HOME CARE SERVICES FOR OLDER AMERICANS: PLANNING FOR THE FUTURE

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BEFORE THE

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UNITED STATES SENATE

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WASHINGTON, D.C.

MAY 7 AND 21, 1979

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MONDAY, MAY 7, 1979

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 10:10 a.m., in room 1318, Dirksen Senate Office Building, Senator Lawton Chiles (chairman) presiding.

Present: Senators Chiles, Pryor, Domenici, Heinz, and Cohen.

Also present: Kathleen M. Deignan and Deborah K. Kilmer, professional staff members; David A. Rust, minority staff director; Tony Arroyos, minority professional staff member; Marjorie J. Finney, operations assistant; and Charlotte B. Lawrence, resource assistant.

OPENING STATEMENT BY SENATOR LAWTON CHILES, CHAIRMAN

Senator CHILES. We are having this hearing today because we think we have a problem. In fact, I know we have a problem.

Nineteen months ago, Congress asked the Department of Health, Education, and Welfare to provide us with recommendations for future directions for home health care. As a matter of fact, it was my colleague on this committee, Senator Cohen, who originated this request as a Member of the House of Representatives.

We have been struggling for some time now to find efficient ways to make sure that our Nation's elderly will have a solid base of both institutional and home health care services they can turn to when support is needed. We still do not have our problems with nursing homes solved, but the most frequently missing element is home care. The intent of our request was to enlist the expertise of the administration to help us set some directions and goals in home health care.

The report which was delivered to us does not do that. We have no recommendations. We have no discussion of optional policy directions and goals. We have a $62,000 report which rephrases the questions and concerns this committee and others have been asking the Department since 1975, and before.

We are told that this is because of budgetary restraints and insufficient information.

Congress is also concerned about budgetary restraints. Congress, I feel, is the agency that has to make the decisions of how much of the taxpayer's money we take from the taxpayer and how we appropriate that money, whether we can afford to spend that money or not, and what the tradeoffs are in regard to trying to

bring inflation under control. Whatever steps we ultimately take to insure comprehensive long-term care services is not going to happen all at once, but we need a broader policy to work with as we take these steps, and that is what we ask the Department to help us with. Let's get the options out in the open, with the price tags if we can, and then we can start making the decisions.

We have been told before that we don't have enough information. That is why we asked for demonstrations under medicare and medicaid back in 1972. That is why we gave new demonstration authority to the Administration on Aging last year. That is why I pushed, in the Appropriations Committee, for more money for long-term care demonstrations in the Health Care Financing Administration. I said: "Tell us what you need and we will put it in." We had some figures in mind, and the Health Care Financing Administration staff came up and said: "We can't use it. Give us less."

Is insufficient information really the problem? I think we had better come to some agreement on that, and I hope we can in this hearing.

I find it hard to believe that if there was a real concern for the problems we face in long-term care, and any real expertise and organization in the Department, this process could have fallen hostage to these excuses.

We don't have any policy. We don't have any focus. We don't have any responsibility. The report on home care services tells us a lot about that.

I have tried to make these points before. We have had hearings before. Secretary Califano and the Administrator of the Health Care Financing Administration agreed that it was "essential that the Department adopt a coordinated focus on these issues." That is his quote. We were told that was being done. We were told that policy development in long-term care services was of the highest priority. It looks like we have to start over again.

We don't have that kind of time. There are 5,500 people who reach their 60th birthday every day, right now, and that number will increase rapidly. We are already considering health insurance proposals which don't address long-term care needs. The report itself points out that we are probably wasting money and harming some home care recipients because of inadequate attention to issues of standards and coordination of services. States are having a difficult time meeting their long-term care responsibilities in the absence of any Federal policy.

We will be hearing about some of these State problems this morning from Dick Batchelor, who is chairman of the Florida House of Representatives Committee on Health and Rehabilitative Services.

Florida has 27,000 elderly persons in nursing homes now. We are told the State will need to have 100,000 nursing home beds by 1990. Right now, there are about 120,000 noninstitutionalized elderly persons in Florida who have an unmet need for some form of long-term care, a large part of it home care services.

Before we hear from Representative Batchelor, I know there are members of the committee who have other opening statements.

Senator Domenici, we will start with you.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator DOMENICI. Thank you, Mr. Chairman.

I will try to be brief. However, I want to open by commending you.

Senator CHILES. Well, I want to point out the work that you have done in this area. You have been in on some of these hearings that we have been holding in the past and trying to get some answers in this area.

Senator DOMENICI. I want to open by saying it is almost impossible for me to understand the administration's philosophy toward health care. On the one hand the President wants to minimize increasing hospital costs. That is an admirable goal—everyone realizes that these expenditures are rising all the time. However, the H.R. 3 report, which has been submitted to us, is proof that the present administration refuses to support even the most basic kinds of commonly accepted notions of change.

The requirement under current medicare law that infirm elderly must be hospitalized for 3 days prior to becoming eligible for home health care services is one reason for rising hospital costs. The administration is essentially "burying its head in the sand" by refusing to support the elimination of the 3-day prior hospitalization requirement.

There is a very fundamental question that needs to be asked here. Should we, or should we not, as a Nation, eliminate the trend toward institutionalization? The report refuses to take a position on this basic question, and the administration, in testimony before the Senate Finance Committee, Mr. Chairman, does not even want to address that issue. The reason given for nonsupport—budgetary constraints—is an admirable one. However, I believe that unless and until we as a Nation decide to eliminate this institutional bias, continued talk about spiraling health care costs is a futile exercise. The traditional policies of our Nation, which emphasize nursing home and other types of institutionalized care for our elderly, contribute to rising health care costs. We must come to the realization that, even if we need to have a few more years of nursing home and institutional costs running parallel to home health care costs, eventually we will be saving resources, and doing a better job in providing cost-effective, adequate, and more humane health care services to our elderly citizens.

Getting to the bottom of this problem, and then advocating and insisting upon, some reasonable changes to eliminate the trend toward institutionalization which pervades our present health care delivery system is exactly the function which our committee can and must perform.

Senator CHILES. Thank you.

Senator Cohen, you started all this.

Senator COHEN. Thank you, Mr. Chairman.

Senator CHILES. I am sure you have some opening remarks. We are delighted to have you as a member of our committee and still pursuing your interest in this area.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator COHEN. I want to congratulate you, Mr. Chairman, for calling this hearing, because I have no doubt that it hastened the

release of the section 18 report which is required by Public Law 95-142.

As you pointed out, as the author of the original legislation that prompted this report that forms the basis for this hearing, I have a few things to say to the administration witnesses who will be coming before the committee this morning. The best assessment I can give this report is that it is a complete disregard of congressional intent. A simple reading of the law tells me that the report should develop methods to assure the quality of services provided, improve efficiency of program administration, curb fraud and abuse, and provide for coordination between Federal in-home service programs particularly with regard to reimbursement and provider qualifications. Outside of some action on fraud and abuse issues—of which compliance is already required by other laws and sections of Public Law 95-142—fail to see that any of these issues have been addressed after exceeding, as you pointed out, Mr. Chairman, the statutory deadline by 6 months and spending some $62,000.

Instead, HEW has applied its own unilateral criteria—that of cost. While cost is, of course, important in assessing and assigning our national priorities, Congress has the constitutional prerogative to set those priorities. This agency was required to submit policy options and recommendations. While those recommendations could have included cost considerations, I think that Congress is the one that is responsible for deciding when those constraints warrant no action be taken.

Furthermore, I would point out, Mr. Chairman, that the assertion that HEW lacks information necessary to even suggest policy options, I think is indefensible, because the appendix which has been submitted and indeed earlier drafts of the report, which I have had the opportunity to review, suggest that there is substantive and substantial data available. I have a copy of an earlier draft [1] which I would like to have entered as part of the record, Mr. Chairman, which is a January draft signed off, I believe, by Administrator Leonard Schaeffer. The red ink which we have drawn through portions of this draft report indicates where the administration stripped information from the bill that it did not feel was convenient to discuss. I would like to know, first of all, as we get into these hearings, who was responsible for cutting the original draft prepared by the Administrator.

Also, I would like to say for the record that the history about this legislation which has led to the requirement of this report involved the situation where I sought initially to set up an independent commission to establish standards of quality care for home health services. The Carter administration objected because this was a new administration and it should be given the opportunity to prove itself by having responsibility for the report. Moreover, President Carter had a policy to cut back the number of governmental commissions and advisory groups. The President may have succeeded in the latter objective, but he has, in my opinion, wasted an opportunity to contribute to the formation of a national policy on home health care.

[1] See appendix 3, page 147.

Despite the statements to the contrary, it seems clear to me that the administration does not have a long-term health care policy. The fact that the earlier drafts, including the January version, had sections dealing with future directions in-home health care which failed to appear in the final report, I think vividly shows that the HEW is not developing a long-term care policy. If it did, I believe the whole tone of this report would have been quite different.

So, after a year and a half, I hope that the witnesses who are going to come before this committee can demonstrate how this report makes any difference at all to the individuals who are in need or to providers of in-home care. Unless they can satisfy on those points, Mr. Chairman, I am going to propose that the committee introduce a resolution directing the Senate Committee on Finance and the House Ways and Means Committee to reject this report.

I hope during the hearing we can focus on the broader aspects of the hearing. I do want to welcome the other witnesses and look forward to their comments on the future direction in home care services. I think we have seen the demographic handwriting on the wall, as the chairman has pointed out. In order to deal with the realities of the future, we must acquire some vision about the issues before us today.

Thank you, Mr. Chairman.

Senator CHILES. Thank you, Senator Cohen. Our first witness is the Honorable Dick J. Batchelor, Chairman of the Committee on Health and Rehabilitative Services in the Florida House of Representatives and Chairman of the Ad Hoc Subcommittee on Aging of that house.

Dick, I am delighted to have you come before our committee. It is of great interest to me to see how your career has progressed.

When I was walking through Florida, I met this young man who was working his way through junior college at the time, and he was an officer in the student government at the junior college. He gathered together some of his fellow students that were interested in government and provided one of the largest audiences I had had up to that time in my campaign for the U.S. Senate.

I am delighted to see that you pursued your education and also your interest in government and are now a member of the Florida House. We are delighted to see the work that you have done in this area on aging and to have you come before our committee.

STATEMENT OF HON. DICK J. BATCHELOR, CHAIRMAN, COMMITTEE ON HEALTH AND REHABILITATIVE SERVICES, AND CHAIRMAN, AD HOC SUBCOMMITTEE ON AGING, FLORIDA HOUSE OF REPRESENTATIVES

Mr. BATCHELOR. Thank you very much, Senator. I appreciate those comments. I remember I knew the Senator when he used to walk every place, including across the State of Florida, and I think he can recall me when I had hair.

Let me, if I might, Mr. Chairman and members of the committee, make a statement and then respond to any particular questions because we all recognize that the State of Florida, because of its aging population, could be severely impacted if a comprehensive

plan on long-term care is not established by the Department of Health, Education, and Welfare.

The Senator and I are certainly from the State that is graying faster than any other State in the Union. Almost one-quarter of its population is over the age of 60, and with between 8,000 and 15,000 additional elderly people making it their home every month it is approaching an era in which we must think creatively about long-term care. I believe that Florida is an indicator as to what lies ahead for the rest of the Nation, and as former chairman of the Florida House Subcommittee on Aging and present chairman of the Committee on Health and Rehabilitative Services it is all too apparent to me that Florida and the Nation cannot afford, either financially or morally, not to start formulating a policy on long-term care.

The current methods of coping with our frail elderly are simply too expensive. In Florida, we have 28,000 people in nursing homes. By the year 2000, this figure is predicted to increase four times over, to approximately 100,000 people in nursing homes in our State. Nursing home care is expensive.

As an aside at this point, we recognize the importance of the administration's efforts to do something about hospital cost containment because 75 percent of all medicaid dollars in Florida are being expended in institutional care. Unfortunately, this exceeds the national expenditure of 70 percent. In addition, Florida has approximately 1,700 elderly patients in State mental hospitals. The vast majority of these people, some 1,400, are there for primary reasons other than mental health. I was recently told that these people could be discharged if there were appropriate community care available. A staggering amount of money is spent in the kind of care that most elderly people don't want and quite frankly don't need. Again, I might interject that in the State of Florida, in our four mental institutions, we have over 850 clients that have been diagnosed as having no sign of mental illness but yet they were put into mental institutions prior to the time that there were alternate placement facilities.

Institutional Care Only Option

There are alternatives that should be encompassed in a long-range plan for long-term care, but I do not feel that the administration, at this point, has developed such a plan. I think it should be on the conscience of HEW that if we are going to harbor people in our State mental institutions it is because there are no plans for alternative placement and the only option in many of these States happen to be institutionalization, be it a nursing home or a State mental institution.

Besides being expensive, institutional care is too often a heartless solution to a delicate social problem. I say a delicate social problem because I believe that our lack of policy for alternatives in long-term care reflects the cultural lag in which our elderly are caught. In our modern transient society, in which families are sometimes spread across the continent, the family is often not around to care for, and much less revere, its elderly members. Nothing in our society has emerged to fill the void frequently left by the family, except institutional care, which I submit is unacceptable in its

current form. A different type of care, a less stigmatizing care, would be a very important part of the continuum of long-term care; thus, institutionalization would be more acceptable to our society.

But until a Federal policy for long-term care is established so as to place institutional care in its proper perspective, America will have shirked her responsibility to her frail elderly. As leaders in this country, we have the responsibility to establish policies that guard our constituents' inalienable right to life with more and lasting dignity. If the only option we leave open to our frail elderly is unnecessary institutionalization, then surely we have done little to assure this liberty.

In an era in which our pouplation is aging rapidly, we must look for alternatives in long-term care. Warehousing our elderly is expensive; it is a sad replacement for the family. We must enter an era of creativity with regard to long-term care, and we must enter this era with a plan in mind, with a policy set forth, or we will soon be forced to establish an ad hoc policy for a problem that has engulfed us. You at the Federal level must establish a policy to cope with the problem of caring for our frail elderly. I am afraid that if you don't, the magnitude of the problem will dictate the establishment of a patchwork undeveloped policy.

When I talk about policy, I am talking about developing a strategy for a continuum of care for the elderly. It is a continuum of care that addresses the problem of an elderly person with an eye toward the specific kind of care that particular person needs. Right now, our financing mechanisms dictate our policy. Largely in response to the funding available under medicare and medicaid, the nursing home industry has expanded with gigantic strides, but I believe that caring for our frail elderly in institutions is shortsighted when home delivered services might keep many of these people from entering a nursing home and do so at a greatly reduced cost.

In Florida, we have developed seven demonstration projects to experiment with various kinds of community based services. These projects are funded under the State's Community Care for the Elderly Act. A recent evaluation of these community services indicated that even the most expensive kind of community based care is less expensive than nursing home care.

It should also be noted that community care was most often provided to people who were "at risk"—in danger of being placed in an institution. The State legislature is now in session and both the House and Senate budgets contain money to begin expanding these programs statewide. This increased funding, I might add, is largely the result of a ground swell of support from individuals around the State.

In Florida it is hoped that community care for the elderly will soon be part of a well-established continuum of care. Ideally, this continuum will include senior centers, home delivered services—such as meals, homemaker and chore services—day care, respite care, family placement, transportation, nursing homes, hospitals and hospices. As a side note I am happy to report that last week my committee approved legislation to license hospices, a concept whose time has arrived. Since Florida has a higher percent of elderly than any other State, as well as the highest incidence of

cancer, innovations in caring for the terminally ill should be pioneered in the State.

I also mentioned family placement. This is a program Florida began 2 years ago, in which a family is paid to keep an elderly person at home. It was our feeling that if the State could pay to place a person in a nursing home, that we should also pay to allow a person to stay with a loved one. This can be viewed as a commitment to the family. It also expresses the legislature's realization that a person's mental health is probably better preserved if they are allowed to remain in familiar surroundings. In developing a continuum of care for the elderly, we have come to realize that a person's mental, as well as physical, health is an essential consideration.

In summary, glaring statistics mandate immediate action. Between fiscal years 1950 and 1977, personal health care expenditures increased from $10 billion to $143 billion. Figures also indicate that personal health care expenditures increase with age, and that the 85-plus population is the fastest growing segment of our society. Since community based services are usually a more appropriate and less costly approach to dealing with the needs of our elderly, we must be creative in developing a policy for long-term care, and we must do it now.

In closing, if I might, Senator, I had the opportunity to review two reports. One is the report that I have submitted to your committee staff that my Committee on Aging developed in the State after holding extensive hearings. The unique part about our report is that we not only have a compilation of the problems that we have and can substantiate those problems, but we made specific recommendations about what to do as far as coordinating delivery systems to address the whole person and not just categorical funding to some isolated problem that some people don't have. This report is now being implemented through the legislative process. There are particular problems that call for action by HEW or in fact the U.S. Congress.

The second report that I had an opportunity to review is the one that the U.S. Congress mandated HEW to complete. It is late, as has been indicated, and since that time, based on the number of people who have moved to the State of Florida, we have probably denied services to at least a portion of some quarter of a million people who have moved to Florida because we have such an ever increasing rate of people coming to our state every day.

I think if you just look at the summary of the report or the introductory comments you won't want to read the rest of the report because they have an automatic disclaimer that we know what the total is to do, we know what needs to be done, but we don't have that here—we have a recitation of the problem. I think it is presumptuous on the part of HEW to assume that they would be making the budget agreements anyway. What we are saying is that it is not necessarily appropriate to try to find more funds, but if you increase the cost of effectiveness of an integrated service delivery system then you can in fact hold the cost down to serve more people in a more realistic approach.

This reminds me of a syndrome that I have seen time and time again throughout so that I have dubbed this "Analysis Paralysis."

Because of the public report we say we don't have the answers here but we will do another 2-year report. I submit another 10,000 people will not have been served in that time.

I will close with those comments, Senator, and I will be glad to respond to any questions.

Senator CHILES. Thank you very much for your statement.

Let me first say that it sounds to me that the family placement program is an innovative program and one in which we really need to see what experience States will have with that program. Is it going to be an answer? On the surface it appears that it will, but how are you going to control it? How are you going to see that it is used properly? How are you going to see that it is not something that someone could try to use to milk funds or to take funds? Certainly that is in the area I think States ought to be experimenting under our Federal system and ought to be trying that program. We can learn by seeing what kinds of experience that Florida has in that program.

Why did you need to get a waiver? Explain that to me.

Mr. BATCHELOR. Senator, let me try to explain it to the best of my knowledge. First of all, family placement, I think, is probably the best approach to allow somebody to stay with the family intact. So many of our categories such as medicaid and medicare seem to lend themselves to forces that put a person into institutional care so that they can at least benefit for his money but the family placement would allow somebody to stay in the home.

We really needed an SSI waiver because when you receive supplemental security income and you count any other income in that household towards the recipient's income you would disqualify them from SSI so we simply needed to allow an SSI waiver demonstration project to see if this family placement would work. We have had it in the State of Florida now for 2 years and it has been extremely successful where people are still wed to the family concept.

Senator CHILES. You said that 75 percent of the State's medicaid program goes to pay for institutional care now. What are you going to do to meet the need for that 100,000 beds; that is, additional beds that are going to be necessary in 10 years' time?

Mr. BATCHELOR. Well, the only obvious choice we have now is to try to be as creative as possible. We would like to establish some alternative to institutionalization. We have tried to do that again with the community care for the elderly concept; the whole concept of community based services is to try to avoid institutionalization. If you have homemaker or chore services, home health care, meals on wheels, some transportation for the nonambulatory clients, I think you have an opportunity to allow people to remain in their own homes and communities. They will not be forced into the institution.

We would like to have an innovative approach to the funding mechanisms available to both medicaid and medicare. With some of the waivers I think we can demonstrate further that when you integrate the plethora of services that you can keep people out of the nursing homes. I am not sold on the idea that we have to have 100,000 nursing home beds.

Senator. CHILES. I think that survey is based on present programs which are pressed by the financial end rather than by the actual physical need.

Mr. BATCHELOR. Yes, sir. I think it can be reduced substantially if there is a continuum of home care to prevent institutionalization.

Senator CHILES. Are there any other questions?

Senator DOMENICI. I want to continue with one point, Mr. Chairman. In my opening remarks, I failed to make the cover letter which accompanied the H.R. 3 report a part of the record, and ask now that this letter be included in the record,[1] dated April 16, 1979. It is directed to the Honorable Frank Church, as chairman of the committee. He is no longer chairman of the committee. The letter also indicates that he is in the House of Representatives, even though he is a Senator. That is the mailing address, and is signed by the Secretary. These inaccuracies probably indicate how important this report was in the eyes of HEW.

Senator COHEN. Would the gentleman yield?

Senator DOMENICI. Yes.

Senator COHEN. I am sure this is not an isolated example. The Air Force has proposed the reduction of an air base in Maine. They prepared an environmental impact study on the proposal, but they had the base located in the wrong part of the State.

Senator DOMENICI. Let me ask this. Do you generally agree, based upon your in-depth studies to this point, that we need to expand home health care services in order to have an appropriate response to the needs of our elderly for health care?

Mr. BATCHELOR. I think the answer is yes, and I think it is very clear because of the increasing costs of hospital care. I think when a doctor has no choice and he is not allowed to offer any type of care other than hospitalization and then you tell the doctor, well, you can take the patient out and they can survive 3 days and enlist them in another home health care program, I think you have just produced the options to that position to have alternative care. I think hospice is a very good example. We have the three demonstration projects there for the terminally ill patients.

I think the answer is yes because we all know what is happening in hospital care in our State. If I might just for a second digress, our population has increased 38 percent since 1965. The number of hospital beds in our State increased by 90 percent. The number of dollars spent for hospital care increased 695 percent. So you can see the proliferation forced institutional care, the first choice being hospitals. I think the economics alone dictate that we have to establish a different type of long-term care.

Senator DOMENICI. Just one last question. Many of us are pushing very hard for an expanded home health care program for this country, including the elimination of some of the arbitrary conditions—such as 3-day prior hospitalization for the seniors—which impedes the development of home care services. We have two programs, medicare and medicaid, running side by side. Seniors have to go to the hospital first before they receive home health care services, but the poor of America don't, they can get home health care without this and other impediments.

[1] See appendix 2, page 60.

How would you explain that, in the long run, this may not cost more money? Most of us think that, to continue on as the administration is doing, will cost us many millions of additional dollars without improving the quality of health care delivery. This approach does not answer the resource allocation question. We must develop a home health care system side by side with the other aspects of our health care system or else everyone is going to be taken care of in either nursing homes or hospitals. At a point in time—2 years, 5 years, 10 years out, we will find that it will be far more expensive to operate a system without a strong home health component than one with it.

Do you basically agree with that premise? If so, have you found any way of putting that into actual dollar figures or not?

Mr. BATCHELOR. Well, let me respond this way. I think it is that commentary that is to increase our medicare deductibles and it would be arbitrary for me to give you a number or deny hospitalization because they cannot generate the $160 deductible which in fact, without that type of deductible on home health care, they would be able to have an option to take care of their medical needs.

Second, is the demonstration project under our community care? We did an evaluation project of all the seven demonstration projects and we can identify very clearly the number of people that either, No. 1, would have been denied the service or, No. 2, would have been forced into institutional care if those services were not available. The whole continuum of things, people need a different type of service, but sometimes the costs of our being involved with categorical funding, and that they don't specifically fit this identity factor, they then are denied the service.

Senator DOMENICI. How would you be able to identify senior citizens who would benefit from home health care but were institutionalized instead? Do you get that information from the professionals?

Mr. BATCHELOR. Well, we have again the community care concept for services such as home health care, the meals-on-wheels, day care for the aging, some nonemergency medical transportation. Probably the most popular one is the homemaker-chore service.

Senator DOMENICI. The what?

Mr. BATCHELOR. The homemaker-chore service, a service that you provide. You identify an old person that is not any longer independent, but if you go into his home and you cook two or three meals a week and tidy up for him, take him to the pharmacy, take him to the doctor, take him shopping, or call him once a day or whatever, that service might be what allows that person to stay in the home. They might be aging. Seventeen percent of those over 70 suffer from progressive atrophy, which is a deterioration of the brain. We seem to forget things. People cannot be maintained independently, but if someone is there to provide those types of support services, you can keep them in the home.

If those services are not provided, the record will clearly reflect that the only option is the nursing home. We have gone back to look at all these services and interview the clients that were served, and at least 50 percent say clearly: If I did not have the support service in the community, the only option I would have would be to have my children put me in a nursing home, because

they did not have the day care facilities to drop me off during the day, or the home-delivered meal was not available to me, or those types of things.

Senator, if I might interject one thing that is of growing importance to the aging demographic, it is in the area of mental health. On medicare, you can only have up to $250 a year for outpatient psychiatric services. Now you can be institutionalized and that will cover the cost for some 190 days if you can pay the medicare deductible.

It is my concern that as the population gets older there are those people that have progressive atrophy that are being denied mental health services. Again, the cost of the guidelines is on the medicare, when in fact you should be able to go to some of your community mental health programs and have access to that system, which is certainly less costly than being forced into a State hospital for short-term crisis intervention or being forced into a State mental institution simply because you have a problem which might be a very, very mild problem.

Senator CHILES. The administration has proposed in their budget request raising that figure, I think, to about $750. The legislation is not here yet to go along with that, but that budget request has been made which would be of some help.

Mr. BATCHELOR. I see that as an embarrassing crisis, and we are trying to address it in our State, but in this continuum of long-term care one has to keep in mind that it not only precludes people from being put in an institution but if you have the mechanism available you can get some of the people out of those mental institutions that need not be there, and I think that is just as important.

Senator DOMENICI. The reason I asked the question, how did you prove it, was because it is obvious that the principal prescriber for institutionalization is the doctor. He or she is the one who basically prescribes hospitalization. Likewise, they are the principal prescribers of home health care.

Now, as to seniors, it would be very difficult to get an array of medical doctors to say, we didn't need to put him in the hospital. That is often very hard for them to say. They may, in private, say, if we could have prescribed home health care, we would not have put him or her in an institution, but you cannot have a survey and get doctors to admit that, because someone will immediately say your motives were to utilize the hospital, to make your own life easier. We all know doctors who are confronted almost daily with this all or nothing situation. That is the reason I asked if you had the evidence and I appreciate your observations.

Thank you, Mr. Chairman.

Senator CHILES. Senator Cohen.

Senator COHEN. A couple of points, Mr. Chairman.

Mr. Batchelor, I would take a little bit of issue with you when you suggest that our mental capacity or intellect deteriorates with age. The Jackson Laboratory, located in Maine, had an extensive study which showed that mental and intellectual capacity does not diminish with age; it depends a great deal upon the diet, upon neglect, upon indifference, upon love and upon activity—that all of this is involved with one's mental capacities.

What we do is set up sort of an institutional mind set which becomes a self-fulfilling prophecy and we assume that because a person reaches a certain age that that person's mental capacities will diminish as well as his physical capacities. So I don't think we should make that assumption. We are trying to reverse that, as a matter of fact, with legislation which was enacted during the last Congress that wipes out mandatory retirement for people who reach the arbitrary age of 65.

Mr. BATCHELOR. Senator Cohen, if I may interject, I said that some of the people over 70 suffer from irreversible atrophy and irreversible brain damage. I apologize if I did not state that accurately. As you get older, you have the diminution of—in fact, my one intern is 91 years old and finishing courses for his Ph. D. in history at Florida State University.

Senator COHEN. Perhaps I misunderstood you. I think you have covered this.

We tend to talk about home health care as an alternative to institutionalization and really we should not propose it as an alternative but rather as part of the continuum health care in this country. One of the bills that I sponsored last year with Congressman Pepper of Florida, which in part has been incorporated into the Older Americans Act, is to have a single entry form into our health care system. For example, if a person 65 or older were to come to a member of this committee and say, Mr. Cohen, or Mr. Chiles, or Mr. Domenici, I have a problem, can you help me with it in terms of which agency I might qualify with for home health care? Whether it is title XVIII, title XIX, or title XX. I would venture to say that neither I nor any member of this committee could tell that person what to do. I suspect you have the same problem in your own State with the overlap of programs.

I am looking at a chart here prepared to show the different types of qualifications for reimbursement under titles XVIII, XIX, and XX. You have to be a Ph. D. to figure it out in terms of where you go.

The one thing that I proposed several years ago was to have a single entry point at the community level, some are already in place, where a person could go to have an evaluation done as to what type of medical care is appropriate for that individual—home health care with periodic visits with some homemaker service would be sufficient for that person. As the needs change the treatment would change.

As a Federal program, this type of service is only in a demonstration stage. In fact, as you pointed out, we don't have the policy right now. We have a series of overlapping statutory regulations which are confusing to the average person, and I suggest even to the professionals, and what makes this particular report so frustrating is it has done nothing to alleviate that confusion.

One final point. I understand that Florida has a regular problem of private and nonprofit providers. I wonder how we can deal with this situation?

Mr. BATCHELOR. Well, can you be more specific?

Senator COHEN. Have you had any situations in which private, nonprofit providers have been abusing the reimbursement policies? Do you have that in Florida?

Mr. BATCHELOR. I think we have had a history of that. We have had some problem with it because we did not think the guidelines were clear enough, but we have now moved to put into our office the certification which I think is more in proportion with it.

There has been abuse throughout this Nation where the investigation was precipitated by that type of abuse, but we think our guidelines are very, very clear, and I think they are very conscious about them. As an example, we were trying to expand our limited medicaid program this year to pay for hearing aids. In my proposed bill, we also had the prior approval, and so we are very conscious of that, but we have had some problems in the past.

Senator COHEN. Is that the principal reason that you have not made greater use of in-home provider services in the State of Florida?

Mr. BATCHELOR. We have moved toward it with our care concept which interestingly enough was introduced by then Senator Graham, who is now the Governor, back in 1975. I think 1975 was the advent and we are now fully funding the whole community care concept. We have just about reached the $14 million figure this year, and will perhaps increase the funding. So we take all the demonstration projects that we employed in 1975 and provide all of them in a continuum of care in our districts throughout the State. Some of them, as you suggest, there is a designated place where the person can go to try to access one or more of those services.

Senator COHEN. I think that too often some of us on the committee point to the HEW studies which show that between 14 and 25 percent of the people who are currently in nursing homes don't have to be there, don't need that level of care, thereby concluding that perhaps we are wasting a great deal of money. There are people that do need that care and those beds, so it is not saving 14 to 25 percent of the nursing beds, we are still going to have those nursing beds filled.

Mr. BATCHELOR. Yes.

Senator COHEN. Thank you.

Senator CHILES. Senator Pryor.

Senator PRYOR. I don't have any questions at this point, Mr. Chairman. Thank you.

Senator CHILES. Thank you, Mr. Batchelor. We thank you very much.

Mr. BATCHELOR. Thank you very much. I appreciate it.

Senator CHILES. Our next witnesses making up a panel are the Honorable Fred Bohen, Assistant Secretary for Management and Budget, Department of Health, Education, and Welfare, and Robert C. Benedict, who is the Commissioner on Aging. We also have some people from the Health Care Financing Administration. I don't know who those other members are. Please introduce them for us.

STATEMENT OF HON. FRED M. BOHEN, ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY ROBERT C. BENEDICT, COMMISSIONER, ADMINISTRATION ON AGING, AND CLIFFORD GAUS, ASSISTANT ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION

Mr. BOHEN. I will; Mr. Chairman and members of the committee, I am pleased to be here this morning as the Secretary's representative to review and answer such questions as you may have on the Department's report on home health services under medicare, medicaid and title XX. Since I did not personally participate in the decisions concerning this report, or its development, I am accompanied by Robert Benedict, who leads the Administration on Aging in HEW, and Dr. Clifford Gaus, Assistant Administrator for Policy of the Health Care Financing Administration, both of whom did work on the report, and both of whom represent agencies in this area.

Let me at the outset express my personal chagrin and the Secretary's deep regret, to you and to the other members of the committee for the indefensible errors and sloppiness in the transmittal of the report to you. While we may have differences with respect to this report, I can assure you that the Secretary does not countenance the mistakes that we made, and we are all embarrassed by that sloppiness.

Senator CHILES. Mr. Secretary, that really does not concern me, that is something that is kind of amusing maybe as far as a cover letter. What really does concern me is what you have just told me and that is that you did not personally participate in the drafting of this report or in the makeup of this report.

Mr. Benedict, did you participate in this personally as the Commissioner of Aging?

Mr. BENEDICT. The Commissioner of Aging was not responsible for the drafting of the report. During its evolution, we had an opportunity to comment on that while it was being prepared.

Senator CHILES. Who did it?

Dr. GAUS. Mr. Chairman, my office in the Health Care Financing Administration was responsible for preparing the various drafts of the report, and this last draft we did participate in, but were not involved in the final changes.

Senator COHEN. Would the Chairman yield?

Senator CHILES. I yield.

Senator COHEN. Was it your office that prepared this initial draft signed by Mr. Schaeffer?

Dr. GAUS. Yes, it was.

Senator COHEN. You say once it came from Mr. Schaeffer it went up to the HEW administration itself. You shipped it over to the OMB and that is where all the changes and revisions were made, is that correct?

Mr. BOHEN. Senator Cohen, some of the changes in that report resulted from review in the Office of the Secretary and decisions made by the Under Secretary. Some represented decisions made in the administration after specific proposals or recommendations were made in the Department.

Senator COHEN. Do you recognize this original report from what was submitted to this committee?

Dr. GAUS. I recognize parts of it.

Senator COHEN. What parts?

Dr. GAUS. There were substantial changes made.

Senator CHILES. Well, who made the decision to do that?

Dr. GAUS. The changes?

Senator CHILES. Absolutely.

Mr. BOHEN. Mr. Chairman, I am prepared to go forward with the testimony indicating why changes were made.

Senator CHILES. Well, I understand that you are ready to go ahead with the statement, Mr. Secretary, and we will put your statement in full in the record.[1]

My concern is I don't know how this panel can ask questions and get responsive answers if you were not a participant in the actual decisions that were made. If you are sent up here now with the statement, once you get out of the four corners of your statement, how are we going to get responsive answers? We know that HCFA sent up a report and then changes were made after that. Was Under Secretary Champion the one that made some of these decisions?

Mr. BOHEN. In the long-term care area of the Department the Secretary relied very heavily on the Under Secretary during the process. This report was reviewed by the Under Secretary; it was commented on by all the staff offices, it came to the departmental level for review after the Department submitted its legislative program and budget to OMB for this year, and it was, in some respects, inconsistent in the sense that it was advancing recommendations and suggestions that were not in our legislative program and not in the budget. It was on the basis of those inconsistencies that the proposals were, in effect, not endorsed but carried over for further study.

Senator CHILES. Well, then are you telling us it was OMB and the budget decisions were what drove the report and made the changes?

Mr. BOHEN. Budget factors were very significant. The report came forward after the budget had been put to bed. As you know, from service on the Appropriations Committee, in preparing its budget for 1980, and then in responding successively to tighter planning ceilings, the Department had difficult choices to make with respect to the budget, and some of these recommendations were a part of that decisionmaking—in HEW and OMB as well.

Senator DOMENICI. Mr. Chairman.

Senator CHILES. First I want to insert in the record at this time a copy of the report as it originally came out of the Health Care Financing Administration.[2]

I also want to insert in the record at this time, without objection, a copy of "Home Health Line," issue 4,[3] which I think is valuable because it points out, in chronological order, all of the hearings and actions that took place prior to the issuance of the report, really going back to 1965, and I think provides a very important chronology of events that took place.

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[1] See appendix 1, item 1, page 49.
[2] See appendix 3, page 147.
[3] See appendix 5, page 227.

Then, again, I really want to express the concern of the Chair that we are still dealing with a report without having parties before us now who I think can answer our questions as to why certain decisions were made and why certain decisions were not made, other than on a secondhand basis, these being budget decisions you have told us. I would think maybe some of those decisions would have come out of your office, but you were not an actual participant, you say.

Mr. BOHEN. I began my duty as Assistant Secretary for Management and Budget in November 1978, after the initial budget submission had been made to OMB. I am familiar with certain aspects of the budget decision that came after that.

Senator DOMENICI. Mr. Chairman.

Senator CHILES. Please.

Senator DOMENICI. Mr. Chairman, I also want to state that I intended nothing personal by introducing this letter into the record. I introduced the letter to illustrate the general attitude, as I saw it, toward this congressional mandate on home health care.

Mr. Chairman, the committee wrote and asked that either the Secretary or Mr. Champion, the man who obviously made many or most of these decisions, come before us and explain this report, and they did not choose to do so. It appears to me we are never going to make any sense out of these disparities unless one or both of them comes before us. Either Mr. Champion or Mr. Califano ought to be asked again in a more urgent manner, Mr. Chairman, to come before this committee and explain why they failed to live up to the minimum legislative mandate. I would also like them to explain what was behind the changes made between the January draft report and this document. Even though we are all busy, I think we have to insist that either Secretary Califano or Under Secretary Champion come here and defend this report, and I would hope that you, Mr. Chairman, would join in telling them that you think it is imperative that they do so.

Senator CHILES. I really think that the committee is entitled to be able to ask people questions and they can respond to those questions on the part of the decisions that have been made. To tell you the truth, Mr. Bohen, I don't think it is fair for them to send you up here.

Senator DOMENICI. I don't either.

Mr. BOHEN. Mr. Chairman——

Senator CHILES. You are the new man in the barrel, and on that basis, they may have felt that they could send you up here, but that is not adequate and, as I say, I don't think it is fair to you. It is not fair to this committee, and it is not responsive to the legislative mandate that asks for this report. If it was not that we have some further witnesses, I would recess the hearing right now, but we have some GAO people and I think we ought to hear from them.

Mr. BOHEN. Mr. Chairman, I think that both the Secretary and Under Secretary read your letter as indicating you wanted a policy level representative of the Secretary here. I believe I have reconstructed, as best I could, the sequence of events, and they are set forth in my testimony, which the whole Department stands behind. I think in this situation both the Department and the administra-

tion were faced with the problem of having a requirement to the Congress that was moving in ways difficult to reconcile with the Department's commitments under the budget and the administration's program. It gave us some difficulties, and that is certainly part of the explanation for the delay, as well as some major part of the explanation for the changes that were made. We cannot send a report to the Congress without clearing it through the Department and reconciling it as best we can with other obligations we have, and indeed getting the administration's support through the OMB. Each of the elements in the chain are affected by that.

Senator CHILES. I understand that, but those changes and the tradeoffs that are made are something that we would become vitally interested in in trying to determine what drove those decisions, and in order for us to be able to explore that I think we have to have people who actually participated in those decisions themselves. I think, really, because the other witnesses from the GAO are going to be also concerned with responding on some of the issues that we had here. I really want to apologize to the other members of the committee, but I think that we really ought to recess now and reschedule this when we can have Mr. Champion or the Secretary come before us.

Senator HEINZ. Mr. Chairman.

Senator CHILES. Yes, sir.

Senator HEINZ. I agree with the Chairman. I remember, on far too many occasions, when I served in the House of Representatives the Nixon administration would get hold of something the Congress would ask for and it would never see the light of day again. It concerns me, as it does the Chairman, that we are once again being put in a box where Congress cannot have the information it needs to legislate. The Department of HEW is created by statutory mandate from the Congress—it is not created by the Office of Management and Budget. Therefore, since the Secretary, Under Secretary, and others are confirmed by the Congress, the Senate being the body confirming on behalf of the Congress, there is a legislative requirement in the law that you report to us, not to OMB.

I think, Mr. Chairman, that the administration has done itself harm, second only to the harm they are doing to our senior citizens. We will have lost, as a result of this absolutely indefensible meddling by OMB, the better part of 2 years. We all know the demographics of how more and more senior citizens are going into the above 80 years of age category and of the groups which need home health care. Thanks to OMB, they are going to be without the benefit of anything that we in the Congress wish to consider. So it seems to me that the Carter administration has shortchanged not just the Congress, but also our senior citizens, and I hope that is what you well recognize.

I would like to join you, Mr. Chairman, and Senator Domenici, in getting some answers from Mr. Champion and Secretary Califano as to why they want to shortchange the senior citizens.

Senator CHILES. I think it might be appropriate if we do submit a full list of the questions we would like to see answered, and I would ask all of you to submit, through your staff or through the full committee staff, questions so we can send them to the Secretary.

Then maybe we can have a good hearing and try to get some of the answers to these questions.

Mr. BOHEN. Mr. Chairman, I just would like to be sure that nothing I said left Senator Heinz with the impression that the primary responsibility for review and decisionmaking on this report took place in OMB. There were certain aspects of the report that indeed were reviewed by OMB because they raised issues of both policy and budget, and the Department and agency is under the obligation to clear those, but the final responsibility for both the development of the report and then the handling of it rests in the Department, and I am sure either the Secretary or the Under Secretary would agree that we, not OMB, bear this responsibility.

Senator CHILES. Mr. Secretary, I think you performed courageously under fire and charged into the cannon, and we thank you very much for your appearance.

We will recess our hearing now.

[Whereupon, at 11:15 a.m., the hearing was recessed.]

HOME CARE SERVICES FOR OLDER AMERICANS: PLANNING FOR THE FUTURE

MONDAY, MAY 21, 1979

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:35 a.m., in room 1318, Dirksen Senate Office Building, Senator Lawton Chiles (chairman) presiding.

Present: Senators Chiles, Glenn, Pryor, Heinz, and Cohen.

Also present: E. Bentley Lipscomb, staff director; Kathleen M. Deignan, professional staff member; David A. Rust, minority staff director; Tony Arroyos, minority professional staff member; Theresa M. Forster, financial assistant; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR LAWTON CHILES, CHAIRMAN

Senator CHILES. We are reconvening today to continue this hearing which I recessed on May 7. It was the sense of the committee at that time that we should have either Secretary Califano or Under Secretary Champion appear before us to explain why this home health care report makes no substantive recommendations, sets forth no options as to policy directions and goals, and certainly does not indicate a coordinated focus within HEW on the issue of long-term care.

It seems to me that the Congress in requesting this report could be likened to a group developing a subdivision. They would go to an architectural firm and ask for a plan or blueprint laying out the options and costs associated with the proposed development. Instead of getting our plan, we are now being told that the 50 States, like 50 builders, are putting into place programs which, by analogy, range from vacant lots to mansions—all of this without policy, guidance, or long-range goals which would assure any overall coherence.

We are told with this report, and we have been told before, that we don't have the knowledge and experience to lay out a policy or plan. Congress has asked for and funded demonstrations under medicare and medicaid since 1972. Congress has given demonstration authority and funding to the Administration on Aging. I pushed in the Appropriations Committee for more money for long-term care demonstrations in the Health Care Financing Administration. I am not sure what it will finally take, or how long it will take, to get policy or focus or responsibility for this vital area.

Since one of the main problems, we are told, is a lack of information, we will take testimony first from the General Accounting Office on a new and promising information system they have developed and then we will hear from Under Secretary Champion.

Mr. Ahart, if you would introduce your colleagues to us.

STATEMENT OF GREGORY AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY WILBERT AMMANN, SYSTEMS ANALYST, AND WILLIAM LAURIE AND THOMAS WALSH, SUPERVISORY AUDITORS

Mr. AHART. Thank you, Mr. Chairman.

On my left is Mr. Ammann who has had a heavy hand in the development of the study. On my right are Tom Walsh and William Laurie.

We are pleased to be here this morning. I understand that you are a little bit pressed for time, so I will try to be as brief as I can and offer my full statement for the record.[1]

We are pleased to be here today as your deliberations focus on planning for the future of home care services for older Americans. My comments, as I have indicated, are based on our proposed report to the Congress on the conditions of older people and the need for a national information system for long-term planning for the delivery of services to older people.

To design and plan for the delivery of services to older persons, society, the Congress and the executive branch need information on: (1) Their well-being, (2) what factors make a difference in their lives, and (3) the impact of services on the well-being of older people. Currently, this information, to the extent it is available, is spread piecemeal throughout Federal, State, local, and private agencies. As a consequence, Federal agencies have not evaluated the combined effect of these services; and, in the absence of such information, it is difficult to assess the impact of various programs on the lives of older people.

Based on our study of the well-being of older people in Cleveland, Ohio, we believe it is possible to collect, measure, and evaluate information on the personal conditions of, and services to, older people.

Our study shows that information from such a system can be used in multiprogram evaluations which can: Measure the current conditions of older people; identify the current cost of helping older people; demonstrate the effects of help on improving the problems and conditions of older people; and estimate future costs of helping all older people in need and costs of alternative kinds of help.

We used an interview instrument that was developed with Federal funding. We interviewed older people at one point in time and reinterviewed them a year later.

In the process, we measured the change in our measurement of their well-being in five areas—social, economic, mental, physical, and the activities of daily living.

We also developed specific definitions of 28 services being provided to older people and the techniques for quantifying those services. We identified the providers of services, including family

[1] See appendix 1, item 3, page 53.

and friends and over 100 social service agencies. We obtained information about the services provided to each person in our sample and the source and intensity of these services. We also developed an average unit cost for these services based on the cost experience of Federal, State, local, and private agencies.

Each piece of data was collected so that it could be related to an individual in our sample. By relating these data to the individual, we were able to make comparative analyses of sampled older people for over 500 different variables. We believe that these kinds of measurements are important to an information system.

We measured the personal conditions—health, security, loneliness, and outlook on life—and I have included in appendix I [1] to my prepared statement definitions of these four conditions. We also combined these conditions into an overall condition for each person. About a third of the sample were in the best overall condition. At the other end of the spectrum, more than one-fifth were in the worst condition.

An information system should contain data on illnesses and the degree these illnesses lead to many older people having trouble doing routine daily tasks. As older people become more and more impaired in their ability to do daily tasks, their probability of being institutionalized increases.

Nearly all of the people in our sample had one or more illnesses. However, for many the illnesses did not greatly interfere with their activities. The most common illnesses that greatly interfered with activities were mental impairments, arthritis, circulation trouble, heart trouble and high blood pressure, as you would expect. These illnesses, along with the wearing out process of aging, lead to many older people, some 39 percent, having trouble doing routine daily tasks.

We think an information system should also have the capability for measuring change in conditions over time. One year after our first interview, we reinterviewed most of our original sample. The overall personal condition of older people improved for 18 percent and declined for 18 percent. The most change was in the outlook on life condition followed by security. The least change was in loneliness and health.

Helps provided by family and friends are significant. The ability to identify the kinds and costs of these helps is crucial and, consequently, another important element of an information system.

We found that older people could receive six kinds of help: (1) Treatment for illnesses; (2) compensatory help to compensate for an older person's inability to do daily tasks; (3) financial help, of course; (4) social and recreational help; (5) care-giving help when the older person feels there is no one to provide care if he or she becomes sick or disabled; and (6) developmental help—for example, educational and employment services—to enrich the life of the older person.

In Cleveland, the annual cost of providing these kinds of help averaged about $6,600 a person. Various agencies provided about $4,600 worth of help, and family and friends provided the remaining $2,000. The greatest portion of help is financial, the next greatest is compensatory help with daily tasks and then medical.

[1] See page 58.

The results of our work are not statistically projectible to the entire country because we cannot demonstrate that Cleveland is typical. However, to illustrate the information that could be obtained from a national information system, we have made national estimates for the 21 million noninstitutionalized older people 65 years old and older in the Nation. I want to make it very clear that the estimates I will be presenting were not made on a statistical basis but were done for illustrative purposes only.

Mr. Chairman, based on our work—which was based in turn on work that had been done by HEW in the past—we recommended that HEW build the kind of a national information system which would tell the Congress and the executive branch the conditions of people, what their characteristics are, what kinds of help they need, where the gaps are in Federal, State, and local programs, and so on. Such a system is needed to get the kind of information that we believe the Congress needs when it takes up consideration of such things as home health services and the other kinds of services that older people need. With this system, we would have a better feel for just what it is that is needed out in the country and to better structure our program—or several programs—to meet those needs.

We have presented these recommendations to HEW. We believe that the methodology that we have built is sound. We ran this by a lot of experts around the country and they agree that it is sound and that the HEW ought to take up the ball at this point and build the kind of a national information system which would be very helpful for policymaking purposes.

We have received an informal response from HEW. We are disappointed, quite frankly. It recognizes the merit of the research that we have done and of the methodology that we have developed, but it stopped short of agreeing to go ahead with building the kind of an information system that we believe is necessary. HEW has taken almost a wait-and-see attitude—saying they want to work with other systems, get more information, and see what they can put together before they try to put together a comprehensive national information system which we believe is important in this area.

That briefly summarizes my statement, Mr. Chairman, and we will be pleased to answer any questions that you might have.

Senator CHILES. Why do you think such a system has not been developed within HEW today?

Mr. AHART. I think part of the problem, Mr. Chairman, is the fragmentation that we have. As I mentioned in my statement, we have a lot of pieces of information that are housed at State, and local, and private agencies, and various parts of HEW. A lot of different information systems working, but none of them go to measure the overall well-being of the older population. I think it is not just a difficulty in HEW, and I think the Government as a whole should try to put these things together, in terms of an overall well-being of people as opposed to one specific need, another specific need, another specific need at the State, local, or Federal level.

Senator CHILES. Is it possible to compare the present systems that they have, or the information that they have, coming from

some of their present systems? Can HEW correlate and prepare the information that they now are receiving from all these different programs?

Mr. AHART. That can be very difficult because all the information systems are built on different bases and deal with different aspects of individuals. I would like to ask Mr. Ammann here, who is an expert in information systems, to comment further on the difficulties of putting that kind of information together.

Mr. AMMANN. Yes, I would like to comment on that. The information picked up by questionnaire varies for every contract and grant and can't be aggregated, particularly when it is based on different concepts. You can find correlations between the different variables, but that won't allow you then to say that there is this percent of people out there that had this percent of characteristics and that percent that had that kind of help. Nor will it allow you to generate data on change over time. A lot of the data is cross-sectional rather than longitudinal, which does not allow you to see a person change or why that person changes.

Senator CHILES. You have recommended that HEW adopt a system and you said that you are disappointed in their response. Did their response indicate that they feel that their present systems are sufficient?

Mr. AHART. Well, it seemed to me their informal response, Mr. Chairman, indicated they want to wait to see what could be done by putting together the various studies that are ongoing with information from the various data systems which are now in place, as opposed to taking the initiative to put together a more comprehensive and, in our view, a more usable system for policymaking purposes.

Senator CHILES. How often do you think this information should be gathered, and how much would it cost to come up with a system capable of making national measurements and projections?

Mr. AHART. Well, we think the kind of a system we are talking about ought to be in 5-year waves; in other words, collect the data each 5 years, perhaps in conjunction with a census-taking operation. As far as cost is concerned, based on estimates of the type of work by the Census Bureau, to gather the data on the individual sample and their well-being would cost in the neighborhood of three-quarters of a million dollars.

Senator CHILES. Three-quarters of a million dollars. That would be a one-time basis, it would not be costing that every 5 years after that?

Mr. AHART. Well, it would be costing that every 5 years for that data gathering part. Another part would be gathering information on the services that are delivered to the people during that same time frame, and we really don't have an estimate on that. At the same time, although three-quarters of a million dollars sounds like a lot of money, it strikes us that we have an awful lot of systems out there that you cannot aggregate since both State and local area agencies on aging have to make a needs assessment. Further, the needs assessment that is now going on is not in a form which could be aggregated for national policymaking purposes.

Senator CHILES. Could this system be used for analysis of other issues? Could it be used, for example, to determine how and when

older people are more likely to enter an institution or whether it would be necessary for certain groups to enter into institutional care?

Mr. AHART. Yes, we think it could, Mr. Chairman. Our sample was not large enough to make it a good measurement of how many people would be expected to enter institutions and what conditions they would be in. But at the same time, we feel that if you properly structured a national data system you could get some good measurements of the need for long-term institutional care and of the conditions of people that need that kind of care.

Senator CHILES. You use the term compensatory and care-giving help. Are you talking about home care services and transportation when you are using those terms?

Mr. AHART. Yes, that is part of it. I will ask Mr. Ammann to expand on what we mean by those two terms.

Senator CHILES. All right.

Mr. AMMANN. That means help that you give to someone to enable them to do something without removing their capability to do it themselves. In other words, if you go shopping for them when they cannot go shopping, you are just compensating for their inability to go shopping. That is compensatory help.

The care-giving help is that kind of help that we use to let older people know someone will help them if they need it, like outreach and information and referral. It is designed to help older people who don't know someone that will care for them, to at least feel somebody out there knows about them and will provide help if needed.

Senator CHILES. You say 76 percent of this kind of compensatory help is now being provided by family and friends and the rest by government. Do you have any projections of how many people who need this kind of help are not receiving it from any source?

Mr. AHART. I think we have that data. Mr. Walsh can respond, I believe, Mr. Chairman.

Mr. WALSH. Yes, sir, Mr. Chairman. In our sample about 16 percent of the older people were in need of more compensatory help and about 9 percent were in need of more care-giving help. If you look at that on the national basis, that would be about 3.4 million people in need of compensatory and 1.9 million in need of care-giving help.

Senator CHILES. Then about 84 percent of the people are receiving compensatory help either from family or friends or the government, but there are some 16 percent that are not, and then about 91 percent of the people are receiving some care-giving help.

Mr. WALSH. Yes. A portion of those are not in need. Roughly, nearly all of the 91 percent would not be in further need of care-giving help.

Senator CHILES. Sixteen percent are in need of compensatory help.

Mr. WALSH. Yes.

Senator CHILES. Does your analysis identify incentives to encourage family members and friends to provide more help to older people?

Mr. AHART. Let me ask Mr. Laurie to respond.

Mr. LAURIE. Our analysis does not get into that. Unfortunately, it does not get into the alternatives, or incentives or what impact they would have. Given a longer period of time, however, you can design the information systems to provide that information because you can watch for changes after the implementation of tax incentives and see what happens as far as the level of help from family and friends is concerned.

Senator CHILES. So it could predict changes in factors that would provide either encouragement or discouragement to the family to care for older persons or changes in the use of public services as well?

Mr. LAURIE. Yes, sir.

Senator CHILES. Senator Cohen.

Senator COHEN. Thank you, Mr. Chairman.

Gentlemen, the reason you are here today is that the Congress, by law, mandated that the HEW come back and comply with a request for a report of established guidelines for a national program for home health care. In fact, we got a report that was 6 months late at the expense of $62,000, as I recall, that did nothing more than simply to state the confusion or fragmentation that currently exists in the departments and agencies in the programs we are currently running. We will have a witness from HEW following your presence here this morning, but it is my understanding that you did present your information to HEW, is that correct?

Mr. AHART. A draft of our study is with the HEW for comment. We have received informal comments.

Senator COHEN. It is clear that HEW did not make use of the information and principally because of, No. 1, budget constraints according to the report; and No. 2, a lack of information—which certainly does not seem to be the case if they had in fact accepted your report and included it in some fashion in the report that they were to submit to the Congress—and third, the statement just given to Senator Chiles, what the impact will be on the family. It seems to me, in listening to your testimony, you have done some studies to find out what the impact would be.

I have a question which has caused some confusion in my mind. I noticed from the report that has been filed by HEW that they list medicare expenditures for fiscal 1979 as $724 million and in your report you have $786 million. The GAO report just released is dated May 15, 1979. Do you have any explanation for that discrepancy?

Mr. AHART. I am not familiar with the figures you have, Mr. Cohen.

Senator COHEN. Well, I can pass over that for the time being and later you can submit that for the record so we can find out why there is this discrepancy.

[Subsequent to the hearing, Mr. Ahart supplied the following information:]

The difference between the two figures is that one includes estimates for home health services for the disabled and the other does not. The 1979 budget shows the following breakdown of estimates for home health services for fiscal year 1979: Aged, $724 million; disabled, $62 million.

Senator COHEN. On page 9 of your statement, you indicate:

Our illustrative projections nationwide for the 65 to 69 age group over the next 20 years show that if medical treatment were expanded to all in need, total medical costs over the 20 years would be slightly decreased from $4.5 billion to $4.3 billion.

Is that for the total 20-year period or on an annual basis?

Mr. AHART. That would be an annual figure, Senator Cohen.

Senator COHEN. That is on an annual basis. You say:

Also, the cost of compensatory help would be reduced significantly due to the effects of expanded medical treatment from $12.6 billion to $11.4 billion. In total, a reduction of about $1.4 billion results—$1.2 billion in compensatory help and $.2 billion in medical treatment.

Again, that is on an annual basis?

Mr. AHART. That would be an annual figure also.

Senator COHEN. I think that is important to take into account the kind of savings we are talking about, particularly in view of the fact that the President's cost containment program is estimated to have a first-year savings of about $403 million. That is a significant amount less than the kind of cost you project, as far as having home health care and the range of treatment that we would like to see develop.

I don't believe I have any more questions other than have you seen the HEW report that has been filed with this committee?

Mr. AHART. Yes, we have had an opportunity to look at that report.

Senator COHEN. Did you also have the opportunity to compare it with prior draft reports submitted?

Mr. AHART. No, I don't think we had that opportunity, sir.

Senator COHEN. All right. I would like to have you also take a look at the earlier draft reports, in that there has been significant changes from the submitted report, with the simple statement that information is not available. I think that that is what we are trying to explore this morning.

Thank you, Mr. Chairman,

Senator CHILES. Senator Glenn.

Senator GLENN. Thank you, Mr. Chairman.

Mr. Walsh, in your review of the Cleveland situation, was this done in Cleveland proper, within the city limits, or within the whole county area?

Mr. WALSH. It was within the city limits.

Senator GLENN. What kind of opinion do you have as to the applicability of this to other areas, or how well this would represent the general population across the country? Do you have any feel for that?

Let me give you a little background. In Cleveland proper there is a very high ethnic community, as you are aware, and they tend to have a cohesiveness and a loyalty to family members. There are probably more family members taking care of family members than might be applicable in the population at large across the country. That is the reason I asked the question. Do you think that the figures in the studies developed out of Cleveland are generally applicable to the general population?

Mr. AHART. As I pointed out in my statement, Senator Glenn, we cannot make a projection from the Cleveland sample because we cannot stipulate that Cleveland is typical. There are a lot of different factors that go into that. What we did was make some national projection to illustrate to you and to the public the kinds of infor-

mation that you could get from a nationally based information system which we think would be quite useful. The numbers that I was talking about with Senator Cohen are not firm statistically sound numbers but they do show the kind of information that we could get from the national information system built on this model with whatever improvement can be made to it as it is developed further. Such a system could give a national projection, and if it was designed properly, it could also give numbers for Cleveland, Chicago, New York, and other cities or area agencies, depending on how refined you wanted to make your statistical sample.

Senator GLENN. I think you found that 8 out of 10 people sampled received service from family or friends in Cleveland. I conducted a hearing for the committee in Cleveland in July 1977. I think that Cleveland is an excellent test tube to look into what is working and what is not working in certain areas. They had, I believe, 134 different organizations or agencies that were working with the elderly, and it was a matter of coordinating many of their activities, some of which has been done within Cleveland itself, to a fairly sophisticated degree. That is the reason I was wondering whether this would really be typical of all places across the country, as far as setting up a national program.

Mr. AHART. I might just mention, Senator, that we were very much impressed with the degree of cooperation we got from the agencies in Cleveland when we were making our study. In particular, the Cleveland Foundation gave us a lot of help in the early part of our study, and I think they have been very supportive of the objectives we had in mind. Mr. Walsh can comment on the degree of cooperation we got. I think we can say almost universally, 100 percent, from everybody out there.

Mr. WALSH. Yes, sir. All the agencies, with the exception of one, agreed to give us data which involved sometimes up to a week of going through their records to find the services that are being provided. I might also add that as a result of having this data available to the people in Cleveland, we were able to use it as a tool to further that coordination which you are talking about. We have had several meetings with the people from the agencies in Cleveland and find them using the data that we have got. They are using the same terms. They are communicating much better because they are using the terms and services that we talk about and they are designing their information systems so they can use ours and compare the people they serve to the city as a whole. For example, the Benjamin Rose Institute used the same methodology on everybody who is served through their service centers.

Senator GLENN. How much of the information that you were gathering concentrated on government programs or established community programs as opposed to family care? What we would like to be driving toward is families taking care of families. Sometimes that is not possible. Families are spread all over the country. A daughter may be in New York, a son in San Diego, and a father and mother in Oklahoma City; it is a difficult situation. We would all like to go back to a time when families took care of families, and it did not become a big Federal responsibility.

What I am asking is how much did your study delve into why and how families do take care of families, or friends take care of

friends? This would be the ideal situation. I would like to see any Federal program which would encourage people taking care of people, at their own level, rather than having some new big federally mandated program come out from Washington, valuable though it may be. Did your questioning, and did your information, develop any facts or patterns that would help us do something that could encourage activities at the local level that would encourage and assist families to take care of families?

Mr. WALSH. We did not get into the whys or the incentive that could be provided to get family members to provide more help. What we did do is capture what is going on. For example, 30 percent of the total help that was provided to the older people in our sample did come from the family members and friends and most of that was compensatory help. We made some further analysis which would support what you are saying in terms of the dollar savings.

For example, we estimated that to provide compensatory help to everyone who needed it would cost an estimated $10 billion. However, if the family and friends of older people could be encouraged in some way to provide expanded help, in the same proportions that they are now helping that would amount to about $8 billion. This would mean about $8 billion savings in terms of what the public sector would have to provide. So it certainly does support the value of that type of an approach.

Senator GLENN. The sampling showed $6,617, I believe it was, expended per elderly person, of which $2,001 came from family and friends, and the remainder of $4,616 came from government sources. Do you have any breakdown of figures as to what percent of that was Federal funding?

Mr. WALSH. Most of it, about 90 or 95 percent, was federally funded.

Senator CHILES. Do you have further questions, Senator Glenn?

Senator GLENN. No. Thank you.

Senator CHILES. Thank you. Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman. I was not here in time to hear the testimony of Mr. Ahart of the GAO, but I do think in looking it over relatively quickly, it is a very helpful starting point and could easily have been a starting point for HEW in meeting the mandate of the Cohen amendment. I will have a brief statement when Mr. Champion is introduced, but I would like to request that my prepared statement be put in the record at this point.

Senator CHILES. Without objection, Senator Heinz' statement will be entered into the record at this time.

[The statement of Senator Heinz follows:]

STATEMENT OF SENATOR JOHN HEINZ

Mr. Chairman, I am extremely disappointed with the final report on home health care which HEW has sent to the Congress.

For some time, the Congress and the Nation have recognized our all too easy acceptance and overreliance on institutionalization as the principal means of providing care for the frail elderly. All too often an elderly person is forced to enter a nursing home, even though they could, with the appropriate support services, continue to live in their own homes. We have relied on institutionalization because it was readily available and made so available through medicare and medicaid, where

at least seven-eighths of each Federal dollar goes for institutionalized care of the elderly.

In many situations, home health care services are preferable and desirable to institutionalization. Clearly, such services should be made available to more older Americans, and evidence has been accumulating to suggest that it could be made available to larger numbers of people at less cost than comparable nursing home care.

While sensing the urgent need to completely make home health services an integral part of our health delivery system for the elderly, Congress in 1977 also recognized the need for additional information regarding home health care services under titles XVIII, XIX, and XX of the Social Security Act. We need to know (1) the most effective combination of home health services and institutionalized care, (2) ways to coordinate home health services between the three programs, (3) ways to assure the quality of services provided, (4) ways to make the administration of the program more efficient, and (5) ways to curb fraud and abuse. With extensive information being gathered by then Department of Health, Education, and Welfare, the Secretary was viewed as being in the best position to provide such information, and thus help Congress set some direction for home health care.

My colleague on this committee, Senator Cohen, expressed the will of the Congress in 1977 with his amendment to H.R. 3, the Medicare and Medicaid Fraud and Abuse Amendments, which required the Secretary of HEW to report to Congress on the home health and other in-home services authorized under titles XVIII, XIX, and XX of the Social Security Act.

This legislation specifically mandated that the report be submitted "no later than 1 year after the date of enactment of this act," which made the deadline October 25, 1978.

Further, this legislation specifically mandated that the report include recommendations for changes in regulations and legislation so that Congress would have information on policy options before making statutory changes necessary to improve the program.

The Cohen amendment specifically mandated that the report include "an analysis of the impact of implementing such recommendations of the cost of such services and the demand for such services, and the methods of financing any recommended increased provision of such services." This would have provided Congress with the information on financial implications of any statutory changes.

This legislation specifically directed the Secretary of Health, Education, and Welfare to prepare and submit the report to Congress, since HEW administers the programs and had conducted field hearings on home health services.

This is what we asked for in October 1977. Instead, we have been sent the report on home health and other in-home services of the Office of Management Budget, 6 months late, completely devoid of any recommendations for statutory change and devoid of recommendations for any legislative policy options, "because of budget constraints."

The intent of the Congress was not for OMB to decide which recommendations might fall within the President's fiscal year 1980 budget, but to obtain information on the options for statutory changes with their funding implications. The Congress will then decide which recommendations to pursue.

Let me remind HEW that the expenditure of any funds and the authority for spending lies entirely with Congress. We are fully cognizant of our budgetary restraints and realize that some recomendations may require additional funds to implement. Let us know what these legislative recommendations are, with their program costs, and the Congress will take the responsibility for evaluating them.

Two weeks ago, the statement of the HEW witness indicated that legislative recommendations were contained in earlier agency drafts, but none "gained the support of the Secretary nor the administration." I for one would be interested in knowing about these recommendations and why they did not gain the support of the Secretary nor the administration.

Mr. Chairman, this report is once again evidence of the Department's inability to develop, agree on, and enunciate a position on home health care services. It is indicative of the fragmentation within the department and contributes to the department's inability to formulate a comprehensive long-term care policy. One of the most repeated frustrations I heard voiced last year during hearings I held on the Federal nursing home standards was the lack of a comprehensive long-term care policy. This even though we have had repeated assurances from HEW that a long-term care policy was being developed.

This report, I believe, is also indicative of the flagrant disregard the Department of HEW has for Congress.

I think it is also indicative of the Department's general level of awareness that the report should be sent to this committee addressed to the Honorable Frank Church, Chairman of the Senate Special Committee on Aging, House of Representatives.

Mr. Chairman, this report does not meet the requirements for the report as mandated in section 18 of Public Law 142. The statute requiring legislative recommendations is a mandatory directive—nothing discretionary about it. This report is inadequate and unacceptable to the Congress, and I doubt that today's witness will provide us with the requisite legislative recommendations.

Mr. Chairman, I suggest that we join our colleague Senator Cohen in sponsoring the resolution to reject this report and return it to the Secretary to be completed as stipulated in the statute.

Mr. AHART. I might make a clarifying comment.

Senator CHILES. Yes, sir.

Mr. AHART. I think the type of approach we have used is certainly a starting point for the policymaking information that this committee is searching for. I don't think it would be fair, in conjunction with the study that has been supplied to this committee, to say that HEW should have used this as a starting point because it was not available at that point in time. This is something that would take time to put into effect nationally. I think it would eventually provide, however, the kind of information necessary to do a better job than is now possible in measuring the need for home health services and other kinds of services for the elderly.

Senator CHILES. Senator Pryor.

Senator PRYOR. The system of accounting, or the projection method that you used in GAO, is that system today capable of projecting and comparing costs between home health care services per individual versus the cost that we are expending per patient in a nursing home? Do you have that capability of comparison?

Mr. AHART. It is a little bit difficult. I think what you can do is determine, over time, what kinds of people need institutionalization and what kinds of characteristics they have. The sample we used in Cleveland did not include people that were already institutionalized. But we did do a study which measured the cost of helping those people with a chronic condition, and we found that it becomes more economic to treat them at an institutionalized setting as opposed to treating them in the community through health services and other kinds of caregiving and compensatory care. I think, over time, yes, this could be measured. As I mentioned in response to an earlier question, I believe our sample was not large enough and not over a long enough period of time to capture very many people that moved from a home setting into an institution. So our data base is not rich enough to address that, but with the national sample and over a longer period of time, we feel that this would be possible and would be very useful.

Senator PRYOR. I also think that there must be some difference in cost between the rural area of America, vis-a-vis, that of an urban area such as Cleveland, and I don't know whether that has been or will be taken into consideration or not.

Mr. AHART. Well, this could certainly be taken into consideration in a national sense. Certainly, with just a study of Cleveland, you cannot measure those kinds of regional or geographic areas.

Bill Laurie may want to comment.

Mr. LAURIE. We are currently doing work on comparing rural population to Cleveland. We have two similar data bases that have

been developed in Oregon and Kentucky. Your committee has requested that we look into the data bases to see the differences between the well-being of the rural population versus Cleveland and also to get at, if we can, the support coming from the family, from friends, and from the agencies that are in that area. That currently is ongoing and we don't have the results yet. We are now feeding the data into the computer and we will be supplying that information to you.

Senator PRYOR. That is all I have at this time.

Senator CHILES. We thank you very much for your testimony.

Senator GLENN. Mr. Chairman, may I ask one more question?

Senator CHILES. Yes, sir.

Senator GLENN. How much more study do you think is necessary? Some of the programs are good. We should start right now, as opposed to waiting for a study on into the future, while people languish in their inability to take care of themselves. We should move ahead with some of this without waiting for a 1-year, 2-year, 3-year study, or whatever it is.

Mr. AHART. Our interest here this morning is to try to get the data base in being that will help over a period of time. I don't think we would have anything to say about whether there is or is not a particular program that should go ahead.

Senator GLENN. I understand that, but you have all looked into this and you have looked at the problems and you have looked at it through the other members of the committee. Do you think there are parts of this that we can move ahead on now?

Mr. AHART. We were supportive of proposed amendments to the home health portion of medicare which would expand home health services. Our support was based in part on the study we did in Cleveland, because we found these services would not cost that much more, and we feel would be supportive and very helpful to the older population. We gave testimony about a year ago on that, and we could provide more details on that.

Senator GLENN. We have to have information on which to move, I realize that, but sometimes our Washington solution is that we recreate another study, and I just would not want to see that happen. I know we have to have information.

Thank you, Mr. Chairman.

Senator CHILES. Senator Heinz.

Senator HEINZ. Mr. Chairman, my understanding is that GAO did this study on their own initiative. Is that correct?

Mr. AHART. That is correct, Senator Heinz.

Senator HEINZ. I appreciate your statement earlier that this was not available to HEW or to any of the agencies in HEW, AOA, Health Care Financing, Public Health, or any of the other agencies that are charged with being generally concerned about the conditions of people, including senior citizens. I might say, Mr. Chairman, I think it is remarkable that the largest bureaucracy in Washington, D.C.—namely, HEW—apparently has done nothing on their own initiative in this area. GAO has done many things that we required of them. They operate day after day trying to meet a variety of requests of committees of Congress and Members of Congress. I think we should commend GAO for their initiative because frankly, gentlemen, if you had not done this we, I suppose,

would still be waiting for HEW to do something, and we might just as well wait until the cows come home. So we sincerely thank you.

Now I do have one specific question. If this has been asked previously I apologize, Mr. Chairman, and please indicate if it has.

In that relatively large collection of agencies and bureaus and offices at HEW, why isn't there anyone down there who might have thought, some time between our last committee meeting and some future point or some past point, that some basic information might be a good thing to have? Who should we look to, if anybody, at HEW for some sense of responsibility and initiative in this area?

Mr. AHART. Well, I would have to comment that during the course of our study we received a high degree of cooperation from the Administration on Aging, which is the focal point for information gathering on older people in the Federal Government—I think that cooperation has been quite good. They have had an awful lot of interests in the study that we have done. They have asked for a transfer of our data base to their archives, as well as the methodology which we developed, which I think is a kind of a breakthrough. We would expect them to build on the work that we have done, as we built on the work that they had done at Duke University and elsewhere, in upgrading methodology on the analysis and collection of data. We would expect them to go forward with a national information system building on our work.

I think, as far as looking for information on the elderly population, the focal point should be the Administration on Aging within the Office of Human Development Services and I would expect them to go forward. I say we are a little bit disappointed with their response to our study because it does not indicate that they will go forward very swiftly.

Senator HEINZ. Mr. Chairman, if I may just continue.

It troubles me that a very large Department such as HEW, which should have the capacity to assemble information, analyze it, and evaluate it, and develop planning options based on it, is apparently unable to do so. Again, we commend you for your initiative, but frankly, in many respects the mandate of GAO is to make sure that when we do something we do it right. When the agencies downtown do something they can learn from the oversight of GAO, either on their initiative or on our request. But we are talking, it seems to me, and maybe I am underestimating your study, but I don't think we are, about an incredible breakthrough when we ask HEW to give us information and evaluate that information and draw conclusions from it. They may not have hit upon your particular method of doing this study. Is that a valid criticism of HEW or not?

Mr. AHART. Well, it is to some degree, Senator. I think we have an awful lot of program fragmentation. When we did our study, we looked at a lot of different Federal, State, and local programs. Each one of those depends for data generally on that which is gathered for program operations. As Mr. Ammann pointed out in response to a previous question, unless you have the same conceptual framework for your data gathering, it is very difficult to aggregate across program lines and come up with something that is very easy to work with in the national policymaking framework, It is much more useful if you are talking about a particular program at a

particular location than it is to try to gather it all up and analyze it across program lines.

Yes, I think HEW should have a leadership role in building the kind of information system which is useful for policymaking, but at the same time they had a fairly short time frame. I think it is not surprising that they could not pull together all the information across program lines and get the answers to the kinds of questions that we are searching for in the national information system. So it is a yes or no kind of an answer.

Senator HEINZ. Thank you, Mr. Chairman.

Senator CHILES. Thank you very much for your testimony.

Mr. AHART. Thank you very much.

Senator CHILES. The ranking minority member of our committee, Senator Pete V. Domenici, is unable to be with us today. He has submitted a statement for the record, and without objection, it will be inserted at this time.

[The statement of Senator Domenici follows:]

STATEMENT OF SENATOR PETE V. DOMENICI

Mr. Chairman, I am pleased to join with you in resuming the Special Committee on Aging's hearing on the H.R. 3 report and the future of long-term care in this country.

I am delighted that Under Secretary Hale Champion will be appearing before our committee this morning. Unlike the HEW witnesses who were sent to testify on May 7, Mr. Champion is clearly one of the top policymakers in the Department and the individual who is reported to have been responsible for overseeing the handling of this report. I believe that Secretary Champion can provide us with direct and explicit answers to our questions on this report. I look forward to receiving his testimony.

Mr. Chairman, regardless of how well Mr. Champion explains the policy considerations before us today, his testimony cannot, in itself, correct the deficiencies and incompleteness of the report which was transmitted to the Congress on April 16. I remain firmly convinced that the Congress should return this inadequate report to the Department with instructions that they carry out the legal mandate required them in Public Law 95–142. I firmly support the resolution proposed by the Senator from Maine (Mr. Cohen), which would achieve this objective.

Senator CHILES. We will now hear from Under Secretary Champion. If you have a statement, we will be happy to have you submit it and we will put it in the record and allow you to go on from there. Whichever way you would like to proceed.

STATEMENT OF HON. HALE CHAMPION, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. CHAMPION. If I may, Mr. Chairman, I would like to read the statement. I will try to get through it as quickly as possible. It is not a long and comprehensive statement, it just tries to set out some position.

Senator CHILES. All right.

Mr. CHAMPION. I am pleased to have this opportunity to answer questions you may have on the Department's report on home health services.

The Department's report, mandated by section 18 of Public Law 95–142, better known as H.R. 3, documents the growth and the cost of home health care under medicare, medicaid, and title XX.

Medicare expenditures for home health care rose from $100 million in fiscal year 1974 to a projected $724 million in fiscal year 1979.

In answer to that earlier question regarding the difference between this and the figure offered by GAO, it may be that they are using an estimate at a different point in time. We keep updating the estimates and we are still within the fiscal year. We will look into that and find out what problem, if any, there is.

Some 393,000 medicare beneficiaries received home health benefits in 1974, compared to over 530,000 today.

Medicaid expenditures for home health care increased from $24 million in 1972 to $179 million in 1977.

In the same period, the number of medicaid recipients who used home health services more than doubled, from 113,000 to over 260,000—medicaid in-home benefits still amount to only 1 percent of total medicaid expenditures.

Most States spend a substantial portion—at least 10 percent—of their title XX budgets on home health services. California actually spent 62 percent of their title XX money for this area.

The Department's report examines a full range of issues relating to problems in the delivery of in-home services and assesses current problems that must be resolved in order to improve the quality of these services. Candidly, I think that one of the problems here is that we don't know as much as we should about some of those problems—that we should know about—and we can deal with that later.

You are well aware that preliminary drafts of the report, prepared by the Health Care Financing Administration, contained legislative and budget proposals addressing some of these issues, and you are aware that these recommendations were not approved by the Department. Let me just tell you quickly the process we go through and why this would happen.

The Health Care Financing Administration did that report on its own without participation of the other major interested departments and agencies in HEW—some of those were referred to by Mr. Ahart. When that report came forward, it was then examined, as is our regular practice, by all of the other line and staff agencies that had an interest in this subject—and there are a lot of them. There were many disagreements in this case—not only disagreements as to what ought to be done, but as to the advocacy of the reporting recommendations and so on. After some discussions back and forth failed to resolve those disagreements, the report came to my office for a series of decisions.

That accounts for the differences in the report that you have and the draft report that was originally prepared by HCFA. Since it became clear there was a kind of deficiency involved in this process, we have put together a departmental task force to make sure that all of the people who should be are involved in the basic working out of a report to avoid a repetition of that problem.

The administration is not recommending any service or eligibility expansion of home health care at this time under titles XVIII, XIX, or XX, and therefore none were submitted to the Congress. Quite simply, as you have heard before, we do not currently have enough knowledge to make bold changes in how home health care services are delivered. Even small policy shifts can often mean major increases in expenditures.

Probably the most difficult program we administer in HEW is medicaid. All of you have heard the original estimates on which medicaid was based and the estimates that were made at various times as the program was expanded. All of them were wrong, and all of them were wrong on the low side. The fact is we have frequently gone ahead in these areas without knowing what we were doing, what the parameters were. We have had this very large growth in these programs, which I outlined to you earlier, without any changes or recommendations and the conclusion was that before moving ahead we should put any recommendations in the context of how they might fit into a coordinated system.

We believe the report does make important administrative recommendations which are key to our ability to eliminate fraud, abuse, and waste, therefore insuring quality within the home health system.

Briefly, in the area of fraud and abuse, the Department plans to:

First, prohibit medicare-only providers by requiring a certain percentage of patients to have sources of payment other than medicare. This is necessary because, in our view, a home health agency—or any other health care provider which only serves one segment of the population—poses the special risks of the lack of observation by and comparison with other clients and systems.

Second, designate a series of intermediaries to serve home health agencies on a geographically determined basis.

Third, increase field audits of cost reports by the intermediary.

Fourth, increase departmental auditing activities in order to improve detection of fraud and abuse where they occur. This has been undertaken.

To improve the reimbursement system and controls over determining allowable costs for home health care services the Health Care Financing Administration will:

Revise the regulations governing allowable costs for the expenses of related organizations.

Publish additional instructions to fiscal intermediaries advising them on how to deal with home health agencies which inappropriately solicit patients.

Aid intermediaries in determining and identifying costs which are substantially out of line with those of other providers by supplying them with national data and guidelines.

Develop criteria for a policy of postpayment claims review on a sample basis.

These are the improvements we are prepared to recommend, based on our current knowledge. They clearly won't solve all the problems, but we need to know more before we do more. To that end, we have contracted for a number of demonstrations which have been going on. In addition, we have requested $30 million in our fiscal year 1980 budget to begin a further demonstration program designed to evaluate alternative approaches to the organization and delivery of a long-term social and health care services at the community level.

It has been the view expressed, I think, by most of the involved agencies in our Department that this is a problem that is best solved, as Senator Glenn said, on a community basis, on a neighborhood basis, on a State basis, and that what the Federal Govern-

ment needs to do is to devise a program that will serve the purposes of such agencies, and we need to know which kinds of agencies at that level work and which kinds we ought to support.

We will test different models of channeling and monitoring agencies at the community level to serve as single entry and case management points for clients. Some models to be tested include: HMO-like organizations providing long-term care services; congregate living facilities that also deliver long-term care services, and hospital based agencies.

To insure that these actions are coordinated on a departmental level, we have given the responsibility for coordination, in both the information and program planning areas, to the Assistant Secretary for Planning and Evaluation, and he is working with a steering committee composed of representatives from the Public Health Service, the Social Security Administration, the Health Care Financing Administration, and Human Development Services.

I will be pleased to answer any questions you may have.

Senator CHILES. Secretary Champion, I want to say at the outset that I think the Congress and the American people will long be in your debt for the work that you did in civil service reform. I consider that to be probably one of the most outstanding pieces of reform legislation that I have seen since the period I have been in the Congress. I think it gives us a great opportunity to turn around some of the directions that the bureaucracy is going in, and some of the directions that most frustrate the American people.

I also want to say that I view with much regret the statement that I saw recently in the paper that you are thinking about leaving the Government service for the greener fields of private life.

I wanted to give you both of those statements because we are getting ready to give you a little unshirted hell here.

Mr. CHAMPION. I appreciate the introduction.

Senator CHILES. I want to preface my remarks——

Mr. CHAMPION. Maybe I should speed my departure.

Senator CHILES [continuing]. Oh, no—and say again when I first found that you were leaving, then I scratched my head for awhile and said:

> Oh, my goodness. We recessed the last hearing because we thought we had somebody before us that was not going to be able to testify about anything in the report, and now we are going to have Under Secretary Champion and he is getting ready to leave.

Maybe we should tell Joe he better come up here. But then I thought maybe it would be very valuable to have you come, because maybe you can speak from the other side of the pail, so to speak, in that you are getting ready to leave.

We are tremendously frustrated on this committee, those of us that have been involved in this area for any length of time. We are tremendously frustrated. You have told us today that this report was out of the Health Care Financing Administration and that they prepared the report and that is what constituted the first draft. And when the other Departments began to look at this draft and comment on it, then they saw some changes should be made, and they sent it up to your office, and then you had to resolve some of those disputes, and based on that we end up with a second

report. Then you go on to tell us that now we have a departmental task force that is going to really coordinate all of those.

You know, my mind is like I am hearing a broken record. Two years ago, in front of this very table, I was asking these same things, and at that time we were assured by the Health Care Financing Administration, by the Public Health Service, and by no less than the Secretary of HEW himself, that we were going to have a coordinated head of this and it was going to the Health Care Financing Administration. It was going to be where we were going to coordinate this and no longer would we have fragmentation. So we sat back and felt: "Oh, goodness, something is going to happen, we are going to see some coordination," and now, 2 years later, we are hearing exactly the same thing.

We found out that HCFA was to service this, supposedly, and their authority was what they were given by the Secretary himself. They in fact had no authority. They in fact were one Department that had a report.

Let me say the first draft I consider to be very weak. We keep talking about the first draft like it got its legs cut out from under it. I don't think it had any legislation to start with.

I didn't find any recommendations in the first draft. I found some legislative options and they were weak, but I didn't find any recommendations. We were told that this is something that is very important, we don't want to step off half cocked. We don't know where we are going. We are talking about tremendous sums of money. We are talking about $8 billion that is being spent in nursing home care and home health care until the present bill that we now have.

Many of the members of this committee are pushing and saying in the bill form we are not going to require the 3 days prior hospitalization that you have to have to go into home heath care. You have to send somebody to the hospital before he can avail himself, under medicare, for home health care. How much money has that cost us to have to put somebody in? I don't think we have any way of knowing, but I think we now know that that is something that we should have addressed years ago.

I find that this talk now about having to study again is just very, very hard to ascertain. Congress has been willing to give demonstration money and a lot of that has been forthcoming. Try to put that in the appropriations bill. I have been one of the ones putting in the money to require demonstrations. We have had demonstrations and studies. With the funding of demonstrations such as the home health care programs, we feel that they should carry with them the responsibility on the part of HEW to continually monitor the programs and collect information on them. How is it working? I don't feel that we are really getting the monitoring results of those demonstration programs.

Mr. CHAMPION. Mr. Chairman, we have done a lot. The early monitoring that was done in home health, as you may be aware, was because of the substantial amount of fraud and abuse activity which had been turned up. We have difficulty. This is something we have tried to get changed with recommendations to Congress.

As you know, providers nominate their own intermediaries. Frequently, when we would turn up information, we got in fact the

intermediaries. We got very slow reaction from them in terms of pursuing the people who nominated them in the first place as intermediaries. That was one of the early problems, but I don't mean to give you the whole litany of difficulties in monitoring this program.

I think you are right, that we have not given it the kind of attention that it deserves. I think, however, that the problem between the last study and the ones we are now conducting is the change in emphasis and the change in view on the part of the Department, and it goes in two ways. One is that we cannot have a huge Federal program that will successfully carry this out.

Like many of the other problems in medicaid, this does not lend itself to a large entitlement program. The present view in many of the demonstrations that are being put together are in terms of State and local, and indeed neighborhood, solutions which are quite different, as you noted earlier, between city and rural situations and otherwise, and finding some way to fund those.

A lot of the money that is being spent most effectively in this area now is title XX money that we made available to the States and in which they make basic choices. We are looking to a heavier involvement of social services in this, not looking at it solely as a health problem, and we are looking at it as a State and a neighborhood set of concerns rather than a Federal and State entitlement program, and that is a change in emphasis from the way HCFA addressed this problem from the start. So it is not as if we have not observed something or drawn some conclusions and designed some demonstrations that are different than the ones that went before. We have done that thing of changing our mind.

Senator CHILES. Mr. Secretary, I think probably the most graphic demonstration of our feeling that no one is in charge of home care in the Department is what you have given us this morning when you tell us that you had not seen the GAO report. Did the GAO report call for a national information system for a long-term planning for the delivery of services to older people? GAO tells us that HEW has turned down the fact that they have a need for that. You have not seen the GAO report?

Mr. CHAMPION. Mr. Chairman, I heard Mr. Ahart's testimony. That is not the situation. They have discussed the report with the Administration on Aging, which talks to them about it, then presents its views, its conclusions, which then come forward to me along with those of others in the Department. The report has not yet reached me, but it will inevitably, and before my departure I might add, and there will be a departmental position and a departmental response. I am quite interested in what Mr. Ahart had to suggest.

Senator CHILES. Well, GAO tells us that the Inspector General of HEW, Tom Morris, has told them they don't agree with their recommendations.

Mr. CHAMPION. Well, I will have a chance to make the judgment for the Department, subject to concurrence by the Secretary, when Mr. Morris' opinion and GAO's come to me, but he does not speak for the Department.

Senator CHILES. Well, I want to try to use the 10-minute rule this time because I know all of the members present have some questions. I will pass now to Senator Cohen.

Senator COHEN. Thank you, Mr. Chairman.

I would say that I share your sense of frustration in dealing with this particular problem, Mr. Champion. I am sorry to see John Glenn had to leave. He and I also serve on the Armed Services Committee, and we are now trying to cope with MPS system to determine where our ICBM's are going to be located. That is the same sort of feeling I get dealing with the issue that a year or so ago we had dramatic televised hearings over in the House about how HEW was going to make this investigation and recommend to the Congress how it was going forward. HCFA was going to be the centralized focal point to carry out this intensive study. Now you come before the committee today to suggest that that was the wrong approach, it is much too narrow a focal point.

What we have to do is take that into account and expand it, within the HEW bureaucracy, so now we have to have a task force to answer the same questions. It is a very difficult situation to tell who is on first and what is on second or I don't know who is heading for home. At best, we are a year or two behind where we started.

Now you indicate you think that this report has made some recommendations for legislative and regulatory changes. I went through the report and it gives the appearance of making changes—but most of them have already been implemented by other sections of the law. The administrative recommendations that I have seen are "possible" on page 20, "potential" on page 25, "exploring" on page 26, "will pursue" on page 33, "actions under consideration" on page 55, "should be encouraged" on page 65, "will begin" on page 34, "will review" on page 34, "planning," "work toward," and "then be suggested." The question, exactly, is what have we done?

Mr. CHAMPION. I don't know what objects surround that language.

Senator COHEN. Do you think this report honestly can be used as a basis for a national home health care program?

Mr. CHAMPION. No.

Senator Cohen, One that is——

Mr. CHAMPION. Basically, the report says it cannot. There is not adequate information, there are problems that are not solved, there are things that we don't know, there are techniques that have not yet been developed, and that is what the report basically says.

I apologize. I should say that after the report came through that long initial process with the recommendations, that the report does not make a very coherent statement of that kind and should have been much better, given the time delay involved in reworking that report. We thought it would be better to get it to you than to redo it.

Senator COHEN. Would it not be better if HEW simply took the report back, took the new task force and updated or substantially revised its recommendations, rather than submit that report to this committee as a means of compliance with the mandated law?

Really, we cannot do anything with this report of any significance, can we?

Mr. CHAMPION. No, I don't think that it advanced your state of knowledge any more than it advanced our knowledge, which is why I refused to make any recommendations.

Senator COHEN. We have spent some odd $60,000 and we are no further down the line than we were those 18 months ago, other than we have a lack of information and complications.

I guess what is frustrating, is that there were certain policy positions made back in a July draft dealing with proprietary participation, certificate of need, home health demonstration grants, deemed status. The report, for example, points out a whole host of problems with deemed status. I think there is an inherent conflict of interest in that position, yet after listening to all of the objections of deemed status, the report concluded that HEW is considering that possibility in the future. I don't understand that, after you list all of the objections, that you suggest that we consider that as a possibility, and that is what makes this report so inadequate, and it really ought to be rejected.

I think it ought to voluntarily be taken by HEW, saying we have not complied with the letter or the spirit of the law, and that you are asking for time to file a new report as organized and researched by this task force and then present it to the committee as compliance with the law. This report really does not tell us anything and it is not in compliance with the law. In fact, and I still may do it unless you are willing to take the report back, I am going to offer a resolution[1] tomorrow that the Finance Committee return it as not being in compliance with what is mandated by Congress.

Mr. CHAMPION. May I consider your suggestion, Senator?

Senator COHEN. I certainly hope you will.

Let me turn to this notion of health aides. This notion of training health aides has been kicking around I think certainly since 1975, and yet HEW is not prepared to make any recommendations in the matter at all—not any. I would like to know how you account, for example, for the discrepancy for estimates by HEW actuaries of $28 million for the additional costs of occupational therapy as opposed to $4.6 million by the Congressional Budget Office. There is no explanation for the difference in the report itself. Can you help me out on that at all?

Mr. CHAMPION. I would be glad to have the actuaries make somewhat conservative assumptions, but I don't see that accounting for that kind of difference. I would be glad to do that.

Senator COHEN. You say that you don't have sufficient information to make recommendations with respect to proprietary agencies. I would assume that HEW does collect some information from the 23 States, as I recall, where proprietary agencies are directly reimbursed. Has there not been any experience gained in your recordkeeping?

Mr. CHAMPION. Experience of what kind, Senator?

Senator COHEN. To make a judgment as to whether the agencies should be treated the same as nonprofits under the law. In other words, there was a recommendation, as I recall, in the original

[1] See appendix 4, item 1, page 224.

draft report that said the proprietary should be treated just as a nonprofit and that was stricken in the final report, saying insufficient information. The question I have, is that we have 23 States now that allow it. Isn't that some kind of basis on which to make a judgment?

Mr. CHAMPION. Yes. As we were trying to monitor some of the home health care, we did find more proprietaries than nonprofits.

Senator COHEN. You did find those?

Mr. CHAMPION. Yes, and if I were called upon to make an immediate judgment based just on what I know today, which is entirely inadequate, I might add this again is another question that I felt needed a lot more attention, but I would not want to include proprietaries without some further study.

Senator COHEN. Then why on page 46 of the report do you say there is no evidence to indicate that they provide services of the best quality?

Mr. CHAMPION. Of what, less quality?

Senator COHEN. Less quality.

Mr. CHAMPION. That was not the issue. The issue was a question that we had more complaints in the fraud and abuse area about the private areas than we did about profits, but once again I want to make it very clear I did not think that the evidence was compelling. I say that only on the basis of what little information there was at that time. It was part of the problem that ran through that whole session, how much did we really know? In that case there was not an adequate base.

Senator COHEN. Well, Mr. Chairman, I have many more questions that I would like to explore, but I know you are very pressed for time. I hope Mr. Champion will take my suggestion apart, because I do intend to file the resolution tomorrow, and I believe a similar one will be filed in the House. I think it would be best all the way around not to—it is an extraordinary procedure—but I think under the circumstances where HEW now says that it needs another year to study this matter to come up with those kinds of recommendations that we need. Perhaps the best thing is just to take it back and admit that you failed to comply with the law as mandated.

Senator CHILES. I say, Mr. Secretary, I just withheld making any statement until we had a chance to really hear testimony from someone at HEW about the report, so there was some conversation about this during the last week. My understanding is that Congressman Pepper is going to file such a resolution on the House side. I think that under the circumstances that it probably would be the best procedure. I don't think the report is adequate. I don't think it does respond, and I think now that is in effect what HEW says, and it seems that the best thing would be to pull the report back and give us a period of time in which we can have——

Mr. CHAMPION. Mr. Chairman, I will certainly agree that it is not adequate to the purpose of future policy in this area. I would like to examine the question of whether or not this is as responsive as we could be, before we decide what is our view of that. The committee, of course, can take its own view.

Senator CHILES. Yes, sir, and the committee will take its own view. Also, if you could examine the legislation, it set forth the

need for the report and each of the steps that it asked be specifically addressed.

Senator Heinz.

Senator HEINZ. Mr. Chairman, I would like to support Senator Cohen's and your remarks. The report is inadequate. I would also like, in view of the fact that what we are dealing with is based on the Cohen amendment, to yield my time to Senator Cohen to continue his questions.

Senator COHEN. I have questions but I am not sure Mr. Champion is prepared to answer all of them. Senator Heinz, I could go through the draft report in which just page upon page have simply been deleted.

I was going to go through almost page by page and ask you "why?" since I assumed that you had principal responsibility for many of the deletions.

Mr. CHAMPION. I made basic decisions, Senator. I simply said what kinds of things we were prepared to deal with now.

Senator COHEN. But every time it came to a policy type of recommendation that this Congress might take and implement, you simply said budgetary constraints. You don't allow us to make this kind of recommendation. I recall going through transcripts during impeachment proceedings in 1974, where it said matters were deleted as not being relevant to Congress needs. This is the same sort of thing, almost, that the whole section just wiped out saying budgetary restraints. I guess the problem I have is that this Congress has responsibility to make those determinations.

It was your obligation to lay out the options for us that we might pursue on a legislative basis, alerting us to potential costs involved, but it is really Congress that has the responsibility to appropriate the budget for this country. What we are looking for is a guidepost and guidelines. All we got was simply a rehash of what we already know, and we spent some odd $60,000 and wasted 18 months of our time.

I could go down through, the list, Mr. Chairman, but I don't think it would serve any useful purpose to question Mr. Champion. I guess I am a little bit disheartened, too, to find the man who carries considerable expertise and experience in the field is about to take his departure and then 3 months from now, or 6 months from now, or a year from now, we will have a new face coming here and saying: "You know, I am new at this particular position and I cannot be responsible for what went on before, but we need another 6 months more to sort of organize this report."

That has been the story of government. I guess that the longer it goes on the more dragged out it becomes, the more fragmentation, the different guidelines. The task force has so many different interests involved they may not reach a consensus. We have to find a focal point that finds out all of these conflicting interests in the Department and come back with a single source recommendation.

Mr. CHAMPION. I would be prepared to make a recommendation.

Senator COHEN. Who does make the long-term recommendations?

Mr. CHAMPION. The Secretary, and to the extent that he delegates that responsibility, we have the responsibility. Nobody else in the Department has the responsibility for making policy recommendations except the people who are appointed to those positions.

Senator COHEN. And you saw none of these recommendations prior to getting the report?

Mr. CHAMPION. No. Generally, in reports of this kind, when there is more than one agency, one agency is given lead responsibility. Now, under our system, we assign a coordinated responsibility. We have a panel to decide who should be involved and what are the subjects. I get a copy of that decision document. That is as of this last year, so I know what is going on out in the Department earlier than when the time is these things come to me. That was not in place at the time this report started.

Senator COHEN. Who is running this task force now?

Mr. CHAMPION. The Assistant Secretary for Planning and Evaluation, Ben Heinemann. His deputy, John Palmer, is the chairman of the long term——

Senator CHILES. What are Mr. Heinemann's qualifications and credentials in regard to health care, and is there anyone in his Department that has any experience?

Mr. CHAMPION. Mr. Palmer has had substantial long-term care experience. He is an expert in the same kinds of things the GAO are expert in—that is, building information systems, getting the system of data and trying with the agency expert to design programs that respond to that data. On the task force is Mr. Benedict, who I think is the best informed person in the Department on the problems of the aging, in terms of health, and representatives of the Health Care Financing Administration, who have had some experience with the financing problems. He is in fact the chairman and coordinator of this effort and these special responsibilities.

Senator CHILES. How long do you think it is going to take for the task force to commence this?

Mr. CHAMPION. I would prefer to give you a carefully supported answer to that because, clearly, there are some things that can be done relatively quickly and there are others that are going to take a long time. I also would like to look at the GAO system.

Senator CHILES. Senator Pryor.

Senator PRYOR. Mr. Champion, your decision to leave HEW at this time reminds me of a man who wants to keep his sanity, and that may have prompted your decision to do so, but I for one would like to echo the frustrations of my colleagues on the committee and would like to add a story that is a true story, that happened in the State of Arkansas last year. I simply point this out because I think it demonstrates once again, Mr. Chairman, the inconsistency within HEW, as we approach these very complicated problems.

Last year, the Administration on Aging awarded our State $750,000 for a model project. This was a grant to demonstrate the feasibility of our State's approach to home health care for the elderly, especially in rural areas. As you probably know, and certainly Senator Chiles knows, the State of Arkansas' percentage of elderly people is second only to the State of Florida, so we have expressed a great interest in this field.

The State had asked for a waiver of income eligibility for medicaid in order that we could serve more people in this project and get a clearer indication of the results being achieved. Subsequent to that, the Administration on Aging said they could not support this request for a waiver. This kind of inconsistency that we find

throughout these programs makes me really wonder what kind of home care policy is being developed in HEW, if any.

I don't know if that statement deserves a comment but I would say that it certainly is one which demonstrates the depth of frustration of the people who are really committed to trying to do something and trying to find some answers in this problem area.

Second, on page 2 of your statement, Mr. Champion, you stated:

> The administration is not recommending any service or eligibility expansion of home health care at this time under titles XVIII, XIX, or XX, and therefore none were submitted to the Congress. Quite simply, we do not currently have enough knowledge at this time to make bold changes in how home health care services are delivered.

Well, Mr. Champion, sometimes I feel that if members of the task force that you referred to earlier were people who were possibly a year or two away from being placed in a nursing home, they might hurry up with some of these plans, and some of these studies, and they might try to find some facts and figures in quicker order. I spoke to a group of elderly citizens back home in our State, and I sensed there was a lot of frustration, very honestly, about the bureaucracy and about our inability to really come in touch with the reality of their problems.

I am just one member of this committee, and I would like to echo the frustrations of my colleagues and to just say, let's please get on with this program and let's do what we should be doing. I would dare say that 5 years ago we were talking about the same thing and trying to accomplish these same goals, and still we are doing studies, and we say we don't have the information, and we have a task force doing this and that. Frankly, it is just a tremendous amount of bureaucracy that seems to be suffocating these programs today.

If you want to comment on that, fine. That is my speech, and I am going to stay within my time.

Mr. CHAMPION. I would like an opportunity to comment if I could, Senator. I don't know the facts of the grant of which you spoke, but I think one of the reasons we are struggling with this effort—and you can see it in many other aspects of the medicaid program which we are struggling with, things like the dialysis program—is that we have not worked out a Federal-State relationship in areas where some of the programs are primarily Federal in character and others are primarily State in character, and where you have combinations of these two things making up the essential services involved, it causes a lot of problems.

We have good management information system programs in only about 20 States. As a matter of fact, to say 20 is stretching the facts. We have lots of other problems and there is no effective sanctioning. HEW attempts, in some ways, but the fact is that when it involves problems for the populations affected by Federal programs, it is very difficult to apply any leverage through those programs.

We have got the States involved in Federal directions. There are different attitudes and different methods that deal with some of these problems or some of these services in different States, and we are going to have to come to some fundamental conclusion about the way in which federally funded entitlement services, or even grant services, are integrated with State programs.

This is perhaps the classic case. I share this committee's frustration. This is one of the most important problems of the last order of this century. The population is growing very, very rapidly. If we have not solved the problem in the next 5 or 10 years, we are going to have far too many people in nursing homes.

We, by the way, went far too fast in setting up the nursing home reimbursement, and that is one of the problems that came from moving before we had a good program. Your sense of urgency is warranted and so is your sense of frustration. We have not found a good answer, but the fact is that until we get good answers from some of these demonstrations, in terms of what I am convinced is going to have to be fundamentally a State and local solution with some Federal financial aid, we are not going to be able to do this. A lot of the problems we are talking about right now are problems that could be solved within States by effective use of the present medicaid program, and they have not chosen to do so.

Senator CHILES. I have some other questions as do other members of the committee. Senator Domenici could not be here today. I think we will submit those questions for the record and we will await eagerly your reply to our letter.

Mr. CHAMPION. Thank you very much, Mr. Chairman.

Senator CHILES. The hearing is adjourned.

[Whereupon, at 11:10 a.m., the hearing was adjourned.]

APPENDIXES

Appendix 1

PREPARED STATEMENTS OF WITNESSES

ITEM 1. FRED M. BOHEN, MAY 7, 1979

Mr. Chairman and members of the committee, I am pleased to be here this morning as the Secretary's representative to review and answer such questions as you may have on the Department's report on home health services under medicare, medicaid, and title XX. I am accompanied by Mr. Robert Benedict, who leads the Administration on Aging in HEW, and Dr. Clifford Gaus, Assistant Administrator for Policy of the Health Care Financing Administration.

The report on home health services was, as you know, mandated by section 18 of Public Law 95-142 (H.R. 3), the Medicare/Medicaid Anti-Fraud and Abuse Amendments. In making this assignment, Congress recognized that there is a great need for improvement in the delivery of home health care if we are to ensure that beneficiaries of federally supported home health programs receive high quality services at cost this Nation can afford. The Congress also recognized that home health programs are today susceptible to fraud and abuse.

The Department's report documents clearly the growth of the home health care delivery system, and the increasing role it is playing in contrast to other, more restrictive, types of care:

Medicare expenditures for home health care rose from $100 million in fiscal year 1974 to a projected $724 million in fiscal year 1979.

393,000 medicare beneficiaries received home health benefits in 1974, compared to over 530,000 today.

Medicaid expenditures for home health care increased from $24 million in 1972 to $179 million in 1977.

In the same period, the number of medicaid recipients who used home health services more than doubled, from 113,000 to over 260,000. (Medicaid in-home benefits still amount to only 1 percent of total medicaid expenditures.)

Most States spend a substantial portion—at least 10 percent—of their title XX budgets on home health services; California spends 62 percent.

The Department's report on home health care also examines a full range of issues relating to problems in the delivery of in-home services. Specifically, it analyzes the different legislative mandates, scope and definition of services, eligibility criteria, standards for certification, licensure and accreditation, and reimbursement methods under titles XVIII, XIX and XX. Some of the more interesting problems pointed to in the report concern lack of coordination of in-home services and the clear need for effective program management. For example:

Titles XVIII, XIX, and XX maintain vastly different relationships to Federal, State, and local authorities. As a result, it is in some instances difficult to coordinate effectively the delivery of in-home services.

The range of financing arrangements and of statutory requirements for reimbursement results in an inability to compare the costs of home health agencies. This makes it difficult to measure whether home health services are being provided in an efficient and effective manner.

Still another problem identified in the report is that the different Federal matching ratios and service standards between titles XIX and XX encourage States to make decisions about services based on the nature of the two programs, rather than by assessing a beneficiary's needs.

We believe the Department's report on home health care candidly assesses current problems in the delivery of in-home services—problems that must be resolved in order to improve the quality of these services.

While agency drafts of the report contained legislative and budget proposals addressing some of these issues, these recommendations did not gain the support of the Secretary or the administration and were not submitted to the Congress. Most

significantly, the administration is not recommending any expansion of services or eligibility for home health care at this time under titles XVIII, XIX, or XX. We have not made such recommendations for the following reasons:

First, we do not currently have enough knowledge at this time to make bold changes in how home-health care services are delivered. For example, we need to learn more about the best way to ensure that key beneficiaries—the poor, the aged, and the disabled—achieve adequate access to in-home services. We also need to know how we can design a program for in-home services that does not encourage a large shift in financing and initiative from the private to the public sector.

Secondly, in preparing our budget for fiscal year 1980, we faced exceedingly tight budget limitations. We had to make hard choices with respect to established programs and new policy initiatives. We have only proposed new starts in areas where we had very high confidence in the general direction and specific proposals we had ready to go.

Finally, although it is clear that some problems result from home health services being provided under three distinct legislative mandates—title XVIII (medicare), title XIX (medicaid), and title XX (social services)—we want to avoid making piecemeal changes in what are clearly independently conceived programs. Before moving ahead, we intend to have a clearer understanding of what the overall system should look like and of how each program can contribute to its effectiveness. To further this objective, the Department has requested $30 million in new demonstration funds in our fiscal year 1980 budget to define how we can best provide long-term care services to those who most need them.

We believe the report does make some important administrative recommendations. These recommendations are essential to cutting down of fraud, abuse, and waste and ensuring quality within the home health system.

To deter fraud and abuse, the Department plans to:

Designate a series of intermediaries to serve home health agencies on a geographically determined basis. This will mean that providers will no longer nominate their own intermediaries. It is anticipated that supplying expert review and audit capacity in a limited number of locations will remove incentives to defraud, and will, in fact, act as a deterrent.

Increase field audits of cost reports by the intermediary.

Increase departmental auditing activities in order to improve detection of fraud and abuse where they occur. This is currently being done in selected areas.

Prohibit medicare-only providers by requiring a certain percentage of patients to have sources of payment other than medicare. This is necessary because, in our view, a home health agency—or any other health care provider which only serves one segment of the population, is acting in defiance of the intent of the program and not in the best interests of our beneficiaries.

To improve the reimbursement system and controls over determining allowable costs for home health care services the Health Care Financing Administration will:

Revise the regulations governing allowable costs for the expenses of related organizations.

Publish additional instructions to fiscal intermediaries advising them on how to deal with long-term contracts between medicare providers and organizations providing management and related services. The instructions will also advise intermediaries about how to deal with home health agencies which inappropriately solicit patients.

Aid intermediaries in determining and identifying costs which are "substantially out-of-line" with those of other providers by supplying them with national data and guidelines.

Develop criteria for a policy of postpayment claims review on a sample basis.

In sum, we believe the report before the committee sets forth the many complex issues that we must resolve in order to develop a rational and effective system of home health care. If we have emphasized the definition of the problem more than a clear sense of direction for the future in this report, it is because of the need to move cautiously. We need more knowledge about what types of changes will improve quality in the delivery of home health care at a cost we can afford. In a time of hard choices, we need to achieve a higher standard of confidence in our recommendations for change. The Department is not complacent about this vital area of policy, but we do not think we are now ready, conceptually or financially, to chart a major new direction.

As I indicated earlier, we have requested $30 million in our fiscal year 1980 budget to begin a demonstration program designed to evaluate alternative approaches to the organization and delivery of long-term care services at the community level. Home health services will be an important element in this demonstration

program. There are two major parts of long-term care initiative, both of which will contribute to our ability to take responsible action in the home health field.

We will gather baseline data for improved policies including information on the degree of disability in the institutionalized and noninstitutionalized population and on amounts, sources, and objectives of current expenditures.

We will test different models of "channeling" agencies at the community level which will serve as a single entry point for clients. Some models to be tested include: HMO-like organizations providing long term care services; congregate living facilities that also deliver long-term care services; and hospital-based agencies.

To ensure that these actions are coordinated on a departmental level, oversight responsibility for this initiative is designated to the Assistant Secretary for Planning and Evaluation, in conjunction with a steering committee composed of representatives from PHS, SSA, HCFA and HDS. The Secretary believes that under this leadership our long-term care demonstration projects will have the coherence and oversight needed to inform future judgments about how those in need of such care—including home health services—can best be served.

My colleagues and I are pleased to try to answer such questions as the Committee may have on the home health report.

ITEM 2. ROBERT C. BENEDICT, MAY 7, 1979

I appreciate this opportunity to discuss the Administration on Aging's in-home services.

With concern for your time, I intend to just touch briefly on the activities which are currently underway and which support growth in the scope and quality of in-home services. I will submit, under separate cover for the record, a description of the impact of Administration on Aging (AoA) program efforts in home care services and also provide you with a listing of activities in the research, development, education, and training areas which support improvements in home services program design and delivery.

The history and development of the Older Americans Act reflects the concern of this Nation to insure a full range of opportunities and community supports for the aging population. The availability of services in the home is, in my view, the key to family or care-giver decisionmaking in regard to an older or disabled adult. To institutionalize or not to institutionalize is the question. The answer is clearly dependent upon the support available.

As you well know, the OAA amendments of 1975 established a list of priority areas in which the expenditures of OAA funds were to provide for the development or expansion of some critical service programs. Services in the home, along with transportation services and legal services, were given this extra impetus and guidance from the Federal and State level. These priority requirements have been helpful. The expenditure of OAA funds for in-home services, through the State and area agencies, significantly increased the availability of in-home supports.

The following figures will give you an idea of the remarkable growth of these services in the past 3 years under the Older Americans Act alone.

In 1976, approximately $700,000 was invested under title III in one component of home care—homemaker service—serving approximately 26,000 persons. That investment grew steadily and in 1978 our figures indicate that 150,000 persons were served. Home delivered meals, home health aid services, shopping, chore service, and residential repair showed similar growth.

The growing interest in home-based services is closely tied to the growing aging population. I think it is again important to briefly mention some of the demographic data relating to chronic impairment.

In 1900, persons 65 and over constituted only 4 percent of the population. Today they are 11 percent or 23.5 million persons and by the year 2030 it is estimated they will constitute 18 percent of the population or 55 million persons. The over 75 age group is increasing even faster, and persons in the over 75 age group are three times more likely to need personal care assistance as those between the ages of 65 and 74. Currently, 38 percent of older persons are over 75 years and by the year 2000 it is estimated they will represent 45 percent of the over 65 population.

Despite a wide variation in estimates of the functionally disabled from several national studies, the relatively high rate of functional disability among the elderly is clear. While 1.2 to 3.9 percent of the 18- to 64-year-old population are estimated to be functionally disabled, 8 to 10 times as many elderly (11.8 to 16.6 percent) are given this incidence of disability, the total potential demand for long-term care is estimated to increase significantly in 1985.

These figures indicate the importance of our support network and services expansion. How best to improve home-based care as a critical component in a system of

care for the chronically impaired is an ongoing concern for the Administration on Aging.

As you know, we are in the process of implementing the 1978 amendments to the Older Americans Act. The regulations, which will be published as proposed rulemaking in the FEDERAL REGISTER in late May or early June, will provide a basis for targeting OAA programs at the State and community level toward services for the most needy, and those confined to home.

The following inclusions in the act set that direction:

The socially or economically needy will be the priority recipients of service under the new regulations.

The new rule requiring that 50 percent of the social service funds be targeted at access, in-home, and legal services by the area agency on aging will serve to strengthen the provision of in-home services.

The new authorization for home delivered meals activities will permit States to establish new home delivered meals projects.

In my judgment, the network is doing an outstanding job in this area. I have no delusions about the scope of the task yet to be done. I do believe that as the system grows, and as we learn more about service delivery and management improvements we will be able to make the dollars appropriated under the Older Americans Act go further to serve more clients.

Important new knowledge is developed and tested under the AoA discretionary grant program. We have funded a number of projects; some of which I am very excited about, and whose potential for broad system adaptation are significant. A listing of the research, development, evaluation, education, and training investments which support in-home services delivery will be available in the subsequent submittal. I would like to give you some highlights of those activities.

MODEL PROJECTS PROGRAM

The National Council for Homemaker Home Health Aide Services has received a grant to help build the capacity of States and area agencies to provide quality in-home services. On-site assistance is underway in six States, and a report has been prepared which, will give guidance to the department relative to standards for homemaker and home health aid services. I am studing the information and will use this as a basis to consider, together with States, the issues of quality improvement.

The Philadelphia Corporation on Aging has received a grant to further test a service coordination design which I find very exciting. This project starts out with three principles: First, before any formal funding sources are used for in-home support, every effort is made to maximize informal support from families, neighbors and friends. Without this basic approach, the system would not be able to effectively maximize the in-home service dollar investments. The second principle maintains that the provision of in-home services should be coordinated out of network of neighborhood senior centers by staff who are thoroughly trained in medicare, medicaid eligibility, and client assessment. The third principal is that medicaid and medicare are the major sources of funds for in-home services and that OAA funds should only be used as a supplement. With these three principles in operation, the Philadelphia Corporation on Aging has been able to increase the number of clients served from 300 per month to 1,300 per month, with no increase in funds.

In this system, OAA dollars are used only when the client is ineligible for medicaid or medicare. The careful client assessment, informal supports. and coordination with a range of service providers through the senior center, help maintain a link for case finding and—as much as possible—reinvolvment of the older person in senior center and community activities.

The five hospital homebound elderly program in Chicago has a grant to test out a hospital linked home care program which includes client assessment, service mobilization, and the involvement in the individual care plan of other older adults whether relatives, friends or volunteers.

The New York Community Service Society is involved in a demonstration of how natural support systems that sustain impaired older persons in their own homes, may be reinforced through formal efforts, such as training, education regarding the aging process, and peer group counseling.

RESEARCH

I think you will also be interested in a few examples of the research investment we are making.

Georgetown University recieved a grant to test the hypothesis that the health needs of the chronically ill elderly (in urban areas) can be met through the intervention of nurse practitioners.

The University of Michigan is studying home health care among the black elderly to determine whether formal intervention can help to maintain the older person at home.

EDUCATION AND TRAINING

In the area of education and training, AoA is making a number of investments which over the long run, should have an enormous impact on dealing with the problems of chronic impairment and the demand for in-home services.

A title IV–E developmental grant announcement will be published shortly which will call for the establishment of 10 multidisciplinary centers for long-term care. These centers will focus on the area of chronic impairment by bringing relevant professional schools together with a social service organization to fill the gap in training professionals who serve the chronically impaired.

Similarly, AoA will soon announce awards for geriatric fellowships which will provide additional training for teaching physicians. These investments will, when the multiplier takes effect, begin to address the problems of misdiagnosis and misunderstanding of the aging process by those who provide the greatest share of direct service.

It is important that I also highlight the activities underway by the Health Care Financing Administration (HCFA) and AoA, to assist States to develop programs which are community-based and which focus on the chronically impaired. Each of these projects is based on a set of very important principles. The first provides that communities should have more authority and responsibility to manage a range of services that impact on the care of the chronically impaired. Second, individual older people and their families should have the benefit of individual assessment of need and some choice in the kind of care they receive. And, third, that various sets of resources should be required to permit the community to provide a full continuum of services. These efforts include: assisting the State of California to implement State legislation, act 998, which is a multiple site demonstration project in the planning stages; a community project known as On-Lok Community Services, which operates out of a community center in San Francisco; a model services access system in Monroe County, N.Y.; a statewide access program in Arkansas; and the Triage project in the State of Connecticut.

In-home services hold enormous promise for a solution to many of the difficult long-term care issues. The department is making investments to test patterns and explore organizational options which will establish a solid experience and policy base in long-term care to guide our decisions over the next decade. It is the experience of the projects I just mentioned which led the department and the administration to request $30 million in fiscal year 1980 for demonstrations in HCFA and AoA to build on these innovative developments. We plan to implement a number of demonstrations in comprehensive care. These demonstrations will bring together multiple sets of resources, targeted toward a wholistic, comprehensive system of services for the chronically impaired, and include the key in-home services. I look forward to a continuing close working relationship with the health care financing administration (HCFA) in this effort.

In closing, I want to briefly mention the White House Conference on Aging which will convene in 1981. Care of the chronically impaired is one of the fundamental issues to be addressed. It is my intention to assure that all of our investments, particularly over the next 3 years—in research, model projects, training and in States and area agencies—set a foundation now, for a strategy to finally overcome the barriers to effective management of services for the chronically impaired. This strategy, and the impetus of the White House Conference on Aging can be expected to have an enormous effect on service, and our communities in the future.

I want to thank you for this opportunity to talk about the Administration on Aging's efforts in home care and services for the chronically impaired. I would be happy to answer any questions you may have.

ITEM 3. GREGORY J. AHART, MAY 21, 1979

Mr. Chairman and members of the committee, I am pleased to be here today as your deliberations focus on planning for the future of home care services for older Americans. My comments are based on our proposed report to the Congress on the conditions of older people and the need for a national information system for long-term planning for the delivery of services to older people.

To design and plan for the delivery of services to older persons, society, the Congress, and the executive branch need information on (1) their well-being, (2) what factors make a difference in their lives, and (3) the impact of services on the well-being of older people. Currently, this information is spread piecemeal throughout Federal, State, local, and private agencies. As a consequence, Federal agencies have not evaluated the combined effect of these services; and, in the absence of such information, it is difficult to assess the impact of various programs on the lives of older people.

Based on our study of the well-being of older people in Cleveland, Ohio, we believe it is possible to collect, measure, and evaluate information on the personal conditions of and services to older people.

We also believe that a national information system should be established for older people. Our study shows that information from such a system can be used in multiprogram evaluations which can:

Measure the current conditions of older people.

Identify the current cost of helping older people.

Demonstrate the effects of help on improving the problems and conditions of older people, and

Estimate future costs of helping all older people in need and costs of alternative kinds of help.

Before covering each of these points, I will give you some background information on our Cleveland study.

WELL-BEING STATUS AND SERVICES DATA BASES

We sampled people from over 80,000 older people in Cleveland, Ohio, who were 65 years old and older and were not in institutions, such as nursing homes. We assured ourselves that our sample was demographically representative by comparing the characteristics of our sample to the population in Cleveland.

In our study, 1,609 older people were interviewed by Case Western Reserve University personnel from June through November 1975. A year later, they reinterviewed 1,325 of these older people.

In interviewing, we used a questionnaire containing 101 questions developed by a multidisciplinary team at the Duke University Center on Aging and Human Development in collaboration with the Administration on Aging, the former Social and Rehabilitation Service, and the Health Resources Administration of HEW. The questionnaire contains questions about an older person's well-being status in five areas of functioning—social, economic, mental, physical, and activities of daily living.

To identify those factors that could affect the well-being of older people, we:

Developed specific definitions of 28 services being provided to older people and dimensions for quantifying the services.

Identified the providers of the services—families and friends, health care providers, and over 100 social service agencies; and

Obtained information about the services provided to each person in our sample and the source and intensity of these services.

We also developed an average unit cost for each service based on the cost experienced of 27 Federal, State, local, and private agencies in Cleveland between October 1976 and March 1977. We compared these costs to similar costs in Chicago, Ill., and Durham, N.C. We assigned the same cost to family and friend services that we found for agencies.

Each piece of data was collected so that it could be related to an individual in our sample. This included the questionnaire data, the data on the 28 services provided by social service agencies, and the services provided by health care providers. By relating these data to the individual, we were able to make comparative analyses of sampled older people for over 500 different variables.

CURRENT CONDITIONS OF OLDER PEOPLE

Measurements of conditions of older people are important in an information system. Our study shows these conditions can be measured. Further, the condition of older people do change and they can improve.

In 1975, we measured the personal conditions—health, security, loneliness, outlook on life—of older people in Cleveland. Over half of the sample were in the best health, security, and loneliness conditions. The definitions of these conditions are shown in appendix I.[1] However, only 24 percent of the sample were in the best condition in outlook on life.

[1] See page 58.

We also combined these conditions into an overall condition. About a third of the sample were in the best overall condition. At the other end of the spectrum, more than one-fifth (21 percent) were in the worst condition.

In determining the conditions of older people, an information system should contain data on illness and the degree these illnesses lead to many older people having trouble doing daily tasks. As older people become more and more impaired in their ability to do daily tasks, their probability of being institutionalized increases.

Nearly all of the people in our sample had one or more illness. However, for many the illnesses did not greatly interfere with their activities. For our analyses, we focused on those illnesses which interfered a great deal with a person's activities. One of every three older people in our sample had such illnesses in 1975.

The most common illnesses that greatly interfered with activities were mental impairment, arthritis, circulation trouble, heart trouble, and high blood pressure. Mental impairments and arthritis each interfered a great deal with the activities of 14 percent of our sample; circulation trouble did so for 8 percent; heart trouble did for 6 percent; and high blood pressure for 5 percent.

These illnesses, along with the "wearing out" process of aging, lead to many older people—39 percent—having trouble doing routine daily tasks. In addition, 27 percent needed help in performing one or more tasks and 12 percent could not do any tasks even if helped. They had the most trouble doing housework (29 percent), getting to places not within walking distance (22 percent), and going shopping (21 percent).

An information system should also have the capability of measuring change in conditions over time. In 1976, 1 year after our first interview, we reinterviewed most of our original sample. The overall personal condition of older people improved for 18 percent and declined for 18 percent. The most change was in the outlook on life condition followed by security. The least change was in loneliness and health.

CURRENT COSTS OF HELPING OLDER PEOPLE

Helps provided by family and friends and Federal, State, local, and private agencies are significant. The ability to identify the kinds and costs of these helps is crucial and, consequently, another important element of an information system.

The helps provided are intended to either remedy a specific problem or to help the older person cope with it. Many such problems afflict older people and more than one kind of help may be appropriate for each problem. Further, it is not unusual for persons to have numerous problems which must be addressed simultaneously. To illustrate, appendix II [1] contains a diagram which depicts the whole person—conditions, related problems, and kinds of help currently being provided. It shows that older people could receive six kinds of help:

(1) Treatment for illnesses.

(2) Compensatory help to compensate for an older person's inability to do daily tasks (e.g., meal preparation, homemaker, etc.).

(3) Financial help for money problems.

(4) Social-recreational help for older people with little or no social contact.

(5) Care-giving help when the older person feels there is no one to provide care if he becomes sick or disabled, and

(6) Developmental help (e.g., educational and employment services) for those people with little interests which leads to a negative outlook on life.

In Cleveland, the annual cost of providing these kinds of help averaged $6,617 a person. Various agencies provided $4,616 worth of help, and family and friends provided the remaining $2,001. The greatest portion (47 percent) of help is financial. The next greatest is compensatory help with daily tasks (36 percent) and then medical (15 percent). Social-recreational help accounts for only 2 percent and care-giving and developmental help accounts for less than 1 percent.

Comparing sources of help, the families and friends of older people provide 76 percent ($1,821 of $2,399) of the compensatory help by performing daily tasks for them, and only about 6 percent of the financial help ($172 of $3,118). The other kinds are provided mostly by public and private agencies funded under Federal programs. From the agency standpoint, 64 percent of their cost was in financial help ($2,946 of $4,616) and 21 percent in treatment of illnesses ($954 of $4,616).

The results of our work are not statistically projectible to the entire country. However, to illustrate the information that could be obtained from a national information system, we have made national estimates for the 21 million noninstitutionalized older people 65 years old and older in 1975 in the Nation. I

[1] See page 59.

want to make it very clear that the estimates I will be presenting were not made on a statistical basis but were done for illustrative purposes only.

Thus, using the results of our Cleveland work, the magnitude of the national picture could look like this—$139 billion in help is provided annually to the 21 million people who are 65 years old and older and live outside institutions. Seventy percent of the $139 billion would be provided through Federal, State, local, and private agencies. Most of this amount is federally funded.

EFFECTS OF HELP ON CONDITIONS OF OLDER PEOPLE

The ability to determine from an information system the effects of expanded help on conditions of older people would aid considerably in formulating and reviewing proposed legislation. We measured the changes in the conditions and problems of older people between 1975 and 1976 and related services to these changes. Using this analysis, we determined that the effects of services on older people can be measured.

To again illustrate what a national information system could show if it were designed similar to our study, we projected the results found in Cleveland to the 21 million noninstitutionalized older people 65 years old and older. These projections demonstrate the role that a national information system on older people can play in major policy decisions.

A sizeable portion of the older population would benefit from expanded help. The most benefit would be realized in their illness situation—about 9.2 percent of our sample (1.9 million people nationwide) would have been in a better situation in 1976 if they had been treated for all their illnesses that interfered a great deal with their activities. The second most benefit would be realized in dealing with the security problems, with 5.6 percent of the sample (1.2 million people nationwide) being in a better situation. Also, about 4.9 pecent of the sample (1 million people nationwide) would have a better outlook on life with developmental help.

FUTURE COSTS OF HELPING OLDER PEOPLE

Better decisions can be made if costs of services can be projected. An information system should have this potential.

Projections of future costs of expanded help to benefit older people are possible. To demonstrate the effects of help over 20 years, we projected the conditions and problems of the 65- to 69-year-old age group for the next 20 years. For example, our projections show 11 percent more of the 65 to 69 age group would be experiencing a better illness situation in 1980 if they had received expanded help. Fourteen percent more would be experiencing a better condition in 1985, 14 percent more in 1990, and 12 percent more in 1995.

Our projected costs to provide expanded help would be reduced considerably in the long run because expanded help leads to better conditions and less need for help in the future. Our illustrative projections nationwide for the 65 to 69 age group over the next 20 years show that if medical treatment were expanded to all in need, total medical costs over the 20 years would be slightly decreased from $4.5 billion to $4.3 billion. Also, the cost of compensatory help would be reduced significantly due to the effects of expanded medical treatment from $12.6 billion to $11.4 billion. In total, a reduction of about $1.4 billion results—$1.2 billion in compensatory help and $.2 billion in medical treatment—from the impact of preventive medical treatment earlier in life.

The Congress needs alternatives to choose from. A national information system could provide projections of the number of older people benefiting from various kinds of help out of the total number of people receiving these helps. Additionally, estimates could be made of the costs of alternative kinds of help.

For example, older people have a better chance of benefiting from some kinds of help than others. One of every two people receiving expanded medical treatment would be in a better illness situation and 1 of every 12 who received expanded financial help would have better feelings about the adequacy of their money.

A cost to have one person benefit can be derived from comparing the number of older people who would be in a measurably better condition or situation because of help to the number receiving expanded help. The average cost per person receiving help is $574 for medical treatment and $1,442 for financial help. For one person to be in a better illness situation because of expanded medical help, however, about two people have to receive this help or a cost of $1,191 per person benefiting.

RELEASE OF OUR DATA BASE

Considerable interest exists in our study. We discussed our methodology with numerous experts in the field of mathematics, systems analysis, operations re-

search, and gerontology. We condicted several seminars and a national symposium with a variety of researchers, methodologists, statisticians, and HEW officials in the field of aging. Our own consultants in the areas of statistics, operations research, and gerontology advised us and reviewed our methodology in minute detail. The consensus of all involved was that we developed a sound methodology.

In addition, the staff of the Subcommittee on Human Services, House Select Committee on Aging, has expressed interest in using data from our study for their human service model which is under development. Further, at the request of the Administration on Aging, we plan to provide it with the details of our methodology along with our data base, for distribution to researchers, planners, and administrators in the field of aging.

We believe that the information contained in our data base will be useful to researchers, planners, service providers, and policymakers. However, this data base will have to be expanded and updated to be useful in the future for long-term planning. Therefore, we are recommending to the Administration on Aging that a national information system be developed based on our methodology and data base. Information for this system should be gathered periodically on a national sample of older people stratified to permit estimates for planning at the State and area agency on aging level.

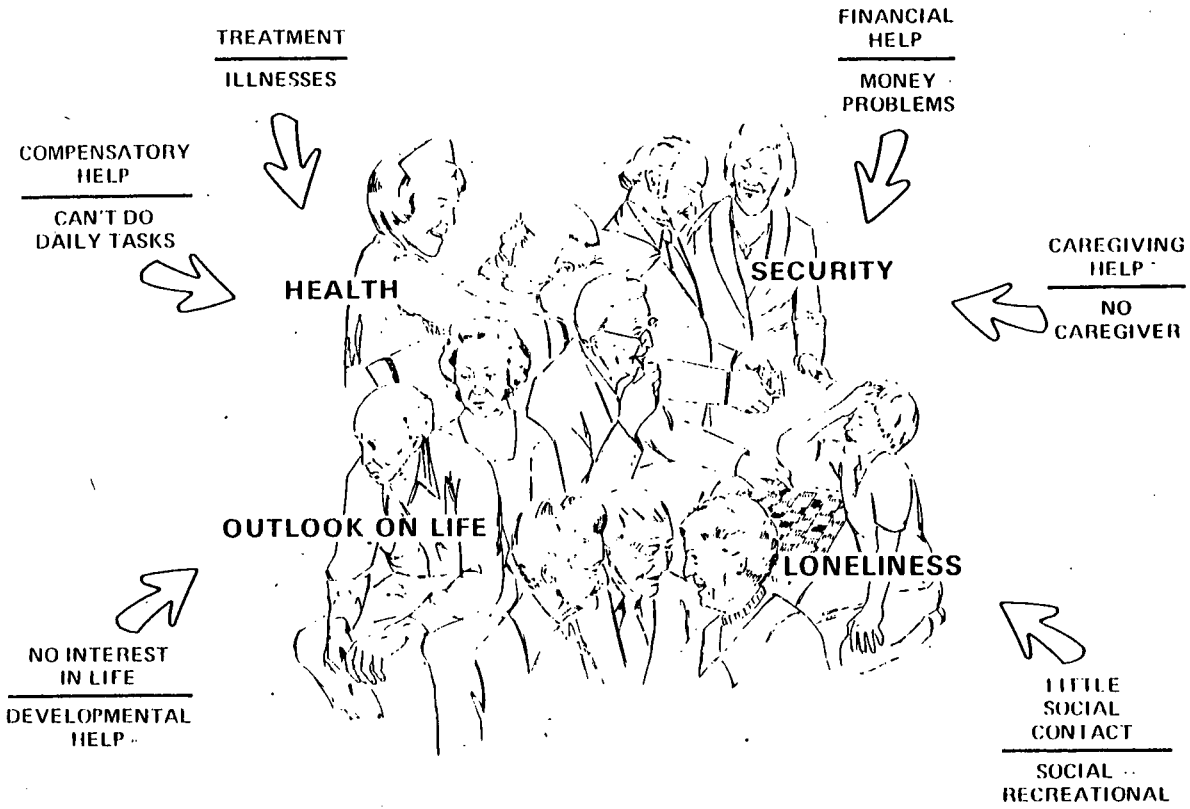
Our draft report on our Cleveland study is in final processing and we expect to issue our report in June 1979.

Mr. Chairman, that concludes our statement. We will be happy to answer any questions that you or the other committee members may have.

APPENDIX I.—CONDITIONS

Level of condition	Health [1]			Security	Loneliness	Outlook on life	Overall personal condition
	Illness	Ability to do daily tasks	Overall [2]				
Best	No illness that interferes a great deal with activities.	Can do all 13 daily tasks without help.	In best category for both illness condition and ability to do daily tasks.	Worries hardly ever	Feels lonely almost never.	Does not feel useless and finds life exciting.	[1] In best category for all 4 conditions or [2] Best for 3 and marginal for the other.
Marginal	One illness that interferes a great deal with activities.	Can do all 13 daily tasks but only with help in one or more.	[1] In best category for illness condition or ability to do daily tasks and marginal in other or [2] In marginal category for both.	Worries fairly often	Feels lonely sometimes.	[1] Finds life exciting but feels useless or [2] Does not feel useless but finds life dull or routine.	[1] In marginal category for 2 or more conditions and best for other(s) or [2] In worst category for only one condition.
Worst	Two or more illnesses that interfere a great deal with activities.	Can't do at least one task even with help.	In worst category for either illness condition or ability to do daily tasks.	Worries very often	Feels lonely quite often.	Feels useless and finds life routine or dull.	[1] In worst category for 2 or more conditions.

[1] Daily tasks include preparing meals, bathing, walking, shopping, eating, etc. Details on these daily tasks are described in our prior report on pages 57–60 of appendix IV.
[2] To be more descriptive in chapter 3, we showed separately the effects of expanded help on illnesses and ability to do daily tasks.


TREATMENT
ILLNESSES
FINANCIAL HELP
MONEY PROBLEMS
COMPENSATORY HELP
CAN'T DO DAILY TASKS
HEALTH
SECURITY
CAREGIVING HELP
NO CAREGIVER
OUTLOOK ON LIFE
LONELINESS
NO INTEREST IN LIFE
DEVELOPMENTAL HELP
LITTLE SOCIAL CONTACT
SOCIAL - RECREATIONAL

Appendix 2

LETTER AND ENCLOSURE FROM JOSEPH A. CALIFANO, JR., SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, DATED APRIL 16, 1979

HON. FRANK CHURCH,
Chairman, Senate Special Committee on Aging, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed is HEW's final report on home health and other in-home services under titles XVIII (medicare), XIX (Medicaid), and XX (social services) of the Social Security Act. This study was requested by section 18 of Public Law 95-142, the Medicare and Medicaid Anti-Fraud and Abuse Act of 1977. This provision requested that the Secretary of Health, Education, and Welfare submit a report "analyzing, evaluating, and making recommendations with respect to all aspects . . . of the delivery of home health and other in-home services authorized to be provided under titles XVIII, XIX, and XX of the Social Security Act." The cost of the report was $62,630.50.

Specific aspects of the programs and their administration that HEW was asked to examine were:

Scope and definition of services.
Eligibility criteria.
Standards for certification, licensure, and accreditation.
Utilization Control.
Quality Assurance.
Reimbursement methods.
Prevention of fraud and abuse; and
Coordination among programs.

The report addresses these issues and makes some recommendations to improve the administration of home health services and to protect such services against fraud and abuse. No legislative recommendations are made at this time because of budgetary restraints and the need for more knowledge and experience before proposing programmatic changes.

Sincerely,

JOSEPH A. CALIFANO, Jr.

Enclosure.

HOME HEALTH SERVICES UNDER TITLES XVIII, XIX, AND XX

Report to the Congress Pursuant to P.L. 95-142

Department of Health, Education, and Welfare

April 1979

SUMMARY

In the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Congress required the Department of Health, Education and Welfare to prepare this report analyzing, evaluating and making recommendations with respect to the delivery of home health and other in-home services provided under Titles XVIII (Medicare), XIX (Medicaid), and XX (Social Services) of the Social Security Act. Home health services under each of the three programs have been provided in accordance with the overall legislative purpose of each program. Under Medicare, those services may be provided as part of the overall health insurance program for the elderly and disabled; Medicaid may cover such services as components of health care services for low income persons; Title XX may support home care as a social service for low income persons and other eligibles. The report provides an analysis of the different legislative mandates, scope and definition of services, eligibility criteria, standards for certification, licensure and accreditation, and reimbursement methods under Titles XVIII, XIX, and XX.

The Department makes no legislative recommendations in this report primarily because of budget constraints. In addition serious questions, which are raised in this report, must be resolved before final recommendations can be made in this area, including:

- o What is the best way to ensure types of beneficiaries, e.g., the aged, low income, the disabled, have adequate access to in-home services?
- o How can we design a program for in-home services that does not encourage a large shift in financing and initiative from the private to the public sector?

In order to analyze these and other questions, the Department plans to undertake, in FY 1980, a major research effort in the in-home services.

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INTRODUCTION

Congress included as part of Public Law 95-142, the Medicare and Medicaid Anti Fraud and Abuse Amendments of 1977, the requirement that the Department review its programs for home health services, assess current status and problems of home-delivered services, and propose changes in directions and programs. This mandate is a broad one, covering nearly all aspects of home health and other in-home services:

- Coordination among programs
- Scope and definition of services
- Eligibility criteria
- Standards for certification, licensure and accreditation
- Utilization control
- Reimbursement methods and controls
- Prevention of fraud and abuse
- Controls over supply.

The Department welcomes the opportunity to review its programs of home health services. Given the opposing goals of controlling expenditures while increasing availability of services, we have chosen a middle-ground solution: to improve service quality and to increase efficiency and economy in our methods of providing and paying for these services. Current budget constraints, in addition to our other concerns, prevent us from recommending statutory changes at this time.

Home health and other in-home services are part of a larger picture: they form part of the health care system; they form part of a system of long term care services; they form part of a social support system. Many issues in home care are broader than the boundaries of specific programs. Hospice programs, an important type of home care, is not covered in this report because it involves unique services and concerns. The legislative mandate to which this report responds clearly spells out the specific areas to be addressed in existing programs and issues specific to home care. This report limits its scope to these matters and does not address the broader issues of long-term care and health care in general.

The mandate for this report instructed the Department to assess "home health and other in-home services" under the three programs. In the absence of specific delineation of those terms, they are fairly loosely construed for the purpose of this report. We have defined "home health services" to mean roughly those types of services described in Medicare and Medicaid law and regulation. They include an array of services, such as professional nursing care, physical, occupational or speech therapy, medical social services,

home health aide services, and medical supplies and equipment. These services are delivered singly or in combination to aid in recovery from an acute episode, or to maintain or improve health status. These services are of such a nature that they must be provided by an agency organized primarily to provide health care in accordance with certain standards.

We believe that the term "other in-home services" was included in Section 18 to encompass the broad variety of health-related and social/environmental services that can be rendered in the home under the Title XX social services program. These services would include home health services that may be reimbursed provided they are integral but subordinate to the package of social services, as well as the home-maker, chore, and other similar services, which are defined differently by the various states.

PART I. IN-HOME SERVICES UNDER MEDICARE, MEDICAID, AND THE SOCIAL SERVICES PROGRAMS

Home health and other in-home services benefits are provided through Title XVIII (Medicare), Title XIX (Medicaid) and Title XX (Social Services) of the Social Security Act. Such services are provided within the context of each program -- as health benefits for the elderly and disabled under Medicare; health services for low-income persons under Medicaid; and social services for low-income persons and other eligibles under Title XX. In FY 1977, these programs spent a combined total of $1 billion ($458 million for Medicare, $179 million in federal and state funds for Medicaid, and $445 million for Title XX) for in-home care. In FY 1977, in-home services were used by 530,000 Medicare beneficiaries, 208,000 Medicaid beneficiaries, and 1,634,000 Title XX beneficiaries. In addition, a large but undetermined amount of home care is paid for privately by individuals, private insurers, and philanthropic programs.

Each of the three Social Security Act programs described below presents different kinds of restrictions on the availability and utilization of in-home services.

A. Medicare (Title XVIII of the Social Security Act)

Medicare is a nationwide health insurance plan for people aged 65 and over, for persons eligible for social security disability payments for over two years, and for certain workers and their dependents who need kidney transplantation or dialysis. Health insurance protection is available to insured persons without regard to income. The program was enacted July 30, 1965, as Title XVIII--Health Insurance for the Aged--of the Social Security Act and became effective on July 1, 1966.

The Medicare program consists of two separate, but coordinated parts: hospital insurance (Part A) and supplementary medical insurance (Part B). Part A pays, after various cost sharing requirements are met, for hospital and skilled nursing facility care and services by home health agencies following a period of hospitalization. Part B covers physician services, home health care (up to 100 visits), medical and other health services, outpatient hospital services, and laboratory, pathology and radiologic services. Participation in Part B of Medicare is voluntary and any individual over 65 may elect to enroll. About 95 percent of those eligible for Part A elect to enroll in Part B.

1. Eligibility for Medicare Home Health Services

In order to receive home health care under Medicare, a Medicare beneficiary must be confined to his or her residence (homebound), have the services prescribed by a physician and be under the care of a physician, and need part-time or intermittent skilled nursing service and/or physical or speech therapy.

In addition, eligibility for Part A home health benefits requires that the beneficiary must have been in a hospital for at least three consecutive days prior to entry into home care. The care to be provided must be for an illness for which the person received services as a bed patient in the hospital and a plan of care must be established within 14 days after discharge from the hospital or skilled nursing facility.

Under Part A, a person's coverage is limited to 100 home care visits a year after the start of one spell of illness and before the beginning of a new spell of illness in the year following the last discharge from hospitalization.

Under Part B, the Medicare beneficiary must be homebound and require skilled nursing services, but there is no prior hospitalization requirement. For Part B, a beneficiary is limited to 100 home care visits in any one calendar year.

2. Home Health Benefits Under Medicare

The Medicare home health care benefits are, by law, oriented toward the need for skilled-care. They were not designed to provide coverage for care related to helping with activities of daily living unless the patient required skilled nursing care or physical or speech therapy. Home health services, as defined by Title XVIII of the Social Security Act, include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- Physical, occupational, or speech therapy;
- Medical social services under the direction of a physician;
- Part-time or intermittent services of a home health aide to the extent permitted in regulations;
- Medical supplies (other than drugs and medications including serums and vaccines) and the use of durable medical equipment; and
- Medical services provided by an intern or resident-in-training under the teaching program of a hospital which is affiliated or under common control with a home health agency.

The statute specifies that these services can be covered if furnished by a home health agency to individuals under the care of a physician, or by others under arrangements with them made by such agency under a plan established and periodically reviewed by a physician. These services are to be provided generally on a visiting basis in the individual's home. Under certain circumstances these services can be provided also on an outpatient basis at a hospital, skilled nursing facility, or a rehabilitation center.

3. Medicare Home Health Providers

Medicare limits the provision of home health services to organizations certified as Home Health Agencies (HHAs). Participating HHAs must provide skilled nursing and at least one other home health service. Home Health Agencies must meet all federal, state and local licensure and certification requirements. Proprietary agencies may participate only if they are licensed by the state. At present, twenty states have licensure laws for home health agencies, 16 of which allow proprietary agencies. Only 126 of 2,612 HHAs participating in Medicare are proprietary agencies; the majority are visiting nurse associations or public health departments. However, the limitation on the participation of proprietary agencies has sometimes been circumvented through the formation of private not-for-profit corporations and through subcontracting arrangements.

Medicare pays for services provided by an HHA on the basis of the lesser of its reasonable costs or charges. Reasonable cost is defined as "the cost actually incurred, excluding therefore any...cost found to be unnecessary in the efficient delivery of needed health services..."

4. Utilization of Home Health Services Under Medicare

In FY 1977, 530,000 Medicare beneficiaries used in-home services resulting in expenditures of $458 million. Home health expenditures under Medicare have been consistently increasing. In FY 1974, $100 million was spent on home health compared to $298 million in FY 1976 and $724 million projected for FY 1979. In 1974, only 393,000 Medicare beneficiaries used home health benefits compared to over 530,000 today. (See also Appendix 1.)

Of the beneficiaries utilizing home health benefits in 1975, 10.4 percent received visits under both parts A and B while 61.7 percent used Part A benefits only and 27.9 percent used Part B visits only. Beneficiaries using both Part A and B benefits used an average of 55.5 visits per year compared to 17.8 visits annually for Part A only beneficiaries and 17.2 visits annually for Part B only beneficiaries. These data suggest that those persons using both Parts A and B benefits are the most in need of such services because although this group represents only 10 percent of the beneficiaries, they receive about 25 percent of the total number of visits.

Use of home health services under Medicare related to age shows a fairly even distribution among home health beneficiaries. In FY 1975, the 65-70 age group had 101,700 home health beneficiaries receiving 2137 visits compared to 109,700 beneficiaries in the 70-79 age group using 2,356 visits and 97,200 beneficiaries in the 80-84 age group using 2,076 visits. All age groups average about 21 visits per home health beneficiary.

Utilization of home health services varies geographically. Over one third of all beneficiaries using home health services reside in the northeast. However, the beneficiaries in the South received the most visits annually and had the highest total charges per person.

B. Medicaid (Title XIX of the Social Security Act)

Medicaid, Title XIX of the Social Security Act, is the major vehicle for financing health care services for low-income people. It was enacted in 1965 for the purpose of enabling states to furnish the aged, blind, and disabled and families with dependent children whose income and resources were insufficient to meet the costs of necessary medical services with medical assistance and rehabilitation. Medicaid programs have been implemented in 49 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Mariana Islands. Only the State of Arizona has not implemented a program.

Medicaid is state administered under federal regulations. Program costs are shared by the states and federal government with the federal share ranging from 50 percent in states with high per capita incomes to 78 percent in Mississippi, the state with the lowest per capita income. Subject to federal legislation and

regulations, states have broad discretion in establishing eligibility criteria, benefit packages, and reimbursement rates.

States must provide Medicaid coverage to all people receiving AFDC and, with certain exceptions, to beneficiaries of Supplemental Security Income (SSI), the federalized blind, disabled, and aged welfare program. Income-related eligibility criteria are determined by the states. States may, at their option, extend coverage to the "medically needy." These are persons or families who meet the SSI or AFDC eligibility criteria (e.g., aged, disabled, etc.) but whose incomes are slightly above welfare levels. States establish the income eligibility standards for the medically needy, which may not exceed 133-1/3 percent of the state AFDC payment standard. States also have the option of covering other categories, including: families headed by an unemployed male; children who are financially eligible, but not in a federal welfare category; spouses who are "essential" to the well-being of an SSI recipient; and persons eligible for, but who voluntarily elect to decline, AFDC or SSI cash payments.

Medicaid plays a significant role in assisting its sister program, Medicare, in providing health insurance for the aged poor. Approximately 3.9 million aged, 16.9 percent of Medicare beneficiaries, are also covered by Medicaid. For these people, in most cases, Medicaid both pays the Medicare Part B premiums, coinsurance and deductibles and provides more extensive benefits than are available under Medicare. Most notably Medicaid provides the aged poor with drugs and long term care services, especially institutional care.

In their Medicaid benefit packages, states must cover hospital, physician, skilled nursing facility, family planning, home health, laboratory, and x-ray services. They must also cover early and periodic screening, diagnosis, and treatment (EPSDT) of children under 21, and rural clinic services. They have the option of covering other services such as outpatient prescription drugs, dental services, eyeglasses, intermediate care facilities, prosthetic devices and care for patients over 65 in tuberculosis or mental institutions. If a state's program includes the medically needy, it must provide that group with either the basic required services or seven of the seventeen optional services authorized for matching funds under Medicaid.

1. Eligibility for Medicaid Home Health Services

   States are required to provide home health coverage to any Medicaid beneficiary who is covered for skilled nursing facility care under Medicaid. By statute, states must provide skilled nursing facility benefits to adult Medicaid beneficiaires (any individual over 21 years of age). Coverage of skilled nursing facility benefits for individuals under 21 is at state option. Since eligibility for home health services is tied to eligibility for SNF services, Medicaid beneficiaries under 21 are covered for home health benefits only if their state has opted to cover them for SNF care. All categorically needy Medicaid beneficiaries over 21 are covered for both home health and SNF benefits.

   Unlike Medicare, Medicaid does not require a patient to be home bound or in need of skilled care to be eligible for home health services. However, a physician must certify that the patient needs home health services.

2. Home Health Benefits Under Medicaid

Medicaid, from its enactment in 1965 to 1970, specified "home health services" in its list of services to be provided at state option. However, definitions, criteria, and requirements were not included. The 1967 amendments to the Social Security Act mandated home health services effective July 1, 1970. New regulations clarifying the Medicaid benefits and eligibility were published on November 18, 1976 to clear up the confusion over eligibility and benefits by requiring the states to meet certain basic criteria. Under these regulations, states must:

- Provide coverage of nursing, medical supplies, equipment and appliances, and home health aide services to Medicaid home health beneficiaries.
- Allow an RN to provide covered services where no organized home health agency exists (LPNs are now excluded).
- Permit medical rehabilitation centers to provide therapy services (if they meet the standards as written in the regulations).
- Require all agencies to meet Medicare standards of certification or be eligible to meet them.
- Define nursing according to each state's Nurse Practice Act.
- Provide home health services for:
  - all categorically needy individuals over 21 years of age,
  - individuals under 21 years of age if the state plan covers such individuals for SNF services, and
  - all corresponding groups of medically needy individuals to whom SNF services are available. Eligibility shall not depend upon need for or discharge from institutional care.
- Permit coverage of home health services in an ICF if the ICF is not required to provide such services (such as RN services during a short, acute illness to avoid the need to transfer patients).

In addition to the required nursing, medical supply, equipment and home health services, a state has the option of providing coverage for physical, occupational, and speech therapies, medical social services, and personal care services. All services must be authorized by a physician and supervised by a professional nurse.

However, although home health benefits are mandatory, states have the discretion to place limits on the amount, duration, and scope of home health benefits. Thus, several states place limits on the number of covered home health visits. Some of the variations resulting from state discretion include:

- Number of allowable visits;

- Comprehensiveness of services
  - whether therapy is included and which therapies are provided;
- Whether home health aide services are available locally;
- Restrictions on provision of supplies, equipment and appliances;
- Restrictions imposed by states contrary to the intent of Medicaid regulations
  - "skilled" care requirement
  - "homebound" requirement
  - different scope of services for Medicare "buy-in" patients from those services available to others;
- Prior authorization of services
  - restrictive criteria; and
- Reimbursement—deviations in amount of payment from Medicare
  - agencies refusing Medicaid payments or patients
  - agencies having quotas for Medicaid patients.

3. Personal Care Services Under Medicaid

Personal care services are an optional benefit under Medicaid. Nine states cover personal care services: District of Columbia, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New York, Oklahoma, and Wisconsin. Personal care services include health related supportive services, such as assistance with household maintenance and activities of daily living. Personal care services are provided in a beneficiary's home by an individual who is qualified to provide such services, but is not a member of the family. The services are to be prescribed by a physician in accordance with a plan of treatment and supervised by a registered nurse. Many of the disabled receive attendant care services under the personal care benefit in the nine states that have elected such coverage.

4. Medicaid Home Health Providers

Medicaid requirements for participating HHAs are the same as for Medicare. However, Medicaid also permits states to provide personal care services from individuals not employed by an HHA.

Payment rates for home health services under Medicaid in some states are inadequate to attract sufficient provider participation. Reimbursement methods and rates for home health services, as for physician services, are left to the state's discretion. In contrast, SNFs and ICFs must be reimbursed on a cost-related basis which HEW must first approve. Some states attempt to contain program costs by keeping these rates low.

5. Medicaid Utilization of In-home Services

In the last ten years, total Medicaid expenditures, and total Medicaid payments for LTC services (primarily consisting of nursing home and home health care) have risen roughly five fold. During this same time span, Medicaid expenditures for home health have increased 25 fold. Even with this huge increase, however, Medicaid in-home benefits still only amount to about one percent of total Medicaid expenditures.

In 1977, Medicaid spent over $179 million on home health for its 261,331 beneficiaries. Approximately 80 percent of all expenditures and 70 percent of all recipients are accounted for by the aged and disabled beneficiary groups.

On a state-by-state basis, Medicaid home health benefits constitute about .1 to .5 percent of total state Medicaid expenditures for most states. The greatest deviation is New York, which spends 4.4 percent of its total on home health. New York is also responsible for 63 percent of all home health recipients and 80 percent of all national Medicaid home health payments.

Appendix 1 of this report summarizes current data concerning the utilization of home health services under Medicaid.

C. Federal-State Social Service Programs (Title XX of the Social Security Act)

In January, 1974, the U.S. Congress passed Title XX, "Grant to States for Services," with implementation scheduled for October 1, 1975. The legislative goal of Title XX was to enable states to make available services for:

- **Self support;**
- **Self-sufficiency;**
- **Protection of children and vulnerable adults from abuse, neglect, or or exploitation, and strengthening family life;**
- **Prevention or reduction of inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; or**
- **Appropriate institutional placement and services when in a person's best interest.**

Title XX is a grant-in-aid program that allows the states a large degree of discretion in providing a range of social services to their populations. A permanent ceiling of $2.5 billion annually is currently imposed (although this was raised to $2.9 billion for FY 1979 only); these funds are distributed to the states on the basis of their populations. The states are required to provide 25 percent matching and required to publish, in an annual plan, a description of the services they will provide, to whom, and by what methods.

1. Eligibility for Title XX Home Health Services

Individuals are eligible for Title XX services if they are eligible for cash assistance, have a low income, or are members of certain designated groups. Fees for Title XX services are mandatory for families whose monthly gross income exceeds 80 percent of the state's median income for a family of four adjusted for family size. Fees are at state option for families with incomes below the 80 percent level.

2. In-home Benefits Under Title XX

Services vary widely from state to state with eligibility and emphasis dependent primarily on decisions made within the state under an open planning process. This needs assessment and planning process gives concerned individuals and organizations a chance to help identify needs, establish priorities, suggest service providers, and assist to coordinate resources to build a systematic services delivery network that responds to the social services needs of local communities.

Local government representatives, interested organizations and concerned citizens can help to decide what services should be offered. At least three services must be made available for SSI recipients and at least one must be directed toward each of the five Title XX goals. Information and referral, family planning, and services directed toward the goal of protection may be offered without regard to income.

A variety of home-based services—including homemaker, choreworker, home management, personal care, consumer education, and financial counselling services—can be provided under a state's Title XX program. Covered services vary from state to state. It is difficult to present a concise description of in-home services delivered under Title XX. However, certain generalities may be noted and patterns observed from one state to another.

The following four services are particularly relevant to helping maintain individuals in their own homes:

- Home Health Aide Services - are medically related home care activities similar to those provided by nursing aides in hospitals. Such activities include maintaining an individual's health by assisting him or her in carrying out physicians' instructions. These services may be provided under Title XX only if they are an essential but subordinate service provided as part of a social service.

- Homemaker Services - are described as general household activities (meal preparation, child care, and routine household care) provided by a trained homemaker when the individual who usually performs activities is temporarily absent or unable to adequately manage the home and care for the personal needs of others.

- Chore Services - are most often described as home maintenance activities (repairs, yard work, shopping, house cleaning) performed by an untrained person for individuals unable to do such chores themselves. Personal care activities are often included.

- Home Management Services - are described as formal or informal instruction and training in home maintenance, meal preparation, budget management, child care, and consumer education.

3. Home Health Providers Under Title XX

There are no federal standards for participation as home health providers under Title XX and, in fact, states may contract with private individuals to provide in-home services.

States provide in-home services in the following ways:

- Direct provision—individuals employed by state or local Title XX agency.

- Purchase-of-service through contractual arrangement with public or private (voluntary, non-profit, or proprietary) agencies. (States vary between state-administered and state-supervised programs. In some cases the local Title XX agency contracts directly with the provider agency.)

- Independent provider—service provided by individual who is not affiliated with an agency—may be self-employed or considered under employment to the service recipient.

Since states have wide latitude within federal regulations in defining services and establishing regulations for the program, those regulations vary substantially from state to state. Only 12 states responding to a recent HEW survey reported having a licensing requirement for providers under Title XX.

4. In-home Services Utilization Under Title XX

In 1976, over 1 million individuals received in-home services under Title XX programs. Over 90 percent of all Title XX beneficiaries are adults who gain access to these services as an SSI or AFDC recipient or by being income eligible. Chore, homemaker, and protective services represent 70 percent of both total recipients and expenditures. Approximately 56 percent of these Title XX services are made available through direct provision; 11 percent are purchased from public sources and 33 percent from private providers.

Most states spend a substantial portion of their total Title XX budgets on these services. For example, California spends 62 percent of its Title XX monies for this purpose. Many other states spend between 40 and 60 percent, and most all states spend at least 10 percent of their total. Thus, Title XX now plays an important role in the provision of in-home services.

PART II. LEGISLATIVE AND ADMINISTRATIVE PROBLEMS IN COORDINATING HOME CARE PROGRAMS

This section briefly discusses some of the reasons for the lack of consistency and coordination among the home care programs, and some of the problems involved in attempting to modify the programs.

A. Legislative Mandates

The reasons for service fragmentation are usually laid at the door of the bureaucracy in charge of operating the programs but the difficulty begins earlier. Our public programs of health care, social services, and income maintenance have developed as separate categorical programs, directed toward many disparate constituencies by legislative and interest groups with different approaches and objectives.

The major programs being considered in this report--Medicare, Medicaid, and Social Services--emanate from what is technically one piece of legislation, the Social Security Act. However, each major part of it has been enacted at different times, for different basic purposes. Medicare is a medical insurance program for the aged; Medicaid is a health program for the poor; the Title XX Social Service programs served AFDC and SSI recipients and other low-income persons at the discretion of the states. In addition, physicians provide or prescribe services under Medicare and Medicaid while social services professionals provide services under Title XX.

B. Programmatic Differences

The programs were enacted for different purposes, and, prior to last year's reorganization which joined Medicare and Medicaid under HCFA, each of the three programs was administered by a different agency: Medicare in the Social Security Administration; Medicaid by the Social and Rehabilitation Service, and Social Services (Title XX) by another arm of the Social and Rehabilitation Service. The result has established the following program characteristics:

- The programs have overlapping constituencies;
- Service definitions and the range and duration of services covered vary substantially from program to program;
- Distinctions have been made between "health" service and "social" service programs which may reinforce fragmentation of services to population groups needing a range of service;
- Regulations governing providers vary from program to program;

TABLE 1: IN-HOME SERVICES PROVIDED UNDER MEDICARE, MEDICAID, AND TITLE XX

	TITLE XVIII	TITLE XIX	TITLE XX
Restrictions on In-Home Care	- need skilled care - restorative, not maintenance - homebound - under physician's care - 3-day prior hospital (Part A) - 100-visits each (Part A & B)	- eligible for skilled nursing facility - under physician's care	- as specified in an approved Title XX social service plan - health care only to be providdd as an essential but subordinate element of social services
Services Available	- skilled nursing - therapy (physical, speech, occupational) - home health aide - medical social services - medical supplies and appliances	as determined by state plans: - home nursing - therapy - home health aides - medical supplies, equipment, and appliances - personal care	as determined by state plans: - homemaker services - chore services - housekeeping services - personal care - home management - attendant care - home health aide
Providers	- certified home health agencies, e.g.,: hospital based agencies public health departments voluntary agencies private not-for-profit agencies proprietary agencies	- certified home health agencies (same as Title XVIII) - individual providers (physicians, nurses, therapists, attendants)	- public aid departments - voluntary agencies - proprietary agencies - private individuals
Eligibility Requirements	- age 65 or older, disabled, - End Stage Renal Disease patients	- all Title XIX categorically needy: Aged, blind, disabled, AFDC in all states - all individuals under 21 in states that include this group in SNF program	- income maintenance status - income eligibles - group eligibles
Administration	- Federal with Fiscal Agents	- State or Fiscal Agents	- State
Total Program Costs: (in millions) FY'76 FY'77	$16,600 20,800 (100% Federal)	$14,200 16,300 (50-78% Federal)	$2,500 ($2,900 in FY '79 (75% Federal)
In-Home Costs: (in millions) FY'76 FY'77	$287 457	$132 (N.Y. State: $107) 179 (N.Y. State: 146)	$284 (California: $ 81) 360 (California: 112)
Percent of Total Dollars Spent on Home Health Care	2%	1%	10%
Estimated Number of Clients [illegible]	530,000	205,000 (78,000 N.Y. State)	1,680,000

- Reimbursement methods are different for each program; and
- Federal, state, and local relationships are different for each program.

1. Changing Payment Sources

When consumers need services over a relatively long period, they sometimes must shift from one provider and funding source to another, with possible interruptions of service that are unrelated to need. Such shifts, even if only one provider is involved, may constitute considerable hazard to the client and administrative expense for verification of eligibility, recertification of eligibility, billing procedures, etc. One agency with a substantial long term caseload reports 28 shifts in payment sources for one individual.

Such shifts among payment sources highlight an interesting problem that, though not well-documented, occurs with some frequency. It happens not only because the status and conditions of people change, for there is considerable evidence that the various programs do indeed serve the same population groups. It happens also because state and local governments shift services and populations among "pots" of money in ways that seem most advantageous to them--either their matching is higher from the federal government, or they can purchase the service more cheaply due to less strict standards, or there is more money in one pot than in another.

The case of one home health agency is illustrative. In one particular year, the amount of reimbursement it received from Medicaid funds dropped from nearly three-quarters of a million dollars to a few thousand dollars while at the same time its payments from Title XX and local social service funds rose by a similar magnitude.

2. Service Definitions

Varying perceptions of home health services, of the components which should or should not be included in the range within the collective title, differences in the definitions of those components and their application--and efforts to define and divide the services by assigning them in accordance with a presumed "health" relatedness or "social" relatedness--have affected both their development and their appropriate use. The confusion and variations among definitions have impeded efforts to develop and coordinate services within communities which might effectively provide the comprehensiveness and continuity so frequently stressed as the desired objective in a service system.

a. "Medical" Definitions

The influence of Medicare on the provision of home health services has been considerable. Because Medicare is a health insurance program, the dichotomy has been reinforced between services perceived as medical and those perceived as social, in the public sector's funding of programs. The private sector, which is not bound by these narrow definitions, has continued to provide a wide range of services to those who purchase their own care.

The conditioning of providers with respect to Medicare contributed to the growth of providers of short term, acute care rather than encouraging development of providers organized to serve clients with diverse service needs.

Medicaid has followed essentially the same pattern in providing home health services, although there is more chance to provide "social" services should the states desire to do so; there is provision for "personal care service in the home," which nine states use, though the primary users are New York and Oklahoma. However, instead of encouraging provision of comprehensive and coordinated services, these two aspects of Medicaid are used totally separately, or else they substitute for one another. For example, Oklahoma has a large personal care program with no home health program.

This program, which seemed at first to bridge the gap, also fails to mesh with the "social" services provided under Title XX. Instead of being complementary, they are used generally on an either/or basis by those states which use the personal care service.

b. "Social" Definitions

Although Title XX supports several in-home services to its clients, it does not define any of them. States are free to use their allotted funds and define in-home services as they wish. Medical or health services are not included in the range of care financed by the Title XX program unless they are a minor and subsidiary aspect of the "social" service.

Definitions, particularly of paraprofessional workers and functions, can be particularly troublesome. For example, the definitions of homemakers and chore workers under Title XX vary among states, and include performance of functions ranging from "attendant" or "sitter" care to household maintenance, and even to such questionable activities (for untrained personnel) as personal care including bowel and bladder care.

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3. Gaps and Duplication

Because of the different basic purposes of Medicare, Medicaid, and Title XX, there may be overlap in the provision of home health services. For the consumer with multiple problems and multiple needs, there may be duplication -- with two or even three paraprofessionals going into the same home; several different providers could be serving the same client, causing both congestion and complex computation in rates of pay.

A recent case history found four different providers or agencies serving a single individual at home (homemaker, chore worker, meals on wheels, and visiting nurse service). In the small living units so common to most of the users of these services, some of the functions of the paraprofessionals could be performed by the same individual, and all services could either be rendered or supervised by one provider.

The European "home help" service, to which all of the functions described above are assigned, with special purpose emphasis in training for services to special groups, is a key element in all European community home care services and is probably central to their success. They are available and accessible and required in all communities; their use is encouraged, and substantial government interest is evidenced in training requirements and in funding of the services. The system for home care is not as simple or as clearly identifiable in the United States, because home health services are a part of several programs with different overall purposes.

4. Different Jurisdictions

The fact that different levels of government have responsibilities for the various home care programs means that in-home services are not standardized.

a. Medicare is a federally financed program with federal standards and reimbursement principles. Its standards are enforced at the state level by state employees paid by the federal government. Reimbursement is handled through fiscal intermediaries which are under contract to the federal government.

b. Medicaid is a shared federal-state program; legislation and basic regulations are federal, while administration and enforcement of standards are carried out by the states. Reimbursement may be done by the state or contracted to a fiscal agent. Reimbursement for home health service is set by the states by whatever method they choose -- cost, maximum allowances, flat rate, or other means. Basic services are prescribed in federal

regulations but states can and do vary both services and eligibility requirements. Financing is on a basic matching formula ranging from 50 to 78 percent federal funding depending on state per capita income.

C. Social Services (Title XX) are financed on the basis of a closed-ended grant-in-aid to the states, which must contribute 25 percent. Other than basic federal enabling legislation, there are few standards or requirements for carrying out the program or providing services, except that the states must use an open planning method. Thus, states can provide whatever services they determine are most important. Many states in turn allow county and other local jurisdictions to acutally operate the programs; in many cases, localities must contribute a matching share. The Social Services program is rarely operated by the same staff that operates Medicaid.

5. Different Criteria for Providers

Under Medicare, and by adoption Medicaid, home health agencies must meet a set of specific conditions of participation. Personal care services under Medicaid, however, can use different types of providers or they can be provided by individuals who are not employed by an agency.

Title XX provides in-home services under a variety of arrangements:

- Self-employed providers
- County employees
- Negotiated rate contracts with homemaker-only providers
- Negotiated rate contracts with agencies that are also Medicare-certified.

PART III: ELIGIBILITY AND COVERAGE ISSUES

Many Medicare and Medicaid beneficiaries are potential users of home health services. However, restrictions on services covered and eligibility requirements for coverage of services may prevent some Medicare beneficiaries from using home health services. For Medicaid beneficiaries, restrictive state implementation of and reimbursement for the home health benefit may retard greater use of home health services. It should be noted that this discussion of benefits and eligibility criteria excludes in-home services of Title XX, the Social Services program. Title XX does not spell out a particular benefit package or eligibility criteria for benefits, other than to exclude health services that are not subordinate to or an integral part of the social services being delivered. This restriction is not viewed as a problem in that the mission of Title XX is to provide social services.

A. Medicare

1. Possible Administrative Changes

The Department is examining what it can do administratively to improve coverage and eligibility of home health care under Medicare. Two examples of possible improvements are:

a. Coverage of evaluation visits as allowable visits rather than as administrative costs
Evaluation visits, which are required for each patient upon initiation of services by a home health agency, would be allowed as separate visits. Administrative costs would thus be limited and confusion reduced in the reporting of costs for reimbursement.

b. Revision of the definition of "part time - intermittent" services.
The intent of this definition was to prohibit provision of full-time care in the home, but it also meant a prohibition against one-time visits or visits that were not needed on a medically predictable basis. The definition will be revised to allow one-time visits for evaluation, education, or service purposes, and to allow visits even though they are not of a predictable frequency.

By means of our demonstration and research programs, we will examine the effects of allowing around the clock care for a short period on the individual, family provision of care, costs, and patterns of individual use.

2. Consideration of Other Medicare Issues

Other changes that were considered, but about which there was concern regarding lack of information, potential costs, or other factors, include these:

a. Inclusion of nutrition service visits as a specific benefit

Visits for the purpose of providing nutrition advice or assistance can now be covered as an administrative cost. Although some individuals and groups felt that these services should be a discrete benefit, we believe that there is a need to further examine how such a benefit would be structured, what type of person should be allowed to provide the service, and under what conditions and requirements. The need for adequate nutrition and nutritional advice is indeed substantial among the Medicare population, but for the time being, these needs can be handled in the existing Medicare benefit structure.

b. Inclusion of occupational therapy services as one of the primary services

The primary services which must be needed by the home health client are skilled nursing, physical therapy or speech pathology. It is contended by some that occupational therapy is frequently the only service needed by stroke, arthritis, or other patients, yet Medicare will not allow occupational therapy unless other services are also provided.

The American Occupational Therapy Association places the cost of this change at $1.4 million, while HEW actuaries placed it at $28 million a year. The Association believes that the available manpower pool is sufficiently limited to preclude a large expansion in use of the service. The Department has in the past opposed this change, in part because, in the absence of the need for any other home health services, defining the need for occupational therapy would be difficult.

c. Proposals for change in the skilled care requirement

The requirement that a beneficiary needs skilled care, whether it be nursing or physical or speech therapy, has been especially criticized. The major national organizations representing home health providers have in the past proposed changing the skilled care definition as a prerequisite for service. However, removing the requirement for skilled care would represent a substantial change in the nature and purpose of the Medicare program, would create a large new eligible group of beneficiaries, and would substantially increase program costs. As a result, most of the organizations representing home health providers have conceded that the skilled care requirement represents a valid control mechanism within the context of the current Medicare program. This is also the position of the Department of Health, Education, and Welfare.

The guidelines implementing the Medicare program define skilled care to mean services which are performed by or under the direct supervision of a licensed nurse, ordered by a physician, intermittent, and reasonable and necesary to the treatment of an illness or injury. Examples of skilled nursing are given to augment the definition, for it is stated that simply having a service performed by a skilled individual does not make it skilled.

3. Other Issues

a. Coverage of home health services to terminally ill patients

Individuals with terminal illness have at times been denied home health coverage by fiscal intermediaries. In the past, care of the terminally ill has been denied by some Medicare intermediaries on the grounds that there are no therapeutic services involved, and there is no restorative potential. However, guidelines have been revised in the past year to clarify this issue, and it is now clearly stated in the guidelines that, if the individual meets the skilled care and other requirements, the fact that he is terminally ill or without restorative potential is irrelevant for reimbursement purposes:

Assuming that all of the conditions and all the other requirements for home health benefits are met, reimbursement can be made under the program for the skilled nursing care required by a beneficiary without regard to whether he has a terminal, chronic, or acute illness, his condition is stabilized or unstabilized, or the need for skilled nursing service may extend over a long period of time.

b. The homebound requirement

Concern over this provision has been raised repeatedly by individuals who believe they have lost coverage because they left their homes briefly for home health hearings and other purposes. Interpretations of the homebound requirement appear to have varied a great deal among fiscal intermediaries.

The Medicare law states that in order for the beneficiary to be eligible for home health services he must be confined to his home. This provision was intended to emphasize that if the individual is able to leave home to carry out general daily activities, then he should obtain needed health services in an ambulatory care setting. Only if this is not possible are home health services to be provided.

The guideline interpreting the "homebound" requirement states that the "condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort." If the patient in fact leaves the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration. Although the guidelines say that most absences from the home are expected to be for purposes of receiving medical treatment, they also say that occasional walks, drives, trips to the barber, and the like would not constitute a breach of the definition. The guidelines further state that the individual is expected to be unable to leave home without the assistance of a device or an individual; this is essentially a definition of disability.

B. MEDICAID

1. State Home Health Benefits

In addition to placing limits on use of home health services, many states have not made efforts to meet the mandate to provide home health services as part of the Medicaid program. Many states have, in effect, no home health services at all. The reasons for state failure to fully implement home health services include:

- Some fear the cost impact of an "added" benefit;
- Some find it easier just to refer patients to nursing homes;
- Some states have shifted to Medicaid "personal care" services (New York, Oklahoma);
- Some states have shifted to Title XX "homemaker" service (California);
- Some states have caused a constriction in supply of Medicaid service through low reimbursement rates; and
- Some states place restrictions on eligibility and coverage (e.g., skilled care, limited visits - sometimes as few as 12 a year).

In Pennsylvania, the reimbursement rate is so low ($5.00 to a hospital-based home health agency and $10.00 to a VNA) that agencies are unable to accept Medicaid patients, since the average agency charge is $22.98 for a nursing visit. These rates have been in effect since 1971. The local health departments are providing services so that one can say that the state is meeting "emergency" needs, but most Medicaid recipients do not receive home health services to which they might be entitled.

Wyoming's Medicaid agency expended only $444 for home health while Medicare's total cost in that state for the same year was $242,000. Only in New York is the Medicaid expenditure as large as Medicare's, exceeding Medicare expenditures by $31 million. In Nevada, which also provides for Personal Care Services costing about $84,000, Medicaid home health expenditures amounted to $19,000, Medicare's to $439,000.

2. Personal Care Services

Some states have also met the home health service requirement by substituting narrower personal care services. This is done through a Medicaid regulation, CFR 449.10(b)(17)(vi), which allows payment for the provision of personal care services "in a recipient's home rendered by an individual not a member of the family, who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse." The impetus for this provision, promulgated by Medicaid in the 1967 regulation, was Oklahoma, which now has no home health program. Nine states, including New York, currently use this mechanism. Some of its advantages to states are these:

- It is cheaper than supervised and professional service by agencies meeting established standards;
- Plans of care and other criteria are not required to be met;
- Payment rates tend to be lower because the state decides the amount to be paid to each individual worker; and
- Little training and supervision are provided, thus lowering the per unit cost.
- More flexibility is available in the services offered.

The nine states providing this personal care benefit are:

- District of Columbia
- Massachusetts
- Minnesota
- Montana
- Nebraska
- Nevada
- New York
- Oklahoma
- Wisconsin

The states provide little information, and apparently have little, on the nature of the services rendered, the skill levels and supervision of the individual providers, or the actual needs of the clients. Personal care services by individual providers are often cheaper to provide than are organized home health services, and this makes them attractive to some states. State data indicate that payments to individual providers range

from $2 to $3 per hour, and that the type and amount of fringe benefits paid vary; indeed, self-employed providers generally receive none.

The District of Columbia pays a maximum of $200.00 per month to any one provider. Most states pay the minimum wage. Several states have policies that limit the case expenditure to a percentage of nursing home costs. Nurses who supervise the aides may be employees of the state, of a home health agency or have a special arrangement with the state for this purpose. In Nevada, the nurses are paid $5.35 per hour and in Montana, $7.50 under a provider agreement with the state.

It is apparent that some states have used the personal care benefit to replace home health services by an organized program with uniform standards. While this method is cheaper for the state, and may be more appropriate for some beneficiaries, there are some indications that standards are not applied to the personal care services, that little or no training or supervision are provided, and that some of the tasks performed have been of a more complex and technical nature than an untrained or unskilled person should perform.

3. Potential Medicaid Eligibility Changes

Medicaid eligibility rules are, in practice, tied to the use of institutional long-term care. Although Medicaid is the major public financer of long-term care services, it spends relatively little (2.3 percent) of its LTC funds on home health care. The principal explanation lies in the process by which many elderly become eligible for Medicaid - the spend-down provision. Many persons become eligible for Medicaid only after incurring large medical expenses--almost always as a result of some form of institutional care. Only the continued high costs of nursing home care can maintain an individual's eligibility. The costs of home health services under most circumstances would not be great enough to establish eligibility for Medicaid.

Medicaid eligibility for home health services could be expanded by revising the general Medicaid eligibility structure. For example, Medicaid spend-down provisions could be revised to allow less spend-down, and thus expand eligibility for and incentives to substitute home health services. However, such changes are beyond the scope of this study and would have broad impact on eligibility for and use of all Medicaid services. Thus, they are not considered in this report.

PART IV. PROGRAM MANAGEMENT ISSUES

This section examines the reimbursement methods and practices of the Medicare, Medicaid and Title XX programs; administrative issues for Medicare such as the selection of fiscal intermediaries and the process of claims review; and policies which would inhibit fraudulent and abusive practices.

A. Reimbursement

The specificity of federal requirements for reimbursement of home health services is greatest for Medicare, more limited for Medicaid, and non-existent for Title XX, since the program content is determined by the States. Home health agencies are "providers" under Medicare, as are hospitals and skilled nursing facilities, and thus are reimbursed on a reasonable cost basis. Medicare pays for home health services on the basis of the lesser of an agency's charges or costs incurred which are reasonable and allowable in the provision of services to Medicare beneficiaries.

The federal Medicaid statute does not require specific payment methods or rates for home health services except that, for any given home health provider, the Medicaid rate may not exceed the Medicare payment rate. Twenty-four states including New York, New Jersey and Massachusetts, use the Medicare method of reimbursing home health agencies, and another three use some kind of cost-related method. Seven states pay for services on the basis of usual and customary charges, and fourteen base payments on fee schedules, maximum allowances, contracts, or negotiated rates.

The Title XX program is a closed-end block grant to the states. States provide and pay for in-home social services in a variety of ways, which include contracts, hourly rates, per visit fees, and cash grants to the individual eligible for services to purchase care. Title XX reimbursement rates frequently are below Medicaid rates for similar services.

This range of financing arrangements and of statutory requirements for reimbursement has resulted in different circumstances and problems for the provision of home health services under each program. Some inefficient and extravagant providers have received excessive payments under Medicare. Under Medicaid, on the other hand, restrictive payment practices and benefit limitations in some states have impeded beneficiaries' access to home health services. The $2.5 billion cap on federal Title XX expenditures, as opposed to the open-ended unlimited financing available under Medicare and Medicaid, has forced tradeoffs between the nature of in-home services and the rates of payment for these services, often resulting in the provision of services in the least costly manner with little or no assurance of their quality. Because federal authority over the management of state Title XX programs is extremely limited, policies regarding this program will not be treated further in this section.

Although Medicare reimburses home health agencies as providers, like skilled nursing facilities and hospitals, the services provided by HHAs resemble those of individual practitioners such as physicians in some respects. There is no room and board component to home health services as there is to institutional care, and the services of HHAs are provided on a one-to-one basis by individual health professionals. Although there is widespread dissatisfaction with reasonable cost reimbursement of home health agencies, there is very little analysis, either theoretical or empirical, which would permit a recommendation at this time for a substantially different reimbursement policy.

1. Medicare

There are several problems with Medicare home health reimbursement which HEW has just recently begun to address. Some are common to providers of services reimbursed on a reasonable-cost basis, whereas others are peculiar to home health providers. Because home health services have accounted for such a small proportion (between one and two percent) of total Medicare expenditures, the application of reimbursement policies and controls for providers of these services was given a lower priority than the development of such policies for hospital or physician services. The result has been significant growth in the cost of home health services and opportunities for providers to abuse the program.

Another result of the relatively low priority given to management of the home health benefit by HEW in the past is the absence of comparable cost information for HHAs. As discussed below, this problem too is now being addressed. The third major problem, unique to home health services under Medicare is the existence of providers which choose to serve only Medicare beneficiaries because of the attractiveness of Medicare reimbursement.

a. Cost control

Section 223 of the 1972 Social Security Amendments authorized "the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals..." Such limits on the costs recognized as reasonable by Medicare for routine hospital services were established in FY 1975. HEW has recently issued a notice of proposed limits under Section 223 for home health services. In addition, HEW is currently developing guidelines for the allowability and reasonableness of specific items of cost. A major problem in setting overall limits is whether to differentiate, and if so how, between "free standing" providers and higher cost hospital-based home health agencies. The cost difference may be due to hospital overhead costs being added to the home health activity.

Fiscal intermediaries are responsible for establishing guidelines on treatment of reasonable costs, though few have done so for home health agencies. The Division of Direct Reimbursement, HCFA, acting as intermediary for 300 home health agencies, has done so in an attempt to control the amounts of reimbursement. Its guidelines are based on a formula which stratifies agencies by size, type of geographical area, and discipline. This effort is acknowledged to be a partial solution while more complete data for comparative purposes are sought.

In efforts to establish better controls over allowable costs, HEW is taking the following actions:

- Revision of regulations governing allowable costs for the expenses of related organizations.
- Publication of additional instructions to fiscal intermediaries advising them on how to deal with long-term contracts between Medicare providers and organizations providing management and related services and with inappropriate practices of patient solicitation by home health agencies.
- Aid to intermediaries, in the form of national data and guidelines, in determining and identifying costs which are "substantially out-of-line" with those of other providers.
- Issuance of rules and guidelines to intermediaries as to the treatment of specific expenses, such as travel.
- Publication of a Notice of Proposed Rulemaking concerning Section 223 limits on overall home health costs by the end of 1978.

b. Lack of comparability of costs

The lack of uniformity of costs among home health providers and their consequent incomparability has impeded Medicare in making changes in the reimbursement system. Comparisons among home health agencies regarding costs are impossible at the present time due to the fact that home health agencies are not required to use the same methods either of apportioning costs to various elements or of reporting costs. For example, such costs as overhead, administration, consultant services, and supervisory costs are allocated differently by different providers so that it is impossible to separate out cost centers or distinguish direct service costs from indirect costs in order to apply tests of reasonableness.

Cost reporting and allocation forms for home health agencies have not been changed since the inception of Medicare in spite of numerous changes in the nature of services, providers, and costs. Section 19 of P.L. 95-142 now clearly establishes authority for HEW to require uniform reporting of costs for health care providers. Further, the Secretary may establish uniform definitions, principles,

and reporting of statistics. This uniform reporting requirement was designed to permit "measuring and comparing the efficiency of and effective use of services in... home health agencies..." and other health care providers.

Work is already underway to replace the current four cost reporting methods for home health agencies with a single one, with explicit instructions for defining and allocating the various cost elements. The uniform forms and reporting methods, in addition to permitting valid comparisons among providers, will facilitate audits and reimbursement determinations. Section 19 of P.L. 95-142 requires the uniform cost reporting system for home health agencies to be in place not later than October 1979. Since the effort for home health agency reporting has already been initiated, however, it is expected that a single cost reporting/cost finding system will be published in draft in the near future.

c. Medicare-only providers

Reasonable cost reimbursement for home health services as administered over the past ten years, coupled with other policies such as waiver of liability (which permits payment for a service which the beneficiary and agency in good faith believed would be covered but in fact was not), has given home health agencies the opportunity to receive high levels of reimbursement from the Medicare program. Some of these issues are discussed further in subsequent sections on fiscal intermediaries and fraud and abuse.

The extreme case of providers which have taken advantage of generous Medicare reimbursement is that of the provider which accepts as clients only Medicare beneficiaries and provides only those services which are program benefits. This provider prefers to allocate all of the costs of its operation to services provided to Medicare beneficiaries rather than accept other sources of payment, including client self payment, at sometimes lower rates than those of Medicare.

HEW is opposed to the existence of Medicare-only providers. First, this practice discriminates against other HEW program beneficiaries, most notably those on Medicaid. Second, Medicare beneficiaries are not well served by providers that terminate them as clients if and when program benefits are exhausted. Finally, other elements of the community are excluded from access to services.

More stringent review of provider costs and upper limits on Medicare reimbursement should diminish the attractiveness of Medicare as a payor relative to other sources of payment. However, more direct steps addressing this situation should be taken; the Department is exploring a variety of ways of eliminating Medicare-only providers.

2. Medicaid

Medicaid services are administered by the states within federal guidelines; the states must provide home health services as one of the seven basic services provided to cash assistance recipients. They retain discretion as to whether to provide services to the medically needy, and to certain other individuals. In addition, since the states decide what reimbursement methods to use and at what levels to reimburse, there is considerable variation. Although 24 states have adopted the Medicare principles of reimbursement, the rest have established their own rates and methods. These methods are cost-based or consist of fixed fees, negotiated rates, or a schedule of maximum allowances (see Table 2). Most states which do not pay for home health services on a cost basis pay less for home health than does Medicare. The level of Medicaid reimbursement may be lower than the cost of providing the services; for example, in some states the Medicaid rate is less than 50 percent of the level of Medicare reimbursment for the same services. Under such circumstances providers often either refuse to particpate in Medicaid or, instead of refusing all Medicaid clients, place limits on numbers of clients or services received, up to a specified amount of available charitable or other funds. A second Medicaid reimbursement problem, one not limited to home health services, is that of lags in payment following the submission of claims for payment. This has resulted in cash flow problems for participating home health agencies. However, Section 2 of P.L. 95-142 now requires that states meet specific standards for claims payment time.

These reimbursement policies have frequently resulted in:

- A limited number of providers serving Medicaid clients;
- A quota system whereby only a small percentage of Medicaid patients are accepted by agencies without assurance of other sources of funding; and
- Unavailability of home health services to Medicaid recipients in many geographic areas.

Several states have indicated their awareness of the problems caused by the low rates but are fearful of expenditure increases inherent in reimbursing full costs. Some states have shown an interest in expanded home health services provided they can predict and control expenditures, and provided they can expect this service to reduce institutional care costs.

HCFA's major emphasis since its inception has been to improve the relationships between Medicare and Medicaid and to promote as much uniformity as possible between the two programs. Uniform policies in certain areas would clarify and facilitate operations by providers, and understanding of the programs by their beneficiaries. Before we develop a single reimbursement policy for Medicare and Medicaid, we need to collect sufficient information on the costs of producing or the potential demand for home health services. We also need to understand better the behavior of home health providers in response to reimbursement incentives before we can establish a single reimbursement policy for both programs.

TABLE 2
MEDICAID PROGRAM DATA
HOME HEALTH SERVICES 1976-1977

Reimbursement Methods

Schedule of Maximum Allowance	Contract or Negotiated Rate	Usual or Customary Charges	Lower of* Cost or Charges	Fee Schedule	Cost Based
Alabama	D.C.	Arkansas (with ceiling of 75th percentile)	Colorado	Alaska	Connecticut
California	Montana	Delaware**	Georgia	Oregon	Indiana
Florida	Oklahoma	Idaho	Iowa	Pennsylvania	Maryland*
Kansas	Utah	Illinois	Louisiana	Rhode Island	Massachusetts*
Minnesota	Connecticut (for proprietary agencies only)	Kentucky	New Hampshire		Michigan*
Ohio		Maine	Tennessee		Minnesota*
		Wisconsin	Virginia		Mississippi*
			Wyoming		Montana*
					Nebraska*
					New Jersey*
					New Mexico*
					New York*
					North Carolina*
					North Dakota*
					South Carolina*
					South Dakota*
					Texas*
					Vermont*

Hawaii and West Virginia have not reported.

* Same payment as Medicare
** Delaware pays 98 percent of charge.

Definitions

Maximum Allowance - maximum amount established by the state for a given product or service; state pays lower of actual charge or maximum allowance.

Fee Schedule - state pays a specified amount included in a schedule of charges for specific goods or services.

Contract - state purchases goods or services through a contract mechanism and pays the amounts specified.

Usual and Customary - an amount based on a provider's charge experience for some period of time; please indicate year or period during which amount was established, e.g., 1974.

Cost Based - state pays for services based on allowable provider costs, e.g., annual operating costs.

B. Fiscal Intermediary Issues in Medicare

The Medicare statute requires administration of benefits primarily through private fiscal agents of two kinds--fiscal intermediaries generally administer Part A benefits and carriers administer Part B benefits. Both agents are responsible for reviewing claims for coverage and reimbursing claims for services rendered to individuals. In general, for purposes of reimbursement, fiscal intermediaries must determine the reasonable costs of Medicare providers, whereas carriers must determine the reasonable charges of the individual practitioners providing services to Medicare beneficiaries. A third fiscal agent within the Medicare Bureau--the Division of Direct Reimbursement (DDR)--determines the costs and reviews and pays the claims of organizations such as HMOs and federally funded health centers, as well as serving as intermediary for about 15 percent of the home health agencies participating in Medicare. All Medicare home health benefits are administered by intermediaries rather than carriers, even though the benefit is split between Parts A and B. Intermediaries were chosen to administer this split benefit because reimbursement for services provided under both Parts A and B is based on an agency's reasonable costs.

The provisions of Medicare, Part A, have permitted each provider to nominate its own fiscal intermediary. Section 14 of P.L. 95-142, however, has given the Secretary authority to designate intermediaries with respect to a provider or a class of providers, but only after first developing and then applying "standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions...and, (2) performance of such functions with respect to specific providers of services," and "...standards and criteria with respect to the efficient and effective administration of this part."

1. Problems

With respect to the home health service benefit, the fiscal intermediary system has presented a number of problems. These problems have been exacerbated by the lack of adequate national guidelines defining and interpreting benefits, and of criteria for coverage and cost reimbursement. The result of the current system has been widespread differences in interpretation of benefits, in reimbursement practices, and in the determination of the legitimacy of claims.

Although efforts have been made in recent years to narrow these differences among intermediaries, they have persisted, at least in part, for the following reasons:

- Home health service claims represent a low-volume item for most fiscal intermediaries; thus they frequently do not take the time to develop careful screening or claims review and sampling guidelines. Similarly, the staff in charge of these activities often spend only a small portion of their work time on home health and thus do not develop the expertise to review claims in a consistent fashion.

- The fact that home health services represent a low-volume activity means that efficiency in this area is not well-developed, resulting in a high processing cost per claim reviewed.

- Fiscal intermediaries exercise considerable freedom in their interpretations of Medicare guidelines about what services are covered under what conditions. Differences in interpretation result from several factors including differing corporate philosophies about home health, differing procedures for reviewing level of care, differing staffing patterns for claims review, and differing requirements for documentation of claims.

- Interpretations of what represents allowable costs have varied widely without apparent reason.

A 1976 study carried out by the Bureau of Health Insurance (BHI), now HCFA's Medicare Bureau, examined the extent and types of variations among fiscal intermediaries regarding claims screening guidelines and interpretation of coverage rules. Its conclusion was that considerable differences continued to exist in both of these areas but that home health services had not been unduly restricted by these differences.

2. Administrative Improvements

Improvements in the reimbursement system could be accomplished both through better federal policy direction and designation of a limited number of regional intermediaries. We will pursue both courses of action.

a. Federal Direction
Two areas of program administration which could benefit from increased guidance from HCFA are claims screening and review activities and the determination of reasonable and allowable costs. HCFA has, over the past six months, issued several intermediary letters concerned with the latter issue; work has not yet begun for the former.

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The current payment practice results in delays in payment to the provider and represents a high administrative cost. This is due largely to the practice of prepayment review of all home health service claims that intermediaries make. A sample review which is well designed and to which intermediaries direct sufficient staff resources could be as effective as and less costly than the complete prepayment review. On the basis of sample review the intermediaries could identify and try to change improper provider practices. A case-by-case review of an individual provider's claims could be used as a last report if many denials are made. HCFA will begin to develop criteria for a policy of postpayment claims review on a sample basis.

Currently each intermediary establishes its own standards for utilization reviews. Variability among intermediaries in their determinations of the appropriateness of amount and duration of home health services could be reduced by the issuance of federal screening guidelines regarding appropriate utilization of services. HCFA will review the feasibility of issuing such guidelines.

Intermediaries are currently receiving increased guidance from HCFA as to the determination of reasonable and allowable costs. These activities are detailed in the previous section on reimbursement practices. These increasingly detailed instructions should lend authority to intermediaries' review and determination of allowable costs as well as promote uniformity in reimbursement practices among intermediaries.

b. Fiscal intermediary assignment

There is a strong belief that the current system of provider nomination of an intermediary and the resulting dispersal of home health claims processing and cost finding among many intermediaries diminish the efficiency and effectiveness of administration of this benefit. In addition to greater federal guidance regarding reimbursement and coverage policies, this administrative problem could be addressed by reducing the number of intermediaries handling home health claims.

Designation by HCFA of a limited number of intermediaries for home health agencies would result in greater uniformity, and hence equity, in the coverage and reimbursement of Medicare benefits. Furthermore, greater consistency and rigor in the determination of reimbursable costs could be achieved. Comparisons of performance among providers would be facilitated by such a consolidation. Finally, efficiency would be improved due to the ability to develop expertise in reviewing a larger number of claims.

We have considered a variety of options with respect to selection of intermediaries for home health agencies. These options include:

- Designation of a single, national fiscal intermediary for all home health agencies. This intermediary could be either DDR or a private sector fiscal agent.

- Designation of a series of intermediaries which serve home health agencies on a geographically determined basis.

We have decided to pursue the latter approach—selection by HEW of a limited number of regional or areawide intermediaries competent in reviewing home health claims and agency costs. Providers would no longer nominate their own intermediaries. DDR could be one of the intermediaries selected under such a plan. While several intermediaries may not be able to achieve the degree of uniformity in implementing coverage and reimbursement policies which could be achieved by a single agent, this course permits continued geographic dispersal of resources and funds and greater opportunity for provider-intermediary contact. Furthermore, home health services under Medicare have been growing and continue to grow at such a rapid rate that the work load of all participating agencies is likely to be too great for a single intermediary. Policies regarding selection of fiscal intermediaries for home health services are being developed further in conjunction with a comprehensive analysis of intermediary contracting policies being conducted by HCFA.

C. Fraud and Abuse in Home Health Care - Medicare and Medicaid

Over the past few years, surveys, investigations, and hearings into the status of home health services have highlighted the existence of major fraud and abuse problems in this area. Among the major investigative activities were hearings on Medicare and Medicaid fraud and abuse in 1977; hearings on proprietary home health agencies in 1975; an investigation by Senator Lawton Chiles' Subcommittee on Federal Spending Practices; and various HEW audit reports, particularly of agencies in California. A substantial record has been built of the patterns of program abuse and fraudulent practices by providers.

The historical reasons for laxness in managing the Medicare home health benefit are documented in the previous section on reimbursement practices. Renewed efforts by HCFA to standardize and assure rigorous review of allowable provider costs, in addition to the initiatives authorized by P.L. 95-142, address many of the opportunities to defraud and abuse the Medicare program which have existed to date. Some of these efforts are reiterated in this section; however, many courses of action which are recommended primarily for other reasons such as promulgating more stringent conditions of participation in order to improve the quality of services would also improve control of fraud and abuse in Medicare and Medicaid.

Before the advent of Medicare, the limited home health services available were provided primarily by Visiting Nurses Associations (VNAs), other charitable organizations, and state and local public health services. As a result of

the Social Security legislation which instituted federal financing for services provided by these programs, several new providers entered the home health services program. Providers can now be grouped into three general categories:

- Public agencies - includes all agencies operated by state or local governmental units.
- Nonprofit agencies - includes nongovernmental organizations exempt from federal income taxation undere Section 501 of the Internal Revenue Code, such as Visiting Nurses Associations or agencies located in hospitals, SNFs, or rehabilitation facilities.. This designation also includes a new breed of provider known as the private-nonprofit agency which is organized and operated by an individual, but has achieved and maintains tax exempt status under the Internal Revenue Code.
- Proprietary agencies - includes all privately owned, profitmaking agencies.

Most of the problems uncovered in the delivery of home health services have been encountered in proprietary and individually operated nonprofit agencies.

In 1974 a total of 329,700 persons received Medicare home health services and about $137,406,000 were reimbursed for such services. The large majority (about 85 percent) of those persons were served by Visiting Nurses Associations, governmental agencies, and voluntary agencies. The other 15 percent were served by proprietary, individually operated nonprofit, and institutionally based agencies. However, this latter group of providers received 21 percent of Medicare reimbursement for home health services. On the average, this same group of providers made about 30 percent more visits per person served and had an average visit charge 30 percent higher than those of all other agencies. Proprietary and individually operated nonprofit home health agencies are expanding in certain parts of the country; many of these agencies provide services to Medicare beneficiaries exclusively. Because these agencies have no other sources of revenue, collection of any overpayment by Medicare becomes extremely difficult since it could result in the agency's financial failure and consequently the loss of services to beneficiaries.

The records of the Office of Program Integrity in HCFA reveal that the types of complaints on home health agencies received and the fraudulent or abusive situations detected and substantiated include:

- Billing for services not rendered
- Misrepresentation of services
- Altering bills and receipts
- Duplicate billings
- Falsifying records or documents
- Certification fraud
- Payroll padding
- Improper allocation of costs
- Interim payment rate violation

1. Occurrence of Fraud and Abuse

Since 1969 (when HEW started to keep records on this type of activity) HEW has received over 200 complaints on home health agencies. One-hundred twenty of the complaints have been closed, i.e., they have been found to be unsubstantiated or they have been substantiated and referred to the U.S. Attorney who either prosecuted the case (or declined to do so) while 80 (61 fraud, 19 abuse) complaints are still in the preliminary investigation process. By far the most common complaints are allegations of billing for services not rendered. To date, seven cases have been referred to U.S. Attorneys for prosecution. Of these seven, one is still pending. In two cases the defendants were found guilty, while the remaining cases either have been declined by the U.S. Attorneys or have been closed because out-of-court settlements were reached. With the creation of HCFA with its Office of Program Integrity, and the earlier creation of the Office of Investigations and with the enactment of P.L. 95-142, it is expected that ultimately there will be more effective investigative prosecutions of HHAs and a reduction in fraudulent and abusive practices.

2. Contributing Factors in Fraud and Abuse

Several factors have played a role in the occurrence of fraud and abuse; these will be discussed only briefly here, since most of them are dealt with in greater detail in other sections of this report.

- Medicare reimbursement guidelines have been unspecific and in certain cases intermediaries have reimbursed excessive costs for such items as salaries, pensions, and fringe benefits. Guidelines for administrative and other costs do not currently exist to control these practices.

- Non-arms-length practices between home health agencies and hospital discharge planning units have been reported to be a problem. The most questionable situation of this kind involves the placement of home health agency personnel in a hospital's discharge planning unit to facilitate the placement of patients with the HHA. These arrangements should be prohibited. However, it is necessary for hospitals and home health agencies to work together in planning for patient care. Prohibition of all communication would not be in the best interests of the patient, for the lack of such joint planning for patients being discharged from hospitals has long been identified as a problem. Thus the methods and rates of patient referral from hospitals to HHAs must be monitored.

  Problems have been encountered with the authorization of home health services by physicians having a financial interest in the home health agency providing the service.

3. Solving Problems of Fraud and Abuse

The Medicare-Medicaid Anti-Fraud and Abuse Act has provided HEW with a number of tools for combating fraud and abuse in its programs:

- HEW may assign providers to fiscal intermediaries for the sake of efficiency and effective administration (Section 14).
- Uniform cost reporting is now required for all groups of providers (Section 19).
- Fraud against any part of the program is now a felony carrying penalties of fines and imprisonment (Section 4).
- All providers must make full disclosure of the identity of each person with an ownership interest and of subcontractors whose business transaction with the entity amounts to more than $35,000 (Section 3).
- The federal government has access to all Medicaid providers' records as it has always had for Medicare providers (Section 9).

The Department is planning to take the following actions to deter fraudulent and abusive activities:

(1) Assign regional or areawide fiscal intermediaries. It is anticipated that building expert review and audit capacity in a limited number of locations will remove incentives to defraud, and will, in fact, act as a deterrent. Grouping home health agencies and comparing costs will improve the intermediaries' ability to identify out-of-line providers.

(2) Explore the feasibility of screening guidelines for use in auditing samples of claims.

(3) Increase field audits of patient records and cost reports by the intermediary.

(4) Increase departmental auditing activities in order to improve detection of fraud and abuse where they occur (this is currently being done in selected areas).

(5) Prohibit Medicare-only providers by requiring a certain percentage of patients to have sources of payment other than Medicare.

(6) Test the effectiveness of requiring home health agencies to submit a duplicate bill to the client, listing services provided and amounts charged. Clients would be instructed to contact the intermediary in the event of a discrepancy.

PART V. QUALITY STANDARDS AND PROVIDER ISSUES

The legislative history of Section 18 of P.L. 95-142, and subsequent statements by members of Congress and their staffs, have stressed that a major reason for the mandated study is a concern for standards in home health services. There is wide agreement that there should be standards or that standards should be improved under HEW in-home services programs. There was much less agreement, however, on what was meant by standards, either in the Congress or among the agencies and organizations that had supported the legislation. Standards were variously defined as meaning that benefits and eligibility for services should be expanded, that proprietary agencies be allowed in, and that Medicare's conditions of participation be improved. The issues of benefits and eligibility have been discussed elsewhere in this report; this section addresses conditions of participation, including the special conditions for proprietary agencies, accreditation and deemed status, and provider issues under Medicare. Finally, quality assurance for Title XX in-home services is discussed.

A. Medicare Conditions of Participation

Home health agencies participating in the Medicare and Medicaid programs are required to meet certain standards of capacity and performance, the conditions of participation. The framework for these conditions is established by law, in Section 1861(C) of the Social Security Act. A home health agency is defined as being primarily engaged in providing skilled nursing services, providing at least two specific services, having certain professional policies, maintaining clinical records, having overall plans and budgets, and meeting "such other conditions of participation as the Secretary may find necessary..." Regulations establishing the conditions of participation cover the following areas:

(1) Definitions

(2) Compliance with federal, state, and local laws

(3) Organization, services, and administration

(4) Procedures for governing and monitoring patient care

(5) Acceptance of patients, plan of treatment and medical supervision

(6) Services - skilled nursing, therapy, medical social, home health aide

(7) Personnel - training requirements, professional practices

(8) Establishment and maintenance of clinical records

(9) Evaluation of the agency's total program and behavior.

Because of the concern expressed about the Medicare conditions of participation, HEW staff have consulted with interested groups and individuals regarding these conditions. On May 18, 1978 a meeting was held with representatives of national

organizations of home health agencies and other organizations to review specific aspects of the conditions of participation. Based on these discussions, as well as on documents submitted and an internal review, the Department is proposing a number of revisions.

There appears to be general satisfaction with the existing conditions as a basic document upon which to build additional assurances of agency capacity to provide services. The consensus of opinion is that the conditions do not adequately address the activities which agencies must engage in to assure the quality and appropriateness of care provided. It should be noted that, although it is always possible to set standards which are higher than the present ones, the consequences must be weighed. Setting stringent standards would constrict the supply of qualified providers. Also, the costs of extremely high standards may outweigh the benefits; a middle ground is therefore necessary, one that protects the beneficiary while creating a realistic environment for service provision.

In this vein, a number of changes are being proposed, and decisions made with respect to enforcement and monitoring of the conditions of participation.

It is recognized that the changes being proposed here concern structure (the agency characteristic deemed necessary to provision of service) and "process" (such things as staff qualifications, utilization review, etc.) in contrast with "outcome' or client-oriented standards. The last is the most desirable, but our current capacity to measure outcome prohibits us from replacing structural and process standards at this time. Our ultimate goal is to develop a system of continuing assessment of the quality of care provided and the impact of that care on the recipient. Efforts to develop such a system will continue through the re-evaluation of standards, capability for assessment of quality, and the search for improved methods of determining desired client outcome.

1. Areas of Proposed Change--Agency Composition

   a. Services under arrangements

   Supervision has been a problem when agencies contract for services. It should be made clear that services provided in such a manner are to be supervised, coordinated, controlled, and evaluated by the primary agency (See 405.120(m)). There must be a written arrangement between the primary agency and the secondary agency regarding personnel and supervisory policies.

   The intent of the current proposal is to assure that the agency is completely responsible for and in control of the performance of homemaker/home health aides working under its auspices. Further, the certified home health agency is responsible for the overall case, its management supervision, and development and implementation of the plan of care. Accountability clearly rests with the certified agency.

   The Department considered requiring all home health agencies providing home health aide services to directly employ the aides, rather than subcontracting for them through another agency, as is now permitted. While such a requirement might reduce problems of supervision and fragmentation of service and aid in assurance of quality, it would require a radical restructuring of the home health care system, and

would put a large number of providers of all auspices out of business. In view of the fact that we wish to promote the availability of home health services we have concluded that this is not the first area on which to place such stringent controls. We hope that by requiring a close and official relationship between the primary agency and the subcontracting agency we can assure quality and adequacy of the service.

Finally, we considered requiring all certified home health agencies to provide a comprehensive range of services rather than just the present two services as a further means of achieving continuity of care. This would also have the effect in current circumstances of severely constricting the availability of the home health benefit. Therefore, although we recognize comprehensive service to be the desirable goal of all providers, we cannot begin to require it at this time.

b. Utilization review in home health

Appropriateness of service is currently determined through three methods which generally function independently of one another: the physician certifying need for care, agency staff, and claims reviewers on a post facto basis. Further controls on use of service under Medicare are the limits on number of visits per benefit period and per year for Parts A and B respectively, the requirement for skilled care, and the requirement of prior hospitalization for the Part A benefit. These controls are crude, at best, and provide little control once a person has begun receiving services. A utilization review function, in addition to monitoring the continued need for services, would focus professional attention on the quality and efficacy of services rendered to the patient.

Either as part of a UR function or as a general utilization gauge, HEW will work toward the development of utilization norms and patterns which could be used as guidelines for judging use. Cases falling outside established norms could be selected for further analysis.

A sample of cases would be periodically reviewed to determine that:

(1) Services are being provided in accordance with the patient's plan of care;

(2) The patient's needs are periodically assessed and appropriate revisions made in the plan of care;

(3) Services are being used appropriately;

(4) Professional policies are followed in providing services;

(5) Needs of patients served by the agency are being met both quantitatively and qualitatively taking account of utilization of other community resources; and

(6) Unmet needs of patients are identified and documented and made available to the patients, their families, physicians and responsible social and health services agencies.

Findings and recommendations should be written and discussed with the agency's director and appropriate staff. The agency's records should indicate action taken in response to the utilization review committee's findings and recommendations.

c. Plan of treatment

Some agencies have separate plans of care for the services provided by contract therapists. These plans should be integrated into one coordinated plan of care, to be reviewed and updated periodically. All services to be provided to the patient must be included in this plan. Each service should be identified, its frequency and duration given, and the professional person who will provide the care or supervise its provision identified by name. It has been suggested that the plan be reviewed monthly to identify need for revision. Currently the requirement is that the plan of care be updated every 60 days. This requires reassesment of the patient's status and recognizes the fact that the patients' condition and needs will change sufficiently to require revision in such areas as treatment goals, and frequency or type of service provided, or a cessation of service.

The plan of care and its maintenance requirements should be kept as simple as possible in order to minimize paperwork and maximize time spent on patient care.

d. Definition of "skilled" nursing

Considerable provider and intermediary dissatisfaction with the current terminology of Medicare has been expressed. In particular, the term "skilled" in front of nursing has created problems for home health care providers, many of whom advocate using the term "professional" instead.

They contend that, with such a change, the definition of nursing would be simplified. Nursing would not be defined according to the relatively complicated and specific set of tasks which define the current term "skilled nursing" and which they say are inappropriate to home care.

On the other hand, such a change (which requires legislation) could result in expanding benefits under Medicare, since a more flexible definition could extend coverage to persons who do not need skilled care. This issue requires much greater analysis of costs and impact before any recommendation can be made for such a change.

2. The Licensure Requirement for Proprietary HHAs

A special condition on for-profit home health agencies in the Social Security Act (Medicare) stipulates that they be licensed by the state in which they operate. Since only 21 states have licensure laws (one New York, prohibits for-profit agencies) this requirement has precluded these agencies from serving Medicare and Medicaid clients in the remaining states except as subcontractors to certified agencies. (Table 3 on the following page shows this information.)

a. Provider experience

Since HEW collects data only for the services for which it pays, little is known about how non-Medicare certified for-profit home health agencies operate, how much of the private paying clientele they serve and what kinds

TABLE 3: STATES WITH LICENSURE LAWS FOR HOME HEALTH AGENCIES

State	Year of Law	Regulations	Certificate of Need Requirement
Arizona	1971	1971	Yes
California	1966	Being Revised	No
Connecticut	1977	Being Developed	No
Florida	1975	Revised 1976	Yes
Hawaii	1969	1969	Yes
Idaho	1975	1976	No
Illinois	1977	Being Developed	Yes
Indiana	1973	1974	No
Louisiana	1967	1967	No
Kentucky	1972	1972	Yes
Maryland	1976	Being Developed	Yes
Montana	1977	Same as Medicare	Yes
Nevada	1973	1973	No
New Jersey	1973	Revised 1976	Yes
New York (does not license proprietaries)	1973	1973	Yes
North Carolina	1971	1971	No
Oregon	1977	Same as Medicare	Yes
Tennessee	1975	Revised 1976	No
Wisconsin	1967	1967	Yes

of services they provide, and how they are organized. It is known that many providers are simply employee pools and central switchboard-referral operations, with no provisions for supervision or assessment and monitoring of client needs. Since we lack sufficient information about the operating characteristics, services, staff, and costs of proprietary agencies now outside of the Medicare and Medicaid programs, we will not make recommendations with respect to proprietary agencies at this time.

b. Arguments about proprietary agencies in Medicare

It should be noted that in 20 of the 21 states which have licensure laws, proprietary agencies are already allowed to participate in Medicaid and Medicare. These licensure requirements are not generally higher than Medicare standards and so do not assure higher quality. The debate about whether to admit proprietary home health agencies to full Medicare and Medicaid participation by removing the licensure requirement from the law has centered on the following points:

(1) Supply issues

- Inclusion of proprietary agencies in Medicare and Medicaid would fill the need for expanded service capacity, which is generally considered to be necessary.
- This need could be filled in other ways, not just through proprietaries. Service capacity of public health agencies and voluntary (charitable) agencies could be expanded through increased third party reimbursement or through capacity-building grants. The definition of Medicare home health provider could include comprehensive health service providers such as HMOs, community health centers, etc. Proprietary agencies tend to locate in areas which promise the most lucrative business, such as suburban and some urban areas. Inner city and rural areas are generally left to the public and voluntary agencies, or continue with no service at all.

(2) Equity

The current licensure requirement for proprietary agencies is discriminatory. Proprietaries already participate as subcontractors for Medicare and as providers under Title XX. The private not-for-profit agencies, which are allowed to participate in Medicare and Medicaid without meeting additional requirements, are subject to even less scrutiny than proprietary agencies, whose business practices must be acceptable to the IRS.

(3) Competition and service

- Some feel that competition introduced by proprietaries would have a beneficial impact on price and services. However, competition in such areas as Florida has not reduced price or increased efficiency. Further, the voluntary agencies feel they should be protected from such competition.

- Proprietary agencies can fill a need for 24-hours-a-day, seven-days-a-week service which public and voluntary agencies have not filled in the past. (This does not necessarily refer to round-the-clock service provided to a patient, but to the agency remaining open at all times to provide services when needed—at night or on a weekend.)

(4) Quality

- It is argued by some that quality of proprietary services is a problem. However, there appears to be little evidence to either support or refute this argument. There is no evidence available to indicate services are of lower quality.

c. Further Requirements for Proprietary Providers

The Medicare law, in addition to requiring licensure of proprietary agencies, states that the Secretary of Health, Education, and Welfare may prescribe by regulations, additional standards for these agencies. In the past this has permitted the Department to issue regulations requiring certified proprietary agencies to provide all their services directly, rather than by contracting for them.

3. Proposals for Monitoring Performance — Accreditation and Deemed Status

The acknowledged federal role in setting standards for home health care under Medicare and Medicaid stems from the principle that the public body purchasing services is obliged to insure a reasonable quality of service at a reasonable cost. In the instances of Medicare and Medicaid, the Federal government has assumed the responsibility for setting standards and monitoring (as well as paying for) their enforcement. Actual enforcement is done under contract with the states.

Criticisms of the federal (Medicare/Medicaid) conditions of participation, and of enforcement at the state level and monitoring at the federal level, can be addressed in two ways. The federal government may continue to work with the states to strengthen enforcement and closely monitor state performance, and at the same time work to improve the conditions of participation themselves (as specified elsewhere in this report). Alternatively, a national accrediting organization or organizations could be determined to apply standards which are equal to or better than those of the federal government. In this case, the accreditation of home health agencies by the national organization could be "deemed" to meet the standards for Medicare and Medicaid. The "deemed" approach is attractive to some within the industry and has the advantage of offering a mark of excellence to some providers. However, there is concern that in an area where fragmentation and abuse have been detected, the granting of "deemed status" would decrease accountability. Monitoring by the federal government would be difficult, particularly in the event that "deemed status" was sought by, and granted to, several organizations.

Further, difficulties are presented by the "deeming" approach:

- First is the one, already mentioned, that if the Department adopted high, "ideal" standards, it would probably exclude all but a small, elite group of providers.

- Second, home health service providers are not a unified entity on the national scene; there is no single national organization that provides leadership. At least five or six organizations represent various segments of providers. Some have their own standards and accreditation procedures, but none accredits more than ten percent of the total Medicare-certified providers. If one organization were granted deemed status, several others would request it.

- Third, there is a multiplicity of professional and paraprofessional services involved in home health care, and the groups representing them could request their own accreditation; if their standards were comparable to Medicare it would be difficult to refuse to grant the request, and fragmentation would result.

There is no single national organization with the strength and membership necessary to become a truly national and universal accreditation program. Although there are several problems in permitting "deemed status," (accreditation by an organization which satisfies Medicare/Medicaid certification requirements) to one organization entity, the Department is exploring this possibility.

Group	Agencies Accredited
Medicare (HCFA) - Certified Agencies	2,400
National League for Nursing/APHA	84
Joint Commission on Accreditation of Hospitals (JCAH)	Accreditation proposal in draft
National Council of Homemaker/Home Health Aides	129
National Association of Home Health Agencies	Accreditation proposal in draft

B. Quality Assurance for Title XX In-Home Services

Under Title XX, homemaker and other in-home care services may be provided by a variety of methods including the private not-for-profit agencies, proprietary agencies, and single service agencies, often through low-bid contracts, as well as by the individual provider who often receives no supervision or assurance of wage or benefits. There are no federal quality controls built into this program. This raises the question of whether quality and appropriateness of service are adequate. Other questions focus on whether authority to set such standards should be provided under Title XX and whether, in the absence of a specific mandate, the program could set standards.

1. Problems of Quality Assurance in Title XX

a. Contracting for services through low unit--cost bids
This competitive bidding process for purchase of service contracts has often resulted in attention to cost factors alone, without consideration of quality, accountability, needs assessment, or service practices. No basic criteria have been established for service and appropriateness evaluation or for fiscal and management practices. Most states have not established criteria for judging the "lowest bidder," based on total costs, or the relationship of these costs to the effects of services on on patients.

b. The lack of standards
Per-case expenditures that appear to be very high have been charged to the federal and state governments in the absence of standards of what constitutes appropriate care and appropriate cost. The different federal matching ratios and service standards between Titles XIX and XX encourage states to provide services under one or the other authority depending on the relation constraints of the two programs, rather than on individual client needs. For example, some clients have been judged on Monday to be in need of home health services as provided under Title XIX, and on Tuesday, to be in need instead of "homemaker/chore services." The two sets of services are theoretically of a different nature from one program to another, yet the client is switched from one to the other depending on the estimated cost and funding limits. The typical question a state might ask itself in this situation is what is the tradeoff between (a) Medicaid home health service with higher reimbursement and lower federal matching rate and more stringent (thus costly) standards and (b) Title XX, with a funding ceiling, but higher federal match and no federal standards?

Audits conducted under the auspices of GAO, and recent HEW audits have added to the documentation of abuse brought out in Senator Chiles' hearings in Florida and in joint hearings of the House Ways and Means and Senate Aging Committees. State agencies have sometimes not established standards, monitored providers, enforced present laws and regulations, prosecuted violators, or developed mechanisms to secure, encourage and retain honest providers of quality services.

The lack of training and supervision of home health agency personnel has resulted in both mismanagement of provider agencies, and inappropriate or ineffective care given to in-home service recipients.

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c. Self-employed provider practices

The growing trend for states to use the individual self-employed provider to perform in-home services under Title XX has sometimes led to problems such as: failure to obtain Social Security and other benefits for the provider; no supervision, training or accountability of the provider; lack of minimum standards of care and protection for vulnerable clients; inappropriate placement of responsibility for monitoring with client.

Under Title XX, a state can opt to have individual provider contracts, with little or no monitoring, where the consumer-client makes the selection. The result has been a lack of accountability, and a residual legal question of who is actually the employer: the local or state government, the Title XX agency, or the recipient? Legal disputes are in process, and in some areas it appears that the local government has been determined to be the actual employer, responsible for recruitment, hiring, salary and fringe benefits, training, and monitoring.

d. Definitions of in-home services under Title XX

In-home services under Title XX have a wide range of definitions which often overlap and are confusing. These services offered under the other Social Security titles also have different meanings. This situation can lead to duplication of services, inappropriate use of the service, inadequate or misrepresented reporting, and difficulties in making state-to-state comparisons. There is wide disparity among the states regarding not only the mix of services provided under Title XX, but also in definitions and key components of each service. For example, one state defines its chore service as a "hands off," heavy task-oriented service including activities such as wood-chopping; another, one of light housekeeping duties; and a third specifies such personal care components as feeding and dressing.

A recent Taxonomy of Title XX Social Services identifies 84 discrete [illegible] which have been written into 37 entries for chore services in the Comprehensive Annual Services Plans (CASPs) for Fiscal Year 1976. Thus it is difficult to paint a single picture of service delivery under Title XX; however, certain broad generalities may be noted and patterns observed from one state to another.

Title XX precludes the federal government from telling states what services to provide. Further the statute is silent about permitting states to define functionally those services that are provided. Recently published Proposed Regulations covering disclosure of ownership begin to define health related and in-home services.

2. Improvements in Quality Assurance under Title XX

Efficiency and effectiveness might be improved by the development of professional health and social service supervision to assess individual needs, order and readjust services, and monitor continued service needs.

It may be most desirable if states developed their own criteria with guidance on model criteria provided by the federal government. Without such standards, the use of self-employed providers, at least for the aged and other vulnerable populations such as the mentally disabled, may not be desirable.

Standardized definitions for in-home service might also improve the quality of Title XX in-home services. HEW could develop such definitions but they would have to be voluntarily adopted by each state.

PART VI. HOME HEALTH SERVICES - DEVELOPING AND CONTROLLING SUPPLY

It may seem contradictory to propose methods of expanding the availability of home health services while voicing concern that the development of capacity be controlled. However, these two concerns are valid with respect to home health services in the United States. As a result both of reimbursement restrictions in public programs and of the nature of home care providers, expansion of service has not occurred rapidly over the past decade in the nation as a whole. On the other hand, in certain geographic areas where favorable conditions existed there has been a rapid expansion of services, to the point of over-saturation.

Thus many believe that both controls and stimuli are needed: controls in areas of rapid growth in availability of providers, and stimuli in rural areas, low-income areas, and other areas determined to be in need of services. A further reason to encourage expanded capacity is to attain the goal of comprehensive health services at the community level by aiding small and single-service providers, and by developing new providers of services.

A. Certificate of Need

State certificate of need programs mandated under P.L. 93-641, the National Health Planning and Resources Development Act of 1974, must ensure that covered health services, equipment, and facilities must be determined by the states to be needed, as must expenditures for these purposes. The predecessor to this program, Section 1122 of the Public Health Service Act, had covered home health services in its reviews. However, interpretations of Congressional intent in the planning law led the Department to determine that non-institutional services were not meant for inclusion, and on March 19, 1976, it published a regulation deleting home health agencies from coverage under the Section 1122 program and from certificate of need requirements. Among the other reasons cited for the exclusion was the belief that the health planning system should concentrate its efforts on high-cost areas, and that adequate criteria for determining home health need did not exist.

1. The Purposes and Functions of Certificate of Need

The purposes of the certificate of need (CON) process are to exert control over supply, availability, accessibility, and adequacy of service, and control over costs through determination of the impact on the amount of expenditures for health services as a result of increases or decreases in the supply of services.

The CON process should be viewed in relation to the other major requirements of P.L. 93-641: consideration of national priorities in health plans and review processes, recommended consistency of plans with national guidelines, and the statutory and regulatory interface of national priorities and health plans through procedures and criteria for reviews.

In summary, the certificate of need process is a tool to be used in developing a rational system of health services at the local level by assuring a balance of types and amounts of services available. However, the very nature of the

certificate of need process--a prospective review of the need for additional service capacity--dictates that it be more of a limiter of supply than a generator of it. The health planning and technical assistance functions are designed to do the latter.

As a prospective review instrument the CON process opts in many cases to maintain the status quo (i.e., no more hospital beds), or to encourage more even geographic distribution (no beds in one part of a county, but need for some in another). A third function of the CON combined with the planning process is to encourage better distribution of levels of care (i.e., the HSA might deny an application for a skilled nursing facility but state that it would accept a domiciliary care facility as a substitute, in line with established local needs). It is in these areas--improved distribution and levels of care--that the CON process has the most relevance for home health services.

The following reasons are given for including home health services in the certificate of need process:

- Proliferation of home health agencies in certain areas would be stopped.
- Development of home health service capacity would become more rational.
- The CON process would encourage providers to go into currently underserved areas.
- The HSA should exercise control over all aspects of health care, not just institutional care.
- Home health would be given priority and visibility in the planning process and as part of the health system. HSAs would be stimulated to develop data and criteria for determining community need for home health services.
- Existing providers, particularly visiting nursing associations, believe that they would be protected from an influx of profit-oriented "businesses."
- The CON process might be a means of forcing agencies to pledge to serve the community, including Medicaid recipients, rather than only Medicare beneficiaries.

Available information shows that 14 states now include home health agencies under required coverage of their certificate of need programs and others are expected to do so. These 14 states are:

(1)	Alabama	(8)	New York
(2)	Arkansas (stated in Regs)	(9)	Texas
(3)	Connecticut	(10)	West Virginia
(4)	Hawaii	(11)	Wisconsin
(5)	Kansas	(12)	Wyoming
(6)	Kentucky	(13)	Maryland
(7)	New Jersey	(14)	Virginia

2. What CON Is Not Intended To Do

Much of the debate over whether home health service providers should be subject to certificate of need has been based on misunderstandings about the nature and purpose of CON; much has also been based on a very real concern that proliferation and overlap of providers in certain localized areas will have a detrimental impact on clients, quality, and costs.

Many of the proponents of CON for home health services expect it to have a kind of impact that it was not designed to have. However, most of the problems CON is believed to be capable of solving must be solved by other means.

The CON process will not:

- Assure quality of services delivered
- Control fraud and abuse.

Quality assurance and the determination of home health agency capacity to provide services are the function of survey, certification, and licensure. If there are weaknesses in these systems they cannot be solved by the CON process; the systems themselves must be strengthened. This confusion of purposes has probably been a major stimulus to the debate over CON.

In the same vein, fraud and abuse will not be dealt with through this process but rather by the enforcement of existing certification standards, service review, reimbursement process and the development of additional necessary safeguards against such practices. Effective administration of checks on reimbursable costs, effective service audit capacity, and special screening for fraud and abuse are the appropriate means of dealing with these problems.

Reasons against inclusion of home health providers in the certificate of need process include:

- HSAs should direct their efforts at reviewing high cost and high volume facilities in order to most effectively target cost controls.
- States with special problems of oversupply or maldistribution are free to establish CON requirements; states without these problems would be forced to adopt a cumbersome procedure.
- There is a general undersupply of home health services rather than an oversupply. Efforts to expand services should not be dampened until a balance is achieved.
- CON will not solve problems of underserved areas; they cannot make the unattractive attractive.
- Keeping new providers out in favor of the status quo of traditional providers might lessen innovation, efficiency and improvements in availability of service.

- Applying CON might not encourage efforts to develop need criteria, since most states with CON requirements for home health have not actively sought to develop them.

- The existence of CON will not aid in the development of capacity.

3. HEW Position

The Department intends to continue to exclude home health services from the certificate of need process as a required activity of local health planning and systems agencies. However, consideration will be given to phasing in CON for home health as criteria for determining need are developed.

Despite the basic decision not to require home health agencies to be within the CON process, the following actions are under consideration:

(1) Improvement of methodologies for determining need/demand for home health services through grants, contracts or in-house resources. Present estimates are that the need for home health care services is large; however, greater specification of the need by types of illnesses, by population, by medical care prognosis, and by cost are needed for more efficient and effective planning.

(2) Development of additional technical assistance documents for planing agencies in regard to home health services, e.g., expansion of Planning Guidelines in relation to home health or development of guidelines on the review criteria considerations.

(3) Grants or contracts to evaluate the various types of home health agencies and their impact on quality of care, costs, utilization of health personnel to assist HSAs and SHPDAs with priority setting.

(4) Establishment of a system (possibly coordinated with a home health trade or professional association, a health planning association, and NPHIC) to alert planning agencies of studies or reports done by the government or the private sector. This would assist them in keeping abreast of pertinent factors in home health delivery.

(5) Consideration of methods to interface the development of home health services with the development of HMOs (on the basis of section 1502(7) priority with HMOs a priority of section 1502(3)).

B. Availability and Distribution of Services

1. Supply Issues

In 1963, not more than 250 agencies met the definition of a home health agency as later defined by Medicare. At that time, 1,163 agencies offered a program of nursing care of the sick at home but only 141 of these nursing agencies could have met the requirement that at least one other therapeutic service must also be provided. In addition, less than 100 qualifying hospital-based programs could be counted. Ninety percent of the agencies offering in-home services were operated by official health agencies and visiting nurse associations (VNAs). The official agencies provided educational and referral services in the home but, in contrast to the services provided by visiting nurse associations, no direct care. The Medicare home health benefit became effective on July 1, 1966 and considerable progress had by then been realized. As of October 1966, 1,275 home health agencies were certified for participation in the Medicare program.

Data presented in Table 4 reveal that, between 1966 and 1976, the number of health agencies participating in the Medicare program increased from 1,275 to 2,165. Although the number of agencies certified varied from year to year, there was a net increase of approximately 910 agencies participating in the Medicare program by the end of the first decade, a 71 percent increase in agencies. VNAs, which in 1966 operated 506, or 40 percent, of participating home health agencies, operated slightly less than one quarter of the agencies certified by Medicare in 1976. In 1966, visiting nurse agencies represented 45 percent of participating home health agencies, but operated slightly less than one quarter of the agencies certified by Medicare in 1976. In 1966, official agencies represented 45 percent of participating home health agencies and in 1976 were 53 percent of the total.

Hospitals and other organizations - except combined government and voluntary agencies - almost quadrupled their participation during the first ten years of the Medicare program and together operated fully 20 percent of the agencies certified in 1976. The combination agencies declined by 46 percent.

2. Geographic Distribution

In 1966, slightly over one third of the nation's home health agencies participating in Medicare were located in the Northeast. Another third were in the South, and the remaining third was divided between the North Central and Western regions. By 1975, increases in the number of certified agencies, particularly in the North Central region and the South, reduced the proportion of certified home health agencies located in the Northeast to approximately 27 percent of the total. In 1975, 32 percent of the home health agencies participating in the Medicare program were in the South as compared to 38 percent in 1966 despite an increase of 232 agencies.

TABLE 4

Number of persons served, number of visits, and amount of charges, by region, calendar year 1975

(Numbers and amounts in thousands)

Region	Persons served		Visits		Total charges		Visit charges		Total reimbursement	
	Number	Per 1,000 enrollees	Number	Per person served	Amount	Per person served	Amount	Per visit	Amount	Per person served
Total	499.6	20.2	10,805	21.6	$227,001	$454	$211,944	$20	$215,497	$431
Northeast	175.9	29.2	3,633	20.6	71,258	405	67,848	19	68,226	388
North Central	101.5	15.2	1,959	19.3	37,315	368	36,012	18	35,186	347
South	139.0	17.7	3,519	25.3	81,080	583	72,830	21	76,175	548
West	78.3	19.9	1,495	19.1	32,908	420	31,523	21	31,656	404
Outlying areas 1/	4.9	18.1	177	36.0	4,459	935	3,732	21	4,254	864

1/ Includes Puerto Rico, Virgin Islands, Guam, other outlying areas, and residence unknown.

Table 5 reveals variations in the distribution of certified home health agencies and the distribution of Medicare beneficiaries by census region and divisions. In the South and the Northeast, the percent distribution of certified agencies is higher than these regions' share of the Medicare population, whereas it is lower than the present Medicare enrollment in the North Central region and the West. These variations reflect differences among the census divisions which comprise the regions; for example, except for the South Atlantic division, the percent distribution of certified agencies is greater than the percent distribution of the service population.

The uneven geographic development of home health agencies is reflected in service utilization by Medicare beneficiaries. Regional utilization data indicate that 175,900 beneficiaries in the Northeast region received home health visits in 1975 (29.3 per 1,000 enrollees), while in the North Central region visits were received by 101,500 enrollees (15.2 per 1,000 enrollees).

The data presented in Table 6 on the distribution of certified home health agencies and the distribution of Medicare beneficiaries suggest that the availability of services of home health agencies is related directly to the percentage of the Medicare enrollment which resides in metropolitan counties. The rankings of census regions in terms of non-metropolitan coverage is the same as for metropolitan coverage, but the differences in the percent population to whom services are available vary markedly.

In the Northeast, where the greatest percentage of Medicare beneficiaries live in metropolitan counties, the availability of home health agencies is nearly universal; services are available to the entire enrollment residing in metropolitan counties and to 89 percent of those who live in non-metropolitan areas. In contrast, the operation of home health agencies relative to beneficiaries' residence is lowest in the North Central region, which has the smallest proportion of metropolitan enrollment to total Medicare enrollment.

Except for the Northeast, home health services are available to less than 70 percent of the Medicare beneficiaries who reside in non-metropolitan counties. For example, services of home health agencies are available to slightly more than the North Central region's beneficiaries: 93 percent of its metropolitan enrollment is covered, compared to 55 percent of the beneficiaries who live in non-metropolitan counties.

3. Service Availability

Table 7 presents data on the number of services offered by agencies participating in the Medicare program in 1975 and 1976. The service offered most frequently after skilled nursing care is physical therapy, followed in order by the services of home health aides, speech therapists, medical social workers, and occupational therapists.

TABLE 5 Number and Percent of Medicare Beneficiaries and Certified Home Health Agencies by Census Region and Division. United States. 1974.

	Medicare Enrollment		Certified Agencies	
	Number* (millions)	Percent**	Number	Percent
United States	21.9	100	2,329	100
Region				
Northeast	5.5	25	625	27
North Central	6.1	28	579	25
South	6.8	31	890	38
West	3.5	16	235	10
Northeast				
New England	1.4	6	343	15
Middle Atlantic	4.1	19	282	12
North Central				
East North Central	4.0	18	335	14
West North Central	2.0	9	244	10
South				
South Atlantic	3.4	16	338	15
East South Central	1.4	6	298	13
West South Central	2.0	9	254	11
West				
Mountain	0.8	4	91	4
Pacific	2.7	12	144	6

Sources: Medicare: Health Insurance for the Aged, 1972-1974. Section 3: Participating Providers. Table 3.14: Number of Home Health Agencies, Persons, Enrolled, etc. Washington: Social Security Administration. 1976.

*Number does not add because of rounding.

**Percentage does not add to 100 because of rounding.

TABLE 6 Number of Medicare Beneficiaries and Percent of Enrollment in Counties with Home Health Agencies by Census Region and Division and Metropolitan/Nonmetropolitan Location. United States, 1974.

	Number of Persons Enrolled (millions)			Percent of Enrollment in Counties with Home Health Agencie		
	Total	Metro	Nonmetro	All	Metro	Nonmetro
United States	21.9	14.9	7.0	84	95	61
Regions						
Northeast	5.5	4.5	0.9	98	100	89
North Central	6.0	3.6	2.4	77	92	55
South	6.8	3.9	2.9	78	98	58
West	3.5	2.7	0.8	86	98	56
Northeast						
New England	1.4	1.1	0.3	97	100	88
Middle Atlantic	4.1	3.5	0.6	98	100	90
North Central						
East North Central	4.0	2.8	1.2	86	95	66
West North Central	2.0	0.8	1.2	61	85	45
South						
South Atlantic	3.4	2.2	1.2	77	91	52
East South Central	1.4	0.6	0.8	86	95	79
West South Central	2.0	1.1	0.9	71	88	49
West						
Mountain	0.8	0.4	0.4	75	97	49
Pacific	2.7	2.3	0.4	92	98	62

Source: Adapted from Table 3.14: Number of Home Health Agencies, Persons Enrolled, etc. Medicare: Health Insurance for the Aged, 1972-1974. Section 3: Participating Providers. Washington: Social Security Administration. 1976.

TABLE 7 Number and Percent of Participating Home Health Agencies Offering Selected Services: March 1967 and January 1975 and 1976

Service	1967		1975		1976	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Total	1,753	100.0	2,254	100.0	2,165	100.0
Nursing Care	1,753	100.0	2,254	100.0	2,189	100.0
Physical Therapy	1,201	68.5	1,678	74.4	1,656	75.6
Occupational Therapy	244	13.9	533	23.6	590	27.0
Speech Therapy	361	20.6	799	35.4	858	39.3
Medical Social Service	400	22.8	558	24.8	599	27.4
Home Health Aides Service	601	34.3	1,600	71.0	1,609	73.6

Source: Social Security Administration, Office of Research and Statistics.

1. Unpublished data for 1976.

In contrast, comparative figures for 1977 indicate a growth of almost 82,000 paraprofessionals employed by 3,732 service agencies. Fifty percent of the agencies employed five or fewer aides; 31 percent, 6 to 24 aides; 15 percent, 24 to 99 aides; and 4 percent, 100 or more aides.

4. Service Configurations in European Systems

Trained paraprofessionals have for many years provided one of the major components of community health-social agencies in many European countries. The services are almost entirely funded or subsidized by the government, quality is sought through government sponsored training, and the services are usually offered as a part of community-based service networks. Eighty-eight percent of services are provided to the 65+ group, and the remainder to families in which there are persons who are handicapped, chronically ill or in which there are multiple problems. England, which offers the services to households rather than to individuals, funds the services of nearly 6,000 whole-time and 124,000 part-time "Home Helps" (Homemaker/Home Health Aides). This means that for a population of 56 million people, England employs as many paraprofessionals as are employed in the United States with a population four times as large. The Netherlands employs 68,000 part-time and 17,000 full-time paraprofessionals, the former providing in-home services exclusively to the aged.

In the ratio of "home helps" to population, the United States ranks midway--sixth among twelve countries providing these services. Denmark, excluded from the ranking because comparative data were not available, would probably rank with Sweden at the top of the list. These services, considered essential in countries with aging population percentages similar to those in the U.S., are primarily home-centered and by far the largest percentage of the personnel is utilized in services to the populations in the older age range and to the handicapped.

The difference between the United States and Western European countries with respect to the development of community based services may be attributed to a variety of factors. The age of the social security system is an important factor. Countries which established the concept of general entitlement to insurance against essential risk (unemployment, old age, sickness) have tended to enlarge or expand the range of services. The concept of general entitlement discouraged approaches which separated the poor from the non-poor and encouraged development of services which, while they were universally accessible, did not involve the development of the most costly resources.

European cultures also retained a family centered ideology with the home and community as the central focus of services. The family centered ideology in the United States placed greater stress upon personal responsibility than than upon the concept of general entitlement. Culturally, the United States has emphasized efficiency, and the use of institutions has seemed to offer more efficient approaches to care compared with dependence upon approaches utilizing the home and the resources of the community. The presence of a substantial institutional complex already in place in the United States tended to discourage the development of community services that are considered "add-on costs."

C. Past and Present Efforts To Expand Home Health Care

1. Grant Programs for Home Health

In the past, home health services have not been viewed as offering the potential for methods of care which might appropriately buffer against institutional use and provide for populations whose need is parallel in magnitude. Home health care involves service development rather than construction. It has been assumed that federal provision for reimbursement of selected services for selected populations would provide adequate financial support for capacity development.

In 1961 the Community Health Services and Facilities Act authorized the Surgeon General "to make project grants to public or non-profit private agencies or organizations for the development of outside-the-hospital health services, particularly for the chronically ill and aged." "Out-of-hospital" services were defined as services "which prevent, detect, and treat disease and disability and improve care for persons - particularly the chronically ill and aged who are not patients in a hospital." Among the examples of such services were "Home Care, including nursing care, homemaker services, physiotherapy, occupational therapy, nutritional services, social services, etc. for the sick at home."

The Community Health Services and Facilities Act provided assistance in the form of time-limited grants which were intended to support studies, experiments, and demonstrations which would "lead to new or improved community health services outside the hospital..." and such demonstrations were to include those directed to coordination to "ensure comprehensive care of patients." In its 1968 report, the review committee reported that "the project grant program as originally conceived was not oriented to any specific chronic illness and had a broad base of eligibility in terms of the type of applicant and the type of project." The authority lasted for six years from fiscal year 1962 to fiscal year 1967. Total funding amounted to $42,319,000.

Of the 295 projects funded, 17 percent were for home care, homemaker services and nursing care and related in-home care (about 15 percent of the funds). All but four of the home care and related services grants were for three years. More than twothirds were for the initiation of new programs. development. More than twothirds were for the initiation of new programs, for coordinated multipurpose programs, for the development of homemaker services, or for the development and incorporation of homemaker services into existing home care programs or visiting nurse services. Seven involved the coordination of fragmented services or extension of urban services to rural areas. A small number were for the addition of specialized services to existing programs.

When Congress endorsed the concept of home health service in the 1965 Social Security Amendments creating the Health Insurance Program for the Aged (Medicare), there was widespread anxiety concerning the availability of home health services to meet the needs of beneficiaries eligible for benefits under both Parts A and B. All but a few states developed plans utilizing federal and/or state, and local funds to expand the services. In September 1965, a supplemental appropriation of $9 million was made available to strengthen existing home care agencies by adding services and to help establish new programs that could meet the Medicare conditions of participation. Another supplemental appropriation of $6.7 million became available for fiscal year 1967. Within the nine months between September 1965, when the funds became available, and July 1, 1966, when Medicare became effective, the number of programs increased as did the range of services offered.

Between 1968 and 1975 little significant federal investment in home health services development occurred with the exception of a short term OEO-PHS paraprofessional training grant program geared to older women on public assistance, and some "add-on" home health components to existing community agencies funded under Title III of the Older Americans Act.

2. Current Activities

In 1975 with the passage of the Health Revenue Sharing and Health Services Act (P.L. 94-63) the sum of $3 million was appropriated for one-year grants to existing agencies and 17-month grants to new agencies to "demonstrate the development and expansion of home health services." Grants are authorized for the purposes of (1) meeting the initial costs of establishing home health agencies, (2) expanding the services available through existing agencies, and (3) compensating personnel during the period of initial operation or agency operation." In extending the grant authorization Senate and House conferees reported their belief that the future of home health services is dependent in large measure on a consistent federal approach to the establishment of and payment for these services. Fifty-six grants were awarded to non-profit home health agencies certified for or meeting conditions of Medicare-Medicaid participation for home health agencies. Forty grants were awarded for expansion of existing agencies and sixteen were awarded for the development of new agencies in areas in which there is a high percentage of individuals who are elderly, indigent or both. The appropriation was increased to $6 million in the following year, with similar requirements.

It is the view of the Administration that since home health agencies do not require large initial capital investments and since the growth in supply of home health services was established without any special federal grants, the grant programs should be eliminated. Accordingly, the FY 1980 budget provides for phasing out these grants.

D. Manpower Issues

Estimates of manpower needs in home health depend to some extent upon how the service package is defined. The Medicare program has identified skilled nursing and physical and speech therapy as the primary services but also reimburses for occupational therapy, medical social services, home health aides, and supplies and equipment.

A method of estimating manpower need in home health is one which examines the services being utilized in current home health programs along with consideration of geographic problems (urban-rural) and personnel currently available to meet what have been demonstrated as being the most urgent needs. The two services which have been most used in existing home health agencies have been nursing and home health aide services, with physical therapy following.

In 1974 approximately 23,000 persons were employed by agencies participating in the Medicare program. All home health agencies certified by Medicare provide nursing services. In 1974 over 90 percent of all home health employees were nursing personnel, 70 percent were registered nurses, 7 percent practical nurses, and 19 percent home health aides. Four percent of home health agency personnel were physical therapists. Occupational therapy, speech therapy and medical social services have been offered by fewer agencies. They are relatively less available in rural and outlying areas. Some agencies also have included through administrative costs the services of nutritionists and psychologists.

Whether full-time or part-time, nursing personnel are generally permanent members of a home health agency staff. In contrast, the principal place of employment for therapists and medical social workers is another community health service organization, e.g., hospitals, clinics, rehabilitation centers. They provide services to patients of the home health agencies under contractual arrangements with the employing institution or on a fee-for-service basis.

The incremental capacity building approach of adding the services of a therapist or a medical social worker on a part-time basis has been successful in many urban areas; it has a number of advantages. One is that the services of another professional discipline can be utilized on a pilot basis to meet the needs of one or more patients and at the same time acquaint the nursing personnel with the contribution another discipline can make to the assessment, plan of care, and treatment of certain patients. A second advantage is that it has permitted the home health agency to obtain access to other community resources, including in-service training opportunities, professional meetings, invitations to serve on utilization review committees, and technical assistance to improve administration management capabilities.

The development and expansion of home health services in rural areas is particularly critical. In contrast to agencies located in major population centers, rural home health agencies frequently experience difficulty in identifying and hiring personnel qualified to provide the number and type of services appropriate. A partial answer has been the ability of certain well established home health agencies to extend services into suburban and/or adjacent rural areas.

Health Departments which are the primary source of home health services in rural counties should be encouraged to explore the possibilities of sharing a therapist(s) and medical social worker with the nearest community hospital or skilled nursing facility. Interesting job possibilities such as the opportunity to provide services to patients in the hospital, nursing home and in their own homes might attract a well qualified person to a rural area.

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APPENDIX 1: PROGRAM STATISTICS

This appendix examines the expenditures for and utilization of public programs providing home health services, primarily the Medicare, Medicaid and Title XX programs. Data on the aspects of each programs' home health component are displayed in the tables below. An overview of total home health expenditures under Medicare, Medicaid, or Title XX is provided as Table 1.

Table 1

TOTAL HOME HEALTH EXPENDITURES FOR 1976 or 1977

	Title XVIII Medicare	Title XIX Home Health	Title XIX Personal Care	Title XX FY 1977 In-Home Services
Alabama	$ 5,092,000	$ 593,417		$ 1,410,415
Alaska	40,000	11,394		560,105
Arizona	1,668,000			1,594,437
Arkansas	674,000	53,484		688,651
California	22,305,000	1,975,609		136,360,000
Colorado	2,187,000	206,546		3,347,560
Connecticut	4,904,000	535,298		1,564,184
Delaware	549,000	68,909		241,691
Dist. of Col.	825,000	1,307,599	$ 976,361	2,231,800
Florida	28,110,000	183,334		No Info. Sub
Georgia	1,829,000	261,576		4,866,477
Guam				
Hawaii	479,000			983,898
Idaho	765,000	80,664		814,025
Illinois	8,865,000	1,561,402		9,953,600
Indiana	1,551,000	1,151,415*		365,332
Iowa	855,000	29,059		2,340,518
Kansas	701,000	63,658		1,198,408
Kentucky	2,315,000	1,809,097*		5,895,610
Louisiana	7,295,000	265,157		2,324,508
Maine	1,610,000	533,660		1,999,697
Maryland	3,258,000	442,022		4,875,068
Massachusetts	9,298,000	5,118,456	Not available	16,874,246
Michigan	4,709,000	801,634		27,400,000
Minnesota	2,217,000	1,184,502	1,500	7,700,000
Mississippi	5,849,000	169,515		1,381,816
Missouri	6,879,000	94,368		1,669,546
Montana	304,000	115,041	Not available	664,708
Nebraska	821,000	88,024	93,309	2,272,500
Nevada	439,000	19,037*	83,784	412,321
New Hampshire	879,000	389,327		1,677,461
New Jersey	12,255,000	1,060,581		Not available
New Mexico	1,258,000	77,359		3,892,000
New York	25,674,000	106,828,324	126,435,823	8,212,467
North Carolina	4,117,000	495,167		17,318,091
North Dakota	70,000	20,933		2,287,226
Ohio	9,160,000	913,624*		17,149,685
Oklahoma	655,000	0	8,686,446	7,670,000
Oregon	2,827,000	114,808		2,457,057
Pennsylvania	18,808,000	1,717,743*		15,953,481
Puerto Rico	4,596,000			800,000
Rhode Island	1,869,000	214,830*		1,317,000
South Carolina	4,084,000	611,421		730,739
South Dakota	4,084,000	9,983		693,428
Tennessee	4,420,000	262,795		2,632,273
Texas	14,688,000	250,579		4,710,423
Utah	430,000	95,438*		351,700
Vermont	1,082,000	395,836		253,000
Virgin Islands	19,000			Not funded
Virginia	2,049,000	631,766		6,725,026
Washington	2,263,000	1,135,301		13,981,864
West Virginia	1,138,000	73,323		3,961,608
Wisconsin	3,693,000	733,102	Not available	12,329,547
Wyoming	242,000	444		400,000

* 1977 Data

I. Medicare Home Health Services

Tables 2-7 provide Medicare actual and projected outlay data for 1967-1983 as well as beneficiary, reimbursement, and visit data for 1974 and 1975. These tables show the costs of Medicare home health services, utilization patterns, and types of users.

Table 2

MEDICARE BENEFIT PAYMENTS FOR HOME HEALTH CARE, FISCAL YEARS 1967-1983 (IN MILLIONS)

Fiscal Year	Home Health Expenditures			
	Total	Part A	Part B	Total Home Health as a Percent of Total Medicare Expenditures
1967	$ 21	$ 13	$ 8	-
1968	60	36	24	-
1969	77	48	29	1.24
1970	89	54	35	.91
1971	73	46	27	.76
1972	70	47	23	.81
1973	80	57	23	.97
1974*	110	73	37	1.21
1975*	188	123	65	1.47
1976*	298	202	96	1.64
1977**	425	287	138	-
1978	561	379	182	-
1979	724	485	239	-
1980	894	591	303	-
1981	1,062	686	376	-
1982	1,240	775	465	-
1983	1,436	863	573	-

* Figures for persons aged 65 and over only are partially estimated.
** Figures for 1977-1983 are estimated projections.

Source: Office of the Actuary, Medicare Benefit Estimates: 1979 Budget Assumptions.

Table 3

1974-5 ANNUAL MEDICARE EXPENDITURES PER RECIPIENT

Year	Number of Visits	Number of Beneficiaries	Mean Number of Visits per Beneficiary	Total Medicare Reimbursement	Average Cost per Beneficiary
1974	8,100,000	393,000	20.6	$143,600,000	$365
1975	10,900,000	500,000	21.6	$215,500,000	$431

Source: U.S. Social Security Administration, Office of Research and Statistics (SSA-ORS), Medicare: Health Insurance for the Aged and Disabled, 1974 and 1975, Washington, D.C., 1977.

Table 4

1975 MEDICARE BENEFICIARY IN-HOME UTILIZATION BY TYPE OF COVERAGE

Type of Coverage	Persons Served	
	Percentage Distribution	Average Number of Annual Visits
Parts A and/or B	100.00	21.6
Parts A and B	10.4	55.5
Part A only	61.7	17.8
Part B only	27.9	17.2

Source: SSA-ORS, Medicare: Health Insurance for the Aged and Disabled, 1974 and 1975, Washington, D.C., 1977.

Table 5

NUMBER AND PERCENTAGE DISTRIBUTION OF PERSONS SERVED UNDER MEDICARE IN-HOME HEALTH PROVISIONS (1975)

Number of Visits	Percent Served: 1974	Percent Served: 1975
1-4	47.0	24.1
5-9		20.2
10-19	44.5	22.1
20-29		11.3
30-39		6.5
40-49		4.3
50-99		8.6
100+	8.5	2.9

Source: SSA-ORS, Medicare: Health Insurance for the Aged and Disabled, Washington, D.C., 1977.

TABLE 6. 1975 MEDICARE HOME HEALTH VISITS BY AGE (IN THOUSANDS)

Age	Number Served	Number Visits	Total Charges*	Visit Charges**	Total Reimbursement***
Under 65	31.4	797	$17,056	$15,787	$16,235
65-66	30.6	623	13,517	12,554	12,827
67-68	33.6	705	15,170	14.196	14,487
69-70	37.5	809	17,351	16,249	16,532
71-72	40.2	851	18,017	16,919	17,172
73-74	41.8	903	19,264	18,054	18,304
75-79	109.7	2,356	49,367	46,237	46,952
80-84	97.2	2,076	42,746	40,096	40,535
85+	77.5	1,684	34.511	31,850	32,452

* Total dollars claimed for Medicare reimbursement by intermediaries and carriers for services rendered.
** Total dollars claimed for Medicare reimbursement for the actual visit.
*** Total dollars paid out by Medicare for services rendered.

Source: SSA-ORS, Medicare: Health Insurance for the Aged and Disabled, Washington, D.C. 1977.

Table 7

1975 COSTS OF MEDICARE IN-HOME SERVICES BY AGE GROUP

Age	Average Number of Visits per Client	Average Amount Reimbursed per Visit	Average Annual Cost per Client
Under 65	25.38	$20.37	$516.99
65-66	20.35	20.59	419,01
67-68	20.98	20.55	431.14
69-70	21.57	20.44	440.89
71-72	21.20	20.18	427.82
73-74	21.60	20.27	437.83
75-79	21.48	19.93	428.10
80-84	21.36	19.53	417.16
85+	21.73	19.27	418.74

Source: Table 6 .

II. Medicaid Home Health Services

Tables 8-11 summarize expenditure and utilization patterns for home health services under Medicaid for FY 1972-1977 and show state by state patterns for FY 1977. It must be noted that New York, which accounts for a large portion of the home health expenditures under Medicaid, did not report its data by recipient group and is therefore missing from Table 10 (Home Health Recipients by State, FY 1977). Hence, with New York absent, one must be careful in drawing conclusions from Table 10.

Table 8

Medicaid Home Health Expenditures and Recipients for FY 1972-1977

Fiscal Year	Total Expenditures	Total # of Recipients
1972	$ 24,250,390	113,372
1973	25,441,952	113,687
1974	31,104,350	150,264
1975	70,291,063	205,100
1976	134,287,520	261,331
1977	179,491,576	NA

Source HCFA/OPPR, Medicaid Statistics: 1972; 1973; 1974; 1975; 1976; 1977, Washington, D.C.

TABLE 9 MEDICAID HOME HEALTH RECIPIENTS AND EXPENDITURES BY STATE, FY 1977

HEW REGION AND STATE	NUMBER OF PARTICIPANTS	HOME HEALTH PAYMENTS	PERCENT OF TOTAL MEDICAID PAYMENTS
TOTAL REPORTING STATES	261,331	$179,491,576	1.1
REGION I	22,514	8,989,076	0.8
CONNECTICUT	---	535,298	0.3
MAINE	1,426	599,099	0.7
MASSACHUSETTS	16,964	6,755,332	1.0
NEW HAMPSHIRE	1,687	427,945	1.0
RHODE ISLAND	1,096	180,120	0.2
VERMONT	1,341	491,282	1.2
REGION II	168,110	148,077,296	3.8
NEW JERSEY	2,861	2,357,466	0.5
NEW YORK	165,172	145,712,116	4.4
PUERTO RICO	---	---	---
VIRGIN ISLANDS	77	7,714	0.3
REGION III	15,569	4,659,154	0.3
DELAWARE	219	105,242	0.4
DIST. OF COL.	1,835	1,354,954	1.1
MARYLAND	2,088	555,202	0.2
PENNSYLVANIA[1/]	9,913	1,822,404	0.2
VIRGINIA	1,337	821,292	0.3
WEST VIRGINIA	177	---	---
REGION IV	13,286	5,464,565	0.3
ALABAMA	1,913	1,109,057	0.6
FLORIDA	846	235,139	0.1
GEORGIA	1,010	487,881	0.2
KENTUCKY	3,147	1,809,096	1.0
MISSISSIPPI	1,098	260,318	0.2
NORTH CAROLINA	1,688	688,536	0.3
SOUTH CAROLINA	2,086	520,796	0.4
TENNESSEE	1,498	353,742	0.2
REGION V	19,340	6,401,250	0.2
ILLINOIS	4,141	1,410,182	0.2
INDIANA	1,586	1,202,818	0.5
MICHIGAN	3,031	910,171	0.1
MINNESOTA	3,120	1,323,297	0.4
OHIO	3,985	909,702	0.2
WISCONSIN	3,477	645,080	0.1
REGION VI	3,000	1,357,312	0.1
ARKANSAS	258	73,900	0.1
LOUISIANA	1,146	434,031	0.2
NEW MEXICO	330	173,033	0.4
OKLAHOMA	---	---	---
TEXAS	1,266	676,348	0.1
REGION VII	2,059	749,773	0.1
IOWA	265	96,628	0.1
KANSAS	344	137,220	0.1
MISSOURI	1,044	210,654	0.1
NEBRASKA	406	305,271	0.4
REGION VIII	2,146	568,344	0.2
COLORADO	1,333	253,595	0.2
MONTANA	358	164,766	0.4
NORTH DAKOTA	77	34,265	0.1
SOUTH DAKOTA	187	4,914	(Z)
UTAH	189	95,439	0.2
WYOMING	2	15,365	0.2
REGION IX	12,981	2,161,710	0.1
CALIFORNIA	12,255	1,848,414	0.1
HAWAII	587	229,186	0.3
NEVADA	139	84,110	0.4
REGION X	2,326	1,063,096	0.3
ALASKA	38	13,586	0.1
IDAHO	219	79,303	0.2
OREGON	542	137,312	0.1
WASHINGTON	1,527	832,895	0.4

1/ Pennsylvania's recipient counts cannot be validated. Source: HCFA/OPPR, Medicaid Statistics 1975, 1976, Washington, D.C.

TABLE 10

HOME HEALTH RECIPIENTS BY CATEGORY AND STATE, FISCAL YEAR 1976

REGION AND STATE	OVER 65	BLIND	DISABLED	DEPENDENT CHILDREN UNDER 21	ADULTS WITH DEPENDENT CHILDREN	OTHERS AGE 21-64
TAL REPORTING STATES	31,743	1,583	34,452	11,944	8,907	2,739
EGION I	10,105	307	5,457	3,332	1,329	9
MAINE	523	9	389	98	208	---
MASSACHUSETTS	8,341	260	4,044	2,688	1,258	9
NEW HAMPSHIRE	752	28	351	348	203	---
VERMONT	489	11	473	198	160	---
EGION II	559	30	1,131	690	451	40
NEW JERSEY	550	30	1,113	690	441	---
PUERTO RICO	---	---	---	---	---	---
VIRGIN ISLANDS	9	---	18	---	10	40
EGION III	2,050	55	7,805	1,517	1,747	2,395
DELAWARE	74	10	94	22	19	---
DIST. OF COL.	241	13	459	528	586	8
MARYLAND	494	8	875	173	274	264
PENNSYLVANIA	705	---	5,675	705	705	2,123
VIRGINIA	474	23	611	86	143	---
WEST VIRGINIA	62	1	91	3	20	---
EGION IV	5,194	289	6,262	563	921	53
ALABAMA	1,157	35	664	14	43	---
FLORIDA	46	24	612	86	78	---
GEORGIA	302	21	574	35	70	---
KENTUCKY	1,500	30	1,189	119	229	---
MISSISSIPPI	689	21	335	33	20	---
NORTH CAROLINA	475	55	449	58	148	---
SOUTH CAROLINA	544	56	1,086	117	324	53
TENNESSEE	421	27	853	101	96	---
EGION V	6,318	191	6,134	4,291	2,276	---
ILLINOIS	750	30	1,559	1,353	449	---
INDIANA	348	40	484	589	122	---
MICHIGAN	309	29	1,554	588	536	---
MINNESOTA	1,724	36	820	252	177	---
OHIO	1,832	18	630	761	744	---
WISCONSIN	1,354	38	1,065	748	248	---
EGION VI	1,486	47	1,230	50	178	---
ARKANSAS	64	7	134	21	25	---
LOUISIANA	666	12	415	7	46	---
NEW MEXICO	62	3	205	23	37	---
OKLAHOMA	---	---	---	---	---	---
TEXAS	694	25	476	1	70	---
EGION VII	932	71	611	85	145	153
IOWA	92	9	62	34	18	---
KANSAS	87	5	119	24	37	61
MISSOURI	537	52	294	---	69	92
NEBRASKA	216	5	136	27	21	---
EGION VIII	284	13	331	90	80	---
MONTANA	141	6	147	43	21	---
NORTH DAKOTA	35	---	31	4	7	---
SOUTH DAKOTA	26	1	73	41	36	---
UTAH	82	6	80	4	16	---
EGION IX	4,510	557	5,113	1,291	1,216	89
CALIFORNIA	4,210	543	4,919	1,256	1,126	---
HAWAII	221	4	151	35	83	89
NEVADA	79	10	43	---	7	---
EGION X	305	23	378	27	64	---
ALASKA	2	---	24	7	3	---
IDAHO	85	6	108	4	16	---
OREGON	218	17	246	16	45	---

urce: HCFA/OPPR, Medicaid State Tables: 1976, Washington, D.C., 1977.

Table 11

MEDICAID BENEFIT PAYMENTS FOR LONG TERM CARE

1968-1977, PERSONS AGE 65 AND OVER 1/
(In Millions)

	1	2	3	4
	Total Medicaid Expenditures	Total Medicaid Dollars for LTC of Persons 65+*	Total Medicaid Dollars for Home Health for Persons 65+	Percent Home Health is of total LTC Expenditures (Col.3/Col.2)
1968(CY)	$ 3,451	$ 950	$ 3.4	0.4
1969(CY)	4,351	1,023	6.2	0.6
1970(CY)	5,094	1,055	8.6	0.0
1971	6,345	NA	NA	0
1972(FY)	7,346	1,177	14.1	1.2
1973(FY)	8,714	2,172	14.8	0.7
1974(FY)	9,737	2,521	17.4	0.7
1975(FY)	12,086	3,418	42.3	1.2
1976(FY)	13,977	3,887	73.0	1.9
1977(FY)	16,257	4,543	85.0	1.9

1/ These estimates include both State and Federal Medicaid expenditures.

* LTC=Long Term Care (Nursing home and home health benefits)

Source: Institute for Medicaid Management Data on the Medicaid Program, Washington, D.C., 1978.

III. TITLE XX IN-HOME SERVICES UTILIZATION

Tables 12-14 contain the most up-to-date operating statistics for in-home services provided by Title XX. The following Title XX services are considered to be in-home services:

- Chore Services are most often described as home maintenance activities, (repairs, yard work, shopping, house cleaning), performed for individuals unable to do such chores themselves.

- Home Delivered/Congregate Meals are designed to provide well balanced medically appropriate meals for clients who because of age or disability are unable to do so themselves.

- Homemaker Services are general household services such as meal preparation, child care and routine household care to individuals unable to manage the home. Data on Title XX programs is very limited. Table 9 of this appendix does however, display Title XX expenditures for in-home services for each state.

Table 12

NATIONAL SUMMARY OF HOME SERVICES PROVIDED TO TITLE XX RECIPIENTS

Quarter Ending. JUN.1976

	NATIONAL TOTALS			
	No. of States Delivering Svc	Total No. of Recip. of Svc	Total Expenditures	Cost Per Recip. (Nat'l Avg)
Chore Services	35	194,679	45,213,758	232
Home Deliv./Cong. Meals	32	37,894	2,643,651	70
Homemaker Services	49	152,781	37,087,217	243
Total	-	385,354	$84,944,626	$220

Source: Office of Human Development, Social Services USA, Washington, D.C., 1977.

Table 13

Total Number of In-Home Recipients by Service; Percent by Category Quarter Ending June, 1976

Services	Total Recipients	% AFDC	% Income Eligibles	% SSI	% Medicaid	% Without Regard to Income	% AFDC-WIN	% CWS	Total Adults	% Adults	Total Children	% Children
Chore Services	194,679	4	11	75	9	1	*	*	178,398	92	16,281	8
Home-Delivered/ Congregated Meals	37,894	3	60	33	3	1	*	*	35,984	95	1,910	5
Homemaker Services	152,781	20	21	52	4	2	1	*	135,448	89	17,333	11

Source: Office of Human Development, Social Services USA, Washington, D.C. 1977.

Table 14

In-Home Expenditures by Service: Percent by Category Quarter Ending June, 1976

Services	Total Cost	Percent AFDC	Percent Income Eligible	Percent SSI	Percent Medicaid	Percent Without Regard to Income	Percent AFDC-WIN	Percent CWS
Chore Services	45,213,758	4	6	88	2	*	0	*
Home-Delivered/ Congregated Meals	2,643,651	2	16	38	14	1	0	0
Homemaker/ Services	37,087,217	21	16	58	2	1	*	*

Source: Office of Human Development, Social Services USA, Washington, D.C., 1977.

APPENDIX 2: FINDINGS FROM RECENT STUDIES ON IN-HOME HEALTH SERVICES UTILIZATION

Although in-home health services research has been limited, results from five recent studies have shed some light on the current utilization. These five studies are:

- The Visiting Nurse Service of New York (VNSNY) collected data on 420 individuals accepted for and discharged from in-home health care during a 15-month (January, 1975 through March, 1976) demonstration project. Medicare and Medicaid reimbursed the customary VNSNY services of: physician visits, nursing care, physical and speech therapy, social services, and home health aide visits. The VNSNY also financed additional services to allow customers access to a fuller range of services such as housekeeping, transportation, laboratory and diagnostic services, and medical equipment and supplies.

- The Visiting Nurse Association of Los Angeles (LAVNA) collected data from 8,959 home health discharge forms from May, 1974 to May, 1975. These discharge forms were submitted quarterly and represent an unknown number of individuals who may have had multiple discharges during the year. The LAVNA study was a data collection and analysis effort only; no funds were available to provide services other than those typically provided by Medicare. Thus, its services and utilization were more closely aligned with Medicare patterns.

- The Triage Project of Connecticut began operation in February, 1974, and reported some results in February, 1978. Triage is a model project providing comprehensive services to the elderly through a single-entry system. Project funds were available from the Connecticut Department on Aging and HEW to supplement traditional services. These additional services include: homemaker and chore workers, day care, meals-on-wheels, transportation, dental, podiatry, laboratory and pharmaceutical services, volunteer visiting and telephone reassurance. In December 1977, Triage had 1,384 active clients.

- The Massachusetts Department of Public Health Study consists of a preliminary analysis of data available for approximately 36,000 discharges from Massachusetts home health agencies from 1974 through 1976. The discharge records are for an unknown number of individuals who had multiple discharges during the 3-year period. All services were reimbursed through traditional sources (Medicare, Medicaid, private insurance and personal funds).

- The San Francisco Home Health Service (SFHHS) study is a retrospective analysis of 7,420 consumers accepted for service over an 18 1/2 year period (May, 1957 through December, 1975). This longitudinal data base contains no duplication of consumers. SFHHS has continued its founding philosophy of focusing on the impoverished chronically ill and disabled

although the Agency has served post-acute and short-term cases as well. At present, only preliminary results are available. This study, sponsored by HEW, is due to be completed in September 1978. (Note: the final results will be incorporated in this study if available by the October deadline) Although SFHHS has participated in some demonstration projects over the years, the majority of the caseload was served using Department of Social Services (DSS) reimbursement sources, with some services reimbursed by Medicare and Medicaid.

Even though data available from these sites are not always comparable, and some of the studies are incomplete (Massachusetts and SFHHS), enough information is present to obtain a general idea of utilization of in-home health services by a broad population consisting of both short- and long-term care users, and of the need for flexible service delivery systems.

1. Characteristics of In-Home Health Care Users

Four sites have reported consumer distributions by sex and age (see Table 15 and 17). In all four sites, females accounted for at least two-thirds of the population served.

There was no appreciable difference in the sex distributions among the four sites, although SFHHS had a slightly lower proportion of males. As Table 17 shows, however, there was a major difference in the age distribution between LAVNA and Triage and the other two sites. About 2/3 of the LAVNA group was under age 65, while less than 1/4 of the VNSNY and SFHHS caseloads were under 65. Both VNSNY and SFHHS concentrated predominantly on the elderly (79.2 and 75.2 percent, respectively), while Triage was concerned exclusively with the elderly (all participants were over age 65).

Data by living arrangement are available from all five sites (see Table 18). Almost 80 percent of the LAVNA population lived with family members or others, followed by 73 percent of the Massachusetts group, 68 percent of the VNSNY population and 64 percent of the Triage participants. In contrast, almost 60 percent of the SFHHS population lived alone.

Three sites reported the abilities of their consumers in carrying out certain activities of daily living as shown in Table 19. Most clients could eat without assistance, whereas ambulation, dressing and especially bathing were significantly more difficult. This information, coupled with data on living arrangements, tends to confirm the hypotheses that homemaker services to assist with the activities of daily living is much needed by the Medicare population.

Table 20 shows that referrals from acute hospitals, private physicians and other nonacute providers accounted for the majority of consumers at LAVNA (87 percent), VNSNY (75 percent) and Massachusetts (81.5 percent). SFHHS, however, received only 43.7 percent of its referrals from hospitals, private physicians and non-acute providers. In contrast to the other sites, 1/4 of SFHHS referrals were from family, friends or other individuals.

Table 15

Proportion of In-Home Health Consumers by Sex:
4 Sites Reporting

SEX	LAVNA*	VNSNY	SFHHS	Triage
Male	33.0	31.9	27.8	33.0
Female	65.0	68.1	72.2	67.0
Total	98.0	100.0	100.0	100.0

*Total does not equal 100.0 percent since unknowns were figured in computation.

Table 16

Proportion of Total Aged Population by Sex
1976

AGE		SEX	
	TOTAL	MALE	FEMALE
65-74	14,188,000	6,153,000	8,034,000
75-84	6,725,000	2,547,000	4,178,000
85+	1,862,000	1,264,000	598,000

Table 17

Proportion of In-Home Health Consumers by Age:
4 Sites Reporting
(Age in uneven intervals)

Age	LAVNA	VNSNY*	SFHHS	Triage
2	18.0	—	24.9	
2-18	6.0	—		
19-44	22.0	20.7		
45-64	17.0			
65-74		32.1	33.1	37.0
75-84	37.0	33.8	32.4	54.0
85+		13.3	9.7	9.0
Total	100.0	99.0	100.1	100.0

*No consumers under 20 years of age were reported.

Table 18

Proportion of In-Home Health Services Consumers by Living Arrangement:
5 Sites Reporting

Living Arrangement	LAVNA	VNSNY	SFHHS	Massachusetts	Triage
alone	16.0	31.9	59.4	27.0	36.0
w/immediate family	74.0		38.5	73.0	64.0
w/others	5.0	61.8	2.2		
unreported	5.0	—	—	—	—
Total	100.0	100.0	100.0	100.0	100.0

Table 19

Proportion of In-Home Health Consumers by Ability to Perform Certain Activities of Daily Living: 3 Sites Reporting

	Eating			Bathing			Dressing			Ambulation/Transferral		
	VNSNY	Mass.	Triage	VNSNY	Mass.	Triage	VNSNY	Mass.	Triage	VNSNY	Mass.	Triage
Independent	92.6	82.0	83.9	57.9	50.5	21.0	67.5	61.0	45.3	50.5	69.0	51.9
Mechanical Assistance	--	--	10.4	2.1	--	46.0	0.2	--	32.1	29.5	--	33.9
Human Assistance	3.8	14.0		20.7	42.3		16.7	32.0		9.7	22.0	
Dependent	3.6	4.0	5.7	18.1	7.2	32.0	15.5	7.0	22.6	10.3	9.0	14.2
Total	100.0	100.0	100.0	98.8	100.0	100.0	99.9	100.0	100.0	100.0	100.0	100.0

Table 20

Proportion of In-Home Health Services Consumers by Referral Sources:
4 Sites Reporting

Referral Sources	LAVNA	VNSNY	SFHHS	Massachusetts
hospitals	73.0	46.0	30.4	58.0
private physicians	13.0	20.0	6.1	21.0
nonacute providers	1.0	9.0	7.2	2.5
community agencies	--	15.0	11.4	?
welfare departments	--	--	14.4	--
self, family, friends	10.0	11.0	24.5	13.0
unspecified	3.0	--	5.9	(5.5?)
Total	100.0	101.0	99.9	100.0

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2. Consumers' Length of Use of In-Home Health Services

SFHHS took the above two classifications of data in Tables 26 and 28 and collected information on length of use by referral source (Table 21) and by living arrangement (Table 22).

The major difference appears in the cases of the American Cancer Society and the Department of Social Services. The former's referrals were largely terminal cancer patients, and thus mainly short-term users, whereas the latter's referrals were long-term (see Table 24). Furthermore, patients discharged from hospitals tended to be short-use recipients (recipients of a few nurse visits - see Table 22) and VNA and self/family referrals showed more extended use. SFHHS intends to examine these aspects further to determine reasons for these utilization patterns. Moreover, the "other" category is extremely high in regard to the referral of short-term users. A definition of what is included in "other" may be of great importance (SFHHS does not define this category in any of its preliminary papers). In short, about 2/5 of all SFHHS clients received services for 3-11 months, and 70% received them for less than one year. This finding suggests that the "turnover" in receiving in-home services is rather high; only 30.2% continued their use for one year or more.

The average lengths of use in Table 23 for the VNSNY, LAVNA, and SFHHS studies even more dramatically portray the distinction between agencies concentrating on the chronically ill and agencies oriented toward medically-related, short-term care. Clearly, SFHHS's concern with providing homemaker/home health aide services resulted in a utilization rate eight times that of the other two more medically-oriented sites, implying that beneficiary utilization is also dependent on the type of services available from the provider. Since per diem cost data are only available from VNSNY ($14.71, however 1/10 of the clients accounted for 1/2 of the costs thereby greatly inflating the total population cost) and LAVNA ($4.45), there is no way to evaluate the cost difference of this greater utilization until later this year when SFHHS completes its work.

SFHHS has released further length of use data shown in Table 24. The top half of the table shows that public assistance recipients' use of in-home services is much greater than that of those not on public assistance. This finding is reinforced in the lower portion of the table. Medicare recipients and full pay clients are mainly short-term users, whereas those receiving public assistance from DSS are long-term users. Thus, the benefit structures of the various home health programs affect the utilization of in-home health services. However, it is this population group, being more disabled, with few supports and lower health status, which is in the greatest need of long term care.

3. Staffing Patterns of the Agencies

Three sites reported the proportion of services provided by professionals and paraprofessionals (see Table 25). There is a wide variation between SFHHS and the other two sites. Both LAVNA and the agencies in Massachusetts concentrated on nursing services, with Massachusetts relying more on homemaker/home health aides than LAVNA. In sharp contrast, SFHHS relied heavily on homemaker/home health aides (almost 89 percent of all visits). SFHHS concentrates on the chronically ill and disabled whose major need is for assistance with the activities of daily living. Overall, since 1967 the average number of visits per SFHHS consumer is 92.5. On the average, each consumer received 81.9 homemaker/home health aide visits and 10.6 professional visits (nurse or social worker).

Table 21

In-Home Service Length of Use by Referral Source (in percent): SFHHS Site Only

Referral Source	Length of Use			Total Number of cases
	1-2 mos.	3-11 mos.	12+ mos.	
Self, family, friends	28.9	38.7	32.5	1816
American Cancer Society	60.6	30.3	9.2	109
Community Agencies	36.7	36.7	26.5	245
VNA	25.8	39.6	34.6	492
MEZ-K-UC hospitals	34.6	46.0	19.4	1175
SFG Gen. Hospital	37.5	36.8	25.7	448
All other hospitals	36.5	40.7	22.8	587
Private physicians	33.8	35.8	30.3	452
Other non-acute providers	26.7	45.1	28.2	532
Letterman, VA, PHS hospitals	37.3	35.3	27.5	51
Dept. of Social Services (DSS)	20.5	35.0	44.5	1072
Government Agencies	33.0	33.6	33.3	342
Other	55.3	31.6	13.2	38
Total	30.8	39.2	30.2	7359

Table 22

In-Home Service Length of Use by Living Arrangement:
SFHHS Site Only

Living Arrangement	Length of Use			Total Number of Cases
	1-2 mos.	3-11 mos.	12+ mos.	
Alone	29.0	38.4	32.6	4321
W/Spouse	31.0	42.2	26.8	1587
W/Minor Children	44.3	38.7	17.0	287
W/Adult Children	34.1	37.3	23.6	549
W/Other Relatives	32.3	35.3	32.3	371
W/Non-Relatives	32.5	41.3	36.2	160
Total	30.6	39.1	30.3	7261

Table 23

Average Length of Case by Agency*

	VNSNY	LAVNA	SFHHS
Days	52.4	56.0	432.0

* Does not mean days of service rendered.

Table 24

Length of Use by Pay Plan (in percent):
SFHHS Site Only

Pay Plan	Length of Use		
	1-3 mos.	3-11 mos.	12+ mos.
Public Assistance Recipients	23.3	36.7	40.0
Non-Public Assistance Recipients	34.6	39.8	25.6
No fee	7.4	5.4	2.9
Part Pay	22.1	16.8	15.1
Full Pay	3.3	1.3	.6
Medicaid	1.7	2.4	2.4
Medicare A	11.1	10.1	5.0
Medicare B	4.9	8.0	7.1
Medicare 222	2.6	4.3	1.2
DSS	23.5	32.9	57.5

Table 25

Proportion of Visits by Staff Categories:
3 Sites Reporting

Staff Category	LAVNA	Massachusetts	SFHHS
registered nurse	75.0	57.1	7.7
licensed vocational nurse	—	5.1	—
HM/HHA	10.0	28.0	88.7
physical therapist	11.0	8.2	0.1
social worker	—	—	3.3
other	4.0	2.0	0.3
Total	100.0	100.0	100.0

Appendix 3

VERSION OF HOME HEALTH REPORT APPROVED BY HCFA ADMINISTRATOR, JANUARY 1979. MAJOR DELETIONS NOTED

FROM SIMPLE IDEA TO COMPLEX EXECUTION: HOME HEALTH SERVICES UNDER TITLES XVIII, XIX, AND XX

Report to the Congress Pursuant to P.L. 95-142

INTRODUCTION

Over the past several years we have seen a shift in public expectations of health care from almost total reliance on technological developments to deal with chronic illness and disability to a less technical, simpler set of services to help the chronically ill cope with these problems. Those faced with chronic problems have increasingly turned to the pursuit of aids to independent living, normalization in environment, basic health care, and personal social services. A major theme in this growing consensus of public opinion has been the promotion of home health services as well as of a range of supportive in-home services.

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The 1976 Public Hearings and numerous staff papers and Congressional hearings have made it clear that the aged, disabled, their relatives and friends, as well as many other citizens, want and believe in home care. They do not want to be limited to the relatively narrow, medically oriented benefit of Medicare, but seek a comprehensive, universally available set of home care services to meet a range of needs. These services encompass the traditional health and medical treatment services as well as preventive and maintenance care, personal care and household services, nutrition and other services. Although people want this service, the subject of who pays, and from what source funds should come is rarely discussed. Thus government at all levels must struggle with the perennial opposing desires for more publicly financed services and a reduced tax burden.

The Department welcomes the opportunity to review its programs of home health services, assess gaps and weaknesses, and propose changes as needed. Given the opposing goals of controlling expenditures while increasing availability of services, we have chosen a middle-ground solution: to improve service quality and to increase efficiency and economy in our methods of providing and paying for these services. Current budget constraints, in addition to our other concerns, prevent us from recommending statutory changes at this time.

A. Scope of the Report

The concerns described above caused Congress to include as part of Public Law 95-142, the Medicare and Medicaid Anti Fraud and Abuse Amendments of 1977, the requirement that the Department review its programs for home health services, assess current status and problems of home-delivered services, and propose changes in directions and programs. This mandate is a broad one, covering nearly all aspects of home health and other in-home services:

- Coordination among programs
- Scope and definition of services
- Eligibility criteria
- Standards for certification, licensure and accreditation
- Utilization control
- Reimbursement methods and controls
- Prevention of fraud and abuse
- Controls over supply.

Home health and other in-home services are part of a larger picture: they form part of the health care system; they form part of a system of long term care services; they form part of a social support system. Many issues in home care are broader than the boundaries of specific programs. However, the legislative mandate to which this report responds clearly spells out the specific areas to be addressed in existing programs and issues specific to home care. This report limits its scope to these matters and does not address the broader issues of long-term care and health care in general.

In addition to the legislative mandate, there are other compelling reasons for focusing this effort on issues specific to home health and other in-home services (in the language of the statute). The major reason is that, twelve years after the implementation of Medicare and Medicaid, it is time to reassess the home health aspects of these programs, and to readjust them in the light of experience. In the case of Title XX, in place for a shorter period, it would be well to take a hard look at its implementation and problems at the same time.

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The report covers all of the areas listed in Section 18 of P.L. 95-142 though in somewhat different order. Following a description of the requirements and operation of the three major programs, and a discussion of some of the major problem areas, the report considers issues of benefits and eligibility criteria, including Medicare coverage and scope of services offered by state Medicaid programs. Next comes a section on management issues in Medicare and Medicaid, focusing particularly on reimbursement policies, provider-fiscal intermediary-government relations, and issues in fraud and abuse. Part V assesses the Medicare conditions of participation and areas in which they should be strengthened or changed, and the issue of standard-setting authority and problems under Title XX. Development and control of supply are considered in Part VI, which addresses such controls as certificate of need programs as well as issues in the expansion of service capacity. The final section briefly addresses some long-range issues and possible ways of addressing them. The appendices contain program data and a comparison of some available studies of utilization patterns of home care.

The mandate for this report instructed the Department to assess "home health and other in-home services" under the three programs. In the absence of specific delineation of those terms, they are fairly loosely construed for the purpose of this report. We have defined "home health services" to mean roughly those types of services described in Medicare and Medicaid law and regulation. They include an array of services, such as professional nursing care, physical, occupational or speech therapy, medical social services, home health aide services, and medical supplies and equipment. These services are delivered singly or in combination to aid in recovery from an acute episode, or to maintain or improve health status. These services are of such a nature that they must be provided by an agency organized primarily to provide health care in accordance with certain standards.

We believe that the term "other in-home services" was included in Section 18 to encompass the broad variety of health-related and social/environmental services that can be rendered in the home under the Title XX social services program. These services would include home health services that may be

reimbursed provided they are integral but subordinate to the package of social services, as well as the home-maker, chore, and other similar services, which are defined differently by the various states.

B. Future Directions for Program Reforms

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The major problems of current programs providing for home health and other in-home services are not amenable to easy solutions, nor to any that can be quickly effected. Such problems as fragmented services and coordination of funding are an organic part of our current legislative and program structure, and can only be addressed through relatively major reforms. A second issue is that of fit between programs and the population groups they are intended to serve; changes in our perceptions of what benefits people, as well as actual demographic changes, have affected our view of programs' effectiveness. A third major issue is that of capacity to provide home health services.

PART I. IN-HOME SERVICES UNDER MEDICARE, MEDICAID, AND THE SOCIAL SERVICES PROGRAMS

Home health and other in-home services benefits are provided through Title XVIII (Medicare), Title XIX (Medicaid) and Title XX (Social Services) of the Social Security Act. ~~In FY 1977, these programs spent a combined total of $1 billion ($458 million for Medicare, $179 million in federal and state funds for Medicaid, and $445 million for Title XX) for in-home care.~~ In FY 1977, in-home services were used by 530,000 Medicare beneficiaries, 208,000 Medicaid beneficiaries, and 1,634,000 Title XX beneficiaries. In addition, a large but undetermined amount of home care is paid for privately by individuals, private insurors, and philanthropic programs.

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~~Many persons in need of services who wish to stay at home or in other non-institutional settings have few, if any, benefits covering in-home services available to assist them.~~ Each of the three Social Security Act programs described below presents different kinds of restrictions on the availability and utilization on in-home services.

A. Medicare (Title XVIII of the Social Security Act)

Medicare is a nationwide health insurance plan for people aged 65 and over, for persons eligible for social security disability payments for over two years, and for certain workers and their dependents who need kidney transplantation or dialysis. Health insurance protection is available to insured persons without regard to income. The program was enacted July 30, 1965, as Title XVIII--Health Insurance for the Aged--of the Social Security Act and became effective on July 1, 1966.

The Medicare program consists of two separate, but coordinated parts: hospital insurance (Part A) and supplementary medical insurance (Part B). Part A pays, after various cost sharing requirements are met, for hospital and skilled nursing facility care and services by home health agencies following a period of hospitalization. Part B covers physician services, home health care (up to 100 visits), medical and other health services, outpatient hospital services, and laboratory, pathology and radiologic services. Participation in Part B of Medicare is voluntary and any individual over 65 may elect to enroll. About 95 percent of those eligible for Part A elect to enroll in Part B.

1. Eligibility for Medicare Home Health Services

In order to receive home health care under Medicare, a Medicare beneficiary must be confined to his or her residence (homebound), have the services prescribed by a physician and be under the care of a physician, and need part-time or intermittent skilled nursing service and/or physical or speech therapy. Unless these requirements are met, the Medicare beneficiary cannot receive covered home health services under either Parts A or B of Medicare.

In addition, eligibility for Part A home health benefits requires that the beneficiary must have been in a hospital for at least three consecutive days prior to entry into home care. The care to be provided must be for an illness for which the person received services as a bed patient in the hospital and a plan of care must be established within 14 days after discharge from the hospital or skilled nursing facility.

Under Part A, a person's coverage is limited to 100 home care visits a year after the start of one spell of illness and before the beginning of a new spell of illness in the year following the last discharge from hospitalization.

Under Part B, the Medicare beneficiary must be homebound and require skilled nursing services, but there is no prior hospitalization requirement. For Part B, a beneficiary is limited to 100 home care visits in any one calendar year.

2. Home Health Benefits Under Medicare

The Medicare home health care benefits are, by law, oriented toward the need for skilled-care. They were not designed to provide coverage for care related to helping with activities of daily living unless the patient required skilled nursing care or physical or speech therapy. Home health services, as defined by Title XVIII of the Social Security Act, include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- Physical, occupational, or speech therapy;
- Medical social services under the direction of a physician;
- Part-time or intermittent services of a home health aide to the extent permitted in regulations;
- Medical supplies (other than drugs and medications including serums and vaccines) and the use of durable medical equipment; and
- Medical services provided by an intern or resident-in-training under the teaching program of a hospital which is affiliated or under common control with a home health agency.

The statute specifies that these services can be covered if furnished by a home health agency to individuals under the care of a physician, or by others under arrangements with them made by such agency under a plan established and periodically reviewed by a physician. These services are to be provided generally on a visiting basis in the individual's home. Under certain circumstances these services can be provided also on an outpatient basis at a hospital, skilled nursing facility, or a rehabilitation center.

3. Medicare Home Health Providers

Medicare limits the provision of home health services to organizations certified as Home Health Agencies (HHAs). Participating HHAs must provide skilled nursing and at least one other home health service. Home Health Agencies must meet all federal, state and local licensure and certification requirements. Proprietary agencies may participate only if they are licensed by the state. ~~At present, twenty states have licensure laws for home health agencies, 16 of which allow proprietary agencies. Only 126 of 2,612 HHAs participating in Medicare are proprietary agencies; the majority are visiting nurse associations of public health departments.~~ However, the limitation on the participation of proprietary agencies has sometimes been circumvented through the formation of private not-for-profit corporations and through subcontracting arrangements.

Medicare pays for services provided by an HHA on the basis of the lesser of its reasonable costs or charges. Reasonable cost is defined as "the cost actually incurred, excluding therefore any...cost found to be unnecessary in the efficient delivery of needed health services..."

4. Utilization of Home Health Services Under Medicare

~~In FY 1977, 530,000 Medicare beneficiaries used in-home services resulting in expenditures of $438 million. Home health expenditures under Medicare have been consistently increasing. In FY 1974, $100 million was spent on home health compared to $208 million in FY 1976 and $724 million projected for FY 1979. In 1974, only 393,000 Medicare beneficiaries used home health benefits compared to over 620,000 today.~~ (See also Appendix 1.)

Of the beneficiaries utilizing home health benefits in 1975, 10.4 percent received visits under both parts A and B while 61.7 percent used Part A benefits only and 27.9 percent used Part B visits only. Beneficiaries using both Part A and B benefits used an average of 55.5 visits per year compared to 17.8 visits annually for Part A only beneficiaries and 17.2 visits annually for Part B only beneficiaries. These data suggest that those persons using both Parts A and B benefits are the most in need of such services because although this group represents only 10 percent of the beneficiaries, they receive about 25 percent of the total number of visits.

Use of home health services under Medicare related to age shows a fairly even distribution among home health beneficiaries. In FY 1975, the 65-70 age group had 101,700 home health beneficiaries receiving 2137 visits compared to 109,700 beneficiaries in the 70-79 age group using 2,356 visits and 97,200 beneficiaries in the 80-84 age group using 2,076 visits. All age groups average about 21 visits per home health beneficiary.

Utilization of home health services varies geographically. Over one third of all beneficiaries using home health services reside in the northeast. However, the beneficiaries in the South received the most visits annually and had the highest total charges per person.

B. Medicaid (Title XIX of the Social Security Act)

Medicaid, Title XIX of the Social Security Act, is the major vehicle for financing health care services for low-income people. It was enacted in 1965 for the purpose of enabling states to furnish the aged, blind, and disabled and families with dependent children whose income and resources were insufficient to meet the costs of necessary medical services with medical assistance and rehabilitation. Medicaid programs have been implemented in 49 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Mariana Islands. Only the State of Arizona has not implemented a program.

Medicaid is state administered under federal regulations. Program costs are shared by the states and federal government with the federal share ranging from 50 percent in states with high per capita incomes to 78 percent in Mississippi, the state with the lowest per capita income. Subject to federal legislation and

regulations, states have broad discretion in establishing eligibility criteria, benefit packages, and reimbursement rates.

States must provide Medicaid coverage to all people receiving AFDC and, with certain exceptions, to beneficiaries of Supplemental Security Income (SSI), the federalized blind, disabled, and aged welfare program. Income-related eligibility criteria are determined by the states. States may, at their option, extend coverage to the "medically needy." These are persons or families who meet the SSI or AFDC eligibility criteria (e.g., aged, disabled, etc.) but whose incomes are slightly above welfare levels. States establish the income eligibility standards for the medically needy, which may not exceed 133-1/3 percent of the state AFDC payment standard. States also have the option of covering other categories, including: families headed by an unemployed male; children who are financially eligible, but not in a federal welfare category; spouses who are "essential" to the well-being of an SSI recipient; and persons eligible for, but who voluntarily elect to decline, AFDC or SSI cash payments.

Medicaid plays a significant role in assisting its sister program, Medicare, in providing health insurance for the aged poor. Approximately 3.9 million aged Medicare beneficiaries are also covered by Medicaid. For these people, in most cases, Medicaid both pays the Medicare Part B premiums, coinsurance and deductibles and provides more extensive benefits than are available under Medicare. Most notably Medicaid provides the aged poor with drugs and long term care services, especially institutional care.

In their Medicaid benefit packages, states must cover hospital, physician, skilled nursing facility, family planning, home health, laboratory, and x-ray services. They must also cover early and periodic screening, diagnosis, and treatment (EPSDT) of children under 21, and rural clinic services. They have the option of covering other services such as outpatient prescription drugs, dental services, eyeglasses, intermediate care facilities, prosthetic devices and care for patients over 65 in tuberculosis or mental institutions. If a state's program includes the medically needy, it must provide that group with either the basic required services or seven of the seventeen optional services authorized for matching funds under Medicaid.

1. Eligibility for Medicaid Home Health Services

   States are required to provide home health coverage to any Medicaid beneficiary who is covered for skilled nursing facility care under Medicaid. By statute, states must provide skilled nursing facility benefits to adult Medicaid beneficiaires (any individual over 21 years of age). Coverage of skilled nursing facility benefits for individuals under 21 is at state option. Since eligibility for home health services is tied to eligibility for SNF services, Medicaid beneficiaries under 21 are covered for home health benefits only if the state has opted to cover them for SNF care. All categorically needy Medicaid beneficiaries over 21 are covered for both home health and SNF benefits.

   Unlike Medicare, Medicaid does not require a patient to be home bound or in need of skilled care to be eligible for home health services. However, a physician must certify that the patient needs home health services.

2. Home Health Benefits Under Medicaid

Medicaid, from its enactment in 1965 to 1970, specified "home health services" in its list of services to be provided at state option. However, definitions, criteria, and requirements were not included. The 1967 amendments to the Social Security Act mandated home health services effective July 1, 1970. New regulations clarifying the Medicaid benefits and eligibility were published on November 18, 1976 to clear up the confusion over eligibility and benefits by requiring the states to meet certain basic criteria. Under these regulations, states must:

- Provide coverage of nursing, medical supplies, equipment and appliances, and home health aide services to Medicaid home health beneficiaries.
- Allow an RN to provide covered services where no organized home health agency exists (LPNs are now excluded).
- Permit medical rehabilitation centers to provide therapy services (if they meet the standards as written in the regulations).
- Require all agencies to meet Medicare standards of certification or be eligible to meet them.
- Define nursing according to each state's Nurse Practice Act.
- Provide home health services for:
  - all categorically needy individuals over 21 years of age,
  - individuals under 21 years of age if the state plan covers such individuals for SNF services, and
  - all corresponding groups of medically needy individuals to whom SNF services are available. Eligibility shall not depend upon need for or discharge from institutional care.
- Permit coverage of home health services in an ICF if the ICF is not required to provide such services (such as RN services during a short, acute illness to avoid the need to transfer patients).

In addition to the required nursing, medical supply, equipment and home health services, a state has the option of providing coverage for physical, occupational, and speech therapies, medical social services, and personal care services. All services must be authorized by a physician and supervised by a professional nurse.

However, although home health benefits are mandatory, states have the discretion to place limits on the amount, duration, and scope of home health benefits. Thus, several states place limits on the number of covered home health visits.

3. Personal Care Services Under Medicaid

Personal care services are an optional benefit under Medicaid. Nine states cover personal care services: District of Columbia, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New York, Oklahoma, and Wisconsin. Personal care

services include health related supportive services, such as assistance with household maintenance and activities of daily living. Personal care services are provided in a beneficiary's home by an individual who is qualified to provide such services, but is not a member of the family. The services are to be prescribed by a physician in accordance with a plan of treatment and supervised by a registered nurse. Many of the disabled receive attendant care services under the personal care benefit in the nine states that have elected such coverage.

4. Medicaid Home Health Providers

Medicaid requirements for participating HHAs are the same as for Medicare. However, Medicaid also permits states to provide personal care services from individuals not employed by an HHA.

Payment rates for home health services under Medicaid in some states are inadequate to attract sufficient provider participation. Reimbursement methods and rates for home health services, as for physician services, are left completely at the state's discretion. In contrast, SNFs and ICFs must be reimbursed on a cost-related basis which HEW must first approve. Some states attempt to contain program costs by keeping these rates low, and in an undetermined number of states the rates are lower than the cost of providing services.

5. Medicaid Utilization of In-home Services

In the last ten years, total Medicaid expenditures, and total Medicaid payments for LTC services (primarily consisting of nursing home and home health care) have risen roughly five fold. During this same time span, Medicaid expenditures for home health have increased 25 fold. Even with this huge increase, however, Medicaid in-home benefits still only amount to about one percent of total Medicaid expenditures.

~~In 1977, Medicaid spent over $179 million on home health for its 261,931 beneficiaries. Approximately 80 percent of all expenditures and 70 percent of all recipients are accounted for by the aged and disabled beneficiary groups.~~

On a state-by-state basis, Medicaid home health benefits constitute about .1 to .5 percent of total state Medicaid expenditures for most states. The greatest deviation is New York, which spends 4.4 percent of its total on home health. New York is also responsible for 63 percent of all home health recipients and 80 percent of all national Medicaid home health payments. Between 1975 and 1976, both New York's beneficiary population and expenditures more than doubled. Hence, New York alone is mainly responsible for the huge increases in Medicaid in-home benefits during the past three years.

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Appendix 1 of this report summarizes current data concerning the utilization of home health services under Medicaid.

C. Federal-State Social Service Programs (Title XX of the Social Security Act)

In January, 1974, the U.S. Congress passed Title XX, "Grant to States for Services," with implementation scheduled for October 1, 1975. The legislative goal of Title XX was to enable states to make available services for:

- Self support;
- Self-sufficiency;
- Protection of children and vulnerable adults from abuse, neglect, or or exploitation, and strengthening family life;
- Prevention or reduction of inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; or
- Appropriate institutional placement and services when in a person's best interest.

Title XX is a grant-in-aid program that allows the states a large degree of discretion in providing a range of social services to their populations. A ceiling of $2.5 billion annually is currently imposed; these funds are distributed to the states on the basis of their populations. The states are required to provide 25 percent matching and required to publish, in an annual plan, a description of the services they will provide, to whom, and by what methods.

1. Eligibility for Title XX Home Health Services

Individuals are eligible for Title XX services if they are eligible for cash assistance, have a low income, need particular social services, or are members of certain designated groups. Fees for Title XX services are mandatory for families whose monthly gross income exceeds 80 percent of the state's median income for a family of four adjusted for family size. Fees for other individuals are at state option. At least 50 percent of the state's aggregate federal allotment must be used for cash assistance recipients.

2. In-home Benefits Under Title XX

Services vary widely from state to state with eligibility and emphasis dependent primarily on decisions made within the state under an open planning process. This needs assessment and planning process gives concerned individuals and organizations a chance to help identify needs, establish priorities, suggest service providers, and assist to coordinate resources to build a systematic services delivery network that responds to the social services needs of local communities.

Local government representatives, interested organizations and concerned citizens can help to decide what services should be offered. At least three services must be made available for SSI recipients and at least one must be directed toward each of the five Title XX goals. Information and referral, family planning, and services directed toward the goal of protection may be offered without regard to income.

A variety of home-based services--including homemaker, home health aide, choreworker, home management, personal care, consumer education, and financial counselling services--can be provided under a state's Title XX program. Covered services vary from state to state. It is difficult to present a concise description of in-home services delivered under Title XX. However, certain generalities may be noted and patterns observed from one state to another.

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The following four services are particularly relevant to helping maintain individuals in their own homes:

- Home Health Aide Services - are medically related home care activities similar to those provided by nursing aides in hospitals. Such activities include maintaining an individual's health by assisting him or her in carrying out physicians' instructions.

- Homemaker Services - are described as general household activities (meal preparation, child care, and routine household care) provided by a trained homemaker when the individual who usually performs activities is temporarily absent or unable to adequately manage the home and care for the personal needs of others.

- Chore Services - are most often described as home maintenance activities (repairs, yard work, shopping, house cleaning) performed by an untrained person for individuals unable to do such chores themselves. Personal care activities are often included.

- Home Management Services - are described as formal or informal instruction and training in home maintenance, meal preparation, budget management, child care, and consumer education.

3. Home Health Providers Under Title XX

There are no federal standards for participation as home health providers under Title XX and, in fact, states may contract with private individuals to provide in-home services. Reimbursement policies are at the state's discretion.

States provide in-home services in the following ways:

- Direct provision--providers employed by state or local Title XX agency.

- Purchase-of-service through contractual arrangement with public or private (voluntary, non-profit, or proprietary) agencies. (States vary between state-administered and state-supervised programs. In some cases the local Title XX agency contracts directly with the provider agency.)

- Independent provider--service provided by individual who is not affiliated with an agency--may be self-employed or considered under employment to the service recipient.

Since states have wide latitude within federal regulations in defining services and establishing regulations for the program, those regulations vary substantially from state to state. Only 12 states responding to a recent HEW survey reported having a licensing requirement for providers under Title XX.

4. In-home Services Utilization Under Title XX

In 1976, over 1 million individuals received in-home services under Title XX programs. Over 90 percent of all Title XX beneficiaries are adults who gain access to these services as an SSI or AFDC recipient or by being income eligible. Chore, homemaker, and protective services represent 70 percent of both total recipients and expenditures. Approximately 56 percent of these Title XX services are made available through direct provision; 11 percent are purchased from public sources and 33 percent from private providers.

Most states spend a substantial portion of their total Title XX budgets on these services. For example, California spends 62 percent of its Title XX monies for this purpose. Many other states spend between 40 and 60 percent, and most all states spend at least 10 percent of their total. Thus, Title XX now plays an important role in the provision of in-home services.

PART II. PROBLEMS OF CURRENT PROGRAMS

This section briefly discusses some of the reasons for the lack of consistency and coordination among the home care programs, and some of the problems involved in attempting to modify the programs.

A. Mandates and Frames Were Different

The reasons for service fragmentation are usually laid at the door of the bureaucracy in charge of operating the programs but the difficulty begins earlier. Our public programs of health care, social services, and income maintenance have developed as separate categorical programs, directed toward many disparate constituencies by legislative and interest groups with different approaches and objectives.

The major programs being considered in this report--Medicare, Medicaid, and Social Services--emanate from what is technically one piece of legislation, the Social Security Act. However, each major part of it has been enacted at different times, for different basic purposes. Medicare is a medical insurance program for the aged; Medicaid is a health program for the poor; the Title XX Social Service programs served AFDC and SSI recipients and other low-income persons at the discretion of the states. The following table provides in capsule form the three programs' structures and goals.

B. Problems Have Emerged

Since the programs were enacted for different purposes, it was not surprising that they were sent to different parts of HEW for implementation. Prior to last year's reorganization and the joining of Medicare and Medicaid under one agency, HCFA, each of the three programs was administered by a different agency: Medicare in the Social Security Administration; Medicaid by the Social and Rehabilitation Service, and Social Services (Title XX) by another arm of the Social and Rehabilitation Service. The result has been to perpetuate these problems:

- The programs are directed at specified populations, thus creating confusion over who is eligible for which programs and leaving some population groups without access to services;
- Service definitions and the range and duration of services covered vary substantially from program to program;
- Distinctions have grown up between "health" service and "social" service programs which reinforce fragmentation of services to population groups needing a range of service;
- Regulations governing providers are inconsistent;

TABLE 1: IN-HOME SERVICES PROVIDED UNDER MEDICARE, MEDICAID, AND TITLE XX

	TITLE		
	XVIII	XIX	XX
Restrictions on In-Home Care	- need skilled care - restorative, not maintenance - homebound - under physician's care - 3-day prior hospital (Part A) - 100-visits each (Part A & B)	- eligible for skilled nursing facility - under physician's care	- as specified in an approved Title XX social service plan
Services Available	- skilled nursing - therapy (physical, speech, occupational) - home health aide - medical social services - medical supplies and appliances	as determined by state plans: - home nursing - therapy - home health aides - medical supplies, equipment, and appliances - personal care	as determined by state plans: - homemaker services - chore services - housekeeping services - personal care - home management - attendant care - home health aide
Providers	- certified home health agencies, e.g.,: hospital based agencies public health departments voluntary agencies private not-for-profit agencies proprietary agencies	- certified home health agencies (same as Title XVIII) - individual providers (physicians, nurses, therapists, attendants)	- public aid departments - voluntary agencies - proprietary agencies - private individuals
Eligibility Requirements	- age 65 or older, disabled, - End Stage Renal Disease patients	- all Title XIX categorically needy: Aged, blind, disabled, AFDC in all states - all individuals under 21 in states that include this group in SNF program	- income maintenance status - income eligibles - eligibles without regard to income (under certain circumstances) - group eligibles
Administration	- Federal with Fiscal Agents	- State or Fiscal Agents	- State
Total Program Costs: (in millions) FY'76 FY'77	$16,600 20,800 (100% Federal)	$14,200 16,300 (50-78% Federal)	$2,500 (75% Federal)
In-Home Costs: (in millions) FY'76 FY'77	$287 457	$132 (N.Y. State: $107) 179 (N.Y. State: 146)	$204 (California: $ 81) 360 (California: 112)
Percent of Total Dollars Spent on Home Health Care	2%	2%	10%
Estimated Number of Clients (National figure)	530,000	205,000 (78,000 N.Y. State)	1,680,000

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- Reimbursement methods are different for each program and are either inequitable or encourage inefficiency; they are confusing to both providers and clients; and
- Federal, state, and local relationships are different for each program.

The results of these problems have been that services are often inaccessible, incomplete, inadequate, or absent. At the service delivery point, providers, health and social service workers, and clients must search through the complexity of programs and payment sources to identify and package services.

C. Programmatic Shell Games Are Played

When consumers need services over a relatively long period, they usually must shift from one provider and funding source to another, with interruptions of service that are unrelated to need. Such shifts, even if only one provider is involved, constitute considerable hazard to the client and administrative expense for verification of eligibility, recertification of eligibility, billing procedures, etc. One agency with a substantial long term caseload reports 28 shifts in payment sources for one individual.

Such shifts among payment sources highlight an interesting problem that, though not well-documented, occurs with some frequency. It happens not only because the status and conditions of people change, for there is considerable evidence that the various programs do indeed serve the same population groups. It happens also because state and local governments shift services and populations among "pots" of money in ways that seem most advantageous to them--either their matching is higher from the federal government, or they can purchase the service more cheaply due to less strict standards, or there is more money in one pot than in another.

The case of one home health agency is illustrative. In one particular year, the amount of reimbursement it received from Medicaid funds dropped from nearly three-quarters of a million dollars to a few thousand dollars while at the same time its payments from Title XX and local social service funds rose by a similar magnitude. The agency continued to serve precisely the same clients whose needs had obviously not changed from "health" to "social" over night.

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D. Service Definitions Are a Major Problem

Varying perceptions of home health services, of the components which should or should not be included in the range within the collective title, differences in the definitions of those components and their application--and efforts to define and divide the services by assigning them arbitrarily in accordance with a presumed "health" relatedness or "social" relatedness--have affected both their development and their appropriate use. The confusion and variations among definitions have impeded efforts to develop and coordinate services within communities which might effectively provide the comprehensiveness and continuity so frequently stressed as the desired objective in a service system.

1. "Medical" Definitions

The influence of Medicare on the provision of home health services has been considerable; in particular it has reinforced the dichotomy between services perceived as medical and those perceived as social, in the public sector's funding of programs. The private sector, which is not bound by these narrow definitions, has continued to provide a wide range of services to those who purchase their own care.

The conditioning of providers with respect to Medicare contributed to the growth of less than comprehensive service providers (Medicare requires an agency to provide skilled nursing plus one additional service), and providers of short term, acute care rather than encouraging development of providers organized to serve clients with diverse service needs.

Medicaid has followed essentially the same pattern in providing home health services, although there is more chance to provide "social" services should the states desire to do so; there is provision for "personal care service in the home," which nine states use, though the primary users are New York and Oklahoma. However, instead of encouraging provision of comprehensive and coordinated services, these two aspects of Medicaid are used totally separately, or else they substitute for one another. For example, Oklahoma has a large personal care program with no home health program.

This program, which seemed at first to bridge the gap, also fails to mesh with the "social" services provided under Title XX. Instead of being complementary, they are used generally on an either/or basis by those states which use the personal care service.

2. "Social" Definitions

Although Title XX supports several in-home services to its clients, it does not define any of them. States are free to use their allotted funds and define in-home services as they wish. Medical or health services are not included in the range of care financed by the Title XX program unless they are a minor and subsidiary aspect of the "social" service.

Definitions, particularly of paraprofessional workers and functions, can be particularly troublesome. For example, the definitions of homemakers and chore workers under Title XX vary among states, and include performance of functions ranging from "attendant" or "sitter" care to household maintenance, and even to such questionable activities (for untrained personnel) as personal care including bowel and bladder care.

E. Gaps and Duplication Both Cause Problems

The requirements for various federal programs for paraprofessional services have produced a situation in which there has been proliferation of provider agencies for relatively low-cost services. For the consumer with mulitple problems and multiple needs, there may be duplication—with two or even three paraprofessionals going into the same home; several different providers could be serving the same client, causing both congestion and complex computation in rates of pay which are at best marginal, administrative costs which may, when all of the procedures necessary to the provision of this fragmented care have been taken into consideration, involve a combined overhead cost which exceeds the cost of the services themselves.

Even more important is the effect that all of this fragmentation and duplication of function may have on the client. A recent case history found four different providers or agencies serving a single individual at home (homemaker, chore worker, meals on wheels, and visiting nurse service). In the small living units so common to most of the users of these services, some of the functions of the paraprofessionals should, if possible, be performed by the same individual, and all services should either be rendered or supervised by one provider.

The European "home help" service, to which all of the functions described above are assigned, with special purpose emphasis in training for services to special groups, is a key element in all European community home care services and is probably central to their success. They are available and accessible and required in all communities; their use is encouraged, and substantial government interest is evidenced in training requirements and in funding of the services. In the United States, confusion with respect to definitions, funding, service provision and integration of the services into coordinated community non-institutional care systems has substantially reduced the usefulness of a supportive resource essential to the provision of coordinated home health care.

F. Different Jurisdictions Impede Coordination

The fact that different levels of government have responsibilities for the various home care programs creates difficulty in coordinating or standardizing services.

1. Medicare is a federally financed program with federal standards and reimbursement principles. Its standards are enforced at the state level by state employees paid by the federal government. Reimbursement is handled through fiscal intermediaries which are under contract to the federal government.

2. Medicaid is a shared federal-state program; legislation and basic regulations are federal, while administration and enforcement of standards are carried out by the states. Reimbursement may be done by the state or contracted to a fiscal agent. Reimbursement for home health service is set by the states by whatever method they choose—cost, maximum allowances, flat rate, or other means. Basic services are prescribed in federal

regulations but states can and do vary both services and eligibility requirements. Financing is on a basic matching formula ranging from 50 to 78 percent federal funding depending on state per capita income.

3. Social Services (Title XX) are financed on the basis of a closed-ended grant-in-aid to the states, which must contribute 25 percent. Other than basic federal enabling legislation, there are few standards or requirements for carrying out the program or providing services, except that the states must use an open planning method. Many states in turn allow county and other local jurisdictions to actually operate the programs; in many cases, localities must contribute a matching share. The Social Services program is rarely operated by the same staff that operates Medicaid.

G. Different Criteria for Providers Impede Coordination

Under Medicare, and by adoption Medicaid, home health agencies must meet a set of specific conditions of participation. Personal care services under Medicaid, however, can use different types of providers or they can be provided by individuals who are not employed by an agency.

The situation is further complicated by Title XX provides in-home service under a variety of arrangements:

- Self-employed providers
- County employees
- Negotiated rate contracts with homemaker-only providers
- Negotiated rate contracts with agencies that are also Medicare-certified.

H. Summary

The above discussion points out the inherent system problems and impediments to achieving coordination of in-home services. Virtually every aspect of the programs precludes development of a rational, organized, cost-effective system of home care. The problems are so basic that they can only be mitigated by improvements in federal (HEW) operations; a wholesale restructuring of programs, or a completely new one, would be required to fully address the problems.

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PART III: BENEFITS AND ELIGIBILITY CRITERIA

Many Medicare and Medicaid beneficiaries are potential users of home health services. However, restrictions on services covered and eligibility requirements for coverage of services prevent many Medicare beneficiaries from using home health services. For Medicaid beneficiaries, restrictive state implementation of and reimbursement for the home health benefit retard greater use of home health services. It should be noted that this discussion of benefits and eligibility criteria excludes in-home services of Title XX, the Social Services program. Title XX does not spell out a particular benefit package or eligibility criteria for benefits, other than to exclude health services that are not subordinate to or an integral part of the social services being delivered. This restriction is not viewed as a problem in that the mission of Title XX is to provide social services.

A. Medicare

~~The current Medicare home health benefit could be expanded either by revising the eligibility criteria for services or increasing the services covered. Medicare is considered by some to be the most appropriate vechicle for increasing publicly financed home health services because it covers virtually all of the elderly who are most likely to need long term care services of any kind.~~

1. Possible Changes

Ways in which benefits could be expanded have been discussed in every major document and testimony on home health services. Past and current utilization patterns and estimates of problems and need of populations at risk have provided a rough set of priorities for any consideration of expansion. The most frequently stated need and desire have been for a substantially expanded health and social services program for the aged and disabled and other vulnerable populations. However, current budgetary difficulties, as well as unresolved issues concerning the purpose and future of Medicare (national health insurance questions, for example) dictate the need for caution. Some of the important areas in which we are considering changes are these:

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a. ~~Redefining home health aide service to homemaker-home health aide service~~

Prior to enactment of Medicare and Medicaid there was no distinction made between the two functions, and both activities were carried out by the same individual. Many providers continue to use the same individual for both purposes, but separate the functions for the purpose of Medicare reimbursement. Their training in health care, personal care, nutrition, and housekeeping is usually identical. The continuing distinction is widely felt to be artificial.

Medicare guidelines allow a home health aide to provide "homemaker" services such as light housekeeping and meal preparation, but only if such activities do not substantially increase the time the aide spends in the home. Removing this restriction and establishing the definition of homemaker-home health aide would permit use of these

services without changing the structure of the Medicare and Medicaid programs. Removal of the time restriction can be done administratively; only the change in definition of homemaker-home health aide would require legislation. This change would facilitate provision of health care in the home. Many post-acute patients or people with medical service needs live alone or in families which could not manage without the supportive service of a homemaker while the patient is convalescing or therapy services are provided. Inclusion of these services would enable home health services to reduce or even replace a certain amount of prolonged hospital or nursing home stays.

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Modification of the term "home health aide" to "homemaker-home health aide" would permit a somewhat wider array of service to be provided under Medicare; it would also increase efficiency by permitting one individual to perform both groups of services instead of creating a situation in which two people from two funding sources would perform services one individual could do. For example, currently Medicare in-home services must often be supplemented (and are often duplicated) by a homemaker service through the Title XX social services program. Estimates of the cost of including homemaker services as a home health benefit vary from about $100 million to over $300 million, depending upon restrictions on eligibility for the services and on utilization controls.

As revised, the homemaker-home health aide benefit would still be aligned with the need for skilled care. Homemaker/home health aide services would become one of the covered services in the home health benefit. Medicare guidelines would continue to use a four-hour visit as the anticipated maximum, beyond which few visits would be expected to go.

b. Combining Parts A and B home health benefits under Part B with no requirement for prior institutionalization

This would be both a benefit change and an eligibility change, and would have these effects:

- Those individuals who have Part A coverage but who have not elected coverage under Part B would be excluded from home health coverage. This group includes about three-quarters of a million individuals; although we have little sound information on who these people are, it is assumed that many have obtained supplemental coverage from other sources. Few of them are thought to be public assistance recipients, as most of those are covered through state "buy-in" programs.

- Combining home health services in Part B would strengthen the attractiveness of obtaining coverage under this Part.

- Ambulatory health services would be placed in one part of Medicare instead of being split between the two sections, as is now the case.

- The three-day prior hospitalization requirement for receipt of home health services would be removed. This requirement is almost universally acknowledged to be an undesirable restriction.

- The restriction that home health services be related to the condition for which hospitalization was required would be removed.

It should be noted that while this proposal would consolidate the current two 100-visit benefits into a single 200-visit one, we believe it necessary to retain the 200-visit limitation. This is an important means of exerting some control over utilization of benefits. This limit is in our judgement preferable to others, which are likely to be more onerous.

A. Coverage of evaluation visits as allowable visits rather than as administrative costs

Evaluation visits, which are required for each patient upon initiation of services by a home health agency, would be allowed as separate visits. Administrative costs would thus be limited and confusion reduced in the reporting of costs for reimbursement.

B. Revision of the definition of "part time - intermittent" services.

The intent of this definition was to prohibit provision of full-time care in the home, but it also meant a prohibition against one-time visits or visits that were not needed on a medically predictable basis. The definition will be revised to allow one-time visits for evaluation, education, or service purposes, and to allow visits even though they are not of a predictable frequency.

By means of our demonstration and research programs, we will examine the effects of allowing around the clock care for a short period on the individual, family provision of care, costs, and patterns of individual use.

2. Consideration of Other Medicare Issues

Other changes that were considered, but about which there was concern regarding lack of information, potential costs, or other factors, include these:

a. Inclusion of nutrition service visits as a specific benefit

Visits for the purpose of providing nutrition advice or assistance can now be covered as an administrative cost. Although some individuals and groups felt that these services should be a discrete benefit, we believe that there is a need to further examine how such a benefit would be structured, what type of person should be allowed to provide the service, and under what conditions and requirements. The need for adequate nutrition and nutritional advice is indeed substantial among the Medicare population, but for the time being, these needs should be handled in the existing Medicare benefit structure.

b. Inclusion of occupational therapy services as one of the primary services

The primary services which must be needed by the home health client are skilled nursing, physical therapy or speech pathology. It is contended by some that occupational therapy is frequently the only service needed by stroke, arthritis, or other patients, yet Medicare

will not allow O.T. unless other services are also provided.

places an artificial barrier before it. Further, it is argued that occupational therapy is no less skilled than the other primary services.

The American Occupational Therapy Association places the cost of this change at $1.4 million, while HEW actuaries placed it at $28 million a year. The Association attributes the difference in the estimate to its more indepth attention to the available manpower pool, which it says is sufficiently limited to preclude a large expansion in use of the service. The Department has in the past opposed this change, in part based on the anticipated costs and in part because the service is already available in the Medicare home health benefit as long as the patient needs one of the other services listed above.

because in the absence of the need for any other home health services defining the need for O.T. would be difficult.

c. Proposals for change in the skilled care requirement

The requirement that a beneficiary needs skilled care, whether it be nursing or physical or speech therapy, has been especially criticized. The major national organizations representing home health providers have in the past proposed changing the skilled care definition as a prerequisite for service. However, removing the requirement for skilled care would represent a substantial change in the nature and purpose of the Medicare program, would create a large new eligible group of beneficiaries, and would substantially increase program costs. As a result, most of the organizations representing home health providers have conceded that the skilled care requirement represents a valid control mechanism within the context of the current Medicare program. This is also the position of the Department of Health, Education, and Welfare.

The guidelines implementing the Medicare program define skilled care to mean services which are performed by or under the direct supervision of a licensed nurse, ordered by a physician, intermittent, and reasonable and necesary to the treatment of an illness or injury. Examples of skilled nursing are given to augment the definition, for it is stated that simply having a service performed by a skilled individual does not make it skilled.

OTHER ISSUES

3. Clarification of Policies

Considerable misunderstanding has surrounded definitions and intentions of particular aspects of the Medicare home health benefits. There have been complaints about inconsistent interpretations, restrictive policies, and the meaning of various program requirements. For this reason, we present a brief discussion with the hope of clarifying some of these issues:

a. Coverage of home health services to terminally ill patients

Individuals with terminal illness have at times been denied home health coverage by fiscal intermediaries. In the past, care of the terminally ill has been denied by some Medicare intermediaries on the grounds that there are no therapeutic services involved, and there is no restorative potential. However, guidelines have been revised in the past year to clarify this issue, and it is now clearly stated in the guidelines that, if the individual meets the skilled care and other requirements, the fact that he is terminally ill or without restorative potential is irrelevant for reimbursement purposes:

Assuming that all of the conditions and all the other requirements for home health benefits are met, reimbursement can be made under the program for the skilled nursing care required by a beneficiary without regard to whether he has a terminal, chronic, or acute illness, his condition is stabilized or unstabilized, or the need for skilled nursing service may extend over a long period of time.

b. The homebound requirement

Concern over this provision has been raised repeatedly by individuals who believe they have lost coverage because they left their homes briefly for home health hearings and other purposes. Interpretations of the homebound requirement appear to have varied a great deal among fiscal intermediaries.

The Medicare law states that in order for the beneficiary to be eligible for home health services he must be confined to his home. This provision was intended to emphasize that if the individual is able to leave home to carry out general daily activities, then he should obtain needed health services in an ambulatory care setting. Only if this is not possible are home health services to be provided.

The guideline interpreting the "homebound" requirement states that the "condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort." If the patient in fact leaves the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration. Although the guidelines say that most absences from the home are expected to be for purposes of receiving medical treatment, they also say that occasional walks, drives, trips to the barber, and the like would not constitute a breach of the definition. The guidelines further state that the individual is expected to be unable to leave home without the assistance of a device or an individual; this is essentially a definition of disability. The Medicare staff has been making efforts to assure consistent interpretation of the homebound requirement.

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In a program of medical care benefits such as Medicare, an appropriate criterion for receiving health care in the home is some requirement of home-boundness. Otherwise it would be more appropriate for beneficiaries to receive their care in ambulatory care settings, which can deliver services more economically. Home health services are expensive to deliver, and should be directed toward those who cannot obtain the services elsewhere.

B. Medicaid

Medicaid is a source of financing for the aged and disabled poor in need of home health services. However, because it is a program for the poor, many non-poor aged and disabled individuals are not eligible. Moreover, because Medicaid is administered by the states and the states have considerable discretion over program design and implementation, the availability and use of home health services varies widely among states.

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1. Medicaid Benefit Issues

States are required to provide home health services under Medicaid, but are allowed to place limits on the amount, duration, and scope of services. Some of the variations resulting from state discretion include:

- Number of allowable visits;
- Comprehensiveness of services
  - whether therapy is included and which therapies are provided;
- Whether home health aide services are available locally;
- Restrictions on provision of supplies, equipment and appliances;
- Restrictions imposed by states contrary to the intent of Medicaid regulations
  - "skilled" care requirement
  - "homebound" requirement
  - different scope of services for Medicare "buy-in" patients from those services available to others;
- Prior authorization of services
  - restrictive criteria; and
- Reimbursement--deviations in amount of payment from Medicare
  - agencies refusing Medicaid payments or patients
  - agencies having quotas for Medicaid patients.

In addition to placing limits on use of home health services, many states have not made efforts to meet the mandate to provide home health services as part of the Medicaid program. Many states have, in effect, no home health services at all. The reasons for state failure to fully implement home health services include:

- Some fear the cost impact of an "added" benefit;
- Some find it easier just to refer patients to nursing homes;
- Some states have shifted to Medicaid "personal care" services (New York, Oklahoma);
- Some states have shifted to Title XX "homemaker" service (California);
- Some states have caused a constriction in supply of Medicaid service through low reimbursement rates; and
- Some states place restrictions on eligibility and coverage (e.g., skilled care, limited visits - sometimes as few as 12 a year).

An example of states' failure to provide a home health care benefit is Oklahoma, which from 1974 to 1975 reported spending less than $100, and since 1976 has reported no spending at all for this purpose.

In Pennsylvania, the reimbursement rate is so low ($5.00 to a hospital-based home health agency and $10.00 to a VNA) that agencies are unable to accept Medicaid patients, since the average agency charge is $22.98 for a nursing visit. These rates have been in effect since 1971. The local health departments are providing services so that one can say that the state is meeting "emergency" needs, but most Medicaid recipients do not receive home health services to which they might be entitled.

Wyoming's Medicaid agency expended only $444 for home health while Medicare's total cost in that state for the same year was $242,000. Only in New York is the Medicaid expenditure substantial, exceeding Medicare expenditures by $31 million. In Nevada, which also provides for for Personal Care Services costing about $84,000, Medicaid home health expenditures amounted to $19,000, Medicare's to $439,000.

2. Personal Care Services

Some states have also circumvented the home health service requirement by substituting narrower personal care services. This is done through a Medicaid regulation, CFR 449.10(b)(17)(vi), which allows payment for the provision of personal care services "in a recipient's home rendered by an individual not a member of the family, who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse." The impetus for this provision, promulgated by Medicaid in the 1967 regulation, was Oklahoma, which now has no home health program. Nine states, including New York, currently use this mechanism. Some of its advantages to states are these:

- It is cheaper than supervised and professional service by agencies meeting established standards;
- Plans of care and other criteria are not required to be met;
- Payment rates tend to be lower because the state decides the amount to be paid to each individual worker; and
- Little training and supervision are provided, thus lowering the per unit cost.

The nine states providing this personal care benefit are:

- District of Columbia
- Massachusetts
- Minnesota
- Montana
- Nebraska
- Nevada
- New York
- Oklahoma
- Wisconsin

The states provide little information, and apparently have little, on the nature of the services rendered, the skill levels and supervision of the individual providers, or the actual needs of the clients. Personal care services by individual providers are often cheaper to provide than are organized home health services, and this makes them attractive to some states. State data indicate that payments to individual providers range

from $2 to $3 per hour, and that the type and amount of fringe benefits paid vary; indeed, self-employed providers generally receive none.

The District of Columbia pays a maximum of $200.00 per month to any one provider. Most states pay the minimum wage. Several states have policies that limit the case expenditure to a percentage of nursing home costs. Nurses who supervise the aides may be employees of the state, of a home health agency or have a special arrangement with the state for this purpose. In Nevada, the nurses are paid $5.35 per hour and in Montana, $7.50 under a provider agreement with the state.

It is apparent that some states have used the personal care benefit to replace home health services by an organized program with uniform standards. While this method is cheaper for the state, it both circumvents the provision for certain mandated services under Medicaid and reduces or eliminates any quality assurance mechanism. There are some indications that standards are not applied to the personal care services, that little or no training or supervision are provided, and that some of the tasks performed have been of a more complex and technical nature than an untrained or unskilled person should perform.

3. Coverage Changes to be Considered

Budget constraints prevent us from offering distinct proposals at this time; however, we are studying changes in these areas:

a. Mandating minimums on amount, duration, and scope of home health services under Medicaid

Such limits would prevent states from unduly restricting home health benefits under Medicaid. For example, currently the state of Texas limits home health benefits to 50 visits a year under Medicaid. Under this provision, HEW could set a minimum of 100 visits per year as a Medicaid benefit.

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Performance standards should be set for implementation of an active home health program under Medicaid. States' performance should be monitored and poor performance penalized. One possible means of imposing penalties, which we will be examining, would be to provide for a penalty of, say, one half of one percent of federal financial participation on states found out of compliance with the law.

Establishing minimums on the amount, duration, and scope of home health services is consistent with the Health Care Financing Administration's proposals for improving the continuity of the Medicaid program in general. Similar minimums are being proposed for hospital and physician services.

Since this represents a significant change in the federal role in the Medicaid program, the Department intends to ask for legislative authority to accomplish it.

b. Reviewing the impact of the regulation (CFR 449.10(b)(17)(vi)) which permits Medicaid payments for personal care services in the home

Personal care services may now be provided by the home health aide as part of the comprehensive home health benefit under Medicaid. It would

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thus appear that, in the existing program structure of Medicaid and the Title XX programs much of what in fact makes up these personal care services (homemaking, attendant care) is already permitted and being provided by most states under Title XX. Possibly, these nine states now utilizing the personal care regulation should more appropriately fold the services into their Medicaid home health benefit or their Title XX Social Services program.

Further review of this issue will be undertaken to assess the financial impact on states as well as quality control mechanisms.

4. Potential Medicaid Eligibility Changes

Medicaid eligibility rules are, in practice, tied to the use of institutional long-term care. Although Medicaid is the major public financer of long-term care services, it spends relatively little (2.3 percent) of its LTC funds on home health care. The principal explanation lies in the process by which many elderly become eligible for Medicaid - the spend-down provision. Many persons become eligible for Medicaid only after incurring large medical expenses--almost always as a result of some form of institutional care. Only the continued high costs of nursing home care can maintain an individual's eligibility. The costs of home health services under most circumstances would not be great enough to establish eligibility for Medicaid. This is not strictly a "bias," but this effect on the structure of Medicaid's LTC benefit should be kept in mind.

Improvements could be made in Medicaid eligibility for home health services by revising the general Medicaid eligibility structure. For example, Medicaid spend-down provisions could be revised to allow less spend-down, and thus expand eligibility for and incentives to substitute home health services. However, such changes are beyond the scope of this study and would have broad impact on eligibility for and use of all Medicaid services. Thus, they are not considered in this report.

PART IV. PROGRAM MANAGEMENT ISSUES

This section examines the reimbursement methods and practices of the Medicare, Medicaid and Title XX programs; administrative issues for Medicare such as the selection of fiscal intermediaries and the process of claims review; and policies which would inhibit fraudulent and abusive practices.

A. Reimbursement

The specificity of federal requirements for reimbursement of home health services is greatest for Medicare, minimal for Medicaid, and non-existent for Title XX. Home health agencies are "providers" under Medicare, as are hospitals and skilled nursing facilities, and thus are reimbursed on a reasonable cost basis. Medicare pays for home health services on the basis of the lesser of an agency's charges or costs incurred which are reasonable and allowable in the provision of services to Medicare beneficiaries.

The federal Medicaid statute does not require specific payment methods or rates for home health services except that, for any given home health provider, the Medicaid rate may not exceed the Medicare payment rate. Twenty-four states including New York, New Jersey and Massachusetts, use the Medicare method of reimbursing home health agencies, and another three use some kind of cost-related method. Seven states pay for services on the basis of usual and customary charges, and fourteen base payments on fee schedules, maximum allowances, contracts, or negotiated rates.

The Title XX program is a closed-end block grant to the states. States provide and pay for in-home social services in a variety of ways, which include contracts, hourly rates, per visit fees, and cash grants to the individual eligible for services to purchase care. Title XX reimbursement rates frequently are below Medicaid rates for similar services.

This range of financing arrangements and of statutory requirements for reimbursement has resulted in different circumstances and problems for the provision of home health services under each program. Some inefficient and extravagant providers have received excessive payments under Medicare. Under Medicaid, on the other hand, restrictive payment practices and benefit limitations in some states have impeded beneficiaries' access to home health services. The $2.5 billion cap on federal Title XX expenditures has forced tradeoffs between the quantity of in-home services which states can provide and the rates of payment for these services, often resulting in the provision of services in the least costly manner with little or no assurance of their quality. Because federal authority over the management of state Title XX programs is extremely limited, policies regarding this program will not be treated further in this section, but will be addressed in the final section on longer range policy issues.

Although Medicare reimburses home health agencies as providers, like skilled nursing facilities and hospitals, the services provided by HHAs more closely resemble those of individual practitioners such as physicians. There is no room and board component to home health services as there is to institutional care, and the services of HHAs are provided on a one-to-one basis by individual health professionals. Although there is widespread dissatisfaction with reasonable cost reimbursement of home health agencies, there is very little analysis, either theoretical or empirical, which would permit a recommendation at this time for a substantially different reimbursement policy.

1. Medicare

There are several problems with Medicare home health reimbursement which HEW has just recently begun to address. Some are common to providers of services reimbursed on a reasonable-cost basis, whereas others are peculiar to home health providers. Because home health services have accounted for such a small proportion (between one and two percent) of total Medicare expenditures, the application of reimbursement policies and controls for providers of these services was given a lower priority than the development of such policies for hospital or physician services. The result has been significant growth in the cost of home health services and opportunities for providers to abuse the program.

Section 223 of the 1972 Social Security Amendments authorized "the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals..." Such limits on the costs recognized as reasonable by Medicare for routine hospital services were established in FY 1975. This authority has not yet been used to establish similar limits for home health services although they are now being developed.

Another result of the relatively low priority given to management of the home health benefit by HEW in the past is the absence of comparable cost information for HHAs. As discussed below, this problem too is now being addressed. The third major problem, unique to home health services under Medicare is the existence of providers which choose to serve only Medicare beneficiaries because of the attractiveness of Medicare reimbursement.

Cost Control

a. Failure to control costs

The reimbursement of costs has not encouraged efficiency or economy on the part of providers; the problems have been exacerbated by the fact that the reasonable cost concept has not been fully applied to home health providers. HEW is currently developing both limits on the overall costs of home health providers recognized as reasonable (authorized by Section 223) and limits and guidelines for the allowability and reasonableness of specific items of cost. A major problem in setting overall limits is whether to differentiate, and if so how, between hospital-based home health agencies, which report much higher costs, and "free-standing" providers. This difference may largely be due to the allocation of hospital overhead costs to the home health activity, although it has not been adequately analyzed.

Fiscal intermediaries are responsible for establishing guidelines on treatment of reasonable costs, though few have done so for home health agencies. The Division of Direct Reimbursement, HCFA, acting as intermediary for 300 home health agencies, has done so in an attempt to control the amounts of reimbursement. Its guidelines are based on a formula which stratifies agencies by size, type of geographical area, and discipline. This effort is acknowledged to be a partial solution while more complete data for comparative purposes are sought.

In efforts to establish better controls over allowable costs, HEW is taking the following actions:

- Revision of regulations governing allowable costs for the expenses of related organizations.
- Publication of additional instructions to fiscal intermediaries advising them on how to deal with long-term contracts between Medicare providers and organizations providing management and related services and with inappropriate practices of patient solicitation by home health agencies.
- Aid to intermediaries, in the form of national data and guidelines, in determining and identifying costs which are "substantially out-of-line" with those of other providers.
- Issuance of rules and guidelines to intermediaries as to the treatment of specific expenses, such as travel.
- Publication of a Notice of Proposed Rulemaking concerning Section 223 limits on overall home health costs by the end of 1978.

b. Lack of comparability of costs

The lack of uniformity of costs among home health providers and their consequent incomparability has impeded Medicare in making changes in the reimbursement system. Comparisons among home health agencies regarding costs are impossible at the present time due to the fact that home health agencies are not required to use the same methods either of apportioning costs to various elements or of reporting costs. For example, such costs as overhead, administration, consultant services, and supervisory costs are allocated differently by different providers so that it is impossible to separate out cost centers or distinguish direct service costs from indirect costs in order to apply tests of reasonableness.

Cost reporting and allocation forms for home health agencies have not been changed since the inception of Medicare in spite of numerous changes in the nature of services, providers, and costs. Section 19 of P.L. 95-142 now clearly establishes authority for HEW to require uniform reporting of costs, both in the aggregate and by "functional accounts and subaccounts." Further, the Secretary may establish a

uniform chart of accounts as well as uniform definitions, principles, and reporting of statistics. This uniform reporting requirement was designed to permit "measuring and comparing the efficiency of and effective use of services in... home health agencies..." Uniform reporting is mandated by this same section for hospitals and SNFs.

Work is already underway to replace the current four cost reporting methods for home health agencies with a single one, with explicit instructions for defining and allocating the various cost elements. The uniform forms and reporting methods, in addition to permitting valid comparisons among providers, will facilitate audits and reimbursement determinations. Section 19 of P.L. 95-142 requires the uniform cost reporting system for home health agencies to be in place not later than October 1979. Since the effort for home health agency reporting has already been initiated, however, it is expected that a single cost reporting/cost finding system will be published in draft by the end of 1978.

c. Medicare-only providers

Reasonable cost reimbursement for home health services as administered over the past ten years, coupled with other policies such as waiver of liability (which permits payment for a service which the beneficiary and agency in good faith believed would be covered but in fact was not), has given home health agencies the opportunity to receive high levels of reimbursement from the Medicare program. Some of these issues are discussed further in subsequent sections on fiscal intermediaries and fraud and abuse.

The extreme case of providers which have taken advantage of generous Medicare reimbursement is that of the provider which accepts as clients only Medicare beneficiaries and provides only those services which are program benefits. This provider prefers to allocate all of the costs of its operation to services provided to Medicare beneficiaries rather than accept other sources of payment, including client self payment, at sometimes lower rates than those of Medicare.

~~HEW is opposed to the existence of Medicare only providers. First, this practice discriminates against other HEW program beneficiaries, most notably those on Medicaid. Second, Medicare beneficiaries are not well served by providers that terminate them as clients if and when program benefits are exhausted.~~ Finally, other elements of the community are excluded from access to services.

More stringent review of provider costs and upper limits on Medicare reimbursement should diminish the attractiveness of Medicare as a payor relative to other sources of payment. However, more direct steps addressing this situation should be taken; the Department is ~~exploring a variety of ways of eliminating Medicare-only providers. These alternatives include but are not necessarily limited to the following:~~

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- Require that certified home health agencies participate in both Medicare and Medicaid. Another recommendation of this report is that HEW be given authority to set standards for Medicaid program reimbursement rates for home health services. If this provision were enacted, very low payments would be prohibited, and a requirement to participate in both programs would not be punitive, as it might otherwise be.

- Enforce Section 501(c)(3) of the IRS Code which governs non-profit status. Medicare-only agencies are almost always in this category. This section of the Code requires non-profit agencies to serve the general community. It is possible to construe this provision as a prohibition against serving in a single class of people and thus as a prohibition against serving only Medicare beneficiaries.

- Require a specific percentage of patients or charges to be associated with sources of payment other than Medicare. Senator Chiles' Governmental Affairs Subcommittee on Federal Spending Practices has recommended that at least 25 percent of an agency's clients have a source of payment other than Medicare. HMO program policy sets a precedent, in that it requires HMOs to serve the entire community within specified limits, rather than accepting only those falling in a particular risk category or other grouping. The 1976 HMO amendments require that at least 51 percent of the enrollees of an HMO are not Medicare or Medicaid patients.

- Require an RHA that is essentially Medicare-only to act as a government entity, under government contracts and with restrictions on salaries, services, and other policies.

2. Medicaid

Medicaid services are administered by the states within federal guidelines; the states must provide home health services as one of the seven basic services provided to cash assistance recipients. They retain discretion as to whether to provide services to the medically needy, and to certain other individuals. In addition, since the states decide what reimbursement methods to use and at what levels to reimburse, there is considerable variation. Although 24 states have adopted the Medicare principles of reimbursement, the rest have established their own rates and methods. These methods are cost-based or consist of fixed fees, negotiated rates, or a schedule of maximum allowances (see Table 2). Most states which do not pay for home health services on a cost basis pay less for home health than does Medicare. The level of Medicaid reimbursement may be lower than the cost of providing the services; for example, in some states the Medicaid rate is less than 50 percent of the level of Medicare reimbursment for the same services. Under such circumstances providers often either refuse to particpate in Medicaid or, instead of refusing all Medicaid clients, place limits on numbers of clients or services received, up to a specified amount of available

TABLE 2
MEDICAID PROGRAM DATA
HOME HEALTH SERVICES 1976-1977

Reimbursement Methods

Schedule of Maximum Allowance	Contract or Negotiated Rate	Usual or Customary Charges	Lower of* Cost or Charges	Fee Schedule	Cost Based
Alabama	D.C.	Arkansas	Colorado	Alaska	Connecticut
California	Montana	(with ceiling of 75th percentile)	Georgia	Oregon	Indiana
Florida	Oklahoma	Delaware**	Iowa	Pennsylvania	Maryland*
Kansas	Utah	Idaho	Louisiana	Rhode Island	Massachusetts*
Minnesota	Connecticut (for proprietary agencies only)	Illinois	New Hampshire		Michigan*
Ohio		Kentucky	Tennessee		Minnesota*
		Maine	Virginia		Mississippi*
		Wisconsin	Wyoming		Montana*
					Nebraska*
					New Jersey*
					New Mexico*
					New York*
					North Carolina*
					North Dakota*
					South Carolina*
					South Dakota*
					Texas*
					Vermont*

Hawaii and West Virginia have not reported.

* Same payment as Medicare
** Delaware pays 98 percent of charge.

Definitions

Maximum Allowance - maximum amount established by the state for a given product or service; state pays lower of actual charge or maximum allowance.

Fee Schedule - state pays a specified amount included in a schedule of charges for specific goods or services.

Contract - state purchases goods or services through a contract mechanism and pays the amounts specified.

Usual and Customary - an amount based on a provider's charge experience for some period of time; please indicate year or period during which amount was established, e.g., 1974.

Cost Based - state pays for services based on allowable provider costs, e.g., annual operating costs.

charitable or other funds. A second Medicaid reimbursement problem, one not limited to home health services, is that of lags in payment following the submission of claims for payment. This has resulted in cash flow problems for participating home health agencies. However, Section 2 of P.L. 95-142 now requires that states meet specific standards for claims payment time.

These reimbursement policies have frequently resulted in:

- A limited number of providers serving Medicaid clients;
- A quota system whereby only a small percentage of Medicaid patients are accepted by agencies without assurance of other sources of funding; and
- Unavailability of home health services to Medicaid recipients in many geographic areas.

Several states have indicated their awareness of the problems caused by the low rates but are fearful of expenditure increases inherent in reimbursing full costs. Some states have shown an interest in expanded home health services provided they can predict and control expenditures, and provided they can expect this service to reduce institutional care costs.

HCFA's major emphasis since its inception has been to improve the relationships between Medicare and Medicaid and to promote as much uniformity as possible between the two programs. Uniform policies in certain areas would clarify and facilitate operations by providers, and understanding of the programs by their beneficiaries. Reimbursement is one area that could benefit from such uniformity; home health services would be enhanced and their efficiency improved by a unified and appropriate set of reimbursement principles and methods for Medicare and Medicaid.

The current Medicare method of reimbursing costs has not, however, encouraged efficiency, agency planning, or cost control. The absence of a more effective system has led to a reluctance by states to encourage more providers or to expand coverage to include additional services. In short, efforts to improve the Medicaid home health benefits are stymied due to justified concerns about potentially excessive reimbursement levels. States have controlled their expenditures for home health services by setting low rates and restricting benefits. Neither the present Medicare cost reimbursement nor an inadequate flat rate represents a wise response to these problems. Furthermore, we have not collected sufficient information on the costs of producing or the potential demand for home health services nor do we understand well enough the behavior of home health providers in response to reimbursement incentives to establish a single reimbursement policy for both programs at the present time.

This proposal to exercise federal review and approval authority within certain limits in the near term and to move to greater uniformity after several years has the advantage of permitting natural experimentation and

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diversity in a little-studied field. It is similar to current federal Medicaid policy regarding reimbursement for nursing home services, which requires that states develop their own methodologies for reasonable cost-related reimbursement, subject to HEW approval. Over the next several years HEW will be experimenting with alternative reimbursement methodologies more formally as well, through health financing demonstrations. These alternatives may include prospective, cost-based reimbursement and capitation payments for all long-term care services or simply for non-institutional care. The experience culled from such demonstrations as well as from varied state experience should equip HEW ultimately to make recommendations to the Congress regarding a single set of reimbursement principles for Medicare and Medicaid.

B. Fiscal Intermediary Issues in Medicare

The Medicare statute requires administration of benefits primarily through private fiscal agents of two kinds--fiscal intermediaries generally administer Part A benefits and carriers administer Part B benefits. Both agents are responsible for reviewing claims for coverage and reimbursing claims for services rendered to individuals. ~~In general, for purposes of reimbursement, fiscal intermediaries must determine the reasonable costs of Medicare providers, whereas carriers must determine the reasonable charges of the individual practitioners providing services to Medicare beneficiaries. A third fiscal agent within the Medicare Bureau--the Division of Direct Reimbursement (DDR)--determines the costs and reviews and pays the claims of organizations such as HMOs and federally funded health centers, as well as serving as intermediary for about 15 percent of the home health agencies participating in Medicare.~~ All Medicare home health benefits are administered by intermediaries rather than carriers, even though the benefit is split between Parts A and B. Intermediaries were chosen to administer this split benefit because reimbursement for services provided under both Parts A and B is based on an agency's reasonable costs.

The provisions of Medicare, Part A, have permitted each provider to nominate its own fiscal intermediary. ~~Section 14 of P.L. 95-142, however, has given the Secretary authority to designate intermediaries with respect to a provider~~ or a class of providers, but only after first developing and then applying "standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions...and, (2) performance of such functions with respect to specific providers of services," and "...standards and criteria with respect to the efficient and effective administration of this part."

~~1. Problems~~

~~With respect to the home health service benefit, the fiscal intermediary~~ system has presented a number of problems. These problems have been exacerbated by the lack of adequate national guidelines defining and interpreting benefits, and of criteria for coverage and cost reimbursement. The result of the current system has been widespread differences in interpretation of benefits, in reimbursement practices, and in the determination of the legitimacy of claims.

Although efforts have been made in recent years to narrow these differences among intermediaries, they have persisted, at least in part, for the following reasons:

- Home health service claims represent a low-volume item for most fiscal intermediaries; thus they frequently do not take the time to develop careful screening or claims review and sampling guidelines. Similarly, the staff in charge of these activities often spend only a small portion of their work time on home health and thus do not develop the expertise to review claims in a consistent fashion.

- The fact that home health services represent a low-volume activity means that efficiency in this area is not well-developed, resulting in a high processing cost per claim reviewed.

- Fiscal intermediaries exercise considerable freedom in their interpretations of Medicare guidelines about what services are covered under what conditions. Differences in interpretation result from several factors including differing corporate philosophies about home health, differing procedures for reviewing level of care, differing staffing patterns for claims review, and differing requirements for documentation of claims.

- Interpretations of what represents allowable costs have varied widely without apparent reason.

A 1976 study carried out by the Bureau of Health Insurance (BHI), now HCFA's Medicare Bureau, examined the extent and types of variations among fiscal intermediaries regarding claims screening guidelines and interpretation of coverage rules. Its conclusion was that considerable differences continued to exist in both of these areas but that home health services had not been unduly restricted by these differences. However, individual beneficiaries have been adversely affected by the inequities of inconsistent coverage determinations.

2. Recommendations for Change

There is wide agreement that changes must be made in order to promote equity, effectiveness and efficiency in home health claims processing and reimbursement. Current practices could be improved through increased federal policy direction and, in addition, broader reform could be achieved through designation of a limited number of regional intermediaries. We will pursue both courses of action.

a. Improvements in current practices

Two areas of program administration which could benefit from increased guidance from HCFA are claims screening and review activities and the determination of reasonable and allowable costs. HCFA has, over the past six months, issued several intermediary letters concerned with the latter issue; work has not yet begun for the former.

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Review of a sample of claims post-payment in order to determine coverage would be more efficient practice than the current prepayment review of all home health service claims which intermediaries make. The current practice results in delays in payment to the provider and represents a high administrative cost. A sample review which is well designed and to which intermediaries direct sufficient staff resources could be as effective as and less costly than the complete prepayment review. On the basis of sample review the intermediaries could identify and try to change improper provider practices. A case-by-case review of an individual provider's claims could be used as a last resort if many denials are made. HCFA will begin to develop criteria for a policy of postpayment claims review on a sample basis.

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Variability among intermediaries in their determinations of the appropriateness of amount and duration of home health services could be reduced by the issuance of federal screening guidelines regarding appropriate utilization of services. Lacking such guidelines each intermediary establishes its own standards for such review, often with limited experience from which to derive standards. Federal guidelines would increase the uniformity and quality of such review by the intermediaries. Such guidelines, however, cannot be used as absolute limits on coverage. This would be inappropriately restrictive. HCFA will review the feasibility of issuing guidelines regarding screening claims for appropriate utilization of services.

Intermediaries are currently receiving increased guidance from HCFA as to the determination of reasonable and allowable costs. These activities are detailed in the previous section on reimbursement practices. These increasingly detailed instructions should lend authority to intermediaries' review and determination of allowable costs as well as promote uniformity in reimbursement practices among intermediaries.

b. Fiscal intermediary assignment

There is a strong belief that the current system of provider nomination of an intermediary and the resulting dispersal of home health claims processing and cost finding among many intermediaries diminish the efficiency and effectiveness of administration of this benefit. In addition to greater federal guidance regarding reimbursement and coverage policies, this administrative problem could be addressed by reducing the number of intermediaries handling home health claims.

Designation by HCFA of a limited number of intermediaries for home health agencies would result in greater uniformity, and hence equity, in the coverage and reimbursement of Medicare benefits. Furthermore, greater consistency and rigor in the determination of reimbursable costs could be achieved. Comparisons of performance among providers would be facilitated by such a consolidation. Finally, efficiency would be improved due to the ability to develop expertise in reviewing a larger number of claims.

We have considered a variety of options with respect to selection of intermediaries for home health agencies. These options include:

~~Designation of a single, national fiscal intermediary for all home health agencies. This intermediary could be either DDR or a private sector fiscal agent.~~

~~Designation of a series of intermediaries which serve home health agencies on a geographically determined basis.~~

We have decided to pursue the latter approach--selection of a limited number of regional or areawide intermediaries competent in reviewing home health claims and agency costs. DDR could be one of the intermediaries selected under such a plan. While several intermediaries may not be able to achieve the degree of uniformity in implementing coverage and reimbursement policies which could be achieved by a single agent, this course permits continued geographic dispersal of resources and funds and greater opportunity for provider-intermediary contact. Furthermore, home health services under Medicare have been growing and continue to grow at such a rapid rate that the work load of all participating agencies is likely to be too great for a single intermediary. Policies regarding selection of fiscal intermediaries for home health services are being developed further in conjunction with a comprehensive analysis of intermediary contracting policies being conducted by HCFA.

C. ~~Fraud and Abuse in Home Health Care - Medicare and Medicaid~~

Over the past few years, surveys, investigations, and hearings into the status of home health services have highlighted the existence of major fraud and abuse problems in this area. Among the major investigative activities were hearings on Medicare and Medicaid fraud and abuse in 1977; hearings on proprietary home health agencies in 1975; an investigation by Senator Lawton Chiles' Subcommittee on Federal Spending Practices; and various HEW audit reports, particularly of agencies in California. A substantial record has been built of the patterns of program abuse and fraudulent practices by providers.

The historical reasons for laxness in managing the Medicare home health benefit are documented in the previous section on reimbursement practices. Renewed efforts by HCFA to standardize and assure rigorous review of allowable provider costs, in addition to the initiatives authoriozed by P.L. 95-142, address many of the opportunities to defraud and abuse the Medicare program which have existed to date. Some of these efforts are reiterated in this section; however, many courses of action which are recommended primarily for other reasons such as promulgating more stringent conditions of participation in order to improve the quality of services would also improve control of fraud and abuse in Medicare and Medicaid.

Before the advent of Medicare, the limited home health services available were provided primarily by Visiting Nurses Associations (VNAs), other charitable organizations, and state and local public health services. As a result of

the Social Security legislation which instituted federal financing for services provided by these programs, several new providers entered the home health services program. Providers can now be grouped into three general categories:

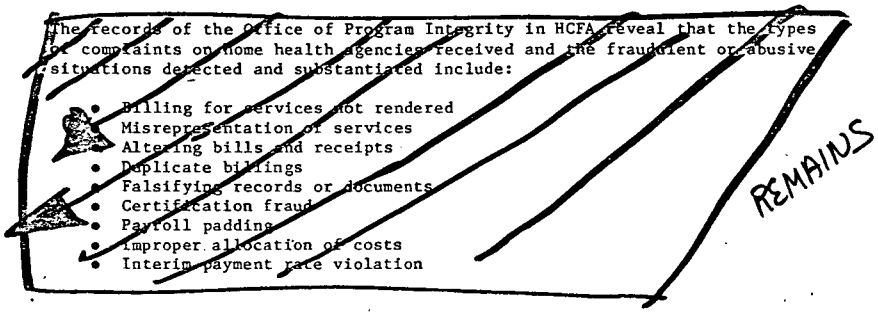
- Public agencies - includes all agencies operated by state or local governmental units.
- Nonprofit agencies - includes nongovernmental organizations exempt from federal income taxation undere Section 501 of the Internal Revenue Code, such as Visiting Nurses Associations or agencies located in hospitals, SNFs, or rehabilitation facilities. This designation also includes a new breed of provider known as the private-nonprofit agency which is organized and operated by an individual, but has achieved and maintains tax exempt status under the Internal Revenue Code.
- Proprietary agencies - includes all privately owned, profitmaking agencies.

Most of the problems uncovered in the delivery of home health services have been encountered in proprietary and individually operated nonprofit agencies.

In 1974 a total of 329,700 persons received Medicare home health services and about $137,406,000 were reimbursed for such services. The large majority (about 85 percent) of those persons were served by Visiting Nurses Associations, governmental agencies, and voluntary agencies. The other 15 percent were served by proprietary, individually operated nonprofit, and institutionally based agencies. However, this latter group of providers received 21 percent of Medicare reimbursement for home health services. On the average, this same group of providers made about 30 percent more visits per person served and had an average visit charge 30 percent higher than those of all other agencies. Proprietary and individually operated nonprofit home health agencies are expanding in certain parts of the country; many of these agencies provide services to Medicare beneficiaries exclusively. Because these agencies have no other sources of revenue, collection of any overpayment by Medicare becomes extremely difficult since it could result in the agency's financial failure and consequently the loss of services to beneficiaries.

The records of the Office of Program Integrity in HCFA reveal that the types of complaints on home health agencies received and the fraudulent or abusive situations detected and substantiated include:

- Billing for services not rendered
- Misrepresentation of services
- Altering bills and receipts
- Duplicate billings
- Falsifying records or documents
- Certification fraud
- Payroll padding
- Improper allocation of costs
- Interim payment rate violation



1. Occurrence of Fraud and Abuse

Since 1969 (when HEW started to keep records on this type of activity) HEW has received over 200 complaints on home health agencies. One hundred twenty of the complaints have been closed, i.e., they have been found to be unsubstantiated or they have been substantiated and referred to the U.S. Attorney who either prosecuted the case (or declined to do so) while 80 (61 fraud, 19 abuse) complaints are still in the preliminary investigation process. By far the most common complaints are allegations of billing for services not rendered. To date, seven cases have been referred to the U.S. Attorney for prosecution. Of these seven, one is still pending action by the U.S. Attorney. In two cases the defendants were found guilty, while the remaining cases either have been declined by the U.S. Attorney or have been closed because out-of-court settlements were reached. With the creation of HCFA with its Office of Program Integrity, and the earlier creation of the Office of Investigations and with the enactment of P.L. 95-142, it is expected that ultimately there will be more effective investigative prosecutions of HHAs and a reduction in fraudulent and abusive practices.

2. Contributing Factors in Fraud and Abuse

Several factors have played a role in the occurrence of fraud and abuse; these will be discussed only briefly here, since most of them are dealt with in greater detail in other sections of this report.

- Medicare reimbursement guidelines have been unspecific and in certain cases intermediaries have reimbursed excessive costs for such items as salaries, pensions, and fringe benefits. Guidelines for administrative and other costs do not currently exist to control these practices.

- Non-arms-length practices between home health agencies and hospital discharge planning units have been reported to be a problem. The most questionable situation of this kind involves the placement of home health agency personnel in a hospital's discharge planning unit to facilitate the placement of patients with the HHA. These arrangements should be prohibited. However, it is necessary for hospitals and home health agencies to work together in planning for patient care. Prohibition of all communication would not be in the best interests of the patient, for the lack of such joint planning for patients being discharged from hospitals has long been identified as a problem. Thus the methods and rates of patient referral from hospitals to HHAs must be monitored.

  Problems have been encountered with the authorization of home health services by physicians having a financial interest in the home health agency providing the service.

3. Solving Problems of Fraud and Abuse

The Medicare-Medicaid Anti-Fraud and Abuse Act has provided HEW with a number of tools for combating fraud and abuse in its programs:

- HEW may assign providers to fiscal intermediaries for the sake of efficiency and effective administration (Section 14).
- Uniform cost reporting is now required for all groups of providers (Section 19).
- Fraud against any part of the program is now a felony carrying penalties of fines and imprisonment (Section 4).
- All providers must make full disclosure of the identity of each person with an ownership interest and of subcontractors whose business transaction with the entity amounts to more than $35,000 (Section 3).
- The federal government has access to all Medicaid providers' records as it has always had for Medicare providers (Section 9).

~~The Department is planning to take the following actions to deter fraudulent and abusive activities:~~

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(1) ~~Assign regional or areawide fiscal intermediaries. It is anticipated that building expert review and audit capacity in a limited number of locations will remove incentives to defraud, and will, in fact, act as a deterrent. Grouping home health agencies and comparing costs will improve the intermediaries' ability to identify out-of-line providers.~~

(2) ~~Explore the feasibility of screening guidelines for use in auditing~~ samples of claims.

(3) Increase field audits of patient records and cost reports by the intermediary.

(4) Increase departmental auditing activities in order to improve detection of fraud and abuse where they occur (this is currently being done in selected areas).

(5) Prohibit Medicare-only providers by requiring a certain percentage of patients to have sources of payment other than Medicare.

(6) Test the effectiveness of requiring home health agencies to submit a duplicate bill to the client, listing services provided and amounts charged. Clients would be instructed to contact the intermediary in the event of a discrepancy.

PART V. QUALITY STANDARDS AND PROVIDER ISSUES

The legislative history of Section 18 of P.L. 95-142, and subsequent statements by members of Congress and their staffs, have stressed that a major reason for the mandated study is a concern for standards in home health services. There is wide agreement that there should be standards or that standards should be improved under HEW in-home services programs. There was much less agreement, however, on what was meant by standards, either in the Congress or among the agencies and organizations that had supported the legislation. Standards were variously defined as meaning that benefits and eligibility for services should be expanded, that proprietary agencies be allowed in, and that Medicare's conditions of participation be improved. The issues of benefits and eligibility have been discussed elsewhere in this report; this section addresses conditions of participation, including the special conditions for proprietary agencies, accreditation and deemed status, and provider issues under Medicare. Finally, quality assurance for Title XX in-home services is discussed.

A. Medicare Conditions of Participation

Home health agencies participating in the Medicare and Medicaid programs are required to meet certain standards of capacity and performance, the conditions of participation. The framework for these conditions is established by law, in Section 1861(O) of the Social Security Act. A home health agency is defined as being primarily engaged in providing skilled nursing services, providing at least two specific services, having certain professional policies, maintaining clinical records, having overall plans and budgets, and meeting "such other conditions of participation as the Secretary may find necessary..." Regulations establishing the conditions of participation cover the following areas:

(1) Definitions

(2) Compliance with federal, state, and local laws

(3) Organization, services, and administration

(4) Procedures for governing and monitoring patient care

(5) Acceptance of patients, plan of treatment and medical supervision

(6) Services - skilled nursing, therapy, medical social, home health aide

(7) Personnel - training requirements, professional practices

(8) Establishment and maintenance of clinical records

(9) Evaluation of the agency's total program and behavior.

Because of the concern expressed about the Medicare conditions of participation, HEW staff have consulted with interested groups and individuals regarding these conditions. On May 18, 1978 a meeting was held with representatives of national

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organizations of home health agencies and other organizations to review specific aspects of the conditions of participation. Based on these discussions, as well as on documents submitted and an internal review, the Department is proposing a number of revisions.

There appears to be general satisfaction with the existing conditions as a basic document upon which to build additional assurances of agency capacity to provide services. The consensus of opinion is that the conditions do not adequately address the activities which agencies must engage in to assure the quality and appropriateness of care provided. It should be noted that, although it is always possible to set standards which are higher than the present ones, the consequences must be weighed. Setting stringent standards would constrict the supply of qualified providers. Also, the costs of extremely high standards may outweigh the benefits; a middle ground is therefore necessary, one that protects the beneficiary while creating a realistic environment for service provision.

In this vein, a number of changes are being proposed, and decisions made with respect to enforcement and monitoring of the conditions of participation.

It is recognized that the changes being proposed here concern structure (the agency characteristic deemed necessary to provision of service) and "process" (such things as staff qualifications, utilization review, etc.) in contrast with "outcome' or client-oriented standards. The last is the most desirable, but our current capacity to measure outcome prohibits us from replacing structural and process standards at this time. Our ultimate goal is to develop a system of continuing assessment of the quality of care provided and the impact of that care on the recipient. Efforts to develop such a system will continue through the re-evaluation of standards, capability for assessment of quality, and the search for improved methods of determining desired client outcome.

1. Areas of Proposed Change—Agency Composition

Services under arrangements

~~Supervision has been a problem when agencies contract for services~~. It ~~should be made clear that services provided in such a manner are to be supervised, coordinated, controlled, and evaluated by the primary agency (See 405.120(m)).~~ There must be a written arrangement between the primary agency and the secondary agency regarding personnel and supervisory policies.

The intent of the current proposal is to assure that the agency is completely responsible for and in control of the performance of homemaker/home health aides working under its auspices. Further, the certified home health agency is responsible for the overall case, its management supervision, and development and implementation of the plan of care. Accountability clearly rests with the certified agency.

The Department considered requiring all home health agencies providing home health aide services to directly employ the aides, rather than subcontracting for them through another agency, as is now permitted. While such a requirement might reduce problems of supervision and fragmentation of service and aid in assurance of quality, it would require a radical restructuring of the home health care system, and

would put a large number of providers of all auspices out of business. In view of the fact that we wish to promote the availability of home health services we have concluded that this is not the first area on which to place such stringent controls. We hope that by requiring a close and official relationship between the primary agency and the subcontracting agency we can assure quality and adequacy of the service.

Finally, we considered requiring all certified home health agencies to provide a comprehensive range of services rather than just the present two services as a further means of achieving continuity of care. This would also have the effect in current circumstances of severely constricting the availability of the home health benefit. Therefore, although we recognize comprehensive service to be the desirable goal for all providers, we cannot begin to require it at this time.

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Training requirements for home health aides

Some states (Connecticut, Massachusetts, and Oregon) have added a requirement to the Medicare conditions of participation for training and supervision of home health aides. Many states require specific training for home health aides in their licensure requirements. Even so, however, home health aides have the least amount of formal training and spend most time providing direct patient care. Uniform training requirements for all homemaker/home health aides providing personal care services in the home would assure a basic knowledge level on which to build skills.

We recommend the following training requirement: Initial and continuing training of the home health aide, based upon a basic generic curriculum which is approved by HEW. A practicum or period of field practice under supervision in the employing agency would be required. An ongoing in-service education program would be required to maintain and improve skill and to add new knowledge for added competence.

The Public Health Service training grant program is expected to help agencies to improve their training capacity and ability. Other training costs would become part of overall agency costs.

Utilization review in home health

Appropriateness of service is currently determined through three methods which generally function independently of one another: the physician certifying need for care, agency staff, and claims reviewers on a post facto basis. Further controls on use of service under Medicare are the limits on number of visits per benefit period and per year for Parts A and B respectively, the requirement for skilled care, and the requirement of prior hospitalization for the Part A benefit. These controls are crude, at best, and provide little control once a person has begun receiving services. A utilization review function, in addition to monitoring the continued need for services, would focus professional attention on the quality and efficacy of services rendered to the patient.

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It should be stressed that we do not believe the type of UR committee currently used for institutional reviews is necessary or appropriate for home health agencies. However, it might be possible to establish some kind of quality and service appropriateness review method combining internal and external staff, or where volume is high enough, establish an area-wide review group that would examine all certified agencies in that area.

Either as part of a UR function or as a general utilization gauge, HEW will work toward the development of utilization norms and patterns which could be used as guidelines for judging use. Cases falling outside established norms could be selected for further analysis.

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If UR committees are established, they should fit into these general guidelines: the committee should be composed of at least three members, one of whom shall be a practicing physician with a general practice orientation, another a public health nurse, and the third member a professionally qualified individual with both institutional and community health service experience. This person could be a medical social worker, therapist (P.T., O.T. or speech) or a representative of another health service provided by the agency. At least one member should not be an agency employee. A sample of cases would be periodically reviewed to determine that:

(1) Services are being provided in accordance with the patient's plan of care;

(2) The patient's needs are periodically assessed and appropriate revisions made in the plan of care;

(3) Services are being used appropriately;

(4) Professional policies are followed in providing services;

(5) Needs of patients served by the agency are being met both quantitatively and qualitatively taking account of utilization of other community resources; and

(6) Unmet needs of patients are identified and documented and made available to the patients, their families, physicians and responsible social and health services agencies.

The committee's findings and recommendations should be written and discussed with the agency's director and appropriate staff. The agency's records should indicate action taken in response to the utilization review committee's findings and recommendations.

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In conclusion, we believe that some means of reviewing quality and appropriateness of home health service is necessary. We are attempting to develop data for use in determining norms, and are working to devise a UR system for home health that is not excessively costly or cumbersome.

d. Plan of treatment

Some agencies have separate plans of care for the services provided by contract therapists. These plans should be integrated into one coordinated plan of care, to be reviewed and updated periodically. All services to be provided to the patient must be included in this plan. Each service should be identified, its frequency and duration given, and the professional person who will provide the care or supervise its provision identified by name. It should be required that the plan be reviewed monthly to identify need for revision. At least every two months the plan of care should be updated. This requires reassessment of the patient's status and recognizes the fact that the patients' condition and needs will change sufficiently to require revision in such areas as treatment goals, and frequency or type of service provided, or a cessation of service.

The plan of care and its maintenance requirements should be kept as simple as possible in order to minimize paperwork and maximize time spent on patient care.

e. Definition of "skilled" nursing

Considerable provider and intermediary dissatisfaction with the current terminology of Medicare has been expressed. In particular, the term "skilled" in front of nursing has troubled the home health field, which has recommended unanimously that the word "skilled" be replaced by "professional." Such a change would require legislation, and it is not clear what effect it would have on the provision of, or eligibility for, home health services under Medicare.

A major argument in favor of such a change, one that indicates it would be more than "cosmetic" is that the definition of nursing would be simplified and clarified and its emphasis would shift. Instead of delineating skilled nursing by means of a relatively complicated and lengthy set of tasks performed by the individual, it is contended that their definition could rest on the professional practices and standards set forth in the Nurse Practice Act.

The Department is analyzing the potential effect of this change, and its impact on the delivery and use of home health care under Medicare; we are making no recommendation at this time.

2. Proposals for Changing the Requirement of Licensure for Proprietary HHAs

A special condition on for-profit home health agencies in the Social Security Act (Medicare) stipulates that they be licensed by the state in which they operate. Since only 21 states have licensure laws (one, New York, prohibits for-profit agencies), this requirement has precluded these agencies from serving Medicare and Medicaid clients in the remaining states except as subcontractors to certified agencies. (Table 3 on the following page shows this information.)

a. Provider experience

Since HEW collects data only for the services for which it pays, little is known about how non-Medicare certified for-profit home health agencies operate, how much of the private paying clientele they serve and what kinds

TABLE 3: STATES WITH LICENSURE LAWS FOR HOME HEALTH AGENCIES

State	Year of Law	Regulations	Certificate of Need Requirement
Arizona	1971	1971	Yes
California	1966	Being Revised	No
Connecticut	1977	Being Developed	No
Florida	1975	Revised 1976	Yes
Hawaii	1969	1969	Yes
Idaho	1975	1976	No
Illinois	1977	Being Developed	Yes
Indiana	1973	1974	No
Louisiana	1967	1967	No
Kentucky	1972	1972	Yes
Maryland	1976	Being Developed	Yes
Montana	1977	Same as Medicare	Yes
Nevada	1973	1973	No
New Jersey	1973	Revised 1976	Yes
New York (does not license proprietaries)	1973	1973	Yes
North Carolina	1971	1971	No
Oregon	1977	Same as Medicare	Yes
Tennessee	1975	Revised 1976	No
Wisconsin	1967	1967	Yes

of services they provide, and how they are organized. It is known that many providers are simply employee pools and central switchboard-referral operations, with no provisions for supervision or assessment and monitoring of client needs. In the private market it appears that providers will give whatever service, for whatever length of time the individual wishes to pay.

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b. Arguments about proprietary agencies in Medicare

It should be noted that in 20 of the 21 states which have licensure laws, proprietary agencies are already allowed to participate in Medicaid and Medicare. These licensure requirements are not generally higher than Medicare standards and so do not assure higher quality. The debate about whether to admit proprietary home health agencies to full Medicare and Medicaid participation by removing the licensure requirement from the law has centered on the following points:

(1) Supply issues

- Inclusion of proprietary agencies in Medicare and Medicaid would fill the need for expanded service capacity, which is generally agreed to be necessary.

- This need could be filled in other ways, not just through proprietaries. Service capacity of public health agencies and voluntary (charitable) agencies could be expanded through increased third party reimbursement or through capacity-building grants. The definition of Medicare home health provider could include comprehensive health service providers such as HMOs, community health centers, etc.. Proprietary agencies tend to locate in areas which promise the most lucrative business, such as suburban and some urban areas. Inner city and rural areas are generally left to the public and voluntary agencies, or continue with no service at all.

(2) Equity

- The current licensure requirement for proprietary agencies is discriminatory. It makes no sense to permit participation in some states and not to permit such agencies to participate in others. Further, proprietaries already participate as subcontractors for Medicare and as providers under Title XX. The private not-for-profit agencies, which are allowed to participate in Medicare and Medicaid without meeting additional requirements, are subject to even less scrutiny than proprietary agencies, whose business practices must at least be acceptable to the IRS.

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(3) Competition and service

- Some feel that competition introduced by proprietaries would have a beneficial impact on price and services. However, competition in such areas as Florida has not reduced price or increased efficiency. Further, the voluntary agencies feel they should be protected from such competition.

- Proprietary agencies can fill a need for 24-hours-a-day, seven-days-a-week service which public and voluntary agencies have not filled in the past. (This does not necessarily refer to round-the-clock service provided to a patient, but to the agency remaining open at all times to provide services when needed--at night or on a weekend.)

(4) Quality

- It is argued by some that quality of proprietary services is a problem. However, there appears to be little evidence to either support or refute this argument. There is no evidence available to indicate services are of lower quality.

c. Further Requirements for Proprietary Providers

The Medicare law, in addition to requiring licensure of proprietary agencies, states that the Secretary of Health, Education, and Welfare may prescribe by regulations, additional standards for these agencies. In the past this has permitted the Department to issue regulations requiring certified proprietary agencies to provide all their services directly, rather than by contracting for them.

d. Conclusion

Given the current lack of information about the operating characteristics, services, staffing, and costs of proprietary providers, as well as the uncertainty about supply responses to legislative changes, we have deferred making a recommendation on this issue. Although HEW has requested this information from proprietary providers, it is apparently not available. Through our research program we will attempt to improve our information in order to facilitate making recommendations in this area.

3. Proposals for Monitoring Performance -- Accreditation and Deemed Status

The acknowledged federal role in setting standards for home health care under Medicare and Medicaid stems from the principle that the public body purchasing services is obliged to insure a reasonable quality of service at a reasonable cost. In the instances of Medicare and Medicaid, the Federal government has assumed the responsibility for setting standards and monitoring (as well as paying for) their enforcement. Actual enforcement is done under contract with the states.

Criticisms of the federal (Medicare/Medicaid) conditions of participation, and of enforcement at the state level and monitoring at the federal level, can be addressed in two ways. The federal government may continue to work with the states to strengthen enforcement and closely monitor state performance, and at the same time work to improve the conditions of participation themselves (as specified elsewhere in this report). Alternatively, a national accrediting organization or organizations could be determined to apply standards which are equal to or better than those of the federal government. In this case, the accreditation of home health agencies by the national organization could be "deemed" to meet the standards for Medicare and Medicaid. The "deemed" approach is attractive to some within the industry and has the advantage of offering a mark of excellence to some providers. However, there is concern that in an area where fragmentation and abuse have been detected, the granting of "deemed status" would decrease accountability. Monitoring by the federal government would be difficult, particularly in the event that "deemed status" was sought by, and granted to, several organizations.

Further, difficulties are presented by the "deeming" approach:

- First is the one, already mentioned, that if the Department adopted high, "ideal" standards, it would probably exclude all but a small, elite group of providers.

- Second, home health service providers are not a unified entity on the national scene; there is no single national organization that provides leadership. At least five or six organizations represent various segments of providers. Some have their own standards and accreditation procedures, but none accredits more than ten percent of the total Medicare-certified providers. If one organization were granted deemed status, several others would request it.

- Third, there is a multiplicity of professional and paraprofessional services involved in home health care, and the groups representing them could request their own accreditation; if their standards were comparable to Medicare it would be difficult to refuse to grant the request, and fragmentation would result.

There is no single national organization with the strength and membership necessary to a truly national and universal accreditation program. Permitting "deemed status," i.e. where accreditation by an organization satisfies Medicare/Medicaid certification requirements, to one organizational entity does not seem justified at this time. Agencies accredited by the national organizations are small in number compared to those certified by Medicare. Until a broader proportion of providers accept accreditation, and until a more nationally representative accrediting organization exists, accreditation does not appear feasible for home health agencies.

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Group	Agencies Accredited
Medicare (HCFA) - Certified Agencies	2,400
National League for Nursing/APHA	84
Joint Commission on Accreditation of Hospitals (JCAH)	Accreditation proposal in draft
National Council of Homemaker/Home Health Aides	129
National Association of Home Health Agencies	Accreditation proposal in draft

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4. Recommendation

The Department does not believe it is feasible to give any organization authority to grant deemed status to anyone at the present time. If federal standards and monitoring practices are inadequate, clearly the most appropriate way of correcting the problem is for the federal government as the payment source to strengthen its standards as feasible and appropriate and to improve the assurance of enforcement and quality of service.

B. Quality Assurance for Title XX In-Home Services

Under Title XX, homemaker and other in-home care services may be provided by a variety of methods including the private not-for-profit agencies, proprietary agencies, and single service agencies, often through low-bid contracts, as well as by the individual provider who often receives no supervision or assurance of wage or benefits. There are no quality controls built into this program. This raises the question of whether quality and appropriateness of service are adequate. Other questions focus on whether authority to set such standards should be provided under Title XX and whether, in the absence of a specific mandate, the program could set standards or whether legislation is required.

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1. Why Consider Standards for Title XX Homemaker Services?

The major objectives are to establish criteria by which in-home services may be provided and to assure that quality care is received by the consumer of the service, to assure the appropriateness of that care, to assure that public funds are properly expended, and to assure that the individual service provider is protected as well as the recipient of service.

These assurances could be achieved through the establishment of basic uniform standards for in-home service providers, regardless of auspices. Such basic standards would encompass training, supervision, needs assessment, and payment.

2. Problems of Quality Assurance in Title XX

a. Many localities contract for services through low unit-cost bids
This competitive bidding process for purchase of service contracts has often resulted in attention to cost factors alone, without consideration of quality, accountability, needs assessment, or service practices. No basic criteria have been established for service and appropriateness evaluation or for fiscal and management practices.

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Auctioning off the delivery of human services to the lowest unit cost bidder without definition has been proven to bear little relationship to the lowest total cost. Most states have not established criteria for judging the "lowest bidder," based on total costs, or the relationship of these costs to the outcome of the patients who receive the services.

b. ~~The lack of standards encourages program abuses~~
~~Per case expenditures that appear to be very high have been charged to the federal and state governments in the absence of standards of what constitutes appropriate care and appropriate cost.~~ The different federal matching ratios and service standards between Titles XIX and XX encourage states to provide services under one or the other authority depending on the relation constraints of the two programs, rather than on individual client needs. ~~For example, some clients have been judged on Monday to be in need of home health services as provided under Title XIX, and on Tuesday, to be in need instead of "homemaker/chore services."~~ The two sets of services are theoretically of a different nature from one program to another, yet the client is switched from one to the other depending on the estimated cost and funding limits. The typical question a state might ask itself in this situation is what is the tradeoff between (a) Medicaid home health service with higher reimbursement and lower federal matching rate and more stringent (thus costly) standards and (b) Title XX, with a funding ceiling, but higher federal match and ~~nonexistent~~ standards?

no Federal

Audits conducted under the auspices of GAO, and recent HEW audits have added to the documentation of abuse brought out in Senator Chiles' hearings in Florida and in joint hearings of the House Ways and Means and Senate Aging Committees. For the most part state agencies have not established standards, monitored providers, enforced present laws and regulations, prosecuted violators, or developed mechanisms to secure, encourage and retain honest providers of quality services.

~~The lack of training and supervision of home health agency personnel has resulted in both mismanagement of provider agencies and inappropriate or ineffective care given to in-home service recipients.~~

c. Self-employed provider practices constitute a major problem in some areas
The growing trend for states to use the individual self-employed provider to perform in-home services under Title XX has resulted in several problems such as: failure to obtain Social Security and other benefits for the provider; payment of less than the minimum wage; no supervision, training or accountability of the provider; lack of minimum standards of care and

protection for vulnerable clients; inappropriate placement of responsibility for monitoring with client; reported incidences of fraud and abuse in the program.

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Prior to Title XX, under the adult financial assistance programs, attendant care was included in the grant to the public assistance recipient. Most consumers were either too ill or infirm to properly hire, supervise, and pay the providers. They were also reluctant to report abusers to the state agency. In other situations, the provider was not properly paid, and received no protection in terms of a minimum wage, social security benefits and income taxes withheld. The individual provider was often assigned tasks which were inappropriate.

Under Title XX, a state can opt to have individual provider contracts, with little or no monitoring, where the consumer-client makes the selection. The result has been a lack of accountability, and a residual legal question of who is actually the employer: the local or state government, the Title XX agency, or the recipient? Legal disputes are in process, and in some areas it appears that the local government has been determined to be the actual employer, responsible for recruitment, hiring, salary and fringe benefits, training, and monitoring.

d. ~~Definitions of in-home services under Title XX continue to be a problem.~~ In-home services under Title XX have a wide range of definitions which often overlap and are confusing. These services offered under the other Social Security titles also have different meanings. This situation causes duplication of services, inappropriate use of the service, inadequate or misrepresented reporting, and difficulties in making state-to-state comparisons. There is wide disparity among the states regarding not only the mix of services provided under Title XX, but also in definitions and key components of each service. For example, one state defines its chore service as a "hands off," heavy task-oriented service including activities such as wood-chopping; another, one of light housekeeping duties; and a third specifies such personal care components as feeding and dressing.

A recent Taxonomy of Title XX Social Services identifies 84 discrete services which have been written into 37 entries for chore services in the Comprehensive Annual Services Plans (CASPs) for Fiscal Year 1976. Thus it is difficult to paint a single picture of service delivery under Title XX; however, certain broad generalities may be noted and patterns observed from one state to another.

Title XX precludes the federal government from telling states what services to provide. Further the statute is silent about permitting states to define functionally those services that are provided. Recently published Proposed Regulations covering disclosure of ownership begin to define health related and in-home services. These definitions could be carried a few steps further to generically define the components of these categories.

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3. How to Assure Quality?

Steps to assure reasonable service quality and safeguards for in-home care under Title XX would require establishment of a minimum set of standards,

using as a guide the basic standards developed by the National Council of Homemaker/Home Health Aides. The standards would cover such areas as training and supervision of homemakers and home health aides.

Further, efficiency and effectiveness would be improved by the development of professional health and social service supervision to assess individual needs, order and readjust services, and monitor continued service needs. Without such standards, the use of self-employed providers, at least for the aged and other vulnerable populations such as the mentally disabled, should not be permitted.

It should be noted that any or all of the recommendations below may result in increased unit costs. However, these increases may be offset by lower case costs.

4. Solutions to the Problems

A number of policy changes would be necessary if abuses and general failure to assure quality service provision under Title XX in-home service programs were to be directly addressed.

a. Standards would have to be adopted either nationally or by a mandate to the states to develop standards. In either case the standards established by the National Council of Homemaker/Home Health Aides provide a valuable framework. If the states are responsible, the federal government must have monitoring powers. We believe legislation is needed to permit the Department to establish standards.

b. State and local contracting responsibilities would have to be clarified and guidelines provided to prevent low unit (i.e., per hour) bids from being the only criteria considered in contracting for services. Basic criteria should be outlined by HEW for the states to follow; contracting agencies would be required to show that they comply with basic quality standards and have a means of continuous evaluation of service need in order to prevent inappropriate use of services.

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c. Individual providers would be eliminated except where it could be documented that there are built-in safeguards, and that the employee is still considered a public employee subject to the rights and responsibilities inherent in that fact. This provision would retain a degree of program flexibility while offering some safeguards to both the consumer and the provider. The provider, for example, would be subject to deductions for Social Security, and income tax withholding, and orientation and basic training.

d. Standardized definitions for in-home services across the nation. Functions would be uniformly applied to service labels, such as homemaker, chore, etc., thus permitting application of standards and collection of data, as well as state comparisons of actual services provided. Finally, service title client needs would be matched with actual tasks rather than a general catch-all.

e. Require states to use training funds for training of home care staff. Under Title XX training funds are available but have apparently not been adequately targeted to in-home service providers.

PART VI. HOME HEALTH SERVICES - DEVELOPING AND CONTROLLING SUPPLY

It may seem contradictory to propose methods of expanding the availability of home health services while voicing concern that the development of capacity be controlled. However, these two concerns are valid with respect to home health services in the United States. As a result both of reimbursement restrictions in public programs and of the nature of home care providers, expansion of service has not occurred rapidly over the past decade in the nation as a whole. On the other hand, in certain geographic areas where favorable conditions existed there has been a rapid expansion of services, to the point of over-saturation.

Thus many believe that both controls and stimuli are needed: controls in areas of rapid growth in availability of providers, and stimuli in rural areas, low-income areas, and other areas determined to be in need of services. A further reason to encourage expanded capacity is to attain the goal of comprehensive health services at the community level by aiding small and single-service providers, and by developing new providers of services.

A. Certificate of Need

State certificate of need programs mandated under P.L. 93-641, the National Health Planning and Resources Development Act of 1974, must ensure that covered health services, equipment, and facilities must be determined by the states to be needed, as must expenditures for these purposes. The predecessor to this program, Section 1122 of the Public Health Service Act, had covered home health services in its reviews. However, interpretations of Congressional intent in the planning law led the Department to determine that non-institutional services were not meant for inclusion, and on March 19, 1976, it published a regulation deleting home health agencies from coverage under the Section 1122 program and from certificate of need requirements. Among the other reasons cited for the exclusion was the belief that the health planning system should concentrate its efforts on high-cost areas, and that adequate criteria for determining home health need did not exist.

1. The Purposes and Functions of Certificate of Need

The purposes of the certificate of need (CON) process are to exert control over supply, availability, accessibility, and adequacy of service, and control over costs through determination of the impact on the amount of expenditures for health services as a result of increases or decreases in the supply of services.

The CON process should be viewed in relation to the other major requirements of P.L. 93-641: consideration of national priorities in health plans and review processes, recommended consistency of plans with national guidelines, and the statutory and regulatory interface of national priorities and health plans through procedures and criteria for reviews.

In summary, the certificate of need process is a tool to be used in developing a rational system of health services at the local level by assuring a balance of types and amounts of services available. However, the very nature of the

certificate of need process--a prospective review of the need for additional service capacity--dictates that it be more of a limiter of supply than a generator of it. The health planning and technical assistance functions are designed to do the latter.

As a prospective review instrument the CON process opts in many cases to maintain the status quo (i.e., no more hospital beds), or to encourage more even geographic distribution (no beds in one part of a county, but need for some in another). A third function of the CON combined with the planning process is to encourage better distribution of levels of care (i.e., the HSA might deny an application for a skilled nursing facility but state that it would accept a domiciliary care facility as a substitute, in line with established local needs). It is in these areas--improved distribution and levels of care--that the CON process has the most relevance for home health services.

The following reasons are given for including home health services in the certificate of need process:

- Proliferation of home health agencies in certain areas would be stopped.
- Development of home health service capacity would become more rational.
- The CON process would encourage providers to go into currently underserved areas.
- The HSA should exercise control over all aspects of health care, not just institutional care.
- Home health would be given priority and visibility in the planning process and as part of the health system. HSAs would be stimulated to develop data and criteria for determining community need for home health services.
- Existing providers, particularly visiting nursing associations, believe that they would be protected from an influx of profit-oriented "businesses."
- The CON process might be a means of forcing agencies to pledge to serve the community, including Medicaid recipients, rather than only Medicare beneficiaries.

Available information shows that 14 states now include home health agencies under required coverage of their certificate of need programs and others are expected to do so. These 14 states are:

(1) Alabama
(2) Arkansas (stated in Regs)
(3) Connecticut
(4) Hawaii
(5) Kansas
(6) Kentucky
(7) New Jersey
(8) New York
(9) Texas
(10) West Virginia
(11) Wisconsin
(12) Wyoming
(13) Maryland
(14) Virginia

2. What CON Is Not Intended To Do

Much of the debate over whether home health service providers should be subject to certificate of need has been based on misunderstandings about the nature and purpose of CON; much has also been based on a very real concern that proliferation and overlap of providers in certain localized areas will have a detrimental impact on clients, quality, and costs.

Many of the proponents of CON for home health services expect it to have a kind of impact that it was not designed to have. However, most of the problems CON is believed to be capable of solving must be solved by other means.

The CON process will not:

- Assure quality of services delivered
- Control fraud and abuse.

Quality assurance and the determination of home health agency capacity to provide services are the function of survey, certification, and licensure. If there are weaknesses in these systems they cannot be solved by the CON process; the systems themselves must be strengthened. This confusion of purposes has probably been a major stimulus to the debate over CON.

In the same vein, fraud and abuse will not be dealt with through this process but rather by the enforcement of existing certification standards, service review, reimbursement process and the development of additional necessary safeguards against such practices. Effective administration of checks on reimbursable costs, effective service audit capacity, and special screening for fraud and abuse are the appropriate means of dealing with these problems.

Reasons against inclusion of home health providers in the certificate of need process include:

- HSAs should direct their efforts at reviewing high cost and high volume facilities in order to most effectively target cost controls.
- States with special problems of oversupply or maldistribution are free to establish CON requirements; states without these problems would be forced to adopt a cumbersome procedure.
- There is a general undersupply of home health services rather than an oversupply. Efforts to expand services should not be dampened until a balance is achieved.
- CON will not solve problems of underserved areas; they cannot make the unattractive attractive.
- Keeping new providers out in favor of the status quo of traditional providers might lessen innovation, efficiency and improvements in availability of service.

- Applying CON might not encourage efforts to develop need criteria, since most states with CON requirements for home health have not actively sought to develop them.

- The existence of CON will not aid in the development of capacity.

3. HEW Position

The Department intends to continue to exclude home health services from the certificate of need process as a required activity of local health planning and systems agencies. However, consideration will be given to phasing in CON for home health as criteria for determining need are developed.

Despite the basic decision not to require home health agencies to be within the CON process, the following actions are under consideration:

(1) Improvement of methodologies for determining need/demand for home health services through grants, contracts or in-house resources. Present estimates are that the need for home health care services is large; however, greater specification of the need by types of illnesses, by population, by medical care prognosis, and by cost are needed for more efficient and effective planning.

(2) Development of additional technical assistance documents for planning agencies in regard to home health services, e.g., expansion of Plan Guidelines in relation to home health or development of guidelines on the review criteria considerations.

(3) Grants or contracts to evaluate the various types of home health agencies and their impact on quality of care, costs, utilization of health personnel to assist HSAs and SHPDAs with priority setting.

(4) Establishment of a system (possibly coordinated with a home health trade or professional association, a health planning association, and NPHIC) to alert planning agencies of studies or reports done by the government or the private sector. This would assist them in keeping abreast of pertinent factors in home health delivery.

(5) Consideration of methods to interface the development of home health services with the development of HMOs (on the basis of section 1502(7) priority with HMOs a priority of section 1502(3)). For example, HMOs could be provided special consideration under the provisions of Title XVIII, XIX and Title XX, or for special subsidization for home health services under Title XIII. (This has been suggested on the Legislative Initiative on HMO Development not only in relation to home health, but also to intermediate care and prescription drugs reimbursements.) In addition, planning agencies may consider a relationship with an HMO as providing a home health applicant as having higher qualifications than one which has no such association.

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B. Availability and Distribution of Services

1. Supply Issues

In 1963, not more than 250 agencies met the definition of a home health agency as later defined by Medicare. At that time, 1,163 agencies offered a program of nursing care of the sick at home but only 141 of these nursing agencies could have met the requirement that at least one other therapeutic service must also be provided. In addition, less than 100 qualifying hospital-based programs could be counted. Ninety percent of the agencies offering in-home services were operated by official health agencies and visiting nurse associations (VNAs). The official agencies provided educational and referral services in the home but, in contrast to the services provided by visiting nurse associations, no direct care. The Medicare home health benefit became effective on July 1, 1966 and considerable progress had by then been realized. As of October 1966, 1,275 home health agencies were certified for participation in the Medicare program.

Data presented in Table 4 reveal that, between 1966 and 1976, the number of health agencies participating in the Medicare program increased from 1,275 to 2,165. Although the number of agencies certified varied from year to year, there was a net increase of approximately 910 agencies participating in the Medicare program by the end of the first decade, a 71 percent increase in agencies. VNAs, which in 1966 operated 506, or 40 percent, of participating home health agencies, operated slightly less than one quarter of the agencies certified by Medicare in 1976. In 1966, visiting nurse agencies represented 45 percent of participating home health agencies, but operated slightly less than one quarter of the agencies certified by Medicare in 1976. In 1966, official agencies represented 45 percent of participating home health agencies and in 1976 were 53 percent of the total.

Hospitals and other organizations - except combined government and voluntary agencies - almost quadrupled their participation during the first ten years of the Medicare program and together operated fully 20 percent of the agencies certified in 1976. The combination agencies declined by 46 percent.

2. Geographic Distribution

In 1966, slightly over one third of the nation's home health agencies participating in Medicare were located in the Northeast. Another third were in the South, and the remaining third was divided between the North Central and Western regions. By 1975, increases in the number of certified agencies, particularly in the North Central region and the South, reduced the proportion of certified home health agencies located in the Northeast to approximately 27 percent of the total. In 1975, 32 percent of the home health agencies participating in the Medicare program were in the South as compared to 38 percent in 1966 despite an increase of 232 agencies.

TABLE 4

Number of persons served, number of visits, and amount of charges, by region, calendar year 1975

(Numbers and amounts in thousands)

Region	Persons served		Visits		Total charges		Visit charges		Total reimbursement	
	Number	Per 1,000 enrollees	Number	Per person served	Amount	Per person served	Amount	Per visit	Amount	Per person served
Total	499.6	20.2	10,805	21.6	$227,001	$454	$211,944	$20	$215,497	$431
Northeast	175.9	29.2	3,655	20.8	71,258	405	67,848	19	68,226	388
North Central	101.5	15.2	1,959	19.3	37,315	368	36,012	18	35,186	347
South	139.0	17.7	3,519	25.3	81,060	583	72,830	21	76,175	548
West	78.3	19.9	1,495	19.1	32,908	420	31,523	21	31,656	404
Outlying areas 1/	4.9	18.1	177	36.0	4,459	905	3,732	21	4,254	864

1/ Includes Puerto Rico, Virgin Islands, Guam, other outlying areas, and residence unknown.

Table 5 reveals variations in the distribution of certified home health agencies and the distribution of Medicare beneficiaries by census region and divisions. In the South and the Northeast, the percent distribution of certified agencies is higher than these regions' share of the Medicare population, whereas it is lower than the present Medicare enrollment in the North Central region and the West. These variations reflect differences among the census divisions which comprise the regions; for example, except for the South Atlantic division, the percent distribution of certified agencies is greater than the percent distribution of the service population.

The uneven geographic development of home health agencies is reflected in service utilization by Medicare beneficiaries. Regional utilization data indicate that 175,900 beneficiaries in the Northeast region received home health visits in 1975 (29.3 per 1,000 enrollees), while in the North Central region visits were received by 101,500 enrollees (15.2 per 1,000 enrollees).

The data presented in Table 6 on the distribution of certified home health agencies and the distribution of Medicare beneficiaries suggest that the availability of services of home health agencies is related directly to the percentage of the Medicare enrollment which resides in metropolitan counties. The rankings of census regions in terms of non-metropolitan coverage is the same as for metropolitan coverage, but the differences in the percent population to whom services are available vary markedly.

In the Northeast, where the greatest percentage of Medicare beneficiaries live in metropolitan counties, the availability of home health agencies is nearly universal; services are available to the entire enrollment residing in metropolitan counties and to 89 percent of those who live in non-metropolitan areas. In contrast, the operation of home health agencies relative to beneficiaries' residence is lowest in the North Central region, which has the smallest proportion of metropolitan enrollment to total Medicare enrollment.

Except for the Northeast, home health services are available to less than 70 percent of the Medicare beneficiaries who reside in non-metropolitan counties. For example, services of home health agencies are available to slightly more than the North Central region's beneficiaries: 93 percent of its metropolitan enrollment is covered, compared to 55 percent of the beneficiaries who live in non-metropolitan counties.

3. Service Availability

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The major problem for all home health agencies, whether newly developed or long standing, has been their inability to expand the range of their services and their coverage of populations at risk within the constraints of Medicare and Medicaid eligibility criteria, definitions of services, and reimbursement policies and procedures.

Table 7 presents data on the number of services offered by agencies participating in the Medicare program in 1975 and 1976. The service offered most frequently after skilled nursing care is physical therapy, followed in order by the services of home health aides, speech therapists, medical social workers, and occupational therapists.

TABLE 5 Number and Percent of Medicare Beneficiaries and Certified Home Health Agencies by Census Region and Division. United States. 1974.

	Medicare Enrollment		Certified Agencies	
	Number* (millions)	Percent**	Number	Percent
United States	21.9	100	2,329	100
Region				
Northeast	5.5	25	625	27
North Central	6.1	28	579	25
South	6.8	31	890	38
West	3.5	16	235	10
Northeast				
New England	1.4	6	343	15
Middle Atlantic	4.1	19	282	12
North Central				
East North Central	4.0	18	335	14
West North Central	2.0	9	244	10
South				
South Atlantic	3.4	16	338	15
East South Central	1.4	6	298	13
West South Central	2.0	9	254	11
West				
Mountain	0.8	4	91	4
Pacific	2.7	12	144	6

Sources: Medicare: Health Insurance for the Aged, 1972-1974. Section 3: Participating Providers. Table 3.14: Number of Home Health Agencies, Persons, Enrolled, etc. Washington: Social Security Administration. 1976.

*Number does not add because of rounding.

**Percentage does not add to 100 because of rounding.

TABLE 6 Number of Medicare Beneficiaries and Percent of Enrollment in Counties with Home Health Agencies by Census Region and Division and Metropolitan/Nonmetropolitan Location. United States, 1974.

	Number of Persons Enrolled (millions)			Percent of Enrollment in Counties with Home Health Agencies		
	Total	Metro	Nonmetro	All	Metro	Nonmetro
United States	21.9	14.9	7.0	84	95	61
Regions						
Northeast	5.5	4.5	0.9	98	100	89
North Central	6.0	3.6	2.4	77	92	55
South	6.8	3.9	2.9	78	98	58
West	3.5	2.7	0.8	86	98	56
Northeast						
New England	1.4	1.1	0.3	97	100	88
Middle Atlantic	4.1	3.5	0.6	98	100	90
North Central						
East North Central	4.0	2.8	1.2	86	95	66
West North Central	2.0	0.8	1.2	61	85	45
South						
South Atlantic	3.4	2.2	1.2	77	91	52
East South Central	1.4	0.6	0.8	86	95	79
West South Central	2.0	1.1	0.9	71	88	49
West						
Mountain	0.8	0.4	0.4	75	97	49
Pacific	2.7	2.3	0.4	92	98	62

Source: Adapted from Table 3.14: Number of Home Health Agencies, Persons Enrolled, etc. Medicare: Health Insurance for the Aged, 1972-1974. Section 3: Participating Providers. Washington: Social Security Administration. 1976.

TABLE 7. Number and Percent of Participating Home Health Agencies Offering Selected Services: March 1967 and January 1975 and 1976

Service	1967		1975		1976[1]	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Total	1,753	100.0	2,254	100.0	2,165	100.0
Nursing Care	1,753	100.0	2,254	100.0	2,185	100.0
Physical Therapy	1,201	68.5	1,678	74.4	1,656	75.8
Occupational Therapy	244	13.9	533	23.6	590	27.0
Speech Therapy	361	20.6	799	35.4	858	39.3
Medical Social Service	400	22.8	558	24.8	599	27.4
Home Health Aides Service	601	34.3	1,600	71.0	1,609	73.6

Source: Social Security Administration, Office of Research and Statistics.

1. Unpublished data for 1976.

In contrast, comparative figures for 1977 indicate a growth of almost 82,000 paraprofessionals employed by 3,732 service agencies. Fifty percent of the agencies employed five or fewer aides; 31 percent, 6 to 24 aides; 15 percent, 24 to 99 aides; and 4 percent, 100 or more aides.

4. Service Configurations in European Systems

Trained paraprofessionals have for many years provided one of the major components of community health-social agencies in many European countries. The services are almost entirely funded or subsidized by the government, quality is assured through government sponsored training, and the services are usually offered as a part of community-based service networks. Eighty-eight percent of services are provided to the 65+ group, and the remainder to families in which there are persons who are handicapped, chronically ill or in which there are multiple problems. England, which offers the services to households rather than to individuals, funds the services of nearly 6,000 whole-time and 124,000 part-time "Home Helps" (Homemaker/Home Health Aides). This means that for a population of 56 million people, England employs as many paraprofessionals as are employed in the United States with a population four times as large. The Netherlands employs 68,000 part-time and 17,000 full-time paraprofessionals, the former providing in-home services exclusively to the aged.

In the ratio of "home helps" to population, the United States ranks midway--sixth among twelve countries providing these services. Denmark, excluded from the ranking because comparative data were not available, would probably rank with Sweden at the top of the list. These services, considered essential in countries with aging population percentages similar to those in the U.S., are used in a variety of community settings (single person households, families, congregate housing, apartment complexes). They are primarily home-centered and by far the largest percentage of the personnel is utilized in services to the populations in the older age range and to the handicapped.

The difference between the United States and Western European countries with respect to the development of community based services may be attributed to a variety of factors. The age of the social security system is an important factor. Countries which established the concept of general entitlement to insurance against essential risk (unemployment, old age, sickness) have tended to enlarge or expand the range of services. The concept of general entitlement discouraged approaches which separated the poor from the non-poor and encouraged development of services which, while they were universally accessible, did not involve the development of the most costly resources.

European cultures also retained a family centered ideology with the home and community as the central focus of services. The family centered ideology in the United States placed greater stress upon personal responsibility than than upon the concept of general entitlement. Culturally, the United States has emphasized efficiency, and the use of institutions has seemed to offer more efficient approaches to care compared with dependence upon approaches utilizing the home and the resources of the community. The presence of a substantial institutional complex already in place in the United States tended to discourage the development of community services that are considered "add-on costs."

C. Past and Present Efforts To Expand Home Health Care

1. Hill-Burton

In the Hospital Survey and Construction Act (Hill-Burton) of 1946, the process of making needed hospital beds available was approached in a systematic manner. The purpose of the act was specific; the several states were:

> to survey the need for construction of hospitals, and to develop programs for construction... the Surgeon General with the approval of the Federal Hospital Council and the administrator shall by general regulation prescribe a) the number of hospital beds required to provide adequate hospital services to the people residing in a state, and the general method or methods by which such beds shall be distributed among base areas, intermediate areas, and rural areas...

Congressional comments attached to the Act noted that:

> the complete absence of hospital facilities in some areas, their inadequacy in other areas, and over the country as whole, their uneven distribution are strong deterrents to an adequate hospitalization and health program...of the more than 3,000 counties in the nation, approximately 40 percent of them containing some 15,000,000 people are without any registered hospitals...The nation's lack of adequate hospitals is not due to lack of interest or initiative. It is caused primarily by a lack of economic means by which hospitals and health facilities are acquired.

These comments with respect to hospitals in 1946 are applicable to home health services now: the absence of resources in some areas, inadequacy of services in others; the effect of the lack of resources on large populations with respect to adequate health care; the placement of responsibility for growth and expansion.

The situation with respect to institutional resources has been considerably altered by means of consistent and continued federal financial support for institutional construction. Financial incentives have also been available to help increase the number of beds in nursing homes. Hill-Burton funds have been available to non-profit organizations and low interest loans have been available from the Small Business Administration to proprietary groups. Now, however, it appears that the building of beds outpaced the need for them.

2. Grant Programs for Home Health

There has not been a similar approach to the consistent development of home health and related community-based services. Home health services apparently have not been viewed seriously as offering the potential for methods of care which might appropriately buffer against institutional use and provide for populations whose need is parallel in magnitude. This difference in perception of the need to build community services is probably related to the fact that in the first instance facilities involved costly construction. Home health care involves service development rather than construction. It was evidently assumed that federal provision for reimbursement of selected services for selected populations would provide adequate financial support for capacity development.

This approach, however, has not been entirely consistent. In 1961 the Community Health Services and Facilities Act authorized the Surgeon General "to make project grants to public or non-profit private agencies or organizations for the development of outside-the-hospital health services, particularly for the chronically ill and aged." "Out-of-hospital" services were defined as services "which prevent, detect, and treat disease and disability and improve care for persons - particularly the chronically ill and aged who are not patients in a hospital." Among the examples of such services were "Home Care, including nursing care, homemaker services, physiotherapy, occupational therapy, nutritional services, social services, etc. for the sick at home."

The Community Health Services and Facilities Act provided assistance in the form of time-limited grants which were intended to support studies, experiments, and demonstrations which would "lead to new or improved community health services outside the hospital..." and such demonstrations were to include those directed to coordination to "ensure comprehensive care of patients." In its 1968 report, the review committee reported that "the project grant program as originally conceived was not oriented to any specific chronic illness and had a broad base of eligibility in terms of the type of applicant and the type of project." The authority lasted for six years from fiscal year 1962 to fiscal year 1967. Total funding amounted to $42,319,000.

Of the 295 projects funded, 17 percent were for home care, homemaker services and nursing care and related in-home care (about 15 percent of the funds). All but four of the home care and related services grants were for three years; the awards were, for that period, adequate for effective service development. More than twothirds were for the initiation of new programs, for coordinated multipurpose programs, for the development of homemaker services, or for the development and incorporation of homemaker services into existing home care programs or visiting nurse services. Seven involved the coordination of fragmented services or extension of urban services to rural areas. A small number were for the addition of specialized services to existing programs. The staff of federal consultants representing the various professions involved in the delivery of home health services, working in a team approach to the communities in which the demonstrations took place provided, in addition to project support, substantial community education concerning the service programs. Most of the projects weathered the end of federal support; some, however, did not survive the complex problems which surrounded Medicare-Medicaid definitions, eligibility criteria, and reimbursement procedures.

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When Congress endorsed the concept of home health service in the 1965 Social Security Amendments creating the Health Insurance Program for the Aged (Medicare), there was widespread anxiety concerning the availability of home health services to meet the needs of beneficiaries eligible for benefits under both Parts A and B. All but a few states developed plans utilizing federal and/or state, and local funds to expand the services. In September 1965, a supplemental appropriation of $9 million was made available to strengthen existing home care agencies by adding services and to help establish new programs that could meet the Medicare conditions of participation. Another supplemental appropriation of $6.7 million became available for fiscal year 1967. Within the nine months between September 1965, when the funds became available, and July 1, 1966, when Medicare became effective, the number of programs increased as did the range of services offered.

Between 1968 and 1975 little significant federal investment in home health services development occurred with the exception of a short term OEO-PHS. paraprofessional training grant program geared to older women on public assistance, and some "add-on" home health components to existing community agencies funded under Title III of the Older Americans Act.

3. Current Activities

In 1975 with the passage of the Health Revenue Sharing and Health Services Act (P.L. 94-63) the sum of $3 million was appropriated for one-year grants to existing agencies and 17-month grants to new agencies to "demonstrate the development and expansion of home health services." Grants are authorized for the purposes of (1) meeting the initial costs of establishing home health agencies, (2) expanding the services available through existing agencies, and (3) compensating personnel during the period of initial operation or agency operation." In extending the grant authorization Senate and House conferees reported their belief that the future of home health services is dependent in large measure on a consistent federal approach to the establishment of and payment for these services. Fifty-six grants were awarded to non-profit home health agencies certified for or meeting conditions of Medicare-Medicaid participation for home health agencies. Forty grants were awarded for expansion of existing agencies and sixteen were awarded for the development of new agencies in areas in which there is a high percentage of individuals who are elderly, indigent or both. The appropriation was increased to $6 million in the following year, with similar requirements. The grantees have become certified Medicare providers and are now operating the newly developed home health agencies without federal subsidies.

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D. Manpower Issues

Estimates of manpower needs in home health depend to some extent upon how the service package is defined. The Medicare program has identified skilled nursing and physical and speech therapy as the primary services but also reimburses for occupational therapy, medical social services, home health aides, and supplies and equipment.

A method of estimating manpower need in home health is one which examines the services being utilized in current home health programs along with consideration of geographic problems (urban-rural) and personnel currently available to meet what have been demonstrated as being the most urgent needs. The two services which have been most used in existing home health agencies have been nursing and home health aide services, with physical therapy following.

In 1974 approximately 23,000 persons were employed by agencies participating in the Medicare program. All home health agencies certified by Medicare provide nursing services. In 1974 over 90 percent of all home health employees were nursing personnel, 70 percent were registered nurses, 7 percent practical nurses, and 19 percent home health aides. Four percent of home health agency personnel were physical therapists. Occupational therapy, speech therapy and medical social services have been offered by fewer agencies. They are relatively less available in rural and outlying areas. Some agencies also have included through administrative costs the services of nutritionists and psychologists.

Whether full-time or part-time, nursing personnel are generally permanent members of a home health agency staff. In contrast, the principal place of employment for therapists and medical social workers is another community health service organization, e.g., hospitals, clinics, rehabilitation centers. They provide services to patients of the home health agencies under contractual arrangements with the employing institution or on a fee-for-service basis.

The incremental capacity building approach of adding the services of a therapist or a medical social worker on a part-time basis has been successful in many urban areas; it has a number of advantages. One is that the services of another professional discipline can be utilized on a pilot basis to meet the needs of one or more patients and at the same time acquaint the nursing personnel with the contribution another discipline can make to the assessment, plan of care, and treatment of certain patients. A second advantage is that it has permitted the home health agency to obtain access to other community resources, including in-service training opportunities, professional meetings, invitations to serve on utilization review committees, and technical assistance to improve administration management capabilities.

The development and expansion of home health services in rural areas is particularly critical. In contrast to agencies located in major population centers, rural home health agencies frequently experience difficulty in identifying and hiring personnel qualified to provide the number and type of services appropriate. A partial answer has been the ability of certain well established home health agencies to extend services into suburban and/or adjacent rural areas.

Health Departments which are the primary source of home health services in rural counties should be encouraged to explore the possibilities of sharing a therapist(s) and medical social worker with the nearest community hospital or skilled nursing facility. Interesting job possibilities such as the opportunity to provide services to patients in the hospital, nursing home and in their own homes might attract a well qualified person to a rural area.

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E. Conclusion

The following issues in capacity and its development are critical in the in-home service area:

(1) The maldistribution of health professionals (generally) and their unavailability in medically underserved areas, such as rural and inner city areas for staffing home health services.

(2) Lack of a focus in educational settings for developing on-going programs for training and preparing service providers in home health care skills.

(3) Need for specialized training for administrators, supervisors, and service personnel of home health agencies to improve and increase capacity to provide services.

(4) Limited understanding of the potential for the development and utilization of manpower for home health and absence of innovative training programs.

At the present time, the Home Health Service Grant Program authorized under P.L. 94-63 and extended by P.L. 94-460 is attempting to help rural and underserved areas with large elderly and poor populations to develop home health services. This should help to overcome part of the maldistribution problem.

In addition, the training needs of paraprofessionals (homemaker/home health aides) will be met in part through the contract to the National Council of Homemakers/Home Health Aides to develop a model curriculum and training guides to prepare trainers to assume the responsibility of preparing aides for employment in Medicare-Medicaid certified Home Health Agencies. Grants also will be available to test the validity of the curriculum content and the training procedures. This should provide a much needed resource to improve the capacity of home health agencies to provide high quality personal care and supportive services to its patients. If the test of the curriculum and training guide plan is successful, satisfactory completion of the basic training course might become the compliance measure for appropriate preparation of homemaker/home health aides.

DELETED

F. Recommendation

The current grant program for development and improvement of capacity to deliver in-home services should be continued and expanded providing the evaluation conclusions show this to be warranted. Preliminary information from the evaluation supports this conclusion.

ENTIRE PART VII DELETED

PART VII. FUTURE DIRECTIONS FOR HOME CARE

It has been said that the HEW programs providing in-home care defy coordination. Services are variously defined and unevenly distributed and provided, payment methods and eligibility criteria differ radically from program to program, and standards are varied or nonexistent. Previous sections of this report have discussed the improvement of coordination and management of home health and related in-home services, but within the existing structure of HEW programs.

Finding ways to improve the coordination of existing services is a major step toward solving problems, but coordination requires, even assumes, the existence of a comprehensive and accessible set of services. Without this, there is nothing to coordinate. The prerequisites to coordination do exist in some areas, but not in others.

Coordination requires these elements:

- Comprehensive service capability
- Uniform definitions of services
- Uniform or aligned benefits
- Clear eligibility criteria that do not leave major gaps
- Use of the same providers where possible, or formal relationships among them
- A coordinated flexible source of payment for services

A major problem in achieving coordination, or even in proposing solutions, is the constraints of existing legislation. Removing them brings elements of other programs and services into the picture, so that solutions tend to become quite global.

A. What Should A Coordinated System Be?

Ideally, home health services are structured with the objective of providing comprehensive coordinated care which will accelerate a return to optimum health in acute illness and which will restore and/or maintain maximum function and independence in individuals in need of long term care so that they can remain at home and in the community for as long as possible. Comprehensive home health care requires a broad range of services, delivered without the impediment of having to seek multiple funding sources. Although the full range of services is not required in every situation and is rarely needed over extended periods, a comprehensive approach depends upon the availability of these services so that selection in appropriate combinations may be made as changes in need arise.

1. Components of Care

Essential services in the comprehensive range include medical care, nursing services, physical therapy, occupational therapy, speech therapy, the combined services of the homemaker-home health aide, medical social services and nutrition services. These may be coordinated with related community services such as health oriented day health or day hospital care, home delivered meals and transportation.

Home health services which are comprehensive and coordinated are provided in a sequence which includes outreach, or early identification of need; professional assessment of health status, functional potential and the goals of treatment; the development of a plan of care and the delivery of services in accordance with the care plan; health monitoring and regular reassessment so that the plan of care and the services required may be changed, adapted, and increased or diminished in frequency and intensity as changes in status and function occur. In this sequence, flexibility is essential. Home health care is therefore based entirely on the capacity of the services to respond to individual need. It is rarely routine in the sense that the plan of care remains static although individuals who require long term care may be maintained with relatively simple combinations of services for very long periods of time with utilization of increased services during periods of acute illness.

2. Multiple, Coordinated Service Types

This approach requires a high degree of coordination among the multiple professional and paraprofessional services which may be utilized in different combinations at different times, and between the home health service complex and other community resources. Effectiveness of this care depends not only on these services, but upon tolerable living conditions, sufficient income to maintain adequate nutrition, and availability of medical care when needed. Consumer participation in care plans, consumer choice and consumer satisfaction with the services and with the plan of service delivery are of primary importance in the selection of home care as the method of care.

3. Personal and Family Supports

When a personal support system is available, i.e., relatives, neighbors and friends -- even where such personal resources are minimal -- the service plan in high quality programs makes maximum use of these resources in order to sustain an environment for the client which is as close to the normal living pattern as possible. Maximum use of the personal support system does not, however, place demands upon this system to the point at which the pressure becomes impossible to maintain. Spouses, children, relatives and friends are evaluated realistically in terms of their capacity to supplement the care at home and are provided with the needed instruction and support which makes the sustained effort possible.

For the family that is considered intact--where there are relatives in the home--working family members are frequently unable to provide all the essential supports and care; the availability of home health services can provide these for acutely or chronically ill family members.

Family members who are available throughout the day are also assisted by home health services to provide skilled services, instruction, and simple relief, the latter particularly in long-term cases. It has been estimated from experience that the continuous pressures entailed in caring for sick and severely disabled family members can be sustained by family members only for relatively brief periods after which personal support systems tend to break down in the absence of some kind of outside help.

4. Who Can Benefit?

In the population in need of long term care, there is a fairly large number of individuals who live alone; many are without relatives and, in the older population, may be without significant social contacts. Another group in need are those living with equally elderly or disabled family members. About one-third of the consumers of long term home health services are individuals who live alone who prefer home care to other methods of care. For these individuals, the service personnel provide a support system which frequently fulfills the need for care and concern from others. Plans which provide for easy access to service personnel--telephone reassurance, friendly visiting, rapid response to emergency situations and the maintenance of an open channel to medical care provided with continuity and consistency--effectively support the choice of care in a personal environment. In a recent longitudinal study of recipients of home health care in an agency which extends services to long term consumers, individuals who live alone have been maintained for periods of years, moving in and out of the service programs with the assurance that care will be available when it is required. The services used by this group were relatively minimal over extended periods. The most used service combination for this group was health monitoring by a nurse, the combined services of the homemaker/home health aide delivered in an intermittent, part time pattern, and occasional visits by the medical social worker.

5. Patterns of Service -- Some Case Examples and Principles

a. Families would receive assistance as needed in caring for ill or disabled relatives

Case: A couple in their 80s lived on the second floor of their working daughter's home. The wife behaved disruptively as a result of chronic brain disease, and also had vision, cardiovascular, and gastro-intestinal problems; she required increasing supervision and assistance. The husband could no longer care for his wife and the house due to his problems of heart valve leakage, vision, and hearing problems. Both he and the daughter had emotional stress because of the wife's problems.

Services: The service agency evaluated the situation and arranged for a home health aide, at first for four hours three times a week, later for two hours a day, to help supervise the wife, prepare lunch, and do light housework. A visiting nurse made monthly monitoring visits.

Outcome: The family situation was stabilized, stress relieved, and the wife cared for. Several months later, she died, at home with her family.

b. People with fluctuating conditions would be monitored and services readjusted as needs changed

Case: An 82 year old widow lives in her own house with an 80 year old friend who pays room and board but does not help with housework or meals. The widow, nearly blind, has trouble cooking and has had fires in her kitchen; she also has hypertension and is depressed over her declining vision. This case is characterized by gradual decline, crisis, recovery, and stability.

Services: The agency arranged for all of the services the women needed over several months:

- Meals on wheels, homemaker once a week
- Nursing home for six weeks
- The return home
- Daily home health aide and meals on wheels, visiting nurse once a week
- Gradual reduction in service until client stabilized with daily meals, homemaker twice a week, visiting nurse every two months.

Outcome: The widow was able to live in her home and to return home after an acute and convalescent episode. Services were added and subtracted as necessary, avoiding dependency or inappropriate services.

c. People without family supports would be able to remain at home with assistance

Case: A 74 year old widow with several chronic conditions resulting in her inability to go out unassisted or to do housekeeping, wanted to remain at home, in her third floor walk-up apartment. Her daughter did her shopping.

Services: Health assessment and monitoring, meals on wheels, and housekeeping services were arranged for, as were physical safety adaptations to the bathroom; physical therapy to teach exercises for maintaining functional abilities.

Outcome: The widow remains in her home, and uses her own resources as much as possible to contribute to the meals and housekeeping services.

B. Major Approaches to Program Reform

Home health and other in-home services are just a part of a continuum of institutional and community, health and social services needed to serve the sick, the aged, and the disabled. It is inappropriate to consider long term reforms in just one segment of that continuum. Overall changes in the organization, delivery, and financing of these services are needed. These changes can be considered in the framework of major long term care reforms as well as in the development of national health insurance proposals.

The nature of a home care program within these larger contexts would encompass the components, enunciated previously, of coordination, comprehensiveness, and continuity.

The major features of an in-home service program would be:

- A single administrative locus at all levels of government for a home care program;
- A single source of funding for services

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- Entitlement, based on criteria other than income; income-related cost sharing;
- A single benefit package, flexible in nature but with specific individual service definitions;
- A single set of provider requirements; and
- A single reimbursement method (based on any principle chosen, such as capitation, cost, negotiation, etc.).

The organizational structure of such a program could consist of using existing home and other health service providers on the local level to perform assessment, care planning, and services for all clients in need of health and support services. This could be a required activity of either the service provider or a local coordinating and single service entry agency such as Triage in Connecticut, and other Community Care Organizations and models.

Existing home health providers could either be given incentives or be required to coordinate services as part of the care plan; they would be responsible for contacting other organizations and arranging for services. Using existing providers instead of creating separate entities appears to have the advantages of being readily instituted, adaptable to most communities, and much less costly since most of the better and larger agencies do this now and administrative overhead would be minimized.

Financing and program loci could follow these or other methods:

- A separate health authority, similar to the maternal and child health or crippled children's programs, with major financing out of general revenues, to set standards, set fee scales, and pay for services. Funding would have to be sufficient to guarantee access.

  In this event, Title XX services provided in the home would be eliminated; Medicare and Medicaid could continue to provide acute, short term care.

- Medicare, either as a broadly defined benefit under Part B, or as a new Part C, could be used as the financing mechanism. The current home health benefit under Medicare would be expanded to include a variety of support services, and eligibility criteria would be expanded by dropping the skilled care requirement. The deductibles would apply under Part B, and consideration would be given to establishing coinsurance. The advantages of the Medicare approach would be the achievement of a comprehensive benefit for the aged and disabled of all income levels; a new part C would in effect create a comprehensive long term care program for Medicare eligibles.

The Department in recent years has supported demonstration projects to test various models of service delivery, organization and single sources of reimbursement. New demonstration projects will build on these past experiences and develop major new initiatives in this area. They will test new relationships among community and institutional services, as well as among federal, state, and local authorities. These efforts at coordinating several disparate funding sources and programs on behalf of clients are costly in terms of resources required to accomplish coordination and to package services as needed. Past experiences in this regard have shown the need for a single funding source for services, as well as flexibility in the provision of services.

A great deal of recent discussion has centered on the need for a single entry point into the long term care or community care system; on the need for entities to coordinate, package, and monitor services on behalf of clients; and on the need for methods of assessing clients' needs. When all is said and done, however, two basic needs remain from the client's viewpoint: available and accessible services of sufficient variety to meet needs; and a source of payment for those who do not have adequate finances to pay for care.

Appendix 4

ITEM 1. RESOLUTION INTRODUCED BY

SENATOR WILLIAM S. COHEN

96TH CONGRESS
1ST SESSION

S. RES. 169

Relating to the report by the Secretary of Health, Education, and Welfare with respect to home health and other inhome services.

IN THE SENATE OF THE UNITED STATES

MAY 22 (legislative day, MAY 21), 1979

Mr. COHEN (for himself, Mr. CHILES, Mrs. KASSEBAUM, Mr. DOMENICI, Mr. HEINZ, Mr. DOLE, Mr. PERCY, Mr. CHURCH, Mr. BRADLEY, Mr. BURDICK, Mr. PACKWOOD, Mr. GLENN, Mr. PRYOR, and Mr. MELCHER) submitted the following resolution; which was referred to the Committee on Finance

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RESOLUTION

Relating to the report by the Secretary of Health, Education, and Welfare with respect to home health and other inhome services.

Whereas section 18 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95–142) directed the Secretary of Health, Education, and Welfare to report to the Congress within one year of enactment with respect to all aspects of the delivery of home health and other inhome services authorized to be provided under titles XVIII, XIX, and XX of the Social Security Act;

Whereas the Secretary failed to submit such report in a timely fashion;

Whereas the Secretary failed to include in such report recommendations for legislation with respect to home health and other inhome services, including the reasons for such recommendations, an analysis of the impact of implementing such recommendations on the cost of such services and the demand for such services, and the methods of financing any recommended increased provision of such services under such titles, as required by such section; and

Whereas the Senate has expressed its will with regard to the need for expanded opportunities for receipt of home health and other inhome services, including the passage of medicare amendments to H.R. 5285 in the Ninety-fifth Congress: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) the report of the Secretary of Health, Education, and Welfare entitled "Report on Home Health Services Under Titles XVIII, XIX, and XX" is not responsive to the requirements of section 18 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95–142); and

(2) such report be returned to the Secretary with the direction that it be revised to comply with the requirements of such section, including the requirement that recommendations for legislation be submitted, and that such report be returned to the appropriate committees of the Congress not later than September 1, 1979.

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ITEM 2. SENATE FINANCE COMMITTEE

REPORT ON S. RES. 169

Calendar No. 245

96TH CONGRESS, 1st Session } SENATE { REPORT No 96-233

HEW HOME HEALTH REPORT

JUNE 27 (legislative day, JUNE 21), 1979.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany S. Res. 169]

The Committee on Finance, to which was referred the resolution (S. Res. 169), relating to the report by the Secretary of Health, Education, and Welfare with respect to home health and other in-home services, having considered the same, reports favorably thereon without amendment and recommends that the resolution do pass.

DESCRIPTION OF THE RESOLUTION

Section 18 of Public Law 95-142 required the Secretary of HEW to submit a report to Congress analyzing, evaluating, and making recommendations on all aspects of the delivery of home health and other in-home services provided under titles XVIII, XIX, and XX of the Social Security Act. The report was also to include an evaluation of the coordination of such services under the different titles, along with recommendations for changes in regulations and legislation on the scope of services provided, eligibility requirements, standards for provider certification, utilization control and quality assurance, reimbursement methods, and the prevention of fraud and abuse. As submitted, the HEW report does not contain the required recommendations for legislative changes.

The resolution would return the report to the Secretary with the direction that it be revised to comply with the requirements of Public Law 95-142, including the requirement that recommendations for legislation be submitted, and that such report be returned to the appropriate committees of the Congress not later than September 1, 1979.

VOTE OF THE COMMITTEE

In compliance with section 133 of the Legislative Reorganization Act of 1946, the following statement is made relative to the vote by the committee to report the resolution. The resolution was ordered reported by voice vote.

NOTE: S. Res. 169 was passed by the Senate on July 11, 1979. A similar resolution, H. Res. 357, introduced in the House by Representatives Waxman, Rangel, and Pepper, was passed by the House on August 2, 1979.

Appendix 5

...home health line

VOLUME IV ISSUE 4 April, 1979

Here is the final HR 3 report--finally, eradicating all other news. Quickly, USHHAR will be proposed by the end of May; comments are in on the 223 cost limits; hearings galore are on the docket.

FINAL H.R. 3 REPORT STRAGGLES TO CONGRESS

On April 17, almost six months late and at a cost of $62,630, HEW Secretary Joseph Califano sent the final H.R. 3 home health report to Capitol Hill, per mandate of the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142).

To give you an idea of the high priority with which this report was treated, one of the copies was addressed to a former Chairman of the Committee. As promised, the final report has been gutted (see ...hhl, Volume IV, February/March 1979).

Before launching into an analysis of the report, ...home health line thought new readers might be interested in a brief, recent history of HEW and Congressional involvement in home health policy:

1965 - Passage of Titles XVIII Medicare and XIX Medicaid, establishing a limited home health care benefit for the poor and elderly

1969 - Social Security Administration issues policy instructions tightening the definition of "skilled" nursing to cut down on aide services

1972 - Three-day conference on home health by HEW's Office of Nursing Home Affairs
- Social & Rehabilitation Service releases hh Issue Paper #10
- Social Security Amendments of 1972 (P.L. 92-603) deletes 20% co-pay for Part B hh services, establishes authority to set cost limits (Section 223), establishes authority to carry on home care demonstration projects (Section 222)

1973 - Senator Muskie's Aging Committee hearings on home health care

1974 - First General Accounting Office report on home health care, pushing the need for HEW to publicize availability of the benefit
- Title XX Social Services (P.L. 93-647) passage

- Health Planning Act (P.L. 93-641) passage
- Social Security Administration Option Paper on home health care
- Office of the Assistant Secretary for Planning and Evaluation Option Paper on home health care
- SRS begins development of Medicaid regulations on home health care

1975 - OAS/Planning issues Callender/LaVor comprehensive hh report
- Secretary Weinberger sends Medicare amendments recommendations to the Hill, asking for inclusion of proprietaries
- SRS proposes Medicaid regulations on August 21 to include proprietaries and establish a home health aide training program
- House and Senate Aging Committees hold joint hearing on proprietaries in home health after a flood of mail opposing the SRS regulations
- HEW holds an industry conference on home health to discuss SRS proposal
- SSA issues regulations allowing proprietaries to subcontract with certified agencies in the wake of a favorable Court decision
- home health training and expansion grant program (P.L. 94-63) passage

1976 - Pepper House Aging Committee hearing on field delivery of hh services
- Office of Assistant Secretary for Health issues memo on hh care
- Senate Federal Spending Subcommittee (Chiles) holds hearings on fraud and abuse in home health agencies in Florida
- OAS/Planning releases a memo on home health care
- SSA sends Intermediary Letter 76-31 and 76-25 on reimbursement for "newly established non-hospital-based home health agencies"
- Undersecretary Marjorie Lynch issues a memo on home health care
- Ways & Means Oversight Subcommittee (Vanik) holds hearings on fraud and abuse in home health care
- Final Medicaid regulations issued in August without proprietaries and without aide training requirement
- HEW publishes schedule of regional home health hearings to get public comment on issues raised by original SRS regs before proposing new regs
- HEW regional hearings held in September and October
- HEW issues report on regional home health hearings (Yellow Report)
- HEW prepares discussion paper (Pink Report), rather than an option paper on regional hearings issues

1977 - Congressional Budget Office issues report on different home care options and the costs of implementing them (actuarial estimates)
- HEW excludes home health agencies from certificate of need
- Ways & Means Oversight (Vanik) and Health (Rostenkowski) Subcommittees hold joint hearing with Senate Aging (Church) on fraud and abuse
- Rural Health Clinics Law (P.L. 95-210) passage
- Second General Accounting Office report on the need for a national policy
- Medicare and Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) passage, mandating a major HEW home health report with recommendations, establishing authority to impose uniform reporting and designation of intermediaries for providers or a class of providers
- Senate Aging (Chiles) hearing on alternative health care delivery
- Senate Aging (Chiles) hearing on HEW home health "focal point"--Derzon
- House Aging (Pepper) hearing on GAO "national policy" report--Califano

1978 - House Aging (Pepper) hearing on progress of GAO recommendations--Derzon

- Senate Aging (Domenici) hearing on hh standards
- HEW calls meeting of hh provider groups and Medicare, Medicaid and Title XX staff to discuss standards
- Ways & Means Oversight (Gibbons) holds hearing on GAO fraud and abuse report
- Division of Direct Reimbursement (Medicare Bureau) issues cost guidelines for hh agencies for whom it acts as fiscal intermediary
- Medicare Bureau issues Intermediary Letter 78-16, to help fiscal intermediaries identify "out of line" costs
- HEW calls industry meeting to discuss H.R. 3 report, without distributing the draft of the paper
- Medicare Bureau issues IL 78-37, cost per visit data on certified hha's
- Medicare Bureau issues IL 78-39, hha management contracts
- Rostenkowski's Medicare Amendments of 1978 (H.R. 13097) with home health expansion and administrative controls passes the House, is not considered by the Senate
- Senate hospital cost containment bill (H.R. 5285) passes Senate with deletion of hh visit limits and prior hospitalization requirement, is not considered by the House

1979 - HCFA issues proposed Section 223 cost limits for home health care
- HCFA issues proposed regulations on cost to related organizations
- HCFA issues personal care service guidelines for Medicaid
- HCFA issues draft of uniform system for home health agency reporting for public comment prior to proposal
- HCFA solicits waiver-only demonstrations for hospice-home care
- HCFA proposes Medicare malpractice insurance limits
- HEW sends final home health report to Congress
- House and Senate Planning Amendments bills marked up without CON for home health
- Senate Finance marks up Talmadge bill, maintaining deletion of hh visit limits and prior hospitalization requirement

It is obvious from this incomplete catalogue of home health events in Washington that Congress is getting ready to enact some home health care legislation, and that HEW has been working on home health care issues in detail for five years. The culmination of these efforts is the final H.R. 3 report.

THE REPORT

"The Department makes no legislative recommendations in this report primarily because of budget constraints. In addition serious questions, which are raised in this report, must be resolved before final recommendations can be made in this area, including:

What is the best way to ensure types of beneficiaries, e.g., the aged, low income, the disabled, have adequate access to in-home services?

How can we design a program for in-home services that

> does not encourage a large shift in financing and initiative from the private to the public sector?
> "In order to analyze these and other questions, the Department plans to undertake, in FY 1980, a major research effort in the in-home services."

Under the influence of the cutting spree touched off by the trimmed down fiscal 1980 Carter budget, there are no legislative recommendations at all in the report. There are no regulatory recommendations in the report. There are a few "administrative" changes HEW is implementing or further studying.

The law mandating the report said nothing, however, about basing recommendations on the availability of funds. The cut and paste job also involved toning down the report altogether from previous drafts, specifically the earlier references to HEW policy having had negative results.

Consequently, the singular significance of the final H.R. 3 report is that it is not responsive to the mandate of P.L. 95-142, which required HEW to submit (by October 28, 1978) a report "analyzing, evaluating, and making recommendations on all aspects (including the availability, administration, provision, reimbursement procedures, and cost) of the delivery of home health and other in-home services...under Titles XVIII, XIX and XX of the Social Security Act." The report was also to include "recommendations for changes in regulations and legislation" about scope and definition of services, eligibility to receive services, standards for provider certification, procedures for utilization and quality control, methods of reimbursement and fraud and abuse prevention, including reasons for the recommendations and analysis of the impact of implementing them on home health cost and demand, and how to finance recommended expansion.

Here is a line-by-line analysis comparing the final report with the January 1979 draft, which had been signed off by HCFA Administrator Leonard Schaeffer, whose office had lead responsibility for the report at HEW.

I. IN-HOME SERVICES UNDER MEDICARE, MEDICAID, AND THE SOCIAL SERVICES PROGRAMS

- "Many persons in need of services who wish to stay at home or in other non-institutional settings have few, if any, benefits covering in-home services available to assist them."*.....CUT*
- references to the inability to receive benefits unless the beneficiary conforms to eligibility requirements*.....CUT*
- medicaid rates in some state are lower than the costs of service provision *.....CUT*
- New York is "mainly responsible" for "huge increases in Medicaid in-home benefits"*.....CUT*
- reference to availability of home health aide services under Title XX*.....CUT*
- reference to reimbursement policies under Title XX being at state discretion *.....CUT*

II. LEGISLATIVE AND ADMINISTRATIVE PROBLEMS IN COORDINATING HOME CARE PROGRAMS

- subtitle previously "Problems Have Emerged" changed to "Programmatic Differences"
- references to fragmentation within HEW.....*CUT*
- where regulations governing providers were previously "inconsistent," they now "vary from program to program"
- "The programs are directed at specified populations, thus creating confusion over who is eligible for which programs and leaving some population groups without access to services" is now written, "The programs have overlapping constituencies."
- reimbursement methods were charged in the earlier draft with being "different for each program and are either inequitable or encourage inefficiency; they are confusing to both providers and clients;" the reimbursement methods in the final draft are called "different for each program."
- "The results of these problems have been that services are often inaccessible, incomplete, inadequate, or absent. At the service delivery point, providers, health and social service workers, and clients must search through the complexity of programs and payment sources to identify and package services."*CUT*
- subhead "Programmatic Shell Games Are Played" now called "Changing Payment Sources"--subhead "Service Definitions Are a Major Problem" is now "Service Definitions"--subhead "Gaps and Duplication Both Cause Problems" is now "Gaps and Duplications"
- an earlier complaint that administrative costs may exceed the cost of the services themselves.....*CUT*
- "In the United States, confusion with respect to definitions, funding, service provision and integration of the services into coordinated community non-institutional care systems has substantially reduced the usefulness of a supportive resource essential to the provision of coordinated home health care" has been changed to "The system for home care is not as simple or as clearly identifiable in the U.S. because home health services are a part of several programs with different overall purposes."
- "The above discussion points out the inherent system problems and impediments to achieving coordination of in-home services. Virtually every aspect of the programs precludes development of a rational, organized, cost-effective system of home care. The problems are so basic that they can only be mitigated by improvements in federal (HEW) operations; a wholesale restructuring of programs, or a completely new one, would be required to fully address the problems."*CUT*
- verbs such as "should" have been changed to "could"

III. BENEFITS AND ELIGIBILITY CRITERIA

Medicare--redefine "home health aide" as "homemaker-home health aide".....*CUT*

delete prior hospitalization requirement.....*CUT*

the Department "is examining" reimbursing evaluation visits as a direct service and revising the definition of part-time intermittent care

nutrition services still rejected, as is making occupational therapy a primary service, "in the absence of the need for any other home health services, defining the need for occupational therapy would be difficult"

skilled care discussion (too expensive), terminal condition coverage clarification (has already been done) and homebound clarification (not needed) remain the same as the January draft

Medicaid--variations among state programs and all coverage changes being studied in the January draft.....*CUT*

IV. PROGRAM MANAGEMENT ISSUES

Reimbursement--"The $2.5 billion cap on federal Title XX expenditures has forced tradeoffs between the quantity of in-home services which states can provide and the rates of payment for the services..." has been changed to the cap on XX expenditures "as opposed to the open ended unlimited financing available under Medicare and Medicaid has forced tradeoffs between the nature of in-home services" and the rates of payment

content has been changed to reflect recent publication of Section 223 cost limits--subhead "Failure to Control Costs" is now "Cost Control"

all recommendations for changes in Medicare and Medicaid reimbursement .....*CUT*, including experiments in reimbursement change

HEW's opposition to Medicare-only providers remains, but the options to eliminate them.....*CUT* (see fraud and abuse section)

Fiscal Intermediaries--whole section is basically unchanged. Final report says that regional intermediaries are needed and inserts, "Providers would no longer nominate their own intermediaries." Increased federal policy direction is also necessary, it says.

Fraud and Abuse--No changes. Ergo, HEW is planning to assign regional intermediaries, explore using screening guidelines for claims audit, increase field audits of cost reports and patients' records, prohibit Medicare-only agencies by requiring that a certain percentage of patients be non-Medicare, send duplicate bills to patients to find discrepancies.

V. QUALITY STANDARDS AND PROVIDER ISSUES

o same as January draft on aide subcontracting and single service agencies (will

not prohibit)

- o require inclusion of a home health aide pre-service and in-service training program.....*CUT*

- o utilization review--final report cuts recommendation to establish it, but says that HEW will "work toward" developing utilization norms

- o skilled nursing--final report says that "many" home health providers advocate using the term "professional" instead of "skilled," where the January draft said that the home health field has "unanimously" recommended that change. Conclusion is the same, though, no change without more data.

- o proprietaries--almost unchanged, other than deleting a sentence, "It makes no sense to permit participation in some states and not to permit such agencies to participate in others." Instead of noting that HEW has "deferred" making a recommendation (for lack of information), the final report says, "We will not make" a recommendation.

- o deemed status--January position reversed by stating that "although there are several problems," HEW is exploring the possibility of granting an organization's accreditation program certification status.

- O Title XX standards--assuring quality care through establishment of basic uniform standards for in-home service providers regardless of auspice has been deleted.

  "Auctioning off the delivery of human services to the lowest unit cost bidder without definition has been proven to bear little relationship to the lowest total cost."......*CUT*

  subhead "Self Employed Provider Practices Constitute a Major Problem..." now reads "Self Employed Provider Practices" and some of the fiery language on self-employed providers has been cut, including the earlier accusation that they were not receiving the minimum wage.

  The final report adds that states "may" need federal guidance on setting standards for Title XX. Further, the January draft statement that without those standards, the use of self-employed providers "should not be permitted" has been changed to "may not be desirable."

  The final report also states that "HEW could develop such definitions, but they would have to be voluntarily adopted by each state." Ergo, all recommendations for solutions to Title XX standards problems.....*CUT*

VI. HOME HEALTH SERVICES--DEVELOPING AND CONTROLLING SUPPLY

Certificate of Need--maintains January draft's opposition to CON for home health agencies

Availability and Distribution of Services--"The major problem for all home health agencies, whether newly developed or long standing, has

been their inability to expand the range of their services and their coverage of populations at risk within the constraints of Medicare and Medicaid eligibility criteria, definitions of services, and reimbursement policies and procedures."..... *CUT*

Capacity Building--Hill Burton history deleted. "It has been assumed that federal provision for reimbursement of selected services for selected populations would provide adequate financial support for capacity development." In the January draft, that was "It was evidently assumed"

On the P.L. 94-63 grants, the January draft read, "The grantees have become certified Medicare providers and are now operating the newly developed home health agencies without federal subsidies." The final report excises that sentence and reads instead, "It is the view of the Administration that since home health agencies do not require a large initial capital investment and since the growth and supply of home health services was established without any special federal grants, the grant programs should be eliminated. Accordingly, the fiscal year 1980 budget provides for phasing out these grants." All conclusions and recommendations in capacity building..... *CUT*

VII. FUTURE DIRECTIONS FOR HOME CARE..... *CUT*

APPENDIX

The entire 21 pages of the Appendix have been left whole in the final report. The tables give current and projected data on utilization, expenditures and statistics on some of the home care demonstrations. The figures have produced some very interesting characteristics of in-home care users by sex, age, living arrangement, ability to perform activities of daily living, length of use of services, staffing patterns of agencies and proportion of visits by staff categories.

What can be said about this report? Perhaps all we need to say is that Congress is going to hold hearings specifically on the report, starting with the Senate Aging Committee (Chiles) on May 7. It would appear that at least this particular report is not going to sit on some bureaucratic shelf. Finally, some Members of Congress are angry.

Editor: Karen Rak