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MEDICARE HOME HEALTH

Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation

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Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss how the Balanced Budget Act of 1997 (BBA)[1] addressed the issues of rapid cost growth in Medicare's home health benefit. The home health benefit is important for many beneficiaries recovering from illness or injury after a hospitalization, the original purpose of the benefit. In recent years, an increasing number of beneficiaries also received under the benefit more custodial-type care for chronic conditions. This change has been a primary contributor to growth in Medicare home health costs, which averaged about 33 percent per year as costs went from about $2 billion in 1989 to almost $18 billion in 1996.

My testimony today focuses on four areas: the reasons for the rapid growth of Medicare home health care costs in the 1990s, the interim changes in the BBA to Medicare's current payment system, issues related to implementing the BBA's requirement to establish a prospective payment system (PPS) for home health care,[2] and the status of efforts by the Congress and the administration to strengthen program safeguards to combat fraud and abuse in home health services. The information presented is based primarily on our analysis of the BBA and on our previous work on Medicare's home health benefit. A list of related GAO products is at the end of this statement.

In brief, changes in law and program guidelines have led to rapid growth in the number of beneficiaries using home health care and in the average number of visits per user. In addition, more patients now receive home health services for longer periods of time. These changes have not only resulted in accelerating costs but also marked a shift from an acute-care, short-term benefit toward a more chronic-care, longer-term benefit.

The recently enacted BBA included a number of provisions designed to slow the growth in home health expenditures. These include tightening payment limits immediately, requiring a PPS beginning in fiscal year 2000, prohibiting certain abusive billing practices, strengthening participation requirements for home health agencies, and authorizing the Secretary of Health and Human Services (HHS) to develop normative guidelines for the frequency and duration of home health services. All of these provisions should help control Medicare costs. However, the Health Care Financing Administration (HCFA), the agency within HHS responsible for administering Medicare, has considerable discretion in implementing the law which, in

[1]P.L. 105-33, Aug. 5, 1997.

[2]A system in which payment is based on a fixed, predetermined amount per unit.

turn, means the agency has much work to do within a limited time period. HCFA's actions, both in designing a PPS and in implementing enhanced program controls to assure that unscrupulous providers cannot readily "game" the system, will determine to a large extent how successful the legislation will be in curbing past abusive billing practices and slowing the rapid growth in spending for this benefit.

Background

To qualify for home health care, a beneficiary must be confined to his or her residence (that is, "homebound"); require intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for part-time or intermittent skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits. Beneficiaries are not liable for any coinsurance or deductibles for these home health services, and there is no limit on the number of visits for which Medicare will pay.

Medicare pays for home health care on the basis of the reasonable costs actually incurred by an agency (costs that are found to be necessary and related to patient care), up to specified limits. The BBA reduced these cost limits for reporting periods beginning on or after October 1, 1997.

Home Health Cost Growth

The Medicare home health benefit is one of the fastest growing components of Medicare spending. From 1989 to 1996, part A expenditures for home health increased from $2.4 billion to $17.7 billion—an increase of over 600 percent. Home health payments currently represent 13.5 percent of Medicare part A expenditures.

At Medicare's inception in 1966, the home health benefit under part A provided limited posthospital care of up to 100 visits per year after a hospitalization of at least 3 days. In addition, the services could only be provided within 1 year after the patient's discharge and had to be for the same illness. Part B coverage of home health was limited to 100 visits per year. These restrictions under part A and part B were eliminated by the Omnibus Reconciliation Act of 1980 (ORA) (P.L. 96-499), but little immediate effect on Medicare costs occurred.

In 1983, the Medicare PPS for inpatient hospital services was implemented, and many health financing experts expected use of the home health

benefit to grow as patients were discharged from the hospital earlier in their recovery periods. However, HCFA's relatively stringent interpretation of coverage and eligibility criteria held growth in check for the next few years. Then, as a result of court decisions in the late 1980s, HCFA issued guideline changes for the home health benefit that had the effect of liberalizing coverage criteria, thereby making it easier for beneficiaries to obtain home health coverage. For example, HCFA policy had been that daily skilled nursing services provided more than four times a week were excluded from coverage because such services were not part-time and intermittent. The court held that regardless of how many days per week services were required they would be covered so long as they were part-time or intermittent.[3] HCFA was then required to revise its coverage policy. Daily skilled nursing care is now covered for a period of up to 3 weeks. Additionally, another court decision prevented HCFA's claims processing contractors from denying certain physician-ordered services unless the contractors could supply specific clinical evidence that indicated which particular service should not be covered.[4]

The combination of these changes has had a dramatic effect on utilization of the home health benefit in the 1990s, both in terms of the number of beneficiaries receiving services and in the extent of these services. (The appendix contains a figure that shows growth in home health expenditures in relation to the legislative and policy changes.) For example, ORA and HCFA's 1989 home health guideline changes have essentially transformed the home health benefit from one focused on patients needing short-term care after hospitalization to one that serves chronic, long-term care patients as well. The number of beneficiaries receiving home health care has more than doubled in recent years, from 1.7 million in 1989 to about 3.9 million in 1996. During the same period, the average number of visits to home health beneficiaries also more than doubled, from 27 to 72.

In a recent report on home health,[5] we found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits increased from 24 percent to 43 percent and those receiving more than 90 visits tripled, from 6 percent to 18 percent, indicating that the program is serving a larger proportion of longer-term patients. Moreover, about a third of beneficiaries receiving home health care in 1992 did not have a prior hospitalization, another indication of the shift of program focus from

[3]Duggan v. Bowen, 691 F.Supp. 1487 (D.D.C. 1988).

[4]Fox v. Bowen, 656 F.Supp. 1236 (D.Conn. 1987). This case involved physical therapy services in skilled nursing facilities, and HCFA also applied the principle to home health services.

[5]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996). This report includes a detailed discussion of the reasons for home health cost growth.

beneficiaries needing short-term care following a hospital stay to those receiving care for chronic conditions.

Interim Changes to Cost Reimbursement

To gain some measure of control over payments immediately, the BBA made some significant changes to the cost-based reimbursement system used for home health care while HCFA is developing a PPS for the longer term. Home health agency cost limits had been set separately for agencies in rural and urban areas, at 112 percent of the mean costs of freestanding agencies.[6] Limits will now be set at 105 percent of the median costs of freestanding agencies. In addition, the BBA added a limit on the average per-beneficiary payment received during a year. This limitation is based on a blend—75 percent on the agency's 1994 costs per beneficiary and 25 percent on the average regional per beneficiary costs in that year, increased for inflation in the home health market basket index since then. Hospital-based agencies have the same limits.

The per-visit cost-limit provision of Medicare's reimbursement system for home health agencies gave some incentives for providers to control their costs, and the revised per-visit and per-beneficiary limits should increase those incentives. However, for providers with per-visit costs considerably below their limits, there is little incentive to control costs, and per-visit limits do not give any incentive to control the number of visits. On the other hand, the new per-beneficiary limit should give an incentive to not increase the number of visits per beneficiary above the 1994 levels used to set this limit. However, the number of visits per beneficiary had already more than doubled by 1994 from that in 1989, so the per-beneficiary limits will be based on historically high visit levels. Moreover, per-beneficiary limits give home health agencies an incentive to increase their caseloads, particularly with lighter-care cases, perhaps in some instances cases that do not even meet Medicare coverage criteria. This creates an immediate need for more extensive and effective review by HCFA of eligibility for home health coverage.

Design Issues for a Home Health PPS

A PPS, where agencies receive a fixed, predetermined amount per unit, is generally seen as having the potential to improve provider incentives to control costs. Effective and timely design and implementation of the BBA's mandate to implement a PPS for home health services requires considerable HCFA action on several fronts. Issues needing HCFA's attention

[6]Home health agencies are classified as "freestanding" or "facility-based." Facility-based agencies are those that are a part of hospitals or other institutional providers.

include selecting an appropriate unit of service, providing for adjustments to reflect case complexity, and assuring that adequate data are available to set the initial payment rates and service use parameters.

The primary goal of a PPS is to give providers incentives to control costs while delivering appropriate services and at the same time pay rates that are adequate for efficient providers to at least cover their costs. If a PPS is not properly designed, Medicare will not save money, cost control incentives will at best be weak, or access to and quality of care can suffer. With the altered incentives inherent in a PPS, HCFA will also need to design and implement appropriate controls to ensure that beneficiaries receive necessary services of adequate quality. Most of the specifics about the home health PPS required by the BBA were left to HCFA's discretion. This delegation was appropriate because insufficient information was available for the Congress to make the choices itself.

Selecting the Unit of Service

Many major decisions need to be made. First, HCFA must choose a unit of service, such as a visit or episode of care, upon which to base payment. A per-visit payment is not a likely choice because it does little to alter home health agency incentives and would encourage making more, and perhaps shorter, visits to maximize revenues. An episode-of-care system is the better choice, and HCFA is looking at options for one.

Designing a PPS based on an episode of care also raises issues. The episode should generally be long enough to capture the care typically furnished to patients, because this tends to strengthen efficiency incentives. A number of ways to accomplish this goal exist. For example, HCFA could choose to set a constant length of time as the episode. In 1993, to cover 82 percent of home health patients, the episode would have to have been long enough to encompass 90 visits, which, assuming four visits a week on average, would mean an episode of about 150 days. Because of the great variability across patients in the number of visits and length of treatment, this alternative places very great importance on the method used to distinguish the differences among patients served across home health agencies in order to ensure reasonable and adequate payments.

Another option for defining an episode of care is to vary the length of the period on the basis of patient characteristics such as the primary condition affecting the patient, other complicating conditions, and any limitations in performing the activities of daily living. For example, a healthy person recovering from a broken leg would normally need a short recovery period

with mainly physical therapy, while a patient with arthritis recovering from the same injury might need a longer period with perhaps more home health aide services. This option would also require a good method for classifying patients into the various patient categories and determining resource needs. A third option is to use a fixed but relatively brief period, such as 30 or 60 days, sufficient to cover the needs of the majority of patients, with subsequent periods justified by the patient's condition at the end of each period. The effectiveness of this option would, among other things, depend on a good process for verifying and evaluating patient condition periodically and adequate resources to operate that process.

Also, HCFA will need to design a utilization and quality control system to guard against decreases in visits, which could affect quality, and home health agencies treating patients who do not quality for benefits. This will be necessary because an episode-of-care system gives home health agencies an incentive to maximize profits by decreasing the number of visits during the episode, potentially harming quality of care. Such a system also gives agencies an incentive to increase their caseloads, perhaps with patients who do not meet Medicare's requirements for the benefit. The effectiveness of PPS will ultimately depend on the effective design of these systems and devoting adequate resources to operate them.

Adjusting for Case Complexity

Another major decision for HCFA, closely related to the unit-of-service decision, is the selection and design of a method to adjust payments to account for the differences in the kinds of patients treated by various home health agencies, commonly called a case-mix adjuster. Without an adequate case-mix adjuster, agencies that serve populations that on average require less care would be overcompensated. Also, agencies would have an incentive to seek out patients expected to need a low level of care and shun those needing a high level of care, thus possibly affecting access to care. Currently, there is limited understanding of the need for, and content of, home health services and, at the same time, a large variation across agencies in the extent of care given to patients with the same medical conditions. HCFA is currently testing a patient classification system for use as a case-mix adjuster, and the BBA requires home health agencies to submit to HCFA the patient-related data HCFA will need to apply this system. However, it is too early to tell whether HCFA's efforts will result in an adequate case-mix adjuster.

Ensuring an Adequate Database for Calculations

A third challenge for HCFA is the need to improve its home health databases so that they will represent an adequate foundation for setting

PPS rates. Historical data on utilization and cost of services form the basis for calculating the "normal" episode of care and the cost of services, so it is important that those data are adequate for that purpose. Our work and that of the HHS Inspector General has found examples of questionable costs in home health agency cost reports. For example, we reported in August 1995 on a number of problems with contractor payments for medical supplies such as surgical dressings, which indicate that excessive costs are being included and not removed from home health agency cost reports.[7] Also, the Inspector General found substantial amounts of unallowable costs in the cost reports of a large home health agency chain, which was convicted of fraud on the basis of these findings. Earlier this year, we suggested that it would be prudent for HCFA to audit thoroughly a projectable sample of home health agency cost reports. The results could then be used to adjust HCFA's cost database to help ensure that unallowable costs are not included in the base for setting prospective rates.

In response to a presidential directive, HCFA is planning to audit about 1,800 home health agency cost reports over the next year, about double the number that it otherwise would have audited. If these audits are thorough and the results are properly used, this effort could represent a significant step toward improving HCFA's home health cost database. A good cost database could be a considerable aid to HCFA in calculating the initial payment rates under PPS.

We are also concerned about the appropriateness of using current Medicare data on utilization in designing a PPS. As we reported in March 1996, controls over the use of home health care are virtually nonexistent.[8] Our report included a number of examples of noncovered services that were billed to Medicare. For example, a physician called a claims processing contractor to complain that some of his patients were being told by a home health agency that they were "homebound" merely because they did not own a car. In another study, we found that some home health agency staff had been directed to alter or falsify medical records to ensure continued or prolonged visits, including recording visits that were never made or noting that patients were homebound even after they were no longer confined to their homes.[9] In another study of home health claims, we asked the fiscal intermediary in California to perform a

[7]Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

[8]GAO/HEHS-96-16.

[9]Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

medical review of 80 high-dollar claims it had previously processed. The intermediary found that it should have denied 46 of them in whole or in part.[10]

Also, Operation Restore Trust, a joint effort by federal and several state agencies to identify fraud and abuse in Medicare and Medicaid, found very high rates of noncompliance with Medicare's coverage conditions. For example, in a sample of 740 patients drawn from 43 home health agencies in Texas and 31 in Louisiana that were selected because of potential problems, some or all of the services received by 39 percent of the beneficiaries were denied. About 70 percent of the denials were because the beneficiary did not meet the homebound definition. Although these are results from agencies suspected of having problems, they illustrate that substantial amounts of noncovered care are likely to be reflected in HCFA's home health care utilization data. Because of these problems, it would also be prudent for HCFA to conduct thorough on-site medical reviews, which increase the likelihood of identifying whether patients are eligible for services, of a projectable sample of agencies to give it a basis on which to adjust utilization rates for purposes of establishing a PPS. We are not aware that such a review is under way or planned.

Safeguards Against Fraud and Abuse Still Needed

A PPS for home health should enable Medicare to give agencies increased incentives to control costs and to slow the growth in program payments. A reduction in program safeguards contributed to the cost growth of the 1990s, and HCFA will need to develop a utilization and quality control program to protect against the likely incentives that agencies will have to increase caseloads unnecessarily and to diminish care, and harm quality. Moreover, a PPS alone will not eliminate home health fraud and abuse. Continued vigilance will be needed, and the BBA gives HCFA additional tools that should help it protect the program.

Reduced Program Safeguards Made the Program Vulnerable

Rapid growth in home health expenditures in the 1990s was accompanied by decreased, rather than increased, funding for program safeguard activities. For example, our March 1996 report found that part A contractor funding for medical review (review of claims for medical necessity) had decreased by almost 50 percent between 1989 and 1995.[11] As a result, while contractors had reviewed over 60 percent of home

[10]Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

[11]GAO/HEHS-96-16.

health claims in fiscal year 1987, the contractors' review target was lowered by 1995 to 3.2 percent of all claims (or even, depending on available resources, to a required minimum of 1 percent). We found that a lack of adequate controls over the home health program, such as little contractor medical review and limited physician involvement, makes it nearly impossible to know whether the beneficiary receiving home care qualifies for the benefit, needs the care being delivered, or even receives the services being billed to Medicare. Also, because of the small percentage of claims selected for review, home health agencies that bill for noncovered services are less likely to be identified than was the case 10 years ago.

In addition, because relatively few resources had been available for auditing end-of-year provider cost reports, HCFA has little ability to identify whether home health agencies were charging Medicare for costs unrelated to patient care or other unallowable costs. Because of the lack of adequate program controls, some of the increase in home health costs likely stemmed from abusive practices. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[12] recently increased funding for program safeguards. However, per-claim expenditures will remain below the level in 1989, after adjusting for inflation. We project that in 2003, payment safeguard spending as authorized by HIPAA will be just over one-half of the 1989 per-claim level, after adjusting for inflation.

Finally, as discussed earlier, a PPS will give home health agencies incentives to increase the number of patients they treat and to cut back on the amount of care furnished to patients in order to maximize profits. To safeguard against the new incentives of a PPS, HCFA needs to implement utilization and quality control systems specifically designed to address the PPS's incentives. Without adequate monitoring, home health agencies that choose to do so could game the system to maximize profits or take actions that reduce quality.

New Anti-Fraud-And-Abuse Provisions and Initiatives

The Congress and the administration recently have taken actions to combat fraud and abuse in the provision of and payment for Medicare home health services. Through BBA, the Congress has given HCFA some new tools to improve the administration of this benefit. The administration also has recently announced a moratorium on home health agency certifications as HCFA revises the criteria for certification.

[12]P.L. 104-191, Aug. 21, 1996.

BBA Provisions

The BBA included several provisions that could be used to prevent untrustworthy providers from entering the Medicare home health market. For example, BBA authorizes HHS to refuse to allow individuals or entities convicted of felonies from participating in Medicare. Also, Medicare can exclude an entity whose former owner transfers ownership to a family or household member in anticipation of, or following, an exclusion or cause for exclusion. In addition, BBA requires entities and individuals to report to HCFA their taxpayer identification numbers and the Social Security numbers of owners and managing employees. This should make easier the tracking of individuals who have been sanctioned under the Social Security Act or convicted of crimes, if they move from one provider to another.

Another provision of the BBA that may prove useful in fighting fraud and abuse is the requirement that any entity seeking to be certified as a home health agency must post a surety bond of at least $50,000. This should provide at least minimal assurance that the entity has some financial and business capability. Finally, BBA authorizes HCFA to establish normative guidelines for the frequency and duration of home health services and to deny payment in cases exceeding those guidelines.

One area where changes could help to control abuse in home health not directly addressed by the BBA is the survey and certification of agencies for participation in Medicare. State health departments under contract with HCFA visit agencies that wish to participate in Medicare to assess whether they meet the program's conditions of participation—a set of 12 criteria covering such things as nursing services, agency organization and governance, and medical records—thought to be indicative of an agency's ability to provide quality care.

When Medicare was set up, it was not done with abusive billers and defrauders in mind. Rather, Medicare's claims system assumes that, for the most part, providers submit proper claims for services actually rendered that are medically necessary and meet Medicare requirements. For home health care, the home health agency usually develops the plan of care and is responsible for monitoring the care provided and ensuring that care is necessary and of adequate quality. In other words, the agency is responsible for managing the care it furnishes. While these functions are subject to review by Medicare's regional home health intermediaries, only a small portion of claims (about 1 percent) are reviewed, and most of those are paper reviews of the agency's records.

Early this year, HCFA proposed regulations to modify the home health conditions of participation and their underlying standards. The modifications would change the emphasis of the survey and certification process from an assessment of whether an agency's internal processes are capable of ensuring quality of care toward an assessment that includes some of the outcomes of the care actually furnished. HCFA believes this change in emphasis will provide a better basis upon which to judge quality of care. HCFA is currently considering the comments received on the proposed revisions in preparation for finalizing them, but it does not yet have a firm date for their issuance.

We believe that the survey and certification process could be further modified so that it would also measure agencies' compliance with their responsibilities to develop plans for, and deliver, only appropriate, necessary, covered care to beneficiaries. Such modifications could be tied to the new features that HCFA selects as it designs the home health PPS. For example, the case-mix adjuster might be designed to take into account the specific illnesses of the patients being treated along with other factors that affect the resources needed to care for patients, such as limitations in their ability to perform the activities of daily living. Agencies would have a financial incentive to exaggerate the extent of illness or limitations because doing so would increase payments. The survey teams might be able to evaluate whether the agency being surveyed had in fact correctly classified patients at the time the outcome information is reviewed. Use of state surveyors for such purposes would not be unprecedented because survey teams also assessed whether Medicare home health coverage criteria were met during Operation Restore Trust.

As discussed previously, HCFA needs to design utilization review systems to ensure that, if home health agencies respond inappropriately to the incentives of PPS, such responses will be identified and corrected. HCFA should also consider as it designs such systems using the survey and certification process to measure whether home health agencies meet their utilization management responsibilities. This would help to identify abusive billers of home health services while at the same time help to ensure quality.

Moratorium on New Certifications

On September 15, 1997, the administration announced a moratorium on the admission of new home health agencies to the Medicare program. HCFA noted in testimony earlier this month that the moratorium was called in response to reports of "the steadily increasing volume of investigations, indictments, and convictions against home health agencies." According to

HCFA, the moratorium is designed to stop the admission of untrustworthy providers while HCFA strengthens its requirements for entering the program.

In a September 19 memorandum, HCFA clarified the provisions of the moratorium. According to the memorandum, the moratorium applies to new home health agencies and new branches of existing agencies. It will last until the requirements to strengthen the home health benefit have been put in place, which HCFA officials estimate to be in 6 months. No new federal or state surveys are to be scheduled or conducted for the purpose of certifying new home health agencies; those surveys in progress but not completed when the moratorium was announced are to be terminated; and previously scheduled surveys for new certifications are to be canceled. HCFA will, however, enter into new home health agency provider agreements if the new agency has completed the initial survey successfully, meaning that the agency has complied with Medicare's conditions of participation and has satisfied all other provider agreement requirements. HCFA said it would make rare exceptions to the certification moratorium if a home health agency provides compelling evidence demonstrating that the agency will operate in an underserved area that has no access to home care.

According to a HCFA official, several actions are planned during the moratorium. HHS is expected to implement the program safeguards mandated by the BBA, such as implementing the requirement for home health agencies to post at least a $50,000 surety bond before they are certified and promulgating a rule requiring new agencies to have enough funds on hand to operate for the first 3 to 6 months. HHS is also expected to develop new regulations requiring home health agencies to provide more ownership and other business-related information and requiring agencies to reenroll every 3 years.

At this point, it is difficult to say what practical effect the moratorium will have on the home health industry or the Medicare program. However, the moratorium could be useful, first, in sending a signal that the administration is serious about weeding out untrustworthy providers and, second, in establishing a milestone for issuing regulatory reforms.

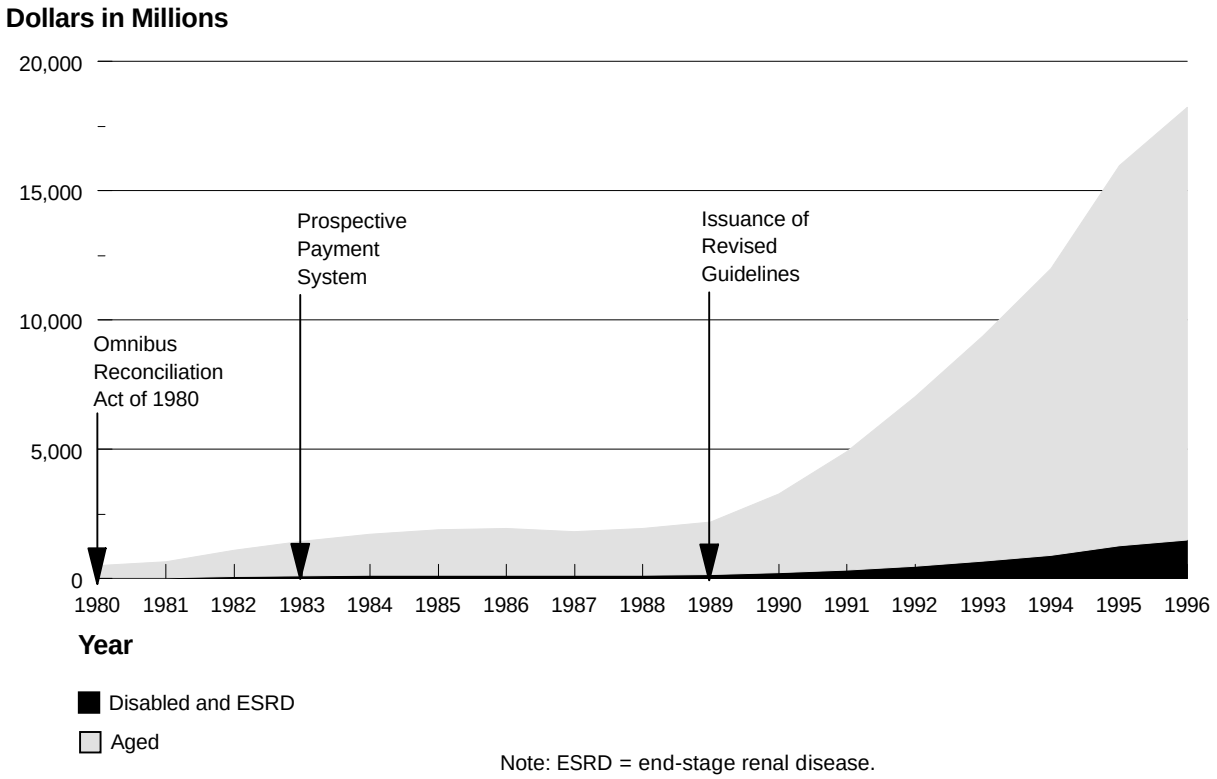
Conclusion

To achieve the intended goals of the cost control and anti-fraud-and-abuse initiatives of the BBA, HCFA will have to take effective and timely actions to implement the initiatives. HCFA needs to select an appropriate unit of

service and an adequate case-mix adjuster for a PPS as well as remove the effects of cost report abuse and inappropriate utilization from its databases so that those problems do not result in overstatement of PPS rates. HCFA also needs to quickly implement the new tools in the BBA so that it can keep untrustworthy providers from gaining access to the program and remove those that already have access. Moreover, HCFA needs a new utilization and quality control system designed specifically to address the new incentives under PPS.

This concludes my prepared remarks, and I will be happy to answer any questions you or Members of the Subcommittee may have.

Medicare Home Health Expenditures, 1980-96



Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

Related GAO Products

Medicare Home Health Agencies: Certification Process Is Ineffective in Excluding Problem Agencies (GAO/T-HEHS-97-180, July 28, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

Medicare Post-Acute Care: Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls (GAO/T-HEHS-97-106, Apr. 9, 1997).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment (GAO/T-HEHS-97-92, Mar. 5. 1997).

Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO/T-HEHS-97-90, Mar. 4, 1997).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Medicare: Increased Denials of Home Health Claims During 1986 and 1987 (GAO/HRD-90-14BR, Jan. 24, 1990).

Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

The Elderly Should Benefit From Expanded Home Health Care but Increasing These Services Will Not Insure Cost Reductions (GAO/IPE-83-1, Dec. 7, 1982).

Response to the Senate Permanent Subcommittee on Investigations' Queries on Abuses in the Home Health Care Industry (GAO/HRD-81-84, Apr. 24, 1981).

Medicare Home Health Services: A Difficult Program to Control (GAO/HRD-81-155, Sept. 25, 1981).

Home Health Care Services—Tighter Fiscal Controls Needed (GAO/HRD-79-17, May 15, 1979).

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