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THE EFFECT OF THE BALANCED BUDGET ACT ON VETERANS' USE OF HOME HEALTH SERVICES

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Introduction

The Balanced Budget Act of 1997 (BBA) included major changes to Medicare's home health benefit designed to slow the growth of spending. In the eight years preceding the BBA, Medicare home health utilization and spending had increased rapidly: the proportion of beneficiaries using the benefit more than doubled, the average number of visits per patient nearly tripled, and spending grew more than six-fold in real terms (Health Care Financing Administration 1998). During this period of rapid growth, questions arose as to whether all of the home health services being provided under Medicare were consistent with the intentions of the benefit, originally envisioned to provide post-acute skilled care and rehabilitative services. Evidence suggested that increasing numbers of visits were for personal assistance with basic tasks provided to individuals with chronic conditions or disabilities (Bishop and Skwara 1993).

The BBA's most significant change was to the manner in which Medicare paid home health agencies, though other changes to eligibility and coverage were also made. An interim payment system (IPS), phased in during FY1998, imposed new and lower payment caps, governed by per-visit and per-beneficiary payment limits. Beginning in FY2001, the IPS was replaced by a prospective payment system (PPS) under which Medicare now pays agencies a fixed case-mix adjusted rate for each 60-day episode of care (U.S. House of Representatives 1997; Federal Register 2000).

A rapid decline in the utilization of and Medicare spending on home health followed the implementation of the IPS.[1] From FY1997 (just prior to the IPS) to FY1999 (the first full year under the IPS), the proportion of beneficiaries using Medicare home health declined 21 percent, the average number of visits dropped 41 percent, and program payments fell 52 percent in real terms (McCall et al. 2001; Komisar 2002). Just over half of the decline in the number of patients was attributed to those who used home health without a recent acute event, an indication that the BBA had the desired effect of reducing personal assistance visits (Komisar 2002). Commensurate with the decline in utilization of home health by beneficiaries was a decline in providers. About 14 percent of home health agencies closed between October 1997 and January 1999. Closures were concentrated in states that had experienced high utilization and high growth in the industry in years just prior to the BBA. About 40 percent of agency closures were in three states—Louisiana, Oklahoma, and Texas (U.S. GAO 1999).

[1] Changes in patterns of use of home health after 1997 cannot all be attributed to the BBA alone. Other policy changes were also intended to reduce or reverse growth and illegitimate use: Operation Restore Trust began in 1995 and is a Federal effort to reduce fraud and abuse among medical providers and suppliers; the Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposed fines for fraudulent certification of ineligible beneficiaries for home health services; regulatory changes in 1997 slowed certification of new home health agencies and required recertification of existing ones; and a sequential payment requirement put into effect in 1998 caused cash-flow problems for agencies with any claim under review (Komisar 2002; McCall et al. 2003b; U.S. GAO 1999).

The loss of providers and reduction in utilization has led some researchers to question whether beneficiaries have sufficient access to home health services or whether more adverse outcomes might result from a decline in services (Komisar and Feder 1998; Smith and Rosenbaum 1998). Conclusions of investigations into this issue diverge. Some studies found little evidence of loss of access and adverse outcomes (McCall et al. 2001, 2002; U.S. GAO 1999; Liu et al. 2003; OIG 1999, 2000). Other studies found evidence that suggests access limitations (McCall et al. 2003a; Murtaugh et al. 2003; Komisar 2002; U.S. GAO 1998; MedPAC 1999) or the potential for some adverse outcomes (McCall et al. 2003b). For example, in interviews with home health agencies and hospital discharge planners, Smith et al. (1999, 2000) found that sicker and more vulnerable beneficiaries had greater difficulty receiving care and that 40 percent of discharge planners felt that home health patients were more likely to be readmitted to a hospital after the BBA.

One question, raised by the work of others in this area (most notably, Komisar 2002) is whether beneficiaries who might have relied on Medicare home health shifted to other non-Medicare financed sources of support. To date (and to our knowledge), there are no quantitative studies that examine how beneficiaries who might have used Medicare home health are receiving care after the changes imposed by the BBA. Medicare beneficiaries who are also eligible for Medicaid, for example, might seek services under that program and there is some qualitative evidence that this has occurred (U.S. GAO 1999), though one study, Laguna Research Associates (2002), suggests otherwise. Most Medicare beneficiaries are not eligible for Medicaid or other programs and might rely on informal care (e.g., by family) or purchase services out-of-pocket.

This Data Brief takes the first step toward addressing whether Medicare beneficiaries who are also eligible for benefits through the Veterans Health Administration (VA) might have shifted utilization from Medicare to VA after the changes imposed by the BBA. Twenty-eight percent (9.8 million) elderly Medicare beneficiaries are also eligible for VA benefits (2002 estimate based on CMS 2002 and Department of Veterans Affairs 2002a) and, of these, approximately 20 percent (2 million) choose to receive care through the VA in a given year (Department of Veterans Affairs 2002a, 2002b). We have combined Medicare claims and administrative data with that of the VA to simultaneously analyze temporal changes in Medicare and VA home health utilization. In summary, we find that

- Between 1997 and 1999, VA patients who were also enrolled in Medicare experienced reductions in Medicare home health use similar in size to those experienced by the general Medicare population.
- During the same time, Medicare-enrolled VA patients experienced increases in utilization of VA home health, while VA patients not enrolled in Medicare decreased their VA home health utilization.

Background

Medicare Home Health

The Benefit, Its Use, and Recent Policy Changes

A Medicare beneficiary qualifies for the Medicare home health benefit if (s)he is homebound and requires intermittent skilled nursing care or physical or speech therapy. The home care must follow a care plan developed and periodically reviewed by a physician. Other specific in-home services not mentioned above may also be covered once the beneficiary qualifies on these grounds, including personal and household assistance (U.S. GAO 1999). As long as eligibility is maintained, there is no cap on the number of visits a beneficiary may receive.

Originally, there were limits on the number of allowable home health visits, 100 days under Part A followed by another 100 under Part B. Additionally, a prior hospital stay was required to qualify for Part A benefits. Both visit limits, the prior hospital stay, and a Part B deductible were eliminated by the Omnibus Budget Reconciliation Act of 1980 (OBRA) (Health Care Financing Administration 1999). Despite these expansions of eligibility and coverage, home health visits per enrollee did not grow substantially in the mid-to-late 1980s (Komisar 2002).

Patterns of home health use changed substantially after 1988, however. In that year, the Health Care Financing Administration (HCFA, now called the Centers for Medicare & Medicaid Services or CMS), broadened eligibility and coverage for home health in an agreement reached in a lawsuit (Duggen v. Bowen 1988). Rapid expansion in Medicare home health use and expenditure followed and home health payments grew from 2.4 percent to 10 percent of total Medicare spending between 1988 and 1996 (Komisar 2002). Much of the growth in home health spending over this period can be attributed to high-volume patients who were receiving supportive and personal care in addition to skilled nursing and rehabilitative care. Patients receiving 200 or more visits per year accounted for 60 percent of the growth between 1991 and 1994 (Komisar and Feder 1998) and there was a shift in the mix of visit types toward increased use of home health aides (Komisar 2002).

Policy-makers placed some of the blame for this rapid growth in the manner in which home health agencies were paid. Payment was cost-based and provided an incentive for agencies to increase their volume of visits. The payment systems imposed by the BBA (first the IPS, followed by the PPS) dramatically changed this incentive. The IPS was phased in during FY1998, becoming fully implemented for all agencies by the start of FY1999. Under the IPS, an agency's payment was capped by the lower of two limits: a per-visit limit and a per-beneficiary limit. The per-beneficiary limit was computed, in part, based on FY1994 costs and was, therefore, lower than the rate agencies had become accustomed to. A dramatic reduction in Medicare home health utilization followed, as described above. In particular, the proportion of patients who received 200 or more visits fell from 10 percent in 1997 to 4 percent in 1999 (Komisar 2002). The PPS replaced the IPS in FY2001 and set case-mix adjusted rates for each 60-day episode of care. This

Data Brief does not analyze data for the PPS period and only covers the years just before and just after the IPS implementation. Additional details on the history of Medicare home health policy and utilization can be found elsewhere (Komsar 2002; McCall et al. 2003b).

Recent Work on Effects of the BBA

Several studies have focused on post-BBA changes in Medicare home health. Using Medicare claims data, Komisar (2002) documents the reduction in home health use and its sharper focus on post-acute skilled nursing and therapy services under the IPS. Komisar found that states with higher levels of per-enrollee Medicare home health spending had greater declines in home health use after the BBA. She reports larger than average reductions in the proportion of beneficiaries using any Medicare home health for certain subpopulations, namely the oldest old, Medicaid enrollees, and beneficiaries living in rural areas, suggesting access problems for these subpopulations.

McCall and colleagues report the changes in patterns of Medicare home health utilization during the IPS period in several publications. McCall et al. (2001) documents changes in utilization between FY1997 and FY1999, overall and by population subgroups defined by demographic, geographic, or diagnostic characteristics. The authors found greater-than-average decreases in the number of home health visits for females, the oldest old, and for individuals with certain diagnoses (cardiac disrythmias, cerebrovascular disease, and hypertensive disease). Murtaugh et al. (2003) continues this study through FY2001, thereby including the first year of the PPS.

Using multivariate analysis, McCall et al. (2003a) study whether the changes brought on by the BBA had differential impacts across particular subgroups of Medicare beneficiaries. Greater than average reduction in the incidence of Medicare home health use was found for the oldest old, those living in states with historically high Medicare home health use, and those with Medicaid buy-in status. Greater than average reduction in the number of visits was found for the oldest old and for those living in states with historically high Medicare home health use, and for individuals with some specific diagnoses.

In McCall et al. (2002), the authors use multivariate techniques to examine whether certain outcomes are more common after the BBA. Results indicated that the incidence of hospitalization decreased by nearly one percent in the post-BBA period, while SNF admissions increased by about the same amount. ER visits and mortality increased by nearly two percent and one percent, respectively.

From a sample of Medicare hospital discharges for five specific DRGs, occurring either six months before or six months after implementation of the IPS, McCall et al. (2003b) analyzed patterns of post-acute care utilization, including home health and institutional care and examined whether adverse outcomes increased during the period. The authors found that home health use declined in the post-IPS period for all five DRGs studied, while the use of rehabilitation and long-term care hospitals increased. Out of 90

outcomes studied, five were significantly worse in the post-IPS period. Three of the five indicated an increased incidence of death for COPD and hip fracture patients.

Liu et al. (2003) also investigate the effects of the IPS on subgroups, using Medicare Current Beneficiary Survey (MCBS) data from calendar years 1996 and 1999. The authors find little evidence that the IPS differentially affected the likelihood of home health use across subgroups defined by demographic, health, Medicaid status, and geographic characteristics. However, disproportionate reduction in number of home health visits was found for beneficiaries with greater functional limitations.

VA Home Health

The Veterans Health Administration (VA) is the largest publicly-funded integrated health care system in the U.S., providing managed primary and specialty care to veterans who choose to enroll. In the late 1990s, the VA underwent a fundamental transformation, from a primarily inpatient, facility-based system to one that included more outpatient and community services (Department of Veterans Affairs 2002c). Nearly 20 percent of the nation's 25.6 million veterans use VA services each year (based on 2002 data from the Department of Veterans Affairs 2002a, 2000b) and over 55 percent of those who do so are Medicare beneficiaries (Department of Veterans Affairs 2002b; Management Sciences Group).

As the VA shifted its focus toward community-based care, it renewed its commitment to meeting the growing demand for care in the home (Department of Veterans Affairs 1998) and the utilization of VA's noninstitutional care programs increased (U.S. GAO 2004). The VA does not have a unified home health program as Medicare does. Instead, services delivered in the home fall under one of several community based long-term care programs. The two VA home services that most resemble the Medicare home health benefit are home based primary care (HBPC) and skilled home care (SHC).[2] The latter provides medically necessary skilled home health services while the former provides medical care, rehabilitation services, and counseling. Each of these programs is described more fully below.

Home Based Primary Care. HBPC provides physician-supervised primary care to functionally dependent, homebound patients. Services include medical care, nursing care and education, rehabilitation, nutritional counseling, social work, clinical pharmacy services, case management, and bereavement counseling. HBPC does not provide skilled services but arranges for them through other programs. HBPC patients typically have moderate to severe ADL or IADL impairment with high medical complexity (e.g., multiple diagnoses). Veterans enrolled in the VA system are eligible for HBPC services if they live within a program service area, are homebound, and have care needs that require and can be met by the program (Department of Veterans Affairs 1996; Health Economics Program 2003).

[2] The homemaker/home health aide program is not analyzed in this Data Brief because there is no unique code in the VA administrative data that identifies use of this service.

Skilled Home Care. SHC services are medically necessary skilled home care including skilled nursing, social work, physical, occupational, and speech therapy. SHC services are prescribed by a VA physician (or VA approved physician) and are contracted out to non-VA agencies. Patients receiving SHC services need not be ADL or IADL dependent or have medical complexities. Veterans enrolled in the VA system are eligible to receive SHC services if they require them and if the cost does not exceed that of nursing home care (Health Economics Program 2003).

There are two other aspects of VA care that distinguish it from that available through Medicare: geographic variation of availability and beneficiary priority. VA services are not uniformly available across the country.[3] VA allocates financial resources to each of its 21 networks which, in turn, allocate those resources across facilities, programs, and services within their geographic service areas. Additionally, while the VA requires that facilities offer a home health service benefit, it does not specify which program must be made available (HBPC, SHC, or another program). One consequence of this decentralized management is that programs are not uniformly funded or available across the nation. For example, a recent GAO study (U.S. GAO 2003) revealed that the majority of facilities do not offer HBPC services across their entire service area.

Veterans are eligible for benefits according to a priority system that includes eight categories. Though complex in detail, generally higher priority veterans are those with high service-connected disability percentages.[4] Medium priority veterans include those with incomes and assets below certain established levels. Low priority veterans do not have a service-connected disability and are not low-income. Lower priority veterans pay higher copayments for VA services. In addition, if sufficient resources are not available to provide timely, quality care for all veterans who seek it, the VA limits enrollment beginning with those with lowest priority. For example, in early 2003 the VA announced that it would not enroll any new veterans in the lowest priority category for that year. Some VA facilities impose additional priority-based delays or eligibility restrictions on receipt of care beyond those set forth nationally, though doing so is in conflict with VA standard procedure (U.S. GAO 2003).

Other than the above cited reports, there have been no studies of VA home health and, to our knowledge, no comparisons of its utilization to that of Medicare home health.

Data and Methods

Data Sources

Analyses are based on data from VA and Medicare administrative sources. Each of these sources is described below.

[3] One could argue the same is true of Medicare benefits in that private managed care plans do not have uniform benefits and are not uniformly available. However, traditional fee-for-service Medicare *is* uniformly available with standardized benefits and there is no analogue in the VA.

[4] Veterans' disabilities are classified according to their degree of severity in percentage terms. The most severely disabled veteran would have a 100 percent service-connected disability.

VA Data. VA utilization data from the VA Patient Treatment File, Outpatient Care File, and Fee Basis File were obtained for all VA patients during a time period that included calendar years 1997 and 1999. Data were downloaded from the Austin Automation Center, the repository for VA utilization data (Health Economics Program 2003).

Medicare Data. Medicare inpatient and home health utilization data from Medicare claims files were obtained for all Medicare-VA duals[5] for calendar years 1997 and 1999.[6] As of 1999, 53 percent of all VA patients were also enrolled in Medicare (Shen 2003). Of VA long-term care patients, 70 percent were Medicare-VA duals (Health Economics Program 2003).

Methods

VA and Medicare data were linked for all duals. For each unique patient in the linked Medicare-VA file (duals) and in the VA only file (non-Medicare enrolled VA patients), the number and type of home health visits (Medicare, HBPC, SHC) were counted. Visits were also grouped into VA and Medicare episodes where an episode is defined as a sequence of home health visits with no gap between visits longer than 59 days. Finally, episodes were categorized as post-acute if they began within 14 days of an acute event. For Medicare, an acute event is signaled by a hospital or SNF discharge. For the VA, an acute even is signaled by a hospital discharge.

To compare patterns of Medicare home health use by Medicare-VA duals to use in the general Medicare population we used Medicare statistics provided by Komisar (2002) for federal fiscal years 1997 and 1999. Due to availability of Medicare data for VA patients, our figures for Medicare-VA duals are for calendar years 1997 and 1999. There is a nine-month overlap between calendar and fiscal year and changes over the two year window are likely to be substantially larger than any difference introduced by the mismatch between fiscal and calendar year.

Veterans' Medicare Home Health Utilization

The proportion of VA patients using Medicare home health is lower than that of the general Medicare population (Table 1), perhaps reflecting the fact that VA patients have another option (namely, VA home health) and/or differ from the Medicare population in their need for home health. The number of Medicare home health visits per patient for duals is also lower than that of the general Medicare population, perhaps for the same reasons. The number of Medicare home health visits per patient with a prior Medicare-covered acute event (i.e., post-acute visits) is higher for duals in 1997 and a bit lower in 1999 as compared to the general Medicare population. The dual population experienced large declines in these measures of Medicare home health utilization, consistent with the large declines experienced by the general Medicare population.

[5] We use the term "Medicare-VA dual" or "dual" to refer to VA patients who are also enrolled in Medicare.
[6] For our analyses VA enrollees are defined as all veterans who had used VA services from 1992 forward.

Table 1: Medicare Home Health Use, by Program Enrollment, 1997 and 1999

	Medicare-VA Duals			*Medicare Population*		
	CY1997	*CY1999*	*Pct. Change*	*FY1997*	*FY1999*	*Pct. Change*
Home Health Patients as Percent of Patients	6.0%	4.1%	-32%	10.1%	8.0%	-21%
Number of Visits per Patient	71	41	-42%	79	46	-41%
Number of Visits per Patient with Prior Medicare-Covered Acute Event[(a)]	51	32	-38%	46	34	-26%

(a) A prior acute event is an inpatient hospital or skilled nursing facility stay within 14 days of the beginning of a home health episode. An episode is defined as a sequence of home health visits preceded and followed by 60 days with no visit.

Source for Medicare population figures: Komisar 2002.

The distribution of patients by number of Medicare home health visits is about the same for duals as for the Medicare population (Table 2), as is the distribution in the number of episodes. The two groups differ substantially, however, in the proportion of patients with a prior Medicare-covered acute event in 1997. In the dual population, the proportion using Medicare home health within 14 days of a Medicare-covered acute event was 54 percent in 1997 while for the larger Medicare population it was 46 percent. This difference may be due to different characteristics of the two populations (e.g., gender). While the proportion of patients with a prior Medicare-covered acute event increases ten percentage points from 1997 to 1999 for the Medicare population, it only increases two percentage points for the dual population, suggesting that the BBA had a smaller effect on the dual population than the general Medicare population.

Table 2: Percent Distribution of Medicare Home Health Patients, by Number of Medicare Home Health Visits, Episodes, and Prior Acute Event, 1997 and 1999

	Medicare-VA Duals		*Medicare Population*	
	CY1997	*CY1999*	*FY1997*	*FY1999*
Number of Visits				
1-4	11%	15%	10%	13%
5-9	14%	18%	13%	17%
10-49	42%	45%	42%	47%
50-99	13%	11%	14%	12%
100-199	10%	6%	11%	7%
200 or More	1%	4%	10%	4%
Number of Episodes[(a)]				
1	91%	89%	90%	88%
2	9%	11%	9%	11%
3 or More	1%	1%	1%	1%
Patients with Prior Medicare-Covered Acute Event[(b)]				
	54%	56%	46%	56%

(a) An episode is defined as a sequence of home health visits preceded and followed by 60 days with no visit.

(b) A prior Medicare-covered acute event is a Medicare approved inpatient hospital or skilled nursing facility stay within 14 days of the beginning of a home health episode.

Source for Medicare population figures: Komisar 2002.

Both the dual and the general Medicare population experienced a sharp decrease in the proportion of Medicare home health visits made by home health aides between 1997 and 1999 (Table 3). The largest proportional increase was for skilled nursing. These changes in the distribution of visits are consistent with the goals of the IPS.

Table 3: Percent Distribution of Medicare Home Health Visits, by Type, 1997 and 1999

Type of Visit	*Medicare-VA Duals*			*Medicare Population*		
	CY1997	*CY1999*	*Pct. Point Dif.*	*FY1997*	*FY1999*	*Pct. Point Dif.*
Total	100%	100%		100%	100%	
Skilled Nursing	43.0%	47.6%	4.6	40.8%	48.2%	7.4
Home Health Aide	46.5%	37.0%	-9.5	48.7%	35.5%	-13.1
Physical Therapy	7.4%	11.2%	3.8	7.6%	12.2%	4.6
Speech Therapy	0.7%	0.8%	0.1	1.3%	2.3%	1.0
Occupational Therapy	1.4%	2.2%	0.8	0.5%	0.7%	0.1
Medical Social Services	1.1%	1.1%	0	1.0%	1.0%	0

Source for Medicare population figures: Komisar 2002.

Veterans' VA Home Health Utilization

In this section we describe patterns of use over time (1997-1999) of VA home health, comparing the utilization of duals to that of non-Medicare enrolled veterans. Over this time period, the proportion of VA home health patients who were duals increased from 64 percent to 74 percent, largely due to the aging of the VA population but also, perhaps, due to an increase in VA home health use among duals relative to non-Medicare VA patients.

The top portion of Table 4 reports the average number of VA home health visits per patient by type of visit for Medicare enrolled and non-enrolled VA patients. There is little change over time for VA patients not enrolled in Medicare, either overall or by type of service. In contrast, duals received more home health visits overall in CY1999 relative to CY1997, with an increase in SHC visits and a decrease in HBPC. Duals with a prior VA acute event (bottom portion of Table 4) received, on average, more visits than VA patients not enrolled in Medicare in both years. For both groups, those receiving only HBPC experienced a decline in average number of visits between 1997 and 1999. While Medicare-VA duals receiving only SHC visits experienced a decline in average number of visits between 1997 and 1999, VA patients not enrolled in Medicare experienced an increase. For Medicare-VA duals receiving both HBPC and SHC, average visits increased, while for VA patients not enrolled in Medicare the average stayed constant.

Table 4: Number of VA Home Health Visits per Patient, by Medicare Enrollment Status and Type of VA Home Health Patient, 1997 and 1999

Type of VA Home Health Patient	*CY1997*		*CY1999*	
	Medicare Enrolled	*Not Medicare Enrolled*	*Medicare Enrolled*	*Not Medicare Enrolled*
Patients of Any Type of VA Home Health	33	24	35	24
Patients Only of HBPC	15	11	13	10
Patients Only of SHC	52	29	59	29
Both HBPC and SHC	81	51	71	46
With Prior VA-Covered Acute Event[(a)]				
Only HBPC	16	14	14	12
Only SHC	50	29	45	33
Both HBPC and SHC	58	37	65	37

(a) A prior VA-covered acute event is a VA financed inpatient hospital stay within 14 days of the beginning of a home health episode.

Table 5 shows the number of home health patients (overall and with a prior VA-covered acute event) as a percent of VA patients. Overall, the percent of duals receiving VA home health increased (from 1.5% in CY1997 to 1.6% in CY1999) and the percent of the non-Medicare VA patients receiving VA home health decreased (from 0.7% in CY1997

to 0.6% in CY1999). The proportion of both groups receiving post-acute VA home health decreased over the time period under study.

Table 5: VA Home Health Use, by Program Enrollment, 1997 and 1999

Characteristic	*Medicare-VA Duals*			*Non-Medicare VA Population*		
	CY1997	*CY1999*	*Pct. Change*	*CY1997*	*CY1999*	*Pct. Change*
Home Health Patients as Percent of VA Patients						
	1.5%	1.6%	6.7%	0.7%	0.6%	-14%
Home Health Patients with Prior VA-Covered Acute Event as Percent of VA Patients[(a)]						
	5.4%	4.3%	-20%	0.4%	0.3%	-25%

(a) A prior VA-covered acute event is a VA financed inpatient hospital stay within 14 days of the beginning of a home health episode.

Conclusion

Analyses presented in this Data Brief have shown that, in general, VA patients enrolled in Medicare experienced similar decreases in Medicare home health utilization between 1997 and 1999 as the overall Medicare population. This is not surprising since veterans were subject to the same post-BBA changes in home health practice patterns as the general Medicare population. However, for patients with a prior Medicare-covered acute event, changes in Medicare home health visits for Medicare-VA duals were not as great as for the general Medicare population. We have also shown that during the same time period, veterans' use of VA home health increased for Medicare-VA duals and decreased for VA patients not enrolled in Medicare.

This latter finding suggests the possibility that Medicare beneficiaries with access to home health benefits through the VA may have shifted utilization from Medicare to VA in reaction to cutbacks in the Medicare program. Medicare sharply reduced non-post acute home health use while attempting to maintain the availability of a home health benefit for post-acute patients. Therefore, if any shifting away from Medicare to the VA did occur, one might expect to find evidence of it by examining patterns of VA and Medicare home health visits that did not follow a hospital stay. Unfortunately, data available to the authors do not permit such an analysis at this time.

Another way to examine the question of shifting utilization is to focus analysis on states that experienced larger than average declines in number of home health agencies or in Medicare home health expenditure. The hypothesis is that in such states the larger than average effect of the IPS might have induced a large enough shift away from Medicare to be evident and statistically significant in aggregate VA utilization measures.

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