Health Care Financing Note

Use of Medicare-covered home health agency services, 1988

by Herbert A. Silverman

From 1974 through 1983, Medicare-covered home health visits and expenditures increased at double digit rates (18.4 and 29.0 percent annually, respectively). During the period from 1984 through 1987, intensified bill review by fiscal intermediaries and increased denial rates led to a decline in the number of home health visits. New reimbursement policies led to a markedly reduced rate of increase in the payments for home health services. By 1988, the use of and expenditures for home health services resumed rising. In this article, the trends in home health service use and expenditures are presented and the changes in legislation and policies that affected them are discussed.

Introduction

In this article, data are presented on the use of and program payments for Medicare-covered home health agency (HHA) services rendered in 1988 to aged and disabled beneficiaries. The data are examined in relation to:

- The trends since 1974.
- The factors contributing to the increase in program payments for HHA visits.
- The distribution of HHA services and program payments by beneficiary residence.
- The distribution of HHA services and program payments by demographic characteristics.
- The service patterns by different types of HHAs.
- The number of visits received by the beneficiary.
- The type of HHA providing the services.
- The geographic distribution of HHAs by type of agency.

Changes in legislation and regulations that have affected the use of HHA services are also discussed.

The HHA concept was originally conceived as a stage in the continuum of care following hospitalization where the patient's recovery and rehabilitation could be effectively continued at the patient's home at lower cost than if furnished either in a hospital or skilled nursing facility (SNF). Subsequent changes in legislation and regulations gave increasing weight to HHA services as a means of providing health care services to the beneficiary in the home to maintain health and functional capabilities to forestall the need for hospitalization or other institution-based care. This will be discussed in more detail later in this article.

Reprint requests: Herbert A. Silverman, Ph.D., Health Care Financing Administration, Office of Research and Demonstrations, Room 2502 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Eligibility criteria

Beneficiary eligibility for HHA services requires that the following conditions be met:

- The beneficiary must be confined to the home. This does not mean that the beneficiary must be bedridden. However, the beneficary's condition should be such that there exists a normal inability to leave home and that to do so would require a considerable effort. If the beneficiary does leave home, he or she may be considered homebound if the absences are infrequent or for periods of relatively short duration or are attributable to the need to receive medical treatment.
- The services are provided under a plan of care established and periodically reviewed by a physician. The plan must contain all pertinent diagnoses, including the beneficiary's mental status; the types of services, supplies, and equipment ordered; the frequency of the visits to be made; prognosis; rehabilitation potential; functional limitations; activities permitted; nutritional requirements; medications and treatment; safety measures to protect against injury; discharge plans; and any additional items the HHA (usually represented by the home health care nurse who assists in the development of the plan) or the physician choose to include. The plan of care must be reviewed and signed by a physician no less frequently than every 2 months.
- The beneficiary is under the care of a physician. The beneficiary is expected to be under the care of the physician who signs the plan of care and the physician certification.
- The beneficiary needs intermittent skilled nursing care, physical therapy, or speech therapy. If these services are required, occupational therapy may also be provided. For the purpose of qualifying for HHA services, "intermittent" is defined as meaning 4 or fewer days of skilled nursing services, physical therapy, or speech therapy per week, or 7 days per week for 21 consecutive days or longer for a finite and predictable period of time in exceptional circumstances.
- The HHA services are provided by an agency certified to participate in the Medicare program.

Covered services

Once eligibility for HHA services is established in accordance with the previous criteria, the services covered under the Medicare HHA benefit include:

- Part-time or intermittent skilled nursing care. To be covered as skilled nursing services, the services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, and must be reasonable and necessary to the treatment of the beneficiary's illness or injury. For the purpose of coverage determination, "part-time" means up to 35 hours per week of combined nursing and

home health aide services for less than 8 hours per day for any number of days per week. "Intermittent" is considered to be up to 35 hours of combined nursing and home health aide services per week provided for 6 or fewer days per week for any number of hours per day, or up to 8 hours per day on a daily basis for up to 21 consecutive days or longer for a finite and predictable period of time in exceptional circumstances.

- Skilled therapy services. These include physical, speech, and occupational therapy. The service of a physical, speech, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. The skilled services must be reasonable and necessary to the treatment of the beneficiary's illness or injury or to the restoration or maintenance of the function affected by the illness or injury.
- Part-time or intermittent (as defined previously) home health aide services. The home health aide provides hands-on personal care of the beneficiary or services needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury.
- Medical social services. The primary role of the medical social worker is to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the beneficiary's medical condition or rate of recovery.
- Medical supplies (except for drugs and biologicals) and the use of durable medical equipment (DME). Medical supplies are items which, because of their therapeutic or diagnostic characteristics, are essential to enabling HHA personnel to carry out effectively the prescribed care. Supplies include such items as catheters, needles, syringes, surgical dressings and materials used for dressings such as cotton gauze and adhesive bandages, and materials used for aseptic techniques. Other medical supplies include, but are not limited to, irrigating solutions and intravenous fluids. DME are items that can stand repeated use and are used primarily for medical purposes and are not generally useful in the absence of illness or injury. Items meeting these criteria include hospital beds, wheelchairs, hemodialysis equipment, iron lungs, crutches, canes, etc. The beneficiary is responsible for a coinsurance payment of 20 percent of the reasonable charge for DME.
- Services of interns and residents. The Medicare HHA benefit includes the medical services of interns and residents-in-training under an approved hospital teaching program.
- Outpatient services. Outpatient services under the HHA benefit include any of the previously described items or services that are provided under arrangements on an outpatient basis at a hospital, SNF, rehabilitation center, or outpatient department affiliated with a medical school because they cannot be readily provided in the beneficiary's home, or which are furnished while the patient is at an outpatient facility to receive services that cannot be readily furnished in the home.

Trends

Data on the use of and program payments for home health services for selected years from 1974 through 1988 are shown in Table 1. The data begin in 1974, when data on the number of HHA visits were first obtained. Program payment data are available for earlier years and will be referenced in the ensuing discussion. The discussion differentiates the data before and after 1983. The year 1983 marked the introduction of the Medicare prospective payment system (PPS) for hospitals. It was anticipated that PPS would have a major impact on the use of Medicare's post-hospital benefits (i.e., SNFs and HHAs). The data in Table 1 do show a shift in the trend for HHA services. For this reason, 1983 is taken as the dividing year for the discussion of the data.

The data show that the use of and payments for HHA services have had a rapid rate of growth since 1974, especially during the period from 1974 through 1983. During that period, the proportion of enrollees receiving HHA services almost tripled, from 16 to 45 per 1,000 enrollees—an average annual rate of growth (AARG) of 12.2 percent. Reflecting the growth in the enrollee population, the actual number of persons using HHA services increased at an even more rapid rate, from about 392,700 to about 1.4 million—an AARG of 14.7 percent. During the same period, program payments for HHA services increased almost tenfold, from about $141 million to almost $1.4 billion—an AARG of 29.0 percent.

The rapid growth in the use of HHA services during the years prior to 1983 reflects the liberalization of the HHA benefit through legislative changes. Among the more significant changes were:

- The Social Security Amendments of 1972 (Public Law 92-603) eliminated the 20-percent coinsurance for HHA services furnished under Part B of Medicare. The first major increase in program payments for HHA services followed the passage of this provision. From 1972 through 1973, program payments increased from $66.2 to $93.3 million. If the rise in program payments for HHA services were shown for the period from 1972 through 1983, the AARG would be 32 percent.
- The Omnibus Reconciliation Act (ORA) of 1980 (Public Law 96-499) contained the following major provisions relating to the HHA benefit: It eliminated the 100 visits per year limit on HHA visits under Part A and Part B (i.e., no limits on the number of HHA visits); it eliminated the 3-day prior hospitalization requirement under Part A as a condition for the receipt of HHA services; it eliminated the requirement of meeting the Part B deductible before Medicare payments for HHA services could be initiated; and it permitted proprietary HHAs to furnish Medicare-covered services in States not having licensure laws. As a result of this provision, the number of proprietary agencies certified to participate in the Medicare program increased from 165 in 1980 to 1,841 in 1985.

The provisions of ORA 1980 became effective July 1, 1981. The first full year of their effect was 1982. Table 1 shows a 67-percent increase in HHA payments from 1980 through 1982.

Table 1

Trends in home health agency services under Medicare for persons served, visits, charges, and program payments, by selected years: 1974-88

Year of service	Persons served		Visits			Total charges in thousands	Visit charges				Program payments		
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per person served	Per 1,000 enrollees		Amount in thousands	Per visit	Per person served	Per enrollee	Amount in thousands	Per person served	Per enrollee
1974	392.7	16	8,070	21	340	$147,499	$137,406	$17	$350	$6	$141,484	$360	$6
1976	588.7	23	13,335	23	520	312,325	292,697	22	497	11	289,851	492	11
1978	769.7	28	17,345	23	639	500,747	474,498	27	617	18	435,322	566	16
1980	957.4	34	22,428	23	788	770,703	734,718	33	767	26	662,133	692	23
1982	1,171.9	40	30,787	26	1,044	1,296,454	1,232,684	40	1,052	42	1,104,715	943	37
1983	1,351.2	45	36,844	27	1,227	1,657,024	1,596,989	43	1,182	53	1,398,092	1,035	47
1984	1,515.9	50	40,337	27	1,324	1,982,033	1,843,706	46	1,216	61	1,666,253	1,099	55
1985	1,588.6	51	39,742	25	1,279	2,124,312	2,040,887	51	1,285	66	1,773,048	1,116	57
1986	1,600.2	50	38,359	24	1,208	2,190,238	2,102,253	55	1,314	66	1,795,820	1,122	57
1987	1,564.5	48	36,088	23	1,113	2,210,670	2,104,753	58	1,345	65	1,791,589	1,145	55
1988	1,601.7	49	37,713	24	1,144	2,453,974	2,341,441	62	1,462	71	1,945,768	1,215	59
						Average annual rate of growth							
1974-88	10.6	8.3	11.6	1.0	9.1	22.2	22.4	9.7	10.8	19.3	20.6	9.1	17.7
1974-83	14.7	12.2	18.4	2.8	15.3	30.8	31.3	10.9	14.5	27.4	29.0	12.5	25.7
1983-88	3.5	1.7	0.5	−2.4	−1.4	8.2	8.0	7.6	4.3	6.0	6.8	3.3	4.6

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data are from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

The net effect of these expansions to the Medicare HHA benefit was to loosen the linkage of HHA services to the treatment of acute illnesses, reduce the institutional bias of the Medicare benefit structure, and place greater emphasis on the availability of in-home and community-based services. In short, HHA services became increasingly viewed as a possible alternative to institutional forms of care as well as being a significant stage in the continuum of care following hospitalization. A report of the Senate Committee on Labor and Human Resources (1982) expressed this viewpoint:

"It is the perception of this committee that increased utilization of home health care should result in long-term federal cost savings through decreased nursing home and hospital admissions and shorter lengths of stay, as well as by increasing family support for the elderly. Of equal importance is the knowledge that increased availability of home health care will enable many elderly and chronically ill persons to maintain their independence and community ties and to lead lives of greater personal dignity and satisfaction."

Although the previously mentioned provisions were fully implemented by 1983, there were expectations that the institution of PPS would lead to further acceleration in the use of HHA services. These expectations were based on incentives embedded in PPS for hospitals to discharge at an earlier date patients who would need more post-hospital nursing and rehabilitative services, particularly HHA services for those discharged to their home.

The data in Table 1 show that the proportion of enrollees served by HHAs rose from 45 per 1,000 in 1983 to 50 per 1,000 in 1984, an increase of 11 percent. The user rate has remained relatively stable since then. The number of HHA visits, the average number of visits per person served, and visits per 1,000 enrollees decreased from their 1984 peaks. This decline in the volume of HHA visits reflects the effect of a series of events affecting the administration of the HHA benefit by the Health Care Financing Administration (HCFA).

During the late 1970s and the early 1980s, reports by the U.S. General Accounting Office (1979; 1981; 1982) and the Office of the Inspector General (1981) of the Department of Health and Human Services were critical of HCFA for its administration of the HHA benefit. In particular, their investigations suggested that up to 30 percent of the home health visits paid for by Medicare did not meet the conditions for coverage. The reports noted inconsistencies in coverage determinations among the Medicare fiscal intermediaries and notable instances of fraud and abuse. In the Deficit Reduction Act of 1984 (Public Law 98-369), Congress mandated that there be no more than 10 regional intermediaries to process HHA claims. Such concentration of function would increase intermediary expertise in the provisions of the HHA benefit, provide greater consistency in the review of claims, and increase alertness to instances of fraud and abuse. Following the congressional mandate, HCFA undertook intensified training of the personnel in the designated regional intermediaries in the criteria of coverage for HHA benefits and made extensive revisions to written administrative guidelines and instructions. These activities intensified the review of HHA claims and resulted in an increased rate of denials of claims for coverage and payment. These are reflected in the decline in the number of covered visits from its 1984 peak. By 1988, the decline in the number of covered visits seemed to have bottomed out and resumed rising.

Program payments for HHA services grew at a much slower rate during the period from 1983 through 1988 (AARG = 6.8 percent) than they did during the period from 1974 through 1983 (AARG = 29.0 percent). Further, unpublished data show that overall Medicare payments grew at a more rapid rate from 1983 through 1988, from $53.4 billion to $81.4 billion (AARG = 8.8 percent), than did HHA payments. During the period from 1967 through 1983, HHA payments grew at a much greater rate (AARG = 24.3 percent) than did overall program payments (AARG = 17.2 percent). From 1983 through 1988, however, program payments for HHA services decreased from 2.6 percent of total Medicare payments to 2.4 percent.

Changes in the rate of growth of program payments for HHA services reflect not only changes in the number of persons admitted to HHA services and the volume of services furnished, but also changes in the methods of paying for the services. During the post-PPS period, Medicare instituted changes in the method of paying for HHA services.

HHAs are generally reimbursed for the costs of furnishing services to Medicare beneficiaries, but the Social Security Act authorizes the establishment of prospective limits on the allowable costs incurred by providers of services that may be reimbursed by the program, based on estimates of the costs necessary for the efficient delivery of needed services. Beginning in 1979, limits have been maintained on HHA per visit costs. Until July 1, 1985, the per visit limit was based on the aggregate of visits made by HHAs. For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986, the limits were imposed for each type of visit. For this period, the limits were established at 120 percent of the mean labor-related and nonlabor per visit costs for freestanding HHAs applied on a discipline-specific basis. The regulations instituting the new limits *(Federal Register,* 1985*)* provided that effective on July 1, 1986, the limit would be reduced further to 115 percent of the mean cost, and to 112 percent effective July 1, 1987. In each year, the mean cost would be adjusted by an input price (market basket) index that reflects the price of goods and services purchased by HHAs.

The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) mandated a return to HHA visit cost limits applied on an aggregate basis rather than on a discipline-specific basis, but retained the target cost limits proposed in the above-noted regulations. The limits and the methodologies developed for establishing visit cost limits have been effective in constraining the rise in program payments for HHA visits. The data show that, on the basis of computations explained in relation to the discussion of Table 2, average program payments per HHA visit increased at an AARG of 9.4 percent from 1974 through 1983. From 1983 through 1988, the AARG for the average payment per visit was reduced to 6.1 percent. However, from 1985 through 1988, the AARG was reduced further to 4.7 percent. For the years

Table 2

Medicare program payments for home health agency visits and average annual rate of growth, by factor: Calendar years 1974, 1983, and 1988

Factor	Calendar years			Average annual rate of growth		
	1974	1983	1988	1974-88	1974-83	1983-88
Charges in thousands					Percent	
Total HHA charges	$147,499	$1,657,024	$2,453,974	22.2	30.8	8.2
Total visit charges	$137,406	$1,596,989	$2,341,441	22.4	31.3	8.0
Ratio of visit to total charges	0.932	0.964	0.954	NA	NA	NA
Reimbursement and visits in thousands						
Total HHA reimbursements	$141,484	$1,398,092	$1,945,768	20.6	29.0	6.8
HHA visit reimbursements	$131,806	$1,347,481	$1,856,457	20.8	29.5	6.6
HHA visits	8,070	36,844	37,713	11.6	18.4	0.5
Reimbursement per HHA visit	$16.33	$36.57	$49.23	8.2	9.4	6.1
Enrollment and use						
Medicare enrollment in thousands	24,201.0	30,026.1	32,980.0	2.2	2.4	1.9
Persons served	392,700	1,351,200	1,601,700	10.6	14.7	3.5
Persons served per 1,000 enrollees	16	45	49	8.3	12.2	1.7
Visits per person served	21	27	24	1.0	2.8	−2.4
Contribution to rise in HHA visit reimbursement					Percent contribution	
Total	—	—	—	—	100.0	100.0
Medicare enrollment[1]	—	—	—	—	8.9	25.8
Persons served per 1,000 enrollees	—	—	—	—	45.4	22.7
HHA visits per person served	—	—	—	—	10.5	−31.8
Average reimbursement per visit	—	—	—	—	35.2	83.3

[1]As of July 1.

NOTES: HHA is home health agency. NA is not applicable.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data are from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

1983 through 1988, the average payments per visit were: $36.57, $38.41, $42.86, $44.93, $47.27, and $49.23.

The rates of change in those factors that affect the amount of program payments for HHA visits are shown in Table 2. The data are shown for three time periods: 1974-88, 1974-83, and 1983-88. Total payments for HHA visits can be represented by the following identity:

$$(R) = (E) \times (PS/E) \times (V/PS) \times (R/V)$$

where

- R = the total Medicare payments for HHA visits. This is derived by taking the ratio of visit charges to total charges and multiplying by total program payments to HHAs.
- E = the total Medicare enrollment as of July 1 of each year.
- PS/E = the proportion of enrollees receiving Medicare-reimbursed HHA services.
- V/PS = the average number of HHA visits per person served.
- R/VN = the average program payment per HHA visit.

For a specified period, the AARG in program payments for HHA visits is equal to the sum of the AARGs of the terms on the right side of the identity. The ratio of each of the individual terms on the right to their sum is the proportion of the increase in total program payments contributed by the individual factor. This procedure distributes the interactive effects of the known factors acting together. The combined interactive effects are distributed in proportion to the effect of the individual factors acting alone (Klarman, 1970).

Examination of the factors affecting program payments for HHA visits during the periods 1974-83 and 1983-88 shows a shift in their relative contributions. During the 1974-83 period, 64.8 percent of the increase in program payments was due to the increased volume of visits attributable to increased enrollment, an increased proportion of enrollees receiving HHA visits, and the rise in average number of visits received by HHA clients. During the 1983-88 period, there was a notable slowing in the rate of growth in the proportion of enrollees receiving HHA services and an actual decrease in the average number of visits received. This significantly reduced the rate of increase in the volume of HHA visits. Thus, despite the previously noted constraint on the rise of the average program payment per visit, it was the rise in this factor that accounted for 83.3 percent of the increase in program payments for HHA visits.

The geographic distribution of HHA services by the residence of the beneficiary is shown in Table 3. Beneficiaries in the South show the greatest use of HHA services. The proportion receiving HHA services (53.1 per 1,000 enrollees) and the average number of visits received per person served (29.6) are highest in the South. Although average charges are not highest in the

Table 3

Home health agency services under Medicare for persons served, visits, charges, and program payments, by area of residence: Calendar year 1988

Area of residence	Persons served		Visits			Charges	Visit charges				Program payments	
	Number in thousands	Per 1,000 enrollees	Number in thousands	Total per person served	Per 1,000 enrollees	in thousands	Amount in thousands	Per visit	Per person served	Per enrollee	Amount in thousands	Per enrollee
All areas	1,602	48.6	37,713	23.5	1,144	$2,453,974	$2,341,441	$62	$1,462	$71	$1,945,768	$59
United States	1,580	48.9	37,341	23.6	1,158	2,424,597	2,316,691	62	1,466	72	1,924,517	60
Northeast	374	51.2	7,595	20.3	1,041	488,532	477,164	63	1,278	65	403,668	55
North Central	354	43.2	7,177	20.3	877	446,950	434,403	61	1,227	53	366,133	45
South	583	53.1	17,250	29.6	1,569	1,095,818	1,029,661	60	1,765	94	823,093	75
West	270	46.5	5,319	19.7	917	393,297	375,463	71	1,392	65	331,624	57
New England	94	51.1	2,071	22.0	1,123	111,199	107,814	52	1,143	58	52,000	55
Connecticut	24	51.8	567	24.0	1,244	30,545	30,261	53	1,280	66	26,498	58
Maine	7	42.0	162	21.7	912	7,920	7,541	47	1,012	42	7,176	40
Massachusetts	44	51.6	899	20.5	1,057	48,705	47,424	53	1,081	56	44,882	53
New Hampshire	6	48.5	128	19.9	966	6,530	6,378	50	995	48	6,062	46
Rhode Island	7	46.7	170	23.5	1,097	11,473	10,333	61	1,423	66	10,928	70
Vermont	6	77.9	145	25.6	1,998	6,027	5,877	41	1,041	81	5,454	75
Middle Atlantic	279	51.2	5,524	18.8	1,014	377,333	369,350	67	1,323	68	922	56
New Jersey	49	45.8	848	17.4	795	53,557	52,643	62	1,078	49	46,276	43
New York	100	40.1	1,670	16.8	873	127,682	125,141	75	1,257	50	99,238	40
Pennsylvania	131	68.8	3,006	23.0	1,580	196,094	191,566	64	1,464	101	157,153	83
East North Central	253	45.1	5,068	20.0	903	321,520	312,608	62	1,235	56	13,198	47
Illinois	76	50.6	1,564	20.6	1,043	107,277	103,494	66	1,363	69	84,284	56
Indiana	26	35.0	530	20.6	720	29,844	28,483	54	1,105	39	26,203	36
Michigan	63	53.0	1,403	22.2	1,179	95,397	93,574	67	1,483	79	78,536	66
Ohio	62	41.3	1,089	17.7	730	64,735	63,378	58	1,030	42	53,786	36
Wisconsin	27	38.5	483	18.1	695	24,267	23,680	49	886	34	22,217	32
West North Central	101	39.2	2,108	20.9	819	125,430	121,795	58	1,207	47	18,581	39
Iowa	13	28.3	234	18.5	523	10,841	10,603	45	836	24	9,464	21
Kansas	11	30.4	242	22.5	682	14,463	14,029	58	1,300	39	10,844	31
Minnesota	11	19.3	177	16.0	309	10,031	9,759	55	884	17	8,647	15
Missouri	52	68.5	1,180	22.6	1,550	74,957	73,081	62	1,401	96	58,886	77
Nebraska	9	37.8	170	19.3	729	9,667	8,988	53	1,019	39	8,537	37
North Dakota	3	29.4	57	19.9	586	3,060	2,983	53	1,049	31	2,571	27
South Dakota	3	23.5	48	18.9	445	2,409	2,352	49	929	22	2,158	20
South Atlantic	296	50.8	7,980	27.0	1,370	505,828	477,543	60	1,613	82	213,697	68
Delaware	5	54.0	125	27.5	1,487	6,711	6,357	52	1,445	78	5,044	60
District of Columbia	4	48.7	82	21.5	1,046	5,574	5,445	66	1,429	70	4,816	62
Florida	131	59.6	3,646	27.8	1,657	234,855	225,948	62	1,722	103	178,594	81
Georgia	33	46.9	1,149	35.0	1,644	78,989	73,234	64	2,233	105	58,972	84
Maryland	26	51.0	542	20.6	1,048	35,387	33,965	63	1,289	66	29,978	58
North Carolina	37	44.5	986	26.3	1,169	55,745	49,997	51	1,333	59	45,733	54
South Carolina	19	44.4	453	24.5	1,085	29,298	26,758	59	1,444	64	22,514	54
Virginia	29	42.9	721	24.5	1,051	43,143	40,863	57	1,387	60	36,962	54
West Virginia	12	39.8	276	23.1	919	16,127	14,976	54	1,240	49	13,003	43

See footnotes at end of table.

Table 3—Continued

Home health agency services under Medicare for persons served, visits, charges, and program payments, by area of residence: Calendar year 1988

Area of residence	Persons served		Visits			Charges	Visit charges				Program payments	
	Number in thousands	Per 1,000 enrollees	Number in thousands	Total per person served	Per 1,000 enrollees	in thousands	Amount in thousands	Per visit	Per person served	Per enrollee	Amount in thousands	Per enrollee
East South Central	137	65.0	5,433	39.8	2,584	$328,496	$306,935	$56	$2,247	$146	$19,398	$115
Alabama	32	56.7	1,144	35.9	2,033	65,885	62,675	55	1,966	111	52,000	92
Kentucky	23	43.6	654	28.9	1,263	35,862	32,509	50	1,439	63	28,216	55
Mississippi	30	84.3	1,401	46.5	3,921	83,734	78,438	56	2,603	219	58,165	163
Tennessee	52	78.2	2,235	43.0	3,359	143,016	133,312	60	2,563	200	104,232	157
West South Central	151	49.2	3,837	25.5	1,253	261,494	245,183	64	1,628	80	26,498	60
Arkansas	15	40.4	421	27.4	1,106	27,416	26,231	62	1,707	69	18,581	49
Louisiana	31	60.6	919	29.6	1,790	60,322	55,356	60	1,781	108	43,725	85
Oklahoma	20	44.6	457	23.4	1,044	30,849	29,530	65	1,514	67	23,607	54
Texas	85	48.9	2,041	24.1	1,178	142,906	134,066	66	1,584	77	98,952	57
Mountain	55	35.9	1,271	23.3	836	81,256	77,762	61	1,424	51	5,044	45
Arizona	11	23.2	224	20.9	485	15,095	13,983	62	1,307	30	13,198	29
Colorado	14	42.1	328	23.3	981	22,542	22,067	67	1,567	66	19,398	58
Idaho	5	39.7	95	18.9	751	5,561	5,148	54	1,028	41	4,928	39
Montana	5	40.9	115	24.9	1,017	6,089	5,862	51	1,272	52	5,134	46
Nevada	5	39.3	119	25.1	987	8,297	7,983	67	1,680	66	6,668	55
New Mexico	6	38.7	118	18.2	706	7,370	6,953	59	1,072	42	5,966	36
Utah	8	51.1	246	32.3	1,650	14,724	14,253	58	1,871	96	11,036	74
Wyoming	(1)	27.7	26	19.6	542	1,579	1,513	58	1,133	31	1,425	30
Pacific	215	50.3	4,048	18.8	946	312,040	297,701	74	1,384	70	4,816	62
Alaska	(1)	23.7	12	22.5	534	769	756	65	1,460	35	922	42
California	171	54.3	3,238	18.9	1,027	256,755	244,272	75	1,428	77	213,697	68
Hawaii	2	20.7	38	15.5	321	2,899	2,748	73	1,126	23	2,479	21
Oregon	16	39.2	282	17.8	700	20,441	19,680	70	1,244	49	18,499	46
Washington	25	43.2	478	18.9	818	31,178	30,246	63	1,198	52	28,275	48
Outlying areas[2]	21	50.3	372	17.5	880	29,378	24,750	67	1,164	59	21,251	50

[1] More than zero but less than 500 persons.
[2] Includes Puerto Rico and other outlying areas.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data are from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 4

Home health agency services under Medicare for persons served, visits, charges, and program payments, by age, sex, and Medicare status: Calendar year 1988

Age, sex, and Medicare status	Persons served		Visits			Total charges	Visit charges				Program payments		
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per person served	Per 1,000 enrollees	in thousands	Amount in thousands	Per visit	Per person served	Per enrollee	Amount in thousands	Per person served	Per enrollee
Total	1,602	48.6	37,713	23.5	1,144	$2,453,974	$2,341,441	$62	$1,462	$71	$1,945,768	$1,215	$59
Age													
Under 65 years	93	30.1	2,663	28.5	859	178,052	165,281	62	1,770	53	137,572	1,473	44
65-69 years	365	38.6	8,126	22.3	858	536,352	513,767	63	1,407	54	424,713	1,163	45
70-74 years	339	43.8	7,791	23.0	1,005	507,606	486,859	62	1,435	63	403,498	1,190	52
75-79 years	345	59.5	8,016	23.3	1,384	519,165	496,544	62	1,441	86	411,642	1,195	71
80-84 years	264	70.1	6,321	24.0	1,679	405,742	388,179	61	1,472	103	323,498	1,227	86
85 years and over	196	63.1	4,796	24.5	1,546	307,056	290,810	61	1,485	94	244,845	1,251	79
Sex													
Male	581	41.7	13,317	22.9	956	873,824	829,606	62	1,428	60	690,477	1,189	50
Female	1,021	53.6	24,396	23.9	1,281	1,580,150	1,511,836	62	1,481	79	1,255,291	1,230	66
Medicare status													
Aged	1,508	52.3	35,105	23.4	1,218	2,279,424	2,179,426	63	1,471	76	1,810,921	1,227	63
Disabled	93	30.1	2,663	28.5	859	178,052	165,281	62	1,770	53	137,572	1,473	44

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data are from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

South, the intensity of use results in an average program payment per enrollee ($75) that is 25 percent above the national average and almost 32 percent greater than the next highest region. States that showed a user rate greater than 60 per 1,000 enrollees and a visit use rate greater than 1,500 per 1,000 enrollees were Vermont, Pennsylvania, Missouri, Mississippi, Tennessee, and Louisiana. Other States with a visit use rate greater than 1,500 per 1,000 enrollees were: Florida, Georgia, Alabama, and Utah. Program payments per enrollee of $74 or greater were made only to the above-noted States.

The patterns of use and expenditures for HHA services by enrollee demographic characteristics are shown in Table 4. The rate of use rises by age through the age groups encompassing those 65-84 years; there is a slight tapering off for those 85 years of age or over, reflecting perhaps the greater use of nursing home services in the oldest age group. Reimbursement per enrollee, which is the product of the user rate (users per enrollee) and the reimbursement per user, shows the same pattern. Among persons served, those under 65 years of age (i.e., the disabled, including persons with end stage renal disease) used more services; that is, they received more visits and higher reimbursement per user. However, because of a lower user rate, the disabled receive a rate of reimbursement per enrollee ($44) that is about two-thirds of that for the aged ($63). By all measures of use and expenditures, women use HHA services to a greater extent than men. This reflects the older age distribution of women.

Table 5 is a summary of the data shown in Tables 6 and 7. Highlighted in Table 5 are the service patterns by the different types of HHAs. Proprietary agencies were the dominant type of agency: They served more beneficiaries, provided more visits, and received more program payments than any other type of agency. Their patterns of services differed notably from the other types of agencies. Persons served by proprietary agencies received more visits, and the distribution by types of visits differed from other agencies. Persons served by proprietary agencies received, on average, 29.6 visits—this was 5.5 visits more than furnished by the next highest category of agencies (i.e., the private nonprofit agencies) and over 25 percent greater than the national average. The proprietary agencies were the only group that derived over one-half (54.2 percent) of its program payments from services to persons receiving 50 or more visits. Proprietary agencies received higher visit payments per person served ($1,401) than other agencies.

In addition to differing from other agencies in the volume of services furnished to their clientele, proprietary agencies also differed in the distribution of visits by type of service. Proprietary agencies were the only group in which nursing care visits constituted less than one-half of all visits. The percent of visits made by home health aides (38.3 percent) was greater than for other agencies. The available data do not permit any explanation of the reasons for these differences in visit patterns—whether because of differences in case mix or administrative practices.

The geographic distribution of the different types of agencies are shown in Table 8. Although the data are for 1989, they approximate the 1988 distribution. The data in Table 8 provide additional insights into the data discussed earlier. Proprietary agencies constitute one-third of all

Table 5

Home health agency services under Medicare, by type of agency and service patterns: Calendar year 1988

Service patterns	All agencies[1]	Visiting nurse association	Combined Government and voluntary	Government	Hospital-based	Proprietary	Private nonprofit
Percent of persons served	100.0	22.9	0.7	8.7	25.7	26.5	14.2
Percent of visits provided	100.0	20.4	0.5	7.9	22.2	33.4	14.5
Percent of total reimbursement received	100.0	21.0	0.5	7.1	24.1	32.2	14.1
Percent of visits by:							
Nurse	51.1	53.6	54.7	50.0	53.8	48.5	50.4
Home health aide	33.8	29.4	26.8	37.6	30.0	38.3	33.7
Physical therapy	11.5	12.6	16.3	9.9	12.4	10.2	12.3
Others	3.5	4.5	2.4	2.5	3.8	2.9	3.6
Visits received by median person	13.0	11.5	8.2	11.0	11.6	16.2	13.5
Visits received by person at median of array of visits	46.5	40.5	31.4	45.5	37.9	58.5	46.2
Average number of visits per person served	23.5	20.9	17.6	21.4	20.3	29.6	24.1
Average reimbursement per visit	$49.23	$51.17	$48.33	$43.50	$53.37	$47.32	$47.53
Average visit reimbursement per person served	$1,157	$1,069	$851	$931	$1,083	$1,401	$1,145
Percent of total reimbursements derived from services to persons with 50 or more visits	45.7	42.1	33.7	45.5	38.4	54.2	45.1

[1] Includes rehabilitation and skilled nursing facility-based agencies, not shown separately.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data are from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 6

Home health agency services under Medicare for persons served, visits, total charges, and program payments, by type of agency and number of visits: Calendar year 1988

Type of agency and number of visits	Persons served		Visits		Total charges		Program payments	
	Number in thousands	Percent	Number in thousands	Percent	Amount in thousands	Percent	Amount in thousands	Percent
All agencies[1]								
Total	1,602	100.0	37,713	100.0	$2,453,974	100.0	$1,945,768	100.0
1-9	665	41.5	3,224	8.5	226,752	9.2	179,243	9.2
10-19	393	24.5	5,441	14.4	374,228	15.2	295,772	15.2
20-29	190	11.9	4,557	12.1	306,762	12.5	243,067	12.5
30-39	105	6.6	3,590	9.5	237,638	9.7	189,145	9.7
40-49	66	4.1	2,898	7.7	189,231	7.7	150,033	7.7
50-99	118	7.4	8,057	21.4	515,507	21.0	408,035	21.0
100 and over	64	4.0	9,946	26.4	603,856	24.6	480,473	24.7
Visiting nurse association								
Total	367	100.0	7,694	100.0	481,424	100.0	408,790	100.0
1-9	165	45.0	790	10.3	53,818	11.2	43,953	10.8
10-19	92	24.9	1,264	16.4	84,548	17.6	69,742	17.1
20-29	41	11.3	989	12.8	64,244	13.3	53,591	13.1
30-39	22	6.0	748	9.7	47,701	9.9	40,229	9.8
40-49	13	3.4	551	7.2	34,547	7.2	29,202	7.1
50-99	23	6.2	1,538	20.0	93,823	19.5	80,171	19.6
100 and over	12	3.2	1,814	23.6	102,744	21.3	91,903	22.5
Combined Government and voluntary								
Total	11	100.0	200	100.0	11,287	100.0	9,996	100.0
1-9	6	50.2	28	13.8	1,710	15.2	1,471	14.7
10-19	3	23.2	36	18.1	2,171	19.2	1,882	18.8
20-29	1	11.8	32	15.9	1,892	16.8	1,631	16.3
30-39	1	5.4	21	10.4	1,159	10.3	1,027	10.3
40-49	0	2.5	12	6.2	712	6.3	625	6.3
50-99	1	4.9	38	19.0	2,063	18.3	1,835	18.4
100 and over	0	2.0	33	16.5	1,579	14.0	1,525	15.3
Government								
Total	140	100.0	2,991	100.0	157,582	100.0	137,689	100.0
1-9	65	46.7	307	10.3	17,598	11.2	15,110	11.0
10-19	33	23.9	460	15.4	25,927	16.5	21,983	16.0
20-29	14	10.3	343	11.5	18,974	12.0	16,103	11.7
30-39	8	5.5	261	8.7	14,121	9.0	12,171	8.8
40-49	5	3.4	207	6.9	11,070	7.0	9,585	7.0
50-99	9	6.5	630	21.1	32,680	20.7	28,800	20.9
100 and over	5	3.8	784	26.2	37,212	23.6	33,937	24.6

See footnotes at end of table.

Table 6—Continued

Home health agency services under Medicare for persons served, visits, total charges, and program payments, by type of agency and number of visits: Calendar year 1988

Type of agency and number of visits	Persons served		Visits		Total charges		Program payments	
	Number in thousands	Percent	Number in thousands	Percent	Amount in thousands	Percent	Amount in thousands	Percent
Hospital-based								
Total	412	100.0	8,388	100.0	$584,911	100.0	$468,309	100.0
1-9	184	44.7	900	10.7	68,212	11.7	53,916	11.5
10-19	104	25.2	1,435	17.1	106,170	18.2	84,015	17.9
20-29	48	11.5	1,138	13.6	81,843	14.0	65,575	14.0
30-39	25	6.1	855	10.2	60,400	10.3	48,610	10.4
40-49	15	3.6	657	7.8	45,604	7.8	36,658	7.8
50-99	25	6.1	1,696	20.2	114,568	19.6	92,509	19.8
100 and over	11	2.8	1,706	20.3	108,114	18.5	87,026	18.6
Proprietary								
Total	425	100.0	12,606	100.0	837,566	100.0	625,968	100.0
1-9	146	34.4	714	5.7	50,927	6.1	38,153	6.1
10-19	99	23.3	1,384	11.0	96,498	11.5	72,448	11.6
20-29	55	13.0	1,331	10.6	90,732	10.8	68,216	10.9
30-39	33	7.8	1,140	9.0	76,551	9.1	57,594	9.2
40-49	23	5.4	1,008	8.0	67,099	8.0	50,279	8.0
50-99	43	10.1	2,923	23.2	192,265	23.0	143,384	22.9
100 and over	26	6.1	4,105	32.6	263,495	31.5	195,895	31.3
Private nonprofit								
Total	227	100.0	5,467	100.0	355,931	100.0	275,242	100.0
1-9	90	39.6	445	8.1	31,692	8.9	24,479	8.9
10-19	58	25.4	801	14.6	54,610	15.3	42,364	15.4
20-29	28	12.3	672	12.3	45,290	12.7	35,027	12.7
30-39	15	6.8	526	9.6	34,953	9.8	27,381	9.9
40-49	10	4.3	431	7.9	27,877	7.8	21,882	8.0
50-99	17	7.5	1,163	21.3	75,346	21.2	57,674	21.0
100 and over	9	4.1	1,429	26.1	86,163	24.2	66,435	24.1

[1] Includes rehabilitation facility and skilled nursing facility-based agencies not shown separately.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data are from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 7

Use and cost of home health agency services under Medicare, by agency and type of visit: Calendar year 1988

Utilization and type of visit	All agencies	Visiting nurse association	Combined Government and voluntary	Government	Hospital based	Proprietary	Private nonprofit	Other[1]
				Persons served in thousands				
Total[2]	1,602	367	11	140	412	425	227	18
Nursing care	1,449	331	10	129	373	386	204	16
Home health aide	609	126	3	49	141	198	86	7
Physical therapy	467	115	3	32	119	125	66	6
Other[3]	279	74	1	11	70	80	39	4
				Percent of persons served				
Total[2]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing care	90.5	90.2	91.5	91.9	90.4	90.6	89.9	89.7
Home health aide	38.0	34.2	27.2	35.1	34.2	46.4	37.8	36.5
Physical therapy	29.1	31.3	27.8	23.2	28.9	29.4	28.8	35.1
Other[3]	17.4	20.2	7.2	7.8	17.0	18.7	17.3	19.7
				Visits in thousands				
Total	37,713	7,694	200	2,991	8,388	12,606	5,467	367
Nursing care	19,289	4,122	109	1,494	4,515	6,113	2,754	180
Home health aide	12,739	2,259	53	1,124	2,513	4,833	1,845	110
Physical therapy	4,352	966	33	296	1,038	1,290	672	57
Other[3]	1,333	346	5	76	321	368	197	20
				Percent of visits				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing care	51.1	53.6	54.7	50.0	53.8	48.5	50.4	49.1
Home health aide	33.8	29.4	26.6	37.6	30.0	38.3	33.7	30.0
Physical therapy	11.5	12.6	16.3	9.9	12.4	10.2	12.3	15.5
Other[3]	3.5	4.5	2.4	2.5	3.8	2.9	3.6	5.4
				Visit charges in thousands				
Total	$2,341,441	$463,388	$10,917	$148,976	$558,979	$798,148	$335,966	$25,067
Nursing care	1,310,774	277,061	6,782	83,439	326,194	420,040	184,088	13,171
Home health aide	628,982	94,952	1,920	43,508	129,715	260,551	92,001	6,335
Physical therapy	298,893	64,971	1,888	17,003	76,289	89,337	45,303	4,100
Other[3]	102,792	26,404	327	5,026	26,781	28,220	14,574	1,461
				Percent of visit charges				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nursing care	56.0	59.8	62.1	56.0	58.4	52.6	54.8	52.5
Home health aide	26.9	20.5	17.6	29.2	23.2	32.6	27.4	25.3
Physical therapy	12.8	14.0	17.3	11.4	13.6	11.2	13.5	16.4
Other[3]	4.4	5.7	3.0	3.4	4.8	3.5	4.3	5.8
				Average number of visits per person served				
Total	23.5	20.9	17.6	21.4	20.3	29.6	24.1	20.4
Nursing care	13.3	12.4	10.5	11.6	12.1	15.9	13.5	11.2
Home health aide	20.9	18.0	17.2	22.9	17.8	24.5	21.5	16.8
Physical therapy	9.3	8.4	10.3	9.1	8.7	10.3	10.2	9.0
Other[3]	4.8	4.7	5.9	7.0	4.6	4.6	5.0	5.6
				Average charge per visit				
Total	$62	$60	$55	$50	$67	$63	$61	$68
Nursing care	68	67	62	56	72	69	67	73
Home health aide	49	42	36	39	52	54	50	58
Physical therapy	69	67	58	57	73	69	67	72
Other[3]	77	76	67	66	84	77	74	73
				Average visit charge per person served				
Total	$1,462	$1,262	$961	$1,065	$1,355	$1,876	$1,478	$1,395
Nursing care	904	836	652	649	875	1,089	901	817
Home health aide	1,033	756	621	885	919	1,319	1,070	966
Physical therapy	640	564	599	525	641	714	691	650
Other[3]	369	358	398	459	382	354	371	413

[1] Includes rehabilitation and skilled nursing facility-based agencies.
[2] Detail does not add to total since persons may receive more than one type of service.
[3] Includes speech or occupational therapy, medical social services, and other health disciplines.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data are from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 8

Number of home health agencies under Medicare, by type of agency and State of provider: Calendar year 1989

State of provider	Total	Visiting nurse association	Combined Government and voluntary agency	Home health agency	Rehabilitation based agency	Hospital based agency	Skilled nursing facility based agency	Proprietary	Private nonprofit
All areas	5,657	478	45	974	8	1,466	102	1,870	714
United States	5,610	474	44	971	8	1,461	102	1,870	680
Northeast	845	256	5	94	1	174	39	194	82
North Central	1,694	112	24	399	5	467	29	454	204
South	2,224	49	11	403	2	516	13	929	301
West	847	57	4	75	0	304	21	293	93
New England	333	171	1	27	1	29	4	64	36
Connecticut	103	49	0	14	0	6	2	28	4
Maine	22	6	0	0	0	3	0	6	7
Massachusetts	140	71	0	12	1	12	1	25	18
New Hampshire	38	24	1	1	0	3	1	4	4
Rhode Island	14	9	0	0	0	3	0	1	1
Vermont	16	12	0	0	0	2	0	0	2
Middle Atlantic	512	85	4	67	0	145	35	130	46
New Jersey	57	23	1	9	0	16	0	6	2
New York	196	18	3	57	0	55	31	20	12
Pennsylvania	259	44	0	1	0	74	4	104	32
East North Central	944	90	10	171	2	204	13	314	140
Illinois	246	22	1	36	1	73	1	79	33
Indiana	134	16	0	7	0	48	1	52	10
Michigan	161	12	1	36	0	9	0	57	46
Ohio	249	27	6	42	1	49	3	83	38
Wisconsin	154	13	2	50	0	25	8	43	13
West North Central	750	22	14	228	3	263	16	140	64
Iowa	153	11	3	87	1	33	0	11	7
Kansas	127	3	4	35	1	46	1	22	15
Minnesota	194	0	2	70	0	54	9	44	15
Missouri	182	6	3	29	1	69	3	48	23
Nebraska	43	1	0	4	0	31	2	5	0
North Dakota	33	0	1	3	0	19	1	7	2
South Dakota	18	1	1	0	0	11	0	3	2
South Atlantic	803	31	1	155	1	146	7	324	138
Delaware	18	2	0	3	1	4	0	4	4
District of Columbia	12	0	0	1	0	2	0	6	3
Florida	225	18	1	9	0	14	0	138	45
Georgia	71	4	0	4	0	11	0	34	18
Maryland	82	2	0	15	0	21	4	28	12
North Carolina	127	1	0	58	0	16	0	24	28
South Carolina	45	0	0	15	0	7	0	13	10
Virginia	167	2	0	33	0	52	3	70	7
West Virginia	56	2	0	17	0	19	0	7	11
East South Central	566	6	9	165	0	105	4	220	57
Alabama	117	2	0	66	0	13	0	24	12
Kentucky	103	2	2	18	0	35	1	35	10
Mississippi	76	0	0	26	0	18	0	17	15
Tennessee	270	2	7	55	0	39	3	144	20
West South Central	855	12	1	83	1	265	2	385	106
Arkansas	158	1	0	76	0	43	1	12	25
Louisiana	173	0	0	1	0	52	1	104	15
Oklahoma	79	1	0	0	0	41	0	28	9
Texas	445	10	1	6	1	129	0	241	57
Mountain	368	17	1	57	0	127	11	110	45
Arizona	56	3	0	7	0	13	4	19	10
Colorado	107	8	1	13	0	31	2	32	20
Idaho	29	0	0	3	0	15	3	8	0
Montana	43	0	0	9	0	27	0	2	5
Nevada	22	1	0	1	0	4	1	13	2
New Mexico	46	4	0	1	0	13	0	20	8
Utah	36	1	0	3	0	21	1	10	0
Wyoming	29	0	0	20	0	3	0	6	0

See footnote at end of table.

Table 8—Continued

Number of home health agencies under Medicare, by type of agency and State of provider: Calendar year 1989

State of provider	Total	Visiting nurse association	Combined Government and voluntary agency	Home health agency	Rehabilitation based agency	Hospital based agency	Skilled nursing facility based agency	Proprietary	Private nonprofit
Pacific	479	40	3	18	0	177	10	183	48
Alaska	7	0	0	0	0	3	0	1	3
California	336	34	3	8	0	109	7	152	23
Hawaii	19	1	0	2	0	8	1	4	3
Oregon	59	1	0	4	0	36	1	12	5
Washington	58	4	0	4	0	21	1	14	14
Other areas	47	4	1	3	0	5	0	0	34
Puerto Rico	45	4	1	1	0	5	0	0	34
Virgin Islands	1	0	0	1	0	0	0	0	0
Other	1	0	0	1	0	0	0	0	0

SOURCE: Health Care Fianncing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

agencies. This would account, in part, for their dominance in the distribution of visits and program payments noted previously. Proprietary agencies are particularly dominant in the South, where they constitute 42 percent of the agencies. This may explain, in part, the pattern of high service use in the South noted earlier.

Conclusion

HHA services have been undergoing a changing role in the Medicare benefit structure. Originally, HHA services were conceived as services furnished at a stage in the continuum of care following an episode of acute illness, generally following hospitalization, when the locus of care for further recovery and rehabilitation could be shifted from an institutional setting to the home. Changes in legislation and regulations have shifted the Medicare HHA benefit to a means of providing home-based health care services to maintain the beneficiary's health and functional capacities to deter hospitalization or premature nursing home placement. This changed conception was accompanied by increased use of and growing program expenditures for HHA services.

Acknowledgments

The author expresses his appreciation to Wilson Kirby for generating the tabulations making this article possible and to Brenda Bailey for preparing the tables. A special thanks is owed to John Thomas of HCFA's Bureau of Policy Development for his guidance of the author through the nuances of the HHA coverage policies. Thanks are due, also, to Robert Kuhl and Michael Bussacca for their guidance of the author through the complexities of HHA reimbursement policies and to Marni Hall and Bill Saunders for helpful comments and suggestions in their review of a draft of this article.

References

Federal Register: Medicare program; Schedule of limits on home health agency costs per visit for cost reporting periods beginning on or after July 1, 1985. Vol. 50, No. 129, 27734-27751. Office of the Federal Register, National Archives and Records Administration. Washington. U.S. Government Printing Office, July 5, 1985.

Klarman, H.E., Rice, D.P., Cooper, B.S., and Stettler III, H.L.: *Sources of Increase in Selected Medical Care Expenditures, 1929-1969.* Staff Paper No. 4. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, April 1970.

Office of the Inspector General: *Competition: An Emerging Force in a Changing Home Health Field,* Department of Health and Human Services. Washington, D.C., Nov. 1981.

U.S. General Accounting Office: *Home Health Care Service—Tighter Fiscal Controls Needed.* HRD-79-17. Washington. May 15, 1979.

U.S. General Accounting Office: *Medicare Home Health Services: A Difficult Program to Control.* HRD-81-155. Washington. Sept. 25, 1981.

U.S. General Accounting Office: The Elderly Should Benefit from Expanded Home Health Care But Increasing These Services Will Not Insure Cost Reductions. GAO/IPE-83-1. Washington. Dec. 7, 1982.

U.S. Senate, Committee on Labor and Human Resources: *Community Home Health Services Act of 1981.* 97th Congress, Second Session. Report No. 97-325. Washington. Mar. 23, 1982.