Memorandum

Date MAY 5 1999

From June Gibbs Brown
Inspector General

Subject Monitoring Quality of Care and Overpayment Issues Associated With Hospital Readmissions Under the Medicare Prospective Payment System (A-01-98-00504)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, *Monitoring Quality of Care and Overpayment Issues Associated With Hospital Readmissions Under the Medicare Prospective Payment System.* The objective of our review was to determine the validity of Medicare prospective payment system (PPS) claims in which a beneficiary was discharged and subsequently readmitted on the same day to the same PPS hospital. In Calendar Year (CY) 1996, PPS hospitals nationwide submitted over 17,000 PPS hospital claims, valued at over $112 million, for the second inpatient hospital stay.

Our review was limited to the top 18 States with over 12,000 same day/same hospital readmissions valued at over $83 million. From that population, we randomly selected 100 readmissions and requested the peer review organizations (PRO) located in the top 18 States to perform a detailed medical review of the randomly selected readmissions. Our review found that 29 readmissions valued at $178,741 were inappropriately paid to PPS hospital providers in CY 1996 for the second inpatient hospital stay. Based on a statistical sample, we estimate the overpayments due to inappropriate hospital readmissions in the 18 States are approximately $22 million in CY 1996.

Our review found the largest number of errors (12 out of the 29 errors identified in our sample) was attributable to premature discharges. We believe this is a serious quality of care issue which needs to be closely monitored.

The results of our review demonstrate that the Health Care Financing Administration (HCFA) needs to utilize the PROs to more actively monitor hospital readmissions to reduce the risk of inappropriate Medicare payments as well as the risk of premature discharges. Moreover, the results to date of our computer match for CY 1997 indicate that the amount paid to PPS hospitals for the second inpatient hospital stay exceeded the $112 million paid to PPS hospitals in CY 1996.

Accordingly, we recommend that HCFA work with the Office of Inspector General (OIG) to do additional work dealing with hospital readmissions to identify additional overpayments, to monitor quality of hospital care, and to profile aberrant hospital providers ensuring corrective action plans are instituted and referrals to the OIG are made, if appropriate. We also recommend HCFA reinstate hospital readmission reviews under the Payment Error Prevention directive in the PROs sixth Scope of Work, and monitor the fiscal intermediaries' recovery of the $178,741 in improper Medicare payments made to PPS hospitals for our sampled episodes in CY 1996.

In response to our draft report, HCFA officials concurred with our recommendations. The HCFA will provide this report to the PROs to help them assess the problems particular to their State and as a suggestion of the types of pattern analyses they should be doing in accordance with the PROs sixth Scope of Work.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-98-00504 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MONITORING QUALITY OF CARE AND OVERPAYMENT ISSUES ASSOCIATED WITH HOSPITAL READMISSIONS UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

JUNE GIBBS BROWN
Inspector General

APRIL 1999
A-01-98-00504

Memorandum

Date MAY 5 1999

From June Gibbs Brown
Inspector General

Subject Monitoring Quality of Care and Overpayment Issues Associated With Hospital Readmissions Under the Medicare Prospective Payment System (A-01-98-00504)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our review of hospital readmissions under the Medicare prospective payment system (PPS). The objective of our review was to determine the validity of Medicare PPS claims in which a beneficiary was discharged and subsequently readmitted on the same day to the same PPS hospital. In Calendar Year (CY) 1996, PPS hospitals nationwide submitted over 17,000 PPS hospital claims, valued at over $112 million, for the second inpatient hospital stay (known hereafter as episodes).

Our review was limited to the top 18 States with over 12,000 episodes valued at over $83 million. From that population, we randomly selected 100 episodes and requested the peer review organizations (PRO) located in the top 18 States to perform a detailed medical review of the randomly selected episodes. We found that 29 episodes valued at $178,741 were inappropriately paid to PPS hospital providers in CY 1996 for the second inpatient hospital stay. Specifically, we noted the following types of errors:

- premature discharges from the initial inpatient hospital stay (12 errors);
- the rendering of additional services that should have been provided and billed as part of one continuous length of stay (8 errors);
- medically unnecessary inpatient hospital readmissions for services that could have been provided in a less acute setting (5 errors);
- no documentation (2 errors); and
- diagnosis related group (DRG) upcoding (2 errors).

Based on our sample results, we estimate the overpayments due to inappropriate hospital readmissions are approximately $22 million in CY 1996 for the 18 States.

In our 100 sample items, we found the largest number of errors (12 of the 29 errors identified in our review) was attributable to a premature discharge from the initial hospital stay. We believe this is a serious quality of care issue which needs to be closely monitored.

The results of our review demonstrate that hospital readmissions to the same PPS hospital on the same day of discharge are vulnerable to improper Medicare payments and may be indicative of problems with quality of care. Moreover, the results to date of our computer match for CY 1997 indicate that the amount paid to PPS hospitals for the second inpatient hospital stay was over $114 million, exceeding the $112 million paid to PPS hospitals in CY 1996.

Accordingly, we recommend that the Health Care Financing Administration (HCFA) work with the Office of Inspector General (OIG) to do additional work dealing with hospital readmissions to identify additional overpayments, to monitor quality of hospital care, and to profile aberrant hospital providers ensuring corrective action plans are instituted and referrals to the OIG are made, if appropriate. We also recommend HCFA reinstate hospital readmission reviews under the Payment Error Prevention (PEP) directive in the PROs sixth Scope of Work, and monitor the fiscal intermediaries' recovery of the $178,741 in improper Medicare payments made to PPS hospitals for our sampled episodes in CY 1996.

In response to our draft report, HCFA officials concurred with our recommendations. The HCFA will provide this report to the PROs to help them assess the problems particular to their State and as a suggestion of the types of pattern analyses they should be doing in accordance with the PROs sixth Scope of Work. The HCFA comments to our draft report are included in their entirety in Appendix V.

INTRODUCTION

BACKGROUND

The Social Security Amendments of 1983 provided for the establishment of a PPS for Medicare payment of inpatient hospital services. Under PPS, hospitals are paid a predetermined rate for each hospital discharge, which are classified into DRGs. In CY 1996, PPS hospitals nationwide submitted over 17,000 hospital claims in which a beneficiary was discharged and subsequently readmitted on the same day to the same PPS hospital. These hospitals received over $112 million in Medicare payments for the second inpatient hospital stay.

The Peer Review Improvement Act of 1982 established the Utilization and Quality Control Peer Review Organization program. Section 1154 of the Social Security Act authorizes PROs that contract with HCFA to review services furnished to Medicare beneficiaries, in settings such as acute care hospitals, to ensure that medical care furnished to Medicare

beneficiaries is medically necessary and reasonable, is provided in the most appropriate setting, and meets professionally accepted standards of quality. The specific review obligations of PROs are outlined in a document known as the Scope of Work which defines the duties and Medicare review functions performed by the PRO.

Prior to the current fifth Scope of Work, HCFA generated a sample of hospital readmission claims to be reviewed by the PROs to determine whether a patient was prematurely discharged from the first confinement, thus causing a readmission. The PROs reviewed the medical record for both the initial admission and the readmission. The PROs performed admission, coverage, documentation, discharge, invasive procedure, DRG validation, and quality reviews on both stays.

In April 1993, the Health Care Quality Improvement Program (HCQIP) was developed to reorganize the PRO program by eliminating the random sample case-by-case review and replacing it with a system designed to encourage providers to maintain and strengthen their own internal quality management systems. The purpose of HCQIP is to promote the quality, efficiency, and effectiveness of services to Medicare beneficiaries. Each PRO is to focus on the development and implementation of cooperative projects as a method for the PRO to improve the quality of care and to help beneficiaries make informed health care choices.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine the validity of Medicare PPS claims in which a beneficiary was discharged and subsequently readmitted on the same day to the same PPS hospital. Our review was conducted in accordance with generally accepted government auditing standards. Our review period covered CY 1996 PPS hospital claims in which the discharge date of service of the first Medicare Part A inpatient stay was the same as the readmission date of service of the second Part A inpatient stay at the same PPS hospital.

Our review of the internal control structure was limited to an understanding of the procedures in place to identify and evaluate hospital readmissions.

To accomplish our objective, we:

- Used the HCFA National Claims History file to extract CY 1996 PPS claims in which the discharge date of service and the subsequent admission date of service were the same, and the provider numbers were the same.

- Identified 17,349 episodes nationwide valued at $112,087,536. The $112 million represent the amount Medicare paid to PPS hospitals for the second inpatient stay (See Appendix II).

- Limited our review to the top 18 States with 12,382 episodes, valued at $83,504,882 which account for 74.5 percent of the total amount paid nationwide for the second hospital stay. The $83 million represent the amount Medicare paid to PPS hospitals for the second inpatient stay in the 18 States.

- Selected a statistical random sample of 100 episodes valued at $659,041 for the second inpatient stay from the top 18 States for review.

- Provided the PROs located in the top 18 States with the sample of episodes to perform a detailed medical review of the randomly selected episodes for the selected providers located in their jurisdiction.

- Discussed with selected fiscal intermediaries their procedures for identifying hospital readmissions.

- Provided a questionnaire to each of the 18 PROs to determine the PROs' past and current procedures for reviewing hospital readmissions.

- Determined the overpayments made to PPS hospitals for the second inpatient stay based on the PROs' results for the 100 episodes.

- Used a variable appraisal program to estimate the potential overpayments made to PPS hospitals in the 18 States in CY 1996.

In addition, a computer match of the CY 1997 PPS claims identified 17,164 episodes nationwide valued at $114,523,103 in which the discharge date of service and the subsequent admission date of service were the same and the provider numbers were the same. However, this data has not been validated or subject to the same review procedures identified above (See Appendix III).

We conducted our review during the period of January 1998 through August 1998 at the HCFA central office in Baltimore, Maryland; the HCFA regional offices in Boston, Dallas, Kansas City, and Seattle; the Boston Regional Office of the OIG; and selected PROs nationwide.

FINDINGS AND RECOMMENDATIONS

IMPROPER PAYMENTS TO PPS HOSPITALS FOR READMISSIONS

According to 42 CFR, section 412.48, if the PRO determines that a hospital has taken an action that results in the unnecessary multiple admissions of a beneficiary, the PRO may as appropriate, deny payment under Part A with respect to unnecessary admissions or subsequent readmissions of a beneficiary. The results of our review demonstrate that HCFA needs to utilize the PROs to more actively monitor hospital readmissions to reduce the risk of inappropriate care as well as inappropriate Medicare payments. Based on a review of 100 randomly selected episodes, we found that in 29 episodes the DRG payment for the readmission was not appropriate or should have been reduced. We estimate that in CY 1996, inappropriate payments for readmissions in the 18 States totaled approximately $22 million.

As part of our review in determining whether the second inpatient hospital stay was appropriate, we requested the assistance of the PROs in each of the 18 States to perform a detailed medical review of the 100 sampled episodes valued at $659,042. This included:

- obtaining the detailed medical records for each episode (both stays);
- performing admission, coverage, documentation, discharge, invasive procedure, DRG validation, and quality reviews on both stays;
- performance of the first level of review of the beneficiary's medical record by a non-physician reviewer (generally a nurse) using criteria and generic quality screens;
- physician review if the case failed the criteria or screens;
- providing the opportunity for the attending physician and provider to discuss the case with the PRO; and
- if the PRO determined that a provider of Medicare services took an action that resulted in unnecessary admissions, premature discharges, and readmissions, or multiple readmissions, the PRO denied the second admission and issued a denial notice to the hospital.

Based on the PROs' medical review of the randomly selected episodes, we found that Medicare inappropriately paid PPS hospitals $178,741 for hospital readmissions, or 27 percent of the total dollars reviewed (See Appendix IV). The PROs' reviews found that the second inpatient hospital stay for the remaining 71 episodes were medically necessary or reasonable. In those 71 instances, the PROs determined that the purpose for the

readmission on the same day to the same PPS hospital was unrelated to the beneficiary's first inpatient hospital stay.

We found the largest number of errors was caused by a premature discharge from the initial hospital stay (12 out of the 29 errors found in our review of 100 sample items). This high percentage of premature discharges raises very serious concerns about the quality of care these beneficiaries received.

The errors identified by the PROs are as follow:

TYPES OF ERRORS IDENTIFIED BY THE PRO

Type of Error	*Number of Claims in Error*	*Amount in Error*
Premature Discharges	12	$ 66,104
Separate Payments for One Continuous Stay	8	44,413
Medically Unnecessary Inpatient Hospital Admissions	5	39,256
No Documentation	2	26,311
DRG Upcoding	2	2,657
Total	***29***	***$178,741***

The following illustrate in more detail the types of errors identified:

- ***Premature Discharges*** - The PROs found that in 12 episodes reviewed, the beneficiaries were either medically unstable on the day of discharge or the medical treatment the beneficiaries received was inappropriate for the existing condition, resulting in the subsequent readmission of the beneficiaries. For example, a beneficiary was admitted on December 6, 1996, for shortness of breath and discharged on December 10, 1996. During the course of this beneficiary's inpatient stay, the beneficiary developed congestive heart failure that resulted in the patient developing chronic renal failure. The PRO found that the congestive heart failure should have been treated more aggressively prior to discharge on December 10, 1996. The failure to adequately treat the congestive heart failure resulted in the patient's readmission on December 10, 1996. In these types of instances, the PRO denied the readmission.

- ***Separate Payments for One Continuous Stay*** - The PROs found that eight episodes reviewed should have been billed as one continuous stay. In these instances, the patient never left the hospital, but was only transferred to another acute level care unit within the hospital. For example, the PRO's review of one episode found that the beneficiary was admitted on March 3, 1996 for a cardiac condition. The beneficiary's condition was monitored, a cardiology consultation was obtained, and an echo was done. The PRO found that the beneficiary was transferred within the hospital for a cardiac catheterization procedure on March 7, 1996. The PRO states that this care should have been continued as part of the first admission. Therefore, in these types of instances, the PRO denied the readmission.

- ***Medically Unnecessary Inpatient Hospital Admissions*** - The PROs found that in five episodes the second inpatient stay was medically unnecessary. In this respect, the services could have been provided on an outpatient basis. For instance, the PRO's review of one episode found that the beneficiary was admitted with infected peritoneal dialysis fluid, discharged, and readmitted as an observation patient. The PRO found that the provider incorrectly submitted the second hospital stay as an inpatient admission when the attending physician admitted the beneficiary as a "23 hour admission." In these types of instances, the PRO denied the readmission.

- ***No Documentation*** - The PROs technically denied two episodes because the providers did not submit the medical records for review. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care.

- ***DRG Upcoding*** - The PROs found that the documentation in the medical records submitted by two providers for two episodes did not support the principle diagnosis submitted for the second inpatient hospital stay. Therefore, adjustment notices were issued by the PROs to the fiscal intermediaries for lower-weighted DRGs.

Based on our sample results, we estimate that the Medicare program inappropriately paid PPS hospitals in the 18 States approximately $22,131,774 with a precision of this estimate at the 90 percent confidence level of ±34.46 percent (See Appendix I).

In our sample of 100 cases, we found 12 errors which were a result of a premature discharge. This high percent of premature discharges raises serious quality of care concerns. To monitor the quality of care concerns involved with premature discharges, per section 1156 of the Social Security Act, a hospital which prematurely discharges is required to enter into a corrective action plan, and if appropriate, a referral should be made to the OIG. We note in the past several years, the OIG has not received premature discharge referrals from the PROs.

Prior to the current Scope of Work, the PROs performed detailed case reviews of hospital medical records that included hospital readmissions. Since April 1993, the PROs Scope of Work has changed significantly. Specifically, HCFA does not mandate that the PROs review hospital readmission data, unless it relates to a beneficiary complaint involving a readmission or a hospital notice of non-coverage.

The significant emphasis of the PROs current Scope of Work is on quality of care and provider education, rather than surveillance type of reviews. However, the results of our review demonstrate that hospital readmissions to the same PPS hospital are vulnerable to improper Medicare payments and could be used to provide valuable insights on quality of care. Moreover, the results of our computer match for CY 1997 indicate that the amount paid to PPS hospitals for the second inpatient hospital stay exceeded the amount paid to PPS hospitals in CY 1996.

The HCFA has issued the PROs sixth Scope of Work which requires the PROs to perform PEP activities. Specifically, the PROs will conduct focused reviews where analysis or other information indicates the possibility that inpatient services could have been provided more economically in a different setting or services were provided in such a way as to circumvent Medicare payment rules.

Based on our discussions with PRO officials, they generally believe that hospital readmissions to the same provider is a high risk area and readmission reviews should be reinstated in subsequent Scopes of Work.

RECOMMENDATIONS

We recommend that HCFA:

- work with the OIG in utilizing our computer analysis to initiate additional reviews for CYs 1996 and 1997 in order to identify and recover additional overpayments and to monitor the quality of hospital care;

- work with the OIG in utilizing the results of our computer analysis to profile aberrant hospital providers in CYs 1996 and 1997, ensuring aberrant providers institute a corrective action plan and make referrals to OIG if appropriate, particularly in incidents of premature discharges;

- reinstate hospital readmission reviews under the PEP directive in its sixth Scope of Work as part of its corrective action plan to reduce improper Medicare payments and monitor the quality of hospital care; and

- monitor the fiscal intermediaries' recovery of the $178,741 in improper Medicare payments made to PPS hospitals for the sampled episodes in CY 1996.

HCFA COMMENTS

In its comments to our draft report, HCFA concurred with our recommendations. Specifically, HCFA stated same day readmissions to the same hospital may be a good indicator for billing and/or quality problems in a hospital. This can be useful when conducting a pattern analysis of charge data to identify problem providers. The HCFA is developing a performance based contract for the PEP program. This will allow the PROs to be in a position to consider readmission reviews as a part of their approach to reach their goals. In addition, HCFA agreed to monitor the fiscal intermediaries' recovery of the $178,741 in improper Medicare payments made to PPS hospitals for the sampled episodes in CY 1996. The HCFA agreed that its regional offices will instruct their respective intermediaries to recover the overpayments and report their findings to their regional offices.

In addition, HCFA requested analysis of the distribution of the readmissions in 1996 and 1997 to determine where the readmissions are occurring.

ADDITIONAL OIG COMMENTS

In response to HCFA's request for analysis of the readmissions, we agree that additional analyses should be done to identify aberrant hospital providers and determine where these readmissions are occurring. We are currently analyzing the readmissions for CYs 1996 and 1997 to provide more detail on the distribution of the readmissions. Upon completion, we will issue a report to HCFA detailing the results of our analyses.

APPENDICES

METHODOLOGY OF STATISTICAL SAMPLE SELECTION

To select a sample for validating our data and estimating the overpayments due to inappropriate hospital readmissions, we extracted 17,349 episodes nationwide valued at $112,087,536 in which the discharge date of service and the subsequent admission date of service were the same and the provider numbers were the same from HCFA's National Claims History file for CY 1996. We limited our population to the top 18 States with 12,382 episodes, valued at $83,504,882 which account for 74.5 percent of the cumulative amount paid nationwide for the second hospital stay.

From the population of 12,382 episodes, we selected a simple random sample of 100 episodes for review. We requested the assistance of the PROs located in the top 18 States to perform a detailed medical review of the randomly selected episodes. Based on a review of the 100 randomly selected episodes, we found that for 29 episodes Medicare inappropriately paid PPS hospitals $178,741 for hospital readmissions, or 27 percent of the total dollars reviewed. Based on our sample results, we estimate that the Medicare program inappropriately paid PPS hospitals in the 18 States approximately $22,131,774 with a precision of this estimate at the 90 percent confidence level of $\pm$34.46 percent.

All random selections and estimations were made using the Office of Audit Services' Statistical Software dated February 1995.

REVIEW OF HOSPITAL READMISSIONS UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

STATISTICAL SAMPLE INFORMATION

	POPULATION	SAMPLE	ERRORS
Episodes Identified for the 18 States	12,382	100	29
Dollars Paid	$83,504,882[1]	$659,042[1]	$178,741[1]

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $22,131,774
Lower Limit: $14,505,360
Upper Limit: $29,758,188
Precision Percent: 34.46%

[1] *The dollars paid represent the amount paid for the second inpatient hospital stay.*

READMISSION EPISODES IDENTIFIED NATIONWIDE IN CY 1996							
	STATE CODE	STATE	PAID AMOUNT FOR 1ST INPATIENT STAY	PAID AMOUNT FOR 2ND INPATIENT STAY	# OF PPS CLAIMS	CUMULATIVE AMOUNT	CUMULATIVE PERCENT
1	33	NEW YORK	13,417,084.34	14,828,410.04	1,603	14,828,410.04	13.23%
2	45	TEXAS	8,581,877.75	7,164,590.85	1,159	21,993,000.89	19.62%
3	36	OHIO	7,240,661.81	6,386,636.16	1,015	28,379,637.05	25.32%
4	5	CALIFORNIA	5,404,847.78	5,652,096.04	735	34,031,733.09	30.36%
5	14	ILLINOIS	4,865,101.31	4,790,358.60	723	38,822,091.69	34.64%
6	39	PENNSYLVANIA	4,913,831.79	4,718,782.15	638	43,540,873.84	38.85%
7	31	NEW JERSEY	4,218,807.28	4,162,604.22	597	47,703,478.06	42.56%
8	10	FLORIDA	4,470,541.22	4,085,256.60	686	51,788,734.66	46.20%
9	26	MISSOURI	3,587,986.89	3,990,187.81	619	55,778,922.47	49.76%
10	22	MASSACHUSETTS	4,261,767.60	3,914,383.78	544	59,693,306.25	53.26%
11	11	GEORGIA	4,782,419.80	3,807,473.40	600	63,500,779.65	56.65%
12	44	TENNESSEE	3,619,585.36	3,449,794.82	613	66,950,574.47	59.73%
13	19	LOUISIANA	3,326,250.93	3,095,580.32	551	70,046,154.79	62.49%
14	34	NORTH CAROLINA	3,328,698.98	3,093,064.64	554	73,139,219.43	65.25%
15	49	VIRGINIA	3,368,462.39	2,808,803.98	504	75,948,023.41	67.76%
16	15	INDIANA	3,058,556.79	2,610,030.95	467	78,558,054.36	70.09%
17	7	CONNECTICUT	2,684,568.78	2,480,979.17	308	81,039,033.53	72.30%
18	1	ALABAMA	2,846,544.48	2,465,847.97	466	83,504,881.50	[2] 74.50%

[2] As part of our approach, we found that the cumulative amount paid to the top 18 States accounted for 74.5% of the cumulative amount paid nationwide for the second hospital stay. Therefore, we limited our review to the top 18 States.

READMISSION EPISODES IDENTIFIED NATIONWIDE IN CY 1996							
	STATE CODE	STATE	PAID AMOUNT FOR 1ST INPATIENT STAY	PAID AMOUNT FOR 2ND INPATIENT STAY	# OF PPS CLAIMS	CUMULATIVE AMOUNT	CUMULATIVE PERCENT
19	23	MICHIGAN	2,685,703.27	2,451,941.31	353	85,956,822.81	76.69%
20	52	WISCONSIN	2,477,124.66	2,207,512.87	355	88,164,335.68	78.66%
21	18	KENTUCKY	2,472,145.99	2,192,744.22	427	90,357,079.90	80.61%
22	50	WASHINGTON	2,017,580.49	2,102,222.37	323	92,459,302.27	82.49%
23	24	MINNESOTA	2,067,977.12	1,923,881.52	327	94,383,183.79	84.20%
24	37	OKLAHOMA	1,697,886.19	1,533,383.89	306	95,916,567.68	85.57%
25	42	SOUTH CAROLINA	1,494,353.57	1,505,918.58	248	97,422,486.26	86.92%
26	6	COLORADO	1,295,691.18	1,498,004.03	197	98,920,490.29	88.25%
27	25	MISSISSIPPI	1,562,720.13	1,368,772.45	328	100,289,262.74	89.47%
28	4	ARKANSAS	1,219,651.27	1,227,150.11	247	101,516,412.85	90.57%
29	38	OREGON	1,368,824.78	1,195,143.67	213	102,711,556.52	91.64%
30	16	IOWA	873,706.61	905,137.51	166	103,616,694.03	92.44%
31	51	WEST VIRGINIA	923,741.89	874,782.58	166	104,491,476.61	93.22%
32	17	KANSAS	841,339.95	739,224.98	162	105,230,701.59	93.88%
33	20	MAINE	757,255.02	699,513.29	130	105,930,214.88	94.51%
34	3	ARIZONA	771,546.96	661,155.44	121	106,591,370.32	95.10%
35	9	DISTRICT OF COLUMBIA	516,298.06	626,949.24	57	107,218,319.56	95.66%
36	29	NEVADA	395,161.53	567,794.63	56	107,786,114.19	96.16%
37	46	UTAH	733,640.36	492,650.75	85	108,278,764.94	96.60%
38	41	RHODE ISLAND	670,632.35	489,621.57	82	108,768,386.51	97.04%

Source: HCFA's Decision Support Access Facility, Standard Analytical File

READMISSION EPISODES IDENTIFIED NATIONWIDE IN CY 1996

	STATE CODE	STATE	PAID AMOUNT FOR 1ST INPATIENT STAY	PAID AMOUNT FOR 2ND INPATIENT STAY	# OF PPS CLAIMS	CUMULATIVE AMOUNT	CUMULATIVE PERCENT
39	13	IDAHO	348,933.61	461,585.62	64	109,229,972.13	97.45%
40	28	NEBRASKA	698,139.40	452,125.02	97	109,682,097.15	97.85%
41	32	NEW MEXICO	479,052.09	331,735.37	69	110,013,832.52	98.15%
42	27	MONTANA	312,935.95	329,327.34	66	110,343,159.86	98.44%
43	30	NEW HAMPSHIRE	298,418.92	317,340.44	52	110,660,500.30	98.73%
44	40	PUERTO RICO	184,049.03	304,154.18	83	110,964,654.48	99.00%
45	35	NORTH DAKOTA	199,516.00	191,131.46	34	111,155,785.94	99.17%
46	47	VERMONT	206,161.76	181,737.46	36	111,337,523.40	99.33%
47	48	VIRGIN ISLANDS	84,338.00	163,828.00	10	111,501,351.40	99.48%
48	8	DELAWARE	98,817.00	132,552.09	17	111,633,903.49	99.60%
49	2	ALASKA	139,180.52	119,040.26	16	111,752,943.75	99.70%
50	12	HAWAII	158,972.78	118,910.86	23	111,871,854.61	99.81%
51	53	WYOMING	214,410.73	116,880.71	25	111,988,735.32	99.91%
52	43	SOUTH DAKOTA	182,532.00	98,800.67	26	112,087,535.99	100.00%
			118,426,034.45	**112,087,535.99**	**17,349**		

READMISSION EPISODES IDENTIFIED NATIONWIDE IN CY 1997

	STATE CODE	STATE	PAID AMOUNT FOR 1ST INPATIENT STAY	PAID AMOUNT FOR 2ND INPATIENT STAY	# OF PPS CLAIMS	CUMULATIVE AMOUNT	CUMULATIVE PERCENT
1	33	NEW YORK	12,364,523.24	12,458,457.83	1,367	12,458,457.83	10.88%
2	45	TEXAS	8,992,694.50	8,032,754.85	1,229	20,491,212.68	17.89%
3	5	CALIFORNIA	8,451,055.91	8,924,583.62	1,056	29,415,796.30	25.69%
4	10	FLORIDA	7,533,909.96	7,053,011.07	1,020	36,468,807.37	31.84%
5	36	OHIO	7,503,508.06	6,827,594.48	986	43,296,401.85	37.81%
6	39	PENNSYLVANIA	6,739,914.71	5,633,767.48	865	48,930,169.33	42.73%
7	14	ILLINOIS	4,777,975.35	4,432,202.59	674	53,362,371.92	46.60%
8	31	NEW JERSEY	4,090,832.03	3,435,655.13	502	56,798,027.05	49.60%
9	44	TENNESSEE	3,993,692.95	3,620,513.51	604	60,418,540.56	52.76%
10	23	MICHIGAN	3,732,569.19	3,348,831.92	464	63,767,372.48	55.68%
11	26	MISSOURI	3,400,168.51	2,800,441.42	486	66,567,813.90	58.13%
12	11	GEORGIA	3,356,382.06	3,061,274.53	448	69,629,088.43	60.80%
13	22	MASSACHUSETTS	3,349,116.87	3,283,661.28	456	72,912,749.71	63.67%
14	19	LOUISIANA	3,162,090.51	3,223,893.81	468	76,136,643.52	66.48%
15	34	NORTH CAROLINA	3,112,263.93	2,892,047.58	467	79,028,691.10	69.01%
16	49	VIRGINIA	3,071,993.48	2,386,910.42	426	81,415,601.52	71.09%
17	15	INDIANA	2,650,167.18	2,593,142.04	389	84,008,743.56	73.36%
18	1	ALABAMA	2,470,493.38	2,266,468.02	418	86,275,211.58	75.33%
19	52	WISCONSIN	2,252,094.99	1,915,920.91	331	88,191,132.49	77.01%
20	7	CONNECTICUT	2,165,229.19	1,848,666.11	234	90,039,798.60	78.62%
21	18	KENTUCKY	2,164,480.63	2,106,674.26	395	92,146,472.86	80.46%
22	24	MINNESOTA	2,081,414.50	1,790,597.12	295	93,937,069.98	82.02%

READMISSION EPISODES IDENTIFIED NATIONWIDE IN CY 1997

	STATE CODE	STATE	PAID AMOUNT FOR 1ST INPATIENT STAY	PAID AMOUNT FOR 2ND INPATIENT STAY	# OF PPS CLAIMS	CUMULATIVE AMOUNT	CUMULATIVE PERCENT
23	50	WASHINGTON	2,008,283.23	1,842,327.36	283	95,779,397.34	83.63%
24	6	COLORADO	1,927,166.67	1,809,153.76	245	97,588,551.10	85.21%
25	51	WEST VIRGINIA	1,712,275.01	1,018,929.33	215	98,607,480.43	86.10%
26	38	OREGON*	1,705,159.63	1,486,809.05	252	100,094,289.48	87.40%
27	25	MISSISSIPPI	1,670,612.79	1,582,497.49	343	101,676,786.97	88.78%
28	37	OKLAHOMA	1,601,586.94	1,366,221.69	248	103,043,008.66	89.98%
29	42	SOUTH CAROLINA	1,404,751.81	1,362,006.49	254	104,405,015.15	91.17%
30	17	KANSAS	1,170,594.23	1,150,883.64	212	105,555,898.79	92.17%
31	4	ARKANSAS	1,146,042.61	1,246,773.08	237	106,802,671.87	93.26%
32	3	ARIZONA	1,026,618.99	900,295.72	144	107,702,967.59	94.04%
33	16	IOWA	867,727.22	812,473.81	177	108,515,441.40	94.75%
34	46	UTAH	770,641.86	696,159.26	97	109,211,600.66	95.36%
35	41	RHODE ISLAND	715,388.75	573,241.30	68	109,784,841.96	95.86%
36	20	MAINE	487,669.03	470,191.65	104	110,255,033.61	96.27%
37	13	IDAHO	455,528.04	359,986.86	67	110,615,020.47	96.59%
38	32	NEW MEXICO	427,932.04	453,894.38	75	111,068,914.85	96.98%
39	30	NEW HAMPSHIRE	419,857.74	357,225.58	61	111,426,140.43	97.30%
40	9	DISTRICT OF COLUMBIA	415,685.80	620,386.40	50	112,046,526.83	97.84%
41	29	NEVADA	352,231.30	295,600.75	46	112,342,127.58	98.10%
42	27	MONTANA	312,930.67	300,413.64	67	112,642,541.22	98.36%
43	12	HAWAII	291,539.71	296,536.55	37	112,939,077.77	98.62%
44	28	NEBRASKA	290,038.11	359,116.23	72	113,298,194.00	98.93%

READMISSION EPISODES IDENTIFIED NATIONWIDE IN CY 1997

	STATE CODE	STATE	PAID AMOUNT FOR 1ST INPATIENT STAY	PAID AMOUNT FOR 2ND INPATIENT STAY	# OF PPS CLAIMS	CUMULATIVE AMOUNT	CUMULATIVE PERCENT
45	53	WYOMING	205,888.10	188,281.91	29	113,486,475.91	99.09%
46	40	PUERTO RICO	201,972.94	165,824.61	71	113,652,300.52	99.24%
47	8	DELAWARE	184,486.84	212,967.75	35	113,865,268.27	99.43%
48	35	NORTH DAKOTA	162,775.84	182,678.72	27	114,047,946.99	99.59%
49	43	SOUTH DAKOTA	140,283.51	165,992.04	27	114,213,939.03	99.73%
50	2	ALASKA	103,062.47	137,980.60	16	114,351,919.63	99.85%
51	48	VIRGIN ISLANDS	80,850.00	90,910.00	6	114,442,829.63	99.93%
52	47	VERMONT	65,945.58	68,284.15	15	114,511,113.78	99.99%
53	65	GUAM	12,776.00	10,188.00	3	114,521,301.78	100.00%
54	64	AMERICAN SAMOA	1,576.00	1,801.00	1	114,523,102.78	100.00%
			123,756,450.59	**114,523,102.78**	**17,164**		

SUMMARY OF 100 RANDOMLY SELECTED EPISODES

PERIOD COVERED CY 1996

PRO REGION	PRO STATE	PAID AMOUNT FOR 1ST INPATIENT STAY	PAID AMOUNT FOR 2ND INPATIENT STAY	# OF PPS EPISODES	# OF PPS EPISODES IN ERROR	OVERPAYMENT AMOUNT
BOSTON	CONNECTICUT	34,005.14	32,645.22	6	1	8,386.45
BOSTON	MASSACHUSETTS	25,451.70	59,717.46	5	1	330.74
BOSTON	NEW JERSEY	50,362.92	28,044.91	6	0	0.00
BOSTON	NEW YORK	173,468.93	181,570.53	19	13	102,893.30
BOSTON	PENNSYLVANIA	40,247.01	33,699.07	5	0	0.00
BOSTON	VIRGINIA	11,673.29	10,642.42	3	0	0.00
DALLAS	ALABAMA	6,159.51	2,640.29	2	1	1,454.71
DALLAS	FLORIDA	16,078.80	21,450.02	3	1	3,404.70
DALLAS	GEORGIA	33,129.05	19,518.77	4	1	4,814.59
DALLAS	LOUISIANA	7,617.34	6,432.19	2	0	0.00
DALLAS	NORTH CAROLINA	18,694.81	21,520.01	5	2	9,950.59
DALLAS	TENNESSEE	11,102.09	11,212.52	3	0	0.00
DALLAS	TEXAS	44,936.27	51,715.51	9	1	2,326.75
KANSAS CITY	ILLINOIS	66,092.05	34,286.89	6	1	4,905.89
KANSAS CITY	INDIANA	39,940.71	19,760.48	4	1	5,243.38
KANSAS CITY	MISSOURI	16,392.81	54,132.30	4	2	18,359.57
KANSAS CITY	OHIO	61,249.16	40,939.77	9	3	9,022.32
SEATTLE	CALIFORNIA	24,722.19	29,113.52	5	1	7,648.52
	TOTAL	**681,323.78**	**659,041.88**	**100**	**29**	**178,741.51**
	PERCENT IN ERROR					**27%**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: MAR 16 1999

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Monitoring Quality of Care and Overpayment Issues Associated with Hospital Readmissions Under the Medicare Prospective Payment System", (A-01-98-00504)

We reviewed the draft report and concur with the recommendations. The report provides important information about possible quality of care problems and program integrity issues related to same-day hospital readmissions. As this report shows, many times a same-day readmission is appropriate for proper care of a Medicare beneficiary. However, we want to make sure that Medicare beneficiaries receive high-quality care and that Medicare pays providers fairly and accurately. Working with your office, we have heightened our focus on correcting improper Medicare payments, and new surveys and audits are helping to pinpoint areas of vulnerability. We appreciate your giving us an opportunity to comment on the report.

This report provides the results of a detailed medical review of a random selection of 100 hospital readmissions under the Medicare inpatient prospective-payment system (PPS). The objective of the review was to determine the validity of Medicare PPS claims when a beneficiary is discharged and subsequently readmitted on the same day to the same PPS hospital. This analysis found that about 70 percent of the readmissions were appropriate in the sample selected. The OIG found that 29 of the 100 episodes valued at $178,741 were inappropriately paid to PPS hospital providers in CY 1996 for the second inpatient hospital stay.

OIG Recommendation 1

The OIG recommends that the Health Care Financing Administration (HCFA) work with the OIG to do more work dealing with hospital readmissions to identify additional overpayments, monitor quality of hospital care, and profile aberrant hospital providers, ensuring corrective action plans are instituted and referrals to the OIG are made, if appropriate.

HCFA Response

We concur. Same day readmissions to the same hospital may be a good indicator for billing and/or quality problems in a hospital. This can be useful when conducting a pattern analysis of discharge data in order to identify problem providers. However, more information is needed to determine if this is also a reasonable indicator for identifying problem providers. Specifically, the OIG identified approximately 17,000 instances of this type of admission in 1996 but did not examine the pattern of their occurrences. The implications of a wide-spread billing problem -- for example, three ocurrances in each of the 5,000 hospitals across the country -- would have a different solution than if only a few facilities were shown to produce these types of admissions.

OIG Recommendation 2

The OIG recommends that HCFA reinstate hospital readmission reviews under the Payment Error Prevention Program (PEPP) in the PROs' next contract and monitor the fiscal intermediaries' recovery of the $178,741 in improper Medicare payments made to PPS hospitals for our sampled episodes in CY 1996.

HCFA Response

We concur. We think this recommendation will fit in well with our current proposal for the PROs' next contract, known as the sixth scope of work. We are developing a performance-based contract for PEPP, and the PROs will be able to consider readmission reviews as part of reaching their goals. We believe that a judicious review of the pattern of these discharges may lead to some PROs conducting such reviews. But others may not, and this determination would be left to the discretion of the local contractor.

Under performance-based contracting, PRO performance will be judged by how successful they are in reaching payment error rate reduction goals. This type of contracting gives the PROs latitude about how they will achieve this goal. The analysis presented by the OIG is representative of the types of analysis we would expect individual PROs to undertake to determine what type of interventions they need to make. If same-day readmissions were shown to occur to a high degree in a state, then the PRO would be well advised to pursue these types of admissions. However, not all States may have a problem with these types of admissions. In tables presented by the OIG in an appendix to the report, most of the sampled readmissions determined to be in error were spread out across the various States. We realize this is a factor of sample size as well as intrinsic variation. However, 13 of the sample error cases occurred in New York. One might suspect that New York would be a place to search for systemic problems that need to be corrected. This kind of variation points to the need for us to give the PROs the freedom to determine which types of problems they need to address.

We intend, once the PROs' next contract is in place -- and possibly even before then as circumstances permit, using modifications to the PROs' current contract -- to provide the

PROs with information to help them assess the problems particular to their state. This report is an example of the kinds of information we will provide them. In fact, we believe that many of the OIG reports we receive will be useful to the PROs both as a description of a potential problem and as a suggestion of the types of pattern analysis they should be doing.

We also agree to monitor the fiscal intermediaries recovery of the $178,741 in improper Medicare payments made to PPS hospitals for the sampled episodes in CY 1996. We recommend that a copy of the OIG's report be sent to the Associate Regional Administrator, Division of Financial Management at each of the HCFA regional offices named in the report, along with the identity of the intermediaries and the overpaid PPS hospitals. The regional offices will instruct their respective intermediaries to recover the overpayments and report their findings back to their regional offices.

Technical Comments

1. It would be of tremendous help to the agency if OIG conducted additional analysis of the distribution of the 17,000 discharges in 1996 and 1997 to determine where the readmissions are occurring. Do they tend to concentrate in certain providers? Are they more prevalent in some states? Has there been a change in the proportion of these readmissions either in a provider or in a State over time? As mentioned above, the answers to these questions would help us determine if only a few states need to engage in a review of same-day readmissions or if there is a generalized problem across all states.

2. One-fifth of the 100 sample patient discharges -- 12 patients with premature discharges and 8 patients who received care that should have been provided as one continuous length of stay -- experienced care that implicitly had a strong potential to affect them negatively. The report's discussion emphasizes cost issues and it omits the question of what happened to these patients as a result of these hospital practices.