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Walden University

College of Management and Technology

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Binzie Roy Davidson

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Walden University 2019

Abstract

Medicare and Medicaid Regulations' Financial Effects on Home Health Agencies' Performance

by

Binzie Roy Davidson

MBA, University of Phoenix, 1995

BA, California State University, Dominguez Hills, 1990

Doctoral Study Submitted in Partial Fulfillment of

the Requirements for the Degree of

Doctor of Business Administration

Walden University

June 2019

Abstract

Some owners of small to medium-sized managed care businesses lack strategies to address the effects of healthcare regulations on their businesses. The purpose of this multiple case study was to identify strategies that owners of small to medium-sized managed care businesses used to address the financial effects of healthcare regulations on their businesses. The conceptual framework for this study was profit maximization and adaptation in changing contexts. Data were gathered from company documents, observations, and semistructured interviews with 5 home healthcare business owners in Los Angeles County, California. Data were coded to identify themes from the narrative segments. Key themes that emerged from the data analysis include home health strategic management, application of business strategies, healthcare reform, and strategic business processes. The implications of this study for social change include the potential to catalyze economic, intellectual, and social developments that improve community health and wellness programs and related activities in home health.

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Dedication

This study is especially dedicated to my deceased dad and mom, Alfanco and Marian Davidson, respectively who brought me into this world by the blessings of the Highest, the Almighty and the Omnipotent God. This is also dedicated to my dear sister, Joycelyn Davidson-Evans, who passed away too early. I am sure God has a purpose for you in heaven. I also dedicate this work to my dear sister, Gloria Davidson-Tharkur, and brother, Gladstone Davidson, for their love and respect. To my three sons, Dwayne O'Neil Davidson, Shane Brian Davidson, and Jevaughn Evans-Davidson, you are all my motivation. Continue to emulate dad and mom and success will be yours. My dear wife, Pauline Maureen Davidson, you are the dream of my life. Thanks for your feedback on my dissertation and your love, patience, support, and understanding. Thanks to my friends and relatives who have made a significant impact on my life.

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Section 1: Foundation of the Study

The transformation of the home healthcare business began in 1990, and the process is ongoing (Centers for Medicare and Medicaid Services [CMS], 2015). Despite the increased cost of healthcare, as of the beginning of 2015, proprietors of managed care facilities in the United States provided 69.1% of healthcare needs (Kaufman, 2013; Weil, 2015). The drastic changes these increased costs foster resulted in the managed care facilities losing financially and owners not knowing how to cope with changes Medicare and Medicaid have been forced to take (CMS, 2015).

Background of the Problem

According to Smith, Arose, and Coustasse (2014), the administrators of the state Medicaid programs implemented Medicare and Medicaid managed care plans to contain costs and improve healthcare delivery. According to the CMS (2015), managed care is a delivery system that integrates the financing and delivering of appropriate health care using a comprehensive set of services to control costs. Medicaid, a federal government sponsored health insurance program administered by the states, provides coverage for home health individuals with disabilities, children, pregnant women, seniors, and the indigent (CMS, 2015). Medicare, on the other hand, is a health insurance program, without state administration, in which the United States government pays part of the cost of medical care and hospital treatment for people over 65 years of age (Lankford, 2015). CMS (2015) further noted that, in 2010, health care in the United States accounted for

17.9% of the U.S. gross domestic product (GDP) and had since amounted to nearly $3.3 trillion annually; healthcare has been the most significant single source of public expenditures (CMS, 2015). With new regulations surrounding the implementation of the Affordable Care Act, Medicare, and Medicaid, general healthcare spending in the United States increased to an estimated $3.3 trillion in 2016 (Martin, Hartman, Benson, Catlin, & National Health Expenditure Team, 2016).

Problem Statement

With new regulations surrounding the implementation of the Affordable Care Act, Medicare, and Medicaid, general healthcare spending in the United States increased to an estimated $3.2 trillion in 2015 (Martin et al., 2016). Despite the increased cost of healthcare, as of the beginning of 2015, proprietors of managed care facilities in the United States provided 69.1% of healthcare needs (Kaufman, 2013;Weil, 2015). The general business problem was the implementation of the Affordable Care Act, as well as Medicare and Medicaid regulations for managed care has caused financial loss to home healthcare businesses. The specific business problem was some proprietors of small-to medium-sized managed care businesses lack business strategies to address the financial effect new healthcare regulations may have on their business.

Purpose Statement

The purpose of this qualitative multiple case study was to identify strategies small-to-medium-sized managed care businesses proprietors use to address the financial effect new healthcare regulations may have on their business. The population for the

study was one owner from each of five home healthcare businesses chosen from the 435 home healthcare businesses in Los Angeles County, California, who have successfully addressed the financial effects of Medicare and Medicaid regulations on the home health agencies. The implications for social change included catalyzing economic, intellectual, and social developments that improve community health and wellness programs and related activities in home health care as community-based healthcare organizations. The positive social change implications included promoting the dignity and self-worth of individuals and their families in the era of Medicare and Medicaid managed care regulations.

Nature of the Study

McCusker and Gunavdin (2015) emphasized three main research methodologies: qualitative, quantitative, and mixed methods. Qualitative researchers explore the meaning individuals or groups attribute to a social or human-interest business phenomenon (Ritchie & Ormiston, 2014). Qualitative researchers seek to arrive at an understanding of an occurrence from those experiencing it (Vaismoradi, Turunen, & Bondas, 2013). Researchers use qualitative researchers to study participants in their natural environments and, thus, to gain more knowledge of their situations (El Hussein, Jakubec & Osuji, 2015). Because I wanted to find out how individuals have dealt with specific regulations, a qualitative multiple research design was more appropriate for this study as a goal of the study is in-depth knowledge. Other research methods did not match the investigative goal

set forth for the study. Scholars use the quantitative method to test hypotheses by examining relationships and differences among variables. Researchers use the quantitative approach to test a theory and numerical data through testing hypotheses using inferential statistics (Branham, 2015). Since I was not testing a hypothesis or theory, nor gathering data for inferential statistics, the quantitative approach was not appropriate for this study. Researchers use the mixed method to combine both qualitative and quantitative methods (Sparkes, 2015). Therefore, the mixed method was not appropriate for this study, as the intent was limited to identifying strategies and not analyzing statistical relationships or differences among variables.

Case studies, ethnography, phenomenology, and narrative research are basic qualitative designs (Yin, 2014). Case studies are an inquiry where the researcher targets an in-depth examination of an individual, a program, activity, or a process (Yin, 2014). Yin (2014) postulated that the case study researcher incorporates the study of a target group functioning within a real-life, contemporary context or setting. The design chosen for this research study was a qualitative multiple case study. I selected a qualitative multiple case study design because I could explore real-life, the multiple-bounded system by collecting various sources of information and reports and analyze the acquired data through rigorous, detailed, in-depth data methods to unearth relevant themes to address the specific business problem.

An ethnographic design was not appropriate for this study. Ethnographic studies focus on research that explores an entire culture of individuals to gain an understanding

of that cultures (Eike, Dale, Espies, & Valmik, 2015); this was not the goal of my research. A phenomenological study is an inquiry in which the researcher identifies the meanings of common human experiences or phenomenon (Marshall & Rossman, 2016). Since I was exploring strategies and did not seek to discover the meanings of participants' lived experiences, a phenomenological study was not an appropriate design for this project. A narrative study is an inquiry wherein the researcher describes the lives of individuals as told through their stories (Wolgemuth, 2014). The narrative design was an author's description of a phenomenon, and the researcher could miss details and themes from the participants (Wolgemuth, 2014). The narrative design was not appropriate for my study since data needed for this research project could not be gathered and collected through a series of stories and individual experience.

Research Question

What strategies do home health proprietors use to address the financial effects of Medicare and Medicaid regulations on their business?

Interview Questions

1. What are the financial strategies and effects of Medicare and Medicaid managed care regulations on your home healthcare business?
2. What are the financial strategies you use to address the costs of complying with new Medicare and Medicaid managed care regulations?
3. What barriers do you encounter in implementing the financial strategies for

Medicare and Medicaid managed care regulations on your home health agency?

4. How do you address the barriers to implementing the financial strategies for Medicare and Medicaid managed care regulations on your home health agency?
5. How do you track the results of your home health agency financial strategies to cope with Medicare and Medicaid managed care regulations?
6. What other issues have you had to face as you address the financial strategies and effects of Medicare and Medicaid regulations that we have not discussed so far?

Conceptual Framework

The conceptual framework used for the study was strategic management theory (SMT). SMT is grounded on profit maximization and adaptation in changing contexts (Hill, Jones, & Schilling, 2015). SMT involves the formulation and implementation of the major goals and initiatives taken by the leadership of an organization (Hill et al., 2015). SMT theory originated in the 1950s and became popular in the 1960s. The early and most influential contributors were Peter Drucker, Phillip Selznick, Alfred Chandler, Igor Ansoff, and Bruce Henderson (Hill et al., 2015). Another important SMT theorist, Michael E. Porter, sought to understand and address the significant problems in healthcare delivery in the United States and other countries. Porter (2013) identified three principles that determine strategic management: creating a unique and valuable market, making trade-offs by choosing what not to do, and creating what is right by aligning company activities with one another.

Building on Porter's insights, Hill et al. (2015) perceived strategic management as involving the formulation and implementation of major goals and initiatives by top business managers on behalf of owners. The formulations and execution of targets by the organization are based on the resources available and the environment in which the organization competes (Hill et al., 2015). Strategic management can provide direction to the home health business enterprise because SMT involves specifying the organization's objectives, developing policies and plans designed to achieve these goals, and then provide resources to implement the programs (Matta, Chahed, Sahin, & Dallery, 2014). The strategy is the determination of the fundamental, long-term performance goals of an enterprise, which must include financial performance through various business cycles (Pagan & Robinson, 2014). Lawmakers who developed the Medicare and Medicaid managed care payment models for home care services focused on outcomes, cost containment, and quality measurements (Matta et al., 2014), which are relevant to my specific business problem. SMT fundamentally requires home health owners to analyze the financial performance of their companies and to identify how their current strategies contribute to or obstruct their profitability (Williamson, 2013). To determine strengths and weaknesses efficiently, the owners need to compare or benchmark their approaches against those of their competitors and the overall home health historical performance (Hill et al., 2015).

Operational Definitions

These terms are central to the development and understanding of this qualitative case study. The following definitions serve to establish understanding:

Adaptive leadership: Adaptive leadership refers to the work of Ronald Heifetz and his colleagues at Harvard University (Obolensky, 2014). According to Obolensky (2014), Heifetz used adaptive leadership to identify how leaders use past experiences to orient and activate their employees toward engaging with and solving complex challenges. In other words, adaptive leadership challenges people to address problems that do not have standard solutions or that are new or unfamiliar to the shareholders facing them. This situation contrasts with technical difficulties that have clear problem definitions that can be resolved using existing methods, tools, and the exercise of traditional authority. Adaptive challenges require leaders to learn old assumption and norms and to learn new ways of knowing and doing things (Nicolaides & McCallum, 2014).

Change management: According to Belias and Koustelios (2014), change management is a process, not an event. Belias and Koustelios, established change management as a process that promotes change by creating a vision based on a clear understanding of managers' strategic objectives and that is attained from an analysis of the existing ideologies and identification of the necessary actions to reach those planned activities.

Healthcare reform: Healthcare reform is a generalization concerning significant health policy creation or changes that require business leaders to take substantial costs out of their systems to maintain positive financial performance (Kaufman, 2013).

Managed care: Managed care is a delivery system that integrates the financing and delivery of appropriate health care using a comprehensive set of services to control cost (CMS, 2015).

Medicaid: The United States Congress created Medicaid in 1965 as a public assistance program that combines federal and state government resources to provide healthcare for people who are unable to pay for healthcare because of inadequate income and resources (Lankford, 2015).

Medicare: Medicare is a federal health insurance program in which the United States government pays a substantial part of the cost of medical care and hospital treatment for people over 65 years of age (Lankford, 2015). Medicare also pays for younger individuals with disabilities and for patients with the end-stage renal disease. Medicare Part A covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some general home health care (CMS, 2015). Medicare Part B includes specific doctor's services, home healthcare services, outpatient care, medical supplies, and preventative services (Lankford, 2015).

Patient Protection and Affordable Care Act (PPACA): Patient Protection and Affordable Care Act (PPACA) is a United States Statute signed into law by President Barack Obama on March 23, 2010. It is the most significant extension of healthcare

coverage in the past 50 years. The PPACA put in place comprehensive health insurance reforms that have improved access, affordability, and quality of healthcare for Americans (Morone & Ehlke, 2013).

Small-and medium-sized business enterprises (SMSBE): The Small Business Administration (USSBA) established two widely used standards to define a SMSBE; that is, a small or medium-sized business has up to a maximum of 500 employees for a manufacturing and mining industries and up to $7.5 million in average annual revenue for non-manufacturing sectors (USSBA, 2016). The SBA provides exceptions to the definition of SMSBE for industries such as agriculture, mining, utilities, construction, transportation and warehousing, information, finance, real estate, healthcare, and other sectors (USSBA, 2017). In this study, I looked at home healthcare businesses earning between $5and $7million annually.

Strategic change initiative: Leader changes necessitate knowing when and to what extent to be effective (O'Kane & Cunningham, 2014). A strategic change initiative is a series of discrete changes in the context and scope of management's existing strategies in response to environmental changes. A strategic change initiative accepts the need to change and promotes a decision to make a difference (Herrmann & Nakarni, 2014).

Assumptions, Limitations, and Delimitations

When conducting scholarly research, an investigator can find the process challenging, tedious, humbling, and an empowering experience mainly when resources

are restricted or lacking (Bouzon, Augusto, Miguel, & Rodriguez, 2014). Lo (2016) postulated that assumptions, limitations, and delimitations are essential components of a doctoral research study. Assumptions, limitations, and delimitations are imperative to prevent evaluators from questioning the credibility of the study (Lo, 2016). Researchers must determine the assumptions, limitations, and delimitations of the study.

Assumptions

Grant (2014) indicated that assumptions are issues that are accepted as true, or at least correct, without supporting evidence. Leedy and Ormond (2013) stated that assumptions are so fundamental to research that, if assumptions are excluded, the research could not exist. My first assumption was the business owners of the home health agencies would respond truthfully to the interview questions throughout the interview process. Second, I assumed that participants would exhibit professionalism, integrity, and validation of the research. Third, I assumed participants' business success depends on the knowledge of keeping up with the new healthcare regulations governing the home healthcare industry.

Limitations

Matza, Boye, Stewart, Curtis, Reaney, and Landrian (2015) shared that limitations are potential weaknesses of a study that are outside a researcher's control. The restrictions inherent in a methodology or characteristics of the study's design can impact the researcher when interpreting the results of the study. The researcher cannot control these influences. Robinson, Gott, Gardiner, and Ingleton (2015) postulated that, in

conducting research, the availability of resources and human error adversely affect and can limit the study. Another limitation is securing information from only the owners and not from an entire organization's management team may have limited this study's results.

Delimitations

According to Bouzon et al. (2014), delimitations are choices a researcher makes that narrow the scope of the research project and, thereby, circumscribe the project. According to Yin (2014), delimitations set research limits and propositions. Schwarzfeld and Sperling (2014) indicated delimitations benefit a study because, by setting them, the researcher identifies planned goals that are achievable and possible to accomplish. For the case study, I chose to limit the focus to home health agency population owners who are licensed and certified in California, who have been in business for at least 5 years, who have fewer than 500 employees, and who gross $5 to $7 million annually. The study boundary was the Los Angeles County, which has a population of 10 million and over 464 home health agencies. I interviewed only home healthcare owners because this group of business people are the ones directly engaged in meeting various federal and state regulations and, at the same time, are focused on making their companies more profitable.

Significance of the Study

The researcher shared the findings from the study that provides business owners with insightful information on Medicare and Medicaid managed care regulations and the effects on home health agencies' financial standing. Business owners value the

integration and positioning of home healthcare systems in the continuum of care to financially benefit from increasing demand and interest in the healthcare space (Landers, Madigan & Leff, 2016). It is imperative that the healthcare system is efficient (Matta et al., 2014).

Contribution to Business Practice

Kongstvedt, Porter, and Lee (2013) postulated that some small-to-medium-sized business owners lack strategies to successfully address the financial effects of Medicare and Medicaid managed care on the home health agency business. Business owners are required to focus on changes in government regulations and funded systems and to position their businesses to be financially viable while providing the highest level of home healthcare services. I probed the knowledge that current owners have as they study and adhere to regulations as they seek to provide quality healthcare services while increasing their companies' profitability. By unearthing successful strategies from this group of interviewees in a highly competitive market (i.e., Los Angeles, California) and by comparing their efforts with the advice from published literature, I was able to identify strategies other companies adopted to increase their profitability.

Implications for Social Change

Study implications for social change included seeking to extend economic, intellectual, and social development for the improvement of community health and wellness programs and activities, as well as identifying how businesses can maintain their employment levels or even increase them. Thus, this potential for affecting beneficial

social change included the ability to apply and improve home health strategic management business practices. Reducing the financial burden on home healthcare businesses could lead to building government agencies that address social problems on an individual, institutional, and community level. Building capacity in home health care will enhance long-term healthcare systems, safety, and efficiency of care provision performance to improve and to achieve better quality healthcare regulations and performance.

A Review of the Professional and Academic Literature

The compilation of a comprehensive literature review follows a rigorous methodological path (Yin, 2014). The account of scholarly research requires an in-depth critical evaluation of that information. Researchers challenge the current situation by identifying a problem, labeling it as new, and then applying an analytical approach that could provide a unique perspective to the problem (Kieser, Nicolai, & Seidl, 2015). A comprehensive literature review involves identifying, summarizing, and synthesizing studies within a large body of knowledge on a topic (O’Connor, Sargeant & Wang, 2014). Buttitta, Iliescu, Rousseau, and Guerrien (2014) shared the view that a literature review provides a new interpretation of existing research strategies within a changing healthcare business environment.

This review of literature includes a detailed, in-depth exploration, analysis, and discussion of information about the research question: What strategies do small business owners use to address the financial effects of Medicare and Medicaid managed care

regulations? I searched numerous publications pertinent to the research topic including scholarly, peer-reviewed articles, industry reports on home health, United States government reports, and data about home health agencies. The databases I used for the literature search include Google Scholar, EBSCOhost, ProQuest, Science Direct, Emerald Management Journals, Management and Organizational Studies, Lexis Nexis Academic, and United States government websites including the Department of Health and Social Services and Homeland Security. The literature review is scholarly and timely. Over 85% of the total sources contained in the literary analysis are peer-reviewed. *Ulrich's Periodical Directory* served as the tool to verify that articles are from recognized peerreviewed journals. Over 85% of all the sources in this review of the academic literature have publication date less than 5 years old. The literature review includes four primary themes: (a) Strategic management theory (SMT), (b) application of business strategies, (c) healthcare reform on home health, and (d) strategic business processes.

Strategic Management Theory (SMT)

This qualitative multiple case study identified strategies that small-to-medium sized managed care businesses proprietors used to address the financial effect new healthcare regulations may have on their business. The Affordable Care Act (ACA), Medicare, and Medicaid have caused regulators to change and to create more procedures that business people must follow. Changed and new regulations are costly, so much so that in 2016 implementing them increased healthcare spending to an estimated $3.3

trillion (Martin et al., 2016). The United States government, through its laws and regulations, has a profound effect on business enterprises (Morone & Ehlke, 2013). Healthcare reform has affected strategic business processes and led to stagnated growth, tax implications, increased administrative costs to small businesses, and decreased long term success (Williamson, 2013). Taxes are a large part of healthcare reform, and small businesses must address their tax liabilities as part of the strategic management plan (Herrick, 2014).

Based on his case study, Kongstvedt (2013) shared the view that a beneficial conceptual framework is one that is grounded in exploring strategies to cope with home healthcare reforms and rising business costs. Clearly the financial effects of the ACA, Medicare, and Medicaid regulations on home health agencies have affected business processes and management for home healthcare companies (Williamson, 2013). Therefore, the theory I used to ground this study was strategic management theory (SMT) that emphasizes profit maximization and adaptation in changing contexts, an approach that involves the formulation and implementation of the primary goals and initiatives taken by the leadership of the organization (Hill et al., 2015). Strategic management theories have their origin from the system perspective, contingency approach, and information technology approach. The following are relevant and well known SMTs: profit-maximizing and competition-based theory, the resource-based theory, the survival based theory, the agency theory, the human resource-based theory, and the contingency theory (Hill et al., 2015). The profit-maximizing and competition-based theory were

based on the perception that a primary business objective is to maximize long-term profit and develop a competitive advantage over the competition in the external marketplace (Kash, Spaulding, Johnson, Gamm, & Hulefeld, 2014). The resource-based theory comes from the proposition that the base of an organization's competitive power rests in its external resources as opposed to its position in the outer surrounding. The survival-based theory centers on the belief that a corporation needs to change to its competitive environment if it is to increase its profitability. The survival-based theory is different from the human resource-based theory, which focuses on the importance of human element in the strategic development of corporations. The agency theory centers on the importance of the secretive relationship among the shareholders or owners that can make an agency successful. Finally, the contingency theory emphasizes the philosophy that a single or unique idea is the best way or approach to managing organizations (Hill et al., 2015). Given these multiple theories, an organization should develop a managerial strategy based on the environment and problems it is experiencing and one that will benefit the organization depending on its industry. In conclusion, during the process of strategy formulation, implementation, and evaluation, the owners of home health agencies should consider which of these main theories will be relevant to managing their agencies and to assisting them in making strategic management decisions (Budak & Kar, 2014).

The strategic management theory originated in the 1950s and 1960s. The most influential contributors were Peter Drucker, Phillip Selznick, Alfred Chandler, Igor

Ansoff, Bruce Henderson, and, later, Michael E. Porter (Hill et al., 2015). Porter, a professor at Harvard Business School, is perhaps the best known of all the strategy theorists because he is a prolific writer. Porter devoted his publications to understanding and addressing the pressing problems in healthcare delivery in the United States and other countries (Porter & Lee, 2013). Information gleaned from the Centers for Medicare and Medicaid Services (CMS, 2015) report postulated that, since the implementation of the Prospective Payment Accountable Care Act (PPACA), the per capita cost of health care remained at or under 3%. The economic slowdown and sluggish recovery have played much of a role in impacting healthcare costs as has the PPACA. In the coming years, more data will be available to measure the impact and effectiveness of this healthcare law. While early results show improvement in some areas, such as the reduction in the numbers of uninsured, there have also been unintended consequences including rising out-of-pocket costs, higher taxes, and increasing regulations.

Budak and Kar (2014) postulated that strategic management is not concerned with the daily or regular management of the business. Strategic management is interested in the administration of companies so that those companies can continue their operations in the long term. A company employing strategic management approaches gains a competitive advantage and increases profits to higher than average levels. The decisive change capabilities have become a primary focus for business people as home healthcare systems attempt to improve and position themselves for reorganization and growth in a competitive market characterized by continuous regulatory changes (Kash et al., 2014).

Litchfield, Cooper, Hancock, and Watt (2016) emphasized that the pace of change continues to exponentially increase, and that change comes primarily from the information technology (IT) revolution that has transformed work for many employees and consumers in less than a generation.

Application of Business Strategies

The five stages of strategic management processes are goal-setting, analysis, strategy formulation, strategy implementation, and strategy monitoring (Ferlie & Ongaro, 2015). The processes are more than just an established set of rules to follow. SMT is a philosophical approach to the home health business enterprise and to business in general. The owners of home health agencies must think strategically and apply that thought to a process. The strategic management process is implemented when everyone understands the strategy (Hill et al., 2015).

Goal Setting. The purpose of goal-setting is to clarify the vision of the business. This very important stage consists of identifying three key factors (a) short-and long-term objectives, (b) identify the process of how to accomplish the objectives, and (c) customize the processes for the staff. The goals must be detailed, realistic, and match the purpose of the home health agency mission.

Gather and analyze information. The gathering and analyzing of important information and data are relevant to the accomplishing the vision of the organization. The focus of this exercise is to understand the needs of the business as a sustainable entity, the strategic direction and identifying initiatives that will help the business to grow. The

strengths, weaknesses, opportunities, threats (SWOT) analysis plays a significant part of this component.

Strategy formation. The review of the information collected from completing the analysis is imperative. The determination of the resources the business currently has that can help to achieve the goals and objectives of the home health agency is important. Because business and economic situations are fluid, it is critical to develop alternative approaches for each step of the plan.

Implementation of the strategy. This is the action stage of the process and the successful strategy is important to the success of the business. If the overall business structure established does not work, there must be room for adjustments and flexibility. Everyone in the organization must be apprised of their responsibilities and duties and understand them very clearly. Securing additional resources and working capital is necessary at this stage. Once funding is in place, everyone should be ready to execute the plan.

Evaluate and control. The strategy evaluation and control actions include performance measurements, review of external and internal issues, and making corrective actions where needed. The successful evaluation of the strategy is initiated with the parameters to be measured. Determining the progress by measuring the results and monitoring external issues will help management react to changes in the business environment (Hill et al., 2015). The owners are the linchpin in the strategic management process. The onus is on the individual owners to take responsibility for formulating

business strategies to achieve a competitive advantage and for putting those strategies into effect (Hill et al., 2015). The most important part of the strategic management process is crafting the mission, vision, and values of the business enterprise. The major goals of management are imperative. The second component of the strategic management process is an analysis of the organization's external operating environment. The essential purpose of the external analysis is to identify strategic opportunities and threats within the system. The third component of the strategic planning process focusses on reviewing the resources, capabilities, and competencies of a company. The next component of a strategic thinking process requires the generation of a series of strategic alternatives, given the company's internal strengths, weaknesses, opportunities, and threats (SWOT) (Hill et al., 2015).

According to Zheng, Haber, Hoover, and Feng (2017), the American healthcare system continues to experience a period of transformation as the federal government seeks to contain costs and, at the same time, provide access to comprehensive health care to all citizens regardless of race, color, creed, and social or economic background. Zheng et al. (2017) shared the view that healthcare costs keep rising at a higher rate than costs in the rest of the economy and that, almost every year, healthcare spending accounts for the highest proportion of the Gross Domestic Product (GDP).

Stakeholders in the complex world of healthcare insurance offer visions of their future under different political and economic scenarios. PPACA, under the Medicare and Medicaid systems, is linked to a tax policy that will need more revenue to cover its

growing population, hence creating a higher tax burden on communities which will impact private insurers, employers, workers, and families (Morone & Ehlke, 2013). Over time, successful cost control in Medicare and Medicaid depends on effective policies to control spending in the broader U.S. healthcare system (Gallman, 2016). Individual states regulate employer-sponsored health plans because the federal government has not promulgated a standardized system (Morone & Ehlke, 2013). According to Morone and Ehlke (2013), there are a considerable number of programs with various coverage terms and provider networks. The federal health information exchange system (Healthcare.gov., 2017) will reduce marketing and underwriting costs for a portion of the market, but the administrative costs will still be high. Additionally, the federal government has increased its powers under different Medicare and Medicaid legislation to detect and prosecute healthcare fraud. Pozgar (2016) noted that Congress explicitly enacted provisions under the PPACA to strengthen detection of fraud and abuse. Healthcare fraud and abuse cost the federal government millions of dollars every year (Pozgar, 2016). The by-laws required by Congress are more stringent application requirements for network participation in Medicare. Congress also empowered the Department of Health and Human Services (DHHS, 2016) to determine which Medicare providers are required to establish compliance programs and increased public reporting of payments and other transfers of value to vendors (DHHS, 2016). The PPACA is the most extensive extension of healthcare coverage in the past half-century. The federal government has a fiduciary responsibility not only to ensure laws are enacted, but also to identify and prosecute

healthcare fraud and, at the same time, strengthen the system to minimize future fraud and abuse. Pozgar (2016) emphasized that laws, such as PPACA, are enacted to regulate human behavior for the overall benefit of society; that is, such laws are designed to prevent harm to others and protect the rights of individuals. According to Williford and Small (2013), establishing an effective compliance and ethics program has become a necessity to safeguard any highly regulated organization. At its core, an effective program protects an organization by detecting and preventing improper conduct and promoting adherence to the organization's legal and ethical obligations. Williford and Small (2013) postulated that reasonable efforts should be taken to exclude bad actors from any healthcare system. To this end, an organization may face severe compliance issues and mandates that will cause some network participants to depart the system. Consequently, an organization should put in place contingency plans to ensure access to care by beneficiaries is not sharply affected. One recommendation is to encourage the network participants who comply with a stated ethics program to increase their staff to meet the needs of the recipients by proving incentives to subsidize the cost of the organization expansion (Williford & Small, 2013).

Pozgar (2016) emphasized that the key to the healthcare system is to deliver care that is safe, effective, patient-centered, efficient, timely, equitable, and profitable. Achieving these goals requires an organization to be efficient and fair. The concepts of efficiency and equity depend on different reasoning. The approach an organization takes

to these two concepts will influence not only the levels of care provided but also the ways that various private insurance companies compete for business.

Inoussa and Foster (2014) postulated that the PPACA presents opportunities to ameliorate problems in the American long-term care (LTC) system. In this system, Rollins (2014) reported over 13 million Americans need support and services. Americans aged 65 and older are projected to more than double from 38.9 million to 88.5 million between the years 2008-2050. The age bracket 85 years and older will triple from 5.7 million to 19.0 million according to statistics Rollins (2014) reported from the 2010 Federal Interagency Forum on Aging-Related Statistics. Rollins further stated that the implementation of the PPACA affects the LTC system in several ways. For example, LTC should be rebalanced toward the more excellent use of non-institutional alternatives to a nursing home. Recruiting and retaining a well-trained, stable workforce along with financing to provide quality care exacerbates the LTC problem. Krooks and Frolik (2015) emphasized that the chronically ill and older Americans prefer to be in their homes rather than institutionalized. They also emphasized that a healthcare system should rebalance from institutional cares towards Home and Community-Based Services (HCBS). Not only would HCBS lessen stress for older citizens, keeping seniors in their homes is more economical than keeping them in assisted care facilities.

Healthcare Reform on Home Health

Healthcare reform, due to the PPACA, could negatively affect small business managed care organizations (Bao, Casalino, & Pincus, 2013). Taxes play a significant role in home healthcare reform, and small business owners must address the rising costs (Herrick, 2014). Without the application of sound management processes, the tax implications for noncompliance with PPACA implementation, particularly with managed care, include increased administrative costs to small businesses, stagnated growth, and decreased long-term success.

Small home healthcare businesses are sensitive to changes in costs, and the slightest upward shift in health premiums changes the companies' long-term strategies for providing home healthcare coverage and business planning (Gabel, Whitmore, Pickreign, Satorius, & Stromberg, 2013). The general business problem was the implementation of the Affordable Care Act, Medicare, and Medicaid regulations for managed care have caused financial loss to healthcare businesses (Williamson, 2013). Implementation of the Affordable Care Act, Medicare, and Medicare regulations for managed care required managing medical costs, reviewing tax plans and forecasts, and improving business processes.

Information gleaned from the Centers for Medicare and Medicaid Services (CMS, 2015) report postulated that, since the implementation of the PPACA, the per capita cost of health care remained at or under 3%. The economic slowdown and sluggish recovery have played much of a role in impacting healthcare costs, as has the PPACA. As the

Affordable Care Act matures, more data will be available to measure the impact and effectiveness of this healthcare law. While early results show improvement in some areas, such as the reduction in the number of uninsured, there have also been unintended consequences including rising out-of-pocket costs, higher taxes, and increasing regulations.

Formation of Small Businesses

The number of small businesses formed in the United States in 2007 exceeded the number of new corporations created by a margin of about two-to-one (USSBA, 2014). The SBA provided more details of interest for small businesses. As of the end of the fiscal year 2016, 28 million small businesses in America accounted for 54% of all U.S. sales (USSBA,2016). Small businesses provide 55% of all jobs and have created 66% of all net new jobs since the 1970s.The more than 600,000 franchised small businesses in the U.S. account for 40% of all retail sales and provide jobs for some eight million people. The small business sector in America occupies 30-50% of all commercial space, an estimated 20-34 billion square feet. Furthermore, the small business sector is proliferating (USSBA, 2017). While large, corporate America has been “downsizing,” the rate of small business “start-ups” has increased, and the rate for small business failures has declined (Longley, 2014).The number of small firms in the United States has grown 49% since 1982. Since 1990, as big business owners eliminated four million jobs, small business owners added nearly eight million new jobs (USSBA, 2017). This increase led to changes in the way the government taxes businesses at all levels.

According to Pomeranz (2015), understanding information flows is imperative to effective taxation.

Weber (2015) noted that changes to the tax code adversely affect small businesses and discussed the impact of switching from pass-through taxation to a single business tax for small companies. Weber (2015) evaluated the tax code and determined that a business owner was a taxpayer engaged in a trade or business who would deduct from the gross income all ordinary and necessary expenses of carrying on the trade or business paid or incurred during the tax year. Small businesses would likely face increased taxes with a single business tax; thus, a single business tax would be difficult to implement because the definition of a small business is broad and could do more damage than good (Weber, 2015). Gallen and Mulligan (2018) examined the income tax effects of the Affordable Care Act on small businesses. After the new law was enforced, small businesses with 50 or more employees faced penalties if the company did not provide health insurance to at least 95% of their full-time employees and dependents up to age 26.

In the past, the Internal Revenue Service (IRS) analysts were unsure how to tax small businesses because regulations failed to define what determined a small business. Small business owners faced a dilemma. They could receive the benefit of pass-through taxation and risk their assets in the business or pay a penalty of double taxation but protect their assets (Ordower, 2014). Romero, Dijkman, Grefen, and Vanweele (2015) argued that, considering such uncertainty, managing any business requires support from an efficient governance structure for business owners to manage increased taxes.

A limited liability company (LLC) has the protection of limited liability while securing the benefits of pass-through taxation (Ordower, 2014). The IRS analysts no longer group LLCs automatically with corporations or partnerships. There is no extended tax for LLCs under the rules applied to corporations or partnerships. In other words, the IRS decoupled the connection between the state-law business organizations and the federal tax requirements for corporations (Brown, 2014).

Tax legislation. Ordower (2014) noted that analyzing tax bills strictly by their revenue estimates is deceiving for at least three reasons. First, some tax bills have important temporary provisions, such as a 10% income tax surcharge on the Revenue and Expenditure Control Act of 1968, which masked the long-term effect of the tax bill for the first year or two after enactment. Second, relatively small differences in the effective dates of tax provisions affect the revenue estimate for the year after enactment. Third, government revenue estimates do not take into account the effect of the bills on the gross domestic product (GDP), even though the primary reason for designing some measures, such as the Tax Reduction Act of 1975, are to stimulate the economy.

The word *tax* can have a broad definition. Small business owners view a premium as a mandatory tax (Jackson, 2015). If both a bonus and a penalty represent a tax, the Affordable Care Act mandate becomes the largest tax increase in the history of the United States (Jackson, 2015). Governments need to increase revenue to avoid challenges, such as budget issues, government shutdowns, and recessions (Jackson, 2015). To manage government organizations efficiently, the management of the business

process mechanism must set clear business goals to achieve an expected result for the team (Romero et al., 2015). Coy (2015) examined the problem of a closing loophole in the tax code, which, seems the easiest way to end an impasse over budget reform. Some decision makers expand what falls under the tax code to generate more revenue without raising rates (Coy, 2015).

Tax compliance. Individuals and corporations must not only make tax payments but also document information to the tax authorities supporting their payment amount, that is on time, and in the required formats to follow the tax laws (Graves, 2014). Graves (2014) perceived that small businesses have a higher tax burden than corporations do. The top tax burden leads to noncompliance with taxes. According to Graves (2014), the current tax code drains essential resources that could be used to grow small businesses and create jobs. Unfortunately, the burden on small businesses has increased over the last few years (Graves, 2014). The cost for compliance is nearly three times greater for small firms than big businesses. According to the Internal Revenue Service's annual report, *National Taxpayer Advocate*, there were over 500 changes to the tax code in 2010 alone (NBSA, 2014). That is an average of more than one change per day that small firms are forced to manage. Small business owners have reported more experiences of contested assessments, audits, and sanctions (Ordower, 2014). Small business owners are more susceptible to audits due to their different exposure to the tax system (Ordower, 2014). Ordower (2014) noted that owners of small businesses were often noncompliant in withholding the appropriate amount of taxes from employees. Ordower (2014) shared the

view that owners of small businesses found it difficult to estimate tax payments amid a global economic slowdown and uncertainty that led to noncompliance. Small business owners have increased concerns about noncompliance with the tax code because they are more likely to self-report their companies' activities and to have limited control over the underlying money flow (Russell, 2015). Estimating taxes is difficult for owners of small to-medium-sized enterprises that do not forecast their business prospects and do not have a clear understanding of the taxation laws (Russell, 2015).

Small-and-medium-sized businesses have more autonomy than other taxpayers which can lead to more noncompliance with their tax payments. Although unintentional, this freedom has led to high incidences of tax implications, such as fines, audits, and charges of tax evasion (Russell, 2015). Changes in the tax system are necessary to simplify the taxation process to mitigate the possibility of noncompliance by small businesses (Russell, 2015). Russell (2015) concluded that the tax authorities need to develop a simplified tax system for SMEs to lighten their tax compliance burden in the midst of an economic downturn. During the 2008 recession, small business owners and real estate owners endured a significant slowdown, which prompted Congress to act. Congress passed the Small Business Jobs Act of 2010, which President Obama signed on September 27, 2010, to provide business tax relief for small businesses and additional support in the process of economic recovery. The primary purpose of enhancing the Internal Revenue Code §1202 exclusion through the Small Business Jobs Act was to encourage investment in specific new qualified small businesses, defined in the law as C

corporations with assets of $50 million or less where at least 80% of its assets are in use for the active conduct of trades or businesses (Russell, 2015).

Tax credits. Brown (2014) emphasized that through tax credits, increased flexibility of expenses, deductions, and depreciation, small businesses can generate more revenue. In another study on the Small Business Jobs Act, Tacchino (2018) noted a 100% exclusion from both capital gains taxes and the alternative minimum tax would be a financial windfall for small businesses with qualified small business stock. Tacchino (2018) postulated that, in the case of a taxpayer other than a corporation, gross income should not include 50% of any gain from the sale or exchange of qualified small business stock held for more than five years**.** Tacchino noted the increased tax rate on the top two marginal tax brackets was significant because the organization of many small businesses is a pass-through entity structure business owner use to avoid double taxation. With a pass-through entity, the business does not pay income taxes at the corporate level. Instead, corporate income is allocated among the owners, and income taxes are only levied at the individual owner’s level. This organization structure allows owners of the small business to pay taxes on net business profits at the applicable individual marginal tax rate. Many wealthy people who hold significant stakes in small business pass-through entities experienced an increase in their tax rate after this law went into place. These people, who comprise most of all private business income generated in the United States, pay substantially higher taxes (Tacchino, 2018).

Home health agency employers who fall into this situation of increased taxes must look at tax reduction processes to avoid tax penalties while abiding by the code. As the excise tax on high-cost employer plans takes effect, costs for employees will increase (Russell, 2015). Owners of small businesses can make use of Section 9022 of the ACA law that allows simple cafeteria plans. These plans permit employees to pay health insurance premiums as pre-tax expenses, thus reducing their total taxable income and increasing their spendable take-home income. Section 9022: Establishment of Simple Cafeteria Plans for Small Businesses amended Section 125 of the Internal Revenue Code of 1986 and added a new section titled Simple Cafeteria Plans for Small Businesses. The plans are available for eligible employees. The new simple cafeteria plan for small businesses primarily benefits C corporations by allowing small business owners to take advantage of pre-tax adjustments (Russell, 2015). Section 45R of the IRS Code of 1986 adds a credit for employee health insurance expenses of small employers (Russell, 2015). The tax credit is available for employers with 25 or fewer employees earning less than $50K. Russell (2015) concluded owners of the small business should review these laws to determine how the ACA rules affect their tax burdens and business operations.

Through surveys, Ordower (2014) reported on public opinion of tax breaks for small businesses. More than two-thirds of individuals surveyed favored tax shelters for small businesses that make coverage for their workers more affordable (Ordower, 2014). Support was significantly more likely (64% vs. 40%) among adults 18 to 29 years of age than among adults age 65 or older (Ordower, 2014). Over 50% of the public approved of

having healthcare coverage, but many were not supportive of additional taxes for small businesses or reductions in Medicare payments (Russell, 2015). Many Americans felt the United States would be better off with healthcare reform legislation before they realized that the penalties for noncompliance with the Affordable Care Act were significant for individuals lacking coverage and for businesses not providing coverage to employees (Russell, 2015). Business campaign contributions directly influence business tax rates and indirectly shape tax competition. For example, the corporate sector contributed over $1.1 billion to House election campaigns (Desilver & Van Kessel, 2015). Campaign contributions directly affected corporate taxes and fiscal policy. Russell (2015) concluded that large companies often paid less in taxes than small businesses. Russell examined the reason for non-neutrality regarding corporate income taxes. An organization's revenue determines its profit. The factors that affect the tax rate of product markets are not transparent (Russell, 2015). It is unclear if the tax burden belongs to employees, shareholders, or customers.

Taxes and home health small businesses. Home health small business owners play a significant role in the economy, but they are less likely to be tax compliant than individuals (Brown, 2014). Owners of small businesses are likely to have more opportunities for noncompliance with the tax code than employed taxpayers (Brown, 2014). There is no such thing as a neutral tax. Taxes affect an owner's budget. While the owners of infra-marginal firms can afford to pay taxes, higher taxes drive some marginal business owners out of the market, as many were only breaking even (Brown, 2014).

Taxation occurs on profits, but companies receive no incentives for losses. A tax that penalizes strong entrepreneurial action is similar to antitrust policies aimed at picking the winners of the competitive process, such as those that prevent and punish mergers and acquisitions (Brown, 2014). Brown (2014) concluded that governments are challenged to introduce non-neutrality in taxation because the marketplace is always evolving.

Gurley-Calvez and Bruce (2013) shared the view that, as the market continues to evolve, entrepreneurs face the question of determining the right time to enter. Because taxes play a significant role in revenue, entrepreneurs must be aware of tax policies for small businesses (Gurley-Calvez & Bruce, 2013). Gurley-Calvez and Bruce (2013) investigated whether tax rates affected the decision to begin a new entrepreneurial venture. The researchers examined 12 years of tax returns to determine entrepreneurial tax rates. Business leaders and working individuals bear the burden of the employers shared responsibility provision of the ACA through tax increases. The ACA contains 20 new or higher taxes on families and small businesses (Heim, Hunter, Lurie & Ramnath, 2015). The Medicare payroll tax, which employers pay, was also increased. The increase in the Medicare payroll tax accounts for $86 million in tax revenue (Heim et al., 2015). Heim et al. (2015) noted that if an employer with 50 or more employees does not offer health coverage, and at least one of these employees qualifies for a health tax credit, the employer pays an additional nondeductible tax of $2,000 for each full-time employee. The penalty for employers that do not provide health coverage serves to encourage businesses to sponsor healthcare insurance. If the employer requires a waiting period of

30-60 days to enroll in coverage, there is a $400 fee per employee, which increases to $600 if the period was more than 60 days (Heim et al., 2015).

Small Business Jobs Act. Gale and Brown (2013) reviewed the Small Business Jobs Act of 2010 and reported changes from the act that affected small businesses and real estate owners. The Small Business Jobs Act increases revenue substantially for small businesses through tax credits. As amended, the Small Business Jobs Act permits original shareholders of available corporation stock to sell stock without taxation on the sale (Tacchino, 2018). The Small Business Jobs Act includes several types of tax relief for small businesses, such as avoiding a secondary or additional tax on S corporations and consists of a more accelerated write-off of tangible personal property used in trade or business (Gale & Brown, 2013). Small business owners were only able to receive exclusions of 50% of the gain on the corporate stock, but 100% is allowable through the Act. For a corporation to achieve a qualified small business status, a corporation must be a C corporation; its aggregate gross assets before and immediately following the issuance of the stock cannot exceed $50 million (Tacchino, 2018).

Taxation on small businesses in other countries. Gurley-Calvez and Bruce, (2013) discussed the impact of corporate taxation on labor and capital demand by firms in developing countries. Gurley-Calvez and Bruce (2013) emphasized the effect of the business tax on investments and company owners decisions, such as investments or human capital. Gurley-Calvez and Bruce (2013) shared the view that the corporate tax affects the ability of enterprise owners of all sizes to generate funds for investments and

their ability to increase the labor force. Corporate taxes have a greater impact on energy demand in a large enterprise than in smaller companies because of the flexibility to hire or fire individuals from their jobs when there are complementarities between capital and labor (Gurley-Calvez & Bruce, 2013).

Entrepreneurs and taxes. Entrepreneurs are more likely to start business ventures when they find they have favorable tax conditions. Any reduction in tax rates, in the form of higher rates for wage workers or lower rates for entrepreneurs, increases entry (Gurley-Calvez & Bruce, 2013). Many expenses that reduce business profits for tax purposes affect contractor taxation. Most income depends on voluntary compliance; therefore, relative tax burdens can vary, even when entrepreneurs and wage-and-salary workers face the same tax rates (Gurley-Calvez & Bruce, 2013). Voluntary compliance increases the risk for underreporting because entrepreneurs are just starting out and may not be aware of tax codes and reporting requirements (Gurley-Calvez & Bruce, 2013). Also, hiring certified public accountants (CPAs) to assist increases expenses and reduces profit. Higher tax rates lead to more tax evasion, which is more likely due to the absence of third-party reporting, and an increase in expected loss offsets makes reporting entrepreneurial income through the personal income tax system relatively more attractive than filing a corporate tax return (Freire-Seren & Panades, 2013). Cutting the entrepreneurial marginal tax rate by one percentage point increases the probability of entrepreneurial entry (Gurley-Calvez & Bruce, 2013). Marginal tax rates are blind to the

source of income under current law. It is, therefore, perhaps more relevant to consider the effects of across-the-board tax cuts of equal amounts (Gurley-Calvez & Bruce, 2013).

Medicaid and Medicare. Medicaid and Medicare are part of the universal health system in the United States. The Medicaid health insurance program is a safety net that one in five Americans depends on (CMS, 2015). CMS (2015) conducted a review that involved evaluating the same period in which the downturn in the economy increased the number of uninsured and underinsured Americans. Decreasing government revenues led to decreases in Medicaid coverage, and administration by non-profit government shifted to for-profit health maintenance organization entities.

Medicare, the government, administered healthcare insurance, serves individuals over 65 years of age and other limited groups of citizens. The home healthcare system, particularly Medicare, does not stay static but is flexible and adapts to changes in technology and treatment options (Morone & Ehlke, 2013). Medicare is at center stage because of its effect on home healthcare costs. Medicare accounts for an estimated 15% of the federal budget, and spending in the program is likely to grow as a share of both the federal budget and total national expenditures as healthcare costs rise (Morone & Ehlke, 2013).

Morone and Ehlke (2013) shared the view that Americans are living longer and requiring extended health coverage. Healthcare costs will continue to increase, and changes in Medicaid and Medicare are inevitable (Morone & Ehlke, 2013). Morone and Ehlke (2013) showed that a viable solution to higher costs is to take the best parts of the

existing Medicare system and add many of the attributes of a premium support plan. The method includes: (a) retaining appropriate safeguards, (b) linking reimbursement to defined quality outcomes, (c) adjusting the age of eligibility, (d) aligning provider incentives, and (e) focusing on prevention and compassionate end-of-life care (Morone & Ehlke, 2013). The adjustments to the Medicare system might prevent any sharp rises in healthcare costs for Americans.

Medicaid and Medicare are a substantial part of the PPACA. One goal of the PPACA is to reduce healthcare costs across the board (Logan & Bacon, 2016). To address healthcare costs for small businesses, many state lawmakers created health insurance exchanges as part of the PPACA (Gravelle & Lowry, 2016). Small business owners will need ways to reduce healthcare costs to sustain their business while still providing coverage for employees (Logan & Bacon, 2016). Provisions of the PPACA, such as healthcare exchanges, will allow leaders of small businesses to pool their buying power, have more choices of health plans, and buy affordable health insurance (Gravelle & Lowry, 2016). Gravelle and Lowry (2016) examined the challenge for successful exchanges. One major problem for small businesses is finding out whether exchanges exist and how to participate in them (Gravelle & Lowry, 2016). The Accountable Care Act required that states expand Medicaid eligibility to include individuals and families with incomes up to 133% of the federal poverty level, including adults without disabilities or dependent children. The law provides a 5% “income disregard,” making effective income eligibility more likely. One goal of the PPACA included reorganizing

and reforming the existing healthcare insurance industry, expanding coverage and access to care, improving the quality of healthcare delivery system, controlling costs, and establishing new revenue sources to pay for PPACA initiatives (American Academy of Family Physicians, 2016).

Cost structure in home health. Mukamel, Fortinsky, White, Harrington, and Ngo-Metzger (2014) examined the cost structure of home health agencies by looking at 2010 Medicare cost data, 10 years before the implementation of the prospective payment system and merged the cost data with information from the Outcome and Assessment Information Set (OASIS) from 7,064 agencies. They calculated marginal costs as a percent of total cost for all variables (Mukamel et al., 2014). They concluded that forprofit companies dominate the home health industry. These for-profit companies are typically newer than nonprofit organizations and, have higher costs per patient; however, they have lower costs per patient visit. Mukamel et al. shared the view that for-profit agencies tend to have smaller scale operations and different cost structures but that they are less likely to be affiliated with chains. The study also estimated diseconomies of scale, zero marginal cost for contracting rehabilitation services, and an actual minimal cost when recruiting with nursing staff for controlling the quality of care. The view suggests that efficiencies may be achieved by promoting more for-profit agencies.

Gressel (2013) viewed clients who take the responsibility and insist on greater transparency and quality indicators can, thereby, ensure that the home healthcare marketplace operates efficiently. Providers should provide the right balance of quality

outcomes and cost. Gressel focused on home health care (HHC), a significant portion of the healthcare market. HHC expenditures in 2009 reached $68.3 billion, an increase of 10% over the previous year. The largest trade association for HHC in the USA, the National Association for Home Care and Hospice (NAHC), estimates that over 12 million people currently receive HHC services from more than 33,000 HHC providers. The HHC industry has experienced significant growth over the past 10 years; however, there are concerns that some providers are not qualified, perform their duties poorly, and are fiscally fraudulent (Gressel,2013).

Gressel (2013) acknowledged that 65% of HHC payments originate from Medicare and Medicaid. While the assessment of HHC aims to provide quality, utilization of Medicaid services and rising healthcare costs influenced efforts to control the growth of spending and improve the quality of attention. For this reason, the Center for Medicaid and Medicaid Services (CMS, 2015) developed a comprehensive instrument to assess healthcare outcomes and treatment quality. The survey is known as Outcome and Assessment Information Set (OASIS). The HHC model utilizes a multidimensional approach to assessing quality. OASIS is comprised of 41 items and is administered only to Medicare-certified HHC providers. The resulting data analysis is then posted on the CMS web page as a home health star rating. The tool allows consumers to search for HHC vendors and make comparisons of the quality of the services they provide (CMS, 2015).

Responsibilities of the Home Healthcare Leader. Home healthcare leaders have a primary responsibility to understand the laws governing their organization and industry if they are to lead, protect, and advance their organizations' system of operations (Morone & Ehlke, 2013). The primary healthcare legislation falls in the areas of tort laws, negligence, and malpractice. Court decisions align with policy, especially with healthcare laws (Morone & Ehlke, 2013). Home health professionals are held accountable for understanding operational law practices within their organizations. According to Pozgar (2016), laws are established to regulate human behavior for the good of society. The terms *negligence* and *malpractice* within the healthcare industry are used interchangeably, but the concepts differ in scope and practice. *Negligence* is an overarching term that focuses on specific details of the case that include criminal negligence, neglect, medical negligence, and medical malpractice (Pozgar, 2016). *Malpractice* in health care is the illegal event in which the trust between the medical professional and the patient or client is breached (Pozgar, 2016).

When patients are given medications for treatment of certain medical conditions, the primary care doctor who is responsible for monitoring the patient's reactions to the medications must adjust where necessary based on his or her scope of practice. With the advent of the technological revolution and the use of electronic medical records, a primary care medical doctor can collaborate with other medical specialists and the pharmacist as well as a visiting registered nurse. Sometimes a patient has multiple specialist doctors, and the primary care physician's job becomes harder as this doctor

must manage all facets of the patient care. A primary care physician has a responsibility to ensure the appropriate delivery of care as well as to coordinate with other medical specialists (Sohn, 2013). The patients, as well as their caregivers, have a responsibility to ensure they follow the physicians' care instructions. The pharmaceutical companies have a responsibility to ensure that they communicate adverse reactions to medications to physicians and their patients. Pharmaceutical companies invest in education and resources to talk to the gatekeepers and the public generally about side-effects to their products. Healthcare providers could accommodate the mandates of the PPACA. Published research reveals many suggestions for owners of home healthcare services, including ways these services can educate themselves on innovative payment models (Yeung, 2016). For example, providers could invest time in understanding new payment mechanisms that are being implemented and the opportunities or challenges they present (Yeung, 2016). Providers could encourage further engagement among physicians to learn more about new payment models. Providers could highlight better alignment in new models correlated to compliance structures and principles that directly increase compensation based on provider efforts. For example, as Medicare payments change from pay-for-volume to pay-for-value, the importance of existing compliance structures and principles remain relevant to ensure participation in new payment mechanisms (Yeung, 2016). Providers who highlight such requirements could see their companies benefit in the long-term. Healthcare providers could increase leverage among the competition through alliances and partnerships. The providers who are prepared would

gain an advantage against those who are not. More likely, some providers would need partnerships or alliances to survive due to unpreparedness for new provisions in the PPACA and lack of compliance with such regulations. The arrangements are critical for provider performance because these agreements potentially impact financial success, customer satisfaction, reputation, and program compliance. This type of diligence would be beneficial when entering into partnerships or agreements with entities that aim to improve organization's performance (Yeung, 2016).

Larger agencies in the healthcare industry need to provide better direction for smaller firms (Yeung, 2016). Organizations should utilize their strategic focus to guide smaller businesses. Small business owners have the power to make strategic choices (McDowell, Harris, & Geho, 2016). Specifically, organizational leaders should provide models for small business owners during decision-making processes to help them better understand the most effective strategy. Strategic understanding is most important for new businesses as this improves strategic decision-making (McDowell et al., 2016). Strategic knowledge is necessary to sustain long-term success in the marketplace (McDowell et al., 2016).

Ethical issues in home health. Decamp et al. (2014) viewed ways the structure of health care affects the ethical problems in the practice of medicine and the home healthcare industry. Accountable Care Organizations (ACO) are an essential component in identifying and managing the ethical challenges. ACO were established as a solution to the crisis in home health care, and they hold clinicians, group practices, hospitals, and

home health agencies financially accountable for reducing expenditures and improving patient health outcomes. Patients perceive medical malpractice regarding physicians who are unprofessional, careless, or have intentions to do harm to the individuals they treat (Decamp et al., 2014). According to *Black's Law Dictionary* (Kass & Rose, 2016), tort law includes a legal wrong-doing committed upon the person or property independent of the contract. When a patient believes a medical professional has acted recklessly, the patient typically files a malpractice tort suit alleging the physician was negligent, grossly negligent, professionally negligent, reckless, or committed acts of intentional harm (Kass & Rose, 2016). Many patients believe malpractice laws benefit physicians more than the patients. Medical error and misdiagnosis were found to be the third leading cause of death in the United States, behind heart disease and cancer (Makary & Daniel, 2016).

Strategic Business Processes

The implementation of Medicare and Medicaid managed care in home health resulted in uncertainty due to new regulations and potential tax penalties for employers and employees (Taneja, Pryor, Humphreys, & Singleton, 2013). To address the possibility of change, owners examine strategic and management processes of small businesses to improve long-term success, survival, and management of change (Taneja et al., 2013). The strategic management business process guides strategic management leadership theory because effective leaders must understand the framework to manage and govern their organization. Santos, Melo, De Melo, Claudino, and Medeiros (2017) used the strategic business process to urge leaders to work with lower level workers on

objectives and goals and to encourage the employees to make decisions on how to achieve these aims and objectives through strategic processes. The policy framework Santos et al. (2017) advocated is an eight-step dynamic process that leaders, managers, and representative stakeholders, both positional and functional, can use to plan and guide their organizations strategically into the future. Leaders use strategic management processes to improve long-term success, survival, and change management (Taneja et al., 2013). A strategic positioning framework and administration process might guide or define how business leaders will meet strategic goals and objectives and achieve the organizational mission (Matta et al., 2014). To manage the framework and lead their team, home health managers of small businesses can implement the managerial grid model, developed in the 1960s by leadership theorists Blake and Mouton (Zerfass & Viertmann, 2017). Managers use the managerial grid to achieve the objective of the project and, at the same time, to manage employees (Zerfas & Viertmann, 2017). Managers of small businesses can use the leadership theory by Blake to maximize employee production by focusing on team management to meet the objectives of the organization (Obolensky, 2014). A strategic leadership framework process might serve as a guiding principle to define how business leaders will achieve strategic goals and targets and move their organization mission forward (Zerfass & Viertmann, 2017).

Objectives evaluation. To make organization-wide objectives, leaders and employees must understand the owner’s organizational goals (Zerfass & Viertmann, 2017). Business leaders must not only evaluate their owner’s corporate goals but also

implement these goals within a context of shared responsibility. Business goals must align with implementing the employer shared responsibility provision of the managed care process to be successful.

Implementing the Medicare and Medicaid Managed Care Plans. Implementation and delivery of Medicare and Medicaid managed care plans requires attention to what these processes cost and how those costs will affect small businesses. Leaders of home health small businesses must look at new alternatives and innovations to improve business operations and offset costs while implementing managed care plans to compete in the marketplace. Business leaders can use strategic management processes to determine successes and reasons for the failure of innovations within the organization. Technology assists business leaders by providing opportunities for collaborative partnerships to manage disruptive innovation (Litchfield et al., 2016). Leaders of small businesses can use the framework to predict whether firms will be successful with new products independently or through partnerships. Disruptive innovation can have a significant role in the success of small businesses during the implementation of managed care (Litchfield et al., 2016). Leaders of small firms face challenges implementing innovation, such as healthcare reform and taxes. Brunswicker and Vanhaverbeke (2015) provided a report aimed at identifying factors that affect the innovativeness of growing small-and-medium-sized enterprises (SMEs). To offset the financial strain of home healthcare reform and taxes, company leaders must examine other opportunities to

increase revenue. Business leaders cannot use copyright as an innovation to offset increased costs from healthcare reform and taxes.

Home health leaders of small businesses must be able to use all the resources and processes to sustain the company during a recession or other market change. Herd et al. (2016) examined small business sustainability and found that small business leaders need to create structural, relational, and social capital before a recession to protect them from additional uncertainty. Small business leaders can create these changes through their supply chains. Leaders of major multinational corporations are placing higher pressure on small business supply-chain vendors to adopt sustainability practices (Herd, Adams-Pope, Bowers, & Sims, 2016). Gallen and Mulligan (2018) examined small business durability and the CPA's role. Business leaders must employ new methods to succeed in changing environments. Business leaders who fail to develop sustainable processes could experience negative impacts (Gallen & Mulligan, 2018). Business leaders must have a plan so that business strategies and processes can be implemented accurately and sustainably (Budak & Kar, 2014). Business leaders must evaluate strategies to ensure they are measurable for applying the employer shared responsibility provision of many managed care plans. Budak and Kar (2014) also noted that business leaders must identify goals and outline objectives while providing leadership to their organization.

Sustainability. Sustainability is a growing area, and challenges can lead to unprepared companies falling into financial chaos (Budak & Kar, 2014). Small business leaders who implement sustainability can take advantage of the associated benefits.

Significant customer-related benefits can accrue SMEs when leaders incorporate sustainability into the entrepreneurial culture (Budak & Kar, 2014). Organizational leaders who succeed in times of economic stress rely on collaborative processes to reduce cost and risks while expanding their networks to increase their operational flexibility and access to markets (Che Yil, 2018). The model Che Yil (2018) recommended shows that leaders who adopt a flexible specialization paradigm focus upon interim relations and private supporting institutions are more likely to survive economic crises. Relationships developed within the supply chain can help small businesses sustain their incomes during economic downturns. Small businesses, however, lack guidance in sustainability. CPAs will have a pivotal role in assisting small businesses with sustainability because of their extensive knowledge. Gallen and Mulligan (2018) noted that CPAs must develop the knowledge and skills necessary to provide small business leaders with sustainability services. Business leaders need capital to sustain their organization. The landscape of financing has changed, and owners need so-called angel investors for growth. Angel investors, affluent individuals who front capital for a business start-up, are relevant for SMEs because they provide money, expertise, knowledge, skills, and contacts for members of the companies in which they invest (Collewaert & Manigart, 2016). Angel investors can provide opportunities for small enterprises at different stages, such as the seed stage, start-up stage, and early stage. Many angel investors prefer early-stage businesses because they can have an active role in creating the enterprise before they sell their position in the company (Collewaert & Manigart, 2016).

Increased business costs from healthcare reform is causing leaders of home health small businesses to explore enticing angel investors to improve capital. Angel investors tend to invest in small businesses instead of large corporations; nonetheless, because of the high risk of an investment, most angel investors invest only 5-15% of their assets in such companies (Collewaert & Manigart, 2016). Collewaert and Manigart (2016) concluded that angel investors want to see young entrepreneurs grow and succeed because they understand many small businesses lack the capital to start or sustain growth with the implementation of managed care. Entrepreneurs have also turned to venture capital as an avenue to increase growth within organizations. Keppler, Olaru, and Marin (2015) examined a venture capital model for innovation management that tests innovation and ideas of entrepreneurs quickly to determine the potential success of the venture. Since the 1970s, a primary source of business innovation has been new businesses, often funded by venture capital (Keppler et al., 2015). Keppler et al. (2015) postulated that the venture capital model of change management included ten first processes to manage uncertainty, mitigate risk, and empower commitment. The methods used in the enterprise model involve investing in teams, focusing on customer development, and always selling (Keppler et al., 2015). These methods helped entrepreneurs create advantages from disadvantages. Innovation gives business leaders opportunities to compete in a larger market and for a longer time. When business owners align venture capital with incentives, they can achieve through sharing ownership of new

business initiatives and structures that share risk and reward and encourage sustained effort over a period of years (Keppler et al., 2015).

Changes in healthcare reform, recessions, legislation, and taxes affect home healthcare revenue. Keppler et al. (2015) concluded the venture capital model provides an opportunity for partnerships, collaborations, and acquisitions. A component of sustainability is an effective business strategy. The strategy is a way of thinking about the business, assessing its strengths, diagnosing its weaknesses, and envisioning its possibilities (Santos et al., 2017). Hill et al. (2015) examined what it meant to implement strategic plans. The definition of a strategy for a company cannot be from one idea or framework. Business leaders must look at processes as multidimensional to be competitive and improve success. The real development of a strategy requires a review of both the current and future states and then the use of available tools to bridge the gap between both states to make organizations competitive in the future (Hill et al., 2015).

Strategies for small businesses. The goal of small business leaders is to continue to improve success with changes in home healthcare reform and potential tax implications in the marketplace. By analyzing and taking strategic actions designed to have effects in both current and future periods on their companies, business leaders can ensure they will remain relevant and viable over time (Budak & Kar, 2014). Role changes at the top will cause position changes throughout the organization, which will provide more strategic options for the company. Kash et al. (2014) noted that business leaders must examine strategy from a future perspective and watch out for potential

challenges while seeking new opportunities. New opportunities lead to the core of the strategy for businesses: learning, discovering, and inventing new possibilities. Kash et al. concluded that learning and discovery should reveal opportunities for improvement within the corporation. Leaders who understand the process of change create sources of competitive advantage for their organizations (Marta-Dominguez, Galán-González, & Barroso, 2015).

Home Health Compliance and Ethics Program. According to Williford and Small (2013), it is necessary for owners to establish an effective compliance and ethics program to protect any highly regulated organization. At its core, an effective program protects an organization by detecting and preventing improper conduct and promoting adherence to the organization's legal and ethical obligations. In 1991, the U.S. Sentencing Commission established the most recognized standards for an effective program within its *Sentencing Guidelines Manual* (2012). These guidelines align with the principles outlined in compliance guidance that various agencies have developed over time and include advice related to home health agencies, investment companies, companies interacting with foreign officials, hospitals, nursing homes, pharmaceutical companies, and government contractors to name a few. These guidelines and this guidance have been used by organizations to design and implement their programs (Williford & Small, 2013). While no program is exactly alike for every organization, several core components must exist to have a successful program. A team is required to have standards of conduct and an internal mechanism that is reasonable and capable of decreasing the possibility of

criminal and other unacceptable behavior (Williford & Small, 2013). The basic premise of controls is a code of conduct. The system should contain a comprehensive description of the program, the roles, and responsibilities of the governing authority, and provide guidance on the business behavior expected of all staff. The code should identify a clear line of power for reporting misconduct or violations of the code and make clear that disciplinary action will be implemented if a staff violate or misrepresent the code (Williford & Small, 2013). In addition to the code, an organization needs to have more specific policies and procedures to provide detailed guidance on the approach the organization wants employees to follow, or avoid, in its business relationships. The more detailed policies and procedures should address legal and regulatory risks relevant to the organization's business. These can be policies that address areas, such as conflicts of interest, political contributions, agent and vendor due diligence, internal accounting practices, anti-corruption expectations, record retention, government-funded projects, export controls, and customs issues. Depending on the industry, there are several guidance manuals, such as those identified above, that attempt to explain the types of areas that are relevant (Williford & Small, 2013).

The Office of Inspector General (OIG) issued a model *Compliance Program Guidance for Individual and Small Group Physician Practices* (OIG, 2000). The *Compliance Program* laid out a path for the physician practice owners to follow in implementing compliance measures. The first step the *Compliance Program* recommended was that a medical practice owner should perform a baseline audit to

identify fraud, waste, and abuse. Afterward, the practice owner should focus the compliance efforts on the risk areas that are associated with the problem. Two types of reviews recommended are standards and procedure review and claim submission (Petersen, 2017).

According to Williford and Small (2013), reasonable efforts are imperative to exclude bad actors from managerial ranks. An organization leader should take the necessary steps to ensure that individual physicians with substantial authority have not engaged in illegal activities or conducted themselves in a manner inconsistent with the established compliance program. The organization leaders should employ screening procedures to check personal background and criminal history. For example, an organization leader who receives federal contracts and certain types of federal assistance and benefits should consider steps to determine whether its employees are listed on the government's Excluded Parties List System (EPLS) database. The EPLS identifies those listed with regulatory and statutory exclusions across the entire government program, as well as individuals barred from entering the United States. An organization leader who receives revenue or payments from federal healthcare programs including Medicaid and Medicare should ensure that employees are not listed on the OIG Excluded Parties List (Williford & Small, 2013).

Williford and Small (2013) postulated that training and education are also essential aspects of the compliance program. The organization should ensure that the application's code of conduct, policies, and procedures are widely disseminated and that

employees are trained on the program's objectives and appropriate strategies. Proper training should require all staff including physicians, governing authority, organizational leadership, agents, and direct staff employees. Proper training includes instruction on the code of conduct, individualized staff training, and components of the compliance and ethics program. It is imperative that training is monitored and documented, and that follow-up work is done and attested. Monitoring, auditing, and evaluation of program effectiveness are essential aspects of compliance (Williford & Small, 2013). An organization program should include monitoring and auditing systems that are designed to detect criminal and other improper conduct.

In general, the audit should assess compliance with the code of conduct as well as the policies and procedures adopted to promote adherence to laws and regulations. Williford and Small (2013) recommended that the review should be performed independently. Active lines of communication are of paramount importance. Performance incentives and disciplinary measures are hallmarks of good compliance. An organization should promote and enforce programs through incentives and disciplinary actions. Enforcement programs should be transparent at all levels of the organization. Appropriate disciplinary actions range from reprimand with additional training, demotion, to termination. The disciplinary actions should be proportional to the conduct of the staff to ensure efficient practices. The appropriate corrective measures are critical to the compliance program.

Williford and Small (2013) further shared that if the improper conduct is detected, it is imperative that an organization takes reasonable steps to ensure corrective action and to prevent future similar behavior. The corrective action includes disciplinary measures aimed at the person responsible for the improper conduct. Finally, risk management is part of the organization compliance plan. A team should assess the risk of improper conduct within the operation and take appropriate steps to design, implement, or modify each element of the program to reduce the risk of inappropriate or unethical behavior (Williford & Small, 2013). The assessment entails evaluating factors such as audit, recent litigation, settlements, compliance complaints, employee claims, and industry enforcement's plans. Risk management is done at least on an annual basis (Mosadeghrad, 2015).

Fraud, waste, and abuse. The estimated annual cost of fraud in the Medicare system is approximately $54 billion (Hill et al., 2014). Contributing to this fraud are false claims resulting from flawed billing systems, a lack of responsibility and commitment by the government, and even involvement in organized crime as the profits are often higher than some penalties assessed for other illegal activities (e.g., dealing drugs). These issues demonstrate a need for fraud detection and prevention programs (Hill et al., 2014). Combating fraud is a priority for the U.S. government (Mitka, 2013). The question remains as to how the federal, state and local governments can accomplish this. The answer appears to lie in five approaches suggested by the Chief Counsel to the United States Inspector General in 2009 (Mitka, 2013). The procedures include enacting more

robust screening systems for enrollees in Medicare and Medicaid, close monitoring of payment systems, and increased training for healthcare providers. CMS also developed an Integrated Data Repository containing all Medicare and Medicaid claims, data on beneficiaries and providers, and contractors' information that allows analyses of comparisons and trends as well as swift and robust prosecution of detected abusers (Malhotra & Lassiter, 2014). Using these approaches on the data allows the identification of outliers as signals of potential concern that lead to aggressive investigations that help ensure the U.S. discovers the most egregious perpetrators of fraud.

Physician self-referral stature of the Stark Act. Home healthcare leaders have fiduciary responsibilities to account for employees, business associates, entities, and stakeholders for the protection, care, and safety of the patients and the organization. Failure to maintain a high standard of expected behavior or failure to follow statutory laws can lead to criminal and civil violations. Home healthcare leaders must be aware of the rules and regulations governing the healthcare industry and should secure the services of seasoned and experienced legal professionals, knowledgeable stakeholders, and staff of compliance officers to protect their organization and to prevent and insulate themselves from serious legal ramifications (Pozgar, 2016). Knowing the intricacies of the physician self-referral statutes of the Stark Act is imperative for healthcare providers who must navigate such complicated regulations (Pozgar, 2016). According to the Center for Medicare and Medicaid Services, the Stark Law is a complex set of regulations that was initially published in 1995 and concluded in 2007 (Stark.org, 2013). Initially, the

Stark Law focused on clinical laboratory services. The Ethics and Patient Referral Act, enacted in 2007, prohibited physicians who have an ownership interest or compensation arrangements with a clinical laboratory from referring Medicare patients to that laboratory. The government requires the management of the clinical laboratory to report the names of all physicians and their immediate relatives with an ownership interest in the entity (Pozgar, 2016). The Stark Law applies to many services jointly referred to as Designated Health Services (DHS) as well as almost any financial relationship between a physician and an entity billing the government unless DHS grants an exception. Penalties for violating the Stark Law are strict, severe, and robust. If no exception exists, sanctions include denial of payment, refund of payment, the imposition of $15,000 per service civil monetary penalty, and $100,000 penalties for so-called circumvention schemes (MGMA, 2017).

Local State and Federal Regulation Individuals Stark Act. Federal agencies regulate conflicts of interest that fall within their domain. For example, the government established the Federal Acquisition Regulation (FAR) to codify uniform policies for purchasing of supplies and services by executive agencies. FAR is issued, maintained, and revised jointly under statutory authorities granted to the General Services Administration (GSA), the Department of Defense (DOD), and the National Aeronautics and Space Administration (NASA) (Tomanelli, 2015). FAR addresses conflicts of interest in government procurement as designated in the Federal Acquisition Regulations, Part 3: Improper Business Practices and Personal Conflicts of Interest. When there is a

conflict between state law and federal law, federal law prevails. The DHS and CMS enforce the Stark Law (Tomanelli, 2015). Designated Health Services are explicitly defined by Current Procedure Terminology (CPT) codes, which are maintained by the American Medical Association through the CPT Editorial Panel. CPT codes include services provided by home health agencies and hospitals such as laboratory, physical therapy, radiology, durable medical equipment, pharmaceuticals, and inpatient and outpatient services (Tomanelli, 2015).

False Claims Act. The False Claims Act (FCA), first enacted during the Civil War and greatly revamped in 1986, provides civil liability for falsely representing a service as completed when it has not or for falsely representing compliance for a government payment (Kim, 2013). A false claim for payment from a government program such as Medicare or Medicaid is the most common type of fraud in the 21st century, estimated at over $54 billion per year (Kim, 2013). The FCA attempts to deter this kind of fraud by imposing a civil penalty between $5,500 and $11,000 per claim (Kim, 2013). A major problem with the FCA centers on whether a third party can be held liable for a claim (Kim, 2013). For example, a healthcare organization, such as a home health agency, may argue that they did not realize their error (Kim, 2013). Liability under the FCA does not require actual knowledge of the violation nor does it require a specific intent to defraud the government (Golinkin, 2013). If a home health agency applies, they can be held liable regardless of whether it was intentionally trying to defraud the

government. Also, the government can win recoveries from a healthcare organization by threatening to exclude the group from Medicare and Medicaid (Golinkin, 2013). Compliance departments are now critical in a home health agency that deals with Medicare and Medicaid or any other government-sponsored healthcare program in part because a home health agency can be held liable as a third party and be forced to pay a civil penalty.

Fisher (2014) conducted a historical review of federal regulatory responses to healthcare fraud and abuse and analyzed the impact of federal laws and policies (e.g., FCA, Anti-Kickback Statute, Stark Law, Deficit Reduction Act, HIPPA, Fraud Enforcement, Recovery Act, and the PPACA) on the commission of fraudulent and abusive practices. Fisher (2014) concluded that the FCA and other statutes helped curb fraud and abuse committed by providers. Fisher (2014) also explained the *qui tam* (i.e., whistleblower lawsuit) provisions of the FCA have proven useful in combating healthcare fraud and abuse. For example, *qui tam* actions in the U.S. pharmaceutical industry have proven highly effective in exposing fraudulent marketing practices in that sector. In fact, *qui tam* settlements in the United States since the beginning of the 21st century have yielded $5 billion (Fisher, 2014). Looking beyond the pharmaceutical industry and the U.S. healthcare system, Fisher (2014) concluded *qui tam* laws are a valuable regulatory asset in any healthcare system in which concern exists about the need to protect federal government funds for the provision of healthcare.

Federal, State, and Local Government Interventions. Federal, state, and local governments working together to combat false claims have made significant changes in the past decade. As of 2014, 30 states and the District of Columbia have passed false claims statutes, modeled on *qui tam* provisions, to protect their publicly funded programs from fraud (Hagens Berman Sobol Shapiro LLP, 2015). The rules enable the state's jurisdiction to recover monies from fraudulent activities. Some states' versions of false claims legislation provided similar protections to those of the federal law, while other states limit recovery to claims of fraud related to the Medicaid and Medicare programs (Office of Inspector General, 2000). The federal government recovered $38.9 billion under the FCA between 1987 and 2013. Of this amount, $27.2 billion or 70% was from *qui tam* cases brought by realtors, private individuals, or whistleblowers (Leagle, Inc., 2017) (United States *ex rel.* Steury v. Cardinal Health, Inc., 625 F.3d 262, 267 (5th Cir.2010), "The FCA is the Government's primary litigation tool for recovering losses resulting from fraud.") (Hesch,2012). The PPACA made further amendments to the FCA including a change to the Public Disclosure Bar, source requirements, overpayments, and Statutory Ant-Kickback Liability (Office of Inspector General, n.d.). The conflict of interest concerning the FCA includes self-investigation. Home health agencies management accused of wrongful conduct trigger an investigation and audit of their organization (Fisher, 2014).

Racketeer Influenced and Corrupt Organizations Act (RICO). The federal law titled the Racketeer Influenced and Corrupt Organizations Act (RICO) prohibits

organizations from participating in racketeering activities. Severe consequences and penalties for noncompliance include up to 20 years imprisonment (Legal Information Institute, 2015). Monetary penalties vary from a $250,000 flat penalty to a fine that is twice the amount of the proceeds secured through the criminal act (Davis, 2014).

Transition

Section 1 introduced the critical points of the foundation of the study. The purpose of this qualitative multiple case study identified strategies that small-to-medium-sized managed care businesses proprietors use to address the financial effect new healthcare regulations may have on their business. The population for this study identified one

owner from each of five home healthcare business agencies chosen from the 435 home healthcare business organizations in Los Angeles County, California, who have successfully addressed the financial effects of Medicare and Medicaid regulations on the home health agencies. A sample of five home health agencies' owners, which have been operating for over 5 years, responded to open-ended, semi-structured interview questions. The research problem, research questions, and conceptual framework contributed to developing an understanding of the strategies the home health agencies' owners used. The strategic management theory grounded in profit maximization and adaptation in changing contexts are the conceptual framework that ground this case study.

The literature review components provide a chronological history of Medicare and Medicaid managed care regulations initiatives that apply to the home health agencies

business enterprise. My review of the academic and professional literature includes an analysis of strategies home health owners use to cope with the financial effects of Medicare and Medicaid managed care regulations initiatives. The review of the literature also includes theories that influence home health agencies strategic management leadership, and strategic change initiatives. The study scope is limited in breadth and design to understanding home health agencies in Los Angeles County, California. The specifics of the overview of the qualitative case study described in Section 1 and Section 2.

In Section 2, I provide my role as the research instrument, details of the participants, ethical considerations, expansion of the study's research method and design, data analysis, and reliability and validity. In Section 3 of the review, I provide presentations of the findings with a description of the result's applications to professional practice and implications for social change.

Section 2: The Project

The purpose of this qualitative multiple case study was to identified strategies that small-to-medium-sized managed care business owners use to address the financial effects new healthcare regulations may have on their business. A qualitative multiple case study design enabled me to address the central research question from a broad perspective and various realities. I interviewed owners of successful home health agencies in Los Angeles County, California, to gather their perspectives and arrived at an understanding of the problem through their lived experience.

Purpose Statement

The purpose of this qualitative multiple case study was to identified strategies that small-to-medium-sized managed care businesses proprietors use to address the financial effect new healthcare regulations may have on their business. The population for this study was one owner from each of five home healthcare businesses chosen from the 435home healthcare businesses in Los Angeles County, California, who have successfully addressed the financial effects of Medicare and Medicaid regulations on the home health agencies. Study implications for social change include catalyzing economic, intellectual, and social developments that improve community health and wellness programs and related activities in home health care as community-based healthcare organizations, as well as improved patient health outcomes.

Role of the Researcher

In a qualitative multiple case study, the researcher assumes the role of the data collection instrument (Abildgaard, Saksvic, & Nielsen, 2016). According to Sanjari, Bahramnezhad, Fomani, Sho-ghi and Cheraghi (2014), a researcher's role includes not only defining the research concept, authenticating, designing, interviewing, transcribing, analyzing, and recording the study's data to develop themes. Perry (2013) emphasized that an original approach involved achieving a cognitive, self-reflective understanding of each participants' experiences that transcend individual preconceptions.

The researcher maintains a sustained and intensive relationship with the participants. I disclosed my personal experience as a 30-year career community home healthcare administrator in the demographic area of the study. As the interviewer, I conducted the surveys at the participants' preferred location: by doing so, I assured the participants that I remained open to any evidence they present. The process diminished any potential bias from the report. The researcher did not interview participants with whom I have had a role in providing direct or indirect services (Yin, 2014). The home health agencies' business owners with whom I have a perceived or acknowledged relationship was excluded to alleviate any undue influence.

By adhering to the Belmont Report protocol, the researcher can protect the rights and welfare of the participants in a study (Yin, 2014). Of importance is the confidentiality of all participants. The sensitive nature of the information obtained from participants necessitates the protection of names, people, places, and activities. I collected

data via observations and open-ended interviews with home health agency owners in the privacy and comfort of their office and work environment. The researcher followed strict guidelines and adhered to a well-planned interview protocol with data collection guidelines and techniques (Corti & Van den Eynden, 2015). The interview protocol consisted of the established topic for the study, opening statements and instructions to the interviewer, the key research questions, probes to follow key questions, and transition messages for the interviewer.

It is critical that I mitigate any personal bias and avoid perceiving the data through a personal lens. Henriques (2014) shared the view that research requires recognizing bias and subjectivity to avoid ignoring perceptions or preconceived notions of the problem. Mitigating bias and subjectivity encompass using bracketing as part of the data collection, interpretation, and presentation process (Hyett, Kenny & Dickson-Swift, 2014). Onwuegbuzie and Byers (2014) postulated that the researcher should set aside preconceptions or judgments of experience, knowledge, beliefs, or meanings to ensure unbiased results. As part of the administration process for the interview, I asked each participant the same open-ended questions in the same order to ensure consistency, accuracy, and brevity of purpose. My personal bias is mitigated by writing memos and audio taping the data collection. Maintaining a journal for reflection during the data collection process can also reduce bias (Hyett et al., 2014). I utilized member checking to reduce bias and achieve the highest ethical standard in my research.

I chose the interview protocol because it allowed me to ask open-ended questions that will solicit rich data that cannot be obtained through questionnaires. Face-to-face interviews provide the advantage of inserting the researcher into the interviewee's contextual environment and offer the opportunity to witness the respondent's facial expressions and gestures (McCusker & Gunaydin, 2015). The face-to-face interviews have the additional benefit of allowing the interviewees to feel comfortable (Brayda & Boyce, 2014).

Participants

Participants for the study were chosen from home health agency owners in Los Angeles County, California. The targeted participants were home health agency owners who have been in business for a minimum of five years and who have grossed $5million to $7 million on an annual basis. Participants must also use successful strategies to meet regulatory standards. According to White and Hind (2015), researchers can use single or multiple participants from numerous or a unique organization to conduct a qualitative research study. A small size of five participants enabled me to capture the thematic experiences. As a home healthcare professional for over 30 years, I gained access to the government website on home health companies to identify agencies in Los Angeles County. The participant selection process included reviewing the researcher's professional associations, reading home health publications, and reviewing home health ratings (Talamo, Mellini, Camilli, Ventura, and Di Lucchio, 2016). Once the selection process was s a relationship was built by communication through telephone

conversations. The researcher begins establishing a professional connection with participants by transmitting emails to potential participants (Kastner, Antony, & Straus, 2016). O'Brien, Harris, Beckman, Reed, and Cook (2014) shared the view that participants for a case study, should involve individuals who have experience in the research phenomenon and who can share their expertise. Participants was screened following the institutional board (IRB) standards, and they were informed of their privacy rights and freedom to participate or refuse to participate in the research process. The process started with a letter of invitation that explains the purpose of the study and requests formal consent from the participants to join the study (Appendix A). I explained in the letter how their participation can benefit the research process and help other home health agency owners sustain their business in the era of high regulations.

My strategies for building a working relationship with participants was to first complete a telephone call to was request a face-to-face meeting. Personal contact, such as a phone conversation, can help establish a working relationship and help participants develop an interest in participation in a study (Carden & Boyd, 2014). The participants' interest was mutual, so we determined a date, time, and place that was convenient to the participant for an interview. I outlined the purpose of the study to the participant during my initial telephone conversation. A follow-up text and email were sent to the participant to ensure clarity, brevity, and precise information. Yin (2014) supported the strategies for building relationships with participants by positing that participant selection should have experience in the phenomenon of the research so they can share their experiences. I

developed a working relationship with participants by clearly explaining the purpose of the study and the research procedures and by responding to any questions they have. White and Hind (2015) shared the view that it is imperative to have a mutual understanding to generate a productive qualitative study**.** I reassured participants that the information they provide will be kept confidential.

The participants for this study included five owners of home health agencies who are doing $5 million to $7 million annually and who successfully have used best practices and strategic management practices in the era of high regulations. According to Bromwich and Rid (2015), scholars are required to ensure that all participants are seasoned, experienced, competent, qualified, astute and that they understand the importance of ethics, research guidelines, and regulations before finalizing the selection process. Rosetto (2014) emphasized that in qualitative multiple case studies the role of the participants is to provide information regarding the subject matter. In-home health care, keeping abreast of regulatory changes are imperative. It is essential the participants have a sense of purpose to share valuable information and to provide the researcher perspectives and knowledge regarding the business phenomenon (Rosetto, 2014).

Research Method and Design

A researcher's worldview may influence their approach to a study (Yin, 2014). My philosophical perspective was ontological, which Roy (2014) characterized as beliefs about the nature of reality. I employed a qualitative multiple case study approach in this study. The research design and method are the blueprints that connect the elements of

research into the process of exploring issues and drawing conclusions from a study (Onwuegbuzie & Corrigan, 2014). The research design served as a logical plan while collecting and analyzing data relevant to the research question by strengthening the study's accuracy and validity (Guercini, 2014).

Research Method

A qualitative multiple case study method enables a researcher to seek an understanding of an occurrence from the perspective of those experiencing it (Vaismoradi et al., 2013). Walker and Taylor (2014) shared the view that exhaustive qualitative research involves exploring participants' experiences descriptively through selfawareness or interactive interpretation to frame a need for change or reform. Roulston and Shelton (2015) purported that the basis of qualitative research includes comparing participants' views under different realities.

The justification for using a qualitative multiple case study research method over other research methods involved addressing the study's central research question from a broad perspective and various realities (Onwuegbuzie & Corrigan, 2014). Researchers use a quantitative approach to test a theory by testing hypotheses using inferential statistics (Branham, 2015). Utilizing a deductive, generalized quantitative method, a researcher would address the study from a small, single reality (Roulston & Shelton, 2015). Since I was not testing a hypothesis or theory nor gathering data for inferential statistics, the quantitative approach is not appropriate for this study. Although using a mixed methods approach, which integrates both qualitative and quantitative methods,

could maximize the strengths and minimize the weaknesses of both quantitative and qualitative methods, its additional cost and complexity made it inappropriate for this study (Starr, 2014).

Research Design

There are several qualitative research designs: a single case study, a multiple case study, ethnographic, phenomenological, and narrative models (Onwuegbuzie & Corrigan, 2014). A multiple case study design enables a researcher to frame and debate one or more cases in real-life settings to do an in-depth study to explore and examine a problem (Yin, 2014). Furthermore, a multiple case study design allows a researcher to examine or discuss a problem within a realistic setting (Hoon, 2013). A multiple case study design allows a researcher to monitor, analyze, and contextualize various participants' knowledge and experience into a single problem (Morse & McEvoy, 2014).

Ethnographic researchers explore and analyze a problem, contextualized through observations and interviews within a historical and cultural setting (Vesa & Vaara, 2014). The ethnographic design involves a prolonged, extensive field research design through which research can obtain values, language, and beliefs of culture, group, or an individual through interviews and observations (Robinson, 2014). An extraordinarily expensive design, ethnographic research requires prolonged negotiated access to a research site and participants (Onwuegbuzie & Corrigan, 2014). Therefore, the ethnographic design did not suit the needs of this study.

Phenomenological research commences with participants describing personal lived experiences, perspectives, or knowledge of a problem concretely without abstract generalization (Wilson, 2015). Phenomenology encompasses exploring the essence of a participant's experience via interviews and observations (Kafle, 2013). Phenomenology interpretively embraces the complex and dynamic aspects of a problem while learning, interpreting, and preserving a participant's clear perception of the event (Onwuegbuzie & Corrigan, 2014). As such, the phenomenological design did not suit the needs of this study.

Narrative design researchers collect data through observation, documentation, questionnaires, interviews, photos, or artifacts to contextualize a participant's experience (Nasr & Enderby, 2014). The nature of the narrative research design causes a researcher to delve deep into a participant's life experiences to contextualize understanding of the problem under study (Venkatesh, Brown, & Bala, 2013). However, the personal interaction between a participant and the researcher can cause negative perceptions of trust (Loh, 2013). A narrative design did not suit the needs of this study.

Population and Sampling

I selected participants through purposeful sampling. Purposeful case sampling, as defined by Baur et al. (2015), is a nonprobability sampling technique that is most effective when researchers need to understand participants' perspectives. Purposeful sampling allows researchers to sample intentionally a group of people who have the best information about the problem under investigation (Azaroff et al., 2013). Purposeful

sampling is appropriate for qualitative research, such as case studies (Guilcher et al., 2013). Marais and Van Wyk (2014) reflect that purposeful sampling allows a researcher to maximize the depth of the data collected for analysis. Barratt, Ferris, and Lenton, (2015) emphasized that purpose sampling is used to select participants having knowledge of and relationship with the topic. According to O'Reilly and Parker (2013), sampling should reflect a flexible or logical process of choosing an appropriate sample size in response to the research question.

Five participants were selected for this study. An appropriate sample size is one that is adequate to address the research question but not so big that the amount of data disallows in-depth analysis (Wei, Dengsheng, Yanlan, & Jixian, 2015). Estimating the number of participants to achieve saturation depends on factors, such as the background of the problem, research method, the design, nature of the study, the study's conceptual framework, and the participants' eligibility criteria (Marshall, Cardon, Poddar, & Fontenot, 2013). Elo et al. (2014) supported the notion that there is no commonly acceptable size for qualitative studies, but the sample depends on the quality of data, goals of the study, and the research question.

Elo et al. (2014) postulated that data saturation could indicate the optimal sample size. Elo et al. emphasized that data saturation ensured replication of themes, which helps form a comprehensive and complete study. If data saturation were incomplete, it could cause problems in data analysis (Elo et al., 2014). Data saturation determines the purposeful sample size. Shahgholian and Yousefi (2015) suggested the number of

participants required to achieve saturation in a qualitative study could range from five to fifty. Orri, Revah-Lévy, and Farges (2015) indicated that saturation could be obtained from the first six interviews. A researcher attains data saturation when no new information is collected, no new themes emerge, and there is enough information to replicate the study (Wei et al., 2015).

A specific set of criteria was used for this study to ensure participants have the knowledge to give meaningful data. The population for the study was limited to owners of home health agencies in Los Angeles County, California. Eligible participants met the following criteria for inclusion in the study: they must have gross revenue of $5 to $7 million annually in Los Angeles County, California, with a minimum of 5 years in business, ensured all participants meet the requirements established through a signed consent form. The owners of the home health agencies have first-hand knowledge of the business enterprise. This study took place in the privacy and comfort of the owners' primary corporate offices. A researcher can utilize purposeful sampling for case study interviews (Guilcher et al., 2013). Sample sizes for qualitative explorations are much smaller than those used in quantitative research (Azaroff et al., 2013). Data for a case study may come from various sources including documents, interviews, direct observations, and participant observations, which eliminate the need for large sample size (Yin, 2014). I selected a sample of owners of home health agencies for this study, due to their success of implementing strategies in their organizations.

Ethical Research

For the ethical protection of the research participants, I obtained permission from the Walden University IRB before commencing research (IRB #12-20-18-0564846). According to Griffiths (2014), the use of informed consent documents, storage, utilization, and data collection is to be explained to each participant. Tsan and Tsan (2015) postulated that an Institutional Review Board (IRB) examination is essential for approved research involving human participants. The recruitment of participants for my study was not started until approval.

Upon selecting a prospective research site, I received permission to use the site to complete the study with that organization. Once site permission is obtained, and IRB granted me permission to conduct the research, a participation inquiry sent to those who meet the criteria for participation in the study. An informed consent form was presented in person (Appendix B) to those who agree to participate. The assurance of confidentiality and detail of the intent of the study in the consent form was noted. Participants were asked to sign the form to indicate their voluntary willingness to participate in the study. Participants were informed of their right to withdraw from the study at any point in the research process. The consent form included a statement that participants could withdraw from the survey verbally or in writing without penalty. Knepp (2014) postulated that the information documented in the informed consent form must include the guidelines for waiver or withdrawal from the research by the researcher

or participant. Jordon (2014) stated that the informed consent form is a legally binding document that all parties should observe during the interview process.

I did not offer any remuneration or incentive for participation in the study to avoid coercion. The guidelines established in accordance with academic research regarding the ethical protection of the participants were followed. Foe and Larson (2016) emphasized showing respect for participants' time by starting the interview in a timely and efficient manner. Foe and Larson (2016) stated that the participants in a research study should not be compensated, forced, or exposed to any risk or discomfort during the interview. Tsan and Tsan (2015) emphasized that the rights and welfare of the participants must always be respected and protected.

Manasanch et al. (2014) postulated that ethical practices include assuring justice, beneficence, and respect for the participants. I ensured that the design and implementation of the research maintain the highest moral standards for the protection of the participants. A copy of the certificate confirming that I completed the National Institute of Health (NIH) Protecting Human Research Participants course is included (Appendix C). Foe and Larson (2016) support the notion of voluntary participant consent as an essential part of the ethical research. Griffiths (2014) emphasized that volunteer for a research study s expect they were provided an informed consent document; the informed consent for this project is included (Appendix D).

Data archiving is a process of securing, storing, preserving research data and resources for future audits to verify research findings (Valdez, McGuire, & Rivera,

2017). The informed consent form, electronic data, hard copies of the research data, and transcripts related to individuals and the home health agencies, participating in the study will be password protected. The information will be stored on a thumb drive and secured in a fireproof vault for 5 years. After 5 years, I will destroy the info by shredding the paper documents and erasing all data from the thumb drive. Prior to the beginning of the interview, the participant and the interviewer signed the informed consent form after a comprehensive and detailed explanation of the nature, purpose, extent, and benefits of the research outcomes to society and to the home health agency system. The interviewermaintained honesty with the participants and the participants did the same. The participants were assured that their names would remain confidential. An introductory letter was sent to each potential participant (Appendix E).

Gibson and Gross (2013) postulated that researchers should ensure availability of data for future audits or research by storing or archiving the research data information securely. The final doctoral dissertation included the Walden IRB approval number. As a researcher, I worked to ensure the confidentiality of participants as a primary guide in ethical research (Adams et al., 2015). I masked the names of the participants and the research organizations to guarantee confidentiality and privacy. I also used a unique fictional company name to conceal the identity of the home health agency by the interviewer. The interviewer labeled the home health agency as ABCDE home health agency. Participants were assigned alphanumeric codes from P1 (Participant 1) to P5 (Participant 5) to conceal participant identities.

Data Collection Instruments

The data collection methods for the study included the interviewer who collected data through multiple interviews with each participant. As the researcher, I was the primary data source. Each of the interviews was audiotaped, and the information analyzed for major themes. Permission was obtained from the participants by the researcher prior to the interview. The researcher conducted the interviews in the privacy and comfort of the participants' private office to ensure each is comfortable. Before each interview, the researcher should establish the protocol for the meeting (Yin, 2014).

I collected the data through a series of interviews using opened-ended questions. Each participant was provided the opportunity to elaborate and ask questions for clarifications on the topic throughout the interview process. As the interviewer, I used Microsoft Word to support the data coding analysis. The participants were informed of the purpose of the study, and permission was obtained by the student from the Walden University Institutional Review Board (IRB) (Cross, Pickering, & Hickey, 2014). The author divided the interview into four categories because they seemed to be the most relevant categories for the data and seven questions (Yin, 2014). One of the most important sources of case study evidence is an interview (Yin, 2014). Interviews can be face to face, questionnaires, over the telephone, or via group interview (Brayda & Boyce, 2014). Brayda and Boyce (2014) stressed that interviews have a sense of formality. Faceto-face social interaction is the most regularly experienced social context for qualitative data collection (Collins & Cooper, 2014). Qualitative inquiry is unique

because it requires both emotional maturity and strong interpersonal skills to collect data, that is, to hear the stories of others and use their words to describe phenomena (Collins & Cooper, 2014). Face-to-face interviews provide the advantage of inserting the researcher into the interviewee's contextual environment and offer the opportunity to witness the respondent's facial expressions and gestures (Brayda & Boyce, 2014). Because these interpretive abilities are difficult to assess, qualitative research has done much to encourage full descriptions of the role of the researcher as the primary data collection instrument (Collins & Cooper, 2014). The face-to-face interviews allow a researcher to make the interviewees feel comfortable (Brayda & Boyce, 2014).

All interviews are unique. Structured interviews include a list of established questions asked in an order with a limited number of typical responses provided (Parker, 2014). Unstructured interviews comprise of informal discussions with participants (Parker, 2014). Semi-structured interviews include questions prepared in advance but provide the investigator with the flexibility to probe based on participants' responses (Parker, 2014). The use of semi-structured interviews allows researchers to ask openended questions without predetermined answers (Panagiotakopoulos, 2014). I used semistructured face-to-face interview questions to gain an understanding of the home health agencies' strategies for accessing the effects of managed care in a changing environment. Yin (2014) identified best practice for semistructured qualitative interviews as (a) not dominating the conversation, (b) not guiding the interviewee, (c) maintaining

impartiality, (d) following a protocol, and (e) developing follow-up questions during the interview. I followed Yin's interview best practices and protocol.

A semi-structured interview comprises prepared questions guided by identifying themes in a consistent and systematic manner interposed with probes designed to elicit elaborate responses (McIntosh & Morse, 2015). Brayda and Boyce (2014) recommended defining a protocol to ensure a standard approach before commencing the interviews in a qualitative study. Following a protocol will keep a researcher targeted on the topic and force a researcher to anticipate problems (Brayda & Boyce, 2014). To increase the reliability of my case study and to guide my research, I used Yin's (2014) protocol framework. The protocol has four sections, which include an overview, data collection procedures, data collection questions, and a guide for the case study report (Yin, 2014). Before any interview commences at the participant's work environment, I emphasized that (a) participation in the study is strictly voluntary, (b) the participant may withdraw at any time, and (c) the participant's identity will remain confidential. A copy of the confidentiality agreement was provided to each participant by the interviewer.

Researchers conduct a pilot study to evaluate the feasibility and applicability of the leading study design and methodology (Whitehead, Sully, & Campbell, 2014). A model case study will help refine the data collection plan on the content of the data and the procedures to follow (Yin, 2014). A pilot study improves the validity of the research questions and the accuracy and reliability of the data collection methods (Kulnik,

Rafferty, Birring, Moxham, & Kalra, 2014). Instead of a pilot study, I used member checking to ensure reliability. To achieve a thorough understanding of participant responses, researchers use member checking to allow members to clarify answers or provide additional data to confirm the accuracy of the data collected or affirm the correctness of the study findings (Harvey, 2015). Offering interview participants', the opportunity to confirm the validity of codes, themes, and study findings interpretively through member checking enhances research creditability and dependability (Collins & Cooper, 2014). Member checking is a quality control technique used to improve the accuracy, credibility, and validity of participants' responses and qualitative research findings (Harvey, 2015). Member checking was conducted by the researcher to enhance the reliability and validity of the study's data collection instruments.

Data Collection Technique

Eitkan, Musa, and Alkassim (2016) argued that a clear data collection technique is essential to the validity and results of a research study, and that the method a researcher uses to collect the data is significant to the research objective and design. Yin (2014) identified six sources of case study evidence: (a) documentation, (b) archival records, (c)interviews, (d) direct observations, (e) participant-observations, and (f) physical artifacts. The interview is the most critical source of data collection (Brayda & Boyce, 2014) in a case study design. Well-informed interviewees can provide critical insight into the topic under study; in addition, interviewing leads a researcher to additional sources of evidence (Collins & Cooper, 2014). However, a disadvantage of the interview can be bias

if the questions are poorly articulated (Yin, 2014). The data collection methods used for the study included the interviewer who collected data through multiple interviews with each participant. The interviewer audiotaped the interview. The information was analyzed for the central themes that support the study. Permission was obtained from the participants prior to data collection and all questions answered. Before each interview, the protocol for the meeting was established and reviewed. The data was collected through a series of open-ended questions. The interviewer gave the opportunity for the participants to elaborate and ask questions for clarifications on the topic throughout the interview process. Another source of data collection was direct observations, which, can range from formal to casual data collection activities (Yin, 2014). Formal observations can include observations of (a) professional advisory committee or total quality control meetings and, (b) educational training sessions. Less formal observation activities include observing the condition of a specific work environment. The advantages of direct observations included covering the case actions in real time and addressing the context of the case immediately (Yin, 2014). The disadvantages of observations included the participants modifying their actions because they are being observed; furthermore, observations can be time-consuming (Yin, 2014). Despite any potential disadvantages, I included formal and informal methods for observation activities.

Research could not begin until permission is granted from the Walden University Institutional Review Board (IRB) (Walden University, 2014). The interviewer divided the interviews into categories which seemed to be the most relevant to the questions. Yin

(2014) supports the notion of five to seven questions to achieve saturation. Qualitative researchers choose from a wide range of data collection techniques including face-to-face interviews and telephone; case notes; focus groups; non-participant observation; paper, audio, video, or diaries; social media and discussions in online chat rooms (O'Cathain et al., 2015). According to O' Cathain et al. (2015), the data collection decisions and analysis methods depend on the research questions asked and the environment in which the data collection will take place. Qualitative researchers use data collection techniques to gather information. According to Rosetto (2014), the interview procedures involve probing, active listening, building rapport, paraphrasing, recording data, provide new explanations, recommendations and establish themes. Omono (2013) postulated that purposeful sampling would enrich the understanding of the problem through the participants' knowledge and experience. The purposeful sampling techniques contributed to information from participants and provided insight into the problem under study. A disadvantage of purposeful sampling is the investigator's bias, that may result from personal values and assumptions, which can influence sample selection (Baškarada, 2014). Bryman and Bell (2015) shared the view that onsite face-to-face semi-structured interviews have the advantages of allowing researchers to keep an open mind to enable concepts and theories to emerge out of the data. Babbie (2015) emphasized that interviews offer the clear advantage of enabling researchers to witness the interviewees' facial expressions and gestures, which can add value to the responses. Baškarada (2014)

emphasized that a disadvantage of semi-structured interviews is a potential lack of discovery of unexpected or surprising evidence.

I documented information using a tape recorder and use notepad to record additional information to capture unfamiliar words and phrases. Moylan, Derr, and Lindhost (2015) emphasized that scholars should use digital technology to enhance data analysis activities, quality of audio recordings, and transcriptions. According to Hand (2016), capturing data, storage, and retrieval are not very expensive. Davidson, Paulus, and Jackson (2016) postulated that scholars secure large volumes of unstructured data and use digital tools to save time. Baškarada (2014) shared the view that losing valuable data can result in adverse connotations.

Harvey (2015) shared the belief that member checking is a quality control process in which each participant reviews the interview summation to ensure the accuracy, validity, and credibility of the study. I validated the accuracy of the themes by involving each participant in the process. According to Cope (2014), scholars should ensure the credibility and dependability of the research by allowing participants to confirm the themes, validity codes, and the findings of the study through member checking. Harvey (2015) supports the notion of member checking as a technique to validate the accuracy of participant interview responses and study findings.

Data Organization Technique

Development in technology have made keeping track of data in an organized, logical, and systematic manner easier. The information received by the interviewer was

tracked and collected with a focus on the interview questions. In fact, even before the analysis begins, reviewing information contained in consent forms; and venues of interviews, and accurate transcripts of the interview, can determine how the process will proceed (Yin, 2014). Yin (2014) shared the view that an orderly and separate case study database is imperative. The database included audio taping, a compilation of all study data, reflective journal entries, investigative research logs and field documentation from the qualitative case study. The ATLAS.ti software was suitable for organizing the data to ensure data accuracy and to support data analysis. All data collected was placed in a reflective journal. The audio recordings of the interviews served to ensure the accuracy of the information obtained. I used a Live-scribe Pen and ATLAS.ti software. Access to all files is the sole responsibility of the interviewer. ATLAS.ti is the computer-aided technology program used for qualitative data analysis software to improve coding and save time in the management of data (Constantine, 2013). The data was organized in the order of the interviews. Codes were used for participant's names to protect the security and safety of the home health agency and to ensure adherence to the Health Insurance Portability and Accountability Act (HIPAA) standards. The researcher provided number for each participant based on each interview from A1, B2, C3, D4, to E5 and maintain the numbers throughout the study for accuracy and consistency. The hard copies of all data collected is stored in sequential and in alphabetical order. The information for each participant is color-coded and placed in a separate hardcover folder. According to Vicente-Lopez et al. (2015), accurate and efficient storage of digital and non-digital

information for governments, organizations, and scholars is important to represent the data and to enhance new information and enhance the retrieval process.

The data will be kept by the researcher in secure storage in my personal vault at my bank for 5 years to comply with Walden University guidelines. Gibson and Gross (2013) postulated that researchers ensure availability of data for future audits or research by storing or archiving the research data securely. The data storage objective is to ensure the safety, confidentiality, security, and accessibility of data. Gibson and Gross (2013) emphasized that data archiving is a process of ensuring the availability of resources and data for future exploration by researchers. Gaur and Sharma (2015) shared the view that in research practice scholars usually store four types of data: audio, video, text, and image. Zhang, Yao, Sun, and Fang (2016) postulated that organizing information is imperative to the data retrieval and analysis processes. Gibson and Gross (2013) stated that data retaining research should be kept for no fewer than 5 years. Gibson and Gross (2013) emphasized that archiving research data is imperative. All data remained in a safe and secure location. The data is kept by the researcher for five years to maintain the privacy of the participants per IRB requirements and then shredded or deleted to protect the members.

Data Analysis

Hussein (2015) shared the view that the use of triangulation in social sciences originated from Fiske's 1959 validation of research work. There are four proposed types of triangulation in case studies: (a) methodological triangulation, (b) data triangulation,

(c) investigator triangulation, and theory triangulation (Finfgeld-Connett, 2014). The relevant data triangulation for my research design was methodological triangulation. Triangulation occured through semi-structured interviews and analysis of home health strategic business processes and documents. The art of using more than one method to gather data is part of triangulation. Member checking and triangulation allowed new specific themes and data saturation to occur. Hussein (2015) supported the fact that triangulation will increase the credibility of my case study by improving generalizability and internal consistency. According to Wilson (2014), scholars use methodological triangulation in a qualitative case study to correlate the data on the same phenomenon and to extend the validity of the findings of the research.

Data analysis in the qualitative case study is the process of systematically applying logical techniques and applying statistical information to describe and evaluate data (Percy, Kostere, & Kostere, 2015). A crucial component of qualitative data analysis is putting together multiple pages of field notes in a comprehensive report through a challenging and tedious process for coherence and understanding. According to Carlsson (2013), qualitative analysis is a codified part of the research process. The rigor of the research process involves showing, instead of telling, to improve the credibility of the results and the analysis procedures. Yin (2014) postulated that there are five stages of data analysis. Once the researcher collects the data, it is placed into groups. The data are grouped into themes and analyzed for data saturation. Finally, conclusions are drawn from the data.

I used ATLAS.ti computer software to support the data analysis process. Computer-assisted tools are relevant to my study to aid in efficiently managing codes and categorizing data. According to Percy et al. (2015), researchers can use ATLAS.ti to conduct an in-depth analysis of the data to identify themes and relationships. The use of ATLAS.ti computer software is suitable for coding and categorizing data (St. Pierre & Jackson, 2014).

According to Percy et al. (2015), thematic analysis is the process used to conduct data analysis of qualitative data. Paulus and Lester (2016) reiterated that scholars use ATLAS.ti to help sort data into themes. Starr (2014) wrote that axial coding referred to the process of the identification of noteworthy responses within transcriptions or open codes. According to Starr (2014), open coding incorporates reading through data, sometimes, creating data for summarizing what is happening and recording samples of participant's words. Scholars use qualitative data analysis software (QDAS) like NVivo, MAXDAQ, or ATLAS.ti to support the coding and analysis of enormous amounts of unsorted audio, image data, text, and video (Starr, 2014).

Reliability and Validity

This qualitative multiple case study included several techniques to establish reliability and validity. According to Yazan (2015), the concepts of reliability and validity first emerged in the natural sciences and then appeared in quantitative research in the social sciences. The measuring of the reliability of qualitative data was essential to determine the quality and, the strength of the data received (Srivastava & Sushil, 2013).

Validity covers the entire experimental concept and sets the foundation as to whether the results obtained align with the requirements of the scientific research method (Yazan, 2015). Noble and Smith (2015) postulated that reliability and validity are essential to ensure the study meets the highest caliber of academic research. The qualitative research includes techniques to determine credibility, transferability, dependability, and confirmability to establish trustworthiness for reliability and validity (Yin, 2014).

Reliability

Yin (2014) refers to reliability as the consistency and transferability of the qualitative research procedures used in the case study. Reliability is the limit to which measurements are repeatable when various individuals perform the same experiment different times, under different conditions, and with alternative instruments that measure the same outcome (Leung, 2015). The determination of reliability in a qualitative study involves receiving reliable results that are transferable to other contexts (Leung, 2015). Dependability and transferability relate in that both provide the precise identification of all research designs and operations (Morse, 2015). In addition to validity and reliability, data quality will guarantee the dependability of my case study (Yazan, 2015). Research has identified a range of relevant data quality dimensions, including accuracy, objectivity, believability, reputation, interpretability, and ease of understanding, concise and consistent representation, and relevancy (Baškarada, 2014). By identifying these steps, a researcher can allow for replication of the methodology with a more significant population or by future researchers. However, a researcher must differentiate between the

dependability of a method for producing similar interpretations and the reliability of a method of producing identical results (Morse, 2015). To enhance the dependability of my study, I utilized Merriam's (1998) strategy for member checking.

Member checking assists with establishing the reliability of the data. Marshall and Rossman (2016) shared the view that member checking is the process of taking a researcher's interpretation back to the participant for review to ensure the researcher interprets the interview process correctly. The reliability of a study validates through member checking as postulated by (St. Pierre & Jackson, 2014). Member checking is part of the quality control process in which the participant improves the meaning of their data for accuracy to ensure validity (Harvey, 2015). Marshall and Rossman (2016) further emphasized that the quality of the data relies on the ability of the researcher to reduce bias and validate the correct interpretation of the phenomenon. Assessing the reliability and integrity of research findings identifies the basis for verifying the credibility of the study research design and methodology (Noble & Smith, 2015). The dependability of the study shows that the findings are consistent and repeatable. Data quality ensured the reliability of my case study (Yazan, 2015).

Validity

The underlying concept of validity is to ensure trustworthiness and credibility of the data collected (Hussein, 2015). Validity draws from the meaningfulness of the research component (Morse & McEvoy, 2014). Construct validity is different from internal validity in that it focuses on measurements of individual construct while internal

validity focuses on alternative explanations of the strength of links between constructs (Finfgeld-Connett, 2015). The data are backed up by scholarly references and eloquently performed and executed (Finfgeld-Connett, 2015).

Prion and Adamson (2014) defined rigor in research as concerning trustworthiness about creditability, transferability, dependability, and confirmability. I increased my rigor by bracketing. Bracketing is identifying, acknowledging, and minimizing personal presuppositions before and during the exploration of the research under study (Chan, Fung, & Chien, 2013).

Creditability. According to Olsen, McAllister, Grinnell, Walters, and Appunn (2016), researchers must establish credibility in qualitative research. To maintain credibility or authenticity, Olsen et al. (2016) emphasized that investigations must follow acceptable scientifically sound qualitative and informational sciences. Research validity and reliability are familiar concepts in quantitative research but also applicable to qualitative research since both researchers must establish credibility using either method (Olsen et al., 2016). To enhance the credibility of my case study, I followed Stake's 1995 methodological triangulation, which aligns with his four triangulation strategies: data source, investigator, theory, or methodology (Finfgeld-Connett, 2014). To maintain credibility or authenticity, Hussein (2015) recognized that researchers must adhere to methods accepted as scientifically sound in the qualitative and informational sciences. The use of methodological triangulation increases the internal validity and creditability of my case study (Baškarada, 2014).

Transferability. The transferability of a research study is a decision the reader makes (Marshall & Rossman, 2014). External validity deals with ensuring the findings of my case study are generalizable to other cases. Baškarada (2014) noted that methodological literature provides little consensus regarding ways to achieve generalization. The threats to external validity will be reduced. Threats to external validity include the interaction of the causal relationship with units, the interaction of the causal relationship over treatment variations, the communication of the causal relationship with outcomes, the interaction of the causal relationship with settings, and context-dependent mediation (Baškarada, 2014). To ensure other investigators may be able to follow the same procedures and arrive at the same results, I deployed Yin's two reliability strategies. First, a researcher creates a case study protocol to standardize investigation. Second, a researcher develops a case study database with an overview of the project, field procedures, guiding questions, and a report outline (Yin, 2014).

Confirmability. The validity of research depends on the trustworthiness, confirmability, and data dependability of the data collected and utilized used to derive valid findings or conclusions (Yin, 2014). I ensured conformability through the creation of an audit trail, an internal audit, an external review, and the writing of the final research report (Husein, 2015). This final research report highlighted shortcomings of the study in the research report and provided clear links between study results and actual experiences of the participants in the study (Kemparaj & Chavan, 2013). Audit trails will not only offer a high methodological reference for other researchers, but also provide an

opportunity for reflective reasoning on chosen themes or categories, interpretations, and criticism as the study progresses (Kemparaj & Chavan, 2013).

Data saturation refers to the depth of the sample and the ability to find repetition in the data (Géssica et al.,2017). According to Fusch and Ness (2013), data saturation occurs when the researcher is unable to obtain new information and when coding is no longer feasible. Saturation is the point in the data when no new or relevant themes emerge. Géssica et al. (2017) postulated that data saturation is more likely with participants who have the knowledge to answer the research questions. I ensured data saturation after five interviews are completed with home health agency owners. According to Roy, Zvonkovic, Goldberg, Sharp, & LaRossa (2015), the amount of data collected distinguishes repetition of themes after five interviews. Coke, Kuper, Richardson, and Cameron (2016) emphasized that in semi-structured interviews data saturation occurs when further discussion would not add new information to the research question. I collected data until saturation is reached to ensure the validity and reliability of the study.

Transition and Summary

The objective of this qualitative multiple case study was to identify strategies that small-to-medium-size managed care business owners use to address the financial effects of Medicare and Medicaid regulations. Before conducting the research, assurance of reliability, validity, and transferability of the current study entailed calibrating and refining the research instrument and data collection to examine the study design's

trustworthiness and rigor. The study details the protection of the participants' identity and confidentiality as well as the integrity of the research. The study presented in Section 2 provides the process for participant sampling, guidelines to ensure ethical research, and an overview of the plans for data collection, organization plans, and data analysis. This section concludes with details of the methods to ensure the study's reliability and validity.

In Section 3, I provided an analytical summary interpretation of the data and research themes in the context of the conceptual framework, a review of the literature, and ontological worldview. This section begins with an overview of the research and include the present study's findings with interpretations, reflections, and conclusions applicable to business practices. In Section 3, I offered my ontological perspective with implications for social change. The current study findings, bound by thoughtful insights and experiences of participants, provided an application to professional practice with recommendations for further research.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative multiple case study was to identify strategies that small-to-medium-sized managed care businesses proprietors use to address the financial effect new healthcare regulations may have on their business. The targeted population consisted of one owner from each of five home healthcare businesses chosen from the 435 home healthcare businesses in Los Angeles County, California, who has successfully

addressed the financial effects of Medicare and Medicaid regulations on the home health agencies.

Presentation of the Findings

During my data collection process, I conducted my research with five owners of home healthcare businesses in Los Angeles County, California, who have successfully addressed the financial effects of Medicare and Medicaid regulations on their home health agencies. The participants I selected are owners of home health agencies who are licensed and certified in California, who have been in business for at least 5 years, who have fewer than 500 employees, and who grossed $5 to $7 million annually. According to Feereasta (2016), participants who have effective proactive business management experience about a researcher's study are befitting for the researcher to interview. Researchers conduct semistructured interviews so the participants can elaborate on answers, ask questions to clarify meanings, and apply follow-up questions to gain valuable data (Powell & Eddleston, 2013).

For this study, I addressed my central research question of what strategies do home health proprietors use to address the financial effects of Medicare and Medicaid regulations on their business. I conducted five interviews which formed the foundation for this project and answered my central research question. Using my interview protocol, I asked each participant six questions:

1. What are the financial strategies and effects of Medicare and Medicaid managed career regulations on your home healthcare business?

2. What are the financial strategies you use to address the costs of complying with new Medicare and Medicaid managed care regulations?
3. What barriers do you encounter in implementing the financial strategies for Medicare and Medicaid managed care regulations on your home health agency?
4. How do you address the barriers to implementing the financial strategies for Medicare and Medicaid managed care regulations on your home health agency?
5. How do you track the results of your home health agency financial strategies to cope with Medicare and Medicaid managed care regulations?
6. What other issues have you had to face as you address the financial strategies and effects of Medicare and Medicaid regulations that we have not discussed so far?

After completing the interviews, I member checked, then analyzed the data collected using Microsoft Excel and ATLAS.ti computer software programs. From my analyses, I developed themes that support my conceptual framework. My themes are (a) strategic management, (b) application of business strategies, (c) healthcare reform on home health and, (d) strategic business processes. (See Table 1). My conceptual framework is strategic management theory (SMT) grounded on profit maximization and adaptation in changing contexts (Hill, Jones, & Schilling, 2015).

Table 1

Themes and Participants Summary of Responses to Interview Questions

Participants	Column 1 Strategic Management	Column 2 Application of Business Strategies	Column 3 Healthcare Reform on Home Health	Column 4 Strategic Business Processes
Row 1A	Regulations	Goal Setting	Application of Sound Management Processes	Business Compliance/ Regulations
Row 2B	Transformation	Analysis	Corporate Performance	Education and Training
Row 3C	Profit Maximization	Formulation/ Regulations	Governance and Leadership	Shared Responsibilities
Row 4D	Adaptation	Implementation	Business Ethics	Risk Management
Row 5E	competitive Advantage	Strategy	Corporate Compliance/ Regulations	Delivery of Care

Note. From "Attitudes Toward Dissertation Editors," by W. Student, 2008, *Journal of Academic Optimism*, *98*, p. 11. Reprinted with permission.

Themes:

Theme 1: Strategic Management

Strategic management emphasizes profit maximization and adaptations in changing contexts. According to Hill et al. (2015), the emphasis on profit maximization involves the formulation and implementation of the primary goals and initiatives taken by the leadership of the organization. The strategies that home health agencies A1, B2, C3, D4, and E5 "pursued impact their exceptional performance relative to that of their competitors." The demographics of the five participants appear in Table 2. The table includes a summary of the gender and years involved in business. With the superior performances of the home health agencies, it is said to have a competitive advantage. "The owners, shareholders provide the home health agencies with the risk capital in order to provide the services that are required. As the legal owners of the corporation, the shares represent a claim on the profits generated by the companies." Each of the companies (100%) has been in business for 10 to 24 years. Each of them "employed a full-time bookkeeper, utilize the services of a cost accountant as an independent contractor who is well versed in the home health agencies' chart of account and operations." According to Tacchino (2013), employers must work closely with financial advisors and accountants to ensure compliance. According to, owners A1, B2 C3, D4, and E5:

The owners formed an interdisciplinary finance committee, a professional advisory committee, and a total quality management team that meets on a quarterly basis to discuss, make recommendations, and to establish financial strategies for sound financial management and how to combat the high regulations on the business.

The owners:

ensured that the agencies are equipped with state-of-the-art telephone system, desktop computers in office and laptop computers for field staff. The use of technology in real time setting for paperless field work is at the forefront of the agencies' operations.

Table 2

Demographic Data for Small-To-Medium-Sized Business Leaders

Categories and Item	Total	% of total
Gender		
Male	3	60
Female	2	40
Years in Small Business		
5-10	0	0
11-15	1	20
16-26	4	80
Years as a Business Leader		
5-10	0	0
11-15	1	20
16-26	4	80

Theme 2: Application of Business Strategies.

The five stages of strategic management processes are goal-setting, analysis, strategy formulation, strategy implementation, and strategy monitoring (Ferlie & Ongaro, 2015). (Figure 1). “The owners of home health agencies must think strategically and apply that thought to a process.” The strategic management process is implemented when everyone understands the strategy (Hill et al., 2015). “The purpose of goal-setting is to clarify the vision of the business.” This very important stage consists of identifying three key factors (a) short-and long-term objectives, (b) identify the process of how to accomplish the objectives, and (c) customize the processes for the staff. “The goals must be detailed, realistic, and match the purpose of the home health agency mission.” The gathering and analyzing of important information and data are relevant to the accomplishing the vision of the organization. The strengths, weaknesses, opportunities, threats (SWOT) analysis plays a significant part of this component.

The review of the information collected from completing the analysis is imperative. The determination of the resources the business currently has that can help to achieve the goals and objectives of the home health agency is important. Because business and economic situations are fluid, it is critical to develop alternative approaches for each step of the plan. Company owner of A1 stated that “implementation of the strategy is the action stage of the process and the successful strategy is important to the success of the business.” According to company owner D2 “if the overall business structure established does not work, there must be room for adjustments and flexibility.

All the company owners agreed that everyone in the organization must be appraised of their responsibilities and duties and understand them clearly. Additional resources and working capital must be secured at this stage. “Once funding is in place, everyone should be ready to execute the plan” as postulated by owner C3. The strategy evaluation and control actions include performance measurements, review of external and internal issues, and making corrective actions where needed. The successful evaluation of the strategy is initiated with the parameters to be measured. Determining the progress by measuring the results and monitoring external issues will help management react to changes in the business environment (Hill et al., 2015). The owners are the linchpin in the strategic management process. The onus is on the individual owners to take responsibility for formulating business strategies to achieve a competitive advantage and for putting those strategies into effect (Hill et al., 2015). The most important part of the strategic management process is crafting the mission, vision, and values of the business enterprise. The second component of the strategic management process is an analysis of the organization’s external operating environment. The essential purpose of the external analysis is to identify strategic opportunities and threats within the system. The third component of the strategic planning process focusses on reviewing the resources, capabilities, and competencies of a company. The next component of a strategic thinking process requires the generation of a series of strategic alternatives, given the company’s internal strengths, weaknesses, opportunities, and threats (SWOT) (Hill et al., 2015).

Stakeholders in the complex world of healthcare insurance offer visions of their future under different political and economic scenarios. Over time, successful cost control in Medicare and Medicaid depends on effective policies to control spending in the broader U.S. healthcare system (Gallman, 2016). Pozgar (2016) emphasized that the key to the healthcare system is to deliver care that is safe, effective, patient-centered, efficient, timely, equitable, and profitable.

"Businesses are required to implement an application strategy to ensure their software meets the needs of the business and support its goals as shared by company owner A1." Home Health owners A1, B2, C3, D4, and E5 shared the view that the software applications they used across the board is the Kinser Software Program. They further reiterated that the program helps them to perform task effectively, efficiently, and is very user friendly in order to achieve planned results. The Department of Health and Human services approves this software. Company owner B2 shared the view that "the software they use has been in use throughout the business operations for over five years and that a 100% of the staff are very familiar with the programs." Owners C3, D4 and E5 stated that the software is customized to meet their specific needs. They all agreed that the size and comparative simplicity of smaller organizations lets smaller businesses manage their business more efficiently and effectively with less disruption than larger companies. The owners agreed that once the companies have identified the software functions and applications that are required, "they decide what to use and what to outsource for example, in our case we outsource the billing services because it is more

economical and less costly for the companies." The final step in the business application strategy is the integration of the company's software so that it works together to improve the operations as supported by the owners of A1, B2, C3, D4, and E5.

Figure 1

The five stages of Strategic Management Processes

Stage 1 Goal-Setting

Stage 2 Analysis

Stage 3 Strategy Formulation

Stage 4 Strategy Implementation

Stage 5 Strategy Monitoring

Theme 3: Healthcare Reform on Home Health.

Healthcare reform, due to the PPACA, could negatively affect small business managed care organizations (Bao, Casalino, & Pincus, 2013). Taxes play a significant role in home healthcare reform, and small business owners must address the rising costs (Herrick, 2014). "Without the application of sound management processes as postulated by owner C3, tax implications for noncompliance with PPACA implementation, particularly with managed care, include increased administrative costs to small businesses, stagnated growth, and decreased long-term success."

Small home healthcare businesses are sensitive to changes in costs, and the slightest upward shift in health premiums changes the companies' long-term strategies

for providing home healthcare coverage and business planning (Gabel, Whitmore, Pickreign, Satorius, & Stromberg, 2013). The general business problem is the implementation of the Affordable Care Act, Medicare, and Medicaid regulations for managed care have caused financial loss to healthcare businesses (Williamson, 2013). "Implementation of the Affordable Care Act, Medicare, and Medicare regulations for managed care required managing medical costs, reviewing tax plans and forecasts, and improving business processes" as emphasized by owner of company E5.

Information gleaned from the Centers for Medicare and Medicaid Services (CMS, 2015) report postulated that, since the implementation of the PPACA, the per capita cost of health care remained at or under 3%. The economic slowdown and sluggish recovery have played much of a role in impacting healthcare costs, as has the PPACA. As the Affordable Care Act matures, more data will be available to measure the impact and effectiveness of this healthcare law. While early results show improvement in some areas, such as the reduction in the number of uninsured, there have also been unintended consequences including rising out-of-pocket costs, higher taxes, and increasing regulations as shared by owners A1, B2, C3, D4, and E5.

Theme 4: Strategic Business Processes.

To address the possibility of change, owners examine strategic and management processes of small businesses to improve long-term success, survival, and management of change (Taneja et al., 2013). The implementation of Medicare and Medicaid managed care in home health resulted in uncertainty due to new regulations and potential tax

penalties for employers and employees (Taneja, Pryor, Humphreys, & Singleton, 2013) To address the possibility of change, owners examined strategic and management processes of small businesses to improve long-term success, survival, and management of change (Taneja et al., 2013). “The strategic management business process guides strategic management leadership theory because effective leaders must understand the framework to manage and govern their organization” as shared by owner of company D4. Santos, Melo, De Melo, Claudino, and Medeiros (2017) used the strategic business process to urge leaders to work with lower level workers on objectives and goals and to encourage the employees to make decisions on how to achieve these aims and objectives through strategic processes. The policy framework Santos et al. (2017) advocated is an eight-step dynamic process that leaders, managers, and representative stakeholders, both positional and functional, used to plan and guide their organizations strategically into the future as shared by owners of companies A1, B2, C3, D4, and E5. Leaders used strategic management processes to improve long-term success, survival, and change management (Taneja et al., 2013). A strategic positioning framework and administration process guide and define how business leaders meet strategic goals, objectives and achieved the organizational mission (Matta et al., 2014). To manage the framework and lead their team, home health managers of small businesses implemented the managerial grid model developed in the 1960s by leadership theorists Blake and Mouton (Zerfass & Viertmann, 2017). Managers used the managerial grid to achieve the objective of the project and, at the same time, to manage employees (Zerfas & Viertmann, 2017). Managers of small

businesses used the leadership theory by Blake to maximize employee production by focusing on team management to meet the objectives of the organization (Obolensky, 2014). A strategic leadership framework process served as a guiding principle to define how business leaders achieved strategic goals and targets and move their organization mission forward (Zerfass & Viertmann, 2017). As shown in Figure 2, to increase shareholder value, owners pursued strategies that increase the profitability of the companies and ensured growth of profits (Hill et al., 2015)

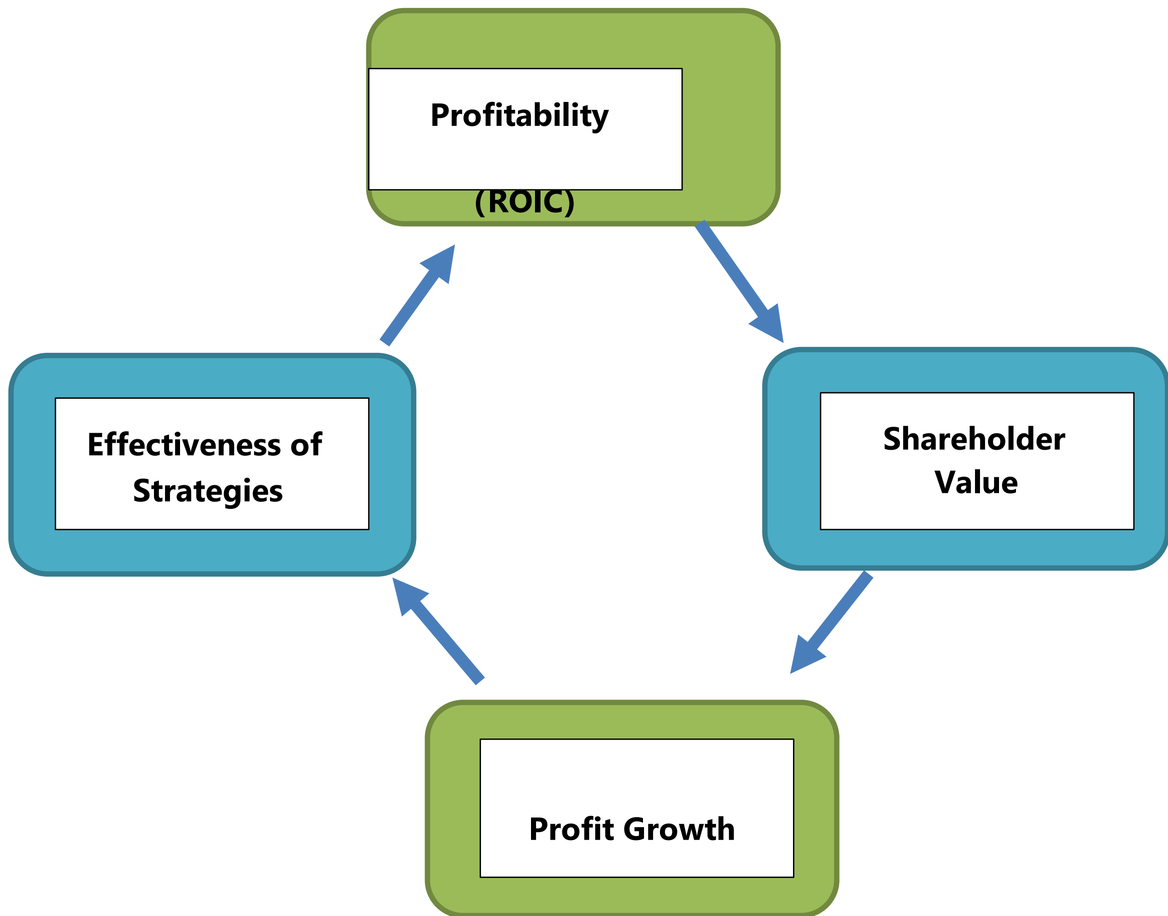

Figure 2. Determinants of shareholder value. Note. From “*Strategic Management: Theory and cases: An integrated approach* (11th.ed),” by Hill, Jones, Schilling, (2015), Cengage Learning, p.4. Reprinted with permission.

Applications to Professional Practice

Healthcare regulations are required by law to protect the integrity and business of the home health agencies. An organization should develop a managerial strategy based on the environment and problems it is experiencing and one that will benefit the organization depending on its industry (Hill et al., 2015). Strategic management is interested in the administration of companies so that those companies can continue their operations in the long term. A company employing strategic management approach gains a competitive advantage and increases profits to higher than average levels. The decisive change capabilities have become a primary focus for business people as home healthcare systems business owners attempt to improve and position themselves for reorganization and growth in a competitive market characterized by continuous regulatory changes (Kash et al., 2014). A primary business objective is to maximize long-term profit and develop a competitive advantage over the competition in the external marketplace (Kash, Spaulding, Johnson, Gamm, & Hulefeld, 2014).

The theory I used to ground this study is strategic management theory (SMT) that emphasizes profit maximization and adaptation in changing contexts, an approach that involves the formulation and implementation of the primary goals and initiatives taken by the leadership of the organization (Hill et al., 2015). Kongstvedt, Porter, and Lee (2013) postulated that some small-to-medium-sized business owners lack strategies for successfully addressing the financial effects of the delivery of Medicare and Medicaid

managed care on the home health agency business. Business owners are required to focus on changes in government regulations and funded systems and to position their businesses to be financially viable while providing the highest level of home health care services. I probed the knowledge that current owners have as they study and adhere to regulations and they seek to provide quality healthcare services while increasing their companies' profitability. By unearthing successful strategies from this group of interviewees in a highly competitive market (i.e., Los Angeles, California) and by comparing their efforts with the advice from published literature, I was able to identify strategies other companies can adopt to increase their profitability. Reducing the financial burden on home health care businesses could lead to building government agencies that address social problems on an individual, institutional, and community level. Building capacity in home health care will enhance long-term health care systems, safety, and efficiency of care provision performance to improve and to achieve better quality healthcare regulations and performance. The findings from this study indicated that even with the high regulations surrounding the healthcare industry, owners of home healthcare agencies formulated and implemented major goals and initiatives for a successful operation. The findings from the study may assist other business leaders to address strategies for Medicare, Medicaid managed care regulations, manage business cost, be compliant, and implement alternative business processes. Effective management requires a commitment of owners to adopt to a changing environment (Hill et al., 2015).

Implications for Social Change

This study supports the existing body of knowledge to develop strategies addressing Medicare and Medicaid regulations financial effects on home health agencies' performance. By analyzing strategies that new healthcare regulations may have on their business an assessment, there are potential implications in terms of tangible improvements to individuals, communities, organizations, institutions, cultures, and societies that come into play. The study of strategic management theory (SMT) has implications for social change. According to Banks et al. (2016), positive social change happens when people change their behavior to benefit the society. In qualitative analysis, newly acquired knowledge and prior research lead towards a worldwide view for social change (Trochim, Donnelly, & Arora, 2015). The findings from the study may provide business owners with insightful information on Medicare and Medicaid managed care regulations and its effects on their home health agencies' financial standing. Business owners value the integration and positioning of the home healthcare systems in the continuum of care to financially benefit from increasing demand and interest in the healthcare space (Landers et al., 2016). It is imperative that the health care system is efficient (Matta et al., 2014).

Learning from other successful businesses with similar interests could assist in growing businesses sustainability and profitability (Gupta, Goktan, & Gunay, 2014). Reducing the financial burden on home health care businesses could lead to building government agencies that address social problems on an individual, institutional, county,

state, and community level. Business leaders might use the information from the findings from the study to gain insight on how to lead their organization in disruptive times and how to navigate change gracefully and successfully. The owners of companies A1, B2, C3, D4, and D5 postulated that to maintain and sustain a successful agency strategic management is important to them because it provides a sense of direction and outlines measurable goals. Strategic management tools are useful for guiding day-to-day operations as well as for evaluating progress and be adaptable to changes as the businesses move forward.

Recommendations for Action

Although my study is very comprehensive and the data I have collected and analyzed indicated participants complied with the strategies new healthcare regulations may have on their business and they are very successful, I am recommending further action. As business owners, we can always learn from new ideas to continue to grow and build a sustainable and successful business. Business owners will need to adjust their policies and procedures and update their plan of action on an ongoing basis to maintain adherence and compliance with the state, federal regulations and Joint Commission on Accreditation of Healthcare Organization (JCAHO). Complying with government healthcare regulations might be time consuming, tedious, challenging, and expensive to maintain, but it is necessary to ensure the protection of the business and for short-and long-term success.

My data analysis, findings from my study, and conclusion may be shared in scholarly literature review. When researchers read my study, they will be aware of strategies utilized in healthcare and strategic management theory from my body of knowledge and from the literature review. Business leaders might use the information from the findings to gain insight on strategies successful business utilized. I will endeavor to utilize all opportunities presented to share and disseminate my findings with state and federal government representatives, community-based healthcare organizations, healthcare service business, home care agencies, and at the Los Angeles County state and national home and healthcare conferences. I will also utilize social media platforms to disseminate information via Facebook, Twitter, LinkedIn, You-tube, Blogs, Mobile Technologies, Google+, Instagram and Snapchat to showcase my findings. I will continue to volunteer to work with non-profit, governmental, and non-governmental organizations as a healthcare consultant to educate and train home health and healthcare professionals.

Recommendations for Further Research

I identified strategies that small-to-medium-sized managed care business owners use for successfully addressing the financial effects new healthcare regulations may have on their business with special reference to the home health agencies. A recommendation for further research would be to do a quantitative study to enhance the financial impact of the home health services and to show concrete financial evidence of the strategies employed for financial success in the era of high regulations. Robinson, Gott, Gardiner,

and Ingleton (2015) postulated that, in conducting research, the availability of resources and human error adversely affect and can limit the study. With the advent of technology, the researcher can utilize more sophisticated tools such as audio taping to ensure all information is captured and with the use of inputting information gathered in the ATLAS.ti software program, it helps to minimize human errors. Another limitation is securing information from only the owners and not from an entire organization's management team may limit this study's results. In the future, the research could be expanded to include the home health leadership team.

The study boundary is the Los Angeles County, which has a population of 10 million and over 464 home health agencies. Future studies could be expanded to the entire state of California to see how they are successfully addressing the financial effects new healthcare regulations may have on their business when compared to other states in the Western United States of America. I interviewed only home healthcare owners because this group of business people are the ones directly engaged in meeting various federal and state regulations and, at the same time, are focused on making their companies more profitable. An interdisciplinary approach could be utilized to empower the management staff to have a say in the decision-making process of the agency since they play a significant role in the day to day operations of the business and have first-hand knowledge of the performance of the agency.

Reflections

The DBA study process is a learning experience that I will cherish for the rest of my life. The journey was educational, tedious, and challenging. The technical preparation and three years of dedication, hard-work, a sound mind, and an astute desire to succeed to fulfill a lifelong journey as an adult learner coupled with building a business, personal family responsibilities, and the cost of doing business was time consuming but at the same time very rewarding. The experience has taught me that perseverance and hardwork can conquer all and that success in life is not so much a matter of talent or opportunity as deduction and perseverance. As a small business owner my innate desire is to see business succeed since small-medium-sized businesses are the engine for the growth of the economy. Owners of businesses are challenged every day in the era of high regulations to succeed. The study revealed strategies that owners used to succeed in a highly competitive healthcare industry. Through this process I gained a strong understanding of the challenges and strategies implemented to ensure success. The criteria established for participants were owners of home health agencies who are licensed and certified in California, who have been in business for at least 5 years, who have fewer than 500 employees, and who gross $5 to $7 million annually. I found the five participants comprised a good sample pool since I was able to reach saturation point after interviewing and reviewing five participants. The responses throughout the interviews were consistent, concise, and meaningful. The business leaders were very intelligent, knowledgeable about their businesses, and have systems and plans in place

that were both systematic and strategic. It is imperative that knowing how business leaders engage in the implementation of processes and in their business could provide valuable information for other small business leaders to reduce cost and increase the profitability of their businesses through various business processes.

Conclusion

Kongstvedt, Porter, and Lee (2013) postulated that some small-to-medium-sized business owners lack strategies for successfully addressing the financial effects of the delivery of Medicare and Medicaid managed care on the home health agency business. The study revealed strategies that owners used to succeed in a highly competitive healthcare industry. Through this process I gained a very good understanding of the challenges and strategies implemented to ensure success. Business owners are required to focus on changes in government regulations and funded systems and to position their businesses to be financially viable while providing the highest level of home health care services. I probed the knowledge that current owners have as they study and adhere to regulations as they seek to provide quality healthcare services while increasing their company's profitability. By unearthing successful strategies from this group of interviewees in a highly competitive market (i.e., Los Angeles County, California) and by comparing their efforts with the advice from published literature, I was able to identify strategies other companies adopted to increase their profitability.

The purpose of this qualitative multiple case study was to identify strategies that small-to-medium-sized managed care businesses proprietors used to address the financial

effect new healthcare regulations may have on their business. The targeted population consisted of one owner from each of five home healthcare businesses chosen from the 435 home healthcare businesses in Los Angeles County, California, who have successfully addressed the financial effects of Medicare and Medicaid regulations on the home health agencies. The conceptual framework that is relevant to this study is strategic management theory (SMT) grounded on profit maximization and adaptation in changing contexts (Hill, Jones, & Schilling, 2015). SMT involves the formulation and implementation of the major goals and initiatives taken by the leadership of an organization (Hill et al., 2015).

Data collected from semi structured interviews, information for business plans, and member checking were analyzed with Atlas.ti software. Semi-structured interviews with open-ended questions led to greater knowledge from the five participants about their lived experience of strategies that small-to-medium-sized managed care businesses proprietors use to address the financial effect new healthcare regulations may have on their business. I uploaded the transcriptions from each interview into Atlas.ti for coding.

Four themes emerged from the data analysis: (a) strategic management, (b) application of business strategies, (c) healthcare reform and, (d) strategic business processes. The first theme that emerged was strategic management. Strategic management emphasizes profit maximization and adaptations in changing contexts. According to Hill et al., (2015) the emphasis on profit maximization involves the formulation and implementation of the primary goals and initiatives taken by the

leadership of the organization. The second theme that emerged was the application of business strategies. The five stages of strategic management processes are goal-setting, analysis, strategy formulation, strategy implementation, and strategy monitoring (Ferlie & Ongaro, 2015). The owners of home health agencies must think strategically and apply that thought to a process. The strategic management process is implemented when everyone understands the strategy (Hill et al., 2015). The third theme that emerged is healthcare reform. Healthcare reform, due to the PPACA, could negatively affect small business managed care organizations (Bao, Casalino, & Pincus, 2013). Taxes play a significant role in home healthcare reform, and small business owners must address the rising costs (Herrick, 2014). Without the application of sound management processes as postulated by owners A1, B2 C3, D4, and E5, the tax implications for noncompliance with PPACA implementation, particularly with managed care, include increased administrative costs to small businesses, stagnated growth, and decreased long-term success. The last theme that emerged was strategic business processes. To address the possibility of change, owners examine strategic and management processes of small businesses to improve long-term success, survival, and management of change (Taneja et al., 2013). The implementation of Medicare and Medicaid managed care in home health resulted in uncertainty due to new regulations and potential tax penalties for employers and employees (Taneja, Pryor, Humphreys, & Singleton, 2013). The strategic management business process guides strategic management leadership theory because effective leaders must understand the framework to manage and govern their organization.

The findings from the study will provide business owners with insightful information on Medicare and Medicaid managed care regulations and its effects on their home health agencies' financial standing. It is imperative that the health care system is efficient (Matta et al., 2014). Business owners value the integration and positioning of the home healthcare systems in the continuum of care to financially benefit from increasing demand and interest in the healthcare space (Landers et al., 2016).

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Appendix A: Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

During my activity in collecting data for this research: “Addressing Medicare and Medicaid Regulations Financial Effects on Home Health Agencies’ Performance,” I will have access to information, that is confidential and that I should not and will not disclose. I acknowledge that the information must remain confidential, and that improper disclosure of sensitive information can be damaging to the participant. To ensure your confidentiality, please review and sign the following agreement:

Name of Signer: ____

By signing this Confidentiality Agreement, I acknowledge and agree that as the primary researcher for this study:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as duly authorized.

3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name not use.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of sensitive information.
5. I agree that my obligations under this agreement will continue after termination of the study that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I am not officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: ________________________________Date: ____________________

Appendix B: Consent Form

CONSENT FORM

You are invited to take part in a research study addressing Medicare and Medicaid regulations financial effects on home health agencies. The researcher is asking home health agencies owners with over 5 years in business doing $5 million to $7million in gross revenue to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part. This study is being conducted by a researcher named Binzie Roy Davidson, who is a doctoral student at Walden University.

Background Information:

The purpose of this qualitative multiple case study will be to identify strategies that small-to-medium-sized managed care businesses owners use to address the financial effects new healthcare regulations may have on their business.

Procedures: If you agree to be in this study, you will be asked to:

1. Share home health strategies during a one-time semi-structured face-to-face interview in the privacy and comfort of your corporate office. Participate in an interview that should last no more than 30 minutes.
2. Here are the sample interview questions:

    1.What are the financial effects of Medicare and Medicaid managed care regulations on your home health care business?

    2. What are the financial strategies you use to address the costs of complying

with Medicare and Medicaid managed care regulations?

3. What barriers do you encounter in implementing the strategies for Medicare and Medicaid regulations managed care on your home health agency?
4. How do you address the barriers to implementing the strategies for Medicare and Medicaid managed care regulations on your home health agency?
5. How do you track the results of your home health agency strategies to cope with Medicare and Medicaid managed care regulations?
6. What other issues have you had to face as you address the financial effects Medicare and Medicaid regulations that we have not discussed so far?

Voluntary Nature of the Study:

This study is voluntary. I will respect your decision of whether or not you choose to be in the study. No one at Walden University will treat you differently if you decide not to be in the study. If you wish to join the study now, you can still change your mind later. You may stop at any time during the interview process.

Risks and Benefits of Being in the Study:

Being in this type of research involves some risk of the minor discomforts that you can encounter in daily life, such as fatigue, stress, or becoming upset. The study provides a greater understanding of strategies home health agencies owners use to cope with the financial effects of Medicare and Medicaid managed care regulations on the home health agencies business. The study may assist business owners in competing more efficiently for sustainability and longevity. The information from this case study may lead to social

change for small firms and communities by helping home health agencies create strategies for growth and sustainability to increase business development, profitability, management, evaluation of patient care, services and community health and wellness programs and activities.

Payment:

There will be no payment, thank you gifts, or reimbursements to participants.

Privacy:

Any information you provide will be kept confidential. The researcher will not use your information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. The electronic data will be kept secure by password-protected security, data encryption, use of codes in place of names and all names discarded. All paper and electronic data will secure in a vault. All data will be kept for 5 years, as required by the university, and then destroyed.

Contacts and Questions:

You may ask any questions you have now, or if you have questions later, you may communicate with the researcher via telephone: **661-495-8834**, or email: Binzie.davidson@waldenu.edu. If you want to talk privately about your rights as a participant, you can call **Dr. Leilani Endicott**. She is the Walden University representative who can discuss this with you. Her phone number is **612-312-1210**.

Walden University's approval number for this study is **12-20-18-0564846** and it expires on **December 19, 2019.**

The researcher will give you a copy of this form to keep.

Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it, please indicate your agreement by signing below.

Printed Name of Participant ______________________

Date of consent ______________________

Participant's Signature ______________________

Researcher's Signature ______________________

Appendix C: Multicase Study Protocol

A. Overview of the Case Study

1. The mission and goals of the case study are to gain an understanding of how small-to-medium-sized home health care agencies leaders are strategically responding to the effects of Medicare and Medicaid managed care regulations on the home healthcare agency business within a changing business environment.
2. The purpose of this qualitative multiple case study will be to identify strategies that small-to-medium-sized managed care businesses proprietors use to address the financial effect new healthcare regulations may have on their business. The population for this study will be 5 home health care owners of home health agencies chosen from the 435 home healthcare business organizations in Los Angeles County, California, who have successfully addressed the financial effects of Medicare and Medicaid managed care regulations on the home health agencies.
3. The study supports using a qualitative approach and case study design. The purpose of a descriptive case study is to describe the case, in a real-world context (Yin, 2014). A descriptive case study research design fits when

studying the extent of control over the behavioral activities, and focus on the contemporary study (Yin, 2014).

B. Data Collection Procedures

1. Data collection will conform to the interviewees' schedules and availability.
2. Open-ended semi-structured questions will allow follow-up questions.
3. The real-world situation made at the participants' place of business requires field procedure coping behaviors to:
   a. Gain access to key organizations or interviewees
   b. Have resources to conduct fieldwork, viz., recording device and notes
   c. Develop a call for assistance
   d. Make a precise schedule of data collection activities
   e. Provide for unanticipated events.

The general orientation of the protocol questions is toward the researcher. The main research question is "What strategies do home health proprietors use to address the financial effects of Medicare and Medicaid regulations on their business?"

C. The Interview Questions

1. What are the financial strategies you use to address the costs of complying with Medicare and Medicaid managed care regulations?
2. What are the financial effects of Medicare and Medicaid managed care regulations on your home health care business?

3. What barriers do you encounter in implementing the strategies for Medicare and Medicaid regulations managed care on your home health agency?
4. How do you address the barriers to implementing the strategies for Medicare Medicaid managed care on your home health agency?
5. How do you track the results of your home health agency strategies to cope with Medicare and Medicaid managed care regulations?
6. What other issues have you had to face as you address the financial effects of Medicare and Medicaid regulations that we have not discussed so far?

D. Guide for the Case Study Report

1. The outline and format of this case study follow Walden University's doctoral study rubric and research handbook.
2. The intended audience of this content of this case study is five participants chosen from the 435 home health care owners in Los Angeles County, California, who have coped with the financial effects of Medicare and Medicaid managed care regulations on the home health agencies.