# A Tale of Two Walls

Less than a decade ago, two walls were torn down. One wall, in Berlin, became fragments in a museum to celebrate the victors in a war over political and economic control. The other wall, erected by the Health Care Financing Administration (HCFA) during the 1980s around home health care benefits, was removed in the *Duggan v Bowen* decision by a federal court that was appalled by the barriers that prevented needy Medicare beneficiaries from getting services. New walls, however, have been erected during the past four years around the Medicare home health benefit. The two walls are not completely unrelated. The end of the cold war freed federal law-enforcement resources to address another drain on the federal treasury—burgeoning health care expenditures. After the federal court decision, Medicare removed regulatory barriers to service use. Federal expenditures on home health care increased 6-fold between 1990 and 1997, from $3.5 billion to more than $19 billion, and nearly 2,700 mostly for-profit firms entered the fee-for-service market between 1990 and 1995.[1] Following the Willie Sutton dictum, the Office of the Inspector General became interested in home health care and HCFA began erecting new barriers to home health care.

The home health care market, however, has distinctive features that should prevent HCFA from applying the traditional theory of medical responsibility, which is based on a hospital model. This theory assumes that health care services are ordered by a physician and that health care providers operate under a physician's direction. The model does not work when applied to home care, where increasingly technological services are delivered by visiting nurses, physical therapists, home health aides, and vendors for intravenous infusions, parenteral nutrition, oxygen, home nebulizers, respirators, and sophisticated wound-care products. Few office-based physicians, who are untrained in the scope of services now being delivered in the home, have the time or knowledge to provide the oversight that HCFA expects. Vendors often determine which services are provided, whether it is the type of equipment or the frequency of nursing visits.

In this issue, Wachtel and Gifford discuss the physician's role in authorizing home services for their patients,[2] a delicate task under current HCFA regulations. These regulations assume that the physician is responsible for any home services that are authorized, as they are for any other type of patient care. Under provisions enacted in 1997, physicians may be liable for up to $5,000 or a multiple of the cost of "unnecessary" services, as defined by regulation.[3] These regulations should heighten physicians' attention when authorizing home services, but only if there were an incentive for prescribing home services. Yet most physicians have no financial interest in home services. Therefore, the regulations may have a chilling effect, as discussed by Wachtel and Gifford, causing physicians to withdraw from managing the care of their frail patients at home. Withdrawal is more likely for physicians who have had little training or experience in home care, which is true for the majority of physicians. Whether physicians authorize fewer services or drop out all together may matter less to payers. Unauthorized services are simply not reimbursed.

When services are not reimbursed, the blow is borne mainly by the frail elderly who remain in their communities using a patchwork of Medicare benefits and regulations that have been pieced together by a knowledgeable visiting nurse and physician. The underlying, but unspoken, tension in this market is that the Medicare home health benefit is designed for persons recovering from an acute illness after hospitalization, but it is often used for persons with chronic functional dependencies.[4] For example, in some areas of the country 43% of beneficiaries haven't had a hospitalization within six months of starting home health services.[5] Also, there is more geographic variation in the use of home health care than in the use of hospital admissions and physicians' services.[5] The explanations for so much variation include fraud, according to the Inspector General, and variable interpretation of unclear eligibility standards, according to Wachtel and Gifford. Other explanations are variations in the regional mix of proprietary and not-for-profit agencies or, alternatively, variations in the regional mix of fee-for-service and capitated agencies.[6] Another explanation is variation in the availability and generosity of state and local long-term care services; the Medicare home health benefit can substitute or complement these services, for example, by providing stopgap services while individuals are on a waiting list for state-supplied services to keep them out of nursing homes.[7]

Wachtel and Gifford focus our attention on recent proposals to quantify the amount of time out of the house that would disqualify an individual from being homebound. This approach is not new—part of the old wall was a regulation saying that patients who went to a dialysis center three days a week were not homebound, regardless of the effort needed for them to get to the center and whether such an effort was available for other trips outside the home. Alternatively, using a patient's functional level to define homebound status had intuitive appeal.[8] If homebound status is defined this way, however, some patients who could benefit from home health services, for example those with congestive heart failure or chronic obstructive pulmonary disease, may qualify for services only when their disease has flared, which would prevent them from getting the services they need to prevent flares of their disease.[9] For example, in Philadelphia the percentage of patients with congestive heart failure who were discharged from a hospital to a home health agency and then rehospitalized within 180 days decreased from 60% during the two years before the *Duggan v Bowen* decision (1987–89) to 35% during the two years

after the decision (1990–92). This decrease was associated with an expansion in the duration and intensity of home health services. (J. Kelly, unpublished doctoral thesis, University of Pennsylvania School of Nursing, Philadelphia, 1996.)

Acting as our patients' advocates for home care can be difficult because practices that meet patients' needs and serve the public interest can exceed the intent of technical regulations. There is inherent tension dealing with a policy flawed by its quixotic attempts to distinguish between acute and long-term functional dependencies.

Physicians providing care to frail patients who have difficulty leaving home or are not able to manage their own medical care at home should learn about the home health services that are available in their communities. Specifically, they need to learn how to tell when needed services are not available because of Medicare regulations and when they are not available because an agency has a defensive policy that is designed to protect it from aggressive oversight by the Inspector General. As Wachtel and Gifford point out, several organizations, including the American Academy of Home Care Physicians, can help physicians deal with local home health care agencies. Physicians should identify home health agencies that have practice styles and perspectives that are complementary to their own[10] and then build an interdisciplinary team slowly, patient by patient. Health systems can foster team building with more organizational support.[8,11,12] At a policy level, home care services need to be brought under the umbrella of prospective payment, so that the clinical nuances of each patient can be weighed when the consequences of home care are balanced against the consequences of acute hospitalization or long-term institutionalization. This change would prevent the shift of costly, capitated patients to uncapitated settings.[13,14,15]

It is our responsibility to take charge of the system and advocate for change that leads to a shared responsibility between physician, home care agency, and patient. Perhaps we should focus on bringing about a system we would want for ourselves, should we ever need it.—**HOLLIS DAY, MD, BRUCE KINOSIAN, MD**, *University of Pennsylvania, Philadelphia.*

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