

ISSUE BRIEF

Access to Home Health Services under Medicare's Interim Payment System

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A discussion featuring

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Access to Home Health Services

In response to tremendous spending growth in Medicare home health services, the Balanced Budget Act (BBA) of 1997 significantly revised the way Medicare pays for home health services. The law mandated a prospective payment system (PPS) intended to reduce costs and give providers incentives to deliver care more efficiently. Recognizing that time was needed to develop such a system, the BBA established an interim payment system (IPS) until the PPS was in place. Since its enactment, the interim system has been a subject of great controversy, with particular concerns raised about its impact on beneficiaries' access to home health care.

The IPS was intended to constrain program outlays by imposing limits on spending per beneficiary and spending per visit in the existing cost-based reimbursement system. With Medicare spending for home health care falling by 14.9 percent between 1997 and 1998,¹ the new payment system appears to have successfully reversed the spending growth in home health care. On the other hand, since the IPS was implemented, a number of home health agencies have closed and reports have suggested that the new payment limits restrict access to care for patients with very costly needs. Congressional attention to the effects of the IPS has increased because it will now be in place longer than originally intended. In 1998, Congress delayed by one year the original deadline for PPS implementation for home health agencies, changing it to October 1, 2000; some observers predict that date could be postponed even further.

Last year, Congress responded to concerns about the IPS by modestly increasing the payment limits for fiscal year (FY) 1999. Pressure continues to intensify from the home health industry to further increase the limits and make changes to the way the limits have been calculated. This Forum session will examine the most recent studies of the impact of the IPS on access to home health care, including home health agencies' responses to the payment system and its impact on provider availability. The session will also focus on the extent to which new payment limits restrict access to care for the sickest or most expensive populations.

REASONS FOR HOME HEALTH COST GROWTH

Payments for home health services have been one of the most rapidly growing parts of the Medicare program

over the past several years. From 1988 to 1996, spending rose from about \$2 billion to \$17 billion, an average annual increase of 31 percent.² This rise has been attributed primarily to an increase in the number of beneficiaries receiving home health services and growth in the number of visits received, rather than rising payments per visit. It is one of the most widely used Medicare services; in 1996, 1 in 10 beneficiaries received Medicare-covered home health services. Per user, annual visits increased by nearly 50 percent (from 53 visits to 77) between 1992 and 1996.³

These higher per person utilization levels reflect longer episodes of care. In 1995, about 20 percent of all home health episodes lasted 166 days or more; in 1990, this percentage was 14 percent. Researcher Barbara Gage has found that although longer episodes account for higher costs per patient, these longer-term cases tend to have a greater proportion of less intensive and less expensive visits.⁴ She notes that, despite the increasing number of longer-term users, the service mix or intensity of an episode has not changed over time. Thus, her research suggests that much of the increase in home health visits has been due to the growth in longer episodes that were associated with a relatively large number of aide services.

Medicare Eligibility and Coverage Rules

Changes in Medicare eligibility and coverage rules have contributed significantly to the increased use of

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this benefit. The original home health benefit included at Medicare's enactment in 1965 was far more restrictive than today's. It was primarily a post-hospitalization benefit, and it limited the annual number of visits covered for each beneficiary. Based on congressional action and a series of court decisions, the eligibility and coverage standards became much more loosely defined.⁵ Coinsurance requirements, prior hospitalization requirements, and annual visit limits were abolished. This expansion of coverage culminated in the landmark class action suit, *Duggan v. Bowen*, which essentially allowed payment for chronic conditions and relaxed limitations on providing multiple visits per day. As a result, it became easier for beneficiaries to receive these services.

Under Medicare's current definition, a beneficiary must be confined to his or her residence (that is, be "homebound") to qualify for home health care. He or she must also require intermittent skilled nursing, physical therapy, or speech therapy and be under the care of a physician. The services must be furnished under a plan of care prescribed and periodically reviewed by a physician. Once a beneficiary becomes eligible for the benefit, home health users can receive any number of visits as long as a physician certifies the need.

Post-Acute versus Long-Term Care

Several observers have noted the gradual blurring of the line between Medicare-covered home health services and long-term care services over the past several years. In recent testimony before Congress, the General Accounting Office (GAO) noted that Medicare's home health care has become "available to more beneficiaries, for less acute conditions, and for longer periods of time."⁶ In 1998, GAO concluded that the home health benefit has "essentially transformed... from one focused on patients needing short-term care after a hospitalization to one that serves chronic long-term care patients as well."⁷

Since the early 1990s, researchers have suggested that Medicare has expanded to cover a void left by other payers.⁸ Since personal care is not well covered by other funding sources, individuals, providers, and other insurers (including state Medicaid programs) seek out Medicare assistance to pay for long-term care services.

Most high users of Medicare's home health benefits also have long-term care needs. More than nine in ten high home health users have limitations in activities of daily living (ADLs), and 79 percent have limitations in three or more ADLs.⁹ However, research by Harriet

Komisar and Judith Feder shows that the need for long-term care does not by itself explain high use of home health care.¹⁰ More than 50 percent of Medicare beneficiaries with long-term care needs who were not in nursing homes did not use home health care in 1996. In 1994, only 16 percent of home health users with limitations in at least three ADLs were high users of Medicare's home health services. Komisar and Feder stress that "most high home health users appear to have multiple, often complex, medical needs requiring a range of acute as well as long-term care services."

High-Cost Cases

The highest users of Medicare's home care services—the 10 percent who had 200 or more visits during the year—accounted for 43 percent of the program's cost in 1994 and 60 percent of the growth in home health spending between 1991 and 1994.¹¹ These data could reflect greater coverage of chronic care needs or a greater provision of discretionary services.

Analysis of the characteristics of expensive home health cases by Gage found that longer episodes reflect higher costs per case and that the proportion of aide visits (relative to nursing and therapy visits) rises dramatically with costs. According to Gage, these results show that, on average, the high-cost cases appear to be the cases receiving substantial numbers of aide visits, rather than the medically intensive ones.¹² Gage points out that it is difficult to distinguish whether a high number of visits is due to agency inefficiencies or to treatment of a more chronic, disabled population.

Fraud and Abuse

As Congress debated the BBA, another big factor contributing to their decision making was widespread reports of fraud and abuse in the home health industry. Several analyses by GAO and the Department of Health and Human Services' Office of the Inspector General (OIG) have demonstrated that Medicare has been billed for home health visits that may not have been needed. Both GAO and the OIG have warned that lack of sufficient program controls has produced an environment that, until recently, has enabled improper billing and cost-reporting practices to go unchecked.

As home health care costs have gone up, funding for program safeguard activities has decreased. According to GAO, "by 1995, fewer than 3.2 percent of all claims were reviewed to determine whether the beneficiary actually qualified for the services, needed them, or even received what was being billed to Medicare."¹³ In a

1997 study, GAO asked the fiscal intermediary to perform a medical review of 80 high-dollar claims that had been processed but not reviewed. The Medicare claims-processing contractor, after examining each claim and supporting documentation, denied more than \$135,000 in charges, about 43 percent of total charges, for 46 claims.¹⁴

In 1995, Operation Restore Trust, a joint effort by federal and several state agencies to identify fraud and abuse in Medicare and Medicaid, was launched. The campaign targeted home health services, among others, for investigation. Numerous reports have found very high rates of noncompliance with Medicare's coverage conditions. For example, one OIG audit of Medicare home health services in California, Illinois, New York, and Texas found that 40 percent of the total services contained in 146 of 250 claims (selected randomly from each of the states) did not meet Medicare reimbursement requirements.¹⁵

CHANGES TO HOME HEALTH PAYMENT POLICY

The BBA made significant changes to Medicare post-acute payment policies, shifting them from cost-based reimbursement to prospective payment systems over the next few years. PPS will apply to all post-acute providers, including skilled nursing facilities, home health agencies, and rehabilitation hospitals. A Forum session scheduled for July 7 will examine in detail the move to PPS for post-acute providers (see NHPF Issue Brief No. 743, "Implementing the BBA: The Challenge of Moving Medicare Post-Acute Services to PPS").

The one-year delay of implementation of the PPS for home health agencies was established under the Omnibus Consolidated Emergency Supplemental Appropriations Act of 1998. The Health Care Financing Administration (HCFA) has stated that the agency is on track to meet the new October 1, 2000 deadline. HCFA plans to publish a proposed regulation for the PPS in October 1999 and issue the final rule in July 2000.¹⁶ Some observers have predicted that Y2K compliance issues and concerns about the Outcome Assessment Information Set (OASIS) may cause the deadline to be pushed back even further.¹⁷

The BBA contains a number of other provisions designed to slow the growth in home health expenditures. Of most concern to the industry is a BBA provision to further reduce home health cost limits by 15 percent, beginning October 1, 2000 (even if the PPS is

delayed). Other provisions include strengthening participation requirements for home health agencies and authorizing the secretary of health and human services to develop normative guidelines for the frequency and duration of home health services. The BBA also requires that payments be based on the location where home health services are provided, not where they are billed. It clarifies definitions of part-time and intermittent nursing care, limits the definition of skilled nursing care to exclude venipuncture solely for the purpose of obtaining a blood sample, and directs the secretary to study the criteria for determining whether a beneficiary is homebound (and eligible to receive home health services under Medicare).¹⁸

The Interim Payment System

The BBA put in place an interim payment system to govern payments to home health agencies until a prospective payment system was developed. Since its implementation, the IPS has generated a great deal of controversy. In testimony before Congress, Gail Wilensky, chair of the Medicare Payment Advisory Commission (MedPAC), attributed the controversy, in part, to "the use of payment policy as a vehicle for curbing the rapidly rising cost of a benefit that was poorly defined."¹⁹

Prior to the BBA, agencies were paid the lower of their actual costs or a limit based on 112 percent of the average cost per visit of free-standing home health agencies. The IPS was designed to immediately control spending by providing incentives to control per-visit costs and the number and mix of visits for each year. The new system adds a third criterion to the payment formula by imposing an annual per-beneficiary limit. Thus, under the IPS, Medicare pays home health agencies the lower of their actual costs, the aggregate per-beneficiary limit, or the aggregate per-visit limit.

Under the BBA, the average per-beneficiary cost limit is based on 98 percent of the average per-patient costs for each agency (which had a 12-month cost report) in FY 1994 (adjusted for inflation for 1996 through 1998) and the average per-patient cost for agencies in the region. The limit is calculated as a blend of 75 percent of the agency's historical costs and 25 percent of the median costs of agencies in the same region. Agencies without a 12-month cost report ending in FY 1994 had their limit set at the national median.

The BBA further restricted the per-visit cost limits by decreasing the limits from 112 percent of the national mean cost per visit to limits based on 105 percent of the

national median. The per-visit and per-beneficiary limits are applied to aggregate agency costs. Thus, agencies can theoretically balance high-cost visits with low-cost visits and treat a mix of more intensive and less intensive beneficiaries and still stay below the limits.

1998 Modifications

In October 1998, Congress passed legislation to moderate the restrictiveness of the IPS. Per-visit limits were increased to 106 percent of median costs per visit. The legislation also changed the per-beneficiary limits for agencies, depending on when the agency was established and whether the agency's costs were below the national median. These provisions were designed to discourage new agencies from entering the market while recognizing the historical efficiencies of the older agencies.²⁰

Under these revisions, older agencies (established before 1994) with costs below the national median will receive one-third of the difference between their per-beneficiary limit under the original BBA formula and the national average. The per-beneficiary limits for newer agencies established prior to 1998 will be based on 100 percent of the national rate instead of 98 percent. The average beneficiary limit for agencies established in FY 1999 or later will be set at 75 percent of the national rate, based on 98 percent of the national median costs.

IMPACT OF THE NEW PAYMENT POLICIES

The new home health payment policies have generated a great deal of debate. New cost estimates by the Congressional Budget Office (CBO) show that Medicare's home health expenditures were significantly lower than expected. A number of home health agencies have closed down, citing the IPS and other billing requirements as the chief reasons. And, as a result, concerns about beneficiary access have arisen.

Cost Estimates

CBO originally estimated that the home health provisions in the BBA would reduce Medicare fee-for-service spending by \$16 billion over the 1998 to 2002 period. In March 1999, CBO revised its baseline projections of Medicare spending for home health services to total about \$47 billion less than the original estimated budget projections.

Proponents of the IPS claim that these lower spending levels show the new system—combined with other

actions—has been successful in achieving its objectives of controlling both spending per user and spending per visit. MedPAC's latest report offers additional explanations for the decrease in reported home health spending, such as antifraud activities targeting home health care, more stringent Medicare claims review and sequential billing policies,²¹ and market forces affecting the supply of home health agency employees. Other possible reasons include increased use of managed care and the maturation of the home health industry.

CBO attributes a substantial slowing of the growth of Medicare home health spending to stepped up antifraud initiatives during 1997 and 1998—which were not fully anticipated when the original projections were made. According to CBO, several investigations and prosecutions were highly publicized during 1997. In addition, in March 1997, Medicare established a background check requirement for home health agency employees, and Operation Restore Trust was expanded from a five-state demonstration to a nationwide program. In September 1997, the secretary of health and human services imposed a four-month moratorium on the certification of new home health agencies.

Lower inflation projections and subsequent legislative changes account for most of the remaining differences between the initial cost estimates and the revised estimates, according to CBO. In addition, increases in the time for processing claims and recoupment of earlier overpayments have also contributed to the slowdown in spending.²²

In its initial analysis, CBO anticipated that home health agencies would alter their behavior, increasing the admission of Medicare home health patients, which would cut into the expenditure reductions that otherwise occur through the legislation. Home health agencies have argued that this behavioral adjustment was “unwarranted and has led to the enactment of legislation that devastated home health agencies and the patients they serve.” Instead of increasing the number of beneficiaries who use home health services, industry representatives say, they have been “forced to severely limit the amount of services they provide in order to survive under the payment limits.”²³

Agency Closures

In fact, a number of home health agencies have not survived since the IPS became effective. According to GAO, more than 1,400 Medicare-certified home health agencies have closed or merged since October 1997. However, GAO reports that more than 9,000 home

health agencies still participate in Medicare—a larger number than in October 1995.

The number of home health agencies has increased significantly in the past decade—a trend which some analysts believe contributed to growth in the use of home health services during this time period. In 1994, there were almost 8,000 home health agencies, about 40 percent more than in 1989. By 1996, there were more than 10,000 Medicare-certified agencies.²⁴

GAO's analysis of agency closures found that half of the recent voluntary closures nationwide were concentrated in four states (California, Louisiana, Oklahoma, and Texas)—three of which had experienced agency growth well above the national average. The agencies that have closed were on average smaller, as measured by the number of beneficiaries served, than remaining agencies. In addition, the closed agencies had provided on average more visits per beneficiary—90.2 compared with 65.2. According to GAO, these findings suggest that less efficient agencies have had the most difficulty adjusting to the new payment limits.²⁵

In March 1999, MedPAC surveyed 1,054 Medicare-eligible home health agencies. About 10 percent of the agencies in the sample said they no longer provided home health services, either Medicare or otherwise. Another 5 percent of the agencies' phones had been disconnected, with no new or forwarding numbers available. Forty percent of the responding agencies surveyed said that they have closed branches since they became subject to the IPS.

Agency Practice Patterns

Because the IPS is based on historical cost patterns and regional and national averages, certain agencies are under more pressure to lower costs than others. Under the IPS, agencies with high costs in 1994 will have a higher cost limit than agencies that had lower costs in 1994. The home health industry has voiced concerns that reliance on agency-specific and regional costs to establish the limits rewards inefficient providers and penalizes efficient providers if changes in their patient mix or other external factors have significantly increased their costs above the base-year amounts.

According to a study conducted by the Lewin Group for the National Association for Home Care (NAHC),²⁶ agencies most affected by the per-beneficiary limit include

- Agencies that have had an increase in severity in their case mix since 1994.

- Small agencies serving a large number of high-use patients.
- Rural agencies where alternative sources of care are less likely to be available.
- Agencies that have added services since 1994 for which the costs will not be included in the per-beneficiary limit calculation.
- New providers and agencies resulting from mergers and acquisitions.

For those agencies with base-year costs higher than other agencies in their region, the annual average per-beneficiary limit will be below base-year costs. This limit is designed to encourage inefficient, high-cost agencies to reduce costs. In a 1998 letter report, GAO acknowledges that certain other factors may produce cost variation across agencies that are beyond the agencies' control. Examples include the influence of state Medicaid policies, type of population served (urban versus rural), and the number of other providers available in a market.

In addition, those agencies that experienced a higher growth in visits per beneficiary than the average since the base year are under more pressure to reduce costs. According to HCFA data, between 1994 and 1997 the number of visits per beneficiary rose, on average, by 4.5 percent. However, many agencies greatly exceeded that average. In 10 states, the average number of visits increased by more than 10 percent. GAO's analysis found that in some states (such as Louisiana, Oklahoma, and Texas), this high growth boosted utilization that already greatly exceeded the national average.²⁷ But in other states with high increases in number of visits—Delaware, Kansas, Minnesota, New Hampshire, South Dakota, and Virginia—utilization levels were still below the national average. Nevertheless, the average annual per-beneficiary limits will constrain payments to these agencies as well as to those above the national average.

An analysis of Medicare claims data by MedPAC found that home health agencies have changed their practice patterns since the implementation of the IPS. Fewer beneficiaries received home health care in the first three months of calendar year 1998 than in the same quarter of 1997. MedPAC also found a substantial decrease in the number of visits per users.²⁸

Other factors may be contributing to this decrease in home health utilization. One contentious issue has been that the payment limits have been applied retroactively. According to HCFA, this is in large measure a result of

the statute that required implementation before limits could be calculated and published by HCFA. Due largely to the inability of fiscal intermediaries to provide accurate and timely coverage information, many agencies did not find out their individual limits until they were well into their FY 1998 cost reporting periods. Agencies, in the meantime, had to estimate their expected payments and adjust their practice patterns accordingly. The home health industry maintains that these retroactive payments have led to service reductions and closings.

Another factor suggested by some analysts has been the increased scrutiny of home health claims and agency billing practices. These antifraud initiatives may have led to more attention to coverage requirements and, hence, less utilization of the benefit. MedPAC found that confusion and anxiety on the part of home health providers may have inadvertently resulted in restricted services. In particular, MedPAC found that home health agency representatives “did not always know their per-beneficiary limits or understand these limits apply to average costs for all patients served.”²⁹ As a result, some agencies may have misinterpreted the limits as absolute caps on the amount they could spend on each beneficiary, which may have led them to reduce services unnecessarily. Finally, HCFA has raised concerns about the accuracy of the claims data due to problems in the way the shift of some home health services to Part B was administered,³⁰ which could have resulted in underreported use.

Beneficiary Access

The key concern for policymakers is whether these changes in the home health payment policy have restricted access for beneficiaries who are entitled to receive care at home. Home health agencies and beneficiary advocates claim that access has been compromised because of the interim payment system. A survey of 1,300 state doctors commissioned by the Massachusetts Medical Society found that two-thirds said home health care is “insufficient at least some of the time, with chronically ill and elderly patients hurt the most.” Nearly half of the physician respondents reported that they extend hospital stays for fear of insufficient home care.³¹ According to NAHC, patients who need the most care are at most risk for cutbacks or being denied access to care. NAHC maintains that, because of lower Medicare payments, “providers are cutting back on staff, leaving agencies unable to care for all who need home care.”³²

Beneficiary advocates have raised concerns about situations in which home health agencies have denied

access to care because they believe Medicare will no longer cover the service. In these instances where no service has been delivered, beneficiaries cannot appeal to Medicare because no claim for reimbursement has been denied.³³ Beneficiary advocates have called for an improved appeals process as it applies to denials, terminations, and reductions of Medicare home health services.

So far, GAO and HCFA have maintained that there is no evidence that access to home health care is a serious problem for most Medicare beneficiaries. GAO’s interviews with hospital discharge planners and local aging organization representatives in seven states with high numbers of closures has not indicated a change over the past year in the willingness or ability of home health agencies to serve Medicare beneficiaries in their areas. However, respondents to GAO’s study did report that patients with intensive skilled nursing needs and those needing a significant number of visits over a long period of time (rather than patients with short-term rehabilitation needs) were the most difficult to place in home health services.³⁴ GAO said it could not determine whether this reflected greater difficulty than in previous years.

MedPAC’s recent survey of home health agencies found that they have adopted new admission and discharge practices since the IPS was implemented. Agencies reported that they are avoiding high-cost or seemingly high-cost patients. Nearly 40 percent of agencies reported that they no longer admit all Medicare patients whom they would have admitted previously. In particular, agencies most frequently identified long-term or chronic care patients as those they no longer admitted or have discharged as a result of the IPS.³⁵

THE FORUM SESSION

This Forum session will examine issues related to Medicare’s coverage of home health care services and the initial effects the IPS is having on provider availability and beneficiary access. Policy options currently under consideration will also be explored. The discussion will center on the following questions:

- Has beneficiary access to home care services been compromised as a result of the interim payment system?
- Are beneficiaries who have experienced access problems truly entitled to Medicare covered home health benefits or do they instead require long-term care services (which are not covered by Medicare)?

- What is known about the agencies that have recently closed? Were they truly viable in an economic sense? Did they provide the highest levels of care? What could be done to improve the oversight and quality of the actual care provided?
- Has the IPS effectively weeded out some of the inefficiencies in the home health industry? Can efficient agencies remain viable under the IPS? What if their populations grow sicker?
- If developing the PPS takes longer than is assumed, should the interim limits be loosened or adapted? For example, should different standards be applied to patients with chronic care needs than to those with acute care needs? Should there be outlier or case mix adjustments for agencies with sicker-than-average patients?
- Should Medicare appeals processes be strengthened to require home health agencies to give beneficiaries a standard notice that explains what services are being denied, reduced, or terminated?
- Will implementation of the PPS correct most of these payment and access problems? Or will demographic trends and preference for home and community-based care put more pressure on Medicare to expand its home health benefits?
- How do Medicare reimbursement policies affect the continuum of care? Should the focus move to coordination of care rather than site of care?

Speakers

Murray Ross, Ph.D., executive director of the Medicare Payment Advisory Commission, will present an overview of Medicare's new payment policies for home health services and factors that might affect access to care, including the number of providers and home health agencies' response to the interim payment system. Dr. Ross will also share the commission's recommendations to Congress and the secretary of health and human services to ameliorate concerns raised. Before joining MedPAC in 1998, Dr. Ross was chief of the Health Cost Estimates Unit in the Budget Analysis Division of CBO. He moved to that division in 1995, after spending six years in the Health and Human Resources Division, where he worked on a variety of issues relating to health care reform and income security.

Laura Dummit, associate director of health financing and public health for the General Accounting Office, will discuss GAO's ongoing work to assess

access to home health care. She will focus on recent closures of home health agencies and the extent to which these closures may have affected access to care. At GAO, Ms. Dummit is responsible for overseeing the body of work related to Medicare payment policies and health care delivery, including post-acute-care payment methods. Prior to joining GAO in 1998, Ms. Dummit was the deputy director of MedPAC (formerly the Prospective Payment Assessment Commission).

Barbara Gage, Ph.D., senior research associate for the Urban Institute, will discuss her work examining the extent to which new payment limits restrict access to care for the sickest, most costly populations. She will present an analysis of the characteristics of the expensive home health cases, regional variation in cost per case, and state level variation in home health cost and use. Dr. Gage will also discuss the likely effects on individual states of moving from a blended payment that combines agency-specific costs with regional costs to state or regional average payment limits. Previously, Dr. Gage was a senior analyst at the Prospective Payment Assessment Commission. She has recently joined Mathematica Policy Research as a senior researcher.

These presentations will be followed by a response panel of experts representing the perspectives of government, the home health industry, and Medicare beneficiaries. Invited respondents include **Robert C. Wardwell**, director of the Division of Community Post-Acute Care in HCFA's Center for Health Plans and Providers. Mr. Wardwell is responsible for Medicare reimbursement and basic benefit policy for home health, durable medical equipment, and hospice. His unit's principal responsibilities include the home health interim payment system and home health prospective payment. Before assuming his current position in 1997, Mr. Wardwell held a wide variety of policy and operational positions in both Medicare and Medicaid components of HCFA for over 25 years.

Nancy King, vice president of Home and Community Based Services for the Ohio Presbyterian Retirement System (OPRS), has nearly 20 years of experience in the home and community-based services field. In her current position, Ms. King is responsible for OPRS's statewide home and community-based services operation, which includes seven home health agencies, 10 adult day care services sites, two home-delivered meal programs, a chore service, a senior center, and miscellaneous caregiver support and education sites.

Peter Cobb is the executive director of the Vermont Assembly of Home Health Agencies, the professional association of the home health and visiting

nurse associations in Vermont. Mr. Cobb has held this position for the past 16 years. Before that, he worked with retarded adults and was a newspaper reporter and grant writer.

Hilary Sohmer Dallin is a staff attorney for the Center for Medicare Advocacy in Willimantic, Connecticut. Previously, she was a senior staff attorney with the Elder Law Unit of Connecticut Legal Services and, prior to that, was the attorney-in-charge of Queens Legal Services for the Elderly in Queens, New York. Her practice has focused on elder law issues and she has written and lectured on topics including Medicare, Medicaid, nursing home residents' rights, and legal issues of home care.

ENDNOTES

1. Congressional Budget Office, "Medicare Projections and the President's Medicare Proposals," Chapter 3 in *An Analysis of the President's Budgetary Proposals for Fiscal Year 2000*, April 1999; accessed June 4, 1999, at <http://www.cbo.gov>.
2. Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Selected Medicare Issues*, June 1999, 108.
3. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 1998, 92.
4. Barbara Gage, "Impact of the BBA on Post-Acute Utilization," Commonwealth Fund, Spring 1999, unpublished, 11.
5. For a summary of the legislative and judicial history of Medicare's home health policy, see Richard E. Hegner, National Health Policy Forum Issue Brief No. 694, "Medicare Coverage for Home Health Care: Reining in a Benefit Out of Control," 6-7.
6. William J. Scanlon, director, health financing and systems issues, U.S. General Accounting Office, "Interim Payment System for Home Health Agencies," testimony before the Senate Finance Committee, March 17, 1999.
7. William J. Scanlon, director, health financing and systems issues, U.S. General Accounting Office, "Progress to Date in Implementing Certain Major Balanced Budget Act Reforms," testimony before the House Ways and Means Subcommittee on Health, August 6, 1998.
8. Christine Bishop and Kathleen Carley Skwara, "Recent Growth of Medicare Home Health," *Health Affairs*, 13, no. 3 (Fall 1993): 106.
9. Joel Leon, Patricia Neuman, and Stephen Parente, "Understanding the Growth in Medicare's Home Health Expenditures," Henry J. Kaiser Family Foundation, June 1997.
10. Harriet L. Komisar and Judith Feder, *The Balanced Budget Act of 1997: Effects on Medicare's Home Health Benefit and Beneficiaries Who Need Long-Term Care*, The Commonwealth Fund, New York, February 1998, 17.
11. Komisar and Feder, "Balanced Budget Act," vi.
12. Barbara Gage, "Medicare's Home Health Interim Payment System: Is Access a Problem?" Commonwealth Fund, Spring 1999, unpublished, 4.
13. Scanlon, House Ways and Means Subcommittee on Health testimony, August 6, 1998.
14. General Accounting Office, "Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings" (Letter Report, 6/13/97, GAO/HEHS-97-108).
15. Office of the Inspector General, Department of Health and Human Services, "Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York, and Texas (A-04-96-02121), July 1997.
16. Nancy-Ann DeParle, administrator, Health Care Financing Administration, testimony on Medicare payment reforms before the Senate Committee on Finance, March 17, 1999.
17. Home health agencies were scheduled to begin transmitting OASIS data to HCFA on April 26, 1999. This requirement has been put on hold due to privacy concerns that were recently raised by members of Congress and Vice President Al Gore. According to an April 7, 1999, notice from HCFA, the agency cannot begin collecting OASIS data until 30 days after the Office of Management and Budget publishes a "system of records notice" in the *Federal Register*.
18. In its report submitted to Congress on April 29, 1999, DHHS recommended that the current homebound policy be retained, with some clarifications to improve its uniformity of administration. DHHS said its analysis found that other options—such as the use of ADL-based tests—would create new problems of eligibility and coverage and generate a large number of "winners" and "losers" within the current Medicare population.
19. Gail Wilensky, chair, Medicare Payment Advisory Commission, "MedPAC Recommendations on Implementing Medicare Provisions of the Balanced Budget Act of 1997," testimony before the Senate Committee on Finance, March 17, 1999.
20. Gage, "Medicare's Home Health Interim Payment System," ii.
21. Under the sequential billing requirement, agencies were barred from submitting new bills on patients until any previous bills had been paid or rejected. The system was designed to discourage fraud and to help keep track of home health funds more accurately as the source of payments for visits above 100 a year shifts from Part A of Medicare to Part B. Home health agencies reported that the backlog of reimbursement was causing serious cash flow problems. After urging from Congress, HCFA terminated its sequential billing requirement, effective July 1, 1999.

22. Congressional Budget Office, "Medicare Projections and the President's Medicare Proposals," Chapter 3 in *An Analysis of the President's Budgetary Proposals for Fiscal Year 2000*, April 1999; accessed June 4, 1999, at <http://www.cbo.gov>.
23. National Association for Home Care, "CBO Analysis Confirms Devastating Home Care Cuts," press release, March 14, 1999.
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