

THE HOME HEALTH CARE CRISIS: MEDICARE'S FASTEST GROWING PROGRAM LEGALIZES SPIRALING COSTS

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Home health care was developed with the benevolent intention of providing a cost-effective alternative to existing forms of long-term health care, while permitting beneficiaries to receive needed short-term, posthospitalization, acute care in their own homes. However, the home health care segment of Medicare recently sustained an unprecedented and explosive growth in program cost. As a result of this alarming expansion, home health care has become the fastest growing expense of the overwhelmingly complex Medicare program and is in danger of spiraling out of control.

This article begins with a review of the current structure and administration of the home health care program under the Health Care Finance Administration (HCFA). Mr. Davis details the requirements of Home Health Agencies and their patients to qualify for full Medicare reimbursement under the home health care program. Current practices, based on lenient administrative and judicial interpretations of these qualifications, have resulted in growing demand for home health services and the resulting increase in program cost. Mr. Davis explores the primary limitations on the home health care program, including the overemphasized potential for fraud and abuse, billing and budget inefficiencies, the overavailability of services, the ease of entry into the home health care market, the lack of meaningful physician or patient involvement, and the lack of any insurance copayment or deductible.

Mr. Davis critiques contemporary solutions offered to cure the program's incredible cost growth, including Medicare amendments from the Balance Budget Act of 1997 and new HCFA initiatives. Mr. Davis, wary of the effectiveness of these solutions, argues that other solutions which have eluded Congress and HCFA are more promising. These solutions include a revision of the prospective payment system, the imposition of an insurance copayment or deductible, increasing the role of the physi-

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cian and patient in the provision of services, a legislative reduction in the availability of services, and a more contained approach to remedying fraud and abuse. The article concludes by emphasizing that the most fundamental problems facing the home health care program are perfectly legal practices and, therefore, the current focus on fraud prevention is largely misplaced. Mr. Davis suggests that only through a comprehensive solution addressing all of these cost factors will the home health care program remain a viable and cost-justified program within the Medicare system.

I. Introduction

Home health care is the fastest growing expense in the Medicare program.¹ The rapid expansion began in 1988, when, as the result of a lawsuit, changes in the Medicare regulations expanded the eligibility for home health care services and effectively eliminated the cap on the number of permissible visits by home health care personnel.² In less than ten years, the total amount of expenditures on home health care has grown from around \$2 billion per year in 1987,³ to over \$18 billion per year in 1996,⁴ and the number of home health care agencies providing such services has grown to more than 10,000 agencies.⁵ The number of beneficiaries receiving home health care services has grown from 1.7 million in 1990 to more than 3.9 million in 1996.⁶ These trends appear to have no end in sight. The Congressional Budget Office recently reported a projected annual growth rate of 8.6% in home health expenditures over the next twenty years,⁷ a pace that would be unmatched by any other Medicare program.

Seeking to halt the spiraling costs of home health care, President Clinton on September 15, 1997, issued an unprecedented moratorium on all new home health agencies (HHAs) seeking Medicare certifica-

1. See Meris L. Bergquist, *Home Health Care: What Is It and Who Pays for It?*, VT. B.J. & L. DIG., Dec. 1991, at 35, 35.

2. See *Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1988) (holding that HHS's interpretation of Medicare provision pertaining to "part-time or intermittent care" as not covering home health aide services if required more than four days a week was arbitrary and capricious).

3. See MEDICARE: HOME HEALTH UTILIZATION EXPANDS WHILE PROGRAM CONTROLS DETERIORATE, U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, U.S. SENATE SPECIAL COMMITTEE ON AGING 6 (1996) [hereinafter GAO REPORT I].

4. See Elizabeth Shogren, *Clinton Plan Targets Surging Medicare Fraud*, L.A. TIMES, Sept. 16, 1997, at A1.

5. See Robert Pear, *Citing Fraud in Home Care, Clinton Halts New Permits*, N.Y. TIMES, Sept. 16, 1997, at A1.

6. See Shogren, *supra* note 4.

7. See CONGRESSIONAL BUDGET OFFICE, REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS ch. 5 tbl.5-2 (1997).

tion.⁸ The moratorium “erects a sudden dam in what has become by far the fastest-growing part of Medicare, with nearly 100 new companies signing up each month.”⁹ One onlooker aptly characterized “[t]he moratorium [a]s a drastic action. It’s an admission that the Government may not have the program under control.”¹⁰

This article explores the provision of home health care through Medicare-certified HHAs with an emphasis on curbing the recent explosion in the number of participants and the amount of delivery costs. Part II reviews the overall structure of the program, consisting of the federal regulators, intermediaries, and the HHA. Part III examines the intricacies of the provision of home health services and its requirements for coverage under Medicare. Part IV exposes the limitations on the home health care system that underlie the exponential growth in cost. Building on these limitations, Part V analyzes solutions to the home health care crisis. Subsections A and B analyze the recent efforts of Congress and the Health Care Finance Administration to address the problem. This analysis reveals that the focus of reform efforts (chiefly reducing fraud and abuse) is entirely too narrow. Finally, subsection C proposes several solutions left unattended and analyzes the merits of such solutions in light of the structure of the current system. Subsection C also illustrates the complexities of the home health care crisis and reinforces the need for a comprehensive solution to a program that, under its current formulation, legalizes spiraling costs.

II. Structure of the Program

The Medicare program, originally authorized under Title XVIII of the Social Security Amendments Act of 1965 (the 1965 Act),¹¹ is a health insurance program that covers all Americans aged sixty-five years and older. The program provides insurance protection in two parts. Part A, the hospital insurance, covers in-patient services, post-hospital care in skilled nursing homes, and home health care.¹² Part B is a supplementary medical insurance program that covers primarily

8. See Amy Goldstein, *President Acts to Curb Home Health Care Fraud*, WASH. POST, Sept. 16, 1997, at A4.

9. *Id.*

10. Pear, *supra* note 5, at A1.

11. Pub. L. No. 89-97, 79 Stat. 286 (codified in scattered sections of 42 U.S.C.).

12. See 42 U.S.C. §§ 1395c to 1395i-4 (1994 & Supp. II 1996). Nearly 98% of home health care is financed under Part A. See Bergquist, *supra* note 1, at 35.

physician services but also covers home health services not otherwise provided under Part A.¹³

The provision of Medicare-reimbursed, home health services and certification is governed primarily by sections 1814, 1835, 1861, and 1866 of the 1965 Act,¹⁴ the Code of Federal Regulations,¹⁵ the Medicare Home Health Agency Manual,¹⁶ and the Medicare Intermediary Manual.¹⁷ Despite occupying just a few sections in the U.S. Code, the home health care system is wrought with vague and ambiguous regulations and requirements. At least thirty-seven states and the District of Columbia also impose licensing requirements for home health care agencies.¹⁸ The coverage of these statutes vary among the states, though most state statutes resemble the federal Medicare statutes.¹⁹ Commentators note that the states' incorporation of Medicare statutory provisions "reflects the continued reliance on the Medicare

13. See 42 U.S.C. §§ 1395j to 1395w-4.

14. *Id.* §§ 1395f, 1395n, 1395x, 1395cc.

15. There are home health provisions codified in scattered sections of 42 C.F.R.

16. Health Care Fin. Admin., Medicare Home Health Agency Manual (last modified Feb. 20, 1997), available for download at <<http://www.hcfa.gov/pubforms/hhaman/hhatoc.htm>> [hereinafter Medicare Home Health Agency Manual].

17. Health Care Fin. Admin., Pub. No. 13, Medicare Intermediary Manual (last modified May 5, 1997), available for download at <<http://www.hcfa.gov/pubforms/pub13/pub13toc.htm>> [hereinafter Medicare Intermediary Manual].

18. See ARIZ. REV. STAT. § 36-425 (West Supp. 1997-98); CAL. HEALTH & SAFETY CODE § 1725 (West 1990); CONN. GEN. STAT. ANN. § 19a-490 (West 1997); DEL. CODE ANN. tit. 16, § 122(3)0.1 (1986); D.C. CODE ANN. § 32-1302 (1988); FLA. STAT. ANN. § 400.461 (West 1998); GA. CODE ANN. § 31-7-151 (Harrison 1996); HAW. REV. STAT. § 321-11 (Michie 1997); IDAHO CODE § 39-1303 (1993); 210 ILL. COMP. STAT. ANN. 355/1-14 (West 1992); IND. CODE ANN. § 16-27-1 (Michie 1998); KAN. STAT. ANN. § 65-5102 (West 1992); KY. REV. STAT. ANN. § 216B.105 (Banks-Baldwin 1992); LA. REV. STAT. ANN. § 40:2116.31-40 (West Supp. 1998); ME. REV. STAT. ANN. tit. 22, § 2143 (West 1992); MD. CODE ANN., HEALTH-GEN. § 19-401 (1996); MINN. STAT. ANN. § 144A.46 (West 1998); MISS. CODE ANN. § 41-71-3 (1993); MO. REV. STAT. § 197.405 (West 1996); MONT. CODE ANN. § 50-5-201 (1997); NEB. REV. STAT. § 71-2018 (Michie 1996); NEV. REV. STAT. § 449.030 (Michie 1997); N.H. REV. STAT. ANN. § 151:2 (West Supp. 1997); N.J. STAT. ANN. § 30:4E-2 (West 1997); N.M. STAT. ANN. § 24-1-5 (Michie 1998); N.Y. PUB. HEALTH LAW § 3605 (McKinney 1998); N.C. GEN. STAT. § 131E-138 (1997); N.D. CENT. CODE § 23-17.3 (1997); OR. REV. STAT. § 443.015 (1992); PA. STAT. ANN. tit. 35, § 448.801 (West 1993); R.I. GEN. LAWS § 23-17-4 (1996); S.C. CODE ANN. § 44-69-30 (Law. Co-op. 1997); TENN. CODE ANN. § 68-11-202 (1996); TEX. HEALTH & SAFETY CODE ANN. § 142.002 (West Supp. 1992); UTAH CODE ANN. § 26-21-8 (1997); VA. CODE ANN. § 32.1-162.9 (Michie 1997); WASH. REV. CODE § 70.127 (West 1997); WIS. STAT. § 50.49 (1997).

19. See Sandra H. Johnson, *Quality-Control Regulation of Home Health Care*, 26 HOUS. L. REV. 901, 934 (1989).

certification system as the primary if not sole, public regulatory scheme for home health care.²⁰

The Medicare program is administered through the Health Care Finance Administration (HCFA), an arm of the Department of Health and Human Services (HHS). HCFA has currently designated nine regional intermediaries that service HHAs within each region.²¹ These intermediaries serve as communication channels between the HHAs and HCFA,²² and are responsible for negotiating and approving contractor budgets with the HHA.²³ In addition, these intermediaries process claims and make reimbursement decisions.²⁴ They are also expected to perform the “policing” elements of auditing and abuse prevention programs.²⁵

Traditionally, virtually all home health care was provided by either public (governmental) or private entities.²⁶ In recent years, however, hospitals have entered the field of home health care, creat-

20. *Id.*

21. The nine regional intermediaries and their respective regions are as follows:

- Associated Hospital Service of Maine—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
- Independence Blue Cross (Philadelphia)—Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia
- Blue Cross and Blue Shield of South Carolina—Kentucky, North Carolina, South Carolina, and Tennessee
- Aetna Life and Casualty—Alabama, Florida, Georgia, and Mississippi
- Blue Cross and Blue Shield United of Wisconsin—Michigan, Minnesota, New Jersey, New York, Puerto Rico, the Virgin Islands, and Wisconsin
- Health Care Service Corporation (Chicago)—Illinois, Indiana, and Ohio
- New Mexico Blue Cross and Blue Shield, Inc.—Arkansas, Louisiana, New Mexico, Oklahoma, and Texas
- Blue Cross of Iowa, Inc.—Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, and Wyoming
- Blue Cross of California—Alaska, Arizona, California, Hawaii, Idaho, Oregon, Nevada, and Washington

See Medicare Home Health Agency Manual, *supra* note 16, § 140(A).

22. See GAO REPORT I, *supra* note 3, at 4.

23. See Medicare Intermediary Manual, *supra* note 17, § 1202.

24. See Medicare Home Health Agency Manual, *supra* note 16, § 140(A).

25. See *id.*

26. See Kenneth Brummel-Smith, *Home Health Care: How Long Will It Remain “Low Tech”?*, 65 S. CAL. L. REV. 491, 493 (1991). Home health care providers can be divided into three categories: government, for-profit, and nonprofit. As of 1994, the percentage share of the total number of HHAs is described in the following graphic:

ing their own programs.²⁷ These HHAs must meet certain requirements before becoming "Medicare-certified."²⁸ Once certified, these HHAs are entitled to 100% reimbursement of costs from Medicare for the provision of home health services, provided such services qualify for reimbursement.²⁹ Though numerous ancillary and home health aide services fall within the Medicare program, nursing care is the "cornerstone" of home health care.³⁰ The HHA acts as the primary caregiver, acting only on the initial instructions of the patient's physician, and interacting with intermediaries usually only for billing and reimbursement purposes.³¹ The care provided by the HHA is intended to be short-term, posthospitalization, acute care.³² Medicare does not cover full-time nursing care.³³

Up to seventy-five percent of frail and disabled older persons receive home-care services through these organizations.³⁴ Beneficiaries receiving home health services are typically female and over seventy-five years old.³⁵ Beneficiaries consistently prefer home health

HHA Type	Number	Percent of Total*
Government	1,353	17.20
For-Profit	3,815	48.51
Nonprofit	2,696	34.28

* percentages may not add to 100 due to rounding.

See GAO REPORT I, *supra* note 3, at 10.

27. See Brummel-Smith, *supra* note 26, at 493. Brummel-Smith adds that one reason for this trend is "the expansion of Medicare coverage for skilled nursing care provided in the home." *Id.* Another reason, though not contemplated by Brummel-Smith, is that home health services are 100% reimbursable through Medicare, whereas hospitalization expenses are only partially reimbursable. This presents a large potential for fraud. See *infra* Part IV.

28. See 42 U.S.C. § 1395x(o) (1994).

29. See *generally id.* § 1395x(v)(1)(A) (discussing reimbursable costs).

30. See Brummel-Smith, *supra* note 26, at 494.

31. See Interview with Director, Medicare-Certified Home Health Agency, in Pittsburgh, Pa. (Oct. 16, 1997) [Interviewee and Agency have requested that their identities remain confidential] [hereinafter Interview (Oct. 16, 1997)].

32. See U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL COMMITTEES, MEDICARE: COMPARISON OF TWO METHODS OF COMPUTING HOME HEALTH CARE COST LIMITS (1990) [hereinafter GAO REPORT II]; GAO REPORT I, *supra* note 3, at 5; S. Mitchell Weitzman, *Legal and Policy Aspects of Home Health Care Coverage*, 1 ANNALS HEALTH L. 1 (1992); Interview (Oct. 16, 1997), *supra* note 31. In fiscal year 1994, the average number of visits per year per beneficiary was 57, while the median number of visits was 34. See GAO REPORT I, *supra* note 3, at 8. The difference indicates that minorities of beneficiaries are receiving far more than 57 visits per year. Other data suggest that such visits are conducted by *private* HHAs, as such agencies averaged nearly 70 visits per year. See *id.* at 12.

33. See Brummel-Smith, *supra* note 26, at 494.

34. See *id.*

35. See GAO REPORT I, *supra* note 3, at 4.

care to the analogue nursing home.³⁶ Home health care offers skilled nursing, home health assistance, and simple companionship, all without a price tag.³⁷ Perhaps home health care's appeal will prove to be its undoing.

III. The Home Health Agency

A home health agency is a public agency or private organization primarily engaged in providing skilled nursing and other therapeutic services.³⁸ Provided certain conditions are met, the HHA is entitled to

36. See Bergquist, *supra* note 1, at 35 (citing a study by the AARP which shows that 86% of the elderly want to live out the remainder of their lives in their own homes).

37. See *id.*

38. See 42 U.S.C. § 1395x(o) (1994). The text of the definition is as follows:

(o) Home health agency

The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

- (1) is primarily engaged in providing skilled nursing services and other therapeutic services;
- (2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, for supervision of such services by a physician or registered professional nurse;
- (3) maintains clinical records on all patients;
- (4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;
- (5) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section;
- (6) meets the conditions of participation specified in section 1395bbb(a) of this title and such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; and
- (7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program; except that for purposes of part A of this subchapter such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

Id.

reimbursement from Medicare for the provision of services.³⁹ As a threshold requirement, the person receiving services must be an eligible Medicare beneficiary.⁴⁰ Four types of individuals are considered eligible for Medicare:

- (1) Individuals who have reached the age of sixty-five and are entitled to receive Social Security benefits, widow's or widower's insurance benefits, or Railroad Retirement benefits;
- (2) Disabled persons of any age who have received Social Security benefits, widow's or widower's insurance benefits, or Railroad Retirement benefits for twenty-five months;
- (3) Persons with end-stage renal disease who require dialysis treatment for a kidney transplant; and
- (4) Persons over age sixty-five who are not eligible for either Social Security or Railroad Retirement who purchase Medicare coverage by payment of a monthly premium.⁴¹

The HHA providing the services must have a valid agreement in effect to participate in the Medicare program.⁴² This agreement essentially states that the provider will not charge any individual or other person for items and services covered by the health insurance program other than allowable charges and deductibles and will return any monies incorrectly collected.⁴³ The agreement between HHS and each HHA is not limited in duration.⁴⁴ The agreement remains in effect until there is a voluntary termination, an involuntary termination, or an invalidation of the agreement by reason of a change in the ownership of the HHA.⁴⁵ First, the HHA may terminate its agreement at any time by filing a written notice of its intent to terminate with HCFA.⁴⁶ HCFA may accept the termination date or select another date that is within six months from the date the HHA's notice was filed.⁴⁷

39. *See id.* § 1395(g).

40. *See id.* § 1395(f).

41. *See id.* § 426.

42. *See id.* § 1395cc(a).

43. *See id.*

44. *See Medicare Home Health Agency Manual, supra* note 16, § 132.

45. *See id.* § 142. However, the termination of participation does not immediately abrogate all of the HHA's responsibilities, and, in some cases, responsibilities may extend beyond the effective date of termination. *See id.* The provider also continues to be responsible for filing a final cost report and/or repayment of any coverage. *See id.*

46. *See* 42 U.S.C. § 1395cc(b)(1).

47. *See id.*

Second, HCFA may terminate an agreement with an HHA if it determines that one of the following conditions exists:

- (1) The HHA is not complying substantially with the provisions of the agreement or with the applicable provisions of Title XVIII of the Act and Regulations; or
- (2) The HHA no longer meets the appropriate conditions of participation; or
- (3) The HHA has failed to supply information that is necessary to determine whether payments are due and the amounts of such payments; or
- (4) The HHA refuses to permit examinations of fiscal and other records, including medical records; or
- (5) The HHA has knowingly and willfully made, or caused to be made, false statements or representations with respect to facts material to the right to payment; or has submitted, or caused to be submitted, requests for payment for amounts substantially in excess of the costs incurred; or has furnished items or services which are either substantially in excess of the individual's needs, harmful, or grossly inferior in terms of quality.⁴⁸

HCFA must give the HHA fifteen-days notice prior to termination of the agreement.⁴⁹ An HHA may request a hearing to review HCFA's determination in accordance with the appeal procedures set forth in the Regulations.⁵⁰

The third method of terminating a Medicare participation agreement concerns a transfer of the HHA's ownership. When an HHA with a valid provider agreement undergoes a change of ownership, the agreement is automatically assigned to the successor owner.⁵¹ An assigned agreement is subject to all applicable laws under which it was initially issued.⁵² If the previous owner ceases to do business, the Regulations treat such action as a termination.⁵³ If, however, the previous owner survives the change, the Regulations are unclear as to

48. Medicare Home Health Agency Manual, *supra* note 16, § 142.2; *see also* 42 U.S.C. § 1395cc(b)(2).

49. *See* Medicare Home Health Agency Manual, *supra* note 16, § 142.2.

50. *See* 42 C.F.R. § 405, Subpt. H (1997).

51. *See id.* § 489.18(c); *see also* Medicare Home Health Agency Manual, *supra* note 16, § 145. The Home Health Care Manual recommends that a participating HHA that plans to change ownership submit an advance notice of such to HCFA. *See id.*

52. *See* 42 C.F.R. § 489.18(d).

53. *See id.* § 489.52(b)(3).

whether the previous owner retains any liability under the provider agreement.⁵⁴

An HHA that files an agreement to participate in Medicare's health insurance program agrees to provide Medicare beneficiaries with care, treatment, and other services ordinarily furnished to its patients.⁵⁵ Each HHA may impose additional restrictions upon its patients; however, the Medicare Home Health Care Manual cautions that the "law does not contemplate that such restrictions . . . apply only to Medicare beneficiaries as a class."⁵⁶

Another requirement for participation in the Medicare program is that the HHA demonstrate that its beneficiaries qualify for coverage of home health services.⁵⁷ This requirement introduces four key limitations or "sub-conditions."⁵⁸ First, the Act requires that a physician certify in all cases that the patient is "confined to his home."⁵⁹ The Medicare Home Health Care Manual, which describes this as the "homebound" determination, elaborates on its limitation:

An individual does not have to be bedridden to be considered as confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment.⁶⁰

As a general matter, if the patient has a condition that restricts her ability to leave the home except with the aid of supportive devices, the individual is considered homebound.⁶¹ The standard for "homebound" status has proven to be highly subjective, as both the physician and HHA retain considerable discretion in making this de-

54. Section 489.18 of title 42 of the Regulations focuses only on the effect of the agreement on the successor owner and does not discuss residual liability resting on the assignor. *See id.* § 489.18.

55. *See id.* § 134.

56. *Id.*

57. *See id.* § 204.1(A).

58. *See id.* § 204.5(A).

59. 42 U.S.C. § 1395f(a)(2) (1994).

60. Medicare Home Health Agency Manual, *supra* note 16, § 204.1(A).

61. *See id.*

termination.⁶² Consequently, the limitation has not interposed any significant obstacle to the provision of home health care services.⁶³

Second, the HHA must provide its services under a plan of care established and approved by a physician.⁶⁴ This plan must contain: "all pertinent diagnoses, the frequency of visits [necessary], prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, all medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and any [other] additional items [deemed necessary] by the HHA or physician."⁶⁵ The physician must sign the plan of care before the HHA submits any bill for reimbursement.⁶⁶ Under the supervision of an HHA professional, the physician who established the plan of care must review and sign the plan at least once every sixty-two days.⁶⁷ Though the Act, Regulations, and guidance manuals appear to require specificity in these plans, in reality these plans have become little more than "rubber stamps" enabling the HHA personnel to commence treatment.⁶⁸

Third, the patient must be under the care of a physician who is qualified to sign a certification statement and plan of care.⁶⁹ However, the physician is not required to see the patient.⁷⁰ The Home Health Care Manual, though recognizing the absence of a visitation requirement, "expect[s]" that a physician will see the patient during this time.⁷¹ Again, in practice, the physician usually has no contact with

62. See GAO REPORT I, *supra* note 3, at 15.

63. See *id.* ("One intermediary official said that the [intermediary] made fewer than 10 denials a year based on the homebound criteria."). Congress recently approved legislation requiring the HHS Secretary to conduct a study on the criteria that should be applied, and method for applying criteria, to the determination of whether an individual is considered "homebound." See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4613, 111 Stat. 251, 474.

64. See 42 U.S.C. § 1395x(m).

65. Medicare Home Health Agency Manual, *supra* note 16, § 204.2.

66. See *id.* § 204.2(C)-(D). However, the regulations permit the use of verbal orders from the physician. See 42 C.F.R. § 242.22 (1997). In that case, the physician may give a verbal order that is then transcribed and signed by the registered nurse or qualified therapist. See Medicare Home Health Agency Manual, *supra* note 16, § 204.2(E). The HHA personnel are then permitted to provide the necessary services to the patient. See *id.* However, the HHA may not submit the bill for these services unless and until the physician countersigns the transcribed order. See *id.*

67. See Medicare Home Health Agency Manual, *supra* note 16, § 204.2(F).

68. See Interview (Oct. 16, 1997), *supra* note 31.

69. See 42 C.F.R. § 424.22.

70. See Medicare Home Health Agency Manual, *supra* note 16, § 204.3.

71. See *id.*

the patient beyond that which is necessary to effectuate the HHA's provision of services.⁷²

Fourth, the patient must require at least one of several types of skilled services. One such service may be skilled nursing care that is "reasonable and necessary" and is needed on an "intermittent" basis.⁷³ If the patient's needs continue, other services will include physical therapy, speech-language pathology services, and occupational therapy.⁷⁴

The physician must certify to HCFA that the HHA has complied with the foregoing four key requirements.⁷⁵ This certification is valid for a period of no more than sixty-two days,⁷⁶ at which time the physician may recertify.⁷⁷ This recertification process can usually be accomplished at the same time the physician amends or confirms the continuance of a plan of care.⁷⁸

To be eligible for Medicare participation, the HHA must also establish an overall plan and budget for administrative expenses.⁷⁹ HCFA makes funds available, through the intermediaries, for administrative costs related to the functions performed by the HHA.⁸⁰ To receive the funds, the HHA must first submit to HCFA an estimate of the administrative costs that are anticipated for the ensuing fiscal year.⁸¹ The HHA must predicate this budget on the Budget and Performance Requirements (BPR) issued by HCFA and on the HHA's previous experience with Medicare reimbursement.⁸² From there, the principles for determining reimbursable administrative costs, as set forth in Chapter 31 of the Federal Acquisition Regulations (FAR), govern the determination of the budget.⁸³ HCFA disburses payments to the HHA for those administrative costs that are "necessary and

72. See Interview (Oct. 16, 1997), *supra* note 31.

73. See Medicare Home Health Agency Manual, *supra* note 16, § 205.1.

74. See *id.* § 205.2.

75. See *id.* § 204.5(A).

76. See *id.* § 204.5(B).

77. See *id.*

78. See 42 C.F.R. § 424.22(b) (1997).

79. See 42 U.S.C. § 1395x(o)(5) (1994); Medicare Intermediary Manual, *supra* note 17, § 1200.

80. See Medicare Intermediary Manual, *supra* note 17, § 1200.

81. See 42 U.S.C. § 1395x(z)(1). HCFA follows a fiscal year that begins October 1st and ends September 30th each year. See Medicare Intermediary Manual, *supra* note 17, § 1200.

82. See Medical Intermediary Manual, *supra* note 17, § 1200.

83. See *id.* § 1211.

proper” as determined by the Principles of Reimbursement.⁸⁴ The amount of settlement is subject to the auditing procedures of HCFA.⁸⁵

HHAs must also adhere to certain limitations concerning the nature, frequency, and duration of services provided. To be eligible for home health care services, the patient must have a need for either intermittent skilled nursing care, physical therapy, speech-language pathology services, or a continuing need for occupational therapy.⁸⁶ To be covered as a “skilled nursing service,” the service must require the skills of a registered nurse or a practitioner under the supervision of a registered nurse and must be reasonable and necessary for the treatment of the patient’s illness.⁸⁷ In addition, the service must be reasonable and necessary for the diagnosis and treatment of the patient’s illness within the context of the patient’s medical condition, with appropriate consideration given towards the plan of treatment established for the patient.⁸⁸

The defining parameters of “reasonable and necessary,” similar to those defining “homebound,” have proven elusive and highly subjective. The Medicare Home Health Care Manual outlines several functions which may be viewed as lying at the outer limits of this definition, though still within the ambit of “reasonable and necessary.”⁸⁹ For instance, observation and assessment of the patient’s condition by a licensed nurse qualifies as reasonable and necessary skilled nursing care⁹⁰—an activity in which HHAs regularly engage in as part of their plan of treatment.⁹¹ However, the Medicare Home Health Care Manual cautions that such activities should be limited only to those situations where the likelihood of change in the patient’s condition necessitates a reevaluation of treatment.⁹² Skilled nursing visits for management and evaluation of the patient’s care plan also fall within the ambit of “reasonable and necessary” skilled nursing serv-

84. See *id.* § 1200.

85. See *id.*

86. See 42 U.S.C. § 1395(a)(2)(C).

87. See Medicare Home Health Agency Manual, *supra* note 16, § 205.1(A). However, a service is not considered a skilled nursing service solely because it was provided by a registered nurse. Rather, the analysis looks more towards the “inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.” *Id.* § 205.1(A)(1).

88. See *id.* § 205.1(A)(4).

89. See *id.* § 205.1(A), (B).

90. See *id.* § 205.1(B)(1).

91. See Interview (Oct. 16, 1997), *supra* note 31.

92. See Medicare Home Health Agency Manual, *supra* note 16, § 205.1(B)(1).

ices.⁹³ Although unlicensed professionals could accomplish these functions, the Manual contemplates that such services are more appropriately delivered by a skilled nurse who is better able to understand the patient's disposition.⁹⁴ In addition, teaching and training activities, when geared towards the treatment regimen, qualify as "reasonable and necessary" skilled nursing services.⁹⁵ The test of whether such activities constitute a "skilled nursing" service focuses on the level of skill required to teach and not on the nature of what is being taught.⁹⁶ Finally, although medications and drugs associated with treatment are specifically excluded from Medicare coverage,⁹⁷ if they are reasonable and necessary to the treatment of the illness, the nursing services required to help in the administration of the drugs may be covered.⁹⁸

Medicare may also cover certain home health aide services provided on an intermittent or part-time basis.⁹⁹ Home health aide services include personal care services such as feeding, bathing, dressing, hair care, and other hygiene that are needed to facilitate treatment or prevent deterioration of the beneficiary's health.¹⁰⁰ Such services also include changing dressings, applying ointments, and assisting "with medications that are ordinarily self-administered and that do not require the skills of a licensed nurse" for administration.¹⁰¹

The "intermittent" requirement in the Act has proven equally elusive, and its interpretation may be the primary cause for the explosion in home health care claims. As stated, the beneficiary must be confined to his or her home; must be under the care of a physician; and must need intermittent skilled nursing care or certain types of physical, speech, or occupational therapy.¹⁰² A beneficiary satisfying these threshold requirements qualifies for "part-time or intermittent" nursing care and "part-time or intermittent" care of a home health aide.¹⁰³ Though this language may appear plain, HHS followed a pol-

93. See *id.* § 205.1(B)(2).

94. See *id.* § 205.1(B)(2) (example 1).

95. See *id.* § 205.1(B)(3).

96. See *id.*

97. See 42 U.S.C. 1395x(m)(5) (1994).

98. See Medicare Home Health Agency Manual, *supra* note 16, § 205.1(B)(4).

99. See *infra* note 122 and accompanying text.

100. See Medicare Home Health Agency Manual, *supra* note 16, § 206.2(a).

101. *Id.* § 206.2(b) and (c).

102. See 42 U.S.C. § 1395f(a)(2)(C).

103. See *id.* § 1395x(m)(1), (4).

icy since 1966 of denying claims for services that were not both part-time *and* intermittent.¹⁰⁴

In 1988, the District Court for the District of Columbia appeared to set the interpretation straight in *Duggan v. Bowen*.¹⁰⁵ In that case, seventeen named Medicare claimants, among others, brought a class action against HHS challenging its long-standing interpretation of the “part-time or intermittent” requirement.¹⁰⁶ The plaintiffs contended that HHS’s “part-time or intermittent” care policy as applied was too restrictive, in effect requiring the patient to demonstrate a need for both part-time *and* intermittent care.¹⁰⁷ The effect of HHS’s policy was to exclude from coverage daily services provided in excess of four days per week¹⁰⁸—a frequency clearly permissible under the definition of part-time.¹⁰⁹ Though HHS denied having such a policy, it refused to stipulate to the statement: “[t]he Medicare Act provides for part-time or intermittent skilled nursing and home health aide services.”¹¹⁰ The court rejected HHS’s interpretation, holding that it was contrary to the plain meaning of the Act.¹¹¹ The court agreed that “or” means “or.”¹¹² The court’s plain meaning approach effectively lifted any HHS-imposed limitation on the number of days per week that health services could be provided.¹¹³ As support for its interpretation, the court turned to the legislative history of this provision and found that “Congress plainly expressed its desire to permit beneficiaries to obtain realistic home health care to be provided without any limit on the number of days per year if such care is provided less than seven days each week.”¹¹⁴ Though this declaration was certainly precedential, the true impact of *Duggan* can be traced to its remedy. The court issued an injunction against HHS from denying Medicare for home

104. See *Duggan v. Bowen*, 691 F. Supp. 1487, 1492, 1496 (D.D.C. 1988).

105. 691 F. Supp. 1487 (D.D.C. 1988).

106. See *id.* at 1489, 1491-92. The opinion notes that the plaintiffs did not contest HHS’s application of the initial eligibility requirements (which uses only the term “intermittent”). See *id.* at 1511 n.38. Rather, plaintiffs challenged HHS’s interpretation of the “part-time or intermittent” care accorded to individuals meeting the initial eligibility requirements. See *id.*

107. See *id.* at 1491-92.

108. See *id.*

109. See *id.* at 1495-96.

110. *Id.* at 1492.

111. See *id.* at 1511.

112. See *id.* at 1511 n.39.

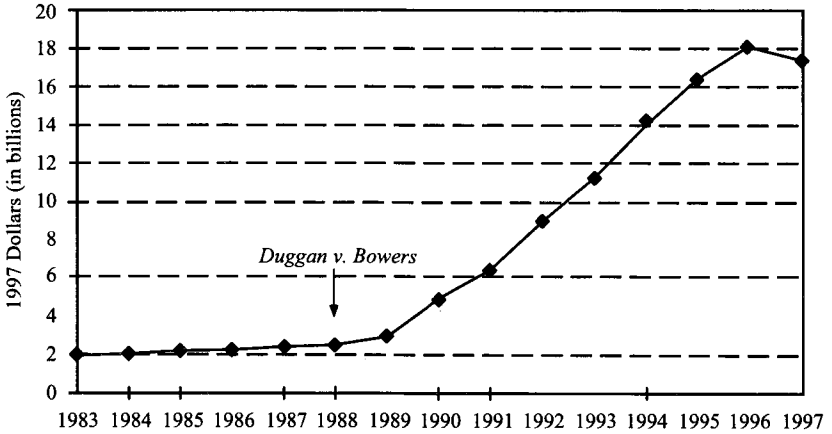
113. See *id.* at 1512.

114. *Id.* at 1513.

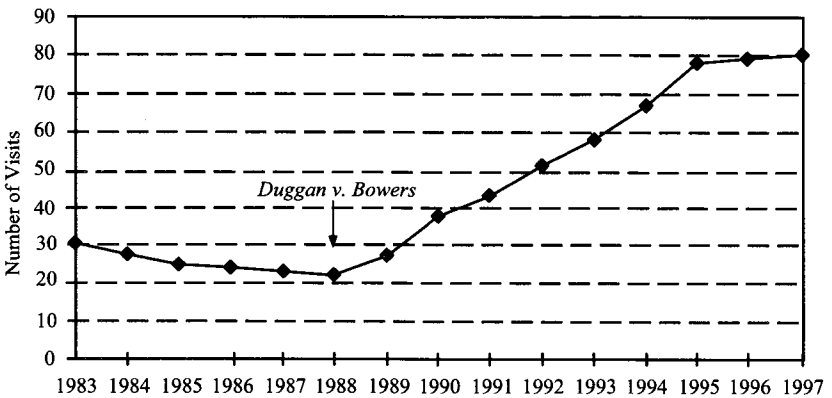
health care services that have or will be denied based on HHS’s “part-time or intermittent” policy interpretation.¹¹⁵

The *Duggan* decision in 1988 effectively expanded the amount and frequency of services covered by Medicare and prompted a dramatic increase in the amount of expenditures on home health care, as seen in the graph below.

Home Health Care Expenditures 1983-1997¹¹⁶



Average Number of Home Health Visits per Medicare Beneficiary 1983-1997¹¹⁷



115. See *id.* at 1515.

116. See Health Care Fin. Admin., Office of the Actuary, available at <<http://www.hcfa.gov>>.

117. See *id.*

The *Duggan* decision required a series of new policy provisions regarding the frequency of care. The revised Medicare Home Health Care Manual explains the parameters of “intermittence” in two components. The first component pertains to the eligibility of the beneficiary.¹¹⁸ To meet this first component, the patient must have a “medically predictable recurring need for skilled nursing services.”¹¹⁹ The second component of “intermittent” pertains to the frequency of visits allowed by Medicare in a given time frame.¹²⁰ To meet this component, the home health services must be provided on a part-time basis, as that term is defined in the manual.¹²¹ Taken together, these components form the following definition of intermittent:

- Up to and including twenty-eight hours per week of skilled nursing and home health aid services combined on a less than daily basis;
- Up to thirty-five hours per week of skilled nursing and home health aide services combined which are provided on a less than daily basis, subject to review by fiscal intermediaries on a case-by-case basis, based upon documentation justifying the need for and reasonableness of such additional care; or
- Up to and including full-time (i.e., eight hours per day) skilled nursing and home health aide services combined which are provided and needed seven days per week for temporary, but not indefinite periods of time of up to twenty-one days, with allowances for extensions in exceptional circumstances where the need for care in excess of twenty-one days is finite and predictable.¹²²

The limitations imposed by the concepts of “intermittent” and “part-time” have proven to be minimal. The definition is devoid of any significant restriction and permits the delivery of daily services as long as such services do not exceed the maximum time limits.¹²³ Moreover, HHAs appear to operate under a regular acquiescence on

118. See Medicare Home Health Agency Manual, *supra* note 16, § 204.1(C).

119. *Id.* The Manual explains that “[i]n most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.” *Id.*

120. See GAO REPORT I, *supra* note 3, at 17.

121. See Medicare Home Health Agency Manual, *supra* note 16, § 206.7(A). This definition is incorporated into the general definition of “intermittent” and is therefore not reproduced here. See *infra* note 122 and accompanying text.

122. Medicare Home Health Agency Manual, *supra* note 16, § 206.7(B).

123. See *id.*

the part of HCFA to not question daily visits during the first twenty-one days.¹²⁴

IV. Limitations on Home Health Care

The most glaring limitation on home health care is its potential for fraud and abuse. Federal investigators estimate that some \$4 of every \$10 disbursed by Medicare is the result of accidental overbilling or outright fraud.¹²⁵ The issue of fraud in home health care has received significant attention in the popular media with the federal investigation of Columbia/HCA Healthcare Corporation (Columbia/HCA), America's largest home health care provider. Columbia/HCA is currently the target of a criminal investigation focusing on whether it overbilled Medicare and other governmental health insurance programs.¹²⁶ Among the allegations against Columbia/HCA is that it committed fraud by funneling inpatient hospital patients into home-health agencies owned by the hospital (otherwise referred to as "self-referral").¹²⁷ This type of fraud would have enabled Columbia/HCA's hospital to disguise nonreimbursable hospital costs as reimbursable home health care costs.¹²⁸ If such allegations are proven true, Columbia/HCA would certainly not be alone in the commission of such fraudulent activities; however, the federal government is treating it as the sacrificial lamb in the government's fight against home health care fraud.

The primary responsibility of identifying fraudulent activities falls upon the regional home health intermediaries who are charged with the responsibility to conduct both prepayment and postpayment audits of HHAs.¹²⁹ The Consolidation Omnibus Budget Reconciliation Act of 1985 more than doubled the amount of funds available for

124. See GAO REPORT I, *supra* note 3, at 17.

125. See Goldstein, *supra* note 8.

126. See *Analysis: Widening Investigation into the Charges of Billing Fraud Against the Columbia/HCA Hospital Chain* (CBS Morning News broadcast, Aug. 19, 1997), available at 1997 WL 5619749.

127. See *Hospitals Funnel Patients to Their Home-Care Clinics Issue One Target of Columbia/HCA Probe*, ST. LOUIS POST-DISP., Sept. 3, 1997, at 5C.

128. See *id.*

129. See Medicare Intermediary Manual, *supra* note 17, § 1202. Prepayment reviews take the form of a medical review of a claim, which the intermediary has the authority to deny. See Interview (Oct. 16, 1997), *supra* note 31. Postpayment review takes the form of audits which can result in Medicare reimbursement, suspension of certification, or other sanctions. See *id.*

medical review and audit of Medicare claims.¹³⁰ In fiscal years 1986 and 1987, intermediaries reviewed approximately 62% of all claims and, in the years 1985 and 1987, denied approximately 10% of claims submitted for review.¹³¹ However, due to budget cuts, intermediaries have reduced the number of medical reviews to approximately 3.2% of all claims.¹³² As a result, a denial of a claim has become an endangered species, with only 0.6% denied in all of 1994.¹³³ In fact, intermediaries are now permitted to “assume that the type of services ordered are reasonable unless objective clinical evidence clearly indicates otherwise, or there is a lack of clinical evidence to support coverage.”¹³⁴

Intermediaries have also fallen far behind in their postpayment auditing procedures. In fiscal year 1994, intermediaries conducted only fifty-one on-site audits, amounting to less than 1% of all Medicare-certified HHAs.¹³⁵ To remedy these deficiencies, HHS in concurrence with the President’s moratorium, assured that it would double the number of audits conducted by intermediaries to 1,800 annually.¹³⁶ Nevertheless, HHS’s proposal is still quite modest considering that the program has some 10,000 providers with nearly 20 million claims filed annually.¹³⁷

In addition, the nine intermediaries appear overburdened in their task of monitoring the claims and cost formulations of the over 10,000 HHAs with any sufficient detail.¹³⁸ The intermediaries make

130. See GAO REPORT I, *supra* note 3, at 20.

131. See *id.*

132. See *id.*

133. See *id.*

134. *Id.* at 18. This report criticizes the current HCFA billing form for not requesting adequate information to make this determination. See *id.* at 19.

135. See *id.* at 21. The lackluster performance may well be explained as follows:

Intermediaries are required to perform 10 on-site [audits] each year for all provider types, including, for example, outpatient, skilled nursing, and rehabilitation facilities. An HCFA representative noted that [audits] are so resource intensive that they may be done only in instances where a high level of return is expected. Because HHA claims may comprise a relatively small portion of an intermediary’s total claims volume, the intermediary may not do *any* home health [audits].

Id. (emphasis added).

136. See Goldstein, *supra* note 8.

137. See *id.*

138. See, e.g., *Chaves County Home Health Serv. v. Sullivan*, 732 F. Supp. 188, 189 (D.D.C. 1990) (stating that HHS supported a sampling method to calculate overpayments because of a “logical impossibility of affording an individual review to every Medicare claim”).

reimbursement payments to providers at least monthly based on an estimated cost basis.¹³⁹ Monthly payments are subject to retroactive adjustment only at the end of the provider's cost reporting period.¹⁴⁰

In response, several intermediaries have turned to questionable auditing procedures, such as the use of statistical methods instead of case-by-case review.¹⁴¹ These practices conflict with the provisions of the Medicare Home Health Care Manual, which focus on individualized need and not "rule of thumb" determinations.¹⁴² This conflict appears to call for a less-attenuated reimbursement system that is based more on actual cost than on formulation.

To fully understand the ineffectiveness of monitoring this overbilling, one only needs to look at the study of just eighty high-dollar claims reported to Congress by the General Accounting Office (GAO).¹⁴³ In this study, an independent claims contractor studied eighty high-dollar claims submitted in May 1995 and found that some \$135,000 in charges (about 43% of total charges submitted) should have been denied under current law.¹⁴⁴ The findings are consistent with prior federal investigations, one of which estimated that in February 1993 alone, Medicare paid \$16.6 million in claims that should not have been submitted.¹⁴⁵

Though the evidence of overbilling is overwhelming, proving fraud remains an arduous task. Criminal prosecution for Medicare fraud can be based on any number of statutes,¹⁴⁶ the most notable being the set of statutes designed specifically for Medicare and Medicaid fraud.¹⁴⁷ These statutes govern three methods of fraud: false claims,

139. See 42 C.F.R. § 413.64(a)-(b) (1997).

140. See *id.* § 413.64(f)(1); see also *infra* notes 155-57 and accompanying text.

141. See *Sullivan*, 732 F. Supp. at 189.

142. See *Rizzi v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 42,768, at 42,309, available at 1994 WL 686630, at *4 (D. Conn. Sept. 29, 1994) ("The revised guidelines also contain numerous provisions designed to insure that coverage determinations are based on individual needs.").

143. See U.S. General Accounting Office, Letter Report to Sen. Tom Harkin, Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, Medicare: Need to Hold Home Health Care Agencies More Accountable for Inappropriate Billings, at 1 (July 13, 1997) [hereinafter *Inappropriate Billings Hearings*].

144. See *id.*

145. See *id.*

146. Criminal prosecution can be based on the Social Security Act, the False Statements Act, or more generic criminal fraud statutes. See Kristine DeBry et al., *Health Care Fraud*, 33 AM. CRIM. L. REV. 815, 818 (1996).

147. See 42 U.S.C. § 1320a-7b (1994 & Supp. II 1996).

“kickbacks,” and self-referrals.¹⁴⁸ Though each method carries significant penalties,¹⁴⁹ the requirement that the government prove a *mens rea* severely limits successful prosecution.¹⁵⁰

The analogue to fraud, or purposeful overbilling, is *legal billing*—a practice that ironically contributes more to runaway health care costs than fraud itself.¹⁵¹ Indeed, legislators criticize the President’s focus on fraud, claiming the solution lies not merely in curbing fraud, but in reducing demand for the program.¹⁵² One commentator aptly stated that what ails home health care are billing practices that are perfectly legal under the current system.¹⁵³ Indeed, *Duggan* caused an exponential growth in health care expenditures because it created a very wide breadth of coverage.¹⁵⁴

Under the current system,¹⁵⁵ providers must file annual cost reports with their respective intermediaries for the reimbursement of costs.¹⁵⁶ The intermediary then determines the amount of reimbursement based upon its analysis and audit of this cost report and sets forth its determination in a Notice of Program Reimbursement.¹⁵⁷ The amount payable under the program is based upon the “reasonable cost” of the services provided to the beneficiary.¹⁵⁸ “Reasonable costs” are the “cost[s] actually incurred, excluding therefrom any part of the

148. *See id.* §§ 1320a-7b, 1395nn.

149. Penalties under the false claims section or antikickback prohibition may include a fine not exceeding \$25,000, imprisonment for not more than five years, or both. *See id.* §§ 1320a-7b(a), (b). Under the self-referral section, any number of the following penalties may be imposed: (1) denial of payment; (2) mandatory refunds to individuals who were billed; (3) a civil penalty (of not more than \$15,000 for each bill or claim); and/or, (4) exclusion from Medicare and Medicaid. *See id.* § 1395nn.

150. Under the false claims section, the government must prove that the defendant knowingly and willfully made the statement. *See id.* § 1320a-7b(a). Under the antikickback prohibition, “the [g]overnment must prove that the defendants ‘knew their conduct was unlawful.’” *The Hanlester Network v. Shalala*, 51 F.3d 1390, 1400 (9th Cir. 1995); *see also* 42 U.S.C. § 1320a-7b(b). Under the self-referral provisions, the only apparent requirement for *mens rea* is the imposition of civil fines. *See id.*; *see also* DeBry, *supra* note 146, at 829 (stating that for imposition of civil fines, government must prove that defendant “knows or should know” the claim violates the self-referral law).

151. *See* George Anders & Eva M. Rodriguez, *By the Book: Never Mind the Fraud; What Ails Medicare Is Often Perfectly Legal*, WALL ST. J., Oct. 9, 1997, at 1.

152. Senator Harkin of Iowa characterized the President’s moratorium as “about a half step.” Goldstein, *supra* note 8 (quoting Senator Tom Harkin).

153. *See* Anders & Rodriguez, *supra* note 151.

154. *See supra* notes 105-16 and accompanying text and graph.

155. *See infra* notes 219-26 (discussing shift to prospective payment system).

156. *See* 42 C.F.R. § 413.20 (1997).

157. *See id.* § 405.1803.

158. *See id.* § 413.64(a), (b).

incurred cost found to be unnecessary in the efficient delivery of needed health services."¹⁵⁹ This formulation gives the HHA a dollar-for-dollar cost reimbursement based on *actual* cost of delivering the service.¹⁶⁰ For example, if an HHA compensates a therapist or nurse on a per-visit basis, the HHA receives a dollar-for-dollar reimbursement according to the number of visits. In this situation, both the employee and the HHA have an incentive to maximize visits or even overvisit the beneficiary. In *In Home Health, Inc. v. Shalala*,¹⁶¹ the District Court for the District of Minnesota found this practice to be within the rules, at least where the HHA is using its own employees.¹⁶² Such practices, however, lead to overuse and overbilling.¹⁶³

One current means of controlling the "valve" on overbilling is the statutory provision giving HHS the ability to offset the "actual cost" by that amount "found to be unnecessary in the efficient delivery of needed health services."¹⁶⁴ HHS has developed a policy for computing these cost limitations.¹⁶⁵ The analysis of cost limitations involves two components: (1) computing the cost limitation across all HHAs and (2) applying the cost limitation to each HHA.¹⁶⁶ However

159. 42 U.S.C. § 1395x(v)(1)(A) (1994).

160. This proposition is limited to HHAs using their own employees and is not the rule for services furnished by outsiders. This latter situation is governed by 42 C.F.R. § 413.106. See *infra* note 162.

161. Medicare & Medicaid Guide (CCH) ¶ 45,129 (D. Minn. Mar. 5, 1997), available at 1997 WL 269486.

162. See *id.* ¶ 53,215. The regulations provide the following formulation designed specifically for "physical or other therapy services," for "outside" providers:

The reasonable cost of services of physical therapists . . . furnished under arrangements . . . with a provider of services . . . may not exceed an amount equivalent to the *prevailing salary* and additional costs that would reasonably have been incurred by the provider . . . had such services been performed by such person in an employment relationship.

Id. ¶ 53,212 (quoting 42 C.F.R. § 413.106(b)(1)) (alterations in original) (emphasis added).

The "prevailing salary" is defined as "the hourly salary rate based on the 75th percentile of salary ranges paid by providers in the geographic area by type of therapy, to therapists working full time in an employment relationship." *Id.* ¶ 53,213. This "prevailing wage" theory, though certainly not the solution to the problem, at least addresses some mechanism of cost control. See Interview (Oct. 16, 1997), *supra* note 31.

163. Many HHAs compensate their employees based upon a fixed-rate salary to avoid this temptation. See Interview (Oct. 16, 1997), *supra* note 31.

164. 42 U.S.C. § 1395x(v)(1)(A).

165. See GAO REPORT II, *supra* note 32, at 11.

166. See *id.*

noble this restraint, the cost limitations, as currently structured, pose no threat to spiraling costs.

The current method of computing the foregoing cost limitations is a primary (though surprisingly not well known) contributor to the rising cost of home health care. Until 1985, HCFA set cost limitations using the percentile method.¹⁶⁷ Under this method, HCFA ranked the standardized costs for each type of visit category ranging from the highest-cost HHA to the lowest-cost HHA.¹⁶⁸ Based on this ranking, the overall HHA cost limit for the applicable type of visit was set equal to the amount that fell at the seventy-fifth percentile mark within the rankings for that specific type of visit.¹⁶⁹ In 1985, HCFA shifted its policy of computation to the percentage-of-mean method.¹⁷⁰ Under this method, the average or mean standardized cost of all HHAs is computed.¹⁷¹ This mean is then multiplied by the applicable percentage, currently 112%,¹⁷² to arrive at the cost limit.¹⁷³ Although this change seems little more than an algebraic exercise, the GAO concluded that the use of the percentage-of-mean approach, as opposed to the percentile method, increases the cost limits.¹⁷⁴

Another key deficiency in the cost limitations is HHS's method in applying these limitations. Beginning in 1979, HHS established a system for applying cost limits on what Medicare will pay for home health care.¹⁷⁵ A maximum amount is set for each type of visit: skilled nursing; physical, speech, or occupational therapy; medical social services; and home health aide services.¹⁷⁶ The maximum amount an HHA could seek in reimbursement was determined by summing the products of the number of each type of visit provided by the cost limit for each type of visit.¹⁷⁷ Thus, the costs exceeding the limit for one type of visit could be offset to the extent that the HHA's costs were below the limit for another type of visit.¹⁷⁸ Thus, notwithstand-

167. See *id.* at 24.

168. See *id.*

169. See *id.*

170. See *id.*

171. See *id.*

172. Congress recently took steps to reduce the cost limitation to 105% of mean; this change will take effect in 1999. See *infra* Part V (discussing Balanced Budget Act of 1997).

173. See GAO REPORT II, *supra* note 32, at 24.

174. See *id.*

175. See *id.*

176. See *id.*

177. See *id.*

178. See *id.*

ing individual cost limitations, HHAs considered cost limitations in the aggregate.¹⁷⁹ In 1985, HHS changed its regulations on cost limitations to effectively eliminate this means of aggregation.¹⁸⁰ However, no sooner had HHS changed such policy, it reverted back to the aggregation method in 1986.¹⁸¹

In a 1990 study of home health care, GAO estimated that if HHA cost limits had been applied by type of visit and without offset, Medicare payments would have been \$49 million lower for the previous year.¹⁸² Some critics argue, however, that this approach may cause decreased access to care if home health agencies dropped certain services or stopped participation because of lower limitations on reimbursement.¹⁸³ Additionally, the cost reductions may correspondingly lead HHAs to decrease their quality of care.¹⁸⁴ However, GAO addressed both of these concerns and found only negligible impact.¹⁸⁵ Although a potential reduction in quality of care may be difficult to quantify, GAO concluded that only one-half of the HHAs it surveyed would be affected, and even those would have cost reductions representing less than 1% of their Medicare revenues.¹⁸⁶

Another glaring problem with the current structure is the amount and frequency of nonmedical services provided. Recall that home health aide services, though perhaps containing no medical basis, are reimbursable expenses if coupled with otherwise reimbursable nursing services.¹⁸⁷ This structure creates a system of federally funded companionship.¹⁸⁸ Again, these services are perfectly legal under the current Medicare reimbursement scheme.

179. *See id.*

180. *See id.* at 12.

181. *See id.*

182. *See id.*

183. *See id.*

184. *See id.*

185. *See id.*

186. *See id.*

187. *See Medicare Home Health Agency Manual, supra* note 16, § 205.1(B)(4); *see also infra* notes 188-90 and accompanying text.

188. Carolyn Hughes Crowley writes that a *skilled* nurse "should discuss non-medical matters, such as the plumber's and electrician's names and telephone numbers, the shut-off valve for the furnace, exits, family members' phone numbers and the establishment of a logbook." Carolyn Hughes Crowley, *Solving the Home Health-Care Equation; When Aging Parents Ail*, WASH. POST, Oct. 29, 1996, at E5. Though Crowley was trying to paint a picture of a compassionate caregiver giving assistance to an ailing patient, her article only serves to fuel the debate over whether such services (ranging in cost from \$50-100 per hour) should come at the expense of Medicare's home health care program.

This problem is exacerbated by the sheer frequency of visits, a natural by-product of the ineffectiveness of the "part-time" or "intermittent" requirement.¹⁸⁹ Even with the "part-time" and "intermittent" policy limitations, advocates have successfully appealed Medicare denials of coverage for services provided in excess of thirty-five hours per week.¹⁹⁰ Certainly, the *Duggan* decision is the source of the dilemma. Discussing the post-*Duggan* reimbursement policies, one scholar states that the "lesson [learned] from this experience is that statutory coverage standards are not able to serve as cost-containment vehicles because, when applied retrospectively, they unduly curtail discretion and harm beneficiaries."¹⁹¹ Moreover, the statutory methods for limiting visitations do not reflect the consensus of the medical community about the delivery of care.¹⁹² However, as one scholar properly notes, providers who find themselves in a situation of overvisiting the beneficiary in the medical sense, yet still within the visitation limits in the legal sense, are faced with the ethical dilemma of deciding whether to terminate the provision of services.¹⁹³

Likewise, the "homebound" limitation is ineffective in filtering out undeserving beneficiaries. For instance, federal investigators found evidence that some home health care beneficiaries were declared "homebound" for simply not owning a car.¹⁹⁴ Another purportedly "homebound" beneficiary postponed treatments so she could go fishing.¹⁹⁵

The problems of overbilling individual claims, accidental or otherwise, sheds light on a more global problem: the ease of entry

189. "The average patient's frequency of use of home health services has surged from twenty-two visits per beneficiary in 1980 to thirty-three visits in 1990 to seventy-six visits in 1996." Merrill Goozner, *Pay Shrinks as Home Health Care Grows: For-Profits Cut Benefits to Keep Costs Low*, HOUS. CHRON., May 28, 1997, at 7.

190. See JOE BAKER, MEDICARE HEALTH MAINTENANCE ORGANIZATIONS: NUTS AND BOLTS 127 (PLI Tax Law & Estate Planning Course Handbook Series No. D4-5270, 1997). The process of commencing an appeal of an initial denial of coverage is quite simple and may involve merely a one-line letter directed to the intermediary. For a discussion on the appeals process of Medicare coverage determinations, see Anthony Szczygiel, *Long Term Care Coverage: The Role of Advocacy*, 44 U. KAN. L. REV. 721, 756-59 (1996).

191. Eleanor D. Kinney, *Medicare Managed Care from the Beneficiary's Perspective*, 26 SETON HALL L. REV. 1163, 1188 (1996).

192. See *id.* at 1188-89.

193. See Brummel-Smith, *supra* note 26, at 499. The issue of ethics in the provision of home health care has received only limited scholarly attention and has been overshadowed by the larger issue of cost-containment.

194. See R.A. Zaldivar, *Battle Looming on the Home Front: Health Care Cost Key Element in Proposals*, FLA. TIMES-UNION, May 22, 1997, at A1.

195. See *id.*

into and continuance in the home health care market. Medicare imposes twelve conditions of participation, covering areas such as patient rights; acceptance of patients, plans of care, and medical supervision; and skilled nursing services.¹⁹⁶ HCFA can reimburse only those HHAs that have been surveyed and certified as meeting these conditions of participation.¹⁹⁷ Notwithstanding this "filter" process, these conditions pose an insignificant barrier to entry into the home health care market. First, the HHA is permitted to self-certify that many of the conditions for certification are or will be met.¹⁹⁸ Second, the survey accompanying the certification process is limited in its scope and investigation.¹⁹⁹ The weakness of this barrier to entry is cited by critics to be one of the primary reasons why some 100 new HHAs were being certified every month.²⁰⁰

Since the date of the moratorium, HHS has considered the promulgation of new rules aimed primarily at restricting new HHA entry into the Medicare program.²⁰¹ Some of these rules include requiring

196. See 42 C.F.R. § 484 (1997). The conditions of participation include the following:

- (1) Patient rights, *see id.* § 484.10;
- (2) Compliance with federal, state and local laws, disclosure of ownership information, and compliance with accepted professional standards and principles, *see id.* § 484.12;
- (3) Organization, services, and administration standards, *see id.* § 484.14;
- (4) Group of professional personnel (which includes at least one physician and one registered nurse), *see id.* § 484.16;
- (5) Acceptance of patients, plan of care, and medical supervision requirements, *see id.* § 484.18;
- (6) Skilled nursing services, *see id.* § 484.30;
- (7) Therapy services, *see id.* § 484.32;
- (8) Medical social services, *see id.* § 484.34;
- (9) Home health aide services, *see id.* § 484.36;
- (10) Qualifying to furnish outpatient physical therapy or speech pathology services, *see id.* § 484.38;
- (11) Maintaining clinical records of patients, *see id.* § 484.48;
- (12) Evaluation of HHA by professional personnel, the HHA staff, consumers, or outside professionals, *see id.* § 484.52.

197. See 42 U.S.C. §§ 1395x(o), 1395bbb(a) (1994).

198. See *Medicare Home Health Agencies: Certification Process Is Ineffective in Excluding Problem Agencies*, Hearing Before the Senate Special Comm. on Aging, 105th Cong. 2 (1997) (statement of Leslie G. Aronovitz, Associate Director of Health Finance and System Issues; Health, Education, and Human Services Division).

199. See *id.* Interestingly, the Social Security Act does not require HHA owners to have any prior health care experience. See *id.* Aronovitz testified that they found one HHA owner whose most recent work experience was driving a taxi cab and another who was operating a pawn shop in addition to his HHA. See *id.*

200. See *id.* This of course excludes the recent moratorium, which effectively halted any new certifications. See *supra* Part II.

201. See *Combating Medicare Waste, Fraud and Abuse Through Information Technologies*, Hearings Before the Subcomm. on Oversight & Investigations of the House Comm.

the HHA to: "(1) post surety bonds of at least \$50,000; (2) show proof that they have served a specified number of patients; and (3) submit detailed information about their business operations."²⁰² These rules, however, focus solely on restricting Medicare-certified market entry for HHAs and do not address the larger problem of cost-containment.

Another significant drawback of the home health care system is the lack of any meaningful involvement by the physician.²⁰³ The most obvious reason for this limitation is found in the law *itself*, as nothing in the Act or regulations requires the physician be involved in the delivery of home health care beyond certification and plan approval.²⁰⁴ Interestingly, when Congress expanded Medicare to include home health care in 1965, it was purportedly seeking to "increase the dwindling physician involvement in home health care by conditioning the provider's reimbursement on physician supervision."²⁰⁵ Currently, however, the *only* substantive physician-related requirement, the physician's signature, "represent[s] little more than a tacit accommodation to permit third party reimbursement of the agency."²⁰⁶

on Commerce, 105th Cong. (1997) (statement of Bruce Merlin Fried, Director, Center for Health Plans and Providers, Health Care Financing Administration).

202. Elizabeth Shogren, *supra* note 4. For a detailed discussion of these rules, see *infra* Part V.B.

203. See Brummel-Smith, *supra* note 26, at 497; Weitzman, *supra* note 32, at 27 ("[M]eaningful physician involvement in home care services is mediocre at best"); Susan Cowan Atkinson, Comment, *Medicare 'Cost Containment' and Home Health Care: Potential Liability for Physicians and Hospitals*, 21 GA. L. REV. 901, 910 (1987). Ms. Atkinson states:

That physicians are rather detached from the process of providing patients with home health care is not particularly surprising, for Medicare does not reimburse physicians for their supervision. Notwithstanding the requirement that they participate, there is no incentive other than goodwill for doctors to become involved with patients receiving home care, and plans frequently end up drawn entirely by the home health care provider.

Id. at 911 (citation omitted).

204. The Medicare Home Health Agency Manual provides:

It is not intended that you [the HHA] contact the physician's office to account for patient's visits. It is expected but not required for coverage that the physician who signs the plan of care will see the patient, but there is no specified interval of time within which the patient is expected to be seen. Your intermediary evaluates the patient's medical condition. *Visits are not denied solely on the basis that the physician does not see the patient.*

Medicare Home Health Agency Manual, *supra* note 16, § 234.8 (emphasis added).

205. Atkinson, *supra* note 203, at 910.

206. Weitzman, *supra* note 32, at 27. Once more, courts have upheld a physician's certification as valid even when made retroactively. See, e.g., *Hayner v. Weinberger*, 382 F. Supp. 762 (E.D. N.Y. 1974) (holding that physician could retroactively certify need for extended care treatment of patient). The implication is

Another reason for the absence of physician participation is the low level of compensation, if any, for home health care.²⁰⁷ Physicians are neither compensated nor reimbursed for telephone consultations or other monitoring services provided to the beneficiary.²⁰⁸ Also, Medicare does not reimburse "house calls" in furtherance of monitoring activity, thereby exacerbating the disincentive for physicians to become involved in the delivery of home health care services.²⁰⁹ Costs alone give physicians no incentive to make home visits in order to inspect the level of care being provided and no reason to deny home health care by not prescribing it.

Another key limitation to the home health care system is its lack of copayments or deductibles. As the system currently exists, so long as the HHA meets its certification requirements, the services provided are fully reimbursable by Medicare.²¹⁰ Contrast this policy with Medicare's hospital insurance program,²¹¹ its skilled nursing facility program,²¹² and its hospice care program,²¹³ all of which impose numerous deductibles and coinsurance payments. Congress has proposed deductibles or cost-sharing alternatives for home health care, though no such provision has found its way into the Code.²¹⁴

clear: the physician's signature is solely a precondition to reimbursement—and does not act as a filter to limiting the provision of care.

207. See *id.*; Brummel-Smith, *supra* note 26, at 497-98.

208. See Weitzman, *supra* note 32, at 27.

209. See *id.* at 27-28.

210. See 42 U.S.C. §§ 1395d, 1395f(a)(2)(D) (1994).

211. Medicare covers 90 days of hospital care per spell of illness plus an additional 60 exhaustible lifetime reserve days. See *id.* §§ 1395d(a)(1), 1395e(a)(1). Medicare imposes a \$540 first day deductible per spell of illness, see 42 C.F.R. § 409.80 (1997); a \$135/day coinsurance payment for the 61st through 90th day of care, see *id.* § 409.83; and a \$270/day coinsurance payment for each lifetime reserve day. See *id.* § 409.83.

212. Limited coverage for skilled nursing facilities is available for up to 100 days during a spell of illness. See 42 U.S.C. § 1395d. A beneficiary under this plan of care is subject to a coinsurance premium of \$67.50 for days 21 through day 100. See 42 C.F.R. § 409.85.

213. Medicare places no limits upon the number of days that it will cover for hospice care. See Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4006(a), 104 Stat. 1388, 1388-43. The hospice patient is responsible for five percent of the cost of respite care and the lesser of five dollars or five percent per prescription. See 42 U.S.C. § 1395e(a)(4).

214. The Senate passed an amendment to the bill which ultimately became the Balanced Budget Act of 1997, that would have established a five-dollar per visit copayment for home health services, however the amendment was ultimately defeated. H.R. CONF. REP. NO. 105-2015 (1997), 143 CONG. REC. H6237. Congress has also considered and rejected a 20% cost-sharing requirement. See Long-term Care Family Security Act of 1992, H.R. 4848, S. 2571, 102d Cong.

Aside from these primary limitations, "lesser known" limitations permeate the home health care system. Take, for example, one commentator's view that home health care actually reduces an elderly person's autonomy.²¹⁵ This view is a certain departure from what many assumed to be true: home health care offers more freedom than the alternative choice of skilled nursing facilities.²¹⁶ The point, however, is still well taken. Indeed, patients in home health care have little if any input in the provision of services.²¹⁷ They are not involved in the development of a plan of care.²¹⁸ Moreover, they do not review or even receive billing statements.²¹⁹ Though having little bearing on costs to the system, these types of alternative limitations are nonetheless useful in understanding the more universal limitations on the home health care system.

V. Solutions

A. Congress's First Step Towards a Solution: The Balanced Budget Act of 1997

It seems all too appropriate that on the eve of the ten-year anniversary of *Duggan*, Congress took its first steps towards curbing the home health care crisis with the passage of the Balanced Budget Act of 1997.²²⁰ Unfortunately, a close analysis of the Act reveals that these "steps" are insufficient in reversing the trend that *Duggan* helped initiate.

Perhaps the most significant measure of the Act is the establishment of a prospective payment system.²²¹ The Act requires HHS to develop and implement a prospective payment system for payments for home health services.²²² The prospective payment system for home health care seems to borrow from the limited success that the

215. See Peter J. Ferrara, *Expanding the Autonomy of the Elderly in Home Health Care Programs*, 25 NEW ENG. L. REV. 421, 427-28 (1990).

216. See Bergquist, *supra* note 1, at 35 ("A profound loss of autonomy accompanies placement in a nursing home.").

217. See Ferrara, *supra* note 215, at 434 ("No mention is made of any role by the recipient in selecting the provider.").

218. See Interview (Oct. 16, 1997), *supra* note 31.

219. See *id.*

220. Pub L. No. 105-33, 111 Stat. 251.

221. See *id.* § 4603(a), 111 Stat. at 467 (codified at 42 U.S.C.A. § 1395fff(a)(West Supp. 1998)).

222. See *id.*

prospective payment system has had on hospitalization costs.²²³ Providing limited guidance,²²⁴ Congress has left the design of such a payment system to the wisdom of HHS.²²⁵ However, at its essence, the prospective payment system will be based on a standardized payment amount, based initially on prior cost reporting data, "that eliminates the effects of variations in relative case mix and wage levels among different home health agencies."²²⁶ The Act provides a series of adjustments to this standardized payment amount²²⁷ and a means to annually increase or index the amount.²²⁸

The Act effectively reduces the cost per visit limitations from 112% of mean labor-related and nonlabor visit costs to 105% of the

223. See 143 CONG. REC. E1720-01 (daily ed. Sept. 10, 1997) (statement of Rep. Hamilton) ("Medicare's prospective payment system for hospitals has helped curb payments to providers. [This system] has created incentives for hospitals to be more efficient.")

224. The Act provides:

In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

Balanced Budget Act of 1997 § 4603(a), 111 Stat. at 468 (codified at 42 U.S.C.A. § 1395fff(b)(2)).

225. HHS's discretion to develop this system seems unfettered. Indeed, Congress precluded administrative or judicial review of HHS's establishment of the payment amounts and all applicable adjustments. See *id.* § 4603(a), 111 Stat. at 470 (codified at 42 U.S.C.A. § 1395fff(d)(1)-(6)).

226. *Id.* § 4603(a), 111 Stat. at 468 (codified at 42 U.S.C.A. § 1395fff(b)(3)(A)(i)).

227. See *id.* The Act provides the following adjustments:

Case Mix Adjustment—"The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of service." *Id.* § 4603(a), 111 Stat. at 469 (codified at 42 U.S.C.A. § 1395fff(b)(4)(B)).

Area Wage Adjustment—"The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level." *Id.* § 4603(a), 111 Stat. at 469 (codified at 42 U.S.C.A. § 1395fff(b)(4)(c)).

Outliers—"The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year." *Id.* § 4603(a) 111 Stat. at 469 (codified at 42 U.S.C.A. § 1395fff(b)(5)).

228. See *id.* § 4603(a) 111 Stat. at 468 (codified at 42 U.S.C.A. § 1395fff(b)(3)(B)). Interestingly, Congress chose not to preclude judicial review of HHS's determination of the annual percentage increases.

median of such costs.²²⁹ The Act requires HHS to eventually incorporate these cost limitations in its prospective payment system.²³⁰ In the meantime, the Act introduces a system of interim payment limits whereby Medicare will reimburse HHAs for the lowest of: (1) actual costs; (2) the per visit limits; or (3) an annual blended agency-specific per beneficiary limit.²³¹

In addition, home health services will be paid based on the location where the service is provided, rather than where the service is billed.²³² Though HCFA touts this provision as having the potential to reduce the Medicare payments,²³³ it has this effect *only* where the HHA is located in an urban area and the particular patient is located in a rural area. It may well have the reverse effect if the HHA is located, say, in a suburban area (which meets the HCFA's standards for rural) and the patient is located in an urban area.

The Act also includes a "bookkeeping" measure whereby home health services will be gradually transferred from Part A to Part B.²³⁴ Currently, Part A is financed through separate payroll contributions paid by employees, employers, and self-employed persons.²³⁵ Part B is financed by monthly premiums of those who voluntarily enroll in the Medicare program and by the federal government which makes contributions from general revenues.²³⁶ Collectively, these funds are deposited in a separate account known as the Federal Supplementary Medical Trust Fund.²³⁷ Under the Balanced Budget Act, Medicare Part A will continue to cover the first 100 visits following a three-day stay in a hospital or skilled nursing facility.²³⁸ Beyond this, expenditures for home health care will gradually transfer from Part A to Part B in a six-year phase-in period.²³⁹ Accompanying the shift of expendi-

229. See *id.* § 4602(a), 111 Stat. at 466.

230. See *id.* § 4603(a) 111 Stat. at 468 (codified at 42 U.S.C.A. § 1395fff(b)(3)(A)).

231. See *id.* § 4602(c), 111 Stat., at 466.

232. See *id.* § 4604(a), 111 Stat. at 472.

233. See *Hearing on Health Care Fraud Before the Subcomm. on Health of the House Ways & Means Comm.*, 105th Cong. (1997) (statement of Linda A. Ruiz, Director of Program Integrity, Health Care Financing Administration) (discussing provisions of Balanced Budget Act of 1997).

234. See Balanced Budget Act of 1997 § 4611(a), (e), 111 Stat. at 472-73.

235. See Medicare Home Health Agency Manual, *supra* note 16, § 102.

236. See *id.*

237. See *id.*

238. See Balanced Budget Act of 1997 § 4611(a), 111 Stat. at 472.

239. See *id.* § 4611(e). The transition from Part A to Part B will occur in constant increments, beginning with 1/6 in 1998, 1/3 in 1999, and so on, until the transition is 100% complete in 2003. See *id.* § 4611(e)(2), 111 Stat. at 473.

tures to Part B is an increase in the Part B premium, which will be phased in over a seven-year period.²⁴⁰ The primary purpose of transfer is the preservation of the life of the Hospital Trust Fund of Part A.²⁴¹ However, the maneuver has been labeled “a shell game” and a “way to avoid real Medicare reform.”²⁴² Indeed, one commentator aptly characterized the transfer as “really only bookkeeping, and it’s merely a shifting from the left hand to the right hand.”²⁴³

The Act requires the Secretary of HHS to submit annual reports to Congress that include an estimate of the outlays expected for home health care for fiscal years 1998 through 2002.²⁴⁴ The Secretary must also submit annual reports that compare the actual expenditures to these estimated outlays.²⁴⁵ If actual outlays are found to be greater than the estimated outlays for any given annual report, the report must include recommendations to reduce growth, such as beneficiary copayments or other methods.²⁴⁶ This provision appears to be little more than a matter of paperwork. If Congress is willing to await the Secretary’s reports, the imposition of beneficiary copayments could be delayed for another four to five years.²⁴⁷ The reports do nothing to analyze the current data surrounding the ten-year boom in home health care costs.²⁴⁸ Moreover, the reports are focused on aligning es-

240. See *id.* § 4611(e), 111 Stat. at 473. The phase-in will occur in constant increments, beginning with an increase in premium equal to 1/7 of the extra costs due to the transfer in 1998, a 2/7 increase in 1999, and so on, until the phase-in is 100% complete in 2004. See *id.* § 4611(e)(3), 111 Stat. at 473. The increase in premium is the apparent response to Republicans’ criticism that earlier plans of the President, which provided for the shift from Part A to Part B without any accompanying increase in premiums, exposed the burdens of home health care to the general revenues (thus risking a general tax hike). See Brian Tumulty, *Republican’s Rap Clinton’s Plan on Medicare Home Health Care Costs*, GANNET NEWS SERV., June 6, 1996, available at 1996 WL 4379311.

241. See Tumulty, *supra* note 240. HCFA seems to have found another reason, stating that the measure will “allow for better payment control.” HCFA Press Release, *HHS Halts Certification of Home Health Agencies; New Regulations Will Fight Fraud and Abuse* (Sept. 15, 1997), available at <<http://www.hcfa.gov/news/n970915.htm>>.

242. Geri Aston & Vida Foubister, *Delegates Oppose Shift in Home Health Care Costs*, AM. MED. NEWS, July 14, 1997, at 4.

243. *Id.* (quoting Donald C. Brown, M.D.).

244. See Balanced Budget Act of 1997 § 4616(a), 111 Stat. at 475.

245. See *id.* § 4616(b), 111 Stat. at 475.

246. See *id.*

247. Because the Balanced Budget Act calls for the estimation of costs from 1998 to 2002 and the annual comparison of actual costs to these estimated costs, Congress would not have the full extent of these reports until 2002. See *id.* § 4616(a), (b), 111 Stat. at 475.

248. See *supra* notes 3-5 and accompanying text (discussing increases in amount of money spent and agencies serving home health care).

timated costs with actual costs and do nothing to simply reduce cost, estimated or otherwise.²⁴⁹

The Act makes very little progress in addressing the frequency of visits or patient eligibility. First, the Act merely clarifies the “part-time” or “intermittent” requirements in conformity with the *Duggan* interpretation.²⁵⁰ The inability to address the substantive elements of this requirement seems to reflect a fundamental misunderstanding of the effect of *Duggan*.²⁵¹ Second, the Act does nothing to alter the ever-expanding definition of “homebound.”²⁵² Rather, the Act merely requires the Secretary of HHS to conduct a study on the criteria for determining whether an individual is “homebound” and submit the findings to Congress by October 1, 1998.²⁵³

B. HCFA's Response

Acting on the mandates of the Balanced Budget Act and the President's moratorium, HCFA proposed a series of new regulations aimed primarily at curbing fraud and abuse, with only a tangential focus on quality of care.²⁵⁴ These proposed rules do little more than respond to the mandates of the Balanced Budget Act of 1997.

HCFA recently proposed rules, requiring all HHAs to post a surety bond and meet certain minimum capitalization requirements, whether or not the HHA is currently certified.²⁵⁵ Under this rule, an HHA would be required to obtain a surety bond that is the greater of \$50,000 or 15% of the annual amount paid to the HHA by Medicare.²⁵⁶ Moreover, the HHA would be required to demonstrate that it has sufficient capital available to start and operate an HHA for the first three months.²⁵⁷ However, this latter requirement appears less concerned

249. See Balanced Budget Act of 1997 § 4616, 111 Stat. at 475.

250. See *id.* § 4612, 111 Stat. at 474.

251. Perhaps, however, there is another explanation: a statutory reversal of *Duggan* at this point would seem to strike the greatest blow to participation in the program—and would certainly represent a step far greater than those which Congress seemed willing to take in late 1997.

252. See *supra* notes 60-63 and accompanying text.

253. See Balanced Budget Act of 1997 § 4613, 111 Stat. at 474.

254. See *infra* notes 259-65 and accompanying text.

255. See Medicare & Medicaid Programs, Surety Bond and Capitalization Requirements for Home Health Agencies, 63 FED. REG. 292 (1998).

256. See *id.*

257. See *id.*

with fraud and abuse and more concerned with quality of patient care.²⁵⁸

HCFA also proposed a rule which would incorporate the prohibitions against self-referrals found in sections 1877 and 1903(s) of the Social Security Act into HHS regulations.²⁵⁹ These regulations prohibits a physician from making a referral to an HHA with which that physician or a member of the physician's family has a financial relationship.²⁶⁰ These rules are undoubtedly an outgrowth of the HCA/Columbia debacle and the President's policy of cutting down on fraud in the form of self-referrals.²⁶¹ In furtherance of this policy, HCFA has decided to reexamine its interpretations of Medicare regulations pertaining to compensation arrangements between the certifying physicians and HHAs.²⁶²

In addition to these rules, HHS Secretary Donna Shalala vowed to increase the number of claim reviews from 200,000 per year to 250,000.²⁶³ Further, HCFA announced that it will double the number of home health agency audits.²⁶⁴ Again, Shalala acknowledged that the measures are designed for the more limited purpose of combating fraud and abuse.²⁶⁵

HCFA has given only limited attention to matters unassociated with fraud and abuse. The only evidence of HCFA's effort in this regard is its proposed rule governing the computation of cost limitations, which incorporates the shift to the 105% of median limitation.²⁶⁶ This rule does nothing more than incorporates the Balanced Budget Act's mandate for a restructured cost limitation.²⁶⁷

258. Indeed, HCFA states that "[u]ndercapitalized providers represent a threat to the quality of patient care." *Id.*

259. See Medicare & Medicaid Programs, Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships, 63 FED. REG. 1659 (1998).

260. See *id.*

261. See *supra* notes 127-28 and accompanying text (discussing self-referrals).

262. See Medicare Program, Home Health Agency Physician Certification Regulations, 62 FED. REG. 59,818 (1997).

263. See HCFA Press Release, *HHS Halts Certification of Home Health Agencies; New Regulations Will Fight Fraud and Abuse* (Sept. 15, 1997), available at <<http://www.hfca.gov/news/n970915.htm>>.

264. See *id.*

265. See *id.*

266. See Medicare Program, Schedule of Limits on Home Health Agency Costs Per Visit for Cost Reporting Periods Beginning on or After October 1, 1997, 63 FED. REG. 89 (1998). HHS declared this as a "major rule" under 5 U.S.C. § 804(2) (1994), and found that prior notice and comment procedures are impracticable and unnecessary. See 63 FED. REG. 90 (1998). This schedule of limits is effective for cost reporting periods beginning on or after Oct. 1, 1997. See *id.*

267. See *supra* notes 227-29 and accompanying text.

C. Solutions the Government Left Behind

Home health care is Medicare's fastest growing program—and for all practical purposes, such growth is without control. Congress and HCFA, having only recently recognized the crisis, worked diligently in the last quarter of 1997 to address the problems confronting home health care. In fact, the President was so confident in this diligence that on January 13, 1998, he decided to prematurely lift the moratorium on certifying new HHAs.²⁶⁸ HHS Secretary Donna Shalala boasted: “[w]e now have more new rules in place that will fight fraud and abuse by keeping unprepared and fly-by-night home-health operators out of Medicare.”²⁶⁹ Shalala's statement, however, underscores two significant shortcomings to the recent reform efforts. First, her statement reflects a continued emphasis on the more narrow solution of simply curbing fraud and abuse. Second, her statement implies that, insofar as home health care reform is concerned, Congress and HCFA's work is done.

The solution, however, is not quite so easy. Most of the problems facing the home health care system are entirely legal. The system, with its \$0 deductible, *nearly* full-time, personalized care is without question the preferred choice among elderly seeking skilled nursing or therapy services.²⁷⁰ However, the system's benefits are the very cause of the system's failure. Building on the outlined limita-

268. See *Home-Health Moratorium Imposed Sept. 15 Is Lifted*, WALL ST. J., Jan. 14, 1998, at B2. The President originally imposed a six-month moratorium, which would have continued through March. See *id.* Moreover, HCFA lifted the moratorium after merely *proposing* certain rulemakings and did not await the final action on any one regulation.

Another, perhaps more interesting, reason that the President and HCFA may have acted so quickly in lifting the moratorium is the questionable constitutionality of the moratorium. The Home Health Services and Staffing Association raised this very objection in a hearing before Congress one month after the imposition of the moratorium. See *Hearing on Medicare Home Health Before the Subcomm. on Oversight & Investigation of the House Comm. on Commerce*, 105th Cong. (1997) (statement of Home Health Services and Staffing Association by James C. Pyles, counsel). Indeed, the language of the statute governing certification is clearly mandatory, not permissive: “[a]ny provider of services . . . shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it first files with the Secretary an agreement.” 42 U.S.C. § 1395cc(a)(1) (1994 & Supp. II 1996) (emphasis added).

269. *Home Health Moratorium Imposed Sept. 15 Is Lifted*, WALL ST. J., Jan. 14, 1998, at B2. Perhaps Shalala spoke prematurely, as most of these proposed rules were in the notice and comment period, and not one rule was “final,” as of the date of her statement.

270. See Marcus Montoya, *Home Is Where Health Care Is: Rising Hospital Costs, Patients' Desire to Stay Home Pump Life Into Industry*, COLO. SPRINGS GAZETTE TELEGRAPH, Dec. 3, 1996, at B1.

tions, the analysis will now shift to a close review of several potential solutions.

First, HCFA must revisit its policies for reimbursing home health care costs, including the prospective payment system. The current system, whether by reimbursement *or* prospective payment, permits and at times even encourages overbilling and overuse. One widely discussed solution is the imposition of cost limitations based upon the type of visit with a prohibition against offsetting—a method HCFA once practiced, however briefly.²⁷¹ The original purpose of cost limitations was to give HHAs a financial incentive to police themselves on cost containment.²⁷² However, the current system permits HHAs to aggregate their costs over all types of visits.²⁷³ GAO asserts that “[c]hanging the method of formulating cost limitations—from aggregate to type-of-visit—would give HHAs increased incentives to control costs for each type of visit.”²⁷⁴ Having researched this issue extensively, GAO found that the criticisms of this proposal were insignificant in light of the potential cost savings.²⁷⁵ Moreover, taking GAO estimated savings of \$49 million in 1990,²⁷⁶ together with the six-fold increase in home health care expenditures,²⁷⁷ current savings from this conversion alone could equal \$300 million per year.

Congress addressed the methods of reimbursement in several provisions of the Balanced Budget Act of 1997. For instance, Congress first did so by reducing the cost limits of home health care from 112% of the mean labor-related/nonlabor per visit costs to 105% of median.²⁷⁸ In addition, Congress included a provision for a *prospective* reimbursement.²⁷⁹ Although at first glance, these measures seem to attack the potential for abuse from the dollar-for-dollar payment system, the conferees themselves conclude that the prospective payment method does nothing to reduce the cost per visit or the volume of visits.²⁸⁰ Likewise, although the cost limitations have the potential for reducing costs, the measure does not address the issue of aggregation

271. See *supra* Part IV (discussing aggregate and type-of-visit cost limitations).

272. See GAO REPORT II, *supra* note 32, at 17.

273. See *supra* Part IV (discussing aggregate and type-of-visit cost limitations).

274. GAO REPORT II, *supra* note 32, at 23.

275. See *supra* note 185 and accompanying text.

276. See GAO REPORT II, *supra* note 32, at 17.

277. See *supra* note 116 and accompanying graph.

278. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4602, 111 Stat. 251, 465.

279. See *id.* § 4603, 111 Stat. at 467.

280. See *id.*

of costs over types of visits. A more comprehensive measure would be to restrict an HHA from carrying over costs, which exceeded one cost limit, to another type of visit, which has not exceeded its limitation.²⁸¹

Second, HCFA must impose a coinsurance payment or deductible to reduce the comparative advantage that home health care affords over other types of care covered under Medicare. Home health care remains as the *only* Medicare program that does not require the beneficiary to bear a portion of the cost.²⁸² A coinsurance provision would not only reduce demand for home health care, but would also reduce fraud because hospitals would have less incentive (or none at all) to shift their hospital costs to home health care. The Heritage Foundation, in a recent study of home health services, concluded that a 20% coinsurance rate would generate \$4.2 billion in savings for 1998 alone, and as much as \$25 billion over the next five years.²⁸³ The study noted that much of the growth in home health care expenditures could be attributed to the over-utilization of services that results from the absence of a cost-sharing component.²⁸⁴ The study concluded:

A 20 percent coinsurance payment is both reasonable and in line with the rest of Medicare's coinsurance requirements for physician services. Raising the coinsurance payment also would increase beneficiaries' awareness of how much a particular benefit actually costs, and lead to a more appropriate—and lower—utilization of services.²⁸⁵

In 1997, Congress was inundated with proposals for making beneficiaries bear a share of the cost of home health care, yet it failed to pass a single measure that would require any such contribution.²⁸⁶ Given

281. GAO has conducted some preliminary investigation into a potential third means of reimbursement that is based upon a maximum cost per episode. See GAO REPORT I, *supra* note 3, at 13. This report is not conclusive as to any cost savings or reductions in visitations.

282. See *supra* notes 210-13 and accompanying text.

283. See Carrie J. Gavora, *Medicare Home Health Care Services*, in BALANCING AMERICA'S BUDGET: ENDING THE ERA OF BIG GOVERNMENT 343, 343 (Scott A. Hodge ed., 1997).

284. See *id.* at 344.

285. *Id.*

286. See 143 CONG. REC. E1720-01 (daily ed. Sept. 10, 1997) (statement of Rep. Hamilton) ("This year Congress considered proposals to strengthen Medicare's financial condition by charging extra premiums to wealthier retirees, raising the eligibility age, and imposing a copayment of \$5 per visit for home health care services. None of the proposals survived in the final bill . . ."). Harris Meyer paints an especially bleak picture of the state of home health care:

[T]he combination of popular demand for more home care, an inexorable increase in the number of frail older Americans, persistent dread

the amount of debate and voluminous testimony that went into the home health care debate, the resulting product did indeed "side-step[] the issue."²⁸⁷

Third, the physician must be given a greater role in the delivery of home health care. The current system places the physician on the periphery. A logical first step for this measure involves a reevaluation of the compensation scheme for the physician. Also, the HHA may be required to surrender some of its functions to the physician, thereby placing the physician in a more centralized role. The American Medical Association (AMA) has called for the medical profession to take on a larger role in the delivery of home health care services.²⁸⁸ The AMA has asserted a need for physician review of *all* orders for home health services.²⁸⁹ Moreover, the AMA has advocated that HHAs provide physicians with itemized billing statements—an element of the process to which physicians were never before privy.²⁹⁰ One scholar argues that increased involvement of physicians would reduce overbilling and perhaps, more interestingly, reduce the potential for negligence in the delivery of health care services.²⁹¹ To accompany such increased involvement, commentators have advocated for a revised reimbursement policy that would adequately compensate physicians for these monitoring functions.²⁹²

of nursing homes, and the widespread sense that care can be delivered more cheaply at home than in institutions, strongly suggests that the current political mania for cutting back on home care won't last. Providers are counting on that.

Harris Meyer, *Home Health on the High Wire: In the Search for Medicare Savings, Politicians Sidestep Important Structural Questions*, HOSP. & HEALTH NETWORKS, July 20, 1997, at 26.

287. Harris Meyer, *supra* note 286.

288. See Marshall B. Kapp, *Family Caregiving for Older Persons in the Home*, 16 J. LEGAL MED. 1, 2 (1995) (noting that "physicians have largely remained on the periphery of home care"). In a July 14, 1997, meeting, the AMA delegates voted to oppose major portions of the then-proposed Balanced Budget Act of 1997. See *Delegates Oppose Shift in Home Health Care Costs*, AM. MED. NEWS, July 14, 1997, at 4, available at 1997 WL 9149425. The primary concern is the Act's shift of home health care costs from the hospital portions of Medicare to the physician side. See *id.* The thought is that such swap could later jeopardize reimbursable costs from physician reimbursement in other areas. See *id.*

289. See *Delegates Oppose Shift in Home Health Care Costs*, *supra* note 288.

290. See *id.*

291. See Atkinson, *supra* note 203, at 926. Atkinson appears to be alone on this issue, as the issue of health care provider liability is overshadowed by the larger problem of spiraling costs.

292. See Weitzman, *supra* note 32, at 28. Atkinson argues that Congress should be the driving force behind this type of action. See Atkinson, *supra* note 203, at 926.

Fourth, Congress must revisit the issue of the frequency of permissible visits under the current system. At present, depending upon the services offered, a provider could be in the home as much as thirty-five hours in any given week.²⁹³ Indeed, *Duggan* (which resolved the most simple issue that “or” meant “or”) served as the impetus for the explosion in home health care costs. The Balanced Budget Act of 1997 clarified the definitions of “part-time” and “intermittent,” yet did nothing to restrict their scope.²⁹⁴ This provision merely adopts *Duggan’s* long-since accepted interpretation. This provision is little more than a massaging of the text of the statute and by no means imposes a meaningful limitation on the frequency of potential visits. Thus, any statutory solution must reform the more basic definitions of “part-time” and “intermittent.” Moreover, in response to criticisms of scholars and physicians, any statutory solution must give the medical community some role in circumscribing the frequency limitations.

Likewise, the beneficiary must be given a greater role in the provision of services. The Balanced Budget Act of 1997 only mildly addresses this point by giving the beneficiary the right to make a written request to any physician or supplier for an itemized statement of Medicare-covered items or services.²⁹⁵ This provision provides an avenue for the beneficiary to become apprised of the services provided; however, the provision by no means incorporates the beneficiary into a position of control or active participation. Moreover, because this provision was not accompanied by any imposition of cost sharing, one would wonder why the beneficiary would *ever* be concerned about the cost, let alone take the affirmative step of making a written request to his provider.

Finally, home health care is no doubt ridden with fraud. However, addressing this point last is no mere accident. Without question, the government must find new and creative means to cut down on fraud. However, the federal government’s current focus on fraud misses the broader problems facing home health care. A “quick fix” solution to the fraud problem will by no means remedy home health care’s spiraling costs that the law *itself* currently allows.

Accompanying the need to increase auditing practices to identify fraud is the need to decrease the cost of each individual audit. One

293. See *supra* note 122 and accompanying text.

294. See Balanced Budget Act of 1997, Pub. L. No. 105-33 § 4612, 111 Stat. 251, 474.

295. See *id.* § 4311, 111 Stat. at 384.

solution already discussed in both chambers of Congress is to place the cost of a follow-up audit on HHAs initially found to be engaged in abusive billing.²⁹⁶ The proposal requires authorizing legislation that gives HCFA authority to broaden its review of claims.²⁹⁷ In addition, this procedure requires HCFA to establish a procedure for identifying abusive billers.²⁹⁸

As a concluding note, HCFA has instituted education initiatives to improve beneficiary and physician awareness of improper billing practices.²⁹⁹ However, money spent on such initiatives are conceivably more wasteful than the overbilling itself. As noted in Part IV, the physician has little or no role in the provision of home health care.³⁰⁰ Likewise, the beneficiary is wholly detached from the billing process and receives the same number of visits regardless of what the HHA has elected to record as billable.³⁰¹ Accordingly, such education falls on deaf ears.

VI. Conclusion

Home health care's most troubling problems are entirely legal. Home health care was once considered the most cost-effective alternative to skilled nursing, hospitalization, or any other means of long term care. However, beginning with the *Duggan* decision in 1988, recent changes in law and policy governing the program have caused the program to self-destruct.

The cost containment problems now facing home health care are the result of HHAs merely following the law. First, home health care continues to be the only Medicare program that does not come with a price tag for the beneficiary. Accordingly, the beneficiary has no incentive to ration or limit her use of the service. Second, HCFA still utilizes cost computation methods that have been proven cost-inefficient. Moreover, by permitting HHAs to offset their costs among the various types of services, any attempt to cap per-visit costs is ineffec-

296. See *Inappropriate Billings Hearings*, *supra* note 143, at 5; see also 143 CONG. REC. E1930-03 (daily ed. Oct. 2, 1997) (statement of Rep. Stark) ("If providers are willing to foot the bill to fly-in compliance consultants from high profile firms like Coopers & Lybrand, they can surely afford Government audits.").

297. See 143 CONG. REC. E1930-03 (1997).

298. See *id.*

299. See *Inappropriate Billings Hearings*, *supra* note 143, at 5.

300. See *supra* notes 203-09 and accompanying text.

301. See *supra* notes 217-19 and accompanying text.

tive. Third, the program promotes overbilling and overvisitation. The program then prevents policing this practice because it fails to give the physician or beneficiary any role in the provision of services. Fourth, Congress has not responded with an appropriate statutory solution to *Duggan*'s interpretation of the terms "part-time" or "intermittent." The *Duggan* decision effectively expanded the reach of home health care along with subsequent legislation, and HCFA policies have only served to bolster its effect. With only limited exceptions, an HHA can now provide nearly full-time service to beneficiaries, and such services can venture far from the realm of medical necessity. These problems exist apart from the issue of fraud and abuse, which has received the most, if not exclusive, attention of the current administration. The current solutions of the administration place heavy emphasis on reducing fraud and illegal billing and fail to address the more comprehensive solution of arresting the growth rate in home health care expenditures.

The home health care cost crisis demands a comprehensive solution that curbs the legal overbilling and over-utilization of the program—and such a solution must embrace more than the mere prosecution of fraud. First, Congress must impose a coinsurance payment or deductible on home health care. Beyond shifting a portion of the burden of funding, such copayment would cause the beneficiary to become a more active participant by creating incentives for self-rationing home health care services. Second, the cost limitations and application of those limitations must be changed to a type-of-visit limitation that prohibits offsets, a policy that GAO has consistently supported. Third, the physician must be given an enhanced, if not central, role in the provision of home health care services. Such a solution requires statutory authorization and increased reimbursements to physicians engaging in home health care plan management or participation. Fourth, Congress must provide a statutory solution to the *Duggan* decision. This solution requires more than a massaging of the definitions of "part-time" and "intermittent" and may require some means for gaining the input of a consensus of the medical community. Finally, Congress must continue to find solutions to identifying and prosecuting fraud. On this issue, the debate over the potential solutions is quite rich. However, this debate has come at the expense of failing to recognize the more global solutions addressed herein. Indeed, home health care's most troubling problems are entirely legal.