
The Medicare Home Health Initiative

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This article describes the Medicare home health benefit and summarizes growth and change in the use of the benefit and in the industry providing home health care. The article also details the organization and goals of the Home Health Initiative, describes its four key components—quality assurance (QA), administration, policy, and research—and concludes with a discussion of the status of the Initiative.

INTRODUCTION

In 1993, Medicare spent more than \$10 billion on home health care services—an amount that has grown fivefold in just 5 years and is expected to double again in the next 5 years. These funds purchased services for roughly 2.5 million people, more than 7 percent of all beneficiaries. For many recipients, Medicare home health care services permit earlier hospital discharge, more personalized care, and the ability to return to or remain in a more hospitable environment. For too many beneficiaries, however, Medicare home health care falls short of fully or adequately meeting their needs. In the most aggregate terms, Medicare home health care expenditures do not appear to be producing a proportionate volume of high-quality, patient-responsive, appropriate care.

As our Nation's population ages and becomes more diverse, the need for home and community-based care will increase at least proportionately. Home and community-based services continue to be the health

care preference for many of the elderly and others with disabilities, their families, and their advocates. Home health care is currently a major issue for Medicare, and it will only become more important in the years ahead.

This is the context for HCFA's Medicare Home Health Initiative, a comprehensive assessment of the Medicare home health benefit. The Home Health Initiative is an examination of the policy, QA, and operational elements of the home health benefit. The Initiative is informed by HCFA-sponsored research that contributes to an understanding of current issues and will continue to guide the direction of improvements in home health care. HCFA's responsibilities are to assure that administration of the home health benefit meets the needs of beneficiaries and to fulfill simultaneous obligations of fiscal prudence and effective program management.

BACKGROUND

The Home Health Care Benefit

Home health services have been covered by Medicare since the inception of the Medicare program. In order to qualify for coverage under the Medicare home health benefit, a beneficiary must be:

- Confined to his or her home.
- In need of physical therapy, speech-language pathology, intermittent skilled nursing care, or continuing occupational therapy.
- Under the care of a physician with a plan of care established and periodically reviewed by a physician.

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The benefit encompasses the following services:

- Part-time or intermittent skilled nursing care and home health aide services.
- Physical therapy, occupational therapy, and speech-language pathology.
- Durable medical equipment (with a 20-percent copayment) and medical supplies.
- Medical social services.
- Outpatient services (when care cannot be furnished in the home because of the nature of required equipment) and the services of a medical intern or resident.

Home health services under Medicare are not limited to a specific period of time (e.g., posthospital) or to a visit ceiling—services are covered as long as they are considered medically reasonable and necessary for treatment of a beneficiary's illness or injury. Services must be furnished by a Medicare-approved home health agency (HHA), in compliance with Medicare HHA Conditions of Participation. Medicare pays HHAs the lower of either total charges or reasonable costs, subject to cost limits on the agency's aggregate costs. Nine regional home health intermediaries process HHAs' claims and conduct monitoring and audit functions for HCFA.

Home Health Utilization and Expenditure Trends

Changes in the benefit, the provider industry, and the characteristics of home health care users have strongly affected home health care utilization and expenditure trends.

Since Medicare began in 1966, eligibility and coverage requirements for Medicare home health care have changed several times. In 1972, Medicare coverage was extended to persons under 65 years of age who are either disabled or have end stage renal disease. In that same year, the

20-percent copayment for home health care under Part B was eliminated. The Omnibus Reconciliation Act (ORA) of 1980 eliminated home health care eligibility requirements of a 3-day prior hospital stay, Part A copayments, and a 100-visit limit. It also allowed for Medicare certification of for-profit HHAs. Most recently, *Medicare Home Health Agency Manual* (HIM-11) revisions (implemented in 1989) clarified coverage criteria in order to reduce inconsistencies in coverage determinations by intermediaries and to comply with the settlement of *Duggan vs. Bowen* (1988). In this decision, a Federal district court found that Medicare's interpretation of the phrase "part-time or intermittent" was too narrow, resulting in denial of care for eligible beneficiaries.

Home health care as an industry has changed significantly. In 1980, proprietary and hospital-based agencies comprised 6.4 percent and 12.3 percent of all HHAs, respectively. Today, largely because of the effects of ORA 1980, 48 percent of all certified HHAs are proprietary and 27 percent are hospital-based (Health Care Financing Administration, 1994). An analysis of 1992 HCFA claims data suggests that this change in HHA characteristics is associated with changes in utilization and expenditure patterns. For example, proprietary and large HHAs had longer episodes of care; further, their higher reimbursement per episode was found to be the result of more visits delivered during an episode rather than higher reimbursement per visit (Goldberg and Schmitz, 1994).

Traditionally, home health care comprises two types of services—those that are medical and technical in nature, commonly referred to as "home health care services," and the less technical "home care services." Home health care services are provided by skilled nurses and therapists. Home care services, on the other hand, are typically provided by a home health aide or

personal care attendant (the latter are not covered by Medicare). These distinctions are sensible in the abstract, but less and less meaningful in practice, as many beneficiaries require both types of services.

Many Medicare home health users receive home health care around an acute event requiring hospitalization. Of the 70 percent of home health care users who were hospitalized in 1992 and who began receiving home health care that same year, about 50 percent used home health care within 30 days of being discharged. Traditionally described as post-acute users of home health, these individuals are quite similar to non-acute home health care users with respect to age, functional limitations, and the number of medical conditions experienced (Mauser and Miller, 1994). About one-fourth of Medicare home health care users are also entitled to receive Medicaid, which, as an additional funding source for both skilled and non-skilled home care, increases the difficulty in demarcating these two services.

As a result of changes in the benefit, the industry, and beneficiary needs, Medicare home health care costs have grown substantially. Indeed, home health care is the most rapidly growing component of Medicare expenditures. Recent trends include the following:

- Home health care expenditures as a percent of total Medicare expenditures have increased from 2.4 percent in 1988 to a projected 7.9 percent in 1994.
- The number of persons per 1,000 Medicare enrollees receiving home health care services has grown from 51 in 1988 to 73 in 1992.
- The average number of Medicare home health visits per beneficiary served increased from 27 in 1989 to 53 in 1992, an increase of 96 percent in 3 years.

While the average number of visits per user has increased, there has also been a change in the distribution of visits, with more beneficiaries receiving an atypically high number of visits. Approximately 10.8 percent of home health users had more than 150 visits in 1992. For this group, the average number of visits was 250, and average charges were \$17,180; for users with fewer than 150 visits, the average number of visits was 31, and average charges were \$2,760. Approximately 17 percent of total charges in 1992 could be attributed to users with more than 150 visits. Individuals who receive more than 150 home health care visits tend to be more frail with respect to functioning and to use a different mix of skilled to non-skilled services throughout their home health episodes (Mauser and Miller, 1994).

ISSUES AND PROPOSALS

The Home Health Initiative was developed to formulate HCFA's response to the challenges posed by the changing characteristics of home health care. The Initiative has the following organizational structure:

- A HCFA interdisciplinary home health team works to ensure the efficient and effective operation of the Medicare benefit through the development and implementation of regulations, evaluations, and enforcement policies and procedures. Legislative initiatives are also under review. Team experts lead home health benefit improvement in four areas: QA; administration and operation; policy issues; and development of a research agenda.
- A HCFA senior management steering committee advises the team on the development of new policies and procedures and works with team members to determine resource allocations necessary to implement the Initiative.

- Consumer and industry representatives contribute to the development and implementation of the Initiative. Representatives from consumer groups, the home health care industry, professional organizations, intermediaries, and States (including State Medicaid agencies) have convened throughout 1994 to discuss the Initiative and recommend improvements.

Six goals have been established for the Home Health Initiative:

- Responsiveness—to make the home health benefit more responsive to the beneficiary's needs.
- Flexibility—to enhance the provider's flexibility in structuring care plans.
- Quality—to ensure the provision of high quality care.
- Efficiency—to improve the efficiency of administration and operations.
- Accountability—to facilitate appropriate utilization of home health care services.
- Fiscal Integrity—to ensure appropriate payments for the benefit and enhance efforts to detect fraud and abuse.

The Initiative contains both short- and long-term strategies for improvement. Short-term strategies involve those changes that can be implemented through revisions to administrative procedures, manuals, or regulations. Long-term strategies include those improvements that require statutory revision or further research in areas such as payment reform.

QUALITY ASSURANCE IMPROVEMENTS

The quality of home health care is difficult to conceptualize and harder to assess. It is also difficult to monitor, due in part to the circumstances of providing services in a home environment and the availability of informal caregiving support that varies

from home to home. Home health care's intermittent nature, and the fact that its users often have multiple complicated medical conditions, adds to the difficulty of evaluating quality.

Despite these complexities, HCFA is responsible for assuring that the care delivered to beneficiaries through the Medicare home health benefit is of high quality and that it meets the needs of beneficiaries who are increasingly frail, medically complex, and diverse. Congressional intent to improve our ability to monitor, assess, and improve quality in home health care is also clear. OBRA 1987 mandated the development of a patient-centered, outcome-oriented, quality process for home health care services.

HCFA-sponsored research has identified potential ways to reliably and validly define and measure care outcomes for Medicare home health care users. Such measures can be built into an ongoing data system for use by agencies to improve the quality of care they provide, and for use by HCFA to monitor beneficiary outcomes. (See Shaughnessy et al. [1994] for a more complete description of this work to develop quality indicators.) Reorienting both providers and surveyors in survey and certification, medical review, and performance standards for HHA management and monitoring will help achieve improvements in the QA process in home health care.

More specifically, the Initiative recommends:

- Revised HHA Conditions of Participation that include a standard assessment instrument and patient-centered, outcome-oriented performance expectations to stimulate continuous quality improvement.
- The use of defined and validated data-based quality indicators for patient clinical criteria.

- A continuous, flexible, data-driven evaluation process that focuses on patient rights, outcomes of care, and patient, physician, and provider satisfaction.

ADMINISTRATIVE AND OPERATIONAL IMPROVEMENTS

Administrative and operational changes to improve program efficiency and integrity are also being addressed through the Home Health Initiative. HCFA needs to improve its ability to ensure that the program pays for only those services that are medically reasonable and necessary and meet home health coverage requirements. Data collection, audit processes (such as medical review), and coordination of services for beneficiaries dually entitled to Medicare and Medicaid have been identified as areas for initial attention.

For example, the forms used to determine eligibility, coverage, and patient care plans have been legitimately criticized for requiring documentation that is of little value to physicians and other professionals in care planning. Treatment codes may be inconsistently applied, in part, because home health care services are ill-defined. Further, the growing volume and intensity of home health care necessitates an evaluation of current medical review processes, including a reexamination of how cases are selected for review and a consideration of giving HHAs greater responsibility for utilization review.

Among the steps we are now taking in response to these problems are the following:

- Improvements in billing and documentation requirements to focus on obtaining data useful to consumers, providers, and HCFA.
- Reforms to improve HCFA's ability to detect and prevent the provision of unnecessary services and fraudulent and abusive practices.

- Improved coordination between Medicare and Medicaid for dually entitled beneficiaries.

COVERAGE AND PAYMENT POLICY REFORMS

Medicare home health policy is too complicated and, as a result, is often difficult to implement. Much of this complexity arises from the statutory structure governing Medicare coverage of home health care.

For example, the statute mandates that home health care beneficiaries be "confined to the home" and in need of "intermittent" skilled nursing care. The statutory definitions of these terms are vague and subject to multiple interpretations. Ultimately, the determination of whether a beneficiary meets these requirements is a matter of subjective judgement. Because these requirements are difficult to precisely and objectively define, they have consistently proven difficult for HHAs, physicians, and beneficiaries to understand and for intermediaries to administer. A major goal of the Home Health Initiative is to recommend improvements in and clarifications to these statutory rules.

The statute's limitation of Medicare coverage to "part-time or intermittent" skilled nursing and home health aide care has also proven problematical. Although the term "part-time or intermittent" has been specifically defined in the HIM-11, it still presents a relatively arbitrary limitation on the level of covered services that can be furnished in a given period of time. Such a limitation restricts the flexibility of the HHA and the physician to establish a plan of care that meets all of the needs of some beneficiaries. In addition, the definition of "part-time or intermittent" is complex and burdensome for HHAs to document, and difficult for intermediaries to monitor and enforce.

The process through which home health care is authorized, and the process for monitoring and revising care plans, also need to be examined. Physicians have an important role in planning patient care for the home health care patient. Too often, however, physician involvement in home health care is limited to signing forms and approving services. As the Medicare home health care population becomes increasingly frail and has more complex health needs, appropriate physician involvement is critical. Because physicians are often the first source to whom patients and their families turn for advice about long-term care (LTC) services, increasing physician knowledge of, as well as direct involvement in, the home health care system is doubly important.

Home health care users often require multiple services, such as skilled nursing care and therapy, as well as the close involvement of social workers with patients and their informal care systems. Unlike other care delivery settings, where professionals may jointly prepare care plans but maintain independence in carrying out treatment, home health care professionals often share tasks but seldom enjoy the direct availability of, or interaction with, other professionals involved in home health care. Therefore, communication and coordination among providers are more challenging than in other settings, but critical to providing an effective home health care program (American Medical Association, 1993). Coverage and payment policies need to be reevaluated to foster appropriate teamwork among care providers.

Coordination among informal and formal caregivers is also important. Professional caregivers are in the home only on an intermittent basis, but informal caregivers are frequently present 24 hours a day. Informal caregivers are in a unique position to

provide information on compliance and satisfaction with the home health care plan, the identification of new problems, and related activities. Home health care professionals must improve their ability to effectively obtain, use, and integrate information from informal caregivers and to assist informal caregivers in helping patients.

The Medicare home health benefit covers a defined set of services. Yet HHAs vary in the scope of services they provide directly and the extent to which they provide services with agency staff as opposed to out-of-agency contracts. Some agencies provide only a small subset of Medicare-covered services. Skilled nursing care (required by law) and home health aide services are provided by virtually all HHAs, but therapy services are offered less consistently. Visiting Nurse Associations offer the broadest array of services, while proprietary agencies are generally below average in their provision of physical, occupational, and speech therapy and home health aide services.

These patterns raise a series of concerns. With no requirement to provide a comprehensive core of services, it is relatively simple to become a certified HHA provider. HHA requirements for oversight of subcontracted or arranged-for services are ambiguous and weak. Additionally, the difficulty involved in terminating or suspending a Medicare-certified HHA that cannot fulfill Medicare requirements means that it is likely to remain certified.

Finally, payment reform is vital. Home health care is one of the few Medicare services still paid on a retrospective cost basis (subject to section 223 cost limits), limiting incentives for efficiency. Payment on a per visit basis also detracts from efforts to focus clinical attention on the entire episode of care, which is essential to fostering continuity of care and to increasing emphasis on outcomes of care.

Payment policy reform, however, is complicated by the difficulty of defining efficiency. Home health payment is currently based on the notion of a "visit," but what a visit entails with respect to activities undertaken, resources used, and time required (i.e., inputs) is quite variable. Additionally, the relationship between visits provided and actual outcomes is ill-defined at best.

Policy changes to be addressed through the Home Health Initiative include:

- Making Medicare home health coverage, eligibility, and payment policy more readily understandable and "user friendly" to beneficiaries, HHAs, and intermediaries.
- Encouraging accountability for home health care utilization while increasing HHA flexibility in meeting patient needs.
- Simplifying administration of the home health benefit.
- Increasing the effectiveness and efficiency of service provision, in part by using payment as an incentive to stimulate ongoing quality improvement.

Each of these policy areas will be discussed at length in future Initiative meetings with representatives for consumers, providers, professional associations, physicians, States, and intermediaries.

HOME HEALTH RESEARCH AND DEMONSTRATION INITIATIVES

Central to efforts to redesign the home health benefit is an understanding of home health users' needs, preferences, and resources, and how these change over time. Payment, QA, and service delivery changes need to reflect and be responsive to these needs. To increase HCFA's understanding of these issues, research and demonstrations focus on the following:

- **Payment Reform**—HCFA is continuing efforts to develop payment methodologies that promote efficiency, foster appropriate

decisionmaking regarding the use of home health care relative to other post-acute services, recognize and appropriately price acute and chronic home health use, and encourage quality of care.

- **Integrated Systems of Care**—HCFA is sponsoring work that more broadly considers the use of home health care services within both fully and partially integrated service systems, such as health maintenance organizations. This work focuses on service needs of beneficiaries for whom a broad array of services (including home health care) is available and considers how home health care and other services can be used more flexibly to respond to beneficiary needs. Payment methodologies and QA activities appropriate to integrated systems of care also are being studied.
- **Home Health Care in a Continuum of Care**—HCFA is pursuing studies and demonstrations that explore the role of home health care in a continuum of care that includes both acute and LTC services. Issues such as the relationship between Medicare and Medicaid in providing home health care and the role of both skilled and maintenance home health care in the LTC service system are being examined.

For example, HCFA is sponsoring several research and demonstration initiatives in home health care payment reform, including prospective payment, bundling post-acute-care services (including Medicare home health), and capitation payments.

Prospective payment is being tested on a per visit and per episode basis. As described in greater detail in this issue (Phillips et al., 1994), impact analyses from the first year of per visit prospective payment indicate that this payment methodology has not affected agencies' cost per visit, revenues or profits, or quality of care.

Under a per episode prospective payment (scheduled for implementation in Fall 1994), providers will have greater opportunity to alter the way they provide services by changing the way in which they deliver a series of visits during the course of an episode (i.e., providing fewer total visits or changing the mix or timing of visits) and by changing the way in which they provide specific visits. Per episode payment may also more appropriately support a focus on patient outcomes.

A 120-day episode period captures 70 percent of home health episodes using 1992 claims data as the basis for analysis. However, per episode payment reform does not directly address the growing "tail" of the home health utilization distribution because, in this demonstration, payments made for visits beyond 120 days but still within a single episode will be made on an outlier, per visit prospective rate basis.

Bundling treats home health as one of several post-acute-care alternatives. It recognizes that there is a great deal of movement between post-acute-care services, but limited knowledge of the most appropriate post-acute-care service(s) for different types of patients and/or diagnoses. The intent of developing a bundled payment for post-acute care would be to:

- Improve functional outcomes and increase independent living.
- Increase efficiency of care.
- Increase appropriate use of post-acute-care services, defined by outcomes (Kane et al., 1993).

Bundling, as presently envisioned, does not address payment reform beyond the defined bundled payment period, typically from 60 to 120 days. Thus, as with prospective payment, it does not address payment reform for the tail of the home health utilization distribution.

The HCFA-sponsored Community Nursing Organization (CNO) demonstration exemplifies both payment reform and a focus on providing home health within broader, integrated systems. Importantly, this demonstration examines the potential role of nurses in authorizing plans of care and providing ongoing nurse case management. Of interest in the demonstration is the examination of how home health care is provided in an environment that affords decisionmaking flexibility to providers regarding the need for, mix, and duration of home health care, with a capitation methodology that encourages efficiency. A further point of interest is the extent to which capitation payment for a partial service package of Medicare home health care and certain Part B ambulatory services, combined with nurse case management, can be used to foster integration of care across the entire range of CNO and other Medicare services in multiple settings.

Demonstrations such as prospective payment and the CNO will also give us the opportunity to examine issues of organizational capacity. For example, Gould, Haslanger, and Vladeck (1992) have argued that the home health care industry should be reconstituted to support larger, more complex agencies. Such agencies may be better equipped to provide the full range of services required by the increasingly diverse home health population. These agencies would have increased capacity to more fully manage activities such as multidisciplinary care coordination, employee training and supervision, and quality assurance. Additionally, these agencies would be able to attract and retain a more qualified work force. Increased agency size, combined with a more diverse patient population with multiple and complex needs, creates an organizational

environment in which the provision of ongoing professional training and the development of more career opportunities are likely to emerge. Finally, large, heterogeneous agencies may have greater capacity to support staff professionals such as physicians and to use these professionals to develop innovative case management strategies that enhance coordination and communication, ultimately leading to improved patient care.

Increasing our understanding of the role of home health care as a part of LTC is essential. The lines between home health care (typically Medicare-funded) and home care (typically Medicaid-funded) will become increasingly blurred. When defined in terms of dollars supporting LTC, the tremendous growth in Medicare home health care imbues Medicare with the distinction of being the largest funder of home and community-based LTC services. An estimated \$33 billion was spent on LTC in 1993, approximately 46 percent of which came from private sources (including out-of-pocket expenditures of \$9 billion), 32 percent from Medicare, and the remaining 22 percent from Medicaid (Vladeck, Miller, and Clauser, 1993). The recent shift from institutional to community-based care as a focus of Medicaid funding for LTC has increased the availability of a wide range of community-based care services, yet the growth in Medicare-funded home health care has outpaced that movement.

The need to understand the relationship between home health care and LTC is also driven by the growth in the number of disabled Medicare beneficiaries. From 1983 to 1992, the number of Medicare disabled enrollees increased 18 percent, to 3.2 million, and is projected to nearly double from 1983 to 2000, to 5.3 million (Board of Trustees, 1993). This growth is expected to have a significant impact on the Medicare

program. In 1990, average Medicare payments for the disabled were 26.3 percent higher than payments for the aged (Helbing, 1993).

The composition of the Medicare disabled population is being transformed. For example, as improved therapeutic regimens for persons with acquired immunodeficiency syndrome (AIDS) have lengthened their expected life span, many who have contributed to Social Security through employment and have since become disabled by AIDS are surviving to attain eligibility for Social Security Disability Income. Subgroups of the Medicare disabled population, such as persons with AIDS or those with developmental disabilities, use home health care; however, their needs diverge from the elderly, both with respect to home health care and LTC. We need to anticipate and prepare for such changes, even as we implement improvements to the benefit.

States are a critical partner in our efforts to address the role of home health care in LTC systems. Almost 25 percent of Medicare home health users are dually entitled to Medicaid services, and this dual entitlement presents significant service and payment coordination issues. Policy changes in coverage or payment can be anticipated to strongly impact State LTC systems. Several States are actively addressing these issues through demonstration initiatives, such as efforts to integrate acute care and LTC for the dually entitled elderly. We must continue to work collaboratively with States as we weigh options for benefit improvements.

STATUS OF THE INITIATIVE

To date, three meetings have been held with consumer, provider, research, and State Medicaid agency representatives to

explore quality assurance, administrative, and operational issues in greater detail. Physicians' and other professionals' roles in home health care and care plan oversight have emerged as central issues during the course of these meetings, culminating in a planned symposium to address these issues in a more focused way. Smaller groups have been convened to provide technical expertise in areas such as the development of a comprehensive assessment instrument. Work has also begun on revising HHA Conditions of Participation and in developing a multi-focused strategy to improve communication regarding the home health benefit. Demonstrations in outcome-based quality assurance and per-episode prospective payment are scheduled for Fall 1994. Discussion sessions with consumer, provider, and research communities on payment issues are also scheduled.

SUMMARY

The work of the research community has played a pivotal role in the Home Health Initiative, and will continue to do so. While the analysis of trends in home health care utilization has provided an important context for benefit revision, advances driven by the research community in QA techniques have made a significant contribution to the shape of the Initiative strategies. Further, current research and demonstration efforts in payment alternatives are critical to home health care improvements over the long term. HCFA encourages the continued collaborative involvement of the research community in our efforts to understand the role of home health care in the LTC system for beneficiaries. In summary, we will continue to work with research, beneficiary, and provider communities, and with States, in seeking innovative solutions to the

challenges of improving home health care services for the beneficiaries we serve.

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