HOME HEALTH CARE

A Discussion Paper

League Exchange No. 113

Intra-Department
HHC Policy Working Group
U.S. Department of Health, Education, and Welfare
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FOREWORD

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It is recognized, however, that the time available at meetings and the pages of professional magazines are limited. Meanwhile, the projects in which nurses are engaged and which they should be sharing with others are increasing in number and scope. Many of them should be reported in detail; yet, such reporting would frequently exceed the limits of other media of communication.

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To the extent that all NLN members draw from, and contribute to, the well of nursing experience and knowledge, we will all move forward together toward our common goal—better nursing care for the public through the improvement of organized services and education for nursing.

Manufactured in the United States of America
FOREWORD

In the fall of 1976, more than 2,000 people attended five HEW sponsored regional hearings on home health care in Atlanta, Chicago, New York, Dallas and Los Angeles. Altogether, 514 citizens testified and more than 900 written statements and exhibits were presented. A synopsis of the 12,000 pages of testimony analyzed by the HEW staff was subsequently published in The Home Health Care Report on the Regional Public Hearings, dated October 29, 1976 (DHEW Publication No. 76-135).

In an attempt to assist the administration policy formation regarding the home health industry, an "in-house" HEW staff group was formed during the winter of 1976-77 to analyze the Home Health Care Public Hearings Report. That Policy Working Group identified and discussed the twenty-two issues raised at the hearings and presented a set of recommendations to the Secretary for future direction in home health.

NLN's Council of Home Health Agencies and Community Health Services (CHHA/CHS), through the mechanism of the League Exchange, is pleased to make the document available to the public at large as a service to all those interested in home health care. It reflects the thinking of the Policy Working Group drawn from all segments of HEW which deal with the industry. The document is illustrative of how the public and private sectors can work together towards the resolution of health care policy.

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FOREWORD
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INTRODUCTION

The dominant theme of the Home Health Care public hearings was that home health care should be expanded. This paper presents the Principal Operating Components' (POCs) analyses of the implications of expanding home health care and other related issues as additional background for subsequent policy decisions on home health care. This paper sets forth the principal issues to be addressed, particularly in the areas of legislative change and cost, if home health care is expanded. The Home Health Care Report on the Regional Public Hearings, dated October 29, 1976 (DHEW Publication No. 76-135), should be read in conjunction with this issue paper.

A Home Health Care Policy Working Group (HHC-PWG) composed of POC representatives, was formed to complete this issue paper within thirty days. Especially in view of this time constraint, there was excellent cooperation of the Working Group. It is evident that home health care has been carefully scrutinized by each POC, and that their strong viewpoints are based on identified legislative and regulatory restrictions perceived to limit their flexibility in resolving issues associated with expanding home health care. This cooperative undertaking has promoted better Departmental understanding of the overall dimensions of the problem, and eliminated many extraneous considerations from the discussion.

A basic decision must first be made as to the social utility of expanded home health care. The overwhelming thrust of
the public hearings is that expanded home health care is highly desirable. The HHC-PWG did not challenge this assumption, but felt it would be prudent to further examine potential negative aspects of this action. If home health care is to be expanded, its social utility must be balanced with cost considerations. More study is required to enable the Department to make the cost projections associated with expanding home health care through such options as enlarging basic eligibility and creating greater public awareness of this service. The possibility of effective cost trade-off must also be considered.

State and local concerns must be considered if federal policy is directed toward expanding home health services, since federal policy will have a substantial effect on home health care. The impact of decisions regarding home health care on state and local government, medical providers, fiscal intermediaries and other segments of the private sector such as voluntary social welfare agencies must be anticipated. State and local governments have essentially the same restraints and inducements as the federal government. For example, it is clear that state and local governments have a strong interest in providing better services to citizens. The perilous financial situation of many states, however, will make them very cautious about the ultimate cost of expanded home health care services, and whether they can afford to provide additional services. Consideration must be given to a federal government policy that will result in states, local entities and the public fully participating in actions to address local needs and priorities. This paper includes two principal sections, "Expansion of Services" and "Management of Expanded Services." All the pertinent issues raised at the public hearings are addressed in these sections. A synopsis of recommendations for home health care is presented in the following section.
STATEMENT OF RECOMMENDATIONS ON HOME HEALTH CARE

Prepared by the Writing Team for the Report on the Regional Hearings on Home Health Care

This statement sets forth recommendations developed by the home health care report writing team for use in the formulation and improvement of Department policy in this area. These recommendations emanate from the long-range goal of system reform involving the increased use of ambulatory and home-based services, coupled with a reduced emphasis on institutional care, except where absolutely necessary. Because much more remains to be learned about the structural configuration and probable consequences of such system reform, and because even minor errors in judgment often are extremely costly, proposed changes are approached circumspectly.

We believe the following recommendations are both feasible and conducive to the achievement of some shorter-range goals that will move the health care delivery system in the right direction.

NATIONAL EXPERIMENTAL BENEFIT PERIOD

The writing team recommends that proposed legislation be developed to authorize a three-year national demonstration of expanded home health care benefits with a uniform Federal definition of home health care. The concept of a "national experimental benefit period" is discussed below, followed by the identification of the principal features of such a demonstration.
In contrast to the inherent appeal of demonstration programs, firsthand experience with the enormous problems of mounting and evaluating these demonstrations militates against the initiation of a major demonstration program for selected localities, states, or other large geographical areas. The Department's experience with Section 222 homemaker/day care projects, the Einstein day hospital program, and Project Triage, in particular, provides the basis for serious questions about the advisability and feasibility of undertaking a new large-scale demonstration program for home health services. Special problems with such demonstrations have included:

1. **System change.** The delivery of home health care affects so many disparate factions—including numerous service providers and third party payors—that difficult and prolonged changes almost always are required in order to develop a demonstration project at the local level. Services frequently have to be developed *de novo*, as well as coordinated among various home health care providers; in addition, relationships have to be worked out with hospitals, skilled nursing facilities, intermediate care facilities, and hundreds of physicians and other individual health practitioners. The level of commitment required on the part of demonstration project staff to bring about necessary system adjustment and responsiveness is stupendous.

2. **Bureaucratic impediments.** The bureaucratic problems surrounding the implementation of such demonstrations cannot be overemphasized, even with the existence of broad waiver authorities such as those provided by Section 222 of the Social Security Amendments of 1972. Project Triage alone involved nearly every aspect of DHEW health and social service policy, grant and contract management, and such complex issues as privacy, confidentiality, and the protection of research subjects. Applicants for demonstration funds rarely are experienced in these areas, and must be exposed to and learn pertinent legislative requirements, regulations, and policy. Federal-State relations become strained in the process.

The implementation of Project Triage has cost well in excess of half a million dollars in DHEW technical assistance alone, and has taken over two and a half years to fully implement. The Einstein day hospital project, which is just becoming operational, took even longer to implement and involved even more formidable obstacles at the State and
local levels, where the problem of establishing accountability was insurmountable for nearly a year. The technical assistance costs to the Department for this project exceeded $250,000 and research costs will have reached $750,000 by the first year of operation.

The six federally-initiated homemaker/day care experiments have also proved to be extremely costly to implement, especially in relation to the narrow scope of benefits to be evaluated (i.e., homemaker and/or day care services provided to Medicare beneficiaries following a hospitalization lasting at least three days). These projects have cost over $2.5 million in demonstration and evaluation funds, and while the cost data furnished will be useful because control groups have been utilized, the subgroups identified for comparative purposes often are so small that the data are not likely to persuade any skeptics.

3. Evaluation problems. The potential for evaluation is affected by problems such as:

- System change (either natural or induced) occurring during the demonstration period;
- The virtual impossibility of collecting adequate baseline data on a small scale (including Medicare, Medicaid, Title XX, Older Americans Act, or private agency data);
- The difficulty (ethically and practically) of obtaining matched sample populations to serve as control groups for evaluation purposes;
- Controversy over the use of a specific diagnosis (the Medicare emphasis) versus an assessment of "functioning status" as the best approach to matching sample populations on a control basis or as comparison groups; and
- Problems of follow-up of project participants, including the difficulty of obtaining information on their use of other health and social services (e.g., physician visits, private or public social services, prescription and over-the-counter medications, and institutional care).

Concept of a “National Experimental Benefit Period”

In view of the significant problems associated with cur-
rent demonstrations, the benefits of a “national experimental benefit period” as a recommended future initiative require some explication. It would certainly not be a small undertaking to evaluate such a national demonstration, but this approach would entail some important advantages if carefully planned and implemented. The national experiment would provide expanded home health coverage by changing the requirements for eligibility under Medicare (as outlined below), and would allow states to pool Title XX and Older Americans Act funds for in-home services. States would also be encouraged to offer comparable benefits under Medicaid.

The choice of a three-year experimental period is somewhat arbitrary; however, three years is probably long enough to gain useful information and experience. A five-year period would allow more time for fundamental changes in order to determine if reductions in the use of institutional care really do result over time with increased availability of home health services.

National baseline data would be gathered before the start of the experimental benefit period. This data would serve as the “control” against which the experimental benefits would be evaluated. Baseline data would have to be obtained from Social Security Administration fiscal intermediaries on how much it costs to provide home health services on a per client, per claim, and per service basis under the present Medicare program. Similar data on Medicaid costs would have to be obtained from the states, as would data on Title XX and Older Americans Act expenditures for home-based (or in-home) services. An important addition to this potential data base will be data from the homemaker/day care experiments under Section 222 and a fifteen-year longitudinal study of clients of a San Francisco home health agency. Both sets of data will be available in the Spring of 1977.

This approach is certainly open to criticism on at least three counts. First, it would be difficult to retract the benefits at the close of the experimental period regardless of the cost/benefit relationship that results, since people will have become accustomed to them. Second, the cost ramifications of the experimental benefits cannot be predicted with any certainty based on available data. Third, although it seems clear that people prefer to use ambulatory and home-based services rather than institutional care whenever possible, adequate proof cannot be amassed to substantiate the claim that home health services will necessarily be less costly than institutional care, or that the projected system reforms will be beneficial in every sense, including with respect to cost.
containment. Notwithstanding these and other criticisms, such benefit changes are in keeping with the overall redirection of the health care system as laid out in the Forward Plan for Health, and with the Department's Bicentennial objective of "freedom from dependence." In addition, while the Department seldom has retrenched on the provision of new or expanded benefits in past programs, it does not necessarily follow that adjustments could not be made in this instance, should the cost consequences be as dire as some predict.

The combination of desirable experimental benefits and the growing need for improved coordination of services, strengthened plans of treatment, and improved quality assurance—together with a general preference for noninstitutional care and the possibility of approximating widespread system reform—strongly suggest that a novel approach to the delivery of home health services in the U.S. is warranted at this time.

Medicare Benefit Changes

Because current Medicare program requirements are viewed as a major impediment to the delivery of home health services required by a large number of individuals, the following modifications would be made during the "national experimental benefit period" to encourage the use of home health care by eliminating artificial barriers that are unduly restrictive and that promote unnecessary institutionalization.

1. Remove the 3-day prior hospitalization requirement. This recommendation is intended to increase the availability of home health services for persons who do not require inpatient care, and to eliminate the need for persons to be hospitalized in order to be eligible for the home health benefit.

2. Eliminate the "skilled" care requirement. Elimination of the "skilled" care requirement would achieve several objectives: (a) facilitate the provision of needed home health care to persons who do not require the services of a nurse, a physical therapist, or a speech pathologist (i.e., "skilled" care as currently defined) and whose needs can be met by other health professionals or someone with a lower level of training; (b) minimize deterioration in the functioning level of persons who require services, but not "skilled" care, and thereby delay or obviate the need for more costly services;
(c) make homemaker and home health aide services more accessible; and (d) permit the matching of services with patients' needs.

3. Remove the "therapeutic" requirement. While services essential to the rehabilitation or recovery of a patient are indispensable to any home health care delivery system, the likelihood of a patient's being cured or restored should not be a deciding factor in determining eligibility for services. It is recommended that steps be taken to ensure that the "therapeutic" requirement not be utilized by fiscal intermediaries as a determinant of eligibility for services. It is further recommended that homebound persons with chronic and terminal illness, for whom recovery or improvement is not likely, be included under eligibility criteria.

Under a well-designed national demonstration program, information could be obtained relative to the cost implications of this proposed modification. It will also be important to examine (a) the relationship between the occurrence of episodes of acute illnesses associated with chronic conditions and the availability and utilization of home health care; and (b) the relationship between the receipt of home health services and the demand for long-term institutional care among the chronically ill.

4. Modify the "homebound" requirement. It is recommended that the "homebound" requirement be modified to allow reimbursement for services provided to persons who should leave the home at predetermined intervals to engage in activities (in addition to the receipt of medical treatment) considered to be part of the treatment regimen as specified in the plan of treatment. Although the definition of "homebound" used in current Medicare guidelines is not entirely inconsistent with this recommendation, varying and restrictive interpretations by fiscal intermediaries serve to reduce the similarities. This revision would foster independence on the part of the patient, result in cost savings by removing a major obstacle to the provision of services that otherwise would have to be provided on an inpatient basis, and in many instances, encourage consideration of activities which can provide the patient with an incentive to "get well."

5. Modify the "part-time or intermittent" requirement. Although the care requirements of many patients fall within the definition of "part-time or intermittent" care as estab-
lished in Medicare guidelines, the achievement of therapeutic goals set for many others frequently is stifled due to the restrictive interpretation of these guidelines. It is recommended that the “part-time or intermittent” requirement be modified to allow the provision of any necessary home health services on a full-time temporary basis, according to the specifications of the plan of treatment.

6. Require an expanded and more comprehensive plan of treatment. The plan of treatment should contain reasonable and achievable goals described in sufficient detail to allow for outcome measurement as a basis for assessing quality of care. Measurable goals form the basis for effective and simplified quality assurance mechanisms, and strengthen the efforts of the various disciplines involved in caring for patients. The plan of treatment established by the physician should allow the professional staff of the home health agency to specify the amount and duration of services, and to add other appropriate services when essential to the achievement of a desired medical result.

Coordination Mechanism

Essential to the success of the experimental benefit period is the establishment of a coordination mechanism with responsibility for fostering the development of and coordinating home health and related services as needed at the local level. Community services are fragmented, with health and social services available under widely dispersed and divergent administrative arrangements. Most people in need of home health care are not equipped to locate and arrange for the appropriate mix of services required to meet their needs, and then to find various payment sources to finance these services. Fragmentation reduces the efficiency and effectiveness of services, and often forces people to turn to institutions for needed comprehensive services. A community coordination mechanism would provide the needed packaging of services and tailor them to individual needs. Having services available when and where needed would assist people to maintain the maximum possible degree of independence in the community and help contain costs.

States and localities would be encouraged to try various coordinative mechanisms depending on the arrangement which is most feasible and acceptable for a given area. Funds for the support of coordination mechanisms would be provid-
ed by the Medicare, Medicaid, Social Services and Older Americans Act programs, possibly as an allowable administrative cost. Individual cost sharing could also be used; and the participation of local funding sources would be encouraged.

CERTIFICATE OF NEED

A second major recommendation relates to requiring a certificate of need for home health services that would promote coordinated and comprehensive planning and development of services at the local level, as well as encourage the integration of home health services with other health and health-related services. Most home health agencies are not now subject to review at the local level as to the need for the type and amount of services to be delivered. Medicare certification provides limited quality control, but does not prevent unnecessary proliferation of home health agencies. Further, states that do not require licensure of home health agencies have no control over the type and number of agencies providing nonmedical services to residents of the state. A certificate-of-need process would require all home health agencies to undergo scrutiny based on the need for services and capability of providing quality care.

OTHER INITIATIVES

Finally, it is recommended that the following initiatives be undertaken. The Public Health Service would have a major role in the conduct of each of these activities.

1. Further develop patient assessment tools appropriate to the provision of home health care;

2. Review the use of home health services as a supplemental service provided under PHS health services delivery projects (e.g., community health centers, community mental health centers, etc.) to determine whether expansion of effort in this area is necessary and feasible;

3. Determine (based on an evaluation of current program experience) whether HMOs constitute a viable mechanism for providing, or arranging for the provision of, home health services in inner-city and rural areas;

4. Utilize home health expansion and developmental proj-
ects to obtain data on cost and cost-effectiveness of home health services;

5. Examine the role of PSROs and other mechanisms relative to assuring the quality of care in the home, and establish this as a priority under ambulatory care review activities;

6. Explore (with SRS, SSA, FDA) possible ways of minimizing and preventing harmful practices related to the utilization of drugs in the home;

7. Develop methodologies for determining community need for home health services (NCHSR and BHPRD);

8. Ensure that home health activities authorized by P.L. 94-63 emphasize the use of satellites and other models suitable for the delivery of home health services in rural areas, and relatedly, determine whether the Rural Health Initiative can be used to expand the delivery of home health services in rural areas;

9. Involve the Office of Health Information and Health Promotion and PHS agencies in the planning and implementation of health information and consumer education activities relative to the use of home health services;

10. Determine how health manpower training and education programs can be utilized to educate providers (both professionals and paraprofessionals) regarding the purpose and significance of home health services;

11. Experiment with the use of nurse practitioners and nurses as "authorizers" of home health services (utilizing the Section 222 mechanism, if possible); and

12. Determine what contribution Health Systems Agencies can make to the coordination of home health services at the local level.

Other appropriate actions would be identified through discussions with PHS agencies. Because other departmental components could contribute much to the satisfactory completion of these initiatives, their views and participation also should be sought.
...bility. The American Health Plan and the National Health Planning Council have stated that hospitals and medical institutions should be encouraged to provide home health services, and that the federal government should continue to support such programs. The American Hospital Association has also stated that home health services are an important part of the total health care system.

A second major recommendation is that the federal government should continue to support public health services in the form of grants to state and local governments, and to hospitals and medical institutions. These grants would be used to support the development of new programs, and to improve the delivery of existing programs.

Furthermore, it is recommended that the federal government should establish a national database of home health services, in order to facilitate the evaluation of the effectiveness of these programs. This database would include information on the number of patients served, the types of services provided, and the outcomes achieved.

In conclusion, the provision of home health services is an important aspect of the total health care system, and the federal government should continue to support these programs in order to ensure that all Americans have access to high-quality care.
SECTION I

EXPANSION OF HOME HEALTH SERVICES

A number of considerations are associated with a decision to provide expanded home health services under federal programs. The principal considerations discussed in this section are expanding:

- services available to Medicare eligible individuals;
- services to Medicaid-eligible individuals;
- eligibility for the Medicare and Medicaid programs;
- changing the emphasis of Administration on Aging programs;
- the number of home health care providers;
- promoting public awareness and use of home health care services.

A. EXPANDING HOME HEALTH SERVICES: MEDICARE ISSUES

In considering the implications of expanding home health services available to Medicare beneficiaries, the Social Security Administration takes the position that Medicare is fundamentally different from other HEW programs that support home health care. Medicare is a medical insurance program, financed through payroll taxes and with premiums paid
by beneficiaries of the program. As is the case with any insurance program, it provides a carefully structured and specifically limited package of benefits, including the home health care benefits. These benefits are directly related to the amount of funds available through the existing financing mechanism. In addition, present Medicare home health care benefits are limited to individuals with skilled care needs. Accordingly, individuals whose medical condition dictates the need only for non-medical services such as homemaker services, meals and nutrition services or transportation, i.e., individuals who need assistance in meeting only the activities of daily living (bathing, eating, taking self-administered medications, routine exercises) and carrying out household functions (shopping, scrubbing, ironing, etc.) do not qualify for Medicare home health benefits.

Expanding Medicare to make individuals needing such non-medical services would change the present structure and purpose of these benefits, and would convert the Medicare home health benefit from a medical insurance benefit to a social needs benefit. Before making such a fundamental change in approach, serious consideration should be given to whether an insurance program, such as Medicare, is an appropriate and desirable mechanism for meeting social needs since there is no precedent for financing such care through an insurance program, either public or private. In addition, particular attention should be given to the question of whether the current financing mechanism represents a viable and equitable means of financing a social needs program.

Issue 1
Medicare three-day prior hospitalization requirement.

Discussion

Under part A of Medicare, a beneficiary must have been a hospital inpatient for at least three consecutive days in order to be eligible for home health benefits. Eliminating this requirement would presumably discourage beneficiaries from seeking costly hospitalization simply to receive home health benefits.

Approximately 97 percent of the beneficiaries who have Medicare part A coverage also are covered under the supplementary medical insurance program (part B), and home health benefits currently are available under part B without any prior hospital admission requirement. Few beneficiaries exhaust their home health coverage under part B, consequently, there is little incentive for them to seek hospital ad-
missions in order to qualify for home health benefits under part A, particularly in view of the fact that deductible expenses incurred under part A are higher than under part B.

Since the part A prior hospitalization requirement applies to only 3 percent of beneficiaries, there may be little reason for retaining the requirement, and the removal might reduce the cost of inappropriate hospital care to the extent that there is any. On the other hand, because part A home health services are linked to a hospital plan for insured beneficiaries, it may be inappropriate for an insurance plan to remove the required hospitalization.

**Issue 2**

**Medicare limitation on the number of home health visits.**

**Discussion**

Under present law, a beneficiary is eligible for one hundred visits after the start of one spell of illness and before the beginning of another following a qualifying hospital or skilled nursing facility stay under part A, and one hundred visits per calendar year under part B. Since few beneficiaries exhaust the number of Medicare home health visits presently allowed, removing the limitation would be expected to have a minimal effect on program costs, if the other requirements of present law remain intact. However, if the proposal were coupled with lowering the skilled level of care requirement or removing other existing legal restrictions, cost increases could be prohibitive.

This issue may not affect large numbers of Medicare beneficiaries. Patients' benefits are usually terminated, not because they exhaust the number of visits, but because the level of care required has changed from skilled to a lesser need, making them ineligible for further care. Removing the limit on visits may not substantially increase the benefit since few individuals may be able to meet the "level of care" requirement for a period long enough to benefit from the increased numbers of visits.

**Issue 3**

**Medicare requirement that patients be "homebound" before receiving covered home health services.**

**Discussion**

The homebound requirement under Medicare is intended to assure that those beneficiaries who do not require services in the home obtain them from more economical locations: i.e., a doctor's office; hospital outpatient department;
clinic; rehabilitation agency, etc. Under present law, a patient need not be bedridden to be considered confined to his home, but is permitted only infrequent or relatively short absences from the home.

The meaning of "homebound" may be artificial and difficult to administer, unfairly limiting the activities of those too frail or ill to regularly receive services outside the home. For example, a quadriplegic who by all rights is homebound, could go to work and lose eligible status, or an elderly person making an occasional visit to friends or relatives may face a loss of eligibility. It should be noted that the lack of transportation is often a factor in making the patient homebound.

A potential adverse consequence of removing the requirement may be the cost implication of expanding benefits to a new category of beneficiaries. For example, removing the homebound restriction is frequently considered for dialysis patients. Under present law, the major restriction that keeps home dialysis from being covered as a home health service is the homebound requirement. More specific means of addressing the problems of renal disease patients may be considered, rather than changing the home health requirements for all categories of patients. SSA believes that a question exists as to the appropriateness of paying home-based services that could be provided safely and effectively in a more cost effective setting.

**Issue 4**
The "requirement" that services must be restorative to be covered under Medicare home health benefits.

**Discussion**
In the past, fiscal intermediaries have incorrectly denied coverage when they determined that the patient had no restorative potential. Subsequent instructional material to fiscal intermediaries has corrected this error. Thus, there is no requirement in present Medicare law, regulations or instructional material that home health services may be provided only if they are restorative in nature.

**Issue 5**
Medicare requirement that a beneficiary require "intermittent" and part-time services.

**Discussion**
To be covered under Medicare, home health services must be provided on an "intermittent" and part-time basis. The intent of this provision is to define the intensity of cov-
ereed care: less than the full-time care required in institutions, but greater than sporadic, one-time visits. Although there are exceptions, coverage is generally not extended to services that are not required at least once every sixty days. In addition, care more continuous than a few hours a day provided several times a week may indicate that an institutional setting would be more appropriate and more economical.

**Issue 6**

**Medicare “skilled” nursing concept.**

**Discussion**

Present interpretive practice confines the definition of “skilled” services to those provided or supervised directly by professionally or technically trained persons, such as physical and speech therapists or nurses. A broader definition is needed to cover services the physician considers necessary to the patient’s medical well-being. The law states that the Secretary shall establish the dimensions of home health aide care. Medicare Condition of Participation (20 CFR 405.1227) includes in the aides’ duties, “household services essential to health care at home.” Coverage provisions (3119.2 Part A Intermediary Manual), however, greatly restrict the home health aide benefit by stating that the home health aide service will be reimbursed only “if these household services are incidental and do not substantially increase the time spent by the home health aide.”

This provision could be changed so that home health agencies would be reimbursed for furnishing those household services essential to health care in the home. The statute could be broadened to include coverage of “in-home services,” an array of medical and support services that can be brought into the home, singly or in combination, to meet the needs of persons in all age groups, in all diagnostic categories and in all economic and psycho-social situations. These services could be used therapeutically, or to prevent or arrest illness and disability, supplement limited function and to protect and support those whose capacities for optimum development, function and participation in family and community life are threatened.

Broadening the statute’s coverage might reduce the need for institutional care by making services available that may delay worsening of the patient’s condition and hospitalization. This change would also permit provision of home health services comparable to those in a skilled nursing facility, where an aggregate of unskilled services is considered
skilled care requiring the management and supervision of the care plan by a licensed nurse.

Broadening the coverage would, however, increase the number of persons who would become eligible for service. The increased costs could be so great that no commercial carrier would include this array of beneficiary benefits. There is also no reason to equate home health services with institutional services, since individuals requiring twenty-four hour institutional care would be unable to obtain equivalent services at home.

Issue 7
Medicare requirement that beneficiaries need skilled nursing care or physical or speech therapy to receive other home health benefits.

Discussion

Under present law, a beneficiary who needs skilled nursing care on an intermittent basis, or physical or speech therapy, and whose care satisfies certain other conditions, is also entitled to receive a variety of additional services. These include the services of home health aides, occupational therapists, medical social workers as well as coverage of medical appliances and supplies. The qualifying requirement for skilled care was included in the original statute to satisfy the legislative intent that Medicare payments be restricted to treatment of a condition necessitating skilled care.

The removal of "skilled care" requirement would allow needed services to be continued long enough to make the beneficiary more independent than is possible under current legislation. Persons would be eligible for long term care using one hundred visits as the criterion for discontinuing service. A change would make home health services available to greater numbers of beneficiaries needing services since the concept of "skilled" care is somewhat artificial and has been used principally to contain costs.

As indicated earlier, SSA believes that removing the skilled care requirement would have the effect of converting the Medicare program from a medical insurance program to a nonmedical, social needs program and that such an expansion would make all beneficiaries eligible for benefits since all beneficiaries have some of these needs. While intended to expand outpatient care and thus delay or prevent more costly institutional care, removal of the qualifying requirement would make it almost impossible to distinguish medical care from care that is beneficial, but not health-related. The pro-
posed change would also be inconsistent with the require-
ments in the law that services are meant for further treatment
of a condition that required admission to a hospital or a
skilled nursing facility. In addition, home health services
would be made available to persons with minimal needs, and
the increased numbers of patients and visits would escalate
the cost to make home health services prohibitive.

B. EXPANDING HOME HEALTH SERVICES:
MEDICAID ISSUES

Issue 8
Uniform practices for Medicaid reimbursement and services.

Discussion

Many home health agencies today can afford to accept
only a small percentage of Medicaid patients, and some pri-
vate not-for-profit agencies will accept only Medicare pa-
tients. One of the principal barriers to home health care under
Medicaid relates to reimbursement, since the law does not re-
quire states to pay "reasonable costs." There are six meth-
ods that states use to determine rates:

(1.) the "reasonable cost" principle which Medicare uti-
lizes;
(2.) usual and customary charges;
(3.) schedule of maximum allowances;
(4.) cost related reimbursement;
(5.) negotiated rate;
(6.) fixed fees.

Only two methods, "reasonable cost" and "usual and
customary charges" assure the provider that reimbursement
by Medicaid will be the same as that by Medicare. One ap-
proach would be legislative change that requires states to
reimburse home health agencies on a cost or cost-related ba-
sis. It is likely that an increase in reimbursement levels would be effective in inducing agencies to accept Medicaid patients.

Another barrier to the provision of comprehensive home health services under Medicaid is the lack of therapy services. These therapies are not provided in many states. For those individuals who require physical or occupational therapy, speech or hearing services on an out-patient or on an in-home basis, the lack of these services may require institutionalization merely to obtain therapy. Even though regulations relating to admission to nursing homes specifically indicate that the lack of out-patient services is not a reason for admission, it can be assumed that such admissions take place.

It must be understood that these barriers are in place to reduce or contain costs. Should they be removed, there would be a significant increase in costs. Under a grant-in-aid program like Medicaid, states could be very unwilling to assume their share of the increase. Such change might require federalization or increased matching funds for home health, in view of the states' efforts to control costs. It is not possible to estimate the additional cost, since availability of services would increase the demand.

Changing the legislation to require Medicaid agencies to use the same reimbursement formula as Medicare would affect about twenty-three states since other states already use the Medicare method of determining costs. Costs in these twenty-three states would increase, unless services are cut. This change would increase the number of agencies accepting Medicaid patients and remove the quota systems in those agencies accepting Medicaid patients. It would make services available to a greater number of eligible persons, and may reduce institutionalization.

To reduce institutional costs that include therapy as an in-patient service, therapy must be available for patients in their own homes or be mandated as an out-patient service. Mandatory home health therapy services could reduce the number of persons being admitted to nursing homes for in-patient therapy services, and provide potential for greater independence for those remaining at home.

On the other hand, this change will increase costs, since some persons not being institutionalized will benefit from therapy. In addition, not all home health agencies provide therapy services, even if the state made the services available, as thirty-two states do currently. Some agencies, however, might add therapy staff if assured of reimbursement.
C. EXPANDING ELIGIBILITY: MEDICARE AND MEDICAID

Issue 9
Expansion of Medicare and Medicaid benefits to include the frail, disabled, chronically and terminally ill, children and the developmentally disabled.

Discussion
All these groups are actually already entitled to home health services if they meet the eligibility criteria for Medicare or Medicaid. Under Medicaid, those who are frail (and over sixty-five years), blind, disabled or are dependent children in need of medical care and entitled to skilled nursing home services, have access to home health. If these individuals are aged, or disabled, require "skilled" care and are homebound, they qualify for Medicare home health services. Children, the developmentally disabled and all others who meet the eligibility requirements for Aid to Families with Dependent Children and Supplementary Security Income may now receive such services, although services are limited by the options permitted in the state Medicaid title XIX medical assistance plan. The real question is not whether to include such groups, but whether the eligibility restrictions for the entire medical assistance program should be removed, since presumably, eligibility would not be broadened for home health services only.

It is important, in determining program consequences and costs, to know what benefit package would be provided to these groups. If the benefit package provided a comprehensive array of services, the increase in cost might be considerable. In addition, it is not known how large the group of "frail" individuals currently ineligible for Medicare or Medicaid might be, and the implications for program costs. It must be assumed that the inclusion of these groups, irrespective of their eligibility for Medicare or Medicaid, constitutes a national health insurance program, and should be considered within that context.

Issue 10
Medicaid categorical and financial restrictions on eligibility.

Discussion
Under Medicaid, home health services must be given to the aged, blind and disabled "categorically needy" (cash assistance eligibles) and to the categorically needy under age twenty-one, if the state provides skilled nursing facility serv-
ices to them. Services must also be given to any groups of "medically needy" who are entitled to skilled nursing facility services. Services may also, at state option, be given to the categorically needy under twenty-one and to the medically needy, even if skilled nursing facility services are not provided. Services cannot be restricted to persons determined to need "skilled" services, or to persons in need of or being discharged from institutions. Federal funds under Medicaid may be used only for services to persons who meet federal definitions of age, blindness, disability, dependency (with respect to children) and specified income limits. Within these restrictions, states have certain options on further limiting eligible groups.

Keeping present restrictions would limit costs for home health services although overall Medicaid costs may increase. However, it would also force states to continue to pay the entire cost for general assistance recipients. Abolishing these restrictions would permit some persons needing home health services and not receiving them to benefit.

Mandating home health services for all Medicaid-eligibles would make these services available to more who need them. It would, however, increase costs for this service, contrary to statutory concept of state option under Medicaid. It may also be impractical, since an adequate number of home health agencies may not be available. Making federal matching funds available for home health services to all, without regard to categorical requirements and/or financial eligibility, would provide services to all who need them. It would relieve states of some financial burden. This action would, however, increase overall costs, and may be impractical, in view of limitations on available agencies.

D. EXPANDING SERVICES: ADMINISTRATION ON AGING ISSUES

Every State Agency on Aging plan must provide for establishing or maintaining programs (including related training) that offer some or all of four priority services to assist older persons in leading independent lives and avoiding institutionalization. One of the four priority services is home services including homemaker services, home health services, shopping services, escort services, reader services, letter writing services and other services designed to assist such persons to continue living independently in a home environment. Title III of the Older Americans Act encourages
State and Area Agencies to enter into new cooperative arrangements for the planning and provision of social services.

By definition, "social services" may include preventive services to avoid institutionalization. The following services have been identified as preventive services:

- periodic screening and evaluation;
- homemaker services;
- home health services;
- chore services;
- friendly visiting services;
- telephone reassurance services;
- protective services;
- housing assistance.

It should be noted that a study in Rochester, New York, found that of total admissions to nursing homes, 68 percent were private pay patients. Two years later, only 15 percent remained private patients, and all others were forced to become Medicaid recipients. This indicates the drain on assets of the elderly imposed by institutionalization.

The overall concern is whether AoA should expand its services and mandate optional services in order to:

- develop comprehensive and coordinated service programs for older persons;
- ensure the availability of supportive services that enable older persons to remain in their own homes as long as possible;
- remove individual and social barriers to economic and personal independence;
- provide nutritious meals in a congregate setting to reduce the isolation of older persons.

**Issue 11**

Expanding services by increasing appropriations to provide home delivered meals in areas where they are non-existent.

**Discussion**

Because homebound elderly persons are unable to shop for food or to cook, the need for home delivered meals to re-
duce illness and consequent institutionalization is acute. Home delivered meals would be less costly than providing home health aide services.

By increasing the appropriations under title VII, the additional funding could be earmarked for this particular service. It should be noted, however, that the intent of the law is to provide congregate settings which require people to leave their homes to socialize. We concur in this concept, but recognize that for the homebound, other forms of socialization must be considered. Consequently, in addition to increased appropriations, it may be necessary to amend the legislation to place emphasis on home delivered meals.

E. EXPANDING SERVICES: PROVIDERS

Issue 12
Availability of home health services.

Discussion

On a nationwide basis, there is a maldistribution of home health services. For example, approximately 700 counties have no home health agencies, although some counties are served by a number of agencies. Uneven availability of home health services is part of the larger problems of maldistribution of health professionals and medically underserved areas such as rural and inner city areas.

Home health care has frequently been viewed only as an alternative to institutional care, when in reality it is a discrete service in the total continuum of health care. It should be used when it meets the patient's need, without regard to institutionalization, just as institutional services should be used when they are the most appropriate means of care. Taking this broader view requires that there be a wide variety of providers in the community or that different kinds of health care agencies include home health in the services they offer. This could also have the effect of making the medical community more aware of the resources available and more willing to consider prescribing such care when appropriate. This would increase the number of qualified manpower capable of providing care.

Among the providers whose programs could be tied into services for persons confined fully or partially to their homes are nursing homes, half-way houses, day treatment centers, day care centers and multi-service centers. In particular, nursing homes (skilled or intermediate) offer a largely untapped,
but potentially valuable source of home care. They already employ or have available qualified professional and administrative staff who are skilled in dealing with conditions home care patients are likely to have, and who are trained in the necessary record-keeping, supervision of care plan and coordination with medical staff. Nursing homes can be found in areas where regular home health agencies do not exist or where the population in need is not adequately served. There is, currently, an incentive to nursing homes to begin offering home care, since the revenue will help compensate for beds that may be vacated as the emphasis on deinstitutionalization continues.

It can be assumed that unless options are given to long-term care facilities to continue to provide services to patients who no longer remain in their facilities, there will be little cooperation to improve the delivery system and to cut costs. It can also be assumed that those facilities will be interested in providing alternative services as a source of additional revenue.

A federal plan to encourage use of long-term care facilities and other agencies for home health could be developed. This would be especially important in those areas where there is a shortage of home health agencies. Publicity, technical assistance, demonstration projects and direct contacts with long-term care provider organizations could be used in such a plan. Special start-up money for this purpose could be used in selected areas of the country, and the results applied to encouraging additional long-term care facilities to enter this field.

### Issue 13

**Participation of proprietary agencies.**

**Discussion**

The Medicare statute requires that all for-profit home health agencies be licensed by the state in which they operate in order to participate in Medicare. To date (December, 1976), sixteen states have such licensure laws and forty for-profit agencies in California and in Louisiana participate. In the other states, only public or non-profit agencies may participate. One state specifically prohibits proprietary agencies from being licensed, while one state licenses only for-profit agencies. A total of sixty-eight proprietary agencies participate nationwide.

Medicaid has no statutory requirement with respect to the standards home health agencies must meet. By regula-
tion, all must be certified for Medicare participation, and therefore proprietary agencies cannot now participate in Medicaid in states without licensing laws. Under Medicaid, proprietary home health agencies as a group are the only vendors that are required to be licensed, based on their ownership status.

A change in Medicaid regulations was proposed in August, 1975, to allow proprietary agencies to participate in that program, whether or not the state had a licensing law (provided that the agency was otherwise qualified to participate). The proposal generated a storm of controversy centering on two main issues: (1) potential for fiscal abuse and (2) potential for quality abuse. Much of the opposition was based on the reports of such abuses by proprietary nursing home operators. No final decision on the proposed change has been reached. As indicated above, a change in Medicaid can be made by regulations; a change in Medicare provisions would require legislation.

In connection with the proprietary issue, it should be noted that another issue has developed relating to the participation of non-profit agencies. Some private not-for-profit agencies have been found to have excessive administrative staff, unusually high salaries or benefits for administrators and directors, luxurious equipment and furnishings, etc. It is possible that some of the same abuses attributed to proprietary nursing homes can be found in these agencies. Issues in this area are treated in the discussion of quality assurance, since the suitability of any provider may be more dependent on ability to comply with quality standards than on financial organization.

**Issue 14**

**Participation of single service home health agencies.**

**Discussion**

The Medicare statute requires all home health agencies to provide one service, in addition to nursing, and Medicaid regulations apply this Medicare standard. Thus, a small visiting nurse service, county public health nursing service, or homemaker-home health aide agency may not participate in Medicaid, even though it may be the only in-home agency in the county. Approximately 1,000 such agencies exist. Medicare permits an agency to provide the second service through arrangements with other providers. This resolves the problem if an agency offering the second service is accessible and willing to execute an agreement.

Many home health patients require only one service rath-
er than the range of services that a multi-service agency can offer. To deny participation to the small agency also denies a possible needed service to eligible patients. In areas where there is no qualified home health agency available, Medicaid allows a local, self-employed Registered Nurse to provide service. This is frequently insufficient to meet the needs of the eligible population. When the proposed Medicaid home health regulations were published on August 21, 1975, permitting visiting nurse or home health aide agencies to participate, a deluge of letters from larger agencies and their membership councils requested that single-service agencies not be permitted to participate, since they are "inefficient" and do not provide a comprehensive array of services. Consideration of the geographic location of many small agencies indicates that they are frequently able to provide a service that would not be available otherwise.

If the single service agency is approved, many new voluntary and proprietary agencies will be established. There is no guarantee that they will be located in areas of greatest need, such as rural and inner city areas. With the increased availability of service there will be an increase in demand for service, thus, escalating costs. On the other hand, it is very possible that persons who are now being admitted to nursing homes, because they are without supportive care, could remain at home providing a substantial saving to the taxpayer.

A phase-in, permitting single-service agencies to participate for one year in areas where no other agency exists, could be considered. Intensive consultation to help achieve certification provides some protection while expanding services. This would not help, however, if no personnel are available on a permanent basis in the area to provide the second service.

F. EXPANSION OF SERVICES:
AWARENESS OF SERVICES ISSUES

Issue 15
Overcoming lack of awareness and interest in home health services on the part of health professionals and the public.

Discussion

One indicator of the inadequate attention given to home health care by health professionals and providers is the fact that half of the Medicare certified home health agencies meet only the mandatory requirement that they provide nursing
and one other skilled service. Approximately half of the agencies employ fewer than three nurses. The lack of consumer and provider involvement with home health is suggested by health care authorities' estimates that about 25 percent of the patient population are treated in facilities with services exceeding their needs.

Furthermore, many elderly and disabled potential home health patients remain unattended in their own homes and receive no health care. Such patients invariably deteriorate to the level that hospitalization or nursing home confinement becomes necessary. The medical profession and the health care system are oriented primarily toward treatment of the acute phase of illness and do not offer a complete spectrum of health care by providing available alternatives to acute care, financing the alternatives and educating physicians and patients in their use.

Federal funding could be made available for expanded education of consumers, providers and payors. This educational process should describe comprehensive home health services, stress their value, provide guidelines for the development and integration of such services into existing health programs and develop, maintain, and expand in-service training programs to meet the health manpower needs of an accelerated program of home health services. Federal funding and technical assistance could also be made available to assist professional schools develop broadly-based training programs that fully educate future service providers regarding the benefits of home health care.

In addition, federal funds could be used to develop arrangements with community colleges and other continuing education facilities in order to establish a broader home health manpower supply. This avenue could assist in giving individuals engaged in the delivery of human services an understanding of the content and value of home health services, and develop skills that will support the effective organization and delivery of such services.
If the decision is made to expand home health care by taking one or more of the alternatives discussed in Section I, management and control of these services must be considered. Expansion could mean unanticipated increases in costs due to broader eligibility and covered services, further fragmentation of the health system and a decline in the quality of service.

A. COST CONTAINMENT ISSUES

Issue 16
Calculating Home Health Care Cost.

Discussion

Unfortunately, the consequences of home health expansion and its impact on other areas of the health care spectrum are unclear. The cost impact would depend upon the nature and extent of the expansion. For example, given the characteristics of the Medicare population—the aged and the severely disabled, many of whom exist at a poverty level—SSA believes it is reasonable to assume that such a drastic shift in the nature of the program could be expected to considerably increase the costs of the Medicare program. Practically all Medicare beneficiaries could be expected to “need” home health services, and it would be difficult, if not impossible, to place meaningful controls and limits on the use of such serv-
ice since, under the insurance concept, beneficiaries are "entitled" to the benefits, irrespective of the fact that family members may be able to furnish the services. In addition, SSA believes if the home health benefit were changed to provide a basis for the coverage of what are primarily social service needs, pressures would be created to meet similar needs for custodial care patients, whose needs can only be met in institutional settings. In short, such changes, while intended and directed only to the home health benefits, would have a ripple effect on the entire Medicare program, and all the consequences of such an action cannot be gauged at the present time. The combinations of actions that could influence the use of the Medicare home health benefit are numerous, and the consequence of each action is difficult to assess.

In addition to the difficulties of assessing the cost of specific actions to expand services, another problem in structuring a cost containment strategy is that cost data currently available do not supply the information needed to determine the actual costs of home health care. It is virtually impossible to determine the cost of a case as opposed to a visit, or the cost of caring for persons with certain conditions and functional limitations: in other words, it is impossible to obtain a patient profile except on the most gross average basis.

Home health cost data are generally limited to cost per unit of service provided, rather than total costs for care of a particular caseload. This is particularly true of Medicare, and Medicaid has virtually no data on costs. However, a number of efforts are underway to produce information on costs and use of home health services by several types of clients as described below:

- Past studies have attempted to show costs of various types of home care to various groups (see bibliography in Appendix).

- SSA is currently implementing a system to track clients over time using a 5 percent continuous case sample. The system will link cost, diagnostic and utilization data under Medicare for the first time. Current operating data on per visit and per service costs, etc., can be obtained from SSA.

- The Congressional Budget Office is estimating costs for various expansions of Medicare and Medicaid home health services.

- The Assistant Secretary for Planning and Evaluation is studying a long-term home health caseload for data on
use of home health and other health services, demographic characteristics, etc. While specific cost data are not being analyzed, it is possible, using standard methods, to determine what the services cost over time.

- Public Health Service Section 222 projects may yield some data on use and costs of homemaker services, and the effects of expanding that aspect of home care. Data on the range of home health costs will be available from the Connecticut Triage program (see page 95 of the Hearing Report).

- A joint New York Visiting Nurse Service/Regional Medical Program project is collecting data on its home care demonstration. The study goal is to determine the need for and cost of home care of homebound and chronically ill adults.

Current cost containment measures employed by Medicare are aimed primarily at controls on initial eligibility for home health services—"gatekeeping mechanisms" such as the three-day prior hospital, homebound, skilled nursing and other prerequisites. It is possible that, in lieu of these criteria, other methods could be employed to permit controlled expansion. An important assumption is that a policy objective may be to allow home health services to benefit more people in more ways, and not necessarily to limit costs. Cost controls are viewed as a means of governing expansion so that costs do not rise so drastically as to jeopardize funding mechanisms. Thus, "gate-keeping" controls may be an essential cost containment factor.

Rather than impose gate-keeping controls on potential clients, it may be more desirable and more feasible, to make use of other administrative mechanisms. These could include:

1. Reimbursement controls such as maximum costs and fees by providers, maximum salaries, fringe benefits, overhead expenses and service costs (incentive reimbursement, capitation and other methods may also be appropriate).

2. Utilization review based on a specific plan of care and goals may insure that only those needing specified services receive them (utilization review would include checks on physicians ordering services as well as on actual providers of home health care).

3. Periodic monitoring and review of client service needs to
determine that only the needed amount and type of care is being delivered.

4. Provision of technical assistance to providers in accounting and management to encourage maximum efficiency in provision of services and tracking costs.

B. COORDINATION AND PLANNING ISSUES

Issue 17
Coordinating and Planning Home Health Services.

Discussion
Currently, the delivery of health and related social services is seriously fragmented at the local level. Medicaid is administered and paid for through single state agencies located variously in umbrella agencies, social service departments, health departments or independent agencies. Social Services (Title XX) are handled by the Department of Social Services at the local level. Neither health nor social services alone will fill the need of the vulnerable population for whom they are intended. In many cases, one or the other element of care is missing. The California Auditor General found that at least 35 percent of the recipients of Title XX homemaker/chore services were also in need of more intensive health services. Community services such as health, social welfare and housing are available only through widely dispersed administrative and service mechanisms. Hospital discharge units are often ill-equipped to make appropriate referrals. People in need of home health care are not equipped to seek out and package the variety of services they need, and then identify various sources to pay for these services. This fragmentation reduces the efficiency and effectiveness of services, and often forces people to turn to institutions for needed comprehensive services.

A community coordination mechanism could package services and provide consideration of special needs of minorities, residents of rural and inner city areas, and those with special language barriers, and tailor them to meet individualized needs. Availability of services when and where needed would help individuals to maintain the maximum possible degree of independence in the community. Reimbursement for administering coordinated services would be provided by Medicaid, Medicare, Social Services and other local funding sources. Individual cost-sharing may also be used. Any federal program providing in-home services (Title XX, Older Ameri-
cans Act, etc.) should permit participants to pool their funds to achieve better coordination and coverage. Legislative change would be required to allow pooling of funds derived from various federal programs.

With the enactment of the National Health Planning and Resources Development Act, Health Systems Agencies (HSAs) have been established to improve access to care, while containing costs. Although considerable knowledge exists to determine the need for hospital beds and, by extrapolation, the need for nursing home and other institutional beds, methods for determining needed home health services are limited. Assistance is being given to HSAs in planning for home health services.

One planning mechanism with inherent regulatory authority is the Certificate of Need requirement. It is a tool to promote coordinated service planning at the local level, and some argue that it would encourage the integration of home health services with other health and medical services. Approximately twelve states have such a requirement. Currently, home health agencies are not subject to any qualitative or quantitative review at the local level. Unless an agency is certified for Medicare, there is no means of requiring agencies to conform to quality standards. Control of proliferation of home health agencies would also be achieved. For example, a state that does not require licensure of home health agencies has absolutely no control over the nature and number of agencies providing non-Medicare services to residents of the state.

Issue 18
Patient Access to Available Services.

Discussion

With careful planning, sufficient alternatives to institutional care and community cooperation, the referral of patients to a home health agency that is familiar with all community resources including transportation, clinics, day care centers and in-home services could be possible. Preventive care should also be an important component of comprehensive services. Services for the aged and handicapped must include care that, as much as possible, prevents "crisis" services that usually require institutionalization and have higher costs.

The certificate of need concept should include planning for and encouraging the development of this type of community care agency. It is assumed, however, that unless this
concept is promoted on the federal level, it will require years before states have sufficient resources to make the planning for and placement of individuals operationally feasible and economical.

QUALITY ASSURANCE ISSUES

Issue 19
Home Health Standards.

Discussion

There is no uniform national standard for quality care assessment, but several mechanisms act as quality control measures in delivery of health care. For example, the requirements of the Joint Commission on the Accreditation of Hospitals serve to upgrade quality of care and set a norm for performance. The standards established for nursing homes seeking federal reimbursement function in the same manner. Traditionally, states have used licensure requirements to assure the delivery of safe and adequate care. In the case of home health agencies, the majority of the states have no licensure requirements, and Medicare regulations prohibit certification of proprietary agencies in states that do not have a licensure law. Since there were many problems with proprietary nursing homes at the time the Medicare home health benefit was created, it was believed necessary to impose the restriction on providers with whom there had been no experience. A state may request the Secretary's approval to establish higher requirements, but fewer than six have done so.

Since both proprietary and non-proprietary agencies are participating in Medicare and Medicaid, it seems appropriate that uniform standards should be applied to all agencies that deliver care to the home, including homemaker agencies (homemaker agency standards were not reinstated in the revised Title XX regulations because of the block grant nature of the program).

Some state licensure laws are based on the Medicare standards that consolidate surveys for licensure and for compliance with regulations for certification purposes. With this great variation among states, it may be necessary to require common standards for all agencies that provide in-home services. With Medicare standards as an acceptable minimum, however, there is doubt as to the value of additional state standards, especially since the states have adapted and, in some instances, adopted Medicare "Conditions of Participation" for their licensure program. To require licensure, in ad-
dition to meeting the Medicare standards, adds little to the quality of care or safety of the patients. It will, however, require a legislative change for Medicare, even if legislation is not required by Medicaid. It would also assure a minimum standard for all agencies.

Proponents of different standards according to local needs and conditions are concerned that a single set of federal regulations may be too rigid to permit exceptions. For example, rural and sparsely settled areas usually have difficulty securing qualified personnel to staff agencies. A method of accommodating these problems would be to include regulatory provision for waivers and alternative ways of meeting requirements that pose no hazard to health and safety. In addition, the whole question of process standards, rather than outcome standards, is currently under study. It is difficult to know whether an agency that meets paper requirements is actually providing quality care without seeing patients and assessing their needs, observing the care that is given and evaluating progress toward mutually agreed upon goals.

Accreditation is another vehicle for assuring program quality. Accreditation is a voluntary action that an agency may request from a national accreditation body to show compliance with standards higher than minimum requirements set by a state or the federal government. The National League for Nursing (NLN) and the American Public Health Association (APHA) jointly sponsor a program to accredit home health agencies and community nursing services. Among the requirements to be eligible to apply for accreditation is the employment of five or more full-time nurses.

The NLN has published a proposed model for home health services delivery that lists basic essential services, other essential services and desirable services. Two classifications of home health programs are proposed in the model based on size of the population served, geographical area covered and whether services are offered directly or by contract. To date 3 percent of the Medicare certified home health agencies have been accredited by the National League for Nursing. The Social Security Administration is considering NLN accreditation as a substitute for the certification process on a limited basis under the authority given to the Secretary by Section 1865 of the Medicare statute.

Establishing federal standards that are equivalent to accreditation requirements would upgrade all agencies and be equitable in terms of standardized uniform requirements. Some areas, however, are not able to meet accreditation standards and there would be no service available. In addi-
tion, agency costs in securing accreditation can easily be used as the argument for requesting a higher reimbursement rate.

Other mechanisms developed to promote quality care are requirements for utilization review (UR) and Professional Standards Review Organizations (PSRO). While the federal program does not require UR in home health agencies, one state (California) enacted this requirement, and the former Health Services and Mental Health Administration funded a project to develop a utilization review program for home health agencies. The results of this study have been published and serve as a "how to do UR" guide. It is anticipated that PSRO concepts and practices will be extended to non-institutional services when this program is fully implemented and operational.

In some respects, however, the state's ability to monitor is actually more crucial than licensure, certification or accreditation. Since it is difficult to monitor care in patients' homes, the possibility of poor care, patient abuse or theft is greater than it might be in an institution. Additional standards with respect to the bonding of personnel and more frequent supervision of para-professional staff might be applied. It should be clear, however, that any agency interested in providing good care will set its own standards, and no superimposed standards will guarantee either compliance or quality care.

**Issue 20**

**Fraud and Abuse Controls.**

**Discussion**

Because of the individualized nature of home health services and the setting in which they are given, possibilities for fraudulent activities are numerous. Some of them are:

- duplicate billing for same service;
- billing for services not rendered;
- billing for higher level of care than actually given (e.g., RN rate for aide service);
- billing two programs (e.g., XIX and XX) for same visit under different nomenclature (home health aide/homemaker);
- providing more services than actually needed (including equipment); or
- "padding" claims for services under contract, or submit-
ting two claims for contractual service (one as home health service and one as specific contract service, e.g., therapy).

States may not have the capability to monitor a large number of new agencies in a manner sufficient to prevent fraud and abuse, harm to patients or poor quality of care that is likely to occur, based on the nursing home experience. Most states also do not have the necessary computer systems to generate profiles and norms that are essential to detection of fraud. Agency record-keeping, which is also vital, may not be of the caliber and level of detail required for fraud and abuse detection and could be the subject of appropriate regulation.

Home health programs could be included in ongoing fraud detection activities in HEW. This would not require substantially increased resources, and would insure that some attention is given to this program area. In addition, a special home health services initiative could be undertaken to provide technical assistance to states in developing computer systems. Special teams could be used to review home health programs in selected areas. This would require considerable HEW investment, but could be of significant importance as home health programs expand and greater crossover between programs (Medicare, Medicaid, Aging Social Services) takes place.

**Issue 21**

**Monitoring Supervision of Patient Care and Assessing Patient Needs.**

**Discussion**

With the potential growth of home health agencies, adequate safeguards must be considered for assessing patient need and agency personnel training, monitoring care and standards and supervising or managing home health cases.

Voluntary and governmental agencies have traditionally provided supervision for their staff, although their emphasis has been redirected from supervision of staff members to case management. Office review of records, case conferences and utilization review are quality control measures, but actual observation of patient care is an assured method for measuring compliance with standards.

Both consumer and ombudsman groups have offered to provide advocacy services to in-home patients, although this may not be wholly acceptable to providers for monitoring care and services in patients’ homes. Telephone monitoring with the patient or family when the aide is not present is
another method of determining the patient’s satisfaction with the aide’s service. This approach is less directed toward ascertaining the quality of care than identifying possible fraud and abuse. Random home visits by non-agency personnel, state agency medical review or survey agency personnel might also be methods for assessing the care an agency is providing. More careful consideration of supervision and monitoring may also be required if more proprietary agencies are permitted to participate in Medicare and Medicaid.

It can be assumed that the quality of care is more closely dependent upon supervision of care by staff than meeting paper requirements for participation. The amount of time required to provide on-the-job training for new personnel can be considerable. To expect proprietary or private not-for-profit agencies to train staff adequately or observe patient care without being reimbursed may not be realistic, since voluntary and public agencies are finding the cost of supervisory visits to be increasing. Proprietary agencies tend to cut costs, and one of the first economies may be to reduce the number of supervisory visits. Adequate performance standards for staff are essential, but supervision of the care is the most important element of quality care.

The following alternatives might be considered:

Emphasize supervision of patient care and case management for quality assurance rather than supervision of aides.

Provide for medical review-type teams or survey teams to make home visits on a sample basis.

Provide ombudsman services to patients receiving home health services.

These emphases would assure safer and higher quality care than is currently possible, since without on-site visits there is no assurance that care is adequate. It should be noted, however, that patient bill of rights regulations provide for privacy, and having outside agencies and individuals enter patients’ homes interferes with this concept. In addition, state agencies do not have the staff to make the required home visits, and the cost of such visits could be prohibitive.
Issue 22
Training for Home Health Agencies' Staff.

Discussion

Consideration of training efforts at any level must include the following:

- Maintaining and improving care;
- Efficiency and cost effectiveness;
- Increasing capacity to provide service.

The most efficient way of achieving these goals must be identified, and emphasis placed on producing better administrators, training new workers and new types of workers and renewing skills of those who may have been away from the work force.

Title XX supports training for provider service delivery personnel, certain individual providers and state agency staff. Training grants can also be awarded for continuing education, or for developing or improving training programs. Congress has recently authorized $3 million for training purposes through P.L. 94-460 for FY 1977, although no appropriation has been made to date.

There can be little improvement in the administration of home health agencies without specialized training for administrators, directors and supervisory staff. In order to increase the numbers of participating agencies, it will be necessary to bring those agencies to a level to meet Medicare standards, and personnel training would be a first step to meet this need. It can also be assumed that unless cost effectiveness can be achieved, home health services will no longer be an acceptable alternative for inappropriate institutionalization.

It should be noted that problems related to surveyor training differ from training agency personnel. A key element in determining compliance with standards that are designed to measure agency capability to provide safe and adequate care rests on the competence of the surveyor who visits the agency and surveys the total operation. Unprepared and inexperienced surveyors cannot be expected to understand the complexities of a home health agency, or to assist an agency struggling to comply with requirements. Efforts have been made to train and educate surveyors, but state salary scales in general do not attract the better qualified persons.

It is likely that physicians will not increase their home
health care referrals unless efforts are made to acquaint them with the advantages of home health services. Actions in this area might include:

Additional physician training to acquaint them with the value of home health services.

Additional training of nurse practitioners and physician extenders.

Training new workers at all levels below medical school (i.e., increase the number of nurses, therapists, social workers, aides, etc.).

Training home health agency administrators, homemakers, homemaker/home health aides, companions, chore worker, escorts, etc.

Recruiting and providing refresher courses for individuals who have left the field or have been unemployed.

Additional surveyor training.
APPENDIX A:

Summary of Legislation and Regulations
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| Title XVIII of the Social Security Act. (Medicare). | Under Section 1812, program payment can be made for visits to homebound beneficiaries under a physician's plan of treatment for part-time or intermittent nursing care, physical, occupational, or speech therapy, medical social services, part-time or intermittent services of a home-health aide, medical supplies, medical appliances, and outpatient services arranged by a home-health agency and a hospital, skilled nursing facility, or rehabilitation center. | Part A Requirements
1. Age 65 or disabled.
2. 3 day stay in participating hospital.
3. For further treatment of condition treated in hospital or SNF.
4. Need for part-time skilled nursing, physical therapy or speech therapy.
5. Homebound.
6. Physician determines need for care and establishes plan of treatment within 14 days after discharge from hospital or SNF. | Home Health Agencies must be in compliance with Federal, State and local laws. Conditions of participation range from the type of services (e.g., an HHA must include part-time intermittent skilled nursing services and one other specific service), to administration and professional personnel requirements. | Subpart L—Regs #5—Conditions of Participation
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<td>Under Section 1812 (a) (3) up to 100 Part A visits per benefit period can be made, but beneficiary must have been an inpatient in a hospital for at least 3 days or have received covered services in a skilled nursing facility for a period not exceeding 1 year from the date the home health plan is implemented.</td>
<td><strong>Part B Requirements</strong> 1. Age 65 or disabled. 2. Need for part-time skilled nursing care, physical therapy, or speech therapy. 3. Physician determines need and establishes plan of treatment. 4. Homebound. 5. Home Health Agency participating in Medicare.</td>
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## Summary of Legislation and Regulations—Continued

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<td>Title XIX of the Social Security Act (Medicaid).</td>
<td>Under <em>Section 1905 (a) (7)</em> Home Health care services are mandated.</td>
<td>All “categorically” needy individuals over age 21, all “categorically needy” individuals under 21, if the States covers them for skilled nursing facility care; and all “medically needy” individuals eligible for skilled nursing facility services.</td>
<td>Home Health Agencies must be Medicare certified or be medical rehabilitation centers meeting the standards in the regulations.</td>
<td>45CFR 249.10 (b) (7) (III) defines the required services as: nursing services, home health aides, and medical supplies, equipment, and appliances; and may make available: physical therapy, occupational therapy and speech pathology/hearing therapy.</td>
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<td>Title XX of the Social Security Act (Social Services).</td>
<td>No section of the legislation mandates inclusion of home health services.</td>
<td>All “categorically” needy eligible individuals plus Medicaid eligible, and income eligible.</td>
<td>Social Service agencies at the State and local level.</td>
<td>Regulations do not require any specific home health service to be included in the State plan but at least one type of Home-Based Service is included in all State plans, and Home-Based Services may in-</td>
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<td>Titles III and VII of the Older Americans Act of 1965.</td>
<td>Under the Area Planning and Social Services (Title III) allotment to the States, home services must be one of four priorities.</td>
<td>Title III—No set age limits are established under these provisions of the Act, however, the Act generally applies to the age group 60 plus. Title VII—Those persons who are aged 60 and over and their spouses regardless of age are eligible to participate in the Title VII programs.</td>
<td>Each State Agency on Aging must divide entire state into planning and service areas and designate Area Agencies on Aging for Coordination of services. There are presently 521 Area Agencies covering 90% of the nation’s persons aged 60 and over.</td>
<td>Title III-45CFR Part 903—Grants for State and Community Program on Aging. Title VII—45CFR Part 909 Nutrition Program for the Elderly.</td>
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APPENDIX B: Home Health Care Updated Bibliography
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<td>Title VIII of the Older Americans Act of 1965</td>
<td>Under the Area Planning and Social Service Board</td>
<td>All older persons of the State, however, applicants must be one of four priority areas</td>
<td>Title VIII—No set eligibility: Area Agency on Aging must divide on-</td>
<td>Title II: 42 CFR part 90—Grants for State and Community Planning and Area Agency. Title VII: 42 CFR part 60—Nutrition Program for the Elderly.</td>
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This study was undertaken “to study the feasibility of a statewide plan providing alternatives to nursing home care.” Recommendations included “legislation to facilitate the development and funding of the full spectrum of care; the encouragement of budgetary systems . . . ” Cost figures are included.


A research report with findings and recommendations for community care for the elderly as an alternative to nursing home care. Includes cost estimates for a pilot community care project. This report was prepared for the State of Florida, Department of Health and Rehabilitative Services by the Research Programs in Social Policy and the Aging, Department of Urban and Regional Planning, The Florida State University, Tallahassee, Florida 32306.

Burt, Marvin R., and Blair, Louis N. *Options for Improving the Care of Neglected and Dependent Children*. Nashville-Da-


Callender, Marie and LaVor, Judith. "Home Health Cost Effectiveness: What are We Measuring?" Medical Care 14:10.


Within this paper is a model for a public system of services to address the personal care needs of the severely disabled. Included are issues such as the population to be served, eligibility for benefits, the form of benefits, administrative structure, and financing.


A descriptive study which demonstrated the “importance of having homemaker service directly available as part of a comprehensive hospital care program.” Address of Community Service Society: 105 East 22nd Street, New York, New York 10016.


In this one year study, one hundred elderly patients, half receiving home aide service after hospitalization, half not, were compared as to containment, institutionalization and survival.

Pfeiffer, Eric. "Alternatives to Institutional Care for the Older


Trager, Brahna. Adult Day Facilities for Treatment, Health Care, and Related Services. A working paper presented to


