BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

PART 15—WASHINGTON, D.C.

JULY 9, 1974

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

46-547 WASHINGTON : 1975

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $1.55

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

HARRISON A. WILLIAMS, New Jersey
ALAN BIBLE, Nevada
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida

HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD J. GURNEY, Florida
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, JR., Maryland
PETE V. DOMENICI, New Mexico
BILL BROCK,[1] Tennessee

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
VAL J. HALAMANDARIS, *Associate Counsel*
JOHN GUY MILLER, *Minority Staff Director*
PATRICIA G. ORIOL, *Chief Clerk*

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

EDMUND S. MUSKIE, Maine, *Chairman*

FRANK E. MOSS, Utah
HARRISON A. WILLIAMS, New Jersey
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida

PETE V. DOMENICI, New Mexico
CLIFFORD P. HANSEN, Wyoming
EDWARD J. GURNEY, Florida
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, JR., Maryland

Barriers to Health Care for Older Americans:
Part 1. Washington, D.C., March 5, 1973.
Part 2. Washington, D.C., March 6, 1973.
Part 3. Livermore Falls, Maine, April 23, 1973.
Part 4. Springfield, Ill., May 16, 1973.
Part 5. Washington, D.C., July 11, 1973.
Part 6. Washington, D.C., July 12, 1973.
Part 7. Coeur d'Alene, Idaho, August 4, 1973.
Part 8. Washington, D.C., March 12, 1974.
Part 9. Washington, D.C., March 13, 1974.
Part 10. Price, Utah, April 20, 1974.
Part 11. Albuquerque, N. Mex., May 25, 1974.
Part 12. Santa Fe, N. Mex., May 25, 1974.
Part 13. Washington, D.C., June 25, 1974.
Part 14. Washington, D.C., June 26, 1974.
Part 15. Washington, D.C., July 9, 1974.
Part 16. Washington, D.C., July 17, 1974.

(Additional hearings anticipated but not scheduled at time of this printing.)

---

[1] Appointed January 25, 1974, to fill vacancy on committee by resignation of William B. Saxbe (R. Ohio) from the Senate, January 3, 1974.

CONTENTS

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

TUESDAY, JULY 9, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 1318, Dirksen Senate Office Building. Hon. Edmund S. Muskie, chairman, presiding.

Present: Senators Muskie and Percy.

Also present: William E. Oriol, staff director; Elizabeth Heidbreder, professional staff member; John Guy Miller, minority staff director; Margaret Fayé minority professional staff member; Gerald Strickler, printing assistant; Yvonne McCoy, assistant chief clerk; and Beth Ming, clerk.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE, CHAIRMAN

Senator MUSKIE. The subcommittee will come to order.

A year ago, this subcommittee held 2 days of hearings on home health care for the elderly. Witnesses representing such diverse groups as the Gray Panthers and the American Medical Association endorsed in-home health services.

Yet it was also made clear that home health under the Medicare program receives less than 1 percent of Medicare expenditures. Payments had, in fact, declined since 1970. Home health agencies were in financial trouble. These figures were disturbing because they indicated that home health benefits under Medicare were not serving their purpose. And as a consequence, some patients were institutionalized unnecessarily.

And, worst of all, some sick patients were going without needed care.

Today, the General Accounting Office is releasing a report [1] on home health benefits under both Medicare and Medicaid. The report further documents the underutilization of home health.

In 11 States which it surveyed, GAO found that from 1968 to 1971:

—The number of home visits to Medicare patients decreased 42 percent.

—The number of nurses in home health programs and home health aides decreased by 41 and 49 percent.

The report shows the facts were worse than we thought.

[1] See appendix 1, p. 1449.

The report says that one of the reasons for this decline was the varying interpretation of the skilled nursing requirement in the law by the Social Security Administration, the fiscal intermediaries, and the home health agencies.

Furthermore, patients and physicians have been confused. Physicians recommended home health care; the Medicare claim forms showed entitlement to home health visits; yet the intermediaries denied payments.

The Social Security Administration has commented that it considers the time covered by the report an "educational" period. "Educational" seems hardly the right word for patients who were denied care, or for agencies who had their staffs reduced and faced financial ruin.

The situation is not much better today, although reimbursements have stopped declining. The mail which I receive still tells of needed care being denied to the elderly, and of agencies struggling to somehow meet the need.

S. 2690 Would Liberalize Restrictions

Legislation which I have introduced, S. 2690, would help home health under Medicare realize its potential by liberalizing current statutory restrictions on home health benefits—notably by lifting the requirement for skilled nursing care. It would allow Medicare to provide home health services that more nearly meet the needs of our aged population rather than to be conditioned by a requirement that is not only stringent but confusing and subject to widely varying interpretations.

The GAO report also analyzes home health care under Medicaid, and concludes that its potential is not being fully realized in the State programs. States are allowed to provide preventive, skilled, and nonskilled care in the Medicaid home health benefit. Unlike Medicare, there is no requirement for skilled nursing care, speech, or physical therapy before patients can become eligible for home care. But the States surveyed by GAO have generally not taken advantage of this flexibility.

Representatives from the General Accounting Office who are here today will be commenting in further detail on the report. We also will be hearing from the American Geriatric Society and the American Public Health Association on home health care and day care. Spokesmen for the associations will be commenting on these alternatives, particularly as they relate to the long-term care component of national health insurance.

I am also pleased to welcome again Thomas Tierney, Director of the Bureau of Health Insurance, Social Security Administration, who was present at our home health hearings last year and at our hearing 2 weeks ago when we examined a difficulty in interpreting the Medicare law by an intermediary. He has, I understand, a brief statement and will be available for questions.

I hope our hearing today will not only give us an opportunity to learn more about the defects of home health care under Medicare in the past, but also how the administration of the program, and the basic

Medicare law, can be improved to allow more effective use of home health and other alternatives to institutionalization.

Our first witness today is Gregory J. Ahart, Director of the Manpower and Welfare Division of the General Accounting Office.

STATEMENT OF GREGORY J. AHART, DIRECTOR, MANPOWER AND WELFARE DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY RONALD F. LAUVE, ASSISTANT DIRECTOR, AND ALAN S. ZIPP, SUPERVISORY AUDITOR

Mr. AHART. Mr. Chairman and members of the subcommittee, I am pleased to appear here today to discuss the results of our review of home health care benefits under Medicare and Medicaid.

During our review, we visited four States—California, Florida, Massachusetts, and Michigan—and obtained information through questionnaires from 11 additional States.

Although home health care benefits are provided under both Medicare and Medicaid, the philosophies, coverages, and methods of administration differ.

Home health care benefits under Medicare, which is administered by the Social Security Administration—SSA—are, by law, skilled-care oriented. They were not designed to provide coverage for care involving only help with activities of daily living.

To be eligible for coverage for home health care under Medicare, a person must be confined to his residence, be under the care of a physician, and need part-time or intermittent skilled nursing service and/or physical or speech therapy. The need for such care must be prescribed by a physician.

To qualify for benefits under hospital insurance—part A, a person must have been in a hospital for at least 3 consecutive days prior to entry into home care. The care provided must be for the condition for which the person was hospitalized and must be provided within the year following hospitalization or a stay in a skilled nursing home following such hospitalization. Coverage is limited to 100 visits per benefit period. A person may have more than 1 benefit period and thereby receive more than 100 visits in a single year.

A person may qualify for home health benefits under part B without prior hospitalization provided certain conditions are met. Visits under part B are limited to 100 in any 1 calendar year. SSA has contracted with intermediaries to assist in administering home health care benefits.

Medicaid, which is a Federal-State program, is administered at the Federal level by HEW's Social and Rehabilitation Service. Primary responsibility for its operation is at the State level.

Home health care became a required service under Medicaid effective July 1, 1970. Under Medicaid, in contrast to Medicare, a person can be eligible for home health care benefits without requiring skilled nursing care or physical or speech therapy. Nor does an individual need prior hospitalization to be eligible for Medicaid benefits.

Much attention has been given to the need for developing alternatives to institutional care. Various studies have been made that support

the position that home health care, in some instances, provides a less expensive and more effective alternative. As you know, some of these studies were prepared for the Senate Special Committee on Aging.

Other studies, which have focused on the early transfer of patients from hospitals to home care programs, have pointed out that home health care can be considerably less expensive than care in a hospital or skilled nursing facility. Studies in this respect have been done by the Rochester, N.Y., Home Care Association and the Denver, Colo., Department of Health and Hospitals. Also, HEW has funded projects to study alternatives to institutional care.

In addition, the Social Security Amendments of 1972 authorize the Secretary of HEW, either directly or through grants and contracts, to conduct experiments and demonstration projects to determine whether coverage of intermediate care facilities' services and homemaker services would provide suitable alternatives to benefits presently provided under Medicare.

On June 28, 1974, HEW awarded six contracts for demonstration projects under this section of the law.

The Record on Medicare

Home health coverage under Medicare experienced some significant problems in its early stages. Some problems have been alleviated but others continue to diminish its overall effectiveness.

During the period covered by our fieldwork a decline in home health care activities under Medicare was occurring. In fiscal year 1970, the peak year for expenditures for home health benefits under Medicare, SSA expended about $115 million for such benefits. By fiscal year 1973, the amount had increased to $75 million. Further, a summary of 65 responses to questionnaires which we sent to home health agencies in 11 States showed that from 1968 to 1971:

—Reimbursements from Medicare for home health services provided decreased 47 percent.

—The number of home visits to Medicare patients decreased 42 percent.

—The number of nurses and home health aides on home health agencies' staffs decreased by 41 and 49 percent, respectively.

I would like to discuss briefly some of the factors that we believe contributed to these circumstances.

First, in the initial stage of Medicare, considerable confusion existed as to what care was covered under home health benefits. As a result, noncovered care was apparently paid for from inception of the program until about August 1969. At that time, in an attempt to restore the statutory integrity of the home health benefits program, SSA issued guidelines to intermediaries to clarify the services covered.

These guidelines, upon implementation by the intermediaries, resulted in numerous denials of claims and caused considerable concern to home health agencies and patients. In May 1971, SSA encouraged intermediaries to better explain to providers the reasons for denying claims. Despite SSA's efforts, home health agencies continued to disagree with intermediaries, and claims for care which home health agencies considered skilled were denied as nonskilled.

Officials of some home health agencies told us at the time of our fieldwork that the application of the definition of skilled nursing care continued to be a problem. SSA officials acknowledged that prior to August 1969 the supervision of intermediary adjudication of home health claims was insufficient. SSA officials told us that they now view the period from 1969 to 1971 as an educational period within the home health field.

A second factor is that Medicare is oriented, by law, to the need for skilled care and does not independently thereof cover home health services considered nonskilled. Determination as to whether skilled care is required is sometimes complicated. Preventive care is another area not covered under Medicare law.

A third factor involved differences in screening guidelines used by intermediaries to assist home health agencies in applying safeguards against such unnecessary utilization of services.

We compared service limits by three intermediaries located in three States for five diagnoses or illnesses, and found that the screening guidelines varied considerably as to the number of visits allowed and the period of coverage.

Fourth, information provided to beneficiaries on allowable home health benefits did not always clearly spell out the limitations of the benefits. Representatives of several home health agencies informed us that beneficiaries were confused regarding the coverage and limitations of Medicare home health care benefits. A problem that often occurred was that after each claim was processed, the patient was mailed a form by SSA which showed how many visits he had received and the number of remaining visits he could receive.

Beneficiaries often assumed that they were entitled to all the additional visits. However, the number of visits covered under Medicare is based on whether the patient continues to need skilled care and the limitations imposed by intermediaries, not necessarily the remaining visits shown on the form sent by SSA to the beneficiary.

This often confused beneficiaries in that their physicians recommended home health care and the claim forms indicated they were entitled to additional visits, yet the intermediaries denied payment.

Fifth, even though physician and hospital involvement is essential to the success of home health care, physician involvement has been limited and hospitals have not always encouraged the effective use of home health care. Physician involvement has been limited because some physicians do not have a thorough understanding of Medicare home health benefits; physicians believe there is no incentive for them to refer their patients to home health care because they are not paid for additional work incidental to maintaining patients in home health programs such as preparing treatment plans and recertifications; and there is potential for conflict between physicians and intermediaries because intermediaries have authority to assist in applying safeguards against unnecessary utilization of services. This means that, even though a physician prescribes care and certifies that it is needed, a claim based on such care can be denied by the intermediary.

Regarding hospital involvement, some home health agencies stated, in response to our questionnaires, that a lack of effective discharge planning was a significant problem. Another problem was low occupancy rates in some hospitals.

SSA officials recognized their responsibility to insure that beneficiaries eligible for home health coverage receive the benefits, but expressed reservations on the degree to which SSA can legitimately assist home health agencies to increase the health field's support of the home health care program. SSA strongly believes that home health agencies themselves must first work toward achieving professional community acceptance.

An overall issue which has emerged has been financial difficulties experienced by some home health agencies. Financial problems have caused some home health agencies to limit their patient loads to persons for which they are certain to receive payment for care provided. This resulted, in large part, from the retroactive denial problem which developed in the early stage of the benefits program.

Current SSA regulations do not require advance approval of care for payment under Medicare. The Social Security Amendments of 1972, however, authorize advance approval to be obtained under part A Medicare home health benefits effective January 1, 1973, and authorize SSA to establish periods of time during which beneficiaries would be presumed to be eligible to receive home health services.

SSA advised us that regulations covering this issue will be ready for issuance under the notice of proposed rulemaking procedures in the near future.

The Social Security Amendments of 1972 also provide for a waiver of liability that will affect retroactive denials. Under this provision, a home health agency will be paid for noncovered services under either parts A and B if it did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services. SSA officials advised us that interim instructions were issued in March 1973 and cases were being processed under this provision effective with services furnished on or after October 30, 1972.

We discussed the issue of retroactive denials with SSA officials. They advised us that initially retroactive denials had a serious impact on some agencies but that the problem had been reduced considerably.

SSA provided us statistics that showed that the retroactive denial rate for home health benefits had peaked at 4.9 percent in fiscal year 1971 but had dropped to 2.1 percent for the first quarter of fiscal year 1974. SSA officials told us that the number of claims received and the number of home health agencies now participating in the program is only slightly less than the pre-1970 level.

We made several recommendations to the Secretary of HEW regarding these matters. By letter dated June 11, 1974, HEW concurred in our recommendations and advised us that a Home Health Coordinating Committee had been established early in 1974 within SSA to make a full-scale review of the home health provision under Medicare.

According to HEW, SSA intends to broadly assess statutory and administrative dimensions of this area of coverage to make sure that its policies and procedures are as supportive of home health care as the law permits.

The Record on Medicaid

The Medicaid home health care benefits program allows States to provide preventive, skilled, and nonskilled care. Therefore, it has the potential to serve as an effective alternative to institutional care in participating States. However, SRS needs to provide more guidance to the States to more fully develop this potential.

Our review disclosed several problems regarding home health benefits under Medicaid.

First, the four States we visited were providing significantly different ranges of home health care services. One State, under its Medicaid program, was limiting home health care for persons age 65 and over, who were Medicare beneficiaries, to the part B home health care program while providing unlimited nursing and home health visits for persons under age 65 and those age 65 and over who were not Medicare beneficiaries. This is contrary to Medicaid regulations.

Another State allowed extensive care to be provided under its home health program. State officials advised us that the program paid for a wide range of home health services. However, we were not able to determine the extent of services provided because the State required health agencies to submit only summary data on claims submitted and services provided.

A third State considered eligibility under its Medicaid home health program to be similar to eligibility under Medicare in that to be able to receive Medicaid benefits a person must need part-time or intermittent skilled nursing care or physical therapy.

Second, regarding the issue of eligibility for home health benefits under Medicaid, Social and Rehabilitation Service conducted a survey in 1972 on a State-by-State basis to determine compliance, strengths, and weaknesses in Medicaid home health benefits and the need for additional assistance to the States by HEW regional office staffs. The survey showed that the single greatest problem limiting home health benefits was the States' interpretations of eligibility for home health services. An agency participating in Medicaid must also be certified by Medicare or be qualified to be certified. Some States have interpreted this to mean that the services are limited to those individuals needing admission to or discharged from a skilled nursing home.

SRS identified 15 States limiting home health services to skilled care only. In February 1973, SRS issued a policy information memorandum stating that such limitations should not continue, requesting its regional staffs to advise the States of the appropriate scope of the program, and requesting the States to take the necessary action to bring their home health care programs into conformance with the law and implementing regulations. More details of the SRS survey findings are included in our report.[1]

Third, States' payment rates for home health care differ significantly. Some States have established extremely low rates which have

[1] See appendix 1, p. 1409.

had an adverse impact on the program. Medicaid regulations provide that payments for home health care be limited to customary charges that are reasonable for comparable services, considering the standards and principles for computing reimbursement to home health agencies under part B of Medicare. However, in one State, home health agencies that responded to our questionnaires received an average payment per visit of $19.51 under Medicare for providing skilled care, but for providing the same service under Medicaid the agencies received a flat rate of $13.13. In another State, the average payment was $8.68 under Medicare and $5 under Medicaid. Medicaid payment rates in these two States for home health care are established by the State Medicaid agencies on the basis of a flat fee per service and are paid to home health agencies statewide. A ratesetting commission established rates in the third State. Home health agencies in the fourth State were paid on a reasonable cost basis using the same standards and principles established for Medicare.

We recommended that the Secretary of HEW (1) impress upon the States the potential of home health care as an alternative to institutional care, (2) clarify for the States the specific home health services covered under Medicaid, (3) encourage the States to establish reasonable payment rates for services provided by home health agencies, and (4) assist home health agencies in their efforts to increase the health field's awareness and support of home health as an alternative to institutional care.

In its June 11 letter, HEW concurred in our recommendations.

Mr. Chairman, this concludes our statement. We shall be happy to answer any questions that you or other members of the subcommittee might have.

Senator MUSKIE. Thank you, Mr. Ahart. I compliment GAO on developing this study, and this information, not only for this committee, but for all of those interested in this problem.

Let me ask you a few questions to try to focus on the essentials of your conclusions.

First of all, is there any serious challenge to the proposition that home health care is an essential supplement to institutionalized care in meeting the needs of the elderly?

Mr. AHART. I think there is no serious challenge to that. Certainly where a person does not need to be institutionalized, but still needs some help in and around the home of a medical nature to help them through a posthospitalization period, or under part B, where they need that kind of medical assistance in the home to keep them out of an institution, or help them overcome a handicap, certainly it is beneficial.

Senator MUSKIE. What are the benefits from the point of view of the patient, and what are the benefits from the point of view of the taxpayer who has to find a way to pay for home health care as an effective supplement to institutionalized care?

BENEFITS "NEBULOUS" TO TAXPAYER

Mr. AHART. I think the benefits to the taxpayer are a little bit nebulous to some degree. There is certainly some potential, where you can put them in a home setting, and supplement their daily care with

whatever medical assistance they need; there is certainly a potential for some benefit to the taxpayer through decreased costs.

From the patient's standpoint, certainly most people would rather be at home, if they can take care of themselves, and probably there is some benefit to them from the standpoint of early recovery.

There is a more comfortable setting, and with their family and close to their neighbors and friends and everybody else that goes with quality of life for elderly people, so there is benefit to both the taxpayer and to the individual patient.

Senator MUSKIE. As I understand, it seems to come down to this: Under present circumstances, there tends to be overutilization of institutionalized care. Yet, there is a fear with respect to home health care that it might be overutilized. Does that pose a dilemma?

Mr. AHART. I think this is part of the problem. I think there is a fear of what the costs of the program will be if it is conducted too widely.

I think really, Mr. Chairman, there are two aspects to consider here. One is, of course, a basic public policy issue of what needs of the elderly we want to meet through the public program.

What kind of support do we want to give them with the Federal taxpayers' support.

Senator MUSKIE. Is the program at the present time, at the Federal level under Medicare, adequate to meet the health needs of the elderly?

Mr. AHART. I think both under the administration's interpretation, and from the language of the law itself, it is a rather restrictive benefit.

One example which might illustrate this is a person that has a multiple diagnosis of some kind, and one of the diagnoses puts him in the hospital with that particular problem, where it is taken care of. They return to their homes, and although they may not need medical assistance for the condition for which they were in the hospital, they may need assistance for some other problem.

Under the present interpretation of the law—and I think it is very clear language—skilled nursing care or any other care would not be available to that person under the home health benefits program. That is just an example which illustrates the very restrictive nature of the present language of the statute.

SKILLED NURSING CARE

Senator MUSKIE. Now, is the phrase "skilled nursing care" intended to establish a safeguard against overutilization of home care—is that its justification?

Mr. AHART. I am not that familiar with the legislative history of the law, Mr. Chairman, to be authoritative on what the justification was.

I think if I had to speculate, the term skilled would be tied to the need for real medical assistance as opposed to just care and the needs of the day-to-day living.

Senator MUSKIE. Does the word skilled relate to quality of training that nurses must have, or does it relate to some other scale?

Mr. AHART. Well, under the interpretation, as I understand it, of the Social Security Administration, it relates to both. No. 1, the skilled care must be such that it is provided by or under supervision of a licensed nurse.

Senator MUSKIE. A registered nurse?

Mr. AHART. A registered nurse or a licensed practical nurse. In addition to that, the nature of the service provided must be one which requires that kind of training.

In other words, nurses can do a lot of things which do not require specialized training. If that is what they are in the home doing, and day-to-day living needs are being provided by them, or under their supervision, they would still not qualify, unless the service required the licensed practitioner.

Senator MUSKIE. From the administrative point of view, since the terms registered nursing and practical nursing are definitely defined in State law, and I assume all of the licensing is done under State law, is there not an easy standard to use to prevent overutilization of home health care services?

Mr. AHART. In terms of who provides the service, yes, Mr. Chairman.

Senator MUSKIE. There is then professionalism or the standards of professionalism as a safeguard, or benchmark to prevent overutilization. Is that correct?

Mr. AHART. Yes, sir, it would serve that purpose.

Senator MUSKIE. One statement you made in your presentation reads: "SSA strongly believes that home health agencies themselves must first work toward achieving professional community acceptance."

What that seems to say is that the burden is on those who want to broaden the use of home health care to meet the health needs of the elderly to establish a new level of professional competence, which can then be used safely by SSA as a benchmark, or a safeguard against overutilization of home health services. Is that a correct interpretation?

Mr. AHART. I think the context of the Social Security Administration statement in that regard centered around who properly should take on the burden of selling the concept of home health services to the medical communities in particular areas, and their view is that it ought to be sold at the community level by qualified home health agencies which gain the acceptance of the medical community in their particular area, and thatis the distinction as opposed to, I think, any direct relationship to their over- or underutilization of the home health care field.

Senator MUSKIE. Does SSA take the position that it has no responsibility to assume leadership to improve the viability of home health services?

Mr. AHART. I would hate to speak directly for them, but I would state the position as I understand it this way, Mr. Chairman, that they ought to support the home health care concept to the extent permitted under the present Medicare statute, but they do not feel they have the legislative directive, so to speak, of going out and beating the bushes and selling doctors, hospitals, and everybody else concerned on using whatever home health agencies may be in their community.

Senator MUSKIE. If they are restricted by statute from assuming a lot of the responsibility, would they also take the position that they are restricted by statute from having an opinion as to what would be a more viable statute to meet the health needs of the elderly?

Mr. AHART. No; I would certainly think they are entitled to their opinion. I think that SSA itself is basically an agency to administer the present law.

Policy Formulation HEW Responsibility

The Secretary of HEW has responsibility in the public policy area there, and would be the one to come forward from the Department level and the administration level as to what changes need to be made as a public policy matter to better serve the needs of the elderly.

Senator Muskie. Well, they, of course, can speak for themselves. Mr. Tierney will testify later, but if they will not give us a professional opinion, it pretty well leaves it to us laymen who serve on these committees to evolve a concept.

It seems to me we ought to have the professional views they may have, and rely on the home health agencies to develop this new public awareness concept, considering the financial difficulties which they face.

If your testimony represents SSA views, it seems to me that they are using a very lame excuse to avoid a leadership responsibility.

I make that statement now in order to flag the questions that I will put later to Mr. Tierney and to the Social Security Administration, and I apologize for pressing you to state SSA's view, but I put the question so I might somewhere along the line this morning get at the point. I have a number of other questions related to your study.

You brought up the issue of intermediaries, and this is a continuing problem. Your testimony outlines several areas of the administration of home health benefits under Medicare. You mentioned that intermediaries used different screening guidelines in applying safeguards against unnecessary utilization of services. Just what does represent unnecessary utilization of home health services?

You indicated that in the early days of the Medicare program, some overutilization developed, but there is no description of the nature of this overutilization, or of the abuses that took place, or of the fears that were realized as a result of it.

Could you expound on that at all so that we could have a concept of just what fears developed in that period that led to the restrictive interpretations?

Overutilization of Services?

Mr. Ahart. Basically, the term overutilization in this context means that services were being provided and paid for which were not covered under the rather restrictive language of the law.

A hypothetical example of that would be a person discharged from a hospital and needed for some period of time skilled nursing services and reached a point of recovery. It was not skilled care that the person still needed, but they needed some help in daily living, getting in and out of bed, going back and forth to the toilet, and other things that people have to do.

In some cases, early in the program, this care continued and was paid for even though the need for skilled care had expired.

Now, the action taken by the Social Security Administration in 1969 was to tighten up the administration by the intermediaries to make sure that the services which were being claimed were within the rather restrictive definition in the law, so it was overutilization of the program in that sense, not necessarily overutilization in the sense that the

people did not need the services in the home. It was overutilization of the Medicare program.

I do not know if that answers your question.

Senator MUSKIE. I am trying to narrow the focus even more than that. What you are saying is that in the hypothetical situation further care of some sort was provided and presumably needed.

Now, did those services include services unrelated to the health need of the patient?

Is there a way of distinguishing between continuing services that were required, not in the skilled nursing category, but that were still health related, and other services that were not health related?

Is there a way of defining this more closely so you can distinguish between services related to health needs compared to services related to other needs?

Mr. AHART. I guess my problem is I have not defined in my own mind all of the things you might classify as being health related as opposed to nonhealth related.

It would seem to me as a personal matter, if a person is discharged from a hospital—let us say a person that has suffered a stroke but no longer needs skilled nursing care in terms of needing prescribed medication that could not be self-administered, but also finds himself half paralyzed, and needs help to get here and there—I could put that in the health related category.

Under the Social Security Act, the Medicare program, that would not meet the criteria for coverage under the home health benefits program. So I think there is a real fuzziness on what would and would not, what should and should not be health related in meeting the needs of our elderly persons in their home.

Senator MUSKIE. Is any effort being made to categorize the kinds of services that would not be described as skilled nursing care, and yet still be sufficiently health related to justify some legislative concern, as well as administrative concern, in a new definition of what should be reimbursable?

Up to now in the hearings, we get a lot of dialog of what is health related, and what is not, and the line that is used is the skilled nursing care line.

It seems to me there is another line below that level of care. It still is a legitimate line that we ought to identify before we start writing legislation.

Now, the bill I introduced, S. 2690, simply eliminates the language "skilled" nursing care, thus in effect broadening the administration discretion that would be available in applying the law. It would be helpful in these hearings, however, to try to draw that other line.

I know GAO is not a medical agency, but I am trying to elicit from you some testimony as to whether or not there has been any attempt to define that other line between health services that are not skilled nursing services but are legitimately health related, and those services that might be desirable to supply, but which are not strictly health related. Is it possible to draw such a line, in your opinion?

Mr. AHART. First of all, in direct answer to your question, I do not know of any specific attempt to try to draw that line.

Second, we might say that because everything we do has some relationship toward health, that line would be difficult to draw without being somewhat arbitrary, but I guess I would raise an additional issue. We are talking about home health benefits under the Medicare program, and of how directly related they are to health, or how remotely related they are to health. There is the additional issue of to what extent these kinds of needs should be picked up in what is basically a medical care insurance program.

We do have many different kinds of programs which provide services to the elderly, as well as to other people that have needs.

Social services and different programs to serve the elderly—they must all be considered. So there is a policy question here too, that once these needs are defined, and the relationship to health determined by somebody, as to what portion of this should be met through the Medicare program, and the home health benefits package, and what portion of the needs might be better met through some other legislative program.

Overdependence on Institutions

Senator Muskie. I might say that a previous GAO report found that 25 percent of the patient population was treated in facilities which are excessive to their needs. That, I assume, is a result of the fact that institutionalization is the only alternative available to provide the health needs of people which could well be provided by lesser degree of health care. I think that even in the analysis you have given in your answer, you do not sufficiently come to grips with the fact that there is another line to be drawn.

If the institutions are the only alternative available to meet the health needs of the elderly, even when institutions are excessive, then we are left in the present situation.

What we are trying to find, it seems to me, is another option. Many people who have studied this field believe there is another option, and I think your report shows there is another option, and it seems to me that the heart of this question is the skilled nursing care standard which has been erected by the law and by the interpretation of the law.

Let me ask you this: From your analysis of Medicaid, it appears that the confusion which has been generated under the Medicare program has been carried over to the State programs, and has limited the use of home health care there, too.

This may be an oversimplification of a very thoughtful analysis that you gave us in your presentation, but is it accurate?

Mr. Ahart. In the Medicaid program, there has been a tendency in many States to interpret the program as being the same as the benefit package made available under the Medicare program.

I would add to that, just to round off the statement, that the States are somewhat less limited in the techniques and the programs they have available to meet the needs of the elderly than the Social Security Administration through the Medicare program.

You could have the services under the public assistance programs which allows them to send caseworkers into the homes of the elderly

on the roles, and help them to some degree under either the Medicaid or the social services component of the welfare program, depending on how you define your package of services.

Some States More Liberal Than Others

Senator Muskie. In some of the more generous States, are services included that are not strictly health related?

Mr. Ahart. Massachusetts was one we found to be quite liberal in the package of benefits made available to people under the Medicaid program. They do it in part as an alternative to institutional care, and as a means of preventive care, so it was a fairly far ranging set of services that were made available in Massachusetts.

Senator Muskie. Incidentally, if there is no objection, I would like your report included in the record.[1]

You discovered that intermediaries used different guidelines in applying safeguards against unnecessary utilization of services.

You discovered this by comparing services of three intermediaries located in three States, and found that screening guidelines varied considerably as to the number of visits allowed in the period of coverage.

Could you expand on your findings of these illnesses found on page 19 of your report?

Mr. Ahart. I would be glad to give some examples from the report.

The first disease category was postcataract care. The screening limits of the first intermediary were services for 1 month with unlimited visits.

Another one had services for 1 month, with 15 visits allowed. The other had services for 1 month, with 20 to 30 visits allowed.

Dropping down to Parkinson's disease, the first used services for 3 months, with 12 visits for the first 3 months and 8 visits per month for the next 2 months.

The next one had services for 3 months, with 4 visits for the first month and 2 per month for the second and third months.

And the other had services for 1 month with 4 to 12 visits allowed.

In the cancer cases, the first used services for 4 months, with unlimited visits for terminal cancer, unlimited visits for the first month and 16 visits per month for the second through the fourth month for nonterminal cancer.

The next used services for 4 months, with unlimited visits for the first month and 16 visits per month for the next 3 months, and the last one had services for 2 months with 4 to 30 visits allowed.

I might mention, Mr. Chairman, these are screening limits, where the intermediary would take a hard look at the case, and see whether the service was justified, and still within the limits of the Medicare definition of home health services. They are not absolute limits on what could be paid.

Senator Muskie. In your view, it would be possible to improve the performance of intermediaries by tightening the administrative language?

---

[1] See appendix 1, p. 1449.

Mr. AHART. The service limits are one example where we feel more needs to be done by the Social Security Administration to look at what the intermediaries are doing and give them guidance in terms of the screening limit so that you would have more uniform administration of the program, or a uniform set of benefits under a national program. Certainly that is one area where the administration would be improved.

Senator MUSKIE. Another question, and then I will yield to Senator Percy. You referred to the demonstration projects recently undertaken by HEW that were authorized in the Social Security Amendments of 1972. I will put an excerpt from the research proposal in the record, if there is no objection. The projects are to determine whether coverage of intermediate care facilities and homemaker services would provide suitable alternatives. Apparently day care is also included. Do you know whether or not there was an evaluation of simply expanded home health care benefits, compared with the present restrictive regulation?

[The excerpt referred to follows:]

ARTICLE I. DESCRIPTION AND SCOPE OF WORK

A. The Contractor shall demonstrate, experimentally, provision of three services, namely, Intermediate Care Facility Services, Homemaker Services, and Day Care Services, as alternatives to benefits currently provided under Titles XVIII and XIX of the Social Security Act, in order to:

(a) Determine the cost of providing each of the currently noncovered services;

(b) Compare the cost of providing the combination of the three new services and the currently covered services (Skilled Nursing Facility Care and Home Health Services); and

(c) Determine and compare the extent to which the new services (as defined) will enable an eligible individual to reach and maintain his highest level of performance or will prevent or retard institutionalization as compared to the effectiveness of benefits currently provided.

B. Specifically, the Contractor shall plan and conduct a research demonstration of the provision of one, two, or three of the proposed new services given in A. above. The demonstration must conform to the following specifications:

1. It must be planned and operated in conformance with the Research Plan and Methodology outlined in Attachment A, which is made a part of Article I.

2. It must utilize existing service(s) within the Contractor's service area (community) which meet the working definitions of the three services in 3. below. The Contractor need not be the provider of the services but can arrange for provision of the services through agencies meeting the definitions. All agencies providing services must meet the regulations, standards, qualifications, and/or licensures required for the service offered.

No start-up funds are available for this demonstration; therefore, any expansion or development of service(s) for the demonstration program must be done under agency or community support.

3. For purposes of the demonstration, the Contractor shall accept the following working definitions of the three alternative services being tested:

(a) Intermediate Care Facility Services means those provided by an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing home is designed to provide but who, because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities; and (2) meets Standards prescribed by the Secretary, DHEW, and published in the Federal Register on January 17, 1974.

Mr. AHART. I have not seen the contract document. I do not know whether it is or not. The provision of the law, as I understand it, was

to study the use of intermediate care facilities, as well as homemaker services, as an alternative to the present package of posthospital benefits, which would be alternative to the extended care facility, and the home health services and skilled nursing. So it would be a comparison between those.

It would seem, however—and this is my own personal opinion, Mr. Chairman—that probably the homemaker services cannot be viewed as an alternative to skilled nursing facilities and skilled nursing care.

If you need skilled nursing care, there is no way to provide that by the homemaker. Probably a more appropriate long-term demonstration or experiment would be to look at homemaker services and of intermediate care facilities as an additional supplement to existing packages of benefits under the Medicare law.

People could conceivably move from a hospital or skilled nursing facility into the intermediate care facility, and then into their home with supportive services, medical care, or otherwise that they might need to carry on day to day.

Senator MUSKIE. An effective demonstration of all aspects would be consistent with the literal language of what the Secretary was authorized to do. We will get more into that when Mr. Tierney testifies.

I appreciate your testimony and your answers to my questions. We may submit other questions to you to which you may submit the answers for the record. At this time, I would like to yield to Senator Percy.

Senator PERCY. Thank you, Mr. Chairman. I know these hearings are helpful.

I again commend GAO for helping Congress with oversight functions which we are not equipped to handle ourselves.

I have tried to visit nursing homes as frequently as I can. I visited one in Chicago the weekend before last. My visits, however, are much more limited in scope than these hearings.

I have a question which may be repetitive, but I would be interested in your general comments. I am concerned that we may have established disincentives for families to take care of their older parents at home, that we have made it easier for families to institutionalize older members at a cost of $400 or $500 a month rather than to provide home care, which is certainly in many cases preferable.

Is there such a disincentive in the way our system is set up now as you have observed it?

Mr. AHART. I think as a generalization, Senator Percy, anytime that people can be relieved of the financial burden, or a personal effort kind of burden, by the benefits of a Federal program, and that is what you described here, where people can be reimbursed for care in an institution and they cannot be reimbursed for care in the home, there is certainly a financial incentive to go the route you are talking about.

I would not want to make the judgment of how extensively that kind of financial incentive would overcome whatever inclination the individual might otherwise have in terms of caring for his own parents.

There could be examples that go each way, but certainly I think there is the proposition that the financial incentive helps move people in one direction or another.

Senator PERCY. To be more specific, did you see indications in the studies that were made that the limited scope of Medicare home health benefits inhibited utilization, or placed beneficiaries at inappropriate levels of care; that is, placing them in skilled nursing facilities rather than intermediate care facilities or home health care which may not be covered, where the other is covered?

Mr. AHART. We have had indications of that in our work in the past.

Senator Muskie a minute ago mentioned a study that was issued in May 1971, as I recall, where the study was made in quite a number of nursing homes, which indicated on the basis of medical evaluation that approximately 25 percent of the patients in skilled nursing facilities did not require that level of care.

ALTERNATIVES TO NURSING HOMES

They could have been handled in an intermediate care facility, and I am sure many cases could have been handled in a home setting with proper supportive services. So I think any time a Federal program makes one kind of benefit available and not others, there is some tendency to move people over the line into the area where they get the kind of services they need even though they may be excessive. I think that is responsive to your question.

Senator PERCY. It certainly confirms the question that I had.

Your response suggests that many of the nursing home patients that I saw the weekend before last would probably be much better off with less care than they were getting. Some of them probably wouldn't need to be institutionalized.

This reminds me of an analogous problem in our welfare system. The very poor would be eligible for benefits, but those just a shade above the poverty line would not be eligible. In a sense it paid to be poor.

In your testimony, you mentioned that Medicare, until about 1969, paid for some noncovered home health care. Can you be more specific as to what those noncovered services were? Has the more stringent definition of home health care limited utilization?

Mr. AHART. I mentioned earlier one example of noncovered services that were being provided.

The hypothetical example I gave was one where a person was discharged from a hospital, did need skilled nursing care for some period of time, but even after they no longer needed a registered nurse or licensed practical nurse, the care in the home continued and was paid for under Medicare, that person could have done better.

I think Mr. Zipp can add to that.

Mr. ZIPP. Senator, I think the problem with respect to the care being paid for that was not covered goes back to the intermediary problem with the definition of skilled care.

Prior to the 1969 issuance of the intermediary letter, which made an attempt to define skilled care, the covered services or skilled services which were covered were interpreted by the intermediaries at varying levels, and at various places to mean different things.

Once the intermediary letter was issued, the intermediaries took a very hard look at what constituted skilled care, and determined at that point that certain services which were being provided were not in fact skilled services under this definition.

A doctor would prescribe these services, certify that they were required skilled services within the program, and yet they would be denied as being nonskilled through the interpretation of the definition of skilled services by the intermediaries.

This is perhaps one of the reasons why hospital and physician involvement have not been as great as they could be or should be to promote the program to its effective level.

Senator PERCY. We have received a great many complaints on Medicare. In your own investigation of home health care, did you run into any specific restrictions on claims determination?

NUMEROUS CLAIMS DENIED AS "NON-SKILLED"

Mr. ZIPP. Senator, with respect to your question, yes; we have seen numerous cases during our review whereby claims were denied on the basis that they were not covered services and on the grounds they were not skilled services.

The intermediaries would deny these claims in full view of the fact that the doctors treating the patients prescribed skilled care, and certified the care that was being provided was in fact skilled care. The home health agencies providing the direct services also said they were skilled care.

We have examples which we can go into today, if you would like, whereby a claim that was denied as being non-skilled, for no other reason than the interpretation by the intermediary that it did not come under the program as a covered service, was overturned by the hearing examiner, and his comments during the proceedings of the review of the case were that there was no apparent reason for the denial of the claim.

These services were in fact skilled services, and were covered within the program.

This is one of the problems that we have seen throughout our review of home health care—that care was being denied, or the coverage was being denied.

Mr. LAUVE. I might add, this is the case where a woman had a terminal disease, and she was being provided skilled care. She was gradually deteriorating; she had been in the hospital, and she had served the requirement for eligibility for home care.

The physician certified that she needed the care, and the treatment plan had been formulated; but as her condition worsened, it appeared that skilled care was really not doing her any good, and as Mr. Zipp mentioned, there was no documentation supporting the determination by the intermediary that the care could not be covered. It was pointed out in the hearings that this is the probable reason for the denial—the fact that she was not getting any better, she was deteriorating, and therefore, skilled care was doing no good.

This is probably the most detailed example and the one that we can speak of in terms of the hearing examiner reversing the decision. The decision was reversed, and the claim was paid, for a certain period of coverage.

Senator PERCY. Thank you. Also in your testimony, you mentioned the lack of physician and hospital involvement in encouraging the effective use of home health care.

Is this the principal obstacle to home health care?

Mr. AHART. I think it is an essential feature of the home health care concept. Unless the concept has support of the medical community in the particular area, it is going to be very difficult to reach its full potential.

CLAIM DENIALS DISCOURAGE DOCTORS

I think it is unfortunate—this is my personal view—that the confusion which existed in the early part of the Medicare program, where claims were denied even though the care was prescribed by the physician, and so forth, I think that kind of denial probably had some effect in discouraging doctors from trying to make full use of home health care.

I think it is disconcerting to doctors who prescribed care, felt the patient was going to get reimbursed for the care, and then found the very care he had prescribed, and presumably the patient received, was not a covered benefit under Medicare. I think this probably served to turn off some physicians from trying to get the patients into the home setting where they ran the risk of having the claim denied, and suffered the financial loss themselves.

Senator PERCY. Is there any pattern to what you picked up about the attitude of the families concerning what they considered to be their responsibility toward the aged?

Traditionally, we tend to think of Asian and European families as far more compassionately oriented toward the aged. They appear to have a higher regard for elderly people, placing them on a pedestal in a sense. Here we seem to be in a more youth-oriented culture, putting elderly people on the shelves and keeping them out of sight. Is there a sense that we just do not want to take care of our older generation? Is it an important part of why institutionalizing people is becoming an increasingly large business in America? Can the Government really do nothing about such an attitude?

Mr. AHART. We have made no studies along that line. I think we, as you, have observed that there seems to be some movement in that direction, and what impact the Federal benefits may have is a question that I think needs public policy consideration.

Senator PERCY. Did you happen to read the book called Tender Loving Greed, by Mary Adelaide Mendelson? If you did, do you find it an overstatement of the case, or is it reasonably accurate and objective?

Mr. LAUVE. I am now reading the book. In some cases, I personally think it is a bit overstated. I find in other cases, that if these are true facts, the nursing home industry does in fact have severe problems. I also know the references that are made in the book to the GAO, and I have talked to the author on occasion in the past. I am not talking about her visits to the nursing homes, I am not questioning those facts, but I do believe that based on some of the things we have found, that

perhaps it is an overstatement, perhaps it is not quite a total picture of some of the facts. I am speaking in terms now completely separate from the situations she describes in some nursing homes; I am not addressing that issue at all, but I have talked to the author on some of the things she mentions in the book about the typical nursing home that was held up to be a basis for a conclusion that Federal reimbursement rates were higher than absolutely necessary.

Mr. AHART. I might just mention that my first acquaintance with the author of that book took place in 1966, and I had the opportunity to testify with her before the House Ways and Means Committee in 1967, as I recall. We did undertake an investigation at that time at the request of this committee to look into the allegations that she was making at that time, and found them all to be quite well founded. So her experience in this field, I know, goes back at least that span of time, and I know she has been in an awful lot of homes over those years, so I would, without having read the book, state that I know she feels very strongly about what she writes, and that her perceptions are probably fairly good.

Senator PERCY. I know of no reason to believe that the facts as stated are not accurate, but I think in this period of time there have been some dramatic improvements.

I think the improvements have come about as a result of the studies and investigations of this committee. The staff and members of this committee have focused public attention on the problem and dramatized it.

I want to ask you if you have been into rural areas, and whether any conclusion can be reached as to the quality of home care in the rural communities as compared with the urban areas?

Mr. AHART. We tried in our sample of home health agencies to which we sent questionnaires directly, to get a mix of urban, rural, and so forth, but I defer to my associates as to whether we have any judgment, or can form a judgment as between the quality in urban areas and rural areas.

Mr. LAUVE. No; we do not, and we have not analyzed the questionnaires by those categories.

Senator PERCY. Can we improve the Medicare home health services to meet the needs of the elderly merely through better administrative practices, and medical community acceptance, or is there a need to expand the scope of benefits under the Medicare?

Mr. AHART. I think there is a need to improve the administration. I think the question of whether or not you can meet more needs of the elderly through the means that you have said is a basic policy question. There are certainly needs which do not fall within the restrictive provisions of the statutes as they are presently.

I would not, however, as GAO, offer a public policy judgment as to whether that should or should not be done.

Senator PERCY. Thank you very much.

Senator MUSKIE. Thank you very much.

Mr. AHART. Thank you, Mr. Chairman.

[The report to the Congress by the General Accounting Office on Home Health Care Benefits under Medicare and Medicaid appears on p. 1449.]

Senator MUSKIE. Our next witness is Thomas M. Tierney, Director of the Bureau of Health Insurance, Social Security Administration.

Mr. TIERNEY. Thank you, Mr. Chairman.

Senator MUSKIE. I would like to say with respect to Mr. Tierney, that he is testifying before the subcommittee for the third time in about a year, and he has been a most forthcoming witness, and we are delighted to have him back today.

We are particularly appreciative of his patience, his understanding, as well as his insight into Medicare and its problems. Although we on the subcommitte may occasionally disagree with the positions he takes as a representative of the administration, we find our exchanges to be fruitful, and we know that his participation this morning will be no different.

By the way, for the record, I should like to note that we have already received a letter from Mr. Tierney indicating that he is taking steps to follow up on our hearing of 2 weeks ago, and without objection, I include his letter as a part of this record.

[The letter referred to follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., June 28, 1974.

Hon. EDMUND S. MUSKIE,
U.S. Senate, Washington, D.C.

DEAR SENATOR MUSKIE: Enclosed for your information is a copy of a letter which I sent today to Mr. Raymond W. Daum, director of finance, Abbott-Northwestern Hospital. In accordance with your request, I will keep you fully advised with regard to the results of our further investigation.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

[Enclosure]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., June 28, 1974.

Mr. RAYMOND W. DAUM,
Director of Finance, Abbott-Northwestern Hospital,
Minneapolis, Minn.

DEAR MR. DAUM: At the close of the hearing held by the Subcommittee on Health of the Elderly on June 26, 1974, I assured the chairman, Senator Muskie, that the Bureau of Health Insurance would see to it that Medicare reimbursement regulations are being fully complied with in the review of claims submitted in behalf of associates of the Minneapolis Age and Opportunity Center, Incorporated, and Abbott-Northwestern Hospital.

As a first step in filling that commitment, I have directed that a team of qualified personnel from here in the central office go to Minnesota on Monday, July 1, to undertake a full review of all of the claims submitted to date. In addition, I have asked our Regional Representative from Chicago, Mr. Robert Green, to arrange a time to meet with you and the appropriate other persons involved in your eflort at a time which you find convenient to discuss not only past procedures but, perhaps even more importantly, to develop a full and joint understanding for the future.

The hearings which Senator Muskie conducted were certainly most helpful in calling attention to the benefit limitations prescribed in the Medicare law as well as the appropriate interpretation of those limitations in actual practice. Some of the language employed in the various communications to date has been unfortu-

nate and perhaps misinterpreted. I want to assure you, as I did the chairman, of our continuous interest and efforts to eliminate any such misinterpretation.

Mr. Green will be in touch with you within the next few days. If you or your associates feel that I can be helpful in any way as your discussion progresses, please let me know.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

Senator MUSKIE. I understand you have a brief statement, Mr. Tierney, which we would be happy to receive.

STATEMENT OF THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION; ACCOMPANIED BY DR. M. KEITH WEIKEL, COMMISSIONER; LUCILLE REIFMAN, ASSOCIATE COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE; AND DR. CLAIRE F. RYDER, CHIEF, AMBULATORY AND HOME HEALTH SERVICES SECTION, HEALTH RESOURCES ADMINISTRATION

Mr. TIERNEY. Thank you very much, Mr. Chairman, I have a brief statement.

Mr. Chairman, this statement incorporates the Department's position on the GAO Draft Report on "Development of the Medicare and Medicaid home health care programs," which was forwarded to the committee on June 11, in response to your request.

We concur in the recommendations of the report which we believe presents a generally fair and objective appraisal of Medicare and Medicaid coverage in the home health care area. It discusses, in appropriate perspective, both administrative problems and accomplishments in effectuating the home health care benefit within the statutory limitations under which we have to operate.

A number of measures have been taken or are in process to implement GAO's recommendations; these are summarized below.

Among the Department's fiscal year 1975 management objectives is an interagency objective which will include the development of a policy paper defining the near- and long-term strategic goals of the Department with respect to home health care as an alternative to institutional care. In addition to the Social Security Administration, the Social and Rehabilitation Service, the Office of the Assistant Secretary for Health, and the Office of the Assistant Secretary for Planning and Evaluation, will participate in the objective.

Earlier this year, SSA established a Home Health Coordinating Committee in the Bureau of Health Insurance to make a full-scale review of the home health provision under Medicare. As part of the review, they will be soliciting input from all major organizations interested in home health care as well as from the home health agencies presently participating in the Medicare program.

In short, the Bureau of Health Insurance intends to broadly reassess the statutory and administrative dimensions of this area of

coverage to make sure that its policies and Medicare procedures are as supportive of home health care as the law permits.

The following recommendations of the GAO Draft Report relate specifically to the Medicare program.

Recommendation: That SSA increase its effort to assure more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding the various coverage requirements for home health services.

We concur. The Home Health Services Coordinating Committee will review all substantive and procedural issuances relating to home health services for areas of potential clarification or further emphasis and will identify, through reviews of adjudicative results, those intermediaries and home health agencies who appear to need additional training in the coverage requirements of the home health benefit.

Recommendation: That SSA review screening guidelines used by intermediaries and, where significant differences exist in service limitations, explore the possibility of requiring intermediaries to apply more uniform screening guidelines.

We concur. The committee will review the screens or parameters now used by the intermediaries and will determine whether they are consistent with program guidelines and with the characteristics of medical practice in the various intermediary services areas. Where they are found to be out of line. SSA will take appropriate steps to have them corrected.

Recommendation: That SSA explore the possibility of further clarifying program benefits, especially the limits on the duration of benefits in an effort to reduce confusion on the part of beneficiaries.

We concur. SSA will expand the explanation of home health benefits in the forthcoming revision of "Your Medicare Handbook" which we plan to send to each Medicare beneficiary in August or September of this year.

At the same time, SSA will review all other informational issuances and will expand or clarify them where needed. Also, the Home Health Services Coordinating Committee will make a special study to determine the need for additional communication vehicles to better reach beneficiaries and other groups within the general and professional public who act in an advisory of assistive capacity to beneficiaries.

Recommendation: That SSA encourage and, where considered feasible, assist home health agencies in their efforts to increase the medical profession's awareness and support of the home health care program.

We concur. The committee will explore the extent to which this kind of assistance can be rendered by the Medicare program. The degree to which this effort would be legitimate on Medicare's part will have to be studied since it is SSA's strong conviction, first, that home health agencies themselves must work toward achieving professional community acceptance and, second, that efforts undertaken by SSA or the Medicare program on the agencies' behalf could be counterproductive to this acceptance.

Recommendation: That SSA establish regulations, as authorized by the advance approval provision of the Social Security Amendments of 1972, to specify limited coverage periods, according to medical condition, during which a patient would be presumed to require a covered level of posthospital home health care services.

We concur. As a matter of fact, SSA expects that these regulations will be ready for issuance under the Notice of Proposed Rulemaking Procedures in the very near future.

Recommendation: That SSA determine whether implementation of the advance approval and waiver of liability provisions is effective in minimizing the problem of denials, and, if necessary, advise the Congress that the amendments need modification to correct the problem.

We concur. The Home Health Services Coordinating Committee will, after the amendments have been in operation for a period of time, make an analysis of the effectiveness of the advance approval and waiver of liability provisions. Depending on the outcome, SSA will take whatever followup steps may be appropriate.

The following recommendation and comments relate specifically to the Medicaid program.

Recommendation: That SRS impress upon the States that the home health care program generally is a less expensive alternative to institutional care and, because of this, it is intended to be used as such when home health care would meet the patient's needs and reduce program costs.

We concur. The Social Security Amendments of 1972 tighten requirements for the admission of patients to skilled nursing facilities and, as a result, the demand for home health services should increase as more careful appraisals are made of alternatives to both skilled nursing and intermediate care facility services. SRS will emphasize to the States the importance of careful appraisals of alternatives to institutional care, and the use of home health care whenever indicated.

Recommendation: That SRS clarify for the States the specific home health services which are eligible for Federal financial participation and define these services for the States.

We concur. SRS plans, in revising Medicaid home health regulations, to include more definitive requirements that will aid in assuring uniformity and preventing misinterpretation.

Recommendation: That SRS clarify for the States the fact that their payment rates for home health care should be established at a level that will encourage utilization of the home health care program.

We concur. While we do not have the authority to require States to adopt a certain level of payment for home health care, SRS will emphasize to them the importance of realistic payment rates as a means of encouraging more frequent use of home health care services.

Recommendation: That SRS encourage and assist home health agencies in their efforts to increase the medical profession's awareness and support of the Medicaid home health care program as an alternative to institutional care.

We concur. In responding above to GAO's first recommendation relating to Medicaid, we mentioned the Social Security Amendments of 1972. These amendments also require that, in prescribing institutional care, the physician must certify that this represents the best means of treatment for his patient. SRS believes that physicians, in making these certifications, will have to become more and more aware of, and knowledgeable about, the home health services that are available. In addition, the Health Maintenance Organization Act of 1973 requires participating HMO's to make home health service available to their members. So that, here again, physicians should become increasingly

aware of the benefits of home health care. While we believe that the implementation of these legislative provisions should lead to significant improvement in physician awareness and support of home health care, SRS will look for steps that it could take to further encourage such support.

Lack of Understanding in Medical Profession

Mr. Chairman, there is a point that you brought up in your questioning, and I would just like to clarify it, if I may. We feel very strongly, and I think Mr. Ahart maybe felt to some extent, that one of the real problems, in increasing utilization of home health services in this country for a long time has been the lack of the medical profession's understanding or acceptance of the concept of this being a good way to take care of people. Often, Mr. Chairman, when Government proceeds on a sales effort, if you will, or if it be regarded as mandating the use of a service, it is always looked upon as an effort to cut costs, or in some way to cut down or change the patterns of practice, and such an effort could be quite counterproductive from that point of view. That is the only reason I do not want you to have the impression, we think that we have no responsibilities in this area. We want to make sure we do it in a way that will answer what we think is a very basic problem, and that is getting the doctors of the Nation to say yes, this is a good way to get treatment. I really think they have not said that yet.

Senator Muskie. On that point, if I may interrupt, if this is a good approach to health care needs, are you saying that the medical profession is not making an organized effort through the AMA, or through whatever association, to form a judgment on this approach, of what needs to be done, to make it more universally applicable and used?

In other words, have they accepted any professional responsibility for making this a more viable adjunct to health care?

Mr. Tierney. I think I have seen statements of the AMA encouraging the development of more sophisticated, and I do not mean to put words in their mouth, but more totally reliable home health services, and encouraging doctors to utilize them. That is quite different, Mr. Chairman, from 200,000 doctors across the Nation, who have had little experience with it, never used it, and had frankly looked at it in the old days as kind of a service for the poor.

It is a real job to get them to realize that this is a viable, reliable, and good way to take care of people. That is something that the home health agencies have as a continuing and ongoing problem of selling.

Senator Muskie. Are there examples of local medical groups, State medical groups that are undertaking, organizing positive programs to develop this kind of a program?

Mr. Tierney. Do you mean of doctors?

Senator Muskie. Of doctors; yes.

Mr. Tierney. I am not aware of any.

Dr. Ryder. I would like to indicate, Mr. Chairman, that I am involved particularly in this area of concern for home health services, and I think, Mr. Miller will remember back years ago that the American Medical Association has taken a positive stand for home health

services, has carried out training programs, and carried out support of beginning programs in communities, since, I would say about 1958–59.

Recently, and I believe you have it in your record, a report of the American Medical Association, their stand on home care, which has passed through their board of directors, at any rate, they have taken an official stand on home health services.

Furthermore, the committee on community health services of the American Medical Association has sponsored and is continuing to be involved in the very thing that we are talking about, and recently we have had some discussions about the role of the medical director in home health services.

Most Succesful Agencies Have Medical Director

Not all of the home health agencies have medical doctors, and we find that the most successful ones use the medical directors as a liaison with the professional community, and so the AMA is discussing the potential of establishing a program to set up guidelines for the medical director, and to develop training, so that he may take a more important part in promoting the home health services.

I do not mean to be speaking for the AMA, but it just happens that we were talking about this quite recently, and I am sure they would like to go on record as being for home health services.

Senator Muskie. Let me ask this one question from the layman's point of view. If home health care services are further developed, would it not require doctors to visit homes?

I would assume that if you had a home health care service that is reimbursable, one of the safeguards would require approval by a physician.

Mr. Tierney. That is true.

Senator Muskie. Does that mean the attending physician would attend to the patient at home, and is that a restraint upon the enthusiasm and encouragement of doctors for this kind of service?

That is what I am trying to get at. We are aware of the AMA's position, but it will not work unless the doctors at the grassroots want to make it work, and they would much prefer, I have noticed, to visit their patients in hospitals and in institutions, rather than out in the neighborhood. Now, is that a problem?

Dr. Ryder. It is a problem in the physician's mind who has not had experience with the home health program, and I think there have been several programs in Pittsburgh and in Rochester, where they have examined the actual number of visits made by physicians to the home.

One of the things they have found, interestingly enough, is that the number of visits decreases that the physician must make to the home, because he has professional people and semiprofessional people, who can report to him much more logically than a family can at 3 o'clock in the morning, getting panicked and calling the physician.

He knows when the nurse has seen that the patient needs attention by him, that it is truly a medical emergency, and so they find that the number of visits by the physician actually diminishes, and some good

experience, and probably this is the only way of selling the profession, a good experience with home care will result in their sending additional cases, because they see that there is an adjunct to their care rather than in increasing it.

The other possibility is that in many programs, arrangements are made to take the patient to the physician, to save the time.

Senator MUSKIE. One of our island communities off the coast of Maine has closed-circuit television, which is used to bring the doctor to the patient, or bring the patient to the doctor, with semiprofessionals in attendance. That is an imaginative use of technology. I suppose it could not be applied universally.

I appreciate those answers, and I think it might be particularly timely at this point of the testimony.

Mr. TIERNEY. I would like to further state that the specific recommendation in my statement is that we take the lead on this. I only suggest that we have to consider whether or not that will get the job done, or whether they can better do it themselves, and we will explore it.

Senator MUSKIE. Well, if this is the suggestion, or the tendency on the part of the people to think that Government bureaucracy is insisting upon its authority, the medical professions are also overresistant to change, so you have two establishments bucking each other on this issue.

NEW REGULATIONS RELEASED

Mr. TIERNEY. You are right there. The final recommendation, I guess, Mr. Chairman, the next to the final one, was that we establish the regulations implementing the provision of the 1972 amendments which authorizes our specifying limited coverage periods during which there would be a presumption of the required level of care which qualifies people. We concur with that, and we have those regulations in virtually final form. They were in fact released from the General Counsel's office yesterday.

This is a tough area. We have talked to doctors and to home health people all over the country about this, and it is something that sounds very good, but poses difficulties. In any scientific way, it would be very difficult to say that in this situation at least five visits can be presumed to be needed, and that in another we need at least six. It is very difficult to mandate. Under the regulations, therefore, people will be required to try to take a look at the average situation in the local community, but that's covered in the regulations which are about to be issued.

The other thing is the waiver of liability provision which the Congress wrote in its 1972 amendments. We do concur with that and have turned over to this home health service committee every authority to move ahead with it.

We have in the interim, however, way back in October of 1973, told the intermediaries how to go ahead and move on this, and in many areas of the country we have the full waiver of liability provision in effect now.

That covers, I think, Mr. Chairman, at least the recommendations I wanted to address to you with regard to the report on Medicare.

Dr. Weikel is here, and he can talk about the Medicaid issues, or if you would like, I will respond to any questions you have on the Medicare program.

Dr. WEIKEL. Thank you, Mr. Chairman. The first is that the home health care is a less expensive alternative to institutional care, and because of this, it is intended to be used as such when home health care would meet the patient's needs and reduce program costs.

The Department concurs with this recommendation, and would also like to note that with the Social Security Amendments of 1972, which really tightened requirements for the admission of patients to the skilled nursing facilities, the demand for home health care services should increase as more careful appraisals are made of the alternatives, to both the skilled nursing care and the intermediary care nursing facilities.

SRS will continue to emphasize to the States the importance of careful appraisals of alternatives to institutional care, and the use of home health care services whenever indicated.

We have over the last year sent out a number of notices to the regional office Medical Services Administration personnel, encouraging them to visit the States, to explain the usefulness and value of the alternatives to institutionalization.

The second recommendation of GAO is that SRS clarify for the States the fact that their payment rates for home health care should be established at a level that will encourage utilization of the home health care program.

We very strongly concur in this recommendation, and SRS is planning to revise the Medicaid home health care regulations, to include more definitive requirements that will aid in insuring uniformity and preventing this interpretation.

MEDICAID REGULATIONS MISINTERPRETED

There have been a number of misinterpretations of past Medicaid regulations, as Mr. Ahart has pointed out this morning. One of these is that we have utilized the Medicare requirements for a home health agency to participate in Medicaid. Medicare requires the Agency to provide nursing services, and to also provide auxiliary services, such as physical therapy or occupational therapy. A number of agencies, such as the community nursing services, have not been eligible for payment under the Medicaid program in our present regulations, because they are not capable of providing the physical therapy or occupational therapy.

In our regulations that we will publish as a notice of proposed rulemaking within the next 3 to 4 weeks, we will change the regulations to make community nursing services eligible for the payment under title XIX.

We will also attempt to clarify the benefit package under title XIX.

It will make payment for nursing services, home health aide services, and for medical supplies and equipment; and in such cases where the State Medicaid plan does not presently include payment for physical therapy or occupational therapy, if the home health agency provides those services, there will be an exception made, and those services will be covered in the program.

Now, in terms of the next recommendation, that SRS clarify for the States the fact that their payment rates for home health care should be established at a level that will encourage utilization of the home health care program.

One of the criticisms has been the rates of reimbursement are so low as to discourage participation of home health agencies in the program. This is a problem that we are aware of.

While we do not have authority to require higher reimbursement rates, we certainly believe we have the responsibility to emphasize the importance of a realistic payment structure as a means of encouraging more frequent use of alternatives to long-term institutionalization, and in this case home health care services.

We do plan to initiate some activity to try to encourage States in this area. There is consideration in the Department at the present time to a proposal for a legislative change.

As you know, as of the present time, the States are not required to reimburse on a reasonable cost basis.

As of July 1, 1976, the result of a provision in Public Law 92–603, the skilled nursing home and the intermediate care facilities will be reimbursed at reasonable costs.

The Department is considering similar legislation at the present time for a proposal to the Congress which may include the same provision for the home health care agency.

The final recommendation that SRS encourage and assist home health agencies is their effort to increase the medical profession's awareness and support of the medical home health care program as an alternative to institutional care. We concur.

Leadership Responsibility Acknowledged

We do believe we have a leadership responsibility, and we do need to work actively with the medical profession, to try to get to the grassroots to develop support and promote the use of home health services where appropriate.

We do believe we have a challenge in trying to get individual practitioners to become more familiar with the services that are provided by the home health care agencies.

I think there is provision in the amendments of 1972 which would require a plan of care when a patient is discharged from a hospital or skilled nursing facility if they want the patient to receive home health care benefits.

We believe that this will bring about more involvement on the part of the physician, as one avenue, or one opportunity for more awareness to be built up on the part of the medical profession.

I think that this concludes our comments on the recommendations as they relate to the Medicaid program.

Senator Muskie. Thank you very much, Dr. Weikel. We appreciate that testimony.

I think both of you have anticipated many of the questions that we would ask. But in your testimony, you state that the Bureau of Health Insurance intends to make sure the policies of Medicare procedures are supportive of home health care as the law permits.

I would like to ask, whether or not the law is liberal enough in respect to home health care in your judgment? Is the law good enough in terms of need for home health care?

Mr. TIERNEY. I am sure it is not good enough for many individuals, but maybe it is too much for others, but let me answer your question from my point of view.

First of all, I am reading simply gross figures, but since the inception of the Medicare program, over a half billion dollars in trust funds have been paid for services provided by the home health agencies. I think that has had a tremendous impact on the recognition of this very valuable part of the medical services, and so from that point of view, it has been very good. Just a little bit more in perspective, if I may, Mr. Chairman, in this fiscal year the number of home health claims Medicare turned down was just under 2 percent.

NINETY-EIGHT PERCENT OF CLAIMS PAID

In other words, 98 percent of the claims submitted were paid, and that was the end of it.

Now, I think what we have to keep in mind, that indicates that it is doing a very good thing. There is, however, no question but that the bills turned down, as you pointed out were, nevertheless, substantial in number.

The Congress first conceived of this thing, Mr. Chairman, on this ground, that there was going to be a progression of care, and that is why there are the requirements of prior hospitalization and skilled nursing services.

The patient first went to the hospital, and then when he no longer required the high level of service offered by the hospital but continued to need skilled nursing services, he was moved either to a skilled nursing facility or to his home where he would be eligible for home health benefits for as long as the need for intermittent skilled nursing services continued. That, as you will recall, Mr. Chairman, was the original idea behind the law.

If you think of it that way, Mr. Chairman, of simply a health insurance financing of an individual episode of illness, then I think perhaps it is adequate the way it is.

If, however, you think of it in terms of whether it is really meeting the broad range of health-related needs you are talking about, then I do not think that we have that authority now and would need further legislation.

Senator MUSKIE. Do you think you should have that authority?

Let us limit it to health-related needs. It seems to me that on the basis of GAO's estimate of 25 percent getting care in excess to their needs, that is a significant enough figure to suggest that we ought to try to find another way to meet their needs rather than the excess care they are getting in institutions.

Now, should you have authority beyond the "skilled nursing care" standard to provide for these needs?

You say you turned down 2 percent of the home health Medicare bills. Well, I think there is evidence that people have been discouraged from using the benefit, so that is not a particularly useful statistic.

Should we not more actively try to develop the home health option? In connection with your answer to that question, I would be interested in your view of S. 2690, which is an approach to that.

Mr. TIERNEY. Yes, sir, as you know, from prior times that I have appeared before your committee, I am not a philosopher; I am a working person who tries to carry out what we have. In answer to your question, however, I would say that this "health related" is the toughest part of that problem.

You focused earlier with Mr. Ahart on the skilled nursing concept and the fact that S. 2690 would eliminate the skilled nursing requirement.

The concept as originally embodied in Medicare was obviously that it is in a hospital you get skilled nursing, and then the concept of extended care, which was an extension of the skilled nursing aspect of hospital care, and then when you were capable of moving back into the home, you continued to get skilled nursing. When you eliminate skilled nursing, and say health related, I would have a very tough time, I think anybody would, establishing guidelines or criteria.

Now, is there a need for that; do the older people of America need it? I think without a question they do.

Senator MUSKIE. You mention the tough time of determining health related. You have now a pretty tough time in defining the skilled nursing; so you only substitute one tough time with another tough time.

Mr. TIERNEY. Skilled care is something you can cling to, Mr. Chairman. Even in the profession, there is some agreement about what a skilled nurse and a skilled service is.

When you say health-related service, you have something else.

Senator MUSKIE. I am not hung up on health related. With respect to nursing, it was not so long ago that it meant only a registered nurse. Now, the concept of practical nurse has become a professionally identifiable skill.

I do not think the idea of defining health related is beyond our capabilities, but I am not pressing you for a definition at this time. I think you have given us the answer that there is a real need, but that you envision some difficulties with imposing limits that would not lead to abuse. That is about the sum and substance of your answer.

Mr. TIERNEY. Yes, Mr. Chairman, I guess I have worse examples than Mr. Ahart had.

If a blind diabetic has to have an insulin injection, of course that is a skilled thing, and, therefore, it requires a skilled person to come in. If that is done, we pay for it, but if all that is required is to fill the syringe, then under the law we should not pay for that. Anybody can learn how to fill a syringe.

It is that kind of nicety that we are held up on with regard to skilled nursing, and if you can resolve that, it would be a very good thing.

Senator MUSKIE. Has any effort been made to try to get at this problem of definition?

It strikes me, as I said to Mr. Ahart, that skilled nursing care has been used in order to avoid opening the door to abuse of the health care concept.

Has there been any effort made, to your knowledge, outside the SSA, or in conjunction with it, to try to develop a new concept that would by definition provide necessary safeguards against overutilization of home health care?

Would you agree, Dr. Weikel, that what the Federal Government does with respect to this program is going to affect what the States do under Medicaid?

Dr. WEIKEL. I would like to point out in that regard, under the Medicaid program we do have authority to go beyond what the Medicare program does.

We can make nonskilled services available under the Medicaid program at the present time.

Senator MUSKIE. I understand that they are reluctant to use it, and that they are leaning on the crutch of the Federal Government's interpretation.

Dr. WEIKEL. That is correct. A number of States have done that, and I think that is the responsibility we have, to try to inform them that this is not a requirement.

Senator MUSKIE. So when we talk about what we ought to do at the Federal level, we are talking about what would happen in this country, the Federal programs and the State programs with respect to developing home health care. We are not talking about this one little illustration in the law, or this one phrase, but we are talking about what we should do to actively develop this kind of care.

Dr. WEIKEL. I think in terms of the Medicaid program it is our responsibility to go out and promote the broader home health services under Medicaid. Medicare has somewhat different problems in terms of restrictions to the legislation.

Mr. TIERNEY. I want to make sure you know that the Department is now engaged in trying to embody this in not only the short-term review of the problem that we are discussing with the GAO, but also in the long-term consideration of this type of thing. I thought your last question, Mr. Chairman, was whether I am aware of any utilization review safeguard, and frankly I am not at the moment.

Senator MUSKIE. What is the Home Health Coordinating Committee doing with respect to this?

I understand from your statement, that it was established to make a full-scale review of home health provision under Medicare.

Does the committee not have the authority to make the kind of inquiry that my question was directed at?

COORDINATION OF EFFORTS IN B.H.I.

Mr. TIERNEY. In a way, sir, but it really was in SSA, and, more specifically, within the Bureau of Health Insurance, that we are trying to coordinate all of the efforts that we have been making, and all of the potentials that ought to be explored. It seems that they should be centralized. As far as going beyond that into long-term policy of care, no. This is an operating effort, to try to see if we can get some things moving.

Senator MUSKIE. It seems to me that in the name of coordinating, that we could gather all of the views that were developed, those that are critical of the SSA's effort in this field, as well as those that are supportive, all of the views that have been developing, we ought to try to find the limits of home health care services, reimbursable home health care services, what they should be.

I think it would be a great service. I suggest that this is something you might want to look at.

Mr. TIERNEY. Yes, sir. I do not want you to misunderstand, but they are working on how can we do everything we can to improve the home health picture within the present law.

The Department, over and above that, is looking at what law changes should be made to get at the bigger picture.

Senator MUSKIE. We would welcome any suggestion as to how we could change the law.

S. 2690 is all we have got before us at the present time, and I am one who does not believe that a piece of legislation cannot be improved upon, so if you could give us some suggestions, it would be very helpful.

I appreciate your testimony very much. As always, you have been very positive, and I appreciate it, and I yield to Senator Percy.

Senator PERCY. Thank you, Mr. Chairman.

From a procedural point, Mr. Tierney, I would be most interested in your office's working relationship with GAO. In your testimony, you seemed to concur with every one of the GAO recommendations.

Mr. TIERNEY. Yes, we did.

Senator PERCY. As you work with GAO, do you first get a draft of a preliminary report to comment on before the report is finalized?

Well, this report is a draft report, but is there a predraft report that comes to you that you can comment on and discuss. If there is such a report, were there any recommendations with which you did not concur and which they subsequently omitted after discussion with you?

BHI–GAO COOPERATION

Mr. TIERNEY. I think this particular report, and Mr. Ahart can correct me, has gone through maybe three stages. I think what was passed out here today is the final draft report. Prior to that, there was a draft report which we discussed with them, as we always do with GAO.

Prior to that, there was a working report. I do not think there were any material changes in their findings or in their recommendations, but maybe a fuller understanding of some of the problems involved. Just look, for example, at a thing like Mr. Ahart was referring to here, when you first look at the variations in screening guidelines used by intermediaries to assist in applying safeguards against unnecessary utilization. One allows 1 day, another gives 5 days. It is just their effort to try to highlight a case that needs to be further looked at.

It is not any kind of mandate, that type of thing we discussed, and I am not aware really of how many changes were made. I am not sure of any basic changes.

Senator PERCY. Well, I am just interested in the procedures used. I think it is really useful to us to have GAO submit to you an early report so you can make comments thoroughly and completely, rather than for us to have two different positions that cannot be resolved, or that we have to resolve, opinions taken that are cemented in, but I am pleased that they do follow that procedure.

I think it makes your working relationship with them very good, but to have a 100-percent batting average is difficult, but I think it is a good average that you have.

On June 28, HEW funded six demonstration projects to test whether intermediary facilities and homemaker care services would be suitable additions to current Medicare coverage. When can results from those projects be expected?

Mr. TIERNEY. Well, Senator, a definitive answer would have to come from the people in the Department who are conducting those experiments.

I would just guess for your information, at least a year. These things have to be designed, and then obviously, another aspect of the experiments is the evaluation, which takes time.

IS INFORMATION ADEQUATE?

Senator PERCY. In your judgment, do we or do we not now have enough information to proceed in expanding Medicare in which to provide for Medicare facilities and homemaker facilities?

Mr. TIERNEY. I do not think you do, Senator, but that depends on what it is, what is the objective. If it is to find out what would be the impact on the total program costs to provide homemaker services, I don't know, I just do not have that now.

If your objective is quite different from that, to do it whatever it costs, because it is a good thing to do, that is something else.

Senator PERCY. One of the concerns has been the question of costs, the fear that expansion of coverage will lead to overutilization.

Is this fear justified, or is it essentially groundless. If we do change our statutes or regulations and expand Medicare coverage of home health services from what we now have, is the cost going to be necessarily excessive? Isn't it a fact that in some instances you may even save money?

Mr. TIERNEY. At its peak, home health care never amounted to more than 1 percent of Medicare expenses, so you can double it or triple or quintuple it, I guess, and it would not have a tremendous impact.

It is an absolute unknown what happens when you depart from skilled care, from the idea of a continuum of service into all of these other areas of just taking care of people with their needs.

That can cost a lot, but how much I don't know, sir.

Senator PERCY. Could any of the other witnesses comment on the question of costs, or do you think this has been an exaggerated point in the consideration?

Dr. WEIKEL. I think from our point of view, certainly our costs have not been excessive. Less than one-third of 1 percent of Medicaid expenditures goes to home health care services. That has been increasing slightly, and we would expect that with some of our initiatives to try to clear up some of the confusion with the State programs, that that will increase in the next fiscal year, but I think as in the case of Social

Security, it would be cost-effective for us to increase that percentage somewhat higher than what it is now.

Senator PERCY. I wonder whether or not priority could be given, if the statute or regulations were changed, to enable people to move from the costly institutionalized setting that is the skilled nursing home, into a less costly and possibly a much more humane setting that is home health care. We may be able to save money to begin with and reduce the need for expensive brick and mortar. I imagine our skilled nursing homes are fairly fully utilized right now. Are there a lot of empty beds?

Mr. TIERNEY. No, I think there are a lot of empty Medicare beds, but I do not know about Medicaid beds.

There are a lot of skilled nursing facilities that are not taking a very high level of Medicare patients because of cost increases.

Mrs. REIFMAN. I would like to add to that. We have an interagency task force in the Office of Nursing Home Affairs, which is directing attention to the very question you are raising, and that is, can people who have been in nursing homes for any length of time be taken back into their own homes?

PENNSYLVANIA PILOT PROJECT

The particular emphasis right now in Pennsylvania where certain of the nursing homes are going to have to be closed because they do not meet the Life Safety Code, and in these homes there is a problem of relocating the people that are patients in those homes, so what the committee is trying to develop is a pilot project that would offer at this moment, when a person is being faced with relocation, offer an opportunity through a broader definition of home, not just their own home, because, you know, many of them do not have their own home, but forced home placement, or congregate living, or in some way give them a protective environment, can they then leave the nursing home and be cared for through home health services.

I would like to point out, however, that we are not very optimistic about large numbers of persons who can't be removed from the nursing homes, but I think that what was already brought up, that is at the time the person is in a hospital, the time to look, where they need home health services, is then, and prevent their going to an institution; and I think this is the major problem that we are facing, we institutionalize first, then ask a lot of things about what happens when you take them out.

We should pay attention to this while they are beginning to show deterioration and facing crises; to give them additional services to prevent deterioration from continuing; or when they are in a hospital, to begin to think about home health services instead of placing them first in a skilled nursing facility.

I use a slogan which I would like to introduce, and that is that we should be thinking of home health services as an alternative to institutional care, and not the other way around.

Senator PERCY. Exactly, but I would think it would be great to reverse the process of institutionalization a little bit and offer hope to those in institutions that they can go back, and I agree, not just

to their own homes or to their children's homes, but to some other alternative—a foster home or a situation where someone is able to provide a homelike atmosphere, certain services, and paramedical care.

I think it would be a great step for us to take, and possibly a cost-effective step.

Dr. WEIKEL. In that regard, there are demonstration projects which the Department is involved with, the Administration on Aging has cooperated with Medicaid in the support of day care centers for the elderly, the day hospital, where the patient does not have to be hospitalized around the clock. There are experiments of that nature going on, where we try to take the patient out of the hospital, and to prevent the need of hospitalization.

Senator PERCY. I wonder if any of you could comment generally on the questions I asked the previous witness about attitudes of Americans toward the aged in this country? Do you have any personal observations to make about this?

I am always frustrated with how little Government can do, if the people aren't with it. Can you add anything to our knowledge about the attitudes of families taking back and helping to provide for their own parents?

If they knew that there was something in between, that it would not be a financial burden to them, and that they would not have to choose between education for their children or parents, would families be willing to do both and be able to do both—educate their children and take care of their parents?

Mrs. REIFMAN. I have to go back to a former life, where at that time at Harvard, there was a study that everything that we are facing now, where they keep talking that older people are not wanted by their children, and I look at the data of the study, and it was back in 1849, and it was in Scotland, and it taught me a lesson that we think we have problems, but it is a universal sign of what is happening to our society.

I think one of the things is that home health services would offer an opportunity to bring the family into the picture a lot more than they are being brought into it now.

It offers an option, it prevents the kind of thing happening, such as a friend of mine just talked about yesterday, when they brought back her husband from very serious surgery to her home; and I said, did you get home care, and she said, we do not need it now. We are doing all right; but she said, the first few days, when we brought him home from the hospital, were just horrendous. We were afraid we were going to hurt him, and so on; so I think we are dealing with not just an acute situation, but with long-term and lifetime care; the family can quickly get worn out by all of the decisions they have to make. In many instances, it used to be the requirement, for example, in a home health agency, they would not take a patient, unless they had a private room and all kinds of things; and they soon realized it was not a matter of physical plant, it was not a matter of money or ability to pay, it was a matter of how strong the family was, how strong the caretaker was.

SKILLED NURSING INCLUDES FAMILY TRAINING

The caretaker often cannot give the time unless they know how to; and I think one of the biggest needs is to consider the fact that the skilled nursing, the question of skilled, and let us take nursing by a skilled professional person which includes the teaching of the family to handle the situation themselves, and it includes the supervision of others who give the direct service.

It includes many things that can be broadly defined, and so if the family has this kind of support, it is amazing what they can handle, what they can take care of, and they are willing to take care of it, because they know they have this potential for support and help.

Many of the agencies tell us that the first few days that a person is on home health care, the telephone rings almost invariably at 3 in the morning. They are testing, they are trying to see whether or not it is true that there is someone concerned about their situation, and they will try it out, and they will try it out with the physician too, just to make sure that the individual is cared for, so the attitude of the family will require a great deal of education, but more importantly, the support of professional persons, and the homemaker and home health aides, those are the people that will be giving the care, those are important components.

Senator PERCY. Well, I appreciate those comments. Again, from the human standpoint, I cannot forget the typical experiences that Mrs. Percy and I have had over the past few years in visiting nursing homes. Of the three we visited the Sunday before last, we estimated that 80 percent of the patients had not had a single visitor in the last year.

One woman has been in an institution for 22 years and has received, I think, 20 letters in that period of time, and she sleeps on them every night. She has a precious little bundle underneath her pillow, and just our going there seemed to mean so much.

We had never met some of the patients before. Some we had seen in homes which we visited previously. With those, it was like seeing old friends, even though we had met them just once. These are the kinds of things that we are concerned with, and medicine alone cannot possibly make up for some of the things that are missing.

One last question; I received a very prompt reply to my letter of May 6 to Secretary Weinberger. On May 16, he wrote that he had asked the Commissioner of Social Security to review a matter that I had called to his attention.

I just wondered if that letter had somehow filtered to your desk, Mr. Tierney, and whether or not you know that I can expect a reply in the near future.

Mr. TIERNEY. I am not sure it filtered to my desk, but I can assure you that you can expect a reply tomorrow.

Senator PERCY. Pardon?

Mr. TIERNEY. I can assure you you can expect a reply tomorrow. I will see to it.

Senator PERCY. Is there anything you can comment on right now?

Mr. TIERNEY. I do not know where it is, but we will certainly get on it.

Senator PERCY. I will read a little section from the letter that I wrote. Mr. Chairman, I would like this letter made a part of the record.

Senator MUSKIE. It will be made a part of the record.

Senator PERCY. And I would also like the reply made a part of the record.

Senator MUSKIE. So ordered.

[The letter and reply referred to follow:]

U.S. SENATE,
SELECT COMMITTEE ON NUTRITION AND HUMAN NEEDS,
Washington, D.C., May 6, 1974.

Hon. CASPAR WEINBERGER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR SECRETARY WEINBERGER: It has come to my attention that home health agencies are experiencing difficulties with the fiscal intermediary process, particularly with the narrow interpretation of the language of the law as it applies to home health coverage under Medicare. I am enclosing several examples of intermediary denials to illustrate the problem.

As you know, Medicare coverage for home health services is limited as it is, and home health agencies are relegated to an almost insignificant provider role under Medicare. Restrictive claims determination would further limit Medicare home health benefits and render a cost effective and humane approach to health care out of reach by a majority of the elderly.

It seems to me that some clarification by the Social Security Administration as to what constitutes home health services under Medicare would help intermediaries do a better job with home health agency claims review. It would also serve to save our elderly a great deal of frustration and uncertainty.

I look forward to hearing from you at your earliest opportunity.

Sincerely,

CHARLES H. PERCY,
U.S. Senator.

[Enclosure]

PROBLEM I

Fiscal intermediary's claims review personnel are denying payment for evaluation visits. In fact, in stating the objectives of care when applying for coverage of initial or subsequent visits, the use of the word "evaluation" is purposely avoided.

EXAMPLE A

Mrs. F. is a 67-year-old lady with congestive heart failure who lives alone. The doctor has ordered twice weekly evaluations of her cardiac status and intramuscular diuretic injections as necessary. All visits except those in which the diuretic was administered were denied. The greater portion of the skill in such a visit is the evaluation (or assessment) aspect. An injection can be administered by a licensed practical nurse. Several such claims have been denied routinely until we have stopped submitting them.

EXAMPLE B

Mrs. B. is a 65-year-old diabetic and double amputee who lives with adult children who are unwilling to give her any physical, emotional, or financial support. Mrs. B. is an unstable diabetic whose blood sugar is routinely high. The Medical Nurse Associate visits at intervals between her monthly clinic visits to take a fasting blood sugar, check her general condition, continue to encourage her to stay on her diet, and to try to help her understand the importance of good technique in insulin administration. Such visits have been going on for a year and Mrs. B. is not improving. The frequency of hospitalization has been reduced, however, and the objectives of her care have been readjusted. The nurse is trying to prevent further deterioration. Medicare would deny such a claim in Illinois.

PROBLEM II

Skilled nursing services which are deemed teachable are denied coverage to those patients (other than diabetics receiving insulin) who have no one available to teach.

EXAMPLE

Mr. and Mrs. W. were both 85 years old and living in their own modest home. Mr. W. had Ca of the prostate and, not being well enough to survive a prostate procedure, had a suprapubic catheter which needed irrigating at least twice weekly. Every attempt was made to teach Mrs. W., but her eyesight was too poor. Mr. W. was physically unable. Claims for routine visits to evaluate the area around the catheter and to irrigate it were denied on the basis that it is a teachable skill. The alternative is deterioration and eventually rehospitalization.

PROBLEM III

Visits made to patients to evaluate and counsel in seeking further medical care are denied in Illinois.

EXAMPLE

In the W. household, as stated above, Mrs. W. fell while getting out of bed early one morning. She injured her head severely and broke her hip. The nurse made several visits, in addition to the physician, to convince the patient that she should be hospitalized. Physical evaluation was a part of the skill indicated as well as the counseling. The claim was denied on the basis that the visits did not constitute skilled nursing care.

PROBLEM IV

Visits made to homebound patients who have bowel problems (including fecal impactions) or who need enemas for a diagnostic test are denied on the basis that it constitutes an unskilled service and is not intermittent.

EXAMPLE

Mr. F. is 83 years old, lives alone, and is to have a lower GI series. The doctor has ordered enemas until clear and the other usual preparations for such a test. Wanting to avoid an overnight hospital stay, he arranged to have the visiting nurse come to help him with the enemas. His gait is unsteady and he had a history of some cardiac difficulties 20 years ago. Because a second visit was not necessary and, in spite of the history of cardiac difficulty, because giving enemas is not considered skilled nursing, such a claim would be denied in Illinois. The alternative is an overnight hospital stay.

PROBLEM V

Parenteral administration of iron preparations which would not be effective if taken orally are being denied in Illinois.

EXAMPLE

Mrs. G. is a 70-year-old lady with a history of frequent bleeding duodenal ulcers. Shortly after her hospitalization for a bleeding ulcer, she was still homebound and her physician ordered weekly imferon injections. The claim was denied on the basis that the oral medication could have been used, even though she had just recovered from an acute episode of bleeding. It may be that the claims reviewers are not prepared to make appropriate judgments.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
May 23, 1974.

Hon. CHARLES H. PERCY,
U.S. Senate, Washington, D.C.

DEAR SENATOR PERCY: This in further response to your letter about home health care services under Medicare.

In the enclosed report, Mr. Thomas M. Tierney, the Director of our Bureau of Health Insurance, discusses the aspects of your concern. As Mr. Tierney points out, the fact that all home health care services are not covered does not reflect on the need or value of such services. It simply reflects the fact that the Medicare statute does not provide coverage for all the home health care needs of our beneficiaries.

Sincerely yours,

JAMES E. CARDWELL,
Commissioner of Social Security.

[Enclosure]

REPORT BY THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, TO COMMISSIONER JAMES B. CARDWELL CONCERNING AN INQUIRY FROM SENATOR CHARLES H. PERCY

I can understand Senator Percy's concern that the home health care needs of our beneficiaries be met. However, as you know, it was necessary for the Congress to decide which medical services could be covered most appropriately with the funds that were available for the Medicare programs. It was concluded that the Medicare home health benefit should be limited to those individuals who are confined to their homes, under the care of a physician, and in need of skilled nursing care on an intermittent basis or physical or speech therapy. Visiting nurse services, on the other hand, have been geared to meeting the social, emotional, and home maintenance of patients without regard to whether or not the individual has a need for a particular type of skilled care. Unfortunately, because of a tendency to equate the Medicare home health benefit with traditional visiting nurse services, there has been some disappointment when it has been necessary to disallow claims made for a type or level of care not covered under the Medicare program.

For Medicare purposes, skilled nursing care has been defined as those services which can be carried out safely and effectively only by or under the direct supervision of a licensed nurse. Under this definition, teaching and training activities and observations and evaluations required in connection with the treatment of an individual's illness or injury which require the special knowledge and skill of a licensed nurse would constitute skilled nursing care. However, if a service can be adequately and safely performed by the average nonmedical person, it is not a skilled service for Medicare purposes even if it is done by a licensed nurse.

Apparently, in the case referred to by Senator Percy the services rendered could have been performed by nonmedical persons with brief instructions. The Medicare intermediary in Illinois is following current guidelines regarding skilled observation and evaluation by a home health nurse and does allow payment for nurses' visits for the purpose of instructing family members or other nonmedical individuals in providing essentially nonskilled services. However, the guidelines do not allow payment to continue over a protracted period of time.

We can certainly understand Senator Percy's concern that Medicare coverage of home care services is not as broad and encompassing as is needed. However, it is not always understood that the level of care covered under Medicare as home health care is intended to meet the needs of the patient who does not require the continuous care provided in hospitals or skilled nursing facilities.

In other words, the home health benefit is intended for patients who require a level of care similar to but less intense than institutional care. We realize this need of older people for kinds of care not covered by Medicare. However, it is not the present design of Medicare to cover all those services which older persons may need or use, particularly those services which are not clearly a part of their health care. Coverage of services under Medicare which would help more with the problems of increasing physical dependence, the need for a protected environment and for personal care that typically accompany advancing age often involve nonhealth matters and would greatly increase the costs of the program.

Concern about the limitations on coverage under Medicare's home health provisions probably led to the inclusion in the Social Security Amendments of 1972 (Public Law 92-603) for a provision under which the Secretary of Health,

Education, and Welfare is authorized to conduct experiments and demonstration projects with the use of certain institutional and homemaker services as substitutes for the more costly skilled nursing and home health benefits covered under Medicare. However, even in the case of the experiment provision the benefits would be limited. One example of an experiment which might be conducted under this provision could involve Medicare payments for the services of homemakers for a short period of an individual who does not require institutional services upon discharge from a hospital but is unable to maintain himself at home without assistance. The purpose of this particular experiment would be to determine whether such coverage would lower the use of more costly, covered, institutional care.

The primary responsibility for developing the experiment program rests with the Health Resources Administration. A Request for Proposal (RFP) has been issued for the development of an experimental design for the conduct of a nationwide research study which, once implemented, will produce data and information necessary for recommending alternative Medicare reimbursement methods.

Mr. TIERNEY. Senator, it is, I guess, a very good example of a difficult situation that we have been talking about here all morning.

I am sorry I did not hear everything you read about the double amputee with diabetes. They feel they have to keep urging her to watch her diet and to take care of herself.

Now, that is obviously a very needed thing, but if you want to read the law very technically, and the regulation very technically, you do not need a skilled person to do that urging, and this in itself is not in a sense a skilled service.

It is urging a very unfortunate person to follow some procedures. When you say to me, "Should not that be paid for?" maybe it should, but it does take a broader definition, I think, Senator, than we construe the law to permit.

Senator PERCY. I have a number of illustrations in my letter, and I will very much look forward to your reply. I very much appreciate your being here.

Senator MUSKIE. Our next witness this morning is Dr. Jeoffry, Mr. Tierney.

We have two more witnesses, and I regret to say that I have an appointment at 1 o'clock with the Secretary of the Treasury that I have to keep, and I know from the testimony, that these two doctors who are scheduled to testify have some important points to make, so I would appreciate it if you would undertake to make sure that those high-priority points are made in this next half hour.

I do want to thank our past witnesses this morning.

Mr. TIERNEY. Thank you, Mr. Chairman.

Senator MUSKIE. Our next witness this morning is Dr. Jeoffry Gordon of the American Public Health Association.

Dr. GORDON. Thank you, Mr. Chairman.

Senator MUSKIE. I see you have a prepared statement, and if you would, I would appreciate your making the best of your time. Your prepared statement will be included in the record.[1]

I regret that the rest of my afternoon will be devoted to business on the Senate floor, and I cannot possibly come back, so let us see how we can best use this time.

[1] See p. 1433.

STATEMENT OF DR. JEOFFRY GORDON, SAN DIEGO CALIF., AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. GORDON. I would like to respond to Senator Percy's comments at the beginning, by saying my work is generally with young people, adolescents, and I am here representing the American Public Health Association and the Visiting Nurse Association of San Diego County, and that I find myself involved with this because I have a great deal of difficulty in working with the "now" generation, because of their definite, what I believe to be egotistical, rejection of their parents. I think the people would rather take a vacation than devote the energy to taking care of their parents. I think it is an attitudinal problem, and certainly legislation will not change that.

I would like to make a few points that came up, and ask that my full statement, and the resolution of the American Public Health Association be inserted in the record.[1]

Senator MUSKIE. It will be, of course.

Dr. GORDON. Thank you. Let me just say a couple of things. One is that with regard to fiscal intermediaries, this does not apply when you ask for prior authorization for services. The State health department in California will authorize these, but at the bottom of the authorization, it says that this authorization for care may be subsequently denied by the intermediary according to their guidelines. So even after you pass one hurdle, determining that there is needed skilled care, they can retrospectively take the money away from you after the care is provided. That is a problem.

Second, I think our Visiting Nurse Association can say that it has been having difficulty in getting money out of Baltimore, and that the reimbursements have been falling 6 months behind. We had a cash flow problem—we had to borrow $40,000 to meet our payroll because we were not getting the money due to us out of Baltimore. So, there are problems from both ends.

I think working with Social Security is much more understanding than the elusiveness of the intermediaries formed by the private insurance agencies.

PROBLEMS OF FUEL CRISIS

I would like to call your attention to something in my statement having to do with the recent fuel crisis.

The American Public Health Association conducted a study, and it pointed out that 80 percent of those surveyed showed they had tremendous problems with fuel allocation during that time. This goes back to the question of rural health care.

Our county is mostly rural. Our nursing staff drives 50,000 miles per month; it makes our overhead a little high. You ought to try doing that when gasoline stations are closed—because the nurses use their own cars—and we have no bulk allocation. There was a lot of trouble serving rural health needs during that time. I draw your attention to the fact that the fuel office made no determination, except for emergency care, that money should be delegated to health services. That was a tremendous burden at that time, and in some ways, continues to be a burden.

[1] See pp. 1433, 1437.

I think that the spinoff from some of the discussion you have had about skilled nursing services is that it is relatively easy to make a definition of emergency, such as threatening to end life, or to lead to permanent pain and disability. That is a bureaucratic determination. But as a practicing physician, you make a different kind of determination, for example, that if there is a 20-percent probability an emergency could exist. I think a lot of the custodial and maintenance care that is not allowed to be reimbursed, is in that order of magnitude.

If a skilled person versus the patient reviews the status of that patient, the vital signs, and does not treat him per se, that observation may be crucial in avoiding emergencies, and maintaining the patient. Yet under all of the limitations of guidelines, and so forth, it is virtually impossible to persuade an intermediary that that kind of preventive emergency care is appropriate and reimbursable.

Senator MUSKIE. We did not, in this morning's discussion, go to preventable care.

Dr. GORDON. It is not prevention of disease. It is prevention of deterioration. We can prevent a lot of deterioration with goodness and care that would not come within the realms of skill.

Again, I am surprised in your discussions that your level of specificity was not always at the level that Senator Percy read from his letter.

Skilled nursing care was a big controversy back home. If a person is not able to maintain bowel control, not only is it discomforting, but it is not considered reimbursable to maintain the patient in his own home and send in a person to relieve the fecal impactions. As I said, monitoring to prevent emergencies is not skilled nursing.

Mr. Tierney brought up insulin syringes. I do not know who will do it if the person has trouble getting homemaker services because they are not reimbursable. Someone has got to do it. That is our big problem.

Finally, I would like to go back to the whole concept of the practicing physician, in the statement of the American Medical Association, which is very good, but in my experience, it is quite to the contrary. There is a lot of frustration. I would like to call your attention to the legislation of S. 3286 for national health insurance, for instance, in title 20, section D, which requires a physician-authorized certification and treatment be established before reimbursable services are provided. This section goes on to talk about physician overutilization and the provision of mechanisms in dealing with overutilization. This mechanism is also in the current legislation. However, it is my impression that this kind of physician control really encourages underutilization.

It is my observation that the physician never has time to do everything. The nurse can initiate the cure and then call the physician for a treatment care plan, but the nurse is discouraged from doing this because it is not a reimbursable service. I would strongly recommend that this inappropriate underutilization can be overcome by changing the language of the proposed legislation to provide that the treatment plan be submitted by the second patient visit, rather than by the first visit. This change would allow one cushion visit on the nurse's knowledge.

I have a lot of bones of contention with the medical profession because they do not make house calls very much. As part of a team, the nurse could make the house calls.

Homemaker Evaluates Situation

In San Diego, we have garnered a lot of revenue-sharing money to make homemaker services available, which generally is nonreimbursable under health insurance legislation. We found that the homemaker goes in and tidies up, and many of them make referrals for nursing care and physician care that would not otherwise be made. Through this mechanism, we find there are large numbers of patients who have needed skilled nursing care but who were not getting it because they are under the aegis of a physician. I think this is a major problem.

We have gone through great lengths to try to work with physicians in our community, and I do not know how far to go in my public testimony, but our local medical society has a hospital-based pathologist as a part of this home nursing care committee.

On the other hand, our association has currently placed nine nurses in various community hospitals to do discharge planning under contract, and through that mechanism, we have provided coordinated care. We are also trying to educate the physician, although it is an uphill job. So I would like to call these things to your attention.

Finally, with regard to title 2 of the legislation, long-term care service program——

Senator Muskie. You are talking about the Kennedy-Mills plan?

Dr. Gordon. Yes. I think that is very exciting, and I think your discussion about making these definitions is the crucial point. I think this committee can make some important decision about how much of this should come under health insurance, and how much under other Social Security or social programs. I am very familiar with the Older Americans Act of 1965, as amended, because it is very active in our community. I think some of these strategies can be financed under that mechanism, and therefore, the incredible inflation and the health care field will not be added to by trying to tag everything with Medicare and Medicaid.

May I suggest that at the same time treatment strategies or maintenance strategies are tried under other legislation—I cannot say strongly enough on behalf of the association—that the underutilized home health services really have to be revised as well.

PSRO Legislation Needs Expanding

We think that the 100-visit-a-year limitation is inappropriate. Most people use quite a bit less than that. We think 200 is inappropriate. We think it should be open ended in conjuction with utilization review. In addition, we believe that utilization review should not be conducted by the physician solely. The sensitivity of the care in the home is provided by the social workers and public health nurses who go into the home. So we think PSRO legislation ought to be expanded to include other than physician input, because it is just in this area that there is a terrible lack. That is why I do not belong to the medical society. That is a quick summary.

Senator MUSKIE. Thank you very much. It would be useful if you would care to submit additional testimony concerning this whole question of finding another category of health-related home services that is quite specific in terms of definition.

Dr. GORDON. I would like to make one point in that regard. The association is working on trying to define preventive services that might exist under health insurance. I would call to your attention that the insurance model is totally inappropriate for health maintenance, insofar as it involves risks that are unpredictable and out of the control of the persons so insured.

Most maintenance and preventive strategy is within the control of the person. There is no risk involved, and it is not appropriate to put it under the insurance model. If payment is going to be done, it is best that it be done by provider mechanisms rather than patient disincentive. I think in this whole area, it cannot be solved solely through fiscal incentive in the insurance mechanism. That is why I think we are looking forward to a broader concept.

Senator MUSKIE. That would not exclude the possibility of liberalizing the insurance program?

Dr. GORDON. No, but I would like to take it out of the insurance model. The statement is that we do not want to restrict it to skilled services, because the definition of "skilled" is in error, but that we want to provide home health services to the extent they are necessary to support the well-being of our senior citizens.

That is not an insurance statement. That is a statement of health care as a right, and that is a different statement than the kind of statements I heard this morning from these people who work for the Government. They want to save money. They aren't interested in maintaining the health of the people. It is expensive to maintain the health of the people, especially when a lot of providers take advantage of the system. But it should be public policy that we are here to protect the health of the people, and that is not an insurance statement. That is a statement of public policy, and the distinction is not made often.

Senator MUSKIE. Should that kind of statement be included in the law?

Dr. GORDON. If you can get certain segments of professional groups to approve it, yes. The American Public Health Association strongly stands behind that kind of statement.

Senator MUSKIE. Thank you very much, Dr. Gordon. I apologize again for the shrinkage of time.

Dr. GORDON. It is a pleasure.

Senator MUSKIE. If there is anything you would like to submit along this line, we would appreciate it.

Dr. GORDON. Thank you, Mr. Chairman.

[The prepared statement of Dr. Gordon follows:]

PREPARED STATEMENT OF DR. JEOFFRY B. GORDON

Mr. Chairman and members of the committee, my name is Jeoffry Gordon. I am a physician and work as clinical coordinator of the Beach Area Community Clinic (a young people's free clinic) in San Diego, Calif., where I am also president of San Diego's Visiting Nurse Association. I am appearing before you today representing the American Public Health Association where I am a member of the association's action board. APHA's 50,000 regular and affiliate members

encompass a broad spectrum of health and health-related disciplines including many of the people who provide the services we are discussing today.

While we do not have the time to delve deeply into APHA's perspective regarding all the ramifications of this major social issue, I want to take this opportunity to applaud the U.S. Senate for establishing the Special Committee on Aging, for your continuing efforts to create social policy supportive of the needs of the elderly, and to thank you for the opportunity to come here today to speak to the subject of home health services as alternatives to institutionalization in the context of national health insurance.

At our last annual meeting, the American Public Health Association adopted a comprehensive position paper on home health services and, although I have submitted the full text for the record, this statement represents the work of members of the association who have day-to-day experience with the problems of home health services. I would like to take this opportunity to share some of the more relevant sections with you:

"It is estimated that between 4–7 million persons in need of long-term care are living outside of institutions. Our modern preoccupation with the organization, equipping, and financing of institutional care has led us to a disproportionate investment of economic and manpower resources in this. We have almost completely ignored the home care field. . . . It is significant that the limited, present concept for fostering 'alternatives to institutional care' has been triggered almost exclusively by the alarm over rising costs. . . . APHA, as well as being concerned with rising costs, believes that a continuum of care must also be available . . . on a flexible basis according to needs and effectiveness.

"Home care services are at present so limited in scope and geographic availability as to seriously reduce such service as a viable choice for large numbers of people . . . (when services are available), coordination is often lacking . . . different eligibility requirements may interfere with an individual's ability to receive necessary services.

"For instance, an individual may be eligible for visits by a visiting nurse for dressings to a wound, but not for housekeeping assistance. (This) lack . . . could mean that this person could not leave the institutional setting. . . . Further, no services can be covered or provided unless physician-prescribed. . . . While physicians are expert in the treatment of disease, they are often less expert in the care and assistance individuals may require to enhance or support functioning when it relates to disability.

"At least 10–25 percent of the population now in institutional homes of varying kinds could be cared for and remain in their own homes if organized services beyond episodic nursing and medical care were available. . . . Nonetheless, home health services are presumed unnecessary until proven essential. . . . Interestingly enough, those in the middle income group are the most affected by the varying restrictions. Their usual income levels do not qualify them for municipal, State, or Federal aid, nor do they afford them sufficient money to pay for the services. The poor are also affected, because the required degree of proof that the services to be provided are essential is almost prohibitive."

Additional Items of Interest

These may seem to be sharply critical words from our generally mellow association but they are very appropriate. Let me call a few more items to your attention:

(1) While the total cost of Medicare appears to be increasing rapidly, the reimbursements specifically for home health care are decreasing. According to the *Social Security Bulletin*, June 1974, the total of *all* reimbursements under parts A and B of Medicare was $6.3 billion in 1969 and $7.9 billion in 1972—an increase of 27 percent; for the same years the total reimbursements for home health services was $79.7 million and $61.2 million respectively, a decrease of about 23 percent. Pause, if you will, to contemplate the implications—how many more expensive services were substituted and how much more disability was endured for the $18 million savings. Where, in fact, is our Nation's commitment to solving the problems we are discussing?

(2) Our own VNA is fortunate to serve an area covered by a relatively good title XIX program, yet the State of California in 1973 paid only $13.12 per home nursing visit, while our actual nonprofit cost was $22.50, still far below the equivalent cost of institutionalized care. During the first 8 months of 1973 this differ-

ence produced an operating deficit of over $17,000 which had to be made up by the local United Way Campaign, thus draining scarce resources from the voluntary sector to support Government insured services. In fact, this fiscal year, we ran out of the United Way funds a full month before the end of the year. I wonder how home health service providers fare in less wealthy States?

(3) Home health services, as with health care in general, appear to represent a low priority in terms of overall Government policy. During the recent national fuel crisis, APHA conducted a survey of energy problems of State, county, and local health departments and visiting nurse associations. Eighty percent of the 41 VNA's responding reported difficulty with automobile gasoline in terms of supply, cost, loss of time, and decreased mobility. Our own VNA which made 25,262 professional visits to 2,560 patients (of whom 6,990 were over 65) in 1973 has staff which drives 50,000 miles per month in their own cars. I want you to imagine the devotion of our employees who spent the very early hours of the morning in gas lines so they could have fuel to make their rounds, and the anxiety of the nurses who had to make weekend calls. And where was the concern of our National Government which made only haphazard reference to health care needs in the regulations governing emergency fuel allocations?

(4) I also want to take this opportunity to call your attention to the incredible confusion which surrounds the functioning of Medicare. I have used the patient-oriented pamphlet published by SSA called *Your Medicare Handbook* to teach medical students about the medical care system. Almost unanimously, they find it confusing and incomprehensible. Think of how lost a not-so-nimble and, perhaps, a quite sick, older person for whom the pamphlet was intended would be if he or she tried to determine what benefits would be covered. Providers across the country must endure an analagous problem. Regulations and interpretations change tremendously in different localities. Medicare intermediaries make different interpretations from State to State and each State's Medicaid program is different. Under these circumstances it is possible that even *allowable* and *needed* services are not being provided when necessary.

(5) I am certain that you are aware of the bind current philosophy places on home health service providers since reimbursable services must follow hospitalization and/or be restricted to those patients with rehabilitative potential. Very many people who could otherwise avoid institutionalization must be literally abandoned to that fate if their prognosis for improvement is poor. We are sympathetic with your responsibility to control health care costs and utilization to appropriate levels, and we urge that the problems of maintenance and custodial care explicitly be dealt with as part of a broader public policy on the aged for the medical care dollar cannot continue to be burdened with nonmedical costs. Yet, in view of the needs of many of the aged, sick, and disabled and, of the absence of other societal commitments to their needs, we strongly recommend that regulations on home health should be extended to cover those services which are necessary to prevent deterioration or to sustain current capacities even when improvement is not imminent. We further believe that the designation "skilled" be deleted when describing the practice of a nurse in the home, for the care needed can often be most cheaply, and best provided by other less "skilled" providers such as homemakers and community health workers.

(6) We share the concerns of both the Congress and the administration in regard to containing costs, and believe that home health services provide just such a means of offering less expensive care without any sacrifice in quality. To restrict the use of such services is, in our opinion, counterproductive to such cost-control efforts. I offer the following example to you as typical and indicative of the lower price of home health care and of the way current restrictions inhibit wider use of those services. Last year, the National League for Nursing, in testifying before this committee cited a case involving a stroke victim served by the Visiting Nurses Association in Salt Lake City. The total cost of 11 home care visits, 28 nursing visits, and 3 social work visits amounted to $399. Comparative per diem rates in a hospital would have amounted to $12,000 and, in a nursing home $4,000, both exclusive of needed ancillary services. Because of their rigid requirements concerning hospital-related conditions, Medicare would only pay $35 of the total. In this instance, funds were made available through other sources, but if, as is often the case, outside moneys were not available, or the patient could not pay out-of-pocket, the individual would have been institutionalized at a much higher cost. Although this is only one example, similar cases could be cited throughout the country.

(7) Finally, before getting down to the actual legislation at hand, I want to share with you my enthusiasm for the public health nurse who, either as provider in the home or as a hospital discharge coordinator, has the skill and concern to integrate and make functional the whole health care system for individual patients. I would like to call to your attention our overwhelming frustration with the many practicing physicians and almost the totality of insurers and institutional providers who either are ignorant of the skills of these individuals or who are motivated by financial reasons to overlook home health care. We thus consider it to be crucial, and I hope that you do as well, that any national health policy be concerned not only with issues of financing but also with the restructuring of the system to make it more appropriate and effective in responding to the needs of the patients who require long-term care.

Home Health and Long-Term Care

With these observations in mind let us now turn to S. 3286, "The Comprehensive National Health Insurance Act of 1974." I will restrict my comments to issues of home health and long term care.

Title XX, part E, section 2051(m) still defines home health services in terms of "skilled nursing care" and these quality designations should be deleted. This same section does not include homemakers among the covered services and it should be as is done in title II and in S. 2690.

Title XX, part A, section 2011(b) still limits home health services to 100 visits per calendar year. We recommend that it is desirable even to go beyond the 200 visit limit suggested in S. 2690. Experience has shown that the average number of home health visits per patient per year is considerably less than 100 visits which belies the allegation that this limit is needed to control costs. Furthermore, in terms of quality of care it is just those patients in such catastrophic circumstances who require these additional visits who will benefit most from them, at the same time as avoiding the more costly alternative of institutionalization.

Title XX, part D, section 2041(f) requires, for home health agencies, that a physician authorized certification and treatment plan be submitted "prior to the first visit" in order to receive payment. While the same section contains language that admits that there may be problems with erroneous certifications by physicians, I assume that the concern here is with inappropriate *overutilization.* Those of us providing home health services see the need for physician authorization prior to the first visit as clearly promoting inappropriate *underutilization* and discouraging the effective use of skilled nursing evaluations and initiative. We would suggest that the section be revised to specify that the treatment plan must be submitted by the second visit.

Title II, part D—long-term care services program. This proposed addition to the Medicare program is to be strongly applauded for the strong initial steps it takes toward resolving the societal problem of creating supports for the elderly. The idea is significant and important. Many of the concepts proposed seem to offer real solutions: the community long-term care center with its recipient board, expanded homemaker, day care, foster care, and mental health services. APHA is concerned, however, that since many of the broad spectrum of services included in long-term care fall outside the purview of medical services, this proposal might place an even greater financial burden on our inflating health care system for nonhealth services and may, thus, prevent sufficient funds from being available for health care. We would, also, have some questions about how such a broad scale program covering many existing agencies could be effectively administered. In addition, we are concerned about the financing mechanisms for this proposal. Premiums might cover as much as 15 percent of the total cost, with the States covering 10 percent more, and general Federal revenues the remainder of an unquestionably high, but unknown, total. The vagaries of the annual appropriations process and the large amounts of money involved certainly give no assurance as to adequate future funding. With these concerns in mind, APHA would make two recommendations:

(1) The Congress should authorize a great acceleration in presently authorized but underutilized home health services under titles XVIII and XIX, both by expanding legal definitions and by liberalizing regulatory constraints, much as I have suggested previously.

(2) This committee and others should carefully explore the whole picture of support for the elderly and, through a functional and, perhaps, empirical analysis, determine what activities properly come under health care (and how they can be exanded, coordinated, or improved), and more importantly what are the inadequacies in other societal sectors that you are proposing to resolve in this expansion of Medicare. Many of the services and institutions proposed here might well be better implemented and managed within other parts of the Social Security system, or, for instance, under such legislation as the Older Americans Act of 1965, as amended.

Title II, part D, section 204, which eliminates the requirement for a hospital stay prior to home health services under part A of Medicare is certainly an important improvement and should be expedited in passage, perhaps through such a mechanism as S. 2690.

I hope that these remarks have been helpful. On behalf of the American Public Health Association, I want to express our appreciation for this opportunity to present these views to the committee. In the event that APHA or myself can be of further assistance in the future, I hope you will not hestitate to call upon us.

RESOLUTION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

HOME HEALTH SERVICES: A NATIONAL NEED

I. Background

Fostering social conditions and programs which safeguard and enhance the health of the population is one of the basic tenets of public health. Yet home health programs and delivery of home health services have been primarily dependent upon the recommendations and referrals of institutions for care of the sick, or upon individual physicians.

It is estimated that between 4–7 million persons in need of long-term care are living outside of institutions. It is imperative that the public health profession address itself to the endorsement, support, and creation of home health services programs which will maintain this "high-risk" group in the mainstream of society, as well as make it possible for those who are institutionalized to return to their homes, families, and communities.

In "A Report to the Special Committee on Aging, United States Senate," prepared by Brahna Trager in April, 1972, Senators Church and Muskie state:

> "For too long these vital services have been pushed to the sidelines. Their potential has not been realized. And this neglect of these services has caused us all to suffer in one way or another. The most unfortunate victims have been the consumers who need their services."

Throughout the history of mankind, people in need of help during illness and disability have been in their homes for the great proportion of the time. Even today, with our sophisticated development for diagnostic and treatment services in institutions, the great bulk of need still exists outside of these facilities. One has only to consider the prevalence and trend of chronic illness in our society to arrive at one very impressive gauge of this fact. The National Health Interview Survey of 1965 and 1967 found that 85.6 percent of persons over age 65 and living at home had one or more chronic illness conditions; 46 percent of those age 65 and over had varying degrees of limitation of major activity (ability to work, keep house, etc.). In addition, nearly 5 percent were confined to the house.

Our modern preoccupation with the organization, equipping, and financing of institutional care has led us to a disproportionate investment of economic and manpower resources in this area, especially in acute care facilities. One cannot argue that these are not an extremely important and vital part of our health care system, for indeed they are. But we have neglected the adequate development of long-term care institutions and have almost completely ignored the home care field. The reasons for this are well known, and need not be more than mentioned here, but a partial listing would include:

> Technological advancements which require patients to come to a given facility;
>
> Urbanization and transportation facilities bringing people within reach of medical center institutions;
>
> Third-party payment which fosters hospitalization;

Relative ease of gaining contributor and government support for the visible "bricks and mortar" facility and for the dramatic application of medical advancements carried out in hospitals;

Convenience and economical expenditure of time for physicians and other health personnel when patients are institutionalized;

Lack of available family members to provide support services outside of institutions, due to population mobility and the high proportion of women employed outside the home.

Development of long-term care facilities has grown impressively in recent years, but there is considerable evidence that we are using many of them inappropriately. A list of studies on the subject is attached (see Appendix A), but in sum, they show that, in the nursing homes studied, from 20 to 50 percent of patients could have used less costly levels of care.

Rising Costs Initiate Concern

It is significant that the limited, recent concern for fostering "alternatives to institutional care" has been triggered almost exclusively by the alarm over rising costs. Legislative action and support have been aimed at finding less expensive means of providing care, and this is entirely appropriate when the less costly avenues meet the patient's needs. Costs cannot, of course, be condoned as the *only* consideration in providing care at any level. It is extremely important that a continuum of care be available, from the most highly sophisticated to the most simple, and that people have access to each level on a flexible basis according to need and effectiveness.

The home care services are at present so limited in scope and geographic availability as to seriously reduce such service as a viable choice for large numbers of people. Financial and manpower resources must be invested in this area to a much greater degree if people are to be served in the most effective way at a supportable cost level.

Home health services have been characteristically defined as "a complex of health and assistive services required by an individual or a family which may be brought when and as needed into the home to support optimum health and improve or restore functioning, or to enhance life and living."

While there are a variety of organizations and agencies, each of which may offer special pieces of this total complex of services, coordination is often lacking. One individual or family, sophisticated and knowledgeable in the use of agencies, may be receiving a plethora of services while another individual or family may not be able to obtain minimal services. Different eligibility requirements may interfere with an individual's ability to receive necessary services. For instance, an individual may be eligible for visits by a visiting nurse for dressings to a wound, but not for housekeeping assistance. The lack of coverage for housekeeping assistance could mean that this person cannot leave the institutional setting because he or she would be unable to get food or prepared meals.

The insistence by third-party payers, either private insurance carriers or governmental insurance carriers, as well as by many agencies, that no services can be covered or provided unless physician-prescribed may cut off many persons from procuring a service which, while not medically indicated from a disease-oriented standpoint, may be psychologically and socially necessary from a health supportive or disease preventive standpoint. While physicians are expert in the treatment of disease, they are often less expert in the care and assistance individuals may require to enhance or support functioning when it relates to disability. Nurses, physical therapists, and occupational therapists are far more knowledgeable in these areas.

Family relationships are often difficult to assess when interaction takes place outside the home setting. Family members who are quite attentive and helpful while the person is institutionalized may grow weary and even resent the constant responsibility, as well as the confinement or limitations upon their life style because of the presence within the home of a chronically ill or disabled person. Roles and family relationships become disrupted and difficult to cope with in the absence of supportive assistance or counseling. Placement of the "patient" may lead to similar problems as well as a sense of isolation for the "patient."

It is well acknowledged that changes in life style and behavior patterns, or uprooting from a familiar environment, can be a causative factor in disorientation and can lead to aberrant behavior, particularly in the elderly. No matter how

good the institution, certain demands for conformity or standardization will be made upon the individual. To some extent, he must alter his pace and accustomed patterns to fit in with the group or the institutional regimen. Often, the process of institutionalization itself aggravates the problem and reduces ability to function.

Many Could Remain in Home

At least 10–25 percent of the population now in institutional homes of varying kinds could be cared for and remain in their own homes if organized services beyond episodic nursing and medical care were available. Some people are there because they require assistance with their activities of daily living—ranging from complete hygiene and feeding to minimal assistance in getting out of and into bed. Some are there because they do not have the physical reserves to maintain a clean and uncluttered environment. Some are there because they do not have family members to assist them, or because those family members can assist them for only a portion of any given day. Some are there because they require medications or treatments, the response and progress of which must be evaluated on a daily basis. Some are there because they require treatments and medications which must be administered by someone else on a daily or twice-daily basis. Some are there because they need special types of equipment in order to function or to survive.

While individuals may be presumed innocent until proven guilty, home health services are presumed unnecessary until proven essential. In certain instances, third-party payers imply that agencies delivering services are either inept in their ability to valuate need for service or dishonest in their claims. On occasion, the position is taken that, while this service may be necessary, it is not reimbursable or covered under the terms of contract or eligibility criteria. Claims by insurance programs imply to the consumer that, in the event of a health crisis or health need, he will receive full service to the extent of his need; policies and contracts are so worded that they may be interpreted in any manner by the insurance companies. While many of us jokingly refer to contracts or policies as having all benefits in large print and all restrictions in microscopic print, it becomes far from laughable when individuals are faced with the economic crisis which often follows the health or illness crisis. There are some insurance policies which offer "X" number of dollars per week or month to people when they are hospitalized. People subscribe to this insurance, expecting to insure income during a non-earning period. However, should this same individual be confined at home receiving services there, this policy would not apply. In fact, many of these companies will not even cover the period an individual is in an extended care facility for continuing treatment of the illness for which he was hospitalized. Thus, a person might well discover that if he remains in the "acute hospital," he would be covered by his hospital insurance and receive an income, while if he remains at home or leaves the hospital sooner with supportive services in his home, he may have to pay all of his own medical bills and nursing bills with no income to fall back on. Insurance carriers should be required to write policies with such clarity that consumers can readily understand the coverage.

Interestingly enough, those in the middle income group are the most affected by the varying restrictions. Their usual income levels do not qualify them for municipal, state, or federal aid, nor do they afford them sufficient money to pay for the services. The poor are also affected, because the degree of proof that services provided are indeed essential is almost prohibitive.

The concept of individuals going into the home to assist or minister during times of crisis or illness has always been present. Many of these services were delivered free of charge to the needy. They were whimsical, dependent upon the extent to which the recipients were considered deserving and were visible. Today our criteria for the "deserving" would, on the surface, appear less whimsical, but, in fact, they are still capricious.

Individuals or families are deprived of necessary services because of rigid restrictions by Medicare or because of the inability of the providers to correctly interpret and understand the implications of the conditions. One must, in effect, prove that home health services are *necessary and a substitute* for institutionalization and consequently less costly.

For want of a walker, an individual may be chairbound. For want of a skilled therapist, an individual may lose the use of a hand or a leg. For want of an hydraulic lift, or individuals skilled in lifting, a person may be bedbound. For want

of delivery of an oxygen tank and instructions in the use of a mask or inhalator, an individual may remain within the confines of an institution, fearful of leaving. Our production line technological approach has extended to the care of the sick, the elderly, the infirm, and the isolated and lonely. We put them where the services are, rather than bringing the services to them.

Most major hospitals today have a home health or home care coordinator. This person, most frequently becomes involved after admission of an individual to the hospital setting and usually when discharge is being considered. It is rare that one sees a home care coordinator involved in the evaluation of admissions to the hospital or in the outpatient units. Again, this reflects a concept of home health services to the ill as an aftermath of continuation of institutional care, so that our present continuum of care is most likely to be hospital, then home, rather than choice of hospital when care in the home is impossible because of the need for specific services which are not transportable and to which the individual cannot be transported for a brief treatment.

In 1972, the Special Committee on Aging of the United States Senate, in the previously cited report on home health services in the United States, made the following major recommendations:

Medicare and Medicaid regulations must be interpreted and applied so as to provide, rather than restrict, home health services;

Home health planning must be based primarily on the professional judgments of those familiar with consumer needs rather than remote decision-makers far removed from the problems;

Institutionalization as a condition for home health care must be eliminated, as well as requirements for coinsurance payments;

Costly and confusing red tape must be eliminated in providing home health services, including in particular the practices of prior authorization and retroactive denials;

Proposals for national health care legislation must include provision for comprehensive home health services;

A national approach to the provision of adequate coverage of the population by home health services is essential.

In 1973, individuals are still being institutionalized and being maintained in institutions because of lack of adequate home care servces or, where the services do exist, because of inability to pay for them or to have them covered through some form of health insurance.

II. Implications for Action

A. Types of Services Necessary

The quantity, range, and pattern of organization of home health services will depend upon the socioeconomic, cultural, and age characteristics of the population to be served and the types of health and social problems most prevalent in the area. Differing geographic areas (urban, suburban, rural) will also influence the range and patterns of services required.

Basic service components which must be available for effective and high-quality care to individuals in their homes include medical, dental, and nursing care; homemaker-home health aide services; physical, occupational, and speech therapies; social work, nutritional, health education, laboratory, and pharmaceutical services; transportation and medical equipment and supplies.

Regardless of the specific components required in individual situations for safe and effective care, all of the above components—with the possible exception of physical, occupational, and speech therapies—should be available on a seven-day-a-week basis.

Social problems have a direct relationship to the health and well-being of individuals within a society. A complete health service program must foster means and methods to improve the social setting as well as provide direct medical and nursing intervention to deal with the resultant health problems. The following factors must also fall within the purview of organized home health services: patient and family education to enhance compliance with prescribed regimens; provision for adequate and safe housing; assistance with maintaining a clean and nonhazardous environment; nutritional services including home-delivered meals, or shopping, as well as preparation of food; arrangements for individuals to move beyond the immediate confines of their homes to socialize and interact with others, whether it be the sick individual or members of the family who may

not be free unless someone can relieve them; and planning for socialization within the home for the completely homebound, through periodic visits of others.

Central to the organization of high quality patient care services at home must be mechanisms for coordination of the various services and components of care required by individual patient and family situations.

B. Present Effect on Economy

1. Loss of Work.—Empirically, it is known that there are a number of individuals who could work either at home or in an outside work setting if provisions could be made to get work to them, or to get them to work. In addition, concentrated supportive rehabilitative services in the home could assist them to develop sufficient capacity to function productively within the home, and, in many instances, to be able to independently travel to and from a work setting. Money spent in such a program would be returned indirectly through the earning capacity of these people.

Family members who might be capable of earning or working are confined to home because of the prolonged or permanent invalidism of a sick member. In addition, this type of input creates emotional as well as energy drains upon well family members, which often precipitates both physiological and psychological illness increasing the health problem.

2. Use of Institutions at Higher Cost.—There are people who are institutionalized beyond a necessary time due to lack of organized services to meet their particular needs. The following figures represent the difference in cost for home health agencies and institutions of any kind.

MEDICARE REIMBURSEMENT FOR HOME HEALTH SERVICES AND INPATIENT HOSPITALIZATION, 1969–72

[In millions of dollars]

Year	Reimbursements	
	Home health	Hospitalization
1969	79.7	4,088.6
1970	68.7	4,514.7
1971	56.6	5,026.0
1972 [1]	58.5	5,550.6

[1] Estimated on the basis of claims received through Dec. 7, 1972 (1st 6 months multiplied by 2).

Source: Monthly Benefit Statistics, Feb. 15, 1972; No. 1, 1973, DHEW/SSA/Office of Research and Statistics.

1971 Medicare reimbursements

[In thousands of dollars]

Hospital Insurance:	
Inpatient hospital	5,026,025
Home health	40,771
Extended care facility	167,834
Subtotal	5,234,630
Medical Insurance:	
Physicians	1,748,270
Home health	15,824
Outpatient hospital	104,778
Independent laboratory	12,398
All other	75,062
Subtotal	[1] 1,956,423
Total	7,191,053

[1] Includes some reimbursables for which type of service is unknown.

NOTE.—Home health (parts A and B) reimbursements for 1971, total $56,595 (in thousands) or 0.787 percent of the total Medicare reimbursement for services in 1971.

Source: Prepared by Department of Home Health Agencies and Community Health Services, NLN 2-20-73.

III. Recommended Policy

We must approach the problems of the chronically ill, aging, and infirm with the same vigorous leadership that we have demonstrated in the past in dealing with communicable diseases and maternal and child health, for these illnesses are also a part of family health and the public's health.

Therefore, it is recommended that APHA:

1. Endorse the "Home Health Services Definition and Statement" (Appendix B), developed by a task force composed of representatives of outpatient and home care institutions, American Hospital Association; the Council of Home Health agencies and Community Health Services, National League for Nursing; the National Association of Home Health Agencies; and the National Council for Homemaker-Home Health Aide Services.
2. Develop a multi-disciplinary task force to develop guidelines and criteria to further the implementation of Home Health Services.
3. Support liaison with other national organizations involved in delineating and supporting Home Health Services with the goal of strengthening delivery and coordination of services. Advise the federal government of the importance of allocating funds in support of these services based upon the guidelines established by the organizations.
4. Encourage local communities through the Comprehensive Health Planning Agency to study and determine the extent and type of needs peculiar to their area and develop programs to meet these needs.
5. APHA should go on record in support of the inclusion of home care coverage in whatever kind of national health insurance is to be enacted.

APPENDIX A

Reference Material

Based on the data from the Health Interview Survey of the civilian, non-institutional population, the U.S. Department of Health, Education, and Welfare has estimated that the number of individuals with some limitation on activity resulting from chronic conditions has increased from 22.2 million in 1961–63 [1] to 24.8 [2] million in 1971. In both periods these persons represented one out of every eight individuals in this country. It is obvious that the problems resulting from the development of chronic diseases are not easing, since the number of persons affected is increasing at the same rate as the general population.

For three-quarters of those with activity limitation, such limitation pertains to their major activity (working, housekeeping, school attendance). Other types of activity affected are recreational, religious, and civic.

The above figures apply to the non-institutional population. Surveys of resident places conducted by DHEW in cooperation with the Bureau of the Census show a very rapid rise in the number of occupants of such establishments as nursing homes, personal care homes, and homes for the aged. During 1969, an estimated 815,000 [3] persons were residents of nursing and personal care homes compared to 554,000 [4] in 1964 and 505,000 [5] in 1963; 1969 thus represented an increase of 61.4 percent above the level in 1963. This, of course, is a much greater rate of increase than that of the general population. The great majority of the patients (75 percent) were in homes where the primary service was nursing care. An additional 18 percent were in personal care homes with nursing facilities. Less than 7 percent of all residents were in homes where the primary service was personal care only.[6]

APPENDIX B

Definition and Statement

Foreword.—The following definition and position statement on Home Health Services was developed by a task force composed of representatives of the Assembly of Outpatient and Home Care Institutions, American Hospital Association;

---

[1] "Chronic Conditions and Activity Limitations," National Center for Health Statistics, PHS Pub. No. 1000, Series 10, No. 17.
[2] "Current Estimates from the Health Interview Survey," NCHS, PHS Pub. No. 1000, Series 10, No. 79.
[3] "Characteristics of Residents in Nursing and Personal Care Homes: June–August 1969," NCHS, PHS Pub. No. 1000, Series 12, No. 19.
[4] "Prevalency of Chronic Conditions and Impairments Among Residents of Nursing and Personal Care Homes: May–June 1964," NCHS, PHS Pub. No. 1000, Series 12, No. 8.
[5] "Characteristics of Residents in Institutions for the Aged and Chronically Ill; April–June 1963," NCHS, PHS Pub. No. 1000, Series 12, No. 2.
[6] "Inpatient Health Facilities," NCHS, PHS Pub. No. 1000, Series 14, No. 6.

the Council of Home Health Agencies and Community Health Services, National League for Nursing; the National Association of Home Health Agencies; and the National Council for Homemaker-Home Health Aide Services, Inc.

Definition.—Home health service is that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health, or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated and made available by an agency/institution, or a unit of an agency/institution, organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.

These services are provided under a plan of care which includes appropriate service components such as, but not limited to, medical care, dental care, nursing, physical therapy, speech therapy, occupational therapy, social work, nutrition, homemaker-home health aide, transportation, laboratory services, medical equipment and supplies.

Statement on Health Services in the Home.—The home environment plays a significant role in promoting health and facilitating the healing process. Properly coordinated and administered home health care provides a meaningful health service for ill persons, speeds recovery and rehabilitation of individuals with acute or chronic health problems, and assists in the prevention of disease and disability.

The provision of appropriate health care services to patients in their homes benefits the patient, the family, and the community. Therefore, it is imperative that quality health service in the home be a basic component of the health care system.

Home health services can:

1. Contribute to the health and well-being of the patient and his family;
2. Restore the patient to health and/or maximum functioning;
3. Prevent costly and inappropriate admission to institutions;
4. Reduce readmission to institutions; and
5. Enable earlier discharge from hospitals, extended or intermediate care facilities, or nursing homes.

Health services at home must be characterized by:

1. Provision of high quality care to patients;
2. Professional coordination of the various services delivered to the individual patient and family;
3. Evaluative techniques to insure the appropriateness and the quality of care provided; and
4. Appropriate administrative controls.

Levels of care varying in intensity and service components responsive to the individual needs of patients must be available in the home. As patients' needs change, there must be adequate mechanisms for movement of patients within the varying levels of home care, as well as for transfer to other care settings.

The economic realities of the cost of health services to individuals, families, and communities make it imperative that health services at home be included in all present and future health care delivery systems. It, therefore, becomes mandatory that:

1. Present and future funding mechanisms, governmental and non-governmental, adequately finance all levels and service components of home health care on a continuing basis;
2. Availability and accessibility of home health services for all populations be assured;
3. Developmental funds be an integral part of all financing for the expansion of existing services and initiation of new programs.

Senator MUSKIE. Our next and last witness today is Dr. Isadore Rossman of the American Geriatrics Society.

STATEMENT OF DR. ISADORE ROSSMAN, AMERICAN GERIATRICS SOCIETY

Dr. ROSSMAN. Thank you, Mr. Chairman. Instead of referring to my testimony,[1] I will give you a few highlights from it, and some further thoughts.

[1] See p. 1445.

We have had a functioning home care program for about 25 years; we started off with a great deal of idealism, but recently we have despaired over the inability of the American medical structure to take home care unto itself.

The question of whether doctors will make house calls, I think is relevant to a much more basic problem, which is whether you can deliver comprehensive coordinated home care at all. By that, I mean that under Medicare we theoretically should have doctor visits, coordinated with physical and other therapies, which the law specifies. The fact is that in our present manpower position we really cannot deliver anything like this. I think one of the basic problems of proposed legislation is the recruitment difficulties we will encounter after it sets up an agency even with adequate funds.

My experience in New York City has been that it is extremely difficult to get people for these kinds of positions. As a result, because as a home care agency, we found that there was a great deficit in our capacity to deliver needed care. We resorted to a different program which is, we find, adaptable to about half of our home care patients. This is our after care program which is keyed to giving transportation to homebound patients. We bring them in groups, as for example six stroke patients in a special van. We bring them to the hospital, and there, as a group, they are given the physical therapy, the access to a doctor, social worker and nurse, to laboratory services, and so forth. What especially commends this to me, is that many patients who have had experience with both of our programs, both home care and after care, prefer the latter. It is described in the May issue of *Nursing Outlook* and the June issue of *Medical Care*. There we described some of the contrasts between home care and after care, and the fact that on after care one can deliver a quantitatively and qualitatively richer program.

I think there is at present a serious personnel shortage favoring after care. You cannot get doctors to make house calls, whereas you can get that doctor in a central setting to see such sick patients. Home care is a little like trying to deliver something undeliverable, whereas with after care, you are talking about something that is realistic and feasible. I think that the after care program is one possible way to meet some of the accumulated unmet needs.

Patient Comparison

The other point I wanted to make is that in setting up the geriatric day care program, we attempted to have a classification system which would enable us to compare the patients that we are seeing in this day care center with patients not getting day care. This would enable us to compare a control group with the treated group and determine whether day care in a geriatric hospital does prevent institutionalization. The classification system describes five grades of increasing sociomedical disability.

If the patient is homebound and completely dependent—class V—he is in the position of needing a nursing home, but there are many intermediate categories in which we face a rather different situation and need alternative solutions.

For example, I have seen old couples delivered into a nursing home because of a transient deficit in their capacities. This placement is irreversible. To avoid this we must have properly oriented community agencies, especially if they can meet a need which might suddenly arise, such as for a homemaker. I think we might be able to prevent some of this overwhelming trend. In New York City, on our nursing home program, we not infrequently see people admitted from the community as an emergency with no medical documentation and where it is said that the nursing home is mandatory because of some change in their total home situation.

Once they are in the nursing home, as one retrospectively analyzes it, there was solely a need for one or two supplementary services, and institutionalization would have been prevented. To quote the words of one of the former professors on our home care institutes, Dr. Franz Goldman, we have to beware of a hardening of the categories. This means that we must be able to deliver alternatives, and be flexible in our approaches.

As to fiscal aspects, I think that if one wanted to be hardboiled about who would get these extensions of services, one could say, that we will deliver home care services, or other closely related health services, if it can be demonstrated—and it often can be demonstrated—that the alternatives would be more expensive.

It is clear to me, if we can keep somebody at home, by delivering some paramedical care, at a cost which is demonstrably less than sending that person to a nursing home, then we should adopt the point of view that it is prudent fiscal policy to offer these kinds of services.

Thank you.

Senator MUSKIE. Thank you very much. I think you wrapped it up pretty well.

Thank you very much, Dr. Rossman and Dr. Gordon, and the rest of our witnesses.

Your statement, Dr. Rossman, will be made a part of the record.

[The prepared statement of Dr. Rossman follows:]

PREPARED STATEMENT OF ISADORE ROSSMAN, M.D., MEDICAL DIRECTOR, HOME CARE AND EXTENDED SERVICES DEPARTMENT, MONTEFIORE HOSPITAL AND MEDICAL CENTER, NEW YORK, N.Y.

The home care and extended services department of Montefiore Hospital and Medical Center has had more than 25 years of experience in the treatment of the chronically ill patient in and out of the hospital setting. The bulk of the patients have been in the older bracket, and our experience has been wide-ranging: we have cared for more than 2,000 patients on our home care program, using a multidisciplinary team approach; our after care program brings homebound patients to the hospital where they are given a package of individualized treatments in a 3-hour session, and by far the greatest number of our patients, some 1,250 in fact, are in six proprietary nursing homes. We give these nursing home patients all of their necessary medical services on a contract basis with the Medicaid administration of New York City. This uniquely diversified experience has illuminated the many contrasts between institutional settings and the home. In addition, Montefiore partakes in a consortium which sponsors a day hospital on our grounds. The research goal of the day hospital is to determine to what extent it can prevent institutionalization of the many disabled elderly who live around us. At the day hospital, from 9–4 they receive a variety of therapies, medical-nursing supervision, a hot lunch, even in some instances prepared food to take home.

HOME CARE

Our home care program traditionally delivers medical, nursing and social work services to all patients plus physical, speech and occupational therapies as indicated. It has been described in numerous articles as hospital-based, comprehensive, coordinated home care. It is a service gratefully received by patients and their families, indeed to such an extent, that some of these families with the opportunity to move to better housing outside our home care area have refused to do so. There is no time limit on our services, the only criterion being ongoing need and thus some patients have been on the program for years. The accumulated experience here and elsewhere amply demonstrates the patients who have the support of a good home care program have fewer hospitalizations. This is documented in one of our studies which showed a decrease in the number and duration of hospitalization pre- and post-home care status—despite the fact that most chronic illnesses tend to get worse with the passage of time. It is also evident that home care will prevent nursing home placement to a significant degree. In fact, many families given the choice between home care and nursing home care will unhesitatingly select the former with all of the responsibilities it may entail.

A good recent example of this is afforded by a 70-year-old patient of mine with generalized, crippling rheumatoid arthritis who was on our program from 1954 through 1973. Throughout much of this time she received necessary nursing and medical care with an accent on physical therapy, and was weakly but determinedly ambulatory despite her great deformity. About 5 years ago she gradually became limited to bed and bedside chair. Appropriate nursing support and good social services helped her married sister with whom she lived to deliver care in these increasingly difficult circumstances. In May 1965, she was discharged from home care to a chronic disease hospital in New York City but after some 6 less than happy weeks there she insisted on returning home and home care was resumed. For the past 2 years, superimposed on all the foregoing has been the further complications of a tracheotomy the care of which has also been performed by her sister with our instruction. At around this time, because of an economic pinch, our social service arranged to have the brother-in-law's home put on a foster home status which thus paid approximately $150 for her support. Finally, in December 1973, and with great reluctance on everyone's part, she was transferred to one of our nursing homes. This case is illustrative of how home care services which are able to be increasingly adaptive in a deteriorating situation can offer a preferable, continuing, and economically cheaper alternative to the institution.

Unfortunately, on a nationwide basis, examples of this kind of care are comparatively scarce, and instead we often observe nursing home care to be the sole alternative offered distressed families. It has somehow seemed the path of least resistance to put up institutions often offering inadequate services into which we shepherd our unhappy aged because they cannot stay on in hospital and allegedly cannot be cared for at home. In fact, many could be cared for at home with supportive services which are on the border of our present formulations, and for which financing is not readily available—perhaps housekeeping services, help with shopping or food preparation, and ready access to home health aides. Difficulties in securing adequate financing have been, and continue to be, a major obstacle to expansion of home care. Thus, two decades after modern home care programs had been launched and demonstrated their value both to patient and community, I noted that the paradoxical obstacle to the spread of home care was the fact that no agency in the community felt that it was financially feasible or rewarding for it to sponsor comprehensive home care programs. To cite another obstacle, nursing service is a basic on home care. Nonetheless a few years ago a restrictive redefinition of "skilled nursing care" was issued by Medicare authorities in Washington with the consequence that what we had always regarded as a mandatory nursing visit for some of our patients became no longer reimburseable. Thus, one of our stroke patients with a severe paralysis, decubitus ulcer, and a catheter requiring irrigation was said to no longer need skilled nursing care.

AFTER CARE PROGRAM

A further obstacle to the spread of home care has been increasing shortages of skilled personnel. It is a fact that home care programs have encountered increasing difficulty in recruiting physicians, physical therapists, occupational therapists and other key personnel. Proceeding on the premise that if necessary services cannot be delivered to the homebound patient, that patient might be brought to a site where necessary services were available we initiated such a program more than two years ago with an RMP grant. Termed the after care program (ACP) the program brings patients grouped in terms of underlying disorder such as hemiparesis to the hospital. At its present level of operation, six to eight patients are brought in each afternoon in a van suitable for wheelchair transportation. During the course of a three hour stay they receive physical, occupational or recreational therapies, access to the doctor, nurse, and social worker, as well as to other institutional facilities such as the laboratory, X-ray and the like. We find that about half of our home care roster is suitable for the ACP. Of interest is the fact that patients who have had experience with both programs frequently prefer ACP, citing the group aspects and the increased richness of the services as reasons for their preference. From a cost effectiveness point of view, ACP more than rivals home care. Despite the increased cost produced by the round trip transportation, this is more than offset by the advantages of treating patients in a group and the savings in the time of skilled personnel including doctors and other therapists.

GERIATRIC DAY CARE HOSPITAL

From home care to after care to geriatric day care hospital seems like a logical progression. Geriatric day hospitals are well known in Great Britain where their usefulness has been validated. They are addressed to the needs of a large, quite variegated group of older people who have various disabilities and frailties, for which nursing, rehabilitation and occupational therapies may be indicated. Perhaps the largest single category are composed of stroke patients. In England, Dr. Brocklehurst compared those attending a geriatric day hospital with a matched group of nonattenders. He found that 8 percent of admissions to hospital were prevented, 6.7 percent postponed. Earlier discharge from hospital was made possible for 11.8 percent of the day patients. It is apparent that an important function of the geriatric hospital is to close the gap between the disabled geriatric patient and the social and medical environment about him.

The elderly collectively present unique blends of physical illness, frailty, and psychiatric disability, which make conducting activities of daily living difficult and sometimes impossible. A first order approach to conceptualizing this is incorporated in our geriatric day center classification which emphasizes functional abilities. Five general groupings are used:

(1) *Fully capable* in necessary areas.

(2) *Capable but frail:* could use assistance in necessary areas such as shopping.

(3) *Intermittently incapable*—subject to temporary situational crises of moderate acuteness: e.g., cannot shop in bad weather, or have exacerbations of medical disorder such as attacks of arthritis or periods of weakness, dizziness, or mild confusion.

(4) *Incapable in important areas:* e.g., severe impairment of vision, nonambulatory due to amputation, or severely depressed and remaining at home for long periods of time.

(5) *Homebound and dependent*—requiring around-the-clock support: e.g., cannot transfer from bed; incontinent, confused, or in poor contact with environment (OMS); or live alone, have no family or friends, have severe incapability in one or more areas.

Clearly, the extremes present no problem: Group (5) requires nursing home or other institutionalization, group (1) can make it in the home setting. On the whole, however, we have done badly and planned poorly for those in groups (2), (3), and (4). There has been an overwhelming trend towards institutionalizing them in nursing homes or intermediate facilities generally at considerable cost. We have managed to support patients in these categories and their families on

our home care program, sometimes admittedly by exercise of an ad hoc ingenuity which can be primitive. I might cite one of our elderly patients with arteriosclerotic heart disease and a mild organic syndrome on the fourth floor of a walk-up and thus completely homebound. She had no relatives and few, if any, friends but her good fortune was to live close to our hospital. One of our compassionate home care secretaries shopped for her and somehow a difficult and borderline situation was maintained for more than two years. Needless to say, services necessary for keeping the elderly at home and out of institutions should not be erected on such shaky foundations as compassion. I would suggest that an important step forward in keeping the elderly out of institutions would be the organization of such basic services as shopping, homemaking and food preparation, and a more liberal use of home health aides. These could be efficiently utilized if channeled through visiting nurse services or home health agencies.

Other difficulties requiring solution that we have become familiar with on our home care program are the problems of getting a house call for an elderly patient, and the dire need for transportation services. It is increasingly difficult to deliver such a basic transaction as a house call by a physician. Perhaps this great need could be handled by home care programs but only with a vast expansion of medical and perhaps new personnel such as the nurse practitioner. Equally difficult are the problems some patients face in trying to get to a doctor's office or an outpatient clinic. Whether one lives in a walk-up apartment or in an elevator apartment or whether one can afford a taxi may, in a city like New York and doubtless elsewhere, be crucial in determining whether one can get medical care. As matters stand at present it becomes easier to ship the older person off to a nursing home or health related facility than to set up adaptive transportation services, after care programs, or other noninstitutional answers.

Our home care program over the decades has cost about one-tenth the cost of the hospital. Our after care program costs no more than our home care program. But more important than cost effectiveness, is our mandate to meet the needs of the elderly—which are for continued care in out of the institution settings.

Senator MUSKIE. The hearing now stands adjourned.

[Whereupon, the hearing was adjourned at 12:55 p.m.]

APPENDIXES

Appendix 1

REPORT TO THE CONGRESS

Home Health Care Benefits Under Medicare And Medicaid

B-164031(3)

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

JULY 9, 1974

46-547 O - 75 - 5

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

To the President of the Senate and the
Speaker of the House of Representatives

This is our report on home health care benefits under Medicare and Medicaid. Medicare and Medicaid are administered by the Social Security Administration and the Social and Rehabilitation Service, respectively, of the Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Elmer B. Staats

Comptroller General
of the United States

Contents

ABBREVIATIONS

AOA	Administration on Aging
BHI	Bureau of Health Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
MSA	Medical Services Administration
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

HOME HEALTH CARE BENEFITS UNDER MEDICARE AND MEDICAID
Department of Health, Education, and Welfare B-164031(3)

D I G E S T

WHY THE REVIEW WAS MADE

Because of indications that the number of agencies providing home health care was declining thus resulting in cutbacks in such services, GAO reviewed the benefits provided under Medicare and Medicaid.

Further, GAO wanted to see which elements of these benefits might relate to alternatives to institutional care.

Medicare and Medicaid are administered at the Federal level by the Department of Health, Education, and Welfare (HEW).

Home health care is generally defined as health care prescribed by a physician and provided to persons in their own homes.

GAO visited home health agencies in 4 States and sent questionnaries to 11 additional States.

FINDINGS AND CONCLUSIONS

Need for home health care

Home health care, while not a substitute for appropriate institutional care, is generally a less expensive alternative when such care would meet the patient's needs. The Congress and the health field have realized the need for developing alternatives to institutional care. (See p. 8.)

For example, reports prepared for the Senate Special Committee on Aging pointed out that many of the Nation's elderly are unable to carry out their daily activities because of chronic disease and disability.

Another report pointed out that in-home services are a major component of a comprehensive health system and that top national priority must be given to developing comprehensive in-home services for the whole population.

Several studies--focusing on savings realized by early transfer of patients from hospitals to home care programs--have pointed out that such care can be less expensive than institutional care. (See p. 9.)

HEW has also recognized the need for alternatives to institutional care and has funded projects to study this area. (See p. 9.)

Developments under Medicare

Home health coverage under Medicare, administered by the Social Security Administration (SSA), experienced significant difficulties in its early stage.

Although some problems have been alleviated, obstacles continue to diminish its overall effectiveness.

In recent years expenditures under Medicare for home health benefits have been declining--from $115 million in fiscal year 1970 to about $75 million in fiscal year 1973.

During the period 1969 to 1971 the number of home visits and the number of nurses and home health aides on some agency staffs decreased also. GAO noted the following factors in its review of the development of home health benefits under Medicare. (See pp. 12 to 30.)

In the early stage of the Medicare home health benefits program, claims for nonskilled care were paid because services covered under home health had not been clarified by SSA. About 3 years after home health benefits began, SSA, in an attempt to restore statutory integrity of the benefits program, issued guidelines to clarify the coverage. SSA believes that this problem has been alleviated considerably. (See p. 13.)

Medicare coverage is oriented, by law, to the need for skilled care and does not cover nonskilled services. Medicare, therefore, is not able to cover preventive care. (See p. 16.)

Intermediaries have established different guidelines for the periods and the number of home health visits covered for various illnesses. As a result there are disparities in the extent of benefits paid for by intermediaries. (See p. 18.)

Information provided to beneficiaries by SSA on allowable care has not always clearly spelled out limitations of the coverage. Accordingly, beneficiaries, at times, have been confused regarding the coverage and limitations of home health benefits. (See p. 19.)

Physician and hospital involvement is essential to a successful home health care program. Physician involvement, however, has been limited and hospitals have not always encouraged effective use of home health care. (See p. 21.)

A major problem for home health agencies and beneficiaries had been denial of payments after services had been furnished by home health agencies. Although this problem has subsequently been reduced, some agencies still have denial problems.

To further reduce the denial problem, the Social Security Amendments of 1972 provided for, effective January 1, 1973, advance approval for home health care services and the establishment of periods of time during which beneficiaries would be presumed to be eligible to receive home health benefits.

The amendments also included a provision for a waiver of liability for certain types of denials.

Since coverage under the advance approval provision is presumed only for an initial period, the provision probably will not totally eliminate the problem. (See pp. 24 to 27.) SSA has not yet issued regulations to implement this provision.

SSA should increase its efforts to assure more effective and uniform

interpretations of existing regulations and guidelines regarding Medicare home health benefits by intermediaries, home health agencies, and beneficiaries.

In addition, SSA should encourage home health agencies to increase the health field's awareness and support of home health care.

Developments under Medicaid

The Medicaid home health benefits program, administered by the Social and Rehabilitation Service (SRS), allows preventive, skilled, and nonskilled care and thus has a potential to serve as an alternative to institutional care.

This potential, however, has not been fully developed. To do so SRS needs to provide more guidance to the States on

--objectives of the program and

--scope of allowable services.

SRS also should encourage the States to establish adequate payment rates to stimulate greater utilization of home health care. (See pp. 31 to 41.)

GAO found:

--Services covered under the States' programs vary significantly. (See p. 31.)

--Some States have adopted Medicare eligibility criteria for skilled nursing care which are more restrictive than intended by Medicaid. (See p. 32.)

--States' payment rates for home health care have not been adequate. (See p. 38.)

RECOMMENDATIONS

Regarding Medicare, the Secretary of HEW should direct SSA to:

--Increase its effort to assure more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding various coverage requirements for home health services.

--Review screening guidelines used by intermediaries and where significant differences exist in service limitations, explore the feasibility of requiring more uniform screening guidelines.

--Explore methods of further clarifying home health benefits, especially the limits on the duration of benefits in an effort to reduce confusion on the part of beneficiaries.

--Encourage and where considered feasible, assist home health agencies in their efforts to increase the health field's awareness and support of home health care.

--Establish regulations, as authorized by the advance approval provision of the Social Security Amendments of 1972, to specify limited coverage periods, according to medical condition, during which a patient would be presumed to require a covered level of post-hospital home health services.

--Determine whether implementation of the advance approval and waiver of liability provisions is effective in minimizing the problem of denials and, if necessary, advise the Congress that the amendments need modification to correct the problem. (See p. 28.)

Regarding Medicaid, the Secretary of HEW should direct SRS to:

--Impress upon the States that home health care generally is a less expensive alternative to institutional care and because of this, it is intended to be used as such when home health care would meet the patient's needs and reduce costs.

--Clarify for States the specific home health services which are eligible for Federal financial participation and define these services for the States.

--Encourage States to establish payment rates for home health care at a level that will stimulate greater utilization of such care.

--Encourage and assist home health agencies in their efforts to increase the health field's awareness and support of Medicaid home health care benefits as an alternative to institutional care. (See p. 40.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW concurred in GAO's recommendations regarding Medicare and advised GAO that a Health Coordinating Committee was established early in 1974 as a part of SSA's Bureau of Health Insurance (BHI) to make a full-scale review of home health. According to HEW, the Committee will work with SSA in implementing GAO's recommendations.

Further, BHI intends to broadly assess the statutory and administrative dimensions of home health care coverage to make sure its policies and procedures are as supportive as the law permits.

HEW has some reservations on the degree to which SSA can legitimately assist home health agencies to increase the medical profession's awarenesss and support of the home health care program. SSA expressed strong convictions that

--home health agencies themselves must first work toward achieving professional community acceptance and

--efforts undertaken by SSA on behalf of the agencies could be counterproductive to this acceptance. (See pp. 29 and 30.)

HEW concurred also with GAO's recommendations regarding Medicaid. To expand use of home health care, SRS will emphasize importance of careful appraisals of alternatives to institutional care and will look for ways to encourage support of the program by the medical profession.

SRS plans to improve home health benefits through clearer explanations of eligible services and emphasizing to the States the importance of realistic payment rates. These measures and the effects of recently enacted legislation should have favorable results. (See pp. 40 and 41.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report contains information on developments in home health care which have limited its effectiveness. This information should be useful to the Congress in its deliberations on the costs of health care and possible alternatives to institutional care.

CHAPTER 1

INTRODUCTION

The Social Security Amendments of 1965 established two health benefit programs--Medicare and Medicaid. Medicare is a federally defined, uniform package of medical care benefits for most persons age 65 and over. Effective July 1, 1973, the Social Security Amendments of 1972 extended Medicare protection to (1) individuals under age 65 who have been entitled to social security or railroad retirement benefits for at least 24 consecutive months because they were disabled and (2) insured individuals under age 65 who have chronic kidney disease. Medicaid is a Federal-State medical assistance program which allows each State, within certain limits, to define the extent of health care benefits to be provided to the financially and/or medically needy.

MEDICARE

Medicare, administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), provides two forms of insurance protection. One form, Hospital Insurance Benefits for the Aged and Disabled (Part A), covers inpatient hospital services and posthospital care in a skilled nursing facility or in a beneficiary's home (home health care). Part A is financed by social security contributions paid by employers, employees, and self-employed persons. For fiscal years 1967 through 1972, Part A payments amounted to about $27.2 billion--93 percent of which was for inpatient hospital services.

Under Part A, as of January 1, 1974, the beneficiary is responsible for paying $84 for the first 60 days of inpatient hospital services (the deductible) and $21 a day for the 61st through the 90th days during a benefit period (the coinsurance). The beneficiary is responsible for paying $42 a day for the 91st through the 150th days if he elects to use his

60-day lifetime reserve of hospital benefits.[1] Part A benefits pay for all covered services in a skilled nursing facility for the first 20 days after a hospital stay and all but $10.50 a day for up to 80 more days during a benefit period. Part A also pays for all covered services--for as many as 100 home health visits--furnished by a home health agency for up to a year after a hospital stay.

The second form of protection, Supplementary Medical Insurance Benefits for the Aged and Disabled (Part B), covers physicians' services and certain medical and health benefits, including home health care. Part B is a voluntary program, financed by premiums collected from participating beneficiaries matched by Federal funds. Under Part B, beneficiaries are responsible, with certain exceptions, for paying the first $60 for covered medical services each year (the deductible) and 20 percent of allowable charges in excess of $60 (the coinsurance). Medicare pays the remaining 80 percent.

The Social Security Amendments of 1972 eliminated the coinsurance requirement for beneficiaries for home health care effective January 1, 1973. (Prior to these amendments, home health beneficiaries were required to pay the coinsurance amounts.) For fiscal years 1967 through 1972, Part B benefit payments amounted to $9.9 billion, of which about 91 percent was for physicians' services.

MEDICAID

Medicaid--a Federal-State program--is administered at the Federal level by HEW's Social and Rehabilitation Service (SRS), but States are primarily responsible for its operation.

---

[1]Under the hospital insurance portion of Medicare, the benefit structure is built around a spell of illness or benefit period. A benefit period starts when a beneficiary is hospitalized or receives covered services in a skilled nursing facility, and ends when a beneficiary has not been an inpatient in any hospital or institution primarily providing skilled nursing care for 60 consecutive days. There is no limit to the number of benefit periods a beneficiary may have. In addition, the law provides for a lifetime reserve of 60 additional days, which is like a bank account of extra days, which can be drawn upon if more than 90 days in one benefit period is needed. Each lifetime reserve day used permanently reduces the total remaining.

Medicaid authorizes medical care to certain categories of persons entitled to public assistance under the Social Security Act. In addition, States may provide services to persons whose incomes or other financial resources exceed State public assistance standards but are not enough to pay for necessary medical care. The Social Security Act requires that State Medicaid programs provide the following services: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing home services; early and periodic screening, diagnosis, and treatment of those under age 21; family planning services; physician services; and home health care services. States may also provide additional services specified by the act, such as dental services and prescription drugs.

The Federal Government pays from 50 to 81 percent of a State's Medicaid costs depending on a State's per capita income. Federal outlays for Medicaid in fiscal year 1972 were $4.6 billion. The Federal budget for fiscal year 1974 estimates these outlays for fiscal years 1973 and 1974 to be $4.3 and $5.2 billion, respectively.

HOME HEALTH CARE

Home health care is generally defined as health care prescribed by a physician and provided to persons in their own homes. Although home health care benefits are provided under both Medicare and Medicaid, the philosophies, coverages, and administrations differ.

Medicare

The Medicare home health care benefits are, by law, skilled care oriented. They were not designed to provide coverage for care related to help with activities of daily living unless the patient requires skilled nursing care or physical or speech therapy.

Home health services, as defined by 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[1] under the direction of a physician;

--to the extent permitted in regulations, part-time or intermittent services of a home health aide;[2]

--medical supplies (other than drugs and other medications including serums and vaccines), and the use of medical appliances, while under such a plan; and

--in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital.

The Act specifies that these services can be furnished to individuals under the care of a physician, by a home health agency or by others under arrangements with them 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 a place of residence used as such individual's home. Under certain circumstances these services can be provided also on an outpatient basis at a hospital or skilled nursing facility or at a rehabilitation center.

---

[1]Medical social services include such services as are necessary to assist the patient and his family in adjusting to social and emotional conditions related to the patient's health problem.

[2]Home health aide services include, among other things, helping the patient with bathing and care of the mouth, skin, and hair; helping the patient to the bathroom and in and out of bed; helping the patient to take self-administered medications ordered by a physician; and helping the patient exercise.

Home health services covered under Medicare are furnished by home health agencies which must meet specific requirements of the Act to participate in the program. The Act defines a home health agency as a public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services. Medicare regulations state that in addition to skilled nursing services, the home health agency must provide at least one of the following other therapeutic services--physical, speech, or occupational therapy, medical social services, or home health aide services.

To be eligible for coverage for home health care under Medicare a person must be confined to his residence, be under the care of a physician, and need part-time or intermittent skilled nursing service and/or physical or speech therapy. The need for such care must be prescribed by a physician. If these requirements are met, a person is eligible to receive other covered home health services. To qualify for home health care benefits under hospital insurance (Part A of Medicare), a person 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 a condition for which the person received services as a bed patient in the hospital and must be provided within the year following hospitalization or after a covered stay in a skilled nursing home following such hospitalization. Under Part A, a person's coverage is limited to 100 home care visits after the start of one spell of illness and before the beginning of another. A person may qualify for home health care benefits under medical insurance, (Part B of Medicare), without prior hospitalization provided certain conditions are met. In such cases a person is limited to 100 home care visits in any one calendar year.

The Bureau of Health Insurance (BHI) of SSA is responsible for establishing policy, and developing operating guidelines, and in collaboration with the Public Health Service, for prescribing standards for the participation of home health agencies under Medicare. SSA has entered into agreements with public and private organizations and agencies to act as fiscal intermediaries in the administration

of home health care benefits under Part A and Part B.[1] Among other things, these fiscal intermediaries are responsible for (1) making payments for services provided, (2) communicating to home health agencies information or instructions furnished by BHI and serving as a channel of communication between home health agencies and BHI, and (3) assisting home health agencies in establishing and applying safeguards against unnecessary use of services under the program.

From the inception of the program in fiscal year 1967 through fiscal year 1973, Medicare home health care outlays were about $506 million. Outlays are expected to increase after fiscal year 1972 because of improvements in the Medicare program provided by recent legislative changes (Public Law 92-603). Among these are the extension of coverage to disabled persons.

Medicaid

Home health care became a required service under Medicaid effective July 1, 1970. Home health agencies which are qualified to participate in the Medicare home health care benefits program are considered to be qualified for participation in Medicaid. Under Medicaid, States may administer their own programs or may contract with private organizations for assistance in administering their programs. The functions and responsibilities assigned to the contractors--referred to as fiscal agents--vary among the States which use fiscal agents and may include any of those functions and responsibilities assumed by the State in its approved State plan.

Any person eligible for skilled nursing home services, and for whom home health services are prescribed by a physician, is eligible to receive home health care. Medicaid home health services include, but are not limited to, nursing

---

[1]With respect to Medicare, SSA generally enters into agreements with fiscal agents, called intermediaries, to reimburse institutions for Part A benefits. The fiscal agents which reimburse for noninstitutional care under Part B benefits are called carriers, (generally insurance companies). However, under the home health care section of both Part A and Part B, reimbursement is made only by intermediaries for home health care benefits.

services on a part-time or intermittent basis, home health aide services, medical supplies, equipment, and appliances.

The Medicaid home health care benefits differ from Medicare benefits in that they do not require that a person need skilled nursing care or physical or speech therapy. Also, they do not provide for medical social services. In contrast to Medicare Part A, a person does not need prior hospitalization to be eligible for Medicaid home health benefits.

For fiscal years 1972 and 1973 States made expenditures of about $24.9 million and $28.6 million, respectively, for home health benefits under their Medicaid programs. The Federal share was about $13.6 million and $15.7 million, respectively.

CHAPTER 2

HOME HEALTH CARE AS AN ALTERNATIVE TO INSTITUTIONAL CARE

Although home health care is not intended to be a substitute for appropriate institutional care, it offers in some instances a less expensive and/or more effective alternative to institutional care.

NEED FOR ALTERNATIVES TO INSTITUTIONAL CARE

Much attention has been given to the need for developing alternatives to institutional care. Studies prepared for the Senate Special Committee on Aging in 1971 and 1972 pointed out that a large portion of the elderly in the Nation are unable to carry out their daily activities because of chronic disease and disability and that home health services of good quality are an essential component of any system of comprehensive health care.

A July 1973 paper on the current status of home health services in the United States issued as a committee print by the Senate Special Committee on Aging summarized proceedings of a June 1972 Conference on "In-Home Services" and pointed out that these services are a major component of a comprehensive system of health care services and that in the absence of in-home services, no system may be considered either comprehensive or effective. The study also stated that top national priority must be given to developing a system of comprehensive in-home services for the whole population.

In testimony before the Subcommittee on Health for the Elderly, Senate Special Committee on Aging, in July 1973, HEW officials discussed the impact of Federal programs in providing home health care as an alternative to institutionalization. They discussed the need to provide household and incidental non-health services, the restrictiveness of Medicare home health benefits and its effect on Medicaid, and the lack of knowledge by many physicians of the advantages of home health care and the resistance by some to utilize home health care.

Also, other publications have pointed out that the need for home health care is becoming increasingly important in

view of the changing age composition of the population and the proportionate increase in long-term illness and disability.

COST BENEFITS OF HOME HEALTH CARE

Several studies have pointed out that home health care can be considerably less expensive than care in a hospital or skilled nursing facility. These studies have generally focused on the savings realized by early transfer of patients from hospitals to home care programs. A study by the Rochester, New York, Home Care Association showed an estimated reduction of 13,713 patient-days and a savings of $1,055,000 in calendar year 1970 and an estimated reduction of 12,579 days and a savings of $1,068,000 in calendar year 1971 as a result of early release of patients from hospitals to home health programs.

Another study by the Denver Department of Health and Hospitals on the results of its Early Hospital Discharge Program showed that savings of $515,729 in hospital costs for Medicare patients were achieved in calendar year 1970 as a result of early discharge of 292 patients from hospitals to home care programs.

A 1970 report prepared by officials of the Health Services Research Center, Kaiser Foundation Hospitals in Portland, Oregon, described a particular home care project. The project involved home care and extended care, such as that available under Medicare, being provided to a select population of more than 100,000 people under 65 years of age in a comprehensive, prepaid group practice program. The study reviewed the impact of these services on the use of hospital care by the population. The comparative daily costs were $5.26 for home health care, $39.08 for an extended care facility, and $72.62 for a hospital. The study cautioned, however, against applying these cost comparisons to a different medical care system because the Kaiser clinics, which were studied, operate on a concept different from other health care plans.

HEW EFFORTS REGARDING ALTERNATIVES TO INSTITUTIONAL CARE

HEW has recognized the need for alternatives to institutional care and has funded projects to study this area. Most

of these projects were funded by the Public Health Service's Health Services and Mental Health Administration[1] or the Administration on Aging (AOA) of HEW, or jointly by these two agencies. Projects were also funded by the Medical Services Administration (MSA) of SRS.

During 1972 AOA and the Health Services and Mental Health Administration jointly contracted with the Massachusetts Executive Office of Elder Affairs for a 3-year demonstration and evaluation of the cost effectiveness of providing home care in lieu of nursing home care. The research portion of the project was estimated to cost about $700,000, of which an estimated $195,000 was spent in fiscal year 1973.

MSA has developed a series of demonstration project models to test various approaches to providing alternatives to institutional care. The models emphasize formation of a single organizational entity responsible for providing or arranging for the provision of a broad range of services. An AOA official told us that, for fiscal year 1974, AOA is providing total funding for four projects--a "Day Hospital" and three "Day Care Centers"--at a cost of about $907,000. AOA's projected fiscal year 1975 funding for these projects is about $981,000.

In a memorandum dated July 25, 1973, an official of MSA outlined a proposal for eight additional project models to test various alternatives to institutional care. These projects, which were being considered by MSA for funding, were estimated to cost about $1.75 million in fiscal year 1974.

Other HEW grants and contracts cover such areas as the development of a manual for training homemaker services personnel, day care as an alternative to institutional care, integration of a home health program with a neighborhood health center, and a study of alternatives to institutional care.

One project, which was completed in August 1972, was funded by an SRS grant of $100,000 to American University,

---

[1]Effective July 1, 1973, the Health Services and Mental Health Administration was abolished and the responsibility for these projects was assumed by the newly established Health Resources Administration.

Washington, D.C. The purpose of the study was to evaluate alternatives to long-term institutional care. The study identified several problems that must be overcome if greater use is to be made of these alternatives.

Among these were:

--The decision to institutionalize a person is often made because the services needed at home are not available or because patients' families do not know what services are available or how to use them. Assessment of a patient's needs and development of a plan of care, focusing on home care, before the patient is discharged from the hospital could lead to a reduction in the use of institutionalized care.

--Many persons who are aged, disabled or chronically ill do not fit into the existing service structure. Some services such as homemaker services are too expensive for persons of moderate means who do not qualify for welfare.

--Publicity is often lacking in promoting the effective use of noninstitutional care.

--Current incentives encourage institutional care. For any noninstitutional alternatives to be valid, it will be necessary to develop appropriate incentives to encourage their growth and development.

The Social Security Amendments of 1972, enacted in October 1972, authorize the Secretary of HEW, either directly or through grants and contracts, to develop experiments and demonstration projects to determine whether coverage of intermediate care facilities' services, which are designed to provide less intensive care than skilled nursing home care, and homemaker services would provide suitable alternatives to benefits presently provided under Medicare.

As of January 1974 no demonstration projects had been started under this section of the law. However, five proposals were being prepared to solicit bids for demonstration projects.

CHAPTER 3

DEVELOPMENT OF HOME HEALTH CARE BENEFITS UNDER MEDICARE

Home health coverage under Medicare experienced some significant difficulties in its early stage. Although some problems have been alleviated, other obstacles continue to diminish the overall effectiveness of home health care benefits.

During the period covered by our fieldwork, reimbursements to home health agencies, the number of visits to Medicare beneficiaries, and the number of nurses and home health aides on some agency staffs decreased significantly. In fiscal year 1970, the peak year for expenditures for home health benefits under Medicare, SSA expended about $115 million for such benefits. By fiscal year 1973, the amount had decreased to $75 million. Over the same period the number of persons age 65 and over has steadily increased.

We believe that the circumstances that existed at the time of our fieldwork had arisen as a result of the following:

--efforts by SSA to clarify and more strictly enforce limitations on the types of services covered (previously, these had not been so rigidly enforced nor were they as adequately defined);

--statutory limitations of Medicare home health benefits;

--disparities in extent of benefits paid for by intermediaries;

--information provided to beneficiaries can be confusing;

--limited physician and hospital involvement in home health care, and

--financial difficulties experienced by some home health agencies caused, in part, by the denial of payment after services had been provided.

Responses to questionnaires that we sent to selected home health agencies in 11 States, showed that activities under the Medicare home health benefits program had dropped considerably from 1968 to 1971. The table below illustrates this trend.

Summary of Selected Data Obtained From GAO Questionnaires Sent to Various Providers (note a)

Description	Calendar year (note b) 1968	1971	Percentage decline
Reimbursement from Medicare	$12,289,705	$6,486,181	47
Home visits to Medicare patients	619,622	359,050	42
Home health agency staff:			
Nurses	22,642	13,254	41
Home health aides	753	382	49

[a]Questionnaires were sent to 91 home health agencies in 11 States. Data in this table are from the 65 responses we received.

[b]In some cases, the information reported was for a 12-month period but not a calendar year.

SSA officials acknowledged that the Medicare benefits program had been beset by some problems which had a serious impact on some agencies but for the most part these problems had been overcome.

PROBLEMS RESULTING FROM DELAYS IN CLARIFYING SERVICES COVERED

Guidelines for the Medicare home health care benefits program provide that benefits are intended to cover skilled care in the home. Initially, however, considerable confusion existed as to what care was covered, with the

result that noncovered home care was apparently paid for by the intermediaries from inception of the program until about August 1969.

Home health agency representatives informed us that they had submitted and were paid for claims for nonskilled care during this period because home health coverage had not been clarified for them and they did not know precisely what was covered. Officials of several intermediaries told us that prior to August 1969 they had not received sufficient guidance from SSA on which services were covered under home health care and, consequently, they paid claims submitted for noncovered care.

Although SSA had issued various guidelines since the inception of the program, it was not until August 1969--about 3 years after Medicare began--that SSA, in an attempt to restore the statutory integrity of the home health benefits program, issued guidelines to intermediaries to clarify the services covered. The guidelines, issued as Intermediary Letter 395, stated in part:

> "The home health benefits provided under Parts A and B were intended only for those beneficiaries whose conditions do not require the 'around-the-clock' medical and related care provided in hospitals and extended care facilities, but nevertheless, are of such severity that the individuals are under the care of a physician and confined to their homes. Accordingly, payment may not be made for home health services unless the services were required because the individual needed skilled nursing care on an intermittent basis, or physical or speech therapy. The purpose of this letter is to clarify several areas of confusion which have arisen in the application of this statutory requirement. * * * If the physician's plan of treatment does not indicate a need for skilled nursing care or physical or speech therapy but prescribes only the provision of supportive services, such as personal care which are rendered by a home health aide, the patient cannot be considered as meeting the certification requirements and is, therefore, ineligible for home health benefits. Consequently, when an intermediary receives an SSA-1487 (claim form) which shows charges for only, say home health aide visits or

for only medical supplies and appliances, the intermediary should investigate the claim to ascertain whether the physician has certified to the need for skilled nursing services or physical or speech therapy services and made provision for such services, and whether the provision of skilled nursing services represents a needed element in the treatment of the patient's illness or injury."

The guidelines set out in Intermediary Letter 395 resulted in numerous denials of claims and caused considerable concern to home health agencies and patients. Consequently, in May 1971, SSA issued Intermediary Letter 71-10 which dealt with the issue of skilled nursing care and encouraged intermediaries to be more definitive in explaining to providers the reasons for denying claims.

Despite SSA's efforts to clarify its definition of skilled nursing care, home health agencies continued to disagree with the intermediaries concerning the interpretation of SSA guidelines; and claims for care they considered skilled were denied as nonskilled.

Officials of some agencies told us at the time of our fieldwork that the application of the definition of skilled nursing care continued to be a problem in administering the program.

SSA officials readily acknowledged that prior to August 1969 the supervision of intermediary adjudication regarding home health claims was insufficient and that home health claims were submitted for services that were not covered and were allowed by intermediaries in an almost cursory review process.

They stated that they could not take exception to our observation that this was the result, in substantial part, of the failure of BHI to furnish definitive guidelines for adjudicative review in this benefit area. SSA officials now view the period from 1969 through 1971 as an educational process within the home health field and with intermediaries in which both parties had to be made aware that BHI could

not administratively violate its statutory obligation to comply with the law.

STATUTORY LIMITATIONS OF MEDICARE HOME HEALTH BENEFITS

Medicare is oriented, by law, to the need for skilled care and does not cover services considered non-skilled in nature regardless of the patient's needs. Determination as to whether skilled care is required sometimes appears complicated as illustrated in the following example given us by an SSA official:

> --If no one is available to fill the syringes for a blind diabetic who is able to inject himself, Medicare will not pay for having the syringes filled on the basis that this is not a skilled service. On the other hand, if the blind diabetic is unable to inject himself, Medicare will pay for a visit by a nurse to give the injection on the basis that this is a skilled service.

Lack of Medicare coverage in cases such as this could result in institutionalization, at a probable higher cost than that of home health care, since the beneficiary would be unable to receive the needed care at home.

Medicare will pay for part-time, intermittent care--defined as more than one visit. An SSA official, informed us that this reasoning is based on the premise that most persons could afford to pay for one visit.

Preventive care is another area not covered under Medicare law. There are instances when it would be less expensive and more beneficial to the patient if preventive care was covered. For instance, visits made by a nurse to take the vital signs, (temperature, pulse, respiration, and blood pressure) of a patient during a period of stability would not be covered. As pointed out by a home health agency official, the agency can obtain reimbursement for caring for this kind of patient only after he regresses.

For example, if a homebound person had recovered from a heart attack, visits made by home health agency personnel to

monitor temperature, respiration, pulse, and blood pressure would not be covered. Although monitoring of these vital signs is helpful in detecting changes in condition which could lead to another heart attack, the visits are not covered. However, if the patient's condition became worse or if another heart attack occurred, subsequent visits would be covered until the patient's condition again stabilized.

The Director, BHI, pointed out in a statement on home health care under Medicare that:

> "The purpose of this part, (home health services under part A), of the Medicare law is essentially to cover cases in which illness or injury requires one of the three skilled services (skilled nursing care, physical therapy, speech therapy) * * * for proper treatment of the patients at home. This is, of course, a smaller group than the one made up of patients who require only supportive or personal-type care. Obviously, elderly patients often have need for many kinds of home health care which Medicare does not cover. But the cost of covering all levels of care under Medicare would exceed the amount of funds available for the program. There would also be the question of whether this kind of additional coverage should take priority over various other coverages that might be included under Medicare, if additional funds were available."

The Commissioner of SSA stated in a January 1971 report to the Secretary of HEW that,

> "while it is recognized that many people who are not in need of either skilled nursing care or of physical or speech therapy could be maintained in their homes if the services of a home health aide were available to them on a regular basis, thereby preventing their institutionalization, the law does not cover these types of cases nor would any of the legislative proposals which have been under consideration."

Although Medicare does not provide for coverage of homemaker services, the Social Security Amendments of 1972 authorized the Secretary of HEW--either directly or through grants to or contracts with public or nonprofit private agencies,

institutions, and organizations--to develop and engage in experiments and demonstration projects to determine whether homemaker services would provide suitable alternatives to benefits presently provided under Medicare. Homemaker services, generally understood to be assistance with preparing meals, assistance with house work, and errand-running, are provided by local organizations.

DISPARITIES IN EXTENT OF BENEFITS PAID FOR BY INTERMEDIARIES

One of the functions of intermediaries is to assist home health agencies in applying safeguards against unnecessary utilization of services. The screening guidelines established by intermediaries for this purpose vary. Our review of guidelines used by intermediaries indicates that there are disparities in benefits among program beneficiaries.

As of June 30, 1971, 85 intermediaries administered the Medicare program. Most of the home health agencies used those intermediaries. The others submitted their claims directly to SSA.

Generally, intermediaries establish limits, by type of illness, on the number of home care visits that can be made to a person before they question the need for future visits.

The intermediary screens claims to determine whether limits have been exceeded and whether the program covers the service provided.

Screening is generally carried out by clerks, however, some intermediaries employ registered nurses to perform this function. In either case, when medical questions arise in the screening process, claims are referred to the intermediary's medical review section for evaluation and disposition. The medical review section is composed of physicians and registered nurses.

We compared service limits by three intermediaries located in three States for five diagnoses or illnesses. This comparison shown on the following page, illustrates the difference in the duration of care and visit limitations. A

provision in the Social Security Amendments of 1972 may help alleviate the disparities in the extent of benefits paid for by intermediaries. This provision is discussed in further detail on page 25.

Diagnosis or Illness	Intermediary A	Intermediary B	Intermediary C
Post-cataract care	Services for 1 month with unlimited visits.	Services for 1 month; 15 visits allowed.	Services for 1 month; 20 to 30 visits allowed.
Cerebral vascular accident (stroke)	Service for 4 months; unlimited visits for the first month, and 16 visits per month for the next 3 months.	Services for 2 months; 8 visits for the first month and 4 visits for the second month.	Services for 3 months; 8 to 30 visits allowed.
Parkinson's disease	Services for 3 months; 12 visits for the first month and 8 visits per month for the next 2 months.	Services for 3 months; 4 visits for the first month and 2 per month for the second and third months.	Services for 1 month; 4 to 12 visits allowed.
Cancer	Services for 4 months; unlimited visits for terminal cancer; unlimited visits for the first month and 16 visits per month for the second through fourth months for nonterminal cancer.	Services for 4 months; unlimited visits for the first month and 16 visits per month for the next 3 months.	Services for 2 months; 4 to 30 visited allowed.
Hip fracture	Services for first 4 months; unlimited visits for the first 2 months, 12 visits for the third month, and 8 visits for the fourth month.	Services for 4 months; unlimited visits for the first 2 months, 12 visits for the third month, and 8 visits for the fourth month.	Services for 2 months; 8 to 32 visits allowed.

INFORMATION PROVIDED TO BENEFICIARIES CAN BE CONFUSING

Information provided to beneficiaries on allowable home health benefits did not always clearly spell out the limitations of the benefits. Representatives of several home health agencies informed us that beneficiaries were confused regarding the coverage and limitations of Medicare home health care benefits.

"Your Medicare Handbook," a booklet published by SSA and provided to persons when they become eligible for Medicare, outlines the benefits of home health care. Early editions of this booklet did not specifically state the limitations on types of care covered under Medicare. Later editions (after 1971) have been improved.

Although SSA has provided intermediaries criteria for defining skilled nursing care, intermediaries continue to differ in interpreting the definition. Misunderstanding on the part of beneficiaries sometimes results. As one home health agency representative observed--"How can a beneficiary understand a term that the home health agencies and intermediaries do not agree upon?"

The Medicare handbook also states that a condition for home health care eligibility is that a doctor determine that such care is needed. This sometimes leads the patient to believe that if his doctor decides home care is needed it is covered by Medicare, although there are other conditions which must be met.

After each claim has been processed the patient is mailed a form by SSA which shows how many visits he has received and the number of additional visits he can receive during the remainder of the year. Hospital insurance pays for all covered services--for as many as 100 home health visits--furnished by a home health agency for up to a year following a hospital stay. Beneficiaries often assume that they are entitled to all the remaining visits. The number of future visits that will be paid by Medicare, however, is based on (1)a determination that the patient continues to need skilled nursing care or physical or speech therapy and (2) limitations imposed by intermediaries (see p. 19) and not necessarily the remaining visits shown on the record.

Although the form tells the beneficiary that visits shown as still available will not be paid unless all Medicare requirements are met, it also adds that the beneficiary should see the Medicare handbook for a detailed explanation of Medicare requirements. This leads the patient back to the language of the handbook, which has confused some patients.

Home health agency officials told us that confusion arises because the physician recommends home care and the claim form indicates to the beneficiary that he is entitled to receive the remaining visits but the intermediary nevertheless denies reimbursement for the care on the basis that skilled nursing care or physical or speech therapy was not needed.

As a result, beneficiaries may become irate and apprehensive because they have been led to believe they are entitled to additional visits, and their care, although recommended by a physician, is not eligible for payment under Medicare.

LIMITED PHYSICIAN AND HOSPITAL INVOLVEMENT

Physician and hospital involvement is essential to the success of home health care. Physician involvement, however, has been limited and hospitals have not always encouraged the effective use of home health care.

Physicians' involvement

Medicare requires that a physician establish a plan of treatment (1) stating the specific care needed by a patient and (2) certifying that a patient is homebound and requires skilled nursing care or physical or speech therapy on an intermittent basis. The physician is required to recertify periodically that these factors still apply.

To find out about the problems that physicians have encountered in home health care, we talked with physicians and officials of home health agencies in the States we visited. They supplied the following reasons for the physicians' reluctance to participate.

--Some physicians do not have a thorough understanding of Medicare home health benefits. A representative of the California Medical Association stated that little information on home health care is included in medical school programs. Further, some home health agencies have not been forceful in promoting through public relations, home health care.

--Physicians believe there is no incentive for them to refer their patients to home health care because they are not paid for additional work incidental to maintaining patients in home health programs (e.g., preparing treatment plans and recertifications).

--There is a potential for conflict between physicians and intermediaries. Medicare regulations provide intermediaries the authority to assist in applying safeguards against unnecessary utilization of services. Even though a physician prescribes care and certifies that it is needed, a claim based on such care can be denied by the intermediary. Some physicians are concerned because they believe their judgment is being questioned and because they must frequently attempt to explain to their patients why the claim was not paid by Medicare even though the physician might not know why the intermediary denied the claim.

The following example illustrates this situation:

Patient
Age: 71
Diagnosis: Stroke
Treatment: Speech therapy, physical therapy, skilled nursing, and home health aide.

Action by intermediary: Paid for 4 months except for skilled nursing; 5th month only speech therapy paid; 6th month denied because patient had stabilized.

Physician's comments: Appealed to intermediary after receiving concurrence from the county medical society that the care was needed.

Final disposition: Appeal not successful and payment for the care still denied. Agency wrote off approximately $716 for care given the patient that was not allowed by the intermediary.

Physicians practicing in a small town that had recently discontinued its home health care agency, partially because of the lack of physician referrals, cited three reasons for their reluctance to use home health care:

--Convalescent homes in the area are not full, and these homes have pressured the physicians to refer patients to them in lieu of using home health care.

--Families resist home care since it is easier to put an older person in an institution.

--Physicians do not have time to devote to learning about home health care.

Some additional reasons were pointed out in our report to the Congress entitled "Study of Health Facilities Construction Costs" (B-164031(3), Nov. 20, 1972), as follows:

--A physician's method of treatment does not often require an organized home care program.

--Home care is seen as a disrupting influence on the doctor-patient relationship.

--Physicians view home care as primarily a social welfare program.

However, it is possible for a home health agency to obtain the support of physicians. For example, the number of referrals by physicians to a home health agency in Michigan increased 229 percent, from 200 in 1967 to 658 in 1971. The agency director informed us that she had worked with the medical community and agencies that provided related services for over 10 years to obtain support for home health care.

Hospitals' involvement

More cooperation is needed from hospitals to channel persons into home health care programs. In some areas where hospitals have discharge systems, the number of referrals to home health programs is generally sufficient to support the

46-547 O - 75 - 7

program. Responses to our questionnaire from numerous home health agencies stated that a lack of effective discharge planning was a significant problem in home health care. According to the home health agencies, the problem may be that hospital personnel do not understand home health care.

Another barrier to hospitals' referring patients to home health care is the low occupancy rate in some hospitals.

As pointed out in our health facilities construction cost report referred to above, hospital administrators informed us that low occupancy rates in hospitals seriously affect the use of any type of out-patient services. Since physicians and hospitals play key roles in home health care programs, the success of the programs requires their involvement. However, obtaining the support of physicians and hospitals can take a great deal of time.

SSA officials recognized their responsibility to assure that beneficiaries qualifying for home health coverage should not be deprived of such services through any administrative insufficiency but expressed apprehension about any campaign to influence the health field in its health care delivery practices. SSA officials expressed the opinion that home health agencies themselves should play the primary role in encouraging the increase of professional acceptance of home health agencies.

FINANCIAL DIFFICULTIES EXPERIENCED BY HOME HEALTH AGENCIES

Financial problems have caused some home health agencies to limit their patient loads to persons for which they are certain to receive payment for care provided. At the time of our fieldwork there were four primary sources of payment for home health care--Medicare, Medicaid, community funds and grants, and the patient. The problems associated with payment for home health care under Medicaid are discussed in Chapter 4.

Denial of payment for services provided

The denial of payments to home health agencies for services which they have provided to Medicare patients, but which an intermediary subsequently determines not to be

reasonable or necessary (a retroactive denial), developed into a significant problem in the early stages of Medicare. A basic problem which has caused retroactive denials is that, at the time care was provided to Medicare beneficiaries, home health agencies were often not sure whether the care was covered by the program.

Current SSA regulations do not require advance approval of care for payment under Medicare. The Social Security Amendments of 1972, however, authorize that advance approval may be obtained under the Part A Medicare home health care benefits effective January 1, 1973, and that SSA establish periods of time during which beneficiaries would be presumed to be able to receive home health care services. (See p. 26.) However, as of January 1974, SSA had not issued regulations to implement this provision.

Several home health agencies informed us that retroactive denials have caused financial problems for them. Generally, when an intermediary denies a claim for a service provided, the only recourse of home health agencies is to attempt to collect payment for their costs from charitable organizations and/or Medicare beneficiaries. If unsuccessful, the home health agency must absorb the cost. Some Medicare beneficiaries cannot afford to pay for their care, and billing them for the cost of the care frequently causes confusion. Beneficiaries believe that, if a physician has prescribed a plan of treatment for them and they are otherwise eligible for benefits, Medicare will--and should--pay for the care.

Home health agencies often receive funds from charitable organizations, such as the United Fund, to assist in providing services. These organizations, however, do not provide as much financial support to some home health agencies as they did before the Medicare home health benefits program was enacted. Some home health agencies we visited stated that financial support from charitable organizations cannot always be depended upon because of the need for funds by many other worthy causes that they support.

We discussed the issue of retroactive denials with SSA officials. They stated that initially retroactive denials had serious impact on some agencies but the problem of

retroactive denials had been reduced considerably. They stated that these agencies had oriented themselves toward the delivery of noncovered services and encountered some difficulties in redirecting their service orientation toward the delivery of covered care under the new criteria. (See pp. 13 to 16.)

SSA officials provided us statistics that showed that the retroactive denial rate had peaked at 4.9 percent during the second quarter of fiscal year 1971. During fiscal years 1972 and 1973 the denial rate ranged from 1.7 to 2.1 and 1.5 to 1.6 percent, respectively. For the first quarter of fiscal year 1974, the denial rate was 2.1 percent. SSA also stated that the number of claims received and the number of home health agencies now participating in the program are only slightly less than the pre-1970 level.

As previously mentioned, the Social Security Amendments of 1972 provide for advance approval of home health care, under Part A only (hospital insurance), effective January 1, 1973. The advance approval provision authorizes the Secretary of HEW to establish in regulations, according to medical condition, limited coverage periods during which a patient would be presumed to require a specified level of posthospital home health services. Periods would vary depending on the patient's illness and physician's diagnosis.

We believe that the advance approval provision should help to further reduce the denial problem and create greater uniformity among intermediaries in establishing visit limitations. (See p. 18 of this report for a discussion of the lack of uniformity among intermediaries in establishing visit limitations.)

As of February 1974, SSA had not issued regulations to implement the advance approval system. We were not able, therefore, to assess the impact that this provision might have on the program. However, SSA officials said that, in their opinion, advance approval would not solve the entire problem of retroactive denials because coverage of care is presumed only for an initial limited number of visits.

The Social Security Amendments of 1972 also provide for a waiver of liability that will affect retroactive denials. Under this provision a home health agency will be paid for noncovered services under both Parts A and B if it "did not know and could not reasonably have been expected to know that payment would not be made for such items or services." In the past, the home health agency had to absorb the cost of these services if payment was denied because the intermediary believed the services were not reasonable and necessary. As of February 1974, SSA had not issued regulations to implement this provision. SSA officials advised us, however, that interim instructions were issued in March 1973 and cases were being processed under this provison effective with services furnished on or after October 30, 1972.

CONCLUSIONS

There have been some significant difficulties in the full implementation of home health benefits under Medicare. Some of these difficulties are due to SSA's administration of the program, and others relate to securing the support and cooperation of medical service providers, including physicians, hospitals, nursing homes, and home health agencies. The problem of denial of payments after services have been furnished by home health agencies still exists to some degree although the severity of the problem seems to have been alleviated.

Provisions in the Social Security Amendments of 1972 for (1) the Secretary of HEW to establish presumed periods of coverage for home health care under the hospital insurance part of Medicare and (2) payments for services that the home health agencies "did not know and could not reasonably have been expected to know" were not covered should further reduce the denial problem. However, since under the advance approval provision coverage is presumed only for an initial limited number of visits, this provision probably will not totally eliminate the problem.

The provision in the Social Security Amendments of 1972 that the Secretary of HEW provide for and conduct experiments and demonstration homemaker projects may be important in providing workable alternatives to

institutional care. It is therefore important that these projects be established to test the feasibility of providing these services.

The success of the Medicare home health benefits program depends, to a large degree, on involvement by physicians and hospitals because persons are eligible for home health benefits under the program only upon discharge from a hospital (Part A) and on a physician's recommendation (Parts A and B).

RECOMMENDATIONS TO THE SECRETARY, HEW

We recommend that the Secretary of HEW direct SSA to:

--increase its effort to assure more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding the various coverage requirements for home health services.

--review screening guidelines used by intermediaries and where significant differences exist, explore the feasibility of requiring intermediaries to apply more uniform screening guidelines.

--explore methods of further clarifying program benefits, especially the limits on the duration of benefits in an effort to reduce confusion on the part of beneficiaries.

--encourage and where considered feasible, assist home health agencies in their efforts to increase the awareness and support by the health field of home health care.

--establish regulations, as authorized by the advance approval provision of the Social Security Amendments of 1972, to specify limited coverage periods, according to medical condition, during which a patient would be presumed to require a covered level of post hospital home health care services.

--determine whether implementation of the advance approval and waiver of liability provisions is effective in minimizing the problem of denials and, if necessary, advise the Congress that the amendments need modification to correct the problem.

AGENCY COMMENTS

By letter dated June 11, 1974, HEW furnished us with its comments on our findings and recommendations. (See app. I.) HEW concurred in our recommendations and advised us that a Home Health Coordinating Committee was established early in 1974 as a part of SSA's BHI to make a full-scale review of the home health provision under Medicare. The Committee will be soliciting input from all major organizations interested in home health care as well as from home health agencies presently participating in the Medicare program.

According to HEW, BHI intends to broadly assess statutory and administrative dimensions of this area of coverage to make sure that its policies and procedures are as supportive of home health care as the law permits.

Actions planned by SSA and its Committee are as follows:

--To assure more effective and uniform interpretation of instructions regarding coverage requirements, the Committee will review all issuances for needed clarification or added emphasis. It will also identify, through various reviews, those intermediaries and home health agencies appearing to need additional training in the coverage requirements of the home health benefit.

--The Committee will review the screens or parameters now used by intermediaries for their consistency with program guidelines and the characteristics of medical practice in intermediary service areas. Where they are found to be out of line, SSA will seek to have them corrected.

--SSA plans to (1) expand the explanation of program benefits and limitations section in its forthcoming revision of "Your Medicare Handbook," which will be sent

to each beneficiary, and (2) review all other informational materials and expand or clarify them where needed. Also, the Committee will make a special study to determine the need for additional communication material for beneficiaries and for those who act in an advisory or assistive capacity to beneficiaries.

--The Committee will explore the extent to which SSA can assist home health agencies in their efforts to increase the medical profession's awareness and support of the home health care program. There appear to be some reservations, however, on the degree to which SSA can legitimately pursue the matter. SSA expressed strong convictions (1) that home health agencies themselves must first work toward achieving professional community acceptance and (2) efforts undertaken by SSA on behalf of the agencies could be counterproductive to this acceptance.

--SSA expects to issue regulations soon to implement the advance approval provision of the Social Security Amendments of 1972. After the amendments have been in operation for a while, the Committee will analyze the effectiveness of the advance approval and waiver of liability provisions. In March 1973 SSA issued interim instructions to implement the waiver of liability provision.

These plans for the most part, if effectively carried out, should substantially improve the home health benefits program. The matter of professional community acceptance obviously will require time and careful application of SSA assistance.

CHAPTER 4

DEVELOPMENT OF HOME HEALTH CARE BENEFITS UNDER MEDICAID

Because the Medicaid home health care benefits program allows States to provide preventive, skilled, and nonskilled care, it has the potential to serve as an alternative to institutional care in participating States. However, this potential has not been fully developed because SRS needs to provide more guidance to the States.

In our review of Medicaid home health benefits we found that:

--Services covered under the States' programs vary significantly.

--Some States have adopted Medicare eligibility criteria regarding the need for skilled nursing care which are more restrictive than Medicaid intended.

--States' payment rates for home health care have not been adequate.

COVERED SERVICES VARY

Under the Social Security Act, States are required to provide home health services to eligible persons who are entitled to skilled nursing home care under Medicaid. HEW regulations provide that home health services may be any of the following.

--Intermittent or part-time nursing services furnished by a home health agency.

--Intermittent or part-time nursing services of a professional registered nurse or a licensed practical nurse under direction of the patient's physician,

when a home health agency is not available to provide nursing services.

--Medical supplies, equipment, and appliances.

--Services of home health aides when provided by a home health agency.

Range of services provided

The four States we visited were providing significantly different ranges of home health care services and had different interpretations of the objectives of home health. (See p. 37 for a discussion of States' interpretations of the objectives of home health benefits.)

Under Florida's Medicaid program, home health care consists of paying for unlimited nursing and home health aide visits for persons under age 65. However, Medicare beneficiaries, also entitled to Medicaid, age 65 and over, eligible for home health care, receive such services under Medicare (Part B) rather than Medicaid. This is accomplished by the State's "buying in" these persons in the Part B Medicare program.

The buy-in program, established by section 1843 of the Social Security Act, provides that States may enroll eligible welfare recipients in the Medicare program. Buy-in involves the State's Medicaid program paying the Medicare beneficiary's share of monthly premiums, and, in some cases the deductible, and coinsurance costs under Part B. Buy-in, however, was not established as a substitute for Medicaid.

The manner in which Florida administers its program is contrary to Medicaid regulations which provide that:

"A State plan for medical assistance under Title XIX of the Social Security Act must: * * * provide that the medical and remedial care and services made available to a group (i.e. either the

> categorically needy or the medically needy[1]) will be equal in amount, duration, and scope for all individuals within the group * * *."

Massachusetts allows extensive care to be provided under its home health care program. State Medicaid officials informed us that the program paid for a wide range of home health services. We were not able, however, to determine the extent of services provided because Massachusetts requires its health agencies to submit only summary information on the claims submitted, claims paid, or services provided to home health beneficiaries.

Since May 1972 Massachusetts has required advance approval by a State-employed physician for all home care beyond the first 60 days. The first 60 days of care without advance approval were to be paid for on the basis of a recommendation of a patient's physician. The State's guidelines allow payment for skilled nursing care; home health aide services; physical, speech, and occupational therapy; and medical-social services.

Michigan considers its Medicaid home health benefits to be similar to Medicare home health care benefits in that to be eligible a person must need part-time or intermittent skilled nursing care or regular physical therapy. The services covered by Michigan's program are skilled nursing care, home health aide services, physical therapy, oxygen administration, and patient evaluation visits by registered nurses. The Michigan position for home health benefits coverage was stated in its guidelines to home health agencies as follows:

> "The home health benefits provided under Medicaid were intended only for those beneficiaries whose conditions do not require around-the-clock medical and related care provided in hospitals and extended care facilities, but, nevertheless, are

---

[1]Categorically needy are persons receiving financial assistance under Titles IV and XVI of the Social Security Act. Medically needy are persons whose income or other financial resources equal or exceed standards set by States to qualify for public assistance programs but are not sufficient to meet the costs of necessary medical care.

> of such severity that the individuals are under the care of a physician and confined to their homes. Accordingly, home health benefits are covered only where a physician certifies to medical necessity of skilled nursing care on an intermittent basis, or physical therapy on a regular basis to a homebound patient."

We believe that the Michigan standards of providing home health benefits only to people who need skilled nursing care or physical therapy, impose a restriction on the Medicaid home health care benefits not intended by SRS under the regulations.

The Code of Federal Regulations pertaining to services and payment in Medical Assistance Programs state, under 45 CFR 249.10(a)(4) that:

> "A State plan for medical assistance under Title XIX of the Social Security Act must * * * provide for the inclusion of home health services for any eligible individual who, under the plan, is entitled to skilled nursing home services * * *."

Under its home health care benefits, California requires advance approval for home visits and pays for skilled nursing care; home health aide services; medical social services; and physical, speech, and occupational therapy.

The range of services provided under the States' home health care benefits--from Michigan's restricted services to Massachusetts' extensive services--points out the need for SRS guidance to achieve greater uniformity among the States' programs by specifying required and optional services.

Eligibility for home health care

Home health services were an optional service under Medicaid until the 1967 amendments to the Social Security Act made home health services mandatory for all persons eligible for skilled nursing home care.

Near the end of calendar year 1972, SRS conducted a survey, using a checklist approach on a State-by-State basis to determine compliance, strengths, and weaknesses in the

Medicaid home health benefits and the need for additional assistance to the States by HEW's 10 regional office staffs. The survey was completed in mid-January 1973.

The survey showed that the single greatest problem limiting home health care benefits was the States' interpretations of eligibility for home health services. An agency participating in Medicaid must also be certified by Medicare or be qualified to be certified. Some States have interpreted this to mean that the services are limited to those individuals needing admission to or discharge from a skilled nursing home.

Medicaid regulations provide no such limit and are, in effect, available to all persons eligible for skilled nursing home services under Medicaid. There is no requirement that only skilled services be provided. The SRS staff reviewers noted the following problems repeatedly.

--State legislatures' low priorities for funding provided no incentive to expand home health services.

--Reimbursement rates were so unrealistically low that home health agencies could not meet their financial obligations and many were going out of business.

--Retroactive denials of payment had prevented agencies from publicizing their services as they were uncertain that payment would be allowed.

--Only one or two home health agencies planned hospital discharge because there was no organized effort to consider home health as an alternative to institutional care.

--Physicians were accustomed to practice in institutions and they either actively resisted using home health services or were unaware of such services. Where public agencies provided the service, there was greater resistance, by physicians, than in those areas where voluntary or proprietary agencies operated.

--Communications were poor between the single State agency and the home health agencies in many States.

--Where the single State agency chose not to use the services of individual licensed nurses, the program was limited to urban areas.

--There were no clear mandates as to the amount, duration, and scope of home health services under Medicaid, and State tended to go the route of least expense.

SRS found at least 15 States limiting home health services to skilled care only.

In February 1973 SRS issued a policy information memorandum which stated:

"There seems to be some misunderstanding about 'entitlement for home health service.' Some States have limited the services to those who are potential admissions to skilled nursing homes or to patients being discharged from such facilities. The narrow interpretation given by some States to the title XIX home health regulation has denied home health services to some persons who are eligible and in need of such services.

"The law (P.L.90-248 subsection 224(c)(ii)) states that home health services must be available 'to any individual who is entitled to skilled nursing home services.' Any person who is eligible for Medicaid and is 21 years of age is automatically eligible for home health services if the care is ordered by his physician, whether or not he may need admission to a nursing home. If the State plan provides skilled nursing home services for individuals under age 21, they too are automatically eligible for home health services. In contradistinction to Medicare, title XIX has no requirement that these be 'skilled' services; i.e., reimbursement may be made for services that are less than skilled. For example, home health aide services or medical supplies and equipment can be provided without requiring that another skilled service be needed by the patient.

"States which have adopted an eligibility definition not in conformity with the above

description should be advised of the appropriate scope of the program and requested to either submit a plan amendment or revise operating procedures in order to bring their home health care program in conformity with the title XIX statute and implementing regulations."

Some States, like Michigan, have adopted the Medicare requirement of a need for skilled nursing care or physical therapy as an eligibility prerequisite for Medicaid home health benefits. These States are therefore applying more restrictive eligibility requirements for Medicaid benefits than the program intended.

The policy information memorandum should help to clarify this situation.

STATES' VIEWS OF HOME HEALTH AS AN ALTERNATIVE TO INSTITUTIONAL CARE

Although Medicaid home health benefits are intended to offer an alternative to institutional care, some States have not administered them as such because SRS has not conveyed the benefit program's intent to the States.

In August 1967 the Chairman, Subcommittee on Long-Term Care, Senate Special Committee on Aging, in hearings on the Social Security Amendments of 1967, explained that the rationale for making home health care a required service under Medicaid was that it would provide a major alternative to institutionalization for persons with minimal health needs. In November 1967, the Senate Finance Committee in its report on the Social Security Amendments of 1967, stated that home health services are needed under Medicaid to insure the availability of a more economic alternative to skilled nursing home and hospital care. SRS, which is responsible for establishing policy and developing operating guidelines for the Medicaid home health care benefits program, also views the program capable of serving as an alternative to institutional care.

Michigan Medicaid officials agreed that home health care is one alterntive to institutional care. Florida Medicaid officials stated that, though they have not implemented home health care as an alternative to institutionalization because of inadequate funding, they have always viewed it

philosophically as an alternative. State Medicaid officials in California agreed that the program was not operating as an alternative at the time of our fieldwork but said they intended to pursue the idea of using home health care as an alternative to institutional care. Massachusetts Medicaid officials viewed home health care as an alternative to institutional care and appeared to be developing means to attain this objective.

ENCOURAGEMENT NEEDED FOR STATES TO INCREASE PAYMENT RATES TO STIMULATE GREATER UTILIZATION

Title XIX of the Social Security Act, as amended, provides that reasonable costs be paid for inpatient hospital services, subject to Medicare limits, and that effective July 1, 1976, reimbursement of skilled nursing homes and intermediate care facilities be on a reasonable cost-related basis. Other providers of Medicaid services may be reimbursed at a rate which may be less than reasonable costs. States' payment rates for home health services differ significantly and some States have established extremely low rates which have had an adverse financial impact on the program. SRS has not provided States enough guidance on establishing payment rates to encourage greater utilization of home health care.

SRS regulations relating to payment for medical services under Medicaid, including home health care services, require States to establish fee structures which are designed to enlist participation of a sufficient number of providers of services so that medical care and services are available to eligible persons to the same extent that they are available to the general public. Regarding home health care the regulations provide that payments be limited to customary charges that are reasonable for comparable service considering the standards and principles for computing reimbursement to home health agencies under Part B of the Medicare program.

However, for skilled nursing care, Medicaid payments are considerably below Medicare payments in some States. In California, for example, home health agencies that responded to our questionnaire received an average payment per visit of $19.51 under Medicare for providing skilled care, but for

providing the same service under Medicaid agencies received a flat rate of $13.13. In Florida, the average payment was $8.68 under Medicare and $5 under Medicaid.

Payment rates in Florida and California for home health care are established by the respective State agencies on the basis of a flat fee per service and are paid to home health agencies statewide. The Massachusetts Rate Setting Commission establishes payment rates in Massachusetts; in Michigan and five other States, home health agencies are paid on a reasonable cost basis using the same standards and principles established for Medicare.

Florida spent about $51,000 during fiscal year 1972 to provide home health care under Medicaid. State Medicaid officials acknowledged that their payment rates were low but informed us that the State could not afford to pay higher rates. Home health agencies in Florida, responding to our questionnaire, reported costs of providing skilled nursing care ranging from $9.15 to $14.17 per visit and the costs of home health aide services from $6 to $7.98 per visit. In California, home health agencies reported costs of $12 to $31 for a skilled nursing visit in the home and $6.50 to $20 for the hourly services of home health aides.

CONCLUSIONS

Medicaid home health benefits have the potential for becoming an effective alternative to institutional care when home health care would meet the patient's needs. To fully realize this potential, however, SRS needs to provide more guidance on (1) the objectives of the program, and (2) the scope of allowable home health care services. Also, SRS should encourage the States to establish adequate payment rates to stimulate greater utilization of home health care.

This additional guidance is needed to overcome the States' differing interpretations of the program's objectives; their confusion concerning the scope of allowable services; and problems associated with low payment rates that result in home health agencies being reimbursed at less than their cost of providing the services.

RECOMMENDATIONS TO THE SECRETARY, HEW

To improve the administration of the Medicaid home health care benefits program, the Secretary should direct SRS to:

--Impress upon the States that home health care is generally a less expensive alternative to institutional care and is therefore intended to be used when home health care would meet the patient's needs and reduce costs.

--Clarify for the States the specific home health services which are eligible for Federal financial participation and define these services.

--Encourage the States to establish payment rates for home health care at a level that will stimulate greater utilization of home health care.

--Encourage and assist home health agencies in their efforts to increase the awareness and support of the health field regarding Medicaid home health care benefits as an alternative to institutional care.

AGENCY COMMENTS

In a letter to us dated June 11, 1974, HEW concurred in our recommendations and said that the following actions would be taken.

--SRS will emphasize to the States the importance of careful appraisals of alternatives to institutional care and the use of home health care whenever indicated. In this respect HEW observed that the Social Security Amendments of 1972 tightened requirements for the admission of patients to skilled nursing facilities and, as a result, the demand for home health services should increase.

--SRS plans to revise Medicaid home health regulations to include more definitive requirements that will aid in assuring uniformity and preventing misinterpretation as to which services are eligible for Federal financial participation.

--Although SRS does not have the authority to require States to adopt a certain level of payment for home health care, it will emphasize to them the importance of realistic payment rates as a means of encouraging more frequent use of home health care services.

--SRS will look for steps it can take to encourage support of home health care by the medical profession. At the same time, it believes that significant improvement in physician awareness and support of home health care will be derived from recent legislative action. The Social Security Amendments of 1972 require that, in prescribing institutional care, the physician certify that this represents the best means of treatment for his patient. SRS believes that in making such certifications physicians will have to become more aware of and know more about available home health services. In addition, physicians should become increasingly aware of the benefits of home health because of provisions in the Health Maintenance Organization Act of 1973 which requires participating health maintenance organizations to make home health services available to their members.

We agree that the recently enacted legislative provisions and SRS' plans for further involvement should increase the awareness of and the use of home health services. The administrative actions, which SRS is taking and plans to take, should also prove beneficial to participants and strengthen the program in general.

CHAPTER 5

SCOPE OF REVIEW

The objectives of our review of Medicare and Medicaid home health care benefits programs were basically to determine (1) whether home care, as currently being implemented, has the potential to be a workable alternative to institutional care when medically feasible, and (2) if not, what improvements are needed. To accomplish these objectives we:

--reviewed the legislative history of the home health care benefits programs under Medicare and Medicaid,

--examined HEW's policies and procedures for administering these benefit programs, and

--examined the policies, procedures, and practices followed by selected States, fiscal intermediaries, fiscal agents, and home health agencies in administering the programs.

We visited California, Florida, Massachusetts, and Michigan to obtain detailed information on Medicare and Medicaid home health care benefits. These States were selected because they were geographically distributed in four HEW regions and had substantial combined Medicare and Medicaid expenditures. Written comments on our findings were obtained from these States and were considered in preparing this report.

Also, we sent questionnaires on the Medicare and Medicaid home health care benefits to 11 other States--Connecticut, Illinois, Louisiana, Minnesota, Missouri, New York, Ohio, Oregon, Pennsylvania, Texas, and Wisconsin. We received 65 responses to the 91 questionnaires sent to home health agencies in these States.

In all 15 States, we obtained information from State agencies administering Medicaid, fiscal agents, fiscal intermediaries, and home health agencies.

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUN 11 1974

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary has asked that I respond to your letter of March 14, 1974, in which you requested our comments on your draft report entitled "Development of Home Health Care Benefits Under Medicare and Medicaid." Our comments are enclosed.

We appreciate the opportunity to comment upon your report before it is released in final form.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX I

COMMENTS ON GAO'S DRAFT REPORT ON "DEVELOPMENT OF THE MEDICARE AND MEDICAID HOME HEALTH CARE PROGRAMS"

We have carefully reviewed this GAO draft report and concur in its recommendations. In our opinion, the report presents a generally fair and objective appraisal of Medicare and Medicaid coverage in the home health care area. It discu[illegible] in appropriate perspective, both administrative problems and ac[illegible]shments in effectuating the home health care benefit within [illegible] statutory limitations under which we have to operate.

The measures that we have taken or are taking to implement GAO's recommendations are summarized below.

MEDICARE

Earlier this year SSA established a Home Health Coordinating Committee in the Bureau of Health Insurance to make a full-scale review of the home health provision under Medicare. As part of the review, they will be soliciting input from all major organizations interested in home health care as well as from the home health agencies presently participating in the Medicare program. In short, the Bureau of Health Insurance intends to broadly reassess the statutory and administrative dimensions of this area of coverage to make sure that its policies and procedures are as supporative of home health care as the law permits. The following recommendations and comments relate specifically to the Medicare program.

> Recommendation: That SSA increase its effort to assure more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding the various coverage requirements for home health services.

We concur. The Home Health Services Coordinating Committee will review all substantive and procedural issuances relating to home health services for areas of potential clarification or further emphasis and will identify, through reviews of adjudicative results, those intermediaries and home health agencies who appear to need additional training in the coverage requirements of the home health benefit.

> Recommendation: That SSA review screening guidelines used by intermediaries and, where significant differences exist in service limitations, explore the possibility of requiring intermediaries to apply more uniform screening guidelines.

We concur. The Committee will review the screens or parameters now used by the intermediaries and will determine whether they are consistent with program guidelines and with the characteristics of medical practice in the various intermediary services areas. Where they are found to be out-of-line, SSA will take appropriate steps to have them corrected.

Recommendation: That SSA explore the possibility of further clarifying program benefits, especially the limits on the duration of benefits in an effort to reduce confusion on the part of beneficiaries.

We concur. SSA will expand the explanation of home health benefits in the forthcoming revision of "Your Medicare Handbook" which we plan to send to each Medicare beneficiary in August or September of this year. At the same time, SSA will review all other informational issuances and will expand or clarify them where needed. Also, the Home Health Services Coordinating Committee will make a special study to determine the need for additional communication vehicles to better reach beneficiaries and other groups within the general and professional public who act in an advisory or assistive capacity to beneficiaries.

Recommendation: That SSA encourage and, where considered feasible, assist home health agencies in their efforts to increase the medical profession's awareness and support of the home health care program.

We concur. The Committee will explore the extent to which this kind of assistance can be rendered by the Medicare program. The degree to which this effort would be legitimate on Medicare's part will have to be studied since it is SSA's strong conviction, first, that home health agencies themselves must work toward achieving professional community acceptance and, second, that efforts undertaken by SSA or the Medicare program on the agencies' behalf could be counterproductive to this acceptance.

Recommendation: That SSA establish regulations, as authorized by the advance approval provision of the Social Security Amendments of 1972, to specify limited coverage periods, according to medical condition, during which a patient would be presumed to require a covered level of post hospital home health care services.

We concur. As a matter of fact, SSA expects that these regulations will be ready for issuance under the Notice of Proposed Rulemaking procedures in the very near future.

Recommendation: That SSA determine whether implementation of the advance approval and waiver of liability provisions is effective in minimizing the problem of denials and, if necessary, advise the Congress that the amendments need modification to correct the problem.

APPENDIX I

We concur. The Home Health Services Coordinating Committee will, after the amendments have been in operation for a period of time, make an analysis of the effectiveness of the advance approval and waiver of liability provisions. Depending on the outcome, SSA will take whatever follow-up steps may be appropriate.

MEDICAID

The following recommendations and comments relate specifically to the Medicaid program.

> Recommendation: That SRS impress upon the States that the home health care program generally is a less expensive alternative to institutional care and, because of this, it is intended to be used as such when home health care would meet the patient's needs and reduce program costs.

We concur. The Social Security Amendments of 1972 tighten requirements for the admission of patients to skilled nursing facilities and, as a result, the demand for home health services should increase as more careful appraisals are made of alternatives to both skilled nursing and intermediate care facility services. SRS will emphasize to the States' the importance of careful appraisals of alternatives to institutional care, and the use of home health care whenever indicated.

> Recommendation: That SRS clarify for the States the specific home health services which are eligible for Federal financial participation and define these services for the States.

We concur. SRS plans, in revising Medicaid home health regulations, to include more definitive requirements that will aid in assuring uniformity and preventing misinterpretation.

> Recommendation: That SRS clarify for the States the fact that their payment rates for home health care should be established at a level that will encourage utilization of the home health care program.

We concur. While we do not have the authority to require States to adopt a certain level of payment for home health care, SRS will emphasize to them the importance of realistic payment rates as a means of encouraging more frequent use of home health care services.

> Recommendation: That SRS encourage and assist home health agencies in their efforts to increase the medical professions

awareness and support of the Medicaid home health care program as an alternative to instituional care.

We concur. In responding above to GAO's first recommendation relating to Medicaid, we mentioned the Social Security Amendments of 1972. These Amendments also require that, in prescribing institutional care, the physician must certify that this represents the best means of treatment for his patient. SRS believes that physicians, in making these certifications, will have to become more and more aware of, and knowledgeable about, the home health services that are available. In addition, the Health Maintenance Organization Act of 1973 requires participating HMO's to make home health service available to their members. So that, here again, physicians should become increasingly aware of the benefits of home health care. While we believe that the implementation of these legislative provisions should lead to significant improvement in physician awareness and support of home health care, SRS will look for steps that it could take to further encourage such support.

APPENDIX II

PRINCIPAL HEW OFFICIALS

RESPONSIBLE FOR ADMINISTERING

ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Caspar W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ASSISTANT SECRETARY FOR HEALTH:		
Dr. Charles C. Edwards	Apr. 1973	Present
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
James S. Dwight, Jr.	June 1973	Present
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Dr. Keith Weikel (acting)	July 1974	Present
Howard N. Newman	Feb. 1970	June 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Aug. 1969
COMMISSIONER, SOCIAL SECURITY ADMINISTRATION:		
James B. Cardwell	Sept. 1973	Present
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973
DIRECTOR, BUREAU OF HEALTH INSURANCE:		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967

APPENDIX 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM JEOFFRY GORDON,[1] M.D., M.P.H., AMERICAN PUBLIC HEALTH ASSOCIATION; TO SENATOR EDMUND S. MUSKIE, DATED AUGUST 1, 1974

DEAR SENATOR MUSKIE: In fulfillment of the request by you and your staff, the following are some additional thoughts concerning home health care. Let me iterate, on behalf of APHA, our encouragement for the excellent and valuable work you and your subcommittee are doing in this important area.

I want to take this opportunity to emphasize again the restrictive nature of current Medicare and Medicaid legislation and regulations regarding reimbursement to patients for home health services. The current philosophy, especially in Medicaid, supports only those services for patients who have rehabilitative potential. This omits reimbursement for services to many patients who, while not rehabilitatible, need the services in order to avoid institutionalization, to give them support during terminal illness, or to maintain a level of disability which continues to allow independent living. Services of this nature may be more difficult to justify on a technical review according to the needs of the patient but are, nevertheless, an important component of health services for the disabled and the elderly. If the concept was to create a health care system which provided health services of an appropriate and effective nature, then it is very appropriate that the full spectrum of home health services be made available according to the health needs of the patient without other artificial restrictions, and they should be fully reimbursable. In regard to realistic controls, the continuing requirements for coordinated patient care plans, the dialogue between the physicians and other providers of home health services, as well as the development of further utilization review activities such as professional standards review organizations, should be sufficient to prevent inappropriate utilization. Also, the limitation of the number of home health care visits to 100 per year is, in this context, also arbitrary, and even if it were extended to 200 visits per year on the basis of physical necessity, it is difficult to accept that it would be better to return a patient in excess of 200 visits to an institution rather than to continue less costs home care. A good example of a circumstance where this might occur involves cases of terminal illness where maintenance in the home is possible with home health services but, should they be discontinued, the patient would either deteriorate and thus require rehospitalization or would have to be transferred to a nursing home. Thus, home health services represent a more fiscally responsible approach to delivering care to the chronically ill, whether or not they are rehabilitatible.

I would also like to expand upon my thoughts regarding the relationship of physicians to utilization of home health services. It is certainly appropriate for the quality care of the patient, as well as for the coordination of the many medical services available, for home health services to be under the control of physician authorization. However, I would argue that authorization prior to the first visit necessarily promotes appropriate utilization. Visiting nurses or other home health personnel often uncover basic medical needs in patients who are not currently under the supervision of a physician, and there should be latitude to allow an evaluating nurse to make decisions regarding the need for home health services in order to quicken and facilitate the initiation of reimbursable home care. This kind of outreach supplements the supply of physicians in reach-

[1] See statement, p. 1430.

ing larger numbers of people and, in addition, may assist in reaching many patients whose physicians are unaware of the benefits of home health services. It is fully appropriate, then, that this first visit be made reimbursable without a physician's prior authorization. Within this context, it has been much to my surprise, and chagrin, to find, within the medical community, a great lack of knowledge as to the skills and competency of not only nurses but physical, respiratory, and occupational therapists, social workers and homemakers in providing support services for both the rehabilitation and general care of people with chronic illness.

Physicians, I think, suffer as a result of the fact that they are generally trained in schools separate from other health professions and do not learn to work as part of a health care team. Rather, their hospital training often engenders the view that the rest of the health care staff is inferior, and are there to carry out the physician's orders rather than being a part of a coordinated team for patient care. Thus, when the physician goes into his own practice, his habits are already well ingrained and, in most cases, the skills of the other members of the health team are markedly underutilized. Many well-intentioned physicians attempt to assume the additional responsibility by themselves for managing family support problems for their patients. In reality, they often have neither the time nor the additional energy (after taking care of all their other patients) to devote the necessary attention to the family's total needs. In addition, as the technical basis for scientific practice for medicine expands, physicians have to devote much more energy to the complicated therapeutic techniques, leaving them even less time to spend caring for the human needs and the support in the home that patients require, especially when it involves maintenance of the chronically ill. Finally, it has become our model of medical education, and practice, that physician home visits are markedly decreasing. This, of course, has increased the efficiency, in many ways of private physicians and those in group practice, but has left large gaps in terms of many needed services, particularly to the homebound chronically ill patient.

In my experiences as a physician, good medical care always involves a sensitivity to the family situation of the sick person. This is true whether the person lives in a wealthy family or poor family. Thus, consideration of the whole environment is one of the major components of quality medical care. For the reasons I have mentioned, physicians do not often have the opportunity to become involved to the extent that perhaps was once possible in family medicine in the home. I think it is, therefore, very appropriate for organizations such as the visiting nurse associations and the public health nurse components of various hospitals and public health departments to make their contribution to the health care team by making these home visits, evaluating the patient and the home environment, and helping physicians to design care plans. These activities are of great significance, especially in the care of the elderly and with the chronically diseased and disabled. Thus, it is my opinion that, while the overall care of the patient must continue to remain under physician supervision and coordination, it is important for regulations to be developed pursuant to national health insurance and other long term care proposals, as well as home nursing regulations, that give more discretion and weight to the opinions of trained public health and visiting nurses and other home health personnel in influencing the care plan for this category of patient.

It certainly would be of high priority and of great import to educate physicians to use home health services more effectively. However, it is difficult to conceive of how to do this. The American Medical Association has a very strong and admirable policy with regard to home health services, yet it is difficult to implement that policy in terms of influencing the actual behavior of either local medical societies or individual physicians in their practice. I think the most effective means of having impact would be by influencing the type of education given to physicians, both in medical school and in their hospital training, through a more team-oriented approach and to raise the stature of the other health professionals, especially those within the nursing profession, in regard to the provision of coordinated patient care.

Another aspect of physicians' involvement in home health care has to be the consideration of their activities with regard to Professional Standards Review Organizations and health maintenance organizations. Certainly PSRO's will have an important impact on the quality and cost of medical care. However, it is the concern of the American Public Health Association that, if the local PSRO committees are maintained under the sole influence of physicians, their

lack of sensitivity to the patient in the home and to the supportive benefits of home health services will seriously affect the delivery of these services. Thus, it is very important to have both consumers and other health professionals as an integral part of the standards setting and review mechanisms of PSRO's. Health maintenance organizations have the potential, by virtue of their more organized, continuous system of care, and their larger pool of available manpower, to substitute the less expensive home health services for institutionalization for chronic disease and other disability. Also, within the HMO context, the incentive is not solely to use home health services but, because of prospective reimbursement, to save money!

With regard to the long term care services program in the Kennedy-Mills bill, it is encouraging to see the enumeration of the various home health services which would be covered by this proposal. These services should certainly all be available under some public program of one sort or another. However, I think that it is important that, in addition to home nursing care, physical and occupational therapy and other services such as health education, nutrition, and homemaking should be made available and reimbursable under a home health package. Intermediate care and long term nursing home care are, of course, important, but should be viewed as a second order of priority and considered as an alternative to home health care rather than vice versa. Finally, day care and foster home care, as well as social work services and food programs such as "Meals-on-Wheels," can be most beneficial to certain classes of elderly and homebound, but perhaps they should be funded through other financing mechanisms. When we are asked to define which services should be covered under home health care, it might be preferable to turn that around and specifically define which services should *not* be covered. We believe this would provide more latitude to the provider in effectively planning and implementing a course of treatment and being sure that those needed services will be covered.

Finally, I would like to make a statement with regard to the role of fiscal intermediaries and their control of health services. I think that, in the general context of this discussion, it is very important to separate out, and to make independent of each other, considerations regarding cost containment and considerations of quality of care. Fiscal intermediaries, almost unanimously, in my experiences both as the president of a visiting nurse association and as the former director of the University Hospital outpatient department in San Diego, have been overly conservative and restrictive in their interpretation of the needs of patients, especially where long term care is concerned. It is apparent, from their behavior, that the considerations of cost containment far outweigh considerations of the necessity of care, even when these determinations are made by physicians. Little attention is paid to the needs of the chronically ill, and rather than seeking means of providing services in the least expensive but highly responsive way, such as with home care, they prefer to reject the claim outright. The insurance mentality is somewhat parallel to that of the gambler who plays the odds. Unfortunately, chronic illness is not compatible with this philosophy, for there is no gamble involved: the care for the chronically ill must be covered. Thus, it is important that those who are charged with determining quality of care should not work for fiscal intermediaries. The delicate balance between cost considerations and those of quality can jeopardize consumer-oriented assessments in regard to care. Whether such review takes place within a PSRO or through some other mechanisms we would discourage the role of the carrier in that process.

If we can be of any additional assistance to you in your endeavors, please feel free to contact us.

Sincerely,

JEOFFRY GORDON, M.D., M.P.H.

ITEM 2. LETTER FROM R. BERNARD HOUSTON, DIRECTOR, DEPARTMENT OF SOCIAL SERVICES, STATE OF MICHIGAN; TO SENATOR EDMUND S. MUSKIE, DATED JUNE 28, 1974

DEAR SENATOR MUSKIE: Michigan is vitally concerned with barriers to health care for the elderly, especially with regard to alternatives for long-term institutional care. We are sending these comments to you as chairman of the Subcommittee on Health to the Elderly, and would appreciate having them entered into the record of your subcommittee hearing scheduled for July 9, 1974.

We feel that home health care is one viable alternative to institutional care, but certain financial factors must be considered. Our experience indicates that home health care is not necessarily a less expensive alternative to institutional care if continuous nursing attention is required. In providing home health services, the Visiting Nurse Association rates are currently $22.50 per nurse visit and $19.50 per day for supervision. This compares to the nursing home average rate of $19 per day, which is based on an even mix of patients receiving either skilled or basic care. These figures illustrate that a patient requiring daily attention may receive more care in an institutional setting and at less cost than he would receive in his own home.

Michigan also limits services under Medicaid to patients who require skilled nursing care. Reimbursement for supportive services which do not require skilled nursing supervision or participation—but which are necessary for the recovery of a home-bound patient—are provided, but under titles IV–A and VI rather than title XIX.

In order to provide a consistent strong commitment by the states on alternatives to institutional care, the Federal Government should either remove the ceiling on Federal funds designated for services programs or increase the title XIX Federal financial participation, as with family planning services. These actions would encourage approaches that enable patients in institutional settings to return home and still receive basic supportive services, such as homemaker services and supervision.

In the area of day care, Michigan supports the concept of day hospital programs and day treatment services as set forth in the policy statement issued by the Medical Services Administration of HEW. However, enabling Federal legislation or regulations are required to clarify whether such related non-medical services included in these programs would be covered under title XIX.

We appreciate the opportunity of providing input to the Subcommittee on Health of the Elderly and hope our comments have been useful.

Sincerely,

R. BERNARD HOUSTON, *Director.*

ITEM 3. STATEMENT FROM THE COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES OF THE NATIONAL LEAGUE FOR NURSING

We commend the legislators for their efforts in studying the feasibility of developing a broad program of health legislation to effect modifications in the organization and methods of delivery of health services. Efforts must be made to increase the availability and continuity of care, enhance its quality, and emphasize the maintenance of health as well as the treatment of illness. By improving the efficiency and the utilization of services and strengthening professional and financial controls, the mounting cost of care will be controlled while providing fair and reasonable compensation to those who furnish it.

Home health care is an integral and essential part of a coordinated health care delivery system in the community. In any community these health services may be offered by a visiting nurse association, a health department, a home care unit of a hospital, a private agency or other health care facility.

The Council of Home Health Agencies and Community Health Services of the National League for Nursing is the national representative of over 1,400 of the 2,200 home health agencies certified for Medicare and Medicaid reimbursement. In this testimony, we propose certain changes in the home health portions of the "Comprehensive National Health Insurance Act of 1974" designed to eliminate existing legislative barriers to appropriate health services to all Americans.

We submit the following recommendations for changes in S. 3286:

Part A, Scope of Benefits Section 2011(b)(2). This section refers to limitation of 100 visits per year for home health services. We *recommend the limitation be deleted.*

Rationale: There are many other provisions built into the law to prohibit abuse, i.e., eligibility criteria such as: "intermittent nursing, physical therapy or speech therapy, etc.," "PSRO review services," "physician certification . . . accompanied by supporting material . . . as may be provided by regulations."

We strongly urge that covered services be determined by the patient's needs rather than limited by an arbitrary number.

Part D, Administration of Program Section 2041(a)(2)(D)(i). Change to read ". . . such services are or were required because the individual is or was confined to home *or is ambulatory and can be most appropriately served in his own home* . . . and needs nursing care on an intermittent basis, or physical or speech therapy, or *homemaker/home health aide services on an intermittent basis. The latter services to be rendered under the supervision of the appropriate professional staff member.* . . ."

Rationale: Since ambulation may be an essential part of the medical care plan the use of the phrase "confined to home" as the sole basis of eligibility is in conflict with the intent of this proposed legislation as stated in Section 2002 ". . . Neither the Board of the Social Security Administration, nor any of its agents, shall make medical judgments with respect to a patient's health care; this function is reserved solely to the physician and his peers. . . ."

Furthermore, in recognition of the homemaker/home health aide as a generalist in personal care, this service should be added to any health insurance package as an extension to professional health services. These services enhance the appropriate utilization of the professional, thereby promoting cost effective measures.

Payment for Home Health Services Section 2041(f)(1)(A). Change to read "the certification and plan referred to in subsection (a)(2)(D) of this section are *formulated* and submitted in timely fashion *following* the first visit by such agency."

2041(f)(1)(B). Delete.

2041(f)(1)(C). Change to read "there is compliance with such other requirements and procedures as may be specified in regulations, taking into account the medical severity of such conditions, the degree of incapacity, and such other factors affecting the type of care to be provided as the Administration deems pertinent."

Rationale: The nature of home health care delivery is such that written certification *prior* to the first home visit is logistically impossible. Referrals for care most often come by telephone, always followed by written confirmation through U.S. postal system.

Section 2042(b)(1). Change to read "The Administration, after consultation with providers of services . . . third party payors for *health* care. . . ." Change "institutional" to *health* services wherever it appears in this section.

Rationale: Third party payors are increasingly including home care in their benefit package. Home Health is a mandated benefit in HMO legislation. Therefore, any comprehensive piece of health legislation should promote this trend.

Part E Miscellaneous Provisions Section 2051(k). Utilization Review—Change to read "a . . . facility *or a home health agency* . . . by the institution *or agency* . . . if it provides:

(1) for the review of admissions to the institution or *the agency*, the duration of stays therein *or care provided* and the services (including drugs and biologicals) furnished (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made *in the case of the institution*, by either . . . the Administration. *In the case of a home health agency, such review to be made by a committee representing both providers and consumers. The provider representation shall consist of a physician, a public health nurse, a social worker and a representative from each of the therapeutic services provided by the agency.*

Home Health Services Section 2051(m). Change to read "the term 'home health services' means . . . and in need of nursing care on an intermittent basis, or physical or speech therapy, or *homemaker/home health aide services on an intermittent basis* . . . as such individual's home."

Rationale: The attachment of the label "skilled" to nursing has become a major barrier to the delivery of care under Medicare. The practice of nursing is an *art*, a *science* and a *skill* as is practice of medicine, physical therapy or ocupational therapy. The limitations placed on the definition of nursing care has resulted in great variance in interpretation of covered services. Greatly needed care has been withheld; patients, families, nurses and SSA/BHI personnel have suffered pain, frustration and expense without return to taxpayers.

Section 2051(m)(4). Change to read "part-time or intermittent services of a homemaker/home health aide provided under the supervision of the appropriate professional staff member."

Rationale: Again, in recognition of the homemaker/home health aide as a generalist in personal care, this service should be added to any health insurance package as an extension to professional health services, which enhance the appropriate utilization of the professional, thereby promoting cost effective measures.

Section 2051(m)(6). Change to read "in the case of a home health agency which is affiliated or under common control *or makes arrangements with* a hospital . . . or such hospital; and"

Rationale: If these services are limited to hospital-based home health agencies, then such services are denied to patients under home health care provided by a nonhospital-based home health agency.

Home Health Agency Section 2051(n)(1). Change to read "is primarily engaged in providing nursing . . . services.

Rationale: delete "skilled" to conform to recommendations for change in 2051(m).

Section 2053. Use of State Agencies to Determine Compliance by Providers of Services with Conditions of Participation.

(c) Change to read, "The Administration . . . which are accredited by the Joint Commission on the Accreditation of Hospitals *in the case of institutions; and home health agencies which have an agreement with the Administration under section 2043 and which are accredited under the National League for Nursing/American Public Health Association accreditation program.*"

Rationale: The National League for Nursing/American Public Health Association accreditation program meets the requirements as stated in Section 2054(a).

We have spoken to the home health care portions of S. 3286 at great length in an attempt to eliminate existing barriers to the delivery of home health services.

We strongly believe that the concepts of continuity of care and health maintenance as well as treatment of illness must pervade the entire health care delivery system if a national health insurance plan is to fulfill its purpose. It is to this end that we submit these recommendations.

ITEM 4. EDITORIAL COMMENT BY WILLIAM REICHEL, M.D., ON DAY CARE PROGRAMS IN THE UNITED STATES; FROM THE AMERICAN GERIATRICS SOCIETY NEWSLETTER

Geriatric day care alternatives are beginning to appear in greater numbers in the United States. In 1973, the Administration on Aging and the Medical Services Administration funded four demonstration projects to study the cost effectiveness of day treatment settings as compared to the more traditional long-term institutional services. These projects included the Burke Day Hospital of White Plains, N.Y., the Levindale Day Treatment Center of Baltimore, Md., the On Lok Day Care Center of San Francisco, Calif., and Montefiore Day Care Center of New York City. The above centers and 11 others in the country, including those in Puerto Rico and Hawaii, vary considerably in size, setting, agency, sponsorship, and source of funding. All share similar goals, trying to provide either maintenance and/or rehabilitation for the chronically ill and disabled older person. The Burke program in White Plains is unique as a day hospital which is involved in providing direct medical care with physicians connected directly to the service as staff members. Day care centers do not include the same degree of medical service and stress social aspects of treatment and other health care supports from various levels of nursing personnel.

The British experience with day treatment alternatives demonstrates the feasibility of both long and short-term maintenance in the community. There, the concept of day hospital has been implemented within many sections of the country. In the United States, we have seen rather a growth of day care centers and it is probable that day hospitals will develop slowly in comparison to day care.

The Levindale program in Baltimore has operated the longest of the four programs dating back to 1970. The Burke Day Hospital, established in 1973, is unique as an American day hospital. The editor of the *Newsletter* believes that we will see the growth of the day care movement throughout the Nation as more and more day care centers develop as alternatives to institutional care. Nursing homes or

other institutions should be prescribed specifically by the physician in the same manner in which digitalis and penicillin are prescribed. The American Geriatrics Society strongly supports the development of additional alternatives to institutional care for the elderly patients of this Nation.

ITEM 5. STATEMENT AND ENCLOSURES FROM THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

INTRODUCTION

The National Council for Homemaker-Home Health Aide Services, Inc., a national, nonprofit 501(c)(3) membership organization, with offices at 67 Irving Place, New York, N.Y. 10003, is pleased to have this opportunity to present a statement on the long-term care section of S. 3286, because the decisions reached on this aspect of a national health insurance plan will have such far reaching implications for the constituency we represent for many years to come.

The National Council's goal is availability of quality homemaker-home health aide service in all sections of the Nation, for individuals and families in all economic brackets, when there are disruptions due to illness, disability, social and other problems, or where there is need of help to enhance the quality of daily life.

MEMBERSHIP

The National Council is a membership organization composed of 545 members of which 264 are agencies providing homemaker-home health aide service; 50 are organizations; and 231 are individuals. (1973 year-end figures.)

DEFINITION OF SERVICE

Homemaker-home health aid service helps families remain together in their own homes when a health and/or social problem occurs or return to their own homes after specialized care. The homemaker-home health aide carries out assigned tasks in the family's place of residence, working under the supervision of a professional person who also assesses the need for the service and implements the plan of care.

DEFINITION AND SUPPORTING STATEMENT ON HOME HEALTH SERVICES

We commend to you the definition and supporting statement on home health services, developed by units of and approved by the boards of four national organizations with direct provider agency members: The American Hospital Association, National Association of Home Health Agencies, National Council for Homemaker-Home Health Aide Services, Inc., and the National League for Nursing. The governing council of the American Public Health Association has also endorsed these concepts. A copy of this material is attached to the original of this statement.[1]

Homemaker-home health aide service is listed in this definition as one of an array of home health services. Frequently it is the cornerstone service which makes possible the delivery of other health services in the home. In other situations it may be the only service which is needed to help someone remain in his own home or return home from the hospital or other out-of-home care.

While we could testify about many aspects of the long term care section of S. 3286, it is from the vantage point of homemaker-home health aide service, a vitally important home health service, that the National Council primarily addresses this statement.

OVERALL VIEW OF CURRENT NATIONAL HEALTH INSURANCE BILLS

The current bills on national health insurance would perpetuate rather than reform the present health system and would greatly extend the present overutilization of costly in-patient care, especially hospital care, as compared with

---

[1] See p. 1518.

out-of-institutional care. We refer particularly to the severely limited home health benefit where a cap of 100 visits per year is specified in the bills, including in title I of S. 3286. For many cases continuing supportive care in the home is the preferable type of care. We propose that the health services delivery system be viewed as a continuum, ranging from an array of health services which can be delivered in the home to intensive care for an acute illness in an institution. An individual's need for service should be the factor which determines the aspect of the health delivery system which is provided at any given time, recognizing that as health care needs change the individual would be referred to another part of the service continuum. There is now an imbalance in the delivery of health services. It is heavily weighted in favor of various forms of institutional care, even though care in the home is often both the most suitable and the least expensive of all forms of care. We urge that national health insurance benefits give priority to care which will enable people to remain in their homes when their condition permits it. Only then can a meaningful service continuum be established.

For emphasis, we repeat that the health services continuum should be viewed as a whole, both from a service delivery standpoint and from the standpoint of accountability. Utilization review and professional service review should be expanded to embrace all forms of health delivery, including home health services. This approach to health service delivery, including proper attention to standards and the monitoring of each service to be provided, would begin to bring some logic and order into health services in this country. Establishing a major national health insurance plan without reference to a unified concept of service delivery and without reference to cost effectiveness will force the health delivery system, already labeled a nonsystem, into an ever-increasing morass. All of us as citizens need a logical well organized and coordinated approach to health services—from prevention through intensive treatment to care during recuperation for long-term illness.

The National Council, whose main concern is homemaker-home health aide service, has developed this point because, unless this overall concept of health care is implemented, it is doubtful that homemaker-home health aide service will ever be accorded its proper role in the health delivery system or be used to the maximum extent of its very considerable potential either for long-term or short-term care.

Support Intent of Long-Term Care Program in S. 3286

The National Council strongly approves the principle of in-home service which undergirds the long-term care services program under title II of S. 3286, a concept long overdue, and one that we hope will be included in the national health insurance plan finally passed by Congress.

We are concerned, however, that the voluntary nature of the program with its monthly enrollment fee of $6, when added to the coinsurance and deductible features currently required under Medicare part B, will mean that many older people who are most in need of the program will not have the funds to take advantage of it. Therefore, it would be desirable to waive the enrollment fee for those persons whose annual income falls below a certain point. This approach would be similar to the plan established under title I of this bill where a waiver of or limitation on deductibles and coinsurance has been established for lower income families. We are also concerned with the current definition of "homemaker service" which permits the service to be given only when an eligible individual is receiving two of the other specified services. We would like to see more flexibility allowed in the use of this service, a service which, in many cases, may be the only one which is required.

Homemaker-home health aide service has an exceedingly important role to play in mental as well as in physical health care. It has been found that persons with emotional or mental problems can often be maintained at home with the help of homemaker-home health aide service when it is made available under the plan of care established for the ill person and his family by the psychiatrist and other members of the mental health team.

Similarly, nutritional and homemaker-home health aide service often fit together extremely well to help an ill or frail elderly individual or couple return to or remain at home. Meals-on-Wheels may be all that is needed 4 days a week, if homemaker-home health aide service, including personal and environmental

care, is provided 1 day a week. Homemaker-home health aide service can also provide important support services to day care, foster homes and institutional care programs.

In short, with some important modifications, the long-term care section of S. 3286 could provide another very significant set of services for older, incapacitated persons in our society.

Homemaker-Home Health Aide Service Delivery Fragmented in Long-Term Care Section of S. 3286

All to frequently, under the current Medicare program, delivery of homemaker-home health aide service is fragmented so that two paraprofessionals are required to go into the same home, during the same period, to undertake tasks which could and should be carried out by one paraprofessional. This split delivery phenomenon escalates costs all along the line and certainly is the least effective way to serve the individual concerned. To compound the illogic of this approach, funds for both paraprofessionals frequently come out of Federal tax dollars, albeit from different pockets.

"Homemaker" service and home health services (which include "home health aide" service) are specifically named in the long-term care section of S. 3286. If this section of the bill is enacted as written now, we could have a situation where two paraprofessionals must go into the same home during the same period to perform tasks that one could readily carry out. In addition, these two individuals and all the extra administrative, travel and service costs which would be involved would be paid for from funds made available under *one* act. We urge that the term "homemaker-home health aide" be used and that homemaker-home health aide service be a covered benefit.

Basic National Standards Needed for Homemaker-Home Health Aide Service

We recognize that the intent of the bill is to establish parameters for this service by using the terms "home health aide," "homemaker," and also by the limitations set for "homemaker" under the long term care section of S. 3286, where it is specified that the aide may serve only one hot meal per day.

We wholeheartedly agree that this service must be regulated in order that a safe, efficient, effective service be provided. However, we find that the approach suggested in the bill is inadequate. We urge that one set of basic national standards be required for homemaker-home health aide service or any aspect of the service, and that this requirement be written into the national health insurance bill which is enacted by the Congress. This will be the single most important *control* feature which can be established to assure the quality, cost effectiveness and proper use of homemaker-home health aide service in the health delivery system. Requiring basic national standards for this service, coupled with a utilization review procedure for all home health services, and adequate monitoring of each, will, we believe, go a long way toward providing the assurance that legislators are seeking against overuse or inappropriate use of the service.

We wish to be specific about some of the basic national standards which are needed and have been developed for homemaker-home health aide service. We are going into this in detail, in part because of a clause in S. 3286 in title II, section 1887(a)(2) and section 1889(a)(1), which provides for the service of a community long-term care center to be provided "(directly or through arrangements with other persons)."

Homemaker-home health aide service should be provided *only* through a responsible agency and the agency should be held accountable for the service provided. Homemaker-home health aides do not receive the kind of training which enables them to be individual practitioners, as do nurses or social workers. Therefore, while a clause allowing services to be provided through arrangements with persons may be quite appropriate for professional services, it is not appropriate for homemaker-home health aide service and it is important that there be no ambiguity on this point in the bill. Homemaker-home health aides must be employed by a community agency and the agency must be held responsible for the service given.

Two of the most important basic national standards for homemaker-home health aide service include training and supervision of homemaker-home health aides. Each aide should undergo an initial generic training program and be provided with ongoing in-service training. Each aide must be supervised by, and

each individual or family served must be provided the services of, a professional person who will be responsible for the assessment of service needed and for implementation of a plan of care.

Adherence to these two basic standards, plus those relating to the appropriate selection of the aides, to the fiscal and service accountability to the community, and to the legal authorization of the agency to operate, provides the foundation on which a safe, efficient and effective homemaker-home health aide service can be bulit. A number of other very important standards are included in the list of 14 basic national standards developed by the National Council for Homemaker-Home Health Aide Services. We commend to you each standard listed on the flyer attached to this statement.[2] Attached to the original copy of this statement is the document entitled *Homemaker-Home Health Aide Services Agency Approval Program.*[3] It is the self-study guide which spells out the standards in more detail and outlines the documentation needed for assessment of an agency's compliance with the 14 standards when it applies for approval (accreditation) status from the National Council for Homemaker-Home Health Aide Services.

S. 3286 points up the need for one set of basic national standards for homemaker-home health aide services to serve as a floor of standards under various agency and State programs and to provide the protection needed by vulnerable individuals. Under title I of this bill, as written, one aspect of the service, namely, "home health aide service" would be given. Under title II, both aspects, namely "homemaker and home health aide service" would be provided, but apparently as separate services. Any variance in the basic standards or in the monitoring of the standards required under these two titles would be very confusing at the local level, especially since this service is often provided through a purchase-of-service arrangement.

Furthermore, our population is now much too mobile for each State to develop a set of standards independent of and at variance with the standards of other States.

Problems With Medicare Reflected in Long-Term Care Section of S. 3286

Earlier in this statement, we indicated that there is a serious fragmentation in the delivery of homemaker-home health aide service through the Medicare program and we urged that this problem not be carried over into a national health insurance plan and particularly in the long-term care section of S. 3286. Several other aspects of the Medicare program with which the field has had severe problems would also affect negatively the long-term care section. They include:

The definition of home health services which requires that before an individual may qualify for another service, he first must need skilled nursing care on an intermittent basis, or physical or speech therapy. We propose that while a home health agency be required to have available these professional services, in addition to homemaker-home health aide and other services, the agency be given the flexibility to determine which of the array of available services a particular individual needs. This need may vary, from one specific home health service to several. Also, the services given to any person must change when his health needs change. It is clear that good professional assessment and reassessment of care are key factors in the delivery of appropriate home health services for as long as they are needed and not longer.

The use of the term "skilled" before nursing is particularly troublesome in the delivery of homemaker-home health aide services because it has not been interpreted to mean supervision of a homemaker-home health aide. It has, in fact, been so narrowly interpreted that the nurse herself must perform a task which involves a "laying on of hands." This interpretation partially invalidates one of the real values of homemaker-home health aide service: the saving of valuable professional time for professional tasks. For example, most individuals can be bathed by a paraprofessional and thereby the nurse's time can be saved for assessment and other areas involving professional knowledge and judgment. We submit that supervision of a homemaker-home health aide when personal care tasks are involved is indeed one form of skilled nursing service.

Another problem which we fear will be carried over from the Medicare program is the much too narrow range of covered health conditions. The program is

[2] See p. 1519.
[3] Retained in committee files.

virtually limited to acute care problems because of the regulatory interpretations being made currently. We urge that the intent of the long term care section, title II, as well as title I, be made clear on this point and that it not be considered so narrowly that once again it partially invalidates the potential of this form of service delivery. Those persons whose health conditions are not likely to improve quickly must have more home health services than are currently available under Medicare.

Support Other Features in the Long-Term Care Section of S. 3286

The National Council strongly supports the elimination of the post-hospital requirements for home health services under part A of Medicare. This has long been an artificial and costly feature of Medicare. We urge that its elimination be a part of the bill that is finally enacted, not only in relation to Medicare, but also in relation to all home health service benefits under national health insurance.

We also strongly endorse the prospective payment feature in S. 3286. One of the most serious problems of provider agencies currently is cash flow. Agencies must meet payrolls and other operating costs on a regular basis. All too often, under the present Federal programs, payment for these services comes months later. A regular ongoing payment mechanism is essential to eliminate needless financial crises. We urge that these features be retained in the final national health insurance plan.

Costs of Homemaker-Home Health Aide and Alternative Forms of Care

To add emphasis to our contention that home health services, including homemaker-home health aide service, should be a vital and integral part of the total health care delivery system, we wish to point out that, in most instances, this form of care is less costly than out-of-home care.

The National Council has recently published "Costs of Homemaker-Home Health Aide and Alternative Forms of Care." While the findings by no means provide all of the information that is desired about costs of homemaker-home health aide services, or of alternative forms of service, the research that was undertaken and the manner in which the findings are presented make a substantive contribution to the knowledge and understanding of the costs of homemaker-home health aide compared to alternative forms of care. A copy of that document is attached to the original copy of this statement.[4]

The report indicates that for 43 National Council approved (accredited) services, using fiscal 1971 and in some cases 1972 figures, the average cost per hour for homemaker-home health aide services was $3.98 within a range from $2.09 to $7.50. The median cost per hour was $3.79.

For 32 of the National Council approved agencies for which data were available the average number of service hours per case was a little over 121; the average cost per case was $468.

The national median cost per day in July 1973, of a hospital stay, was $94.93. An average stay was 7 days, at a cost of $667.08. The average cost per day for an elderly person in a Maryland nursing home, the most up-to-date figure we could find, varied from $24 per day for intermediate care to $39 for chronic care.

Institutional care, which requires that employees be on duty around the clock, cannot easily be varied, nor does it allow individuals to do as much for themselves as possible. In-home care, on the other hand, can be custom-fitted to the needs of the individual and families served, while simultaneously making the most of their strengths. For example, the hours a week of care, the duration of care, and the tasks performed by the homemaker-home health aide all can be fitted to the need and can be changed to meet a changing situation.

Summary

In conclusion, the National Council for Homemaker-Home Health Aide Services urges the passage of a national health insurance bill and strongly supports the inclusion of the long-term care plan of S. 3286 provided it includes the modifications which are recommended in this statement.

---

[4] Retained in committee files.

[Enclosures]

HOME HEALTH SERVICES

FOREWORD

The following definition and position statement on home health services was developed by a task force composed of representatives of the Assembly of Outpatient and Home Care Institutions, American Hospital Association; the Council of Home Health Agencies and Community Health Services, National League for Nursing; the National Association of Home Health Agencies; and the National Council for Homemaker-Home Health Aide Services, Inc.

The definition and statement have been endorsed by the following organizations: American Hospital Association, National Association of Home Health Agencies, National Council for Homemaker-Home Health Aide Services, Inc., and the National League for Nursing.

DEFINITION

Home health service is that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health, or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated and made available by an agency/institution, or a unit of an agency/institution, organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.

These services are provided under a plan of care which includes appropriate service components such as, but not limited to, medical care, dental care, nursing, physical therapy, speech therapy, occupational therapy, social work, nutrition, homemaker-home health aide, transportation, laboratory services, medical equipment and supplies.

STATEMENT ON HEALTH SERVICES IN THE HOME

The home environment plays a significant role in promoting health and facilitating the healing process. Properly coordinated and administered home health care provides a meaningful health service for ill persons, speeds recovery and rehabilitation of indivduals with acute or chronic health problems, and assists in the prevention of disease and disability.

The provision of appropriate health care services to patients in their homes benefits the patient, the family, and the community. Therefore, it is imperative that quality health service *in the home* be a basic component of the health care system.

Home Health Services Can:

1. Contribute to the health and well-being of the patient and his family;
2. Restore the patient to health and/or maximum functioning;
3. Prevent costly and inappropriate admission to institutions;
4. Reduce readmission to institutions; and
5. Enable earlier discharge from hospitals, extended or intermediate care facilities, or nursing homes.

Health Services at Home Must Be Characterized by:

1. Provision of high quality care to patients;
2. Professional coordination of the various services delivered to the individual patient and family;
3. Evaluative techniques to insure the appropriateness and the quality of care provided; and
4. Appropriate administrative controls.

Levels of care varying in intensity and service components responsive to the individual needs of patients must be available in the home. As patients, needs change, there must be adequate mechanisms for movement of patients within the varying levels of home care, as well as for transfer to other care settings.

The economic realities of the cost of health services to individuals, families, and communities make it imperative that health services at home be included in all present and future health care delivery systems. It therefore becomes mandatory that:

1. Present and future funding mechanisms, governmental and nongovernmental, adequately finance all levels and service components of home health care on a continuing basis.
2. Availability and accessibility of home health services for all populations be assured.
3. Developmental funds be an integral part of all financing for the expansion of existing services and initiation of new programs.

BASIC NATIONAL STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES

I. The agency shall have legal authorization to operate.
II. There shall be an appropriate duly constituted authority in which ultimate responsibility and accountability are lodged.
III. There shall be no discriminatory practices based on race, color or national origin; and the agency either must have or be working toward an integrated board, advisory committee, homemaker-home health aide services staff, and clientele.
IV. There shall be designated responsibility for the planning and provision of financial support to at least maintain the current level of service on a continuing basis.
V. The service shall have written personnel policies; a wage scale shall be established for each job category.
VI. There shall be a written job description for each job category for all staff and volunteer positions which are part of the service.
VII. Every individual and/or family served shall be provided with these two essential components of the service:
A. Service of a homemaker-home health aide and supervisor.
B. Service of a professional person responsible for assessment and implementation of a plan of care.
VIII. There shall be an appropriate process utilized in the selection of homemaker-home health aides.
IX. There shall be: A) initial generic training for homemaker-home health aides such as outlined in the National Council for Homemaker Services' training manual; B) an on-going in-service training program for homemaker-home health aides.
X. There shall be a written statement of eligibility criteria for the service.
XI. The service, as an integral part of the community's health and welfare delivery system, shall work toward assuming an active role in an on-going assessment of community needs and in planning to meet these needs including making appropriate adaptations in the service.
XII. There shall be an on-going agency program of interpreting the service to the public, both lay and professional.
XIII. The governing authority shall evaluate through regular systematic review all aspects of its organization and activities in relation to the service's purpose(s) and to the community needs.
XIV. Reports shall be made to the community, and to the National Council for Homemaker-Home Health Aide Services, as requested.

ITEM 6. STATEMENT AND ENCLOSURES FROM JANET E. STARR, EXECUTIVE DIRECTOR, COALITION FOR HOME HEALTH SERVICES IN NEW YORK STATE

The following statement on the home health provisions of S. 3286 and H.R. 13870 is submitted for the record in response to a request from the committee for technical advice and for information gathered by the Coalition. The Coalition is a statewide collective effort on the part of 88 organizations and 148 individuals to strengthen the development of comprehensive programs of home health services in New York State.

Title II of the legislation in question contains a shift in emphasis of great import to elderly citizens. It proposes adding to Medicare a long-term care program which would require that care at home or in a day care or foster home program be considered and used, if possible, before a patient is placed in an institution. This provision is designed to make better use of health care dollars, since care at home or as an outpatient is usually less expensive than care in an institution.

A recent report by Regina Reibstein for the office of program analysis, planning and budgeting of the New York City Health Services Administration, states, "If 1,000 persons are treated at home instead of placed in nursing homes, the (annual) savings to the city could amount to as much as $1.5 million." The saving to the Federal Government would be even greater because it pays one-half the cost of institutional care, while the city pays one-quarter.

Even more important than dollar savings are the human values involved. Under the proposed programs the dignity and independence of an elderly person would be nurtured. Most people not acutely ill prefer to be at home, and they do better at home if their health needs can be met there. Physical and mental deterioration can be slowed or halted.

In concept the proposed long-term care program is a major step in the right direction. Whether it can achieve its aims is open to question, in my estimation, because of the limited range of services to be made available.

Important Additions

The proposed program does add homemaker and nutrition services to those covered by Medicare. These are urgently needed additions. The important role of the homemaker on the home health care team has been pointed out previously in testimony from the National Council for Homemaker-Home Health Aide Services and in publications prepared for the Special Committee on Aging by Brahna Trager. The Coalition's experience supports this testimony.

The addition of home-delivered meals and services given by a nutritionist in a patient's home remedies a major defect in the Medicare program. This is pointed out in a position paper on implementation and delivery of nutritional care services in the health care system which was prepared for the U.S. Senate Select Committee on Nutrition and Human Needs. Miss Ruth Kocher, regional director of public health nutrition for the New York State Department of Health and a Coalition director, is one of the authors of the paper. The position paper states that the net effect of being unable to recover direct costs of nutrition services has been that few home health agencies provide them. In New York State, for example, only six of the 129 home health agencies employ a nutritionist on a full- or part-time basis. Yet nutritional deficiencies are at the root of many of the health problems of older Americans. Nutrition counseling in the home may be needed to explain therapeutic diets. The effect of drugs and other therapy on the nutrition of a patient may need monitoring, especially when the physician does not see the patient frequently. Home-delivered meals may be a lifeline to those who cannot shop, prepare meals or have social contacts with others.

Wide Range of Services Needed

The other home health services included in the proposed legislation are those covered under the present Medicare program. The inadequacy of programs restricted to these services to meet the home health needs of older Americans are amply documented by the hearings on barriers to health care held by this subcommittee during the past 2 years. The testimony of the Coalition last July emphasized this.

Supportive as well as professional services may be needed if care at home is to be possible. Some patients may need one or two services. Others may need several. The availability of a range of services makes it possible to meet the needs of the individual.

The effectiveness of programs offering a comprehensive range of services is illustrated by cost figures from the Home Care Association of Rochester and Monroe County, N.Y., where Blue Cross covers a full spectrum of services. A study [1] of 16 terminal cancer patients who died at home shows that the average cost of home care per patient day was $24.39, compared to $116, the average daily cost of hospital care in the community. The estimated saving in hospital costs was $54,233 for the 16 patients. Eight of the patients were over age 65, with an average age of 76 years. For these patients, Blue Cross 65 insurance supplemented Medicare coverage to make the full range of needed services available. The services used were nursing, laboratory, homemaker-home health aide, patient transportation, equipment rental, equipment delivery, medical supplies, drugs, oxygen and medical social work.

[1] See table, p. 1522.

A similar cost analysis[2] of 14 uncomplicated myrocardial infarct patients (8 of them 65 or over), with the same range of services available, plus electrocardiogram, shows that the average cost per patient day for home care was $13.98. Again, Medicare A and B were supplemented in most cases by Blue Cross 65 coverage. Unfortunately, most older Americans do not have supplementary insurance which will cover such a range of services. Home health care programs are discouraged from offering a truly comprehensive range of services by the restrictive coverage available for home care in most health insurance policies, including Medicare.

The Eastman Kodak Co. in Rochester has found that coverage of home care pays dividends. A company spokesman stated in the fall of 1973 that Kodak covers up to 90 days of home care per year under the basic health plan, with unrestricted additional coverage under the major medical plan. This results in an average reduction in hospital stays for Kodak employees of 21 days per patient and a net savings in health costs to Kodak of $160,000 per year.

Safeguards for Use of Supporting Services

Funding sources are concerned about whether supportive services are a legitimate part of patient care mainly, I feel, because they fear use will be uncontrolled in a noninstitutional setting. It is evident, as shown above, that one or more such services may be needed to make care at home feasible. Criteria could be developed to determine legitimate use of supportive services when professional services are not needed regularly. The following stipulations might be made:

1. The service is needed for a health or health-releated reason and would prevent, postpone or shorten institutional care.
2. Evaluation of the patient's situation shows that care at home is the appropriate choice.
3. The initial evaluation of the patient's needs, periodic reassessment and either supervision, where required, or periodic monitoring of the supportive service is done by a professional person connected with a comprehensive home health services program.
4. The agency coordinating the supportive services provides access to a continuity of care, and is held accountable for the services provided or coordinated under its auspices.

Opportunity for Creative Combinations

The proposed inclusion of day care and broader home care benefits under Medicare presents an opportunity for creative combinations which will enrich the lives of those having long-term illnesses, as well as provide support and reinforcement to families trying to care for such members at home.

St. Camillus Nursing Home in Syracuse, N.Y., has such an experimental program underway. Chronically ill patients come to a day care program 1 to 5 days a week. Services available to them are physical therapy, occupational therapy, speech therapy, recreation therapy, lunch and group social activities. The charge for this is $15/day for private patients and $12.60/day for Medicaid patients. The private fee is reduced to the level of the Medicaid fee in cases of need. Transportation costs are extra. Most patients come by wheelchair cab (cost: $12/round trip). Others come by private car or regular taxi. The program now serves 45 patients.

Mrs. Eleanor Fiumano, social services director at St. Camillus and a Coalition member, says that many of the patients in the day care program receive home health care services on the days they remain at home. Others may need an aide to come in for an hour or so on the days they attend the day care program to help them dress and get ready. She feels that the patients in the program need the services offered to maintain their present level of functioning; otherwise their condition deteriorates.

Mrs. Fiumano sees day care and home care as natural partners for many patients. A combined day care-home care program frees home health aides in cases where day-long aide service is necessary. It keeps patients out of a nursing home and in their normal environment. It keeps the family unit intact. Inclusion of day care benefits in Medicare will make it available to patients who do not qualify for Medicaid but cannot afford even the reduced day care fee.

---

[1] See table, p. 1522.

The program at St. Camillus and the after care program at Montefiore Hospital in New York City, described to the subcommittee in the testimony of Isadore Rossman,[3] M.D., demonstrate what can be done when there is an opportunity for innovation. The inclusion of a broader range of home health services under Medicare, emphasis on care at home or in the community when possible and an opportunity to use home health services in new arrangements with other health services offer new hope to the many older Americans who are victims of long-term and chronic illnesses.

[Enclosures]

HOME CARE ASSOCIATION

1/74

RECENT HOME CARE EXPERIENCE WITH UNCOMPLICATED MYOCARDIAL INFARCT PATIENTS - JULY - DECEMBER, 1973

					SERVICES PROVIDED												
Case No.	Age	Sex	Length of Hospital Stay in Days	Length of Home Care Stay in Days	Nursing	Lab	E.K.G.	Aides' Help	Drugs	Ambulance	Wheel Chair-Walker	Equipment	Oxygen	Med(al) Supply	Source of Payment	Total Home Care Cost per Patient including Administration	Average Home Care Cost per Patient per Day
0751	58	M	18	40	x		x		x	x					Blue Cross	$ 156.80	$ 3.92
0696	41	M	0	53	x	x	x		x						Blue Cross	295.00	5.57
0844*	27	F	19	30	x			x	x		x	x			Blue Cross	1,059.28	35.31
0733	65	M	19	57	x			x	x						Medicare A BC	792.61	13.91
0739	75	F	14	53	x	x	x	x	x			x			Medicare A BC	884.63	16.69
0725	50	M	22	16	x			x	x		x				Blue Cross	344.32	21.52
0690	63	M	13	10	x		x		x		x				Blue Cross	100.90	10.09
0545	70	F	12	26	x	x		x	x				x		Medicare A BC	534.24	20.55
0508	80	F	6	8	x		x	x	x	x		x			Medicare A BC	178.40	22.30
0250	78	F	21	26	x	x		x	x	x		x			Medicare A Self-Pay	357.75	13.76
0191	74	F	10	53	x	x		x	x			x		x	Medicare A BC	386.44	7.29
0167	69	M	13	31	x	x		x	x			x			Medicare A BC	376.72	12.15
9899	68	M	17	30	x	x			x			x			Medicare A BC	179.51	5.98
9740	48	F	14	38	x	x			x			x			Blue Cross	254.65	6.70

* mother of 5 young children

14 Patients: 7 males, 7 females

Average Length of Hospital Stay: 14 days

Average Length of Home Care Stay: 34 days

Average Total Cost per Patient: $421.52

Average Cost per patient day: $13.98

PAYMENT IN FULL FROM MEDICARE AND/OR BLUE CROSS FOR ALL PATIENTS, EXCEPT #0250, NOT HOLDING BLUE CROSS 65 CONTRACT, WHO PAID FOR DRUGS.

HOME CARE ASSOCIATION OF ROCHESTER AND MONROE COUNTY, INC.

JAN. 1974

Services, Costs, Sources of Payment for 16 Terminal Cancer Patients who expired at home while on the Home Care Program.

			Services Provided															
Case No.	Age	Type of Cancer	Nursing Care (Visits)	Laboratory	Health Aide (dys.)	Patient Trans. (trips)	Equipment Rental	Equipment deliv. (trips)	Med. Supplies	Drugs	O_2	Med. Soc. Work (visits)	Length of Hosp. stay (dys.)	Length of H.C. stay (dys.)	Full Payment from	Total H.C. Cost incl. Admin.costs	Average H.C.Cost Per Day	Misc.
0164	53	Breast	10		27		x	15	x	x	x		14	47	Blue Cross	$1780.89	$37.89	
0195	60	Mandible	10		3		x	2	x	x			0	51	Blue Cross	616.15	12.08	
0140	46	Colon	2				x	4	x	x			0	17	Blue Cross	187.52	11.03	
0276	73	Ovary	13		20		x	3	x				12	30	Medicare A Blue Cross	723.55	24.12	
0266	59	Multiple Myeloma	13	5	22	1	x	4	x				35	32	Blue Cross	1003.75	31.37	
0127	64	Lung	8		33		x	2	x	x			10	50	Blue Cross	1361.14	27.22	
0209	74	Pancreas	8		7		x	2	x	x			0	27	Medicare Blue Cross	474.25	17.56	
9364	80	Urethra	19	1	32	2	x	2	x				26	55	Medicare A	1065.70	19.38	no B/C 65-Patient paid for transp. and laboratory
9765	60	Lung	18	2	28	2	x	3	x	x			12	51	Blue Cross	1011.97	19.84	
9907	76	Prostate	4		6	2	x	2	x	x			21	17	Medicare A Blue Cross	451.49	26.56	
0573	68	Lung	4	2	10	2	x	2	x	x			35	18	Medicare A Blue Cross	478.05	26.56	
0347	82	Jaw	31		14	2	x	2	x	x			12	26	Medicare A Blue Cross	793.50	30.52	
0551	62	Lung	2		1		x	1	x				1	7	Blue Cross	114.30	16.33	
0583	77	Brain	2	1	4		x	2	x	x			0	8	Medicare B Blue Cross	135.40	16.93	
0363	56	Glioblastoma	18		49	2	x	2	x	x		x	14	70	Blue Cross	2345.02	33.50	
0375	57	Colon	21	4	52	1	x	5	x	x		x	10	82	Blue Cross	3227.13	39.36	

Average age, Over 65: 76 years

Average age, Under 65: 57 years

Average length of Home Care stay : 37

Home Care average cost per patient day : $24.39
(This includes payment of full fees for all visits, days, trips and items checked (X) and the Home Care Administrative charge)

1973 Monroe County average cost of hospital care per day . $116.00

AVERAGE ESTIMATED SAVINGS IN HOSPITAL COSTS: $54,233.00

[3] See statement, p. 1443.

ITEM 7. STATEMENT FROM ARLENE M. WILSON, R.D., PRESIDENT, AMERICAN DIETETIC ASSOCIATION

Dietitians who have worked closely with agencies providing diet counseling services to persons requiring nutritional care at home know that whenever appropriate and possible utilizing home health services is preferable to institutional care. Most persons who are chronically ill prefer to be at home and home care is much less costly. For many persons utilizing the spectrum of home health services achieving and maintaining optimum nutritional status may be the key to benefiting from related care services, particularly the rehabilitative services such as physical therapy, speech therapy or occupational therapy. Patients debilitated by poor nutritional status have been known to respond dramatically to rehabilitative therapies only after dietary improvements that helped to correct a nutritional anemia, provided the nutrients for healing decubitus ulcers, or fractured bone, or generally improved the patient's stamina and well being. For many patients inactivity and/or excessive calorie intake contribute to undesirable weight gain which may interfere with mobility and impede rehabilitation efforts.

The concern of the members of the American Dietetic Association is that the full range of nutrition services is available to the Medicare patient as long as he is hospitalized. Upon discharge to a home health agency his eligibility for the services of a dietitian through home health visits is denied under existing law. Under the present conditions of the hospital insurance program of Medicare the utilization of home health services has declined while the cost of inpatient hospital care has risen sharply.

In 1971, 45 percent of the health bills in this country were paid by those 65 and over while this group represented only 10 percent of the population. The average daily rate for hospital care now exceeds $110 according to figures quoted by the Secretary of the Department of Health, Education, and Welfare. Services that would assist in keeping patients from hospitalization or rehospitalization certainly are worthy of serious consideration.

The position of the American Dietetic Association is that the inclusion of nutrition as a component of health care will significantly reduce the number of people requiring sick care service.

A number of dietitians working with certified home health agencies have been providing some nutrition services for many years so we do have knowledge of the scope of needed services and their value to the recipients. The services include: assessment of dietary intake, consultation with physicans prescribing diets, patient and family counseling and followup conferences with nurses and therapists, and the recording, reporting and monitoring of progress and results of the nutritional care.

Nutrition services, however, are not reimbursable so the costs must be absorbed by other resources available to the agency. This has limited the number of agencies that could offer service so it is not universally available. Home health services account for less than 1 percent of the Medicare dollar. It is estimated that the extension of home health benefits to include nutritional care would cost less than $5 million.

While dietary evaluation or assessment is desirable for all patients receiving home health services so that they can be assured optimum nutritional health and benefit from the variety of home health services offered not all beneficiaries of home health services need nutritional care. Those who do need it are not having it under the present terms of Medicare simply because they cannot afford it. Although some nutrition counseling can and should be offered by the public health nurse the knowledge and experience of the registered dietitian should be coordinated with the nursing services.

Many patients need more in-depth guidance on dietary needs as well as dietary adaptations than the nurse can provide. Some patients receiving care at home require a physician prescribed therapeutic diet. Few patients receive full adequate dietary instructions in the hospital or doctor's office. For some families the requirements of a therapeutic diet and the relative problems of food buying and preparation are both baffling and frustrating as well as costly. Careful, considerate counseling adapting the therapeutic meal pattern to the patient and the family eating pattern, life style and food budget is required so that the diet can function effectively in therapy.

DIETITIAN HOME VISIT OBJECTIVES

Some of the objectives of home visits from the dietitian are: to help diabetics to achieve control, avoid complications leading to rehospitalization and to lead seemingly normal lives; to help patients lose weight and achieve mobility; to speed the healing of bedsores so that other therapies can begin; to help restore the patient to a positive state of health; to assist the patients and their families in managing their specific nutritional needs.

To date no provisions have been made for the overall financing of nutrition services to make these services a widely available, viable component of the health delivery system, particularly for those receiving home health services. In Florida, however, many county health units which are also certified home health agencies have employed nutritionists who are providing some of the services described. Florida has 41 certified home health agencies in 29 counties with 19 of these in county public health units. In 1973, 47,300 patients received nursing services reimbursed as home health services under Medicare. It is estimated that while 100 percent of these would benefit from assessment of the nutritional quality of their lives and general nutrition information, about 30 to 40 percent of these would probably require intensive diet counseling with a series of visits from a registered dietitian. A home health visit by a dietitian in this State has been costed out to be $15 for a visit of 30 to 45 minutes, comparable to the visit of the public health nurse or other therapists in that State.

Cost benefit figures are frequently requested for nutrition and health services. These are difficult to provide for any health service but much more difficult when a service is offered on a scale limited in both breadth and depth. Should this type of data be desired it is suggested that the appropriate expertise be provided to programs when they are funded to offer nutrition services so that data may be collected and analyzed.

The health and nutrition examination survey (HANES) has been conducted by the National Center for Health Statistics since 1971 as a continuing national system to measure and then to monitor nutritional status in the United States.

In a preliminary report released in late February of this year relative to findings of 1971–72, the report reveals that over 29 percent of people ages 60–74, who were sampled in the data collection, with incomes below the poverty level had an intake of less than 1,000 calories for the period prior to interview, as compared with 16 percent of such age persons with incomes above poverty level. These figures represent individuals who are "noninstitutional." Certainly they could benefit health-wise from appropriate dietary counseling if it were available as a covered service.

A recommendation from the 1971 White House Conference on Aging was: "It is recommended that nutrition services and nutrition counseling be a required component of all health delivery systems, including such plans as Medicare, Medicaid, health maintenance organizations, home health services, extended care facilities and prevention programs."

In the spring of this year the National Nutrition Consortium, Inc.,[1] proposed "Guidelines for a National Nutrition Policy" which had been prepared for the Senate Select Committee on Nutrition and Human Needs. Under "Measures for Attaining the Goals of a National Nutrition Policy" taken from the "guidelines" are two which seem most appropriate to quote: "develop programs within the health care system that will prevent and rectify nutritional problems; assist the health professions in coordinated efforts to improve the nutritional status of the population throughout the life cycle."

Furthermore, the "Guidelines" in suggesting programs to meet the recommended goals said relative to services: "Nutrition programs should be established and expanded in the health care system. . . . Maintenance of good nutrition in all segments of the population should be promoted through health care centers which should be responsible for nutrition diagnosis and counseling. . . . Programs should include provision of a nutrition component in all health care centers in all geographic areas. Nutrition services should be under the direction (at some level) of a professional with competence in nutrition and dietetics."

[1] The American Dietetic Association, The American Institute of Nutrition, The American Society for Clinical Nutrition, The Institute of Food Technology.

In October 1971, The American Hospital Association published a "Policy Statement on Provisions of Health Services" in which are listed several recommended goals and programs. Of the 10 specific goals that this association endorses in this statement four relate to the position which the American Dietetic Association is putting forth at this time:

"1. A system for the delivery of health services must be developed which has as a primary objective the optimum health care of each and every person. Untreated illness in the community must be sought out and treated.

"2. The system for the delivery of health services must focus on individual needs, must be personalized through the skills and humanity of health personnel, and must preserve the dignity of the individual.

"3. The system for the delivery of health services must provide comprehensive health care. It must be able to provide the following components of care to each individual as needed: health maintenance, primary care, speciality care, restorative care, and health-related custodial care. Comprehensive health care must be developed as rapidly as possible.

"4. The system must include financial incentives for encouraging utilization of ambulatory facilities, extended care and nursing home facilities, and home care programs, rather than reliance predominantly on hospitalization."

Because nutritional health is increasingly being identified as a critical component of total health care, the American Dietetic Association recommends that any national health legislation provide for reimbursement for nutritional care. Otherwise for the vast majority of consumers these services needed by all will be provided only to the fortunate few served by those public or private health agencies who provide nutrition services through their own resources.

○