MEDICARE AND MEDICAID HOME HEALTH BENEFITS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

S. 421

A BILL TO PROVIDE FOR DEMONSTRATION PROJECTS FOR TRAINING AND EMPLOYMENT OF RECIPIENTS OF BENEFITS, UNDER PROGRAMS OF AID TO FAMILIES WITH DEPENDENT CHILDREN, AS HOMEMAKERS AND HOME HEALTH AIDES

S. 489

A BILL TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO ELIMINATE CERTAIN RESTRICTIONS AND LIMITATIONS IMPOSED FOR THE RECEIPT OF HOME HEALTH SERVICES AND TO MAKE MORE ACCESSIBLE HOME HEALTH SERVICES TO THOSE IN NEED, AND FOR OTHER PURPOSES

MAY 21 AND 22, 1979

Printed for the use of the Committee on Finance

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MEDICARE AND MEDICAID HOME HEALTH BENEFITS

MONDAY, MAY 21, 1979

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:30 p.m. in room 2221, Hon. Herman Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Dole, Packwood, Durenberger, and Chafee.

[The press release announcing the hearing and the bills S. 421 and S. 489 follows:]

[Press Release No H-20]

SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON MEDICARE AND MEDICAID HOME HEALTH BENEFITS

The Honorable Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will hold a hearing on Monday afternoon, May 21, 1979 to review the provision of home health benefits under the Medicare and Medicaid programs.

The hearing will begin at 2:30 P.M., Monday, May 21, 1979, in Room 2221 Dirksen Senate Office Building.

Senator Talmadge said, "There is growing acceptance and appreciation of the value of appropriate and properly provided home health services as a humane and less costly alternative to institutional care. Many home health agencies are now providing vitally needed services to older Americans under Medicare and to the poor under Medicaid. Now is a good time for us to evaluate the advantages and shortcomings of the existing home health programs, as well as to review proposals intended to expand and improve upon those services."

Requests to testify.—Senator Talmadge stated that witnesses desiring to testify during this hearing must make their requests to testify to Michael Stern, Staff Director, Committee on Finance, Room 2227, Dirksen Senate Office Building, Washington, D.C. 20510, not later than Friday, April 20, 1979.

Senator Talmadge said that because an unusually large number of requests to testify are anticipated, the Committee will not be able to schedule all those who request to testify. Those persons who are not scheduled to appear in person to present oral testimony are invited to submit written statements. He emphasized that the views presented in such written statements will be as carefuliy considered by the Committee as if they were presented orally.

All parties who are scheduled to testify orally are urged to comply with the guidelines below:

Notification of witnesses.—Parties who have submitted written requests to testify will be notified as soon as possible as to the time they are scheduled to appear. Once a witness has been advised of the time of his appearance, rescheduling will not be permitted. If a witness is unable to testify at the time he is scheduled to appear, he may file a written statement for the record of the hearing.

Consolidated testimony.—The Chairman also stated that the Committee urges all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common

viewpoint orally to the Committee. This procedure will enable the Committee to receive a wider expression of views on the total bill than it might otherwise obtain.

Panel groups.—Groups with similar viewpoints but who cannot designate a single spokesman will be encouraged to form panels. Each panelist will be required to restrict his or her comments to no longer than a ten-minute summation of the principal points of the written statements. The panelists are urged to avoid repetition whenever possible in their presentations.

Legislative Reorganization Act.—The Chairman observed that the Legislative Reorganization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument. The statute also directs the staff to prepare digests of all testimony for the use of Committee Members.

Senator Talmadge stated that in light of this statute and in view of the large number of witnesses who desire to appear before the Committee in the limited time available for the hearing, all witnesses must comply with the following rules:

(1) All statements must be filed with the Committee at least one day in advance of the day on which the witness is to appear. If a witness is scheduled to testify on a Monday or Tuesday, he must file his written statement with the Committee by the Friday preceding his appearance.

(2) All witnesses must include with their written statements a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 100 copies must be submitted to the Committee.

(4) Witnesses are not to read their written statements to the Committee, but are to confine their ten-minute oral presentations to a summary of the points included in the statement.

(5) Not more than ten minutes will be allowed for the oral summary.

Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written statements.—Witnesses who are not scheduled for oral presentation, and others who desire to present a statement to the Committee, are urged to prepare a written position of their views for submission and inclusion in the record of the hearings. These written statements should be submitted to Michael Stern, Staff Director, Committee on Finance, Room 2227, Dirksen Senate Office Building by June 4, 1979.

96TH CONGRESS
1ST SESSION

S. 421

To provide for demonstration projects for training and employment of recipients of benefits, under programs of aid to families with dependent children, as homemakers and home health aides.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 9 (legislative day, JANUARY 15), 1979

Mr. INOUYE and TALMADGE (for himself, Mr. INOUYE, Mr. NUNN, and Mr. MATSUNAGA) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for demonstration projects for training and employment of recipients of benefits, under programs of aid to families with dependent children, as homemakers and home health aides.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) the Secretary of Health, Education, and Welfare is authorized to enter into agreements with States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of eligible partici-

pants as homemakers or home health aides, who shall provide authorized services to elderly or disabled individuals, or other individuals in need of such services, and to whom such services are not otherwise reasonably and actually available or provided, who would, without the availability of such services, be reasonably anticipated to require institutional care.

(b) For purposes of this section the term "eligible participant" means an individual who has voluntarily applied for participation and who, at the time such individual enters the project established under this section, has been certified by the appropriate agency of State or local government as being eligible for financial assistance under a State plan approved under part A of title IV of the Social Security Act and as having continuously received such financial assistance during the ninety-day period which immediately precedes the date on which such individual enters such project and who, within such ninety-day period, had not been employed as a homemaker or home health aide.

(c)(1) The Secretary shall enter into agreements under this section with no more than twelve States. Priority shall be given to States which have demonstrated interest in providing services of the type authorized under this section.

(2) A State may apply to enter into an agreement under this section in such manner and at such time as the Secretary

may in his judgment prescribe through formal regulatory process or by other appropriate and expeditious means.

(3) Any State entering into an agreement with the Secretary under this section must—

(A) provide that the demonstration project shall be administered by a State health services agency designated for this purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act);

(B) provide that the agency designated pursuant to subparagraph (A) shall, to the maximum extent feasible, arrange for coordinating its activities under the agreement with activities of other State agencies having related responsibilities;

(C) establish a formal training program, which meets such standards as the Secretary may establish to assure the adequacy of such program, to prepare eligible participants to provide part-time and intermittent homemaker services or home health aide services to individuals who are elderly, disabled, or otherwise in need of such services, who would, without the availability of such services, be reasonably anticipated to require institutional care;

(D) provide for the full-time employment of those eligible participants who successfully complete the training program with one or more public agencies (or, by contract, with private bona fide nonprofit agencies) as homemakers or home health aides, rendering authorized services, under the supervision of persons determined by the State to be qualified to supervise the performance of such services, to individuals who are elderly, disabled, or otherwise in need of such services, who would, without the availability of such services, be reasonably anticipated to require institutional care, at wage levels comparable to the prevailing wage levels in the area for similar work;

(E) provide that such services provided under subparagraph (D) shall be made available without regard to income of the individual requiring such services, but that a reasonable fee will be charged (on a sliding scale basis) for such services provided to individuals who have income in excess of 200 percent of the needs standard in such State under the State plan approved under part A of title IV of the Social Security Act for a household of the same size as such individual's household;

(F) provide for a system of continuing independent professional review by an appropriate panel, which is

not affiliated with the entity providing the services involved, to assure that services are provided only to individuals reasonably determined in need of such supportive services;

(G) provide for evaluation of the project and review of all agencies providing services under the project;

(H) submit periodic reports to the Secretary as he may require; and

(I) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

(4) The number of participants in any project shall not exceed that number which the Secretary determines to be reasonable, based upon the capability of the agencies involved to train, employ, and properly utilize eligible participants. Such number may be appropriately modified, subsequently, with the approval of the Secretary.

(5) Any contract with a private bona fide nonprofit agency entered into pursuant to paragraph (3)(D) shall provide for reasonable reimbursement of such agencies for services on a basis proportionate to the amount of time allocated to individuals eligible to receive such services under this section (and, in case such agency is an institution, the amount of the reimbursement shall not exceed the amount of reimburse-

ment which would have been payable if the services involved had been provided by a free-standing agency).

(6) For purposes of this section, a facility of the Veterans' Administration shall, at the request of the Administrator of Veterans' Affairs, be considered to be a public agency. In the case of any such facility which is so considered to be a public agency, of the costs determined under this section which are attributable to such facility, 90 percent shall be paid by the State and 10 percent by the Veterans' Administration.

(d)(1) For purposes of this section, authorized homemaker and home health aid services include part-time or intermittent—

(A) personal care, such as bathing, grooming, and toilet care;

(B) assisting patients having limited mobility;

(C) feeding and diet assistance;

(D) home management, housekeeping, and shopping;

(E) health-oriented record keeping;

(F) family planning services; and

(G) simple procedures for identifying potential health problems.

(2) Such authorized services do not include any services performed in an institution, or any services provided under

circumstances where institutionalization would be substantially more efficient as a means of providing such services.

(e)(1) Agreements shall be entered into under this section between the Secretary and the State agency designated by the Governor. Under such agreement the Secretary shall pay to the State, as an additional payment under section 1903 of such Act for each quarter, an amount equal to 90 percent of the reasonable costs incurred (less the Federal share of any related fees collected) by such State during such quarter in carrying out a demonstration project under this section, including reasonable wages and other employment costs of eligible participants employed full time under such project (and, for purposes of determining the amount of such additional payment, the 10 percent referred to in subsection (c)(6), paid by the Veterans' Administration, shall be deemed to be a cost incurred by the State in carrying out such a project).

(2) Demonstration projects under this section shall be of a maximum duration of four years, plus an additional time period of up to six months for planning and development, and up to six months for final evaluation and reporting. Federal funding under this subsection shall not be available for the employment of any eligible participant under the project after such participant has been employed for a period of three years.

(f) For purposes of title IV of the Social Security Act, any eligible participant taking part in a training program under a project authorized under this section shall be deemed to be participating in a work incentive program established by part C of such title.

(g) For the first year (and such additional immediately succeeding period as the State may specify) during which an eligible participant is employed under the project established under this section, such participant shall, notwithstanding any other provision of law, retain any eligibility for medical assistance under a State plan approved under title XIX of the Social Security Act, and any eligibility for social and supportive services provided under the State plan approved under part A of title IV of such Act, which such participant had at the time such participant entered the training program established under this section.

(h) The Secretary shall submit annual reports to the Congress evaluating the demonstration projects carried out under this section, and shall submit a final report to the Congress not less than six months after he has received the final reports from all States participating in such projects.

(i) The Secretary shall, and is hereby authorized to, waive such requirements, including formal solicitation and approval requirements, as will further expeditious and effective implementation of this Act.

96TH CONGRESS
1ST SESSION

S. 489

To amend title XVIII of the Social Security Act to eliminate certain restrictions and limitations imposed for the receipt of home health services and to make more accessible home health services to those in need, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 26 (legislative day, FEBRUARY 22), 1979

Mr. DOMENICI (for himself, Mr. PACKWOOD, Mr. CHILES, Mr. LEAHY, Mr. BELLMON, Mr. BAKER, Mr. EAGLETON, Mr. CHAFEE, Mr. PERCY, Mr. CHURCH, Mr. HEINZ, Mr. RIEGLE, Mr. THURMOND, Mr. BURDICK, Mr. COHEN, Ms. KASSEBAUM, and Mr. SCHMITT) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend title XVIII of the Social Security Act to eliminate certain restrictions and limitations imposed for the receipt of home health services and to make more accessible home health services to those in need, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Medicare Home Health Amendments of 1979".

SEC. 2. (a) Section 1811 of the Social Security Act is amended by inserting "and home health services" immediately after "hospital and related post-hospital services".

(b) Section 1812(a)(3) of such Act is amended to read as follows:

"(3) home health services.".

(c) Section 1812(d) of such Act is repealed.

(d) Section 1812(e) of such Act is amended—

(1) by striking out "(b), (c), and (d)" and inserting in lieu thereof "(b) and (c)"; and

(2) by striking out "post-hospital extended care services, and post-hospital home health services" and inserting in lieu thereof "and post-hospital extended care services".

(e) Section 1814(a)(2)(D) of such Act is amended to read as follows:

"(D) in the case of home health services, (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, occupational, or speech therapy; (ii) a plan for the furnishing of such services has been established and is periodically reviewed by a physician or, in the case of home health services provided in a

rural area described in clause (i) of the second sentence of section 1861(aa)(2), by a physician's assistant or nurse practitioner (as defined in section 1861(aa)(3)) who is under the general supervision of a physician and is certified as being competent to establish and review such a plan (as determined pursuant to regulations of the Secretary); and (iii) such services are or were furnished while the individual is or was under the care of a physician; or".

(f)(1) Section 1814(i)(1) of such Act is amended by striking out "posthospital".

(2) Section 1814(i)(2) of such Act is amended—

(A) by striking out "that individuals have conditions designated in regulations as provided in this subsection" and inserting in lieu thereof "with respect to the condition or conditions by reason of which the individual is required to have home health services"; and

(B) by inserting after "physician" each place it appears therein, "or physician's assistant or nurse practitioner (as defined in section 1861(aa)(3)) certified under subsection (a)(2)(D)".

(3) The heading of section 1814(i) of such Act is amended by striking out "Posthospital".

(g) Section 1832(a)(2)(A) of such Act is amended by striking out "for up to 100 visits during a calendar year".

(h) Section 1834 of such Act is repealed.

(i) Section 1835(a)(2)(A) of such Act is amended to read as follows:

"(A) in the case of home health services, (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical occupational, or speech therapy; (ii) a plan for the furnishing of such services has been established and is periodically reviewed by a physician or, in the case of home health services provided in a rural area described in clause (i) of the second sentence of section 1861(aa)(2), by a physician's assistant or nurse practitioner (as defined in section 1861(aa)(3)) who is under the general supervision of a physician and is certified as being competent to establish and review such plan (as determined pursuant to regulations of the Secretary); and (iii) such services are or were furnished while the individual is or was under the care of a physician;".

(j) Section 1861(m) of such Act is amended—

(1) in the matter preceding paragraph (1), by inserting "or, in the case of home health services provided in a rural area described in clause (i) of the

second sentence of subsection (aa)(2), by a physician's assistant, or nurse practitioner (as defined in subsection (aa)(3)) who is under the general supervision of a physician and is certified as being competent to establish and review such a plan (as determined pursuant to regulations of the Secretary)" immediately after "reviewed by a physician";

(2) by inserting "who has successfully completed a training program which is in conformity with applicable standards developed by the Secretary under section 1861(o)(6))" before the semicolon at the end of paragraph (4); and

(3) by adding at the end thereof the following new sentence: "In establishing the plan required by this subsection the physician (or physician's assistant or nurse practitioner) shall include a program of patient education aimed at achieving (to the maximum extent feasible) independence for the individual from the need for care provided by other persons.".

(k)(1) Section 1861(n) of such Act is repealed.

(2) Section 1861(e) of such Act is amended by striking out "subsections (i) and (n) of this section" each place it appears and inserting in lieu thereof in each instance "subsection (i) of this section".

(l) Section 1861(o) of such Act is amended—

(1) by striking out "and" at the end of paragraph (5);

(2) by inserting before the semicolon at the end of paragraph (6) the following: ", which shall include standards developed by the Secretary with respect to health, safety, and the quality and appropriateness of services, including (A) training of home health aides, and (B) uniform standards for data collection to ensure appropriate evaluation of care"; and

(3) by adding after paragraph (6) the following new paragraphs:

"(7) submits on a bimonthly basis, in accordance with uniform standards to be established by the Secretary, a bill to each individual receiving home health services from such agency which lists all services provided to such individual during that 2-week period, the day on which each service was provided, the charge for each service, and the name and title of the individual who provided each service; and

"(8) meets such additional requirements as the Secretary may find necessary for the effective and efficient operation of the programs established under this title.".

(m)(1) Section 1861(e) of such Act is amended—

(A) by inserting "(subject to the provisions of paragraph (4))" after "the Secretary may" in paragraph (2); and

(B) by adding the following new paragraph at the end thereof:

"(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region (except those home health agencies which choose to have payments made to them directly by the Secretary). Such agencies or organizations shall perform activities such as monitoring home health agency costs in each region, preparing and publishing annual cost comparison tables for such agencies in each region, and monitoring the standards that are developed by the Secretary under section 1861(o)(6).".

(2) Section 1842(f) of such Act is amended—

(A) by inserting "(but subject to paragraph (3))" after "other persons" in paragraph (1);

(B) by inserting "(but subject to paragraph (3))" after "providers of services only" in paragraph (2);

(C) by striking out "and" at the end of paragraph (1);

(D) by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; and"; and

(E) by adding at the end thereof the following new paragraph:

"(3) with respect to home health agencies, only a regional agency or organization designated by the Secretary under section 1816(e)(4).".

(n) Section 226(c)(1) of such Act is amended—

(1) by striking out "and post-hospital home health services" and inserting in lieu thereof "and home health services"; and

(2) by striking out "or post-hospital home health services" in clause (B).

(o) Section 7(d)(1) of the Railroad Retirement Act of 1974 is amended by striking out "posthospital home health services" and inserting in lieu thereof "home health services".

SEC. 3. (a) The Secretary of Health, Education, and Welfare shall establish, in accordance with the provisions of section 1861(v)(1)(A) of the Social Security Act, guidelines for the direct and indirect incurred costs of providers of home health services, within one hundred and twenty days after the date of the enactment of this Act, and such guidelines shall be the basis for determining reasonable cost for home health services as provided in such section 1861(v)(1)(A).

The guidelines shall apply to specific line item costs which constitute home health services.

(b) The Secretary of Health, Education, and Welfare shall monitor the costs of home health services and shall report to the Congress within thirty days if he determines for any period that the cost of home health services is increasing at a rate greater than the rate of increase in the medical care services component of the Consumer Price Index (as determined by the Department of Labor). Such report shall include any recommendations for action, including recommendations for legislative action, which the Secretary considers necessary or appropriate.

(c) The Secretary of Health, Education, and Welfare shall issue an interim report to the Congress eighteen months after the date of the enactment of this Act, and shall issue a final report to the Congress three years after the date of the enactment of this Act, on the frequency of use of home health services by individuals eligible for benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act. The report shall include an analysis of the increase (if any) in the number of home health visits resulting from the removal of the one hundred-visit limit (under this Act), and any recommendations with respect to a numerical limitation on such visits.

SEC. 4. (a) The amendments made by section 2 shall, except as provided in subsection (b), apply with respect to items and services furnished on or after the first day of the first month which begins more than one hundred and twenty days after the date of the enactment of this Act.

(b) The standards required to be developed by the Secretary of Health, Education, and Welfare by the amendment made by section 2(l)(2) shall be developed within one year after the date of the enactment of this Act.

SEC. 5. (a) The Secretary of Health, Education, and Welfare shall establish demonstration projects to test, over a two-year period, the effectiveness of agency or multiagency utilization review committees in ensuring the medical necessity, cost efficiency, and appropriate use of home health services.

(b) Such committees shall be composed of professional personnel from the home health agency or from that agency and other home health agencies which share the same utilization review committee with such agency and at least three professional personnel who are not employees of any such agency and have no financial interest in any such agency. The professional personnel who are not employees of any such agency must have a working knowledge of home health care services. Further, the three or more professional personnel who are not agency staff, but are part of the utilization

review committee, must include at least one physician and one representative from the community.

(c) The utilization review committee shall be responsible for assuring the efficient use, medical necessity and appropriate utilization of home health services. Such committee shall (1) focus on the quality and efficacy of home health services; (2) monitor the continued need for home health services; (3) determine if the services are being provided in accordance with the patient's plan of care; (4) determine if such services are appropriately used; and (5) determine that a periodic reassessment is made of the patient's needs, with appropriate revisions in the plan of care.

(d) The demonstration projects shall be established in such areas so as to include variations in population density, geographical areas, types of agencies, and types of facilities which house such agencies.

(e) The Secretary shall report to Congress within six months after the completion of the demonstration projects with respect to the effectiveness of the projects and any proposals he may have for legislative action.

Senator TALMADGE. The subcommittee will please come to order.

Today is the first of 2 days of testimony on the important subject of home health care services.

Properly provided home health care and related services are generally conceded to be the humane and economic alternative to institutional care.

But there is an obvious need to approach the question of expansion of home health services with caution.

As the Comptroller General of the United States and others have pointed out, there is in many areas a lack of an effective definition of services and, even greater, a lack of effective control over the utilization and costs of these services. The work of the Senate Special Committee on Aging, the Senate Permanent Subcommittee on Investigations, the General Accounting Office, and the Department of Health, Education, and Welfare have indicated areas of significant abuses and apparent fraud in the operations of some of the home health and homemaker agencies in a number of States, including California, Illinois, and Florida—problems from one coast to the other.

At the same time there is a need to accelerate proper development of coordinated and properly utilized home health care services.

Probably the greatest area where health insurance coverage is lacking is that of long-term care.

Obviously, then, the pressure is on to provide coverage for that kind of care in any new national health insurance legislation.

My own concern is that, absent effective and generally available home care programs, the end result would be a further increase in the placing of people in long-term institutions who could more appropriately and more humanely be cared for at home.

We will hear testimony concerning what appear to be excessive costs charged by some agencies in providing care.

At the same time, I believe we need to recognize differences in patients and services of different home health programs.

Certainly, many hospital-based programs provide care to patients who need a more extensive and complex level of services.

Legitimate differences in costs should be recognized.

On the other hand, recognition of legitimate differences should not be an excuse for piling the expense of services of dubious value onto the federally financed programs.

There is also the question of proposed participation in medicare of proprietary for-profit home health agencies without regard to whether they are licensed by a state.

Today, medicare will pay for a for-profit agency if it is licensed by a State.

Legislation is being proposed to have the Secretary of HEW set the standards for proprietary agencies, bypassing any requirements of State licensure.

Since medicare and medicaid were enacted, the quality of State supervision of health care providers has, in my opinion, increased significantly.

The Federal Government, in fact, relies more and more on the States to assure compliance with proper standards of health and safety of operation.

Frankly, I do not think we need any more authority lodged in the Secretary of HEW to override a State decision with respect to licensure of for-profit home health agencies.

On the other hand, my inclination is that nonprofit home health agencies should also be licensed and all home health agencies should be subject to certification of need requirements.

In any case, we have an extensive list of witnesses, and I suspect that we will hear testimony pro and con on these matters.

Again, in view of the large number of witnesses, I would ask that every effort be made to comply with the committee's time requirements.

And now, it is a pleasure to hear from Senators Chiles, Cohen, and Domenici.

I want to welcome you to this hearing and we look forward to your constructive statements.

Before we proceed, gentlemen, do you have any statements, Senator Packwood?

Senator PACKWOOD. Mr. Chairman, I have a rather lengthy opening statement that I ask be placed in the record.

Senator TALMADGE. Without objection, it will be inserted in full at this point.

[The opening statement of Senator Packwood follows:]

STATEMENT BY BOB PACKWOOD

Mr. CHAIRMAN. I am very pleased that the Senate finance Committee has chosen to accept my recommendation to hold hearings on the most important issue of home health care, and I'd like to thank Jay Constantine, the chief health professional staff member, for his immediated assistance on this issue.

Home health care represents one of the most effective alternatives to institutionalization for older Americans who become ill but would prefer to remain in their own homes as long as possible. Yet the Administration has chosen not to support this vital program because of "budgetary limitations." This was demonstrated again when the Administration sent Congress the long-awaited and long-delayed H.R. 3 Report. This report was originally designed to analyze, evaluate, and make recommendations to Congress on all aspects of home health services under the Social Security Act. However, when we finally received this report, it lacked one essential ingredient: legislative recommendations. As a consequence, I believe it is necessary that the Administration witnesses be prepared to answer questions about the report, and more importantly, state their position on strengthening the home health care program under Medicare.

Demographers project a numerical increase in the older American population to a total of over 32 million persons over the age of 65 by the year 2000. Between the years of 1975 and the year 2000, we can expect the age group 65-74 to increase 22.3 percent; the age group 75-84 to increase by 56.9 percent; and the age group 85 and older to increase by 92.1 percent. That health-related problems currently experienced by the elderly are expected to increase and diversify as a result of the increasing numbers of older persons, substantiates the need for greater availability of alternative healthy delivery systems such as home health care.

Much research has been conducted documenting the effectiveness of home health care as a mechanism to allow older people to remain in their own homes for as long as possible. The recent publication of "Health U.S.A.," 1978, reported that, "In a recent H.C.F.A. study (soon to be released) it has been estimated that a year of home care services based upon 1975 average of $428 per year for those 65 years of age costs approximately half the monthly bill for a nursing home (using a 1975 nursing home cost average of $800 per month)."

Since it is clear that providing home health care for older Americans will benefit all concerned from both a humane and an economic standpoint, it would behoove the Congress, and particularly this committee, to determine how we can best strengthen the home health care program under Medicare.

To date, the Finance Committee has accepted two of the provisions from S. 489, the elimination of the three-day prior hospitalization requirement and the provision for unlimited home health visits.

While Senator Domenici is going to touch upon the remaining provisions of our bill, I would like to commend the Senator for his leadership on this issue, and his staff for their excellent work. Therefore, I would like to examine some other provisions which have not been addressed to date, in legislative form.

First, one of the major concerns of home health agencies is the issue of coverage for the evaluation visit, that is, those visits that are required by Medicare for each home health recipient prior to receiving services. To date, the cost of such visits has been charged as administrative expenses to each agency, and as a result, the agency's expenses increase. It is important that we consider changing this requirement to provide coverage of the evaluation visit as an allowable cost rather than continue this provision as an administrative expense.

Second, we have thousands of trained dieticians in this country, whose services go unrecognized as a covered benefit under the current design of the Medicare home health program. Subsequently, nurses and other professionals, who are not formally trained in this area, are forced to give nutrition counseling. While I recognize the excellent job nurses and others have been able to perform to date, I believe we should consider amending current law to include nutrition service visits as an allowable medicare benefit.

Third, this country has experienced an increase in the number of terminally ill persons who wish to stay at home, rather than be forced to spend their last remaining days in an institution. Yet, while the desire to do so is there, the current Medicare program does not cover the types of services often needed by these persons. It is important that we examine the possibility of including some coverage of home health services to terminally ill patients.

Fourth, homemaker services—those services which are not considered to be skilled services—should be given careful consideration as a covered benefit under Medicare. Often a Medicare beneficiary is not in need of skilled nursing services, but is in need of some form of non-skilled homemaker-type of assistance. Such services will enable these persons to remain at home, rather than be prematurely and often unnecessarily institutionalized.

In my own State of Oregon, we have a program entitled Project Independence, which is designed to provide supportive services to help older Americans remain in their own homes. The success of this program has been publicized nationwide. The need, therefore, for the availability of supportive homemaker-type services increases as our elderly population continues to grow.

Fifth, H.E.W. recently proposed "cost limit" guidelines for home health agencies. While I believe it is important to set cost limits in home health care, I also believe we should do so realistically. The distinction H.E.W. has chosen to use between urban and rural areas needs to be closely examined. Often the geographical differences are important ones. Further, I am concerned that these proposed limits do not take into consideration the "start-up" costs experienced by new home health agencies. Therefore, I am hopeful that the witness for the Administration will also be able to address this issue.

Finally, while there is a pressing need to strengthen and prudently expand the availability of home health services in this country, it is equally important that we also address other long-term health care needs of our aging population. I believe we are at a point in this country today where we must develop over the next decade a comprehensive approach to the health delivery problem which recognizes fully the problems of this country's aging population. Such an approach must not only provide health services, but must begin to realistically develop preventive health education programs which consist, in part, of teaching self-care and self-examination. Further, available alternatives to institutionalization must also be developed. Home health care is only part of this systems approach. The remaining parts must be developed as part of a comprehensive long-term care bill.

I believe it is important we recognize that while incremental changes are needed to make home health care more effective, it is equally as important we begin to look at the serious problems surrounding Medicare, Medicaid, and Title XX.

There is currently a lack of coordination among these programs. While we have discussed changes to make these programs more effective, we really have NOT followed through. Medicare was developed with an institutional bias that still exists and continues to be an administrative nightmare. Medicaid's problems speak for themselves, and the role of Title XX in health care remains, in part, a question of interpretation.

Therefore, we are faced with more than just changing the allowable benefits structure under Medicare. As responsible legislators, we are faced with the challenge of moving immediately to examine these programmatic problems and developing workable solutions, and the time to do so is now!

As a consequence, I hope that my colleagues on the Finance Committee will join with me in working toward this goal. To this end, I have asked my staff to prepare a series of long-term care initiatives which will help solve these problems, but which also recognizes the need to maintain a cost-sharing approach. It is my hope that these proposals will be introduced over the next six weeks.

Senator PACKWOOD. I would like to read a brief statement.

Mr. Chairman, I am pleased that the Senate Finance Committee has chosen to hold hearings on the important issue of home health care. I further would like to thank Jay Constantine, chief health professional staff member for his immediate assistance on this issue.

Home health care represents one of the most effective alternatives to institutionalization, yet the administration has chosen not to support this vital program because of budgetary limitations.

This was further demonstrated when the administration sent Congress the long-awaited, long-delayed H.R. 3 report. Numerous research has been conducted documenting the effectiveness of home health care as a mechanism which assists older people to remain in their own homes for as long as possible.

The recent publication of "Health, U.S.A., 1978," reported that in a recent HCF study, soon to be released, it has been estimated that a year of home care services based on the 1975 average of $428 per year for those 65 years of age, costs approximately half the monthly bill for a nursing home, using a 1975 nursing home cost average of $800 per month.

Therefore, the question really faces this Congress, particularly this committee, is how we can best strengthen the home health care program under medicare.

As we discuss amending the medicare home health program, I think it is important that we should give consideration to: One, amending the requirement to provide coverage of the evaluation visit as an allowable cost rather than continuing this provision as an administrative expense.

Two, allowing certified dietitian services as a covered benefit.

Three, including some coverage of home health services to terminally ill patients and four, allowing for the coverage of homemaker-home health aides.

I believe it is important to recognize that, while incremental changes are needed to make home health care more effective, it is equally as important that we begin to look at the serious problems surrounding medicare, medicaid and title XX.

There is currently a lack of coordination among these programs. While we have discussed changes to make these programs more effective, we have not really followed through. Medicare was developed with an institutional bias that still exists and continues to be an administrative nightmare. Medicaid's problems speak for themselves and for title XX, health care remains, in part, a question of interpretation. Therefore, we are faced with more than just changing the allowable benefits structure under medicaid. As responsible legislators we are faced with the challenge of moving immediately

to examine these programmatic problems and developing workable solutions, and the time to do so is now.

As a consequence, I hope that my colleagues on the Finance Committee will join with me in working toward this goal. To this end, I have asked my staff to prepare a series of long-term health care initiatives which will help solve these problems but which also recognize the need to maintain a cost-sharing program.

Senator TALMADGE. Thank you, Senator Packwood.

Any statement, Senator Dole?

Senator DOLE. Just very briefly.

I appreciate the comments of the chairman, Senator Talmadge, and would also underscore the outstanding work both the chairman and Senator Packwood have done and one of the measures that we will be discussing today, proposed by the distinguished Senator from Oregon.

As he properly pointed out, the medicare program has previously favored institutionalization. I would hope we can change that bias.

Senator TALMADGE. Without objection it will be inserted in full in the record.

[The prepared statement of Senator Dole follows:]

STATEMENT OF SENATOR BOB DOLE

Mr. Chairman, I am pleased to join with you this afternoon, in welcoming our witnesses. The subject of home health care is an important area, one that deserves our attention.

INSTITUTIONAL BIAS

Home-based health services offer to many individuals the opportunity to remain in surroundings most supportive of their physical and mental well being. But traditionally, the Medicare Program has heavily favored institutionalization. In addition to being costly, this focus has also often resulted in unnecessary use of institutions, at a time when there are many efforts to decrease the costs of health care. We must begin to seek out alternative locations for the delivery of care. One such location should certainly be the home.

HISTORICAL PERSPECTIVE AND PROBLEMS

Congress originally included home care benefits in the Social Security Amendments of 1965; utilization of these services has increased since that time, but so have the problems. The problems are found in many areas.

Congressional hearings in 1976 and 1977 raised numerous questions about the reasonableness of home health agency costs; questions have been raised about the restrictive nature of the homebound requirement; some have claimed that there is no coordinated home health policy in this country, others have noted our failure to use these services to their fullest extent.

All of these, and other issues that I hope will be raised today, must be addressed. It is, however, of no use to merely point out the problems, we must also seek out answers. Because of this I was disappointed to note that the Administration did not include in their report any recommendations for change.

While recognizing the fiscal difficulties facing the Medicare Program, I nonetheless believe that the Department does have the responsibility to point out potential solutions to problems and then allow the Congress the opportunity to debate them on their merits. To provide us no suggestions for change, and merely a listing of problems, is to have only done half the job. I am hopeful, however, that the Administration in its testimony today will provide us with some solutions to the problems they note in their report.

As many of you may be aware, Senators Danforth, Domenici and I recently introduced catastrophic health insurance and Medicare amendments of 1979. This legislation contains a number of provisions dealing with home health care which would delete all limits on the number of days, liberalize the homebound requirement, and add occupational therapy as a primary service. Other provisions are also included. Senators Domenici and Packwood have also introduced S. 489, the Home

Health Care amendments of 1979, which contains a number of additional suggestions.

I believe our bills address some of the problems that exist—certainly not all. I hope to hear from the witnesses some further recommendations.

ALTERNATIVE CARE FOR TERMINALLY ILL

One area that I hope receives particular attention is the potential for the use of home care services by the terminally ill. The focus of our health care delivery system, even home care, has been historically directed toward caring and curing. Central to this is the question of what kind of care is more appropriate for the terminally ill?

As society has moved from the extended family of old to the smaller, non-extended family of today, the support systems necessary to care for a terminally ill family member have become less available. This is further complicated by our present reimbursement system which pays for institutional care but not for home care in most instances.

There is a desire on the part of many to look to home care again as a viable resource.

In a south-central Connecticut survey of deaths from cancer, between 1969 and 1971, 67 percent of the patients expressed a desire to die at home as opposed to the 20 percent who did die at home. However, in order for home care to again become a reality we must determine the type of support systems the family and the individual need.

We must also continue to seek out other models of care, for while there is general consensus that for the individual with appropriate support systems, financial means, etc., the best place to die may be at home, there are circumstances, such as the physical condition of the individual, where this is not appropriate.

What appears to be emerging is a sensitivity toward the dying individual and an appreciation for the role of the family and the home in caring for these people. We must seek out forms of treatment that support this movement, and afford the individual the optimum opportunity to make their own decisions.

CONCLUSION

I look forward to hearing from each of you today, and from those witnesses scheduled to testify tomorrow. Together we must seek out answers that will result in a health care delivery system that is sensitive to the needs of our people.

Senator DOLE. As we hear the statements from our distinguished witnesses, starting with our colleagues, Senators Chiles, Cohen, and Domenici, I hope that we can come to grips with the problem and perhaps make the necessary modifications, and that the HEW witnesses will not only address the problems that we may underscore but provide us some guidelines for finding solutions.

I would like to touch on one area that I hope receives attention in this intensive use of home care services by the terminally ill. The focus of our health care delivery service, even home care, has been historically directed toward caring and curing. An example of this is a question of what kind of care is more appropriate for the terminally ill.

Our society has moved from the extended family to the small centralized family of today. Service to care for the terminally ill is less available in our present system, which favors institutional care, not home care, in most instances.

There is a desire on the part of many for home care as a viable resource. In south central Connecticut, a survey of deaths from cancer between 1969 and 1971 show that 67 percent of the patients expressed a desire to die at home as opposed to the 20 percent who did die at home.

However, in order for home care to again become a reality, we must discover the type of support system the family and individual need. It just seems to me that this is a highly appropriate time for

these hearings, and I look forward to the testimony of the witnesses.

Thank you, Mr. Chairman.

Senator TALMADGE. Thank you, Senator Dole.

Senator Chiles is chairman and Senators Domenici and Cohen are members of the Subcommittee on Aging and have requested an appearance. I am delighted that you could come.

Senator Chiles has been delayed.

Senators Domenici and Cohen, you may proceed in any manner that you see fit.

STATEMENT OF HON. PETE V. DOMENICI, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Senator DOMENICI. Thank you, Mr. Chairman and members of the committee. If Mr. Cohen would agree, I would like to go first, and I will be very brief.

Senator TALMADGE. You may insert your full statement in the record and summarize it in any manner that you see fit, Senator.

Senator DOMENICI. Thank you, Mr. Chairman.

I would say that Senator Chiles, the chairman of the Special Committee on Aging has exhibited a very significant interest in this area. I am sure that he is detained for good and proper reasons. I am also involved in another hearing on energy. So I intend to be very brief.

However, I want to start with two accolades.

First, I want to thank Jay Constantine, a member of your majority staff, for the cooperation and kindness he has shown to our staff on the Aging Committee in helping us on this matter. I would also like to thank this committee for holding these hearings and deciding, in spite of the administration's opposition, to consider making some significant changes in home health care this year.

Senator Cohen, while he was a Member of the House, did a genuine service in getting legislation passed that required the administration to study in detail issues related to home health care.

I think he can tell you what has happened to that report. I think it is common knowledge that we have to begin to get away from favoring institutionalization and move toward alternative forms of health care delivery.

I have a rather detailed statement, Mr. Chairman, along with a letter that I have sent to about 1,000 people who participate as managers and administrators of home health care providers. We are beginning to receive replies. We will try to put them in a meaningful manner and, if the record is still open, we will supply the committee with the responses.

Senator TALMADGE. We will keep the record open for any material you desire to insert.

Senator DOMENICI. I ask that my full statement be submitted at this point.

Senator TALMADGE. It will be inserted.

Senator DOMENICI. Let me commend the committee for taking a step in the right direction. Senate bill 489 has a number of provisions that we think would greatly improve home health care. Senator Cohen is a cosponsor, as is Senator Packwood, and, of course, Senator Chiles, chairman of the Aging Committee.

I understand that two very important parts of that bill have already been considered and are going to be included in major legislation modifying our health care delivery system. First, is the elimination of the 3-day hospitalization requirement for senior citizens under medicare. That is an absolute must, in my opinion. The 3-day requirement is a disincentive, as I see it, to expanding home health care and, conversely, an incentive to hospitalize—the true cost of which we will never be able to measure until we got rid of it. I think it is good that this subcommittee is going to abolish it.

Second, I understand you have decided, as a committee, to lift the limit on home health visits.

There are a number of other provisions in S. 489 such as designating regional intermediaries, allowing physician assistants and nurse practitioners who are under the general supervision of a physician to develop plans of care for home health recipients in rural areas, including occupational therapy as a primary service, and requiring all home health care aids to complete an approved training course. I have itemized these points in greater detail in my full statement. I think they are important and I urge this committee to include as many of those innovations as possible in your final bill.

Having said that, let me say to this committee that, for too many years this administration and other committees in the Senate and the House have refused to make major changes of the type we are contemplating here today. They have argued that health care is already too expensive and to make any changes will just cost the Federal Government more money. I urge you to follow through with what you are doing and ignore that kind of rationale. If you follow the old line of thinking, you are never going to make any changes away from the present institutional thrust, because anything new costs more money.

That is not the issue. The issue is a delivery system that includes more than one thrust, because that is what this country needs. Ultimately, it will be more efficient, more cost effective, and more importantly, it will probably serve Americans better.

I thank the members of the committee.

Senator TALMADGE. Senator, I thank you for an excellent statement. It is my recollection that your State, New Mexico, took the lead in training people on welfare as home health aids under the work incentive program. I understand they have done an outstanding job.

Is that a correct assessment?

Senator DOMENICI. That is absolutely correct, Mr. Chairman.

Also, because of the efforts of our State legislature, our medical schools have gone out into the rural areas and are experimenting with innovative ways to deliver services.

As long as medical students and paramedics are under the direction of a doctor, they have an important place in rural communities which have no doctors. Some of those paramedics and aides were trained under the program you described and it has been a tremendous success.

Senator TALMADGE. Are there any questions?

Senator Packwood?

Senator PACKWOOD. No.

Senator TALMADGE. Senator Dole?

Senator DOLE. No.

COST AND CHARGE OF SERVICES

	Nursing	Physical Therapy	Speech Therapy	Occupational Therapy	Home Health Aide	Social Work Service	Other (Specify)
Agency Cost per Visit based on last completed fiscal year ending _____.							
Current Charge per Visit as of _____. (date)							
Cost per Hour (if applicable) based on last completed fiscal year ending _____.							
Current Charge per Hour (if applicable) as of _____.							
Average Number of Visits Per Patient							
Average Length of Visit (includes pre, post, and travel time)							
Medicare Reimbursement per Visit (adjustment based on last settled cost report) (year ending _____.)							

Senator TALMADGE. Senator Chiles has arrived.

You may proceed in any manner you see fit, Senator. We are delighted to have you.

STATEMENT OF HON. LAWTON CHILES, A U.S. SENATOR FROM THE STATE OF FLORIDA

Senator CHILES. Thank you very much, Mr. Chairman. I want to commend the Finance Committee for its review of needed changes in Federal programs in support of home health care, and I appreciate this opportunity to appear before you. Senator Domenici and Senator Cohen are also addressing provisions of S. 489 which I have cosponsored to make improvements in medicare's home health program.

I strongly endorse this bill. Many of its provisions have already been approved by your committee. Insuring access to quality home health care is an important issue now and will continue to demand close attention. I would like to direct my comments to other areas that I feel must be acknowledged and acted upon very soon.

I urge you to recognize and carefully consider the dilemma we face in home health care. Controls against financial waste and abuse must be significantly improved and the quality of home health care services must also be improved. This is true for home care financed under medicaid and title XX as well as medicare.

Access to home care must be significantly expanded before we can begin to meet current needs.

Our Committee on Aging estimates that up to 4 million noninstitutionalized persons over the age of 65 have a need for some form of supportive home care. Less than 2 million now have access to this care and this gap is going to increase as our older population increases.

Hale Champion told us at a hearing this morning that coming to grips with the home care system is one of the most important problems of the last quarter century and if we do not solve our problems, we will be in real trouble.

At the same time, we are afraid we will not be able to meet these needs without careful attention to cost. Significant savings can be achieved through better program management.

All three programs must be viewed together.

I urge you to direct the Department of Health, Education, and Welfare to move quickly in this area. Delay and procrastination give those who choose to control costs by denying service the opportunity to cry fraud and abuse and use that as a crutch and as a reason why we should not increase services.

The time is running out and action needs to be taken now. The authority given to the Department under the 72 amendments to the Social Security Act and the 1977 Anti-Fraud and Abuse Amendments to strengthen management of home care programs has not been wisely used. Action has been too slow.

S. 489 would require action now and guidelines for administrative and contracting costs, regional intermediaries, and in other areas.

Investigations conducted by the Subcommittee on Federal Spending Practices, which I chair, and the Committee on Aging, have produced ample evidence of weakness in administration of home

care programs. A report issued by the General Accounting Office just last week again has confirmed that opportunities for program waste and abuse exist.

GAO has recommended the Department develop medicare guidelines for administrative costs of home health agencies and clarify contracting practices. I believe this committee should require the Department to act on these recommendations.

I repeat again, the needs are great and time is running out. The question of whether or not an increased emphasis on home health is a desired objective has already been answered. A Committee on Aging survey shows a pronounced trend toward increased state reliance on home care services under medicaid and title XX, particularly under title XX.

Medicare home health expenditures are also increasing, even though they account for only 2 percent of overall medicare expenditures. We certainly should expect further growth.

Home health care must be viewed in the context of all three programs. Without this integrated view, opportunities for program abuse are magnified and overall costs are increased. We are inviting trouble when manipulation of reimbursement sources is forced on providers by the programs themselves, and this has been the case. Home care services provided under medicaid and title XX are often of inferior quality and abuses are now emerging.

The most basic needs filled through these three separate programs are similar, differing mostly in the degree of medical care provided. The authorizing legislation and regulations do not recognize this. The goals are the same; but eligibility, definitions of services allowed, and needs to be served are all different.

The HEW staff has concluded that every aspect of the program precludes the development of a rational, organized cost-effective system of health care and, in the long term, it may be desirable for this committee to address the complete integration of home care services reimbursed under the three programs. The questions of Federal and State responsibility should also be addressed in this context.

The committee can make some steps now toward this goal:

One, to encourage States to develop uniform definitions and standards for home care services delivered under title XX and medicaid, under guidelines prepared by the Secretary. Uniform reporting and auditing in title XX and medicaid home-care services should be encouraged. This should coincide with similar initiatives between medicare and medicaid.

Two, we should change the medicare definition of home health aid to homemaker home health aid, in recognition of the artificial distinctions which are now drawn between these similar services Benefit restrictions could be similar to restrictions now placed on the use of home-health aide services alone. This step would not expand the medicare home health program to a whole new category of service. It would, however, allow a home health aide who is already in the home to provide simple services which now must be delivered by two or more providers, each provider paid by a different Federal program, doubling the cost of service.

Three, you could require the Department to present Congress with additional options for reaching this long range goal. We

thought this already had been done, but in a report mandated by this committee in 1977, delivered last month, that report simply has not fulfilled the intent. It may be necessary for Congress to require the creation of a special high level office to address this question with a sunset provision to avoid the bureaucratic politics which have prevented action for several years.

Again, I want to congratulate the committee on treading into this area. I hope that we can get some needed movement going right now.

Thank you very much.

Senator TALMADGE. Senator Chiles, I compliment you on an excellent statement. You conducted extensive hearings on home health agencies for the Subcommittee for Investigations. Can you tell us briefly what kinds of problems you discovered during the course of your investigation and hearings?

Senator CHILES. We looked at several areas. In the Committee on Federal Spending Practices, we looked at some of the so-called nonprofit providers for home health care and we found that in many instances that is sort of a misnomer because many of these providers have been created clearly for a profit motive, even though they have set up a nonprofit corporation.

We found instances in which a man and his wife, both of whom had been former schoolteachers, provided themselves with salaries in the $35,000 and $40,000 range as the administrators of this program. They had not been health providers before at all before they hired their daughter at $20,000 as a secretary. They paid their nurses one and a half times what the rate was for the visiting nurses, the true voluntary association that had been out there, and they billed for reasonable services, and they were reimbursed for all these services.

Senator TALMADGE. Is it still operating?

Senator CHILES. As far as I know they are. We found other instances in which outright fraud had existed in which the Justice Department has later actually done something about this, where a nonprofit home health provider was giving free trips to doctors who would finger their patients, so to speak, to go onto the services, trips to vacation islands.

Also, we were finding, in many instances, those people, the people who were rendering those services, were billed for therapy and all kinds of services, while they were actually comatose patients so they were not able to accept those services. I do not know how much some of those services would be for them, exercising and all while they were comatose, but they were being billed for a whole range of services.

In the Committee on Investigations, I think, in looking at that, and in the Committee on Aging, we found that some of the volunteers—not volunteers, but some of the medicaid home health aides in the State of New York—were supervised only by the aged recipient of their services. There was no supervision outside of that.

So we found in some instances where the aides were abusing the older citizens and we found conversely true that in some areas where the recipients were abusing the aides because, in effect, there was no outside party at all to look over those services. So certainly abuse could be prevalent in those areas.

Senator TALMADGE. Thank you very much. Senator Packwood?

Senator PACKWOOD. Weren't most of the examples you just gave in private nonprofit, home health care agencies?

Senator CHILES. Yes.

That is, they were actually what we were looking at. In Florida, we were only licensing nonprofits.

Senator PACKWOOD. Have there been any similar experiences with proprietary home health agencies?

Senator CHILES. Yes; there has.

My particular hearings were not involved with that, but I have seen that.

Senator PACKWOOD. Do you think that we should amend the Social Security Act to allow participation of the for-profit proprietary home health agencies and the medicare reimbursements?

Senator CHILES. Not right now.

Senator PACKWOOD. Why not?

Senator CHILES. I think, until you come to grips with how you provide some kind of certificate of need or some kind of—how are we going to come to grips with putting some local nonprofit, true nonprofit planning agency in charge of this range of services?

Just to open this up to for-profits right now might lend itself to further abuse, but more than that would lend itself to unnecessary services being provided. What we were finding, even with the nine programs, we were finding that there was a competition and a solicitation going on of trying to get the nurses who would be the last person to discharge the patient to give names and recommended to these people runners going into the hospital, as someone has said, bad lawyers do sometimes, running cases. We had a number of cases where runners were working the floors trying to get these people.

It has convinced me it is not one that you can just say supply and demand is going to take care of it.

We are dealing with aged people, just like we are now running into these medigap insurance companies. Whoever talks to these people and tells them they need a service, they are liable to sign up for it, and they will start taking the service, particularly if the Government is paying the bill—even more so, because the Government is paying the bill and not the individual themselves.

Until you determine how you are going to say who qualifies for the service that, I think, has to be done before you open it up for the for-profits.

Senator PACKWOOD. You are not saying profits are any worse or any better?

Senator CHILES. No.

Senator PACKWOOD. Senator Chiles, from what you are saying it sounds like you want the equivalent of a hospital licensing law, for home health agencies.

Senator CHILES. I do not know how far you have to go, but there has to be someone, some agency. I think that should be a local sponsoring or voluntary agency, community agency, to say this patient qualifies for this range of services and is entitled to this range of services. If you just have it out there where that is a part of your so-called policy, and you turn loose all of the for-profits and

the nonprofits—what I am saying is you almost have too many. In Florida, we have too many people in the field now.

The nonprofits have boomed in some of the States—or, they had 2 years ago when I was particularly looking at this. I do not know how it is now.

I am saying, if you put all of that competition out there without somewhere saying how you are going to designate those services, it is not a true supply-demand field.

These people are aged. They do not know how to say no. They do not really know what they need and what they do not need. If the Government will pay the bill, it will break the bank.

Senator PACKWOOD. One last question, somewhat unrelated. Do you think we should go to regional intermediaries for home health services?

Senator CHILES. I think that we should try that. I think, again, that could provide a better service and a closer service.

Senator PACKWOOD. Thank you.

Senator TALMADGE. Senator Dole?

Senator DOLE. No questions.

Senator TALMADGE. Thank you very much.

Senator Cohen?

STATEMENT OF HON. WILLIAM S. COHEN, A U.S. SENATOR FROM THE STATE OF MAINE

Senator COHEN. Thank you very much, Mr. Chairman. During my brief term in the Senate, I have been learning the first-in/last-out method of accounting.

I would like to, first of all, thank you for allowing me to participate with the chairman of the Aging Committee in testifying before you. Perhaps I should just summarize the first part of my testimony concerning the home health care study that was mandated by Congress by section 18 in Public Law 95-142 as a result of legislation I introduced last session.

The law mandated the Department of HEW to come forward with recommendations that we could use to implement a wider use of home health care as a part of our continuum of health care in this country.

The fact of the matter is that the report the Department of HEW submitted was 6 months late. It cost, as I recall, $62,000 and said virtually nothing.

Many reports, I understand, are transmitted in a pro forma, or a perfunctory basis, but I think, considering the importance we attached to this report as a guide to further congressional action, this apathetic, or lackadaisical approach, is unacceptable.

It is quite apparent that HEW did not assign a very high priority to this particular report. People who were not even responsible for its preparation came before the Aging Committee a week or so ago. To his credit, Senator Chiles refused to continue the hearings, recessed them and ordered the Department to send up someone who had some measure of information about the report that was submitted to us in compliance with the law.

The person appeared today. I must say, although he was well intentioned, he did not possess much more in the way of information that the committee required. I indicated this morning that it

was my intent to file a resolution, a sense of the Senate resolution, to return the report with the understanding that the Senate has no intention of accepting it as complying with our mandated law and to require HEW to come back in 3 months with another report, which is what I am told they will need to update the report to make it adequate. I hope that this committee would give serious consideration to returning the report.

I also should point out that the gentleman who testified, Mr. Champion, this morning seemed at least receptive to the suggestion I made that HEW voluntarily withdraw the report and update it and then resubmit it at a later time. In the absence of a decision made by HEW, I would hope that many members on the Finance Committee would be receptive to endorsing this particular proposal. I think that Senator Pepper in the House intends to file a similar resolution. Home health care is so important that we ought to send a very strong message to the Department that we think it is of the highest possible priority.

The second point I wanted to make this afternoon pertains to the question raised by Senator Packwood. I think, as a consequence of the existing requirements for certification, Congress has created a situation in the health care industry which is unique for home health care delivery. Hospitals, nursing homes, physicians all have to be licensed before they can participate in the Federal health care programs, but of home health providers, only the proprietaries must meet a State licensure requirement. Yet some of the greatest problems we have seen in the provision of home health care has been, as Senator Chiles has stated, the providers of in-home services under title XX, a program which has no standards for any type of provider and with private, nonprofit medicare only providers, who masquerade as nonprofits only to siphon off the lucrative medicare trade.

We have not encouraged the development of home health or any in-home services within the Federal entitlement programs principally because we were reluctant to make these services available without the assurance our public dollars are going to be well spent.

My primary objective in introducing the legislation which led to the requirement of the section 18 report, was to force the administration to come up with a set of enforceable standards of quality assurance for all Federal home health agencies and programs.

This would have meant an upgrading of the existing standards; in other cases, the development of standards where none now exists. Whatever standards we adopt, I think it is essential that they be enforceable and we would then have a reasonable guarantee that any agency, regardless of its tax status, nonprofit or proprietary, would provide quality care.

At the same time, we would eliminate the discriminatory treatment we accord to providers in the home health care and perhaps the action we take with regard to the section 18 report will induce HEW to move more swiftly in this area.

I think the ironic outcome of the licensure requirement is that it has not prevented proprietary participation in the Federal home health care programs. Title XX is open to all providers and many for-profit agencies provide services on a subcontracting basis under medicare and medicaid in States that did not require licensure.

At best, the licensure requirement in those States has moved HEW one step further from controlling the industry practices that we may find abusive.

I know it has been suggested to me, at least, that perhaps all home health providers be required to obtain State licensure before they are allowed to participate in the Federal in-home programs. As a first step, I could support the proposal if all the States were given ample time to comply so existing programs would not be curtailed, or cut back. Certainly, that is one solution to the problem of the discrimination that now exists as far as the proprietaries and the nonprofits are concerned.

It also gives the impression that we are raising everybody to a higher standard of quality assurance rather than really deleting the licensure requirement for proprietaries.

I think that is an illusion. We have found out that State license requirements are not necessarily adequate. HEW has vacillated on several policy issues under section 18 of the report but it has been consistent in the view that licensure requirements are not generally higher than medicare standards and do not insure a high level of quality.

In short, I think it may be tempting to pass an all-inclusive licensing requirement and feel we have washed our hands of the matter, turn it over to the States and leave them to the problem of upgrading and enforcing their quality standards, but I do not think that is really a panacea for the problem. I think that we have to develop systems and procedures to enable us to move away from the type of paper compliance of existing standards which address process, but really do not address patient outcome.

I would like, in closing, to quote from a letter I recently received on this issue.

> It costs the taxpayers more to obtain a "procedural statement" of how the Board of Directors approved the budget for San Francisco Home Health Service for the California Licensing Bureau than the cost of accreditation by a national standard-setting body. The existing standards are not "extremely high"; they are basic, minimum criteria.

I think, members of the committee, until we begin to grapple with these issues, home health care is going to continue to remain an insignificant part of the medicare-medicaid programs rather than a partner with institutional services on a continuum of health care delivery.

Senator TALMADGE. Thank you very much.

Senators, any questions?

Senator PACKWOOD. No questions.

Senator DOLE. No questions.

Senator TALMADGE. Thank you. We appreciate your comments and contribution to our deliberations.

Senator DOLE. Mr. Chairman, I do not have any questions, but I appreciate the Senator's patience and an excellent statement. We will be happy to join in the resolution you talked about in the first part of your statement.

Senator TALMADGE. Senator Chafee?

Senator CHAFEE. I would like to ask one question. I am a cosponsor of this bill so I strongly support it. I apologize for missing some of the testimony. In all of these things, you always have the con-

cern that if you make a service available in a simplified fashion that frequently makes commonsense, that you end up with a whole host of people taking advantage of the service that probably are not now being served, so that the cost may be far more than what you initially anticipated.

Do you have any comment on that?

Senator COHEN. Let me say that many people look to home health care as an alternative to institutionalization under the illusion, perhaps, that we are going to save a lot of money. I do not believe that to be the case.

The fact of the matter is, while we will save money on an individual basis, that it is indeed cheaper, or less costly, to care for people in their homes on a part-time basis, two visits a week or one visit a week, whatever it might take, homemaker health service, whatever it may be.

Senator Chafee, that does not reduce the overall cost. The studies show between 14 and 25 percent of the people now confined or institutionalized in nursing homes, by way of an example, do not have to be there. They do not need that level of care. Yet they are placed in institutions because there is no acceptable alternative to institutionalization. It does not mean because 14 to 25 percent of the people in nursing homes do not have to be there, you are going to save that amount of money. The fact of the matter is there is a lot of very sick people who need that kind of intensive care who will fill those spots.

The question we have to resolve is, Do we want to move toward a more humane, more cost-effective form of health care to provide home health treatment as not an alternative, but a part of a continuum of health care in this country? Most people want to stay in their homes. It is more cost-effective to the individual, certainly. The fact of the matter is it is not going to save a lot of money, as far as the taxpayers are concerned. There are a lot of people who need that intensive, special treatment that they do not now receive.

Senator CHAFEE. What you also see is not only a host of people coming in who are not getting the care now, but you will find some now receiving care from relatives or someone not being paid who will realize that they can now be paid under the federal system, so they will start collecting, too.

Senator COHEN. You might inquire of the GAO. The GAO has done a study in Cleveland which they testified to this morning—families have not abandoned relatives.

Senator CHAFEE. I am not saying it is abused. People have been providing services who are entitled to collect, who could collect, and will start collecting. I am not saying those are arguments against the program which, as I say, I cosponsored. I just think probably the costs are going to be pretty substantial once we get into it.

Senator COHEN. I guess we have to weigh that risk against continuing with the policy of simply pulling people out of their homes and putting them into an institution where they do not want to go. I just think it is not the humane way to do it and we could find a better way, and this is the better way.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator PACKWOOD. On the last statement, it is infinitely more expensive. It is going to be hard to tell how many people are not going to go to hospitals that would otherwise go to hospitals. For everyone that does not, we can afford to take care of, I think, almost 10 people at home.

Senator COHEN. I agree, Senator.

Senator TALMADGE. Thank you very much, Senator Cohen.

[The prepared statements of the preceding panel follow:]

STATEMENT OF SENATOR PETE V. DOMENICI

Mr. Chairman, I would like to thank the Members of the Health Subcommittee of the Senate Finance Committee for convening today's hearing to focus attention on a very important issue confronting older Americans, namely, the need to expand home health care services. I worked closely with Senator Packwood in the development of S. 489, and am pleased that this proposal has been consponsored by three other Members who serve on the Senate Finance Committee, Senators, Chafee, Heinz and Moynihan. I would also like to acknowledge, Mr. Chairman, Jay Constantine's deep interest and efforts in this area. I believe that we have an opportunity, this year, to enact legislation that will significantly extend and prudently expand home health care services to older and disabled Americans.

As the Ranking Minority Member on the Special Committee on Aging, I have a keen interest in exploring cost effective ways of expanding services to older Americans. In the 95th Congress I introduced S. 2009, a bill that was the forerunner of the Medicare Home Health Amendments of 1979. After introducing S. 2009, I invited comments from hundreds of individuals and organizations in an effort to evolve the best possible approach to solving this problem. I believe, Mr. Chairman, that S. 489 would enable the 96th Congress to move quickly and effectively in this area. Home Health Care services can help us to meet the growing health needs of older Americans and become part of a complete health care delivery system. Home care can provide a viable alternative to inappropriate, unnecessary, or premature institutionalization.

America today is confronted by a number of economic and demographic realities which will make it difficult for us to ignore these needs much longer. Throughout the last ten or fifteen years inflation has run at an unacceptably high level, and it has currently risen above 10 percent throughout the economy and it is rising at an even higher rate for medical services. It is time, therefore, that "serious" consideration be given to methods of reducing unnecessary and costly institutional services, and focus greater attention on such services as home health care.

With a current population of 22 million persons over age 65, which is expected to increase to over 32 million by the year 2000, there will inevitably be an increase in the rate of utilization of health services by this segment of our population. Research has shown that elderly persons are more likely to suffer from the disabling effects of chronic and acute health conditions than are younger persons. Furthermore, as the number of older Americans with severe chronic conditions increases, the availability of medical services must also increase. As a result, there is and will continue to be a growing need to develop and implement an effective health care delivery system which will maximize an individual's independence and enable the older person to remain in his or her own home. It is my conclusion, that there is an unquestioned need to increase the effectiveness and availability of home health care under the Medicare program, as a viable method of maintaining older Americans in their own homes for as long as it is possible.

Mr. Chairman, it is my understanding that the Finance Committee has already accepted two of the provisions from S. 489 as part of S. 505:

1. the elimination of the three-day prior hospitalization requirement, and
2. the unlimited home health visits provisions.

I am pleased by the receptivity of this Committee to the proposals put forth in S. 489 but I would like to urge you in the strongest possible way to look at the other provisions in my bill which would further expand and strengthen the home health care delivery mechanism.

I believe it is important to maximize the current opportunity to truly strengthen the Medicare home health program. I would like to call the Committee's attention to the following provisions in S. 489 which would:

1. Designate regional intermediaries specifically for home health care who can develop the expertise needed to control fraud and abuse in this expanding area.

These regional intermediaries will also help us to better monitor home health agency costs and maintain uniform standards for services.

2. Allow physician assistants and nurse practitioners who are under the general supervision of a physician to establish a plan of care for home health patients living in rural areas.

3. Establish occupational therapy as a primary service, not a secondary service, as in current law.

4. Require all home aides to complete a training course approved by the Secretary as a means of improving the quality of home health services.

5. Test, through demonstration projects, the validity of applying the utilization review concept to home health agencies.

6. Direct the Secretary of Health, Education, and Welfare to:

a. Monitor the costs of home health services,

b. Compile a report on the frequency of use of home health services by individuals who are eligible.

c. Develop standards for the training of home health aides and uniform standards for data collection to insure appropriate evaluation of care.

d. Establish a uniform reporting system for billing a home health patient on a bi-monthly basis as a method of protecting Medicare from being billed for services that were not rendered.

e. Establish "reasonable cost guidelines" for transportation, administrative salaries, fiscal services, legal services, public relations, and other specific line item costs directly related to providing home health care.

In addition, Mr. Chairman, the Finance Committee may want to explore language which would require the home health service provider to undergo an annual independent audit and the annual publishing of their fiscal report. Although I did not provide for either of these requirements in S. 489, I believe they may be useful tools in our ongoing effort to combat fraud and abuse in the Medicare program. The Committee should give consideration to allowing certified dietitians to provide nutrition counseling and nutrition education as a covered service under Medicare.

In closing, I would like to advise the members of the Finance Committee that on April 3, 1979, I sent a letter to every Medicare certified home health agency in the Country. This letter contained a questionnaire requesting information on the agency, its staffing patterns, its costs, and its charges for various in home services. To date, I have received over 1,000 responses to this questionnaire and I am in the process of compiling the data.

Mr. Chairman, I would ask unanimous concent that the text of my letter and the questionnaire be printed in the hearing report. If I can get the data tabulated while the Hearing Report is still open, I will provide the Committee with that information so that it too may be included in the record of this hearing.

Mr. Chairman, I would like to thank you once again for permitting me to testify this afternoon and I will be glad to answer any questions the Committee may have.

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., April 3, 1979.

DEAR DIRECTOR: On February 26, 1979 I introduced with 17 cosponsors S. 489, "The Medicare Home Health Amendments of 1979." The purpose of this legislation is to improve and prudently expand the availability of home health services to Medicare recipients.

On May 21, 1979 the Senate Finance Committee will be holding hearings on this bill. To coincide with this hearing I am asking that you complete the enclosed questionnaire and return it to me as soon as possible. The questionnaire was developed because of our URGENT need to have the most current and accurate information on the cost of home health services across the country. With your assistance, this goal can be accomplished.

I do not have to tell you how important it is for us to amend the current Medicare law to strengthen the home health section, but to reach that goal will require your assistance. I am enclosing a self-addressed envelope for your convenience.

I want to thank you for your assistance. If you have any questions please contact Jeff Lewis of my staff at (202) 224-1467.

With warm regards, I am

Sincerely,

PETE V. DOMENICI,
Ranking Minority Member.

HOME HEALTH CARE COST QUESTIONNAIRE
FOR MEDICARE-CERTIFIED HOME HEALTH AGENCIES

Name of Agency _____
Address _____
City _____ Population of area served _____
State _____ Zip Code _____
Date of Initial Medicare Certification _____
In what year was your agency incorporated _____
Contact person _____

TYPE OF AGENCY (Circle applicable one)

City, County, or State Health Dept.
Hospital-based Facility
Private Non-Profit
Proprietary
Rehabilitation Based Facility
Skilled Nursing Facility
Voluntary Non-Profit
Other

	Full-time Agency Staff	Part-time Agency Staff	Contracted Agency Employees
Administrative Employees			
Supervising Employees			
Field or Direct Service Staff			
Public Health Nurse			
Registered Nurse			
Physical Therapist			
Occupational Therapist			
Medical Social Worker			
Home Health Aide			
Homemaker/Home Health Aide			
Office Support Staff (Clerical, escort, etc.)			
Other (please specify) _____ _____ _____			

ANNUAL VISIT COST*

	Total	Nursing	Physical Therapy	Speech Therapy	Occupational Therapy	Home Health Aide	Social Work Services	Other
Total # of Home Visits During Last Fiscal Year (indicate for what year _____)								
Total # of Medicare Visits for Last Fiscal Year								
Total # of Medicare Visits -- PART A								
Total # of Medicare Visits -- PART B								
Total # of Medicaid Visits for Last Fiscal Year								
Total # of Title XX Visits for Last Fiscal Year								
Total # of Other Visits								
Total # of Medicare Visits: 1 Year Previous								
2 Years Previous								
3 Years Previous								
4 Years Previous								
5 Years Previous								

*Do not include no home, no found, supervisory or orientation visit

COST AND CHARGE OF SERVICES

	Nursing	Physical Therapy	Speech Therapy	Occupational Therapy	Home Health Aide	Social Work Service	Other (Specify)
Agency Cost per Visit based on last completed fiscal year ending _____.							
Current Charge per Visit as of _____. (date)							
Cost per Hour (if applicable) based on last completed fiscal year ending _____.							
Current Charge per Hour (if applicable) as of _____.							
Average Number of Visits Per Patient							
Average Length of Visit (includes pre, post, and travel time)							
Medicare Reimbursement per Visit (adjustment based on last settled cost report) (year ending _____.)							

STATEMENT OF SENATOR LAWTON CHILES, CHAIRMAN, SPECIAL COMMITTEE ON AGING

As Chairman of the Senate Special Committee on Aging, and a firm supporter of action to strengthen home health services, I would like to comment members of the Committee on Finance for the efforts you are making to review needed changes in Federal programs which support home health care.

Ensuring access by older Americans and others to quality home health care services is an all-important issue now, and will continue to demand our close attention.

This Committee has already taken a number of important steps to expand and strengthen home health care programs in all three Titles of the Social Security Act which support these services (Medicare, Medicaid, and Title XX), and you have before you now legislation which will take further steps within Medicare.

Other witnesses this afternoon will address the specific provisions of S. 489, which I have co-sponsored with other members of the Committee on Aging. I strongly endorse the recommendations which are before this Committee to expand the availability of home health care services by:

1. Eliminating the current Medicare Part A requirement that a patient be hospitalized for three days before becoming eligible for home health services;

2. Eliminating restrictions on the number of home health visits allowed under Medicare Parts A and B; and

3. Adding occupational therapy services as a qualifying service for home health eligibility.

It is worthy of note that there now appears to be clear agreement in Congress on the need for making these changes.

I also strongly endorse proposals before this Committee which would provide additional assurances of the quality of home health care, and guard against Medicare waste by improving program administration and strengthening safeguards against provider abuse.

I would urge members of this Committee to recognize and carefully consider the dilemma we face in assuring access to quality home health care. There is a dual need to both:

1. Significantly improve controls against financial waste and abuse as well as strengthen the quality of care in home care services financed under Medicare, Medicaid, and Title XX social services; and

2. Expand the availability of home health services before we can begin to fully meet needs.

The Committee on Aging estimates that up to four million noninstitutionalized persons over the age of 65 now have a need for some form of supportive home care, but less than two million now have access to this form of care. This gap can be expected to increase as the older population increases.

We are all fearful that we will not be able to meet the needs for home care services without careful attention to cost controls. I am convinced significant savings can be achieved through better management of the home care programs financed through all three of these programs.

I urge this Committee to make every effort to see that the Department of Health, Education, and Welfare moves quickly in this area. Delay and procrastination only give those who choose to control costs by denying service an opportunity to use cries of fraud and abuse as an excuse. We cannot allow inaction and delay to be used as a crutch.

The members of this Committee have recognized this dilemma, and have moved cautiously in both directions. The Department of Health, Education, and Welfare, however, is moving very slowly.

The authority given to the Department under the 1972 Amendments to the Social Security Act and the 1977 Medicare-Medicaid Anti-Fraud and Abuse Amendments—to establish uniform reporting for home health agencies, to set cost guidelines for services and administrative operations, to enhance audit capabilities and improve program administration through designation of regional intermediaries, and to provide clearer direction and guidance to intermediaries in making determinations of reasonaable costs—has not been wisely exercised. Action has been slow. Very few changes have been made, and most of the areas have yet to be addressed. The bill before the Committee addresses this concern by requiring action now on guidelines for administrative and contracting costs, regional home health intermediaries, and other areas.

I think my colleagues on this Committee know that investigations conducted by both the Subcommittee on Federal Spending Practices, which I chair, and the Special Committee on Aging have produced ample evidence of weaknesses which

still exist in statute and in the administration of Medicare home health programs, as well as Title XX and Medicaid.

A report issued by the General Accounting Office just last week ("Home Health Care Services—Tighter Fiscal Controls Needed," May 15, 1979) has again confirmed the opportunities for program waste and abuse which still exist, and has endorsed a number of proposals in S. 489. In particular, the GAO has recommended that the Department develop cost limits for individual costs or groups of costs of home health agencies and clarify contracting practices and guidelines.

Similarly, the authority given to the Department under Sections 222 and 1115 of the 1972 Amendments to the Social Security Act to develop and test non-institutional home and ambulatory care approaches under Medicare and Medicaid has still not been exercised to an extent, evidently, that can give us any answers.

Congress has been waiting for this and other information and recommendations based on research initiatives for over five years. In 1977, Congress finally instructed the Department to produce a comprehensive analysis of options for home health care programs. That report said that there was not enough information to make any recommendations or even discuss options.

I repeat again that the needs are great, and that time is running out. The question of whether increased emphasis on home health care and other home care services is a desired national objective has been answered.

Committee on Aging surveys of State program initiatives in caring for chronically ill and disabled elderly show a pronounced trend toward increased reliance on home health and other home care services such as homemaker/home health aide and personal care services. This trend is reflected in the increased utilization of Medicare and Medicaid home health benefits, even though they still account for only 2 percent and 1 percent, respectively, of overall program expenditures. The most significant development is the rapid expansion of Title XX programs of home care services.

I would ask the members of this Committee to recognize that home health services must be viewed in the context of all three programs. Without this integrated view, opportunities for program abuse are intensified and overall costs are increased. When manipulation of reimbursement sources is forced upon providers by the programs themselves we are inviting trouble.

The most basic needs for home care that these three separate programs attempt to fill are by and large the same, differing mostly in the degree of skilled medical support which is needed by the recipient of service. The authorizing legislation and program regulations do not recognize this fact. Different statements of program goals, definitions of services allowed, of specific physical needs to be served, and eligibility for services, are all different.

An early draft of the home health report developed by the Department of Health, Education, and Welfare cited some of these problems, and concluded that: "Virtually every aspect of the programs (Medicare, Medicaid, Title XX) precludes development of a rational, organized, cost-effective system of home care. The problems are so basic that they can only be mitigated by improvements in Federal operations; a wholesale restructuring of programs, or a completely new one, would be required to really address the problems."

In the long term, it may be desirable for this Committee to address the complete integration of major aspects of home care services reimbursed under these three programs.

I recommend that you consider some initial steps now toward adoption of broader and more uniform definitions of services, standards, reimbursement reporting, and audit criteria.

This can be done by:

1. Expanding the definition of home health aide services under Medicare to homemaker/home health aide services in recognition of the artificial distinctions which are now drawn between these service titles. Restrictions on the availability of this Medicare benefit could be similar to restrictions now placed on use of home health aide services alone. This proposal would therefore not expand the Medicare home health program to a whole new category of service. It would, however, allow a home health aide already in a home to perform simple services which now must be performed by two or more providers, doubling the total cost of the service.

2. Encouraging States to develop uniform definitions of home care services delivered under Title XX and Medicaid, under guidelines prepared by the Secretary. This would facilitate uniform reporting and auditing of Title XX and Medicaid home care services and should be done in conjunction with HEW's current initiatives between Medicaid and Medicare.

I would like to say that the Committee on Aging will continue its work in this area, and we stand ready to offer full cooperation and assistance to members of this Committee.

STATEMENT OF SENATOR WILLIAM S. COHEN

Mr. Chairman, members of the Finance Committee, I am pleased to participate on this panel and to be able to share my concerns with you about home health care. Though home health is a relatively small program in terms of total Medicare and Medicaid expenditures, it is, nevertheless, an important link in a continuum of health care services that we would like to foster in America. I would like to associate myself with the comments of my colleagues, and focus briefly on two additional points.

Senator Chiles has aptly described the proceedings at hearings held by the Senate Special Committee on Aging on a major home health report required by legislation reported from this committee and submitted to the congress by the Department of Health, Education, and Welfare. The report not only failed to meet the statutory deadline for submission, but its substance did not satisfy congressionally mandated requirements particularly with regard to legislative recommendations.

Many reports are transmitted on a pro forma and perfunctory basis, but considering the importance attached to this report—as a guide to future congressional action—this kind of lackadaisical approach is unacceptable. The low priority attached to this report by HEW was apparent at the first hearing the Aging committee held on this issue. Persons not even responsible for the preparation of the report were sent to present the Department's position. The committee had no choice but to recess the hearing. Subsequently, as you know, we were able to reconvene that hearing with a responsible administration witness. While this witness did his best to justify and explain the inadequacies of the report, the fact remains that the administration's statement does not change the content of the report that was transmitted to the Senate through your committee.

As the author of legislation which led to this report, I have a deep interest in seeing that the intent of the congress is carried out. This concern is shared equally by the other members of the Special Committee on Aging. At this morning's hearings, I suggested that the Administration voluntarily withdraw its report and revise it and present the Congress with a document worthy of our attention. I have been promised an answer on this suggestion by tomorrow. Should the Administration refuse to take such action, I have prepared a "sense of the Senate" resolution which I will introduce tomorrow to refuse to accept this document as satisfying the requirements of Section 18 Public Law 95-142. The resolution further indicates that the Senate has no intention of releasing HEW from its obligation to fulfill those requirements. I have been told that, given three months, the department could provide us with the recommendations sought. Consequently, the resolution directs the Secretary to return the report to the appropriate committees of the congress not later than September 1.

I have been told by the congressional research Service that not since the Civil War has the Congress taken such a dramatic step with regard to material prepared and submitted to the Congress by the Administration. That fact notwithstanding, I hope that the members of the Finance Committee will recognize the importance of this matter and will join with us in sponsoring this resolution.

My second point concerns the inadequacy of current standards for provider participation in federal home health care and in-home service programs. As a consequence of existing requirements for certification the Congress has created a situation in the health care industry unique to home health delivery. Hospitals, nursing homes, and physicians all have to be licensed before they can participate in federal health care programs. Of home health providers, only proprietary (or for-profit) agencies must meet a state licensure requirement. Yet, some of the greatest problems we have seen in the provision of home health care has been, as Senator Chiles states, with providers of in-home services under the Title XX program which has no standards for any type of provider and with private non-profit Medicare-only providers who masquerade as non-profits only to siphon the lucrative Medicare trade.

Congress and the Administration have not encouraged the development of home health or other in-home services within federal entitlement programs, because they are reluctant to make these services available without assurance that the public dollars needed to support such care would be well spent. My primary objective in introducing the legislation which led to the requirement for the Section 18 report was to force the Administration to come up with a set of enforceable standards of quality assurance for all federal home health care and in-home programs. In some

cases, this would mean an upgrading of existing standards; in other cases, the development of standards where none now exist. Whatever standard we adopt, it is essential that it be enforceable. We would then have a reasonable guarantee that any agency, regardless of its tax status, would provide quality care. At the same time, we would eliminate the discriminatory treatment accorded proprietary providers of home health care. Perhaps the action we take with regard to the Section 18 report will induce HEW to move swiftly ahead in this area.

The ironic outcome of the licensure requirement is that it has not prevented proprietary participation in federal home care programs. Title XX is open to all providers, and many for-profit agencies provide services on a subcontracting basis under Medicare and Medicaid in states that do not license. At best, the licensure requirement in those states has removed HEW one step more from controlling industry practices it may find abusive.

It has been suggested that all home health providers be required to obtain state licensure before they are allowed to participate in federal in-home service programs. As a first step, I could support this proposal as long as states were given ample time to comply so that existing program capacity is not jeopardized. Certainly, this is one solution to the problem of discrimination in the conditions for certification of home health providers. As such it gives the impression that we are raising everyone to a higher level of quality assurance, rather than merely deleting the licensure requirement for proprietaries, thus seeming to lower them to the status of non-profit participants now.

Yet let me stress that state licensure is not enough. While HEW has vacillated on several policy issues in the Section 18 report, it has been consistent in the view that "licensure requirements are not generally higher than Medicare standards and so do not assure higher quality." In short, it may be tempting to pass an all-inclusive licensure requirement and feel that we can wash our hands of the need to upgrade and enforce quality standards. But such action is not a panacea for the problem. We need to develop systems and procedures to enable us to move away from the paper compliance of existing standards which address process, but not patient outcome. If I may quote from a letter I recently received on this issue, "it cost the taxpayers more to obtain a 'procedural statement' of how the board of directors approved the budget for San Francisco Home Health Service for the California Licensing Bureau than the cost of accreditation by a national standard-setting body. The existing standards are not 'extremely high'; they are basic minimum criteria."

Until we can begin to grapple with these issues, home health care will continue to remain an insignificant part of the Medicare and medicaid programs, rather than a partner with institutional services on a continuum of health care delivery.

Senator TALMADGE. The next witness is Mr. Leonard B. Schaeffer, Administrator, Health Care Financing Administration, Department of Health, Education, and Welfare.

Mr. Schaeffer, you may introduce your associate and insert your full statement in the record and summarize it as you see fit, sir.

STATEMENT OF LEONARD B. SCHAEFFER, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. SCHAEFFER. Thank you, Mr. Chairman. I am accompanied today by Mildred Tyssowski, Acting Director of the Medicare Bureau and Dick Hein, Director of the Medicaid Bureau. To my immediate left is Dr. Clif Gaus, head of our Office of Research, Demonstrations and Statistics. Your staff requested that Dr. Gaus accompany me today because they anticipated some questions about our demonstration projects.

I have a statement that will be submitted for the record. I would like to briefly summarize it.

I am very pleased to be here today to review with you the provision of home health services under the medicare and medicaid programs. In enacting the home health provisions in 1965, as part of the original medicare/medicaid statute, Congress intended these benefits to serve the purpose of providing a needed health service

and, in many cases, serving as a lower cost alternative to institutional care.

As you, Mr. Chairman, have pointed out in announcing this hearing, "There is a growing acceptance and appreciation of the value of appropriate and properly provided home health services as a humane and less costly alternative to institutional care."

In particular, the home health benefit has been a blessing for older Americans who can look forward to an increased life expectancy without the fear of automatic, long-term institutionalization following hospitalization. Not only are the costs of care often reduced in a home care environment, but such an independent environment and the assistance of family members can promote more rapid recovery. Our citizens can and should lead full lives away from institutions to the greatest extent possible.

Problems have arisen, however, as home health services have expanded in availability and use.

Initially, the Congress planned rather tight limits on home health benefits, including strict conditions for eligibility and limits on the number of visits per year. In spite of this, expenditures for home health services have increased markedly.

In fiscal year 1979, medicare expenditures are expected to reach $711 million compared to $119 million in 1974. Medicaid has also seen a rapid expansion, with expenditures for home health increasing from $30 million to $255 million during the same period. In fiscal year 1977, in-home services were used by 530,000 medicare and 208,000 medicaid beneficiaries.

With HCFA expenditures for home health services increasing at an annual rate of 20 percent, it is important to view them in the context of whether they are strictly health services or fall into the larger continuum of social services for people in the home.

Medicare finances acute care services for the elderly and disabled. Medicaid finances acute and institutional medical services for the disabled, poor and elderly. While home health benefits are included in both of these programs, medicare and medicaid can offer only a partial solution to the larger problem of how society can best respond to the needs of these populations.

The financing of health care services was not intended to replace the role of the family, nor was it meant to provide other social services. Rather, it was intended to supplement those resources where specific medical needs had to be met.

These health dollars are limited and must be directed to the specific goals of the program. An expanded definition of the medicare and medicaid home health benefit may provide more services to some. However, before initiating such an expansion, we must be sure that we do not inappropriately use health care funds, thereby depriving other people of needed medical services.

In addition to medicare and medicaid funds, many other sources of money and services are available to individuals which can prevent the need for institutionalization and improve their health and productivity. For example, the title XX program, nutrition programs, HUD's support for housing for the elderly, and other efforts such as the VA's aide and attendance program are all mechanisms to provide such services.

It is apparent, therefore, that for home health to succeed as an alternative to institutional care, a coordinated package of health and social services is required. Thus, as we consider modifying the existing home health benefit, we must view such changes in terms of what are the most appropriate sources for funding those efforts and how we can assure that the entitled individual can benefit from all available resources.

In addition, as we total up the cost of all the services we can provide, it is important that we assure that care is provided in the most cost-effective manner. To that end, we must determine whether we are offering a lower cost alternative to institutional care or whether the patient's needs are best served by home health care even if that care costs more than institutional services.

To this end, HCFA has been working closely with the Administration on Aging, the Office of Human Development, and the Department's planning and evaluation staff to develop adequate knowledge about the most effective ways to organize and deliver services and coordinate the Department's overall effort in providing long-term care services.

For example, the $30 million requested in the fiscal year 1980 budget will involve a joint effort between AOA and HCFA to determine how health and social services may be used in an integrated manner.

Many of our ongoing demonstrations address the integration of a variety of programs, the cost-effectiveness of new organizational models and the impact of benefit changes.

Among these demonstrations are:

Under a demonstration grant, the Georgia Department of Medical Assistance is developing community services such as foster care, day health care and home care for medicaid clients, in order to determine the impact of these services on the extent of institutionalization. In this project, approximately 1,000 beneficiaries are receiving expanded community services. Their use of institutional care will be compared to the cost and amount of institutional care received by a similar group not receiving community services.

We are currently supporting two projects in New York State dealing with home health and related community services. One project in Monroe County is coordinating health and social services on a communitywide basis. The goal is to prevent unnecessary institutionalization and to provide more effective, less costly alternatives. The cost and quality of care delivered to project participants will be compared to a similar group of nonproject beneficiaries that do not have access to alternative care services. The Monroe County project serves approximately 800 patients per month.

HCFA is also working with the New York State Department of Social Services to implement a long-term home health care program in several localities across the State. Under this demonstration, social and health services are provided at home rather than in institutional settings. This demonstration caps the cost of home care at the 75th percentile of the cost of nursing home care. It is expected that this project will maintain approximately 2,000 medicaid beneficiaries in their own homes during the first year. HCFA

will be conducting an independent evaluation of the impact of this approach.

In Connecticut, we are experimenting with a single entry point into the health care system through a community organization that provides assessment and case management. Through contractual arrangements with over 190 providers, the Triage project insures a more coordinated and efficient provision of long-term care services for 1,500 medicare beneficiaries. While this project includes the full spectrum of services, one of the questions to be addressed is the appropriate role of home health services in overall health care and social service systems.

Another important reimbursement demonstration is On Lok Senior Health Services in San Francisco. On Lok provides community and home-based services and has a contract with a skilled nursing facility and a hospital to care for its clientele. Through medicare waivers, we will be reimbursing On Lok on a prepaid capitation basis—testing the feasibility of the health maintenance organization concept for comprehensive health care needs, including home health services.

Hospice care is another area of interest to HCFA. We have received over 250 applications to test a package of hospice services through medicare and medicaid waivers. We have targeted these benefits to in-home use by requiring that the basic component of the hospice be a home care program.

While these projects will greatly expand our knowledge about the benefits and costs of long-term care, much more information is needed. To this end, the President has included in his fiscal year 1980 budget request for HCFA an additional $15 million for research and demonstrations in home health and other long-term care services.

These additional funds would enable HCFA to collect important survey data on characteristics of our beneficiaries who use long-term care services and the amount and cost of these services. We would also use these funds to sponsor more projects aimed at determining the costs and benefits of home health services, hospice services, and other alternatives to institutionalization.

Finally, these funds would allow us to experiment with innovative reimbursement methodologies that would include capitation payment schemes systems that relate reimbursement to individual levels of care, and prospective payment systems for SNF's and ICF's.

Among the kinds of projects that will be solicited in fiscal year 1980 are:

Comprehensive programs for organization and delivery of services as well as reimbursement. These models would allow one agency to control utilization and reimbursement for long-term care services under medicare and medicaid, and title XX social services.

Reimbursement for a comprehensive package of acute and long-term care services on a prepaid, capitation basis. These models would utilize the HMO and IPA-HMO mechanisms to include long-term care benefits.

Innovative reimbursement methodologies for skilled nursing facilities. These projects would be aimed along several lines. One would be to try to relate reimbursement to individual levels of

care. Another might be to test methodologies providing incentives for quality care and controlling and reimbursing for capital cost.

Comprehensive grants for all long-term services.

Joint projects with private insurors. We hope to develop an interest in the private sector for demonstrations involving long-term care benefits. Such a package could be very meaningful as a supplementary benefit.

The information that would come from these new projects as well as existing demonstrations, would be invaluable to future decisions your committee might make in home health services and long-term care in general. We look forward to your continued support in these endeavors.

The results of our research and demonstrations projects are encouraging and will prove useful in the future. Over the past few years, however, with the rapid expansion of the program, certain problems have developed. Our own surveys and investigations, as well as information gathered through several congressional hearings and GAO investigations into the status of home health services, have highlighted both the existence of, and potential for, major fraud and abuse.

Several factors have played a role in the occurrence of fraud and abuse. Medicare reimbursement guidelines often have not been specific enough. As a result, some intermediaries have overreimbursed such items as salaries, pensions, and fringe benefits. There is evidence of non-arms-length practices between home health agencies and hospital discharge planning units. Referrals have been made to home health services by physicians and other individuals who have a financial interest in the home health agency providing the service.

Finally, we may have failed to uncover problems in a timely fashion because scarce audit resources were concentrated on hospitals and nursing homes where the great majority of our funds are being expended.

We have an environment in which fraud and abuse detection and prevention have not been as vigorous as they might have been. The original medicare reimbursement guidelines were not sufficiently specific in delineating appropriate financial arrangements in home health agencies. Abusive physician and hospital discharge practices have grown up over time and were not cut off or disallowed early enough.

Since home health expenditures represent a relatively small percentage of our total program dollars, most of our scarce audit and control resources were initially targeted elsewhere, primarily toward hospitals and nursing homes. Obviously, we are now moving to change this. However, in the past those practices did lead to an environment where fraud and abuse seemed to grow.

Recently, we have uncovered additional problems. We have experience with agency operators' falsely claiming costs for salaries for relatives. We have uncovered the use of phony books and records and inflated costs, and we have found situations where directors and employees are using agency credit cards and TV's for personal use.

The Congress is aware of these problems. In 1977, you passed Public Law 95-142 to help control fraud and abuse.

We are moving aggressively to implement this statute. In my statement, I outline in more detail the efforts underway today.

In addition to this congressional mandate, however, HCFA is also considering additional steps to control fraud and abuse. We will be issuing screening guidelines to be used in many areas to determine where audits of questionable claims should be done. We are considering moving to prohibit home health agencies which accept only medicare patients in order to control the abuses occurring in these so-called 100 percenters.

We are also increasing audit activity and focusing on agencies where fraud and abuse potential is greatest.

In addition, we have sent to the Congress a civil money penalty bill which will provide a civil fine which could be levied by the Secretary of up to $2,000 per fraudulent claim. This would give us the ability to have a deterrent short of full and complete court action.

We believe that it is a desirable goal to make high-quality home health care services available to beneficiaries who can most appropriately be cared for at home. However, the potential for large increases in expenditures underscores a need for caution in expanding the current benefit.

Through our research and demonstration program, we hope to learn more about the need for home health care services and the best ways to organize, deliver and reimburse such services. As these demonstrations yield the data necessary, we will be back to Congress with specific recommendations. Meanwhile, we are moving aggressively to improve the current administration of the program by achieving better control over reimbursable costs and by reducing the opportunities for fraud and abuse.

These efforts will enable us to be sure that our beneficiaries receive the home health care services that are required. We are most concerned, Mr. Chairman, that all eligible beneficiaries receive appropriate services under our programs in a timely basis. We feel that our efforts should be focused to that end at this time. Thank you

Senator TALMADGE. Thank you, Mr. Schaeffer.

You dwelled at some length in your prepared statement about what you are doing in the areas of fraud and abuse. Now, you were here when Senator Chiles testified, I am sure. Do you think you are putting a stop to most of the corruption, fraud and abuse that he referred to?

Mr. SCHAEFFER. I think we are changing the environment where much of that occurred. I think, by virtue of the actions we have taken, we are making it more risky and more difficult for unscrupulous operators.

Senator TALMADGE. Would you lift their license? Do you have that authority?

Mr. SCHAEFFER. We can exclude home health agencies from participation in our program. We have indeed done that.

There was mention made of a situation in Texas, I believe, where a home health operator was convicted——

Senator TALMADGE. You cannot lift a license?

Mr. SCHAEFFER. No, sir, we cannot; licensure is a State function, but we can exclude them from participating in the medicare program and we have done that.

Senator TALMADGE. You heard Senator Cohen testify. Did you send up this report?

Mr. SCHAEFFER. We provided a lot of staff assistance to the Secretary's office. It was sent by the Secretary.

Senator TALMADGE. Do you think there are good reasons for us to reject the report and to adopt Senator Cohen's resolution?

Mr. SCHAEFFER. There was a good faith effort.

Senator TALMADGE. I think we are asking for legislative suggestions and you sent us a report tracking the problems. You made no legislative recommendations.

Mr. SCHAEFFER. There was a review done that attempted to make the report consistent with the administration's budget and legislative proposals

Senator TALMADGE. Could you review it and see if you could do a little better job?

Now, based on available research concerning day care programs, what conclusions can be drawn with respect to the effect of these services on the cost and use of hospital and nursing home services?

Mr. SCHAEFFER. Mr. Chairman, I wish we could regale you with an informed set of facts and figures in terms of the effects of the demonstrations. They are relatively recent in terms of our ability to look at comprehensive alternatives and modes of care.

Dr. Gaus is here and can briefly summarize.

Dr. GAUS. Briefly, in the few studies done between 1972 and 1977, we looked at homemaker services and day care services, not home health, but homemaker day care and found that the cost of those services were additive. That is, they did not substitute for other institutional costs. On the other hand, they did provide for some improved functioning of the patient at home and psychological benefits.

There were no real dollar cost benefits derived from those two services.

Senator TALMADGE. You do not know if we are saving money or losing money. Is that what your answer is?

Dr. GAUS. On those two services it was costing money. There was an incremental and added cost to the medicare benefit payments. There was some benefit to those services, we think, in the form of better functioning at home and improved psychological functioning, but they did cost more.

Senator TALMADGE. The next is related——

Senator CHAFEE. What were the two services he was talking about?

Dr. GAUS. These were homemaker and day care services, more on the scale of social support services in the home. We do not have any definitive studies that look at home health, the medical components of these services.

Senator TALMADGE. What has been the experience of the medicare program with respect to the number of visits and cost provisions of proprietary and so-called private not-for-profit agencies in comparison with governmental and visiting nurse association agencies?

Dr. GAUS. I would like to submit a more detailed answer for the record, if I could.

In general, I think we have found patterns where proprietaries may have lower per-unit costs on average but a much greater cost per beneficiary because there is a higher volume of services and higher frequency of visits.

[The following was subsequently supplied for the record:]

In general, we have found that proprietary and private non-profit home health agencies have the highest average number of visits and average visit charges per person served, well above the National averages. For example, these agencies accounted for only about 14 percent of the persons served but for 21 percent of the total visits and 25 percent of total charges for visits.

Mr. SCHAEFFER. An issue of utilization, Mr. Chairman.

Mr. GAUS. The costs to our beneficiaries in our program in the aggregate is greater than the not-for-profits.

Senator. TALMADGE. Can you send us some detailed information in response to both those questions?

I think the committee is of accord, and the three Senators from the Committee on Aging are of accord. I think these home care services, properly utilized, managed, and handled will not only make a great contribution to the citizens it is supposed to serve, but could save the government a great deal of money.

The alternative is to put them in a nursing home. In many instances, the family does not want to put them in a nursing home. In many instances, the individual does not want to go to a nursing home, and if we could adopt this alternative plan under effective control and eliminate fraud and abuses and so on, it should save the Government money, should it not?

Dr. GAUS. I would agree with that, if done properly and with careful controls on utilization.

Senator TALMADGE. Tell us how to do it.

Dr. GAUS. We will try.

[The material to be furnished follows:]

TABLE 4.--Number of persons served, number of visits, and amount of charges, by type of visit and type of agency, calendar year 1975

Utilization and type of visit	All agencies	Visiting nurse association	Combined government and voluntary agency	Governmental health agency	Hospital-based agency	Proprietary agency	Private nonprofit	Other 1/
Persons served 2/								
Total (in thousands)..	499.6	231.7	20.9	112.5	57.7	18.9	50.5	7.5
Nursing care.....	479.5	224.1	20.0	108.4	55.4	17.5	47.1	6.9
Home health aide....	137.6	56.7	4.3	27.2	11.9	10.0	25.1	2.3
Physical therapy....	100.9	43.9	3.1	18.2	13.6	4.5	13.6	1.8
Other 3/.....	43.2	16.4	0.7	5.2	8.4	3.0	8.1	1.3
Visits								
Total (in thousands)..	10,805	4,555	322	2,331	1,159	603	1,656	177
Nursing care.....	6,647	2,942	213	1,493	743	242	889	104
Home health aide....	2,840	1,095	74	610	206	256	552	47
Physical therapy....	1,037	407	30	188	160	70	166	18
Other.....	281	112	5	39	51	16	49	9
Visit charges								
Total (in thousands)..	211,966	60,578	6,477	39,448	28,631	13,801	39,682	3,326
Nursing care.....	133,200	53,171	4,685	27,184	18,167	6,260	21,679	2,056
Home health aide....	48,230	16,673	1,089	8,118	4,812	5,239	11,550	749
Physical therapy....	23,530	8,103	605	3,609	4,259	1,846	4,969	337
Other.....	6,984	2,631	98	740	1,393	456	1,484	184
Average number of visits per persons served								
Total.....	21.6	19.7	15.5	20.7	20.1	32.0	32.8	23.8
Nursing care.....	13.9	13.1	10.6	13.8	13.4	15.0	18.9	15.0
Home health aide....	20.7	19.3	17.2	22.5	17.4	25.6	22.0	20.4
Physical therapy....	10.3	9.3	9.5	10.3	10.2	15.3	12.2	9.8
Other.....	6.5	6.8	7.5	7.5	5.9	5.3	6.1	6.6
Average visit charges per person served								
Total.....	424	348	311	351	497	731	786	445
Nursing care.....	278	237	234	251	325	359	460	297
Home health aide....	351	294	252	299	405	524	460	326
Physical therapy....	233	184	194	187	273	407	364	187
Other.....	162	161	142	141	165	153	183	137
Average charge per visit								
Total.....	20	18	20	17	25	23	24	19
Nursing care.....	20	18	22	18	25	24	24	20
Home health aide....	17	15	15	13	23	21	21	16
Physical therapy....	23	20	21	18	27	27	30	19
Other.....	25	23	19	19	27	29	30	21

1/ Includes rehabilitation and skilled nursing facility-based agencies.
2/ Detail does not add to total since persons may receive more than one type of service.
3/ Includes speech or occupational therapy, medical social services and other health disciplines.

Senator TALMADGE. Senator Packwood?

Senator PACKWOOD. Mr. Schaeffer, in your report on home health, you indicated a preference for regional intermediaries. Why?

Mr. SCHAEFFER. There are about 3,000 home health agencies in the country. They do not operate in the sense of programmatically or financially——

Senator PACKWOOD. What?

Mr. SCHAEFFER. They do not operate programmatically or financially the way hospitals do. One of the things that we would like to do is to be sure that the intermediaries that relate to home health agencies are fully informed and fully able to deal with those agencies.

We would like to see fewer intermediaries deal with home health agencies.

I do not feel, however, that we should set up a network of intermediaries just for home health agencies.

Senator PACKWOOD. Would you move all of medicare to a regional intermediary reimbursing system?

Mr. SCHAEFFER. No. What we see is a long-term strategy to reduce the number of intermediaries dealing with all medicare providers including hospitals and home health agencies so that we have a number of strong, capable intermediaries that have a sufficient volume of business to deal expertly with the variety of institutions they serve.

Senator PACKWOOD. Do you reduce them by regionalizing them? If so. What is HCFA proposing to do?

Mr. SCHAEFFER. There are a variety of ways that we could make changes. Typically the way we will reduce the number over time will be to not renew the contracts of those intermediaries not performing well. Better performing intermediaries will pick up the responsibilities.

Senator PACKWOOD. If the intermediary in the State of Idaho is not doing well, do you merge it out or merge it in with the State of Montana or Washington?

Mr. SCHAEFFER. That is an option. In the past, we normally began with an operational plan, an intermediary, where it has worked well. We have, in this country, over 100 carrier intermediaries. It is difficult to do business with that broad number of entities.

Further, with a small number of home health agencies, it is difficult for them to become expert in dealing with home health agencies.

Senator PACKWOOD. You have a greater faith than I think I do for establishing regional intermediaries—or maybe ultimately making one national intermediary—resulting in better quality control than we will get out of the local intermediary.

How do you come to that conclusion? That is what you are talking about, quality control isn't it?.

Mr. SCHAEFFER. I think the issue is simply that since there are currently only 3,000 home health agencies, it is difficult when they are divided among 70 or so intermediaries for all those intermediaries to fully develop the expertise to deal with those home health agencies. We would like to reduce the number of interme-

diaries so that each intermediary deals with a larger number of home health agencies.

The logic is, if you have a higher volume of transactions, you can become more expert. There is no goal to have one single national, or 10 regional entities, for instance. It is simply to reduce the number slightly so we get expert intermediaries dealing with this particular kind of care.

Senator PACKWOOD. You know the fear is, that a State would be squeezed out of any intermediary if they get served only in that State. They will go to the State next to them, who probably will pay no attention to them.

Mr. SCHAEFFER. That is not the goal. In the larger states where we have more than one, where we have several intermediaries that is where we have the problem.

Senator PACKWOOD. Do you agree that there is great concern raised in this country about your cost limits. I am curious at how they were determined.

Mr. SCHAEFFER. The cost limits for home health care?

Senator PACKWOOD. Yes.

Mr. SCHAEFFER. If you would like to know the technical rationale, I think we could submit it for the record, the background documents as to how we arrived at those particular limits.

Basically, the rationale is that there is a wide variety and discrepancy of rates and costs incurred by home health agencies, often in the same geographic area. In order to impose some kind of upper limit, a maximum, we developed these cost limits.

It is similar to what we did for hospitals where there also was a very wide discrepancy in terms of total cost.

The program reimburses providers on the basis of costs. Where there are reasonable costs, the program reimburses for those reasonable costs.

Our attempt here is to put some limit on what is reasonable and, with section 223, that is what we have done.

Senator PACKWOOD. I heard what you said and I am not sure I understood your explanation. Would you please submit the data for the record.

[The material to be furnished follows:]

METHODOLOGY FOR CALCULATING LIMITS

The limits were developed separately for home health agencies located in metropolitan and nonmetropolitan areas in the following manner:

(1) We obtained cost report data for 12-month reporting periods ending after June 30, 1976, and on or before June 30, 1977, for each participating home health agency from the fiscal intermediaries.

(2) We determined the average per visit cost for each type of service provided by a home health agency based on the Medicare cost apportionment method used by the provider. Many home health agencies separately determine the average per visit costs of each service they provide. In these cases, the necessary cost data were extracted directly from the cost reports. Other home health agencies have elected to utilize cost finding methods that do not result in a separate determination of costs per visit by type of service. We were able to include these providers in the data base by obtaining supplemental information from the fiscal intermediaries and billing data submitted by the providers and computing an average cost per visit by type of service on the basis of this information.

(3) To insure a comparable data base, the average per visit costs of each home health agency with a cost reporting period ending before June 30, 1977, were adjusted upward to reflect an estimated 7.00 percent increase on an annual basis in average per visit costs between cost reporting periods ending June 30, 1976, and

those ending June 30, 1977. This estimate was developed by the Office of Financial and Actuarial Analysis, Office of Policy, Planning and Research, Health Care Financing Administration and is based on the increase in the average per visit interim reimbursement to participating home health agencies in 1976.

(4) We arrayed the data from each type of service separately in descending order of adjusted per visit costs.

(5) We computed a base limit equal to the adjusted average cost per visit at the 80th percentile of each array.

(6) We increased the base limit by an adjustment factor of 27.08 percent to take into account increases in per visit costs from cost reporting periods ending June 30, 1977, to the effective date of the midpoint of the period covered by the limits. The adjustment factor was computed by compounding various inflation rates for this period as follows:

The Office of Financial and Actuarial Analysis, based on interim reimbursement data, has estimated that average per visit costs increased 8.75 percent from cost reporting periods ending June 30, 1977, to December 31, 1977, and 6.92 percent during the first 9 months of 1978. We have used these estimates to inflate per visit costs to September 30, 1978. After October 1, 1978, we have computed an annual inflation rate of 7.371 percent according to the formula established by the Council on Wage and Price Stability for calculating the voluntary standard for noninflationary price behavior in the health care sector. The formula consists of averaging the cost increases for the base years, and subtracting one-half of one percent. The base period is calendar years 1976 and 1977, during which home health agency per visit costs increased an estimated 7.0 percent and 8.75 percent, respectively. Subtracting a one-half percentage point from the average annual rate of increase over 1976-1977 results in an annual inflation rate of 7.371 percent. We used this to increase per visit costs from October 1, 1978, to the midpoint of cost reporting periods beginning July 1, 1979. We believe that this standard is appropriate for setting limits on costs necessary in the efficient delivery of needed health services.

Senator PACKWOOD. My last question. Is there a division in HCFA that is directly responsible for long-term care and the policy development of long-term care?

Mr. SCHAEFFER. There is not now in the sense of the operating programs, but we have made some organizational changes which will put responsibility for long-term care policy vis-a-vis the intermediaries in a single organization. In terms of demonstration projects, there is a single organization dealing with long-term care demonstration projects.

Senator PACKWOOD. I have no other questions. I hope you will have time tomorrow to meet with County Commissioner Clark on project health. I would personally appreciate it.

Mr. SCHAEFFER. Yes, sir. It will be tomorrow morning.

Senator PACKWOOD. Thank you.

Senator TALMADGE. Senator Dole, any questions?

Senator DOLE. As I understand it, you did not make any recommendations in your report.

Mr. SCHAEFFER. The report as transmitted to the Congress did not have the recommendations already in the budget or the legislative program that the administration submitted, that is correct, sir.

Senator DOLE. Are there some better methods in operation of the programs that would result in cost savings?

Mr. SCHAEFFER. Yes, sir. We believe so.

I have a fairly detailed list of actions we are taking administratively and could refer to some briefly, in terms of the major ones, if you would like.

We think that, from the administrative point of view, there is a great deal that we can do to tighten up the program and improve it. As I mentioned in my remarks, we are moving to prohibit the 100 percenters. We will be moving on the question of consolidating

intermediaries. The section 223 cost limits are about to be published in final form.

We will shortly have final regulations concerning related organizations. We are considering the provision of a copy of the bill, or an improved explanation, of benefits to the beneficiary to get at the problem I mentioned earlier of the program being billed where the beneficiary had not received a service.

We have a three-pronged program in terms of improving audit surveillance. First, medicare is working on intermediary screening guidelines. Second, our medicare contractor's budget guidelines for fiscal year 1980 directs intermediaries to audit all 100 percenters, all of the home health agencies that are totally dependent on medicare.

Third, we are increasing the departmental audits, those done by the audit agency and those done by the Office of the Inspector General, and those done by the Office of Program Integrity.

Senator DOLE. I think that any other information you have in that area would be helpful.

What about—we have had a lot of attention focused on the restricted nature of the homebound requirement and the restriction on the home health services by the terminally ill. Do you have some demonstration projects in progress? Can you give us any information on the status of those?

Mr. SCHAEFFER. Yes, sir. The Department is very interested in the provision of services to the terminally ill, as I am sure you know. Under our current home health benefits, individuals who are suffering from terminal illnesses get existing benefits on the same basis as nonterminal individuals. We also initiated a demonstration project and received over 250 applications for hospice demonstrations. Many of the applicants are home health agencies that would like to provide a hospice-type program. We will be moving with that.

These demonstrations will provide agencies with medicare and medicaid waivers necessary to reimburse hospice services. An evaluation will be made so that we may be able to make some specific recommendations about hospice programs.

Senator DOLE. When will you be able to make those recommendations?

Dr. GAUS. Within the hospice area, we are several years away from completing studies. The applications are just being screened now.

We anticipate at least 1 year's service, starting sometime in the fall before we can really have any good data on the costs and the benefits of that service. The projects will conclude 1 year after that, so it will be 2 years until we have really completed the projects, hopefully having some earlier data by the fall of 1980.

Senator DOLE. Thank you, Mr. Chairman.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. No questions.

Senator TALMADGE. Senator Chafee?

Senator CHAFEE. I did not quite understand the gist of your report, in which you discussed a series of frauds that have been uncovered and you pointed out some of the problems involved. But

there have been tremendous problems in regular medicare and medicaid involving nursing homes.

What is unique about home health agencies' having problems, particularly when you point out that you fail to cover them in a timely fashion because scarce resources were concentrated on hospitals and nursing homes where a great majority of the fraud occurred.

Fraud exists all through medicare and medicaid that you must deal with. There is nothing unique about finding it in the home health agencies.

Mr. SCHAEFFER. I think that what we are trying to get across is that this is a small but dramatically growing type of service.

Senator CHAFEE. Could I ask you about that? Is it any more dramatic and growing than medicaid in 5 years, or medicare?

Mr. SCHAEFFER. The total programs, probably not.

Senator CHAFEE. I mean percentagewise.

Mr. SCHAEFFER. Twenty percent a year. That is a figure that is greater than the rate of growth for hospitals, for instance, much greater.

Senator CHAFEE. Nothing like food stamps. But never mind, that is a separate issue.

Mr. SCHAEFFER. I would like to get to the point. I think the point is because of the relatively small expenditures; we have focused our resources on hospitals and nursing homes, because there are almost necessarily more program dollars and thus a more opportunity for fraud. What we have encountered in the home health agencies has been a big surprise to us because of the growth of these so-called 100 percenters, not-for-profit agencies.

Senator CHAFEE. Is that not a problem that can be controlled?

If you can answer briefly this question. Sure you have uncovered problems. Sure there are specific problems related to this field. The 100 percenters you talked about, they do not present extremely different challenges, do they? I cannot understand that as a reason for unusual problems in connection with this proposed program.

Mr. SCHAEFFER. They present challenges for a couple of reasons. One, we do not have the ability to audit and review as you do in a hospital. You do not have the individuals.

Senator CHAFEE. That is what—the 100 percenters?

Mr. SCHAEFFER. The home health agencies. They are different from the institutions where we have some experience, hospital or nursing homes.

Also, the existence of the 100 percenters has caused us problems. There have grown up a number of firms which provide consulting services to home health agencies. The home health agencies have suddenly sprung up as shell corporations and have maybe three or four employees that are often either related through business connections or through some personal connection with the people who provide the management services.

I have knowledge, for instance, of a home health agency that is totally made up of family members who contract with four other business associates to provide management, consulting and the actual nursing and home health aid services. I do not mean to imply that all home health agencies exhibit this type of abusive setup; that is not true. There are many excellent organizations.

But the nature of this particular service makes it possible for a home health agency to exist which is really nothing but three or four people on salary.

And, since we reimburse on the basis of cost, those salaries can be increased.

Senator CHAFEE. We have had some experience with this thing. I do not consider that a real challenge. You should be able to get some line of experience to determine what is a reasonable cost.

Let me go to another point you make on page 8, kind of a shocking disclosure. Referrals have been made to home health services by physicians and other individuals who have a financial interest in the home health agency providing the service. Half the nursing homes in the country are owned by doctors.

Mr. SCHAEFFER. I do not know.

Senator CHAFEE. Certainly in our State they are, so this business of a potential conflict of interest by referrals from a hospital to a nursing home is no greater than from a phsyician's office to a home health service owned by that physician, or a group of them.

I do not think there is anything unique in that.

Mr. SCHAEFFER. We find that class of providers difficult to deal with. Our charge is not to expend funds if we know of the existence of fraud.

Senator CHAFEE. I am not saying there is automatically fraud in such a situation. In other words, I found your statement—in all fairness, we had to read the longer statement while you were giving the briefer one—I thought you presented a whole series of obstacles that I did not consider any greater than the obstacles we are already facing in the present medicare and medicaid program.

Mr. SCHAEFFER. Our goal is, before we proceed on this or on the regular medicare or medicaid program, to reduce the incidence of fraud if that is the issue and, more importantly in the case of home health, to make sure we have an optional and alternative service which is beneficial to the beneficiaries. In most cases, there will be less cost.

If the issue whether is there is more fraud in home health or not, I really do not know. That was a point we tried to make, that if there is any fraud, we are concerned.

Senator CHAFEE. You are going to have opportunities for fraud in everything. In your examples here, these tests, experiments, demonstrations, I was sorry you did not give us some indication of how they worked out—the one in Georgia, Connecticut, New York, wherever it might be.

Mr. SCHAEFFER. Most of them are between 1 and 2 years old, and we really just have preliminary results, if that.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator DOLE. I meant to ask you, we are going to have a witness later on who will be testifying that in certain States, Florida for example, the home health agencies refuse to care for medicaid recipients. Is this true in other areas of the country? What is being done, if anything, to handle it?

Mr. SCHAEFFER. I am not personally familiar with how widespread that practice is. Most of the problem that we have, frankly, is with agencies who deal with only medicare beneficiaries.

We can get you that information for the record.

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[The material referred to follows:]

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

In a number of States, these reimbursement policies and problems have resulted in:

A limited number of providers serving Medicaid clients,

A quota system whereby only a small percentage of Medicaid patients are accepted by agencies without assurance of other sources of funding, and

Unavailability of home health services to Medicaid recipients in many geographic areas.

Several States have indicated that they are aware of the problems caused by the low rates but are fearful of expenditure increases inherent in reimbursing full costs. Some States have shown an interest in expanded home health services provided they can predict and control expenditures, and provided they can expect this service to reduce institutional care costs. HCFA's major emphasis since its inception has been to improve the relationships between Medicare and Medicaid and to promote as much uniformity as possible between the two programs. Uniform policies in certain areas would simplify administration of these programs, and would make less confusing to both service providers and program beneficiaries. Before we develop a single reimbursement policy for Medicare and Medicaid, we need to collect sufficient information on the costs of producing or the potential demand for home health services. We also need to understand better the behavior of home health providers in response to reimbursement incentives before we establish a single reimbursement policy for both programs.

MEDICAID PROGRAM DATA—HOME HEALTH SERVICES 1976-77

Reimbursement Methods

Schedule of maximum allowance—Alabama, California, Florida, Kansas, Minnesota, and Ohio

Contract or negotiated rate—District of Columbia, Montana, Oklahoma, Utah, and Connecticut (for proprietary agencies only)

Usual or customary charges—Arkansas (with ceiling of 75th percentile), Delaware,[2] Idaho, Illinois, Kentucky, Maine, and Wisconsin

Lower cost or charges—Colorado, Georgia, Iowa, Louisiana, New Hampshire, Tennessee, Virginia, and Wyoming

Fee schedule.—Alaska, Oregon, Pennsylvania, and Rhode Island

Cost based—Connecticut, Indiana, Maryland,[1] Massachusetts,[1] Michigan,[1] Minnesota,[1] Mississippi,[1] Montana,[1] Nebraska,[1] New Jersey,[1] New Mexico,[1] New York,[1] North Carolina,[1] North Dakota,[1] South Carolina,[1] South Dakota,[1] Texas,[1] and Vermont.[1]

NOTE—Hawaii and West Virginia have not reported.

[1] Same payment as Medicare.

[2] Delaware pays 98 percent of charge.

Definitions

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

Fee schedule: State pays a specified amount included in a schedule of charges for specific goods or services.

Contract: State purchases goods or services through a contract mechanism and pays the amounts specified.

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

Cost based: State pays for services based on allowable provider costs, e.g., annual operating costs.

Senator DOLE. Maybe we can find out more from the witness who will testify later.

I think that Senator Chafee is right, there is probably a lot of fraud in anything. What happens if you discover fraud, you just stop the program?

Mr. SCHAEFFER. I wish it were that easy. Most of what we are talking about is probably more properly characterized as abuse, although there sometimes are illegal activities.

Senator DOLE. Any prosecutions?

Mr. SCHAEFFER. There is a lengthy practice of factfinding and documentation. We then disallow costs. There is an appeal process.

Those few that are so egregious that the prosecutor is willing to continue the process and go to court, many of those people indeed are punished in the court.

Senator DOLE. There actually has been somebody brought to trial for fraud?

Mr. SCHAEFFER. Yes, sir.

Senator DOLE. Could you supply the number of cases? I was not aware there has been any great number.

Mr. SCHAEFFER. There are relatively few, due to the cumbersome process.

Senator CHAFEE. In home health, or other medicaid and medicare?

Mr. SCHAEFFER. Home health.

Senator CHAFEE. Home health. Is that any more complicated than medicare and medicaid fraud?

Mr. SCHAEFFER. I think the opportunities that is afforded the 100 percenters have made it easier for unscrupulous operators to take advantage.

Senator CHAFEE. Trying the cases, the procedure?

Mr. SCHAEFFER. The same procedure. That is why we have a civil money penalty bill before you this session. It would be very helpful if we had an administrative mechanism that could act as a deterrent.

Senator CHAFEE. That is a bill you are quite anxious to pass. That will cover also home health?

Mr. SCHAEFFER. This, and any abuse, any claim that is determined to be fraudulent, or abusive. Frequently the prosecutors do not want to take the case, because it is either a very complicated or a lengthy case and the dollars are very small, a $25,000 disallowance, for instance.

From the point of view of some prosecutors, it is not worth the effort of going through this very costly procedure.

I believe you will hear testimony later today from Charles S. Hynes of New York. He can tell you some of the frustrations they have been through.

Senator DOLE. It looks like we are inviting fraud if everybody knows nothing will happen, an open invitation to get in the busi-

ness. If you are caught, we are not going to do anything. If we pass this civil money penalty bill, that is sort of a slap on the hand.

Mr. SCHAEFFER. Senator, I think it is a very effective slap on the wrist because it assesses a fine of $2,000 per fraudulent claim. I think we can demonstrate that in many cases it is not only one claim, it is quite a few. That becomes a deterrent.

Also there are many claims passed through inadvertently because, in many situations, there is not enough care taken in preparing claims.

Senator DOLE. I do not quarrel with that. That is the same argument we hear in food stamp violations and every Federal program. While we have a lot of abuse, a lot of fraud, nothing ever happens because it is so complicated. Therefore, the invitation is sort of an open-ended one.

Mr. SCHAEFFER. We would be happy to submit this for the record. We have removed a number of providers from our program on the basis of actions taken by courts and actions we have taken. We have been making some progress.

The fact is, if the provider has the financial support to take us all the way through all the hearings and appeals mechanisms it is very cumbersome, very time-consuming and frequently they get out from the net.

Senator DOLE. Thank you.

Senator TALMADGE. That leads me to one final question. Congress has given you a host of health care programs, as you know. Do you have the resources in the Department to adequately administer them?

Mr. SCHAEFFER. We are going through a rearraying of resources so that we can more adequately respond to the demands placed on us. We are not in this alone. We rely on carriers, intermediaries and the States, as well as the medical profession, and the providers. By and large, the providers and our fiscal agents are trying to do a good job. I think the incidence of fraud and abuse is probably no greater in health care than it is anyplace else.

We are shocked at it because we do not have a history of monitoring health care as carefully as we monitor other transactions the Government is involved in.

We feel, when we finish our organizational changes, that we will be in the right posture to adequately address all of the things you have asked us to do. We can always use help, but this is a time of lean budgets and lean agencies, and we will stay lean.

Senator TALMADGE. Thank you very much, Mr. Schaeffer, and your associates, for your contribution.

[The prepared statement of Mr. Schaeffer follows:]

STATEMENT OF LEONARD D. SCHAEFFER, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

I am pleased to be here today to review with you the provision of home health services under the Medicare and medicaid programs. In enacting the home health provisions in 1965, as part of the original Medicare/Medicaid statute, Congress intended these benefits to serve the purpose of providing a needed health service and, in many cases, serving as a lower cost alternative to institutional care. as you, Mr. Chariman, have pointed out in announcing this hearing, "there is growing acceptance and appreciation of the value of appropriate and properly provided home health services as a humane and less costly alternative to institutional care."

In particular, the home health benefit has been a blessing for older Americans who can look forward to an increased life expectancy without the fear of automatic, long-term institutionalization following hospitalization. Not only are the costs of care often reduced in a home care environment, but such an independent environment and the assistance of family members can promote more rapid recovery. Our citizens can and should lead full lives away from institutions to the greatest extent possible.

Problems have arisen, however, as home health services have expanded in availability and in use.

Initially, the congress planned rather tight limits on home health benefits, including strict conditions for eligibility and limits on the number of visits per year. In spite of this, expenditures for home health services have increased markedly. In fiscal year 1979, Medicare expenditures are expected to reach $711 million compared to $119 million in 1974. Medicaid has also seen a rapid expansion, with expenditures for home health increasing from $30 million to $255 million during the same period. In fiscal year 1977, in-home services were used by 530,000 Medicare and 208,000 Medicaid beneficiaries.

With HCFA expenditures for home health services increasing at an annual rate of 20 percent, it is important to view them in the context of whether they are strictly health services or fall into the larger continuum of social services for people in the home.

Medicare finances acute care services for the elderly and disabled. Medicaid finances acute and institutional medical services for the disabled, poor, and many elderly. While home health benefits are included in both of these programs, Medicare and Medicaid can offer only a partial solution to the larger problem of how society can best respond to the needs of these populations.

The financing of health care services was not intended to replace the role of the family, nor was it meant to provide other social services. Rather, it was intended to supplement those resources where specific medical needs had to be met.

These health dollars are limited and must be directed to the specific goals of the program. An expanded definition of the Medicare and Medicaid home health benefit may provide more services to some. However, before initiating such an expansion, we must be sure that we do not inappropriately use health care funds, thereby depriving other people of needed medical services.

In addition to the Medicare and Medicaid funds, many other sources of money and services are available to individuals which can prevent the need for institutionalization and improve their health and productivity. For example, the title XX program, nutrition programs, HUD's support for housing for the elderly, and other efforts such as the VA's aid and attendance program are all mechanisms to provide such services.

It is apparent, therefore, that for home health to succeed as an alternative to institutional care, a coordinated package of health and social services is required. Thus, as we consider modifying the existing home health benefit, we must view such changes in terms of what are the most appropriate sources for funding those efforts and how we can assure that the entitled individual can benefit from all available resources.

In addition, as we total up the cost of all the services we can provide, it is important that we assume that care is provided in the most cost-effective manner. To that end, we must determine whether we are offering a lower cost alternative to institutional care or whether the patients' needs are best served by home health care even if that care costs more than institutional services.

To this end, HCFA has been working closely with the Administration on Aging, the Office of Human Development, and the Department's Planning and Evaluation staff to develop adequate knowledge about the most effective ways to organize and deliver servicea and coordinate the Departments overall effort in providing long-term care services. For example, the $30 million requested in the fiscal year 1980 budget will involve a joint effort between AoA and HCFA to determine how health and social services may be used in an integrated manner.

Many of our on-going demonstrations address the integration of a variety of programs, the cost-effectiveness of new organizational models and the impact of benefit changes.

Among these demonstrations are:

Under a demonstration grant, the Georgia Department of Medical Assistance is developing community services such as foster care, day health care and home care for Medicaid clients, in order to determine the impact of these services on the extent of institutionalization. In this project approximately 1,000 beneficiaries are receiving expanded community services. Their use of institutional care will be

compared to the cost and amount of institutional care received by a similiar group not receiving community services.

We are currently supporting two projects in New York State dealing with home health and related community services. One project in Monroe County is coordinating health and social services on a community-wide basis. the goal is to prevent unnecessary institutionalization and to provide more effective, less costly alternatives. The cost and quality of care delivered to project paritcpants will be compared to a similar group of non-project beneficiaries that do not have access to alternative care services. The Monroe county project serves approximately 800 patients per month.

HCFA is also working with the New York State Department of Social Services to implement a long-term home health care program in several localities across the State. Under this demonstration, social and health services are provided at home rather than in institutional settings. This demonstration caps the cost of home care at the 75th percentile of the cost of nursing home care. It is expected that this project will maintain approximately 2,000 Medicaid beneficiaries in their own home during the first year. HCFA will be conducting an independent evaluation of the impact of this approach.

In Connecticut, we are experimenting with a single entry point into the health care system through a community organization that provides assessment and case management. Through contractual arrangements with over 190 providers, the Triage project ensures a more coordinated and efficient provision of long-term care services for 1,500 Medicare beneficiaries. While this project includes the full spectrum of services, one of the questions to be addressed is the appropriate role of home health services in overall health care and social service systems.

Another important reimbursement demonstration is On Lok Senior Health Services in San Francisco. On Lok provides community and home-based services and has a contract with a skilled nursing facility and a hospital to care for its clientele. Through Medicare waivers, we will be reimbursing On Lok on a prepaid capitation basis—testing the feasibility of the health maintenance organization concept for comprehensive health care needs, including home health services.

Hospice care is another area of interest to HCFA. We have received over 250 applications to test a package of hospice services through Medicare and Medicaid waivers. We have targeted these benefits to in-home use by requiring that the basic component of the hospice be a home care program.

While these projects will greatly expand our knowledge about the benefits and costs of long-term care, much more information is needed. To this end, the President has included in his fiscal year 1980 budget request for HCFA an additional $15 million for research and demonstrations in home health and other long-term care services. These additional funds would enable HCFA to collect important survey data on characteristics of our beneficiaries who use long-term care services and the amount and cost of these services. We would also use these funds to sponsor more projects aimed at determining the costs and benefits of home health services, hospice services, and other alternatives to institutionalization. Finally, these funds would allow us to experiment with innovative reimbursement methodologies that would include capitation payment schemes, systems that relate reimbursement to individual levels of care, and prospective payment systems for SNF's and ICF's.

Among the kinds of projects that will be solicited in fiscal year 1980 are:

Comprehensive programs for organization and delivery of services as well as reimbursement: these models would allow one agency to control utilization and reimbursement for long term care services under Medicare and Medicaid, and title XX—Social Services.

Reimbursement for a comprehensive package of acute and long-term care services on a prepaid, capitation basis: These models would utilize the HMO and IPA-HMO mechanisms to include long term care benefits.

Innvoative reimbursement methodologies for skilled nursing facilities: These projects would be aimed along several lines. One would be to try to relate reimbursement to individual levels of care. Another might be to test methodologies providing incentives for quality care and controlling and reimbursing for capital costs

Comprehensive grants for all long-term care services.

Joint projects with private insurors: We hope to develop an interest in the private sector for demonstrations involving long-term care benefits. Such a package could be very meaningful as a supplementary benefit.

The information that would come from these new projects, as well as existing demonstrations, would be invaluable to future decisions your Committee might make in home health services and long-term care in general. We look forward to your continued support in these endeavors.

The results of our research and demonstrations projects are encouraging and will prove useful in the future. Over the past few years, however, with the rapid expansion of the program, certain problems have developed. Our own surveys and investigations, as well as information gathered through several Congressional hearings and GAO investigations into the status of home health services, have highlighted both the existence of, and potential for, major fraud and abuse.

Several factors have played a role in the occurrence of fraud and abuse: Medicare reimbursement guidelines often have not been specific enough As a result, some intermediaries have over-reimbursed such items as salaries, pensions, and fringe benefits. There is evidence of non-arms-length practices between home health agencies and hospital discharge planning units. Referrals have been made to home health services by physicians and other individuals who have a financial interest in the home health agency providing the service.

Finally, we may have failed to uncover problems in a timely fashion because scarce audit resources were concentrated on hospitals and nursing homes where the great majority of our funds are being expended.

As a result, we have been confronted with the need to control fraudulent and abusive practices in a number of areas throughout the country. For example, in Texas, executives of a home health agency were indicted for conspiring to defraud the government of the United States by filing false cost reports and using phony books and records to inflate costs. In March, 1978, the three defendants were found guilty on 12 counts of the indictment. The executive director received a seven year prison term and five years probation. The other official received a two year prison term and three years probation. The home health agency was fined $20,000.

In the Midwest, HEW has been investigating a chain of home health agencies which allegedly defrauded the government of over half a million dollars. The questioned practices involved claiming costs for the employment of relatives who actually worked elsewhere on a full-time basis, paying unjustified management fees and inflating costs for subcontracted services.

These represent examples of cases of open fraud. Many other cases involve practices which, while not obviously fraudulent, are abuses that cost the program extensive sums. For example, in Florida, validation reviews revealed a number of abusive practices. Directors of one agency were making personal use of agency assets—such as cars, credit cards, and televisions Over a four-year period, another Florida home health agency paid over 7 percent of its charges (between $35,000 and $50,000 per year) to a management consulting firm owned by the administrators.

Another matter we are concerned about within the Medicare program involves home health agencies which restrict their patient population to Medicare beneficiaries. By doing so, these "100 percent" agencies claim their full costs of operation as Medicare reasonable costs. Since there are no non-Medicare patients, no opportunity exists for comparing Medicare costs with costs attributable to other patients. Moreover, payments that are subsequently identified as excessive are difficult to recover because these agencies have no other source of income. Allegations have also been made that the "100 percenters" strip the patient of their Medicare benefits and then transfer them to other home health providers. Fraud and abuse also seems to be more prevalent among "100 percent" agencies than among other types of HHA's.

Responding to these and other questionable practices, the Congress passed in 1977 the Medicare-Medicaid Antifraud and Abuse Amendments (Public Law 95-142). This legislation provided us with a number of tools to address fraud and abuse problems:

To resolve the problem of hidden ownership and interlocking corporate structures, Sections 3 and 8 require that all providers must now make full disclosure of the indentity of each person with an ownership interest and of subcontractors whose business transactions with the provider exceed $35,000.

Also, to address the problems of hidden ownership, Section 9 permits the Federal Government access to all Medicaid providers records to the same extent as it does Medicare providers.

Section 14 authorized the Secretary to assign providers to specific intermediaries, based on his determination that the selection of these intermediaries would permit more efficient operation of the program. Final regulations to implement this section will be issued shortly. This authority would permit us to select a more limited number of intermediaries to serve all home health agencies. We believe that a smaller number of intermediaries serving home health agencies will permit us to use more experienced intermediaries who are better able to provide sufficient resources and attention to reimbursing, auditing and monitoring those agencies.

Section 19 required uniform cost reports for all providers. Uniform reports make it easier for an intermediary to identify aberrant patterns of costs. It will also provide the data necessary to better define and determine reasonable costs for home

health agencies. The NPRM on the home health agency cost reports which HCFA has developed will be issued shortly.

Fraud against any part of the program was upgraded from a misdemeanor to a felony as a more potent deterrent.

In addition to implementing the provisions of Public Law 95-142, we are taking several additional steps to improve the administration of home health benefits.

We will be publishing in the near future limits on the amount Medicare will pay for home health visits.

We are exploring the feasibility of screening guidelines to use in auditing samples of claims. This could enable us to quickly identify abusive patterns and target full scale audits.

We are examining ways to prohibit home health agencies from restricting themselves to furnishing services to Medicare patients only. In fiscal year 1980, funds have been allocated for HCFA to conduct audits of all "100 percent" Medicare home health agencies.

We will consider requiring home health agencies to submit a duplicate bill to the client, listing services provided and amounts charged. Through this, the client can then verify whether the services claimed were in fact provided. Clients would be specifically instructed to contact the intermediary in the event of a discrepancy.

We are increasing audit activities for home health agencies, especially in those areas where abuses have been identified. Given the small size of the agencies and the potential amounts that may be recovered, audit expenses may sometimes surpass recoveries. However, through the use of information gathered by the HEW Office of the Inspector General, and HCFA's Office of Program Integrity, we can focus our audit activity on those agencies where the potential for overpayments or fraud is more likely.

Finally, the Administration recently sent to the Congress a bill that would give the Secretary authority to impose a civil money penalty of up to $2,000 per fraudulent claim for reimbursement under the Medicare and Medicaid programs. The bill would provide administrative procedures that would help us move quickly against defrauders in those instances where a criminal prosecution might not be warranted or practical. It will also serve as a further deterrent against fraudulent practices of home health agencies.

This bill was recently introduced in the House of Representatives. I hope this Subcommittee will consider giving its support to this measure.

With the creation of HCFA and its new Bureau of Quality Control, the growth of the Department's Inspector General's Office, and the enactment of Public Law 95-142, we expect that there will be a greater capacity to more effectively investigate and prosecute fraudulent home health agencies. While we have made great progress in the last year in implementing a more effective system of reducing fraud and abuse, we must continue to expand our capacity to manage these programs before we consider significant modification of expansion. It is only by doing so that we can assure that our beneficiaries receive the full benefit of services available under present law.

We must also bear in mind that Medicaid and Medicare cannot be expected to support the full range of home services or be the sole means to meet the long-term care needs of the elderly and the poor. Neither program can substitute for the family. Neither program can provide all of the medical, housing, and social services necessary to care for this population.

Therefore, we must determine what services are most appropriately the responsibility of Medicare and Medicaid. In addition, we must determine what funds are currently available from other programs to assist in meeting the needs of this population. Lastly, we must develop mechanisms, at both the Federal and local levels that will guarantee individuals the full benefit of available resources. These include not only Federal financing mechanisms, but community services and support that can be provided through family members.

Given the budget constraints and uncertainty about how best to proceed, we must move cautiously in expending home health benefit. Some of the questions we hope to answer through our research and demonstration program are the extent of need and the best ways of organizing and delivering services.

Meanwhile, we are moving aggressively to improve our administration of home health services by achieving better contol over reimbursement costs and reducing the opportunities for home health agencies to abuse the program. These efforts will enable us to ensure that our beneficiaries receive the home health services to which they are entitled.

Senator TALMADGE. We have a multiplicity of witnesses to be heard. The hour is getting late and the Senate is in session. Therefore, we have to limit the time of each witness to 6 minutes, and try to hear all of the witnesses if we possibly can.

The next witness is Mr. Charles J. Hynes, deputy attorney general, special prosecutor for Nursing Homes, Health, and Social Services, State of New York.

You may insert your full statement in the record. I understand Mr. Hynes is not with us.

STATEMENT OF ALBERT F. APPLETON, EXECUTIVE ASSISTANT, SPECIAL PROSECUTOR FOR NURSING HOMES, HEALTH AND SOCIAL SERVICES, STATE OF NEW YORK, ACCOMPANIED BY ANN BERSON, SENIOR PROGRAM ANALYST

Mr. APPLETON. Senator Talmadge, Mr. Hynes had a last minute crisis with our State legislature on our budget so he has asked me to represent him.

Senator TALMADGE. Identify yourself for the record, please, and insert your full statement in the record and summarize it as briefly as you know how.

Mr. APPLETON. Thank you, Senator. I am Albert F. Appleton, I am Mr. Hynes' executive assistant and with me is Ann Berson, our senior program analyst.

Senator TALMADGE. We are delighted to have both of you.

Mr. APPLETON. Mr. Hynes has asked me to express his regrets that he could not be here, particularly, Senator, because we so much appreciate the leadership your committee has shown in the efforts of medicaid——

Senator TALMADGE. I understand he has done a fine job with the weapons we gave him. I personally wanted to congratulate him. Will you please extend my congratulations to him?

Mr. APPLETON. Thank you, Senator. That means very much to us.

Mr. Chairman, our office has run for 4 years the largest white-collar crime investigation into health care in the country. We feel that we have a right to be proud of our record, both in rooting out fraud and in dealing with problems of patient care. We are particularly glad to be here on home health today because, as we look at home health, we see an area in which the growth is just beginning. A long overdue expansion in this area seems finally about to take place. What we are here to speak to you today about is that this is perhaps the last major health policy area in which we can do it right the first time, that what we have here is a superb idea, but superb ideas are not necessarily self-executing. If we do not address the root causes of the fraud, abuse and waste that have underlined so much health care, that is: the poorly thought-out program designs, the bureaucratic mismanagement and the lack of any effective monitoring capability, we very much fear that we will have a repeat of the fraud and abuse that has taken place in so many areas.

We believe that home care is such an important idea that we should not allow it to be discredited by some of our failures in the past. We urge this committee, in designing its expansion of home care, to recall the experience in nursing homes and in other areas in the early 1970's. Remember there how a combination of poor

program design, hasty implementation, bureaucratic indifference and underfunding of enforcement led to massive scandals that have called into question the whole concept of publicly supported health care.

Mr. Chairman, home health care has been in existence for about 15 years and, except for the last few years, its growth has been very slow. As we have reviewed the area in the 4 or 5 months that we have been actively investigating it, as we have attempted to educate ourselves to this problem, we have seen the fact that, time and again, the same criticisms consistently reemerge. We have listed two pages of what are practically a standard consensus critique of home health in our testimony.

To summarize, it is underfunded, it is overbureaucratized. There is no common entry, no quality control standards, no monitoring and review, diffuse bureaucratic authority, and we could go on and on.

On a theoretical level, it is often criticized for overemphasizing its role as an alternative to institutionalization. Its preventive aspect, the aspect we look at in terms of patient care, seems often to be ignored.

Senator CHAFEE. Mr. Chairman, could I ask one question?

Senator TALMADGE. Senator Chafee.

Senator CHAFEE. What home care programs are in existence now that you are making this judgment on?

Mr. APPLETON. Senator, we have been looking at the home care program as it has been presented to us in our investigation in New York, which includes both title XVIII, the medicare program; title XIX, the medicaid program; and Title XX, the various social services programs. We have been reviewing, as best we can, both the New York experience and educating ourselves as to the experience that exists nationally, partially through materials provided to us, through members of this committee.

Mr. Chairman, we feel that if we are to get beyond the bureaucratic problems that seem to have inhibited health and currently are offering opportunities for fraud, abuse, and waste, that we must consider some kind of major change in program philosophy. We must look beyond home care as simply an alternative to institutionalization, to a philosophy that emphasizes home care as a preventive health service, a philosophy that attempts to merge the concepts of medical care and social service into one care package for those who need it.

What we would urge this committee, is to consider a concept along the lines of the following: To take the existing home care services that are provided in a fragmented form under titles XVIII, XIX, and XX, and to merge them into one, unified administrative program. We would see this program as being based on a localized intake assessment, monitoring and funding center with decentralized service delivery.

This kind of centralized enforcement administration would be easy to monitor, it would provide ready access for people who need home health care and would permit a variety of flexible services to be provided for the various patients who need it.

We believe that only this kind of fundamental reorganization is going to break home care out of the constraints, out of the frag-

mentation that is presently limiting its growth, presently keeping it from being a cost-effective service, and turn it into the preventive health care service it should be.

Senator TALMADGE. Mr. Appleton, I hate to call time on you. We have to get to other witneses. I have read a portion of Mr. Hynes' statement while you were testifying. I think it is a superb statement. I have only one question.

In a May 15 report to the Congress, GAO stressed the need for tighter fiscal controls for home health agencies. In particular, the GAO cited abuses of nonprofit status by some agencies such as excessive costs, self-dealing arrangements, excessive contracts for for-profit organizations and so on.

Earlier, GAO, in a congressional report, cited abuses with respect to for-profit agencies. What is the extent of home health care fraud and abuse in New York and what parallels do you see between home health and nursing homes?

Answer that as cogently as you can.

Mr. APPLETON. We will try to do that in all instances, sir. I think it is too early for us to comment on our ongoing investigations into home health. We have been in the area for 4 months. We have a number of investigations that we are undertaking. The non-for-profit private facilities, we probably will not have much to contribute to this committee because that is not a particularly large program in the state of New York. I think it will take us another 3 to 6 months to get the kinds of hands-on knowledge and the kind of investigative results we want.

Certainly, though, there are allegations in New York and we are looking into them. It seems to me the parallel with the nursing home industry in the early 1970's is obvious. We had a very good idea. There was a lot of pressure to expand the service. The only ready source was the proprietary industry.

We may face the same problem in home care. Those industries organized and ready to enter the industry are the proprietaries. Without proper monitoring and enforcement, I think you are going to have some major problems.

Senator TALMADGE. I take it, with proper monitoring, you would have no objection to for-profit institutions?

Mr. APPLETON. That depends on what you mean by proper monitoring. If it were possible to insure that the costs paid to the proprietaries would go to patient care and not to profit that is unrelated to patient care, yes. But I think we will have to see that system first before we could endorse it. We have no objection theory to the proprietary principle. Every time it has been put in, without careful design and very careful monitoring, we have had some very big problems.

We spent 3 years in New York cleaning up the nursing homes.

Senator TALMADGE. Senator Packwood?

Senator PACKWOOD. Accompanying Mr. Hynes' testimony is this book, "Profit-making in Long-term Care Facilities" in which he discovered one-quarter of the for-profit nursing homes had been involved in medicaid, fraud and related crimes. Did you do a similar study on nonprofits?

Mr. APPLETON. We did not survey every nonprofit nursing home, because we did not have the same kind of allegations of criminal-

ity. We are conducting an investigation into approximately a quarter of the nonprofit industry in New York State. So far, we have found three instances of indictable crime.

Senator PACKWOOD. Did you find any of the examples that Senator Chiles made reference to, that is, the nonprofit institutions with inflated salaries, overblown budgets, although not proprietary for-profit in the sense of reaping profits, but reaping profits in terms of wages in terms of those working for them.

Mr. APPLETON. The nonprofit nursing home industry is different than the nonprofit home care industry. The nonprofit nursing homes tend to be run by long-established eleemosynary institutions, churches, religious organizations, formal sectarians. We have seen some of that in New York. In other nonprofit programs, such as diagnostic and treatment centers that were organized in response to the medicaid program, paper nonprofits were created. These were the kind of institutions that caused problems in Florida. But those kind of operations, the nonprofit profits, as they are called, have not been present in nursing homes.

Senator PACKWOOD. Say that again? You have not had the development of new organization or nonprofit that Senator Chiles talked about?

Mr. APPLETON. That is correct.

Senator PACKWOOD. I have no other questions.

Senator TALMADGE. Senator Dole, any questions?

Senator DOLE. I think the record should show that Mr. Schaeffer was talking about the lean budget. When he left, about half the audience left, which I assume were HEW staff people. That is one of the problems when you talk about lean budgets. I do not think they really are that lean. But we are happy to have the vacancies in the audience.

The point I want to make, we talk about getting some action as far as fraud and abuse is concerned. You have not seemed to have that much difficulty. I have tried to read part of the report, and Mr. Hynes' statement and you have been moving ahead with indictments and saving a lot of public money. Why should it be so difficult to do it in Washington?

Mr. APPLETON. Is that a question, Senator?

Senator DOLE. I guess it is not a question. Well, it is a question. How can you be successful and we be so unsuccessful?

Mr. APPLETON. I think that it is easier for us to speak of the reasons behind our success. We have had a determined leadership, proper funding. We have been able to hire a good staff and we had a scandal in New York where it was made very clear to everyone if we did not deal with fraud and abuse, we would not have a health care system. And we have had the support of the Governor and most of the major administrative agencies and fortunately, the State legislature.

Frankly, we have been very fortunate in the relations we have had with Congress. Senator Talmadge, his staff, Jay Constantine and the others have made a very significant contribution to our success.

HEW says the right things, and means to do well. They have tried to help us in the fraud program. The reality often comes out

different. I am not sure that something does not get caught in the bureaucratic gears.

Senator DOLE. You suggest in the statement, or at least Mr. Hynes suggests, that we establish a program to coordinate the medical social service now provided in titles XVIII, XIX, and XX and have a title XXI. Are you familiar with that part of the statement?

Mr. APPLETON. Yes.

Senator DOLE. That is his recommendation based on a lot of practical experience and observation.

Mr. APPLETON. Yes, Senator. What we are particularly concerned with, after 4 years, is that we have seen an enormous gap that comes between the laws that are passed and the laws that are administered. For example, we have heard a proposal here to have regional intermediaries. That is not a proposal that we would come before this committee and recommend, necessarily.

Senator DOLE. It is not?

Mr. APPLETON. No. If you had been unable to supervise 70 intermediaries are you going to be able to supervise 10 any better? We wanted to put before this committee with the title XXI proposal the issue of whether we could slim down the bureaucracy around home health care and get a concept that would be much simpler to administer and monitor.

As we look at titles XVIII, XIX, and XX, they fragment and narrow the enforcement viewpoint. We can only look at section XIX. We can look at section XVIII indirectly with HEW. We cannot look at title XX at all.

The first thing a provider is going to do, faced with the threat of enforcement, is pass on his costs around the three programs. He will put it on title XVIII, where he can put it on the cost-plus reimbursement. There is less scrutiny.

These kinds of very simple administrative problems—Ann is in a position to tell a little bit about the quality of service problems lead us to believe, in the real world, that something has to be done to slim down this bureaucracy.

Ms. BERSON. Mostly, what we would like to see is a model that allows people to be served with the necessary services, health, medical, and social support services, starting from enabling people to remain in their own homes and only bringing in the medical components as necessary to these people. Large numbers of people could really be sustained with much more informal supports.

What happens to them is that they deteriorate because of personal care services are not available to persons who are not medicaid-eligible. Then it becomes necessary to hospitalize them or provide medical services that we could otherwise avoid had they had some kind of continued support service system available to them.

Senator DOLE. Thank you.

Senator TALMADGE. Any questions, Senator Chafee?

Senator CHAFEE. One quick question. I do not think you mean to leave the impression—did you—that the proprietary nursing homes were bad? You were indicating you had had scandals in maybe one quarter of the nursing homes and had no problems in the nonprofit nursing homes. At the same time, I assume that many of the

proprietary nursing homes are very good nursing homes, not only in care, but in efficient management.

Mr. APPLETON. Certainly there are many dedicated, capable people in the proprietary sector. There is a different industry now than there was 3 years ago.

What happened, the bad apples jumped in once they saw they were going to get a free ride from the Government. That is the bottom line.

Senator TALMADGE. Thank you very much, Mr. Appleton. We appreciate your appearance.

[The prepared statement of Mr. Hynes follows:]

STATEMENT OF CHARLES J. HYNES, DEPUTY ATTORNEY GENERAL, STATE OF NEW YORK

Mr. Chairman, members of the committee, I am Charles J. Hynes, New York State Deputy Attorney General for Medicaid Fraud Control. I also serve as President of the National Association of Medicaid Fraud Control Units. I want to open by commending your committee's continuing efforts to combat Medicaid fraud and reform health care. Senator Talmadge, your leadership in this area has been of major assistance to my office, and we are most grateful. I'm very pleased to appear before you today.

Home care has been defined by the home Care Association of New York State as follows:

Home care is the provision of in-home health and related support services to individuals and their families so that those who are ill, frail, vulnerable, disabled or incapacitated may achieve and sustain an optimum level of health, activity and independence in their place of residence.

This definition suggests a unity of concept and approach that does not exist in the actual administration of home care. In the real world, we have home health funded by Medicare under Title XVIII of the Social Security Act, which is largely limited to skilled care for patients at home. Personal care services, medically oriented tasks to accommodate long term maintenance or supportive care, are funded out of Title XIX, Medicaid. Finally, Title XX pays for home-based social services including homemaker, home health aide, home management, personal care and consumer education.

Home care should be one of the most important elements of our health and social services system. Tragically, it has been the most neglected. I hope this hearing will lead to a long overdue reorientation in our health care thinking, towards a new emphasis on home care, and particularly we would hope, towards informal, individualized community based health care.

Since 1975, my office has conducted the largest single investigation of white collar crime in the country. Starting with nursing homes, our mandate has been expanded to encompass criminal and civil-factfinding jurisdiction over the entire health care system in New York State. I also act as Special Prosecutor in New York State for the investigation of adult homes, New York's equivalent of boarding house facilities.

To date our investigation has resulted in over 150 indictments. We have recovered nearly $10 million dollars of public funds. We have identified over $60 million in overstated Medicaid cost claims. These findings, I am confident, will eventually, through our civil recovery program, yield additional of millions of dollars in returns for New York State.

We have developed a pioneering patient abuse program and played a substantial role in overhauling New York's patient care code. Our factfinding work in adult homes led to a major legislative reform of the industry. We have also identified needed reforms in state administrative practices; the handling of patient personal funds; and, the State's criminal laws and procedures.

In the nursing home industry, we have largely eliminated the fraudulent billing of personal expenses to Medicaid, and the frauds practiced by providers and vendors. In addition, we have largely put an end to the mistreatment of nursing home patients.

I am proud to say that our work was the model your Committee used in 1977 for the Medicaid Fraud Control Unit Program. This program was a critical first step towards establishing the principle that meaningful enforcement mechanisms must be built into government spending programs.

It is becoming increasingly clear that we must deal with more than individual wrongdoers. If we are to end the scandals that now seem to be the almost inevitable accompaniment of trying to translate our good intentions into reality, then we must attack the underlying causes of fraud, abuse and waste. We must cease to tolerate the poorly thought out program designs, the bureaucratic mismanagement, and the absence of any independent monitoring and enforcement of program performance. As long as these manifestations of our country's irresponsibility about public funds persist, fraud, abuse and waste will continue to plague us, continue to deprive our poor, sick and elderly of the services we wish to provide them.

I think the attitudes in this country are beginning to change. I think we are all beginning to realize that if we are to achieve our social goals our government programs must be tightly organized, prudently managed and continually monitored for any misuse of public funds.

These concepts are particularly important in home care. The full development of home care is yet to come. As we build this new service, a desperately needed service in my opinion, we should learn from the mistakes of the past. Unless we do, this vitally needed idea will provide yet another unnecessary victim for the unholy trinity of fraud, abuse and waste.

Home health has the promise to end the unnecessary institutionalization of patients and build a community orientated system of care based on service to the individuals in their own homes. More than that, it could become a major element in an overall strategy of preventive health care. It is a concept which should be basic to our society. But so far, it is only a promise.

Numerous critiques, studies, comments and Congressional hearings have documented beyond serious challenge the myriad structural problems with present home care programs. Home care is underfunded and over-bureaucratized. It has no organized system of patient entry, a lack of coordination with other health care levels and social service programs, and too many compartmentalized funding sources. Conflicting eligibility criteria combine with fragmented services to make it virtually impossible for the individual to piece together a total care package. Indeed, they often squeeze individuals entirely out of the home care system.

There has been, little, if any effective program monitoring, a lack of adequate or available services, unnecessarily rigid patient eligibility criteria, an overemphasis on home care as a money saving alternative to use of health facilities, a lack of emphasis on the preventive aspect of home care, a complete absence of uniform program and professional standards, a vague and undefined role for family and community members, and on a more theoretical level, a split between medical and social service models.

It should therefore be no surprise that fraud, abuse and waste are now surfacing in home care programs in a number of states.

So far the ideal of home care has survived, and in the face of great odds, a beginning has been made on meeting the need for home care services. That we have come as far as we have is a tribute to a handful of dedicated activists, such as we have been fortunate to have in New York State. Happily, we are at last beginning to heed what they have been trying to tell us: home care is a better and more humane way to help people.

But we will cruelly dash their hopes unless we couple the expansion of home care with a major overhaul in the way we deliver and monitor home care services.

I urge this Committee to recall the experience of the early 1970's in nursing homes. Then a push to expand the industry, a poorly thought out bureaucratic system, and a lack of effective monitoring led to massive amounts of fraud, abuse and waste. Home health is far too important a concept to risk repeating that history.

Good ideas are not self-executing And the fact that we have a superb idea in home care should not blind us to the fact that the present home care system, or non-system to be more accurate, is no way to implement it

At the heart of the problem is the fragmentation of home care between Titles XVIII, XIX and XX, each with different goals, philosophy and administration. No matter how many specific improvements we make in the administration of those systems, no matter how many paper plans we devise for better coordination, as long as we pay for and manage home care out of three separate pots, we will never have an efficient home care system Quite apart from the program and management implications of such a system, it will be close to impossible to monitor such a system efficiently

From an enforcement viewpoint, home care is a bureaucratic shell game As a State Medicaid Fraud Control Unit, we can only look at Title XIX programs. Title

XVIII we can review only indirectly through HEW. Over Title XX, we have no authority at all

What will happen is obvious. A provider will push his costs around among three programs where they will be most profitably reimbursed, and where they will receive the least scrutiny. What this will do to program integrity is also obvious

The answer to these problems, the key to building a good, cost effective home care system is, in my opinion, to redesign the program so we have a unified administrative concept that reflects our program goals. Home care combines both medical and social service elements, but incredibly, we now oppose those two services instead of merging them into a unified approach to care. Though home care is partially preventative/supportive, and partially remedial, we insist on treating it as either one or the other. Though home care should be a keystone of a national health care system, we insist on shunting it into the role of an alternative to institutionalization, when, most appropriately, institutionalization should be the "only if necessary" alternative to home care.

It is time to recognize that in home care we have a new kind of service. In home care we can translate our rhetoric about preventive medicine into action. We can make our ideal of individualized community based care a reality once again. We can restore the family to its rightful therapeutic role.

I do not quarrel with the intent of the many proposals for improving home care now before this Congress. But I do not believe they go far enough towards providing the basic change in philosophy or organization that we need to provide an efficient system of home care, and to insulate the delivery of home care services from fraud, abuse and waste.

I propose the establishment of a new service program to be Title XXI of the Social Security Act, Home Care and Family Support services. This new Title XXI should take the medical and social services now variously provided under Titles XVIII, XIX and XX and integrate them into one independent unified service program that would provide the home health care and support services families need to maintain an aged, sick or frail person in a home environment. This program would have a unified funding stream and a single system of service eligibility. Provision of Home Care under Titles XVIII, XIX and XX should be phased out in favor of the new Title XXI system.

The Title XXI program envisions a centralized Home and Family Service Unit for each appropriate local geographic area. These agencies would manage patient intake for their entire area, would provide each patient with an individual service assessment, would arrange for the necessary services, would manage and coordinate all funding, and would monitor service delivery. Around this unified administrative center, service delivery would be decentralized using a variety of existing and new local programs and providers, such as individual family members, community organizations, and where appropriate, medical facilities. With a Title XXI approach, we can build home care into a service readily available to all who need it, providing individuals and families with the supports services necessary to help their loved ones in their own homes and communities. Finally, the Title XXI approach with its unified organization, structure and philosophy will enable us to easily monitor and review on an ongoing basis the quality and cost of home care services.

Mr. Chairman, whatever the initial cost, I am confident that over time the replacement of our present non-system by this Title XXI program, with its organizing of home care with an emphasis on preventive services, will be profoundly cost-effective

I realize the pressures on this Congress for cost containment. That is a necessarily cautious sentiment about innovation. But what looks less costly now, we may pay for in the future. This is an issue on which a long view would be of particular importance to this country.

Mr. Chairman, before I close I would like to make one immediate point about the problems Medicaid Fraud Control Units face, as they struggle to monitor the health system and home health programs effectively. Of the three programs that pay for Home Health Care, we only have a mandate to deal with Title XIX. As I previously described, the providers can lead us a merry chase through these programs. We are like the posse in the old Western movies, we have to stop when the bad guys reach the border.

This is not only a problem for us in home health. It is a growing problem in other areas. Most Federal programs overlap with other Federal, State or local funding programs. Providers and recipients often deal with a number of programs. They are increasingly learning to use those programs intersections to their advantage.

We have also seen this in our adult homes/boarding homes investigation, where we have had to work around a limited jurisdiction over the SSI payments that are the actual funding support of such facilities.

Increasingly, I feel we must consider a concept of cross-audit and investigation. I think this Committee and this Congress has to consider amending the Medicaid Fraud Unit Program to permit the fraud units to undertake, perhaps on a State option basis, cross-audit and investigation of funding programs other than Medicaid, when they have an important relation to health care or Medicaid funded services. The profiteers we are dealing with are not constrained by these distinctions between programs, nor is the misery of the people they exploit.

Mr. Chairman, I think the average person, hearing the term home care, envisions a system of informal supports for themselves and family members, so that they could go on functioning in the community. I don't think it would add to the public's faith in government if they saw the bureaucratic mish-mash home care is in reality. I think the fact we have any meaningful home care at all in this country is a tribute to the dedication of the individuals involved with such programs and their sensitivity and concern for people. But home care advocates should not have to fight the government to obtain for people the services they need. Government should be helping to support our sick and elderly through a simple and unified system of home care, and through the provision of enough monitoring and enforcement to insure that home care services go to help patients and not subsidize profiteers. To create such a system would be the largest step yet taken towards that oft proclaimed but seldom realized goal of preventive health care.

Senator TALMADGE. The next witness is Grace M. Braden, executive director, Visiting Nurse Association of Orange County; president, California Association for Health Services at Home; member, Board of Directors of National Association of Home Health Agencies.

Ms. Braden, you may insert your full statement in the record and summarize in not more than 6 minutes.

STATEMENT OF GRACE M. BRADEN, EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION, ORANGE COUNTY; PRESIDENT, CALIFORNIA ASSOCIATION FOR HEALTH SERVICES AT HOME; MEMBER, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Ms. BRADEN. Thank you, Senator.

I am very happy to be able to talk to you this afternoon. I feel a great deal better after hearing the testimony this morning and listening to you gentlemen this afternoon than I did when I prepared my testimony. I was feeling pretty depressed about home care and some of the things developing.

The fraud and abuse we hear about today is a cop-out, a real, flat-out cop-out. We have had people in California who have been heard by the Senate, by the House, whatever, and indicted for fraud and abuse. They are still operating. Nothing has happened to them. They are consultants, if they are nothing else, to home health in other areas in the State.

I have pointed out—I have been executive director for 18 years, 5 of those years before medicare and 13 with medicare. I have grown up with the program. I have an understandable bias. I am somewhat annoyed when I hear home care referred to as an alternative to institutionalization. I consider my home my normal environment and any removal from my home is an alternative to that normal environment.

I have taken a tack today in preparing my testimony where I point out—Senator Talmadge, you have said in your remarks before this hearing, that you wanted to see home care expanded

and improved. I think it is a very important point of our health care continuum.

Are you aware that the nonprofit community-based agency is discriminated against, that we have no opportunity in the cost reimbursement method currently in effect to grow at all, other than to utilize what cash reserves we might have, what inheritances we might be fortunate enough to receive to fund such a thing.

The Health Care Financing Administration has blasted to the skies this idea that we are going to have $724 million expended this year as compared to $298 million in 1976. During that same fiscal period, my agency changed from 36,000 visits to, we extrapolate, over 80,000 visits for 1979 and that is in excess of 100 percent increase.

We have also increased the number of patients we are seeing, but we have decreased the units, the average units of patients to each one of those from 13 plus to 11 plus.

Our patients are changing in character. They are no longer chronically ill patients. These patients are acutely ill, discharged much more rapidly from acute hospitals today. We had to have some kind of 24-hour service to accommodate the needs of this patient.

I think if they put in the cost savings that accrues to the program as a result of the lower hospital costs, you will find it will not cost medicare more. Home care is saving money.

I would like for you to really give some thought to some way that we can put in, put back to 2 percent, perhaps, for nonprofit agencies. Forget the bad guy nonprofit. Those people surely we can control.

There has to be some growth, some incentive for a nonprofit agency to exist, continue to exist, or we will see them go out of existence.

I have been talking to my Board quite seriously about this. It is discriminatory that you reimburse the proprietary agency on capital equity and you do not give anything to a nonprofit agency. We have no way to even replace our capital equipment.

I have found this unfair and inequitable and, I think, unintentional. Surely a method can be developed that would be more evenhanded.

I think that some of the cost reimbursement methods are diametrically opposed, and I am thinking of the 223 caps that were loudly touted as being helpful. And you can read the testimony. I find it ludicrous that they would go through a great array of costs throughout the Nation and arrive at an average cost, and then reduce that cost by $2 for each service, and then further reduce it another $4. At any rate, they have just reduced it. My agency can live within these cost caps. It is the concept. There is no control over what is happening to my agency today. The workers compensation in California for this particular classification, increased the premium by 25 percent this year and will increase it another 25 percent next year.

Senator TALMADGE. I hate to call time on you, Ms. Braden, but we have a number of witnesses to hear.

Ms. BRADEN. I hope you will look at the proof of eligibility, the memorandum I have attached.

Senator TALMADGE. I read your statement in full while you testified.

Ms. BRADEN. I think it is too bad, dealing with this type of thing.

Senator TALMADGE. Any questions?

Senator DOLE. Just briefly. You indicated earlier on that it was a cop-out, that people were still operating. Has there been rigid enforcement of that in California?

Ms. BRADEN. I do not know. We have always had licensing. I suppose they could pick up the license. I think they did pick up the license for these two particular operators.

There has not been that grave a concern on the part of the Health Department that does the licensing. I think it generally has been left to the Federal Government to ferret out these people.

There has been, on the part of the State association a great deal of activity and some reporting of instances that appear to constitute fraud and abuse.

Senator DOLE. It might be an area that Governor Brown may want to address next time he is there.

Ms. BRADEN. If there is any other question I can answer, I would be glad to address it in writing.

Senator TALMADGE. Thank you very much for your contribution, Ms. Braden.

[The prepared statement of Ms. Braden follows:]

STATEMENT OF GRACE M. BRADEN

I am Grace M. Braden, the Executive Director of the Visiting Nurse Association of Orange County in Southern California. I have been at this post for 18 years—13 years with medicare and 5 years preceeding the program. I am also the president of the California Association for Health Services at Home and serve on the board of directors of the national Association of Home Health Agencies. I hope you will agree that my experience enables me to speak with some authority. Both the State and national associations are pleased to have you address your interest to home care and look forward to many positive and innovative developments.

As you evaluate the advantages and shortcomings of the existing home health programs please consider the "significant growth" in the cost of home health services. Figures have bgeen announced that project $724 million expenditure for 1979 as compared to $298 million in 1976. The VNA of Orange County made 36,373 visits to 2,690 patients in 1976. Based upon service through April, we estimate that we will make very close to 80,000 vitits to about 7,000 patients in 1979. This means we will have well over a 100 percent increase in service for the period while reducing the average number of visits/patient from 13 plus to 11 plus. Our current patient profile indicates that patients are being discharged from the hospitals much sooner with more acute needs. A year ago we began providing our services 24 hours a day, 7 days a week to accomodate this seriously ill patient. Shouldn't there be some offset to the increased (?) cost when you factor in the savings that should inure to the program as a result of reduced hospital costs?

Could you also consider the dilemma of the community sponsored nonprofit agencies? We are reimbursed on a cost basis * * * and an historical cost basis at that * * * for services. This will not permit expansion beyond the agency's cash reserves and ability to fund such expansion. In fact we will eventually be faced with the necessity to diminish service in order to remain solvent. This is not the case with proprietary agencies. They are given a return on equity capital that amounted to 13.3 percent by the most recent computation. (See Reg. 405.429, HIM-1)

This is discriminatory, inequitable and grossly unfair.

Surely a method to deal more even-handedly can be developed before we begin to see the demise of the VNA's and lie organizations.

Some reimbursement issues currently being considered are diametrically opposed to your interest in improving and expanding home health care services. The proposed 223 caps are a case in point. Please do not misunderstand. I am not opposed to

cost containment. On the contrary—I believe most home health agency administrators agree that there must be a serious movement to contain costs and many of us resent the astronomical fees put forth by a few isolated agencies, but surely the machinery is in place to control such abuses. As the recent Report to Congress on Home Services pointed out, on page 27; "although there is widespread dissatisfaction with reasonable cost reimbursement of home health agencies, there is very little analysis, either theoretical or empirical, which would permit a recommendation at this time for a substantially different reimbursement policy." Nevertheless, HCFA has proposed a radically different method of reimbursement, some attempt at a statistically valid method of cost determination was made, but after this laborious study, it is my understanding the, first, an arbitrary $2. was chopped from the proposed cap for each category of service—and then, in total abandonment of all validity, another $4. was slashed from each category of service. How does such a methodology—or lack of methodology—relate to "reasonable cost"? And how can we pretend that there is a national average cost of anything—especially salaries! If the intent is to curtail service it will certainly work! This verges on an abusive practice.

In fact, it would appear to me that the fraud and abuse by some home health agencies that is so frequently cited as the reason for all manner of unreasonable behaviour on the part of various levels in HCFA is not always engendered by the "bad-guy" home health agency. Sometimes the home health agency is victimized. Irrational approaches to reimbursement is one method. A more flagrant—and I think scandalous abuse of providers of medicaid (Medi-Cal) services in California has recently come to my attention and I think is worthy of yours in your deliberation. In a Memorandum to Members of Subcommittee 1, committee on Ways and Means, Assembly, California Legislature, (copy attached and made part of this testimony). Subject: hearing, Items 262 (Medi-Cal Fiscal Intermediary Services, and Item 265 (Medi-Cal Other Provider Rate Increases). May I quote from pages 4 and 5 of this memorandum?

3. *Proof of Eligibility Labels.*—A major change order is currently in process with respect to proof of eligibility labels, the so-called "sticky labels." Under the current system for processing claims, a claim for services must be accompanied by a proof of eligibility label in order to establish the validity of the claim. Claims are not paid unless the labels are attached. The contract between the State and the new contractor is based upon the elimination of this feature of the program. Specifically, claims submitted for out-patient medical services by physicians which do not have sticky labels could be verified by utilizing an on-line eligibility system. Thus, legitimate claims which currently are not paid would be honored under the new system. The Department is currently proposing to amend this feature of the contract and instead retain the current "sticky label" system. This decision is based upon purely fiscal reasons. It has been estimated that approximately $34 million worth of claims are currently submitted to Medi-Cal annually which are denied because of failure to comply with the sticky label requirement. Additionally, it has been estimated that fare more claims could be submitted, but are not, because patients do not have the necessary sticky labels and providers recognized that submission of the claim would be an exercise in futility. The upper range of estimates for the total cost of implementing the new system to permit all legitimate claims to be honored is approximately $150 million annually (State and Federal Funds).

It is disheartening to attempt to continue providing service in good faith in such a climate. Wouldn't you agree that such a clumsy method to avoid payment of legitimate claims amounts to fraud and abuse against the providers?? The Schedue of Maximum Allowances in California is punitive enough. Why should a state be permitted to "free-load" at the expense of a community agency? In my own agency we are approaching the time when we must consider if we can continue seeing the Medi-Cal eligible client. The United Way in our county feels strongly that the charitable dollar should not be used to underwrite as supposedly tax supported, government imposed program. Believe me, the members of Cahsah all look forward to the time when title 18, 19 and 20 will all be consolidated and federally supervised. Perhaps this will provide a more equitable administrative program. Certainly it would eliminate some of the duplicative administrative costs. It would surely go far toward eliminating some of the chaotic fragmentation of services as we move patients from program to program.

There are many other areas of concern that have been expressed by members of the State association, but I recognize the time constraints you are under. Perhaps we will be permitted to provide written materials to you a little later. I am very grateful for this opportunity to appear before you and I hope you will call upon me at any time that I might be of assistance to you. Thank you.

CALIFORNIA LEGISLATURE,
COMMITTEE ON WAYS AND MEANS,
April 16, 1979.

Memorandum to: Members of Subcommittee No. 1.
From: Bill Abalona.
Subject: Hearing, items 262 (Medi-Cal Fiscal Intermediary Services), and Item 265 (Medi-Cal other provider rate increases).

Item 262—Fiscal intermediary services

The Governor's Budget proposes approximately $23.5 million for the processing of medical claims and approximately $1.5 million for the processing of dental claims for various fiscal intermediaries under Medi-Cal. The proposed budget for processing medical claims reflects the results of a recent competitive bid process. Consequently, the budget contains $15.5 million for Blue Cross/Blue Shield, the current fiscal intermediary, and approximately $8 million for Computer Sciences Corporation, the bid winner.

The recently completed Medi-Cal competitive procurement project lead to a 5½ year contract with Computer Sciences Corporation to perform fiscal intermediary for the State for the processing of medical claims under the Medi-Cal program. The amount of the contract for this 5½ year period, $129.6 million, makes it one of the largest contracts ever awarded to a private corporation by California or any other State.

Under the provisions of the new contract, the State will assume many functions previously performed by the contractor. These include the actual writing of checks, which will be performed by the State Controller; recovery of funds from casualty insurers; certification of providers; on-sight review of medical judgments made by the fiscal intermediary; and surveillance of program abuse by non-institutional providers. All of the latter functions will be performed by the Department of Health Services. The actual processing of provider claims by the new fiscal intermediary, as well as functions by the Department of Health Services and the Controller, are to be phased in over a period of time. Under the current timetable, CSC will begin processing pharmacy claims in March 1979, followed by skilled nursing and intermediate care facilities in June 1979, and then hospitals in September 1979.

If all goes well, the competitive procurement project just completed will undoubtably save the State substantial money for fiscal intermediary services. Additionally, in the view of staff, the Department has put forth a good effort in completing the procurement phase of the project. However, it is critically important that the operational phase of the project work properly. If the new contractor and the State are not able to process claims effectively, so that timely and appropriate reimbursement is made to providers, the entire program could easily disintegrate. There is no "fail safe" system to back-up the new contractor in the event that unanticipated difficulties arise.

Staff has request the Department to make a very brief presentation to the Subcommittee on the status of the Department's plan to phase in the new contractor. Additionally, there are several specific issues of current concern:

1. *Departmental preparedness.*—The most important overall issue concerns the Department's ability to perform as anticipated under the contract. During budget hearings last year, the Subcommittee requested assurances from the Secretary for Health and Welfare that the Medi-Cal procurement team would not be disrupted by personnel and leadership changes as a result of the reorganization then occurring within the Agency. The Secretary provided such assurances in writing. Although the reorganization did not affect this unit, as the Secretary promised, shortly after the bid was awarded, several key personnel changes occurred. The project director left the State to accept a job with one of the unsuccessful bidders, and another key person accepted a job with the new contractor. Other personnel changes have also occurred. Because the contract specifications are highly technical, the transitional phase which is now occurring is especially important. The Department must not only gear up to assume a number of new functions, but also monitor the ability of the new contractor to assume basic claims processing functions. Any delay is likely to be expensive, since it would extend the period of time in which two contractors were involved, as well as creating serious management problems.

2. *Change orders.*—A fundamental premise of the new contract is that the contractor is at risk to perform his responsibilities within the amount agreed upon. However, there are provisions permitting both technical and fundamental changes to be made to the basic agreement, which could result in additional costs. Any change order which has a fiscal impact of greater than $50,000 must, under the terms of the contract be approved by both the Departments of Finance and General Services. A

latent danger is that the basic agreement could be fundamentally rewritten by a series of change orders, which could result in substantial additional costs to the State. The State is in an inherently poor bargaining position, since it must rely totally on the contractor to keep this program operating.

The present contractor has suggested that the Legislature may wish to require, through budget language, 30 day notification prior to the adoption of any change order with a fiscal impact of greater than $50,000. It is anticipated that this proposal will be discussed during the hearing.

3. *Proof of eligibility labels.*—A major change order is currently in process with respect to proof of eligibility labels, the so-called "sticky labels." Under the current system for processing claims, a claim for services must be accompanied by a proof of eligibility label in order to establish the validity of the claim. Claims are not paid unless the labels are attached.

The contract between the State and the new contractor is based upon the elimination of this feature of the program. Specifically, claims submitted for out-patient medical services by physicians which do not have sticky labels could be verified by utilizing an on-line eligibility system. Thus, legitimate claims which currently are not paid would be honored under the new system.

The Department is currently proposing to amend this feature of the contract and instead retain the current "sticky label" system. This decision is based upon purely fiscal reasons. It has been estimated that approximately $34 million worth of claims are currently submitted to Medi-Cal annually which are denied because of failure to comply with the sticky label requirement. Additionally, it has been estimated that far more claims could be submitted, but are not, because patients do not have the necessary sticky labels and providers recognize that submission of the claim would be an exercise in futility. The upper range of estimates for the total cost of implementing the new system to permit all legitimate claims to be honored is approximately $150 million annually (State and Federal Funds).

Additionally, AB 297 (Young) is currently pending in the Ways and Means Committee, and would require the Department to implement the new on-line eligibility system to back-up the "sticky labels." This legislation is sponsored by the California Hospital Associations.

It should be noted that there are some exceptions to the sticky label requirement currently in effect. Facilities contracting with counties for the care of indigents, as well as county hospitals themselves, may obtain replacement documentation where an eligible patient does not have proof of eligibility labels. AB 297 would extend this privilege to all providers, in addition to those currently affected.

Item 265—Provider rate increase

The Governor's Budget proposes approximately $61.9 million for provider rate increases under the Medi-Cal and other health services programs. Of this amount, approximately $59.2 million is for the Medi-Cal program, which, when matched with Federal Funds, would amount to an increase of approximately $106.5 million in total spending. This represents an overall increase of approximately 6 percent.

When the Governor's Budget was published, no allocation of these funds among individual provider groups was proposed. On Friday, April 13th, the Department of Health Services submitted a memorandum indicating how these funds would be distributed by the Department if no limitations or specific obligations were imposed by the Legislature. Basically, the Department's proposal would give some providers a 6 percent cost-of-living increase, other providers a much larger increase, and some providers no increase whatsoever. The precise distribution is described in the Department's proposal which is attached to this memorandum. However, these recommendations are premised on the idea that certain provider groups are more severely under reimbursed by the Medi-Cal program than others, and it is more important to raise a reimbursement levels for these groups than to provide a cost-of-living increase for providers whose reimbursement is relatively high.

In a general sense, the provider rate increase item is illustrative of the general dilemma of the Medi-Cal program. All provider rates under this program are subject to budgetary and administrative limitation with the exception of hospitals. By Federal law, hospitals must be paid their actual reasonable costs or charges, whichever is lower, subject only to certain overall limitations. All other providers are subject to administrative limitations on their reimbursement, and most are paid under a schedule of maximum allowances. Since the State has little control over caseload and utilization increase, one of the few budgetary constraints which may be placed upon the program is by restricting provider reimbursement. As a consequence, over the past several years reimbursement for most providers has eroded to slightly more than half of actual reasonable or customary charges. Although little actual information is available which relates provider participation and quality of

care to provider reimbursement rates, it is known that providers generally are increasingly reluctant to care for Medi-Cal patients, and that most Medi-Cal recipients are cared for by relatively few providers.

Neither the executive branch nor the Legislative Branch of State government have ever established clear policies regarding the level of provider reimbursement under Medi-Cal which is appropriate. To bring all providers up to a level of reimbursement approximating reasonable actual costs or charges could easily cost both the State and the Federal Government an half billion dollars annually. An amount less than this which could be paid and still provide patients with reasonable access to most providers is unknown, because of data limitations. It seems clear, however, that at this point that some fundamental reform must be made to either the method of financing care under Medi-Cal, or else the basic design of the program.

As of this writing (Sunday, April 15), nine provider groups have requested permission to testify regarding the provider rate increase item. Because it is currently unknown to staff what will be proposed, this memorandum does not attempt an analysis of each provider group's reimbursement level. However, briefly set forth below, are the results of four studies completed recently by the rate development unit within the Department of Health Services. Additionally, nursing home reimbursement is also discussed briefly.

1. *Physical/occupational therapy.*—A rate study published February, 1978, recommended increases averaging 69.7 percent in reimbursement for physical and occupational therapy. So far, these increases have not been granted.

2. *Physician reimbursement.*—In a report dated January, 1979, the Department made the following findings regarding physician reimbursement under MediCal: although the CPI has increased by approximately 76 percent since 1969, Medi-Cal physician rates have increased only by an average of 22.5 percent during the same period; physician reimbursement levels for Medicare are, on the average, from 33 percent to 60 percent higher than Medi-Cal; physician charges to Medi-Cal generally range from 60 to 100 plus percent greater than Medi-Cal maximums; the Department has still not adopted the 1974 relative value studies as a basis for reimbursement; in 1977, 41 percent of all out-patient and physician primary care was rendered by 3 percent of all providers.

3. *Speech pathology and audiology.*—In a draft report completed in July of 1978, the Department indicated that rates for speech and hearing services be increased by an overall average of 35.2 percent to cover the medium costs of providing these services. These increases have not been implemented.

4. *Hospital out-patient services.*—In a report issued in May 1977, the Department proposed that various reimbursement rates for the use of hospital out-patient facilities be increased, some slightly and some more than 100 percent. Additionally, this report recommended that the reimbursement for county hospitals and other facilities which may legally employ physicians be made equal to out-patient reimbursement allowed for other hospitals. Last year, the Legislature appropriated $25 million to increase hospital out-patient reimbursement for county hospitals and county contract hospitals and also to establish uniform reimbursement for facilities which employ physicians. $3 million was also provided for free and community clinics. The Governor vetoed $8.3 million of this augmentation, which related to increasing reimbursement for county and county contract hospitals. In his veto message, the Governor indicated that he was instructing the Director of Health Services to "* * * develop the means of reimbursing clinics on a cost related basis that will restrain the rate of cost increase and be consistent with Federal legislation." Staff has no knowledge of any response by the Department to this budget veto language.

Nursing home reimbursement.—This issue is of special concern to the Legislature this year because the Department currently has no accepted State plan for nursing home reimbursement. An acceptable State plan which is "reasonably cost related" is a requirement of Public Law 93-603.

Although the Department of HEW has rejected an earlier proposal by the Department of Health Services for an acceptable method of reimbursing nursing homes, the Federal Government and the State appear to fairly close to an agreement at this time. However, the nursing home industry has objected to several features of the Department's proposal.

Currently, nursing home and intermediate care facilities are reimbursed according to a schedule of maximum allowances. The SMA is set at the median of actual costs incurred by all nursing homes throughout the State, based upon a survey periodically performed by the Department. Under the Department's latest proposal for amending the State plan, the State will be divided into four regions for purposes of reimbursement, and there will be two bed size groupings of facilities instead of

three. Reimbursement will continue to be at the median of actual costs in each of the four areas.

The industry has recommended two areas instead of four, the continuation of three bed size groupings, and reimbursement at the mean cost level (or 60-second percentile) instead of the 50th percentile. It is estimated that the industry's proposal is approximately $60 million more expensive than the State's proposal in total annual costs.

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH SERVICES,
April 12, 1979.

Memorandum to: William Abalona, Consultant Ways & Means, State Capitol, Room 3091.

From: Office of the Director.

Subject: Proposed Medi-Cal rate increases, fiscal year 1979-80.

Attached is a copy of the Department of Health Services proposal for rate increases for Medi-Cal providers in fiscal year 1979-80, item 265 of the Budget Act of 1979.

BEVERLEE A. MYERS, *Director.*

Attachment.

PROPOSED RATE INCREASES FISCAL YEAR 1979-80

The Governor's budget for fiscal year 1979-80 contains $59,186,400 (representing a program total of $106,452,100) for Medi-Cal provider rate increases. This represents a six percent average rate increase across all providers.

It is proposed that differential rate increases should be granted based on program priorities. Under this proposal, proportionately higher rate increases would be adopted for those services which are in short supply but are highly needed, and/or for which reimbursement levels are especially low. In order to stay within available funds, and yet distribute these funds as equitably as possible, consistent with listed priorities, proposed rate increases were basically determined by proportionately allocating the increases in relation to the findings of cost studies and other available data. Although this approach does not ensure that all reimbursement needs will be met, it does provide a means for channeling limited rate increase funds to the most crucial priority requirements. It has been estimated that in excess of $500 million for rate increases would be necessary to meet all requirements if no fiscal limitations were imposed. Of the funds available for rate increases, $2,681,768 general fund ($4.781,908 program) has been left unallocated as a contingency. The Actual rates for SNF/ICF and Prepaid health Plans will depend upon the outcome of cost studies and other factors. If the amounts included for SNF/ICF and PHP rate increases and the unallocated funds are insufficient to meet the needs of these providers, the proposed rates for other providers would have to be adjusted accordingly. If the unallocated funds are not necessary to meet these requirements they will be apprortioned among the other providers receiving increases. The following criteria were used to determine the priority list of providers selected for rate increases:

1. Promote essential ambulatory outpatient primary care, and effective alternatives to hospital or other inpatient care.
2. Promote Medi-Cal participation in organized comprehensive health care systems.
3. There is a substantial, demonstrable need for a rate increase to ensure continued or increased participation in the Medi-Cal program, considering current participation levels relative to need.
4. Need requirements of law, regulation, or contract.

PROVIDERS PROPOSED FOR RATE INCREASES 1979-80

PHYSICIAN SERVICES

Maternity care—35.7 percent increase

The Department has experienced considerable difficulties in securing adequate total obstetrical care services The current reimbursement maximum for this service ranges from one-third to one-half of current charges. While the proposed rate increase may not appreciably increase the number of physicians willing to provide these services, it should substantially mitigate a further worsening of the participa-

tion problem until alternative solutions (such as the O.B. Access Project) can be developed and fully implemented.

The average charge to Medi-Cal for total obstetrical services is in excess of $600. This is undoubtedly a low-side average charge and not representative of O.B. specialists because of their underpresentation as Medi-Cal providers. Most O.B. specialists charge from $600 to $900 for total O.B. care. A 35.7 percent increase would increase the maximum allowance for total O.B. services from $300 to $407.10 and from $150 to $203.50 for a normal vaginal delivery.

Other primary care services—12.5 percent increase

In order to ensure at least current access levels to primary care physician services an adjustment to current rates is necessary based on analyses of increases in physician overhead costs, what other third party payors are reimbursing, and charge data. A 12.5 percent increase would substantially reduce the disparity between Medi-Cal maximums and Medicare allowances and charges.

The 12.5 percent increase would have the effect of moving the average allowance for primary care from 63 percent of the average charge to 71 percent and from 66 percent to 74 percent of Medicare's average allowance. Physicians' average overhead expenses have increased by nearly 90 percent since 1969, while Medi-Cal rates for primary care have increased by 22.5 percent during the same period.

Therapies and rehabilitation centers—21.2 percent to 34.2 percent increase

Studies performed by the Department to determine the operating and service costs of these providers show that current reimbursement levels are substantially below delivery costs. The continuing and desired increased accessibility to therapy services is crucial to many Medi-Cal recipients, who if denied access to these services, may experience increased medical problems with a corresponding increase in medical costs.

Durable medical equipment—13.7 percent increase

A large portion of the overhead costs borne by a DME dealer (primarily equipment, materials and supplies) are largely beyond the dealer's immediate control. The costs of many of these items have been increasing rapidly and current reimbursement rates are below acquisition costs for some products. If a rate increase to cover these increased costs if not granted, the program may experience acute supply difficulties with some crucial DME products. The 13.7 percent would not be distributed equally over all DME products, but would be distributed to products most needing a rate increase (some items would receive no increases, while some would receive large increases).

Free and community clinics—6 percent increase

Free and community clinics function as a material source of organized primary care services, usually in low income and otherwise underserved areas A cost-of-living increase would help keep them abreast of current cost trends until a method of reimbursing them on an actual cost related basis can be developed and implemented. On November 2, 1978, Free and Community Clinics were granted a 25 percent rate increase for primary care physicians. Since 1976 their rates have been increased by 50 percent.

Currently F. & C. clinics are paid on the basis of $.86 per 1969 CRVS unit for primary care services and $.80 per unit for other medicine procedures. A 6-percent increase would increase these rates to $.91 and $.85 per unit, respectively. Current charges from F & C clinics average $.94 per unit per clinic for primary care services. A 6-percent cost-of-living increase for 1979-80 would help keep them abreast of current cost trends and would put them close to what we believe would be an optimum rate level pending the development of a cost related reimbursement system.

County and community hospital outpatient departments—28.1 percent increase

Hospital outpatient departments continue to be an important source of primary care services for many Medi-Cal patients, particularly in high density, low income areas where access to other sources of primary care is restricted.

Information derived from study data indicates the current reimbursement levels are not meeting the actual incurred costs of many hospitals. Testimony received at a recent public hearing indicated some hospitals (particularly those serving a high proportion of Medi-Cal patients) may be forced to curtail some services to Medi-Cal recipients if some rate relief is not given. Within the funds available we are recommending a 28.1 percent increase. Because of the varying mix of services (including physicians) the 28.1 percent outpatient room rate increase and the proposed increases to physician primary and maternity care would produce an average

revenue increase of 20.3 percent for county and 12.3 percent for community hospital outpatient departments.

Surgical clinics—28.1 percent increase

Outpatient surgical clinics provide a substantially less costly alternative to expensive inpatient hospitalization. Although there are only a few outpatient surgical clinics in operation in California (it is still a relatively new and expanding delivery model they are undoubtedly saving the program the costs of inpatient stays in many instances. A rate increase would help meet current operating costs and would focus priorities on removing disincentives to providing less costly outpatient surgeries.

Medical transportation—Ambulance 6 percent increase—Nonemergency 13.7 percent increase

Both emergency and non-emergency transportation industries have been affected by rapid increases in the costs of petroleum and related products and increases in licensing and certification standards for operating personnel. Non-emergency medical transportation, where available, provides a cost effective alternative to more costly ambulance transportation. It is important that the Department remove, to the extent possible, the disincentives to providing non-emergency transportation in this small but growing industry in lieu of more expensive ambulance transportation. Also, as non-emergency services expand, the patient mix of ambulance transportation shifts more to true emergency cases, thus increasing per unit operating costs for emergency runs.

Child health and disability prevention—7.8 percent increase

Services provided under this program focus on the early detection and treatment of diseases and disabilities in children. CHDP rates are currently based on Medi-Cal maximum allowances plus an add-on for continuing care. Rate increases for physicians and screening clinics providing these essential primary care services are necessary to ensure current provider participation levels. It is proposed that the physician office visit component be increased by the same amount as primary care medicine (12.5 percent). This would increase expenditures by 7.8 percent due to the mix of primary care and other procedures covered under the CHDP program.

Prepaid health plans—6 percent increase

PHP reimbursement rates are dependent upon the results of actuarial studies required by law and regulation and will not be known until the studies are completed. A 6-percent increase has been included to encumber funds for this purpose.

Home health agencies—6 percent increase

Home Health Agencies provide services to individuals in their homes who might otherwise become a costly inpatient. A rate increase to at least partially offset increased operating costs would help ensure the availability of those services at current levels.

Adult day care centers—6 percent increase

Adult Day Care Center rates are established based on a budget review process subject to reasonable budget screening standards. It reasonably can be anticipated that the Center's costs will have increased since the last budet review cycle in 1978. Six percent has been included to set aside funds for this purpose.

Redwood Health Foundation—6 percent increase

The contract with the Redwood Health Foundation requires they reimburse providers at Medi-Cal rates. If a 6-percent overall increase is granted, appropriate adjustments must be made. The precise adjustment will not be known until a full analysis of their utilization experience and other cost factors has been made.

SNF and ICF—6 percent increase

SNF/ICF rates will depend upon the results of current cost studies, decisions regarding the State Plan Amendment, as well as court decisions. Six percent has been included to encumber some funds.

Hearing aids—13.4 percent increase

A recently completed cost study shows that Medi-Cal reimbursement falls short of covering the average fee-for-service cost of dispensing hearing aids. Based on the results of our study and with appropriate reductions to stay within available funds, a 13.4 percent increase for hearing aids of proposed.

PROVIDERS NOT PROPOSED FOR RATE INCREASES 1979-80

Physician services other than primary care and maternity—No increase

We do not anticipate much further dimunition in surgical, anesthesia, radiology, or pathology services if no increases is granted. Surgery, radiology and pathology services received a 9½ percent increase in 1976. Anesthesia services received a 65 percent increase in 1976. Pathology received another 6 percent in 1977. If no increases are granted we believe the market place is such that we would still be able to purchase a sufficient volume of non-primary services. In any event, a six percent increase probably would not be sufficient to increase participation or reduce complaints.

Clinical laboratories—No increase

Clinical laboratories received a 9½ percent increase in 1976 and a 6 percent increase in 1977. Information collected from our recent charge survey, as well as information received from SURS and HEW indicates that for many procedures the maximum allowances are too high.

Optometrists and eye appliances—No increase

In 1975-76, based on a cost study, optometric services received a 30% increase. Increases of 6% were granted in 1976-77 and 1977-78. Eye appliances received a 16.8 percent rate adjustment in 1974-75; 30.3 percent in 1975-76; and 6 percent in 1976-77 and 1977-78. We are just beginning a rate study of these services and items. We do not believe a rate adjustment is absolutely necessary to secure the adequate availability of these services.

Chiropractors—No increase

Although a rate increase, based on the cost of living, could be justified, we do not believe it is necessary to maintain the current volume of services (about 18,000 visits per month). Currently we are reimbursing chiropractors 50 percent of their usual and customary charges.

Psychologists—No increase

A survey recently completed by Rate Development Branch, after adjustments for cost-of-living increases, concludes that some rate increases could be justified to fuly reimburse the combined cost and reasonable professional component of psychology services. Nevertheless, because the current rate of $23.00 per hour more than covers the estimated current operating cost of $14-15 per chargeable hour, and because access to care does not appear to be a major problem with these services, no rate increase is proposed at this time.

Podiatrists—No increase

Podiatrists are reimbursed at the same level as physicians, except the primary care differential is not applied. If no increase is given to non-primary care physician services, podiatrists will not receive an increase.

Nurse anesthetists—No increase

Nurse anesthetist reimbursement maximums were increased by 65 percent in 1976 at the same time physician anesthetist rates were increased. If no increase for physician anesthetist services is given we do not believe an increase for nurse anesthetist services should be given.

Portable X-ray—No increase

Portable X-Ray services are reimbursed separately for the X-Rays and for the transportation. No cost data is currently available to indicate a rate increase is necessary.

Pharmacy dispensing fee—No increase

Medi-Cal rates for prescription drugs are a much higher percentage of usual charges (95 percent) than for most other provider groups and about 35 percent to 40 percent of program reimbursement is increased each calendar quarter to reflect changes in market prices of drug commodities. Additionally, the absence of a dispensing fee rate increase in 1979-1980 will not drastically affect the economic viability of California pharmacies. Rate Development Branch conducted a study of pharmacy operating costs in mid-1977. Based on the results of that study, staff recommended a maximum rate of $3.01 per prescription for 1978-1979. This amount would provide for pharmacist-operator income at average levels and for a profit. Consequently, we believe the current professional component of $3.06 per prescription is adequate.

Dental—No increase

Reimbursement levels for children's dentistry were generally based on usual and customary charges through 1974. Since then the Department has adopted a statewide uniform fee schedule. In 1976-77 and again in 1977-78 reimbursement maximums were increased by 6 percent. Adult dentistry maximums were increased by an average of 24 percent in 1976 and by 6 percent in 1977-78. Relative to what we are reimbursing many other providers in terms of their charges, dentistry reimbursement levels (70 percent to 80 percent of charges) are generally adequate.

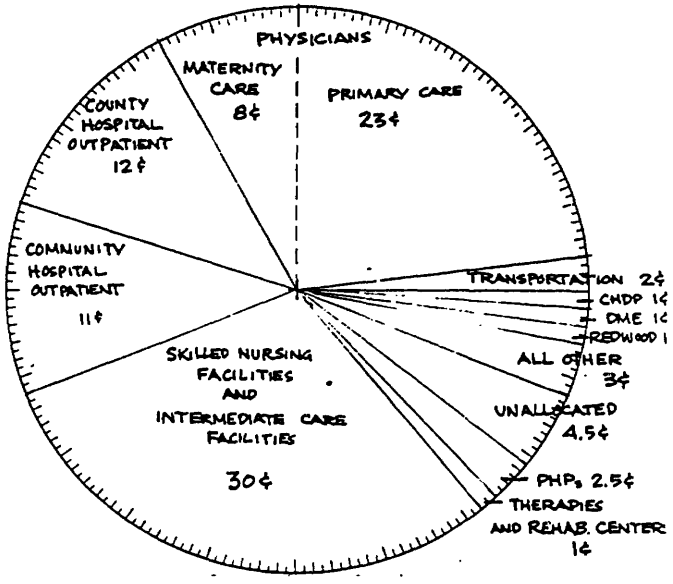
Prosthetic and orthotic appliances—No increase

Staff is currently in the process of tabulating responses from a statewide charge survey of P & O providers. Rates for P & O appliances have been increased a total of 63.4 percent over the past five years (37.4 percent in 1977, 6 percent in 1976, and 20 percent in 1974) and there does not appear to be any major problems with availability of service.

Proposed Medi-Cal Provider
Rate Increases F.Y. 1979-80 Lagged
(Within Available 6% Funds)

Provider	Lagged General Fund Costs Each 1% Increase	Proposed % Increase	Lagged Fiscal Impact Program	Lagged Fiscal Impact General Fund
Physician Services:	$2,942,816	6.2		
Primary Care	1,077,106	12.5	$ 23,086,129	$13,463,830
Maternity Care	134,578	35.7	8,238,026	4,804,417
Other	1,731,132	---	---	---
Other Medical:				
Clinical Laboratories	166,680	---	---	---
Optometrists	79,196	---	---	---
Eye Appliances	107,817	---	---	---
Chiropractors	10,750	---	---	---
Psychologists	41,508	---	---	---
Podiatrists	61,259	---	---	---
Physical Therapists	3,867	34.2	226,438	132,262
Speech Therapist/Aud.	17,368	21.2	630,382	368,206
Prosthetic/Orthotic	29,898	---	---	---
Nurse Anesthetists	1,036	---	---	---
Community Rehab. Centers	2,714	34.2	158,893	92,809
Free and Community Clinics	105,933	6.0	1,088,172	635,601
Surgical Clinics	8,589	28.1	413,210	241,356
Independent Rehab. Facilities	950	34.2	55,609	32,481
County Hospital Outpatient	350,853	20.3	11,493,190	7,122,330
Community Hospital Outpatient	532,840	12.3	11,261,056	6,553,935
Drugs-Dispensing Fee	339,268	---	---	---
Skilled Nursing Facilities	2,853,067	6.0	33,859,900	17,118,400
Intermediate Care Facilities	131,617	6.0	1,562,900	789,700
Home Health Agencies	12,800	6.0	134,700	76,800
Medical Transportation:				
Ambulance	93,928	6.0	995,352	563,568
Other	46,263	13.7	1,119,400	633,804
Other Services:				
Portable X-Ray	10,986	---	---	---
Hearing Aids	35,094	13.4	843,519	470,262
Occupational Therapy	127	34.2	7,763	4,328
Durable Medical Equipment	43,852	13.7	1,077,615	600,770
Dental	673,577	---	---	---
Adult Day Care Centers	4,736	6.0	56,838	28,419
CHDP	81,648	7.8	1,092,000	636,85-
Redwood Foundation	107,433	6.0	1,289,200	644,600
PHPs	248,317	6.0	2,979,900	1,489,900
Unallocated		---	4,781,908	2,681,768
Total			$106,452,100	$59,186,400

THE PROPOSED RATE INCREASE DOLLAR
FY 1979-1980



Distribution of the proposed rate increase dollar reflects both the percentage increase in rates and the absolute size of the base budget. The absolute size of the base budget is a result of current rates and predicted utilization.

Senator TALMADGE. The next witness is Hope Runnels, executive director, Visiting Nurse Association and Rehabilitation Service, Portland, Oreg.

You may insert your full statement in the record.

STATEMENT OF HOPE RUNNELS, R.N., M.S., EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION AND REHABILITATION SERVICE, PORTLAND, OREG.

Ms. RUNNELS. Thank you.

I shall be as brief as possible.

I believe it was the intention of S. 489 to liberalize the benefits for home health in removing the 3-day hospital stay and giving unlimited home health visits.

I should like to point out to the committee as long as we continue to have the very rigid interpretation that is being made by the intermediaries of the skilled level of care, I am afraid that it will not have the impact that you would like for it to have.

I think you will find that most patients are still going to use 15 to 20 visits, and that is all that is going to be allowed. As a matter of fact, I think it is a short-sighted policy because patients have to be dismissed so rapidly. If we could have an intermediate level of care to keep the patients on the caseload a little longer, to be sure they are not going to get back in trouble, in the long run there would be money saved for the medicare program.

I do have some concerns about the bimonthly bills that are proposed to be sent to patients. I certainly do not have any objection to any patient's knowing what services he has received on behalf of our agency. However, they do now receive copies of bills that have been sent by the Social Security Administration. They find these very confusing. They think they are additional bills. Many of the patients are disoriented as to time and place.

I would suggest that, as an alternative to this, that the agencies be required to verify that they did, in fact, make the visit. I think the itinerary of the worker could be signed by the patient when the worker goes into the home and it should become an audit step for the intermediary to verify the system to be assured that visits billed for have, indeed, been made.

I certainly commend the increase of occupational therapy as a primary service. We are finding the patients are reaching the point where they can profit the most from it but they no longer are eligible for the nursing or physical therapy and therefore sometimes cannot receive the activity of daily living services that are so necessary.

I was very pleased to hear Senator Packwood point out that he would like to see dietary services added. We see this as a very real necessity.

I have some concerns about the mandated regional intermediaries. I think there is a great need for intermediaries to become more familiar with home health care. I think that some of the people who are reviewing claims ought to go out in the field occasionally and see some of these patients instead of sitting in offices and denying claims on the basis of evidence or documentation that has been submitted from the agency.

I think there have been too many instances of financial problems between the intermediary and home health agency. I would like to see some attempts made to overcome this and have more consistency in the interpretation of the regulations.

I think that the direct and indirect cost guidelines which are also a part of S. 489 are a good idea. However, I sincerely hope that they are not interpreted by the Health Care Financing Administration to be so complex that agencies cannot comply with them and, as a consequence, are forced to drop out of the program; or, if they do comply, will have their costs increased.

We estimate the impact of the proposed uniform system for home health agency reporting will increase our costs by 5 percent just in order to comply. We see the need for more rural agencies to be providing services so if we are going to make it so difficult that they cannot function and drop out of the program, then I think the impact will be very negative.

I certainly do commend the improvement in quality of care through training of home health aids. I might say we have had this in Oregon since medicare was started, and it should be mandatory.

One concern that I do have, there is nothing in the conditions of participation that spell out at all what the ratio of home health aides to professional personnel will be. I would like to see utilization review committees looking at this in the demonstration research.

I would be very pleased if conditions of participation could be strengthened to add conditions which pertain to supervision and control. At the present time, there is no provision, for instance, that any agency has to have any kind of outside audit. There are many agencies who never report how many patients they are seeing, how many visits are made, and I think that this information should be made public.

I think that there is a need to deal appropriately with those providers who are guilty of fraud and abuse rather than use overregulation and underfinancing as a mechanism to achieve this.

Thank you.

Senator TALMADGE. Thank you very much. Any questions?

Senator PACKWOOD. Just a statement, Mr. Chairman.

I want to congratulate you on the extraordinary job that you have done in the Visiting Nurses Association in Portland. Throughout Oregon, your reputation is well known. I appreciate your comments. They were mostly supportive of the bill that I introduced, and I agree with you about the intermediaries and others coming and seeing what is actually going on rather than simply reviewing claims forms.

The one advantage of running for Congress, whether we like it or not, we are forced to go out in the field and meet with people and see what goes on and do it constantly, because things change every 2 or 3 years.

I can see how easy it would be if we did not have to run and never went out and lost touch with what actually happens with people who have to go out in the field and administer the plans that we draw up.

I appreciate your coming.

Ms. RUNNELS. Thank you.

[The prepared statement of Ms. Runnels follows:]

STATEMENT OF HOPE RUNNELS, R.N., EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION OF PORTLAND, OREG.

SUMMARY OF PRINCIPAL POINTS IN STATEMENT

1. Unlimited visits and elimination of three day prior hospital stay will not liberalize benefits substantially unless provision is made for an intermediate level of care for appropriate patients.

2. Bimonthly bills to patients will add to cost and confusion. Suggested alternative is to require provider to verify signature by beneficiary at time of visit with compliance to be monitored by the intermediary as an audit step.

3. Occupational therapy as a primary service will add to more comprehensive rehabilitation.

The addition of nutrition counseling as a billable service is also needed.

4. Mandated regional intermediaries would need to assure consistent interpretation of regulations and to become more familiar with home health care.

5. Direct and indirect cost guidelines should not be so complex that agencies cannot comply and are forced to drop out as Medicare and Medicaid providers which will probably result if current draft of USHHAR remains unchanged.

6. Quality of care will be improved with mandatory home health aide training; however, there is need to study the ratio of home health aides to professional nurses which could be encompassed in utilization review demonstration projects.

7. Medicare Conditions of Participation should be strengthened by adding conditions pertaining to supervision and fiscal controls.

8. There is need to deal appropriately with providers guilty of fraud and abuse rather than to use over-regulation and under-financing of all agencies as mechanisms to achieve that result.

My name is Hope Runnels. I am a nurse and the Executive Director of the Visiting Nurse Association of Portland, Oregon. I have asked to appear before you today to discuss some aspects of Senate Bill 489, as well as my particular concerns for areas it does not address.

I commend the Subcommittee on Health for its interest in Medicare and Medicaid benefits for the elderly, because I believe that many older Americans languish in nursing homes and have frequent hospitalizations because of inadequate home health benefits in both programs.

Unlimited visits under A and B.—I believe it is the intention of Senate Bill 489 to liberalize benefits for Medicare patients by eliminating the 3-day prior hospital stay and allowing unlimited visits under parts A and B. I do not believe this will necessarily be the result, because intermediaries are very rigid in their interpretation of skilled care, and most patients do not use up the current number of allowable visits for this reason. In our experience, as soon as the patient is stabilized or reaches maintenance level, Medicare reimbursement is withdrawn. Consequently, the condition of many patients rapidly deteriorates, hospital readmissions are required and intensive home care services are again needed. I believe this "revolving-door syndrome" could be minimized if there were intermediate levels of care during which appropriate patients who are stabilized, but not custodial, could continue to be monitored on a regular basis by the home-health agency. If this level of care were authorized for 4 to 6 weeks with a gradual diminution in the frequency of visits, I believe this would be very beneficial to patients as well as cost-effective. For instance, the cost of a 3-day hospital stay in Portland, Oregon, is more than the cost of 19.3 visits made in our agency to the average patient who is carried on our caseload for 60 to 90 days.

Bimonthly bills to patients.—No doubt, the intent of sending bimonthly bills to patients is to allow them the opportunity to alert Medicare authorities of possible fraudulent action by providers. At the present time, the Social Security Administration does send direct reports of benefits paid to Medicare patients. These confuse many patients because they interpret these as bills. Since many patients are poorly oriented to time and date, some do not even remember that visits were ever made. If a similar statement is sent from the agency, it will add to the confusion, and it will also add to agency costs. A better approach might be to require providers to maintain systems to verify by patient (or family) signature at the time of the visit that service was provided and to add this as an audit step for the intermediary to check.

Occupational therapy.—A very positive aspect of Senate Bill 489 would make occupational therapy a primary service. The self-help methods which are the stock-

in-trade of the occupational therapists are invaluable to the home care team. At the present time, many patients cannot benefit from this service until nursing and other needs have been met, at which time the patient no longer qualifies for Medicare coverage. As a primary service, we can ensure service for a long enough period of time to have a long lasting impact on the patient and family.

I would also add that I hope you will consider the addition of nutrition counseling as a billable service. There is a tremendous need for special diet assistance in the home, and while nursing staff may have a good understanding of basic nutrition and routine special diets, they are not equipped to give the guidance required in problem situations.

Regional intermediaries.—Most of the home health agencies in Oregon have been fortunate in dealing with Blue Cross of Oregon, and I for one would be reluctant to be required to abandon this because regional intermediaries would be mandated by Senate Bill 489. I recognize the multiple problems between fiscal intermediaries and home health agencies in other states. There is a tremendous need for uniform interpretation of regulations by intermediaries. There is considerable discrepancy in interpretation of benefits among intermediaries, and patients may be denied benefits in one state which are allowed in another state. If the regional intermediary provision is passed, I would urge that the Secretary of HEW not only monitor costs by region but establish methodologies to assure consistent interpretation of regulations. I further hope that such a system will eliminate the adversary attitude which is prevalent in many areas of the country. Intermediaries need to learn a great deal more about home health agencies. They should be required to accompany field staff occasionally and to become more familiar with health care in the home setting which is vastly different from institutional care.

Guidance for direct and indirect costs.—The concept that home health care is pseudo-institutional care is no more evident than in this area. The recent Uniform System for Home Health Agency Reporting draft, popularly known as USHHAR, is a prime example. I agree that there is entirely too much disparity in the cost finding systems and statistical data collection in our current programs, but to inflict this proposed system on the industry could have disastrous results for patients in need of home care. For an agency the size of the Portland Visiting Nurse Association, the reporting requirements are mind boggling. For a small agency, it may be impossible to adapt, forcing them to reconsider their participation in the Medicare program altogether because of the restrictive reporting requirements. A superficial study of the numbers of home health agencies which made fewer than 4,000 annual visits in 1976 [1] amounted to 60.9 per cent of the total. If one worker can be expected to make 1000 visits per year, then most of these agencies had 4 to 5 employees. Many small agencies serve rural populations and we could ill-afford their loss.

It is doubtful if any home health agency in the United States is presently using a chart of accounts as sophisticated and complex as the one being recommended. Home health agencies who presently use a good system, such as Portland Visiting Nursing Association, will need to virtually start from scratch. This is because our chart of accounts is based upon responsibility accounting rather than the required functional accounting system.

We can succeed in meeting the requirements of a Uniform System of Home Health Agency Reporting. However, the conversion to and maintenance of the concept presently recommended will be extremely costly. A reasonable projection would be that visit costs would increase by 5 per cent. If the intent of mandating the Secretary to establish guidelines for direct and indirect costs is to bring consistency to reporting, I commend this provision of the bill; however, I urge that provider participation in the development of new systems be integrated into Senate Bill 489.

Quality of care.—Because of my keen interest in the quality of home health services, I endorse the necessity of uniform training of home health aides, which we have had in Oregon since the enactment of the Medicare law. I hope the time will come when the functions of the home health aide can be enlarged to encompass some homemaker activities, particularly during the acute and convalescent periods of illness in the home. I also believe we should strengthen the criteria for their supervision particularly in regard to the ratio of professional nurses to home health aides. I certainly do not advocate rigid formulas because agency programs should have flexibility, but the current regulations are silent on this point. Perhaps the demonstration projects for Utilization Review Committees could encompass this activity to give some hard statistical data on the appropriate use of home health aides and the amount of supervision exercised.

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[1] Medicare Listing of Home Health Agency Cost Per Visit, HCFA, Medicare Bureau, July 1, 1978.

For a long time I have been concerned that quality and fiscal controls are not more specific in the Conditions of Participation. We have state surveyors who certify agencies for participation in the Medicare Program. There are few specifics in the guidelines to evaluate whether there is adequate supervision of staff, and even less for fiscal controls within the agency, so on one is charged with monitoring this kind of compliance. I think the public and the consumer are entitled to know whether the agency ever has an independent audit, to know the sources of support, and to see an annual report which at least tabulates the numbers of patients seen and types of services provided.

One final point I would like to make is that home health visits are not fully subsidized by Medicare. Certain expenses are offset by the Social Security Administration as non-allowable, and in order to survive, we must solicit community funds and other sources of revenue. If home health is to be a viable adjunct to the health care system, and is to be a more humane and cost effective way to take care of people as a mode of care in its own right, there must be a recognition that fraud and abuse will not be controlled by over regulation and under financing. The guilty should be dealt with appropriately. The vast majority of us are in this field because of our concern for people, so let us develop more trust in home health by enacting laws such as this which will make it easier for patients to receive home health care services.

Senator TALMADGE. The next witness is Anne M. Smith, director, Bureau of Public Health Nursing, Division of Home Health Services, State of Alabama.

Ms. Smith, you may insert your full statement in the record and summarize it, if you will.

STATEMENT OF ANNE M. SMITH, DIRECTOR, BUREAU OF PUBLIC HEALTH NURSING, DIVISION OF HOME HEALTH SERVICES, STATE OF ALABAMA

Ms. SMITH. Thank you for this opportunity to appear before you this afternoon and I would like to commend the committee for its interest in home health and for recognizing the need to make it more available and accessible to all of the needy citizens we have in the United States.

We, in Alabama, the Division of Home Health Services, are the parent agency for 58 subunits located within the local and district health departments within the division of public health nursing. In those departments, we cover the state of Alabama, so services are available.

In addition to our services, there are 20 other certified home health agencies throughout the State. In addition to these, there are quite a few, and they continue to come in with a great influx of proprietary agencies.

I feel the need very greatly for a good certificate-of-need law, both in Alabama and in every State. I have never seen one that really had a good method for determining whether or not there was additional need. I think this should be worked on. A licensure law, I believe, should not be effected until there is a good certificate-of-need law in place. With the influx of proprietary agencies that represent large corporations, they can put the little people out of business, and they move out of the rural counties and back into the urban areas. I think this needs much attention.

I agree with the elimination of 3-day prior hospitalization. This is cost-effective and will make services more available to those who need it.

I would like to see the removal of the deductible from part B. In our rural counties, possibly the only other covered service is one

visit to a physician. That means that the small agencies have to bear the cost of the deductible, and this is an expense to them.

Also, I would like to see the evaluation visit made reimbursable. I would like to see all of the services be more liberal, for instance. Some drugs can be given in the home under certain conditions and allow the patient to be at home instead of in an institution.

Also, our PT services are greatly curtailed and need to be liberalized. There is a difference for a person who is 25 years old and PT for a person 75 years old and I think this should be recognized.

I am opposed to physicians assistants and nurse practitioners in lieu of physicians in rural counties. We are just about as rural as anybody gets down in Alabama and we have not had any trouble with getting a physician to approve our care for a patient. In fact, our patients are getting sicker all the time, as somebody has already mentioned, and they need the skill of a qualified physician.

Certainly, the nurse in the agency is the one who should deal most closely with that physician and making the plan of care should be a joint responsibility of the agency nurse and the patients and physician. We do not need another person to come between them.

Also I am very concerned about this bimonthly billing. I do not think that people have thought through how much paperwork this is going to be for all of us. It is going to cut down on the amount of time that we have for service.

If something of this type is needed, why not have it when the patient's care is terminated, or as an ongoing thing.

As she just mentioned in her testimony, for regional intermediaries, I do think we need something so that there is better and more uniform interpretation of the law. We have been dealing with this since 1966. I hope that we will be allowed to remain direct dealers. We have had good consultation surveillance. We have had visits to the State. We have had the consultants come and help us in putting on workshops so they have worked directly with the people dealing with the patients, and I think this has been very, very good.

Something needs to be done about uniform cost reporting. Please, when it is done, consider the small agencies, consider the official agencies. We have very serious and different problems from some of the other agencies.

I do think there are some changes to be made, one, the uniform cost-reporting system that is now being circulated. As to home health aid training, I certainly believe that they should be well trained.

I think we should have a good program. This, we have had within our own agency for some time. Maybe we need one to be similar statewide. I thought this was included in the criteria set up in the original medicaid amendment, but perhaps it is not being enforced and needs to be looked into.

I do oppose what is happening with the grant funds in which some junior colleges are asking for funds to train aides and it is spreading statewide, into vocational schools and different places and many of the people who are teaching those aides have never set foot in a home health agency and do not know what they are talking about.

So I would like to see this put into effect before we say, blanket, there has to be a particular program.

I am concerned that we have patients for whom there is no coverage. We call these disease and disability. Either they had used up the number of visits for which they were eligible—this does not mean 100; something like 15—but something should be done to see that these are cared for.

The official agencies at this time are the only certified agencies giving them care.

Thank you.

Senator TALMADGE. Thank you very much, Ms. Smith. I read most of your statement while you were testifying.

Medicare now pays skilled nursing care and physical therapy in the home. What kind of patients would benefit from the addition of occupational therapy with services already available?

Ms. SMITH. Senator, this is a difficult question for me to answer since last fiscal year we had only six occupational therapy visits, because the occupational therapists are so few we cannot get their service.

Senator TALMADGE. A shortage of personnel?

Ms. SMITH. Yes, shortage of personnel.

I certainly think those fees should be a reimbursable service. Personally, I would like to see one of the other skilled services required with it because OT really deals with the patient's really getting back to self-help and this type of thing. But I do not know whether we will have the same sort of referral back and forth as we have, for instance, our PT's and nurses have a referral back and forth, back to the patient and discussion.

We have not found this with the OT's that we have been able to utilize.

As I say, we have had very few in our State.

Senator TALMADGE. I have one further question. It is alleged that proprietary and some private nonprofit agencies tend to skim patients, that is, they serve the easiest patients and the paying patients while leaving the difficult cases and the nonpaying patients to other agencies. Would you comment on that?

Ms. SMITH. Yes. I think this is true to some extent. When I was mentioning that the medicare patients who are found to be not eligible because of the strictness of the interpretation of skill and maybe they are dischargd after having had 15 or 20 visits, but they still need some care. The nonprofit agencies will discharge them and refer them to us.

At this time, they do not provide services—I should say, for any of those who are unable to have reimbursement under either medicare or medicaid.

We also have certified agencies in Alabama that refuse to do medicaid simply because medicaid has a cap on the home visit of $25 because of funding. So they refuse to do it.

The VNA's, we only have VNA's now, one in Birmingham and one in Mobile. They also see patients that are eligible for reimbursement, but they and the official agencies are the only ones who do.

The proprietary agencies mostly represent large corporations and we have no licensing laws, so they are not certified.

We have found that there is a good bit of lack of continuity of care because they use so many part-time workers. They furnish a lot of our hospitals with personnel. That seems to be one of the big things they do.

Senator TALMADGE. Thank you very much.

Are there any questions?

Senator PACKWOOD. No questions.

Senator TALMADGE. Thank you very much. We appreciate your contribution.

[The prepared statement of Ms. Smith follows:]

STATEMENT OF ANNE M. SMITH, DIRECTOR, BUREAU OF PUBLIC HEALTH NURSING, ALABAMA DEPARTMENT OF PUBLIC HEALTH MONTGOMERY, ALA.

INTRODUCTION

My name is Anne Smith and I represent the Division of Home Health Services, Bureau of Public Health Nursing, Alabama Department of Public Health. The Division is the parent agency of 58 subunits located in the nursing divisions of the county of district health departments. These subunits provide home health services throughout Alabama. In addition, there are 20 certified agencies representing private, nonprofit, visiting nursing associations, hospital based and one other governmental agency. There are numerous proprietary agencies, but since we have no licensing law these are not certified. Every county in Alabama is served by one or more home health agencies.

SUMMARY OF TESTIMONY

Opening statements regarding agency—offical agency with 58 subunits. Covers State of Alabama. Twenty other certified agencies and numerous proprietary.

Support elimination of 3-day prior hospitalization for Part A.

Support elimination of deductible for Part B.

Support eliminating 200 visit limitations for Parts A and B or substituting additional visits on a per need basis.

Do not support use of physician's assistant or nurse practitioner in lieu of physician for rural areas.

Do support physician and agency nurse establishing plan of care together. Agency nurse more knowledgeable of patient's needs and community resources.

Support regional intermediaries for uniformity of interpretations and surveillance of programs. Request that direct dealers continue to deal directly with HCFA.

Continue home health aide training under present guidelines, but surveyors must see that criteria are met.

Utilization review needs further study. Consider parts we are already doing. Consider rural counties with few professionals.

Costs of home health services—uniform system needed, but please work with providers before initiating a system. Suggested system needs revisions. Official agencies have special problems.

Bimontly billing to patients—this presents too much paper work and penalizes the "honest" agencies, besides confusing the patients. Documentation is in current records if appropriately recorded.

Data collection should be uniform to a certain degree—should have leeway for innovation. Doubt that data can be collected to appropriately evaluate care. Other methods available.

Teaching patients independence—built in with official agencies.

Occupational therapy should be reimbursable, but only included if skilled nursing, physical therapy or speech therapy is also needed.

Responsibility of agencies for nonreimbursable services—at present only the official agencies and some VNA's are providing any of these services. Why should the other agencies not have to share in this provision of care?

Certificate of Need—Licensure—Why? Strong certificate of need should be working before licensure law passed. Question uncontrolled profit making in home health.

The difference home health services makc—I wish you could talk with our patients and their families, and also with a number of the referring physicians.

I wish to commend your support for home health services and the efforts being made to expand and to make more accessible this much needed care. There are a

number of issues and concerns which we have. Some of these are included in S. 489; others are not, but I willl include them in this testimony.

ELIMINATION OF 3-DAY PRIOR HOSPITALIZATION REQUIREMENT

If passed this action would improve the availability of home care by simplifying the procedure for admission to service and by providing those patients without Part B coverage an opportunity to receive home care when hospitalization is not necessary. Since there is a deductible requirement for Part B patients and none for Part A, I suggest that the deductible be removed as a requirement for Part B home health coverage. In the rural areas, except for perhaps one physician's visit, the patients have no other covered services, so home health visits are used to meet this deductible provision. To a small rural agency, this proves to be a real expense.

INCLUSION OF EVALUATION VISIT IN REIMBURSABLE CHARGES

Many agencies manage to render a prescribed skilled service during the evaluation visit and thus receive reimbursement. However, the evaluation visit may be made to give the family instructions or to make sure that the patient can be cared for in the home. If properly documented these visits should be reimbursable.

UNLIMITED HOME HEALTH VISITS UNDER PART A AND PART B

Few patients seldom use the 100 allowed visits under Part A or Part B. However, if the prior hospitalization is to be removed the 100 limitation on visits should be removed. If the number of visits do become unlimited, state agencies should be instructed to check carefully for abuse and over-utilization of services. The number of home health visits per medicare patient in our agencies has averaged from 18 to 22 for several years. In comparing figures with other agencies in Alabama this seems a fair average. However, in a study done by Health Planning some private agencies were averaging as many as 48 visits per patient.

An alternative to removing the limitation on visits would be to extend coverage on per need basis. We do this in the medicaid program and it has worked well.

PHYSICIAN'S ASSISTANTS AND NURSE PRACTITIONERS

Although these two groups have their area of functioning, I do not see them as having a role in the home care program. Most of our medicare patients are very ill and with the trend toward even shorter lengths of hospital care, patients will probably require even more skilled care. Therefore, I do not see other professionals substituting for the physician. I do think that the plan of care should be a joint responsibility of the patient's physician and the professional nurse who is caring for the patient. (In actual practice it works out this way already.) Although ours is a very rural state, we have not found it impossible to have physician coverage. In fact, we have often found the rural physician more interested and supportive than those in urban areas. The nurse working in the home health agency has much more expertise in assessing and caring for patients in their homes and in being able to utilize community resources than does the physician's assistant or nurse practitioner who has little if any knowledge of community nursing. People who live in rural areas should have access to the same level of care as those in urban areas. What has happened to medical education? The medical schools should be required to include in their curriculum the care and management of patients receiving home care.

REGIONAL INTERMEDIARIES

Interpretation of the law, rules, and regulations by fiscal intermediaries is sadly lacking in uniform interpretation. In other words, one fiscal intermediary might allow services to a particular patient while another fiscal intermediary would deny the same services under a similar situation. I believe that having regional intermediaries would be helpful. However, I do urge that if an agency is dealing directly with HCFA it should be allowed to continue. We are a direct dealing agency and have been since the program started in 1966. Although strict in application of rules and regulations, we have found the consultation, monitoring of cost reports, and review of subunit activities to be fair and helpful. We do prefer to continue to deal directly with HCFA.

TRAINING FOR HOME HEALTH AIDES

Guidelines for training and supervising home health aides have already been established. It has been the responsibility of the state agency to enforce these standards. This should be continued. Grant money for training home health aides has been made available. A number of junior colleges and vocational schools have undertaken to do this training. Objection—most of the faculty have never been in a home health agency nor have they had public health nursing experience. Therefore, I doubt their ability to teach aides to function in a home care setting. If an agency has a training program that meets the criteria as presently set forth in the medicare regulations, this should be recognized and approved by the surveying agency. Aides are not a very mobile group and cannot be travelling all over the country.

DEMONSTRATION PROJECT FOR UTILIZATION REVIEW

We agree with the idea that the concept of utilization review for home health agencies should be tested. If you get too many on the committee or require too many professionals, agencies in rural settings will not be able to certify. I suggest that you consider the audit of records which is now required of all agencies and which embodies many of the points of the proposed utilization review such as assessment and reassessment of patient needs, revisions made as indicated and care provided in accordance with patient's plan of care, to name a few. There is no need to duplicate activities. There is a tendency to add on rather than to replace or revise present functions. There should be an all out effort to cut down on paper work rather than to increase. Too much reporting reduces time for patient service.

COSTS OF HOME HEALTH SERVICES

We support the need for a uniform system of cost reporting. However, in planning and implementing such a system, the special needs of official agencies should be considered. One half or more of the home health services in the U.S. are provided by official agencies. Often these services are a part of the generalized public health nursing program (this cuts down on travel time and supports patient and family teaching for independence). Therefore, we are working with personnel who are less than full time in home health. Also, we have some different administrative costs. It has been our experience that auditors and accountants have had limited experience or orientation in the area of official agency budgeting or cost reporting.

BIMONTHLY BILLING OF PATIENTS

This may be a method of controlling some agencies, but if they can pad and abuse existing records they can surely misuse or find a way of padding these. For the rest of us it will be another time consuming lot of busy work in which the honest agencies are penalized for the fraud and abuse of those who pad reports. For us it will increase paper work excessively. Can you imagine sending bimonthly bills to 19,142 patients? I expect a number of our badly needed small agencies would simply withdraw from service. I also think that the elderly patients would be as confused as they are when they receive the letters that medicare will no longer reimburse for their visits. We are deeply concerned with the amount of time that is spent in record keeping and documentation and feel that the current records should be ample documentation. It is time that states and agencies take some responsibility for their own peer review. We are working with our subunits and by contract with medicaid are working with some of the private agencies and the VNA's in Alabama.

UNIFORM STANDARDS FOR DATA COLLECTION TO INSURE APPROPRIATE EVALUATION OF CARE

We support uniform standards for data collection if providers are allowed to help with suggestions. However, I do not believe that the gathering of data will ensure appropriate evaluation of care. There are other means for evaluating care. Good data might help to determine if any agency is functioning efficiently.

We support teaching patient independence to the maximum extent. This already is being done by official agencies for it is a basic principle of public health. Most private agencies do not because they are task oriented.

Inclusion of occupational therapy as primary skilled care. We think that occupational therapy visits should be reimbursable, but it is not a primary skilled care; i.e., if it is ordered the patient should also need skilled nursing, physical therapy, or speech therapy.

There are statements made in the law that the secretary may add additional requirements as he finds necessary for the effective and efficient operation of this program. Is this usual wording and is it a necessary part of the law? Does not this statement allow changes in the law without congressional action?

OTHER CONCERNS

We have always cared for patients who do not fit into either medicare, medicaid or other reimbursable programs if the physician stated that the patient needed continued care in order to prevent regression or return to hospital or nursing home. With reduction of state and local appropriations, we will have difficulty in meeting the needs for this type of maintenance care. Could not other agencies be required to continue to see their own patients when they are no longer eligible for medicare?

We are also concerned regarding licensure and certificate of need. At the present time Upjohn has written a bill to license home health agencies in Alabama. We have had a great influx of proprietary agencies into the State. Our concern is that the licensing law will be passed before we have a certificate of need law firmly in place. If this happens, not only the proprietaries we already have, but others will be asking for certification. I seriously doubt that these large corporations, opening agencies in states, have any interest in the people of our state—it is a moneymaking project for them.

Another concern is "do we make a difference?" Yes, we do. Letters from beneficiaries because family members can remain at home; hospitals concerned because patients are discharged earlier. Patients can also have a peaceful death. Home care is not an alternate to institutional care—institutional care is an alternate to home care. The patient begins at home. Is any thought being given to the suggestion that family members who give up jobs or stay home in order to care for a patient be reimbursed in some manner. The idea has merit, but would have to have many safeguards to avoid abuse.

HOME HEALTH

FY 1978

	Patients	Visits	
*Disease and Disability	9,510	71,370	
*Medicaid	3,080	54,062	Average per pt. 17.5
**Medicare A	4,469	86,061	Average per pt. 18.5
**Medicare B	2,083	35,659	
TOTAL	19,142	247,152	

	NURSING	P.T.	S.T.	O.T.	MSS	HHA	ORDERLY
Medicare A							
D.P.Print-out	40,603	2,507	232	6	0	33,888	853
Manual Tabulation	4,331	164	40	0	0	3,320	117
(Error Billings)TOTAL	44,934	2,671	272	6	0	37,208	970
Medicare B							
D.P. Print-out	17,336	749	148	0	0	12,252	455
Manual Tabulation	2,436	78	14	0	0	2,061	130
(Error Billings)TOTAL	19,772	827	162	0	0	14,313	585

*From A-3 Report

**From Data Processing Print-Out and Error Bills Manual Tabulation

HOME HEALTH SERVICES
VISITS BY DISCIPLINE

SNC	146,536
P.T.	3,498
S.T.	434
O.T.	6
HHA	96,678
TOTAL	247,152

Senator TALMADGE. Next, we have a panel consisting of Edward C. King, directing attorney, National Senior Citizens Law Center; Elmer Cerin, coordinator, National Senior Citizens Law Center, Home Health Task Force; and Frances Klafter, chairman, Gray Panthers National Health Task Force.

You may insert your full statement in the record and summarize it in any way you see fit.

STATEMENT OF EDWARD C. KING, DIRECTING ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER

Mr. KING. Thank you, Mr. Chairman. My name is Edward C. King of the National Senior Citizens Law Center. We have filed a statement. I would like to turn over our time today to Elmer Cerin who is on a task force for home health with the National Senior Citizens Law Center, as well as Frances Klafter who is a member of the Gray Panthers, and the Gray Panthers are a part of the National Senior Citizens Law Center.

STATEMENT OF ELMER CERIN, COORDINATOR, NATIONAL SENIOR CITIZENS LAW CENTER, HOME HEALTH TASK FORCE; AND AMYOTROPHIC LATERAL SCLEROSIS SOCIETY OF AMERICA

Mr. CERIN. Thank you for giving me the opportunity of expressing my thoughts before you. With your permission I would prefer to depart from my written statement. Although I am a coordinator of the National Senior Citizens Law Center, I am also the vice president and voluntary representative of the Amyotrophic Lateral Sclerosis Society of America. My wife is a victim. I am speaking for my wife and for 20,000 other ALS patients in this country.

Eighty percent of the ALS patients terminate within 2, 3 or 4 years. Medical science has just begun to do some research on ALS. Thus far, medical science has not been able to determine the cause, cure, treatment, or prevention of ALS.

In my own personal case, my wife—this is the third year of her illness. She will probably terminate within the next 12 months. We have no home care because we do not require skilled nursing care—not that we do not require home health care; we do. But, under medicare, there is no treatment, no therapeutic treatment for this illness. Therefore, I must engage my own personnel.

I have two nurses' aides at a cost of $18,000 plus a physical therapist which is over $2,000 a year. So last year and this year, it has cost me personally over $20,000 and not a single penny of that is reimbursable under medicare.

I can afford it for another year or two, and then I am bankrupt.

I have a proposal to make to this committee on how to take care of the permanently disabled that does not fit within the medicare regulations, these people who are homebound, are bedfast, and require 24-hours-a-day, 7-days a-week-service. I would suggest the medicare provision be broadened to permit one 8-hour shift 5-days-a-week, not of a registered nurse, but a person who is trained, a nurse's aide, maybe a paramedic, or some other individuals who can take care of these people.

ALS patients only require to be dressed, to be fed, to be bathed, to be put on the commode. There is no other medical requirement.

This would give the opportunity to the members of the family to do two things. One, that person could go out and earn some income to supplement the family income, help pay some of the expenses and, second, and equally important, it would relieve that person from the terrible ordeal of trying to take care of the ALS patient 7-days-a-week, 24-hours-a-day.

I would therefore suggest, to give that person a rest, that medicare open up slightly to those who are chronically disabled, who are homebound, requiring 24-hours-a-day service for one 8-hour tour of home health care.

Thank you.

Senator TALMADGE. Thank you.

STATEMENT OF FRANCES KLAFTER, CHAIRMAN, GRAY PANTHERS NATIONAL HEALTH TASK FORCE

Ms. KLAFTER. I am Frances Klafter. I chair the National Health Task Force of Gray Panthers. As you can see, I am in that age category which is approaching the time when I might be needing the services discussed here today.

I work in the community and on the national level with my contemporaries, who are also in this category. Therefore, I wanted to say that we are very grateful that an effort is being made to turn the bias around from institutionalization to what is called alternatives.

I want to agree with the statements made here today that certainly home care should be an available alternative. However, we do not feel that either have care or institutionalization should be considered interchangeable alternatives. We want very much to plead for the tying in of home care with a whole long-term care continuum which would include home care, and we are very glad for the efforts, the legislative efforts which have been made so far in that direction, the demonstration funds that have been made available, not only to HEW but to the AOA to try to coordinate these services that are provided at the State level under titles XVIII, XIX, and XX into an integrated comprehensive long-term care package including home care so that appropriate service, whether it be home care or institutionalization will be available.

Senator TALMADGE. Thank you very much. Are there any questions?

Senator Packwood?

Senator Dole?

Senator DOLE. If I could just ask one. I am not certain I understood your proposal. Would you repeat it again?

Mr. CERIN. Yes, Senator Dole. For those who are chronically disabled and are homebound and require 24-hours-a-day, 7-days-a-week service, I would suggest to the Senate that they give consideration to the possibility of providing home health care for one 8-hour shift, 5-days-a-week. The other two shifts, and Saturday and Sunday and holidays would still be the responsibility of the family to take care of the disabled person.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much for your contribution to our deliberations.

[The prepared statement of the preceding panel follows:]

Testimony of National Senior Citizens Law Center

SUMMARY

1. Medicare and Medicaid, with their limits on eligibility and scope of coverage for home health services have created a bias toward institutionalization and against home health care. (pp. 1, 2)

2. Until significant increases in the availability, use, and funding of home health care occurs, Medicare will continue to be unresponsive to the crucial home health care needs of the elderly. Beneficiaries who refuse home health coverage become unnecessarily institutionalized for long periods of time at high cost. (p. 3)

3. To assure that the elderly have the option to be cared for at home, Medicare and Medicaid legislation and regulations must be revised so as to permit the liberalization of home health care eligibility and benefits. (pp. 4-5)

4. At the state and federal levels, we need to develop a comprehensive system of long-tern care—one which does not rely primarily upon institutionalization, but which provides to individuals what they need to maintain themselves in health at home. (p. 5)

5. Medicare's statutory insurance-like orientation toward treatment of acute care, rather than health maintenance, or treatment of chronic illness, greatly limits the program's utility for those needing home health care. (p. 6)

6. Even though under Medicaid states are required to provide home health services, most states have exercised their options in such a way as to minimize the availability of reimbursable home health care. Many states have excluded services which are considered traditional under home health care, such as physical, occupational and speech therapy. Some states have erected restrictions agasist home health care which are of doubtful legality but in which HEW has acquiesced. Moreover, states through eligibility limitations increase institutional bias of the Medicaid program. (pp. 7-9)

7. Providers are often not willing to provide home health services to Medicaid beneficiaries. Some providers are unwilling to operate in communities in which poor people live; some hold more generalized discriminatory attitudes against minority groups or poor people. Providers also contend that reimbursement formula are inadequate and that administrative red tape strangles their desire to furnish home health care. (pp. 10-11)

This statement has been prepared by Edward King and Barbara Skolnick of the Washington, D.C. office of the National Senior Citizens Law Center ("NSCLC"), Elmer Cerin, Area Vice President of the Amyotrophic Lateral Sclerosis Society of America and chairperson of the NSCLC's Task Force on Home Health; and Frances Klafter, chairperson of the Health Task Force of the Gray Panthers, clients of NSCLC. Ms. Klafter is also a member of the NSCLC Task Force on Home Health. In preparing this testimony, we have also drawn heavily on a major and important paper being prepared by an attorney formerly with the National Health Law Program, Patricia A. Butler. This paper, entitled "Financing Non Institutional Long Term Care Services for the Elderly and Chronically Ill: Alteratives to Nursing Homes", will be completed shortly and we commend it to this committee for careful consideration.

The National Senior Citizens Law Center is a national support center, with offices in Los Angeles and Washington, D.C., specializing in the legal problems of elderly poor people. We are jointly funded by the Legal Services Corporation and the Community Services Administration. Pursuant to the Law Center's Community Services Administration grant, we provide technical assistance and training to Community Action Agency advocates in legislative advocacy and legal problems of the elderly. We also draft and analyze State legislation affecting the elderly.

Under our Legal Services Corporation grant, our principal function is providing support services to legal services attorneys throughout the country on the legal problems of their elderly clients. In this connection, we repond to requests from legal service attorneys for assistance in areas of the law which substantially affect elderly people.

We are pleased that Congress has begun to focus its attention on the neglected area of home health care. With enactment in 1965 of Title XVIII of the Social Security Act, which established the Medicare program for the elderly, and Title XIX, which set up health care services for low-income individuals, Congress provided landmark health legislation which has been of enormous import to older and poorer persons throughout the nation. Now, however, more than a decade later, we are in a good position to evaluate both Medicare and Medicaid and recognize that these programs have created an inadvertent and most unfortunate systemic bias against home health care.

Medicaid and Medicare, with their generous cost-based reimbursement of hospitals and nursing homes and their limits on eligibility and scope of coverage of home health services, encourage, indeed in some circumstances practically make mandatory, the institutionalization of chronically ill elderly and disabled persons. This familiar tendency is not particularly surprising, since nursing homes are familiar, are medically-oriented and provide a "package" of services under one roof, while community-based services are often innovative, unusual, nore socially-oriented and lack a single physical location where all recipients of care are gathered to receive the services. For these reasons, institutionalization is replacing family-centered and community-based health and social services, as our national tradition.

The fact that over 70 percent of the Medicare health dollar is annually spent for institutional care confirms this bias toward institutionalization. In addition, spending for institutional care has been increasing faster than enrollment in the program. In contrast to the growth in spending for institutional care, the percentage of Medicare payments for home health care, as shown in Table 1, page 3A, averaged about one percent until FY 1974 and now accounts for about two percent. Plainly, home health care plays a relatively insignificant role in the Medicare program.

As presently authorized, Medicare provides for acute, emergent, and convalescent care but reimbursement for preventive care and health maintenance services is denied. Thus, many beneficiaries refused home health coverage become unnecessarily institutionalized for long periods of time at considerable personal and federal government cost. Until significant increases in the availability, use, and funding of home health care occurs, Medicare will continue to be unresponsive to the crucial home health care needs of the elderly.

As bad as the picture is for home health services under Medicare, it is even worse under Medicaid. Only in the last two years have Medicaid payments for home health services crept over the one percent mark, as shown in Table 2, page 3A. From its inception Medicaid has spent between 30 and 35 percent for patients institutionalized in skilled nursing and intermediate care facilities. Yet a substantial number of these institutionalized patients, probably as much as 20 percent, could have been better cared for at lower costs in their homes—with great personal and economic savings to themselves and the nation.

Table 1.--Total Medicare Benefit Payments and Medicare Payments to Home Health Agencies, Fiscal Years 1967 through 1978.

(in millions)

Fiscal Year	Total Medicare Payments	Home Health Agency Payments	Percent Home Health to Total
1967	$3,172	$21	0.66%
1968	5,126	60	1.17
1969	6,299	77	1.22
1970	6,783	89	1.31
1971	7,477	73	0.98
1972	8,363	70	0.84
1973	9,039	80	0.89
1974	10,680	119	1.11
1975	14,118	203	1.44
1976	16,939	321	1.90
1977	20,773	457	2.20
1978	24,250	548	2.26

Source: Office of Policy Planning and Research, Health Care Financing Administration, HEW

Table 2.--Total Medicaid Benefit Payments and Medicaid Payments to Home Health Agencies, Fiscal Years 1967 through 1978.

(in millions)

Fiscal Year	Total Medicaid Payments	Home Health Agency Payments	Percent Home Health to Total
1967	$1,937	$7	0.36%
1968	3,222	12	0.37
1969	4,126	13	0.32
1970	4,978	17	0.34
1971	6,345	23	0.36
1972	7,346	24	0.33
1973	8,714	25	0.29
1974	9,737	30	0.31
1975	12,086	73	0.60
1976	13,977	126	0.90
1977	16,257	178	1.09
1978	17,738	219	1.23

Source: Office of Policy Planning and Research
Health Care Financing Administration, HEW

Medicaid unquestionably spends hundreds of millions of dollars each year on unnecessary, excessive, and premature institutional care. Denial of home health services for the elderly and chronically disabled often results in the individual eventually being placed in a hospital or nursing home at much higher cost. See "Comptroller General of the United States, Home Health—The Need For A National Policy To Better Provide For The Elderly" (1977). Medicare and Medicaid statutes provide coverage for home health care but some of the statutory provisions and regulations and informal guidelines and policies issued by Federal and State administrations have relegated home health care to a minor program and the inferior role which it has today.

Home health care should not be thought of as merely an alternative but as the primary method of care. Until introduction of Medicare and Medicaid programs and the accompanying growth in the number of nursing homes and other health care facilities and agencies, the home was the primary place for the care of the elderly and chronically disabled, who had little prospect for total recovery but required part-time nursing observation and preventive and restorative services. The home must again become the center for caring for the disabled and the sick, provided that Medicare and Medicaid legislation and regulations are revised so as to permit the liberalization of home health care eligibility and benefits.

It is nursing homes that should be seen as "alternatives" to an accepted, comprehensive array of noninstitutional health and social services available to persons at home before they are condemned to an institution from which they will probably not return. Forcing persons to remain in nursing homes because there are not adequate in-home services is poor public policy. Persons should not be institutionalized if their health and social needs can be met in the community. Furthermore, in view of the abysmal record of quality of nursing care revealed in state and federal studies, it is inhumane to relegate the chronically ill to nursing homes if they don't need to be there. We should not be trapped into thinking in terms of institutional care as the primary means of providing long term health services since the funding mechanisms make it so. We need to pursue the broader policy goals of developing, at state and federal levels, a comprehensive system of long-term care—one which does not rely primarily upon institutionalization, but which provides to individuals what they need to maintain themselves in health at home. Services in such a comprehensive and rational system must, of course, include more than medical, nursing or other health services; they must meet residential, social, recreational, nutritional and emotional needs.

ELIGIBILITY RESTRICTIONS

A. Medicare

Medicare's statutory insurance-like orientation toward treatment of acute care, rather than health maintenance, or treatment of chronic illness, greatly limits the program's utility for those needing home health care. Expressly restrictive statutory provisions include:

1. The Part A requirement of prior hospitalization, 42 U.S.C. §§ 1395d(a)(3) and 1395x(n).

2. The limitation to 100 visits per calendar year under Parts A and B, *Id.* and 42 U.S.C. § 1395m.

3. The requirement that, to receive home health benefits, the person must be homebound and require skilled nursing care on an intermittent basis, or physical or speech therapy, 42 U.S.C. § 1395n(e)(2)(A).

4. The restriction of home health care providers to non-proprietaries, or proprietaries licensed by the states, 42 U.S.C. § 1395x(o).

There are presently bills pending in the Senate would alter or abolish the 100 visit limitation (S. 489, S. 505, S. 507) and eliminate the prior hospitalization requirement, S. 505, S. 507. These changes would be of great assistance in decreasing the institutional bias of the Medicare statute and we urge their enactment. For the same reasons, we also urge reconsideration and modification of the "homebound," "intermittency" and "skilled nursing" requirements.

In addition to abolition of these express statutory provisions, we also suggest expansion of home health aid service to include homemakers, and inclusion of occupational and nutrition services in the definition of home health care.

B. Medicaid

The Medicaid program providing health care coverage for those who fall within the federal welfare coverage of AFDC and SSI programs, is of course of critical import to those most in need of assistance. Since July 1, 1970, home health care has

been a mandatory service under Medicaid for persons "entitled to skilled nursing facility services." 42 U.S.C. § 1396e(13)(A)(ii).

There is, therefore, no federal prior hospitalization requirement nor are there any federal requirements that a beneficiary be homebound, be previously institutionalized, or require "skilled" or "intermittent" nursing care.

Nevertheless, this Committee should be aware that there are several factors which perpetuate a pronounced institutional bias in the Medicaid program.

1. *Options available to the States.*—Although States must include in-home health services nursing, home health aide care, medical supplies, equipment and appliances, the States retain a great deal of freedom to establish the parameters of their programs.

Unfortunately, most States have exercised these options in such a way as to minimize the availability of reimbursable home health care. For example, many States have excluded physical, occupational and speech therapy although these are traditionally a part of home health care and an integral component of Medicare home health benefits. Sixteen States have limited the number of home visits available or have established prior authorization requirements for home health care.

Worse, some States have erected restrictions against home health care which are of doubtful legality but in which HEW has acquiesced. Thus, some States have illegally limited home health care to post-institutional care and very few States have complied with the HEW requirement that they arrange with registered nurses to provide home health care where no home health agencies exist. Further, a number of States have established a "homebound" requirement and more than half of the States have specifically noted that "skilled" nursing is a home health care service, suggesting that at least some of these States may be illegally establishing skilled nursing as a prerequisite to receipt of home health care. Some Medicaid programs provide medical supplies, but not equipment and appliances as part of the home health programs. Idaho does not even pay for the medical supplies or equipment under home health care although this is expressly required by HEW regulations. 42 C.F.R. §§ 441.15(a)(3), 440.70. The statements in this and the preceding paragraph are based upon the Butler paper, which in turn draws from the Sundeman Survey entitled "Home Health Care Services: State Descriptions" prepared for the HCFA Medicaid Bureau in July of 1978.

These restrictions upon home health benefits obviously can have a major retarding effect on the use of such benefits and should be reviewed carefully, remembering that their likely effect is not necessarily the reduction of health costs, but instead the substitution of institutional, in place of home health care.

2. *Institutional bias in State eligibility limits for health care.*—Through variations now permissible under Medicaid for setting eligibility standards, various States have also, perhaps inadvertently, increased institutional bias of the Medicaid program within such States. Examples include:

1. Some persons in "optional categorically needy" categories find themselves eligible for nursing home care, but not for home health care, under the Medicaid program because of the income eligibility formulae employed in those States.

2. Some States use differing periods of time in making spend-down calculations to determine "medically needy" eligibility, depending on whether the potential beneficiary is or is not institutionalized. When there is such a variance, the longer period is always applied for the noninstitutized group. This longer period increases the amount which must be spent for medical care in order to qualify for medical benefits, thereby making it more difficult to get benefits for noninstitutional care.

A careful review of income eligibility formulae employed by the States should be conducted. Institutional bias could then be prevented administratively by HEW, or statutorily by spelling out guidelines for calculating eligibilty so as to prevent the bias toward institutionalization.

ACCESS TO SERVICES

Beneficiaries eligible under the Medicaid program often find it difficult, if not practically impossible, actually to obtain the home health services to which they are entitled. Three explanations are commonly offered for this problem. First, some providers are simply unwilling to go into the communities in which poor people live, or hold more generalized discriminatory attitudes against minority groups or poor people.

Second, providers have repeatedly contended that reimbursement formula are inadequate to compensate them for the services and that administrative red tape (complex billing and accounting requirements, prior authorization, retroactive payment denials, etc.) strangles their desire to furnish home health care.

Two other factors are far easily remediable. The HCFA-sponsored Sandeman Survey of state medicaid home health services found that some home health agencies refuse to serve Medicaid beneficiaries. (In Florida only 15 out of 120 served Medicaid). In it 1976 home health regulations, HEW mandated States to contract with registered nurses under physician direction to provide home health care in areas where no agency serves Medicaid. This requirement was imposed under the "Statewideness" provisions of the Medicaid law which requires the law to be in effect in all political subdivisions of a State. Despite Medicaid beneficiaries' continuing and serious difficulty obtaining all types of health providers, HEW has never used this provision to require States to assure availability for other services, but it does appear to be an appropriate authority for such a contract requirement.

A third factor is the limitation on providers, borrowed from Medicare and inserted into Medicaid via regulations. 42 C.F.R. § 440.70(d). To participate in Medicaid, home health agencies must qualify for Medicare participation which means: (1) they must provide at least two of the Medicare home health services, and (2) proprietary agencies are prohibited unless licensed under State law. Many potential Medicaid home health agencies are eliminated from participation. It has been estimated that the multiple service requirement prevents some 500 to 700 agencies in rural areas from participating in Medicaid. 40 Fed. Reg. 36702 (Aug. 8, 1975). The proprietary agency restrictions have caused great controversy as did an attempt in 1975 by HEW to reduce these restrictions. The time may be propitious once again to review the desirability of such restrictions.

CONCLUSION

In the time allotted, we have attempted to briefly sketch just a few of the characteristics of the Medicare and Medicaid program which create institutional bias in those programs, with the consequent and unfortunate underutilization of home health care benefits.

We are pleased that the Committee is considering these most important problems and we appreciate the opportunity to discuss them here today.

Senator TALMADGE. The next witness is Paul Kerschner, associate director, National Retired Teachers Association-American Association of Retired Persons.

You may insert your full statement in the record and summarize it, sir.

STATEMENT OF PAUL KERSCHNER, ASSOCIATE DIRECTOR, NATIONAL RETIRED TEACHERS ASSOCIATION-AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. KERSCHNER. Thank you. I am Paul Kerschner, associate director of the 12.3 million member National Retired Teachers Association-American Association of Retired Persons. Accompanying me this afternoon are James Hacking and Laurie Fiori, members of our legislative staff.

Of all the possible areas of medicare and medicaid benefit improvement, our associations believe expansion of home health care deserves priority consideration. Improvement of home health coverage under these programs offers an opportunity to begin to neutralize the excessive emphasis these programs place on institutionalization and acute care.

This bias has caused an overutilization of costly, often unnecessary and inappropriate, types of care while detracting from financial resources available to be channeled into less costly and more desirable in-home care.

It is unfortunate that Congress has not been able to enact a single major benefit improvement in the medicare program since 1972. Many long overdue and sorely needed benefit expansions, like home health liberalizations, have been held in abeyance over the last seven years because of the overriding cost escalation issue.

In light of the recently released 1979 Trustees Report for the Hospital Insurance Trust Fund—which predicts depletion of the fund in the early 1990's—it appears Congress will be finding it increasingly difficult to provide sufficient funds to guarantee—into the future—benefits already in place—let alone finance substantive benefit improvements—unless the cost spiral issue is addressed in an immediate and effective manner. NRTA/AARP strongly urge the committee to expedite consideration of S. 570, the Hospital Cost Containment Act of 1979.

Our associations look upon expansion of home health benefits as the first incremental step toward dealing with the critical lack of a long-term care program in this country. The aging of our population is already causing the demand for long-term care services to grow and this demand cannot be ignored much longer since it will increase rapidly after the turn of the century.

It is unlikely, however, that such a long-term care program would be created and implemented all at once because of the costs and comprehensive program changes that it would entail. For instance, none of the major national health insurance or catastrophic health insurance proposals are ambitious enough to address this issue.

The administration and other skeptics would have us ignore the home health issue area and delay enactment of even the most minor improvements. The administration revealed this attitude in the presentation of their home health report by contending that not enough is known about how changes in home health benefits will affect utilization rates, cost of services, et cetera and any piecemeal changes may exacerbate the already fragmented and ill-coordinated delivery of services.

Our associations reject the assertion that we should hold hostage home care improvements for lack of complete, detailed information. We would contend that some basic information and statistics regarding the need for and relative cost-effectiveness of home health services are already available.

Our main recommendations in the home health care area relating to medicare improvements are: elimination of the 3-day prior hospital rule under part A; removal of the 100-visit limitation under parts A and B; elimination of the homebound requirement; addition of coverage for homemaker/chore services; and elimination of the skilled requirement.

The major piece of home health legislation pending before this committee is S. 489, the Medicare Home Health Amendments of 1979. Our associations fully support this legislation and commend its sponsors for developing a package of improvements which should be readily acceptable and supported by Congress. The lack of controversy surrounding most of the provisions of S. 489 should insure its enactment and hence Congress will be able to take a firm, incremental step in the direction of expanding home health benefits.

To our disappointment, however, the improvements proposed by S. 489 will probably not have any significant impact on discouraging institutionalization nor will they elevate home health benefits sufficiently to make home care a realistic alternative to nursing homes. The removal of the skilled requirement, homebound re-

quirement and the coverage of homemaker/chore services would have to be added in order to accomplish that goal.

Obviously, this self-limiting legislation has been purposely circumscribed, not due to lack of concern for the elderly or lack of knowledge of the issue, but rather due to the unavailability of the financial resources necessary to make a major expansion in this area. We appreciate the budget constraints within which this committee must work and we understand quite well that the health care cost spiral has voraciously consumed all the available moneys that could be channeled into benefit improvements like home health care.

The committee is on the verge of acting on a piece of legislation that can slow this cost spiral significantly—S. 570, the 1979 Hospital Cost Containment Act. Our associations suggest that, if enactment of S. 570 is achieved, then the necessary funds in the form of cost-savings for the medicare program will become available to expand the scope of S. 489 so that home health care can be made a viable alternative to institutionalization.

Senator TALMADGE. Thank you very much, Mr. Kerschner. I have only one question.

You testified that it is critical that medicare cover homemaker chore services for all beneficiaries who need them. Has your association arranged to provide benefits for housekeeping services under the health benefit plans they sponsor?

Mr. KERSCHNER. Senator, I am not sure of that. I will check into it and let you know. I do not have the information available.

[The following was subsequently supplied for the record:]

NATIONAL RETIRED TEACHERS ASSOCIATION,
AMERICAN ASSOCIATION OF RETIRED PERSONS,
Washington, D.C., June 20, 1979.

Hon. HERMAN TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR TALMADGE: The following is the additional information I offered to supply to the Subcommittee on Health during its May 21st hearing on Medicare and Medicaid home health care benefits.

During the question and answer period, you inquired whether the home health care benefit programs endorsed by our Associations offer coverage of homemaker/chore services (page 111 of transcript). In response, I would indicate that none of the Associations' health benefit plans offer such coverage and, to our knowledge, no other health insurance plan in the private Medicare supplemental market offers coverage of homemaker/chore services. I would also like to point out that, because Medicare does not reimburse for homemaker/chore services, there are no provider and reimbursement standards for the private supplemental market to use in judging claims.

This situation serves to underscore the need for Medicare coverage of these very services. In my testimony, I stated that if home health care is to be made a viable alternative to institutionalization, the inclusion of homemaker/chore services under the Medicare program is of vital importance. While certain improvements may be made in the Medicare program with respect to medically-oriented home health care, the total needs of homebound older persons would not be fully met until homemaker/chore service assistance is provided to older persons so that they may maintain orderly, normal lives at home.

In conclusion, I would like to reiterate our Associations' appreciation of the opportunity to present our views and suggestions on this most important issue. We are encouraged by your Subcommittee's initiative to explore home health care

benefits for Medicare and Medicaid participants and are hopeful that substantive legislative reforms may result from your Subcommittee's deliberations.

Sincerely,

PAUL A. KERSCHNER, PH. D.,
Associate Director,
Legislation, Research and
Developmental/Services Division.

Senator TALMADGE. Senator Dole?

Senator DOLE. Just to comment on the five recommendations. Most of those are included in some of the proposals, I think all, with the exception of one. The proposal introduced by myself and Senators Domenici and Danforth, include many of your recommendations come to think of it.

Mr. KERSCHNER. Senator, may I also add something that you brought up earlier on the issue of hospices? I think we cannot ignore that issue. One of my personal concerns is that we do not allow hospices to go the way of the nursing home industry. Hospice care, essentially, should be based in the home to allow family members to care for the dying patient at home.

Senator TALMADGE. Thank you very much.

[The prepared statement of Mr. Kerschner follows:]

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman, I am Paul Kerschner, Associate Director for the 12.3 million member National Retired Teachers Association/American Association of Retired Persons. Accompanying me this afternoon are James Hacking and Laurie Fiori, members of our legislative staff. Our Associations appreciate your granting us the opportunity to present our views on Medicare/Medicaid home health care benefit expansion, one of the most important health care issues for older persons.

At the outset, let me state that it is unfortunate that Congress has not been able to enact a single major benefit improvement in the Medicare Program since 1972. Many long-overdue and sorely-needed benefit expansions, like home health improvements, have been held in abeyance over the last seven years because of the overriding cost escalation issue. A collection of relatively modest expansions was seriously considered last year; both House and Senate passed a package of improvements amounting to less than $100 million in increased expenditure, but this legislation failed final conference action.

In light of the recently-released 1979 Trustees Report for the Hospital Insurance Trust Fund, it appears Congress will be finding it increasingly difficult to provide sufficient funds to guarantee (into the future) benefits already in place—let alone finance substantive benefit improvements—unless the costs spiral issue is addressed in an immediate and effective manner. The 1979 Trustees Report predicts depletion of the Hospital Insurance Trust Fund by the early 1990's unless alternative financing mechanisms are found, benefits are cut or cost control measures are put into place.

This increasingly dismal and constraining situation has largely been caused by the rampant rate of inflation over the past decade in the health care sector—especially among hospitals—and Congress' inability to gain control over public and private resources being funneled into that sector. Much debate has been conducted on solutions to the cost escalation problem and this Committee's work has contributed a great deal to developing remedies. We recognize that this issue is complex and that reaching a consensus on the proper solution is difficult. For this reason, we feel it is imperative that Congress impose immediate ceilings on cost increases for major health care items while long-term remedies are developed, discussed and tested for their effectiveness. The cost problem is so severe and so detrimental to the interests of the elderly and the nation, that we must utilize the crude mechanism of cost controls. This is the only mechanism available to us that will begin effecting immediate cost savings in the health programs.

NRTA/AARP strongly urge this Committee to expedite consideration of S. 570, the Hospital Cost Containment Act of 1979. Enactment of this measure would permit consideration of truly significant and sorely needed Medicare benefit improvements.

THE NEED FOR HOME HEALTH BENEFIT EXPANSION

Of all the possible areas of benefit improvement, our Associations believe expansion of home health care deserves priority consideration. Improvement of home health coverage under Medicare and Medicaid offers an opportunity to begin to neutralize the excessive emphasis these programs place on institutionalization and acute-care. This bias has caused an over-utilization of costly, often unnecessary and inappropriate, types of care while detracting from financial resources available to be channeled into less-costly and more desirable in-home care.

Furthermore, our Associations look upon expansion of home health benefits as the first incremental step toward dealing with the critical lack of a long-term care program in this country. The aging of our population—and especially the increase in the proportion of persons age 75 plus—is already causing the demand for long-term care services to grow. This demand cannot be ignored for much longer since it will increase rapidly after the turn of the century. The rise in the incidence of chronic illnesses and conditions which accompany this population trend should prompt us to make changes in the current system that will maximize the elderly's independence and ability to remain in their own homes. It is unlikely, however, that such a long-term care program would be created and implemented all at once because of the costs and comprehensive program changes that it would entail. For instance, none of the major national health insurance or catastrophic health insurance proposals are ambitious enough to address this issue. Therefore, we feel, a long-term care program is likely to be contructed in a piecemeal fashion and we must look to the current Medicare/Medicaid structure to begin to effect the progressive changes necessary for that incremental evolution.

The Administration and other skeptics would have us ignore the home health issue area and delay enactment of even the most minor improvements. The Administration revealed this attitude in the presentation of their home health report, mandated by Congress by Public Law 95-142, the Medicare/Medicaid Anti-Fraud and Abuse Amendments. In this report, the Administration contends that not enough is known about how changes in home health benefits will affect untilization rates, costs of services, etc. and any piecemeal changes may excacerbate the already fragmented and ill-coordinated delivery of services. For these reasons, they made no legislative recommendations in their report, restricting themselves to administrative suggestions.

Our Associations reject the assertion that we should hold hostage home care improvements for lack of complete, detailed information. This rationale could easily be used to justify delay in any health benefit expansion. We would contend that some basic information and statistics regarding the need for and relative cost-effectiveness of home health services are already available. HEW Secretary Califano himself has stated that approximately 100,000 of the 700,000 persons currently in acute-care hospitals do not need to be there and could be cared for at home.

The General Accounting Office has also asserted that 25 percent of the nursing home population could be cared for at less intensive levels of care if home health services were available. In its December 1977 report entitled, "Home Health—the Need for a National Policy to Better Provide for the Elderly" (HRD-78-19), the GAO examined the comparative cost question and stated that until older persons become greatly or extremely impaired, the cost of nursing home care exceeds the cost of home health care (only about 17 percent of persons age 65 and over fall within that category).

A recent study, by the NRTA/AARP Andrus Foundation, observed a group of 50 elderly Massachusetts residents who were about to enter a nursing home. This study, authorized by Alan Sager and entitled "Costs of Diverting Nursing Home Patients to Home Care," confirmed that home care is a less costly alternative to institutionalization for a significant portion of patients. Roughly 16 to 38 percent of the patients observed could have been cared for at home more cheaply than in the institution to which they were actually admitted.

Health policy analysts also have fairly accurate knowledge of the comparative impact of home health versus nursing home care on the well-being of elderly patients. An HEW-funded, 4-year Medicaid demonstration project conducted in Georgia (called the Georgia Alternative Health Services Project) examined the effect of home health service on mortality rates. (The project's preliminary findings were presented to the Gerontological Society in a paper authored by Albert Skellie and entitled "The Impact of Alternatives to Nursing Home Care," November 17, 1978.) Preliminary findings of this project indicate that the availability of alternative community-based services (ranging from home-delivered services, adult day care and congregate living) decreased the incidence of death among Medicaid recipients to one-third of what it would have been if patients had only had access to services

normally available to Medicaid recipients. Availability of home-delivered services specifically reduced the death rate from 27 percent to 6 percent. This study is also examining costs and, although complete cost figures are not yet available, preliminary data show that the average direct monthly cost to Medicaid for these alternative services was $160 while the monthly nursing home cost under Medicaid was $500.

These reports and studies as well as the many others preceding them have produced ample evidence that home care—in comparison to nursing home care—is a more humane and desirable long-term care setting for the elderly person and can be a more cost-effective alternative for a significant portion of our institutionalized population. Before home care can become a realistic alternative to institutionalization, we must obviously increase the supply of services available and, at the same time, increase the elderly's access to those services by covering them more fully under the Medicare/Medicaid Programs.

CURRENT PROGRAM EFFORTS IN THE HOME HEALTH AREA

Home health care services are primarily available to the elderly through four government programs—Medicare, Medicaid, Title XX Social Services and the Older Americans Act. Federal expenditures for in-home services in 1977 were estimated by HCFA to be about $1.44 billion, with the states adding about $216 million under the Medicaid and Title XX Programs. These total expenditures, however, amount to only 1 percent of the total outlays for all four programs—a fact that accurately reflects the severe restrictions and lack of emphasis placed on home health benefits.

This fact is particularly astonishing when current effort is compared to need. In 1979, it is estimated that 530,000 Medicare beneficiaries and 260,000 Medicaid patients will receive home health benefits. In their recent Home Health Services (H.R. 3) Report, HCFA gives us an idea of the potential need for home health services by stating that over 7 million of the non-institutionalized civilian population are unable to perform a major activity of daily living. The Congressional Budget Office, in their 1977 budget issue paper entitled "Long-Term Care for the Elderly and Disabled," focused specifically on measuring the potential need and available supply of home health care and estimated that 1.7 to 2.7 million persons were in need of home health care services, but only 300,000 to 500,000 persons were being supplied such services.

The wide gap between demand and supply in the home health field has been a product of the acute-care emphasis and the highly restrictive nature of Medicare and Medicaid requirements for care. Not only are the law and regulations narrowly-defined and acute-oriented, but their complexity has made them subject to a variety of interpretations by intermediaries. Most important, benefits are not designed to cover care related to assisting with daily living activities unless the patient requires skilled nursing care and/or physical or speech therapy.

To be eligible for Medicare home care benefits, a person must be confined to his residence (homebound), under the care of a physician and in need of part-time, skilled nursing services. To qualify for benefits under Part A Medicare, a person must be hospitalized for three consecutive days. The patient's coverage under Part A is limited to 100 visits per year after the start of one spell of illness and before the beginning of another. A physician must draw up a home health plan within 14 days of the patient's discharge from a hospital or nursing home and must certify that the patient needs skilled nursing care, physical therapy or speech therapy as a means of recovery from a condition or illness treated in the hospital or nursing home. Under Part B, there is no prior hospitalization requirement, but the homebound and skilled care requirements must still be met. Visits under this part are also limited to 100 per calendar year. It is no wonder with this maze of rules and barriers, that only 3 percent of total Medicare expenditures are for home health benefits.

Under the Medicaid Program, states are required to provided home health services, which are defined as part-time and intermittent services by a certified home health agency. Home health services provided under Medicaid vary a great deal from state to state because the statute permits wide variations in number of allowable visits and comprehensiveness of services. In contrast with Medicare, Medicaid does not require skilled nursing care or physical or speech therapy for eligibility and prior hospitalizaion is not needed. Although the number of visits is not limited by federal law, many states impose limitations.

In 1977, total state and federal expenditures for home health care under Medicaid amounted to only $241 million while over $5.8 billion was spent by state and federal governments on skilled nursing care and intermediate care facilities. It is obvious

from these statistics that Medicaid, like Medicare, carries with it an acute-care orientation to services.

Under Title XX of the Social Security Act, states can provide a variety of home-based and chore services, such as homemaker/home health aide, home management, financial management and personal care. Covered services vary from state to state, but data shows that at least one home-based service is included in each Title XX plan. In 1976, the federal government spent $284 million (or about 11 percent) of the total $2.5 billion Title XX funds on home care. Standards for the delivery and quality of these services are lacking and coordination between Medicaid and Title XX is poor in most states.

The Older Americans Act programs also provide home-based services. Under Title III of the Act, projects and services to help older persons maintain an independent life-style are authorized. The services include visiting nurses, homemaker services, health education, immunization and screening programs, home repairs, home-delivered meals and meals provided in a congregate setting. The funding provided for home-delivered and congregate meals in 1979 is in excess of $250 million.

BENEFIT CAPS AND LIMITATIONS: NRTA/AARP RECOMMENDATIONS

Medicare program

Allow me to highlight what our Associations consider to be the home health benefit gaps and objectionable requirements that currently exist in the Medicare Program.

(1) Requirement for 3-day prior hospitalization (and requirement that treatment received by related to a prior hospital stay). We consider this requirement to be an unnecessary and irrational barrier to eligibilty for home health care benefits. Elimination of this barrier would benefit about 1.1 million beneficiaries who are only covered under Part A and do not have access to Part B benefits (Part B does not require any prior hospitalization). Although some evidence exists to demonstrate that individuals are not actually encouraged to be hospitalized by the prior-hospitalization requirement (since 97 percent of Medicare beneficiaries are covered by Part B), we believe the requirement ought to be removed. The costs of this removal was estimated by the Social Security Administration to be $12.5 billion in 1978.

(2) 100-visit limits under parts A and B. Although few Medicare beneficiaries currently exhaust these limits, our Associations feel they ought to be removed. The cost of this liberalization is estimated by the Social Security Administration to be minor, approximately $12.5 million. We do not agree with some analysts who contend that removal of the limits might lead to excessive and uncontrolled utilization. Existing data indicates that only 2 percent of Medicare beneficiaries currently exhaust the total 200 visits under Parts A and B. We believe that other changes in the home health benefit structure would impact utilization far more significantly that removal of the 100 visit limits. Removing the visit limits would provide a catastrophic-type protection for long-term, seriously ill patients.

(3) Homebound requirement. The elimination of this rule which requires a physician to certify that the patient is confined to his or her home in order to be eligible for home health benefits would benefit an estimated 10 percent of the Medicare population at an additional cost of $56.5 million. The GAO has specifically pointed out that elimination of the homebound requirement could provide an incentive for beneficiaries who require skilled care (but who are not homebound) to remain at home and out of an institution because it is often difficult to obtain appropriate skilled care on an ambulatory basis.

(4) Addition of homemaker/chore services. The addition of homemaker services to home health benefits was one of the primary Medicare recommendations of the original H.R. 3 Report—that was, of course, before HEW officials removed all its recommendations. If home health is ever to become a realistic alternative to institutionalization, homemaker/chore services must be covered in any rational set of home health benefits. Provision of skilled-type care alone will not maintain the elderly patient at home. Receipt of supportive services is crucial. Several studies of the cost-effectiveness of homemaker/chore services as a deterrent to institutionalization are producing encouraging results. An interim report from Georgia's homemaker demonstration project indicates the availability of homemaker services is directly preventing institutionalization and reducing overall health costs. The report showed that during the first 3 months, homemaker services prevented over 2,300 months of institutional care and saved $278,231. The cost of adding homemaker/chore services to Medicare is estimated to be approximately $92 million.

Another beneficial side-effect of covering homemaker/chore services under Medicare would be to reduce the current fragmentation of services between Medicare

and Title XX. Medicare's home health aide is not permitted to perform homemaker services unless these do not substantially increase the aide's time spent with the patient. Consequently, the Medicare patient must often separately seek the services of a Title XX homemaker.

(5) Skilled care requirement. Our Associations strongly support the elimination of the "skilled care" requirement as a determining factor in establishing eligibility for Medicare home health benefits. This prerequisite unfairly denies millions of beneficiaries various crucial supportive home health services and operates as the major barrier to permitting them to remain in their own homes. The test of the need for home health services should be need for any type of nursing services and/or home health services—such as need for occupational therapy services or part-time services of a home health aide. The availability of non-skilled nursing services and personal care services would permit a large number of patients currently in institutions to be cared for at home. Critics maintain that Medicare—a medically-oriented program—is not the appropriate program to use in making "unskilled," non-medical services available. We would counter by first pointing out that there is no other "appropriate" program available to us at this time that would reach the broad majority of elderly patients is need of home health care. As we stated earlier, a long-term care program—probably a more "appropriate" program—is not financially within our grasp and in the meantime, we must be realistic and seek incremental improvements. Second, we reject the ironclad rule that Medicare must provide services of a strict medical nature. This narrow mindset ignores the value and cost-effectiveness of preventive-type care and ignores the overwhelming preference on the part of older persons to remain at home and out of institutions. It is precisely this medical, acute-care orientation syndrome that we must break in order to begin to transform our health system into one which is more humane, rational and ultimately more efficient and cost-effective.

Medicaid program

With respect to improvements that could be made in the home health care coverage of the Mediciad program, our Associations have several suggestions to make. Federal law regulations require home health benefits to be provided to all aged, blind and disabled categorically needy persons age 21 and older. Although home health benefits for the medically needy are technically not required under the law, 32 states are offering these benefits. Nevertheless, spending for home health benefits amounts to only 1 percent of total Medicaid expenditures.

The comprehensiveness and amount of Medicaid home health benefits offered by the states vary widely. Some states severely restrict the number of allowable visits while others place no limits. Our Associations recommend that federal minimums be mandated under the Medicaid law as to the amount, duration and scope of home health services to prohibit states from overly restricting benefits. These minimums should at least parallel Medicare benefits. Since the cost of nursing home care is covered by Medicaid with practically no limits, encouraging home health benefit expansion would provide a direct cost-saving to the Medicaid Program to the extent that it discourages and prevents institutionalization.

Medicaid reimbursement procedures also need to be reformed. Reimbursement levels for Medicaid home health benefits tend to be low as sometimes as much as 50 percent lower than for Medicare patients. This causes home health agencies to often refuse Medicaid patients or use quotas on how many Medicaid patients they will accept. These practices should be specifically prohibited and uniformity in Medicare/Medicaid reimbursement levels should be brought about.

In reimbursing under Medicaid, many states do not insist that certain standards be set in establishing a plan of care for a patient or in the training or supervision of providers. For instance, some states reimburse individual providers who are unconnected with any agency because these providers tend to provide cheaper care than those supervised by an agency. These states are often unable to monitor the nature or quality of the service rendered and, without adherence to a prescribed plan of care, cannot monitor changes in patient needs. Federal law should outline specific standards in these areas to ensure that Medicaid recipients are receiving quality care.

Pending legislation: S. 489

The major piece of home health legislation pending before this Committee is S. 489, the Medicare Home Health Amendments of 1979, sponsored by Senators Packwood, Domenici and others. Briefly, S. 489 would: eliminate the 3-day prior hospitalization requirement; provide unlimited visits under both Parts A and B; establish occupational therapy as a primary home health service; create regional intermediaries specifically for home health services; empower the Secretary of HEW to monitor

costs, set up agency reporting guidelines, establish uniform billing practices and standards for home health aides; and test the concept of utilization review through demonstration projects.

Our associations fully support this legislation and commend its sponsors for developing a package of improvements which should be readily acceptable and supported by Congress. The lack of controversy surrounding most of the provisions of S. 489 should ensure its enactment and hence Congress will be able to take a firm, incremental step in the direction of expanding home health benefits.

As discussed earlier in our statement, our Associations consider eliminating the prior hospitalization requirement and the 100 visit limitations to be highly desirable changes in the home health benefit structure. The combined costs of these alterations would be minor ($25 million).

The provision of S. 489 relative to improving coverage of occupational therapy is also beneficial. This provision makes occupational therapy a primary home health service by essentially removing the requirement that the patient need either skilled nursing care or physical or speech therapy to receive occupational therapy services. The addition of occupational therapy as a primary service will permit elderly persons who need the services of an occupational therapist so they may be able to remain in their homes to receive other Medicare home health benefits. Again, the cost of this improvement would also be minor ($2 to $5 million).

The creation of regional home health intermediaries is another important reform contained in S. 489. Home health currently represents only about 2.5 percent of most intermediaries' reimbursement loads and therefore receives little attention. Regional intermediaries should permit the development of home health expertise and thus encourage more consistent reimbursement practices for determining reasonable and allowable costs as well as permit the application of uniform accounting and reporting standards for detecting fraud and abuse. Our only caution in this area is that, to foster unbiased auditing and reviews, providers should not be permitted to nominate their own intermediaries. The supply by the intermediaries of consumer information containing the addresses of home health service agencies in the area and the comparative charges for services is an excellent idea. Such a "shopping list" for elderly consumers should encourage competition among agencies.

With the creation of regional intermediaries, the opportunity exists for implementing reimbursement reforms that will contain future cost increases. Undoubtedly, cost containment will become increasingly important as home health benefits are expanded. Competition is probably the best mechanism for containing costs, but until that perfect solution is achieved we would hope that elements of prenegotiated fees and budgets be emphasized in home health reimbursement practices. Cost guidelines for all specific home health care items (for instance, nursing costs per hour or administrative costs per hour) should be utilized.

To our disappointment, the improvements in home health benefit coverage under S. 489 are very limited in scope. We doubt that the suggested improvements would have any significant impact on discouraging institutionalization nor would they elevate home health benefits sufficiently to make home care a realistic alternative to nursing homes. The removal of the skilled requirement, homebound requirement and the coverage of homemaker/chore services would have to be added in order to accomplish that goal.

This self-limiting legislation has been purposely circumscribed not due to lack of concern for the elderly or lack of knowledge of the issue, but rather due to the unavailability of the financial resources necessary to make a major expansion in this area. We appreciate the budget constraints within which this Committee must work and we understand quite well that the health care cost spiral has voraciously consumed all available monies that could be channeled into benefit improvements like home health care.

This Committee is on the verge of acting on a piece of legislation that can slow this cost spiral significantly—S. 570, the 1979 Hospital Cost Containment Act. Our Associations suggest that if enactment of S. 570 is achieved, then the necessary funds in the form of cost-savings for the Medicare Program will become available to expand the scope of S. 489 so that home health care can be made a viable alternative to institutionalization.

This reform would give us a major opportunity to begin skewing our health care programs away from costly and undersirable institutions. It simply makes no sense to throw automatically and unwillingly more and more resources into expensive, acute-care settings. This is happening by virtue of the fact that we do not adequately cover home care while we continue to reimburse hospitals on a cost-plus basis. We hope this Committee will reverse this trend by moving boldly to expand home health care coverage and by favorably approving S. 570.

S. 421—Demonstration projects for training and employment of AFDC recipients as homemaker/home health aides

Legislation (S. 421), introduced by Senators Talmadge, Inouye, Nunn and Matsunaga would help increase the supply of individuals available as homemaker/home health aides primarily under the Medicaid Program. S. 421 would authorize demonstration projects in 12 states for five years. AFDC recipients would be trained in a 10 to 12 week program and would, upon completion of such a course, be available to public and non-profit agencies to provide home health services. It is expected these trained individuals would largely be used by state and local health departments through the Medicaid and Title XX Programs.

Funding for these projects would be provided by Medicaid with 90 percent federal matching of state costs. It is expected that there will be no net increase in Medicaid outlays for these projects since cost savings would accrue from the increased prevention of institutionalization resulting from the expanded supply of home health benefits.

The main recipients of these services would be Medicaid beneficiaries since recipients of care must have incomes within 200 percent of the state's standard of need. Some Medicare beneficiaries would be potentially eligible for these services although most of the services provided would not be reimbursable under Medicare. For those persons above the income standard, services could be purchased using a sliding fee scale.

Our Associations support this legislation since it would help increase the supply of properly-trained home health aides. We would hope, with proven success, the program could eventually move from the level of a demonstration project to a permanent program augmenting Medicaid in all fifty states. (Our earlier suggestions on Medicaid home health care improvements are separate from the training question and should be pursued along with S. 421.)

NEW currently has some input into the supply of home health services through the efforts of the Public Health Service (PHS). PHS administers home health agency developmental and expansion activities authorized under the 1975 Health Revenue Sharing Act. Approximately $3 million was appropriated in fiscal year 1976 to start or expand 15 developmental and 40 expansion projects in areas where home health is either unavailable or insufficient. Just recently, however, the Administration proposed as part of their fiscal year 1980 budget to cut drastically the level of funding for these projects from the fiscal year 1979 level of $6 million to $804,000 (even though the authorization level for fiscal year 1980 is $18 million). The Administration has once again demonstrated little sensitivity to the home health issue.

CONCLUSION

Home health care improvements would give us a major opportunity to begin skewing our government health care programs away from costly and undesirable institutionalization. It simply makes no sense to throw—automatically and unwillingly—more and more resources into expensive, acute-care settings. This is happening by virtue of the fact that we do not adequately cover home care while we continue to reimburse hospitals on a cost-plus basis. We hope this Committee will reverse this trend by favorably approving S. 570 and then moving boldly to expand home health care coverage.

Senator TALMADGE. Our final witness for the day is Betty Duskin, director of research, National Council of Senior Citizens, Inc. You may insert your full statement in the record, Ms. Duskin, and summarize it.

STATEMENT OF BETTY DUSKIN, DIRECTOR OF RESEARCH, NATIONAL COUNCIL OF SENIOR CITIZENS, INC.

Ms. DUSKIN. Mr. Chairman, members of the committee, I am Betty Duskin, director of research of the National Council of Senior Citizens.

The National Council is a nonprofit, nonpartisan organization composed of 3,800 local clubs and state and area councils across the country. We have testified on innumerable occasions on proposals to provide adequate health care for all Americans. We are pleased

to be here today to present our views and suggestions regarding the medicare and medicaid home health benefit programs.

Our organization has long advocated the use of home health services—both to promote recovery from acute or episodic illness, and to provide long-term care for persons chronically ill and disabled. We know that older persons prefer to receive health and supportive care in their own homes, rather than in an institution. We know, too, that for many patients in-home services are less expensive than either hospital or nursing home care.

It seems to us that medicare and medicaid should be designed so as to encourage the use of home health services whenever it would enable a patient to achieve recovery or maintain optimal health and functioning, and whenever that mode of care is less costly than others and is presumed to have equal benefit for the patient.

The tragedy is that at the present time only a fraction of the medicare and medicaid recipients who could benefit from home care actually receive it. It is most significant that in fiscal year 1976 and 1977 medicare spent only 2 percent of its total budget on home health care. More importantly, in these same years, medicaid, the major source of public financing for long-term care, spent only 1 percent of its budget on home health services; and more than 75 percent of this was expended in a single State.

The major obstacle to home care—and the reason for much overall cost inefficiency—is the limited coverage available under both medicare and medicaid. Under medicare, for example, eligibility criteria for part A home health benefits require prior hospitalization, thereby effectively eliminating the use of home care services as an alternative to unnecessary hospitalization.

In addition, the lack of coverage for homemaker services under both medicare part A and part B makes it impossible for many persons who are without family and friends to utilize medicare home health benefits. Moreover, the 100 visit limitation closes off all opportunity for the chronically ill and disabled elderly to receive home care on a long-term basis under the medicare program.

This means that impaired elderly who do not meet medicaid poverty guidelines generally have no choice but to spend down or deplete their resources to the medicaid-eligible income level if they wish to receive Government assistance for long-term care.

Yet, in many States, home health care coverage under medicaid is no better than under medicare. It is true that medicaid home health benefits theoretically are more flexible and comprehensive. In order to receive benefits persons meeting medicaid's financial eligibility requirements need only be eligible for a skilled nursing home care facility—this means 21 years of age in most States—and have a health-related problem for which a doctor has prescribed home health care.

In addition, benefits are not limited to 100 visits and the reimbursable services include those of the nonskilled homemaker. However, in actual practice, the majority of States, still operating in compliance with Federal statutory and regulatory law, provide only a limited benefit package, making it virtually impossible for low-income people to obtain long-term care outside of an institution.

Another serious problem affecting access to home health care is the limited availability of federally certified providers. In the past

decade, the number of certified agencies has increased by 70 percent. Yet, for many sections of the country and large segments of the population, home health providers are virtually nonexistent. This is especially true for rural areas, particularly in the north-central States. Moreover, even in those areas covered by a certified home health agency, specific services may be unavailable, since the majority of certified agencies do not offer the complete range of services covered by medicare and medicaid.

Other problems in the delivery of home health care concern poor service quality and inefficient administration. Because Federal law mandates only that certified agencies provide skilled nursing plus one additional service, patients requiring a range of home services frequently are delivered care by several agencies in a fragmented fashion without professional supervision or monitoring. Further, in many States, homemakers and home health aides are inadequately trained.

It is important to note that some of the same statutory provisions which foster poor quality of care also promote excessive administrative and indirect costs. This is because: Often several agencies request reimbursement for a single patient, thus duplicating billings and management staff; reimbursement methods, which differ for the medicare and medicaid programs, are confusing and complex; and, medicare reimburses on a cost-related basis, thereby rewarding inefficient agency administration and uncoordinated and overlapping service.

The National Council of Senior Citizens gives its full endorsement to the home health benefit proposals contained in S. 505, S. 748, and S. 487 now pending before this committee. This removal of the prior hospitalization requirement and 100 visit limit under medicare Part A are essential steps toward the goal of improving the provision of home health benefits.

So, too, are the establishment of training programs and standards for home health aides, and the inclusion of occupational therapy as a primary service.

Not surprisingly, however, we do not believe these provisions move far enough. In themselves, they will not assure that persons who require home health care as part of a medical treatment plan either to achieve recovery from illness, or to improve or maintain optional functioning, will receive it. Nor will they reduce excessive use of expensive resources.

The issue of home health care is an important one to the national council. As you know, the vast majority of Americans who are chronically ill and impaired are elderly. Each year at the NCSC's national legislative conference, our members express support for certain health, social services, and housing proposals that would assist them to function with maximum independence in their later years.

Our recommendation to improve the medicare and medicaid home health benefit programs are as follows:

Medicare home health benefits should not be conditioned upon the patient's need for skilled nursing care and strict confinement to the home. In addition, benefits should cover homemaker as well as home health services which, for administrative simplicity, should be provided by the same home-care worker.

Two, with respect to medicaid, States should either be provided with incentives or expressly required to liberalize home health care benefits and eligibility criteria to the extent already authorized by Federal statute and regulation.

Three, both medicare and medicaid should provide coverage for professional case management services to assess the total service needs of the patient, prescribe an appropriate service plan, arrange for the delivery of these services, and review the plan periodically in order to add and subtract services as necessary. The case management service can assure that the service plan is both effective and cost efficient.

Four, certified home health agencies should be required, over a reasonable period of time, to offer all medicare and medicaid covered services in-house rather than by contract of other arrangement. This policy, which will foster supervision and coordination of services for individual clients, does not seem unreasonable given the expected rise in caseload once benefit restrictions are limited.

Five, funds to start up certified home health agencies in underserved areas should be increased to assure all Americans access to quality home health care.

We hope that the comm..tee, in its deliberations, will consider these recommendations seriously. Thank you for allowing us the opportunity to present our views.

Senator TALMADGE. Thank you very much, Ms. Duskin. I have read, most of your statement. It is well thought out and comprehensive. I congratulate you on it.

I notice on page 2 you stated, more importantly in these years, medicaid, a major source of public financing for long-term care, spent only 1 percent of its budget on home health services, and more than 75 percent of this was expended in a single State. What State is that?

Ms. DUSKIN. I knew you were going to ask me that and I have forgotten which State it is, Mr. Chairman.

Senator TALMADGE. Would California be a good guess?

Ms. DUSKIN. Probably that is a very good guess. However, the correct State referred to is New York.

Senator TALMADGE. I think Mr. Kerschner is nodding his head over there. Have I guessed it right?

Mr. KERSCHNER. You guessed it right.

Senator TALMADGE. I appreciate it very much.

Senator Packwood, any questions?

Senator PACKWOOD. No questions.

Senator TALMADGE. There being no further business coming before the subcommittee, we stand in recess until 2:30 p.m. tomorrow.

[Whereupon, at 5:05 p.m., the subcommittee recessed, to reconvene on Tuesday, May 22, 1979.]

MEDICARE AND MEDICAID HOME HEALTH BENEFITS

TUESDAY, MAY 22, 1979

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:30 p.m. in room 2221, Dirksen Senate Office Building, Hon. Herman Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Dole and Packwood.

Senator TALMADGE. The subcommittee will come to order.

This is the second day of our hearings to evaluate present and prospective coverage of home health services under the medicare and medicaid programs.

I thought yesterday's hearing was constructive and informative.

In testimony yesterday, the committee was asked to approve the administration's hospital cost containment bill so that the savings could be used to finance home health benefit liberalization.

Of course, it should be kept in mind that the medicare hospital insurance program already has an actuarial deficit for the next 25 years of about $10 billion a year.

Enactment of the hospital cap proposal, with a 5-year sunset provision, would still leave medicare—even under very optimistic assumptions—with an actuarial deficit of $300 to $400 million a year.

Once again, there just are no magic, easy answers.

Again, I hope that witnesses will observe the time limitations established by the committee in order to hear the many witnesses who are scheduled.

It is a pleasure this afternoon to welcome the distinguished Senator from Vermont, Senator Leahy.

Senator, you may proceed in whatever manner you feel appropriate.

Senator LEAHY. Thank you very much, Mr. Chairman. I have a long statement that I would ask your permission to have my full statement be a part of the record.

Senator TALMADGE. You may insert it in full in the record and summarize it in any way you see fit.

Senator LEAHY. Thank you, sir.

STATEMENT OF HON. PATRICK LEAHY, A U. S. SENATOR FROM THE STATE OF VERMONT

Senator LEAHY. It is a privilege to be before the committee. I am sorry that the reason that I am here is necessary, that is, that we are having a hearing on the need to expand home health services for the elderly and the disabled under medicare.

The Senate Finance Committee is considering several amendments to the medicare program which it first considered and some of which it approved way back in 1965. In 1979, its recommendations have still not been implemented.

We are all 14 years older, and there are 1 million more people who have reached the age of 65 and who are eligible for medicare. The Nation is graying fast, and we are not moving swiftly enough to insure that the elderly's needs for short- and long-term care will be met.

We have had hundreds of witnesses come before the Congress, the House and Senate. They have testified not only that home health care is more humane, it is often less costly than institutional care. Numerous studies, Federal and private, have shown that home health services can reduce inappropriate, costly care in a nursing home or hospital.

My own studies in this regard, my own observations in Vermont, bear this out time and time again.

The Congressional Budget Office has reported that:

> Ten to 20 percent of skilled nursing facility patients and 20 to 40 percent of intermediate care facility residents are receiving unnecessarily high levels of care.

The Secretary of HEW, Mr. Califano, has stated that as many as 15 percent of the people in the Nation's acute hospitals alone do not need to be there. This is costing Americans $7 million a day, $2.6 billion a year.

The Secretary has stated that most of these people would be better and more appropriately cared for at home or on an outpatient basis.

I might say that this would be both at great economic and social savings.

Now, in 1979, HEW sent to Congress the home health report that it was mandated to develop pursuant to section 18 of Public Law 95-142. That report cost more than $60,000. It was several months late. Surprisingly enough, it contained no recommendations for legislative improvements in the home health program under medicare.

I cannot help but think, Mr. Chairman, of a farmer who was sitting on his porch, glumly staring into space. A passerby called out to him and said, "How's your cotton this year?"

He says, "Ain't got none. Afraid of boll weevils."

So he says, "What about your corn?"

"Season looked dry, so I didn't plant any."

The neighbor was puzzled and said, "What did you plant, then?"

"Nothing," said the farmer. "I am playing it safe."

I think HEW is playing it safe by not making any recommendations for the expansion of home health care benefits. HEW is not the one to lose out as a result. It is going to be the thousands of medicare beneficiaries who are hurt by this attitude.

In my testimony, I discuss my support for the various provisions of S. 489, a bill which amends Title XVIII of the Social Security Act to expand home health care services under medicare. I am particularly supportive of the provision which would remove the present medicare requirement that the recipient of home health services, require skilled nursing, physical therapy, or speech pathology in order to obtain the services of an occupational therapist in the home.

Part of my testimony deals with a problem which if it persists, might nullify any benefits this legislation could provide the elderly and disabled. That is a problem of restrictive interpretations of home health restrictions on intermediaries.

In order to be eligible for home health services under medicare, they must be homebound, under the care of a physician, require part-time skilled nursing, or speech therapy.

In Burlington, Vt. there is a man who is a quadraplegic, lives at home. A home health aide visits him three times a week and receives skilled care periodically. He is a highly motivated person.

With a specially equipped van, he is able to work 6 to 9 hours a week in a bank. While at work, he has to be assisted by a visiting nurse.

Officials interpreting the medicare regulations do not consider him homebound because he is able to work part-time. In other words, if he was not the least bit motivated to do anything for himself and would stay home, he would be considered homebound and reimbursed under medicare. If he were in a nursing home, those services he requires would be paid for by medicare. Because, notwithstanding the enormous difficulties he has, he wants to make himself a useful part of the community, he is cut out.

Another woman was confined to the home, dependent on the use of her walker. She had a diagnosis of degenerative arthritis with decreased muscle tone, heart disease, depression. She attempted outpatient physical therapy. It required too much assistance from others. She was cited by a physician to receive home services.

Part of the therapeutic plan was to increase socialization. With great effort, the use of a special bus for the handicapped and a companion, she was able to attend the Senior Citizens Club for the first time.

Reimbursement under medicare was then denied because she was no longer considered essentially homebound, although she needed a cane, a walker, a special bus, and a companion. A fairly expensive social call that she paid as a part of her therapy.

Another thing, the care has to be intermittent. Let me tell you of one case where a patient was discharged from the hospital, was to be admitted to a skilled nursing facility, but the patient refused to go to a nursing home and went home. He had a heart attack, was recently diagnosed diabetic, insulin-dependent requiring daily care initially of a nurse and an aide and reimbursement was denied because care was too frequent and did not meet intermittent requirements. This was contested by the billing staff, denied by the intermediary, contested by the nurse, denied by the supervisor. He was sent for further review, finally reversed and paid.

My testimony has example after example of where these things have been done to really frustrate what we are trying to do under

medicare. The guidelines clearly state that the condition of these patients should be such that they have a normal inability to leave home, and consequently leaving their home would require considerable and taxing effort.

The guidelines further state that the individual is expected to be able to leave home without the assistance of a device or individual, yet those people who really need all the help to leave home are denied benefits. Denial of home health services to the elderly and the disabled because of restrictive interpretations of Federal regulations is an easy way to reduce the Federal health bill, but it is not necessarily the just way. In the long run, I am not so sure it saves money at all.

It is unfortunate that the medicare program is crisis rather than prevention oriented. Our country and our culture firmly believes in the concept of personal freedom and personal independence. There are always going to be people who will require full-time care in an institution. Those capable of remaining in their own homes should have the right to stay there. We should do everything possible to make it possible for them to do that.

I think, within this—I am looking at one aspect, as the Senator from a very rural State—where people have very strong ties to their community, they want to stay within their own homes where they are better able to cope. Nonetheless, Mr. Chairman, much of the material I have received raises the same questions in an urban area and I think, while medicare-medicaid has been a very, very valuable concept for this country, I question whether, the way that the regulations are built up, whether people have forgotten what the main purpose of it is.

So I have submitted my testimony. I would be glad to answer any questions.

Senator TALMADGE. Thank you very much, Senator Leahy, for a very fine statement.

Any questions?

Thank you. We appreciate it greatly.

[The prepared statement of Senator Leahy follows:]

STATEMENT OF SENATOR PATRICK LEAHY

Mr. Chairman:

Though it is my privilege to testify before this Committee today, I am terribly sorry to be here. Sorry that yet one more hearing must be held on the need to expand home health services for the elderly and disabled under Medicare.

Today, the Senate Finance Committee is considering several amendments to the Medicare program which it first considered and some of which it approved way back in 1965. In 1979, its recommendations have still not been implemented. We are all 14 years older, and there are a million more people who have reached the age of 65 and who are eligible for Medicare. The nation is "graying" fast, and we are not moving swiftly enough to ensure that the elderly's needs for short and long-term care will be met.

In the past decade, this Committee, the House Ways and Means Committee, and the Senate and House Committees on Aging have held dozens and months of hearings on home health care and other alternatives to care in an institutional setting. Hundreds of witnesses have testified that not only is home health care more humane, it is often less costly than institutional care. Numerous studies, federal and private, have shown that home health services can reduce inappropriate, costly care in a nursing home or hospital. A 1977 study of the General

Accounting Office has found that, "Until older people become greatly or extremely impaired, the cost of nursing home care exceeds the cost of home care."

The Congressional Budget Office has reported that "10 to 20 percent of skilled nursing facility patients and 20 to 40 percent of intermediate care facility residents are receiving unnecessarily high levels of care." These persons could be cared for in their homes if adequate home health services were available in this nation.

The Secretary of the Department of HEW, Mr. Joseph Califano, Jr., has stated that as many as 15 percent of the people in the nation's acute hospitals alone do not need to be there. This is costing Americans $7 million a day, $2.6 billion a year. Mr. Califano has stated that most of these people would be better and more appropriately cared for at home or on an outpatient basis.

It is interesting and sad to note that the Department of HEW has historically been possessed by a schizophrenia, which at times recognizes the need for alternatives to institutional care, but which is extremely reluctant to do anything substantive about it.

Let me give you a few examples. At a 1975 hearing before the House Select Committee on Aging, an HEW spokesman stated, "Our principle objective is to develop a full range of alternatives for those who do not need institutional care . . . Home health care programs have demonstrated an ability to expand the capacity of a (health) delivery system by providing necessary care while conserving scarce and costly resources, both institutional and professional."

A report issued by the Department of HEW in April, 1975, that same year stated, "While the assertion of the efficacy of alternatives may

well be fiscally and socially sound . . . it is equally clear that no comprehensive examination of the subject has been conducted to date. Accordingly, to proceed with the development of a national policy, to encourage or stipulate a major increase in resources and activity, is a risky venture in the absence of more definitive verification of the supposition."

This report goes on to say, "on the other hand, the social and economic pressures for the urgent development of alternatives are also increasing. Any delay in the implementation of a federal policy which is addressed to the issues, may be costly in money and in the health and comfort of thousands of older people."

In 1977, we could not have a national policy developed for home health services again because, "Existing data are not adequate to determine whether increased utilization of home care would decrease or increase Medicare program costs." The then Administrator of the Health Care Financing Administration, Mr. Robert Derzon, goes on to say, that "in our view, this (lack of data) has contributed to a delay in effective policy-making." That is one statement on which I am sure most people can agree. At that 1977 hearing before the Senate Committee on Aging, the Committee was told that HEW would issue recommendations in the next several months.

Well, in 1978, we didn't get those recommendations. In hearings before the House Aging Committee, the Administrator of HCFA stated that it was in the process of preparing a report in the area of home health and alternative long-term care pursuant to Section 18 of Public Law 95-142. This is the infamous H.R. 3 report. In 1978, the excuse

again was that, "in the absence of these analyses, experience shows that care ought to be taken in steps which seek to improve the appropriate utilization of home health services."

The Administrator promised, "The Department is moving ahead to develop a comprehensive national home health policy for consideration by Congress and at the request of Congress . . . a report will be submitted to Congress no later than October 25, 1978." No later than October, 1978, became early to mid-1979, and the long-awaited $62,000 report made no legislative recommendations, "primarily because of budget constraints in addition to serious questions . . . In order to analyze these and other questions, the Department plans to undertake in FY80, a major research effort in the in-home services."

And only yesterday, I understand the current Administrator of the Health Care Financing Administration stated that, "We need more information and a better understanding of these programs."

I cannot help being reminded of the story of the farmer who was sitting on his porch, glumly staring into space, when a passerby called to him, "How's your cotton this year?"

"Ain't got none," answered the farmer. "Afraid of boll weevils."

"Well what about your corn?" asked the passerby.

"Season looked dry, so I didn't plant none."

The stranger was puzzled, and asked, "What did you plant then?"

"Nuthin'," said the farmer. "I'm playing it safe."

HEW is playing it safe by not making any recommendations for the expansion of home health care benefits. HEW is not the one to lose out as a result. It is the thousands of Medicare beneficiaries who are hurt by this attitude. While HEW's data are indefinite, their

is not. As HEW files away its statistics in an old metal drawer, or shuffles them about, so are the elderly and disabled filed into institutions and shuffled around the health care system.

While HEW opposes legislative changes in the Medicare program for home health services as a result of budgetary restraints, I feel it is for this very same reason that we should expand home health services. A dismal one percent of the Medicare budget supports home health services with the vast majority remaining going to more expensive institutional care.

The legislation before the Senate Finance Committee is not costly. The Congressional Budget Office has estimated its total cost at approximately $18 million.

This legislation will increase home health benefits for the elderly and disabled under Medicare. It also includes provisions to assure a more efficient and economical administration of home health benefits.

The Bill would remove the current requirement under Medicare that recipients of home health care be hospitalized for three consecutive days prior to receiving in-home health services. The current requirement has resulted in the unnecessary and costly hospitalization of many elderly people. The present requirement can create a ping-pong effect where a patient goes to a hospital for three days to be eligible for home health, and then returns to the hospital after having exhausted the allowable number of benefits. The removal of the three-day prior hospitalization requirement is especially important in view of our need to contain hospital costs wherever and whenever possible. Its removal would benefit an estimated 1.1 million people.

This legislation, S. 489, would increase the number of home health visits under Medicare Parts A and B (hospital and medical insurance). Medicare beneficiaries are presently limited to 100 visits under each part.

This improvement in the Medicare program will not be costly. Approximately two percent of Medicare beneficiaries exhaust the total number of allowable visits. Yet removing the visit limitation may result in keeping this small percentage of individuals who are in need of additional care in their homes.

An important provision of S. 489 concerns Medicare reimbursement for occupational therapy. Occupational therapy is a rehabilitative service which is used extensively in the medical management of patients who suffer from strokes, heart attacks, cancer, diabetes, and other debilitating conditions. Occupational therapists work with their patients to assist in and speed their recovery or teach them compensatory techniques for daily life independence if disability is permanent.

Occupational therapy is a reimbursable service under the Medicare program when rendered to inpatients in hospitals and skilled nursing facilities, outpatients in clinics attached to approved hospitals and recipients of home health care. A serious restriction on occupational therapy services occurs in the home health area. Here a patient must require skilled nursing care, physical therapy or speech therapy before reimbursement for occupational therapy can be provided. This current restriction is unfair and unrealistic. It frequently denies necessary services for those elderly or disabled citizens who require occupational therapy to remain independent at home and avoid placement in a hospital

or skilled nursing facility. I fully support this provision and would support Medicare coverage of occupational therapy in approved free-standing clinics, although the latter is not covered under S. 489. The Senate Finance Committee has unanimously accepted these particular provisions on two occasions in the past, and the full Senate has three times approved them.

S. 489 also makes several major administrative improvements in the home health care program. Most notably, it further recognizes the significant role that nurse practitioners and physician assistants play in the delivery of health care in rural areas. This Bill would allow nurse practitioners and physician assistants who are under the general supervision of a physician, to establish a plan of care for home health patients living in rural areas.

The Rural Health Clinic Services Act, which Senator Dick Clark and I sponsored in the 95th Congress, has already accomplished a great deal toward alleviating the problems of health delivery in rural areas. Under Medicare and Medicaid the Act provides for the reimbursement of services rendered by physician assistants and nurse practitioners in clinics in rural, medically underserved areas. The Rural Health Clinic Services Act also provides for the reimbursement of the services of visiting nurses rendered to homebound patients in rural areas in which there is a shortage of home health agencies.

This provision of S. 489 is especially important in that it has been estimated that over 50 percent of the rural elderly suffer from continued poor health, 87 percent of rural elderly suffer from some form of chronic illness, and 36 percent of these are compelled to restrict their activities. Further, of the 340 counties in the United

States which do not have a home health agency, all are rural.

I believe that a minimum set of standards should be established for the training of home health aides. S. 489 would allow the Secretary to establish a set of uniform standards. Because uniform standards do not always reflect the particular concerns and needs of rural citizens, however, I would support a plan whereby the Secretary could approve or disapprove of a state's plan for home health aide training.

I believe that utilization review is a concept which should be applied to home health agencies. This is already the case in my own State of Vermont.

One section of S. 489 with which I disagree is the establishment of a uniform reporting system for the billing of a home patient on a bi-monthly basis. While I agree that patients should be adequately informed as to the types of services provided, and other such information, to do this on a bi-monthly basis would impose a great administrative burden on rural and small home health agencies which serve a geographically diffuse population. Some home health agencies in Vermont are already expending 30 percent of their time on "paperwork" and this takes time away from patient care.

S. 489 also addresses the present inequity in administrative and reimbursement practices for home health care by requiring the Secretary of HEW to designate regional intermediaries specifically for home health care. There have been great disparities in reimbursement practices for home health care in this nation. This is partly due to the fact that home health service claims represent a low-volume item for most fiscal intermediaries. Often they do not have the time, nor skills to do an adequate review of home health claims. It is my sincere hope that the

nature of home health practice, whether urban or rural, will be taken into consideration when regional intermediaries are designated.

Mr. Chairman, I would now like to discuss a problem which, if it persists, might nullify any benefits this legislation could potentially provide. The problem of restrictive interpretation of regulations on the part of intermediaries and on the part of HEW is obviously one that has affected many states, as evidenced by the May, 1979 resolution of the National League for Nursing that, "the membership of this convention (should) request the Board of Directors of the National League for Nursing to write to the Secretary of HEW requesting the creation of a task force with representation of the Council of Home Health Agencies and Community Health Services to review and make recommendations on the interpretation of the (home health) reimbursement regulations."

As you know, Medicare beneficiaries must be homebound, under the care of a physician and require part-time or intermittent skilled nursing and/or physical or speech therapy to receive home health services. The problems arise when intermediaries interpret what constitutes "homebound" "skilled nursing" services, and "intermittent care", to name a few.

Let me give you a few examples. Marcel Carrier, a quadraplegic, lives at home. A home health aide visits him three times a week, and he receives skilled care periodically. He is a highly motivated person who, with great effort, including a specially equipped van, is able to go to work for six to nine hours a week in a bank. While at work, he must be assisted by a nurse or nurse's aide. Officials interpreting

the Medicare regulations do not consider Mr. Carrier homebound because he is able to work part-time. Were Mr. Carrier an unmotivated person, he'd be considered homebound and reimbursed. The greatest irony of it all is that were Mr. Carrier in a nursing home, the services he requires would, of course, be paid by Medicare.

The Medicare guidelines clearly state that "the condition of these patients should be such that there exists a normal inability to leave home, and consequently, leaving their homes should require a considerable and taxing effort." The guidelines further state that the individual is expected to be unable to leave home without the assistance of a device or individual. If Mr. Carrier is not essentially homebound, I'd like to know who is.

Another Vermonter was confined to her home and dependent on the use of a walker. She had a diagnosis of degenerative arthritis with decreased muscle tone, heart disease and depression. She had attempted outpatient physical therapy after hospitalization but required too much assistance from others to get out of her home, and the effort was extremely taxing. It was decided by her physician that she should receive home services. Part of the therapeutic plan was to encourage socialization. With great effort, use of the special bus for the handicapped and a companion, she was able to attend the Senior Citizens Club for the first time. Reimbursement under Medicare was then denied for she was not considered essentially homebound, though she needed a cane, a walker, special bus, and a companion. This was an expensive social call for this woman.

In another realm, according to Medicare regulations and statute, care must be intermittent, that is usually for a few hours a day, several times a week and occasionally for short periods of intense care. Let me give you an example of where Medicare coverage was denied in this instance. A patient was discharged from the hospital and was to be admitted to a skilled nursing facility, but the patient refused to go to a nursing home and was sent home. The patient had a heart attack and was a recently diagnosed diabetic, insulin dependent, requiring daily care initially of both a nurse and an aide. Reimbursement was denied because care was too frequent and did not meet intermittent requirements. This was contested by the billing staff and denied by the intermediary, contested by the nurse, and denied by the supervisor and other personnel. It was sent for further review and finally reversed and paid. A great deal of time, energy, and frustration to erode the value of the services the home health agency was struggling to provide.

Medicare coverage for the terminally ill is often denied reimbursement by intermediaries for several reasons: that the care rendered was "too custodial" that is, maintenance care, that the care which was rendered was on "too frequent" a basis. Part of this problem has resulted from the acute care orientation of Medicare. As soon as a patient is stablized, Medicare reimbursement is denied. What happens is that the condition of some patients deteriorates, and further hospital admissions are required and further intensive home services. Monitoring and evaluation visits should be covered under Medicare.

Some of the regulations governing Medicare home health reimbursement require more than medical knowledge to interpret. Home health agency nurses are expected to be modern day Solomons. Regulations state that documentation for Medicare home health claims must show "that the reasonable probability exists that significant changes may occur, that there is a medically predictable recurring need for skilled care, that care is reasonable and necessary. The range of differing opinions as to whether a patient requires "skilled nursing care" is tremendous."

Let me share with you one final example of difficulties in regulation interpretations. One agency in Vermont received a letter from its intermediary saying that services it provided to a terminally ill patient were "too skilled" for home health agency level of care, and that the patient belonged in a hospital. The family, the physician, the patient, and the nurse had determined that home care was appropriate for this person. The decision was appealed in the Region I Office of HEW. In rejecting the claim for coverage HEW stated, "We note that the American Nurses Association standards of nursing practice Standard 2, Assessment Factors Area calls for the nurse to compare the patient's health status to the norm and to determine the deviation and the direction of the deviation from the norm, and to identify the patient's capabilities and limitations, and to make diagnosis related to and congruent with the diagnosis of all the other professionals caring for the client patient. We believe that these are services primarily reserved to the physician, except in highly structured, closely supervised situations, such as a hospital intensive care situation." This letter was not written by a physician or a nurse. I question whether HEW has the right to dispute with the definition of professional nursing practice.

A local Vermont physician, who is also Chairman of the Utilization Review Committee for the local hospital, wrote in the Agency's defense, "I have been appalled at the capricious, irrational, inconsistent, and destructive review procedures that this home health agency has been subjected to in the past few months. Many of the patients denied coverage for services were acutely ill and could not have survived in their home environments without the assistance and supervision of home health nurses.

"One particularly troubling interpretation of "proper utilization" has been invoked to deny coverage. This has been to state that these nurses have been providing services that should have been provided by a physician. This group of nurses possess a high level of professional nursing proficiency. They are closely supervised and maintain close contact with referring physicians. In several cases with which I have been directly involved, coverage was denied on this ground in spite of the fact that I specifically requested the services, relied on the nurses' findings, and utilized these nurses to provide care for people with unstable illnesses. If I, who was directly supervising the clinical situation, did not feel that the nurse was practicing beyond her ability, how could a reviewer legitimately reach this conclusion and deny essential services?"

This particular agency in the six-month period beginning in January, 1978, had as many home health Medicare claims denied as it had in the entire seven-year period before.

Mr. Chairman, the denial of home health services to the elderly and disabled because of restrictive interpretations of federal regulations, is an easy way to reduce the federal health bill. But

it is not necessarily the just way. It is unfortunate that the Medicare program encourages institutional care rather than home health care, despite studies which have shown home health care to be less costly and certainly more humane.

While the legislation I have sponsored with Senators Domenici, Packwood, and Chiles is not perfect in that even more expansion of home care would be desirable, I feel that it is a major beginning toward reversing the institutional bias which prevents the Medicare program from meeting the health needs of Older Americans and the nation's disabled.

Our country, our culture, strongly believes in the family life, the homelife, the concept of personal freedom and personal independence. While there will always be persons who require full-time care in an institution, those capable of remaining in their own homes should have the freedom, the right to choose where they shall be cared for.

Mr. Chairman, because Vermont is the third highest utilizer of home health in the nation, I ask that the testimony of the following Vermont organizations be submitted into this hearing record: Vermont Assembly of Home Health Agencies, Vermont Department of Health, Vermont Department of Social Welfare, the Orleans and Northern Essex Home Health Agency.

I further request that the hearing record be kept open until such time as I have received and have had an opportunity to review and comment on the recommendations which the Public Health Service made to the Health Care Financing Administration on home health policy. It is my understanding that the Public Health Service addressed several of the areas of concern I have mentioned today, and that the Health Care Financing Administration did not accept these recommendations.

I appreciate having had the opportunity to testify before you today, and I encourage you wholeheartedly to adopt the provisions of S. 489, amendments to Title XVIII of the Social Security Act.

Vermont Assembly of Home Health Agencies, Inc.

37 School Street ~~P.O. Box 603~~ — Tel (802) ~~479-2355~~ 229-0579
Montpelier, ~~BARRE~~ VERMONT ~~05641~~ 05602

May 18, 1979

Senator Patrick J. Leahy
1203 Dirksen Building
United States Senate
Washington, D.C. 20510

Re: S489

Dear Senator Leahy:

The Vermont Assembly of Home Health Agencies wants to express its appreciation for the efforts being made on behalf of home health, and to express its overall support for S489.

The bill reflects a variety of issues and the Board did have several concerns regarding the following:

Nurse practitioners

- regarding the issue of allowing nurse practitioners "...and physician assistants, under the general supervision of a physician, to establish a plan of care for home health patients living in rural areas." The Assembly questions the legality relative to state nursing and medical practice acts.

HHA Training

The Assembly questions whether it wouldn't be better for individual states to set their own training standards rather than mandating federal standards which might not be uniformly applicable.

The proposed uniform reporting system appears cumbersome in the specifics it requires,i.e. the provider's name, time of day of visit. If adequate rationale were given for these items, the Assembly would consider supporting them. The Assembly, however, cannot support the system being on a bi-monthly basis. The necessity of reporting every two weeks would add a considerable burden to our home health agencies.

Demonstration project

The Assembly not only supports the concept of ~~uniform reporting~~ for home health, but all agencies in Vermont already have ~~uniform reporting~~ programs in place. If this is not so in the rest of the country we support the concept of developing it. Our objection would be to duplicate existing efforts.

As requested, the Assembly Board also discussed problems with the current Medicare regulations. Basically the Assembly supports comments already made by several of its individual members; to be specific:

1. There is grave concern over the current interpretations of regulations by the intermediary. They are not only very restrictive but seem to represent some arbitrary changes in previous interpretations. Primarily these include interpretations of the terms "skilled nursing," "homebound," "intermittent care," "preventive," and "maintenance." All of these terms have impact on our reimbursement for services provided within the limits of current regulations.

   Examples of problems include:

   a. designating some care as "too skilled"

   b. not considering assessment and physical examinations to be "skilled nursing"

   c. considering trips to physicians' offices to render a patient non-homebound

   d. daily visits for treatments are rejected as not being intermittent

   e. terminal care is denied as being maintenance

   f. some treatments being considered preventive - case cited - physical therapy visits to prevent contractures. Payment would be possible to pay for treatment of contractures. The

treatment would be more costly and painful for the patient than the prevention.

2. The results of these changed interpretations are having significant financial impact on agencies' abilities to provide care as a result of:

   a. loss of waivers

   b. denial of payment for services rendered.

3. One other frustration is the refusal of the intermediary to acknowledge these interpretations as changes.

4. The Assembly also would like to document its concern for the ability of home health to expand or increase its capabilities to provide alternatives to institutionalization unless there is a change in the overall commitment of the Medicare program. The current regulations restrict care to treatment of acute illness only. In order to decrease institutionalization (and therefore - cost of health care) Medicare regulations must address home treatment of the chronically ill and disabled, and preventive care.

Sincerely,

Mary F. Taylor

Mary F. Taylor
Administrator

MFT:cl

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF SOCIAL WELFARE
MONTPELIER 05602

May 16, 1979

The Honorable Patrick J. Leahy
The United States Senate
1203 Dirksen Office Building
Washington, D.C. 20510

Dear Senator Leahy:

As you are aware, the Vermont Department of Social Welfare and the Vermont Professional Standards Review Organization have worked together under a Medicaid Demonstration Project during the past two years. One of the purposes of this project was to conduct an intensive review of patients in nursing homes in order to assess (1) the needs of those patients; (2) the quality of services rendered to meet those needs, and (3) each patient's potential for discharge into a home care situation. The results of this activity tended to confirm something we have always suspected was true: that for a significant percentage of patients in Vermont nursing homes - perhaps as high as 10-20% - the necessity for institutionalization is not a function of medical care management alone, but also a function of the availability of home support resources. The extent to which the latter of these two functions determines the decision to "institutionalize" a patient is difficult to measure, but the fact that it operates to any significant degree is disturbing when Vermont's nursing home beds are in excess of 95% occupancy and several Vermont hospitals have patients "backing-up" while awaiting appropriate nursing home placement. In addition, recent surveys of community care homes by the State Departments of Health, and Social and Rehabilitation Services, suggest that there are a number of residents of these facilities whose medical needs are not now adequately managed, thus placing them at great risk of hospitalization. Even when we are successful at discharging a patient back into the "community", the lack of a well organized, and well funded, resource to be accountable for meeting that patient's needs can often spell rapid deterioration and subsequent re-institutionalization. Such a sequence of events raises the legitimate question as to whether it might not have been better to leave the patient in the institution in the first place. Community based accountability for establishing and managing patient plans of care is an important prerequisite for maximizing independent living potential and insuring continuity. Use of nurse practitioners and physician assistants in this context should be explored.

There is no one simple answer to this problem, but we do believe that a strong and accountable home health network is a major part of the solution. We are taking steps within the Vermont Medicaid program to test this proposition. The test will be characterized by removing as much regulatory constraint as possible from Medicaid home health reimbursements while still retaining a financial "cap". We intend to create a home health program wherein selected agencies will have considerable freedom to determine the scope and frequency of home health benefits for patients defined as "at risk" of institutionalization. The quality and necessity of services rendered will be carefully monitored by the State Health Department, and comparisons will be made to the relative cost and results of keeping a similar mix of patients in a nursing home.

Unfortunately, Medicaid by itself cannot have a large impact on home health services. Medicaid's responsibility and subsequent concern for the care of the chronically ill has not been matched by Medicare, which tends to tailor it's home health policy to acute illness only. In the area of home health, if no other, it seems to make sense to consider broadening Medicare benefits to match the coverage possible under Medicaid. This would ultimately mean not only adopting the provisions of S.489 with regard to scope and duration of benefits, but also considering relief from the restrictions on "homeboundness" and "skilled service". We are realistic enough to recognize the volume of increased expenditures which could occur in the Medicare program as a result of dropping those latter restrictions, however, we do believe that careful program planning now can save us money in future years. If it were done, certainly some additional methodology would be required in order to keep effective controls on expenditures. A combined Medicare/Medicaid project conducted under carefully controlled circumstances in a limited geographic area, would have the potential of truly testing the potential impact of a well organized home health system.

We further suggest that the administrative and billing requirements be carefully tailored to place as little "paper work" burden as possible on the home health agencies. Such burdens are a real problem in rural areas served by smaller home health agencies which must cover a geographically diffuse population. Although we do support having both Part A and Part B coverage paid by the same fiscal intermediary, we do not believe that the concept of a regional fiscal intermediary and twice-a-month billing contributes to more efficient delivery of services or to cost effectiveness.

This is not suggesting an unbridled expansion of home health benefits with no regard paid to the cost or potential abuse of such services. We unequivocably support the need to examine the quality and necessity of home health services and the need to employ strict analyses of expenditures as reflected in S.489. It is to suggest that by working together we could construct a more imaginative Federal/State approach to home health care than we have evidenced in the past. Certainly S.489 takes a step in the right direction, and we offer the possibility of the State of Vermont's being used as a test area see if still another step might be feasible.

Sincerely,

David M. Wilson
Commissioner

DMW/rfa

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DEPARTMENT OF HEALTH
60 MAIN STREET
BURLINGTON, VERMONT 05401
(802) 862-5701

May 17, 1977

The Honorable Patrick J. Leahy
United States Senate
Washington, D. C. 20510

Dear Senator Leahy:

Thank you for the opportunity to comment on S.489 which you and Senator Domenici have introduced. Dr. Novick and I have discussed S.489, and he has requested that I reply in his behalf. As Home Health legislation has not been revised since 1975, it is appropriate that legislation be introduced to more clearly define the parameters and quality assurance aspects of Home Health Services.

My comments are as follows:

1. Elimination of 3-day prior hospital requirement

I fully subscribe to this revision. Not only will it decrease the burden placed on an individual, it will also save the cost of a 3-day hospital charge, which is unnecessary in many cases and done just to meet current regulations.

2. Unlimited Home Health Visits Under Parts A and B

Again, I fully support this change.

3. Occupational Therapy

This revision would permit expanded utilization of this service, which in many cases could assist clients to achieve a higher degree of independence in activities of daily living. If other Skilled services are being provided, a mechanism must be in place which insures this service is integrated into the patient's total care plan.

4. Physicians Assistants and Nurse Practitioners

In general, I support this concept. However, caution should be taken in defining the parameters of practice. The role of these physicians extenders must be clearly stated so that the following conditions do not occur: the roles of the physician is usurped, the physician extenders practice outside the

framework of their licenses, and overutilization of these services is permitted to occur.

5. Regional Intermediaries

The present system works well for Vermont. We have not encountered any problems dealing with our fiscal intermediary. In fact, we have found them to be very specific in addressing any questionable charges. Therefore, we would support continuation of our present arrangement.

6. Training for Home Health Aides

An excellent proposal, it will provide uniformity of service and assure some aspects of performance standards. It is my understanding that DHEW is field-testing a model curriculum developed by The National Council for Homemaker-Home Health Aide Services. Results of this demonstration may provide a basis for any training program that might be developed for approval.

7. Demonstration Projects for Utilization Review

This is a timely recommendation.

8. Duties of the Secretary

Items 1 through 5 are all consistent in providing the Health Care System with necessary evaluation tools and cost containment processes as relates to Home Health Services. However, I question whether bi-monthly billing, as described in item 6, will achieve its stated purposes. The current billing method works well in Vermont. Some of our smaller Agencies can presently accomplish this with part-time help. If the paperwork burden is increased, it will necessitate increasing costs at the local level which will result in increased cost to the patient or third-party payer. Therefore, I question if this requirement will reduce cost or will, in fact, increase it.

As S. 489 is currently under consideration, I respectfully request that consideration be given to eliminating the homebound and Skilled Nursing requirements so that Home Health Services can have more flexibility in meeting the needs of the long-term chronically-ill population, which at present is not receiving the attention it deserves.

Thank you again for the opportunity to respond to this proposed legislation. If you should have any questions regarding my reply, please do not hesitate to contact me.

Sincerely,

Carolyn J. Harris

Carolyn J. Harris
Chief, Medical Care Facilities
/ec
cc - Lloyd F. Novick, M.D., Commissioner

Orleans and Northern Essex
Home Health Agency, Inc.
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Newport, Vermont 05855
Tel 802/334-7897

Part-Time Skilled Nursing
Physical Therapy
Home Health Aids
Maternal Child Health

Nancy Linstad, B.S., R.N.
Executive Director

#2364

May 11, 1979

Patrick J. Leahy,
United States Senator
United States Senate
Committee on Appropriations
Washington, D.C. 20510

Dear Senator Leahy:

The Orleans & Northern Essex Home Health Agency has been providing services for the past 10 years in an area which is economically deprived and is most rural in nature. In many instances, communities have available to them, only the services of home health. We have a population that readily accepts receiving care in the home. Despite the above, home health care is severely hampered for several reasons; those I will list later. Our agency employs 10 staff nurses to cover our assigned territory. It is distressing to find that only 70% of their time can be utilized for care, the remainder of time on "paper" work. We are further frustrated by the fact that although we employ highly qualified professionals, the decision for level of care, or, in fact, if care is needed at all, is made by the whim of the staff of our intermediary several miles from the actual setting of care.

We are pleased that you, along with your collegues, are looking into the home health delivery system and how to better utilize it. We certainly support your efforts.

Our comments on Bill 8.489 are as follows:

1. Support removal of 3 day hospital requirement for home health services, without limiting number of visits available.

2. Training requirements for home health aides by Secretary of HEW. Feel this could be harmful and would not necessarily meet needs of individual states or localities. Better this type of regulation be left to individual states. Home Health has demonstrated its ability to deal with this locally (ie. Vermont developed criteria and standards for training aides).

3. Utilization review for home health. Strongly support that utilization process be available, however, feel presently that home health is carrying out Utilization Review. Our agency has

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Executive Director

a review team made up of membership of professionals not involved in the agency. This is carried out quarterly with written report of findings submitted to the Board. Someone has to pay for regulatory activities carried out by our government, and this increases indirectly the cost of all direct services.

4. Billing System: We certainly support a uniform billing system for home health, however, to impose a bimonthly system on agencies the size of ours would increase our support costs dramatically. We question the necessity of this. Also, the additional documentation of time of service, length of visit and to specify what nurse are additional items that must be monitored for completeness, etc. on both daysheets and billing forms. Again, the value for this information in relation to the increased cost of carrying out is questionable.

5. Establishment of "Reasonable Cost Guidelines". The problem of such guides is determining what is reasonable for the multi locales that provide home care. We have found that our agency must pay premium prices for specialties if we desire to provide speech and physical therapy. In addition, line items such as mentioned in the Congressional Record (ie. gas) are tightly controlled by local charges, distance to provide services, and square miles in Agency catchment area. Both the wage scale and the benefit package of our agency has been lower than that of the State Nursing Service (Health Department). Disclosure of items mentioned is already carried out by our agency.

If the intent is to support the concept of providing care in the homes as a rational approach to conservation of health dollars and in maintaining "quality of life" for persons capable of remaining in their homes, we propose the following:

1. Removal of the word "skilled" from nursing service. All nursing care is skilled.

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Executive Director

2. Providing reimbursement for services provided for the terminally ill in the home.

3. Removal of the restriction of "homebound" and allow for office visits at a reduced charge.

4. Remove the authority of intermediary to summarily deny claims when local physicians certify care is needed. Also, the ability of intermediary to determine length of stay a person needs with home health.

In summary, we support any efforts that will strengthen the delivery system of home care services. Our society has allowed the development and support of systems that isolate the patient from his environment, his family and himself. It is of utmost importance to support our system in a manner that contiues the strengths inherent in our system and addresses the problems that curtail the services we are capable of providing. Already, we are burdened with restrictive regulations and documentation of compliance of same. Our agency expended 30% of its professional hours on documentation of services provided. We are proud of our tradition to provide quality care.

We thank you for your support enabling us to continue this tradition.

Sincerely,

Nancy Lillicrap

Nancy Lillicrap,
Executive Director

NL/bhh

enc.

Senator TALMADGE. We have a long list of witnesses this morning. We will be interrupted, I know, with votes from time to time. It will be necessary to restrict witnesses to 6 minutes.

The next witness is Ms. Ruth E. Coan, director, alternative health services project, State of Georgia, Department of Medical Assistance.

Ms. Coan, we are delighted to see you and appreciate your coming up. I know what a fine job you are doing in my home State. I am very proud of it.

Ms. COAN. I appreciate the assistance you have given to us.

Senator TALMADGE. You may put your full statement in the record.

STATEMENT OF RUTH E. COAN, DIRECTOR, ALTERNATIVE HEALTH SERVICES PROJECT, STATE OF GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Ms. COAN. Thank you, Senator Talmadge. Your interest in the provision of quality home health care has been gratifying.

My name is Ruth Coan. I am director of the alternative health services project which is sponsored by the Georgia Department of Medical Assistance.

What I would like to do today, is to first provide an historical overview of the project's development and then, based on experience with implementing this project, I would like to make some general recommendations with regard to what we believe to be the necessary elements for the provision of quality, and cost-effective community-based health care.

Georgia Governor George Busby, in 1975, identified several confounding medicaid problems. First, there were spiralling medicaid costs. Second, a disproportionate share of the medicaid dollar was being spent on a very small percentage of Georgia's population. And, third, national statistics were indicating that up to 40 percent of the persons in nursing homes actually did not need this care, but were seeking nursing home care simply because there were no other alternative available to them.

As a result, Governor Busbee sought from HEW an 1115 waiver to allow the State to implement a new project which could address some of these issues. The waiver that was granted allows the State of Georgia to use medicaid funds to pay for services which are not traditionally covered under the medicaid program.

The intent of the project is to evaluate the cost and health impact of these new alternative services.

The alternative health services program, at present, has been functioning for about 3 years. It is operating in 17 of the State's 159 counties. These counties account for approximately one-third of the over 65 population of the State.

The project provides three basic types of services: Alternative living, services, home delivered services, and adult day rehabilitation services. These services resemblances other federally funded program services. But, an important distinction is that they are all funded out of the medicaid program.

Briefly, adult day rehabilitation is a type of day health care program which must include physical therapy, speech therapy, medically related transportation, and home delivered meals. Alter-

native living services include boarding care and foster care, but must include medically related transportation, and chore services as well as the traditional home health services.

Clients eligible for our program are those persons who are 50 and over, medicaid eligible and, according to Georgia medicaid nursing home certification criteria, qualified for nursing home coverage under the medicaid program.

I would like now to overview some of the components which I feel are important to any community-based health care program. I would also like to note that, while the need for some of these components seem quite obvious, in fact they are not components of most community-based health care programs at this time.

First, our recommendation is to review applicants prior to service and to determine the approximate cost of these community-based care services as compared to nursing home care. Then, based on that estimation, make an appropriate referral. The necessity of this approach stems from the fact that the services we are speaking of today are desirable and attractive, therefore, many persons are interested in accessing these services. Yet, the reality is that, in some instances, the cost of maintaining some of these persons in the community would far exceed the costs of nursing home care.

Second, our recommendation is that any community-based program should be governed by precise service definitions, guidelines, and manuals to asure quality services provision. This recommendation stems from the reality that though most providers are interested in providing quality care, the capability of providers to design and implement services varies significantly.

In conjunction with this recommendation, the project advocates the provision of utilization reviews by an outside evaluator to assure an impartial, unbiased review of adequacy and quality of services. The outside evaluator, as part of its role, should look at the quality of service being provided as well as the appropriateness of the amount, duration and scope of these services.

Additionally, the timeliness of providers accepting client referrals and initiating services as well as the effectiveness of discharge planning should be a part of the utilization review.

To maximize the impact of Federal dollars—which I acknowledge are limited—we need to work as closely as possible with other Federal programs which are attempting to provide similar services. For example, medicaid needs to mesh its efforts with title XX and title XVIII of the Social Security Act and title III of the Older Americans Act.

In our efforts to accomplish this integration of services and to avoid duplication and overlapping of efforts, we have had great difficulty adhering to Federal regulations for all of these programs at the same time because they are in conflict with each other.

To achieve programmatic coordination, I would, therefore, recommend the appointment of a panel of Federal officials to provide technical assistance to projects such as ours and to facilitate programmatic coordination.

Thank you very much.

Senator TALMADGE. Thank you very much for a fine statement. I have a few very simple questions.

What are the relative costs to Georgia of keeping someone in a nursing home in contrast to keeping them home under the alternative health services program?

Ms. COAN. The average cost to medicaid for nursing home care is approximately $500.

Senator TALMADGE. Per month?

Ms. COAN. Per month. The average client cost to medicaid for alternative health services has been about $170. The range is from approximately $135 per month for home delivered services to approximately $240 for those clients who receive a combination of home delivered services and adult day rehabilitation.

The above figures, it should be explained, are preliminary, since the project is in the beginning stages of data generation. The final research document is not due for approximately 1 year.

I would also like to say that we have designed our program in such a way that we have both a service and control group. This allows us to make some very careful estimates of what the cost of alternative health services are versus what the cost of regular medicaid services tends to be when alternative health services are not available.

Senator TALMADGE. Do you have any information as to changes in mortality rates or the health status of those who are institutionalized versus those who have received alternative health services?

Ms. COAN. Yes, we do. We looked at statistics 6 months after enrollment of clients in the program as well as statistics of those in the control group. Those persons receiving alternative health services have a mortality rate which was one-third of that of the control group which had access to the regular medicaid services but not to alternative health services.

Senator TALMADGE. Does Georgia regard the alternative health services program as a success and do you have any plans to expand?

Ms. COAN. At this point, we are quite pleased with the results of the project although, of course, we do have another year before the final research document will be complete. The responsibility of the project at this point is to develop a statewide implementation plan which will be submitted to the Department for consideration by the general assembly for the fiscal year 1981 budget.

Senator TALMADGE. One of the real problems, one of the real tragedies, is that many of those who live in rural areas need supportive services, but do not get them. Does the program in Georgia reach out to the rural population?

Ms. COAN. Yes. The design of our project was to assure that we would be both testing the services in urban areas as well as rural areas. Part of the geographic area we are serving is very rural.

We have been very pleased with the success of the project, particularly in the rural area where we have attempted to provide services which, heretofore, were not available.

This would include, trying some innovative approaches to providing adult day rehabilitation services, boarding care, special diet home-delivered meals, and medically related transportation. In these areas we feel we have succeeded and we are pleased with the results.

Senator TALMADGE. You, no doubt, are familiar with the program that they have in New Mexico where they are training people on welfare as home health aids under the work incentive program. I understand they are doing an outstanding job there.

I understand Georgia hopes to adopt a similar program. Is that correct?

Ms. COAN. That is my understanding.

Senator TALMADGE. The program takes people off welfare and train them for useful service at the same time.

Ms. COAN. Such a program has considerable potential since so many home health agencies indicate that one major problem is that they have not been able to hire enough persons to provide necessary services. I think all would benefit by such a program.

Senator TALMADGE. Thank you very much. Are there any further questions?

Senator Packwood?

Senator PACKWOOD. It was very interesting testimony.

Ms. COAN. Thank you very much.

Senator PACKWOOD. Some of the best we have had.

In response to Senator Talmadge's question, he asked about cost of nursing homes versus the HHA's cost. You responded with the $500 average figure for nursing homes, and the $135 to $240 range for HHAs.

You have those figures in your testimony, but you referred to the nursing home care as that of an intermediate care facility. I am curious if that is what you mean by a nursing home.

Ms. COAN. Yes. We have two types of nursing homes in Georgia; intermediate and skilled, because we felt that the majority of our clients would more appropriately be in intermediate care as opposed to skilled care, we compared the two.

Senator PACKWOOD. Which two?

Ms. COAN. Intermediate care costs to those of AHS.

Senator PACKWOOD. The intermediate care facility is not a skilled nursing home?

Ms. COAN. No; intermediate care is a lower level of nursing care.

Senator PACKWOOD. If you were talking about a skilled nursing facility, you would have a substantially higher cost.

Ms. COAN. In reality, in Georgia the difference between reimbursement between the two is not very different, at least in intermingled facilities. In some States, there is a large difference; in Georgia, there is not.

Senator PACKWOOD. That is very impressive. I would appreciate it if you would keep my office personally advised as you have more data coming in and your universe gets larger.

Ms. COAN. There will be an annual report that will be submitted in the next month and a half. I will be glad to send you a copy.

Senator PACKWOOD. Do send it to me personally. I would appreciate it. This is very conclusive information.

Ms. COAN. Thank you.

Senator TALMADGE. Thank you very much, Ms. Coan. We appreciate your contribution.

[The prepared statement of Ms. Coan follows:]

SUMMARY STATEMENT
Ruth E. Coan, Director
May 22, 1979

The goal of the Alternative Health Services Project (AHS) is to test the effectiveness of a comprehensive set of Medicaid funded, community-based services as an alternative to nursing home care for the elderly. The services provided under the project include: Alternative Living Services (adult foster care, boarding care, congregate living); Home-Delivered Services (home health services and personal care assistance); and Adult Day Rehabilitation (ambulatory health care and health-related supportive services in a day center).

Preliminary data analysis by AHS suggests that community-based services are less costly than institutional care and that they have reduced the mortality rate of AHS clients. As a consequence, the project strongly supports the expansion of federally funded health and health-related support systems for older persons who, without access to these services, might be inappropriately institutionalized. The AHS Project believes, however, that much of its success to date is directly attributable to the strict controls it has developed for program administration and service delivery.

Maintaining a person in the community is generally considered preferable to institutional care, but it is not always better than institutional care, nor is it always more appropriate or more economical. The full range of client needs cannot be met, for example, if there are not sufficient resources available in the community. Further, the needs of some persons may be so extensive that the cost of maintaining them in the community can be as much as two to three times that of nursing home care. Therefore, the selection of the most appropriate level of care must always be based upon individuals' needs and the availability of adequate support systems to enable them to remain in the community.

The development of adequate community-based health and health-related support services requires that attention be directed to the very real difficulties in administering home delivered services. Specifically, provisions must be made for tighter controls on both the costs and quality of service provision. A well-defined intake and case management system must be developed to assure service delivery to those in greatest need and to asssure that the appropriate array of alternative services is provided. Assistance in coordinating all available funding resources to maximize service impact must be given to providers by the project. All of these elements are essential if clients are to receive a full range of quality services which are necessary for the successful maintenance of individuals in the community. Further, these controls must be present if the services are to be delivered in the most efficient and cost effective manner.

TESTIMONY
MAY, 1979

I am Ruth Coan, Director of the Alternative Health Services Project of the Georgia Department of Medical Assistance. Mr. David Poythress, the Commissioner of the Georgia Department of Medical Assistance, and I appreciate this opportunity for me to speak to you about our system of community-based care that we have developed under "1115" waiver from the Health Care Financing Administration (HCFA).

HISTORICAL BACKGROUND

Late in 1975, Georgia, like many other states, was faced with spiraling increases in Medicaid costs for long-term care of the elderly. Cognizant of the fact, however, that national statistics indicated that up to forty percent of the institutionalized elderly were receiving nursing home care because of the lack of adequate alternatives, the state sought and received an "1115" waiver from HCFA to develop a community-based comprehensive system of health and health-related supportive services. It was the project's intent to provide a comprehensive system of community-based care to older persons wishing to remain in the community but who without supportive services would require nursing home care. Further, the project sought to determine whether such a community-based system for long-term care could be cost effective.

Since July of 1976, the AHS Project has worked to develop a comprehensive system of alternative services not only to investigate the project's research hypotheses, but also to lay the groundwork for expanding Medicaid coverage for community-based long term care in Georgia, and hopefully, nationwide. To date, the project has designed a carefully conceived intake and referral system for clients "at risk" of requiring nursing home care. Administrative controls have been imposed on the service delivery system to assure that quality services are being provided. Further, the overall design of the project permits the collection and analysis of reliable longitudinal data on costs, effectiveness, and utilization of alternative services.

The preliminary data presented in this report indicates that the system developed by AHS has the potential of being cost effective while having a positive impact on the health of the clients served. For example, data collected thus far reveal that the average AHS service costs have been significantly lower than those for nursing home care and that mortality rates of clients receiving project services have been lower than those of the control group.

PROJECT OVERVIEW

The goal of the Alternative Health Services Project (AHS) is to test the cost and effectiveness of comprehensive, Medicaid funded community-based services as an alternative to nursing home care for the elderly. The major services offered by the project include:

- o Adult Day Rehabilitation which provides ambulatory health care and health-related supportive services within an adult day center for clients who cannot live independently and do not need 24-hour care.

- o Home Delivered Services which provide traditional skilled home health services and personal care services in the client's home along with home delivered meals and special med cal equipment and appliances for clients who otherwise could not remain at home.

- o Alternative Living Services which provide personal care services and supervision in adult foster care, boarding care, or congregate living arrangements for clients who are unable to remain in their own homes independently.

All clients receive medically-related transportation. Clients may be offered one or a combination of AHS services. Additionally, clients are assisted in locating and utilizing health and health-related services provided through other community-based service agencies.

All AHS clients are Medicaid eligible, age 50 or older, and either reside in a nursing home or have been certified as eligible for nursing home care. To date, there are approximately 1,000 clients in the AHS service and control groups. The number of clients added each month is between 30 and 50.

The AHS Project serves the elderly populations of two of the state's ten districts designated by the Georgia Department of Human Resources for the delivery of state social services. District III, the Metropolitan Atlanta area and District X, the Athens area together account for 17 counties and range in population density from crowded, inner city neighborhoods to isolated rural communities. The elderly population of these two districts is more than 30% of the total state elderly population.

All potential clients referred to AHS from the community at-large and service agencies receive a health and social needs assessment. Data is collected using a standardized assessment interview designed by the project. Those persons who are selected as appropriate for alternative services are randomly assigned either to services or a control group. Specifically, 75 percent are referred to service providers, and 25% are assigned to a control group. Although the control group persons do not receive AHS services, they may utilize the routine and customary services that exist within the community and which are available through regular Medicaid. The existence of the control group is critical to the project because it allows AHS to compare the effectiveness of project services with nursing home care and other services ordinarily available in the community.

PROJECT HYPOTHESES

A major hypotheses is that the nursing home utilization rate will be lowered and the growth in the Medicaid-financed nursing home population will be slower as a result of the availability of alternative services. To this end, AHS gathers client data on utilization of nursing homes, project services, and other community-based services. Data sources include regular Medicaid and Medicare billing tapes, Title XX service records, and the AHS client interviews.

It is further hypothesized that alternative health services have an equivalent or greater positive impact than nursing home services on the health of clients who have the capacity to be self-sufficient. To test this hypothesis, functional health status and client satisfaction data are collected at six-month intervals for both the service and control group.

EVALUATION

Services monitoring is conducted regularly to assure contract compliance and program development in accordance with program objectives. Utilization reviews by an independent review agency are performed to assure appropriateness and quality of service. In addition, an independent contractor who assisted the project in producing an evaluation plan will also prepare a final research report analyzing the cost-effectiveness of the alternative services.

PRELIMINARY RESULTS[1]

At present, data on the costs of AHS services are available for 463 clients who received project services prior to September 1978. In addition, data on mortality within 6 months of enrollment are available for 283 clients referred to project services and for 93 control group members.

The typical AHS project enrollee is a woman 70 years of age or older. The sample is nearly equally divided between whites and blacks. Most are widows with less than nine years of education and have a monthly income between $151 and $200. All are eligible for Medicaid and either met Georgia Medicaid's preadmission standards for nursing home care or were nursing home residents prior to receiving services. Most live with others in a private home or apartment. The majority was referred to intake caseworkers by a county welfare worker or by family or friends.

Prior to entering project services, these clients generally were dependent on another person or on some equipment in order to perform activities such as going outside or walking on level ground. Most were "dependent" in no more than one basic Activity of Daily Living (e.g., feeding themselves).

The average monthly cost to Medicaid of maintaining these persons in the community with alternative health services was $169, with costs ranging from a low of $135 per month for those only receiving Home Delivered Services to a high of $242 for persons receiving a combination of Home Delivered and Adult Day Rehabilitation Services. Interestingly, the most frequently used service, Home Delivered Services, was the least costly. These costs can be contrasted with the average monthly cost to Medicaid for maintaining a person in an Intermediate Care Facility (ICF), which was approximately $500[2] in Georgia during the first nine months of 1978.

1 Given sample size considerations, the results reported here should be considered subject to later qualification as the size of the project's data base increases.

2 Institutional recipients must contribute their income to the cost of care. The $500 represents the net cost to Medicaid after this patient income has been taken into account.

Mean monthly project service costs per person by type of project service received through September 1978 are summarized in the following table.

TABLE 1
MONTHLY COST PER PERSON BY SERVICE TYPE

Service Type	Monthly Service Cost Per Person Mean	Std. Dev.	Clients In Service %	(N)
Home Delivered Services (HDS)	$135	$120	53%	(246)
Adult Day Rehabilitation (ADR)	$222	$118	20%	(95)
Alternative Living Services (ALS)	$173	$262	5%	(22)
ALS/Other	$167	$113	12%	(54)
HDS/ADR	$242	$152	10%	(46)
Total	$169	$112	100%	(463)

Data on client mortality within six months of enrollment indicate that project services have had a positive impact on client health status, as shown in Table 2 below.

TABLE 2
MORTALITY WITHIN SIX MONTHS OF ENROLLMENT BY GROUP

Mortality	Service Group %	(N)	Control Group %	(N)
Deceased	6%	(17)	17%	(16)
Living	94%	(266)	83%	(77)
Total	100%	(283)	100%	(93)

In the group referred to project services, 6% died within six months of enrollment compared to 17% of the control group. This difference was statistically significant at p .01.

In summary, preliminary data on alternative services suggests that community-based services are less costly than institutional care, and that the alternative services have reduces the mortality rate for AHS clients.

STATEWIDE IMPLEMENTATION: NATIONAL MODEL

The Georgia Department of Medical Assistance is encouraged by the preliminary data findings of the AHS Project and anticipates proposing to the Governor and General Assembly in the fall, a plan to phase in the services in

additional areas of the state. This plan will include a proposal for supportive legislative changes necessary for statewide implementation of the services.

The AHS Project is developing extensive manuals dealing with each service both to prepare for statewide implementation efforts and to provide HCFA with complete operational guides which other states can use to replicate the program. These manuals will include the project's methodologies for contracting with providers, client intake and service placement, case management, monitoring, utilization review, auditing, integration of services with other public programs, and overall program assessment and management.

ISSUES

As a result of the project's experience with the provision of community-based health and health-related supportive services, I would like to discuss some issues which may be of interest to the Subcommittee as it considers the implications of expanding home health services and other community-based health care services in an effort to provide alternatives to long-term institutional care.

Maintaining a person in the community is generally considered preferable to institutional care. However, selection of the most appropriate level of care must always be based on the client's needs and capabilities. True, there is much to recommend community-based care. But it is not always better than institutional care, nor is it always the most appropriate care. The AHS data suggest that there may be resultant lower mortality rates, better patient morale, and better supports if these services are offered. Yet, there are very real difficulties in the provision of home delivered services, and these also merit attention. There is a need for better systems design overall.

Specifically, the average program needs:

- o Quality control
- o Cost controls
- o Intake and case management
- o Coordination with other federal programs

Each of these topics is discussed briefly in the subsections which follow.

Quality Controls

The AHS Project has found three types of quality controls to be particularly effective:

- Service standards - Carefully designed standards for services can make a significant contribution both to educating new providers and to providing a benchmark against which services can be evaluated. Service standards include guidelines for staffing, scope of services, and client record keeping.

- Program Monitoring - Consistent with the project's emphasis on quality services, AHS has established a system to periodically monitor all providers for compliance with program policies, guidelines, and standards. The monitoring effort is focused on assisting providers to upgrade services, but it is also directed at assuring that no providers fall below certain minimum standards. An effective way to provide this guidance is through the use of staff persons knowledgeable in the area of community health services who can evaluate the adequacy of each provider's system for the administration and operation of program services. These staff persons also work with the provider, offering educational or technical assistance for the development of an effective approach to service delivery.

- Utilization review - As in any system of services, there needs to be a counterbalance to the tendency of providers to maintain clients in service longer than absolutely necessary. Although the provider's action is usually based upon concern for the client's well-being, this can lead to an inappropriate increase in the cost of services when other alternatives may be more adequate to meet the client's needs. While the need to prevent unnecessary and inappropriate service utilization seems obvious, most federally funded demonstrations have been run without utilization review. The AHS Project has developed a model utilization review system which assures that the amount, duration, and scope of provided services are appropriate.

It should be noted that quality control implies the potential of terminating programs which do not meet quality standards. Such a termination can, in fact, have positive consequences for the service system as a whole.

Cost Control

A service provider can experience wide fluctuations in operating costs depending on client volume and start up costs. Erratic client levels requiring different staffing, facility, space, etc, and limited start-up funds have all been important design factors. The AHS Project developed two approaches to assist providers with these fluctuating operating costs:

- Budgets and incentive contracts - A simple reimbursement formula based on a fixed fee per client in attendance at a program will not work for all service providers. At low client volume the cost per client served is high; as volume increases the unit cost decreases. But if the predetermined rate does not change to accomodate erratic program attendance, the provider will not be able to pay for fixed operating costs. An effective way to provide cost controls is by negotiating a budget with the provider which includes provisions for rates which vary with the client census. Further, incentives should be provided for providers who are able to perform at a cost below that budgeted while still offering quality services.

- Audits - During the beginning phases, when states are just starting to implement new services, semiannual audits by the funding agency are recommended. AHS has found that this schedule allows it to intervene and remedy potential financial problems in a timely manner when appropriate. Because provider books are simple, most audits take only about three days. Thus, the staff resources required for audits are not excessive. Yet, the benefits to the provider and sponsoring agency of timely cost settlement and timely intervention in the resolution of problems are significant. This is particularly true when the provider's continued existence may depend on its ability to generate adequate, timely revenues from services.

Intake and Case Management

The client intake function is crucial to the success of a community-based care system. There are a number of issues associated with intake:

- Target population - The concept of limited available resources for health care is accepted more than it once was. Not only are federal dollars limited but also there are limited numbers of professionals to meet the service demand. Alternative services are in demand and this could cause their use and cost to mushroom if access is not controlled. Since unrestricted availability would be fiscally irresponsible, an approach must be taken to restrict the use of alternative services (home health, personal care services, etc.) to those who by receiving them could avoid premature institutionalization, are capable of functioning in the community, and have the greatest health needs. The AHS Project suggests that an appropriate approach is to focus intake on elderly Medicaid eligibles who are applying for nursing home care. These individuals should undergo screening prior to placement in a nursing home, a process the project calls mandatory pre-screening. Such a process would assure that persons seeking to enter a nursing home would be appropriately evaluated, assured access to information about services in the community, and offered these services if their health status warranted their provision.

- Maximum Units of Service Guideline - The AHS Project has found that most nursing home residents and even many hospital residents could be maintained in the community if cost were no object. Thus, the cost of alternative services is an important factor in determining which clients can be reasonably served in the community and which in institutional services. Recognizing this, the AHS Project has developed "Maximum Units of Service Guidelines" which are used by the medical assessment team to determine when community placement would be so expensive as to be impractical. This has been a critical factor in the success of the project to date.

- Services for the medically needy - Many states provide Medicaid reimbursement for "medically needy" persons who have incomes above SSI limitations but below state Medicaid caps only while they are institutionalized in a long-term care facility. Individuals with comparable incomes would not be eligible for Medicaid if they were not institutionalized. Typically, a program such as AHS, designed to offer cost effective noninstitutional services to these individuals, would find that Medicaid eligibility would be terminated when the individuals left the institutional setting.

  Yet, if we are to be able to limit total Medicaid costs for institutional care, we must also make provisions to serve those who become eligible after admission to the nursing home. As a consequence, Georgia applied for and received a waiver from the Health Care Financing Administration to allow the project to provide Medicaid coverage to these "medically needy" persons when they leave the nursing home to enroll in alternative services. HEW has also allowed the project to implement special procedures to protect Medicaid eligibility for persons whose incomes rise above SSI eligibility limits after enrollment in project services. The "medically needy" clients described above are required to pay a share of the cost of services. The project has developed a system whereby clients advance fixed monthly payments to the project based upon their income. Quarterly settlements for any overpayments are made with the client. The establishment of this new payment system eliminates the need for "spend down" programs which are more difficult to administer.

- Case management and coordination - A critical aspect of community-based care is the provision of centralized case management to coordinate services offered by various participating providers. Without effective case management, it is surprisingly easy to have two different providers note a change in the patient's status and independently develop a plan of care which can either conflict with or duplicate the other. The case manager can also assure that the client receives appropriate care when service needs change. A

strong system of intake will help home health, personal care or other community services focus on the patients most in need of care and facilitate use of services by the target population.

Program Coordination

A common theme among those providing community services is the difficulty of coordinating patient care given the myriad federal, state, local and voluntary programs and their often conflicting regulations.

- Conflicting Federal Program Regulations - At the federal level, there are Titles XVIII, XIX, and XX of the Social Security Act as well as Title III of the Older Americans Act which fund services for the elderly. For each title, there are different eligibility rules, different systems of accountability for service provision, and different match requirements. The relationships between these titles must be negotiated with state and local agencies on a program by program or agency by agency basis. Flexibility in federal guidelines for funding integration is essential for the development of a comprehensive coordinated network of services.

- Need for Federal Review Panel - As we have attempted to mesh with existing programs, we have continually encountered overwhelming obstacles to success despite the combined efforts of numerous cooperative federal and state agency representatives to assist us in overcoming these barriers to coordination. While each of these persons has been able to offer a specialized expertise in one program area and generalized knowledge in other related areas, we have all been stymied by what appears to be the lack of consolidated federal direction and guidelines for programs like ours.

  One solution to this problem might be DHEW's establishment of a federal review panel comprised of individuals with specialized expertise in each of the funding sources (HEW and others) which are commonly used in multiple funding programs. Such a panel could serve not only to assist programs with complex needs for technical assistance in programmatic and fiscal issues but also to assure that the programs achieve the kind of results which will be in

accord with federal long-range plans for comprehensive service delivery systems. To be truly effective, the panel would need to have decision-making authority and be capable of granting waivers (on an individual project basis) to regulations which inhibit the development of innovative service delivery systems.

CONCLUDING REMARKS

The Alternative Health Services Project and others like it in the country are demonstrating that many older persons can continue to live in their own homes or other non-institutional settings if adequate community-based health and health related social services are made available to them. This fact is of critical importance in light of the growing interest in such programs as national health insurance and catastrophic national health insurance. One effect of any such health insurance may be to increase the number of persons who would be eligible for long-term care programs. If we are to meet the needs of the nation's elderly for long-term care in the most effective and economical manner, serious consideration must be given to ongoing federal support for comprehensive, community-based alternative services for those persons who have the potential for self-sufficiency with only minimal supports. The potential cost savings are impressive; the effectiveness of the services are well documented; and perhaps most importantly, the alternatives offer the elderly an opportunity to maintain the independence and dignity which they so richly deserve for as long as possible.

Senator TALMADGE. The next witness is Gerald Reilly, deputy commissioner, Department of Human Services, State of New Jersey.

You may insert your full statement for the record and summarize it, if you please.

STATEMENT OF GERALD REILLY, DEPUTY COMMISSIONER, DEPARTMENT OF HUMAN SERVICES, STATE OF NEW JERSEY

Mr. REILLY. Mr. Chairman, distinguished members of the subcommittee, my name is Gerald Reilly, deputy commissioner of the New Jersey Department of Human Services, and at one time, I was the director of the New Jersey Division of Medical Assistance, medicaid.

I come here today to discuss with you two propositions that we think will serve to reduce the unintended institutional biases of the medical assistance program.

As you are probably familiar, a person may receive medical assistance in a nursing home with an income up to $568 per month. We have had situations where a person may have had income of $400 or $415 and where home health would have been an appropriate alternative for that person, but if they were to leave the institution, they would not be eligible for medical assistance, nor for the necessary home health and the support system around that home health.

Therefore, they may stay institutionalized.

What we are suggesting is that the medicaid program, title XIX, be amended to permit a home health eligibility threshold at the same level as the nursing home eligibility threshold, providing the person meets the medical necessity requirements for admission to a nursing home.

Here is how would work: If we had an individual whom the family was having a difficult time caring for, and it appears that institutionalization was necessary, and a medical necessity workup was being done on that individual, and if he did qualify for the long-term care, and it was determined that it was possible to provide home health services and support services in the community, then he would be eligible for medical assistance independent of the fact that his income might be above the SSI level, which, in our State, is $227, as long as it was below the $568.

Now, you can work up several models describing what the normal package of home health service would be for a client and, in a number of situations, the home health alternative will be less expensive than the institutional alternative. We think that it would make sense to change the regulations, change the laws, to permit that to happen.

We could argue, from a public policy point of view, that we ought to be willing to expend even a little more on home health services than the alternative cost in an institution in order to maintain maximum feasible independence. But, in line with the cost containment strategy, what we are suggesting is that this only become operative when it is demonstrated that it is a less costly alternative.

We think, in our State, that this may be the case in as many as 10 percent of the current admissions into long-term care facilities.

The second proposition is that we provide, through the medical assistance program, a single point of entry to all of the home health services necessary to maintain someone in the community. As you now recognize, medicaid is oriented to only the health aspects of home services—one must assemble a package of services from title XX, Older American Act funds, Meals-on-Wheels and so on. The fragmentation of the funding sources can lead to a fragmentation of services at the point of delivery, that, for failure of one of those systems to operate, we may not be able to develop a package of home health services for our client.

For example, the Meals-on-Wheels funds in our community have run dry; the title XX funds have run dry, and so on. What we are suggesting, through the medical assistance program, again, as a cost containment strategy, is that all the necessary support services be able to come through that one door.

Right now, the home health nurse in the community often has to act as the broker to weave the way through the plethora of programs to get it back to the client.

We think we could administratively reduce that obligation on their part and return them to the task of supervising health care and not patching the financial support for necessary services.

We are very supportive of S. 505, which in part would provide AFDC recipients as homemaker-home health aides. We think that is an excellent proposition. We are also in favor of eliminating the medicare 100-day limit, and the prior hospitalization requirement.

But I think that if these changes in the medicare system are going to be important and useful, in the long run, there is going to have to be a much greater investment in the medicaid home health program. What we are proposing today are some modest, short-term improvements that will be cost effective before they are put into effect.

We think we can also develop some valuable demonstration data on the effect of this technique, which may be useful to you and the Congress as you look at the broader question of enhancing the home health service system.

Thank you.

Senator TALMADGE. Thank you very much.

This is an excellent statement. I read most of it while you were testifying. I congratulate you, sir.

Any questions?

Senator DOLE. No questions, just a comment.

As I understand home health expenditures for fiscal year 1978, they are $3.8 million?

Mr. REILLY. Yes, sir.

Senator DOLE. You said that is less than 1 percent of the total for medical assistance, which indicates what potential there is for expanding the program.

Mr. REILLY. That statistic is a 100-percent increase over several years ago. We were spending very little and put a lot of effort in an attempt to maximize home health and one of the barriers to its use is this institutional bias I described. That for some individuals it just becomes impossible for them to remain in the community because of their health expenditures, lack of basic resources for subsistence, and the institution becomes a more viable alternative.

The other thing I did not mention in my oral testimony was the medical day care program where we have four or five sites around the State where people who would be institutionalized are in day care because they have a family that can care for them in the evening and on weekends, and this financial eligibility gap is also a problem for them.

We think there would be many more people eligible if we were able to adjust this eligibility problem.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much. I appreciate your contribution, Mr. Reilly.

[The prepared statement of Mr. Reilly follows:]

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ANN KLEIN
COMMISSIONER

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
TRENTON, N.J. 08625

STATEMENT OF DEPUTY COMMISSIONER GERALD REILLY, NEW JERSEY
DEPARTMENT OF HUMAN SERVICES

Our Department would like to facilitate greater use of home health services by Medicaid recipients, particularly in situations where such services are a less costly alternative to institutional care. A shift in policy at the Federal level is crucial to our efforts. To overcome Medicaid's unintended bias against home care and toward institutional care, we propose the following:

1. Title XIX should be amended to, in certain situations, equalize institutional and community eligibility standards so that persons who might otherwise be institutionalized can remain in their own homes when it is cost effective to do so.

   Under current Medicaid regulations, persons having up to $568 in monthly income may receive Medicaid nursing home care, but may not receive Medicaid home health services unless their income is below the SSI standard. We propose that, for persons medically determined to require institutional care, Medicaid eligibility for home health services should be made equivalent to the institutional eligibility ceiling of $568 per month. Once determined eligible, the person would pay a certain percent of his income toward the cost of his home health services.

2. Federal financial participation in the full range of home care services for low income persons should be provided through a single funding source such as Medicaid.

   The medical orientation of Title XIX home health services precludes maintenance of the individual in the community without supplementary social and personal services derived from other sources. If one of these support services is disrupted, the home care recipient is often forced to enter an institution. Single source funding of a full range of home health related services will overcome the current fragmentation, and in many cases, may prevent or delay the use of more expensive institutional care.

MR. CHAIRMAN, DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

I am Gerald Reilly, Deputy Commissioner of the New Jersey Department of Human Services, and former Director of the Department's Division of Medical Assistance and Health Services.

Faced with the increased costs of institutional care, with a severe shortage of long term care beds in our State, and with the knowledge that some of our recipients could be better served in the community, we are studying ways to increase the effective utilization of home health services in our Medicaid Program. A shift in policy at the Federal level is crucial to our efforts. Today I will summarize for you two proposals which constitute a practical approach to the expansion of Medicaid home health services, and which would broaden alternatives to institutionalization within a cost containment framework.

The following statistics about New Jersey's Medicaid Program clearly indicate why our interest in home health services has risen. Medicaid expenditures for nursing home care in our State were $157.2 million in FY 78 and provided care for 18,730 persons. In addition, about 2,600 Medicaid eligible individuals are also awaiting placement into long term care facilities. At the same time, Medicaid's FY 78 home health expenditures were only $3.8 million or less than one percent of the total for medical assistance. (However, this figure does represent a 99% increase over FY 77 home health expenditures). While the Federal and State Governments are paying a high price for nursing home care in New Jersey, a study conducted for our Department two years ago

showed that about 10% of the total nursing home population (about 1,800 persons), while meeting the medical necessity criteria for nursing home care, could have received appropriate care in the community, if the adequate social and medical services were available.

Increased availability of home health services under both Medicare and Medicaid would enable New Jersey and other states to create a more rational system of long term care, with levels of care more closely matched to individuals' needs. I would like to suggest two changes in the Medicaid Program that would foster greater utilization of home health care, and that would better integrate such services into a continuum of care.

First, Title XIX should be amended to, in certain situations, equalize institutional and community eligibility standards so that persons who might otherwise be institutionalized can remain in their own homes when it is cost effective to do so.

Under current Medicaid regulations, states may expand eligibility to persons needing nursing home care if their income is 300% of the SSI standard or less, that is, up to $568 per month. However, in order to be income eligible for Medicaid home health services, these persons' incomes must fall below the state's SSI standard, which in New Jersey is $227 per month. About 30 percent of New Jersey's elderly population fall into this "eligibility gap": their monthly incomes of between $227 and $568 make them potentially eligible for nursing home care but not for community based care.

Even the establishment of a medically needy program, which New Jersey currently does not have, would not be enough to resolve this problem. The income level to which a medically needy person must "spend down" is 133% of the AFDC standard for a unit of one; in New Jersey this would equal $165 in monthly income. Evidence from other states has shown that this "spend down" income standard is so low that persons must have crushing health costs in order to become eligible for Medicaid. Rather than suffer a sharp drop to a subsistence level standard of living, they may choose to enter a nursing home, where they are at least guaranteed adequate food and shelter.

To equalize the institutional/community eligibility standards and to remove Medicaid's unintended bias toward institutionalization, we propose the following:

For persons medically determined to require institutional care, Medicaid eligibility for home health services (or medical day care) should be made equivalent to the institutional eligibility ceiling of $568 per month. Once determined eligible, the person would pay a certain percent of his income toward the cost of his home health services. Persons should be permitted to choose the community care over the institutional option as long as the cost of community care is less than the net cost of institutional care. This provision would prevent utilization of home health services in situations where nursing home care would be more efficient. A reasonable argument could be made that, consistent with a social policy calling

for maximum independence, we should be willing to pay for such home based care even if it exceeds the cost of institutional care by some acceptable amount (for example, no more than 125%). However, this would compromise the cost containment aspect of our proposal.

In contrast to a spend-down program, this proposal would be simpler to administer, and with an income based co-pay system, it would better provide for an individual's normal costs of living while he is receiving home health services.

Our second proposal is that Federal financial participation in the full range of home care services for low income persons should be provided through a single funding source, such as Medicaid.

A frequently cited barrier to utilization of home health services as an alternative to institutionalization is fragmentation of funding sources and providers. The medical orientation of Title XIX home health services precludes maintenance of the individual in the community without supplementary social and personal services derived from other sources. Fragmentation of funding tends to foster fragmentation at the point of service delivery. For example, a typical Title XIX home health recipient might receive medical services from a home health agency, homemaker services from a Title XX contractor, and nutritional services through a Meals-on-Wheels program. If any of these services is disrupted, the entire plan of home treatment is often jeopardized.

In instances where home care is equally or less expensive than institutional care, the reluctance to expand Medicaid reimbursement to nonmedical services necessary for the implementation of the medical treatment plan is shortsighted. In the institutional setting, items such as housekeeping, meals, and personal care are part of the per diem cost that is Medicaid reimbursed. If parity between home care and institutional care is to be created, such services must be reimbursed when the recipient is not able to pay for or provide them himself.

As for the current fragmentation of service providers, a single source of reimbursement could encourage existing home health agencies to provide a more comprehensive package of services or to coordinate other providers and ensure that all necessary services are supplied.

We believe that increased utilization of home health services under Medicaid is dependent upon the availability of a full range of support services. If such reimbursement is not made available on an income related basis to individuals in their own homes, the result is often more expensive institutional care at a higher public cost.

SUMMARY

The two proposals that we have outlined here are expanded Medicaid eligibility for community care of persons otherwise needing institutionalization, and reimbursement for a broader range of

services under one funding stream. These proposals comprise a logical expansion of the existing Medicaid Program. The current system encourages institutional care even when less expensive home care is a viable option. Our two recommendations are designed to overcome this perverse incentive and to foster a more rational system of long term care.

Over the long run, increased home health services for all elderly and disabled persons through Medicare is a desirable national goal. However, we recognize that there are many unanswered questions - particularly in regard to cost - that currently prohibit such a large scale change in the Medicare program. Therefore, as an intermediate step, we are advocating the expansion of home health services to persons otherwise requiring Medicaid institutional care and in situations where the cost of home care is roughly equivalent to or cheaper than institutional care. Increased home health services in this context will alter Medicaid's current bias toward institutionalization, and at the same time, will provide further data that may help us effectively plan for the provision of such services on a universal basis.

Senator TALMADGE. The next witness is Delora Cotter, registered nurse, executive director of the Denver Visiting Nurse Service, on behalf of the American Nurses Association, Inc.

We have a vote going on on the Senate Floor. I will go over and vote and rush back. Senator Packwood has agreed to preside in my absence so we can keep the hearings going. You may insert your full statement in the record and summarize it in the time allotted, please.

Thank you.

STATEMENT OF DELORA COTTER, EXECUTIVE DIRECTOR, DENVER VISITING NURSE SERVICE, ON BEHALF OF THE AMERICAN NURSES ASSOCIATION, INC.

Ms. COTTER. Thank you, Mr. Chairman.

Senator Packwood, Senator Dole. I am Delora Cotter, the director of the Denver Visiting Nurse Service. I am pleased to appear today on behalf of the ANA. I share with you the concerns of those working in home health services to whom certain policies are

clear. In the limited time available, I will cite some of the suggestions we have for changes in the law.

I refer you to specific examples given in my full statement and ask that it be made a part of the record.

A great obstacle to access to home health services is the lack of uniform interpretation of eligibility by fiscal intermediaries. Presently, an intermediary can arbitrarily deny payment based on paper review.

The American Nurses Association supports the elimination of the 3-day prior hospitalization requirement and the deletion of the 100-visit limit. This would do much to improve patient access to services.

Next, the role of the physician as the only doorkeeper should be examined. Professional nurses are able to assess home health needs and to direct such care. Nurses in hospitals should also be able to make home nursing referrals based on the needs of the patient.

Next, legislation must assure that the provider agencies will be accountable to the users and payers. We strongly urge you to consider a regional model of monitoring that involves providers as well as State, Federal, and intermediary representatives to provide regional surveillance.

In my judgment, the only kind of surveillance that will ever be effective is when peers monitor other peers, because of the difficulty of surveillance of that service.

We support the development of a uniform quality assurance program for home health care, as for all health care services, consisting of several components, including development of measurements, standards, ascertaining the degree to which the stated standards are met, and introducing changes based on information supplied by the measurements.

These changes are directed to the improvement of care; the degree to which care is improved will indicate program effectiveness. Quality assurance is an action oriented program, not a static paper review program.

Current methods of home care financing are fragmented for the Federal programs. The elderly patient must be under title XVIII, XIX, XX.

We believe that the following principles apply in efforts to improve home health care benefits: First, that financing should maximize the individual's usual support system. The family's role in providing home health care financing should be enhanced and supported.

Second, that reimbursement mechanisms should facilitate patient entry into the service based on the need for service, rather than a medical diagnosis. That reimbursement should be based on the appropriateness of the service rather than on the site where care is provided.

Next, that the appropriateness of health care services should not be determined by financial determination. Current legislative proposals for current health costs or growth of the costly acute care model. We fail to recognize that nursing services are the central service of any home health care program and professional nurses should be clearly identified in proposed home health legislation as providers of home health nursing services.

Last, we hope that the cost per case can be considered as the appropriate way to finance home health care. The purpose of costs can destroy the real cost of the program by those agencies using a lower charge per visit but providing an excess of visits to patients, thus inflating the real dollars spent.

No national mechanism currently assures orderly growth of home health services. It is argued that lack of certificate of need may assist the growth of home health services, but there is no data to support this claim. Further, there is some evidence that fraud and abuse of reimbursement is greater where excessive services exist. We hope that legislation will assure that the health planning agencies responsible for planning in this country would be given the responsibility for assuring that there is available home health services in each community and there is elimination of costly duplication of services where this exists.

Such fixing of accountability for planning for home health care would assist the consumer, the Federal payer communities and providers in their desire to have the best care for the least cost.

I appreciate the opportunity to appear here today. I will be happy to answer any questions.

Senator PACKWOOD. Thank you. I do not have any questions.

Senator DOLE. An excellent statement. I do not have any questions. Thank you.

Ms. COTTER. Thank you.

[The prepared statement of Ms. Cotter follows:]

PREPARED STATEMENT OF THE AMERICAN NURSES' ASSOCIATION,
BY DELORA COTTER, R.N., EXECUTIVE DIRECTOR, DENVER
VISITING NURSE SERVICE

Mr. Chairman, I am Dolora Cotter, the Director of the Denver Visiting Nurses Service. I am pleased to have the opportunity to appear today on behalf of the American Nurses' Association. Before I address the problems of home health I would like first to focus on its successes. There are in this country millions of older persons who have used home health care benefits under Medicare since 1966. Only their stories of receiving the nursing, physical therapy, home health aide or other services and what it meant in terms of sustained independence and quality of life would give us the human glimpse of this issue today.

In their absence, I cite the example of an 82 year-old man who died last year. He had a stroke in 1966 at 70 years of age, the year the Medicare program started. He returned home with total paralysis of right arm, a brace on his right leg and the need to learn new skills in feeding himself, dressing and walking. He had a nurse and a physical therapist for several months the first year, then went four years without service. He had prostate surgery, lost strength with the hospitalization, required a visiting nurse for a month after he went home to help him regain his ability to walk, restore normal management for his bowels, and provide teaching of his wife to cope with his somewhat lower level of functioning. In 1973 both he and his wife had severe flu. Family members from across the country mobilized to return to help their parents for three or four weeks. An occupational therapist and nurse were needed for a month to re-teach skills of independence.

In 1975, at age 80 the man developed cancer of the lung. The final year of his life was more demanding. Home health aide care was essential, and a visiting nurse was needed more often in the last two months of this illness. He died at home -- after eleven years of fairly severe handicap and one year of severe debilitation. Was home care a success? Yes, in his eyes and those of his family because he remained at home. Yes, in the eyes of the Medicare/Medicaid which could have incurred probably a minimum payment of $100,000 for his care in hospitals and a nursing home had home care not been available. Total costs to the Medicare program were under $5,000.

Why then do we talk about failure of home health? We talk about failure because for every person whose needs are served, there is one who is not, for whom the Medicare or Medicaid benefits don't match up with needs, who don't remain independent with a chronic illness, who have early debilitation, loss of apartment or home, separation from family and friends and return to the dependence of a child in an institution.

The underutilization of the benefits for home health care relate to several things: lack of information, excessive paperwork and regulations that restrict the full utilization possible for those in need.

Availability of Home Health Service

What is needed then for more consistent success? Health care services must be available for individuals to manage their health at home. It is basic that services must exist. I am often asked to teach health planners how to plan for a community's needs for in-home health services. It is a more difficult task than planning for CAT scanners or hospital beds. The Congress should insist that the Health Systems Agencies develop a rational planning base for home care so that each community has adequate services available for residents. The start-up money under Section 602, P.L. 94-63 is also a viable tool. With very modest expenditure, there has been substantial gain in the availability of services.

Accessibility of Home Health Service

One of the greatest deterrents to access to home health service is the lack of uniform interpretation of eligibility by fiscal intermediaries. The 1977 GAO Report To the Congress On Home Health identified this as a major problem. The 1979 HEW Report mandated by P.L. 95-142 states: "the fiscal intermediary system has presented a number of problems. These problems have been exacerbated by the lack of adequate national guidelines defining and interpreting benefits, and of criteria for coverage and cost reimbursement. The result ... has been widespread differences in interpretation of benefits, in reimbursement practices, and in the determination of the legitimacy of claims."

A Home Health Agency in Mississippi has consistently received denials on the basis that the nursing service provided was not medically necessary according to the intermediary's point of view. All the denials for nursing services centered around a change in the patient's status - usually a complication such as dehydration, stupor, or shortness of breath - which necessitated increased nursing visits. The intermediary would not acknowledge the complication and referred to the diagnosis for the initial plan of care as the basis for denial. This is an area that needs to be clarified. Nurses should be recognized as providers and they should be subject to peer and utilization review for care provided. An intermediary should not be able to arbitrarily deny payment based on a paper review.

This same home health agency received routine denials for the services of the social worker on the basis that the social worker's services were not medically related. It seems that with this particular intermediary the social work activities had to relate specifically to a disease. Arranging for admission to a nursing home because a patient was no longer manageable at home was not reimbursable.

Another category of individuals who are ineligible for benefits is those patients who may have had complications and/or secondary effects of an acute illness which were not treated initially following discharge to home because of lack of professional resources to meet the need, or the physical inability of the patient to participate in treatment at the time. For example, a patient was discharged following a stroke and was aphasic. Three years later his physician requested home care speech therapy which was denied because the asphasia was of long standing and he was therefore ineligible for services. In other words, he who gets poor care in the beginning must suffer on.

Entry to Home Health Care

The role of the physician as the only gatekeeper for home care must be examined. The long-term chronic illnesses of the aged do not lend themselves to the acute care model of health insurance. The physician may see an elderly patient with a chronic condition once a year, if that often. A professional nurse, called to the home by friends or family, because of health problems is often better able to assess the in-home needs and direct the care. A significant failure of the program has been to limit benefits to those ordered by the physician, related to acute care, and for services to be provided in an environment the doctor has rarely if ever seen. The role of the physician as gatekeeper for acute episodes may be defensible. Equally defensible is the role of the registered nurse as gatekeeper for benefits during periods of relative stabilization when maintenance services are required. Nurses in hospitals should be able to make home nursing referrals based on nursing needs of the patient.

Regulation to Assure Accountability

National health policy must assure that provider agencies will be accountable to the users and the payor. Paper regulations which are coming

in increasing abudance since home health scandals in Florida are creating real problems for in-home services. The nature of care, given where it is, defies application of regulatory constraint. The increasing regulatory constraints developed to catch the offender, and with the penalties to come from Washington of the local intermediary are not really effective and we think care can be better improved through other mechanisms.

We strongly urge you to consider a model of monitoring which could be regional in nature, involve providers and state, federal and intermediary representatives to provide regional surveillance. I believe I could walk into the Brooklyn Visiting Nurse Association or the Fort Lauderdale agency with selected data and, in a fairly short time, have a sense of that agency's fidelity to its consumer and the Medicare program. Providers must take responsibility to share in utilization and peer review of other agencies.

Reimbursement

Current methods of home care financing are fragmented. A positive trend is the inclusion of home care benefits in private health insurance. For the federal programs, the elderly indigent patient often must weave between the eligibility under Titles XVIII, XIX, XX. Principles for improving reimbursement include:

(1) To the degree possible, financing should maximize the individual's usual support systems. The individual and the family should be encouraged to take personal financial responsibility for health care. Wherever possible, the family's role in providing home health care financing should be enhanced and supported. Out-of-pocket health care expenditures should be tax deductible regardless of the family member for whom they were spent.

(2) Current financing for home care includes public, voluntary, third-party, and individual payment for services. Such collaboration should be continued in order to sustain home care. However, the principal current payment mechanism must solidly incorporate out-of-institutional care in the benefit package.

(3) Reimbursement mechanisms should facilitate patient entry into the service based on the need for the service rather than the medical diagnosis.

(4) Reimbursement should be based on the appropriateness of the service, rather than on the site where care is provided.

(5) Professional services within the scope of practice, when needed and when deemed appropriate by professional providers, should be reimbursed. The appropriateness of professional services should not be determined by financial regulations. The appropriateness of nursing service should be determined by the professional nurse.

(6) Reimbursement for durable medical equipment used in home care should be based on lowest cost in terms of rental vs purchase. This now is a real problem area.

Lastly, the cost per case should be considered as an appropriate way to finance home health care. The present method of using the per visit cost distorts the real cost of the program by those agencies using a low charge per visit but providing an excess of visits to patients, thus inflating the real dollars spent. Utilization review effort could help here.

Current Legislative Proposals, (S489, S505, S748)

The Home Health Report prepared by the Health care Financing Administration and eventually released by the Secretary to the Congress is a disappointment. Despite the Congressional mandate to do a thorough and comprehensive study of home health services for the purposes of recommending legislative changes, the choice, due to fiscal restraints, was not to make recommendations but to undertake a major research effort for F.Y. 1980. We question the cost effectiveness of this approach.

In the current legislative proposals before the Senate, The American Nurses' Association supports the elimination of the 3-day prior hospitalization requirement and deletion of the 100-visit home health visit limit.

We support the development of a uniform quality assurance program for home health care, as for all health care services, consisting of several components, including development of measurements (standards), ascertaining the degree to which the stated standards are met, and introducing changes based on information supplied by the measurements. These changes are directed to the improvement of care; the degree to which care is improved will indicate program effectiveness. Quality assurance is an action oriented program, not a static, paper review program.

We are concerned that current legislative proposals for home health continue to foster the growth of the costly acute care model and do not recognize that nursing services are the central services of any health care program provided at home, and therefore that the registered nurse is the most appropriate professional provider to identify, plan for, and manage the health needs of persons in their homes. Professional nurses should be clearly identified in the proposed home care legislation as providers of home health nursing services.

No national mechanism currently assures orderly growth of services provided in the home. Only a few states have certificate-of-need legislation for home care services. Although it is argued that this lack of constraint may assist the growth of health services to be provided in the home, there is no data which would support this claim. Further there is some evidence that fraud and abuse of federal reimbursement is greater where excessive services exist.

With the exception of those states having certificate-of-need legislation for home care, planning agencies do not have the opportunity to influence the development of home care services in underserved areas. They lack the leverage and expertise they would have if all applications for new programs for services at home were submitted for review and comment. The American Nurses' Association urges the inclusion of certificate-of-need provision in the proposed home care legislation.

Legislation to assure that health planning agencies take responsibility to assure availability and lack of costly duplication of home health services would assist the consumer, the federal payor, communities and providers in their desire to have the best possible care for the least cost.

Senator PACKWOOD. Merritt Jacoby.

STATEMENT OF MERRITT W. JACOBY, ACTING SENIOR VICE PRESIDENT, GOVERNMENT PROGRAMS DIVISION, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. JACOBY. Mr. Chairman, Senator Packwood, I am Merritt Jacoby, acting senior vice president of the Government Programs Division of the Blue Cross and Blue Shield Associations. We are happy to have this opportunity to comment on the current and prospective matters of interest in the home health care program.

I have submitted, as have the others, written testimony for the record. I ask that it be accepted.

Senator PACKWOOD. It will all be in the record.

Mr. JACOBY. I will therefore provide a brief, oral summary of our position with respect to this health care benefit. As a private health underwriter, we are encouraging Blue Cross plans, in their offering of home health care coverage to local groups, national employee groups, and to individual subscribers.

More than 60 of the 68 Blue Cross plans offer this benefit in a variety of forms. We believe that appropriate and controlled use of the benefit, and expansion of the benefit coverage, offer opportunities for cost savings as an alternative to more expensive institutional care and, as expansion of services, to more completely meet the needs of homebound patients as identified by some of the previous people who have testified.

In that context, however, in conducting the administration of this benefit for medicare and for our own lines of business, we believe it is important to carefully consider any benefit changes in terms of the objective to be achieved. Moving off of the objective and with the clear understanding of what it is you want to accomplish, you can then structure the benefit change in such a way as to enhance achievement of the objective.

Related policy, procedures, and operational or administrative controls are often critical in the achievement of that goal. In fact, in some instances, experimentation is warranted. For example, among other considerations before this subcommittee is the addition of an intensive, or more intensive level of home health agency care, which offers a real opportunity for cost savings in today's environment, a very desirable objective.

However, it's conceivable that, without appropriate administrative development, possibly even some form of experimentation, that the addition of that benefit would not, in fact, become an alternative to the higher cost of the inpatient care, but could become an add-on, thereby failing to achieve the objective.

As you know, we are also a prime contractor for the administration of medicare part A benefits. The association is intermediary for 77 percent of the participating home health agencies. We relate our experience in our own line of business, and our administrative experiences as a contractor to the Federal Government, to our perceptions of the benefit that is under discussion, and the needs being identified, both those that have to do with expanding the benefit and those that have to do with introducing more effective administrative controls.

As a medicare intermediary, we are very sensitive to the several areas of concern in administration which are sometimes cited as reasons not to more effectively use the home care benefit as a needed alternative to in-patient care and as an expanded benefit to meet the needs of maintenance care in the home.

We believe that these problems can be, and will be, adequately addressed and resolved. Our recommendations, specific recommendations, have been provided to the health care financing administration.

Senator PACKWOOD. Let me stop you for just a moment. I have to recess the hearing for 2 to 3 minutes so I can go vote. Senator Talmadge should be right back.

[A brief recess was taken.]

Senator TALMADGE. Mr. Jacoby, you may proceed, sir.

Mr. JACOBY. Mr. Chairman, as I was indicating, we believe that the current problems in medicare administration which have been identified in a variety of reports, and matters of concern in terms of possible expansion of the scope and depth of this benefit, can be and will be resolved. We have provided specific information and

recommendations to the health care financing administration with respect to how we feel these can be resolved, and we have provided to the Congress in previous testimony similar kinds of recommendations.

Our written testimony, submitted to this subcommittee, includes those recommendations and some of our thinking on the problems.

To summarize, we believe that there are three areas of administrative policy and procedure which need a combination of change and refinement to achieve needed controls and clarification. We would regard it as unfortunate if expanded use of this benefit could not be achieved because we together were not able to resolve these problems.

First, we believe a uniform set of definitions policies and procedures for claims processing and provider audit and reimbursement, should be developed. Second, we think a reliable data base is needed with which uniform, equitable and comprehensive screening could be accomplished in claims review and for audit of providers cost.

Finally, we believe that timely notification of changes and clarification in current program policy should be made available to home health agency providers and all parties with responsibility of administration.

It seems apparent to us that there are confusions and misunderstandings with respect to the benefits, as well as some of the administrative activities that we carry out.

The actions which we are recommending are in accord with recommendations that are in the May 15 GAO report, "Home Health Care Services: Tighter Fiscal Controls Needed."

We believe that these actions will provide needed improvement in administrative controls as a basis for more effective use of this alternative to in-patient care.

We believe that improved administrative tools should be implemented quickly.

Thank you, Mr. Chairman.

Senator TALMADGE. Thank you, Mr. Jacoby. I have only a couple of questions.

Has anyone ever prepared a report on Blue Cross's own experiences in paying home health benefits that you might submit?

Mr. JACOBY. Yes, sir. I am sure we could put together some information that would be useful to this committee. I will make a note to do so.

Senator TALMADGE. You will submit it for the record?

Mr. JACOBY. Yes, sir.

[The information to be provided follows:]

In response to Senator Talmadge's request of Merritt W. Jacoby during the May 22 hearings on home health care, we are submitting further views on various home health care issues for the Committee's information and consideration. The following is a brief report discussing some of the Medicare benefit expansion proposals now before the Committee. In this discussion, as requested by the Senator, we draw on Blue Cross and Blue Shield Plan experience in administering Plan home health care benefits. In addition, we are providing a copy of the Blue Cross Association's Home Health Care Model Benefit Program and Related Guidelines, which provides a thorough description of the Association's guidance to Plans with regard to financing home health services.

Blue Cross and Blue Shield Home Health Coverages

As our May 22 testimony indicated, the Blue Cross and Blue Shield organizations support broad home health care coverage. Blue Cross and Blue Shield Plan involvement in home health care began as early as the 1950's. Today, 61 of the 68 Blue Cross Plans offer home health care benefits covering over 40 million subscribers and their dependents. In many places, such as Rochester (New York), Connecticut and Philadelphia, Plans have been partners in the development of some of the most innovative and successful community home health care programs in the country. The Philadelphia Plan, for example, has helped pioneer the development and financing of hospital-based, coordinated home health care. The Rochester

and Connecticut Plans have been active in the development and financing of coordinated home care in their communities. In addition, the Rochester and Connecticut Plans are among several Plans now reimbursing for an extended range of home care services for the terminally ill. Many other Plans are actively working with various providers to improve the coverage and delivery of home health services in their communities.

An important lesson learned from this experience with home health care, and other benefit programs as well, is that there are no inherently good health care benefits. How health care benefits are implemented is as critical as the ideas behind them. For Blue Cross and Blue Shield Plans, this has sometimes meant years of discussion and cooperative effort with health care providers, subscribers and government agencies to assure that benefits are what subscribers want and can afford and what providers can effectively and economically deliver.

The concept of working with local providers is central to the development and financing of effective home health care services; and it is this aspect of health care financing that is stressed repeatedly by Plans which offer home health care coverage. Their experience indicates that considerable effort directed at provider education, discharge planning, appropriate patient treatment plans, service coordination and utilization review is fundamental in making quality home health care services available in their communities. The beneficiary of cooperation between local Plans and

providers is the patient, since the primary objective of these efforts is to provide needed services in a way that will most economically use health care dollars.

This suggests that concommitant with changes in Medicare policy on home health care coverage, there must be an administrative structure that is sensitive and responsive to local differences in the need, capacity, and capability to provide home health care services. Our experience indicates that because of these differences, some communities have far more difficulty than others in dealing effectively with additional incentives to expand home health care delivery. For these communities especially, resolution of the administrative, reimbursement and auditing problems discussed in our May 22 testimony, proper government planning for home health coverage expansion, and a strong intermediary system can mask the difference between achieving and not achieving sound, systematic delivery and financing of local home health care services.

Position on Medicare Home Health Coverage Expansion

Reiterating our earlier testimony, we support the development of a more comprehensive home health care program for Medicare beneficiaries, just as we do for our own subscribers. Availability of and payment for a comprehensive range of health care services for patients in their homes is an essential part of a total health care system. However, movement toward this goal--such as expansion of Medicare home health coverage

into the intensive and maintenance levels of care and the elimination of the prior hospitalization, 100 visit and homebound restrictions--should be accomplished in a manner that promotes appropriate use of home health care as an alternative to more expensive levels of care. Our experience tells us this goal cannot be accomplished through benefit expansion alone. Also required are time, cooperative effort and an understanding of why physicians, hospitals, consumers, and others make the health care utilization decisions they do and what can be done to influence people to decide differently. Accordingly, we recommend that any expansion of Medicare home health coverage authorized by the Congress at this time be done in a controlled and phased manner. We will discuss each of the areas of proposed expansion separately.

Expansion of Coverage to Intensive Levels of Care

Currently, Medicare covers what can be termed an "intermediate" level of care. This care is appropriate for patients who require active treatment or rehabilitation of a relatively controlled disease or injury. Thus, intermediate home care focuses primarily on skilled nursing care, physician, respiratory and occupational therapy and health aid services.

An "intensive" level of home care services is directed toward less medically stable patients requiring an array of professional, technical and health related services that would usually be provided to hospitalized patients. In theory, patients receiving an intensive level of home health

care services would otherwise have to be hospitalized or confined to a skilled nursing facility. In this context, properly organized and administered intensive home health care services should help contain health care costs by reducing the use of inpatient care.

About half the Blue Cross Plans offer benefits for the intensive level of home health services. Their experiences indicate that significant time and resources are required to develop, implement and administer intensive level home health care programs that can contain health care costs through reductions in inpatient utilization. Moreover, documenting cost savings associated with such programs is difficult. The costs associated with the inpatient capacity made available because of home care utilization can offset savings that result from this use of home as opposed to inpatient care.

The Philadelphia Plan, for example, has operated one of the country's most highly regarded home health care benefit programs for nearly two decades. Growth in the program's admissions has been relatively steady, attaining approximately 4,000 intensive home care admissions during last year. Yet utilization of the benefit program is considered low, indicative of the length of time required for ever the best home health care programs to reach their potential. The program has nonetheless achieved significant cost savings in patient care. The Philadelphia Plan has calculated that between 1972 and 1974, utilization of home health care services under this program helped

result in average savings of 12 inpatient days per case, yielding an average net dollar savings of approximately $500 per case.

Several other Plans offering intensive levels of benefits, such as those in New York City, Michigan, Connecticut, Maryland, Rhode Island, Toledo and Maine, have had similar experiences. Home care benefit utilization has been growing, with estimated inpatient days saved ranging from 7 to about 15 days per case. As in the Philadelphia case, favorable results have not been achieved rapidly, as most patients and health care providers have been generally cautious in using intensive home health care benefits.

Administration of Intensive Home Health Coverage

The complexity of a benefit program covering an intensive level of home health services can be best appreciated by considering the administrative and other factors Blue Cross and Blue Shield Plans find important in meeting the service delivery and financing of these programs. There must be providers that are capable of delivering the broad range of services frequently required by patients having relatively unstable medical conditions. There must be substantial coordination among providers of the different types of required services, so that there is a clear continuum of care, and neither patients nor their families are left with the responsibility of contacting multiple providers to assure that needed services are rendered. Hence, there must be strong linkages among home care agencies, hospitals, physicians and others, an element of organization difficult to achieve in many communities. There must also be effective hospital discharge planning, a factor frequently complicated by staffing problems and other priorities.

Critically important to the success of intensive home health services is the education of physicians and other health care professionals. One of the most difficult tasks in implementing an intensive home health care program is assuring physicians that the program can provide the types and quality of services patients need if they are to be cared for effectively in the home.

Utilization review (UR) is also essential. Plans have implemented many forms of home care UR, including prior service approval, retrospective claims review, and active review of providers' patient treatment summaries. Effective utilization review requires that Plans work closely with home health providers to avoid inconveniencing patients and to instruct providers in appropriate use of home health benefits. Many Plans maintain an administrative flexibility that permits benefit decisions to be made on the basis of medically necessary service needs outlined in individual patient treatment plans. The latter requires close scrutiny of care rendered, but appears to result in little unnecessary or inappropriate utilization.

Finally, there must also be accurate and thorough provider reporting including financial information. Without such, monitoring and evaluation of intensive home health care service delivery and financing is not possible.

Intensive Home Health Service Coverage Recommendations

Our recommendation regarding the expansion of Medicare coverage to the intensive level of home health care services is to proceed cautiously, considering the following:

- First, we believe that there needs to be separate or additional certification criteria for providers of

intensive home health care services. This is necessary so that providers claiming to provide or coordinate this level of service can really do so.

- Second, the intensive home care benefit must include an array of professional, technical and other health related services necessary to care for patients experiencing an unstable illness or disease.

  Ambulance or similar transportation services that are medically required should also be included. All services should be provided under intensive physician and nursing management, with appropriate documentation of treatment plans.

- Third, appropriate utilization and financial monitoring criteria and procedures must be developed and implemented.

- Fourth, there must be an educational program directed at patients, physicians, hospitals and home health agencies to encourage and to instruct in the use of intensive home health care services.

- Finally, there must be adequate support for intermediaries to maintain productive working relations with home care providers to assure proper administration of Medicare coverage.

Expansion of Coverage to Maintenance Levels of Care

The "maintenance" level of home health services focuses on assistance with daily living activities and personal care. Patients receiving such services are generally stable medically and usually require only periodic assessment to maintain stability or progress in recovery or rehabilitation. A significant portion of maintenance level services are supportive in nature and thus may not be as closely related to a patient's medical care plan as are the services provided in the intensive or intermediate levels of care.

Very few Blue Cross Plans offer maintenance level home health care benefits. Primary reasons for this are the complexity of relating maintenance category services to medically necessary treatment, difficulty in establishing utilization and other administrative controls, and the risk of high costs and adverse impact on subscriber rates. In short, neither Plans nor their accounts are convinced that payment for this level of care is a reasonable responsibility for health insurers to undertake at this time. Moreover, there is no evidence that benefits for this level of care would be cost containing. While there is a need for such care among the elderly, we would predicate expansion of Medicare coverage for maintenance level home care on:

- o Availability of adequate Title XVIII funds;
- o Development of strict utilization controls; and,
- o Evaluation of experience in funding this level of care under Title XX of the Social Security Act.

Elimination of the Three-Day Prior Hospitalization Requirement

Over half the Plans offering home health care coverage have no prior-hospitalization restrictions, and several others are considering dropping such restrictions in favor of direct admission policies. Some of the Plans that retain prior hospitalization restrictions will waive them on a case by case basis to permit direct home care admission where patient care will clearly benefit. Generally, it appears that direct admission to home care programs provides an additional incentive for patients and physicians to use home health services as an alternative to hospitalization.

A prior hospitalization requirement can be a useful mechanism for program control. Hospitalization or prior use of intensive home care services can act as evidence of the medical need for recovery or rehabilitation services during the same spell of illness. It should not, however, act as an arbitrary barrier to accessibility of appropriate, needed care. We therefore recommend that the Committee:

- Eliminate the prior hospitalization requirement and permit direct admission to the intensive level of care; and
- Retain the requirement as applied to the intermediate level of services, with a waiver permitting admission to intermediate care for patients previously receiving intensive home care services during the same spell of illness.

We note that effective utilization of direct admission policies is particularly sensitive to physician acceptance and confidence in the home care concept and local home health programs and providers. Plans find that without such acceptance, admission to home care programs prior to hospitalization occurs infrequently. A relatively long period of implementation

and promotion of home care among physicians is therefore quite important in achieving effective direct admissions policies.

Elimination of the 100 Visit Restriction

Very few Plans have open-ended benefits with regard to home health care visits. Most Plans place limitations on home health benefits by restricting the number of visits or restricting the duration of stay, or by specifying a ratio that links number of visits available to the number of unused hospital days provided in a subscriber's contract. Many Plans apply these restrictions flexibly, allowing exceptions to be made where medically necessary.

A few Plans have no contractual visit limitations, but instead determine administratively the number of visits that will be covered. This is done by reviewing individual patient treatment plans with home health providers. Decisions are based on whether the services outlined in each treatment plan are medically necessary and appropriate.

Interestingly, few Plans find that subscribers exhaust their home health benefits, even under the most restrictive programs. Most Plans nonetheless appear inclined to maintain visit limitations as an element of benefit control. Until more is known about duration of stay and other home care utilization factors, Plans believe that home care programs should not have open-ended benefit provisions.

Based on the practices of most Blue Cross and Blue Shield Plans, we recommend that the 100 visit limitation be eliminated only after

alternative means of controlling this aspect of home care coverage have been developed and tested on a pilot basis. For example, the visit limitation might be dropped for skilled nursing services but retained in some form for home health aide and other services.

Elimination of the Homebound Requirement

The majority of Plans restrict home health care benefits to services provided to "homebound" patients. This requirement acts as an administrative control much as it does in the Medicare program. However, administration of Plan homebound restrictions tends to be more flexible than in the Medicare program. Exceptions are sometimes made in cases where visits away from the home are necessary to obtain health care (e.g., laboratory and x-ray services) that cannot be provided in the home, or where a patient's health can clearly benefit. Such exceptions can be especially important to the success of intensive home health care programs, since physicians and patients are reluctant to use home care if reimbursement or other obstacles make hospitalization financially and administratively more convenient.

Eliminating the homebound restriction entirely and all at once could create significant administrative problems for a program as large as Medicare. Our recommendation is to replace the current homebound restriction with a new provision that would permit exceptions to be made on the basis of approved patient treatment plans that justify medically related travel or other necessary visits away from a patient's home.

Additional Consideration: Importance of Health Planning

As has been mentioned, successful home health care delivery and financing entail substantial cooperation among payers and all levels of providers. In this context, community wide planning can be an important adjunct in assuring that home health care capacity is neither so excessive nor so restrictive as to discourage or distort the utilization of such services. The Congress should therefore encourage greater use of the health planning process to achieve these goals.

One way this can be accomplished is to require that all home health care programs be subject to certificate of need (CON) reviews and that home health care be specifically addressed in HSAs and SHPs. We believe that this position ought to be included in any renewal legislation for P.L. 93-641.

Conclusion

Effective community home health care systems that provide a comprehensive range of health services to individuals in their homes are an essential element of a total health care system. Cost effective home health care is difficult to achieve however; yet health insurers and policy makers at the local, state and national levels must provide the framework for accessible services while minimizing opportunities for inappropriate utilization. The Blue Cross and Blue Shield organizations support broad home health care coverage within the limits of community need, subscriber demand, financial feasibility and provider capacity and capability. We believe that changes in Medicare's home health care coverage should be made within the context of similar limitations, and that the government, through its intermediaries, will have to emphasize local administration in the context of national policy.

We appreciate the opportunity to comment further on this matter and are available to provide additional information to the Committee.

HOME HEALTH CARE

MODEL BENEFIT PROGRAM
AND
RELATED GUIDELINES

BLUE CROSS ASSOCIATION
840 North Lake Shore Drive
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PREFACE

The Blue Cross Association recognizes the need for Home Health Care to be a viable and essential component of the health care delivery system. Although Home Health Care represents a long standing form of patient care, its effective use continues to be hampered by a general lack of acceptance and understanding of its nature and merits, by a delivery system limited in scope and unavailable to large portions of the population, and by a lack of adequate and appropriate financing. These obstacles need to be overcome to achieve the maximum potential of Home Health Care as a quality, cost-effective patient care service.

For over two decades, the Blue Cross organization has been involved in providing benefits for Home Health Care services. This involvement has grown to the point where now most of the 70 Blue Cross Plans throughout the U.S. provide some form of prepayment benefits for this service. In the interests of expanding this activity and to help promote greater acceptance and effective use of Home Health Care, the Blue Cross Association has prepared this document which sets forth a model for the design of comprehensive Home Health Care benefit programs.

This document is primarily intended for use by local Blue Cross Plans as an informational guide to aid discussions with providers and other interested parties in planning and development efforts. As such, the information presented seeks to provide insight into what are desirable characteristics of an effective Home Health Care delivery system and supportive benefit program, and also what are desirable related responsibilities of both providers and Blue Cross Plans.

Achieving the improvements necessary to advance the Home Health Care field will require the cooperative efforts of all concerned -- providers, third-party payers and consumers. It is hoped that this Model Benefit Program and related guidelines will help in this worthy endeavor.

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INTRODUCTION

In 1974, the Blue Cross Association (BCA) Board of Governors adopted a policy statement urging Blue Cross Plans to offer Home Health Care benefits and to participate in planning, developing and implementing Home Health Care programs.

The quality and cost of health care must be effectively balanced in an acceptable health care system. Essential elements of health care encompass the efficient application of medical, professional, technical and related bio-medical resources and knowledge to the treatment of acute and long term illness and disability; health education and the necessary measures to promote and maintain health and to prevent illness; and the administration and coordination of all health care services in a manner that will ensure delivery of, and access to, care of acceptable quality. A system for the delivery of health services to individuals in their homes is a fundamental component of an effective and efficient health care system.

The Blue Cross Association Home Health Care Benefit Program, which is offered as a recommended model to local Blue Cross Plans, is intended to promote and support the development of a Home Health Care delivery system that will impact favorably on both the quality and cost of health care. Subject to limitations imposed by local conditions, it proposes an extensive range of Home Health Care benefits. It also calls for reimbursement that will logically support the benefit package and ensure appropriate payment to providers.

Personal care and environmental supportive services as well as medical services are frequently needed to care for patients in their homes. This presents difficult challenges in structuring a cost-effective Home Health Care benefit program which is consistent with the role of the health insurance mechanism. The recommended program attempts to meet these challenges. While it is essentially medically-oriented, it includes coverage for certain personal care and supportive services which may be necessary to achieve medical goals. This minimizes financial disincentives to the use of home care because of the cost of such services; at the same time the financial risk of the program is kept within reasonable and manageable limits.

Providing and financing all personal care and environmental supportive services that might be necessary to maintain an acceptable condition in the patient's home for health promotion and rehabilitation are part of a larger social problem and

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challenge -- one that health insurance cannot alone resolve, but one in which it can and should play a part.

The Home Health Care Benefit recommended by BCA is a carefully structured and balanced approach to providing Home Health Care benefits. The fact that Home Health Care services are presently offered under varying circumstances and through diverse types of organizations has been considered. The Program and related guidelines and principles can be applied to all Home Health Care provider organizations, although minor modifications of administrative procedures may be necessary to enable Blue Cross Plans to respond to local situations and governmental requirements.

SECTION I

HOME HEALTH CARE AND THIRD-PARTY REIMBURSEMENT

An effective Home Health Care system that provides a comprehensive range of health services to individuals in their homes is an essential component of a total health care system. In addition to providing needed health care services, it uses to the degree practicable all resources that are available in the patient's home. The family and home environment offer substantial therapeutic and supportive resources for the care of the patient, and are central to the prevention of illness and to the maintenance of health.

A. CHARACTERISTICS OF AN EFFECTIVE HOME HEALTH CARE SYSTEM

The conditions of patients for whom Home Health Care is an appropriate treatment modality may range from complex and fluctuating illness situations to relatively controlled disabilities. Therefore, Home Health Care encompasses a wide range of professional, para-professional, technical, and related medical and supportive services. The organization and administration of these services may involve diverse health care provider organizations including community home health agencies, general and special hospitals, and various other community health and social agencies. Within this context, the following characteristics should be considered in developing Home Health Care programs:

1. A Home Health Care system should include INTENSIVE, INTERMEDIATE and MAINTENANCE (or BASIC)* structures of services to ensure that the needs of patients are effectively and efficiently served. These frameworks of services help to rationalize the system and to foster an orderly continuum of care that is related to the changing needs of patients.

   a. INTENSIVE HOME HEALTH CARE is appropriate for patients who --

      - o require active treatment and/or rehabilitation of an unstable disease or injury;
      - o require a concentrated degree of physician and professional nursing management including frequent observation and/or treatment;

*See definition of Categories of Home Health Care, page 8.

- o require centralized administrative and professional coordination of the treatment plan and the various services provided; and

- o without the availability and use of INTENSIVE Home Health Care would require inpatient care.

INTENSIVE HOME HEALTH CARE includes the array of professional, technical and health related services usually provided by hospitals to inpatients, plus ambulance or similar transportation services that are medically required and cannot be furnished via public or private transportation resources that are available to the patient. Such services are provided under active physician and nursing management. They are provided through a central administrative unit and are professionally coordinated by a registered nurse.

b. INTERMEDIATE HOME HEALTH CARE is appropriate for patients who --

- o require active treatment and/or rehabilitation of a relatively controlled disease or injury;

- o require a lesser degree of physician supervision and management; and

- o require primarily nursing care and/or physical rehabilitation and health aide services.

INTERMEDIATE HOME HEALTH CARE includes nursing care, physical, respiratory, and occupational therapy, speech pathologist service, medical social service and health aide services. Such services are provided by home health agencies either singly or in various combinations.

c. MAINTENANCE HOME HEALTH CARE is appropriate for patients who --

- o are relatively stable medically;

- o have reached a plateau in their rehabilitation;

- require periodic assessment of their clinical status and regular monitoring to ensure, as possible, maintenance of the rehabilitation achieved; and

- require assistance with activities of daily living and/or supportive personal care services.

MAINTENANCE HOME HEALTH CARE includes the various health and related social and supportive personal care services needed by patients who require maintenance care which is sometimes inaccurately referred to as "custodial care".

2. The delivery of Home Health Care services must be coordinated by a professional nurse.

3. Because of the complexities involved in administering and delivering INTENSIVE Home Health Care, this category requires a central administrative unit within a provider organization and ready access to the ancillary medical services usually provided by a general hospital. Effective linkages with other providers of health care must be established to ensure the delivery of needed services and, when necessary, prompt admission to a hospital.

4. A current and complete medical record must be conveniently available to the attending physician, the professional coordinator of services and others providing care to the patient.

5. Both community home health agencies and hospital home care departments can structure and deliver all categories of Home Health Care. At the present time, however, most community home health agencies provide the INTERMEDIATE and MAINTENANCE categories. Hospitals, which usually provide INTENSIVE Home Health Care, generally establish contractual arrangements with approved community home health agencies for the purchase of nursing and therapy services provided in patients' homes on a visiting basis.

6. The Home Health Care system should offer a therapeutic resource and process that can be and is in fact used for all patients without restrictions regarding age, sex, diagnosis, race, creed, color or principal source of payment.

7. The quality of care provided should be monitored and generally recognized professional standards enforced.

8. The Home Health Care provider staff should be directly and continuously involved in an established process of patient care planning. This includes ongoing evaluation of patients' continuing care needs to determine, in association with attending physicians, the most appropriate modality of continuing care; participation in the establishment of care plans; and arranging for the timely transfer of patients to the proper care setting.

9. Patients who have not been previously treated as inpatients of a hospital or other inpatient facility should be eligible for direct admission to all categories of Home Health Care when such services can properly serve their needs.

10. Reasonable utilization review processes should be applied in a consistent manner.

11. Operational procedures for data collection, analysis and reporting should permit valid appraisal of costs and provider efficiency.

12. Standardized administrative and professional policies and procedures should be developed and maintained, as practicable. They should be flexible enough to ensure the delivery of services that are responsive to the particular and varying needs of patients and their physicians.

B. DEFINITIONS*

1. HOME HEALTH CARE SERVICES

Home Health Care Services include an extensive range of physician-directed professional, technical, and related medical and personal care services which are delivered to patients in their places of residence on a visiting basis. They are provided to implement a plan of treatment established for a

*See "Glossary" in Appendix B for additional definitions of pertinent terms.

patient's care, and to supply health related services which are needed to care for and maintain patients in their own homes. Home Health Care Services can include, but are not limited to*:

a. Nursing.

b. Physical therapy.

c. Respiratory therapy.

d. Speech pathologist service.

e. Occupational therapy.

f. Medical social service.

g. Nutritional guidance.

h. Home health aide service.

i. Homemaker service.

j. Diagnostic and therapeutic services and materials hospitals usually furnish to their patients.

k. Pharmaceuticals.

l. Medical/surgical supplies.

m. Durable medical equipment (on a short-term rental basis).

n. Medical appliances and prosthetic devices.

o. Services provided in a hospital outpatient department or other facility when needed to properly care for a Home Health Care patient, if such services cannot be delivered in the home.

p. Ambulance or similar special transportation services that cannot be furnished by public or private transportation available to the patient.

q. Dietary assistance (e.g., meals-on-wheels).

*This does not represent a list of benefits, but is included to indicate the range of health care services which may be delivered to patients in their homes.

r. Supportive devices required to establish and maintain an acceptable environment in the home, and which are necessary for proper implementation of a Home Health Care therapeutic plan, such as installation of hand rails, ramps, telephone, etc.

s. Various services provided by community agencies such as visiting teachers, friendly visitors, vocational counseling, diversional, occupational and social activities, etc.

Home Health Care Services noted above and others not listed are organized and provided singly or in various combinations according to the patient's needs.

2. CATEGORIES OF HOME HEALTH CARE

The Categories of Home Health Care are service programs which are structured administratively to relate most effectively the delivery of services to the medical conditions and needs of patients.

3. PROFESSIONAL COORDINATION

Professional Coordination means the responsibility and related functions carried out, or supervised, by a registered nurse in the delivery of Home Health Care services, particularly those ordered in a plan of treatment for INTENSIVE Home Health Care services. Carried out under physician direction, as appropriate, this is key to the effective administration of Home Health Care. It includes such functions as case finding, planning the timely admission of patients to Home Health Care, coordinating the delivery of necessary services to patients in their homes, planning the discharge of patients from Home Health Care and/or arranging their transfer to other categories of Home Health Care or to other modalities of care.

4. CENTRAL ADMINISTRATION

Central Administration of Home Health Care means an identifiable unit within a hospital or other community health agency that is responsible for administering an INTENSIVE Home Health Care program and supervising the delivery of such services to patients.

5. PROVIDER ORGANIZATION

Provider Organization means one of the various community agencies or institutions which furnish health related services. The two principal types of organizations that provide Home Health Care are community home health agencies and general acute care or special hospitals.

a. Community Home Health Agencies --

are organizations which provide professional nursing and at least one additional home health service (i.e., physical or occupational therapy, speech pathologist service, medical social services or home health aide) on a visiting basis. To qualify for Medicare and Medicaid reimbursement, they must meet the administrative and quality of care standards specified in regulations governing certification as a Medicare provider of home health services. Many community home health agencies also voluntarily seek accreditation under the National League for Nursing/American Public Health Association accreditation program.

The scope of services provided by community home health agencies varies considerably. The majority of them offer INTERMEDIATE and MAINTENANCE categories of Home Health Care. Some also offer the INTENSIVE category.

In some communities, various agencies have merged into a single provider organization. In others, special agencies have been established to administer particular Home Health Care programs.

b. Hospital Home Health Care Programs --

are managed within the hospital by a department or unit established to administer a Home Health Care Service. Administrative variations are found among hospital Home Health Care programs.

Due to the absence of generally recognized definitions in the home care field until recently, many hospitals have identified any

unit responsible for case finding and referral of patients to community home health agencies as home care units or departments. The Joint Commission on Accreditation of Hospitals established Standards for Hospital-Based Home Care Programs effective January, 1974. This action, combined with the Medicare Conditions of Participation for Home Health Agencies and the definition of the three categories of Home Health Care, have resulted in an increasing number of general hospitals establishing Home Health Care departments which generally provide INTENSIVE Home Health Care. In most instances, the hospital administered Home Health Care program establishes cooperative arrangements with community agencies for the purchase of visiting nurse and therapy services for its patients. Some hospitals provide all categories of Home Health Care where community home health agencies do not exist..

6. LINKAGES AMONG PROVIDERS

Linkages Among Providers means the administrative and operational relationships which the various health care provider agencies and institutions establish to facilitate the coordination and delivery of the complex range of services needed by patients who can be cared for at home. Such linkages are desirable and necessary to ensure efficient and effective continuity of patient care, the availability and accessibility of needed services of an acceptable quality and to avoid unnecessary and costly duplication of health care services and facilities.

Administrative arrangements are established by written agreements. Operational arrangements are developed cooperatively among the organizations involved and are based upon acceptable professional standards and effective administrative processes.

C. FINANCING

1. FINANCIAL REQUIREMENTS OF HOME HEALTH CARE PROVIDERS

Financial requirements of Home Health Care providers include the costs of planning, development and growth of service programs, staff development, the

costs of services delivered to patients, and other administrative expenses.

The reasonable costs of operating an effective Home Health Care provider organization should be met by third-party payers, individual patients and, as appropriate and necessary, by public funds and general taxes. Start-up, development and growth activities should be subject to the community health planning process; inappropriate and unnecessary duplication of services should be avoided. Provider organizations must identify their financial requirements using generally accepted accounting principles that properly document their expenses and allocation of costs according to the services provided.

2. RESPONSIBILITIES OF THIRD-PARTY PAYERS

Payment policies and procedures should be established by third-party payers:

a. To furnish effective support for the delivery of services of an acceptable quality according to the medical needs of patients;

b. To cover the cost of medically required services and the related direct and indirect administrative expenses incurred in delivering such services;

c. To promote and support the economical delivery of Home Health Care services;

d. To promote and support the rational organization and effective administration of Home Health Care services; and

e. To support community planning for development of a Home Health Care system.

These responsibilities fall equally upon private and public third-party payers. In addition, charitable and public funds should help support growth, development, education and research costs.

It is especially important for reasonably standard statistical and cost recording and reporting methods to be established. This is necessary to enable providers and payment organizations to

identify costs accurately, to allocate expenses appropriately, and to measure cost-effectiveness.

D. CHARACTERISTICS OF AN EFFECTIVE HOME HEALTH CARE BENEFIT PROGRAM

1. A Home Health Care benefit program should foster and support compliance with accepted quality standards in the administration and delivery of services to patients.

2. A Home Health Care benefit program must logically support its overall objectives through appropriate benefit coverage and provider payment policies and procedures.

3. The benefit program should be formulated and administered in a manner that is compatible with and supportive of the Characteristics of an Effective Home Health Care System stated above.

4. The benefit program should be constructed in a manner that will maximize the cost savings potential of Home Health Care. When both providers and Plans administer the benefit program properly, INTENSIVE Home Health Care should produce measurable cost savings by permitting the period of inpatient care to be shortened or avoided entirely. INTERMEDIATE and MAINTENANCE Home Health Care offer cost savings potential in particular cases by avoiding or postponing the need for the various levels of nursing home or other institutional care.

5. Promotional and marketing practices should be established that present the Home Health Care benefit program as useful, desirable and competitive in the marketplace.

6. Recognition of the differences between Home Health Care and institutional care is essential. A thorough understanding of its organization, administration and financing complexities is necessary.

SECTION II

MODEL HOME HEALTH CARE BENEFIT PROGRAM

A. OBJECTIVES OF THE HOME HEALTH CARE BENEFIT PROGRAM

The Blue Cross Association recognizes that one of the major deficiencies of the health care system is the absence of an effective sub-system for the organization and delivery of a comprehensive range of health care services to patients in their homes. The Home Health Care Benefit Program recommended by BCA is intended to encourage and support the rationalization of professional and related technical and supportive medical services provided in the home so a continuum of health care of an acceptable scope and quality will be more available and accessible to patients.

Specific objectives of the Benefit Program are:

1. To serve better the needs of present and potential Blue Cross subscribers by encouraging and supporting the availability and accessibility of Home Health Care of an acceptable quality;

2. To promote the development and use of Home Health Care as an integral component of the total health care system in order to help bring about more effective use of health care institutions, services, facilities and manpower;

3. To promote the appropriate use of Home Health Care as a viable alternative to institutional care;

4. To foster the development and implementation of a more uniform, comprehensive Home Health Care benefit program within the Blue Cross organization which will promote a more viable Home Health Care delivery system in the United States;

5. To recommend guidelines, principles and procedures to help Blue Cross Plans develop, implement and administer effective Home Health Care benefit programs; and

6. To encourage the collection and reporting of reliable and comparable experience data regarding the administration, utilization and costs of Home Health Care which will facilitate consistent local

and national evaluation of Home Health Care services and the Benefit Program.

B. MODEL HOME HEALTH CARE BENEFIT PROGRAM PROVISIONS

1. BASIC CONTRACT BENEFITS

a. Covered Services

Full service benefit coverage for the following Home Health Care services that are delivered by a Blue Cross Plan approved participating provider organization, subject to the conditions, limitations, and exclusions specified in the patient's Basic Subscriber Agreement:

(1) INTENSIVE Home Health Care --

including all professional, technical, ancillary medical services, supplies and medical equipment that are usually provided by a general hospital and which would be covered if the subscriber were an inpatient in a general hospital or skilled nursing facility; also, health aide services. In addition, ambulance or similar patient transportation services that are medically necessary and cannot be furnished by public or private transportation available to the patient.

(2) INTERMEDIATE Home Health Care --

including specifically nursing care, physical, occupational and respiratory therapy, speech pathologist service, medical social service and related health aide services.

b. Duration of Home Health Care Service Benefits

(1) INTENSIVE Home Health Care --

that is reasonable and medically necessary should be covered for a maximum of 90 patient days during each benefit period as defined in the patient's Subscriber Agreement. Unused Home Health Care benefit days should not be carried over from one benefit period to another.

(2) INTERMEDIATE Home Health Care --

that is reasonable and medically necessary should be covered for a maximum of 90 visits during each benefit period as defined in the patient's Subscriber Agreement. Unused visits should not be carried over from one benefit period to another.

c. Conditions Applicable to the Allowance of Home Health Care Service Benefits

(1) The following conditions should apply to the allowance of service benefits for INTENSIVE and INTERMEDIATE Home Health Care:

(a) Subscribers to be entitled to service benefits for INTENSIVE and INTERMEDIATE Home Health Care must be enrolled under a Blue Cross Plan Basic Contract Subscriber Agreement.

(b) Covered INTENSIVE and INTERMEDIATE Home Health Care must be furnished by a provider organization with which the Blue Cross Plan has a Home Health Care participating provider agreement. The participating provider organization should supply covered services through its own personnel and as appropriate through written agreements, approved by the Plan, for the purchase of particular services from other qualified provider organizations.

(c) To be eligible for INTENSIVE or INTERMEDIATE Home Health Care service benefits, the subscriber patient must be essentially homebound for medical reasons and physically unable to obtain needed medical services on an outpatient basis. Patients may be considered essentially homebound for medical reasons if they leave their homes occasionally to visit their physicians or to obtain treatment in an outpatient facility because equipment and/or

professional services or supervision are required which cannot be furnished in the patient's home, or for other therapeutic purposes.

(d) To be eligible for covered Home Health Care service benefits, a subscriber must be under the care of a physician.

(e) Covered Home Health Care services must be furnished according to a plan of treatment approved by the patient's attending physician and incorporated into the patient's medical record.

(f) The Home Health Care medical record, or a suitable summary or transcript, must be reviewed by the attending physician on a timely basis at regular intervals and the services ordered and provided must be certified as reasonable and medically necessary for the patient's continuing treatment.

(g) Health aide services, to be covered, must be necessary for medical reasons and furnished by appropriately trained personnel employed by participating providers of Home Health Care or through approved arrangements with other provider organizations. Their duties must be assigned and supervised by a professional nurse on the staff of the participating provider of Home Health Care services.

(2) Additional conditions applicable to INTENSIVE Home Health Care:

(a) Service benefits for covered INTENSIVE Home Health Care services should be allowable:

i. when an eligible subscriber is transferred from inpatient to

INTENSIVE Home Health Care immediately following inpatient care in a hospital or skilled nursing facility with no interruption of treatment. The first visit by a registered nurse or therapist should be medically required and made within 24-36 hours of the patient's admission to INTENSIVE Home Health Care;

ii. when an eligible subscriber is admitted directly to INTENSIVE Home Health Care without immediately preceding inpatient care in a hospital or skilled nursing facility.

(b) At the time of admission to INTENSIVE Home Health Care, there must be medical evidence in the patient's record that the patient would require continuing care in or admission to a hospital or skilled nursing facility if INTENSIVE Home Health Care were not provided.

d. Services Not Covered Under Basic Contract Home Health Care Benefits

The following exclusions should apply to coverage under Basic Contract benefits:

(1) Services exceeding the specified limits of liability;

(2) Services not in compliance with the "Conditions Applicable to the Allowance of Home Health Care Service Benefits";

(3) Services for a condition arising out of and during pregnancy, except in the case of Caesarean section, ectopic pregnancy, miscarriage or other complication of pregnancy. (Note: Home delivery including post-partum care for up to 7 days should be covered);

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(4) Food, housing, homemaker services and home delivered meals;

(5) Home or outpatient hemodialysis services including the purchase or rental of equipment required for renal dialysis procedures;*

(6) The purchase of medical appliances and prosthetic devices;

(7) Supportive environmental materials such as hand rails, ramps, telephones, air-conditioners, and similar services, appliances and devices;

(8) Services provided by the patient's private physician(s)**; also services provided by registered nurses and other health workers who are not functioning as employees of or under approved arrangements with a participating provider;

(9) Services provided by a member of the patient's family;

(10) Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational and social activities;

(11) Services deemed not to be medically necessary or appropriate through an approved utilization review process;

(12) Services provided to individuals who are not essentially homebound for medical reasons.

2. MAJOR MEDICAL CONTRACT BENEFITS

Major Medical benefits should be allowed for the following Home Health Care services that are delivered by a Blue Cross Plan approved provider organization, subject to the conditions, limitations and exclusions specified:

a. Benefits Supplementary to Basic Contract Coverage

(1) Subject to the deductible, co-insurance and limits of liability specified in the

*This type of care is usually covered under special conditions specified in a Subscriber Agreement.
**Private physician services are subject to Blue Shield benefit coverage.

subscriber's Major Medical Contract, all services covered under the Basic Contract for INTENSIVE and INTERMEDIATE Home Health Care should be allowed as reasonable and medically necessary* when the maximum Basic Contract benefits for such services have been used.

(2) The following services that are not covered under the Basic Contract should be covered under the Major Medical Contract*:

(a) Purchase of medical appliances and prosthetic devices that become the property of the subscriber.

(b) Services that are reasonable and necessary to carry out effectively a MAINTENANCE Home Health Care plan of treatment, as follows:

i. Nursing care, professional therapy services, social service counseling by a qualified medical social service worker and services of health aides** functioning as employees of an approved Home Health Care provider.

ii. Homemaker services provided by the participating Home Health Care provider, either by its own employees or through acceptable arrangements established with a homemaker/home health aide organization approved by the National Council for Homemaker-Home Health Aide Services. Qualified homemaker services should be allowable only when they are provided on a part-time visiting basis and are ordered by a registered

*The Home Health Care medical record, or a suitable summary or transcript, may be reviewed on a timely basis at regular intervals and the services ordered and provided determined to be reasonable and medically necessary according to a utilization review process approved and subject to monitoring by the Blue Cross Plan.

**See applicable conditions specified on page 16.

nurse employee of a participating Home Health Care provider organization which is providing Home Health Care services to the patient pursuant to a physician's orders and an established plan of treatment.

iii. Hand rails and ramps necessary to enable the patient to ambulate or to move safely about in the home.

b. Services Not Covered Under Major Medical Contract Home Health Care Benefits

The following exclusions should apply to coverage under Major Medical Contract Home Health Care benefits:

(1) Charges for services exceeding the limits of liability specified in the patient's Subscriber Agreement.

(2) Services which are not in compliance with the "Conditions Applicable to the Allowance of Home Health Care Service Benefits."

(3) Services for a condition arising out of pregnancy, except in the case of Caesarean section, ectopic pregnancy, miscarriage or other complications of pregnancy. (Note: Home delivery including post-partum care for up to 7 days should be covered.)

(4) Food, housing, and home-delivered meals.

(5) Services which are not provided by or through an approved participating provider.

(6) Services provided by a member of the patient's family.

(7) Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, friendly visitors, vocational guidance and other counselors, except for social service counseling by a qualified medical social service worker and services related to diversional occupational and social activities.

(8) Services deemed not to be medically necessary or appropriate through an approved utilization review process.

C. ARRANGEMENTS BETWEEN BLUE CROSS PLANS AND PROVIDERS OF HOME HEALTH CARE SERVICES

1. CONDITIONS GOVERNING APPROVAL OF PARTICIPATING PROVIDER ORGANIZATIONS

Home Health Care services are offered by various health care provider organizations. These may include community home health agencies, visiting nurse associations, general and special hospitals, skilled nursing facilities, official health departments, and similar community agencies and proprietary health organizations. To serve properly the interests of subscribers in terms of the availability, accessibility, quality and cost of needed health care, it is necessary to establish conditions that will ensure, as possible, the effective delivery of Home Health Care services. Similarly, the availability of and access to information necessary for planning, evaluation, claims processing, and payment purposes are essential. For these reasons structured relationships must be developed between Plans and qualified providers of Home Health Care services. In developing such relationships, Plans should recognize the diverse administrative characteristics of Home Health Care provider organizations and exercise appropriate flexibility in extending participating provider recognition. The fundamental objectives of encouraging and supporting the development of an effective Home Health Care delivery system should be a basic consideration in all planning and development endeavors.

The following conditions should be required in granting Blue Cross Plan participating recognition to a Home Health Care provider:

a. The provider organization should be accredited and/or certified under all applicable federal, state and local official regulations and have a participating agreement with the Plan for the provision of Home Health Care services.

b. Hospital administered Home Health Care programs should be approved by the Joint Commission on

Accreditation of Hospitals and certified by the Social Security Administration as Medicare providers of home health services.

c. Community home health agencies and similar organizations should be approved by appropriate governmental units and be certified by the Social Security Administration as Medicare providers of home health services. Accreditation under the National League for Nursing/American Public Health Association accreditation program is desirable.

d. Appropriate and effective linkages, subject to Plan approval, should be established by written agreements among provider institutions and agencies to ensure the efficient delivery of services that are required to furnish the various categories of Home Health Care and to avoid unnecessary duplication of services. The particular categories of Home Health Care to be offered by a participating provider must be specified in the provider's written administrative policies. The Plan must specify in provider participating agreements the category(ies) of Home Health Care that are reimbursable by the Plan to the provider.

e. To be recognized as a provider of INTENSIVE Home Health Care, a community home health agency must have written agreements with the majority of general hospitals located in the geographic area served by the agency to ensure access to needed services and to establish the principles of central administration, patient care planning for timely transfer of patients to Home Health Care, central professional coordination of Home Health Care services delivered to patients and the availability of and ready access to ancillary medical services. Ancillary medical services include, but are not limited to, pharmaceuticals, medical/surgical supplies, laboratory procedures, electrocardiograms, diagnostic and therapeutic radiology procedures and outpatient services. The agreement should also ensure prompt admission to the hospital of patients receiving INTENSIVE Home Health Care when such action is medically necessary.

f. A patient care planning process that is approved by the Blue Cross Plan must ensure the

transfer of inpatients to Home Health Care as early as medically acceptable in their course of illness. It must be consistently implemented by the professional nursing personnel of primary and related participating Home Health Care providers. The patient care planning process should be carried out cooperatively with attending physicians.

g. The Plan must be assured that the provider and all organizations with which the provider has agreements for the purchase of services will maintain medical records for all patients to ensure properly documented continuity of care and the availability of necessary medical information. The Plan must also be assured that such records will be made available as appropriate to qualified staff of the Plan.

h. The participating provider of Home Health Care must agree to deliver medically necessary services to patients on every day of the week as required by the physician's orders, the plan of treatment and/or change in a patient's condition.

i. The provider must establish a utilization review process that is acceptable to and can be monitored by the Plan.

j. The provider must record and make available to the Plan statistical and financial data necessary for the effective administration of the program, for financial audits and for program evaluation.

k. Participating providers of Home Health Care services must agree to serve all patients referred to them, subject to the geographic area served by the provider, for whom this type of care is feasible and medically acceptable. Providers should agree not to withhold their services from any patient because of age, sex, race, creed, color or principal source of payment.

l. Recognition by the Plan of the Home Health Care provider should be for a fixed term, renewable on the basis of an evaluation of the service programs. Plan evaluation should

include program administration, professional review and financial audit. The professional review process should be developed in cooperation with medical professionals and approved by the provider and Plan prior to granting the participating provider recognition.

m. The provider must agree to the claims processing procedures and the payment arrangements established by the Plan.

In granting participating provider status for Home Health Care services, Plans must take into consideration the scope of Home Health Care services the provider can effectively and efficiently administer and deliver. A provider that wishes to qualify for reimbursement for a particular category(ies) of Home Health Care must present acceptable evidence that it will be able to provide all of the necessary services ordered by patients' physicians. Providers should be considered for recognition if they offer either INTENSIVE or INTERMEDIATE Home Health Care services, or both, with the particular category(ies) of care that are reimbursable specified in the agreement between the Plan and provider.

2. AGREEMENTS BETWEEN BLUE CROSS PLANS AND PROVIDERS

Participating agreements must be established between Blue Cross Plans and providers of Home Health Care services.

In consideration of the fact that the Home Health Care Benefit Program represents an innovative action in an area of health care services that is not well understood, widely used, or effectively organized at the present time; and in consideration of the fact that Blue Cross Plans generally have limited experience in the Home Health Care field, it is important to avoid agreements that might thwart the opportunity for the Plan and provider organizations to maximize the potential value of Home Health Care through flexible and innovative actions. For these reasons many Plans offer benefits for Home Health Care as a pilot program, allowing benefit coverage on an administrative basis to preserve the freedom to develop programs that are most efficient and responsive to the needs of the communities they serve as experience is gained by both the Plan and providers. This approach is recommended when it is appropriate and feasible to implement.

D. BLUE CROSS PLAN AND PROVIDER ORGANIZATION RELATIONSHIPS

1. PLANNING, DEVELOPMENT AND IMPLEMENTATION OF HOME HEALTH CARE PROGRAMS

Some Blue Cross Plans offering Home Health Care benefits have taken such action in response to requests from community agencies for third-party payment to cover the services they provide. Other Plans have taken the initiative in planning and developing Home Health Care services. Information that is available suggests that the most effective programs have taken root where Plans have been directly and fully involved in the planning, development and implementation process, providing guidance and facilitating understanding regarding third-party payment policies.

Planning, development, implementation and appropriate financing of Home Health Care require informed and balanced judgments that take into consideration many interrelated factors. Initially, the characteristics of medical practice and the use of existing health services and facilities in the community must be analyzed.

- Where is medical practice centered?
- Because modern medicine is usually focused in hospitals, in what manner does medical staff membership overlap?
- What services are provided by community home health agencies?
- To what extent and for what types of patients do physicians use these services?
- What relationships exist between hospitals and community home health agencies and is action needed to strengthen such relationships?
- If necessary, will community agencies expand their service programs and modify administrative and professional policies to support development of a comprehensive Home Health Care system that will ensure the availability and appropriate use of INTENSIVE Home Health Care as well as the INTERMEDIATE and MAINTENANCE categories?*

*Helen L. Rawlinson, "Planning Home Care Services," HOSPITALS, Vol. 49, June 16, 1975, p. 67.

It has been demonstrated that the viability of a home care program depends on the effectiveness of its administrative structure, the efficiency of its operational methods, the scope and quality of services provided, the degree to which it is useful to physicians and acceptable to their patients, and the logical and appropriate financing policies established.*

2. BLUE CROSS PLAN AND PROVIDER ORGANIZATION ACCOUNTABILITIES

Plans and providers have discrete and shared accountabilities in the areas of administration, delivery of services, and financial affairs. These accountabilities merge to form a reciprocating mechanism that involves and serves patients, providers and Plans. The patient is the ultimate beneficiary since the primary objective is to provide needed services through an improved continuum of care in a manner that will utilize most economically the health care dollar.

Provider accountabilities are generally incorporated in the "Conditions Governing Approval of Participating Provider Organizations."

*Helen L. Rawlinson, "Planning Home Care Services," HOSPITALS, Vol. 49, June 16, 1975, p. 67.

SECTION III

ADMINISTRATION OF THE HOME HEALTH CARE BENEFIT PROGRAM

Blue Cross Plan administration of a Home Health Care Benefit Program encompasses: (a) provider relations, promotional, and consultative activities; (b) maintenance of an adequate staff of properly qualified personnel; (c) claims administration; (d) monitoring provider administrative practices and records; (e) developing and enforcing reimbursement policies and procedures; and (f) recording, reporting, and evaluating experience data.

A. PROVIDER RELATIONS, PROMOTIONAL AND CONSULTATIVE ACTIVITIES

1. PROVIDER RELATIONS

It is important for Plans to establish and maintain effective relationships with all providers of the various Home Health Care services and, as appropriate, with the suppliers of related services, materials and equipment. Plans should promote physician support and use of Home Health Care and cohesiveness among the various institutional providers of health services, community home health agencies and community organizations which supply health-related social and supportive services. Helpful assistance should be furnished to aid these various groups to establish approved linkages and the administrative procedures that are required to develop and maintain an acceptable and viable Home Health Care system and to qualify for Blue Cross Plan reimbursement. For example, Plan personnel may initiate and/or participate in cooperative planning endeavors, offering constructive assistance in the development and implementation of Home Health Care programs; Plans can be a focal point for information and materials needed in the organization, management, and evaluation of Home Health Care programs; Plans should foster and assist in the standardization, as feasible, of policies and procedures for the administration, professional coordination, and delivery of Home Health Care services.

Plans have a special responsibility to interpret the Home Health Care Benefit Program to provider organizations, physicians, allied medical professionals, employers, unions, subscribers and the community-at-large.

2. PROMOTIONAL ACTIVITIES

In addition to the provider relations activities noted above, Plans may be helpful in developing of attractive literature, reliable experience reports and other materials for use by the Plan and providers which will promote the understanding and appropriate use of Home Health Care.

Perpetuating the stigmas which for many years have sustained misconceptions about Home Health Care must be avoided. It is important to emphasize that Home Health Care is not primarily for elderly, disabled and chronically ill individuals. Promotional programs and materials should present Home Health Care as a valid therapeutic process, as an integral element of the health care system which should be used whenever it will properly serve a patient's needs.

3. CONSULTATIVE ACTIVITIES

Plan personnel may provide responsible administrative and professional consultation and technical advice to providers, planning agencies and related organizations. Liaison or advisory committees sponsored by the Plan are frequently established to assist in this work.

In addition to interpreting the Benefit Program and provider payment policies, the goal is for all concerned groups and individuals to work collaboratively to develop, implement and encourage the growth of effective Home Health Care systems. A basic problem in offering benefits for Home Health Care services is how to ensure for Subscribers the availability of and access to covered services. This requires Plans to be involved in cooperative planning endeavors and in the identification and solution of problems.

B. PARTICIPATING PROVIDER AGREEMENTS

The Home Health Care Benefit Program recommended by the Blue Cross Association is a carefully structured, balanced program. It is designed to be responsive to the needs of patients and the health professionals who are responsible for their care. It stipulates conditions

that are intended to ensure a system for the delivery of medically necessary services of an acceptable quality at the lowest possible cost. Consumers and providers should understand the fact that the character of an insured risk, especially in the field of human services, is subject to diverse influences, i.e., the laws of averages applicable to the risk, the personal preferences and selections of the insured and his family, the efficiency of provider operations, the costs of the services at risk, the level of funds available to finance covered services, and the objective controls required to effect an acceptable balance of all these services and the enforcement of administrative procedures and utilization controls that will stimulate the most effective and economical use of all health care resources.

The agreement between Plans and participating providers should cover the following items:

1. The identity of the provider organization, the categories of Home Health Care to be provided as reimbursable services, the related professional and ancillary medical services that will be covered and the "Conditions Applicable to the Allowance of Home Health Care Service Benefits" (including the approved administrative policies and procedures);

2. If the primary provider organization contracts for certain services from other providers, such contracts must be approved by the Plan. They should:

   a. protect the integrity of the overall administrative plan and specify the responsibilities and lines of accountability,

   b. provide for the purchase of services of an acceptable quality,

   c. support prudent buying principles, and

   d. insure compliance with required utilization review and quality assurance processes;

3. The schedule of covered services and applicable conditions governing the allowance of benefits;

4. Policies and procedures applicable to Plan reimbursement for covered services and the related administrative expenses incurred by providers;

5. Provider agreement to disclose administrative, medical and financial information;

6. Approved quality standards provider organizations are required to meet;

7. Agreement that covered services will not be withheld from any individual for whom they are suitable because of age, sex, race, creed, color or principal source of payment;

8. Agreement that the provider will implement a Plan approved patient care planning process that will, as practicable, ensure the timely admission of patients to Home Health Care when such care is feasible and medically acceptable; and

9. The provider will establish a utilization review and quality assurance process that is acceptable to the Plan.

The items noted above should also be covered in the provider organization's written administrative plan.

C. MONITORING OF PATIENT RECORDS AND RELATED DOCUMENTATION

UTILIZATION REVIEW PROGRAM

An effective utilization review program must be a process involving both the providers and the Plan in a cooperative endeavor to achieve mutually desirable goals. These include efficient administrative procedures, appropriate utilization of covered services, and the delivery of services of an acceptable quality to patients. Achievement of these goals requires the enforcement of policies that are consistently supportive of the objectives of the Home Health Care Benefit Program.

Cost containment is a major consideration in the use of Home Health Care services, particularly the INTENSIVE and INTERMEDIATE categories of Home Health Care, which should lessen the use of more costly institutional facilities. The utilization review process should ensure, to the extent possible, that patients are cared for through the category of Home Health Care that will serve their medical needs adequately.

Home environments vary, as do the medical needs of patients. Therefore, it is not practical to

formulate inflexible guidelines applicable to the proper utilization of Home Health Care services. Rather, the appropriate use of these services should be determined by continuing professional assessments of patients' medical and related needs and the degree to which they can be satisfactorily met in the particular home environment. These facts must be documented in a complete medical record, not only to ensure the delivery of an acceptable quality and continuum of care, but also to facilitate effective utilization review and claims control processes.

Four major activities are included in a utilization review program:

a. Consultation and instruction to Home Health Care provider personnel regarding Blue Cross Home Health Care benefits and the conditions governing the allowance of such benefits;

b. Consultation and instruction to provider personnel regarding covered categories of Home Health Care;

c. Approval and reapproval of benefits and verification of billing statements; and

d. Validation of benefit allowances through a consistently applied process for the review of patient records by qualified professional staff of the Plan.

D. PROVIDER PAYMENT

1. GENERAL PRINCIPLES

Principles governing Blue Cross Plan provider payment policies and procedures for Home Health Care should logically support the objectives of the Home Health Care Benefit Program. They should also contribute to the effective use and efficient administration and delivery of such services. The particular characteristics of the various institutions and community organizations that are involved in providing the differing categories of Home Health Care should be recognized. Similarly, the needs of patients, which may range through all the categories of Home Health Care during an episode of illness, should be considered. Provider payment

policies should accommodate these fluctuations and be compatible with utilization review processes that properly identify the covered medical and related needs of patients. This should result in appropriate reimbursement which in turn should promote the delivery of medically required services through the most efficient structure of the Home Health Care system.

Provider payment policies significantly affect the degree to which Home Health Care will be used as an acceptable alternative to more costly inpatient facilities. For this reason, the unit of service and reimbursement rates must be reasonably related to the category of services provided. Care must be taken to ensure that provider payment policies do not foster undesirable duplication or fragmentation of service programs and administrative operations. Also, the principles of central administration and professional coordination of services should be protected through provider payment policies that recognize and direct all payments to only the primary participating provider organization (i.e., the participating provider organization which is responsible for establishing the plan of treatment and carrying out the physician's orders).

2. IDENTIFICATION AND ALLOCATION OF COSTS

a. Institutional Providers

The cost allocation schedule and related instructions included in Appendix C have been reviewed and endorsed by cost accountants and reimbursement specialists in both institutional provider organizations and Blue Cross Plans. This schedule furnishes directions to providers for the identification and appropriate allocation of expenses to the Home Health Care cost center.

The cost allocation schedule enables providers to account for the costs of services delivered directly to patients, for the costs incurred in administering the Home Health Care program, and for the allocation of indirect administrative expenses to the home care cost center. With appropriate adaptations, the schedule may be used by community home health agencies as well as by institutional providers.

b. Community Home Health Agency Providers

Community home health agencies currently use one of four recognized cost analysis methods. These include: 1) the National League for Nursing --Method I (Revised), 2) the National League for Nursing -- Method II, 3) the Combined National League for Nursing/Public Health Service Method, and 4) the Ratio of Covered Charges to Costs (RCCAC) method.

Deficiencies have been identified in each of these methods in relation to the identification and allocation of costs, in establishing charges, and in determining appropriate payment for services provided in a particular case. For example, the variables in the "visit" need to be accounted for, particularly the length of time involved and the personnel qualifications required to provide the necessary services. These deficiencies result in uneven reporting of statistical and cost information so that reliable data is not available for comparison and evaluation.

Plans and providers should work toward establishing methods to collect and report accurate financial and utilization data for program evaluation and ensure appropriate payment to providers for the services furnished to Blue Cross subscribers.

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APPENDIX A

A STATEMENT OF POLICY OF THE BLUE CROSS ASSOCIATION

RELATIONSHIPS BETWEEN BLUE CROSS PLANS AND HOME HEALTH CARE PROVIDERS

ADOPTED BY THE
BOARD OF GOVERNORS
APRIL 17, 1974

HOME HEALTH CARE

The public's concern over the cost of health care, combined with its increasing demands for greater access to needed health care services of high quality requires that the traditional patterns of financing and delivering health care services be re-examined, and that greater emphasis be placed upon the use of cost effective methods of delivery. Home Health Care is one long standing delivery mode which may have potential for favorably impacting the cost and quality of health care services.

For the purposes of this discussion, the term Home Health Care (HHC) shall be used to describe an array of services provided under medical direction "which may be brought into the home singly or in combination in order to achieve and sustain the optimal state of health, activity, and independence for individuals of all ages who require such services because of acute illness, exacerbation of chronic illness, long term or permanent limitations due to chronic illness and disability."[1] This array includes, but is not restricted to, professional nursing, therapeutic services provided by allied health professionals (e.g., physical therapy, speech therapy, occupational therapy, etc.) and as feasible, ancillary medical services (e.g., laboratory procedures, electrocardiography, pharmaceuticals, medical supplies and durable medical equipment.) The provision of HHC encompasses three major categories of care: Intensive, Intermediate, and Basic.

The Intensive category usually requires professional coordination of a range of health care services; central administration with structured linkages to all participating providers of direct patient services; and active medical and professional nursing management of the patient's care.

The Intermediate category of HHC requires a less concentrated array of services than the Intensive category. It may involve only a single professional service or a combination of nursing and therapy services provided under appropriate professional supervision according to established medical programs.

The Basic category of HHC requires a minimum of services that contains proportionately less professional nursing and therapy services, but includes more professionally supervised health aide and supportive social services that are needed to carry out a program of maintenance care.

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1. Traeger, Brahna, Home Care Services in the United States: A Report to the Special Senate Committee on Aging, 92nd Congress, 2nd Session, Washington, D.C.: U.S. Government Printing Office, 1972.

Currently, 42 Blue Cross Plans offer some form of HHC benefits to approximately thirty million members (46% of the Blue Cross organization membership). Although benefits for the Intermediate category of care predominate, the type and extent of HHC services that are covered varies widely among Plans. For example, of the 42 Plans offering some form of HHC benefit, eleven cover pre-hospital home care, twenty cover nervous and pulmonary disorders, and eight cover homemaker services. The diversity of HHC benefits provided by Plans mirrors the uncertainty in the Blue Cross organization regarding the proper role of Home Health Care.

The purpose of the statement is to resolve this uncertainty through an examination of the potential contribution to the health care system of Home Health Care and to set out the Blue Cross organization's position concerning its present and future development.

ISSUES

The central questions presented to the Blue Cross organization by Home Health Care are:

1. Should Blue Cross Plans provide Home Health Care benefits?

2. If so, what should be the nature of the relationships between Blue Cross Plans and Home Health Care providers; and what conditions, if any, should govern the development of such relationships?

3. What responsibilities, if any, should the Blue Cross organization and individual Plans assume in the development and promotion of Home Health Care programs?

The resolution of these issues rests principally on the implications of the provision of Home Health Care for the cost and quality of health care services.

COST IMPLICATIONS

It has been frequently asserted that the provision of HHC will result in a cost savings to the health care system. To evaluate this statement adequately, it is necessary to examine each category of HHC, and to determine its potential cost impacts.

Intensive Category

The Intensive category of HHC can be, for some patients, a less costly alternative to some phases of inpatient hospital or skilled nursing facility care. The use of Intensive category HHC frequently represents a recognition that some types of care

generally accepted as appropriately rendered in hospitals may also be provided in the home setting if the necessary support is available. As such, the appropriate use of this category of home care can result in a lower cost per case through decreased length of stay, a decrease in admissions through maintaining patients at a health level that reduces the need to be admitted, and, if appropriate adjustments are made within the health care capital structure, a lower total cost to the community.

Empirical evidence documenting the cost impact of home care, is unfortunately, not readily available. However, limited information has been gathered by Blue Cross Plans concerning the number of inpatient days saved by home care and the related cost savings. The experience of Blue Cross of Greater Philadelphia in the eight years from 1962 to 1970[2] showed that the use of Intensive category home care resulted in an average of 12.9 days saved per case[3] and an average saving of $330 per case[4]. Similarly, Blue Cross of Michigan found that during the period from 1963 to 1972 the provision of a combination of Intensive and Intermediate category home care resulted in an average savings of days that ranged from 18.5 to 10.2 days per case.[5] Dollar savings per case ranged from $519 to $917 per case.

The actual impact of home care on the community's total health care costs is less clear. The appropriate use of Intensive home care creates an opportunity for a community to restructure its health care resources into a more cost effective pattern. For example, if the Intensive category of home care reduced the need for hospital services in a community by 5%, a potential cost savings of somewhat less that 5% could exist (5%, less the cost of the home care program.) However, this saving would be fully realized only if the hospitals in the community were able to appropriately reduce their resources, convert them to other use, or avoid the construction of additional acute care or skilled nursing beds.

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2. Blue Cross of Greater Philadelphia Coordinated Home Care Study 1962-1970, Helen Rawlinson, Florence Brown.

3. Estimates established after professional review of the complete Home Care clinical record following discharge of patients from Home Care Service.

4. Savings per case is determined by ((inpatient days saved X average inpatient per day cost) - Home Care Cost) ÷ Home Care Cases.

5. Blue Cross of Michigan Home Care Experience 1963-1972, Home Care Department.

Factual information documenting this impact is not presently available. To determine the magnitude of the potential savings and the extent to which it may be fully realized will require future careful research.

Intermediate Category

The Intermediate category of home care also can potentially provide cost savings to the community. Although it does not usually represent an alternative to appropriate hospital care, it does provide an alternative locus for some phases of nursing home care and for the provision of care that is often inappropriately given at the hospital level. The Intermediate category of home care permits physicians to discharge patients who would have been kept in the hospital only because adequate support was unavailable at home. The availability and proper use of this level of care can contribute significantly to the ability of health care professionals to rationally use the resources of the health care system.

Additionally, Intermediate category home care may provide savings by helping to maintain patients at a health level that reduces their need to be admitted to the hospital. Although this reduction of hospitalization either due to appropriate discharge or avoidance of admission is not documented, it is reasonable to assume that it does occur and results in some additional cost savings.

Basic Home Care

The Basic category of home care does not appear to create a cost savings to the community except as it may reduce the need for care in nursing home facilities. In fact, it appears to increase the total cost of care because it represents an additional level of services, which are necessary and appropriate in specific instances, but do not, as a rule, reduce the need for other types of health care services.

QUALITY

The American Medical Association has endorsed the appropriate use of the several levels of HHC and has recommended that practicing physicians, medical societies, and institutional medical staffs join in using, promoting, and strengthening home care programs. This endorsement indicates that care of appropriate technical quality can be provided in the home. The parameters of the quality of medical care, however, include more than the technical aspects of care. Aspects of care such as continuity, ease of access, patient satisfaction and comprehensiveness must also be considered. Each, in some way, can be affected and improved upon by the appropriate use of HHC.

The primary effect of all three categories of HHC is to improve comprehensiveness, continuity, access, and patient satisfaction. Although there is little factual data to demonstrate the effects of HHC on these parameters of quality, extensive case studies support these effects. In a report prepared for the Kellogg Foundation, Griffith indicates that patients are generally pleased with home care and are frequently convinced that HHC saved them from either a hospital or nursing home stay.[6]

A study prepared by Katz, et. al. on the effects of continued care showed that patients with certain characteristics (generally those less severely ill) receiving care from a visiting nurse after discharge from a chronic disease rehabilitation hospital often maintained a greater physical function than those not receiving such care. For other groups of patients (those more severely ill) it was shown that the patients receiving care from a visiting nurse utilized more of other professional medical services than those not receiving such care. These results indicate that the HHC served to both increase the level of the patient's recovery and to increase the patient's access to the health care system.[7]

Although these studies indicate that the appropriate use of HHC generally increases the quality of care, through increased access, patient satisfaction and better health levels, they are not specifically related to particular categories of care. The determination of the impact of each category of HHC on the quality of care, will require additional research.

POSITION

The available information concerning HHC indicates that the provision of all categories of HHC increase the quality of health care and that the Intensive and Intermediate categories of care present potential cost savings to the health care system. The Blue Cross organization has traditionally supported promising alternative methods of delivering health care, and firmly supports the concept of HHC.

Therefore, Blue Cross Plans should both offer Home Health Care benefits to interested members and take an active role in planning, developing, implementing and evaluating the Intensive and Intermediate categories of Home Health Care. Similarly, Plans are urged to evaluate the potential advantages of providing Basic category benefits.

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6. Griffith, J.R. "Taking the Hospital to the Patient", Kellogg Foundation, Battle Creek, Michigan, 1966.

7. Katz, et. al. "The Effects of Continued Care", National Center for Health Services Research and Development, 1972.

To assure that the structural requirements of quality as well as the informational needs of planning and evaluation are met, it is essential that soundly structured relationships between Plans and providers of home care be developed. The Blue Cross organization therefore, has established the following conditions which providers of HHC should meet to be eligible for contractual relationships. In applying these guidelines, the diverse nature of the facilities involved should be recognized and flexibility should be exercised in their interpretation and implementation.

Hospital Based Home Care Programs

1. The Hospital shall have a contractual relationship with the Plan.*

2. The program shall be approved by the JCAH, and appropriate state and local authorities and shall meet the requirements for Medicare participation.

Non-Hospital Based Home Care Programs**

1. The agency shall be approved by the appropriate governmental units, or other appropriate authority and meet the requirements for Medicare participation.

2. The agency shall establish working relationships with hospitals or other providers of care to assure coordinated patient care planning, and the availability of needed services.

All Home Care Programs

1. The hospital or other agency shall establish an effective utilization review program.

2. The hospital or other agency shall engage in patient care planning that will ensure the timely transfer of patients to home care, the provision of needed health care services, as well as discharge from the program.

3. The agreement between the Plan and the hospital or other agency shall be of fixed term, renewable on the basis of an evaluation of the effectiveness and efficiency of the program. The evaluation shall be designed in cooperation with medical professionals and approved by the program and the Plan prior to the commencement of the agreement.

*See BCA Policy Statement on Guidelines for Contractual Relationships with Health Care Institutions (1973). Hospital Based home care programs should be treated in the same manner as other hospital services by the Plan.

**Home Care Programs are frequently sponsored by such community agencies as health departments and visiting nurse associations.

APPENDIX B

GLOSSARY

ACTIVE TREATMENT: Treatment which is directed immediately to the cure of a disease or injury.

HEALTH AIDE: A health aide is an individual employed by an approved health agency who after appropriate training is qualified to function as a member of the Home Health Care team. Duties to be performed by the health aide are designated and assigned by a registered nurse who also supervises the health aide. The primary function of a health aide is the personal care of a patient through the performance of simple procedures that are related to and an extension of professional nursing and/or therapy services. Essential household services directly related to the care of a patient at home may be an integral part of health aide services. The assignment of a health aide to a particular case must be made in accordance with the written plan of treatment that is established for the patient and which indicates that the personal care services to be provided by a health aide are needed as an extension of professional nursing and/or therapy services to achieve the medically desired results.

HOMEMAKER: A homemaker is an individual employed by a participating home health care provider or a community homemaker/ home health aide organization that is approved by the National Council for Homemaker/Home Health Aides who, after completing appropriate training, is qualified to perform homemaker duties on a part-time visiting basis in a patient's home. Such duties must be assigned by and performed under the supervision of a registered nurse, and they must be necessary to carry out effectively a Home Health Care plan of treatment. Homemakers perform such duties as: light housekeeping, light laundry, preparing and serving meals, shopping, necessary simple errands, teaching of household routine and skills to well members of the family, and general supervision of the patient's children.

MEDICAL: Pertaining to the treatment of disease or injury.

MEDICAL SOCIAL SERVICE: Medical Social Service is provided by an individual who has earned a masters degree from an accredited school of social work and has completed at least one year of social work experience in a health care setting. The medical social service worker assists the physician and others participating in the care of a patient to understand the emotional, social and en-

vironmental factors resulting from or affecting the patient's illness and participates, according to physician's orders and to the written plan of treatment, with other members of the Home Health Care team in solving problems that are identified unfavorably influencing the patient's medical condition and his response to treatment.

NURSING: See PROFESSIONAL NURSING.

NUTRITIONAL GUIDANCE: Consultation and teaching by an individual particularly trained in the scientific use of diet in health and disease (a dietician).

OCCUPATIONAL THERAPY: The teaching by a qualified occupational therapist of useful skills to sick or handicapped persons to promote their rehabilitation and recovery.

PATIENT CARE PLANNING: A process carried out by a professional nurse under physician direction and in consultation with other health professionals, the patient and his family, as appropriate, for the purpose of assessing on a continuing basis the treatment needed by the patient and ensuring that needed care is provided in the most effective and economical setting.

PATIENT DAY: A day during which the patient's care, either directly or through the monitoring and supervision of others, is the responsibility of a home health care provider organization.

PERSONAL CARE: Services which can be provided by a health aide including, but not limited to, assistance in the activities of daily living, e.g., helping the patient to bathe, to care for his hair and teeth, to get in and out of bed, to exercise, to take medications specifically ordered by a physician which are ordinarily self-administered, and to retrain the patient in necessary self-help skills.

PHYSICAL THERAPY: Treatment by a registered physical therapist involving the use of physical agents and methods in rehabilitation and restoration of normal bodily function after illness or injury.

PROFESSIONAL NURSING: Professional nursing encompasses seven particular areas which include:*

(1) The supervision of a patient involving the whole management of care, requiring the application of principles based upon the biologic, the physical and the social sciences.

* Lesnick and Anderson, Nursing Practice and the Law, 2nd Edition.

(2) The observation of symptoms and reactions requiring evaluation or application of principles based upon the biologic, the physical and the social sciences.

(3) The accurate recording and reporting of facts, including evaluation of the whole care of the patient.

(4) The supervision of others, except physicians, contributing to the care of the patient.

(5) The application and the execution of nursing procedures and techniques.

(6) Direction and education for sustaining and preventive health care.

(7) The application and the execution of legal orders of physicians concerning treatments and medications, with an understanding of cause and effect thereof.

REHABILITATION: The restoration of an ill or injured patient to self-sufficiency or to gainful employment at his highest attainable ability in the shortest possible time.

RESPIRATORY THERAPY: Treatment and instruction by an individual particularly trained in the use of physical procedures and mechanical devices for the care of respiratory disorders.

SPEECH PATHOLOGIST SERVICE: Treatment and instruction by a qualified speech pathologist for correction of speech and language disorders resulting from illness or injury.

SOURCES

1. Dorland, Medical Dictionary

2. HEW/SSA, Health Insurance for the Aged, Home Health Agency Manual (HIM-11).

3. Miller and Keane, Encyclopedia and Dictionary of Medicine and Nursing, 1972.

APPENDIX C

SPECIMEN HOSPITAL HOME CARE DEPARTMENT
COST ALLOCATION INSTRUCTIONS AND SCHEDULE*

*SOURCE: Blue Cross of Greater Philadelphia

NOTE: The specimen included in this Appendix C has been reviewed by the American Hospital Association and was distributed to the Association's member institutions in September, 1974.

APPENDIX C

INSTRUCTIONS FOR COMPLETING THE STATEMENT OF HOSPITAL HOME CARE DEPARTMENT COSTS

The purpose of THE STATEMENT OF HOME CARE DEPARTMENT COSTS is to provide a form for uniform reporting of costs incurred by the hospital in providing home care services to patients and the related direct and indirect administrative costs. The form is to be completed by the hospital and submitted to the Home Care Department, Blue Cross of Greater Philadelphia. The form, which is required of all hospitals participating in the Blue Cross Home Care Benefit Program, provides for the standardization of appropriate and full reporting of costs related to the operation of hospital home care departments. Section I calls for the itemization of the costs of services provided by or through the home care department directly to home care patients. Section II calls for the itemization of the direct administrative costs of operating the hospital home care department and the indirect administrative costs that are allocated to the home care department from the hospital step-down schedule.

SECTION I. A. LINES 1 THROUGH 10

The cost to the hospital, including payroll expenses and/or the cost of professional and paraprofessional services purchased by the hospital on behalf of its home care patients are reported in this paragraph. Payroll expenses should include the hourly rate for the positions represented plus the appropriate percentage for taxes, insurance, and approved employee benefit programs. The total cost to the hospital for services purchased on behalf of home care patients, such as visiting nursing, therapy, and health aide services, will be the costs entered in this paragraph.

SECTION I. B. LINE 1

The cost to the hospital for rental of durable medical equipment for home care patients, or the expenses incurred by the hospital in purchasing, transporting and maintaining such items for use by home care patients will be entered in this line.

SECTION I. C. LINES 1 THROUGH 14

The cost of direct patient services supplied by other departments of the hospital to patients of the home care department are to be itemized in this paragraph. Services by other hospital department directors and/or staff on home care department committees and the time such personnel may spend in consultation with home care department personnel

may not be charged to the home care department since such activity is regarded as part of the responsibility of such positions. However, if the personnel of other hospital departments actually visit home care patients in their homes as called for in the therapeutic plan, the cost of such visits will be entered in Section I.A. as noted above.

It is recognized that it is impossible to determine precisely the cost of such items of service furnished to patients, i.e., pharmaceuticals, medical/surgical supplies, laboratory procedures, etc. Therefore, the cost of prescribed drugs and medications, medical/surgical supplies, laboratory procedures, electrocardiograms, radiology examinations and treatment, and other similar ancillary medical services provided by other hospital departments are to be determined according to the ratio of the total charges for the services supplied by the other department to the home care department patients to the total charges for all services supplied to all patients by the other department applied to the other department's total costs. This is to say, if the total charges for laboratory services supplied to home care department patients represented charges equivalent to 15% of the aggregate charges for the laboratory services provided to all patients served by the laboratory, the amount to be entered in line 6 would be 15% of the total costs of the laboratory department.

SECTION II. A.

1. PAYROLL
Enter only the costs incurred by the hospital in administering and operating the home care department. Do not include such costs when they are related to the actual delivery of care to patients in their homes. (See Sec. I. A.)

2. SUPPLIES
Enter the costs of supplies requisitioned and/or purchased which are used in the operation of the home care department. Lines c and d refer to materials that correspond to floor stock items issued to inpatient departments. Such items should be charged to the home care department according to approved hospital policies that apply to allocation of such costs to other hospital departments.

3. COMMUNICATIONS AND TRANSPORTATION
The costs incurred by the home care department for books, subscriptions, professional organization dues, travel expenses, etc. will be entered in lines a through e. Line c should include all travel and transportation costs related to furnishing services directly to patients.

4. PURCHASED OFFICE EQUIPMENT, REPAIRS AND DEPRECIATION
The costs of equipment, repairs and depreciation applicable to the operation of the home care department that are not charged directly to patients are entered in this paragraph. Such costs include the purchase and repair of office equipment, furnishings, etc.

5. MISCELLANEOUS
Various expenses incurred in the operation of the home care department that are not included in other parts of paragraph A should be identified and entered in this part.

SECTION II. B. LINES 1 THROUGH 11

INDIRECT ADMINISTRATIVE COSTS
Costs applicable to items 1 through 8 and other similar costs, to be identified in lines 9 through 11, should be entered in this paragraph according to the hospital accounting step-down per "Worksheet B" (Form SSA-1562). Employee health and welfare expenses are included along with taxes in payroll costs, therefore, such costs should not be added in this paragraph. The amount of general administrative expenses allocated to the home care department should be calculated on the basis of the ratio of the home care department's accumulated total costs to the total hospital costs applied to the total general administrative costs.

Blue Cross of Greater Philadephia
Home Care Department

Revised March 7, 1975

_____
(Hospital)

STATEMENT OF HOME CARE DEPARTMENT COSTS FROM_____ TO_____

SECTION I
DIRECT PATIENT SERVICES

		COST TO HOSPITAL		
A.	EXPENSES FOR SERVICES PROVIDED ON A VISITING BASIS TO PATIENTS IN THEIR HOMES	PURCHASED SERVICES	HOSPITAL PERSONNEL*	
	1. Nursing Visits	$	$	
	2. Physical Therapy Visits			
	3. Speech Therapy Visits			
	4. Occupational Therapy Visits			
	5. Medical Social Service Visits			
	6. Home Health Aide Visits			
	7. Technician			
	Other: (Identify)			
	8. _____			
	9. _____			
	10. _____			
	SUB-TOTAL	$	$	$
B.	DURABLE MEDICAL EQUIPMENT	$	$	
	1. Rental and/or Hosp. Service Costs	$	$	$
C.	ALLOCATION OF COSTS TO HOME CARE DEPT. COST CENTER FOR DIRECT PATIENT SERVICES SUPPLIED BY OTHER HOSPITAL DEPARTMENTS			
	1. Drugs & Solutions		$	
	2. Medical/Surgical Supplies (CSR)			
	3. Laboratory Procedures			
	4. Electrocardiograms			
	5. X-Ray			
	6. OPD: Services			
	7. Emergency Room			
	8. Clinic Visits			
	9. Operating Room			
	Other: (Identify)			
	10. _____			
	11. _____			
	12. _____			
	13. _____			
	14. _____			
	SUB-TOTAL		$	$
	TOTAL COSTS - DIRECT PATIENT SERVICES			$

* Include all payroll expenses (salaries, taxes, insurance) for professional and paraprofessional staff employees of the home care department, or other departments of the hospital, who visit patients in their homes. Do not include in this paragraph the payroll expenses of administrative personnel such as the home care department director, nurse assistants who coordinate patient services, technicians who visit patients to do EKGs, collect lab. specimens, etc.

HOSPITAL_____

STATEMENT OF HOME CARE DEPARTMENT COSTS FROM_____ TO_____

SECTION II
ADMINISTRATIVE COSTS

A. DIRECT COST OF OPERATING HOME CARE DEPARTMENT		AMOUNT
1. PAYROLL (Include Salaries, Taxes, Insurance)		
* a.	Director of Home Care Dept.....	$_____
** b.	Salaried Medical Director or Consultant..	_____
* c.	Nurse Coordinators/Assistant to Director.	_____
	Other Prof. Administrative Staff: (Identify)	
* d.	_____.....	_____
* e.	_____.....	_____
* f.	Secretarial.....	_____
* g.	Clerical.....	_____
	SUB-TOTAL	$_____
2. SUPPLIES		
a.	Stationery and Printed Forms.....	_____
b.	General Office.....	_____
c.	Medications Not Billed to Patients.....	_____
d.	Med./Surg. Supplies Not Billed to Patients	_____
e.	Replacement of Non-dep. Equipment.....	_____
	Other: (Identify)	
f.	_____.....	_____
g.	_____.....	_____
	SUB-TOTAL	$_____
3. COMMUNICATIONS AND TRANSPORTATION		
a.	Books and Subscriptions.....	_____
b.	Professional Organization Dues.....	_____
c.	Travel Expenses (Prof. & Technician Visits to Patients' Homes, Ambulance & Other Approved Transportation Costs).....	_____
d.	Travel Expenses (Administrative).....	_____
e.	_____.....	_____
	SUB-TOTAL	$_____
4. PURCHASED OFFICE EQUIPMENT, REPAIRS & DEPRECIATION		
a.	Office Equipment.....	_____
b.	Repairs & Depreciation.....	_____
5. MISCELLANEOUS		
a.	Recruitment Expenses.....	_____
	Other: (Identify)	
b.	_____.....	_____
c.	_____.....	_____
	SUB-TOTAL	$_____
	TOTAL DIRECT ADMINISTRATIVE COSTS	$_____

* Time spent in patient screening, evaluation and care planning activities before patients are transferred or admitted to home care service and on PAT activities is to be allocated to other hospital cost centers as appropriate.

** Pro-rated time according to established hospital policies.

48-611 O - 79 - 17

HOSPITAL_____

STATEMENT OF HOME CARE DEPARTMENT COSTS FROM_____ TO_____

B. INDIRECT ADMINISTRATIVE COSTS ALLOCATED TO HOME CARE DEPARTMENT FROM ACCOUNTING STEP-DOWN

		AMOUNT
1.	Depreciation - Building & Fixtures.....	$_____
2.	Depreciation - Movable Equipment.....	_____
3.	Administration & General.....	_____
4.	Operation of Plant.....	_____
5.	Maintenance of Plant.....	_____
6.	Laundry & Linen Service.....	_____
7.	Housekeeping.....	_____
8.	Cafeteria (Employees).....	_____
9.	_____.....	_____
10.	_____.....	_____
11.	_____.....	_____

TOTAL INDIRECT ADMINISTRATIVE COSTS $_____

TOTAL DIRECT ADMINISTRATIVE COSTS (SEC. II A.) _____

TOTAL COSTS FOR DIRECT PATIENT SERVICES (SEC. I) _____

TOTAL HOME CARE DEPARTMENT COSTS $_____

APPENDIX D

SELECTED REFERENCE SOURCES

1. Cost Analysis for Public Health Nursing Services, Methods I and II, New York: National League for Nursing, Department of Public Health Nursing, 1967.

2. Directory of Home Health Agencies--Certified as Medicare Providers, New York: National League for Nursing, Council of Home Health Agencies and Community Health Services, Pub. No. 21-1565, 1975.

3. The Hospital and the Home Care Program, Chicago, Illinois: American Hospital Association, 1972.

4. In-Home Services: Toward a National Policy, Proceedings from a Conference, Columbia, Maryland: Urban Life Center, June, 1972. Available through the U.S. Government Printing Office--Stock No. 5270-01874.

5. SSA-Medicare, "Conditions of Participation: Home Health Agencies," HIRM-1, Regulations No. 5, Subpart L.

6. "Standards for Hospital-Based Home Care Programs", Accreditation Manual for Hospitals, Chicago, Illinois: Joint Commission on Accreditation of Hospitals, 1970 (Update 1973 and revision of August 3, 1974).

7. Statement on Home Health Care, Chicago, Illinois: American Medical Association, Department of Community Health, 1973.

8. Traeger, Brahna, Home Care Services in the United States: A Report to the Special Senate Committee on Aging, 92nd Congress, 2nd Session, Washington D.C.: U.S. Government Printing Office, 1972.

9. Traeger, Brahna, "Home Health Services and Health Insurance," Medical Care, 9:89-98, January-February, 1971.

Senator TALMADGE. What problems, if any, has Blue Cross experienced?

Mr. JACOBY. Our problems would be very similar to those in the medicare administration in that, as I indicated in my brief summary—you were not present at the time—the development of a health care benefit should be carefully constructed and thought through in terms of what it is the benefit is to accomplish.

For example, home health care has been pointed out to be extremely useful as an alternative to in-patient care. It has also been pointed out as an area of need that is not being fully met.

However, if you adopt, for example, a more intensive benefit level for home health care in order to accomplish earlier discharges from skilled nursing facilities, for example, if you do not establish the policy clearly enough and construct a benefit and the controls in such a fashion as to assure that that objective is reached, you can find you have increased costs and have not used the benefit as an alternative. You have not accomplished the goal.

Senator TALMADGE. Effective control is the real key?

Mr. JACOBY. I would say so, sir, but control is one of the key difficulty areas that we are now trying to deal with in the administration of the benefit for medicare. An adequate data base of comparative home health agency cost is needed to prevent penalizing the majority of excellent agencies for the transgressions of a few.

Senator TALMADGE. Thank you very much, Mr. Jacoby, for an excellent statement.

[The prepared statement of Mr. Jacoby follows:]

STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATIONS ON HOME HEALTH CARE PROGRAMS, BY MERRITT W. JACOBY, ACTING SENIOR VICE PRESIDENT, GOVERNMENT PROGRAMS DIVISION

Mr. Chairman and members of the committee.

I am Merritt W. Jacoby, acting senior vice president of the Government Programs Division, of the Blue Cross and Blue Shield Associations. We are pleased to have this opportunity to comment on current and prospective issues in home health care programs. Our interest and involvement in home health care is multi-faceted:

-- As a private health insurer, we are supporting and encouraging the Blue Cross and Blue Shield Plans in offering home care coverage in local accounts, national accounts, and individual subscriber benefit packages. More than 60 of the 68 Blue Cross Plans currently offer one or more home care benefits, covering a wide range of patient needs and conditions. As a result, we have considerable experience in identifying the appropriate parameters of home care benefits and in responding to the needs of patients with quality services at the lowest possible cost.

-- As a prime contractor for administration of the Medicare Part A program, BCA has a major role in ensuring the full and proper reimbursement for services rendered by home health agencies (HHAs) to Medicare beneficiaries. Blue Cross Plans serve approximately 77% of all HHAs participating in the Medicare program and are responsible for distributing the major portion of the more than $450 million in annual Medicare payments for home health care services.

-- As an advisor to Blue Cross and Blue Shield Plans, we are aware of home care issues in state Medicaid programs. The problems in funding and disparities in coverages in Medicaid programs, which have been addressed in detail in the recent HEW report to Congress, will become a more direct concern since the Medicare and Medicaid programs are being combined under HCFA.

We are therefore most interested in the various issues being considered by this committee to expand the home health care coverage, increase home care utilization, and promote sophistication and quality in home care services available.

We support development of a comprehensive, national approach to home health care. The need is clear, since home health care represents a viable alternative to more costly institutional care of patients. Our detailed comments in Section II focus on five commonly-mentioned proposals for changes in Medicare's benefit:

- o Elimination of the three-day prior hospitalization requirement
- o Elimination of the 100 visit restriction
- o Elimination of the homebound requirement
- o Expansion of coverage to "intensive" levels of care
- o Expansion of coverage to "maintenance" levels of care

While we support the basic intention to develop a more comprehensive home health care program, we recommend caution in movement toward implementation of these proposed changes. There are serious and wide-spread problems in the Medicare and Medicaid programs' approaches to home health claims, and audit and reimbursement issues which have not been adequately addressed or resolved. Current problems should be corrected before new initiatives in home health care are undertaken. We have identified three improvements we believe are necessary for proper administration of the current home health care programs:

1) A uniform set of definitions, policies and procedures for claims, audit and reimbursement.

2) A reliable data base upon which uniform and comprehensive screening mechanisms for claims and audit reviews can be formulated.

3) Timely and formal notification of changes and clarifications in current program policies available to the HHA providers and all parties responsible for adminstering the Medicare and Medicaid programs.

Without these elements, the potential for fraudulent and abusive conditions would be magnified and accelerated as home health care coverage is expanded and utilization is increased. We have consistently recommended a comprehensive national initiative by the government, its intermediaries and

the industry to strengthen and clarify the existing home health care programs. Our detailed comments in Section I speak primarily to the Medicare Part A program but are equally applicable to Medicaid as these programs are unified under HCFA.

SECTION I: CORRECTION OF CURRENT MEDICARE PROBLEMS

Home health care is the most rapidly expanding and changing patient care program. In the early 1970's, the numbers of HHAs and the types and amounts of costs increased dramatically. With these changes in the industry came increased potential for fraud and abuse as well as increased problems for the Medicare intermediary in applying Medicare rules to claims coverage and reimbursement. The Medicare program was not able to place a high priority on addressing these developing concerns and, as a result, the program and its intermediaries were caught without all the tools, policies, and procedures necessary to respond quickly and effectively. We have testified before the U.S. House Ways & Means oversight subcommittee in August 1978 that the series of interim measures, which were fragmentary and reactionary, met the immediate needs but can no longer be considered appropriate.

We recommended immediate implementation by HCFA of a comprehensive national approach to resolving these problems in HHA reimbursement, claims adjudication, and audit. Some of these projects currently underway promise the needed uniformity and clarity. These initiatives are now becoming appropriately responsive to industry changes.

Claims/Coverage Issues

In the intermediary review of claims submitted by HHAs, it is necessary that detailed information be available on the patient's medical condition and the specific nature of services being provided so that the intermediary may determine if Medicare coverage requirements are met. Two significant problems have been identified in this regard: (1) the claim form does not capture the necessary information in detail and (2) the program instructions on the extent of and limitations to program coverage are not sufficiently clear for uniform determinations.

In the absence of definitive program guidelines, BCA as intermediary has developed a full spectrum of screening parameters on skilled nursing services for use by Blue Cross Plans in claims review. These have been given to HCFA. Similar guidelines are necessary for home health aide services. We are also seeking more definitive policy statements from HCFA on key coverage issues to provide a clear and uniform basis for denial of claims and for correlation of services to the patient's medical needs.

Currently, there is an inadequate instruction base for denial of over-utilized services; for example, continued skilled nursing observations and monitoring after the patient's condition is stabilized. There is also potential for wide disparities among intermediaries in coverage decisions due to incomplete or unclear coverage guidelines, such as the necessity of home health aide services when family resources are available for such care. These and other coverage guidelines are being addressed.

These activities will help stem the potential for fraud and abuse as well as provide a clear and uniform application of program rules to HHA providers.

Audit/Reimbursement Problems

In review of costs claimed by HHAs for Medicare reimbursement, the intermediary must determine that the costs are reasonable and incurred in rendering necessary patient care services. While there are many issues to be addressed during this process, the most important example of the problems currently faced by intermediaries is the test of reasonableness.

The intermediary must be able to identify costs which are substantially out-of-line by statistically comparing the costs of like providers. This process has been hampered because the Medicare cost reporting form, from which the comparative data is collected, contains insufficient definition on categorization of like costs, lacks the necessary specificity, and allows various reporting methods. Since the data base is not uniform, the information cannot be reliably utilized in comparing providers. The recent HEW report to Congress on home health services agrees that cost comparisons among HHAs is currently impossible.

For these reasons, we have opposed the recent HCFA proposal to set cost limits on HHAs until more uniform and reliable data can be obtained. A copy of our response to the proposal is attached. Our past experience in defending reasonable cost adjustments on the basis of statistically-unreliable, unauditable, and unedited data in the Medicare appeals process has been unsuccessful. Two projects have recently been undertaken to correct nonuniformity in the data base: (1) development of a standard Medicare cost report, with a single cost apportionment method, and (2) development of a uniform reporting system for HHAs. BCA is actively coordinating with HCFA on these projects. When these projects are completed and implemented, the data base obtained through these reports will be useful and appropriate in establishing reasonable cost guidelines on line items (such as space or transportation), cost categories (such as total effective compensation), and cost disciplines (such as physical therapy).

In the interim, BCA as prime contractor has developed a set of "reasonable cost indicators" and a standard field audit program to assist Blue Cross Plans in applying the Medicare principles of reimbursement to HHAs. The indicators (AB series #1337, copies are attached) are a statistically-sound data base arrayed by computer under the inter-quartile statistical method recognizing the effect of industry variables. These indicators are used on desk review to identify specific areas of cost which need further review for reasonableness under the BCA standard field audit program (AB #1154). The indicators focus the intermediary's limited audit funds and time. The field audit program provides a detailed procedures for undertaking the reviews.

We believe that these initiatives in audit and reimbursement will help stem the potential for fraud and abuse as well as provide a clear and uniform application of existing program rules to HHA providers.

Administrative Considerations

Communication of changes and clarifications in program policy to the Medicare intermediaries and HHA providers must be improved. All previously-issued instructions from HCFA, its regional offices, and the intermediaries should

be reviewed. Those no longer appropriate should be rescinded. Those still applicable should be integrated into a single national policy statement and issued to the intermediaries and providers. We understand this project is currently underway at HCFA.

Timely and formal notification of all new policies should be placed in the Part A Intermediary Manual (HIM-13), the HHA Manual (HIM-11), and the Provider Reimbursement Manual (HIM-15). Intermediary Letters and other less formal statements should be interim steps to formal changes in the appropriate manuals.

An often proposed administrative change to combat fraud and abuse is elimination of HHAs which serve only Medicare beneficiaries (100%ers). We have not identified a correlation between Medicare utilization and fraud and abuse activities. Our studies show that high-utilization HHAs account for less than 2% of all HHAs. The need for reasonable cost adjustments does not increase proportionately with utilization levels. However, high-utilization HHAs are screened for more extensive claims review and audit review since any adjustments or claims denials will more significantly affect program payments than in low-utilization HHAs. It should be noted that it is more difficult to recover monies from 100% Medicare utilization agencies, since the sole source of funding for such providers is the Medicare program itself. We believe that the proposal to eliminate certification of high-utilization agencies will not effectively address the potential for fraud and abuse. We believe that more definitive policy and procedure statements from HCFA are the most effective means of eliminating any incentive to fraudulent and abusive activities, not only in high-utilization HHAs but in all HHAs.

SECTION II: PROPOSALS FOR EXPANDING HOME HEALTH CARE BENEFITS

A workable and acceptable definition of home health care must identify the services available to patients in the home environment, must logically correlate services available to the patient's needs, and must recognize home health care as part of the total health care system including hospitals, nursing homes, physicians, and all other health care components.

The family and home environment offer substantial therapeutic and supportive resources in addition to the professional and technical health care resources. Home health care initiatives should encompass all available medical and support services and correlate these services to the full spectrum of patient needs, from complex and fluctuating illness to relatively-controlled disabilities.

A successful home health care system should include intensive, intermediate, and maintenance service programs to ensure that the needs of the patient are effectively and efficiently met.

- Intensive care is appropriate for the patient with an unstable medical condition requiring active treatment and/or rehabilitation. The care would include a wide array of professional and technical services, including frequent observations and treatment in a concentrated degree. Without intensive home health care, the patient would require inpatient care.

- Intermediate care is appropriate for the patient with a relatively stable medical condition requiring active treatment and/or rehabilitation. The care would focus on professional and technical services, including nursing care, therapy, and aide services. Intermediate care is intended to assist the patient in the recovery and rehabilitation stages of illness. Home health care benefits covered under the Medicare program are primarily intermediate care.

- Maintenance care is appropriate for the patient with a relatively stable medical condition requiring periodic assessment or regular monitoring to ensure maintenance of the achieved plateau in the recovery or rehabilitation from an illness. The services would focus on assistance with daily living activities and supportive personal care services.

Expansion of coverage to intensive levels of home care would encourage an earlier discharge of patients from institutions to the home. In our private health insurance activities, some of the Blue Cross Plans have included

coverage of intensive home care. We have found that since a more unstable or critical illness must be monitored and treated, the types of services must be appropriately intensified. The HHA must directly provide or have ready access to ancillary and crisis-care services, such as portable x-ray, oxygen tents, heart monitors, and ambulance, etc. Intensive care also requires a concentrated degree of physician and professional nursing management to ensure a coordinated treatment of the unstable patient condition.

The current Medicare definition of home health care is "part-time and intermittant services." Expansion of care to intensive levels of service can require full-time and continuous services for proper patient care. It can also be expected that the costs of providing intensive care will be significantly higher than in intermediate care; for example, salaries for professional staff necessary to provide the care will be greater and the cost of equipment for routine and stand-by crisis care will be more expensive to the HHA. We suggest that a cost/benefit study or a pilot project be undertaken to determine (1) the extent to which intensive care should be covered and (2) the effect coverage of intensive care will have on health care costs.

Maintenance home health care, such as homemakers, "meals on wheels", and chore services, often represent the key to allowing patients to remain in the home when family is unable or unavailable to provide such personal and health support services. In our private health insurance activities, some Blue Cross Plans have included maintenance care benefits. Medicaid and other programs have also expanded coverage to some maintenance services.

Expansion of care to maintenance services will reduce the need for nursing care as well as reduce the current impetus for direct patient financing of such care. As such, maintenance home health care represents an "add-on" to current health care costs and does not significantly reduce the need for other types of care. We believe that current projects to eliminate the fragmentation of home care services among the Medicare, Medicaid, and Older Americans Act programs will demonstrate the need for coverage of maintenance services and will provide the appropriate funding to offset the add-on costs.

The three other proposals to extend benefit coverage -- elimination of the homebound requirement, three-day prior hospitalization, and 100 visit limit -- have been thoroughly analyzed by GAO in its December 1977 report to Congress entitled "Home Health -- the Need for a National Policy to Better Provide for the Elderly." GAO concluded that elimination of these three restrictions would not be costly under Medicare. We agree that the initiative to formulate a comprehensive national approach to home health care should eliminate these three current restrictions. However, we recommend that this initiative be predicated on correction of the problems identified in implementation of the current home health care program under Medicare and Medicaid.

Thank you for the opportunity to comment.

Blue Cross
Association

Medicare

840 North Lake Shore Drive
Chicago, Illinois 60611
312/440-6000

Administrative Bulletin #1337

March 6, 1979

To: Directors of Federal Programs
Reimbursement Managers

From: Merritt W. Jacoby, Acting Senior Vice President
Government Programs Division

Subject: Medicare Provider Cost Reports:
Reasonable Cost Indicators for Home Health Agencies

Action Indicated: The procedures and data contained in this bulletin should be incorporated into desk review programs and audit scope procedures applicable to the review of HHA Medicare provider cost reports.

All HHA Medicare provider cost reports ending on or after July 1, 1974 which have not passed the three-year limitation on reopening should be reanalyzed using this data to determine reasonable costs.

This bulletin transmits desk review procedures and reasonable cost indicators for use by Plans in the review of HHA Medicare provider cost reports.

In August 1978, the Medicare Bureau issued Intermediary Letter #78-37 which arrayed certain cost per visit information from HHA provider cost reports for use by the intermediaries in developing methods for reviewing the reasonableness of HHA costs. BCA/BSA had requested data from audited HHA cost reports from all Blue Cross Plans under AB #758, 78.01, dated March 30, 1978. This information has been analyzed and processed by computer using the inter-quartile statistical method. This process has resulted in the development of statistically-reliable cost per visit data which can be used during the desk review and audit scope process to identify costs which appear substantially out-of-line with the costs of HHAs of like size on a national basis. These costs may then be subjected to additional audit and review procedures as outlined in the Standard Field Audit Program for Home Health Agencies, AB #1154, dated May 25, 1977, to determine the reasonableness of these costs.

Distribution: Directors of Federal Programs - List 35
Reimbursement Managers - List 35C

Reasonable Cost Indicators

Data cards reflecting information from approximately 3700 cost reports covering fiscal years ending on or after July 1, 1974 and on or before June 30, 1977 formed the initial survey base. These cost reports were subjected to numerous edits to ensure the accuracy of the information and the comparability of the data.

Based on the results of computer analysis, it was determined that in general facility-based agencies and official (governmentally sponsored) agencies have a higher cost per visit than the free-standing voluntary agencies of like size. Since it could not be determined whether these higher costs resulted from uncontrollable factors, unreasonable expenditures, or other factors and since the inclusion of the data from such agencies would significantly inflate the reasonable cost indicators, the sample excluded all data collected from facility-based and official home health agencies.

It was also determined that during the first period or year of operation, HHAs have a higher cost per visit than those with more than a year of operation. Data collected from first-year or -period cost reports was, therefore, also excluded from the final sample.

After all edits and other exclusions had been accomplished, the final sample size was 1067 cost reports: 367 for years ending on or before June 30, 1975, 381 for years ending on or before June 30, 1976, and 319 for years ending on or before June 30, 1977. The data was annualized by individual cost report to the June 30 dates by using aggregate annual inflation rates of 12.0% for 1975, 8.8% for 1976, and 6.8% for 1977. The 1978 data is a projection of the 1977 indicators using a 9.0% inflation factor.

This final sample was then arrayed by computer using the inter-quartile statistical method to develop reliable and useful reasonable cost indicators.

Inter-Quartile Statistical Method

The inter-quartile statistical method is a statistical technique which sets ranges based on the distribution of actual performance data. The basic concept is that the middle 50% of the provider data is used to establish a range. By doubling the inter-quartile range, the data is clustered to determine reasonable variations in performance.

The inter-quartile statistical method is preferable over other statistical methods because:

a) All providers can theoretically meet the acceptable ranges. Normally, however, some providers will fall outside the ranges. These "out-lyers" are by definition under Medicare guidelines to be considered substantially out-of-line and these costs should be further analyzed.

b) The inter-quartile method does not require any assumptions about the distribution of performance, such as a bell-curve distribution.

c) The ranges are not as significantly influenced by the "out-lyers" as in other statistical methods. Provider costs which are substantially out-of-line with the inter-quartile range will not expand the acceptable ranges considerably.

BCA/BSA has studied the other available statistical methods and has determined that the inter-quartile statistical method provides the best basis for application of the Medicare principles on reasonable costs. Additional information about the inter-quartile method is available upon request.

Desk Review and Audit Scope Procedures

These reasonable cost indicators are to be used as a desk review tool to assist in determining both whether a field audit is warranted and, if so, the appropriate scope of the field audit. In addition, the indicators may be used to assign audit priority to the cost reports.

The reasonable cost indicators are not cost limitations, or "caps" and should not be used in themselves as the basis for disallowing provider costs. The data represents merely indicators which are helpful during the desk review and audit scope process in an initial identification of HHA costs which are "substantially out-of-line" in accordance with 42 CFR Regulation Section 405.451(c)(2). Where costs are found to be substantially out-of-line through use of the reasonable cost indicators and/or other desk review procedures, the cost report should be sent to field audit for further testing and review procedures.

During field audit, the provider is given an opportunity to supply the intermediary with documentation and rationales to justify the higher costs. Where the higher costs are sufficiently justified, the costs may be allowed as reasonable. Since the reasonable cost indicators have been developed from the data pertaining to free-standing voluntary agencies only, some special considerations must be given when the indicators have been applied to the costs of facility-based HHAs, official HHAs, and first-year or -period cost reports.

Facility-Based HHAs

The intermediary should consider that the costs of a facility-based HHA are influenced by the cost reporting mechanism itself. Overhead from the primary provider will be stepped-down on an appropriate allocation basis into the HHA cost report. In general, this allocation is an uncontrollable factor to the HHA. Therefore, where the HHA's costs are substantially out-of-line due to this overhead allocation and the intermediary has determined that the allocation base is appropriate, the higher HHA costs may be considered reasonable.

Official HHAs

The costs of official agencies may be substantially out-of-line, either too high or too low, due to (a) allocations from related governmental entities and (b) subsidization of the HHA through donations or unbilled support from the governmental unit. Examples would include United Fund support, donated space or equipment, unbilled access to messenger and motor pool, etc. These factors should be taken into consideration when evaluating the reasonableness of the HHA's costs.

First-Year or -Period Cost Reports

In general, an HHA may experience a higher cost per visit during the initial period of operation (that is, 12 months or less) when the total visit volume of the agency is insufficient to absorb the fixed costs and stand-by costs of the agency. In other instances, however, the higher costs per visit could have resulted from inefficiencies in management or inattentiveness to cost containment. To determine whether these higher costs are reasonable, some suggested methodologies are:

a) Annualize the visit volume by determining the number of visits rendered by the HHA during its 12th full month of operation. (This would not be the last month of the reporting period if a short-period cost report had been filed.) Multiply the visits by 12 and divide the result into the total allowable costs to re-determine the cost per visit as it would have been had the agency been operating at peak visit volume throughout the period. This cost per visit should be compared to the reasonable cost indicators.

b) Apply the principles used to evaluate exception requests to the hospital routine cost limits, as outlined in Regulation Section 405.460(f)(2) and (3). Compute the amount of cost per visit attributable to fixed costs and stand-by costs. This cost per visit should be deleted from total cost per visit and a reasonable cost per visit for similar elements incurred by like providers substituted. The resulting total cost per visit amount should be compared to the reasonable cost indicators.

Both of these suggestions would give appropriate recognition to the special problems in absorbing fixed costs and stand-by costs in the low visit volumes experienced by HHAs during the initial periods of operation.

Implementation

Plans are instructed to re-analyze all Medicare provider cost reports for HHAs ending on or after July 1, 1974 which are subject to the three-year reopening provision, using the attached reasonable cost indicators.

The reasonable cost indicators should be adjusted based on the cost report fiscal year end date as shown in the attachments for other than 6/30 year end dates.

It should be emphasized that the data for cost reporting periods ending on or after July 1, 1977 are projections and are not based on actual, audited cost reporting data from these periods. These projections, however, may be used in the desk review and audit scope process as noted. The reasonable cost indicators for periods ending on or after July 1, 1977 based on audited cost reporting information are being compiled and arrayed and will be issued to all Blue Cross Plans under Administrative Bulletin series #1337.

Questions regarding this bulletin should be referred to:

Peter Harmon
Senior Manager
EDP/Reimbursement Activities
(312) 440-5908

or

David R. Elwell
Senior Manager
Chain Organizations
(312) 440-5810

ADJUSTMENT FACTORS FOR PERIODS ENDED OTHER THAN 6/30

Month Ended \ Year Ended	1974	1975	1976	1977	1978
January	N/A	- 5.0%	- 3.67%	- 2.83%	- 3.75%
February	N/A	- 4.0%	- 2.93%	- 2.27%	- 3.00%
March	N/A	- 3.0%	- 2.20%	- 1.70%	- 2.25%
April	N/A	- 2.0%	- 1.47%	- 1.13%	- 1.50%
May	N/A	- 1.0%	- 0.73%	- 0.57%	- 0.75%
June	N/A	6/75 table	6/76 table	6/77 table	6/78 table
July	- 11.0%	- 8.07%	- 6.23%	- 8.25%	+ 0.75%
August	- 10.0%	- 7.33%	- 5.67%	- 7.50%	+ 1.50%
September	- 9.0%	- 6.60%	- 5.10%	- 6.75%	+ 2.25%
October	- 8.0%	- 5.87%	- 4.53%	- 6.00%	+ 3.00%
November	- 7.0%	- 5.13%	- 3.97%	- 5.25%	+ 3.75%
December	- 6.0%	- 4.40%	- 3.40%	- 4.50%	+ 4.50%

COST REPORT PERIODS ENDED 7/1/74 THROUGH 6/30/75 **

HI VISITS	HI COST PER VISIT		SKILLED NURS. CARE		PHYSICAL THERAPY		SPEECH THERAPY		OCCUP. THERAPY		MED. SOC. SERVICES		HOME HEALTH AIDES	
	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT
0 - 1,999	9.24	24.56	10.90	26.85	8.35	22.85	N/A	N/A	N/A	N/A	N/A	N/A	4.47	19.53
2,000 - 9,999	10.14	20.79	9.08	22.71	9.41	23.34	8.50#	25.35#	11.44#	22.04#	14.59#	45.96#	7.03	17.38
10,000 +	10.67	21.74	9.00	21.94	11.18	24.92	8.02	33.90	10.89#	26.51#	4.81#	55.00#	8.36	22.96

COST REPORT PERIODS ENDED 7/1/75 THROUGH 6/30/76 **

HI VISITS	HI COST PER VISIT		SKILLED NURS. CARE		PHYSICAL THERAPY		SPEECH THERAPY		OCCUP. THERAPY		MED. SOC. SERVICES		HOME HEALTH AIDES	
	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT
0 - 1,999	6.53	29.27	9.09	32.15	10.24	26.79	9.44#	52.98#	N/A	N/A	N/A	N/A	4.89	20.76
2,000 - 9,999	10.86	22.26	9.70	23.46	9.03	22.19	11.01#	24.09#	8.68#	22.71#	0.00#	30.95#	6.48	21.46
10,000 +	11.57	23.60	11.32	24.79	11.09	26.17	6.22	28.07	10.11	26.81	6.03#	45.45#	6.28	22.17

COST REPORT PERIODS ENDED 7/1/76 THROUGH 6/30/77 **

HI VISITS	HI COST PER VISIT		SKILLED NURS. CARE		PHYSICAL THERAPY		SPEECH THERAPY		OCCUP. THERAPY		MED. SOC. SERVICES		HOME HEALTH AIDES	
	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT
0 - 1,999	10.62	26.29	8.32	27.26	9.56	22.58	N/A	N/A	N/A	N/A	N/A	N/A	7.80	26.92
2,000 - 9,999	11.34	22.89	11.46	24.46	12.79	21.22	11.41#	33.09#	10.97#	25.31#	9.51#	54.04#	6.10	20.77
10,000 +	10.76	24.30	11.32	25.49	12.04	27.07	9.87	40.00	11.72	45.67	16.60#	39.72#	5.96	24.23

COST REPORT PERIODS ENDED 7/1/77 THROUGH 6/30/78 (PROJECTED)

HI VISITS	HI COST PER VISIT		SKILLED NURS. CARE		PHYSICAL THERAPY		SPEECH THERAPY		OCCUP. THERAPY		MED. SOC. SERVICES		HOME HEALTH AIDES	
	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT	LOWER LIMIT	UPPER LIMIT
0 - 1,999	11.58	28.66	9.07	29.71	10.42	24.61	N/A	N/A	N/A	N/A	N/A	N/A	8.50	29.34
2,000 - 9,999	12.36	24.95	12.49	26.66	13.94	23.13	12.44#	36.07#	11.96#	27.59#	10.37#	58.90#	6.65	22.64
10,000 +	11.73	26.49	12.34	27.78	13.12	29.51	10.76	43.60	12.77	49.78	18.09#	43.29#	6.50	26.41

- RANGES ARE STATISTICALLY QUESTIONABLE BECAUSE LESS THAN 25% OF SAMPLE REPORTED DATA IN THIS CATEGORY
- BASED ON DATA RECEIVED THROUGH JUNE, 1978

Blue Cross
Association

Medicare

840 North Lake Shore Drive
Chicago, Illinois 60611
312/440-6000

Administrative Bulletin #1337, 79.01

April 25, 1979

TO: Directors of Federal Programs
Reimbursement Managers

FROM: Merritt W. Jacoby, Acting Senior Vice President
Government Programs Division

SUBJECT: Medicare Provider Cost Reports:
Reasonable Cost Indicators of Official Home Health Agencies
(Governmentally Sponsored)

ACTION INDICATED: The procedures and data contained in this bulletin should be incorporated into desk review programs and audit scope procedures applicable to the review of HHA Medicare provider cost reports of official agencies.

All HHA Medicare official home health agency cost reports ending on or after July 1, 1974 which have not passed the three-year limitation on reopening should be reanalyzed using this data to determine reasonable costs.

This data supplements AB #1337 for application to official agencies only. If a provider exceeds the indicator in AB 1337, evaluate and document comparison with this Administrative Bulletin.

Distribution: Directors of Federal Programs - List 35
Reimbursement Managers - List 35C

This bulletin transmits desk review procedures and reasonable cost indicators for use by Plans in the review of HHA Medicare provider cost reports of official agencies.

In August, 1978, the Medicare Bureau issued Intermodiary Letter #78-37 which arrayed certain cost per visit information from HHA provider cost reports for use by the intermediaries in developing methods for reviewing the reasonableness of HHA costs. BCA/BSA had requested data from audited HHA cost reports from all Blue Cross Plans under AB 758, 78.01, dated March 30, 1978. This information has been analyzed and processed by computer using the interquartile statistical method. This process has resulted in the development of statistically-reliable cost per visit data which can be used during the desk review and audit scope process to identify costs which appear substantially out-of-line with the costs of HHAs of like-size on a national basis. These costs may then be subjected to additional audit and review procedures as outlined in Standard Field Audit Program for Home Health Agencies, AB #1154, dated May 25, 1977, to determine the reasonableness of these costs.

Reasonable Cost Indicators

Data cards reflecting information from approximately 3700 cost reports covering fiscal years ending on or after July 1, 1974 and on or before June 30, 1977 formed the initial survey base. These cost reports were subjected to numerous edits to ensure the accuracy of the information and the comparability of the data.

Based on the results of the computer analysis, it was determined that, in general, facility-based agencies and official (governmentally sponsored) agencies have a higher cost per visit than the free-standing voluntary agencies of like-size. Since it could not be determined whether these higher costs resulted from uncontrollable factors, unreasonable expenditures, or other factors and since the inclusion of the data from such agencies would significantly inflate the reasonable cost indicators, the sample excluded all data collected from facility-based or official home health agencies.

These indicators are supplements to those issued for free-standing agencies. If an official agency's cost per visit as filed does not exceed the indicators for free-standing agencies, then the use of the indicators inthis AB will not be necessary. If the official agency's cost per visit exceeds the indicators for free-standing agencies but does not exceed the attached indicators, the Plan should justify the difference. The desk review file should clearly indicate that any difference was investigated and either justified or adjusted.

If the cost per visit exceeds the attached indicators, then the Plan should investigate the difference and give consideration to performing an audit of that provider.

It was also determined that during the first period or year of operation, HHAs have a higher cost per visit than those with more than a year of operation. Data collected from first-year or first-period cost reports was, therefore, also excluded from the final sample.

After all edits and other exclusions had been accomplished, the final sample size was 1,049 cost reports: 372 for years ending on or before June 30, 1975, 414 for years ending on or before June 30, 1076, and 263 for years ending on or before June 30, 1977. The data was annualized by individual cost report to June 30 dates by using aggregate annual inflation rates of 12.0% for 1975, 8.8% for 1976 and 6.8% for 1977. The 1978 data is a projection of the 1977 indicators using a 9.0% inflation factor.

This final sample was then arrayed by computer using the interquartile statistical method to develop reliable and useful reasonable cost indicators.

This methodology was explained in AB 1337, dated March 6, 1979.

Desk Review and Audit Scope Procedures

These reasonable cost indicators are to be used as a desk review tool to assist in determining both whether a field audit is warranted and, if so, the appropriate scope of the field audit. In addition, the indicators may be used to assign audit priority to the cost reports.

The reasonable cost indicators are not cost limitations, or "caps" and should not be used in themselves as the basis for disallowing provider costs. The data represents merely indicators which are helpful during the desk review and audit scope process in an initial identification of HHA costs which are "substantially out-of-line" in accordance with 42 CFR Regulation Section 405.451 (c)(2). Where costs are found to be substantially out-of-line through use of the reasonable cost indicators and/or other desk review procedures, the cost report should be sent to field audit for further testing and review procedures.

During field audit, the provider is given an opportunity to supply the intermediary with documentation and rationales to justify the higher costs. Where the higher costs are sufficiently justified, the costs may be allowed as reasonable. Since the reasonable cost indicators have been developed from the data pertaining to free-standing voluntary agencies only, some special considerations must be given when the indicators have been applied to the costs of facility-based HHAs, official HHAs, and first-year or first-period cost reports.

Official HHAs

The costs of official agencies may be substantially out-of-line, either too high or too low, due to (a) allocations from related governmental

entities and (b) subsidization of the HHA through donations or unbilled support from the governmental unit. Examples would include United Fund support, donated space or equipment, unbilled access to messenger and motor pool, etc. These factors should be taken into consideration when evaluating the reasonableness of the HHA's costs.

Implementation

Plans are instructed to re-analyze all Medicare provider cost reports for HHAs ending on or after July 1, 1974 which are subject to the three-year reopening provision, using the attached reasonable cost indicators.

The reasonable cost indicators should be adjusted based on the cost report fiscal year end date as shown in the attachments for other than 6/30 year end dates.

It should be emphasized that the data for cost reporting periods ending on or after July 1, 1977 are projections and are not based on actual, audited cost reporting data from these periods. These projections, however, may be used in the desk review and audit scope process as noted. The reasonable cost indicators for periods ending on or after July 1, 1977 based on audited cost reporting information are being compiled and arrayed and will be issued to all Blue Cross Plans under Administrative Bulletin series #1337.

Questions regarding this bulletin should be referred to:

Peter Harmon
Senior Manager
EDP/Reimbursement Activities
(312) 440-5908

or

David R. Elwell
Senior Manager
Chain Organizations
(312) 440-5810

COST REPORT PERIODS ENDED 7/1/74 THROUGH 6/30/75 **

TOTAL VISITS	HI COST PER VISIT LOWER LIMIT	HI COST PER VISIT UPPER LIMIT	SKILLED NURS. CARE LOWER LIMIT	SKILLED NURS. CARE UPPER LIMIT	PHYSICAL THERAPY LOWER LIMIT	PHYSICAL THERAPY UPPER LIMIT	SPEECH THERAPY LOWER LIMIT	SPEECH THERAPY UPPER LIMIT	OCCUP. THERAPY LOWER LIMIT	OCCUP. THERAPY UPPER LIMIT	MED. SOC. SERVICES LOWER LIMIT	MED. SOC. SERVICES UPPER LIMIT	HOME HEALTH AIDES LOWER LIMIT	HOME HEALTH AIDES UPPER LIMIT
0 - 1,999	6.37	29.15	7.37	30.79	9.64	30.47	N/A	N/A	N/A	N/A	N/A	N/A	3.58	16.59
2,000 - 9,999	10.68	25.44	11.69	28.50	10.16	28.53	5.57#	29.08#	1.80#	25.71#	N/A	N/A	5.72	18.15
10,000 +	11.40	32.45	10.09	28.94	9.02	34.72	14.35	50.63	10.34#	46.14#	N/A	N/A	6.17	19.81

COST REPORT PERIODS ENDED 7/1/75 THROUGH 6/30/76 **

TOTAL VISITS	HI COST PER VISIT LOWER LIMIT	HI COST PER VISIT UPPER LIMIT	SKILLED NURS. CARE LOWER LIMIT	SKILLED NURS. CARE UPPER LIMIT	PHYSICAL THERAPY LOWER LIMIT	PHYSICAL THERAPY UPPER LIMIT	SPEECH THERAPY LOWER LIMIT	SPEECH THERAPY UPPER LIMIT	OCCUP. THERAPY LOWER LIMIT	OCCUP. THERAPY UPPER LIMIT	MED. SOC. SERVICES LOWER LIMIT	MED. SOC. SERVICES UPPER LIMIT	HOME HEALTH AIDES LOWER LIMIT	HOME HEALTH AIDES UPPER LIMIT
0 - 1,999	8.85	35.79	10.92	37.87	12.04	30.45	0.00#	44.41#	N/A	N/A	N/A	N/A	3.80	23.81
2,000 - 9,999	11.49	27.17	13.00	28.92	11.48	31.68	9.92#	57.32#	1.02#	32.83#	14.83#	36.33#	6.05	20.70
10,000 +	13.57	33.57	10.32	31.47	10.55	44.47	24.09	46.64	3.82#	68.75#	N/A	N/A	6.16	24.08

COST REPORT PERIODS ENDED 7/1/76 THROUGH 6/30/77 **

TOTAL VISITS	HI COST PER VISIT LOWER LIMIT	HI COST PER VISIT UPPER LIMIT	SKILLED NURS. CARE LOWER LIMIT	SKILLED NURS. CARE UPPER LIMIT	PHYSICAL THERAPY LOWER LIMIT	PHYSICAL THERAPY UPPER LIMIT	SPEECH THERAPY LOWER LIMIT	SPEECH THERAPY UPPER LIMIT	OCCUP. THERAPY LOWER LIMIT	OCCUP. THERAPY UPPER LIMIT	MED. SOC. SERVICES LOWER LIMIT	MED. SOC. SERVICES UPPER LIMIT	HOME HEALTH AIDES LOWER LIMIT	HOME HEALTH AIDES UPPER LIMIT
0 - 1,999	8.82	38.74	11.85	36.83	9.97	23.97	N/A	N/A	N/A	N/A	N/A	N/A	4.29	20.13
2,000 - 9,999	10.27	29.13	11.62	29.56	11.94	26.01	10.37#	28.09#	14.39#	18.35#	N/A	N/A	6.16	21.12
10,000 +	14.06	29.76	13.52	34.99	6.43	30.58	10.66	26.74	10.08#	24.16#	N/A	N/A	8.67	18.21

COST REPORT PERIODS ENDED 7/1/77 THROUGH 6/30/78 (PROJECTED)

TOTAL VISITS	HI COST PER VISIT LOWER LIMIT	HI COST PER VISIT UPPER LIMIT	SKILLED NURS. CARE LOWER LIMIT	SKILLED NURS. CARE UPPER LIMIT	PHYSICAL THERAPY LOWER LIMIT	PHYSICAL THERAPY UPPER LIMIT	SPEECH THERAPY LOWER LIMIT	SPEECH THERAPY UPPER LIMIT	OCCUP. THERAPY LOWER LIMIT	OCCUP. THERAPY UPPER LIMIT	MED. SOC. SERVICES LOWER LIMIT	MED. SOC. SERVICES UPPER LIMIT	HOME HEALTH AIDES LOWER LIMIT	HOME HEALTH AIDES UPPER LIMIT
0 - 1,999	9.61	42.23	12.92	40.14	10.87	26.13	N/A	N/A	N/A	N/A	N/A	N/A	4.68	21.94
2,000 - 9,999	11.19	31.75	12.67	32.22	13.01	28.35	11.30#	30.62#	15.69#	20.00#	N/A	N/A	6.71	23.02
10,000 +	16.20	32.44	14.74	38.14	7.01	33.33	11.62	29.15	10.99#	26.33#	N/A	N/A	9.45	19.85

- RANGES ARE STATISTICALLY QUESTIONABLE BECAUSE LESS THAN 25% OF SAMPLE REPORTED DATA IN THIS CATEGORY
- BASED ON DATA RECEIVED THROUGH JUNE, 1978

ADJUSTMENT FACTORS FOR PERIODS ENDED OTHER THAN 6/30

Month Ended \ Year Ended	1974	1975	1976	1977	1978
January	N/A	- 5.0%	- 3.67%	- 2.83%	- 3.75%
February	N/A	- 4.0%	- 2.93%	- 2.27%	- 3.00%
March	N/A	- 3.0%	- 2.20%	- 1.70%	- 2.25%
April	N/A	- 2.0%	- 1.47%	- 1.13%	- 1.50%
May	N/A	- 1.0%	- 0.73%	- 0.57%	- 0.75%
June	N/A	6/75 table	6/76 table	6/77 table	6/78 table
July	- 11.0%	- 8.07%	- 6.23%	- 8.25%	+ 0.75%
August	- 10.0%	- 7.33%	- 5.67%	- 7.50%	+ 1.50%
September	- 9.0%	- 6.60%	- 5.10%	- 6.75%	+ 2.25%
October	- 8.0%	- 5.87%	- 4.53%	- 6.00%	+ 3.00%
November	- 7.0%	- 5.13%	- 3.97%	- 5.25%	+ 3.75%
December	- 6.0%	- 4.40%	- 3.40%	- 4.50%	+ 4.50%

Blue Cross
Association

Medicare

840 North Lake Shore Drive
Chicago, Illinois 60611
312/440-6000

May 3, 1979

Mr. Leonard Schaeffer
Administrator
Health Care Financing Administration
Department of Health, Education and Welfare
Post Office Box 2372
Washington, D.C. 20013

RE: MAB-102-N

Dear Mr. Schaeffer:

The following comments are presented on behalf of the Blue Cross Association and all Blue Cross Plans in response to the proposed Schedule of Limits on Home Health Agency Costs Per Visit as issued in the Federal Register on March 7, 1979.

We do not favor establishment of cost limitations on home health agencies (HHAs) and do not support the schedule of limits proposed by HCFA.

Home health care is the most rapidly developing sector of the health care industry. There has been impetus in increasing the number of home care programs and in expanding the scope and intensity of benefits available in the search for a cost-effective alternative in patient care. Home health care has thus been promoted and encouraged due to its potential for cost containment in patient care. We fully support these efforts.

Given the efforts to contain health care costs, any initiatives taken in regard to the provision of home health care should be consistent with these goals. We believe, however, that the cost limits may discourage growth, prompt discontinuance of existing home care programs, work as a disincentive to cost containment, and divert the Medicare program's attention from the development of other policy and procedural tools necessary for proper administration of the program to HHA providers.

The rapid expansion in numbers of HHAs, the increase in sophistication of home care programs, and changes to the more traditional patterns of home care delivery systems caught the Medicare program and its intermediaries without all of the tools, policies, and procedures to meet the changes in the industry. As a result, a series of interim measures were necessary to enable the intermediary to respond effectively as potentially abusive

situations were identified and HHA cost reports were reviewed for reasonableness of costs. We have testified before Congress that these measures were fragmentary and reactionary, and while meeting an immediate need, may no longer be appropriate. We have worked with the Medicare Bureau in the development of a comprehensive national approach to the problems in HHA reimbursement, claims adjudication, and audit. It is these initiatives which are now becoming appropriately responsive to industry changes.

One of the most important projects undertaken by the Medicare program is the issuance of a uniform Medicare cost reporting form, establishing a single cost apportionment method and promoting increased sophistication in the reporting and categorization of costs. This new cost report will be supplemented by a uniform reporting system for HHAs (USHHAR). USHHAR will further assist the Medicare program and its intermediaries in evaluating the reasonableness of costs. Once these projects are completed and used in the industry, a reliable data base will be available upon which HHA cost limits could be formulated. The factors which are affecting the costs of HHAs should be more apparent and could be more appropriately analyzed for inclusion or exclusion in formulating cost limits. With these projects nearing completion, we strongly suggest that it would be in the best interests of the Medicare program and the home health industry that formulation of cost limits be delayed until the most reliable data base is available.

It should be emphasized that cost limits are not the best available means of identifying unreasonable provider costs, only the most excessive. While costs above the limits are unreasonable by definition, provider costs below the limits are not automatically reasonable. In addition, past experience shows that provider costs have a tendency to rise to the established cost limit level. Since cost limits do not address these problems, BCA has taken the initiative in developing "reasonable cost indicators" and a standard field audit program to assist Blue Cross Plans in applying the Medicare principles of reimbursement to HHA providers.

BCA obtained data from final settled HHA cost reports from the Blue Cross Plans. This data was edited to provide a statistically-sound data base and was analyzed with regard to the effect of industry variables. The data was arrayed by computer using the inter-quartile statistical method. The result was an array of "reasonable cost indicators" (AB #1337) which can be used to identify on desk review those areas of HHA costs which need further review for reasonableness under the BCA standard field audit program for HHA providers (AB #1154). The indicators serve an important function in focusing intermediary attention and audit priority to the particular HHA costs which fall outside the reasonable cost indicator ranges. Combined with informed intermediary judgement, the intermediary may use its limited audit funds and time in investigation of areas where there is the greatest

potential for an audit adjustment. At the same time, the HHA is provided an opportunity to justify its expenditures where unusual or unique circumstances have necessitated the higher costs. We find this an effective prioritization of audit effort and an equitable treatment of the HHA.

We believe that the Medicare program and the industry would be best served if the proposed cost limitations were withdrawn to allow time for research and analysis to ensure the statistical realibility of the data base and appropriate inclusion of industry variables which effect cost. In the interim, the Medicare program should continue development of a uniform Medicare cost report, USHHAR, and detailed policies and procedures to assist the intermediaries in properly administering the program to home health providers of service.

SPECIFIC COMMENTS

Statistical Reliability of the Data Base

In order for the cost limitations to be equitable and reliable, it is necessary that the data base be as uniform and accurate as possible. Since the HHA Medicare cost reports themselves are not uniform, the initial extraction of information from these cost reports may yield a non-uniform data base. Secondly, there should be a system for editing the data extracted to ensure that the reporting and collection of data is accurate. The HCFA proposal may not have recognized or corrected nonuniformity and inaccuracies in the data base and, if so, the cost limits developed from the data base may not be a statistically-reliable reflection of cost levels in the industry.

Our own data collection efforts to compile reasonable cost indicators were based on the same cost reporting periods and collected the same types of information as the HCFA proposal. Our data collection was limited to HHA cost reports finalized by the Blue Cross Plans while HCFA was able to collect data from all Medicare intermediaries. Our data base, however, was edited to enhance the uniformity and accuracy of the information collected. Our method differed from the method used by HCFA in four major categories:

1) Facility-based HHAs receive an allocation of overhead from the main facility. A facility-based HHA is treated as an "other reimbursable cost center" to the main facility in HCFA Forms 2552 and 2551. The main facility's administrative and general costs are apportioned to the HHA and reported on HCFA Form 1729. This is uncontrollable by the HHA and is a mandatory function of the Medicare cost reporting form.

We have compared the administrative and general costs in both free-standing and facility-based HHAs and found that this component can be as much as 25% of total cost in the facility-based HHA and generally only 5-10% in the free-standing HHA. At least part of this difference may be attributable to the cost reporting methodology and not necessarily to inefficiencies or other controllable factors by the HHA.

In development of our reasonable cost indicators, we excluded all information from facility-based HHAs from the data base. We felt that the existence of uncontrollable allocation of administrative and general costs found in such HHAs could distort our total cost per visit indicator upward when applied to all types of HHAs. In addition, HCFA Form 1729 does not require or supply cost per visit information by discipline; therefore, there was no data available for use in the reasonable cost indicators by discipline. The HCFA proposal, however, includes facility-based HHAs in the data base.

2) Official, or governmentally-sponsored, HHAs in general have a higher cost per visit than do free-standing agencies. Our data indicates that total Medicare cost in an official HHA is 20-25% higher than total Medicare cost in a free-standing HHA when computed as a cost per visit.

The reasons for this significant difference are unclear, and we are currently analyzing the official HHA data to determine if the higher costs have resulted from inefficient management, low productivity standards, variances in intensity of services, or other factors.

In recognition of these higher, unexplained costs, we excluded all information from official HHAs from the data base used in formulating our reasonable cost indicators. HCFA has included official HHAs in developing the cost limits.

3) Our studies indicate that HHAs will normally incur higher costs per visit during the initial year or periods of operation. We believe this higher cost is unavoidable in many instances because visit volume will initially be insufficient to absorb the HHA's fixed and stand-by costs. As visit volume increases, these costs per visit are substantially decreased.

In developing our reasonable cost indicators, we deleted all data from HHA cost reports in the initial year or period of operation. The HCFA data base excluded only cost reports which were less than a full 12 months of operation.

4) In developing our indicators, we sought out inaccuracies in the cost reporting data gathered. We instituted a system of 40 edits to ensure that the final data base was as accurate as possible.

The BCA reasonable cost indicators were based on information gathered from approximately 3700 cost reports. After edits and the other exclusions listed above, the final sample size was 1067 cost reports. This final sample represented the most uniform and most accurate data base available. The reasonable cost indicators, as a result, are as equitable and appropriate a reflection of cost levels in the industry as possible.

An analysis of the data base should be undertaken to determine that the data base used by HCFA in formulating the cost limits is statistically-reliable.

Recognition of Industry Variables

In deriving cost limits, it is appropriate that due consideration be given to the impact of industry variables on the levels of costs incurred. The Medicare program has recognized that the actions of the most cost-conscious and prudent buyer will be affected by certain economic and environmental factors which are uncontrollable. It is only those costs which are substantially out-of-line which are to be considered unreasonable. Cost limits, by definition, establish these maximum prudent buyer levels. Thus, economic and environmental variables in the industry must be considered in establishment of the limitations.

The HCFA proposal notes that of all the variables considered, only the urban/rural location was found to be an uncontrollable cost variable. Thus, different limits have been suggested for HHAs on an SMSA (urban) and nonSMSA (rural) classification system. In all disciplines except occupational therapy, the SMSA limits are higher than the nonSMSA limits. HCFA's decision to permit a higher level of reimbursable cost to urban HHAs rests on perceived differences in "operating modes." It does not recognize differences in wage levels, economic environment, size (visit volume), or patient population, etc. which we believe could significantly affect HHA costs.

Space costs, such as rent and taxes, is the only cost element which is likely to be impacted by the SMSA/nonSMSA classification, which is based on the location of the HHA main office. The other types of costs are not necessarily dependent upon the location of the HHA. Our study results are as follows:

1) The SMSA/nonSMSA assignments are based on the location of the HHA main office. We believe, however, that HHA costs are affected primarily by the service area rather than the office location.

Home care is a mobile patient care service; the services are rendered in the patient's location. In a hospital, on the other hand, the patient services are tied to the location of the hospital. For example, a beneficiary who lives in a nonSMSA area may be hospitalized in an SMSA area. When discharged, the beneficiary may be served by an HHA near the hospital (SMSA) or one that serves the area in which he lives (nonSMSA). Considering that the patient care treatment for his condition would be identical, the SMSA agency would be permitted a higher level of reimbursable cost than would the nonSMSA agency.

Secondly, it would be practical for an HHA to relocate its main office to an SMSA area for the greater reimbursement potential while still serving the nonSMSA area. Another mechanism available would be to establish a new main office in the SMSA area while retaining a branch office in the nonSMSA area. We note that many rural HHA offices are subunits to a main headquarters in the state capital, for example; this is common in mid-American states for official HHAs. Since the main office is in an SMSA area, a higher amount of reimbursement could be gained. Part of this problem centers on the certification procedures for HHAs which permits establishment of branches or subunits without separate certification from the main HHA unit.

We suggest that the service area or residence of the majority of patients served would be a more accurate and reasonable criterion in classifying HHAs as SMSA or nonSMSA in nature.

2) The home health care industry is a labor-intensive industry. Statistics drawn from the industry's associations indicate that 85¢ of every dollar spent by an HHA is for wages and fringe benefits. The HCFA proposal, however, found no correlation between wage levels and HHA cost.

A recent proposal in regard to cost limits for hospitals recognizes the need for a wage differential. The home care industry is more wage-intensive than the hospital industry. Approximately 72% of total hospital cost is wage-related; in an HHA, approximately 85% of total cost is wage-related. The HCFA proposal on HHA cost limits, however, does not suggest a wage differential similar to that proposed for hospitals.

To demonstrate the effect, the proposed hospital limits set a relative wage index for Dallas-Fort Worth at .9371, for Beaumont-Port Arthur-Orange at .8257, and for Houston at 1.404. Since HHA

wage costs are 85% of total costs, we can reasonably expect a Dallas HHA to incur wage costs 13% higher than those in a Beaumont HHA. A Houston HHA's wages would be 26% higher than in Beaumont and 11% higher than in Dallas. These differences are significant.

The hospitals and HHAs are searching the same marketplace for employees, independent contractors, and suppliers. Both types of facilities will be affected by national or local wage levels. Given a limited marketplace, the SMSA agency may not necessarily incur higher wage levels than the nonSMSA. An inverse relationship might be identified where a wage incentive would be necessary to attract qualified professionals to rural areas. We suggest a study be undertaken by HCFA to reassess the need for a wage differential in formulation of the HHA cost limits.

3) Since home health care is highly mobile, the time needed for travel to patient locations and the corresponding effect on visit volume and productivity levels will be affected by the urban/rural nature of the service area. The nonSMSA areas would likely incur higher transportation costs than would the SMSA areas. With recent increases in gasoline costs, the transportation costs of HHAs may inflate at a rate much in excess of the established and estimated inflation percentages suggested by HCFA. We feel that the transportation component of HHA costs should be granted a differential or special exception.

4) The previously-mentioned proposal on hospital cost limits exempts new providers from application of the limits for the first three years of operation. Under the current hospital cost limits, there is a carry-forward provision for costs above the limits during these initial periods. Neither of these provisions have been incorporated into the HCFA proposal on HHAs. We suggest that some recognition be given that HHA costs during the initial year or periods of operation may be uncontrollably higher due to the developing visit volume which is unable to absorb an appropriate proportion of fixed and stand-by costs.

5) The HCFA proposal found no correlation between cost and size of the HHA. Our own data regression analyses showed that visit volume affected costs in three broad, natural classifications of total visit volume: 0-1999, 2000-9999, and 10,000 and over. We suggest that HCFA reevaluate the relationship between HHA size and cost.

6) The HCFA proposal notes that there is no evidence available that the intensity of services varies among HHA providers · · type. One argument raised by facility-based HHAs is that an early release of a patient from a hospital may be contemplated where the HHA has access to the ancillary services in the hospital, such as X-ray and blood-tests, etc. to supplement the home care program. Since an HHA has no mechanism for reimbursement of ancillary services, the hospital must bill for the services and report all revenues. While it is difficult to determine the extent of costs incurred by the HHA in providing for such services, we believe that a study should be done before assuming that facility-based HHAs and free-standing HHAs offer the same services for the same kind of patient.

A complete and thorough analysis on the effect of industry variables on HHA costs is an important factor in the development of an appropriate cost limit. We suggest that the proposed cost limits be withdrawn to permit time for this analysis.

Thank you for the opportunity to comment on this material.

Very truly yours,

Merritt W. Jacoby
Acting Senior Vice President
Government Programs Division

Senator TALMADGE. The next witness is Mr. Robert P. Liversidge, Jr., chairman, Legislative Committee, National Association of Home Health Agencies.

Mr. Liversidge, you may insert your full statement in the record and summarize it, sir.

STATEMENT OF ROBERT P. LIVERSIDGE, JR., CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Mr. LIVERSIDGE. Mr. Chairman, members of the committee and ladies and gentlemen. My name is Robert P. Liversidge, Jr. I am executive director of Community Nursing Services of Toledo, Ohio, a medicare-certified nonprofit agency combining the home and community health services of the Toledo District Nurse Association and the city of Toledo public health nursing program. Our agency was founded in 1901 and currently provides 65,000 home visits to Toledo residents each year, offering a full range of services—skilled nursing; physical, occupational, and speech therapy; home health aide; social work, and nutrition consultation.

I am also legislative chairman for the National Association of Home Health Agencies, a membership organization devoted to concerns related to agencies providing health care services in the home. We currently have about 300 agency members and 300 individual members. Our membership comprises agencies of every type of auspice. I am speaking on their behalf as well.

I appreciate the opportunity of appearing before you today to offer my perspective on proposals intended to expand and improve upon home health services, and to comment on what I believe are advantages and shortcomings of the existing home health programs.

Home health services, in our country, are in a difficult position right now. We see a variety of conflicting pressures. We see an atmosphere which calls for an expansion of home health care services, recognizing the humane value of the patient's being able to stay at home, in familiar surroundings, rather than having to enter the nursing home or be hospitalized any longer than absolutely necessary and recognizing that, on a day-to-day basis, care in the home may be less expensive than care in an institution.

However, in contradiction to this pressure to expand, we are seeing a variety of measures proposed or in effect to restrict growth and expansion. Cost caps have been proposed which, in some parts of the country, may force home health agencies to close at the same rate gas stations are closing in those same areas. The proposed USSHAR uniform cost accounting system, designed to control fraud and abuse in home health agencies, will actually, according to what I have heard, offer clever accountants an opportunity to bury more inappropriate costs in a report which will range in consequence from an impossibility for smaller agencies to a very expensive exercise for larger agencies. As James Kilpatrick said in a recent column:

> One requirement of the new accounting scheme would redistribute the expense of washing windows—one ledger entry for washing windows inside and another ledger entry for washing windows outside. This will prevent fraud?

Added to these well-intentioned but misguided measures is a system of reimbursement that, for nonprofit agencies such as mine, allows absolutely no margin for growth. It is easy to be cynical when I can look at a discriminatory pricing system in which a profitmaking agency can secure a medicare-financed 11 to 12 percent return on investment to assure its growth when a nonprofit agency can secure no return on investment, at best can break even and in most cases, due to retrospective disallowances, will be programed to lose money and possibly eventually fall.

I personally am very concerned when I see legislation proposed excluding home health agencies from the certificate-of-need process, and in which proprietary agencies may be exempted from licensure requirements. That tells me that Congress intends home health services bypass the health planning process, imperfect though it may be, in this country.

Home health agencies should be covered, along with other health services, by certificate-of-need regulations issued pursuant to the Health Planning Act of 1974—Public Law 93-641—and section 1122 of the Social Security Act.

The inclusion of home health agencies in the planning process would assist in stemming the undue proliferation of agencies in some areas while helping to promote the extension of home health care to unserved areas.

Accompanying this developing policy of expansionism is a situation in which standards to assure quality care for patients is woefully lacking. The medicare conditions of participation are a bottom

line standard, to be sure. Indeed, when they were developed at the creation of the medicare program some ten years ago, they were a credit to the wisdom of their designers.

But with the growth of the home health industry and the subtle shifts away from the traditional visiting nurse service/public health department delivery of home health services to more independently owned or proprietary agency service, it is apparent that the limited protection for the patient afforded by the medicare conditions of participation is inadequate.

When the primary objective of your income and profit, even though satisfactory quality may be important, the medicare conditions are insufficient and the patient becomes very vulnerable. To monitor 200 patients at 200 different locations in their own homes is extremely complicated.

I am sure that many of my colleagues can repeat stories of abused patients, neglect, and other situations they have encountered when they arrived on a case where services had been previously provided by unsupervised, undertrained, careless staff. We can describe situations in which patients whose benefits were exhausted were unceremoniously dropped by one agency and the visiting nurse agency either had to use dwindling United Way resources to see the patient, or saw the patient at a financial loss, because we and the communities in which we are based recognize our primary commitment is to service and to the patient not to the dollar.

However, having cataloged a series of dilemmas for home health agencies, "the advantages and shortcomings of the existing home health agencies," as Senator Talmadge described in his announcement of this hearing, I would like to comment on the proposed improvements in medicare coverage for patients covered for home health services.

NAHHA has consistently supported modification of medicare regulations to accommodate needs of noninstitutionalized patients who are medicare-eligible, as these needs are defined and shown to be not met by the program. NAHHA recognizes that to merely extend or modify a benefit may have implications for other aspects of services for recipients and for the agencies and intermediaries supporting those changes.

We wish to not only offer our enthusiastic endorsement to the changes outlined below, but also to suggest some implications that must be considered at the same time. A number of these proposed changes are outlined in S. 489, the Domenici-Packwood "Medicare Home Health Amendments of 1979" and S. 505.

NAHHA supports the proposal to eliminate the 3-day hospitalization requirement. We believe this amendment, as proposed by Senators Domenici and Packwood and Representatives Pepper and Rangel, are highly desirable.

We feel that some coordination of benefits between part A and part B of medicare should be considered. While there is a deductible under part B, no deductible applies in the case of part A. If these two aspects of the medicare program are merged into one home health benefit, it must be acknowledged that no longer is there a separation between a program to reimburse for hospital costs and a program to reimburse for other costs, and we recom-

mend that the deductible be dropped, since such a requirement applied to the first use of services would work an extreme hardship on many old people.

NAHHA also supports the elimination of the 100-visit limitation under both parts A and B of medicare, as recommended by the GAO and contained in the legislation described above. In our experience, few patients exceed the present limits, but for those who do have needs in excess of 200 visits allowed under parts A and B, this represents an important improvement.

However, as modification of this provision could represent a veritable bonanza for those very few providers who are overutilizing services and thereby contribute to the fraud and abuse reported at several congressional hearings, we would also support more vigorous rooting out and prosecution of those few providers, at the same time.

NAHHA supports the addition of payment for single evaluation visits to be covered by the medicare home health benefit, both prior to release from an institution and in the home. The first can be of value in establishing the plan of care for the patient after discharge from an institution, and in preparing the patient and his family for visits to be made. The second is of importance in assessing the patient's living environment, to make a more rational determination of the kind and extent of in-home services required. While this has not been included in all of the legislation described above, we view it as an important yet relatively inexpensive need for coverage for medicare home health recipients.

NAHHA supports the addition of visits by occupational therapists and nutritional consultants to be paid on a primary basis as skilled services. Nutritional guidance and monitoring is an extremely important need for the elderly and the necessity of using highly trained persons to deliver these skilled services is of utmost importance.

Not only do such persons work with specialized diets, such as for the diebetic, and with diets which relate to various types of medications and groups of medications but they consider the need of the elderly as a group, who are often undernourished or malnourished. Occupational therapy is similar in type of skill level applied as other types of therapies, and NAHHA has urged its inclusion as a skilled service for some time now. The present liability of agencies to be reimbursed directly for such services severely limits their availability.

There are a number of other improvements that we believe should be considered, including the inclusion of homemaker services, relaxation of the skilled nursing requirement and definition of the homebound status which are presently given an overly restrictive interpretation by some administrators and fiscal intermediaries.

We recognize that these are potentially big money items and that there are severe cost restraints on program improvements, however. But while we are aware of the basic rationale for the medicare program as a health insurance program, and the definition of the home health benefit within that program and the consequent limitation that places on changing the nature of the medicare law to accommodate these big-money items, we also see the

need to realine Federal support for home care services under titles 18, 19, and 20 of the Social Security Act and titles 3 and 7 of the Older Americans Act.

Each has its own program definitions and eligibility requirements. These programs need to be more consistent with each other, and regulations must be revised to at least create more usable and economically efficient crosswalks from one program to another.

While none of the above items was included in the Domenici-Packwood legislation, NAHHA believes that they are important and should be considered at an early date.

In reviewing other provisions proposed in S. 489, NAHHA's Legislative Committee, made up of directors of 10 member agencies dispersed geographically and by auspice, felt that the only provision of the bill which would cause a significant administrative problem is the proposed amendment to section 1861(o)(7) calling for bimonthly billing, to include dates service provided, charges, and name and title of individual providing the service.

This would call for significant changes in billing procedures, we estimate, in over 95 percent of agencies.

While some agencies do provide visit verification forms signed both by the patient and the provider, a procedure which I favor, a copy of the bill sent to medicare, sent by the intermediary to the patient, should suffice to provide the rest of the information needed.

It is inescapably evident that the need for services far exceeds current utilization. Existing data demonstrates a marked variability in utilization from region to region. Overall, the utilization rate is said to be slightly below 2 percent of beneficiaries. Confirming this data are several recent Blue Cross studies indicating a substantial percentage of both hospital and nursing home patients could be cared for at home with some level of nursing service at a significant cost saving. One study indicates that 25 percent of all hospital patients could have a shortened hospital stay and complete their recovery at home. A second state's home care could eliminate from 10.2 to 18.5 hospital days per case for an estimated saving of $300 to $900 per case.

The pressure to meet the needs of the unserved are augmented by the knowledge of the inevitable growth in the population at risk. The national forecast is for an increase of 17.5 percent in the number of aged for the years between 1975 to 1985 with an increasing percentage of those age 75 and over.

By the end of the century, it is estimated that the age group 64 to 74 will increase by 22.8 percent. Those 75 to 84 will increase by 56.9 percent and the age group 85 and over will increase by 91.1 percent.

The dilemma of home care is that despite this demonstrable need and the comparative cost advantages of home care, providers of service are increasingly faced with arbitrary regulations, restrictive interpretations, duplicative paperwork, and fractionated authority. The most recent example of this inconsistent stimulus is the reduction in authorization requested for the home care expansion grants by more than 90 percent.

The reduction request was accompanied by the justification that "home health is no longer in its infancy," yet estimates indicate 70

percent of the medicare beneficiaries living in nonmetropolitan counties outside the northeast have no certified home health agency to serve them. Many of the existing agencies are said to serve only a portion of the county in which they were located.

NAHHA believes a rational, coordinated home care system must be an essential element of any program designed to effectively and economically meet the health and related social service needs of the American people. We encourage you to consider the need to bring about this system by including home care as a logical, full participating member in health planning, which it is not at the present time; to allow all home health agencies to secure a return on investment to enable them to grow, which they cannot do at the present time; and to insist on an adequate system of standards of fiscal and professional performance to prevent the potential for tremendous fraud and abuse of the medicare program and, more important, the patient, which we do not have at the present time.

We applaud your holding these hearings and appreciate the concerns that Senators Domenici, Packwood and others have shown in sponsoring S. 489 and similar much-needed legislation.

Senator TALMADGE. Thank you very much for a very fine statement. I have only two questions.

Have you noticed a tendency among proprietary home health agencies and certain private nonprofit agencies to skim off the more remunerative patients?

Mr. LIVERSIDGE. Unfortunately, we do not have any statistics on that. However, many of my colleagues have reported to me instances in which that has happened.

Senator TALMADGE. Would this threaten the financial position of the other agencies in the community?

Mr. LIVERSIDGE. I believe it would. I believe that home health agencies which are now nonprofit would have to base more on their required administrative costs on the voluntary sector, such as United Way and other kinds of situations, if this were to occur.

Senator TALMADGE. Thank you very much for your contribution. It will be helpful to the committee.

[The prepared statement of Mr. Liversidge follows:]

Statement of Robert P. Liversidge, Jr.

Mr. Chairman, members of the Committee, ladies and gentlemen: my name is Robert P. Liversidge, Jr. I am Executive Director of Community Nursing Services of Toledo, Ohio, a Medicare-certified nonprofit agency combining the home and community health services of the Toledo District Nurse Association and the City of Toledo Public Health Nursing Program. Our agency was founded in 1901, and currently provides 65,000 home visits to Toledo residents each year, offering a full range of services - skilled nursing; physical, occupational and speech therapy; home health aide; social work, and nutrition consultation.

I am also Legislative Chairman for the National Association of Home Health Agencies, a membership organization devoted to concerns related to agencies providing health care services in the home. We currently have about 300 agency members and 300 individual members. Our membership comprises agencies of every type of auspice. I am speaking in their behalf as well.

I appreciate the opportunity of appearing before you today to offer my perspective on proposals intended to expand and improve upon home health services, and to comment on what I believe are advantages and shortcomings of the existing home health programs.

Home health services, in our county, are in a difficult position right now. We see a variety of conflicting pressures. We see an atmosphere which calls for an expansion of home health care services, recognizing the humane value of the patient's being able to stay at home, in familiar surroundings, rather than having to enter the nursing home or be hospitalized any longer than absolutely necessary, and recognizing that, on a day-to-day basis, care in the home may be less expensive than care in an institution.

However, in contradiction to this pressure to expand, we are seeing a variety of measures proposed or in effect to restrict growth and expansion. Cost caps have been proposed which, in some parts of the country, may force home health agencies to close at the same rate gas stations are closing in those same areas. The proposed USSHAR uniform cost accounting system, designed to control fraud and abuse in home health agencies, will actually, according to what I have heard, offer clever accountants an opportunity to bury more inappropriate costs in a report which will range in consequence from an impossibility for smaller agencies to a very expensive exercise for larger agencies. As James Kilpatrick said in a recent column, "One requirement of the new accounting scheme would redistribute the expense of washing windows - one ledger entry for washing windows inside and another ledger entry for washing windows outside. This will prevent fraud?"

Added to these well-intentioned but misguided measures is a system of reimbursement that, for nonprofit agencies such as mine, allows absolutely no margin for growth. It is easy to be cynical when I can look at a discriminatory pricing system in which a profit-making agency can secure a Medicare-financed 11-12% return on investment to assure its growth when a nonprofit agency can secure no return on investment, at best can break even and in most cases, due to retrospective disallowances, will be programmed to lose money and possibly eventually fail.

I personally am very concerned when I see legislation proposed excluding home health agencies from the certificate-of-need process, and in which proprietary agencies may be exempted from licensure requirements. That tells me that Congress intends that home health services bypass the health planning process, imperfect though it may be, in this country.

Home health agencies should be covered, along with other health services, by certificate-of-need regulations issued pursuant to the Health Planning Act of

1974 (P.L. 93-641) and Section 1122 of the Social Security Act. The inclusion of home health agencies in the planning process would assist in stemming the undue proliferation of agencies in some areas while helping to promote the extension of home health care to unserved areas. The failure to include such agencies in the final certificate-of-need regulations signed by former HEW Secretary Mathews on January 13, 1977 (1/21/77 Federal Register, pp. 4002-4032) was contrary to the intent of Congress in mandating the creation of a comprehensive health planning scheme to require that decisions regarding the establishment and expansion of health facilities and services be made on a rational and systematic basis.

In March, when the House considered a bill to extend health planning authorities for one year, Chairman Rogers commented on the failure of HEW to include home health agencies in these regulations, stating (Cong. Record, 3/31/77, p. H2795):

> "Particularly disturbing was the omission of home health agencies from coverage by certificate of need since these are clearly within the legislative intent, see for instance the Conference Committee report on Public Law 94-641."

The Senate Human Resources Committee report on its version of the same one-year extension bill (Sen. Rpt. 95-102) expressed the same view with respect to omitting home health agencies from the certificate-of-need program, stating (p. 25):

> "The Committee is also concerned that the state certificate of need regulations issued on January 13, 1977 ... did not cover home health agencies, contrary to the recommendation of the Public Health Service that such agencies be included. The committee is of the view that such action was not consistent with the intent of Congress in mandating the state certificate of need program."
>
> "The Committee expects that the state certificate of need regulations will be revised to conform to the intent of Congress with respect to home health agencies."

Finally, the Conference Committee report on the one-year extension bill (Hse. Conf. Rpt. 95-500) stated that the omission of home health agencies from the certificate-of-need regulations by HEW "should be immediately reconsidered and rectified" (pp 21-22). NAHHA concurs. The regulations should be revised so as to include home health agencies in their coverage.

Accompanying this developing policy of expansionism is a situation in which standards to assure quality care for patients is woefully lacking. The Medicare Conditions of Participation are a bottom line standard, to be sure. Indeed, when they were developed at the creation of the Medicare program some ten years ago, they were a credit to the wisdom of their designers.

But with the growth of the home health industry and the subtle shifts away from the traditional visiting nurse service/public health department delivery of home health services to more independently owned or proprietary agency service, it is apparent that the limited protection for the patient afforded by the Medicare Conditions of Participation is inadequate. When the primary objective of your agency shifts from service and quality delivery of health care to maximizing income and profit, even though satisfactory quality may be important, the Medicare Conditions are insufficient and the patient becomes very vulnerable. To monitor 200 patients at 200 different locations in their own homes is extremely complicated.

I am sure that many of my colleagues can repeat stories of abused patients, neglect, and other situations they have encountered when they arrived on a case where services had been previously provided by unsupervised, undertrained, careless staff. We can describe situations in which patients whose benefits were exhausted were unceremoniously dropped by one agency and the visiting nurse agency either

had to use dwindling United Way resources to see the patient, or saw the patient at a financial loss, because we and the communities in which we are based recognize our primary commitment is to service and to the patient, not to the dollar.

However, having catalogued a series of dilemmas for home health agencies, "the advantages and shortcomings of the existing home health agencies," as Senator Talmadge described in his announcement of this hearing, I would like to comment on the proposed improvements in Medicare coverage for patients covered for home health services.

N.A.H.H.A. has consistently supported modification of Medicare regulations to accommodate needs of noninstitutionalized patients who are Medicare-eligible, as these needs are defined and shown to be not met by the program. N.A.H.H.A. recognizes that to merely extend or modify a benefit may have implications for other aspects of services for recipients and for the agencies and intermediaries supporting those changes. We wish to not only offer our enthusiastic endorsement to the changes outlined below, but also to suggest some implications that must be considered at the same time. A number of these proposed changes are outlined in S. 489, the Domenici-Packwood "Medicare Home Health Amendments of 1979" and S.505.

N.A.H.H.A. supports the proposal to eliminate the three-day hospitalization requirement. We believe this amendment, as proposed by Senators Domenici and Packwood, and Representatives Pepper and Rangel, are highly desirable.

We feel that some coordination of benefits between Part A and Part B of Medicare should be considered. While there is a deductible under Part B, no deductible applies in the case of Part A. If these two aspects of the Medicare program are merged into one home health benefit, it must be acknowledged that no longer is there a separation between a program to reimburse for hospital costs and a program

to reimburse for other costs, and we recommend that the deductible be dropped, since such a requirement applied to the first use of services would work an extreme hardship on many old people.

N.A.H.H.A. also supports the elimination of the 100-visit limitation under both Parts A and B of Medicare, as recommended by the G.A.O. and contained in the legislation described above. In our experience, few patients exceed the present limits, but for those who do have needs in excess of the 200 visits allowed under Parts A and B, this represents an important improvement. However, as modification of this provision could represent a veritable bonanza for those very few providers who are overutilizing services and thereby contribute to the fraud and abuse reported at several Congressional hearings, we would also support more vigorous rooting out and prosecution of those few providers, at the same time.

N.A.H.H.A. supports the addition of payment for single evaluation visits to be covered by the Medicare home health benefit, both prior to release from an institution, and in the home. The first can be of value in establishing the plan of care for the patient after discharge from an institution, and in preparing the patient and his family for visits to be made. The second is of importance in assessing the patient's living environment, to make a more rational determination of the kind and extent of in-home services required. While this has not been included in all of the legislation described above, we view it as an important yet relatively inexpensive need for coverage for Medicare home health recipients.

N.A.H.H.A. supports the addition of visits by occupational therapists and nutritional consultants to be paid on a primary basis as skilled services. Nutritional guidance and monitoring is an extremely important need for the elderly, and the necessity of using highly trained persons to deliver these skilled services is of

utmost importance. Not only do such persons work with specialized diets, such as for the diabetic, and with diets which relate to various types of medications and groups of medications, but they consider the needs of the elderly as a group, who are often undernourished or malnourished. Occupational therapy is similar in type of skill level applied as other types of therapies, and N.A.H.H.A. has urged its inclusion as a skilled service for some time now. The present inability of agencies to be reimbursed directly for such services severely limits their availability.

There are a number of other improvements that we believe should be considered, including the inclusion of homemaker services, relaxation of the skilled nursing requirement, and definition of the homebound status which are presently given an overly restrictive interpretation by some administrators and fiscal intermediaries. We recognize that these are potentially big money items, and that there are severe cost restraints on program improvements, however. But while we are aware of the basic rationale for the Medicare program as a health insurance program, and the definition of the home health benefit within that program, and the consequent limitation that places on changing the nature of the Medicare law to accommodate these big-money items, we also see the need to realign Federal support for home care services under Titles 18, 19, and 20 of the Social Security Act and Titles 3 and 7 of the Older Americans Act. Each has its own program definitions and eligibility requirements. These programs need to be more consistent with each other, and regulations must be revised to at least create more usable and economically efficient "crosswalks" from one program to another.

While none of the above items was included in the Domenici-Packwood legislation, N.A.H.H.A. believes they are important and should be considered at an early date.

In reviewing other provisions proposed in S. 489, N.A.H.H.A.'s Legislative Committee, made up of directors of ten member agencies dispersed geographically and by auspice, felt that the only provision of the Bill which would cause a significant administrative problem is the proposed amendment to Section 1861 (o)(7) calling for bimonthly billing, to include dates service provided, charges, and name and title of individual providing the service. This would call for significant changes in billing procedures, we estimate, in over 95% of agencies. While some agencies do provide visit verification forms signed both by the patient and the provider, a procedure which I favor, a copy of the Bill sent to Medicare, sent by the intermediary to the patient, should suffice to provide the rest of the information needed.

It is inescapably evident that the need for services far exceeds current utilization. Existing data demonstrates a marked variability in utilization from region to region. Overall, the utilization rate is said to be slightly below 2% of beneficiaries. Confirming this data are several recent Blue Cross studies indicating a substantial percentage of both hospital and nursing home patients could be cared for at home with some level of nursing service at a significant cost saving. One study indicates that 25% of all hospital patients could have a shortened hospital stay and complete their recovery at home. A second states home care could eliminate from 10.2 to 18.5 hospital days per case for an estimated saving of $300 to $900 per case.

The pressure to meet the needs of the unserved are augmented by the knowledge of the inevitable growth in the population at risk. The national forecast is for an increase of 17.5% in the number of aged for the years between 1975-85 with an increasing percentage of those age 75 and over. By the end of the century,

It is estimated that the age group 64-74 will increase by 22.8%. Those 75-84 will increase by 56.9% and the age group 85 and over will increase by 91.1%.

The dilemma of home care is that despite this demonstrable need and the comparative cost advantages of home care, providers of service are increasingly faced with arbitrary regulations, restrictive interpretations, duplicative paperwork, and fractionated authority. The most recent example of this inconsistent stimulus is the reduction in authorization requested for the Home Care Expansion Grants by more than 90%. The reduction request was accompanied by the justification that "home health is no longer in its infancy", yet estimates indicate 70% of the Medicare beneficiaries living in non-metropolitan counties outside the northeast have no certified home health agency to serve them. Many of the existing agencies are said to serve only a portion of the county in which they were located.

N.A.H.H.A. believes a rational, coordinated home care system must be an essential element of any program designed to effectively and economically meet the health and related social service needs of the American people. We encourage you to consider the need to bring about this system by including home care as a logical, full participating member in health planning, which it is not at the present time; to allow <u>all</u> home health agencies to secure a return on investment to enable them to grow, which they cannot do at the present time; and to insist on an adequate system of standards of fiscal and professional performance to prevent the potential for tremendous fraud and abuse of the Medicare program and, more important, the patient, which we do not have at the present time.

We applaud your holding these hearings, and appreciate the concern that Senators Domenici, Packwood, and others have shown in sponsoring S.489 and similar much-needed legislation.

Senator TALMADGE. The next witness is Mr. Ronald E. Rosenberg, chairman of the board, Home Health Services Association.

Mr. Rosenberg, you may insert your full statement in the record and summarize it in the time allotted.

STATEMENT OF RONALD E. ROSENBERG, CHAIRMAN OF THE BOARD, HOME HEALTH SERVICES ASSOCIATION

Mr. ROSENBERG. Thank you, sir. I appreciate that.

As you said, I am Ron Rosenberg, chairman of the Home Health Services Association, an organization of six investor-owned taxpaying companies which provide home health care services to persons in their own homes.

We do this through over 600 offices in 45 States. I will make just a few comments in support of the written testimony.

As you have heard from a number of witneses, there is a need for home health care services today. That need is growing, and will grow even more tomorrow.

In the face of this present growing need, proprietary home health agencies are prohibited from participating in the medicare program unless a State has passed a licensure law. To date, only 22 States have done so since 1965. In other words, medicare law requires that a major source of service be discouraged from helping to fill the need for home health care.

Proprietary home health care has grown, in spite of this systematic discrimination. It is, by the way, the only point in the medicare law we can find where such a discrimination is based on the taxpaying status of the provider. Our services have grown because the quality of our service is beneficial to our clients.

Our patients need home health care and are willing and able to pay for it personally. No government funds, Mr. Chairman, no Federal, State, or local taxes are involved. Frankly, I cannot think of any better testimony to the quality of our service.

Likewise, where public or nonprofit home health agencies have had a problem of providing service because of the shortage of personnel or because of the availability of services at certain hours of the day, they have turned to proprietary organizations to provide contract services, to provide home health aides. This is further testimony to the quality of the proprietary home health industry and the service we provide.

There have been problem with the administration of the home health care program and they have become more evident as the program has grown. There is no point in my repeating all of them. They are well-known to this committee. They have been talked about before in other hearings.

We in proprietary home care believe that much can be done under existing law to assist with these problems. Specifically, I would like to refer to page 14 of my testimony where we list a number of these points.

Specifically, our association suggests the designation of regional fiscal intermediaries for home health care with an option to choose a single intermediary to handle all home health care claims. We feel there should be a prohibition on medicare-only providers, although care must be taken to avoid rigid quotas for any type of patient.

We think there should be improved audit activity by HEW and fiscal intermediaries. We think there should be a reasonable system of uniform cost reporting.

There should be full access to the financial records of home health agencies, as well as to patient records. There should be reasonable, flexible guidelines for fiscal intermediaries to use on salaries, fringe benefits, and other appropriate charges. There should be reasonable, flexible guidelines in the percentage of administrative personnel allowed in each agency.

There should be a specified minimum of services provided directly by the home health care agency, and the home health agency should maintain the ability and right to contract for other services.

There should be patient, family or guardian verification of services provided. This is something we use in the proprietary system where the patient receives a copy of the bill, the patient receives a document as to the number of hours, the service provided, and the cost of those services.

We feel there should be vigorous efforts to identify and deal appropriately and properly with cases of fraud or abuse. In this regard, each member of the association pledges to work closely with the subcommittee and with officials charged with administering the medicare program to verify and deal with any bona fide allegations of fraud or abuse which may be brought to their attention.

We support S. 505 and provisions of home health care in that bill, removing the 3-day prior hospitalization and the deletion of the 100-visit limitation. We also support the provisions of S. 489.

In conclusion, Mr. Chairman, our position is simple. Proprietary organizations will help to fill the great, unmet need for home health care. In so doing, we will provide a source of high-quality, fairly priced services.

The medicare program should be administered with improved efficiencies so the quality and reputation of home health care and the patient is protected.

Our recommendations are simple: First, amend section 1861(o) of the Social Security Act, so that proprietary home health care agencies may participate fully in the medicare program on an equal basis with all other providers. Second, direct HEW to adopt the program changes we support and to move vigorously to eradicate fraud and abuse wherever it is found.

Also, we recommend the subcommittee make certain other amendments to the home health care laws, as proposed in your bill, S. 505, and in S. 489.

Thank you for the opportunity to present this statement. We look forward to answering any questions you may have.

Senator TALMADGE. Thank you, Mr. Rosenberg for a very good statement. I just have two or three questions.

In your testimony, you indicated that full participation of proprietary agencies will not increase the cost to medicare. Based on a sample of medicare claims in 1975, proprietary and so-called private not-for-profit agencies supplied more visits to persons served and charged more per visit than other types of agencies, such as visiting nurse associations and governmental, voluntary, and hospital-based agencies.

How would you reconcile that information with your view that the cost to medicare will not increase with more proprietary agencies?

Mr. ROSENBERG. It is a good question, Mr. Chairman. I am not sure I can answer all of it. I will try.

Last year, the House Ways and Means Committee had a study done for them where they looked at what would happen to the total cost of the medicare program if the proprietaries were allowed in. They found, at that time, in their study, that there would be no increases in costs to the medicare program.

As to the study you just cited in 1975, I do not know enough about the agencies that were looked at, the type of patients that were treated in those particular studies.

I would suggest that if there is something out of line, that HEW vigorously pursue those numbers in those agencies.

Senator TALMADGE. Now, I understand that you also represent the so-called manpower pools, which supply temporary help to health care facilities, including the home health care agencies. Do some of the organizations providing temporary help also engage in providing home health services?

Mr. ROSENBERG. Yes, sir.

Senator TALMADGE. If so, would not these so-called self-dealing arrangements tend to increase costs to the medicare program?

Mr. ROSENBERG. No; I do not think they would. The conditions of participation in the medicare program, prescribe the kind of employee that can provide services, such as home health aides as well as the supervision that must be provided for employees, their preservice education, and their in-service education. So I do not see that as a problem.

The medicare business must be separate from the type of pool business that you described. In fact, proprietary home health agencies, unlike other home health agencies, are prohibited from subcontracting for any service. So the sort of self-dealing you describe would not be possible for a proprietary home health agency.

Senator TALMADGE. Have you heard, or do you now of any other agency that makes direct, or indirect, payments for patient referrals?

Mr. ROSENBERG. No, sir, I do not.

Senator TALMADGE. Are there any questions? Senator Packwood?

Senator PACKWOOD. I missed all of your statement. I will read it, but I can tell from talking with those witnesses when they are not testifying through letters, there is a great, I think, unjustifiable suspicion of proprietary home health services. They often get them mixed up with the nonprofit home health services. In many cases, if there is an allegation of fraud or worse in nonprofits, it goes over into the proprietaries.

But have you or your association prepared or presented a first lawyer's brief in defense of your positions and on the fact that, by and large, your organizations are clean?

Mr. ROSENBERG. No, sir, we have not. What we try to do is visit with staff, both in the Senate and in the House, and with HEW to present our story, because we do get painted with that large brush in State after State.

Many times, the allegation is made that there is proprietary abuse in home health care across the Nation. That cannot be. We can only participate in medicare in 22 States, nine in the last year or so.

Senator PACKWOOD. Why can you not participate in the others?

Mr. ROSENBERG. Because they have not enacted a licensure law since 1965. Only 22 States have done it, and the majority of those have been in the last few years.

Senator PACKWOOD. You face a further problem. There is a substantial bias against anybody who makes money in the health delivery service. They do not like physicians making it either.

Mr. ROSENBERG. That is right. That is one strike you start with.

Senator PACKWOOD. There is no way we can overcome that bias. People with that attitude are likely supporters of a British type of national health insurance.

Mr. ROSENBERG. That bias is there. Literally you get thousands and thousands of people every day turning to us for service, paying for this service out of their own pocket, and coming back to our members for more service. In hospital after hospital, discharge planners across the country refer patients to us.

This has been going on now for 10 years. We must be doing something right in the clients eyes.

Senator PACKWOOD. I will read the statement. I may be back in touch with you. I may need further information.

Mr. ROSENBERG. Thank you, sir.

[The prepared statement of Mr. Rosenberg follows:]

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Statement of
Home Health Services Association

Appendix 1

The Association recommends that Section 1861(o) of the Social Security Act be changed to permit proprietary home health care providers to participate in the Medicare program on the same basis as all other home health care providers.

The proposed change can be accomplished by a simple deletion from the existing language of Section 1861(o). The complete section showing the proposed deletion in brackets is as follows:

"(o) The term 'home health agency' means a public agency or private organization, or subdivision of such an agency or organization, which—

"(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

"(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

"(3) maintains clinical records on all patients;

"(4) in the case of an agency or organization in any State in which State or applicable law provides for the licensure of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

"(5) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section; and

"(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

" [~~except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of Title 26 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and~~] except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases."

Statement of
Home Health Services Association

Appendix 2

States with Home Health Agency Licensure Laws

Arizona

California

Connecticut

Florida

Hawaii

Idaho

Illinois

Indiana

Kentucky

Louisiana

Maryland

Montana

Nevada

New Jersey

New York (Licenses only non-profit organizations)

North Carolina

Oregon

Rhode Island

South Carolina

Tennessee

Virginia

Wisconsin

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

PROPOSED AMENDMENTS

TO THE

MEDICARE PROGRAM

AUGUST 4, 1978

Prepared for the use of the Committee on Ways and Means by its staff

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U.S. GOVERNMENT PRINTING OFFICE
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(e) Elimination of the homebound requirement

To be eligible for home health care, the patient must be confined to his or her home. A person does not have to be bedridden to be considered to be confined to his home. However, the patient's condition should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. Occasional absences from home are allowed for both medical and nonmedical reasons. Elimination of the homebound requirement, with no other change in the benefit, would expand benefits to a new category of patients who are in need of skilled care but would ordinarily be expected to obtain such care in an ambulatory setting, that is, a doctor's office or a clinic. Many have expressed concern that, given such a liberalization, beneficiaries now obtaining care in an ambulatory setting would have an incentive to receive the care under the home health benefit along with all the attendant supportive services. In addition, elimination of the homebound requirement would make enforcement of the skilled care requirement exceedingly difficult.

(f) Addition of homemaker services

Services furnished by homemakers are not presently covered under the home health benefit. The home health aide—whose primary function is to perform personal care duties for a patient—may perform certain household services, but only if such services do not substantially increase the time spent by the aide in the patient's home. Such household services can include light cleaning, shopping for food, assistance in the preparation of meals, and laundering essential to the comfort and cleanliness of the patient. Coverage of homemaker services would represent a significant benefit expansion and would be of particular assistance to those who do not have the services of family or friends available. Many have expressed concern, however, that such a benefit would serve largely to substitute for services presently being furnished by family and friends and be subject to over-utilization and abuse.

(g) Elimination of the licensing requirement for proprietary home health agencies

By law, proprietary or for-profit home health agencies are not eligible to participate in the medicare program unless the agency is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations. Currently 17 States license home health agencies. One of these States, New York, specifically licenses only nonproprietary home health agencies and reimbursement would not be made available to proprietary agencies in that State by virtue of this proposed change. With respect to additional standards which by law may be imposed on proprietary home health agencies, it is required that such agencies offer skilled nursing services and one other therapeutic service directly, whereas public and nonprofit agencies are allowed to contract for either the skilled nursing service or the other therapeutic service.

Those who advocate the elimination of the licensing requirement for proprietary agencies and elimination of authority to impose additional standards for such agencies argue that this is the only type of facility so discriminated against in the medicare program. When the medicare program was enacted, it was thought that eventually all States would license home health agencies and that such licensure would provide some assurance for provision of quality services and against possible abuse. In practice, however, States have not been quick to license home health agencies. Proponents of the change further argue that it would make home health services more available to those who need such services.

On the other hand, some have expressed strong concern that adequate standards for home health agencies do not exist and easing the barriers to the entry of many new proprietary agencies (particularly if they accept only medicare beneficiaries as clients) may lead to more abuse and higher expenditures for the program. Their concern is particularly with respect to the high utilization rates and high cost per patient generated, on the average, by those proprietary agencies that are licensed and participating in the program; however, this same concern extends to private nonprofit agencies. In this regard, HEW is required, under existing law, to report to the Congress by October 25, 1978, with recommendations for regulatory and legislative changes on the issues of quality assurance and administrative efficiency with respect to all home health agencies.

(h) Elimination of the skilled care requirement

It has also been suggested that the requirement that a beneficiary require skilled nursing care, speech therapy or physical therapy in order to qualify for the full range of home health benefits, be eliminated. The test of need for home health services would then be the need for any type of nursing services and or a need for any other of the home health benefits—for example, home health aide services.

Although the availability of nonskilled nursing services and personal care services would enable a number of those who are now in institutions to be cared for at home, it has been suggested that medicare—a medically oriented program—is not the appropriate program to use in making these services available. More importantly—since without a skilled care requirement, the medicare program would be providing home health benefits as an alternative to or extension of care which is generally paid for by the medicaid program, by private funds, or furnished by family and friends—such a liberalization would represent a significant additional expenditure to the program with no opportunity for offsetting savings.

It has been urged that any expansion of the present home health benefit be considered in light of the recent work by various committees of the Congress which indicate some incidence of fraud and abuse among home health agencies. The home health business can be highly profitable—little capital is required and those who serve only medicare patients are virtually assured that 100 percent of their costs will be reimbursed.

There also is some concern that medicare home health expenditures have been growing so rapidly in the last few years. Program expenditures have averaged a yearly increase of over 50 percent in the last 5 years and have exceeded—by as much as 1½ times—the medicare expenditures for skilled nursing facility benefits in the last 3 years. Others would counter this concern by pointing out that home health expenditures still account for only 3 percent of total medicare expenditures. This rapid growth in the medicare home health benefit, the ease with which home health agencies can be established, and the evidence of abuse suggest that any significant expansion of the present benefit should be accompanied by efforts to provide for more efficient and uniform reimbursement policies, the tightening of conditions of participation for home health agencies, and improvement in administration by medicare intermediaries.

Cost:

[In millions except where otherwise specified]

	Eliminate 3-day requirement	Unlimited visits	Eliminate homebound requirement	Add homemaker services	Eliminate skilled care requirement (billions)	Occupational therapy	Eliminate licensing requirement for proprietaries
Fiscal year:							
1979	$8	$4	$105	$300	$1.2	$28	0
1980	9	4	130	370	1.5	35	0
1981	11	5	150	440	1.7	41	0
1982	12	6	180	520	2.0	49	0
1983	13	7	210	600	2.3	56	0

2. Services Furnished to Medicare Beneficiaries Outside the United States

Present law: Medicare coverage is provided, with a few limited exceptions, only for health care services rendered within the United States. These exceptions cover only cases in which the beneficiary needs emergency hospital services while traveling in Canada between the 48 contiguous States and Alaska; or needs hospital services because of a medical problem that arose while traveling or residing within the United States near the border, and a Canadian or Mexican hospital is more accessible than the nearest United States hospital. This limitation on medicare coverage was included in the law because of the administrative problems involved in verifying the medical necessity for services furnished outside the United States, establishing the qualifications of foreign medical practitioners and institutions, and determining the appropriate amount of payment to make for services.

Issue: A significant number of medicare beneficiaries are deprived, during such times as they may be traveling or living outside the United States, of their medicare benefits. Since the basis of the limitation in present law is administrative, it is widely believed that considerations of equity dictate the development of a reasonably workable arrangement for assuring medicare protection, to the extent feasible, for such beneficiaries.

Discussion: A proposal has been made to authorize the negotiation of reciprocal agreements with other countries under which provision

Home Health Services Association

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Congressional Research Service

WASHINGTON, D.C. 20540

March 7, 1979

TO : Honorable John J. Duncan
Attention: Mr. Scrivner

FROM : American Law Division

SUBJECT: Legal Interpretation of the Definition of Home Health Agency Under Section 1861(o) of the Social Security Act, As Amended

This summarizes our telephone conversation regarding an analysis of Section 1861(o) of the Social Security Act, as amended, 42 U.S.C. §1395 x(o). That section reads as follows:

> Home health agency
>
> (o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—
>
> (1) is primarily engaged in providing skilled nursing services and other therapeutic services;
>
> (2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;
>
> (3) maintains clinical records on all patients;
>
> (4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;
>
> (5) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section; and
>
> (6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of Title 26 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

A question has been raised as to the effect of deleting from the above section the underlined portion. Section 1861(o) defines the term "home health agency" for purposes of the Supplementary Medical Insurance Benefits for the Aged and Disabled Program (Medicare). "Home health agency" specifically includes a public agency or private organization which (1) primarily provides skilled nursing or other therapeutic services; (2) has policies established by a professional (medical) group to govern provisions of services; (3) maintains clinical records on all patients; (4) is licensed, or meets licensing standards, if state law requires licensing; (5) has in effect a budget plan meeting federal requirements; and (6) meets other conditions set by the Secretary of H.E.W. The term does not include a private organization which is not a nonprofit organization exempt from federal income taxation unless it is licensed pursuant to state law and meets federal standards. For purposes of part A "home health agency" does not include any organization primarily engaged in the treatment of mental diseases. See legislative history of P.L. 89-97, section 102(a), U.S. CONG. AND ADMIN. NEWS, 89th Cong., 1st Sess. 1965, p. 2124.

The effect of this section as it presently reads is to disallow reimbursement under Medicare to proprietary home health organizations (i.e., a "private organization which is not a nonprofit organization exempt from federal income taxation"), unless such organizations are state licensed and meet federal requirements. Thus, non-licensed proprietary home health agencies may not receive reimbursement under Medicare.

If this exception were deleted from Section 1861(o) then the effect would be to allow non-licensed proprietary organizations to qualify as a "home health agency" under this section. However under subsection (4) of this section, if States require licensing of such proprietary organizations, then such organizations must be either licensed or approved for licensing in order to meet definitional requirements. In addition, Section 1861(o) would not preclude state licensing of proprietary home care organizations at present or in the future.

While a reading of Section 1861(o) indicates that state licensing of proprietary home care organizations would be unaffected by deleting the present exception, congressional intent regarding retention of the right of States to require such licensing might be expressed in the report accompanying deletion of the exception.

We hope you will find the above discussion helpful for your needs. If further information or analysis is needed, please let us know.

Kathleen S. Swendiman
Legislative Attorney

HOME HEALTH SERVICES ASSOCIATION
Suite 312/1156 Fifteenth Street, N.W./Washington, D.C. 20005/(202)466-4087

Statement of
Home Health Services Association

Summary of Principal Points

I. Generally, there is a great and growing unmet need for home health care services and for improved administration of federal home health care programs.

II. Specifically, the Home Health Services Association recommends:

A. Modifying section 1861(o) of the Social Security Act to permit proprietary home health organizations to participate fully in the medicare program.

B. Adopting the following improved procedures for administering existing home health services law:

1. Designation of regional fiscal intermediaries for home health care, with the option for home health care providers to choose a single fiscal intermediary to handle all their home health care claims.

2. Prohibition of Medicare-only providers, although care must be taken to avoid rigid quotas for any type of patient.

3. Improved audit activity by both HEW and fiscal intermediaries.

4. A reasonable system of uniform cost reporting.

5. Full access to financial records of home health agencies.

6. Reasonable, flexible guidelines for fiscal intermediaries to use in reviewing salaries, fringe benefits, and management service contracts and fees, with appropriate recognition of startup costs.
7. Reasonable, flexible guidelines on percentage of administrative personnel.
8. A specified minimum of services to be provided directly by the home health agency.
9. Patient or family verification of services provided.
10. Vigorous efforts to identify and deal appropriately and promptly with cases of fraud or abuse. In this regard, each member of the Association pledges to work closely with the Subcommittee and with officials charged with administering the medicare program to verify and deal with any bona fide allegations of fraud or abuse which way be brought to their attention.

C. Amending existing home health services law as proposed by S.505 and S.489.

Statement of
Home Health Services Association

Submitted by

Ronald E. Rosenberg
Chairman of the Board

Mr. Chairman and Members of the Subcommittee on Health:

The Home Health Services Association respectfully requests the Subcommittee:

(1) To approve legislation modifying Section 1861(o) of the Social Security Act to permit proprietary home health care organizations to participate fully in the Medicare program,

(2) To direct HEW (a) to enforce more rigorously existing Medicare conditions of participation for all home health agencies, and (b) to make certain changes in program administration to improve quality, achieve fair costs, and reduce fraud and abuse, and

(3) To approve proposals in bills pending before the Subcommittee to make certain very useful changes in the home health program.

The Association represents tax-paying organizations providing home health services through over 624 offices in 45 states. We are pleased that the Subcommittee has decided to hold hearings on home health care benefits. These hearings are significant evidence of the importance home health care services have already achieved and, more importantly, of the increased importance they will have as our country's elderly population grows in number and longevity.

A. Introduction to Home Health Sevices and to the Association

There are presently three major types of organizations providing services to individuals in their own homes:*/

1. "Public agencies - includes all agencies operated by state or local governmental units.

2. "Nonprofit agencies - includes nongovernmental organizations exempt from federal income taxation under Section 501 of the Internal Revenue Code, such as Visiting Nurses Associations or agencies located in hospitals, skilled nursing facilities, or rehabilitation facilities. This designation also includes a new breed of provider known as the private-nonprofit agency which is organized and operated by an individual, but has achieved and maintains tax exempt status under the Internal Revenue Code.

3. "Proprietary agencies - includes all privately-owned, profit making agencies."

Home health care is an old idea with a new focus. Traditionally, family and friends provided home care. With the advent of the Medicare and Medicaid programs, home health benefits came to be provided by Federal government programs as well. The demand for Medicare-financed home health care services has increased very substantially in recent years. The Health Care Financing Administration recently stated that Medicare home health expenditures increased from $287 million in fiscal year 1976 to a projected $789 million in fiscal year 1979.**/

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*/ These definitions are the ones given by the Department of Health, Education and Welfare in the "H.R. 3 study", Home Health Services under Titles XVIII, XIX, and XX, Report to the Congress Pursuant to P.L. 95-142, p. 36.

**/ See Federal Register (vol. 44, no. 465), March 7, 1979, page 12509.

One reason for this increase is that home health care has become recognized as a more humane and successful mode of treatment for many illnesses. Another reason is that home health care is almost always a less expensive alternative to institutionalization in hospitals or nursing homes. For example, a 1977 General Accounting Office report stated:

> "Until older people become greatly or extremely impaired, the cost for home services, including the large portion provided by families and friends, is less than the cost of putting these people in institutions."*/ (Emphasis added)

Proprietary home health organizations are a relatively recent phenomenon. A few came into existence in the mid-1960's. Significant growth began in the early 1970's because of the great need for home health services that remained unmet by the pre-existing public and non-profit agencies. This growth was not financed by public programs like Medicare. That is because, as will be described below, tax-paying home health organizations are not eligible for Medicare payments like public and non-profit agencies. Consequently, proprietary home health agencies grew because they filled a need that many patients were willing and, fortunately, able to pay for out of their own pockets. Today, there is no authoritative information on the amount of home health

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*/ Comptroller General's Report to the Congress; Home Health - The Need for a National Health Policy to Better Provide for the Elderly: December 30, 1977, page i.

services provided and funded by all sources other than the HEW and other government programs, e.g. by individuals, private insurers, and philanthropic programs. We believe it is a significant addition to government programs, perhaps as much as $500 million.

The Home Health Services Association was formed in 1978 to encourage efficiency, reliability, and safety and to enhance quality in the delivery of home health care to the general public. The Association's members now number six organizations which collectively provide home health services through 624 offices in 45 states. In 1978, our members employed 2900 full-time and an estimated 160,000 part-time employees and served over 105,000 patients. Although there are no authoritative figures for our own sector of home health care, we believe the range of total services provided by proprietary organizations was $300 million to $400 million in calendar 1978 with our members representing a major share of that total.

Members of the Association employ a variety of people ranging in skills and training from registered nurses and physical therapists to home health aides and homemakers. By far the largest number of employees are homemaker-home health aides. We estimate that approximately 60% of our total employees are in this category while approximately 15% to 20% are registered nurses and licensed practical nurses.

B. The Nation's Need for Home Health Services is Not Being Met

In spite of the growth in federal expenditures for home health care, the need for such services is still largely unmet. The underlying reality is that, according to 1976 estimate, 81% of persons over 65 are affected by chronic illness and 26% are limited in performing their major activity.*/ The Congressional Budget Office estimated in 1977 that only 300,000 to 500,000 adults can be served by personnel from existing home health care providers, while 1.7 to 2.7 million adults have a need for home care.**/

In addition to this unmet need, according to the CBO, 20-40% of nursing home patients could be cared for adequately without institutionalization if sufficient home health care were available.**/ And the sponsors of S.489, in introducing that bill this past February, noted HEW Secretary Califano's estimate that as many as 100,000 of the people in acute care hospital beds--at an estimated cost, incidentally, of $2.6 billion a year--could better be cared for at home. In the context of unmet need, it important to keep in mind (see page 3) the GAO conclusion that home health care is less costly than institutionalized care.

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*/ Stanley J. Brody, "Long-term Care in the Community" in A Social Works Guide for Long-term Care Facilities, by Elaine M. Brody, DHEW Publication No. (ADM) 76-177, 1976, p. 49.

**/ Budget Issue Paper, Long-Term Care for the Elderly and Disabled, Congressional Budget Office, February 1977, page x.

The demand for home care--great as it is now--is likely to expand over the years to come as our elderly population increases in absolute numbers, in percent of the total population, and in longevity.

In summary, more home care services are needed for the following reasons:

- there is today a demand for home health care services in excess of the supply of services.
- home health care is becoming recognized as a socially desirable and more dignified alternative to institutionalized care.
- in an age of deep concern with health care costs, home health care offers a way of reducing costs.
- future demographic shifts will create increased demand for both home health care and for less expensive alternatives to inpatient hospital and nursing home care.

In spite of these factors, proprietary home health organizations are discouraged from helping to expand the supply of home health services for Medicare beneficiaries by an existing statutory provision which discriminates against such agencies solely because of their tax status.

C. Present Home Health Law Discriminates Against Proprietary Organizations, the Only Such Discrimination in the Medicare Program.

Present law, Section 1861(o) of the Social Security Act, was first enacted in 1965. It defines a home health agency to exclude specifically from Medicare reimbursement any organization which is not non-profit under the Internal Revenue Code unless it is licensed under state law and meets applicable standards.*/ This law is discriminatory. It is the only section in the Medicare law where tax-paying, for-profit organizations are excluded as providers. For example, profit-making hospitals are eligible for Medicare reimbursement; profit-making home health providers are not.

In 1965, when Congress established the Medicare program and the definition of home health agency, no proprietary home health providers existed. Nevertheless, Congress envisioned the advent of such organizations, and the Senate Finance Committee's report noted that:

> "It is the understanding of the committee that organizations providing organized home care on a profit basis are presently non-existent. However, the language of the bill permits covering such agencies if they come into being, are licensed, and meet the high standards which the present nonprofit agencies offering organized care meet."**/

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*/ See Appendix 1 for the existing language of Section 1861(o).

**/ Senate Report 404, 89th Congress, 1st Session, June 30, 1965; U.S. Code Congressional and Administrative News, 1965, page 1975.

It is apparent from this statement of Congressional intent that the drafters of the 1965 law intended to allow tax-paying home health agencies to be Medicare providers, and that each state was expected to enact a licensure law for home health providers. This anticipation of state action is understandable; after all, the states had enacted licensure statutes for virtually every other segment of the health industry in the interests of the health and safety of their residents.

Unfortunately, states have been slow to enact licensing statutes for home health providers. Only 22 states have passed these laws to date (See Appendix 2). This lack of licensing means that tax-paying home health organizations cannot provide home health services to Medicare patients, even where there are not enough personnel in the non-profit agencies to serve them. Even where licensing is possible, the double burden of red tape and consumption of time has discouraged many proprietary agencies from becoming both licensed under State law and then certified under the Medicare program.

As noted previously, proprietary agencies have grown in spite of this discrimination because some people are willing and able to pay for needed home health care out of their own pockets. We estimate that from 70% to 80% of all the patients we serve valued our services highly enough and had the ability to pay for them themselves.

Another element of growth is provided by public and non-profit agencies which cannot meet the needs for home health care in their localities and which subcontract with proprietary organizations to provide that care. In addition, many such agencies only operate 40 hours each week, while the needs for home health care obviously cannot be limited to one quarter of the hours in the week. Proprietary providers, as the Congressional Budget Office has said, "are often the only home health care providers that offer 24-hour and weekend care."*/ Consequently, proprietary organizations provide off-hours and weekend care under subcontract to the public and non-profit agencies. But the major portion of services under subcontract is for home health care during the regular working day in situations where the public or non-profit agency does not have the resources to provide needed care.

The important point to note is that the performance of proprietary providers is not in question and provides no basis for the continuing discrimination in the medicare law. The simple fact is that proprietary organizations perform as well as or better than other home health agencies. Their growing services to private pay patients and their frequent subcontracts with public and non-profit agencies are proof of their creditable performance.

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*/ Budget Issue Paper, Long-Term Care for the Elderly and Disabled, Congressional Budget Office, February 1977, page 29.

Mr. Chairman, we recognize that there is some concern with what would happen if proprietary home health organizations were fully admitted to Medicare participation. Let me now turn to some of the results of that change.

1. Revision of section 1861(o) will not increase costs for the Medicare program

There is presently a serious concern in this Subcommittee, the Congress and the public over the steeply rising costs of health care. Some may fear that allowing proprietary providers to participate in the Medicare program will inflate Medicare costs at a time when we can least afford it. This fear is, we believe, unfounded. The best support for our view comes from action last year in the 95th Congress.

Last October, the House of Representatives passed, 398-2, a Medicare benefits bill (H.R. 13097) which was designed to provide additional services while keeping additional costs to a minimum. That bill changed section 1861(o) to allow proprietary home health care providers to participate fully in Medicare. HEW actuaries, working with the Ways and Means Committee, determined that full participation of proprietary providers in the Medicare program would not increase the costs to Medicare at all in each of the next five years. The relevant Committee report is attached in Appendix 3.

2. Revision of section 1861(o) would not interfere with the states' rights to enact licensure statutes.

Another concern with our proposal is that it would restrict the states' rights to protect their own citizens' health and safety by enacting licensure statutes for home health agencies. Here again, we believe this concern to be unfounded.

First, the full participation in Medicare by public and non-profit home health agencies since 1965 has not prevented 22 states from enacting licensure laws covering those agencies. This is the best indication that there has in fact been no diminution of states' rights to enact licensure laws.

Second, as a matter of legislative interpretation, the Congressional Research Service has reported that, even if the Federal government changes the law to allow proprietary home health organizations to qualify as a home health agency for participation in the Medicare program, states would not be precluded from licensing proprietary home care organizations. (A copy of the CRS study is attached as Appendix 4.)

The issue is not whether states' rights will be infringed; they will not be. The issue is whether a discriminatory Federal statute should be allowed to stand.

3. Competition will enhance the quality of all home health services.

We recognize that in health care, economic forces are different from those in the conventional marketplace because of the prevalence of third-party payment mechanisms. However, we believe that giving the patient a choice between several providers, regardless of whether they are profit or non-profit, will naturally lead to a choice of the agency which has the reputation for delivering the best quality care. We submit that allowing competition among different forms of provider organizations will result in an overall upgrading of the services given in the home health care field. Certainly it is too late in the day to argue that providing health care services under Medicare in the same old ways they've always been provided will achieve better quality and more reasonable cost. We want to play by the same rules as other home health agencies. We believe that if all home health care providers abide by the same rules, the result will not just be more widely available home health services but improvement in the performance of all home health care providers.

D. Program and Administrative Improvements are Necessary for the Medicare Home Health Program

As both the demand and the federal financial support for home health care increased, so did the awareness that there is substantial room for improvement in managing the home health program. The following criticisms have frequently been heard:

- loose cost controls
- absence of cost information for home health agencies
- limitation of some home health agencies to serving Medicare beneficiaries only
- lack of attention from medicare fiscal intermediaries
- fraud and abuse in providing and billing for services

These problems are well-known to this subcommittee, other Congressional committees and the Department of Health, Education and Welfare, and their existence has motivated many suggestions for improvement. For ourselves, the six members of the Association firmly believe that our continued observance during the ordinary operation of our business of sound, ethical business practices is the best way for us to cooperate in achieving legitimate, high quality home health care at a fair cost.

In addition, the members of the Association urge that improved administrative procedures under the existing law be instituted to improve program performance and integrity, to increase the credibility of home health care services, and to save the taxpayers money.

Specifically, the Association supports:

1. Designation of regional fiscal intermediaries for home health care, with the option for home health care providers to choose a single fiscal intermediary to handle all their home health care claims.
2. Prohibition of Medicare-only providers, although care must be taken to avoid rigid quotas for any type of patient.
3. Improved audit activity by both HEW and fiscal intermediaries.
4. A reasonable system of uniform cost reporting.
5. Full access to financial records of home health agencies.
6. Reasonable, flexible guidelines for fiscal intermediaries to use in reviewing salaries, fringe benefits, and management service contracts and fees, with appropriate recognition of startup costs.
7. Reasonable, flexible guidelines on percentage of administrative personnel.

8. A specified minimum of services to be provided directly by the home health agency.

9. Patient or family verification of services provided.

10. Vigorous efforts to identify and deal appropriately and promptly with cases of fraud or abuse. In this regard, each member of the Association pledges to work closely with the Subcommittee and with officials charged with administering the medicare program to verify and deal with any bona fide allegations of fraud or abuse which way be brought to their attention.

None of these improvements is a panacea and none can be successful if pursued in a simplistic, unreasonable way. But together they can help the American people receive the improved home health care they need and deserve, both as beneficiaries and as taypayers.

E. Comments on Pending Legislation

Mr. Chairman, I would like to conclude our statement by turning to bills pending before your Subcommittee which would amend existing law dealing with home health services.

The first of these is the bill sponsored by yourself and Senator Dole, S.505, which includes two provisions relating to home health: elimination of the three-day prior hospitalization requirement for Part A of Medicare, and deletion of the 100-visit limitations in

in both Parts A and B of Medicare. We believe that both of these proposals are desirable. The GAO estimated the fiscal 1978 costs of these changes at $12.5 million each.*/ These costs are modest in comparison to the need to be filled. Moreover, we believe unnecessary added costs will be avoided by improved monitoring of home health service providers. We hope, therefore, that, when your Subcommittee proceeds to consider home health legislation, the two proposals which you and Senator Dole support will be included in the final bill.

S.489, The Medicare Home Health Amendments of 1979, sponsored by Senators Domenici and Packwood and several of your colleagues, also includes these two provisions which you, Mr. Chairman, have included in your bill. In addition, S.489 also includes several improvements in the Medicare home health program which have modest costs and important benefits. In particular, we would like to express our support for the following provisions of that bill:

- The bill would allow rural physicians' assistants and nurse practitioners who are operating under the general supervision of a physician to establish a plan of home health care. We believe that this is a useful change which would help encourage the provision of home health services in presently underserved areas.

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*/ Comptroller General's Report to the Congress; Home Health - The Need for a National Health Policy to Better Provide for the Elderly, December 30, 1977, p. 24.

- The bill would require a system of regional fiscal intermediaries for home health. As I noted, we firmly believe that improved performance by fiscal intermediaries is necessary. However, we would add to the concept of regional intermediaries the option—just as it exists today-- for home health care providers to choose a single national intermediary for all their home health claims. For companies which operate in several states, as members of this Association do, the option of dealing with one fiscal intermediary would be highly desirable.

- We strongly support the concept of training for home health aides. We have no objection to S.489's requirement that they be trained in accordance with a course approved by the HEW Secretary. We point out, however, that no such course exists at the moment, although steps are underway toward that goal. Therefore, we would urge that this provision be given sufficient flexibility to take account of the lack of existing approved training programs and to assure that the training requirement does not become a way of limiting the supply of home health aides or in overqualifying them for the jobs which they must perform. We are now participating with the organization that is attempting to devise an approved training course and we look forward to further participation in that effort.

F. Conclusion

Our position is simple, Mr. Chairman: proprietary organizations will help to fill the great unmet need for home health care. In so doing, we will provide a source of high quality, fairly priced services. The Medicare program should be administered with improved efficiency so that the quality and reputation of home health care is protected and enhanced.

Our recommendations are just as simple:

1. Amend 1861(o) to allow proprietary home health organizations to participate fully in Medicare.
2. Direct HEW to adopt the program changes we support and to move vigorously to eradicate fraud and abuse whenever it is found.
3. Make certain other amendments to the home health care law as proposed by your bill, S.505, and S.489.

Thank you for the opportunity to present this statement. We look forward to responding to any questions the Subcommittee may have.

Senator TALMADGE. At this point, without objection, I would like to insert in the record a Chicago Tribune article dated January 2, "U.S. Probing Cheating on Medicare," an article by William Gaines: "Federal medicare program has been charged excessive amounts of money in complex profiteering schemes developed by several Chicago home health care agencies, the Tribune investigation found."

Without objection, that will be inserted into the record at this point.

[The material referred to follows:]

[From the Chicago Tribune, Jan 2, 1979]

U.S. PROBING CHEATING ON MEDICARE

(By William Gaines)

The Federal Medicare program has been charged excessive amounts of money in complex profiteering schemes developed by several Chicago home health agencies, a Tribune investigation has found.

Federal officials, contacted by The Tribune about the findings, said they have investigated the firms involved and have turned the matter over to U.S. Atty. Thomas Sullivan for possible action.

Home health agencies are private, not for profit firms set up to provide health services at cost to elderly persons in their homes to enable many of them to avoid having to go into nursing homes.

The Tribune investigation found that several Chicago firms have made questionable billings to Medicare, the government health insurance program for the elderly, inflating the costs of services they are supposed to provide. Among the findings:

One home health agency operator, John D. Hirn, charged Medicare the $80,000 in costs he incurred in a lawsuit brought against him involving a private, profitmaking firm he owned. Christopher Cohen, regional director of the U.S. Department of Health, Education, and Welfare [HEW], the agency that oversees home health agencies, was a partner at the time in the law firm that represented Hirn in the lawsuit. Cohen told the Tribune he did not work on the case and had no knowledge of it.

Chicago Home Care, Inc., a profitmaking company that supplies nursing aides to five home health agencies, pays its aides $6 for each visit to a patient. But the firm bills the agencies $17.87 a visit, and they in turn charge $19 to Medicare. The practice may be costing Medicaid more than $80,000 a year above the normal charges for such services.

Nurses who have worked for one home health agency told The Tribune they were forced to short-change patients on the services they provided because they were assigned an excessive number of patients to visit each week. Feeds of a profitmaking consulting firm that serves the agency are based on the number of visits made. So, but short-changing patients on visiting time, the agency increases the profits of the consultants.

The Tribune investigation was an outgrowth of an examination of home health agencies last summer as part of a series of articles on problems of the elderly.

The investigation found that some operators are profiteering at federal expense through complex arrangements involving the establishment of private, profitmaking firms that provide consulting and billing services to not-for-profit health agencies.

Through these schemes, the operators are able to charge high prices for services to their own not-for-profit agencies—then collect the charges from Medicare.

For example, John Hirn and his wife Doris own two home health agencies—Home Health Service of Chicago North, Inc., and Suburban Home Health Service, Inc., of Des Plaines.

They also own a profit-making consulting firm called National Health Delivery Systems, Inc. National Health handles billings for the two agencies at a cost of 75 cents for each nursing visit, or a total of $60,000 a year.

A comparable billing service by another firm can be had for 41 cents, and some agencies bill as low as 30 to 35 cents a visit.

In 1975, Hirn was sued by Unihealth Services Corp., a consulting and billing service by which he was employed as a salesman while he operated his not-for-profit home health agency.

Unihealth charged that he had used his position as a salesman to lure customers from Unihealth for the benefit of his profitmaking company, National Health. It charged that Hirn's home health agency permitted it.

Unihealth eventually settled the case out of court for $70,000. Hirn has billed this to Medicare at $10,000 a year, HEW records show.

The suit resulted in another $10,000 in legal fees, part of which went to Schwartzberg, Barnett, and Cohen, one of the law firms that represented him.

Instead of paying the bill himself or through his profitmaking company, Hirn submitted to Medicare a bill from the law firm made out to his Home Health Service of Chicago North, Inc.

Christopher Cohen left Schwartzberg, Barnett, and Cohen in 1977 to become HEW area director.

His former law partner, Hugh J. Schwartzberg is an officer in both of Hirn's home health agencies. Schwartzberg's wife, Joanne, also is an officer and draws an aggregate salary of more than $39,000 for services "as required."

Blue Cross, which acts as auditor for HEW, has questioned the billing of the law firm's legal fees to Medicare as not relevant to home health care. It also found the cost of data-processing services by Hirn's National Health firm to be not reasonable or necessary.

Schwartzberg told the Tribune he has been instructed by his client, Hirn, not to answer questions about the billing of costs of the lawsuit to Medicare.

Efforts to reach officials of Chicago Home Care, 1808 W. 103d St., for comment about their billing practices were unsuccessful. Mrs. Patricia Tinder is owner of the firm.

Reports submitted to Medicare show that Chicago Home Care aides make two-hour visits to patients. But Tribune reporter Jane Fritsch, who worked undercover

for the firm last summer, found that aides spend less than an hour with each patient.

Nurses for Home Health Service of Orland-Tinley, a home health agency, Chicago Home Care, told the Tribune they seldom saw nurse's aides while making their rounds.

The nurses themselves said they were required to make 40 to 50 visits to patients each week. Most agencies make no more than 30 visits a week.

"All I could do would be to run in and do vital signs and try to get back out as soon as possible, said Carol Phillips, a former nurse for the agency.

Another nurse said she had made as many as 16 visits a day and was required to spend some days recruiting new patients.

The Tribune learned that some persons serve as officers of more than one of the home health agencies that have contracts with Chicago Home Care.

Michael Morrisroe, founder of two of the agencies also owns a profit-making firm called Northrad that provides consulting services to the agencies. He bills each agency as much as $1,600 a month for these services, with Medicare paying the bill.

Auditors for Aetna Insurance Co., the government-appointed fiscal intermediary that deals with one of Morrisroe's agencies, asked in 1977 for a fraud investigation of the agency.

The auditors said the agency—Southwest Community Home Health Agency, 10105 S. Western Av.—may have been guilty of a number of financial improprieties. They said the agency submitted unexplained invoices from a travel agency to Medicare, submitted invoices for other firms that were paid through the agency's books, and paid excessive legal fees.

Records in the office of the HEW health care finance administration show that the auditors were removed from the case and replaced with Blue Cross auditors after U.S. Representative Morgan Murphy [D., Chicago] intervened on behalf of the agency.

Ownership of the various agencies was determined by The Tribune from a study of agency reports to HEW that were obtained under the Freedom of Information Act.

One agency, Home Health Service of Orland-Tinley, unsuccessfully sought a restraining order in federal court to keep the reports from being released.

Senator TALMADGE. I also have a document, addressed to a physician in California from 680 Parkington Street, San Francisco, Calif.

Down at the bottom, it says, and I quote: "We are pleased to give you a $5 gift certificate to Macy's or Magnum's for each patient referral."

That is a felony under the law.

I am informed we have already sent it to the appropriate prosecution group in the State of California.

Without objection, the document will be inserted at this point in the record.

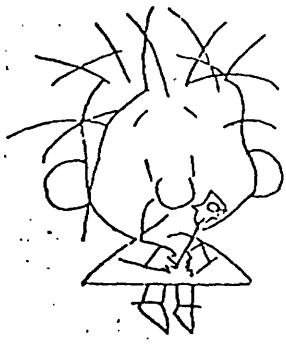
[The material referred to follows:]

TEM POSITIONS

TemPositions Home Care Personnel Service, Inc.
690 Market Street/San Francisco, CA 94104

JAN 19 '77 CALIF. 10167477 U.S. POSTAGE 0.10

DR HARRY WEINSTEIN
1000 DIVISADERO ST PHY
SAN FRANCISCO CA 94115



HELP YOUR PATIENTS STAY AT HOME. A little tender loving care, familiar surroundings, and professional care will speed recovery. Companion sitters, home health aides, nurse assistants, LVN's, RN's — 24 hours a day, seven days a week. RN supervised.

TemPositions is a sixteen year old temporary service that has recently expanded into home health care. If you have any questions, please call Martha at 956-1041.

FIVE

We will be pleased to give you a five dollar gift certificate to Macys or Magnin's for each patient referal.

Senator TALMADGE. The next witness is Mary Jane Mayer, chief executive officer, Visiting Nurse Association, on behalf of the Council of Home Health Agencies, Community Health Services, National League for Nursing.

Ms. Mayer, we are delighted to have you. You may insert your full statement in the record and summarize it in the allotted time.

STATEMENT OF MARY JANE MAYER, CHIEF EXECUTIVE OFFICER, VISITING NURSE ASSOCIATION, ON BEHALF OF COUNCIL OF HOME HEALTH AGENCIES, COMMUNITY HEALTH SERVICES, NATIONAL LEAGUE FOR NURSING

Ms. MAYER. Mr. Chairman, and Senator Packwood, I am delighted to be here. I would like to be entered into the record along with the Visiting Nurse Association of Milwaukee, Wis. I request that the testimony of the Council of Home Health Agencies and Community Health Services be entered into the record and I would like to spend the remaining portion of my time specifically giving examples from our own agency of what the council's testimony addresses.

The Visiting Nurse's Association total visit volume has been increasing, 11 percent in 1976, 19 percent in 1978, up to 163,000 visits in 1978. During this same period, we have seen a decrease in medicare volume and income. Medicare is giving less and less to the needs of the elderly, particularly in the acute, intensive care and terminal illness parts of our program.

In 1976, medicare income was 49 percent of total VNA income. In the first quarter of 1979, 43.4 percent. Our total number of professional medicaid visits remains constant at 54 percent of our total visits.

A more dramatic change is seen in homemaker home health aide hours. In 1976, medicare aide hours was 29.4 percent of our total aide hours. In 1978, 24.8 percent.

I would like to preface my next remarks by saying that we do have an excellent relationship with our fiscal intermediaries and that the following problems I will address, the intermediary believes are the interpretation from HEW and that they are following HEW regulations.

No. 1, in medicare reimbursement, we seem to see a change in the interpretation of the definition of visits. This has resulted in a retroactive denial of care after 4 to 6 months after service has been given. The Visiting Nurse Association in Milwaukee has waiver liability status, but the waiver does not cover denial due to homebound status.

The VNA patients requiring fee adjustments after denied by medicare have a median annual income of $4,300 a year with median savings of $1,500. Often the agency cannot recoup the total amount of the bill.

In 1978, the Visiting Nurses Association and Milwaukee Charitable Services was behind a half million dollars. This was often denied in chemotherapy patients, the terminally ill being taken by ambulance, with assistance, to the hospital for chemotherapy and brought back home to continue treatment. These cases have been denied as not homebound.

Often if a patient is assisted to PT on an outpatient department basis—we have one case where it took two people to get the individual into the van, two people to get him home. That patient was denied because of not being homebound.

A second thing we have noted is a change in the interpretation of skilled nursing and physical therapy which often results in denial of services, particularly in skilled physical therapy, which goes beyond 10 to 14 days of service and skilled nursing care of terminally ill patients beyond a certain period of time, and, unfortunately, many of our nurses began to believe that a patient just does not die quickly enough, in order to keep being covered by medicare.

I think this is disgraceful.

The care of patients receiving renal dialysis on an outpatient basis that requires follow-up home care is often a decision that the care is not a skilled nursing care, even though we have had examples of patients who have rheumatoid arthritis and are incapable of doing their care.

A good example of retroactive denial due to a determination of nonskilled PT is an 87-year-old woman who lived alone independently until she fell while someone was stealing her purse.

She fractured her right shoulder. She left the hospital 7 days earlier because the VNA had a cooperative plan in cooperation with the hospital, physician, and with the family. The physician ordered Mrs. W to have PT until she was able to move her arm in a prescribed manner.

Mrs. W's daughter cared for all her personal needs during this time. We served her from November 1 to January 16. She had 28 physical therapy visits at a cost of $616. She was independent on dismissal from our service.

On March 9, 1979, 3 months after we had dismissed this patient, medicare retroactively denied payment as of November 15. The VNA, or Mrs. W, was responsible for $420 of that bill.

Mrs. W lives on social security alone. She wished, however, to pay $1 a visit, which the VNA felt she could not afford. The VNA absorbed the rest of the bill.

As medicare covers less and less of the needs of the patient, agencies such as the VNA are experiencing greater gaps in charitable dollars available from sources such as the United Fund, private foundations, et cetera. The need far exceed the source for charitable services.

We are fearful that many agencies may turn to serving the patient only as long as medicare covers, which we know will result in the seesawing of patients from hospital to home, to hospital to home, and finally, the only alternative skilled nursing home care.

Senator TALMADGE. I hate to call time on you but we have another witness to be heard.

Senator Nelson had hoped to be present to greet you personally. He is an able member of this subcommittee. Unfortunately, he has another commitment.

I have only one or two questions.

We have heard an allegation that the franchiser of home health agencies offered to commit $1 million to your organization to promote home health care, that the National League of Nurses would

support and admit the membership of proprietary home health agencies.

Do you know whether or not that is true?

Ms. MAYER. I am not familiar with that at all. I am certain I could talk to somebody and find out about it.

Senator TALMADGE. Mrs. Brock, could you respond to that?

Mrs. BROCK. I think that allegation is a little bit untrue. We had heard that ourselves. That was never committed to us. We certainly did not participate in anything of that nature.

Senator TALMADGE. Thank you very much.

Ms. Mayer, under the current law, occupational therapy is paid for in a home care setting when provided in conjunction with the need for skilled nursing, physical therapy or speech pathology services.

What kinds of patients would benefit from the addition of occupational therapy as a free-standing reimbursable service that would be different from the services already available?

Ms. MAYER. I do not think there are any. Frankly, I think OT is an adjunct therapy to other therapies, and I support payment for OT, but not as a primary service.

Senator TALMADGE. Do you believe a change in current law is needed with respect to occupational therapy?

Ms. MAYER. No. I think they presently get a fee for service, and I think that is appropriate.

Senator TALMADGE. Thank you.

Any questions, Senator Packwood?

Senator PACKWOOD. No questions.

Senator TALMADGE. Thank you, Mrs. Mayer, for a very constructive statement.

[The prepared statement of Ms. Mayer follows:]

nln chha/chs
council of home health agencies and community health services

Statement of the
Council of Home Health Agencies and Community Health Services
National League for Nursing

MEDICARE AND MEDICAID HOME HEALTH BENEFITS

Introduction

Mr. Chairman and members of the Committee, I am Mary Jane Mayer, Chief Executive Officer of the Visiting Nurse Association, Milwaukee, Wisconsin. The VNA is a Medicare-certified and National League for Nursing/American Public Health Association - accredited home health agency which last year provided nearly 163,000 home visits to 7,500 people. Our 1979 operating budget is $5.1 million.

I appear before you today representing the Council of Home Health Agencies and Community Health Services (CHHA/CHS) of which my agency is an active member. The Council is a coalition of providers which deliver Medicare and Medicaid reimbursable home health services as well as preventive, supportive and health education programs.

We are pleased to have the opportunity to express our views and we commend the sub-committee for holding these hearings. We wholeheartedly agree with Senator Talmadge that it is time for an evaluation of "... the advantages and shortcomings of the existing home health programs ...."

We have long been concerned that policy decisions are being made in the absence of hard, timely data. Because of this, CHHA/CHS has assumed the leadership and is developing a data bank of home health information.

The data bank will allow the accumulation of statistics on home health services, patient characteristics and costs. Although some individual agencies are keeping this information there has not been a mechanism for collecting, aggregating and analyzing the data on a national basis. Through the use of discharge summaries completed by the agency for each patient discharged from service, we will have the ability to evaluate the total service and the cost for each patient.

We have attached as Exhibit A an analysis of the data collected during 1978 from nineteen agencies. We think this clearly demonstrates the potential use of such information for program planning.

> We recommend that this committee include in the Medicare bill under consideration authorization for demonstration projects on prospective reimbursement for home health agencies using the CHHA/CHS discharge summary as the data base.

Please note that these data are not limited to Medicare and Medicaid but cover all patients receiving care-of-sick services regardless of payment source. In addition, Medicare and/or Medicaid only information is easily extractable from the data.

Another major concern of ours is the Administration's apparent lack of commitment to communicate with its constituents. This was most recently evidenced at our Council's national meeting held in Atlanta, Georgia three weeks ago. Despite a six month lead time for the Health Care Financing Administration to schedule someone to attend this meeting, no one from central office was made available. We deplore the apathy toward home care and have expressed this to the Administration.

This apathy is reflected also in the report, "Home Health Services Under Titles XVIII, XIX and XX," which was recently transmitted to Congress. As this Committee well knows, the report was to include"...recommendations for changes in regulations and legislation..." The final report, however, states, "The Department makes no legislative recommendations in this report primarily because of budget constraints. In addition serious questions, which are raised in this report, must be resolved before final recommendations can be made..."

The report continues by posing two questions and asserting that a major research effort in the in-home services will be undertaken by the Department in FY 1980 in order to analyze these and other questions. The two questions posed were:

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

We contend the answers to these and other questions do not necessitate another major research effort; Congress requested answers to these questions when it mandated the report by enacting P.L. 95-142.

Medicare Eligibility Issues

At the outset we wish to applaud the Committee for its support of those measures which will improve the Medicare home health benefit. These include:

- elimination of the 100 - visit limitation under Parts A and B;
- removal of the 3-day prior hospitalization requirement for Part A services.

There are four other improvements we think are vitally needed to make the home health benefit a viable, meaningful part of the Medicare program. We urge your support of them.

Homebound

The regulation concerning the homebound requirement is actually reasonably stated: "...the condition of these patients should be that there exists a normal inability to leave home and consequently leaving their homes would require a considerable and taxing effort."

Yet, case examples prove that the program administrators--the regional office and fiscal intermediary staff--do not follow this regulation. Consider the case of the patient who, while under a home health plan of treatment, left his home for a few hours to attend his son's funeral. Reimbursement denied, patient no longer homebound. Or the case of the patient whose record indicated she had fallen while crossing the street. Reimbursement denied, patient not homebound.

We are not asking for a change in the legislation, nor even a change in the regulation; only that the reimbursement mechanism adhere to the regulation.

Nutrition Services

We support the addition of nutrition services, when provided by a registered dietitian as a reimbursable home health benefit.

A recent study conducted by the National Institutes of Health states that "one of the key causes of mental aberrations in the elderly is malnutrition." Another study compiled by the Select Committee on Aging in 1977 states that 34.2% of the population over the age of 65 years suffer from diabetes (an endocrine disease requiring nutritional intervention) while 51.8% suffer from heart conditions and another 12.3% from hypertension. This is the Medicare population and we submit that it is this group in which reimbursable nutrition services under the Medicare program can be most cost-effective.

Finally we endorse the recommendations made by the "National Institute of Mental Health" in 1978 - which support the development of appropriate services which would avoid unwarranted institutionalization. We believe nutrition services are vital in meeting this goal.

Skilled Nursing

The issue of skilled nursing is probably the single most controversial one and the one that has polarized the program administrators and home health agency administrators. Skilled nursing has been used as the gatekeepers to a Medicare program originally intended by Congress as an "acute care" insurance program. We hope Congress in it's wisdom would see that any National Health Insurance program enacted would not make that same mistake.

Unfortunately, misuse of the definition of "skilled nursing" has led to hospitalization of many people who might have been kept at home.

The following cases will illustrate some of the insanities which both providers and beneficiaries face in application of the "skilled" definition.

1) Patient denied services because skilled nursing not required to "clean a wound and apply sterile dressings" as this can be done by a non-medical person. Home Health aide services denied also because skilled nursing not required. The patient had a fractured right wrist, laceration of the left arm requiring assistance in the home with a written physicians plan of treatment.

2) A stroke patient was denied coverage when, under a physician's plan of care, the patient was visited by the nurse and his vital signs were normal on the first visit. Two visits were made and the intermediary decided to disallow 2 visits made because of the first visit findings.

3) A polio victim in younger years with multiple deformities suffered a fractured femur. She had a history of hypertension and a consistent pattern of elevated diastolic pressure, dyspnea on exertion, blurring of vision and chest pain requiring monitoring and reporting to the doctor. She also required the assistance of a home health aide. The intermediary denied coverage as it was felt no skilled nursing was required.

The National League for Nursing in its chart of "Current Statements of Competencies and Abilities" delineates competencies and abilities of the nurse according to educational preparation through the nursing process of assessing, planning, implementing and evaluating the professional skills made evident. Skill includes more than "laying on of hands." It includes taking care and planning for the total patient and family and mobilizing the necessary resources to promote, maintain or restore health and well-being. With the expanded role of the nurse including physical assessment and the use of nurse practitioners, the skilled definition should be modified to encompass the changing preparation of professional practice and the needs of patients.

We therefore recommend that the skilled nursing definition be broadened to include the evaluation and assessment functions performed by skilled professional nurses.

These functions may be understood by the following definitions.

Assessment is the act of reviewing a situation for the purpose of diagnosing the patient's problems. The nurse can judge which actions are necessary to assist the patient with his problems, she uses her skills of physical assessment, perception, observation and communication. The patient's needs are viewed in light of physical, emotional, social and environmental factors.

Evaluation is the process of appraising the patient in light of past, present or potential conditions to determine their status and the course of remedial action if necessary.

Terminally Ill

Hospice care of the dying patient can be defined as care of the terminally ill within the last six to nine months of life. It is anticipated that within this time frame that approximately six weeks will be spent within an institutional setting. The

remainder of the time skilled nursing services within the home may be required and intensified as the time of death approaches. Skilled nursing care to provide planning for pain management and physical care, as well as consultation and coordination of other needed services such as home health aides, pastoral services, social services and volunteer groups, is essential while the patient is at home.

These very humane and necessary services have been denied in some instances under the guise that the patient has no rehabilitative potential-"skilled nursing" not required. Another denial was issued for a terminally ill patient because the care was "too skilled" for the home health agency level of care and it was determined that the patient belonged in the hospital. In this situation the family, physician, patient and nurse had determined home care was appropriate. Other denials have been issued for the terminally ill stating "no coverage for custodial care."

Terminally ill patients require a special kind of skilled nursing care not addressed under the present Medicare definitions. We do not need another layer of health care providers that will be reimbursed under seperate coverage. We need to redefine "skilled nursing" in light of the hospice concept and the expressed desire of patients and families to remain at home as long as possible and to die in peace and dignity.

Reimbursement Issues

"Caps"

The 1972 Social Security Amendments (P.L.92-603) authorizes the Secretary of HEW to set prospective limits on allowable costs for Medicare providers. On March 7, 1979, HEW published its proposed initial schedule of limits on home health agency costs per visit. These limits were scheduled to be effective for cost reporting periods beginning on or after June 1, 1979. In promulgating the proposed regulation, HEW stated that they would carefully consider any written comments received by May 7, 1979.

How much careful consideration can be given in such a short time frame? There have been many comments submitted which, if taken into account, may mean a reconsideration of some of the issues as well as a recalculation of the limits themselves.

We believe that the implementation of "caps" in the home health industry is premature; that the data used to compute these is incomplete and not correlatedwith the macro-economic situation of health care in this nation. We further believe that the failure of the caps to regulate home health costs will be evidenced by increased costs to negotiate fiscal intermediary and provider appeals and exceptions.

> We would therefore recommend that cost containment measures be implemented through the demonstration of negotiated prospective reimbursement rates. A policy which is consonant with the Congressional mandate for balancing the budget through both government and citizen participation.

Uniform Reporting

Concurrent with the issuance of cost limits is the advent of the Uniform System for Home Health Agency Reporting (USHHAR) which was mandated by the 1978 Social Security Amendments (P.L.95-142). We are told that the USHHAR proposal will be published in the May 30 Federal Register with a 60 day comment period and that it will be effective January 1, 1980. We are very concerned that a proposal as broad as USHHAR is being

given such a short lead time. We believe also that USHHAR will dramatically change the management information systems in the agencies with the adverse effect of increasing operating costs thereby escalating the cost per visit.

We recommend, therefore, that:

> Implementation of cost limits and of USHHAR be coordinated and that adequate time (one fiscal year) be allotted for testing USHHAR in agencies and for agencies to gear up for changes in operation.

Management Issues

Minimal standards of accountability for home health agencies are established in the Conditions of Participation. Upgrading the conditions with uniform application and compliance by all home health agencies is recommended. The following suggestions for improvement are:

- ... the agency administrator shall be an individual with training and one year of experience or an individual with one year supervisory or administrative experience in home health care and must be a full-time employee of the agency;
- ... all agencies must determine the range of other services available in the community and must endeavor to provide or arrange for such services for patients as needed;
- ... all ownership interests must be disclosed. At least one-third of the governing body must be outside members having no financial, family or operational relationships with the agency. No member may vote on matters in which that member has a direct financial interest;
- ... governing body has responsibility for professional review conducted persuant to Section 405.1222;
- ... all personnel must be paid the minimum hourly wage;
- ... the locus of responsibility for coordination of services between two agencies must be clearly defined; the home health agency maintains overall responsibility of patient care and is accountable for same;
- ... home health aides should have satisfactorily completed a basic generic curriculum which is recognized by HEW;
- ... an annual report of agency's activities including the names of the governing body shall be published and made available upon request;
- ... a system of supervision and continuing education must be in place;

... a system of long range planning which includes client evaluation should be ongoing.

Quality Control

A higher quality of evaluation for home health agencies is available through the NLN/APHA Accreditation program. A voluntary process, the accreditation program, operates from a base of predetermined nationally accepted standards in the home health industry. This voluntary accreditation process involves preparation of a self study report which requires an indepth look at all systems-clinical, financial and managerial and a report is written. The agency is site visited by 2-3 visitors and a board of review made up of peers determines to what degree the agency meets these professionally determined standards.

The NLN/APHA accreditation process assesses agencies at a higher level than the Medicare Certification process and provides incentives for agency growth. This consideration is a factor for action by HEW to grant NLN/APHA "deemed status" thereby accepting accreditation in lieu of Medicare recertification. This acceptance eliminates duplication and provides the industry with incentives to meet high quality standards versus minimal requirements. The granting of "deemed status" to the NLN/APHA accreditation program will increase accountability and recognition of home health agencies and make applicable high professional standards for home health operations and services that have been set, refined and upgraded over the years.

Regional Intermediaries

We support the concept of regional intermediaries and would urge that the Administration be authorized to enter into 5 year contracts with the regional intermediaries with an annual performance evaluation. Performance criteria must be established and used in the annual evaluation and some penalities imposed for not meeting the criteria.

Among the criteria must be a requirement for intermediaries to have a public health nurse with recent experience in home health on its utilization and claims review staff. The major problems identified by home health agency staff is that the claims reviewers are not prepared in nor familiar with community health practice and therefore are not in a position to judge the adequacy or efficacy of care rendered.

Finally, we believe HEW has a responsibility to provide continuing education to intermediaries in order to achieve consistency and uniformity and the industry must have input into this continuing education.

Medicaid Issues

We recognize that Medicaid is a state program and as such has some inherent states' rights, but we think one's place of residence should not be the basis for the type and amount of health care received.

Two conditions serve as de facto barriers to home health services for the Medicaid recipient. One is the limits some states place on eligibility and on the range and frequency of services. These limits include placing such requirements as homebound, skilled nursing, or maximums on number of visits, even though the law itself is not as restrictive. Moreover, these requirements are superimposed on often restrictive target populations making place of residence a determinent in the health services on individual is entitled to receive.

A second barrier to home health services for Medicaid recipients is the method some states have adopted for reimbursing home health services. The table attached to this testimony as Exhibit B pointedly demonstrates this problem: nearly one-third of the states reimburse home health agencies on less than a cost-related basis. About 95 percent of these agencies are public or private nonprofit agencies which do not have a profit margin. Any service provided to Medicaid recipients, therefore, is provided at a loss to the agency which in turn means no or reduced service to other people. We believe the data shown in the last column of the table (proportion of home health payments to total Medicaid payments) is a result of these low payments as well as of the service limits that states establish.

We urge the Committee to take remedial action to prevent the home health services portion of Medicaid from becoming a program in name only. To this end,

> We recommend Title XIX be amended to define the home health service components and to mandate cost-related prospective reimbursement for such services provided to Medicaid recipients.

Summary

CHHA/CHS believes that the future health care of people is threatened by the vast bureaucratic web being spun by HEW. By the year 2000, it is expected that nearly 17 percent of our population will be 65 years of age or older. Unless Congress plans intelligently, there will be no in home support system for that population.

We are firmly committed to the expansion of quality, cost-effective home health services and are convinced that this cannot be accomplished in the current governmental climate. We return to the subject of our introduction -- the H.R. 3 Report -- and submit as Exhibit C a copy of testimony we presented to the Administration last September. Although the mandate from Congress was to have input from the field, we think there was in fact none.

We appreciate the opportunity to present our views and will be pleased to respond to any questions you may have.

nln chha/chs
council of home health agencies and community health services

Exhibit A

USE OF PATIENT STATISTICS FOR PROGRAM PLANNING

Introduction

In the past, we have looked at cost in terms of cost per visit but have had no basis for knowing cost per patient or of evaluating the benefit of home care in terms of improvement in the condition of the patient. In the summer of 1973, the Council of Home Health Agencies and Community Health Services of the National League for Nursing convened an informal conference of directors of home and community health agencies to discuss mutual problems and to explore future directions in administration and programming. The participants came from cities all across the U.S.: Baltimore, Boston, Chicago, Dallas, Detroit, Los Angeles, New Haven, New York, Omaha, Philadelphia.

As leaders in the delivery of community health services, these directors wished to have input into the enactment of any national health insurance program. They felt they could make a contribution through their deliberations on appropriate patterns of service and mechanisms for costing. Among the concerns listed by these administrators was the need for utilization and cost information for patient, diagnosis and length of service, not presently available from ongoing statistical reporting. They felt such information would be especially useful in planning health care coverage and negotiating with third party payers. A subcommittee was set up to explore ways of analyzing the care of sick services provided to people in their homes, and met in November 1973 with CHHA/CHS statistical staff to plan the most effective way to accomplish this purpose. It was decided that a home health agency discharge summary form would be developed and used in a feasibility study to determine the kinds of information that could be obtained through this medium. A simple tool was designed for use by clerks in recording discharge information. Each agency in the conference group decided to participate in the feasibility study by supplying at least 100 care of sick statistical discharge summaries during one month in the spring of 1974.

This feasibility study, "Type, Length and Cost for Home Health Patients," showed conclusively that the discharge summary can produce valuable information to present a more meaningful picture of services provided and needed. It showed that it was possible to determine cost per patient or per day once the cost per visit was known. CHHA/CHS therefore recommended the inclusion of the discharge summary as an essential part of the statistical reporting system of the home and community health agency. A new form was designed to include source of payment and outcomes and tabulation of the data is now being offered on a fee for service basis. Nineteen agencies participated in the study in 1978 and have received half-year printouts of their own experience compared with that of all of the other agencies. Our goal is to provide quarterly printouts eventually. Tape-

to-tape input from agencies with their own computers is being explored and it is hoped that invaluable data will be available for real cost comparison and health planning.

During the past two weeks we have mailed to the nineteen agencies the following information for each agency compared with the composite of all agencies in the study:

- Patient Characteristics - Sex, ethnicity, source of physician care, source of referral, living arrangement, reason for discharge, disposition on discharge, fee source, summary of change in patient's condition, and percentage of cases in which expected outcome is met.
- Number and percent of cases and visits, professional visits by discipline, home health aide visits, length of stay, age, and cost per case and per day for each of the 17 major diagnoses identified in the ICDA.
- Case, visit, length of stay, and cost data by age group classifications.
- Case, visit, length of stay, age, and cost data by condition of patient on admission.
- Cases, visits, length of stay, age, cost per case and day according to number of services offered - nursing only, PT only, nursing plus one, nursing plus two, etc.

During the last two weeks we have been in the process of analyzing the data from the 11,182 discharge summaries received from 19 agencies during the calendar year 1978. The number of cases per agency ranged from 187 for one agency to 1,525 cases for the largest agency. These agencies are located in Illinois, Indiana, Iowa, Kentucky, Massachusetts, Minnesota, New Hampshire, Nevada, New York, Pennsylvania and Wisconsin.

In discussing the data in the rest of the report, I want to point out that the wide range of results among the agencies reflects differences in policy in regard to intake and patterns of utilization of personnel - e.g., whether a nursing assessment is made in every case, how home health aides are used, etc.

Patient Characteristics

Age - Among the 11,182 cases, age varied from under 1 year to over 100 years with an average age of 69 and a median age of 73; the median age ranged from 67 years in one agency to 77. In general, the concentration of the middle 50 percent fell between 63 and 81 years. Only one agency had a somewhat lower concentration - between 43 and 76. Unquestionably, since these were summaries of care of sick services, the service was predominately among the elderly.

Sex - In general, there were almost twice as many female patients as male patients, with the variation in this percentage ranging from 58 percent to 71 percent for female patients among the 19 agencies.

Living Arrangements - Of the patients for whom living arrangements were reported, 29 percent lived alone. The figure ranged from 11 to 39 percent among the 19 agencies.

Primary diagnosis - The largest proportion of cases for each of the agencies reported a primary diagnosis of diseases of the circulatory system with neoplasms and musculoskeletal next in concentration. On an overall basis, 27 percent of the cases fell in the circulatory system. This figure ranged from 20 percent to 39 percent. Circulatory diseases accounted for the largest proportion of cases for each fee source with the exception of private insurance where 23 percent of the cases were neoplasms and 15.5 percent circulatory.

Reason for discharge - A review of the reason for discharge revealed that 47 percent of the cases were discharged because they were recovered or stabilized and 33 percent were discharged because they were admitted to a hospital or a nursing home. Of the remaining patients, 3 percent moved out of the district, and 7 percent died.

Source of Referral and Medical Care

An overwhelming number (94 percent) had physician care from a family physician; the other 6 percent listed the clinic as their source of M.D. care. The percentage reporting the family physician ranged from 86 percent in one agency to 100 percent in another.

Source of Referral - 18 percent of the cases were referred by private physicians and 44 percent by inpatient hospitals. 14 percent were referred by self or family, 3 percent by outpatient hospitals, 13 percent by hospital home care and the rest by health departments and other sources. There was variation among the agencies but almost all of them recorded most of their referrals from inpatient hospitals.

Number of visits per case

Although the arithmetic average number of visits per case was calculated, the median - or midpoint - is more meaningful because it is not affected by the extremes - such as the number of one day cases (1325 or 12 percent, ranging from 0 to 22 percent among the agencies) and the number of cases over 365 days (562 or 5 percent overall, ranging from 1 percent to 17 percent in one agency). The median number of visits per case for all diagnoses was 6 nursing visits per nursing case (range of 4 in two agencies to a high of 10 in one agency, with four having a median of 5 and eight having a median of 6, three a median of 7, and one a median of 8 visits per case.) Among the 2,222 PT cases (20 percent) the median number of visits per case was 5, for OT it was 4, SP - 5, MSW 2, and HHA 15.

Length of Stay in Days

Number of days between first visit and last visit varied from one day to 5,805 days, with the average stay 94 days and the median 34 days (varying from 21 to 65 days among the agencies). The middle 50 percent for all the cases combined fell between 9 and 92 days.

Cost per Patient and per Day

There was a wide range of cost per patient, from the one visit cost for a one-day case to a high of $44,000 for all services provided. The arithmetic mean was $482 but the median cost per patient was $171, with the middle 50 percent concentration between $64 and $472. There was a greater clustering in the median total cost per patient among the agencies where the range was between $111 to $261 in 18 agencies (one did not provide cost data). Examining median cost per patients by fee source, the lowest figure of $83 was in the full pay fee source category and the highest ($299) for Medicaid patients where the long-term maintenance care would usually fall. Cost per day varied with the amount of services provided. The median cost per day was $6.90 with a middle 50 percent concentration between $4 and $16. The median cost per day ranged between $4.07 and $10.23 among the 18 agencies providing this information. Median cost per day varied inversely with the length of stay - from a median cost of $20.96 per day for the one-day stay to a low of $2.46 per day for cases with stays longer than 730 days. Also median cost per day varied with the fee source - from a $14.88 cost per day for patients paying full fee to a cost of $3.75 for "other welfare" patients. For private insurance, the median cost per day was $9.09, while for Medicare A, B and Medicaid, it ran $7.36, $7.70, and $5.69 respectively. As one would expect, shorter, more intensive periods on home care cost more per day.

Variety of Services Offered

Of the 11,182 cases in the 19 agencies, 6,969 (62.3 percent) received nursing services only and 268 cases (2.4 percent) physical therapy without nursing. An additional 2,959 (26.5 percent) received nursing plus one other service which could include PT. 6.7 percent received nursing plus two other services, 1.6 percent nursing plus three and only 0.3 percent nursing plus four. The percentage of cases receiving nursing services only varied from 40.1 percent to 78.4 among the agencies. Nursing only and nursing plus one service accounted for the major portion of cases - 88.9 percent overall and a range of 73.9 percent to 99.6 percent among the agencies.

As expected, the average cost per day was higher where a greater variety of services were offered - an average of $15.40 per day for the nursing plus four other services as opposed to an average of $9.61 for nursing only.

Sources of Funding

As a single source of funding 6 percent reported "self", 9 percent insurance, 47 percent Medicare A, 14 percent Medicare B, 13 percent Medicaid, 1 percent other welfare, 4 percent no fee as agency policy, 1 percent U.F. and 5 percent "other". But any one case could have involved more than one source of funding; Medicare A was involved in 49 percent of the cases, Medicare B in 18 percent, and Medicaid in 16 percent - a total of 83 percent for Medicare and Medicaid. Medicare A and B figures varied from 45 percent to 88 percent among the agencies. Median cost per patient and per day varied for the different sources of funding, reflecting the availability of service when reimbursement was available. In general, also as expected, the median age group for insurance and other welfare was lower (between 50 and 59) than for the other sources where the age group tended to be in the 65 - 74 and 75 - 84 group.

Exhibit 8

COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES
National League for Nursing

SELECTED DATA ON MEDICAID HOME HEALTH SERVICES, JULY 1978

State*	Medicare-certified agencies as of July, 1978							Method of Medicaid Reimbursement	HH as a % of Total Medicaid Payments
	Total	VNA	Off.	Priv.	Prop.	Hosp.	Other		
Total	2,583	494	1,241	330	125	288	105		
Alabama	81	2	61	12	-	2	4	Sched. max. allow.	.4 %
Alaska	1	-	1	-	-	-	-	Fee schedule	.1
Arkansas	80	1	74	1	-	3	1	Cost-based	.05
California	111	27	13	14	36	17	4	Sched. max. allow.	.1
Colorado	32	4	22	3	-	1	2	Lower of cost/charge	.2
Connecticut	84	61	17	1	-	2	3	Cost based;prop.-neg.	-
Delaware	6	1	3	1	-	1	-	Lower of cost/charge	.38
Dist. of Col.	5	1	1	3	-	-	-	Neg. rate	1.24
Florida	122	11	16	64	23	4	4	Sched. max. allow.	.1
Georgia	23	1	5	8	-	4	5	Lower of cost/charge	.12
Hawaii	6	-	1	-	1	3	1	Medicare upper limit	.3
Idaho	11	-	4	-	2	4	1	Usual & customary	.26
Illinois	110	23	35	30	1	14	7	Usual & customary	.21
Indiana	44	15	9	6	10	3	1	Cost based	.35
Iowa	84	12	67	-	-	3	2	Lower of cost/charge	.02
Kansas	42	2	30	3	-	5	2	Sched. max. allow.	.05
Kentucky	55	1	27	1	3	18	5	Usual & customary	.94
Louisiana	81	-	43	6	28	2	2	Lower of cost/charge	.14
Maine	19	5	2	8	-	2	2	Lower of cost/charge	.75
Maryland	26	1	16	4	-	4	1	Sched. max. allow.	.19
Massachusetts	150	92	34	5	-	16	3	Lower of cost/charge**	1.1
Michigan	55	11	31	8	-	3	2	Lower of cost/charge	.12
Minnesota	70	-	62	2	-	4	2	Lower of cost/charge	.37
Mississippi	112	-	82	18	1	8	3	Lower of cost/charge	.15
Missouri	42	4	16	7	-	9	6	Lower of cost/charge	.08
Montana	15	-	6	3	-	5	1	Contract	.37
Nebraska	17	1	1	-	-	14	1	Lower of cost/charge	.15
Nevada	6	-	2	1	2	-	1	Lower of cost/charge	.47
New Hamp.	43	39	2	1	-	-	1	Lower of cost/charge	1.0
New Jersey	44	19	15	1	-	8	1	Lower of cost/charge	.3
New Mexico	12	3	1	1	5	1	1	Lower of cost/charge	.2
New York	117	15	53	2	-	43	4	Lower of cost/charge	3.2
No. Carolina	72	2	48	8	4	7	3	Lower of cost/charge	.3
No. Dakota	9	-	6	-	-	3	-	Lower of cost/charge	.1
Ohio	106	20	61	4	-	15	6	Usual & customary to $2	.2
Oklahoma	60	1	52	3	-	2	2	Nursing - $5.	-
Oregon	24	1	14	2	-	6	1	Neg. rate	.1
Pennsylvania	112	57	10	10	-	28	7	Fee schedule	.3
Rhode Island	14	9	-	1	-	3	1	Fee schedule	.2
So. Carolina	23	-	19	3	-	-	1	Lower of cost/charge	.6
So. Dakota	31	1	27	-	-	3	-	Cost based; billed chgs.	..
Tennessee	131	2	100	17	8	1	3	Lower of cost/charge	.2
Texas	81	9	10	55	-	4	3	Lower of cost/charge	-
Utah	9	1	6	-	-	2	-	Contract	.2
Vermont	19	14	3	1	-	-	1	Usual & customary	1.1
Virginia	46	4	42	-	-	-	-	Lower of cost/charge	.4
Washington	26	4	10	7	-	5	-	Sched. max. allow.	.6
West Va.	21	4	11	5	-	1	-	Lower of cost/charge	.1
Wisconsin	79	13	57	-	1	4	4	Usual & customary	.2
Wyoming	14	-	13	-	-	1	-	Lower of cost/charge	-

* Arizona does not have a Medicaid program.
** With growth restrictions.
SOURCE: Unpublished data from Medicaid Bureau, HCFA, DHEW, January 1979.

LB:rc

Change in Patient Condition

Of the 10,137 cases reporting expected and actual condition on discharge, 74 percent reported expected outcome as having been met and 3 additional percent showed improvement in expected status on discharge. Percentage of cases in which expected outcome was met or exceeded ranged from 64 percent to 96 percent.

For all cases reporting this information on admission 27 percent were dependent, 46 percent needed assistance, 23 percent needed supervision, and only 5 percent were independent. On discharge 37 percent were independent. Average length of stay was longest for the dependent group and decreased proportionately as independency increased (102, 100, 89, 69 average days per case.) Total cost also decreased in the same proportion. Although this measure of outcome is rather simplistic, it is at least a beginning atlooking at what happens to a patient as a result of home health agency intervention. As more sophisticated measures of outcomes are developed by the health professions, they will be incorporated into the discharge summary data.

Conclusion

Although the 11,182 cases from 19 agencies cannot be considered a representative sample for the whole country, there is valuable evidence of overall trends in the variables of home health care and possibilities of use of the data to project needs for expansion of program. Whether the cost per day is a median figure of $6.90 or an average of $10.22 there is no question that home care can be less costly and more satisfactory for most patients when their needed services can be provided. Even with this limited sample it is encouraging to note the similarities in the resulting data among the agencies in the sample as well as with the results of the feasibility study and a special study of Vermont agencies. As the data bank is enlarged by the enrollment of a greater number of agencies and by tape-to-tape input from the larger computerized agency systems, the sample will be more representative of practice throughout the country and the data will be able to be used for program and community planning not only by the individual agencies but by HSAs and governmental groups on a national and local basis.

Presented By...Goldie Levenson
Statistician/Consultant
DHHA/CHS-NLN

Text of speech delivered at NLN Biennial Convention, May 3, 1979, Atlanta, Georgia
Publication in process.

Exhibit C

Statement of the
Council of Home Health Agencies and
Community Health Services
National League for Nursing
before DHEW's
Office of Policy, Planning and Research
Health Care Financing Administration
September 15, 1978

P.L. 95-142 Section 18
Report on Home Health and
Other "In Home" Services

My name is Joan E. Caserta. I am the Director of the Council of Home Health Agencies and Community Health Services (CHHA/CHS) of the National League for Nursing.

CHHA/CHS is a coalition of provider agencies certified to deliver "Home Health and In Home" services under the Medicare, Medicaid, Title XX and Older Americans Acts. With me today is Margaret Kauffman, Chairman of the CHHA/CHS Executive Committee, who is the former Director of the Community Nursing Service of Philadelphia, Pennsylvania, an APHA/NLN accredited and Medicare certified provider of home health services as well as preventive and health education programs.

We commend the staff of HCFA for holding this final public hearing on home health before it presents its report to the Congress in October, and wish to comment on specific portions of that report.

Scope and Definitions of Services

Home health care has developed primarily within the context of care for individuals with acute, self-limiting and/or debilitating terminal conditions. The legislative authority for "Home Health and In Home Care" rests in Titles XVIII, XIX, XX of the Social Security Act as well as Titles III and VII of the Older Americans Act. Health services covered under Title XVIII are largely confined to acute self-limiting conditions while coverage for social and health related services is largely found under Titles XX, III and IV as indicated above. These entitlement differences have led to fragmentation of services delivered to people and increased costs stemming from conflicting data collection, statistical reporting, cost formula and eligibility requirements.

CHHA/CHS believes in a more wholistic approach to the care of individuals and families at home. For this reason we have adopted the concept expressed in the term Home Care. Home Care as we define it, means a blend of health and social services provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health, or, of minimizing the effects of illness and disability. (1)

(1) A Prospectus For A National Home Care Policy, prepared by the Assembly of Ambulatory and Home Care Services, AHA; Council of Home Health Agencies and Community Health Services, NLN; National Association of Home Health Agencies; National Council of Homemaker-Home Health Aide Services, Inc. Published 1978.

Professional experience and consumer satisfaction surveys have yielded the understanding that a basic service benefit of about 14 services are needed to restore and maintain people at home. These are:

Home Health Aide
Nursing
Physical Therapy
Nutrition
Occupational Therapy
Speech Pathology
Laboratory Services
Medical Equipment and Supplies

As Well As

Transportation
Meals on Wheels
Homemaker
Social Work Services
Chore

We, therefore, support an expanded home care benefit which would reimburse for one or more of the aforementioned services in such combinations as determined by the individual patient needs. We further support the development of home care agencies which provide those services either directly or with other certified providers.

Eligibility and Coverage

It is estimated that approximately 1.5 percent of the total population of the U.S. on any given day needs home care services, according to a formula developed by CHHA/CHS statistical staff and based upon analyses of data collected during the Health Interview Survey conducted by the National Center for Health Statistics.

Current studies indicate that only two of a potential five percent of discharged patients are referred for home care services while about 25 percent of persons currently residing in intermediate care facilities may be inappropriately placed. This is largely due to the focus of reimbursement mechanism, both public and private, upon coverage for illness care.

CHHS/CHS believes that a basic home care package should be available to all clients who experience acute illness as well as to those where illness may lead to chronic disability and/or death. Costs should be supported by appropriate 1st, 2nd and 3rd party arrangements, a combination of out-of-pocket, private and public dollars.

Methods of Administrative and Delivery of Home Care Services

As you know, the provision of services to people at home is one of the oldest modalities of medical care. As scientific technology and information grew, the individual practitioner was forced to collaborate with and rely upon many kinds of care givers as well as complex diagnostic equipment. Thus, the focus of activity changed from the individual's home to a congregate institutional setting.

In the late 19th Century, disease patterns showed a high percentage of acute illness to a concommitant low percentage of chronic, debilitating illness. The 20th Century saw a reverse of this situation, so that today with a population growing older and the incidence of chronic illness on the increase - congregate settings with dramatic techological approaches to care become less and less appropriate and effective.

CHHA/CHS believes that the future of health care will be in the community setting - that is - at home, in family health and adult day care centers as well as home based hospice programs. In particular, care of the terminally ill will take place at home with episodic pain control and thanatological techniques applied intermittently through congregate "in-patient" settings.

To assure this kind of continuous care in the community setting and remain cost effective a wholistic approach to provider management will have to be adopted. To this end, we recommend reimbursement incentives which will promote the use of shared management, purchasing, data processing and cost determination services.

Adoption of this concept will permit provider agencies to retain policy making authority for their service innovations, while at the same time minimizing the costs of administrative support services.

Quality Assurance: Standards

CHHA/CHS has already addressed the issue of upgrading the current Federal standards for the home health agency provider certified under Title XVIII. Earlier this Spring at a meeting of HCFA staff, in conjunction with four other national organizations concerned with home care, we uniformly agreed upon areas for upgrading these standards. Our group recommendations are on file in the Office of the Administrator.

Today, we wish to address our concerns about the process of implementing and monitoring these "standards" in the provider agency.

In the process of certification, each year a government official on the State level visits the provider agency, collects data about the agency as required in the "conditions of participation" reviews clinical records and speaks with key staff members about the program evaluation practices. A decision is made by that reviewer about compliance with the conditions - discussed with the agency and a corrective plan is suggested.

Contrast this to a voluntary accrediation process, in which the agency engages in a self-study of all its systems - clinical, financial and managerial - develops a written report with examples of outcomes of these practices; is site visited and audited by a team of 2-3 visitors and is then reviewed by a board of their peers about whether and to what degree thay meet professionally determined standards. Frankly, this is the process uniformly carried out through the NLN/APHA accreditation program.

As you know, CHHA/CHS has introduced a proposal to the Secretary of HEW requesting that he recognize the standards of the accreditation program as equal to the "conditions for participation" and "deem" accredited agencies as eligible Medicare providers.

We are disappointed that the leadership within DHEW has not been able to come to grips with the "deeming" issue. We believe that this failure has little to do with the accrediation program or its standards. Rather, it has to do with the politics of the situation. Buffeting by differing views of special interests in the public and private sector has immobilized the deeming power authorized in the original Medicare legislation.

While we empathize with DHEW's situation, we are chagrined that our colleagues in government do not learn from one another! The Office of Education, Bureau of Higher and Continuing Education, Division of Eligibility and Agency Evaluation, has for some years, recognized voluntary accrediting agencies in the field of education. This recognition process, however, has been depoliticized through the application of "Criteria and Procedures for Recognition of Nationally Recognized Accrediting Agencies and Associations" most recently published in the Federal Register on August 20, 1978, under Title 45 - Public Welfare, Chapter 1 - Office of Education, DHEW.
"Recognition is granted.....only when the agency or association meets the criteria thus established."

CHHA/CHS believes the precedent be set for "deeming" by government and commends this reference to HCFA staff. CHHA/CHS also believes that no consistent application of Federal standards is possible through the current certification process!

Fraud and Abuse

Finally, and perhaps most importantly, CHHA/CHS endorses the establishment of screening devices in agency systems which will deter and/or detect fraud and abuse of program benefits.

As you know, the systems in home health agencies have been greatly behind in the application of sound fiscal and business practices. Agencies are hampered in capacity building in this area for several reasons:

1. A need for transition from a cottage industry to small business within a relatively short span of time.
2. Lack of adequate resources to employ expert financial and business systems, including marketing personnel.
3. Concommitant demand for increased and expanded kinds of services.
4. A dearth of reimbursement mechanisms available from 3rd party payors.
5. A concommitant explosion of reporting requirements by multiple governmental funding mechanisms.

CHHA/CHS is highly involved in promoting sound business practices in agencies. Through the programs of accrediation and agency management consultation we are helping agencies to establish and monitor:

- Manual and automated management information systems.
- Cost analysis and reporting techniques.
- Clinical and fiscal record systems.
- Consumer and community policy and advisory systems.
- Personnel and employee relations management systems.
- Cost control and productivity mechanisms.

We believe that all aspects of an agency operation can be held within reasonable cost. Intermediary letter 78-16 enumerates those aspects of operations which must be looked at.

We believe that applicative methodologies for those screening devices described in this letter must be developed by provider representatives together with government and fiscal intermediary personnel. It is only by a tripartite working together that fraud and abuse can be controlled and/or averted.

In summary then CHHA/CHS has stated the position in favor of:

1. Blending the health and social care benefits into a program of Federally funded services called a "Home Care" benefit.

2. Availability of the Home Care benefit to all people irrespective of age.

3. The development and support of funding techniques in both private and governmental sectors for that benefit.

4. A prospective reimbursement formula which supports capacity building.

5. Additional reimbursement incentives which promote sharing management functions and systems among agencies.

6. The development of internal mechanisms which allow government to "deem" eligible accrediting agencies or associations without recourse to the political process.

7. The continuation and enhancement of an industry/government/intermediary coalition to evolve and upgrade fiscal and clinical home care practices.

We appreciate the opportunity to share these positions with you and stand ready to clarify or respond to any questions you might have.

Thank you.

Senator TALMADGE. The next witness is Emily Layzer, staff associate for social policy and legislation, National Council for Homemaker and Home Health Aide Services, Inc.

Ms. Layzer, you may insert your full statement in the record and summarize it in the allotted time, please.

STATEMENT OF EMILY LAYZER, STAFF ASSOCIATE FOR SOCIAL POLICY AND LEGISLATION, NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

Ms. LAYZER. Thank you, Mr. Chairman.

My name is Emily Layzer, staff associate for social policy and legislation of the National Council for Homemaker-Home Health Services. Since we have filed our prepared testimony, I will summarize the key points.

Based upon data revealing the unmet demand for and cost-effectiveness of home care vis-a-vis institutional care in most cases, the National Council believes that rigid restrictions covering home health coverage under titles XVIII and XIX should be relaxed to meet the chronic care needs of our Nation's aged and indigent citizens.

Three of the bills currently under consideration by the Senate Committee on Finance—S. 489, S. 505, and S. 507—propose to eliminate the 3-day prior hospitalization requirement and the 100-day visit limitation.

On the House side, H.R. 3990 proposes similar changes.

The council endorses these recommendations as a necessary first step toward increasing accessibility of home care and deterring costly, unnecessary institutional care.

However, we also urge that the following three recommendations be incorporated into this legislation.

First, add homemaker-to the home health aide services currently authorized under medicare and medicaid, reducing much of the current fragmentation and costly duplication of effort that currently exists.

Second, loosen the homebound restriction to allow for full or partial confinement to the home, recognizing the needs of frail elderly or recuperating hospital patients to get out of the home sporadically for necessary errands or visitation.

Finally, substitute professional nursing for skilled nursing as a prerequisite for home care and allow those requiring such care or such supervision to be eligible for home health benefits.

Supervision by social workers or home economists should also be recognized as integral to the development of comprehensive care plans for the elderly.

The National Council had earnestly hoped that many of these recommendations would be forthcoming from HEW in the H.R. 3 report. However, because the Department seems to have abrogated its responsibility for suggesting appropriate modifications to the medicare home health benefits, we look to the Senate Committee on Finance to take leadership for this important home care legislation.

There are several additional features of the Domenici bill which the Council would like to address. First, the training requirement should be extended to all homemaker-home health aides and a blend of social and health skills should be required in all HEW-approved training programs.

We strongly urge that HEW endorse for this purpose a comprehensive training curriculum which has been developed by the National Council in cooperation with other national agencies under a grant from HEW's Public Health Service.

This curriculum should be officially recognized throughout the Department in all of its home care programs, including those administered under Social Security Act Titles XVIII, XIX and XX and under Older Americans Act Title III.

Second, the billing procedures spelled out in item 4 under Duties of the Secretary in the Domenici bill appear to be extremely detailed for Federal legislation and may be better handled in regulatory language. This requirement should allow for bimonthly or monthly billing of home health patients. Monthly billing procedures would save time and administrative costs.

The development of reasonable cost guidelines described in item 5 is an extremely complicated feature. The Council recommends that this be approached on a regional, rather than national, basis and that such guidelines be specified in regulations rather than in legislation.

Finally, we would urge that an agency's overhead costs be broken out and reviewed as a separate line item. They should be limited by cap, sufficient to allow for appropriate administrative

and supervisory costs, in order to minimize the incentives for fraud and abuse in our public entitlement programs.

The Council would now like to comment on two current proposals authorizing demonstration projects for training and employing AFDC recipients as homemaker—home health aides: S. 421 and Section 22 of S. 507. The Council believes that such projects would help to provide much-needed manpower for the home care field. However, we would caution that the labor implications of this legislation should not overshadow service objectives for the home care field.

It is critically important that service safeguards be firmly in place before such demonstration projects are authorized. In particular, AFDC recipients should be trained solely for employment by a homemaker—home health aide agency; the agency must maintain responsibility for selection of the homemaker—home health aide; and the formal training program referred to in this legislation should be one that has been endorsed throughout HEW, as recommended earlier in this testimony.

In closing, I would like to bring several additional points to your attention.

First, we urge enactment of further regulatory changes in the medicare conditions of participation.

Second, we urge that there be a Federal requirement for a certificate of need for home health agencies.

Finally, we do hope that you will review and endorse the prospectus for a National Home Care Policy which has been developed jointly by the forum of four organizations.

I thank you for this opportunity to present our views on the home health care benefits and I welcome any questions you might have.

Senator TALMADGE. Thank you very much. I had an opportunity to read a good portion of your statement while you were testifying. I congratulate you on what I consider a fine, detailed statement.

Ms. LAYZER. Thank you very much.

[The prepared statement of Ms. Layzer follows:]

STATEMENT OF EMILY LAYZER, STAFF ASSOCIATE FOR SOCIAL POLICY AND LEGISLATION OF THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

My name is Emily Layzer, staff associate for Social Policy and Legislation of the National Council for Homemaker-Home Health Aide Services, Inc. The Council is a national, nonprofit 501(c)(3) membership organization, with offices at 67 Irving Place, New York, New York 10003. The National Council's goal is availability of quality homemaker-home health aide services in all sections of the nation to help individuals and families in all economic brackets when there are disruptions due to illness, disability, social and other problems, or where there is need to help enhance the quality of daily life.

Membership

The National Council is comprised of 597 dues-paying members, of which 260 are agencies providing homemaker-home health aide services in 45 states and in several Canadian provinces; 46 are organizations, and 291 are individuals. (1978 year-end figures.) Programs from all auspices - voluntary nonprofit, public, and proprietary - are included in the Council's membership. Written and visual materials, conference and other services are available to and used by many organziations, including nonmember agencies providing homemaker-home health aide services in the United States and Canada.

Reference to Earlier Testimony

The National Council for Homemaker-Home Health Aide Services, Inc., appreciates this opportunity to present its views on proposed legislation to change Medicare and Medicaid home health benefits. The Council presented testimony on similar legislative initiatives before the House Ways and Means Committee's Subcommittee on Health on June 22, 1978. Since that time, our overriding concern for home health benefits under Titles XVIII and XIX of the Social Security Act has remained

constant: that the federal government provide adequate coverage for the long-term care needs of our elderly and indigent Americans by removing unrealistic and punitive restrictions on reimbursable allowances for home health care.

Background Information

Before presenting our recommendations on the proposed home health legislation, a brief review of the current situation seems in order.

Although home care services are growing rapidly nationwide, statistical projections indicate the need, both potential and actual, far outstrips the current, available supply. The potential population of service recipients is progressively increasing as more persons live longer with related increases in chronic and/or disabling conditions. It has been estimated that 18 million persons between the ages of 18 and 64, plus 15 million elderly individuals - a total of 33 million persons - have one or more chronic physical conditions which limit their freedom of movement or make them functionally dependent. Of the 18 million non-institutionalized elderly in this country, almost 3 million or 16 percent, are totally unable to carry out their daily activities because of chronic disease or disability.[1]

It is highly probable that the incidence of chronic disabling conditions will continue well into the twenty-first century as our aging population continues to grow in both relative and absolute terms. Indeed, the ranks of the elderly can be expected to swell from 23 million in 1978 to 51.6 million by the year 2030 - from one out of every 10 individuals to more than 1 in 8. Projections of actual need indicate that about 14 percent of the non-institutionalized aged - excluding those with mental illness - require some in-home supportive assistance. Within the disabled population aged 18-64, it has been estimated that 40 percent require some assistance with household chores and 10 percent require some personal care.[2]

Despite these projections, a scant 12 percent of those aged and disabled persons who require in-home services actually receive them.[3] The lack of an adequate federal reimbursement policy for home care has forced countless individuals into premature or unnecessary institutional placements. Indeed, studies of nursing home populations in New York, Massachusetts, and Florida have estimated that from 18 to 40 percent of the institutionalized elderly could be transferred out if appropriate in-home services were provided.[4]

Our country's commitment to home-based care appears even more inadequate when compared to the sophisticated "home help" programs in several European countries. While the United States reports a ratio of one aide for every 2,800 persons, Sweden estimates one home help for every 101 persons; Norway, one for every 119 persons; and The Netherlands, one for every 151 persons. Finland gives credit to its solid network of home help services for the substantial decline in its infant mortality rate in recent years. All of these countries have made a conscious shift in support from "bricks and mortar" to a rich mixture of community-based services in recent years.

Not only has the need for supportive, in-home services been persuasively documented,

but its cost-effectiveness vis-a-vis institutional care has also gained increasing national attention. Coming on the heels of numerous studies revealing significant dollar savings through the use of home-based rather than institutional services, the U.S. General Accounting Office has recently declared that, "until old people become greatly or extremely impaired, the cost for home care services, including the large portion provided by families and friends, is less than the cost of putting those people in institutions."

Recommendations For Medicare and Medicaid
Home Health Benefits

Expansion of Home Health Benefits: Based upon the above-mentioned data, the National Council strongly believes that the rigid restrictions governing home health coverage under Titles XVIII and XIX should be relaxed to meet the chronic care needs of our nation's aged and indigent citizens in a more realistic and humanitarian fashion.

Three of the bills currently under consideration by the 96th Congress and by the Senate Committee on Finance - S.489 (Domenici, R-NM), S.505 (Talmadge, D-GA), and S-507 (Dole, R-KS) - propose to eliminate the three-day prior hospitalization requirement under Medicare Part A and the 100-day visit limitation under Medicare Parts A and B. On the House side, H.R.3990 (Rangel, D-NY) proposes similar changes. The Council endorses these recommendations as a necessary first step toward increasing accessibility of home care and deterring costly, unnecessary institutional care.

However, the Council also urges that the following three additional recommendations be incorporated in the legislation:

1. The Council recommends that "homemaker hyphen" be added to home health services currently authorized under Medicare. The National Council's definition of homemaker-home health aide service, which has been adopted by numerous state units and organizations, is appended to this testimony. (Appendix A.)*

   The delivery of both health and socially-related services is essential if we as a society are to deal effectively and efficiently with the home care needs of our aged and disabled population. Moreover, authorizing both personal care and environmentally-focused services from the same funding source - i.e., Medicare - would be a major step toward reducing the current fragmentation in service delivery which promotes costly duplication of effort. We often hear of instances where two paraprofessionals go into one home to provide different aspects of homemaker-home health aide service or even provide the same service (such as a bath) twice in one day. This change would also help to free up some funds under Title XX of the Social Security Act to serve the long-term care needs of the aged and disabled population.

2. The "confined to home" restriction should be loosened somewhat to recognize the needs of frail elderly and recuperating hospital cases to

* All appendices are attached to the original copy of this testimony only.

get out of their homes occasionally to visit friends and family, do personal shopping, and the like. Thus, the National Council recommends that home health benefits be extended to those who are "fully or partially confined to home."

3. The National Council recommends that the requirement of skilled nursing as a prerequisite for home care be modified by substituting "professional" for the "skilled" proviso before nursing. Like the prior hospitalization and maximum visit requirements, the need for skilled nursing relies far too heavily on an acute care model and ignores the pressing needs of our many chronically ill and disabled older Americans. Simarily, the benefits should be extended to those needed nursing care or supervision, with recognition of the fact that supervision by social workers and home economist/nutritionists is also integral to the development of comprehensive home health care plans for the elderly.

Many of these recommendations for expanding home health coverage have been incorporated in recent drafts of HEW's H.R.3 report on home care, mandated under the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L.95-142). The National Council had worked closely with staff from the Health Care Financing Administration, who prepared the early versions of this report, to interpret the need for a less restrictive home care policy under Titles XVIII and XIX. Although HEW appeared eager to take the leadership role in expanding home care coverage during the 95th Congress, the Department appears to have changed its position this year. The Council was extremely disappointed to discover that previously endorsed legislative recommendations have been deleted from the text of HEW's final H.R.3 report.

It appears that budget constraints issued by the White House have played a significant role in shaping HEW's low home care profile this year. The National Council believes that this is false economics, particularly in light of mounting, factual evidence regarding the cost-effectiveness of home care vis-a-vis institutional alternatives. The National Council for Homemaker-Home Health Aide Services, Inc., therefore looks to the Committee on Finance to take the leadership for this important home care legislation in the 95th Congress.

Additional Comments on S.489

There are several additional features of the Domenici bill (S.489) which the National Council would like to address:

1. S.489 would require that all home health aides complete a training course which has been approved by the Secretary of HEW. The National Council applauds this safeguard and recommends several important elements.

First of all, the training requirement should be extended to all homemaker-home health aides, and a comprehensive blend of health and social/environmental skills should be required in all HEW-approved training programs. We strongly urge that HEW endorse for this purpose a comprehensive training curriculum* which has been

* Public Health Service, D/HEW. A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide.

developed by the National Council for Homemaker-Home Health Aide Services, Inc., in cooperation with the American Red Cross, the American Home Economics Association, the National League for Nursing, and other national agencies, voluntary and governmental, under a grant from HEW's Public Health Service. Furthermore, this D/HEW Curriculum should be officially recognized throughout the Department in all of its home care programs, including those administered under Titles XVIII, XIX and XX of the Social Security Act and Title III of the Older Americans Act.

Secondly, S.489 requires the D/HEW Secretary to undertake extensive monitoring of home health providers. The billing procedures which are spelled out in item four under "Duties of the Secretary" appear to be extremely detailed for Federal legislation, and would be better handled in the regulatory language. Furthermore, this requirement should allow for either bimonthly or monthly billing of home health patients. Monthly billing procedures would save time and administrative costs - as most clients pay from their Social Security checks and other income supplements arriving around the first of the month.

The development of "reasonable cost guidelines," as described under item five of this section, is an extremely complicated procedure in a country as diverse as ours. Not only must rural/urban disparities be taken into consideration, but also such factors as unionization and regional salary levels must be examined for their impact upon agency costs. For these reasons, the National Council recommends that development of cost guidelines be approached on a regional rather than a national basis and that such guidelines be specified in regulations rather than legislation.

Furthermore, we would urge that an agency's overhead costs - including administrative/supervisory costs - be broken out and reviewed as a separate line item. Such overhead costs should be limited by a cap in order to minimize the incentives for fraud and abuse in our public entitlement programs. However, the cap should be sufficient to allow for adequate administrative and supervisory costs. The payment of excessive salaries and fringe benefits to administrative staff of certified home health agencies has been extensively documented by Congress within the past several years. We urge that such practices be discouraged to prevent the widespread scandals which have been so vividly documented in the nursing home industry.

Training of Welfare Recipients As
Homemaker-Home Health Aides

The National Council would like to comment upon two current legislative proposals which would authorize demonstration projects for training and employing AFDC recipients as homemaker-home health aides: S.421 (Inouye, D-HI, and Talmadge, D-GA) and Section 22 of S.507 (Dole, R-KS).

The National Council believes that these bills are sound in concept and that such projects would help to provide much-needed manpower for the home care field. Indeed, the number of agency-employed homemaker-home health aides in the United States has grown from 60,000 in 1975 to an estimated 100,000 in 1978 - a 40 percent increase in just three years. Econometric projections indicate that the demand for homemaker-home health aides will continue to spiral well into the twenty-first century.

However, the National Council would caution that the labor implications of this legislation should not overshadow service objectives for the home care field. It is critically important that service safeguards be firmly in place before such demonstration efforts are authorized.

In particular, the Council urges that the following standards be endorsed as part of this legislation:

1. AFDC recipients should be trained solely for employment by a homemaker-home health aide agency meeting basic standards of quality, as recognized by national standard-setting organizations such as the National Council for Homemaker-Home Health Aide Services, Inc. The trend toward the use of "self-employed providers" in many localities has presented serious problems of service accountability and may also be exploitive of the providers, who often are not accorded minimum wages or fringe benefits.

2. The employing agency must retain the responsibility for selection of the homemaker-home health aide.

3. The "formal training program" referred to in this legislation should be the one which has been endorsed throughout HEW. As stated earlier in this testimony, the National Council recommends that HEW endorse the Public Health Service comprehensive training curriculum, which has been developed by the National Council for Homemaker-Home Health Aide Services, Inc., as the guide for training requirements throughout the Department of Health, Education, and Welfare.

Recommended Changes in Medicare Conditions of Participation

In order for Titles XVIII and XIX home health benefits to be effective, the National Council believes that further regulatory changes must be enacted to strengthen the Medicare Conditions of Participation. The National Council has worked with the Forum of Four* to develop a comprehensive set of recommendations for improving the Conditions, which have been carefully interpreted to the Health Care Financing Administration. Key among these recommendations - which appear as Appendix B following this testimony - are those which strengthen agency accountability by giving full legal responsibility to the governing body, require such standards as a personnel interview, job descriptions, and training of home health aides, and specify planning requirements for home health agencies.

Certificate-of-Need Requirement Urged

The National Council strongly believes that there should be a federal requirement for

* Forum of Four organizations include: National Council for Homemaker-Home Health Aide Services, Inc.; National Association of Home Health Agencies; National League for Nursing, Council of Home Health Agencies and Community Health Services; and American Hospital Association, Center for Ambulatory and Home Health Services.

inclusion of home health agencies in the Certificate-of-Need process. Not only would such a requirement help to strengthen home care within the broad spectrum of health services, but it would also help to insure an appropriate distribution of resources within each community, thereby alleviating costly duplication and fragmentation of home care services in many areas.

Endorsement of Prospectus Recommended

In closing, the National Council urges the Finance Committee to endorse the attached Prospectus for a National Home Care Policy (Appendix C), which has been developed jointly by the Forum of Four organizations. This important document emphasizes the role of home care as "an essential part of any effective plan to meet fully and economically the health and related social services needed by the American people."

Thank you for this opportunity to present our views on home health benefits under Titles XVIII and XIX.

FOOTNOTES

1. Levinson Policy Institute, "Alternatives to Nursing Home Care: A Proposal." Washington, DC: U.S. Senate Special Committee on Aging, 1971.

2. Morris, Harris, and Kistin. "An Alternative to Institutional Care for the Elderly and Disabled: A Proposal For A New Policy." Waltham, MA: Levinson Policy Institute, 1971.

3. Morris and Harris. "Home Health Services in Massachusetts, 1971: Their Role in Care of The Long-Term Sick." American Journal of Public Health, August 1972, pp.1088-1093.

4. Davis and Gibbs. "An Areawide Examination of Nursing Home Use, Misuse, and Nonuse." American Journal of Public Health, 61:6, pp. 1146-1155.

Bell, William G. "Community Care For The Elderly: An Alternative To Institutionalization." Tallahassee, FL: Florida State University.

NATIONAL COUNCIL
for Homemaker-Home Health Aide Services, Inc.
67 Irving Place · 6th Floor · New York, N.Y. 10003 · (212) 674-4990

Appendix A

RECOMMENDED WORDING FOR
REGULATIONS TO IMPLEMENT P.L. 93-647

HOMEMAKER-HOME HEALTH AIDE SERVICES

State plans should provide for homemaker-home health aide services as follows:

a) Include personal care and home management services for aged, blind and disabled and families with children who are determined by the agency to need the service of trained and supervised homemaker-home health aides.

b) Be in accord with the recommended standards of related national voluntary non-profit standard setting organizations such as the National Council for Homemaker-Home Health Aide Services, Inc.

DEFINITIONS

HOMEMAKER-HOME HEALTH AIDE SERVICES

Homemaker-home health aide services means professionally directed personal care and home management services by trained and professionally supervised homemaker-home health aides to maintain, strengthen and safeguard the functioning of eligible persons in their own homes where no responsible person is available for this purpose. The term professionally directed means individual assessment and implementation of a plan of care.

CHORE SERVICES

Chore services mean services in performing minor home repairs, heavy cleaning, yard and walk maintenance which eligible persons are unable to do for themselves because of frailty or other conditions and which do not require the services of a trained and supervised homemaker-home health aide or other specialist. Chore services may include such activities as: help in lawn care, periodic heavy cleaning, simple household repairs, running errands, etc.

NOTE: That part of homemaker-home health aide services, sometimes referred to as housekeeper service, is homemaker-home health aide service and should meet the National Council's basic national standards for homemaker-home health aide services.

#67R-1-11/75

APPENDIX B.

NATIONAL COUNCIL
for Homemaker-Home Health Aide Services, Inc.
A non-profit national standard-setting organization
67 Irving Place, New York, N.Y. 10003 (212) 674-4990

June 8, 1978

Judith LaVor
Acting Branch Chief
Long Term Care Demonstrations
Office of Policy, Planning, and Research
Health Care Financing Administration
Department of Health, Education and Welfare
Switzer Building
330 C Street, S.W., #5523
Washington, DC 20201

Dear Judy:

Enclosed are the National Council's recommendations for changes in the Conditions of Participation: Home Health Agencies. Adoption of these changes would strengthen standards in some instances, clarify language in others. These changes do not get at the overriding concern we all have: that home care should be available to people who desperately need it and cannot get it under the current laws, regulations or funding available through Medicare, Medicaid, and Social Services. Since this is not your immediate focus, the suggestions we are mailing you today do not touch the lack of availability of funds even for short-term "custodial" care or for long-term care at home.

The changes recommended cluster in relation to specific concerns:

A. The homemaker-home health aide: We believe that homemaker-home health aide services should be available directly or indirectly through every agency certified for Medicare. See the suggested change in the Conditions on page 8, Section 405.1221(a).

We are especially concerned about agencies which accept an application for employment over the telephone from a potential homemaker-home health aide and send the aide on an assignment without an in-person interview. However, all home care personnel should have a pre-employment in-person interview so our recommendation is generally applicable to all employees rather than specific to the homemaker-home health aide, page 9, Section 405.1221(e).

We are also concerned that some agencies provide only on-the-job training. Relevant to this concern are the recommendations that: evidence of education and in-service training be included in the personnel records, page 9, Section 405.1221(e); that the homemaker-home health aide shall have satisfactorily completed a basic generic curriculum, including a practicum or field practice under supervision in the employing agency and that this training is based on a program recognized by DHEW*, and that the agency shall provide an ongoing in-service education program, page 15, Section 405.1227(c).

B. The "skim and dump" practice: Agencies may take the ready money, for example, a Medicare payment for the number of visits allowed or a fee for services from a full pay patient; and when the money runs out, drop the service. Relevant to our concern about this practice are our recommendations to add requirements for documenting patients' status, the reason for discharge, and the documented efforts toward needed continuing care on page 16, Section 405.1228, and for a system of patient care, planning and evaluation on page 12, Section 405.1223(a). An example of such a system is a problem-oriented record-keeping system, but it would probably be unwise to confine agencies to one system, since improved systems may evolve.

C. The profit in non-profit institutions: Under current IRS and BHI regulations, a privately-owned home health agency may incorporate as a private non-profit agency and accordingly present a public impression that no profit is involved. The owners may arrange to receive large salaries and fringe benefits and otherwise profit from property or business associated with the nonprofit agency. Relevant to clear public understanding of this type of arrangement are recommendations (1) to differentiate "privately owned" from "voluntary non-profit" agencies on page 3, Section 405.1202(a); (2) a requirement for disclosure of ownership on page 8, Section 405.1221(b); a requirement that if an agency is a non-profit one, one third of the members of the governing body have no financial, family, or operational relationship with the agency (it would be even better to have this requirement for both profitmaking and non-profit agencies) page 8, Section 405.1221(b); and the requirement for the public accountability of a published annual report on page 11, Section 405.1221(5).

D. One writer for all patient care records: We are concerned about the agencies which employ a professional nurse or other employee who may work on the records of patients never seen by that employee. Therefore, it

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*We are making an assumption in recommending use of the training program "recognized by DHEW" that the one currently being developed by the National Council under contract with the Public Health Service will be recognized by all relevant DHEW departments -- aging, social services, mental health, etc.

is recommended on page 3, Section 405.1202(d), page 5, Section 405.1202 (n), and page 15, Section 405.1228, that clinical notes be made by the homemaker-home health aide or person directly providing the service in the home.

E. The operate-in-isolation phenomenon: An agency which assumes no responsibility for helping a patient to meet needs outside the agency's own services, fails to participate in coordination of services between agencies, and does not help the community establish other services to meet needs for which there are no existing services, is, in effect, operating in isolation. Relevant to avoiding such an undesirable situation are recommendations to require knowledge of other services in the community and to endeavor to help the patient who needs them obtain them, page 8, Section 405.1221(a); definition of the locus of responsibility for coordination of services between two agencies, page 9, Section 405.1221(g); a plan related to community needs on page 10, Section 405.1221(i); the system of patient care planning and evaluation, page 12, Section 405.1223(a); and, again, the discharge summary on page 16, Section 405.1228.

F. Evaluation: You asked in your letter that we speak to ways to develop measurable criteria for performance and service. We have tried to set the framework for the collection of useful data in the recommendations on definitions, including the more careful differentiation of auspices, page 3, Section 405.1202(e); stated need for institutional planning to be related to community needs and program goals and objectives, page 10, Section 405.1221(i); a published annual report, page 11, Section 405.1221 (5); a system of patient care, planning, and evaluation, page 12, Section 405.1223(a); and the discharge summary, page 16, Section 405.1228.

We are concerned about agencies which limit service to high-density areas where travel time and costs are lowest, competing in charge-per-hour with agencies that probably have greater operating cost because they also serve rural areas. However, we do not see any place in the Conditions where a requirement to extend agencies' responsibility could be written in. A certificate of need requirement would help.

It is believed that a nutritionist should be added as a covered cost for service, and we recommend that this be incorporated into the law.

Under Title XIX certification for Medicaid generally follows the requirement for certification for Medicare, but there are no standards for personal care workers receiving Medicaid money, and there are in effect no standards for in-home services under Title XX, nor are there adequate requirements for standards under Title III of the Older Americans Act. We believe that these problems should be resolved at an early date. Consideration might be given to amending Conditions further so they might also apply to Title XX of the Social Security Act, Title III of the Older Americans Act and the Personal Care Service under Title XIX of the Social Security Act. Immediate steps should be that definitions of homemaker-home health aide, chore, and related programs be established so that they mean the same services in all parts of the country, and all agencies receiving federal funds should be required to pay all workers at least the federal minimum hourly wage.

We would be glad to discuss any point further.

Sincerely,

Peter

Peter G. Meek
Chairperson
Standards Committee

PGM: gct

Subpart L—Conditions of Participation; Home Health Agencies

Sec.

Subpart L—Conditions of Participation; Home Health Agencies

AUTHORITY: Secs. 1102, 1302, 1861, 1870, 1871, 49 Stat. 647, as amended, 79 Stat. 329, 79 Stat. 323, 79 Stat. 331, 81 Stat. 845-847; 42 U.S.C. 1302, 1395 et seq.

SOURCE: The provisions of this Subpart L appear at 38FR 12090, Aug. 27, 1973, as amended at 38 FR 18978, July 16, 1973, unless otherwise noted.

§ 405.1201 General.

(a) In order to participate as a home health agency in the health insurance program for the aged, an institution must be a "home health agency" within the meaning of section 1861(o) of the Social Security Act. This section of the law states a number of specific requirements which must be met by participating home health agencies and authorizes the Secretary of Health, Education, and Welfare to prescribe other requirements considered necessary in the interest of health and safety of beneficiaries. Section 1861 (o) of the Act provides:

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) Is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) Has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) Maintains clinical records on all patients;

(4) In the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) Has in effect an overall plan and budget that meets the requirements of subsection (z); and

(6) Meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and

→ delete skilled, add professional

the governing body on the recommendation of

(It is recognized that this is a direct quote from the statute and thus cannot be changed by HEW. It should be noted, however, that the group of professionals has responsibility for advising the governing body regarding patient care policies.)

requirements as may be prescribed in regulations; and except that for purposes of Part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

(b) The requirements included in the statute and the additional health and safety requirements prescribed by the Secretary are set forth in the conditions of participation for home health agencies.

§ 405.1202 Definitions.

As used in this subpart, the following definitions apply:

(a) *Administrator, home health agency.* A person who:

(1) Is a licensed physician; or

(2) Is a registered nurse; or

(3) Has training and experience in health service administration and at least 1 year of supervisory or administrative experience in home health care or related health programs.

(b) *Bylaws or equivalent.* A set of rules adopted by a home health agency for governing the agency's operation.

(c) *Branch office.* A location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the conditions of participation as a home health agency.

(d) *Clinical note.* A dated written notation by a member of the health team of a contact with a patient containing a description of signs and symptoms, treatment and/or drug given, the patient's reaction, and any changes in physical or emotional condition.

(e) *Nonprofit agency.* An agency exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954.

(f) *Occupational therapist.* A person who:

(1) Is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association; or

(2) Is eligible for the National Registration Examination of the American Occupational Therapy Association; or

(3) Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public

delete (1) Is a licensed physician; or
(2) Is a registered nurse

is a full-time employee who

the individual who provided the service to

define privately owned nonprofit agency
Voluntary nonprofit agency. A nonprofit agency which
(1) has neither individual nor corporate shareholders; an
(2) has a board of directors drawn from the community, the members of which serve without compensation.

— (definitions pertaining to each discipline should be cleared with the appropriate national organizations; a definition of homemaker-home health aide should be added to this section.

Homemaker-home health aide: The homemaker-home health aid is a trained home care worker, employed by a community agency, who carries out assigned tasks in the family's or individual's place of residence. These assignments are carried out under the supervision of a professional person who also assesses the need for the service and implements the plan of care.

Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapist after December 31, 1977.

(g) *Occupational therapy assistant.* A person who:

(1) Meets the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association; or

(2) Has 2 years of appropriate experience as an occupational therapy assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

(h) *Parent home health agency.* The agency that develops and maintains administrative controls of subunits and/or branch offices.

(i) *Physical therapist.* A person who is licensed as a physical therapist by the State in which practicing, and

(1) Has graduated from a physical therapy curriculum approved by

(i) The American Physical Therapy Association, or

(ii) The Council on Medical Education and Hospitals of the American Medical Association, or

(iii) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or

(2) Prior to January 1, 1966,

(i) Was admitted to membership by the American Physical Therapy Association, or

(ii) Was admitted to registration by the American Registry of Physical Therapists, or

(iii) Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or

(3) Has 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 197.; or

(4) Was licensed or registered prior to January 1, 1956, and prior to January 1, 1970, had 15 years of full-time ex-

perience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

(5) If trained outside the United States,

(i) Was graduated since 1923 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.

(ii) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

(iii) Has 1 year of experience under the supervision of an active member of the American Physical Therapy Association, and

(iv) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(j) *Physical therapist assistant.* A person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and

(1) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or

(2) Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapist assistant after December 31, 1977.

(k) *Physician.* A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which such function or action is performed.

(l) *Practical (vocational) nurse.* A person who is licensed as a practical (vocational) nurse by the State in which practicing.

(m) *Primary home health agency.* The agency that is responsible for the service rendered to patients and for implementation of the plan of treatment.

(n) *Progress note.* A dated, written notation by ~~a member of the health team~~ summarizing facts about care and the patient's response during a given period of time. → the individual who provided a service

(o) *Proprietary agency.* A private profit-making agency licensed by the State.

(p) *Public agency.* An agency operated by a State or local government.

(q) *Public health nurse.* A registered nurse who has completed a baccalaureate degree program approved by the National League for Nursing for public health nursing preparation or post-registered nurse study which includes content approved by the National League for Nursing for public health nursing preparation.

(r) *Registered nurse.* A graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing.

(s) *Social work assistant.* A person who:

(1) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least 1 year of social work experience in a health care setting; or

(2) Has 2 years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a social work assistant after December 31, 1977.

(t) *Social worker.* A person who has a master's degree from a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

(u) *Speech pathologist or audiologist.* A person who:

(1) Meets the education and experience requirements for a Certificate of Clinical Competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association; or

(2) Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

(v) *Subdivision.* A component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the conditions of participation for home health agencies. A subdivision which has subunits and/or branches is regarded as a parent agency.

(w) *Subunit.* A semi-autonomous organization, which serves patients in a geographic area different from that of the parent agency. The subunit by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision, and services on a daily basis with the parent agency and must, therefore, independently meet the conditions of participation for home health agencies.

(x) *Summary report.* A compilation of the pertinent factors from the clinical notes and progress notes regarding a patient, which is submitted as a summary report to the patient's physician.

(y) *Supervision.* Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Unless otherwise provided in this subpart, the supervisor must be on the premises if the person does not meet qualifications for assistants specified in the definitions in this section.

[FR 405.1203—405.1208 deleted, 39 FR 2231, Jan. 17, 1974]

§ 405.1220 Condition of participation: Compliance with Federal, State, and local laws.

The home health agency and its staff are in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of home health agencies, an agency not subject to licensure must be approved by the licensing authority as meeting the standards established for such licensure. A proprietary organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 must be licensed as a home health agency pursuant to State law. If no State law exists for the licensure of a proprietary home health agency, it cannot be certified for participation in the health insurance program.

§ 405.1221 Condition of participation: Organization, services, administration.

Organization, services provided, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Administrative and supervisory

insert

Standard. Generally, a measure set by competent authority as the rule for measuring quantity or quality. Conformity with standards is usually a condition of licensure, accreditation, or payment for services. Standards may be defined in relation to: the actual or predicted effects of care; the performance or credential of professional personnel; and the physical plant, governance, and administration of facilities and progras

Clinical management functions of supervision

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[1]Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, U.S. Hous of Representatives. A Discursive Dictionary of Health Care, February 1976, pp. 3, 4.

functions are not delegated to another agency or organization and all services not provided directly are monitored and controlled by the primary agency, including services provided through subunits of the parent agency. If an agency has subunits, appropriate administrative records are maintained for each subunit.

(a) *Standard: Services provided.* Part-time or intermittent ~~skilled~~ nursing services and at least one other therapeutic service (physical, speech, or occupational therapy; medical social services; ~~or home health aide services~~) must be made available on a visiting basis, in a place of residence used as a patient's home. A public or nonprofit home health agency must provide at least one of the qualifying services directly through agency employees, but may provide the second qualifying service and additional services under arrangements with another agency or organization. A proprietary home health agency, however, must provide all services directly, through agency employees.

(b) *Standard: Governing body.* ~~A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. The governing body appoints a qualified administrator, arranges for professional advice (see § 405.1223), adopts and periodically reviews written bylaws or an acceptable equivalent, and oversees the management and fiscal affairs of the agency. The name and address of each officer, director, and owner are disclosed. If the agency is a corporation, all ownership interests of 5 percent or more (direct or indirect) are also disclosed.~~

(c) *Standard: Administrator.* The administrator, ~~who may also be the supervising physician or registered nurse (see paragraph (d) of this section), organizes~~ and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff; employs qualified personnel and ensures adequate staff education and evaluations; ensures the accuracy of public information materials and activities; and implements an effective budgeting and accounting system. A qualified person is authorized in writing to act in the absence of the administrator.

(d) *Standard: Supervising physician or registered nurse.* The ~~skilled~~ nursing and other therapeutic services provided are under the supervision and direction

delete skilled, substitute professional

homemaker-home health aide services, and supplies and equipment
or
delete s from services

All agencies must determine the range of other services available in the community and must endeavor to provide either directly or by referral such services for patients as needed.

A governing body assumes full legal authority and responsibility for the operation of the agency. The governing body appoints a qualified administrator, has responsibility for professional review and conducted pursuant to section 405.1222 and for appointment of professional advisory and reviewing personnel, adopts and periodically reviews written bylaws or an acceptable equivalent, and oversees the management and fiscal affairs of the agency. The name and address of each officer, director, and owner are disclosed, and all ownership interests (direct or indirect are also disclosed. No member of the governing body may vote on matters in which that member has a direct financial interest. If the agency is a nonprofit agency, at least one-third of the members of the governing body are outside members, having no financial, family, or operational relationship with the agency.

organizes, plans,
supervision

including a patient's bill of rights and responsibilities which shall be made available to all patients and/or representatives,

delete skilled; add professional

of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse). This person, or similarly qualified alternate, is available at all times during operating hours and participates in all activities relevant to the professional services provided, including the development of qualifications and assignments of personnel.

(See Connecticut, Massachusetts, New Jersey, and Rhode Island Addenda in the Appendix.)

(e) *Standard: Personnel policies.* Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include job descriptions, qualifications, licensure, performance evaluations, and health examinations, and are kept current.

(f) *Standard: Personnel under hourly or per visit contracts.* (1) If personnel under hourly or per visit contracts are utilized by the home health agency, there is a written contract between such personnel and the agency clearly designating:

(i) That patients are accepted for care only by the primary home health agency.

(ii) The services to be provided.

(iii) The necessity to conform to all applicable agency policies including personnel qualifications.

(iv) The responsibility for participating in developing plans of treatment.

(v) The manner in which services will be controlled, coordinated, and evaluated by the primary agency.

(vi) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation, and

(vii) The procedures for determining charges and reimbursement.

(g) *Standard: Coordination of patient services.* All personnel providing services maintain liaison to assure that their efforts effectively complement one another and support the objectives outlined in the plan of treatment. The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordinated patient evaluation does occur. A written summary report for each patient is sent to the attending physician at least every 60 days.

(h) *Standard: Services under arrangements.* Services ~~for paragraph (a) of this section provided under arrangements must be subject to a written contract conforming with the requirements specified in paragraph (f) of this section and with the requirements of section 1861(w) of the Act (42 U.S.C. 1395x(w)).~~

All personnel must have a pre-employment in-person interview, which provides indications that the individual is able to meet the requirements stated in the job description and communicates effectively.

for all categories of personnel

evidence of education, in-service training,

supervised

The locus of responsibility for coordination of services between two agencies must be clearly defined.

provided with another agency must be subject to a written contract conforming with the requirements specified in 405.1221(f).[1]

[1]Medicare Surveyor Form

(f) *Standard: Institutional planning.* The home health agency, under the direction of the governing body, prepares an overall plan and budget which provides for an annual operating budget and a capital expenditure plan.

(1) *Annual operating budget.* There is an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense).

(2) *Capital expenditure plan.* (i) There is a capital expenditure plan for at least a 3-year period (including the year to which the operating budget described in paragraph (f)(1) of this section is applicable), which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 for items which would, under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $100,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions which are separated in time but are components of an overall plan or patient care objective are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds.

(ii) If the anticipated source of such financing is, in any part, the anticipated reimbursement from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Health Insurance for the Aged and Disabled) or title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act, the plan states:

has a mechanism for a conscious planning process.

it

which encompasses a statement of goals and objectives, a program plan, an annual operating budget, a staffing, equipment, and capital expenditure plan. The program plan should reflect an effort toward coordination of the agency's home care program with other services in the community.

(c) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed pursuant to the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, to meet the need for adequate health care facilities in the area covered by the plan or plans so developed;

(b) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval pursuant to section 1122 of the Social Security Act (42 U.S.C. 1320a-1) and implementing regulations; and

(c) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it has been so presented.

(3) *Preparation of plan and budget.* The overall plan and budget is prepared under the direction of the governing body of the home health agency by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the home health agency.

(4) *Annual review of plan and budget.* The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (b)(3) of this section under the direction of the governing body of the home health agency.

(33 FR 12090, Aug. 27, 1968, as amended at 33 FR 18647, Dec. 18, 1968; 36 FR 7050, Apr. 14, 1971; 38 FR 18979, July 16, 1973; 40 FR 24325, June 5, 1975; 40 FR 56661, Dec. 4, 1975)

(5) Annual report. An annual report of activities including the names of the governing body and a certified public audit shall be published and be available to the public.

§ 405.1222 Condition of participation: Group of professional personnel.

A group of professional personnel, which includes at least one physician and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, ~~established and annually reviews~~ advisory committee representative of the services provided by the agency, and

the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, personnel qualifications, and program evaluation. ~~At least one member of the group (as defined in section (§ 405.1221(b)) not an employee of the agency.~~ and administrative personnel

recommends policy to the governing body

At least two members of this group shall have no ~~fina~~ family, or operational relationship with the agency o any affiliated agency.

(a) *Standard: Advisory and evaluation function.* The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in its community information program. Its meetings are documented by dated minutes.

(See New Jersey Addendum in the Appendix.)

signed and

§ 405.1223 Condition of participation: Acceptance of patients, plan of treatment, medical supervision.

Note: S 405.1229 should be placed under S 405.1222 and sections should be renumbered accordingly

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of treatment established and periodically reviewed by a physician, and care continues under the supervision of a physician.

(a) *Standard: Plan of treatment.* The plan of treatment, developed in consultation with the agency staff, covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of treatment which cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. The therapist and other agency personnel participate in developing the plan of treatment.

is

A system of patient care, planning, and evaluation is evident in every agency. It

(b) *Standard: Periodic review of plan of treatment.* The total plan of treatment is reviewed by the attending physician and home health agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of treatment.

(c) *Standard: Conformance with physician's orders.* Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medicines a patient may be taking to identify possibly ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication, and promptly report any problems to the physician.

§ 405.1224 Condition of participation: Skilled nursing service.

-- delete skilled; add professional

The home health agency provides skilled nursing service by or under the supervision of a registered nurse and is

-- delete skilled; add professional

(See Connecticut, Massachusetts, and Rhode Island Addenda in the Appendix)

(a) *Standard: Duties of the registered nurse.* The registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, initiates the plan of treatment and necessary revisions, provides those services requiring substantial specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, ~~coordinates services~~, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related needs, participates in inservice programs, and supervises and teaches other nursing personnel.

for all patients,

has responsibility for coordination of services

(b) *Standard: Duties of the licensed practical nurse.* The licensed practical nurse provides services in accordance with agency policies, prepares clinical and progress notes, assists the physician and/or registered nurse in performing specialized procedures, prepares equipment and materials for treatments observing aseptic technique as required, and assists the patient in learning appropriate self-care techniques.

[33 FR 12090, August 27, 1968, as amended at 33 FR 18547, December 18, 1968; 38 FR 18978, July 16, 1973]

§ 405.1225 Condition of participation: Therapy services.

Any therapy services offered by the home health agency directly or under arrangement are given by a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist in accordance with the plan of treatment. The qualified therapist assists the physician in evaluating level of function, helps develop the plan of treatment (revising as necessary), prepares clinical and progress notes, advises and consults with the family and other agency personnel, and participates in inservice programs.

(a) *Standard: Supervision of physical therapist assistant and occupational therapy assistant.* Services provided by a qualified physical therapist assistant

or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapist assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist, assists in preparing clinical notes and progress reports, and participates in educating the patient and family, and in inservice programs.

(b) *Standard: Supervision of speech therapy services.* Speech therapy services are provided only by or under supervision of a qualified speech pathologist or audiologist.

[33 FR 12090, August 27, 1968, as amended, at 36 FR 19250, October 1, 1971; 38 FR 18978, July 16, 1973]

§ 405.1226 Condition of participation: Medical social services.

Medical social services, when provided, are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of treatment. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems, participates in the development of the plan of treatment, prepares clinical and progress notes, works with the family, utilizes appropriate community resources, participates in discharge planning and inservice programs, and acts as a consultant to other agency personnel.

§ 405.1227 Condition of participation: Home health aide services.

Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. Aides are carefully trained in methods of assisting patients to achieve maximum

self-reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, procedures for maintaining a clean, healthful, and pleasant environment, changes in patient's condition that should be reported, work of the agency and the health team, ethics, confidentiality, and recordkeeping. They are closely supervised to assure their competence in providing care.

(See Connecticut and Oregon Addenda in the Appendix.)

(a) *Standard: Assignment and duties of the home health aide.* The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or therapist as appropriate. Duties include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs, and completing appropriate records.

(b) *Standard: Supervision.* The registered nurse, or appropriate professional staff member, if other services are provided, makes a supervisory visit to the patient's residence at least every 2 weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

(See Massachusetts Addendum in the Appendix.)

[33 FR 12090, August 27, 1968, as amended, at 33 FR 18648, December 18, 1968; 38 FR 18978, July 16, 1973]

§ 405.1222 *Condition of participation:* Clinical records.

A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of treatment (see § 405.1223(a)), the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes (clinical notes are written the day service is rendered and incorporated no less often than weekly);

(c) Standard: Initial and continuing training of the homemaker-home health aide. The aide shall have satisfactorily completed a basic generic curriculum which is recognized by D/HEW. It requires a practicum or field practice under supervision in the employing agency. An ongoing in-service education program, provided at least quarterly, for the homemaker-home health aide is required to maintain and improve skills and to add new knowledge for added competence.

written by the individuals who provide services and

copies of summary reports sent to the physician; and a discharge summary.

(a) *Standard : Retention of records.* Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the home health agency discontinues operations. If a patient is transferred to another health facility, a copy of the record or abstract accompanies the patient.

(b) *Standard : Protection of records.* Clinical record information is safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and conditions for release of information. Patient's written consent is required for release of information not authorized by law.

The discharge summary shall include patients' status on admission and at time of discharge, summary of services delivered, reason for discharge, and provision for needed continuing care.

§ 405.1229 Condition of participation: Evaluation.

Section 1229 should follow Section 1222

The home health agency has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), home health agency staff, and consumers; or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

(a) *Standard: Policy and administrative review.* As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation. The data to be considered may include but are not limited to: number of patients receiving each service offered, number of patient visits,

at least annually

reasons for discharge, breakdown by diagnosis, sources of referral, number of patients not accepted with reasons, and total staff days for each service offered.

(b) *Standard: Clinical record review.* At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct services as well as services under arrangement). There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of treatment and appropriateness of continuation of care.

§ 405.1230 Condition of participation: Qualifying to provide outpatient physical therapy or speech pathology services.

(a) Section 1861(p) of the Social Security Act provides in pertinent part as follows:

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, a rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

* * * * *

The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

(b) As a provider of services, a home health agency may qualify to provide outpatient physical therapy or speech pathology services if such agency meets the statutory requirements of section 1861(o) of the Act and complies with other health and safety requirements prescribed by the Secretary for home health agencies, and, additionally, is in compliance with applicable health and safety requirements pertaining to rendition of outpatient physical therapy or speech pathology services. The applicable health and safety requirements pertaining to outpatient physical therapy or speech pathology services are included in the conditions of participation in Subpart Q of this part. (Sec. §§ 405.1717, 405.1718, 405.1719, 405.1721, 405.1722, and 405.1725.)

[38 FR 18978, July 16, 1973; 41 FR 20671, May 21, 1976]

APPENDIX—ADDENDA FOR SEVERAL STATES INCORPORATIVE CONDITIONS OF PARTICIPATION DIFFER THAN THOSE IMPOSED BY THE HEALTH INSURANCE FOR THE AGED PROGRAM

ADDENDA TO § 405.1227(d)

Pursuant to the provisions of section 1861 of title XVIII of the Act, there are approved the following higher conditions of participation relating to agency supervision applicable to those States identified below:

CONNECTICUT

Agency supervision—condition. The home health agency designates a physician or registered professional nurse qualified as a public health nurse director or nursing supervisor to supervise the agency's performance in providing home health services in accordance with the orders of the physician responsible for the care of the patient and under a plan of treatment established by the physician. The following qualifications apply to the supervisor and director:

(a) *Supervisor.* (1) *Towns having a population of more than 25,000.* The minimum qualifications for a nursing supervisor are a baccalaureate degree from a university program in nursing approved by the National League for Nursing for public health nursing preparation, and a minimum of 2 years of experience in a public health nursing program under qualified nursing supervision which included supervisory responsibilities.

(2) *Towns having a population of 25,000 or less.* Any nursing supervisor shall be at least:

(i) A registered nurse, licensed to practice in Connecticut, with 5 years of experience as a nurse in charge of a visiting nurse agency or other home health agency; or

(ii) A registered nurse, licensed to practice in Connecticut, with a baccalaureate degree in nursing and 2 years of experience in a visiting nurse agency or other home health agency.

(b) *Director.* Where a unit through which home health services are provided reaches a total nursing staff of 9 to 12, depending upon the number of towns involved and area served, a qualified public health nursing director shall be employed in addition to the nursing supervisor. The qualifications for the director are:

(1) *Preferred.* A master's degree with a major in public health nursing administration or supervision from a university program approved by the National League for Nursing, or a master's degree in public health from a university program approved by the American Public Health Association, and at least 5 years of experience in public health nursing, including 2 years under qualified supervision and 3 years as a supervisor.

(2) *Acceptable.* A baccalaureate degree from a university program in nursing approved by the National League for Nursing for public health nursing preparation, supplemented by approved courses in public health nursing supervision and administration, and at least 5 years of experience in public health nursing, including 2 years under qualified supervision and 3 years as a supervisor.

MASSACHUSETTS

Agency supervision—condition. The home health agency designates a physician or registered professional nurse qualified as a public health nursing director and/or supervisor to direct the agency's services. In the event that a physician is the administrator of the home health agency, the nursing service shall be under the direction of a registered professional nurse qualified as a public health nursing director and/or supervisor. All home health services shall be provided in accordance with the orders of a physician responsible for the care of the patient and under a plan of treatment established by such physician.

(a) *Public Health Nursing Director—qualifications.* The public health nursing director is currently licensed to practice professional nursing by the State and meets the following requirements:

A master's degree with a major in public health nursing administration or supervision from a program approved by the National League for Nursing or a master's degree in public health from a program approved by the American Public Health Association, and at least 5 years of progressively responsible experience in public health nursing or community health nursing, none of which should be in supervision, teaching, and/or consultation.

(b) *Public Health Nursing Supervisor—qualifications.* The public health nursing supervisor meets the following minimum requirements:

A master's degree in nursing from a program approved by the National League for Nursing and 1 year of experience in a family-centered public health nursing program which included supervisory responsibilities, or a baccalaureate degree from a program approved by the National League for Nursing for public health nursing preparation and 2 years of the above-described experience.

NEW JERSEY

Agency supervision—condition. The home health agency designates a physician or registered professional nurse qualified as a public health nurse director or supervisor to supervise the agency's performance in providing home health services in accordance with orders of the physician responsible for the care of the patient and under a plan of treatment established by such physician. In the event that a physician is designated to supervise the agency's services, the nursing service shall be under the direction of a registered professional nurse qualified as a public health nurse director or supervisor. The following are the requirements for qualifying as a public health nurse director or supervisor:

(a) *Director.* A public health nurse director has completed:

(1) A master's degree program accredited by the National League for Nursing with a nursing major in supervision, teaching, consultation or administration and advanced study in a clinical specialty; or a master's program in public health in an institution accredited by the American Public Health Association; and

(2) Five years of experience in public health nursing, 1 year of which shall have been in a supervisory experience.

(b) *Supervisor.* A public health nurse

supervisor has completed:

(1) A baccalaureate degree program approved by the National League for Nursing for public health nursing preparation or postbaccalaureate study which includes content approved by the National League for Nursing for public health nursing preparation; and

(2) Three years of experience in public health nursing under qualified nursing supervision.

NEW MEXICO

Agency supervision—condition. The home health agency designates a physician or registered professional nurse qualified as a public health nurse director to direct the agency's services. In the event that a physician is the administrator of the home health agency, the nursing service shall be under the direction of a registered professional nurse qualified as a public health nurse director. All home health services shall be provided in accordance with the orders of the physician responsible for the care of the patient and under a plan of treatment established by such physician.

Public Health Nursing Director—Qualifications. The nursing director must meet one of the following requirements:

(a) *Preferred.* A master's degree with a major in public health nursing administration, supervision, or specialty from a university program approved by the National League for Nursing or a master's degree in public health from a university program approved by the American Public Health Association; and with a minimum of 3 years of experience with a generalized public health nursing service under qualified supervision and with supervisory experience in a public health nursing agency.

(b) *Acceptable.* A baccalaureate degree from a university program in nursing approved by the National League for Nursing for public health nursing preparation supplemented by approved courses in public health nursing supervision and administration, and at least 3 years of experience in public health nursing, including 2 years under qualified supervision and 2 years as a supervisor.

ASSURANCE TO [illegible]

Pursuant to the provisions of section 1513 of title XVIII of the Act, there is approved the following higher condition of participation relating to the Advisory Group of Professional Personnel in the State identified below:

NEW JERSEY

Advisory group of professional personnel—condition. Persons carrying skilled nursing and other therapeutic services, and the professional health experts of other persons are established with the approval of and subject to regular review by a group of professional personnel which includes at least three licensed physicians and a registered profes-

[illegible] nurse, qualified as a public health nurse or otherwise as a public health nurse supervisor.

(c) *Composition of group.* (1) This group may be, for example: (i) An advisory committee to the agency's executive council or board of directors; (ii) a subcommittee of such council or board, or (3) other similar arrangement.

(2) *Term.* Number of members of the professional group and persons not employed by the agency.

(e) The physician members of the Advisory Group serve in relation with the County Medical Society and interpret agency medical policies to individual physicians.

(f) It is desirable for the group to include lay persons knowledgeable in health affairs and also to have a wide range of professional representatives such as social workers, rehabilitation speech, physical, and occupational therapists.

§ 405.1224 Standards for [illegible] services.

Pursuant to the provisions of section 1861 of title XVIII of the Act, there are approved the following higher conditions of participation relating to skilled nursing services in those States identified below:

Connecticut

Skilled nursing service—condition. Skilled nursing service is provided by or under the supervision of a public health nursing supervisor currently licensed by the State.

(a) *Professional nursing service—duties.* [The provisions of § 405.1224(a) are applicable.]

(b) *Public Health Nursing Supervisor—qualifications.* The public health nursing supervisor must have a baccalaureate degree from a university program in nursing approved by the National League for Nursing for public health nursing preparation, and a minimum of 2 years of experience in a public health nursing program under qualified nursing supervision which included supervisory responsibility.

(c) *Registered Professional Nurse—qualifications.* (See § 405.1202.)

(d) *Public Health Nurse—qualifications.* (See § 405.1202.)

(e) *Practical nursing—duties.* (The provisions of § 405.1224(b) are applicable.)

(f) *Practical Nurse—qualifications.* (See § 405.1202.)

Massachusetts

Skilled nursing service—condition. Skilled nursing service is provided by or under the supervision of a qualified public health nurse [illegible] and/or supervisor. (See § 405.1224(d) regarding qualifications.)

North Dakota

Skilled nursing service—condition. Skilled nursing service is provided by or under the supervision of a qualified public health nursing supervisor currently licensed by the State.

(a) *Professional nursing service—duties.*

APPENDIX C

A PROSPECTUS FOR A NATIONAL HOME CARE POLICY

STATEMENT OF THE PROBLEM

Home care is used throughout this document to make explicit the blend of health and social services provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or of minimizing the effects of illness and disability.

Home care must be an essential part of any effective plan to meet fully and economically the health and related social services needed by the American people.

Analysis of available studies and current use indicates that approximately 1.5 percent of the total population of the U.S. on any given day needs home care services, according to the ***Estimate of Home Health Needs,*** published in 1977 by the NLN Council of Home Health Agencies and Community Health Services. The formula used to arrive at this estimate of need was based on current knowledge of population trends, hospital discharge rates for people with and without chronic limitations, and utilization of home health services within the mix of the seven services now being funded through the Medicare program. However, the potential need for and the optimum use of home care have yet to be established through definitive studies. This is due to the fact that the necessary range of home care services has not been generally available through coordinated delivery systems.

Historically, the tendency has been for services to be developed in response to reimbursement policies. This has contributed to duplication, fragmentation, excessive costs, underutilization of preventive services, and other undesirable results.

An effective home care system does not now exist in the United States. The financing of home care, by both public and private payment agencies, varies greatly throughout the country. Current home

care laws and regulations are inadequate and, in many respects, unresponsive to the needs of the people. This situation has been documented in published authoritative reports and is evident in the disparity among the home care benefit entitlements in federal and state programs such as Titles XVIII, XIX, and XX of the Social Security Act, Titles III and VII of the Older Americans Act, and other government programs.

It is proposed that a home care system, as defined below, be developed to meet the home care needs of the people and that financial policies be established to give logical support to the system. In recognition of this basic view, the Assembly of Ambulatory and Home Care Services of the American Hospital Association, the National Association of Home Health Agencies, the National Council for Homemaker-Home Health Aide Services, and the Council of Home Health Agencies and Community Health Services of the National League for Nursing present this *Prospectus* for a national policy on the administration and financing of home care and call on the federal and other government entities and all other concerned organizations, agencies, and individuals to recognize and observe the principles for a home care system stated herein.

A HOME CARE SYSTEM

The objective of this prospectus is to encourage the establishment of a home care system that will operate according to professionally approved standards and that will serve and may be used by all individuals for whom home care is appropriate.

A home care system is a coordinated network of preventive, treatment, and maintenance services. All home care systems should include the essential elements stated in this document and must be integral parts of the total community health and welfare systems.

To ensure the availability, accessibility, acceptable quality, appropriate utilization, and financing of home care services, it is necessary to have an identifiable, effective, and efficiently administered system for providing home care in a defined community. Each community should be enabled to determine the particular administrative approach which will best serve the needs of its people.

The following conditions are essential to ensure in each community the effective delivery of services and an orderly continuum of care:

1. The system must be readily available and accessible to potential consumers and providers;
2. Uniform policies, standards, and procedures must be established and enforced for the administration, delivery, use, monitoring,

and evaluation of home care services; and

3. The home care system must ensure the availability of primary, secondary, and tertiary prevention and treatment services. (Secondary and tertiary treatment services include intensive, intermediate, and maintenance home care.)

Intensive, intermediate, and maintenance home care refer to categories of home care services which, according to each individual's condition and needs, are organized and coordinated by the provider primarily responsible for management of the care plan. The required health and social services are mobilized as necessary from various sources. The identity of the primary home care provider depends on the individual's dominant needs and the conditions governing effective case management.

- *Intensive home care* is provided to persons with serious illness whose medical condition is unstable and who require concentrated physician and nursing management. Such patients would normally require in-patient care if the professional, technical, ancillary medical services, personal care, and environmental supportive services needed were not readily available and professionally coordinated by the appropriate primary providers.
- *Intermediate home care* is provided to persons whose medical condition is not expected to fluctuate significantly as rehabilitation is achieved or the disease progresses. Such patients require professional health services and may also need personal care and other environmental supportive social services.
- *Maintenance home care* is provided to persons whose primary needs are usually for personal care and/or other supportive environmental and social services. The medical condition of such persons is generally stable and requires only periodic monitoring to ensure maintenance of an optimum state of health.

Rationalization of the home care system according to this conceptual framework is basic to its effective organization, administration, and financing as called for in this *Prospectus.*

Home care is applicable to primary, secondary, and tertiary prevention and treatment services, as described in ***Preventive Medicine for the Doctor and His Community*** by Leavell and Clark:

Primary prevention and care are directed to the apparently well population for the purpose of promoting general optimum health or the specific protection against disease agents.

Secondary prevention and care are directed toward early diagnosis and prompt and adequate treatment, as well as adequate treat-

ment to prevent sequelae and limit disability.

Tertiary prevention and care are directed toward rehabilitation and the prevention of further disability.

Individuals' needs for preventive health care and treatment in relation to their physical, emotional, and environmental situations are the basis for deciding whether or not home care is appropriate. The administration and use of home care should not be restricted by categories of disease, disability, age, prognosis, or financial resources.

Home care encompasses both the health and social services which, according to the particular needs and situations of individuals, are required either singly or in combination to care for persons in their homes when this is determined to be both desirable and feasible.

Elements of a Home Care System

Individuals in need of home care generally require professional guidance to establish the most effective plan of care. A home care plan must be authorized, supervised, and evaluated by appropriate professional personnel to ensure that the plan is timely and properly carried out and that the services provided comply with established standards of quality. Consumers of care at home are particularly vulnerable to exploitation. It is essential that providers of home care services comply with professionally established standards and be subject to regular external professional and financial audits.

Each community home care system should be based on continuous planning for necessary and orderly growth and development. Planning strategies should be responsive to gaps in service programs and unmet needs as they are identified. They avoid unnecessary duplication of services and of provider organizations.

Home care systems must also incorporate at least the following elements:

1. Home care services, which include:
   (a) professional assessment of health and social needs;
   (b) establishment of a plan of care;
   (c) professional preventive, treatment, and maintenance services;
   (d) professionally supervised personal care, environmental, and other supportive services; and
   (e) centralized professional coordination of all services included in an individual's plan of care when multiple services and/or providers are involved;
2. Formally arranged administrative and operational links among

provider organizations participating in the home care system;

3. Uniform guidelines both for the designation and role of the primary provider according to the individual's condition and plan of care and for the primary provider organization's professional and administrative responsibilities;
4. Participation of health care institutions, community health and social agencies, and individual professional practitioners to provide the full scope of preventive, treatment, and maintenance services;
5. Administrative policies that adhere to nationally recognized accreditation/certification standards; and
6. Arrangements for external monitoring and evaluation of the appropriate utilization, quality, and cost of the services provided, according to established professional standards and prudent fiscal policies.

Financing a Home Care System

Financing of the home care system must ensure that all persons for whom home care is appropriate will have timely access and entitlement to such services. An individual should not be denied home care because of diagnosis, disability, age, prognosis, or financial resources. Revenues for home care programs may come from public and private third-party payment programs, self-pay, and charitable and tax funds.

In order to create and maintain a financially stable home care system based on the principles stated in this *Prospectus:*

1. The financial requirements of home care provider organizations must be fully met on a timely basis and must include:
   (a) the direct and indirect costs (current operating requirements) of providing services to individuals;
   (b) training and educational expenses;
   (c) research, planning, and development expenses; and
   (d) capital requirements.
2. Payment to provider organizations in accordance with each purchaser's use of services. (Any apportionment that permits a purchaser to assume a lesser responsibility is not appropriate and does not alter the total financial requirements of the provider; rather, it requires other purchasers to make up the deficiency.)

CONCLUSION

The organizations that have prepared this *Prospectus* are committed to furthering the early and effective implementation of the principles set forth in this document. They call upon all concerned individuals, organizations, and governmental entities also to promote and support the development and expansion of home care systems based on these principles to ensure that home care services of an acceptable quality are available.

Assembly of Ambulatory and Home Care Services
of the American Hospital Association

National Association of Home Health Agencies

National Council for Homemaker-Home Health Aide Services, Inc.

Council of Home Health Agencies and Community Health Services
of the National League for Nursing

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Senator TALMADGE. Without objection, the subcommittee will stand in recess, subject to the call of the Chair.

[Whereupon, at 4 p.m., the subcommittee recessed, to reconvene at the call of the Chair.]

[By direction of the chairman, the following communications were made a part of the hearing record:]

STATEMENT OF CONGRESSMAN SAM M. GIBBONS, CHAIRMAN OF THE HOUSE WAYS AND MEANS OVERSIGHT SUBCOMMITTEE

Home health is a great idea that has simply gone wrong. Congress is now considering several proposals to expand the home health program under Medicare. Some of these proposals have considerable merit. But we cannot, in good conscience, endorse any of them, unless we also simultaneously do something to bring the home health program under control. Allowing expansion without additional controls would be tantamount to dereliction of duty.

I think I can best sum up the situation with two hypothetical stories that reflect our current situation.

The first is the story of an old, frightened man or woman who has been hospitalized and is anxious to return home to familiar surroundings and get away from the sterility of institutional care. But some care is still needed. If we can get this person out of the hospital, everyone will benefit. First the patient will be more comfortable. Second, the bill that the Federal government is paying will decrease. And third the hospital won't be providing its sophisticated services to someone who no longer really needs them. By providing home health services, we can bring this situation about. We have done so, with excellent results, thousands of times.

My second story involves a businessman who is looking for a lucrative investment. One day he visits with a promoter who tells him that a home health agency is the Holiday Inn or McDonald's franchise of the seventies. If the businessman will sign on, the promoter will provide everything needed, from the staff to the patients,

and start up capital can be borrowed, with the government paying the interest on this money. As President of the firm, the businessman can use a fancy car leased by the agency and paid for by the government. He can visit faraway romantic places and the government will pay. He can use staff nurses to beat the bushes for additional business and give solicitation gifts to hospital personnel. And he can sign a long term contract with the promoter to give him consulting services. And the government will pay for it all.

My goal is to make this second story an impossibility while preserving the benefits of home health services. We must determine how to provide the services to those in need and insure that the benefits accrue to them, not to investors.

How can we get from here to there? It is my contention that Congress has, in the past, been more generous than wise. We have tended to act more like philanthropists than accountants. The people want cash without controls and we have largely given the people what they wanted. The current attitude of austerity, however, is an indication that it's time for a change.

HEW responded to a Congressional mandate for reform suggestions by saying they didn't know enough to know how things should be changed. But HEW does know enough to support liberalization of the program and there are now no less than 15 bills before the Congress to do just that. I believe the two issues should be—must be—linked. There should be no liberalization without needed reforms to capture some of the additional costs. I support the idea of removing the hundred visit limit and the three-day prior hospitalization requirement but my support has a price.

That price is the imposition of needed controls.

For a start I believe that home health agencies should be required to have a rising percentage of non-Medicare patients and should be placed under a certificate of need program administered by local health systems agencies. The existence of too many providers in a given area tends to drive prices up notwithstanding any theoretical beliefs we may have about competition. I believe such requirements would raise the quality of care while lowering costs. We could also get rid of those home health aides my staff identified in Chicago whose sole training consisted of eight hours of observation. Patients deserve better than that.

In addition, we should require founders of home health agencies to post their own initial capital and the government should stop paying the costs of borrowed money used to start an agency. This will end the situation that currently exists where a home health operator overbills the government, collects the money, and then simply walks away, having no direct investment, when the government tries to recover overpayments.

We should allow and encourage the imposition of civil penalties on those agencies that do abuse the system. How else can we get rid of the situation in Chicago where nurses were pressured to understate patient progress so as to maximize the number of visits needed? I am sponsoring a bill in the House that would permit the imposition of civil penalties and I urge your support of this needed legislation.

There is also a need to take direct action on the question of costs. Now we operate on the "reasonable cost" basis which means that if all the home health agencies in an area give their personnel Cadillac limousines to make calls, then this is a reasonable cost that the government will pay. The Health Care Finance Administration is now proposing limits on costs per visit, but these limits are so high that I fear they will encourage the majority of agencies to raise rates and thus the limits will become a floor as well as a ceiling. Also needed are limits on individual expense items and given HCFA's past performance in this area, I think Congress should mandate such limits by a date certain.

We've also got to rein in the lawyers who seem to be getting more help than the patients from this program. As things now stand, providers can hire the finest—and most expensive—lawyers to contest HCFA rulings administratively and through the Federal courts. Whether the agency ultimately prevails or not, the government pays the lawyer's bill. I think it would be adequate to reimburse only through the administrative process and beyond that only in cases where the agency ultimately wins in court. In all cases, we should pay only reasonable legal fees.

The final point I have involves management consulting contracts that are really little more than franchise fees. These setups are particularly susceptible to abuse where the servicing group is really a related organization. Medicare intemediaries have been hamstrung in checking out such arrangements because they cannot get to the books of the servicing agencies to determine whether real services are being rendered for the fee. The Inspector General of HEW agrees with me about the need for such access.

That completes my list of major reforms needed. In a number of these areas, actions by HCFA are also needed and are long overdue, such as in establishing and enforcing minimum rules of supervision and training, guidelines for utilization review and audit coverage, and reimbursement policies on management contracts and related organizations. I hope my laundry list does not convince you that the home health program is a bad one because it it not. If I believed it were, my statement would be much shorter and I would simply recommend that the program be abolished. Rather, it is my hope that this list will convince you that presently, abuse of the program is typical, widespread and in fact scandalous. The program is a good idea and the services are needed. I want the program preserved and strengthened.

The Oversight Subcommittee of the House Ways and Means Committee, which I chair, has documented the abuses I am discussing. If we don't stop them they will grow. If they grow, they will become like a pervasive cancer and make it impossible to save the program itself. It is still early enough for legislative surgery that will leave the program with an excellent prognosis for recovery. If we wait too long, though, this option may become an impossibility.

Thank you.

STATEMENT OF THE TENNESSEE SOCIETY OF HEALTH CARE SOCIAL WORKERS

From: Jean A. Cohen, M.S.S.W., Legislative Chairman
Subject: Home Health Services

The Tennessee Society of Health Care Social Workers represents approximately 175 members who are engaged in the provision of social services in health care facilities or who have a concern for the delivery of such services. We are actively involved with home health services as a viable alternative to institutionalization and as a mechanism that can limit the cost of health care.

We appreciate the opportunity to provide input to the Committee on this area of vital interest to us. We would like to point out to the Committee some areas in the present program presenting problems from our perspective. They are listed below:

1. Inequities of the services provided under Medicaid compared to those available through Medicare.
2. Conflict of interest by persons who make referrals and who are sometimes providers of services for which they are reimbursed.
3. Accountability of agencies providing home health services.
4. Services not being provided at the most economical level.
5. Home health services not always ensuring continuity of care from hospital level to the community level and vice versa.
6. Coverage being contingent upon services such as skilled nursing, physical therapy, and speech therapy while patient's needs may be better met through services from home health aides, occupational therapists, and medical social workers.
7. Insufficient or inappropriate coverage presently available resulting in the need for an expansion of coverage definitions with efforts to authorize lower levels of skills if they meet patient needs.
8. The rates of reimbursement being often inappropriate and not commensurate with services delivered.
9. Present program not permitting sufficient coverage to maintain patient's level of functioning and possibly preventing need for re-hospitalization.
10. Service delivery emphasis reflecting sometimes a philosophy of quantity rather than quality.

We again thank you for giving us the opportunity to share these concerns and will remain interested in the outcome of the hearing.

MEMORANDUM FROM THE INSTITUTE ON LAW AND RIGHTS OF OLDER ADULTS, BROOKDALE CENTER ON AGING OF HUNTER COLLEGE

From: Sam Sadin, Executive Director, and Julia Spring, Senior Staff Attorney
Re: Provision of Home Health Care Under Medicare

In New York City, elderly persons whose income and resources are above the eligibility line for medical assistance are often forced into institutions for lack of personal home health services which would allow them to remain in their own homes. This is so because the local practice is to limit Medicare home health services to twenty hours a week, despite the fact that the elderly are clearly entitled to more extensive home health care as recipients of Medicare.

An examination of the statutes, regulations, and HCFA manuals governing Medicare service mandates and reimbursement criteria, shows that such an hourly limitation is not required, and, in fact, that more liberal provision of home health services is permitted. The Social Security Act places only the qualifying word "intermittent" as a time limit on the services of professional nurses or home health aides (42 USCA 1395f (a)(2)(D)). The Code of Federal Regulations states that 100 visits are reimbursable under each Medicare Part, and adds the phrase "part-time" to "intermittent" (42 CFR 405.238; 42 CFR 405.234 (a) and (d)). The Home Health Agency Manual states that 20 hours weekly is the average for Medicare home health care case, but allows for circumstances in which up to 40 hours a week of professional or home health aide nursing are reimbursable. Examples of such circumstances are need for orientation to health care routines, a relapse not necessitating hospitalization, and a terminal condition. Home health agencies do not have to justify this extensive assignment of nursing employees until the number of hours reaches 40 hours a week of professional nursing care or 100 hours a month of home health aide care (HIM-11 § 204.2).

Why, then is less than this amount of care being provided to Medicare recipients? The practice of limiting time seems to stem, at least in part, from the fact that home health agencies pay their nursing employees in hours, but are reimbursed under the regulations cited above, on the basis of visits. The Home Health Agencies Manual specifies that "regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one 'visit' is counted for each such day" (HIM-11 § 218.2). Understandably, then, the provider and/or the intermediary have an economic incentive to limit the number of hours of service in order to ensure reimbursement that reflects the actual amount paid. Similarly, home visits by professional nurses to evaluate the need for and provision of home health aide services are mandated by the regulations (20 CFR 405.1227a)), but the cost must be borne by the home health agency rather than being reimbursable as a visit. (HIM-11 § 218.3) Again, then, the reimbursement requirements below the statutory level create an incentive for limitation rather than expansion of home health care.

In order to ensure that elderly Medicare recipients, who have earned their entitlement to medical care through their history of productive labor, Congress could mandate any of the following in the Social Security Act:

1. That when actual visits exceed a certain length of time, more than one reimbursable visit be permitted under Medicare;
2. That a Medicare home health agency be reimbursed for evaluation home visits by professional nursing personnel;
3. That Medicare reimbursement be by easily quantifiable service hours, not visits;
4. That the limitation on hours or visits be eliminated so that home health care is provided for the individual Medicare recipient as medically prescribed.

Statement of United Cerebral Palsy Associations, Inc., and National Association for Retarded Citizens

Introduction to Home Health Services and the Developmentally Disabled

United Cerebral Palsy Associations, Inc. and the National Association for Retarded Citizens commends the Senate Subcommittee on Health of the Committee on Finance for reviewing the provisions of home health benefits under the Medicare and Medicaid programs.

From our perspective the goals of home health services are twofold: to enhance the opportunities for disabled individuals to achieve functional autonomy to the greatest extent possible, and to maximize their participation in the daily activities of their families and communities. These goals—independent living and integration into the community—have not been fully met within the context of existing legislation, due in large measure to the chronic fragmentation of the health and social service delivery systems and the resulting lack of coordination in the delivery of home health services among state and local agencies. Nonetheless, it is becoming increasingly evident that despite its administrative difficulties the home health concept is one of the most promising long-range components of the deinstitutionalization process currently available at the federal level.

UCPA and NARC generally accept the definition of home health services used by the Wisconsin Community Care Project: services "include assistance with personal care (including attendant care), hygiene, prescribed exercises, medication, and incidential household services, such as meal preparation, shopping, and light housekeeping."

Medically oriented home health services for the developmentally disabled generally include such activities as bowel and bladder programs, changing bags and other devices, skin care, turning and lifting support, and oral medication supervision. Attendant care services generally include getting the individual in and out of bed; giving baths, showers, and shampoos; combing, brushing, and setting hair; and dressing and undressing the individual. Personal assistance is greatly needed because of the restricted self-mobility of many individuals with disabilities. Homemaker services generally include general household management such as meal preparation, child care, and routine household care provided by a trained homemaker. Home management services generally include instruction in child care, home maintenance, meal preparation, financial management, and consumer education.

In a simplistic way, persons severely disabled with cerebral palsy generally require the medically oriented services and the attendant care/personal care services as primary considerations while mentally retarded persons in general primarily require the homemaker/home management services. Since there is a great amount of multiple handicaps with the developmentally disabled (for example, an estimated 50% of the 750,000 persons with cerebral palsy are mentally retarded) a comprehensive package of home health services are required.

The Congressional Budget Office 1977 study, "Long Term Care for the Elderly and Disabled," has estimated that there are between 1.3 and 1.7 million chronically disabled persons who need but are not receiving congregate housing services, which are home health services as defined by the Wisconsin project. The Social Security Administration has projected that the annual cost of maintaining an individual in a nursing home is 5.5 times greater than the cost of providing home services in a congregate setting. And Gordon K. MacLeod in "Ten Commandments for Home Health Care" (Washington Post, January 3, 1979) has declared that "it has been shown again and again that somewhere between 20 and 40 percent of institutionalized persons could benefit from less expensive in-home programs."

PROBLEMS WITH HOME HEALTH SERVICES UNDER EXISTING FEDERAL PROGRAMS

A number of fundamental difficulties in implementing home health services for persons with developmental disabilities under existing Federal programs have yet to be adequately addressed either by Congress or the Health Care Financing Administration.

Significant problems include:

Lack of emphasis upon developmentally disabled individuals

The special needs of persons with developmental disabilities have not received adequate recognition in the authorizing legislation or in subsequent regulations issued by HEW concerning the delivery of home health services under Medicare and Medicaid. While the elderly and medically indigent have been specified as target groups for home health services, and funds allocated preferentially to catchment areas in proportion to the numbers of elderly and medically indigent they contain, no similar provisions has been made for persons with development disabilities, although it is obvious that they would constitute prime, ongoing consumers of such services. As a result the availability of a home health agency serving persons with developmental disabilities is contingent upon the geographical accident of their residing in an area in which large numbers of elderly or medically indigent individuals are present.

A corollary problem is that of inappropriate service options, including both the lack of those services of greatest utility to persons with developmental disabilities, and the unavailability of home health personnel outside the traditional 8 a.m.-5 p.m. work day. Thus, for example, while an individual with cerebral palsy might only require personal care services early in the morning and before retiring at night, he or she might well be unable to find a home health aid available to deliver services at those hours. Similarly, the services delivered by home health agencies are generally geared more toward acute than chronic care, resulting in an overabundance of skilled nursing personnel and a relative shortage of paraprofessional aide/attendant service. These problems are cited in Gerben DeJong's April 1977 study "The Need for Personal Care Services by Severely Physically Disabled Citizens of Massachusetts" published by the Levinson Policy Institute, Brandeis University, Waltham, Massachusetts.

Inadequate funding

Under the Administration's proposed F.Y. 1980 budget only $850,000 has been allocated to support home health service delivery, training, and expansion in the ten HEW regions, a figure grossly inadequate to meet the needs of all individuals

identified as requiring home health care, much less those who have yet to enter the system in the wake of improved case-finding and access to care.

Disincentives for noninstitutional alternatives

Medicare and Medicaid are currently structured to make it much easier to obtain in-patient services in a medical facility than in a noninstitutional setting. Benefit structures and federal matching rates provide incentives for the continued development and expansion of institutional services. These problems have been fully documented in the Government Accounting Office 1977 report "Returning the Mentally Disabled to the Community: Government Needs To Do More," in the Congressional Budget Office 1976 report on "Long-Term Care for the Elderly and Disabled," and in the various draft reports and proposals of DHEW's Task Force on deinstitutionalization between 1977 and 1978.

Medicare limitations

Medicare is by far the largest third-party payor of home health services yet the program contains numerous restrictions on home health care which effectively excludes a large proportion of developmentally disabled persons, particularly those requiring home based services. These limitations include:

(1) Three-day prior hospitalization requirement;

(2) Benefit period requirement whereby services can only be offered within one year of a hospital or skilled nursing facility stay;

(3) Condition-related requirement whereby home health services can only be offered for the same condition for which the person was hospitalized;

(4) Physician plan of treatment requirement whereby home health services can only be authorized by a physician;

(5) One hundred visits during a year limitation; and

(6) One hundred hour limit on personal care per month.

Medicaid limitations

Most severely disabled persons are eligible for Medicaid by reason of their receipt of Supplemental Security Income and yet they remain ineligible for home health services because of the way Medicaid benefits are structured federally.

Medicaid regulations require that in order to qualify for home health services an individual must demonstrate a need for skilled medical care. Yet many persons with developmental disabilities do not need this advanced level of care in order to have their physical requirements appropriately met. The services of a home health aide, for example, might be sufficient for them to function optimally in a home environment. Under current restrictions, however, they would be barred from receiving home health care.

The great disparity among states in the types of home services provided under Title XIX creates considerable problems in attempting to monitor the quality of care on a nationwide basis. The problem is compounded by the fact that state licensure requirements for home health agencies vary widely, and as HEW has not yet required home health agencies to acceed to certificate of need regulations (whereby they would have to demonstrate the need for and quality of services provided in order to come into being or expand), there exist virtually no mechanisms for insuring the quality of services.

UCPA/NARC LEGISLATIVE RECOMMENDATIONS FOR HOME HEALTH SERVICES PROMOTION

The federal government should make a national commitment to financing the promotion, development, organization, and delivery of home health services including specific recognition of the needs of the developmentally disabled as a primary target population.

The federal government should facilitate, in full partnership with all appropriate national interests, the development of a set of principles for home health services. Such a statement of principles should recognize the specific health care needs and home service needs of the severely disabled.

Home health benefits under Medicare and Medicaid should be broadened into a rational and effective national financing approach in order for developmentally disabled persons to receive needed and appropriate services. Such benefit changes should include:

(1) Remove the requirement that home health care be predicated on the need for prior hospitalization, skilled nursing, occupational therapy, or physical therapy;

(2) Limit allowances for home health care realistically in terms of hours of care provided rather than the number of visits allowed, thus permitting some daily care;

(3) Specifically provide for coverage of personal care, including attendant care, subject to appropriate prescription and supervision in both Medicare and Medicaid;

(4) Specifically allow coverage of occupational, physical, and speech therapy as qualifying services for home health services, subject to appropriate prescription and supervision in both Medicare and Medicaid;

(5) Recognize non-profit community agencies which provide specialized services to narrowly defined populations (rather than global home health agencies which must provide comprehensive services to all persons) as Medicare/Medicaid home health service providers; and

(6) Develop nationally recognized standards to insure service quality and appropriateness of care. Such standards, developed in full partnership with all appropriate national interests, should recognize the specific health care needs of persons with developmental disabilities.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (AHA), which represents more than 6,100 member institutions and over 30,000 personal members, appreciates this opportunity to present our views and recommendations on the provision of home health benefits under the Medicare and Medicaid programs.

The AHA believes that home health services can contribute to the health and well being of patients and their families; restore patients to health and/or maximum function; reduce incentives for inappropriate admissions to hospitals; and make possible earlier discharge from hospitals, skilled or intermediate care facilities, or nursing homes. By providing an extension to acute inpatient care, high quality home health services can perform a vital role in our health care delivery system ensuring that patients receive care in an economical manner and at a level commensurate with their medical needs.

The AHA has given the establishment of hospital-sponsored home care programs a high priority. In 1978 the Association established the Center for Ambulatory and Home Care, which in addition to its other functions, serves as a focal point for consideration and promotion of hospital-sponsored home health programs, as well as encouraging hospital linkages with free-standing home care programs. We are also participants in the council on accreditation of such programs of the Joint Commission on Accreditation of Hospitals.

Hospitals serve a dual role in the provision of home health services, contributing both as direct providers of care (through such services as nursing, physical and occupational therapy, nutrition, speech therapy, and social services) and in a support capacity. Hospitals provide important backup resources to community home care programs, including the following: X ray, laboratory, medical equipment, and pharmacy services; medical, nursing or other therapeutic consultants; and administrative services, home care coordination, or physical facilities.

A recent AHA survey indicates that the number of hospitals with home care departments more than doubled between 1972 and 1978; nevertheless, comprehensive home health services remain unavailable to many citizens despite the therapeutic and physical advantages which can be realized by caring for patients in their home settings. The need for extension of home care is urgent because existing comprehensive home health services are reaching less than the full target patient population. Currently, 653 counties, with an aggregate population of approximately 9 million persons, do not have Medicare-certified home health agencies.

In a report to Congress by the Department of Health, Education, and Welfare (HEW) of April 17, 1979, on home health services under Titles XVIII, XIX, and XX, this critical shortage was recognized. The report stated "as a result both of reimbursement restrictions in public programs and of the nature of home care providers, expansion of service has not occurred rapidly over the past decade in the nation as a whole." Acute needs were cited in rural and low-income areas; and, in fact, an alarming statistic cited in the report is that home health services are available to less than 70 percent of the Medicare beneficiaries who reside in non-metropolitan areas. Only in metropolitan counties is the availability of home health agencies nearly universal. Therefore, even though the findings of the AHA survey indicate that hospital-administered home care programs have increased, and that these programs supply a wide range of home services, hospitals must be encouraged to develop these programs to their full potential in order to meet increasing demand from a growing aged population.

SPECIFIC HOME HEALTH ISSUES

The AHA strongly supports legislative proposals to remove arbitrary barriers to the most efficient and appropriate use of health care services such as presently imposed by the three-day prior hospitalization requirement for home care services

under Part A of Medicare and by the 100-visit limit for home health services under Parts A and B of the program.

Some costly inpatient care may be avoided if home care is more widely available. The three-day prior hospitalization requirement artificially impedes the use of home care in its most efficient and effective mode. For example, a patient's physical condition may change or deteriorate short of requiring hospitalization, and under these circumstances, medical management aimed at stabilizing or improving the condition can often be accomplished in the home, thereby avoiding more costly and disruptive inpatient care. Currently, this approach is discouraged by the three-day rule.

Moreover, since Part B of Medicare currently does not require prior hospitalization for a patient to receive home care benefits, this indicates recognition of the concept that home care does not have to be preceded by hospitalization. It is contradictory and inequitable that Medicare impose different eligibility criteria for home health benefits under Part A and B.

In addition, we believe home care should not be viewed narrowly as a continuation of acute care. Senator Lawton Chiles, in supporting this view, stated that removing the three-day prior hospitalization requirement would "change the prevalent image of home health care as simply a continuation of acute, inpatient hospital care to the community service it is intended to be."

The 100-visit limit is also unduely restrictive and disruptive in managing the are of chronically disabled patients. It forces either the cessation of the home care service or costly and unnecessary hospitalization to reestablish eligibility for home care benefits. While it has been demonstrated that very few patients exceed the visit limits, those that do are frequently severely disabled, or are patients requiring long-term medical supervision. Repeal of the 100-visit rule could result in avoidance of hospitalization for these types of patients.

AHA therefore recommends that both the three-day prior hospitalization requirement under Part A and the 100-visit limitation under both Parts A and Ba of Medicare be eliminated from the program. The Association strongly supports S. 489, to the extent that it incorporates provisions to accomplish this desirable result.

We also support the proposal included in S. 489 for monitoring changes in utilization patterns and increased costs as a means of dealing with program fraud and abuse. In addition to such a plan, we believe the potential for fraud and abuse can best be addressed through enhanced quality review programs and effective enforcement of program standards and operating procedures.

ADDITIONAL ISSUES ADDRESSED IN S. 489

We would like to take this opportunity to address additional issues raised in S. 489.

The AHA supports the inclusion of occupational therapy in the home as a primary service, not as a secondary service as current law provides. Further, under existing Medicare regulations, reimbursement for occupational therapy services is only possible if the patient is already receiving physical therapy and/or skilled nursing services.

The need for occupational therapy should not be treated as secondary to nor contingent on a patient's need for skilled nursing or physical therapy. Occupational therapy services are directed toward helping the patient become independent through adaptation to the home environment, teaching the patient as well as his or her family to adapt the home environment to minimize the effects of the patient's disability, and assisting a patient in reacquiring or relearning job skills or developing new skills. Occupational therapy services frequently are required independent of the need for nursing or physical therapy services. The present reimbursement system promotes the inappropriate extension of nursing or physical therapy services in order to satisfy the patient's actual, continuing need for occupational therapy.

It is critical to the effective management of home care programs that reasonable operating expenses as well as the unique characteristics of different types of home health agencies (public, Visiting Nurse Association (VNA), hospital-sponsored, proprietary, etc.) be taken into consideration in evaluating the costs of the programs and the impact that legislation would have on them. We believe it is essential the reported financial data accurately reflect the actual cost differences of various types of home health agencies.

We support the further recognition in S. 489 of the role of physician assistants, nurse practitioners, and other allied health practitioners in providing home health services. This provision is particularly important to the increased availability and cost-effectiveness of home health services in rural areas, since many categories of

health manpower (e.g., physicians, registered nurses) are often in short supply in such areas.

While we agree that necessary administrative controls must be in place to assure that program abuses do not occur, we oppose the requirement in S. 489 that only regional home health intermediaries may be designated to serve home health agencies. We recognize the need for qualified intermediaries for home health services, but strongly believe that hospitl-based home care programs should be able to use the same intermediary for such services that they use for inpatient and ambulatory care services. The experience and working knowledge which presently exists between providers and intermediaries is conducive to the efficient and effective monitoring of costs and the assurances of high quality care. This advantage could be lost if hospitals were forced to deal with a separate regional intermediary for its home care program and another intermediary for hospital services.

Using a second intermediary for home care would require that the Medicare cost report be audited by two intermediaries, thereby necessitating dual auditing and reciprocal agreements on acceptance. This could lead to conflicts in determining which intermediary would prevail if the two intermediaries involved did not agree. In light of such concerns, we oppose the mandatory utilization of regional home health intermediaries for hospital-based programs.

The AHA supports the utilization of demonstration projects to test the effectiveness of agency or multi-agency providers. It also supports the implementation of utilization review mechanisms as incorporated in S. 489. Periodic review of utilization is essential to the quality control of home care programs and to ensure the medical necessity, cost efficiency, and appropriate use of those programs.

PROVISIONS OF S. 421

We support the provision in S. 421 to provide for demonstration projects for the training and employment of eligible participants as homemakers or home health aides. However, while the administration of the projects would rest with the state health agency designated by the governor of each state—generally the agency responsible for the administration of the state plan for medical assistance under Title XIX (Medicaid)—AHA strongly recommends that the training programs be administered and conducted by existing home health agencies or home care programs and not by the Medicaid state agency. Accordingly, the trainees supported by this bill would be included in existing training programs, and the establishment of separate state programs would be avoided.

In addition, we recommended that the program provide ongoing educational "refresher" programs at regular intervals. Moreover, the program content or credits should be developed so that participants can gain entry into licensed practical nurse (LPN) or registered nurse (RN) education programs; through use of existing training programs, performance of the students may be better evaluated. This can avert the placing of incompetent aides or homemakers in the delivery setting.

COMMENTS ON REGULATORY ISSUES

We would like to take this opportunity to comment briefly on two additional issues which are of concern to AHA and administrators of home health programs—the regulations promulgated by HEW's Health Care Financing Administration (HCFA) to limit home health agency reimbursement per visit and the H.R. 3 Report.

In our comments on May 7, 1979, to HCFA Administrator Leonard Schaeffer regarding the proposed limitations on home health agency reimbursement, we focused attention on the potential adverse and inequitable impact of the limitations on certain home health agencies. The AHA shares HCFA's concern over the rising costs of home care that are not attributable to demand for service or inflation, and we support efforts to moderate cost increases. However, the final regulations issued June 1, 1979, limiting home health reimbursement do not recognize or respond to the AHA's expressed concerns. For example, the methodology used by HCFA in developing the limitations for home health reimbursement does not allow for legitimate program cost differences. These differences are caused by such key factors as regional labor cost variances, state and local regulations, utilization of different accounting procedures by Medicare certified home health agencies, the Medicare mandated "step-down" cost allocation system in hospital-based home care, and differences in services and intensity of patient care provided by individual programs.

It is very important that payment limitations accurately recognize legitimate cost structure differences among home health agencies. A soon-to-be-released study on home health services suggests significant differences in the service intensity and case mix of free-standing agencies and hospital-based home health departments. In

addition, the reimbursement of home health agencies on a cost basis provides no opportunity for the agency to accumulate front end capital to expand services or serve additional patients. At a time when home health services are playing an increasingly significant role in the health care system, it is of great importance that regulation not impede this development and expansion but, rather facilitate effective management and needed extension of home care.

The second issue we wish to address is the recently completed HEW study required by Section 18 of Public Law 95-142, the Medicare and Medicaid Anti-Fraud and Abuse Act of 1977. The law requested the Department to submit a report to Congress "analyzing, evaluating, and making recommendations with respect to all aspects . . . of the delivery of home health and other home services. . . ." In our review of the final report submitted on April 17, 1979, entitled, "Home Health Services Under Titles XVIII, XIX, and XX" (H.R. 3 Report), we were disappointed at the lack of attention given to certain critical issues and at the absence of specific legislative recommendations. The HEW report stated that these gaps were based on "budgetary restraints and the need for more knowledge and experience before proposing programmatic changes." However, no regulatory recommendations were made, and few administrative changes were targeted for implementation or further study.

If the H.R. 3 Report had been responsive to the mandate of Congress, it could have provided a much needed overview, a framework for the analysis of what currently is happening in the field, and appropriate future directions which should be pursued at this time of growth and increased emphasis on home health services. Such an overview could provide a much needed step in drawing together in the disparate areas of concern in home health care. However, the H.R. 3 Report—at considerable expense—only proposes for Fiscal Year 1980, "a major research effort in the in-home services." It does very little to propose changes in the Medicare and Medicaid programs to improve home health services for these beneficiaries.

CONCLUSION

We enthusiastically support proposed legislative initiatives directed toward the improvement and expansion of home health services to provide appropriate care in an economical manner in line with a patient's particular need. We appreciate the opportunity to present our views. We would be happy to discuss these issues and any possible solutions with the Subcommittee and its staff, and would be pleased to provide any additional information.

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.,
Rockville, Md., May 31, 1979.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Committee on Finance, 2227 Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the American Occupational Therapy Association I congratulate you and your Subcommittee on your efforts to improve the Medicare and Medicaid home health care program. I also appreciate the opportunity to submit this testimony and I request that both this letter and the attached statement be included in the record of the Subcommittee's home health hearings on May 21 and 22 of this year.

I realize the substantial number of requests to testify which you must have received. I regret, however, that our Association was not permitted the opportunity to appear personally before you, especially in light of the attention accorded to S. 489, which includes the occupational therapy home health provision, and your own questions concerning the benefits which would derive from permitting coverage for occupational therapy as a primary service. Although I was greatly encouraged to learn of the overwhelming testimony in favor of this proposal, I was seriously dismayed by the very inadequate response of two witnesses who were questioned about occupational therapy.

I can understand that the response of one of the witnesses was made more difficult because of her lack of familiarity with occupational therapy, a fact which she stated orally and which was evident from her written testimony since her agency only recorded six occupational therapy visits under Medicare for FY 1978. The other witness gave no indication of her knowledge of occupational therapy, nor did she provide any substantive rationale for her opinion that it should not be covered as a primary service. The opinion of this witness, moreover, was in direct conflict with earlier statements in support of this proposal offered by Senators Dole, Chiles, Domenici and Leahy, and representatives from the National Association of

Home Health Agencies, the National Senior Citizens Council, the National Association of Retired Teachers/American Association of Retired Persons, and Ms. Hope Runnels, Director, Visiting Nurse Association (Portland, Oregon).

I would like to take this opportunity, Mr. Chairman, to respond to the questions you raised by describing specifically the types of patients and treatment conditions which could require only the services of an occupational therapist under the Medicare home health benefit. The usual Medicare coverage criteria would apply to all of these conditions. These criteria include prescription by a physician, provision of the service by a qualified occupational therapist and the expectation that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time.

The following patients and conditions might require only the home health services of an occupational therapist:

The patient who has been ambulatory and functioning independently in her home calls her physician because she is no longer able to walk safely and has fallen several times. The physician determines that she has decreased knee and ankle motion bilaterally due to accelerated osteoarthritic changes. The physician orders a home health occupational therapist to design and fabricate night resting splints to increase knee and ankle motion and prevent further deformity. Without these splints, the joints will permanently lose range of motion, and the patient may never walk again. The physician's alternative to occupational therapy in the home is admitting the patient to a hospital or transporting her by ambulance to the occupational therapy outpatient department of the hospital.

A person who has a brainstem stroke often experiences generalized weakness, inability to swallow, and impaired oral function. After the physician evaluates the patient, the occupational therapist uses specific treatment techniques to control the drooling and facilitate swallowing. The occupational therapist also works with the family members to teach them ways of assisting the patient to improve swallowing skills. Again, only the occupational therapist is needed to decide the appropriate treatment program or determine the length of treatment required.

The diabetic wheelchair-bound patient with bilateral above-knee amputation, partial blindness, and decreased sensation in her hands due to diabetic neuropathy has been discharged from home health physical therapy soon after she was independent in wheelchair transfer techniques. She needs the continued services of an occupational therapist to teach her an acute awareness of her sensory deficits and compensatory techniques to overcome her partial blindness and poor hand sensation. Without the occupational therapy program, complications such as accidental burns in the kitchen and decubiti can easily occur.

The homebound patient with chronic lung disease and subsequent weakness, decreased endurance, and a continuous need for oxygen has difficulty performing daily functional activities. She is unable to pace her activities with her limited breathing capacity, and her physician has ordered occupational therapy to see if an energy conservation program will allow the patient to perform the necessary daily activities to remain at home and avoid nursing home placement.

The patient with a long history of multiple sclerosis is experiencing increased difficulty with coordination due to spacticity and is no longer able to feed herself. She needs an occupational therapist to decide whether adaptive equipment would allow her to regain independence. Only the occupational therapist is skilled in assessing and providing this type of equipment, and no other service is necessary.

These are but a few of the many situations in which only occupational therapy is needed. I hope these brief descriptions serve to clarify the benefits which would accrue to Medicare beneficiaries and the significant need for coverage of occupational therpy as a primary home health service. The types of patients described above need occupational therapy, and frequently only occupational therapy, as an integral part of their rehabilitation treatment program. The current law often frustrates efforts to meet this very real medical need which Medicare beneficiaries have. As a result, debilitating conditions are prolonged and sometimes become permanent; longer and more expensive institutional care is encouraged; and additional services of questionable necessity are continued so that occupational therapy may be provided on a covered basis.

Mr. Chairman, the Finance Committee has unanimously supported making occupational therapy a primary home health service on two occasions in the past. Likewise, the full Senate has three times voted in favor of this provision. I strongly urge you to reaffirm this past support and incorporate the provision into your current Medicare proposals.

I appreciate the opportunity to offer these comments. If I can provide any further clarification or information, I will be more than willing to do so.

Sincerely,

MAE D. HIGHTOWER-VANDAMM, OTR, FAOTA,
President, American Occupational Therapy Association.

Attachment.

STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The American Occupational Therapy Association and its 27,000 members strongly support the Health Subcommittee's efforts to improve home health care under the Medicare and Medicaid programs. Home health care is frequently both more efective and less costly than treatment provided in an institutional setting. The rehabilitation of individuals receiving treatment at home frequently progresses further and faster because of the psychological benefits which surround the provision of care in a familiar setting. Administrative and overhead costs, moreover, do not reach the same high level as those which institutions must apportion to each patient's bill. For these and other reasons related to improving the quality and efficiency of our health care system, it is clearly evident that Congress should assign a high priority to the development and implementation of a comprehensive home health care program.

Through its present hearings, the Health Subcommittee has taken a significant step towards achieving such a goal. By focusing attention on recommendations to correct some of the current problems with home health care, the Subcommittee has begun to lay the foundation for an effective program. Several important improvements are contained in pending legislation and have been frequently addressed by witnesses before the Subcommittee. Among the recommendations which the American Occupational Therapy Association especially supports are removal of the prior hospitalization requirement under Part A, elimination of the limitation on number of visits under both Parts A and B, liberalization of the interpretation of the homebound requirement and the provision permitting coverage for occupational therapy as a primary home health service.

Many sound arguments have already been advanced in support of the first three proposals mentioned above. The American Occupational Therapy Association, therfore, will concentrate its testimony on occupational therapy and the need for primary service coverage of this service in the home setting. It should be noted, however, that enactment of all of these proposals will improve access to needed service provided under quality conditions in less costly settings.

Coverage for occupational therapy as a primary home health service

This proposed amendment will help provide some of the services needed by the 7.7 million persons now living at home who are limited in their daily life activity because of a chronic medical condition. It will also aid in reducing the number of institutionalized persons who, given appropriate access to necessary treatment, could be removed from the institution to the home. Specifically, the provison will permit approximately 25,000 Medicare beneficiaries who need occupational therapy, and are not now getting it, to receive this service. It will also prevent the return to a hospital or nursing home for those beneficiaries who degenerative conditions were stabilized as a result of the timely provision of this necessary service.

This provision is currently included in S. 489, the home health legislation introduced by Senators Domenici, Packwood, Chiles and Leahy. It is also contained in S. 350, the national health insurance bill introduced by Senator Dole.

This provision, together with a proposal which would permit coverage for occupational therapy in approved freestanding outpatient settings, has unanimously passed the Finance Committee on two occasions in the past and been adopted by the full Senate three times.

The provision is also currently contained in House legislation, H.R. 4063, introduced by Representative Lindy (Mrs. Hale) Boggs and cosponsored by 51 members of the House of Representatives.

The practice of occupational therapy

Occupational therapy is a health profession which has its foundation in the medical management of patients. The service is provided to persons of all ages who are physically, psychologically, or developmentally disabled. It includes the functional evaluation and treatment of several different types of patients including those suffering from strokes, heart attacks, arthritis, diabetes, serious burns, spinal cord injuries, and psychiatric disorders. The purpose of occupational therapy is to direct these patients to achieve a maximum level of independent living by developing those capacities which remain after disease, accident, or deformity.

The occupational therapists's initial focus is on treating that pathology or those impaired functions which preclude independence and productivity. Occupational therapists evaluate and treat:

Impaired muscle strength, range of motion, and physical endurance;

Impaired eye-motor coordination, sensory integration, and motor planning;

Impaired concentration, attention span, thought organization, and problem solving;

Impaired visual-spatial relationships, body schema, figure-ground discrimination.

Occupational therapists also seek to inhibit muscle atrophy, minimize deformity, and increase pain tolerance. They are also vitally concerned with the psychological impairments which frequently result form the patient's illness or trauma.

The treatment modalities used by occupational therapists are those which, in addition to reducing specific pathology or impairment, will simultaneously help the patient learn to apply the newly restored or impaired function to the demands of daily living, thus speeding recovery and an early return to a more independent life.

In summary, occupational therapists use selected rehabilitative tasks to reduce specific pathology or impairment and help individuals achieve independence.

Occupational therapists provide services in rehabilitation centers, through home health agencies, in acute care hospitals, long and short-term psychiatric facilities, skilled nursing facilities, outpatient clinics, community mental health centers, tuberculosis hospitals, day care centers, and private and public school systems.

Occupational Therapists, Registered (OTRs) carry professional and administrative responsibilities for occupational therapy programs and services. They are responsible for evaluating patients, developing program goals, working with patients to achieve these goals, and documenting progress. Certified Occupational Therapy Assistants (COTAs), working under the supervision of OTRs, assist in patient treatment and total program implementation.

Occupational therapy education and credentialing

An Occupational Therapist, Registered (OTR) has completed a four-year baccalaureate degree program and six to nine months of supervised field work experience. The occupational therapy curriculum includes courses in developmental psychology, anatomy, neurophysiology, and the social sciences. The supervised field work covers such areas as psychiatry, physical medicine, gerontology, and developmental disabilities.There are currently 50 professional level occupational therapy programs in colleges and universities throughout the country. All programs are accredited by the American Medical Association in collaboration with the American Occupational Therapy Association. This collaborative relationship, dating from 1934, is the oldest existing involvement between the AMA and an allied health profession in the accreditation area.

Graduate programs for OTRs are also available. Many of these prepared the therapist for specialized practice, teaching of occupational therapy, or research. One doctoral program in occupational therapy is available and several others are being developed.

The Certified Occupational Therapy Assistant (COTA) is a high school graduate or the equivalent, who has completed a post-secondary program in occupational therapy approved by the American Occupational Therapy Association. Course work focuses on human physiology, and the tasks and skills used in daily life, and includes at least two months of supervised field work experience.

Following completion of course and clinical work, the entry level OTR or COTA candidate must pass a national certification examination to become credentialed for practice.

At the present time 11 states, the District of Columbia, and Puerto Rico have enacted occupational therapy licensure laws. Two states have enacted certification laws which set requirements for those who represent themselves as occupational therapists. All of these laws are mandatory.

Occupational therapy under the medicare program

Occupational therapy is a covered service under Medicare as in many other Federal programs. Under the present Medicare law, occupational therapy services are reimbursable when provided to inpatients in hospitals and skilled nursing facilities, outpatients in clinics attached to approved hospitals and receipients of home health care if they also require either intermittent skilled nursing or physical therapy or speech pathology services. Occupational therapy is also covered on an outpatient basis when provided "incident to a physician's professional service."

The Department of Health, Education and Welfare has defined occupational therapy and established coverage criteria for Medicare purposes in the intermediary

manuals for hospitals (Ch. II, Sec. 3101.9) skilled nursing facilities (CH. II, Sec. 3133 3c), and home health agencies (Ch. II, Sec. 3118.2). These manuals require that occupational therapy be prescribed by a physician, be performed by a qualified occupational therapist or assistant, and be reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy is considered reasonable and necessary when "an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time (Ch. II, Sec. 3101.9 B)."

Problems with current medicare coverage for occupational therapy in the home setting

The existing Medicare coverage of occupational therapy in the home health setting is seriously deficient. This deficiency can be remedied by permitting reimbursement for occupational therapy as a primary service for home health coverage. The nature of the service, the needs of Medicare beneficiaries, and certain cost considerations all support the enactment of this change.

Medicare beneficiaries who need physician certified occupational therapy as a sole service in the home require precisely that acute level of care which the Medicare program is intended to cover. Occupational therapy is an integral component of medical care. Occupational therapists work with the same types of disabled patients as do physical therapists and speech pathologists. The patient's need for occupational therapy, moreover, emerges at the same or a comparable time in the remediation process as does the need for these other services. To segregate patients who need occupational therapy from those who need physical therapy or speech pathology services and to classify the former as requiring a less intense level of care is a gross injustice to those beneficiaries whose rehabilitation will be hastened by the timely delivery of occupational therapy. Such a classification also blatantly contradicts the dictates of quality medical care and denies necessary services to disabled people.

Certain specific situations illustrate the need to correct these inequities in the current Medicare policy.

For many Medicare patients, the continuation at home of their specific occupational therapy program is a critical factor in their full recovery or the prevention of further disability. A patient who has suffered a stroke and has residual paralysis in his arm needs a home-based occupational therapy program of remedial tasks to increase range of motion and maximize muscle tone, to encourage sensory integration and coordination, and to decrease painful and debilitating contractures. The occupational therapist may also design or prescribe assistive devices to allow purposeful movement.

An occupational therapist is also needed to train the patient in essential activities of daily living, such as feeding, dressing and personal hygiene, and to teach the patient safety techniques to avoid accidental injury. Patients with sensory loss may bump into objects and sustain fractures, or burn themselves with household appliances. Patients with visual perceptual loss (such as a loss of vision in one half of the visual field) may fall out of bed or off a commode, or walk into a wall and severly injure themselves.

Occupational therapy is also essential treatment for a homebound patient with severe arthritis. An occupational therapy home program would include instructing the patient in manual tasks to decrease contractures and deformities, muscle atrophy and degeneration of joints, so as to sustain the patient's ability to perform the crucial tasks of daily living. The occupational therapist would also teach energy conservation and joint protection and provide instruction in the use of assistive devices to minimize the stress on joints and develop independence. Instruction in methods of protecting joints will help keep the patient independent by inhibiting further deformity, and reducing the need for rehospitalization or corrective surgery.

Occupational therapy may be the only service required for the stroke and arthritic patients described above, as well as for other diagnosed conditions, at the time when the treatment program can be safely shifted from the hospital to the home. At this time the physician prescribed treatment plan will still be in process. Completion of this program through the provision of occupational therapy in the home setting will ensure continuation of the functional improvement begun in the hospital. As the previously noted Medicare guidelines state, this treatment will continue only as long as "an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time." Both the level of care required by these patients, and the occupational therapy provided in response to these patients' needs, properly fall within the scope of Medicare coverage.

The quality health care due a Medicare beneficiary is one of the strongest—if not the strongest—reason for removing the restrictions on home health coverage of

occupational therapy. For too long, this restriction has forced older people covered by Medicare to surmount unnecessary barriers to secure the necessary treatment which the program is intended to provide. There is no reasonable justification for a policy which contains incentives for longer and more frequent institutional care, and increases the likelihood that needed services will not be received—all of which flow from the current restrictions on home health coverage for occupational therapy. The enactment of the occupational therapy amendments contained in S. 489, S. 350, and H.R. 4063 will contribute significantly to improving the consistency of Medicare policies and the quality and effectiveness of health care under this program.

Cost considerations

Cost considerations must be an essential component of any effort to improve services supported by the federal government. This is especially true in the context of proposing amendments to the Medicare law because of the extraordinary spiralling of health care costs in recent years. Costs for improved coverage, therefore, must be carefully weighed against the benefits which accrue from the changes. The relatively minimal cost projected for these amendments will be readily offset by improvements in quality of care and efficiency of the program and by the potential cost savings which these amendments could produce.

Medicare coverage for occupational therapy as a primary (or "skilled") service in home health would provide incentives for reducing the length of institutional care. If it is known that ready access to necessary treatment is available in the home, the patient could leave the hospital earlier. Enactment of this amendment will foster precisely that form of outpatient care which several studies have shown to be cost effective (e.g., see studies cited in "New Perspectives in Health Care," 1976 Report of the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging at pp. 14-25; and "Home Health—The Need for a National Policy To Better Provide for The Elderly", 1977 Report to the Congress from the Comptroller General at Ch. 2).

Adoption of this proposal can also contribute to reducing the need for rehospitalization caused by recurring disability. Frequently the recurrence of disability can be avoided by the timely provision of necessary treatment. Patients and practitioners who are involved daily in the delivery of services, however, can readily attest to this fact. As Representative Lindy Boggs recently noted in a speech before the House of Representatives, both the Health Insurance Association of America and the National Association of Insurance Commissioners have recognized the cost saving potential of occupational therapy in reducing instances of recurring disability and accident. The current Medicare law, on the other hand, ignores this fact and, by establishing arbitrary barriers to the provision of this service, in essence contributes to unnecessary cost escalation. Amendment of the law in this regard will constitute a real cost containment decision.

Three specific cost estimates have been projected in recent months for this proposal. The American Occupational Therapy Association has projected a first year cost of $1.7 million; the Congressional Budget Office projected a cost of $4.6 million; and the Department of Health, Education and Welfare projected a cost of $28 million.

The American Occupational Therapy Association estimate is based on data derived from a December 1977 survey of occupational therapists throughout the country. The response rate to the survey was over 60 percent and the data has been updated to reflect a February 1979 status.

The cost estimate derived from this data is based on the number of occupational therapists available to practice in settings covered by these proposals, current earnings of therapists, administrative and other incidental costs connected with delivery of these services, and consideration of increased utilization.

The American Occupational Therapy Association rejects outright the validity of the DHEW home health cost estimate. The estimate completely neglects significant aspects of the occupational therapy workforce, such as the number of working therapists, current and projected employment patterns for occupational therapists, the capabilities of the educational system, and reasonable expectations of increased utilization. It would be impossible to find sufficient numbers of qualified occupational therapists who could deliver anywhere near the magnitude of services required to support a cost projection of $28 million for the occupational therapy home health amendment.

Additional support for proposal making occupational therapy a primary home health service

This proposal has won widespread support from a variety of sources. During these present hearings Senator Robert Dole, Senator Lawton Chiles, Senator Pete V.

Domenici and Senator Patrick J. Leahy spoke out in favor of this amendment. Representatives of the National Association of Home Health Agencies, the National Senior Citizens Council, and the National Association of Retired Teachers/American Association of Retired Persons, together with Ms. Hope Runnels, Director, Visiting Nurses Association (Portland, Oregon) supported its enactment. The American Medical Association has also recommended its adoption. The statements of these individuals and groups are enhanced by the strong support of countless individuals throughout the country who have benefited from occupational therapy and keenly understand the loss for those persons who are deprived access to this service.

Conclusion

In summary, the American Occupational Therapy Association supports the Subcommittee's home health care initiatives. It strenuously urges the development of a comprehensive home health care plan. It especially recommends specific modifications in the current Medicare law including removal of the prior hospitalization requirement and the restriction on number of visits, liberalization of the "homebound" interpretation, and adoption of the provision permitting coverage for occupational therapy as a primary home health service.

STATEMENT OF THE NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES

The National Federation of Licensed Practical Nurses is the professional organization of licensed practical nurses and comprised exclusively of LPN's. Presently, there are more than 600,000 licensed practical nurses throughout the country who serve as an integral part of the health team. As the nation's second largest group of health providers, LPN's play a vital role in the delivery of health care services, and because we provide these services in a wide range of settings, we are keenly aware of our nation's health needs.

One such area where we find present health care services inadequate is in the area of home health services. Besides the staggering statistics of spiraling costs and increasing numbers of people who need health services and can neither afford nor find adequate health care, is the human suffering and the loss of personal pride and dignity because of these inadequacies. As the bedside nurse, we see the needless suffering by many patients.

Emphasis in the health area is now turning from institutionalization to less costly, more effective and more humane home health care and ambulatory care. We are now discovering that it costs less to keep a patient well and treat them at home in familiar settings than it does to treat patients in a hospital.

In 1975, nearly 500,000 persons received home health services covered under Medicare, an increase of 27 percent of those receiving care in 1974. Nationally, 20 out of 1,000 Medicare enrollees received home health benefits.

Social Security Administration actuaries estimated the cost impact of proposed changes liberalizing the home health benefits under Medicare, such as eliminating the requirement that beneficiaries be confined to their homes and be in need of skilled care, limitations on the number of home visits, and the addition of homemaker services in fiscal year 1978.

In GAO's view, except for the removal of the skilled care requirement, the costs associated with these changes would not be prohibitive and could provide disincentives to institutionalization. In fact, a bill approved by the House of Representatives in September, 1977, to encourage the use of less costly home dialysis for Medicare beneficiaries with kidney failure would eliminate the homebound requirement for one class of Medicare beneficiaries.

Of major concern to us is that we perceive a great inability on the part of America to provide adequate health care delivery. The prime reason for this is the underutilization of health care providers and an outdated philosophy that medical care is synonomus with health care.

The National Federation of Licensed Practical Nurses sees the necessity to distinguish between "medical care" and "health care." It is our contention that health care encompasses a broad range of services designed to maintain the physical, mental and social well-being of people. There is no one profession or discipline which can do all this, and if we are to provide the proper planning, delivery and evaluation of health care, if we are to provide a truly comprehensive health care program which will include preventive, diagnostic, therapeutic and restorative or maintenance care, we must use all qualified health providers and produce a system which is both effective and economical.

The burden of providing such are should not fall on one group of providers but rather many different disciplines who are skilled and educationally prepared to offer a wide range of services.

The educational preparation of an LPN uniquely qualifies us to be better utilized in home health settings. For example, our education includes clinical and classroom preparation from between 9-18 months, depending on the state in which an LPN receives his or her education. The clinical experience of LPN's, in some states, often surpasses that of the registered nurse in the 2-year nursing program.

The clinical experience and the theory preparation includes specific preparation for working with a patient in home health settings. This usually means the patient's condition in stable and not acute. The LPN is able, by law and by educational preparation, to administer medication.

Historically, the practical nurse is the provider who works in the home with the patient. The basic educational preparation, which includes the fundamental concepts of diet and nutrition, body mechanics, immunology and asceptic techniques, are the usual skills and knowledge necessary to administer health care to the stable home health patient.

Usually the type of patient the LPN has traditionally served is better off at home than in an institutional setting. Studies have found, which we are sure you are aware, that patients convalescing from surgery or living with a chronic illness will inevitably recover more quickly and more completely in a familiar setting.

It is in this setting that the LPN can best use his or her educational preparation, skill and knowledge to administer to the stable patient convalescing from surgery.

The LPN is able to change dressings, check for infection, administer medication by checking dosage and evaluate its effectiveness. Also, the LPN is familiar with basic diet therapy and can be certain that sufficient vitamins are taken along with a proper and balanced diet.

Similarly, the LPN can serve the patient who needs long-term care because of a chronic illness. The practical nurse can provide the level of care which is customary and necessary for the patient's health and recovery.

Constant monitoring of the patient's condition along with assisting the patient in the activities of daily living (ADL) make the LPN the ideal health professional to provide this level of care in this kind of setting.

As the nation's second largest group of health providers, we are painfully aware of federal and state policies and programs which encourage participation of only a few professions in the delivery of health care services. We see an urgent need to reverse the policies and programs and fully utilize not only LPN's but other qualified health providers.

These policies greatly affect the cost and quality of present health care programs and waste valuable resurces. Specifically, we would like to address ourselves to three areas of deficiencies in the current medicare program which, because of these requirements, greatly impair the delivery of health care services:

1. Present Medicare regulations prohibit and discourage alternatives to institutional care because of their skilled nursing requirement.
2. Present Medicare requirements limit the number of home health care visits to 100.
3. Present Medicare requirements mandate prior hospitalization before an individual becomes eligible for home health care services.
4. Present Medicare requirements mandate a $60 Part B deductible for home health services.

We see these requirements as needless and costly barriers which prevent low-cost quality health care delivery.

The inadequate utilization of home health care benefits is due primarily to the Medicare requirement for "skilled nursing care." The government has selected a series of medically-oriented tasks and observations and defined them as "skilled" care and limited reimbursement eligibility to these tasks, thereby eliminating many preventive and maintenance services needed to keep the elderly out of hospitals and other institutions. An elderly widow in North Carolina, who was weak and palsied, needed certain eye medication administered on a daily basis. However, because of her infirmities, she could not administer the medication herself. Though the actual giving of the medication would take less than one minute, as a result of such impractical regulations, Medicare did not pay for the services because they weren't termed "skilled" nursing care.

Clearly one could see that this artificial and unnecessary requirement for reimbursement severely impairs the ability of LPN's and others to provide needed services.

Similarly, 600,000 LPN's who are educationally prepared to do many of the same tasks as the Registered Nurse cannot provide that service because of the use of the word "skilled." We want to emphasize a point here, Mr. Chairman, that the thrust of our argument in no way lessens the quality of care, but merely utilizes more effectively and efficiently those practitioners who have been educationally prepared.

What is particularly encouraging about the full utilization of health care practitioners is that it will eventually enable more people to enter the delivery system. We feel that this action in the long run will encourage greater use of home health benefits and reduce dependency on more costly institutional care.

Congress is just beginning to recognize that some Medicare and Medicaid policies are too restrictive and prevent the utilization of many health care providers. The Rural Health Clinic bill establishes a more multi-level and multi-disciplined approach where health services would be provided by practitioners other than physicians. We think that this is a step in the right direction, and we were glad to see that LPN's were included in this bill by appropriate language in the Committee Report.

The second area of professional concern to us regarding the limitations in the present Medicare program is that present requirements limit the number of home health visits to 100. This restriction prevents the needed delivery of health care on a need basis and becomes costly when the maximum home health visits are used and institutionalization is required.

Many elderly people are prone to chronic long-term illnesses, and the 100-visit limitations under parts A and B of Medicare expire before the patient has had sufficient opportunity to recover. Unlimited home health care would also discourage the use of hospitals and institutions and would provide a more familiar and welcome convalescent place to an elderly individual.

Also, through the expanded role of such health providers as LPN's in a situation where home health visits would be unlimited, preventive and diagnostic services could be delivered and perhaps save a patient from becoming ill, save money, and spare the patient possible hospitalization. We do know that it costs less to prevent an illness than it does to treat it.

It is in these areas that new and expanding roles for RN's, LPN's and other providers can help keep people out of hospitals and yet provide them with quality care. We must add at this point, however, that the unlimited use of home health visits sould be closely tied to an effective utilization review program and that this review mechanism should be developed and administered by representatives of all the providers rendering service.

Our third area of concern is that present Medicare requirements which mandate prior hospitalization before an individual becomes eligible for home health care services are too costly. Last Spring, we learned that each day American taxpayers pay $48 million for hospital care under Medicare-Medicaid.

The Department of Health, Education and Welfare estimated that in fiscal year 1976, the Medicare program spent more than 75 percent of its funds for hospitals and nursing home care. They report that in 1976, $55 billion was spent on hospital care alone, and that if present trends continue, total spending on hospital care in 1986—just 7 years from now—will be a staggering $220 billion.

Many times, in an effort to assist a patient in receiving needed benefits, physicians will unnecessarily admit a patient to a hospital so that the patient will be eligible for home health or nursing home care. We see that not only is this costly, but it causes a physician to choose between properly treating his patient or complying with the law.

In addressing these three areas, we hope that we have been helpful to the Committee in pointing out severe problems in the delivery of health care which impact on the quality of health care, as well as the cost. Needless to say, we all have a stake in our health care system. In our desire to provide necessary health services, we must constantly evaluate the present system, correct its glaring deficiencies and inefficiencies and remember that our goal is to maximize health care delivery services and minimize costs. We suggest that the three Medicare regulations discussed here today impede the process and keep us from our goal, and we suggest that there be greater utilization of LPN's and home health care programs.

The National Federation of Licensed Practical Nurses believes that enactment of S. 220, introduced by Senator Matsunaga, will help provide better health care services. This legislation would permit LPN's to be reimbursed for the health services they provide to patients covered under the Medicare/Medicaid provisions of the Social Security Act. We believe this bill will bring health care to those who can't afford such services now, bring health care to those who are geographically unable to see a physician or go to a hospital, and we think it would lower the cost of

health care because LPN's would not be reimbursed at the same rate as physician's or hospitals.

This Committee has traditionally been one of the leaders in articulating the health needs of our citizens. We applaud your efforts, and we are proud to work with you, and we eagerly await the day when all those in need of health care are able to receive the best care at a reasonable cost.

THE NATIONAL CANCER FOUNDATION, INC.,
New York, N.Y., May 21, 1979.

To: Senator Herman E. Talmadge, Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate
From: The National Cancer Foundation, Inc. and Cancer Care, Inc.; James P. Erdman, President, Irene C. Buckley, Executive Director.
Subject: Medicare's Home Health Benefits.

Public Affairs Committee: William C. Pelster, Chairman, Richard O. Aichele, Mrs. Alfred R. Bell, Mrs. Hiram D. Black, Paul H. Briger, Mrs. Frederick L. Ehrman, James P. Erdman, Eric L. Hirschhorn, Mrs. Margaret Holmes, John Matthews, A. Alexander Morisey, Sanford Schwarz, James B. Swire, Mrs. William Tall, Robert E. Wallace, Werner Weinstock, Mrs. Wallace B. White, Mrs. Frederic D. Zeman, and Doris B. Nash, Public Affairs Associate.

We are most appreciative of the fact that Senator Talmadge and the Subcommittee on Health has seen fit to stimulate discussion and deliberation of the problems relating to Medicare's home health services. We are pleased by this opportunity to submit written testimony in lieu of a personal appearance and we will speak to the desperate need for broadening Medicare's coverage of home health services.

The National Cancer Foundation, Inc. and Cancer Care, Inc. has for over 33 years offered comprehensive social services to advanced cancer patients and their families. In this time we have given service to over 400,000 persons, including approximately 115,000 patients.

Our services include social work counseling and assistance with planning for the care of the patient. Our focus at Cancer Care, Inc. is not only upon the patient's illness, but also upon the family as a whole. We strive both to help the patient live to the very end with dignity and comfort and to help the family and/or spouse cope more adequately with the patient's illness so that family or personal breakdown may be prevented. Consequently, we offer individual counseling, as well as group counseling for both patients and the bereaved.

We direct our efforts toward self-supporting families who are not eligible for services from public agencies—the largest segment of our country's population. Those whose incomes are not high, and the aged living on low, fixed incomes, are always the hardest hit when a catastrophic illness strikes. While they may have saved for such a rainy day, and even though they may have some insurance coverage, both savings and insurance often are far from sufficient.

An integral part of our service is supplementary financial assistance, when needed, to help defray the cost of services in the home when it is medically feasible to maintain the patient at home.

We help patients who are above the Medicaid eligibility level, and have continued to assist patients after they have "spent-down" sufficiently to become eligible. In many instances, patients have died while awaiting certification for Medicaid.

Over the years, we have consistently found that most advanced cancer patients, if they can be at home at all, can be cared for by homemaker-home health aides, and do not necessarily need skilled nursing care. We wish to relate this basic and important fact to the issue of home health services under Medicare. Year after year, nearly half of our caseload has consisted of persons over age 65, and Medicare eligible. Cancer clearly is not respectful of age, and for the elderly, insult is added to injury by the fact that the illness is often more drawn out than it is for younger victims of cancer.

The elderly cancer patients we have known and assisted provide vivid testimony to the basic inadequacies of Medicare's coverage for home health services. Many of the limitations and deficiencies of the Medicare program can be traced to its focus on short-term or acute illnesses. Medicare's stringent requirements governing the delivery of home health services are directly traceable to this emphasis. Under Medicare, home health services are allowable only when skilled nursing care or physical or speech therapy are required. Only then can the patient receive assistance from home-health aides and, except in extraordinary situations, only on a part-time or intermittent basis. This stipulation and the severe restrictions on the

number of allowable visits explains why home health care accounts for such an extremely small percentage of Medicare expenditures.

What happens then, to the elderly person who has a chronic or long-term illness but doesn't want, or need, an institutional setting? What happens to the elderly cancer patient who could be maintained at home if he or she is helped with homemaking or housekeeping services, but can not secure it because of Medicare's restrictions?

Our long experience has shown that skilled services are usually not needed, at least until the patient's medical condition worsens. Time and again our agency's assistance with homemaker services has enabled families and spouses to maintain the patient at home until he dies, often at home.

Medicare's part-time home health visits can meet only very specific nursing therapy, or personal care needs of some patients. Valuable as this may be, it answers only a small part of the problem faced by the elderly ill. The major problem is one of overall care and supportive services to maintain the patient and keep the home intact.

Some have suggested that the children of older patients should supply the overall care to maintain their ill parents. However, in our experience this often is not possible because geographic distances between parents and children, and the fact that daughters and daughters-in-law, who traditionally cared for older persons in the family, often are working themselves.

We must be realistic about the changing patterns that have occurred in our highly industrialized and mobile society, and we must not create legislation that is based on former lifestyles. Surely, we, as a civilized nation and society, owe to those who have spent a lifetime as constructive citizens at least decent and comprehensive medical care in their old age. they must also be given the opportunity to live out their remaining days with as much dignity as possible. This can only be achieved through the provision of a broad variety of home-based services, as well as counseling services, so that the elderly may be helped to cope with the problem of illness and old age.

It is sad, but very true, that the elderly person with a long-term or catastrophic illness, must use up his savings (often very meager) to pay for the supports he needs at home such as homemakers, domestic chore services, special equipment, just to name some. He lives then with increased anxieties and fears about what will become of him. And he learns, sadly, that he deceived himself when he thought that the Medicare program would be of sufficient help when he got ill.

We would like to offer the following specific recommendations:

1. That present restrictions limiting home health care services to part-time and intermittent skilled nursing care be removed and time limitations imposed upon home health visits be extended.

That the definition of a home health aide be expanded to include such other supportive services as housekeeping. In fact, the title should really be "homemaker-home health aide." Medicare coverage should be extended to include a broad variety of home-based services. The scope and type of service to be utilized should be planned and periodically reviewed by a professional team which might include some or all of the following disciplines: physician, nurse, social worker, or therapist. The social worker should also be available to counsel the patient and family.

2. The "post-hospital" requirements for home health services must be eliminated. Such requirements create severe hardships as well as unnecessary hospitalizations, which frequently are recommended in order to qualify for reimbursement from Medicare for eventual home health services or nursing homes.

3. Medicare should provide coverage, on an out-patient basis, for drugs, medications, and other treatments, such as chemotherapy. This last item is an extremely costly one, and creates severe hardships for the elderly who often must live on low, fixed incomes. Likewise, coverage must be broadened for dental, eye and hearing care.

4. Medicare should also provide coverage for *all* the recognized skills and professions needed by the elderly. Recent legislative proposals have singled out psychologists for such coverage. While there is coverage for medical social work services (under the direction of a physician) in hospitals, nursing homes, and home health services agencies, there is no coverage for counseling services offered by trained social workers under the auspices of social agencies or licensed mental health clinics. The mental health needs of the elderly must not be overlooked, and social work is one of the helping professions uniquely equipped with skills to meet these needs.

Medicare home health and out-patient coverage must be broadened in the ways we have outlined, so that it will finally meet the needs of the elderly ill in a more

realistic and humanitarian manner. The time has come for a truly comprehensive and worthwhile health insurance program for our older citizens.

In conclusion, we are taking the liberty of sending with this testimony a copy of "The Impact—Costs and Consequences of Catastrophic Illness on Patients and Families," published by our agency in 1973. The findings of this research study attest to the severe inadequacies of both health insurance and Medicare when there is a catastrophic illness. We recommend it to you for its vivid and heartbreaking analysis of the costs, both the obvious and the "hidden," of a catastrophic illness. Clearly, this study, which has been widely quoted, gives further evidence beyond our agency's day-to-day experience of the unmet needs of the catastrophically ill, both young and old. The only change that has occurred since our research was done has been escalated costs and increased human suffering.

Statement of the American Association for Respiratory Therapy

The American Association for Respiratory Therapy (AART), a professional association representing close to 20,000 respiratory therapy professionals across the country, welcomes the opportunity to comment on the subject of home care, its impact on the health of the people of this country, and the role of Medicare in financing home health benefits to its beneficiaries.

Home care in general is certainly an idea whose time has come. It offers many things that our national health care delivery system needs: a mechanism providing appropriate levels of care for those who do not need institutionalization, inherent cost savings related to reduced hospitalizations, and a humane setting familiar to the consumer/patient.

APPROPRIATE LEVELS OF CARE

Simply stated, the cost of health care is too high in this country. No one can deny that high costs are related to intricacies of the present reimbursement system, a system which already reimburses for high cost procedures such as coronary bypasses, hip replacements, and renal dialysis, regardless of documentable short or long term benefits. PSROs appear to be headed in the right direction, but progress has been slow. The problem of identifying appropriate levels of care is still a major flaw in our delivery system and it appears to the AART that home care is a solution (not THE solution) to our present situation.

There appears to be reasonable documentation available to address the pointed conclusion that certain populations in hospitals and nursing homes are receiving a level of care in excess of their medical needs. Both the Congressional Budget Office (February, 1977) and the General Accounting Office (December, 1977) emphasize that a significant percentage of the institutionalized population could be cared for in less intensive settings if more community based programs were available.

AART strongly believes that home care is one answer to the problem of excessive levels of care to the institutionalized population.

COST SAVINGS

The issue of cost savings related to home care is not as clear as originally perceived. AART recognizes that home care has traditionally been a "curative" service, but we believe there is certainly benefit in its role as a preventive program. Regardless, home care can be quite economical if handled appropriately, but recent experiences in the Medicare/Medicaid programs seem to indicate that home care, by definition is not always the cost saver it was believed to be. There is little question that home care in general is cheaper than institutionalization; likewise AART recognizes that home care is more expensive than no care at all. The dilemma, therefore, is to establish through certain quality control mechanisms assurances that patients receiving home care are receiving care that is medically indicated, physician reviewed, and beneficial to the patient.

The art of quality assurance has not come very far in health care, and that fact concerns AART. We recognize that it is difficult to gauge quality in a hospital setting with one physician reviewing another's work, and that gauging similar care in the home certainly is more difficult. Nonetheless, AART firmly believes that quality control mechanisms can be developed to assure appropriate care to the consumer.

A HUMANE SETTING

We must not lose sight of the very important principles of home care—the delivery of needed health care services in a setting familiar to the patient. There is little doubt that most people feel more comfortable in the home, certainly as compared to hospitals and nursing homes. Many in fact feel that nursing homes are places to die, and home care offers a logical alternative to that stigma. AART believes that home care provides health care services in a dignified and comfortable setting for the consumer.

THE MEDICARE HOME CARE PROGRAM

The present Medicare statutes specifically spell out who is eligible for home care benefits and limits those benefits to certain medical services. Noticeably absent from the conditions of eligibility and the scope of beneifts is respiratory therapy.

Section 1835 (a)(2)(A) clearly states which Medicare beneficiaries are eligible for the home health benefits. The interpretation of that language has resulted in what AART believes to be a serious flaw. At the present time a medicare beneficiary whose sole medical need is the use of oxygen, a life sustaining therapy, is not eligible for the medicare home health benefits. For a certain population there is no question that administration in the home is a life sustaining service, yet it is not reimbursed under the home care benefits.

AART certainly recognizes the fact that the cost of oxygen in the home is reimbursed unde the durable medical equipment provisions of the Medicare program, yet there are not services available to those in need of oxygen or other aerosol therapies. This simple fact leads to serious quality control problems that are reflected in the rapid increase of Medicare expenses in this area. A recent study by the South Hills Health System Home Health Agency (outside Pittsburgh, Pa.) which examined respiratory therapy services in the home stated, "Home visits by a respiratory therapist are usually in conjunction with the delivery of respiratory equipment by the rental company. These visits are limited primarily to instruction in machine use. There have been instances when this instruction has been completed by the truck driver." This type of health care delivery is totally unacceptable to AART and we have strong reservations about medicare encouraging this behavior to continue.

The same South Hills study mentioned above examined in great detail the potential cost savings of providing respiratory therapy to a select population with respiratory ailments. "There was a total reduction of 421 hospital days after home care respiratory therapy, which was approximately 8.1 fewer days per patient per year. Thus, reductions can be seen in the number of admissions, the number of hospital days, the number of patients hospitalized, and the length of stay after home care respiratory therapy." Furthermore, the study notes specific dollar savings. "The total costs prior to home care respiratory therapy (the cost of hospitalizations) was $127,395.00 for the 52 study patients. The total costs after home care respiratory therapy (the costs of hospitalization, registered nurse visits, respiratory therapist visits, and equipment) was $98,154.00. This represents savings of $29,241.00 or $562.32 per patient per year.

Under the current Medicare statutes respiratory therapy is not a reimbursable service. AART firmly believes that such a situation leads to poor quality health care, inappropriate levels of health care, and escalated health care costs.

RECOMMENDATIONS

As the Senate Finance Subcommittee on Health considers possible improvements in the Medicare home care program, AART makes the following recommendations:

1. Change Section 1835(a)(2)(A) to permit need of respiratory therapy to become a means of determining eligibility for the Medicare home health benefits.
2. Change Section 1861(m)(2) to include respiratory therapy as a covered service under the Medicare home health benefits.

It is only logical that the Subcommittee consider the costs of changing the statutes to meet these recommendations. AART is sensitive to the political climate and the inflationary nature of the entire Federal budget. Yet we firmly believe that the costs of not implementing these changes are even higher, not only in terms of dollars, but in terms of a significant portion of the durable medical equipment program going without quality control, a significant portion of the Medicare population not receiving life sustaining services, and a significant portion of the Medicare population continuing to receive costly unnecessary care.

The Association is willing to discuss these issues with the Subcommittee as you might deem appropriate.

ST. MARY'S HOSPITAL,
Athens, Ga., May 18, 1979.

Hon. SENATOR HERMAN TALMADGE,
U.S. Senate,
Washington, D.C.

DEAR SENATOR TALMADGE: In a recent telephone conversation with Mr. Jay Constantine, I was informed of the hearings to be held by the Senate Finance Committee on S. 489—the proposed bill limiting restrictions and expanding Home Health Care services to those in need. As a provider of Home Health Care services, I would like to submit to you and other committee members relevant information based on our home health services experiences. It is my hope you will include our comments in your report and recommendations.

PROGRAM DESCRIPTION AND BACKGROUND

St. Mary's Hospital Home Health Care is a hospital-based home health agency providing professional nursing and other health services to patients within an 11 county mainly rural area in Northeast Georgia. St. Mary's Home Health Care has brought hospital and rehabilitation services to the patient in the home since 1968. Its services include: Skilled Nursing, Physical Therapy, Speech Therapy and Occupational Therapy, Medical Social Services, Home Health Aide, Nutritional Guidance, Laboratory Services and Patient Care Equipment. All care is supervised by the patient's personal physician. The St. Mary's Home Health Care program is in compliance with the standards of the Joint Commission on Accreditation of Hospitals and is licensed and certified under Medicare and Medicaid.

In 1976, the State of Georgia sponsored, Alternative Health Services Project (AHS), a cost effective alternatives to nursing home institutionalization project, contracted with our Agency in June of 1977, to provide home health care services to persons aged 50 years and over in need of health services and Medicaid eligible. Known as the "Medicaid Waiver Project" (Section 1115 waiver of Section 1903 of Title XIX of the Social Security Act), the four years extended project ensures Medicaid eligible persons continued coverage while receiving health care services in their home setting.

As a result of the Agency's participation in the Alternative Health Services Project, our home health care services have been expanded to include homemaker/chore services, meals including special nutritional diets, Occupational Therapy, and Medical Social Services to persons in need who previously would have been ineligible for such services as Medicaid recipients only.

The number of visits made by both the skilled and supportive services are compared for Alternative Health Services only patients and is noted below.

	Number of visits during	
	April 1978	April 1979
Skilled services:		
Skilled nursing	80	163
Physical therapy	3	13
Speech	0	0
Occupational therapy	3	1
Medical social service	0	11
Totals	86	188
Supportive services:		
Home health aide	54	199
Homemaker/chore	85	103
Home delivered meals	458	2,128
Totals	597	2,530

The comparison of April figures for two successive years indicates that skilled visits supplied to Alternative Health Services patients rose by 218 percent and supportive service visits rose by 424 percent.

The above figures represent visits made under the Alternative Health Services project only. Skilled service visits made by the Home Health Care Agency for the month of April 1979 (including those made under Title XVIII and Title XIX were 558. Alternative Health Services visits constituted 188 of these or 34 percent.

RESULTS

We are aware that service count figures alone are insufficient data in the evaluation of effectiveness of home health care services in helping impaired elderly to remain in home settings and avoiding frequent and costly rehospitalization and premature or unnecessary institutionalization. We also need to examine the crucial variables of (1) patient's level of impairment, (2) his living arrangement; and (3) available community supports.

Our Agency is beginning to gather data on the above variables which will prove useful in comparing the two elderly groups currently served (i.e., Alternative Health Services patients and other Home Health Care patients). The following, therefore, are general observations based on our experience in delivery of home health services and in discharge planning experiences with Home Health Care patients.

Level of impairment

With the elimination of the homebound status and skilled nursing requirements under the Medicaid Waiver project, Alternative Health Services patients tend to be less impaired than other elderly Home Health Care patients served. Since we know that the greatest probability of rehospitalization and institutionalization exists at the extremely impaired levels, we need to be aware of this when examining rehospitalization or admission to institution rates of both groups.

Living arrangements

Family involvement and cooperation are absolutely essential to the implementation of home health care services for the severely disabled and chronically ill elderly. Evaluation of the family and living arrangment component of the patient care program is an important factor to be considered. We know that persons who have no spouses, children, or other relatives or friends to assist in providing on going daily care are more likely to be institutionalized. Alternative Health Services patients tend to have less available family and financial supports and less access to ongoing daily care provided by family, friends or paid helpers.

Thus, a vital and essential component of the program is supportive services to the patient such as counseling, education and community services to augment the care provided by the family. If the family care system breaks down, institutionalization is more likely to be the only alternative irrespective of the quality and quantity of skilled medical services.

Community supports

If community services cannot provide assistance with the elderly person's basic needs when there is limited family or friends support available often institutionalization is the only alternative left. Alternative Health Service patients tend to be more dependent upon community services than other home health care patients due to inadequate income and other financial resources, less family support and ongoing daily care. A growing number of other Home Health Care elderly patients are also living on inadequate incomes just above the allowable maximum income requirements for SSI. They are often ineligible for community services typically available to SSI recipients.

Based on our experience in discharge planning within the 11 county rural communities we serve, we find there are individual differences in the kind and quality of community services available and accessible to elderly persons. For example, some local county commissioners have refused to allow home delivered meals or congregate meals in their counties. In only a few counties medical transportation is provided by volunteers and most counties have only travel reimbursement available to families of patients not living in the home or friends and limited information about reimbursement is available. Some physicians in a few counties do not refer patients to home delivered services or do not provide adequate medical supervision of the patient's care under Home Health Care services. Pharmacies in a few counties are unable or unwilling to deliver medications or provide adequate labeling of medications. Some County Departments of Family and Children Services are inadequately staffed and funded and workers have limited experience in providing

effective Protective Services to the frail elderly, living alone and without family or friends and who have great or extreme impairment.

GAPS IN SERVICES

Funding

Current limitations of the two major funding sources of Home Health Care Services, Medicare and Medicaid, including skilled nursing care need for prior three day hositalization and 100 home health visits have imposed severe restrictions on services to the chronically impaired and often the terminally ill patient. Neither funding source along provides maintenance or preventative coverage when skilled services are no longer justified. Federal resources currently utilized to fund such programs as Titles III and VII as well as Title XX are inadequate to meet the full scope of need for home care services, are not viable alternative services for the moderate to severe physically and mentally impaired and lack coordination of services at the local level due, in part, to lack of availability of medical and social services.

Coordination

There is a definite lack in follow-up by referred community agencies for continuation of services upon discharge from Home Health Care Services. This varies by community response as reported earlier; e.g., discharged patients on special diets are not ensured continuation of the diet at nutrition sites of home delivered meal provided by nutrition site programs. Limited numbers of homemaker services in the community. Counseling with the family regarding patient's care and resolution of problems associated from stress/burden of chronic illness in the home is not provided by the typical social service agency or caseworkers with no health care experience. Outreach services provided by mental health, senior centers and Department of Family and Children Services, and Public Health, are limited and few discharged patients can expect these services to contact them—they must walk-in to receive services.

Quality control

Currently, our Agency receives quarterly reviews by Medicare, Medicaid-Alternative Health Services for which no system of standardized guidelines have been developed. Coverage for Home Health Care service charges are based on funding source reviews which include clinical and financial audit with varying standards. Audits are expensive; negative reviews often demoralizing to staff and upsetting to patients.

Recommendations

The following are recommendations and lend in support to S. 489;

1. Repeal of limiting restrictions imposed by Medicare and Medicaid.
2. Elimination of middle man approach to service delivery—direct service monies to be expended directly to individuals in need of health care services.
3. Standardization of guidelines from major funding sources of Health Care Services.
4. Coordination of services (medical and social) at the local level would be more effective under supervision of the comprehensive home health care agency.
5. Training and supervision of homemakers and aides would be more appropriate by skilled nursing and other skilled services within home health care agency.

I appreciate the opportunity to present this information for your consideration in the review of the need for expansion of Home Health Care services. Please do not hesitate to let me know if you would like additional information or further comment from us.

Respectfully yours,

HESTER FORTSON, R.N.,
Director, Home Health Care.

STATEMENT OF THE WEST-MONT COMMUNITY CARE, INC., HELENA, MONT.

West-Mont Community Care, Inc. is a free standing, non-profit home health agency which has been providing service to Helena and the surrounding three counties for five and one half years. We see approximately 800 patients per year, with approximately 75% of these being Medicare eligible. We would like to submit the following comments regarding the proposed "Medicare Home Health Amendments of 1979" and how these amendments will affect our service to patients.

1. We strongly support the elimination of the three day prior hospitalization requirement under Part A of Medicare. The presence of this requirement only encourages unnecessary institutionalization of patients in order to secure Medicare coverage of needed home health services. We have often been asked why patients requiring home health services without prior hospital or nursing home care are not simply billed under Part B of Medicare. We do this whenever possible; however, we occassionally care for patients who are not covered by Part B. For such persons who have no institutional health care needs, the prior hospitalization requirement represents a costly stumbling block to obtaining needed home health services.

2. We strongly support the inclusion of occupational therapy as a primary home health service under Medicare's Hospital and Medical Plans. In addition, we recommend that it be included as a covered service in the Outpatient Services section of Part B, of the Medicare Medical Plan. Next to physical therapy, occupational therapy is our most heavily utilized rehabilitation service. It is also the most difficult for which to secure reimbursement. Very few commercial health insurance policies will cover occupational therapy and Medicare currently covers only if a registered nurse, a physical therapist or a speech therapist is also on the case. It has been our experience that frequently the occupational therapist is the only discipline required on a case. If skilled nursing is required, it is often needed for a much shorter period of time than the occupational therapy. The requirement of concurrent provision of skilled nursing, physical therapy or speech therapy in order to secure reimbursement for occupational therapy only encourages agencies to "find a need" for these services in an effort to get the truly needed service—occupational therapy—paid for. The other options are that the patient pay privately for the service (many low income elderly cannot afford this) or, unless the home health agency has community funds to cover charity services, the patient goes without the service.

Occupational therapy is a well established, separate discipline, having been in existence for approximately 60 years. Occupational therapists have invaluable skills to offer home health patients. Many of those they treat suffer from arthritis, strokes or diabetes. The age group hardest hit by these ailments is the elderly—those Medicare is designed to serve. We submit that Medicare would serve these persons much better if occupational therapy were covered as a primary home health service and as an outpatient service.

3. We support the elimination of the limitation on the number of home health visits allowed in a calendar year. It is not often that we have a patient who requires more than 100 visits in a year. However, it has happened and for those patients who experience a need for more visits, elimination of this restriction would be most helpful. In addition, we recommend the elimination of the limitation on the number of reimbursable visits per benefit period under Part A of Medicare. The current limit encourages those who have exhausted their visits to seek hospitalization, not because institutionalization is needed, but as the only way they can rejuvinate needed home health benefits.

4. We support the development of standards for the training of home health aides. We suggest that in developing such standards, the Secretary utilize the wealth of data already available through the National Council for Homemaker-Home Health Aide Services, Inc. It was the Council which developed the home health aid training program which was used by agencies participating in aid training funded through P.L. 94-63. Our agency used this program to train four aides this year and we found it to be excellent.

5. We object to Section 2(1)(7) of S.489 which would require home health agencies to bill all patients every two weeks. We currently bill on a monthly basis. To be required to bill twice as often would substantially increase our costs. Also, the way this section is worded seems to indicate that all patients would be sent a billing every two weeks, regardless of whether they were private pay, Medicare or Medicaid. Services to our Medicare and Medicaid patients we currently bill only to our intermediary—on a monthly basis. To be required to send notification to the patient every two weeks, in addition to our current billing process, could only substantially increase costs.

We appreciate the opportunity to give input on this legislation. Thank you.

STATEMENT OF MARY JANE MAYER, EXECUTIVE DIRECTOR, THE VISITING NURSE ASSOCIATION OF MILWAUKEE

I am pleased to have an opportunity to present specific concerns which The Visiting Nurse Association of Milwaukee is experiencing in the reimbursement of services under Title 18 and Title 19. The Visiting Nurse Association of Milwaukee

provides 24 hour a day, 7 days a week, professional nursing and homemaker-home health aide service. Other VNA services are: physical therapy, occupational therapy, social work and nutritional services (including a mobile meals program). The VNA provides by contract speech therapy, medical supplies and equipment, transportation, inhalation therapy, oxygen and laboratory services. The agency's total visit volume has increased from 11 percent in 1976 to 19 percent in 1978, 163,000 home visits. During this same period, we have seen a decrease in Medicare volume and income. Medicare is meeting less and less of the needs of the elderly in the acute, intensive care and terminal illness parts of our programs. In 1976, Medicare income was 49 percent of total VNA income and in the first quarter of 1979, 43.4 percent. Our total number of Medicare professional service visits remain constant at 54 percent. A more dramatic change is seen in homemaker-home health aide hours: in 1976, Medicare aide visits were 29.4 percent of total aide hours; in 1978, 24.8 percent of total.

The Visiting Nurse Association of Milwaukee believes the Medicare reimbursement is decreasing for several reasons:

1. Change in the interpretation of the definition of homebound status. This has resulted in retroactive denial of care as long as 4-6 months after service has been given. The Visiting Nurse Association of Milwaukee has waiver of liability status, but the waiver does not cover denial due to homebound status. The VNA patients who require fee adjustments have median annual incomes of $4,300 per year with a median savings of $1,500. Often the agency cannot recoup the total amount of the bill. In 1978, the Visiting Nurse Associaition of Milwaukee's charitable service was half a million dollars.

2. Change in the interpretation of skilled nursing and physical therapy service, resulting in the denial of services. This change is frequently seen in skilled physical therapy which goes beyond 10-14 days of service and in skilled nursing in care of terminally ill beyond a certain period of time and in the care of patients who are receiving renal dialysis as an OP and require shunt care. Mrs. W. is a good example of retroactive denial due to a determination of non-skilled physical therapy. Mrs. W. is an 87 year old woman who lived alone independently until she fell while someone was stealing her purse. She sustained a fracture of the right shoulder. Mrs. W. left the hospital 7 days early due to the cooperative planning of the family, the hospital, VNA and physician. The physician ordered Mrs. W. to have physical therapy until she was able to move her arm in a prescribed manner. Mrs. W's daughter cared for all Mrs. W.'s personal needs during this time, and was taught to do simple range of motion by the physical therapist. Mrs. W. received service from November 1, 1978, to January 16, 1979, 28 physical therapy visits at a cost of $616.00. She was independent on dismissal. March 9, 1979, Medicare retroactively denied payment as of November 15, 1978. The VNA or Mrs. W. was responsible for $420.00 of that bill. Mrs. W. lived on social security alone. She was able to pay only $1.00 per visit. The VNA absorbed the rest. As Medicare covers less and less of the needs of the patient, agencies, such as the VNA, are experiencing greater gaps in charitable dollars available from sources such as United Way, private foundations, etc., and the need for such funds. We are fearful that many agencies may turn to serving the patient only as long as Medicare covers—resulting in a seesawing of patients from hospital, to home, to hospital and finally the only alternative, skilled nursing home care.

The restrictive payment of homemaker-home health aide hours is also increasing. The VNA has an acute, intensive care program, a program for the terminally ill and a program for care of the patient following hospitalization. We rarely (less than 1 percent of the time) receive more than 2 hours of Medicare covered aide service a day, or more than 3 times a week for any one patient. Our concern in this area intensifies as we begin a joint hospice program with a hospital in our area.

4. The majority of service to Medicare patients which lasts more than 30 days results in requests for increased documentation and often denial of care. The Visiting Nurse Association of Milwaukee's caseload, as well as many other home health agencies, is experiencing an increase in patients 75 years of age and older. The median age of the VNA caseload is 75 years. They may require a little longer to recover, but often do return to full independence or independence with limited help if they have care based on need not payment source. We regret that neither Medicare or Medicaid has recognized the value of periodic assessment and evaluation of the elderly, particularly those over 75 years of age, to prevent or retard complications of age, and thus reduce institutionalization.

Another interesting statistic which demonstrates what little cost impact removal of a 100 visit limit will have, is the fact that of 6,000 Medicare A patients admitted to VNA services in 1978, 10 achieved 100 visit limit.

I wish to discuss briefly problems with Title 19 and Title 20 reimbursement. Confusion exists among providers of service, legislators and policy makers regarding the use of Title 19 and Title 20 monies as it relates to personal care. It is my belief, that the introduction of Title 20 monies for payment of personal care services without a clear definition of what level of care Title 20 was to serve, has caused much of the problem. It is impossible to categorize patients' needs into Titles 18, 19 and 20. Patients are not static, they are ever changing. Personal care regardless of source of funding must provide the patient an opportunity to move from minimal professional supervision to maximum as his condition changes. Often people giving personal care are unable to recognize the change or have not developed agency linkages which would provide for continuity of personal care.

Title 19 in the State of Wisconsin has been paying cost of covered home health services. It is only this year that the possibility of a cost cap on homemaker-home health aide service has been recommended. A cap which is well below the median cost of the certified home health agencies. We are presently working with the state to resolve this issue, as I am sure we will. I bring it to this committee's attention because I know of many other states where agencies are paid far below cost by Title 19, thus increasing the already addressed dilemma of charitable service. Home health agencies are often reminded to become more businesslike. Good business practice requires cost be paid for covered service.

In closing, I would like to comment on the proposed cost caps and uniform accounting systems. We feel the proposed Medicare cost caps, if they must exist, should have been set after the Uniform System for Home Health Agency Reporting had been developed and tested, and the additional cost to the agencies for such a system was determined. A further cost to our agencies, which we would like to bring to your attention, impacting on cost, and which this committee should be cognizant of, is cost of mileage. In 1978, the Visiting Nurse Association of Milwaukee's field staff travelled over 770,000 miles at a cost of $166,500 (17¢ a mile). This cost will increase as gas prices increase. Costs will further increase if we are to wait in lines for gas, thus reducing staff productivity. Many of our medical supplies have oil and petroleum basis and will also be adding to additional cost.

Thank you gentlemen. It has been an honor to address you.

STATEMENT OF THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION, BY MORGAN DOWNEY, DIRECTOR, GOVERNMENTAL AFFAIRS DIVISION

Mr. Chairman, the American Speech-Language-Hearing Association is grateful for this opportunity to offer its views on changes in Medicare's home health benefits. The Association is composed of over 30,000 speech-language pathologists and audiologists, many of whom participate in Medicare and Medicaid programs and in their home health care components.

Under the present Medicare law, home health care benefits are skilled care oriented. They are not designed to provide coverage for care related to helping 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 do include part-time or intermittent nursing care; physical, occupational, or speech therapy; medical social services; services of home health aides; medical supplies and appliances; and, for agencies affiliated with a hospital, medical services provided by an intern or resident in training.

To be eligible for home health care under Medicare, the person must be confined in his residence, under the care of a physician, and in need of part-time or intermittent skilled nursing services and/or physical or speech therapy. A physician must prescribe the need for such care. If these requirements are met, a person is eligible to receive other covered home health services.

The qualifications for home health benefit include a period of hospitalization for at least three consecutive days prior to the start of inhome care. The care must be provided for an illness for which the person received services as a bed patient in the hospital and must be provided within a 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 a year 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, without prior hospitalization provided certain conditions are met.

In commenting at the outset, we would like you to know that our Association's position is in favor of the elimination of limits on number of visits under Part A and Part B of Medicare as well as the elimination of prior hospitalization requirement under Part A. We believe that these limitations do not provide any significant cost

savings and unduly restrict access to home health by persons in need of such care. The requirement of a three-day hospital stay prior to home health service delivery does nothing to contain costs and frequently inflates them. It is an arbitrary imposition that imposes an unneeded restriction on the delivery of these services. HEW reported in Health, United States, 1978:

The restrictive nature of these requirements (for Medicare coverage of home health service delivery) has been a major cause of a generally recognized underutilization of home health care. Not only are the regulations and definitions restrictive, but their complexity also makes them subject to a variety of interpretations. Consequently, payment is sometimes denied to those who have supplied services. Although often cited as an important factor in long-term care financing, Medicare is, in fact, more geared to meeting the short-term needs of acutely ill, rather than those with chronic illnesses or lasting disabilities. (at pp. 102-3)

What is integral to the delivery of home health care is the availability and accessibility of the services that Congress meant home health agencies to provide. We cannot speak for the other services that home health agencies deliver. But our experience in terms of home health agencies' delivery of speech-language pathology services might be helpful for this Committee to analyze whether the Congressional requirements are being met.

We will not rephrase at this point the statistics with which this Committee is no doubt familiar. Speech and the hearing problems that often are related to disorders of speech have already been analyzed and their prevalence in the elderly population has been found to be from 30-70 percent. Despite the requirement that those who provide home care must be able to provide more than simple nursing care, that is, the home health agency must provide at least one other therapeutic service if it is to be eligible for Medicare reimbursement, less than one-half of the home health agencies provide speech-language pathology services either through an employee or under contract. Data obtained from Health, United States, 1975, reveal that in 1967 20.6 percent of home health agencies surveyed provided speech-language pathology services, and in 1974, seven years later, 30.7 percent provided speech-language pathology services. These figures might be compared with those of nursing care (100 percent in 1967 and 100 percent in 1974) and physical therapy services (68.5 percent in 1967 and 71.9 percent in 1974). Although medical social services and home health aide services are not requirements for Medicare reimbursement, according to Health, United States, 1975, in 1967 22.8 percent of home health agencies surveyed provided medical and social services and 34.3 percent provided home health aide services; in 1974 23.3 percent provided medical social services and 67.4 percent provided home health aide services (at p. 145).

In addition to home health agencies which do not offer speech-language pathology services, other agencies complicate the lack of accessibility through "paper compliance"—that is, demonstrating a signed contract with a speech pathologist to provide services, but never in fact providing those services.

What are the causes of this underutilization? There may be several, but some can be identified at the outset. First, Section 1861(o) of the Social Security Act requires that home health agencies provide services that are supervised by a physician or registered professional nurse. The unfortunate result of this provision is that speech-language pathologists and other health professionals providing services usually have no input into policies, procedures (including referral procedures), or review of services provided by the home health agency. Despite Congress' apparent intention to attempt to provide an integrated program through home health agencies for Medicare beneficiaries, the result has been the opposite: nurse- or physician-dominated control has resulted in limited use of other disciplines to provide services. This lack of integration of services makes maximizing benefits for patients extremely difficult.

Secondly, in many cases physicians and nurses are not trained to identify and deal with speech problems; they may simply attribute a decline in verbal ability to an elderly patient's decline in ability to hear. Progressive deterioration of an older person's hearing can deny that person self-corrective mechanisms to keep his or her speech clear and understandable by others. Yet Medicare excludes any services relating to hearing aids and provides for evaluations by audiologists only when they aid the physician in the diagnosis of a medical condition. Audiological rehabilitative services for the hearing impaired (e.g., speechreading, auditory training, speech conservation) are not covered services under Medicare Part B. We propose that this Committee make audiological rehabilitative services conducted by qualified audiologists a covered health benefit to the extent that home health agencies should reimburse qualified audiologists to evaluate their beneficiaries to determine the nature of any hearing loss and to provide rehabilitative services to facilitate com-

munication of the hearing impaired. That does not include the provision of a hearing aid but it does provide that Medicare beneficiaries would receive the best audiological testing and rehabilitation possible for their condition. We recommend that as much as possible the requirement provide for transportation to a suitable speech and hearing facility, be it hospital clinic, speech and hearing center, or other office, since the use of sound-proof chambers and sophisticated equipment is necessary to proper evaluation. Only in exceptional circumstances should an evaluation actually be done in the home.

Third, we urge that this Committee recommend that HEW undertake a program of instruction for home health agency administrators so that they may become more adept at understanding the nature of communication impairments in the elderly and understand what services are available to them. This Association has undertaken some activities in this regard and would certainly be interested in working with the Department of Health, Education, and Welfare or Administration on Aging to develop such an educational program.

Fourth, the unavailability or inaccessibility of speech pathology services may in part be due to some reimbursement problems. Specifically, we have received complaints from speech-language pathologists who have health agencies reimburse them at shockingly low rates, often much less than usual charges. We believe that the Committee should not encourage home health agencies to hide behind confusing reimbursement rationales. Rather, this Committee should make clear that home health services should be reimbursed on a reasonable charge basis to the speech-language pathologist (and audiologist) practitioner. The delivery of this form of care must be on an equal basis with that of hospital inpatient, outpatient, and skilled nursing facilities or those facilities will be the only locations where services can be received.

One final comment concerns the Medicaid program's home health provisions. We are concerned that under Title XIX and Medicaid regulations there is a discrepancy between what the income eligibility standards are for nursing home care and for home health care. This discrepancy favors the institutionalization of elderly persons. We support changes to equalize institutional and community eligibility standards so that persons who might otherwise be institutionalized can remain in their own homes when it is cost-effective to do so.

Statement of the American Dietetic Association

The American Dietetic Association is submitting the attached statement to be inlcuded as part of the printed record of hearings on Medicare and Medicaid Home Health Benefits by the Senate Committee on Finance.

This statement is being presented by The American Dietetic Association in behalf of its 39,000 members. Founded in 1917, the objectives of the association are: To improve the nutrition of human beings; to advance the science of dietetics and nutrition; and to improve education in these and allied areas.

The American Dietetic Association has adopted a policy statement supporting the premise that nutrition services under the supervision of qualified nutrition personnel should be a component of ALL health and health related programs and should be designed to reach the total population with priority to such nutritionally vulnerable groups as infants, children and youth in the growing years; women in the childbearing years and the older population.

In its commitment to professional and social responsibilities for the promotion of optimal nutritional health the Association believes that dietitians as the only professionally educated group whose primary concern is the application of nutrition science to the care of people, should be involved in the planning and execution of all comprehensive health care programs. Registered dietitians believe that nutrition is an integral part of total health and life care and urge that all efforts in nutrition and health be multidisciplinary.

The American Dietetic Association is committed to the principle that the inclusion of nutrition services in comprehensive health care is positively related to the maintenance of health and the reduction of sick care costs and services. Registered Dietitians recommend that nutritional care provided by qualified personnel be included as a basis service in Title XVIII of the Social Security Act so that nutritional counseling would become a reimbursable service under the home health care provisions of the Act.

Under the present health care system the Medicare eligibles are provided all of the professional, nutritional care that a hospital can provide. Upon discharge to their homes this service is not a reimbursable one. There are those who continue to need some professional assistance in learning to cope with their diets while they try

to maintain independent living in a home atmosphere. Failure to manage their daily regimen can result in a prolonged illness or possible rehospitalization. This is far more costly than providing nutritional counseling as a home health service where it is needed.

Not every Medicare patient needs nutritional counseling but when it is deemed necessary and is prescribed by a physician it is not presently a reimbursable service and most often is not used. Including nutrition services among the covered home health services could help to reduce some prolonged hospital and skilled nursing home confinements. The elderly are the most likely to need long term care services of any kind. This is the very population group that finds it most difficult to understand a modified diet and to learn to live with it.

Knowledge of food and nutrition qualifies the dietitian as the health professional equipped to help individuals to improve their food practices and their nutritional status. The Registered Dietitian is a translator of the science of nutrition into the skill of furnishing optimal nourishment to people. The dietitian is educated in providing nutrition information, in interpreting nutrition facts accurately and using terminology that the public can understand and apply. Dietitians recognize and utilize human motivation to bring about change in food practices.

In a report from the Department of Health, Education and Welfare to the Congress pursuant to P.L. 95-142, it is stated: "The need for adequate nutrition and nutritional advice is indeed substantial among the Medicare population, but for the time being, these needs should be handled in the existing Medicare benefit structure."

The "existing Medicare structure" provides that "nutritional advice" can be covered as an administrative cost. In fact, where home health agencies employ registered dietitians their services are limited to counseling ambulatory patients who are able to come to the agency or advising home health, visiting nurses who in turn counsel the patient in the home. The home bound do not have the benefit of the direct service of the best qualified provider of nutritional care.

Home health services account for only between one and two percent of the total Medicare expenditures. We believe that including professional nutritional care could help to prevent hospitalization and rehospitalization which are far more costly.

Nutrition is a critical factor in the promotion of health and the prevention of disease. The public is becoming increasingly aware of this fact as science identifies the importance of nutrition in the recovery and rehabilitation from illness and injury.

Six of the leading causes of death in the United States have been connected to diet: heart disease, stroke, cancer, diabetes, arteriosclerosis and cirrhosis of the liver. In the report of the Senate Select Committee on Nutrition and Human Needs related to "Diet and Killer Diseases", there is material on, "Benefits from Human Nutrition Research" by C. Edith Weir, Ph.D., Assistant Director, Human Research Division, Agricultural Research Service, U.S. Department of Agriculture. Dr. Weir emphasizes the benefits to be obtained from improved diets and nutrition.

In addition to the health and social benefits to be derived from improved nutritional health, Dr. Weir's report estimates the potential dollar benefits to individuals or to the nation, as well as the possible reduction in the incidence of some diseases, e.g. heart and vasculatory disease, estimated 20 percent reduction in expenditures; respitatory and infections, $1 million in medical and hospital costs and an additional potential saving of $20 million in cold remedies and tissues; diabetes and carbohydrate disorders, 50 percent of cases avoided or improved; kidney and urinary, 20 percent reduction in deaths and acute conditions; cancer, 20 percent reduction in incidence and deaths.

The report from which we have just quoted ("Benefits From Human Nutrition Research") lists some nineteen disease states that require dietary treatment, monitoring and followup. Each of these has an impact on the health care and health care costs to the nation. It becomes more apparent that improvements in the nutrition of people will have a direct effect on the level of health and the resulting need for health care services.

In August 1976, the Public Health Service, DHEW, issued "Forward Plan for Health—Fiscal Years 1978-82", the third in a series of "Forward Plans". Among the "substantive priorities of the Public Health Service" the plan lists six major health care concerns, with nutrition mentioned as number three. Positive indentification of the importance of nutrition provides this subject with long overdue visibility.

The "primary focus" of the program of action is stated as a "major attack on cost escalation". We believe it is appropriate, therefore, that nutrition be identified as a major factor in health maintenance for all segments of the population. For many

Medicare recipients nutritional care and dietary counseling can be provided more economically and efficiently in their home setting, where it is a reimbursable service. In the home environment the Registered Dietitian can assess the physical and economic factors that influence the food habits of the individual and the ability to adjust to prescribed modifications.

Congresswoman Barbara A. Mikulski, a member of the House of Representatives Interstate and Foreign Commerce Subcommittee on Health and the Environment, is quoted as saying, "We should be encouraging more extensive use of other health professionals, such as nurse practioners, nurse midwives, and physician assistants or extenders * * *.

* * * By paying more attention to preventive medicine such as the recommendations of nutritionists and community health educators, and by developing more extensive use of other health professionals, I believe that we can insure greater access to high quality health care at a reasonable cost, while maintaining the concept of medical service as personal service. The American consumer is entitled to a wider choice of prevention and treatment modes". (From the Wall Street Journal, Monday, May 14, 1979)

When the incidence of prolonged illness or recurrence of contributing factors can be reduced the cost of sick care services such as hospitalization and rehospitalization can be reduced. This frees funds to both extend health care services and to reach additional people.

The concept of providing a comprehensive continuum of care for the Medicare beneficiaries after they leave a skilled care facility should insure that all aspects of health care be given due and proper consideration. The omission of nutritional care as one of the appropriate services in the continuum is ignoring our increasing knowledge of the contribution which positive nutrition makes to health.

The introduction to the Report of DHEW to the Congress, mentioned previously in this statement, has the following remarks: "The 1976 Pulbic Hearings and numerous staff papers and Congressional hearings have made it clear that the aged, disabled, their relatives and friends, as well as many other citizens want and believe in home care. They do not want to be limited to the relatively narrow, medically oriented benefit of Medicare, but seek a comprehensive, universally available set of home care services to meet a large range of needs. These services encompass the traditional health and medical treatment services as well as preventive and maintenance care, personal care and household services, nutrition and other services."

The need and demand for quality health care is not being met by and is critically straining the current health care delivery system. The alarming increase in the cost of health care services mandates a review and evaluation of the present health care services being provided and the gaps therein.

The American Dietetic Association recommends that the Congress amend title XVIII of the Social Security Act to include the recognition of the services of a Registered Dietitian in providing nutritional care in the category of health care "extender". Such action would bridge the gap that currently exists between the needs and expectations of the beneficiaries and the services being provided.

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ATTACHMENTS

The American Dietetic Associatin Fact Sheet-"Nutritional Care and Dietary Counseling".

THE AMERICAN DIETETIC ASSOCIATION, FACT SHEET—NUTRITIONAL CARE-DIETARY COUNSELING

The American Dietetic Association in commitment to professional and social responsibilities for the promotion of optimal nutritional health recommends that adequately funded programs of nutritional care be an integral part of all health care programs.

WHAT IS NUTRITIONAL CARE?

Nutritional care is the application of the science of nutrition to the health care of people. Nutritional care is not complete without dietary counseling.

WHAT IS DIETARY COUNSELING?

Dietary counseling is the process of providing individualized, professional guidance to assist people in adjusting their daily food consumption to meet their health needs.

The objective of dietary counseling is modification of behavior. This objective is accomplished when individuals understand how to make wise food choices.

WHAT DOES DIETARY COUNSELING SERVICE PROVIDE?

Dietary counseling is a component of a nutritional care program in which a registered dietitian gives professional guidance to an individual as part of a physician's treatment plan. The service includes:

1. Assessing present food habits, eating practices and related factors.
2. Developing a written plan for appropriate dietary counseling.
3. Translating the detailed plan with the individual.
4. Planning follow-up care and evaluating achievement of objectives.
5. Using records and reports for sharing pertinent information with other health professionals concerned with the individual's care.

Dietary Counseling includes the exploration of the patterns of food intake, socioeconomic factors and ethnic beliefs which may influence the individual's choice of food.

WHO IS RESPONSIBLE FOR NUTRITIONAL CARE?

The Dietitian: The American Dietetic Association believes that nutrition is an integral part of total health and life care and urges that all efforts in nutrition and health be multidisciplinary.

The American Dietetic Association believes that registered dietitians, as the only professionally educated group whose primary concern is the application of nutrition science to the health care of people, should be involved in the planning and execution of all health care programs.

The Consumers: As consumers become more aware that nutrition is a cornerstone of positive health, they will realize that it is their right to expect professional guidance and dietary counseling to assist them in developing and maintaining sound "nutritional" habits. It is their responsibility to assure the inclusion of nutritional care in all health programs.

The Government: As the government becomes more deeply involved in legislation to meet the health care needs of the population, it has a responsibility to provide nutritional care for both individuals and groups. Dietary counseling should be a part of every nutritional care program. Increasing costs for both inpatient and ambulatory health care make it mandatory that attention be turned to programs that will prepare citizens to assume more personal responsibility for their nutritional well-being.

To neglect the opportunity to insure more positive health for the population is not being totally responsive to a major health concern in this country. Health care legislation for the 70's must provide access to nutritional care.

The American Dietetic Association recommends that nutritional care, including dietary counseling, be integrated into preventive, diagnostic, curative and restorative health services provided under all national health programs and that nutritional care, as a component of health care, be available to all people on a continuing and coordinated basis. The Association recommends further that the planning and supervision of nutritional care be under the direction of persons professionally educated in nutrition as it relates to human health needs.

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