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Tracing the History of Medicare Home Health Care: The Impact of Policy on Benefit Use

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We trace key policy changes that affected use of the Medicare home health benefit from the 1980s through the prospective payment system implemented in 2000, analyzing the impact on three measures of home care use: expenditures, users and visits. We demonstrate the impact of policies generated in the legislative, the judicial, and the executive branches of government and the gaming behavior of home health agencies in response to policy changes. Our analysis suggests that the policy itself and the implementation process are critical to understanding benefit use. The incentives in the policies and agency reactions had the potential to generate fraud in two directions, either over or underuse. Throughout this history, use of the benefit was driven less by patient need than by arbitrary interpretations of eligibility. These interpretations were in turn influenced by opposing ideologies favoring redistribution based on market principles versus those based on need.

Keywords: *Medicare, policy, home health care.*

Introduction

Medicare, created in 1965 as an amendment to the Social Security Act (P.L. 89-97), established the first system of public health insurance for the elderly in this country. The original statute focused on covering older adults' acute health care needs, since this was perceived as the area in which the elderly were most financially vulnerable to catastrophic losses. It did not, however, rule out post-acute care as an appropriate option to meet the healthcare needs of older adults. Both home health care and nursing facility care were part of the original law. However, home health care benefits were restricted. Under Part A (the hospital insurance trust fund), home health services were limited to 100 days per benefit period for patients who had spent at least three days in the hospital immediately prior to receiving home care. Part B (the supplementary medical insurance trust fund) covered up to 100 days per year for patients with or without a hospital stay with both a deductible (\$60 in the beginning) and a 20% copay.

All patients under the original law and currently have to meet certain eligibility criteria in order to have Medicare pay for home health care. They have to be homebound, in need of intermittent skilled care, have a physician certify and review the care plan, and the agency delivering the service has to be Medicare certified. The services rendered by the agency have to be medically reasonable and necessary in order for Medicare to reimburse the agency. Specific services covered by Medicare include: skilled nursing, physical therapy, speech therapy, occupational therapy, home health aide services, and medical social work.

Actual eligibility criteria have changed little since the program's inception. However, interpretation of those criteria has varied historically, at times enhancing benefit access and at other times restricting access. In this paper, we analyze the major policy changes in the program and their impact on utilization of the home care benefit, mainly in the fee-for-service program. We give a brief summary of policy debates and changes in the 1970s to set the stage for dramatic changes which occurred in the 1980s and 1990s. We highlight changes in program use measured by actual figures (e.g. costs, users, and visits) as well as growth in use over time. Our rationale for discussing actual use and program growth is related to the

assumptions made by analysts at various historical points and the use of growth rates to argue for program cuts. Finally, we offer a critical analysis of the policy incentives, their impact on agency practice and on benefit use.

Major Policy Shifts and Impact on the Program

The 1970s

The political atmosphere of the 1970s was one of Medicare expansion. Medicare was viewed by many policy makers as a "first step toward universal [health] coverage" (Ball, 1996, p. 13). For example, in 1972, amendments to Social Security (P.L. 92-603) expanded Medicare eligibility to those receiving Social Security Disability and, in 1978, to those with End Stage Renal Disease, thus enhancing Medicare access for chronically ill individuals. In home health care, specifically, the 1972 amendments eliminated the Part B coinsurance requirement (Benjamin, 1993). Waiver of liability was established for denied claims when the provider or beneficiary was not at fault (U.S. House of Representatives, 1978). Also, homemaker service delivery demonstrations were established (Benjamin, 1993). Interestingly, the number of Medicare certified home health agencies declined between 1970 and 1975 (Estes & Swan, 1993). However, the number of persons served and total visits gradually increased through the 1970s while the number of visits per user remained the same (Table 1). These increases make sense in light of the expanding categories of Medicare enrollees and elimination of the coinsurance barrier (Benjamin, 1993).

Supporters of home health care advocated for expansion of the benefit to cover chronic health care needs in the late 1970s. The rationale for expansion rested on three main points. First, home health care was seen as a less costly alternative to hospital and nursing home care (Congressional Budget Office [CBO], 1977; General Accounting Office [GAO], 1977). Second, home health care was considered a more humane way to provide treatment, as it was older adults' preference to receive care at home. Finally, Medicare needed to better cover the major health care problems of the elderly, that is, chronic medical conditions that did not require hospitalization (U.S. House of Representatives, 1977, 1978; U.S. Senate, 1979).

Medicare is oriented to the coverage of acute episodic

illness, and yet the illnesses of the elderly tend to be chronic.... Certainly outpatient drugs, preventive medical services, and more flexibility in the delivery of home health care would serve to delay the need for other more costly types of services. (U.S. House of Representatives, 1977, p. 2)

Although there was ample pressure for expansion of the benefit, there were also concerns related to inconsistent standards within the system, which could result in inappropriate service denials (underuse) or unnecessary service use (overuse) [Benjamin, 1993]. Issues were also raised regarding the variation in unit costs for similar services across agencies, and interpretations of reasonable costs and allowable administrative expenses. These inconsistencies made it impossible to predict total program costs from year to year and thus difficult to project the financial impact of expansionary program changes (GAO, 1978a; GAO, 1978b). These issues were raised repeatedly by the GAO over time, but little was done to eradicate these flaws.

The 1980s: Expansion vs. Retrenchment

OBRA 1980: Expanding the Home Health Care Benefit. Several benefit changes were made by the Omnibus Budget Reconciliation Act of 1980 (OBRA). The Act removed the Part A visit limit, 3-day hospital stay and the Part B deductible. Now the benefit could be available to eligible enrollees without a prior hospital stay and on an unlimited basis not subject to out-of-pocket expenditures. Congressional intent was clearly to expand services. The law, however, did not provide additional clarity on the intermittent care or homebound criteria nor did it require the Centers for Medicare and Medicaid Services (CMS) to establish consistent standards for intermediaries (Keenan, Fanale, Ripsin, & Billows, 1990).

OBRA opened the Medicare home health door to for-profit providers by eliminating the state licensure requirement for proprietary agencies. In fact, between 1983 and 1986 the rate of growth of proprietary agencies was 90% while non-profits grew by 21%. In 1982 there were 471 for-profit agencies in the U.S. In 1983 this number increased to 997 (Estes & Swan, 1993). Early studies and audits were demonstrating a tendency among proprietary providers to participate in fraudulent practices, such

as illegal subcontracting and referral kickbacks (Benjamin, 1993; Estes & Swan, 1993; U.S. House of Representatives, 1978). Yet, this change complemented the Reagan administration's emphasis on market-based alternatives for health and human services.

After enactment of the changes, use of Medicare home care increased, but not at an alarming rate (see Table 1 and Figures 1-3). Although total users and users per 1,000 enrollees increased, the rate of growth in users actually declined between 1978 and 1984. Also, total visits and visits per user increased, but the rate of growth in visits slowed dramatically. Fears that expanded home care would not generate savings for the overall Medicare program encouraged CMS to continue their strict interpretation of the homebound and intermittent care criteria, thereby continuing the high claims denial rate (Benjamin, 1993; Keenan et al., 1990). Although some client outcomes, including longevity and satisfaction with life, were improved with the receipt of expanded home care, CMS feared that increased longevity among patients with chronic conditions could increase need for services. Second, expanding eligibility criteria would make the benefit available to people who would otherwise not be in the system, as home health care might substitute for nursing home and/or informal care. In fact, research showed that even if hospital and nursing home use decreased in a given study, generally total health costs increased (GAO, 1983). Furthermore, GAO suggested that inefficiencies in the home health cost system might contribute to increased costs.

The rhetorical battle between expansion and retrenchment continued through the 1980s.

Expansion or revision in the present system is being considered because of: changes in health care demands stemming from growth in the size of the disabled elderly population; the need to reduce high government expenditures for nursing home and hospital care; and a desire to improve the physical and mental health status of the elderly. (GAO, 1983, p. i)

Congress intended to expand the benefit. However, the executive branch was controlled in the 1980s by fiscally conservative republican presidents focused on reducing the size of the federal budget and devolution of social and health care to

state and informal sectors. Medicare was not immune to these reduction initiatives.

Inpatient Prospective Payment System and Controlling Benefit Access (1983-1987)

In fact, the inpatient prospective payment system (IPPS) was established in 1983 to control Medicare hospital costs. Implementation of the IPPS led to earlier patient discharges, with sicker patients released from the hospital in greater need of transitional support (Benjamin, 1993; Estes & Swan, 1993; Feder & Lambrew, 1996; Komisar & Feder, 1998). The assumption was that post-acute services, including home health, would increase dramatically due to this policy. However, there were only minor increases in the number of home health users through 1986, while total visits and visits per user decreased between 1985 and 1987 (see Table 1). Even actual expenditures decreased after 1984. Between 1983 and 1987 the growth rates for home health use hit negative numbers (see Figures 1-3), with the biggest declines in visits and visits per user.

Decreases in home care use were attributed to two CMS transmittals to Fiscal Intermediaries (FI) issued in 1984 and 1986. The first transmittal clarified the type of care that would be covered, "daily...care of an indefinite duration will not be considered to meet the intermittent requirement and such services are not covered under the Medicare home health benefit" (Duggan, 1988, p. 1495). The second transmittal, responding to questions from the FIs seeking further clarification on the term *daily*, defined daily as "five days per week...therefore care which is ordered five, six, or seven days per week would be considered daily care" (Duggan, 1988, p. 1495) and would disqualify a beneficiary from the benefit.

These transmittals in essence forced the intermediaries to use a new standard for eligibility. This standard indicated that patients had to meet both the part-time and intermittent criteria in order to be eligible, since prior to these transmittals, the part-time category would pick up daily care as long as it was not for an indefinite period of time. Furthermore, intermediaries denied the claims in full, rather than denying the excess days. Therefore, beneficiaries with such needs were losing complete access to the benefit.

In the wake of these transmittals claims reviews increased, with concurrent demand for more detailed documentation, and an increase in claims denial rates from 3.1% in 1985 to 9.0% in 1987 (GAO, 1990). Likewise, agencies reacted to these changes by doing less home care under the Medicare benefit. The number of claims filed decreased by 5% between 1985 and 1986 (Estes & Swan, 1993). Given the retrospective reimbursement procedure, "home health agencies were financially liable for uncovered claims, [and] the availability of services tended to closely reflect coverage rules" (Feder & Lambrew, 1996, p. 105). Unless the provider had a low pattern of denials, and thus benefited from the waiver of liability, they would have to eat the cost of denied claims. In less than one year, from February to November 1986, the percentage of agencies that lost this waiver went from 16% to 32% (GAO, 1990).

This new policy created by the transmittals could have been an attempt to respond to GAO's recommendations to improve overall system monitoring and administration. However, the actual impact of these changes did little in the way of establishing consistent and uniform guidelines on reasonable and necessary costs, on patient care costs vs. administrative costs and on upper limits for reimbursements. CMS failed to address the identified weaknesses in the system and instead created an arbitrary rule to attempt to curb utilization. Although Congress was in favor of expanding the program, the Executive branch at this time was keen on reducing federal government outlays for domestic programs (Benjamin, 1993) and likely influenced the reaction of the administrative department responsible for issuing these transmittals.

Duggan v. Bowen (1987): The Push for Expansion

Pressure from increased demand for post-acute care due to the IPPS and tightening of eligibility limits by CMS generated ripe conditions for court challenges. Of specific importance was the charge that CMS, through its intermediaries, was using arbitrary mechanisms to constrain expenditure growth (Feder & Lambrew, 1996). This culminated in a class action lawsuit filed in 1987 (*Duggan*, 1988). The *Duggan* court ruled that CMS had violated the letter of the law and the intent of Congress that only full-time care be excluded from the benefit by

creating a stricter definition of daily care and requiring that beneficiaries meet both criteria, "part-time and intermittent" to be eligible. The court also looked at the history of the benefit and interpretations of the statute up to 1984 and found the new transmittals to be antithema to previous practice. Likewise, the court found the changes to be arbitrary and capricious. Someone could get up to eight hours of care per day on four days per week for 32 hours per week, while a person needing one hour of care per day for five or more days (five-seven hours per week) would be ineligible. CMS also violated the Administrative Procedures Act (5 U.S.C. 553) by not issuing a notice for public comment prior to distributing the transmittal. "Defendant's conversion of the 'part-time or intermittent' requirement to a 'part-time and intermittent' requirement effected material changes. As such, these changes constitute a new rule" (*Duggan*, 1988, p. 1514).

CMS was forced to revise the Medicare home health manual. The new manual stated:

the determination of whether a beneficiary needs skilled nursing care should be based upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal or expected to extend over a long period of time. (Medicare Manual, 1989, as cited in Keenan et al., 1990, p.1043)

The manual, issued in 1989, included several key changes in terms of the interpretation of coverage. First, CMS redefined eligibility criteria from part-time and intermittent to part-time or intermittent need for skilled care. This allowed those who needed care on greater than four days per week to still receive it. Second, observations by a skilled professional and maintenance therapy were added as medically reasonable and necessary services which could establish eligibility. Patients could be given therapy in order to maintain functional levels. Likewise, nursing visits pre-*Duggan* had to be for active treatment, whereas post-*Duggan*, care management services could be included under skilled care. Finally, each visit had to be reviewed separately before denying the entire claim. This added tremendous burden and cost to the

intermediary process, leading to a reduction in claims denied (Feder & Lambrew, 1996; GAO, 1996; Komisar & Feder, 1998).

The net effect of these changes was that Medicare home care became available to more beneficiaries for less acute conditions and longer periods of time (GAO, 1996; Feder & Lambrew, 1996). The changes may have prevented or reduced nursing home placement as well. Not only did the proportion of elderly residing in nursing homes decline (from 4.6 to 4.1%), but the average stay decreased by 18% from 1985 to 1995 (Komisar & Feder, 1998). Furthermore, had it not been for the transmittals in the mid-80s, expansion of home health care probably would have increased gradually over this time, due to the natural effects of changes in the health care delivery system, technology and demographic patterns.

The 1990s: Rising Health Care Costs and Cost Control Measures

The patterns of increased use reflect both the trend of expanding categories of eligibility and increasing use at the beneficiary level. Post-*Duggan* growth in utilization spiked dramatically in the first two years after the revised manual was issued in 1989, but declined steadily thereafter (Table 1 and Figures 1-3). For instance, the rate of growth between 1989 and 1990 in total expenditures was 48% and between 1990 and 1991 it was 40%. However, expenditure growth declined to 34% in 1992 and to 5% in 1996. Likewise, growth in charges per user rose dramatically in the first two years after the revised manual, but declined each year from 1991. The number of users per 1,000 enrollees grew by 12% between 1989 and 1990, compared to 4% between 1988 and 1989, but by 1996 the growth rate was back down to 4.9%. Likewise, total visits and visits per user grew dramatically between 1988 and 1990. Growth in total visits peaked in 1990 at 48% but was down to 6% in 1996. Growth in visits per user crested in the first year after issuance of the revised manual at 33% and then declined to a rate of only 2.78% in 1996.

However, concerns grew around whether incentives created by the payment system and benefit structure and lack of administrative oversight were resulting in more home care being provided than was needed for appropriate care. The service-specific per-visit limits under which agencies were paid offered little incentive for providers to control volume

per person. At this time, each service's per-visit limit was based on 112% of the national average for freestanding home health agencies adjusted for wage and regional differences. If the agency kept its costs below the national visit limits for each service, they could simply increase profit by providing more visits. Thus, agencies had little incentive to deliver an efficient amount or mix of services. Also, copays and deductibles for home health care had been eliminated; beneficiaries had little incentive to refuse services. During this period, average payment per visit only increased by 2.2%, indicating that agencies were using lower cost visit types (Komisar & Feder, 1998). Tremendous growth in the number of proprietary providers, increasing their market share from 36% (5,647) in 1990 to 64% (10,524) in 1997, generated suspicion that the benefit was too generous (GAO, 1998).

Simultaneously, Congress began cutting Medicare's administrative funds. Thus, when claims began to increase, funds to review the claims and to monitor the process were cut between 1989 and 1991 (GAO, 1991). Finally, CMS still had not developed a uniform claims processing system. Even though the number of intermediaries was reduced to nine in 1989 from 47 in 1987 (GAO, 1990), each intermediary had its own system, which made it almost impossible to gain accurate data on spending patterns and potential abuse.

Broader concerns in the 1990s over rising health care costs, their increasing share of GDP and potential depletion of the Hospital Insurance Trust fund, generated much activity in relation to controlling overall Medicare program costs. In addition, as described above, the increase in home health use and oversight problems made the home health benefit ripe for more careful scrutiny by policy makers attempting to control spending and reduce the deficit. Home health care was one of the few health care markets that had not yet been fiscally regulated.

Congress began looking for methods to control expenditures and in 1990 enacted the National Home Health Prospective Payment Demonstration (NHHPPD). This law resurrected the original authorization to study alternative reimbursement methods generated in 1983 as part of the Orphan Drug Act (P.L. 97-414). However, it was not until 1990 that CMS began to study alternative reimbursement strategies

(Leon, Davitt, & Marainen, 2002). The NHHPPD attempted to determine whether program expenditures could be reduced by enhancing program efficiency in terms of service delivery. The program tested "a predetermined per-visit payment rate" (1990-1993) and a per-episode payment system (1995-1998) (Cheh, 2001, p.1).

Even though utilization had already begun to decline within two years of the revised manual, the first direct attempt at controlling costs under this program consisted of a two-year freeze on the inflation (market-basket) updates for home health care beginning in 1994 (Omnibus Budget Reconciliation Act of 1993). The rate of growth in users decreased steadily after the freeze. However, total visits and visits per user growth jumped between 1993 and 1994. This suggests that agencies may have countered the freeze on their cost limits by providing more visits to eligible enrollees. Thus, although the freeze reduced expenditures overall, it did little to make the program more adequate or efficient, because the incentives encouraged agencies to simply provide more visits to recoup their losses. It did not, unfortunately, encourage agencies to gear service to actual patient need and reimburse accordingly.

The 1990s: The Pursuit of Fraudulent Practice

Concerns about the program also centered on whether the program was being turned into a long-term care benefit. Leon, Parente, and Neuman (1997) found that only 10 percent of beneficiaries received over 200 visits, yet these 10 percent accounted for over 42 percent of expenditures for Medicare home health care in 1994. However, such patients tend to have more complex care needs, to use greater amounts of hospital care, to need multiple episodes of home care and to have severe functional impairments (Leon, et al., 1997; Lewin Group, 1998).

The other problem, the tremendous degree of variation in payments and visits across geographic regions and agency types, was generated by a lack of consistent standards and procedures for claims review across the fiscal intermediaries. For example, two of the nine intermediaries served the vast majority of agencies with higher than normal utilization patterns (GAO, 1996), suggesting that lack of oversight and consistent standards might have played a role in any inappropriate benefit use. This problem had been clearly identified in

numerous government reports as early as the 1970s (Benjamin 1993; GAO, 1978a, 1978b). Studies by the Office of Inspector General (OIG), using 1993 data, found that "the average reimbursement per beneficiary for the four [types of agencies studied] ranged from \$1,534 to \$7,978" (OIG, 1995a, p. 7; 1995b). They also found wide variation in the average number of visits with a range of 27 visits for the low utilization agencies and 141 visits for the highest agencies. The fact that proprietary agencies provided significantly more visits than non-profit or public agencies (GAO, 1996) increased suspicions regarding fraudulent practice.

The highest regional average was found in Region IV, including Alabama, Florida, Georgia, Kentucky, Mississippi, North and South Carolina and Tennessee (OIG, 1995b; GAO, 1996). Some of this regional variation may have been attributable to lack of alternative services (Mauser & Miller, 1994). Other research found that patient characteristics could partially explain such variation (Schore, 1994). For example, beneficiaries in the East South Central region (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas) with the second highest use rates in 1993, "were more likely to be frail, chronically ill and in poorer health" and from non-metropolitan counties with high proportions of impoverished elderly (GAO, 1996, p.13).

From the mid-1990s Congress pushed for additional programs focused on uncovering fraud and abuse within the Medicare system, including the Medicare Home Health Initiative, Operation Restore Trust and the Health Insurance Portability Act (P.L. 104-191). Using the high use figures from the early years after the *Duggan* decision, a picture was painted of a benefit running rampant and eating ever larger amounts of the GDP. Clearly, however, utilization had begun to level off, and growth rates were declining for the most part after 1991. Interestingly, early findings from OIG reported 219 cases (in five states studied) of potential fraud and abuse in 1995. Only 20% of these fraud cases were home health agencies, and of those cases, only one conviction and one settlement concerned home health providers (OIG, 1995c). As with other social welfare programs, the argument regarding abuse of the system may have been based more on a desire to curb costs than on reality.

Table 1: Medicare Home Health Care Utilization by Cost, Users and Visits 1974-2003

CY	Expenditures			Users			Visits				
	Total		Per Person Served	Total		Per 1,000 Enrollees	Total		Per Person Served		
	Actual ^a (in 1,000s)	Growth (%) ^b	Actual ^a (%) ^b	Actual (in 1,000s)	Growth (%) ^b	Actual	Growth (%) ^b	Actual (in 1,000s)	Growth (%) ^b	Actual	Growth (%) ^b
1974	na		na	392.7		16		8,070		21	
1976	na		na	588.7	49.91	23	43.75	13,335	65.24	23	9.52
1978	na		na	769.7	30.74	28	21.74	17,345	30.07	23	0
1980	na		na	957.4	24.39	34	21.43	22,428	29.30	23	0
1982	na		na	1,171.9	22.4	40	17.65	30,787	37.27	26	13.04
1983	\$3,416,638		\$2,529	1,351.2	15.3	45	12.5	36,844	19.67	27	3.85
1984	3,866,298	13.16	2,550	1,515.9	12.19	50	11.11	40,337	9.48	27	0
1985	3,972,777	2.75	2,501	1,588.6	4.79	51	2	39,742	-1.47	25	-7.41
1986	3,970,514	-0.6	2,481	1,600.2	0.73	50	-1.96	38,359	-3.48	24	-4.00
1987	3,870,127	-2.53	2,474	1,564.5	-2.23	48	-4	36,088	-5.92	23	-4.17
1988	4,115,238	6.33	2,569	1,601.7	2.38	49	2.08	37,713	4.50	24	4.35
1989	5,183,726	25.96	3,005	1,724.9	7.69	51	4.08	47,258	25.31	27	12.5
1990	7,662,925	47.83	3,896	1,967.1	14.04	57	11.76	70,268	48.69	36	33.33
1991	10,724,069	39.95	4,781	2,242.9	14.02	64	12.28	99,825	42.06	45	25.00
1992	14,375,209	34.05	5,736	2,506.2	11.74	70	9.37	132,220	32.45	53	17.78
1993	18,627,283	29.58	6,481	2,874.1	14.68	79	12.86	164,234	24.21	57	7.55
1994	23,531,975	26.33	7,402	3,179.2	10.61	86	8.86	208,621	27.03	66	15.79
1995	27,873,552	18.45	8,034	3,469.4	9.13	102	18.6	249,394	19.54	72	9.09
1996	29,347,709	5.29	8,153	3,599.7	3.75	107	4.9	264,798	6.18	74	2.78
1997	28,694,054	-2.23	8,066	3,557.5	-1.17	108	0.934	258,168	-2.50	73	-1.35
1998	17,625,634	-38.57	5,757	3,061.6	-13.94	95	-12.04	155,407	-39.8	51	-30.14
1999	13,114,514	-25.59	4,822	2,719.7	-11.17	85	-10.53	113,439	-27.00	42	-17.65
2000	10,550,532	-19.55	4,287	2,461.2	-9.5	75	-11.76	90,566	-20.16	37	-11.90
2001	8,751,006	-17.06	3,642	2,402.5	-2.38	71	-5.33	73,573	-18.76	31	-16.22
2002	9,376,956	7.15	3,685	2,544.4	5.9	73	2.82	78,192	6.28	31	0
2003	9,966,568	6.29	3,717	2,681.1	5.37	75	2.74	82,851	5.96	31	0

Data are from CMS, Office of Information Services, Data Extract System, Table 7.1; ^a adjusted for inflation using the home health market basket updates, in constant 2003 dollars; ^b rate of growth in program from previous year; na – market basket updates not available before 1983.

The Balanced Budget Act (BBA) of 1997

Although expenditure growth had declined dramatically through the 90s from a high of almost 40% in 1991 to only 5% in 1996, the Republican-controlled Congress established the rhetoric and defined the argument for additional program cuts in the mid to late 1990s. Their argument rested on the premise that home health spending was increasing disproportionately compared to overall Medicare spending. For example, analysts began citing that while the average annual growth rate for total Medicare spending was only 11% (1989-1996) the average annual growth rate for home health care was 29% in that same time period (Komisar & Feder, 1998). They stressed two assumptions to define the problem causing the so-called rampant growth in the benefit: 1) home health care was being turned into a long-term care benefit, which was not part of the original legislative intent; and 2) fraud and abuse were driving much of this inappropriate utilization. Congressional activity culminated in the passage of the Balanced Budget Act of 1997, which made major changes to the Medicare program overall and specifically to the home health care benefit.

The key provisions relevant to home health care included creation of a new, short-term reimbursement structure—the interim payment system (IPS), elimination of venipuncture as a qualifying benefit, creation of a surety bond procedure for providers, establishment of a prospective payment system (PPS) and an additional 15% cut when the PPS went into effect (budget neutrality clause). Also, the Act redefined the term *intermittent* for eligibility purposes to include:

skilled nursing care that is either provided or needed on fewer than seven days each week or less than eight hours of each day for periods of 21 days or less [with extensions in exceptional circumstances when the need for additional care is finite and predictable]. (Balanced Budget Act, 1997, p. 224)

The Interim Payment System (1997)

The most substantial change in terms of cost-cutting potential and home care practice was the IPS. There were two main goals behind the creation of the IPS. First, this would immediately restrain expenditures within the home health program by controlling volume per person. Second, it would allow

time for CMS to ready a prospective payment system. In fact, implementation of the PPS was delayed and the IPS extended until October of 2000 (see Table 2 for Post-BBA legislation.) The IPS set new cost limits for Medicare-certified home health care agencies. Under the IPS, agencies would be reimbursed based on "the lowest of: (1) actual costs; (2) new per-visit limits; or (3) a blended, agency-specific per-beneficiary annual limit" (BBA, 1997, p.87-88). Visit limits were set at 105% of the median national visit limits, down from 112% of the mean national costs. This was increased to 106% after October 1998 (see Table 2). Early projections indicated that the per-visit limits alone could have reduced expenditures by 15-22% (Berke, 1998; Forster, 1998).

However, most agencies would fall under the per-beneficiary limit. The per-beneficiary limit was the first time that Medicare established a cap on home health reimbursement at the beneficiary level. This limit was calculated using a blended formula incorporating 75% of the agency's average per-beneficiary payment and 25% of the regional average from 1994, which, due to the market basket freeze, meant 1993 costs (Berke, 1998; Forster, 1998; GAO, 1998). This limit was also increased slightly for some agencies after October, 1998 (see Table 2).

As can be seen in Table 1, utilization plummeted after implementation of the IPS. Dramatic decreases in users, visits and expenditures occurred. In fact, utilization decreased much more than originally projected by the Congressional Budget Office (Leon, Davitt, & Marainen, 2002). Growth in the program hit negative numbers; growth in total charges and total visits declined by almost 40%, while charges and visits per user declined by almost 30% from 1997 to 1998. Negative growth in the program continued through 2001.

There were several problems with the IPS. First, agency reimbursements were reduced to 1993 levels, representing a dramatic reduction. Second, the per-beneficiary limit introduced capitation in the traditional home care benefit for the first time, forcing agencies into a risk-sharing arrangement, thus requiring drastic changes in how agencies delivered services. Although the per-beneficiary limit was an aggregate agency limit, it was not case-mix adjusted for the varying care needs of individual patients (Berke, 1998; GAO, 1998; Komisar & Feder, 1998). Many agency directors did not understand the

aggregate nature of the limit and thus slashed services to each patient (Davitt & Choi, 2007). Also, agencies were not given their per-beneficiary limits until March of 1998, requiring them to operate for several months without knowing their cap (Leon, Davitt, & Marainen, 2002). This encouraged agencies to cut services more drastically than necessary to ensure financial stability. These problems and the agencies' reactions explain the dramatic drop in use and costs at the beginning of the IPS.

Lacking case-mix adjustment, agencies were encouraged to discriminate in admissions against higher-cost patients, either those needing more care, those further from the agency, or those with expensive care needs (Kaye & Davitt, 1999). "The adjuster would not only protect access to care but would also help ensure that Medicare was paying agencies appropriately," that is, based on patient acuity (Dummit, 1998, p.10). Although the rhetoric focused on fraud and abuse, the actual changes did not focus on inappropriate use as the target for reduction. Rather, the reductions were applied across the board and did not attempt to provide a way for agencies to continue serving legitimate, high-cost or high-use patients.

Also, the incentives in the capitated rates did not factor in previous efficiency patterns of the agency, even though the assumption was that those agencies with higher use and expenditure rates pre-BBA '97 were providing inappropriate, if not fraudulent services to patients (Lewin, 1997). Because the per-beneficiary limits were based on a blended formula, using 75 percent of the agency's average costs and 25 percent of the region's average costs in 1994, agencies with higher reimbursements in 1994 received a higher reimbursement under the IPS. Thus, those agencies that were operating in a fiscally conservative manner prior to the BBA '97, were penalized more severely under the IPS. Again, the design of the policy did not create incentives to eliminate inappropriate use of the benefit.

Changes in Home Health Care After the IPS

Dramatic shifts in the system of care and the use of the home health benefit occurred immediately after implementation of the IPS. Between 1997 and 1999, over 3,800 agencies left the Medicare program (Davitt & Choi, 2006). Some studies also documented increases in skilled nursing facility (SNF) use during the IPS (Davitt & Marcus, 2008; Lin, Kane, Mehr,

Madsen, & Petroski, 2006; McCall et.al., 2002). Also, agencies altered their admissions practices in order to limit the number of high-cost patients admitted, provided fewer services to individual patients than previously, and established stricter discharge procedures, especially for perceived high-cost patients (Davitt & Choi, 2007; Markham-Smith, Maloy, & Hawkins, 1999; MedPAC, 1999). Directors used various strategies to sustain the agency financially during these dramatic cuts in

Table 2: Legislative Changes to Medicare Home Health Care Post-BBA

Legislation	Changes to Home Health Care
Omnibus Consolidated and Emergency Appropriations Act of 1998 (Pub. L. 105-277)	Increased the per-visit reimbursement to 106% of the national median after October 1, 1998. Per-beneficiary limits for established agencies (those that had full year participation in Medicare before FY 1994) were increased by 1/3 of the difference between their amount (lesser) and the national median; agencies created between 94-98 were increased to 100% of FY 94 costs; agencies created after Oct. 1 1998 decreased to 75% of national median based on 98% of FY 1994 costs. Reduced home health market basket updates for FY2002 and 2003. Changed effective date of PPS implementation and 15% contingency reduction to October 1, 2000.
Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113)	Delayed the 15% reduction in payments until 1 year after PPS implementation. Excluded durable medical equipment from consolidated billing requirements.
Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554)	Delayed the mandated 15% reduction in the PPS until October 1, 2002. Reduced the rural add-on to 10% for 2 years beginning April 1, 2001.
Medicare Prescription Drug Improvement and Modernization Act of 2003 (Pub. L. 108-173)	Eliminated OASIS assessments on non-Medicare patients. Modified the rural add-on, 5% for 1 year beginning April 1, 2004. Established a 2-year demonstration study on the homebound definition and a MedPAC study on payment margins for home health agencies. Altered the market basket (inflation) updates from fiscal to calendar year beginning Jan. 1, 2005 and .8% reductions in updates from April 2004-Dec. 2006.
The Deficit Reduction Act of 2005 (Pub. L. 109-171)	Restored the 5% rural add-on for one year. Established a requirement for submission of health care quality data and financial penalties beginning in 2007 for failure to report quality data to CMS. Provided a 2.3% market basket update in 2005 but 0% update for 2006. Lowered the fixed dollar limit used to calculate outlier payments for 2005.

reimbursements, including eliminating staff, shifting staff roles, staff training on reimbursement methods, increased use of telephone monitoring, increasing patient–family education and self-care, and cutting services to patients (Davitt, 2003; Davitt & Choi, 2007; Markham-Smith Maloy, & Hawkins, 1999).

Agencies cut staff and visits more dramatically for non-skilled services (home health aide and medical social work) during the IPS. Skilled nursing and therapy services increased the most (Davitt & Choi, 2007; Komisar, 2002; McCall, Petersons, Moore, & Korb, 2003; MedPAC, 1999; McCall et al., 2001). Other studies showed that agencies were shifting dually eligible patients from Medicare to Medicaid because they could get more services under the Medicaid program (Davitt & Choi, 2007; Spector, Cohen, & Pesis-Katz, 2004). Agencies also reported greater referrals to aging network providers, and increased use of informal caregivers to supplement the agency's service (Davitt & Choi, 2007). Again, such shifting of care from one system to another does not necessarily mean savings in overall expenditures—it simply shifts which component of the health system is paying for care. Responsibility for care was devolving from the federal to state and local levels, as well as being informalized (Estes & Swan, 1993).

Studies demonstrated greater decreases in services for vulnerable subgroups of patients. Fitzgerald et al. (2006) found larger decreases in use for elderly and female patients. McCall et al. (2003) found higher-than-average decreases in home health care use and the likelihood of any use during the IPS period for beneficiaries over age 85, and a greater decrease in visits for patients over 85 and with diabetes, heart failure, cerebrovascular disease, and skin ulcers. While controlling for predisposing and enabling characteristics, studies showed that users with greater functional impairment saw a greater decrease in visits than those with fewer impairments (Davitt & Marcus, 2008; Liu et al., 2003). Other studies also found reductions in use of the benefit for less healthy users (Davitt & Marcus, 2008; McKnight, 2006). Furthermore, studies found greater decreases in access to or use of home health care for minority beneficiaries (Davitt & Kaye, 2007; McCall et al., 2001; McCall et al., 2003) and for lower-income beneficiaries after the IPS (Davitt, 2003; Fitzgerald et al., 2006; McKnight, 2006).

Such across-the-board cuts could not discriminate legitimate from illegitimate use. The goal of the IPS was to quickly reduce costs. Thus, incentives in this policy were not tied directly to the provision of appropriate and adequate care. In fact, the cuts may have generated additional problems related to fraud when truly needy patients were discharged too soon or denied access to the benefit. Retrospective research studies provide evidence that vulnerable patients were more dramatically affected by these changes. However, there are mixed results regarding whether reduced access to this benefit led to poorer health outcomes for home health users (McCall 2002; McKnight, 2006).

2000 and Beyond: Focus on the Prospective Payment System (2000)

With implementation of the Prospective Payment System (PPS) in October 2000, CMS began to deal with the chronic oversight problems by establishing a structure which reimbursed agencies based on patient need rather than on arbitrary criteria or agency cost history. The PPS continues the prospective payment arrangement but with case mix adjustment. Agencies now receive a fixed payment for a 60-day episode of care for each patient which is based on their acuity, originally measured via 80 home health resource groups. Acuity is established through a comprehensive assessment, Outcomes and Assessment Information Set (OASIS), conducted by the home care agency, which measures client's clinical severity, functional status and service needs. Thus, agencies are paid based on the expected service needs for different categories of patients, rather than on actual cost to deliver the service (pre-BBA) or on an arbitrarily derived per-beneficiary limit (IPS). Under PPS, however, the agency continues to shoulder the financial risk of serving the patient.

The main concern with the PPS was that its base rate was established using cost figures from the drastically reduced IPS. Thus, researchers continue to evaluate the impact on patients and agencies. Studies show a slight decline in the likelihood of home care use after the PPS was implemented (Murtaugh, McCall, Moore, & Meadow, 2003), but this was much less than under the IPS (Fitzgerald et al., 2006). After 2001, use of the home health benefit gradually increased. While growth rates moved onto the positive side, they remain well below

the average growth rate for the overall Medicare program (see Table 1 and Figures 1-3). Also, over 1,200 agencies left the Medicare program from 2000-2002 (Davitt & Choi, 2006). Cuts in staff and visits were greater under the IPS than the PPS. Agencies continued to cut non-skilled services more than skilled services under the PPS (Davitt & Choi, 2007). One study showed that patients with orthopedic and neurologic diagnoses experienced increases in access to home health care during the first year of the PPS relative to other diagnosis groupings (Murtaugh et al., 2003). Again, incentives under the PPS (namely increased payment for therapy needs) encouraged agencies to target certain types of patients for whom they could get higher reimbursements.

Figure 1: Expenditure Growth, Total and Per User

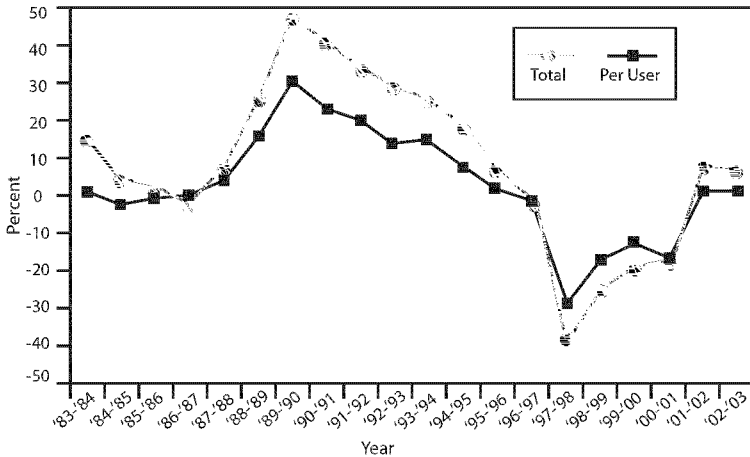
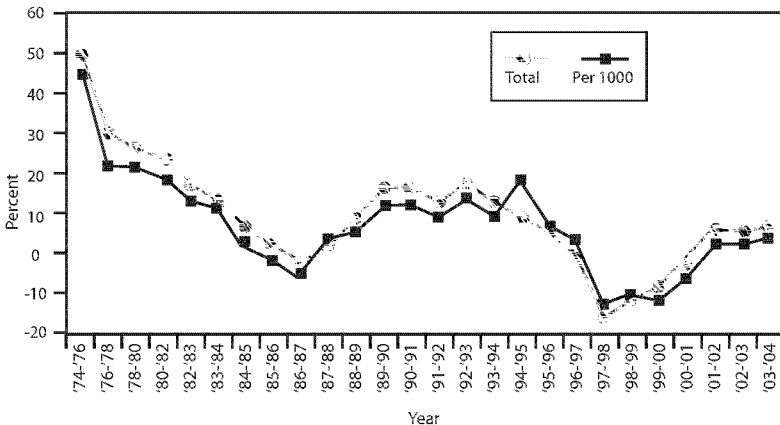


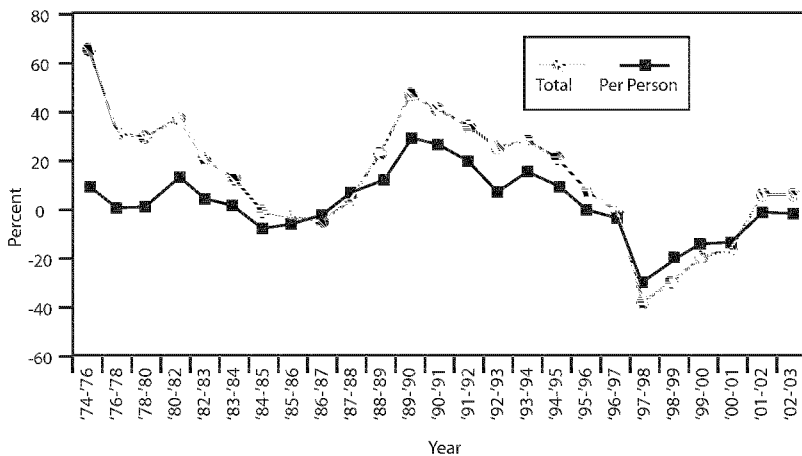
Figure 2: Growth in Users, Total and Per 1,000 Enrollees



Post-PPS Changes (2000-2008)

Early changes after the PPS focused mainly on adjustments to agency reimbursements to achieve the mandated level of savings [budget neutrality component of the BBA] (GAO, 2002). Research conducted by the GAO and MedPAC demonstrated higher payments than costs, on average, for agencies, and MedPAC recommended decreases in or freezes on the market basket updates (GAO, 2002; 2004; MedPAC, 2006; 2007).

Figure 3: Growth in Total and Per Person Visits



Likewise, monitoring systems were established which require agencies to report certain quality indicator data to CMS for the Home Health Quality Initiative. Agency submission of quality data was mandated beginning in calendar year 2007, with financial penalties for failure to submit (CMS, 2007). The focus is on providing consumers with information on the practice effectiveness of home health agencies. In addition, some analysts have recommended incorporating Medicare–agency risk sharing in relation to profit–loss margins and/or tying agency payment to outcome indicators (GAO, 2004; MedPAC, 2006).

The most substantial changes, scheduled to be implemented on January 1, 2008, will dramatically alter the case-mix adjustment formula, resulting in 153 Home Health Resource Groups. These revisions are the result of extensive research which showed that the original case-mix model was no longer accurate in predicting service needs and that therapy

thresholds were inadequate (CMS, 2007b). In 2008 a new, four-equation case-mix formula will be used, which expands the number of therapy thresholds, the number of diagnosis groups, and adds scores for certain conditions and certain secondary diagnoses. This model also “recognizes and differentiates payment for episodes of care based on whether a patient is in...an early (1st or 2nd episode...) or later (the 3rd episode and beyond...) episode of care as well as recognizing whether a patient was a high therapy (14 or more therapy visits) or low therapy (13 or fewer therapy visits) case” (CMS, 2007, p. 49764). The expressed goal of these changes is to “ensure that the payment system continues to produce appropriate compensation for providers while retaining opportunities to manage home health care efficiently” (CMS, 2007b, p. 25358).

Analysis

Assumptions regarding the goal of the Medicare home health care benefit (acute care vs. long-term care) and the appropriate target population for service (post-acute vs. chronically ill) have been at the heart of this policy debate over time. Fluctuations in these assumptions have dramatically altered eligibility, at times expanding and at times restricting access. In the early history, Congressional intent was focused on expansion. This was controlled by a conservative executive branch focused on reducing the size of the federal government. Likewise, CMS' inability to develop consistent standards for review of practice was both influenced by this tug-of-war (mixed messages and a desire to control costs by maintaining vague guidelines) while also providing fuel for the debate (the argument that variation in use patterns were indicative of the need for cost control measures). Throughout the program's history, policy interventions focused on controlling costs rather than responding to legitimate need by improving quality and efficient delivery. Likewise, policy changes generated reactions at the practice level. Agencies *gamed* the system, that is, they strategically altered their admissions and service delivery practices in response to these changes, in order to continue to provide services while maintaining fiscal stability (Dowd, 2004; Ford, Wells, & Bailey, 2004). Thus, both policy and implementation were critical to benefit use throughout this history

(Pressman & Wildavsky, 1984).

Home health care trends are embedded in a larger socio-political-economic context that is influenced by and influences the social construction of categories of redistribution (Calasanti & Zajicek, 1993; Stone, 1984). In a capitalist economy, production and surplus value are necessary to establish any system of redistribution. Thus entitlement programs are, by nature, limited (Offe, 1984; Stone, 1984). The management of category creation and expansion, therefore, becomes central to the program and the welfare state in general (Stone), and assumptions must be made about who should be recognized as deserving of social aid, and how much or what type of aid they deserve. In order to prevent complete breakdown of the economic system, categories of entitlement must be highly restrictive, defined so that the number of people who can possibly belong to them is very small relative to those who can not (Stone). In home health care, the market-based assumption would limit use to those requiring short-term post-acute care. The needs-based assumption would expand access to those needing care on a longer-term basis for chronic conditions. The battle is waged between forces supporting distribution based on market principles (restrictive) and those based on need (expansionary), the fundamental assumptions in this debate (Estes & Swan, 1993; Higgins, 1988).

Furthermore, categories of redistribution require a validating device to determine who is actually eligible. The validating device must either be restrictive or intentionally vague to manage distribution and maintain the status quo (Stone, 1984). In home health care, there is a two-tier process of eligibility. First, there is an administrative category which establishes broad-based eligibility for Medicare. This includes either being age 65 or older, having a long-term disability or a diagnosis of End Stage Renal Disease (ESRD). However, eligibility for the home health benefit can only be established based on specific clinical criteria, that is, whether the person is homebound and has a need for intermittent skilled care. This system of eligibility determination has an inherent flaw in that the validating device can be manipulated by the beneficiary, the provider or the system (Stone). There is also a great deal of uncertainty and subjective judgment on the part of the physician in determining eligibility and the agency in deciding how much service

the person should receive. Thus, providers become mediators between the patient and the system and a central player in the implementation process and the battle for control over benefit use.

The restrictive and unclear nature of the categories of redistribution in home health care can be seen in the early days of the program and especially in the definition of part-time and intermittent care. Agencies responded to these restrictions by limiting access to the benefit. After Congress eliminated specific restrictions on the benefit (e.g. visit limits, hospitalization rule), agencies began offering services to additional beneficiaries. This required even greater tightening of the validating device to control redistribution. Thus, CMS, an arm of the executive branch of government which was then controlled by a Republican administration keen on reducing the size of the federal government, issued transmittals further restricting access to the benefit by changing the validating device from part-time or intermittent care to part-time and intermittent care. Agencies hoping to avoid financial liability for non-reimbursed care responded by reducing the number of patients and the amount of care provided. Pressure from increased demand due to the IPPS resulted in a lawsuit, which focused on redefining the validating device in an expansionary direction. Agencies again reacted to this by providing services to additional beneficiaries and by providing more service per beneficiary. Post-*Duggan* agencies had nothing to lose, and in fact, much to gain, if a patient was certified as eligible. The lack of patient cost-sharing at that time also eliminated any financial incentive for the beneficiary to refuse service.

The focus historically was not on meeting older adults' needs but on manipulating the categories of redistribution in order to control expenditures. The policy incentives were not geared to encourage appropriate, adequate and efficient care delivery. The focus in the 1970s and 1980s was on directly controlling the validating device (part-time-intermittent). When that effort was derailed by the *Duggan* decision, the focus in the 1990s turned to controlling the mediator or agency behavior, thus indirectly controlling the validating device (e.g., anti-fraud measures, inflation freezes, IPS). Of course, each change generated a reaction from agencies which also influenced benefit use. The interests of the agency were reversed

over time, shifting back and forth between being aligned with the beneficiary to being aligned with the program.

The combination of incentives in the policy and gaming behaviors at the practice level had the potential to generate fraud in two directions—either over or under use (Dowd, 2004; Ford, Wells, & Bailey, 2004). Our health care system encourages agencies to be invested in providing health care services, rather than invested in health. For most of this history, the policy was to reward (through reimbursements) agencies, not for improving or maintaining health, but for providing health care (Dowd, 2004). As reimbursement incentives change, agency practices adjust to continue the provision of health care and organization maintenance (Dowd, 2004). For example, post-*Duggan* incentives discouraged agencies from eliminating overuse and may have encouraged many agencies to provide too much service relative to need. On the other hand, the IPS encouraged agencies to serve fewer patients and to offer fewer visits, regardless of patient need or health status. It may be more accurate to say that the goal of the IPS and the 1984-86 transmittals was not to reduce inappropriate utilization but simply to reduce utilization—to shift the balance between the market-based system of redistribution and the needs-based system. The *Duggan* decision also did not force CMS to devise a reimbursement structure directly responsive to need. Throughout this history, use of the benefit, therefore, was driven less by patient need or health status than by arbitrary interpretations of the validating device and perverse incentives which encouraged agencies to adjust the amount of service, based not on patient need but on specific reimbursement procedures. These interpretations were influenced by opposing political ideologies—on one side the market-based model and on the other the needs-based-equity model (Andersen, 1995; Estes & Swan, 1993; Higgins, 1988).

Conclusion

The home health care policy history demonstrates the importance of all three branches of government in creating policy, as well as the influence of both the policy mandate and policy implementation in shaping benefit use (Pressman & Wildavsky, 1984). The legislative branch enacted the

original Medicare program and changes intended to expand access to the home health benefit. The executive branch, through its administrative arm (CMS), tightened eligibility via its oversight and implementation function through the creation of a new program rule. This arbitrary rule was overturned by the judicial branch (*Duggan* decision), dramatically expanding eligibility and altering oversight procedures. Finally, in the 1990s the Republican-controlled Congress used the BBA to reign in costs by encouraging agencies to cut services to patients. Every change in the policy generated reactions from agency providers focused on sustaining their role in the health care system (Dowd, 2004). Benefit use was thus affected, not only by the policy sanction, but by program implementation at the administrative as well as the agency level (Pressman & Wildavsky, 1984).

It took decades for CMS to create appropriate limits on use of the benefit and consistent standards for providing home health care based on need. The bad news is that the base rate for the PPS was derived from dramatically slashed IPS costs, thus to some degree continuing a market-based approach. Likewise, incentives around therapy thresholds in the original case-mix formula may have encouraged agencies to provide more therapy services than needed to increase their reimbursement. The good news is that under the home health PPS, we now have consistent rules for determining eligibility (albeit still subject to some degree of manipulation at the practice end) and service need based on a comprehensive and empirically tested set of patient factors. These factors are currently being revised to promote efficient but quality care. The OASIS assessment allows care to be geared to each patient's need or health status and allows an opportunity to assess the quality of care provided by generating data on patient outcomes, thus shifting from a focus on health care delivery to health status. This will enable us to more accurately monitor quality and efficiency patterns in the future and determine whether the market-based foundation (IPS) and future revisions to the case-mix model are adequate to meet patient need.

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