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Effects of medicare reimbursement on home health care

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San Jose State University, 1989

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EFFECTS OF MEDICARE REIMBURSEMENT ON HOME HEALTH CARE

A Thesis

Presented To

The Faculty of the Department of Nursing
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

By

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August, 1989

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ABSTRACT

EFFECTS OF MEDICARE REIMBURSEMENT ON HOME HEALTH CARE

by Cynthia Ann Chalkley Hatton

This research study examined the extent to which the 1985 initiation of cost containment measures by the Health Care Financing Administration affected Medicare beneficiaries' access to home health services. The general systems theory served as the theoretical framework for this non-experimental study.

An anonymous survey, with a 47% response rate ($n=94$), was mailed to a random sample of 200 directors ($N=423$) of Medicare certified home health agencies in California. A secondary review of the Annual Report of Home Health Agencies, 1987 (Office of Statewide Health Planning and Development [OSHPD], 1988) was also conducted.

Positive correlations were found between a decrease in home visits and agencies changing methods of determining the number of home visits secondary to Medicare policy changes ($r=.32$), and between clients' needs being met and Medicare policy changes affecting access to services ($r=.32$). The findings suggest that Medicare policy changes have negatively affected beneficiaries' access to home health services.

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Chapter 1

INTRODUCTION

Home health care is the fastest growing segment in the United States health care industry, but its mere survival is being threatened. The National Association for Home Care has taken the position that the Reagan administration was attempting to dismantle the home care benefit under the Medicare program (Firshein, 1986). Over the past 4 years, the Health Care Financing Administration (HCFA) enacted new regulations to restrict home health care expenditures. Unfortunately, these restrictions came at a time when home care was experiencing rapid growth. The initiation of prospective payments for hospitals has increased the "quicker and sicker" phenomena (Weinstein, 1987) and the need for home health care to bridge the gap.

There are many other factors that have influenced the growth of the home health care industry. The elderly population in the United States is increasing and is choosing to stay in their own homes. Our mobile society has dispersed families with many children living thousands of miles away from their elderly parents. In addition, adult children are not only caring for their own children in their homes, but their elderly parents as well. In response to the increased need, there has been a great surge of new home health care agencies and what had been a small industry is

now the third largest provider of health care in America (Firshein, 1986). Physicians, as well as families, are more aware of the services available in the home and educated consumers are demanding these services. There has also been an increase in the treatment of children and young adults in the home, with many children now being able to attend school with the help of sophisticated equipment and home care support. Finally, the cost of home health care is still less expensive than a lengthy acute hospital or extended care facility stay.

The United States Congress concluded that the major problem in the home health care industry was overutilization and unwarranted growth (Elwell & Laff, 1987). Therefore, to limit this expenditure and growth, the Health Care Financing Administration (HCFA) initiated a series of regulations. Beginning July 1985, reimbursement would be based on a per discipline rate, eliminating the aggregate system. Also, incremental decreases in reimbursement were initiated. In September 1985, new forms were introduced for data collection and 100% review of all claims was initiated.

In 1986, the National Association for Home Care surveyed 2,100 Medicare certified home health agencies and reported that 67% were experiencing an increase in the number of claims denied by Medicare (Firshein, 1986). Two years after the initiation of these cost containment

measures, the claim denial rate increased nationally from 3.5% in 1984 to 6.9% in 1987 (Omdahl, 1987). Locally, the denial rate for the Central Coast Visiting Nurse Association increased from 1.9% to 9.5%. To combat the increase in denial rates, many agencies initiated measures to improve this rate. According to Seifer (1987), agencies reported changing preadmission screening and documentation process to decrease denial rates. Some agencies used selective screening and accepted only private pay or those qualifying for the restricted home health benefit under Medicare (Seifer, 1987). Other agencies reported overstating care to guarantee Medicare reimbursement (Seifer, 1987). The Central Coast Visiting Nurse Association initiated a new documentation and form review system. As a result of the new systems, the denial rate decreased to 1.1% in the first two quarters and 0% in the third quarter of 1987.

Along with the decrease in denials, Central Coast Visiting Nurse Association also experienced a decrease in the average number of home visits per patient. This average went from 17.5 in 1985 to 11.0 in the first three quarters of 1987. Elwell & Laff (1987) note that staff reaction to fear of denials is generally to provide fewer visits. The 1986 National Association of Home Care survey also reported 92% of the agencies experiencing a sharp increase in patient acuity and 75% reported patients going home from hospitals without needed home care services (Firshein, 1986). Val

Halamandaris (cited in Firshein, 1986), President of the National Association of Home Care, states that the Administration has "tried to trim the candle at both ends" (p. 26). Halamandaris (cited in Firshein, 1986) believes that the government is saving billions of dollars by early hospital discharges but has failed to increase the level of home health expenditures and seems intent on "shredding the home health safety net" (p. 26).

The Problem and Research Question

This research study addressed the home care reimbursement issue. The reported increase in claim denials in addition to incremental decreases in payments is jeopardizing access to home health services. According to Guildroy (cited in Firshein, 1986), spokesperson for the American Association of Retired Persons (AARP), "Arbitrary eligibility determinations make agencies vulnerable to payment denials and discourage patients from using home health services" (p.26). The initiation of cost containment measures by the Health Care Financing Administration (HCFA) has altered the providers' system of determining the amount of home care services required.

This study addressed the following question: to what extent has the implementation of Health Care Financing Administration's cost containment measures affected Medicare beneficiaries' access to home health care services?

The following hypothesis was tested in this study:

The cost containment measures implemented by the Health Care Financing Administration (HCFA) have negatively affected Medicare beneficiaries' access to home health care services.

Purpose and Need

It is important that this issue be studied at a time when the Health Care Financing Administration (HCFA) and other groups are looking into a prospective payment system for home health care. A prospective payment system based on the last 3 years of utilization will not be accurate. Therefore, the above question must be answered before a prospective payment system is initiated. The home care industry is largely dependent on Medicare and is not able to subsidize Medicare with other patient populations (Elwell & Laff, 1987). The home care industry must document these inequities and work with Medicare to develop a system that guarantees reimbursement for required services. Seifer (1987) recommends further investigation in this area and Steller (1986) questions who should decide what constitutes skilled care: nurses, the government, or private insurances.

Definition of Terms

For the purpose of this study, the following definitions apply:

1. Home health care is skilled services rendered to patients in their homes, by a Medicare certified agency.
2. Home visit is a unit of measure representing one visit to a patient's home to provide a skilled service.

3. Skilled Care is care requiring the expertise of a registered nurse, physical therapist, or speech therapist.

4. Denial Rate is the percentage of home health care agency's claims denied by the fiscal intermediary.

Research Design

The study utilized a non-experimental research design. Since the study attempts to link present events to events that have occurred in the past, a retrospective study was done (LoBiondo-Wood & Haber, 1986). The two variables in the study are Medicare policies and beneficiaries' access to home health services. A random sample of 200 directors of Medicare certified home health care agencies was surveyed. The data were collected utilizing a mailed anonymous descriptive survey. Descriptive statistics were used to analyze the data.

Scope and Limitations

One limitation of this study was the use of a non-experimental design. The researcher was unable to draw a causal linkage between the two variables, or exclude the possibility of an alternate hypothesis. The internal validity of this study was affected by the validity of the instrument. External validity was challenged because the home health care agencies of only one state were studied and generalization of the results to other populations is limited. The use of a retrospective study demanded a reliance on the memory of the respondents.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

Conceptual Framework

The theoretical framework utilized in this study is the general systems theory. The general systems theory studies "wholes" (Hamilton, 1984). According to Hamilton (1984), a system is "any set of interrelated components that interact with each other within a boundary that filters inputs and outputs" (p. 155). Feedback allows the system to be self-directing and corrects discrepancies between actual and intended output (Hamilton, 1984). In systems theory, the whole is greater than the sum of its parts, and a change in one component leads to a change in all other components (Hamilton, 1984). Characteristics that apply to the system also apply to all the component parts (Hamilton, 1984). Hamilton (1984) views health care in America as a system. If health care is a system, then home health care can be viewed as a subsystem. Hamilton (1984) also states that "alterations in the amount and type of resources/inputs will lead to changes within the system and each of its subsystems" (p. 155). Therefore, changes in the Medicare reimbursement system will affect all the components of the system.

The health care industry has already seen the impact of reimbursement adjustments on the acute care setting. With the implementation of the prospective payment program, the entire health care system changed. Home health care

agencies have experienced a rapid growth as a result of the "quicker and sicker" phenomena (Weinstein, 1987).

A home health care agency can be further explained using the general open system model, as shown in Figure 1. An open system reacts continually with the environment to achieve a state of equilibrium (Kast & Rosenzweig, 1972). The survival of the organization is dependent upon the continuous inflow, transformation and outflow (Kast & Rosenzweig, 1972). According to Kast & Rosenzweig (1972), organizations must receive sufficient input of resources to maintain operations and export sufficient outputs to the environment, to continue the cycle. On an organizational level, a home health care agency's inputs include: (a) Medicare and other insurance reimbursements, (b) licensing requirements and regulations, (c) current medical practices and standards, and (d) availability of professional staff. The throughputs include: (a) changes in organizational structure, (b) changes in fees and scope of services, (c) changes in medical policies, and (d) procedures and changes in professional staff caseloads. A home health care agency's outputs include: (a) medical treatments, (b) knowledge and information, and (c) financial profit or loss. On an individual level, the input is the client's needs. The throughput is the development of an individualized plan of treatment and the output is medical treatment, information and knowledge. The feedback mechanism allows the system to

HOME HEALTH AGENCY

Figure 1. Model of Home Health Agency as an open system. Hatton, 1988.

adapt to the changes in the external as well as the internal environment.

A current study indicates that some organizations are restructuring as a response to Medicare policy (Bergthold, Swan, Spohn, & Estes, 1988). The clients' access to services may be altered and there could be a change in the professional staff caseload. The following study examines and states the extent to which the cost containment measures effect Medicare beneficiaries' access to home health care services.

Related Literature

Review of the literature produced two research studies directly related to the topic. Spohn, Bergthold, and Estes (1988) explored the influence Medicare legislation and policy initiatives have had on the home health care market expansion. Initial regression analysis revealed statistical significance in the following relationships: proprietary agencies and refusal of services based on ability to pay, Medicare agencies and refusal of services due to government reimbursement limitations, and Medicare agencies and refusal of services due to restrictive eligibility requirements (Spohn, Bergthold, & Estes, 1988). Further analysis is required before a causal relationship can be established (Spohn, Bergthold, & Estes, 1988). A second study by Bergthold, Estes, Spohn, and Swan (1988) examines the organizational changes in home health care in response to public policy changes. The small sample size utilized in

this study limits generalizability. In addition, the study did not utilize all the possible organizational structures and may have omitted other influential factors (Bergthold, Estes, Spohn, & Swan, 1988).

Corollary literature did speak to the following areas. Hamilton (1984) applied the general systems theory to the health care system and its reimbursement. Moyer (1986), Saltzman (1985), and Hay and Mandes (1984) discussed the cost of home care versus hospitalization or institutionalization and recommended further studies regarding the cost benefit of home care. MacMillan-Scattergood (1986), Rozelle (1987), Seifer (1987), and Auerbach (1985) reviewed the effects of the hospital prospective payment system on the home care industry. Auerbach (1985) states that "understanding the full effects of the changes in health care reimbursement on patient care and nursing care will require research and investigation" (p. 291). The actual changes in the regulations and legislation and their impact on home care and nursing was addressed in 18 other articles. Steller (1986), Hergert (1986), and Salladay (1986) discussed the ethical conflicts surrounding limited reimbursement for home care. The literature reviewed does imply the need for further research in this area to document the inequity of home health reimbursement before the initiation of prospective payment. This study addressed this need for more investigation.

Chapter 3

METHOD

The research design is an extension of the theoretical framework of the study (LoBiondo-Wood & Haber, 1986). The design must reflect the purpose of the study and be appropriate for the research problem (LoBiondo-Wood & Haber, 1986). In addition, it must be suited to collect the data required for the study (LoBiondo-Wood & Haber, 1986). LoBiondo-Wood & Haber (1986) state that objectivity in conceptualization, accuracy, economy, control, internal validity and external validity should be considered when choosing a research design. The following describes how this study incorporated the above components in the research design.

Research Design

A non-experimental design was chosen for the study since the variables cannot be manipulated. LoBiondo-Wood & Haber (1986) classify non-experimental studies into two types, surveys and interrelationships. According to LoBiondo-Wood and Haber (1986), "Survey studies collect detailed descriptions of existing phenomena and use the data to justify and assess current conditions and practices to make more intelligent plans for improving them" (p.130).

A classical approach was used to formulate the hypothesis and develop the testing instrument. Secondary data analysis about the total population constructed a profile of current

and historical utilization patterns of California's Medicare certified home health agencies. To document the relationship of the two variables, Medicare reimbursement and beneficiaries' access to services, a descriptive survey with closed-ended questions was utilized. The advantage of utilizing this design is that it obtains accurate information from a large population with a relatively low expense (LoBiondo-Wood & Haber, 1986). The survey was developed by the researcher and reviewed by a panel of five current or past directors of home health care agencies for clarity and validity.

The population for this study consisted of the directors of all Medicare certified home health care agencies in the State of California. A random sample of 200 of these agencies was selected utilizing computerized random sampling with replacement technique.

Data Collection

A mailed descriptive survey and analysis of the Annual Report of Home Health Agencies, 1987 (Office of Statewide Health Planning and Development [OSHPD], 1988) produced the required data. The survey received approval from the San Jose State University Human Subjects Committee prior to its use. The directors of the selected agencies received the survey with a stamped return envelope and a participation response reply card enclosed. Response cards were numbered with the agency's designated number and respondents were

instructed to mail them independent of the survey. The mailed surveys were followed, 3 weeks later, with telephone calls to those with unreturned response cards.

Analysis of Data

The data were analyzed utilizing frequency distribution, grouped data, percentages, and descriptive statistics. The significant statistical relationships were expressed utilizing the correlation coefficient. Chi-square was used to test independence and Pearson's product moment correlation coefficient tested the strength of the relationship of the variables.

Chapter 4

ANALYSIS AND INTERPRETATION OF DATA

The data from the Home Health Care survey and the Annual Report of Home Health Agencies, 1987 (Office of Statewide Health Planning and Development [OSHPD], 1988) were analyzed to: (a) document the problem, (b) test the hypothesis that cost containment measures implemented by the Health Care Financing Administration (HCFA) have negatively affected Medicare beneficiaries' access to home care services, and (c) construct a profile of current and historical utilization patterns.

Survey Results

Of the 200 surveys mailed, 94 were returned completed, 6 subjects chose not to participate, 5 surveys were returned by the post office with no forwarding address and 2 subjects completed only the first page of the survey. The survey response rate was 47%. All of the 14 Health Service Areas in the State of California were represented in the sample. The mean number of home visits per month was 1,572 with the maximum reporting 9,000 and the minimum reporting 35 (see Table 1). Of the respondents ($n=92$), 14% reported 251-540 home visits per month, 13% reported 951-1100, and 12% reported 341- 705. The average number of total RN FTE (full-time equivalent) was 10.8 with the greatest reporting 75 and the least reporting one (see Table 2). Out of the 91 responses, 70.4% of the agencies reported 1-10 RN FTE

Table 1

Frequency Distribution and Percentages of Home Health Care
Agencies' Visits per Month (n = 92)

<u>Number of Home Visits</u>	<u>Number</u>	<u>%</u>
35 - 250	9	10.0
251 - 540	13	14.1
541 - 750	11	12.0
751 - 950	9	10.0
951 - 1100	12	13.0
1101 - 1450	9	10.0
1451 - 2000	9	10.0
2001 - 3000	7	7.6
3001 - 4800	9	10.0
4801 - 9000	4	4.3

Note. Two agencies did not respond to the question.

Table 2

Frequency Distribution and Percentages of Home Health Care
Agencies' Number of RN FTE (full-time equivalent) (n=91)

<u>RN</u>	<u>FTE</u>	<u>Number</u>	<u>%</u>
1 -	5	36	39.6
6 -	10	28	30.8
11 -	16	10	11.0
17 -	24	9	10.0
25 -	50	6	6.6
51 -	75	2	2.2

Note. Three agencies did not respond to the question.

(full-time equivalent), 21% employ 11-24 RN FTE (full-time equivalent), and 8.8% reported 25-75 RN FTE (full-time equivalent). Among the respondents (n=92), 78.3% are classified as urban and 21.7% are classified as rural.

To document the existence of the problem, the directors were asked whether the implementation of Medicare policy changes had increased or decreased beneficiaries' access to home health care services at their agency. A decrease in access was reported by 77.5% of the respondents (n=80).

Medicare beneficiaries' needs were not satisfied by the current number of reimbursed home visits in 63.6% of the respondents' agencies (n=88). Table 3 illustrates the reasons cited by the respondents (n=61) for Medicare clients' needs not being met. Limitation of the number of reimbursed home visits was reported by 49.2% of the agencies. No coverage for custodial or maintenance and limitations of home health aide visits were cited by 21.3% of the agencies (n=61). Other reasons for Medicare clients' needs not being met included: (a) no reimbursement for chronic conditions, specific diseases and, one time and long visits (22.9%); (b) premature discharges (18%), (c) acute care needs marginally satisfied and long term needs not addressed (18.1%), (d) families and clients pressured into learning too quickly (14.8%), (e) limitations of intermittent and skilled care definitions (8.2%), (f) homebound criteria and definition (6.6%), (g) no

Table 3

Frequency and Percentage Distribution of the Reasons for
Home Health Care Agencies Medicare Clients' Needs Not Being
Met (n=61)

Reason	Number	%
Number of visits/duration limited	21	34.4
Limited HHA/no custodial care reimbursed	11	18.0
D/C prematurely	10	16.4
Chronic conditions not reimbursed	9	14.8
# visits limited 2ndary to reimbursement	9	14.8
Family/client pressured to learn quickly	9	14.8
Long term care needs not met	5	8.2
Homebound criteria/definition	4	6.6
Only acute care needs met	4	6.6
No reimbursement for required needs	4	6.6
Skilled nursing definition	3	4.9
No coverage for cataracts/diabetes dialysis/Alzheimers	3	4.9
Intermittent definition	2	3.3
Increases documentation requirement reduces client time	2	3.3
Maintenance visits needed	2	3.3
Partially/marginally	2	3.3
Cutting corners/home health care motto	1	1.6
D/C too early in rural areas/no relatives	1	1.6
One time visits not covered	1	1.6
Long visits not reimbursed	1	1.6

Note. Numbers are not mutually exclusive.

reimbursement for services required to meet clients' needs (6.6%), and (h) increased documentation requirement reduces patient care time and encourages cutting corners (4.9%).

In 57.6% of the agencies ($n=87$), the number of home visits per client has been decreased to curtail Medicare denials. Only 5.8% of the agencies ($n=87$) have increased the number of home visits per day for their staff members.

Individual need is the primary method utilized by 57.0% of the agencies ($n=78$) to determine the number of home visits per client. Other methods utilized by the agencies include Medicare guidelines/length of stay (15.4%) and past reimbursement experience (14.1%). Medicare policy changes have caused 49.4% of the agencies ($n=87$) to change the method used to determine the number of home visits per client. The agencies report that they are more conservative, cautious and exercise underutilization secondary to Medicare denials. Additionally, (see Table 4) the agencies ($n=60$) cited the following as the method they are currently using: (a) increased utilization review (48.3%) and quality assurance (10%), (b) education/in-service training (28.3%), (c) denial appeals (15%), (d) no coverage/no service (5%), (e) improved documentation (5.0%), (f) increased screening (3.3%), and (g) free care or billing only reimbursable visits (1.7%).

Finally, 23.6% of the agencies ($n=89$) have implemented other measures that have affected Medicare beneficiaries'

Table 4

Measures Implemented by Home Health Care Agencies To Decrease
Medicare Claim Denials (n=60)

<u>Measure</u>	<u>Number</u>	<u>%</u>
Utilization review	29	48.3
Inservice/education/training	17	28.3
Appeal denials	9	15.0
Quality assurance	6	10.0
Computer care plans	3	5.0
Improved documentation	3	5.0
Decrease # of visits	2	3.3
Do not open certain cases	2	3.3
Changed forms	2	3.3
Increased staff	2	3.3
Screening clients/visits	2	3.3
Standardized protocols	1	1.7
In-house billing	1	1.7
Do not submit questionable visits	1	1.7

access to their services. Some of these measures include: (a) increased marketing (4.5%), (b) pre-screening clients (3.4%), (c) addition of a discharge planning component (3.4%), (d) refusing clients that do not meet reimbursement criteria (2.3%), (e) eliminating services to clients requiring wound care, clients on dialysis, and clients with cataracts (2.3%); and (f) increasing community education programs (2.3%).

The Chi-square demonstrates the significance of the interrelationship between the variables (Haber & Runyon, 1977). This calculation indicates that there is a relationship ($p \leq .05$) between: (a) decreasing the number of home visits per client and changing the method of determining the number of home visits secondary to Medicare policy changes (see Table 5), (b) decreasing the number of home visits per client and the primary method of determining the number of home visits (see Table 6), (c) clients' needs being met and decreasing the number of home visits per client (see Table 7), (d) clients' needs being met and the primary method of determining the number of home visits per client (see Table 8), and (e) the primary method of determining the number of home visits per client and changing the method of determining the number of home visits secondary to Medicare policy changes (see Table 9).

The Pearson product moment correlation coefficient is utilized to demonstrate any linear relationships between two

Table 5

Crosstabulation of Question 6: Decreasing the Number of
Home Visits by Question 11: Changing the Method of
Determining the Number of Home Visits (n=83)

	Change Method of Determining Number		
	No	Yes	Total
Decrease Number			
No	22 53.7	11 26.2	33 39.8
Yes	19 46.3	31 73.8	50 60.2
Total	41 49.4	42 50.6	83 100.0

Chi-square = 6.535567 with 1 df; $p \leq .05$

Table 6

Crosstabulation of Question 6: Decreasing the Number of Home Visits by Question
 10: The Primary Method of Determining the Number of Home Visits (n=75)

Decrease Number	Determining Number of Home Visits				
	Medicare and Clients' Needs	Medicare Guidelines	Past Experience	Clients' Needs	Other
No	0 0.0	2 18.2	0 0.0	25 58.1	1 10.0
Yes	1 100.0	9 81.8	10 100.0	18 41.9	9 90.0
Total	1 1.3	11 14.7	10 13.3	43 57.3	10 13.3
					28 37.3
					47 62.7
					75 100.0

Chi-square = 19.427565 with 4 df; $p \leq .01$

Table 7

Crosstabulation of Question 4: Clients' Needs Being Met
by Question 6: Decreasing the Number of Home Visits (n=76)

	Decrease Number		Total
	No	Yes	
Clients' Needs			
No	16 57.1	42 87.5	58 76.3
Yes	12 42.9	6 12.5	18 23.7
Total	28 36.8	48 63.2	76 100.0

Chi-square = 9.016420 with 1 df; $p \leq .01$

Table 8

Crosstabulation of Question 6: Decreasing the Number of Home Visits by Question
 10: The Primary Method of Determining the Number of Home Visits (n=75)

		Determining Number of Home Visits				
Clients' Needs		Medicare and Clients' Needs	Medicare Guidelines	Past Experience	Clients' Needs	Total
					Other	
No	0 0.0	7 63.6	11 100.0	22 52.4	10 100.0	50 37.3
Yes	1 100.0	4 36.4	0 0.0	20 47.6	0 0.0	25 33.3
Total	1 1.3	11 14.7	11 14.7	42 56.0	10 13.3	75 100.0

Chi-square = 16.402597 with 4 df; $p \leq .01$

Table 9

Crosstabulation of Question 10: Primary Method of
Determining the Number of Home Visits by Question 11:
Changing the Method of Determining the Number of Home
Visits Secondary to Medicare Policy Changes (n=78)

Primary Method	Change Method of Determining Number		
	No	Yes	Total
Medicare & Clients' Needs	1 2.6	0 0.0	1 1.3
Medicare Guidelines	2 5.3	9 22.5	11 14.1
Past Experience	3 7.9	8 20.0	11 14.1
Clients' Needs	30 78.9	15 37.5	45 57.7
Other	2 5.3	8 20.0	10 12.8
Total	38 48.7	40 51.3	78 100.0

Chi-square = 16.286699 with 4 df; $p \leq .01$

variables (Haber & Runyon, 1977). Linear relationships of moderate positive correlation were demonstrated between the following variables: (a) total number of home visits per month and total number of RN FTE (full-time equivalent) ($r=.70$), (b) the agency classification and needs met ($r=.23$), (c) access to services and needs met ($r=.32$), (d) a decrease in the number of home visits per client and Medicare policy changes altering the agency's method of determining the number of home visits ($r=.32$), (e) improved documentation process and primary method used to determine the number of home visits ($r=.14$), (f) other measures implemented to decrease claim denials and Medicare policy changes altering the method of determining the number of home visits ($r=.28$), and (g) other measures implemented to decrease the number of claim denials and other changes implemented that have changed the beneficiaries' access to services ($r=.25$). There are no strong variable relationships demonstrated.

Secondary Data Analysis

A secondary data analysis of the Annual Report of Home Health Agencies, 1987 (Office of the Statewide Health Planning and Development [OSHPD], 1988) also confirmed the existence of the problem. The average number of home visits per client has decreased from an average of 15.4 visits in 1985 to an average of 12.8 visits in 1987 (see Figure 2).

To profile the current and historical utilization

Figure 2. California Home Health Care Agencies' Average Number of Home Visits Per Patient 1970-1987.

Note. From Licensed services and utilization profiles annual report of home health agencies, 1987 (p. 6) by Office of Statewide Health Planning and Development, 1988, Sacramento, California.

patterns of the home health agencies, the following data were analyzed: (a) the total number of agencies, (b) the number and age of clients, (c) visits by reimbursement, and (d) growth patterns. At the beginning of 1987, there were 436 licensed home health agencies in the State of California (OSHDP, 1988). During 1987, 29 new agencies were licensed, 35 agencies closed or were delicensed, and seven agencies had their license suspended. This resulted in 465 agencies being licensed for some portion of 1987 with 423 agencies operating and licensed at the end of 1987 (OSHDP, 1988). Of the 465 agencies, 93.5% of them submitted annual reports to the Office of Statewide Planning and Development as required by Section 74729 of Title 22, California Code of Regulations (OSHDP, 1988). There has been a 7.2% decrease in the total number of home health agencies since 1985 (OSHDP, 1988).

In 1987, 310,929 clients received home health services. This is a 14% increase since 1985 and a 26% increase since 1983 (OSHDP, 1988). The percentage of clients over 65 years of age in 1987 was 70, (see Figure 3) compared to 76.1% in 1983 and 72.1% in 1981 (OSHDP, 1988). Comparing total number of residents in the state of California over 65 years of age to the number of clients over 65 receiving home health care services reveals that in 1987, 7.2% of Californians over age 65 received home health services (OSHDP, 1988). This ratio has increased by 21% since 1983

Figure 3. Age of Home Health Patients California, 1987.

Note. From Licensed services and utilization profiles annual report of home health agencies, 1987 (p. 5) by Office of Statewide Health Planning and Development, 1988, Sacramento, California.

Figure 4. Reimbursement Source for Home Health Visits California, 1987.

Note. From Licensed services and utilization profiles annual report of home health agencies, 1987 (p. 7) by Office of Statewide Health Planning and Development, 1989 Sacramento, California.

when 5.7% of Californians over 65 received home health services (OSHDP, 1988). There has been a 2.8% increase since 1985 (OSHDP, 1988).

Figure 4 illustrates Medicare as the primary reimbursement source for home health agencies. In 1987, 75% of the clients were Medicare, a decrease from 84.4% in 1984 (OSHDP, 1988). Of the 418 reporting agencies, 33 reported no Medicare visits, 88 reported 90-99% of the visits reimbursed by Medicare, and 11 agencies reported 100% Medicare clients (OSHDP, 1988). Medicare contributed to 80% of the reimbursement for one-half of the agencies (OSHDP, 1988). The total summary of number of visits by reimbursement is not available due to the inability of some agencies to separate payment sources (OSHDP, 1988). As of December 1987, 387 or 93% of the agencies were Medicare certified, compared to 421 or 95% in 1986 (OSHDP, 1988).

Analysis Regarding Complications

The 94 surveys were mailed out and returned within a five week period. The cover letter did not state the deadline for returning the surveys. If this had been included, the number of follow-up telephone calls would have decreased. The word "over" or "next page" on the bottom of page one of the survey would have eliminated incomplete surveys being submitted.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

This study has documented the extent to which Medicare cost containment measures have decreased beneficiary access and number of home health visits over the last 4 years. Since this study is non-experimental, it cannot be concluded that the 1985 Medicare policy changes have caused this problem. However, respondents in this study verified the relationship between access and number of home visits per client. The results are significant. Seventy-eight percent of the directors surveyed stated that Medicare beneficiaries had experienced a decrease in access. Further documentation includes 65.2% of the respondents stating that the needs of Medicare beneficiaries were not being met under the current regulations.

Other observations found that urban clients are more likely to not have their needs satisfied and a decrease in access to services results in clients' needs not being met. The study also suggests that Medicare policy changes are directly responsible for home health care agencies altering their methods of determining the number of home visits per client.

The majority of agencies in the study have implemented utilization review and quality assurance programs. In addition, most agencies report an extensive review process in

all cases. The agencies stated that the areas of greatest need for inclusion in the Medicare program are custodial services and services for clients with chronic medical conditions.

Recommendations

Further studies are needed to document and clarify the extent and the effect Medicare policy changes are having on the beneficiaries' ability to utilize needed services.

Specifically, studies should be focused on:

1. Widespread documentation of the extent of this problem nationally.
2. Determining what effect the addition of utilization review and quality assurance programs have had on the quality of patient care.
3. Performing a cost analysis of nursing time and administrative costs associated with utilization review and quality assurance programs.
4. Establishing the criteria utilized to determine the amount of services required by a home care client.
5. Documenting the cost effectiveness of home health care services for clients with chronic medical conditions and clients needing custodial care.

The importance of continued study in this area cannot be overemphasized. In a nation where cost containment for health care is an issue, it is imperative that professionals working within the home health care industry participate in

the development of the policies that impact the clients they serve. The home health care industry must clearly document the current situation and its ability to provide a cost effective alternative health care setting.

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APPENDIX A
Cover Letter

San José State University

SAN JOSE, CALIFORNIA 95192

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SCHOOL OF APPLIED ARTS AND SCIENCES

Department of Nursing
Graduate Program

(408) 277-2694

Cynthia A. Hatton
3850 Rio Road #42
Carmel, California 93923

February 28, 1989

Dear Director,

I am a Community Health Nursing Administration graduate student, at San Jose State University, conducting a study addressing the affects of Medicare policy changes on beneficiary's access to home health care services. The results of this study will substantiate the home health care industry's request for a more equitable system of reimbursement.

Your participation will enhance the reliability of the study, so please, take 15 minutes to complete the enclosed survey. After completing the survey, simply return it in the self-addressed stamped envelope provided. Your participation in this study is voluntary and your responses will remain anonymous.

If you have any questions regarding the study I would be happy to discuss them with you. I can be reached from 8:00am - 5:00pm Monday-Friday at 408-755-8000. I appreciate your assistance and your time.

Sincerely,

Cynthia A. Hatton PHN, BSN

APPENDIX B
Home Health Agency Survey

Home Health Agency Survey

Please check one response for each question.

1. What is your agency's total number of intermittent health care visits per month

2. What is your agency's total number of RN FTE (full-time equivalent)?

3. Is your agency classified by Medicare as rural or urban?

Rural _____

Urban _____

4. Have recent Medicare policy changes (1985) increased or decreased Medicare beneficiary's access to services offered by your agency?

Increased _____

Decreased _____

5. Are Medicare beneficiary's needs being met by current number(s) of reimbursed home visits?

Yes _____ No _____

If no, why _____

6. To curtail Medicare claim denials have you decreased the number of home visits per client?

Yes _____ No _____

7. To curtail claim denials have you improved your treatment plan documentation process?

Yes _____ No _____

If yes, in what way _____

8. Has your agency implemented any other measures to decrease Medicare claim denials?

Yes _____ No _____

If yes, what measures _____

9. To compensate for increased Medicare claim denials have you increased the number of home visits per day for your professional staff?

Yes _____ No _____

If yes, by what percent _____

10. What is the primary method your agency uses to determine the number of home visits a Medicare beneficiary receives per treatment plan? (Please circle only one answer)

A. Medicare guidelines/ length of stay

B. Past reimbursement experience

C. Client's needs

D. Other _____

11. Have recent Medicare policy changes (1985) caused your agency to change the method used to determine the number of home visits a patient is to receive?

Yes _____ No _____

If yes, in what way _____

12. Has your agency implemented any other changes that directly effect Medicare beneficiary's access to your services?

Yes _____ No _____

If yes, what measures _____