	Mean: HHA Ownership	Standard Error	Mean: No HHA Ownership	Standard Error	t-test	p-value	Degrees of Freedom
DRG 148	11.15	1.41	15.18	1.12	2.242	0.03279	29
DRG 127	5.22	0.21	5.62	0.29	1.092	0.28214	35
DRG 209	5.88	0.22	7.48	0.55	2.703	0.01119	30
DRG 88	5.42	0.35	6.47	0.32	2.236	0.03222	33
DRG 478	10.11	1.12	11.22	0.67	0.845	0.40701	23
DRGs 105,106,107	10.80	0.73	9.94	0.94	-0.727	0.47311	30

A P P E N D I X B

COMMENTS ON THE DRAFT REPORT

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



The Administrator
Washington, D.C. 20201

DATE: JUL 22 1998

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TO: June Gibbs Brown
Inspector General

GENERAL

FROM: Nancy-Ann DeParle *Nancy-Ann DeParle*
Administrator

IG	✓
EAIG	✓
SAIG	✓
FDIG	✓
DIG-AS	✓
DIG-EC	✓
DIG-EI	✓
DIG-OI	✓
DIG-MP	✓
AD-PLC	✓
CC-PLC	✓
EA-PLC	✓
EA-PLC	7/23/98

SUBJECT: Office of Inspector General (OIG) Draft Report: "Hospital Stays for Medicare Beneficiaries Who Are Discharged to Home Health Agencies" (OEI-02-94-00321)

We reviewed the above-referenced report that discusses hospital ownership of home health agencies (HHAs) and its effect on the inpatient length of stay. The report found that patients discharged to any HHA from hospitals owning HHAs had a shorter length of stay than similar patients discharged from hospitals not owning HHAs. The difference was found to occur regardless of whether the patient was discharged to the hospital's own HHA or discharged to an HHA not owned by the discharging hospital.

The report raises concerns that hospitals are lowering their costs for patients for whom they are receiving a lump sum prospective payment by discharging these patients to post-hospital services for which they are being paid on a cost basis. This cost shifting results in increased Medicare reimbursement for the hospital.

Our detailed comments follow:

OIG Recommendation

We suggest that the Health Care Financing Administration (HCFA) consider hospital ownership as an additional factor when selecting future diagnosis related groups (DRGs) to be covered under the new "transfer reimbursement provision."

HCFA Response

We agree that HCFA should continue to monitor the data to understand the effect of hospital ownership on post-acute patient referral patterns. We do not agree that this study provides an appropriate basis at this time to consider hospital ownership as a factor when selecting DRGs to be covered under the new transfer provision. The study does not clearly show that hospital stays for beneficiaries discharged from hospitals that own HHAs are shorter than are stays for similar patients discharged from hospitals that do not own HHAs. Rather, the evidence indicates that hospital length of stay varies due to several factors that were not controlled in the OIG analysis. These factors must be

considered in any analysis before concluding that hospital ownership of HHAs may be a significant factor in hospital length of stay.

If HCFA included hospital ownership as a factor when selecting DRGs, the transfer provision would disproportionately affect hospitals that owned post-acute care facilities. The transfer provision is intended to reimburse hospitals fairly while allowing Medicare to share in the efficiencies due to hospital use of post acute care, but it was not intended to encourage or discourage hospital ownership arrangements with post acute-care facilities. We will continue to monitor the data and to work with the OIG and the Congress to address our findings.

Technical Comments

It is unclear from the text of the study whether it is reasonable to conclude that hospital stays for Medicare beneficiaries who are discharged to HHAs are shorter than those for similar patients discharged from hospitals not owning HHAs. Hospital length of stay varies due to several factors including regional differences and urban/rural location. Variables associated with shorter length of stay may also be associated with ownership of HHAs. Unless such variables have been controlled for in the analysis, this may not be a reasonable conclusion.

An earlier OIG report, "Medicare Hospital Discharge Planning" (OEI-02-94-00320), found that hospital ownership seemed to have little influence on nursing home referrals. This previous finding should at least be noted in view of this report's findings.

As previously stated, a number of variables could impact the disparity in length of hospital stays between Medicare patients who are discharged to HHAs owned by hospitals and those who are discharged to HHAs not owned by their attending hospitals. A table showing mean values for some of the characteristics for the hospital groups in the sample would be helpful. (For example: lengths of stay by region; how were the sample hospitals distributed geographically; case-mix index and the hospital's overall utilization of post acute care; teaching/nonteaching.)

While some hospitals may transfer patients earlier than others to self-owned or other HHAs in an attempt to maximize hospital prospective payment and/or home health (HH) payment, there should be recognition of other reasons for the OIG's findings. For example, it is possible that hospitals owning HHAs also have the resources and infrastructure to more quickly and efficiently evaluate and determine necessity for HH care. This would explain why hospitals owning HHAs discharged to all HHAs sooner, not just to their own.

The sequence of referral to HHAs is consistent with HCFA's focus on earlier release from inpatient hospitals. Referrals to the next lesser, but appropriate, level of care from hospitals that also have HHA extensions would seem a natural progression.

It is reasonable to assume that providers with HHA affiliation are more aware of the available services through HH and, therefore, more apt to refer patients to an HHA (their own or freestanding). There is, however, the concern about payment. It would be useful to know if overall, the total Medicare payment is higher if the patient is 'transferred' to an HHA. The care provided even over a 60-day period would exceed the one additional hospital day payment. There would need to be a correlation of patients discharged as dictated by the specific DRG and whether they receive HH services for approximately the same period of time.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

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EAIG	<input checked="" type="checkbox"/>
SAIG	<input checked="" type="checkbox"/>
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OCC/IG	<input checked="" type="checkbox"/>
ExecSec	<input checked="" type="checkbox"/>
Date Sent	6-29

MEMORANDUM TO: The Inspector General
June Gibbs Brown

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

SUBJECT: **Concur with Comment:** OIG Draft Report "Hospital Stays for Medicare Beneficiaries Who Are Discharged to Home Health Agencies" *OEI-02-94-00321*

OIG recommends that HCFA consider hospital ownership of a home health agency (HHA) as an additional factor when selecting future DRGs to be covered under the new BBA transfer provision. ASMB believes this is a reasonable recommendation.

Yet, ASMB would like to offer the following comments on this report, one an editorial change, the other an observation regarding the interplay between this new transfer policy and new payment systems for SNFs and HHAs enacted in the BBA.

Editorial Change

On page 2, paragraph 2 of the report, OIG states "Medicare patients in these yet to be determined DRGs will be considered 'transfer' cases instead of 'discharges.'" This is not accurate. In a proposed rule published on May 8, 1998, HCFA identified 10 DRGs that they recommend be considered "transfer" cases under the new BBA provisions, if the patient is referred to an HHA within three days of a hospital admission. HCFA will make final decisions as to whether these 10 DRGs will be considered "transfer" cases after the comment period closes on July 7. OIG should update this language to reflect the information contained in HCFA's recently published proposed rule.

Interaction Between Transfer Policy/Post-Acute Care Payment Changes

BBA established a new interim payment system for HHAs that includes a new per beneficiary annual payment limit. In addition, BBA creates a new prospective payment system for SNFs that is effective July 1. These new payment systems could change discharge planning incentives for hospitals that own post-acute care providers such as HHAs or SNFs.

The pre-BBA system encouraged hospitals to discharge patients "quicker and sicker" to post-acute providers, particularly if the hospital owned the facility. The new BBA payment limits for HHAs and SNFs may discourage hospitals with ownership interests in such facilities to discharge patients as quickly, as Medicare payments in these settings will likely be reduced. Furthermore, HCFA's proposed three-day rule (i.e., for patients in selected DRGs, discharges within the first three days are considered "transfers" and subject to lower reimbursement, whereas discharges after three days are considered "discharges" and subject to the full DRG payment), in tandem with the new SNF and HHA payment systems, could strengthen a hospital's incentive not to

Page 2

discharge patients as quickly. At this time, it is unclear what these potential changes in hospital discharge planning behavior might mean for patient quality of care and outcomes or Medicare costs.

While not the subject of this OIG report, ASMB suggest that OIG may want to address this issue in a future report.